Building A Bridge
to the Future

Savannah’s
Ten-Year Plan
to End
Chronic
Homelessness

Prepared By:
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Executive Director

The Homeless Authority

Revision IV
Savannah, Georgia’s first city is nationally known for its beauty, rich history and southern hospitality. Thousands of people travel here every year to see the splendor and charm of the South. However, like many cities across this nation, there is a hidden reality, not all residents experience the beauty of their City the way tourists do.

As Mayor of Savannah, I have come to know that the Homeless Continuum of Care most often is the “safety-net” for other systems of care that do not meet the needs of our most vulnerable individuals and families. It has been determined that 90% of our chronic homeless population can be traced to a behavioral health issue. We have had excellent success in our community by addressing homeless issues in a systematic way through the leadership of the Homeless Authority. Our Continuum of Care organizations have lowered the number of those experiencing homelessness by 37% over the last ten years. We have, however, become a victim of our own success. Though we have had excellent results with lowering the number of people who experience homelessness, the mainstream population, we have encountered many challenges addressing the chronic homeless population in our community.

The Chronic Homeless population is “service resistant” and often times moves back and forth through local shelters, the city and county jail, hospital emergency rooms, and ultimately to the street. Our county jail over the last decade has become one of our community’s largest treatment facilities for those with behavioral health disorders. Our community needs to be in a position to identify, treat, and house those most in need rather than incarcerate those suffering from behavioral health disorders.

Savannah’s ten-year plan to end chronic homelessness will aim to address these issues through a combination of efforts. Currently, we are now moving forward with two innovative efforts. Our community is the first community in the State of Georgia to effectively link the Homeless Continuum of Care and the Behavioral health Continuum of Care. Additionally, the Savannah-Chatham Police Department has recently adopted and developed the C.I.T. (Crisis Intervention Team) model that will place trained officers in each precinct to effectively identify, assess and refer those with behavioral health issues in our community to local programs.

It is with these creative and innovative ideas that our community can move forward. Like all effective efforts, we will need to continually blend current strategies, and redesign our systems of care to effectively meet the changing needs of our residents. This ten-year plan is a step in that direction, and I am confident that we will succeed while always keeping in mind the compassion, dignity, and respect for those we serve.

Sincerely,

Mayor Otis Johnson
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As in the Mayors of cities across our country, we have committed ourselves and our cities, in partnership with the United States Interagency Council on Homelessness, to end chronic homelessness in the United States within ten years. In our local communities, we have invited a diverse array of stakeholders including the public, private, non-profit, and faith-based sectors, and homeless people themselves, to collaborate with us and one another to create plans to achieve this urgent goal.

Now, as leaders in this national initiative to end chronic homelessness, we declare our intention to collaborate with one another in this effort. As a group of cities varying in size and geography, we will explore and implement strategies that will create a visible, measurable, and quantifiable reduction of chronic homelessness on our streets and in our shelters with the intent of ending this national disgrace. Our objective is to hasten the achievement of our collective goal by establishing successful, replicable practices that lead to ending chronic homelessness nationwide.

Initially, we will pursue in common efforts to reduce chronic street homelessness in our cities.

- We will be guided by research and data, results and performance.
- We will seek the most innovative initiatives in cities across our country and the world, including those in Philadelphia, San Francisco, and London, to achieve this goal.
- We will serve as leaders for other cities that seek to follow our example.
- We will commit to creating strategies to reduce deaths of homeless people on the streets of our cities.
- We will ensure that homeless veterans are prioritized in our individual and collective efforts.

To advance these efforts, we covenant with one another:

- To design a common methodology for conducting repetitive counts of street homelessness, to establish a baseline number, to monitor results, and to share that information with each other;
- To advance productive partnerships that establish in each of our communities a central, cross-agency record of persons experiencing chronic homelessness, their involvement with public and private agencies, and the resources that can assist with their housing placement;
- To share with one another on a regular basis our progress in placing persons experiencing chronic homelessness into housing;
- To develop and maintain mental health, substance abuse, life skills, and other resources that engage and support individuals and end chronic homelessness;
- To test and advance new messages to reframe the issue of homelessness in our communities through a coordinated public education/communications campaign; and
- To meet regularly to review our progress in achieving our goal and to study together the latest developments that will support our direction and commitment.

We further covenant to assist each other in implementing these measures; to report openly on our learning and progress; to explore other complementary and replicable strategies to prevent and end chronic homelessness; and to welcome additional cities into our collaboration.

We commit together to end chronic homelessness.
Executive Summary

Congress established the Interagency Council on Homelessness in 1987 with the passage of the Stewart B. McKinney Homeless Assistance Act. The Council is responsible for providing Federal leadership for activities to assist homeless families and individuals.

Ending chronic homelessness was brought to the forefront at the beginning of the decade as a key strategy. During the first term of the Bush Administration, the federal entity charged units of state and local governments with the tasks of developing strategic plans to end Chronic Homelessness within a ten-year period.

In 2003, the Interagency Council on Homelessness began to guide and coordinate the efforts of Federal agencies, and the U. S. Conference of Mayors adopted the effort to energize local efforts to develop plans to end chronic homelessness in the next 10 years.

Under Governor Roy Barnes, the State of Georgia applied to participate in the nation’s first Homeless Policy Academy to address the needs of the homeless through an initiative to improve access to mainstream services for persons who are homeless. The state was also charged with the responsibility of developing an action plan to end homelessness in ten years. Under Governor Sonny Purdue, The State of Georgia Interagency Homeless Coordinating Council completed their final revisions to the Homeless Action Plan in the Fall of 2004.

The City of Savannah, through its designee, the Homeless Authority, began working with local organizations, and advocates on innovative solutions to address the issues of chronic homelessness at the same time. This taskforce began looking at creative partnerships that would address system barriers that affect the delivery of services to the chronic homeless.

Examining chronic homelessness and the systematic barriers that commonly affected service delivery was the prime focus. All those involved in the planning process also addressed creative solutions and the implementation of a new delivery system that would be based on client needs, rather than funding restrictions.

The U.S. Conference of Mayors signed a new covenant with the Interagency Council on Homelessness agreeing to collaborate in the exchange of data, share best practices, and welcome other cities to join the collaboration.

The ten-year plan to end chronic homelessness is a “Bridge to the Future”. It is a way to systematically and structurally change how we deliver services by linking the Homeless Continuum of Care with the Behavioral Health Continuum of Care, including housing, supportive services, and primary health care.

Craig J. Cashman

Executive Director of the Homeless Authority

For Questions regarding the content of “A Bridge to the Future, Savannah’s Ten-Year Plan to End Chronic Homelessness”, please contact Craig Cashman, Executive Director of the Homeless Authority at (912) 790-3400, or by e-mail at craig@homelessauthority.org
Building a Bridge to the Future

**An Advocates Message**

We all have dreams. That’s healthy, they direct, push, and challenge us.

Homelessness was never in my dreams, yet it happened to me like it happens to so many others like me. I lost everything, ended up on the street, went from shelter to shelter, soup kitchen to soup kitchen, and bottle to bottle. I was considered a “Chronically Homeless Person”

Have you ever heard, or even thought of these statements about homeless people before: “they’re just free loaders”, “they’re lazy, they don’t want to work, or, they’re just looking for a hand out.

