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HELPING PEOPLE HOME

ANALYZING HOMELESSNESS IN THE CHARLOTTESVILLE COMMUNITY

A POLICY REPORT COMPILED BY DARIA WINSKY, MICHAEL RUSSELL, CHANDLER ROSENBERG, AND KEVIN HARMON

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1. EXECUTIVE SUMMARY

According to Article 25 of the UN Universal Declaration of Human Rights, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.[1]" Unfortunately, homelessness continues to remain an issue of critical concern both locally and across the United States. While many Charlottesville residents regularly see homeless individuals on the Corner or panhandling by the side of the road, few realize the extent and complexity of an issue that so profoundly impacts so many members of this community.

Over the course of the Spring 2016 semester, our team has attempted to gain an insight into the state of care for homeless individuals throughout the Charlottesville community. In addition to general research on national trends and evidenced based practices, we conducted a series of interviews with representatives from eleven non-profit and governmental organizations who are directly involved in addressing this issue at the local level. While by no means comprehensive, we have attempted to consolidate our newfound knowledge into a single report to be used as an introductory resource for those interested in learning more about this problem area and the local system of care.

In researching this issue, our team came to realize that the problem of homelessness is substantially higher in Charlottesville than many other regions in the state. Out of the five Virginian cities for which we were able to find similar data, Charlottesville has the highest rate of homelessness per capita, even when compared to major metropolitan areas like Richmond. Encouragingly, our research also revealed a clear, evidenced-based approach to solving this problem. From our interviews and research, we believe that the Housing First philosophy is the best way to address homelessness due the model's overwhelming track record of success - both nationally and locally. Led by the Thomas Jefferson Coalition for the Homeless (TJACH), the Charlottesville Continuum of Care is making strides to solve the homelessness issue, but gaps in services still persist. The issues in our community include mismatch of resources, lack of Permanent Supportive Housing, incomplete data collection, and philosophical differences, all of which hinder creating the best possible care for homeless individuals.

While we have collectively been impressed by the extraordinary dedication, commitment and compassion of local actors working on this issue, we conclude with our belief that Charlottesville will be unable to truly address the needs of its homeless population unless the community is able to rally the resources and support for additional Permanent Supportive Housing.

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1 United Nations., General Assembly. (1948). Universal Declaration of Human Rights 60th anniversary special edition, 1948-2008. New York: United Nations Dept. of Public Information.

2. CONTEXTUALIZING HOMELESSNESS POLICY

2.1 UNDERSTANDING HOMELESSNESS

In our exploration of this problem, we have consistently found the issue of homelessness to defy simplistic descriptions and explanations. One needs only to perform a quick internet search to find stories such as that of Maurice, a middle aged man with multiple Masters degrees in Engineering from Dartmouth and Purdue.[2] After spending all of his savings on his parent's health needs, and after Lockheed Martin downsized his facility from 30,000 engineers to 3,000 during the Great Recession, he found himself on the streets. Another powerful story of homelessness involves a young woman named Rebecca, who began using drugs to numb the pain of years of rape and physical violence from her step-father.[3] As Rebecca's mother continued to stay with her abuser, the 15-year-old was forced into homelessness. Stories like Rebecca's demonstrate that, while substance abuse and behavioral issues plague the homeless population, these problems often arise as the result of trauma and abuse rather than willful choices.

2.2 DEFINING HOMELESSNESS

The Department of Housing and Urban Development (HUD) considers an individual or family to be homeless if they lack a fixed, regular, and adequate nighttime residence.[4] This includes those occupying nighttime residences not designed for regular sleeping accommodation (including car, park, campground, bus/train station, abandoned building). Persons sleeping in publicly or privately operated shelters or transitional housing also fit these criteria. A person does not meet the HUD definition of homeless if they are living with friends or relatives, living in substandard housing that is overcrowded or in need of repair, or staying in a motel. Beyond the national level, Charlottesville organizations such as TJACH also follow HUD's definition.[5]

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[2] 60Days60Nights. (2011). 55 year old Homeless Man carries 2 Masters Degrees (Maurice Johnson). Retrieved from https://www.YouTube.com/watch?v=8eNPAH46ol8

[3] Mapstone, D. Homeless People - Rebecca's Story.

[4] United States, Department of Housing and Urban Development. (2012). *Guidance on housing individuals and families experiencing homelessness through the Public Housing and Housing Choice Voucher programs*.

[5] Homelessness In A World-Class Community: Creating An Action Agenda

Our group chose to define homelessness the same way as TJACH and HUD, due to the fact that the most accurate and abundant data comes from these sources. Given that homelessness is already a difficult issue to track quantitatively, we believe this definition allowed us to perform the most informed and comprehensive research possible.

2.3 MEASURING HOMELESSNESS

The transient nature of homelessness makes it one of the most difficult problems to measure and track in an era defined by big data. In the past, record keeping varied immensely between different organizations and regions across the nation. However, HUD has made efforts to standardize data collection on homeless individuals through the use of regular Point-in-Time (PIT) counts. To administer these surveys, local organizations across the country collect information on every homeless individual they can find on the streets, in shelters, in hospitals, and even in the woods. In order to ensure consistency, the organizations all conduct the surveys within the same short time period, typically on a single day in late January. Although these counts do not provide information on day-to-day variations in the population, they do provide enough data to measure trends over time.

2.4 ADDRESSING HOMELESSNESS

TRADITIONAL APPROACH

Historically, local communities took a substantially different approach to ending homelessness than is common today. Most care providers operated under the belief that this issue is caused by external personal or social problems, so the natural solution is to fix these associated issues prior to reintegrating individuals back into housing. Thousands of shelters and food pantries were opened to keep individuals from freezing to death or dying of starvation, but many took a "high barrier approach" preventing individuals who drank or failed drug tests from using their services. Transitional housing programs were also used as a means of helping the most stable homeless individuals readjust to living in housing, but these programs typically left behind the most vulnerable (and therefore most "risky") subpopulations like the chronically homeless and those with severe mental illness. In the past, local organizations also rarely had streamlined, coordinative programs; organizations such as food pantries, shelters, and emergency care worked on a more independent basis to do their part to end homelessness. This often led to duplicated services or critical gaps in the system of care.

In recent years, there has been a paradigm shift in terms of how local and national organizations approach the issue of homelessness. Some minor national action undertaken by President Bush's administration signaled this change, but the wholehearted embrace of the Housing First approach by the Obama administration directly led many local organizations to adopt this methodology.[6]

HOUSING FIRST

Housing First is a low-barrier approach to ending homelessness that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed.[7] The fundamental idea behind this approach is that a lack of stable housing is not merely a symptom of other problems, but a problem in and of itself. A lack of housing dramatically increases an individual's risk of negative health outcomes and sexual assault, exacerbates problems with mental health and substance abuse problems, and severely limits a person's ability to "get back on their feet." The low-barrier nature of Housing First allows individuals to gain housing without the prerequisite of sobriety or employment. Instead of this, Housing First attempts to first stabilize an individual's housing situation even before providing attempting to solve associated issues. Case management teams provide consistent services for things such as financial management, employment, transportation, and access to mental health/substance abuse treatment.

While enrolled in a Housing First program, participants must comply with standard lease agreements but are provided the support and resources to help them do so. Participants often receive job training, substance abuse treatment, and other resources to help with their specific needs. The Housing First philosophy states that social services will be more effective when a person is receiving treatment in their own home. This approach seeks to provide stability in Housing First, in order to provide stability in other aspects of one's life.

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[6] First Lady on Ending Veteran Homelessness. Retrieved from http://www.c-span.org/video/?319743-1/first-lady-ending-veteran-homelessness

[7] Housing First. Retrieved from http://www.endhomelessness.org/pages/housing_first.

