A TEN YEAR PLAN TO END HOMELESSNESS ON CAPE COD AND THE ISLANDS

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LEADERSHIP COUNCIL TO END HOMELESSNESS ON CAPE COD AND THE ISLANDS

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LEADERSHIP COUNCIL TO END HOMELESSNESS ON CAPE COD AND THE ISLANDS

1. INTRODUCTION

The Leadership Council to End Homelessness on Cape Cod and the Islands is one of over 500 Continuum of Care groups across the country and one of 22 in the Commonwealth of Massachusetts. The Council's region, covering Barnstable, Dukes (Martha's Vineyard) and Nantucket Counties, comes together to plan and coordinate services regarding homelessness in the region to ensure a seamless continuum of care of services. The U.S. Department of Housing and Urban Development (HUD) definition of a Continuum of Care is "…a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness" (U.S. Department of Housing and Urban Development, undated).

As an approved consortium, the Council is also eligible to apply for the U.S. Department of Housing and Urban Development (HUD) Continuum of Care McKinney-Vento funds for homelessness services and programs. Since the early 1990s well over $12 million in HUD McKinney-Vento funds have been awarded to the region through this annual application process. Since HUD has strongly encouraged regional continuums to develop Ten Year Plans to End Homelessness, with an emphasis on ending chronic homelessness, the Council has been working hard to address this issue.

The evolution of the development of a ten-year plan began in 2003 during the HUD SuperNOFA Continuum of Care application process when the Council was challenged to address this issue. As this process evolved, it included bringing the community together for a homelessness summit and later a task force meeting to actually develop the ten-year plan.

As part of this process, a subcommittee of the Council met over the summer of 2003 with members of the Cape Cod Council of Churches to coordinate the October 25, 2003 *Grand Community Effort to End Homelessness on Cape Cod and the Islands*, highlighted by keynote speaker Philip Mangano, the Executive Director of the U.S. Interagency Council on Homelessness. The summit not only represented the Council's growing collaboration with the faith-based community, but also served to create community awareness regarding issues impacting on the homeless in the region.

Challenged by Philip Mangano's keynote message at the October 2003 Homelessness Summit, the Council appointed a subcommittee charged with the responsibility of involving the community in the formulation of a ten year plan to end homelessness for the region. On December 1, 2003, subcommittee members met with John O'Brien, the New England Regional Coordinator of the U.S. Interagency Council for the Homeless and also consulted with Philip Mangano throughout the planning process.

The next step, the April 9, 2004 task force meeting, coordinated by the Leadership Council, brought key members of the community together to begin the serious work of developing the

Ten-Year Plan to End Homelessness on Cape Cod and the Islands. Philip Mangano and John O'Brien both attended the April task force meeting with Mangano presenting the opening message. The following key officials were also involved in developing the Ten Year Plan and present at meetings: State Representative Shirley Gomes, State Senator Robert O'Leary, Barnstable County Commissioner Mary LeClair, members of the Cape Cod Assembly of Delegates, Tom Lynch and Mary Lou Petitt (with the latter serving as co-facilitator), president of the Cape Cod chapter of the United Way, Richard Brothers, along with additional community participation beyond the Council's usual continuum members.

At the initial task force meeting those present were either assigned or self-selected into the following four working groups (the four areas chosen by the planning committee):

- Prevention,
- Discharge Planning,
- Coordination of Existing Services, and
- Development of Permanent Housing.

The four working groups met briefly and each appointed a chairperson. In the process of developing the plan, the four working groups met almost weekly to develop strategic plans for their specific areas and also reported their findings at a second task force meeting on May 17, 2004. Each group then refined their reports and met with the facilitators on June 19, 2004 who coordinated the four working group reports and oversaw the completion of this report.

2. HISTORY OF THE LEADERSHIP COUNCIL TO END HOMELESSNESS ON CAPE COD AND THE ISLANDS AS A CONTINUUM OF CARE

In the early 1990s HUD changed the application process for McKinney funds and required the formulation of Continuum of Care Councils to coordinate and plan services for the homeless in designated regions within United States territories. Under these guidelines the application process required that decisions regarding application projects and prioritization be conducted through a Continuum comprised of representatives from consumers, government, business entities, and service providers. When these changes were made, the region originally submitted applications through the Boston Continuum of Care until 1995 when Housing Assistance Corporation (HAC) developed a separate Continuum for the Cape and Islands. HAC then led the Continuum until the spring of 2002 when Community Action Committee of Cape Cod and the Islands, Inc. (CACCI) took over the leadership role. CACCI currently oversees the coordination of the Council and the grant writing of the annual HUD application.

The Cape Cod and Islands Continuum of Care consortium region covers Barnstable County, Dukes County (Martha's Vineyard) and Nantucket County. Since the Leadership Council became a separate continuum in 1995, the Council has grown to represent homeless individuals and service providers in an ever-broadening reach throughout the region. From a group of approximately 10, over 70 groups are now represented through the Council with over 35 groups actively involved. The Council presently represents a network of homeless services providers, non-profit agencies, private businesses, the banking community, housing developers, public

housing authorities, representatives from local, county and state government, members from the faith-based community, and formerly homeless individuals.

The Council has also experienced a strengthening of political and community consensus in the region. One result of an increasing awareness of the needs of the homeless, along with community recognition of the Council's work, was the recent $465,000 allocation from Barnstable County toward a variety of homeless and prevention initiatives in addition to $74,529 for a new county position of Housing Development Specialist. As a result of these significant strides in building bridges within the community, the Council has strengthened collaboration with the faith-based community and has expanded its membership base. This is reflected in the Council's leadership role in collaborating with the larger community to develop a ten-year plan to end homelessness.

The goal of the Council is to mobilize the community to end homelessness, as reflected in its mission statement. The Council strives to maintain the existing seamless continuum of shelter, housing and supportive services while also continuously finding ways to improve the continuum of care with the ultimate long-term goal of ending homelessness, especially among chronically homeless individuals. The Council considers the *Ten Year Plan to End Homelessness on Cape Cod and the Islands* a 'living' document that establishes a regional strategic plan to be revised as necessary as the Council works through this process. In such a changing and complex economic climate, continuing to update and revise this plan will be essential.

3. DEMOGRAPHICS ON CAPE COD AND THE ISLANDS

The Council includes three counties: Barnstable, Dukes (Martha's Vineyard) and Nantucket comprising 23 towns (15 in Barnstable County, seven in Dukes County and Nantucket as one town only). While many of the towns also consist of villages, there is great variation among the different regions ranging from city-like density in the Mid-Cape area to sparse density in rural areas such as Truro and parts of the Islands. An influx (in-migration) of more affluent retirees and second homeowners has served to drive up housing costs while an economy based on retail trade and seasonal tourism produces lower wages. This also results in higher unemployment rates off-season, and thus restrains economic opportunities, in comparison to the rest of the state (Cape Cod Commission, 1995). A decrease in availability of rental housing is also a consequence of these trends.

Population Growth: A profile of demographics on Cape Cod and the Islands, based on the 2000 U.S. Census shows all three counties as the fastest growing in the state in comparison to the 1990 census data: the Barnstable County population increased by 19.1%, Dukes County increased by 28.8% and Nantucket County increased by 58.3% while the state increase was 5.5% (Cape Cod Commission table based on 2000 U.S. Census data). The following data emphasizes some of the pertinent demographics impacting the region.

Median Age: Barnstable County has the highest median age in the state with 11 towns listed in the "Top 20 Oldest Communities" based on the 2000 U.S. Census. In 2000 the county median age was 44.6 in comparison to 36.5 for the state. The town of Orleans was number one on the

list with a median age of 55.5. Chilmark, Dukes County, the only town from the Islands on the list, was number 17 with a median age of 45.6. The increase in median age across the area is related to relocation of retirees to the region coupled with an out-migration of young adults. While the region experienced an increase in the population age 17 and under as part of this population growth (see following section), the serious affordable housing crisis in the region has resulted in an out-migration of its workforce. From 1990 to 2000 Barnstable County experienced a decline by more than 23% in the population between the ages of 20-24; and a decline of just under 21% of the population between the ages of 25-34 (based on the 2000 U.S. Census data as cited in Cape Cod Times tables).

Age 17 and Under: While the overall population age 17 and under increased in Barnstable County by 16% from 1990 to 2000 (the state increase for the same period was 11%), this differed dramatically across Barnstable County. For example, while the towns of Mashpee and Sandwich experienced the largest increase in youth (65% and 35% respectively), the proportion of youth living in the town of Provincetown substantially decreased by 41% from 1990 to 2000. This decrease is very likely due to the high cost of property and limited affordable rentals. The town of Chatham also experienced a decrease in youth, but not as dramatically as Provincetown with an 11% decline from 1990 to 2000.

