

# Overcome Street Homelessness

## Initiative

Establish Citywide Outreach/Drop-In Center Coordinating Council

## Background/Context

A Citywide Interagency Council should be created to guide and coordinate the policy and practice of providers and city agencies engaged in outreach and drop-in services. The Council will have the responsibility of assuring that the defined roles and responsibilities of the providers and city agencies are met, are consistent with established performance measures and agreements, and are at desired levels of quality. The Council will use transparent and readily understandable measures of performance to monitor effectiveness to achieve the goal of ending street homelessness.

There has been an absence of a systematic approach to the coordination of and communication between Outreach and Drop-In Center programs that operate under separate funding streams. This results in duplicative efforts, lost client opportunities, and poor resource usage. There is a consensus among stakeholders that overcoming chronic homelessness requires a coordinated, accountable and quality-controlled service delivery system to replace the fragmented one that currently exists. Identifying stakeholders will enable critical agencies to establish concrete goals for council.

This initiative will provide a pragmatic and structured approach to reach the goal of ending chronic homelessness within a set time period. Annual decreases in street population will allow for planned reinvestment of resources currently spent on chronic street homelessness.

## Critical Partners

Key members of the Council will include representatives from DHS, DOHMH, MTA, HPD, OASAS, NYPD, and DOC.

Government agencies involved with the street homeless population will also be consulted:

NYC: HRA, FDNY/EMS, Parks Dept.

NYS: OMH, OTADA, DOH

Feds: VA, DOL, HHS, SSA

Additionally, partnerships will be created with the Business Improvement Districts, service providers, consumers, and advocacy communities. Partners will be engaged through an inclusive, collaborative planning process that involves representatives from the areas of policy, planning and practice.

## Timeline

Most of the elements in this initiative can be accomplished in the short term, with only a few requiring a longer time-frame. The process of generating a 10-year plan to end chronic homelessness has already galvanized many of the major stakeholders. However, the sheer number of agencies may require a longer time-frame once the initial consensus is achieved.

# Overcome Street Homelessness

## Initiative

Reconfigure Outreach Services

## Background/Context

This initiative will reconstruct the nature of outreach programs by developing them into professionalized multidisciplinary teams with a prominent peer component, and offering comprehensive and integrated treatment for co-occurring disorders (substance abuse, chemical dependency, mental health, and medical, particularly HIV, issues) along with rehabilitation services. These teams should be borough-based and as closely linked to their community as possible. They must also be able to adapt to changing conditions on the streets via programmatic update and modification, as indicated by ongoing surveys and research.

Require outreach teams to provide:

- 24-hour team-based case management
- geographic flexibility and access to all sites where homeless people congregate
- up to date communications and clinical record-keeping systems
- low-demand respite capacity (onsite, faith-based, or drop-in center beds)
- ease of access to transitional and permanent housing beds
- linkage to mobile or otherwise easily accessible medical/psych/detox units
- collaborative relationships with NYPD and mental health and substance abuse service providers

Historically, outreach programs have not utilized a case management approach that is supported by clinically trained staff and resources. The absence of a uniform information system also hampers providers' efforts to track their clients, work collaboratively and avoid costly and time-consuming duplication of efforts. Different funding streams have shaped programmatic approaches without attention to overlapping client bases and client profiles.

This model targets chronic street homelessness among people with severe psychiatric and co-morbid disorders, emphasizes multidisciplinary outreach, focuses on housing stability, and leads to reinvestment of resources by allowing program staff in outmoded models to be reallocated. Providing more precise details of outreach services desired will allow agencies to evaluate their programs in light of these standards. Parts of this recommendation are currently employed by city-funded outreach programs – notable exceptions are a common information system, and coordination between teams covering overlapping catchment areas.

## Critical Partners

Critical partners include city and state agencies, like HHC, NYPD and the MTA, along with service providers and medical providers, including HIV providers.

Consumers, advocates, and academic/research institutions will help to provide data on program quality. The various partners and stakeholders will be engaged through routine practitioners' meetings, quarterly practice forums and research activities. Consumer input will be gathered through surveys conducted by academic and research institutions and recommendations will be integrated into regular practice.

## Timeline

Because some city-funded street outreach programs have already begun implementing similar initiatives on a smaller scale, most elements of this initiative can be achieved in the short-term – up to 18 months – with adjustments completed by the midterm (within 4 years).

# Overcome Street Homelessness

## Initiative

Create an Accessible Citywide Clinical Database

## Background/Context

A citywide database providing historical information on homeless individuals who have been served in the past will allow all outreach providers, hospital emergency departments, and city agencies to interact in a cohesive manner. Information would include demographics, lodging and housing history (including incarceration), and clinical information (including medical and psychiatric information). Access to information on prior homeless episodes can also lead to the prevention of re-homelessness if agencies are aware of such history when coming into contact with an individual.

There is no information management system or database that collects information about homeless individuals receiving services from drop-in centers, outreach programs, hospitals or other city services. Sharing information or gaining complete information about a client is largely a matter of personal and institutional contacts, and may or may not result in a provider getting access to the most useful or most recent information about a homeless individual. Many street-dwelling homeless individuals do not stay in one fixed location or area, and may thus be contacted or served by more than one (or even many) different service provider(s). This duplication of effort not only slows, but may actually damage the engagement process – targeted information sharing is critical in working with a chronically homeless street population. A uniform database will improve direct service and evaluation efforts and it will assist the effort to set measurable goals that emphasize effective outreach.

Next steps will involve creating a template for the database – agencies will be able to adjust data-gathering procedures to mesh with the proposed database well in advance of its implementation. There are client consent and regulatory issues (e.g. HIPAA) concerning client confidentiality that may be barriers to implementing this initiative.

## Critical Partners

Critical partners include the various city agencies, including HHC, DOHMH, and DOC as well as Corporation Counsel, service providers and advocacy groups.

Consumers, advocates, and local communities can assist in notifying city agencies of people living in public spaces. The most significant engagement tool for the City will be the database itself and the ability of all the stakeholders to have a hand in creating it and in defining its use.

## Timeline

This initiative can be accomplished in the mid-term because of the need to coordinate among many stakeholders and resolve confidentiality requirements.

# Overcome Street Homelessness

## Initiative

Expand the Capacity of Drop-In Centers

## Background/Context

The capacity of drop-in centers with respite capacity/safe havens should be expanded to provide low-threshold access and integrated services to homeless individuals unwilling to enter shelters, and secure funding sources to sustain this model of homeless engagement and care should be established. These programs afford an alternative pathway for homeless people seeking services, but unwilling to access shelter. With a full complement of social and medical services, and access to system resources, they successfully out-place clients.

Drop-in centers were developed in the late 1980's and early 1990's in response to a growing street population that was increasingly resistant to entering the shelter system. This model enables outreach providers to effectively engage chronically homeless individuals living in public spaces and help them move towards permanency. This model builds on the engagement process initiated by outreach by meeting the clients where they are, and then slowly introducing increased demands. It also permits an individual to remain in a program if s/he experiences a relapse.

Identifying criteria for such programs will give agencies the opportunity to research, propose, develop, and implement flexible models that reflect changing customer needs. Finding viable locations for such programs remains a challenge, as does a finding stable funding stream.

## Critical Partners

DOHMH, DHS, HHS, and service providers are all critical partners in this effort.

Advocates, consumers, and the community will provide feedback and input. Engagement of critical partners and stakeholders can be accomplished through information sharing that highlights the model. Milestones, achievements, inputs and measurement of outcomes will be solicited and will enhance the providers' ability to share best practices.

## Timeline

This initiative will be accomplished in the mid- or long-term. Existing drop-in center program models can be modified by new program additions, as can models already in the planning stages.

# Overcome Street Homelessness

## Initiative

Expand “Housing First” Options for Those on the Street

## Background/Context

Developing a housing-first model that wraps supportive services around a scatter-site apartment, single room, or other rooming house model and provides a range of housing options will eliminate the need for some chronically homeless, street-dwelling individuals to enter the shelter system in order to gain access to housing. Some proportion of this housing should be targeted to outreach and drop-in center providers, and to undocumented individuals.

Different members of the chronically homeless population have different needs – for example, those with chronic substance or alcohol abuse, versus those with serious medical and mental health issues. Historically, housing has not been available directly to the street population, who are best served by no-demand or low-demand permanent housing with access to services. This initiative will help reduce chronic street homelessness and shrink the shelter system. It will make housing a realistic opportunity for those who are currently living on the streets. Housing-first is an established, tested, effective model for the service resistant. It recognizes different levels of housing readiness and reduces demands on the client to a level that is more easily attainable.

## Critical Partners

The City, State, and Federal Government, housing and community development agencies, and health and human service agencies all play a critical role in this initiative.

Additional partners include housing finance agencies, NYCHA, community-based providers, non-profit and affordable housing developers, and financial institutions and intermediaries. The consumer is also an important stakeholder in that the consumer’s participation will help guide the initiative. Engagement will occur through collaborative planning efforts and informal sharing activities.

## Timeline

This initiative can be accomplished in the mid- to long-term timeframe, although some providers are in the start-up phase of implementing similar programs.

# Overcome Street Homelessness

## Initiative

Expand Transitional Programs with Low Threshold/Progressive Demand

## Background/Context

This recommendation consists of a collection of models designed to help homeless people living in public spaces who are resistant to services and who have not taken advantage of or benefited from homelessness prevention efforts. This could include drop-in centers with on-site (or easy access to) respite beds, shelter-based harm-reduction models (including components that gradually phase in demands on the consumer), or service models that are tied directly to housing or long-term drug or alcohol rehabilitation.

Historically, people who are not ready for services or unable to maintain sobriety in order to access services tend to remain on the streets. Traditional shelter services require direction and motivation by the client toward a long-term goal that is often overshadowed by the client's current circumstances. Moving services closer to the immediate needs and daily realities of the clients offers a greater hope for continued engagement and more effective long-term housing placement. It will increase the ability of service providers to convince street-dwelling homeless people to come indoors by providing an array of programs that address their needs in a concrete and immediate fashion. Using a variety of models will enable homeless service providers to match programs with populations and/or geographic areas to find and measure the most effective combinations. Some models may contain elements of harm-reduction strategies that concentrate on reducing destructive behavior gradually, rather than requiring strict behavior standards.

## Critical Partners

City Government (DHS, DOHMH) and service providers are the key players required to implement this recommendation.

Academia and consumers will need to provide input on program efficacy and usage. By creating these programs, the City will automatically engage the network of service providers desiring such an approach, as well as the consumers who may benefit from it. Local communities will be engaged by the decrease in public homelessness.

## Timeline

Some pilot programs may be able to begin in the short term, but many will require a mid-term time-frame. Finding sites for homeless service programs is often difficult.

# Overcome Street Homelessness

## Initiative

Decentralize Men's Intake

## Background/Context

New, smaller intake sites will make access into shelter for street homeless, service-resistant men more convenient, less overwhelming, and less threatening. These sites should feature a user-friendly design, a computerized bed reservation system, and enhanced staffing models that will expedite placement and/or diversionary activities.

Decentralizing men's intake further affords the agency the opportunity to explore new directions in the physical design of the new intake centers. Greater consideration can be given to end-user considerations such as new spatial adjacencies to improve interior circulation, program-friendly interior textures and surfaces, comfortable and durable interior furnishings for clients and staff and, most importantly, increased interior flexibility to accommodate agency changes in adult intake policy and direction for years to come.

