

# Homelessness in the Omaha/Council Bluffs metro area

*Assessment of current needs and services,  
and options for action*

AUGUST 13, 2007



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# Summary

## *Background*

Wilder Research was asked by the Omaha Community Foundation to conduct a four-month study of homelessness in the Omaha and Council Bluffs area (April to July 2007). The primary purpose of the study is to assess current needs and identify potential strategies to support and build on the community's response to homelessness. This report describes the findings of that study and identifies opportunities for future action.

## *Method*

Multiple data sources were used in this investigation including notes from site visits and community forums, local planning and proposal documents, in-depth phone interviews with agency directors and service providers, a web survey of forum participants, and a review of published literature of effective service strategies.

## *Findings*

- Recent one-night estimates of the number of homeless adults, youth, and children in the Omaha-Council Bluffs area range between 1,750 and 1,900. According to the most recent survey of providers conducted by Wilder in June 2007, single men make up about one-half (48%) of the area's homeless population. Parents who are homeless with their children (mainly single mothers) together make up another 37 percent of the population. The remaining groups include women on their own (11%) and unaccompanied youth (4%).
- Current information does not provide an adequate description of the area's homeless population. The Homeless Management Information System (HMIS) is a useful tool for enumerating and describing some aspects of the population, but enrollment in this system is incomplete, especially among emergency shelter providers. Even where participation is nearly full, however, HMIS data are of limited utility to describe the characteristics and needs of the homeless with adequate detail.
- Although HMIS records are still incomplete, an analysis of recent data shows that in the Omaha/Council Bluffs area, as in other major cities across the U.S., racial disparities in the shelter system are pronounced. In particular, African Americans and Latinos are substantially over-represented among the homeless compared to their numbers in the general population. This fact was not widely discussed by providers during the two public forums that preceded this report.

- There is substantial evidence of good quality planning work, most recently with the Decision Accelerator and previously in the Community Development Plan (using specialty networks) prepared by the Omaha City Planning Department and the Omaha Area Continuum of Care for the Homeless (the predecessor of MACCH). While these plans identify most of the critical ingredients necessary for an effective community response to homelessness, they have been incompletely executed.
- Compared to other metropolitan areas of similar size, the approximately 1 to 1 ratio of emergency shelter beds to transitional and permanent supportive housing beds is unusual. During the past decade it has been more typical to hold down the growth of emergency beds and place greater emphasis on increasing the availability of transitional and permanent supportive housing units with ratios of 1 emergency bed to 2 or more transitional and supportive beds.
- The inclusion of residential substance abuse treatment programs as a part of the continuum of shelter services (grouped here mainly with transitional housing) is also unusual. Federal funding does not consider residents of such programs “homeless.” In planning and proposal documents from communities of similar size, these are typically not included as a primary housing resource.
- An analysis of current funding sources shows that, compared to other communities of similar size, private philanthropy bears an unusually large portion of the burden and that potential sources of public support (especially county and municipal government) are underrepresented in the overall mix. Potentially available federal dollars are also not being fully accessed, in part because the region’s funding requests do not match as well as they could with the federal priority on longer-term housing strategies.
- Many components of the basic safety net are underfunded compared to current need, including affordable housing, emergency assistance for rent and utilities, and affordable, accessible health care (including mental health, substance abuse treatment, and prescriptions). Especially in light of the number of persons that area stakeholders report to be in need of mental health services, this situation makes it harder to prevent homelessness, and to serve those already homeless and help them exit homelessness.

Area service providers are in substantial consensus on the following points:

- There should be a common goal to reduce or end homelessness.
- The resources required to help poor people avoid homelessness and to exit homelessness after becoming homeless are less than adequate for an effective response.
- The supply of housing that is available and affordable to low-income individuals and families, especially those with criminal histories and bad credit, is less than adequate.

- There is a high demand for emergency shelter services, but limited funding for them. Some providers are concerned that an increased emphasis on prevention could result in even fewer resources being available to respond to the high levels of distress of those already in shelters.
- There is a high level of interest in meeting the area’s needs for day services. However, most stakeholders who are not directly involved in providing such services do not appear to have strong opinions on how these needs should best be met. Based on the views that were shared with us as part of this assessment, it is not yet clear what role day services would play in an overall strategic plan for reducing or ending homelessness.
- MACCH is widely endorsed as the right organization to lead area planning and implementation efforts. There is significant interest among providers to simply “... get on with it and get something done,” suggesting that there may be substantial benefit associated with the completion of a fully coordinated plan with goals, accountabilities, and some early achievable objectives that can be realized within a 6 to 12 month time frame.

### *Opportunities for action*

The following ideas represent a range of potential action opportunities for consideration by funders, service providers, elected officials, and other stakeholders:

1. **Set a goal to reduce or end homelessness.** Seek commitment from all stakeholders including public officials in municipal, county, and state government to set a goal of significantly reducing or ending homelessness over the next 10 years in the Omaha/Council Bluffs area. This goal can serve as a beginning point for the development of specific strategies and a rallying point for public interest. It can also serve as a starting point for the creation of a “10 year plan for ending long-term homelessness,” a type of blueprint for addressing chronic homelessness that the U.S. Department of Housing and Urban Development (HUD) has encouraged and supported in cities and regions across America.
2. **Collect more extensive data for planning.** With MACCH leadership, in conjunction with or following the next January shelter count required by HUD (but early enough to ensure availability of data for the 2008 federal funding application), organize a more extensive data collection effort in order to more fully describe the population of people experiencing homelessness within the Continuum of Care region. This information can be used as a baseline planning document when setting targets for reducing or eliminating homelessness and as a tool for matching service needs with appropriate service provisions. Use of volunteer interviewers can also help build understanding and support for the needs of the homeless. During the same time

period, Omaha providers can more fully implement the HMIS system as a method for tracking individual service users over time and as a method of meeting reporting requirements established by HUD.

3. **Use current starting points to develop an action plan.** Undertake a strategic planning initiative led by MACCH that builds on the previous Decision Accelerator and specifies a series of action steps and accountabilities.
4. **Address distinct needs of families and youth.** In the strategic planning process, ensure that needs of homeless parents (mainly women) with children are separately assessed, and that shelter and program planning address the unique needs of this group. Also specifically address the distinct service needs of unaccompanied youth, who are among the least visible and most vulnerable of people who experience homelessness.
5. **Address systemic causes of racial disparities.** Historically, poverty has been more concentrated in minority populations and this pattern is amplified among the homeless. Virtually all studies of homelessness in the U.S. show a similar result. In the face of this, any plan for addressing and ending homelessness must take account of the potential causes of these disparities and respond appropriately, by improving access to education and job training, support for educational success, and access to equal employment and housing opportunities.
6. **Use private philanthropy for gap funding.** Over the next five years, seek to transition the role of private philanthropy to that of “gap funder” providing resources only in those cases where no other resources can be found at the federal, state, county, or municipal level. Shift the general funding of crisis services, as feasible, to the public “safety net” with private funders moving toward the role of producing more of the “start-up capital” necessary to test new shelter and service models and create more permanent housing and related support services for homeless and very low-income people.
7. **Create a technical assistance fund.** Create a technical assistance fund for MACCH and area providers to assist with the development of proposals and other requests for funding and resources to assist the homeless, prevent homelessness, and provide access to housing and services that can help people escape homelessness. When the region’s priorities are identified, such a fund could be used by MACCH as an entity, or by the specific agencies developing the highest-priority projects, to hire a grant writer or project developer with the needed specialized expertise. It could also be a way to offer training to help increase the project planning and proposal development skills of agency staff in general.

8. **Empower inter-agency pipeline committees.** Consider forming a “housing pipeline committee” made up of members of the MACCH board, together with representatives from affordable housing development groups; city, county, and state government representatives; funders; and other potential stakeholders. Such a group could plan, oversee, and facilitate the creation of housing opportunities for low-income, precariously housed and homeless people. Because of jurisdictional boundaries, it may be best to have one committee for Douglas and Sarpy Counties and a second committee for the Pottawattamie County.
9. **Strengthen the basic safety net.** In addition to affordable housing, address other areas of weakness in the basic safety net of services that help to prevent homelessness and help people who are already homeless to get and maintain stable housing. These include mental health services, health care, education and job training, transportation, and emergency housing and utilities assistance.

Overall it is expected that an agreed-upon plan with specific goals describing how all partners will contribute and be held accountable is essential to long-term and incremental progress in addressing homelessness in the Omaha and Council Bluffs area.

Moving toward a plan that is squarely focused on reducing homelessness and enhancing self-sufficiency for the homeless and near-homeless will require a fully developed continuum of care; a flexible provider response; substantial cooperation and engagement among service providers, funders, local and state government, and the community at large; and cooperative service strategies that help connect homeless people with the available services.

# Introduction and purpose

The Omaha Community Foundation, on behalf of a consortium of private funders in the Omaha/Council Bluffs metropolitan area, asked Wilder Research to study homelessness in the area, with particular attention to an assessment of current needs and potential strategies for supporting and building on the community's response to the issue. Wilder Research was also asked to develop a needs-based model for funding that response.

Wilder's study involved the following activities, which provided the data for this report:

- Notes from two visits to the community, including discussions with funders, the director of the Metro Area Continuum of Care for the Homeless (MACCH) and several of its members, site visits to two of the largest shelters, and community forums.
- A telephone survey of 19 directors of metro area agencies involved in direct service to the homeless, including detailed descriptions of 48 separate programs operated by these agencies (28 emergency shelter and supportive housing programs for homeless people, 14 residential treatment programs primarily serving homeless people, and 6 supportive service programs primarily serving homeless people).
- A telephone survey of 15 directors of metro area agencies involved in services intended to prevent homelessness.
- A web survey of individuals interested in helping to shape a coordinated response to homelessness in the Omaha metro area.
- A telephone survey of representatives of seven day services programs across the United States.
- A review of published literature on effective strategies for preventing and responding to homelessness and sources of funding for those strategies.
- A review of available documents relating to the incidence of homelessness in the Omaha metro area and current and planned activities to respond to the needs of those who are homeless or at risk of becoming homeless.
- A review of the Continuum's "SuperNOFA" application for federal homelessness funding by a professional consultant with specialized expertise in the development and funding of housing and services for people who are homeless.

# The current situation

This section reports the findings of the study on the Omaha/Council Bluffs region's current needs and services relating to homelessness, and findings on area representatives' views about the adequacy of the region's current response to homelessness.

## *Needs*

How many people are homeless?

The Omaha/Council Bluffs Continuum of Care, in its June 2007 application for federal Housing and Urban Development (HUD) funds, reported a total of 1,870 persons homeless on a single night in the three-county metropolitan area. This count is based on a census of shelter residents and a count of unsheltered homeless people on a single night in January 2007. It includes 1,632 homeless persons in shelters and 238 not in shelters.

Wilder's telephone interviews with area service providers, in June 2007, found a one-night count of 1,086 people in emergency shelters and transitional housing programs. An additional 257 people were in residential treatment programs that primarily serve persons who are homeless when they enter the programs. (We list this number separately because the federal government does not define such people as homeless during the time they are in treatment.) The difference between the survey numbers and the January point-in-time numbers may be due to slight differences in which programs were included, as well as seasonal variation.

Eventually, it is the goal of the Homeless Management Information System (HMIS) to track shelter usage and homeless persons served, and thus to be able to provide on-going counts of the homeless at any given point in time. However, the system is still relatively new and not all providers are using it yet.

It is notoriously difficult to estimate the number of people experiencing homelessness. The actual number (including those not using shelters) is unknown. Reported numbers are based largely on counts of those using shelters and other non-shelter services for the homeless, and thus typically rise and fall with the funding available to operate such services. In addition, the number of those in shelters fluctuates both daily and seasonally. Furthermore, an undue emphasis on one-night counts tends to under-represent the far larger number of people who experience homelessness over the course of a year. National studies show this number is three to five times the number on any given night.

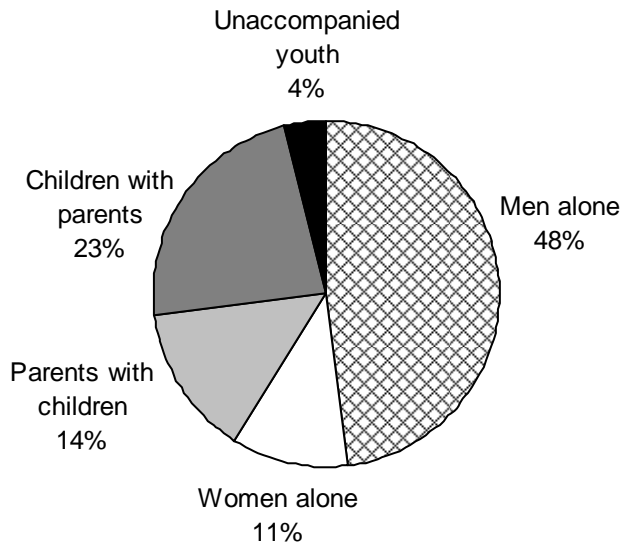
## Characteristics of people experiencing homelessness

The Continuum of Care's 2007 application reports that 1,870 persons were identified as homeless in January, including 532 in households that included dependent children, and 1,338 individuals who were on their own (not with dependent children). Of these individuals, 1,225 were adults and 113 were youth age 17 or younger who were on their own (not with a parent or guardian). The total of 1,870 includes 238 who were unsheltered on the date of the count.

In the one-night count provided by shelter programs in the June survey, there were 527 adult men and 123 adult women who did not have children with them, 151 parents who did have children with them, 254 children who were with their parents, and 39 unaccompanied youth (18 or younger in Nebraska, 17 or younger in Iowa) who were not with a parent or guardian. Based on studies done elsewhere, it seems likely that these numbers significantly underestimate the actual incidence of homelessness among unaccompanied youth, who are among the most invisible of all those who experience homelessness.

