

# **Solutions for Homeless Chronic Alcoholics in Austin**

Produced by the Ending Community Homelessness Coalition (ECHO)  
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## Executive Summary

Living on the streets is not only undesirable, it is dangerous: mortality rates are three times higher among homeless populations than among the housed, and the average life expectancy for this population ranges from 42 to 52<sup>i</sup>, significantly lower than the average American lifespan of 78.<sup>ii</sup> The high cost of homelessness doesn't just affect individuals; it also impacts the local economy. Cities with comparable demographics spend close to \$40,000 a year per individual for chronically homeless users of public resources including hospitals, courts, jails, shelters, and the police.<sup>iii</sup> And while these services are all important, there is little evidence that they stop the harmful patterns associated with homelessness. Best practices demonstrate, however, that it is possible to save lives, reduce costs, and free needed public services from the burden of constantly cycling the same individuals through the system. Housing First and Harm Reduction are innovative and proven strategies that are being utilized elsewhere to great success to address homelessness, and it is time to bring these strategies to Travis County.

In order to isolate one of the most common and painful problems found in the homeless population, this paper is focused on the overlap between homelessness and alcoholism. Although many of these individuals probably have additional and overlapping addictions and/or mental illness, there is evidence from other cities of the benefit of specific attention to this group. It is estimated that over 1,200<sup>iv</sup> people on the Austin streets suffer from some form of alcohol disorder, and outside research affirms the high cost of addressing the health problems and public inebriation that result.<sup>v</sup> Other cities have implemented Housing First models with similar populations, and have reduced their costs by roughly \$16,000 per frequent service user annually, and decreased the burden on public resources by more than 50%.

### **The purpose of this paper is threefold:**

- 1) To initiate a conversation about the overlap between homelessness and alcoholism in Austin;
- 2) To introduce the concepts of Harm Reduction and Housing First as ways to address the needs of homeless individuals with varied alcohol disorders, and;
- 3) To recommend the initial community steps needed to plan for housing programs with appropriate support for homeless alcoholics, and save vital public service dollars currently spent on these individuals:
  1. Obtain commitment and support for housing solutions for the chronically homeless with alcohol and/or mental health problems from the Mayor, County Judge, City Council, Travis County Commissioners and other key leaders from both the private and public sectors
  2. Set housing the chronically homeless street population as a priority for the City and County
  3. Identify frequent service users and assess their needs: Determine the service gap
  4. Assess the cost of frequent service users
  5. Examine the funding sources used in more successful cities and determine what resources may be applied in Travis County
  6. Identify the leadership responsible for implementing the plan

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## Homelessness

According to the Continuum of Care (CoC) report submitted by Austin’s homeless service providers to the U.S. Housing and Urban Development Department (HUD), a 2008 count in Austin determined an approximate homeless population of 3,451. Although it is difficult to obtain accurate counts and the current economic recession means it is likely that this number is far higher<sup>vi</sup>, for the purpose of this paper it will be used as our most recently assessed baseline homeless population. Thus, according to the CoC report, Austin is short 1,800 units of housing for this population, which represents an unmet need of 52% for the homeless in our community.

The CoC report also noted that 919 (27%) of the 3,451 people were considered chronically homeless, a term that refers to an unaccompanied homeless individual with a disabling condition who have either been continuously homeless for a year or more, or have had at least 4 episodes of homelessness in the past 3 years. This report notes that there are currently only 115 permanent supportive housing beds for this population, leaving a gap of 804 beds.

National estimates place the percentage of chronically homeless between 10-23% of the overall homeless population, however this group typically uses roughly half of the available resources for the homeless.<sup>vii</sup> These resources include shelters, hospitals, emergency rooms, jails and prisons.

### Alcoholism among the homeless

National estimates place the percent of homeless individuals who have problems with alcohol in the range of 35-40%, which is dramatically higher than the roughly 5%<sup>viii</sup> found in the housed population.<sup>ix</sup> Homeless individuals with alcohol problems often also suffer from mental and physical illnesses<sup>x</sup>, and those with the most severe alcohol and drug problems are the least likely to exit homelessness for housing of any kind.<sup>xi</sup> The following table illustrates what is known about the volume of homelessness in Austin, and its overlap with substance abuse. Although we cannot specify the extent to which homeless individuals have severe problems related to alcohol abuse, the rate of chronic substance abuse of any kind is included because of the significant overlap between drug *and* alcohol problems among these populations.

**Figure 1:** Estimated number of homeless individuals in Austin with alcohol and drug problems

|  |              |
|--|--------------|
| <b>2008 Homeless count in Austin<sup>xii</sup></b>                                       | <b>3,451</b> |
| Estimated # with some form of alcohol problem <sup>xiii</sup>                            | 1208         |
| Number of individuals from 2008 count with <i>chronic</i> substance abuse <sup>xiv</sup> | 875          |

Homeless individuals with the most severe, late stage forms of alcoholism are in serious danger of dying of their illnesses on the street, and they are typically the most frequent users of resources including

hospitals, police, and the court system. Symptoms of severe alcoholism include the need to drink from morning until night, and the inability to seek food, shelter, or aid. These symptoms greatly restrict the ability to maintain any form of work. Unfortunately, at this stage the need for alcohol can be so severe that homeless addicts will resort to drinking harmful substances including mouthwash in order to supplement their bodies' need for alcohol. Additionally, there are a high percentage of dual diagnoses between alcohol abuse and mental or physical illnesses.

### **Cost of frequent service users from other cities**

Although Travis County has yet to conduct a comprehensive analysis of the cost of services spent on the homeless in our community, much can be learned from studies conducted in other cities around the country. According to the National Alliance to End Homelessness, Portland, Oregon compared the city's costs before and after placing 35 people with high levels of resource use into permanent housing.<sup>xv</sup> Each person cost Portland over \$42,000 annually before they were housed, and afterwards, even with housing costs, they dropped to less than \$26,000 each. New York City determined a similar average individual pre-housing cost of \$40,000 for their population of mentally ill homeless people, and also saw costs drop by over \$16,000 per participant with the implementation of permanent housing solutions. Closer to home, Dallas recently conducted an analysis of their "frequent users" of public resources, and found that the city spends roughly \$50 million dollars a year on the homeless in the city.<sup>xvi</sup> When contributing agencies tallied their costs separately, the results point to the tremendous drain that homelessness places upon particular community services. One central hospital estimated it spent \$15.6 million dollars annually treating homeless individuals, while there were price tags of \$10.6 million on the county jail, \$5 million on ambulance services through the Dallas Fire-Rescue Department, \$2 million spent on court costs, and close to \$1 million on downtown arrests.

Consider the example of an arrest of a public inebriate. According to the Dallas figures, it costs \$30.91 an hour for the police to deal with these situations, and an average of two hours to book an individual into jail for this kind of offense. \$61.82, when added to the average daily state correctional cost of \$47.50 per offender<sup>xvii</sup>, and a single arrest and night spent in jail costs taxpayers well over a hundred dollars. When these numbers are multiplied by the volume of chronically homeless individuals facing severe alcohol problems, and the number of times annually that each may be arrested for public intoxication, it is clear how expensive the cycle may become. Furthermore, because most of the costs associated with episodically processing and handling the homeless population do not contribute at all towards solving the problem, this money is being thrown towards a pattern that likely ends only with an individual's death.