Historically, chronically street homeless men with mental health issues have been resistant to and/or intimidated by the intake site, which is co-located with a large shelter. The Men's Intake Center at 30<sup>th</sup> Street in Manhattan has traditionally been perceived as threatening, partially due to the large number of consumers who receive services there. Outer-borough outreach providers have long identified the lack of access points in the boroughs as a barrier to movement off the streets. Decentralization will help agencies more effectively engage the chronically homeless, service-resistant street population and increase access to the shelter system.

## Critical Partners

DHS proves to be the main partner responsible for the implementation of this initiative, but consumers, advocates, and the community are also important stakeholders. Increasingly consumer-friendly intake services will help to enhance the engagement process and encourage chronically homeless men to seek shelter.

## Timeline

This initiative can be fully accomplished in the mid-term with a phase-in process that begins in the short-term. Capital funding is available to assist with its implementation.

# Overcome Street Homelessness

## Initiative

Conduct Citywide Street Estimate Annually

## Background/Context

This is an initiative to inform policy decisions on chronic street homelessness and to evaluate the impact of these decisions. Presently, an estimate of the size of the street homeless population throughout New York City, or how it has changed over time, does not exist. The lack of a citywide estimate has been a barrier in evaluating the impact of new outreach programs and policies.

The Homeless Outreach Population Estimate (HOPE), recently established by DHS, is a point-in-time estimate of the unsheltered homeless population that is conducted annually on the last Monday in February. HOPE is conducted with the assistance of hundreds of volunteers who are trained and sent out in teams to canvass selected areas of the City to obtain an accurate count of the unsheltered individuals in their area. HOPE 2003 covered Manhattan. HOPE 2004 was expanded to include Brooklyn, Manhattan, and Staten Island. In 2005, HOPE will expand citywide.

By establishing an annual benchmark, DHS and its partners will be able to measure the effectiveness of various initiatives aimed towards overcoming chronic street homelessness. Through volunteerism, HOPE is engaging communities to join the City in its efforts to overcome chronic street homelessness as well as educating communities on this vulnerable population and the services that are available to them.

## Critical Partners

Critical partners include DHS, NYPD, MTA, Department of Parks and Recreation, non-profit outreach providers, and community organizations. All of these partners contribute information on the anticipated density of unsheltered homeless individuals in study areas. This information determines which areas are included in the survey. Additionally, they provide staff that lend their services and expertise on the night of the survey.

The main stakeholders are the clients. They provide the information through annual surveys and outreach. Clients are given the opportunity to accept services on the actual night of the survey. Other stakeholders include volunteer organizations, universities, the faith community, and all residents of New York City who can participate and contribute to this extraordinary effort by volunteering their time.

DHS has already engaged many of these partners in order to accomplish HOPE 2003 and HOPE 2004. Citywide expansion will require further engagement. Possible opportunities for engagement include public service announcements and presentations to universities, the faith community, and volunteer organizations.

## Timeline

This initiative can be achieved in the mid-term (within 4 years). Repeated estimates are necessary to develop a clear understanding of changes in the magnitude of the street homeless population and evaluate the impact of policies to reduce street homelessness. Four repeated estimates will assist in an evaluation of programs. The next citywide estimate will be conducted within 12 months and would require at least one more repeated estimate to evaluate the success of various programs.

# Overcome Street Homelessness

## **Initiative**

Create Community Estimates and Targets, with Accountability Mechanisms

## **Background/Context**

This initiative will develop community/neighborhood-level estimates of the size of the street homeless population. Targeted neighborhoods will include those with a high concentration of street homeless individuals as indicated from the annual Homeless Population Estimate (HOPE). Annual targets to reduce homelessness will be set. The target setting should be client-based. This will allow the question, “how many clients were on the streets in your community, and how many were housed in permanent or temporary housing?” It is important for providers implementing the neighborhood-based policies to cooperate, share resources, and provide adequate data.

Accountability mechanisms for outreach providers will be developed around these targets. The street homeless population is usually a transient population. As a result, decreases in street homelessness in a particular neighborhood may not be directly due to placement into housing, but due to individual movements to another area without services. Therefore, measuring target successes will be difficult.

## **Critical Partners**

City agencies, outreach groups, community based groups, and DHS program and research staff are all critical partners in this initiative.

Clients must be engaged in the selected neighborhoods to encourage them to accept services. Critical partners can be engaged through regular workgroup meetings. It is vital that community-based groups and outreach groups that will implement the programs agree with research staff on what data they will collect and provide to research staff prior to the design and implementation of programs.

## **Timeline**

Targets can be set and developed in the short-term (within 18 months). However, measuring the success of these targets will take much longer.

# Prevent Homelessness

## Initiative

Implement Community-Based Prevention Services

## Background/Context

This initiative creates and implements a community-based system to deliver prevention services to households at-risk of homelessness (including families, single adults, and adult couples without children). Prevention services are provided by community-based organizations funded and managed by DHS. Historically, shelter was seen as the primary service intervention to assist households with housing instability; other interventions (rental assistance, anti-eviction legal or mediation services, casework to strengthen families, and other skill-building services) were offered on a very limited basis, if at all. To initiate a prevention focus, DHS has begun to fund community-based prevention services to six communities which have historically experienced a high rate of homelessness. Expanding this approach to provide community-based prevention services throughout New York City will provide the assistance needed by households who are either experiencing a housing crisis or those whose housing difficulties are just developing. By providing this service as an alternative to shelter, there will be less demand for shelter in the future. The immediate next steps, to deliver and evaluate the service to the six chosen communities, will lay the groundwork for the future expansion.

## Critical Partners

The critical partners to accomplish this goal are the community-based prevention providers, DHS and other City agencies (HRA, NYCHA, ACS, HPD), that will need to collaborate to facilitate the work of the providers.

The other stakeholders, which include other community-based agencies and treatment providers, landlords, and the Housing Courts, will need to be supportive of the providers to ensure their effectiveness. These other groups should be engaged through workgroups that meet regularly to discuss and resolve systemic issues and through liaisons for the community-based providers to handle individual household issues.

## Timeline

The community-based prevention services to the first six communities will begin in the very short term, and evaluation of their work can be accomplished within 18 months. Immediately thereafter, DHS will procure additional providers to expand the initiative throughout the City.

# Prevent Homelessness

## Initiative

Introduce Innovation to Housing Court to Focus on Homelessness Prevention

## Background/Context

An integrated service model in housing court should be created to prevent homelessness and improve case management practices for agencies serving the same client (including both tenants and landlords). Community court models that stress mediation can be examined. Coordinated efforts to share client data would be pursued where benefit history and eligibility from NYC agencies can be facilitated.

Currently, it is often difficult to resolve cases in housing court in a timely manner due to the inability of the resident to navigate the various City social service agencies to obtain proof of income or to access all benefits for which the client is eligible, which might maintain that client in the current residence. Coordination of the various agencies serving low-income tenants is critical in reducing homelessness resulting from eviction.

In 2003, there were over 350,000 filings and 23,000 evictions in the New York City Housing Court. Although not all those evictions resulted directly in homelessness, many of those who find their way to housing court are at-risk of homelessness at some point in the future due to precarious living situations.

## Critical Partners

United Way, Housing Court, DHS, DHCR, HPD, NYCHA, HRA, and HRA-APS are the critical partners. Legal service providers might also play a role in providing legal services in some fashion to this targeted population. Each of these agencies will need to explore ways of sharing client level information with each other in a timely fashion and will also explore the possibility of expeditious processing of services.

## Timeline

Within the first 18 months, an initial phase of operation may be set up, but creating an integrated database will require additional planning time.

# Prevent Homelessness

## Initiative

Expand Aftercare Initiatives

## Background/Context

This initiative will expand the provision of community-based aftercare services to families, adult couples without children, and single adults leaving shelter. Aftercare services help former shelter clients stabilize in their new housing and in their new community. Historically, aftercare services have been provided on a voluntary basis to only a very limited number of high-risk families leaving shelter. Additionally, the linkage to aftercare services has often been made after the family has already left shelter and is in their new home. The expansion of community-based aftercare services to be a mandatory service, that is attached to a permanent housing placement and made while the client is still in shelter, should result in a significant reduction in the number of clients who return to the shelter system. Furthermore, the improved evaluation of the effectiveness of the aftercare service will lead to better targeting and modeling of the service. The next steps are to study how to increase aftercare effectiveness, to promote best practices among all aftercare providers, and, most importantly, to expand the provision of the service to all clients deemed in need.

## Critical Partners

The critical partners are DHS, aftercare providers, OTDA, and shelter providers.

Additional stakeholders include other community service providers and city agencies that assist aftercare clients to obtain the services they need to remain housed (HRA, NYCHA), in addition to landlords and Housing Court. Building on current work, the partners can continue to be engaged through shared reporting on aftercare services, monitoring to ensure service delivery, shared evaluation of outcomes, and increased funding for the service expansion. The best methods to achieve this are regularly held meetings to discuss issues of joint concern and the publication of an outcome report to all interested parties.

## Timeline

This initiative can be accomplished in the short term although some amount of time is needed to procure the expansion of services and regularize the evaluation and reporting of outcomes.

# Prevent Homelessness

**Initiative**

Provide Brief Legal Services

**Background/Context**

This initiative will promote the provision of brief legal services to assist tenants experiencing housing problems (including, but not limited to, evictions and holdovers) so they prevail in a housing court proceeding or gain enough time to relocate. The brief service can consist of any short-term legal assistance, such as drafting a document, negotiating with a landlord, or providing guidance on how to represent oneself in housing court. Many housing court actions that involve landlords seeking to evict tenants based on non-payment of rent involve fairly simple legal positions being asserted while the arrears are being worked out. The expanded use of brief services leverages the limited funding and staffing available to provide legal assistance and helps to balance the playing field where most landlords have full legal representation in housing court while most tenants do not. This should lead to a significant increase in the number of tenants who retain their housing, as well as the retention of affordable housing,

**Critical Partners**

The critical partners are DHS, legal service providers, and the Housing Courts.

Other stakeholders are HRA and other community-based agencies that will refer clients for brief services. The partners should be engaged through provider meetings to promote best practices and discuss program outcomes and effectiveness.

**Timeline**

This initiative can be accomplished in the short term because some amount of time is needed to procure the expansion of services and routinize the evaluation and reporting of outcomes.

# Prevent Homelessness

**Initiative**

Include HRA Adult Protective Services (APS) as a Full Partner in Targeting Prevention Service

**Background/Context**

Services with APS should be coordinated to develop a full array of interventions to prevent homelessness, including for individuals ineligible for APS. Homelessness prevention for APS special populations should be strengthened, including those for senior citizens, adult dependent children, and developmentally delayed individuals. Connections with community-based service networks should be explored for homelessness prevention activities for the 90% ineligible APS referrals. Additional financial management tools and services should be researched and developed for clients who are able to remain independent in the community, but are unable to manage their finances.

Those who are referred to APS are likely to be at-risk for homelessness and, therefore, are an excellent target population for services, even if they are ineligible for the current array of APS services.

