

20 in 20 . . .

20 Innovations in 20 Days . . .

20 Ideas to Prevent and End Homelessness . . .

Brought to you by the United States Interagency Council on Homelessness

WITH THIS ISSUE, the e-news launches 20 Special Issues, one per day, every day for the rest of May, each focusing on a single innovation achieving results in preventing or ending homelessness.

Innovation Number 1

Virginia CASH Campaign (Creating Assets, Savings and Hope)

- Virginia invests in a statewide initiative to increase access to the federal Earned Income Tax Credit for low income working individuals and families
- Virginia matches deposited EITC refunds 2:1 for homeownership, education, and entrepreneurship and invests in statewide enrollment outreach which includes data-matching and individual outreach
- Virginia supports a results-oriented initiative consistent with its State 10-Year Plan goal to ensure financial resources to meet housing and other needs

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Virginia CASH Campaign (Creating Assets, Savings and Hope)

The Virginia CASH Campaign is supported by a Commonwealth of Virginia General Fund appropriation of \$230,000 annually to maximize use of the federal Earned Income Tax Credit. The targeted state resources incentivize community-based outreach initiatives and free tax preparation services for low income working families and individuals to assist them in receiving all EITC credits to which they are entitled.

Many persons who are homeless need access to both EITC outreach and free tax preparation services if they are to benefit from the tax credit, which also operates retroactively.

Virginia Governor Tim Kaine designated Earned Income Tax Credit Kickoff Day in January, launching events around the state to raise awareness of EITC filing resources and tax preparation services and to demonstrate political will in support of the state's consumer-focused initiative. **Executive Branch** agencies for housing, housing finance, and social services have also partnered to offer **Virginia Individual Development Accounts (VIDA)** with a 2:1 match of funds (including funds provided through the federal Assets for Independence program of HHS) for purchasing a home, starting a business, or financing post-secondary education, if the EITC filer deposits any refund of up to \$2,000 in a VIDA.

The **Virginia Community Action Partnership** is the lead community agency for the statewide initiative, annually reporting results to the Governor and General Assembly. VACAP re-distributes state resources in mini-grants to local partners who provide education, outreach, financial literacy and free income tax preparation services to eligible EITC recipients.

The Commonwealth of Virginia estimates that Virginia taxpayers are eligible for approximately \$1 billion in EITC payments annually and that 91,000 - 114,000 households do not file for a projected \$167-209 million in credit refunds.

WHO BENEFITS FROM THE INNOVATION?

Low income working people benefit: In tax year 2005, 478,365 Virginia households benefited from EITC; the average credit amount was \$1,834 per household. Free tax preparation services also can save low income workers hundreds of dollars and help them better provide for basic needs.

Virginia's residents and economy benefit: In tax year 2005, Virginians received \$877,336,397 in EITC refunds. The EITC, 100% federally funded, brings money into the state's economy. Data show the most common uses of EITC refunds include medical care, dental work and car repair and purchase, all accessed through local communities.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

The Virginia EITC Campaign is achieving quantifiable results for low income working filers and for the Commonwealth.

In the 2007 tax season, through VA EITC, over 860 volunteers partnered with 22 local coalitions provided free tax preparation services to eligible persons, preparing over 11,000 federal returns with refunds of over \$10.6 million. Almost \$4 million was claimed in EITC refunds in 2,900 returns. Volunteer tax preparation time was valued at \$500,000.

According to the VA EITC 2007 annual report to the state, compared to the 2005 tax year, the 2007 outcomes represent:

- double the number of tax returns prepared
- almost a 50% increase in the number of EITC returns
- almost a \$1 million increase in EITC refunds
- double the savings to taxpayers
- one -third more local coalitions partnered to the initiative

Most of the local coalitions use TaxWise to file returns and track data. Volunteers are trained and certified by the IRS. Programs report results to the VACAP EITC Project Manager, including returns prepared, total refunds, tax preparation service savings, number of EITC eligible persons, total EITC refunds, Child Tax Credit refunds, Direct Deposit refunds, Split Refunds, number of press releases and public service announcements generated, financial literacy and IDA programs, and more.

VDSS directly contacts individuals eligible for the credit but not claiming it, using client level data from tax returns where EITC was not claimed. VDSS also helps raise awareness of the EITC by printing notices on TANF and child support enforcement checks from December through April and using AmeriCorps members at the local level to conduct outreach.

WHO IS THE INNOVATOR?

In Virginia, both the **Executive** and **Legislative** branches of the Commonwealth's government have supported statewide EITC initiatives and built a strong partnership with the **Virginia Community Action Partnership (VACAP)**, the statewide membership association for Virginia's thirty non-profit private and public community action agencies. Virginia also has a non-refundable state tax credit.

In 2003, the **Virginia General Assembly's Joint Legislative Audit and Review Commission** examined EITC participation by clients of the **Virginia Department of Social Services (VDSS)** and estimated a participation rate of only 13% of those eligible. The State has also estimated unclaimed benefits on a regional basis according to local social service offices.

Upon the recommendation of the Commission, the General Assembly amended the Code of Virginia to add a question to the state tax return form about whether a taxpayer claimed the federal EITC, and to allow the Tax Commissioner to share data with VDSS on whether clients claimed the federal EITC, enabling VDSS to measure EITC utilization and identify eligible persons who did not claim the credit.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Visit the Commonwealth of Virginia Department of Social Services web site for EITC: <http://www.dss.virginia.gov/community/eitc.cgi>

For local DSS Office contact information, visit: <http://www.dss.virginia.gov/localagency>

Or call toll-free: 800-552-3431 or by email: citizen.services@dss.virginia.gov

Visit the **Virginia Community Action Partnership web site for the VAEITC Campaign** and also find background information, fliers, asset building information, and more: www.vaeitc.org

Contact **VCAP's EITC Project Manager** at 804-644-0417.

Virginia Community Action Partnership's office is located at 700 E. Franklin Street, Suite 14T2, Richmond, VA 23219.

Innovation Number 2

Reporting Results in 10 Year Plans: Sacramento's scorecard that assures public accountability and community education

- Public accountability is increased through a quantified results "report card" documenting progress toward goals and benchmarks in a city-county 10 Year Plan to End Chronic Homelessness
- Public education and awareness improve by creating an easily-read and understood report on progress in creating visible, measurable and quantifiable change in the lives of everyone in the community, housed and homeless

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

A public press conference in February 2008 and resulting media coverage, including in *The Sacramento Bee*, achieved the goal of public accountability for Sacramento City and County's 10 Year Plan to End Chronic Homelessness created in 2006.

Public reporting and community education were included in the five strategies in Sacramento's Plan, and the new Progress Report provides the future foundation for the public accessibility to outcomes that the Plan called for.

Mayor Heather Fargo, County Supervisor Roger Dickinson, 10 Year Plan point person Bruce Wagstaff, Director of the Sacramento County Department of Human Assistance, and former Plan point person Diane Luther prepared and released a report card on progress, *"The First Year: 2007 Progress Report For Sacramento's Ten Year Plan To End Chronic Homelessness."*

The report card fulfills two purposes.

First, it quantifies progress in achieving the goal of new housing for persons who are chronically homeless, in preventing homelessness through housing preservation and development, and creating the new Leadership Structure to oversee implementation and measure results. The report also provides illustrated profiles of formerly homeless neighbors who are succeeding in their new housing.

Second, the report card explains key concepts and plan activities in an easily read format, giving the progress report added value in educating the broader community about strategies and goals.

The report card defines the housing and services pipeline ahead in the next phase of action steps, as well as potential barriers and challenges (budget issues, development underway, and funding applications pending).

WHO BENEFITS FROM THE INNOVATION?

Persons who are chronically homeless benefit by Sacramento's public expression of political will by the Mayor and County officials demonstrating public commitment and accountability for the 10 Year Plan and its goal of ending homelessness for the most disabled and vulnerable persons in the community

Community infrastructure - law enforcement, hospitals, emergency rooms - benefits by seeing the continuing expression of political will of jurisdictional CEO's from the City and County who are committed to ending chronic homelessness.

Residents of Sacramento benefit by learning about what's working to end homelessness for their neighbor, including engagement strategies and housing opportunities organized for results for the most vulnerable, disabled, and expensive.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

A public press event for the release of the scorecard and resulting regional media coverage ensure broad community knowledge of the 10 Year Plan and its first year results.

Quantifiable outcomes reported in the scorecard demonstrate that results are being measured, including:

Goal: The Plan's 3-year housing goal was the creation of 218 new rental opportunities for persons who are chronically homelessness.

Result: 171 persons housed in year 1 and funding for an additional 140 rental units planned for 2008 - 2009.

Goal: The Plan called for preventing homelessness through housing preservation and development, with a goal to create 200 new SRO units and preserve 100 SROs for extremely low income people with disabilities.

Results: The 100-unit downtown Berry Hotel has been purchased by a developer who is assembling financing to rehabilitate and preserve the building as very low income housing. Two more projects are in the pipeline to preserve or replace SRO resources; the YWCA has requested funding to preserve an existing 32 SRO units, and a site at the corner of 7th and H Streets may be developed to provide up to 160 replacement units.

WHO IS THE INNOVATOR?

All of the Sacramento 10 Year Plan Committee, Plan Chair Jeanne Reaves, President-CEO of River City Bank, and public and private sector leaders, including Mayor Fargo and County Supervisor Dickinson, committed to the Plan's goal of evaluation and reporting to the community, which resulted in the preparation and release of the report card.

City and County leaders, under the new 10 Year Plan Leadership Structure called for by the Plan and now in place, are implementing the Plan's strategies and measuring and reporting results using a community-oriented report card format.

The new **Policy Board**, made up of high-level public and private sector community leaders, has the task of providing strategic direction, oversight, and advocacy for the 10 Year Plan and for homeless services. The Board, chaired by Tom Gagen, CEO of Sutter Health Systems, is made up of political and private sector representatives such as Mayor Fargo, County Supervisor Dickinson, Police Chief Rick Braziel and others. The Policy Board provides community accountability, oversight and advocacy for homeless housing and services.

The new **Interagency Council**, made up of government agencies, service providers, and community stakeholders, is tasked to plan and coordinate service delivery and recommend policies and strategies to the Policy Board. The Council's 30 members represent "the critical housing and services sectors which must come together in new partnerships to end chronic homelessness." The Interagency Council includes more than ten committees which focus on specific issues related to homelessness, such as health care, criminal justice, and Project Homeless Connect. These committees report to the Interagency Council.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To read "The First Year: 2007 Progress Report For Sacramento's Ten Year Plan To End Chronic Homelessness," visit www.communitycouncil.org/homelessplan

To learn more about Sacramento's Ending Chronic Homelessness Initiative, contact: Tim Brown, Chronic Homelessness Initiative Director at: 916-447-7063.

Innovation Number 3

Securing an ID for persons who are homeless: A Project Homeless Connect innovation from Norfolk and San Francisco

- Public-private Project Homeless Connect partnership creates increased access to the vital resource of identification for persons who are homeless, bringing benefits, employment, and housing closer
- One-day, one-stop engagement at Project Homeless Connect is the opportunity to lower barriers, solve problems, and create immediate results for persons who are homeless

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Securing an ID for persons who are homeless: A Project Homeless Connect innovation from Norfolk and San Francisco

For a person experiencing homelessness, the loss, theft, or damage of identification, personal papers, or discharge documents can mean no longer having vital records that help create a trajectory to end homelessness. Further, lack of a place to receive one's mail, document costs and fees, and often sequential filing requirements for key items (first, you need a document from another state, then you can file for an ID, then you can apply for a benefit) pose extra difficulties.

One place where solutions have emerged to secure ID on-site or on an expedited basis and at no cost is through Project Homeless Connect events and their expansive community partnerships. Securing identification needed for everything from benefits applications to employment and housing gives hope for the future.

Today we profile the innovations of two Project Connect cities in securing ID for guests.

In Norfolk, Virginia, the indispensable feature of the ID innovation at Project Homeless Connect, by which a person walks away from the event with an ID card, is the ability to confirm a person's identity on site using existing data sources. Food stamp records can be accessed on site during the Connect event. City officials have found that most Project Connect

guests have a food stamp eligibility record, and that those who don't may have another qualifying record that verifies their identity, such as a corrections record.

As a result, the individual receives a city-sponsored ID card which is accepted for employment assistance, use of homeless programs, and as an accepted second form of ID for the Department of Motor Vehicles. The Project Homeless Connect event is not the only time a person can get a city sponsored ID, but the event offers a one-stop process.

At the Connect event, a worker from the Department of Social Services accesses food stamp records to confirm that identity was established in the food stamp eligibility process and that the file is not more than 5 years old. All documents in the food stamp files have been electronically scanned. A worker from the Department of Human Services prepares the actual ID using the same process as is done for city employees. Background color is changed to distinguish the city-sponsored ID from a city employee ID. The city-sponsored ID which the homeless guest receives that day includes photo, food stamp case number, and an expiration date. The ID is valid for 2 years.

In San Francisco, an individual with a birth certificate or another form of identification can register for an ID at the Project Homeless Connect site. For those who do not have a birth certificate, Project Connect provides a registration process to obtain a new document within the Department of Motor Vehicles station creating ID's at the event. Individuals register at the DMV station and receive a voucher for their new ID. Project Homeless Connect negotiated both a reduction in the \$21 fee to \$6 and obtained the resources to pay the fee for the client, resulting in free ID. DMV mails the free identification card within two weeks. The agency will use general delivery or a caseworker as the recipient address for an individual's new identification document.

Many Project Homeless Connect events are using a sponsorship approach for needed fees, a strategy which quantifies for a donor that, for example, a specific amount of money will help obtain a birth certificate or driver's license for one individual, which helps donors understand that fairly small sums often stand between an individual and needed outcomes. \$50, for example, will secure an out-of-state birth certificate.



WHO BENEFITS FROM THE INNOVATION?

Individual homeless persons benefit by acquiring needed identification documents that ease their access to apply for needed benefits and entitlements, as well as to complete applications for employment and housing. Further, legal identification helps consumers resolve other outstanding matters that may impede their path out of homelessness, whether legal matters or connections with family and friends. Success in obtaining ID at a Project Homeless Connect event after what may have been multiple failed attempts can provide a new outlook for the future.

The community benefits when individual consumers are able to apply for and receive financial and other resources that help end their homelessness, making them new neighbors in the community with the means to work, rent housing, and conduct other business.

Project Homeless Connect sponsors and partners benefit by knowing that their individual sponsorship of a resource at the event makes a genuine difference in a person's life and future.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

In Norfolk, which began its ID program at the August 2006 Project Homeless Connect, about 50 IDs were issued at the first event.

At the most recent Project Homeless Connect in February 2008, 175 IDs were issued.

Norfolk Office to End Homelessness Director Katie Kitchin estimated that at least 100 ID's were issued at each Project Connect since the first event, after staff at the inaugural Project Connect found that at least 50% of the homeless guests had no form of ID.

In San Francisco, during all the PHC events in the city in 2007, 970 ID's were issued.

San Francisco's Project Homeless Connect event in February 2008 resulted in 286 DMV identification cards being issued.

The city [reports its results on its web site](#) after each Connect event.

San Francisco Project Homeless Connect, the pioneer of the innovative one-day, one-stop model, has created a multi- pronged strategy for securing identification on-site for its guests. San Francisco has now convened more than 20 Connect events since 2004, "breaking the myth that people do not seek assistance and services and would simply prefer to be on the street" and offering community volunteers from the public and private sector an opportunity to welcome their homeless neighbors into the "living room" and life of the community.

WHO IS THE INNOVATOR?

In Norfolk, Mayor Paul Fraim's Office to End Homelessness, directed by Katie Kitchin, worked with the Departments of Human Services and Social Services, as well as the City Attorney to develop its innovation. The City Attorney reviewed and approved the on-site verification using existing data sources with personal identifiers.