Rental Costs and Median Costs of Homes: Rental costs for Barnstable County are on average $1,000 to $1,200 for a two-bedroom unit and $1,300 to $1,400 for a three-bedroom unit and are even higher for Dukes and Nantucket Counties: on Nantucket a two-bedroom rental averages between $1,600 to $2,000 and a three-bedroom rental averages between $2,000 to $3,000. The median cost of a single-family home for 2004 year-to-date (up to the end of October 2004) was $350,000 for Barnstable County, and (up to the end of November 2004) was $560,750 for Dukes County, and $1,050,000 for Nantucket County. In addition, Nantucket has experienced a banner year in both development and purchases and is fast approaching build-out.

Transportation: Access to a vehicle on Cape Cod and the islands is essential since public transportation throughout the Cape and Islands is very limited. Although public transportation has been improving, since many parts of the region are rural, there are still areas with nonexistent or very limited public transportation services, which negatively impacts residents' opportunity to obtain and maintain employment to support their housing and their ability to access needed services. The Cape and Islands Transit Task Force was established three years ago to improve the availability and affordability of public transportation throughout the Cape and Islands.

Race and ethnicity: Barnstable County has a growing Brazilian community in the Hyannis/Yarmouth area of the Mid Cape with Brazilians also migrating to Dukes County. In addition, the region also has two Native American tribes: The Aquinnah Wampanoag Tribe on Martha's Vineyard on Dukes County (currently the only Federally recognized tribe in Massachusetts) and the Mashpee Wampanoag Tribe (in Barnstable County). In addition, Harwich also has a Cape Verdean community. Nantucket has a large Spanish speaking population.

While the Cape and Islands appears to be an idyllic resort community, the region imports seasonal workers because of the lack of affordable housing and the out migration of young

adults. In addition, workers commute to both islands year-round (construction workers and other manual laborers) due to the lack of affordable housing on the islands.

Reports show that the housing market has 'softened' nationally. Although for a second year in a row (2002 - 2003) Massachusetts was found to be the least affordable state in the country for renters based on a study conducted by the National Low Income Housing Coalition (2003), it is estimated that rents may have dropped somewhat over the past two years in Barnstable County. While the rental market may have softened somewhat on Cape Cod on the upper half of the rental market, there remains very few rentals available that low income people can afford. This market adjustment presents an opportunity to move people from shelters to permanent housing as more landlords are willing to participate in the Section 8 program; however, the state and federal governments need to provide additional voucher funding to make this possible. In addition, there needs to be a concerted effort to convince the Massachusetts Legislature to strengthen the state rental subsidy program (Massachusetts Housing Voucher Program) to fill this gap.

The Barnstable County Human Condition 2001 (a county-wide needs assessment study) found that 22% of Cape Cod households report having trouble paying for housing. A Nantucket needs assessment study conducted in 2004 found that 22% of residents reported that they are not able to find affordable year-round housing (this increased to 57% for low-income households) and 22% reported not being able to repair/rehabilitate their present housing (this increased to 45% for low-income households). In addition, a recent study conducted by the Center for Survey Research at the University of Massachusetts at Boston also identified Hyannis (a village in the town of Barnstable) as one of 34 communities where children are suffering from or on the brink of hunger based on an analysis of Census tracts where at least 20% of the population lived below the poverty level (they identified two census tracts in Hyannis with poverty levels between 21 and 37%) (Cape Cod Times, 11/15/03, p. A-6; Project Bread, 2003). The region has experienced an increase in the number of people seeking assistance at local food pantries. The director of the Family Pantry, the largest food pantry on Cape Cod, located in Harwich, reports the recent dramatic increase in clients, with a notable increase in new clients. The Greater Boston Food Bank reports an anticipated 30% increase in usage in Eastern Massachusetts, according to Paul Kelley, the director of The Family Pantry, while acknowledging that the food pantry usually follows their pattern. The increase in the cost of heating fuel is expected to play a role in the increasing need.

The Cape and Islands is far from how it is perceived to those who briefly visit its shores to enjoy its scenic beauty with its many inlets, harbors and ponds representing the majority of the state's coastline. When the population almost triples during the summer months, most visitors never think about the social problems resulting from a primarily rural-tourist-based, second homebuyer, seasonal economy, which makes living in the region a challenge not only for the poor, but increasingly for low and moderate income households.

4. CURRENT NEED

The following chart (see next page) shows the gap between the current inventory of homeless beds in the region versus the unmet need. This data is based on the Leadership Council's annual point-in-time count of the homeless, which was conducted on March 23, 2004. This includes a count of all homelessness beds/units in the region, those unsheltered and those living temporarily in motels (only those whom will be displaced once the summer tourist season begins). In conducting the annual point-in-time count, the Council utilizes HUD's definition of homelessness,[1] which excludes those doubled-up and at risk of homelessness (with the exception of those about to be evicted within a week and have no where to go).

The 2004 count shows **1,733 homeless persons** (1,041 individuals and 692 persons in families with children) with 796 beds in the 2004 inventory leaving a gap of 937 unsheltered persons.

The Gaps Analysis subcommittee of the Council determines the allocation of the unsheltered homeless into either Transitional Housing or Permanent Supportive Housing. The unmet need for emergency shelter is based on the actual number in shelter overflow or waiting for shelter at the time the count was conducted. The subcommittee determined that 25% of the evictions, 25% of the motel population and 25% of the street population would require Transitional Housing with 75% of the evictions, 75% of the motel population, and 75% of the street population would require Permanent Supportive Housing. This calculation applied to both individuals and persons in families. These estimates take into consideration the HUD emphasis on permanent supportive housing as the best method to stabilize the homeless population.

Leadership Council Continuum of Care Housing Gaps Analysis Chart

		Current Inventory in 2004	Under Development in 2004	Unmet Need/ Gap
	Individuals			
Beds	Emergency Shelter	**58**		**27**
	Transitional Housing	**184**		**131**
	Permanent Supportive Housing	**245**		**396**
	Total	**487**		**554**
	Persons in Families With Children			
Beds	Emergency Shelter	**239**		**0**
	Transitional Housing	**70**		**95**
	Permanent Supportive Housing	**0**		**288**
	Total	**309**		**383**

[1]Homeless Person means a person sleeping in a place not meant for human habitation or in an emergency shelter; and a person in transitional or supportive housing for homeless persons who originally came from the street or an emergency shelter. The definition also includes persons 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; or being discharged within a week from an institution in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks needed to obtain housing.

The Gaps Analysis subcommittee also estimates the number individuals who fit the definition of ***chronically homeless*** (HUD only acknowledges individuals as chronically homeless).[2] This estimate is based on the assumption that 40% of the sheltered population and 68% of the unsheltered population fit the definition of chronically homeless. Based on these calculations, an estimated **473 homeless individuals** fit the definition of chronically homeless (HUD guidelines require that individuals living in permanent supportive housing be eliminated from this calculation).

The Hidden Homeless

While the above information pertains to data gathered through the Council's point-in-time count of those fitting the HUD definition of homelessness, the need extends beyond just these numbers, especially when noting that this definition does not include what might be considered the *hidden homeless*: those doubled-up not by choice. Although the HUD CoC application specifies not to include doubled-up persons, other grant applications, such as the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) acknowledges those doubled-up as homeless. Martha Burt's publication *Practical Methods for Counting the Homeless: A Manual for State and Local Jurisdictions* (1996), until recently, has been the recommended HUD resource to aid continuums in their annual point-in-time count of the homeless[3], a requirement for the HUD Continuum of Care Homeless application. While HUD does not accept doubled-up as homeless, Burt argues that if one is to include doubled-up in an annual count of the homeless (one would assume for additional information beyond the HUD requirements) this must be defined. Burt discusses the distinction between just doubled-up and precariously housed. While Jencks (1994) argues against counting those doubled-up because the distinction between voluntary and involuntary is often unclear, and therefore wealthy widows living with children out of choice could possibly be counted, other researchers argue that those doubled-up -- living with others out of financial necessity, should be counted as homeless (Bakar, 1991; Breakey and Fischer, 1990; Jahiel, 1992). Therefore, when counting doubled-up the methodology at the very least should include a definition of doubled-up not by choice.

In an attempt to estimate the numbers of homeless, including those doubled-up in Barnstable County, the Barnstable County data analyst for the Department of Human Services, using a rather broad definition of homelessness, that counts persons: living in a shelter, living on the street, living in a motel, and living temporarily with friends or family for even a short time, estimated that some 5,710 persons may have been "homeless" at any point in time during the year 2004. This estimate was based on year 2001 population homelessness percentages and ratios determined through The Human Condition research in 2001. This estimate is thought to be accurate to within about + or - 10%" (Warren Smith, data analyst, Barnstable County Department of Human Services, email communication, Oct. 26, 2004).

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[2] A chronically homeless person 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. 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." To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) or in an emergency homeless shelter during that time.

[3] In October 2004, HUD released "A Guide to Counting Unsheltered Homeless People" prepared by Abt Associates, Inc. with Martha Burt of the Urban Institute as one of the primary authors.

