A Proposal to Reduce Homelessness: Maine's Strategic Plan

A Report to Governor Angus King

Endorsed by his Subcabinet on Homelessness

Presented by the Senior Staff Committee to Reduce Homelessness

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Written by Michael R. DeVos, Chairperson

Senior Staff Committee to Reduce Homelessness

Mission Statement

Our mission is to work to end the cycle of homelessness in Maine through interagency collaboration, potential reallocation of state resources and increased access to immediate services, and development of new strategies. Using shelters as a point of contact, we will identify the service and housing needs of people who are homeless, provide immediate services, and create solutions needed to move people from homelessness to housing and self-sufficiency.

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Executive Summary

More Mainers are homeless than ever before. Homelessness increased steadily over the last decade and preliminary data from 2001 indicates it will rise again this year. While shelters have doubled their capacity since 1993, they regularly must turn people away at night due to lack of beds. As in other parts of the country, government decision makers did not set out with the objective of establishing a prevalent and persistent phenomenon of homelessness. However, our failure to take the steps necessary to reduce or eliminate homelessness has, in effect, served as policy which allowed the current situation to develop. No state agency in Maine, or elsewhere in the country, has drafted a comprehensive statewide plan to reduce homelessness. If we wish to reduce homelessness in Maine, we will need to adopt a new framework that promotes a more thoroughly planned strategy which integrates the efforts of key players, public and nonprofit.

Over a dozen separate consortium efforts have arisen in Maine to develop "finger in the dike" strategies to address different aspects of the homeless problem. Some bodies target issues of specific sub-populations of the homeless such as youth, some are geographically focused, and others represent constituency groups or prepare funding applications. Much valuable work has been done. As a result, Maine receives its share of federal funds for the homeless. Also, well-planned initiatives are being carried out for victims of domestic violence and homeless youth. Still, homelessness has risen dramatically despite the worthy activity of these groups. The presence of increasing homelessness in the face of these efforts demonstrates the need for a more cohesive strategy and a solid implementation plan.

Certain elements will play a major role in any effective strategy to reduce homelessness in Maine. We must increase the supply of affordable housing available to homeless people. We must increase access to mental health and substance abuse services for the chronic, disabled homeless. We must improve the link to income benefits for eligible members of the homeless population. We have known this for some time. However, understanding the basic elements does not necessarily lead to development of an effective strategy. The development of a successful strategy will require a planning effort that proposes solutions after rigorously analyzing why people go to shelters and what keeps them there. Our challenge is not insurmountable. Yet it will require a higher, unprecedented level of interagency cooperation, participation and responsibility.

Before presenting a strategy to reduce homelessness, this report provides an overview of the problem. The first section illustrates the nature of the problem through a description of the homeless population and the root causes of homelessness. We then highlight the problem here in the state of Maine through a review of data and interviews with shelter operators. This is followed by a brief discussion of the current efforts underway to address the homeless problem, along with some of the challenges faced by homeless individuals when they attempt to access housing and services. Finally, this report outlines a new strategy. The strategy section recommends a new organizational structure, a planning and evaluation process, resource allocation methods and public leadership to support this effort.

The highlights of this strategy are as follows:

- The first and essential step to reduce homelessness in Maine is to make a

public commitment from the highest levels of government. Due to the complex nature of the homeless population and their unique needs, we can only make real progress if the process to develop solutions to reduce homelessness is shared by the Maine State Housing Authority, the Department of Human Services, the Department of Corrections, and the Department of Behavioral and Developmental Services. A public demonstration by the four agencies to jointly develop solutions to address this problem would provide a positive and unequivocal signal to the public about the importance of this issue.

- Our major goal in the first year should be to develop a statewide action plan that reflects the combined effort of the state agencies working in concert with service providers who intimately understand the nature of the homeless problem. The challenge of reducing homelessness must be owned as a collaborative effort.

- To ensure we close the loop, the Commissioners will need to annually prepare a report that documents our progress with the homeless population during the term of the plan. Using this strategy, we can make Maine a better place to live for our most disenfranchised citizens.

Understanding Homelessness

We begin by providing a brief overview of homelessness today. To do this, we answer two questions: Who are the homeless and what caused them to become homeless? Since there is an extensive body of excellent research that exists on homelessness, we rely on studies and texts by national experts. This provides the best opportunity for a complete understanding of the nature of the problem. We will later find that homelessness in Maine is a microcosm of the national problem.

The face and scope of homelessness changed markedly beginning in the 1970's and has continued into the year 2001. While there was little public homelessness in the 1950's and 1960's, today we commonly see our less fortunate citizens congregating near shelters and soup kitchens or living on the streets. There has been a myriad of studies undertaken to estimate the size of the homeless population, its characteristics and the underlying causes for its growth. The following outline, which draws from several studies, is intended to provide a snapshot of today's homeless population.

In recognition of the emergence of a growing homeless problem, Congress passed the *Stewart B. McKinney Homeless Assistance Act* in 1987. The Act created a federal authority to coordinate efforts of twelve federal agencies, the Interagency Council on the Homeless. One of the first tasks of this body was to estimate the number of homeless persons. The original estimate was 600,000 people homeless on any given night.[1] This estimate has been updated to 750,000 on any given night or 2 million US residents on an annual basis as of 2001.[2] The Council estimated that 7 million different Americans experienced homelessness over a 5 year period during the Clinton Administration.[3]

The Council on the Homeless describes the homeless population as falling into two categories. The first category is people who experience episodic disruptions in their lives brought about as a result of living in poverty. The second category, who tend to experience more chronic homelessness, are individuals with disabilities. The common disabilities cited are severe mental illness or addiction disorders, caused by drug and/or alcohol abuse.[4] Although this simplification is useful in grasping the big picture of homelessness, we gain a deeper understanding by examining data on the homeless population and the attributes of the sub-populations of the homeless.

The majority of the homeless population, roughly 70%, is comprised of adult males.[5] The more urban the setting, the higher the proportion of males.[6] Three out of every four homeless men have a history of institutional stays, including foster care homes, correctional facilities, mental health facilities or inpatient chemical dependency treatment.[7] Approximately 45% of shelter occupants have mental health problems while 60% of homeless adults have a drug or alcohol dependency problem.[8] Although the majority of shelter residents are males, there are increasing numbers of women, youth and families among the homeless. [9]

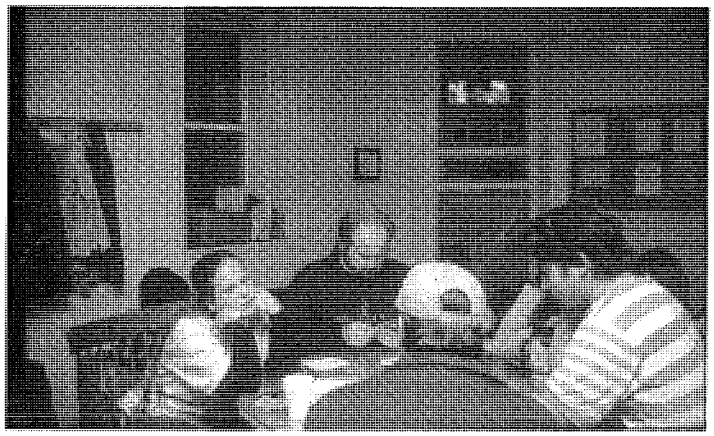
The 1998 US Conference of Mayors identified families, the fastest growing segment of the homeless population, as now comprising 38% of the homeless problem.[10] A significant portion of homeless families experience domestic violence.[11] Another rapidly growing segment is the working poor. Maine's data corroborates the emergence of these two segments. One segment of the population that researchers have found difficult to measure is homeless youth. Estimates range from 500,000 to 1.5 million.[12]

The National Center for Disease Control estimates that homeless youth (12-17 year olds) comprise 7.6% of homelessness.[13]

Several studies list the common denominator across the homeless sub-populations as extreme poverty. This defining characteristic of the homeless is also a principal cause of homelessness. Before exploring the causes of homelessness, we need to more closely examine the specific attributes of the sub-populations of the homeless.

Families

Family homelessness is increasing rapidly, both nationally and in Maine. The typical homeless family is made up of a homeless mother with 2 children under the age of 5.[14] They are extremely poor with income significantly below poverty level. The mother has limited earning power, low job skills, and limited education. She is often overwhelmed at the prospect of arranging for childcare. Frequently, the mother is a victim of domestic violence.



Families only reach the shelter system as a last resort. The mother often has been working sporadically at a low wage service job.[15] A 1996 study showed that many families moved 3-5 times in the year before entering a shelter, often doubling up with family or friends in their attempt to avoid shelters.[16]

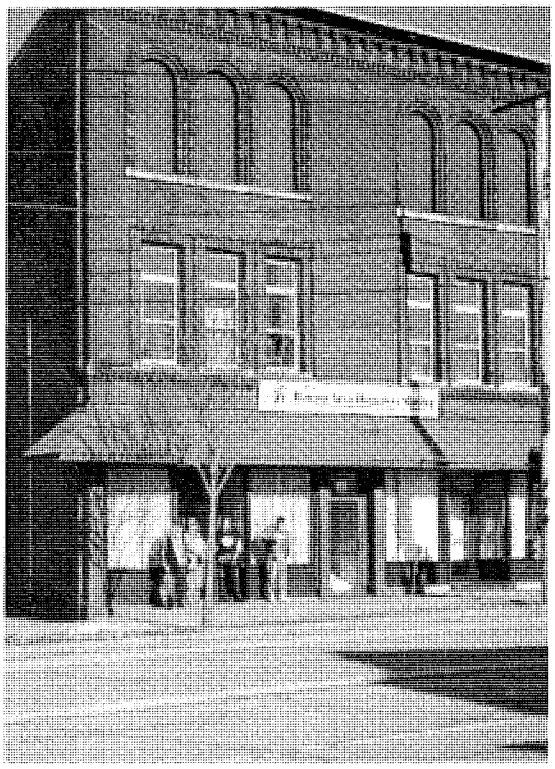
Extreme poverty and shelter experiences have devastating effects on families and children. Homeless children are more likely to have delayed immunizations, elevated levels of lead in their blood, high rates of developmental delays and emotional/behavioral difficulties. Homeless children are more likely to be expelled from school or retained in the same grade.[17] The Interagency Council estimates that one third of homeless children are not attending school on a regular basis.[18] A 1996 study shows that homelessness can cause dissolution of the family. Some families willingly place their children with others to allow them to avoid the shelter. Others lose their children to the foster care system.[19]

The two primary reasons cited by researchers for the increase in family homelessness are domestic violence and the inability to pay rent.[20] The underlying causes for a woman's inability to pay rent are the erosion of public welfare benefits and the decline of marriage by extremely low income women with children. In 1969, 16% of this population had children. By 1989, 31% of this population had children.[21] This increase in the number of extremely low income households of single women with children has been cited as a reason for the increasing numbers of homeless families in shelters. [22]

Researchers agree that families need housing, daycare, job training and job placement to exit the cycles of homelessness. Families that have experienced the trauma of domestic violence need an even more intensive array of services. Given the rise in family homelessness, we will need to develop appropriate service solutions for this subpopulation.

Mental Health

There is no question that people with severe mental illness comprise a significant proportion of the homeless population. The Department of Health & Human Services estimates one third of the homeless have severe mental illness.[23] The General Accounting Office estimates that a total of 45% suffer from mental health problems.[24] Yet according to the Federal Task Force on Homelessness and Severe Mental Illness, only 5-7% of homeless persons with mental illness need to be institutionalized; most can live in the community with appropriate supportive housing options.[25] It is important to understand why this sub-population represents an intransigent presence in the shelter population if we are to make headway in reducing this population's role in the shelter system.



