Breaking the Cycle:

Delaware's Ten-Year Plan to End Chronic Homelessness And Reduce Long-Term Homelessness

Prepared by the Delaware Interagency Council on Homelessness
February 2007

Governor Ruth Ann Minner
The Tatnall Building
Dover, DE 19901

Dear Governor Minner:

The Delaware Interagency Council on Homelessness (DICH) is pleased to provide Delaware's Ten-Year Plan to End Chronic Homelessness and Reduce Long-Term Homelessness. We thank you for this opportunity to work together to develop this important Plan and wish to express our gratitude to those who helped create it. We would also like to thank those people who have been homeless, who took time to talk to us about their experiences.

If fully implemented, this plan would end chronic homelessness in Delaware. People who are chronically homeless are those individuals who have a disabling condition and find themselves without a home, either frequently or for long periods of time.

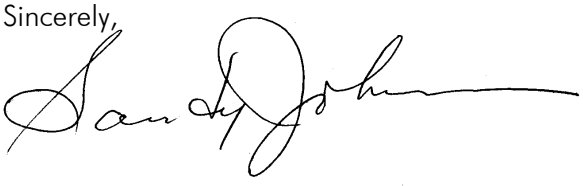
Delaware already has much of the infrastructure needed to address this issue. The Homeless Planning Council of Delaware (HPC) has successfully accessed over $20,000,000 in federal funds over the last five years to develop and operate supportive housing. Additionally, the HPC administers the Delaware Homeless Management Information System, which collects extensive data on the extent and nature of homelessness in Delaware. We know that many of the people who have the most serious mental health and/or substance abuse problems already have treatment teams in place that have been proven effective when paired with affordable housing both here in Delaware and across the country.

Through its work, the DICH has identified five major strategies to end chronic homelessness in Delaware:

1. Develop New Housing for Persons Who Are Chronically Homeless or At-Risk for Chronic Homelessness
2. Remove Barriers to Accessing Existing Affordable Housing
3. Improve Discharge and Transition Planning
4. Improve Supportive Services for Persons who are Homeless
5. Enhance Data Collection and the Use of Technology

Finding the resources to implement this Plan will be challenging; however, implementation of similar measures in other areas has proven that reductions in the use of high cost services almost totally offset the increased investment in housing. We greatly appreciate the opportunity to provide this information and hope that you will agree that chronic homelessness is a problem that we simply cannot afford to ignore.

Sincerely,



Saundra Ross Johnson
Chair

Sincerely,

Catherine Devaney McKay
Co-Chair

Preface

In March 2005, Governor Ruth Ann Minner appointed the Delaware Interagency Council on the Homelessness (DICH) to adopt and oversee the implementation of a plan to reduce homelessness and end chronic homelessness in Delaware within ten years.

Delaware's Ten-Year Plan to End Chronic Homelessness and Reduce Long-Term Homelessness (Delaware's Ten-Year Plan), written to address the charge set out by the Governor, addresses the needs of persons who meet the federal definition of chronic homelessness: unaccompanied persons who have been homeless for twelve consecutive months, or four times over the last three years, and who have a diagnosable mental health or substance use condition, developmental, physical or other disability. It also addresses those persons who are at risk for chronic homelessness because they meet the criteria for diagnosis with a qualifying condition and have experienced homelessness or are precariously housed. Although persons who meet the criteria or are at risk for chronic homelessness represent approximately 50% of homeless persons in Delaware, there are clearly homeless persons that this Plan does not address.

Delaware's Ten-Year Plan focuses on the needs of unaccompanied homeless persons who have disabling conditions that have caused or put them at risk for chronic homelessness; the Plan does not address the needs of homeless children, families with children in their custody, or homeless adults who do not have a qualifying condition. Recommendations made in this Plan are intended to be additive to what currently exists in Delaware to serve homeless people. The Plan recommends that additional funds and strategies be implemented to augment the existing floor of services that provide critical resources for all homeless persons in Delaware.

This Plan is the first installment of the DICH's work. The DICH will continue to develop a similar Plan to address homelessness among families, children, and adults who do not have disabling conditions. In order to ensure the ongoing implementation and monitoring of Delaware's Ten-Year Plan and any subsequent Plans that are developed, the DICH will research appropriate mechanisms to ensure the continuity and full implementation of this and future plans to end homelessness in Delaware for all people.

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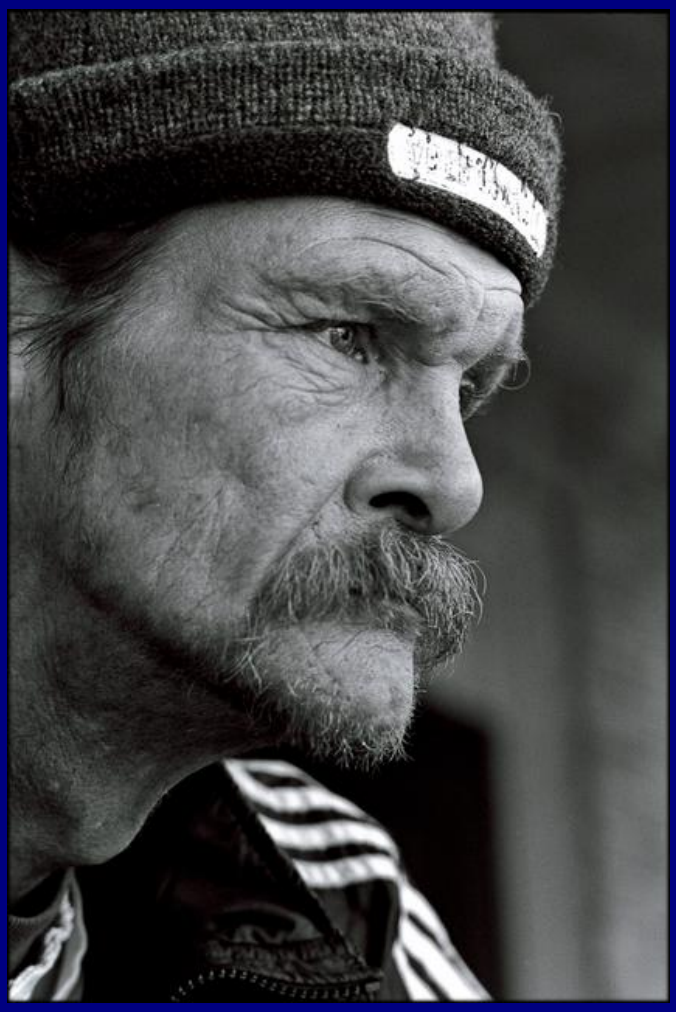


Introduction

Introduction

The United States Congress established the U.S. Interagency Council on Homelessness (USICH) in 1987, to bring together cabinet departments at the federal level to pool resources and ideas about ways to address the issues of homelessness that had emerged during that decade. In 2001, The DICH was reinvigorated, and charged with working with states and housing jurisdictions throughout the country to end a new problem – chronic homelessness – within ten years. Research had identified that while persons who meet the definitions of chronic homelessness make up only 10% of homeless people nationwide, they consume more than 50% of the resources allocated to providing homeless services. The business case for developing a solution to this problem was clear: not only is chronic homelessness unacceptable in terms of the human cost, it is also economically costly.

In response to the USICH recommendation that each state develop a plan to End Chronic Homelessness in ten years, Delaware assembled a team to participate in the 6th Policy Academy on Homelessness held December 9-11, 2003 in Miami, Florida. The Policy Academy team consisted of representatives of state and local government and members of the Homeless Planning Council of Delaware (HPC), a private, nonprofit corporation that was established in 1997 as the planning and coordinating entity for Delaware's statewide Continuum of Care (CoC) for the Homeless.

In March 2005, Delaware Governor Ruth Ann Minner appointed the DICH by Executive Order 65. The DICH consists of a wide array of stakeholders including housing providers, service providers, state and local representatives, funders, and representatives of the HPC. Governor Minner charged the DICH with the following:

- To adopt and oversee the implementation of a plan to end chronic homelessness and reduce long-term homelessness in Delaware;
- To review data, activities and programs in the State of Delaware that provide housing services to the homeless;
- To use the Delaware Homeless Management Information System (DE-HMIS) and other non-duplicative methods of collecting information for analysis;
- To identify impediments, including any statutory and regulatory restrictions, to the effective provision of needed services to homeless persons in Delaware;
- To recommend such changes in existing programs and services, expansion of existing programs and additional programs and services as may be necessary to address diverse causes and conditions of homelessness; and,
- To ensure positive results and accountability of existing and new efforts and programs by shifting from funding programs to investing in solutions.

The DICH was constructed to ensure that cabinet-level members of state government, local government officials, providers of a wide range of services impacted by homelessness, and the HPC, would come together in an official forum to provide the vision and leadership needed to reduce homelessness and end chronic homelessness in Delaware.

The 15 members of The DICH include:

- The Director of the Delaware State Housing Authority;
- The Secretary of the Department of Health and Social Services;
- The Secretary of the Department of Services for Children, Youth, and Their Families;
- The Secretary of the Department of Labor;
- The Secretary of the Department of Education;
- The Commissioner of the Department of Corrections;
- The Chairs of the Senate Community/County Affairs Committee and the House of Representatives Housing and Community Affairs Committee;
- The Mayor of the City of Wilmington or the Mayor's designee;
- The County Executive of New Castle County or the Executive's designee;
- The Mayor of the City of Dover or the Mayor's designee;
- A person who is homeless or formerly homeless;
- Three representatives from emergency housing and/or service providers, at least one of whom will represent the HPC; and,
- A representative of the Delaware Apartment Association.

The DICH is Chaired by Saundra Ross Johnson, Director of the Delaware State Housing Authority (DSHA) and Co-Chaired by Catherine Devaney McKay, Director of Connections CSP, Inc. and also the representative of the HPC.

In addition to its appointed members, the DICH also benefits from participation of a number of agencies and organizations that comprise the Working Group. The representatives of these agencies and organizations provide valuable input to the DICH in its goal to end chronic homelessness and reduce long-term homelessness in Delaware.

The DICH approached the development of Delaware's Ten-Year Plan by dividing the work among three primary committees: Data Collection, Recommendations, and Implementation. These committees worked sequentially to articulate the extent of homelessness and chronic homelessness in Delaware, to identify subpopulations at high risk to become homeless, to make recommendations for systems change in a variety of domains and to identify funding strategies for implementation. An Implementation Committee, with representatives from each of the other committees, prioritized and identified financing sources for the objectives and strategies identified by the Recommendations Committee.

Delaware's Ten-Year Plan may appear expensive with recommendations for creating supportive housing options for over 2,000 people. Best estimates put the costs at more than $42,000,000 for capital costs and over $22,000,000 in reoccurring annual costs, at 2006 prices. However, formal and informal studies done throughout the United States have demonstrated that investments in supportive housing for certain populations are offset by reductions of costs in other systems. It would be expected that Delaware would have similar results, as people who are chronically homeless tend also to be high users of the criminal justice system, the inpatient mental health and emergency health care services. Use of these systems has been reduced drastically in other areas with the provision of supportive housing.

The most frequently cited study demonstrating the cost effectiveness of providing supportive housing is the study published by the Fannie Mae Foundation in 2002, *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing,* by Dennis P. Culhane, Stephen Metraux and Trevor Hadley. In this study cost data from 4,579 people placed in supportive housing in New York City was examined. The study found that prior to placement in supportive housing study subjects had used over $40,000 a year in services in a variety of public sector systems – prisons, psychiatric hospitals, emergency rooms, emergency shelters. In this study it was documented that savings covered 95% of the cost of providing supportive housing in other systems for which costs could be easily gathered.

In other less formal studies similar results have been found. For example the University of California/San Diego Medical Center tracked just 15 chronic alcohol abusers beginning in 1998 and found that the tax bill for services for these people was over $3 million annually. They estimate there to be 180-250 such people living on the streets of San Diego. A Serial Inebriate Program was implemented to address the approximately 250 people who met the study criteria. The program includes supportive housing as an alternative to jail. Sixty three percent of the target group accepted treatment in the first two years and approximately 50% completed the program and moved on to healthier lives.

The task of ending chronic homelessness in Delaware is not impossible, although it will not be easy. Through cooperation and collaboration between the governmental, community, non-profit and business sectors, Delaware can end chronic homelessness in less than ten years. Delaware's Ten-Year Plan combines permanent supportive housing, outreach and engagement-oriented supportive services, improved discharge and transition planning, and other evidence-based practices to alleviate homelessness among the populations most likely to fall into chronic homelessness – persons with mental health and/or substance use conditions, offenders leaving the prisons and young adults leaving the foster care system – to create an efficient and cost-effective service delivery system that addresses chronic homelessness now and prevents it in the future.

Homelessness In Delaware

Homelessness in Delaware

Delaware is a small state, ranked 49th in size with a total area of 1,982 square miles. During the 2000 census, the population was 783,600, 45th among the states. The population density is 401 persons per square mile, but this is deceiving. Although New Castle County has only 22% of the landmass, it has 63% of the population. Kent County with 30% of the landmass has 17% of the population. Sussex County, with 48% of the landmass and 20% of the population, is less densely populated than the other two, but is growing at a faster rate.

Delaware's counties are different in terms of their demographics and economics. New Castle County is an urban location, approximately 30 miles south of Philadelphia with a population that is 73% White, 20% African American and 5% Hispanic. The City of Wilmington is Delaware's largest city and is located in New Castle County. Wilmington's population of approximately 72,000 people is made up primarily of persons who identify themselves as Black or African American (56%) and has a growing Hispanic and Latino population (10%). Wilmington is home to several major employers in the chemical, pharmaceutical, and financial services industries, with a large number of suburban and incorporated "bedroom" communities making up its total metropolitan area. The total population of New Castle County (including the City of Wilmington) is 523,000, or more than 60% of the total population of the state. By contrast, Kent and Sussex Counties are largely agricultural, except for the City of Dover, the capital of Delaware and home to a large Air Force base. The population of Kent County is 74% White, 21% African American and 3% Hispanic. Sussex County is less diverse economically and racially than the other two counties. Its economy consists primarily of agricultural and service industry jobs related to its coastal areas. Only 15% of the population of Sussex County is African American, 80% White and 4% is Hispanic. In all three counties, the Hispanic population is a mixture of persons of Mexican, Puerto Rican, Dominican and Central American heritage, and is the fastest growing subpopulation in the state. There are migrant farm workers of Hispanic origin in all three counties. The Hispanic population in Delaware may be undercounted because many of its members are undocumented immigrants, and cultural values and norms may prevent them from identifying themselves as being homeless or having a mental health condition.

