University of New Hampshire

University of New Hampshire Scholars' Repository

Manchester Research Group | UNH Community Projects

2-22-2008

A home for everyone: a 10-year plan to end homelessness in the city of Manchester.

Mayor Frank Guinta and Patrick Tufts, the President of Heritage United Way

Follow this and additional works at: https://scholars.unh.edu/mrg

Recommended Citation

Mayor Frank Guinta and Patrick Tufts, the President of Heritage United Way, "A home for everyone: a 10-year plan to end homelessness in the city of Manchester." (2008). *Manchester Research Group*. 9.
https://scholars.unh.edu/mrg/9

This Text is brought to you for free and open access by the UNH Community Projects at University of New Hampshire Scholars' Repository. It has been accepted for inclusion in Manchester Research Group by an authorized administrator of University of New Hampshire Scholars' Repository. For more information, please contact Scholarly.Communication@unh.edu.

A Home for Everyone: A 10-Year Plan to End Homelessness in the City of Manchester

February 22, 2008

Table of Contents

EXECUTIVE SUMMARY	3
MANCHESTER 10-YEAR PLAN: VISION, PREMISES, GOALS	5
NEXT STEPS	9
HOW MANY PEOPLE ARE HOMELESS?	10
WHY ARE PEOPLE HOMELESS?	14
HOW AFFORDABLE IS MANCHESTER?	15
WHAT ARE THE COSTS OF HOMELESSNESS?	18
WHAT WORKS?	20
APPENDIX A: TASK FORCE MEMBERS	22
APPENDIX B: STAKEHOLDERS IN MANCHESTER'S PLAN	23
APPENDIX C: MOST IMPORTANT THINGS THIS PLAN MUST DO	24
APPENDIX D: HISTORY OF 10-YEAR PLANS	25
APPENDIX E: MANCHESTER CONTINUUM OF CARE AND ASSISTED HOUSING	26
APPENDIX F: HOUSING FIRST	32
APPENDIX G: WHAT IS SUPPORTIVE HOUSING?	33
APPENDIX H: ASSERTIVE COMMUNITY TREATMENT	35
APPENDIX I: REFERENCES	37

Executive Summary

This Ten-Year Plan to End Homelessness is a call to action for the City of Manchester. It is time to take a moral stand in declaring homelessness to be unacceptable in our city. While we will no doubt always have the need for emergency assistance and safety nets for people in need, there are known practices that work to prevent homelessness and to re-house and stabilize in housing even those who seem to be the most difficult to help. Not only is long-term homelessness immoral, it is also unnecessarily costly to communities. Cost studies have demonstrated that it more expensive to keep people on the streets, incurring the excessive costs of crisis intervention, emergency room health care, and revolving-door intervention programs, than it is to provide permanent supported housing that produces much better outcomes.

In the course of a year, over 1500 people in the City of Manchester experience homelessness, approximately 400 of whom are children. Nationally, one fourth of homeless people are children in homeless families (Burt, 2001). Research demonstrates that children who experience homelessness are more likely to be homeless as adults and to experience serious difficulties, including physical, cognitive, emotional, and mental problems. (Burt, 2001)

Nationally, approximately 26% of homeless persons are veterans, with the numbers likely to increase from the wars in Iraq and Afghanistan. Almost half (46%) of homeless adults report chronic physical conditions. More than 20% of the homeless are chronically homeless as defined by the U.S. Department of Housing and Urban Development (HUD). They have chronic illnesses and have been homeless for more than a year or more than 4 times in 3 years. When chronically ill people are also homeless, the costs are high and the outcomes poor. Studies have demonstrated that chronically ill individuals in long-term homelessness utilize community resources costing $40,000 to more than $100,000 per person per year. Recognizing the high costs of long-term homelessness, cities throughout the U.S. are demonstrating success in reducing homelessness and improving health outcomes with permanent housing combined with intensive supports that cost no more and often less than keeping seriously disabled people in long-term homelessness, jails, and hospitals.

Homelessness is a complex problem that stems from a combination of extreme poverty, health issues, and unaffordable and unavailable housing stock. Numerous agencies in Manchester have been working hard on these issues for many years and are doing exceptional work (see Appendix D). Yet, there are long waiting lists of those in need and too many people still living on the streets in Manchester. This plan recognizes the need to make a community-wide commitment to ending homelessness, to increasing the resources available to meet the needs, and to focus on integrated strategies and solutions that demonstrate that they will end homelessness.

This plan was developed with the leadership of Mayor Frank Guinta and Patrick Tufts, the President of Heritage United Way, as co-chairs of a task force of leaders from a broad cross-section of the Manchester community (see Appendix A). The plan was written with the help of an independent facilitator, Pamela Brown, who combined input from 3 meetings with the Task Force, individual interviews with numerous stakeholders, and meetings with the membership of the Manchester Continuum of Care (MCoC), the Healthy Manchester Leadership Council, and the Greater Manchester Association of Social Agencies (GMASA). As a result, this plan

represents the insights, commitment, and support of a broad cross-section of the Manchester community.

Over 310 cities throughout the U.S. have developed or are committed to developing 10-year plans to end homelessness. Positive results are being reported by cities large and small, including Nashua, NH, Portland, ME, Denver, CO, Portland, OR, Seattle, WA, Tulsa, OK, Columbus, OH, and Boston, MA. Cities that are implementing permanent supportive housing programs are experiencing declines in homelessness as high as 50% to 70%. While the greatest cost savings and successes in reducing the numbers of people on the streets come from addressing the needs of the chronically homeless, Manchester's 10-Year Plan to End Homelessness is intended to continue the efforts that have been underway up to this point and address the needs of all persons vulnerable to or experiencing homelessness, including families, veterans, single adults, children and youth.

This 10-Year Plan incorporates both what has been learned through the efforts of other cities and what the Task Force members and other participants determined to be needed in Manchester. All endorse the following lists of 10 keys to implementation success and 5 potential barriers that must be overcome:

10 Keys to Success:

1. Political leadership
2. Community champions
3. Point person to coordinate and manage the effort
4. Public-private partnerships
5. Broad endorsement and commitment
6. Consumer-centric solutions
7. Valid and complete data collection to demonstrate successes
8. Innovative and creative thinking
9. Disciplined planning and implementation accountability
10. Timely monitoring and review of progress.

5 Potential Barriers to Success:

1. Lack of public awareness and education on homelessness issues, costs, and solutions
2. Stigma and misinformation regarding homelessness, serious mental illness, and substance use disorders
3. Neighborhood resistance (NIMBY)
4. Lack of engagement and partnership by key city agencies (e.g. Welfare) and housing and service providers
5. Lack of fidelity to best practices.

Homelessness is an issue that affects and reflects on the entire Manchester community. This document presents Manchester's 10-Year Plan to End Homelessness and the research and data on which it is based. The purpose of this plan is to provide a framework for integrating and coordinating the activities of many inter-related agencies, organizations, and individuals toward addressing and eliminating homelessness within the Greater Manchester area. Through this plan, the people and organizations of Manchester and surrounding towns can end long-term homelessness and significantly reduce the numbers of people experiencing homelessness in our city. This plan documents what we believe it will take and represents the will to get it done.

City of Manchester
10-Year Plan to End Homelessness

The Vision: Manchester as a city where all children, adults, and families have access to decent, safe and affordable housing and the resources and supports needed to sustain it.

Premises:

A. Homelessness is fundamentally a poverty, health, and housing availability issue.

B. The best way to eliminate homelessness is to actively address systemic problems as well as provide emergency assistance and prevention (Burt, 2001).

C. Manchester's Plan is focused on all homeless: chronic, temporary, families, youth, single adults, veterans.

D. Neither housing nor services alone will solve the problem of homelessness. Both housing and services are critical. Essential services include integrated case management, employment training and support, transportation, health and life skills training and education, clinical care for primary health, mental health, substance abuse, dental and eye care, medication management, and social work.

E. By definition, permanent supportive housing includes both housing and the supportive services required to successfully stabilize at least 70% of individuals and families in housing. Permanent supportive housing according to the "housing first" model whereby housing is contingent only on adhering to standard lessee requirements has been demonstrated to be the most successful solution to long-term homelessness.

F. All those who qualify for federal and state benefits should be assisted in applying for and accessing the benefits to which they are entitled as a basic means of accessing and paying for housing and services.

G. The City of Manchester's Welfare Department is a critical player in ensuring that the city's funds are used most effectively in preventing and addressing homelessness in collaboration with other providers within the City and region. Manchester is unique in having a Welfare Commissioner who is elected rather than appointed. Without full knowledge and understanding of the issues by the public, costs may be saved in the Welfare budget at the expense of increased costs to other sectors of the community.

H. The experiences of other cities and the quality of organizations and people within Manchester suggest that there is no shortage of capabilities available to implement this plan. Success will depend on leadership, political will, public understanding of the issues, and community-wide commitment, collaboration, and implementation discipline.

Funding Premises:

A. Most of the increased resources will come from private and public sources that have not been engaged up to this point.

B. In order to optimize private resources, the City must maximize the availability of Federal and State funding. This is the role of Manchester's Planning Department.

C. Similarly, the City must demonstrate commitment to this plan through alignment of resources, the budget, funding allocations, and local incentives. This is the role of the Mayor and the Board of Aldermen.

D. The housing and service providers have accountability for the quality of their services and management of their organizations, for compliance with funder expectations, for positive

outcomes and impact, and for generating additional private and philanthropic funds to implement this plan.