Professor Christopher Jencks describes the de-institutionalization of mentally ill and the effects on homelessness in his book, The Homeless. The majority of de-institutionalization, which occurred in the 1950's and 1960's, had very little impact on homelessness. Jencks describes several rounds of de-institutionalization. In the late 1950's, the advent of drugs, particularly Thorazine and Lithium, made outpatient treatment easier at a time when psychiatric professionals were beginning to condone patients leaving institutions. This round of de-institutionalization created little homelessness as there was adequate inexpensive housing available and the highest functioning adults left institutions. In 1965, Congress set off the second round of de-institutionalization when it established Medicaid. Medicaid would not cover people in a mental hospital, but would cover short term psychiatric care in general hospitals or nursing homes. States transferred many patients to nursing homes. Again, there was little effect on homelessness. Congress initiated a third round of de-institutionalization by establishing Supplemental Security Income (SSI) in 1972. Patients of state mental hospitals became eligible for these benefits upon discharge, giving states a financial incentive to move the mentally ill out. Between 1965 and 1975, the number of adults in state mental hospitals dropped by 60% with little noticeable increase in homelessness. Inexpensive housing was still plentiful. The SSI benefit was as high as it would ever be in terms of buying power for the disabled. The final round of de-institutionalization began in 1975 when the Supreme Court ruled that mental illness alone was not grounds for involuntary commitment. With the end of involuntary commitment, the population in institutions dropped by 54% over the next 15 years. During this period, a significant number of inexpensive housing units were destroyed through urban renewal, SSI lagged inflation and rents rose faster than inflation. As a result, by the late 1980's, people with severe mental illness became a significant and chronic portion of the homeless population.[26]

Additional insights into the strong correlation between homelessness and the disabled, mentally ill are offered in Down and Out In America by Peter Rossi, one of the best quantitative studies on the subject. Rossi compares extremely poor people who have a place to live with homeless persons and finds that individuals with chronic mental illness or severe alcoholism are more vulnerable to homelessness.[27] Rossi states that "the disabled are least able to negotiate successfully the labor and housing markets, to use the welfare system, or to obtain support from family."[28] Rossi presents compelling evidence that few of the homeless participate in the welfare programs they appear to be eligible for. For example, only 22% receive General Assistance and less than 7% receive SSI or SSDI.[29] Of note, over 70% applied for benefits and most were turned down or later terminated.

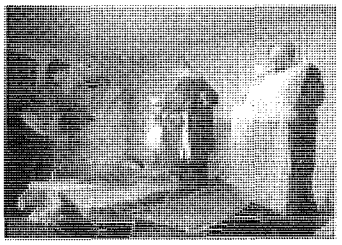
Procuring income benefits for the homeless mentally ill is critical. A study of homeless mentally ill shows that 50% exited homelessness within three months of receiving Social Security Disability.[30] Currently, it is estimated that less than 3% of the homeless mentally ill receive their entitled disability benefit.[31] One of the major recommendations from Rossi's study is to make enrollment of chronically mentally ill in the disability support net easier.[32]

A thesis put forward by researchers of the homeless mentally ill is that homelessness is both an effect and a cause of serious mental illness. As individuals spend prolonged periods of time living on the street, some "seek refuge in alternative realities."[33] However, one observation from a study of 170 homeless street people by Snow and Anderson is that focusing on disabilities and imperfections can lead one to view the homeless with stereotypic characterizations. We tend to see them as individuals who are disabled and in need of medical curatives rather than as individuals coping with the direst of circumstances. The study's point is that "the disabilities or pathologies we tend to associate with individuals are not always so much attributes of individuals as attributes of disabling situations. If the presumably troubled individual is removed from the disabling context or the context is repaired, the disabilities often disappear or at least lose salience."[34] People who spend prolonged periods living on the streets cannot help but have doubts about their self worth. As one subject stated, "It's real hard to feel good about yourself when almost everyone you see is looking down on you."[35] Yet, the study documents in detail the resourcefulness and resilience of the homeless disabled as they make their way in the face of extraordinarily difficult circumstances.

Inadequate access to affordable housing and jobs along with a reduction in public benefits are cited as major causes of homelessness for this sub-population. Snow and Anderson go further, stating that our shelter system is accommodative rather than curative. The homeless do not receive the necessary support and services they need to cycle out of homelessness.

Addiction Disorders

The Federal Interagency Council on Homeless states that 60% of homeless adults have past or current alcohol or drug use problems. Three studies found that about one half of the homeless population had histories



of alcohol abuse or dependence and about one third had histories of drug abuse or dependence.[36] This phenomenon of addiction disorders is also cited as both a cause and effect of homelessness. A statistical analysis of homeless street people documents the direct correlation between the increasing use of

alcohol and drugs and the length of stay in homelessness.[37] Street culture is one that increases the prospects of alcohol and drug use. The researcher found that "alcoholism and mental illness sometimes function as means of coping psychologically with the traumas of street life".[38]

Many homeless people are dually diagnosed. About half of those with serious mental illness also have substance abuse disorders.[39] Additionally, alcohol abuse and dependence are often combined with the use of illicit drugs.[40]

The phenomenon of increased drug and alcohol use is not limited to adults. There is clear documentation of disproportionately high rates of substance abuse problems among homeless youth as well.[41]

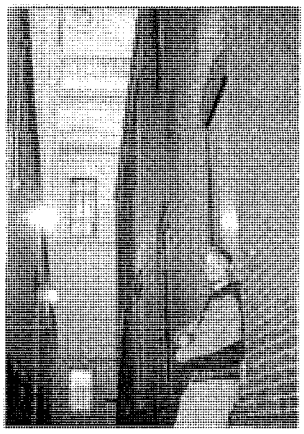
As stated earlier, homeless individuals with disabilities have a remarkably difficult time negotiating the public systems from which they should be receiving income benefits and services. These same people have difficulty successfully negotiating the job market and a tight housing market. At the same time, there are a number of studies that show people with disabilities can exit homelessness when given the appropriate services and income support.[42] One of Rossi's recommendations is to create an easier enrollment process into the disability safety net for long term substance abusers. This recommendation is bolstered by his study of two control groups; a control group which received income support in the form of general assistance has much lower homelessness than a control group without income support.[43] Unless we institute this change, we can expect persistent and chronic homelessness among a significant number of individuals with addiction disorders.

Researchers state that a reduction in the number of homeless people with addiction disorders can be achieved by offering appropriate supports. People with mental illness and addiction disorders have similar needs: outreach and engagement, case management, income support, a range of supportive housing, and treatment options. Evidence shows they are willing to use these services.[44] There are challenges to bringing those necessary supports to people with addiction disorders. In 1996, a law passed that denies Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) disability benefits and, by extension, access to Medicaid, to people whose addictions are considered to be a cause of their disability status. This action increased homelessness; two thirds of those who were paying for their own housing who lost their benefits as a result of this law have also lost their housing.[45] Another significant challenge is the lack of a federal program that targets funds to services for homeless people who have addiction disorders. The main source of federal substance abuse treatment funds, the Substance Abuse Prevention and Treatment Block Grant, does not target funds to homeless people.[46] Services alone, however, will not be sufficient to remove disabled individuals from the shelters. A 1996 study shows that housing vouchers, not intensive case management alone, improved housing outcomes.[47] And, even with vouchers, there must exist an adequate supply of appropriate housing options in which these people can live.

Homeless Youth

The Department of Health and Human Services estimates that 2.8 million youth run away in a given year.[48] A significant portion end up homeless with estimates ranging from 500,000 to 1,500,000.[49] This is another segment of the homeless population that is growing. The National Center for Disease Control defines homeless youth as single individuals, aged 12 to 17.[50]

The most common causes cited for youth becoming homeless are family conflict and physical and sexual abuse.[51] Studies of homeless youth show an incidence of physical abuse in the family of origin ranging from 40% to 65%. Studies of homeless youth show an incidence of sexual abuse ranging from 17% to 35%.[52] Two additional causes are cited which link homelessness to underlying family poverty. The first is family dissolution brought about due to economic crisis. The second is "residential instability"; it is well documented that homeless youth often come from families experiencing multiple moves in the year prior to homelessness.[53]



Several studies document the profound effects of homelessness on youth. They experience depression, conduct disorder and post traumatic disorder at three times the normal rate.[54] There are high rates of emotional and mental health problems. "Rates of serious disorders assessed with standardized instruments with diagnostic criteria range from 19 to 50 percent.[55] Another study documents the direct relationship that exists between substance abuse and time spent on the street. The longer a youth is homeless, the higher the probability he or she will use drugs.[56] Additionally, and of equal concern, youth become more likely to engage in criminal activity as their time on the street increases.[57]

There are a number of long term effects to youth that remain homeless. One study shows that 42% of homeless youth were physically assaulted and another 12% were sexually assaulted while living on the streets.[58] And as adults, runaways have higher rates of mental disorder, divorce and arrest than non-runaways.[59]

As stated above, many youth also develop addictive disorders while homeless. Due to the stresses involved with living on the streets, youth exhibit high levels of suicidal behavior.[60]

It is possible to seriously mitigate the effects of homelessness on youth. This requires a comprehensive array of services including housing, education, vocational training, health care, mental health care, substance abuse services and legal assistance. Researchers recommend early intervention at shelters.[61] It is also necessary to work at intervention before youth reach the shelter. An extraordinarily high number of youth who end up in shelters come from institutional care: foster care homes, criminal justice and psychiatric hospitals.[62] Experts recommend three strategies to prevent homelessness for this population: discharge planning, aftercare tracking and expanding next step residential options. The intent of these strategies is to ensure that youth are placed in appropriate residential settings and monitored to assure suitable services are provided.

Single Unattached and Working Poor

Our final category of the homeless population is single unattached individuals and the working poor. Clearly, there is crossover between this category and the sub-populations listed above. Since the homeless do not fit into neat little boxes, this catch-all category is a convenient device to discuss the balance of the homeless not listed above.

The vast majority of the homeless are single; the Interagency Council provides an estimate of 75% of the homeless population.[63] Of course, many of these unattached singles fit into the sub-populations listed above: mentally ill, people with addictive disorders or homeless youth. Although we do not know the exact size of the nondisabled, adult single population, it would appear to be less than

20%. Although the majority of single homeless are males, the percentage of homeless women has been increasing since the mid 1980's.[64] This is a disturbing trend. Homeless women face extreme hazards. The vast majority of single women who have been on the streets for longer than 6 months have been assaulted and/or raped.[65]

Single unattached homeless share one common denominator: they are extremely poor. Another common attribute is the absence of income support. Research shows that few participate in welfare programs.[66] A characteristic that has remained consistent over time is the core presence of homeless veterans. Estimates show forty percent of homeless men are veterans.[67] Additionally, a small percentage of the single homeless are elderly.

An increasing phenomenon among the homeless is the emergence of individuals who are working, but whose income is at a level where they are unable to support an apartment. There are estimates that up to 40% of the homeless work nationwide.[68] Although this fact seems counterintuitive, it is easily explained when we examine the causes of homelessness.

Causes of Homelessness

The Interagency Council distinguishes between risk factors and causes of homelessness. Risk factors are attributes of families or individuals that increase their probability of entering homelessness. They are not the cause of homelessness, but a characteristic of a family or individual that increases the likelihood that homelessness will occur.

Poverty is the most dominant risk factor. Psychiatric disability, substance abuse and domestic violence are all significant risk factors. Institutional confinement in jails, prisons or psychiatric hospitals is a risk factor as is one's "aging out" of foster care.[69] Risk factors among youth also include residential instability, physical or sexual abuse and family dissolution.[70]

Researchers often refer to the causes of homelessness as "structural" or "underlying". Typically, they are referring to economic or policy changes that have occurred on a societal level which directly contributed to the rise in homelessness or increased the prospects for at least some element of our society to become homeless. Although there are a multitude of studies and books that speak to the causes of homelessness, there is consistency in their findings.

