

Ending Chronic Homelessness by 2015

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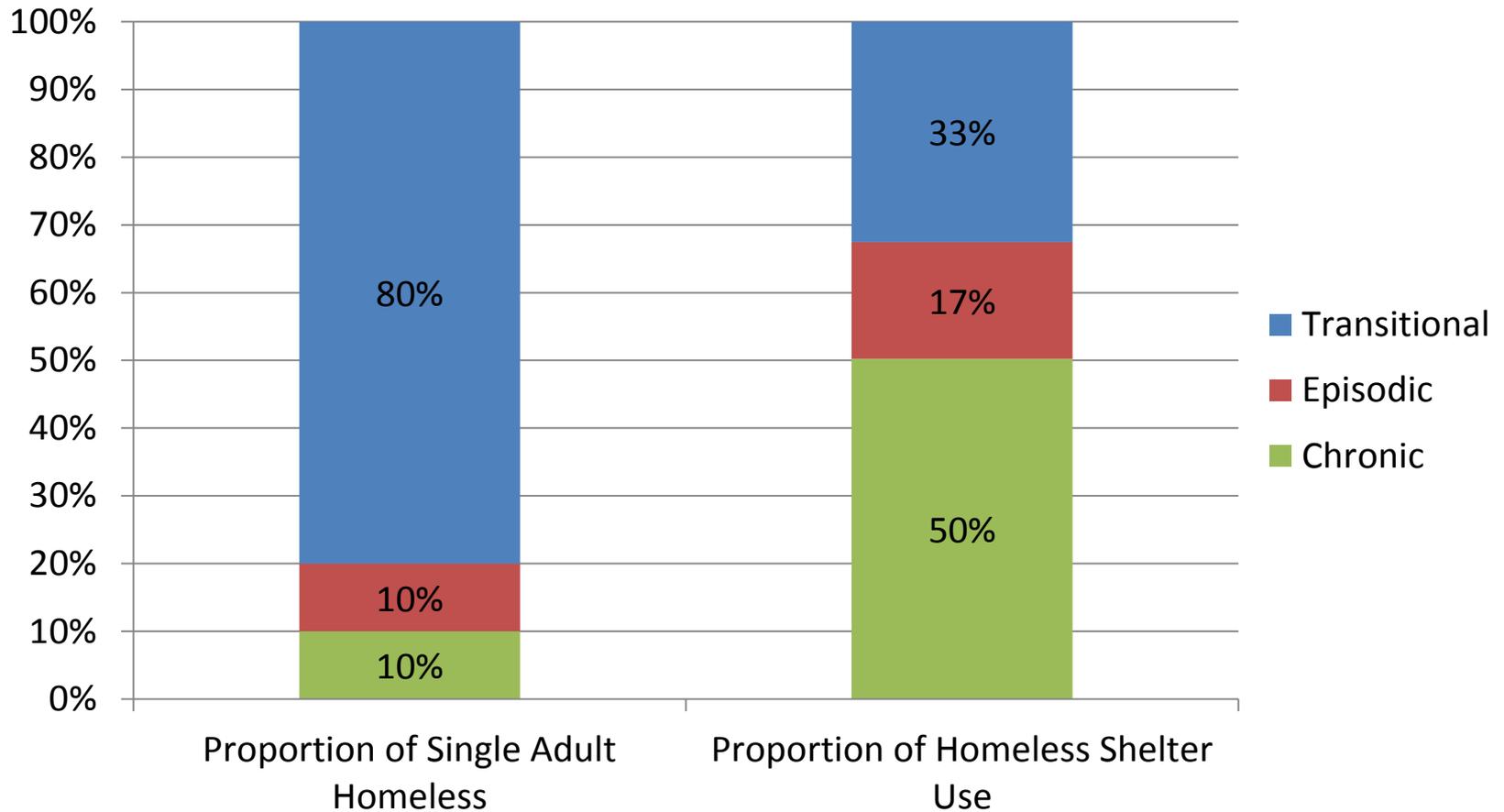


Overview

- Background on chronic homelessness
- Current progress on goal
- Community-level actions needed Federal strategy for accelerating progress
- Looking ahead
- Client story



Background on Chronic Homelessness



Source: Kuhn and Culhane (1998)



