COMMUNITY ASSESSMENT

Addressing Homelessness in Sangamon County

Prepared by LathanHarris, Inc. for Heartland Continuum of Care.
2022

EXECUTIVE SUMMARY

Homelessness remains a critical public health concern in the city of Springfield, Illinois. Research shows that approximately 271 people are homeless on a given night in Sangamon County and Springfield IL. There is an urgent need to eradicate homelessness as it affects the health and well-being of the entire community.

As part of the initiatives to combat homelessness in the target area, a needs assessment was conducted to identify where to focus efforts to meet the most critical needs of homeless individuals in the target area. The needs assessment addresses 5 key areas: 1) expanded and increased coordination for permanent housing resources; 2) outreach and case management; 3) fully integrated clinical services; 4) comprehensive two-way communication and training; and 5) integration of equity measures, benchmarks, and outcomes. Evidence-based best practices and models that outlines housing, healthcare and social needs of the homeless, as well as integration across programs and the need to increase independence through capacity building were identified for each key area. Time-specific recommendations at 3-, 6-, and 12-month marks were developed to ensure timely delivery of essential services highlighted in the needs assessment.

1. Housing – Expanded and Increased Coordination for Permanent Housing Resources

Demonstrated Need

Homelessness is a persistent societal and public health issue in the United States. Individuals experiencing homelessness often lack healthcare and live in overcrowded, unsanitary conditions (Balagot et al, 2019). There is a need for more permanent housing resources to efficiently house the growing homeless population. Initiatives like the Housing First model provides permanent housing and case management services to the homeless. However, the level of need for any type of homeless service far exceeds the ability of existing programs to serve all individuals seeking help (Balagot et al, 2019). This is particularly the case for permanent housing placements in a community with high rent to income ratios and limited low-income housing. Providing permanent housing to people experiencing chronic homelessness, homeless people with chronic health conditions who have been hospitalized, or frequent users of emergency and inpatient care has been shown to increase rates of housing stability, reduce mortality and considerable reductions in the use of hospital inpatient and emergency room care (Wilkins, 2015).

For all homeless individuals to have access to permanent housing services, agencies should have in place a system-wide Coordinated Entry System (CES). The Coordinated Entry System can provide a thorough assessment of individuals entering the homeless system, which will be essential in providing the most appropriate level of care. Additionally,

implementing a CES ensures that all vital information is compiled in one easily accessible database that can be viewed by multiple service providers. This ensures coordination of efforts across agencies in a person-centered way and offers more opportunities for chronically homeless individuals to be prioritized for housing resources. Policies and procedures directing the CES process must be equitable, transparent and consistently and universally applied.

Homelessness incurs moral and financial costs to society through tax revenue for hospitals, psychiatric facilities, and social services that attempt to meet the emergent needs of homeless individuals. This reiterates even further the need for integrated care. Research evidence suggests that providing integrated care can potentially improve outcomes at reduced costs (Guerrero et al., 2014). Access to permanent housing as part of an integrated approach is an efficient strategy that can deliver evidence-based mental health care, effectively monitor physical health indicators, and result in significant cost offsets (Guerrero et al., 2014). Although some programs may have achieved some measure of integrated care, the larger system of care is not designed to address the need for coordination. This is urgently needed for improved and cost-effective outcomes related to homelessness (Guerrero et al., 2014).

BEST PRACTICES/MODELS FOR HOUSING - Expanded and Increased Coordination for Permanent Housing Resources

1. **Collaborating in evidence-based permanent housing techniques such as Housing First**

Housing First is a homeless assistance technique that provides permanent housing to homeless individuals, which creates an opportunity for them to improve their quality of life. The flexible nature of this approach allows for its application to households who become homeless due to temporary or personal financial crisis and need help accessing and securing permanent housing.