### **Evidence-based practices that work**

There are evidence-based programs from around the country that are making great strides with this population, however, and it is possible now to identify the best practices in the field.

## **Harm Reduction**

Many of the recent housing success stories fall under a general philosophy called Harm Reduction, which meets substance abusers “where they’re at” without trying to immediately impose abstinence. Although the long-term goal is to stop substance use, Harm Reduction aims practically to do exactly what it says: reduce the level of harm faced by the individual. These reductions may be large or small, but they work with what the participant is willing and able to offer towards their own recovery. Two well known examples of Harm Reduction strategies within an illegal drug context are methadone clinics and needle exchanges, both of which are used to decrease the risks associated with heroin addiction.

The strategies implemented by the Harm Reduction model for alcoholics starkly contrast the sobriety centers still used nationally to quickly, yet temporarily, dry out individuals arrested for public inebriation. Although these programs, often referred to as “drunk tanks,” may produce rapid sobriety, it is a fleeting achievement that in some cases can actually endanger a severe alcoholic with extreme levels of dependence.

When applied specifically to alcohol abuse, Harm Reduction aims to decrease the risk of dangers associated with the disease. Because alcoholism can cause a myriad of physical and mental problems, improving overall health is a major goal of Harm Reduction with alcoholics, and reducing drinking levels and helping addicts attend to necessary medications and treatments are ways to accomplish this. Although there may be a long-term goal of total sobriety, Harm Reduction acknowledges that some progress is better than none, and that it is preferable to reduce drinking and improve overall wellness than to try but fail to demand sobriety.

## **Housing First**

Housing is also healthcare. Housing First was developed by the nonprofit Pathways to Housing in New York City, which started using the model after their inception in 1992.<sup>xviii</sup> For the past 15 years, communities across the nation have implemented Housing First as a best practice model for working with chronically homeless individuals, many of whom have additional problems such as substance abuse, and mental or physical illnesses. There is a growing body of literature, and proof in cities across the country, that the most effective way to solve the problem of chronic homelessness and to improve the quality of life for these individuals is to begin treatment by first providing affordable housing with low barriers for entry. Housing First provides someone immediately with permanent housing and services rather than place them in a shelter or transitional housing unit. It assumes that housing stabilization is key in the return of the individual or family to independent living and that needed supportive services can effectively be provided to the client either on-site or at agency offices.<sup>xix</sup> There are no preconditions for Housing First programs other than that the individual demonstrates an ability to live alone.

Studies and evaluations of programs around the country point to the power of these strategies to decrease both homelessness and community costs associated with the use of public emergency services. Housing First models that place the chronically homeless into permanent housing can lead to financial reductions as high as \$18,000<sup>xx</sup> per person annually. Furthermore, research shows that roughly 85% of

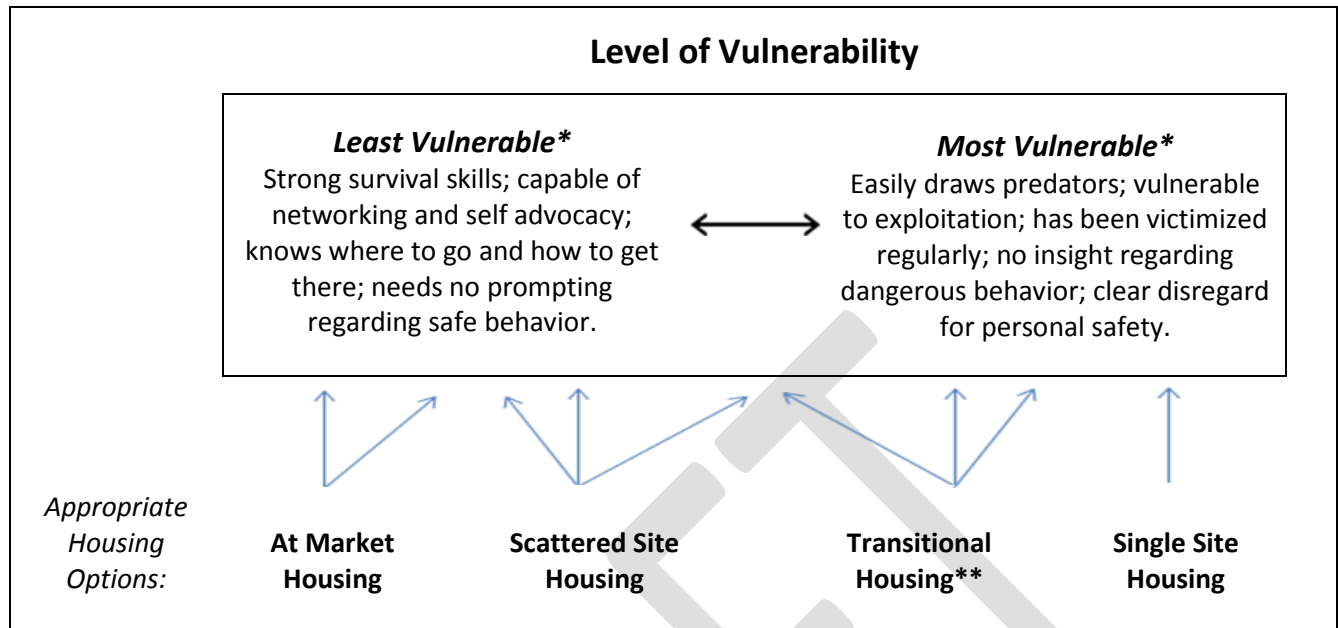
Housing First residents remain housed in a stable environment.<sup>xxi</sup> Best Practice Housing First options for chronically homeless people include supportive services such as case management, which provides a wide range of assistance tailored to an individual's needs. There are two types of Housing First options: scattered site and fixed site.

**Scattered site housing:** Scattered site housing is designed for individuals who are able to be placed in apartment complexes throughout the community. There may be only one or two scattered site apartments for the homeless in a particular complex, and while the residents may not have on-site services, they will still have access to case managers and related services through their sponsoring organization.

**Fixed or single site housing:** Fixed or single site housing is designed as a permanent, group-based home specifically for homeless individuals facing particular disabilities such as alcoholism and mental illness. These homes generally hold up to 100 small, single occupancy apartments and provide staff 24 hours a day to assist as needed with medical issues and other problems.

Both of these models can be utilized for homeless people with substance abuse or mental health problems. Different individuals will require varying levels of support, and the appropriate option may be related in part to the level of alcohol addiction faced. The higher the level of dependency, it can be assumed the higher the level of vulnerability. Typically the most vulnerable people will need a single site housing option while moderately vulnerable people can progress in a scattered site location. The following chart uses the concept of vulnerability, one's susceptibility to danger on the streets, as a way to begin examining what types of housing may be best suited for each person.

**Figure 2:** Levels of vulnerability and appropriate housing options



\* Vulnerability terms adapted from the “Vulnerability Assessment Tool” used at the Downtown Emergency Service Center, Seattle, WA.

\*\*Transitional housing refers to more short-term programs that address specific needs, and it is not a Housing First model. There are opportunities, however, for these to become pathways into Housing First options, and certain individuals, the severely ill for example, may require this intermediate step before being able to live alone.