According to data in the Human Condition Report, conducted in 2001, one Human Condition survey question, "Has any household member been homeless for more than a day or two in the past 24 months?" found that 7% of the respondents answered affirmatively. When extrapolating the survey results to the total population, this comes to 6,474 households. Twenty-two percent of the households surveyed reported they did not have enough money to pay for housing. These households were also two-and-a-half times more likely to report "having a lot of anxiety and stress in the household." The survey also found that 33% of renters paid by the month as they and did not have a year-round lease. Of those who rented by the month, 53% earned less than $25,000. Six percent of households reported that they received a private charity emergency money grant for housing in the past 24 months: extrapolated to the population this comes to 5,310 households (Barnstable County, Health and Human Services Advisory Council and Barnstable County Department of Human Services 2002a).

In addition, a Barnstable County-wide study of in-depth interviews with 42 women who had received prevention services because they and their families were at risk of becoming homeless, found that 75 % continued to experience trouble making the rent/or mortgage payments most of the time. Housing vulnerability is also noted in the frequency of moves of the women. The average number of times the women moved in the past five years was 3.12 with an average length of stay of 2.79 years. Housing vulnerability was further revealed in the finding that 69% of the women reported at least one homeless episode (as defined as not having a place of one's own not by choice) and 31% were homeless more than once. Most of these episodes would have been considered "hidden homelessness" since the majority of the women were not part of the emergency shelter system during their homeless episode. While just over half of the women reported that they feared becoming homeless, over half of the women also noted that they had no one to shelter them if they were about to become homeless (Hamilton, 2000).

5. CURRENT SYSTEM IN PLACE TO RESPOND TO HOMELESSNESS ON CAPE COD AND THE ISLANDS

The current system in place includes:

- Homelessness Prevention
- Homelessness Beds/units (796 beds according to the 2004 count)
  - Emergency Shelter (297 beds for individuals and persons in families)
  - Transitional Housing (254 beds for individuals and persons in families)
  - Permanent Supportive Housing (245 beds for individuals)
- Outreach to the Homeless
- Support Services
- Discharge Planning

Although the Cape and Islands has a comprehensive prevention system in place through an array of prevention programs such as Project Prevention at Housing Assistance Corporation and Interfaith Council for the Homeless to name a few, it is not able to keep up with the need due to the constantly increasing costs of housing in the region and the lack of affordable housing and adequate permanent supportive housing, along with the lack of adequate employment opportunities with sufficient income, to provide long-term stability to the homeless population

once housed. Coupled with this is the high cost of living in the area rendering service sector incomes insufficient for self-sufficiency.

The current system does not provide enough permanent supportive housing and affordable housing to move homeless persons from shelter and/or transitional housing into more stable housing. It also does not include enough long-term stabilization to prevent recidivism back into homelessness. Currently there are no permanent supportive units/beds for homeless families coming out of transitional housing.

The need for models to provide *housing first* to include long-term stabilization for both individuals and families is evident in the fact that those working in direct contact with the homeless population report a recycling back into homelessness even after being sheltered in transitional housing. The housing first model is based on the concept of first getting homeless persons into housing which in itself is a stabilizing factor, and then providing the necessary support services in order to maintain stabilization of the housing. Preventing someone from becoming homeless in the first place and/or limiting the time actually homeless is crucial, especially when noting that the enclosed Discharge Planning Report discusses "a very small window of time once an individual enters the shelter system until the individual becomes somewhat swallowed up in the system and is at high risk to become a long-term, chronic homeless man or woman. This window is estimated to be approximately three weeks."
In addition, Massachusetts Housing and Shelter Alliance is discussing the need for studies to better identify markers/milestones that lead to chronic homelessness. It is hoped that further studies along with a comprehensive Homeless Management Information System (HMIS) will help identify indicators of chronic homelessness to tailor effective interventions.

While existing discharge planning policies within the regions' continuum display some strong components already in place, especially for the chronically homeless coming out of prisons and medical facilities, more needs to be done. Preventing homelessness in the first place, which includes good discharge planning, are all essential elements of a comprehensive system, which could end homelessness in ten years and also substantially reduce the cost of the present system.

Within a two-year period (2003-2004) the region has received over 15 million dollars[4] specifically for homelessness. These funds represent an array of private, state, and federal funds covering emergency shelter beds, transitional housing beds, domestic violence shelters, permanent supportive housing (including shelter-plus-care), outreach to homeless individuals (Tri-City Shelter Specialist, Vinfen's Homeless Outreach Team, CACCI's Main Street Outreach Worker, Nam Vets Outreach to homeless vets, and Legal Services for Cape, Plymouth and Islands, Homeless Outreach Project), supportive services for those in shelter, transitional housing, and permanent supportive housing, health care for the homeless (which also includes HRSA funds for Duffy Health Center), services for the homeless at the Salvation Army, and funds to implement the Homeless Management Information System (this list is not conclusive). While the exact amount of prevention funds available for the region is not known, it is estimated that over one million dollars was available in 2004, which includes some one-time funds only.

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[4] This figure includes some of the county funds awarded from the surplus budget in 2004 solely for homelessness but it does not include County funds for Bridgeport**.** It also includes the HUD CoC McKinney-Vento grant awards in the amount of $2,147,309 for 2003 and 2004 combined.

6. THE VISION

The Council has made the decision to move beyond simply responding to crises by developing long term strategic planning including goals and a mission statement as the first part in developing a Ten Year Plan. This process also included a series of strategic planning sessions facilitated by Steve Brown, Community Organizer for the Barnstable County Department of Human Services. On February 2, 2004, during a key strategic planning session of the Council, the decision to formerly change the name *from* the Cape Cod and Islands Coordinating Council for the Homeless *to* the Leadership Council to End Homelessness on Cape Cod and the Islands was approved.

Changing the name of the Council was a key part of the evolutionary process in addressing the need to end homelessness in the region and represents a drastic change from the Council's focus on managing homeless to the refocusing of resources on actions to end homelessness. The Council also adopted the following mission statement: ***The Leadership Council to End Homelessness on Cape Cod and the Islands mobilizes the community to end homelessness.***

In order to actualize the vision to end homelessness within ten years, especially among the chronically homeless, a combination of action steps will be needed such as: 1) strengthening existing services, including prevention: 2) developing new programs/services where needed; and 3) developing more housing, especially *housing first models* to get homeless persons off the street. It will take a concerted, coordinated effort to make this a reality, one in which the Council will play a key role, but cannot succeed without community input, support and partnerships.

Since there is no specific governing body or chief executive officer covering any one county or all three counties, the Leadership Council took the responsibility of facilitating the process to develop a Ten Year Plan to End Homelessness. Due to the logistics and expense of commuting from the islands, it unfortunately was not possible to get representation from either Dukes or Nantucket Counties at the planning sessions. Therefore, the Council brought the plan to the governing bodies at Dukes County and Nantucket County for endorsement and/or support and revisions. Meetings to accomplish this goal were viewed as an opportunity to strengthen the Council's linkages with community representatives from both Islands. The results of these meetings are outlined below.

On November 19, 2004 Leadership Council representatives met with a group on Nantucket to present the Ten Year Plan, gather feedback and seek approval of the plan (see List of Participants, page iii). After discussion, the conclusion was that the Leadership Council would help Nantucket develop capacity through the following steps:

1. Strengthen their participation in the point-in-time count of the homeless.
   It was agreed that in January key members of the Leadership Council will conduct a training session on Nantucket in preparation for the January 25th point-in-time count of the homeless. Maryanne Worth agreed to be the point person for the Island.
2. Strengthen the relationship between the counties to enhance Nantucket's involvement in the Leadership Council by providing linkages with the grant application and funding sources, as well as other Leadership Council communication.

3. Eventual endorsement and/or support of the ten year plan after a period of feedback to add ideas and comments.

The Nantucket visit was followed by a visit to Dukes County (Martha's Vineyard) on November 22, 2004, also attended by two representatives from the leadership Council (see the List of Participants on page iii). The consensus was that this meeting was the beginning of establishing a dialogue on the island regarding the 'hidden homeless' and the need to further define existing programs. The following is a summary of the major conclusions of this meeting:

1. Although it was noted that Martha's Vineyard was not well represented in the plan, this meeting could be a first step in strengthening the linkages. However, there was a need to discuss the issues and the plan among themselves first.
2. There was discussion of the need to highlight what services already exist on the Island, such as the Assertive Community Treatment program at the Vineyard House, identify what is available, and then reinforce what works. The question was raised if the Martha's Vineyard Commission could help with planning.
3. The Leadership Council needs to continue to finds ways to strengthen the linkages between Martha's Vineyard and the Council.
4. Those present expressed support for the plan, but felt that as an ad hoc committee, they were not in a position to approve the plan.

Both meetings were viewed as a successful means of strengthening contact between the island communities and the Leadership Council and in maintaining this contact on an ongoing basis.