Despite its small size, Delaware has social problems more characteristic of larger metropolitan areas. On three nights in 2005 and 2006, the HPC counted more than 4,500 homeless persons, most of them in New Castle County. More than 50% of the homeless persons counted self-reported a substance use and/or mental health condition. Despite its relative affluence – the median income in Delaware is in the top ten of all states – Delaware has the highest rate of infant mortality and consistently ranks in the top ten states for HIV infection, with a rate 58% higher than the national average. Almost 50% of persons diagnosed with HIV/AIDS in Delaware indicate that they contracted the disease through intravenous drug use or sexual contact with an intravenous drug user. The rate of poverty in Delaware is approaching 10%, and there is a significant problem with housing affordability.

According to the National Low Income Housing Coalition Report *Out of Reach 2005*, the cost of a one-bedroom unit in Delaware is more than 200% of minimum wage. The Delaware Social Security Income (SSI) amount of $603 – an income level typical for adults who are homeless in

Delaware – is clearly not adequate to allow a person with a disability to lease a one-bedroom unit at the average Fair Market Rent of $730. New approaches to affordable housing are needed if Delaware is to end homelessness once and for all.

Our Goal

Delaware's Ten-Year Plan is not just about creating housing units – although more than 2,000 beds will be needed. It also calls for implementing a range of prevention and service-delivery strategies that have a basis in evidence and have been demonstrated to be effective. It requires a willingness to examine the assumptions under which we have approached issues in the past, to assess honestly and critically our activities and initiatives, and ultimately, to do business differently through changing systems, redirecting existing resources and securing commitments for additional funding. The significant focus of this Plan is on investing our precious local resources in a manner that better serves homeless people and, in so doing, eliminates chronic and reduces long-term homelessness in Delaware.

The DICH will seek support and endorsement of the Plan from key stakeholders throughout the state, including civic and faith groups, communities of color and their institutions and organizations, businesses, small business owners, housing and service providers, homeless persons and their advocates, and elected and appointed officials.

Through endorsing Delaware's Ten-Year Plan, communities throughout the state are joining forces to end homelessness. It is a housing and human services undertaking of unprecedented proportions, one that may require a decade to complete. We can – and we will – end chronic homelessness in Delaware by 2017. By 2017 the Delaware homeless service system will:

- Develop and maintain an adequate level of permanent supportive housing options for persons experiencing homelessness, especially the chronically homeless;
- Establish discharge and transition policies for persons exiting from prisons, hospitals, foster care an other public institutions that provide the client a comprehensive, long-term plan for sustained care without falling into homelessness;
- Have a coordinated and adequately funded supportive service system that affords homeless citizens centralized access to care, employment and transportation;
- Create a voice for Delaware's homeless citizens through advocacy, education and public awareness;
- Use data and research on Delaware's homeless to identify needs and to inform policy and funding decisions; and,
- Have a system of evaluation that ensures resources are targeted at effective, needed programs.

Data and Methodology

Data and Methodology

Accurately determining the number of persons who are homeless can be difficult. Often persons are hidden from traditional methods of counting the homeless. To this end, the DICH used quantitative and qualitative data in the creation of Delaware's Ten-Year Plan.

Data Committee

The Data Committee was comprised of six members. These members represented the HPC, DSHA, the City of Wilmington, Delaware Department of Education (DOE), Home of the Brave Foundation, Inc., and Connections CSP, Inc. The Committee's charge was to, *"gather, analyze and put forward data on homelessness to the Delaware Interagency Council on Homelessness."* To this end, the Data Committee researched current data trends, designed and implemented focus groups and researched evidence-based practices and studies.

The primary data sources utilized were the HPC's Point-in-Time (PIT) Study conducted on January 26, 2006, supplemented by information obtained in the January and August 2005 counts, and data collected through the DE-HMIS. Additional data sources included the City of Wilmington Consolidated Plan, U.S. Bureau of Census data, and information from focus groups of providers and homeless persons that were conducted in all three Delaware counties. Additionally, the Committee considered input from key informants, including thirteen providers of emergency, transitional, and permanent supportive housing statewide; the Projects for Assistance in Transition from Homelessness (PATH) providers who conduct homeless outreach and services linkage for persons with mental health and substance use conditions; and all of the providers funded through the U.S. Department of Housing and Urban Development (HUD) Supportive Housing Program (SHP) in Delaware. Finally, extensive research of evidence-based practices and studies were reviewed to see how Delaware compared and to develop methodologies for projecting homeless persons.

Point-in-Time Methodology

Twice a year (January and August) the HPC conducts PIT surveys. These surveys are a snapshot of homelessness across the state on that particular night. These counts provide insight into the number of homeless persons in Delaware, their demographic characteristics, geographic distribution and subpopulation groups.

Sheltered Survey:

- Two weeks prior to the survey date of January 26, 2006 the sheltered surveys were distributed via United States mail to emergency shelters, transitional housing programs, permanent supportive housing facilities, halfway houses and domestic violence shelters across the state.
- Three to five days prior to January 26, 2006, contact was made to each participating agency as a reminder, definitions/methods were reviewed and follow-up times for data collection were established.

- Data collection calls took place between January 27, 2006 and January 31, 2006.
- 75 programs submitted data.

Unsheltered Survey

- On January 11 and 12, 2006, trainings were held for the unsheltered count participants in each county to assign survey locations, review survey forms and answer questions.
- The following agencies participated in the unsheltered survey count: Casa San Francisco, Ministry of Caring, Connections CSP, Inc., Psychotherapeutic Services, Brandywine Counseling, Veterans' Administration, The Salvation Army and the HPC.
- Interviews were conducted between January 27, 2006 and January 31, 2006.

Delaware Homeless Management Information System (DE-HMIS)

Information about the characteristics of homeless persons in Delaware was derived from the DE-HMIS, a web-based data bank that is currently used by 18 homeless service programs across the state. DE-HMIS allows agencies to centralize and computerize their intake, reporting, case management and service transaction information. The data is centralized on a state level, allowing the HPC to aggregate statistics.

Focus Groups

Focus groups of consumers and front-line staff were conducted in each county on the following dates:

Sussex County: March 29, 2006
Kent County: April 2, 2006
New Castle County: April 9, 2006
New Castle County: May 9, 2006

The purposes of the focus groups were to attain qualitative experiences, opinions and suggestions of those experiencing or working on the front lines of homelessness. The focus groups lasted two hours and were transcribed via audiocassette. According to these focus groups, the following were identified as the main gaps in the Delaware homeless delivery system:

- Services for persons with mental health conditions;
- Lack of Transportation;
- Programs to serve those with substance use problems;
- Affordable Housing;
- Coordination among state agencies (discharge planning);
- Central Point of Contact;
- Transitional Points i.e. between detox and rehab; and,
- Permanent Housing;

Other Data Sources

Other data sources used to further analyze the historical and current needs of homeless citizens in Delaware were:

- *Delaware Analysis of Impediments to Fair Housing Choice, Peuquet and Ware, 2003;*
- The Delaware Psychiatric Center (DPC) Discharge Readiness Data;
- Department of Services for Children, Youth and their Families (DSCYF) foster care discharge projections;
- Survey of providers of services to persons in the CoC Program for persons with severe and persistent mental illness funded by the Delaware Division of Substance Abuse and Mental Health (DSAMH);
- DE-HMIS data; and,
- U.S. Bureau of Census data.

Point-in-Time Data

According to the PIT Study there were 1,834 homeless persons in Delaware on January 26, 2006. The geographic distribution was as follows:

	New Castle County	Kent County	Sussex County	Statewide
Sheltered	756	151	176	1,083
Unsheltered	149	28	36	213
Hotel/Motel	75	45	18	138
Doubled Up	137	18	24	179
Drop-In	221	n/a	n/a	221
Total	1,338	242	254	1,834

Of the 1,834 persons

- 70% were individuals and 30% were persons in families.
- 32% reported having no income, 24% had a monthly household income between $1 - $500, 29% between $501 - $1,000 and 11% over $1,000.
- 60% were African-American, 32% were white and 4% multiracial.
- 51% were between the ages of 31- 49, 17% were between the ages of 18 – 30, 21% between the ages of 51- 64.

The typical homeless person in Delaware is an African-American male in Wilmington between the ages of 31- 49 with a high school education/GED with either a mental illness and/or substance use condition.

Primary reasons for homelessness

The principal underlying cause of homelessness is the gap between the cost of living and the ability of persons to maintain an income to be able to afford those costs. Of all adults surveyed on January 26, 2006, the following reasons (not mutually exclusive) were the most cited as the reason for their homelessness:

- Substance use
- Mental Illness
- Could not Find Work
- Eviction
- High Cost of Housing
- Family Breakup

Who are the homeless?

Delaware's homeless often have accompanying disorders that, with proper services, prevent them from accessing mainstream housing options. The following subpopulations are counted during each PIT Study:

- Serious Mental Illness
- Substance Use Condition
- HIV/AIDS
- Veterans
- Unaccompanied Youth
- Children in Families
- Chronically Homeless
- Domestic Violence Victims

Homeless Subpopulation	Sheltered	Unsheltered	Hotel/Motel	Doubled-Up	Total
Chronically Homeless	224	70	n/a	n/a	294
Seriously Mentally Ill	380	57	9	23	469
Chronic Substance Use	410	90	5	32	537
Veterans	116	66	3	23	208
Domestic Violence Victims	78	6	4	7	95
Children in Families	190	8	37	44	279
Unaccompanied Youth	10	n/a	n/a	n/a	10

Who are the chronically homeless?

There are many persons who experience multiple and/or extended episodes of homelessness over a period of several years. These persons are often chronically homeless.

A person is chronically homeless if they are:

- **an unaccompanied individual**
- **Who has a disabling condition**
- **And has been homeless a year or more, OR**
- **Had at least four episodes of homelessness in the past three years.**

The 294 persons identified on January 26, 2006 who met the definition of chronically homeless in Delaware were geographically distributed as follows:

County	Unsheltered	Emergency Shelter	Transitional Housing	Statewide	Percentage
New Castle	49	93	72	214	73%
Kent	9	9	15	33	11%
Sussex	12	12	23	47	16%
Total	70	114	110	294	100%

Of those 294 chronically homeless persons:

- 42% had a serious mental illness
- 52% had a substance use condition
- 4% had HIV/AIDS

Of those unsheltered chronically homeless persons:

- 55% reported a substance use condition
- 43% reported a mental health condition

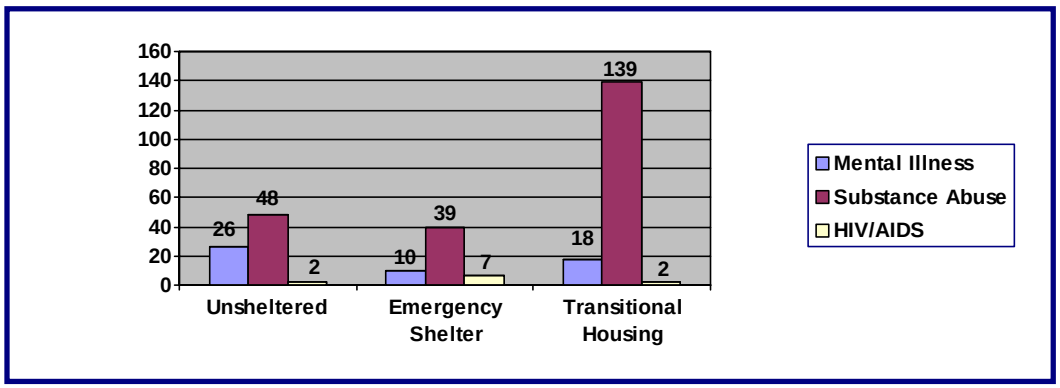
Who is at risk for chronic homelessness?

Throughout the state there are persons who, due to their living situations and disability, are at risk to fall into chronic homelessness. On January 26, 2006, there were:

- 54 unaccompanied individuals with a serious mental illness.
  - 16 were in Kent County;
  - 31 were in New Castle County; and,
  - 7 were in Sussex County.

- 226 unaccompanied individuals had a substance use condition.
  - 47 were in Kent County;
  - 124 were in New Castle County; and,
  - 55 were in Sussex County.

The following chart demonstrated the geographic distribution and condition of persons at risk for chronic homelessness on January 26, 2006:



Data from the National Institute of Health conservatively suggests that 25% of all Delawareans, more than 200,000 citizens, have or will experience mental health and/or substance use problems during their lifetimes. According to the National Study on Drug Use and Health, at any given time, 10% of all adults meet the criteria for a diagnosis of substance use or dependence. That means today in Delaware, there are at least 50,000 who have diagnosable problems related to the use of alcohol and/or other drugs.

What is the annual projection for Delaware?

The method described in the Corporation for Supportive Housing, a national nonprofit housing development and technical assistance organization, publication *Estimating the Need: Projecting from the Point-in-Time* was applied to the January 2006 PIT Study data. Using this method, it is estimated that over the course of one year, there are 6,758 homeless persons in Delaware. Of those, 73% are in New Castle County; 13% are in Kent County; and 14% are in Sussex County. Of the estimated 6,758 homeless people in Delaware, it is further estimated that 337 meet the definition of chronic homelessness.

Delaware's experience with persons who are homeless closely mirrors the national experience. A Delaware PIT Survey conducted in August 2005 and repeated in January 2006 found the incidence of homelessness to be approximately 204/100,000 and 217/100,000 persons respectively. This is congruent with the national rate of 211/100,000 (Burt et al., 2001), although Delaware's rate of chronic homelessness at 16% is higher than the 10% national average. The Delaware data also reflects the findings of Culhane and Associates in 2001, which estimated that nearly half of the persons who are homeless have substance use disorders. Data collected by the HPC in 2005 and 2006 showed that occupancy rates at permanent supportive housing programs serving persons who were homeless and diagnosed with mental health and/or substance use conditions were near 100%. Among unsheltered persons, more than 50% self-reported a substance use condition. These statistics reflect the national picture of homelessness, which is portrayed in *Blueprint for Change: Ending Chronic Homelessness* published by CMHS in 2003.