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### 1. Characteristics of sheltered homeless, June 2007 N=1,086



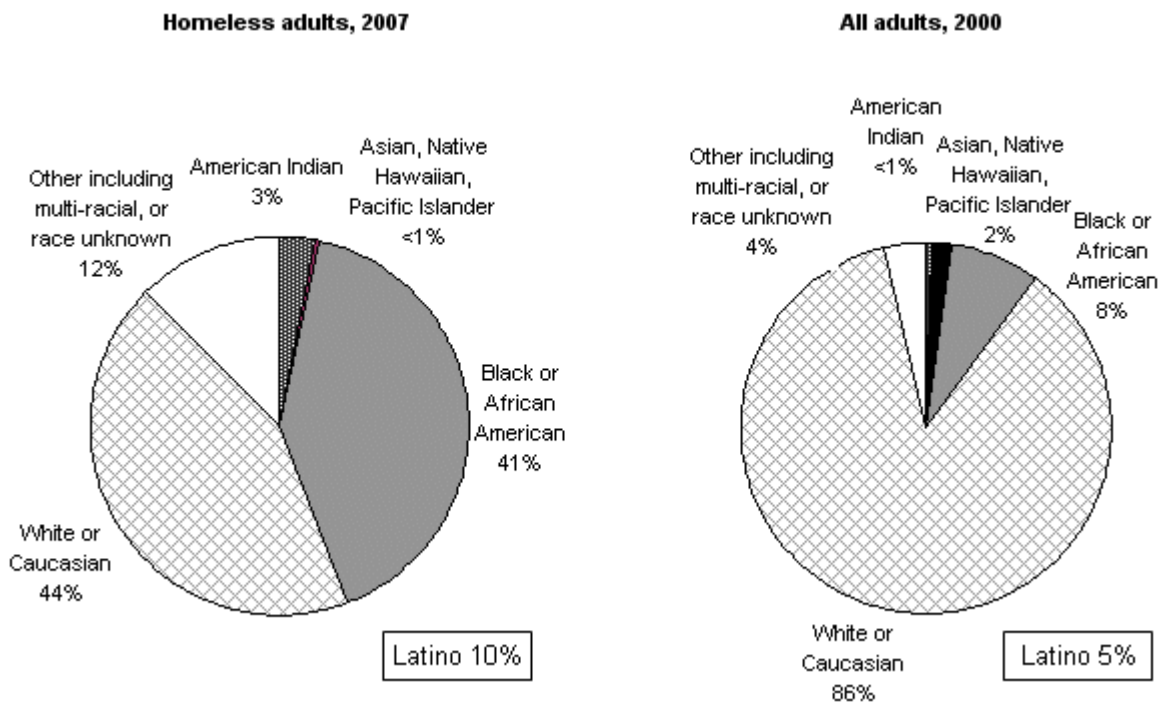
*Source: Wilder survey of shelter programs, June 2007.*

Based on information available from the Homeless Management Information System (HMIS) for the first half of 2007, homeless adults served by the area's shelter and other service providers were 44 percent White and 41 percent Black. Three percent were American Indian, fewer than one-half of one percent were Asian, Pacific Islander, or Native Hawaiian, and the remainder reported their race as multi-racial or "other." Ten

percent reported their ethnicity as Hispanic or Latino. By contrast, in the latest figures for the overall adult population of the region (the 2000 Census), Whites accounted for 86 percent, with Blacks only 8 percent and American Indians less than one-half of one percent. Five percent reported Hispanic or Latino ethnicity. (See Figure 2 below.)

This racial disparity in the incidence of homelessness is striking. However, it is not surprising, given comparable disparities in poverty rates already documented in the area. It is also not unique to the Omaha/Council Bluffs area. It reflects widespread disparities in other aspects of society, including access to education and other services, employment, and housing. The contrast is illustrated below in Figure 2.

**2. Racial and ethnic distribution of homeless adults compared to the overall adult population**



Sources: Homeless adults: HMIS data provided by MACCH. All adults: U.S. Census, 2000.

Shelter program representatives estimated that about 40 percent of people who are in their shelters at any given time have been homeless a year or longer in the current episode, or homeless four or more times in the last three years.

Among the 257 treatment center residents, individual men made up about the same proportion as in the shelters (47%). Compared to those in emergency and transitional programs, far more were individual women (40%), fewer were parents with children

(4%), or children with parents (9%), and none were unaccompanied youth. Just over half (52%) of treatment program residents were estimated to be chronically homeless at the time they entered the program.

The 1,870 people identified as homeless in the Continuum's January one-night count were estimated to have the following characteristics:

- Chronic substance abuse problems: 39% (731)
- Severely mentally ill: 22% (407)
- Victims of domestic violence: 15% (272)
- Veterans: 7% (123)
- Unaccompanied youth: 6% (113)
- Chronically homeless: 33% (615)

The incidence of substance abuse and mental illness, as well as of chronic homelessness, were estimated to be significantly higher among the unsheltered homeless than among those staying in shelters. This is consistent with what has been observed in other metropolitan areas.

In the Wilder survey, program representatives were asked about the biggest barriers that program residents face. Many different barriers were cited, but the most frequently mentioned (at 26% of respondents) was poor jobs and/or job skills. The other most commonly-cited barriers were poor health and/or health care (13%, including 32% of treatment program representatives) and a shortage of affordable housing and/or landlords willing to accept people (also 13%, including 18% of shelter representatives). Ten percent mentioned lack of financial resources.

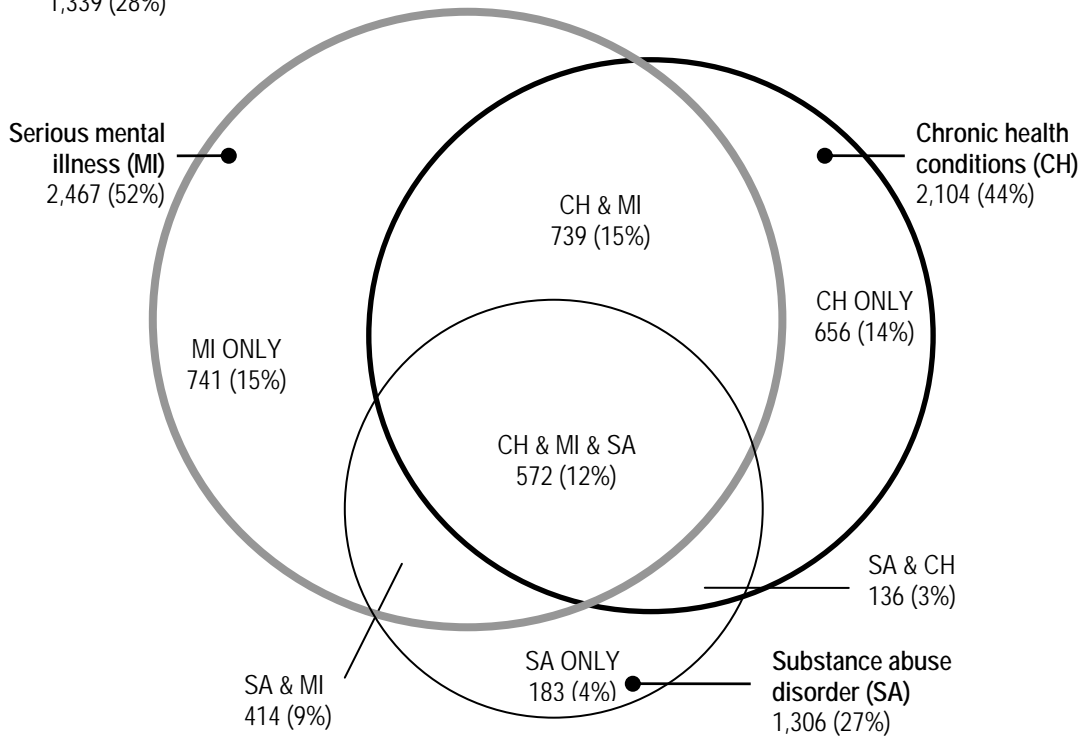
These findings suggest that the needs and characteristics of those experiencing homelessness in the Omaha/Council Bluffs area are consistent with characteristics observed in other homeless populations throughout the U.S. during the past decade: that is, significant concentrations of distress and disability, especially among those who have been homeless over longer periods of time (Weinreb et. al., 2006; Burt et al., 2001; Brown, 2006; Wilder Research, 2007). In particular, high rates of mental health problems, cognitive impairments and other health-related problems have been reported in multiple point-in-time studies conducted since 1997. For the long-term homeless these problems often occur in combination with other difficulties including substance abuse, partner and familial violence as well as recent incarceration for criminal behavior. The diagram below

(Figure 3) shows the co-occurrence of several of these disorders in Minnesota’s 2006 statewide study of homeless adults.

**3. Incidence and co-occurrence of disabilities among homeless adults**

Total homeless adults identified:  
4,781 (100%)

Proportion with none of these three disabilities:  
1,339 (28%)



Source: Wilder Research, 2006 Minnesota statewide survey of persons without permanent shelter.

In addition to these trends, the age, gender and racial/ethnic characteristics of the homeless in Omaha and Council Bluffs (based on available HMIS data) are similar to the demographic characteristics of homeless persons in other parts of the county. Approximately two-thirds of the sheltered homeless adult population is men but as many as 20 percent of homeless adults (mostly women) are accompanied by children. The average age of children is approximately 6, and the average number of children per household is two. Most family households (75-80%) are single-parent female headed households (Wilder Research, 2007).

People who are homeless for only a short period of time are less likely to be included in a count that takes place on just one single night. As a result, descriptions of characteristics of the homeless based on one-night counts tend to over-represent the characteristics of the long-term homeless. Experience elsewhere indicates that descriptions of those who experience homelessness at least once during the course of a full year include a higher proportion of women and children, whites, and people who do not have mental illness, addictions, or criminal histories.

### Community characteristics

Analysis of the 2005 American Community Survey shows that for Nebraska statewide, 56 percent of “Extremely Low Income” households – those with incomes at or below 30 percent of the median income – were paying half or more of their income for housing. This is considered a severe housing cost burden, and since so little money remains for other necessities, it constitutes a high risk factor for homelessness. It is also a significant increase from just one year earlier, in 2004, when the corresponding figure was 45 percent (Pelletiere & Wardrip, 2006).

According to a 2007 national analysis, there is currently a rapid increase in the number of households that are severely cost-burdened (spend more than half their incomes on housing). The problem is increasingly concentrated in households that are in the bottom quartile by income, which include a disproportionate share of residents who are low-wage workers, elderly, or disabled. At the same time, the share of the federal discretionary budget allocated for housing assistance is dropping, from 10.2 percent in 1998 to 7.7 percent in 2006 (Harvard, 2007).

In the surveys conducted by Wilder Research as part of this assessment, respondents frequently observed that there is a serious shortage of available, affordable housing in the Omaha metro area. This finding is hard to reconcile with the finding of *Omaha’s Five-year housing action plan for extremely low income persons with a serious mental illness* (Keelan, 2004, p.1.9), which stated that “The Community of Omaha has an excellent supply of modern, affordable housing for persons and families of low- to moderate income.” The Keelan report, prepared as part of the planning for the state’s mental health reform initiative, acknowledges that occupancy rates in nearly all of the affordable housing programs were at 98 percent or higher. The analysis estimated 3,379 severely mentally ill adults in Douglas County who were likely to be cost burdened or have other housing problems, and determined that there would be affordable housing units or beds targeted to meet the needs of about 31 percent of them by 2008. Some of these targeted beds include spaces in emergency shelters.

According to respondents to the Wilder surveys, much of the housing in the Omaha metropolitan area that is considered affordable is in practice not accessible to the current homeless population (with or without mental illness) because of a variety of restrictions in eligibility, including disqualifications for prior criminal behavior or drug use, or debt owed on past utility bills.

## *Services*

In order to examine current services available to respond to the needs of the homeless in the Omaha/Council Bluffs area, relevant questions were included in the agency director survey, the shelter provider survey, and the prevention services survey.

This section covers:

- Types of shelter programs available
- Numbers of transitional and permanent supportive beds compared to emergency (availability of support services with housing)
- Prevention services and other kinds of service (health, education, mental health, and others)
- Coordination of services (possible collaboration of providers in a day services model)

### Housing and shelter

As part of this assessment, Wilder Research collected in-depth information on 42 shelter and housing programs serving the homeless in the Omaha/Council Bluffs area. This is nearly all of the programs in the area. The Appendix includes a complete list of the surveyed programs, together with each one's location (Iowa or Nebraska), main population served, maximum capacity, number of residents on the most recent night, and residents' average length of stay.

To help assess the region's capacity to respond to differing kinds and levels of need, it is helpful to group programs into different categories based on the kind and level of services they offer (recognizing that the categories are not mutually exclusive, and it is sometimes difficult to clearly assign a program to one rather than another):

- **Emergency shelters:** Typically short-term programs, accessed directly by clients or by referral from another agency. Offer a safe sleeping space but may not be open during the day. Some also offer other services such as hot meals, health care, employment and/or housing information, and connections to other services. Some emergency shelters may be focused on the needs of unaccompanied youth, some on

victims of domestic violence. Residents in emergency shelters are considered homeless under federal definitions.

- **Transitional housing programs:** Typically longer-term programs of several months to two years. Offer subsidized housing with on-going support services, for people willing to work with a case manager to set and work on personal and housing stability goals, to prevent future homelessness. Some may be focused on families or other groups with special needs such as veterans or persons with mental illness. The federal definition of homelessness also considers residents in these programs as homeless.
- **Permanent supportive housing programs:** A different model of longer-term housing with supportive services in which there is no fixed limit to the resident's time in the program. In some (but not all), participants may not be required to participate in services as a condition to remaining in the subsidized housing. Typically focused on the needs of the chronically homeless or other individuals unlikely to be able to maintain stable housing without on-going support. Because the housing is not time-limited, the federal government does not count permanent supportive housing residents as homeless.
- **Treatment programs:** Like the above programs, these typically offer short-term or longer-term housing together with supportive services. Programs categorized as treatment programs in this list are those whose representatives identified the program's primary focus as treatment (with housing provided as a way to deliver or improve treatment) rather than housing (with supportive services as a means to stabilize housing). The federal government does not consider persons in residential treatment programs as homeless during the time they are in care.

According to MACCH documents and the Wilder survey, the region's Continuum of Care currently includes the following emergency and transitional housing programs for the homeless:<sup>1</sup>

- 14 or 15 emergency shelter programs with a total bed capacity of 907. At the time of the survey, these programs were housing a total of 685 people.

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<sup>1</sup> The count of programs is inexact, because agencies group their range of services into "programs" differently depending on the purpose for which they are being grouped. A set of shelter beds and associated services that serves the same primary population with the same overall mix of services may be counted as two separate programs if funded from different funding sources with different reporting requirements. A program with a common and interchangeable set of rooms that serves a varying mix of individuals and families depending on need may be classified as one program or two depending on the reason for the classification. It was not always possible to be certain whether a "program" in the Wilder survey matched with a "program" in the Continuum's documents.

- 2 domestic violence shelters for emergency shelter, with a total bed capacity of 69. At the time of the survey, these programs were housing 34 people. (There are also transitional housing programs focused on women and children who are recovering from domestic violence.)
- 14 to 16 transitional housing programs with a total bed capacity of 436. At the time of the survey, these programs were housing 367 people.

This totals to an overall capacity of 1,412 emergency and transitional housing spaces. Over half of these spaces – 779, of which all but 40 are in emergency shelters – are considered “overflow” capacity, beyond what shelters are designed to serve. These overflow spaces include 292 beds or cots in common areas, 255 mats on the floor in common areas, 167 motel vouchers, and 40 parking spots for people who cannot be sheltered inside a facility but who are provided with places nearby to sleep in their cars.

At the time of the survey these beds and overflow spaces were in use by 1,086 people.

#### Residential treatment and permanent supportive housing

Although the federal government does not consider people in residential treatment programs or permanent supportive housing to be homeless, such programs, like affordable housing, are an important part of an effective Continuum of Care for the homeless. Continuum documents and the Wilder survey show the following programs:

- 14 residential treatment programs, from single-night detoxification facilities to longer-term residential facilities, serving 257 people who were homeless at the time they entered. Although some programs such as short-term detox have no real limit, the bed capacities that were provided totaled 280 beds. Most of these programs report that their treatment is mainly for substance abuse. A few focus on co-occurring disorders. None reports focusing primarily on mental health treatment.
- 2 permanent supportive housing programs with a stated bed capacity of 138. A third permanent supportive housing program with 70 beds is in development. These programs are intended for formerly homeless individuals in need of subsidized housing with supportive services for an indefinite length of time.

According to the Continuum’s Housing Activities Chart (in its 2007 application for federal funds), emergency beds are 55 percent of all those intended for the homeless. Transitional and permanent supportive beds, which link supportive services to longer-term, more stable housing, are 39 percent and 6 percent, respectively, of the total beds intended for the homeless.

