A Blueprint for Ending Chronic Homelessness and Reducing Overall Homelessness in Dayton and Montgomery County, OH

2006
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Homeless Solutions Leadership Team
Work Groups

**Behavioral Health Work Group:**

Chair: Rebecca Lee, ADAMHS Human Service Levy Community Review Team
Staff: Geraldine Pegues, Manager of Community Programming,
Office of Family and Children First

Thomas Breitenbach, Premier Health Partners
Doug Craddock, Eastway Corporation
Ginni Findlay, South Community Behavioral Healthcare
Janet Housenick, Samaritan Healthcare Clinic for the Homeless
Beverly Jones-Arthur, ADAMHS for Montgomery County
Victor McCarley, Psy.D., Wright State University School of Psychology
Sue McGatha, Samaritan Behavioral Health
Tina Patterson, The Other Place, Inc.
Brenda Peters, ADAMHS Board for Montgomery County
Carol Shanahan, Shelter Policy Board
Carol Smerz, South Community Behavioral Healthcare
Tom Stricker, St. Vincent DePaul Society
Joseph Szoke, ADAMHS Board for Montgomery County

**Closing the Front Door Work Group:**

Chair: Marc Levy, President, United Way of the Greater Dayton Area
Staff: Kathy Emery, Community Affairs Manager, City of Dayton

**Adult Re-Entry Team**
Judge Walter H. Rice, Chair, U.S., District Court
Tom Brunty, Ohio Department of Rehabilitation and Corrections
Vanessa Carter, Montgomery County Common Pleas Court
Glen Dewar, Montgomery County Office of the Public Defender
Gamaliel Hartley, Southeast Priority Board
Lesle Liszak, Center for Alcohol & Drug Addiction Services
Craig Powell, PowerNet

**People Living on the Edge Team**
Bill Staler, Chair, Lutheran Social Services
Linda Allen, Montgomery County Department of Job and Family Services
Trudy Elder, The Other Place, Inc.
Debbie Ferguson, Community Action Partnership
Dan Foley, Montgomery County Clerk of Common Pleas Court
Diane Gentile, Cooper and Gentile, Co.
Joanne Hale, Sunrise Center
Key Kelbley, Salvation Army Family Shelter
Kevin Mulder, Legal Aid of Western Ohio
Closing the Front Door Work Group:
People Living on the Edge Team - continued
Rev. Robert Walker, Wesley Community Center, Inc.
Diane Welborn, Ombudsman’s Office

Youth Emancipation Team
Jane Beach, Chair, Murr, Compton, Claypoole & Macbeth
Tim Donnellan, Montgomery County Community Action Partnership
Doris Edelmann, Montgomery County Department of Job and Family Services
- Children Services Division
Kay McCarthy, Montgomery County Board of Mental Retardation and Developmental Disabilities
Cindy Minton, Daybreak, Inc.
Su-Ann Newport, ADAMHS Board
Catherine Rauch, Miami Valley Teen Coalition
Alan Thorn, Miami Valley Hospital
Georgia Wortham, Southwest Priority Board

Shortening the Stay Work Group:
Chair: Brother Ray Fitz, Ferree Professor of Social Justice, University of Dayton
Staff: Kathleen Shanahan, Director, Shelter Policy Board

Douglas Argue/Cindy Minton, Daybreak, Inc.
Donna Audette, YWCA of Dayton
Judith Barr, Samaritan Clinic for the Homeless
Jane Benner, Salvation Army Booth House
Tom Breitenbach, Premier Health Partners
Jim Butler, St. Vincent DePaul Society
Robin Hecht, Montgomery County Department of Job and Family Services
  – Children Services Division Diversion Team
Kay Kelbley, Salvation Army Family Shelter
Robert Kelley, Red Cross Emergency Housing Program
Rev. John Paddock, Christ Episcopal Church/Downtown Churches
Tina Patterson, The Other Place, Inc.
Dave Poliquin, South Park Neighborhood
Christine Pruitt, Dayton Public Schools
Richard Saphire, University of Dayton Law School/The Other Place Board
David Snipes, Montgomery County Department of Jobs and Family Services
Cindi Stevens, Target Dayton Ministries
Larry Stephens, DayMont Behavioral Health
Rev. Beth Weisbrod, United Methodist Mission Society
Sandy Williams, HelpLink/211
Homeless Solutions Leadership Team
Work Groups

Opening the Back Door Working Group:
Chair: Walt Hibner, Vice President, Oberer Thompson Companies
Staff: Roberta Longfellow, Housing Administrator, Montgomery County

**Affordable Housing**
- Lynn Coleman, MV Communities
- Mark Elma, City of Dayton
- Frank Gorman, Habitat for Humanity
- Jim Hoehn, National City Bank
- Greg Johnson, Dayton Metropolitan Housing Authority
- Buddy LaChance, CityWide Development
- Jim Martone, County Corp
- Dick McBride, St. Mary’s Development
- Maureen Pero, Downtown Dayton Partnership
- Tom Robillard, City of Kettering

**Supportive Housing**
- Cynthia Bremer, YWCA of Dayton
- Richard Brooks, Adult Parole Authority
- Doug Craddock, Eastway Corporation
- Roy Craig, PLACES, Inc.
- Gail Gordon, St. Vincent de Paul
- Jayne Jones-Smith, ADAMHS Board
- Linda Kramer, Daybreak, Inc.
- Cecelia Long, Mercy Manor
- Andrea McGriff/Natalie Harris, Miami Valley Housing Opportunities
- CME Church

Governance Subcommittee:
Chair: Doug Franklin, Publisher, Dayton Daily News
Staff: Joe Tuss, Assistant County Administrator and
       Tom Kelley, Director, Office of Family and Children First

Deborah Feldman, Montgomery County Administrator
Brother Raymond Fitz, S.M., Ph.D. (Shortening the Stay) Ferree Professor of Social Justice, University of Dayton
Walt Hibner, (Opening the Back Door) Vice President, Oberer Thompson Company
Jim Hoehn, President and CEO, Southwest Region, National City Bank
Greg Johnson, Director, Dayton Metropolitan Housing Authority
Rebecca Lee, (Behavioral Health) ADAMHS Human Services Levy Community Review Team Chair
Marc Levy, (Closing the Front Door) President, United Way of the Greater Dayton Area
Alice O. McCollum, Judge, Montgomery County Probate Court
Maureen Pero, President, Downtown Dayton Partnership
Dr. Judith W. Woll, CEO & Medical Director, Community Blood Center
The Community’s Response to Homelessness

In Dayton & Montgomery County
Background

- The Partnership, a coalition of major funders, was formed in 1974 to provide human services-focused research and planning
  - ADAMHS
  - City of Dayton
  - Mont. County
  - MVRPC
  - United Way
  - The Dayton Foundation

- Sheltering the Homeless: A Profile and Plan for Montgomery County, OH, published in Dec. 1985, focused attention on homelessness as a community issue
Shelter Policy Board

- Shelter Policy Board (SPB) was created in 1986 to provide a policy-level umbrella to the direct service organizations that make up the Emergency Housing Coalition.

- SPB members include representatives from:
  - governmental jurisdictions
  - service providers
  - business community
  - faith community
  - advocacy groups
Role of Shelter Policy Board

- Oversee the community’s CofC process
- Maintain ongoing strategic planning process for homeless issues
- Advocate for a coordinated, community-wide system of homeless services
- Advocate for the development of affordable low income housing in the region
- Manage implementation of the HMIS (homeless management information system)
- Explore ways to prevent homelessness
Continuum of Care

- The Continuum of Care (CofC) is a community planning and priority setting process.
  - Who are the homeless in our community?
  - What do they need to make the transition from homelessness to permanent housing?
  - How does that compare to the continuum of services available?

- The goal is to create a single, coordinated homeless assistance system for the community.
The SPB assumed responsibility for the community’s CofC process in 1999.

The CofC awards from 1999-2003 total more than $22 million.

There are currently 17 programs receiving funding through the CofC.

CofC $ cannot be used for prevention or the operation of emergency shelters.
Prevention

Outreach

↓

Emergency Shelters

↓

Transitional Housing

↓

Permanent Supportive Housing

Health & Treatment
## Funding

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUD CofC</td>
<td>$6,196,000</td>
</tr>
<tr>
<td>Private &amp; Religious</td>
<td>$4,372,000</td>
</tr>
<tr>
<td>Other Federal</td>
<td>$2,372,000</td>
</tr>
<tr>
<td>Local Public</td>
<td>$1,982,000</td>
</tr>
<tr>
<td>State</td>
<td>$1,500,000</td>
</tr>
</tbody>
</table>

**Total Annual Funding**  $16,422,000
Breakdown of CofC Funds

- 54% targeted to permanent housing
- 8% targeted to transitional housing
- 36% targeted to supportive services
- 2% targeted to HMIS
**Key Changes**

- Emergency shelter beds have decreased from **244** shelter beds for singles and families in 1985 to **187** in 2003
- Transitional and permanent housing units have increased
- Substance abuse treatment for homeless persons has increased through the CofC
Who are the Homeless?

- In 1997, the shelters served 4,000 men, women, and children.
- In the first year of the new HMIS, the shelters have identified nearly 5,000 homeless persons.
- Almost 2,000 homeless have entered transitional or permanent supportive housing.
- On any given night, more than 600 people are homeless in Montgomery County.
Who are the homeless? (cont.)

- 35% of the homeless are single adults
- 65% are in families
- 40% are children

**Last Permanent Address**

- Montgomery County – 81%
- Greene, Preble, Darke, Miami, Clark counties – 4%
- Balance of State – 7%
- Outside Ohio – 8%
10-Year Plan

- HUD and the Interagency Council on Homelessness have challenged communities to establish 10-Year Plans to end chronic homelessness
- The SPB develops the annual CofC plan and will facilitate the development of the 10-year plan
- A longer-term, more strategic, initiative with broad community participation and commitment from community leaders is needed
Chronic Homelessness

- Unaccompanied individual with a disability who has been homeless, living on the street or in an emergency shelter, for a year or more OR who has had at least four distinct episodes of homelessness over a three-year period

- National estimate: 10% of homeless population is chronically homeless
10-Year Plan Key Steps

1. Commit to Develop a 10-Year Plan to End Chronic Homelessness and Reduce Overall Homelessness

2. Identify Stakeholders and Their Role in the Process

3. Convene Group to Oversee and Champion Plan

4. Gather Research & Data on Homelessness

5. Define the Problem and Establish Goals and Outcomes
6. Develop Strategies to Achieve Goals and Outcomes
7. Solicit Stakeholder Feedback and Finalize Strategic Plan
8. Create 5-Year Action Plan to Implement Strategies
9. Announce and Publicize the Plan
10. Implement the Plan
Dayton, Kettering, Montgomery County Homeless Assistance Network

Prevention

Emergency Assistance
Community Action Partnership (SCOPE)
Sunrise Center
Faith & Community-based groups

Referral
HelpLink
Ombudsman’s Office

Food/Hot Meal Sites
Food pantries
Meal sites
Faith & Community-based Groups

Outreach

AIDS Resource Center Ohio (HIV/AIDS)
Crisis Care (mentally ill, substance abusing)
  Daybreak (adolescents, young adults)
  PATH (seriously mentally ill)
Samaritan Homeless Clinic (medical)
  The Other Place (general)
  VA Medical Center (veterans)

Emergency Shelter

212 beds for singles; 73 units for families (additional 50 beds for singles in winter)

Gateway

Daytime
The Other Place

Overnight
St. Vincent Hotel

Winter
St. Vincent Hotel

Programmatic

Men
Salvation Army
DePaul Center
Holt Street

Women
YWCA

Families
Red Cross

Teens
Daybreak

Domestic Violence
YWCA

Medical Respite Care
Samaritan Clinic

Veterans
VA

Transitional Housing for Homeless

92 beds for singles; 57 units for families (20 beds for singles under development)

Men
DePaul Center

Women and/or Families
Mercy Manor

Teens/Young Adults
Daybreak

St. Vincent Supportive Housing

Permanent Supportive Housing for Homeless

276 beds for singles; 100 units for families (50 beds for singles under development)

Miami Valley Housing Opportunities (mental illness, substance abuse, HIV/AIDS)

PLACEs (mental illness)

YWCA/St. Vincent (mental illness)

Health and Treatment Service Providers

Alcohol & Drug Treatment
CADAS
CAM
DayMont
Nova House
Project Care
Salvation Army
Samaritan Homeless Clinic

HealthCare
Samaritan Homeless Clinic

Mental Health Treatment
Samaritan Homeless Clinic

Community non-profits

AoD/MH Assessment
CrisisCare

Follow-up Case Management
YWCA Supportive Housing Program
## Homeless Solutions: A Process and Timeline

### 1. Commit to Develop a 10-Year Plan to End Chronic Homelessness* and Reduce Overall Homelessness in Dayton & Montgomery County.

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop timeline and structure for planning process.</td>
<td>mid-March 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Process and timeline approved by Shelter Policy Board.</td>
<td>mid-March 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Process and timeline approved by Dayton City Manager and Montgomery County Administrator.</td>
<td>end-March 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Solicit feedback from Homeless System Agency Directors.</td>
<td>mid-April 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Share process, timeline and purpose with key groups (FCFC, Mayors &amp; Managers, Township Association, U.W. Public Policy, Downtown Dayton Partnership, CNDAB, HAB, Levy Council, Emergency Housing Coalition)</td>
<td>end-April 2004</td>
<td>✓</td>
</tr>
<tr>
<td>City of Dayton &amp; Montgomery County Commissions pass formal resolutions endorsing planning process.</td>
<td>mid-May 2004</td>
<td>✓</td>
</tr>
</tbody>
</table>

### 2. Identify Stakeholders and Their Role in the Process

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop list of key stakeholders, including persons to be interviewed, focus group participants, survey recipients, Working Groups members.</td>
<td>mid-July 2004</td>
<td>✓</td>
</tr>
</tbody>
</table>

### 3. Convene Group to Oversee and Champion Plan

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convene Leadership Team to End Homelessness.</td>
<td>end-Sept 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Hold community “kick-off” meeting.</td>
<td>mid-Oct 2004</td>
<td>✓</td>
</tr>
</tbody>
</table>

### 4. Gather Research and Data on Homelessness

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop preliminary inventory of service resources and funding.</td>
<td>end-July 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Interview homeless and formerly homeless individuals.</td>
<td>end-Sept 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Compile existing local and national data.</td>
<td>end-Oct 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Survey community stakeholders.</td>
<td>mid-Jan 2005</td>
<td>✓</td>
</tr>
<tr>
<td>Identify initial best practices for closing the front door into homelessness and opening the back door out of homelessness.</td>
<td>end-March 2005</td>
<td>✓</td>
</tr>
</tbody>
</table>

### 5. Define the Problem and Establish Goals & Outcomes

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate and analyze data gathered in step 4. Answer the questions: What does the problem of homelessness look like in Montgomery County? What are the regional implications? In what areas do we need to develop strategies?</td>
<td>end-Dec 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Update community stakeholders.</td>
<td>end-Dec 2004</td>
<td>✓</td>
</tr>
<tr>
<td>Leadership Team reviews data and begins defining the issue.</td>
<td>early Jan 2005</td>
<td>✓</td>
</tr>
<tr>
<td>Leadership Team meets with providers for additional input on data and the key issues.</td>
<td>end-April 2005</td>
<td>✓</td>
</tr>
<tr>
<td>Leadership Team establishes goals and outcomes.</td>
<td>early May 2005</td>
<td>✓</td>
</tr>
</tbody>
</table>

* Chronically Homeless Person: An unaccompanied individual with a disability such as mental illness, addiction, or a chronic physical illness who has been homeless, living on the street or in an emergency shelter, for a year or more OR who has had at least four distinct episodes of homelessness over a three-year period.
### 6. Develop Strategies to Achieve Goals & Outcomes

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convene Working Groups of consumers, service providers, and community representatives to develop strategies for prevention, systems change, new initiatives and housing needed to prevent homelessness and shorten the length of time persons experience homelessness.</td>
<td>mid-July 2005</td>
<td>✓</td>
</tr>
<tr>
<td>Facilitate development of draft strategies by Working Groups needed to end chronic homelessness and reduce overall homelessness in Dayton &amp; Montgomery County.</td>
<td>end-Nov 2005</td>
<td>✓</td>
</tr>
<tr>
<td>Integrate findings, proposed outcomes and recommended strategies from Behavioral Health, Closing the Front Door, Shortening the Stay, Opening the Back Door and Governance Working Groups into a single document.</td>
<td>end-Jan 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Leadership Team tackles two complex issues not addressed by the Working Groups—the future of public housing and gateway services. Agreements are developed with the Housing Authority to modify its Strategic Plan, and with the gateway providers to make needed changes in their operations.</td>
<td>early-March 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Initial draft of Homeless Solutions Plan prepared.</td>
<td>mid-March 2006</td>
<td>✓</td>
</tr>
</tbody>
</table>

### 7. Solicit Stakeholder Feedback and Finalize Strategic Plan

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Team holds facilitated meeting with homeless services providers to receive input and seek consensus on the content of the draft Homeless Solutions Plan.</td>
<td>mid-April 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Homeless Solutions Plan recommendations modified based on input from homeless providers and the Leadership Team. Leadership Team adopts the revised Homeless Solutions Plan.</td>
<td>end-April 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Hold Focus Groups with formerly homeless persons to obtain their feedback on major plan recommendations.</td>
<td>May 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Present Homeless Solutions 10-Year Plan to multiple stakeholder groups including Working Group participants, neighborhood groups, city and suburban government officials, members of the faith community, business organizations, human services funding bodies, and housing organizations to obtain input and build consensus.</td>
<td>mid-June 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Secure funding for immediate implementation of recommended changes to the operations of the gateway shelters.</td>
<td>end-May 2006</td>
<td>✓</td>
</tr>
<tr>
<td>Identify specific action steps, responsible person/agency, costs and funding sources, timelines and performance measures.</td>
<td>July 2006</td>
<td></td>
</tr>
</tbody>
</table>

### 8. Implement the Plan

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Planned Completion Date</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify individuals to lead and serve on the Homeless Solutions Policy Board.</td>
<td>mid-July 2006</td>
<td></td>
</tr>
<tr>
<td>Dayton &amp; Montgomery County Commissioners and United Way convene the Homeless Solutions Policy Board to oversee the implementation of the Homeless Solutions Plan; hold community event to kick-off the Plan’s implementation.</td>
<td>end-July 2006</td>
<td></td>
</tr>
<tr>
<td>Utilize HMIS to track/monitor performance in achieving outcome measures.</td>
<td>ongoing</td>
<td></td>
</tr>
<tr>
<td>Update community stakeholders on implementation &amp; progress made in achieving outcome measures.</td>
<td>annually</td>
<td></td>
</tr>
</tbody>
</table>
Montgomery County Renter Households with a Cost Burden
Source: 2000 Census

Total Households
229,000

Renters
81,000 (35%)

Below 50% MFI*
33,000

With Rent Burden
(Pay more than 30% income for rent)
23,000

With Major Rent Burden
(Pay more than 50% income for rent)
18,000

* In 2000, below 50% of Median Family Income (MFI) equaled below $30,100 for a family of four.
MONTGOMERY COUNTY

Public and Assisted Housing Units

<table>
<thead>
<tr>
<th>Jurisdiction:</th>
<th>Elderly Units</th>
<th>Family Units</th>
<th>Total Units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Dayton</td>
<td>3,240</td>
<td>3,626</td>
<td>6,866</td>
</tr>
<tr>
<td></td>
<td>(47%)</td>
<td>(53%)</td>
<td></td>
</tr>
<tr>
<td>Balance of County</td>
<td>1,702</td>
<td>3,766</td>
<td>5,468</td>
</tr>
<tr>
<td></td>
<td>(31%)</td>
<td>(69%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,942</td>
<td>7,392</td>
<td>12,334</td>
</tr>
<tr>
<td></td>
<td>(40%)</td>
<td>(60%)</td>
<td></td>
</tr>
</tbody>
</table>

Section 8 Vouchers (Scattered sites / private landlords): 3,500

Grand Total: 15,834

55% of total (12,334) units are located in the City of Dayton.
45% of total units are located in suburban jurisdictions.

60%+ of Section 8 Vouchers are used within the City of Dayton, the remainder are used in suburban jurisdictions.

August, 2005
According to Montgomery County Court records, 1,523 evictions were filed by the Dayton Metropolitan Housing Authority during 2002-2005.
# American Red Cross Emergency Housing Program

## Report Totals Covering June 2004 - May 2005

### Cause of Housing Emergency

<table>
<thead>
<tr>
<th>Cause</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displaced (By family, friends, or landlord; court system is not involved)</td>
<td>431</td>
<td>(30%)</td>
</tr>
<tr>
<td>Eviction (Landlord filed with the court)</td>
<td>389</td>
<td>(27%)</td>
</tr>
<tr>
<td>Transient (Has been living place to place with no address or moved from out of state to start over)</td>
<td>137</td>
<td>(10%)</td>
</tr>
<tr>
<td>Other (Lost job; cannot afford current rent; return from military service; death of a parent; moved out of childhood home; released from jail; CSB requires that family relocate; reason is not specified, etc.)</td>
<td>127</td>
<td>(9%)</td>
</tr>
<tr>
<td>Housing was overcrowded</td>
<td>58</td>
<td>(4%)</td>
</tr>
<tr>
<td>Housing was considered a health or safety hazard/condemned (Generally caused by the landlord not taking care of the property)</td>
<td>54</td>
<td>(4%)</td>
</tr>
<tr>
<td>Separation from Spouse/Boyfriend</td>
<td>53</td>
<td>(4%)</td>
</tr>
<tr>
<td>Spousal Abuse / Domestic Violence involving other family members</td>
<td>50</td>
<td>(4%)</td>
</tr>
<tr>
<td>Foreclosure (Bank filed with the court)</td>
<td>40</td>
<td>(3%)</td>
</tr>
<tr>
<td>House was sold (By landlord or the family member that the client was living with)</td>
<td>35</td>
<td>(2%)</td>
</tr>
<tr>
<td>Utilities shut off (Can be the fault of landlord or the tenant)</td>
<td>27</td>
<td>(2%)</td>
</tr>
<tr>
<td>Fire</td>
<td>21</td>
<td>(1%)</td>
</tr>
</tbody>
</table>

**Total Referrals: 1422**

### Numbers of Referrals...

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Referrals</td>
<td>1422</td>
<td></td>
</tr>
<tr>
<td>Number of Families Housed</td>
<td>285</td>
<td>(20% of Families Referred)</td>
</tr>
<tr>
<td>Number of families that maintained stable housing for 1 year and did not return to homelessness</td>
<td>261</td>
<td></td>
</tr>
<tr>
<td>Percentage of families that maintained stable housing for 1 year and did not return to the homeless status</td>
<td>91.5%</td>
<td></td>
</tr>
<tr>
<td>Number of families that reapplied for EHP within a year of leaving EHP and were re-housed. *</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Percentage of families that are re-housed less than a year from leaving EHP</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

* Due to the limited amount of units we cannot house all of the repeats. We do collaborate with Mercy Manor, People Taking Charge, and Children Services if they refer a family to us.
FAMILIES EXPERIENCING HOMELESSNESS MOVEMENT THROUGH THE CURRENT SYSTEM

Prevention

HelpLink

Gateway

Children Services

Churches

Programmatic Shelter

Treatment

Prison

Unknown / Other

Temporary Supportive Housing

Permanent Housing

Self / Family

Receive Assistance/ Maintain Housing

50%

30%

23%

4%

4%

5%

10%

9%

60%

91%

30%

Programmatic Shelter

Unknown / Other

68%

4%

60%

91%

50%

23%

10%

9%

Barriers to End Homelessness:
• Poor credit/money owed to DP&L, Vectren, landlords
• Criminal history
• Waiting list for public/assisted housing
• Inability to afford market rate housing
• Poor social/life skills
• Lack of employment skills/experience
YOUNG ADULTS EXPERIENCING HOMELESSNESS
MOVEMENT THROUGH THE CURRENT SYSTEM

Barriers to End Homelessness:
- Limited housing options
- Lack of education/employment skills
- Poor social/life skills
- Uncooperative parents
CHRONICALLY HOMELESS ADULTS
MOVEMENT THROUGH THE CURRENT SYSTEM

Barriers to End Homelessness:
• Lack of housing options (Housing First, post-treatment, post-incarceration)
• Limitations on participation by repeat users
• Time to access CrisisCare, substance abuse and mental health treatment
• Criminal history
• Lack of employment skills/experience
• Poor social/life skills
Interviews with
Homeless and Formerly Homeless Adults in Dayton/Montgomery County
August 2004
Shelter Policy Board

IN THEIR OWN WORDS

I'm not bad; I just couldn’t get along with my step dad. He made my mom choose, she did and I lost (19 year old male)

From being homeless to self-sufficiency is the answer. I was here for 4 months. We need more places that are decent like this agency. I just need to do like they say and stay focused. If I do that and take all the things they taught me here, I can make it. (18 year old female with 3 children)

The system must change, but we must change too. Homeless folks have to change the way we do things. We have to want to get better situations. (64 year old female)

Where I was living was drug infested. I wanted to change and quit doing drugs. There are people who want you to continue doing the things you want to stop that you have to stay away from. Yeah, that’s right, you said it – a change of people, places, and things. (50 year old female)

This is an incredible program. They helped furnish my whole home. We have a computer, a couch, desk, carpeting, pots & pans. They gave us everything. They make you feel self-sufficient and independent. There is no comparison between this agency and others. Here they help with education. (36 year old female with 1 child)

The houses we can afford are not drug free. I am rehabilitated back into the workplace. I am a printer, heavy equipment operator, computer technician. I need a place to stay. I have skills and a trade, now it is your turn to help me. (58 year old male)

Bad employment move—went for salary increase and the job didn’t pan out. I had a car wreck. I was working long hours. I used drugs to stay awake and then drugs to put me to sleep. I was working on high voltage wires and I had a seizure. There were more jobs, more drugs and more seizures. I was living with other people and flitting from place to pace. It was a downhill spiral and I ended up at the agency. (48 year old male)

WHO WE INTERVIEWED
Continuum of Care service providers were asked to identify residents/clients who would be willing and able to respond to an hour interview format. The number of respondents from each agency was selected to reflect, to the extent practicable, the people served within the Continuum.

Respondents (41)

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
<th>Respondent</th>
<th>Referring Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>32%</td>
<td>Single Men</td>
<td>Daybreak, DePaul, Miami Valley Housing Opportunities, Ombudsman, St. Vincent Hotel, Samaritan Clinic, The Other Place</td>
</tr>
<tr>
<td>12</td>
<td>29%</td>
<td>Single Women</td>
<td>Daybreak, Miami Valley Housing Opportunities, Mercy Manor, St. Vincent Hotel, The Other Place, YWCA, PLACES, AIDS Resource Center</td>
</tr>
<tr>
<td>16</td>
<td>39%</td>
<td>Families &amp; Kids • 14 female headed • 1/3 had 1 child 1/3 had 2</td>
<td>Red Cross Emergency Housing, Daybreak, Mercy Manor, Miami Valley Housing Opportunities, St. Vincent Hotel, St. Vincent Supportive Housing, Salvation Army Women &amp; Children, YWCA</td>
</tr>
<tr>
<td>41</td>
<td>100%</td>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

Characteristics
Gender 63% female, 37% male
Age Range: 18 to 69; Average: 40; 1/3 46-55
Race/ethnicity 54% White/Caucasian; 46% Black/African American
Education 54% High School or above;
Probation/Parole 56% are or have been on probation or parole
Veteran Status 7% are veterans
Current Living/Sleeping Arrangement

<table>
<thead>
<tr>
<th>% of 41</th>
<th>Number</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>34%</td>
<td>14</td>
<td>Own housing (including subsidized and supportive housing)</td>
</tr>
<tr>
<td>32%</td>
<td>13</td>
<td>Programmatic shelters and transitional housing programs</td>
</tr>
<tr>
<td>17%</td>
<td>7</td>
<td>Streets</td>
</tr>
<tr>
<td>17%</td>
<td>7</td>
<td>Emergency overnight shelter</td>
</tr>
</tbody>
</table>

VIOLENCE IS A FACT OF LIFE FOR THE HOMELESS IN DAYTON/MONTGOMERY COUNTY

 Experienced Violence
58%  Report violence in their lives: 7 men, 15 women (22/38)
45%  Report partner violence against female (9)
15%  Report street violence against male (3)

Other violence include: in agency setting (2); intra-family, not partner (2); partner violence against male (2)

EVERYONE INDICATED THAT THEY HAD NEEDS BEYOND HOUSING.
A primary source of direct assistance or referrals to other services are shelter and housing programs serving the homeless and formerly homeless.

Assistance Provided by Shelter & Housing Programs*

<table>
<thead>
<tr>
<th>% (of 41)</th>
<th>Total (of 41)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>34%</td>
<td>14</td>
<td>Provided case management, referrals</td>
</tr>
<tr>
<td>32%</td>
<td>13</td>
<td>Other comments, no answer (Been here too short of time; unable to evaluate; there is a need for more full service shelter programs that can connect with housing; I like the way no one knows who is staying here)</td>
</tr>
<tr>
<td>20%</td>
<td>8</td>
<td>Helped me find permanent housing</td>
</tr>
<tr>
<td>15%</td>
<td>6</td>
<td>Provided other types of assistance (Helped with transportation; hygiene and other things)</td>
</tr>
<tr>
<td>10%</td>
<td>4</td>
<td>Helped me become self-sufficient/ independent</td>
</tr>
<tr>
<td>7%</td>
<td>3</td>
<td>Helped with my addiction(s)</td>
</tr>
<tr>
<td>37%</td>
<td>15</td>
<td>Sought help, but did not receive it/ negative comment about agency</td>
</tr>
</tbody>
</table>

When asked in a different set of questions where they sought help for a variety of key needs, some respondents used a wide range of community agencies, but others indicated that they were not successful finding help. The following responses will vary from responses to the previous question.

Assistance*
27%  Received medical care, prescriptions and/or dental care from Samaritan Clinic (11/41); 8 had Medicaid, 5 a “Medical Card”
59%  Reported that a specific agency helped them find a place to live (24/41) Agencies included Mercy Manor, DMHA, Red Cross Emergency Housing, Daybreak, The Other Place, South Community
49%  Report having some type of government benefit (20/41) Of these, 11 are in families
44%  Report that they have a full or part time job (18/41) Jobs listed included Eastco, CBS Personnel Services, Lowe’s, fast food, waitress, Big Lots nursing assistant
42%  Received mental health services from a community mental health center (13/31); 10 named a specific agency such as Samaritan Homeless Clinic, VA, AIDS Resource Center, Daybreak, Mercy Manor, and PLACES.
31%  Received alcohol/drug abuse treatment from a community mental health center (8/26); 8 named a specific agency/program such as Samaritan Homeless Clinic, TOP, Mercy Manor, Narcotics Anonymous
46%  Use food stamps (16/35); 43% eat at a feeding site or shelter (15/35); 38% report being hungry at times (15/40)
49%  Reported a specific agency/staff person sought for help (20/41); 29% (12/41) seek help from family members; 24% seek help from church/Bible/God (10/41); 20% seek help from friends (8/41); 5% don’t seek help
35%  Reported getting help from a specific agency for help with transportation to look for housing, a job, etc. (12/34); 9% indicated that they own a car (3/34). Specific agencies mentioned that helped with transportation include Daybreak, Red Cross Emergency Housing, Living Word Church.
When asked where they spend the day, respondents listed a variety of places, many dependent on where they are living. For example, if they stayed in an emergency overnight shelter or “on the streets” they could use The Other Place Day Shelter. Respondents who are in a programmatic shelter do not use TOP and rely on their programmatic shelter to support day activities such as looking for work, going to school, etc. Others, who are formerly homeless, have jobs, visit with friends, or volunteer.

### Spend the Day

<table>
<thead>
<tr>
<th>% (of 41)</th>
<th>Total (of 41)</th>
<th>Response*</th>
</tr>
</thead>
<tbody>
<tr>
<td>39%</td>
<td>16</td>
<td>My place/family/friends (includes 7 formerly homeless)</td>
</tr>
<tr>
<td>29%</td>
<td>12</td>
<td>Work (5 formerly homeless)</td>
</tr>
<tr>
<td>22%</td>
<td>9</td>
<td>Downtown/library/walking around (1 formerly homeless)</td>
</tr>
<tr>
<td>15%</td>
<td>6</td>
<td>Specific agency, not The Other Place (1 formerly homeless)</td>
</tr>
<tr>
<td>15%</td>
<td>6</td>
<td>Other (I have a hobby; keeping appointments; church; looking for a job) (2 formerly homeless)</td>
</tr>
<tr>
<td>12%</td>
<td>5</td>
<td>School/classes (4 formerly homeless)</td>
</tr>
<tr>
<td>9%</td>
<td>4</td>
<td>Volunteer (2 formerly homeless)</td>
</tr>
<tr>
<td>9%</td>
<td>4</td>
<td>The Other Place (formerly homeless are not served by TOP)</td>
</tr>
<tr>
<td>5%</td>
<td>2</td>
<td>Meetings/groups (0 formerly homeless)</td>
</tr>
</tbody>
</table>

### PATHS TO HOMELESSNESS

Half of the respondents listed two or more reasons that took them down the path to homelessness. We asked respondents to describe the contributing factors to their homelessness.

- Drugs, jail sentences, prison, probation. I had no stability. (46 year old female)
- A whole list—quit my job, my mom had a stroke, we got a gas leak and mom had to move out—she moved in with a cousin and I have no where to go. (37 year old female)
- My mom moved from place to place. She could never keep us in a house. We moved all of our lives. Never staying put anywhere. (19 year old female)
- Drug use—but you keep saying homeless, I was never homeless. First I graduated from the Programmatic Shelter then I went to a DMHA Project to live for 3 years. Then I bought a house. My marriage didn’t work. The same Programmatic Shelter staff hooked me up with another agency and I am here in this house. I get Section 8. (35 year old female with children)
- I worked long hours and lost my transportation. I did heavy lifting and lost my health. My house was condemned. I was jobless and could not even dress myself. I was isolated and could not walk. I lost my kids. When I moved into emergency housing I got my kids back. (50 year old female with children)
- Help getting evictions off my record, past bills, debt with DP&L, etc. (females, males, families)

### What Happened that Made you Homeless?

<table>
<thead>
<tr>
<th>% (of 41)</th>
<th>Total (of 41)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>51%</td>
<td>21</td>
<td>2 or more reasons</td>
</tr>
<tr>
<td>41%</td>
<td>17</td>
<td>Family member issues: divorce/domestic violence/drug problem/unemployment</td>
</tr>
<tr>
<td>27%</td>
<td>11</td>
<td>Drugs/alcohol</td>
</tr>
<tr>
<td>22%</td>
<td>9</td>
<td>Lost job/not keeping steady job</td>
</tr>
<tr>
<td>22%</td>
<td>9</td>
<td>Health problem/accident</td>
</tr>
<tr>
<td>20%</td>
<td>8</td>
<td>Eviction</td>
</tr>
<tr>
<td>17%</td>
<td>7</td>
<td>Other (homeless 12 years, never had a place; no stability; lack of skills)</td>
</tr>
<tr>
<td>15%</td>
<td>6</td>
<td>Kicked out by relatives/lost relative housing</td>
</tr>
<tr>
<td>7%</td>
<td>3</td>
<td>Criminal offenses</td>
</tr>
<tr>
<td>7%</td>
<td>3</td>
<td>Program-based housing or treatment didn’t lead to independent housing</td>
</tr>
</tbody>
</table>
Nearly all respondents responded when we asked if they could have done things differently so they may not have ended up being homeless.

Things you could have done differently that would have helped you keep your own place to live?

<table>
<thead>
<tr>
<th>Response</th>
<th>% (of 41)</th>
<th>Total (of 41)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, avoid drugs/alcohol/incarceration</td>
<td>22%</td>
<td>9</td>
</tr>
<tr>
<td>Yes, other (Better judgment maybe, not leaving home, try to stop the eviction, stayed with first job, of course!)</td>
<td>22%</td>
<td>9</td>
</tr>
<tr>
<td>No, it was the fault of someone else (mother couldn’t keep our place, father passed, we had no income, just a bunch of problems; kept my mouth shut &amp; kept the job)</td>
<td>15%</td>
<td>6</td>
</tr>
<tr>
<td>No, it was my health</td>
<td>15%</td>
<td>6</td>
</tr>
<tr>
<td>No, domestic violence/partner issues</td>
<td>15%</td>
<td>6</td>
</tr>
<tr>
<td>No, other (I was dealt this hand; I really don’t care; I made the best)</td>
<td>12%</td>
<td>5</td>
</tr>
<tr>
<td>No answer</td>
<td>5%</td>
<td>2</td>
</tr>
</tbody>
</table>

We asked respondents who are currently homeless, what types of help they needed to find a place to live.

Currently Homeless—help needed to get “own place” to live*

<table>
<thead>
<tr>
<th>Response</th>
<th>% (of 25)</th>
<th>Total (of 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe/affordable housing</td>
<td>40%</td>
<td>10</td>
</tr>
<tr>
<td>Job</td>
<td>28%</td>
<td>7</td>
</tr>
<tr>
<td>Resolve debts, damaging records</td>
<td>20%</td>
<td>5</td>
</tr>
<tr>
<td>Substance-free situation</td>
<td>16%</td>
<td>4</td>
</tr>
<tr>
<td>Case management; counseling</td>
<td>12%</td>
<td>3</td>
</tr>
<tr>
<td>Secure SSI</td>
<td>8%</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td>4%</td>
<td>1</td>
</tr>
<tr>
<td>NA</td>
<td>24%</td>
<td>6</td>
</tr>
</tbody>
</table>

[Of the 25 currently homeless respondents, 14 (88% of the 16 respondents to this question) report they have already tried these things]

Finding a place to live solves a major problem, but the formerly homeless must continue to struggle with all of the issues that caused their homelessness. We asked what they continue to worry about even though they have their own place to live.