7. ELEMENTS OF THE PLAN

The four working groups met and compiled a committee report along with a chart of goals and action steps with target dates as part of each committee's strategic planning. The following are each committee's report: the four strategic charts for each area follow in the appendices.

Prevention

Homelessness prevention activities help prevent households from becoming homeless and are extended to individuals/singles and families with dependent children. The activities can consist of advocacy to prevent mortgage foreclosure or eviction and financial assistance, which can extend beyond just help with the mortgage or rent payments. Other types of financial assistance that enable household to stabilize consist of automobile maintenance, medical and prescription bills, food, and so forth. The goal of prevention is simply to advocate and provide any necessary assistance that allows the household to maintain their current residence if it appears that they will be able to sustain the residence once the crisis has subsided.

Although the Cape and Islands already has extensive services in place to prevent homelessness, gaps in the services, such as lack of funds, coordination of available funds and sources, and the need for case management emerged again and again as primary issues. Addressing these issues allowed the group to examine what is in place, discuss ways to improve existing services, look to

other sources for funds and add services and training to fully address preventing homelessness thus ultimately ending homelessness.

Services not fully in place but seen as necessary included mediation in its true, formal sense (landlord-tenant mediation); centralized information including outreach to achieve better usage of data and resources; and more training for case managers to deal with the multiplicity of issues and to provide support to staff to prevent turnover and enhance better service.

Some of the identified solutions require additional funding, either from existing or new sources. Existing funding sources consist of private (Dennis-Yarmouth Ecumenical Council for Homelessness and the Barnstable Interfaith Council), local, or state (Department of Transitional Assistance) or federal sources (HUD McKinney). The group has already advocated for and received two new funds: one from Barnstable County and the other from the state's Department of Housing and Community Development. These new funds are being distributed by three Cape agencies to cover the Lower, Mid, and Upper Cape towns as well as the Islands.

The issue of case management involves bringing together case managers from the many groups who provide prevention services so that they can share information, brainstorm to problem solve, receive training, including peer training, and support each other. The goal is to provide a continuity of care and develop standardized methods of preventing homelessness.

The Cape has become a model for the state in its efforts to prevent homelessness. We are building on the foundations already in place and reaching out to additional segments of the community in order to solve the problem of homelessness. The Prevention Chart provided gives a detailed look at the specifics of these attempts, which also displays the firm commitment by all involved in this process to end homelessness in our community.

The Leadership Council is fully aware of the cost-effectiveness of preventing homelessness both from a financial and emotional standpoint, and strives to strengthen this component of the CoC. Unfortunately, due to the high cost of housing on the Cape and Islands the need for prevention continues to be even greater than ever. The cost-efficiency of preventing homeless is clear when comparing the following figures.

The cost-efficiency of preventing ***families*** from becoming homeless is as follows:

- According to Housing Assistance Corporation, the average cost of sheltering a family (including services) ranges from $23,490 for the least expensive shelter to $54,000 for the most expensive shelter for women in recovery from substance abuse (based on calculating the average monthly costs of $2,610 and $6,000 respectively times the average length of stay of nine months).
- In comparison, Project Prevention, available countywide and coordinated by Housing Assistance Corporation spends, on average, $1,333 per family for homelessness prevention.

The cost-efficiency of preventing ***individuals*** from becoming homeless is as follows:

- According to NOAH Center, the average cost of sheltering a guest (including services) is $1,845 (based on calculating $45 per night times the average length of stay of 41 nights).

- In comparison, in 2003, the Barnstable Interfaith Council prevention program, coordinated by NOAH staff, assisted 78 individuals for an average of $317.

While the above analysis provides information on the cost-effectiveness of preventing homelessness in comparison to sheltering the homeless, more information is needed regarding the actual costs homeless persons, especially chronically homeless individuals, accrue in order to better understand the actual costs of homeless. Therefore more extensive studies must be conducted.

At the October 19, 2004 Massachusetts Housing and Shelter Alliance, Ninth Annual Ending Homelessness Conference, in his speech, Philip Mangano, Executive Director of the U.S. Interagency Council for the Homeless, referred to studies that tracked homeless individuals over time. One study, conducted by the University of California, San Diego Medical Center, tracked 15 serial inebriates (chronic alcohol abusers) documenting over $3 million annually in expenditures for services, equaling $200,000 per individual (http:/www.ich.gov.innovations/).

Therefore, in order to develop a clear understanding of the actual costs of homelessness, especially among the chronically homeless subpopulation, a cost benefit analysis should be conducted within the region to analyze the actual costs accrued in comparison to the costs of housing with supportive services.

Discharge Planning

> Discharge planning is preparing a homeless person in an institution to return to the community and linking that individual to essential housing and services, including enhancing and expanding their treatment options and effectiveness *(MHSA, Tools and Resources for Discharge Planning).*

Determination of Need for Discharge Planning

Over the past decade in Massachusetts, literally thousands of homeless people have moved out of shelter, beyond homelessness to housing, employment and appropriate supportive services. But despite these efforts there are more homeless individuals in Massachusetts than ever before. Thousands have moved beyond homelessness. Thousands more have fallen in.

Why have emptied shelter beds refilled overnight? The Massachusetts Housing and Shelter Alliance (MHSA) put forth an effort to answer that question and this effort became the foundation for its multi-year work on discharge planning as homelessness prevention. MHSA instituted a monthly census of emerging subpopulations in the shelters across the state. This effort, now five years old, documented the emergence of growing numbers of individuals falling into homelessness.

MHSA's research showed that too often, the people without residential or housing options coming to the front door of shelters have come from the back door of state systems and institutions: young people 18-24 years old who have aged out of state services; ex-offenders released from state or county facilities with no place to go; people from detox at the beginning of their recovery; and people with mental illness released directly from a hospital. Research regarding these homeless sub-populations dispelled the old myth that homeless people are

anonymous street people wandering from shelter to shelter. Rather they are known – in fact, quite well known – to state funded residential treatment, corrections, and youth programs.

In January 2000, Governor Cellucci and Lieutenant Governor Swift directed the Executive Office for Administration and Finance to establish the Working Group on Discharge Planning. The Group was charged with examining the discharge planning policies and systems within correctional facilities and the Commonwealth's human service agencies and identifying initiatives to improve those systems.

In fulfillment of its charge to recommend improvements to discharge planning policies and systems, the Working Group offered a list of "best practices" and agency-specific initiatives to improve discharge planning. In addition, the Group identified five "cross-cutting" initiatives to improve policies and practices across multiple state agencies. Both sets of initiatives largely reflect agency efforts to bring existing policies and systems into accord with a list of "Characteristics of an Effective Discharge Planning Policy and System," produced by the Working Group. There are many similarities among the agency-specific initiatives to be implemented by the organizations represented in the Working Group. For example, many focus on agency efforts to incorporate the goal of effective discharge planning into the overall missions of the agencies.

Other common points of focus include:

- enhanced assessment tools to evaluate client or inmate needs;
- expanded involvement of community-based service providers in service delivery prior to discharge;
- enhanced training in the post-discharge availability of community-based resources;
- identification of potential opportunities for interagency collaborations;
- enhanced ability to assess the available supply of housing resources being utilized by discharged individuals and how that supply corresponds with the demand for those resources; and
- improved data collection regarding the post-discharge disposition of former clients or inmates.

Various public and private institutions contribute to homelessness by discharging their wards to the streets or shelters. Ending such practices is an important current tactic in the struggle to end homelessness itself.

State Discharge Planning Policy

(In June of 2004 the state's policy was released and is outlined in the following report.)

The Commonwealth has worked and continues to work to develop effective policies to prevent discharge from institutions and health care facilities that result in homelessness.

One of the ways in which the Commonwealth provides for appropriate discharge planning across programs is the inclusion of discharge specifications in contracts. The state's Operational Services Division, the agency responsible for overseeing the Massachusetts Purchase of Service system has developed discharge planning specifications for certain requests for proposals (the

method for state procurement of services including all human services). The language aims to ensure consistency in discharge planning among vendors and to establish an effective discharge planning policy and system statewide.

Individual departments have worked to ensure appropriate discharge planning internally as well. Since 1983, the Department of Mental Health, for example, has adhered to an inpatient discharge planning policy that includes housing search among other measures, and is explicitly aimed at preventing homelessness. The policy prohibits DMH state hospitals and community mental health centers from electing to discharge clients from inpatient units with directions to seek housing or shelter in an emergency shelter. It directs staff to make every effort to place clients in suitable, affordable housing coupled with clinically appropriate services.

Successful efforts have also been made to ensure appropriate discharge from privately contracted mental health and substance abuse services. The Massachusetts Behavioral Health Partnership (MBHP) is a private, for profit managed care organization that has contracts to manage mental health care and substance abuse services for over 500,000 low-income individuals. In FY98, the Commonwealth added performance standard in contract with MBHP to improve aftercare. In 1999, a performance standard was added in the contract specifically to improve discharge planning of homeless individuals. MBHP, in turn, has adopted discharge planning protocols, provided training and developed information al resources in order to fulfill this contract obligation.