## Supportive services

Wilder's survey of shelter program providers collected detailed information about the services made available to emergency shelter and transitional housing residents, either directly by the shelter program itself or by arrangement with partner organizations. Figure 4 below shows the number and percent of programs that provide each kind of service, and (for those that provide it) the percent who provide it directly, indirectly, or both.<sup>2</sup>

### 4. Services provided or made available to shelter residents

	Shelters that provide the service (N=28 shelters)		How services are provided (as a percent of those shelters that provide the service)		
	N	%	Directly by the shelter	Indirectly by another organization	Either or both
Assessment of needs	26	93%	89%	4%	8%
Case management	25	89%	68%	4%	28%
Other health care	24	86%	4%	79%	17%
Mental health care	23	82%	52%	17%	30%
Transportation assistance	23	82%	83%	9%	9%
Services for children (if applies)	17	81%	53%	24%	24%
Referral/help with public benefits	22	79%	73%	9%	18%
Housing info/referral or tenant ed	21	75%	52%	5%	43%
Substance abuse services	21	75%	48%	24%	29%
Employment services	21	75%	67%	5%	29%
Counseling/legal advocacy for domestic violence	19	68%	16%	84%	0%
Hot meals	19	68%	95%	5%	0%
Life skills training	18	64%	53%	18%	29%
Other legal advocacy	17	61%	6%	94%	0%
Follow-up services after exit	15	54%	80%	7%	13%
Mediation (tenant/landlord)	11	39%	73%	9%	18%
Rent subsidy	10	36%	70%	30%	0%

Source: Wilder Research survey of homeless shelter program representatives, June 2007.

<sup>2</sup> Note that an assessment of the quality, scope, and accessibility of the identified services was beyond the scope of the current investigation.

Shelter representatives were also asked about the services that their residents most needed that could not be adequately provided. Affordable housing and mental health services led the list (21% each), followed by substance abuse services and case management services (11% each).

In a separate survey, representatives of a range of agencies that work with near-homeless individuals described a range of prevention services available in the Omaha/Council Bluffs area, and any limitations on their availability. These include:

- **Housing-related services** such as rent and utility assistance, mortgage foreclosure assistance, housing mediation and/or education. Some report that these are available to anyone of low income, but most report that the services are not funded at levels that match the extent of need.
- **Health-related services** including behavioral and mental health treatment and support, substance abuse treatment, and general health care services (including prescriptions and dental care). While most respondents report that these are nominally available for all people of low income, nearly all also report significant shortages, delays, or other impediments to service.
- **Help to meet other basic needs** including food, clothing, and furnishings. These were generally reported to be available to all who need them, although there may be limitations on frequency, and they may be more available to families than to individuals.
- **Other kinds of help** that were mentioned by more than one survey respondent included General Assistance; education in budgeting and financial literacy, and other kinds of training in basic life skills; help to access social services; and employment assistance. Respondents reported very mixed perceptions on how widely available these services are and the extent to which there might be limitations or restrictions to access for people at risk of becoming homeless.

The Homeless Management Information System (HMIS) allows service providers to record the services provided to each individual participant. However, Omaha and Council Bluffs use two different formats to collect and record service data, due in part to differing state reporting requirements. It is therefore not currently possible to describe actual services provided for the region as a whole, and differences in state requirements make it difficult to envision a simple or cost-effective resolution to this issue.

Currently the quality and quantity of data in HMIS varies greatly from one homeless service provider to another. According to the Omaha/Council Bluffs Continuum of Care SuperNOFA application, as of the fall of 2007, about 87 percent of emergency shelter

providers will be using HMIS but at the same time only 22 percent of transitional housing programs and 8 percent of permanent supportive housing programs will be using HMIS.

### ***Funding sources***

The Continuum of Care federal funding application indicates that five transitional housing programs currently receive federal funding through the McKinney-Vento Homeless Assistance Programs. According to budget information collected during the Wilder survey, funds received directly from federal sources make up only 10 percent of shelter budgets, on average. The main source, on average, is private individuals, at 32 percent, followed by state sources at 23 percent. (State and city funds include some federal funds received initially by the state or city and then re-distributed, as well as funds appropriated directly by the state or city.)

Based on available data, it appears that only two programs receive any county funding, and both are youth shelters serving primarily children removed from their homes due to abuse or neglect. Only four programs received any funding from the city, three of which are funded by federal dollars passed through the city. Two of these are operated in whole or in part by the City of Omaha Housing Authority. The fourth program reports receiving 1 percent of its overall budget from city sources.

Figure 5 below shows the sources of funding reported by the 26 shelter programs. Reading across the first row, 18 programs received at least some federal funds in the most recent complete fiscal year. These 18 programs combined received \$1,286,241 in federal funds. Overall, federal funds represented 10.0 percent of all reported funds for the 26 programs for the last complete fiscal year.

**5. Sources of funding for 26 emergency and transitional housing programs in the most recently completed fiscal year**

	<b>Programs funded</b>	<b>Total funds (\$)</b>	<b>% of all funds</b>
Federal <sup>(a)</sup>	18	\$1,286,241	10.0%
State	17	\$3,000,128	23.2%
County	2	\$217,504	1.7%
City	4	\$1,617,311	12.5%
<i>Subtotal: government</i>	<i>24</i>	<i>\$6,121,184</i>	<i>47.4%</i>
Private individuals	16	\$4,096,317	31.7%
The United Way	10	\$626,040	4.8%
Corporations/Businesses	12	\$755,820	5.8%
Foundations/Charities	13	\$469,734	3.6%
Other <sup>(b)</sup>	19	\$867,701	6.7%
<i>Subtotal: private</i>	<i>26</i>	<i>\$6,815,612</i>	<i>52.6%</i>
<b>Total</b>	<b>26</b>	<b>\$12,936,796</b>	<b>100.0%</b>

*Source:* Wilder Research survey of shelter representatives, June 2007.

*Notes.* (a) City, county, and state funding amounts include some federal flow-through funds that were applied for and re-distributed by the lower level of government. (b) "Other" includes earned income, client fees, the program's own parent agency and/or other community organizations, reimbursements, and bank interest. In-kind donations are not represented in this table.

The following table (Figure 6) shows the comparable information about funding sources for treatment programs. Compared to shelter programs, treatment programs receive a higher proportion of funds from government sources, and especially from the state.

**6. Sources of funding for 14 treatment programs in the most recently completed fiscal year**

	<b>Programs funded</b>	<b>Total funds (\$)</b>	<b>% of all funds</b>
Federal <sup>(a)</sup>	10	\$956,357	12.8%
State	10	\$3,978,905	53.1%
County	7	\$780,387	10.4%
City	6	\$39,397	0.5%
<i>Subtotal: government</i>	<i>12</i>	<i>\$5,755,046</i>	<i>76.8%</i>
Private individuals	13	\$1,299,092	17.3%
The United Way	2	\$6,925	0.1%
Corporations/Businesses	4	\$107,845	1.4%
Foundations/Charities	5	\$156,322	2.1%
Other <sup>(b)</sup>	10	\$164,610	2.2%
<i>Subtotal: private</i>	<i>14</i>	<i>\$1,734,794</i>	<i>23.1%</i>
<b>Total</b>	<b>14</b>	<b>\$7,489,839</b>	<b>100.0%</b>

*Source:* Wilder Research survey of shelter representatives, June 2007.

*Notes.* (a) City, county, and state funding amounts include some federal flow-through funds that were applied for and re-distributed by the lower level of government. (b) "Other" includes earned income, client fees, the program's own parent agency and/or other community organizations, reimbursements, and bank interest. In-kind donations are not represented in this table.

These amounts include only cash funding, not the dollar value of additional in-kind donations. Of the 26 shelter programs, 19 (or two-thirds) received at least some in-kind donations in the last fiscal year. These were almost all from private individuals (all 19 programs) and corporations or businesses (14 programs), with a smaller number of programs reporting in-kind donations from foundations or public charities (6 programs).

## ***The adequacy of the region's current response to homelessness***

The city of Omaha's 2006 Consolidated Action Plan recognizes "an increase in need for shelter nights of 25 percent and in meals provided of 12 percent" from the 2004 action plan. This increase in service need is causing strain on shelters and service providers.

### Findings on overall bed capacity

The 39 programs that provided one-night count data and the overall capacity of their program showed a combined 77 percent use of overall capacity. This includes 71 percent capacity in shelters, 78 percent capacity in treatment programs, and 114 percent capacity in non-shelter services. Emergency shelters, at 75 percent of capacity, and treatment programs, at 78 percent, were operating at higher percentage of capacity than the other shelters (63%). In the case of the emergency shelters, where over half of capacity is in the form of overflow accommodations (beds or mats in common spaces, motel vouchers, or parking spaces), this represents a significant use of spaces beyond what the facilities were designed for.

Substance abuse treatment programs were operating at a higher percentage of designed capacity than other programs except for emergency shelters. None of the programs reported being primarily for mental health treatment. Both treatment and shelter providers ranked mental and chemical health treatment at the top of their clients' unmet needs. One-third of all providers indicated that mental health services are one of the main service needs that cannot be met for their clients (17% for chemical health services). This need for mental and chemical health services was also indicated by respondents of the web survey in which they were ranked the highest needed services in the Omaha metro area. Survey respondents and forum participants also frequently mentioned the difficulty of meeting acute and chronic health care needs of the homeless.

Another measure of the adequacy of services is the number of potential residents who must be turned away for lack of space on any given night. In the Wilder survey, 10 out of 13 emergency shelters were able to estimate the number turned away nightly, and only 2 of these 10 reported that they were usually able to serve all who requested a place. Including all 10, the average number turned away per night was 4.7, or 11 percent of capacity. All three of the domestic violence shelters reported regularly having to turn people away, with an average number of 2.7, or 12 percent of capacity.

While it may seem odd that programs operating at less than 100 percent of capacity would report having to turn people away, it is normal for at least some rooms to be unavailable at any given time due to repairs or other maintenance. When programs are operating above

designed capacity (as many of the emergency shelters are), it is especially hard to maintain maximum capacity at all times.

Transitional housing programs, treatment programs, and permanent supportive housing programs typically operate with waiting lists, so there is no comparable calculation for turnaway statistics.

In its January application for HUD funding the Continuum of Care reported an unmet need for 714 emergency beds (including 160 family beds and 554 individual beds), 421 transitional housing beds (all individual), and 679 permanent supportive housing beds (all individual). These figures were estimated by the Omaha/Council Bluffs Continuum of Care based on the sheltered and unsheltered count of homeless people, the count of beds in the current housing inventory, and the views of region providers. They are likely to be sensitive to variation based on judgments about how to classify certain programs that cross standard categories.

Findings on needs for certain kinds of programs

Besides the adequacy of the overall number of beds, it is also important to consider whether there are enough beds (or programs) to serve the *kinds* of people who need help to escape homelessness.

Currently, aside from domestic violence shelters, relatively few of the emergency shelters are set up to serve families. However, almost all of the transitional housing programs serve families as their main focus. It is heartening that the region thus ensures that most homeless children are served in the safer and more stable environment that transitional housing offers. However, there is thus very limited capacity in the Continuum of Care for individuals to leave emergency settings for environments in which they can learn and practice the skills for more normal living.

Although five youth emergency shelters are listed as part of the Continuum, all but one focus on youth placed through the child welfare or juvenile justice systems. Only one is familiar with the unique needs of youth who are homeless and not under the jurisdiction of the state or county. It is rarely safe for such youth to seek shelter in adult facilities.

Given the high proportion of homeless persons who are estimated to suffer from chronic alcohol or chemical dependencies (39%), it is striking that only one emergency shelter will accept such individuals without a commitment to participate in treatment.

Emergency shelters function as the front door to assistance for people experiencing homelessness, and this restriction effectively closes the door to help for a large fraction of those who need it. Research (reviewed in the next section) shows that homeless persons

in need of treatment for substance abuse or mental health are more likely to enter and complete treatment when it is not required as a condition for housing.

### Opinions about the adequacy of the response

There is some disagreement among stakeholders in the Omaha/Council Bluffs area about the adequacy of the region's current response to homelessness. A few feel that the current emphasis on services in mainly emergency housing settings is serving the region reasonably well and should be continued. Most feel that there should be more service available in the context of longer-term supported housing (on-going supportive services in temporary or non-time-limited subsidized housing).

There is much more agreement on the need for more effort to reduce the flow of people into homelessness and to strengthen the region's capacity to more quickly move homeless people into permanent housing. There is also strong interest in greater coordination of the region's efforts, increasing assessment of needs and planning to identify gaps and prioritize responses.

Most agency directors believe their own agencies, programs, and/or clients would benefit from a more coordinated regional response. All express willingness to participate, although a small minority of answers reflect some degree of skepticism or mistrust of other agencies or directors. However, shelter providers and representatives of prevention-oriented agencies are nearly unanimous in their agreement that MACCH is the right organization to bring shelter and other service providers together in a coordinated response. Significant numbers of agency leaders look to MACCH, as an independent organization, to collect and use reliable data to assess needs and prioritize outcomes, help increase and diversify the region's sources of funding, and help develop and implement coordinated, evidence-based plans for responding to the needs of the homeless. There is also substantial interest in having MACCH help to coordinate greater advocacy efforts on behalf of the homeless and the agencies working to prevent and respond to it.

The following services are most often mentioned as needed but not being adequately met:

#### **For people at risk of homelessness:**

- Emergency help with rent, utilities, or mortgage foreclosure prevention
- Basic income/financial support and emergency financial assistance
- Budgeting and/or financial education and appropriate banking products and services
- Mental health care, treatment, and support services

- Substance abuse (and other addiction) treatment and support services
- Adequate, reliable transportation

**For people already homeless:**

- More shelter and supportive housing capacity and more affordable housing in the community in which people leaving shelters can be placed (that is, without eligibility restrictions that make them inaccessible)
- Mental health assessment, treatment, and other services including shelter beds or other emergency and longer-term supportive housing for people with mental illness
- Shelter and services for people with chemical dependency, including assessment, treatment, and support
- Case management and/or an on-going supportive relationship between staff and clients, including case management that follows clients across programs. This theme also includes follow-up services for clients after they leave shelter.

***Summary of the current situation***

A review of available services for the homeless, current funding sources, and provider opinion regarding existing and needed services, leads to the following conclusions:

1. Providers agree that it is desirable to improve the coordination of homeless services within the region. MACCH is seen as the right organization to lead in the development of a coordinated service plan. There is also a desire to have better information about the characteristics and needs of people experiencing homelessness, in order to better understand their needs. This can help to respond appropriately to the distinctive needs of the chronic homeless, homeless families, and unaccompanied homeless youth.
2. People at risk of homelessness are likely underserved. Although there are a variety of services in the community that can help to keep people from slipping into homelessness, current resources to prevent evictions, foreclosures, and utility shutoffs are enough to serve only a small fraction of those who need them.
3. Nearly half the region's nightly emergency shelter capacity is in spaces designated as "overflow," most of which offer little or no privacy, and many of which do not include a bed.

4. Longer-term accommodations in transitional or permanent supportive housing programs are fewer than half (45%) of available spaces for homeless persons.
5. Although most programs provide multiple kinds of services, directly or by arrangement with other agencies, most agency leaders feel that their residents have needs they are unable to meet adequately, especially for affordable housing and mental health services.
6. Many people are unable to leave shelters because of the lack of affordable and accessible permanent and supportive housing options. Although this problem is not located within the emergency shelter system, it makes the emergency shelters appear overtaxed and in need of additional resources. The lack of longer-term housing with supportive services is likely also a part of the reason for the widely shared view that the region needs to create a capacity to have case management that can follow an individual from shelter to shelter. As a result of Nebraska's statewide mental health reform, which will include the closing of two regional treatment centers, there will be a number of previously institutionalized low-income persons with mental illness who will need appropriate care and housing in the community. This is likely to add to the shortage of affordable housing.
7. Funding is heavily dependent on private giving. Few shelters receive funding from local government. Although a majority receive some funds from federal sources, the total amount of federal funding comprises only 10 percent of the total required for shelter programs.