Formerly Homeless –Things they still worry about keeping own place*

<table>
<thead>
<tr>
<th>Response</th>
<th>% (of 16)</th>
<th>Total (of 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry about work/loss of income/budgeting</td>
<td>69%</td>
<td>11</td>
</tr>
<tr>
<td>Maintaining sobriety, mental health</td>
<td>19%</td>
<td>3</td>
</tr>
<tr>
<td>Health issues (I’m sick now and just left the hospital, if I can’t stay healthy I lose my apartment; I need to stay healthy to be independent)</td>
<td>13%</td>
<td>2</td>
</tr>
<tr>
<td>Other (my safety; I only worry about doing the perfect will of God)</td>
<td>13%</td>
<td>2</td>
</tr>
<tr>
<td>Education issues (I worry about going back to school; not having an education)</td>
<td>13%</td>
<td>2</td>
</tr>
<tr>
<td>Overcoming damaging records (help eliminating the eviction; my credit needs to be straight)</td>
<td>13%</td>
<td>2</td>
</tr>
<tr>
<td>Nothing, no answer</td>
<td>13%</td>
<td>2</td>
</tr>
</tbody>
</table>
SUGGESTIONS

Every respondent gave suggestions that they believe could help the agencies and the community do better or differently to help homeless people find their own place to live.

Suggestions for agencies or the community*

<table>
<thead>
<tr>
<th>% (of 41)</th>
<th>Total (of 41)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>22</td>
<td>Improve quantity of services available (Need more shelters/beds; more transitional shelters/beds; more subsidized housing/affordable housing; longer stays in programs, huge gaps in employment for ex-offenders)</td>
</tr>
<tr>
<td>41%</td>
<td>17</td>
<td>Improve quality of services available (Street specialists need to dig deeper when they see the same person over and over and find out what is going on; cameras needed in group homes (drugs, thefts, gangs); guards in shelters; move things faster for homeless people; people don’t care)</td>
</tr>
<tr>
<td>39%</td>
<td>16</td>
<td>More than one response (also factored)</td>
</tr>
<tr>
<td>20%</td>
<td>8</td>
<td>Other comments (Need more support homeless; I worried about my safety; I can’t stay at the transitional shelter forever)</td>
</tr>
<tr>
<td>15%</td>
<td>6</td>
<td>Agency(ies) doing a good job (I could not ask for better; I’m blessed to be here)</td>
</tr>
<tr>
<td>10%</td>
<td>4</td>
<td>Improve availability of transportation assistance (Transportation is my main problem; to get a bus token you have to go to class)</td>
</tr>
<tr>
<td>17%</td>
<td>7</td>
<td>No answer</td>
</tr>
</tbody>
</table>

When asked if they had anything else to tell us about their experiences with homelessness or ideas that would help people find and keep a safe place of their own to live, we received numerous comments. Some were positive suggestions, while others expressed frustration with being homeless or seeking assistance.

- Agency made me budget my money and also grocery shop. I hated it, but it was the best thing that ever happened to me. (19 year old male)
- They want you to learn to be independent. They teach you to save and to budget. They place you in counseling and provide child therapy. They give you anything you need to stay out of the system. (44 year old female with one child)
- They are as helpful as they can be, they can only do so much. (39 year old female)
- Need help finding affordable housing—I will be back on the street in 2 months (female)
- Dayton has no skinny homeless people. You can eat 13 times a week if you want! (50 year old male)
- These people don’t care (male and female respondents)
- There should be more shelters, safer conditions (male and female respondents)
- Things need to move faster for homeless people. It took 8 months to get me into a place. There aren’t enough places. I have had five case managers. You have five different people telling you five different things and I fell through the cracks. (50 year old male)
- Transportation is one of my main problems. I give plasma to keep money in my pocket. We need transportation to the doctors and to the Job Center and places like that. We have no way to get around. It is a big problem. (formerly homeless 53 year old male)
- Programmatic shelter helped me with my recovery and understanding how to get back out there. They provided me with a home. (48 year old male)

For more information, contact Kathleen Shanahan, Director, Shelter Policy Board, 937-225-3097

Note: * Indicates multiple responses have been tabulated
The Homeless Solution
Ten Year Plan

Service Provider Survey
2005
METHODOLOGY:

Participants: Strategic Visioning, Inc was provided with a list of one hundred thirty-five people representing sixty-seven organizations that provide service to the homeless population of Montgomery County. Every person on the list was asked to complete a survey for this study. Sixty-nine individuals (51 percent) from thirty-seven (55 percent) different organizations chose to participate.

This is an excellent cooperation rate.

Survey distribution: Each participant was first sent an e-mail from Kathleen Shanahan of the Montgomery County Shelter Policy Board explaining the purpose of the study and asking for cooperation. Within twenty-four hours of that e-mail, all targeted individuals were sent the WEB based survey. Everyone who had not completed the questionnaire within the specified ten days was sent a follow-up e-mail request for participation.

Survey dates: January 2 through February 2, 2005

Note: Throughout this report, the verbatim responses supplied by participants are included in italicized text.
The Rewards and Frustrations of Working with Homeless People

The first question asked of the people involved with this study was, "What do you find most rewarding about working with homeless people?" Responses were diverse, but many talked about the joy they find in helping people reclaim a sense of worth and establishing their lives.

The reward is actually making a difference in someone's life; to see their faces when I give them there keys to there "own" unit is priceless.

I take great pleasure in witnessing the power of people to be change agents in their own lives and seeing the difference a set of keys can make to a person, family, and community

I enjoy the opportunity to give someone a chance to get his or her life back together. I enjoy empowering individuals and giving them hope in their own lives.

Other people find a reward in their day-to-day interaction with homeless people, a group the public may prefer to ignore.

I find reward in working with a population many find to be 'deserving' of their circumstances. People experiencing homeless are no more 'deserving' of their situation than a marooned ship at sea.

Homeless folks can be anyone for any number of reasons. It could be us some day. We need to treat everyone the same.

Some respondents noted that there are times when the individuals in need help to strengthen the caregiver.

I am constantly amazed at the survival skills of the persons we work with, their resilience and tenacity. I am inspired to be courageous when I see what they survive.

My experience has been that many (homeless people) have a higher degree of intelligence than perceived by the general public. In some situations they have circumstances that have affected their ability to cope in the mainstream. I learn a great deal from them.

Regardless of the circumstance, people who provide service to the homeless experience both the joy of seeing people succeed and move into the mainstream of life, and the frustrations of working to make such change possible. Frustration is part of any occupation, yet when working to supply people something as basic as shelter, these service providers know that overcoming their frustrations can make an actual life or death difference to their clients.

Participants were also asked about their frustrations in trying to assist homeless persons. A common frustration is navigating the many agencies and systems involved in providing needed services.

The red tape!

My clients need so much; some don't even have an ID. Often times we can't help, like when we need immediate access to user-friendly substance abuse and mental health services. Many have pending cases for social security, which takes way too long to process.

Overcoming the barriers that stand in the way of people becoming self-sufficient is one of the most frustrating aspects of working with this population.

Working with various systems that have rules and regulations that exclude individuals who may be most at need.
The limitations of the most basic services can limit clients' ability to succeed and frustrate those who try to help.

Either there is no decent housing available, which causes waits as long as 6 months, or applications for housing are not even being accepted

A fragmented system of services for people experiencing homelessness that often time leads to long waits, denial of services and ultimately to barriers in overcoming homelessness

Not enough resources to serve the clients we have and waiting lists continuing to expand.

These challenges are especially evident when clients suffer from mental illness and/or addictions.

I think the most frustrating issue that I deal with is many AOD clients. They take all the time to go through the treatment and finally get housing of their own only to relapse within the first month. I realize this is a part of their recovery; it's just extremely frustrating to see them have so many goals and throw them all away so quickly.

The fact that even for my clients who are in recovery there is scarcity of affordable housing and a scarcity of funds to assist people in getting adequate housing. When my recovering clients are able to find affordable housing it is usually in areas where drug use is rampant! These influences coupled with the inability to find sustaining work often leads them back into illegal activities and eventually drug use.

What blocks my efforts to services are the long waiting lists to services for mental health, addiction, transitional and permanent housing. Sometimes the client gets frustrated waiting and begins missing appointments, falling into past destructive behaviors or disappears from the shelter completely only to come back at a later time still homeless and still waiting.

The services we provide, specifically drug addiction treatment, are at a high quality. The block occurs with our discharge planning. A client newly in recovery needs safe, drug free affordable housing to support her new lifestyle. This is rarely available. She is often faced with returning to the using boyfriend or parents just to have a place to live. Children make the situation even more difficult.

There are also times when the frustration is with the clients themselves, especially when the person chooses to remain on the streets or is unable or unwilling to do what is necessary to change their circumstances.

Sometimes homeless folks want to stay on the streets.

Some of the homeless populations that I work with don’t really want to work to find housing. Some of them would prefer if I found them free housing so that they would not be responsible for the rent or utilities.

The most frustrating aspect is the rate of recidivism experienced by many of them. It is frustrating because housing is not the only issue and when the other problems aren’t adequately addressed then they ultimately become homeless again.

Much of the frustration is created by constantly fighting obstacles that block these service providers from meeting the needs of their clients. Funding is now, and is very likely to remain, one of the biggest obstacles to providing service to the homeless.

The most evident and obvious obstacle is money! There is never enough funding to provide the services that Montgomery County needs for our homeless population.

Politicians need to realize that supportive housing programs are extremely beneficial in teaching people to maintain their permanent housing once they get it and it is cheaper in the long run to fund such programs.
Funding. With the new or current administration, we have little or no funding sources to work with. Most of the housing programs are either closed due to a lack of funding or have waiting list that takes months or even years to get through.

The greatest obstacle to serving the homeless is the piecemeal funding strategies necessary to keep even basic services in place. The private non-profit agencies that provide all the front line services are at the mercy of annual public funding cycles and political priorities.

Sometimes the obstacles are in the very nature of homelessness.

Customer mobility, inability to provide the long-range time needed to work with customer and follow-up.

It's hard to deal with our inability to contact them by phone or mail.

We continue to provide services to homeless clients, offering transportation and all the other services we normally provide (support, information, court accompaniment, systems advocacy, child therapy, etc.) but without a constant place to reside, it can be hard for them to focus on their safety and that of their children.

The greatest obstacle however, may be misconceptions about homelessness and the reasons for it. As each respondent talks about his or her involvement with the homeless population, the frustration with these misconceptions is evident.

The greatest obstacle to serving the homeless are those in the community who have the belief that homeless people are just too lazy to work, and those who believe homeless persons have no rights.

Sometimes it is just the attitude of our society to homeless individuals. It is not expected by some that our homeless persons deserve or should have high quality services.

I find the perception and prejudices of the community at large to be frustrating when neighbors cannot see the value of a person’s life because that person does not have a permanent address.
Creating Homelessness

While every person who becomes homeless reaches that state by a unique route, there are some significant factors that influence the lives of many. People who provide services to homeless persons consider three factors as having the greatest influence on people becoming homeless; the inability to put together the funding necessary to move into a home, unemployment or job loss and being unable to find affordable housing.

Interestingly enough, few respondents believe welfare time limits are creating homelessness.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Issue</th>
<th>Most/All</th>
<th>Some</th>
<th>Few</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unable to pay rent/mortgage/security deposit/eviction</td>
<td>72%</td>
<td>25%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>Unemployment/job loss</td>
<td>64%</td>
<td>35%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>Unable to find affordable housing</td>
<td>65%</td>
<td>26%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol/substance abuse</td>
<td>43%</td>
<td>52%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>5</td>
<td>Mental illness</td>
<td>30%</td>
<td>61%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>6</td>
<td>Divorce/family breakdown</td>
<td>25%</td>
<td>67%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>7</td>
<td>Argument with family/friends, i.e. asked to leave family home or home of relatives or friends</td>
<td>17%</td>
<td>62%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>8</td>
<td>Prison/jail record</td>
<td>14%</td>
<td>68%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>9</td>
<td>Physical disabilities or illness</td>
<td>13%</td>
<td>65%</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>10</td>
<td>Family/domestic violence</td>
<td>9%</td>
<td>72%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>11</td>
<td>Welfare time limits</td>
<td>9%</td>
<td>41%</td>
<td>48%</td>
<td>1%</td>
</tr>
</tbody>
</table>

While the above factors are individually strong influences on people's overall quality of life, but when faced with multiple issues the challenge increases exponentially. This point is evident in the following comments from the service providers who took part in this study:

*We need a holistic approach that understands the multiple overlays of contributing problems that cause homelessness. Economic reasons, i.e. unable to pay rent or job loss often follow mental and physical disabilities. Alcohol and substance abuse are most often self-medication of mental health and relationship problems. In our culture, the ability to address economic empowerment - i.e. income seems to provide a basis not only for problem resolution but method of increasing self-esteem and motives to address underlying problems. However, our work environments do not often support the accommodations needed by those with physical and mental difficulties.*

*I don't know how many are affected by welfare time limits - I assume that's the reason for increased homelessness among families. Our intake records show that for 2004, 38% were victims of abuse; 61% indicated that substance abuse was a life problem; 43% indicate a history of mental illness; 35% indicate a history of both mental illness and substance abuse; 25% had been convicted of a crime and 5% had experienced all of the above. All of these things are part of the mainstream culture, but money and family support keep people from homelessness. People become homeless when that runs out.*
Young mothers who have a lot of children early, do not complete their education or training have a lot of trouble making it. Lack of education and job skills for most of the homeless is a reason. Of course, lack of affordable, decent housing is a big problem.

Many of the women clients with whom I work are 'technically' homeless. That is to say they may have been staying with friends, family or drug using or abusive husband or boyfriend. Often times these individuals are not counted on the homeless roles and may even be further punished by losing their children through 'abandonment' if they leave the abusive or drug infested home situation. Having a drug infested or unsafe home still counts as a home when counting the homeless population.

For our young population in this county (particularly those with mental health issues or an IQ of 70) who leave the county foster care network, there are no supports from the community or available options. They are particularly vulnerable and have absolutely no family supports anywhere.

Predatory lending practices lead to home foreclosures and this situation can cause homelessness.

They get caught up in the system that helps just enough to keep them alive, but doesn't provide the tools or resources they need to move out of homelessness to being self sufficient. It's an endless cycle they’re caught up in with no hope of getting out.
Serving the Homeless Population

There are many programs in place to assist people who are homeless. Three series of questions were developed to evaluate both the availability and the quality of these services as well as to determine the changes necessary to improve the overall effectiveness of the program.

When rating the quality and availability of the sixteen services, respondents were asked to use the response scale of “excellent, good, fair, poor and very poor.” By converting this five-point scale to numeric equivalents where “excellent” equals five and “very poor,” one, it is possible to compare mean or average scores. In the table below, the closer the mean is to five, the more favorable the rating.

<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>Food programs including pantries, soup kitchens, mobile</td>
<td>1</td>
<td>3.74</td>
</tr>
<tr>
<td>programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS programs</td>
<td>2</td>
<td>3.55</td>
</tr>
<tr>
<td>Adult education/job training programs</td>
<td>3</td>
<td>3.50</td>
</tr>
<tr>
<td>Outreach programs</td>
<td>4</td>
<td>3.35</td>
</tr>
<tr>
<td>Case management</td>
<td>5</td>
<td>3.33</td>
</tr>
<tr>
<td>Emergency Shelters (day, night, programmatic)</td>
<td>6</td>
<td>3.19</td>
</tr>
<tr>
<td>Alcohol/drug programs</td>
<td>7</td>
<td>3.09</td>
</tr>
<tr>
<td>Mental health counseling</td>
<td>8</td>
<td>3.04</td>
</tr>
<tr>
<td>Primary health care</td>
<td>9</td>
<td>2.99</td>
</tr>
<tr>
<td>Credit counseling/money management/budgeting</td>
<td>10</td>
<td>2.91</td>
</tr>
<tr>
<td>Transitional housing programs</td>
<td>11</td>
<td>2.81</td>
</tr>
<tr>
<td>Child daycare</td>
<td>12</td>
<td>2.63</td>
</tr>
<tr>
<td>Prevention/emergency assistance</td>
<td>13</td>
<td>2.60</td>
</tr>
<tr>
<td>Permanent supportive housing programs</td>
<td>14</td>
<td>2.58</td>
</tr>
<tr>
<td>Legal Assistance/Advocacy</td>
<td>15</td>
<td>2.52</td>
</tr>
<tr>
<td>Transportation services</td>
<td>16</td>
<td>2.48</td>
</tr>
</tbody>
</table>
Food programs including pantries, soup kitchens, mobile food programs

The Miami Valley has a variety of food programs that can be accessed by the homeless and others in need. Food programs are considered more available to homeless persons and of higher quality than are any of the other services considered.

Sixty-one percent of the people who took part in this survey feel that the availability of food programs are “excellent” (14 percent) or “good” (47 percent). On the five-point scale, the area’s food programs scored 3.74.

Food programs also received the highest quality rating. Three-fourths (73 percent) of the study participants consider these programs “excellent” (22 percent) or “good” (51 percent). On the five-point scale, the average was 3.98.

When asked for one change to the food programs that would increase their effectiveness, more than half (52 percent) of the people interviewed replied that no change is necessary. An additional seventeen percent did not answer this question about changing the food programs.

The few suggestions that were offered included the need for more locations, greater access by expanding the hours the programs are open, offering healthier food, and increasing the number of mobile programs.
HIV/AIDS Programs

Nearly half (48 percent) of the people who completed questionnaires believe that the availability of area HIV/AIDS programs is “excellent” (7 percent) or “good” (41 percent). The average on the five-point scale was 3.55.

The quality of the HIV/AIDS programs deserve an “excellent” (16 percent) or “good” (35 percent) according to half (51 percent) of the study participants. One in four did not know how to rate the quality of these programs. On the whole, the mean score was 3.84.

When asked about changes to improve the effectiveness of the HIV/AIDS programs, only one in three respondents (32 percent) offered an idea.

Thirteen percent would like to see greater visibility and public awareness of the programs. An additional four percent see a need for more programs to address HIV/AIDS. Four percent would like to see greater financial assistance. Some of the suggestions are listed below.

*More awareness amongst providers in regards to what ARC is doing*

*More educational outreach to schools, clinics and non-traditional locations*

*Greater allocation of emergency financial assistance*

*Assistance with medication cost*
About half (48 percent) of the respondents believe that there are an “excellent” (10 percent) or “good” (38 percent) number of adult education and job training programs available in Montgomery County. In this instance, however, ten percent of the people polled see a need for more programs. On the five-point scale the average score was 3.50.

There is a difference of opinion when it comes to rating the quality of these programs. Forty percent selected the “excellent” (6 percent) or “good” (34 percent) rating, but another thirty-three percent consider the programs “fair”. The average rating for the quality of these programs was 3.53.

When asked for suggestions about ways to improve the effectiveness of job training programs, thirty-six percent could offer no ideas. When suggestions were offered they were likely to focus on need for more programs offering a wider variety of training options, increasing the “user friendliness” of the programs and financial support.

The following are some of those suggestions:

- These programs need to be more user-friendly and client focused
- There should be an emphasis on jobs with potential for growth
- Provide more support services during the training program
- The training should be geared more to living wage jobs
- More structured work mentoring situations for those with mental health issues or disabilities
- More job training programs that will realistically lead to employment
- Have GED in one or two of the shelters again. Really offer job training that will lead to a good job
- More on-the-job training in various fields in various geographic locations
- More sheltered workplaces to teach basic employment skills
Outreach Programs

Forty-five percent of the survey participants think Montgomery County has “excellent” (4 percent) or “good” (41 percent) outreach to the homeless population. An additional thirty-five percent consider these programs only “fair”. On the five-point scale, the average was 3.35

How would you rate the availability of outreach programs?

- Excellent: 4%
- Good: 41%
- Fair: 35%
- Poor: 13%
- Don’t know: 6%
- Very poor: 1%

When rating the quality of the outreach programs, responses were somewhat more positive. Forty-eight percent selected the “excellent” (20 percent) or “good” (28 percent) rating.

Only thirteen percent of the study participants could offer any suggestions to make the outreach programs more effective. Those suggestions included developing more outreach programs and increasing the funding of these programs. Some of the suggestions include the following:

- Find a way to get outreach clients into the mental health system
- More neighborhood outreach areas
- There needs to be a greater ability to access mainstream services
- Outreach workers need to come into shelters to engage clients face-to-face.
- Much is needed here; this is a very important need
- There should be more coordination among all agencies
Case Management

Half (50 percent) of the survey participants believe case management is “excellent” (4 percent) or “good” (45 percent). Seventeen percent selected the “poor” (13 percent) or “very poor” (4 percent) response. On the five-point scale, the average was a “good” rating at 3.33

The perceived quality of the available case management is quite good. Forty-six percent selected the “excellent” (13 percent) or “good” (33 percent) rating.

More than one-third (36 percent) of the professionals interviewed offered at least one suggestion to make the case management system more effective. Two points accounted for the majority of the suggestions; the need for more staff so that caseloads are manageable and more training and supervision of caseworkers.

Create more caseworker positions
More highly trained case managers in all settings
Increase skill and quality of case management
Less punitive and more consistent case management throughout shelters
More case managers, greater collaboration between case managers at various agencies, wholistic case management.
Would like to see case management services available for the more chronically homeless
Higher standards for case managers
Case managers are overburdened. We need many more case managers so that they are able to work more intensely with each client
Case managers who do not punish clients for low functioning
Emergency Shelters (Day, Night and Programmatic)

The availability of emergency shelters is too limited according to survey participants. Although thirty-eight percent rated the shelter’s availability “excellent” (9 percent) or “good” (29%), twenty-three percent selected the “poor” (19 percent) or “very poor” (4 percent) rating. On the five-point scale the average response was 3.19.

Although the availability is too limited, the quality of the county’s emergency shelters is thought to be quite good. Three people in four (73 percent) consider the shelters “excellent” (16 percent) or “good” (57 percent).

When asked for suggestions to improve the effectiveness of the area’s shelters, forty-eight percent believe more facilities are the answer.

There are presently not nearly enough beds available.

We need so many, many more shelters

Create a drop-in shelter

More beds, somewhere for mentally ill persons to stay

More available beds, especially for women and children

More space for the emergency overnight and for program shelters

Consistent funding as a community safety net rather than annual push with cold weather

Rapid intake programs

Need more beds so there are shorter waiting lists

Better support from government and neighborhoods

Shelter and services to the homeless who cannot stop using drugs and/or alcohol
Alcohol and Drug Programs

There is also a need for greater access to alcohol and drug abuse treatment programs. Three fifth of the people responding to this study consider the programs “fair” (40 percent), “poor” (19 percent) or “very poor” (4 percent). On the five-point scale, the average 3.09

Although there are too few programs available, the quality of the current options is quite good. More than half (55 percent) considers the programs “excellent” (7 percent) or “good” (48 percent).

The great majority (88 percent) of the respondents offered at least one suggestion to improve the effectiveness of the alcohol and drug programs. Of those who did offer an idea it was for “quicker access/more openings” in sixty-four percent of the cases. Some of the suggestions include the following:

Quicker access for out-patient and in-patient treatment

We need childcare for mothers to go to in-patient treatment

Eliminate waiting lists

More in-house programs with longer stay

Don't seem skilled in working with mentally ill patients

Realistic, non-intimidating programs meeting the needs of the homeless

More programs are needed with extended time and aftercare housing

The in-patient treatment should last at least 60-90 days and need funding for more beds.

Need dual diagnosis treatment for mental health as well as substance abuse

Increase duration of program, step-down program, transitional housing and case management

More enhanced recovery and support groups
Many of the people who took part in this study see a need for greater availability of mental health counseling for people who are homeless. Three respondents in five consider the current access to these counseling programs “fair” (35 percent), “poor” (22 percent) or “very poor” (7 percent). On the five-point scale, these programs scored 3.04.

The evaluation of the quality of the mental health programs is more favorable. Forty-six percent of the participants rated the programs “excellent” (12 percent) or “good” (34 percent) while only one in five (19 percent) selected the “poor” (16 percent) or “very poor” (3 percent) ratings.

When asked for one change to the mental health counseling programs to increase their effectiveness, sixty-one percent offered at least one suggestion. One-third (33 percent) of the people interviewed see a need for quicker access while twelve percent would like to see an improvement in the quality of these programs.

More access to therapists and increase the monitoring and management of medications

Counselors more attuned to homeless problems

Need to be able to access appointments more quickly in the mental health services

More professional help with understanding mental illness

Have available much sooner and offer ongoing case management

Longer term structured residential setting to accomplish long term rehabilitation

Evidenced based programs; therapy not just medication management

Increased funding for general mental health counseling
Primary Health Care

Respondents are divided on their perception of the availability of primary health care services for the homeless. About one-third rate the availability “excellent” (4 percent) or “good” (26 percent), a third selected the “fair” response and the final third chose “poor” (25 percent) or “very poor” (6 percent). On the five-point scale the average rating was 2.99.

Although the availability of primary health care is too limited, the quality of the programs that are available is quite good. Fifty-five percent of the study participants selected the “excellent” (14 percent) or “good” (41 percent) rating, and another twenty-three percent consider the programs “fair”. The average rating was 3.61.

When asked for suggestions about ways to improve the effectiveness of the primary health care programs, fifty-five percent offered no suggestions. Those who did offer ways to improve these programs were likely to focus on the need for more programs that are more flexible in meeting the needs of the homeless. The following are some of those suggestions:

- Provide funding for prescriptions
- Mobile access – go to where the homeless are
- Reduce response time
- Too limited in area of prevention
- More just for the homeless population
- Have Medicaid available for youth through age 21
- Need broad based support from entire health care industry
- Increase number of clinics available and the number of hours open
- More affordable and preventive health care
Credit Counseling, Money Management and Budgeting

Many homeless people would benefit from learning the basics of money management, but according to the people polled, the availability of money management counseling is far too limited. Only seventeen percent of the respondents rated the availability of these programs as “excellent” (3 percent) or “good” (14 percent).

The qualities of the programs familiar to study participants are generally “fair” (26 percent) or “good” (25 percent). However, more than one-third (38 percent) did not know about the quality of these programs. The average rating of the quality of these money management programs was 3.45.

A majority (52 percent) of the people polled could offer no change to this system that would make it more effective in serving the homeless population. When suggestions were offered they likely focused on the need for more programs and a curriculum tailored to the needs of people currently homeless.

Who does this now? Is it free?

Programs need more visibility

Agencies need to be working with programs to offer these services to the clients

We need to increase the number of these programs and concentrate on where clients need

Offer with a curriculum that clients understand

There needs to be an office in Dayton, nearer to the west side and north side.

Offer a more realistic curriculum

Recruit more interested people to volunteer from private sector

Programs need to be offered in high school
Transitional Housing Programs

There appears to be a weakness in the availability of transitional housing programs. Although twenty-eight percent of the respondents consider these programs “excellent” (3 percent) or “good” (28 percent), a far greater share selected the “fair” (33 percent), “poor” (23 percent) or “very poor” (13 percent) ratings. The average rating was 2.81.

While the availability of transition housing programs may be limited, the quality of the available programs is quite good. Fifty-eight percent of the respondents selected the “excellent” (12 percent) or “good” (46 percent) response. The average on the five-point scale was 3.62.

Since the quality received a positive evaluation, it is understandable that the majority of suggestions to improve the effectiveness of transitional housing focus on increasing the number available.

Inadequate capacity, supervision

Need many more beds and housing units

Greater funding and community advocacy

Greater inclusively

There is a serious need for more programs for families and single women

These programs are good but it is finding permanent housing after

Those we have are going well but we need more

More structured housing for mental disabilities

Additional transitional housing programs for women and children
Child Daycare

Respondents see a serious need for additional child daycare services to meet the needs of the area’s homeless population. Only thirteen percent rated the current availability of daycare as “excellent” (3 percent) or “good” (10 percent). On the other hand, thirty-eight percent rate the availability “poor” (29 percent) or “very poor” (9 percent). On the five-point scale, the area’s child daycare programs scored 2.63.

While many respondents are concerned about a shortage of child daycare, one-third (33 percent) do not know how to rate the quality of the options that are currently available. Those who did rate the quality of the programs consider them “fair” (28 percent) or better (29 percent).

When asked what one change would improve the effectiveness of child daycare in the Miami Valley, the most common comment focused on the need for greater availability (30 percent) and centers that are more affordable (17 percent).

Need temporary and/or drop in daycare

Must be affordable daycare for homeless

Fund “Safe Sanctuary” and increase access for homeless parents

Homeless persons need to be approved for Title 20 for daycare before starting a job

We are in need of professionally run daycare services in all section of the community

Greater subsidy for low-income people and those in transition out of shelters

Make sure that daycare is user-friendly in terms of drop-in access

Increase funding for homeless individuals to access daycare

Provide for free if subject is actively working or enrolled in education
Prevention and Emergency Assistance

Respondents see a significant need for additional prevention and emergency assistance programs. When asked to rate the availability of these programs, forty percent rated the current availability as “poor” (23 percent) or “very poor” (17 percent). On the five-point scale the average rating was 2.60.

Although the availability is limited, the quality of the emergency assistance programs now in place is considered “excellent” (3 percent), “good” (29 percent) or “fair” (36 percent). The average on the five-point scale is 3.23.

When asked for suggestions about ways to improve the effectiveness of the prevention programs, one-third (37 percent) offered no suggestion. The most common suggestion is to increase the funding available to (22 percent) and to increase the number of programs (16 percent) addressing these needs. The following are some of those suggestions:

Greater inclusively in programs
Devise a cooperative model for the entire region
Crisis care outreach needed to assess and assist when needed.
More concentration on prevention rather than fixing
Increase community awareness of the changing demographics of homeless
Educate the community about the available resources and how to access those resources
There needs to be much greater availability of emergency funds for rent, utilities, etc
We need to have the ability to stop or intervene in evictions
Permanent Supportive Housing Programs

People who work with the homeless members of the community clearly feel that there are not enough permanent supportive housing programs in the area. When asked about the availability of these programs, forty-three percent selected the “poor” (29 percent) or “very poor” (14 percent) response. On the five-point scale the average rating was 2.58.

Although the availability of these housing programs is limited, the quality the ones that are available is good. Fifty-three percent of the study participants selected the “excellent” (4 percent) or “good” (48 percent) rating, and another sixteen percent consider the programs “fair”.

When asked for suggestions about ways to improve the effectiveness of permanent supportive housing programs, forty-two percent of the people polled see the need to increase the number of programs and fourteen percent would like an increase in the overall funding. The following are some of those suggestions:

We need to make this top priority

Increase access for low-income families. Prevent homelessness before it happens

These programs need more funding and greater community advocacy

Need to have more affordable housing in drug free areas for the homeless

Increase the length of the programs

Need many additional sober, supportive housing programs

Have to decrease the waiting list, need to have more units or options
Legal Assistance/Advocacy

Many homeless people face legal problems or situations where legal advocacy would be helpful. Unfortunately, according to the people interviewed there is a significant need for more programs in this area. Only eleven percent of the respondents rated the availability of legal advocacy programs as “excellent” (1 percent) or “good” (10 percent). Nearly four times that many respondents selected the “poor” (28 percent) or “very poor” (14 percent) ratings.

Even when programs are available, many are lacking in the needed quality. The quality of the programs familiar to study participants is generally “fair” (40 percent). On the five point scale, the average rating was 3.02.

Forty percent of the people who returned surveys could think of no change that would improve the effectiveness of the legal assistance programs available to homeless people. One in four (23 percent) would like to see greater availability and sixteen percent would like the current programs to be more easily accessed by potential clients. Some of the offered suggestions are listed below:

More opportunities for free consultation
Create advocacy structure to counter discrimination against homeless people
More legal aid counselors available to answer even the little questions
Need more room and cooperation from the community
Legal aid representative should be visiting shelters, just for homeless people
Need to answer phone and not direct people in crises to voice mail
Scope of practice needs to be expanded
Realistic walk-in availability
Reduce the difficulty to get assistance, the wait time and amount paper work
Transportation Services

Transportation services available to the area’s homeless people received the lowest score for availability. Nearly half (48 percent) of the people who completed questionnaires believe that the availability of these services deserve a rating of “poor” (29 percent) or “very poor” (19 percent). On the five-point scale the average rating was 2.48.

The quality of the transportation programs that are available generally received a “fair” (37 percent) or “good” (26 percent) rating. About one in four (22 percent) respondents did not know how to rate the quality of these programs. The average score was 3.22.

When asked about changes to improve the effectiveness of these programs, only forty percent of the people polled could offer an idea.

When suggestions were offered they were likely to focus on issues connected with the use of RTA (14 percent), the needs for additional programs (10 percent) and greater funding (7 percent). Some of those suggestions are listed below.

*Travel to outlying communities for greater job accessibility*

*More availability of transportation services to jobs not on the RTA line*

*Bus tokens for folks with no income and job seekers*

*Bus service should be free to homeless; we spend $1000's on tokens yearly*

*Bus lines do not always run where there are better jobs*

*Tokens and bus passes at reduced rates to shelter and clinic clients*

*Monthly bus passes to clients as long as they are sober and doing the right things*
Effecting Systemic Change

Numerous systems impact homeless people in Montgomery County. While there are many ways to change the delivery of individual services, systemic change could impact the flow of people from the various involved systems into homelessness.

Eleven systems were addressed. Respondents were asked to note one change in policy or practice that would do most to prevent people from becoming homeless.

<table>
<thead>
<tr>
<th>System</th>
<th>Percent offering suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable and public housing system</td>
<td>81%</td>
</tr>
<tr>
<td>Alcohol and drug abuse treatment system</td>
<td>72%</td>
</tr>
<tr>
<td>Mental health care system</td>
<td>68%</td>
</tr>
<tr>
<td>Job training system</td>
<td>61%</td>
</tr>
<tr>
<td>Criminal /juvenile justice system</td>
<td>57%</td>
</tr>
<tr>
<td>Welfare system</td>
<td>55%</td>
</tr>
<tr>
<td>Physical health care system</td>
<td>53%</td>
</tr>
<tr>
<td>Social Security system</td>
<td>52%</td>
</tr>
<tr>
<td>Veterans benefits system</td>
<td>51%</td>
</tr>
<tr>
<td>Mental retardation system</td>
<td>51%</td>
</tr>
<tr>
<td>Child protection/foster care system</td>
<td>48%</td>
</tr>
</tbody>
</table>

Affordable and Public Housing System

In a study about homelessness, it is understandable that the majority of the people who work directly with the homeless population could offer some suggestion about ways that the public housing system could change to help prevent the expansion of homelessness in the county.

The most common (38 percent) change to the public housing system to decrease homelessness is an increase in the number and type of homes available. Another twelve percent would like to see greater funding of the housing system. Four percent would like to see an expansion of the Section Eight options.

Is there an affordable housing system?

More affordable housing and more Section 8 vouchers

More subsidies; mixed-use developments

Integrate public housing in neighborhoods; increase affordable housing

Need to realize that dispersal countywide is the key

Personal safety can be an issue in some public housing programs. Creating a safe environment (9 percent) and confronting drug use by residents and visitors (3 percent) would increase the overall quality of life for residents.
Creating housing that is decent, safe and affordable.

Enforcement of drug violations to make for a safer environment for others

Open up more units and do more about drugs in public housing

Another area that these service providers would like to see addressed is the process by which people are able to access affordable housing. The process is currently complex and tends to be inflexible. Creating a more user friendly system may improve the effective use of public housing.

Applications are too cumbersome and take too long to get apt.

Relax requirements for entry

Criteria too difficult for those with criminal records

Screening methods so that those in need of supportive housing are able to access

Alcohol and Drug Abuse Treatment System

Seventy-two percent of the people who took part in this study offered a suggestion about ways drug and alcohol treatment system could help keep their clients from becoming homeless.

Understandably, one in ten (10 percent) respondents focused on the need for greater access to treatment and more in-patient beds.

Increase access to services and decrease waiting list

More transitional housing beds

Many (19 percent) of the suggestions focused on the need for greater follow-up after treatment. A similar share (14 percent) thinks that longer in-patient treatment when needed is an important and necessary change to this system. Changes to the case management (9 percent) would also be beneficial.

If needed, continue program longer

Much increased case management to follow clients following treat

Increase aftercare and post treatment follow-up

Longer stays with more prevention tools and suggesting ways of maintaining housing after release

Having the treatment programs to help despite relapse

Community coordination, longer stays and follow-up

Consistent case management

Some respondents would like housing issues addressed throughout treatment.

Begin at admission to work on post-treatment housing

Addressing housing issues and viable options early in treatment

Incorporate housing component into the whole system.
Another significant change would be at the front-end of this system, i.e. increasing the emphasis on outreach and informing the public about the services available.

- Earlier assessment and treatment
- Earlier intervention for youth
- Better competency, change ORC to allow forced treatment
- Programs that help addicts make the transition

**Mental Health Care System**

Two-thirds (68 percent) of the service providers who responded to this survey offered at least change to the mental health care system that could improve system’s ability to help prevent homelessness.

The most frequent comments focused on the need for an improved approach to case management (16 percent).

- More intense case management
- Develop better case management practices and protocols
- Greater follow-up and stronger case management
- Increase access to therapist and better prescription monitoring and management
- More therapy and case management rather than just medication management
- Increase number of case managers

Twelve percent of the comments focused on the need for larger staffs so that each staff member is handling a lighter caseload. Expanding the number of workers available would address the suggestion of ten percent of the people interviewed, greater access to the mental health care system.

- Easier to access and quicker to enroll
- Major reduction in waiting time to receive care
- Give shelter clients quicker appointments
- More immediate counseling resources
- Community mental health workers should not have more 20 on their caseload.

There is also a need for greater public awareness of the mental health programs that are available and to encourage earlier access when needed.

- Public Service Announcements as to where to go
- Have outreach workers or liaisons
- We need educational programs for clients to alleviate fears of treatment.
Other suggestions include:

- *We need access to child and adolescent psychiatry*
- *More places for people to reside*
- *We need more professionals trained to work with persons with mental health disabilities*
- *Need evening hours for working clients*

**Job Training System**

More than three-fifths (61 percent) of the people polled offered at least one way the job training system could prevent homelessness.

Ten percent of the respondents believe the training should focus only on those jobs that provide a living wage and jobs that have the potential for advancement. Without a living wage, the likelihood of maintaining a home is limited.

- *Training for an increase in livable wages*
- *More emphasis on skilled employment*
- *Train people for jobs that pay a livable wage*
- *More programs useable in today’s most needed areas of employment*
- *Advance the level of education beyond basic knowledge*

Six percent would like job-training programs to include job coaches or mentors.

- *Include job mentors*
- *Hire a job coach to work with folks after training*
- *Structured mentoring for sustained employment in living wage job*

Four percent would like to see public promotion of these job-training programs and outreach to the homeless population about what is available.