**Critical Partners**

DHS and HRA – Adult Protective Services (APS) are the critical partners. Community-based providers would also be stakeholders, if the City decides to develop a community-based service network for homelessness prevention activities for the ineligible APS referrals.

**Timeline**

The timeline is 3-5 years.

# Prevent Homelessness

**Initiative**

Implement Standards of Client and Provider Responsibility in Prevention Interventions

**Background/Context**

The prevailing belief is that most clients will willingly utilize prevention programs to help them avoid homelessness. However, some clients will refuse prevention services and exacerbate their housing crisis, precipitating a need for shelter. To prevent clients from becoming homeless through inaction – for example, failing to respond to an eviction proceeding in an apartment that the client no longer desires – prevention programs must include standards of expectation of reasonable, responsible behaviors for clients. This recommendation is necessary to enable the City's prevention strategy to have the maximum impact on demand for shelter and engage every client in efforts to prevent homelessness. This expectation may be particularly critical in aftercare services for at-risk clients leaving shelter.

**Critical Partners**

Prevention and shelter services providers will need to be engaged and their staff trained. Additional prevention services may be needed to service all clients citywide. Housing court must be made aware of the prevention program in order to disseminate the information to clients facing legal challenges.

**Timeline**

This initiative can be accomplished in the mid-term range.

# Prevent Homelessness

## Initiative

Enhance Client Involvement and Self-Advocacy

## Background/Context

Clients must be an integral part of policy-making at all levels, from developing the rules and regulations of local community and city programs that impact services to influencing how the government decides to administer assistance to the public. The process of client engagement is a multi-layered project, which involves the training of clients, providers, and governmental agencies until the practice becomes integrated into everyday activities. Client self-advocacy must be implemented into the community-based network and the government system as a philosophy for worker/client interaction. When clients are able to advocate for themselves, and the service culture is receptive to client participation, individuals will be able to improve their ability to communicate and navigate bureaucracies in order to obtain the services they require to avert crisis through prevention and/or expedite the move to permanency.

The proposal to engage in client self-advocacy advances the ten-year plan by eliminating the need for seeking shelter and minimizing people's experiences with homelessness.

Client participation has been historically low, mainly due to resistance from those offering services and creating policy. The range of reasons have included such factors as urgency, where time may not allow for client involvement, to staff members who do not understand the value of client empowerment and feel the need to retaliate against those who advocate for themselves. Additionally, the culture of some agencies may conflict with the principles of client self-advocacy and engagement. Decision-makers need to see clients as equal partners and not as adversaries.

## Critical Partners

Critical partners include client self-advocates, policy makers, government agencies and their service providers, and community social service providers. Engagement and relationship building must occur once the client seeks assistance and first comes into contact with an agency. The ideology and method of client engagement must be first taught to service providers who can then present clients with the tools to advocate for themselves in the future.

## Timeline

Implementation can begin immediately, but the training process and culture change to fully integrate clients into case and policy level decision-making will be accomplished in the mid-term range.

# Prevent Homelessness

## **Initiative**

Make Alternative Housing Solutions Preferable to Shelter

## **Background/Context**

Current City policies and practices can make shelter an attractive option compared to maintaining a current housing situation. For example, the likelihood of access to subsidized housing following a shelter stay is attractive compared to the next best alternative, a potentially futile wait for subsidized housing. To properly align incentives among shelter, supportive housing, and housing, public agencies need to ensure that shelter is provided in a clean, safe, supportive and healthy setting, but that the physical, social, and fiscal entitlements do not act as an incentive to access shelter.

To align incentives with the goal of a short stay in shelter, DHS needs to ensure that decisions, from eligibility consideration to the design of shelters, reinforce the emergency and temporary functions of shelter. Possible areas of exploration include implementing an eligibility process in the single shelter system, de-linking Section 8 vouchers with shelter, and ensuring that those who can pay for shelter do. Disincentivizing unnecessary utilization of shelter is critical to the ten-year strategy because it will help to ensure that fewer clients are drawn to shelter for reasons other than their homelessness.

## **Critical Partners**

Critical partners include OTDA, scatter site providers, and shelter providers. Collaboration with HRA will be required in order to assist with client shelter payments and with NYCHA for the allocation of housing subsidies.

## **Timeline**

These initiatives are short and medium term initiatives. Depending on the priority given to the initiative, certain of these initiatives can be accomplished in the short term (within 18 months); the remainder can be accomplished in the mid-term (within 4 years).

# Coordinate Discharge Planning

## Initiative

Coordinate Discharge Planning for Individuals Entering Shelter from Jail

## Background/Context

In a process spearheaded by the Department of Correction and DHS, numerous community-based organizations, and other stakeholders have been engaging in an ongoing strategic planning process aimed at improving re-entry outcomes for individuals leaving jail. Specifically, efforts have been focused on preventing discharge into homelessness and recidivism back to jail. The initial phase of the collaborative planning process, spanning over several months, allowed the participants to reach consensus about which recommendations to prioritize. The various workgroups are currently taking up the challenge of identifying strategies to accomplish the following goals:

- Address the needs of the “heavy user” of both shelter and jail to decrease use of both systems;
- Establish continuity of benefits;
- Enable current short-term jail stayers to avoid incarceration whenever possible;
- Improve information collection and data sharing;
- Interagency coordination.

A considerable number of formerly incarcerated individuals enter shelter each year, some of whom have patterns of cycling back and forth between jail and shelter. For these individuals a re-arrest could result in loss of benefits, and require the search for permanent housing to begin again upon the individual’s release from jail. Another obstacle in identifying solutions for the formerly incarcerated is that they tend to face a variety of barriers in obtaining employment and access to public housing. Additionally, meaningful discharge planning is often compromised by the short term nature of jail stays – 25 percent of which are for 3 or fewer days and 50 percent of which are for 7 or fewer days.

The goals outlined above will remove some of the obstacles facing this population – thereby allowing the facilitation of long term solutions beyond shelter.

## Critical Partners

DHS, DOC, HRA, NYCHA, OTDA, DOH, DOHMH, CJC, DOE, ACS, OMB, DOF, community-based organizations, philanthropic organizations, the Bar Association, and the DA’s office are all critical partners. Additional stakeholders include the clients who can be engaged in advisory sessions and focus groups.

## Timeline

The timeline for the different initiatives vary, but most of them are in the short or mid-term parameters.

# Coordinate Discharge Planning

## Initiative

Coordinate Discharge Planning for Individuals Entering Shelter from Prison

## Background/Context

Ex-prisoners represent a considerable portion of the shelter population. In FY2001, ten percent of parolees spent eight or more days in shelter in the year following their release. Additionally, on average, parolees comprise nine percent of the daily census of the adult shelter population. Dramatically reducing the number of individuals entering shelter from prison will require public agencies to build on existing programs, forge new partnerships within State government and work to address some of the re-entry barriers that formerly incarcerated individuals face. Specifically, these efforts will include:

- Continue ongoing weekly data matches with the Department of Parole to learn more about the shared population
- Continue to use the DHS/DOP Pilot Project as an opportunity to collaborate with Parole and ensure that parolees are utilizing all available resources, such as parole officers in adult shelters, to move towards independence;
- Pool resources within State government to identify transitional and permanent housing opportunities for incarcerated individuals who are reporting that they will be homeless upon release;
- Develop new initiatives with partners in State government with respect to identifying supportive housing options for mentally ill individuals upon release from prison, and using resources within shelter to try to move this population towards supportive housing options.

While in prison, individuals can lose their entitlements and housing, and their personal relationships may suffer. Additionally, this population tends to face barriers in obtaining employment and access to public housing.

Since individuals discharged from prison represent nine percent of the adult shelter system, reducing their shelter use is a critical component of ending homelessness. To be successful, city and state agencies must work together to:

- Identify opportunities for diversion from shelter to permanent housing;
- Move parolees currently in shelter onto permanent housing or other longer-term options.

Having initiated a pilot project with Parole, DHS is now in a position to review the success of its joint initiative in an ongoing fashion. Renewed public partnerships with OMH and other agencies will facilitate improvements in re-entry outcomes for various client populations.

## Critical Partners

Critical partners include DHS, Department of Parole, State Department of Correction, Correctional Association, Office of Mental Health, and the Office of Alcohol and Substance Abuse Services.

The partners will be engaged within the context of existing initiatives and the development of new ones. Existing data analysis affords the opportunity to provide information to relevant stakeholders.

## Timeline

The timeframe for the different initiatives will vary. It is likely that they will begin in the short term and that positive outcomes will become evident by the mid-term.

# Coordinate Discharge Planning

## Initiative

Coordinate Discharge Planning for Individuals Entering Shelter from Hospitals and Community-based Treatment Facilities

## Background/Context

Since 1994, the federal government has recognized that inadequate discharge planning was a leading cause of homelessness among people with mental illness and/or substance abuse disorders. In June 1997, the Center for Mental Health Services published "Exemplary Practices in Discharge Planning", which outlined components of successful discharge planning at the community level. More recently, the Commonwealth of Massachusetts and the Massachusetts Housing Shelter Alliance (MHSA) have developed extensive State-wide efforts to improve discharge planning. New York City should draw on the recommendations from these efforts, including:

- Convening a working group on discharge planning from hospitals and treatment facilities;
- Adopting a goal of zero tolerance for discharge into homelessness;
- Developing residential and service resources necessary for successful discharge;
- Identifying and disseminating best practices in discharge planning;
- Training discharge planners in availability of community-based resources;
- Improving data collection and sharing data across systems to identify post discharge outcomes;
- Assuring that public funders monitor and hold providers accountable for providing effective discharge planning.

## Critical Partners

Critical partners include DOC, DHS, DOHMH, SOMH, OASAS, Hospitals (HHC, GNYHA), residential mental health treatment providers, residential substance abuse treatment providers, and detox providers.

Consumers, families, advocacy organizations, outreach teams and homeless service providers will play an important role in the development of policies, initiatives, advocacy, and in holding government agencies accountable.

## Timeline

Convening a working group can be accomplished in the short term. Assuming that working group will take time to deliberate and establish concrete recommendations, most of the other items listed above can be accomplished in the medium term. However, developing some types of permanent housing resources will take longer.

# Coordinate Discharge Planning

**Initiative**

Coordinate City Services and Benefits in a Child Welfare Collaboration

**Background/Context**

Establishing safe housing to support reunification for families with children in foster care is a challenge that can complicate reunification plans. Although the majority of such families are reunified in permanent housing, some families are reunified in temporary shelter. DHS and ACS believe that families who are being reunified should not be reunified in temporary emergency shelter. Homelessness is a crisis of instability and families should be reunified into stable permanent housing where community supports are available. Another child welfare population that is vulnerable to homelessness is youth aging out of foster care. Although youth do not necessarily enter the homeless shelter system immediately, they are vulnerable to homelessness at later periods of time.

DHS and ACS have committed to developing programs for reunifying families and youth aging out of foster care so that permanent, stable homes can be achieved without becoming homeless. For families and individuals already living in DHS facilities, the agencies will work together to reunite them with their children outside of the shelter system, in permanent housing. The agencies will also work together to reunite children and young adults with their families within the shelter system. A data match has already been conducted to identify clients who are being served by both agencies. ACS' strategic plan recognizes that youth aging out of foster care should be assisted in establishing relationships with caring adults and in developing community ties. DHS and ACS will continue to work together in an interagency workgroup to develop programmatic details and protocol for reunifying families and youth aging out of foster care.

