USICH Briefing Paper

Preface:

Five federal workgroups were convened to initiate development of the federal plan. At their first meeting, each workgroup was presented with an overview of the literature. These were prepared and presented by Carol Wilkins and Janice Elliott, under contract with USICH.

Chronic Homelessness

Scope of the Problem

1. As defined by current federal policy: a chronically homeless person is
   - Unaccompanied (single adult) - and
   - Disabled - and
   - Homeless continuously one year or more, or 4 or more episodes in the past 3 years

2. The recently enacted HEARTH Act expands this definition to include families in addition to single adults. A relatively small number of homeless families (estimated to be approximately 5% of homeless families) include a disabled parent and experience repeated or prolonged episodes of homelessness.

3. **Number of chronically homeless individuals - Point in Time (on any given night)**[1]

   - 110,917 people were experiencing chronic homelessness on a single night in January 2009.
     - This is 17% of all homeless people (sheltered and unsheltered) or 27% of homeless individuals counted that night
     - The 2009 figure is a decrease of 11% from the 2008 count (124,135). 2008 was level with the number counted in 2007, after declining 30% between 2005-2007
     - Several large cities (including NYC, Phoenix, Philadelphia, and Boston) reported declines in the number of chronically homeless people in 2008.

   - Total number of homeless individuals in shelters increased by 5% from January 2008 to January 2009
     - The proportion of chronically homeless people who were sheltered increased slightly in 2009 to 41%. (from 37%). 58% of chronically homeless people were unsheltered (sleeping outdoors or in other

[1] The point in time information presented here is from two sources. U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2010). 2009 Annual Homeless Assessment Report (AHAR), forthcoming; and U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2009, July). *The 2008 Annual Homeless Assessment Report to Congress (AHAR)*. Washington, DC.

places not meant for human habitation)

- Homeless persons in shelters and on the streets are concentrated in urban areas
  - 1 in 5 homeless households on a single night were in the city and county areas of Los Angeles, New York City, Las Vegas, and New Orleans.

- In 2009, 25 Continuums of Care reported the largest numbers of chronically homeless individuals.
  - Nearly half of all chronically homeless people in the US live in these areas
  - 10 of these 25 Continuums of Care are in California

4. **Additional information about individuals experiencing chronic homelessness**

- 75 – 80% of individuals experiencing chronic homelessness are men; 20 – 25% are women
  - Most "single" homeless women are mothers. Mothers who are homeless for more than a year are more likely to lose custody of their children.

- The average age of the chronically homeless population is increasing (the average is now close to 50) [2]

- African Americans and Native Americans are over-represented relative to their share of the population

- Despite disabling health conditions, most chronically homeless people are not currently enrolled in Medicaid or other health insurance programs

  - Only 35% of participants in a HUD study of Housing First programs for homeless persons with serious mental illness had Medicaid at the time of enrollment[3]

  - 55% of participants were uninsured in a Chicago study that enrolled people who were homeless (for at least 30 days) and who were receiving inpatient care for a chronic illness.[4]

  - Many (but not all) chronically homeless people are potentially eligible for Medicaid, and some may also

25 Continuums of Care reporting the Largest Number of chronically homeless individuals on a single night in January 2009:

San Jose/Santa Clara City & County CoC, CA
New Orleans/Jefferson Parish CoC, LA
San Francisco CoC, CA
New York City CoC, NY
Oakland/Alameda County CoC, CA
Santa Rosa/Petaluma/Sonoma County CoC, CA
Las Vegas/Clark County CoC, NV
District of Columbia CoC
Texas Balance of State CoC
Atlanta/Roswell/DeKalb, Fulton Counties CoC, GA
Orlando/Orange, Osceola, Seminole Counties CoC, FL
Nashville/Davidson County CoC, TN
Georgia Balance of State CoC
Puerto Rico Balance of Commonwealth CoC
Houston/Harris County CoC, TX
South/Southeast Puerto Rico CoC
Richmond/Contra Costa County CoC, CA
Pasco County CoC, FL
Fresno/Madera County CoC, CA
Seattle/King County CoC, WA
Los Angeles City & County CoC, CA
San Diego CoC, CA
Tucson/Pima County CoC, AZ
Santa Ana/Anaheim/Orange County CoC, CA
Riverside City & County CoC, CA