### What other cities specifically address homelessness and alcoholism?

The popularity of Housing First and Harm Reduction models are spreading across the country as evidence of their efficacy increases, and many cities and counties already use them to specifically tackle the issue of housing homeless individuals with alcohol dependency problems.

#### **Chicago: Housing a diverse group of homeless people in Housing First scattered site apartments**

The Christian Community Health Center (CCHC) in Chicago developed an impressive and large Housing First program to place the homeless in scattered site housing primarily located in South Chicago. Although their housing model is not specifically tailored to alcoholics, many of the residents have dual diagnoses and there is significant overlap between populations. The success of this program is a good indicator of its benefits for homeless people with a large variety of difficulties including HIV/AIDS, mental illness, and substance abuse. Like its client population, the program receives a diverse spectrum of funding including HUD Supportive Housing Program and Shelter Plus Care Grants, local organizations, and state funds.

The organization began by housing just 6 people in 2001, but has since grown to support more than 300 clients. People are recommended for the housing by local health clinics, mental health agencies, substance abuse providers, and through self-identification. The goal is to get leases written under the client’s name, although they will work from master leases intermediately until the resident has proven

themselves to a landlord. No more than two individuals qualifying for CCHC housing are placed in any one location at a time. The results are impressive: six months after placement 100% of CCHC residents were still in housing.<sup>xxii</sup>

All residents meet with case managers no less than twice a month, and these relationships have helped secure increased income, either by employment or receipt of social services, for 90% of the clients. Residents are therefore asked to pay up to 30% of the rent, and if possible case managers work to help them save 10-20% of their income for housing expenses in the future.<sup>xxiii</sup> The caseload ratio is 15 to 1, which is higher than many other similar programs. The apartments qualify as Housing First because, while residents are encouraged and briefed before moving in to be good neighbors by living peacefully, keeping away illegal behaviors, etc., there are no restrictions for residency based on sobriety or other conditions. Most problems that do arise between residents and their landlords are handled efficiently between the case manager and the client. So far no one has had to be evicted using the legal system, and the few people that have been asked to move have worked with the organization to find alternative housing arrangements.

#### **San Jose: Building a scattered site Harm Reduction and Housing First plan for alcoholics**

EHC LifeBuilders in San Jose, California also has a Housing First program targeting chronically homeless alcoholics, but they implemented a scattered site version that disperses individuals throughout the community. Their Housing for Homeless Addicted to Alcohol (HHAA) program places alcoholics directly from the streets into permanent, supportive, affordable housing that includes assistance with basic needs and access to counseling for substance abuse. There are 42 spaces in the program with an average per person cost of \$928 a month, and it has served approximately 70 individuals since it started in 2005. Based on client surveys, they estimate an 85% reduction in client use of public resources including emergency services, ER visits, and arrests. This program fits a Housing First model because the housing is permanent, and because individuals do not have barriers to entry based on treatment requirements. Although official evaluations of the program are not yet available, preliminary results indicate its success at addressing this particular population.

#### **Seattle: Pioneering a single site Harm Reduction and Housing First model with alcoholics**

Seattle's Downtown Emergency Service Center (DESC) opened in 2005 as one of the first Housing First, fixed site facilities specifically designed for chronically homeless, late-stage alcoholics. While other service providers in Seattle selected residents based on overall vulnerability, DESC offered its 75 rooms to the individuals putting the greatest financial strain on city resources including hospitals, jails and shelters. Within the facility, 26 of the units are without doors or ceilings, and are designed for individuals who require closer monitoring and cannot be safely left unattended in a closed single occupancy apartment. This program qualifies as a Housing First model because it provides permanent housing, and does not require individuals to prepare for or qualify with housing readiness of any sort.

In the 4 years since DESC opened, the city reported a savings of 1.8 million dollars by the reduction of emergency room visits alone. Furthermore, the longer individuals were enrolled in the program, the

greater the reductions in cost and usage of services. In a 2009 study in the Journal of the American Medical Association (JAMA), researchers reported that<sup>xxiv</sup>:

- When compared to individuals on a waiting list to get into the home, the cost rate for residents was reduced by 53% in the reduction of police, hospital, and jail services.
- When the average monthly per person cost of \$1120 is subtracted from the \$3569 saved over the control group, there was a total mean cost offset of \$2449 per person per month.
- If these savings are extended over 12 months with 75 residents, the result is an annual reduction in costs of over 2.2 million dollars.

While residents are allowed to drink alcohol in their rooms, alcohol use also dropped from an average of 15.7 drinks daily to 10.6 after 1 year. Again, these rates continued to decrease as clients remained in the program. In addition, researchers also found a statistically significant reduction in the number of days the residents reported intoxication.

While there was some initial rejection of the DESC by potential neighbors, the project is considered a huge success, and many of its former critics adopted a more positive view after seeing how successful and non-intrusive the project was in their neighborhoods.

#### **Ottawa: Using Harm Reduction to minimize the risk for homeless alcoholics**

Before Seattle implemented their extensive Housing First plan for homeless alcoholics, in 2001 Ottawa built a more modest single site program based on the Harm Reduction model. Unlike Seattle, they did not provide separate rooms that resembled permanent housing for their residents, but instead created a shelter of beds and a system to dispense alcohol hourly in small medical dosages. As with the program design, their results were more modest than Seattle's but still point to the power of these types of programs to reduce city costs and improve the quality of life for its residents. The population targeted was one of the most vulnerable in the city:

- the average resident indicated their alcoholism was ongoing for 35 years;
- most reported daily use of alcohol through the consumption of at least one non-beverage such as mouthwash;
- the majority indicated they had tried at some point to abstain, or had been through detoxification programs without success; and
- 88% of the participants also had some form of mental or physical illness.

The results from a study in the Canadian Medical Association Journal indicate clear benefits for the individuals involved in the program<sup>xxv</sup>:

- the average daily consumption of alcoholic drinks dropped from 46 to 8;
- most participants indicated they had improved qualities of sleep, personal hygiene, nutrition and health;

- employees reported that 88% of participants complied with their prescription medication requirements;
- problems with the police decreased by 51%; and,
- trips to the emergency department decreased by 36%.

The program cost \$771 Canadian per individual monthly, which was offset by reductions in emergency department, hospital, and police services of a combined \$447 monthly. While the program did not pay for itself, the positive improvements in the lives of the residents and the reduction of burden on needed community services indicate that it provides a very valuable resource in Ottawa. Furthermore, it points to the power of this type of program to change lives. As demonstrated in Seattle, the potential for positive outcomes increases when a harm reduction model is paired with Housing First.

### **How do other cities pay for these services?**

In a comprehensive review of cities targeting reductions in chronic homelessness, HUD found commonalities in the ways the most successful programs were funded.<sup>xxvi</sup> The report indicated that a diverse group of funding sources is extremely important, and they write that reduction goals will not be achieved if only Federal aid is utilized for services. The report found that the integration of Federal, state, and local dollars, and the inclusion of mainstream public agencies was critical to the success of most initiatives. One example of non-Federal funding is the contribution of downtown business organizations, which HUD connected to success in Birmingham, Columbus, Philadelphia, and San Diego. For a complete list of HUD recommendations, please see Appendix A.