Characteristics of Chronic Homelessness

- More than 60% have lifetime mental health problems
- More than 80% have lifetime alcohol and/or drug problems
- Mortality rates 4-9 times higher than general population
- High rates of infectious disease (TB, HIV/AIDS) and chronic conditions (asthma, hypertension)
- Up to 80% of men and 50% of women have a history of incarceration



Ending Chronic Homelessness: A Timeline

- 1998** – Chronic homelessness first identified in research literature
- 2000** - National Alliance to End Homelessness launches plan to end homelessness (including chronic) in 10 years
- 2000-2001** – Bush Administration and HUD Secretary Martinez endorsed goal of ending chronic homelessness
- 2002** – Millennial Housing Commission calls for ending chronic homelessness by creating 150,000 units of PSH
- 2003** – Collaborative Initiative to End Chronic Homelessness launched along with Policy Academies on Chronic Homelessness
- 2009** – HEARTH Act signed into law, consolidates homeless programs, calls for changes to definition of homelessness and chronic homelessness
- 2010** – *Opening Doors* adopted



Opening Doors

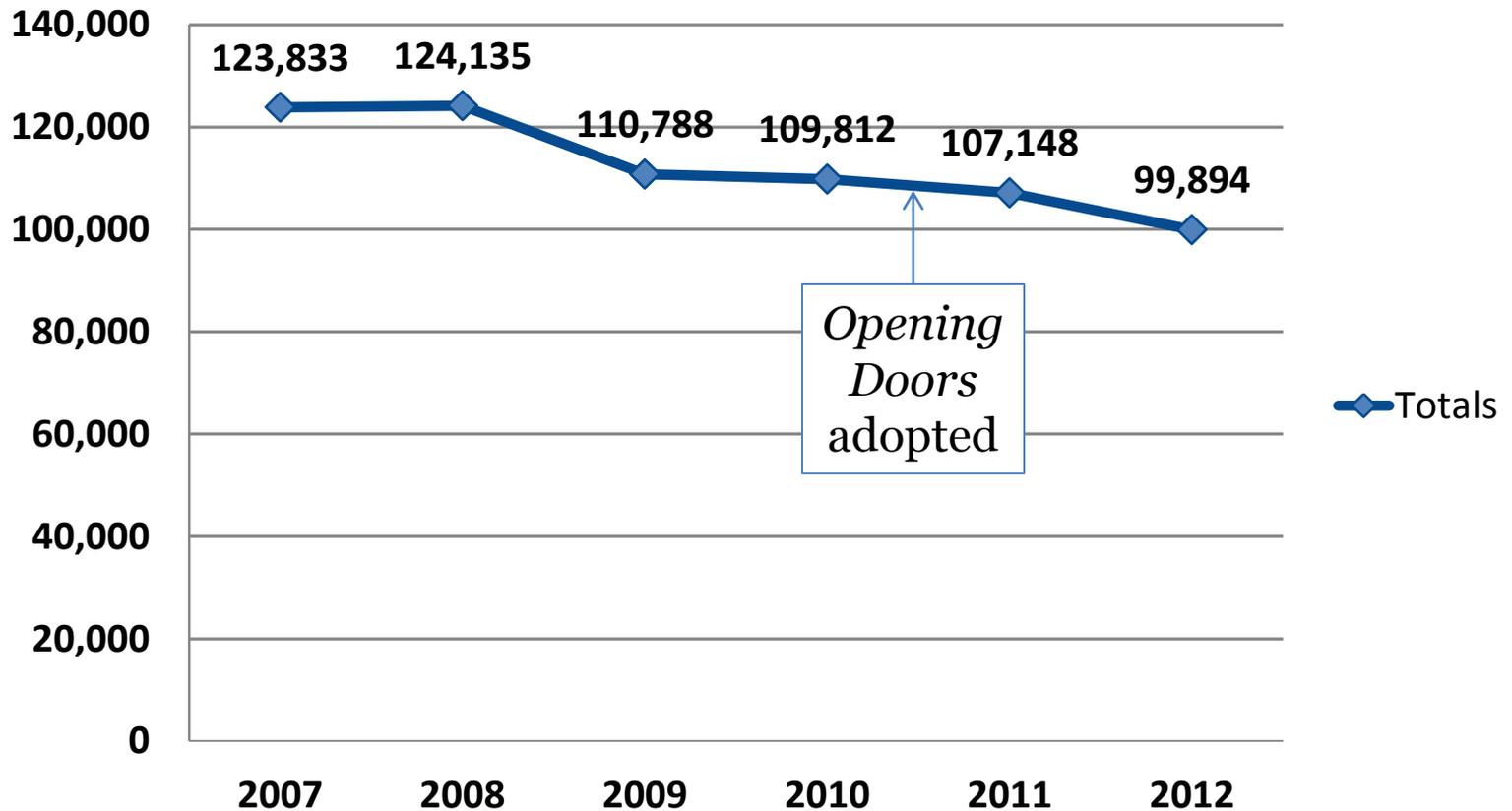
- ***No one** should experience homelessness.*
- ***No one** should be without a safe, stable place to call **home**.*