# What can be learned from best practices in the field

## *Matching needs to service delivery*

How needs can be better understood

One of the best ways to understand the scope of homelessness and the ability of service providers to respond is through the use of reliable, accurate, and comprehensive data that can be used to measure current needs and future progress in addressing homelessness. Evidence-based decisions are critical in taking steps to use scarce system resources in the most effective and efficient manner possible.

While the Homeless Management Information System (HMIS) offers a future promise of consistency of data elements, the reality is that not all service providers enter data into HMIS, data elements are not consistent across the entire Continuum of Care region (Iowa and Nebraska), and not all providers who participate enter data on all of their clients. Agencies serving clients experiencing domestic violence are currently exempt from using HMIS. Service providers receiving only corporate or private funding are also not required to use HMIS, although many such agencies do report at least minimal data to HMIS.

A second concern regarding HMIS is that it is mainly designed to aggregate data for reporting to federal and state funding sources. Although it is a complex data system, it yields an incomplete picture of history, service needs, and health background, and is not readily accessible for in-depth analysis. The nine universal data elements are only partially available and the additional supplemental assessments are completed on only a small number of homeless adults.

HMIS data can generate a variety of data reports that will be very useful to MACCH and other homeless service providers, but caution must be used not to over-promise what HMIS can do. One idea currently being discussed is to have central intake and open data sharing between programs in order to eliminate the repeated data entry and duplication of participant data. While on the surface this has great appeal, careful consideration of the feasibility of implementing such a system warrants great caution. The first concern would be how to maintain data integrity when more than one agency has data access. The second major concern is protecting the data privacy rights of the participant. Policies to ensure data security and data privacy would need to be addressed carefully.

HMIS data, the January point-in-time survey required for HUD funding, and individual agency and program records all play an important role in understanding homelessness issues, but by themselves they are not able to adequately describe the range of characteristics of people experiencing homelessness in the Omaha/Council Bluffs area. Survey responses from agency representatives as part of the present study reiterate the need for more comprehensive data as basis for planning and grant writing. By supplementing these three data collection resources with an annual or biennial survey of persons experiencing homelessness, the quality of the data would be strengthened.

The benefit of such a survey would be to provide a more comprehensive picture of the characteristics of homeless persons, service needs, service use, history of homeless, disabilities, and other areas to be determined by the MACCH group. This survey would attempt to include all homeless service providers as well as a strategy for reaching the unsheltered homeless population. Such a survey, using volunteer interviewers, could also help build awareness and support for addressing the needs of those experiencing homelessness.

In conclusion, each data source mentioned above has its strengths and limitations but together it is possible to create a profile of the local homeless population, their needs, and an understanding of the range of possible solutions. This, combined with enhanced analysis of the data collected, can be used as a basis for proposals, planning, and policy decisions, and for measuring success in addressing and ending homelessness in the Omaha/Council Bluffs area.

How services can be better matched to needs

A Continuum of Care for homeless persons is understood to include outreach, emergency shelter, treatment, transitional housing, and permanent supportive housing (Tsemberis et al., 2004). Initially it was presumed that people must progress in that sequence, from one step to the next, in order to be ready for each subsequent level of independence. However, recent studies of outcomes of different types of supportive housing find that such a sequence of steps is often perceived by the homeless as a sequence of barriers rather than a ramp toward independence, and that homeless persons can re-establish stable housing more quickly in “low-demand” supportive housing that includes relatively few conditions on their behavior or compliance (Tsemberis et al., 2004). Even for chronically homeless individuals with serious mental illness and co-occurring substance abuse, supportive housing has been shown to be effective and successful, and some evaluations have identified specific program components that appear to help to produce this success (Wells et al., 2003).

In response to emerging findings on the value and effectiveness of longer-term supportive housing – housing that includes rental subsidies and supportive services in the context of

an individualized case plan – the mix of shelter services for homeless people has shifted over the past 10 years. Between 1996 and 2005, while the total number of beds grew by about 6 percent, the number of emergency beds fell by 35 percent while the number of transitional housing beds grew by 38 percent and the number of permanent supportive housing beds grew by 83 percent (HUD 2007).

The ratio of longer-term supportive housing beds to emergency beds is now typically well over 1 to 1, and often exceeds 2 to 1. For this assessment, Wilder reviewed Housing Inventories from the 2007 HUD funding applications of the Omaha/Council Bluffs region and two other mid-sized, Midwestern Continuums of Care, chosen because of their success in reducing homelessness (as documented by the National Alliance to End Homelessness). The comparison (Figure 7) shows that the Omaha/Council Bluffs region has 0.8 longer-term beds for every 1 emergency bed listed in the Housing Activity chart. Since as many as 40 percent of the longer-term beds may be more accurately classified as residential treatment (based on information provided by the programs), this ratio is likely to be closer to 0.5 longer-term beds for every 1 emergency bed. The ratios in the other two regions are 1.5 to 1 and 3.6 to 1. (A more extensive comparison, including social and economic context and selected federal funding amounts, is included in the Appendix.)

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## 7. Mix of emergency and longer-term shelter capacity in three regions

	Omaha/ Council Bluffs	Columbus	Minneapolis
Adult emergency (including overflow)	902	1225	859
Domestic violence shelters	55	34	74
Youth emergency	52	16	50
Emergency total	1009	1275	983
Adult transitional	662 <sup>(a)</sup>	108	742
Youth transitional	0	51	48
Permanent supportive housing	117	1,772	2761
Supportive housing total	779	1931	3551
Ratio of longer-term to emergency beds	0.77	1.51	3.61

*Source:* Calculations by Wilder Research based on each Continuum of Care's 2007 SuperNOFA application for McKinney-Vento funding.

*Note.* (a) Based on information from providers, it is likely that approximately 40 percent of these beds are better described as residential treatment.

The cost per bed of supportive housing programs has been found to be no more than those for emergency shelter (Wong, Park, & Nemon, 2006). For persons with serious mental illness, the cost of the program has been found to be more than offset by decreased public costs incurred by the public hospital, prison, and shelter systems (Culhane, 2001).

As with programs for persons experiencing chronic homelessness, studies of programs for homeless parents with children also show higher motivation and completion rates for “low-demand” programs compared to those with more stringent rules and conditions (Camasso et al., 2004; Nolan et al., 2005). The evidence so far suggests that the main priority in service design has less to do with specific services than with certain key principles of good practice: a climate of respect and trust in which client autonomy and satisfaction are valued; identification of individual needs and tailoring of services to meet them; communication between service providers and housing providers to resolve any problems arising between the two key components of the program; and provision of services specific to the needs of children (not only services for parents) (Nolan et al., 2005).

These findings of the value of supportive housing do not detract from the important roles of the other components in the Continuum of Care. Outreach is important to find and build trust among those not yet using shelters or services. Emergency shelter is important to meet basic needs while homeless peoples’ conditions can be assessed and stabilized and appropriate housing can be arranged. However, research consistently documents the importance of placement as quickly as possible into housing that has both greater stability and greater privacy than is possible in most emergency shelters. A Continuum needs a coordinating organization to set plans for a balanced mix of the types of shelter, ensure effective linkages among them, and develop and support linkages to mainstream services (Wong, Park, & Nemon, 2006).

The full continuum also includes prevention. Research shows that even for individuals with serious disabilities, subsidized and/or affordable housing and culturally appropriate discharge planning (for hospitals, treatment programs, and detention facilities) can be effective in preventing homelessness. Attention to the adequacy of the basic safety net is also important, including income supports, health care, education and training, employment, and life skills training. Finally, an essential component of the full response to homelessness must include attention to the supply of safe, accessible, affordable housing.

An effective Continuum of Care also includes specific provision for the prevention of homelessness and response to homelessness among unaccompanied youth and young adults. Most of this group have prior experience in foster care, group care, residential treatment, and/or juvenile corrections (Owen et al., 2007; Toro et al., 2007). Prevention services can be thus be most effectively targeted at youth in foster care just before and

after they reach the age of majority and are released from guardianship, as well as to youth who are leaving treatment or juvenile corrections programs or facilities.

There is little evaluation research available on the effectiveness of programs serving homeless youth. Practices thought to be promising include: first, emergency shelter that provides not only basic needs but also family counseling for reunification, at a level of intensity suitable for the extensive conflict that is often present in families of runaway and “throwaway” youth (Owen et al., 2003). Youth who are unlikely to be reunified with families should be housed as soon as possible in more stable transitional housing or independent living facilities, where housing is combined with case management services that include educational and employment goals and services, health care including mental and chemical health as needed, training in independent living skills including financial management and tenant education, and parenting education for those who already have children of their own (Owen et al., 2003; Toro et al., 2007). In addition, effective prevention and service programs are sometimes located in public schools, usually as after-school programs, and often include not only educational support but also a range of physical and behavioral health supports. School-based interventions may be the most effective way to provide services to homeless youth who are “couch surfing” – that is, staying temporarily with a succession of other people (Toro et al., 2007).

### Day services

Most literature on effective Continuums of Care for persons experiencing homelessness emphasize the provision of housing, with services mainly as a means to help clients get or keep the housing. Day services are mainly discussed as part of an outreach effort to help unsheltered homeless people gain the trust and motivation needed to seek additional help in a program that includes housing.

In order to better understand current day service program models and how they might best fit within the Omaha/Council Bluffs mix of services, Wilder conducted a telephone survey of day service program directors in seven communities across the United States. The survey examined service goals and objectives, variations in service models and populations served, funding sources, and any program restrictions or exclusions. The survey found that of the programs surveyed, most shared the following common goals:

- To provide a safe place for people to spend their day
- To help take care of people’s immediate needs such as food, clothing, laundry, health care, and the like
- To help people connect to services to get them into stable housing

- To help people connect to other services or benefits such as SSI, welfare, education, job training, or the like
- To reach out and build trust with people in need of shelter or treatment who are not currently receiving them

In addition, while most program directors felt it was desirable to serve populations of women and children separately from single men, in practice most did not. However, two of five program directors would not serve people who were intoxicated or actively using, and a third program director said that services would be conditional on individual functioning.

Each program offers a unique array of services. The particular configuration of services within each program is shown below:

1. Daily: Breakfast, hot lunch, showers, bathroom. Rotating days: Mental health worker, clothing, Health Care for Homeless, help for housing needs, arts and crafts, movies. Only clothing and meals are provided by own agency; others are from outside providers.
2. Breakfast 7 days/week. Bathrooms, storage, showers, clothing closet, local and long distance phone, mailing address, message board, personal care items, social work services (case management, employment, etc.), mental health services, advocacy (consumer, political), multicultural services (Spanish-language caseworker). Weekly food pantry. At night, the center is an overnight shelter for adult women.
3. Meals, laundry, showers, day rehab (workshops, Narcotics Anonymous, arts, crafts), access to medical – must participate hourly in groups. “Uplifting components” e.g., parties, annual barbecue, field trips, etc.
4. Bus tickets, showers, clothing, mailing address, local and long distance phone calls, vouchers for food boxes from food pantry, help getting ID (state ID, birth certificate), rest rooms, info on access to other services, VA social worker, case managers, laundry voucher to laundromat, personal hygiene kits. Access to housing and shelter.
5. Breakfast and lunch, food shelf, clothing bank, hygiene center (showers etc.), an address to use, message service, washers/dryers, a place to get information on where to go to find housing and other services. “A place where people can come to regather themselves.” Help people get free glasses, if they have their prescriptions.
6. Health Care for Homeless, Access, VA, eye doctor, some case management. Student dentists. Employment lab with computer; connections with temp agencies.

7. Phone messages, address, voice mail. Help with resumes and applications. Professionals from others groups to provide services. Mental health services. Storage, meals, laundry, showers, clothing. Help with GED/tutoring. Linkages to other services.

Two of the programs report that they do not serve adults with children. Of those who do serve adults with children, one offers a separate teen center for those under 21, and another reports that very few adults in the population served are actually accompanied by children. Three of the programs also serve unaccompanied youth.

All but one of the programs will serve poor and near-homeless people, in addition to those in shelters or on the streets.

All programs report a diversity of funding sources. The most common sources include (in order of frequency) city dollars, private donations, including annual fundraising campaigns, United Way, Federal HUD or CDBG dollars, and county dollars. Corporate donations (outside of the United Way) were available to only one of the day centers.

#### Components of the full Continuum of Care

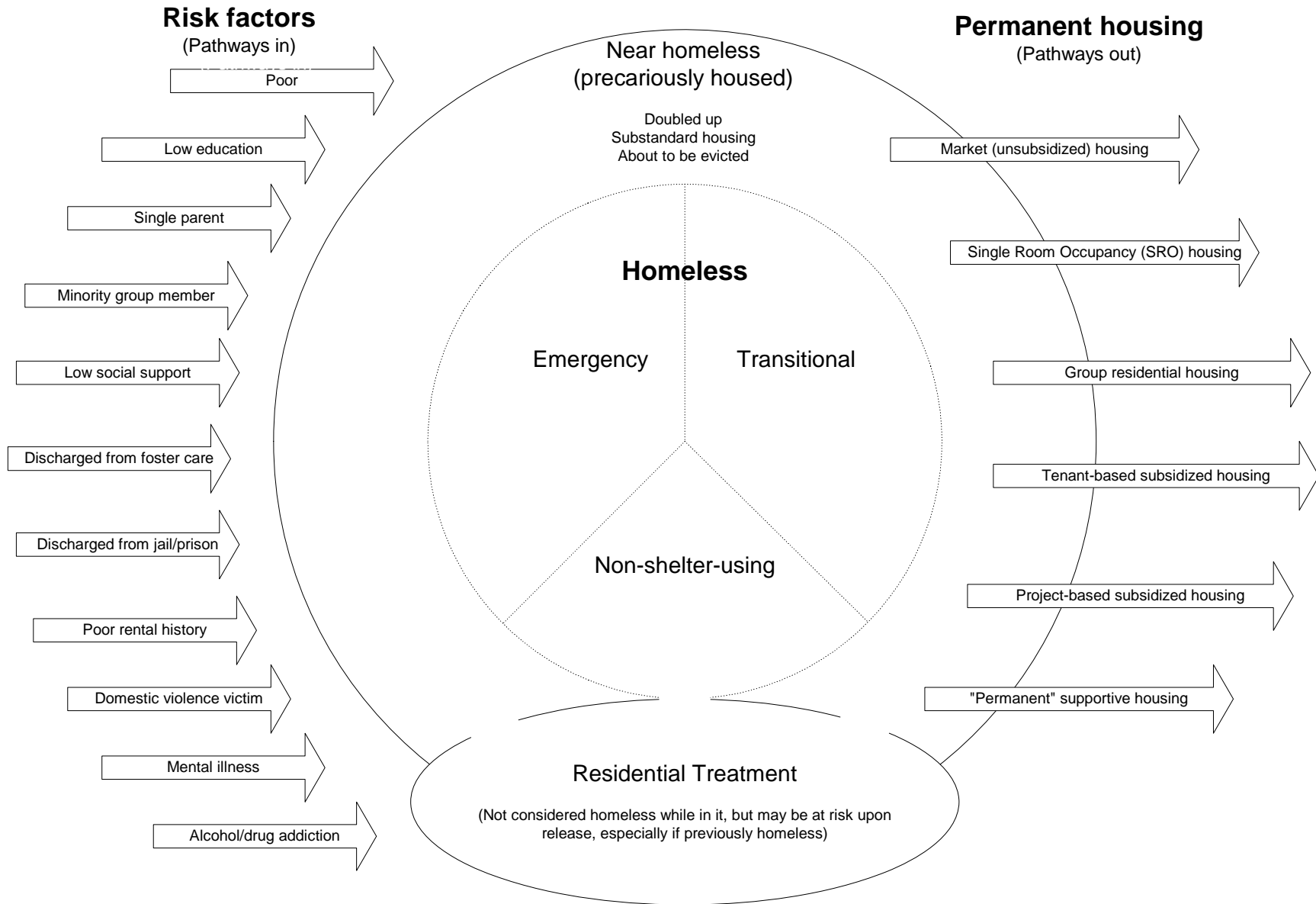
The figure on the following page (Figure 8) provides a visual representation of pathways in and out of homelessness. Risk factors, shown on the left side of the figure, have been identified from a wide range of research findings from throughout the U.S.