The findings provided in several books and studies can be presented as the following five causes of homelessness:

1. Extreme poverty brought about through:
   (a) Changes in the labor market
   (b) Reduction in the real dollar value of public benefits
   (c) Changes in marriage patterns
2. Rents in the 1970's and 1980's rose faster than income
3. De-institutionalization of the mentally ill
4. Insufficient supply of affordable housing
5. Poor links between existing government resources and the homeless or near homeless

Following is a brief review of these causes:

Extreme poverty is generally considered the primary cause of homelessness. Three factors, which occurred in the last 25 years, contribute to the increase in extreme poverty: changes in the labor and wage market, the reduction of the real dollar value in public benefits and changes in marriage patterns.

America's job market has changed. The Interagency Council on the Homeless cites America's transition from a goods production economy to service production with its displacement of workers and simultaneous reduction in real wages as a contributing factor.[71] Researchers have documented that the demand for unskilled and semiskilled workers declined in the late 1970's and 1980's.[72] Additionally, and perhaps of more consequence, the demand for day laborers has significantly declined.[73] Thus the job opportunities for those most likely to become homeless are vanishing.

Almost any study that discusses the causes of homelessness cites the reduction in the real dollar value of public benefits. The Interagency Council states the reduction in monthly state benefits declined from $799 in 1970 to $435 in 1992.[74] Another study shows that the real dollar value of AFDC (now TANF) decreased 63% from 1968 to 1985.[75] Two prominent national homeless advocacy organizations cite a reduction in public assistance as one of the three principal causes of homelessness.[76] Few would question the relevance of the decline in value of public assistance as a contributing factor. There is ample evidence to show the significance of income supplements in keeping poor people off the streets.[77]

In The Homeless, a landmark text on the subject, Jencks presents data that ties changing marriage patterns to increased family homelessness. In a period of twenty years, from 1969 to 1989, there was a significant decline of marriage by extremely low-income women with children. In 1969, 16% of this population had children. By 1989, this number had increased to 31%. This rise in poor single mothers with children corresponded with increased homelessness.[78]

Researchers agree that the growing disparity between rents and wages was a principal cause of the rise in homelessness. An analysis of rents by the Joint Center of Housing Studies at Harvard University shows that "real rents in unsubsidized units rose 11 percent between 1973 and 1979, and another 20 percent between 1979 and 1989".[79] The primary cause is not the increase in rents that occurred in the 1970's and 1980's, but the rate of change between rents and incomes. We will later see that this also holds true for Maine. In the 1970's and 1980's, rents rose faster than the rate of inflation. While tenants purchasing power remained flat between 1973 and 1989, rent claimed a growing share of it. The two best quantitative studies of homelessness show that this trend contributed to the increase in homelessness during this period.[80] During the period from 1973 to 1989 the rent burden (percentage of family income that must be spent on rent) for a family with income under $10,000 increased in real dollars from 49.5% to 68.1%.[81]

A third major cause of homelessness is the de-institutionalization of the mentally ill. Although most would agree that persons with mental illness can live in the community with appropriate supports, there is evidence from many studies that de-institutionalization created homelessness in the 1980's, and that even today, the disabled have an extraordinarily difficult time negotiating complex systems to secure services, benefits, housing, etc.

A fourth major cause cited in virtually all studies is the inadequate supply of affordable housing. The demand for low-income rentals exceeded supply by 4.4 million units in 1995. This imbalance has grown since that time.[82] The Section 8 voucher waiting list, an indicator of the need for affordable

housing, grew significantly in the 1990's. By 1998, the average waiting period for a Section 8 voucher was 28 months.[83] A contributing factor to the inadequate supply was the destruction of SRO housing and rooming houses which occurred in the 1960's and 1970's.[84] While 640,000 people lived in these residences in 1960, only 137,000 lived there by 1990. The Interagency Council states that only one of four eligible households with incomes of less than one half the area median income receives any rental assistance.[85]

The fifth and final major cause of homelessness is the inadequate link which exists between government services and the homeless. The difficulty that homeless people have securing government services has been documented at least since the late 1980's.[86] Also well documented is the fact that an inability to receive these services prolongs homelessness. However, there has been increasing recognition by the federal government of the need to make changes. Congress commissioned a study to examine the delivery of federal mainstream programs to the homeless in 2000. The GAO's report "Homelessness: Barriers to Using Mainstream Programs" was released in July 2000. The GAO found that "homeless people are often unable to access and use federal mainstream programs because of the inherent conditions of homelessness as well as the structure and operation of the programs themselves."[87] Further, they found that "fragmentation at the federal level also creates fragmentation at the local and provider levels."[88] Problems exist in securing and using food stamps, TANF, housing vouchers, employment training, SSI, federal Medicaid funds, mental health services and substance abuse services. Many specific examples of this phenomenon are offered. To obtain SSI, for example, the homeless person must complete a complex 19-page form, including questions about living arrangements, resources, income and medical history. Often this medical history must be collected from several emergency rooms. Successful completion may require several trips to the SSA office. This requires transportation. Documentation requirements are onerous for an individual with no place to store private papers or documents. Follow up communication is difficult. Most homeless applicants apply for SSI on the basis of a mental disability, which can prove problematic to diagnose. Applications that rely on substance abuse disorders are even more problematic.[89]

Summary

We have now examined the "nature of the problem": Who are the homeless and what caused them to become homeless? An understanding of the population and the causes of homelessness provides the background necessary to begin developing a strategy to reduce homelessness. The information presented above is drawn from a series of texts and studies performed over the last 15 years. The conclusions are directly applicable here in Maine. Although we have our idiosyncrasies, Maine's homeless situation is a microcosm of the national homeless problem. Before we move to solutions, we will present data on Maine's homeless problem.

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A., Ph.D. Page 6. 7-17-01 See also "Special Populations." Page 6.
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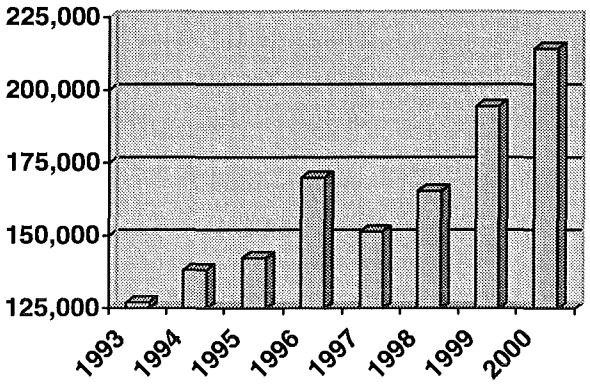
Maine's Homeless Problem

Homelessness in Maine increased significantly in the 1990's. The Maine State Housing Authority has collected occupancy data from 42 shelter facilities on a monthly basis since 1993. In 1993, homeless people spent 127,031 nights in Maine shelter beds. By the year 2000, this number had increased to 214,248. This represents an increase in homelessness of 69% from 1993 to 2000.[1] Although this data shows a rise in homelessness across the State during this period, more detailed analysis provides insights into trends in Maine's growing homeless problem.

The following graph charts the growth of Maine's homelessness over the last eight years.[2]

Maine's Homeless Data



With the exception of a spike in bednights due to a severe winter in 1996, homelessness has consistently increased over the last eight years. A breakdown of this data shows that the problem has increased universally across the entire State and especially in the City of Portland.[3]

Homeless Bednights

	1993	2000	Increase
Maine	127,031	214,248	69%
Portland	43,408	87,732	102%
Balance of State	83,623	126,516	51%

We can see that Portland's homeless problem has risen by 102% while the balance of the State has increased by 51% over the same period.

To better understand our homeless problem, including trends within specific sub-populations, we have additional data available to us. First, MSHA conducts a detailed survey at all shelters twice a year, in March and July. In the March 2001 survey, 1,471 guests were surveyed at the homeless shelters. This information, which comes directly from shelter residents, often proves insightful. The City of Portland's Department of Social Services maintains comparable data for review. The City of Portland conducts an annual point in time survey of its homeless population that provides useful data. The city also publishes annual reports for Portland's Family Shelter and Oxford Street Shelter. Finally, we interviewed operators of several shelters. Following are some of the key findings from these data sources.

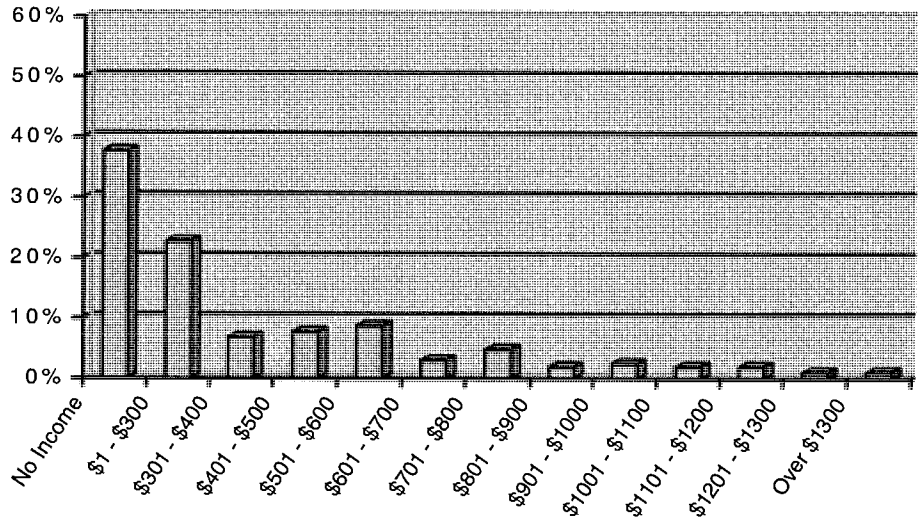
The March 2001 Homeless Demographic Data shows that 36% of the residents were female and 64% male. Although this may seem a high percentage of females, this

finding is consistent with the national trend of increasing homelessness for women. This is also not unusual for a rural state since rural populations have higher concentrations of homeless females than urban areas.[4] Approximately, 42.5% of residents in Maine shelters have not finished high school. The percentage of individuals under age 18 in Maine's shelters is 28.4%. Although high, this figure is also consistent with an increasingly younger homeless population nationwide. Elderly (over age 60) comprise 3% of the population, which is consistent with national data.[5] Maine's veterans comprise a lower than national average of 13% of the population.

Maine's homeless data bears out the national studies finding that extreme poverty is a primary cause of homelessness. More than one half of Maine guests stated they had income of zero dollars. The average income per household is $240.67 per month. Very few homeless persons are receiving public benefits. 10% of households receive TANF. 12% of households receive General Assistance. 21% of households receive food stamps. 29% of households receive SSI or SSDI. Data from the Portland shelters yields comparable results. Fully 60.4% of adults have incomes ranging from $0 - $300. According to the City of Portland, less than five percent of 207 people surveyed in Portland shelters would be able to afford a single room occupancy unit.[6]

Included here is a graph of the incomes of Portland's homeless population showing the correlation between extreme poverty and homelessness.