- *Better outreach to people who could utilize services*
- *Make this system more visible to the general community*

There are also populations that have special needs where job training is concerned.

- *More jobs for ex-offenders*
- *Moms need various supports in order to complete training*
- *We need to have a program for the young people in the house, 13-16 years*
Other suggestions include the following:

- Need to have job availability during the job training
- Be sure they get jobs after training
- Actually train people about how to get and maintain employment
- More realistic placement even if it means entry-level positions
- Provide housing while in training.

Criminal and Juvenile Justice System

More than half (57 percent) of the people polled offered at least one suggestion that would help the criminal and juvenile justice system prevent the people leaving the system from becoming homelessness.

Some suggestions focused on changes needed while people are incarcerated or instead of incarceration.

- Not a punitive system but a rehabilitative system
- More education along with some type of treatment while incarcerated
- Therapy during incarceration
- Treatment in lieu of prison for those with a drug history
- More preventative services rather than incarceration

A common (10 percent) suggestion is to improve discharge planning for this population. Some respondents suggest greater family involvement.

- Prisons need to prepare persons better for the community
- Incorporate a comprehensive discharge plan to include a housing
- Improve planning for release from incarceration to include planning for medications
- Mandate family participation in services
- Wholistic treatment including the family

Another suggestion is the need for more transitional housing (9 percent) and other programs for people leaving the criminal justice program.

- Create re-entry programs to cover all aspects of life including housing
- More transitional housing/beds
- More employment opportunities for recently released felons
- More available programs to take released people
- More employment opportunities for recently released felons
Case management and follow-up was the focus of seven percent of the comments offered.

- More intense case management for families
- Follow-up programs after transition has been made
- Follow-up/Case Management, funds for additional staff

### Welfare System

Fifty-five percent of the people who responded to this survey offered some suggestion about the way the discharge from the welfare system could be changed to help prevent homelessness.

In this case, suggestions varied widely. Some people would like to overhaul the entire system, while others see a need for a "change of heart."

- Needs a complete overhaul
- Working better with people who are on assistance
- More understanding, compassion, patience and better attitude toward those who are on welfare

Four percent would streamline the application process and make the system more flexible to address individual needs.

- Reduce adversarial nature of application process
- Streamline the intake system, eligibility requirements

Nine percent would like the system to offer greater benefits and three percent would end the current time limits.

- Increase benefits, easier access
- Extend time when necessary and make it more user-friendly
- Increase delivery of needs beyond housing
- End time limits; increase childcare assistance and availability

There should be greater rewards or incentives for welfare recipients according to three percent of the people interviewed.

- A reward system for when a person is moving towards independence
- More incentives to work; more childcare
- Don't penalize people who are working
- Provide more jobs for them to work for their checks

Four percent of the respondent would like to see changes in case management and personnel.

- Improve case management to include life skills, increase contact
Better training in policy, paper work and case management skills

Even when people are able to leave the welfare rolls, some services should continue to assist people as they become increasingly self-sufficient.

Continue to provide medical, food and childcare post cash award

Continued support services like medical and childcare subsidies

Physical Health Care System

Fifty-three percent of the people who returned surveys offered a suggestion concerning the link between the medical health care system and homelessness.

The most common suggestion is to offer lower cost or free services when needed and to increase emphasis on preventive care.

More indigent care

Need to be available regardless of ability to pay

Universal minimum healthcare and stop pretending that health care is free at the ER

Public health care free; focus on prevention

More services for the low income in addition to the Samaritan Clinic

Increase education about preventative care

More “addictionologists” who can educate users as to their disease

Six percent of the suggestion concerned changes to the current discharge planning process.

Better discharge planning

Discharge planning, communication with outreach

Four percent of the comments focused on the need for additional clinics, which may also improve accessibility, a concern of another six percent of the people polled.

More clinics for underemployed

More homeless clinics for physical health services

Reduction in waiting time for care

Provide additional clinics
Social Security System

About half (52 percent) of the people polled offered some suggestion about the way the Social Security System could prevent homelessness. Understandably, a few people noted issues about the programs solvency. As one person noted, "Just be sure the program is still there."

Two suggestions accounted for the great majority of those offered. Nineteen percent believe Social Security would be more effective if it were able to reduce the time necessary for applications to be approved. Another nine percent believe the system needs to become more “user-friendly” overall.

- **Reduce the wait time to have SSI / SSD approved.**
- **Reduce adversarial nature of process**
- **Decrease time between application, determination, and streamline appeal process**
- **Less bureaucracy, less barriers, more advocacies**
- **Assistance with filling out forms and supervision of follow through**
- **Decrease the number of forms and the wait time to be approved**
- **More rapid determination in the case of mentally ill patients**

Other suggestions concerning the Social Security System include the following:

- **Better system of assisting the truly disabled**
- **Less rigidity and empathy training**
- **Reduce disincentives to work.**
- **Allow young people to put some SS money into private investments**

Veterans Benefits System

About half (51 percent) of the people who completed this survey offered a suggestion to improve the way the Veterans Benefits system helps to prevent homelessness.

The largest share of suggestions (12 percent) focused on accessing the veterans benefit system.

- **Easier accessibility**
- **Takes forever to adjudicate a case**
- **Quick verification of DD214**
- **Reduce the difficulty of entering the system**

Others would like to see an increase in assistance and benefits and the reinstatement of some programs that have been cut.

- **Re-instate funding to places like Booth House and Holt Street**
- **No more cuts, rather increase the benefits**
Create more and affordable housing for vets.

More funding for current programs

Three percent would like to see an increase in the appreciation shown to area veterans.

Veterans need more respect

More appreciation of veterans

Give homeless veterans a priority and place within a month.

Mental Retardation System

Fifty-one percent of the people who returned surveys offered some comment about how the mental retardation system could help prevent homelessness. Twelve percent of those comments were simply “I don’t know.”

The need for more group living situations is an issue mentioned by seven percent of the respondents.

More group living situations

They have a 15-year waiting list for group homes! Lots of hype, no substance

More affordable group homes are needed

Greater funding for housing

More group homes needed. Too long of a waiting list

Four percent of the respondents suggested that mentally retarded individuals should be treated within the mental retardation system and not through the system in place to address homelessness.

Mentally retarded clients should be treated within the mental retardation system and not the Homeless system

Serve clients with in their own system

This system needs and emergency shelter similar to St. Vincent’s Hotel

Other comments include the following:

Provide optimum levels of care as long as necessary

Additional emphasis on services for adults

Follow-up programs after transition has been made

More custodial care

More sheltered workshops

Stop weeding folks out who are clearly eligible
Child Protection/Foster Care System

Fewer than half (48 percent) of the people polled offered a suggestion concerning child protective services.

When dealing with homeless families the child protective services are often involved. Six percent of the people interviewed believe that improving communication between the shelters and Children's Services Bureau would improve the care of homeless children.

- Develop a communication system between CSB and shelters to improve communication.
- Better communication with shelter providers
- Increase collaboration with shelters
- Better collaboration with shelters

Ten percent of the comments focused on the continuum of care with four percent focused on the beginning of care and six percent on aftercare.

- Early referral, outreach, wholistic case management
- Involvement earlier in living condition of children
- Follow-up programs after transition has been made
- Linkage with follow-up supportive services
- More in home monitoring, patience and a great support team
- Better assurance that recidivism is unlikely

Another six percent of the comments focused on the recruitment and training of caregivers.

- Increase screening for foster caregivers
- Much better trained workers
- Intense screening and monitoring
- More thorough investigation/training of foster parents/case workers

Four percent of the comments focused on the specific needs of older children.

- More services for older youth
- More safeguards for those aging out
- Allow CSB to pay for 100% placement beyond age 18
Participating Organizations

Alcohol Drug Addiction and Mental Health Services Board
AIDS Resource Center Ohio
ARC Ohio
Artemis Center

Catholic Social Services
Combined Health District
Community Action Partnership
Children’s Services Board

Daybreak
DePaul Center
Department of Veterans Affairs

Family Service Association

Good Sam

HelpLink
House of Bread

Mercy Manor
Miami Valley Innovations
Miami Valley Housing Opportunities
Montgomery County Jobs & Family Services
Montgomery County MR/DD

Ohio Department of Rehabilitation and Corrections, Adult Parole Authority

PLACES
Project Impact

Red Cross Emergency Housing Program

Salvation Army Booth House
Salvation Army Women & Children
Samaritan Clinic
Samaritan CrisisCare
St. Vincent Hotel, Inc.
St. Vincent Hotel
St. Vincent Supportive Housing

The Food Bank
The Other Place
Twin Valley Behavioral Healthcare

United Health Solutions

Women’s Recovery Center

YWCA
4. Please tell us if you think the following issues effects most, some, few or none of the homeless in Montgomery County.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Most/All</th>
<th>Some</th>
<th>Few</th>
<th>None</th>
<th>Does not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to pay rent/mortgage/security deposit/eviction</td>
<td>73%</td>
<td>27%</td>
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<td>0%</td>
<td>0%</td>
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<tr>
<td>Unemployment/job loss</td>
<td>63%</td>
<td>38%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Unable to find affordable housing</td>
<td>63%</td>
<td>29%</td>
<td>9%</td>
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<tr>
<td>Alcohol/substance abuse</td>
<td>39%</td>
<td>59%</td>
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<tr>
<td>Mental illness</td>
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<td>61%</td>
<td>7%</td>
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<td>0%</td>
</tr>
<tr>
<td>Divorce/family breakdown</td>
<td>27%</td>
<td>66%</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Argument with family/friends, i.e. asked to leave family home or</td>
<td>16%</td>
<td>66%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>home of relatives or friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical or disabilities or illness</td>
<td>14%</td>
<td>68%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Prison/jail record</td>
<td>14%</td>
<td>66%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Family/domestic violence</td>
<td>7%</td>
<td>77%</td>
<td>16%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Welfare time limits</td>
<td>9%</td>
<td>41%</td>
<td>48%</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

6. In the table below, please rate the AVAILABILITY of each service as excellent, good, fair, poor or very poor. There is a space below the table for any comments you would like to make about the AVAILABILITY of these services?

<table>
<thead>
<tr>
<th>Service</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very Poor</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food programs including pantries, soup kitchens, mobile food programs</td>
<td>16%</td>
<td>45%</td>
<td>32%</td>
<td>18%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Adult educational/job training programs</td>
<td>13%</td>
<td>41%</td>
<td>30%</td>
<td>7%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Case management</td>
<td>4%</td>
<td>46%</td>
<td>29%</td>
<td>14%</td>
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<td>2%</td>
</tr>
<tr>
<td>Outreach programs</td>
<td>4%</td>
<td>43%</td>
<td>36%</td>
<td>11%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Emergency Shelters (day, night, programmatic)</td>
<td>7%</td>
<td>30%</td>
<td>41%</td>
<td>16%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>HIV/AIDS programs</td>
<td>7%</td>
<td>45%</td>
<td>30%</td>
<td>4%</td>
<td>0%</td>
<td>14%</td>
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<tr>
<td>Mental health counseling</td>
<td>5%</td>
<td>30%</td>
<td>38%</td>
<td>20%</td>
<td>7%</td>
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<tr>
<td>Alcohol/drug programs</td>
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<td>41%</td>
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<tr>
<td>Primary health care</td>
<td>5%</td>
<td>21%</td>
<td>39%</td>
<td>25%</td>
<td>7%</td>
<td>2%</td>
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<tr>
<td>Transitional housing programs</td>
<td>4%</td>
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<td>32%</td>
<td>27%</td>
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<tr>
<td>Credit counseling/money management/budgeting</td>
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<td>18%</td>
<td>38%</td>
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<td>0%</td>
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<tr>
<td>Permanent supportive housing programs</td>
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<td>30%</td>
<td>27%</td>
<td>18%</td>
<td>5%</td>
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<tr>
<td>Prevention/emergency assistance</td>
<td>4%</td>
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<td>36%</td>
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<tr>
<td>Legal Assistance/Advocacy</td>
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<td>11%</td>
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<td>13%</td>
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<tr>
<td>Transportation services</td>
<td>4%</td>
<td>7%</td>
<td>32%</td>
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<td>20%</td>
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<tr>
<td>Child daycare</td>
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<td>29%</td>
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<td>4%</td>
<td>19%</td>
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<tr>
<td>Legal Assistance/Advocacy</td>
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<td>4%</td>
<td>20%</td>
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<td>25%</td>
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<td>39%</td>
</tr>
</tbody>
</table>

8. For each service listed below, what ONE change in policy or practice do you think would do MOST to improve the overall effectiveness of the continuum of care for Montgomery County’s homeless? If no changes are necessary, please indicate in column provided.

Adult education and training:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>16%</td>
</tr>
<tr>
<td>More programs/a wider variety of programs</td>
<td>19%</td>
</tr>
<tr>
<td>Easier access</td>
<td>10%</td>
</tr>
<tr>
<td>Funding/low cost/free for homeless</td>
<td>9%</td>
</tr>
<tr>
<td>Outreach/promotion of programs</td>
<td>6%</td>
</tr>
<tr>
<td>Support and housing during training</td>
<td>4%</td>
</tr>
<tr>
<td>Train for jobs that can support a family</td>
<td>4%</td>
</tr>
<tr>
<td>Improve user friendliness</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>10%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>19%</td>
</tr>
</tbody>
</table>
### Alcohol/Drug programs:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>7%</td>
</tr>
<tr>
<td>More programs/quicker access</td>
<td>51%</td>
</tr>
<tr>
<td>Longer stay/aftercare</td>
<td>9%</td>
</tr>
<tr>
<td>Other comments</td>
<td>20%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
</tr>
<tr>
<td>No answer</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Case management:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>19%</td>
</tr>
<tr>
<td>More training/supervision/standards</td>
<td>22%</td>
</tr>
<tr>
<td>More staff/lighter caseloads</td>
<td>20%</td>
</tr>
<tr>
<td>Less punitive</td>
<td>6%</td>
</tr>
<tr>
<td>Collaboration/networking</td>
<td>6%</td>
</tr>
<tr>
<td>Target homeless issues</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
</tr>
<tr>
<td>No answer</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Child daycare:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>16%</td>
</tr>
<tr>
<td>More/greater availability</td>
<td>30%</td>
</tr>
<tr>
<td>Lower cost/subsidies/free to homeless</td>
<td>17%</td>
</tr>
<tr>
<td>Professional/monitored</td>
<td>6%</td>
</tr>
<tr>
<td>Designed to meet the needs of the homeless</td>
<td>4%</td>
</tr>
<tr>
<td>For single parents</td>
<td>4%</td>
</tr>
<tr>
<td>Temporary/drop-in</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>9%</td>
</tr>
<tr>
<td>No answer</td>
<td>14%</td>
</tr>
</tbody>
</table>
Credit counseling/money management assistance:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>33%</td>
</tr>
<tr>
<td>More programs</td>
<td>13%</td>
</tr>
<tr>
<td>Realistic curriculum</td>
<td>12%</td>
</tr>
<tr>
<td>More outreach/advertising</td>
<td>6%</td>
</tr>
<tr>
<td>Other comments</td>
<td>10%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>9%</td>
</tr>
<tr>
<td>No answer</td>
<td>19%</td>
</tr>
</tbody>
</table>

Emergency shelters:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>12%</td>
</tr>
<tr>
<td>More shelters/beds</td>
<td>48%</td>
</tr>
<tr>
<td>Greater support/funding</td>
<td>7%</td>
</tr>
<tr>
<td>Long-term shelters</td>
<td>6%</td>
</tr>
<tr>
<td>Staff training</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>14%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>14%</td>
</tr>
</tbody>
</table>

Food programs:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>52%</td>
</tr>
<tr>
<td>More programs/locations</td>
<td>6%</td>
</tr>
<tr>
<td>Greater access/longer hours</td>
<td>6%</td>
</tr>
<tr>
<td>Healthy food/food quality</td>
<td>3%</td>
</tr>
<tr>
<td>More mobile programs</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>12%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>17%</td>
</tr>
</tbody>
</table>
### HIV/AIDS Programs:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>43%</td>
</tr>
<tr>
<td>Greater awareness/visibility</td>
<td>13%</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>4%</td>
</tr>
<tr>
<td>More programs/availability</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Legal Assistance/advocacy:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>14%</td>
</tr>
<tr>
<td>More/availability</td>
<td>23%</td>
</tr>
<tr>
<td>Accessibility</td>
<td>16%</td>
</tr>
<tr>
<td>Wider range of services</td>
<td>7%</td>
</tr>
<tr>
<td>Free for the homeless</td>
<td>3%</td>
</tr>
<tr>
<td>Expand funding</td>
<td>3%</td>
</tr>
<tr>
<td>More locations</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>26%</td>
</tr>
</tbody>
</table>

### Mental health counseling:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>22%</td>
</tr>
<tr>
<td>Quicker access</td>
<td>33%</td>
</tr>
<tr>
<td>Improve quality</td>
<td>12%</td>
</tr>
<tr>
<td>Evidenced based programs</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>13%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>17%</td>
</tr>
</tbody>
</table>
Outreach programs:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>51%</td>
</tr>
<tr>
<td>More programs</td>
<td>7%</td>
</tr>
<tr>
<td>Greater funding</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>12%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>25%</td>
</tr>
</tbody>
</table>

Permanent supportive housing programs:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>14%</td>
</tr>
<tr>
<td>More rooms/homes</td>
<td>42%</td>
</tr>
<tr>
<td>More funding</td>
<td>14%</td>
</tr>
<tr>
<td>Other comments</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>20%</td>
</tr>
</tbody>
</table>

Prevention/emergency assistance:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>20%</td>
</tr>
<tr>
<td>More funding</td>
<td>22%</td>
</tr>
<tr>
<td>More programs</td>
<td>16%</td>
</tr>
<tr>
<td>Greater availability</td>
<td>9%</td>
</tr>
<tr>
<td>Increased awareness</td>
<td>6%</td>
</tr>
<tr>
<td>Other comments</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>17%</td>
</tr>
</tbody>
</table>
Primary health care:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>33%</td>
</tr>
<tr>
<td>More programs</td>
<td>13%</td>
</tr>
<tr>
<td>Accessibility</td>
<td>9%</td>
</tr>
<tr>
<td>Greater flexibility</td>
<td>7%</td>
</tr>
<tr>
<td>Greater funding</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
</tr>
<tr>
<td>No answer</td>
<td>22%</td>
</tr>
</tbody>
</table>

Transitional housing programs:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>12%</td>
</tr>
<tr>
<td>More housing/rooms</td>
<td>52%</td>
</tr>
<tr>
<td>More funding</td>
<td>9%</td>
</tr>
<tr>
<td>Other comments</td>
<td>23%</td>
</tr>
<tr>
<td>No answer</td>
<td>13%</td>
</tr>
</tbody>
</table>

Transportation Services:

<table>
<thead>
<tr>
<th>How to improve the overall effectiveness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>32%</td>
</tr>
<tr>
<td>More programs</td>
<td>10%</td>
</tr>
<tr>
<td>Greater funding</td>
<td>7%</td>
</tr>
<tr>
<td>RTA issues/costs</td>
<td>7%</td>
</tr>
<tr>
<td>Accessing areas off RTA routes</td>
<td>6%</td>
</tr>
<tr>
<td>Accessibility</td>
<td>6%</td>
</tr>
<tr>
<td>Affordability</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>1%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>29%</td>
</tr>
</tbody>
</table>
9. For each system listed below, what ONE change in policy or practice do you think would do MOST to prevent people from becoming homeless? If no changes are necessary, please indicate in column provided.

**Alcohol and drug abuse treatment system:**

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>9%</td>
</tr>
<tr>
<td>Follow-up/after care</td>
<td>19%</td>
</tr>
<tr>
<td>Longer stays when needed</td>
<td>14%</td>
</tr>
<tr>
<td>Greater access/more beds</td>
<td>10%</td>
</tr>
<tr>
<td>Case management</td>
<td>9%</td>
</tr>
<tr>
<td>Housing/post treatment</td>
<td>6%</td>
</tr>
<tr>
<td>Intervention</td>
<td>4%</td>
</tr>
<tr>
<td>Outreach</td>
<td>3%</td>
</tr>
<tr>
<td>Funding/costs</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>12%</td>
</tr>
<tr>
<td>No answer</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Child protection/Foster care system**

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>20%</td>
</tr>
<tr>
<td>Improve communication with shelters</td>
<td>6%</td>
</tr>
<tr>
<td>Better screening/training of caregivers</td>
<td>6%</td>
</tr>
<tr>
<td>Increase aftercare</td>
<td>6%</td>
</tr>
<tr>
<td>Early intervention</td>
<td>4%</td>
</tr>
<tr>
<td>Safeguards for older children</td>
<td>4%</td>
</tr>
<tr>
<td>Increased funding</td>
<td>3%</td>
</tr>
<tr>
<td>More caseworkers/lighter caseloads</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>12%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>32%</td>
</tr>
</tbody>
</table>
### Criminal/Juvenile justice system:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>14%</td>
</tr>
<tr>
<td>Improve discharge plans</td>
<td>10%</td>
</tr>
<tr>
<td>Transitional programs/housing</td>
<td>9%</td>
</tr>
<tr>
<td>Greater follow-up/case management</td>
<td>7%</td>
</tr>
<tr>
<td>Family participation</td>
<td>6%</td>
</tr>
<tr>
<td>Use rehabilitation, not punishment for some crimes</td>
<td>4%</td>
</tr>
<tr>
<td>Treatment while incarcerated</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>13%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Job training system:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>13%</td>
</tr>
<tr>
<td>Train for living wage jobs</td>
<td>10%</td>
</tr>
<tr>
<td>Use job coaches/mentors</td>
<td>6%</td>
</tr>
<tr>
<td>More programs/options</td>
<td>4%</td>
</tr>
<tr>
<td>Outreach/promotions</td>
<td>4%</td>
</tr>
<tr>
<td>Case management/follow-up</td>
<td>4%</td>
</tr>
<tr>
<td>Placement upon completion/corporate links</td>
<td>4%</td>
</tr>
<tr>
<td>Supply housing during training</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>26%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>26%</td>
</tr>
</tbody>
</table>

### Mental health care system:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>12%</td>
</tr>
<tr>
<td>Improve case management</td>
<td>16%</td>
</tr>
<tr>
<td>More staff/lighter caseloads</td>
<td>12%</td>
</tr>
<tr>
<td>Greater availability</td>
<td>10%</td>
</tr>
<tr>
<td>More housing options</td>
<td>7%</td>
</tr>
<tr>
<td>Outreach/promotion of services available</td>
<td>3%</td>
</tr>
<tr>
<td>Longer treatment when needed</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>14%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>20%</td>
</tr>
</tbody>
</table>
### Mental Retardation System:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>20%</td>
</tr>
<tr>
<td>More group homes</td>
<td>7%</td>
</tr>
<tr>
<td>Greater access</td>
<td>6%</td>
</tr>
<tr>
<td>Serve homeless clients in MRDD system/not homeless</td>
<td>4%</td>
</tr>
<tr>
<td>Greater follow-up</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12%</td>
</tr>
<tr>
<td>No answer</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Physical Health Care System:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>17%</td>
</tr>
<tr>
<td>Free/low cost/ability to pay</td>
<td>14%</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>6%</td>
</tr>
<tr>
<td>Accessibility</td>
<td>6%</td>
</tr>
<tr>
<td>More clinics</td>
<td>4%</td>
</tr>
<tr>
<td>Case management/follow-up</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Welfare system:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>13%</td>
</tr>
<tr>
<td>Increase benefits</td>
<td>9%</td>
</tr>
<tr>
<td>More user-friendly/compassion</td>
<td>6%</td>
</tr>
<tr>
<td>Fix application process</td>
<td>4%</td>
</tr>
<tr>
<td>More for those who can’t work</td>
<td>4%</td>
</tr>
<tr>
<td>Case management</td>
<td>4%</td>
</tr>
<tr>
<td>No time limits</td>
<td>3%</td>
</tr>
<tr>
<td>Continue some benefits after leaving rolls</td>
<td>3%</td>
</tr>
<tr>
<td>More childcare</td>
<td>3%</td>
</tr>
<tr>
<td>More rewards/incentives</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>16%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>33%</td>
</tr>
</tbody>
</table>
### Social Security System:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>25%</td>
</tr>
<tr>
<td>Reduce time from application to approval</td>
<td>19%</td>
</tr>
<tr>
<td>Increase user-friendliness</td>
<td>9%</td>
</tr>
<tr>
<td>Increase benefits</td>
<td>6%</td>
</tr>
<tr>
<td>Maintain SSI system</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>12%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>No answer</td>
<td>23%</td>
</tr>
</tbody>
</table>

### Veterans Benefits System:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>22%</td>
</tr>
<tr>
<td>Accessibility</td>
<td>12%</td>
</tr>
<tr>
<td>Increase assistance/benefits</td>
<td>4%</td>
</tr>
<tr>
<td>More housing</td>
<td>4%</td>
</tr>
<tr>
<td>Follow-up</td>
<td>3%</td>
</tr>
<tr>
<td>Respect for veterans</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>13%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10%</td>
</tr>
<tr>
<td>No answer</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Affordable and public housing system:

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>3%</td>
</tr>
<tr>
<td>More housing/units/variety</td>
<td>38%</td>
</tr>
<tr>
<td>Stronger funding/more funds</td>
<td>12%</td>
</tr>
<tr>
<td>Create safer environments</td>
<td>9%</td>
</tr>
<tr>
<td>More Section 8 options</td>
<td>4%</td>
</tr>
<tr>
<td>Open housing to people with criminal records</td>
<td>4%</td>
</tr>
<tr>
<td>Greater flexibility</td>
<td>4%</td>
</tr>
<tr>
<td>Improve quality of available housing</td>
<td>3%</td>
</tr>
<tr>
<td>Adjust income criteria</td>
<td>3%</td>
</tr>
<tr>
<td>Address drug issues in and around housing</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>No answer</td>
<td>16%</td>
</tr>
</tbody>
</table>
### Mental retardation system

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>20%</td>
</tr>
<tr>
<td>More group homes</td>
<td>7%</td>
</tr>
<tr>
<td>Greater access</td>
<td>6%</td>
</tr>
<tr>
<td>Serve homeless clients in MRDD system/not homeless</td>
<td>4%</td>
</tr>
<tr>
<td>Greater follow-up</td>
<td>4%</td>
</tr>
<tr>
<td>Other comments</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12%</td>
</tr>
<tr>
<td>No answer</td>
<td>29%</td>
</tr>
</tbody>
</table>

### 10. What is the number one issue that you think should be addressed when developing “The Homeless Solution Ten Year Plan?”

<table>
<thead>
<tr>
<th>One change that would do most to prevent homelessness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change needed</td>
<td>17%</td>
</tr>
<tr>
<td>More affordable housing</td>
<td>28%</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>14%</td>
</tr>
<tr>
<td>Strengthen the Continuum of Care</td>
<td>12%</td>
</tr>
<tr>
<td>Need government cooperation/community cooperation</td>
<td>12%</td>
</tr>
<tr>
<td>Greater variety of housing programs/options</td>
<td>10%</td>
</tr>
<tr>
<td>Need transitional housing</td>
<td>10%</td>
</tr>
<tr>
<td>Permanent supportive housing</td>
<td>10%</td>
</tr>
<tr>
<td>Greater agency cooperation</td>
<td>9%</td>
</tr>
<tr>
<td>Teach life skills</td>
<td>7%</td>
</tr>
<tr>
<td>Need public education about homelessness</td>
<td>6%</td>
</tr>
<tr>
<td>Substance abuse treatment</td>
<td>6%</td>
</tr>
<tr>
<td>Address “revolving door”</td>
<td>6%</td>
</tr>
<tr>
<td>Need more emergency shelters/housing/no wait</td>
<td>4%</td>
</tr>
<tr>
<td>Improve case management system</td>
<td>4%</td>
</tr>
<tr>
<td>Childcare options</td>
<td>4%</td>
</tr>
<tr>
<td>Need programs for youth/foster children</td>
<td>4%</td>
</tr>
<tr>
<td>Safe environments around housing</td>
<td>4%</td>
</tr>
<tr>
<td>Job training/employment placement</td>
<td>4%</td>
</tr>
<tr>
<td>Need a living wage</td>
<td>3%</td>
</tr>
<tr>
<td>Greater options for ex-offenders</td>
<td>3%</td>
</tr>
<tr>
<td>Other comments</td>
<td>3%</td>
</tr>
</tbody>
</table>
The Homeless Solution
Ten Year Plan

Community Stakeholder Survey
2005
METHODOLOGY:

Participants: Strategic Visioning, Inc was provided with a list of one hundred sixty-four people representing one hundred forty-eight organizations representing a variety of concerns across Montgomery County. Every person on the list was asked to complete a survey for this study. Fifty-two individuals (31 percent) from thirty-seven (25 percent) different organizations chose to participate.

Survey distribution: Each participant was first sent an e-mail from Kathleen Shanahan of the Montgomery County Shelter Policy Board explaining the purpose of the study and asking for cooperation. Within twenty-four hours of that e-mail, all targeted individuals were sent the WEB based survey. Everyone who had not completed the questionnaire within the specified ten days was sent a follow-up e-mail request for participation.

Survey dates: January 2 through February 2, 2005

THE REPORT:

Information is presented in two formats for open-end questions, i.e., those questions that ask respondents to supply their own responses. First, a table shows the results when similar comments are grouped together. This was done to assist in the use of this data for planning purposes. Following those tables is a listing of the verbatim responses. These responses offer insights into the specific feelings of the individuals who took part in the study.
10-YEAR PLAN TO END HOMELESSNESS
STAKEHOLDERS SURVEYS

COMMUNITY STAKEHOLDERS
52 respondents

1. How informed are you about the issue of homelessness in the Dayton/Montgomery County area?
   - 37% Well informed
   - 50% Informed
   - 13% Don't know much about homelessness

2. How serious is the problem of homelessness in the Dayton/Montgomery County area? Would you say it is:
   - 29% A critical problem
   - 56% A serious problem
   - 15% A problem, but not serious
   - 0% No problem at all

3. How serious is the problem of homelessness in the community where you live? Would you say it is:
   - 19% A critical problem
   - 19% A serious problem
   - 31% A problem, but not serious
   - 31% No problem at all

4. How does homelessness impact you personally?

<table>
<thead>
<tr>
<th>Grouped Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not affect me at all</td>
<td>31%</td>
</tr>
<tr>
<td>Has a negative impact on Dayton</td>
<td>21%</td>
</tr>
<tr>
<td>We should be able to solve this problem</td>
<td>13%</td>
</tr>
<tr>
<td>See homeless people in downtown Dayton</td>
<td>12%</td>
</tr>
<tr>
<td>Have personally tried to help</td>
<td>10%</td>
</tr>
<tr>
<td>Has a strong impact on me personally</td>
<td>10%</td>
</tr>
<tr>
<td>Homeless deserve compassion</td>
<td>10%</td>
</tr>
<tr>
<td>Family/friend/self has been/is homeless</td>
<td>8%</td>
</tr>
<tr>
<td>Panhandled by homeless</td>
<td>4%</td>
</tr>
<tr>
<td>Attempts to solve this problem have failed</td>
<td>4%</td>
</tr>
<tr>
<td>Homeless have mental health problems</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>
Verbatim responses:

I work downtown and come in contact with several homeless people on a daily basis. Most seem harmless, other seem a little intimidating. I suspect that these folks also have some mental problems as well. My job often times includes downtown development and therefore 'quality of life ' issues inevitably come into play. The perceptions do influence how decisions are made. I live in a nearby downtown neighborhood. I have four children. Generally speaking, I have come to accept homelessness as a reality in the urban environment. We teach our children not to be afraid but careful. We also use this as way to teach them about the need to show compassion for those less fortunate than us.

It makes me question whether all of these glorious efforts to better poverty in all aspects haven't been a complete waste of time. We seem to perpetually attempt to empty an ocean one teaspoon at a time, and have concentrated vast resources of time and money toward no real effects.

I see the folks lined up at the nearby church to get a meal. I also see people chronically roaming the streets of Dayton. The need is great and the response is not adequate.

Homelessness does not affect me personally to any great extent except for the understanding of the social impacts and cost to the individuals and community.

I get panhandled everyday. All the social services for homeless are downtown, so we are the most impacted.

It leaves me with a profound sense of embarrassment about the collective failure of our community; feelings of guilt and powerlessness; and anger at policymakers for 25 years of terrible decisions about how to meet -- or rather not meet -- the human service needs of the homeless.

If I lost two paychecks, I would be homeless.

I do not see homelessness where I live but know that it is a major problem in Dayton and reflects the struggle of people to earn enough money to maintain a home with food, health care, etc. It takes more money to help people to leave homelessness than to prevent it. It so negatively impacts the quality of life in our area.

Reduces the value of properties in downtown Dayton and gives the city an image of poverty and hopelessness

It drives me crazy because I do not know how to help solve the problems. I strongly support the St. Vincent De Paul new housing location.

I work at the downtown library so it impacts our events and usage. People afraid or uncomfortable with the homeless stay away from downtown.

It impacts how others view our community when they see homeless people begging and/or sleeping in the streets

The personal effect is minimal. I have coordinated efforts to assist the homeless through my church and regularly donate to homeless resources. The effect for me is more professional. As a hospital/ER Social Worker, I see many homeless patients and provide direction to resources. I also collaborate with homeless resources.

I work at a law firm that deals with a significant homeless client base. I'm active (outside of the office) in ministry to/for the homeless. As a member of the minority community, I believe that many of my family and friends are just a few paychecks away from homelessness.

I find it troubling that a country with our resources we cannot find better solutions to these types of issues.
It doesn't affect me much at all. Although after being homeless myself, it does cause me to have great compassion for the people who become homeless. I give to organizations my time, talent and money whenever I can.

It's discouraging to see how we live in a country that can send billions of dollars to foreign entities and forget the people in need in the United States. I have little confidence that the present administration will come up with plans to significantly address this problem. With the continually declining tax base in Dayton and Montgomery County, the homeless issue needs to secure money from outside of our area to have a profound impact.

Most of the community reacts to the homeless; they are nameless, faceless individuals. I feel sad that these people for various reasons cannot be more productive citizens. The most hidden homeless are the children and that is the saddest of all. I have no contact with any of them. My connection is through my job of making grants to support shelters and programs. My son was part of a homeless shelter for several months in Cincinnati when the family was separated from him through his choice. That did affect me personally and I felt very helpless.

I am personally and professionally concerned for those who are homeless and who suffer from mental health or substance abuse problems. Impact is upon them, their families, and the community as a whole, but to date no personal affect upon me. No member of my family nor acquaintance is known to be homeless.

It does not speak very well for this community and its citizens when homeless issue are not addressed and ignored. There must be efforts to continue and improve on the current services and expand our effort to provide housing for homeless persons.

Other than seeing homeless people on the street, homelessness doesn't affect my day-to-day life.

I feel sympathy for the homeless folks, especially the families. I worry about their safety during the winter. I give money to organizations that help the homeless and I work to help whenever I can. I feel angry that our nation would rather wage a war than provide help to those who need it.

I am saddened by it, but at the same time I find myself offended, particularly by the men who sit near highway on and off ramps with signs on a daily bases. I was raised knowing that “but for the Grace of God go I” so I am not one to ask how could they be homeless, etc. My heart particularly goes out to women living on the streets.

The daily image of citizens trudging up and down Patterson Blvd. as they make their way from the overnight shelter to the day shelter is one of the most distressing sites that I personally see. It is a constant reminder that as a community, we have not only failed to support our families, but that are failures are without compassion.

Negatively impacts the ability to bring new people and visitors to our downtown; requires a great deal of financial resources to serve the clients properly. While Dayton’s problem is relatively small compared to other urban areas, it is still a problem we need to address.

Personally the problem is very troubling. I feel we need to try to provide solutions that empower all of our citizens to succeed and move toward self-sufficiency. Adequate shelter and living options are certainly an important component as are case management; job training skills and others to support this goal.

I live downtown and see many people affected by the problem. I also appreciate that homelessness is a by-product of other systemic problems and that it can affect anyone. We are all only a couple of paychecks and a couple of friends away.

Working in psychiatry we care for a significant number of homeless patients.

I personally do not feel affected by homelessness with the exception of my concern for the individuals experiencing it.
It diminishes my spirit because my community is not whole and some of my brothers and sisters suffer. Also, I feel powerlessness because the problem feels larger than I can solve.

It does not, to the best of my knowledge. I live in a community where there does not appear to be any homelessness. I do drive occasionally through an area where I see the homeless shelter and people standing around waiting to get in.

It reduces community stability and removes what could be valuable skills and resources from the community.

Negative impact on community; results in criminal activity; businesses leave Dayton, and people decide not to live in Dayton.

The homeless problem seems to be a forgotten problem unless the news media reports a cold night and does a report from in front of a homeless shelter, or they find a homeless person dead, as recently as the man found on the railroad tracks in Dayton. As a police officer, I see many issues like drunk driving or domestic violence get much attention, mostly because of certain organizations that have an effective public awareness plan, that promote the issue and solutions. I believe it takes much more that just a shelter to solve this problem, a comprehensive assessment and plan for these individuals is a step in ending the problem.

Homelessness leads to criminal problems and also complaints regarding vagrants and their personal habits, e.g., begging, drug use, drunk and disorderly, etc.

I encounter homeless people but I do not know anyone personally who is homeless. I have a relative whose home deteriorated and became unlivable -- but we are in the position to act as a safety net for her. Overall, I believe that our community is no stronger than our weakest link and that we are all responsible for building a strong community. How one does that in relationship to homelessness, I do not know.

It cost us all valuable resources and thousands of dollars, yet get us very little or no return on that investment.

It does not affect me but somehow I have not connected emotionally with the issue.