[2] Several research studies published between 2004 to 2006 documented the in and/or homeless individuals in shelters. The average age at that time was mid- over the prior 10-15 years. This research is summarized in a paper by Caton, W Long-Term Homelessness: Characteristics and Interventions" which was prepar on Homelessness Research.
[3] Abt Associates, et al. (2007, July). *The Applicability of Housing First Models to* Washington, DC: U.S. Department of Housing and Urban Development.
[4] Sadowski, L., Kee, R., VanderWeele, T., Buchanan, D. (2009, May 6). Effect of a Emergency Department Visits and Hospitalizations among Chronically Homeles

qualify for Medicare or VA health benefits. Communities that have implemented effective strategies to facilitate SSI eligibility (e.g. SOAR) have increased the number of chronically homeless people who obtain Medicaid benefits.[5]

5. Long-term homelessness among families

Families experiencing prolonged or repeated episodes of homelessness are currently not included in the count of chronically homeless persons reported by HUD.

- Only a small group of families use shelters repeatedly. These families also appeared more troubled, with higher levels of inpatient treatment for mental health and substance use problems and higher levels of disability, as measured by receipt of supplemental security income (SSI), and more foster care placements. Families in this small group of episodic shelter users (2 percent in Columbus; 5 to 8 percent in New York City, Philadelphia, and Massachusetts) seem good candidates for intensive service models, such as supportive housing.[6]

- Mothers in families experiencing long-term homelessness differ from most homeless families. Among those participating in an evaluation of permanent supportive housing for families, the average duration of homelessness as an adult was 44 months. 93% of these families reported having been homeless at least once in the past (before their current homeless episode), and 40 % had been homeless three or more times previously, roughly double the proportion found in a nationally representative study that examined families in homeless assistance programs. One-third of the women in these supportive housing programs had their first homeless experience as a minor.[7]

  - Heads of households in these families often faced challenges related to substance use and/or mental health disorders

  - The average age of mothers in the permanent supportive housing programs was 36 years, substantially older than the population of homeless mothers seen in shelter settings, who tend to be in their late 20's. The families typically have both young children (under age 5), and school age children (age 5-12), with teens being a minority.

6. **Causes of Chronic Homelessness and Contributing Factors**[8]

[5] More information on SOAR outcomes can be found at: http://www.prainc.com/SOAR/training/module_overview.asp
[6] National Alliance to End Homelessness. (2006, June). *Promising Strategies to End Family Homelessness*. Washington, DC: National Alliance to End Homelessness and Freddie Mac.
[7] Corporation for Supportive Housing. (2006, December). *The role of Permanent Supportive Housing in Addressing Family Homelessness*. New York: Corporation for Supportive Housing and National Center on Family Homelessness.
[8] The summary of causes and contributing factors listed here is based upon the findings of research summarized by: Caton, C.L.M., Wilkins, C., & Anderson, J. (2007, September). People Who Experience Long-Term Homelessness: Characteristics and Interventions. *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development. More details including citations are available at http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm

- Very high rates of current or past mental illness (approximately 60%) and/or substance abuse disorders (approximately 80%)
  - Many have not been effectively engaged or retained in outpatient treatment or appropriate care, although they may frequently use crisis or inpatient care (e.g. psychiatric emergency, detox, sobering centers)
  - Low continuity of outpatient care puts homeless people with severe mental illness and/or substance use problems at high risk for encounters with the criminal justice system
  - Chronicity of homelessness is associated with more severe symptoms of alcohol abuse, schizophrenia, personality disorder

- Increasingly high rates (more than 50%) of chronic, disabling, and/or life-threatening health conditions (hypertension, asthma, HIV/AIDS, liver disease)

- History of incarceration and older age are factors associated with increased likelihood that a homeless person entering shelter will remain homeless

- Social isolation

- Extreme poverty

- History of child welfare placement. Family histories often include residential instability, physical and sexual abuse

- Compared to homeless men or women in homeless families, women who are homeless without children (single adults) are more disabled by mental illness; very high rates of victimization including history of sexual assault and physical abuse experienced in childhood and/or after becoming homeless

Costs and Consequences of Chronic Homelessness

1. Extraordinarily high costs for use of public services by chronically homeless persons (and/or homeless people with mental illness or other disabling health conditions) have been documented in studies conducted in a wide range of communities

   - In Seattle, median costs for public services used by chronically homeless persons with severe alcohol problems were $4,066 per person per month in the year before they entered supportive housing.[9]

   - In Portland OR, pre-enrollment costs for services used by chronically homeless disabled adults averaged $42,075 per person[10]

[9] Larimer, M. et al. (2009, April). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problem. *JAMA*, 301(13):1349-1357.