Now I want you to ask yourself, who would:

- Willingly lose their job,
- Their family,
- Their health, and
- Ultimately, their dignity?

Would someone voluntarily put himself or herself in this position? Would that be your dream for your future?

So what does a chronically homeless person look like? Maybe some one that is down and out on their luck for years, disheveled, panhandling and sleeping on the streets? My answer to you is no. Every person and every situation is different.

I’m a graduate of the University of Georgia in Business Administration. I served our country in the military, and successfully worked in the business world for 30 years. Yet I found myself on the streets like so many other people.

I also found so many caring people willing to help me address my situation and my addiction. But so many people fall through the cracks.

Through my experience of living on the street and later sitting on the Boards of the Homeless Authority, and The Georgia Coalition to End Homelessness, I discovered that systems of care and funding do not adequately address chronic homelessness. The regulatory barriers to funding do not address the homeless individual that needs multiple services.

Housing, supportive services, primary health care, and behavioral health treatment are too often provided separately. This has to change in our communities if we hope to successfully treat the chronic homeless.

I appreciate life, I appreciate everyone that helped me on my journey, and now I appreciate giving back by staying actively involved as an advocate.

Savannah has always been a leader in developing creative solutions to address homelessness. This 10-year Plan will address Chronic Homelessness and draw on new creative solutions that will ultimately help many others in need.

Sincerely,

Robert V. Smith

Robert Vincent Smith
Advocate, Chairperson of the Homeless Authority

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“Homelessness was never in my dreams”
What is Chronic Homelessness?

HUD Definition:

A person who is “chronically homeless” is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, OR has had at least four (4) episodes of homelessness in the past three (3) years.

In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter.

A disabling condition is defined as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability including the co-occurrence of two or more of these conditions. A disabling condition limits an individual’s ability to work or perform one or more activities of daily living.

Why Plan to End Chronic Homelessness?

In 2001, the U.S. Department of Housing and Urban Development (HUD) announced that the Bush Administration had established the goal of ending chronic homelessness within a decade. This initiative targeted single homeless persons with disabilities and long periods of homelessness – a year or more – or frequent experiences of homelessness over several years.

Chronically Homeless persons are generally “service resistant” and do not take advantage of available resources due to bad experiences and severity of their illness. Reluctance to use services often times exacerbates their illness, and increases their need for higher levels of care. This ultimately fosters a life-time dependence on the

With adequate services and housing, those that were held hostage by their disability discovered productive lives.

What is the Problem Locally?

Though we have significantly reduced the number of mainstream homeless people in our community over the last decade by 37%, from 6,511 to 4099, we have been burdened by insufficient behavioral health services. This has placed our Homeless Continuum of Care in the position of becoming a safety net for a broken behavioral health system.

Locally, according to the HUD definition, Savannah’s Chronic Homelessness population is two times the national average.

Can We Make an Impact on Chronic Homelessness?

Yes. Savannah has had a long history of prioritizing homelessness. With the creation of the Chatham-Savannah Authority for the Homeless over a decade ago as the planning and coordinating entity many, innovative services have been generated.

After three years of planning and redesign, we have successfully developed a new Behavioral Health Continuum of Care and integrated it into the Homeless Continuum of Care so that housing, primary health care, and behavioral health treatment are provided by a formal collaboration of agencies.

The Savannah Area Behavioral Health Collaborative, (SABHC) is a formal partnership that brings together a local regional healthcare provider, Memorial Health University, the largest housing & primary health provider for homelessness, Union Mission, Inc., a local outpatient substance abuse treatment organization,
Recovery Place, and the Homeless Continuum of Care coordinating agency, the Homeless Authority.

**Homelessness is the most visible sign of poverty.** According to data generated from the Anti-Poverty Task Force here in Savannah, about 30,000 people are at or below the poverty level in the city of Savannah each year. On average, 4000 individuals and families experience homelessness and seek established services in the homeless Continuum of Care. Approximately 2000 people are considered “couch homeless”, with no fixed permanent place to stay but are temporarily making housing connections through friends, families, and acquaintances.

**Common Myths About Poverty**

- **Myth:** The federal threshold for poverty is enough to get by.
- **Reality:** The poverty rate for a family of 4 is $18,600. Based on the local cost of living, the income necessary to live without government subsidy for a Chatham County family of 4 is $36,419.

- **Myth:** That people in poverty are lazy.
- **Reality:** Sixty percent (60%) of all families in poverty locally report earning wages.

- **Myth:** There is a large government welfare support system.
- **Reality:** Welfare reform has reduced it.

**Poverty is also the strongest indicator of homelessness.** Without adequate prevention efforts with those most at risk for homelessness, the front door to entering the homeless Continuum of Care will unfortunately remain wide open.

This is especially true for those with substance abuse and/or behavioral health issues. Over the last 10 years the Chatham-Savannah Continuum of Care has developed a wide array of services from an increase in emergency shelter beds, to the development of transitional and permanent housing programs. In addition, many needed supportive services were identified, developed, and successfully implemented. As a result, Savannah has demonstrated a 37% reduction in homelessness over a 10-year period.

We are however a victim of our own success. Although we have had much success with the mainstream homeless population through the development of initiatives like employment programs, healthcare for the homeless, and unified case management, we have had limited success with the more chronic population...
and our ability to link systems of care, and with development of transitional, and permanent supportive housing.

**Regional Challenge:**

Given the distinction of being the largest metropolitan area in the coastal region in the State of Georgia, Chatham County and the City of Savannah maintain the largest capacity of services both in health care and human service organizations. Both communities are easily accessible and are located in close proximity to I-95 and I-16.

As a direct result of these facts, individuals seeking services in the coastal region, enter the system from rural areas and remain as part of the community. It is estimated by a local regional hospital, Memorial Health University, that 52% of their general admissions are from outside Chatham County.

Georgia State Regional Behavioral Health Hospital, located here in Chatham County, discharges one third of their admissions back to Chatham County. The data collected by the Homeless Authority has consistently determined that 25% (1,025) of the (4,009) unduplicated homeless population, has a county of origin outside Chatham.

The lack of coordination, service delivery, and experiential knowledge of the complex issues confronting those who are homeless, or at risk of becoming homeless, forces those in need to seek alternative services outside their community of origin.

The Bush administration, through the U.S. Department of Housing and Urban Development, has placed an increased emphasis on serving chronically homeless people. Additionally, emphasis has been placed on housing and the development of mainstream funding for this population.

**Behavioral Health Challenge:**

According to a local behavioral health provider, there are over 40,000 people in Chatham County who suffer from substance abuse problems. These problems affect not only them but their families as well. It is estimated that over 160,000 people in Chatham County have behavioral health needs. With 19% of the county below the federal poverty level and an additional 13% under 200% of the poverty level, and over 4,000 homeless individuals, the need for a strong system of care is obvious.

The current cycle of treatment and release with little or no follow up care locally, has led to a severely chronically ill population who need continued intervention and sustained treatment. Frequent delays in treatment and lack of coordination between service providers have left many seeking treatment with a series of...
disjointed and inadequate services. Many of these individuals end up in Georgia Regional Hospital, or become involved with the criminal justice system, which is neither appropriate nor necessary.

Repeated patterns of hospitalization, incarceration, crisis treatment, and sporadic shelter stays are characteristic of this population. Institutional care at hospitals, jails, and other facilities carries a very high, uncompensated cost to the State. Offering permanent supportive housing with associated services is a much more cost effective public policy than continuing to bear the costs of repeated institutionalization.