The Department of Correction has developed system-wide policies and practices to encourage the discharge of offenders to appropriate housing or placements. As soon as an offender enters the corrections system, a needs assessment is conducted. This assessment forms the basis for the study and work the individual will do while incarcerated to prepare the individual for a successful discharge. One year prior to release, offenders attend a transition workshop; the workshop addresses all aspects of the transition back into the community including housing. Prior to release, the individual's transition plan is reviewed by a multi-disciplinary team. A case manager facilitates the transition to a Community Resource Center once the individual is released. Many resources are offered to ex-offenders; whether or not the individual avails themselves of these resources is determined by the individual alone unless the individual is under supervision after incarceration.

The Department of Social Services is in the process of reviewing its discharge planning policies to improve discharge planning from foster care and other youth facilities. The draft Permanent Planning Policy recommends changes to discharge planning, reinforcing Foster Care Review staff's involvement in focusing all involved with youth on planning for discharge and/or accepting a VPA[5] to remain in custody until age 18. The agency has a Discharge Support Program that provides youth leaving DSS without returning home or being adopted up to $1,500 in funds to pay for housing and related expenses. The agency also has each youth meet with an Outreach worker to assist with discharge planning including the completion of a Mass Health application. Youth leaving DSS also receive a Leaving Care packet that includes a Discharge Guide, a $50 gift card to a grocery store in the appropriate area, $25 phone card and a $50 gift certificate to a clothing or department store.

[5] VPA means voluntary placement agreement – footnote not in the original document.

Representatives of the local Continuum of Care as well as representatives of the local Discharge Planning Working Group / Oversight Committee will continue attending the ongoing meetings of the State-Wide Continuum Meetings where discharge planning policies are under discussion.

Local Discharge Planning Policy
At the local level the following list shows the existing discharge planning policies in place within the region which displays some strong components, especially for the chronically homeless individuals coming out of prisons and medical facilities.

Criminal Justice System:

- Drug Court at Barnstable Courthouse, implemented by Judge Reardon, is designed to coordinate services for people with repeated drug and alcohol problems to prevent homelessness. This team collaboration includes a court DMH Homeless Task Force, which meets regularly to assess individual cases. This process can also include bringing someone in for mandated services.
- The Barnstable County House of Correction has a SHOCK unit, a separate component within the prison for substance abusers who are serious in working on recovery. The SHOCK program refers substance abuse prisoners to Family and Children Services of Nantucket, as well as other agencies working with substance abuse populations, upon release from prison.
- The Community Resource Center works with the Barnstable County Department of Correction and conducts a needs assessment once someone enters the system to develop comprehensive discharge planning to prevent homeless upon release.
- The Duffy Health Center also works with the criminal justice system to provide pre-release assessment and post-release services to parolees. Inmates to be released within three months who report they are homeless are introduced to services at Duffy by the Certified Alcohol and Drug Addiction Counselor or nurse, and assessed for need for entitlement programs and for other services. Follow-up is provided upon release from jail.

Mental Health / Medical:

- The Department of Mental Health Director of Homeless services for the Cape and Islands, an active member of the Council, meets regularly regarding ongoing coordination of services with an array of agencies overseeing existing services to prevent discharge to the streets (VinFen, Duffy, CACCI, NOAH).
- Duffy works with the two hospitals in Barnstable County (Cape Cod and Falmouth Hospital) Social Services Department to develop discharge plans for chronically homeless and other homeless clients.
- A local hospital has been coordinating discharge planning with the NOAH Center. The Cape Cod Hospital has been coordinating discharge planning with the Council On Aging (COA) in the Lower Cape towns. This originated with the Town of Harwich with collaboration between the COA, Fire Department, and Police Department and has prevented homelessness among the elderly population. All eight Lower Cape towns have formulated a group called “Reaching Elders With Additional Community Help” to further coordinate discharge planning. The Nantucket Cottage Hospital discharge planner works with the Human Services Council and Nantucket Interfaith Council for temporary placements until a more permanent placement can be found.

Service Gaps and Needs

Even with the above-mentioned efforts there are individuals arriving at our shelter doors who have been discharged with no place to go but the shelter and the streets. These people come from medical hospitals, psychiatric hospitals, jails, nursing homes, rest homes, detox services and other services. Often facilities have no viable discharge plans. The need to move less ill people from hospital and program beds to make room for more acutely ill people sometimes leaves persons on the street, or referred to shelter beds.

Using the 2004 Gaps Analysis conducted by the Leadership Council for the 2004 HUD application, the Cape and Islands has 1,041 homeless individuals with 249 on the streets and 692 homeless persons in families with 253 on the streets (this includes 6 individuals and 21 persons in families about to be evicted which HUD includes as homeless). Based on this data, the Housing Development Subcommittee of the Cape and Islands Ten-Year Plan to End Homelessness has determined a need for approximately 550 units for single homeless individuals and about 125 units for homeless families.

This huge residential gap creates a significant backlog in all services throughout the continuum of care. Consider the service need in one area, substance abuse. Per summary data prepared for Cape Cod Healthcare, Cape & Islands Behavioral Health Service Needs and Gaps, it was estimated that in 2001 there were 12,313 individuals on the Cape & Islands who met the national definition for alcohol/substance abuse and/or dependence. Only 5,635 were admitted to recognized Cape & Island treatment facilities during 2001. Thus, roughly half of those with treatment needs did not receive treatment.

- What has happened to the 5,635 who did receive treatment? The Cape & Islands has approximately 45 beds in sober housing. The waiting lists are typically six months long.
- What has happened to the 6,678 who did not receive treatment?

Some of the 12,313 have become homeless. Many of those who become homeless will become chronically homeless. It is the experience of those who work with the local homeless population that there is a very small window of time once an individual enters the shelter system until the individual becomes somewhat swallowed up in the system and is at high risk to become a long-term, chronic homeless man or woman. This window is estimated to be approximately three weeks

There is much more work to be done in the area of discharge planning. The Discharge Planning Working Committee has developed the following action plan to assess needs, expand awareness, educate stakeholders and improve outcomes. The plan calls for expansion of the existing working committee into an ongoing Discharge Planning Oversight Committee. This committee is to include representatives of service providers, business and other stakeholders who can build on the work already done and in development at the state level and beyond. The Discharge Planning Oversight Committee is charged with adopting a local policy, selecting an assessment tool and educating the larger community as well as continuing to work with the other subcommittees.

Coordination of Existing Services

While many agencies are diligently working together to assist homeless clients to achieve housing and other supports, there is a need to 1) strengthen existing services to homeless persons by coordinating a system wide response to homelessness through provision of housing and support services and 2) develop a comprehensive, efficient and user-friendly information system that enables agencies to track services and assist residents who are homeless.

To strengthen existing homeless services, the Leadership Council will seek to engage additional participating agencies in order to broaden its safety net, increase commitment, and reduce duplication of services. The Council will have as a focus cross-cutting areas that have the most impact in assisting clients through the continuum of care. Often these cross-cutting areas may be essential to the transition out of homelessness, but may lack funding. Examples include outreach (the process of engaging people in a trust relationship so that they become motivated to access needed services) and case management (enabling and facilitating services that are customized to individuals whose needs are multiple and complex). Such components may be described as "boundary spanning" activities to ensure service provision is client rather than organizationally driven. These services are vital to getting and keeping people housed. Additional issues to engage those who are homeless and to keep formerly homeless persons housed include provision of health care (including mental health and substance abuse), employment, job training, and other supports, as well as fundraising and advocacy. As an ongoing priority, the Leadership Council will review the documented gaps in services and develop a system-wide response to these issues as part of its mandate. Cross-cutting projects will be research supported, evidence-based practices that have been demonstrated to be successful and cost effective, such as the modified therapeutic community model (which evolved during the Pilot House program) and Assertive Community Treatment (a multidisciplinary team approach).

The Leadership Council is fortunate to have HUD funding to develop a Homeless Management Information System (HMIS). The two-year funding (2004-2006) will support services of a coordinator and purchase of equipment (hardware and software) for a number of agencies. The HMIS system will be based on local needs and support all components of the continuum of care (prevention, services and housing resources, and discharge planning). The HMIS program will include the means to assess:

- how long people are homeless
- what their needs are
- what the causes of homelessness are
- how people interact with mainstream systems of care
- the effectiveness of interventions
- the number of homeless people

Initial priorities are to identify community resources, understand the service linkages and gaps for assisting residents, and devise a real-time management tool to strengthen services delivery among agencies, meet HUD requirements, and be a community resource. Once this is done, the second stage of the project will be to promote the use of this regional HMIS system as a community resource, by developing a "train-the trainer" presentation to facilitate use, and to

conduct outreach to encourage faith-based and other non-profit agencies to participate in the program.