Eight Primary Goals and Associated Actions:

Goal One: Rapidly re-house people who become homeless and provide wrap-around, supportive services that promote housing stability and self-sufficiency.

a) Decrease the total number of homeless persons on the streets and in emergency shelters in Manchester by 40% within 5 years by increasing permanent supportive housing and maintaining a housing stability success rate of 70% or better after 1 year.
b) Reduce duplication of effort by developing an efficient and coordinated intake system for housing and services referrals, placement, and tracking that unites all potential entry points and providers within Manchester into a seamless system that results in "no wrong door" of entry for people in need. The system should be designed to move individuals and families out of emergency and transitional housing into permanent supportive housing as efficiently and quickly as possible.
c) Put discharge procedures and respite housing and support services in place for individuals being discharged from hospitals, mental health, and substance abuse treatment programs until appropriate permanent supportive housing is available.
d) Put discharge procedures and permanent supportive housing in place for individuals being discharged from the corrections system so that no one is discharged into homelessness
e) Provide for segregated emergency shelter and transitional housing facilities as needed for the safety and support of vulnerable populations and move them into permanent supportive housing as quickly as possible:
    - Victims of domestic and sexual violence
    - Single women
    - Youth
    - Families with children
    - Adults and youth seeking to maintain sobriety/abstinence from drugs.

Goal Two: Prevent individuals and families from becoming homeless whenever possible.

a) Use City Welfare funds and create supplementary funds as needed to provide emergency assistance to prevent evictions into homelessness when subsidies and support would sustain families and individuals through a temporary crisis.
b) Create incentives for real estate developers and landlords to increase the stock of housing units affordable and available to households at 50% or less of the area median income (AMI)
c) Create incentives that increase the stock of sober living housing and recreational alternatives in locations conducive to sobriety for those in need of sustained, long-term support for recovery from substance use disorders
d) Make it easier for homeless and vulnerable individuals and families to access complete and accurate information on the resources and services available in the Manchester area for prevention, housing, and support services.
e) Make quality rep payee services available for those who want and need budgeting assistance to pay for housing, food, and other essentials.

Goal Three: Provide adequate employment and/or educational services to increase wages to housing affordability, particularly for individuals at or below 50% of AMI.

a) Track stabilized employment as an outcome indicator of transitional and permanent supportive housing programs
b) Create incentives for local businesses to expand employment opportunities, workforce training and development, and employment counseling that increase jobs that provide a housing wage and improve the ability of those below 50% of AMI to afford housing
c) Expand public transportation to include more extensive coverage areas and expanded hours of operation as a means for low income persons to get to and from places of employment.

Goal Four: No one sleeps and lives on the streets

a) Maintain an adequate safety net of emergency and transitional housing for families, youth, and adults, including places for families and individuals (youth and adults) to be housed after hours, on weekends, and/or holidays when the primary facilities are unavailable to new admissions.
b) Increase availability of permanent supportive housing according to the model of "housing first" to get the chronically homeless into supported housing. Provide the supportive services needed to successfully stabilize at least 70% of those engaged in housing after 1 year.
c) Provide shelter, bathing, and laundry options during the day as well as nights for those in emergency shelters.

Goal Five: Focus on the specific needs of veterans as a vulnerable population segment.

a) Gather accurate and complete information on the number and needs of homeless veterans in Manchester.
b) Maximize access to available funding for emergency, transitional, and permanent supportive housing and supportive services to meet the needs of veterans in the Manchester area.
c) Support current providers and seek additional providers as needed to take advantage of available funding and increase emergency, transitional and permanent supportive housing units for veterans.

Goal Six: Increase access to supportive services.

a) Assist all homeless and potentially homeless persons in applying for Federal and State benefits for which they qualify
b) Seek and incorporate consumer input and participation in defining service and support needs
c) Expand access to integrated mental health, substance abuse, primary health, and dental health care services
d) Increase the availability of and access to effective outpatient and residential substance abuse treatment and counseling services in the Manchester area
e) Provide legal assistance to overcome barriers: credit histories, criminal records, etc. (meet people where they are.)

Goal Seven: Build public awareness and education about the causes and costs of homelessness, the rationale behind the City's plan, the models of success, and the need to engage the entire community in the solutions.

a) Conduct a conference in Manchester in 2008 to promote community-wide education and dialogue about homelessness, engage more organizations and individuals, and facilitate innovative solutions and public-private partnerships in implementing the 10-Year Plan
b) Through our elected representatives, advocate for city, state, and federal policies and legislation that help end homelessness (e.g. increased access to rent subsidies, diversity in housing stock, living wages)
c) Engage the citizens and public and private organizations in the towns adjacent to Manchester to join forces with those of the City in working together to eliminate homelessness in the region
d) Annually report progress and the contributions of each town, agency, organization, and individual in achieving the goals of the Ten-Year Plan.

Goal Eight: Establish a Steering Committee of 10-12 leaders and a Chairperson to serve as political and community champions for the 10-Year Plan, to provide oversight and evaluation of plan implementation, and to help generate resources and commitment for ending homelessness in Greater Manchester.
a) Fund and recruit a full-time Coordinator reporting to the President of Heritage United Way to take day-to-day responsibility for implementing the 10-Year Plan, improving integration, coordination, and collaboration between public and private agencies within the city, region, and state toward ending homelessness, and providing administrative support for the Manchester Continuum of Care.
b) Establish the benchmarks, with appropriate timeframes, for each of the goals, based on Manchester's baseline data.
c) Strengthen and broaden participation in the Manchester Continuum of Care to include all agencies and providers involved in addressing, preventing, and ending homelessness in Greater Manchester, regardless of sources of funding or specific scope of operations
d) Strengthen information gathering and evaluation of outcomes through participation in HMIS by all agencies that receive Federal, State, or city funding. Maintain complete and accurate information on the numbers and composition of the homeless in Manchester, current capacity and utilization, waiting lists and unmet needs, and key outcome measures.
e) Develop and maintain an accurate and complete directory of all housing and homeless service providers within the Greater Manchester area, with a description of the services offered by each agency, contact information, and other relevant information for public use.
f) Grow the funding available to address housing and supportive service needs.

Next Steps

Next Steps	By Whom	By When
1. Final meeting of the Task Force for endorsement of the Plan	Mayor Guinta Patrick Tufts	Early Feb/08
2. Identify the members of the Steering Committee and the Chairperson	Mayor Guinta Patrick Tufts	2/15/08
3. Submission of the plan to the Board of Aldermen	Mayor Guinta	2/08
4. Approval and announcement of the Ten-Year Plan by the Mayor and Task Force members	Mayor Guinta Patrick Tufts	2/28/08
5. Define the job description for the Plan Coordinator	Patrick Tufts Steering Comm. Chair	March 2008
6. Conduct search and hire the Coordinator	Patrick Tufts Steering Comm. Chair	5/15/08
7. Develop the operating plan for the next 12 months	Coordinator	6/30/08
8. Plan and conduct a conference within Manchester to promote education and dialogue within the community	Coordinator	9/30/08
9. At the end of the first year, evaluate, assess, and adjust the plan and structure as needed. Continue with annual operating plans.	Coordinator	6/30/09

How Many People are Homeless?

Definitions of Homelessness:
Accurately counting the number of homeless people in the U.S., the state of NH, and the City of Manchester is a challenge. Homeless counts vary depending on the definition of homelessness, which is typically driven by funders, and the quality of the methodology used. The U.S. Department of Housing and Urban Development (HUD) defines a homeless individual as one who "lacks a fixed, regular, and adequate nighttime residence or who has a primary nighttime residence that is:

- a supervised publicly or privately operated shelter designed to provide temporary living accommodations
- an institution that provides a temporary residence for individuals intended to be institutionalized
- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

An operational definition of the homeless according to the U.S. Health Resources and Services Administration (HRSA) is anyone who "lives on the streets, stays in a shelter, abandoned building, vehicle or other unstable or non-permanent situation, is a resident of transitional housing, is doubled up temporarily with another family member, or has no permanent place to return to after hospitalization or incarceration."

The McKinney-Vento Homeless Assistance Act defines homeless children and youth as individuals who lack a fixed, regular, and adequate nighttime residence and includes:

- Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
- Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings
- Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
- Migratory children (as defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless as defined above.

The primary difference between HUD's definition of homelessness and the others is that HUD excludes those who are temporarily doubled up or "couch surfing."

HUD Point-in-Time Counts:
NH has three HUD-designated Continuums of Care: Manchester, Nashua/Hillsborough County, and the Balance of State. To gather homelessness data, HUD requires all Continuums of Care to have Homeless Management Information Systems (HMIS) and to conduct local point-in-time (one day) counts every other year in January, which are then aggregated into a national count.

Point-in-time counts avoid duplication in numbers but underestimate the total number of people experiencing homelessness because of the large percentage (75%+) of people who go in and out of homelessness within a year. Experts suggest that the point in time estimates should be multiplied by at least 4 times (Burt, 2001) to get an accurate estimate of the total number of individuals experiencing homelessness in a given year.