CHOOSING HOUSING FIRST

After reviewing multiple evidence-based reports that detail the success of Housing First programs in all kinds of environments and learning that federal, state, and local governments have overwhelmingly adopted this model, we believe that the Housing First approach is the best way to solve this issue. Our decision to adopt this approach was informed by Housing First program successes on the state level in New York, NY and Denver, CO, as well as on the national level. New York City noticed that placing homeless individuals with mental illnesses in Permanent Supportive Housing saved the city $24,000 in what they would have paid in emergency, shelter and other expenses while keeping these individuals homeless.[8] Similarly, Denver saw a savings of $31,545 per person in emergency-service costs.[9]

On a national level, the US Department of Veteran Affairs also tested the Housing First approach and observed positive results. Using the Housing First approach, the VA housed 700 homeless veterans, 84% of which remained in Permanent Supportive Housing – effectively ending their homelessness. Among the 115 Veterans who have left the program, almost half moved to independent living, meaning only ~7% of participants were not successfully helped by the program.[10]

Charlottesville has also seen similar successes with Permanent Supportive Housing and housing retention versus chronic homelessness rates. In 2011, Charlottesville had 60 chronically homeless individuals and 46 individuals in Permanent Supportive Housing (TJACH 2016 PIT).[11] In 2016, Charlottesville has 30 chronically homeless individuals and 105 individuals in Permanent Supportive Housing (TJACH 2016 PIT). While correlation does not equal causation, we believe that the number of chronically homeless individuals decreased by 50% substantially due to the increase in permanent housing options. Although other factors surely played a role in this decrease, we feel that this impressive result mirrors the results of national studies and should be viewed as evidence for the success of Permanent Supportive Housing in the local community.

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[8] Culhane, D. P., Metraux, S., & Hadley, T. Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing.

[9] Perlman, J., & Parvensky, J. Denver Housing First Collaborative: Cost Benefit Analysis and Programs Outcome Report.

[10] Montgomery, A. E., Hill, L., Culhane, D. P., & Kane, V. Housing First Implementation Brief.

[11] TJACH. (2016). [Charlottesville Point-in-Time Count

2.5 ENDING HOMELESSNESS

The ultimate goal of organizations that have accepted the Housing First approach is to make homelessness ***brief***, ***rare***, and ***non-recurring***.[12]

Brief - A person who slips into homelessness should be identified and moved into housing within 30 days.

Rare - Regardless of the resources available for homeless individuals, homelessness should not be notably prevalent in a particular locality.

Non-recurring - Individuals who are helped out of homelessness should have the support and necessary resources to not fall back into homelessness.

If these three goals are achieved, homelessness can be considered at a "functional-zero." At this point, while temporary homelessness may still exist within a community, more people are returned to housing than are actively becoming homeless at any given period of time, effectively eliminating the problems associated with chronic homelessness.

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[12] About The Coalition. Retreived from http://tjach.org/

3. POLICY HISTORY

3.1 Foundational Policy

MCKINNEY-VENTO HOMELESS ASSISTANCE ACT

The McKinney-Vento Homeless Assistance Act[13], originally signed into law in 1987 by President Ronald Reagan, was the first Federal legislative response to homelessness. The most groundbreaking aspect of the legislation is its declaration that homelessness is a problem of national concern. Until this time, most policymakers considered homelessness to be primarily a local issue. Additionally, the act established the Interagency Council on the Homeless and the Continuum of Care concept. McKinney-Vento originally consisted of 15 programs that provided services such as primary health care, education, job training, emergency shelters and transitional housing, and some permanent housing to the homeless communities.[14]

3.2 Recent Policy

HEARTH ACT

On May 20, 2009, President Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.[15] The Act reauthorizes the McKinney-Vento Homeless Assistance programs while adding some substantial changes. First, the bill updates the definition of homelessness by including situations where a person is at imminent risk of homelessness or where a family or unaccompanied youth is living unstably. Imminent risk includes situations in which an individual is at risk of losing housing within 14 days and has no resources or support networks in place to help them obtain housing.

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[13] United States., Congress., House. (1987). *H.R. 558 (100th): Stewart B. McKinney Homeless Assistance Act*. Washington, D.C.: U.S. G.P.O.

[14] National Coalition for the Homeless. (2006). NCH Fact Sheet #18 - McKinney Vento Act.

[15] National Alliance to End Homelessness. (2008). *Summary of HEARTH Act*. Washington, D.C.: NAEH.

Instability refers to families with children and unaccompanied youth who:

- are defined as homeless under other federal programs (such as the Department of Education's Education for Homeless Children and Youth program)
- have gone for a long period without living independently in permanent housing
- have moved frequently
- will continue to experience instability because of a disabling condition, history of domestic violence or abuse, or multiple barriers to employment

The act also consolidates HUD's competitive grant programs and appoints a "Collaborative Applicant" within a community. The Collaborative Applicant is responsible for submitting a consolidated funding application to HUD. In certain circumstances, the Collaborative Applicant may receive all HUD funding designated for their particular community and distribute it to "project sponsors" (organizations within the Continuum of Care) as they see fit. In this case, a Collaborative Applicant is known as a "Unified Funding Agency" and must also ensure that project sponsors within the community adhere to standardized data collection methods and are audited annually.

Additionally, the HEARTH act mandates that the Interagency Council on Homelessness develop a National Strategic Plan to End Homelessness and update it annually (Opening Doors). It increases emphasis on prevention resources and organizational performance, and creates a Rural Housing Stability Assistance Program (which allows rural communities to apply for funding under a more flexible set of criteria).

OPENING DOORS:

Opening Doors[16] is the first comprehensive federal strategy to prevent and end homelessness, as mandated by the HEARTH Act. Introduced in 2010 and updated in 2015, the plan outlines the following goals for ending homelessness:

- end veteran homelessness by 2015
- end chronic homelessness by 2017
- prevent and end homelessness for family and youth by 2020
- set a path for ending all types of homelessness.

[16] United States, Interagency Council on Homelessness. (2015). *Opening Doors*. Washington, D.C.

Opening Doors hopes to meet these goals by ensuring that every community has a systematic response system in place. Key elements of this system include increased leadership, collaboration, civic engagement, and access to stable and affordable housing. Specifically, the aim is to equip each community to promptly identify and engage homeless individuals; prevent at-risk individuals from losing housing and divert them from entering the homelessness services system; and provide low-barrier emergency shelter and services for individuals that do fall into homelessness while more permanent housing solutions are being secured. Since the launch of Opening Doors in 2010, homelessness among Veterans has decreased by 33%, followed by a decline of chronic homelessness by 21% and family homelessness by 15%.

3.3 LOCAL LEVEL POLICY ADOPTION

While homelessness policy has mainly been created and developed at the national level, this is not because state and local governments are not involved in the issue. Rather, state and local governments have overwhelmingly followed the prescriptions of the national policy, which includes adopting a Housing First approach - at least if they wish to keep receiving funding. Charlottesville is no exception. While some organizations reject the Housing First philosophy, most actors in the Charlottesville homelessness arena follow federal policies and trends.

3.4 INTERRELATED ISSUES

Homelessness is not an isolated issue. Rather, it strongly overlaps with a multitude of associated issues including mental health, substance abuse, and domestic violence. In many situations, these issues are both catalysts and the consequence of homelessness. While the population of local homeless individuals may seem small in absolute terms, examining them in the context of their interrelated issues underscores the gravity and far-reaching implications of homelessness.

In order to depict these issues as accurately as possible, we have decided to primarily use statistically rigorous national studies in our discussion of this section. However, through our extensive interviews and research, we understand that the same national issues are prevalent within our community and should be considered as we examine homelessness in Charlottesville. As such, we have included relevant statistics from the 2015 Housing & Homelessness Symposium where applicable.[17]

[17] Dimock, Kaki. The Scope of the Problem. Rep. Charlottesville: Housing and Homelessness Symposium, 2015. Print.

MENTAL HEALTH

About 29% of the national homeless population suffers from a mental illness.[18] The most common mental illnesses include schizophrenia, bipolar disorder, and severe depression—all conditions that adequate counseling can address, but become debilitating when coupled with homelessness and left untreated. Mental illness can eliminate a potentially valuable safety net from the homeless when it prevents individuals from developing and maintaining support networks with family and peers. It can also render a homeless individual unable to perform essential tasks of daily life, making it much more difficult to find and maintain housing or employment. Because the mentally ill homeless may not take necessary precautions against disease, poor physical health often becomes an issue as well. Mental illness is also highly associated with substance abuse.. According to the most recent data from the National Coalition for the Homeless, roughly 50% of the mentally ill homeless population also suffers from alcohol or drug abuse problems.[19] Even in circumstances where mental health and substance abuse services are available, a mistrust of service providers resulting from mental illness can cause an individual to go untreated. Encouragingly, only 16% of unhoused individuals in Charlottesville face severe problems with mental illness.[17] We believe this may be in part due to the strength of the local mental health provider, Region 10, which has multiple programs dedicated specifically to helping homeless individuals who struggle with mental illness.