San Francisco pioneered Project Homeless Connect as an innovative one-day, one-stop engagement strategy under Mayor Gavin Newsom and 10 Year Plan Community Champion Angela Alioto. Implementation by Mayor's staff Dariush Kayhan and Department of Public Health Project Homeless Connect Director Judith Klain has ensured that Project Homeless Connect's partners and results continue to grow.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Norfolk: To learn more about Norfolk's ID innovation, contact the Office to End Homelessness:

Phone: 757-664-4488

Email: homelessness@norfolk.gov

San Francisco: To learn more about San Francisco's ID resources, contact Project Homeless Connect:

Phone: 415- 255-3908

Email: help@projecthomelessconnect.com

Or visit the [Project Homeless Connect web site](#).

With encouragement and technical assistance from the United States Interagency Council on Homelessness, Project Homeless Connect has now been adopted by more than 170 cities across the nation. Project Homeless Connect has another goal besides immediate access to quality of life resources and on-site housing and employment opportunities to end homelessness: Project Homeless Connect is intended to change how business is done in local communities when it comes to expediting outcomes, lowering barriers, removing obstacles, and increasing results.

Consistent with the Council's commitment to the rapid dissemination of what's working, Project Homeless Connect events have brought to light new solutions to old challenges shared across the country.

Project Homeless Connect's "under one roof" offerings for consumers and the "mobile hospitality" of volunteers who act as escorts, shepherds, and conductors for their homeless neighbors help lower their barriers and achieve results. Public and private sector resource providers work side-by-side in a new configuration, with a focus on problem - solving and results.

Innovation Number 4

Measuring Local Results in Ending Homelessness through a State Plan: Washington State's Intergovernmental Partnership

- Washington's Counties report their results in ending homelessness from County 10 Year Plans to the Washington State Interagency Council for an Annual Report to the Governor and Legislature on progress in ending homelessness in the state
- Counties identify to the State Interagency Council recommended state level policy changes that could improve 10 Year Plan outcomes

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

A formal structure for reporting progress, measuring results, and recommending policy change in legislatively-mandated County 10 Year Plans across Washington State was established through the Washington Department of Community, Trade, and Economic Development (CTED) as one step in the implementation of Washington's Homeless Housing and Assistance Act passed in 2005. The Act required counties to develop 10 Year Plans and made available targeted new state budget resources to end homelessness. Washington's action is one example of state political will and resources coupled with intergovernmental partnership informed by local strategies.

The Washington State Legislature's action, intended to guide the state's plan and initiatives to end homelessness, charged CTED - which also chairs the State Interagency Council - with the responsibility of establishing a progress report for local governments regarding their 10 Year Plans.

- CTED created an Annual County Report Form in which counties identify state level changes in policy and law necessary to reduce and end homelessness.
- Recommendations are categorized as: Policy Changes Only; State Law Changes (no funding increases); and New State Funding.

Counties are also required to report progress to the State in areas including both quantified primary performance measures (such as expenditures for housing and services dedicated to reducing homelessness) and plan implementation measures (such as state, federal and local operating and services costs per homeless person served).

WHO BENEFITS FROM THE INNOVATION?

Washington State's 10 Year Plan, supported by both the Legislative and Executive branches, benefits from the aggregate identification of issues and challenges faced by counties as they develop and implement their 10 Year Plans.

The State of Washington benefits from local jurisdictional planning and performance reporting that draws on each county's utilization of targeted resources available that are focused on measurable reductions in homelessness; demonstrate government cost savings over time; employ evidence- based models or promising approaches; could be supported after the state's project funding ends using criminal justice, social services, health, and other system resources; are replicable; include a strong performance measurement component (up to 20 percent of a project award can be used to ensure that outcomes are collected using academically rigorous methodology); and are consistent with the state and local homeless plans.

The Executive and Legislative branches benefit from performance reporting on state revenue. The Homeless Grant Assistance Program (HGAP) helps finance programs and projects described in local homeless plans that are intended to achieve a higher level of coordination with criminal justice, social service, health, and other state and local systems that result in positive system changes. Local jurisdictions are expected to propose innovative, cost-effective models that are replicable throughout the state.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

CTED has compiled the counties' policy change requests and brought recommendations to the State Council for next steps. The Council's other members include the Departments of Corrections (DOC), Employment Security (ESD), Health (DOH), Social and Health Services (DSHS), Veterans Affairs (DVA), and Office of Financial Management (OFM).

The State Council is currently reviewing the first round of recommendations from counties under the new process. Recommendations came from individual county 10 Year Plans to End Homelessness and from county annual reports required by the Homelessness Housing and Assistance Act. Recommendations came from stakeholders, community members, service and housing providers who participated in the development of the plans.

The Council in late 2007 received formal county requests for state policy changes communicated via local plans and annual reports. Recommendations were in the areas of corrections, youth, de-siloing funding, and data and reports. Discharge and reentry issues were most widely identified for state remedies.

The Council then reviewed the recommendations for consistency with the Council's charter and formed four work groups within the Council. The requests for policy action are combined with draft responses from state agency staff for a review currently underway. The recommendations will also be used to inform an update of the State Plan later this year.

WHO IS THE INNOVATOR?

Washington State has effectively designed a comprehensive system of county reporting that combines quantitative progress measures in reducing homelessness with contextual reporting on barriers, challenges, and policy issues. The State's initiative is a product of a legislative strategy for statewide planning and results in ending homelessness.

The innovation in reporting and policy review reflects the larger results-oriented strategy that - from its origins in legislation and gubernatorial Executive Order establishing the State Council - has been mutually reinforcing between levels and branches of government to achieve results. Along with 48 other states and 3 territories, the State Council is partnered with the United States Interagency Council on Homelessness.

This trajectory can also be seen in the document fee funding structure that was set up with counties automatically receiving a portion of the funding and the state receiving funding that it passes through to promote innovative initiatives at the county level through the homeless grant assistance program (HGAP) administered by CTED.

The reporting process has also resulted in a peer group of the counties who are grantees being established last year to help them communicate best practices, problem solve, and provide support to one other.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the [County Report](#) to Washington State, visit the CTED site.

To learn more about the [Homeless Housing and Assistance Act](#) sponsored by Rep. Mark Miloscia, visit the State Legislature's web site. For his work on Washington's legislative initiative, Rep. Miloscia was recognized at the United States Interagency Council on Homelessness Third Annual National Summit for Jurisdictional Leaders with the 2008 *Home for Every American* Award to a State Legislator.

To learn more about the Homeless Housing and Assistance Act's targeted resources which are derived from a document recording fee and split between the state and the counties to invest in 10 Year Plans, visit [CTED's information site](#).

Innovation Number 5

Federal-State Partnership to create the Prince Home as new permanent supported housing for homeless veterans with disabilities

- Federal-State investment partnership creates new permanent supported housing for homeless and disabled veterans in Illinois at the Prince Home on the Manteno State Veterans' Home campus
- Illinois' Governor's initiative partners state and federal agencies to maximize use of State Veterans' Home campus and further Governor's commitment to homeless and veterans populations and housing preservation

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Creating new permanent supported housing for homeless and disabled veterans in a Federal-State partnership on State Veterans Home campus in Illinois

The Illinois Department of Veterans' Affairs Prince Home at Manteno is a permanent supported housing program for homeless and disabled veterans located at the State Veterans' Home in Manteno, Illinois and is a "first" for the state. In 2006, Governor Blagojevich announced his vision for a new pilot program to give homeless Illinois veterans housing and assistance at the State's Manteno Veterans' Home. The newly renovated Prince Home at Manteno provides housing and supportive services for 15 disabled, homeless Illinois veterans, providing a model for how to overcome challenges in financing housing for disabled veterans, including veterans suffering from Post Traumatic Stress Disorder (PTSD). The Manteno campus is located in rural Kankakee County, Illinois, 40 miles south of Chicago.

The new Illinois resource opens its doors to male and female veterans just as more than 200 new permanent housing vouchers targeted to homeless veterans were also awarded to Illinois communities through the 2008 HUD-VASH program, which is making more than 10,000 newly-funded vouchers available across the country.

Work on the Prince Home began in 2006, and the new site opened in November 2007 to provide permanent housing, advocacy, therapeutic and supportive services for 15 veterans. The new housing facility is wheelchair accessible and provides residential housing for eligible men and women veterans. It offers a community environment within its therapeutic milieu, one of structure, interdependence and care and concern. Volunteer work, employment and treatment are components of the Prince Home model.

New residents are now moving in. The Prince Home is staffed by a program director, a caseworker, two addiction counselors, and one psychiatric nurse. Seventy-five percent of the veterans in the program are homeless individuals referred by federal VA medical centers and Illinois Department of Veterans Affairs. The additional 25 percent of residents are homeless veterans referred by the Veterans' Assistance Commission and community providers.

WHO BENEFITS FROM THE INNOVATION?

Illinois veterans who are homeless and living with disabilities benefit from the new single permanent housing units that provide stable housing with services, including semi-private bathrooms, kitchenettes, new carpet, and on-site laundry facilities.

The State of Illinois government benefits by partnering state and federal housing resources in a renovation initiative that maximizes use of a state veterans campus.

The community benefits by ending the homelessness of individuals who have served their country and are living with mental and physical disabilities, making them vulnerable and expensive to community infrastructure and veterans programs.

The community benefits from advancing the implementation of Governor Blagojevich's housing goals for homeless and veterans populations, as called for in the *2007 Annual Comprehensive Housing Plan*, which is based on three principles: affordability and choice; creation and preservation; and leadership.

Notes the Housing Plan, which focuses on the needs of both persons who are homeless and veterans: ". . . it is critical for policymakers at all levels of government and in all types of communities to guide and promote housing as fundamental to community and economic health. Leadership requires accountability through identifying priorities, setting goals for the use of resources that reflect these priorities, and reporting on production."

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

Fifteen formerly homeless veterans living with disabilities are now moving into permanent supported housing at the Prince Home. The housing initiative costs the State less than \$7,000 per year, per veteran in operating and supportive service expenses.

The Prince Home tapped into state and federal resources to create new permanent supported housing, renovating and improving a site on the State Veterans Home campus. The new housing adds capacity to state veterans initiatives in health care, income, and employment.

"The Prince Home is an example of the political will and leadership of a Governor who is focused on housing solutions for homeless people and veterans, and state agencies with leaders such as Department of Veterans Affairs Director Tammy Duckworth and Housing Development Authority Director Dibble who are partnered to end the homelessness of their poorest and most vulnerable neighbors," indicated United States Interagency Council on Homelessness Executive Director Philip Mangano. "Combining state resources with federal investment to create new housing is good for everyone, housed and homeless alike."

WHO IS THE INNOVATOR?

Governor Ron Blagojevich and Illinois state agencies for housing and veterans affairs successfully coupled \$1.3 million from state and federal investment for the renovation of the Prince Home. Federal investment included resources awarded by the Department of Housing and Urban Development.

Illinois Department of Veterans Affairs Director L. Tammy Duckworth and Illinois Housing Development Authority (IHDA) Executive Director Kelly King Dibble partnered to create the new housing. The Illinois Housing Development Authority (IHDA) allocated \$816,000 from the State Affordable Housing Trust Fund following on Gov. Blagojevich's *2005 Building for Success: Illinois Comprehensive Housing Plan* which identified the homeless community, including homeless war veterans, as one of the priority populations targeted for affordable housing spending. The Illinois Veterans Foundation provided pre- development capital for the initiative.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the Prince Home, contact the Illinois Department of Veterans' Affairs, Homeless and Disabled Program Director Deanna Mackey
Phone: 815- 468-6581

To learn more about Veterans Care, the state's program to provide comprehensive, affordable healthcare to Illinois' uninsured veterans who have the least access to reliable healthcare, cannot currently access Veterans Health Administration's benefits, and who meet specific income requirements, [visit their site](#).

To learn more about Governor Ron Blagojevich's initiatives for veterans, including Veterans Cash, an Illinois lottery ticket where 100 percent of proceeds (\$4 million as of Nov. 2007) go to support Illinois veterans, [visit their site](#).

To read the 2007 Illinois Comprehensive Housing Plan, visit the [Illinois Housing Development Authority](#).

To learn more about the federal HUD-VASH permanent housing voucher program for homeless veterans, visit the [HUD Veteran Resource Center \(HUDVET\)](#) or the [Department of Veterans Affairs](#).

To learn more about The State Home Program partnership between the U.S. Department of Veterans Affairs and the States to construct or acquire nursing home, domiciliary and/or adult day health care facilities, visit www.va.gov.

Innovation Number 6

Cost Benefit Analysis and Consumer Satisfaction: Results from Philanthropic Investment to End Chronic Homelessness in Housing First RI

- Both cost benefit outcomes and consumer satisfaction of formerly chronically homeless persons are focus of university-led evaluation of Housing First RI initiative with evaluation measures for permanent supported housing pilot recognizing role of consumer- centric analysis in long-term housing retention and cost effectiveness
- Cost analysis can be strategic tool for sustaining public and private sector investment in permanent supported housing, using United Way of Rhode Island's example of investing both in supportive services for Housing First and results-oriented and client-focused evaluation

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Cost benefit outcomes and consumer satisfaction of formerly chronically homeless persons are focus of evaluation of Housing First RI initiative

A Housing First evaluation that combines cost benefit analysis with measures of client satisfaction recognizes the key role of consumer choice in achieving long-term housing stability and reduced economic impact on community infrastructure using United Way's investment in Housing First supportive services and a university-led assessment.

The pilot housing project was initiated in late 2005 and consists of both scattered site apartments and congregate housing for 50 chronically homeless individuals at any one time.

Providence College Professor of Sociology Eric Hirsch and Roger Williams University Professor of Anthropology Irene Glasser conducted a preliminary evaluation of Housing First RI. The researchers used client service cost data and both baseline and ongoing followup interviews with consumers to measure consumer satisfaction, noting, "These cost savings can only be realized if clients remain in their new homes. A return to a life in the street or in shelters is destructive to the client's health, mental health, and level of social integration. And it dramatically increases the costs to the government and taxpayers due to increased use of health, mental health, corrections, and shelter facilities."

Areas of consumer satisfaction examined were housing, progress in health, mental health, and social interaction goals, as well as job status.

WHO BENEFITS FROM THE INNOVATION?

85 formerly chronically homeless individuals - with an average 7.6 years of prior homelessness - who have moved to permanent supported housing through this initiative benefit from stable housing and improved health and well-being.

Rhode Island benefits from the identification of \$424,000 in annual savings in health care and public safety costs from the new housing stability of consumers.

United Way of Rhode Island and the HousingWorks RI campaign benefit from having data that demonstrate the cost effectiveness of permanent supported housing as partners pursue more resources to create additional permanent supported housing opportunities.

Communities in the Providence metropolitan area benefit from an improved quality of life for all citizens and reduced economic impact on costly community infrastructure, including health care, treatment, and law enforcement.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

78% of consumers maintained their housing and overall costs to the community were reduced as individuals were no longer randomly ricocheting between streets, shelters, and expensive health and law enforcement systems.

Total savings of \$424,272 in public systems in one year reflect per person annual supportive service costs of \$9500 and housing subsidies of \$5643 versus the "institutional costs" of the preceding one year of homelessness for 48 individuals.

In the year prior to entering supported housing, the formerly chronically homeless individuals spent a combined total of 534 nights in hospitals, 919 nights in jail, and had 177 emergency room visits. In contrast, the newly housed individuals had a combined total of only 149 nights in hospitals, 149 jail nights, and 75 emergency room visits in the first year of housing.

Overall housing retention was reduced by a higher initial rate of turnover for the congregate housing site.

WHO IS THE INNOVATOR?

Identifying "ending chronic homelessness" as one of its Community Impact Areas, the United Way of Rhode Island committed \$250,000 to supportive services for the pilot which leveraged \$300,000 for each of two years from the Rhode Island General Assembly for a pilot permanent supported housing initiative in the Providence metropolitan area. The pilot also utilizes 25 U.S. Department of Housing and Urban Development Shelter +Care subsidies and other rental assistance from the state's Neighborhood Opportunity Program.