The Cape and Islands is fortunate that several community-based information systems/databases have already been developed on a regional level (such as that developed by the Barnstable County Department of Human Services). However, the expectation is that this regional HMIS will significantly enhance our ability to track and therefore develop a more comprehensive understanding of the homeless population and therefore enhance long-range planning.

Key to success of the continuum of care will be ongoing evaluation and refinement of both the provision of homeless services as well as the HMIS. Formal and ongoing community-based input will be gathered to ensure that the homeless service delivery system is user-friendly, effective, and efficient.

Also a major piece of coordination of existing services is the development of a campus complex. This concept stemmed from community consensus that relocation of many of the homeless services to one location is desirable and will also enhance the delivery of services by providing comprehensive services at one site, thus improving an individual's ability to transition to permanent housing. Pilot House, Duffy Health Center and NOAH Center will all be part of this campus complex. At this point a steering committee is meeting on a regular basis to establish the plan and select a site.

Housing Development

The upsurge in homelessness that we have witnessed over the last 20 plus years is fundamentally a result of government policy choices made at the federal and state levels. First, there has been an absolute decline in federal and state support for the development of low-income housing, especially public housing. Using constant dollars, the HUD budget of 1977 was about $76 billion; last year HUD's budget was about $34 billion. In 1989, housing accounted for 2.9% of the state budget; in 2004, housing accounted for less than .7% of the budget. One manifestation of these reductions has been that the Cape has seen the loss of about 1,400 housing subsidy vouchers over the last 10 years. Secondly, the early 1980's saw about 500,000 disabled people nationwide terminated from Supplemental Security Income (SSI) and Social Security Disability Income (SSDI). This immediately thrust vulnerable people onto the streets. Finally, the Commonwealth's policy of deinstitutionalization that occurred without the provision of sufficient resources for housing and supportive services for those who were released from mental institutions clearly exacerbated the problem of homelessness. The Cape and virtually every other region across the country have been struggling with the consequences of these policy choices ever since.

In order to meet the need as determined from the March 2004 Point in Time homeless count and the 2004 Gaps Analysis done by the Leadership Council for the HUD SuperNOFA application, we need to create about <u>550 units for single homeless individuals</u> and about <u>125 units for homeless families</u>.

Fundamentally, no Ten Year Plan To End Homelessness can succeed without a strong federal commitment of resources- both for public and private housing development as well as Section 8 and Massachusetts Rental Voucher Program (MRVP) rent subsidies. Collaboration and creativity can only go so far to end homelessness; without sufficient financial and other resources, this plan will be one more unfulfilled dream. The estimated amount of financial resources from the public sector that will be needed to end homelessness in the region in 10 years is approximately $50,000,000 from County, state, and federal sources. For development projects underway or planned that will create 145 units, there will be a need for about $10,000,000 in private equity, including that from federal tax credits, and about $1,500,000 in bank mortgage financing.

The attached housing development plan calls for the completion of four projects currently underway or in advanced planning which will create 75 units, and the creation of an additional 70 units through the replication of the Bridgeport model introduced by the Council of Churches along with securing the resources to introduce the Assertive Community Treatment model to the region. This plan also calls upon each community to take specific actions to take responsibility for providing housing for the homeless: 150 units will be created if each community creates one unit for the homeless each year for the next ten years. Finally, the plan calls upon the community to mobilize to secure enough federal and state housing subsidy resources to create an additional 255 units for individuals and 125 units for families.

8. IMPLEMENTATION AND MONITORING OF THE PLAN

The Leadership Council will oversee the implementation and monitoring of the Ten Year Plan through the monthly Council meetings. The chairs of each working committee will continue to play a role in monitoring their component of the plan and will report to the full Council on a regular basis.

As part of the monitoring process, the Council will implement the approach utilized by the Commonwealth of Massachusetts' Governor's Executive Commission for Homeless Services Coordination's *Housing the Homeless: A More Effective Approach* by adopting the method of putting the key components of its strategic plan into a chart to include a *status category* as a 'living' document to be updated monthly by reporting progress made within each area of the strategic plan during the monthly Council meetings.

However, the Leadership Council will need ongoing collaboration with the wider community in order to actualize the Ten Year Plan to End Homelessness. Active participation and support of all members of the community - the business sector, realtors, builders and government entities, in addition to the human service and housing/homelessness advocates, is needed.

An ongoing partnership with the Barnstable County Commissioners and Assembly of Delegates is also a necessity in order to make this plan a reality. In 2004 the Leadership Council and other important components of the region's Continuum of Care received an unprecedented amount of financial support from the Barnstable County government.

The following list outlines the financial support received in 2004 from the county:

- $40,000 for the Leadership Council for coordination and grant writing (FY04 & FY05)
- $75,000 toward the development of Pilot House
- $50,000 for the Hyannis Street Outreach Worker (FY04 & FY05)
- $50,000 for NOAH Center
- $20,000 toward the development of Bridgeport (permanent supportive housing)
- $200,000 for direct financial assistance and case management for prevention
- $30,000 for the homelessness and prevention services, Cape Cod Council of Churches
- $73,520 (FY05 with renewal dependent upon performance) for a new county position of Housing Development Specialist at the Cape Cod Commission

The Barnstable County government's acknowledgment of the need to address homelessness and affordable housing issues in our region is as essential as the County financial support. However, this needs to be an ongoing relationship as noted throughout the strategic plans.

In addition to the need for ongoing support and funding, it should be noted that the region already has many services and programs in place, some funded through the annual HUD Continuum of Care McKinney-Vento application. In 2003 this successful application brought over one million dollars to the region, which included funding for new programs including eight beds of new permanent supportive housing for Bridgeport, support services for clients living in CHAMP Homes, funding for the Homeless Management Information System (HMIS), funding for Legal Services of Cape, Plymouth and Islands, Inc. to conduct outreach to the homeless, plus renewals for support services and shelter plus care beds. The successful 2004 application will also bring over one million dollars which will allow for the development of five new beds of permanent supportive housing for chronically homeless individuals with mental illness, along with an array of renewal funding for support services and shelter-plus-care programs. In addition, over 13 million dollars has come into the region during a-two year period (2003-2004) covering an array of homeless services and beds.[6] When including the HUD CoC McKinney-Vento awards for 2003 and 2004 the amount specifically for homelessness for the region totals over 15 million dollars. When including the conservative estimate of prevention funds (for 2004 only) of one million dollars (which includes some one-time funds), this totals over 16 million dollars.

Although the different aspects of the plan must converge so all the components fit together to create a seamless stream of support services to prevent homelessness and to also limit the time anyone remains homeless, the *Community Collaborative Campus Model* is an important piece of the plan and therefore must become a reality. This collaborative project will bring Pilot House, Duffy Health Center, and NOAH Center all under one location. From January 2003 to July 2004 during the short existence of Pilot House, over 130 individuals, barred from other shelters because of mental health and addiction problems, were able to utilize these services. Some were able to move on to other transitional and permanent housing through this therapeutic community. On land owned by the Barnstable Municipal Airport Commission, this demonstration project experienced an unfortunate six-month hiatus when in late July 2004 the building was demolished due to airport expansion plans. In December 2004 a new location was found and Pilot House

[6] See page 9 for a comprehensive list.

once again was back in operation. The three agencies, Community Action Committee of Cape Cod and the Islands, Inc., Duffy Health Center, and Housing Assistance Corporation, are collaborating to make this Campus a reality, which may include the relocation of Pilot House.

The development of the Campus model, along with the rest of the plan to end homelessness, must include many segments of the community, as this plan will not happen without this involvement. This plan will come at a cost both financially and otherwise.

The following are conservative estimates of what is required in the way of new funds to make this plan a reality based on yearly estimates for each area:

- Prevention - an estimated amount of $278,000 is needed. This includes ongoing continuation of additional funds for prevention assistance and case management, mediation funds and funds for the new position of Project Prevention Coordinator.
- Discharge Planning - an estimated amount of $103,286 is needed for a full-time clinician, a full-time outreach worker and funds for presentation materials and equipment.
- Coordination of Existing Services - $50,000 for coordination of LC and grant writer for the Council's annual HUD CoC application. Also included in this plan is the need for ACT staff of five at $225,000, which is included in the Housing Development budget.
- Housing Development - $6,150,000 per year for an estimated amount of $61,500,000 over 10 years.

The above estimates total $6,581,286 per year for a total of $65,812,860 over a ten-year period (not adjusted for inflation).

<u>Conclusion</u>

Although it will be costly to prevent homelessness and develop more permanent supportive housing to stabilize homeless persons as we move toward a housing first model, in the long-run this is not only cost-efficient but the morally right thing to do for the individuals and families who are without shelter. Homeless persons range in age from infancy to elders, even including individuals in their eighties and nineties. Without safe and stable housing, it is much more difficult to be a productive member of the community, whether it be paid work, volunteer work, creative work, or whatever contribution one might make to society.