Other cities have also developed innovative new ways to fund their homeless initiatives. For example, in 1993 Miami imposed a 1% tax<sup>xxvii</sup> on meals in restaurants with liquor licenses that generate over \$400,000 in revenue.<sup>xxviii</sup> This tax creates roughly 13 million dollars annually for their homeless programs, and is credited with an 87% reduction in homelessness in the city.<sup>xxix</sup>

### **Housing First programs in Travis County**

The Central Texas Recuperative Care Program (RCP) is the only Housing First option for chronically homeless single adults in Austin. This is a small, but successful program. Additionally, the Mobile Loaves and Fishes Habitat on Wheels (HOW) program is a unique concept that is currently housing 45 individuals in a variety of sites. The Mobile Loaves and Fishes organization is planning a large community in a single site.

#### **Central Texas Recuperative Care**

The Central Texas Recuperative Care program, operated by Front Steps, began in April of 2008. This program is designed for homeless individuals who require home health care after being released from the hospital. The purpose of the program is to improve patient health outcomes, decrease the cost of hospital recidivism, increase the use of community clinics rather than hospital emergency rooms, and

end the clients' homelessness. Substance abuse intervention is also included. The program places clients in a nursing home during their illness, and then moves them directly into housing thus ending their homelessness. Sobriety is not a requirement of continued housing; however, more permanent housing needs to be identified because the program's capacity for housing is nearing exhaustion. Most of the participants face significant substance abuse problems along with their illnesses, and the program has seen many become sober as a result of the housing, support, and counseling provided.

Although 182 patients were initially recommended for the program, there was only space for 30, and of these 22 exited successfully. Those who did not exit the nursing home successfully either died, left against medical advice, or were asked to leave due to behavior issues. 17 of the 22 are now housed. 6 clients had a history of frequent use of the ER; 1 of these had 30 visits in one year, another had 16 in 1 year, another 14 in 1 year. For these heavy users, admission to the RCP resulted in a clearly demonstrated reduction in ER visits. 2 success stories illustrate the power of this program:

- 1 patient who averaged 15 ER visits per year for over 5 years had only 2 ER visits in the year following his discharge from the RCP. It is worth noting that neither of these visits was related to alcohol abuse, when very nearly each of the 90 ER visits in the previous 5 years had been. This patient now maintains housing, a steady income, and health insurance, in addition to his sobriety.
- Another of these frequent users has reduced his ER use from 14 visits in the 6 months prior to his RCP admission to only 3 in the year following his discharge from the RCP. Mental health issues and drug use contributed to this client's poor health and poor self care over the years; however, he is no longer using illegal drugs, is receiving mental health services, and is continuing to meet regularly with the RCP case manager who has assisted him to obtain SSI income and placed him on the waiting list for public housing.

The Nursing Home Component of the RCP costs \$284 per day. Once clients are housed, the cost is approximately \$11,000 per year for housing and support services. As more clients exit the program a study will be conducted to determine the cost savings to the community.

### **Habitat on Wheels (HOW)**

Habitat on Wheels (HOW) is a housing option provided by Mobile Loaves and Fishes. Currently HOW has 35 recreational vehicles that house 45 individuals in very well maintained mobile homes parks. The HOW vision is to create a community comprised of site-built park homes, single occupancy recreational vehicles, and camping cottages. A wide array of support services will be available on-site including case management, job training, and access to food. Residents will be charged anywhere from \$50 per month for a camping cottage up to \$350 per month for a recreational vehicle. Residents will be accepted regardless of their level of sobriety and will be allowed to live in the community as long as their behavior is not bothersome to their neighbors, similar to the scattered site models discussed previously in this paper.

### Substance abuse intervention programs in Travis County

There are a few substance abuse programs that provide emergency and transitional housing to individuals in the Austin community. However, other than emergency shelter beds many housing options are not open to individuals with demonstrated alcohol or substance problems. According to the 2008 CoC report, the following housing options were available for the overall homeless population:

**Figure 3:** Available Beds in Austin

| Type of Housing | Number of Year Round Beds Available |
|-----------------|-------------------------------------|
| Emergency       | 703                                 |
| Transitional    | 477                                 |
| Permanent       | 324                                 |
| Safe Haven      | 15                                  |
| <b>Total</b>    | <b>1519</b>                         |

There are several alcohol intervention programs in Austin that provide treatment services to the homeless. The following may not be an exhaustive list of what is available, but it demonstrates the types of programs that exist currently.

#### **My Place**

The *Make your Path, Leave Addiction and Choose Excellence* (MYPLACE) Program, operated by Caritas of Austin, provides 20 transitional housing beds and substance abuse counseling for homeless adults with chemical dependencies. 25 percent of program clients are chronically homeless. The objectives of MYPLACE are client income generation, residential stability, self-care, and appropriate use of the recovery-based group housing model. MYPLACE is in 5 nearly new 4 bedroom homes in stable neighborhoods; located in north and south Austin. It is a recovery resource for any case manager in Austin working with a single adult person who is homeless and in recovery. MYPLACE has been operating since the fall of 2007. Of the 13 persons who exited the program during the most recent program year, 8 have exited to permanent housing.

#### **The Salvation Army**

The Salvation Army Adult Rehabilitation Center is a Christian-based residential program with room for 117 men who commit to complete sobriety from alcohol and drugs as a condition for entrance into the home.<sup>xxx</sup> They must also agree to 6 full months of treatment at the center, and are frequently tested for compliance with the drug and alcohol free policies. Services including work training, counseling, and substance abuse classes are available to residents, along with religious courses to help encourage participants to embrace Christianity during their treatment.

### **Project Recovery**

Project Recovery, operated by Travis County MHMR, is aimed at individuals repeatedly arrested for public inebriation who are given a choice between committing to this substance abuse program or going to jail. Individuals may have combined diagnoses of mental illness and alcohol dependence. The program is limited to 15 individuals at a time, and served a total of 92 individuals in 2008. Those who opt for treatment rather than serving out their jail term are admitted to Project Recovery which utilizes a 180-day treatment model. The first 30 days consist of intensive residential treatment that includes a minimum of 30 hours a week of substance abuse treatment programming. During next 31-60 days, individuals receive help to obtain identification cards, primary health care from the health district and employment. Days 61-90 are focused on helping employed individuals open a bank account and facilitate their reintegration to community living. After completing the initial 90 residential component of the program, individuals receive follow-up case management services. In addition, program graduates are encouraged to attend Alcoholics Anonymous meetings and peer support with other graduates. Those individuals who decide to withdraw from the program before completion are required to return to jail.

### **Alameda House**

Alameda House, operated by ATCMHMR, is a 90-day transitional living program. The goals of the program are to assist adult mentally ill individuals with developing skills to live independently in the community. Alameda House also serves mentally ill adults who have substance abuse issues and are on probation. Caseworkers and consumers develop a treatment plan together which addresses areas of identified deficits. Consumers work on such issues as anger management, relapse prevention, medication management, leisure skills, budgeting skills, and stress management. The goal is to apply the learned skills towards independent living in the community.

### **Oxford Houses**

The Oxford Houses are individual homes scattered throughout the community that are linked through a national nonprofit organization supporting sober living. The rented homes are described as democratically run, self-supporting, and drug free<sup>xxxi</sup>. Austin has 10 homes for men, and 4 for women throughout the city. Residency is strictly based on sobriety, and relapses are unconditional terms for eviction. The rent for each resident is around \$100 a month, and admittance is based on a favorable vote by at least 80% of the current residents of a home. Those who enter Oxford Houses are typically exiting short-term treatment facilities or detoxification programs, and all are considered recovering addicts.