According to local emergency shelters, 68% (2,787) of (4,099) of the homeless population identify as having a history of behavioral health problems.

In accordance with HUD’s definition of Chronic Homelessness, the Chatham-Savannah Authority for the Homeless applied this definition to determine a baseline.

According to results generated from the Homeless Management Information System through the Homeless Authority, the Savannah Continuum of Care realized a (2%) reduction in chronic homelessness from 2002 to 2003. Additionally, the continuum developed new housing in the last 12 months for those with behavioral health needs.

With the integration of a new behavioral health system and the homeless Continuum of Care, the identification of those individuals in the community with chronic issues has been greatly enhanced. There has also been an immediate reduction in the length of time to provide psychiatric assessments to the homeless mentally ill, down from a one month waiting period a year ago, to one day. The same length of time has been reduced for addiction services. According to Savannah Area Behavioral Health, though they are treating more chronic homeless, they are seeing a reduction of recidivism both with inpatient and outpatient.

This document will:

Briefly review the previous success of our first 10-year plan, examine a “system redesign”, the development of Savannah Area Behavioral Health Collaborative, and focus on the challenges, and opportunities that lie in front of our community to continue addressing chronic homelessness.

In preparing this document, we recognize the following:

- This plan is a “living document” and will need to be periodically reviewed, evaluated, and amended as new challenges and opportunities
Homelessness is the most visible sign of poverty, and though not the main focus of this 10-year plan, significant consideration must be given to address all the factors that lead to poverty. Future findings addressed by the “Anti-Poverty Task Force,” in conjunction with the Homeless Continuum of Care, will need to be incorporated into this “living document” as evaluated.

Collaboration with a centralized approach to planning, implementation, delivery of service, and evaluation is critical to address the complex issue of homelessness.

Funding silos, from local, state, and federal initiatives, are often barriers to collaboration, and new program initiatives.

Chronic Homelessness, has to be addressed by redefining the system of care, linking the Behavioral Health System with the Homeless Continuum of Care, supportive services, housing, and primary health care.

Coordinated, unified case management must link the community, not only the homeless Continuum of Care, but also the behavioral health continuum of care and DFACS, and focus on the most at-risk families in our neighborhoods.

The Homeless Authority wishes to express a special thank you to the City of Savannah, the Board of Directors and staff of the organization, the many providers of services, volunteers, advocates, and most importantly, those that have experienced homelessness for their input and discussion during the formation of this plan.

We would also like to dedicate this initiative in memory of Russ Billings, a board member of the Homeless Authority, and a true advocate in the Savannah community for the homeless and those suffering from behavioral health issues.
Savannah has had a rich history of developing innovative approaches to address community needs. As a result of an increase in the number of homeless people, the community conceived of the Chatham-Savannah Authority for the Homeless in order to mount a systematic response.

The Chatham-Savannah Authority for the Homeless was created by the Georgia Legislature in 1989 to accomplish the following:

- Develop a comprehensive plan for public and private agencies to deal effectively with problems of homeless people in Savannah and Chatham County,
- Coordinate, evaluate, and provide administrative services and assistance in implementing the plan,
- Contract with public and private agencies to approve programs and services developed in the plan.

This unique body was charged with the responsibility of addressing the many issues surrounding the problems of homelessness. The Authority was comprised of representatives from the City of Savannah, Chatham County, the Georgia Department of Labor, the local Board of Education, the Georgia Department of Community Affairs (Housing Trust Fund), the Georgia Department of Human Resources, the housing Authority of Savannah, and eight (8) additional appointees elected by the Authority members which include the homeless.

**Created by the Georgia State Legislature in 1989**

This Community-based organization fulfills its role through collaborative arrangements and innovative partnerships with providers of services, and advocates, local governments, religious bodies, civic clubs, law enforcement officials, social agencies, volunteer organizations, and other groups with similar goals and objectives. The City planning staff works closely with Authority members and staff to ensure the participation of residents and local merchants in dealing with a broad range of concerns affecting homeless people.

Presently funded by the City of Savannah, the Department of Community Affairs, and other local, state, and federal sources, the organization has instituted a planning process which
emphasizes the development of a comprehensive and integrated system of social services based on case management to assist homeless people and those at risk of becoming homeless.

As an umbrella agency responsible for the coordination of services for homeless people in the community, the Authority has established working relationships with each of the social service agencies involved in homeless issues.

When problems surface surrounding homelessness, they are brought to the attention of the Authority by service providers, advocates for homeless people, local government, and homeless people themselves. To resolve the problems or attend to the issue at hand, the Authority marshals resources to respond to needy parties and encourages joint decision-making.

This all-inclusive approach has enabled the Authority to address concerns voiced by many different agencies in the community in a collective manner. As a direct result, the Homeless Continuum of care is viewed by the public as a cohesive unit with individual agencies combining knowledge, skill, and resources for a common purpose.

Shelters and service providers advocate together and pursue joint ventures when gaps in service delivery are identified. Educational forums are held to increase the ability of elected officials to retain funding for Homeless programs and secure monies for new initiatives.

Over the last 10 years the Chatham-Savannah Continuum of Care has developed a wide array of services from an increase in emergency shelter beds, to the development of transitional and permanent housing programs. In addition, many needed supportive services were identified, developed, and successfully implemented. As a result, Savannah has demonstrated a 37% reduction in homelessness over a 10-year period.

**Brief Review of Prior 10-Year Plan**

In January 2004, the Chatham-Savannah Authority for the Homeless began the process to review the community’s first Comprehensive Plan to respond to the needs of homeless people. The 1993 Comprehensive Plan mobilized independent organizations and agencies into a common army for an attack on the country’s most visible form of poverty. The Authority proved successful in accomplishing a majority of the activities established in the plan, and in the spring of 1994, began planning for the next phase in its response to homelessness.

In 1994 the Comprehensive Plan was updated and included additional goals which served as the new battle plan for the attack on homelessness based on the Continuum of Care defined in *Priority Home: The Federal Plan to Break the Cycle of Homelessness*. The new goals were both qualitative and quantitative measurements designed to strengthen the Continuum of Care, and to reduce the number of homeless people in our community. This revision was endorsed by the Savannah City Council in November 1994.

It is important to note that the revised plan did not include a detailed allocations process. This is due to the method by which city, county, state, and federal monies are distributed. The plan did, however, position the Homeless Authority as the lead entity to plan and coordinate all homeless services in the city and...
Presently, the Homeless Authority makes recommendations to the City of Savannah, the Georgia Department of Community Affairs (Housing Trust Fund), and participates on local boards for the distribution of homeless funds. Other units of government choose to allocate funds intended to help homeless persons independently from the community’s Housing and Community Development Plan. Until the allocations process serves to facilitate the implementation of the Comprehensive Plan, fragmentation, duplication, turf battles, and unnecessary services have the potential to exist in our community.

The six goals in 1994 for the 10-year plan were as follows:

Goal 1: Establish legitimacy for the Chatham-Savannah Authority for the Homeless.
Goal 2: Ensure maximum coordination and training among agencies and programs serving homeless people.
Goal 3: Achieve community-wide accountable and efficient service delivery among homeless service providers.
Goal 4: Provide access to training and service opportunities for all homeless people.
Goal 5: Reduce the number of homeless people in the community annually.
Goal 6: Serve as the primary entity charged with keeping the community focused on the problems of homeless people until they have been adequately addressed.