**Critical Partners**

ACS and DHS are the critical partners. Other stakeholders involved may include providers, consumers, OMB, NYCHA, HRA, and HPD. These stakeholders will provide valuable input in the initiative development phase. They will also provide the supports needed to help families and individuals secure permanent housing. These partners will be engaged through regular workgroup meetings.

**Timeline**

This initiative is already underway, so the beginning phases will be complete in the short term. The initiative should last into a long-term period, as needs continue and change.

# Coordinate City Services and Benefits

## Initiative

Coordinate City's Human Services and Benefits With a One City Integrated Case Management System

## Background/Context

The City's human services agencies which provide case management services are working towards an integrated approach to case management. The Integrated Case Management System is an initiative that will expand the use of technology to integrate screening and eligibility, case management, contract management, and policy and planning functions within and across human services agencies. The project seeks to support the coordination of resources and delivery of services to populations interacting with multiple City agencies so as to reduce redundancy and increase efficiency. This project will expedite the delivery of services to eliminate time lags, which may reduce client vulnerability.

By facilitating communication and case coordination for clients that are being served by more than one agency, agencies will be able to move away from a silo approach towards a strength-based model. Data collection and sharing will be simplified by the creation of an integrated case management system, which will, in turn, improve the City's capacity to plan.

Currently, the City is exploring the benefits of developing a coordinated case management approach across human service agencies and identifying strategies for its implementation.

## Critical Partners

Through the Integrated Human Services Project, the Mayor's Office is supporting the development of a coordinated case management approach for human service agencies. Some of these agencies include DHS, NYCHA, HPD, HRA, ACS, the criminal justice agencies, and OMB.

## Timeline

This initiative can be accomplished in the mid-term. The development of the system is in the planning stage. Requirements for case management pilots are currently being defined.

# Coordinate City Services and Benefits

**Initiative**

Implement Cross-Agency Case Conferencing

**Background/Context**

Clients involved with multiple City agencies have been challenged to meet the goals and objectives of each respective agency without regard for a coordinated system of solving problems. A cross agency case conference can bring together City agencies in a coordinated way to minimize duplication of efforts and provide resources to resolve problems. Cross agency case conferencing will bring City agencies together to develop shared goals with the client that emphasize self-sufficiency by maximizing client strengths. Through this case conferencing model, the client and public agencies will be able to determine the coordinated assistance to meet client goals holistically, and streamline agency case plan requirements into a coherent service plan for the client. Additionally, City services and resources that are frequently duplicated can be fully leveraged for maximum family strengthening and improvement.

This initiative will be advanced by, but not limited to, the Bedford Stuyvesant initiative. City agencies should adopt practices to identify clients in need of cross agency case conferencing and inform prospective policy decisions.

**Critical Partners**

Several City human service agencies are critical partners in this initiative, including ACS, DHS, HRA, NYCHA, DOHMH, Aging, DYCD, DJJ, HPD, and Department of Correction and Probation, among others.

**Timeline**

This initiative can begin its first phase in the short-term and be implemented citywide in the mid-term.

# Coordinate City Services and Benefits

## Initiative

Deliver and Coordinate Services and Benefits at the Community Level

## Background/Context

City agencies have individual mandates to serve New Yorkers with particular needs (e.g., child welfare at ACS, homelessness at DHS, and employment training at DSBS). Agency programs are structured to address those particular needs and measure success against those goals. Regulations and funding sources often mandate and reinforce these directions. The result over time has been that the services are provided in isolation from a full assessment of family needs and strengths, often seeing the individual in isolation from the family, and seeing the need in isolation of other family and social dynamics.

This has generally caused great challenges for agencies and community providers who are frustrated in their efforts to navigate multiple service systems on behalf of clients, encountering separate intake, assessment, service delivery, and accountability measures. At worst, services can create contradictory directions and develop conflicting schedules for compliance. Services can also be duplicative and resources not fully leveraged for maximum family strengthening and improvement, resulting in less than maximum use of scarce service dollars.

The city, acting through the participating agencies, is committing to a fuller understanding of these challenges and solutions around an integrated neighborhood-based service approach. City human service agencies, acting directly or through their non-profit service providers, will operate collectively at the community level, holistically supporting individuals and families in need. The model will not only integrate services at a local level, but will also rotate the approach of those services to a client's point of view in a strengths-based philosophy, supporting the individual and family in their roles as fully-functioning members of a broader and vibrant community. It will also emphasize early identification of emerging needs, using a common assessment tool in order to develop coordinated responses to community residents in need of assistance with health care, housing assistance, employment training and referral, income support, child welfare, adolescent and senior services, and substance abuse and mental health resources.

The City intends to begin this initiative in Brooklyn Community District 3, Bedford Stuyvesant. Planning for this initiative takes place within the One-City strategy workgroup drawing from vast human services and government experience and, more recently, several interagency case conferences conducted in Bedford Stuyvesant.

## Critical Partners

Several City human service agencies are critical partners in this initiative, including ACS, DHS, HRA, NYCHA, DOHMH, Aging, DYCD, DJJ, HPD, and Probation, among others.

## Timeline

This initiative can be accomplished in the short term. Critical partners have already been engaged.

# Coordinate City Services and Benefits

## Initiative

Implement New Tools to Increase Access to Benefits

## Background/Context

This initiative will integrate tools currently utilized by HRA and other agencies that administer benefits with the goal of accomplishing the following:

- Developing a uniform process by which a client's eligibility for benefits can be determined;
- Accessing training and technical assistance to disseminate basic information about how to access benefits;
- Empowering caseworkers with greater depth and breadth of knowledge about which benefits a client may be eligible for, in turn enabling the caseworker to ensure that the client applies for all benefits and entitlements to which s/he is entitled;
- Adopting a self-sufficiency calculator framework through which informed determinations can be made about how much income any given client, depending on his or her circumstances, will need to live independently.

If a client is not receiving entitlements, his ability to access housing, medical, mental health, and other services is extremely hampered. A concerted, multi-pronged approach to ensure that at-risk clients maintain entitlements will improve outcomes for clients and contribute to the goal of ending homelessness. If DHS utilizes a computer program, similar to the one used by HRA, to calculate what benefits clients are eligible for, caseworkers can more effectively partner with clients to ensure that they are using all resources at their disposal to move towards permanent housing and independence.

The "calculators" that are currently used in government and by community-based organizations have several purposes. One such purpose is to facilitate rapid assessments of a client's eligibility for certain benefits. Another use may be to calculate how much income an individual must make to live independently, taking into consideration entitlements and benefits the individual may already be receiving.

These calculators could potentially be utilized when a client first arrives at shelter for the purpose of determining what benefits (e.g. SSI,SSD, or Veterans Benefits) or entitlements (e.g. Public Assistance, Medicaid and food stamps) s/he should apply for. A self-sufficiency calculator can also be incorporated when the caseworker is working with the client on rehousing issues to determine where the client can afford to live, what income she would need to make, and what additional help she can get from the government. This will allow the client and caseworker to partner together to thoughtfully plan for solutions beyond shelter. This initiative may require interagency data sharing and confidentiality issues must be considered.

## Critical Partners

DHS, HRA, OTDA, and the Federal Social Security Administration comprise the critical partners. Additional stakeholders include clients and caseworkers. DHS has a great opportunity to capitalize on the innovation of benefits and self-sufficiency Calculators.

## Timeline

This initiative can be accomplished in the short term.

# Coordinate City Services and Benefits

## Initiative

Coordinate Services and Benefits to Chronically Homeless Individuals

## Background/Context

Many homeless clients are either receiving services from multiple city, state, and federal agencies and/or are eligible to receive such services but have a difficult time accessing them. These services and entitlements include public assistance, Medicaid, employment services, substance abuse services, mental health services, social security/SSI, and veteran's benefits. Often, the chronically homeless have a multitude of issues that may make it difficult to navigate the mainstream service systems, or they do not fit neatly into the narrow definitions of eligibility. In other cases, duplication in services occurs because one person interfaces with multiple case managers and service providers.

Linkage to mainstream services and better coordination between the government agencies would achieve several goals. First, it would enable homeless individuals to receive services that are not tied to the shelter or drop-in program in which they reside; the service or benefit will not end when the person or family moves into housing. Second, it would link people who are not currently receiving services or benefits to those benefits which they are eligible for and require for independent living, speeding up the process to obtaining permanent housing. Third, by streamlining services and removing duplication, resources would be freed up for other purposes or to assist additional people.

Specific next steps include developing interagency workgroups and/or the development of key initiatives that bridge multiple agencies. Another important next step will be the implementation and coordination of federally funded programs such as those selected for the Social Security Administration's HOPE awards and the Department of Veteran's Affairs (VA) Grant and Per Diem Programs. The HOPE awards will assist eligible chronic homeless individuals apply for Supplemental Security Income (SSI) and Social Security disability benefits, while the VA's awards will fund new supportive housing and service centers for homeless veterans.

## Critical Partners

HRA, Small Business Services, OASAS, HRA, DoHMH, OMH, SSA, and VA, as well as OMB and Mayor's Office of Operations are all critical partners. The Federal Interagency Committee on Homelessness can be instrumental in bringing the federal agencies on board. Work with recent grant-funded initiatives in New York City pursuing this type of effort will occur.

Identification of specific barriers and pilot projects can be an important way to develop relationships across agencies from which additional ideas can grow. At the same time, high-level involvement in the form of taskforces or oversight committees is critical to ensure that bureaucratic processes do not prevent innovation from occurring.

## Timeline

Development of key initiatives and workgroups can occur within the short-term, but other projects requiring policy or regulatory changes at the federal or state level may take longer.

# Coordinate City Services and Benefits

## **Initiative**

Pursue "Express Eligibility"

## **Background/Context**

Express (presumptive) eligibility encompasses the idea that information about an individual's eligibility for one public benefit should influence one's eligibility for another benefit. If an individual applies for a particular benefit, and is already receiving another benefit, he may be automatically eligible for the new benefit. The purpose of this initiative is to coordinate communication between the multiple agencies providing services and benefits to reduce application processing times, redundancy, and even homelessness that may result from lapses in the receipt of public resources. As a next step, the partnering agencies should identify the range of benefits and their associated eligibility requirements. While maintaining awareness of confidentiality issues, structures can be developed to share data and information between the involved agencies. This initiative may materialize as a shared database with client benefit histories and eligibility information. Organizational staff liaisons and Federal/State/City regulatory and/or administrative changes may also be required.

## **Critical Partners**

Critical partners include DHS, NYCHA, HPD, HRA, ACS, the criminal justice agencies, DOHMH, housing court, OMB, and the Mayor's Office. Other stakeholders include service providers and consumers. Providers and consumers can influence this initiative by representing the experience of applying for and providing access to multiple resources.

## **Timeline**

The collaboration and data gathering involved in the first phases of this initiative can begin immediately. The implementation of the initiative may last into a mid-term time period, since it will require the development of a new computer system and data sharing structures.