On January 26, 2007, in the middle of a winter blizzard, the Manchester Continuum of Care conducted the latest point-in-time survey of Manchester's homeless population, using the HUD definition of homeless. The results were as follows:

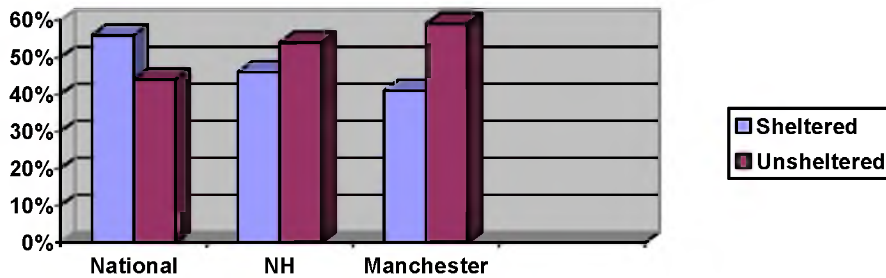
Characteristics	Sheltered	%	Unsheltered	%	Total	%
Total # homeless	307	61	197	39	504	100
# of persons in families with children (# of families)	135 (47)	85	24 (15)	15	159 (62)	32
# single individuals and persons in households without children:	172	50	173	50	345	68
Chronically homeless	112	83	23	17	135	27
Severely mentally ill	110		17		127	25
Chronic substance abuse	110		14		124	25
Veterans	21		7		28	6
Persons with HIV/AIDS	0		0			0
Victims of domestic violence	68		11		79	16
Unaccompanied youth (Under 18)	0		2		2	0

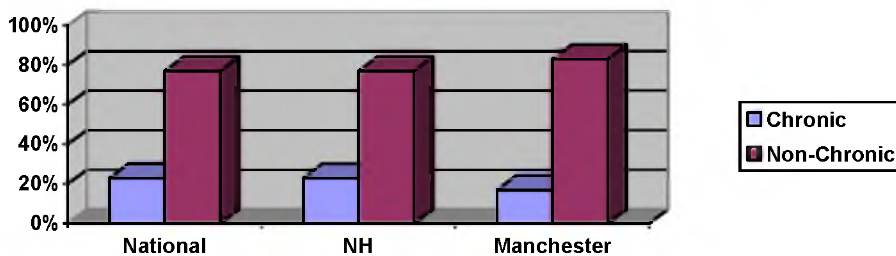
Source: Manchester Continuum of Care, 1/26/2007

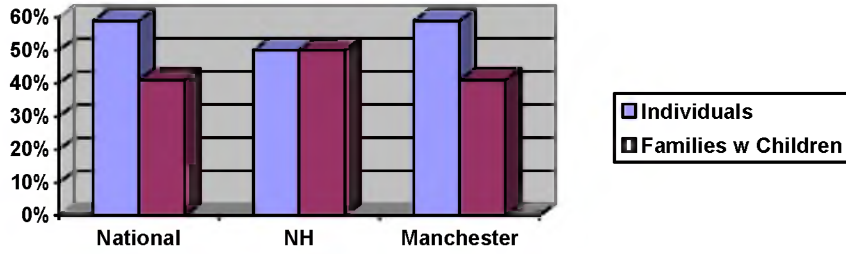
Using the rule of thumb of multiplying point-in-time counts by 4 to get an annual count of the homeless in Manchester would suggest that the numbers approximate 2000, excluding those who are doubled up.

Another count of the homeless in Manchester is available through the work of the Mobile Community Health Team (HCHT), which uses the HRSA definition of homelessness that includes the doubled up. In 2006, the MCHT saw 1,351 homeless patients in Manchester, 16% of whom met the HUD definition for chronic homelessness.

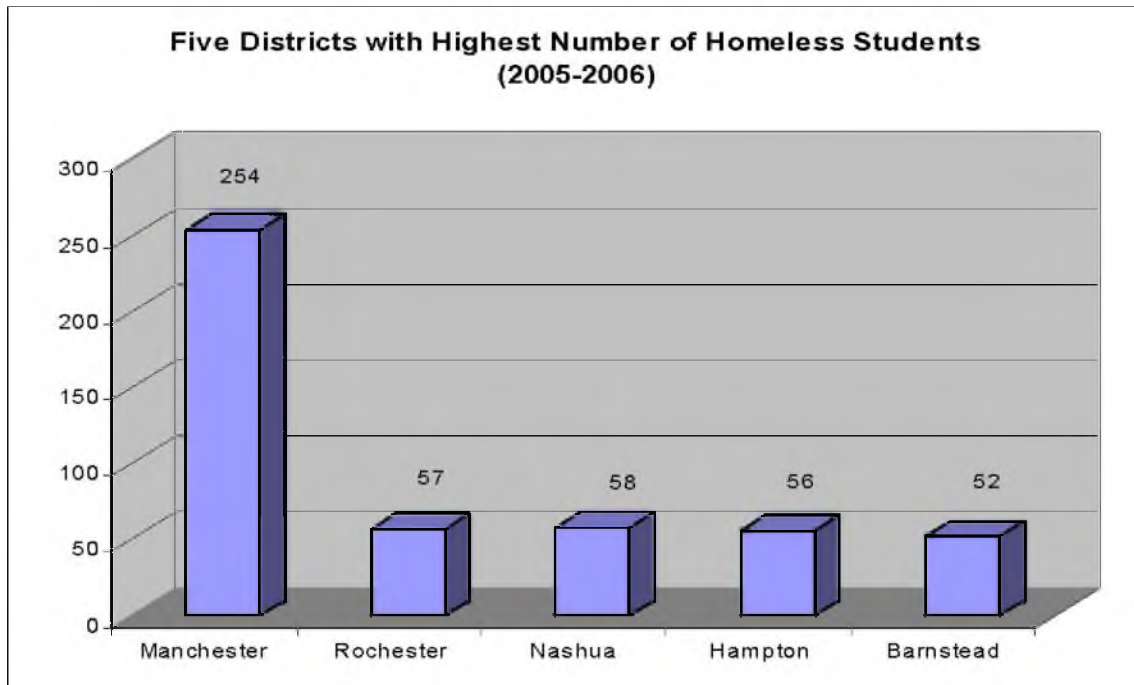
The latest published point-in-time national, state, and Continuum of Care data is from January, 2005. ("Homelessness Counts," NAEH 2007). The total number of homeless nationally on that date was 744,313. In NH the total number of homeless was 3,233. In Manchester, the total was 1, 277, or 40% of the state total. Following are charts, based on that one-day count.

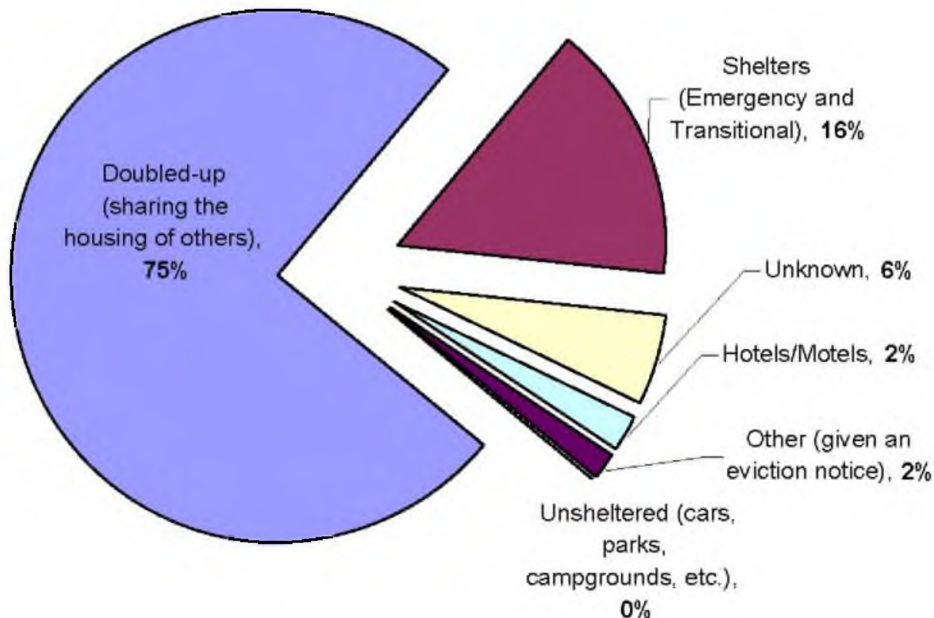






For the past several years, the NH Department of Education has conducted a one-day count of homeless students. The following charts illustrate the numbers from that count:





Source: NH Department of Education

It is important to realize that the charts above only reflect the number of homeless school-age children in Manchester. The most recent state statistics (collected by the NH Office of Homeless, Housing, and Transportation Services) show that in the state-funded shelters, 54% of the children were less than six years old. Based on that percentage, there are estimated to be over 2,000 homeless children in New Hampshire, 391 of which are in Manchester. Nationally, 25% of homeless people are children in homeless families, 42% of which are under the age of 6. (Burt, 2001)

Why Are People Homeless?

Lack of availability of affordable rental housing is the largest factor contributing to homelessness in the U.S. (National Alliance to End Homelessness, 2004). The U.S. Department of Housing and Urban Development (HUD) defines affordability of housing as 30 percent or less of annual income. When housing-related costs exceed 30%, individuals and families have to make trade-offs between housing and other necessities such as food, clothing, transportation, medical care, and higher education for their children.