SUBSTANCE ABUSE

Substance abuse is both a leading cause and consequence of homelessness, especially among single adults. While some individuals find themselves homeless after negative experiences associated with both legal and illegal drugs, substance abuse can also be an outcome of homelessness that individuals resort to as a method of coping with their situations. Addiction can sever familial ties and isolate an individual from his or her support network, making escaping homelessness exceptionally difficult. Naturally, providing housing, food and shelter are higher priorities than substance abuse treatment, contributing to many service providers in these fields. However, many shelters and service providers follow the traditional approach of ending homelessness requiring clients to be sober before receiving services. This makes it even more difficult for homeless individuals to obtain a baseline standard of living.

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[18] Lowe, E. T., Thomas, G., & Salmas, G. (2015). *Hunger and Homelessness Survey* (pp. 5-6, Rep.). The United States Conference of Mayors.

[19] *Mental Illness and Homelessness* (Rep.). (2009, July). Retrieved http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

Although it is difficult to obtain a current, accurate statistic, the most recent data (from 2003, cited in a 2009 report) estimates that 38% of homeless individuals are dependent on alcohol, while 26% abuse other drugs. Charlottesville appears to have a similar rate with around 32% of homeless individuals addicted to some kind of substance.[17] Comparatively, among the general population, only 15% of people over 12 reported using drugs in the past year.[20]

DOMESTIC VIOLENCE

Especially among women, domestic violence can be an immediate cause of homelessness. This is evidenced by the fact that at least 12% of the female homeless population had experienced domestic violence prior to loosing their housing.[21] Women suffering domestic abuse frequently must choose between staying with their abuser for shelter and financial support or living on the streets. This issue is further complicated when children are involved, as mothers may not wish to endanger their children by leaving even if it means enduring further abuse. In addition, domestic abuse is often associated with mental illness, most commonly PTSD, anxiety, or depression. Over 50% of women who live with a mental illness have previously experienced some sort of trauma such as physical or sexual abuse.[22] Moreover, living on the streets often makes women far more vulnerable to being abused. Homeless women fleeing domestic abuse can also be difficult to track and house due to concerns about confidentiality. In Charlottesville, 31% of unhoused homeless women are survivors of domestic violence.[17]

CYCLICAL NATURE

These issues, when interacting with each other, cause homelessness to be characterized by a cyclical nature. Women, for example, experience mental illness and homelessness not just in conjunction with the other, or as a result of the other, but instead as a vicious cycle. According to our interviews with mental health professionals, women who experience trauma such as sexual assault or child abuse can develop mental illnesses and disorders such as PTSD and depression. This can cause them to fall into homelessness, whereby their mental conditions worsen and their disorders intensify. Then, since poor mental and physical health—not to mention substance abuse—make it difficult to obtain employment and obtain and/or maintain stable housing, survivors struggle to get back on track. While there is no quantitative data to support this conclusion, the mental health professionals we spoke to noted that all homeless women they have worked with have experienced some sort of trauma, and that the trauma played into or caused the vicious cycle of mental illness and homelessness.

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[20] *Substance Abuse and Homelessness* (Rep.). (2009, July). Retrieved http://www.nationalhomeless.org/factsheets/addiction.pdf

[21] Domestic Violence. Retrieved from http://www.endhomelessness.org/pages/domestic_violence

[22] Trauma, Mental Health and Domestic Violence. (2009). Retrieved from http://fcadv.org/projects-programs/trauma-mental-health-domestic-violence

4. HOMELESSNESS IN CHARLOTTESVILLE

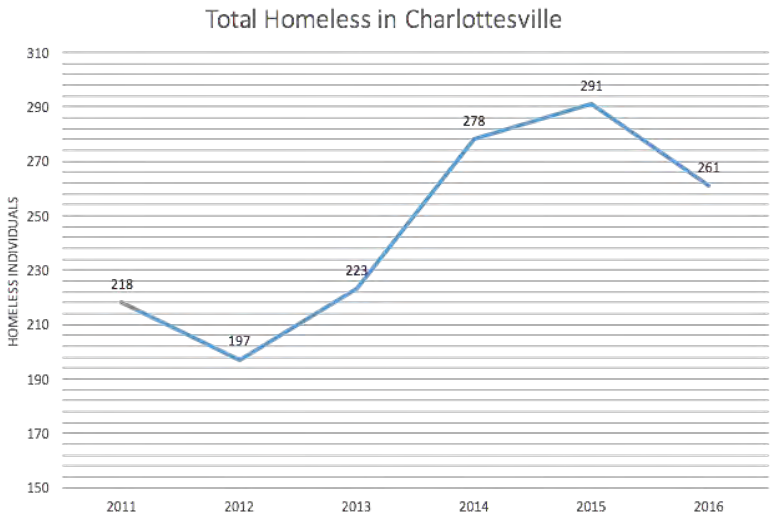
4.1 SCALE OF THE PROBLEM

Given the time and logistical constraints of our course, we focused our efforts primarily on understanding the issue within the City of Charlottesville, with some overlap with the county of Albemarle.

RATE OF HOMELESSNESS

As of 2016, TJACH's PIT count revealed a total of 261 individuals in Charlottesville who were either literally homeless or in housing or shelter programs.[23] Specifically:

- 105 individuals were living in permanent housing programs (Permanent Supportive Housing or Rapid Re-Housing)
- 33 in transitional housing programs
- 101 in emergency shelters.



Concerningly, this leaves an additional 22 individuals completely unsheltered. 2016 positively appears to be a break in a trend of increasing homelessness rates over the past six years. With the exception of 2012, the number of homeless individuals increased from around 200 individuals to nearly 300 in 2015.

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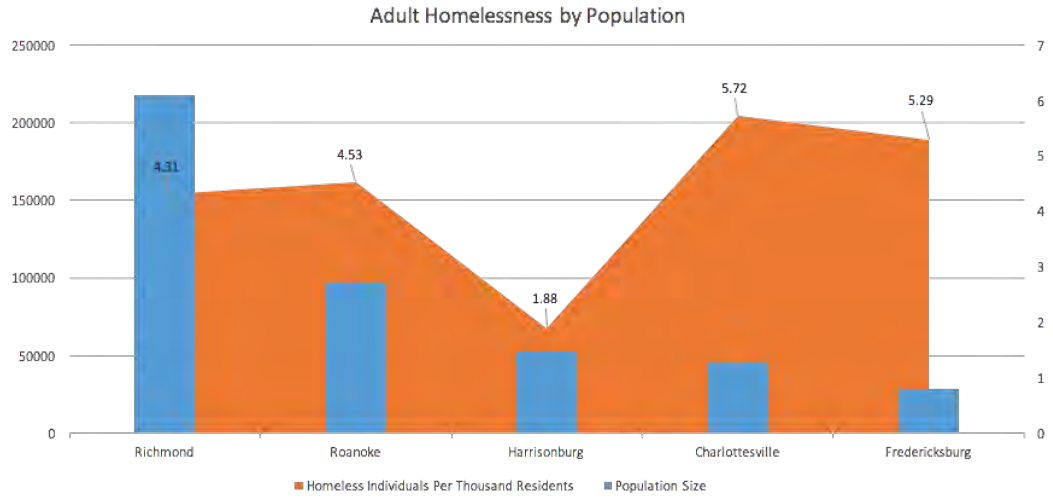
[23] TJACH. (2016). [Charlottesville Point-in-Time Count]
NOTE: Graph Includes Individuals in Permanent Supportive Housing and Rapid Rehousing Programs as the vast majority of these individuals would fall back into homelessness if support was removed.