Goals

- 1. Finish the job of ending chronic homelessness by 2015**
2. Prevent and end homelessness among Veterans by 2015
3. Prevent and end homelessness for families, youth, and children by 2020
4. Set a path to ending all types of homelessness



Chronic Homelessness, 2007-2012





2012 Trend Analysis Shows Slow Progress

- Some communities showed progress, most did not
- Nation's PSH inventory increased 45% between 2007 – 2012
- No statistically significant relationship between increases in PSH inventory and reductions in chronic homelessness



Reasons for Slow Progress

1. Existing PSH is inadequately targeted
 - Only 45% of PSH for single adults nationally dedicated to chronic homelessness
2. Geographic mismatch between Federal resources and need/prevalence
 - South and West regions have 50% of PSH units but 80% of chronically homeless population
3. Population more complex and involved in institutions than originally realized



Episodic Homelessness Higher than Realized

- Based on a recent study in Philadelphia, 60-70% of individuals met episodic definition
- New York City found that over 80% met episodic definition





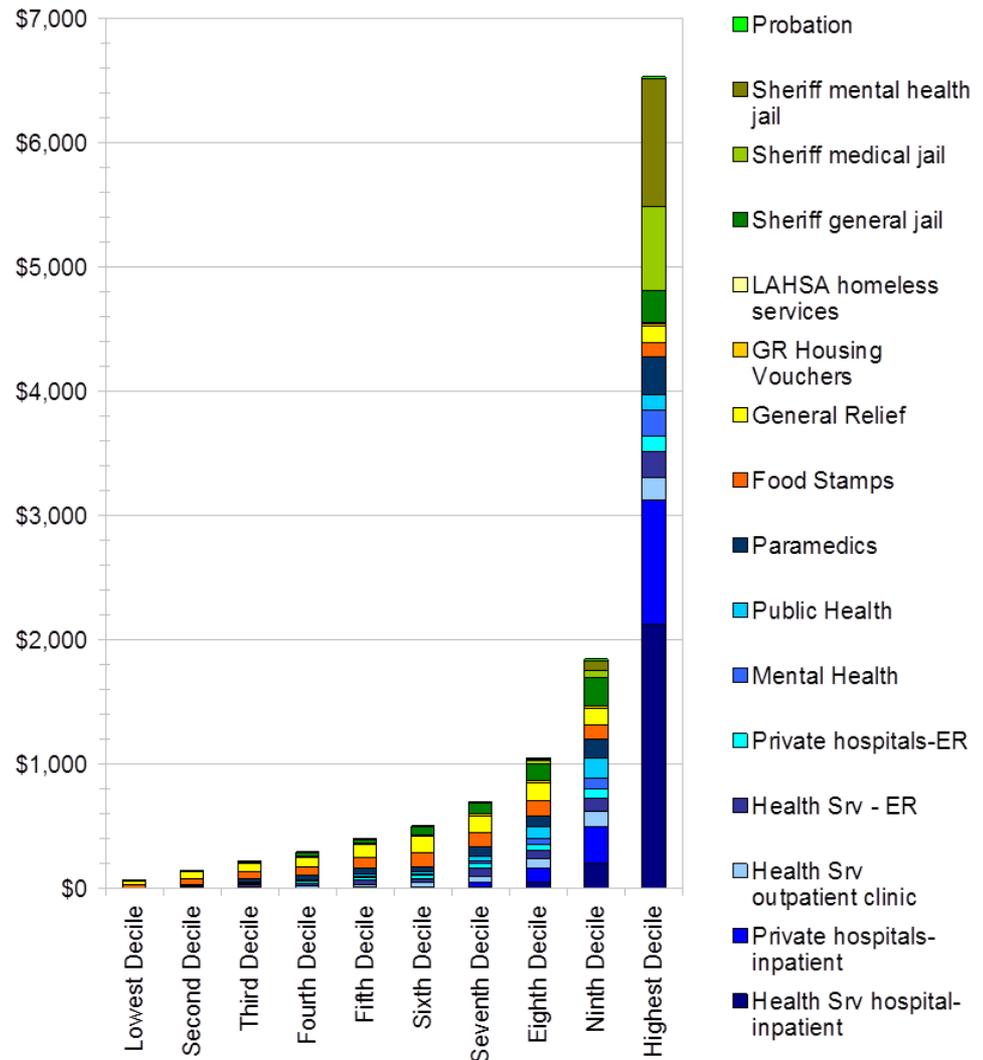
Role of Institutional Discharge

- 81% of State Mental Health Agencies reported cuts in FY 2011
 - Nearly half of the cuts would result in shutdown of state psychiatric hospitals or wards within hospitals
 - 8% reduction in national inventory of state hospital beds
- In 2010, prison releases exceeded admissions for first time
 - State of California ordered to reduce prison population by 55,000 inmates in next 3 years (Brown v. Plata)
 - Number of people in custody exceeds total prison capacity in 19 states