Thirty years ago, homelessness was not the wide-spread problem in America that it is today. The primary roots of homelessness can be traced to the end of the market expansion of affordable housing in the 1970s and drastic cuts to the federal budget for affordable housing in the 1980s. Since the 1980s, homelessness has exploded as a result of converging structural, political, and social factors. The trends include:

A. Housing market forces leading to the replacement of affordable housing with condominiums and high-end housing, increasing median purchase prices and rental costs
B. Dwindling employment opportunities and incomes for people with high school educations or less
C. Failure of Social Security disability benefits to keep pace with the costs of living, relegating the chronically ill and disabled to the most extreme levels of poverty
D. Inadequate and unaffordable treatment and recovery services and supports for persons with severe mental illness and substance use disorders, leaving those individuals unable to sustain the basic requirements for housing
E. Rampant illegal drug and alcohol abuse and increasing prevalence of gambling, all of which are high risk to those vulnerable to addiction
F. Increasing single parent and teen-headed households with low earning power
G. Weakening support networks within families and communities.

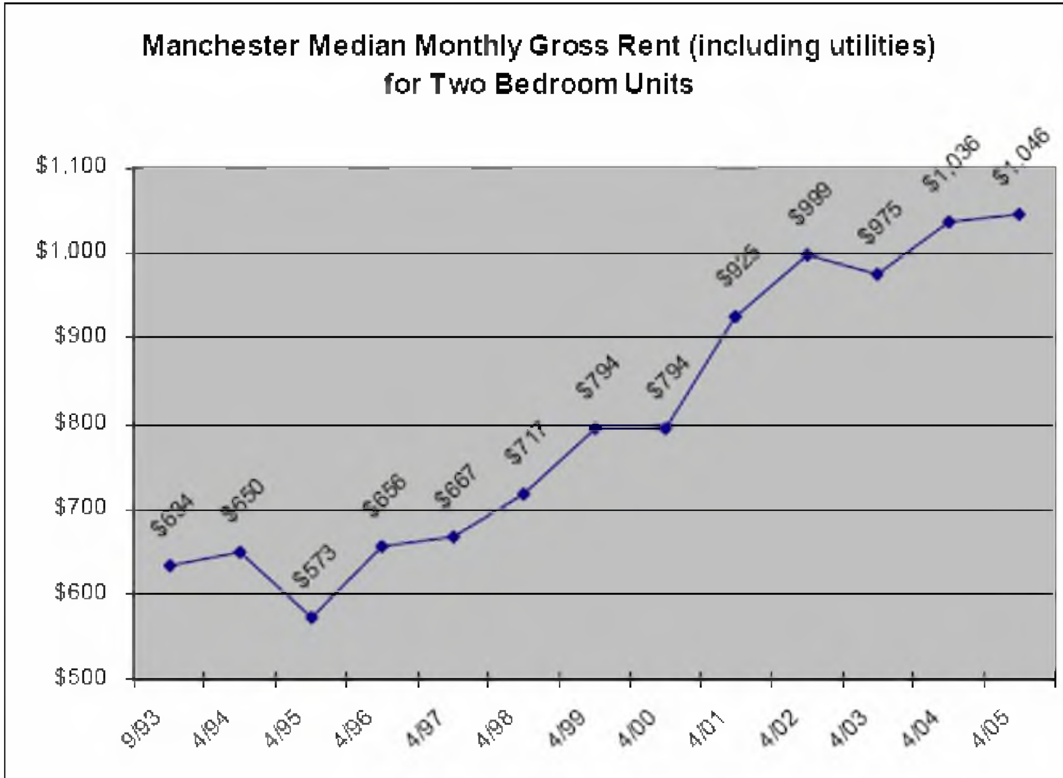
As a result, homelessness has become an increasing risk to those at the low end of the income scale and to those with chronic illnesses and disabilities. A national survey of the homeless (Burt, 2001) reveals:

- 46% report chronic physical conditions
- 31% report a combination of mental health and substance use problems
- 17% report drug or alcohol use problems alone
- 15% report mental health problems alone
- 25% report no mental health or substance use problems in the past year.

Other predictors of the risk of homelessness include trauma, such as physical or sexual abuse, foster care, and (for males) incarceration.

How Affordable is Manchester?

Housing costs in Manchester have increased steadily since 1998. Lack of affordable purchase prices push people into the rental market. Lack of affordable rental housing pushes people into emergency shelters and transitional housing. The evidence can be seen in the survey of Manchester's homeless population in the summer of 2007 that revealed that 19% are employed in regular, full-time jobs. (Manchester CoC)



Source: New Hampshire Housing Finance Authority

The gap between housing costs and low income wages is widening. Between 2000 and 2007, fair market rents in Manchester increased 41%. The following tables illustrate the increasing difficulty in affording housing in Manchester by individuals and families at the low end of the income scale. On a national scale, New Hampshire ranks 43rd out of 52 states (D.C. and Puerto Rico included) in terms of the income required to afford a 2-bedroom apartment (1 is lowest; 52 is highest).

2000 Data on Number of Renter Households

	NH	Manchester
Total # households	474,606	58,757
# Renter households	143,823	26,081
% Renters	30%	44%

Income Data and Housing Affordability

	NH	Manchester	Max. Affordable Housing/Month* (Manchester)
2006 Annual Area Median Income (AMI)	$72,076	$76,900	$1,923
Low Income: 80% AMI	$57,660	61,520	$1,538
Very Low Income: 50% AMI	$36,038	38,450	$961
Extremely Low Income (ELI): 30% AMI	$21,623	$23,070	$577
Estimated Renter Median Household Income	$39,619	$39,128	$978
Minimum Wage ($5.85/hr.)	$12,168	$12,168	$304
Supplemental Security Income (Disability) ($603/mo.)	$7,236	$7,236	$181

Source: Low Income Housing Coalition
* Calculated at the HUD affordability standard of 30% of income

2007 Fair Market Rents (FMR) and Corresponding Income Requirements

Apartment Sizes	NH	Manchester	Manchester Income Needed to Afford FMR	Housing Wage
0 Bedroom	$643	$682	$27,280	$13.12
1 Bedroom	$758	$837	$33,480	$16.10
2 Bedroom	$941	$1,001	$40,040	$19.25
3 Bedroom	$1,205	$1,196	$47,840	$23.00
4 Bedroom	$1,341	$1,232	$49,280	$23.69

Source: National Low Income Housing Coalition from HUD and Census data.

2007 Fair Market Rents in Manchester as % of Levels of Income

Apartment Sizes	Manchester	FMR as % Renter Median Income	FMR as % Extremely Low Income (30% AMI)	FMR as % Min. Wage Monthly Income	FMR as % SSI Monthly Income
0 Bedroom	$682	21%	35%	67%	113%
1 Bedroom	$837	26%	44%	83%	139%
2 Bedroom	$1,001	31%	52%	99%	166%
3 Bedroom	$1,196	37%	62%	118%	198%
4 Bedroom	$1,232	38%	64%	122%	204%

As illustrated above, a minimum wage worker earning an hourly wage of $5.85 and $12,168 annually can afford housing costs of $304 per month according to the HUD standard. In order to afford the median rent for a two-bedroom apartment, a minimum wage earner would have to work 143 hours per week, 52 weeks per year. Alternatively, a household would have to include 3.6 minimum wage earners, working 40 hours per week year-round, in order to afford the current median cost of a two bedroom apartment in Manchester.

In addition to affordability, the availability of rental units is an important determinant of the overall homeless situation. According to 2005 data provided by the New Hampshire Housing Finance Authority, the overall vacancy rate of rental housing units in Manchester was 4.2%. A vacancy rate below 5% is considered low by HUD standards and tends to create upward pricing pressure. The vacancy rates on low income housing through providers such as Manchester Neighborhood Housing Services and the Manchester Housing and Redevelopment Authority are even lower at 1% or below, resulting in waiting lists of 6 months to 3 years. The waiting list for Section 8 subsidies through the Manchester Housing and Redevelopment Authority, which are essential to housing for disabled individuals on SSI, is 4 years.

What Are the Costs of Homelessness?

Studies show that homelessness destroys the hope and health of human lives and saps the economic, social, and moral vitality of communities. Extended periods of time in homelessness leads to institutionalization to the streets, increased incidence of trauma, poor health outcomes, and a mortality rate that is 4 times that of the housed population.

Studies of medical problems and patterns of disease among homeless persons reveal a population suffering disproportionately from common primary problems such as hypertension, diabetes, peripheral vascular disease, respiratory problems, chronic liver and renal disease, and skin diseases. Tuberculosis and HIV/AIDS are also endemic in this population. One study that analyzed 1,260 homeless adults in New York City found that physical health problems resulted in far more use of hospital emergency rooms than mental illness and substance abuse issues, pointing out that significant health care cost savings can be achieved by housing homeless individuals and families and providing supportive services that include primary health care (O'Connell, 1999).

Major health concerns for homeless children and youth include nutritional deficiencies, sleep

deprivation, trauma and emotional and developmental difficulties. Homeless children have a rate of chronic disease twice as high as their peers and higher rates of upper respiratory infections, skin disorders, chronic problems with eyes, ears, and teeth, malnutrition, gastrointestinal disorders, genitourinary difficulties and sexually transmitted diseases (National Policy and Advocacy Council on Homelessness, 2005). Homeless children are much more likely than housed children to experience physical, cognitive, emotional, and mental health problems, translating into a greater risk of homeless in adulthood. (Burt, 2001)

Since the late 1990s, 3 major areas of groundbreaking research have challenged traditional assumptions and practices:

1. Studies of the characteristics of homeless people and the systems with which they interact reveal that
   A. The majority (75% or more) of the homeless are homeless for temporary periods of time and, with the proper services and supports, can get back into sustainable housing
   B. A small percentage (10-20%) of the homeless have chronic disabilities and are "chronically homeless," either continuously for more than a year or 4 or more times within 3 years.
2. Pioneering interventions in permanent supportive housing using the "Housing First" model (see Appendices E and F) have demonstrated success in achieving stable housing for 70% or more of their chronically homeless participants. In addition to housing stability, the outcomes for improved health and recovery measures are proving to be better than traditional efforts to treat chronically ill individuals while homeless.
3. Cost/benefit studies reveal that chronic homelessness is extremely costly to communities. The small percentage of "chronically homeless" (10%+) use the largest percentage (50%+) of emergency assistance resources. When including the costs of repeated emergency room visits and hospitalizations, police interventions, jails, and repeated mental health and substance use treatment, chronically homeless persons have been shown to cost cities $40,000 to $800,000 per person per year. Permanent supportive housing, even with the required intensive supports, has been found to cost significantly less than chronic homelessness.