Homeless Income Range– Overall



Reasons shelter residents stated for homelessness also correspond with findings from national studies. The six top reasons cited by homeless persons in rank order are:

1. Housing costs too much
2. Lack of employment
3. Family Conflict
4. Substance Abuse
5. Mental Illness
6. Violence in household

These findings vary slightly from Portland's Oxford Street adult shelter, which lists the top four reasons for homelessness as:

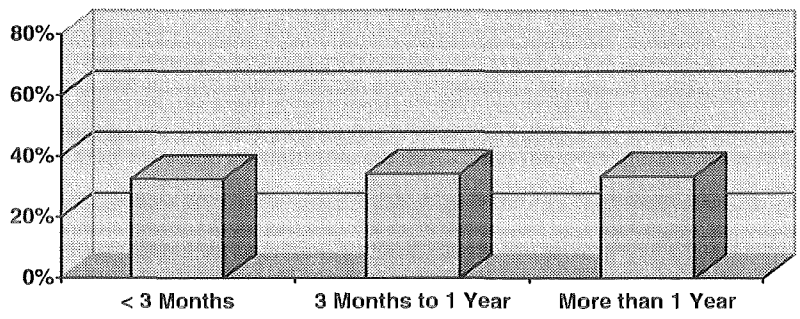
1. Housing costs too much
2. Lack of employment
3. Drug and alcohol abuse
4. Mental illness

It is also fairly clear from our information that mental illness and drug and/or alcohol abuse are contributing factors for some

respondents who identified housing costs or lack of a job as their reason for homelessness. The Oxford Street shelter annual report provides important insights in this area since it is an adult shelter with a capacity of 152 beds. The report states the shelter has two types of clients: people who have fallen on hard economic times and people who are chronically homeless due to mental illness and/or substance abuse problems.[7] This finding exactly mirrors the finding of the Federal Interagency Council on the Homeless.[8] The Oxford Street shelter report estimates their population with mental illness at 45%.[9] It should be noted that one of the authors of the report providing this estimate runs the shelter and is clinically trained. The Bangor Area Homeless shelter, the largest shelter north of Portland, also estimates their population as 45% seriously mentally ill. The Bangor Area Homeless shelter also claims that "historical statistics for our guests are in the range of 55%-75% mentally ill, chronic abuse of substances and/or dually diagnosed."[10] Meanwhile, only 16% of homeless guests receive mental health services.[11]

MSHA's March 2001 data shows that 51% of respondents state they suffer from a drug and/or alcohol dependency. The Oxford Street shelter study estimates that 41% of their population has substance abuse issues. When we compare this service need with services received, we find that only 16% of homeless surveyed receive substance abuse services.

Length of Homelessness - Adult



The homeless population is clear about what they need to leave the shelter. When asked the services they most need, the six highest ranked were:

1. Housing placement
2. Job training
3. Transportation
4. Health care
5. Case management
6. Mental health care

Interestingly, there also was a huge write-in contingency by 119 respondents for General Assistance income.

When we look at frequency and length of stay, we see a clear distinction between chronic shelter users and people who have fallen on hard times. Of the 1,470 shelter guests in March, two thirds were entering the system for the first time. As a result, the median length of stay statewide is 3 days. 75% of guests leave Maine shelters within one week of entering, although roughly 1/3 of homeless will re-enter the shelter on multiple occasions during the year. However, there is a core group of individuals who cycle in and out of homelessness. This remaining 1/3 of the clients had used shelters 2 to 5 times in the previous year. This chronic population is a major user group of the shelters. For example, 15% of the Oxford Street shelter clients represent 70% of the usage of the shelter.

Worse still, if we look at the pattern of homelessness in Portland we find that 33.3% have been homeless for 3 months to 1 year while an additional 22.4% have been homeless for more than 1 year. The fact that 55.7% of Portland's homeless people have been in shelters or on the streets for longer than three months is telling. Even more troubling is the

fact that 67.5% of adults have been homeless longer than three months.

Thus far, we have found that most homeless persons exit the shelters within 7 days but that a core group of people spends significant periods of time in shelters. We have also learned that a very large proportion of Maine's homeless have mental illness and/or substance abuse problems while very few are receiving services or public benefits. Data shows that the homeless problem has risen across the State and that Portland has experienced the most acute increase.

Further examination of data also shows us that adult occupancy of Portland shelters has increased 108% since 1993.

Family homelessness is also on the rise in Maine. Family occupancy of shelters has increased by 167%.[12] Two factors have been documented that contribute to these increases: the influx of refugee families and the rapidly increasing rents in the Portland market.

Refugees now represent more than 25% of the caseload at the Portland Family Shelter.[13] In an 11-month period, the shelter served 54 families of 263 persons from six countries. These families often need a complete array of services before they can exit homelessness. Cullen Ryan, Director of the Oxford Street Shelter, states that these families often take a year or more to place in permanent housing. Meanwhile, the Family shelter remains at 100% occupancy. A factor which contributes to these long family stays is Portland's tight housing market.

A 1999 study by Frank O'Hara of Planning Decision shows that the demand for affordable apartments in Portland exceeds the supply by more than 4,700 units.[14] As a result of increasing demand, the vacancy rate has dropped to historic levels. The City of Portland Housing Services Department has released a report stating the vacancy rate is 1%.[15] The result of such a tight housing market is escalating rents. This rapid increase in rents contributes to the historic levels of homelessness we are experiencing in the Portland area. And while the average rent in Portland from 1980 to 2000 has increased by 289%, wages have gone up only 132%.[16] This growing disparity between rents and wages in Maine mirrors a principal cause of homelessness nationally, as documented in the preceding section.

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[1] See data from monthly occupancy reports of shelters, 1993-2000.

[2] See data from monthly occupancy reports of shelters, 1993-2000.

[3] See data from monthly occupancy reports of shelters, 1993-2000. Also, see City of Portland Shelter Beds Usage 10 Year Comparison, 1991-2000.

[4] March 2001 Homeless Demographic Data. Page 2. June 28,2001. Also, see "Demographics and Geography: Estimating Needs." Burt, Martha R., Ph.D. Page 4. 7-17-01.

[5] March 2001 Homeless Demographic Data. Page 2. June 28,2001.

[6] See "2001 HUD Continuum of Care Point in Time Survey: Survey Results and Final Report." Ryan, Cullen, MA, City of Portland, Department of Health and Human Services—Social Services Division. - Relocation was listed as #4, however, we have omitted this as a reason due to concerns over the multiple definitions of relocation. Future studies will more clearly define this cause.

[7] See "Oxford Street Shelter Year End Report FY 2000." Duranleau, Robert and Ryan, Cullen. City of

Portland Department of Health and Human Services Social Services Division. Pages 5-6.

[8] "Face of Homelessness: No Longer a Poor Apart." Published by the Federal Interagency Council on the Homeless. Page 2.

[9] See "Oxford Street shelter Year End Report FY 2000." Duranleau, Robert and Ryan, Cullen. City of Portland Department of Health and Human Services Social Services Division. Page 5.

[10] See The Bangor Area Homeless Shelter letter from Dennis Marble, Executive Director to Michael Finnegan, Director MSHA, dated October 16, 2000.

[11] March 2001 Homeless Demographic Data. Page 7. June 28, 2001.

[12] See City of Portland Shelter Beds Usage 10 Year Comparison, 1991-2000.

[13] See Portland Family shelter report FY2000.

[14] State of Maine Housing Study – O'Hara, F. – Planning Decisions.

[15] See City of Portland Study.

[16] "No Quick Fix Seen for Rental Crisis." Richardson, John. Portland Press Herald. January 23, 2001.

*To assure accuracy, all statistics cited in this section were independently corroborated by four MSHA staff persons.

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The Bangor Area Homeless Shelter letter from Dennis Marble, Executive Director to Michael Finnegan, Director MSHA, dated October 16, 2000.

*To assure accuracy, all statistics cited in this section were independently corroborated by four MSHA staff persons.

Current Efforts and Needs

There are 42 shelter facilities operating 840 beds spread across the state of Maine. It is estimated that on any given night, approximately 1100 people are homeless in Maine. Over 500 residents sleep in Maine shelters each night. But shelters no longer view themselves as merely a place for homeless people to sleep; they serve as the entry point for individuals and families to receive the housing and support services they need to get back on their feet. A review of the current efforts of the shelters along with a review of other services needed to reduce homelessness provides insight into how we can begin to make a difference with this population.

Most shelters are operated by nonprofit organizations. As is typical of nonprofits, they must cobble together a variety of funding sources to fuel their programs. Two of the major funding sources for Maine shelters are Emergency Shelter Grant Funds (ESG) from HUD and Shelter Operating Subsidies from the Maine real estate transfer tax. As part of its ESG monitoring function, HUD recently conducted an audit of shelters nationwide, which documents services being provided by shelters. We use these findings and information from the HUD homeless funding applications from the City of Portland and State of Maine to document services being offered to the homeless.

Shelters typically provide a bed and meals to homeless persons. Shelter staff also either provide direct services or link people to additional services at other nonprofit organizations. Some of the services include areas such as employment, health, drug abuse and education. The following chart gives an indication of how active shelters are in offering services or links to services to homeless persons. [1]

Services Offered by ESG-Funded Providers, FY 91

Essential Services (beyond benefits)	Percent Offering Service
Assistance in obtaining benefits	94.2%
Assistance in obtaining permanent housing	92.2%
Assistance with daily living skills	86.2%
Transportation	79.1%
Support Groups	78.6%
Nutritional counseling	50.1%
Job referrals	69.8%
Child care	42.2%
Clothing	81.7%
Assistance in GED preparation	47.9%

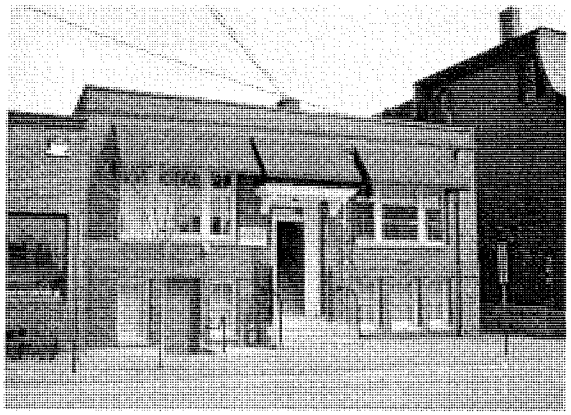
Certain services are considered critical to moving all people out of homelessness. The most prominent are assistance in obtaining housing, case management and benefits assistance.

Case management has emerged over time as one of the principal steps to moving people out of homelessness. Currently, 80% of the shelters surveyed state they either offer or require case management.[2] The benefits of case management in reducing homelessness are well documented and were delivered in a paper at the Department of Health and Human Services, discussed below.

Case management is comprised of six primary functions: client identification and outreach, assessment, developing a treatment and service plan, linkage to services, monitoring and client advocacy.[3] A principal reason a case manager is needed is to secure services from a fragmented and complex system. She brings knowledge of the system,

(often multiple systems) and an ability to wade through obstacles or barriers to secure the necessary resources.[4] Case management has proven effective for homeless families, victims of domestic violence and people with severe mental illness, substance abuse problems and dual diagnosis. There are different case management models tailored to each sub-population. What is critical here is that several studies have documented the ability of case management to reduce the amount of time people spent in homelessness.[5] Interestingly, only 33% of Maine shelter residents surveyed received case management services.

Case management is a particularly critical service for people with mental health problems. Maine's Continuum of Care application to the federal government states "case management is the primary service available to homeless persons in Maine and the key service that ensures movement along the continuum."[6] Yet, when we look at this from a shelter's perspective, it often takes too long for a "community support worker" to be assigned to a homeless person.[7]



Benefits assistance is another service to reduce homelessness. The data above shows that over 94% of shelters offer benefits assistance. However, our Maine data shows that only 12% receive General Assistance and that General Assistance was listed as a needed service by the homeless.[8] A national study shows that benefits assistance projects with good access to the targeted population can be successful.[9]

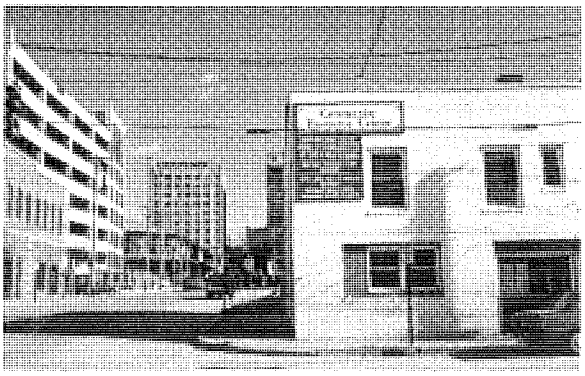
Housing Placement services are another key service needed. Research has shown this to be the single most important service to reducing homelessness. From the grid above, we see that 92% of shelters state they provide assistance with housing. Our March 2001 data shows, however, that only 23% of shelter guests stated they received help with housing.