APPENDIX A

PREVENTION

GOALS	ACTION STEPS	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
***Goal #1:* Coordination of services across the region**	1) Regional Meetings to include all CC&I prevention service providers with a coordinator to focus on the regional piece	HAC – Dolores Barbati-Poore (Coordinator of Project Prevention)	September 2004 and ongoing ($50,000 annual salary and administrative overhead)
***Goal #2*: Improve case management**	1) Intensify case management within existing programs to conduct the following: stabilization/tracking and measurable outcomes to be agreed upon regionally	Barnstable County Funding to provide an additional $100,000 for case management – the three regional organizations (HAC, CACCI, & Interfaith) will come together to design this program (see related Goal #5)	County Funds available late June 2004 ($100,000 for Case Management for a minimum of one year to track clients – this is only for clients receiving county funds)
***Goal #3*: Make prevention information available Cape & Islands wide** • Comprehensive information to include: prevention funds/ services, food pantries/soup kitchens, help with utilities, vehicle, medical, eligibility requirements, geographic location	1) Data gathering 2) Improve & update BCDHS website (web based) 3) Create notebook of info (hard copy) 4) Flyers/brochures on specific issues/areas (food pantries, etc) 5) Make available locally 6) *Update* data regularly	BCDHS Human Condition Housing/Homelessness Working Group and HMIS information gathering HAC - Deborah Converse	Information gathering completed by October 2004 & ready for dissemination Dec 2004 Costs – in-kind– supervision portion of HMIS contract

(*continued*) **GOALS**	**ACTION STEPS**	**RESPONSIBLE PERSON/ ORGANIZATION**	**TARGET DATES**
***Goal #4*: Improve mediation services** • Landlord tenant mediation • Court mediation • Outside mediation available to agencies • Social workers at LHA	1) Provide training for prevention workers in negotiation/mediation 2) Provide outside mediation (a certified mediator) 3) Stabilization & intensive case management 4) Reactivate regional coordination meetings among LHA to encourage early referrals and info/resources sharing	HAC w/work with Cape Cod Mediation Services and explore group rates for training non-profits (or grant funds) Consumer Assistance Council and/or LSCCI See above/County funds to enhance case management Barnstable Housing Authority - Tom Lynch	Winter 2004-2005 At a per session cost to be determined by # of participants but not to exceed $200 per training for a total of $3,000 Winter 2004-2005 (estimated cost of $25,000) $100,000 County Funding through to May 31, 2004 Fall 2004
***Goal 5*: Increase overall funding and make available locally**	1) Increase promotion of supermarket certificates 2) Tap into Local funding in each town 3) Raise additional prevention funds by bringing large institutions on board to sell supermarket certificates such as CC Healthcare, Cape Cod Community College, etc 4) Barnstable County funds for Prevention ($100,000) 5) Residential Assistance to Families in Transition (RAFT/DHCD)	Wampanoag Housing Program/Alice Lopez Local agencies such as Interfaith, Wampanoag Housing Program, etc. HAC - Project Prevention HAC to coordinate County Funds ($100,000 for case management and $100,000 for direct financial support to be distributed according to population and three regions (Upper, Mid & Lower Cape – HAC, CACCI & Interfaith) Will be administered by HAC & Other Non-profits	Ongoing Ongoing Ongoing County $ released late June 2004 and expended by October 1, 2004 for the Upper and Mid Cape areas July/August 2004 & Ongoing $100,000 + administrative costs of $200 per case

(*continued*) **GOALS**	**ACTION STEPS**	**RESPONSIBLE PERSON/ ORGANIZATION**	**TARGET DATES**
***Goal 6*: Enhance early intervention and strengthen services for specific subpopulations**	1) Provide info and training to all section 8 /LHA & low income complex reps to enhance early referrals	HAC –Project Prevention Coord. Dolores Barbati-Poore	Fall 2004 and ongoing
	2) Outreach to DTA offices	HAC – Project Prevention Coord. Dolores Barbati-Poor	Fall 2004 and ongoing
	3) Initiate outreach to Elders thru COA, Elder Services, Medical facilities/Dr's offices	HAC Project Prev. Coord. will utilize community service programs (High Schools, 4Cs, Court Ordered Community Service, Cape (volunteer) Corp., Parish Nurses	December 2004
	4) Gather info on home modification, reverse mortgages and disseminate info by region	HC Housing/ Homelessness group will gather data	December 2004
	5) Conduct survey of housing needs of elderly (include above plus other elder groups – also see what data is available on U.S. Census)	Barnstable County Department of Human Services/Warren Smith, data analyst	Completed
***Goal 7*: Need trauma referral & prevention** • All case managers need info on available services and make referrals to appropriate resources with follow-up if possible	1) Provide training during regional meetings to address recognition and information	DMR, Independence House, CC Human Services, MSPCC can play a role in training	October 2004

(*continued*) GOALS	ACTION STEPS	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
***Goal #8*: Address seasonal crisis issues in order to keep people sheltered and alive during the winter months & during summer housing crunch**	1) Agencies receiving county money for case management delivered on local level will take any steps necessary to keep people housed/ work with local motel owners, landlords, etc. 2) Forum on Workforce Housing	HAC, CACCI & Interfaith 2A) Deborah Converse at HAC has been working on this issue 2B) Workforce Resource Fair /HC Economic Literacy – Terri Huff	County Funds for Prevention released June 2004 Fall 2005
***Goal #9*: Establish case management support mechanisms**	1) A one day retreat for all workers 2) Group meetings with qualified persons to facilitate stress reduction	Leadership Council/Prevention Subcommittee to coordinate with CC Council of Churches	November 2004 Cape Cod Council of Churches in-kind
***Goal #10:* Conduct a cost-benefit analysis of a subset of chronically homeless individuals to determine actual costs accrued over a period of time in comparison to the cost of housing with supportive services**	1) Design a study to track a subset of chronically homeless individuals over a period of time to determine actual costs accrued 2) Conduct study over a one year period 3) Compare above costs to the cost of housing with supportive services for same period 4) Determine cost-efficiency based on results	Leadership Council	2005-2006 $5,000 - $10,000

APPENDIX B
DISCHARGE PLANNING

GOALS	ACTION STEPS	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
***Goal #1:* Implement assessment tools to evaluate local discharge issues**	1) Collect tools / reports selected at state level, evaluate, and select. 2) Track intake to shelter from State agencies - Hire FT Clinician - Hire FT Outreach Worker	Discharge Planning Working Group Discharge Planning Working Group	07/15/2004 Ongoing Cost: $55,062 (inc. benefit & admin.) $43,224 (inc. benefit & admin.)
***Goal #2:* Develop collaboration with local stakeholders**	1) Broaden Discharge Planning & Oversight Committee 2) Develop method of identifying and retaining linkages among key discharging agencies 3) Train in post-discharge availability of community based resources. 4) Disseminate written educational material with case studies including presentations – particularly to private sector	Discharge Planning Working Group Discharge Planning Working Group w/consultation with Existing Services / HMIS subcom. Discharge Planning Working Group w/consultation with Existing Services / HMIS subcom. Discharge Planning Oversight Committee	07/15/2004 - 10/01/2004 07/15/2004 12/01/2004 Cost: $5,000 presentation equip. 12/01/2004
***Goal #3*: Identify Exemplary Policies and Procedures**	1) Collect exemplary policies and procedures 2) Evaluate exemplary policies and procedures	Discharge Planning Working Group Discharge Planning Oversight Committee	10/01/2004 12/01/2004

Goal #4: **Improve outcomes**	1) Develop Plan for Ongoing monitoring of discharge outcomes 2) Identification of potential opportunities for interagency collaborations 3) Improve data collection regarding the post-discharge disposition of former clients/inmates	Discharge Planning Oversight Committee	12/01/2004

Additional cost considerations: Office Space and furniture, computer, phone lines

APPENDIX C
COORDINATION OF EXISTING SERVICES

Overall Goal: Development of a comprehensive, efficient and user-friendly system to track services and assist residents who are at risk of or are homeless. *The system will be able to assess how long people are homeless, what their needs are, what the causes of homelessness are, how people interact with mainstream systems of care, the effectiveness of interventions, and the number of homeless people.*