Comprehensive studies of the financial costs of homelessness have been conducted by Dr. Dennis Culhane of the University of Pennsylvania and associates. His groundbreaking study of 4,679 homeless people in New York City over an 8-year period revealed:

- The chronically homeless, found to comprise 10% of the homeless at a given point in time, use 50% or more of the shelters and other homeless assistance resources designed primarily for emergency and temporary use.
- Upon analyzing the full costs of emergency room use, hospitalizations, police, jails, treatment program admissions, etc., the chronically homeless use $40,451 (1999 dollars) per person per year in services (Culhane, 2002)

Other studies conducted around the country on the costs of homelessness incurred by communities include: (US Interagency Council on Homelessness e-newsletter, 1/6/06)

- Boston Health Care for the Homeless reviewed records for 119 chronically homeless individuals and found that they accumulated 18,000 emergency room visits in five years at an average cost of $1,000 per visit.
- 10-Year planners in Asheville, North Carolina analyzed the service use of 37 homeless men and women over a three-year period. Including emergency services, hospitalizations and arrests, the city and county spent over $800,000 per person per year.
- In 2000, 20 persons studied by King County (Washington) Mental Health, Chemical Abuse and Dependency Division totaled close to $1.1 million in jail days, emergency room visits, hospital inpatient stays, detox and substance abuse treatment. 24 persons tracked in 2003 totaled close to $1.2 million. The highest utilizers in the group cost $100,000 per person per year in emergency room and hospital services alone.
- In San Diego, California, a study by the University of San Diego revealed that costs incurred by 15 homeless people on the street totaled $3 million over an 18 month period for emergency services, primary and behavioral health care, law enforcement and the justice system.
- Two Reno, Nevada police officers, on their own initiative, collected costs associated with two homeless, mentally ill individuals they repeatedly encountered on the streets. When they added up health care and law enforcement costs, each person cost over $100,000 per year.

What Works?

The best way to end homelessness is to address the systemic issues that create homelessness, provide emergency assistance, and prevent homelessness whenever possible. (Burt, 2001) Policies and practices that expand the availability of affordable housing to people with low incomes is one way to prevent homelessness. The results of over a decade and a half of research are fairly conclusive about the most effective approaches. Programs throughout the country that have been effective in preventing homelessness include efforts to:

- Build more affordable housing and subsidize costs to make it affordable to more people with low incomes
- Help people increase their incomes through education, training, and employment at housing-wage jobs
- Provide permanent housing and intensive case management and supportive services for those with severe mental health and substance use disorders to stabilize them in housing first and then make recovery treatment services available.

Permanent, supportive housing utilizing the "Housing First" concept along with case management and other service supports is considered by national experts to be the most successful and cost-effective solution to chronic homelessness. The success of permanent supportive housing is well-documented. Studies consistently find high rates of housing retention, typically in the range of 70% after 1 year or more. (Culhane, 2002) Examples of the research documenting improved outcomes and cost savings include:

- Dr. Dennis Culhane's study of 4,679 homeless people with severe mental illness in New York City between 1989 and 1997. He found that persons placed in permanent supportive housing experienced marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated compared to control groups. Before placement in

supportive housing, individuals used about $40,451 per person per year in services (1999 dollars). The cost of supportive housing was estimated to be $17,277 per person. The reduction in community service use was $16,281, resulting in a net cost of the supportive housing of $995 per unit per year over the first 2 years.

- The California Department of Mental Health conducted a state-wide study of 4,881 individuals to determine the impact of a supportive housing initiative implemented in 1999 to address the needs of homeless adults with serious mental illness. Pre- and post-placement results found a 55.8% reduction in hospital inpatient days, a 72.1% reduction in days incarcerated, and a 65% increase in days of full-time employment. The study also documented $27 million in annual savings in hospitalizations, incarcerations, and emergency room visits.
- The City of Denver estimated that the monthly average cost to shelter an adult was 153% the monthly cost of an efficiency apartment. They concluded that Denver could save between $3,200 and $12,500 per homeless individual by placing people in housing units instead of shelter beds (The Denver Commission to End Homelessness, 2005).
- A San Francisco study, examining 253 homeless persons, compared the first two years of people living in permanent supportive housing to the prior two years. The study found that yearly emergency room visits dropped from approximately two per person to less than one per person, and that inpatient days fell 63% during the first year and an additional 15% during the second year of housing. (Friedman, 2005).
- A cost analysis in Greater Portland, ME published in Sept., 2007, concluded that permanent supportive housing for 99 homeless persons cut emergency room costs by 62%, health care costs by 59%, ambulance costs by 66%, police costs by 66%, incarceration by 62% and shelter visits by 98% in the first year.
- A cost analysis of the results of a housing first model in Boston, MA published in June, 2007 showed an 86% residential stability after a year and a 35% decrease in the need for medical and mental health services and a 38% reduction in costly jail use. The costs saving in medical and jail services offset the cost of housing and intensive case management and yielded a net savings of $918/person per month.

Appendix A: Task Force Members

- Mayor Frank Guinta, City of Manchester – Co-Chair
- Patrick Tufts, President, Heritage United Way – Co-Chair
- Maureen Beauregard, President, Families in Transition and Chairperson of the Manchester Continuum of Care
- Bruce Bissett, Homeless Program Specialist, VA Medical Center, Manchester
- Thomas E. Blonski, President and CEO, NH Catholic Charities
- Robin Comstock, President and CEO, Greater Manchester Chamber of Commerce
- Craig Everett, Executive Director, Helping Hands Outreach
- Ed George, President and CEO, Manchester Community Health Center
- Glenn Leidemer, Deputy Chief of Police
- Andy Leach, Senator Sununu's Office
- Alderman Mike Lopez
- Robert MacKenzie, Director Planning and Community Development
- Steven Paris, M.D., Dartmouth-Hitchcock Manchester
- Cathleen Schmidt, President, Citizens Bank
- Mary Sliney, President, The Way Home
- Kendall Snow, Vice President of Community Relations, Mental Health Center of Greater Manchester
- Sean W. Thomas, Senior Policy Advisor to the Mayor, City of Manchester
- Robert Tourigny, Executive Director, NeighborWorks Greater Manchester
- Richard L. Webster, Housing Development Manager, Manchester Housing and Redevelopment Authority

Facilitator and Plan Editor:

Pamela Brown, President, Brown Performance Group

Additional Stakeholders Interviewed/Consulted by Pamela Brown:

- Manchester Continuum of Care Strategic Planning Meeting
- Meena Gywali and Samuel Maranto, Community Development, Planning and Community Development Dept.
- Peter Kelleher, Executive Director, Harbor Homes, Inc., Nashua, NH
- Sarah Jane Knoy, Lead Organizer, Granite State Organizing
- Keith Kuenning, Executive Director, NH Coalition to End Homelessness
- Paul Martineau, Welfare Commissioner
- John O'Brien, Region 1 Coordinator, U.S. Interagency Council on Homelessness
- Chris S. Pitcher, HMIS Program Manager, Community Services Council
- Fred Robinson, Executive Director, New Horizons for NH, Inc.
- Marianne Savarese, Project Coordinator, Health Care for the Homeless Program (HCH)/ Mobile Community Health Team Project (MCHTP)
- Anna Thomas, Deputy Public Health Director, City of Manchester

Appendix B: Stakeholders in the 10-Year Plan to End Homelessness

- City of Manchester: Mayor, Board of Aldermen, City Departments: Welfare, Planning, Public Health, Corrections, Courts, Building, Education
- Hillsborough County Departments: Corrections, Courts
- Surrounding cities and towns
- State of New Hampshire: Governor, U.S. and State senators and representatives, Executive Council, Court System, State Departments: HHS
- U.S. government: Courts, HUD, HHS, HRSA, VA, Education, Interagency Council on Homelessness
- Citizens -- all
- Civic agencies and organizations: Chamber of Commerce, Rotary
- Colleges and universities
- Employers
- Faith community
- Financial institutions
- Foundations and philanthropic organizations: United Way
- Homeless assistance providers: emergency housing, transitional housing, permanent supportive housing
- Housing authorities and agencies
- Housing developers: non-profit, for-profit
- Landlords
- Mental health care providers, NH Hospital
- Primary health care providers, hospitals, dental care providers, eye care providers
- Schools: private, public
- Substance abuse counselors and treatment providers
- Social service agencies

Appendix C: Most Important Things This Plan Must Do

(as compiled from "top 3" for each task force member)

Collaboration

- Improve housing and service partnerships
- Establish a model of collaborative partnerships with nonprofits to share best practices
- Community-wide buy-in and support: all city departments engaged, business, education, city must lead
- Must have broad public support: business, elected officials
- Coordinated effort: United Way, city, providers – all moving in one direction
- Develop innovation by "thinking out of the box"
- Create unique medical delivery model
- Must be fair
- Must tap into successful organizations

Funding

- Obtain more existing resources (fed. housing assistance, etc.)
- Improve education of existing resources
- Funding: federal, state, donors, program directors, civic organizations
- Fund existing and new housing projects
- Strategy for funding for housing subsidy
- Strategy for funding for services
- Maximize federal and funders dollars

Housing

- Provide permanent affordable housing
- Create housing alternatives, e.g. use barracks
- Increase low cost housing stock
- Establish a city-wide housing plan to target resources
- Housing First
- Address the most chronic first – get off the street

Services

- Successful model
- Commit social service "tree"
- Find the ability to provide dedicated case management
- Include substance abuse treatment in all housing plans
- Provide wrap-around services that provide access to: mental health care, poly-substance abuse care, day care, transportation, and career training
- "Intense Family Outreach" program: parents, siblings, cousins, not just financial but supportive
- A place to take people when they are in the streets on parks and have nowhere to go

Public Education

- Awareness/PR campaign: what can you do as – president, neighboring town, state, church, citizen
- Get the issue public: PSAs, news coverage, keep Mayor and Board of Aldermen publicly committed, don't take eye off the ball
- Create community awareness, acceptance.