Portland's application for homeless funding to HUD says that "homeless people are provided with whatever supports are needed to help them access resources for which they are eligible."[10] Further, the application says that "while there are insufficient resources to meet all the needs of every homeless person in the system, ... Portland has enjoyed considerable success in creating a comprehensive support network in which most significant needs are addressed."[11] The State of Maine homeless funding application to HUD states we have "developed a statewide strategy to both coordinate homeless assistance with mainstream programs (including Medicaid, TANF, Food Stamps, mental health services and substance abuse services), and to ensure that homeless individuals access appropriate mainstream resources."[12] Although these are admirable goals, using the three key services of housing placement, benefits assistance, and case management as indicators, we find that shelters often believe they are offering a service while a client believes it is not available.

There appears to be a gap between services offered and services needed by our homeless population. Clearly, the people living in shelters do not believe they are getting all they need to move out. Our data also suggests the same gap exists with other essential services including mental health and substance abuse services, transportation and

job training.[13] This is not to suggest that our system is doing poor work or that there have not been planning efforts to improve the situation for Maine's homeless population. In fact, there have been many. Included as Appendix A is a list of some of the existing planning efforts devoted to improving conditions for Maine's homeless population. Recognition that such gaps exist, however, begins the process of creating a system more responsive to the needs of Maine's homeless people.

In an effort to garner a clearer sense of the needs of homeless people, we conducted one on one interviews with the Directors and service staff from four of the major shelter providers in the state: Bangor Area Homeless Shelter, Preble Street Resource Center in Portland, Oxford Street Adult Shelter in Portland, and the Tedford Shelter in Brunswick. Certain common themes emerged. While these interviews provided valuable feedback, it is important to note that their statements regarding the characteristics of shelter residents are anecdotal and not necessarily derived from data collection and analysis. Following are salient excerpts from the interviews and correspondence.



At the Preble Street Resource Center, Director Mark Swann was joined by service staff member John Bradley. John is an LCSW and has a Doctorate in Social Work which enables him to understand clinical characteristics of their clients. Mark stated that most people who end up here are people who aren't working well with systems of care. John said that many of their clients fell into one of three categories. First are people who are suffering from psychosis and will not engage with outreach workers. Second are people that are dually diagnosed and do not currently qualify for Department of Behavioral and Developmental Services (DBDS) funding. The staff stated these homeless people often have substance abuse problems and may have tried unsuccessfully for years to get SSDI so they could access Medicaid. In the last category are chronic substance abusers that also would not qualify for DBDS funding. They estimated that one half of Preble Street guests suffered from substance abuse problems. They were not hopeful that this would change without a new resource. Mark stated that many homeless need to be able to access Medicaid funds if they are to move off the streets. He also said there are insufficient mental health case managers to handle the workload of homeless people with severe mental illness (SMI). John and Mark both concurred there is a strong need for permanent housing with services for homeless people with severe mental illness. They emphasized that the DBDS funding would need to be less restrictive than it currently is if individuals with SMI are going to be served in community based housing. They also cited a need for Single Room Occupancy (SRO) housing in Portland.[14]

Helen Hemminger is the Director of the Tedford Shelter in Brunswick. Helen stated that the wait for Community Support Workers (case managers) is now up to 4 to 6 weeks. She also said DBDS needs to restore funding to bring back a liaison between DBDS and the shelters. She recommended new housing for persons with severe and persistent mental illness funded by MSHA and DBDS. She suggested new housing for homeless teens in the care of DHS. She recommended MSHA adopt a more flexible policy for its vouchers so that they can be

used in a wider geographic area. She also asked for a new program to fund security deposits for homeless people who are unable to leave the shelter because they don't have enough funds saved up to move out. Last, Helen said the barriers homeless people encounter while attempting to secure income benefits keep them from getting back on their feet.[15]

Cullen Ryan runs the Oxford Street Shelter and works closely with the Portland Family Shelter. Cullen has an LICSW, a Masters Degree in Counseling and Psychological Services and extensive experience in clinical diagnosis. Cullen said that 23 people lived in his shelter year round in fiscal year 2000. He stated that many are psychotic and are often up screaming all night. He stated they might have posttraumatic disorder, thought disorders and/or psychosis. Cullen also estimated that 90% of the women in his shelter have chronic mental illness. Housing subsidies alone will not help them. He recommended that interagency cooperation between DBDS, MSHA, Shalom House and Ingraham could end homelessness for some people who have been living on the streets for more than 10 years.

Cullen emphasized that Portland is experiencing a housing supply problem and that MSHA needs to make more housing resources available. He recommended the construction of family units and supportive housing with DBDS services for chronically, mentally ill. Cullen also stated there was a need for more tenant-based rental assistance.

Cullen cited the overwhelming need for a source of non-categorical funding to help clients with severe mental illness. He shared an example of a building with four apartments that DBDS funded with services through Shalom as an extremely useful way to move people out of shelters. He stated that after one year, DBDS changed the project to Medicaid funding and due to Medicaid restrictions, the project was no longer helpful to Portland's homeless with severe mental illness.[16]

Dennis Marble, Director of the Bangor Area Homeless Shelter, was interviewed along with Tammy Hanson of Northeast Occupational Exchange, which provides substance abuse and mental health services. Dennis cited the most important need as noncategorical funds for homeless with severe mental illness combined with new housing dedicated to this population. Dennis and Tammy concurred that there were insufficient numbers of affordable units. In particular, they articulated the need for small units such as single room occupancy units or one-bedroom apartments. Currently, some people with mental illness who have housing vouchers must stay in the shelter due to a lack of units. Dennis also stated there is a tremendous need for housing for people with severe mental illness with non-categorical DBDS funding. Dennis and Tammy expressed a need for more tenant based rental assistance.

Dennis praised the DBDS Assertive Community Team (ACT) form of case management funded through medicaid. He stated it provides people a higher quality of life, helps them maintain housing, and keeps people out of hospitals. He estimated that demand for this method of case management exceeds supply by a ratio of 3 to 1. He strongly urged increasing this service. Dennis stated that most of his clients have mental illness and/or substance abuse problems. He estimated that 65% of the homeless population he serves are mentally ill.[17]

These four operators of homeless shelters were remarkably consistent. In sum, they emphasized needs in three areas. First, they feel that the chronically and persistently homeless population must have access to mental health and substance abuse services.

This includes both increased case management services and services that would follow the client into permanent housing. There was a general level of frustration that individuals that should be able to receive services cannot secure them. Second, they called for increased affordable housing of three types: production of small, inexpensive units such as SROs, special needs housing (particularly for people with severe mental illness) and tenant based rental assistance. Last, they asked for a system change that would make it easier for homeless clients to access income benefits and Medicaid funding when they are eligible. All who were interviewed stated that the inability to access Medicaid for many people was the barrier to moving out of the shelter into supportive housing.

One of the challenges with this information from the directors is the difficulty we have distinguishing between which service needs are unavailable due to poor linkage to providers and which are unavailable due to a lack of supply. This same problem exists when we look at the gap between the services offered by shelters and services needed by the homeless population. We can see that a gap exists, but we need to know whether the problem is one of linking the client to a service or creating a new service entirely. An attempt to evaluate when we should improve linkages versus when we should offer new services leads us to a discussion of a new strategy that would move us toward reducing homelessness.

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[1] "Emergency Shelter and Services: Opening a Front Door to the Continuum of Care." Feins, Judith D., Ph.D. and Fosburg, Linda B., Ph.D. Page 10. 7-17-01.
[2] "Emergency Shelter and Services: Opening a Front Door to the Continuum of Care." Feins, Judith D., Ph.D. and Fosburg, Linda B., Ph.D. Page 12. 7-17-01.
[3] "A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research." Morse, Gary, Ph.D. Page 3. 7-17-01.
[4] "A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research." Morse, Gary, Ph.D. Page 2. 7-17-01.
[5] "A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research." Morse, Gary, Ph.D. Page 9. 7-17-01.
[6] "Adapting Head Start for Homeless Families. Published by the Department of Health and Human Services Homeless Reports and Studies. Page 4. 7-17-01.
[7] "Reducing Homelessness, Reducing Nights of Emergency Shelter." Discussion & Notes from a meeting with Helen Heminger, a representative from MSHA, and a representative from DBDS. April 26, 2001
[8] Maine Continuum of Care.
[9] Maine March 2001 Demographic Data. Page 5 & 9.
[10] Letter from Helen Heminger. April 26, 2001.
[11] Maine March 2001 Demographic Data.
[12] Interview with Mark Swann and John Bradley.
[13] Interview and Letters dated April 26, 2001.
[14] Interview with Cullen Ryan.
[15] Portland 2001 Continuum of Care Funding Application. Page 21.
[16] Portland 2001 Continuum of Care Funding Application. Page 90.
[17] State of Maine 2001 Continuum of Care Funding Application. Page 22.

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State of Maine 2001 Continuum of Care Funding Application.

A Strategy to Reduce Homelessness

Maine's homeless funding application to the federal government articulates our vision for helping Maine's homeless: "that each individual in the State of Maine has barrier-free access to a comprehensive array of coordinated housing and supportive service options that maximize self-sufficiency and quality of life." Our strategy to fulfill this vision includes "the creation of a collaborative housing and service delivery system for all people who experience or are at risk of homelessness."[1] The development of this vision and its related strategy involved the hard work of many constituent groups including nonprofit service providers and government agencies. Additionally, forty-two shelters, several state agencies and a dozen or more planning bodies have dedicated staff and resources to develop other visions, strategies and goals to improve our ability to help the homeless. Most of these initiatives have been ongoing for several years and much good work has been done. Despite these efforts, homelessness has increased significantly and likely will continue to increase for the foreseeable future. The rapid increase in Maine's homeless bednights suggests that both our current method of assisting the homeless and the current system of developing strategies to help the homeless need improvement. The following proposal outlines an alternative approach that would lead us toward a reduction in homelessness.

To reduce homelessness in the State of Maine, we must start by identifying who will tackle this problem. A fundamental tenet of this strategy is the working premise that the problem of homelessness, and the challenge to reduce homelessness, must be owned by a broad base of constituents: state agencies, shelters, municipalities and an extensive network of non-profit service providers. We must own this problem collectively for no proposed solution can succeed without the combined efforts of all vested parties. And it is in the interest of Maine' s homeless people for us to agree on the broad based ownership of this challenge to reduce homelessness.

Enhancing our level of effectiveness will require a revision of the existing system of caring for the homeless. Currently, our system is comprised of a series of loosely related and disjointed government agency, nonprofit and planning body efforts. These initiatives often represent a narrow band of constituents, are isolated from other strategies, and may not have endorsement from policy makers. Clearly, stronger collaboration among the vested government agencies and nonprofit community to develop a detailed plan would improve the situation for Maine's homeless population.

Although a new approach to the homeless problem can build upon existing efforts, there are five core elements our strategy must incorporate to succeed:

- An organizational structure that promotes a higher level of interagency cooperation and participation, with inclusion of constituent provider groups
- A planning and evaluation process that assures local input and measures progress
- A resource development strategy
- Complementary public leadership
- Long term commitment

All five elements are key to success; they rely on one another to create an effective system, and the absence of any one of them will negatively impact the outcome.