Other Data Supporting the Need for Housing for Persons who are Chronically Homeless or At-Risk for Chronic Homelessness

Despite Delaware's success in developing and implementing evidence-based models for housing and supportive services, there are still many people in need of permanent supportive housing. Most of these are adults with mental health and/or substance use disorders:

- The Delaware Psychiatric Center (DPC), the state hospital for persons with mental illness, reported that there are patients clinically ready for discharge, but have housing-related disposition problems.
- The providers of Assertive Community Treatment (ACT) services to approximately 1,300 adults with severe and persistent mental illness living in the community report that up to 50% of them are precariously housed, living with family or in substandard housing, or paying more than 50% of their incomes for rent. Almost all of them have incomes below 30% of median.
- The Chance House, which provides transitional housing for adults with substance use disorders, who have completed detoxification and are awaiting residential treatment, has served more than 400 people since it opened in 2002. During that same time period, it has turned away more than 1,200 for lack of bed space.
- Since 2003, Brandywine Counseling has served 168 persons with substance use disorders in a homeless outreach program exclusively targeting Sussex County.
- More than 200 children (an average of 58 per year) will exit the residential care of DSCYF in the years between 2006 and 2009, and many of them will be without the financial resources needed to obtain safe, affordable housing. Many will exit with accompanying risk factors for chronic homelessness, such as mental health diagnoses and/or substance use problems.
- During PIT Studies conducted in January 2005, August 2005, and January 2006, persons meeting the definition of chronic homelessness represented between 14% and 16% of the total number of homeless persons identified. Among all homeless persons counted in Delaware, more than 50% consistently identify themselves as having mental health and/or substance use conditions, and may be at risk to become chronically homeless.

Studies and Best Practices

More than a decade after the Federal Task Force on Homelessness and Severe Mental Illness called it "unacceptable" for people with serious mental illness to live in unsafe and threatening conditions, more than 630,000 individuals are homeless in the United States on any given night (Burt, Aron, Lee, & Valente, 2001). About half of all adults who are homeless have substance use conditions, and many have co-occurring mental conditions. The human cost of inadequate service delivery for this population is tied to a tangible fiscal impact. Without intervention, people with serious mental health and/or co-occurring substance use conditions who are homeless often cycle between the streets, jails and high-cost care such as emergency rooms and inpatient psychiatric hospitals (Culhane, Metraux, & Hadley 2001).

Research conducted over the last twenty years demonstrates that people who are homeless – and especially those who are chronically homeless – use a variety of public systems, often in an inefficient and costly way. Preventing a homeless episode or ensuring a speedy transition into stable permanent housing can result in a significant cost savings. According to a landmark study, *The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative*, conducted by University of Pennsylvania researchers Culhane, Metraux and Hadley, providing permanent supportive housing for homeless persons is an economical solution to the problem of homelessness. The study shows that mentally ill homeless people who cycle between expensive emergency room, inpatient care, and homeless shelters in New York City cost taxpayers approximately the same amount that it would cost to provide them with permanent housing. According to the New York City Coalition for the Homeless, permanent housing for both homeless families and homeless individuals costs less than shelter and other emergency care. The cost of sheltering a homeless individual in New York City is $23,000 per year. By contrast, a supportive housing apartment with services costs as little as $12,500 per year, and rental assistance with support services for a family costs as little as $8,900 per year.

A study of hospital admissions of homeless people in Hawaii revealed that 1,751 adults were responsible for 564 hospitalizations and $4 million in admission costs. Their rate of psychiatric hospitalization was over 100 times their non-homeless cohort. The researchers conducting the study estimate that the excess cost for treating these homeless individuals was $3.5 million or about $2,000 per person. People who are homeless also spend more time in jail or prison – sometimes for crimes directly related to homelessness such as loitering. According to a University of Texas two-year survey of homeless individuals, each person cost the taxpayers $14,480 per year, primarily for overnight jail.[1]

The evidence-based "housing first" approach of providing wraparound housing and supportive services to homeless persons with mental health and/or substance use disorders and other disabilities, including those who meet the HUD definition of chronically homeless, has been effective in eliminating homelessness among them (Culhane et al, 2002). These programs include a variety of approaches documented in the literature. "Pathways to Housing" in New York City combines scattered site rental subsidies with ACT and harm reduction approaches to provide immediate access to permanent housing for homeless persons with mental health conditions, while building supports to help residents maintain community tenure. Another approach is based on "Direct Access to Housing", a model used in San Francisco in which motel rooms and efficiency apartments are master leased from an owner who brings them up to code in exchange for a long-term lease, and services are collocated with the housing. Safe Havens, which provide indefinite-length-of-stay, low demand housing for persons with substance use and/or mental health conditions have been proven effective across the country in reaching persons for whom shelters and other traditional homeless services have been ineffective.

Extensive research conducted by the Center for Mental Health Policy and Services Research of the University of Pennsylvania has clearly demonstrated that long-term homelessness is expensive, not only to the health and well being of the persons who suffer from it, but to the well

[1] Diamond, Pamela and Steven B. Schneed, Lives in the Shadows: *Some of the Costs and Consequences* of a "Non-System" of Care. Hogg Foundation for Mental Health, University of Texas, Austin, TX, 1991.

being of the communities in which they live. When supportive housing with appropriate services is established for them, there is a significant decrease in the utilization of psychiatric hospitals (60%); private hospitals (40%); incarceration in state prisons (74%); and emergency shelters (85%) by the target population. The reduction in the use of public services – valued at approximately $28,000 per person per year – almost offsets the cost of providing the supportive housing (Culhane, Metraux and Hadley, 2002). Evidence-based models for both supportive housing and supportive services for the population of chronically homeless persons and those at risk for chronic homelessness have proven to be effective, both in the research and in practice in Delaware.

Affordable Housing in Delaware?

More than 16,000 persons in Delaware earn less than 30% of the median family income. Of those, 53% pay more than 50% of their incomes for rent. Families and individuals who meet both criteria (<30% of MFI and >50% of income spent on rent) are defined as "rent-burdened" households, at risk for homelessness. Of the 8,890 rent-burdened households in Delaware, 72% of them are in New Castle County.

The median income for a homeless Delawarean in January 2006 was $123 per month.

The 2006 Fair Market Rent established by HUD for a one-bedroom apartment in New Castle County is $792 per month. A person whose only income source is Supplemental Security Income (SSI) receives $603 per month. A person whose income is from General Assistance (GA) receives $127 per month. Most people with mental health and/or substance use conditions are dependent on these entitlements, and live on the margins of poverty. Safe, affordable housing in Delaware is beyond their reach financially.

Recommendations

Recommendations

The Recommendations Committee

Saundra Johnson, the Chair of The DICH, appointed a Recommendations Committee consisting of both members of The DICH and members of the DICH's Working Group. Recommendation Committee members included representatives of local housing jurisdictions, hospitals, state and federal agencies, corrections officials, service providers, and persons who were homeless or formerly homeless. The Recommendations Committee, Chaired by Catherine D. McKay, had three subcommittees, each charged with reviewing the needs of a different target population:

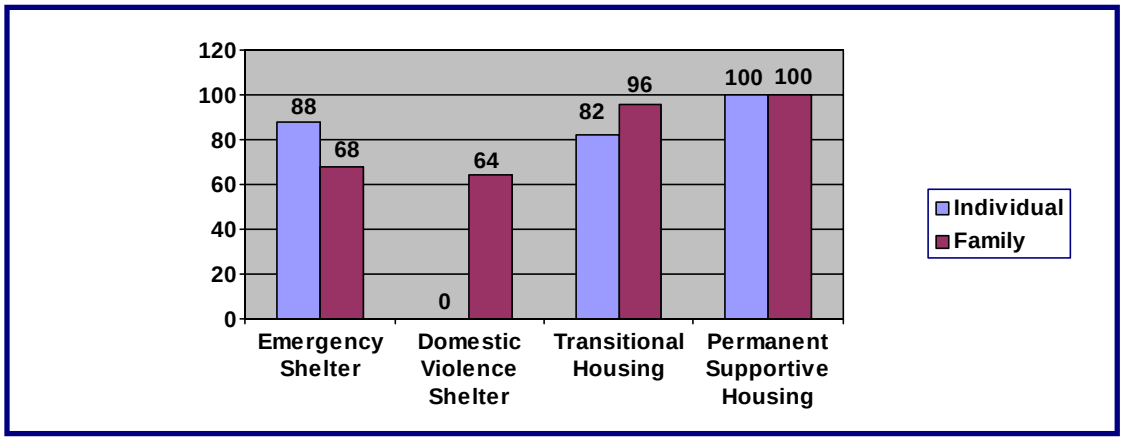
- Persons with mental health and/or substance use disorders;
- Re-entering offenders and persons on probation and parole; and,
- Youth exiting foster care, child mental health or the youth rehabilitation system.

The Recommendations Committee outlined five broad categories of recommendations, developed a list of specific recommendations in each category, and then prioritized the categories themselves and the recommendations within them. There was significant consensus within the Committee regarding these priorities, listed below in rank order:

1. Create New Housing Specifically for Persons Who Are Chronically Homeless or at Risk for Becoming Chronically Homeless
2. Remove Barriers to Existing Housing
3. Improve Discharge and Transition Planning
4. Enhance Supportive Services
5. Enhance Data Collection and Technology

What is Delaware's Homeless Delivery System?

Delaware maintains a delivery system that extends from street outreach to permanent supportive housing. The current system maintains 532 year-round emergency shelter beds with 76 seasonal beds, 471 transitional housing beds and 277 permanent supportive housing beds. In addition there are approximately 120 motel voucher certificates being used across the state on any given night.



Capacity of Delaware's homeless beds on January 26, 2006

Delaware has a good foundation on which to build better treatment systems and improve dissemination of evidence-based practices related to serving persons who are homeless. The HPC has been a successful applicant to the HUD SHP. Because Delaware is small, the State's pro rata share of the funds available through this competitive process is approximately $1.9 million. However, Delaware's statewide CoC, has brought in more than $25 million in funds since 1998, with a current average annual amount of more than $5 million. Eleven of the 20 funded projects are permanent supportive housing projects using evidence-based practices including Housing First and Safe Havens to address the needs of homeless persons with mental and/or substance use conditions. Several projects serve additional sub-populations including persons with HIV/AIDS and young adults transitioning from foster care.

Delaware is in a good position to end chronic homelessness, because we have already adopted many of the evidence-based practices described in the literature. Through the CoC, funded by HUD, and managed by the HPC, Delaware currently has 277 permanent supportive housing beds, most of which are designed to meet the needs of persons with mental health and/or substance use conditions and/or HIV/AIDS. Most of these beds are modeled after three evidence-based practices promoted by the USICH on Homelessness. Delaware currently has 57 beds that use the *Pathways to Housing* model in which rental subsidies in scattered sites are combined with ACT. Several other existing programs follow the *Direct Access to Housing* model used in San Francisco or the *Safe Haven* model used in Philadelphia to provide immediate access to permanent supportive housing for 167 persons with HIV/AIDS, substance use and/or mental health conditions, and young adults transitioning from foster care. Together, these programs have achieved benchmarks set by HUD for assisting participants to stay in permanent housing for seven months or more (81%); for accessing mainstream resources (60%); and for achieving employment income (41%).

Delaware was an early adopter of ACT, an evidence-based practice that has documented effectiveness in reducing homelessness and hospital admissions. In 1988, Delaware established ACT as its flagship mental health service delivery system, ultimately developing twelve teams statewide serving 1,300 people. Some of the housing programs which have been developed with HUD funding – including SHP, Housing Opportunities for Persons with AIDS (HOPWA) and 811 – have been tied to the ACT teams for professional service provisions. We believe that this early adherence to evidence-based practices ultimately decreased the total number of persons with serious mental illness entering the ranks of the chronically homeless. These services have reduced expensive hospitalization rates to fewer than four days per year per person and have been effective in assisting persons to access mainstream resources to get and keep housing and employment. However, because ACT is not designed to serve persons with primary substance use disorders, it did not similarly impact persons with substance use conditions. Access to the ACT teams is also limited, primarily because of funding constraints. Additional levels of easily accessible, outreach-oriented care may be needed to meet the needs of the growing population of persons with mental health and/or substance use conditions, including those who are homeless.

On the nights in 2005 and 2006 when the PIT Surveys were conducted in Delaware, occupancy rates at permanent supportive housing programs for persons who were homeless and were diagnosed with mental health and/or substance use conditions were near 100%, while transitional and emergency shelters were operating well below capacity. This supports the

recommendation for a paradigm shift to "Housing First" through the provision of permanent supportive housing and wrap-around services at an early point of contact with homeless individuals. This strategy was initiated in 2000, and has resulted in the development of more than 300 permanent supportive housing beds, primarily serving chronically homeless people with mental and/or substance use conditions. In addition, DSAMH funds 121 group home beds and 82 supervised apartment beds, which provide permanent housing for persons with severe and persistent mental illness in community-based settings, and which maintain very high rates of occupancy.

In consideration of these facts, The DICH has concluded that Delaware should develop a range of supportive housing options with at least 2,000 beds, based on evidence-based practices, which maximize choice and address the shortage of affordable rental housing throughout the state. The types and intensity of services offered in the housing should be individualized and should change over time as the needs of persons served change.

The majority of the new beds proposed would serve target populations with diagnosed mental health and/or substance use conditions, many of whom have preferred to live on the streets as opposed to shelters or other settings where the rules have either prevented their admission or proven too onerous to follow. Many of them have not had stable housing in their adult lives. Supportive services that are offered to them must be appropriate to their needs – that is, they must include access to mental health and/or substance use treatment, including appropriate medications, and to primary medical care – but they must also be flexible and low demand. Housing cannot be contingent on the acceptance of these services or on abstinence from substances. The permanent supportive housing programs must have staffing to ensure that property management and security are attended to, and should have onsite services that are easily accessible. At the same time, the programs and services must have flexible rules to prevent eviction of residents for reasons related to their mental health and/or substance use conditions.