Appendix D: History of 10-Year Plans

Based on the research and outcomes from permanent supportive housing programs, the National Alliance to End Homelessness (NAEH) started a groundswell of new initiatives with its call to action in 2000 entitled "A Plan, Not a Dream: How to End Homelessness in Ten Years." Since 2000, the momentum has continued to build with support by HUD and the U.S. Interagency Council on Homelessness. The following table outlines the history of this movement:

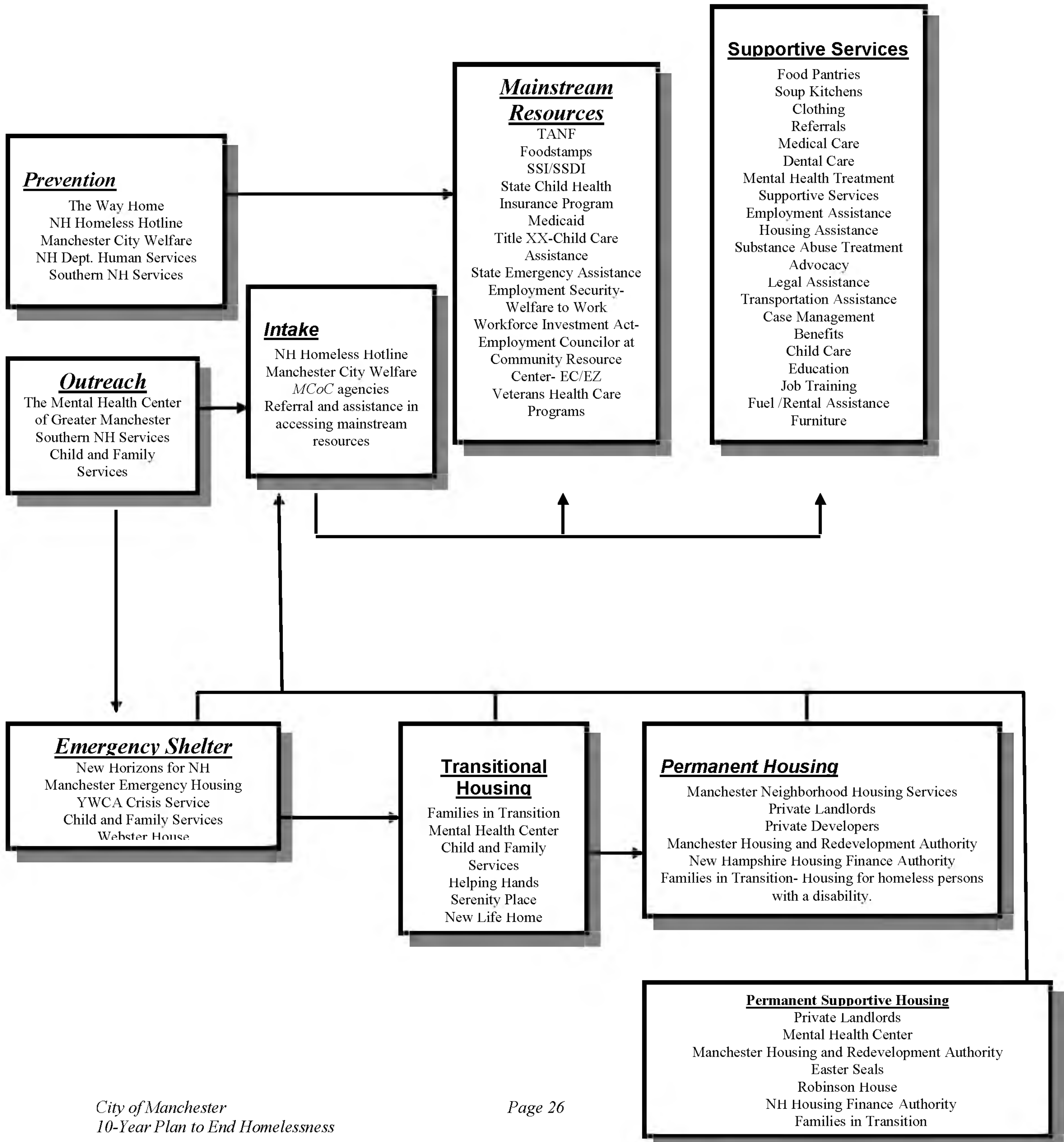
Plans to End Homelessness Timeline	
2000	The National Alliance to End Homelessness announces *A Plan, Not A Dream: How to End Homelessness in Ten Years.*
2001	U.S. Department of Housing and Urban Development Secretary Mel Martinez endorses the idea of ending chronic homelessness.
2002	The U.S. Interagency Council on Homelessness is reactivated. The Administration's proposed FY03 budget affirms that the administration has a goal of ending chronic homelessness in 10 years. Indianapolis, Chicago, and Memphis all complete plans to end homelessness.
2003	At the annual meeting of the U.S. Conference of Mayors, U.S. Interagency Council on Homelessness Executive Director Philip Mangano challenges 100 cities to create plans to end homelessness. The U.S. Conference of Mayors adopts a resolution in support of this challenge. The National League of Cities and the National Association of Counties adopt resolutions in favor of plans to end homelessness.
2004	Approximately 100 communities initiate 10-year planning efforts.
2005	Approximately 190 communities initiate 10-year planning efforts.
2006	220 communities have embarked on the process of creating plans to end homelessness, and 90 plans are complete.

National Alliance to End Homelessness, "A New Vision: What is in Community Plans to End Homelessness?" (Nov., 2006)

As stated by Governor Lynch in the announcement of New Hampshire's 10-year plan to end homelessness in December 2005, "Reaching the goal of ending chronic homelessness in New Hampshire requires a new way of approaching that problem, and a new degree of collaboration among all sectors of the community. Having a concrete, well thought out, measurable 10-Year Plan for ending homelessness in New Hampshire positions the state to take maximum advantage of federal resources for homelessness; provides the framework for aligning efforts throughout the State of New Hampshire, and is a starting point for coordinating state-wide change; helps transform the myriad of publicly funded programs that provide services, housing and income supports to homeless individuals to make them more accessible, relevant, and appropriate; provides guidance to bolster the capacity and responsibility of these service systems for collaborative planning, financing and delivery of housing and support services for homeless persons, and improves statewide efficiencies and outcomes."

Appendix E: Manchester Continuum of Care (MCoC)

The Manchester Continuum of Care (MCoC) is comprised of agencies in the City that provide housing and assistance to homeless and vulnerable individuals and families.



The following charts provide information from the Manchester Continuum of Care, 2007 HUD SuperNOFA Application, NH Housing listing of housing assistance, and the agencies directly.

Current Emergency Intake Services

Name of agency	Services
Manchester Welfare Department	By State statute (RSA 165), serves as an important source of emergency assistance for the poor and is often the initial contact with the emergency system in Manchester
NH Homeless Hotline	Operated by Community Services Council of NH in Concord, refers homeless persons to emergency shelters and transitional housing in the state.

Emergency Shelter for Families

Name of agency	# Beds	# Families	Comments
Manchester Emergency Shelter	36	8	Referrals through Manchester Welfare Department.
Emily's Place (YWCA)	6 rooms	6	Women and their children fleeing imminent domestic and sexual violence.
Families in Transition	12	3	Includes access to Employment and Training Program, Therapeutic Groups, Intensive Case Management, Child and Youth Programming.

Emergency Shelter: Male and Female Individuals

Name of agency	# Beds	Comments
New Horizons for NH	76	NH's only "wet shelter" (i.e. sobriety is not a precondition of admission). Case management, AA, NA, medical services on site.

Transitional Housing: Male and Female Individuals

Name of agency	# Beds	Comments
Robinson House (Southern NH Services)	24	Single Room Occupancy (SRO) for men recovering from substance abuse.

Emergency Shelter/Transitional Housing: Female Individuals

Name of agency	# Beds	Comments
Angie's Shelter for Women	26	Operated by New Horizons. Sober house with case management, weekly groups.
Families in Transition	14	Includes access to Employment and Training Program, Therapeutic Groups, Intensive Case Management

Emergency Shelter/Transitional Housing: Youth

Name of agency	# Beds	Comments
Child and Family Services	2	Youth are placed in host homes. Includes crisis intervention for potential runaways and outreach to street youth.
Webster House	21	Youth ages 8-18 who are unable to live at home for some period of time.