United Way of Rhode Island partnered with the State of Rhode Island and with HousingWorks RI, a coalition of banks, builders, Chambers of Commerce, colleges, community and faith based agencies, realtors, municipal officials and unions, to initiate the Housing First RI pilot. Other partners for housing and case management services were Riverwood Mental Health Services and House of Hope Community Development Corporation.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To read the **Executive Summary** of "Rhode Island's Housing First Program: First Year Evaluation", [click here](#).

To learn more about the **Community Impact - Ending Chronic Homelessness** efforts of the United Way of Rhode Island, visit <http://www.uwri.org>

To learn more about the [State of Rhode Island's Plan to End Homelessness](#), contact the Rhode Island Housing Commission, visit <http://www.hrc.ri.gov>

To learn more about **HousingWorks RI**, visit <http://www.housingworksri.org>

To learn more about the evidence-based practice of Housing First at **SAMHSA's National Registry of Evidenced-based Programs and Practices**, [click here](#).

Innovation Number 7

Inter-Faith Ministries'

Kansas Benefit Bank:

A One- Stop Solution to Access Mainstream Resources to Prevent and End Homelessness

- In Wichita, Kansas, Inter-Faith Ministries is advancing a statewide initiative linking modern technology with the time honored concept of neighborhood assistance to prevent and end homelessness and increase the economic stability of families and individuals by improving access to a wide variety of state and federal benefit programs.
- Efforts to identify and reduce barriers to accessing state and federal assistance programs produces economic benefits for both at risk families and local and state economies.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

A statewide network of free community-based sites provides access to an expansive range of mainstream resources that can prevent and end homelessness.

Wichita-based Inter-Faith Ministries, a key partner in the Wichita-Sedgwick County, Kansas 10 Year Plan, has partnered with the National Council of Churches USA and the Philadelphia-based public policy technology company Solutions for Progress to build a strong statewide network of free community-based sites - including permanent supported housing and homeless programs - where consumers, including persons who are homeless, can be screened for and submit applications for an expanded variety of mainstream resources that can prevent and end homelessness.

Using Solutions' Benefit Bank one-stop technology, a proprietary tool, Inter-Faith Ministries has increased both the number of public benefit programs included in the benefit screening and the number of sites at which consumers can access the Benefit Bank. Inter-Faith has targeted both rural and urban areas for the establishment of these key supports to prevent and end homelessness.

There are now more than 17 Kansas Benefit Bank sites open with a goal of having multiple sites within all the counties in the state. Catholic Social Services is a key partner in the expansion.

To maximize accessibility for the consumer, a variety of neighborhood locations serve as access points, including permanent supportive housing sites, homeless shelters, United Way locations, faith congregations, health and social service organizations, food and nutrition organizations, community-based organizations, CDCs, job-training programs, home ownership programs, asset building programs, prisoner reentry programs, employers, food pantries, job training programs, and neighborhood associations. In all cases, the benefits service is free to the consumer, and sites are established with an eye to offering access at convenient times - weekends, before and after worship, evenings, etc.

According to Inter-Faith, in Kansas only 57% of eligible Kansans receive food stamps (average \$2,500 per application). 39,000 eligible children who are eligible for "HealthWave" or Medicaid do not receive the benefit (an average of \$1,800 per application). Child care subsidies, averaging an estimated \$4,000 per application are underused. Stated Inter-Faith's Director, Sam Muyskens, "It only makes sense that if we can increase the income of households we will reduce the number of persons falling into homelessness."

WHO BENEFITS FROM THE INNOVATION?

Homeless and low income families and individuals who are able to achieve greater financial stability that prevents and ends homelessness benefit by successfully obtaining State and Federal resources for which they are eligible, offering a powerful tool for the Housing First goal to move homeless persons into housing rapidly.

Eligible persons benefit from having a "one stop" centralized process of application for benefits, minimizing time spent on travel, appointments, collecting documentation, and more. Individuals also benefit by having trained counselors complete applications accurately, providing an efficient and time saving strategy for applying and receiving benefits.

Local and state economies benefit as incomes and assets increase, and families have greater economic stability and more disposable income. The increased revenue received by each household strengthens the overall economic health of the community and the State.

The wide range of faith and community based sites increases the breadth of outreach efforts for other resources and supports.

Program staff benefit from increased reliability in making applications successful for clients, given that the counselor-assisted software tool results in greater certainty about eligibility when staffing pressures on local and state agencies make it difficult to keep up with program rules and requirements.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE

INNOVATION?

Nearly 500 families and individuals have been served since startup just six months ago.

As of April 2008, beneficiaries have received **\$704,529** creating an economic impact to the state's economy estimated at \$1,111,463.

Since Inter-Faith Ministries inaugurated the program six months ago, **17 screening sites** throughout Kansas have been established.

Inter-Faith has concentrated on southwestern Kansas, including the cities and rural areas of Dodge City, Garden City, Great Bend, Hays, and Hiawatha. The state's southwest counties where the number of families below the poverty line exceeds the statewide 6.7% average were a priority area for the expansion.

WHO IS THE INNOVATOR?

Wichita's Inter-Faith Ministries (IFM) is leading the Kansas Benefit Bank effort. IFM has a 123-year history in the community and served over 35,000 individuals last year through a variety of programs including its Campaign to End Childhood Hunger. IFM's Housing and Homeless Services includes a 20-bed Safe Haven that assists over 80 chronically homeless persons with mental illness annually, and more recently the development of permanent supportive housing units and case management services.

Inter-Faith Ministries, under the leadership of Executive Director Sam Muyskens, has a history of partnership with business strategies in the community and last year opened Inter-Faith Enrichment Center with the support of Cargill, an international agricultural company. The Enrichment Center is located next to another new construction project called Inter-Faith Villa Courts, 40 new housing units that will include supportive services with a full-time case manager within the building. Within the new project will be Cessna Learning Center supported by Cessna Corporation. Villa Courts is slated for completion this summer, providing 105 housing units with supportive services, a Community Room, the Cargill Enrichment Center, and the Cessna Learning Center.

Inter-Faith Ministries raised approximately \$750,000 to expand the number of public benefit programs included in the Kansas Benefit Bank, including Kansas' Child Health Insurance Program (known as HealthWave) and began the statewide expansion in Fall 2007.

The "Benefit Bank" concept was initiated by the **National Council of Churches USA** which partnered with **Solutions for Progress**, a public policy technology company to create the web-based software. First introduced in Philadelphia as a pilot program for tax preparation in 2004, The Benefit Bank served just over 400 people and secured almost \$800,000 in federal tax refunds and credits. In January 2005, a new, more robust program was released and began to be used in sites in Pennsylvania, Florida, and Kansas. The program has continued to grow expanding beyond tax preparation to include myriad state and Federal benefit programs.

The Benefit Bank is a web-based, counselor- assisted program that simplifies and centralizes in a neighborhood location the process for applying for numerous state and federal programs that can provide families and individuals with the financial resources to meet housing and other needs.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the **Kansas Benefit Bank**, visit www.ifmnet.org or contact IFM Director Sam Muyskens at the IFM Program Center
829 North Market
Wichita, KS 67214-3519
Phone: 316-264-9303

To read more about the **Benefit Bank** concept, visit:
www.thebenefitbank.com and
www.solutionsforprogress.com

To learn about the more than [70 Federal programs](#) across 11 Federal agencies with the capacity to serve families, read the United States Interagency Council on Homelessness' new program inventory.

Innovation Number 8

Project Re-Connect: Achieving Successful Reentry for Ex-Prisoners through St. Louis' 10 Year Plan

- In St. Louis, MO a special initiative rooted in the 10 Year Plan focuses on engaging and supporting re-entering prisoners - those who have served maximum sentences and are returning to the community with no requirement for further supervision - to achieve successful reentry.
- Project Re-Connect is a city-initiated, state- funded partnership of community and faith based agencies with a network of volunteer mentors supporting a high risk population as they re-enter the community.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Pre-release engagement and post-release services, mentoring, and supports achieve successful reentry in St. Louis

Through the cooperation of the Superintendents of Missouri's 23 state prisons, St. Louis' Project Re-Connect receives a list each month of the target population of prisoners who have served maximum sentences and are scheduled to be released to St. Louis over the coming three months. Since state law does not require prisons to create a discharge plan for prisoners who have served their maximum sentences, Project Re-Connect began with an educational campaign for the Superintendents that included making a formal presentation at the monthly meeting of Superintendents convened by the Missouri Department of Corrections.

Each prisoner on the target list is sent a letter describing the reentry opportunity offered by Project Re-Connect to assist them with finding a place to live, a job, and connection to mental health and substance abuse services if needed. Case managers are assigned to prisoners who express interest and work with them by phone and letters prior to release to develop an Individual Support Plan that considers health needs, where they would like to live, any existing family supports, work interests, and other matters.

Each individual is asked to recognize that "reentry is not just about individuals coming home; it is also about the homes and communities to which they return." Returning prisoners are expected to commit to making responsible choices, making positive changes in their lives, and pursuing Project Re-Connect goals that they set for themselves.

A partnership of community and faith based organizations including Center for Women in Transition (CWIT), the Criminal Justice Ministries of St. Vincent de Paul, Provident Counseling, Employment Connections and the Peace and Justice Institute then provide support, access to resources, and mentoring to the released individual.

Project Re-Connect launched in March 2007 with a budget of \$3000 per client that is used to meet a variety of needs including rent, transportation, food, and clothing during the 6-month post release program. Most clients live in transitional housing in the community for the first month or so while they are being assisted to find employment. After that time, they are able to locate and obtain more permanent housing with the assistance of Project Re-Connect. Clients receiving outpatient treatment for substance abuse remain longer in the transitional housing. Mentoring relationships continue beyond the 6 months.

WHO BENEFITS FROM THE INNOVATION?

The reentry population experiences support in coming back into the community and is able to achieve greater self sufficiency more quickly with better access to key resources of housing, treatment, and services, lowering recidivism rates.

Citizens of the City of St. Louis benefit from improved public safety and thus a better quality of life as fewer new crimes are committed.

St. Louis and Missouri benefit from lower judicial and incarceration costs associated with recidivism, law enforcement, and courts. St. Louis also benefits from achieving progress in a 10 Year Plan goal to prevent and end chronic homelessness.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

275 men and women being released from state prison to St. Louis having served their maximum sentences have participated in the program since Project Re-Connect launched in March 2007; this number includes 54 who are still in the pre-release phase.

Only 2.7% of participants have re-offended compared to 23.8 % of those meeting the same target population definition released between January 1, 2006 - March 31, 2008 who did not have the opportunity or chose not to participate in Project Re-Connect.

Less than 1% of participants have dropped out of the program.

WHO IS THE INNOVATOR?

St. Louis Mayor Francis Slay partnered with St. Louis County Executive Charlie Dooley in developing a 10 Year Plan to End Chronic Homelessness in 2005; the plan identified prisoner re-entry as an "area of emphasis" for housing and services delivery.

While many 10 Year Plans have identified the reentry population for prevention resources, Mayor Slay took the lead to develop a city strategy in partnership with the state prison system. The city and county combined their focus with the work of the state Department of Corrections in response to Governor Matt Blunt's 2005 Executive Order creating the Missouri Re-Entry Process Steering Team.

Working with the state legislature, Mayor Slay secured a \$1 million appropriation in 2006 to focus on prisoners who were returning to the city after serving out their maximum sentences, "possessed few resources to support themselves," and historically used the city's emergency shelters.

According to William Siedhoff, Director of the St. Louis Department of Human Services, Mayor Slay's initiative focuses on a population of returning ex-offenders with high rates of dual diagnosis who make up a disproportionate number of persons using the city's emergency shelter system. A high percentage of ex-offenders were identified among the homeless population on the streets of the city and in homeless shelters. This was particularly true for those released from state correctional facilities on "Director's Release" who had served out their entire sentences with no time off for good behavior. Since 2006, a total of 809 people maxed out their sentences and found their way to St. Louis, according to city data.

The St. Louis-based Center for Women in Transition (CWIT) was awarded the contract for Project Re-Connect which is a partnership of community and faith based organizations including CWIT, the Criminal Justice Ministries of St. Vincent de Paul, Provident Counseling, Employment Connections, and the Peace and Justice Institute. Each of these agencies brought to the table a history of working with special populations and a "rolodex" of relationships that had been cultivated over the years with landlords, employers, and mental health and

substance abuse service providers that allows them to offer immediate post release services to the target population.

CWIT Associate Director Georgia Walker, who manages Project Re-Connect, says that "mentoring combined with this network of wraparound services" are the heart of the Project Re-Connect effort : "Mentoring is indispensable, to have someone from the community willing to welcome you back, to say let me help you focus on your goals . . . let me be the one to walk with you." CWIT has a network of mentor volunteers who are working with women ex-prisoners; the men's mentoring program is provided through the Peace and Justice Institute.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about Project Re-Connect, visit the Center for Women in Transition web site at www.cwitstl.org or contact Associate Director Georgia Walker at 314-771-5207 .

To learn more about the work of Project Re-Connect partner agencies, click on each agency name below:

[Employment Connections](#)

[St. Vincent de Paul Criminal Justice Ministry](#)

[Provident Counseling](#)

[Peace and Justice Institute](#)

To learn more about the City and County of St. Louis [10 Year Plan to End Chronic Homelessness](#) initiatives, contact St. Louis Department of Human Services Director William Siedhoff at 314-612-5900.

To read or download a copy of the 2007 Report to the Governor on the Missouri Re-Entry Process, visit the [web site](#).

To read about federal prisoner re-entry initiatives, visit the [White House Office of Faith Based and Community Initiatives](#) re-entry web page.

To read about the recently enacted federal legislation, Reducing Recidivism and Second Chance Act, signed by the President in April, check out [recent editions](#) of the [USICH e-newsletter](#)

Innovation Number 9

Ohio's Special Courts: The courts as leader and partner in preventing and ending chronic homelessness

- Ohio's Mental Health Court - just one of the Special Courts in Ohio's Supreme Court "Specialized Docket" - is an active leader in seeking better outcomes through policy and

practice for persons who are homeless with mental health issues and in the criminal justice system.

- The Court creates strategic intergovernmental partnerships with state agencies in both the executive and judicial branches and with local agencies seeking to break the costly cycle of random ricocheting for persons with behavioral health issues and histories of homelessness who are in the court system.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Ohio's Mental Health Court builds leadership and intergovernmental and community partnership to prevent and end chronic homelessness.

Ohio's Mental Health Court - one of the Special Courts in Ohio's Supreme Court "Specialized Docket" - demonstrates political will in partnerships for better outcomes for persons who are homeless with mental health issues and in the criminal justice system. Ohio judicial leaders have created strategic partnerships with state agencies in both the executive and judicial branches, and with local judicial and service agencies seeking to break the cycle of random ricocheting for persons with behavioral health issues and histories of homelessness who are in the court system.

The result is an active intergovernmental partnership model for the judiciary in pursuit of the goal of preventing and ending chronic homelessness, demonstrated in *policy* through participation in the Ohio Interagency Council on Homelessness and Affordable Housing and other collaborative interagency venues at the national, state, and local level, and in *practice* through training events, conferences, and best practice events for judges and their court staffs on issues and resources (including housing, counseling, medication, and employment assistance) for special populations.

Ohio's Mental Health Court is an example of the "problem-solving courts" that Ohio has encouraged statewide. The Specialized Docket model focuses on the "cultivation of community collaborations for a complete systems approach to handle cases with the highest recidivism rates." In practice, Ohio's example shows the importance of the judiciary as a partner in State Interagency Councils and jurisdictional 10 Year Plans.