The center portion of the figure distinguishes between the near homeless (those who are precariously housed and at risk of becoming homeless) and the literally homeless (those who fit the federal definition of people experiencing homelessness). A separate portion near the bottom of the figure identifies those who are in residential treatment for substance abuse and/or mental health problems, who may have been homeless prior to entry, and/or may be at risk for homelessness upon release.

The right side of the diagram identifies the range of permanent and supportive housing options that are necessary for responding to the diverse range of those who become homeless.

The diagram does not represent the array of service options that have been found to be useful in preventing those who are precariously housed from becoming homeless. These are represented in a later diagram (Figure 11).

**8. Pathways in and out of homelessness**



## *How funding can be well balanced and maximized*

According to Wong, Hadley, et al. (2006, p.2), “Since the establishment of Stewart B. McKinney Homeless Assistance Act in 1987, permanent housing has been a major focus of HUD programs that specifically serve homeless people.” Most of the growth of permanent supportive housing has occurred in the last 10 years, during which time federal funding for the homeless has shifted from 17 percent devoted to permanent housing options in 1997, to 45 percent in 2004 (Wong, Hadley, et al., 2006).

A national study conducted in 1997 found that one-fourth of all housing programs for the homeless were entirely supported by government funding, another 30 percent received more than half their funds from government sources, and 22 percent received government funds that contributed less than half of their total annual funding (Burt et al. 1999). We were unable to find any more recent comprehensive descriptions of funding sources, or any studies that compare sources of funding over time, or for different geographic regions. Most of the sources we consulted found that federal, state, county, and city funding are all important sources in a balanced response to local homelessness.

A comparison of the Omaha/Council Bluffs region’s funding sources to those of the nationally representative sample of shelters finds a much higher reliance on private sources in Omaha/Council Bluffs than is typical elsewhere. Since 1997, when the national sample was studied, an even higher proportion of shelter and related service funds has been shifted to government sources. Figure 9 below summarizes this comparison.

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### **9. Comparison of Omaha/Council Bluffs sources of funding with those for a national sample of shelters**

	<b>Omaha/Council Bluffs, 2007</b>	<b>National sample of shelters, 1997</b>
Less than half of funding from government sources	50%	22%
More than half (but not all) of funding from government sources	42%	30%
All of funding from government sources	8%	25%

*Sources:* Omaha/Council Bluffs: Wilder Research survey of shelter providers. National sample: Burt et al., 1999.

In addition to funding for emergency shelter and transitional housing, most sources in the published literature also stress the importance of strengthening resources for supportive housing and affordable housing, to help reduce the number of people becoming homeless. Since the flow into homelessness, especially long-term homelessness, has been shown to be strongly linked to increased need for public services, it is common for advocates and policy analysts to call for government funding, at all levels, to help address the needs for affordable housing, rent subsidies, and other safety net services to help prevent homelessness. This logical link is generally recognized in many of the recent plans for ending long-term homelessness, which include funding commitments from state and local governments, especially for the creation of supportive and/or affordable housing units. In some places, private funders have helped spur public funding by offering their own funds as seed money, contingent on the unit of government (municipality, county, or state) matching them.

In addition to using local revenues, cities and counties can also help to fund homeless assistance and prevention programs through their ability to draw down grant funds from state and federal sources. For this assessment, we examined current “flow-through” funding from the federal Community Planning and Development Program, which bases its funding on Consolidated Plans developed at the city, county, and/or state levels. (This analysis omits statewide amounts.) Note that funds accessed under these Consolidated Plans are to be used for community development to improve the well-being of low-income residents in general. Although they represent one important source of potential funding for services to people experiencing homelessness, they are typically also used for a variety of other purposes.

Figure 10 below compares the Omaha/Council Bluffs region with two other medium-sized Midwestern communities, Minneapolis (Minnesota) and Columbus (Ohio), chosen for their documented success in reducing homelessness. The City of Omaha receives less than the other two cities, although its per capita amount is approximately equal to one of the other two cities (Columbus). When county funding is added, the regional per-capita differences are greater, because none of the counties in the Omaha/Council Bluffs region currently receives funding under the Community Planning and Development Program. Even when the City of Council Bluffs funding is added (\$1,099,991 under the Community Development Block Grant, or CDBG), the combined amount for the Omaha/Council Bluffs region is slightly smaller on a per-capita basis than the lower of the other two regions in this comparison. A lengthier comparison of the three cities and their regions is included in the Appendix.

**10. Comparison of Community Planning and Development funding for Omaha and two other medium-sized, Midwestern cities**

County(ies) in region	Omaha Area Douglas & Sarpy, NE; Pottawattamie, IA	Columbus Franklin, OH	Minneapolis Hennepin, MN
<b>Population size</b>			
City population (est) 2006 <sup>(a)</sup>	424,988	728,432	373,188
Region population (est) 2006	724,858	1,095,662	1,122,093
<b>FY07 HUD funding received under Community Planning and Development Program</b>			
<b>City only</b>			
CDBG (Community Devt Block Grant)	\$5,076,098	\$6,609,044	\$13,828,033
HOME (HOME Investment Partnerships)	\$2,334,861	\$4,870,715	\$3,531,207
ADDI (Amer.Dream Downpayment Init.)	\$54,300	\$111,977	\$64,984
ESG (Emergency Shelter Grants)	\$220,997	\$286,322	\$597,347
HOPWA (Hsg Oppties for Persons w AIDS)	\$0 <sup>(b)</sup>	\$608,000	\$833,000
City total	7,686,256	12,486,058	18,854,571
City funds per capita for city	\$18.09	\$17.14	\$50.52
<b>County(ies) only</b>			
CDBG (Community Devt Block Grant)	\$0	\$1,866,367	\$2,485,239
HOME (HOME Investment Partnerships)	\$0	\$900,252	\$1,966,531
ADDI (Amer.Dream Downpayment Init.)	\$0	\$23,054	\$49,142
ESG (Emergency Shelter Grants)	\$0	\$80,862	\$107,896
HOPWA (Hsg Oppties for Persons w AIDS)	\$0	\$0	\$0
County total	\$0	\$2,870,535	\$4,608,808
County funds per capita for county	\$0	\$2.62	\$4.11
Total funds received <sup>(c)</sup>	\$8,786,247	\$15,356,593	\$23,463,379
Total funds per capita for region	\$12.12	\$14.02	\$20.91

*Source:* Calculations by Wilder Research based on data from U.S. Department of Housing and Urban Development (<http://www.hud.gov/offices/cpd/about/budget/budget07>) and population data from the U.S. Census (<http://quickfacts.census.gov/qfd/states>).

*Notes.* (a) Population for Columbus is from 2003. (b) HOPWA formula funds are only available to metropolitan areas with at least 1,500 cumulative AIDS cases. (c) The total funds for the Omaha/Council Bluffs area includes \$1,099,991 in CDBG funds received by Council Bluffs.

Funding for homelessness programs is increasingly based on a combination of multiple sources, even for individual programs. In a 2006 study of 28 permanent supportive housing programs in one major city, one study (Wong, Hadley, et al., 2006) found that only nine of the programs included no federal funding, while 10 included two, three, or more HUD program sources. Seventeen included local funding, some of it from the local municipal mental health department.

Combining multiple sources of funding requires knowledge of the availability and criteria for many separate levels of government as well as a variety of private sources, each of which often has different priorities and purposes. It thus requires increased knowledge and sophistication to secure the funding, know how to strategically combine different funding streams, and maintain records in order to report back to each funder as required. One important role of a coalition is to help develop and support this capacity among individual agencies and programs. Some consulting services specialize in keeping track of funding sources and their requirements, and help assemble needed partners, plans, and applications. Some regions have bundled funding sources to permit individual providers to submit a single consolidated funding request for all their needs (Burt & Spellman, 2007).

Plans to develop more supportive housing opportunities must be developed in close consultation with ongoing planning for housing needs identified in Nebraska's plans for mental health reform. The 2004 Omaha study referenced earlier included a number of housing program priorities and identified sources of funding, most of which overlap with sources most commonly accessed for programs to serve the homeless. Since the populations themselves overlap significantly, joint planning will be important. For example, the mental health plan indicates considerable expectations for use of the Nebraska Affordable Housing Trust Fund and other state-administered federal flow-through programs for this specific population, as well as local Housing Authority set-asides for the purpose. It also expects to use emergency shelter beds to house some of the persons with mental illness who will be needing care in Douglas County.

For communities seeking to develop a more integrated response to homelessness, one important challenge is securing the participation of critical systems outside of direct homeless assistance providers – especially behavioral health services and housing services (Wong, Park, & Nemon, 2006). Omaha is fortunate to already have active participation of both systems in its Continuum of Care planning. Given the vital role of affordable housing, it is desirable to have the involvement of as many Public Housing Authorities as possible. Similarly, the involvement of local Workforce Investment Boards is helpful in development of strategies to increase the incomes of people seeking to avoid or leave homelessness.

## Maximizing McKinney-Vento funding from HUD

In addition to the strategies listed above, there are several ways in which the Continuum of Care can put together its 2008 SuperNOFA application for McKinney-Vento funds to maximize its points and thus increase its chances for increased funding (Beech, 2007).

These include:

- Carefully assess each program listed in the Housing Inventory to be sure all of the beds listed serve people who fit the federal definition of homelessness (for example, do not include residential treatment centers or places for youth who are housed because of their involvement in child protection or juvenile justice systems). This will not only increase the accuracy of the inventory, but may also gain points by improving the percentage of beds participating in HMIS.
- Carefully review the methods by which unmet need is estimated. To make a convincing case for unmet need, ensure that reported unmet need is no larger than (a) the number of people identified as unsheltered, and (b) the number of available beds (capacity minus one-night count).
- Formulate objectives and action steps that give the greatest chance of being able to report positive outcomes in the coming year. List more, and more detailed, action steps if these are achievable. Concentrate on objectives that can be documented based on APR reports.
- Continue to leverage as much non-federal funding as possible, to maximize HUD points. In seeking matching sources of funding, concentrate efforts on projects that have the lowest leveraged proportion (that is, where federal funds current represent the largest proportion of total project budget). Make sure all currently leveraged funds – including the dollar value of donated goods and time – are fully documented and reported by each project.
- Examine how McKinney-Vento funds are divided between Supportive Services vs. Operations or Leasing. If more than half of HUD funding is currently being allocated to supportive services, consider increasing the application's points by modifying project budgets to allocate a higher proportion to leasing and operations. HUD awards full points to Continuums that have a housing emphasis of 85 percent. Continuums with a housing emphasis of 50 percent receive only half points.
- Given its current status of relatively few HUD-funded projects, the Omaha/Council Bluffs will be in an excellent position to develop new projects in the next few years, especially in 2008 and 2009. For full points, as many of these as possible should be

established as permanent supportive housing. Compared to other metropolitan areas, the region has a very low level of permanent supportive housing. Furthermore, the region is very fortunate in having unused “pro-rata” funds that can be used, without penalty, to create permanent supportive housing for populations other than the current HUD priority (persons experiencing chronic homelessness).

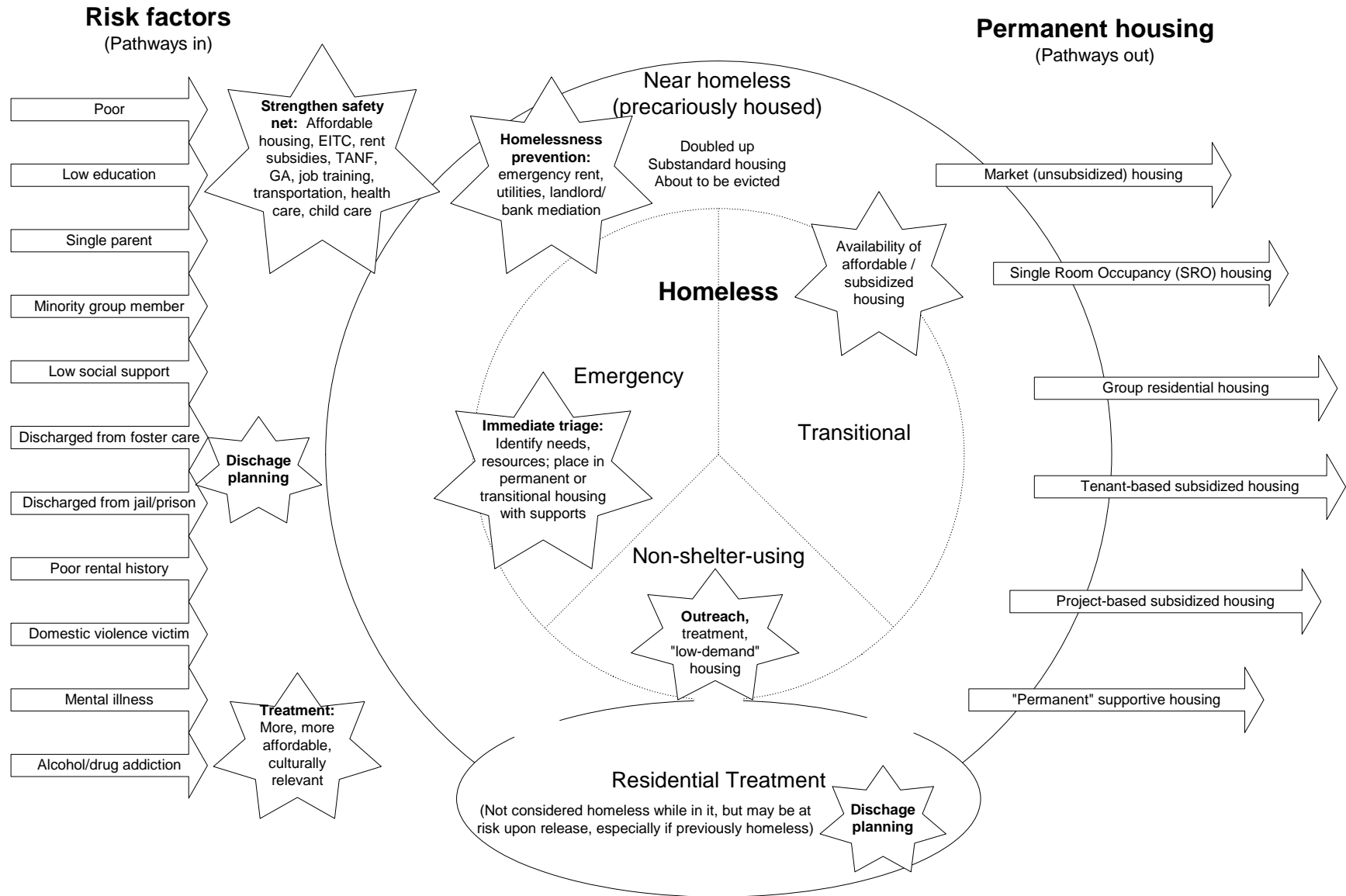
- Successful strategies for developing new projects that meet HUD funding criteria begin with a thorough analysis of the needs of each population of homeless persons in the population/subpopulation chart. Examine best practices in housing and services, available service and housing resources, and potential funding sources. For example, for the people in households with dependent children who were identified in Emergency Shelter on the date of the point-in-time survey, identify the percentage that are expected to need short term emergency shelter, the percentage that need the structure and stability of transitional housing, the percentage that are expected to need long-term permanent supportive housing, and the percentage that need short term support to move from shelter to independent housing. Use this information to more specifically quantify unmet need and plan for development of shelter and housing options over time.
- Points can be increased by raising the overall proportion of individuals entering permanent housing after transitional housing, by concentrating on those programs that are below HUD’s benchmark of 61.5 percent. Currently, two programs in the Continuum’s Housing Activity Chart fall into this category. Also be sure that only qualifying transitional housing projects are included in this calculation (that is, do not include Supportive Service Only projects, even if they provide services to residents in transitional housing programs).
- Similarly, higher points can be gained by increasing the overall percentage of persons who become employed, by focusing on projects in which this percentage is low and learning from those projects in which it is high.
- Review mainstream programs in which the region’s enrollment rates are lower than the national averages. In 2007, these included SSI (9.5% vs. 11.4% national average), Social Security (1.4% vs. 1.7%), General Public Assistance (4.5% vs. 6.2%), Veterans Benefits (0.5% vs. 1.4%), and Veterans Health Care (0.3% vs. 1.1%).
- In selecting projects to fund with McKinney-Vento funds, prioritize those projects that can be expected to meet HUD funding priorities by achieving high performance on HUD’s benchmark measures: high service outcomes for HUD-funded services; high rates of transfer to permanent housing for HUD-funded transitional housing projects; percent of participants who access mainstream resources and/or gain