I deal with homeless people almost daily. They come to me for aid. I have homeless friends. I see the homeless in shelters and on the streets and in the underpasses

I deal with homeless students in my job as campus minister at Sinclair. Way too much!
5. Please tell us if the following issue effects most, some, few or none of the people who are homeless.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Issue</th>
<th>Most/All</th>
<th>Some</th>
<th>Few</th>
<th>None</th>
<th>Does not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unable to pay rent/mortgage/ Eviction</td>
<td>52%</td>
<td>33%</td>
<td>8%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>2</td>
<td>Unemployment/job loss</td>
<td>50%</td>
<td>37%</td>
<td>6%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol/substance abuse</td>
<td>35%</td>
<td>56%</td>
<td>6%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>4</td>
<td>Physical disabilities or illness</td>
<td>27%</td>
<td>62%</td>
<td>8%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>5</td>
<td>Mental illness</td>
<td>23%</td>
<td>58%</td>
<td>11%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>6</td>
<td>Divorce/family breakdown</td>
<td>21%</td>
<td>56%</td>
<td>15%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>7</td>
<td>Prison/jail record</td>
<td>8%</td>
<td>73%</td>
<td>8%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>8</td>
<td>Family/domestic violence</td>
<td>6%</td>
<td>69%</td>
<td>19%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>9</td>
<td>Welfare time limits</td>
<td>15%</td>
<td>56%</td>
<td>12%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>10</td>
<td>Argument with family/friends, i.e. asked to leave family home or home of relatives or friends</td>
<td>6%</td>
<td>65%</td>
<td>17%</td>
<td>4%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Q6. In developing solutions to end homelessness, planners talk about “closing the front door” by preventing people from becoming homeless and “opening the back door” to help people permanently leave homelessness. What services or programs do most to “close the front door” and prevent people from becoming homeless?

<table>
<thead>
<tr>
<th>Coded responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education/job training</td>
<td>33%</td>
</tr>
<tr>
<td>Mental health services</td>
<td>31%</td>
</tr>
<tr>
<td>Addiction treatment</td>
<td>15%</td>
</tr>
<tr>
<td>Life skills training</td>
<td>15%</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>13%</td>
</tr>
<tr>
<td>Job development</td>
<td>13%</td>
</tr>
<tr>
<td>Prevention programs/efforts</td>
<td>12%</td>
</tr>
<tr>
<td>Living wages</td>
<td>10%</td>
</tr>
<tr>
<td>Emergency/short-term help</td>
<td>10%</td>
</tr>
<tr>
<td>Medical insurance/health care</td>
<td>10%</td>
</tr>
<tr>
<td>Case management</td>
<td>8%</td>
</tr>
<tr>
<td>Nothing will work</td>
<td>6%</td>
</tr>
<tr>
<td>Ban predatory lending</td>
<td>6%</td>
</tr>
<tr>
<td>Child care</td>
<td>6%</td>
</tr>
<tr>
<td>MRDD Issues</td>
<td>4%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
</tbody>
</table>
Verbatim responses:

Adequate social work, counseling and follow up would help to close the door.

I don't believe that any program would eliminate homelessness.

Counseling programs that would help families stay together and understand the advantages of staying together, keeping a job or taking even a low paying job. Pantry type programs that provide assistance to those going through a rough stretch but may not want to 'enter the system. These types of programs can feel more like a helping hand than a hand out. People need to feel okay about taking advantage of this option. Churches close the front door, or could. Linking church volunteers with individuals or families on the edge can be a win-win. Many churches, even suburban ones, are looking for outreach opportunities to minister to the 'unchurched.' Encouraging them to do more than provide just a meal but to 'adopt' a family or individual for a period of time that they could mentor.

Job opportunities; financial management education; predatory lending education; health care coverage;

Ban predatory lending and make more affordable rental housing. Stop concentrating so much effort on home ownership and spend more on life-skills education.

We need more assistance with mental health and substance abuse issues. Without permanent appropriate hospitals, this issue has become critical. Job training and like skill training will help. A continual mentoring program for the chronically homeless is also necessary.

The underlying issue is a lack of education and bad decisions in their lives. We need to stress education to young people and teach decision making i.e., if you get pregnant and drop out of school, you are more likely to become homeless. Or if you take drugs, you are more likely to lose your job, family and house and will become homeless.

Our country and our community would be very well served if we returned to pre-Reagan criteria for the institutionalization and care of the mentally challenged, the physically disabled and chemically addicted -- and to adequate federal funding for providing this care at the local level.

More affordable safe housing with supportive services so people can learn how to maintain their home. On a larger viewpoint, improved education and job training, job development, jobs with health care, so people can earn a living wage

Permanent non-voluntary help for the mentally ill

Job training - Finance Education - more jobs - safe environments for the mentally ill

It seems there is 'little' on the front end to prevent homelessness. Rent and/or mortgage assistance in minimal in this community

Short time financial help, better jobs, increasing minimum wage. Maybe the best thing is a person (social worker) people on the edge can contact and get personal assistance from.

Better health insurance to cover adult males for medical and prescriptive needs; more community-wide counseling available free of charge

Family support and maintenance

Education - finishing high school/learning a trade, so they have marketable skills. Drug education. Prevent teenage pregnancy

Maybe if we had some kind of early warning system. Perhaps an ad that refers people to an agency that could do intake to find out what issues they face that could lead to homelessness. You could use the HelpLink system as the first point of contact.
Provide more jobs and training. Also, increase allocations to social service agencies that address these issues.

Government support for low income (minimum wage earners). i.e., for government to supplement their income, provide free or low cost good daycare.

Mental health intervention; substance abuse prevention and intervention

Better and more social services: aid for the poor, daycare, better public transportation, and healthcare. And more and better public housing with fewer barriers that keep people out of public housing

The job market is crucial for income needed to be independent. Monitor landlords for problem renters (non-paying, evicted). Offer financial counseling as well as social services. Ending homelessness is a wonderful goal, but I am too pessimistic to feel it can ever be totally solved. Many people do not want to share financial information. So many factors are involved. I think that a safety net must always be offered by the community with the goal of getting them off the system as soon as possible.

Emergency rent assistance for short term

A community wide case management system -- this would get people the services they need in a time of crisis

Increased mental health services

It is my opinion that the front door can never be closed, as new homeless person will be created with each economic downturn, governmental regulation changes, mental health status and family crises.

Education and an incentive to get off welfare; we can't cut people's benefits if they are trying to work to pay rent, etc.

Better upfront support services and realistic program to help those with mental disabilities

A working wage!! Programs to work with those who need education to get a decent job. Medical insurance for all

More long-term treatment options for the addicted and people with mental health issues. We need to change in how we penalize those whose main crime are being an addict or mentally disabled. The penal system in this country needs to be revolutionized.

Additional assistance in finding affordable housing; addressing the needs of single parents in terms of child care and finding jobs; additional training in trades where jobs often go unfilled

Prevention efforts that address the most common factors that lead to homelessness, affordable rental, tenant/landlord services

I don't think that we should ever plan to 'close the front door’. It would be reckless to propose the solution or solutions to the homeless or homelessness in such a short survey. The issues are complex, long term, and ever changing.

Job creation, affordable housing, and more prevention-based programs

More free legal services, credit counseling, more domestic violence services, better mental health services!

Employment training. Free health care clinics
We need to have temporary emergency aid for those who need one-time assistance with rent. Comprehensive services for the mentally ill and addicted, provided in a manner that is not threatening to them and that are easy for them to use on their terms.

**Better social safety net, stronger education system, living wage**

While I am not knowledgeable about the issue, I would guess that mental health services, as well as emergency financial assistance to the truly needy, would be the best way.

Jobs and education programs along with emergency intervention programs for those facing imminent homelessness.

More housing, treatment programs for substance abuse and mental illness, and more support

An outreach program to find not only those resident here that fall upon hard times or other issues, but those who perhaps migrate to this area and don’t know who to seek out for help.

Training on how to cope with problems and what services are available.

Providing life skill training to those most at risk and having hope at the end of the training. Jobs, treatment, shelter a vision of success, etc.

Many homeless people are mentally ill and/or drug dependent and/or they do not want to be part of any system. Helping get people off drugs is one program (high recidivism rate). Mentally ill can be treated, but when released often stop taking medications. These are tough issues to address. People who are homeless due to job loss -- job training and financial management programs could help.

Low cost affordable housing, transitional housing and jobs that pay livable wages.

Homelessness due to job loss: better linkage to job center services for those experiencing job loss...the average person does not know about the services of the job center in Dayton.
Q7. What services or programs do you think would do most to "open the back door" and help people get off the streets or out of shelters and into permanent housing?

<table>
<thead>
<tr>
<th>Coded responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting services/housing</td>
<td>31%</td>
</tr>
<tr>
<td>Job training/mentoring</td>
<td>29%</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>23%</td>
</tr>
<tr>
<td>Mental Health treatment</td>
<td>21%</td>
</tr>
<tr>
<td>Substance abuse treatment</td>
<td>21%</td>
</tr>
<tr>
<td>Case management</td>
<td>17%</td>
</tr>
<tr>
<td>Education</td>
<td>13%</td>
</tr>
<tr>
<td>Life skills training</td>
<td>12%</td>
</tr>
<tr>
<td>Job/job access</td>
<td>12%</td>
</tr>
<tr>
<td>Community-wide cooperative effort</td>
<td>6%</td>
</tr>
<tr>
<td>Government support/vouchers</td>
<td>4%</td>
</tr>
<tr>
<td>Childcare</td>
<td>4%</td>
</tr>
<tr>
<td>Emergency assistance</td>
<td>4%</td>
</tr>
<tr>
<td>Living wage</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
</tr>
<tr>
<td>Don't know</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Verbatim Responses:**

Adequate social work, counseling and follow up

Lack of housing is not the issue. The problem is getting the homeless to participate

Having affordable housing close to the services needed to keep people from going back to homelessness.

Information, education, hand holding

First, if a family or individual has medical needs, they must be addressed. It's hard to think about the next step if you're not physically or mentally prepared for the world. Counseling. Helping the person to understand that they do have choices and that there are opportunities (for employment). Starting over is okay! Training, i.e., helping a person to move from where they are to where they want to be.

Affordable housing units that meet the physical needs of the individual/family and are located in such a way as to make getting to work feasible.

Create more shelters that provide a broader spectrum of social services and education.

A series of interventions that progressively assist with life skills and work skills would go a long way to closing the back door.

We need more drug alcohol help and services for mental problems. Job training, life skills i.e. you need to show up for your job

Increased availability of low income/subsidized housing with supportive services to help people deal with the causes of their homelessness so they can maintain their homes

Education. Lack of education and understanding the need for it is the major cause
Social services, education and a user-friendly center where some long-term help can be given

For the long term homeless, mental illness is at the root, often complicated by substance abuse (which I see as a symptom of the mental illness). Nothing will really help the long term homeless until their mental illnesses issues are addressed

More affordable housing; more case management of those vulnerable people

Other Place/Samaritan Clinic social workers/caseworkers work with people on housing, but the housing resources are too minimal.

Available government facilitated housing and/or vouchers.

GED, job training and drug programs.

It will take a holistic approach, as people who become homeless tend to have a number of life issues that need to be addressed.

Provide more jobs and training. Also, increase allocations to social service agencies that address these issues.

Job training with a job coach.

Remedial education in reading and simple math

We need life skills programming, mentoring, employment, affordable housing and more jobs. We also need better services for the mentally ill and additional drug and alcohol treatment programs.

The lack of mental health services is appalling. Some of these individuals are simply not capable of handling finances or lives on their own. Education for work, very modest independent living quarters, counseling, and handholding...all is being done in some fashion. I have no magic ideas or solutions.

We need decent affordable housing alternatives. We need the old fashion boarding home brought back. A place where people can rent a room, have contact with other people and perhaps dinner together to alleviate the loneliness.

There should be a transitional housing program.

Employment skills

Low income housing with a minimum total cost that is affordable to person at the lowest income levels and permanent housing to address homeless individual with mental and drug problems until they are appropriately treated or the balance of their lives.

There are those who are strong advocates for the homeless, yet they will not allow them to live with them in their own homes. There needs to be a mentoring program so that people will be encouraged to gain an education, get off drugs and save for a place to live.

Need to offer job training and/or education, childcare, support and greater availability of affordable housing

A working wage!! Should offer social services on a long-term basis. Education and job training and childcare that is affordable.
Extend the transitional housing concepts using innovative models that certainly must be proven elsewhere. Utilize some of Dayton's vacant structures for highly skilled professionals to run homelessness to home program. The entire county needs to take on more of the homeless needs (shelters, etc.) I feel very strongly that our city borders have taken on much too much of this concern. Homeless who can be trained for work, need to be near more services and other employment opportunities in the suburbs.

Additional assistance in finding affordable housing; addressing the needs of single parents in terms of child care and finding jobs; additional training in trades where jobs often go unfilled

Partnerships with landlords, job training, life skills training, drug treatment programs that encourage the use of long-term services when needed, adequate mental health services

I don't think that we should ever plan to 'open the back door'. It would be reckless to propose the solution or solutions to the homeless or homelessness in such a short survey. The issues are complex, long term, and ever changing.

Employment training and opportunities, case management and affordable housing. Community-wide education (all communities) of the true circumstances realities of homelessness and causes.

Better mental health services!! We see a lot of pregnant homeless. Need to offer family planning services, free and easily available alcohol and substance abuse treatment. My own personal and uneducated opinion is that the homeless often lose their socialization and become more or less feral people and it is important not to isolate and ostracize them.

Life management training or possibly halfway houses

Should offer one-time assistance with rent or utility deposits. Many more transitional housing programs that provide case management to support families as they move out of homelessness.

Substance abuse, stable housing (range from shelter, transition, and affordable)

Again, mental health services and emergency financial assistance to the truly needy.

Jobs, education, life skills, tenant rights, consumer rights training programs and substance abuse programs.

More support needed so people don’t fall back into the same environment that they were in

A comprehensive assessment by an organization that has the resources to help solve most issues causing homeless, i.e. job placement, family counseling, metal illness etc.

Drug / alcohol treatment, job training and mental Health Services

Providing life skill training to those most at risk and having hope at the end of the training. Jobs, treatment, shelter a vision of success, etc.

Many homeless people are mentally ill and/or drug dependent and/or they do not want to be part of any system. Helping get people off drugs is one program (high recidivism rate). Mentally ill can be treated but when released often stop taking meds. These are tough issues to address. People who are homeless due to job loss need job training and financial management programs.

Low cost, affordable housing, transitional housing and jobs that pay livable wages

Better outreach to the homeless and better linkage to existing services. Must take care of immediate needs for the homeless to be able to concentrate on self-sufficiency. Need better follow-up to ensure the success of homeless clients (intensive case management).
Q8. What barriers do you see to the location of low-income housing or emergency shelters in the community were you live?

<table>
<thead>
<tr>
<th>Coded responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Not in my back yard&quot;</td>
<td>50%</td>
</tr>
<tr>
<td>Should be shared county-wide</td>
<td>13%</td>
</tr>
<tr>
<td>Lowers property values</td>
<td>10%</td>
</tr>
<tr>
<td>No homeless in our area</td>
<td>10%</td>
</tr>
<tr>
<td>Zoning issues</td>
<td>10%</td>
</tr>
<tr>
<td>There would be no opposition</td>
<td>8%</td>
</tr>
<tr>
<td>Increase in crime</td>
<td>6%</td>
</tr>
<tr>
<td>Public ignorance of issues</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
<tr>
<td>Don't know</td>
<td>8%</td>
</tr>
</tbody>
</table>

Verbatim responses:

There needs to be very careful selection of sites; not often suitable for single-family residential areas and heavily trafficked business areas.

My community has a large number of low-income housing available.

Very few obstacles since most of the low-income population live in the City of Dayton and near my neighborhood in the downtown area. With regard to additional housing, the barriers are those who feel that the Dayton community has more than its fair share. I don’t.

They are unwanted.

There is a need to spread opportunities for housing throughout the community; however, the social services needed to assist homeless people are almost all located in the City of Dayton. This means that transportation becomes another cost/barrier to self-sufficiency.

No one wants a shelter in his or her neighborhood. They need to be dispersed through out the region as to not impact one area like downtown Dayton.

Fear, ignorance and prejudice animate much of the discussion on this issue. Having said that, homeless persons’ access to nearby residential communities and businesses does pose a problem. My own view is that concentrating the homeless in centralized, institution-like, highly bureaucratized facilities is a mistake -- the same mistake we discovered with low- and moderate-income housing.

People are afraid that property values and the quality of life will decrease if low income housing and shelters are in their neighborhoods, need to demonstrate that it can work with quality programs that succeed.

There are just not enough of them and not enough services where they do exist.

All shelters have to get along with each other; the day shelter has isolated themselves from the other shelters; need a united community front

I live at the edge of Montgomery County/Miami County; my area is too rural for services.

NIMBY. Lack of suitable buildings.
The age-old NIMBY mindset is prevalent. People seen to view this as the 'kiss of death' as it relates to property values.

Lowering of property values for homeowners and possible increase in crime.

NIMBY---people are afraid of decreasing home values when shelters are located too close to residential areas.

There is a lot of community resistance (not in my back yard [NIMBY]). Stigma and stereotypes associated with homelessness, and a lack of community/neighborhood tolerance for non-conforming behaviors.

No desire from community members to bring in low-income housing

General public is unaware that there are homeless in this area or that a need for any shelter exists. I doubt that it would be well received locally. Misunderstanding of the 'who, what, why' of homeless and their stereotyped reputation would make educating community imperative.

My community (Brookville) would probably never zone low-income housing. How money could be allocated to front line church/community based resources would be useful too

NIMBY -- Having homeless people walking in the neighborhood.

Most communities have restriction and the NIMBY attitudes of persons in all neighborhoods.

The neighbors are biggest barrier to any low-income housing. Those words cannot be discussed or else people will come out in droves against the project. We need to think along the lines of workforce housing

People don't want them - fear of those who aren't like us - concern over loss of property value - rise of crime – ignorance

In Dayton where I live there is a backlash against additional housing or shelters because this is where most of it is. People need to see the real face of homelessness, not just the stereotypical drunk. They are not educated about the families who fall on hard times. Insufficient funding is also a serious barrier.

As stated above, many of the City of Dayton neighborhoods have taken on too many boarding houses and homeless services. I do feel with many it is a NIMBY issue.

NIMBY attitude: Too much focus on putting all low income people together, both for services and for housing, instead of dispersing services, shelters and housing into all areas of our community to break down the NIMBY

Lack of knowledge, compassion, and ignorance would top my list of barriers.

I am certain that people in Miamisburg would not believe there is a problem with homelessness in their city. The 'not in my backyard' mentality would be common and residents would put up a huge fight because of the stigma associated with homelessness and with being 'low-income.'

I live in a pretty well to do community. There are at least 2 low-income housing complexes in the area, but I know nothing about them. I am not aware of anyone trying to put an emergency shelter in the community.

Already saturated in Dayton, and resistance to more is common

Nobody wants it where they live or play.

Not generally well received, documented higher incidence of crime. Higher need for education intervention.
Q9. What are the major barriers homeless people in the Dayton/Montgomery County area encounter when trying to leave the streets and move into housing?

<table>
<thead>
<tr>
<th>Coded responses</th>
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<tbody>
<tr>
<td>Lack dependable income</td>
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<tr>
<td>Available affordable housing</td>
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<tr>
<td>Credit/personal history</td>
<td>13%</td>
</tr>
<tr>
<td>Transportation issues</td>
<td>10%</td>
</tr>
<tr>
<td>Case management</td>
<td>10%</td>
</tr>
<tr>
<td>Community resistance</td>
<td>10%</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>8%</td>
</tr>
<tr>
<td>Substance abuse issue</td>
<td>8%</td>
</tr>
<tr>
<td>Lack basic life skills</td>
<td>8%</td>
</tr>
<tr>
<td>Supportive housing</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>19%</td>
</tr>
<tr>
<td>Don't know</td>
<td>10%</td>
</tr>
</tbody>
</table>

Verbatim responses:

Adequate options, funding, mental illness, drugs, on-going support from social service agencies

Housing needs to be close to jobs and family/friend support. Dispersing homeless people throughout the county only makes the problem spread out and does nothing to solve the problem.

Affordability and availability

While unclear as to the precise reasons, it is my sense that there is insufficient housing available.

Lack of disseminated information

There are stigmas attached to homeless people, as well as problems with work histories, addresses etc. on job applications. Additionally, landlords are reluctant to place homeless people in their units for fear there will be destruction of property and loss of rent whether there is an actual factor or not. We need more non-profit transitional housing that will help establish a track record.

Many good intentioned people become enablers and don't let people address their issues by hitting bottom.

We need an effective strategy for more equitable dispersal of housing opportunities for the homeless. This is necessary not only to reduce the disproportionate burden on municipalities like Dayton. Dispersal will also make it impossible for residents of suburban communities to remain in a state of denial about homelessness.

There is a lack of affordable safe housing with supportive services to help people address the reasons why they became homeless--mental health, substance abuse treatment, job training/education, transportation, and health care.

Too little help for so many people.
I would just say the usual - employment, family, school, health care. As much as anything, I think they could use personal advocates who can work with them for a year while they transition. Even if they do find someplace, they often lack the skills to really improve their lives and avoid falling into the same old problems that led to homelessness to begin with. When most of us think about how we got through tough times in our lives, there was family or friends who helped. Most the homeless don’t have that, so a trained volunteer or a paid person that will be there for them can help with all the barriers.

Lack of jobs, health insurance, and confidence that they can make it

Need affordable housing and necessary funds for initial 'move in' expenses.

They have a lack of consistent income, and/or a support system that will aid them in maintaining the housing.

They lack a dependable income and have poor life skills.

The stigma of having been homeless and credit history

Lack of adequate housing, no permanent jobs, mental health issues/substance abuse issues.

Lack of employment opportunity, economic resources, support system (family and friends), and life skills.

Low paying jobs, poor health care, and poor public transportation to suburban jobs, felony convictions, poor credit and past debts, too few public housing units and Section 8 funds.

Apathy

Need for continuing stream of income. Probably transportation. Social skills may be lacking. General public misunderstanding. Never any celebration of success: You made it! Stigma of being homeless (or having just been). Continued contact with support system. Furnishings? Ability to stay out of shelters now.

Rent deposits and regular income/job security. Also having safe affordable housing options for folks.

Managing all dimensions of the transition -- we need case management.

Affordability and employment with a living wage.

I believe no clothes, credit, financial situation, job, lack of an education etc. are the problems

Cost of doing so, lack of transportation, loss of support facilities in home

The lack of education, training, a way to earn a living. Insufficient housing is a huge obstacle, need housing with supportive services. Many also have a criminal record or need drug/alcohol treatment.

People need for a permanent address when seeking jobs or other services. A catch 22 situation. The lack of job/employment history. Developing trust and sense of dependability. In this tight job market more employers are not as apt to take a risk on a temporary or permanent employee with a sketchy history.

Availability of units

Lack of stable income, ongoing issues with mental health and drug addiction

I would assume the reoccurrence of the same barriers that led to their original homeless situation
Lack of affordable options, lack of employment options, intervention access as needed to adequately resolve issues.

Lack of resources and support

An address, income and job skills (clothing to interview for a position)

Affordability and safety

I do not know but would guess that finances (for a deposit on apartment & utilities) and a steady income stream would be serious barriers.

Availability of safe, well-maintained, affordable housing

Lack of adequate housing available on demand

Need to have a plan to solve the issues causing the problem, or counseling to create a better quality of life. Some residents I see are happy to get housing but stop there and do not have a plan.

Finding affordable housing in areas where there are economic opportunities.

Affordability. Ability to manage finances and life skills to stay in housing. Transportation issues for job

Issues of respect and dignity; fear of loss of freedoms and sense of helplessness

History of job instability affects the willingness of landlords to rent to homeless.
**Q10. What is the number one issue that you think should be addressed when developing “The Homeless Solution Ten Year Plan”?**

<table>
<thead>
<tr>
<th>Coded responses</th>
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</tr>
</thead>
<tbody>
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<td>Community consensus</td>
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</tr>
<tr>
<td>Focus on prevention</td>
<td>12%</td>
</tr>
<tr>
<td>Campus setting for homeless</td>
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</tr>
<tr>
<td>Case management</td>
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</tr>
<tr>
<td>Adequate affordable housing</td>
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<tr>
<td>Long range planning</td>
<td>6%</td>
</tr>
<tr>
<td>Educate the public about homelessness</td>
<td>6%</td>
</tr>
<tr>
<td>Emphasize personal responsibility</td>
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</tr>
<tr>
<td>Housing for mentally ill</td>
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</tr>
<tr>
<td>Secure needed funding before beginning</td>
<td>4%</td>
</tr>
<tr>
<td>Employment opportunities</td>
<td>4%</td>
</tr>
<tr>
<td>Housing for substance abuse treatment</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>27%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Verbatim responses:**

- Getting broad based involvement from the public, private and religious segments of our community
- Adequate shelter space for all participants
- Services to homeless people need to be available where those people also have the family/friend and community (church) support.
- What is the root cause of homelessness for the individual or family?
- Location of homeless/low income housing units: concentration or dispersal?
- Assuring sufficient affordable housing units that are strategically located to accommodate the numbers of homeless.
- Creating shelters and emergency housing that is more like a mini-university or charter school. The homeless would be trained with a proper job skill and more importantly the proper life skills required to navigate through our society. These efforts would join forces with our area’s college campuses and social service organizations.
- The community needs to develop a comprehensive case management system that will be available one-on-one to counsel and assist families or individuals to overcome the multitude of barriers to their becoming self-sufficient. Housing is just one issue. There are many other needs that need to be met.
- Look at this as a long-term problem. Start with education now. I like the idea a campus concept that has all the services under one roof. We need to do a screening of each person to determine need. The client needs to determine that they want to change their life. Personal responsibility is left out of much of this discussion. We can feed and clothe but if behavior is not changed, they will be back on the street.
Reaching consensus among elected officials, policymakers, educators, churches and the business community that (a) homelessness is the most important social issue confronting us; (b) every community in our region has some responsibility for solving the problem; and (c) that a five, ten or twenty-year plan is doomed to failure unless adequate resources are dedicated to it.

Building a community consensus to address the problems related to homelessness that will support adequate funding, program design and collaboration.

Personal responsibility and education

City and county should work together on this issue. Long range planning is imperative. The problem has slowly grown and the solution will take awhile to fix.

Creating a community campus for homeless people so resources can be shared

Accessible services and support to those who are homeless who have a desire to 'get out from under' their homeless situation.

We need to make an examination of the culture of poverty and how it relates to race and class bias.

Put more resources into prevention, less into trying to 'fix' current homeless population.

Prevention

Where will you get the money? All of the plans are useless without viable financial resources.

Try to concentrate all services into one area ---- similar to what the job center has done.

Mental health and substance abuse early intervention before someone becomes homeless; for example, an early warning system for identifying those persons likely to becomes homeless.

Should focus on homeless families with children. If we can't provide the kids with stable homes, educations, and environments then we are setting up the next generation for homelessness

We need an understanding of the problem from community leaders and the political will to fix it.

I personally think that mental health help is desperately needed for many of these individuals. I do not think that Dayton as a community provides the help that is needed. The number one issue has to be employment for continued income and independence and success. Our community does not offer as many factory/manual jobs as one time, which could be a solution for some of these needs. It will take more education and skill building so that these people can function in a world of service and technology.

Small housing/boarding home availability for those making minimum wage

A case management system

Finding employment and housing

I think the homeless need a personal advocate who can help them on a long-term (one year) basis to make the transition and overcome their individual barriers.

Educating the families and their children and finding a way to provide financial incentives for children who receive good grades. For example if a child maintains a 3.0 GPA they receive a monthly bonus of $500. This way the cycle is stopped.
ABLE
Area Agency on Aging

Christ Episcopal (Downtown Churches)
City of Centerville
City of Clayton
City of Dayton
City of Dayton – Neighborhood Affairs
City of Kettering
CityWide Development Corporation
County Corp

Dayton Metro Library
Dayton Municipal Court
Downtown Dayton Partnership
Downtown Priority Board

FCFC

Fifth Third Bank

Good Samaritan Hospital
Greater Dayton Christian Connection

HealthLink Miami Valley
Home Builders Association
Homeownership Center

Iddings Foundation

Kettering School District

Legal Aid Society of Western Ohio
Levin Family Foundation

Miami Valley Hospital
Montgomery County
Montgomery County Sheriff's Office

National City Bank

St. Mary's Development Corporation
Shelter Policy Board
Southeast Priority Board
State of Ohio Auditor, Regional Liaison
Supportive Education Program, Sinclair

Teen Coalition
Third Congressional District

University of Dayton
Homeless Solutions: SWOT Results 2-9-05

Top Issues by Type (S, W, O, T)

Strengths

1. **Significant public and private funds committed to homelessness locally.** (24 votes)
   - Significant public and private funds are being spent on homelessness locally – 19
   - Millions of dollars committed to the issue locally – 3
   - Success in obtaining funding for homeless assistance programs – 2

2. **Dedicated, competent service providers representing broad spectrum of agencies.** (23 votes)
   - Dedicated, competent, committed service providers – 19
   - Broad spectrum of agencies dealing with homelessness – 4

3. **Strong sense of cooperation in system – between government and providers, among providers, between City of Dayton and Montgomery County.** (22 votes)
   - Strong sense of cooperation between government and services providers and among providers - 16
   - Cooperation between city and county on this issue – 3
   - One of the strongest shelter coalitions in the state; collaborative effort and effort to avoid any duplication – 2
   - Collaboration evident based on who is here – 1

Weaknesses

1. **Inadequate supply of safe, affordable housing.** (21 votes)
   - Inadequate supply of safe, affordable housing – 19
   - Housing, employment for felons. We’re not prepared to address the number of prisoners released (also a threat) – 2

2. **Lack of overall coordination/oversight over system.** (20 votes)
   - Lack of overall coordination/oversight over system, particularly with faith and community groups. No oversight to steer them to what is really needed. - 15
   - Don’t fit parts into a whole – 3
   - Lack of coordination and case management across the system – 2

3. **Lack of a business case and comprehensive marketing plan demonstrating why the community should address homelessness.** (17 votes)
   - Lack of a business case for why the community should address homelessness – 14
   - Lack of strategic, comprehensive marketing plans for why/how we should address homelessness – 3

3. **Limited availability of needed beds and services within continuum.** (17 votes)
   - Limited availability of beds and services within continuum – 9
   - Lack of beds/services for homeless mentally ill - 5
   - Hard to place ex-offender population – lack of resources – 3
Opportunities

1. **Opportunity to realign the overall system and construct a system that truly interconnects all of the providers (e.g., connect $ to clients instead of agencies, tackle affordable housing issue locally, develop system-wide outcomes, prevention, cross-system case management)** (49 votes)
   - Opportunity to really realign the overall system (e.g., connect $ to clients instead of agencies, really tackle the affordable housing issue locally) – 18
   - Opportunity to construct a system that truly interconnects all of the service providers to work together – 17
   - Case manager/service broker to work with and follow homeless person or family across agencies and systems to a positive outcome – 9
   - Opportunity to develop a prevention continuum – 2
   - Opportunity to look at what we’re doing and redesign outcomes and look at all of this collectively – 1
   - Opportunity to better collaborate across systems, especially between homeless system and mental health system – 1
   - Opportunity to really focus on how our current system negatively impacts children and make necessary changes to fix this - 1

2. **Potential to “grow” HMIS into a well-developed system to track services and clients and support comprehensive case management across agencies/systems.** (14 votes)
   - Potential to “grow” HMIS … - 13
   - Every agency would have access to a service database that also provides tracking systems – 1

3. **Opportunity for shrinking dollars to be the catalyst for generating more creativity in how we manage our resources.** (12 votes)
   - Shrinking dollars can bring more creativity to how we manage our existing resources – 12

Threats

1. **Failure to resolve underlying causes of homelessness and address impact of other mainstream systems on homelessness.** (27 votes)
   - Failure to resolve underlying causes of homelessness – 12
   - Impact of other systems “dumping” into homeless system (criminal justice, foster care, etc.) – 10
   - Increase in mentally ill population in the system and lack of resources to “track” what happens when referrals are made - 5

2. **Major decreases in funding for programs and services for very-low individuals.** (21 votes)
   - Major decreases in funding for programs and services for very-low income individuals – 20
   - Competition with funding for other areas (e.g., the arts) - 1

3. **Demolition of DMHA apartment units.** (15 votes)
   - Loss of DMHA apartment units - 15
1. **Opportunity to realign the overall system and construct a system that *truly* interconnects all of the providers (e.g., connect $ to clients instead of agencies, tackle affordable housing issue locally, develop system-wide outcomes, prevention, cross-system case management) (51 votes)**
   - Opportunity to really realign the overall system (e.g., connect $ to clients instead of agencies, really tackle the affordable housing issue locally) – 18
   - Opportunity to construct a system that *truly* interconnects all of the service providers to work together – 17
   - Case manager/service broker to work with and follow homeless person or family across agencies and systems to a positive outcome – 9
   - Opportunity to develop a prevention continuum – 2
   - Opportunity to address lack of coordination and case management across system – 2
   - Opportunity to look at what we’re doing and redesign outcomes and look at all of this collectively – 1
   - Opportunity to better collaborate across systems, especially between homeless system and mental health system – 1
   - Opportunity to really focus on how our current system negatively impacts children and make necessary changes to fix this – 1

2. **Threat of the failure to resolve underlying causes of homelessness and address impact of other mainstream systems on homelessness. (27 votes)**
   - Failure to resolve underlying causes of homelessness – 12
   - Impact of other systems “dumping” into homeless system (criminal justice, foster care, etc.) – 10
   - Increase in mentally ill population in the system and lack of resources to “track” what happens when referrals are made – 5

3. **Strength and opportunity of a strong sense of cooperation in system – between government and providers, among providers, between City of Dayton and Montgomery County. (26 votes)**
   - Strong sense of cooperation between government and services providers and among providers – 16
   - Opportunity to use existing level of coordination among homeless provider agencies to increase collaboration and achieve 10-Year Plan goals and outcomes – 4
   - Cooperation between city and county on this issue – 3
   - One of the strongest shelter coalitions in the state; collaborative effort and effort to avoid any duplication – 2
   - Collaboration evident based on who is here – 1
Funding

1. Threat of major decreases in funding for programs and services for very-low individuals and weakness of restrictions on use of funds. (26 votes)
   - Major decreases in funding for programs and services for very-low income individuals – 20
   - Inflexible funding streams (e.g., restrictive rules on eligibility or services that can be provided) – 3
   - Funding incentives are built in to provide services for a need not to eliminate the need - 2
   - Competition with funding for other areas (e.g., the arts) - 1

2. Strength of significant public and private funds committed to homelessness locally. (24 votes)
   - Significant public and private funds are being spent on homelessness locally – 19
   - Millions of dollars committed to the issue locally – 3
   - Success in obtaining funding for homeless assistance programs – 2

3. Opportunity for shrinking dollars to be the catalyst for generating more creativity in how we manage our resources. (12 votes)
   - Shrinking dollars can bring more creativity to how we manage our existing resources – 12

Housing/Services

1. Weakness and Threat of inadequate supply of safe, affordable housing. (56 votes)
   - Inadequate supply of safe, affordable housing – 19
   - Demolition of DMHA apartment units – 15
   - NIMBY - 10
   - Restrictions on jobs, housing for ex-offenders, particularly sex-offenders – 5
   - Zoning that doesn’t allow for affordable housing; lack of regional approach - 4
   - Housing, employment for felons. We’re not prepared to address the number of prisoners released (also a threat) – 2
   - Aging housing stock that is difficult and expensive to maintain - 1

2. Strength of dedicated, competent service providers representing broad spectrum of agencies. (23 votes)
   - Dedicated, competent, committed service providers – 19
   - Broad spectrum of agencies dealing with homelessness – 4

3. Threat and Weakness of lack of beds and services within continuum. (22 votes)
   - Limited availability of beds and services within continuum – 9
   - Lack of beds/services for homeless mentally ill – 5
   - Lack of resources for hard-to-place ex-offender population – 3
   - Resources devoted to homeless youth/young adults- 5
Top Issues Overall

1. **Weakness and Threat of inadequate supply of safe, affordable housing.** (56 votes)
   - Inadequate supply of safe, affordable housing – 19
   - Demolition of DMHA apartment units – 15
   - NIMBY - 10
   - Restrictions on jobs, housing for ex-offenders, particularly sex-offenders – 5
   - Zoning that doesn’t allow for affordable housing; lack of regional approach - 4
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3. **Threat of the failure to resolve underlying causes of homelessness and address impact of other mainstream systems on homelessness.** (27 votes)
   - Failure to resolve underlying causes of homelessness – 12
   - Impact of other systems “dumping” into homeless system (criminal justice, foster care, etc.) – 10
   - Increase in mentally ill population in the system and lack of resources to “track” what happens when referrals are made - 5

4. **Strength and opportunity of a strong sense of cooperation in system – between government and providers, among providers, between City of Dayton and Montgomery County.** (26 votes)
   - Strong sense of cooperation between government and services providers and among providers -16
   - Opportunity to use existing level of coordination among homeless provider agencies to increase collaboration and achieve 10-Year Plan goals and outcomes - 4
   - Cooperation between city and county on this issue – 3
   - One of the strongest shelter coalitions in the state; collaborative effort and effort to avoid any duplication – 2
   - Collaboration evident based on who is here – 1

4. **Threat of major decreases in funding for programs and services for very-low individuals and weakness of restrictions on use of funds.** (26 votes)
   - Major decreases in funding for programs and services for very-low income individuals – 20
   - Inflexible funding streams (e.g., restrictive rules on eligibility or services that can be provided) – 3
   - Funding incentives are built in to provide services for a need not to eliminate the need - 2
   - Competition with funding for other areas (e.g., the arts) – 1
Homeless Solutions Leadership Team

February 9, 2005

SWOT Analysis Participants

Leadership Team Members Present
Jim Dinneen, Co-chair
Deb Feldman, Co-chair
Dannetta Graves
Walt Hibner
Jim Hoehn
Marc Levy
Victor McCarley
Judge Alice McCollum
Dr. Morton Nelson
Maureen Pero
Joe Szoke
Dr. Judy Woll

Leadership Team Members Absent
Tom Breitenbach
Brother Ray Fitz
Doug Franklin
Rev. John Paddock
Judge Walter Rice
Rev. Jimmy Washington

Providers Present
Ruth Addison, CrisisCare
Donna Audette, YWCA
Judith Barr, Samaritan Clinic
Richard Brooks, Adult Parole Authority
Jim Butler, St. Vincent
Doug Craddock, Eastway
Roy Craig, PLACES
Kristen Dunn, CAM
Gaynell Durham, DayMont
Debbie Ferguson, Community Action Partnership
Walter Gilbert, Holt Street
Joanne Hale, Sunrise Center

Robert Kelley, Red Cross Emergency Housing
Kay Kelbley, Salvation Army
Sister Donna Liette, Mercy Manor
Leslie Liszak, CADAS
Tom Kelley, Family and Children First Council
Linda Kramer, Daybreak
Tina Patterson, The Other Place
Cheryl Spencer, Children Services Board
Brad Wainwright, Nova House
Diane Welborn, Ombudsman
Jim Wilson, MVHO
Russell Winters, AIDS Resource Center Ohio

Facilitator
Beth Mehlberth

Observers
Barbara Brown, DayMont
Eddie Roth, Dayton Daily News

Staff
Kathy Emery
Gayle Ingram
Roberta Longfellow
Nancy Schiffer
Kathleen Shanahan
Joe Tuss
MONTGOMERY COUNTY SHELTER POLICY BOARD
Initial Report: Homeless Solutions Focus Groups
Submitted: May 30, 2006

Before finalizing recommendations developed as parts of the 10-year plan to end chronic and reduce overall homeless in Dayton and Montgomery County, the Shelter Policy Board contracted with Strategic Visioning, Inc. to conduct consumer focus groups. The people selected to participate in the groups were homeless and formerly homeless individuals.