Supreme Court of Ohio Justice Evelyn Lundberg Stratton, who is a national leader on the strategy of special courts, established the Ohio Supreme Court's Advisory Committee on Mental Illness and the Courts (ACMIC) in 2001, which she chairs. The Advisory Committee is made up of over 50 representatives from the Ohio Departments of Mental Health, Alcohol and Drug Addiction Services, and Rehabilitation and Correction, and the Ohio Office of Criminal Justice Services, Judges, law enforcement, mediation experts, housing and treatment providers, consumer advocacy groups, and other officials from across the state.

Collaborative partnership between the judiciary and executive branches in Ohio is further supported by the inclusion of the Supreme Court on the state Interagency Council on Homelessness and Affordable Housing, created by Executive Order of Governor Ted Strickland last year. Chaired by Lieutenant Governor Lee Fisher, the state ICH recently convened its meeting at the Ohio Judicial Center, where they were welcomed by Judge Stratton.

WHO BENEFITS FROM THE INNOVATION?

Individuals who are homeless or at risk and living with mental illness benefit from a collaborative, holistic, and informed strategy to support and stabilize them in the community, monitor progress and compliance, and address barriers and challenges.

Judicial partners benefit from having a broader network of choices, resources, and experts who can identify critical partners and expand positive outcomes for individuals, while supporting the court's role.

State and local government and service agencies benefit by working together to solve the issues facing their clients, stabilizing individuals, promoting treatment and recovery, and reducing costly recidivism.

The community benefits by increasing stabilization for vulnerable and costly individuals. According to Justice Stratton, in Ohio, the mental health program costs taxpayers \$30 a day, versus prison (\$60), a mental hospital (\$450), and a general hospital (\$1,500).

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

The Supreme Court's Advisory Committee has organized numerous trainings and conferences for judges and their court staffs on issues related to mental illness impacting both adults and juveniles. The Advisory Committee has also supported the local creation of mental health courts and jail diversion programs. Over 100 specialized dockets are in operation in Ohio, including over 70 Drug Courts, over 30 Mental Health Courts, and 5 Re-Entry Courts.

Along with the Criminal Justice Coordinating Center of Excellence, the Advisory Committee has fostered the adoption of Crisis Intervention Team (CIT) training by police academies, departments, and sheriff's offices. Ohio has more courts operating mental health dockets and law enforcement officers trained in crisis intervention than any other state.

The Ohio Specialized Dockets Practitioner Network is another component of the strategy and consists of several sub-networks of specialized docket professionals organized by discipline. These include: Judges and Magistrates, Prosecutors, Defense Counsel, Probation Officers, Mental Health Clinicians, Drug Treatment Counselors, Coordinators, Case Managers, and Children Services Workers. These groups are further divided by jurisdiction - adults or juveniles.

Two Kent State University evaluations of Ohio mental health courts found that those individuals who completed their court process reported an increased quality of life because of reduced stigma about their illness, and that "those who successfully complete MHC experienced fewer incarcerations after program participation when compared to their previous

behaviors and in comparison to other consumers of mental health services. We conclude that this indicates that the program has the desired effects in slowing the revolving door of criminalization."

WHO IS THE INNOVATOR?

The **Supreme Court of Ohio** and **Justice Evelyn Lundberg Stratton** have provided national leadership on the strategy of special courts and have sought out partners from all sectors to expand awareness and solutions. Justice Stratton has used her position to foster dialogue on the issues of mental illness and the criminal justice system.

To promote effective judicial efforts nationally on this issue, she became co-founder along with Miami/Dade County Circuit Court Judge Steven Leifman of the national Judges' Criminal Justice/Mental Health Leadership Initiative (JLI) and co-chairs the Returning Home Advisory Commission, which assists with prisoner re-entry to reduce recidivism and its cost to society. The Council of State Governments (CSG) Criminal Justice / Mental Health Consensus Project and the Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion convene JLI.

Some Mental Health Courts are funded federally through the *Mentally Ill Offender Treatment and Crime Reduction Act in 2004*, spearheaded by then Sen. Mike DeWine and then Rep. Ted Strickland, now Ohio Governor, to advance local efforts to divert mentally ill offenders into community treatment programs.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the **Ohio Specialized Dockets** Section, contact the Supreme Court of Ohio:

65 South Front Street, 6th Floor

Columbus, Ohio 43215-3431

Phone: 614-387-9425

E-mail: specdocs@sconet.state.oh.us or visit the [web site](#).

To learn more about the **Ohio Supreme Court Advisory Committee on Mental Illness and the Courts** and read articles about effectively dealing with mentally ill offenders in the criminal justice system, visit the [web site](#).

To learn more about the **Judges' Criminal Justice/Mental Health Leadership Initiative (JLI)**, and see resources for Judges, including sample forms, fact sheets, research on mental health courts, and other materials for a court's day-to-day operations, visit <http://consensusproject.org/JLI/>

Read the [new Department of Justice report](#): Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court or [Strategies for Court Collaboration with Service Communities](#).

The National GAINS Center has operated since 1995 to collect and disseminate information about effective mental health and substance abuse services for people with co-occurring disorders in the justice system. The TAPA Center for Jail Diversion and the Center for Evidence-Based Programs in the Justice System (funded by the Center for Mental Health Services (CMHS) in 2001 and 2004 respectively), comprise the National GAINS Center. Read more at: <http://gainscenter.samhsa.gov/html/>

The Judiciary is an important partner in local and state response to homeless persons with mental illness, joining local and state agencies in seeking solutions to the revolving door of this population in the criminal justice system. Judges have recognized that people with mental illness and co-occurring disorders, who often were also homeless, were significantly over-represented among the defendants appearing before them again and again. In some communities, Courts and Special Courts have convened proceedings at Project Homeless Connect events

According to the U.S. Department of Justice, Mental Health Courts typically employ a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants, with judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement. Courts hold regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are imposed on participants who do not adhere to the conditions of participation. Generally there are specific criteria defining a participant's completion of the program.

Innovation Number 10

Give Change to Make Change: Denver's Parking Meter Initiative Fosters Community 10 Year Plan Engagement and Reduces Panhandling

- Denver's Donation Meter Program is reducing panhandling and increasing community awareness and support for *Denver's Road Home*, which prioritized public education and community engagement as a 10 Year Plan goal

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Denver's Donation Meter Program has increased public awareness and civic engagement in its 10 Year Plan and reduced panhandling.

Denver prioritized public education and community engagement as essential to the successful implementation of its 10 Year Plan, *Denver's Road Home*. A Donation Meter Program initiated in the Spring of 2007 has provided an opportunity for individual citizens to participate directly and productively in *Denver's Road Home* to provide housing, employment, behavioral health treatment, and other services to homeless and at risk individuals and families in the community. The Donation Meter Program is a promising response to citizen and business concerns about panhandling.

Under the Donation Meter Program, parking meters are painted red, redesigned with *Denver's Road Home* decals, and installed in strategic downtown locations with significant foot traffic and panhandling issues. Coin donations can be made into the meters as a means to engage citizens and redirect money given to panhandlers into local initiatives that provide meals, job training, substance abuse counseling, housing, and other programs.

Local businesses are supporting the initiative by adopting the meters for \$1000 each per year. Denver Public Works make collections from the meters, with 100% of the monies collected made available to support *Denver's Road Home* initiatives.

The collections are turned over to the Mile High United Way which is partnered with the city and county of Denver and is the financial steward for *Denver's Road Home*. The money is distributed to service providers to address gaps in homeless services including housing, employment, prevention efforts, and medical, mental health, and substance abuse treatment.

WHO BENEFITS FROM THE INNOVATION?

Homeless and at risk individuals and families benefit from the increased availability of housing, employment, and other services supported with the money collected from the Donation Meters Program.

Denver's Road Home benefits from increased visibility in the community and with that has come:

- greater awareness among citizens of the scope of homelessness in the community and solutions that end homelessness in their community
- greater understanding of the cost effectiveness of the investments being made through the Plan and the results being achieved
- more civic engagement through the act of donating

Residents and businesses in the Downtown Business District and other areas of the city where the meters have reduced the incidence of panhandling, leading to a perceived improvement in the quality of life.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

36 meters were installed in the spring of 2007 at strategic downtown locations that had significant foot traffic and panhandling issues.

The **first increment of meters expanded** to 86 meters including 10 at Denver International Airport, and the Donation Meters Program generated \$15,000 in coin donations from citizens in this first year.

\$86,000 in revenue was generated from the **business community** where businesses adopted meters at \$1000 apiece per year.

City officials say that the revenues collected in the first year totaling nearly \$100,000 have "exceeded their expectations" and that the Donation Meters Program will generate over \$500,000 in sustained revenue over the next five years to support *Denver's Road Home* initiatives.

The Downtown Denver Partnership reported an estimated 92% **reduction in panhandling** in the first year of the Donation Meters Program.

Just as Denver looked to the example of Baltimore's green "Make a Change" meter program in 2006, and Portland, Oregon's Business Alliance initiative called "Real Change, Not Spare Change," Denver's own launch created a new wave of inquires about replication from more than 20 cities. Denver reported coast to coast interest, as well as inquiries from Dublin, Toronto, and Montreal.

WHO IS THE INNOVATOR?

Denver Mayor John Hickenlooper has said of his city that: " People choose to come to live in Denver because of Denver . . . the quality of life available here. So we have a population more willing to invest in itself and more demanding of solutions and positive outcomes." In 2005, Mayor Hickenlooper lead development of a 10 Year Plan to end homelessness, *Denver's Road Home* that was concrete about its intention: to invest in cost effective measures that would bring measurable results in ending homelessness in the community.

Mayor Hickenlooper and his public-private partnership in *Denver's Road Home* team - including former Department of Human Services Director Roxane White and 10 Year Plan Manager Jamie van Leeuwen - have continually sought new ways to engage the broader community in opportunities "to own *Denver's Road Home*" and be part of solutions. Denver became an early adopter of the Project Homeless Connect innovation and has convened 6 Project Homeless Connect events since December 2005. 250 congregations representing hundreds of volunteers have responded to the Mayor's call on the faith community to mentor at risk and homeless families. Through a combination of innovation and replication, Denver's Road Home achieved an 11% reduction in overall homelessness and a 36% decrease in chronic homelessness in its first two years of implementation.

The **Denver Business Improvement District** in 2005 helped commission a survey showing that that more than \$4.5 million was being given directly to panhandlers each year in Denver. The survey also showed that over 42% of Denver adults had given directly to a panhandler in

the prior year. City partners were determined to engage the community's good will and redirect it.

The Business Improvement District ensured that over 150,000 brochures about the initiative were distributed to office workers and residents, with posters and education materials in target areas serving as a reminder to the public to give in ways that have long term, positive impacts.

Denver Public Works, *Denver's Road Home*, Leadership Denver, the Downtown Denver Partnership, Mile High United Way, rabble+rouser, and OZ Architecture worked together to coordinate the meter design, decal messaging, printing installation, and meter sponsorships. Mile High United Way and Leadership Denver alumni coordinate annual meter sponsorship.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the Denver **Donation Meters Program** and other *Denver's Road Home* initiatives and results, visit www.denversroadhome.org

To read about the "Give Your Change to Make A Change" **Baltimore** effort, visit the [web site](#).

Innovation Number 11

Soldier On: Success in the Community through an Employment and Housing Strategy with Results for Homeless Veterans in Massachusetts

- Veteran-focused strategies for employment and housing promote community integration.
- Community partnership with education, training, and employment sectors ensures job opportunities in the region.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Creating sustainable employment opportunities and innovative permanent housing choices for homeless veterans.

Soldier On, a non-profit in Western Massachusetts, has created an expansive community partnership that offers veterans skills training, employment opportunities - including veteran-owned and managed businesses - community service opportunities, and banking and financial

education services. Employment and training resources for veterans through Soldier On are linked to identified market needs and business opportunities in the regional economy of western Massachusetts.

Soldier On will break ground this year on an innovative housing opportunity: a 39-unit limited equity cooperative at its Pittsfield, MA site will provide homeownership and housing management opportunities for formerly homeless veterans. In order to achieve this goal, job training, stable employment, and financial education are the cornerstones that every veteran needs to have a chance to be successful.

Soldier On's employment and training programs have been carefully crafted to offer sustainable employment opportunities in the region. The Soldier On employment and training program is supported by the U.S. Department of Labor, Veterans Employment and Training Services (VETS) through a Homeless Veterans Reintegration Program (HVRP) grant.

Having identified a need in the community for well-trained and reliable construction contractors, Soldier On created the veteran owned and operated *Berkshire Veterans Construction Company* and partners with Berkshire Community College to prepare veterans for the construction supervisor's test. The Berkshire Veterans Construction Company performs work for organizations such as the Pittsfield Boys and Girls Club, Berkshire Housing and Development, Inc. and private citizens in the Berkshire County area.

A *Culinary Training Program* addresses employment opportunities in this tourist and arts destination area and also provides daily meals for the Berkshire Veterans Residence. Trainees receive a "serve safe" certificate, and learn how to design menus, order food, and cook and serve meals. The culinary program has catered special events in the area.

Soldier On has given veterans an entrepreneurship opportunity with its *Veteran Vending* business. Veterans gain the knowledge of what it takes to run a small business, including budgeting, ordering, accounting, and networking skills needed to work with vendors in the local community. The Veteran Vending business currently works with Coca-Cola Co. and J. Polep Distribution Services.

A therapeutic sheltered workshop - the *Veterans Skills Development Center* - is located at the Berkshire Veterans Residence and has been embraced by the region's large number of plastics companies - 26 plastics firms in the area employ a total of 2,500 people and manufacture \$200 million of product every year - including Apex Mold, Lansen Mold, Injected Solutions, Pittsfield Plastics, and China Array who provide work to the Center to supplement their production capacity.

The *Community Service Program* offers other opportunities. For people in the community that can no longer take care of their homes, veterans assist them with clean up and organizing. In the Daniel Petithory Greenhouse, veterans grow flowers for organizations such as Pittsfield Beautiful, Retired Senior Volunteer Program, Red Cross, and for families of local veterans. The veterans provide support services for staff at nearby shelters, along with providing custodial services to the Pittsfield Police Department.

Financial security and responsibility will help to ensure that veterans who live in permanent housing will remain stable and have the tools necessary to sustain a new life. Berkshire Bank offers every veteran a chance to open a bank account regardless of past banking history. Berkshire Bank then assigns every veteran a personal banker that works closely on financial planning for that veteran.

WHO BENEFITS FROM THE INNOVATION?

Formerly homeless veterans benefit from having a stable residence, access to medical and mental health care, a chance to secure gainful employment, and resources for banking and financial services - all of which help the veteran reintegrate into the labor force and the community. A new housing initiative will provide an opportunity for veterans to own and manage their own limited equity cooperative apartment.

Local employers benefit from having access to a trained and flexible work force. The Veteran Skills Development Center streamlines recruitment, record keeping, and health insurance for employers, as well as addressing other market issues. Employers may be eligible for the Work Opportunity Tax Credit which allows employers to recover a portion of the wages paid during the initial period of employment.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

Soldier On reports these employment results in the last year:

- **147 veterans were enrolled** into the employment/training program.
- **47 veterans gained employment and moved into permanent housing.**
- **96 veterans were placed** into full-time or part-time employment.
- 44 veterans were employed **for at least 90 days** and are still residing at Soldier On.
- 25 veterans were employed **for 180 days or longer** and are still residing at Soldier On.
- **Average wage** for employment is \$9.55 per hour.

WHO IS THE INNOVATOR?

Soldier On is a private non-profit agency headquartered in Leeds, Massachusetts which provides shelter, support, and job training to veterans in need within an environment that offers integrity, dignity, and hope (formerly United Veterans of America). John F. Downing is the President and Chief Executive Officer, bringing to his leadership role over thirty-five years of service to the community of the addicted, incarcerated, mentally ill, and homeless individuals. Steven E. Como is Executive Vice President and Director of Government Relations of Soldier On, working with federal, state, and local agencies.