# Coordinate City Services and Benefits

## Initiative

Expand Benefits Access Supports

## Background/Context

The goal of the Case Management Field Team (CMFT) is to provide the support services to families in the DHS shelter system required to open and reopen their public assistance cases. CMFT analyzes pending public assistance closures, current closed cases, and follows up with families that have missed their scheduled appointments to ensure that DHS clients are successful in maintaining compliant cases. The team has been instrumental in assisting shelter caseworkers and housing specialists to resolve problems that their clients are experiencing. The team also advocates for and negotiates with HRA on behalf of the clients.

Developing and strengthening the relationship with the various divisions and job centers in HRA has been another factor in the unit's success. The collaborative effort between DHS and HRA has benefited both agencies and the clients.

An analysis of the issues raised by field staff and the types of inquiries that are received by CMFT demonstrates the benefits for the unit to expand its scope of services, source of referrals, and target population. The vast majority of clients require public assistance to secure and maintain housing. Enhancing the services provided by CMFT will address the public assistance needs of homeless clients as they progress through the continuum of care.

The steps involved in implementing the plan include:

- Staffing and monitoring video conferencing at various DHS facilities
- Expanding to include families who have returned to the community, and to single adults
- Developing linkages to community-based organizations
- Assisting in the development of a public assistance training curriculum

## Critical Partners

Critical partners include HRA, DHS, shelter providers, and community-based organizations.

## Timeline

The initiative can be initiated within the short term, with most of the accomplishments being achieved in the same time frame. Components that may require a longer time frame are those centered around technological issues.

# Coordinate City Services and Benefits

**Initiative**

Advance "Take Care New York" Community Initiatives

**Background/Context**

People living in poverty experience high rates of HIV, depression, substance abuse, mental health problems, and other medical difficulties. Take Care New York is a health policy that prioritizes actions to help individuals, healthcare providers, and New York City as a whole to improve health. The ten-year plan will support Take Care New York by advancing it via neighborhood-based homelessness prevention programs. As close points of contact with New Yorkers, these community-based programs will be able to provide health information and referrals quickly and effectively. Good health will help New Yorkers avoid homelessness. Additionally, community-based homeless prevention programs will facilitate access to stable living arrangements, so that individuals and families are situated to better manage the range of health problems that poverty exacerbates.

**Critical Partners**

DOHMH and HHC will be critical partners in this endeavor. Other stakeholders will include the Department of Education, health care providers, businesses and employers, unions, community-based organizations, and individual community members.

**Timeline**

Initial relationships necessary to advance this initiative can be built in the short term, since it should not take too long to identify partners and begin working together. The initiative should be carried out into the long term.

# Minimize Duration of Homelessness

## Initiative

Strengthen Performance Management Systems for Shelter Providers

## Background/Context

Every provider is accountable for meeting standards and achieving successful outcomes for clients. Performance management systems are critical tools to ensure provider efficiency, quality, effectiveness, and accountability. They specify key outcomes that providers should achieve and then hold providers accountable for attaining those outcomes.

In the homelessness crisis of the late 1980s, providers were focused on learning how to manage the ever-increasing shelter population. As the system became more adept at providing safe shelter, it shifted its focus to providing services to clients to help them achieve self-sufficiency. Performance management systems are the logical next step, moving from a focus on outputs to a focus on outcomes. Currently, DHS has performance incentive/investment systems in place for single adult and family shelter providers. These systems reward providers for superior performance and hold them accountable for poor performance.

Performance management systems encourage shelter providers to work proactively on moving clients from shelter to housing. They provide a measure of shelter provider accountability for placement rates and client length of stay. Additionally, it accurately measures and recognizes success while rewarding and investing in the best performers. Providers can begin to manage staff around client outcomes rather than specific service activities. This concerted focus on placing clients in housing and reducing client length of stay is central to the effort to rapidly rehouse those experiencing homelessness.

## Critical Partners

DHS and shelter providers are the critical partners. Client, housing providers, and city agencies that provide funding for housing are important stakeholders who need to be engaged. Shelter providers should have input into the identification of key outcomes that will be promoted.

## Timeline

This initiative can be accomplished in the short term. DHS' performance incentive/investment programs, which are already in place, can be used as the starting point for developing and implementing a more comprehensive system of performance management.

# Minimize Duration of Homelessness

**Initiative**

Ensure that Clients Assume Responsibility for Reducing Reliance on Shelter

**Background/Context**

As discussed in the prevention initiatives, engaging the client in the assessment and solution is a critical problem-solving approach that brings the client's strengths and resources to bear, while clarifying the central role of the client in overcoming the challenges presented. No one should need shelter if a preventive intervention can maintain stable housing. If prevention services are not successful and a client enters the homeless service system, permanency planning should begin immediately.

For individuals and clients in the shelter system, clients and providers are expected to partner together to focus on the most appropriate plan to achieve permanency and to minimize the episode of homelessness. Client responsibility standards have been implemented in both the single and the family shelter systems. A cornerstone of the City's approach to client responsibility is the principle that individuals and families will not be required to do any more than they are capable of doing. The implementation will be evaluated and is expected to inform quality improvement initiatives to better assist clients in implementing their independent living plans and achieving permanency.

**Critical Partners**

Clients, providers, and public agencies are critical partners.

**Timeline**

Benchmarks will be established immediately. A monitoring system will be established within the short term.

# Minimize Duration of Homelessness

## Initiative

Track and Introduce New Tools to Help Long-Term Shelter Residents

## Background/Context

Barriers facing long-staying clients must be analyzed to determine their unique challenges and providers should be supported as they assist long-staying clients in the transition to permanent housing. Key findings of system-wide research on long-term staying families show that the majority of these families had open public assistance cases and were certified for housing. The analysis also indicated a high incidence of common barriers, such as criminal backgrounds impeding the housing application process, and new barriers, such as delays caused by frequent public assistance and housing application family composition upgrades. Case conferences were conducted with several facilities with the highest proportional number of long-term families, compared to their respective capacity. One finding is that shelter staff require technical assistance with the issues surrounding these long-term cases.

The next steps for this initiative involve providing greater technical assistance to the shelter staff, working closely with NYCHA, analyzing the information on barriers gathered through the case conferences and continuing to offer information to shelters where the incidence of long-term staying clients is the greatest. The information provided from case conferences with the shelters will help to develop a better strategy to decrease the length of stay for long-term clients. Case conferences will reveal the systematic problems DHS can trouble-shoot in-house, as well as with City agency stakeholders. Finally, DHS will continue to analyze long-term staying residents on a regular basis and develop a protocol to better manage and prevent clients from becoming long-term stayers.

## Critical Partners

DHS, clients, and shelter providers are all critical partners. Additional stakeholders include NYCHA, HPD, HRA, and OTDA.

## Timeline

Long term family analysis is already underway. The development of a monitoring system of these clients as well as technical assistance provision is in its early stages. The completion of a formal process will be structured within 18 months.

# Minimize Duration of Homelessness

## Initiative

Prioritize Housing Resources for Chronically Homeless Individuals and Families

## Background/Context

A number of initiatives to prioritize chronically homeless individuals and families have been developed, and such efforts are critically important as additional housing is developed. Specific steps that have been undertaken and would be expanded include:

- A commitment on the part of supportive housing providers to fill new units with the chronically homeless;
- The development of a rental assistance program to assist long-term family shelter residents with flexible assistance, providing families who are categorically ineligible for Section 8 or public housing an opportunity to access permanent housing;
- The development of new housing models targeted at populations who are or are likely to become chronically homeless and are not adequately served by existing resources.

For a variety of reasons, the people who are chronically homeless and living in public spaces or in shelters have not been able to access housing. In some cases, they may not have been linked to appropriate services or treatment; others are resistant to change and need additional encouragement to move into a supportive housing setting; others face entry barriers from landlords and supportive housing providers who look for “housing ready” tenants.

To implement this initiative, the commitment of future housing providers to prioritize chronically homeless individuals and families needs to be obtained. New housing models also need to be developed to serve those chronically homeless clients who do not fit into the existing supportive housing models. For example, by developing low-demand supportive models, chronically homeless people could move directly from the street or shelter into housing. Efforts to prioritize chronically homeless into supportive housing this past year have been very successful. Long term shelter residents who otherwise would not have made it through the interview process have been housed in supportive housing projects and are now thriving tenants.

## Critical Partners

Critical partners include supportive housing providers, outreach, shelter and drop-in providers, OMH, DOHMH, HPD, and DHS. SHNNY and the NYC Continuum of Care Coalition have and can continue to be used to garner support for these initiatives.

## Timeline

Several of these efforts are already underway. Discussions to develop new housing models should begin in the short term with agreement on which models to pursue and how funding mechanisms will be leveraged. New models that rely on existing housing stock can also begin within the short term. Models requiring the development of supportive housing facilities will be accomplished in the mid-term.

# Minimize Duration of Homelessness

## Initiative

Develop a Mobile Services Model to Bridge Transition of Chronically Homeless Individuals and Families from Shelter to Housing

## Background/Context

The mobile services team would be a new model designed to specifically engage and serve chronically homeless clients living in shelters and help bridge their transition to housing. The model would be a combination of in-reach and intensive case management to serve clients with multiple needs.

Currently, some clients require intensive services that are not available in shelter, and they are likely to continue needing these services as they make the transition to permanent housing. Both mental health shelters and supportive housing facilities have services available, but because most residents do not require the highest level of care, the shelter and housing models are geared towards a less fragile population. Furthermore, because these services are tied to the facilities, the case managers do not move with the client. Rather, clients are transitioned from one program to another. For the neediest clients, the transition to a new setting may take time and the move itself may intensify the need for supportive services, beyond that which the supportive housing facility can provide. Additionally the neediest clients are placed throughout the shelter system and mobile teams would have the flexibility to work with these clients wherever they reside.

A number of homeless clients in the shelter system have mental health and/or co-occurring substance abuse issues. The needs of many of these clients extend beyond the capability of current program shelters. Additionally, housing providers may be reluctant to accept such clients as tenants because of limited functioning, personality disorders, or non-compliance with medication. Such clients often do not meet the eligibility criteria of different service delivery systems. An intensive mobile service model would enable a targeted approach to the clients most in need, and allow those services to travel with the client, enabling a smoother transition to housing. Once the client has moved into housing, the mobile team can begin linking the client with mainstream services in the community in order to slowly transition the client from mobile services and free up these resources for additional clients.

## Critical Partners

DHS, OMH, DOHMH, non-profit service providers, and CUCS are all critical partners needed to accomplish this initiative. Shelter and Housing providers are also important stakeholders.

## Timeline

This initiative could be accomplished within short term. This initiative could build off of existing service initiatives that link mental health services.

# Minimize Duration of Homelessness

## Initiative

Assist Single Adults at the Front End of the Shelter System to Avoid Homelessness or Avoid Unnecessarily Long Stays

## Background/Context

Little effort is currently made to divert single adults seeking shelter for the first time or returning after long absences. Diversion services may include specialized reunification services with families, anti-eviction services, and financial and housing assistance. This initiative would add a diversion function at the decentralized intake sites to assess the service and housing needs of incoming clients. Employed and employable clients with existing social support networks would be rapidly reattached to housing before becoming long-term shelter residents. Specific efforts would include:

- Ensuring that all decentralized intake sites and assessment shelters have specialized knowledge about existing community resources and prevention efforts, family mediation and reunification skills, linkages to anti-eviction services, and access to short-term cash assistance and housing;
- Connecting clients with available rental or housing assistance or alternative residential services when applicable and available;
- Connecting clients who have another place to stay with community-based services, including mental health services, substance abuse treatment, and job training.