Four focus groups were scheduled with consumers of services designed to assist the homeless find permanent shelter. The groups included one single woman, fourteen single men, ten women with children and seven men who live in supportive housing.

Each group lasted about two hours and took place at locations convenient to participants. The single people met at St. Vincent Hotel, the women with children met at the downtown YWCA and the men in who live in supportive housing met at PLACES Cobblegate.

FINDINGS

Increase employment skills of homeless (Recommendation 1-4)

Everyone who took part in the groups supported the idea of developing a business or job program for the homeless. One of the most difficult transitions for people who have lived on the street is to successfully manage the structure of the work environment. A program developed for homeless individuals could assist people with the transition.

For some, this business would be a long-term permanent position. People who have criminal records support this idea as the only option they may have work.

It would enhance the potential success of this program if the work opportunity could be linked with supportive and transitional housing.

A variety of jobs were suggested. Men leaned toward construction or services like painting, landscaping or hauling. Women thought a day care center operated by homeless women would allow women to gain supervised parenting experience while providing a much needed service.
Develop centralized case management system (*Recommendation IVc-2*)

This idea received mixed response. The essential issue for group members is not how many case managers they are assigned, but how effectively those people advocate for them.

In some instances, people supported the single case manager approach as a way to streamline efforts. One man had four case managers who scheduled a total of sixteen appointments with various agencies during one month. Relying on public transportation or walking to the various appointments made it difficult for that individual to find food that day and to get to St. Vincent’s shelter before the cut off time. Other participants reported being sent to the same agency by more than one case manager because managers are not aware of the efforts of their colleagues at other agencies.

Develop 24/7 intake and screening  (*Recommendation IVc-1*)

New to the streets, most group participants relied on others in the shelters or on the streets to teach them “the ropes.” It would be helpful to have a way to ensure that everyone who finds themselves without shelter learn about all of the available assistance programs as quickly as possible. One woman suggested a handbook titled “How to be Homeless in Dayton”. Compiling a handbook would help not only those in need of assistance but would keep providers up to date on the sources available.

Design gateway shelter services to reduce density and neighborhood impact  (*Recommendation IVc-8*)

Moving The Other Place to a new location was not well received by many, but not all, group participants. The convenience of having both shelters in one area serves people who rely walking to the shelters and free meal programs. Although folks who stay at St. Vincent’s Hotel appreciate the accessibility, they do understand why city leaders may want to move The Other Place to a new location. They appreciate that having many homeless people congregating in one area does not enhance the appearance of that neighborhood.

The greatest difficulty that would be created by relocating the day shelter would be transportation. If bus tokens were provided for transportation, the move would not keep people from accessing either the day or evening shelter.

Single men who often visit The Other Place expressed concern about the availability of drugs around the current day shelter. Homeless folks who have drug problems tend to hang around the neighborhood waiting to buy drugs. Because they wait on public property, The Other Place is not in a position to force the groups to disperse. Some type of security should be considered at a new location; the homeless themselves could possibly staff such a service.

All participants support all day availability of St. Vincent Hotel to families. The ideal situation would be to have a separate shelter for families.
Separate shelters for young single adults (18-24)  \textit{(Recommendation IVc-6)}

The single men feel this may be a good idea. Young men are seen as disrespectful of older men and of shelter staff. Their needs differ. Older men would like a quieter environment than do younger men who tend to generate more noise. These conflicts can result in fights between the age groups.

After some discussion, the single men said that it may not be possible to use age as the determining characteristic, but could offer no alternative selection criteria.

Separate shelters for people who are drinking or using drugs  \textit{(Recommendation IVc-8)}

People who are using drugs and alcohol can be problematic in the shelters, but generally shelter staff is aware of potential problems when people arrive. Since no one who is drunk or high is suppose to have access to the shelters, people who are abusing some substance tend to work hard to hide that fact and, consequently, do not create problems.

Separate shelters for people who have been approved for a drug or alcohol treatment but are waiting for a bed.  \textit{(Recommendation IVc-7)}

Sharing a shelter with other people who are waiting for a bed in a drug treatment program would help those who have been approved to maintain their resolve. Some participants suggested that housing for people waiting to enter programs could be shared with those who have just completed a program. Such shared supportive housing could be helpful to both groups.

Create 750 units of supportive housing  \textit{(Recommendation III-4)}

Every group agreed that there is a great need for additional supportive housing in Montgomery County. Without continuing assistance, most people who are in the shelters would be unable to manage housing successfully.

Men who live in Cobblegate feel that the program should be used as a pilot for other supportive housing programs. All of Cobblegate’s residents stated that acceptance in the program was life saving to them. The idea of having permanent housing is critical to staying off the street.

People who believe that they will be able to handle their own housing issues at some point feel that they will certainly need supportive housing initially.

Each group indicated that it would be very helpful if supportive housing could be designed in stages that would move people from homelessness to shelter, to supportive housing to permanent housing.
For example, some of the men have been able to find employment in second or third shift jobs but lose the job because they do not have a shelter to go to for a shower and change of clothes. Some said they lost their job due to the need to call for a space at St. Vincent Hotel. Even those who find first shift jobs are not always able to get to St. Vincent Hotel before the cut-off time.

A stage two shelter for people who are employed would help those individuals maintain their jobs and give them a greater chance to become permanently sheltered.

A third stage would be supportive housing. For some people this may be a permanent location, while for others it could be the final transition before permanent housing.

**Recruit and coordinate volunteers from faith and broader communities (Recommendation IVa-6)**

No group offered suggestions for new ways volunteers could assist the homeless

**Implement a single HMIS (Recommendation Iva-4)**

The idea of single HMIS system received mixed reviews. Some of the mothers with children are concerned about their confidentiality, an important concern when domestic violence has occurred. For other women the concern would be the amount of information available, especially if medical histories would be included.

Men generally approved of the idea if it meant that people would not have to fill out the same type of form at every agency visited.
**SUMMARY FINANCIAL OVERVIEW BY CONTINUUM OF CARE SERVICE SECTORS**

### HOMLESS ASSISTANCE SYSTEM

<table>
<thead>
<tr>
<th>Original Funding Source</th>
<th>Prevention¹</th>
<th>Outreach</th>
<th>Gateway Shelters</th>
<th>Programmatic Shelters</th>
<th>Transitional Housing</th>
<th>Permanent Supportive Housing</th>
<th>Alcohol, Drug, Mental Health Services²</th>
<th>Other Supportive Services³</th>
<th>Grand Total</th>
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### LOCAL

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<th>Local</th>
<th>Prevention¹</th>
<th>Outreach</th>
<th>Gateway Shelters</th>
<th>Programmatic Shelters</th>
<th>Transitional Housing</th>
<th>Permanent Supportive Housing</th>
<th>Alcohol, Drug, Mental Health Services²</th>
<th>Other Supportive Services³</th>
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### NOTES

- Financial data collected from providers & ADAMHS Board in a variety of formats for 12 month period.
- Program costs may not include share of Management & Administration or Fund raising costs.

### Homeless Continuum Service Sectors

- **Prevention**: Includes emergency services & Case Management for Montgomery Co.
- **Outreach**: Includes both the Domestic Violence Shelter & Women's & Children's Emergency Shelter, follow-up services provided by the House Keys, & SHP direct client assistance & administration.
- **Gateway Shelters**: Day or night shelter with linkage to case managers.
- **Programmatic Shelters**: Residences services, counseling, case management, linkages to other services.
- **Transitional Housing**: Focuses on developing independent living skills, money management, etc.
- **Permanent Supportive Housing**: Long term housing with supportive services as needed.
- **Alcohol, Other Drug, Mental Health Services**: Assessment & Treatment services in residential & outpatient settings.
- **Other Supportive Services**: Includes health care, child care, supportive services for Doors clients, etc.

### Footnotes

1. ADAMHS includes funds from HHS, state, federal, and pass through grants when not separately identifiable
2. AIP Includes emergency services & Case Management for Montgomery Co.
3. Prevention includes funds for all clients–homeless and housed, except as noted
4. Foodbank is estimate for food costs for homeless services only
5. St. Vincent includes both the Hotel & Winter Shelter
6. Salvation Army includes both Booth House & Women & Children Shelter
7. YWCA includes both the Domestic Violence Shelter & Women's Emergency Shelter, follow-up services provided by the House Keys, & SHP direct client assistance & administration
8. HUD-Continuum of Care includes both the Emergency Shelter, Follow up program & Crisis Hotline & Outreach includes both Safe Place & Street Outreach
9. Gateway Includes HAP units & permanent supportive housing
10. McPHE includes low Ave. SRO, Inc. McKinney Projects, & subcontract for case management for IOWA Ave. residents with TOP ($67,208), CSB ($16,800) & MRDO ($16,800)
11. PLACES Includes Housing 1st & Adult Care Facilities homeless residents
12. CADAS Includes Residential and Outpatient services
13. Treatment services reported from ADAMHS Board reports for homeless clients/patients
14. Other Supportive Services reflects estimate of funds for services for homeless only
15. CAP Includes WorkPAYS & Housing Reincarnation

6/2005 Working Draft
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## Financial Overview by Agency
### Homeless Assistance System

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## FINANCIAL OVERVIEW BY AGENCY
### HOMELESS ASSISTANCE SYSTEM

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### NOTES

Financial data collected from providers & ADAMHS Board in a variety of formats for 12 month period. Program costs may not include share of Management & Administration or Fund Raising costs.

### Homeless Continuum Service Sectors
(For more detail, see Services Provider Network document)

- **Prevention**: Closing the Front Door to homelessness, includes wide variety of emergency assistance services such as rent & food assistance, information & linkage to services.
- **Outreach**: Client identification generally outside of traditional office setting or by agency referrals.
- **Gateway Shelters**: Day or night shelter with linkages to case managers.
- **Programmatic Shelters**: Residential services, counseling, case management, linkages to other services.
- **Transitional Housing**: Focuses on developing independent living skills, money management, etc.
- **Permanent Supportive Housing**: Long term housing with supportive services as needed.

### Alcohol, Other Drug, Mental Health Services
Assessment & Treatment services in residential & outpatient settings

### Other Supportive Services
Includes health care, child care, supportive services for Doors clients, etc.

### Footnotes

1. ADAMHS includes funds from HSL, state, federal, and pass through grants when not separately identifiable.
2. CAP includes Emergency Services & Case Management for Montgomery Co.
3. Prevention includes funds for all clients—homeless and housed, except as noted.
4. Salvation Army includes both Booth House & Women & Children Shelter.
5. Salvation Army includes both Booth House & Women & Children Shelter.
6. Salvation Army includes both Booth House & Women & Children Shelter.
7. Salvation Army includes both Booth House & Women & Children Shelter.
8. Salvation Army includes both Booth House & Women & Children Shelter.
9. Salvation Army includes both Booth House & Women & Children Shelter.
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13. Salvation Army includes both Booth House & Women & Children Shelter.
14. Salvation Army includes both Booth House & Women & Children Shelter.
15. Salvation Army includes both Booth House & Women & Children Shelter.

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4/20/05
Working Draft
Dayton, Kettering, Montgomery County Homeless Assistance Provider Network
Financial and Program Summary by Agency

PREVENTION  *Closing the Front Door to Homelessness*

Emergency Assistance (Direct financial assistance to clients to maintain or secure housing)

**Community Action Partnership (SCOPE)**
- Emergency/Energy Services (HEAP available November-March)
  - $1,105,000  ($55,250)*
  - 5% Homeless (250 people)
  - 8-5 M-F T/TH evenings
  - 12 FTE
- Case Management
  - $52,466  ($2,099)*
  - 4% Homeless (10 people, est.)
  - 1.5 FTE

**Salvation Army**
- $344,702  ($68,940)*
- 20% homeless (460 cases, est.)
- M-F 9-4

**Sunrise Center**
- SHP Homeless Grant
  - $62,000
  - 1.4% of total agency clients served in 2004 were homeless (SHP served 47 clients)
- M-F
  - 2 FTEs
- Prevention Program
  - $110,767  Financial assistance provided to 970 individuals at-risk of homelessness and 176 clients prescreened but not served due to size of need.
  - 215 additional clients ineligible for financial assistance were referred to area churches or other assistance programs.
  - Application for financial assistance taken 4 days a week, from 8 to 11 AM (frequently stop at 10 due to volume of requests)
  - Application for food assistance from East Dayton Emergency Services Program and East Dayton Food Pantry accepted from 8 to 11:30 AM and 1 to 3 PM Monday to Thursday.
  - Served 2,550 people last year.
  - 2.75 FTE

**TOP Prevention Program:**
- $136,500
- 100% homeless clients  Clients must have eviction notice and be within 7 days of eviction
- Hours Monday – Friday
- 2 FTE

**AIDS Resource Center, Ohio**
- Client Services & Emergency Assistance
  - $435,144  ($44,820)*
  - 10.3% of clients are homeless (64)
  - M-F 8 AM- 5 PM, after hours services provided, as needed
  - 9 FTE

* Estimate of resources used to serve homeless clients
St. Vincent DePaul Conferences (28 conferences)
$1,019,651
Services to keep people in their housing (rent, utility assistance, food, clothing, telephone, water, furniture, medicine, transportation)
49,418 people served
All volunteers

Referral (Information to secure needed services to maintain or secure assistance)
Ombudsman’s Office: Governmental Ombudsman’s Program
$170,000 ($15,300)*
Approximately 9% of cases are from homeless clients (90-100 clients had cases developed)
M-F 8 to 5 PM

HelpLink
8,553 referral for emergency food
4,448 referral for housing
37% of total Montgomery County referrals in 2004
$458,447 ($169,447)*
24 hours/7 days a week by telephone
9 FTE

Food/Hot Meals Sites
The Food Bank
$336,323*
Estimates that 8.9% of food is used for homeless shelters/soup kitchens

OUTREACH (Client identification generally outside of traditional office setting)
Crisis Care
$60,000
100% homeless (Clients not included in ADAMHS client tracking system)
One FTE therapist does community outreach working directly with homeless helping them secure a place to stay and addressing other needs

Daybreak
$228,742
Street Outreach program estimates that 21% (35) clients are truly homeless, 45% (75) are at imminent risk of becoming homeless, and 34% (57) are likely to become homeless within 6 months

Safe Place program serves 100 clients (est.) a year with 20% (20) being truly homeless and 80% (80) being temporarily homeless due to family crisis.
Two program staff maintain core hours 40 hours a week M-F and flex to allow for evening and weekend outreach
Safe Place provides 24/7 transportation to Daybreak Shelter from 300+ community sites.
3.67 FTE

PATH (Miami Valley Housing Opportunities)
$78,141
100% Homeless (Severely mentally ill living on the street)
8-5 M-F
1 FTE

Samaritan Homeless Clinic
$ Included in Clinic Budget
100% homeless
Assign 2 medical staff to do street outreach Wednesday afternoons and mental health therapist to two feeding sites each week
The Other Place
$54,000
Hours Monday to Friday
100% homeless
1.25 FTE

**EMERGENCY SHELTER**
104 beds for singles; 70 units for families (year-round; additional 55 beds in Winter)

**Gateway Shelters (Includes shelter, linkages to case managers/services, 2 meal [St. Vincent Hotel] over a variable length of time)**
St. Vincent Hotel (overnight) Winter Shelter (November – March)
$905,600 (includes Winter Shelter that averages $9,000/month)
Open 24/7; Families enter at 5:00PM, others at 7:00 PM All leave at 7:00 AM
In bad weather, have flexible hours opening as early as 3 or 4 PM and exiting as late as 9 AM
100% homeless
17 FTE

The Other Place (daytime)
$359,662
Open 7 days a week; 7:30 AM-6:30 PM (hours could vary during the year)
100% homeless
4.5 FTE

**Programmatic Shelters (Includes residential services, counseling, case management, linkages to other services generally over 1-2 month time period.**)

**Salvation Army**
$1,254,854
90% homeless: Booth House (for men) [Includes 80 Doors clients]
100% homeless Women & Children (generally longer than 2 months)
9.2 FTE: Booth House
7.2 FTE: Women & Children

**YWCA (Battered Women Shelter, Emergency Shelter, House Keys follow-up, SHP administration)**
$1,328,861
100% homeless or post shelter receiving support services
40 FTE

**Red Cross Emergency Housing (Families)**
$558,900
96% homeless, 2% becoming homeless, 2% living in undesirable or abusive situation
12 FTE

**Daybreak (unaccompanied youth & young adults)**
$817,256
Age 17-18: 90% truly homeless
Age 10-16: 5% truly homeless, 95% pushed out, runaways, abused, seeking help no place to live
16.47 FTE Average client to staff ratio is 8 to 1

**Samaritan Homeless Clinic Respite Care (Serves homeless too ill to stay in a shelter)**
$85,000
100% homeless
1 FTE

* Estimate of resources used to serve homeless clients
TRANSITIONAL HOUSING (Focuses on developing independent living skills, money management, parenting skills, obtaining job training/education. Residents may live in transitional housing for up to 2 years.)
93 beds for singles; 72 units for families

DePaul Center
$731,500
100% homeless males
6 FTEs

Holt Street
$61,712
100% homeless males
6 FTE

Mercy Manor
$350,000
100% homeless females
5 FTE

St. Vincent Supportive Housing
$444,900
100% homeless families
6 FTE

Daybreak
$691,078
100% homeless youth/young adults 18-21
9.83 FTE

PERMANENT SUPPORTIVE HOUSING (Long term housing in scattered site apartments, Single Room Occupancy units(SRO), or group homes with supportive services, as needed.)
310 beds for singles; 132 units for families

Eastway (mental illness)
• Permanent Supportive Housing
  $382,000  (additional $ from clients who pay 30% of income for rent)
  68 beds
  100% homeless
• Housing Assistance Program (30 month time limit)
  $1,263,400 (resident pays 65-70% of rent, balance from HUD with some start-up costs)
  100% mental health hospital discharge or homeless

Miami Valley Housing Opportunities (mental illness, substance abuse, HIV/AIDS)
$3,237,842
100% homeless
15.2 FTE
1.9 FTE TOP for Iowa Ave. case management ($67,200)
0.5 FTE CSB case management ($16,800)
0.5 FTE MRDD case management ($16,800)

Country View Manor (Low income seniors who need protective environment)
$2,437,595 ($675,003)
29% homeless
35 FTEs
PLACES (mental illness & substance abuse)
- Housing First (documented disability, mental illness)
  $248,727
  100% homeless
  5.5 FTE
- Adult Care Facilities (4 facilities serving severe & persistent mental illness)
  $1,440,295 ($446,479)*
  North Main Group Home: 100% homeless
  31% of all ACFs residents are homeless
  32 FTE

ALCOHOL, OTHER DRUGS AND MENTAL HEALTH TREATMENT SERVICE PROVIDERS
Alcohol & Drug Treatment
CADAS (Montgomery County Combined Health District (alcohol and other drugs))
- Adult Residential
  $1,310,680 ($203,620)*
  11.7% homeless (49 admissions, includes 41 Doors clients @ $65,120)
  FTE: range from 1 to 7 FTE depending on time of day
- Adult Outpatient
  $1,194,370 ($34,637)*
  2.9% homeless (41 admissions)
  FTE: range from 4 to 10 FTE depending on time of day
  97 homeless @ $138,500 residential services and $35,946 outpatient services (ADAMHS FY 04)

Nova House (Residential treatment for alcohol and other drugs abuse)
$3.3 million ($990,000)*
Estimate 30% homeless (104 individuals, includes 34 Doors clients @$133,532)
50 FTE
(70 homeless @ $618,047 ADAMHS FY 04)

Project Cure (Residential treatment for drug abuse)
$2,993,614 ($88,857)
23 homeless clients FY 04 ADAMHS reports

Alcohol and Other Drugs and Mental Health Assessment and Services
CrisisCare (Gateway to publicly supported mental health, alcohol, drugs, and other substances care system)
$5,335,087 ($533,509 to $800,263)*
Estimates 10-15% (627-941 individuals) of clients are homeless or in temporary housing
24/7 availability of service
72 FTE
(378 people @ $91,393 ADAMHS FY ’04)

CAM (Serves individuals with head trauma, cognitive disorders, or physical disabilities with alcohol, drug, or mental illness)
$1.2M ($300,000)
Estimate that 25% of clients (275) are homeless (ADAMHS reports 21 homeless @$23,697)
M-F 8 - 5
17.5 FTE

Eastway Community Mental Health Center (Behavioral health counseling, mental health pharmacy management, community psychiatric support, etc.)
$16,559,121 ($1,457,203)*
8.8% est. homeless (160 individuals) [81 @ $238,203 in ADAMHS FY 04]
133 direct service FTE
DayMont West (community psych support, individual & group counseling, mental health pharmacy management)
$5,662,560
Served 50 homeless @ $63,984  FY04 ADAMHS
Also served 145 Doors Clients @ $33,980

South Community Mental Health Center (Behavioral Health counseling, mental health community psych support, mental health pharmacy management)
$10,160,550
Served 22 homeless @ $49,240  FY 04  ADAMHS

OTHER SUPPORTIVE SERVICES
Health Care
Samaritan Homeless Clinic (medical, dental, mental health, alcohol & drug treatment)
$1,603,514
100% homeless or within 6 months of homelessness
50 hours per week:  8-5 M-F, 5-8 T&Th, 8-12 Saturday
18 FTE

Doors Clients Supportive Services
PLACES (mental illness & substance abuse)
Supportive Living Program
Wraparound case management for residents who need frequent support in addition to regular case management
$517,233  ($232,952)*
45% homeless (54 adults at any one time)
10 FTE

TOP (Case Management & Client Assistance Services)
$339,797
M-F
4.5 FTE

Eastco
Provided job development, placement and coaching for 389 Doors clients
Contract:  $88,873

Child Day Care
YWCA Safe Sanctuary
$185,551
100% homeless children living in shelters
M-F 8:30 – 5:30 PM
4 FTE & 3 PT Summer Camp Counselors

Employment Assistance
Community Action Partnership
WorkPAYS
$106,996  ($32,099)*
M-F 8-5
30% Homeless (65 people, est.)
2.2 FTE

Housing Relocation
Community Action Partnership
$25,000
M-F 8-5
100% Homeless- would be without emergency relocation assistance (20 families est.)
.35 FTE
Other Residential Programs
Salvation Army Adult Rehabilitation Center
$11,700 (6 month stay for homeless served to $17,550 for 9 month stay for homeless)
52 beds (men) 12 beds (women) total capacity
Residential program, 6-9 months stay; with 90% services for drug & alcohol
20% homeless (13 individuals)

*Estimate of resources used to serve homeless clients

4/05/05
### BEST PRACTICES SOURCE INFORMATION

#### CLOSING THE FRONT DOOR

<table>
<thead>
<tr>
<th>Program</th>
<th>Location</th>
<th>For more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eviction Prevention: Volunteers of America</td>
<td>Louisville, Kentucky</td>
<td><a href="http://www.voaky.org/">http://www.voaky.org/</a></td>
</tr>
<tr>
<td>Prisoner Re-Entry: Re-Entry Court</td>
<td>Richland County, Ohio</td>
<td><a href="http://www.odrc.state.oh.us">http://www.odrc.state.oh.us</a></td>
</tr>
<tr>
<td>SSI Benefit Certification Prior to Release</td>
<td>Massachusetts</td>
<td><a href="http://www.nrchmi.samhsa.gov">http://www.nrchmi.samhsa.gov</a></td>
</tr>
<tr>
<td>Transitional Jobs Programs</td>
<td>Cleveland, Ohio</td>
<td><a href="http://www.drc.state.oh.us/web/joboffen.htm">http://www.drc.state.oh.us/web/joboffen.htm</a></td>
</tr>
</tbody>
</table>

#### SHORTENING THE STAY

<table>
<thead>
<tr>
<th>Program</th>
<th>Location</th>
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<tbody>
<tr>
<td>Engagement Centers: The Healing Place</td>
<td>Louisville, Kentucky</td>
<td><a href="http://www.thehealingplace.org/">http://www.thehealingplace.org/</a></td>
</tr>
<tr>
<td>Maryhaven</td>
<td>Columbus, Ohio</td>
<td><a href="http://www.maryhaven.com/">http://www.maryhaven.com/</a></td>
</tr>
<tr>
<td>Employment Programs: Cookie Cart</td>
<td>Minnesota</td>
<td><a href="http://www.cookiecart.org/">http://www.cookiecart.org/</a></td>
</tr>
<tr>
<td>Ready, Willing and Able</td>
<td>New York</td>
<td><a href="http://www.doe.org/programs/">http://www.doe.org/programs/</a></td>
</tr>
<tr>
<td>T-Shirt Vendor</td>
<td>Los Angeles</td>
<td></td>
</tr>
<tr>
<td>Faith-Based Supportive Housing for Families: Bridge of Hope</td>
<td>Pennsylvania, Ohio, Michigan</td>
<td><a href="http://www.bridgeofhopeinc.org/template/page.cfm?id=96">http://www.bridgeofhopeinc.org/template/page.cfm?id=96</a></td>
</tr>
<tr>
<td>Resettlement Program: Catholic Relief Services Refugee Resettlement Program</td>
<td></td>
<td><a href="http://www.crs.org">http://www.crs.org</a></td>
</tr>
<tr>
<td>High Users of Crisis Public Services</td>
<td>Seattle, Washington</td>
<td></td>
</tr>
<tr>
<td>Homeless Court</td>
<td>San Diego, CA</td>
<td><a href="http://www.sandag.cog.ca.us/index.asp?subclassid=19&amp;fuseaction=home.subclasshome">http://www.sandag.cog.ca.us/index.asp?subclassid=19&amp;fuseaction=home.subclasshome</a></td>
</tr>
</tbody>
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### BEST PRACTICES SOURCE INFORMATION

#### OPENING THE BACK DOOR

<table>
<thead>
<tr>
<th>Program</th>
<th>Location</th>
<th>For more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Locator Service: HousingPoint</td>
<td>Shreveport, Louisiana</td>
<td><a href="http://www.bowmansystems.com/housing_point.php">http://www.bowmansystems.com/housing_point.php</a></td>
</tr>
<tr>
<td>Social Serve</td>
<td>Charlotte, North Carolina</td>
<td><a href="http://www.socialserve.com/">http://www.socialserve.com/</a></td>
</tr>
<tr>
<td>Housing Connections</td>
<td>Portland, Oregon</td>
<td><a href="http://www.housingconnections.org/HomePage.cfm">http://www.housingconnections.org/HomePage.cfm</a></td>
</tr>
<tr>
<td>Supportive Housing: Corporation for Supportive Housing</td>
<td>Columbus, Ohio</td>
<td><a href="http://www.csh.org/index.cfm?nodeld=87">http://www.csh.org/index.cfm?nodeld=87</a></td>
</tr>
<tr>
<td>Rebuilding Lives</td>
<td>Columbus, Ohio</td>
<td><a href="http://www.csb.org/Rebuilding_Lives/rebuilding_lives.htm">http://www.csb.org/Rebuilding_Lives/rebuilding_lives.htm</a></td>
</tr>
<tr>
<td>The Commons at Grant</td>
<td>Columbus, Ohio</td>
<td><a href="http://www.csh.org/index.cfm?fuseaction=Page.viewPage&amp;pageID=787">http://www.csh.org/index.cfm?fuseaction=Page.viewPage&amp;pageID=787</a></td>
</tr>
<tr>
<td>Sunshine Terrace</td>
<td>Columbus, Ohio</td>
<td><a href="http://www.cmhanet.com/sites/sunshineterrace.htm">http://www.cmhanet.com/sites/sunshineterrace.htm</a></td>
</tr>
<tr>
<td>Inclusionary Zoning</td>
<td>Montgomery County, Maryland</td>
<td><a href="http://www.brookings.edu/metro/publications/inclusionary.htm">http://www.brookings.edu/metro/publications/inclusionary.htm</a></td>
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#### BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Program</th>
<th>Location</th>
<th>For more information</th>
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<tbody>
<tr>
<td>Mobile Interdisciplinary Outreach Team</td>
<td>Dayton, Ohio</td>
<td><a href="http://www.montcsb.org">http://www.montcsb.org</a></td>
</tr>
<tr>
<td>Projects for Assistance in Transition from Homelessness (PATH)</td>
<td>Dayton, Ohio</td>
<td>Miami Valley Housing Opportunities</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>Dayton, Ohio</td>
<td>Places, Inc</td>
</tr>
<tr>
<td>Low – Demand Services</td>
<td>HUD Safe Havens</td>
<td><a href="http://www.hud.gov/offices/cpd/homeless/library/havens/index.cfm">http://www.hud.gov/offices/cpd/homeless/library/havens/index.cfm</a></td>
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</tbody>
</table>
People who are homeless are people first. They also may have disorders including serious mental illnesses and substance use. The fact that they have illnesses that may significantly disrupt their lives doesn’t diminish their rights, their responsibilities, or their dreams.¹

**Charge:** The Homeless Solutions Behavioral Health Workgroup was created with the purpose to develop a better understanding of the publicly funded behavioral health network and how it “fits” with the homeless system; to determine how the behavioral health network can effectively support the community’s plans to solve the problem of homelessness and to research best practice models from other communities regarding how the provision of mental health and substance abuse services are being used to prevent homelessness; to shorten the length of time people are homeless; and to determine how behavioral health services are connected to permanent supportive housing.

**Team Membership**

Rebecca Lee, Chair, ADAMHS Human Service Levy Community Review Team Leader*
Thomas Breitenbach, President & CEO, Premier Health Partners*
Doug Craddock, Director of Housing and Employment Services, Eastway Corporation
Ginni Findlay, Co-CEO, South Community Behavioral Healthcare
Janet Housenick, Chemical Dependency Therapist, Samaritan Healthcare Clinic for the Homeless
Beverly Jones-Arthur, Director, Behavioral Health Operations, ADAMHS for Montgomery County
Victor McCarley, Psy.D., Director, PreDoctoral Internship Program, WSU School of Psychology*
Sue McGatha, President, Samaritan Behavioral Health
Tina Patterson, Executive Director, The Other Place, Inc.
Brenda Peters, Board Member, ADAMHS Board for Montgomery County
Kathleen Shanahan, Director, Shelter Policy Board
Carol Smerz, Co-CEO South Community Behavioral Healthcare
Tom Stricker, Program Director, St. Vincent DePaul Society
Joseph Szoke, Executive Director, ADAMHS Board for Montgomery County*

* Homeless Solutions Leadership Team Member

¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services. (2003). *Blueprint For Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-Occurring Substance Use Disorders.* Washington DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services
Overarching Themes of the Groups’ Recommendations

- Homeless people have NO significant income!
- Without Income: Affordable housing is a dream never achieved for the homeless
- Over 1,500 homeless people need general mental health services
- Almost 1,700 homeless people with substance abuse disorders need Treatment
- A homeless person new to the public behavioral health system may experience wait times of 14 – 21 days for an assessment. Existing clients may experience wait times of two – three months for the same service.
- After receiving an assessment, on average there is a month wait to enter Outpatient Treatment and almost a two month wait to enter Residential Treatment.
- Homeless have difficulty carrying their belongings and receiving the medication required to enter treatment
- No Housing and No Support Network: Homeless people often enter the treatment continuum at the Short-Term Residential level
- Decrease in funding from federal and state officials has increased local financial responsibility

Part I: Profile of the Homeless with Behavioral Health Disorders

The Public Behavioral Health System was never designed for the changes of today, but has evolved over time by adding on to the existing system as needed. In the 1990’s legislation was passed combining the alcohol and mental health boards. Historically these two boards operated separately focused on their respective discipline areas. During this period the State gave the 10 largest counties the option of having two separate stand alone boards for Mental Health and Alcohol and Other Drugs. Montgomery County was one of three counties that decided to have a combined board. The other seven large counties have two completely separate stand alone Boards. In Montgomery County, Mental Health and Substance Disorder services are coordinated under one entity the Alcohol, Drug Addiction and Mental Health Services Board (ADAMHS). The coordination of these services being under one entity gave us the opportunity to address behavioral health issues in a holistic approach.

The ADAMHS Board does not provide direct services; they purchase services from providers based on the needs of the community. It should be noted that the state’s request for changes to the system over the years has meant increased financial responsibility was shifted to the local level. The focus of this report is on homeless adults in the community with behavioral health disorders. It is the understanding of this work group that homeless families and children will come to the attention of the child welfare and/or public assistance systems at which point the family and children will be linked to supportive services.
This report focuses on adult homeless individuals with behavioral health disorders. The disorders will be classified in the following categories and are defined below:

**General Mental Health Disorder:** General mental illness refers to the presence of a psychiatric disorder, usually not accompanied by significant functional impairment nor a disruption of normal life and treatment is usually short term.

**Severe Mental Health Disorder:** Severe Mental illness refers to the presence of a severe psychiatric disorder accompanied by significant functional impairment, disruption of normal life tasks, periods of hospitalization and need for psychotropic medication.

**Substance Abuse Disorder:** Substance Abuse refers to regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning.

Nationally, 38% of the homeless report alcohol use problems, 26% report other drug use problems, 39% report some form of mental health problems (20-25% meet criteria for serious mental illness) and 66% report either substance use and/or mental health problems. Of the national homeless population 23% are veterans (compared to 13% of the general population); 25% were physically or sexually abused as children; 27% were in foster care or institutions as children; 21% were homeless as children; and 54% were incarcerated at some point of their lives.²

The statistics discussed in this paragraph were extracted from the Montgomery County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board database system from people living in Montgomery County who identified themselves as being homeless and people who gave one of the homeless shelters address as their own during their intake. The number of homeless served may be greater than identified here. From July 2003 through June 2004, 495 homeless people received mental health and substance abuse services from the public behavioral health system. Of that total, 107 homeless people received Severe Mental Health disorder/disability services, 58 homeless people received General Mental Health services and 330 homeless people received Substance Abuse treatment services. The largest age group receiving services during this time period was adult men ages 18 – 55. Of the homeless adults in our community, 20 – 25% is severely mentally ill. A high percentage of the rest of the homeless have general mental health issues.

In August 2005, a survey was conducted with local homeless service providers to determine the estimated need for severe mental health, general mental health and substance abuse treatment. The survey results were gathered from the following homeless service providers: Gateway Shelters (primary entryway, meeting immediate crisis needs for shelter and making appropriate referrals), Programmatic Shelters (Generally longer average length of stay than at a Gateway; able to provide more intensive case

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management services; stronger connection to mainstream resources and more assistance in locating permanent housing). Temporary Supportive housing (Longer-term, may reside in housing for up to two years; housing is combined with supportive services designed to assist homeless individuals and families to acquire independent living and job skills), Permanent Supportive housing (long-term, permanent housing, combined with some level of supportive services; enables homeless individuals and families to live in the community independently).

The results of the provider survey indicated that almost 1,700 homeless people need substance abuse treatment, 1,500 need general mental health services and 400 – 500 need severe mental health treatment services. Results obtained from Crisis Care demonstrate that July 2004 through June 2005, 541 assessments for homeless individuals were scheduled of which only 280 mental health and drug/alcohol assessments were completed. This is a show rate of 52% which is comparable to the national rate for the homeless population. As you can see, a high percentage of the homeless need general mental services and/or substance abuse treatment.

**Homeless Income:**
People who are homeless are the poorest of the poor. While almost half (44%) of people who are homeless work at least part-time, their monthly income averages only $367 compared to the median monthly income for U.S. households of $2,840.3

Based on information collected from more than 3,500 homeless adults in 2005, 58% had no source of income. Sources of income that were identified are listed below. People were able to select more than one source of income.

- 29% Public Assistance
- 24% Disability income
- 21% Earned Income
- 16% Other
- 3% Retirement income

The workgroup discussed taking elements from the three best practice models discussed below to develop and implement a program within our community to impact the economic well-being of the homeless.

**Best Practice Models:**
The *Maryland Supplemental Security Income (SSI) Outreach Project* is providing services that assist the homeless with record gathering, completing the application and advocating on their behalf when necessary. Their target population is working with the severely mentally ill who are living on the streets. Referrals are taken from many sources in the community. This project addresses three of the major obstacles for the homeless seeking benefits, their illness, the stigma placed upon them by society and the challenge

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of completing the paper work correctly. Once contact is made with the project the homeless is seen within three days, at which time an on-site screening is conducted and a release of “appointment of representative” form is signed. This release allows the Social Security Association (SSA) to release the client’s information to the SSI Project. After receipt of the release the SSA makes contact with the SSI Project to report that the client is eligible or the application is pending. An average of 30 hours a week is spent on each case.

During the SSI process, the Maryland SSI outreach project is able to provide presumptive benefits to the homeless they are certain will be approved for SSI benefits. This means that while the homeless person waits for their eligibility determination (up to six months), they are receiving SSI benefits. The project acts as a payee for some of the severely disabled clients. Since the beginning of the project in 1994, it has had a 98% acceptance rate of the applications that were presumptively deemed eligible. This project could not have happened without the collaborative relationship built with their SSA office staff and the project staff training. It was suggested to invite Yvonne Perret from Maryland to share with us how they developed and implemented their project.