Soldier On operates a shelter with space for 120 homeless veterans in two buildings leased from the Veterans Affairs Medical Center in Leeds, Massachusetts. Former staff cottages on the site are leased from VA to house homeless women veterans and elderly frail male veterans. The Berkshire Veterans Residence in Pittsfield, MA houses 60 formerly homeless veterans in a transitional program and 10 formerly homeless veterans with disabilities in

studio apartments, with resources from the U.S. Department of Housing and Urban Development. All Soldier On facilities are managed by formerly homeless veterans.

The average Soldier On client is 54, but the mean age is trending younger with the return of more veterans of Operation Enduring Freedom and Operation Iraqi Freedom. Some 10% are age 65 or older. Approximately 88% of the veterans suffer mental health and/or substance abuse issues. More than 25% have been diagnosed with post-traumatic stress disorder (PTSD). 5% are women. 28% are on parole or probation.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Learn more about **Soldier On** at their website: <http://www.wesoldieron.org> or contact President and CEO John "Jack" Downing or Executive Vice President Steve Como at 413-582-3059.

Learn about the [U.S. Department of Labor's](#) HVRP resources.

Learn about the [U.S. Department of Veterans Affairs](#) homeless veterans programs.

Learn about the [U.S. Department of Housing and Urban Development's](#) resources for veterans.

Visit the [U.S. Interagency Council's](#) homeless veterans resource web page.

Innovation Number 12

[Road]Map to the Future: Chicago's Homeless System Mapping Project Plans to End Homelessness

- On-line, interactive map of current program inventory and projected future realignment during 10 Year Plan implementation
- Visual guide to community wide strategy for conversion of resources to align with 10 Year Plan goals

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

On-line interactive mapping of current resources and projected realignments during implementation of Chicago's 10 Year Plan is a city-wide snapshot of the current and

future status of more than 300 programs providing prevention and intervention resources.

The City's 10 Year Plan adopted by Mayor Richard Daley in 2003 - "Getting Housed, Staying Housed" - called for a broad transformation of the existing response to homelessness and a realignment of existing and new resources, acknowledging and pointing the way to a series of "conversion" strategies to accomplish the goal of ending homelessness. The Mapping Project is the visual road map for the strategy.

The on-line Mapping Project, funded by the Prince Charitable Trusts, allows selective or comprehensive viewing of permanent supportive housing, permanent housing with short-term supports, Safe Havens, Interim Housing, transitional programs, overnight shelter, supportive services, engagement services, and multi-service programs, by location (citywide or by region), study of special program features, and insight into projected changes during the 1-3 and 3-5 years ahead in plan implementation.

Chicago's innovative multi-level conversion strategy has been supported on several levels besides the visual and quantifiable technology of the Mapping Project. In a 2005 concept paper by the Chicago Partnership to End Homelessness, the problem statement was direct: ". . . Chicago now moves from creating a plan to major system conversion. For the past two years, since a draft of the plan was finalized, service providers, government partners, consumers, funders and advocates have wrangled with the complexities of turning vision into action. Lessons learned include the fact that change must occur at multiple levels - in the daily operations of homeless service agencies; in the shifting of resources from a shelter-based to a housing-based system; in the coordination at a regional level of what services should be changed and what should be preserved; and at the regulatory level, where existing legislation and regulations raise unexpected roadblocks."

Recognizing that "Small community-based agencies are vital to the success of Chicago's 10 Year Plan to end homelessness," a Conversion Roundtable has also been convened in the Chicago partnership to support dialogue and problem-solving in the movement from an emergency response to a housing response.

As noted by the Chicago partners, a key goal is to ensure that there is no disruption of services during a move to a Housing First strategy and to make Chicago's conversion experience replicable in other jurisdictions.

WHO BENEFITS FROM THE INNOVATION?

Individuals and families experiencing homelessness or the risk of homelessness benefit by strategic alignment of prevention and intervention resources on a city-wide basis, with increasing benchmarked development of new housing opportunities to end homelessness.

Community programs benefit by having a strong partnership for support, technical assistance, and implementation, while having access to the best of "what's working" to guide their investment of resources.

The **City of Chicago** benefits by seeing quantifiable increases in successful prevention of homelessness and increased movement of persons experiencing homelessness and chronic homelessness, into permanent and permanent supportive housing, reducing costly economic impact on community infrastructure of law enforcement, primary and behavioral health care, and hospitals.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

Chicago's plan is achieving results: the city announced a 12 percent decrease in overall homelessness from 2005 to 2007, with more than a 20 percent decrease among families. By developing a strategy based on conversion and creating an expectation of both partnership and accountability, steady progress has been made in realigning both resources to prevent and end homelessness and the community based partnerships to achieve those goals.

According to the Chicago Alliance, identification by collaborative partners of homeless programs that are considered to be in alignment with the Chicago Plan has resulted in a priority status for resources. The recognized models include: permanent supportive housing, permanent housing with short-term supports, Safe Havens, Interim Housing, transitional programs, overnight shelter, supportive services, and engagement services.

In order to implement the Plan, a schedule of goals and priorities was developed and adopted by all partners working on the Plan. This Implementation Schedule sets out tasks, accountable entities, and completion dates for key activities around the major tenets of the Plan.

In its April 2008 report on the Plan - "The Journey Home" - which highlights achievements and challenges in the five years of strategic implementation since the Plan was developed, the Chicago Alliance notes the following Plan results in the community:

- **450 new units** of permanent housing for persons who are chronically homeless
- **Housing Locator Program**, an "apartment finder" for homeless individuals and families with some income which assisted over 560 households in its first two years
- **778 new units** of supportive housing for singles and families under development
- **Rental housing support** to over 4,000 rent- burdened families
- **Street-to-Home** Initiative moved 155 people directly from the street into permanent housing
- **141 permanent housing units** for homeless veterans
- **Housing for homeless people** discharged from hospitals through the Council-recognized Housing to Health Partnership
- **700 households** consisting of women and children provided with rental support and homeless services in the new permanent housing with short-term support model
- **Interim housing and supportive services** program serving 200 homeless youth annually
- **Total of \$4.5 million** annually for homeless prevention
- **Homelessness Prevention Call Center** to centralize access to homelessness prevention resources



WHO IS THE INNOVATOR?

The **City of Chicago**, through its strategic development of a jurisdictionally led, community based, results oriented plan to end homelessness that has been adopted and reported on by the Mayor, is achieving results that benefit everyone in Chicago, housed and homeless alike. Housing Commissioner Ellen Sahli oversees implementation collaboratively with the Chicago Alliance to End Homelessness and other community- based organizations. The Housing Commissioner directs initiatives that include creating and preserving SRO and supportive housing units and provides leadership on policies and programs affecting overall supportive housing development, including family housing and foster care initiatives.

Chicago's Alliance to End Homelessness is a new independent non-profit created through the strategic merger of two entities with central roles in advancing Plan implementation - the Partnership to End Homelessness and the Continuum of Care - to bring best practices, system coordination and evaluation initiatives to the 10 Year Plan, manage investment resources from state and federal government, advance policies to address barriers, and increase public support for the Plan. The creation of the Alliance partnered key stakeholders in ending homelessness: service providers, philanthropic leaders, the research community, and consumers. Nancy Radner is Chief Executive Officer of the Alliance. Before becoming CEO of the Alliance, she served as Executive Director of the Partnership to End Homelessness.



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Learn more about the Chicago Alliance's [Mapping Project](#).

Learn more about the [Chicago Alliance](#):
Chicago Alliance to End Homelessness
205 W. Wacker, Suite 1321
Chicago, Illinois 60606
Phone: 312-223-9870
Email: info@thechicagoalliance.org

Learn more about the [Chicago 10 Year Plan](#).

Learn more about the Chicago [10 Year Plan Progress Report](#).

Learn more about [the City of Chicago's housing and homelessness initiatives](#).

Innovation Number 13

Improving outcomes, reducing recidivism, and cutting costs: King County Jail initiative for veterans

- King County, Washington partners to reduce recidivism and improve outcomes for incarcerated veterans through an intervention that moves from booking, to diversion and discharge, to employment, housing, and stabilization.
- The incarcerated veterans project returns cost savings on average of over \$550,000 annually, ending costly random ricocheting in law enforcement, health care, and treatment systems.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Partnership and collaboration are central to achieving cost savings, improved individual and community outcomes, and reduced recidivism in a King County jail initiative targeted to veterans. The King County, Washington initiative for incarcerated veterans demonstrates how to use the jail setting - where there are challenges to interventions given higher rates of turnover and shorter sentences - to identify and divert veterans onto a path to successful reentry. The project provides less expensive alternatives to jail, has demonstrated success in reducing recidivism, and provides the opportunity for each veteran to stabilize in the community.

Jail staff identifies veterans during the booking process, and fliers are also posted in jail units informing veterans of the services available. Project staff research an individual's booking and criminal history and conduct an assessment. The assessment determines eligibility to be enrolled, identifies barriers that have hindered the veteran's reentry previously, highlights assets and skills, projects steps for effective case management, and maximizes awareness of federal, state, and local programs and benefits for veterans and family members. This initial contact concentrates primarily on court advocacy (early release or sentence reduction), securing treatment, and identifying employment, housing, and other services needed on release to the community.

Incarcerated veterans who enroll typically are in jail for possession or sale of drugs; DUI/public intoxication; domestic violence; shoplifting; and/or public nuisance. Many have histories of homelessness and have held multiple short-term jobs since leaving the military, or been unemployed. Many have also had multiple failed attempts with drug or alcohol treatment programs. Untreated mental illness and Post-Traumatic Stress Disorder (PTSD) are common.

Upon release, staff assist the veteran with an array of stabilization and other services, such as emergency financial assistance, mental health/trauma counseling, employment and skills training assistance, temporary housing, advocacy, and other referral services.

Once stable, the veteran begins work readiness and employment assistance services. When the veteran has secured full-time employment and is ready for independent living, long-term housing is the goal - using any financial assistance to which the veteran is entitled and available housing programs for which the veteran is eligible. Case management at this stage has specific time limits for each veteran to address barriers and meet specific requirements of the case plan in order to help ensure success.

WHO BENEFITS FROM THE INNOVATION?

Homeless veterans benefit from jail diversion, access to treatment and health care, housing and job opportunities, and the resources to address barriers and challenges to stability in the community.

State and County systems benefit from partnership with resource providers who can help divert and stabilize potentially recidivating individuals into a positive trajectory in the community.

Taxpayers benefit from cost savings resulting from reduced length of stay in jail and decreased recidivism in the corrections system, as well as use of treatment and service resources that promote recovery in the community and reduce chronic homelessness. Ending the random ricocheting of veterans between streets and shelters, jail, treatment, and other systems benefits everyone in the community, housed and homeless alike.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

The King County intervention for incarcerated veterans has:

- **Reduced the number of episodes and duration of incarcerations by participating veterans**
- **Reduced recidivism of veterans to the jail system**
- **Increased the number of veterans who become employed and secure a stable living environment**

King County data for 2006 show that, over the lifetime of the program (1998 - 2005), there has been an average annual savings to taxpayers of \$550,791. The average annual recidivism rate in the program is 16.6% versus the general recidivism rate for King County of 57.7%.

- Total 2006 enrollment in the program = 250

- 100 housing placements
- 35 individuals housed for more than 30 days
- 49 employment placements
- 34 individuals employed for more than 30 days
- 43 PTSD referrals to the VA Medical Center
- 93 discharge upgrades
- Early release days for King County = 5,942
- Early release savings = \$546,664
- 2006 recidivism rate = 9.6%

The program currently is being replicated in Tacoma and Vancouver, WA.

WHO IS THE INNOVATOR?

King County Corrections works closely with the King County Veterans Program (KCVP) - within the Department of Community and Human Services, Community Services Division - the King County Court System and Prosecutors' Office, the Washington Department of Veterans Affairs (WDVA), Addictions Treatment Center at the Veterans Affairs Medical Center in Seattle, and a variety of public and private agencies, including the U.S. Department of Veterans Affairs.

Also in King County, voters passed the Veterans and Human Services Levy in November 2005 to generate resources for veterans, military personnel and their families and other individuals and families in need through a variety of housing and supportive services. The levy allocates approximately \$13.3 million per year for six years to implement human services for veterans, their families, and other low-income residents of King County. One half of these revenues are targeted for veterans and their families, and the remaining half is dedicated to other King County residents in need of human services. The levy remains in effect until 2011.

Half of the revenue raised funds services for veterans, military personnel and their families, including services specific to veterans' needs such as PTSD treatment. The balance funds regional health and human services, including housing, homelessness prevention, mental health and substance abuse services and employment assistance.

A Veterans and Human Services Levy implementation ordinance received approval by the King County Council on April 10, 2006. The levy ordinance identified three goal areas for service enhancements and funding allocations: reduce homelessness and emergency medical costs; reduce criminal justice system involvement; and increase self-sufficiency by means of employment.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Learn more about the King County initiative by visiting the [web site](#).

Learn more about the [Washington State Department of Veterans Affairs](#) initiatives.

Learn more about [Incarcerated Veteran Re-Entry Specialists](#), who operate in the VA medical system which is organized into 22 geographic networks known as Veterans Integrated Service Networks, or VISNs. VHA has allocated an an Incarcerated Veterans Re-Entry Specialist to each VISN who is the VA regional point of contact and also provide outreach and assessment services to incarcerated veterans.

Learn more about VA's [Healthcare for Re-Entry Veterans \(HCRV\)](#), a program designed to address the community re- entry needs of incarcerated veterans. HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community re-adjustment, and decrease the likelihood of re-incarceration for those leaving prison. HCRV services include: outreach and pre-release assessments services; referrals and linkages to medical, psychiatric, and social services, including employment services; and short term case management assistance.

Learn about VA's [state guides](#) for incarcerated veterans to identify services and community contacts.

Learn about the [U.S. Department of Labor's](#) programs for veterans.

Learn about resources for homeless veterans at the [U.S. Interagency Council on Homelessness'](#) veterans resource web page.

Innovation Number 14

St. Paul Police Department partners for housing solutions to chronic homelessness

- A police-homeless outreach partnership in St Paul/Ramsey County creates tenancies for men and women experiencing chronic homelessness who have been living on downtown streets, in encampments, and in abandoned buildings.
- Pilot funding came from the Minnesota Department of Public Safety, in collaboration with Ending Long-Term Homelessness Advisory Council and the Minnesota Department of Human Services Office of Economic Opportunity, which has extended its investment through 2009.

Read on to learn more . . .



WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Police officers working the St. Paul "downtown beat" and responding to encampments and abandoned buildings are creating housing opportunities for men and women experiencing long term homelessness, using 30 state rental vouchers for the Police-Homeless Outreach Program (P-HOP).

P-HOP began in 2005 as one of three pilot homeless outreach projects funded by the Minnesota Department of Public Safety (DPS). South Metro Homeless Services, a non-profit in St. Paul/Ramsey County applied to DPS at the request of the St. Paul Police Department. With the new grant, South Metro added an outreach worker to its ACCESS team and co-located the worker in a police sub-station to work directly with police officers to improve outcomes from repeated police encounters with individuals who are homeless. Outreach worker Bret Byfield is working with "Downtown Beat" officer Sgt. Paul Paulos and Code Enforcement Officer Dean Koehnen to promote cross training, secure treatment and housing opportunities for individuals who are experiencing long term homelessness, and enhance police and community dialogue through a "police-provider forum" and monthly breakfast meetings between police officers and other members of the criminal justice system.

Recognizing that many of the persons they routinely encountered have poor rental histories, criminal records, and/or substance abuse histories that exclude them from housing opportunities, one P-HOP focus has been on developing relationships with landlords to facilitate housing access. The team has demonstrated resilience in dealing with the loss of housing units as landlord circumstances change. One loss involved 23 individuals living in shared housing in three buildings that had been accessed through one participating landlord. Alternate housing was located within 30 days using a variety of community resources nurtured through the P-HOP program and included 8 persons who were able to be housed through the P-HOP rental voucher initiative.