employment; percent of leveraged resources; rates of HMIS participation; and costs of case management per participant.

Potential intervention points on the pathways in and out of homelessness

The following diagram (Figure 11) provides a visual representation of key areas in which resources and service availability can expect to have significant payoff in addressing homelessness in the Omaha/Council Bluffs area. In particular, increasing the general supply of affordable housing, including access to rent subsidies and emergency rent and utilities assistance, can help the working poor and those at risk of eviction to avoid homelessness. Similarly, strengthening the supply of supportive housing, including both “low demand” housing and other forms of permanent supportive housing, can serve as key stepping stones out of homelessness. Other services, including culturally relevant treatment; discharge planning for those leaving foster care, treatment, and incarceration; effective transportation, job training, and landlord mediation; are all thought to be effective and appropriate strategies within a continuum designed to reduce or end homelessness.

**11. Potential intervention points on the pathways in and out of homelessness**



# Options for action

Interviews with homeless service providers and staff involved in prevention efforts in Omaha and Council Bluffs reflect significant frustration with the adequacy of current resources and efforts to address homelessness. Service providers report that mental health issues, substance abuse, recent incarceration, and partner violence are all part of what makes it increasingly difficult to mount a service response that can effectively launch people on a path toward lasting hope and greater self-sufficiency.

In addition to these factors affecting individuals, stakeholders also cite the challenges posed by larger-scale considerations such as a shortage of affordable housing, difficulty in accessing affordable care for medical, mental, and chemical health, and a shortage of subsidies to fill the growing gap between housing costs and income from employment.

This review has found, however, that much of what is needed to make effective strides forward can be found in the recently completed Decision Accelerator and a variety of the proposed steps embodied in this document through the year 2013. In particular the Decision Accelerator calls for the following actions:

- Resolve data and information barriers that impede planning and fund raising.
- Develop clear outcomes and a sustainability plan including consensus on priorities and benchmarks.
- Foster a culture of service that is reflective and prepared to adapt to new information.
- Build relationships with the business community and the community at large.
- Include the client (and information about their needs) in determining service strategies.
- Provide collaborative case management (potentially within a day services program model).
- Conduct and use best practices research.
- Continue funding for current safety net and crisis services.
- Establish a more complete continuum of housing with an eventual shift to more permanent supportive and long-term affordable safe housing.
- Secure additional financial support from government.
- Strengthen mainstream services including health insurance, rental assistance, and similar benefits.

- Make HMIS a prevention tool for assessment and planning.
- Insure that all potential clients have access to services.

Given these objectives previously identified and the results of the current investigation, Wilder has identified the following potential action opportunities for consideration by funders, service providers, elected officials, and other stakeholders as a means of strengthening the response to homelessness in the Omaha and Council Bluffs area:

1. **Set a goal to reduce or end homelessness.** Seek commitment from all stakeholders including public officials in municipal, county, and state government to set a goal of significantly reducing or ending homelessness over the next 10 years in the Omaha/Council Bluffs area. This goal can serve as a beginning point for the development of specific strategies and a rallying point for public interest. It can also serve as a starting point for the creation of a “10 year plan for ending long-term homelessness.” Such a plan is a type of blueprint for addressing chronic homelessness that the U.S. Department of Housing and Urban Development (HUD) has encouraged and supported throughout cities across America.
2. **Collect more extensive data for planning.** In conjunction with or following the next January shelter count required by HUD (early enough to ensure that results will be available in time for the 2008 SuperNOFA application), organize a more extensive data collection effort, led by MACCH, in order to more fully describe the population of people experiencing homelessness within the Continuum of Care region. This information can be used as a baseline planning document when setting targets for reducing or eliminating homelessness and as a tool for matching service needs with appropriate service provisions. Use of volunteer interviewers can also help build understanding and support for the needs of the homeless. During the same time period, Omaha providers can more fully implement the HMIS system as a method for tracking individual service users over time and as a method of meeting reporting requirements established by HUD. Further collaboration between state HMIS managers in Iowa and Nebraska will be required to resolve data disparity issues between the two systems.
3. **Use current starting points to develop an action plan.** Undertake a strategic planning initiative, led by MACCH, that builds on the previous Decision Accelerator and specifies a series of action steps and accountabilities. These action steps may include (but not be limited to) the following:
  - Ways of creating education, training, and employment or entrepreneurship opportunities for homeless people who can work.

- Ways of improving the ability of homeless people to pay for housing when they are unable to work.
  - Ways to better use and grow mainstream resources including SSI, SSDI, TANF, Food Stamps, Medicaid, EITC and others for use by the homeless population.
  - Ways to enhance prevention strategies and resources including mental health and substance abuse treatment programs, rental assistance, utility assistance, landlord-tenant dispute resolution, etc.
  - Ways to better connect homeless people with available services and to make outreach to the unsheltered homeless more effective, potentially through day activity centers.
  - Ways to more quickly stabilize the housing situation of those temporarily in emergency shelters, through rapid access to settings that combine free or subsidized housing with supportive services.
  - Ways to address the flow of people who are “discharged into homelessness” from jail, treatment facilities, and foster care.
  - Ways to create additional housing resources, especially SRO units and permanent supportive housing units, that are available and suitable to the needs of those experiencing homelessness.
4. **Address distinct needs of families and youth.** In the strategic planning process, ensure that needs of homeless parents (mainly women) with children are separately assessed, and that shelter and program planning address the unique needs of this group. Also specifically address the distinct service needs of unaccompanied youth, who are some of the least visible and most vulnerable among persons experiencing homelessness.
  5. **Address systemic causes of racial disparities.** Historically, poverty has been more concentrated in minority populations and this pattern is amplified among the homeless. Virtually all studies of homelessness in the U.S. show a similar result. In the face of this, any plan for addressing and ending homelessness must take account of the potential causes of these disparities and respond appropriately, by improving access to education and job training, support for educational success, and access to equal employment and housing opportunities.
  6. **Use private philanthropy for gap funding.** Over the next five years, seek to transition the role of private philanthropy to that of “gap funder” providing resources only in those cases where no other resources can be found at the federal, state, county, or municipal

level. Shift the general funding of crisis services, as feasible, to the public “safety net” with private funders moving toward the role of producing more of the “start-up capital” necessary to test new shelter and service models and create more permanent housing and related support services for homeless and very low-income people.

7. **Create a technical assistance fund.** Create a technical assistance fund for MACCH and area providers to assist with the development of proposals and other requests for funding and resources to assist the homeless, prevent homelessness, and provide access to housing and services that can help people escape homelessness. When the region’s priorities are identified, such a fund could be used by MACCH as an entity, or by the specific agencies developing the highest-priority projects, to hire a grant writer or project developer with the needed specialized expertise. It could also be a way to offer training to help increase the project planning and proposal development skills of agency staff in general.
8. **Empower inter-agency housing pipeline committees.** Consider forming a “housing pipeline committee” made up of members of the MACCH board, together with representatives from affordable housing development groups; city, county, and state-government representatives; funders, and other potential stakeholders. Such a group could plan, oversee, and facilitate the creation of housing opportunities for low-income, precariously housed and homeless people. Because of jurisdictional boundaries, it may be best to have one committee for Douglas and Sarpy Counties and a second committee for Pottawattamie County.
9. **Strengthen the basic safety net.** In addition to affordable housing, address other areas of weakness in the basic safety net of services that help to prevent homelessness and help people who are already homeless to get and maintain stable housing. These include mental health services, health care, education and job training, transportation, and emergency housing and utilities assistance.

Overall it is expected that an agreed-upon plan with specific goals describing how all partners will contribute and be held accountable is essential to long-term and incremental progress in addressing homelessness in the Omaha and Council Bluffs area.

Moving toward a plan that is squarely focused on reducing homelessness and enhancing self-sufficiency for the homeless and near-homeless will require a fully developed continuum of care; a flexible provider response; substantial cooperation and engagement among service providers, funders, local and state government, and the community at large; and cooperative strategies that help connect homeless people with the available services.



# Appendix

## *Shelter and treatment programs included in the Wilder survey*

### *Summary of findings from data sources*

Community forums and follow-up electronic survey

Agency leaders survey

Homeless assistance program provider survey

Prevention services survey

Key informant interviews about day service programs

Continuum of Care planning and reporting documents

Review of published literature on best practices and funding for homeless shelter programs

Review of published literature on best practices and funding for homelessness prevention programs

## *Comparison of three mid-sized, Midwestern cities and their regions*

### *List of references*



## *Shelter and treatment programs included in the Wilder survey*

The table below lists all the programs surveyed by Wilder Research as part of the data collection undertaken for this study. Only one organization (Restored Hope) that was on the list to be included was unavailable to respond to our questions during the short time frame available for this study.

The categories shown are those in common use in other Continuum of Care regions with which Wilder is familiar. These include:

- Emergency programs, including some focused specifically on the needs of unaccompanied youth and victims of domestic violence
- Transitional housing programs, which also include some focused specifically on the needs of victims of domestic violence
- Permanent supportive housing programs
- Treatment programs

Throughout the U.S., definitions of program types vary considerably, and the same program may be classified differently by different observers. We distinguish between shelter programs (emergency, transitional, or permanent supportive housing) on the one hand and treatment programs on the other hand based on whether the program's primary focus is on housing (with supportive services, including treatment, as a means to stabilize housing) or treatment (with housing provided as a way to deliver or improve treatment).

## Shelter and treatment programs included in the Wilder survey

Organization and program name	Loc.	Main population(s) served	Max. capacity (a)	One-night count	Avg. days/stay
<b>Emergency shelters</b>					
Christian Worship Center – New Visions Men’s Shelter (not open yet)	IA	Homeless males without children	40	--	--
McAuley Center for Women and Families (emergency and transitional)	NE	Single women and families	45	41	40
MICAH House Emergency Shelter	IA	Priority is families, then couples, then single women	48	45	42
Open Door Mission – Lydia House Emergency Program	NE	Single women and families in emergency situations	71	42	42
Open Door Mission – Men’s Emergency Program	NE	Men in emergency situations	217	137	42
Salvation Army – Transitional Residential Program	NE	Single adults with mental illness	16	14	45
Siena Francis – Emergency Shelter	NE	Chronically homeless, actively addicted, predominantly mentally ill street people; many with developmental disabilities, physical illness, physical disability, and/or (among women) experience of violence	242	307	(b)
Stephen Center – Emergency Shelter	NE	Men, women, and children (but not intact families) needing emergency shelter who have made a decision to seek treatment for alcohol or substance abuse	80	60	14
<b>Youth emergency shelters</b>					
Child Saving Institute – Children’s Crisis Center	NE	Children and youth who have been victims of abuse and neglect, have been removed from their homes, and need a safe shelter	12	11	30
Child Saving Institute – Kids Cottage	NE	Primarily youth in the child welfare system, and youth who are homeless or need shelter as a result of juvenile justice issues (e.g. released from detention with no place to go)	24	3	50
Christian Home Assoc. (Children’s Square) – Children’s Emergency Shelter	IA	Unaccompanied minors (most in protective custody)	15	7	12
Heartland Family Services – Children’s Emergency Shelter	NE	Children removed from homes due to abuse and neglect, including sibling groups from 0-18	12	7	14
Youth Emergency Services – Emergency Shelter	NE	Any youth who is unattached or not residing with a parent or guardian; referral by a variety of means (homeless youth are 20% of overall shelter population)	12	11	19
<b>Domestic violence emergency shelters</b>					
Catholic Charities, Council Bluffs – Phoenix House	IA	Women who self-identify as victims of domestic violence or sexual abuse, and their children if they have any	24	20	45
Catholic Charities, Omaha – The Shelter	NE	Single women or women with children who are homeless as a result of domestic violence	41	14	8

Organization and program name	Loc.	Main population(s) served	Max. capacity (a)	One-night count	Avg. days/stay
<b>Transitional housing programs</b>					
Catholic Charities, Omaha – Family Passages	NE	Single women or women with children who are homeless as a result of domestic violence	56	30	548
Heartland Family Services – Safe Haven	NE	Women and children fleeing from a domestic violence situation	20	17	101
Heartland Family Services – Transitions	IA	Single-parent and two-parent families with children (plus two one-bedroom apartments for single adult individuals)	26	19	517
Omaha Housing Authority – HOME Transitional Housing Voucher Program	NE	Individuals and families coming out of transitional living programs (including domestic violence programs, housing programs, transitional housing programs, etc). Also people with chronic disabilities.	no real limit	152	731
Open Door Mission – Lydia House Journey to Work Program	NE	Single women and one- and two-parent families who do not have life-altering addictions	27	7	365
Open Door Mission – Men's Journey to Work Program	NE	Single men who do not have life-altering addictions	24	21	365
Salvation Army – 37th Street	NE	Mainly families, also single men and/or single women	45	29	152
Salvation Army – Harrington Homes	NE	Adults with children	35	16	365
Salvation Army – Scattered Site Transitional Housing	NE	Families with children	38	23	365
Salvation Army – THRU Program	NE	Homeless families with children and single female adults	33	28	365
Stephen Center – Transitional Living Program	NE	Single men or women and women who have children; graduates of any treatment program who were homeless when they entered treatment	30	25	426
<b>Permanent supportive housing</b>					
Heartland Homes (not open yet)	IA	Primarily single-parent and two-parent families with children	.	.	.
Omaha Housing Authority – Shelter Plus Care	NE	Chronically homeless individuals by HUD's definition (single persons with a chronic disability)	21	9	.
<b>Treatment programs</b>					
Christian Worship Center – New Visions Trans. Living (not open yet)	IA	Mainly single homeless males; also single homeless females	.	.	.
Omaha Campus for Home – Civil Protective Custody	NE	Adult males and females (usually homeless) intoxicated to the point of being a risk to self or others, referred by law enforcement	no real limit	3	1
Omaha Campus for Home – Detoxification	NE	Currently intoxicated males and females who voluntarily present themselves	no real limit	10	2
Omaha Campus for Home – Dual Diagnosis Program	NE	Single adult males and females with diagnosed chemical dependency and a severe and persistent mental illness, referred through the State of Nebraska	24	16	200
Omaha Campus for Home – Emergency Protective Custody	NE	Intoxicated adult males and females who are demonstrating psychiatric symptoms, referred from law enforcement	no real limit	1	1