All new single adult clients are currently assessed over a 21-day period and placed in the most appropriate shelter that is available. Clients are placed into either long-term program shelters or into general shelters where fewer services are available. Backlogs in assessment can occur periodically which further increase a client's stay before they are connected to services or housing. For many clients, these result in longer than necessary shelter stays in order to access services or assistance. For other clients who may have an alternative place to stay, a program shelter provides an access point to services that are unavailable in the community.

## Critical Partners

DHS, shelter providers, community-based organizations, and HRA are all critical partners. Shelter providers at the front-end would need to be engaged early on. HRA would need to be involved in order to develop models of cash assistance, but these efforts should mirror those occurring in prevention.

## Timeline

This initiative can be accomplished within the short term. The four-site RFP which includes a diversion component should result in programs beginning in FY 2006. Additionally, the diversion effort would rely on prevention services that are beginning next year.

# Minimize Duration of Homelessness

**Initiative**

Develop Permanency Interventions for Adult Families

**Background/Context**

The number of adult families without children is increasing in the homeless shelter system. The needs of these families vary and may include issues of domestic violence, substance dependency, mental health, and criminal histories. Since this population does not fit into the traditional framework of family composition and does not qualify for the same benefits and subsidies as families with children, they have been underserved. Specialized interventions for this population are necessary to prevent their homelessness from becoming long term.

The first step in achieving this goal was the development of a separate intake center to serve this population that determines eligibility and can assess their needs. Next steps include developing enriched services and community resources, on-going case management training, redesigning client responsibility, and specialized housing strategies.

**Critical Partners**

DHS, shelter providers, NYCHA, HPD, OTDA, and HRA are all critical partners. Additional stakeholders include clients and legal advocates. Partnerships are needed to develop services and resources for this population.

**Timeline**

This initiative has already started and can be completed in the short term, but services and access to housing must be developed.

# Minimize Disruption to Families who Experience Homelessness

**Initiative**

Reinforce Prevention and Diversion at Family Shelter Intake

**Background/Context**

A prevention-first agenda must ensure that every effort is made to preserve a viable housing option, even at the point the family is applying for shelter. Now, few families avail themselves of the opportunity to discuss diversion with diversion staff at the EAU. This may be due to the insufficiency of resources being offered, the ineffectiveness of the process, the incentive of shelter being too great, or all of the above. The dynamic must be shifted such that there is no preference to be in shelter over remaining in safe and stable housing, and no opportunity to achieve this goal is missed. Clearly, the community-based prevention effort is the preferred venue to achieve prevention results. If, a family does find themselves applying for shelter, continued efforts must be made at the point of intake to determine if homelessness can be avoided.

**Critical Partners**

DHS must work in partnership with prevention service providers, HRA, and ACS to coordinate knowledge and resources around family needs and make appropriate benefit and service connections to meet needs.

**Timeline**

This initiative can be accomplished within the short-term.

# Minimize Disruption to Families who Experience Homelessness

## **Initiative**

Streamline Application and Eligibility Review Process at Family Shelter Intake

## **Background/Context**

Currently, an application for family shelter may take over two days to complete, with a shelter placement also requiring an additional day or two. Many applicant families are also determined ineligible on their first application. Eligible families who reapply must endure the lengthy and disruptive process of the EAU again, while reapplicant families who are not found eligible may repeat the experience multiple times, leaving their family in a prolonged state of impermanence. During this period, most applicants experience two or more stays at overnight facilities. They are awaiting more stable shelter placements while rotating in and out of the EAU and attempting to address their daily routines in the course of the process.

This cycle results from an intake process that has, over time, attempted to accommodate applicant families' needs. However, as these adjustments have been made, their impact on the functioning of the intake process has not been considered. The outcome has been an intake process that contradicts the very objectives it was trying to achieve. The implication for applicant families is that prevention and support cannot be effectively addressed while these secondary objectives are being met.

Clearly, a more rational process must be achieved that allows families to apply for shelter and be placed on the same day, after every effort is exhausted to determine if their homelessness can be prevented.

## **Critical Partners**

DHS will need to partner with HRA, community-based providers, and shelter providers to work on prevention at intake, services for applicant families within communities, and shelter placement policies and services.

## **Timeline**

This initiative should be accomplished in the short-term.

# Minimize Disruption to Families who Experience Homelessness

**Initiative**

Expedite Shelter Placements from Family Shelter Intake

**Background/Context**

Families needing shelter placement should be placed on the same day they make their application, unless the application occurs in the late hours of the day. To achieve this goal, the array of shelter placements must meet the demographic composition of families likely to request shelter. Historically, shelter capacity has not been developed to meet the needs of large families, and many facilities have restrictions and will not shelter men and adolescents. Many facilities also have limited intake hours, causing overnight delays in placement. The result is that such families often wait days at the EAU for placement into shelter. Additionally, the shelter placement protocol has preferred a first come/first served placement process, rather than ensuring the best match of family to home community to minimize school and community disruptions.

By making timely and appropriate placements, the work of overcoming family homelessness can occur swiftly and effectively, in a manner that strengthens family functioning and minimizes disruptive interruptions that delay permanency.

To achieve this goal, DHS must develop a sufficient supply of shelter to meet the array of family needs, eliminate placement restrictions, expedite placement into shelters, and place families in shelters close to their home communities.

**Critical Partners**

The initiative requires collaborative work between DHS and contracted providers to achieve this goal.

**Timeline**

It can be accomplished in the short term.

# Minimize Disruption to Families who Experience Homelessness

## **Initiative**

Place Families in Shelters Near Their Home Communities

## **Background/Context**

Community-based shelter placements would minimize the disruption to those entering the shelter system by placing the individual/family in a facility that is in or close to their area of origin. Shelter clients will benefit from having a familiar setting where their support network exists, and can receive a continuity of social services by accessing programs where they will permanently reside. For families, school-aged children will be able to continue their education in a familiar setting. The assumptions of this model are that families will have greater incentives to seek housing in a neighborhood that they are familiar with and that families will build upon existing linkages and supports as resources to find permanent housing. As a result of finding permanent housing in an area that they are receiving community, social, and medical service support, the likelihood of recidivism will decrease.

While the objective would be to place every client in their home community, that may not be feasible. Therefore, some clients will be placed in a nearby community. Another challenge in the future will be presented when prevention reduces shelter census and consequently reduces the need for capacity, thereby minimizing the number of shelters. The target should be retaining capacity in areas where the majority of clients are coming from, utilizing existing data of the last known address obtained during the intake process.

## **Critical Partners**

Partnership is essential to the success of this proposal, including relationships with key stakeholders such as DHS, shelter providers, community social, mental, and medical service providers, HRA, NYCHA, community boards, landlords, community residents, and clients.

## **Timeline**

This proposal can reach final completion in the mid-term range of approximately two years.

# Shift Resources into Preferred Solutions

**Initiative**

Analyze Resource Reinvestment by Sector

**Background/Context**

By increasing funding to programs that address the factors contributing to homelessness, the City can prevent entry into the shelter system. Externally, these factors include discharges from correctional facilities, ACS, mental health facilities or hospitals. Additionally, shelter entries can be decreased by using funds to prevent eviction or to mediate issues in doubled-up situations. Client length of stay can also be reduced for the current homeless population by analyzing long-term stayers, recidivism, shifts in shelter types, and overall capacity management. This initiative will analyze the cost-effectiveness of various programs in terms of their ability to reduce the shelter population and will strategize about how to increase funding for these programs using the savings generated by reducing the homeless shelter system census.

Traditionally, all funding has been directed toward meeting shelter demand on any given day. The lack of a sufficiently rigorous analysis of which prevention programs would provide the greatest reduction of shelter costs has increased the practice of funding shelters rather than prevention programs. Currently, there are few programs that allow funds to be spent on prevention. Interagency projects have often been limited, since many joint projects do not qualify for federal or state reimbursement, due to their failure to specifically meet an agency's mandate. The reallocation of shelter dollars to prevention may also affect the funding mix and minimize the reimbursement dollars that the City receives from state and federal sources. Lastly, there will be an initial period of simultaneously funding prevention and the existing shelter system before the enhanced prevention efforts can reduce the number of homeless.

**Critical Partners**

Critical partners include OTDA, OMB, city agencies (such as DHS, DOC, ACS, HRA, HPD, and NYCHA), shelter providers, community social service providers, and consultants to do resource reinvestment analysis.

**Timeline**

This initiative must be completed in the short term to better support other ten-year initiatives.

# Shift Resources into Preferred Solutions

## Initiative

Obtain State and Federal Waivers to Current Reimbursement Limitations

## Background/Context

At the state and federal level, matching funds are often unavailable to reimburse costs of prevention, aftercare, or other programs not specifically addressed in statutes or regulations. Accordingly, this initiative will broaden federal and state funding by:

- Presenting New York State with cost-neutral demonstration projects to waive current restrictions on the inclusion of preventative community-based services and aftercare in funding streams;
- Proposing new legislation to include prevention, community-based services, and aftercare in Federal/State funding and identifying other funding streams;
- Securing additional funding for up-front investments;
- Merging funding streams of DHS and other NYC agencies while increasing collaboration of those agencies.

New York City has had difficulty justifying prevention programs in the past, as the state often sees prevention and aftercare as costly concepts with benefits occurring over a long period of time. There is often a belief that prevention and aftercare are more expensive than maintaining the current system. The state has also indicated that there is a need for both a data strategy and a sequencing strategy in order for a reconfiguration of the current system to be approved.

Currently, even if other agencies that have clients that enter the shelter system were to provide money to fund prevention, aftercare, or community-based services, due to statutory and regulatory restrictions that money could not be targeted to such services. In order to implement the proposed initiatives within the ten-year strategy, it is imperative that present funding streams are expanded, and that current restrictions are modified to ensure funding for programs that will include such services as prevention and aftercare.

## Critical Partners

Critical partners include state legislators, state agencies (primarily OTDA), city legislators, OMB, city agencies (such as DHS, DOC, ACS, HRA, HPD, NYCHA), and community social service providers. Other stakeholders are clients served by various city agencies and community-based service providers.

## Timeline

In the short term, the City can propose demonstration projects to the State. In the mid-term, state and local levels of government may be able to pass new legislation and establish coordination protocols to accomplish the initiatives.

# Shift Resources into Preferred Solutions

**Initiative**

Increase Up-Front Investments to Fund Prevention Models

**Background/Context**

The City will invest in new program models that will reduce entry or re-entry to the homeless system. This funding will be used to develop interagency projects, which will be eligible for state and federal reimbursement. Additionally, this initiative will develop new funding streams for innovative approaches to address homelessness. Currently, there are few programs that allow funds to be spent on prevention. Historically, the restrictions and pressure from litigation have limited the ability of the City to be innovative.

This initiative will address the issue of “seed money”, or how to begin the process of shifting funding to prevention when funding is still needed for mandated shelter services. There will be an initial period of simultaneously funding prevention and the existing shelter system before the enhanced prevention efforts can reduce the number of homeless.