The rental voucher initiative was a successful application to the Minnesota Housing Finance Agency "Long Term Homeless Rental Assistance Program" by South Metro Human Resources, which had secured 30 vouchers for a unique collaboration in which the vouchers would be administered by South Metro but would only be available for persons experiencing long term homelessness and referred by police officers through the P-HOP program. To date, 20 such individuals have been identified and referred by the officers and have received vouchers. One man in his 60s had a cancer diagnosis, was without income for housing and medicine, and had been living in an encampment for two years. Since the voucher resources from the MHFA come "without services attached," case management is provided by four staff from South Metro Human Services' PATH program in collaboration with P-HOP coordinator Byfield.

WHO BENEFITS FROM THE INNOVATION?

Men and women experiencing long term homelessness and living on St. Paul's downtown streets, in encampments, and abandoned buildings are being assisted off the streets into permanent housing and connected to community services.

"New pathways of trust and communication" have been opened between the **police and persons living on the downtown streets** and in encampments. St. Paul/Ramsey County

10-Year Plan "Heading Home Ramsey" Coordinator Carol Zierman describes the commitment of the police officers to helping persons off the streets into housing through the P-HOP effort as having a "transforming" impact for many individuals who previously viewed the police only as "adversaries."

The **St. Paul community** is benefiting from reduced costs in detoxification and re-arrests and increased stability for persons who had been homeless long term and living with disabilities.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

20 men and women living long term on the streets, or in encampments and abandoned buildings have been housed using the MHFA rental vouchers. All but one remain currently housed.

Ramsey County Detox Director Peter Bieri reports a notable decline in the number of repeat visits to detox from the P-HOP effort: " Detox used to be 50% of the same chronics - now it is down to about 15% chronic return. It saves money and it saves people."

A November 2007 Report to the Minnesota Legislature on the Homeless Pilot Project Grants reported that the P-HOP program has been approved for a second two-year grant of \$98,000 to continue the program till 2009. During the initial 2-year funding, the three pilot projects - which included People Incorporated in Hennepin County and Churches United Ministry in St. Louis County - collectively served 354 persons experiencing homelessness, including more than 80% identified as long term homeless. Of the 218 actively receiving services at the end of the funding period, 65 percent had obtained stable housing. Additional services offered by the programs included access to benefits, medical care, substance abuse and mental health treatment, and case management. Other report findings:

- Data collected from the Bureau of Criminal Apprehension (BCA) illustrates a decrease in arrests for program participants. Prior to entering the program, 87 percent of program participants had been arrested at least once as compared to 33 percent who have been arrested one or more times since entering the program.
- Detoxification center admissions data showed that 70 percent of program participants had one or more admissions to detox previously versus 45 percent with one or more admissions during the program.

WHO IS THE INNOVATOR?

At the request of the St. Paul Police Department, South Metro Human Services, a non-profit organization in St. Paul, applied for and received \$82,000 to create a Police-Homeless Outreach Program (P-HOP) as one of three Homeless Pilot Projects funded by the Minnesota Department of Public Safety in 2005. The purpose of these 2-year pilot project grants was to "reduce the use of public safety and correctional resources in response to the community of

homeless; promote stronger communities through street and shelter outreach; connect people experiencing homelessness with housing and services; and develop cooperative, collaborative relationships with local police departments."

The state funds, including a \$5000 match from the City of St. Paul, allowed South Metro Human Services to hire an additional outreach worker for their ACCESS team to develop an active, ongoing collaboration with the St. Paul Police Department to respond more effectively to issues arising from encounters between the police and persons experiencing homelessness. Outreach worker Bret Byfield acts as the overall coordinator for the P-HOP effort and works closely with Sgt. Paul Paulos of the "downtown beat" and Code Enforcement Officer Dean Koehnen on encampment and abandoned buildings issues. Officer Koehnen was recognized by the U.S. Interagency Council on Homelessness in 2007 with a "Home for Every American" award for innovation for his work.

In addition to their direct outreach and engagement work, the P-HOP team are founding members of a Police-Provider Forum which meets regularly to air issues. St. Paul Police Chief John Harrington and Listening House Director Rosemarie Rumsey received the Minnesota Housing Finance Agency 2006 "Leadership to End Long Term Homelessness" award.

The P-HOP team also meets regularly with other members of the criminal justice community, including the Ramsey County Mental Health Court.



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about P-HOP, contact P-HOP Coordinator Bret Byfield at South Metro Human Services:

400 Sibley Street, Suite 500
St. Paul, MN 55101
Phone: 651-291-1979

To learn more about Heading Home Ramsey, contact the City and County 10- Year Plan Coordinator, Carol Zierman:

Phone: 651-266-8004

To learn more about the [Homeless Pilot Project Grants](#), read the Report to the Minnesota Legislature.

Innovation Number 15

Creating Housing, Closing Shelters, Ending Homelessness: Transforming policy and practice in one community agency in Massachusetts

- South Middlesex Opportunity Council (SMOC) commits to a conversion strategy for its agency mission and resources with a goal of closing its emergency shelters in two years and transforming its agency-wide policy and practice to housing- focused solutions
- Top-to-bottom reexamination of resources and results impacts points of entry, operating philosophy, data collection, and housing and employment goals

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

In June 2006, the South Middlesex Opportunity Council (SMOC) publicly announced a fundamental change in the agency's mission for people who experience homelessness: SMOC would phase out its emergency shelters over two years and shift its resources and focus to permanent supportive housing. SMOC's conversion strategy was laid out in its new plan, *Ending Homelessness for Single Adults in the MetroWest Region of the Commonwealth of Massachusetts*, which called for a transformation in agency policy and practice, with a Board and staff commitment to place individuals experiencing homelessness in permanent housing, not shelter.

The planned transformation included addressing the history at the heart of SMOC's initiatives: as an agency, SMOC embraced sobriety and abstinence from drugs and alcohol. In addition, the vast network of SMOC's own resources as a Community Action Program had evolved over time with multiple points of entry and gaps in internal integration.

Each phase of the planned conversion was to be marked with the closing of a shelter or the conversion of shelter to supported housing. Phase One would launch a new service delivery system and the conversion from a shelter-to-housing approach for shelter "graduates" to a housing-focused model of homeless prevention, triage, and rapid re-housing. At the heart of the new system is the Common Ground Resource Center which opened as the Common Ground Shelter, a facility of last resort for many, was closed. Now serving as the hub for the housing network in the MetroWest region, the Resource Center is staffed by an interdisciplinary team of resource providers with an integrated use of data and technology to facilitate client flow and outcome monitoring.

From services and support at the new resource center funded by MetroWest Community Healthcare Foundation (providing intake, screening assessment, homeless diversion stabilization, and services by professional staff with expertise in case management, employment, housing placement, behavioral health, and primary care), some people avoid homelessness altogether or receive assistance to return to their "home community." Others receive an immediate referral for detoxification services or medical or psychiatric

hospitalization. Still others, depending on history, income, addiction, mental health and other variables, may be able to go directly into a sober, affordable, or transitional residential program. Those who are not immediately placed may become guests in a 20-bed, 10-day emergency placement facility for further assessment and determination of needs.

Additional housing options and resources, coupled with access to treatment and an economic development plan that puts people to work immediately are the other critical elements for rapid re-housing. Integrated throughout the model is a system of evaluation and an integration of evidence-based practices, with outcomes measured at various points in the system.

Key to the transformation plan was the specific outlining of resources and policy and contract changes needed to support the conversion. The details included: pilot prevention funding, amendments to existing public contracts to support the conversion strategy, strategies for housing and service integration, expansion of treatment options and resources for specific populations (such as youth), and new partnership initiatives with business and civic leaders.



WHO BENEFITS FROM THE INNOVATION?

At the outset, SMOC predicted that the benefits of the new strategy would include the local community, clients, and the entire Commonwealth of Massachusetts. SMOC expected that the primary and most obvious benefit to the community would be the closing of the downtown shelter. The plan would also reduce the utilization of expensive systems of care including hospitals. SMOC also predicted that the Commonwealth would benefit when the agency showed leadership in a national movement to end homelessness, creating a model that is measurable and replicable.

SMOC clients have more dignity through securing housing, and economic development and self-sufficiency are increased.

People who experience chronic homelessness in MetroWest now move much more quickly into housing with the support services they need and with the opportunity to rejoin the workforce.

Staff of SMOC Homeless Services are re-committed and energized as they see the individuals they are working with move into permanent housing.

Public and private sector policymakers and investors are seeing reductions in the overall costs to move people into permanent housing with services (*Home and Healthy for Good Progress Report*, March 2008).



WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

The results of the implementation of *Ending Homelessness for Single Adults in the MetroWest Region of the Commonwealth of Massachusetts* to date are:

The Common Ground Shelter was closed. Homelessness in the MetroWest region has been reduced by 60%. SMOC opened its Housing Resource Center, including 3 new staff positions funded by the MetroWest Community Healthcare Foundation.

Each individual that is referred or walks in for services goes at the new center through an assessment process.

- 1,421 people were assessed through the Resource Center.
- 25% were moved directly into housing.
- 22% were diverted from emergency shelter to the most appropriate housing resource.
- 40% were referred for emergency housing placement.

At SMOC's new emergency placement program, the average length of stay dropped from 90 days to 30 days. Of those that went into emergency placement, 45% moved into permanent housing, and 20% went to an appropriate treatment facility.

SMOC has added 47 units of housing for chronically homeless individuals in MetroWest through additional subsidies from Massachusetts' *Home and Healthy for Good* program.

SMOC opened Ready, Willing, and Able (RWA), a temporary labor program. The program employs people on a temporary basis to move them into permanent employment. RWA is fully integrated with SMOC's shelter, housing, and behavioral health programs. RWA is often a "first step" employment program that allows people the opportunity to engage (or re-engage) with the workplace. It also helps people maintain tenancy by providing a chance to earn income. Currently, the program has one director that screens, interviews, and hires applicants; markets, establishes, and maintains relationships with local employers.

Ready, Willing, and Able screened 157 people from October 2007 to March 2008. Of those, 101 are eligible to work with the program and of the 101, 17 have been employed.

Understanding the prevalence and impact of trauma on people seeking services, SMOC has adopted the principles to become a trauma-informed agency.

Based on its results to date, SMOC has now embarked on a similar transformative initiative in its work with homeless and at risk families.



WHO IS THE INNOVATOR?

South Middlesex Opportunity Council (SMOC), headquartered in Framingham, Massachusetts is a comprehensive Community Action Program founded over 40 years ago. Under the leadership of Executive Director Jim Cuddy, SMOC partners in the community and across the state to provide housing, employment and training, food and nutrition programs, treatment, child care and Head Start, reentry services, and more for low income, working, and homeless people. CEO Cuddy is Board Chair of the Massachusetts Housing and Shelter Alliance, lead agency of the *Home and Healthy for Good* initiative.

Starting in the late 1980s, SMOC began to acquire many former nursing homes and boarding houses and convert them into single-room-occupancy housing for people experiencing homelessness. To finance housing initiatives, SMOC relies on conventional first mortgages through community banks and the Federal Home Loan Bank of Boston Affordable Housing Program (AHP) grants and advances.

WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the results of Phase One of the conversion, read SMOC's [outcome report](#).

To learn more about South Middlesex Opportunity Council (SMOC), visit their [web site](#) or contact them at:

300 Howard Street
Framingham, MA 01702
Phone: 508- 620-2300

To learn more about the *Home and Healthy for Good* initiative in Massachusetts, visit the [Massachusetts Housing and Shelter Alliance](#) web site.

Innovation Number 16

Innovating the Innovation of Project Homeless Connect: Video sharing and social networking "show" results in ending homelessness

- Project Homeless Connect partners around the country are using video sharing websites to distribute short videos of their one-day, one-stop engagement events, offering a visual image of the experiences of both volunteers and consumers, demonstrating real-life results from on-site, and helping promote volunteer participation in ending homelessness.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Video sharing on-line shows the spirit and results from Project Homeless Connect partners around the country .

Social networking is all about making connections among individuals more visible and creating further opportunities for engagement. Project Homeless Connect, the now internationally-

adopted, one-day, one-stop engagement innovation for people experiencing homelessness, is also about creating new relationships between neighbors - housed and homeless - and providing needed access and supports to end homelessness, ranging from quality of life resources such as haircuts and clothing, to housing placement and jobs, and offering opportunities for engagement of volunteers from all walks of life.

So it's no surprise that, just three years into the widespread adoption in more than 170 U.S., Canadian, and Australian cities of the Project Homeless Connect innovation through its encouragement by the United States Interagency Council on Homelessness, on-line video sharing of local events has become a tool for both recruiting and reporting, adding an important layer of information and insight to other established supports, such as pilgrimages to Project Homeless Connect events in other cities, dedicated web sites, and Council peer-to-peer events, toolkits, and technical assistance activities.

Video sharing is also a smart step in developing a hybrid strategy to engage all partners in the community by changing "how we do business" in addressing homelessness - applying emerging strategies to new goals. Any business promoting a product would develop an appropriate and even unique distribution strategy to reach potential consumers, and video sharing is among the most contemporary.

On-line content currently available about Project Homeless Connect events includes interviews with event organizers, consumers, and resource providers, as well as focused pieces featuring specific resources, such as bike repair (always popular at Project Homeless Connect events).



WHO BENEFITS FROM THE INNOVATION?

Partners in cities which have convened Project Homeless Connect events benefit from seeing a visual record of their success, and have a chance to view other events from around the country to access new ideas.

Partners planning a Project Homeless Connect event benefit from having an authentic image of what Connect looks and sounds like, as consumers and resource providers are interviewed about their experiences and results.

Community partners who have not connected with the innovation benefit by finding video on line and learning about Project Homeless Connect and the opportunity to welcome their homeless neighbors into the community.



WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

In this **20 in 20** issue, we've profiled just five of the available videos in order to offer a sense of what's been done around the country. All offer a view into what event sites look like, and highlight the important "mobile hospitality" of volunteers and guest escorts. While a number

of cities have created videos on their events, we have focused here on several videos posted to mainstream video sharing sites, where they may be more widely viewed by a broader audience than on dedicated web sites.

Springfield, Massachusetts, has a Project Homeless Connect event scheduled for June 6 at the Mass Mutual Center, and its video is a strong recruiting tool for volunteers. Pastor Greg Dyson, leading the charge for the upcoming event, has captured the goals for consumers in his outreach materials: Expect refreshments all day long, and expect to receive real help and achieve real results, develop a life assessment and set real world goals, receive personal care, enjoy live music and local entertainment, receive help for your body, mind, and spirit - Expect Change!

San Francisco, the pioneer city in innovating Project Homeless Connect, features organizer Judith Klain and one consumer describing the movement through San Francisco's services with the aide of escorts. Several of San Francisco's corporate partners - including salesforce.com which manages Connect data - and Levi Strauss and Xerox describe their involvement. Other features are the benefits one-stop area, ID station, and Café Connect, the meal site staffed by volunteer waiters, who assist guests seated at fully dressed tables with centerpieces.

Eugene and Lane County, Oregon's video depicts a consumer seeking a haircut and a meal - two key resources for events - and interviews a Eugene Police Department official who is taking part.

Louisville, Kentucky's event - supported by and participated in by Kentucky Housing Corporation, interviews Louisville Metro Housing and Health Department officials on site, noting the role that their participation in the U.S. Interagency Council on Homelessness-National League of Cities 2006 Project Connect webinar played in their organizing of the event. Organizers describe how triage tables are used to move guests rapidly through points of entry, and how local public transit was enlisted to help consumers "connect."

Portland, Oregon has a very brief 2007 video that focuses on bicycle repair services, which are always popular at Project Homeless Connect. The video reports on bikes, strollers, and wheelchairs repaired, as well as hundreds of bike helmets distributed to consumers. Portland's Create-a-Commuter program, which distributes bikes to low income adults, also was on site and registered over 80 interested users.



WHO IS THE INNOVATOR?