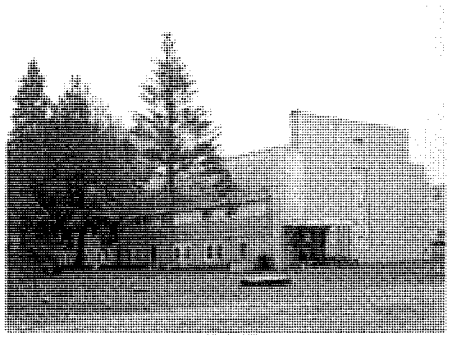
Organizational Structure

Certain elements must be in place for an organizational structure to succeed. First, the appropriate state agencies must be directly and continuously involved. Second, the structure must assure local input from vested constituent groups. Last, there should be geographic balance. Given the scope of work to be done, it will be critical for appropriate agency staff to be assigned within the organizational structure. A chart which depicts this structure is attached as Appendix B.

The Maine State Housing Authority, DOC, the DBDS and the DHS must be involved in any process that creates strategies to address Maine's homeless problem. To date, there has been no single agency or interagency body assigned responsibility for homelessness. MSHA is a core funder of the shelters, maintains shelter relationships, provides the affordable housing funds needed, and has acted as lead agency in this area for many years. DBDS has created several planning bodies examining homeless issues, controls much of the funding for behavioral and developmental health services, funding for substance abuse services, and targeted housing subsidies for eligible consumers. The Department of Human Services is very active on homeless planning bodies and controls funding for income benefits and services needed by most of the non-chronic sub-populations of the homeless. Although no single agency has responsibility, these four agencies are in a unique position to identify and document needs, develop and implement solutions, and monitor and evaluate outcomes.

It will be important to have a lead agency. However, all the agencies must have joint responsibility since clients and services cross departmental lines. MSHA would welcome the chance to be the lead agency.

An essential step in solving the homeless problem is achieving better integration of state agency systems. It will be necessary for the four state agencies to demonstrate their united commitment at the highest level. The Governor's Subcabinet on Homelessness should be identified as the authority that oversees this effort, and it should make a commitment to hold quarterly meetings to monitor progress. Reporting to the Subcabinet would be senior agency staff who will carry out the work of coordinating constituents, examining issues and making planning and policy recommendations to the Subcabinet. The Senior Staff Committee to Reduce Homelessness will fulfill this function if staff are assigned with authorization to speak to their agency's position on policy and resources. Each agency will need to construct a team of staff members who have familiarity with homeless problems, authority to craft policy and the ability to direct resources.



It will also be necessary to structurally allow for input from vested constituent groups and balanced geographic interests. This will create a more informed process for generating solutions. These same constituents will provide input to craft solutions they must implement. Appendix B illustrates this structure as the "Advisory Council." As stated previously, the challenge of reducing homelessness is owned by state agencies and nonprofit groups together. We must ensure that the solutions are also owned by all vested parties.

MSHA, DHS, DOC, DBDS, and the shelters will also need to be accountable for reporting our progress in reducing

homelessness. This is not a trivial matter. Many shelters have articulated the imperative for MSHA, DBDS and DHS to become more involved with the homeless population; they welcome this involvement. However, one result of our participation may be the imposition of new requirements that change how nonprofit agencies operate shelters. It is going to be much easier effecting change without resentment if shelters understand that ownership of our progress is being shared by all, including the state agencies. Determining how we measure our mutual progress would be done through the planning and evaluation process.

Three other entities will be brought in to assist this effort on an as needed basis: the Department of Labor (DOL), the Department of Economic and Community Development (DECD), and the Interagency Task Force on Homelessness. Each of the state agencies has had limited involvement with the homeless population but could be helpful if brought in as issues arise relevant to their jurisdiction. As examples, DOL would be brought in to discuss job training, and DECD would be brought in to discuss how their housing funds benefit homeless families. Regular involvement will not be necessary since they have limited involvement with this population. The Interagency Task Force on Homelessness, created by the Legislature in 1989, has issued three reports in its 13 years of existence. Its duties are to coordinate information, identify resources and service gaps with MSHA, and to review and monitor plans required by the Legislature. Given their historic role, a representative from the Task Force should sit on the Advisory Council. Although the Task Force may serve as an appropriate adjunct to an effective organizational structure, it has not fulfilled the role of an organizing body over the last 13 years and could not reasonably be expected to do so at this time. The Subcabinet members who sit on the Interagency Council will need to assess how, or if, they wish to solicit advice from the Interagency Council. This body may be the appropriate forum to discuss potential legislation since the Task Force answers to the Legislature.

Planning and Evaluation

"Failing to plan for a better system is planning to fail."[2] (Gardiner, 1991) Currently, there is no single statewide plan to reduce homelessness in Maine or elsewhere in the country. This is a foundation that must be laid to clarify exactly what we are trying to achieve and how we will bring it about. A logical starting point would be to publicly announce an initiative to develop Maine's state plan to reduce homelessness.

Maine's plan must have buy-in and be responsive to local needs. The organizational structure on Appendix B provides for this. The key to buy-in is to incorporate input provided from the Local Homeless Working Groups (LHWG) and to include the appropriate constituent groups on the Advisory Council. This structure needs to be maintained in a manner that promotes monitoring of progress.

Current LHWGs represent the shelters, consumers of mental health services, homeless youth, victims of domestic violence, United Way chapters, law enforcement, state agencies, municipalities and private businesses. Continued representation by a wide spectrum of constituencies will allow for a plan that considers the needs of the homeless population from many vital perspectives and increases the probability of successful implementation.

The plan must provide for careful measurement of our system's ability to link homeless people to services and housing through a data collection and evaluation element. This will identify gaps that exist between the needs of the homeless and the services delivered by shelters and state

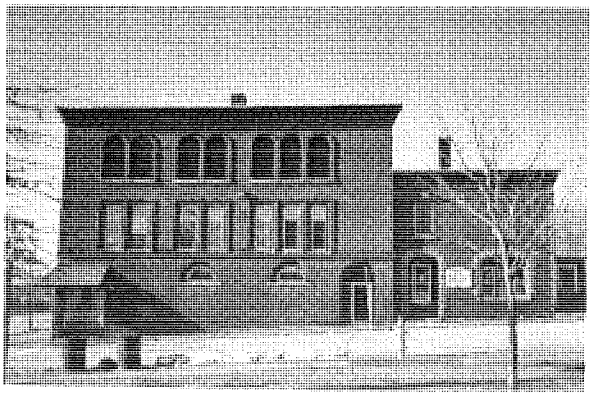
agencies. Only through detailed analysis of problems can we generate practical solutions. For example, when a shelter believes they are making housing assistance available and the homeless guests believe they are not receiving assistance, an evaluation would need to establish what there might be about the form of communication between shelter and guest that causes this gap.

We must also improve our data collection and analysis system so that we better understand the population. Currently there is a lack of a consistent assessment tool being utilized by trained professionals at the shelters. Clearly there exists vastly conflicting documentation that is developed and reported by persons who are not qualified to make determinations as to an individuals behavioral health status. For example, the August 2001 activity report from the York County Shelters indicates that 90% of clients had no behavioral health issues while according to an official at the Oxford Street Shelter, 90% of the women in the shelter have chronic mental illness.

The devil is in the details; we will make headway through analysis of smaller logistical issues. For example, we will need to examine our ability to provide General Assistance, SSI, mental health case management and housing vouchers to the homeless. For the purpose of illustration, attached as Appendix C, and labeled "Outline of Workplan," is a list of the types of issues that we will need to incorporate into our planning and evaluation process.

Although state agencies or shelter operators may think they have solutions that resolve identified needs, generally the individual living in the shelter is in the best position to determine the prospective value of a proposed solution. Therefore, it will be crucial to involve shelter residents in any evaluation system. Data collection must help us document how effectively we meet the needs from a consumer prospective. Most consumers can articulate why their needs are not being met. And basic marketing theory stresses the importance of hearing directly from the consumer or the customer. As an example, if 30% of shelter residents say they need more help with transportation while all shelters feel they are making this resource available, we need to identify where the breakdown exists: Is it that the resident is unaware of this service, that the service doesn't work well for them, that there is a gap between the state funding agency and shelter, or that the demand for services exceeds supply?

The evaluation process should lead us to implement changes that make us more effective at moving homeless people out of shelters. As stated above, our detailed system needs to evaluate the actual links that exist between homeless persons and services that are intended to move them on to a stable housing situation. The evaluation element must also establish whether we are underusing an existing resource or need to appropriate a new resource. As we learn from our evaluation system how to create more effective links to housing and services, we will be able to establish procedures and protocols to be implemented by the relevant agencies: shelters, nonprofit service providers, state agencies.



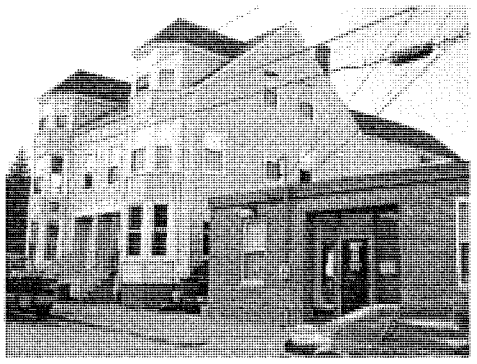
An effective method for providing incentive for all parties to incorporate new protocols and procedures is through the use of performance-based contracting. Although this strategy has not been used to date in our efforts to reduce homelessness, it could prove an effective tool for ensuring that all parties implement the most effective techniques to reduce homelessness.

Implementing new protocols and measuring the effectiveness of parties to incorporate these new standards may encounter resistance since providers are already working hard to help the homeless and protocols may imply new work. Yet it will be critical for all parties to make recommended changes to reduce homelessness. And a cooperative partnership between state agencies and non-profit providers will serve as the foundation for successful changes in our system of helping the homeless. Concerns can be mitigated in two ways. First, the shelters can be involved in the development of the performance measures so there is buy-in that the measures used represent real indicators they agree will move us to reduce homelessness. Second, we can demonstrate this effort is a partnership and that all parties are responsible for measuring progress by allowing the shelters to participate in the development of measures intended to indicate the effectiveness of the state agencies in adopting new protocols and processes to reduce homelessness.

It will be critical to use a "planning while doing" approach. Rather than waiting until the end of the planning process, where possible we will implement solutions in an ongoing fashion. It may prove practical to identify and target specific sites to test the effectiveness of new program initiatives. We can then use our knowledge and experiences gained from these "pilot initiatives" to develop broader based models.

Resources

Reducing homelessness will require state agencies to examine how we can most judiciously use resources in a manner that improves outcomes. The outcomes we desire are to move more people out of shelters, to move all people out faster, and to keep them out. We realize we cannot meet every service need of every individual who is homeless or near homeless, nor are we looking to just throw more resources at the problem. Additional resources will not necessarily improve outcomes. For example, between 1994 and 2001, the MSHA quintupled the resources dedicated to Maine's homeless effort. Still, homelessness increased 69% statewide. Instead, the best approach to reduce homelessness is to adopt a comprehensive strategy as outlined here, not to blindly increase resource allocation. That said, we will need to examine how we can better use resources if we are going to address gaps.



There are four approaches to consider as we evaluate gaps in homeless services. First, we have inefficiencies that currently exist within our system. Thus, we can bring additional resources to the table by identifying inefficiencies in the administration of a program or improving links so that the homeless can secure services that are currently funded. An excellent example of this is the change made in the Shelter Plus Care Housing Voucher program this spring by DBDS and MSHA. Through improved administration, approximately an additional $45,000.00 per month was made available to the homeless.

The second approach to be examined is reallocation of existing resources. DBDS used this strategy to redirect resources to housing for people with severe mental illness in the late 1990's. As a result, together with MSHA, over 200 apartments were created for consumers. This was a very successful model which could be duplicated. It will be important, however, to involve the nonprofit community in some capacity during this discussion since resources will be drawn from existing programs.