- A summary of these and other cost studies with citations and links to published research is available on the CSH website at http://documents.csh.org/documents/policy/UpdatedCostMatrixSept09.pdf

- Health care is the largest component of costs: frequent and avoidable emergency room visits, inpatient hospitalization for medical or psychiatric care, detox / sobering centers, and nursing homes. In an evaluation of programs funded through the Collaborative Initiative to Help End Chronic Homelessness (CICH) estimates of costs for health care at baseline across sites averaged $6,832 per quarter[11]

- Other costs include shelter and incarceration

2. Impact on businesses and neighbors, quality of community life

3. High rates of mortality (age adjusted mortality rates 4-9 times higher than general population)

4. Increased risks of HIV-infection and risky behaviors and limited access to appropriate care, resulting in higher viral load, hospitalizations and greater risk of transmission to others

5. Arrests and incarceration (often repeated)

Overview of Best & Promising Practices

1. **Permanent Supportive Housing**: the combination of permanent affordable housing with supportive services that are designed to help tenants achieve housing stability

   Supportive housing includes a range of approaches that include single sites (housing developments or apartment buildings in which units are designated as supportive housing) or scattered site programs in which participants often use rent subsidies to obtain housing from private landlords and supportive services may be provided through home visits. Services in supportive housing are flexible and primarily focused on the outcome of housing stability, often delivered by case managers and/or inter-disciplinary teams, and may include services to address mental health, substance abuse, health, and employment needs.

   "Housing first" or " low demand" models of supportive housing incorporate strategies that minimize barriers to housing access or pre-conditions such as "housing readiness", sobriety or engagement in treatment, and instead assist participants to move into permanent housing quickly and provide the supportive services needed to help residents achieve the goal of housing stability. These program approaches do not represent a single program model, but rather a set of practices that seek to "screen in rather than screen out" and end homelessness for people with the greatest barriers to housing success. Scattered site programs often have

[10] Moore, T. (2006, June). *Estimated Cost Savings Following Enrollment in the Community Engagement Program: Findings from a Pilot Study of Homeless Dually Diagnosed Adults*. Portland, OR: Central City Concern.
[11] Mares, A. & Rosenheck, R. (2010, April). Twelve Month Client Outcomes and Service Use in a Multisite Project for Chronically Homeless Adults. *Journal of Behavioral Health Services & Research*, Vol. 37, No. 2.

the capacity to help participants find new housing if they are unsuccessful keeping housing the first time (or repeatedly) and can allow tenants to move from one apartment or neighborhood to another while maintaining relationships with supportive service providers. Single site programs may have on-site services and security that can provide a level of access and support that may be unavailable in rental housing available in the private market.[12]

- "Housing first" compared to "housing readiness"
    - Chronically homeless people are often unable to meet demanding standards of program participation or sobriety prior to housing.
    - Changing program models has been shown to be more successful than efforts to prepare chronically homeless people to meet high threshold requirements (e.g. sobriety, treatment compliance)
    - Transitional housing has limited effectiveness for chronically homeless people if permanent housing programs have requirements that screen them out

- "Low demand" compared to "high demand" program models
    - Chronically homeless people more likely to stay in housing with a "low demand" approach, but a minority will succeed in "high demand" programs

Evaluations of permanent supportive housing, implemented in a range of communities for chronically homeless people and homeless people with disabilities, have demonstrated significant improvements in housing stability, reductions in days of homelessness, and reductions in the utilization and costs of public services such as emergency shelter, hospital emergency room and inpatient care, detox or sobering centers, and jails.[13]

- In Seattle Medicaid costs were reduced 41%, sobering center admissions reduced 87% and average total costs reduced more than 75% after 12 months[14]

- In the Collaborative Initiative to Help End Chronic Homelessness, participants who had been homeless for an average of 8 years were placed rapidly into permanent housing. The CICH evaluation reported 95% were in independent housing after 12 months; average costs for health care and treatment costs were reduced by about half. The largest decline was associated with costs for inpatient hospital care.[15]

---

[12] U.S. Department of Housing and Urban Development, Office of Policy Development and Research. (2007, July). *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*. Washington, DC.
More information about differences between "housing first/ low demand" and "High demand" or "housing readiness" can be found in Caton, C.L.M., Wilkins, C., & Anderson, J. (2007, September). See Exhibit 1 on page 4-19.