Transitional Housing: People with Mental Illnesses and Substance Use Disorders

Name of Agency	# Beds	Comments
A Way To Better Living	6	
Gemini House (Mental Health Center of Greater Manchester)	15	For homeless individuals suffering from severe and persistent mental illness and substance use disorders.

Transitional Housing: Veterans

Name of agency	# Beds	Comments
Liberty House	10	

Transitional Housing: Drug and Alcohol Treatment

Name of agency	# Beds	Comments
Serenity House		Social detox facility
Farnum Center		28-day treatment
Terrell House		90-day treatment
New Life Home for Women and Children	15 women with children	Non-denominational, Christian, voluntary, 18-24 month residential drug and alcohol crisis intervention facility for women and their children.

Transitional Housing: Discharges from Corrections/Drug Treatment/NH Hospital

Name of agency	# Beds	Notes:
Helping Hands Outreach Ministries	29	Men referred from correctional or treatment facility

Transitional Housing for Families: Male and Female Head of Households

Name of agency	# Beds	# Families	Comments
Families in Transition	93	31	Includes access to Employment and Training Program, Therapeutic Groups, Intensive Case Management, Child and Youth Programming.
The Way Home	17	7	
Transitional Living Program (Child and Family Services)	6	3	Safe, stable housing and supportive services for homeless youth, 18-21 year olds.

Permanent Supportive Housing for Individuals: Females

Name of agency	Number of Beds	Comments
Families in Transition	3	Includes access to Employment and Training Program, Therapeutic Groups, Intensive Case Management.

Permanent Supportive Housing for Families: Female Heads of Household

Name of agency	Number of Beds	Comments
Families in Transition	28	Includes access to Employment and Training Program, Therapeutic Groups, Intensive Case Management, Child and Youth Programming.

Health Care for the Homeless

Name of agency	Services
Health Care for the Homeless Project	The Mobile Community Health Team operates free clinics housed at New Horizons and Families in Transition. In 2006 they provided health care services to 1,351 homeless patients.

Soup Kitchens and Food Pantries

Name of agency	Services
New Horizons for NH	1 meal/day for anyone in need Food Pantry

Other Services to the Homeless

Name of agency	Services
Families in Transition	Community Program providing supportive services for 10 families in scattered sites around the Manchester community
A Way To Better Living	Drop-In Center for individuals with mental illnesses is open daily 11:00-5:00 (?)
The Way Home	Provides tenant education, budgeting, advocacy, landlord-tenant negotiations and security deposit loans through a variety of programs including • Housing Counseling • Security Deposit Loan Fund • NH Rental Guarantee Program • Healthy Home Services • Steps to Success

The Manchester Continuum of Care estimates that that the City needs the following additional beds:

Unmet Needs:	Individual Beds	Family Beds	Total Beds
Emergency Shelter	0	0	0
Transitional Shelter	8	20	28
Permanent Supportive Housing	49	109	176

Source: Manchester Continuum of Care, 2007 HUD SuperNOFA Application

Rent Assisted Housing

The New Hampshire Housing Finance Authority regularly updates a Directory of Assisted Housing to serve as a guide to rent assisted housing facilities throughout NH. It includes housing developments currently subsidized with funding from the U.S. Dept. of Housing and Urban Development, USDA-Rural Development, or New Hampshire Housing through permanent financing or rental assistance payment mechanisms. As of 11-28-07, the Directory lists the following housing facilities in Manchester:

Contact Organization	# Family Units	# Elderly Units	# Special Needs Units	Comments
Manchester Housing and Redevelopment Authority	394	913		• Administers Section 8 Housing Choice Voucher program for 1,800 persons • Provides various services
Preservation Management	288			
NeighborWorks	266			• Includes Silver Hill under construction • Developed 8 homes for sale
Metropolis Management	242	30		• Includes ACA Management
Stewart Property	214	56	23	
DBH Management		96	9	
Finlay Management	96			
Fairfield Properties	90			• Elderly-Family combined
Simon Companies		78		
Southern NH Services		69		
Families in Transition	65			
Wellington Hill	58			
East Point Properties		58		
CP Management	48			
Meeting House at Riverfront		25		
Crotched Mountain		24		
Greater Manchester Mental Health			8	
The Way Home	7			
MB Management	7			
Property Services Co.	6			

THE NATIONAL ALLIANCE TO END HOMELESSNESS, INC.

Appendix F: Housing First: A New Approach to Ending Homelessness

The approach is based on two very simple principles:

1. *The best way to end homelessness is to help people move into permanent housing as quickly as possible.*
2. *Once in housing, formerly homeless people may require some level of services to help them stabilize, link them to long-term supports, and prevent a recurrence.*

What is a Housing First approach?

A Housing First approach consists of three components:

- **Crisis intervention, emergency services, screening and needs assessment:** Individuals and families who have become homeless have immediate, crisis needs that need to be accommodated, including the provision of emergency shelter. There should be an early screening of the challenges and resources that will affect a re-housing plan.
- **Permanent housing services:** The provision of services to help families' access and sustain housing includes working with the client to identify affordable units, access housing subsidies, and negotiate leases. Clients may require assistance to overcome barriers, such as poor tenant history, credit history and discrimination based on ethnicity, gender, family make-up and income source. Providers may need to develop a roster of landlords willing to work with the program and engage in strategies to reduce disincentives to participate.
- **Case management services:** The provision of case management occurs (1) to ensure individuals and families have a source of income through employment and/or public benefits, and to identify service needs *before the move into permanent housing*; and (2) to work with families *after the move into permanent housing* to help solve problems that may arise that threaten the clients' tenancy including difficulties sustaining housing or interacting with the landlord and to connect families with community-based services to meet long term support/service needs.

Appendix G: What is Supportive Housing?

A Better Approach

Supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. The effectiveness of supportive housing in ending homelessness has depended upon a willingness to take risks and experiment with new models, approaches, and strategies. CSH's approach and strategies also continue to evolve as we learn more about what practices are proving most effective.

From CSH's perspective, a supportive housing unit is defined by the following elements[1]:

- The unit is available to, and intended for, a person or family whose head of household is homeless, or at-risk of homelessness, and has multiple barriers to employment and housing stability, which might include mental illness, chemical dependency, and/or other disabling or chronic health conditions;
- The tenant household ideally pays no more than 30% household income towards rent and utilities, and never pays more than 50% of income toward such housing expenses;
- The tenant household has a lease (or similar form of occupancy agreement) with no limits on length of tenancy, as long as the terms and conditions of the lease or agreement are met;
- The unit's operations are managed through an effective partnership among representatives of the project owner and/or sponsor, the property management agent, the supportive services providers, the relevant public agencies, and the tenants;
- All members of the tenant household have easy, facilitated access to a flexible and comprehensive array of supportive services designed to assist the tenants to achieve and sustain housing stability.
- Service providers proactively seek to engage tenants in on-site and community-based supportive services, but participation in such supportive services is not a condition of ongoing tenancy.
- Service and property management strategies include effective, coordinated approaches for addressing issues resulting from substance use, relapse, and mental health crises, with a focus on fostering housing stability.

A Range of Housing Models

While there may not be a single perfect model, there are a number of preferred housing models for supportive housing. The housing setting will vary dramatically and be based on a range of factors including the tenant's preference, the type of housing stock available, and the norms and history of a local community's real estate market, and might include:

- Apartment or single-room occupancy (SRO) buildings, townhouses, or single-family homes that exclusively house formerly homeless individuals and/or families;
- Apartment or SRO buildings, or townhouses that mix special-needs housing with general

[1] This definition reflects CSH's perspective that service participation should not be a condition of tenancy in supportive housing, and that harm reduction and housing first strategies have been shown to be effective approaches. CSH recognizes, however, that a variety of housing options are needed to end homelessness. Therefore, we continue to engage in, and learn from, constructive dialogues on these and other issues with our provider and advocacy partners in the housing, supportive services, and disability rights communities, and with all those engaged in efforts to end homelessness.

affordable housing;

- Rent-subsidized apartments leased in the open market; and
- Long-term set-asides of units within privately owned buildings.

CSH's Target Populations

While supportive housing is a useful intervention for a wide range of people who are homeless or at risk of homelessness, CSH focuses on working with our partners to create permanent supportive housing opportunities for adults, youth/young adults, and families with children who:

- Have extremely low-incomes, defined as household income no higher than 30% of Area Median Income; *and*
- Have chronic health conditions that are at least episodically disabling, such as mental illness, HIV/AIDS, and/or substance use issues, and/or face other substantial barriers to housing stability (such as experiences of domestic violence or other trauma or have histories of out of home placements); *and*
- Are not able to obtain or retain appropriate stable housing without easy, facilitated access to services focused on providing necessary supports to the tenant household.

These target populations include people who may be homeless (for any length of time) or are at risk of homelessness, and includes those who may be leaving other systems of care without a place to live, such as (1) young people aging out of foster care, (2) people with mental illness or other disabilities leaving jail or prison, and (3) some members of the elderly population.

CSH's Priority Population

Within this target group, CSH has increased its efforts to ensure that supportive housing is delivered to a "priority" population that includes persons experiencing long-term homelessness, including persons:

- Who have chronic health conditions that are at least episodically disabling, such as mental illness, substance abuse, and HIV/AIDS, or other substantial barriers to housing stability (e.g., domestic violence, trauma, or history of out-of-home placements); and
- Who have been homeless for long periods of time (one year or more), or have experienced repeated (three or more times) stays in the streets, emergency shelters, or other temporary settings, often cycling between homelessness and hospitals, jails, prisons, or other emergency systems.