City agencies will work together to obtain baseline funding for the six community districts already included in the Housing Stability Initiative (HSI). Expanded funding for HSI to include other communities will also be sought. Additionally, city agencies and community-based organizations will work together to determine which are the most effective prevention models and will increase up-front funding accordingly. In the short run, opportunities will be sought for the insertion of prevention components into current programs lacking that emphasis.

**Critical Partners**

This initiative requires the partnering of OTDA, OMB, city agencies (such as DHS, DOC, ACS, HRA, HPD, and NYCHA), shelter providers, and community social service providers.

**Timeline**

This is a short term initiative. Completing these tasks in the short term will allow the increased funds to better support other ten-year initiatives.

# Shift Resources into Preferred Solutions

## Initiative

Reinvest Targeted Savings

## Background/Context

As prevention programs are implemented, the City will realize savings from a reduction in homelessness. The actual savings and the effectiveness of various prevention programs will also be analyzed, as well as the potential of redistributing the savings to the most effective prevention programs. Reimbursement schedules limit the ability to shift resources to preventions programs.

The steps delineated below are some examples of how to accomplish this initiative:

- Analyze where targeted savings are, where they are needed most, and how to maximize spending to achieve outcomes;
- Create joint interagency models that present alternatives other than shelter to clients who leave other agencies' systems. For example, the DOC and DHS could establish temporary supportive housing units that address the needs of that population;
- Reinvest savings from decreased capacity needs to prevention/aftercare/permanency programs;
- Perform cost analyses concerning how much additional housing could be financed through savings in current homelessness costs.

## Critical Partners

Partnership is needed between OTDA, OMB, City agencies (such as DHS, DOC, ACS, HRA, HPD, NYCHA), shelter providers, community social service providers, financial institutions (public and private), and community boards.

## Timeline

This is a mid-term initiative. Reinvestment of savings will occur after they have been generated through the implementation of other program initiatives.

# Shift Resources into Preferred Solutions

## Initiative

Close Shelters to Reinforce Savings

## Background/Context

The goal of this initiative is to significantly reduce the total shelter capacity. The sequence of closing shelters will be determined by service needs and performance in the Performance Investment Program (PIP). The capacity management plan will dictate the number of units reduced each year.

The capacity management plan will be reviewed in-depth and will facilitate the development of an annual closing plan. A protocol will be established to analyze annual targets. The possibility of converting shelter to supportive, transitional or permanent housing will also be examined.

A mechanism will be created to indicate the need for reexamination of the closing schedule in the course of the ten-year timeframe. This will prepare the homeless system for temporary and long-term surges that may occur due to a number of factors (for example, economic decline) and also give the strategy the stability it needs to adapt to changing circumstances.

## Critical Partners

Critical partners include OTDA, OMB, City agencies (such as DHS, DOC, ACS, HRA, HPD, and NYCHA), shelter providers, community boards, local landlords, Housing Court, aftercare and prevention providers, and low cost housing providers.

## Timeline

The plan will be created in the short term, milestones will be evaluated in the mid-term (and throughout the process) and success will be evaluated in the long term. The prevention initiatives must be in place prior to reducing the overall size of the shelter system, and they must have time to be effective prior to completing the closings.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

**Initiative**

Coordinate Rental Assistance Across All Agencies

**Background/Context**

The citywide rental assistance program should be based on need, not on agency priority. All city agencies should avail themselves of the same rental and household assistance resources, targeted to priority populations agreed upon as part of a citywide strategy. This will reduce the level of competition among agencies to engage landlords, minimize the inconsistency of standards and practices between agencies, and ensure resources are allocated based on an assessment of client need.

Rental subsidies can inflate rents in certain areas by creating competition between individuals or families in receipt of rental assistance and working families in the community. The citywide rental assistance program should address these issues by setting a single subsidy rate, across agency lines, based on “rent reasonableness” on a community district (CD) level.

**Critical Partners**

Critical partners in this process include OMB, DHS, HRA, NYCHA, HPD, ACS, and OTDA.

**Timeline**

This initiative can be accomplished in the short term, as the City has made this a priority issue.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

**Initiative**

Develop a Rental Assistance Primer

**Background/Context**

A rental assistance construct should be developed upon the completion of the City rental assistance program. This construct will provide city agencies, community service providers, residents, and other stakeholders with a comprehensive source of information regarding the program, including eligibility, regulations, requirements, and levels of assistance. A particular unit and position must be identified to assume the responsibility for creating and updating the construct on a periodic basis to reflect any policy changes. The construct should be disseminated strategically to maximize knowledge and understanding of the program.

**Critical Partners**

Critical partners in this process include HRA, ACS, and DHS.

**Timeline**

This initiative can be accomplished in the mid-term, as the timing of this initiative is contingent on the completion of the City rental assistance program.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

**Initiative**

Streamline the Rental Assistance Application

**Background/Context**

The New York City Housing Authority (NYCHA) has been developing a new computer system that provides on-line access to its housing applications. This new system will be web-based, therefore allowing easier access to the NYCHA housing application process. The new system will also create an on-line file, which will contain required proof documentation.

In the past, applications were completed on paper forms, which caused delays in processing because in some cases, applications were lost or misplaced. Clients were also required to set-up appointments with NYCHA to provide supportive documentation and review their needs. Through the use of digital scanners, supportive documentation can be added to the on-line file. With the use of signature pads, clients will then complete the forms and processing will begin. The automation of this process will greatly decrease the time required for the application process and, for those individuals and families applying from shelter, decrease their shelter stay.

**Critical Partners**

DHS and NYCHA are the critical partners, as DHS was identified as the pilot agency. Providers will also be critical in assisting clients with applications.

**Timeline**

This initiative can be accomplished in the short term. This new system has been in development by NYCHA for the past two years and is almost ready for deployment. DHS will become the pilot site for this system, which is scheduled for December 2004.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

**Initiative**

Redesign Rental Assistance to Disincentivize Shelter

**Background/Context**

Entry into shelter should not be, as it is currently, the predominant path to the most comprehensive rental assistance available. This arrangement incentivizes applications for and entry into shelter by providing priority status for such rental assistance. Instead, the citywide rental assistance program should be structured to provide rental assistance to residents at-risk of homelessness in the community so that entry into shelter is not necessary.

The extensive use of Section 8 and NYCHA housing for the re-housing of shelter residents contributes significantly to the demand for shelter. As such, priority for Section 8 and NYCHA should be de-linked with shelter entry. At the same time, assisting chronically homeless individuals and families with rental assistance remains critical to overcoming homelessness for the hardest to engage and place in housing. The prevention-first strategy must be complimented by a strategy that targets specialized rental assistance resources to chronically homeless individuals and families.

**Critical Partners**

Critical partners in this process include OMB, the Mayor's Office, DHS, HRA, NYCHA, HPD, and ACS.

**Timeline**

This initiative can be accomplished in the short term, as the City has made this a priority issue.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

## Initiative

Increase the Supply of Supportive Housing for Adults and Families

## Background/Context

The commitments reflected in the Mayor's 5-year *New Housing Marketplace* should be built upon to further develop housing opportunities sufficient to end chronic homelessness for individuals and families. Specifically:

- Develop new supportive housing with residential models for homeless individuals with special needs not adequately served by existing programs, including:
  - Persons living with serious medical conditions, and/or the elderly;
  - Persons involved with the criminal justice system;
  - Individuals with chronic alcohol and substance use problems;
  - Youth aging out of foster care; and
  - Families reunifying from foster care.
- Expand the Moving On program model, which provides access to rental assistance for those "graduating" from supportive housing, and backfilling those vacancies with the chronic homeless to create a flow within the system.

The supportive housing model is essential for the homeless population with special needs and for those clients who would not otherwise succeed in independent housing in the community without supports. This model allows for a focus on vacancies for the harder to place clients. This model also prevents incidences of homelessness and reduces shelter recidivism by better matching housing settings to individual needs.

A housing first approach will move more clients off the street and out of shelter faster. Agencies will be able to better match clients to supportive housing models that best meet the client's need with more varied population-specific supportive housing models and less restriction in eligibility criteria. Clients ready to "graduate" from supportive housing can begin to prepare for more independent living with access to rental assistance.

## Critical Partners

Critical partners include city, state, and federal government housing and community development agencies and health and human service agencies, institutions, hospitals, criminal justice system, non profit organizations, and NYCHA.

## Timeline

This initiative can be accomplished in the long term. The success of prevention efforts, reduced reliance on the shelter system, and resource reinvestment all require a successful housing strategy to move clients through the continuum of services.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

## Initiative

Increase the Supply of Service-Enriched Housing for Adults and Families

## Background/Context

The phrase “service-enriched housing” is used to describe the integration of supportive service programs into the operation and management of permanent rental housing. In this context, service-enriched housing represents an innovative and systemic change in confronting the long-term needs of individuals caught in a cycle of chronic homelessness.<sup>1</sup> There are no mandatory requirements for participation, but there remains a mechanism for immediate support and assistance when residents are in need. Case management is focused upon the coordination of programs and services available in the community, as well as crisis intervention and short-term case management.

This initiative seeks to (i) increase the supply of service-enriched housing for homeless and at-risk adults, as well as families, in all five boroughs of New York City; and (ii) build on the commitments in the Mayor’s 5-year *New Housing Marketplace* plan to develop housing opportunities sufficient to end chronic homelessness for individuals and families.

Specifically:

- Create a stock of “service-enriched housing” to target special needs populations using a housing-first approach that combines rental subsidies and service provision to address the housing needs of clients capable of independent living, but who have co-existing disabilities.
- Develop new service-enriched housing models for homeless individuals and families with special needs who are not adequately served by existing programs, including:
  - Replicate the Best Practices model cited by the National Alliance to End Homelessness.
  - Develop a similar model for the chronically homeless using a progressive demand model and an awareness of the multiple and complex issues that often prevent admission to traditional treatment and housing options.
  - Expand models for working homeless individuals and families.
- Expand the point of access for housing-first, rental subsidy programs to include clients who enter the system through outreach teams, drop-in centers, reception, and institutions (jail, prison, hospitals), and those who are often funneled into the shelter system but are not appropriate for, or are resistant to, supportive housing.

By expanding the point of access to rental subsidy and service provision, the number of clients that enter the shelter system from other service systems and institutions can be reduced. A more focused approach per target population is possible with a larger variety of housing options, which are flexible to meet the needs of homeless clients that either do not meet the criteria for supportive housing, or who have demonstrated some level of independent living skills. The success of prevention efforts, reduced reliance on the shelter system, and resource reinvestment all require a successful housing strategy to move clients through the continuum of services.

## Critical Partners

Critical partners include community-based providers and nonprofit housing developers, financial institutions and intermediaries, city, state and federal government housing and community development agencies and health and human service agencies, housing finance agencies and NYCHA, and private housing owners and managers.

## Timeline

The expansion of currently existing programs can be accomplished in the short term. In the long term, additional service-enriched housing options, along with a process for increased points of access to rental subsidies, will have to be developed.

<sup>1</sup> Unlocking the Door – Keys to Women’s Housing, McAuley Institute, September 2000.