The Housing First has two models -Permanent Supportive Housing and rapid re-housing. Permanent supportive housing (PSH) is targeted to individuals and families with chronic illnesses, disabilities, mental health substance use disorders who have experienced long-term or repeated homelessness. It provides long-term rental assistance and supportive services. Rapid re-housing on the other hand is designed to help individuals and families quickly exit homelessness and return to permanent housing. There is research evidence that points to the effectiveness of rapid re-housing. A statewide study "Connecticut Coalition to End Homelessness" found that, of those families who exited rapid re-housing programs in Connecticut in 2010, 95 percent had not returned to shelter three years later. It would be worthwhile for states to participate in these great initiatives to increase permanent housing resources for the homeless. Even when these programs are appropriately implemented, the priority need is continuous funding to sustain and expand services to meet the overwhelming need.

2. **Non-profit organizations in the community should consider utilizing the Supportive Housing Scattered-Site Ownership model**

In a Supportive Housing Scattered-Site Ownership model the supportive housing units are acquired and operated by a non-profit organization (or mission focused for profit organization) and dispersed among multiple buildings or properties in a community (Corporation Supportive Housing, 2015). This model provides a great opportunity to integrate supportive housing units in the general community, thereby offering opportunities for permanent housing for those who need it. Integrating supportive housing units across scattered-site properties should be considered as one approach in which communities can create permanent housing options for supportive housing populations. Supportive housing units are affordable (the tenant household ideally pays no more than 30% of its household income toward rent), tenants are linked to community-based resources, and participating organizations effectively coordinate with key partners to address issues resulting from substance use, mental health and other crises, with a focus on fostering housing stability.

3. **Encourage states and communities to coordinate services and housing**

Despite the availability of housing resources, they may not be readily accessible for homeless individuals. States and community-based organizations should be encouraged to create a coordinated, comprehensive system of services to address homelessness. This may include establishing an infrastructure that develops systemic relationships among providers for effective client referral and treatment, more effective leveraging of fiscal and human resources, and cross-system training.

Community Input

- Need to have and integrate clinicians to conduct initial standardized assessments to determine need and eligibility of permanent housing.
- Need to determine and identify solutions to barriers and limitations that prohibit the Continuum in receiving and competing for additional funds for permanent housing.
- Need to have an expanded database that captures profiles, housing services, resources opportunities to increase funding, collaboration characteristics and, short and long-term services that can support transition to permanent housing of diverse existing and new partnerships.
- Need real-time, user friendly resource inventory database of all supplemental funding streams including eligibility requirements.
- Need a standardized seamless system of comprehensive services leading to permanent housing that is inclusive of transition services, initial intensive case management and long-term maintenance.

Time Specific Recommendations

By Month 9

- Update comprehensive housing inventory by category and eligibility in Sangamon County
- Maintain and monitor real-time housing inventory database by population characteristics and eligibility
- Integrate clinical services in assessment process to aid in appropriate placement and correlative resources that support transition and maintenance in permanent housing

By Month 12

- Identify and resolve barriers that prohibit Sangamon County in receiving maximum federal funds for permanent housing.

2. Outreach and Case Management

Demonstrated Need

Homeless individuals are constantly under stress due to uncertainty of finding a place to sleep or obtain regular meals. In addition to the hardship of being homeless, a disproportionate number of individuals experiencing homelessness have endured other forms of traumatic stress including adverse childhood experiences (ACEs), such as child abuse and neglect, and domestic violence (Resler, 2017). A nationally represented study found individuals experiencing repeated homelessness had higher rates of all ACEs compared with individuals not experiencing repeated homelessness (Resler, 2017). Case management for the homeless should involve having an in-depth understanding of trauma and how it affects an individual's physical and mental health, economic and housing status (Resler, 2017). In general, community-based case management homeless services help ensure individuals who are homeless have appropriate referrals for housing and incorporate a patient-centered approach emphasizing values and preferences (Fraino, 2015).