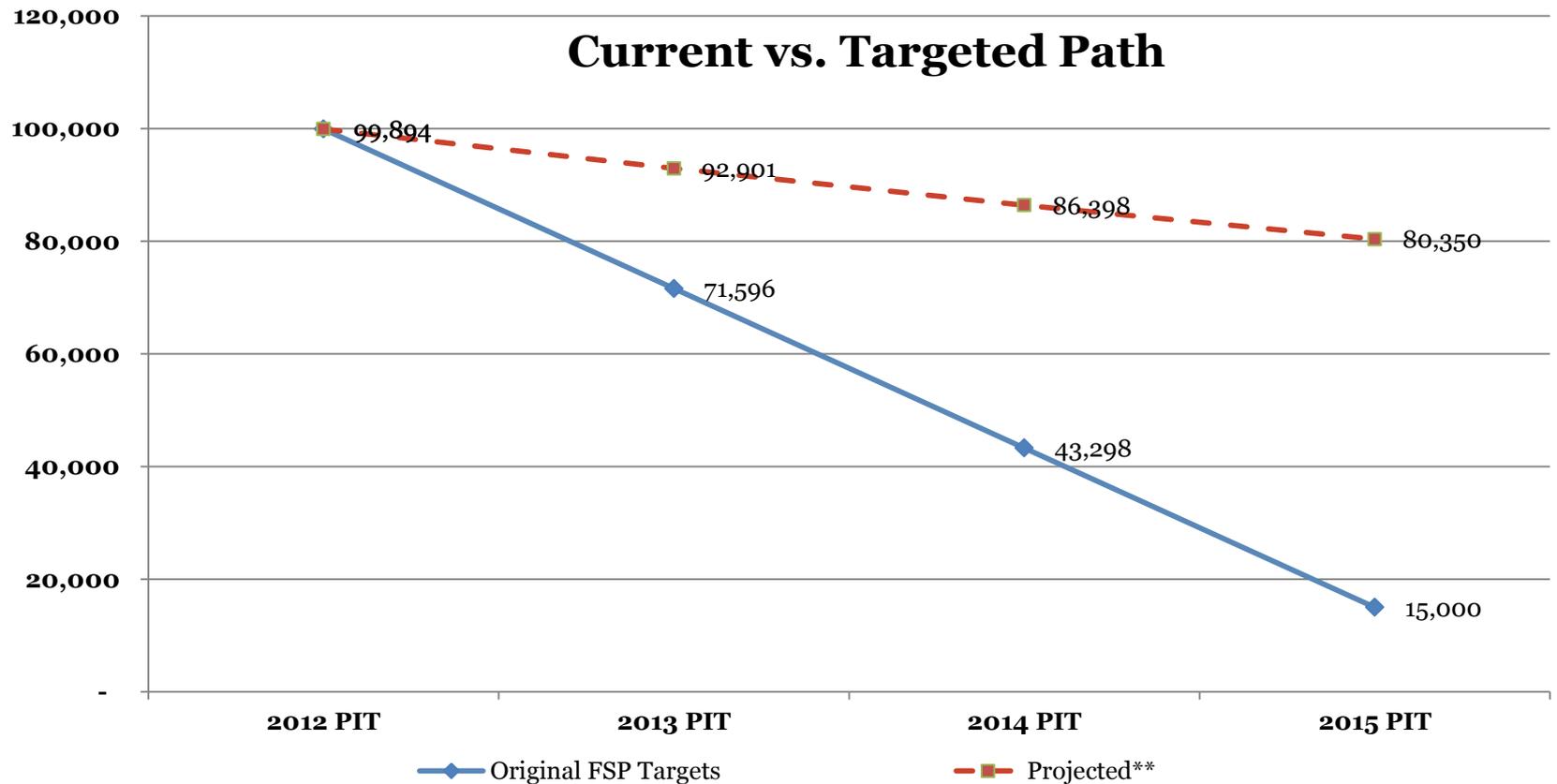
High Utilization of Hospitals, Jails

- Los Angeles analysis by Economic Roundtable (2010) found subset of people experiencing chronic homelessness that consumes \$6,500 per month in county health and correctional services





