



Hard-to-Place Task Force: Interagency Coordination on Long-Term Shelter Stayers

The Hard-to-Place Task Force serves as a model of city-state interagency collaboration to address long-term homelessness. In an effort to bring together many of the various entities involved in setting policy for working with long-term shelter stayers, Mayor Michael Bloomberg's administration in New York City established the Hard-to-Place Task Force in 2002. Members include representatives from city and state government agencies as well as a few nonprofit organizations. The task force meets regularly and has made significant progress toward improving services for those who are homeless for the long-term.

Who

The task force is co-chaired by staff from the New York City Department of Homeless Services (DHS) and the New York State Office of Mental Health (OMH). Members include staff from:

- NYC's Department of Homeless Services, which directly operates and contracts out shelter and drop-in centers for homeless individuals and families;
- NYS Office of Mental Health, which is responsible for the operation of psychiatric centers and programs including various inpatient and outpatient programs, emergency, community support, residential, and family care programs;
- NYC's Human Resources Administration (HRA), which determines eligibility for housing for people with psychiatric disabilities;
- NYS's Office of Temporary Disability Assistance, which provides oversight of the City's shelters;
- NYC's Department of Health and Mental Hygiene, which provides health and mental health services for the homeless;
- Center for Urban Community Services (CUCS), a New York City nonprofit service provider and technical assistance organization which manages the city's supportive housing vacancy list;
- Corporation for Supportive Housing, a national organization that helps communities create permanent housing with services to prevent and end homelessness.

History

The needs of long-term shelter stayers have been a focus of DHS since 1998, largely because the department realized that this population was using a large portion of the city's homeless resources. The department's work to address the needs of this population was initially isolated within the department, however. In January 2002, the new Bloomberg mayoral administration decided to take a fresh look at the shelter system and long-term shelter stayers. To do this, the administration sought to create work groups that crossed agency lines and also included external parties. The new administration also wanted to work with the state as a partner. With the backdrop of a stronger working relationship with the state and a new spirit of interagency collaboration, the city formed the Hard-to-Place Task Force, with its first priority population: long term shelter stayers. Long term shelter stayers (LTSS) were defined as those individuals in the shelter system who had been there for at least 730 days out of the last four years, whether the time was contiguous or not.

Implementation

The task force met monthly initially and now meets quarterly. The task force focuses on reducing the number of individuals in the municipal shelter system. Meetings are a time for different organizations to update each other about news in their respective programs. The meetings also provide an ideal forum for problem-solving. Having people with a variety of levels of responsibility, from line staff to decision-makers, in the room at one time allows problems to be raised and solutions implemented swiftly.

Accomplishments

- *Project MatchUp.* Under Project MatchUp, whenever a new supportive housing project opens its doors, the project is matched with a shelter that has long-term residents. A set-aside of units, typically 25%, is negotiated and all agencies involved assist the provider in placing the long-term shelter stayers in these permanent supportive housing units. As of March 2004, 334 housing slots have been committed for long-term shelter stayers, of whom 179 have already moved in.
 - Two benefits of the program are that it is relatively easy to understand and tracking results is simplified.
 - The program encourages supportive housing providers to proactively serve the most challenging clients, and not just those clients that actively seek housing from them.
 - The program also benefits supportive housing providers by creating a more stable community faster, since many of their new residents know each other from their previous shelter.
 - Shelter providers are often pleasantly surprised that their long-term residents can be very successful in supportive housing.
 - Keys to success:
 - DHS has hired a couple of staff to oversee the entire process, including which shelter gets matched with each opening.
 - The supportive housing provider must have a weekly presence in their matched shelter 2-3 months in advance of opening to build familiarity and trust with long-term shelter stayers.
 - A key management staff person from the shelter must be involved in the process so that it is taken seriously.
- *New dedicated staff.* New York City's Department of Homeless Services hired two new permanent program analysts to focus on individuals homeless for the long-term in early 2004. The new staff is analyzing the barriers to leaving shelters and working to improve the situations one location at a time.
- *New awareness.* The NYS Office of Mental Health has recognized long-term shelter stayers as a critical issue, citing them in its *Statwide Comprehensive Plan for Mental Health Services*.
- *Data collection and sharing.* DHS and its shelter vendors maintain a database of all individuals and families in the shelter system. This system has allowed DHS to collect an accurate account of the number of homeless people in the system at any given point, their length of homelessness, and their number of incidences of shelter usage. This ability to collect complete and accurate information has allowed DHS and others working with them to analyze the data and trends, including changes over time. Additionally, the Human Resources Administration's (HRA) Office of Mental Health Housing has begun to identify

and coordinate with DHS around those shelter stayers who may be mentally ill. The DHS database system theoretically tracks this information, but the information is not necessarily updated or even input. When shelter stayers would move from one shelter to another, the next shelter did not know that a mental health concern was raised, diagnosis given, or that an application for mental health housing was submitted in the past. Now, HRA and DHS are cross-checking and sharing data. Not only does this save staff time and resources, it also highlights unidentified mentally ill shelter stayers who qualify for mental health housing.

- *Assertive Community Treatment (ACT) Teams.*¹ The city and state jointly contracted with two ACT teams to work with 136 long-term shelter stayers who may be eligible recipients of set-aside Section 8 vouchers. As of March 2004, 51 consumers have been admitted to the program and another 89 are in the intake stage. Of the 51 consumers in the program, 40 have applied for Section 8, of which 21 have received a voucher. Originally, the New York City Housing Authority (NYCHA) had laid out a plan for “expedited Section 8 vouchers” that would have taken 10-12 months from application to receipt of a voucher. The Hard-to-Place Taskforce worked with NYCHA to reduce the wait down to 6 weeks.
- *McKinney-Vento priority.* The Continuum of Care has prioritized long-term shelter stayers for both new awards and renewals. Existing supportive housing projects must fill every third vacancy with a long-term shelter stayer until the population occupies 25% of the units.

Lessons Learned

- The group must have key decision makers from each agency in the room. In addition, participation of policy makers and line staff is extremely valuable.
- Participation must be comprehensive, that is, every system that touches clients’ lives must be present. For example, if a client interacts with both a city and a state agency to receive services, both must be present at the table.
- The collection of data is a critical, first step to identifying and tracking problems or trends. For example, shelter providers might have had “a sense” that some shelter stayers were there for long period of time, but until DHS could analyze the data and realize that 17% of the shelter stayers used 50% of the shelter bed-days, the anecdotal information from shelter providers was insufficient to ignite specific programs or policies.
- Government entities and Continuums of Care should recognize their ability to address the needs of the chronically homeless through contracts and regulatory changes. By DHS implementing “Match-Up” and the Continuum of Care requiring that a percent of new and turned-over units go to long-term shelter-stayers, attention and outreach to this population has been achieved at a level that would not otherwise likely be possible.

¹ ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. For homeless clients, this can mean providing services on the streets or in shelters. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation (definition from <http://www.nami.org>).