The third approach is to use or capture new resources. We are not maximizing the amount of federal resources that can be used for the homeless. Other than the three Continuums of Care, there currently is little joint planning around this topic. There have been very few interagency efforts to date to capture competitive funding for the homeless. We also want to explore spending unused TANF funds in a targeted manner. Several states now use these funds for tenant based rental assistance, which is an enormous unmet need for the homeless. The passage of the housing bond will also provide needed funds for additional special needs housing for the homeless. We will want to consider appropriate uses of Medicaid funds for chronic members of this population. For example, DHS, DBDS, and MSHA are currently completing a study which may allow many of the most troubled chronic homeless to receive Medicaid benefits. This is the type of targeted effort to gain new resources that could make a huge difference for the homeless problem.

Finally, there must be a new emphasis on joint resource planning between government agencies. A number of problems we will address dictate that multiple state agencies simultaneously commit resources to a proposed solution. For example, housing for people with severe mental illness cannot succeed if we pay only for the services or for the building. Both agencies must step forward following a joint resource planning process.

Fortunately, Maine has a track record of several interagency efforts resulting from joint resource planning. As an example, Maine is considered a leader in the country in the area of affordable assisted living because we created over 650 apartments for seniors following a joint resource planning process between MSHA and DHS. This same model of resource planning was used to provide over 150 units of housing for kids coming back into the state and for a statewide housing initiative for victims of domestic violence. A similar model proved effective for class members with DBDS. We should emphasize that, without joint resource planning, undertaking any new effort may prove unrealistic.

Using these four resource planning strategies, while bearing in mind the need to judiciously allocate resources, is a necessary step in the ongoing planning and evaluation process.

Public Leadership

It would be difficult to effect system change without leadership at the highest levels. The change will require full cooperation and significant effort from entities throughout the state. We need to signal there is a new approach supported at the highest levels and that this issue is a priority for the administration. Public announcement of a new initiative by the Governor and cabinet members promotes both positive energy and momentum to the many parties, including nonprofits, municipal representatives and state employees that must be engaged if this endeavor is to succeed.

Many in the shelter community feel we have reached a crisis situation in homelessness. There are high expectations from the nonprofit community due to the

creation of the Governor's Subcabinet on Homelessness and related Senior Staff Committee to Reduce Homelessness. They are waiting for an announcement or action of some form.

Senior policy makers must take three steps to support this strategy to reduce homelessness.

- First, we must begin with a public announcement of an interagency initiative to reduce homelessness. An announcement that the issue is a priority for this administration would be welcomed in the nonprofit community.
- Second, the Subcabinet should articulate the objective of creating a statewide "Action Plan to Reduce Homelessness" within one year.
- Third, in support of this initiative, the Governor's Subcabinet should announce the formation of an Advisory Council of representative constituent groups that will assure inclusion as we create the states Action Plan.

Ongoing continued public support from cabinet members will be necessary to sustain the effort.

Long Term Commitment

A study of nine state efforts to better integrate their systems for delivering services showed the need for leadership, planning and performance measures as discussed above.[3] The study also showed the critical nature of making a long-term commitment. Systems change takes work and it takes time. A successful model of system change in Maine is the work of the Governor's Children Cabinet. Considered hugely successful, this was a multi-year effort, resulting from the work of many dedicated people in the public, private and nonprofit sectors. The same is true of this effort. There are multiple agencies, both public and nonprofit. Those involved want to make a real difference in the lives of people. They confront a complex and daunting task. We must know going in that it will take a commitment of several years to effect concrete, measurable change. For the men, women and children living in Maine's shelters, it is a commitment worth making.

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[1] Maine 2001 Continuum of Care Funding Application.
[2] Dennis, Deborah, L., M.A., Cocozza, Joseph J., Ph.D., and Steadman, Henry J., Ph.D. "What Do We Know About Systems Integration and Homelessness?" Page 16. 7-17-01.
[3] Dennis, Deborah, L., M.A., Cocozza, Joseph J., Ph.D., and Steadman, Henry J., Ph.D. "What Do We Know About Systems Integration and Homelessness?" Page 16. 7-17-01.

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Dennis, Deborah, L., M.A., Cocozza, Joseph J., Ph.D., and Steadman, Henry J., Ph.D. What Do We Know About Systems Integration and Homelessness? 7-17-01.

Maine 2001 Continuum of Care Funding Application.

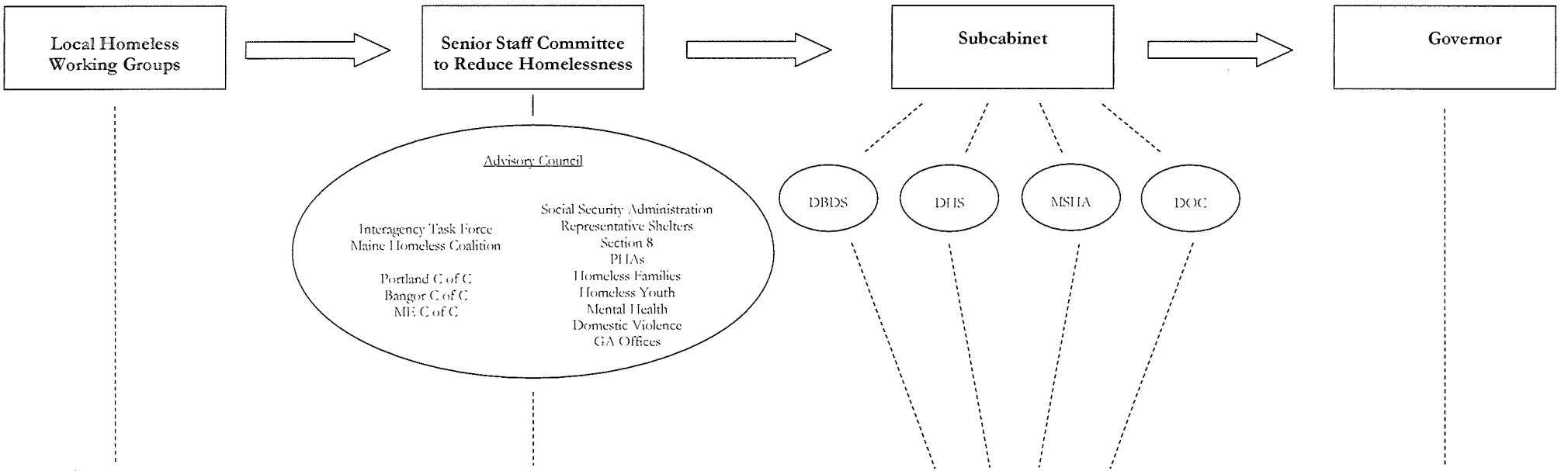
Appendix A

Appendix A: Ongoing Planning Efforts

- Statewide Shelter Provider Network
- Maine Coalition to End Domestic Violence
- Emergency Shelter Assessment Committee
- State of Maine Continuum of Care
- Bangor Continuum of Care
- Maine Coalition for the Homeless
- Portland Partnership for Homeless Youth
- Maine Way, Inc. – Saco/Biddeford/Old Orchard Beach
- Youth in Need of services (Bangor & Portland)-Rapid Response 14 & under
- Lewiston/Auburn Services for Homeless
- Regional Homeless Working Groups
- United Way - Southern Kennebec County
- York County Youth Homeless Project
- York County Task Force
- Homeless/Substance Abuse- Portland
- Homeless Veterans- Augusta
- United Way Franklin County Task Force

Appendix B

Appendix B: Organizational Structure



Appendix C

Appendix C: Outline of Workplan

The following list represents some of the important issues the Senior Staff Committee and Advisory Council will need to consider as it develops a statewide plan. Certain issues will require one time analysis while others will need ongoing measurement and evaluation. Many issues are currently part of the workplans of MSHA, DHS, DBDS, and the Senior Staff Committee to Reduce Homelessness or other planning efforts. Although many of the significant issues to be covered are cited below, this outline should not be considered all inclusive.

Data Analysis

- Implementation of Homeless Management Information System (HMIS)
- Rewrite surveys to collect data that analyzes delivery of services that will move homeless people out of shelters
- Structure ongoing consumer focus groups for direct feedback

Medicaid Waivers

- Review waivers allowed by the Health Care Finance Administration (HCFA) to provide homeless services
- Evaluate need and process for waiver to benefit chronic populations: persons with severe mental illness and/or substance abuse problems

Links to Income Benefits

- Assess appropriateness of individual benefits
- Evaluate effectiveness of links to: General Assistance, TANF, food stamps, SSI, SSDI

Effectiveness of Housing Vouchers

- Measure utilization rate of Shelter Plus Care, State Section 8 Vouchers, PHA Section 8 Vouchers & BRAP
- Measure speed of access to resource clients
- Evaluate obstacles that block use of resource
- Evaluate effectiveness of homeless preference
- Discuss links to landlord groups
- Develop protocols
- Analyze links of delivery systems (e.g. Section 8 Agents and Shelters)

Tenant Based Rental Assistance (TBRA)

- Evaluate need
- Identify resources (e.g. McKinney, TANF surplus)

Security Deposits

- Evaluate need
- Identify resources (e.g. General Assistance, real estate transfer tax)

Case Managers

- Evaluate need
- Measure utilization and speed of access to resource

Housing Counselors/Advocates

- Evaluate need
- Identify resources (e.g. Medicaid Waiver Funds)

Safe Haven Housing (for persons with severe mental illness)

- Evaluate need
- Identify resources to develop

Transitional & Permanent Supportive Housing

- Evaluate links to existing facilities
- Evaluate need (Demand Analysis)
- Discuss types needed (e.g. SRO, master leases)
- Discuss partnerships with cities
- Discuss resources

Coordination of Planning Efforts

- Evaluate consistency across Continuum of Care processes
- Evaluate Local Homeless Working Group (LHWG) processes
- Identify constituent groups that should be linked structurally to LHWG's (e.g. United Way Efforts)
- Evaluate link between LHWG, Continuum of Care and Blue Ribbon Commission

Transportation

- Evaluate link to service
- Discuss methods to strengthen

Discharge Planning

Evaluate effectiveness and make recommendations relating to discharge planning from:

- Correctional facilities
- Youth facilities
- Mental Health facilities
- Substance Abuse facilities
- Hospitals

Use of CDBG Resource

- Evaluate effectiveness of use of this resource

Federal Resources

- Evaluate effectiveness of securing federal resources
- Identify additional resources available and defines process for securing

Public Awareness

- Discuss need
- Identify processes (e.g. interfacing with press, school program)

Ongoing Measurement System

- Establish performance measures for all parties
- Determine methodology for ongoing data collection
- Establish protocols relating to best practices

Municipal Engagement

- Evaluate effectiveness
- Define strategies to enhance municipalities' engagement in reducing homelessness

National Models

- Review successful national models
- Interview organizations such as the Corporation for Supportive Housing for potential strategies

Resource Allocation/Joint Resource Planning/Efficiency of Resources

- Evaluate efficiency of current resources used
- Jointly allocate resources to targeted initiatives
- Identify new federal resources
- Request new resources, if applicable
- Identify barriers to existing funding