[13] Summaries of outcomes from these and other cost studies with citations and links to published research are available at: Corporation for Supportive Housing. (2009, September). *Summary of Studies: Medicaid/Health Services Utilization and Costs*. Retrieved April 19, 2010 at http://documents.csh.org/documents/policy/UpdatedCostMatrixSept09.pdf.

[14] Larimer, M. et al. (2009, April).

[15] Mares, A. & Rosenheck, R. (2010, April).

- The Chicago Housing and Health Partnership implemented a rigorous evaluation in which homeless persons who were receiving inpatient hospital care for chronic medical conditions were randomly assigned to receive usual care or access to recuperative care (respite) and permanent supportive housing. The intervention group had 29% fewer hospitalizations, and 24% fewer emergency room visits, and 45% fewer days in nursing homes, compared to the usual care group. [16]

From 2002 to 2007 an estimated 65,000 to 72,000 units of supportive housing were created in the United States. This represents about half of the current supply of supported housing units,

- About half of all new units of supportive housing added in 2007 were targeted to chronically homeless individuals.

- In 2007 about one-fifth of all supportive housing units were for homeless families and the rest were for homeless individuals.

- In 2008 communities reported that the total number of permanent supportive housing beds were 195,724, a 22% increase since 2006.[17] Of these 42,172 beds were targeted to chronically homeless individuals.

- According to data provided by Continuums of Care (in Housing Inventory Charts submitted with applications for grants through HUD 's Homeless Assistance Programs) in 2008 communities added new units of supportive housing for more than 16,800 people, including 6,014 new units of permanent supportive housing for chronically homeless people[18]

2. Safe Havens[19]

- The low demand approach of Safe Havens works toward engagement in trusting relationships
- Few rules; focus is on safety (no alcohol, drugs or weapons on site; no violence)
- No mandatory program requirements, but services are available to address mental health and other needs and enhance motivation to change
- No curfew, sobriety, or medication adherence requirements
- Short term goal is to provide safety and move off the streets
- Work toward goal of permanent housing with access to supports as needed; flexible timeline.

3. Targeting, outreach and engagement

[16] Sadowski, L., Kee, R., VanderWeele, T., Buchanan, D. (2009, May 6). Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Homeless Adults. *JAMA*, 301, (17): 1771-1778. Additional study results available from the AIDS Foundation of Chicago at http://www.aidschicago.org/about_afc/3_6_2008.php
[17] U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2009, July). 2008 AHAR; and additional data analysis provided by researcher Martha Burt (personal communication).
[18] Data analysis provided by Martha Burt (personal communication).
[19] Ward Family Foundation, Inc. (2005, July). *Safe Haven Programs: Analysis of Strategies and Operating Practices*. Alexandria, VA.

- Another best practice is targeting outreach and prioritizing access to housing based on vulnerability (e.g. heightened risk of death on the streets or avoidable hospitalization) and/or frequent use of emergency and inpatient health care services and/or frequent stays in shelters and jails.

    - A "Vulnerability Index" based on research about health conditions that lead to death on the streets has been used in several communities (including Los Angeles, Santa Monica, New Orleans and Washington DC) as part of strategies for targeting outreach and prioritizing access to housing and services for homeless persons who have been homeless the longest and those who have the greatest risk of death or avoidable hospitalizations.[20]

    - Across the country, communities have implemented programs that target frequent users of emergency services in hospitals (emergency rooms and psychiatric emergency services), sobering centers / detox, and jails. A significant percentage (but not all) of those who are frequent users of these services, or the most high-cost, high-need Medicaid beneficiaries, are homeless people with disabilities or other complex health conditions. Targeted initiatives that include services and housing have achieved significant savings and improved outcomes. [21]

    - Outreach has limited effectiveness if not linked to an offer of housing.

- "In-reach" to engage homeless persons who have frequent incarcerations and link to housing and stabilizing community support services upon release.

    - In New York City the Frequent Users Service Enhancement (FUSE) Initiative is targeted to homeless people who have been in both jail and shelter repeatedly. The Initiative facilitates placement into supportive housing with enhanced services to break the cycle of incarceration and homelessness. First year results include 91% housing retention, 53% reduction days in jail, and 92% reduction in shelter days used.[22]

4. Medical respite / recuperative care

- Specialized shelter or temporary housing with health care upon discharge or diversion from hospital. Unlike many shelters, respite programs do not require homeless people to leave during the day, allowing for bed rest and access to medications and limited health care services through on-site or visiting nurses or