Although the cost to develop and operate the proposed new housing will be high, many of the supportive services that will be needed are already funded with mainstream resources. For example, we expect that the vast majority of the persons with mental health conditions who will receive rental subsidies will be enrolled in the statewide CoC Program for persons with severe and persistent mental illness and will be receiving ACT or Intensive Case Management services through the program. These services are funded through a combination of Delaware Medicaid, General Fund and Community Mental Health Block Grant dollars. An essential service provided by the program is assistance to obtain and maximize eligibility for mainstream resources. Delaware also funds integrated intensive outpatient and outpatient alcohol and other drug services for uninsured and indigent people using mainstream resources such as the Substance Abuse Prevention and Treatment Grant and Delaware Medicaid. These services will be available to persons living in the proposed housing, onsite or with transportation.

These persons experience significant barriers to getting and keeping affordable housing. Many landlords (including the housing authorities) exclude potential tenants as the result of criminal record and credit checks. Policies vary in this regard, but represent a significant barrier. There is discrimination against people seeking housing for a wide range of reasons – income, race,

criminal background, disability.[2] Sex offenders are being almost uniformly excluded from housing and from certain programs. At the same time, emergency shelters in parts of Delaware are under-utilized (69% of capacity on two nights in 2005) while on the same nights there were more than 300 unsheltered homeless people. The number of unsheltered homeless people reporting chronic substance use (51%) suggests that there is a gap between what they need in order to be housed and what is currently available.

[2] *Delaware Analysis of Impediments to Fair Housing Choice, Peuquet and Ware, 2003.*

Recommendation 1: Develop New Housing for Persons Who Are Chronically Homeless or At-Risk for Chronic Homelessness

The DICH recommends the development of 1,648 beds in 1,284 units of new housing for persons with incomes below 30% of median who have diagnosable mental health conditions, substance use conditions, physical disabilities including HIV/AIDS, and/or developmental disabilities, who have been homeless or who pay more than 50% of their incomes for rent. Many of these persons are members of other sub-populations as well, including veterans, re-entering offenders and youth who are aging out of the child mental health, foster care or rehabilitation systems.

Types of Housing

The DICH recommends a mixture of permanent supportive housing, rental subsidies, safe havens and transitional housing defined as follows:

- *Permanent Supportive Housing* couples rapid access to long-term affordable housing ("housing first") with wrap-around supportive services to help persons with disabling conditions, including those who are chronically homeless, to get and keep long-term affordable housing that meets their needs.

- *Rental Subsidies* provide the financial resources needed by persons with extremely low and no incomes, who have demonstrated the ability to live independently while using mainstream resources, to obtain rental housing on the economy despite their lack of resources. Rental subsidies can be used for permanent housing, with no limitation on the length of the subsidy, or for more transitional, time-limited situations.

- *Safe Havens* offer low-demand, indefinite-length-of-stay, supervised housing alternatives for persons with substance use and/or mental health conditions who need a place to stay that does not tie compliance with rules or service expectations to the maintenance of housing.

- *Transitional Housing* offers limited-term access to housing (18 to 24 months) to persons who are participating in treatment programs and other opportunities to improve their social and economic standing and who will ultimately be able to live independently in the community once they have addressed problems that contributed to or caused their homelessness.

Type of Housing	Target Populations	Beds	Units
Permanent Supportive Housing	Chronically homeless persons with mental health and/or substance use disorders; persons with severe and persistent mental illness who are at risk for chronic homelessness; families whose heads of household meet all aspects of the definition of chronic homelessness, except that they are accompanied; youth with qualifying conditions transitioning to adulthood.	433	409
Rental Subsidies	Rent-burdened persons with severe and persistent mental health conditions enrolled in ACT; persons with substance use disorders re-entering from prison; youth with qualifying conditions transitioning to adulthood.	1,000	667
Safe Haven and Sober Transitional Housing	Persons with substance use disorders, including those with co-occurring mental health conditions, who are unsheltered or living in emergency shelters	215	208

Not all of the proposed housing units will be new construction. In New Castle and Kent Counties, where there is a stock of existing rental housing with vacancies to meet the projected needs, many of the proposed beds will be located in existing rental housing that can be master-leased or leased directly to individuals with rental subsidies. Even in cases where "new development" is proposed in New Castle and Kent Counties, it is most likely that the development will reclaim existing buildings that are vacant, under-utilized or substandard through acquisition and rehabilitation. In Sussex County, where the supply of rental housing is scarce and/or unaffordable, new development may be necessary. The table below depicts the mix of new development and rental of existing housing-by-housing type (in number of beds).

Housing Type	New Development	Rental of Existing Units
Permanent Supportive Housing	364	69
Rental Subsidies	0	1,000
Safe Haven/Sober Transitional Housing	215	0
Total	579	1,069
% of Total (n=1,648)	35%	65%

Location of Housing

The new housing to be developed should be allocated to each of the three Delaware Counties (New Castle, Kent and Sussex) in the same distribution of homeless persons by location that the data collected during the 2005 and 2006 PIT Surveys reflects. The table below depicts the allocation of beds by type and county.

Type of Housing	New Castle County	Kent County	Sussex County
Permanent Supportive Housing	315	48	70
Rental Subsidies	730	107	163
Safe Havens/Sober Transitional Housing	118	45	52
Total	1163	200	285
% of Total (n-1,648)	71%	12%	17%

Recommendation 2: Remove Barriers to Accessing Existing Affordable Housing

The Recommendations Committee identified many barriers that prevent persons with criminal convictions, persons with mental health and/or substance use disorders and young adults exiting the child foster care or child mental health system from gaining entry to existing units of affordable rental housing. The Committee also raised concerns that programs that had been developed through the Delaware statewide CoC, funded by HUD, might be at risk of closing over time because of the increasing burden of federally required local match and the lack of funding for inflation.

There are 20 programs currently in operation in Delaware that are funded by the HUD CoC SHP, funded with more than $5 million per year in federal funds brought in through the HPC's CoC application. Nineteen of these programs include 12 permanent supportive housing programs and seven transitional housing programs with more than 300 beds. These 19 programs represent all of the "housing first" programs currently operating in Delaware targeting persons who are chronically homeless, and most of the beds that provide supportive housing for persons with mental health and/or substance use conditions, HIV/AIDS, youth aging out of foster care who have behavioral health conditions and families with children who need supportive services within the context of their living arrangement. The 19 housing programs supported by the HUD CoC SHP form the essential building blocks to Delaware's Ten-Year Plan.

There is a gap of almost $2 million between the actual cost of those programs and the funding received from HUD. Some of the gap is created by the local match requirements, which range from 0% for leasing to 20% for operations to 25% for supportive services. Despite significant efforts on the part of the HPC to find alternative supportive services funding through mainstream resources, there remains a gap in funding. Some of this gap is caused by housing inflation over the twenty-year life of the CoC. During that same period, HUD has not allowed existing programs to apply for funding increases to cover the rising costs of rent, utilities and insurance. Philanthropic sources have been filling the gap in Delaware, but they are dwindling, and are increasingly reluctant to pay for the ongoing operating costs of homeless programs that they perceive to be the responsibility of state government.

The Recommendations Committee also turned to other members of the community, including the acute care hospitals, in an attempt to understand other barriers to addressing homelessness in Delaware. It learned that most hospitals, prisons, and other institutional service providers do not routinely ask people whether or not they are homeless. In many cases, the individual is asked for an address, and when they provide one (even if it is not actually a place where they are welcome to live) the question is considered answered. When the Committee explored this issue in depth, it discovered that the reluctance to ask the question was tied to two factors:

1) If the answer was "yes", the staff did not have the resources to address the issue, in part because there is not a single entity in the state that has the responsibility for accepting referrals, doing outreach and providing immediate access to respite beds while an assessment is done and permanent supportive housing is located; and,

2) Not all agencies that are trying to help people find housing have a good understanding of what is available and who is eligible.

As described earlier, it also is clear that housing is simply not affordable for persons in Delaware who have very low incomes. The rate of poverty in Delaware is approaching 10%, and there is a significant problem with housing affordability. According to the National Low Income Housing Coalition Report *Out of Reach 2005*, the cost of a one-bedroom unit in Delaware is more than 200% of minimum wage. The 2006 Fair Market Rent established by HUD for a one-bedroom apartment in New Castle County is $792 per month. A person whose only income source is SSI receives $603 per month. A person whose income is from GA receives $127 per month. Many persons with substance use and/or mental health conditions rely on these sources as their only income. At the same time, almost all of the non-federal dollars that are going to fund permanent housing development in Delaware are tied to low-income housing tax credits that do not address the needs of persons with incomes below 40% of median (the target population is all below 30%, and most of them are significantly below that). Additionally, even in the case of existing, affordable housing, it is not always accessible to the target population. For example, federally assisted housing waiting lists rarely open for new applications, and notification of list openings does not always reach the target population. For those people already on the waiting list, if they cannot be reached annually to verify their information, they are purged from the list. Homelessness, lack of mailing addresses and literacy problems all contribute to persons from at-risk groups being purged from these waiting lists. Further, members of the homeless population are often excluded from access to subsidized housing because of issues related to poor credit, criminal background and behavioral health issues.

Strategies to Remove Barriers to Accessing Existing Affordable Housing

The DICH established the following three recommendations as priority in the removal of barriers to existing affordable housing:

1) Develop funds from a state government source to cover the gap between what HUD funds under the CoC and the actual costs of operating those programs and to support the HPC, the entity that collects data about homelessness in Delaware and manages the CoC. This gap of approximately $2 million per year needs to be covered in a consistent and reliable way to prevent a loss of 330 beds of existing transitional and permanent supportive housing for homeless people in Delaware.

2) Establish a set aside of available Housing Development Fund (HDF), Low Income Housing Tax Credit (LIHTC), Community Development Block Grant (CDBG), and HOME Investments Partnership (HOME) funds to ensure that at least 25% of the housing developed under those initiatives each year targets persons with income below 30% of median.

3) Establish a single entity in each county that is designated and funded to have the responsibility for coordinating discharge-planning activity for persons who are homeless as a single point of contact. This agency must have access to immediate housing for people while they complete the process of assessment and locate permanent housing,

competencies to address mental health and/or substance use issues and well-developed outreach and housing locator capability. This recommendation is also made in the section of this chapter regarding discharge and transition planning.

In addition to the three high priority recommendations listed above, the DICH recommends that DSHA take the lead in establishing with HUD what specific exclusions from housing eligibility are required when the housing is funded by HUD. Once those are identified, representatives from the DICH should approach each public housing agency and jurisdictions with specific suggestions for loosening restrictions that are not required by HUD and which represent barriers to access to existing low-income housing.

The DICH also recommends that an inventory be compiled of vacant public housing units in need of extensive renovations and other vacant buildings, which might have potential for conversion to housing for the target population. The inventory should include the housing stock controlled by DSHA, Wilmington Housing Authority (WHA), Dover Housing Authority (DHA), and Newark Housing Authority (NHA) and should include the number, size, and location of vacant units that are in need of repairs in order to be occupied, and an estimate of the costs to complete those repairs. An additional inventory should be compiled of other vacant buildings indicating the size of each building, the number of potential units of housing it could provide, the estimated costs of conversion, and any other factors that impact the feasibility of conversion.

Finally, the DICH recommends that the process for opening and purging the federal housing assistance waiting lists be standardized across the housing authorities and jurisdictions in Delaware, and that a simple and uniform process be established to ensure that homeless persons on the waiting list for federally assisted housing are not purged from the list simply because they cannot be reached by phone or mail. These tasks should be undertaken as part of the implementation of the Delaware's Ten-Year Plan.

Recommendation 3: Improve Discharge and Transition Planning to Prevent Homelessness Subsequent to Release from Prison, Hospitalization, and Transition from the Children's System to the Adult System

The Recommendations Committee collected all known written documents that existed describing discharge and transition planning for persons served by DHSS, DSCYF and DOC in their programs and institutions.

Although some attempts have been made to address the transition and discharge needs of vulnerable populations in Delaware, there are few formal policies or agreements. In addition, some groups of persons who are vulnerable for becoming homeless are not addressed at all in existing discharge planning processes. For example, no policies or procedures were identified regarding the planning for inmates exiting prison and no policies or procedures were identified regarding the housing needs of persons who are leaving acute care hospitals who are homeless. The question of homelessness often goes unasked during intake at hospitals and other services –

people are asked for an address, and if they give one, it is assumed that they are not homeless. However, evidence suggests that many persons served may in fact be homeless.

Persons with substance use disorders, the largest group of homeless people in Delaware according to the PIT Study, are not addressed in any formal discharge planning policy or procedure, even when they are leaving a setting such as residential treatment, detoxification center or prison. Although contracts between the DHSS and private providers of addictions services state that those providers will help persons served to find housing, the lack of affordable housing is not addressed. Some youth with mental health problems have diagnoses only applicable to children and are not seen as eligible for transition to the adult system because they lack a qualifying adult diagnosis. Most of them are leaving settings such as residential treatment centers or foster care where housing is part of their care. If they cannot transfer to the adult system, they are vulnerable to homelessness and other problems. Sex offenders of all ages are having trouble finding housing. This is a problem for people who are leaving prisons, psychiatric facilities and youth treatment and rehabilitation facilities.

Strategies to Improve Discharge and Transition Planning

The DICH recommends the establishment of a Discharge Planning Work Group that includes leadership from State agencies (especially DOC, DHSS, DSAMH, DSHA, and DSCYF) who would collaborate among themselves and with community providers to review and strengthen discharge and aftercare planning strategies to ensure that appropriate linkages with housing and community-based care are in place to prevent subsequent homelessness. This applies especially to people with substance use and/or mental health conditions, including those who are leaving hospitals and prisons and those who are transitioning from Child Mental Health and/or Youth Rehabilitation Services. Specific discharge planning protocols need to be developed to address the unique needs of sex offenders. The planning process for sex offenders needs to include all of the state agencies that have an interest in this issue – DOC, Homeland Security, DSCYF, DHSS and DSHA.

No person should leave a hospital, nursing home, or residential treatment program without an identified transitional or permanent place to live (not an emergency shelter), the necessary entitlements or employment income to pay for it, and the supportive services needed to sustain it. All children in foster care should be eligible and assisted to sign up for federal housing assistance waiting lists at the age of 16, so that when they turn 18 they will have a chance of having moved high enough on the list to receive housing.