Services Developed and Accomplishments

The following services have been developed for homeless people over the last 10 years. It is important to note that each service did not duplicate current efforts but rather addressed gaps in services that were carefully identified, planned, and implemented by the Homeless Authority and the Continuum of Care planning structure.

The subsequent flow chart illustrates existing services, and programs that were developed under the planning and direction of the Homeless Authority and the Continuum of Care organizations. Services
underlined represent those that were developed over the 10-year period. (See next page)
Accomplishments

In 1994, the Chatham-Savannah Authority for the Homeless completed the revisions to the first 10-year plan endorsed by the City Council. Over that period of time the available beds dedicated to homelessness increased almost three fold, from 423 in the community to today with 1139.

In order to avoid estimations and to arrive at a true analysis of the scope of the homeless problem, the Authority instituted a methodology by which all agencies report the name, social security number, birth-date, race, and veteran’s status of every individual served in the Continuum of Care. These are reported monthly by outreach workers and case managers and all certified member agencies to the Authority.

Building a Bridge to the Future

Beginning in 1992, the count established that 6,511 persons experienced homelessness that year. This enabled the Authority to establish a baseline by which to measure the Continuum of Care’s effectiveness in reducing homelessness. Because the Continuum of Care is built upon movement, and the Authority is a proponent of outcome-performance based measurements, the annual count is compared with the previous years to determine the effectiveness of the effort, and to determine gaps in service.

Sheltered homeless since 1992 represented 58% (27,187) men, 19% (9,108) women, and 22% (10,426) children. The recidivism rate remained the highest for men at 34%. Women and children reentered the system 9% of the time.

Accomplishments of the Chatham-Savannah Continuum of Care Model
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<td>13%</td>
<td>40%</td>
<td>50%</td>
<td>43%</td>
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This collaborative, all-inclusive approach has caused the number of homeless people to be reduced by 37% since 1992.

Numbers furnished by the Homeless Authority.
"Building a Bridge to the Future"

*Ending Chronic Homelessness*

**Strategic Plan**

**Savannah’s Vision Statement:**

"**A city free of chronic homelessness**"

**Savannah’s Mission Statement:**

"**To prevent and end chronic homelessness in the City of Savannah by developing and implementing a comprehensive, innovative ten-year strategy to end chronic homelessness**"

**Evaluation of Plan**

- The goals of this initiative are designed to strengthen the Continuum of Care, and to reduce the number of Chronic Homeless people in our community.

- Each goal will have strategies, actions and outcomes.

- The strategies outlined in the plan will be reviewed in six-month intervals.

- The review of the strategies will be the responsibility of the Homeless Authority and the Continuum of Care Planning Committee.

- The plan is a “living document”, and may be amended or altered by the Planning Committee after careful review of new information at six-month intervals.

- After evaluating the plan, and reviewing all available data, The Homeless Authority, and the Planning Committee will generate a year-end report to the community.
### Summary of Goals

**Goal 1  Reduce and prevent homelessness by integrating and redesigning the services delivery system.**

Service delivery systems often times function in conflict with each other. This is especially true for the service resistant client. The development of a collaborative system that is flexible and meets the needs of the more chronic population such as Savannah Area Behavioral Health Collaborative, can generate more productive outcomes.

The role of law enforcement is critical to a behavioral health event in the community. Police-based intervention with a crisis can redirect consumers away from the criminal justice system, and to the behavioral health system. The Crisis Intervention Team (CIT) is such a model and establishes a front door for treatment.

**Goal 2  Decrease the number of chronic people on the street and in shelters.**

Community case management and outreach is the cornerstone for the prevention, and reduction of chronic homelessness. Linking behavioral health treatment, housing, and primary health care, by providing one case management system in the community for the Homeless Continuum of Care, and the Behavioral Health Continuum of Care will ensure continuity of services.

**Goal 3  Expand and preserve the supply of permanent supportive housing.**

Without safe, decent, supportive housing, ongoing services to the chronic homeless will ultimately fail. The “Housing First Model” relies heavily on a community’s recognition that housing is a priority for this population and that wraparound services, especially case management, will be maintained.

**Goal 4  Increase the number of chronically homeless persons obtaining employment and benefits for which they are eligible.**

The Chronic homeless seldom access SSI/SSDI benefits. The development of a service system that can be sensitive to acquiring mainstream benefits and develop targeted employment programs which can expedite individuals in reaching self-sufficiency.

**Goal 5  Prevent future homelessness by avoiding discharges into the street.**

All public institutions such as: Hospitals/Emergency Rooms, correctional facilities, youth detention and foster care services, Mental Health Institutions, bear a responsibility with that community to adequately place individuals in housing upon discharge. This will ensure self-sufficiency.

**Goal 6  Enhance the data collection system to measure results.**

The evaluation of the chronic homeless plan will be the responsibility of the Homeless Authority and will occur bi-annually. The Homeless Management Information System (Pathways) will be the primary data collection tool.
Goal 1: Reduce and prevent homelessness by integrating and redesigning the services delivery system.

Redesigning a System of Care
* Innovation in progress

Background Information:

The infrastructure developed over the last decade across the United States and, in particular, here in the Savannah Homeless Continuum of Care has positioned communities to more effectively address the many facets of homelessness. Housing and Supportive Services are equally important to ensure an effective transition plan, most particularly for the Chronic Homeless.

Successful Homeless Continuum of Cares effectively identify gaps in services, develop programs to address these needs, and evaluate the progress of those that are homeless as they transition back into the mainstream community. Effectively addressing “Chronic Homelessness” however requires a community to not just look at the gaps in services, but also to intensely examine how the service delivery system for this population is working.

If there is one important factor that our community has learned over the last decade about homelessness is that needs continuously change. This factor may be driven by the economy, funding, political climate, or ultimately, the lack of services, and/or the inflexibility of current systems in place. All must equally be considered.

However, if a community can adapt to changing needs by developing a system of care that “Builds a Bridge” to other systems, new and innovative approaches to service delivery can be made possible.

“The Homeless Continuum of Care, and local jails became the safety net for a broken behavioral health system.”

Recent History of Behavioral Health Services

The City of Savannah and the County of Chatham, have been plagued over the last decade with a behavioral health system that was ineffective and deteriorating due to the lack of appropriate funding and mismanagement. State and Medicaid funding, the two primary funding sources for behavioral health services, were continually reduced, and for some critical services, discontinued altogether. During this time, two behavioral health systems experienced financial difficulties, one ceased to exist, and the other experienced such deficits and mismanagement, the State assumed management and contracts were eventually taken away.
With the reduction, and in some cases, a total lack of behavioral services in the community, the homeless continuum of care, and local jails rapidly became the safety net for a broken behavioral health system. Chronic Homelessness, those on the streets and in shelters began to rise. Over a period of five years, as illustrated by the annual homeless count conducted by the Homeless Authority, the number of those on the streets and in shelters increased by 20%, from (2,799) to (4,099).

The Formation of the Savannah Area Behavioral Health Collaborative

*The mission of the Savannah Area Behavioral Health Collaborative is:*

“To facilitate the movement of persons most in need with behavioral health issues through a Continuum of Care of services in a timely, compassionate, and cost-effective manner so that they can achieve self-sufficiency.”