Homeless outreach entails seeking and making direct contact with individuals in the community to provide information about services they may be eligible for, and either providing the service or making a referral to a service provider (Guild, 2021). Research shows that agencies need to apply a person-centered approach that recognizes both the diversity of client needs and the limitations of existing resources (Randall et al., 2020). There is also a need to adopt more extensive outreach models that engage citizens, empower homeless clients, and leverage mobile technology so that case workers can focus on high-risk clients.

Individuals experiencing chronic homelessness suffer disproportionately from serious physical and mental health conditions. In addition, they are less likely to seek services to address these conditions on their own (Ashwood et al., 2019). In order to better serve homeless individuals with different health issues, services should be delivered by specialist multidisciplinary

outreach teams that can meet a person's needs. These needs include physical health, mental health, social care, drug and alcohol treatment, as well as help with benefits, housing, and legal advice (Lacobucci, 2022).

The prevalence of mental illness among homeless people in the United States is high. Research shows that 21% of homeless individuals have serious mental illness, compared with 5% in the general U.S. population (Choi et al., 2021). Mental illness among people who are homeless is associated with increased risk for mortality, disability, substance use disorders, and suicide (Choi et al., 2021). The healthcare system needs to incorporate a recovery-oriented approach targeted towards the homeless. A recovery-oriented system requires that the full range of comprehensive services that an individual needs to fully recover be accessible, flexible, individualized and coordinated (Felton et al., 2010). The services need to be delivered with respect, while taking into consideration any racial, cultural, and gender differences. It is also essential for consumers to be involved in the planning, delivery, and evaluation of services (Felton et al., 2010).

BEST PRACTICES – Models for Outreach and Case Management for the Homeless

Case Management

1. **Identify and develop guiding principles for case management**

   Trauma informed

   Integrating a trauma informed approach is essential. This approach is based on the principle that individuals experiencing homelessness have a higher prevalence of

trauma histories. There should be a skillset to recognize these trauma symptoms, and the services provided should be sensitive and appropriate.

Housing informed

Programs addressing homelessness should place more emphasis on adopting approaches that help the client exit homelessness and remain stably housed. If clients need services beyond assistance identifying and moving into permanent housing, then they should be connected to the community agency providing those services.

Outreach

1. **Emulating models like the San Diego Homeless Outreach Worker (HOW) best practices**

   The San Diego HOW program recommends utilizing agency collaboration tools like online central referral systems (i.e. Homeless Management Information System (HMIS), and Coordinated Entry System (CES) to effectively conduct outreach. Such central referral systems have served as a central point of contact for outreach workers across agencies to stay informed about mutual clients. The following are best practices for providing effective homeless outreach and engagement:

   i. Person-Centered Practice- This entails involving the homeless individuals in the decision-making process to empower them and give them control over the available choices.

   ii. Harm reduction- In this approach, quality services are provided to the homeless to decrease the adverse effects of homelessness. It also helps outreach workers form trusting relationships and provide a platform to continuously monitor safety issues.

iii. Building consistent and trusting relationships are essential. This may be useful in rectifying mistrust of services and the trauma of demeaning behaviors and attitudes.

iv. Culturally sensitive practice- It is crucial that outreach workers receive training in culturally sensitive practice. A lack of awareness about the needs and issues affecting culturally diverse people can result in re-traumatization and perpetuate damaging stereotypes.

2. Developing multidisciplinary outreach teams

Outreach workers should represent a diverse population with different skillsets and a combination of roles. Ideally, outreach teams should include community health workers, case managers, hospital liaisons, social workers, disability acceptance staff, and other relevant staff members. Having a multidisciplinary team approach ensures the availability of comprehensive resources for homeless people dealing with a range of issues. The Santa Cruz County in California for instance utilizes the Homeless Outreach, Proactive Engagement Services (HOPES) model, which makes use of a multidisciplinary team to provide resources to homeless individuals.