Organization and program name	Loc.	Main population(s) served	Max. capacity (a)	One-night count	Avg. days/stay
Omaha Campus for Home – Intermediate Residential Program	NE	Single adult males who are chronically dependent with several prior short-term residential treatment experiences and multiple relapses without significant periods of sobriety.	8	3	396
Omaha Campus for Home – Short-term Residential	NE	Single adult males and females who are chemically dependent and need 24-hour services	26	6	30
Open Door Mission – Lydia House New Life Recovery Program	NE	Single women and one- and two-parent families who seek treatment for life-altering addictions (drugs, alcohol, anger, gambling)	?	49	365
Open Door Mission – Men's New Life Recovery Program	NE	Single men who seek treatment for life-altering addictions (drugs, alcohol, anger, gambling)	24	20	365
Santa Monica – Half-way House	NE	Homeless women with substance abuse and co-occurring disorders	14	12	274
Santa Monica – Intermediate Residential	NE	Women who have experienced several prior treatments for chemical dependency and have not been successful and as a result have become homeless	4	3	457
Siena Francis – Miracles Chemical Addiction Treatment Program	NE	Homeless people living on the streets who have chronic illness, are addicted, and have mental illness; many have just been released from incarceration with nowhere to go	56	80	255
Spring Center	NE	Adults with mental illness	10	12	10
Stephen Center – HERO Program	NE	Homeless people	64	42	79

**Sources:** Wilder Research survey of program representatives. Some capacity figures are based on a combination of survey data and information in the Continuum of Care 2007 SuperNOFA application.

**Notes:** (a) "Maximum capacity" includes overflow capacity beyond what facilities were designed for, including cots or mats in common areas, motel vouchers, parking spaces, or other accommodations. (b) Lengths of stay are too varied for an average to be meaningful. Director estimates 25% stay less than 7 days, 40% stay 1 week–2 months, 30% stay 2 months–1 year, and 5% stay more than 1 year.

## ***Summary of findings from data sources***

On the next pages are one- and two-page summaries of findings from the following data sources that were the main basis for this study:

**Community forums and follow-up electronic survey**

**Agency leaders survey**

**Homeless assistance program provider survey**

**Prevention services survey**

**Key informant interviews about day service programs**

**Continuum of Care planning and reporting documents**

**Review of published literature on best practices and funding for homeless shelter programs**

**Review of published literature on best practices and funding for homelessness prevention programs**

## Community forums and follow-up electronic survey

**Who:** Forum participants: community stakeholders who are involved in various ways with serving the homeless population in the Omaha/Council Bluffs region.

**What:** Two forums were conducted during two site visits. After the first forum, a follow-up electronic survey included eight closed-ended questions and an opportunity to comment on each question. The survey asked respondents to rank most needed services, populations most in need, and potential changes that would improve the service delivery system. Respondents were also asked to describe any obstacles they observed that would make it difficult to make progress toward the goal of ending long-term homelessness. Completed by 54 respondents.

### **Key findings:**

#### **Respondents endorse a goal of reducing or ending homelessness.**

More than 4 out of 5 respondents felt that the Omaha Metropolitan Area Homelessness Response Plan should include a goal of reducing homelessness by a targeted amount, and more than 7 out of 10 felt that the area plan should include the plan of ending long-term homelessness. On average, when asked about the amount of reduction in homelessness that the area should try to achieve in the next three years, respondents proposed a target between 25 and 35 percent.

#### **Mental health services and affordable housing are given a top priority.**

Mental health services were seen as the most needed type of services, followed closely by chemical dependency services. In addition, adults with mental illness were viewed as one of the top populations most in need of additional service.

Safe and affordable housing was viewed as the most important type of housing or shelter and a lack of safe and affordable housing was viewed as the biggest obstacle to ending long-term homelessness.

#### **Respondents call for more advocacy and a greater public role in responding to homelessness.**

Help to obtain public funding, and advocacy for stronger public services, were viewed as two of the most important changes for improving the delivery of homeless services. The lack of state and local funding and an unreceptive political environment were seen as two of the top obstacles to making progress toward the goal of ending long-term homelessness.

#### **Many different groups of the homeless are in need of additional services.**

The populations reported to be most in need of additional services were:

1. Parents with children
2. Adults with mental illness
3. Adults with serious or chronic health care needs
4. Alcoholics
5. Chronically or long-term homeless people

## Agency leaders survey

**Who:** 19 agency leaders of organizations that provide homeless shelter or housing services, or whose leaders are on the MACCH executive board.

**What:** Interview included 5 closed-ended and 10 open-ended questions about the agency's programs for serving the homeless, awareness of and perceptions about MACCH and its role, and perceptions of the region's response to homelessness and the agency's place in that response.

### **Key findings:**

#### **Agency leaders have many suggestions for improving the region's response to homelessness.**

There was no consensus on the most important change to make in the region's current response. The answers most often given (grouped by themes) were: more help to transition back to permanent housing (10); address the issue of day programs (8); more collaboration among agencies and/or more coordination of services, programs, and/or information among agencies (7); more programs and/or services to address mental, physical, and/or chemical health issues (4); more public awareness and/or more services to prevent homelessness (4).

#### **All agency leaders feel that MACCH is the right organization to lead efforts relating to homelessness in the region.**

Attributes of MACCH that were most often cited in support of this perception were its history or potential to bring the providers together (9) and its independence as an organization not tied to one type of provider and not in competition for service dollars (6).

#### **All agency leaders are prepared to participate in MACCH's efforts. Most see that their participation will help to improve services to the homeless in general, and over half also report that participation strengthens their own agency's programs.**

Most-often cited ways in which agency leaders feel MACCH currently or potentially could be helpful include: doing or coordinating advocacy on behalf of the homeless; providing or coordinating information and technical assistance to agencies and programs (including training, identifying best practices, and helping with needs assessments and evaluations), and collecting data and helping prepare coordinated plans based on that information.

#### **Long-standing relationships among agencies may need help to move forward.**

The agencies now involved in addressing homelessness are nearly all the same ones that have been doing it for 20 years. Some of the perceptions and relationships among agency leaders and staff may reflect histories that are not currently relevant, and may require time, effort, better information, and increased trust to overcome.

## Homeless assistance program provider survey

**Who:** Sample of 48 homeless assistance programs including 28 identified as providing primarily shelter, 14 providing shelter as part of a treatment program, and 6 programs providing only non-shelter support services. Of the 28 programs providing shelter 12 identified themselves as emergency shelters, 10 as transitional housing, 3 as domestic violence shelters, 2 as permanent supportive housing, and 1 as both emergency and transitional.

**What:** The survey asked mostly closed-ended questions about populations served, funding streams and budgets, and services provided by the programs. Open-ended questions were asked about the populations they serve, barriers their clients face in gaining housing stability, service gaps, and how to help clients overcome housing barriers.

### Key findings:

#### Populations served

Adult men who had no children with them made up the primary population served by the providers. Adult men on their own were almost three-quarters (71%) of the 939 clients in treatment programs, and one-half (48%) of the 1,094 clients in shelter programs. The other residents in shelter programs were 11 percent women on their own, 14 percent adults who had children with them, 23 percent children (with their parents), and four percent unaccompanied youth (children 17 or younger and not with a parent). Shelters reported two-fifths (39%) of their population could be considered chronically homeless.

The top services provided by shelters (either directly or through another contracted agency) were assessment of needs (93%), case management (89%), health care services (86%), mental health services (82%), and transportation assistance (82%). Least-provided services include rent subsidy (36%), tenant or landlord mediation (39%), and follow-up services after leaving the program (54%).

#### Needs of clients

The two biggest needs providers mentioned that can not be met for their clients are access to affordable housing options (including more supportive housing and rental assistance capacity) and mental health service needs. Chemical dependency services, case management, and education or job training were also needs that were mentioned by many providers.

The lack of job skills, education, or work history was reported most frequently as the single biggest barrier faced by the providers' clients. Lack of affordable housing or landlords willing to rent to their clients and poor physical health or lack of health care were also mentioned by many providers as the single biggest barrier. Providers see job training, education, and links with employers as most needed to help their clients overcome their housing barriers. Also important are help to access services, improved mainstream support services, and life skills training.

## **Funding**

The total funding for the 26 shelter programs for which we have information was \$12,936,736. Almost one-third (32% or \$4 million) came from individual, private donations with another 14 percent (\$1.85 million) coming from other private sector sources (United Way, corporations and businesses, or non-corporate foundations and charities). The state governments supplied 23 percent of shelter funding, the counties 2 percent, the cities 13 percent, and the Federal government 10 percent.

Overall, funding sources coming directly from private sector sources accounted for about 46 percent of shelter funding while funding coming directly from public sector sources accounted for about 47 percent. About 7 percent of funding came from other sources including earned income, client fees, other community agencies or organizations, and the programs' own parent organizations.

The \$7,489,839 of funding for the 14 treatment programs was mostly from the state government (53%) but these programs also had sizable income from private individuals (17%), the Federal government (13%) and county governments (10%).

Of the 26 shelter programs, 19 (or two-thirds) received at least some in-kind donations in the last fiscal year. These were almost all from private individuals (all 19 programs) and corporations or businesses (14 programs), with a smaller number of programs reporting in-kind donations from foundations or public charities (6 programs).

## Prevention services survey

**Who:** Sample of 15 agency leaders of organizations that directly or indirectly provide preventive services to persons at risk of becoming homeless and those seeking to exit homelessness.

**What:** Interview included 5 closed-ended and 12 open-ended questions about prevention service programs, awareness and perceptions about MACCH and its role, perceptions of the region's response to homelessness, and recommendations to improve the community's response to homelessness.

### **Key findings:**

#### **Agency leaders endorse a more coordinated response and more prevention resources.**

Prevention service providers generally report growing numbers of near-homeless and those who are "one or two paychecks away from homelessness." In general they feel that current resources available to support prevention efforts are less than adequate given the current need. The vast majority of respondents would like to see more case management available to people at risk of homelessness or who have recently become homeless. This would include resources to prevent utility cutoffs or default on rent or mortgage, and support services to follow a person once they have entered a more stable housing situation.

#### **All prevention service providers feel that MACCH is the right organization to lead efforts relating to homelessness in the region.**

Respondents report that MACCH is a "very professional organization," receptive to input, and able to organize the needed range of organizations in a coordinated response to homelessness. They generally feel that MACCH is in a good position to secure additional funding and make people aware of issues and the funding that is available to support the efforts of service providers.

#### **There is not an adequate supply of safe and affordable housing.**

Prevention service providers would like to see a wider range of supportive housing including single room occupancy housing and permanent supportive housing. They recognize generally that a significant proportion of persons that they serve have multiple problems including mental illness, previous incarceration, and family violence. The support for families and individuals with these problems is generally seen as less than adequate.

#### **A day activity center or centers are seen as an appropriate place to provide case management, assess people's needs, and secure needed services for those currently homeless and those at risk of homelessness.**

The current housing market makes it very difficult to house people with significant barriers including those with a criminal record, bad credit, and mental health or chemical dependency problems. It was generally agreed that chronically homeless people are difficult to help with prevention services because there are few housing options available and many rules that prevent them from obtaining housing.

## Key informant interviews about day service programs

**Who:** Leaders of seven agencies in large or medium-sized metropolitan areas across the country that operate day service programs for the homeless.

**What:** Interview included 10 closed-ended questions about the program's clientele, purposes, and configuration; and 4 open-ended questions describing programs and services, main population or populations served, and the respondent's opinions on serving different populations together or separately.

### **Key findings:**

#### **Programs vary greatly in who they serve.**

Different programs target different groups, from a very narrow group (homeless adults age 50 or older) to very broad (any homeless or low-income person). Nearly all serve single adults; about half serve families, and about half serve unaccompanied youth. A few screen out people who are drunk; some screen out those who are violent or threaten violence.

#### **Programs are quite similar to each other in their purposes and types of services.**

Most representatives identified purposes from a list of possible purposes. Those most commonly identified as "main purposes" were: to help take care of people's immediate needs; to provide a safe place to spend the day; and to reach out and build trust with people needing housing or treatment who are not currently receiving it. Other purposes commonly identified as "a purpose" but slightly less often named as a "main purpose" were: to help connect people to services to access stable housing; and to connect them with other services or benefits. Most programs include showers, meals, clothing, laundry facilities, health care services, mailing address or message services, and case management and/or help to access other services.

#### **Most programs serve different populations together.**

For four programs, different groups served together include: (1) Adult and teen women; (2) Men, women, unaccompanied youth, and families with children of all ages; (3) Single men and single women; (4) Adults 50 or older with or without children.

#### **Almost all program leaders advise that it is better to serve families and single adults separately.**

Although a single facility may be less costly to run, nearly all respondents recommend separating families with children from single adults (especially single men). Some also recommend serving unaccompanied youth separately. There are two main reasons for the separation: (1) the different groups have different needs, cultures, ways to be successfully engaged; and (2) some people may feel uncomfortable or even threatened in the presence of some people in a different group. For example, women victims of domestic violence may not be comfortable around men; unaccompanied youth should not be served where adult sex offenders may be present; adults dealing with mental illness or chemical dependencies may create a poor environment for children, and small children may be irritating to adults who have behavioral problems.

## Continuum of Care planning and reporting documents

**Who:** Omaha/Council Bluffs Continuum of Care provided Wilder with the 2007 SuperNOFA application for McKinney-Vento funding from HUD, as well as a report of unduplicated counts of clients served by MACCH Service Point agencies.

**What:** The Housing Inventory Charts from the 2007 SuperNOFA application include a list of providers in the Omaha/Council Bluffs area that are currently providing emergency shelter, transitional housing, and permanent supportive housing to persons experiencing homelessness in the region.

The Unduplicated Counts of Clients report includes counts of single persons, families, and family members served by agencies who are currently using HMIS. Also included are primary race, ethnicity (Hispanic/ Latino), and type of services provided. A list of service providers currently using HMIS and copies of the two primary ServicePoint assessments: ServicePoint MACCHBook Basic Questionnaire for Adults and ServicePoint MACCHBook Questionnaire for Adults – Nebraska Homeless Assistance Program (NHAP) were also provided.