The Savannah Area Behavioral Health Collaborative is a 501-(c)-3 non-profit corporation and is comprised of four member organizations: Union Mission, Inc., Recovery Place of Savannah, Memorial Health University Medical Center, and the Chatham-Savannah Authority for the Homeless.

The organization was formed to develop an accessible, seamless, outcome performance-based service delivery system targeting the substance abusers, the mentally ill, the dual-diagnosed, and chronic homeless. Through a continuum of behavioral health services integrated with the homeless Continuum...
SABHC has a 11-member Board of Directors. A four member Executive Committee and a Chief Executive Officer provide the day-to-day operational directions. SABHC expects all of its member agencies to meet the required licensure and accreditation standards, as well as meet and/or exceed specific service and outcome requirements. Among the member agencies, there is accreditation from both CARF and JACHO. Towards this effort, SABHC utilizes Memorandums of Agreements (MOA) to contractually obligate each member agency.

The Savannah Area Behavioral Health Collaborative (SABHC) organizational philosophy has produced a prototype of a continuum of services designed to aide in the recovery of adults who are experiencing the debilitating effects of mental illness and/or substance abuse disorders. SABHC utilizes existing resources and infrastructure of the controlling members to address the multi-faceted needs of each individual consumer: housing, primary care, hospitalization, dental services, mental health services, addictive disease treatment, employment and training, case management, literacy education, and HIV/AIDS services. This comprehensive behavioral health configuration leverages over 100 years of collective experience with the infrastructure of a proven collaboration to produce a cost-effective continuum of services.

**FOUR ASPECTS OF THE COLLABORATIVE MODEL MAKE IT DIFFERENT FROM OTHER SERVICE DELIVERY SYSTEMS**

1. **Housing and primary health care is not assumed.** Most organizations offering behavioral health services assume that consumers have a home to go to when they are not in treatment. This is often not the case, and homelessness fosters relapse and recidivism. Often consumers with housing reside in places that are not conducive to treatment, again fostering relapse and recidivism. Primary health care is significant to treatment outcomes and critical to prevent relapse.

2. **Case Management is the cornerstone of the SABHC delivery system.** Linking Case Management and Outreach from the Behavioral Heath Continuum of Care with the Homeless Continuum of Care provides for continuity of services for the most chronic population. An integrated case management system that combines the resources of the homeless continuum of care with behavioral health services ensures transportation, benefit enrollment, crisis respite, housing placement, medication management, and crisis intervention for those most in need.

3. **The emphasis is on service delivery and not administration.** Because each of the member agencies already have administrative staffs in place, contracts for services awarded to SABHC do not require the establishment of expanded administrative capacities. Administrative and any additional staff, that is necessary, are kept to a minimum. This means that more resources are available for the consumers rather than the organization.
The collaborative is expandable. As gaps are identified in services, or particular programs need to be enhanced, other experienced providers may be brought into the collaborative to ensure a seamless service delivery system.

There are several obvious strengths of the collaborative effort that current delivery systems cannot match. These strengths would be very attractive to entities that provide funds to substance abuse, mental health, and dual-diagnosed programs.

Specifically, the collaborative model offers the following strengths:

1. Established capacity in that all of the facilities are already owned by the collaborative members and are ready for immediate or imminent utilization for these purposes. For those facilities not immediately ready, a bridge plan is in place.

2. The collaborative is comprised of members in the community who are experienced in the delivery of services to the target populations.

3. There are numerous points of entry into the system, thereby enhancing service delivery and ensuring that the most chronic do not fall through the cracks.

4. Because there is an existing inventory of transitional and supportive housing units, consumers who require long-term care may be appropriately housed for the duration of treatment. This significantly reduces hospitalization recidivism and crisis management.

5. The collaborative model produces a Behavioral Health Continuum of Care of services that manages movement from crisis to self-sufficiency.

6. The collaborative model is outcome-performance based and can quantify its success with patients as they move through the Continuum of Care.

7. The collaborative brings numerous existing resources to the effort which would be utilized to match any funds requested, thereby reducing the overall cost of the program as compared to existing delivery systems.

8. The collaborative allows for more intensive services, thereby achieving faster movement through the Continuum of Care in comparison to other delivery systems.

9. The collaborative allows for consumer choice whereas a singular delivery system does not.

Finally, the formation and implementation of the Savannah Area Behavioral Health Collaborative was the community’s response to a broken behavioral health system. The need to redesign how services were provided was apparent. The new system brought together collaborative partners with creative ideas and tangible solutions to a previously under funded system.

The Savannah Area Behavioral Health Collaborative is now the catalyst to develop new strategies in the
community simply because it is designed to adapt, and take advantage of new and existing partnerships.

Developing the Crisis Intervention Team (Memphis Model) to address Chronic Homelessness

Background Information:

To End Chronic Homelessness, the Savannah-Chatham Metropolitan Police Department must assume a significant role. The police are the “first responders” in any crisis and for the most part are well aware of the chronic homeless in the community.

In many cities and communities across the United States, the implementation of a mobile crisis team, operated by one of the local mental health providers, responds to all emergency behavioral health calls and proceeds to the person in need. The team often works in conjunction with the police department and calls are received either through a crisis line, or they are contacted by the police through the means of a 911 call.

This type of system, however, tends to duplicate the efforts of those involved during a crisis, as well as may extend the time frame that an individual eventually receives services. In comparison, the Memphis Crisis Intervention Team Model places the responsibility for the management of the crisis squarely on the CIT officer and in most cases, ensures treatment, rather than incarcerating the individual. As “first responders” to any scene, the local police are mobile 24 hours/7 days a week. With advanced training, and careful selection of C.I.T. officers, the front door to services for those most in need can be opened.

According to Dupont and Cochran, the Crisis Intervention Team (CIT) model focuses on the necessity for advanced training and specialization with patrol officers, the immediacy of the crisis response, the emphasis on officer and consumer safety, and proper referral for those in crisis. CIT has been shown to positively impact on officer perceptions, decrease the need for higher levels of police intervention, decrease officer injuries, and re-directing those in crisis from the criminal justice system to the health care system.

Ending Chronic Homelessness depends heavily on the linkages with the police department, the Homeless Continuum of Care, local behavioral health services, and the emergency receiving center. Coordinating these services is critical to get those most in need into treatment, and stable housing.

Connecting the local police department and their liaisons, the current Homeless Resource Officers, and future CIT Coordinators, will also establish a communication link with the Unified
Community Support Team, (case management and outreach for this population). This bridge between the two systems will: identify chronic homeless consumers in the community, ensure proper follow-up services, and prevent recidivism.

The flow chart below illustrates the C.I.T. officer as the “first responder” to any behavioral health crisis. After making the determination as to the severity of the crisis, based on the C.I.T. officers’ training and experience, he/she may bring the consumer to the emergency receiving center for an evaluation, determine if the individual/consumer warrants arrest, or if the consumer needs to be connected to the array of homeless and/or behavioral health services in the community. The officer would document the call, either contact the service directly and transport, or contact the Unified Community Support Team. The Unified Community Support Team will follow-up on a daily basis with the police department to establish a listing of consumers needing further assistance. (See C.I.T. Flow Chart for Chronic Homelessness)
**Goal 1: Reduce and prevent homelessness by integrating and redesigning the services delivery system.**

**Responsible Entity**

**Strategy:**

A. Establish a Crisis Intervention Team (C.I.T.), with the Savannah-Chatham Metropolitan Police Department (Savannah-Chatham Police Department) and the National Alliance for the Mentally Ill, Local Chapter (N.A.M.I.)