COMPARISON WITH OTHER CITIES

Relative to comparable cities in Virginia, Charlottesville has an extremely high rate of homelessness. Although Charlottesville is somewhat unique in the state of Virginia, we attempted to reference it against nearby cities of a similar size in order to gauge the relative scale of the issue in this community. For example, the cities of Harrisonburg and Charlottesville each have approximately 50,000 residents according to the most recent census data.[24] Yet, in 2014, Harrisonburg had a rate of 1.88 homeless adults per thousand residents, while Charlottesville had approximately 5.72. In fact, out of the five cities for which we were able to find accessible Point-in-Time data, Charlottesville had the highest rate of homelessness.[25]



[24] QuickFacts: Harrisonburg City, Virginia. Retrieved from https://www.census.gov/quickfacts/table/PST045214/5135624,51540

[25] **Adult Homelessness by Population Sources:**

Richmond: Homeward VA. (2014). Point-in-Time Count in Richmond/Henrico County. Retrieved from http://www.homewardva.org/images/pdf/AHAR20132014localreportwithestimates.pdf

Roanoke: Blue Ridge Continuum of Care. (2014). 2014 Point-in-Time Count Street and Shelter Report. Retrieved from http://www.councilofcommunityservices.com/wp-content/uploads/2010/12/ FINAL-2014-Annual-Report-Point-in-Time-3-21-20141.pdf

Harrisonburg: Harrisonburg Housing and Redevelopment Authority. (2014). *Harrisonburg and Rockingham County Point-in-Time Count* .

OldSouthHigh, A. (2014). Homelessness trends in Harrisonburg/Rockingham. Retrieved from http://www.oldsouthhigh.com/2014/06/03/homelessness-trends-in-harrisonburg

Harrisonburg & Rockingham County, Virginia. (2010). *ENDING HOMELESSNESS IN TEN YEARS: HARRISONBURG AND ROCKINGHAM COUNTY, VA*.

Charlottesville: TJACH. (2016). [Charlottesville Point-in-Time Count].

Fredericksburg: Fredericksburg Regional Continuum of Care. (2015). *Point-In-Time Count Report*. Retrieved from http://www.fredericksburgcoc.org/wp-content/uploads/2015/03/PIT-Count-Report-Winter-2015.pdf

Fredericksburg Regional Continuum of Care. (2014). *Point-In-Time (PIT) Report*. Retrieved from http://www.fredericksburgcoc.org/wp-content/uploads/2015/03/2014-PIT-Report.pdf

4.2 CRITICAL ORGANIZATIONS

The Charlottesville Community is fortunate to have a large and talented group of organizations operating within it with the goal of ending homelessness.

THOMAS JEFFERSON AREA COALITION FOR THE HOMELESS

Most local non-profits directly addressing the issue are connected to the Thomas Jefferson Area Coalition for the Homeless (TJACH)[26], which is the HUD-Designated coordinator of the regional Continuum of Care. As such, TJACH functions as an administrative body for 16 coalition member organizations ensuring that all of the organizations perform efficiently and follow the HUD guidelines. This responsibility includes overseeing data collection and auditing member organizations.

At the same time, TJACH also coordinates funding for all of the coalition member organizations. In its HUD-Designated role, TJACH receives a set amount of funding from the state, which it then distributes to the member organizations. Coalition member organizations must apply jointly for grants through TJACH in order to receive the money. This helps to streamline the Continuum of Care.

TJACH is also the primary data collector within the Charlottesville community. It organizes the annual Point in Time (PIT) Count, a 28 question survey distributed via a community wide canvass methodology. Volunteers venture to natural homeless communities, such as soup kitchens, shelters, woods, and the streets, to survey homeless people.

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[26] About the Coalition. Retrieved from http://tjach.org/?page_id=23

The 2016 TJACH PIT Count not only asked people about their housing statuses, but also asked for information regarding mental health, substance abuse, HIV status, and domestic violence histories. TJACH also does a shelter count by asking service providers that have beds to report how many beds they have, how many are in use, and who is in them.

The other main way TJACH collects data is via the Homelessness Management Information System (HMIS). The system used to only collect entry data at year one and exit data at year four for permanent housing. However, HUD now mandates that all groups do things the same way, so even emergency shelters are supposed to do entry and exit data for every person who comes in and out in one day.

Data quality is always a major component of addressing a policy issue. Specifically, in Charlottesville, not all organizations that aim to end homelessness are a part of the Continuum of Care and thus have no obligation or incentive to report data. As such, TJACH's efforts to develop and implement effective data collection strategies fills a key need in the community.

VIRGINIA SUPPORTIVE HOUSING / THE CROSSINGS

SERVICES PROVIDED

The Crossings [27] is a Permanent Supportive Housing (PSH) / affordable housing building in the Charlottesville community. It believes that by providing a stable living space first, with subsequent supportive services, a homeless individual will be more successful. Due to the lack of housing options for the chronically homeless locally, the Crossings directly addresses the biggest gap in care in Charlottesville.

The Crossings has 60 rooms, each with a single resident. Out of these, 35 rooms are "entirely subsidized," meaning that individuals living there pay either 30% of their income (including Social Security/Disability payments), or $25 (city residents) - $50 (county residents), whichever is greater. The other 25 rooms are "rent-controlled," meaning residents must pay $525 per month. Tenants in the rent-controlled rooms are generally better off, making between $1200-$2200 per month.

The Crossings also offers case management services to its residents. Staff members help housed individuals access community services and resources such as counseling and skills training. They help tenants with life issues, with managing recovery, as well as with any health issues that may arise or persist. Lastly, the Crossings emphasizes community building. They organize communal activities such as bingo, movie nights, and bowling to foster more interaction among tenants. The Crossings also provides transportation for its tenants to receive outside care and services.

By adopting Housing First's low-barrier approach, the Crossings does not require its residents to be substance-free. It is important to note that the primary goal of the Crossings is not to reintegrate homeless individuals back into the community, but instead, to provide a healthy place where individuals can find stability over time and access vital services for their health and wellbeing.

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[27] How We Help - Virginia Supportive Housing. Retrieved From http://www.virginiasupportivehousing.org/how-we-help/

ORGANIZATIONAL STRUCTURE

The Crossings is operated by Virginia Supportive Housing, a non-profit real estate developer that works to create affordable housing communities for the chronically homeless. Virginia Supportive Housing serves as the state's largest supportive housing organization as it manages more than 650 housing units in 15 separate communities. It also serves additional clients in permanent housing with private landlords. Virginia Supportive Housing operates buildings in three large areas across the state of Virginia: Charlottesville, Central Virginia, and Hampton Roads.

ORGANIZATIONAL CAPACITY

The Crossings strongly believes that the city of Charlottesville needs additional Permanent Supportive Housing. In order to truly eliminate chronic homelessness in the area, the Crossings estimates that 180 - 200 extra rooms are needed. These additional rooms would allow for quick intake when new individuals fall into homelessness, contributing to the goal of making homelessness brief and nonrecurring in the local area.

The Crossings believes that the biggest challenges they face are from funding efforts and city politics. Due to the difference in financial support from local governments, Virginia Supportive Housing observes significant regional variations in the number of facilities they can open. For instance, Virginia Beach saw the success of its first facility and was immediately willing to fund additional locations. Charlottesville, on the other hand, only funds approximately 50% of the Crossings' rooms, though there is a clear need for another facility. While upfront costs are expensive, the Crossings argues that the reduction of costs in healthcare and law enforcement (plus others) from Permanent Supportive Housing would save money for the city in the long run.

The Crossings also mentioned that better transportation services would be useful for the organization. Transporting residents to and from different locations is time consuming, and current vehicles are not large enough to take multiple people. A van and volunteer driver would free up time for staff and help residents better receive necessary services.

PACEM

SERVICES PROVIDED

People in Congregations Engaged in Ministry (PACEM)[28] serves as a seasonal night shelter for the Charlottesville community, operating between the months of October and April to prevent individuals from dying on the streets from starvation or exposure. The organization works closely with local church congregations to accomplish its mission, using church facilities and volunteers to provide its services.

PACEM provides shelters paid security staff who can respond to emergencies–psychiatric, interpersonal, and medical–and can call 911 or break up a fight. PACEM does not predicate shelter on cooperation with the alcohol and drug treatment or other supportive services due to the Housing First approach. However, they strongly encourage people to go to treatment and to meet with their case manager once every 2 weeks. Additionally, PACEM hires, trains, and pays JAUNT bus drivers for twice a day routes to other supportive services, and served over 42 people last year.

During the non-winter months, PACEM primarily channels energy into the Journey Volunteers Program, which matches congregation volunteers with a homeless person or newly housed person. This is intended to create positive relationships and personal/emotional support–not provide homeless individuals with a person to pay for their wants and needs. In the off months, PACEM also focuses on hiring, training, fundraising, grant writing, shelter scheduling between 80 congregations and hundreds more volunteers, outreach to potential congregation partners, and improving other supportive programs.