The **Assertive Community Treatment (ACT) Model** serves individuals with serious mental illness who have avoided or not responded well to traditional treatment services. The professional backgrounds of the team may include social work, rehabilitation, counseling, nursing, psychiatry, etc. The types of services the team provides are case management, initial and ongoing assessments, psychiatric services, employment and housing assistance; family support and education, substance abuse and other services based on the individuals needs. Services are available 24 hours per day, 365 days a year. This model has been extensively researched and evaluated for homeless people with severe mental illness and proven to be clinically and cost effective.\(^4\)

The **Mobile Interdisciplinary Outreach Team** tracks down homeless missing clients and works to keep the homeless involved in services engaged. This team involves many of the other human service community systems i.e. Children Services, Juvenile Court. The Mobile Interdisciplinary Outreach Team would operate similar to the current local Inter-Agency Clinical Assessment Team (ICAT) that includes representatives from different disciplines such as Child Welfare, Mental Health and Substance Abuse, Juvenile Court, DYS, etc. As a part of the focus of the outreach team, they would identify high users of the multiple systems and suggest alternative clinical treatment.

**Access to Services:**
The concern brought to this workgroup was the lengthy time it takes homeless people to access public behavioral health services. Crisis Care is the central access point for anyone accessing the public behavioral health system. They conduct all the alcohol and drug assessments and severe mental health assessments for individuals who have a disorder. Crisis Care also determines the Level of Care for services and makes referrals for treatment in the community.

\(^4\) Assertive Community Treatment Association, Copyright © 2001-2005. Last Revised: November 22, 2004
Access to care is determined by priority populations established by Federal and State regulations and the Montgomery County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board. The homeless are listed in the third priority population and must be scheduled for a diagnostic assessment appointment within 4 calendar days, if there are no other factors given at the time of intake that would elevate the person into one of the other priority populations. As a result of the assessment conducted a level of care is determined for each person, which will determine the options for treatment. From the level of care determination an appointment is scheduled with a community provider for the services.

The current assessment process should take a maximum of six days to complete. If the call for an assessment is received in the evening or on a weekend the person must wait until the next business day to get an appointment. The therapist conducts the assessment, completes the written paperwork and determines the level of care within 24 – 48 hours. The Care Coordinator receives the paperwork then contacts the individual to present treatment options. Once a treatment option is selected the treatment provider is contacted to see when the next appointment is available. The assessment information must be sent by mail or secure fax to the provider within 72 hours of setting the appointment. However, it was noted during workgroup discussions that this is not always the practice.

Identification of the person as being homeless during the scheduling time for an assessment would possibly reduce the wait time for an assessment. It was suggested that cross training of the scheduling process with the homeless providers and the treatment service providers is necessary. This would create a more coordinated approach and would alleviate some of the confusion during this process.

Several diagrams were created to give a visual view of how the homeless would access the mental health and substance abuse systems (Appendix A – C).

A homeless person needing Mental Health Services may enter the system through one of the homeless providers or self refer for an assessment. The person is screened over the phone and given an appointment time for an assessment to be conducted. Assessment times vary depending on if you are new to the public behavioral health system or if you are an existing client. Crisis Care only provides mental health assessments for the severely mentally ill homeless population.

Crisis Care shares information on community practitioners with the homeless individual that has general mental health issues. There is no entity that refers or links the homeless with general mental issues with service providers. This creates financial issues for the practitioners because if a homeless person self-refers directly to the service providers, the reimbursement rate isn’t such that it pays for all the services provided. New homeless clients experience wait times from 14 – 21 days for general mental health services. An existing homeless client may experience wait times of two – three months for the same services. If a homeless person has a history of missed appointments or no shows, they are directed to attend Crisis Care Open Clinic or come to Crisis Care as a Walk-In and wait. These appointments are on a first come, first serve basis. It should be noted that if a
person is requesting a specific time for an appointment, it will cause a delay as well. (This is the case for all populations seeking services except the general mental health population.)

Once the homeless person receives the assessment, it was reported that there is a delay with the information being provided to the homeless and being sent to the treatment providers. Since the homeless person has no address or phone number for the Crisis Care person to contact them, they are often given a slip of paper and told to contact the office within a few days to find out which provider they are being referred. Many times the information is still not available when contact is made therefore this process may happen several times before an appointment is made. Lack of available and reliable resources in the community poses difficulties for the homeless person experiencing mental illness.

As the wait times indicate above, there are limited services in the community to address the needs of the general mental health homeless population. Results of the homeless provider survey indicated that over 1,500 homeless people in our community need general mental health services. Their general mental health needs if untreated may become severe over time. During the wait time Crisis Care has provided prescription assistance and counselors for homeless waiting to enter treatment or who have not linked with a doctor. The process can take from five days to five weeks depending on when the assessment is conducted, the needs of the homeless, and the availability of treatment. Receiving an assessment to entering treatment can be a four month process.

Additionally, concerns were expressed that assessments conducted by the Samaritan Healthcare Clinic for the Homeless (outside of the Crisis Care system) were not being honored even though they are conducted by an ADAMHS Board certified doctor. It was reported that assessments conducted by the Samaritan Healthcare Clinic for the Homeless does not adhere to the State Rules. A question was raised if Crisis Care could conduct diagnostic assessments at the Samaritan Healthcare Clinic for the Homeless. It was noted that assessments are being conducted by Crisis Care at other sites such as Juvenile Court. Having the Samaritan Healthcare Clinic for the Homeless as an assessment site would eliminate one of the biggest barriers identified by the homeless to receiving mental health services, their bad experiences in the past with the current mental health system. Services would be provided within close proximity to where the homeless are located.

Substance Abuse Disorders are also assessed through the central access point Crisis Care. A person with substance abuse disorders may enter Crisis Care in the same manner as individuals with severe mental health disorders. After being released from the hospital for Detox services (up to 72 hours) the homeless can also access the public system through Crisis Care. An assessment is conducted and the level of care determined. Protocols established by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) are strictly enforced. The protocols are based upon federal, state and local priorities. Anyone entering substance abuse treatment must receive an assessment from Crisis Care, as they are the agency designated by ADAMHS to conduct all the substance abuse assessments in the community.
As stated before missed appointments and no shows create a significant delay in services for the homeless. There are almost 1,700 homeless people needing substance abuse treatment in the community based on the homeless provider survey. As discussed before wait times vary depending on the type of services needed and if the homeless person keeps the scheduled appointment time. Some treatment providers require the homeless to attend pre-service treatment prior to receiving an entry date for treatment, which can extend the length of their wait to enter treatment. To compound the issue often as a part of the requirements of the program the homeless must find a way to transport all their belongings, sometimes across town and enter with a thirty day supply of medication. This is another obstacle faced by the homeless.

Discussion provided by service providers in the community suggest that the recognition some people may go through the cycle of recovery five or six times before becoming sober should also be considered when making adjustments to the current system. Frequently, when a homeless person completes treatment and returns to society as legitimate they are faced with all their past bills, back child support, fines and taxes, etc. which are not uncommon to be estimated debts of $50,000 - $75,000. With limited skills and their current education, a person may find it overwhelming and decide “It’s not worth it” and return to their prior behaviors. This is also common when a parent completes treatment and the children may have been placed into foster care, all at once the children are returned to the care of the parent. There are high expectations set for the recovering parent to succeed but the pressures of caring for all the children can be an obstacle to their success. Having a support system in place which includes access to education, employment skills and respite care for the parent of children is critical to their success and their ability not to return to past behaviors.

**Treatment Services for Mental Health & Substance Abuse Services:**

People experiencing homelessness have certain shared basic needs, including affordable housing, adequate incomes and health care. Some homeless people may need additional services such as mental health and alcohol and drug treatment in order to remain securely housed. All of these needs must be met to prevent and to end homelessness.\(^5\)

Most people enter the treatment system at the least restrictive program level. Homeless people usually enter the continuum at the Short Term Residential level due to not having housing or a supportive network. The consensus of the public Behavioral Health System is that the structure of the system is good but there are not enough services available in the community. Currently treatment services are offered on the following continuum: outpatient services – group and/or individual sessions a couple times a week, intensive outpatient services – sessions for 3 hours/3 times a week for 12 weeks, aftercare treatment services, short-term residential treatment – sessions for 6 hours a day during the 24 hour day treatment / 5 days a week and the person stays at the treatment facility for up to 30 days, long-term residential – a person stays in the facility for 30 – 90 days for treatment with a possible extension up to 90 days and halfway house - a person can stay at the facility for up to 90 days to help them transition back into the community. This is a

place where transition from primary treatment to community living allows the individual to work or attend school while practicing recovery skills in a protective environment.

The ADAMHS Board has a network of providers in the community to provide these services and other supportive services. There are also several other community providers that are not a part of the public behavioral health system which provide services to the homeless and add additional capacity to the system. However, there is still need for additional services.

**Housing for the Homeless:**
Without income affordable housing is a dream never achieved by the homeless. Those homeless who have disabilities and are unable to work can find it nearly impossible to secure affordable housing in virtually every major housing market in the country.\(^6\) Housing stability is essential for successful treatment and/or recovery. When combined with supportive services, meaningful daily activity in the community (employment) and access to treatment, appropriate housing can provide the framework necessary to end homelessness for many individuals. Without a stable place to live, recovery often remains out of reach.\(^7\)

There were two models discussed during the work group sessions which are described below. Both of these best practice housing models place homeless into housing first with the attempt to engage them at some level of their stay in treatment. The goal once the person is stabilized is to help them become independent and self sufficient.

*Low Demand Housing* allows the homeless person to enter the housing to stabilize without initially having demands imposed on them. Once stabilized then the responsibilities increase for the person in housing. The *Housing First* model attempts to significantly reduce the length of time people are homeless. The model provides supportive housing with structured programming that will keep the homeless engaged while they wait for treatment.

**Funding of the Public Behavioral Health System:**
Decrease in funding from federal and state officials over the years has increased local financial responsibility. Local Human Service Levy funds must assume the entire costs if a person isn’t eligible for Medicaid, if they are eligible for Medicaid the Levy only pays 40% of the costs. Most of the homeless we have discussed in this report are not Medicaid eligible. The shifting of the funding responsibility to the local level has created a significant challenge for the public behavioral health system.

Funding levels have remained flat over time, unable to keep pace with the growing needs and rising cost of services. Costs continue to rise, reducing the level of services offered in the community. To add complexity to the level of funding issue, any provider that

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\(^7\) National Coalition for the Homeless Fact Sheet #6, April 1999. Website: [http://www.nationalhomeless.org](http://www.nationalhomeless.org).
becomes a State of Ohio certified provider and locates in Montgomery County, the ADAMHS Board must contract with the organization at the set reimbursement rate and must provide the fiscal match (about forty cents on the dollar). Therefore, funding identified for non-Medicaid services (which includes general mental health services and other services) must be shifted to cover these unforeseen costs. ADAMHS has continually brought this advocacy issue to the forefront and additional support is warranted.

Another financial issue that was not discussed in much detail in the body of this report but does deserve attention is the significant per diem rate increase for State Hospital (Twin Valley Psychiatric Hospital) beds. In 1988, the Ohio Department of Mental Health wanted local areas to be responsible for the state psychiatric hospitals. In 1990, there were almost 200 people from Montgomery County housed at the state facility. Due to the foresight of our local ADAMHS Board to redesign and implement additional community services, they were able to reduce the number of people housed today at the state facility to about 33 Montgomery County residents daily.

Although the ADAMHS Board was able to reduce the number of Montgomery County residents housed, the increase in costs incurred has raised other issues. The per diem rate for a client to receive psychiatric inpatient treatment at the Twin Valley Psychiatric Hospital has gone from $126 to $472 per person per day. This alarming trend can be conservatively expected each year with at least a 5% increase in the per diem rate. The ADAMHS Board does recognize that hospitalization is needed in the community, when clinically indicated and medically necessary. Additionally, another large expense incurred by the public behavioral health system is the purchase of residential services from out of county facilities and Montgomery County residents receiving services in other counties. This information is shared, to inform the reader of the financial impact these services have on the overall budget of the local public system.

Also, currently each jurisdiction within the County is collecting fines from substance abuse related offenses. Within the County almost a million dollars has been collected over time. To date the effort to utilize these funds for substance abuse prevention or treatment services in the community has not been successful. The monies collected can only be used within the jurisdiction where it is collected.
Part II: Team Recommendations

After many weeks of dialogue about the needs of the homeless in the community, the Behavioral Health Work Group has identified recommendations that will impact the delivery of services to be more efficient and responsive to the needs of the homeless population. Many homeless people have both mental illness and substance disorders therefore the work group felt it appropriate to address the independent needs of both services. The recommendations of the Behavioral Health Work Group are divided into two sections based on priority. There is one recommendation that stretches across both of the service areas therefore it is listed as the over arching recommendation and the others are listed based on group consensus.

Target Population: Homeless Individuals with Behavioral Health Disorders which include severe mental illnesses, general mental health disorders and substance abuse disorders.

Over Arching Problem Statement: The lengthy time it takes homeless people to access public behavioral health services. Also, currently there are limited services for people with general mental health disorders due to limited dollars and the shift of the use of funding to provide for the other prioritized populations.

Desired Outcome: On-Site Behavioral Health Assessments conducted at the Samaritan Healthcare Clinic for the Homeless.

Goal: Provide assessments for severe mental illnesses and general mental health diagnosis and substance abuse disorder assessments in close proximity to the homeless.

Strategy: The Samaritan Healthcare Clinic for the Homeless would be an access point for conducting assessments. A Crisis Care worker would be housed at the Samaritan Clinic to provide assessments for those individuals with a substance abuse and severe mental illness. In addition to those assessments, general mental health assessments will also be conducted if it is determined that their mental health illness is contributing to the person being homeless.

Estimated Costs: $85,000 Annually
(One F/T Independently licensed mental health professional with benefits and administrative costs to include .15 FTE for back-up coverage)

Business Case for Implementing the Strategies: Transportation and the perception of the current behavioral health system are identified by the homeless as barriers for them receiving services. Having easier access to behavioral health assessments eliminates the barriers associated with transportation. Services delivered in a familiar environment with the assistance of the Samaritan Homeless Clinic staff will help to engage the homeless in the recommendations developed for treatment.
**Substance Abuse Disorders:**

**Target Population:** Homeless Individuals with Substance Abuse Disorders.

1. **Problem Statement:** Most people enter the treatment system at the least restrictive program level. Homeless people usually enter the continuum at the Short Term Residential level due to not having housing or a supportive network. Results gathered from the homeless provider survey conducted by the Shelter Policy Board indicated that there are almost 1,700 homeless people with substance abuse disorders who need some type of Treatment. It was noted that there are treatment programs for families but no family residential programs. There are not enough available services in the continuum of treatment services for the community need.

**Desired Outcome:** Increase Alcohol and Other Drugs Treatment services in the community.

**Goal:** To increase the quantity of intensive outpatient and residential treatment services and Halfway Houses in the community.

**Strategy:** Provide additional treatment services throughout the continuum of services currently available.

**Estimated Costs:** Additional Short-Term and Long Term Non-Medical Residential Treatment Cost per diem per bed:

- Short term Residential $145.80
- Long term Residential range from $95.45 to $129.70
- Long term Residential for Women range from $129.70 to $147.16
- Long term Residential for SAMI (Severe Mental Ill with Substance Abuse) $184.81
- Halfway House range from $95.45 to $129.70
- Intensive Outpatient Treatment range from $134.00 to $150.19

**Business Case for Implementing the Strategies:** Once the homeless person receives an assessment and it is determined that treatment services are needed, then there needs to be services available for them to enter into or there is the high probability that they will continue the cycle of substance abusing and homelessness. Most of the women with children who are homeless are in that situation because of domestic violence or spousal substance abuse. Often children are cared for by relatives or friends while their parent(s) are in treatment.

2. **Problem Statement:** There is no place for a homeless person to live while receiving outpatient treatment services. Several residential treatment programs require that a person has attained some level of sobriety prior to entering treatment and there is no place for a homeless person to go in order to dry out. These are barriers to the homeless achieving sobriety for an extended period of time.
**Desired Outcome:** Fifteen (15) beds of Pre-Treatment Supportive Housing in the community. The length of a person stay would be determined by their prescribed treatment plan (estimated 30 day stay). Pre-Treatment Supportive housing is provided to individuals that are waiting to enter residential treatment or may be used for those involved in outpatient treatment.

**Goal:** To provide supportive pre-treatment housing in the community while the person is waiting to enter services ranging from outpatient to intensive outpatient or residential treatment services.

**Strategy:** The housing would be located in a separate area of a shelter or different location. This would keep the people engaged in receiving treatment and reduce triggers / risk for use of addictive substances. The homeless persons would be involved in structured programming that would keep them engaged while they wait on treatment. It is recommended that people who are in outpatient treatment could benefit from pre-treatment supportive services as well.

**Estimated Cost:** Base cost on per diem for Halfway House Range from $95.45 to $129.70

**Business Case for Implementing the Strategies:** Without a stable place to live, recovery often remains out of reach for the homeless. Securing Pre-Treatment Supportive Housing in the community will allow the homeless person to stabilize prior to entering treatment possibly reducing the length of time it takes a person to engage in treatment thereby reducing the length of homelessness. Pre-Treatment Services keeps the homeless person engaged while they wait for treatment.

**Mental Health Disorders:**

**Target Population:** Individuals who are homeless with Mental Health Disorders

1. **Problem Statement:** Many of the homeless with behavioral health disorders have little or no income. This is a significant barrier to the homeless, as many of the housing assistance programs require a person to have some income to access the housing.

**Desired Outcome:** To increase the success rate of eligibility for homeless persons eligible to receive SSI benefits. When successful this will increase the income of the homeless and may also increase those homeless eligible for medical benefits to include Medicare and Medicaid.

**Goal:** To establish a SSI (Supplemental Security Income) Outreach program similar to the Maryland SSI Outreach model.
Strategy: To identify an agency with the capacity to establish or expand a current outreach program to be the central access contact for the homeless applying for SSI benefits.

Estimated Cost: $80,000 Annually

Business Case for Implementing the Strategies: SSI (Social Security Income) and SSDI (Social Security Disability Insurance) benefits are often the only income that stands between an individual and homelessness. SSI is federally funded, provides financial benefits to individuals based on their economic need and provides health insurance that is either federally matched (Medicaid with SSI) or fully federally funded (Medicare). The premise of the program is to establish a relationship with the local Social Security Administration office to receive training and guidance on completing the SSI applications and supporting documentation, in order to increase the approval rate of the applications submitted. It is recommended that one agency in the community be the lead agency in spearheading this effort. This would give the eligible homeless person with a qualifying disability some income and health insurance. There has been success with this type of effort in other communities. It is also recommended that we bring Yvonne Perret from the Maryland SSI project for technical assistance in developing our local program.

2. Problem Statement: Permanent Supportive Housing

Desired Outcome: Increase the number of permanent supportive housing units in the community. Specific numbers to identify the increase is forthcoming.

Goal: To stabilize and assist the homeless to become independent. Also, to increase the number of Permanent Supportive Housing units available in the community.

Strategy: Develop a model similar to the Housing First model. The program would put the homeless person (with a sever mental illness and/or co-occurring disorder of mental illness and substance abuse) into housing first and then engage them in treatment. The program will be designed for addressing the needs of the homeless (severe mentally ill homeless individual) in our community.

Estimated Cost: $300,000 Annually – serving 10 individuals, 5.5 staff
(Costs are based on the annual operational costs of Places, Inc.)

Business Case for Implementing the Strategies: In 2004, Montgomery County through the Continuum of Care project opened their first permanent supportive housing program operated by PLACES, Inc. The program has experienced a 70% success rate for tenants remaining in housing for at least a year from the date of occupancy. Most of the tenants living in the PLACES, Inc. units meet the definition of “chronic homelessness”. In addition to a severe mental illness the tenants may also

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experience a serious medical issue, a history of substance abuse disorders, and a lack of income and/or criminal record.

Some accomplishments of the tenants include use of various educational systems; regular medical care, criminal record and income don’t preclude them from housing, and the tenants report a decrease in substance abuse while living in the housing units. The program also noted barriers encountered by the tenants, which include denials of SSI benefits and medical insurance, reluctance to be involved in the public behavioral health system due to the negative public stigma and the length of wait to receive treatment services.

3. **Problem Statement:** There are homeless individuals in the community that are not linked with supportive services. In order to address the needs of the homeless we must be able to contact them and offer alternative ways of seeking treatment.

**Desired Outcome:** To develop or expand a current outreach program to engage homeless individuals with a general mental health disorder in services based on their needs.

**Goal:** To link the homeless to appropriate services in the community.

**Strategy:** Develop mobile outreach team or enhance current services by engaging team members from multiple disciplines to go into the field to reach the chronically homeless. The team would provide follow up on those homeless in the system to retain them so they don’t drop out of treatment and link people with services to keep them from becoming homeless. Combining the Projects for Assistance in Transition from Homelessness (PATH) program with a model similar to the SSI Outreach project would be beneficial to serving the homeless population. Our local PATH program operated by Miami Valley Housing Opportunities organization is a model for serving the severely mentally ill homeless population. PATH provides outreach services to a person who is homeless or living in a place not intended for habitation, and is severely and persistently mentally ill, including persons with co-occurring mental disabilities and substance abuse diagnoses. Through their outreach they are able to build relationships with the homeless mentally ill by supplying basic items such as blankets, food, clothing and other essential survival items.

Homeless individuals involved in the PATH program receive referrals to local health care, human services, and social services agencies, with the ultimate goal of guiding the participant from homelessness to appropriate permanent housing opportunities. They are encouraged to seek mental health services that will make positive impacts in their lives. They also receive assistance with costs associated with obtaining housing, such as security deposits and application fees, as well as household start-up items. The PATH program also provides staff training to organizations within the community who serve the homeless, the severely mentally disabled, and those individuals with co-occurring mental disabilities and substance abuse diagnoses.
In 2005, the PATH program provided the following services: PATH outreach to 277 individuals; enrolled 93 homeless in PATH; 47 PATH enrollees engaged in mental health services and 113 PATH enrollees were housed.

**Estimated Cost:** $75,000 Annually
(Based on the PATH program to include one FTE outreach worker; add $30,000 per additional staff person to include benefits.)

**Business Case for Implementing the Strategies:** Mental disorders prevent people from carrying out essential aspects of their daily life. People with mental disorders remain homeless for longer periods of time, they encounter barriers to employment, tend to be poorer in health, and have more contact with the legal system than homeless people who do not suffer from mental disorders. People with mental illness must be able to live as independently as possible with the help of expanded comprehensive, community-based mental health services and other supports.\(^9\)

\(^9\) National Coalition for the Homeless Fact Sheet #5, April 1999. Website: [http://www.nationalhomeless.org](http://www.nationalhomeless.org)
**APPENDIX A**

**ACCESS TO MENTAL HEALTH TREATMENT**

- **Gateway**
  - Programmatic Shelters
  - Transitional Housing
  - Permanent Supportive Housing

- **Open Clinic**
  - Walk-Ins
  - Assessment & Referral
  - First come - First serve
  - Times determined by Agency
  - Two missed appts - must attend

- **Missed Appointments**
  - Create a significant delay in accessing services

- **Assessment & Referral**
  - CrisisCare (Level of Care determined)
  - Required to Access Treatment

- **Intervention Services**
  - Voluntary services offered between assessment and treatment

- **Mental Health Treatment Providers**
  - CrisisCare assess the severely mentally ill/disabled in an emergency

- **Existing Clients**
  - 2 - 3 month wait for services

- **New Clients**
  - 14 - 21 days wait for an appointment

- **General Mental Health Services**
  - Crisis Care does not provide assessments for general mental health
  - General Mental Health provided by community practitioners

- **Lack of Resources In the Community to Address the General Mental Health Needs of the Homeless**

- **After MH Assessment:**
  - Community Support Services (Case Management) - provided for the severely mentally ill/disabled

- **Outreach Services**
APPENDIX B

ACCESS TO SUBSTANCE ABUSE TREATMENT

- Gateway
- Programmatic Shelters
- Transitional Housing
- Permanent Supportive Housing
- Direct Referral

DETOX Services

Assessment & Referral
(Level of Care determined)
Required to Access Treatment Levels of Care
- Enforced Protocols (i.e. for Pregnant Female IV Users, HIV)

Open Clinic
Walk-Ins
Assessment & Referral
- First come - First serve
- Times determined by Agency
- Other Populations - Two missed appts - must attend

Missed Appointments create a significant delay in Accessing Services

Substance Abuse Treatment Providers
- Must go through Crisis Care and receive an assessment to receive substance abuse treatment
- Substance Abuse Treatment - Outpatient: 10-14 day wait
  Bed Date: 2-3 weeks wait
  Receive a Bed: @2 weeks wait from Bed Date
- Residential Services: 30 – 120 days wait

Intervention Services
- Voluntary services offered between assessment and treatment
- Drug Education
- 12 Step
- Engagement Services
- Homeless Clinic – Intervention Services (unofficial)

After Substance Abuse Assessment:
- Residential Treatment -
  w/CofC $ - 1-2 wk wait
  w/out CofC $ - 3 month wait
- It is likely the wait time will increase due to the changes in the new CofC in relation to providing services

DETOX Services

Other Populations - Two missed appts - must attend

Missed Appointments create a significant delay in Accessing Services

Substance Abuse Treatment Providers
- Must go through Crisis Care and receive an assessment to receive substance abuse treatment
- Substance Abuse Treatment - Outpatient: 10-14 day wait
  Bed Date: 2-3 weeks wait
  Receive a Bed: @2 weeks wait from Bed Date
- Residential Services: 30 – 120 days wait

Intervention Services
- Voluntary services offered between assessment and treatment
- Drug Education
- 12 Step
- Engagement Services
- Homeless Clinic – Intervention Services (unofficial)
APPENDIX C

FLOW OF SUBSTANCE ABUSE TREATMENT

CLIENT

Hospital ER

DETTOX
(Up to 72 hours per Medicaid)

Engagement Services
(Interim Services to include AoD Education and Support Groups)

CrisisCare ASSESSMENT & REFERRAL

Outpatient

Intensive Outpatient

After Care

Short Term Residential

Long Term Residential

Halfway House

Homeless Clinic – Outpatient Services

No Treatment

After Care Treatment
(Not part of the Public Behavioral Health System)
Supportive Housing
Transitional Housing
Rehabilitation Services

Independent Housing or Living with Others

Back on the Street
Homeless Solutions Community 10-Year Plan

Closing the Front Door Working Group
Summary of Findings & Recommendations
November, 2005

Chair: Marc Levy, President United Way of Greater Dayton Area
Staff: Kathy Emery, Community Affairs Manager, City of Dayton

Charge: Develop a better understanding of the current network of services that are being used to prevent homelessness, as well as the discharge policies and practices in the criminal justice, mental health, child welfare, and health care systems serving our community. Determine if the existing prevention services network and current discharge practices effectively support the community’s plans for solving the problem of homelessness. Research best practice models underway in other communities that are effective in preventing homelessness and discharge policy and practices that ensure that people are not discharged from mainstream institutions into homelessness.

Team Membership

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<td>Bill Staler, Chair</td>
<td>Jean Beach, Chair</td>
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<td>Tom Brunty</td>
<td>Linda Allen</td>
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<td>Diane Welborn</td>
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Overarching Themes of the Groups’ Recommendations

♦ Keeping people housed must become the priority.

♦ Develop an early warning system that connects people at risk to collaborative efforts of earlier, more sustained prevention/intervention.

♦ Recognize that we have two groups who are at risk of homelessness—one group can become self-sufficient, the other group needs lifetime support.

♦ Community education about who is at risk of homelessness and why, is a critical strategy for developing the community will and financial resources required to reduce/eliminate homelessness.
Part I: What We Know & What We’ve Learned

People Living on the Edge

Income Matters
Families and individuals, who are at risk of becoming homeless, generally have very low incomes. According to the 2000 Census, 22,500 households had incomes below $10,000 in Montgomery County. Just over half of them (56%) live in the City of Dayton.

Of the 285 families sheltered by the Red Cross Emergency Housing Program in FY2005:
- 25% had no income
- 50% received either TANF or Social Security income
- 25% were employed

100% of the persons seeking emergency financial assistance from Sunrise Center in 2004 had incomes <$10,000.
- 26% were working full or part time
- 29% were unemployed and looking for work
- 43% were unemployed, but not available for work
- 2% were retired

The rising cost of health care and prescription medication coupled with the lack of health insurance for many low-wage workers has added economic pressure to already strained household budgets.

The number of persons in Montgomery County receiving Food Stamps in June 2005 was 53,587, an increase of 34% since July 2002.

Moderate Income Level Needed to Obtain Market Rate Housing
In Montgomery County, a full-time worker must earn $11.44 per hour (approximately $23,000 annually) or work 89 hours per week at minimum wage to afford a two-bedroom apartment. The Fair Market rent in Montgomery County for a two-bedroom apartment is $595 per month (National Low Income Housing Coalition).

Living Wage Jobs Declining
The Dayton area and the State of Ohio have been literally hemorrhaging living wage (>$15 per hour + benefits) manufacturing and non-manufacturing jobs for several years. Between 1999 and 2004, the Dayton region lost 25,000 manufacturing jobs. An additional 1,400 jobs will be lost once UPS closes its air cargo hub at the Dayton Airport; 5,400 Delphi jobs are also at risk following Delphi’s bankruptcy filing in late October.

The Ohio Bureau of Labor Market Information reports that the five occupations with the most annual job openings in the Dayton region pay between $6.84 and $12.82 an hour. Many of these jobs are part-time and provide few or no benefits—retail sales persons, cashiers, waiters and waitresses, food preparers and servers, and laborers and material movers.
The Job Center has seen a reduction in job placements. In 2000, the Job Center made 5,671 job placements; in 2004, it made only 3,951. In 2003 the Job Center developed a Rapid Response Program for employees of companies that are closing or having mass layoffs. During 2003 & 2004 the Rapid Response Program worked with 41 companies to assist 4,825 laid-off workers.

Public Benefits That Provide Income Less Available Now
Temporary Assistance to Needy Families (TANF) caseloads have dramatically declined since the mid-1990s. In June 2005 the number of families in Montgomery County consisting of a parent and one or more children, who received TANF income, was about 2,700. They represent half of the total local TANF caseload; the remaining cases are “Child Only” cases. Lifetime limits for families are five years. “Child Only” cases are not limited to five years.

Obtaining Supplemental Security Income (SSI) for disabled adults, aged 18-64 has become extremely complex, time consuming and difficult. Rejected applications are common.

Public Housing in Transition
The supply of safe, well-maintained public housing units for families in our community is limited, and both public housing and Section 8 waiting lists are long. Recent federal directives are moving Public Housing Authorities away from their historic mission of providing housing for the community’s lowest income families. (The average income of the Dayton Metropolitan Housing Authority’s (DMHA) resident families in 2004 was $7,300.) DMHA has determined that $93 million in capital funding will be required to modernize its aging housing stock. Federal funding for public housing operating subsidies and capital improvements has been declining. The federal Asset Management Model will require each local public housing site to become self-supporting, with tenant rents providing a larger portion of the operating costs to offset reductions in federal support.

DMHA is planning to remove 1,425 family units and 102 elderly/handicapped units from its current inventory between 2006 and 2008. All of these units are in need of costly, substantial renovation; more than 400 are currently vacant. Unless DMHA receives a large infusion of new Section 8 vouchers and replacement housing funding from the federal government, the public housing inventory for families in the City of Dayton and Montgomery County will decline by 50%--65%.

Evictions on the Rise; Local Foreclosure Rates Highest in Ohio
There were 5,700 court ordered evictions in Montgomery County in 2004; up 15% over 2003. 3,200 or 56% of the households evicted lived in the City of Dayton, which has 30% of the County’s population. DMHA has tightened its rules regarding delinquent rent and utility payments, and increased its eviction filings in 2004 & 2005. According to court records, DMHA filed 1,523 evictions between 2002 and 2005. Current DMHA policy denies housing to persons with past credit problems or a prior DMHA eviction.

Montgomery County had the highest rate of foreclosures in the State of Ohio in 2004, with just over 4,000 filings. The pathway from foreclosure to homelessness takes approximately two years for those foreclosed households who do become homeless. As homeowners, they generally have more resources at their disposal than very low-income
renters. However, by the time those who do become homeless reach the shelter system, they may be there due to either a formal or informal eviction from a rental situation. Of the 1,100 families referred to the Red Cross Emergency Housing Program in FY2005, 3% listed foreclosure of their home as the cause of their housing emergency, while 57% reported formal or informal eviction as the cause.

**Free Civil Legal Services Inadequate to Meet Need**
A reduction in federal support for Legal Aid has reduced the size and capacity of the program within Montgomery County. The Bar Association’s Volunteer Lawyers Program provides pro bono assistance, but the need of low-income families and individuals for legal services to assist with evictions, public benefit applications (especially SSI), tenant-landlord issues, expunging criminal records, etc. far exceeds the capacity of both organizations.

**Data Lacking to Develop Early Warning System**
Data regarding households facing utility shut-offs is not reported, or within the public domain. Eviction and foreclosure data is reported only after the action is filed with the court system.

**Emergency Financial Assistance—Too Little Too Late**
The total annual dollars provided to families and individuals to prevent homelessness in Montgomery County in 2004 exceeded $3 million. This number includes the $1M+ that is provided by the 28 member parishes in the St Vincent DePaul Conferences, but does not include funds provided by other churches or faith-based groups, since information about those funds is not publicly reported. Therefore, the $3M is an incomplete figure.

Generally, agencies restrict emergency financial assistance grants to one per household per year, and limit access to funds only after the family or individual is on the brink of homelessness. The person must have an eviction or utility shut-off notice in hand to be helped. In some cases, the person has to also show that they have the ability to make future rent or utility payments in order to receive the assistance. Often the amount of assistance from certain providers is so small that the individual is forced to piece together the dollars needed from several different sources.

The emergency assistance network is also regularly tapped to help homeless families staying in shelters pay rent and utility deposits and arrearages so that they can move into permanent housing.

Because the emergency assistance network is not tied together with an integrated data system, when people are sent to multiple agencies to piece together the funds needed, they usually have to provide the same intake information multiple times. On the other hand, one provider doesn’t necessarily know how much assistance an individual has already received from another agency or faith based group within a given period of time. For adults in crisis, the local emergency financial assistance network is perceived as bureaucratic, fragmented and not user friendly.
Emancipating Youth

Transition from Adolescence to Adulthood More Protracted Now
“Most young people continue to depend on their parents for financial help, health insurance, or a place to live between jobs, well into their early twenties. Yet not all parents have the resources to offer these supports, and still others face even greater demands because their children have physical, mental, or behavioral problems. Some youth have no families at all to fall back on. These vulnerable youth—those with mental or physical disabilities, those with involvement in the juvenile justice or criminal justice systems, those leaving special education programs, those aging out of foster care, those young adults who are homeless—are often on their own without a safety net.” From, “Programs and Policy Goals for Helping Vulnerable Youth as They Move into Adulthood,” in Network on Transitions to Adulthood Policy Brief, February, 2005.

High Number of Youth in Need of Community Support
An estimated 1,250 older teens and young adults aged 17-22 in Montgomery County are in need of housing and other community supports as they transition from adolescence to adulthood. (Note: this age grouping reflects the age at which a parent can legally push a child out of the home and the initial age that youth emancipating from foster care and Children Services custody are eligible to enter independent living.) Without community support, they are at high risk of becoming and remaining homeless. With support, most will grow into self-sufficient adults; however, some will continue to need some level of support services for the rest of their lives due to developmental, social, psychological or other factors.

- Non-Systems Youth
Over 1,000 older homeless youth are “non-systems” youth. They are youth who are fleeing or being thrown out of their homes by parents and/or family members. They have no supports and there is no “system” such as Child Welfare or Juvenile Justice to assist them. Their only options are Daybreak’s shelter (for 18-year olds), Daybreak’s Independent Living Program, the adult homeless system, couch hopping, and the streets. Daybreak receives over 700 requests for housing and support each year; a large number of the requests involve pregnant and/or parenting teens and young adults.

- Foster Care Youth
120 youth in foster care emancipate from Montgomery County Children Services (CSB) each year. CSB operates an Independent Living Program for youth aged 16 and older who are in their custody, and coordinates the emancipation process for mental health and MRDD youth. CSB custody generally ends once a young person turns 18. If the young person has a mental or physical disability, CSB can retain custody until age 21.

The Independent Living Program provides an array of services including mentoring, life skills training, support for high school completion or a GED. The program also provides housing placement once the youth turns 17, has graduated from the approved Independent Living Class, and demonstrates the capacity to manage an independent living placement. CSB contracts with agencies such as Daybreak, Choices and other community networks to provide supported housing for youth in its Independent Living Program, who are still in
CSB’s custody. 25-30 CSB youth are referred each year to Daybreak for transitional supported housing. Once foster care youth emancipate and are no longer in CSB’s custody, the “Chafee Bill,” can be an important resource. It provides federal funding for tuition assistance and living expenses to emancipated foster care youth, who are full-time students in good standing at a 2- or 4-year college or university.

• Low-Functioning Emancipating Youth
Finding housing for specific categories of emancipating youth is very difficult. This includes: low functioning “gapper” youth who are not eligible for either the ADAMHS or MR/DD systems, teen mothers with children, special needs mental health youth, and youth who are registered sex offenders. Discussions are now underway between CSB, ADAMHS and the Dayton Metropolitan Housing Authority to determine if Section 8 Housing Vouchers can be made available to provide affordable housing options for these youth as they make the transition to adulthood.

Due to their developmental and experiential immaturity and dependence, emancipating youth have an extremely difficult time accessing services without high levels of support. Their critical thinking skills are still developing and many are educationally challenged. They often lack the critical life skills or the emotional maturity required to navigate bureaucracies and public systems.

Adult Re-Entry

High Number of Offenders Entering the Community
The number of individuals returning to Montgomery County annually from state prisons is 1100-1200. 57 people returning from state prisons were released directly to the streets and homelessness in Dayton and Montgomery County during the first five months of 2005. If the offender is without a local family support system, there are few housing options beyond the homeless provider network. Most ex-offenders return to the community with $0 income. No firm figures are available on federal prisoner re-entry, but local sources estimate that number to be 300. This brings the total annual number of persons released from federal or state prison to Montgomery County to 1,400-1,500. In addition, there are 2000 persons on State-supervised Parole, and 139 persons on Federal Supervised Release currently living in Dayton and Montgomery County.