All hospitals (general and specialty), providers of mental health and/or substance use treatment services, and federally qualified community health centers should specifically ask the question, "Are you homeless?" to any person who presents for treatment. Discharge planning processes should include direction to those entities as to how to respond when the answer to that question is "yes". *Exemplary Practices in Discharge Planning* recommends that "a single entity" – one agency in each county – should have the responsibility for coordinating such discharge planning activity and funding should be provided for that purpose. The establishment of such an entity is described in the recommendations contained in the "removing barriers to existing housing" section of this chapter.

Objective 4: Improve Supportive Services for Persons Who Are Homeless

Delaware has an extensive system of care for persons with mental health, substance use and primary care conditions, and much of that system of care includes evidence-based practices such as integrated treatment for mental health and/or substance use conditions, ACT, performance-based contracting and other nationally promoted methodologies. Despite this, not all persons who are homeless are able to access the services they need to get and keep housing and to address the underlying conditions that contributed to or resulted from their homelessness.

Access to primary health care, as well as to treatment for mental health and/or substance use conditions is a critical component of good public health. More people in Delaware have now, have had, or will have a mental health and/or substance use problem than almost any other disorder: more than cancer, more than diabetes, many more than developmental disabilities. Data from the National Institutes of Health conservatively suggests that 25% of all Delawareans, more than 200,000 citizens, have or will experience mental health and/or substance use problems during their lifetimes. According to the National Study on Drug Use and Health, at any given time, 10% of all adults meet the criteria for a diagnosis of substance use or dependence. This means that today in Delaware, there are at least 50,000 who have diagnosable problems related to the use of alcohol and other drugs.

Stigma is associated with mental illness and addiction, and the unwillingness to accept treatment for these conditions leads to poor outcomes – of the almost 3,000 homeless people counted in Delaware on two nights in 2005, half said they had a long-term mental health and/or substance use disorder. Delaware continues to rank in the top ten states for HIV infection, and almost half of the people who have HIV in Delaware contracted it from intravenous drug use or sex with a partner who was an IV drug user.

In addition to the data developed by the HPC PIT Studies and DE-HMIS, the Recommendations Committee conducted key informant interviews with 20 different outreach, shelter, transitional and permanent supportive housing programs regarding the need and availability of mental health, substance use and primary health care services for persons who are homeless. Through these interviews, the Committee learned that payer, location and diagnosis often fragment services. There are significant gaps created by the bifurcation of services available for persons with Medicaid versus those services available for uninsured persons. In many locations, services are available only by appointment and times of service are not always compatible with the schedules of persons served, especially those who are trying to achieve employment outcomes. Waiting times for appointments often prevent providers or the persons they serve from obtaining access to service when they need it. Hours need to be flexible, and include evenings and perhaps even weekends, in order to meet needs. When services can be offered at the housing site, it is more likely that residents will participate.

Transportation is a problem for people who are homeless throughout the State. The problem is worse in Kent and Sussex Counties. Persons with mental health and/or substance use problems, especially those with criminal convictions, face serious obstacles to finding and keeping

employment. Treatment for mental illness and/or co-occurring mental health and substance use conditions should include access to medications. Medication access is a problem for people who lack insurance – 14.5% of the general population.

Strategies to Improve Supportive Services for Persons who are Homeless

The DICH recommends that, in addition to supportive services which will be specifically tied to the new housing developed and the service centers established under the plan, at least some medical and behavioral health services should be made available on a walk-in basis in each county. Homeless people who need primary care, mental health and/or substance use services have been unable to get services if they have had to wait for an appointment. Services need to be fully integrated – there cannot be barriers related to payer source, diagnosis, geography, and other artificially imposed rules that fragment the system and make it difficult to navigate. Primary care services need to be integrated with mental health and/or substance use services whenever possible. The reverse is also true. The designated homeless service centers described throughout this chapter would be the ideal place to locate the additional supportive services.

Services need to include case management, especially direct assistance to get income supports and other entitlements, and direct assistance to find affordable housing. They need to be culturally competent and to respect the language and cultural beliefs of the target populations, and make provisions to address them. The stigma of mental illness and substance use disorders, and cultural beliefs regarding those conditions among each of the sub-populations, need to be considered in the development of the services. Mainstream employment services offered by the DOL and those offered through Vocational Rehabilitation for people with disabilities should commit to providing services to all persons who are homeless and have other challenges, including, substance use and/or mental health conditions, who request such services. Performance quotas imposed by federal regulations need to be examined and amended so that they do not prevent appropriate employment efforts from reaching the target populations.

The DICH also expressed concern regarding the large number of task forces, commissions and committees whose goals and assigned tasks overlap in the area of housing for persons with special needs. The DICH recommends coordination between the Governor's Commission on Community-Based Alternatives to Institutionalization and the DICH in order that both groups might present a united voice regarding the housing needs of vulnerable Delawareans.

Finally, the DICH recommends that data systems be enhanced and improved. Specifically, a "housing locator's guide" should be developed online, which includes a single application for persons who are seeking affordable housing and is linked to available housing options. A formal link between DSHA E-Housing initiative and the DE-HMIS would be one way to accomplish this goal. Further, the DE-HMIS should be expanded and strengthened. State Departments and Divisions should become users of DE-HMIS, both as the recipients and the providers of data. These would include at least DSAMH (including the CAPES program and the DPC), State Service Centers, DSCYF, the Office of Community Services, Delaware Helpline and DSHA.

Complete List of Recommendations

New Housing Needed This was ranked as the highest priority category	# of Beds
New beds of permanent housing, for people with extremely low or no incomes to accommodate chronically homeless persons who are unsheltered, living in emergency or transitional housing. Supportive services need to be appropriate to the needs of persons with mental health and/or substance use conditions and have flexible rules to prevent the eviction of persons for reasons related to those conditions.	294
New beds of permanent housing, for people with extremely low or no incomes, to accommodate persons with mental health disorders who are currently unsheltered, living in emergency or transitional housing, or living in the DPC because they lack alternative housing with adequate supports. Most of these units need on-site supervision and support.	99
New beds of Safe Havens and sober transitional housing for people with extremely low or no incomes with substance use disorders that are unsheltered or living in transitional housing. These units need to have supportive services and flexible rules designed to prevent eviction as the result of substance use. Most of these units should have onsite supervision.	215
New units of transitional and permanent supportive housing specifically designed to serve young adults exiting foster care who need additional onsite support services.	10
New rental subsidy vouchers for persons with mental health and/or substance use conditions that are served in the CoC or other DSAMH programs with mainstream supportive services.	600
New rental subsidy vouchers, good for 5 years, for youth exiting foster care who wish to live independently and have the skills to do so.	200
New transitional rental subsidy vouchers, good for a maximum of 5 years, for re-entering offenders with qualifying disabilities.	200
New permanent supportive housing to accommodate families where the head of household has a diagnosable mental health and/or substance use disorder and is accompanied by his/her children. These units need to have supportive services and flexible rules designed to prevent eviction as the result of mental illness and/or substance use.	30

Removing Barriers to Housing This was tied with "discharge planning" as a medium priority category	# of Beds
Funds must be developed from a State government source to preserve the units funded through the HUD CoC, including the costs of planning and operating those programs. HUD requires a 25% match for much of what is funded through the CoC. The gap is approximately $1.8 million, including funding for the HPC as the entity that manages the process.	330
A set aside should be established of available LIHTC and HOME funds to ensure that at least 25% of the housing developed under those initiatives each year targets persons with incomes below 30% of median.	TBD
A single entity – one agency in each county – should be designated and funded to have the responsibility for coordinating discharge planning activities for persons who are homeless as a single point of contact. Each entity should have respite beds to facilitate transition to permanent supportive housing.	25
The DICH should collect from all Delaware housing authorities and jurisdictions a list of exclusions to public housing that are currently in place, and should approach the housing entities with specific suggestions for loosening restrictions that are not required by law.	TBD
An inventory should be compiled of vacant existing public housing units in all of the public housing authorities (DSHA, WHA, DHA and NHA), which includes the number, size, and location of vacant units that are in need of repairs in order to be occupied, and an estimate of the costs to complete those repairs. An additional inventory should be compiled of other vacant buildings that indicates the size of each building, the number of potential units of housing it could provide, the estimated costs of conversion, and any other factors that impact the feasibility of conversion.	TBD

Discharge and Transition Planning This was tied with "removing barriers" as a medium priority category	# of Beds
A Discharge Planning Work Group should be established that includes leadership from State agencies (especially DOC, DHSS, DSHA, and DSCYF) who would collaborate with community providers to review and strengthen discharge and aftercare planning strategies to ensure that appropriate linkages with housing and community-based care are in place before people leave too avoid subsequent homelessness.	N/A
Hospitals, providers of mental health and/or substance use treatment services, and community health centers should specifically ask the question, "Are you homeless?" to any person who presents for treatment. Discharge planning processes should include direction to those entities as to how to respond when the answer to that question is "yes".	N/A
There should be an identified, non-shelter living arrangement for each person who is leaving one of the settings described above before they are discharged. No persons should leave a hospital, nursing home, or residential treatment program without an identified transitional or permanent place to live (not an emergency shelter), the necessary entitlements or employment income to pay for it, and the supportive services needed to sustain it.	TBD
All children in foster care should be eligible and assisted to sign up for federally assisted housing Waiting Lists at the age of 16, to improve access to housing at age 18.	N/A
Discharge planning processes should include specific housing locator services that "reach in" to hospitals, nursing homes, prisons, residential alcohol and/or drug treatment programs, and other institutional settings to become a part of the discharge planning process for persons who are leaving those settings.	N/A

Enhancement of Supportive Services Needed This category was tied with "data collection and technology enhancement" as a low priority category	# of Beds
At least some medical and behavioral health services need to be available on a walk-in basis in each county. Homeless people who need primary care, mental health and/or substance use services have been unable to get services if they have had to wait for an appointment.	N/A
Services need to be fully integrated—there cannot be barriers related to payer source, diagnosis, geography, and other artificially imposed rules that fragment the system and make it difficult to navigate.	N/A
Services need to include case management, especially direct assistance to get income supports and other entitlements, and direct assistance to find affordable housing.	N/A
Services need to respect the language and cultural beliefs of the target populations, and make provisions to address them. The stigma of mental illness and/or substance use disorders, and cultural beliefs regarding those conditions among each of the sub-populations need to be considered in the development of the services.	N/A
Primary care services need to be integrated with mental health and/or substance use services whenever possible. The reverse is also true.	N/A
A brief screening tool needs to be integrated into the assessment process for every person who is receiving homeless services. This tool should be built into the DE-HMIS.	N/A
Services need to be available at various times of the day, including the afternoons and early evenings, and in all counties, so that they do not interfere with employment efforts.	N/A
Transportation needs to be provided either directly for those in areas where public transportation is unavailable, or through the provision of bus passes or cab vouchers for those with access to public transportation routes.	N/A
Mainstream employment services offered by DOL and those offered through DVR for people with disabilities must commit to providing services to all persons who are homeless and have other challenges, including substance use and/or mental health conditions, who apply for such services. Performance quotas imposed by federal regulations need to be examined and amended so that they do not prevent appropriate employment efforts from reaching the target populations.	N/A

Data Collection and Technology Enhancements This category was tied with "data collection and technology enhancement" as a low priority category	# of Beds
A "housing locator's guide" should be developed online, which includes a single application for persons who are seeking affordable housing and is linked to available housing options. A formal link between the DSHA E-Housing initiative and the DE-HMIS would be one way to accomplish this goal.	N/A
The DE-HMIS should be expanded and strengthened. State Departments and Divisions should become users of DE-HMIS, both as the recipients and the providers of data. These would include at least DSAMH (including the CAPES program and DPC), State Service Centers, DSCYF, the Office of Community Services, Delaware Helpline and DSHA.	N/A
The Governor's Commission on Community-Based Alternatives to Institutionalization for People with Disabilities (CCBAID) recommends that the DSHA Housing Needs Assessment be expanded to include information about the housing needs of people with disabilities. The DICH and the CCBAID should coordinate their efforts to maximize effectiveness.	N/A

Funding the Plan

Implementation

The Implementation Committee

Subsequent to adopting the recommendations, the DICH set out to develop a plan to fund and implement them. The Implementation Committee, Chaired by DSHA Director and the DICH Chair, Saundra Johnson, consisted of Chairs of the Data and Recommendations Committees and the appointed representatives of the City of Wilmington, New Castle County, City of Dover, DHSS, DOC, DSCYF and the Chairs of the Senate Community/County Affairs Committee and the House of Representatives Housing and Community Affairs Committee. The charge of the Implementation Committee was to *determine the costs of the proposed recommendations, to identify gaps in funding, and to propose possible funding sources to close the gaps.*

Implementation Chart

The table below depicts the nine recommendations that were made that have verifiable capital costs for the development of bricks and mortar and annual costs for operations and supportive services. These recommendations are divided between programs that will require the development of new bricks and mortar and/or supportive services and those, which can be implemented with rental subsidies alone.

Recommendations for Rental Subsidies/Vouchers	Beds	Capital Development Cost	Annual Operating Cost	Annual Service Cost
1. Rental subsidies for persons with substance use and/or mental health conditions with incomes below 30% of median, receiving services from DSAMH.	600	$0	$4,320,000	$0
1a. Rental subsidies for youth exiting foster care with incomes below 30% of median and qualifying conditions.	200	$0	$1,440,000	$0
1b. Rental subsidies for persons re-entering from prison with incomes below 30% of median and qualifying conditions.	200	$0	$1,440,000	$0
Total	**1,000**	**$0**	**$7,200,000**	**$0**

The Implementation Committee notes that rental subsidies will be most effective in New Castle and Kent Counties where there is sufficient rental housing to absorb them. The development of additional rental housing in Sussex County (not included in this Plan) would be necessary for this strategy to be effective there.