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[28] About PACEM. From http://pacemshelter.org/about-pacem/

ORGANIZATIONAL STRUCTURE

There are 27 hosting congregations, with two shelters hosting simultaneously—one shelter for men and one for women. The congregations set up cots, provide and serve food, schedule overnight volunteers, and more. Many smaller congregations, including those that operate out of schools or have home sites that are not large enough to host, chip in via activities instead. Overall, 70-90 groups are involved on an annual basis. Most host and/or provide for one to two weeks, with the shelter moving from congregation to congregation all season.

Originally, representatives from each member congregations formed PACEM's board. However, while multiple reverends remain on the board, the sheer number of of congregations involved in the organization make it impossible for each Church to directly contribute to decision making. Now, each board member has a few congregations under his/her domain and is responsible for meeting with them and acting as a liaison.

ORGANIZATIONAL CAPACITY

PACEM does not have the resources to stay open all year round, partially due to the fact that national funding streams have shifted to support Rapid Re-Housing over shelters. However, despite the current resource limitations, its administrators and participating congregations want to provide help all year round. If PACEM was able to generate additional private funding, it would be able to operate throughout the summer as well as the winter—local Churches have already formed a waiting list in the hope of providing services during the off-season. Unless Charlottesville is able to open more Permanent Supportive Housing facilities, this service is needed locally since homeless individuals with substance abuse problems are banned from the only year round shelter.

SALVATION ARMY

SERVICES PROVIDED

The Salvation Army[29] is a religious organization that serves as the largest local homeless shelter, as well as the only shelter to operate year-round. As the only major organization in this field not to embrace the Housing First approach on the local level, they are a high-barrier shelter that emphasizes transitional housing and "work therapy" to end homelessness. Salvation Army's requires guests to abide by certain regulations such as sobriety and meeting a curfew each night in order to guarantee a bed. They have implemented a "strike system" that penalizes those who continue to break sobriety while under their care. Their strike system prohibits access to the shelter for 30 days after the first offense, 6 months after a second offense, and one year in the event of a third offense. In order to help people with substance abuse issues, Salvation Army has three detox rehab centers located around Virginia and DC.

Salvation Army's Transitional Housing program is another key aspect of their organization. Officially known as their "Center of Hope Transitional Housing Program," they operate nine one-and-two bedroom apartments within their building for homeless individuals. Residents pay a small monthly fee for the furnished apartment, childcare, food, and any counseling that they may need in order to re-accustom them to living independently. Individuals can stay in these transitional housing apartments for up to two years, with the goal of graduating them into more stable housing at the end of the program.

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[29] Programs & Services. From http://virginiasalvationarmy.org/charlottesvilleva/programs-services/

The Salvation army serves as the largest shelter in the Charlottesville community as they provide 67 total beds for homeless individuals. Their emergency shelter, which contains 58 of those 67 beds, is available for overnight stay. While in the emergency shelter, homeless individuals have access to to free meals everyday and receive help from the Salvation Army to find employment, save money and locate suitable housing.

Through the the Homeless Intervention Program, the Salvation Army also provides rent or mortgage assistance to people who are unable to pay due to emergency circumstances. In addition, the medical assistance program services the community through the University of Virginia Medical Center Indigent Care Program. It offers assistance with financial screening, prescription copayments, doctors appointments, referrals, and Social Security Disability.

ORGANIZATIONAL STRUCTURE

The Salvation Army is a large, international organization that operates a local branch here in Charlottesville. According to their mission statement: "The Salvation Army, an international movement, is an evangelical part of the universal Christian Church. Its message is based on the Bible. Its ministry is motivated by the love of God. Its mission is to preach the gospel of Jesus Christ and to meet human needs in His name without discrimination."

The Salvation Army models the military in its structure, being led by a global Commander with several levels of officers overseeing regional and local offices. They proclaim the Gospel and serve as administrators, teachers, social workers, counselors, youth leaders, and musicians. Salvation Army Soldiers serve as local workers who pledge allegiance to the doctrines and disciplines of the Army. Volunteers are not usually direct members of the Church, but still provide substantial help with the day to day services and programs that the Salvation Army seeks to provide as well as fundraising efforts. The Charlottesville branch stressed that the national and international organizations do not exert much practical control over daily operations, instead acting primarily in a public relations role.

On a regional level, the Salvation Army has 9 divisions in the south with about 28-60 local branches within each division. Locally, it has two Majors who lead the organization with employees underneath them who work to help with their social services and programs. In order to maintain control over how to use its funds, the Salvation Army does not accept government funding.

ORGANIZATIONAL CAPACITY

Since the Salvation Army's rejection of Housing First contradicts that of the Federal government and other local Charlottesville organizations, our team clearly observed a strained relationship with organizations that align more closely with TJACH. Although some coordination exists, we believe the dynamics between the largest shelter provider and the largest funder and housing providers hinders the community's attempts to efficiently provide the homeless population with the care they need. Additionally, the Salvation Army expressed to our team that it "does not see the need for statistics" to carry out their services, and as such does not prioritize data collection of the population it serves. This limits the ability for TJACH to create a cohesive statistical database that accurately depicts the homeless community in Charlottesville.

Looking ahead, the local chapter of The Salvation Army in the Charlottesville created a 5-year strategic plan to continue to fight homelessness. Leadership wants to expand the organization's services to include elderly individuals by providing services such as free lunches to those over the age of 55. They hope to reduce loneliness amongst this population by providing them with resources that increases their interaction within the community. As of now, they do not know if there is a critical need for this specific service in the community but they are looking for creative ways to answer this question.

THE HAVEN

SERVICES PROVIDED

The Haven[30] functions as a main day shelter in the Charlottesville community. As part of the day shelter, the Haven provides breakfast, showers, a permanent mailing address, laundry services, storage space, a telephone, and internet. The Haven serves as a local hub for service provision and administrative communication, physically housing the offices of TJACH and PACEM as well as providing a space for service providers (such as Support Services for Veteran Families, career planning, NA/AA transportation, etc.) to meet with individuals who are homeless.

The Haven also serves as the primary intake point in the Charlottesville Continuum of Care, performing coordinated assessments on all those who enter the system and compiling data from other entry points throughout the community. The coordinated intake assessment involves a brief interview in which individuals are scored to determine vulnerability and then placed into an eligibility category for a particular housing program. In the past, this step was more extensive and exhaustive, but the Haven leadership realized that much of the information was not being used and that there was no reason to intensify the dehumanization of this process.

30 Our Services. From http://www.thehaven.org/our_services

The VI-SPDAT ranking system[31] of the coordinated intake assessment is structured as follows:

- 1 - 3: eligible for homelessness prevention services, housing navigation services, etc.
- 4 - 8: eligible for rapid re-housing
- 9 +: eligible for Permanent Supportive Housing

After the coordinated intake assessment, the Haven either provides services directly or refers clients to other coalition member organizations for help. In the case of a 1 - 4 score, the Haven provides clients with homelessness prevention or housing navigation resources. The state says that in order for someone to receive homelessness prevention services they have to be imminently at risk, i.e. evicted or staying with family and friends. However, the Haven still works to provide people with less formal homelessness prevention resources. In certain circumstances, the Haven provides one-time emergency funds to prevent individuals that are imminently at risk from slipping into homelessness. As for housing navigation services, a Housing Navigation Coordinator works with realtors and landlords to locate and negotiate available housing and leases for homeless people. For scores of 4 - 8, the Haven steps in with Rapid Re-Housing. Before July 2015, THRIVE ran this step, but now the Haven serves as the Charlottesville Rapid Re-Housing coordinator, providing people with short term rental subsidies to bounce them out of homelessness and back to stability. For scores of 9 and above, the Haven refers clients to one of the Permanent Supportive Housing providers including the Crossings or Region Ten.

In addition to coordinating housing, the Haven also operates the House2Home Initiative, a program that targets the "human side" of homelessness. The Haven received a private grant for $200,000 to partner with New City Arts and to design "houses" that are more "homey"—adding art, paint, and design. Right after being housed, many people express feelings of social isolation and find it difficult to connect to their new communities. The idea of this project is to make their houses more comfortable and integrated. Additionally, the Haven is working on a project called SSI/SSDI Outreach Access and Recovery (SOAR), which is intended to help homeless individuals apply for federal disability status. Trained SOAR workers are able to fast-track Social Security applications by filling them out more accurately on behalf of individuals and submitting them through expedited channels. The Haven suggested this could mean a person in need may receive government benefits in 1-2 months instead of half a year or more.