[20] More information about the Vulnerability Index is available at Common Ground Community. (no date). *Vulnerability Index: Prioritizing the Street Homeless Population by Mortality Risk*. Retrieved April 19, 2010 at http://www.commonground.org/wpcontent/uploads/2008/04/Vulnerability%20Index%20101.pdf http://www.commonground.org/wp-content/uploads/2008/04/Vulnerability%20Index%20101.pdf
[21] Corporation for Supportive Housing. (2009). *Frequent Users of Public Services: Ending the Institutional Circuit*. New York. Retrieved April 19, 2010 at http://documents.csh.org/documents/pubs/FUFReportFINAL1209.pdf
[22] Corporation for Supportive Housing. (2009). *Frequent Users Service Enhancement Initiative (FUSE) – New York, New York*. Retrieved April 19, 2010, at http://documents.csh.org/documents/policy/Reentry/Reentry_NY_FUSE_2009.pdf

other health workers.

- Evaluations have documented savings associated with reduced hospital readmissions or emergency room visits. One study found a 49% reduction in hospital admissions among patients who received respite care compared to similar patients who received usual care.[23]

- Opportunity for engagement in treatment and ongoing care, motivation to change risky behaviors, linkage to permanent housing and stabilizing services to achieve long term outcomes

5. Best practices in emergency shelter

- Although chronically homeless people use up to half of the capacity of homeless shelters, there is little documentation available about shelter practices which are effective in addressing the needs of chronically homeless people or evidence from research that would indicate which shelter practices are most effective in ending long-term homelessness.

- One evaluation of shelter-based programs designed to help prepare chronically homeless people for housing found that these efforts resulted in limited success if housing programs required applicants to demonstrate "housing readiness".[24]

6. Targeted Supportive Services

- Supportive service strategies are flexible, multi-disciplinary, individualized, and delivered in a range of settings. Sustained efforts may be needed to establish trust and overcome barriers related to isolation and symptoms of mental illness, trauma and/or substance abuse. Services must be sustained and intensified or modified as needed during relapse.

- Assertive Community Treatment (ACT) [25]

    - Team-based model of intensive, flexible and client-centered support for people with serious mental illness, has been recognized as an Evidence Based Practice for people with serious mental illness, including those with co-occurring substance abuse problems, and adapted for serving chronically homeless people with serious substance abuse problems

    - ACT may be most effective for chronically homeless people when motivational interviewing and integrated treatment approaches are incorporated into practice[26]

---

[23] Buchanan, D., Doblin, B., Sai, T.,& Garcia, P. (2006, July). The Effects of Respite Care for Homeless Patients: A Cohort Study. *American Journal of Public Health*, Vol. 96, No.7, 1278-1281.

[24] Barrow, S., Soto, G., & Cordova, P. (2004). *Final Report on the Evaluation of the Closer to Home Initiative*, New York: Corporation for Supportive Housing.

[25] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2008). *Assertive Community Treatment: Building Your Program*. DHHS Pub. No. SMA-08-4344. Rockville, MD: Center for Mental Health Services. Information about ACT is available from SAMHSA at http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/ and at http://www.actassociation.org/

- Motivational Interviewing and a Stages of Change model [27]

  - A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

  - Motivational Interviewing can be effective in helping clients begin treatment, stay in treatment longer, and follow treatment recommendations

  - Most documentation and evidence is related to substance abuse but also effective for addressing mental illness and other challenges to housing stability. Practitioners have found these strategies particularly effective for chronically homeless people who have not been engaged in or effectively served by other treatment programs.

- Critical Time Intervention – a structured approach to providing individualized support and assistance with linkages to community resources during transitions (e.g. from shelter to housing)

- Integrated treatment for co-occurring mental illness and substance abuse[28]

- Primary care / behavioral health care integration

7. Treatment as alternative to incarceration for public inebriates / Problem-Solving Courts

- For individuals who are chronically homeless and often intoxicated in public places, collaborations between police, courts, homeless services and treatment providers have offered treatment services as an alternative to incarceration following arrests for illegal and disruptive behavior. Programs such as San Diego's Serial Inebriate Program (SIP) and problem-solving courts (e.g. Homeless Courts or Mental Health Courts) are showing promising results, including reductions in utilization and costs for ambulances and emergency room care.[29]

---

[26] McGraw, S., et al. (2010, April). Adopting Best Practices: Lessons Learned in the Collaborative Initiative to Help End Chronic Homelessness (CICH). *The Journal of Behavioral Health Services and Research*, Vol. 37, No.2, 197-212.