"Results are infectious," business thinker Jim Collins of "Good to Great" tells us. Communities of all sizes across the country - and now across our borders and across the ocean - have adopted the innovation of Project Homeless Connect to welcome their homeless neighbors into the "living room" of the community.

More than 170 cities over the last four years have mobilized civic will to end homelessness, using the technology first pioneered by San Francisco, the model of veterans Stand Downs, and community response to Katrina evacuees. Innovation continues to emerge from Project Homeless Connect planning, partnership, implementation, and follow-up.



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

While there are a number of on-line sites featuring Project Homeless Connect content, below are several videos that show a range of event details and interview a variety of partners and consumers.

Watch the video for the upcoming [Springfield, Massachusetts](#) Project Homeless Connect on June 6.

Watch [San Francisco's](#) video of Project Homeless Connect.

Watch [Eugene and Lane County, Oregon's](#) event.

Watch the video from [Kentucky Housing Corporation](#), which supported Louisville, Kentucky's 2007 event.

Watch [Portland, Oregon's](#) bicycle repair services at Project Homeless Connect.

Has your Project Homeless Connect event innovated to benefit consumers? Send a short description of your innovation to the Council, and we might use it in an upcoming feature.

If you are interested in learning more about the Interagency Council's upcoming technical assistance activities for Project Homeless Connect - including support for 2008 National Week cities - send an email to nphc@usich.gov

To read the Interagency Council's [Project Homeless Connect Toolkit](#), visit our web site.

If your community is planning to partner in the 2008 National Project Homeless Connect Week - December 1-7, 2008 - be sure to contact us at nphc@usich.gov so you receive all National Week updates.

Innovation Number 17

**Researching Risk,
Ending Homelessness:
A replicable strategy targets the most vulnerable and
disabled people living on the streets**

- The Vulnerability Index is a research and data driven tool that is consumer centric, housing focused, and replicable, demonstrating results in ending homelessness for the most vulnerable and disabled people living long term on the streets.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Using research data that identifies the most vulnerable and disabled people living on the streets, a replicable street-based strategy targets individuals for housing interventions.

Problem: Translate available research on health conditions that disproportionately lead to death for people living long term on the streets to a tool that can identify and target those most at risk for priority intervention and move them from homelessness to housing, thus closing the gap between knowledge and practice and demonstrating positive results on the streets and in the lives of those experiencing chronic homelessness.

Solution: The Vulnerability Index employed by Common Ground's Street to Home engagement initiative converts more than a decade of research and results to a format that surveys, captures, and measures "medical vulnerability" and creates a numbered registry of individuals for housing priority based on mortality risk and length of homelessness.

A fundamental dilemma for preventive strategies is identifying specific indicators before the fact to profile those for whom a given intervention can be subsequently documented to prevent the possible alternative outcome. Identifying the factors, the population, and the solution with specificity aids in targeting scarce resources to the greatest demonstrated effect.

The Vulnerability Index as developed by Street to Home is applied as a street-level survey, intended to change strategies addressing street homelessness and reduce deaths. Based on research by Dr. James O'Connell of Boston Healthcare for the Homeless, Street to Home categorized as "high risk" those individuals who have been homeless for at least six months with one or more of the following characteristics: more than three hospitalizations or emergency room visits in a year; more than three emergency room visits in the previous three months; aged 60 or older with cirrhosis of the liver, end-stage renal disease, history of frostbite, immersion/trench foot, or hypothermia, HIV+/AIDS, or tri-morbidity of co-occurring psychiatric, substance abuse, and chronic medical conditions.

Street to Home then conducts a three-night survey in the early morning hours using the index in a specified geographic area, canvassing to identify and interview people routinely sleeping on the streets, and generating a registry based on their responses to the list of characteristics named above. The registry results in a prioritized housing list which acts as an action plan for the Street to Home team.

WHO BENEFITS FROM THE INNOVATION?

Individuals living long term on the streets with disabilities and other serious health conditions benefit from a goal of solving - not servicing - their homelessness, by being engaged with a housing solution to end their homelessness, rather than by having their homelessness serviced on the street.

The community benefits by the highlighting of serious health issues among a vulnerable population that are now the focus of results-oriented intervention and the antidote of housing to end homelessness, rather than a continuation of random ricocheting of an expensive population through emergency and acute public systems of care and treatment.

Public systems of care and treatment benefit by reducing the costly impact of frequent users through the antidote of housing that ends homelessness, and housing and service agencies benefit by a data-driven plan to organize resources, supports, and housing for vulnerable individuals.

Communities not currently engaged in targeted strategies to end chronic homelessness can observe a results-oriented trajectory that provides an identifiable starting point for engagement and intervention that is both compassionate and cost effective for the community.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

Common Ground's Street to Home initiative has reported the following results from employing the Vulnerability Index in sites around the country where it is working currently. The Street to Home strategy is also at work in Canada and Australia.


In New York's Times Square, the Street to Home partnership of Common Ground Community and the Times Square Alliance reduced homelessness in a 20-block area by 87% over two years. In Brooklyn and Queens, over 300 individuals sleeping on the streets have been surveyed. The City of New York has adopted Street to Home as the citywide strategy to reduce street homelessness.

Los Angeles County, Santa Monica, and New Orleans have all used a version of the survey to promote rapid response and housing results. Los Angeles County has placed 27 of the 50 most vulnerable persons on Skid Row directly into housing, with an average time from initial contact to housing placement of less than 14 days.

Santa Monica has moved 10 of the 110 most vulnerable persons into housing, and the City Council has pledged support for all 110.

UNITY of Greater New Orleans used the survey results to secure emergency housing funds initially for the 41 people identified as most at risk, and subsequently for a total of more than 50 of 150 individuals surveyed.

WHO IS THE INNOVATOR?



Dr. James O'Connell, President of Boston Health Care for the Homeless, has been researching risk factors for death among people who are chronically homeless for over a decade. With his research colleagues, he has examined the profile of those homeless individuals who were more likely to die than their counterparts in the general population, and what factors other than their homelessness were associated with their high risk of death.

In 1999, Dr. O'Connell presented to a Massachusetts Housing and Shelter Alliance -U.S. Department of Health and Human Services conference on discharge planning the findings from his Massachusetts Department of Public Health funded morbidity review of the records and recent treatment contacts of 13 people who were homeless who had died on downtown Boston streets in a matter of months. In 2006, Dr. O'Connell acted as expert faculty for a meeting of jurisdictional leaders convened jointly by the U.S. Interagency Council on Homelessness, Common Ground, and the Rockefeller Foundation to examine city data practices in tracking deaths of people who are homeless.

The **Street to Home initiative** of New York City's Common Ground, under the leadership of founder and President Rosanne Haggerty and Innovations Director Becky Kanis, incorporates strategic targeting of individuals and intensive followup modeled on the successful approach used in the United Kingdom's Rough Sleepers Initiative. The Rough Sleepers Initiative achieved a 75% reduction in street homelessness across England and prompted deeper investment in homelessness from Parliament.

Street to Home replaced the random "first come, first served" approach with a targeted, strategic process: identify and prioritize the most vulnerable individuals on the street, assess and negotiate housing options with them, then house those individuals quickly and support their tenancies with services. Those are three key elements of Street to Home's initiative with the Times Square Alliance. The strategy has reduced homelessness in the area by 87% over two years. A simple tracking tool enables workers to differentiate between those who are consistently in the targeted area - "anchors" - and those who are transients. The role of "anchor" individuals in street homelessness was identified in the Rough Sleepers Initiative, with subsequent targeting of those individuals yielding greater success - a tipping point - in engaging and moving individuals in the surrounding area.



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Read the research of [Dr. James O'Connell](#) and his colleagues on street deaths.

Read more about [Boston Health Care for the Homeless'](#) research on chronic homelessness and frequent users of care.

Contact Dr. O'Connell at BHCHP:
729 Massachusetts Avenue
Boston MA 02118
Phone: 857-654-1000

Read more about Common Ground's [Street to Home Initiative](#).

Contact Innovations Director Becky Kanis at Common Ground:
Phone: 212-389-9300
E-mail: info@commonground.org

Innovation Number 18

Put on Your Traveling Shoes: Make a pilgrimage to see what's working

- "Pilgrimage" is an innovation that brings policymakers and practitioners closer to the results they are seeking as they focus on preventing and ending homelessness.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

"Pilgrimage" is a national innovation that has emerged as a key research ingredient in identifying and adopting results oriented solutions to prevent and end homelessness.

Since its revitalization in 2002, the United States Interagency Council on Homelessness has been committed to the rapid dissemination of innovation, identifying "what's working and what's not" to prevent and end homelessness. No longer does a policymaker or practitioner have to wait and hope that next year's conference will provide the opportunity to "bump into" a new idea. Instead, the Council actively encourages the "legitimate larceny" of evidence-based best practices through "pilgrimages" (both geographic and virtual) that support highly effective peer-to-peer exchanges focused on results.

"Results are infectious," business thinker Jim Collins of "Good to Great" tells us. And that is why pilgrimages have taken hold as a practical strategy. Today we profile examples of best practices in this national innovation of pilgrimage, from states, to 10 Year Plan cities and counties, to Community Champions, and Project Homeless Connect events.

In this issue of **20in20**, we outline both geographic and virtual pilgrimages, with examples of actual travel to working sites of innovation - such as a delegation making a visit to Denver or San Francisco or Atlanta - as well as examples of virtual journeys to gather with peers, such as a national or regional convening of Community Champions.

Pilgrimages - whether virtual or geographic - are generally self-organized and funded, with an itinerary dictated by local priorities and interests.

WHO BENEFITS FROM THE INNOVATION?

People experiencing homelessness benefit from having best practices available for the creation and allocation of resources that can prevent and end homelessness.

Jurisdictional leaders at every level of government and the private sector benefit from the first-hand opportunity to be an eyewitness to results in another community, then translating and applying the innovation to a home community.

Innovators from every sector benefit from seeing their local results translated into opportunity in other jurisdictions.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

The innovation of pilgrimage has been identified and promoted as an essential research element of developing a jurisdictional plan. 10 Year Plan cities and counties, Housing First, and Project Homeless Connect have been among the most popular focal points of pilgrims. Just a few years ago, popular pilgrimage sites were the streets of Philadelphia to see street engagement strategies under the leadership of then Deputy Managing Director Rob Hess, now New York City Commissioner of Homeless Services, and Pathways to Housing in New York City, where innovator Dr. Sam Tsemberis was modeling the evidence-based, consumer-centric Housing First technology, now spread across the nation and internationally.

Here we offer a few examples of recent popular pilgrimage destinations.

10 Year Plans.

In October 2007, Fort Worth Mayor Mike Moncrief led a 22-person Study Group of business and community leaders - who were instrumental in developing the new draft 10 Year Plan for the city - on a pilgrimage to Denver, to 1811 Eastlake in Seattle, and to Los Angeles.

In September 2007, then Los Angeles County Board of Supervisors Chair Zev Yaroslavsky also visited Denver where he met with Mayor John Hickenlooper and other key *Denver's Road Home* implementers. The Chair and Council Director Mangano toured successful Housing First programs that have reduced chronic homelessness in Denver.

St. Louis' St. Patrick Center has hosted visitors to its engagement, employment, and Housing First initiatives, including Columbia, South Carolina Mayor Bob Coble and City Councilman E.W. Cromartie.

Atlanta's Gateway Center is a centerpiece of the Atlanta Regional Blueprint. Under the leadership of Mayor Shirley Franklin and Community Champion Horace Sibley, the new center has galvanized public and private sector investment and refocused solutions in the city. Atlanta has hosted pilgrims from Birmingham, Alabama; Dallas, Texas; Charlotte, North Carolina; Raleigh, North Carolina; Napa Valley, California; Greenville, South Carolina; Orlando, Florida; Chattanooga, Tennessee; and Wichita, Kansas.

For example, Winston-Salem, North Carolina organized a pilgrimage to Atlanta in June 2007 which included Mayor Alan Joines; Chris Henson, CFO of BB&T and 10 Year Plan Commission

Chair, as well as other Commission members and service providers. Mayors Joines and Franklin met to discuss strategies for the City to back the 10 Year Plan. Visitors met with Community Champion Sibley and were interested in the Gateway Center as well as other housing strategies developed for the chronic population. While in Atlanta they also visited Hope House, a transitional substance abuse program for individuals in recovery.

Community Champions.

A "virtual pilgrimage" occurred in 2007, as Community Champions - those business and civic leaders tapped by Mayors and County Executives to lead development and implementation of a 10 Year Plan - convened to share their own best practices in creating partnerships, sustaining political will, and expanding investment in the plan. Not designed as a visit to a site, but as a practical retreat where leaders - often prominent and in demand in their own communities - could share lessons learned and emerging practices with their peers, as well as strategize about new ideas.

In 2008, Community Champions from ten New England cities met in Boston with five New England community innovators to discuss innovations in permanent supportive housing, including creating housing for homeless veterans; leveraging of private sector resources; sustaining political will; and accessing mainstream resources.

The convening benefited Community Champions, as this was their first opportunity to meet with other Community Champions from communities throughout New England to discuss what was and was not working to engage community stakeholders and leverage resources in the creation and implementation of 10 Year Plans. Community Champions dialogued with Community Innovators to bring the innovations that are leading to the result of preventing and ending homelessness back to their communities. Community Innovators benefited as they were able to converse with private sector leaders from throughout New England who are successfully leveraging new investment resources to prevent and end homelessness.

Project Homeless Connect.

By far, one of the key attractions for a wide variety of partners has been a pilgrimage to San Francisco to see Project Homeless Connect in action, providing the opportunity to learn more about the city's 10 Year Plan and other local innovations such as the city's Direct Access to Housing initiatives. On site at the innovative one-day, one-stop PHC engagement events, pilgrims could see and hear what the event had to offer, its welcoming spirit, and the commitment of its innovators and partners, starting with Mayor Gavin Newsom. Cities regularly travel to San Francisco to experience the event as they plan their own Project Homeless Connect event.

In 2005, the Interagency Council organized a national pilgrimage for cities from New York to Portland, Oregon who were interested in partnering in the first National Project Homeless Connect in December 2005. Representatives from Atlanta, Knoxville, Indianapolis, St. Louis, Portland, OR, San Diego, Los Angeles County, Santa Monica, Pasadena, Miami, San Jose, and New York were welcomed by San Francisco Mayor Gavin Newsom and Deputy Chief of Staff Alex Tourk, who organized Project Connect. City officials spent time with the group answering questions and conducting a site tour. Participants spent the day much the same way as any volunteer: they walked the streets, interviewed consumers, served meals, and acted as "shepherds" to help guests find their way to resources.

The Project Homeless Connect pilgrimage has spread, along with the adoption of the innovation in more than 170 cities across the nation and across borders. Among those attending the September 2007 North Carolina Triangle Project Homeless Connect event were

a team of representatives of U.S. Virgin Islands Governor John deJonge, Jr. who were observing the event as they planned for hosting their inaugural Virgin Islands Project Homeless Connect in November.

In Region X in the Northwest states, United States Interagency Council on Homelessness Region 10 Coordinator Paul Carlson has facilitated several visits by jurisdictional leaders, 10 Year Planners, and community leaders as a key strategy in his region to encourage "legitimate larceny" by representatives of 10 Year Plan jurisdictions in Washington, Oregon, Alaska, and Idaho to Project Homeless Connect events in Portland and other Northwest communities.

Recently in an example of a "reverse pilgrimage," outgoing Portland City Commissioner Erik Sten - who has been instrumental in the development and implementation of the Portland and Multnomah County 10 Year Plan and has been actively involved in Portland's Project Homeless Connect events for both chronically homeless individuals and for families - was invited to travel to Seattle to present to the Seattle/King County 10 Year Plan Governing Board. In just three years, Project Homeless Connect has grown from one city to being held in more than 170 communities.

State Interagency Councils on Homelessness.