Recommendations for New Development	Beds	Capital Development Cost	Annual Operating Cost	Annual Services Cost
2. New units of permanent supportive housing for chronically homeless persons.	294	$23,520,000	$4,998,000	$3,324,000
3. New units of permanent supportive housing for persons with serious mental illness, including those who are institutionalized and those who are homeless.	42	$3,360,000	$567,000	$462,000
3a. Rental of existing units in which to provide permanent supportive housing for the population described in (2) above.	57	$0	$1,316,700	$627,000
4. New units of Safe Haven and sober transitional housing for homeless persons with extremely low and no incomes and substance use conditions.	215	$14,690,000	$3,145,000	$414,000
5. New units of permanent supportive and transitional housing for youth exiting foster care that need onsite support services.	10	$250,000	$50,000	$30,000
6. New units of permanent supportive housing to accommodate families where the head of household meets criteria for chronic homelessness, except that children accompany them.	18	$480,000	$48,000	$18,000
6a. Rental of existing units to provide permanent supportive housing for the target population described in (6) above.	12	$0	$68,000	$12,000
7. New single entity homeless service centers in each county with respite beds where residents can stay while screening and housing locator services are completed.	25	$100,000	$92,400	$10,000
8. Funding of match for existing SHP programs to maintain the current "floor" of housing for homeless and chronically homeless persons in Delaware.	330	$0	$1,400,000	$200,000
Totals	1,003	$42,400,000	$11,685,100	$5,097,000

The Funding Gap

Delaware has been fortunate to have received funding under the HUD CoC well in excess of the amount determined by HUD as the pro rata need. Whereas our population and poverty rate would establish our annual funding rate at approximately $1.9 million, the HPC has brought an average of $4.6 million per year in funding over the past six years for housing and services for Delaware's homeless. CoC funding is renewable on an annual basis and with current renewals; the HPC is projecting an average annual allocation over the next five years in excess of $5.1 million per year. However, HUD requires a match for much of the funding provided and in recent years has not allowed applicants to request increases to cover increasing cost. Thus, this puts a burden on the agencies providing the housing and services to find additional resources to maintain these programs. The HPC estimates an ongoing need of between $1.1 and $1.3 million annually to leverage the federal CoC funding. Currently, the only state funding to these programs is approximately $35,000, which has been made available from Grant-in Aid to assist a few of the programs funded by the CoC.

Capital Costs

Capital costs are the one-time costs to acquire and renovate, or build from the ground up, the necessary "bricks and mortar" to provide the supportive housing. These are one-time costs. The total capital development costs to fund Delaware's Ten-Year Plan are estimated at $42,400,000 in 2006 dollars.

Not all of the recommendations contain capital costs. Whenever possible, the DICH considered the viability of using existing rental housing to accommodate the proposed programs. However, in some locations, such as Sussex County, there are very few rental units available. Most of the housing, which is planned for that county, will be new development. Similarly, in the City of Wilmington, where most of the homeless population is clustered, there is a need to acquire and rehabilitate existing property, which is abandoned or substandard. In these cases, the reclamation of existing property is characterized as the development of new units because it will require a capital investment.

Operating Costs

Operating costs are the day-to-day costs of maintaining the property such as utilities, insurance, taxes, maintenance, cleaning, security, and any debt service. We are also considering the payment of rental subsidies allowing persons with disabilities and incomes below 30% of median to live independently in scattered site housing. In many cases, the new units recommended will require onsite property management and staffing to monitor for safety and security. These costs are included in operating costs.

The operating costs for each recommendation are presented as the annual cost to operate all of the units proposed. These can be broken down further into the cost per bed so that the incremental annual operating costs can be calculated if fewer than the total number of beds is developed. For example, it will cost $4,998,000 per year to operate all of the 294 beds of permanent supportive housing proposed for persons who meet the criteria for chronic

homelessness, translating into an annual cost per bed of $17,000. If 10% of these beds are developed (29 beds), the annual cost to operate them will be $493,000 per year. Similarly, each proposed rental subsidy will cost an average of $7,200 per person per year. To fund 10% of the total proposed 1,000 subsidies would cost $720,000 per year. Tenants will be expected to pay 30% of their income in rent to offset the total costs of each proposed housing unit. However, many of them will have little to no income, and this was considered when costing out the recommendations.

Services

Supportive services costs include outreach and engagement, case management, crisis intervention, substance use and/or mental health treatment, primary medical care, transportation, employment support and other professional services needed to help people with special needs and extremely low or no income to get and keep stable, affordable housing.

Many of the supportive services already exist and are funded by mainstream resources including Delaware Medical Assistance, Delaware General Funds, Appropriated Special Funds (mostly derived through the DHCC's "Tobacco Fund"), the Substance Abuse Prevention and Treatment Block Grant, the Community Mental Health Block Grant, PATH and the Community Services Block Grant (CSBG). However, there are limits on the total number of persons each currently funded program can serve. A large influx of persons new to the system would stress demand for supportive services funding. In addition, several of the initiatives call for funding that is not currently in hand, including the development of designated homeless service centers and the local match for the federally funded SHP. It is estimated that at least 25% of the proposed annual supportive services cost, or $1,257,750, would need to be funded to fully implement the proposed plan.

Capital Cost Strategies

The Implementation Committee reviewed strategies that have been used in other jurisdictions to fund plans similar to Delaware's Ten-Year Plan. These strategies include:

- General Obligation Bonds;
- Multi-Family Housing Bonds;
- Low Income Housing Tax Credits;
- Federal Home Loan Bank, Affordable Housing Program;
- Philanthropic Resources;
- Increases to state-appropriated housing funds such as the Housing Development Fund and the Housing Tax Check-off;
- Tobacco settlement proceeds allocated by the Delaware Health Care Commission;
- Federal Community Development Block Grant (CDBG) and HOME funds;
- Designation of a portion of an existing tax program such as Delaware's real estate transfer taxes to fund the development of housing for homeless persons; and,
- Reallocation of funds used to support institutions such as the state hospital to reflect the downsizing of those institutions and the movement of persons with mental illness and/or other disabilities into community settings.

All of these sources are available to Delaware and it is likely that a combination of sources will be necessary to accomplish the Plan. Currently a number of these sources are being used to address other affordable housing priorities. For example, most of Delaware's LIHTC funding in recent years has been used for the preservation of existing rental housing stock that is in need of rehabilitation. Much of the resources available from the LIHTC, CDBG, HOME and HDF have been used to preserve affordable housing for persons with incomes between 50% and 80% of median. While maintaining the current housing stock for people in these income ranges is important, these housing resources are rarely available for the populations whose needs are addressed by Delaware's Ten-Year Plan. People identified as chronically homeless or at risk of chronic homelessness generally have incomes less than 30% of median. Often they have no income or have only a government source such as SSI, SSDI or GA.

While LIHTC is the only major federal program for producing affordable housing, the program provides special challenges for producing housing for people at the lowest income levels. The program is not a viable alternative without some type of long-term rental subsidy in addition to the tax credits. Similarly, multi-family housing bonds can be used to develop affordable housing, but again without a long-term rental subsidy, the bond-financed housing cannot address the needs of those people with the lowest incomes.

A recommendation has been made that at least 25% of the available tax credits, as well as 25% of HOME and HDF funds, be set aside each year for the development of housing specifically for persons with special needs and incomes below 30% of median. However, funds to provide rental subsidy for each unit produced will be critical to the long-term success of the Plan.

General obligation bonds have not been used to develop housing in Delaware, but they have been used to build and expand institutions. As advocates have pushed for more community-based alternatives for people with disabilities, there is a need to look at general obligation bonds as a potential source of funding for housing alternatives for homeless persons and persons with disabilities. Quality community living is only possible if there is a safe, decent, affordable place in the community for a person to live.

A mixture of funding streams, including bonds, federal tax credits, and state dollars will have to be pursued and committed to if Delaware's Ten-Year Plan is to be implemented.

Operating and Supportive Services Cost Strategies

Both operating and supportive services costs will be best addressed by maximizing access to mainstream resources that improve income and healthcare benefits for homeless persons with special needs. Strategies to maximize entitlements include:

Maximizing Mainstream Resources

- Case management that ensures that persons eligible for SSI and Medical Assistance make timely application for benefits by educating them about eligibility criteria and methods of application and assisting them to ensure that they follow through. Although

SSI is not enough to pay rent in Delaware, it does provide increased income to the household and increases the amount that each individual can contribute for rent. Medical Assistance opens up an array of supportive services options including mental health care and medication, not as widely available to persons who are uninsured;

- Assistance to ensure that homeless persons and persons in the target populations receive all public benefits to which they are entitled (e.g., food stamps, mainstream public housing assistance, etc.);
- Employment support to persons who can work where doing so would increase their income and the portion of rent they can pay; and,
- Advocating for the passage of Medicaid Buy-In Legislation, currently being promoted by the Governor's Commission on Community-Based Alternatives to Institutionalization for People with Disabilities. Medicaid Buy-In allows persons with disabilities to go to work full time while purchasing the continuation of Medicaid benefits. This enables people to work without losing critical aspects of their healthcare, such as prescription drug benefits and access to services available only to Medicaid recipients.

The Shift from Institutional Services to Community-Based Services

As public institutions in Delaware have downsized over the last 20 years, for many complex reasons, a disproportionate share of the resources have remained tied to the institutions. Since 1980, the size of the DPC, the only state hospital for persons with serious mental health conditions in Delaware, has decreased from 1,500 beds to approximately 235 beds. Between 1985 and 2005, some funds were allocated to the development of housing alternatives in the community: 121 group home beds and 82 supervised apartment beds have been developed, providing alternative housing arrangements for 203 individuals. The facilities in which the DPC operates are in disrepair, and plans are underway to build a new hospital. A possibility for deriving resources to fund Delaware's Ten-Year Plan would be to add some of the costs associated with the one-time capital development of new housing to the bond issue, which will be used to fund the building of the new hospital. The addition of $10 million to that bond issue would allow the development of almost 25% of the housing units proposed in this Plan. Support from the Governor's Commission on Community-Based Alternatives to Institutionalization for People with Disabilities should be sought to extend their "money follows the person" initiative further to address the needs of persons with mental health and/or substance use disorders.

The annual cost per year to keep a person in the DPC is more than $170,000. At comparable costs of $72,000 per year for a licensed group home bed and $34,000 per year for a bed in a supervised apartment program, 5 new beds of supervised apartments or 2.4 group home beds could be developed for each state hospital bed that could be eliminated. While it is clear that there is not a dollar-for-dollar exchange, i.e., certain fixed costs related to hospital infrastructure will not be reduced as each person leaves by the entire amount of current annual cost per person. Money that is saved by reducing the use of inpatient hospital beds – both long term and acute care – could be used to develop and support the operation of permanent supportive housing beds that have been demonstrated to keep people out of less expensive forms of care.

Housing Vouchers

The DICH is recommending increased state funding be appropriated to create a state-operated voucher program. The current federal voucher program has long waiting lists and only a small percentage of vouchers become available each year. However, each local housing authority and other housing jurisdictions could allocate some portion of their federal Housing Choice Vouchers to offset the operating costs of some of the proposed projects.

Delaware Health Care Commission

As did many states, Delaware received a significant monetary settlement related to lawsuits against big tobacco companies. Most of the funds received from that source went to fund prescription drugs for elderly persons and persons with disabilities who were ineligible for Medicaid. However, the Delaware Health Care Commission (DHCC), which allocates and administers the funds, has made grants for residential substance use and homeless services, including an outreach program operating in Sussex County and a transition house for persons who have completed detoxification and are waiting for a residential placement. In light of the recent implementation of Medicare Part D, which covers a significant portion of the costs of prescription drugs for elderly persons and persons with disabilities, some of the funds previously allocated to this use from the DHCC may become available for use in the development and operation of housing for homeless persons. An approach to the Commission regarding the use of any freed-up funds to support the development and operation for the projects aimed at the chronically homeless and persons with primary substance use conditions should be considered.

Reallocation of Existing Resources

The research described in the Plan clearly indicates that once permanent supportive housing alternatives are made available to episodically and chronically homeless persons with mental health and/or substance use conditions and other disabilities such as HIV/AIDS, there is a rapid and measurable decline in costs of other services such as emergency room use, inpatient psychiatric admissions, and emergency shelter utilization. Delaware's data already suggests a decline in state hospital use, acute care admissions, and emergency shelter use. In fact, during the three PIT surveys conducted in 2005 and 2006, emergency shelter use hovered below 80%. Domestic violence shelter utilization was even lower, at no more than 65%. More than 1,000 short-term motel vouchers are issued each year at significant cost, but they do little to address long-term homelessness. Restrictions on the resources that are used to fund these alternatives may limit consideration of their reallocation. However, the DICH should continue to assess the effectiveness of emergency shelter versus permanent housing, and should research the extent to which resources can be reallocated to end long-term homelessness.

Pooled Funding

Several other local jurisdictions, including Fairfax County, Virginia and King County, Washington, have pooled a wide variety of funding streams, such as those discussed in this chapter, to maximize the resources available in any given time period towards the implementation of their plans to end homelessness. The DICH will consider such options in the future. One possible option in this arena is to turn to Delaware's large faith-based community.

Many churches and other faith-based organizations in Delaware want to do something for homeless people. However, most of them lack the resources and the capacity to have the impact on the problem that they would like to have. Taking this Plan to them and asking each separate group to contribute something to its implementation might achieve a broader impact on the total problem of homelessness in Delaware.

Summary

In order to complete the development of new housing which is proposed in Delaware's Ten-Year Plan over the next ten years, estimated to have capital costs of $42,400,000, $4.2 million in capital funds per year will need to be allocated from among the variety of potential sources identified in this chapter. For the most part, these will have to be state and local resources, because Delaware has maximized its participation in most of the federal programs available for this purpose.

Assuming that 75% of the supportive services that will be offered to participants of the new housing will be paid for using existing mainstream resources, approximately $18 million in 2006 dollars will be needed at the end of ten years to operate all of the 2,003 beds of housing proposed in this Plan. This amount seems more manageable, however, if it is considered in terms of annual allocations of $1.9 million each year for ten years.

Annual Objectives

Annual Objectives for Implementation and Funding

In addition to monitoring data collected by the HPC to assess the impact of this Plan on the incidence and prevalence of homelessness in Delaware among the target populations, the DICH will also use the annual objectives detailed in the charts below to determine the extent to which the Plan is being implemented.