[27] A good description of the Stages of Change approach is available on the American Academy of Family Physicians website: Zimmerman, G., Olsen, C., & Bostworth, M. (2000, March 1). A "Stages of Change" Approach to Helping Patients Change Behavior. *American Family Physician*. Retrieved April 19, 2010, at http://www.aafp.org/afp/20000301/1409.html

[28] Information about integrated treatment for co-occurring disorders is available from at: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2009). *Integrated Treatment for Co-Occurring Disorders: Building Your Program*. DHHS Pub. No. SMA-08-4366. Rockville, MD: Center for Mental Health Services. Retrieved April 19, 2010 at http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/cooccurring/

[29] Dunford, J., et al. (2006, April). Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources. Annals of Emergency Medicine, Vol. 47, No. 4.

8. Employment

- Vocational and employment services and supports linked to housing: Through collaborations that involve housing and workforce organizations, promising models have been developed to link housing and vocational and employment services and supports for formerly homeless individuals, including those who have experienced chronic homelessness.

- Because chronically homeless people often have multiple barriers to employment (which may include disabilities, criminal records, limited education, etc) individualized, sometimes intensive, and ongoing supports may need to be coupled with and customized employment or supported employment approaches. [30]
- Work can be an integral and stabilizing part of the recovery process for many people with disabilities and histories of chronic homelessness. The prospect of employment can help to motivate change and restore hope.

- A range of employment options, including temporary or part-time jobs, and jobs that offer opportunities for on-the-job training, can be important stepping stones and allow opportunities to tailor employment opportunities to the skills, strengths and interests of formerly homeless people.

9. Supported Employment[31]

- An evidence-based practice used to assist persons find and keep competitive employment. Originally conceived for mentally ill persons.

- Obtain competitive employment in the community and provide support to ensure success in the workplace

- Principles include: consumer choice/preferences, employment integrated with treatment, job search/employment work begins upon entrance to program, on-going support once employment is obtained

10. SOAR SSI Training

- Targeted training to increase approval rates for SSI coverage on initial application

---

More information about problem-solving courts is available from the Center for Court Innovation at http://www.courtinnovation.org/index.cfm?fuseaction=page.viewPage&pageID=505&documentTopicID=31

[30] The US Department of Labor and HUD jointly implemented a demonstration initiative called Ending Homelessness through Employment and Housing. The initiative linked permanent housing, support services, and employment assistance for chronically homeless people in five communities. More information about this initiative is available at http://www.csh.org/index.cfm?nodeid=94 Additional information is available at www.csh.org/EmploymentToolkit

[31] Information about supported employment is available at U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2009). *Supported Employment: Building Your Program*. DHHS Pub. No. SMA-08-4364. Rockville, MD: Center for Mental Health Services. Retrieved April 19, 2010 at http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/employment/

- Training has been demonstrated to be highly effective with multiple groups with significant disability and services needs including:
  - People living with HIV/AIDS
  - People with disabilities leaving criminal justice settings
  - Homeless persons with disabilities including the chronically homeless

- SOAR has a rigorously structured curriculum to train case managers in processing applications with Social Security including detailing the information to be initially presented to SS and comprehensive follow-up

- Data shows that of the 4,386 total decisions of SOAR applications, 71% were positive (compared to 10-15% which is the average for this population) and took an average of 89 days for the decision.[32]

What works to prevent chronic homelessness?

Generally when we talk about prevention, efforts are focused on preventing families and individuals from becoming homeless, or helping them exit homelessness as quickly as possible. Preventing chronic homelessness requires a slightly different approach – focusing on people who are already homeless and those who are being discharged from institutional settings without housing, who also have additional risk factors associated with prolonged or repeated episodes of homelessness. Prevention strategies seek to shorten their experience of homelessness and help the most vulnerable people get or return to housing with the supports they need to achieve stability.

For example, based on evidence that chronically homeless people have high rates of serious mental illness and severe substance abuse problems, prevention strategies may include providing permanent supportive housing to persons with disabilities who are living on the streets or in emergency shelters, and for persons with serious mental illness who are returning to communities from incarceration, hospitals or treatment facilities.[33]

[32] Policy Research Associates, Inc. (2009, December 1). *National SOAR Outcomes – Spring/Summer 2009*. Retrieved April 19, 2010 at http://www.prainc.com/SOAR/soar101/pdfs/SOAROutcomes2009.pdf

[33] Burt, M., et al. (2004, January). Strategies for Reducing Chronic Street Homelessness: Final Report. Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.