**Action Steps:**

A1. Develop a Task Force with key individuals from law enforcement, behavioral health, and consumers in the community

A2. Send key individuals to C.I.T. (Memphis Model Training)

A3. Identify Emergency Receiving Center

A4. Establish time-line and protocols

A5. Select and train C.I.T. members as train-the-trainers

A6. Select and train C.I.T. officers

A7. Establish a baseline of consumers to be served

A8. Implement C.I.T. in Savannah/Chatham County

**Outcomes:**

Reduce admissions (500) of those with behavioral health disorders to the Chatham County Jail by 10% each year during the lifetime of the plan

Increase the number of chronically homeless persons participating in behavioral health outpatient services (250) by 10% each year.

Decrease the number of chronically homeless persons on the street (1000) and in the Continuum of Care by 10% each year.
Goal 2: Decrease the number of chronic people on the street and in shelters.

Background Information:
Beginning in January of 2005, the Unified Community Support Team is an integrated case management system that combines the resources of the homeless continuum of care with behavioral health services in order to provide one coordinated effort for those most in need of housing and or other support services.

The four teams listed below provided case management in various forms, in different systems, and with different funding requirements. As a result of redesigning the system to more effectively address those that fall through the cracks in services, the Unified Community Support team became one community case management system.

The team, coordinated by the Homeless Authority, provides an array of services such as: transportation, benefit enrollment, staffing intensity, housing placement, community outreach, and crisis intervention for those that are homeless, at-risk of homeless, or in need of behavioral health services.
The integrated staff will provide services 24 hrs. each day, seven days a week. The Homeless Authority will rotate staff from their regular placement sites to ensure 2 FTE’s are available during the workweek, 9-5, to address service needs as they arise. After hours, and on weekends, a rotating schedule will be in place for on-call, primarily for crisis and housing respite support.

**How each service works:**

*Transportation:*

The Homeless Authority coordinates transportation for homeless services and behavioral health services. Routine appointments can be coordinated by the service site and with the available staff and or driver assigned to that facility. If additional transportation needs arise at facilities during the workweek, i.e., (transportation of an outreach consumer to the clinic by the U.C. S. T.), team staff will be made available to ensure the safety of the staff, and consumer. After hour transportation will be made available on case-by-case basis. Those in severe crisis will be transported by the local police.

*Homeless Project/Benefit Enrollment:*

The Homeless Authority, through the U.C.S.T., will be responsible for benefit enrollment in the Homeless/Behavioral Health Continuum of Care. The integrated staff will rotate, and be assigned to the Homeless Authority to enroll consumers. Service providers will contact the Homeless Authority, and either the consumer can be brought directly to the office, or the team member can travel to the service site to begin the initial paperwork. It is the responsibility of the caseworker to follow through, and provide an enrollment status of each consumer at the bi-monthly team meetings at the Homeless Authority.

*Staffing Intensity:*

The PATH Peer Support Specialists and other members will be available to provide intensity of staffing to ensure housing of the homeless mentally ill. Each of the five staff members will rotate weeks and be available for crisis staffing, and or patient observation. The Path Team’s primary focus is to identify, engage, and refer the homeless mentally ill to services. As part of this focus, the PATH team will provide intensity of staffing to keep people housed and stay housed.

*Housing Placement:*

The team will screen potential consumers in need of housing placement, determine level of housing need, and follow-through with applications and procedures of placement for that facility. Follow-up placement, once a consumer has been initially placed in housing, will be the responsibility of the U.C.S.T., and the member currently assigned to that facility. Housing status, availability, and consumer progress, will be reviewed at regularly scheduled UCST/Housing meetings.
**Community Outreach:**

Community support services will provide behavioral health outreach to ensure consumers can maintain the community. Routine visits will occur at a consumer’s place of residence. Referrals will be received from institutions and health care facilities for community placement. The U.C.S.T. will coordinate the referral process and connect consumers to the appropriate support services. Staff will work with local police, be available at local soup kitchens, emergency shelters, and on the street for the chronic homeless.

**Crisis Services:**

The Outreach Team will be available for all crisis calls. Protocol requires the police to transport consumers to the local hospital emergency room for assessment. If a higher level of care is required, the ER will make arrangements for transportation. The Outreach Team will assist in respite housing if the consumer is discharged.

**Goal 2: Decrease the number of chronic people on the street and in shelters.**

**Strategy:**

A. Establish a community-wide case management system based on the Unified Community Support Team, that focuses on out-reach, prevention, management and follow-up

**Responsible Entity**

Homeless Authority

**Action Steps:**

A1. Convene a meeting with the local Department of Family and Children’s Services to determine cross over needs and those at-risk of homelessness, and develop procedures to communicate

Homeless Authority

A2. Convene a meeting with local hospitals and the county jail to determine cross over needs, and develop procedures to communicate

C.I.T. Task Force

A3. Identify procedures with the Savannah Metropolitan Police Department to work collaboratively to identify and follow-up with those in crisis in our community.

C.I.T. Task Force

A4. Develop a task force with providers of services, (Anti-Poverty Task Force

Homeless Authority/
Members) to discuss melding of case
mgmt. Determine how case mgmt
would address prevention

A5. Identify and leverage existing community
resources using the Unified Community Support Team as a model

Case Mgmt. Task Force

A6. Demonstrate the effectiveness to a variety
of community providers of the Pathways
Case Management Information System,
the current MIS in place for the homeless Continuum of Care

A7. Identify potential funding sources for
Innovative projects

Pathways

A8. Identify a select number of most at-risk
families and individuals in neighborhoods
and provide a case plan and needed services
for these individuals.

A9. Initiate intensive case mgmt for “Housing
First” recipients, to keep them housed and stay housed.

Unified Community Support
Savannah Area Behavioral Health

A10. Provide mobile primary health care
to those struggling to stay housed

J.C.Lewis Health Center

A11. Use pathways MIS to track progress
of individuals

Homeless Authority
Community Agencies

Outcomes:

By January 2006, all procedures will be in
place between systems to identify, prevent,
and follow-up with those most in need

By January 2007, implement a case management
system that will actively seek to assist those most
in need in our community across services systems,
and throughout neighborhoods.
Goal 3: Expand and preserve the supply of permanent supportive housing.

Background Information:

Current data indicates that there are 1,271 chronically homeless persons in the City of Savannah throughout the year. Data also indicates that there are an estimated 400 individuals on any given day that fit the chronic homeless definition. These are individuals on the street and in emergency shelters. Of the 4,099 documented cases of homelessness, 68% (2,787) experienced behavioral health issues that became a factor leading to their homelessness.

At least half of the chronic homeless are estimated to need permanent supportive housing. We should therefore plan for the development of 200 units of permanent supportive housing over the next 5 years to address this estimated unmet need.

It should be underscored that behavioral health needs are a significant factor leading to homelessness and most particularly chronic homelessness. The general population of homelessness suggests a past history with behavioral health problems. Identification, assessment and treatment for behavioral issues for those initially entering the homeless continuum of care would prevent long-term or chronic homelessness.