GOALS	ACTION STEPS	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
***Goal #1*: Identify community resources**	Work with community agencies to compile and document existing resources.	Service Providers HMIS Subcommittee	September 2004 HMIS Staff Person @ $20,000 (HUD Funds)
***Goal #2*: Understand the service linkages and gaps for assisting residents**	Review current MIS components from different agencies and relationship of MIS to agencies' services	HMIS Subcommittee	September 2004 (see above)
***Goal #3*: Develop a system-wide response to cross-cutting issues to strengthen continuity and avoid duplication of services**	1. Target additional community agencies for participation in Council. 2 Take a leadership role through advocacy and fundraising. 3. Develop and implement regional responses to client needs: case management, outreach, wrap-around services: e.g., ACT team: -- Assertive Community Treatment – 40 units of innovative supportive housing scattered sites	1,2, Leadership Council 3. Duffy Health Center Barnstable Housing Authority Vinfen Housing Assistance Corporation	Ongoing Council services (costs = county funded coordinator + grantwriter + $50,000/yr. in kind participation from various staff at approx. 20 CBOs on Council) *3. ACT* costs: $225,000 per year for five staff to provide supportive services; psychiatrist, psychiatric nurse, substance abuse/mental health counselor, benefits coordinator/case manager, and employment counselor
***Goal #4*: Devise a real-time management tool to strengthen service delivery among agencies, meet HUD requirements, and be a community resource.**	Utilize HUD funding to set up HIMS development and coordination -- Hire HUD HMIS personnel --Convene meeting of agencies to discuss client tracking systems and	HAC HMIS mgr. HMIS Coordinator Human Condition Housing and Homelessness Subcommittee	November 2004 Personnel: 1.5 FTE at $52,000 (HUD) $28,120 plus $5,000 admin. (HAC Match/in-kind)

(*continued*) GOALS	ACTION STEPS	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
***Goal #4(continued.*: Devise a real-time management tool to strengthen service delivery among agencies, meet HUD requirements, and be a community resource.**	How information could be shared and compiled. -- Evaluate software options based on level of expertise available in the community and based on community need. --Design HMIS user-friendly system. -- Review current websites that could integrate/link CoC effort -- Include participation of homeless clients in design and feedback on needs		Training, hosting, and online connectivity: $19,458 (HUD) Software costs: $1,000 (HUD) Equipment costs: $7,700 (HUD) Leveraging by HAC: $20,000
***Goal #5*: Promote use of regional HMIS system as a community resource**	1) Develop "Train-the-trainer" curriculum to provide service providers with knowledge of using directory. 2) Encourage faith-based and other non-profit agencies to participate 3) Leadership Council will use and distribute data to wider community.	Leadership Council HMIS staff	Jan 2005 and Ongoing For calendar year 2005: FTE 1.5, plus continued software and equipment costs for expanded HMIS system to other regional agencies: $107,000 (HUD) Matching/in-kind: $43,000 (HAC)
***Goal #6*: Increase efficacy and efficiency of client-driven services.**	1) Design an evaluation form for use at individual agency level for Ongoing HMIS refinement. 2) Hold monthly reviews to determine efficacy of HMIS system and revise as needed. 3) Evaluate objectives as set by HUD HMIS 4) Evaluate HMIS system in terms of its utility as a community resource	HMIS staff Leadership Council	Feb. 2005 and Ongoing (see above)
Goal #7: Develop the Campus Complex	1) Establish a Campus Complex Plan 2) Select Site 3) Construct campus/relocate programs	Housing Assistance Corporation CACCI Duffy	2005 Costs undetermined at this time - based on final site selection

APPENDIX D
HOUSING DEVELOPMENT

GOALS	ACTION STEPS (& resources needed)	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
***Goal #1:* Create 550 units of rental housing for homeless individuals by 2014**			
***Goal #1A:* Complete those housing projects planned or underway – 75 units**	1) Complete Dana's Field in Sandwich – 50 units of permanent supportive housing (PSH) (single room occupancy units) Development costs - $12.6 million: Public sources - $1.5 million: Tax credit equity - $4.7 million; Contributions/loan of developer fee - $5.6 million; Frst mortgage - $750,000	Housing Assistance Corporation	1) Permitting permitted- timing uncertain as under appeal 2) Funding secured - one year after permitting 3) Construction start – 18 months after permitting 4) Construction completion- 12 months after construction start
	2) Baybridge – 5 units of PSH - Clubhouse Development costs - $600,000: Public source - $300,000 HUD SuperNOFA ; First mortgage - $300,000; Operating/supportive services - $50,000 per year	Friends of Baybridge	1) Secure funding – Dec. 2004 2) Construction start – summer 2006 3) Project completion – June 2006
	3) Bridgeport – 8 efficiency units of PSH, for participants of the Overnights of Hospitality program – Falmouth Development costs - $1,000,000; Public sources - $990,000 ($298,000 of HUD SuperNOFA funds) Donations - $10,000	Falmouth Housing Corporation Cape Cod Council of Churches	1) Permitting – summer 2004 2) Funding secured – summer 2004 3) Construction start – fall 2004 4) Construction completion and occupancy – end 2004/early 2005

continued) GOALS	ACTION STEPS	RESPONSIBLE PERSON/ ORGANIZATION	TARGET DATES
Goal #1A:* Complete those housing projects planned or underway – 75 units *(continued)	3) Bridgeport continued Annual operating expenses – plus mortgage - $31,500; Need at least 3 project based Section 8's ($18,000 per year) 4) Pilot House transitional housing as part of campus – 12 units Development costs – To be determined Public sources – County $75,000 Other public – TBD Donations – TBD First mortgage - TBD	Community Action Committee, Duffy Health Center Housing Assistance Corporation	Project manager funded by $75,000 from the County to produce a production schedule and cost estimate by end of 2004
***Goal 1B:* Implement Models to Create Housing with Support Services – 70 units**	1) Bridgeport model – three other 8-12 unit programs across the County - 30 units Estimated development costs: $1 million per project: Public - $750,000; Donations - $100,000; Mortgage - $150,000. At least four project-based Section 8 vouchers for tenants per project 2) Assertive Community Treatment – 40 units of innovative supportive housing scattered sites Public $225,000 per year for five staff to provide supportive services; psychiatrist, psychiatric nurse, substance abuse/mental health counselor, benefits coordinator, and employment counselor	Cape Cod Council of Churches, Housing non-profits and housing advocates Duffy Health Center Barnstable Housing Authority Vinfen Housing Assistance Corporation	Completion in 2006, 2008 and 2010 July 1, 2007

(*continued*) **GOALS**	**ACTION STEPS**	**RESPONSIBLE PERSON/ ORGANIZATION**	**TARGET DATES**
***Goal 1C*: Each community should take responsibility for providing some homeless housing – 1 unit per year for each of the 15 Cape Communities – 150 units**			
1) County development Consultant available to Towns to assist in housing development projects	1) Commitment of Public (County) resource: $70,000 per year	Cape Cod Commission	August 2004
2) Towns should require at least some housing in Chapter 40B projects be available to homeless individuals or families	1) Housing Summit 2) Public education effort 3) Need communications process between homeless providers and towns and 40B developers	Cape Cod Commission Cape Cod commission Local housing committees and HAC/CACCI	Spring 2005 Ongoing Ongoing
3) Towns should also have bylaw for affordable accessory apartments	1) Housing Summit 2) Public education effort to share best practices	Cape Cod Commission Cape Cod Commission	Spring 2005 Ongoing
4) Towns should adopt inclusionary zoning bylaws (require % affordable in all developments) and zoning like Dennis' municipally sponsored development bylaw that promotes affordable housing	1) Housing Summit 2) Public education effort to share best practices	Cape Cod Commission Cape Cod Commission	Spring 2005 Ongoing

(*continued*) **GOALS**	**ACTION STEPS**	**RESPONSIBLE PERSON/ ORGANIZATION**	**TARGET DATES**
5) All town housing plans should have goals for housing for the homeless **6) All towns should substitute the CPA for the Land Bank**	1) Housing Summit 2) Public education effort to share best practices 1) Town Meeting and general election votes	Cape Cod Commission Cape Cod Commission Coalition of housing advocates and environmental and preservation groups in each community	Spring 2005 Ongoing Spring 2005
***Goal #1D*: Increase public resources sufficient to produce another 255 rental units for individuals over the next 10 years**	1) Propose three year demonstration ISSI program – time limited Sec. 8's usually one year – propose demonstration program for Cape with County Match for state funding – County **-** $150,000; State – $350,000 Total units 75 (25 per year) 2) Increase funding for Section 8 by $250,000 per year for the Cape - $2.5 million year ten of the plan 3) Advocate that County HOME Consortium set aside at least $100,000 of the development fund it allocates annually to rental housing developments targeted to the homeless	Housing Assistance Corporation Housing Assistance Corporation and local housing authorities Housing Assistance Corporation, non-profit housing developers, and local housing authorities	Adoption in FY07 state budget Ongoing Consolidated Plan process / Spring 2005
Goal #2: Create 125 units of housing for homeless families by 2014	1) Add 125 Section 8 vouchers targeted to homeless families – public costs - $1.25 million annually – 10 year total - $12.5 million 2) Increase USDA funding enough to fund a rental housing development each year; public costs - $1,5 million per year at 1% interest for each project – ten year total - $15 million	Housing Assistance Corporation, & local housing authorities Housing Assistance Corporation, & local housing authorities	Ongoing Ongoing

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