3. Coordination between agencies and organizations

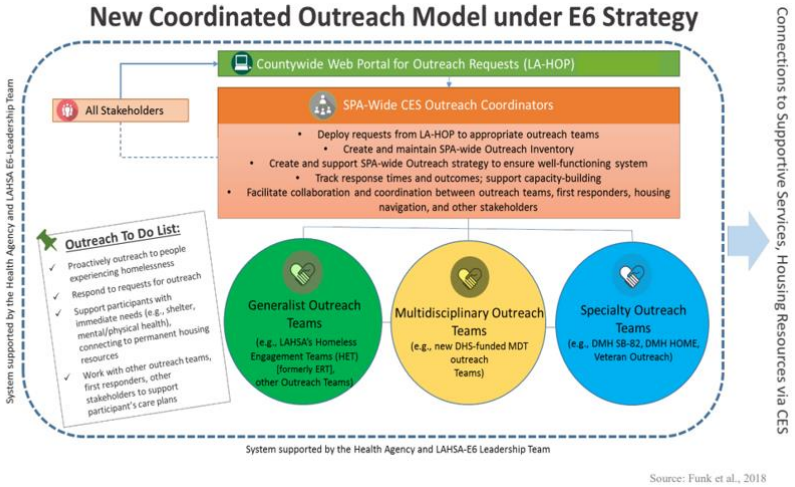
Systematic coordination between the different agencies and organizations conducting outreach is a key component of program success. It ensures that services are not duplicated and reduces the likelihood of missing hard-to-reach homeless populations. To promote coordination among agencies, certain strategies need to be adopted: a) central referral systems, b) identify specific coverage areas for agencies, c) conduct regular interagency meetings on outreach work and d) develop a compilation of a referral database of agency and organizational contacts.

4. **Lived experience staffing**

   Agencies may consider employing people with lived experience of homelessness as outreach workers. This can create more trusting relationships between the outreach workers and homeless individuals and may encourage the team to be more proactive in its efforts to find service linkages for clients.

5. **Developing a comprehensive outreach system**

   The LA County Department of Mental Health (DMH) combined the efforts of the Los Angeles Homeless Services Authority (LAHSA) and other relevant County agencies and community-based service providers to leverage existing outreach efforts and create a countywide network of multidisciplinary, integrated, and street-based teams to identify, engage, and connect or re-connect homeless individuals to interim and/or permanent housing and supportive services. The figure below outlines the structure of the County's outreach system under the E6 strategy:



https://socialinnovation.usc.edu/wp-content/uploads/2020/09/Homeless-Outreach-Literature-Review-Draft-V7.pdf

Community Input

- Need for intense and fully integrated outreach and case management.
- Need to standardize and define terms and strategies of outreach and case management
- Need for population specific standardized strategies and expected outcomes for outreach and case management services.
- Need for outreach and case management to increase permanent housing placement.
- Need to ensure that all clients receive equitable assessment, treatment planning, linkage to appropriate resources and adequate maintenance.

Time Specific Recommendations

By month 9

- Integrate a person-centered approach in policy and practice
- Implement a comprehensive county-wide outreach model that utilizes technology to feed outreach contact, client specific demonstrated need referrals, and geographic and demographic data to database
- Outreach team liaisons with specialty providers to aid in treatment adherence

By month 12

- Via policy and practice, prioritize strategies that foster persons exiting homelessness
- Via policy and practice, prioritize strategies that increase knowledge, education, and consideration for representation, diversity, culture, and norms by providers

3. Fully Integrated Clinical Services – Targeted, Flexible and Accessible

Demonstrated Need

Individuals experiencing homelessness often have poor living conditions and have limited access to health care, which makes them vulnerable to the spread of disease (Su, 2020).