State Rental Voucher Program

	Recommendation	New Beds	Total Beds	Current Year Cost New Beds	Inflation Increase[1]	Cumulative Costs
Year 1 2008	Rental Vouchers					
	- Persons with MH/SA conditions	100	100	$720,000	n/a	$720,000
	- Youth aging from foster care	25	25	$180,000	n/a	$720,000
	Total	**125**	**125**	**$900,000**	**n/a**	**$900,000**
Year 2 2009	Rental Vouchers					
	- Persons with MH/SA conditions	200	300	$1,483,200	$741,600	$2,224,800
	- Youth aging from foster care	50	75	$370,800	$185,400	$556,200
	Total	**250**	**375**	**$1,854,000**	**$927,000**	**$2,781,000**
Year 3 2010	Rental Vouchers					
	- Persons with MH/SA conditions	200	500	$1,527,696	$2,291,544	$3,819,240
	- Youth aging from foster care	50	125	$381,924	$556,200	$938,124
	- Re-entering offenders	50	50	$381,924	n/a	$381,924
	Total	**300**	**675**	**$2,291,544**	**$2,847,744**	**$5,139,288**
Year 4 2011	Rental Vouchers					
	- Persons with MH/SA conditions	100	600	$786,800	$3,933,817	$4,720,617
	- Youth aging from foster care	75	200	$590,100	$966,268	$1,556,368
	- Re-entering offenders	100	150	$786,800	$393,382	$1,180,182
	Total	**275**	**950**	**$2,163,700**	**$5,293,467**	**$7,457,167**
Year 5 2012	Rental Vouchers					
	- Persons with MH/SA conditions	0	600		$4,862,265	$4,862,265
	- Youth aging from foster care	0	200		$1,603,059	$1,603,059
	- Re-entering offenders	50	200	$405,202	$1,215,587	$1,620,789
	Total	**50**	**1000**	**$405,202**	**$7,680,911**	**$8,086,113**
Year 6 2013	Rental Voucher	All	1000		$8,328,696	$8,328,696
Year 7 2014	Rental Voucher	All	1000		$8,578,557	$8,578,557
Year 8 2015	Rental Voucher	All	1000		$8,835,914	$8,835,914
Year 9 2016	Rental Voucher	All	1000		$9,100,991	$9,100,991
Year 10 2017	Rental Voucher	All	1000		$9,374,021	$9,374,021

[1] Annualized recurring costs for beds added in prior years plus 3% inflation.

Development and Other New Programs

	Recommendation	New Beds	Total Beds to Date	One Time Capital Costs	Operating /& Supportive Services Cost	Inflation Increase[1]	Cumulative Costs
Year 1 2008	New units permanent supportive housing - chronically homeless	20	20	$1,600,000	$561,120	N/A	$2,161,120
	Rental of existing units for SAP - persons with MH conditions	10	10		$341,100	N/A	$341,000
	Single point of contact entity - Respite beds	6	6		$485,000	N/A	$485,000
	Total	**36**	**36**	**$1,600,000**	**$1,387,120**	**N/A**	**$2,987,120**
Year 2 2009	New units permanent supportive housing - chronically homeless	20	40	$1,648,000	$577,954	$577,954	$2,803,908
	Rental - existing units for SAP - persons with MH conditions	10	20		$351,230	$351,230	$702,460
	Single point of contact entity - Respite beds	4	10		$86,667	$499,550	$586,217
	Total	**34**	**70**	**$1,648,000**	**$1,015,851**	**$1,428,734**	**$4,092,585**
Year 3 2010	New units permanent supportive housing - chronically homeless	20	60	$1,697,440	$595,293	$1,190,585	$3,483,318
	Rental - existing units for SAP - persons with MH conditions	10	30		$361,767	$723,534	$1,085,301
	Safe Haven/Sober Transitional Housing - persons with SAC	18	18	$1,303,652	$306,901	n/a	$1,610,553
	Single point of contact entity - Respite beds	2	12		$44,634	$603,803	$648,437
	Match for existing HUD SHP programs	0	330		$1,697,440	n/a	$1,697,440
	Total	**50**	**450**	**$3,001,092**	**$3,006,035**	**$2,517,922**	**$8,525,049**

[1] Annualized recurring costs for beds added in prior years plus 3% inflation.

	Recommendation	New Beds	Total Beds to Date	One Time Capital Costs	Operating /& Supportive Services Cost	Inflation Increase[1]	Cumulative Costs
Year 4 2011	New units permanent supportive housing - chronically homeless	40	100	$3,496,726	$1,226,304	$1,839,454	$6,562,484
	Rental - existing units for SAP - persons with MH conditions	0	30			$1,117,860	$1,117,860
	New units of rental housing for SAP-persons with MH conditions	10	10	$872,000	$267,718	n/a	$1,139,718
	Safe Haven/Sober Transitional Housing - persons with SAC	20	38	$1,495,391	$351,231	$316,108	$2,162,730
	Single point of contact entity - Respite Beds	0	12			$667,890	$667,890
	Match for existing HUD SHP programs	0	330			$1,151,396	$1,151,396
	Total	70	520	$5,864,117	$1,845,253	$5,092,708	$12,802,078
Year 5 2012	New units permanent supportive housing - chronically homeless	100	200	$9,004,069	$3,157,733	$3,157,733	$15,319,535
	Rental - existing units for SAP - persons with MH conditions	0	30			$1,151,210	$1,151,210
	New units of rental housing for SAP-persons with MH conditions	10	20	$898,160	$275,750	$275,750	$1,449,660
	Safe Haven/Sober Transitional Housing - persons with SAC	40	78	$3,080,505	$723,536	$687,359	$4,491,400
	Single point of contact entity - Respite beds	2	14		$47,312	$687,927	$735,239
	Match for existing HUD SHP programs	0	330			$1,185,938	$1,185,938
	New units supportive housing for youth exiting foster care	10	10	$523,200	$87,200	n/a	$610,400
	Total	70	520	$5,864,117	$1,845,253	$5,092,708	$12,802,078

[1] Annualized recurring costs for beds added in prior years plus 3% inflation.

	Recommendation	New Beds	Total Beds to Date	One Time Capital Costs	Operating /& Supportive Services Cost	Inflation Increase[1]	Cumulative Costs
Year 6 2013	New units permanent supportive housing - chronically homeless	100	300	$9,274,191	$3,252,465	$6,504,930	$19,031,586
	Rental - existing units for SAP - persons with MH conditions	10	40		$395,249	$1,185,746	$1,580,995
	New units of rental housing for SAP-persons with MH conditions	10	30	$925,105	$284,023	$568,045	$1,777,173
	Safe Haven/Sober Transitional Housing - persons with SAC	40	118	$3,172,920	$745,242	$1,266,912	$5,185,074
	Single point of contact entity - Respite beds	2	16		$48,731	$757,296	$806,027
	Match for existing HUD SHP programs	0	330			$1,121,516	$1,221,516
	Supportive housing for youth exiting foster care	0	10			$89,816	$89,816
	Total	**162**	**844**	**$13,372,216**	**$4,725,710**	**$11,594,261**	**$29,692,187**
Year 7 2014	New units permanent supportive housing - chronically homeless	0	300			$7,063,117	$7,063,117
	Rental - existing units for SAP - persons with MH conditions	16	56		$651,370	$1,580,995	$2,232,365
	New units of rental housing for SAP-persons with MH conditions	12	42	$1,110,126	$340,828	$877,630	$2,328,584
	Safe Haven/Sober Transitional Housing - persons with SAC	80	198	$6,536,215	$1,535,199	$2,072,519	$10,143,933
	Single point of contact entity - Respite beds	2	18		$50,193	$830,208	$880,401
	Match for existing HUD SHP programs	0	330			$1,258,161	$1,258,161
	Supportive housing for youth exiting foster care	0	10			$92,510	$92,510
	Total	**110**	**954**	**$7,646,341**	**$2,577,590**	**$13,775,140**	**$23,999,071**

[1] Annualized recurring costs for beds added in prior years plus 3% inflation.

	Recommendation	New Beds	Total Beds to Date	One Time Capital Costs	Operating /& Supportive Services Cost	Inflation Increase[1]	Cumulative Costs
Year 8 2015	New units permanent supportive housing - chronically homeless	0	300			$7,275,011	$7,275,011
	Rental - existing units for SAP - persons with MH conditions	0	56			$2,299,336	$2,299,336
	New units of rental housing for SAP-persons with MH conditions	0	42			$1,255,011	$1,255,011
	Safe Haven/Sober Transitional Housing - persons with SAC	17	215	$1,388,946	$326,230	$3,607,718	$5,322,894
	Single point of contact entity - Respite beds	2	20		$51,699	$906,813	$958,512
	Match for existing HUD SHP programs	0	330			$1,295,906	$1,295,906
	Supportive housing for youth exiting foster care	0	10			$95,285	$95,285
	Total	**19**	**973**	**$1,388,946**	**$377,929**	**$16,735,080**	**$18,501,955**
Year 9 2016	New permanent supportive housing - chronically homeless	0	300			$7,493,231	$7,493,231
	Rental - existing units for SAP - persons with MH conditions	0	56			$2,368,316	$2,368,316
	New units of rental housing for SAP-persons with MH conditions	0	42			$1,292,661	$1,292,661
	Safe Haven/Sober Transitional Housing - persons with SAC	0	215			$4,051,966	$4,051,966
	Single point of contact entity - Respite beds	5	25		$133,125	$987,236	$1,120,361
	Match for existing HUD SHP programs	0	330			$1,334,783	$1,334,783
	Supportive housing for youth exiting foster care	0	10			$98,143	$98,143
	Permanent supportive Housing - families with qualifying conditions	18	18	$552,000	$75,900	n/a	$627,900
	Rental of existing units for families with qualifying conditions	12	12		$80,000	n/a	$80,000
	Total	**35**	**1008**	**$552,000**	**$289,025**	**$17,626,336**	**$18,467,361**
Year 10 2017	See above	0	1008			$18,452,821	$18,452,821

[1] Annualized recurring costs for beds added in prior years plus 3% inflation.

Assumptions for Previous Chart

1. The costs are based on the implementation chart depicted in Chapter 3. For each year after FY2008, construction and recurring costs are increased by 3% per year to account for inflation.
2. Recurring program costs are increased by 3% each year.
3. The cumulative cost column to the far right depicts total spending need in any given year to achieve the implementation benchmark shown in the third column from the left. It includes one-time capital costs, that year's cost to operate new programs, and the annualized cost plus 3% needed to fund the recurring costs of all programs implemented in prior years.
4. All initiatives have been implemented by the end of FY2016; therefore, the total cumulative costs shown in FY2017 represent the total costs going forward to operate all of the programs. From FY2017 and beyond, the incremental increase in that total cost is assumed to be 3% per year.

Acronyms

SAC – Substance Abuse Condition
SAP – Supportive Apartment Program

Monitoring and Status Reports

Plan Monitoring and Status Reports

Oversight

Delaware's Ten-Year Plan lays the framework for ending chronic homelessness and reducing long-term homelessness. Integral to meeting this goal is diligent oversight of the Plan implementation, continued assessment of the needs of the homeless, regular measurement of success in meeting specific outcomes, adaptation of strategies and action steps to meet changing circumstances and reporting on the progress of the Plan. The DICH will monitor this work and establish the appropriate committee structure to achieve the Plan's strategies and objectives.

Status Reports

The DICH will serve as the government liaison and lead entity for the oversight of the implementation of Delaware's Ten-Year Plan and its future updates. The DICH will develop annual objectives and identify funding resources for monitoring purposes. It will also present quarterly and annual reports to the Governor on the progress made toward achieving goals stated in the Plan.

Data Collection

The HPC will continue to serve as the data collection entity, identifying the numbers of homeless persons in Delaware and the resources available to serve them. This will provide baseline data from which to determine the effectiveness of the Plan in addressing the prevalence of chronic and long-term homelessness. The DICH recognizes that the HPC is the coordinating entity for the statewide HUD CoC applications. The DICH will, through its DSHA staff support, and as long as such is feasible and appropriate, contract with the HPC for the data to support the Plan's revisions and updates.

Appendices

Executive Order Number Sixty-Five Creating The Interagency Council On Homelessness For The State Of Delaware

WHEREAS, the McKinney –Vento Homeless Assistance Act channels funds targeted to the diverse homeless population in Delaware through federal agencies, which administer programs for the homeless; and

WHEREAS, the programs authorized in the McKinney –Vento Homeless Assistance Act are administered by a number of state agencies and local governments and private agencies in Delaware; and

WHEREAS, state and federal support for services to the homeless is currently provided through the State of Delaware Grant-in-Aid program and several state agencies and local governments; and

WHEREAS, the Department of Health and Social Services and the Delaware State Housing Authority receive public funds for services targeted to the homeless which are carried out by private, non-profit service providers throughout the State; and

WHEREAS, the diversity of administrative and service provider agencies requires a coordinated effort to provide effective services and recommend solutions to the diverse needs of the homeless in Delaware.

NOW, THEREFORE, I, RUTH ANN MINNER, by virtue of the authority vested in me as Governor of the State of Delaware, do hereby declare and order the following:

1. The Delaware Interagency Council on Homelessness (the "Council") is hereby established.

2. The Council shall be composed of persons charged with the management of programs mandated and authorized by the McKinney –Vento Homeless Assistance Act in Delaware and persons currently charged with the management of other public funds targeted to services for the homeless in Delaware. The Council shall include representatives from appropriate administering entities within the following departments or agencies:

a. The Director of the Delaware State Housing Authority;
b. The Secretary of the Department of Health and Social Services;
c. The Secretary of the Department of Services for Children, Youth, and Their Families;
d. The Secretary of the Department of Labor;
e. The Secretary of the Department of Education;
f. The Commissioner of the Department of Correction;
g. The Chairs of the Senate Community/County Affairs Committee and the House of Representatives Housing and Community Affairs Committee;
h. The Mayor of the City of Wilmington or the Mayor's designee;

i. The County Executive of New Castle County or the Executive's designee;
j. The Mayor of the City of Dover or the Mayor's designee;
k. A person who is homeless or formerly homeless;
l. Three representatives from emergency housing and/or service providers, at least one of whom will represent the Homeless Planning Council; and
m. A representative of the Delaware Apartment Association.

3. Members of the Council, except those serving pursuant to paragraph 2g, 2h, 2i, and 2j above, shall be appointed by the Governor and shall serve at the Governor's pleasure. The Cabinet-level officials identified in paragraph 2 may be represented by designees, as necessary. The Governor shall designate a member or members to serve as Chairperson or Co-Chairs of the Council. The Council Chair(s) shall be individual(s) appointed by the Governor and shall serve at her pleasure.