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[31] Coordinated Access Packet. Retrieved from http://tjach.org/wp-content/uploads/2015/07/Coordinated-Access-Packet-7-6-2015-with-VI-SPDATS-Releases.pdf

ORGANIZATIONAL STRUCTURE

The Haven operates out of a large rent-free church building in a central location in Charlottesville. As such, it is able to act as both a space for service provision as well as an administrative organization. Organizationally, the Haven differentiates employees between its Day Shelter services, Housing First programs, and administration. It employs a larger number of permanent administrative staff relative to other local organizations including an Executive Director and heads of areas including Development and Operations, Financial Management, Volunteer Coordination, and Event Coordination. In order to serve as the primary coordinator of Housing First programs, it also employs individuals dedicated to homeless prevention, housing stabilization, case management, and housing navigation amongst others.

Public and city grants fund most of the Haven's programs and services, while private funding from foundations and local families pay for the day shelter and for administrative and overhead costs such as keeping the lights on and paying salaries. The original benefactor actually owns the building, so luckily the Haven uses the facility rent-free. Currently, they have a $1.3 million budget that is split equally between all housing services. The Haven likes to think of the shelter as onboarding to housing programs.

ORGANIZATIONAL CAPACITY

The Haven currently has the capacity to serve any homeless individual that comes to the day shelter. Where resources lack, however, is in matching individuals with appropriate housing interventions. Most of their clients qualify for Permanent Supportive Housing but due to very limited space, they are forced to place them into Rapid Re-Housing. Because of the mismatch, the Haven must decide whether to place the most vulnerable individuals in whatever housing is available (Rapid Re-Housing), or to give the Rapid Re-Housing services to those that actually qualify for it and may be more successful.

OTHER RELEVANT ORGANIZATIONS

Finally, a wide variety of supportive services organizations exist to help individuals who have entered shelters or stable housing. Region Ten is the largest provider of mental health services, while the Shelter for Help in Emergency provides resources for victims of domestic violence. Additionally, smaller transitional housing programs exist, often dedicated to specific demographic needs. For instance, Hope House is a facility dedicated to helping families transition out of homelessness and gain skills necessary to live independently after they leave. More information about these and other relevant organizations can be found in the appendix.

5. CHALLENGES TO CARE

5.1 MISMATCH OF RESOURCES

One of the difficulties faced by local organizations is how to allocate financial and physical resources in order to best address the problem. Since Housing First requires that organizations provide care to the most vulnerable first, we discovered that programs are not always able to help the type of population and problems they were designed to address. A key example of this is the Haven's Rapid Re-Housing program. While national studies suggest these types of programs are highly successful for helping their intended beneficiaries, the Haven has had to use Rapid Re-Housing resources to help the chronically homeless due to a lack of Permanent Supportive Housing for these individuals. This implies that the success and failure rates of Rapid Re-Housing in Charlottesville are not reflective of the program's efficacy, since the program is not intended to address many of the needs of the people benefiting from them.

5.2 LACK OF PERMANENT SUPPORTIVE HOUSING

The primary reason for the aforementioned mismatch of Rapid Re-Housing resources is due to a large gap in Permanent Supportive Housing within the community. Once again, national studies suggest that the most vulnerable homeless populations, notably the chronically homeless and those with multiple associated issues, find the most success through programs that provide low-barrier, stable housing over long periods of time. While it's difficult to prove causality, an increase in PSH by 59 in Charlottesville since 2011 strongly correlates with a 50% decrease in chronic homelessness.[32] Unfortunately, current PSH programs at The Crossings and Region 10 cannot provide for the entire chronically homeless population. While anecdotal, the employee we spoke to at Virginia Supportive Housing suggested that Charlottesville would need approximately three buildings as large as The Crossings to truly meet the needs of the community.

	2011	2016
Individuals in Permanent Supportive Housing	46	105
Unhoused Chronically Homeless	60	30

[32] TJACH. (2016). [Charlottesville Point-in-Time Count].

Several challenges stand in the way of creating more Permanent Supportive Housing. Although studies show that PSH often results in lower long-term costs while compared to medical treatment and safety net services for the chronically homeless, the up front costs are large for a city this size. In our discussions with a local housing development specialist, we discovered that Charlottesville's landlocked nature dramatically limits the number of suitable locations for PSH facilities and greatly increases property costs. The Crossings alone cost $7 million to build[33], and the city must continue to subsidize individual rooms each year. While some communities such as Virginia Beach have fully embraced the concept of PSH and called for more, Charlottesville does not appear to have the immediate political will to develop more of these facilities.

5.3 INCOMPLETE DATA COLLECTION

As actors within the Charlottesville community attempt to address the issue of homelessness, challenges collecting data limits their ability to improve programs and track progress. Not unique to the local area, the transient nature of homelessness makes it extremely difficult to track homeless populations over time. It requires significant financial resources and dozens of volunteers simply to track down homeless people in a local area, and individuals easily slip through the cracks. Even if data collectors are able to locate and speak with the entire homeless population, self-reporting is often inaccurate, especially regarding highly personal information like one's history with mental health or domestic violence. Another limitation with the national standard of data collection is that Point-in-Time counts are typically only performed on an annual basis. Seasonal variations and transfers of individuals in and out of homelessness suggest any statistical results are imprecise and can only be used to track long-term trends.

Beyond general difficulties collecting data, Charlottesville faces a unique challenge in this area. Although TJACH has attempted to standardize and improve methods throughout the community, it informed our team that it has faced difficulties collaborating with the Salvation Army on this issue. One potential reason for this challenge is due to the time and cost of collecting data consistently throughout the year. PACEM suggested that it would have difficulty carrying out this task if they did not have a devoted volunteer from the University of Virginia assisting them. Since the Salvation Army does not see data collection as a pressing need, it is unlikely to devote scare resources and volunteer/worker hours to carry it out. However, as the largest and only year-round shelter in the community, this leaves a huge gap in Charlottesville's records. Without a greater buy in from the Salvation Army, the local Continuum of Care will continue to face difficulty tracking progress and update its programs to reflect the needs of the community.

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5.4 PHILOSOPHICAL DIFFERENCES

Although many local organizations have dedicated themselves to addressing homelessness and interrelated issues, not all of them are unified in how to accomplish this.

One area in which this conflict is evident is the difference between Housing First and substance abuse care. As discussed many times in this report, Housing First attempts to provide stable housing and supportive services as quickly as possible in order to keep an individual from facing the full consequences of homelessness. However, many care providers addressing substance abuse require total commitment from participants, something that usually only occurs after an individual reaches "rock bottom." While not completely contradictory, this creates a set of conflicting goals where proponents of Housing First are actively working to prevent the event that is often required to change habits related to addictive substances. However, this is something that homeless care providers are aware of in Charlottesville, and TJACH has begun considering ways to better collaborate with substance abuse care providers in order to unify strategies and goals.

Our team also believes it is important to acknowledge the philosophical difference that exists between local Housing First organizations and the Salvation Army's approach to addressing homelessness. Although every organization is attempting to do its best work for the population it serves, this division limits collaboration, fundraising efforts, and the efficacy of the Charlottesville Continuum of Care to work in the most efficient way possible.

6. LOOKING FORWARD

The Charlottesville community faces unique challenges moving forward as it continues to address the issue of homelessness. The local Continuum of Care has made great strides in recent years to enhance the state of care for the most vulnerable individuals in our city, but more work remains to be done. While some nonprofit communities across the nation lack solid implementation strategies or evidenced based programing, our team believes that the majority of organizations in Charlottesville have been successful in coordinating efforts to end homelessness and updating systems to reflect proven best practices. As such, the biggest gap we see in this community is simply a lack of resources.