Chronic Homelessness, Projected Path vs. Target

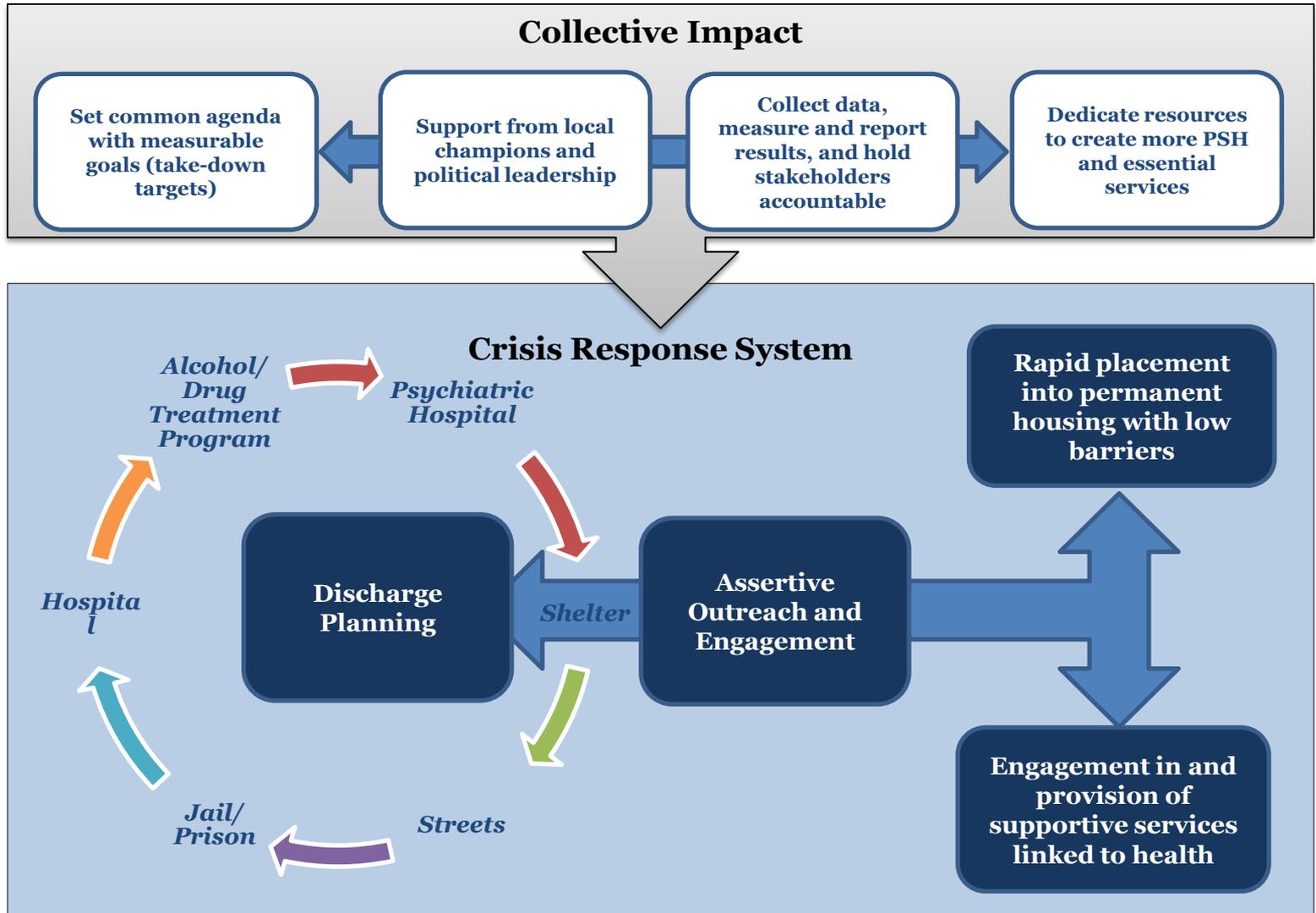


*Based on PIT Data

**Based on current investment & performance



A “Systems” Approach Needed





Necessary Community-Level Actions

- **Coordinate outreach and engagement** across community and institutional points (shelters, streets, jails, hospitals, substance abuse treatment, health centers) to identify and rapidly people to PSH
- **Direct and coordinate resources** (Federal, state, local, and philanthropic) to increase PSH
 - Targeted homeless grants - CoC, SAMHSA
 - Mainstream - PHA, Medicaid, state rental assistance, state housing trust funds



Necessary Community-Level Actions

- **Prioritize people experiencing chronic homelessness for PSH** as part of coordinated entry
- **Adopt Housing First** approaches that reduce barriers to and streamline housing entry
- **Provide supportive services** that place low demands on clients, but engage frequently
- **Connect services to health and behavioral health care** (health homes)



Prioritizing Chronic Homelessness in PSH

- Shift away from:
 - “First come, first served” approach to allocating affordable and supportive housing
 - Passive role of housing agencies and providers in identifying prospective tenants
- Shift towards:
 - Prioritization of people based on objective measures of need, vulnerability, and cost
 - Proactive, assertive outreach that identifies, engages, and rapidly connects highest-need to permanent housing



Approaches to Prioritization

- Length/duration of homelessness: prioritize those who have been homeless the longest and who have disabling conditions
 - Based on self-report
 - Analysis of HMIS data
- Vulnerability: prioritize those who have objectively highest need
 - Mortality risk
 - Health challenges and functional impairments
- Service utilization and cost: prioritize those who use the most crisis services and public costs (ED, hospital, jail, detox, etc.)
 - Data matches
 - Predictive algorithms/actuarial tools



Federal Strategy to Accelerate Progress

- Increasing PSH availability through targeted homeless grants and mainstream resources