# Provide Resources for Vulnerable Populations to Access and Afford Housing

**Initiative**

*Advance New Housing Marketplace Initiative*

**Background/Context**

The Mayor's 5-year plan to develop and preserve 65,000 units of affordable housing for individuals and families is ambitious and will require collective creativity and support to accomplish. Both city agencies and private interests will leverage funding, provide financial incentives, and simplify the regulatory and development processes to increase the supply of affordable housing. This plan will encourage the development of lower-cost housing, for singles in particular, by reducing barriers to the development of more modern models of SRO-type housing.

**Critical Partners****Timeline**

# Provide Resources for Vulnerable Populations to Access and Afford Housing

**Initiative**

Improve Community Relationships to Support New Community Housing Initiatives

**Background/Context**

The ten-year plan calls for an expansion of supportive and service-enriched housing and rental assistance interventions aimed at reducing reliance on shelter as an answer to homelessness. Developing or implementing these interventions will require sustained community support. While there is great public support for affordable housing development, these supportive interventions are not always perceived as having a similar benefit, especially at the neighborhood level. A coordinated effort to educate the public about the benefits and successes of these interventions is needed. On a parallel track, increased communication around existing shelter facilities and programs will increase public confidence in a range of interventions aimed at assisting the homeless.

**Critical Partners**

Community relations efforts should include public agencies, business leaders, nonprofit organizations, and advocates. A public education component around the benefits of these housing affordability interventions, and a neighborhood-by-neighborhood engagement process represent important strategies.

**Timeline**

While this initiative can be accomplished in the mid-term, there are numerous components that can be achieved more rapidly. Developing a community relations council, identifying a community engagement strategy, and creating public education materials can be achieved within the short term. Utilizing these materials to bring about community support for affordability initiatives will take a longer period.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

**Initiative**

Create and Maintain a Research Advisory Board

**Background/Context**

The Research Advisory Board will provide guidance to DHS and partnering agencies when launching new homeless research initiatives and drawing conclusions from ongoing projects. The Board will have expertise to set priorities, review methodology, and help create structures conducive to productive research. It will play a critical role in the data collection, research, and information sharing components of the ten-year plan. The Board will also serve as a vehicle for communicating important information about local homelessness to the research, provider, and government communities. In the past, DHS has relied on informal relationships with university-based researchers when conducting and analyzing research; the Research Advisory Board will formalize this type of important relationship.

**Critical Partners**

Critical partners include DHS, NYCHA, HPD, HRA, ACS, DOHMH, the criminal justice agencies, New York University, Columbia University, and City University of New York. University-based research will provide guidance on advanced research techniques and data analysis. Other stakeholders may include representatives from the provider community. Providers may offer guidance on research initiatives that should be informed by programmatic knowledge.

**Timeline**

The Research Advisory Board can be created in the short term. The task essentially requires the identification and engagement of possible members.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

**Initiative**

Conduct One-City Data Matches

**Background/Context**

DHS is beginning to document client pathways to homelessness. The purpose of this initiative is to increase interagency communication about common populations through data matching and sharing. As the City implements the ten-year plan, this initiative will help hold institutions accountable (possibly via Homestat) for the members of their populations that enter DHS, so as to ultimately decrease the incidence of homelessness. It will also help partnering agencies identify and implement new programmatic structures to prevent homelessness. For example, DHS and NYCHA are working together to implement a tracking system that would enable both agencies to identify individuals who need to re-certify their Section 8 vouchers and NYCHA apartments in order to prevent homelessness.

**Critical Partners**

Critical partners may include DHS, NYCHA, HPD, HRA, ACS, DOHMH, and the criminal justice agencies. Other stakeholders will include researchers and providers.

**Timeline**

This initiative can be accomplished in the long term. New data sharing initiatives will begin within a short term period, but will last throughout the ten years of the project.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

## Initiative

Track Key Indicators Impacting Homeless New Yorkers

## Background/Context

The Homeless Health Tracking initiative will begin to track key health indicators impacting homeless New Yorkers, using data from the New York City Department of Homeless Services and the NYC Department of Health.

Research suggests that high prevalence rates for drug, alcohol, mental health, and physical health problems are common among homeless people. The Homeless Health Tracking initiative is a tool that will be used to track specific health indicators impacting homeless people.

A component of the tracking will include the creation of a process for reviewing the nature of fatalities of known street homeless individuals. A process will be developed in collaboration with DOHMH Vital Statistics to quantify deaths of known street homeless individuals by way of incident reports, and verbal reports from outreach, drop-in staff, and other medical/social service providers. An additional component will include confidential reviews of deaths to identify potential changes in procedure or practice. This initiative will help the City respond to existing and emerging trends of health issues that impact vulnerable New Yorkers.

Currently, there is a wide range of literature documenting health-related issues impacting homeless people. Yet there is no central or easily accessible source of data about homeless people in the city. DHS records the deaths of homeless individuals currently receiving shelter or drop-in services and is informed of deaths when outreach teams become aware of one of their clients' deaths. However, in order to prevent street deaths, the City needs to know the profile of people who die on the streets— demographic information, like mental and medical health status. To remedy this, Homeless Health Tracking will integrate multiple data sets from the Department of Health to present updated information about the health status of homeless New Yorkers. The tracking system will be used to identify needs and gaps, and plan better programs and target resources.

Confidentiality requirements and an inability to verify the homeless status of some individuals may make the gathering of data inconsistent, particularly for those individuals not known to the system. However, in-house reviews of case records for those people who were clients will add considerably to the awareness of conditions leading to avoidable fatalities. Internal review of data will be able to be kept confidential, and a mechanism will be created to share data outside the agency so that no confidential information is released. Client information will be handled sensitively according to the confidentiality requirements of all the social service or other disciplines involved, and the legal department will be consulted about the exchange of information.

## Critical Partners

Critical partners include: DOH, DHS, and service providers. outreach service providers, city agencies (DHS, Parks, MTA, NYPD, ACS, DYCD, DOHMH, NYPD, EMS, Medical Examiners, HHC and Criminal Justice), research staff/researchers, program staff, and hospitals.

The stakeholders will be the consumers, who will provide information regarding general health status. They will be engaged through a case review process, information system sharing and collaboration, and multi-disciplinary planning sessions.

## Timeline

The tracking component can be accomplished in the short term and a street deaths database can be compiled in the mid-term. However, the Homeless Health Tracking will be modified as more information is collected going into the mid-term and then used as a tool for the long term.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

## **Initiative**

Use Data and Research to Inform and Evaluate Homeless Prevention Efforts

## **Background/Context**

HOMESTAT is a tool that will be used to evaluate the effectiveness of new homeless programs; track community, structural, and individual indicators of homelessness; and hold government and providers accountable for providing effective services. Despite impressive increases in the placement of homeless individuals and families into permanent housing, the DHS shelter census remains high. DHS' average daily family census in calendar year 2003 was higher than in any previous year. DHS has identified the need to address this sharp increase in the number of families and adults living in homeless shelters. As New York City launches its ten-year plan and implements its Housing Stability Initiative, the implementation of HOMESTAT is both timely and crucial. Given limited resources, it is critical that local government administrators and service providers work together to understand factors leading to homelessness, identify effective interventions and best practices, and implement broad policies that ultimately reduce the incidence of homelessness.

Additionally, DHS, HPD, NYCHA, and the Vera Institute of Justice have been working together over the past year to develop a dynamic prevention research agenda. The main goal of the project is to understand pathways to homelessness by researching how households enter the homeless system and where they come from prior to seeking shelter by exploring their housing and social histories. The project also seeks to identify the most common routes to the shelter system and identify the conditions and precipitating events that lead families into homelessness. The results of the "Vera Project" will play a crucial role in homelessness prevention program development and will guide and serve as a baseline for research conducted as part of the ten-year plan.

## **Critical Partners**

Critical partners include DHS, HPD, HRA, NYCHA, ACS, DOHMH, Vera, the criminal justice agencies, providers, and researchers.

## **Timeline**

This initiative can be accomplished in the short term. However, Homestat will be modified as more information is collected going into the mid-term and then used as tool for the long term.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

**Initiative**

Track Community Level Performance

**Background/Context**

Once the ten-year plan is created, the partnering agencies will need to identify the key related milestones, targets, and outcomes. Progress toward the key milestones, targets, and outcomes should then be tracked in comparison to baseline performance in one central location. The manager of the tracking system will meet with all key players involved in the implementation of the ten-year plan to identify indicators to track, create methods of data collection, and establish a data warehouse. The manager of the tracking system will regularly meet with key players to discuss progress and maintain accountability.

**Critical Partners**

Critical partners will include DHS, NYCHA, HPD, HRA, ACS, DOHMH, OMB, the criminal justice agencies and providers. Other stakeholders will include consumers and community members. Stakeholders will participate in workgroups organized around setting targets and goals and discussing and improving upon performance. All partners will be engaged in the development of the tracking system, as well as regular meetings to hold key players accountable.

**Timeline**

The tracking system will develop as other ten-year plan initiatives develop – in the short term, mid-term, and long term.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

## **Initiative**

Reinforce the Objectives of *Uniting for Solutions Beyond Shelter* Through Staff Training and Development

## **Background/Context**

As the City launches its ten-year plan to end chronic homelessness, it will be crucial to communicate the principles and goals of the plan to all staff involved in implementation. The plan will require a change in thinking about services for people vulnerable to and experiencing homelessness, if it is going to be effective. Staff will need to know basic and advanced skills involved in empowering clients and preventing homelessness. For example, line staff working in community-based programs will need to know how to deal with and prevent evictions. Staff will also need to understand how to find housing and acquire public benefits in New York City. One idea is to create an academy approach to training in-house, cross-agency staff and providers. Next steps would include developing cross-agency training relationships and identifying training goals and curriculums.

## **Critical Partners**

Critical partners will include DHS, NYCHA, HPD, HRA, ACS, DOHMH, OMB, and the criminal justice agencies. Other stakeholders will include providers and consumers. Providers and consumers will play an important role in creating training curriculums.

## **Timeline**

Training must incorporate the goals and principles involved in the other ten-year plan initiatives, so this initiative will evolve over time. The initial brainstorming structures can be achieved in the short term, but the specific training initiatives/program may be completed in the long term, as needs are defined and redefined. Training may last into a long-term period, as needs change.

# Measure Progress, Evaluate Success and Invest in Continuous Improvement

**Initiative**

Implement a Broad Public Education Campaign

**Background/Context**

Overcoming chronic homelessness cannot be accomplished by a single public agency or the public sector alone. Central to the ten-year plan is the proposition that a strong partnership between public agencies, the private sector, and nonprofit organizations must form the foundation of any successful strategy. Even more, the goodwill of concerned citizens and neighborhood groups must be tapped to advance key initiatives and reinforce the notion that many solutions to homelessness must occur locally. A broad-based public education campaign has potential to build public support for solutions, create a sense of community ownership around addressing homelessness, and build confidence in ongoing and substantial public investments. Additionally, public education strategies can do much to overcome the often-polarizing climate in which homelessness policy is shaped in New York City, building collaboration and new partnerships in the process.

**Critical Partners**

Marketing and public education professionals, as well as those with expertise in public opinion research, should be engaged to create a public education framework. These professionals should consult with advocates, service providers, and policy makers to help identify this framework, which should focus on key initiatives.

**Timeline**

This initiative can be accomplished in the short term, as it relies only on bringing together marketing and public education professionals to start the framework discussion. Identifying resources may take longer, but should be achievable within the short term, as well.