CSH has increased its efforts to help communities create supportive housing for such persons because:

- Data shows that this smaller percentage of homeless people currently take up about half of the shelter resources meant to address temporary homelessness;
- Supportive housing is the key intervention that works to end homelessness for them;
- There is too little being done now to ensure that this population is able to get into and stay in supportive housing; and
- Policymakers—particularly at the federal level—are especially focused on making sure that this group obtains supportive housing.

This document is included within the *Understanding Permanent Supportive Housing* section of CSH's *Toolkit for Developing and Operating Supportive Housing*, which is available at www.csh.org/toolkit2.

Appendix H: Evidence-Based Practice: ACT – Assertive Community Treatment

What is assertive community treatment?

Assertive community treatment is a way of delivering a full range of services to people in need of intensive supports. The goal of assertive community treatment is to stabilize people in housing and keep them in the community and out of the hospital.

How is assertive community treatment different from other services?

Team approach to service delivery

An assertive community treatment team is made up of practitioners who have training and experience in a variety of areas, such as psychiatry, nursing, social work, substance abuse treatment, and employment. Rather than sending people to different agencies or providers for services, members of the team work closely together to provide individuals with a highly integrated array of services that best meet their needs.

Low staff-to-consumer ratio

One reason that ACT teams can provide personalized services is that teams only work with a relatively small group of people. Because an ACT team has a small staff-to-consumer ratio, team members get to really know the individuals they're working with and can closely monitor how they're doing.

Services are provided where they are needed

Most of the services provided by an ACT team are provided in the community. That means that services are provided in peoples homes, where they work, and in other settings in the community where problems occur or support is needed.

Services are provided when they are needed

The team meets frequently, often daily, to discuss how things are going. So if changes need to be made in the type of services someone is getting or how often they are getting those services, those changes can be made quickly. If a person needs a lot of help and support, team members will be in touch with the person as many times each day as necessary. Services are available 24 hours a day, 7 days a week so someone is always available to handle emergencies whenever they arise. Because of the team's ongoing involvement and the team's ability to quickly change the amount and type of services someone receives, emergencies can often be avoided.

Uninterrupted care

Several members of the team work with each person on a regular basis. If a team member goes on vacation or leaves, the services a person is receiving are not interrupted and they don't have to start at the beginning with someone new. There are always team members who know each individual who can carry on if a team member leaves.

Time-unlimited support

ACT teams make a long-term commitment to individuals. Teams provide whatever services and supports an individual may need for as long as they are needed. As individuals progress toward their recovery goals, team members are in touch less often but continue to be available if a need for additional support arises.

Areas in which assertive community treatment teams provide assistance:

Housing Assistance

- Finding suitable housing
- Helping negotiate leases and pay rent
- Purchasing and repairing household items
- Developing relationships with landlords
- Improving housekeeping skills

Entitlements

- Assisting with applications for benefits
- Managing food stamps if needed
- Assisting with redetermination of benefits

Daily Activities

- Grocery shopping and cooking
- Purchasing and caring for clothing
- Using transportation

Family Life

- Crisis management
- Counseling for family members
- Coordination with child welfare and family service agencies
- Supporting people in carrying out their roles as parents

Counseling

- Oriented toward problem solving
- Goals addressed by all team members

Employment Support

- Help finding and keeping employment
- Help prepare employees and employers

Financial Management

- Planning a budget
- Troubleshooting financial problems e.g., disability payments
- Assisting with bills
- Increasing independence in money management

Health

- Education to prevent health problems
- Medical screening
- Scheduling routine visits
- Linking people with medical providers for acute care

Medication Support

- Ordering and delivering medications, if needed
- Education about medications
- Reminding individuals to take medications
- Monitoring side effects

Substance Abuse Treatment

- Substance abuse treatment provided directly by team members

Is assertive community treatment effective?

There has been a lot of research done comparing assertive community treatment to case management. Studies show that people who received assertive community treatment are more likely to maintain stable housing.

Appendix I: References

New Hampshire Information:

- Angelou Economics (2005). Global Economic Development Strategy (Report 1: Community Assessment). City of Manchester.
- City of Manchester. (2004). *Consolidated Plan for the Department of Housing and Urban Development: 2005-2010*.
- City of Manchester. (2005, September). *Consolidated Annual Performance Evaluation Report: Fiscal Year 2005 Prepared for the Department of Housing and Urban Development*.
- Governor's Interagency Council on Homelessness. (2005, December 1). A Home for Everyone: New Hampshire's Ten-Year Plan to End Homelessness.
- Greater Nashua Continuum of Care. (2004, September 9). *A Home for Everyone: A Plan for Ending Homelessness in Greater Nashua*.
- Manchester Continuum of Care. *2006 SuperNOFA Application.*
- Manchester Continuum of Care, Homeless Liaison Committee, *Annual Survey of Manchester's Homeless Population* (2007)
- Manchester Task Force on Housing (2002, summer). *Action Strategy for Housing*.
- New Hampshire Department of Education. (2006). *2005-2006 One Day Count of Homeless Children and Youth: Reported by Local Homeless Education Liaisons.*
- New Hampshire Economic and Labor Market Information Bureau, NH Employment Security (2005, May 23). *Community Profile: Manchester*.
- New Hampshire Housing. (2005). *2005 Residential Rental Cost Survey*.
- New Hampshire Office of Homeless, Housing and Transportation Services. (2005). Emergency *Shelter and Homeless Coordination Commission Annual Report July 2004 – June 2005*.
- Yoel Camayd-Freixas et. al., Applied Research Center, School of Community Economic Development, Southern New Hampshire University. Community Indicators: Greater Manchester, NH (2006). Funded by Heritage United Way and SNHU.

Research References on Housing and Homelessness:

- Corporation for Supportive Housing: www.csh.org
- Homelessness Resource Center: homeless.samhsa.gov
- National Alliance to End Homelessness: www.endhomelessness.org
  - *A Plan, not a Dream: How to End Homelessness in 10 Years* (2000)
  - *A New Vision: What is in Community Plans to End Homelessness?* (Nov., 2006)
  - *Toolkit for Ending Homelessness: Featuring the Ten Essentials for Ending Homelessness in Your Community* (2003)
  - *Chronic Homelessness* (March, 2007)
  - *Homelessness Counts: Research Reports on Homelessness.* Homelessness Research Institute. (January, 2007)
- National Center for Homeless Education: www.serve.org/nche/
- National Center on Family Homelessness: www.familyhomelessness.org
- National Coalition for the Homeless: www.nationalhomeless.org
- National Health Care for the Homeless Council: www.nhchc.org

- National Law Center on Homelessness and Poverty: www.nlchp.org
- National Low Income Housing Coalition: www.nlihc.org
  - *Out of Reach: Manchester, NH HMFA. (2006).*
- Partnership to End Long Term Homelessness: www.endlongtermhomelessness.org
- The Urban Institute: www.urban.org
  - *Burt, Martha R., Urban Institute. (September, 2001), What Will It Take to End Homelessness?*
  - *Burt, M.R. (2004, November). The Do-It-Yourself Cost-Study Guide – Assessing Public Costs Before and After Permanent Supportive Housing: A Guide for State and Local Jurisdictions.*
- U.S. Department of Housing and Urban Development: www.hud.gov/offices/cpd/homeless
- U.S. Interagency Council on Homelessness: www.ich.gov
  - *United States Interagency Council on Homelessness. (2005, November 2). Good…to Better…to Great: Innovations in 10-Year Plans to End Chronic Homelessness in Your Community.*

Articles

- Culhane, D.P., Metraux, S., and Hadley, T. (2002). *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing.* (Housing Policy Debate, Volume 13, Issue 1. Fannie Mae Foundation.)
- Culhane, D.P., Metraux, S., and Hadley, T. (2001, May). *The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative*.
- Friedman, D.H., McGah, J., Tripp, J., Kahan, M., Witherbee, N., and Carlin, A. (2005, April). *Partners in Prevention: Community-Wide Homelessness Prevention in Massachusetts and the United States*. Center for Social Policy, McCormack Graduate School of Policy Studies, University of Massachusetts, Boston.
- Houghton, T. (2001). *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*, A Summary of: The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York/New York Initiative by Culhane, D.P., Metraux, S., and Hadley, T.
- Massachusetts Housing and Shelter Alliance, June, 2007. "Home and Healthy for Good: A Statewide Pilot Housing First Program.
- Mishel, L., Ettlinger, M., and Gould, E. (2004, October 21). Less Cash in Their Pockets: Trends in Income, Wages, Taxes, and Health Spending of Middle-Income Families, 2000-03. *Economic Policy Institute Briefing Paper # 154*. Retrieved May 23, 2006 from http://www.epinet.org/briefingpapers/154/bp154.pdf.
- O'Connell, J.J. (1999, April). *Utilization and Costs of Medical Services by Homeless Persons: A Review of the Literature and Implications for the Future*.
- State of Maine – Greater Portland, September, 2007. "Cost of Homelessness: Cost Analysis of Permanent Supportive Housing.
- Technical Assistance Collaborative, Inc., Consortium for Citizens with Disabilities, Housing Task Force, funded by the Melville Charitable Trust. Priced Out in 2006: the Housing Crisis for People with Disabilities. (2007)