Health services for the homeless should follow a universal system standardized assessment and referral process to provide coordinated access to community resources. Coordinated access ensures that services are well publicized to homeless individuals and families. Having such a system in place creates a simplified way for people in need to access assistance and improves collaboration, communication, efficiency, and transparency between service providers (Connecticut Coalition to End Homelessness, 2015). Additionally, the U.S Department of Health and Human Services states that the coordination of services for the homeless is a critical component of achieving the goal of preventing and ending homelessness (U.S. Department of Health and Human Services, 2007).

An integrated delivery systems is needed for homeless individuals to access healthcare services. There is evidence in the literature that fragmented service definitions and inflexible program rules can be a poor fit for the flexible and individualized services needed by homeless people with multiple co-occurring chronic health conditions, mental health, and substance use disorders (Wilkins, 2015).

The prevalence of mental illness among homeless people in the United States is high. Research shows that 21% of homeless individuals have serious mental illness, compared with 5% in the general U.S. population (Choi et al., 2021). Mental illness among people who are homeless is associated with increased risk for mortality, disability, substance use disorders, and suicide (Choi et al., 2021). The healthcare system needs to incorporate a recovery-oriented approach

targeted towards the homeless. A recovery-oriented system requires that the full range of comprehensive services that an individual needs to fully recover be accessible, flexible, individualized and coordinated (Felton et al., 2010). The services need to be delivered with respect, while taking into consideration any racial, cultural, and gender differences. It is also essential for consumers to be involved in the planning, delivery, and evaluation of services (Felton et al., 2010).

BEST PRACTICES – To Create Targeted, flexible, and accessible clinical services for the homeless

1. **Development of guidelines and recommendations to support delivery of care**

   Research shows that clinical practice guidelines have been developed to improve social and health outcomes for the homeless and those at risk of becoming homeless (Pottie et al., 2020). These guidelines target health providers, policymakers, public health practitioners and researchers. The "good practice statements" created to support delivery of care are outlined below:

   i) Homeless and vulnerably housed populations should receive trauma-informed and person-centered care

   ii) Homeless and vulnerably housed populations should be linked to comprehensive primary care to facilitate the management of multiple health and social needs

   iii) Providers should collaborate with public health and community organizations to ensure programs are accessible and resources appropriate to meet local patient needs

   Each of these good practice statements are backed by research evidence.

2. **Adapting different care models into the health system**

There is evidence in the literature which suggests that shelter-based collaborative mental health care models may be effective for individuals experiencing homelessness and mental illness (Stergiopoulos et al., 2015). In collaborative mental health care models, patients, their families, their caregivers, and health providers from primary and mental health care settings work together to provide more coordinated services for individuals with mental health needs (Stergiopoulos et al., 2015).

A. Integrated multidisciplinary collaborative care models (IMCC)

In the IMCC model, an on-site psychiatrist or mental health worker becomes an integral part of a primary care team. Shelter staff and health care providers work as a single team and share a common electronic medical record. A psychiatric consultant is available onsite four half days per week. The IMCC model offers increased ease of referral, an interdisciplinary stepped approach to care, increased communication between diverse providers, coordinated care plans, and more integrated and comprehensive shelter-based care and case management.

B. Shifted outpatient collaborative care model (SOCC)

The SOCC model focuses on the provision of timely psychiatric care, and offers ease of referral, promotes better communication between shelter staff and on-site psychiatrist, including review of treatment progress and care coordination plans.

3. **Develop integrated delivery systems to enable homeless individuals to access services at numerous points of entry into the health care system**

Multi-level interventions are needed to meet the needs of homeless individuals. The Allegheny Initiative for Mental Health Integration for the Homeless (AIM-HIGH) has successfully used system-, provider-, and client-level interventions to cater to homeless

individuals (Gordon et al., 2011). Several best practices can be derived from this strategy:

i. System level - Set up advanced behavioral health care services at existing homeless medical clinics. This is especially essential in geographically diverse neighborhoods where homeless persons frequent. Such clinics can provide a blend of medical, mental health, pharmaceutical, drug and alcohol, and case management services using multidisciplinary teams.

ii. Provider level - Host widespread training sessions to educate service providers about housing opportunities for the homeless, improve networking between providers, and create resource manuals for the homeless.