The current number of units for supportive housing are not a factor in the estimation of need. Though they remain full, the estimated need will focus on what is not available. The need will be adjusted periodically as better data is available through homeless surveys, and more reliable data generated by the Homeless Authority through the Pathways Homeless Management Information System.

Goal 3: Expand and preserve the supply of Permanent housing

STRATEGY:

A. Develop additional Shelter Plus Care and Section 8 housing
   Responsible Entity
   Homeless Authority
   CofC

B. Promote greater community understanding of housing needs
   Responsible Entity
   Homeless Authority
   C of C Planning Committee
ACTION STEPS:
A1. Identify Shelter Plus Care and or permanent housing for the Chronic homeless as the number one community priority under The Supportive Housing Grant in the HUD Super NOFA
A2. Determine a local housing agency skilled in providing Shelter-plus care or permanent housing to the chronic homeless.
A4. Submit SHP grant application under the City of Savannah For Shelter Plus Care and or Permanent Housing
A5. Initiate meeting with the Housing Trust Fund, Georgia Dept. of community Affairs to secure additional Shelter Plus care funding for Savannah and the region.
A6. Advocate with the GA. Dept. of Human Resources & Dept of Human Resources & Dept of Community Affairs for increased section 8 housing vouchers for the chronic homeless in the region.
A7. Develop an agreement with the local Housing Authority to Set aside 20 section 8 housing vouchers for the homeless each Year.
B1. Initiate and join current efforts to advocate the lack of supportive housing in the region for the chronic population.
B2. Identify the numbers of Chronic Homeless/ those with Behavioral problems residing in personal care homes.
B3. Identify any current loss of housing due to gentrification.
B4. Educate the public as to housing needs and tenant Rights.
B5. Advocate and defend tenants who are dispossessed Due in part to behavioral health difficulties.

OUTCOMES:
Increase the number of Shelter Plus Care or permanent Supportive housing beds by 30 each year over the lifetime Plan.
Total = 300

Increase the number of permanent housing bed/ units and or group home beds for those with behavioral health disorders by 20 each year over the lifetime of this plan.
Total = 200
Goal 4: Increase the number of chronically homeless persons obtaining employment and benefits for which they are eligible.

Background Information:

The network of community agencies coordinated by the Homeless Authority is ideally positioned to offer services regarding benefit eligibility. One of the coordinating functions of the Homeless Authority is to place over 60 staff in facilities throughout the network. The Homeless Authority staff, coordinated by C.S.A.H., and supervised by the community agencies, provides a variety of services with the Unified Community Support Team, case management as the cornerstone.

Beginning in November of 2004, the Homeless Authority began coordinating a pilot project, the first accelerated benefit program in the State of Georgia. Working with the Georgia Department of Labor, and the Social Security Administration, a team of over 40 staff were trained in SSI enrollment programs. All homeless persons began receiving priority at the local Social Security Administration offices through this project.

In January 2005, Project NOW, (New Opportunities to Work), developed by the Employment & Training Center for the Homeless, Union Mission, implemented a ten (10) week program with classes held Monday-Friday and is designed to provide employment training and job placement services to TANF recipients in Chatham County. Savannah Area Behavioral Health Collaborative will refer TANF recipients along with the State Department of Children and Family Services.

The program focuses on employment assessment/work readiness, life skills training, work experience management, and job placement. Employment retention support by continuing service assistance to retain employment is offered 12 months after completion. Services include, but are not limited to, childcare, transportation, mental health counseling, and provider referral such as medical services, legal services, food, and housing.
Goal 4: Increase the number of chronically homeless persons receiving employment and benefits for which they are eligible.

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<thead>
<tr>
<th>STRATEGY:</th>
<th>Responsible Entity</th>
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<tbody>
<tr>
<td>A. Identify Chronic Homeless persons and determine what Potential benefits they may be eligible for.</td>
<td>Homeless Authority</td>
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<tr>
<th>ACTION STEPS:</th>
<th>Employment and Training Program</th>
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<tr>
<td>A1. Obtain policies associated with accessing addition mainstream resources. (Food Stamps, TANF, etc.)</td>
<td>Union Mission</td>
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<td>A2. Expand the number of representative payees who would Manage SSI/SSDI.</td>
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<td>A3. Expedite applications for cases that would clearly meet eligibility requirements for disability benefits.</td>
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<td>A4. Closely monitor SSI/SSDI applications after submission to determine length of time and results of the process.</td>
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<td>A5. Strengthen partnerships with state and federal agencies administering mainstream benefits.</td>
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<td>A6. Research potential employment training programs for the disabled.</td>
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<td>A7. Research and apply for employment grant opportunities For the Chronic Homeless.</td>
<td>Employment and Training Program</td>
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<tr>
<td>A8. Develop additional training for chronic population (ie. TANF women's program. Project Now)</td>
<td>Union Mission</td>
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<th>OUTCOMES:</th>
<th>Homeless Authority</th>
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<tr>
<td>The Unified Community Support Team will link with the Savanna Area Behavioral Health to compete on average 20 SSI application/per month.</td>
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<tr>
<td>The Employment &amp; Training Center will train and develop Employment and Training Program</td>
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Goal 5: Prevent future homelessness by avoiding discharges into the street.

Background Information:

This section is designed to strengthen relationships, and discharge planning policies of public and private institutions to ensure proper placement of individuals transitioning back into the community.

Discharge planning for public and private institutions can be challenging for the hard to place individual. Those that lack support systems such as friends and families require well thought out discharge plans. The development of plans that are based on short-term living arrangements, without adequate supportive services and follow-up, will in the end create a new wave of chronic homeless.

Goal 5: Prevent future homelessness by avoiding discharges into the street.

STRATEGY:
A. Identify the extent of improper discharges.
B. Establish documented procedures with the homeless continuum of care and public and private institutions around discharge planning.

ACTION STEPS:
A1. Determine a baseline of improper discharges within the community by surveying both street and shelter based charges.
A2. Track the path of discharge on a select group to determine the gaps in procedures.
A3. Determine proper discharges that ended up on the street within a year.
A4. Use the HMIS to flag and track potential improper discharges from institutions throughout the year.

Responsible Entity
Homeless Authority
C of C
United Support Team
B1. Review the admission policy of each shelter.  

**Homeless Authority**

**Building a Bridge to the Future**

B2. Establish one continuum of care admission policy Across all shelters for the acceptance of discharges from institutions into facilities. 

**Homeless Authority**

B3. Strengthen the relationship with the public and Private entities by convening a meeting with each Individually. 

**Homeless Authority**

B4. Obtain and review discharge planning procedures Of regional discharging institutions. 

**Homeless Authority**

B5. Establish a point of contact, (Unified Community Support Team) as the single point of entry for discharges. 

**Homeless Authority**

B6. Determine the amount of new veterans on the street And date of discharge. 

**Homeless Authority**

**V.A.**

**OUTCOME:**

Reduction of inappropriate discharges to the street by 10% each year. (Baseline to be determined) 

**Homeless Authority**
Goal 6:  Enhance the data collection system to measure results.

Background Information:

The Chatham-Savannah Authority for the Homeless is the legislatively created organization designated as the lead entity to plan, coordinate, and evaluate the Homeless Continuum of Care. The Authority, has collected demographic data uniformly with all homeless providers since 1992. In 2003 the implementation of a new Homeless Management Information System began. By the end of 2004, 80% of the agencies in the Homeless Continuum went live onto the Pathways intake system.