4. The duties of the Council shall be:

a. to adopt and oversee the implementation of a plan to reduce homelessness and end chronic homelessness in Delaware;
b. to review data, activities and programs in the State of Delaware that provide housing services to the homeless;
c. to use the Homeless Management Information System and other non-duplicative methods of collecting such information for analyses;
d. to effectively coordinate and maximize resources of existing programs and activities to prevent homelessness and to assist homeless individuals and families;
e. to identify impediments, including any statutory and regulatory restrictions, to the effective provision of needed services to homeless persons in Delaware;
f. to recommend such changes in existing programs and services, expansion of existing programs and services, and additional programs and services as may be necessary to address the diverse causes and conditions of homelessness; and,
g. to ensure positive results and accountability of existing and new efforts and programs by shifting from funding programs to investing in solutions.

5. The Council may establish ad hoc committees as may be necessary and practicable to carry out the aforementioned duties.

6. Staffing for the Council shall be undertaken or coordinated by the Delaware State Housing Authority. The Council shall seek information and advice from service providers and research organizations as may be necessary and practicable to carry out the aforementioned duties.

Approved: March 8, 2005

A Special Acknowledgement

The Delaware Interagency Council on Homelessness thanks Cara Robinson and Catherine Devaney McKay for committing our thoughts and ideas to writing so that we could produce this document.

Members

James Baker	*Mayor*	*City of Wilmington*
Christopher Coons	*County Executive*	*New Castle County*
Carol Ann DeSantis	*Cabinet Secretary*	*Department of Services for Children, Youth, and Their Families*
Marian L. Harris	*Homeless Service Provider*	*House of Pride*
Saundra R. Johnson	*Chair, Director*	*Delaware State Housing Authority*
Gregory F. Lavelle	*Representative*	*House of Representatives*
Sheera M. Lipshitz	*Formerly Homeless Person*	*Brandywine Counseling*
Catherine D. McKay	*Co-Chair, HPC Representative*	*Connections CSP, Inc.*
Vincent P. Meconi	*Cabinet Secretary*	*Department of Health and Social Services*
Richard Pokorny	*Veteran's Provider*	*Home of the Brave, Inc.*
Thomas B. Sharp	*Cabinet Secretary*	*Department of Labor*
David P. Sokola	*Senator*	*Senate*
Stephen R. Speed	*Mayor*	*City of Dover*
Stanley W. Taylor	*Commissioner*	*Department of Corrections*
Valerie A. Woodruff	*Cabinet Secretary*	*Department of Education*

Designees

Marguerite Ashley	*New Castle County*
Timothy Crawl-Bey	*City of Wilmington*
Truman Bolden	*Department of Services for Children, Youth and Their Families*
Richard Eakle	*Department of Labor*
Carlyse Giddins	*Department of Services for Children, Youth and Their Families*
Nailah Gilliam	*City of Wilmington*
Renata Henry	*Department of Health and Social Services*
Kimberly Hoffman	*Senate*
Cliffvon Howell	*Department of Health and Social Services*
Rosalind Kotz	*City of Wilmington*
Joanne Miro	*Department of Education*
Joseph Paesani	*Department of Corrections*
Carie Riley	*House of Representatives*
Dennis Savage	*Department of Health and Social Services*
Melissa Smith	*Department of Health and Social Services*
Maureen Tucker	*Department of Health and Social Services*

Working Group

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Linda Brittingham	*Christiana Care Hospital*
Carl Danberg	*Department of Justice*
Tony Davila	*Delaware Commission of Veterans Affairs*
Scott Felderman	*United Way of Delaware*
Gary Ferguson	*Christiana Care Hospital*
Sally King	*Sussex Community Crisis Housing, Inc.*
Lakena Hammond	*The Shepherd Place, Inc.*
Lottie Lee	*Department of Health and Social Services*
Diane Lello	*U. S. Department of Housing & Urban Development*
Ginny Marino	*YWCA Delaware*
David Mitchell	*Department of Safety and Homeland Security*
Marie Morole	*Sussex Community Crisis Housing, Inc.*
Elizabeth Olsen	*Department of Safety and Homeland Security*
Kirsten Olson	*Connections CSP, Inc.*
Cara Robinson	*Homeless Planning Council*
Ben Shamburger	*Social Security Administration*
John Teoli	*Ministry of Caring, Inc.*
Sue Weimer	*United Way of Delaware*
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Glossary

Affordable Housing: Housing is "affordable" when the occupant(s) pays no more than 30% of their total income on rent and utilities; or, if the occupant(s) owns their own home, they pay no more than 35% of their total income on their mortgage payment, insurance, taxes and utilities.

Area Median Income (AMI): The midpoint income for an area—half of all wage earners have a salary higher than the median, and half of all wage earners have a salary lower than the median.

Best Practices: Strategies, activities, or approaches that have been shown through research and evaluation to be effective and/or efficient in addressing homelessness.

Chronically Homeless: (*As defined by HUD*): An unaccompanied adult who has a disabling condition and had been homeless for a year or more or have had at least four episodes of homelessness in the past three years.

Community Development Block Grant (CDBG) Program: A HUD program authorized by the Housing and Community Development Act of 1974. The CDBG program provides eligible communities with annual direct grants that they can use to revitalize neighborhoods, expand affordable housing and economic development opportunities, and/or improve community facilities and services, principally to benefit low- and moderate-income persons.

Consolidated Plan: Required by HUD to apply for CDBG, HOME, ESG, and HOPWA funds, the Consolidated Plan serves four functions:

- A planning document for each state/community, built upon public participation and input;
- The application for funds under HUD's formula grant programs (CDBG, HOME, ESG and HOPWA);
- It lays out a 3-5 year strategy that the jurisdiction will follow in implementing HUD programs; and
- An action plan, which provides a basis for assessing performance.

Community Services Block Grant (CSBG): A federal block grant which provides assistance to states and local communities, working through a network of community action agencies and other neighborhood-based organizations, for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient (particularly families who are attempting to transition off of a state program.)

Continuum of Care (CoC): (*As defined by HUD*): A community plan to organize and deliver housing and services to meet specific needs of people who are homeless as they move to stable housing and maximum self sufficiency.

Corporation for Supportive Housing (CSH): CSH is a national organization that makes supportive housing understood, available, and effective. CSH provides high-quality advice and

development expertise; by making loans and grants to supportive housing sponsors; by strengthening the supportive housing industry; and by reforming public policy to make it easier to create and operate supportive housing. CSH works with partners to foster innovative approaches to supportive housing, and builds awareness and support for these new ideas.

DHA: Dover Housing Authority

DHSS: Department of Health and Social Services

DSAMH: Department of Substance Abuse and Mental Health

DSCYF: Department of Services for Children, Youth and their Families

DSHA: Delaware State Housing Authority

DOC: Department of Corrections

DOJ: Department of Justice

Emergency Shelter: (*As defined by HUD*): Any facility whose primary purpose is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless for a period of 90 days or less. Supportive services may or may not be provided in addition to the provision of shelter.

Emergency Shelter Grants (ESG) Program: A HUD program designed to help improve the quality of existing emergency shelters for the homeless, to make available additional shelters, to meet the costs of operating shelters, to provide essential services to homeless individuals, and to help prevent homelessness.

Episodically Homeless: People who cycle in and out of homelessness; this is included in the definition of chronic homelessness.

Extremely Low Income: Is defined as at or below 30% of the area wide median income.

Grant in Aid: Grant in Aid is an appropriation made by the Delaware General Assembly to support the activities of nonprofit organizations, which provide services to the citizens of Delaware. The purpose of Grant in Aid is to provide supplemental funding to service agencies and should not be construed as a sole source of funding.

Delaware Homeless Management Information System (DE-HMIS): A computerized data collection application designed to capture client level information over time in the characteristics and service needs of people experiencing homelessness, while also protecting client confidentiality.

HOME Investments Partnership (HOME): A HUD program that provides funds to local governments and states for new construction, rehabilitation, acquisition of standard housing, assistance to homebuyers and tenant-based rental assistance.

Homeless: (*as defined by HUD*):

- an individual who lacks a fixed, regular, and adequate nighttime residence; and
- an individual who has a primary nighttime residence that is-
    - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
    - an institution that provides a temporary residence for individuals intended to be institutionalized or
    - a public or private place designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Housing Choice Vouchers: A HUD program, usually administered by local housing authorities, that provides rental assistance. A household with a voucher usually has to pay only 30% of their income for rent and utilities. The vouchers cover the remaining housing costs.

Housing First: A consumer-driven housing model that offers permanent housing to those without homes. It is based on the belief that helping people access affordable permanent housing should be the central goal in ending homelessness. Housing First has an immediate and primary focus on quick access to and sustainability of permanent housing, and often is offered simultaneously with support services. The housing is not time-limited, and is not contingent on compliance with services or regulations.

Housing Opportunities for People with AIDS (HOPWA): A HUD program that provides states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with AIDS or related diseases and their families. Funds can be used to support acquisition, rehabilitation, conversion, lease, and repair of facilities, new construction, rental assistance, support services and operating costs.

Homeless Planning Council (HPC): The HPC of Delaware, established in early 1998 and incorporated in June 2000, is an active, cooperative coalition of public, nonprofit and private-sector organizations and individuals working together year-round to address issues related to homelessness. The primary goal of the HPC is to ensure a complete, statewide continuum of services for the homeless. The elements of this continuum of services are: outreach and assessment; emergency shelter; transitional housing; and permanent housing. Supportive services are required at each stage to help individuals and families move through the system and achieve long-term self-sufficiency.

Low Income: Households whose incomes are between 51% and 80% of the area median income (AMI), as determined by HUD, based on family size.

McKinney-Vento Act: The McKinney-Vento Act was enacted in 1987 to support the homeless. The law was reauthorized in July 2002 expanding the definition of homeless to include foster youth awaiting placement in a foster or group home. This guarantees that foster youth who are between placements will be granted school enrollment regardless of their immunization status or the availability of school records.

McKinney-Vento Education: The Education for the Homeless Children and Youth (EHCY) program is part of the No Child Left Behind Act and is more commonly called "the McKinney-Vento Homeless Education Program". The Act includes a number of provisions that help homeless students to enroll, attend and succeed in school.

McKinney-Vento Food and Shelter: The Emergency Food and Shelter National Board Program (EFSP) is a federal program administered by the Federal Emergency Management Agency (FEMA) to supplement and expand ongoing efforts to provide shelter, food and supportive services for homeless and hungry individuals.

Moderate Income: Households whose incomes are between 81% and 120% of the area median income (AMI), as determined by HUD, based on family size.

Notice of Funding Availability (NOFA): Published in the Federal Register to announce available funds and application requirements from a specific source. A HUD NOFA containing notices of funding availability for many grant programs all released at the same time is called the SuperNOFA.

Office of Community Services (OCS): A division of the Department of Health and Social Service, (DHSS), which allocates and monitors a large portion of state funds provided to fund the operation of emergency shelters and transitional housing.

Permanent Supportive Housing: (*As defined by HUD - in terms of their programs*) Permanent housing for homeless persons with disabilities is another type of supportive housing. It is long-term community-based housing, which includes supportive services for homeless persons with disabilities. The intent of this type of supportive housing is to enable this special needs population to live as independently as possible in a permanent setting. The supportive services may be provided by the organization managing the housing or coordinated by the applicant and provided by other public or private service agencies.

Point-In-Time Study: A one-day count of all homeless people in a defined area.

Public Housing Authority (PHA): There are five in Delaware – Delaware State Housing Authority, Dover Housing Authority, New Castle County Housing Authority, Newark Housing Authority, and Wilmington Housing Authority.

Runaway Homeless Youth Grant (RHYG): This Grant establishes or strengthens locally controlled community-based programs that address the immediate needs of the runaway and homeless youth and their families. Services must be delivered outside of the law enforcement, child welfare, mental health and juvenile justice systems. The goals and objectives of the Basic Center Program are to:

- Alleviate problems of runaway and homeless youth;
- Reunite youth with their families and encourage the resolution of interfamily problems through counseling and other services;
- Strengthen family relationships and encourage stable living conditions for youth; and
- Help youth decide upon constructive courses of action.

Safe Havens offer low-demand, indefinite-length-of-stay, supervised housing alternatives for persons with substance use and/or mental health conditions who need a place to stay that does not tie compliance with rules or service expectations to the maintenance of housing.

Section 811: A HUD program that provides capital grants and project-based rental assistance to non-profit sponsored housing developments for people with disabilities. It allows persons with disabilities to live as independently as possible in the community by increasing the supply of rental housing with the availability of supportive services. The program also provides project rental assistance, which covers the difference between HUD-approved operating costs of the project and tenants' contribution toward rent.

Section 202: This program is similar to Section 811, but funds elderly housing.

Supportive Housing Program (SHP): A HUD program that promotes the development of supportive housing and supportive services, including innovative approaches that assist homeless persons in the transition from homelessness and enable them to live as independently as possible. SHP funds may be used to provide transitional housing, permanent housing for persons with disabilities, innovative supportive housing, supportive services, or safe havens for the homeless.

Supportive Housing: Housing with services that enable participants to live more independently than they would otherwise be able to. The types of services depend on the needs of the residents. Services may be short term, sporadic, or ongoing indefinitely.

SuperNOFA: When several Notices of Funding Availability (NOFA) are released in one package at the same time it is often called a SuperNOFA. The HUD SuperNOFA, includes the Continuum of Care grants, which include programs such as the Supportive Housing Program and the Shelter Plus Care Program.

Supplemental Security Income (SSI): A federal financial benefit program sponsored by the Social Security Administration (SSA), available to financially needy individuals with disabilities who have been qualified by SSA as having a disability, which prevents them from engaging in productive employment.

Supportive Services: Services such as case management, medical or psychological counseling and supervision, childcare, transportation and job training provided for the purpose of facilitating the independence of residents.

Transitional Housing: A type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing. Generally, homeless persons may live in transitional housing for up to 24 months and receive supportive services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or coordinated by them and provided by other public or private agencies. Transitional housing can be provided in one structure or several structures, at one site or in multiple structures at scattered sites.

Unsheltered: Homeless people living in places not meant for human habitation, which may include streets, parks, alleys, parking ramps, part of the highway system, transportation depots, all night commercial establishments, abandoned buildings, marginal motels/hotels which are not normally operational, farm outbuilding and other similar places.

Veteran: One who has served in the armed forces.