Unlike many other contemporary social problems faced by our society, long-term homelessness is neither inevitable nor unsolvable. Housing First strategies have the potential to eliminate the most devastating forms of homelessness in the near future, and the first step in this process is eliminating chronic homelessness locally. While shelters have done their best to support the most urgent needs of this population, the issue will never truly be addressed unless the Charlottesville community is able to provide the financial resources and political will to install new Permanent Supportive Housing facilities. Not only would this provide a stable and safe home for the ~30 chronically homeless individuals that remain unhoused, new PSH facilities would also go a long way towards addressing the issue of mismatched resources. Without as many highly vulnerable individuals to care for, Rapid Re-Housing funds could be allocated back to their intended population—increasing success rates for beneficiaries and providing useful data on the efficacy of housing programs Charlottesville currently has in place.

Until the gap of Permanent Supportive Housing is filled, our team also sees the potential for increased collaboration between the Salvation Army and Housing First organizations. In our interviews, representatives from both TJACH and the Salvation Army expressed a strong desire to increase communication and partnership with the other. Unfortunately, well-intentioned philosophical differences in the way to approach the issue of homelessness appear to be limiting the extent of this relationship. While not every program each organization operates will be compatible with the other's approach, similar goals exist between them and should be pursued more strongly for the benefit of the people being served. One area in which we see room for collaboration is the collection of better data. Although the SA views data collection as less critical to its mission than TJACH, our interview revealed it was open to the concept of an intern performing these tasks and had the infrastructure to take one on. If TJACH and the Salvation Army could partner to bring in a student intern or volunteer from the University, we would see the dual benefit of enhancing our understanding of the state of homelessness locally while increasing communication between these two critical organizations.

While our team has come to respect how complex and deep the issue of homelessness is over the course of our research this semester, we are optimistic that through collaboration and more resources, Charlottesville will be able to eliminate it.

7. APPENDIX

7.1. TJACH POINT-IN-TIME COUNT PRELIMINARY DATA (2016)

	Emergency Shelter						Transitional Housing *				Permanent Housing						Unsheltered
	PACEM	SA	SHE	CA	MC	Total	MACAA	SA	SHE	Total	R10 DRC	R10 S+C	PP	VSH	RRH	Total	Unsheltered
2016	42	51	7	1	0	*101*	9/3	22/8	2/1	*33*	32			35	38	*105*	*22*
2015	48	50	15	0	0	*113*	10/4	27/9	10/3	*47*	13	19	8	29	37	*106*	*25*
2014	54	57	11	1	5	*128*	11/4	28/9	11/3	*50*	10	20	13	28	23	*74*	*26*
2013	55	57	10	1	5	*128*	10/4	32/9	8/3	*50*	9	25	2	29	0	*45*	*28*
2012	54	58	7	1	5	*125*	11/3	18/7	5/3	*34*	9	18	11	0	0	*38*	*27*
2011	57	54	18	1	5	*135*	12/4	18/9	7/3	*37*	8	19	19	0	0	*46*	*18*

7.2 KEY TERMS

HOMELESSNESS, EDUCATION DEPARTMENT DEFINITION

The Department of Education defines homeless children and youth as individuals who lack a fixed, regular, and adequate nighttime residence. This includes youth who are sharing the housing of another person due to loss of housing or economic hardship; living in emergency or transitional shelters and institutions; living in motels, hotels, trailer parks or camping grounds; or awaiting foster care placement. This definition also includes children and youth with a primary nighttime residence that is a public or private place not designed for regular sleeping accommodation for human beings.

CHRONIC HOMELESSNESS

The Federal government defines a chronically homeless individual as someone who has either experienced homelessness for a year or longer, or has experienced homelessness at least four times in the past three years, and has a disabling condition (i.e. mental illness, physical disability).

HOUSING FIRST

Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then providing services as needed. Its primary goal is to get people into stable housing situations as quickly as possible to avoid the problems homelessness causes or exacerbates directly, treating associated issues after stability is achieved. It is characterized by low-barrier treatments, prioritizing the most vulnerable first, and objective data-driven programs.

HIGH/LOW BARRIER

A high barrier program is one that places restrictions on an individual before they may receive benefits. For instance, employment requirements for transitional housing and sobriety requirements for some shelters would be considered high-barrier. A low barrier approach generally removes obstacles to receiving treatment, with exceptions if an individual is placing others in danger.

CONTINUUM OF CARE

Codified into law by the HEARTH Act in 2009, the Continuum of Care is a grant program that streamlines the HUD funding application process for organizations targeting homelessness. The program aims to promote community-wide planning and strategic use of resources to address homelessness; improve coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness; improve data collection and performance measurement; and allow each community to tailor its program to the particular strengths and challenges within that community.

PERMANENT SUPPORTIVE HOUSING

Permanent Supportive Housing attempts to provide a stable and cost-effective living situation for the chronically homeless and those facing multiple problems that prevent them from living independently. The primary goal of these facilities is not to transition people from homeless to independent living, but rather to prevent them from the negative personal, psychological, and financial impacts of living on the streets for extended periods.

RAPID RE-HOUSING

Following the Housing First approach, Rapid Re-Housing programs are designed to help individuals and families who recently became homeless due to short-term economic problems get back into stable housing as quickly as possible. The three pillars of the program are *housing identification* (finding appropriate housing options and negotiating with landlords), *rent and move-in assistance* (providing financial assistance to cover upfront costs and the first few months of rent), and *Case Management/Supportive Services* (a wide variety of optional services to help individuals get back on track). Increasingly, Rapid Re-Housing is being used to help individuals with more severe issues than merely short term financial problems, often due to difficulty securing Permanent Supportive Housing.

TRANSITIONAL HOUSING

The provision of temporary housing to homeless individuals in addition to the provision of supportive services, typically ranging in length between six months and two years. The ultimate goal of transitional housing is to help individuals move from homelessness back into independent living. Since transitional housing does not necessarily fit into the Housing First approach, federal funding for these programs has been greatly reduced in recent years.

FUNCTIONAL ZERO

At any point in time, the number of people experiencing sheltered and unsheltered homelessness in a community will be no greater than a community's average monthly housing placement rate for people experiencing homelessness.

HUD

The United States Department of Housing and Urban Development - A Cabinet Department intended to develop and execute policies on housing and metropolises. HUD is ultimately responsible for overseeing and funding many of the most important programs designed to promote affordable housing and reduce homelessness.

UNITED STATES INTERAGENCY COUNCIL ON HOMELESSNESS

The Interagency Council on Homelessness, authorized by the McKinney-Vento Act coordinates and catalyzes the federal response to homelessness. The Council is comprised of heads of 19 federal agencies and meets four times a year to ensure that each agency's goals and strategies are aligned to most effectively combat homelessness. As mandated by the HEARTH Act, the Council is charged with creating a national strategy to end homelessness and update it annually.

7.3 ADDITIONAL HOUSING FIRST EVIDENCE

In making this choice, we chose to look at statistics from other communities that have adapted a Housing First approach in order to end homelessness. On a base level, chronically homeless individuals spend many of their nights in homeless shelters, jails, and hospitals costing about $30,000-$50,000 per year to the Government (Interagency Council on Homelessness). This figure is concerning to many taxpayers, thus the need for a cheaper approach became important.

In examining other cities and its statistics, we found that New York City, home to one of the largest homeless populations in the United States saw that "of 4,679 New York City homeless with severe mental illness found that each cost an average of $40,449 a year in emergency room, shelter, and

other expenses to the system, and that getting those individuals in supportive housing saved an average of $16,282." (http://shnny.org/uploads/The_Culhane_Report.pdf).
In conjunction, Denver, CO found that: "Emergency-service costs alone went down 73 percent for people put in Housing First, for a savings of $31,545 per person." (http://denversroadhome.org/files/FinalDHFCCostStudy_1.pdf) Success of Housing First is also evident in communities outside of New York City and Denver. Cities such as Seattle, WA Portland, ME, and many others found a link between decreased government spending and an increase in Permanent Supportive Housing.

On a national level, the Housing First approach has also proven itself to be a strong model for implementation. The US Department of Veteran Affairs tested the model in 2010 by providing 14 VA medical centers with 50-75 additional HUD-VASH vouchers each and enhanced funding for more intensive case management services. The pilot involved approximately 700 Veterans experiencing homelessness at 14 VAMCs - 91% of whom were single males, of which 48% were divorced or separated; 50% were Black and 50% were White; over two-thirds were between the ages of 45 and 64 years. Also, about 94% of Veterans who were admitted to the program met criteria for chronic homelessness and 78% had an active or prior diagnosis of a mental health or addiction condition.