## **Recommendations**

In order to respond to the County-wide problem of alcohol abuse among our homeless population, Travis County requires a range of services intended to address this issue. Those with lower stage alcohol problems require a different set of resources than those with the most severe forms of dependency. While some homeless individuals will benefit from and respond to transitional housing paired with

substance abuse programs, others may require a more intense, supportive environment that provides on-site healthcare, case management, and additional resources.

In order to initiate a plan to address these problems, we recommend 6 initial steps:

1. Obtain commitment and support for housing solutions for the chronically homeless with alcohol and/or mental health problems from the Mayor, County Judge, City Council, Travis County Commissioners and other key leaders from both the public and private sectors;
2. Set housing the chronically homeless street population as a priority for the City and County;
3. Identify frequent service users and assess their needs. Determine the service gaps that Housing First options will fill using nationally respected surveys to identify the subpopulation of homeless individuals with alcohol disorders, and to determine the overall level of vulnerability and need in Travis County;
4. Assess the cost of frequent service users and explore ways to redirect current funding towards Housing First options for middle and late stage alcoholics under a Harm Reduction model;
5. Examine the funding sources used in more successful cities and determine what resources may be applied in Travis County, and;
6. Identify the leadership responsible for implementing the plan.

**1. Obtain commitment for housing solutions for the chronically homeless with alcohol and/or mental health problems from the Mayor, County Judge, City Council, Travis County Commissioners, and other key leaders both from the public and private sectors.** Several community leaders, including Mayor Leffingwell and City Council Member Sheryl Cole, have demonstrated commitment to helping homeless people in Austin. The End Community Homelessness Organization (ECHO) is the umbrella organization whose members coordinate and plan for the continuum of homeless services. ECHO should work with the community in taking a leadership role in ending chronic homelessness.

**2. Set housing the chronically homeless street population as a priority for the City and County.** This step is recommended by the U.S. Department of Housing and Urban Development Department. The basis of the recommendation lies in the fact that addressing this high service utilization population will free up needed resources for other populations.

**3. Identify frequent service users and assess their needs: Determine the service gaps.** The Downtown Austin Community Court and Austin Resource Center for the Homeless (ARCH) both have lists of the “frequent service users” who repeatedly and consistently appear in their programs. ARCH, for example, has identified a small subset of shelter residents who utilize their basic needs services (showers, restrooms) but do not access the case management services that would help them in ending their homelessness. Shelter managers have observed a significant amount of alcoholics among this population.

**Survey Tools:** As part of the implementation of the spectrum of services for homeless alcoholics in Austin, we recommend that Austin implements one or more of the best practice assessment tools used to collect data on the numbers, needs, and distinctions among our local homeless population. In particular, we would like to identify those who are frequent users of basic services but do not access available services. Three possible examples of survey tools are described below.

- a. **The Vulnerability Assessment Tool:** Developed by the Downtown Emergency Service Center in Seattle, the Vulnerability Assessment Tool is a short but powerful tool that case managers and shelter staff can use to quickly assess an individual's level of vulnerability. The staff member who fills out the form has a very explicit scale for each factor that allows them to carefully rate the individual's impairment, and the probability that they will face increased difficulties on the street. This assessment could be an important part of the identification of clients for many of the Housing First options proposed in this paper, and will help emergency shelter staff and other service providers isolate those who require additional, immediate aid. For more information on this assessment, please see Appendix B for the full description of each scale.
- b. **The Vulnerability Index:** Developed in cooperation between Dr. Jim O'Connell and the nonprofit Common Ground, the Vulnerability Index (VI) is an inexpensive and quick way to gather a great deal of information about the homeless community and the level of risks faced by its members. The VI, which consists of 45 questions, is administered early in the morning over the course of several days by a team of volunteers, under the management of an expert. Homeless individuals are asked to participate but may refuse, and if comfortable, are digitally photographed in order to create an inventory of the population. The VI is a way to gather and share data that raise awareness of the issue of homelessness and its associated mortality rates. By bringing these issues to light, individuals in the community will begin to notice, consider, and care for the homeless around them more than before they had specific information about the population as well as individual stories of struggle and tragedy. For more information on this index, please see Appendix C.
- c. **The Arizona Self-Sufficiency Matrix:** Similar to the Vulnerability Assessment Tool, Arizona Department of Housing's Self-Sufficiency Matrix is used to assess the ability for a homeless individual to function independently. People are assessed along 17 domains of functioning including substance abuse, income, childcare, and parenting skills. The results of the assessment questions can be scored and placed into the matrix to determine how someone ranks – from 1 to 5 – along a scale of sufficiency in each category. For more information on this matrix, please see Appendix D for the full description of each domain along the scale.

- 4. Assess the cost of frequent service users.** Another way to increase public support for these projects is to conduct a comprehensive study of the cost to taxpayers of the most frequent users of public services including hospitals, ambulances, police, courts, and prisons. The burden on all of these resources will likely be reduced with the implementation of Housing First and Harm Reduction-based programs for homeless alcoholics. Identifying the current price tag of the chronically homeless may motivate community members to support new programs. Work from other cities indicates that there may be initial resistance to the idea of providing housing to homeless alcoholics, but that the cost benefits and ease on city services are persuasive to those not motivated by the call for housing as healthcare.
- 5. Examine funding sources in Austin and other more successful cities.** HUD recommendations call for a varied and diverse set of funding sources in order to fully implement successful programs that reduce chronic homelessness. A detailed evaluation of the resources used in more successful cities will help clarify the best practices for funding new initiatives, and make it easier for Austin to determine what new resources may be applied to create and maintain a spectrum of services for homeless alcoholics.
- 6. Identify the leadership responsible for implementing the plan.** Service providers and government agencies cannot solve the problem of homelessness alone. The range of resources and services needed are beyond the scope of any one administrative entity or community organization. Business, community, and social service leaders should help fashion the long-term plan, and communicate the need and benefits to the city. By building collaboration among many groups, it will emphasize both the importance and the widespread support of the project.

The Ending Community Homelessness Organization (ECHO) is a coalition of service providers and community members in Austin dedicated to planning, prioritizing, and developing strategies to end homelessness. ECHO is working to expand its membership to include political organizations, business organizations, law enforcement officials, hospitals, housing authorities, and other non traditional partners. One organizing model for Austin may be Seattle, which forged a Chronic Public Inebriates (CPI) Task Force alliance between providers, senior law enforcement officials, neighborhood association leaders, and the Downtown Seattle Association to combat the problems associated with this homeless population. The CPI Task Force published a report that recommended increasing treatment and housing options for chronic public inebriates, working with law enforcement officials to manage illegal and disruptive public behaviors, and adopting evidence-based Harm Reduction and Housing First models. Thereafter, the CPI Task Force enlisted a large number of community partners to stand together to deal with potential opposition by emphasizing cost savings and looking for partners with significant political influence. A large partner “safety net” reduced the risk for all participants. Ultimately, Seattle has successfully collaborated to reduce the cost and social burden of chronic public inebriates while at the same time providing them appropriate housing and support.