### **Key findings:**

**HMIS coverage of emergency beds will greatly improve in 2007. However, only a limited number of other homeless service providers are currently reporting to HMIS.**

The SuperNOFA Application shows that 39 percent of emergency shelter beds (excluding domestic violence beds) are currently reporting to HMIS, with an anticipated increase to 87 percent in the next operating year. Fourteen percent of transitional housing beds (excluding domestic violence beds) are reporting to HMIS, with an anticipated increase to 22 percent in the next operating year. Eight percent of permanent supportive beds are reporting to HMIS, with no anticipated increase in the next operating year.

**Data integration between HMIS and agencies not currently using HMIS could increase the ratings given to the SuperNOFA by HUD.**

The HMIS coverage of year-round emergency, transitional housing, and permanent supportive housing beds is considered by HUD in awarding points on the SuperNOFA application. The region could increase its HUD funding if agencies that are not currently reporting to HMIS begin to report at least the nine required universal data elements (name, Social Security number, date of birth, ethnicity and race, gender, veterans status, disabling condition, residence prior to entry, and zip code of last permanent address).

**HMIS data plays an important but limited role in describing the characteristics and service needs of persons experiencing homelessness in the Omaha/Council Bluffs area.**

HMIS is designed to aggregate data required for reports to federal and state funding sources. Although it is a complex data system, it is not designed for in-depth descriptive analysis of populations. Furthermore, the assessments designed to collect more detailed data elements are collected in different formats for HMIS in Nebraska and Iowa. As a result, it would be cost significant time and resources to combine, aggregate, and/or analyze data.

## Review of published literature on best practices and funding for homeless shelter programs

**What:** A review of 20 journal and applied research articles relating to funding, best practices, and/or outcomes of programs that provide shelter and housing services to people who are homeless.

### **Key findings:**

**In the last 25 years homeless populations, services, and funding sources have all become more diverse.**

Homeless people are now less exclusively single men and include more women, families with children, and unaccompanied youth; less exclusively chronic alcoholics and increasingly working poor, people with mental illness, and/or ex-offenders.

Homeless programs are less exclusively emergency shelters and now include at least as many spaces in transitional housing and, increasingly in the 2000s, “permanent” (not time-limited) supportive housing.

Funding for services, mainly from private sources in the 1980s, are now mainly from a combination of public sources (including city, county, state, and federal). Also, for any individual program, the average number of sources has risen, and now averages 2-3, or more for transitional and permanent supportive housing.

**A working continuum of care includes prevention, outreach, emergency shelter, treatment, transitional (temporary) and permanent (not time-limited) supportive housing, access to specialized and mainstream services, and an adequate supply of accessible, affordable housing.**

Developing and maintaining this continuum requires a coordinating organization at the local level that (1) assesses needs and currently available services, (2) ensures an adequate supply of emergency, transitional, and permanent supportive housing beds as well as affordable housing, (3) ensures effective referral systems among the components of the continuum, and (4) links elements of the continuum with mainstream services in the community, including affordable housing.

**Fully implementing such a continuum requires significant system change.**

The change can be driven either by bottom-up or top-down energy. Either way, it can be helped by: (1) spelling out in advance how difficult decisions will be made; (2) defining and monitoring the desired outcomes for each kind of program; (3) providing technical assistance to help programs implement practices needed to meet outcomes; (4) dedicating additional resources up front for the needed change, with incentives for voluntary changes first, and mandates only later. Some communities have found it helpful to coordinate the funding sources through a single funnel, enabling individual programs or agencies to submit a single, consolidated funding request and a single, consolidated report back.

**There is a growing body of evidence that “high-control” programs are less effective than “low-demand” programs that place fewer requirements on clients.**

Requiring homeless people to progress through a sequence of programs, one at a time as earlier programs help them become “ready,” is often perceived by clients as a sequence of barriers. Skills are best learned in the setting in which they are to be applied. Programs with multiple or stringent client requirements (whether to enter the program or to stay in it) are found by evaluations to break down prior social networks and increase social isolation, and impair progress to self-sufficiency. Emergency shelters, which act as the gateway into the homeless services continuum, effectively prevent needed help if they deny services to clients for any reason (such as mental illness or active substance use). Studies show that even clients with severe mental illness, substance abuse, or both, can be just as successfully treated in a “low-demand” setting, and can be more effectively motivated to participate in treatment in such settings.

**There is limited research evidence for any specific program elements or models, but growing evidence about effective principles.**

Promising practices include:

- The program creates a “low-demand” environment of respect and trust in which clients’ desires and satisfaction are honored;
- It provides supportive housing (temporary or permanent) in which the client pays 30 percent of their income in rent;
- Services are flexible, responsive, and culturally appropriate;
- Resources needed by the clients are provided or arranged for;
- If families are served, there are activities and services specifically designed for the children;
- The service providers and housing providers regularly communicate with each other to work out any difficulties; and
- There is follow-up support that follows the client after they leave the program.

Review of published literature on best practices and funding for homelessness prevention programs

**What:** Review of 10 sources including reference and scholarly books, journal articles, and applied research reports relating to homeless prevention with a focus on best practice strategies and funding streams.

**Key findings:**

**Levels of prevention strategies**

- **Primary prevention** is interacting with at-risk populations before the event of homelessness occurs. The purpose is to keep people out of homelessness. It can occur at two levels: (1) *universal primary prevention* includes less focused approaches meant to reach a large number of people, and (2) *selective primary prevention* is more targeted at providing individually-determined services to those at imminent risk of losing housing.
- **Secondary prevention** is an interaction that happens after the event of homelessness occurs. Its purpose is to get someone out of homelessness soon after entering. Secondary prevention seeks to intervene with individuals before they enter chronic homelessness.
- **Tertiary prevention** is not always considered prevention, because it targets people after they have already become chronically homeless and works to move them into stable housing. Tertiary prevention can be successful in preventing continued homelessness.

**Elements of effective homelessness prevention**

- **Public obligation:** To make prevention activities effective, public jurisdictions should not only work to publicly fund prevention activities, but should also recognize a legal and/or moral obligation to shelter.
- **Data sharing:** Information sharing across agencies and systems can help make prevention activities more coordinated and effective. It is most helpful when it has the ability to track clients across different data systems, with a single agency controlling the eligibility requirements.
- **Mainstream services:** Effective prevention depends on the existence of an adequate safety net of non-housing mainstream services; a commitment by the agencies responsible for those services to accept their clients' housing situation as one of their responsibilities; and participation by those agencies together with homelessness agencies in a coordinated approach to prevent homelessness from occurring.
- **Goals and leadership:** The community and providers must have a clear goal of preventing homelessness among targeted populations and develop a strategy for how to reach that goal. Leadership is necessary on two levels: agency heads and public officials must commit to developing and sustaining a comprehensive community-wide prevention strategy.

## Funding sources

HUD's 2005 case study of 6 "best practice" homelessness prevention programs, *Strategies for Preventing Homelessness*, shows diverse and innovative funding of prevention activities that promote community-wide strategic planning and integrated approaches to ending homelessness. These include:

- **Federal:** Prevention programs used funding from HUD including Supportive Services Only grants (SSO), Supportive Housing Program (SHP) funding, and Emergency Shelter Grants (ESG). Programs also emphasized referral to other Federally-funded mainstream services such as TANF, Food Stamps, and Medicaid.
- **State:** State welfare and health department funding was also well utilized. These monies are used for preventing eviction, sustaining housing, rapid exit services, and mental and chemical health services.
- **Local:** County property tax dollars as well as Federal monies funneled through the county were available to assist families experiencing housing crises or needing emergency assistance. County shelter systems and prevention-services funding also funded access to prevention, emergency shelter, and some transitional housing services. County and city dollars generally allow more flexibility to serve clients.
- **Private sector:** Private funding was utilized mainly for specific aspects of the prevention programs or to supplement the existing public funding (e.g., local power and media companies setting up a fund to help low-income individuals pay their overdue utility bills).
- **Partnering organizations:** Beyond their individual work, organizations were mainly asked to support preventive programs through the giving of administrative and staff time as well as funding to implement prevention planning, activities, and initiatives.

## Comparison of three mid-sized, Midwestern cities and their regions

### Part I: Demographics and social/economic context

County(ies) in region	Omaha Area Douglas & Sarpy, NE; Pottawattamie, IA	Columbus Franklin, OH	Minneapolis Hennepin, MN	Ratio O/C	Ratio O/M
<b>Population size</b>					
City population (est) 2006 (2003 for Columbus)	424,988	728,432	373,188	0.58	1.14
Region population (est) 2006	724,858	1,095,662	1,122,093	0.66	0.65
State population (est) 2006	1,768,331 NE + 2,982,085 IA = 4,750,416 total	11,478,006	5,167,101	0.41	0.92
Region as percent of state	15.3%	9.5%	21.7%	1.60	0.70
<b>Social and economic context</b>					
Unemployment rate, May 2007 (county)	3.5%	4.6%	3.8%	0.76	0.92
Poverty rate, 2005 (city)	15.3	18.5	19.9	0.83	0.77
Crime rate, 2005 (city) (violent crimes per 100,000)	564.6	836.7	1454.2	0.67	0.39
Minimum wage, April 2007	\$5.15	6.85	\$6.15	0.75	0.84
Fair market rent, 2005, one bedroom	\$523	534	\$763	0.98	0.69
Fair market rent, 2005, two bedrooms	\$650	675	\$928	0.96	0.70
Statewide average spending per person in low-income families with children, for:					
Federal + state Earned Income Tax Credit	\$ 682 + 0 NE \$ 642 + 21 IA	\$ 766 + 0	\$ 693 + 233	0.88	0.73
Medicaid	\$ 1,104 NE \$ 1,332 IA	\$1,685	\$2,632	0.72	0.46
Food Stamps	\$ 350 NE \$ 373 IA	\$459	\$341	0.79	1.06
General assistance, monthly, single non-disabled adult	\$325	none	\$203	-	1.60
Welfare monthly benefit, family of 3, no income, July 2005 (state)	\$364	373	\$532	0.98	0.68
Welfare monthly benefit if working half-time, July '03	\$230	275	\$651	0.84	0.35
Halftime@min.wage plus welfare benefit	\$673	\$864	\$1,180	0.78	0.57
Percent of income (wage+welfare benefit ) remaining after rent for 2 BR apartment	3.4%	21.9%	21.3%	0.16	0.16

Part 2: Shelter resources and federal funding streams

	Omaha Area	Columbus	Minneapolis	Ratio O/C	Ratio O/M
<b>Number of programs available, by type, in region</b>					
Adult emergency	10	11	13	0.91	0.77
Domestic violence shelters	2	1	4	2.00	0.50
Adult transitional	20	5	30	4.00	0.67
Permanent supportive housing	2	27	59	0.07	0.03
Youth emergency	5	1	3	5.00	1.67
Youth transitional	0	1	5	0.00	0.00
<b>Shelter beds available in region (capacity)</b>					
Adult emergency (including overflow)	902	1225	859	0.74	1.05
Domestic violence shelters	55	34	74	1.62	0.74
Adult transitional	662	108	742	6.13	0.89
Permanent supportive housing	117	1,772	2761	0.07	0.04
Youth emergency	52	16	50	3.25	1.04
Youth transitional	0	51	48	0.00	0.00
<b>Estimated number of homeless, one night</b>					
Sheltered	1632	1,259	2877	1.30	0.57
Counted unsheltered	238	114	383	2.09	0.62
TOTAL	1870	1,373	3260	1.36	0.57
<b>FY07 HUD funding received under Community Planning and Development Program</b>					
City only <sup>(a)</sup>					
CDBG (Cmty Devt Block Grant)	\$5,076,098	\$6,609,044	\$13,828,033	0.77	0.37
HOME (HOME Investment Partnerships)	\$2,334,861	\$4,870,715	\$3,531,207	0.48	0.66
ADDI (Amer.Dream Downpayment Init.)	\$54,300	\$111,977	\$64,984	0.48	0.84
ESG (Emerg Shelter Grants)	\$220,997	\$286,322	\$597,347	0.77	0.37
HOPWA (Hsg Oppties for Persons w AIDS)	\$0	\$608,000	\$833,000	0.00	0.00
County(ies) only					
CDBG (Cmty Devt Block Grant)	\$0	\$1,866,367	\$2,485,239	0.59	0.44
HOME (HOME Investment Partnerships)	\$0	\$900,252	\$1,966,531	0.00	0.00
ADDI (Amer.Dream Downpayment Init.)	\$0	\$23,054	\$49,142	0.00	0.00
ESG (Emerg Shelter Grants)	\$0	\$80,862	\$107,896	0.00	0.00
HOPWA (Hsg Oppties for Persons w AIDS)	\$0	\$0	\$0		
<b>Runaway and Homeless Youth Act, Basic Center Program allocations, 2007</b>					
Continuations (state)	\$360,813 NE + \$258,957 IA = \$619,770 total	\$975,501	\$640,272	0.64	0.97
New Awards (state)	\$0 NE + \$258,957 IA	\$687,485	\$108,100	0.38	2.40
Total (state)	\$360,813 NE + \$430,422 IA = \$791,235 total	\$1,662,986	\$748,372	0.48	1.06

Sources: See next page.

Note: (a) In addition, the City of Council Bluffs received \$1,099,991 in CDBG funding for FY07.

Sources for the data included in the three-city comparison table:

Population: <http://quickfacts.census.gov/qfd/states/>

Unemployment rate:

<http://data.bls.gov/map/servlet/map.servlet.MapToolServlet?survey=la&map=county&seasonal=u>

Poverty rates: [http://www.brook.edu/metro/pubs/20061205\\_citysuburban.htm](http://www.brook.edu/metro/pubs/20061205_citysuburban.htm)

Crime rate:

<http://www.city-data.com/forum/nebraska/62435-2005-crime-rates-cities-225-000-a.html>

Minimum wage: <http://www.dol.gov/esa/minwage/america.htm>

Fair market rents: <http://www.huduser.org/Datasets/fmr/fmrs/index.asp?data=hist>

State's average spending on low-income families: <http://www.urban.org/url.cfm?ID=311495>

General assistance:

Douglas County: [http://www.ne211.org/ne211\\_pub/pages/details\\_test.fo?...](http://www.ne211.org/ne211_pub/pages/details_test.fo?...)

Hennepin County: <http://www.dhs.state.mn.us/main/>

Welfare benefits if no income:

[http://www.acf.hhs.gov/programs/opre/welfare\\_employ/state\\_tanf/reports/wel\\_rules05/databook\\_2005.pdf](http://www.acf.hhs.gov/programs/opre/welfare_employ/state_tanf/reports/wel_rules05/databook_2005.pdf)

Welfare monthly benefit if working half-time:

[http://www.urban.org/UploadedPDF/311349\\_A70.pdf](http://www.urban.org/UploadedPDF/311349_A70.pdf)

Number of programs; shelter beds available; estimated number of homeless, one night: Continuum of Care Exhibit 1 (application for McKinney-Vento funding under HUD's SuperNOFA)

FY07 HUD funding received under Community Planning and Development Program:

<http://www.hud.gov/offices/cpd/about/budget/budget07/>

Runaway and Homeless Youth Act, Basic Center Program allocations, 2007:

<http://www.acf.dhhs.gov/grants/open/HHS-2007-ACF-ACYF-CY-0063.html>

The two comparison communities of Columbus and Minneapolis were selected because (1) they are reasonably similar to Omaha in general size and part of the country, (2) they represent somewhat different social and political contexts, and (3) there is publicly-available descriptive information for each of them about the approaches they are taking that are reducing homelessness in their region (available at <http://www.endhomelessness.org>).

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