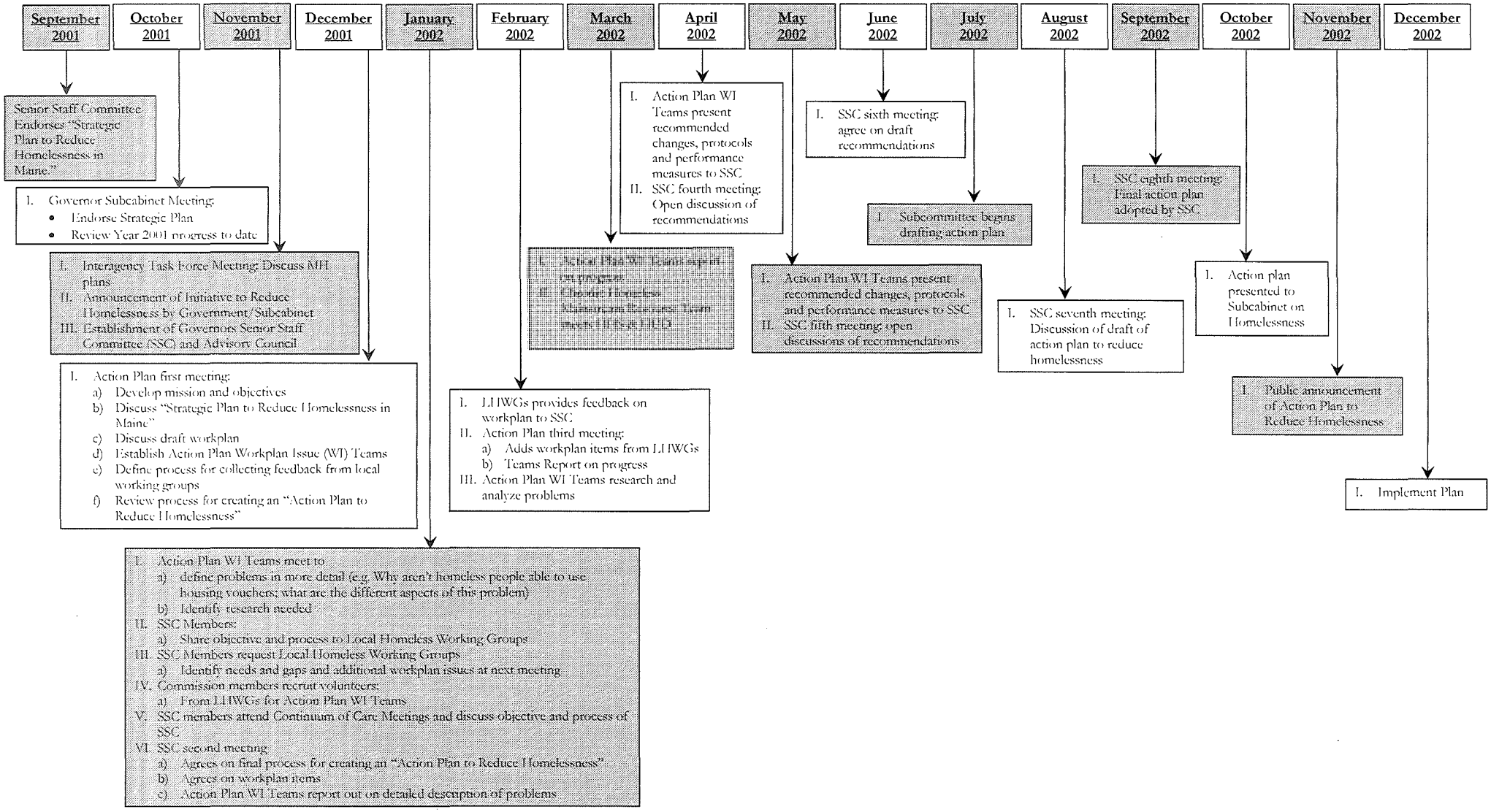
Mental Health Service Beds

- Evaluate need
- Explore existing models
- Identify resources

Appendix D

Appendix D: Timeline

(One of the first steps of the Senior Staff Committee and Advisory Council will be to evaluate an appropriate time line to develop an Action Plan.)



Appendix E: Year 2001 Progress To Date

Topic: Rapid Response Project
Description: A two –year demonstration program serving homeless youth in Bangor and Portland was jointly funded by the Department of Human Services and the Department of Behavioral and Developmental Services. A single community plan was developed by stakeholders with emphasis on early intervention, engagement of hard to engage youth, case management services and individual service plans with linkages to parents, mediation services, DHS, vocational services, academic programs, and stable housing. Evaluation of the project is to be completed in the fall of 2002.

Topic: Housing Resource
Description: Sixteen (16) transitional housing beds have been developed for homeless youth.

Topic: Youth In Need of Services
Description: Two pilots were funded in Bangor and Portland for Youth In Need of Services. Thirty-two (32) homeless youth, 14 years and younger, and their families received intensive case management services in Region I. Bangor came on line later in the year with 6 youth under 15 years of age, and 25 youth 15 and older and their families served. Community planning meetings have begun for the most challenging youth to maximize successful outcomes for youth and their families. The goal is to keep youth with their own families when possible, and to place them in stable housing situations.

Topic: Tenant Based Rental Assistance Pilot
Description: A collaborative effort between MSHA and DHS, emergency shelter committees, city governments and other community stakeholders, DHS has developed pathways for homeless individuals, families, and youth to access Tenant Based Rental Assistance program. This program is designed to provide immediate rental assistance to certain populations of homeless families/individuals who are willing to participate in a service program. The pilot program will be available in the Portland and Bangor areas. A housing subsidy program is expected to begin within the next few months in conjunction with Aspire.

Topic: Medicaid Waiver
Description: Department of Human Services, Maine State Housing Authority and Department of Behavioral and Development Services conducted an interagency survey targeting chronically homeless individuals in four large shelters. Focus groups and interviews with these clients has given insight into the challenges faced when accessing resources that would assist the chronically homeless in securing and maintaining their housing. Most supportive service options require Medicaid eligibility. MSHA is working with DHS to develop a strategy to improve and mainstream the link to Medicaid benefits. A DHS Medicaid policy specialist was a member of the team.

Topic: Focus on Homeless Youth in York County
Description: A homeless youth initiative in York county is emerging, led by the United Way with support and direction from DHS, MSHA, non-profit agencies, city personnel, youth, schools, and community individuals. The focus is on safe short-term housing with the goal of return to home wherever possible and keeping youth in their own communities and schools. Two homes will be developed in Saco-Old Orchard Beach Area.

Topic: Enhanced Services at Teen Center
Description: A position was created at the Teen Center to act as liaison to DHS offices statewide with the goal of enhancing linkages to youth who are new to the street and for youth who pose significant challenges in leaving the streets. This position allows for quicker and coordinated intervention when youth appear at the Teen Center. Expanded hours at the Portland Teen Center will include weekend hours as a safety net for homeless youth. Meals, day shelter, and case management are to be provided.

Topic: General Assistance
Description: General Assistance provides for basic needs for eligible applicants. One of the basic needs is shelter. In fiscal year 2001 General Assistance spent $4,159,414 on shelter. Of this total $1,257, 836 was spent on emergency housing. A total of 6,557 households were assisted with emergency housing. Applicants need to apply for General assistance every thirty days. One of the requirements of eligibility would be to actively search for permanent housing. About 1/5 of General assistance's total expenditure is for emergency housing.

Topic: Maine State Housing Authority/Department of Behavioral and Developmental Services (DBDS) RFP for chronically homeless consumers of mental health services
Description: Three recipients were awarded funds through this RFP. The RFP will establish three housing projects in Maine targeted to consumers of mental health services who are chronically homeless. A core requirement of this RFP is to establish and maintain a link between the shelters and service providers.

Topic: Analysis of Homeless Data: Maine's Homeless Problem
Description: In an effort to understand and develop an action plan for Maine's homeless population, MSHA's staff compiled and analyzed data.

Topic: Security Deposit Program
Description: These funds will be used to assist homeless clients move from shelters to apartments. A workgroup consisting of six shelter providers has been established to discuss the process of distributing these funds.

Topic: Department of Health and Human Services and Department of Housing and Urban Development Policy Academy
Description: Wrote two grants to send inter-agency state teams to meet with Federal agencies (Health, Human Services & HUD) to improve links to federal resources for homeless families and persons with mental health and substance abuse problems.

Topic: Housing Counselors
Description: Housing Counselors will be available to homeless clients wanting to take advantage of the TBRA program. The Counselors will assist clients with applying for appropriate housing programs, determine if the client is eligible for the TBRA program, assist in the search for housing, advocate on behalf of the tenant with the landlord/community, as well as a variety of other services.

Topic: Electronic transfers of shelter ESG and SOS payments
Description: This service is offered to all shelters for their convenience and to make their funds accessible within a short period of time. Sixteen of the forty-two shelters took advantage of having

their ESG and SOS payments automatically deposited. The initial electronic deposits were completed in August and were successful.

Topic: Quarterly newsletter
Description: The quarterly newsletter will serve as a form of communication between MSHA and the shelters. The newsletter will share information about resources, best practices and issues relating to homelessness. The September 2001 newsletter has been completed and is scheduled to be mailed the first week in September.

Topic: Section 8 Vouchers
Description: MSHA issued 600 housing vouchers targeted to homeless clients.

Topic: Homeless Management Information System
Description: The homeless client will be linked to housing and services within a reasonable time frame, thereby, decreasing the number of homeless people.

Topic: Single Room Occupancy (SRO) Housing
Description: Maine State Housing Authority offered $2,500,000 in financing to create single room occupancy housing for very low income persons.

Topic: $18,000,000 Workforce Housing RFP
Description: MSHA offered $18,000,000 in the spring of 2001 to finance the production of new rental housing in southern Maine.

Topic: Planning and Program Development for Department of Human Services/MSHA RFP targeting domestic violence, families, and homeless youth
Description: Target sub-populations served by the Department of Human Services with service enriched housing, e.g., domestic violence, families, and homeless youth.

Topic: Shelter Plus Care – Enhanced Administration
Description: DBDS and MSHA work together to enhance utilization of this resource. This collaborative effort has resulted in the issuance of an additional 100 housing vouchers targeted to consumers of mental health and substance abuse services who are homeless. DBDS and MSHA are committed to continued coordination among Shelter Plus Care grantees, implementation of monitoring protocols, performance based contracting, and implementation of additional federal grants.

Topic: New Shelter Plus Care Application
Description: BDS received the number one priority ranking in the statewide Continuum of Care application for an additional 24 Shelter Plus Care vouchers.

Topic: Bridging Rental Assistance Program - Department of Behavioral and Developmental Services (DBDS)
Description: Increased outreach to the shelter systems resulting in 425 previously homeless persons with a mental illness who are now receiving housing, an increase of 65%, into the Bridging Rental Assistance Program, from 780 to 1205.

Topic: Intensive Case Management Program (ICM) - Department of Behavioral and Developmental Services (DBDS)
Description: Intensive Case Managers are working with shelters to identify and engage homeless individuals with disabilities into appropriate systems of care and housing. ICM's are also coordinating outreach workers from various non-profit agencies under contract with BDS to better meet the needs of homeless persons with disabilities in Maine.

Topic: Projects for Assistance in Transition from Homelessness (PATH) - Department of Behavioral and Developmental Services (DBDS)
Description: The Substance Abuse and Mental Health Services Administration's (HHS) PATH grant, totaling $300,000, is designed to assist homeless adults with serious mental illness and at risk youth by helping to support an array of comprehensive services which include: outreach and engagement services; counseling; referral for necessary hospital, primary health, substance abuse; rehabilitation; mental health and diagnostic services; case management services, including advocacy, education and training to service providers.

Topic: Supportive Housing Program - Department of Behavioral and Developmental Services (DBDS)
Description: The Department has applied for and received a conditional selection of a one year extension to it's MaineStay program in the amount of $304,999. MaineStay, funded through HUD's Supportive Housing Program provides housing and supportive services to people age 16 to 23 who are homeless. These individuals are youths with serious emotional disorders who may also have co-occurring substance abuse. The population to be served also includes youth with severe mental illness who also may have co-occurring substance abuse. The MaineStay program is located in Portland, ME.