## Conclusion

Even without a comprehensive survey of our homeless population, we know there are hundreds of individuals in danger on the Austin streets. Though there are many structures in place to target those without housing, Austin and Travis County need a long-term plan rooted in proven Housing First and Harm Reduction strategies to handle the dramatically overlapped problems of homelessness and severe alcoholism. With the guidance of other cities like Seattle and Portland, our community can provide better care to the most vulnerable members of the homeless population, save valuable resources in our community, and increase the quality of life and hope for a better future for individuals experiencing the dually debilitating conditions of homelessness and alcoholism.

DRAFT

**Appendix A: “Key Elements of Success to Reducing Chronic Street Homelessness”<sup>xxxii</sup>**

U.S. Department of Housing and Development, Office of Policy Development and Research

The following were determined to be connected to success in cities where chronic homeless was reduced significantly as part of community-wide long-term plans:

- 1) A paradigm shift in the goals and approaches of the homeless assistance network.
- 2) Setting a clear goal of reducing chronic street homelessness.
- 3) Committing to a community-wide level of organization.
- 4) Having leadership and an effective organizational structure.
- 5) Having significant resources from mainstream public agencies that go well beyond homeless-specific funding sources.
- 6) A trigger event that was the catalyst for developing the preceding five elements.
- 7) Significant involvement of the private sector.
- 8) Commitment and support from mayors, city and county councils, and other local elected officials.
- 9) Having a mechanism to track progress, provide feedback, and support improvements.
- 10) Being willing to try new approaches to services.
- 11) Having a strategy to handle and minimize negative reactions to locating projects in neighborhoods (“Not in my neighborhood” NIMBY responses).

**Appendix B: The Vulnerability Assessment Tool**  
 The Downtown Emergency Service Center, Seattle WA

The following are the nine scales used to rate individuals' level of vulnerability:

**Survival Skills:** Vulnerability, safety, dependency on others, ability to maneuver independently in safe manner, judgment

| No evidence of vulnerability  | Evidence of mild vulnerability   | Evidence of moderate vulnerability  | Evidence of high vulnerability  | Evidence of severe vulnerability   |
|---|--|---|---|--|
| Strong survival skills; capable of networking and self advocacy; knows where to go and how to get there; needs no prompting regarding safe behavior | Has some survival skills; is occasionally taken advantage of (e.g. friends only present on paydays); needs some assistance in recognizing unsafe behaviors and willing to talk about them. | Is frequently in dangerous situations; dependent on detrimental social network; communicates some fears about people or situations; reports being taken advantage of (e.g. gave \$ to someone for an errand and person never returned or short changed) | Is a loner and lacks street smarts"; possessions often stolen, may be "befriended" by predators; lacks social protection; presents w/ fearful, childlike or helpless demeanor; has marked difficulty understanding unsafe behaviors | Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g. physical assault, robbed); prefers street to shelter; no insight regarding dangerous behavior (e.g. solicitation of sex/drugs) clear disregard for personal safety (e.g. walks into traffic) |
| <b>0</b>  | <b>1</b>   | <b>2</b>  | <b>3</b>  | <b>4</b>   |

**Basic Needs:** Ability to obtain/maintain food, clothing, hygiene, etc.

| No Trouble Meeting Needs  | Mild Difficulty Meeting Needs   | Moderate Difficulty Meeting Needs  | High Difficulty Meeting Needs   | Severe Difficulty Meeting Needs  |
|---|---|--|---|--|
| Generally able to use services to get food, clothing, takes care of hygiene, etc. | Some trouble staying on top of basic needs, but usually can do for self, e.g. hygiene/clothing are usually clear/good | Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs to assistance, e.g. prompting, I&R | Doesn't wash regularly; uninterested in I&R or help, but will access services in emergent situations; low insight re: needs | Unable to access food on own; very poor hygiene/clothing, e.g. clothes very soiled, body very dirty, goes thru garbage & eats rotten food; resistant to offers of help on things; no insight |
| <b>0</b>  | <b>1</b>  | <b>2</b>   | <b>3</b>  | <b>4</b>   |

**Physical/Medical:** Physical limitations or medical conditions that impact person's ability to function

| No impairment | Temporary impairment                    | Significant medical or physical issue, or Chronic medical condition that is being managed                            | Chronic medical condition that is not well-managed or physical impairment | Totally neglectful of physical health, extremely impaired by condition  |
|---------------|---|--|---|---|
|               | Cast x 4 weeks; recovering from surgery | Sight or hearing-impaired; Cerebral Palsy; smaller or larger stature/size making person vulnerable; seizure disorder | e.g. symptomatic & disabling physical illness                             | e.g. open wound, appears sickly, refusal to get treatment, missing limb |
| <b>0</b>      | <b>1</b>                                | <b>2</b>   | <b>3</b>  | <b>4</b>  |

**Organization/Orientation:** Thinking, Development Disability, memory, awareness, cognitive abilities – how these present and affect functioning

| No impairment   | Mild impairment   | Moderate impairment  | High impairment   | Severe impairment   |
|---|---|--|---|---|
| Good attention span; adequate self care; able to keep track of appointments | Occasional difficulty in staying organized; may require minimal prompting re: appointments; possible evidence of mild developmental disability; dementia or other organic brain disorder; some mild memory problems | Appearance is sometimes disorganized; has a significant amount of belongings making mobility challenging; occasional confusion w/ regard to orientation; moderate memory or dev. disability problems | Disorganized or disoriented; poor awareness of surroundings; memory impaired making simple follow-through difficult | Highly confused; disorientation in reference to time, place or person; evidence of serious developmental disability, dementia or other organic brain disorder; too many belongings to manage; memory fully or almost or absent / impaired |
| <b>0</b>  | <b>1</b>  | <b>2</b>   | <b>3</b>  | <b>4</b>  |

**Mental Health:** Issues related to mental health status, MH services, spectrum of MH symptoms & how these impair functioning

| No MH issues | Mild MH issues                                      | Moderate MH issues   | High MH issues   | Severe MH needs  |
|--------------|---|--|--|--|
|              | Reports feeling down about situation, circumstances | Reports having MH issues, but does not talk about them or reports having service connection already in place, may be taking prescribed medications | Tenuous service engagement, possibly not taking medications that are needed for MH, not interested in services due to mental illness / low insight | No connection to services (but needed clearly), extreme symptoms that impair functioning (e.g. talking to self, distracted, severe delusions/paranoia, fearful/phobic, extreme depressed or manic mood), no insight re: Mental Illness |
| <b>0</b>     | <b>1</b>  | <b>2</b>   | <b>3</b>   | <b>4</b>   |

**Substance Use:** Issues related to substance use, services, spectrum of substance use & how use impairs functioning

| No or Non-Problematic Substance Use  | Mild Substance use  | Moderate Substance Use  | High Substance use   | Severe Substance Use   |
|--|---|---|--|--|
| No substance use or strictly social – having no Negative impact on level of functioning. | Sporadic use of substances not obviously affecting level of functioning, is aware of Sub Use, still able to meet basic needs most of the time | Sub Use affecting ability to follow through on basic needs, has some support available for substance use issues but may not be actively involved, some trouble making progress in goals, e.g. could be a binge user | Sub Use obviously impacting ability to gain/maintain functioning in many areas, e.g. clear difficulty following through with appointments, self-care, interactions with others, basic needs (food, hygiene), not interested in support for substance use issues but this may be due to low insight or other reasons, e.g. mental illness | Obvious deterioration in functioning, e.g. MH, due to Sub Use, severe symptoms of both Sub use & Mental Illness, low or no insight into Sub Use issues, clear cognitive damage due to substances, no engagement with substance use support services (and clearly needed) |
| <b>0</b>   | <b>1</b>  | <b>2</b>  | <b>3</b>   | <b>4</b>   |