Scarce Funding for Prisoner Re-Entry Initiatives
The Ohio Department of Rehabilitation and Corrections has a number of task forces, commissions, research studies and pilot programs underway that are addressing various aspects of the prisoner re-entry process. For example—Citizen Circles, where groups of community volunteers work with the offender and the offender’s family to develop a plan to help them make the transition from offender to citizen, have been formed in Parole Authority regions throughout the state, including Montgomery County.

However, actual funding and implementation of program initiatives currently being piloted in a few counties such as Re-Entry Court, SSI benefit certification prior to release, or transitional jobs programs could be years away for Montgomery County unless local funding is identified and committed.
County Jail Serves as Major Psychiatric Facility
According to the Public Defender’s Office, persons who are mentally ill will serve far more time in jail than other inmates, often the maximum sentence or longer. A 2005 funding request for Human Services Levy funding by the Montgomery County Jail estimated that 350 inmates required some kind of psychiatric services, usually medication. The individuals who receive such medicine while in Jail are not allowed to take any of the medication with them once they are released.

For Short-Term Stays: Go in Homeless—Return to a Shelter or the Street
The Montgomery County Jail has no discharge policy regarding homeless persons. The local hospitals will seek temporary placement of a homeless patient in a nursing facility, if that person requires continued nursing care. However, finding a homeless patient permanent housing at the time of discharge is not viewed by the hospitals as appropriate or feasible.

Part II: Team Recommendations

People Living on the Edge Team Recommendations

Target Population: Individuals and families with very low incomes (<$10,000) who are at high risk of becoming homeless.

Problem Statement: Many very low-income families and individuals are one family or financial crisis away from becoming homeless. Rent and utility arrearages, high medical bills, bad credit, inadequate income to meet basic needs and family conflicts can result in formal and informal evictions and homelessness. Just over 1,100 homeless families were identified by one of the homeless provider agencies locally according to 2004 HMIS data. Of this number, close to half were determined to be homeless and eligible for programmatic shelter, but were never sheltered due to a lack of beds in the shelter system.

Desired Outcome: Reduce the number of families and single adults who become homeless.

Goal 1: Influence public opinion and public policies to address the key factors that lead to homelessness—low wages, shortage of housing for very low-income households, and lack of health insurance for low-wage workers and other low-income adults who are not Medicaid eligible.

Strategy 1-A: Form an alliance with local and statewide public interest / public policy groups to focus on the needs of “people living on the edge” and their high risk of homelessness. Develop consensus on a plan for growing the number of jobs that provide a “living wage,” and increasing housing and health insurance options for very low-income families and non-elderly single adults. Educate all of the community’s stakeholders about the problem of homelessness in this region, and the costs of not doing what is required to eliminate homelessness.
**Goal 2:** Develop an early warning system that provides an integrated network of early and sustained prevention and intervention resources that targets community resources in a focused and effective way to enable at risk families and single adults to avoid homelessness.

**Strategy 2-A:** Consolidate emergency financial assistance currently managed by Sunrise Center, Salvation Army, the Community Action Partnership, Volunteers of America, The Other Place, the Wesley Center, and other partners yet to be identified, into a shared system where fundraising, fund management and fund disbursement is centralized, and the partner agencies are linked together with a shared electronic financial disbursement and client tracking system. All clients would receive case management services and would be required to develop and work on their individualized plan.

**Strategy 2-B:** Eliminate both the “once a year” rule and the “no assistance unless you have an eviction or utility shut-off notice in hand” rule to qualify for emergency financial assistance.

**Strategy 2-C:** Implement an eviction prevention program, based on a program in place in Louisville, Kentucky since 1993. The Louisville program is a collaboration between Volunteers of America and the local housing authority. It provides assessments, rental assistance, tenants’ rights information, budgeting assistance, mediation and referrals to other resources such as payee services.

**Strategy 2-D:** Create an eviction database using the existing court records information system within Montgomery County, and explore the feasibility of accessing other data such as utility shut-off and foreclosure notifications to develop the database for an early warning system aimed at preventing homelessness.

**Strategy 2-E:** Work proactively with DMHA to secure the necessary financing and rent subsidies to replace and rebuild the public housing inventory for very low-income families in scattered sites, outside areas of concentration within Dayton and suburban Montgomery County. Commit to a goal of 1,000 - 1,500 units by 2010.

**Business Case for Implementing People Living on the Edge Strategies**

1. The cost of sheltering a homeless family for an average of two months at the Red Cross Emergency Housing Program and then re-housing them in permanent housing is approximately $5,000, if the family has no utility arrearages. In contrast, the Louisville Eviction Prevention Program spends an average of $445 per family to keep them in their current public housing unit.

2. A parent or single individual working full time at minimum wage earns $5.15 per hour and grosses about $206 per week before payroll taxes and other deductions. Their annual gross salary is $10,712. For families and individuals at this level, only the deep rent and utility subsidies provided by traditional public housing make housing costs affordable.
3. A consolidated emergency financial assistance system will reduce overhead costs and the duplicative processes performed by multiple agencies. A standardized intake system and comprehensive database will track who is receiving assistance, how much assistance is provided for what period, and what results are achieved. The current Homeless Management Information System (HMIS) that connects the shelter provider network would require only minor modifications to carry out these functions.

Youth Emancipation Recommendations

**Target Population:** 1) 1,000+ low income teens and young adults (many are teen mothers with children), who have no family, or are being pushed out—emancipated—by their families without the financial, social, educational or life skills, financial resources or maturity to leave on their own. 2) 120 youth connected to Children Services (CSB), Mental Retardation /Developmental Disabilities (MRDD), who are emancipating from foster homes, institutions or other protective care. 3) 60 “Gapper” youth, who don’t qualify for ongoing protective care through ADAMHS or MRDD but are too low functioning to live on their own.

**Estimated size of the population:** 1,250 young people per year.

**Desired Outcome:** Reduce the number of older teens and young adults, including teen parent families, who become homeless.

**Goal 1:** Develop a sustained public/private community commitment to create conditions for this group of vulnerable teens and young adults to make a successful transition to adulthood.

**Strategy 1-A:** Develop an interagency triage system for dealing with youth at-risk of homelessness that is characterized by a screen-in philosophy with multiple points of access. The triage system would provide a seamless network of hands-on youth focused service delivery and support, free of unnecessary barriers and turf issues. Triage system would include, but not be limited to the following agencies: Children Services, ADAMHS, MRDD, Daybreak and Juvenile Court.

**Strategy 1-B:** Develop 60 units of supervised transitional housing, and expand the supply of staff-monitored, scattered-site apartment units from the current number of 35 to 80.

**Strategy 1-C:** Develop 15-30 units of permanent supportive housing with varied levels of supervision for “gapper” low functioning youth/young adults, who are unable to live independently. Develop resident-operated enterprises that provide activities and gainful, but structured employment to address their needs beyond housing.

**Business Case for Youth Emancipation Support**

1. Comprehensive, age-appropriate services provided to the 17 to 22-year-old at the critical point of emancipation can be the key to preventing the first episode of homelessness. The upfront costs invested at the time of emancipation are far less than supporting a chronically homeless adult who was not provided with the
services, skills, education and resources to achieve successful independence early in adulthood.

2. Many of the young people in this target population can grow into self-sufficient adults that will pay off in better outcomes for them and for their children. Some individuals will never be able to achieve complete independence due to developmental, social, psychological or other factors, but their chances of living a productive, stable life are much greater with community support, than with the absence of that support.

Adult Re-Entry Recommendations

Target Population: Adults re-entering the community from prison, mental health facilities or substance abuse treatment.

Problem Statement: 1) The re-entering population is stigmatized as a result of their past and present status, and suffers bias and discrimination within the community once they return. There is little community support for funding services or providing housing for this population, or the acknowledgment of its existence as a group of people needing assistance. 2) Federal and state funding will provide only a small portion of the funds needed to implement a community-level continuum of care for this population.

Desired Outcome: Achieve a substantial reduction in A) recidivism of criminal conduct; B) relapse in substance abuse and alcohol sobriety; and, C) instability in the community of persons with mental illness.

Goal 1: Mobilize the community to develop a sense of ownership in the successful re-entry of adults returning from prison or behavioral health treatment facilities.

Strategy 1-A: Educate the community about the nature of the problem, including the benefits of successful re-entry for both the people returning, and the rest of the community; and the costs and collateral consequences of a failed re-entry.

Strategy 1-B: Work with professional stakeholder groups to identify assets and existing programs, suggest efficiencies, prioritize needs, and engage them in the ongoing process of educating the broader community.

Strategy 1-C: Implement the Continuum of Care concept within the criminal justice system that begins re-entry planning and preparation for discharge back to the community from adjudication through incarceration and during the first six months of re-entry.

Strategy 1-D: Provide housing, education and support to individuals who are re-entering to prepare and motivate them for gainful employment.

Resources Needed by the Re-entering Population:
- Housing / Employment / Income
- Support Systems: Family, Friends, Mentors
- H.S. Completion or GED / Vocational Training / Employability Skills
- Specialty Courts: Drug Court, Mental Health Court, Re-Entry Court
- Life Skills Training / Financial Literacy
• Health and Behavioral Health Services
• Transportation
• Child Care

**Business Case for Adult Re-Entry**

1. An estimated 1,450 adults are being released from state and federal prisons each year to communities and neighborhoods within Dayton and Montgomery County. Some are returning to their families, but others have no family and no home to return to other than the homeless shelters or the streets. Whatever their housing situation at the time of release, the vast majority have no job and no income to support themselves. Without the necessary community support to become gainfully employed, the likelihood is very high that they will either become chronically homeless and/or re-offend and return to state or federal prison.

2. Investing in individuals to enable them to transition from offenders to employed, tax-paying citizens will pay for itself in terms of reduced rates of criminal conduct and re-incarceration, and a safer community for everyone.
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Homeless Solutions Community 10-Year Plan

Shortening the Stay Work Group
Summary of Findings and Recommendations
November 2005

Chair: Brother Ray Fitz, Ferree Professor of Social Justice, University of Dayton
Staff: Kathleen Shanahan, Director, Shelter Policy Board

Charge: Develop a better understanding of the current system of shelters and services targeted toward persons who become homeless. Determine the mix of beds/units and services needed to shorten the length of time people experience homelessness, as well as how to best provide them. Research best practice models from other communities regarding outreach, engagement, shelter and supportive services needed to transition people from homelessness to permanent housing.

Team Membership

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<tr>
<th>Name</th>
<th>Organization</th>
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<tr>
<td>Brother Ray Fitz *</td>
<td>University of Dayton</td>
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<tr>
<td>Douglas Argue/Cindy Minton</td>
<td>Daybreak</td>
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<tr>
<td>Donna Audette</td>
<td>YWCA</td>
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<td>Judith Barr</td>
<td>Samaritan Clinic</td>
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<td>Jane Benner</td>
<td>Salvation Army Booth House</td>
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<tr>
<td>Tom Breitenbach *</td>
<td>Premier Health Partners</td>
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<tr>
<td>Jim Butler</td>
<td>St. Vincent DePaul Society</td>
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<tr>
<td>Robin Hecht</td>
<td>CSB Diversion Team</td>
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<tr>
<td>Kay Kelbley</td>
<td>Salvation Army Women and Children</td>
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<tr>
<td>Robert Kelley</td>
<td>Red Cross Emergency Housing Program</td>
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<tr>
<td>Rev. John Paddock *</td>
<td>Christ Episcopal Church/Downtown Churches</td>
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<tr>
<td>Tina Patterson</td>
<td>The Other Place</td>
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<tr>
<td>Dave Poliquin</td>
<td>South Park Neighborhood</td>
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<tr>
<td>Christine Pruitt</td>
<td>Dayton Public Schools</td>
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<tr>
<td>Richard Saphire</td>
<td>University of Dayton Law School/The Other Place Board</td>
</tr>
<tr>
<td>David Snipes *</td>
<td>Mont. Co. Department of Jobs &amp; Family Service</td>
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<tr>
<td>Cindi Stevens</td>
<td>Target Dayton Ministries</td>
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<tr>
<td>Larry Stephens</td>
<td>DayMont Behavioral Health</td>
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<tr>
<td>Rev. Beth Weisbrod</td>
<td>United Methodist Mission Society</td>
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<td>Sandy Williams</td>
<td>HelpLink/211</td>
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* Homeless Solutions Leadership Team member.

Overarching Themes of the Group’s Recommendations

♦ Early engagement and connection to appropriate shelter and case management are key.
Mental illness and alcohol or drug addiction play a major role in extending the homelessness of chronically homeless adults. Alternative shelter and housing first options are needed to engage this population.

Quick access to services and treatment through the behavioral health system is important.

Access to housing – affordable and supportive housing – is the best tool for shortening the stay.

Focusing resources on young adults (ages 18-24) separate from the adult homeless system will help break the cycle of homelessness and prevent them from becoming the chronically homeless adults of the future.

**Part I: Who Are The Homeless and What Services Are Available?**

*At varying levels of analysis, homelessness is a housing problem, an employment problem, a demographic problem, a problem of social disaffiliation, a mental health problem, a substance abuse problem, a family violence problem, a problem created by cutbacks in social welfare spending, a problem resulting from the decay of the traditional nuclear family, and a problem intimately connected to the recent increase in persons living below the poverty, as well as others.*  

**Who Becomes Homeless?**

Insufficient income, mental illness, addiction, poor health, and domestic violence are some of the factors contributing to homelessness. Between 20-25% of homeless single adults have a serious mental illness. Persons with a serious mental illness or addiction experience longer episodes of homelessness. Even with other contributing factors, at its core, homelessness is a poverty issue. People living in poverty often face difficult, if not impossible, choices between housing, healthcare, food, childcare, transportation, and other living expenses. Poor people who have a serious mental illness or addiction are at higher risk for homelessness than are poor people without mental illness or addiction or persons with those disabilities who are not poor.

Persons experiencing homelessness can be broken into four groups: unaccompanied minors, families, young adults on their own (ages 18-24) and unaccompanied older adults (age 25+), with persons in families comprising the largest group. The data on numbers of homeless persons locally is taken from the Dayton-Montgomery County Homeless Management Information System (HMIS). For this purpose, family status is based on who accompanied the individual when he/she attempted to access the homeless system. For example, youth between the ages of 10-17 who are sheltered at Daybreak are considered to be homeless, unaccompanied minors. Similarly, adults who access the shelter system by themselves are considered to be unaccompanied or “single” adults, regardless of marital status or whether they have dependent children.

In 2004, more than 6,000 people experienced homelessness in Montgomery County.

- 61% were families with children
- 20% were single males (age 25+)
7% were single females (ages 25+)
7% were single young adults (ages 18-24)
5% were unaccompanied minors

Families
There were more than 1,100 families entered into the HMIS (homeless management information system) during 2004. Approximately half of these families were identified as being homeless and eligible for programmatic shelter but were never sheltered due to a lack of beds in the shelter system. Nearly two-thirds of the families are headed by an older adult (age 25+), with just over one third headed by young adults (ages 18-24). 66% of older adults in families had a high school diploma, GED or better, compared to only 42% of younger adults in families. For approximately 20-30% of the families, homelessness is strictly an economic issue. The point-in-time count in January 2005 identified 89 families in shelters.

Single Adults (age 25+)
There were more than 1,600 unaccompanied homeless adults age 25+ entered into the HMIS during 2004. This group is predominately male (76%). Close to three-fourths (73%) of homeless single adults have their high school diploma, a GED or better. An estimated 100-150 homeless adults are chronically homeless. The point-in-time count in January 2005 identified 339 unaccompanied adults ages 18 or older.

Single Young Adults (ages 18-24)
There were close to 500 young adults who experienced homelessness in 2004. 46% had a high school diploma, GED or better. With the exception of some of the 18 year olds who were sheltered at Daybreak, the majority of this age group receives shelter and services as part of the adult system. Too old for the youth system, these young adults have unique developmental needs and can too easily become acculturated into a culture of homelessness in the adult system.

Unaccompanied Minors
Almost 300 unaccompanied minors were sheltered in 2004. The vast majority are ages 14-17. The unaccompanied minors who come into contact with the homeless system are evenly split between males and females. These youth are runaways or throwaways and many are also involved with the child welfare system. The point-in-time count in January 2005 identified 7 youth in shelter.

Continuum of Service
The current continuum of shelter and supportive services includes outreach, emergency shelters, temporary supportive housing, permanent supportive housing, and supportive services. Emergency shelters can be broken into two categories: gateway and programmatic. The community’s day shelter, emergency overnight shelter and the healthcare clinic for the homeless all serve as a gateway to the rest of the continuum, meeting immediate crisis needs for shelter and making appropriate referrals to programmatic shelters, temporary supportive housing programs, or permanent housing. Programmatic shelters generally have a longer average length of stay and are able to provide more intensive case management services, a stronger connection to mainstream resources, and more assistance in locating permanent housing than is the case with the gateway shelters.
Temporary supportive housing is longer-term. Participants can reside in temporary supportive housing programs for up to two years. Temporary supportive housing in the continuum is provided in various types of housing, including single structures with multiple bedrooms, small apartment buildings, and scattered-site apartments. The housing is combined with supportive services designed to assist homeless individuals and families to acquire the independent living and job skills they will need to maintain permanent housing.

Permanent supportive housing is, by definition, long-term, permanent housing, combined with some level of supportive services. Permanent supportive housing is targeted to homeless persons with disabilities, including serious mental illness, chronic substance abuse, or HIV/AIDS. The supportive services enable homeless individuals and families to live in the community as independently as their disability will allow. There are many different options for permanent supportive housing in the continuum, ranging from highly supported residential care facilities to scattered site apartments without 24-hour on-site support.

**Access to shelter and services is essential.**
Homeless persons need improved access to mental health and substance abuse treatment services. Often, because of missed appointments, homeless persons experience a longer wait for assessments at CrisisCare to be evaluated for behavioral health services. A coordinated intake and screening process is needed to ensure that newly homeless persons are assigned immediately to the appropriate shelter and then assigned to a case manager.

**More alternative shelter and supportive housing options are needed.**
The majority of the shelter, temporary supportive, and permanent supportive housing units in Montgomery County are targeted to homeless persons who are generally following the rules and working with a case manager. Traditional shelter and supportive housing models are not always able to successfully engage homeless individuals with serious mental illness and/or alcohol or drug addictions.

Over the last several years, the community has begun to fill some of this gap with the opening of Montgomery County’s first Housing First program in 2003, a Safe Haven in mid-2004 and the implementation of two expansion grants to the Shelter+Care in late 2004. Housing First is a housing model that provides immediate housing with intensive supportive services to homeless individuals who have been living on the streets or in a gateway shelter **without** requiring them to first get connected to and be compliant with the mental health system or to successfully complete drug treatment. A Safe Haven provides supportive housing for an indefinite period of time to long-term, seriously mentally ill homeless persons who are not currently accessing either the mental health system or the traditional shelter system. Shelter+Care is a rental subsidy program or homeless persons with disabilities. A gap still remains between the relatively small number of units (around 50) and the number of chronically homeless individuals still living on the streets or in shelters.

**An adequate supply of affordable housing is the best tool for shortening the stay.**
Public or other heavily subsidized housing is often the best option for homeless families with very-low incomes. There are 12,000 public and other assisted units in Montgomery County. It will be important for the community to maintain the overall number of units in Montgomery County.

**Part II: Team Recommendations**

**Recommendations targeting all persons who experience homelessness and the multiple systems with which they interact.**

**Problem Statement:** Inadequate income, mental illness, substance abuse, poor health, and domestic violence are some of the contributing factors to homelessness. Because there are a multitude of causes, a single type of shelter or service will result in neither a reduction of homelessness nor in shortening someone’s stay while homeless. A coordinated, efficient continuum of shelter and supportive services designed to engage and meet the varied needs of *all* homeless individuals and families who seek service is needed. This cannot be accomplished by the homeless providers on their own. It will require the participation and close cooperation of mainstream systems of child welfare, public assistance, criminal justice, and healthcare.

**Desired Outcome/Goal:** All persons who experience homelessness are quickly engaged and connected to appropriate shelter, case management, and the supportive services necessary or them to obtain and maintain housing.

**Strategy 1:** Develop a 24 hour/7 day Intake and Screening process that would immediately assign newly homeless individuals or families to the appropriate shelter and then to a case manager within three days. HelpLink 211 should be the focal point for information and referral.

**Strategy 2:** Implement a single Homeless Management Information System that is flexible and robust enough to serve as a collaborative case management tool. With appropriate release of information and signed data sharing agreements, share intake and case manager information for all clients of the adult gateway shelters (Samaritan Clinic, St. Vincent Hotel, The Other Place). Initial coverage of the HMIS should include all homeless providers. Over time, the HMIS should expand to include providers in other systems who interact with homeless persons.

**Strategy 3:** Dramatically shorten the time that it takes for a homeless person to receive an assessment at CrisisCare and treatment through the Behavioral Health system.

**Strategy 4:** Develop employment skills of homeless persons through partnerships with area employers, supportive employment programs similar to models in New York, Minnesota, and Los Angeles (i.e., Ready, Willing and Able, Cookie Cart, t-shirt vendor), and employment models for young adults similar to the Conservation Corps.

**Strategy 5:** Work with the Department of Jobs and Family Services to identify those regulations or policies that are creating barriers (e.g., can't get child care assistance unless you have a job, and can't start employment until you have child care).
**Strategy 6:** Add a “homeless system” Service Broker to the existing group of community Service Brokers to allow the group to more easily address barrier to service for homeless individuals who are involved with multiple systems.

**Strategy 7:** Support DMHA’s efforts to improve the application process and turnaround time from application to move-in.

**Strategy 8:** Work with ABLE, the Volunteer Lawyer’s Project, and the UD Law School Clinic to explore models of legal services to address appropriate record expungement, eviction prevention, and poor credit histories of many homeless individuals.

**Strategy 9:** Through the new Governance structure, coordinate the outreach efforts of the faith-based communities in serving the homeless.

**Strategy 10:** Convene a group to study and make recommendations about the best service delivery model and location for gateway shelter services in the community.

**Recommendations targeting unaccompanied minors (17 years or younger)**

**Problem Statement:** Close to 300 unaccompanied minors are sheltered at Daybreak annually. A small percentage of these youth are children younger than age 14. For children under 14, the length of stay is generally 24 hours or less. For homeless children ages 10-13, shelter is not the primary issue and the response needs to be focused on community services to help stabilize the family and improve parenting skills. While CSB has legal responsibility for all dependent children who are abused, neglected, or abandoned, less than 5% of shelter youth are actually in the custody of CSB. Approximately 35% may have a CSB caseworker and the remaining 60% are not involved with the child welfare system at all. The youth shelter is viewed as an important bridge to stability. Many homeless youth face personal barriers such as their own behavior and uncooperative parents. There are also system barriers such as limited options in the child welfare system for older youth, an inadequate supply of child and adolescent psychiatrists, and a lack of emergency shelter beds for pregnant and parenting teens.

**Desired Outcome/Goal:** Reduce the number of unaccompanied minors who become homeless and shorten the length of time they experience homelessness. Family reunification is the primary goal. A secondary outcome is a stable, family-like environment such as congregate living or foster care.

**Strategy 1:** Convene a Task Group with members from Children Services, Daybreak, and Juvenile Court to establish protocols for working with homeless unaccompanied minors and their families. The Task Group should be modeled on the group from Children Services, Artemis and the YWCA that successfully developed protocols for resolving cases with joint child welfare and domestic violence involvement. The group should identify specific strategies for providing emergency, 24-hour shelter to youth ages 10-13 and 14-17. The group should also explore the development of congregate living
models for youth ages 14-17 who may or may not be in the custodial care of Children’s Services or Juvenile Court.

Recommendations targeting families

Problem Statement: There were approximately 1,100 families entered into the HMIS during 2004. This number includes 417 families headed by a young adult between the ages of 18-24 and 765 families headed by an older adult (age 25+). Approximately half of these families were identified as being homeless and eligible for programmatic shelter but were never sheltered due to a lack of beds in the shelter system. Homeless providers estimate that between one-quarter to one-third of homeless families are homeless strictly for economic reasons. Many homeless families have personal barriers to housing including negative housing histories, poor credit, large amounts of debt owed to DP&L, Vectren, DMHA or other landlords, and/or criminal histories. System barriers include: all family shelters do not allow adolescent males, number of households housed per month by DMHA has been reduced by 30-50%. In addition, the community’s largest emergency shelter for families is slated to be demolished in 2006 when the Parkside public housing project is torn down.

Desired Outcome/Goal: Homeless families are able to access shelter, case management and other supportive services needed to enable them to quickly obtain and maintain permanent housing. Decent, affordable permanent housing is the goal.

Strategy 1: Convene a Task Group to develop a replacement solution for the Red Cross family shelter at Parkside, including number of units needed and where they should be located.

Strategy 2: Under the sponsorship of the faith community, develop a temporary supportive housing model for homeless families similar to the Bridge of Hope or Catholic Relief Services Refugee Resettlement Program.

Recommendations targeting young adults (Ages 18-24)

Problem Statement: There were 462 young adults (ages 18-24) on their own who were entered into the HMIS during 2004. Options for these young adults are minimal. With the exception of some of the 18 year olds who were sheltered by Daybreak, the vast majority of young adults are served through the adult homeless system. Many of these young adults have underdeveloped cognitive and social skills that result in a myriad of developmental and psychosocial deficits. Homeless young adults are more likely to be female (60%) and African American (63%). Less than half have either a high school diploma or a GED. Personal barriers faced by young adults include a lack of employment experience, arrested development, lack of social skills, and an inability to conform well in overly-structured environments. System barriers include an inadequate supply of temporary supportive housing units and limited housing options e.g., congregate living models.
**Desired Outcome/Goal:** Economic independence and stabilization in permanent housing is the goal for this population. Flexible options of temporary supportive housing, including congregate living models, are needed to achieve this goal.

**Strategy 1:** Develop a programmatic shelter for unaccompanied young adults to address the developmental needs of this population and separate them from the older adult homeless population.

Strategy 2: Develop a housing first model of supportive housing for 18-24 year-old homeless and/or very low-income young adults. (Similar to the programs seen in Minnesota.)

**Recommendations targeting single adults (Ages 25+)**

**Problem Statement:** Of the nearly 1,700 homeless single adults (ages 25+) in 2004, approximately 100-150 are chronically homeless. Single adults are much more likely to be male (74%) and also to be African American (52%). Nearly three-fourths of single adults (73%) have a high school diploma, GED or better. Personal barriers for singles include: Criminal background, history of evictions, lack of employment skills, poor social skills (anger management issues, etc.). For persons who are chronically homeless, personal barriers to housing include serious mental illness and addiction to alcohol or drugs. A system barrier for this group is the lack of public benefits for adults without dependent children.

**Desired Outcome/Goal:** Shorten the length of time that single adults are homeless so that no one “qualifies” as chronically homeless. Provide necessary shelter and supportive services to enable single adults to obtain and maintain housing.

**Strategy 1:** Develop a 24-hour Engagement Center as an alternative shelter for homeless persons who are actively using alcohol or drugs. The Engagement Center would provide rudimentary shelter with a goal of engaging clients and moving them to programmatic shelters or permanent supportive housing.

**Strategy 2:** Significantly increase the number of Housing First units targeted to chronically homeless individuals with mental illness and/or chronic substance abuse.

**Strategy 3:** Implement a Multi-Agency High Users team targeting individuals who access CrisisCare, hospital emergency rooms, detox beds and other crisis services more than four times in three months. (Seattle’s High Users of Crisis Public Services team model).

**Strategy 4:** Add 8 programmatic shelter beds for single women back into the YWCA to beds back to the level where they were before funding cuts led to a reduction in beds.

**Business Case for Implementing Shortening the Stay Strategies**
The Homeless Solutions 10 Year Plan will outlines ambitious goals to prevent homelessness in our community complemented by plans to assure the availability of safe affordable housing throughout the County by building on local, state and national
resources and best practices. Despite these and additional strategies to provide behavioral and physical health care, supportive services aligned with permanent housing, and a refined structure to govern the Homeless Assistance System, planners recognized that the community will still have homeless people and must provide a continuum of shelter and supportive services designed to engage and then meet the varied needs of all homeless individuals and families. Homeless individuals then must accept personal responsibility to move out of the homeless assistance system and maintain their own housing.

To be successful our current shelter continuum must be realigned: away from managing homelessness to ending homelessness. This requires the key step of shortening the stay within a shelter and moving quickly to permanent housing. Research demonstrates that “housing first” models are effective with the most vulnerable chronic homeless who are moved from the streets to housing and then engaged in a variety of treatment and training services so they can achieve their greatest possible independence and stability. This “housing first” model has been expanded to include both single individuals and families with children who are the primary residents in our emergency gateway shelters and transitional housing programs. The proposed recommendations require the development and implementation of new service delivery models and greater cooperation and coordination within the homeless assistance system and with other major systems such as employment, public benefits (Medicaid, social security), and criminal justice. The recommendations focus on breaking the cycle of homelessness with earlier, readily accessible assessments and case management, specialized housing plans responsive to individual strengths and needs, and aggressive timelines to move from shelter to permanent housing. Resources can then be prioritized to support prevention and permanent housing.
Housing Self-Sufficiency
Struggling with Housing Self-Sufficiency
Front Door
Prevention Services
Struggling with Chronic Problems
Assessment
Supportive Services
Gateway Shelters
Programmatic Shelters
Permanent Supportive Housing
Temporary Supportive Housing
Housing Self-Sufficiency
Backdoor Door
Follow Up Services
Other Systems – Prisons and Foster Care
Crisis Stabilization Shelter
Support Services
Housing Self-Sufficiency
Homeless Solutions Policy Board & Funders Collaborative
Homeless Case Management System
Homeless Solutions Community 10-Year Plan

Opening the Back Door Working Group
Summary of Findings and Recommendations
November 2005

Chair: Walt Hibner, Vice President, Oberer Thompson Companies
Staff: Roberta Longfellow, Housing Administrator, Montgomery County

Charge: Determine the type of permanent housing needed for each homeless subpopulation and the number of units needed for each group (affordable housing for the homeless, affordable housing for those at risk of homelessness and supportive housing, both temporary and permanent); develop a better understanding of zoning and regulatory barriers impeding the development of affordable and supportive housing; identify housing subsidy and financing resources and research best practice models from other communities.

Team Membership

<table>
<thead>
<tr>
<th>Affordable Housing</th>
<th>Supportive Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynn Coleman</td>
<td>Cindy Bremer</td>
</tr>
<tr>
<td>Mark Elma</td>
<td>Richard Brooks</td>
</tr>
<tr>
<td>Frank Gorman</td>
<td>Doug Craddock</td>
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<tr>
<td>Jim Hoehn</td>
<td>Roy Craig</td>
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<tr>
<td>Greg Johnson</td>
<td>Gail Gordon</td>
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<tr>
<td>Buddy LaChance</td>
<td>Jayne Jones-Smith</td>
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<tr>
<td>Jim Martone</td>
<td>Linda Kramer</td>
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<tr>
<td>Dick McBride</td>
<td>Cecelia Long</td>
</tr>
<tr>
<td>Maureen Pero</td>
<td>Andrea McGriff/Natalie Harris</td>
</tr>
<tr>
<td>Tom Robillard</td>
<td>Rev. Jimmy Washington</td>
</tr>
</tbody>
</table>

Overarching Themes of the Groups’ Recommendations

- A better connection is needed between low-income people who need housing and the decent vacant affordable housing stock.

- Additional affordable units should be provided outside areas of low-income concentrations.

- Many homeless need housing with supportive services, either on a temporary or permanent basis.
Part I: What We Know & What We’ve Learned

Permanent Affordable Housing for the Homeless

DEFINITION: For the purpose of this report, affordable housing is defined as housing affordable to households making 50% or less of the median family income ($30,000 for a family of four). To be affordable, a household should pay no more than 30% of its income for all housing expenses. Attachment 1 shows the income limits and affordable housing costs.

A Limited Supply of Assisted Housing

There are some 12,000 public and assisted housing units in Montgomery County, most of which are fully occupied and have waiting lists. The Dayton Metropolitan Housing Authority has determined that it will demolish or dispose of several hundred units in the City of Dayton because of their poor condition and the declining Federal funds to rehabilitate and maintain the units. The only funding program of any substance for new units is the State of Ohio Tax Credit program, which is very competitive.

A Fragmented Rental Assistance System

There are several small programs operated with Federal, State and local funding which provide small amounts of rental assistance on a limited basis for those who are facing eviction or who have located a unit with a willing landlord. There is no central point of contact or consistent application process. The funds available are never enough.

Vacant Non-Subsidized Units in Good Supply

It is common knowledge that the current Dayton rental market is soft. There are vacant units in every community, many within the same rent ranges as the subsidized units.

Matching the Homeless with Available Units – A Better System Needed

Several emergency shelters maintain their own lists of landlords willing to house that agency’s referrals. This means duplication of effort by those agencies and a lack of efficiency. The demolition of DMHA units over the next few years will diminish the resources available to homeless as well.
Permanent Affordable Housing for Those At-Risk of Homelessness

Thousands at-risk of homelessness

There are some 18,000 renter households with incomes under 50% of the median family income who pay more than 30% of their incomes for housing in Montgomery County. With such low incomes, these households are in grave danger of losing their housing whenever a change in that income happens or there is a major unplanned event, such as an illness or divorce. This number is conservative, as it does not include owner households in similar circumstances.

Preservation of existing units critical

The subsidized housing stock plays a critical role in housing lower income households. Some of this housing is in danger of being lost because of the loss of Federal subsidy or because of its poor condition. A good portion of this stock is located in areas outside of low-income concentrations and provides a supply of units not otherwise available in those communities. Rehabilitation of appropriate rental units that are in disrepair could also preserve needed housing stock.

Use of vacant non-subsidized housing: important resource

As with those already homeless, the supply of modest priced rental housing in the County that is vacant is an important resource. However, even with modest rents, many of those at-risk of homelessness will need rental assistance, on either a temporary or permanent basis.

Substantially more units are needed for this population

Additional affordable rental units are needed in the County to address this need. These new units should be located outside areas of low income concentration, in areas where there are available jobs. The NIMBY (Not in my backyard) movement has been and will continue to be a threat to this location. The cooperation of the suburban jurisdictions is critical to providing these units.
Permanent and Temporary Supportive Housing

Need for Housing for Persons with Significant Disabilities

Housing for persons suffering from mental illness, drug or alcohol abuse and other disabilities is difficult to site and to fund. The NIMBY (not in my backyard) syndrome and local zoning laws often prevent the location of this type of housing in appropriate areas.

Supportive Services in Short Supply

There are relatively few resources for providing the necessary supportive services for the disabled population. This lack of resources contributes to the lack of housing provided.

Part II: Team Recommendations

Permanent Housing for the Homeless

**Target Population:** Individuals and families who are currently identified as homeless and do not need supportive housing.

**Problem Statement:** Many homeless lack the skills to locate housing that they can afford and are in need of rental assistance to stay in housing.

**Desired Outcome:** More quickly move appropriate homeless families and individuals into permanent housing that they can afford and enable them to stay on a permanent basis.

**Goal 1:** Provide an efficient system for the shelters to find appropriate housing for the homeless clients and for the shelters to locate landlords willing to house homeless folks.

**Strategy 1:** Develop a Centralized Housing Locator Service that will provide information on quality affordable housing available in the community, available to all shelters to assist the homeless and available to other agencies that can utilize such a service to prevent homelessness. Such a service should be web-base, extremely easy to use by both
those seeking housing and those who have housing to rent. It should be controlled by an agency with the ability to keep the information current and accurate, to address all technical needs in maintaining and upgrading the system, and to update the listing of units and market the program to landlords. It should be an agency well respected in the community, which has the financial and personnel capacity to carry on this service over the long term.

**Goal 2:** Provide an efficient system of financial assistance for security deposits, utility deposits and rental assistance for those homeless ready to live in permanent housing.

**Strategy 1:** Establish a Rental Assistance Network that will provide temporary rental subsidy plus utility and security deposits for those homeless ready to move into permanent housing. The Network would be accessed by shelters with appropriate clients or by the clients themselves. It should have a centralized application process that would reduce the difficulty for the clients of accessing these funds. The Network would provide a point of coordination for the distribution of funds and criteria for the use of the funds. Funding for the Network is recommended to come from members of the faith community who can donate funds and from the foundation and corporate sector.

**Permanent Affordable Housing for Those At-Risk of Homelessness**

**Target Population:** The 18,000 renter households with incomes under 50% of the median family income paying more than 30% of their income for housing.

**Problem Statement:** These households are in need of housing that does not cost so much or of an increase in income. Non-subsidized housing that is affordable is concentrated in low income areas and is often substandard. Most subsidized housing is full and has waiting lists. Additional units are needed outside areas of concentration and existing units must be preserved.

**Desired Outcome:** Increase the number of units affordable to very low income households by increasing the supply or providing rental assistance to reduce the cost.

**Goal 1:** To provide additional units of affordable housing outside areas of current concentrations.

**Strategy 1:** Develop a Countywide Affordable Housing Implementation Plan to promote additional affordable units – existing, new and rehabbed- outside areas of concentration. This Plan would be consistent with the jurisdictions’ Consolidated Plans, would include preferences for small developments and mixed income developments and would encourage DMHA and other non-profit and for profit developers to be actively involved.
Strategy 2: Establish a Rental Assistance Network, as noted above, that would also provide longer term assistance to low income households in need so that they can live in decent housing outside areas of concentration.

Strategy 3: Establish a countywide Rental Rehabilitation Program that would provide funding to rehab rental units that are cost effective to repair and make them available to appropriate low income households.

Strategy 4: Investigate the development of a countywide land use/zoning regulation that would require a certain percentage of new or rehabs units to be set aside as affordable units in those communities that have not met their goals in the Consolidated Plan. Incentives should also be considered.

Strategy 5: Provide additional community funding for new construction of affordable housing. This funding could be used to complement the Tax Credit program to make units affordable to lower income households than could otherwise happen or to provide gap financing for other appropriate proposals.

Strategy 6: Provide incentives to encourage suburban and township jurisdictions to assist in the development of additional units. Examples include the EDGE program and Issue II as well as other programs of county or regional nature.

Strategy 7: Develop and implement a targeted communications campaign and strategy to educate the community about affordable housing and address the NIMBY threat to new units.

Strategy 8: Encourage jurisdictions of the County to actively participate in the identifying of vacant land for new construction, existing units that might be rehabs, and other ways to provide additional affordable units in their communities.