It is expected that the system in 2005 will generate accurate reporting to enhance our understanding of Chronic Homelessness. Regular point-in-time counts will occur bi-yearly. The process will be facilitated by the Unified Community Support Team for the sheltered, and unsheltered homeless. Subpopulations will be determined by data entry of point-in-time counts, and using statistically reliable data maintained in the HMIS. Future unmet needs will be determined in much of the same way; however, the Authority, and the Continuum of Care Planning Committee will apply the data, and determine through community participation, the gaps that need to be addressed.

GOAL 6: Enhance the data collection system to measure results.

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<tr>
<th>STRATEGY:</th>
<th>Responsible Entity</th>
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A. Improve data on the number of chronically homeless persons and their needs.  

B. Use Pathways Homeless Management Information System (HMIS) to implement a more systematic approach to data collection.

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<th>ACTION STEPS:</th>
<th>Responsible Entity</th>
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A2. Develop procedures through the C.I.T. Coordinator and Homeless Resource Officer to obtain reports related to the chronically homeless.  

A3. Develop a more complete inventory of housing serving the chronically homeless persons, including boarding homes, personal care homes, private housing, motels, etc.
A4. Conduct focus groups and surveys to obtain input from Chronically homeless persons and their priority needs.

B1. Develop recommendations to increase community participation on Pathways.

B2. Work with participating agencies and Pathways to Reconfigure HMIS to collect information on Chronically homeless persons.

B3. Use HMIS to collect data on chronically homeless Persons using public or private institutions in the last 12 months.

B4. Use HMIS to collect data on those veterans that have Been discharged over the last two years.

B5. Improve reporting capabilities of HMIS to provide Data more useful to planning.

OUTCOMES:
Statistically reliable data to support/demonstrate effective change with the chronic homeless population by January 2006
Glossary

**Affordable Housing** - Housing with rent that is affordable to households of low and moderate income, which are households within the lowest 80% of the area median income for the region, as determined by the Department of Housing and Urban Development. Affordable in this context means annual housing costs do not exceed 30% of gross annual household income.

**At-risk of Homelessness** - Potential households considered at-risk of homelessness are: households paying more than 50% of their income for rent; households doubling up with others or "couch surfing" (temporarily staying with friends); and living in single room occupancy hotels represent a conservative definition of those at risk of homelessness.

**Case Management** - The process by which all matters of a homeless individual's needs are assessed and managed by a social worker or case manager. Case managers coordinate designated management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the individual's needs over time.

**Chronically Homeless** - An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four (4) episodes of homelessness in the past three (3) years.

**Continuum of Care** - A comprehensive and coordinated housing and service delivery system. This approach helps communities plan for and provide a balance of emergency, transitional, and permanent housing and service resources to address the needs of homeless persons so they can make the critical transition from the streets to jobs and independent living.

**Co-occurring Disorders** - Typically refers to homeless individuals with the occurrence of mental and substance use disorders.

**Discharge Planning** - The process of coordinating and evaluating an individual's needs in order to arrange for appropriate care following discharge from a hospital or other institutional care setting.

**Dually Diagnosed** - Individuals who are substantially limited in one or more major life activity by mental illness and alcohol or drug addiction. Persons with other diagnoses qualify under multiple diagnoses.

**Emergency Shelter** - Free temporary shelter provided as an alternative to residing in a place not meant for human habitation and typically is limited to 90 days.

**Extremely Low-Income Households** - Households who have incomes that are 30% or less of median income.
Glossary continued:

**Family**- Defined as any of the following: minor parents with child (ren); one or more adults with legal custody of minor child (ren); a couple in which one person is pregnant; grandparents or others who are legal guardians with child (ren) present; multi-generational families with grandparents, parents (adult child) and minor child (ren).

**Federal Poverty Level**- The federal government's working definition of poverty that is used as the reference point for the income standard for eligibility for many federal benefits programs. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2004 is $9,310 for an individual, $12,490 for a family of two, $15,670 for a family of three and $18,850 for a family of four.

**Homeless Management Information System (HMIS)**- Refers to Pathways Case management that will allow agencies to track service usage over time. The usage data collected in Savannah plan for future services and programs.

**Homeless**- A person is considered homeless only when he/she resides in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, on the street, in an emergency shelter, in transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters, in any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution, is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing; is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources an support networks needed to obtain housing; is fleeing a domestic violence housing situation and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.

**Homeless Veterans**- An eligible Veteran is defined as one who: (1) served on active duty in the US Armed forces for more than 160 days and was discharged with other than a dishonorable discharge; (2) was discharged or released from active duty because of service connected disability; or (3) served on active duty during a period of war, or in a campaign or expedition to which a campaign badge is authorized.

**Homeless Youth**- Unaccompanied person, age 12 to 24. Youth may have run away or were forced out of their home and are not in the company of a parent or guardian, and who may or may not be legally emancipated.

**Housing Affordability**- Housing affordability means annual housing costs do not exceed 30% of gross annual household income.

**Housing Wage**- The amount a person working full-time has to earn to afford a two-bedroom rental unit at fair market rent while paying no more than 30% of income in rent.

**McKinney-Vento Act**- The primary federal legislation that funds housing and services specifically for homeless individuals and families and is administered by various federal departments.
Glossary continued:

**Mentally Ill Individual**—an individual substantially limited in one or more major life activities by mental illness based on confirmed clinical diagnosis, or initially by referral or staff assessment and later confirmed by clinical diagnosis.

**Permanent Housing**—Housing that is not time-limited and is intended to be a home for as long as a person chooses to live there and continues to be eligible if the unit is subsidized.

**Permanent Supportive Housing**—Housing that is not time-limited and is linked to support services such as mental health, case management, employment assistance and other services to enable residents to maintain self-sufficiency.

**Recidivism**—Return or relapse to a type of behavior, such as substance abuse.

**Safe Haven**—A facility that provides shelter and services to chronically homeless and chronically mentally ill individuals that cannot comply with strict rules of traditional shelters.

**Section 8**—A federal housing subsidy program that is administered locally by housing authorities. The subsidy program is both tenant and project-based. The Section 8 voucher program provides assistance in order for the voucher recipient to pay no more than 30% of their gross monthly income on rent in a unit that complies with the rent guidelines. Housing authorities may spend a portion of their Section 8 certificate program funds to specific housing projects and thus subsidizing the unit.

**Service Enriched Housing**—Rental housing in the community at-large, in which "services coordination", is available, to help all residents attain improved social and/or economic well-being.

**Street Outreach**—Services delivered directly to homeless individuals residing in places not meant for human habitation in order to connect the individuals to existing service providers.

**Substance Abuse Individual**—An individual who has acknowledged addiction problems related to alcohol and drug use and who seek services or housing to support their sobriety.

**Supportive Housing**—Housing that is coupled with supportive services in order to assist individuals and families in maintaining financial and personal stability and self-sufficiency to prevent homelessness.

**Supportive Services**—Services provided directly to homeless individuals and/or families intended to assist homeless individuals and/or families in attaining or maintaining residential, financial and personal stability and self-sufficiency.

**Transitional Housing**—Housing that has as its purpose facilitating the movement of homeless individuals and families to permanent housing within usually 24 months.