**Communication:** Ability to communicate with others, when asked questions, initiating conversations

| <b>No communications barrier</b>   | <b>Mild communication barrier</b>   | <b>Moderate communication barrier</b>   | <b>High level communication barrier</b>   | <b>Severe communication barrier</b>   |
|--|---|---|---|---|
| Has strong and organized abilities; no language barriers; able to communicate clearly with staff about needs | Has occasional trouble Communicating needs; language barrier may be an issue; occasionally reacts inappropriately when stressed | Some disorganized thoughts; poor attention span; withdrawn but will interact with staff/service providers when approached; pressured speech; very limited English | Physical impairment making communication very difficult ( e.g. hearing impaired & unable to use ASL); unwilling/unable to communicate w/ staff (e.g. shy, poor or no eye contact); doesn't speak English at all | Significant difficulty communicating with others (e.g. mute, fragmented speech) draws attention to self (e.g. angry talk to self/others) refuses to talk to staff when approached; may leave to avoid talking to provider |
| <b>0</b>   | <b>1</b>  | <b>2</b>  | <b>3</b>  | <b>4</b>  |

**Social Behaviors:** Ability to tolerate people & conversations, ability to advocate for self, cooperation, etc.

| <b>Predatory behaviors, and/or no problems advocating for self</b>  | <b>Mildly problematic social behaviors</b>   | <b>Moderately problematic social behaviors</b>   | <b>Highly problematic social behaviors</b>   | <b>Severely problematic social behaviors</b>   |
|---|--|--|--|--|
| Has a hx of predatory behavior; is observed to be targeting vulnerable clients to "befriend"; uses intimidation to get needs met (e.g. threatening and menacing to staff/clients); more than adequately advocates for own needs, if not overly so | Mostly "gets along" in general; if staff need to approach person, s/he can tolerate input & respond with minimal problems; may need repeated approaches about same issue even though it seems s/he "gets it" | Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some noncooperation problems at times | Often has difficulty engaging positively with others; withdrawn and isolated; has minimal insight regarding behavior and consequences; has few social contacts; negative behavior often interferes with others in surrounding; often yells, screams or talks to self | Responds in angry, profane, obscene or menacing verbal ways; may come across as intimidating and offputting to providers; may provoke verbal and physical attacks from other clients; has significantly impaired ability to deal with stress; has no apparent social network |
| <b>0</b>  | <b>1</b>   | <b>2</b>   | <b>3</b>   | <b>4</b>   |

**Homelessness:** Length of Time Homeless

| <b>Newly homeless</b>   | <b>Moderate hx of homelessness</b>                                      | <b>Chronically homeless</b>  |
|---|---|--|
| Has been homeless less than 1 month; new to the area (e.g. moved here looking for work or only here for the season) | Has been homeless for 1-12 months; few prospects for housing at present | Has been homeless for 1 year + or has had at least 4 episodes of homelessness within the last 3 years; may have no options for housing due to history, ability to participate in process, etc. |
| <b>0</b>  | <b>1</b>  | <b>2</b>   |

### **Appendix C: The Vulnerability Index**

The Vulnerability Index is based on a series of eight variables that, when individually or collectively paired with homelessness, dramatically increase the probability that an individual will die prematurely on the streets. These factors are:

- 1) more than three hospitalizations or emergency room visits in a year
- 2) more than three emergency room visits in the previous three months
- 3) aged 60 or older
- 4) cirrhosis of the liver
- 5) end-stage renal disease
- 6) history of frostbite, immersion foot, or hypothermia
- 7) HIV+/AIDS
- 8) tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition.

Other cities have used the VI to rank order the most vulnerable homeless individuals, and to immediately target these people for services. Although the primary goal of this paper is to present the idea of a focus on homeless alcoholics, the VI would provide a quick and inexpensive way to gauge the level of vulnerability in the overall population, to see how extensively proposed services for alcoholics would alleviate the overall degree of vulnerability in the community, and to determine how to precede with the construction of a spectrum of services for these individuals.

Portland Oregon recently discovered the power of the VI when they conducted the survey as part of a 10 year plan to end homelessness in their city. When the results were tallied, they found surprising and disturbing data about their homeless populations. Higher levels of vulnerability, and specifically tri-morbidity, were found than in other municipalities in which Common Ground worked. Newspaper articles highlighted the findings, public attention was raised, and city officials called for additional programs as a result.

**Appendix D: The Arizona Self-Sufficiency Matrix<sup>xxxiii</sup>**

| <b>DOMAIN</b>                           | <b>1</b>  | <b>2</b>   | <b>3</b>  | <b>4</b>   | <b>5</b>  |
|---|---|--|---|--|---|
| <b>Income</b>                           | No income.  | Inadequate income and/or spontaneous or inappropriate spending.  | Can meet basic needs with subsidy; appropriate spending.                          | Can meet basic needs and manage debt without assistance.   | Income is sufficient, well managed; has discretionary income and is able to save.   |
| <b>Employment</b>                       | No job.   | Temporary, part-time or seasonal; inadequate pay, no benefits.   | Employed full time; inadequate pay; few or no benefits.                           | Employed full time with adequate pay and benefits.   | Maintains permanent employment with adequate income and benefits.                   |
| <b>Housing</b>                          | Homeless or threatened with eviction.   | In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).      | In stable housing that is safe but only marginally adequate.                      | Household is in safe, adequate subsidized housing.   | Household is safe, adequate, unsubsidized housing.                                  |
| <b>Food</b>                             | No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food. | Household is on food stamps.   | Can meet basic food needs, but requires occasional assistance.                    | Can meet basic food needs without assistance.  | Can choose to purchase any food household desires.                                  |
| <b>Childcare<br/>(0=N/A)</b>            | Needs childcare, but none is available/accessible and/or child is not eligible.                           | Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.                      | Affordable subsidized childcare is available, but limited.                        | Reliable, affordable childcare is available, no need for subsidies.  | Able to select quality childcare of choice.   |
| <b>Children's Education<br/>(0=N/A)</b> | One or more school-aged children not enrolled in school.  | One or more school-aged children enrolled in school, but not attending classes.  | Enrolled in school, but one or more children only occasionally attending classes. | Enrolled in school and attending classes most of the time.   | All school-aged children enrolled and attending on a regular basis.                 |
| <b>Adult Education</b>                  | Literacy problems and/or no high school diploma/GED are serious barriers to employment.                   | Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment. | Has high school diploma/GED.  | Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society. | Has completed education/training needed to become employable. No literacy problems. |