- Guidance and assistance in financing services through Medicaid and other targeted grant funds
- Encouraging communities to prioritize people experiencing chronic homelessness for existing PSH
- Technical assistance around outreach and engagement and Housing First



Scotty the “Medical Miracle”

- Scotty is client of CSH’s Social Innovation Fund demonstration project
- Identified by hospital using Economic Roundtable’s Triage Tool
 - Hospitalized 52 times in 2009
 - Rare metabolic disorder; subsists on baby formula
 - Physically disabled, wheelchair-bound
 - Substance abuse disorder
- Engaged by OPCC (PSH provider and SAMHSA grantee) and placed into PSH (HACLA voucher); connected to medical/health home at Venice Family Clinic (HRSA FQHC)
- Has been housed more than one year, hospitalized only 3 times



For more information:

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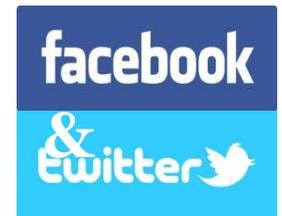


Stay Connected

The screenshot shows the USICH website homepage. At the top left is the USICH logo and the text "United States Interagency Council on Homelessness" with the tagline "No one should experience homelessness. No one should be without a safe, stable place to call home." Below this is a navigation menu with links for Resources, Funding & Programs, Opening Doors, Partners, Take Action, Media Center, and About USICH. A search bar is located on the right. The main content area features a large image of a man in a red "VIETNAM VETERAN" shirt, a "The Plan: Opening Doors >" banner, and a green box with the headline "Veterans Homelessness Declines 17% since 2009" and buttons for "I am homeless and need help" and "State Resources". Below this are sections for "Information By..." (Member Agency, Population, Plan Objective, Audience, Issue), "Explore the USICH Solutions Database" (with an "Explore the Database" button), and a "News" section with links for "Calendar" and "Blog". The news section includes headlines such as "HUD & VA Team Up to Provide Permanent Homes to 9,000 Homeless Veterans" and "Second Chance Act Two-Phase Program FY 2013 Competitive Grant Announcement".

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