Strategy 9: Create a minimum of 1800 additional units of affordable housing for families and non-elderly individuals over a ten year period, with a minimum of 180 units per year. The units should be provided in compliance with the Countywide Implementation Plan.

Permanent and Temporary Supportive Housing

**DEFINITION: Supportive Housing** is affordable rental housing linked to health, mental health, substance abuse, life skills, employment and other necessary services. It is geared toward the very poor homeless who have chronic health conditions including mental illness, HIV/AIDS, substance abuse issues or other substantial barriers to housing stability. There is a lease or some form of occupancy agreement with conditions of occupancy clearly spelled out.

Temporary supportive housing works best for those whose disabilities can be ameliorated within two years so that they can move into permanent affordable housing.
In some forms of supportive housing, such as successful Housing First models, use of services and programs is not a condition of ongoing tenancy. In others, participation with case managers and in appropriate services is expected or required.

**Target Population:** Homeless persons with serious disabilities who need housing and supportive services.

**Problem Statement:** Persons with disabilities, which require supportive services to address the disability and the consequences of it, have a very limited supply of housing available to them. Many must live in other kinds of housing without the services or with limited services that do not really address all of their needs.

**Desired Outcome:** Increase the number of units of supportive housing, both temporary and permanent.

**Goal 1:** Establish a funding source for this needed type of housing.

**Strategy 1:** Convene a Funder’s Collaborative, similar to the one in Columbus, Ohio, to be responsible for providing these units. It would be made up of important community stakeholders such as private corporations, involved non-profits, community foundations, the faith community and government agencies. See Attachment 2.

**Strategy 2:** Develop 750 beds of supportive housing over a ten-year period through the Funder’s Collaborative, with a minimum of 75 per year, consistent with attached goal table. See Attachment 3.

**Goal 2:** Establish a system to provide additional supportive services beyond what is currently available. Lack of sufficient funding for case managers and supportive services prevents effective care and treatment for many who live in supportive housing. Many who leave prematurely leave supportive housing would be more likely to stay with additional supportive services.

**Strategy 1:** Form a Homeless Services Network through the leadership of the faith-based community. The Network would partner with the shelter and housing providers to define the needed services that could be provided and organize the faith-based and community volunteers to provide the appropriate services. Training for volunteers would be given and coordination between the agencies with needy clients and the Network would be established.

**Strategy 2:** Enhance supportive services provided through ADAMHS.

**Goal 3:** Make changes in Federal and State policies to better address homeless issues.
Strategy 1: Advocate for these policy changes: At the Federal level, more funding for the non-chronic homeless in order to address the critical needs of families. At the State level, to remove barriers to economic self-sufficiency in employment and welfare to work programs by providing longer term intervention and services and to provide a combined application process and expedited access to SSI, SSDI, Medicaid and food stamps for homeless person.

BUSINESS CASE: Research by the National Corporation for Supportive Housing shows that it costs little more to permanently house and support people than it does to leave them homeless. This does not even take into account the positive impacts on health and employment status or improvements to neighborhoods and communities.
# ATTACHMENT 2

## SUPPORTIVE HOUSING NEEDS MATRIX

<table>
<thead>
<tr>
<th>Support. Housing Needs</th>
<th>Current resources</th>
<th>Possible future resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Developers/Owners</strong></td>
<td>MVHO Daybreak PLACES St. Vincent Mercy Manor Eastway YWCA Private developers</td>
<td>Non-profit developers such as County Corp, CityWide and St. Mary’s Habitat for Humanity DMHA</td>
</tr>
<tr>
<td><strong>B. Construction/Rehab</strong></td>
<td>Federal, State &amp; local programs including HOME, CDBG, ODMH, FHLB, OHFA, ODOD, CSH, Continuum of Care, private donations</td>
<td><strong>Funders Collaborative</strong> Habitat for Humanity Corp. for Support. Housing Private donors/foundations Private lenders</td>
</tr>
<tr>
<td><strong>C. Operating/Management</strong></td>
<td>Same as A. with B. for funding Including S+C, SHP, HOME, ADAMHS, ODOD, Section 8</td>
<td><strong>Funders Collaborative</strong> Private donors/foundations Human Services Levy (increase)</td>
</tr>
<tr>
<td><strong>D. Services</strong></td>
<td>Numerous non-profits and ADAMHS, JFS, Continuum of Care, United Way, Human Services Levy, Samaritan Clinic, State funds, County Indigent Levy</td>
<td>Volunteer Network Private donors/foundations Human Services Levy (increase) RTA</td>
</tr>
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## ATTACHMENT 3
### SUPPORTIVE HOUSING GOALS- NUMBER OF BEDS

<table>
<thead>
<tr>
<th>PERMANENT SUPPORTIVE HOUSING</th>
<th>Additional Beds Needed</th>
<th>Additional Beds Needed</th>
<th>Additional Beds Needed</th>
<th>Current Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FOR CHRONIC HOMELESS</td>
<td>FOR OTHER HOMELESS</td>
<td>TOTALS</td>
<td></td>
</tr>
<tr>
<td>Suggested Goal by type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals</td>
<td>100</td>
<td>300</td>
<td>400</td>
<td>325</td>
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<tr>
<td>Families</td>
<td>100</td>
<td>100</td>
<td>200</td>
<td>208</td>
</tr>
<tr>
<td>Young Adults</td>
<td>20</td>
<td>20</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>100</td>
<td>420</td>
<td>520</td>
<td>533</td>
</tr>
</tbody>
</table>

| TEMPORARY SUPPORTIVE HOUSING  |                        |                        |                        |                   |
| Suggested Goal by type       |                        |                        |                        |                   |
| Individuals                  | 60                     | 60                     | 63                     |                   |
| Families                     | 75                     | 75                     | 116                    |                   |
| Young Adults                 | 95                     | 95                     | 53                     |                   |
| Subtotal                     | 230                    | 230                    | 232                    |                   |

|                              | 100                    | 650                    | 750                    | 765               |

**PERMANENT SUPPORTIVE HOUSING:**

Chronic Homeless= 50 Housing First and 50 Safe Haven  
Other Homeless Individuals= 75 with intensive services, 150 with moderate services and 75 with limited services  
Other Homeless Families=100 with moderate services  
Other Homeless Young Adults=20 with intensive services

**TEMPORARY SUPPORTIVE HOUSING:**

Other Homeless Individuals=30 for ex-offenders and 30 with moderate services  
Other Homeless Families= 75 with moderate services  
Other Homeless Young Adults=95 with moderate services
Homeless Solutions Community 10-Year Plan

Governance Subcommittee
Summary of Findings & Recommendations
November, 2005

Chair: Doug Franklin, Publisher, Dayton Daily News
Staff: Joe Tuss, Assistant County Administrator and
Tom Kelley, Director, M.C. Office of Family and Children First

Charge: Review the current organization of homeless system oversight, other existing models and to recommend an effective structure to advance local efforts to implement the ten year plan to end chronic homelessness and reduce overall homelessness.

Team Membership
Doug Franklin, Chair, Publisher, Dayton Daily News
Deborah Feldman, Montgomery County Administrator
Brother Raymond Fitz, SM, Ph.D. (Shortening the Stay) Ferree Professor of Social Justice, U.D.
Walt Hibner (Opening the Back Door) Vice President, Oberer Thompson Company
Jim Hoehn President and CEO, Southwest Region, National City Bank
Greg Johnson, Director, Dayton Metropolitan Housing Authority
Rebecca Lee (Behavioral Health) ADAMHS Human Services Levy CRT Chair
Marc Levy (Closing the Front Door) President, United Way of the Greater Dayton Area
Alice O. McCollum, Judge, Montgomery County Probate Court
Maureen Pero, President, Downtown Dayton Partnership
Dr. Judith W. Woll, CEO & Medical Director, Community Blood Center

Overarching Themes of the Groups’ Recommendations

Establishment of a formal organization to enact the expectations set by the Homeless Solutions Leadership Team to provide policy direction, allocate funding and coordinate programs and projects in the four areas outlined below:

• Provide homeless system oversight, develop and implement strategic plans and policies to end chronic homelessness and reduce overall homelessness in the Dayton area

• Establish a funder collaborative to generate funds and set funding priorities and criteria consistent with the strategic plan and policy goals to ensure implementation

• Ensure an effective data system is in place to support the homeless service network and require all agencies in the homeless services network to participate in the data system through consistent data collection and data management to provide high quality data for planning, policy goals, funding allocation, and accountability

• Establish clear outcome and accountability measures consistent with the strategic plans and policy goals, and utilize the management information system data and other evaluation tools to measure effectiveness and progress.
Part I: What We Know & What We’ve Learned

Oversight of the System

Background
Oversight of the shelter / homeless system has evolved since 1974 to support the increased needs of the clients and the system.

Oversight Timeline:

1974 Partnership established at MVRPC (Miami Valley Regional Planning Commission) to do human services planning and research. Partners included: City of Dayton, Montgomery County, United Way, and the ADAMHS Board. Each partner pays annual dues. A small, two-person staff is hired by MVRPC to provide primary research and planning to the Partnership. For larger research projects, planning staff from each of the primary partner agencies is “assigned” to the Partnership. The Dayton Foundation and the Dayton Public Schools later join the Partnership.

1983 Emergency Housing Coalition, a coalition of providers of emergency shelter and related supportive services, is established.

1985 Partnership’s seminal plan, Sheltering the Homeless, is published. The first comprehensive study on homelessness in Montgomery County, Sheltering the Homeless, lays the foundation for the Shelter Policy Board.

1986 Shelter Policy Board is created by the primary partners: the City of Dayton, Montgomery County, United Way, the ADAMHS Board, MVRPC to provide a policy-level umbrella to the Emergency Housing Coalition. MVRPC provides an administrative home to the Shelter Policy Board, which is staffed, part-time, by Partnership staff.

1992 Partnership conducts follow up study of homelessness, resulting in the release of Homeless in our Midst.

1995 The Partnership is dissolved to make way for the new Office of Family and Children First at Montgomery County. United Way agrees to provide an administrative home for the Shelter Policy Board and contracts for part-time staff support. $50,000 in remaining Partnership dues is given to United Way to staff the Shelter Policy Board. The funding lasts approximately four years.

1998 Dayton Community’s Continuum of Care (CofC) proposal to HUD is not competitively funded because HUD does not like the local CofC process, which does not have a lead, neutral body.

1999 Shelter Policy Board assumes responsibility for the Dayton, Kettering, Montgomery County Continuum of Care ongoing planning and priority setting process. The Shelter Policy Board was successful in negotiating priorities which resulted in continued HUD funding for the provider network.

2000 The City of Dayton, Montgomery County, United Way, Dayton Metropolitan Housing Authority and the Dayton Foundation allocate a total of $65,000 to cover the operations of the Shelter Policy Board from 1/1/00-12/31/02.

2004 Homeless Solutions planning process to develop a 10-Year plan to end chronic homelessness and reduce overall homelessness in Montgomery County begins. Shelter Policy Board, in coordination with the City of Dayton and Montgomery County, provides primary staff support.

**Existing Structure – Informal Collaborative**

**Description:** Oversight of the homeless system is currently provided through an informal collaborative model. The Shelter Policy Board (SPB) was formed in 1986 by United Way, the City of Dayton, Montgomery County, the Miami Valley Regional Planning Commission and the Montgomery County ADAMHS Board. The SPB is completely voluntary and currently includes approximately twenty members including a variety of government, business, faith community, health, housing and non-profit service organizations. The voluntary members are primarily management and senior staffers of the agencies they represent. A few are community volunteers.

The SPB’s role has included advocacy for a coordinated, community-wide system of housing and services for the homeless, advocacy for affordable and supportive housing policies. Its primary responsibilities are to facilitate and oversee the community’s Continuum of Care planning process and the management of the Homeless Management Information System (HMIS). The SPB has also led a process that resulted in community consensus to establish a Safe Haven program for the homeless and mental health service systems and the community’s first Housing First program to move individuals directly into housing from the street or an emergency shelter and then focus on making appropriate service connections. It has also identified young adults (18-21) as another priority population for housing and services in our community to move these young adults off the streets and into safe, permanent housing before they become the next generation of chronically homeless adults.

**Operating Costs:** Costs are viewed as low. There is currently one part time staff person. The current budget is $65,000. Any other assistance as needed is provided in-kind.

**Strengths:** This structure has been successful negotiating specific initiatives as a neutral forum with the non-profit service providers. This partnership establishes community priorities for the application to HUD for Continuum of Care funding ($5 million in 2005). It has also implemented the HMIS data system which is available to all providers and required of those receiving Continuum of Care funds.

**Possible Limitations:** As a voluntary community board it has no real authority over the non-profit service providers which are separately incorporated. Its neutral facilitating position provides influence to a point, but limits its leverage. Staffing capacity limits the level of system-wide support and evaluation.

**Alternate Structure – Formal Non-Profit**

**Description:** In Columbus, Ohio system oversight is provided by a non-profit organization known as the Community Shelter Board (CSB). The CSB began in 1986 and currently has a membership of twenty appointments. Members are established based on a class-tier structure. The City of Columbus and Franklin County are the lead members with four appointments each. The Greater Columbus Chamber of Commerce and United Way are second tier with two appointments each. The Columbus Foundation, Franklin County ADAMHS and the Metropolitan Area Church Council are
third tier with one appointment each. Three other appointments are at-large by the board. The appointed members are currently highly visibly senior executives almost exclusively from the Columbus business community.

The CSB’s role is to oversee resource development and investment, service delivery coordination and planning, program accountability and systems change and public policy reform. It also provides funding oversight of approximately $8 million in local funding and approximately $6 million in HUD Continuum of Care funds and oversees the HMIS.

**Operating Costs:** Costs are viewed as high. There is currently a staff of fourteen. It supports all of the infrastructure costs typical of a non-profit organization its size.

**Strengths:** This structure has been successful in allocating many of the resources available for Columbus-area homeless services. The CSB provides monitoring, evaluation and accountability for the system. The CSB has the leverage of the combined funding partners for decision-making. It has received national recognition.

**Possible Limitations:** A non-profit structure this large would require significant start up funding. It also requires a significant ongoing commitment of new resources.

**Alternate Structure – Governmental**

**Description:** Montgomery County’s Family and Children First Council is established based on mandated requirements of the Ohio Revised Code. It includes a variety of mandated health and human services directors, government, education, law enforcement and business community leaders. By statute it serves as the lead collaborative for health, human and social services in the county. The Montgomery County Board of County Commissioners (BCC) serve as the FCFC’s administrative agent and hire the staffing. All at-large members are approved by the FCFC and appointed by the (BCC). The FCFC began in 1995 and currently has a membership of forty appointments.

The FCFC currently oversees local health and human services resources allocated from the Human Services Levy of about $4 million plus about $4 million in state and federal program funds. The FCFC’s role is to serve as the lead community collaborative to facilitate planning, initiative development, resource allocation and community outcome reporting.

**Operating Costs:** Costs are viewed as moderate. There is currently a staff of seven. Existing staff could be complimented so that costs are incremental vs. completely additional.

**Strengths:** This structure has been successful in accessing and allocating community resources, including about $600,000 directly tied to homelessness. It also works with the BCC to help position other county funds related to homelessness services. The FCFC provides monitoring, evaluation and accountability. The FCFC’s membership has leverage over many of the combined funding partners for decision-making.

**Possible Limitations:** The homelessness issue is just one of many community issues. While the FCFC could add focus, it would not be its singular focus.

**Financing the System**
The research conducted for the full Homelessness Work Group indicates that approximately $23 million in federal, state and local resources support the local homelessness system. Of this amount about 48% ($11.4 million) may be locally controlled by governmental entities. This includes the $5 million in HUD Continuum of Care grants and $4.6 from county mandated agencies. Another $1.5 may be locally influenced from United Way and local foundations. It is estimated that of the remaining $11.6 million funding, the majority comes from the faith community and other private contributions (about $6 million). This leaves about $4.4 million that is made up of other state and federal funds.

**Estimated Funding Summary**

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<thead>
<tr>
<th>Direct Control within Federal Guidelines:</th>
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<tr>
<td>HUD Grant Funding</td>
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<tr>
<td>HUD Section 8 Rent Subsidies</td>
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<td>TANF – County JFS</td>
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<table>
<thead>
<tr>
<th>Direct Local Control within State / County Guidelines:</th>
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<td>Human Services Levy</td>
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<td>CSB</td>
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<td>$4,603,500</td>
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<td>Subtotal</td>
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<th>Local Influence within Local Guidelines:</th>
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<tbody>
<tr>
<td>United Way</td>
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<tr>
<td>Foundations</td>
<td>$465,200</td>
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<tr>
<td></td>
<td>$1,550,800</td>
</tr>
</tbody>
</table>

| Faith Community and Donations           | $6,000,000 |
| Total                                  | $18,952,500 |

| Other State and Federal Funds           | $4,412,125 |
| Estimated Grand Total                   | $23,364,625 |

**HUD Continuum of Care Application Process**

HUD Continuum of Care funding has been received for many years. This process began with the shelter service agencies facilitating their own singular application for funding. In 1998 HUD changed the process to require that a lead entity be used to facilitate this process instead of the providers themselves. Due to this change, the continuing projects were funded in 1998, but about $1 million for new projects was not awarded. As a result, in 1999 the SPB assumed the role of facilitating this application process and negotiating these funding priorities to meet the changing HUD requirements. The role of the SPB does not include receipt and
distribution of the HUD funds. HUD contracts independently with each funded agency once the award decisions are made. Each agency maintains independent accountability with HUD.

It is unclear how much coordination of funding currently occurs outside of the Continuum of Care funding application process. The service agencies are of course focused on their own funding needs to maintain or expand their service offerings. They seem to share selected information concerning clients and funding, but a more complete system funding strategy does not appear to be in place.

System Data

Background
Data management began in the shelter network with the Shelter Information Management System (SIMS). It was only used by the emergency shelter providers and only captured basic demographic information at intake. SIMS was phased out with the implementation of the original version of the Homeless Management Information System (HMIS). The last year of good information from the original HMIS was 1997. The original HMIS was not used at all after about 1999.

Under the leadership of the Shelter Policy Board, the new HMIS was implemented in late August 2003. Implementation of the updated and expanded system has resulted in better data about the needs of the homeless men, women and children in Montgomery County as well as gaps in service and the short and longer-term impact of the current array of services. Currently, 11 different agencies and more than 25 different programs, including emergency shelters, outreach programs, transitional housing, and permanent supportive housing programs are participating in the HMIS.

Because not all agencies and programs are using HMIS there is a gap in data availability. This data gap applies at some level to both the more official / traditional providers and the loosely held unofficial homeless providers and adds to the complexities of developing a community wide strategy for the homeless. Unreported data from emergency assistance programming, drug treatment and substance abuse, hospital emergency room admissions, the criminal justice system and others that work with the homeless population also creates gaps in the full continuum of homeless information.

Agencies / Programs included in the HUD CofC Housing Inventory Using HMIS

1. AIDS Resource Center Ohio
   SHP follow up program
2. Daybreak
   Outreach
   Shelter
   Independent Living
3. Mercy Manor
4. MVHO
   Iowa Ave SRO
   PATH outreach
   Shelter+Care
5. St. Vincent Hotel, Inc.
   DePaul Center
   Safe Haven for men
   St. Vincent Hotel
   St. Vincent Supportive Housing
6. Red Cross Emergency Housing Program
   Shelter
7. Salvation Army Booth House
   Booth House
   Women and Children
8. Samaritan Homeless Clinic
   DePaul Center
   Safe Haven for men
   St. Vincent Hotel
   St. Vincent Supportive Housing
5. Ombudsman

6. PLACES
   Housing First at Cobblegate
   N. Main Group Home
   Huber Heights Group Home
   Supportive Living Program

11. YWCA
    Housekeys
    Safe Haven for women

**Agencies / Programs included in the HUD CofC Housing Inventory Not Using HMIS**

1. Holt Street (not currently requested)
2. Veterans Administration (VA) Domiciliary
3. The Other Place
4. YWCA Domestic Violence Shelter
   Women In Need

The new HMIS has much more capacity than is currently being used and can be used as a case management tool to capture and share information electronically. That has not happened widely to date. The focus has been on capturing data at individual agencies to get an unduplicated count of clients, services, etc. The SPB has recently started working with the agencies around sharing information electronically when they are making referrals and are scheduling refresher training with all the end users on opening records and sharing information with other agencies.

**HUD Data Standards**

**Required Universal Data Elements:**
Name
Social Security Number
Date of Birth
Ethnicity* and Race
Gender
Veteran Status
Disabling Condition*
Residence Prior to Program Entry*
Zip Code of Last Permanent Address
Program Entry Date
Program Exit Date
Unique Person Identification Number*
Program Identification Number*
Household Identification Number*

**Required Program-Specific Data Elements** (required for programs that receive funding through SHP, S+C, Section 8 Mod Rehab for SROs, and homeless programs funded through HOPWA – strongly encouraged for everyone else):
Source and Amount of Income
Source of Non-Cash Benefits*
Physical Disability*
Developmental Disability*
HIV/AIDS*
Mental Health*
Substance Abuse*
Domestic Violence*
Services Received*
Destination*
Reasons for Leaving

Optional Program-Specific Data Elements:
Employment*
Education
General Health Status*
Pregnancy Status*
Veteran’s Information*
Children’s Education*

* not included in Dayton-Montgomery County HMIS initial list of required data elements

Part II: Subcommittee Recommendations

Oversight

Problem Statement: The homeless system is not strategically organized to meet the goal of ending chronic homelessness and reducing overall homelessness in ten years.

Desired Outcome: Organize the homeless system to meet the needs of the community (service population, providers, system and all other interested parties) so that it is as strategically informed, educated, effective, efficient and accountable as possible while implementing the goal of ending chronic homelessness and reducing overall homelessness in ten years.

Goal 1: Establish formal policy oversight of the homeless system.

Strategy 1-A: The Dayton City Commission, the Montgomery County Board of County Commissioners and the United Way of the Greater Dayton Area should be vested with the authority to create and convene the initial membership of the new Homeless Solutions Policy Board.

Strategy 1-B: Identify, recruit and engage specific key leadership from local government, business, foundation, non-profit and educational organizations with a vested interest in ending chronic homelessness and reducing overall homelessness in ten years to form a new Homeless Solutions Policy Board. The Homeless Solutions Policy Board will be a hybrid of the models the committee reviewed. The board will have broad high level community representation (like the Columbus Community Shelter Board) and fiscal responsibility (expanding on all three). (see appendix 1-B/2-B)
Strategy 1-C: The Homeless Solutions Policy Board will develop strategic planning and policies to guide the ten year plan to end chronic homelessness and reduce overall homelessness.

Strategy 1-D: The Homeless Solutions Policy Board will oversee the implementation of the strategic plan and policies to guide the ten year plan to end chronic homelessness and reduce overall homelessness.

Strategy 1-E: The Homeless Solutions Policy Board will establish working committees with ongoing and ad-hoc membership to address implementation activities of the ten year plan to end chronic homelessness and reduce overall homelessness. The committee memberships should include an effective mix of the Board, policy-makers, consultants and experts in the field, technical staff and others with a vested interest in implementing the Board’s strategies. The Board’s process should include participation in activities and receiving feedback from current and former homeless clients. This also includes active roles for service providers and users of the system. There should also be fluid relationships among the committees to prevent gaps in knowledge and support effective integration of concepts. The committees will be determined / formed by the Homeless Solutions Policy Board to meet the needs of the implementation strategies.

Responsibilities of the committees to support implementation will include:

- Assuring quality information
- Data collection
- Data management
- Accountability
- Quality assurance
- Assuring effective program design
- Program implementation
- Program change
- Forecasting of trends
- Best practice research / assessment
- Data analysis
- Projections
- Evaluation of the system, its components and strategies
- Strategic education of the suburban governments, the community, the homeless system and others
- Strategic advocacy as identified through the plan
- Others as identified

Goal 2: Establish formal fiscal oversight through the Funder Collaborative for all locally controlled and influenced resource decision-making for the homeless system.

Strategy 2-A: The new Homeless Solutions Policy Board will establish the Funder Collaborative as a subcommittee. The Funder Collaborative will ensure that funding criteria and decisions are in alignment with the policies and outcomes established by the Homeless Solutions Policy Board.

Strategy 2-B: Identify, recruit and engage specific key leadership from local government, private and non-profit organizations that control and influence funding that can end chronic homelessness and reduce overall homelessness in ten years to form the Funder Collaborative as a subcommittee of the new Homeless Solutions Policy Board. (see appendix 1-B/2-B)
**Strategy 2-C:** The Funder Collaborative will raise / secure funding to invest in the implementation of the ten year plan to end chronic homelessness and reduce overall homelessness.

**Strategy 2-D:** The Funder Collaborative will make funding decisions to support the implementation of the ten year plan to end chronic homelessness and reduce overall homelessness.

**Goal 3:** Strategic planning and policies will be developed using thorough data and information from the homeless system.

**Strategy 3-A:** All providers in the homeless system will participate in a consistent data collection and data management system to provide high quality data for planning, policy goals, funding allocation and accountability.

**Goal 4:** Integration of all other systems which affect and are affected by homelessness into the ten year plan to end chronic homelessness and reduce overall homelessness. (examples include: work force development, child protection, health and hospitals, education, drug abuse and mental health, criminal justice, etc.)

**Strategy 4-A:** All other systems will be assessed to determine their relationship with the population at-risk of becoming homeless, the homeless population and homeless system.

**Strategy 4-B:** All other systems which affect and are affected by homelessness will be engaged to identify issues that create homelessness and further the circumstances of homelessness to identify, analyze and recommend system change strategies to better support the needs of the at-risk of becoming homeless, the homeless population and homeless system that may be integrated into the ten year plan to end chronic homelessness and reduce overall homelessness.

**Goal 5:** The HUD Continuum of Care application process will be maintained and completed in compliance with the strategic plan.

**Strategy 5-A:** A transition plan will be developed to effectively migrate the HUD Continuum of Care responsibilities to the new Homeless Solutions Policy Board that does not jeopardize the application process.

**Strategy 5-B:** The providers will be engaged, facilitated and supported in the application process.

**Strategy 5-C:** Implementation strategies will be integrated into the application process.

**Strategy 5-D:** HUD requirements will be met.

**Goal 6:** Clear outcome and accountability measures will be developed.

**Strategy 6-A:** The outcome and accountability measures will be consistent with the strategic plans and policy goals, and utilize the management information system data and other evaluation tools to
measure effectiveness and progress implementing the ten year plan to end chronic homelessness and reduce overall homelessness.

**Goal 7:** Strategic community and homeless system education and advocacy will be provided to support the implementation of the ten year plan to end chronic homelessness and reduce overall homelessness.

**Strategy 7-A:** Increased engagement and participation in homelessness solutions should result from the broader community as a result of homelessness system education.

**Strategy 7-B:** Increased education, understanding, engagement and participation in homeless solutions should result from the suburban municipalities and townships as a result of homelessness system education. Other cities, municipalities and townships should understand why their partnership with the City of Dayton through actions to support homeless planning and solutions is important to them and the region. They must also understand the effects of homelessness on their own communities and participate in the strategic planning.

**Strategy 7-C:** Communication of success stories should leverage further success for the ten year plan to end chronic homelessness and reduce overall homelessness.

**Strategy 7-D:** Lead strategic advocacy for funding and state and federal actions as identified through the implementation of the ten year plan to end chronic homelessness and reduce overall homelessness.

**Goal 8:** Align the staffing of the Homeless Solutions Policy Board to reduce start up time, costs and take advantage of existing infrastructure and capacity.

**Strategy 8-A:** Staffing of the Homeless Solutions Policy Board will be provided by the Montgomery County Office of Family and Children First. The use of an existing governmental organization for staff support will allow the new structure to “hit the ground running”, and keep initial start-up costs low. It can quickly begin implementation of the task force recommendations by adding key staff that will focus solely on homelessness, and utilize existing overhead and support staff.

**Strategy 8-B:** Staffing of the Homeless Solutions Policy Board should be flexible to meet changing needs in an efficient, effective manner. This approach also will provide flexibility, so that as the Board and its programs demonstrate success, the staff function can become free standing if appropriate and as additional resources are made available to directly fund the staffing, support and overhead for the Board’s activities. An assessment should be performed after some experience has been gained to determine if the staffing and operation should be spun-off from the Office of Family and Children First and if so, its proper placement.

**Strategy 8-C:** The current partners that fund the staffing and operations of the Shelter Policy Board (SPB) should continue their level of investment to the Montgomery County Office of Family and Children First.

**Business Case for Implementing Homeless Solutions Policy Board Strategies**
The homelessness system depends heavily on government and private funding, but is not guided by specific statutory authority of its own. Research indicates that at least $23 million per year is currently spent to support the homelessness system throughout Montgomery County. Without statutory accountability it is imperative that local oversight provides assurances that the system operates effectively and efficiently for all affected parties.

The funding streams are changing the way services will be funded in the future. HUD has mandated that all communities must develop ten year plans to end chronic homelessness or face the loss of funding. In Montgomery County HUD funds account for about $8.5 million, or 36% of total funds. Given the actual and potential loss in local jobs and wages, the increase in bankruptcies and foreclosures rates and increases in homeless single adults and families it is critical to position our homelessness network to secure all available funding.

It is similarly as critical to be sure that the homelessness system works to provide real solutions for those that need for it to work for them. There are many differing demographics for the homeless. An effective ten year plan will address these varying needs. It should move all that can into permanence so that self-sufficiency becomes a reality. It should also support the needs of those that are most vulnerable to provide safety. Without a strategic plan to make effective change, the ongoing financial and human costs will increase dramatically.
**HOMESLESS SOLUTIONS POLICY BOARD (1-B) PROPOSED MEMBERSHIP**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Member</th>
</tr>
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<tbody>
<tr>
<td>ADAMHS Board</td>
<td>ADAMHS Board Chair</td>
</tr>
<tr>
<td>At-Large</td>
<td>Selected by HSPB</td>
</tr>
<tr>
<td>At-Large</td>
<td>Selected by HSPB</td>
</tr>
<tr>
<td>Bank / Financial institutions</td>
<td>Dayton Business Committee</td>
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<tr>
<td>Business Community</td>
<td>Downtown Dayton Partnership</td>
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<tr>
<td>Business Community</td>
<td>Dayton Urban League</td>
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<tr>
<td>Business Community</td>
<td>Dayton Area Chamber of Commerce</td>
</tr>
<tr>
<td>City of Dayton</td>
<td>City Manager</td>
</tr>
<tr>
<td>Dayton Foundation</td>
<td>President / Designee</td>
</tr>
<tr>
<td>Dayton Metropolitan Housing Authority</td>
<td>DMHA Board Chair</td>
</tr>
<tr>
<td>Faith-Based Community</td>
<td>Selected by HSPB</td>
</tr>
<tr>
<td>Faith-Based Community</td>
<td>Selected by HSPB</td>
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<tr>
<td>Greater Dayton Real Estate Investors Association</td>
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<td>Kettering Health Network</td>
<td>President</td>
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<tr>
<td>Area Foundations</td>
<td>President / Designee</td>
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<tr>
<td>Mayors and Managers</td>
<td>Chair/Designee</td>
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<tr>
<td>Montgomery County</td>
<td>County Administrator</td>
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<td>Premier Health Network</td>
<td>President / Designee</td>
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<tr>
<td>Provider Agency Director Group</td>
<td>Designee</td>
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<td>Sinclair Community College</td>
<td>President / Designee</td>
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<tr>
<td>United Way of Greater Dayton</td>
<td>United Way Board Chair</td>
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<tr>
<td>University of Dayton</td>
<td>President / Designee</td>
</tr>
<tr>
<td>Wright State University</td>
<td>President / Designee</td>
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**Funder Collaborative Subcommittee Proposed Membership (2-B)**

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<tr>
<th>Organization</th>
<th>Member</th>
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<tbody>
<tr>
<td>ADAMHS Board</td>
<td>ADAMHS Board Chair</td>
</tr>
<tr>
<td>City of Dayton</td>
<td>City Manager</td>
</tr>
<tr>
<td>Dayton Foundation</td>
<td>President / Designee</td>
</tr>
<tr>
<td>Dayton Metropolitan Housing Authority</td>
<td>DMHA Board Chair</td>
</tr>
<tr>
<td>Greater Dayton Area Hospital Association</td>
<td>President (GDAHA)</td>
</tr>
<tr>
<td>Human Services Levy</td>
<td>HSL Council Chair</td>
</tr>
<tr>
<td>Area Foundations</td>
<td>President / Designee</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>County Administrator</td>
</tr>
<tr>
<td>United Way of the Greater Dayton Area</td>
<td>United Way Board Chair / Designee</td>
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RESOLUTION NO. 06-1006
JUNE 13, 2006

RESOLUTION ENDORSING THE HOMELESS SOLUTIONS TEN-YEAR PLAN TO END CHRONIC HOMELESSNESS AND REDUCE OVERALL HOMELESSNESS IN DAYTON AND MONTGOMERY COUNTY AND ENDORSING THE CREATION OF A HOMELESS SOLUTIONS POLICY BOARD.

WHEREAS, homelessness has become a critical problem in Dayton and Montgomery County with increasing numbers of homeless individuals and families; and

WHEREAS, the shelter system is seriously overburdened in providing shelter and necessary services for this population; and

WHEREAS, the U.S. Department of Housing and Urban Development and the U.S. Interagency Council on Homelessness have encouraged communities receiving funding for homeless services to develop a ten-year plan to end chronic homelessness; and

WHEREAS, The Homeless Solutions Leadership Team, co-chaired by the Montgomery County Administrator and the Dayton City Manager, determined that a Plan for our community should reduce homelessness for families, youth and other single adults as well as end homelessness for the chronically homeless; and

WHEREAS, The Homeless Solutions 10-Year Plan developed by the Homeless Solutions Leadership Team provides critical recommendations for reducing poverty, better homeless prevention, additional housing, a more effective multi-system service response to homelessness and a new governance structure to guide the Plan implementation;

NOW, THEREFORE, BE IT RESOLVED that the Montgomery County Board of County Commissioners do hereby endorse the Homeless Solutions Ten-Year Plan to End Chronic Homelessness and Reduce Overall Homelessness in Dayton and Montgomery County and do endorse the creation of a Homeless Solutions Policy Board.

BE IT FURTHER RESOLVED that the Clerk certify copies of this Resolution and make an imaged copy of this resolution available on the Montgomery County website at http://www.mcohoio.org/.
RESOLUTION NO. 06-1006
JUNE 13, 2006

Mrs. Lieberman moved the adoption of the foregoing resolution. It was seconded by Mrs. Pegg and upon call of the roll, the following vote resulted:

Mrs. Lieberman, aye; Mrs. Pegg, aye; Mr. Curran, aye: Motion carried.

- - - - - - - - -

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the Board of County Commissioners of Montgomery County, Ohio, the 13th day of June, 2006.

Juanita M. Hunn, Clerk
Board of County Commissioners
Montgomery County, Ohio

JMH

THE BOARD OF COUNTY COMMISSIONERS HEREBY FINDS THAT:
1. DETERMINED THAT ALL PREVIOUS ACTIONS RELATIVE TO
   ADOPTION OF THE RESOLUTION OF MONTGOMERY COUNTY
2. THE MOUNTAIN VIEW TRACT
   COMMUNITY DEVELOPMENT DISTRICT
3. RESOLVED TO ENACT THE FOLLOWING
   OPEN TO THE PUBLIC UNDER THE RULES OF THE REVISION CODE
   THE MOUNTAIN VIEW TRACT COMMUNITY DEVELOPMENT DISTRICT
   RESOLUTION 121.32 OF
AN INFORMAL RESOLUTION

Endorsing the Homeless Solutions 10-Year Plan for
Ending Chronic Homelessness and Reducing Overall
Homelessness in Dayton and Montgomery County.

WHEREAS, More than 6,000 people experienced homelessness in Dayton and
Montgomery County during 2004; and

WHEREAS, The City of Dayton is home to the community’s seven homeless
shelters and most of the agencies that provide health and human services and
permanent housing to Montgomery County’s homeless populations; and

WHEREAS, This community cannot afford to have people living on the street
or in shelters—the toll that homelessness exacts on all of the people who experience it,
especially children and adolescents, coupled with the negative impacts on
neighborhood revitalization and economic development is far too costly; and

WHEREAS, The U.S. Department of Housing and Urban Development, and the
U.S. Interagency Council on Homelessness have established the goal of eliminating
chronic homelessness by 2012, and have asked Dayton and Montgomery County to
develop and adopt our own ten-year plan to end chronic homelessness; and

WHEREAS, In Dayton and Montgomery County two-thirds of the homeless
population consists of families with children, or runaway youth between the ages of
eleven and seventeen, while chronically homeless single adults comprise three percent
of our homeless population; and

WHEREAS, The Homeless Solutions Leadership Team, co-chaired by the City
Manager and the Montgomery County Administrator, and whose members represent the
public, private and non-profit sectors of the community, determined that it was
unacceptable to mobilize the community to address only the needs of the chronically
homeless without also addressing the needs of families with children, homeless youth
and single adults without disabilities; and

WHEREAS, The Homeless Solutions 10-Year Plan provides a roadmap that will
eliminate barriers to ensure better outcomes for all persons who are homeless in our
community by redirecting the focus from managing homelessness to ending chronic
homelessness, and reducing homelessness overall; and

WHEREAS, Committed leadership and strong governance are essential for the
Homeless Solutions 10-Year Plan to achieve its goals; now, therefore,
BE IT RESOLVED BY THE COMMISSION OF THE CITY OF DAYTON:

Section 1. That the City of Dayton endorses the Homeless Solutions 10-Year Plan for Ending Chronic Homelessness and Reducing Overall Homelessness in Dayton and Montgomery County, a copy of which is attached hereto.

Section 2. That the City Commission will work in partnership with the Montgomery County Commission and the United Way Board to convene the Homeless Solutions Policy Board that will oversee and guide the implementation of the Homeless Solutions 10-Year Plan, including the management of funding allocations and interagency collaboration.

Section 3. That the City Commission authorizes the City Manager and appropriate City staff to participate in the Homeless Solutions Policy Board and the implementation of the Homeless Solutions 10-Year Plan.

Adopted by the Commission .................., 2006

Signed by the Mayor ......................, 2006

Mayor Rhine McLin, City of Dayton, Ohio

Attest:

Clerk of the Commission

Approved as to form:

City Attorney