|                         |   |   |  |  |   |
|-------------------------|---|---|--|--|---|
| <b>Legal</b>            | Current outstanding tickets or warrants.  | Current charges/trial pending, noncompliance with probation/parole.   | Fully compliant with probation/parole terms.   | Has successfully completed probation/parole within past 12 months, no new charges filed.   | No active criminal justice involvement in more than 12 months and/or no felony criminal history.                                    |
| <b>Health Care</b>      | No medical coverage with immediate need.  | No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.  | Some members (e.g. Children) on AHCCCS.  | All members can get medical care when needed, but may strain budget.   | All members are covered by affordable, adequate health insurance.   |
| <b>Life Skills</b>      | Unable to meet basic needs such as hygiene, food, activities of daily living.   | Can meet a few but not all needs of daily living without assistance.  | Can meet most but not all daily living needs without assistance.   | Able to meet all basic needs of daily living without assistance.   | Able to provide beyond basic needs of daily living for self and family.   |
| <b>Mental Health</b>    | Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems. | Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.   | Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.   | Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.   | Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns. |
| <b>Substance Abuse</b>  | Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary. | Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities. | Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month. | Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use. | No drug use/alcohol abuse in last 6 months.   |
| <b>Family Relations</b> | Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect.                               | Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.  | Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.   | Strong support from family or friends. Household members support each other's efforts.   | Has healthy/expanding support network; household is stable and communication is consistently open.                                  |

|                                     |   |   |  |  |  |
|-------------------------------------|---|---|--|--|--|
| <b>Mobility</b>                     | No access to transportation, public or private; may have car that is inoperable.                        | Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc. | Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured. | Transportation is generally accessible to meet basic travel needs.   | Transportation is readily available and affordable; car is adequately insured. |
| <b>Community Involvement</b>        | Not applicable due to crisis situation; in "survival" mode.   | Socially isolated and/or no social skills and/or lacks motivation to become involved.                                   | Lacks knowledge of ways to become involved.  | Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues. | Actively involved in community.  |
| <b>Safety</b>                       | Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement | Safety is threatened/temporary protection is available; level of lethality is high                                      | Current level of safety is minimally adequate; ongoing safety planning is essential                                    | Environment is safe, however, future of such is uncertain; safety planning is important                                | Environment is apparently safe and stable                                      |
| <b>Parenting Skills<br/>(0=N/A)</b> | There are safety concerns regarding parenting skills  | Parenting skills are minimal  | Parenting skills are apparent but not adequate   | Parenting skills are adequate  | Parenting skills are well developed  |

## Notes

- <sup>i</sup> O'Connell, Jim, MD. *Premature Mortality in Homeless Populations: A Review of the Literature* Nashville: National Health Care for the Homeless Council, December 2005.
- <sup>ii</sup> National Center for Health Statistics. "Deaths: Preliminary Data for 2006". 56(16) National Vital Statistics Report. June 11, 2008.
- <sup>iii</sup> National Alliance to End Homelessness, Fact Checker: Chronic Homelessness, March 2007. Available for download at [www.endhomelessness.org](http://www.endhomelessness.org).
- <sup>iv</sup> Estimated at 35% of homeless population, which is based on estimates of 35-40% throughout the literature.
- <sup>v</sup> See xvii , xxv, and xxvi.
- <sup>vi</sup> [www.commonground.org](http://www.commonground.org)
- <sup>vii</sup> National Alliance to End Homelessness, Fact Checker: Chronic Homelessness, March 2007. Available for download at [www.endhomelessness.org](http://www.endhomelessness.org).
- <sup>viii</sup> National Institute on Alcohol Abuse and Alcoholism, "Twelve-month prevalence and population estimates of DSM-IV alcohol abuse by age, sex, and race-ethnicity: United States, 2001-2002 (NESARC)" Downloaded from <http://www.niaaa.nih.gov/Resources/DatabaseResources/QuickFacts/AlcoholDependence/abusdep1.htm>
- <sup>ix</sup> Gregoire, Thomas, PhD. 1996. Subtypes of Alcohol Involvement and their Relationships to Exits from Homelessness. *Substance Use & Misuse*, 31(10), p.1333-1357.
- <sup>x</sup> *ibid* Gregoire.
- <sup>xi</sup> *ibid* Gregoire.
- <sup>xii</sup> 2008 HUD Homeless Programs Consolidated Application, Austin/Travis County Continuum of Care.
- <sup>xiii</sup> Estimate based on 35%.
- <sup>xiv</sup> <sup>xiv</sup> 2008 HUD Homeless Programs Consolidated Application, Austin/Travis County Continuum of Care.
- <sup>xv</sup> National Alliance to End Homelessness, Fact Checker: Chronic Homelessness, March 2007. Available for download at [www.endhomelessness.org](http://www.endhomelessness.org).
- <sup>xvi</sup> Horner, K. "'Frequent Fliers' run up Dallas County's homeless tab". The Dallas Morning News, August 2, 2009.
- <sup>xvii</sup> Criminal Justice Uniform Cost Report 2006-08, Texas Legislative Budget Board 2009
- <sup>xviii</sup> Tsemberis, S. (2004). "Housing First". In *Encyclopedia of Homelessness*. London: Sage Publications, 277-280.
- <sup>xix</sup> HUD Definition.
- <sup>xx</sup> Tsemberis, S. (2004). "Housing First". In *Encyclopedia of Homelessness*. London: Sage Publications, 277-280.
- <sup>xxi</sup> United States Interagency Council on Homelessness e-newsletter, "08 in 08", No. 4. December 30, 2008. Available for download from [http://www.ich.gov/newsletter/archive/12-30-08\\_8-8\\_e-newsletter.htm](http://www.ich.gov/newsletter/archive/12-30-08_8-8_e-newsletter.htm).
- <sup>xxii</sup> <http://www.endhomelessness.org/content/article/detail/2183>.
- <sup>xxiii</sup> National Alliance to End Homelessness, "Christian Community Health Center, Chicago, Illinois Providing Supportive Housing and Health Care". February 2009. Available for download at <http://www.endhomelessness.org/content/article/detail/2183>.
- <sup>xxiv</sup> Larimer, M., Malone, D., Garner, M., Atkins, D., Burlingham, B., Lonczak, H., Tanzer, K., Ginzler, J., Clifasefi, S., Hobson, W., Marlatt, A., 1999. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. *Journal of the American Medical Association*, 301(13), p.1349-1357.
- <sup>xxv</sup> Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., and Wells, G., 2006. Shelter-Based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol. *The Canadian Medical Association Journal*, 174(1), p.45-49.
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- <sup>xxvii</sup> Rohter, L., "Meal Tax to Aid Miami's Homeless". The New York Times, August 3, 1993
- <sup>xxviii</sup> Brook, R. & Raymond, D. "Fighting Homelessness in Miami". Gotham Gazette, September 22, 2008.
- <sup>xxix</sup> *Ibid* Brook & Raymond.
- <sup>xxx</sup> Information on the program is available at: [http://www.uss.salvationarmy.org/uss/www\\_uss\\_austinma.nsf/vw-sublinks/9A2663907BBC00DE802573140068AC0C?openDocument](http://www.uss.salvationarmy.org/uss/www_uss_austinma.nsf/vw-sublinks/9A2663907BBC00DE802573140068AC0C?openDocument)
- <sup>xxxi</sup> Information available at [www.texasoxfordhouses.org/austin](http://www.texasoxfordhouses.org/austin)

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<sup>xxxii</sup> Ibid U.S. Department of Housing and Urban Development.

<sup>xxxiii</sup> Available for download at the Arizona Department of Housing website, under the Rural Arizona Continuum of Care: <http://symmetricsolutions.com/ruralazhmis/documents.html>

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