Of the 700 homeless Veterans admitted to HUD-VASH utilizing a Housing First approach, 84% (585) are still living in permanent housing. Among the 115 Veterans who have left the program, 37% (43) moved on to more independent living; 20% (23) discharged to a hospital, nursing home, or prison; 30% (34) relapsed into homeless or were lost to care; and 13% (15) died, mostly from natural causes.

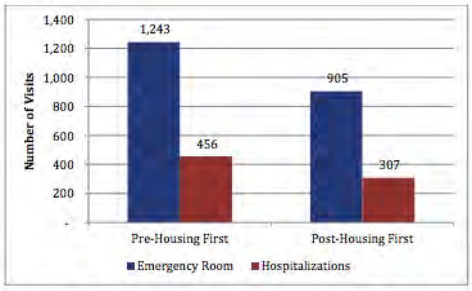

Figure 3. Total Emergency Room Visits and Hospitalizations During the 12 Months Prior to and Following Admission to Housing First

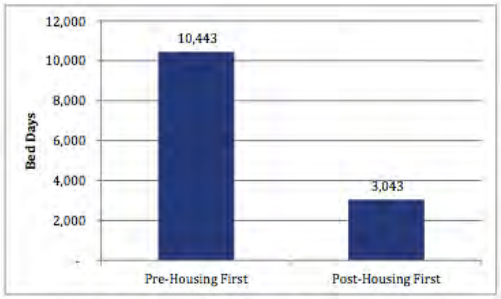

Figure 2. Total Bed Days During the 12 Months Prior to and Following Admmission to Housing First

For the 622 Veterans for whom there was complete data, the number of emergency room visits decreased by 27% (1,243 to 905) and acute inpatient hospitalizations decreased by 33% (456 to 307). Remarkably, the average length of stay for a hospitalization decreased from 17 days to 5 days and the total number of hospital bed days declined by 71% (10,443 to 3,043). See Figure 2.

Overall, between 2010 and 2013, the number of Veterans experiencing homelessness on a single night in January decreased by 24% (76,329 to 57,849). Clearly, Housing First is both a clinically effective and fiscally efficient model that can be implemented successfully in VA Homeless Programs and elsewhere. This approach successfully reduced rates of homelessness and associated healthcare utilization, particularly emergency care and inpatient hospitalizations. Further evidence of this program's success is that this reduction happened during one of the worst recessions in history, an affordable housing crisis, and approximately 46.5 million people living in poverty. (http://www.va.gov/homeless/nchav/docs/Housing%20First%20Implementation%20brief.pdf)

7.4 ADDITIONAL INTERRELATED ISSUES

VETERAN ISSUES

In 2015, 47,725 veterans experienced homelessness on a single night, a 4% decline compared to 2014 and a 35% decline from 2014. Veterans are more likely than civilians to experience homelessness because they find it difficult to re-acclimate to civilian life, many suffer from PTSD, and many lack skills relevant to employment outside the military. As of November 2015, Virginia became the first state to reach a functional zero of veteran homelessness, accomplishing the goal set forth in the Opening Doors plan.

LGBT ISSUES

Homeless LGBT individuals face a unique set of challenges including discrimination, social stigma, and rejection by family members that can both catalyze homelessness and make homelessness more mentally challenging. They are often at a greater risk of becoming victims of violence and abuse. Additionally, homeless LGBT individuals have a difficult time finding shelters and service providers that will accept and respect them and presently, there are no programs specifically targeted at the LGBT homeless population nor protections in place to prevent discrimination. This a serious concern because 40% of homeless youth served by agencies identify as LGBT (figures increase to 43% for those serviced by street outreach programs).

INCARCERATION

According to the National Alliance for Homelessness, 1 in 5 people who leave prison will become homeless soon thereafter, and there are virtually no systems in place to help ex-offenders get back on their feet. Ex-offenders usually have limited funds and few remaining relationships upon leaving prison. Additionally, because of their criminal history, individuals leaving the prison system often do not have access to housing channels that assist other low-income individuals. Re-entry often then becomes the most viable option because prison offers food and shelter.

FOSTER CARE ISSUES

Nationally, roughly 25,000-30,000 foster youth age out of the foster care system each year. It is estimated that anywhere from 11%-36% of these youth become homeless during the transition to adulthood, while only 4% of a nationally representative sample of youth ages 18-26 reported ever being homeless. Aging out into homelessness puts these already vulnerable youths at risk of developing mental illnesses, becoming dependent on drugs and alcohol, and falling victim to sexual abuse.

POVERTY AND LACK OF AFFORDABLE HOUSING

One of the key issues contributing to Charlottesville's rate of homelessness is the high cost of living in the region. According to recent census data, the median cost of owner occupied housing in Charlottesville between 2010 - 2014 is $283,100 while compared to the national median of $175,700. Furthermore, in Charlottesville, the median gross rent is $920 per month as compared to a median rate of $1,015 nationally. The high cost of housing impacts homelessness on two levels. First, individuals living in poverty who experience a financial crisis such as a job loss or broken car may easily slip into homelessness if they are unable to come up with the necessary money to pay rent. However, limited statistical evidence exists locally to truly show how large an impact this has. Secondly, high land costs increase the upfront costs of building supportive housing complexes, and increase the cost of providing Rapid Re-Housing options to homeless individuals.

7.5 ADDITIONAL RELEVANT ORGANIZATIONS

REGION TEN

Region Ten is a statewide provider of mental health services. The local branch in Charlottesville specifically focuses on addressing the mental health needs of the homeless population through its Shelter + Care Program and its Dual Recovery Center. Specifically, the Dual Recovery Center provides Permanent Supportive Housing for individuals struggling with both mental health and substance abuse problems through the use of psychiatry, case management, mental health skill building, psychosocial rehabilitation programs, and outpatient therapy.

FAMILIES IN CRISIS

Albemarle County Public Schools' Families in Crisis Program is a federally funded grant authorized by the McKinney-Vento Homeless Education Assistance Act through Project Hope. The program is meant to ensure access to stable educational opportunities for children and youth who are homeless or live in inadequate housing. In addition, they may provide emergency services,

referrals for health services, transportation, school supplies, and assistance in obtaining school records.

MENTAL HEALTH AMERICA

Mental Health of America (MHA) works to assist agency clients who are facing challenging life circumstances such as homelessness to access mental health services, community based care, and resources that promote wellness and recovery. MHA connects clients with other mental health focused community organizations right now, but they are looking to expand their scope in the coming years to include more direct services.

SHELTER FOR HELP IN EMERGENCY

The Shelter for Help in Emergency works to support and empower victims of domestic violence through a combination of residential, community-based and outreach services. In addition to providing case management, counseling, and legal advocacy to homeless individuals who have been victimized by domestic violence, the organization also provides a key preventative service through its emergency shelter. Nationally, women often report having to choose between becoming homeless or staying in housing with an abusive partner, but the emergency shelter provides a stable living space for women and children for up to six weeks.

DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services is an agency of city government, which administers federal, state, and local public assistance and social work service programs. The wide extent of the DSS's services make it a key partner for referring individuals into the TJACH Continuum of Care.

CITY OF CHARLOTTESVILLE NEIGHBORHOOD DEVELOPMENT SERVICES / HOUSING AUTHORITY

The Charlottesville Housing Authority works in collaboration with housing specialists to ensure the availability of affordable housing options for low-income and at-risk individuals. The city specifically requires new housing developers to either create new affordable dwelling units or pay into a housing fund that provides resources to affordable housing and refurbishment projects.

ALBEMARLE COUNTY OFFICE OF HOUSING

The Albemarle County Office of Housing seeks to assist people with securing rental housing and paying rental subsidy. The Housing Department also assists people in purchasing homes and can help people set goals to become economically self-sufficient.

CHARLOTTESVILLE CITY COUNCIL

City Council works in collaboration with local nonprofits to ensure that necessary resources are being directed towards homelessness organizations. Members of City Council serve on the board of TJACH to help integrate public and private services targeting the issue.

CHARLOTTESVILLE AND ALBEMARLE POLICE DEPARTMENTS

In conjunction with the daily duties of the police departments, the departments have a Crisis Intervention Team, which works to improve police interactions with those experiencing acute episodes of mental illness. The Crisis Intervention Team is trained and educated on how to handle people in crisis while recognizing the signs and symptoms of those with a mental illness.