State Interagency Councils also have a role to play to create virtual destinations for regional partners eager to learn from one another. In 2006, the Chairs of the New England State Interagency Councils on Homelessness from New Hampshire, Massachusetts, Vermont, and Connecticut gathered - along with the Federal members of the New England Region Federal Interagency Council on Homelessness - to brief one another as State Council peers on current state initiatives. State partners also identified Federal program areas of interest, especially those where Federal resources have an impact for state agencies. These included: SOAR initiative for SSI, HUD's mainstream permanent housing resources, prisoner re-entry, and supportive services. The presence of Federal officials helped create a regional picture of what's working in states and where Federal resources could have an impact.



WHO IS THE INNOVATOR?

A single profile defies the innovation of pilgrimage and is testimony to the widespread adoption of journeying to other jurisdictions by jurisdictional leaders from states, cities, counties, business and civic leaders, faith based and community partners, and more - to witness, to inquire, to value what is responding to the consumer, what is creating partnership, what is achieving results.
Put on your traveling shoes . . .



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

To learn more about the innovations that are preventing and ending homelessness, visit the Council's [Innovations](#) web site.

Innovation Number 19

Academia:

How many roles can a partner play in new initiatives to prevent and end homelessness?

- Academia is re-defining what it means to be a partner in preventing and ending homelessness in local communities.
- As communities cast a broad net to create the most expansive and inclusive group of stakeholders in the National Partnership that has been constellated to end homelessness, academia has answered the challenge in both new and familiar roles.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

City and county jurisdictions developing and implementing 10 Year Plans have cast a broad net to create an expansive and inclusive group of stakeholders, and academia has answered the challenge to take on both new and familiar roles in partnership.

In the same spirit that business partners have joined the planning table to partner from their expertise - not to volunteer in servicing homeless people but to partner in solving homelessness - the academic community has stepped up with new resources and commitment reflective of their assets and insights. In this **20 in 20** issue, we look at several of the diverse roles being played by colleges and universities - from the President to the student body - all with the intent of solutions to homelessness for vulnerable neighbors.

WHO BENEFITS FROM THE INNOVATION?

People experiencing homelessness benefit from the addition of expertise, volunteers, and campus resources targeted to solutions to their homelessness.

The **academic community** benefits from identifying new roles for its expertise and resources in solving homelessness, as well as using campus assets and volunteers to achieve results both for individuals and for the broader community.

Communities of all sizes benefit from new partnerships and the investment of volunteer, student, and faculty resources in ending homelessness in the community.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

Academic partnership in ending homelessness is now identified and promoted as an essential element of developing a jurisdictional 10 Year Plan, as well as in implementing and evaluating innovations, such as Housing First and Project Homeless Connect. The examples presented here - ranging from a university's commitment of targeted faculty for initiatives, to 10 Year Plan student service-learning, to long-term partnership in Project Homeless Connect, to a research paper competition on innovation - demonstrate the evolving range of commitments that have moved academic involvement and partnership from a term paper topic and student volunteer opportunity to a key resource and investment.

Research and Results: Cost Benefit Analysis and 10 Year Plans

Across the country, we're learning that the economics of homelessness, the economic impact and consequences, further solutions in the community. In more than 65 communities which have conducted cost analysis, research has shown that it is more expensive to maintain the most vulnerable and disabled people in the community in their homelessness than to end their homelessness through proven solutions. This finding drives political will and resources beyond managing, maintaining, and accommodating homelessness, to solving, to remedying our neighbor's homelessness. And what makes sense for the homeless person makes common sense for the community, and dollars and sense for elected officials and the taxpayer.

In Waco, Texas, Mayor Virginia Dupuy's Homeless Planning Committee enlisted the partnership of Baylor University to conduct cost benefit analysis in support of Waco's 10 Year Plan. The academic institution contributed insights to the plan on the use of homelessness resources in the community, as well as law enforcement and hospital costs.

Baylor examined the economic costs and benefits of using resources to alleviate "core issues" rather than investing in short-term aid. According to the study that was completed in January 2005, homelessness cost Waco an estimated \$7.6 million annually, with a percentage of this figure derived from the City budget. Waco has estimated that every chronically homeless individual costs the community approximately \$39,000 per year.

In Tacoma/Pierce County, Washington, University of Puget Sound (UPS) President Ron Thomas gave the university's support to the Tacoma/Pierce County 10 Year Plan, designating two UPS faculty from the Social Sciences department to conduct an evaluation of the local Housing First initiative.

In Indianapolis, Indiana, "Issues for Policymakers, Serving the Homeless Well could Save Taxpayer Dollars" was the title of cost analysis conducted by Indiana University, School of Public and Environmental Affairs, Center for Health Policy for the Indianapolis Blueprint. The research identified chronically homeless individuals who frequently use public services and estimated the costs associated with their care.

In Portland, Maine, the University of New England contributed its expertise to planners who published new cost benefit data early this year, identifying savings achieved by the Greater Portland area by moving individuals from chronic homelessness to stability in housing. Service costs in ambulance and emergency room use, jail nights, and police contacts were cut in half after housing placement, dropping from an average of over \$28,000 per person annually to \$14,000, as shown in research also supported by MaineHousing, Maine Department of Health and Human Services, and the Corporation for Supportive Housing.

Changing The Way We Do Business: Denver's Project Homeless Connect Partnership with Denver and Regis Universities

Denver, Colorado, which has just completed its sixth Project Homeless Connect event as a key element of *Denver's Road Home*, the city's 10 Year Plan developed by Mayor John Hickenlooper, has now partnered with the University of Denver and Regis University for half of those PHC events. Denver's most recent Connect event was May 9 with DU. More than 800 University of Denver students, staff members, faculty and community members teamed up to volunteer their time and resources as part of the annual DU Volunteer Days, the largest single-day volunteer effort at the university.

For the University of Denver, Project Homeless Connect 4 ushered in a now ongoing partnership between the University and the city. Just a few months before, the DU Provost's Annual Conference committed to form additional partnerships with the city to identify and work toward the resolution of the city's most pressing issues, including homelessness. For PHC4, researchers from the Departments of Political Science and Sociology conducted a pre- and post-survey for volunteers to measure changes in attitudes about homelessness. The pairing of guests and escorts for events has also been seen as a route to "dispelling myths and misunderstandings that prevent finding real solutions."

One of the Denver volunteer opportunities puts on-site staff from various Career Centers and Financial Aid Office at the event to answer questions that guests may have about applying for jobs and the college application process. Staff also work with guests on resume building and offer support for completing job applications.

North Carolina Student Innovation In Ending Homelessness: A 10-Year Plan Service-Learning Partnership

Three Raleigh, North Carolina, colleges combined their resources in 2004 to create an innovative service learning collaborative in support of the Raleigh 10 Year Planning process. NC State, Meredith College (an all-women's institution), and St. Augustine's College (an Historically Black College) showcased the results of their partnership at the Inter-College Conference at St. Augustine's College. Council Director Philip Mangano keynoted the event.

The service-learning tie-in was originally conceived by Dr. Liz O'Sullivan, Director of the Public Administration program at NC State and member of the 10 Year Plan Policy Committee for the Raleigh/Wake County planning initiative. In January 2004, Raleigh initiated its process and an inaugural 10 Year Plan forum was hosted by Meredith College in February. The three participating institutions then linked nine courses to the effort, across fields such as Political Science, Public Administration, Social Work, Psychology, and Criminal Justice. At St. Augustine's, Dr. Monica Porter presented to her Senior Seminar in Psychology class the situation of the impending closure of Dorothea Dix Hospital, a local mental health facility. She challenged the students to think about whether patients might fall into homelessness without proper planning. Students then directed their thesis research to some aspect of homelessness.

Students pursued research and experiential learning that could directly contribute to Raleigh's strategy. Meredith students hosted a teleconference on Civil Engagement, and NC State students conducted focus groups with consumers. St. Augustine's students researched discharge planning, nutrition, mental health services, health care, and education as they relate to homelessness. NC State initiated a new course, Community Dialogue to End Homelessness. Community speakers addressed class sessions, with speakers including representatives from the NC Department of Human Services, the City of Raleigh, Wake County, community-based service providers, advocates, and people experiencing homelessness. The speakers were video taped and broadcast to the community at large on a local cable station.

Innovating Across Borders: Canadian University Essay Contest Winners "Think Outside The Box" To End Homelessness

Today's final profile comes from across the northern border, where three student winners of an essay contest offered ideas to the City of Vancouver, British Columbia, of what's working in other cities. The Pivot Legal Society invited entries on addressing housing and homelessness in the Downtown Eastside community. Entries were judged by a panel that included Cameron Gray of the City of Vancouver Housing Department, Nick Blomley, Professor of Urban Geography at Simon Fraser University, and developer Robert Brown, founder of reSource Rethinking Building Inc.

The contest was open to students in planning, geography and political science departments of Canadian universities, and the rules were simple: "don't displace the existing community; provide high-quality accommodation; look to models from other jurisdictions; think outside the box." The judges evaluated essays for "creative thinking, the practicality of the recommendations, and whether or not the proposals drew from successful models in other jurisdictions."

Winning entries identified solutions including San Francisco's master leasing program of the Direct Access to Housing initiative, Project Homeless Connect, employment for people who are homeless in housing development, and special development bonds, among other topics.



WHO IS THE INNOVATOR?

The innovators' profile for the academic community proves the point that all elements of the learning community have a role to play in ending homelessness: institutional leadership, faculty, students, and those responsible for the physical facility.

The reverse is true as well: jurisdictions have a broad horizon to explore all the dimensions of partnership now evolving with their local learning institutions, whether as 10 Year Plan partners, research and evaluation partners, hosts of Project Homeless Connect, or sources of new learning through student initiatives.



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Learn more about the academic partnerships featured today.

Read the [Waco, Texas](#) 10 Year Plan updates.

Read the [Indianapolis](#) cost benefit analysis.

Read the [Portland, Maine](#) cost benefit analysis.

Read about the [University of Denver's partnership](#) in Project Homeless Connect.

Read more about [Raleigh and Wake County's](#) 10 Year Plan.

Read about the [Canadian](#) university students' winning essays.

Innovation Number 20

Listening to the consumer: In San Diego, how delivering what homeless veterans wanted yielded the national innovation of Homeless Courts

- Consumer preference is a key theme of Council innovations, and the voice of the consumer has recently shaped new strategies ranging from Housing First to Project Homeless Connect. Here's how the voices of homeless veterans inspired a new judicial model now in use across the nation.

Read on to learn more . . .

WHAT IS THE INNOVATION AND HOW DOES IT WORK?

Homeless veterans ask for support in addressing legal issues, and the result is an innovative judicial strategy of problem-solving, consumer-focused courts now in use across the nation.

Consumer preference is a key theme of Council innovations, and the voice of the consumer has recently shaped new strategies ranging from Housing First to Project Homeless Connect. Here's how the voices of homeless veterans inspired a new judicial model now in use across the nation.

At the conclusion of the 1988 Vietnam Veterans of San Diego inaugural Stand Down event, homeless veterans were asked to identify their greatest need. More than 20% responded by identifying their need for assistance in the criminal justice system to resolve court cases and warrants.

While many of these court issues involved misdemeanor offenses and warrants for such things as disorderly conduct, there were many barriers to individuals pursuing resolution of these issues on their own and no assurance of an outcome that would put them on a positive trajectory rather than risk fines or custody. Program staff also learned from veterans that it was lack of resources and documentation, as well as their focus on everyday survival, that prevented their participation in court proceedings, not a lack of respect for the court.

The following year, with the support of event organizers, the San Diego Superior Court convened a special court session at the Stand Down, on the handball courts, as the history is told. At that event, some 130 individuals resolved over 450 cases.

From 1989 - 1992, this new special court resolved almost 4900 cases for more than 900 individuals, eventually becoming known as the "Homeless Court Program," and expanding both to more areas and populations and eventually to the national model being replicated today. The San Diego Homeless Court Program was one of 15 finalists for the prestigious Kennedy School of Government *Innovations in American Government* award in 2004.

The Homeless Court and its partners in the process, including the local prosecutor and public defender, provide a guarantee of "no custody" and no fines and use alternative sentencing strategies to secure an individual's participation in programs and services ranging from AA to employment search and volunteer work. Individuals are essentially referred in to the court through participating shelters and homeless programs, which work with individuals to address challenges and create self-sufficiency plans. Outreach meetings with an orientation video at homeless programs help familiarize individuals with the court.

The focus is on the future of the individual who puts their name on an "Interest List" at the program, agreeing to surrender to the court and be prosecuted. A criminal records search is done, and a plea offer constructed. Then the individual appears at one of the monthly court sessions convened in a program meeting room, a setting generally familiar to the individual and far less formal than a court room. For each case, the public defender submits letters from treatment, counseling, and shelter staff as to the individual's participation and progress.

"Confront your past and look to the future" is the proviso that Vietnam Veterans of San Diego offers in describing the possibility offered by participation in Homeless Court for an individual to move from the risk of jail forward to stability and opportunity.



WHO BENEFITS FROM THE INNOVATION?

All sectors of the community benefit from the solution offered by the court. Unresolved legal issues can pose numerous barriers to applying for benefits and identification, seeking housing and employment, and more.

Individuals benefit by resolving past issues with the court system and presenting their progress report from their agency sponsor regarding program participation and self-sufficiency.

The **judicial system** benefits by providing a more accessible venue for individuals to use the courts, clearing old cases and creating greater efficiency by resolving multiple hearings for the same individuals, thus contributing to reduced demand in the court.

Community based programs benefit by having consumers with fewer barriers to a positive path and stability, due to risk of incarceration or re-arrest.

The **community at large** benefits from having individuals working to resolve judicial issues while engaging needed resources for housing, employment, treatment, and more.

WHAT RESULTS ARE BEING ACHIEVED AND REPORTED FROM THE INNOVATION?

The San Diego court meets monthly and reports that about 35-40 individuals are seen each month. Approximately 96% of all cases were resolved in a three-year period evaluated.

A 2001 San Diego Association of Governments evaluation of the court found that its benefits had exceeded expectations. "Participants reported a reduced fear of law enforcement, and collaboration was high among court personnel, the community, and the defendants." Most participants said they would not have gone to court on their own.

Evaluators also found that, while cost benefit figures would be difficult to calculate, there were underlying savings by using the Homeless Court instead of traditional judicial processes, including incarceration.

The problem-solving court model has been adopted in numerous jurisdictions, including 15 additional sites in California. The American Bar Association, through its Commission on Homelessness and Poverty, provides technical assistance for courts. In 2004 and 2006 the Commission hosted national conferences on Homeless Courts in San Diego and Alameda, California, respectively.

WHO IS THE INNOVATOR?

San Diego Public Defender Steve Binder is widely recognized for his leadership in responding first to the need for support in the judicial system identified by veterans at the San Diego Stand Down, and then for developing and spreading the innovation now known as Homeless Court. He is a past Chair of the American Bar Association Commission on Homelessness and Poverty.

Homeless Court also convenes at Stand Downs in many locations, and special problem-solving courts have convened at Project Homeless Connect. All have the same intent as the original innovator did: responding to the consumer, addressing barriers, and creating results that lead to more positive outcomes for ending homelessness and achieving stability.



WHERE CAN I LEARN MORE ABOUT THE INNOVATION?

Learn more about the San Diego County Homeless Court Program.
Contact: Steve Binder, Office of the Public Defender of San Diego County
233 A Street, Suite 500
San Diego, CA 92101
Phone: 619-338-4700

Learn more about resources to develop Homeless Courts, Stand Down Courts, and more from the American Bar Association [Commission on Homelessness and Poverty](#), including "Homeless Courts Conference Coursebook," "The Homeless Court Program: Taking the Court to the Streets," "Taking the Court to Stand Down," and "Taking the Court to Streets: A Roundtable on Homeless Courts. "

Learn more about [San Diego's 10 Year Plan](#), the unique judicial participation in the Plan, and the Plan's Judicial Systems Committee.

Learn more about San Diego's effective [Serial Inebriate Program \(SIP\)](#), a collaborative effort of law enforcement and treatment services.