Community Input

- Need to reduce and address chronic homelessness that is rooted in childhood and long-term trauma.
- Need to utilize clinical expertise and technique to standardize assessment processes and service eligibility determinations.
- Need for a diverse range of clinical service providers that possess unique expertise in cultural experiences, norms, traumas, and clinical base solutions and techniques that affirms identity.
- Need for increased access to clinical services beyond normal business hours.
- Need for clinical services for persons experiencing homelessness that coordinate with law enforcement and court services to be more positively normalized through use of less punitive name recognitions, increased engagement, and collaboration with new and existing partners for promotion and education.

Time Specific Recommendations

By Month 9

Fully integrate flexible and responsive diverse psychiatric services into all levels of service delivery

4. Comprehensive Two-Way Communication and Training

Demonstrated Need

Research shows that the homeless, especially youths, have perceived mistrust of systems and often resist engagement with any service or intervention (Curry et al., 2021). Given this distrust, the way staff initiate their first encounters can have lasting first impressions on youths' decisions to continue with a program or intervention over time (Curry et al., 2021). Recurring training opportunities should therefore be available for frontline workers dealing with homeless individuals and families.

Several barriers to communication exist within housing programs. Homeless individuals are often unable to communicate effectively with agency staff, which may negatively affect their ability to transition from homelessness (Parker & Albrecht, 2012). Additionally, chronically homeless persons not enrolled in intensive case management have a lower likelihood of understanding eligibility requirements for housing, and therefore self-disqualify because of this lack of knowledge (Parker & Albrecht, 2012). The literature suggests that for case managers and outreach workers to improve communication, less jargons and acronyms should be used, and written materials should be no higher than an eighth-grade reading level (Parker & Albrecht, 2012).

Communication must also exist between workers and agencies for effective consumer engagement. There is evidence that deficits in coordination and communication between hospitals and homeless shelters lead to patients being turned away (Greysen et al., 2012). This is a cause for concern because of the high victimization in this population, especially

among women and seniors. These failures are also crucial because they signify missed opportunities to improve outcomes of care (Greysen et al., 2012).

Best Practices

BEST PRACTICES – Expansive Communication, Training and Engagement

1. **Conduct cross-training activities for providers and other frontline workers**

   Regular meetings should be held to provide educational and cross-training activities for key community and political stakeholders, professional providers, and ancillary service providers. The Professional Development Program's (PDP) Upstate Homeless Services Training and Resource System project provides trainings related to homeless services to providers. These educational sessions aim to increase the providers' knowledge, skills, and ultimately attitude in working with people experiencing homelessness and to help foster a career path for participants. They cover essential topics related to trauma and homelessness, ways to increase staff effectiveness in interviewing, documentation, and goal setting, conflict and crisis management, and vocabulary surrounding specific subpopulations (e.g., the LGBTQIA+ community) etc. More educational initiatives like these should be made available to individuals working with the homeless.

2. **Fostering effective communication between workers and agencies**

   Many mechanisms for improving access to homeless services start by improving communication between those who have homeless clients needing a benefit or service and those in mainstream agencies who process applications. Research shows that community organizations with strong central organizing structures and have regular staff meetings that often lead to new or revised procedures, approaches, or even programs (US Department of Housing and Urban Development, 2010) foster effective communication between workers and their agencies. There is also evidence that health

care workers who meet regularly in some communities see improvements in homeless service delivery.

3. **Project Homeless Connect (PHC) model**

   Project Homeless Connect (PHC) is a national best practice model that addresses the needs of homeless individuals and families. PHC brings together individuals experiencing homelessness and service providers in one central location for a full day devoted to innovative resource delivery and service linkage (Charlesworth & Metzger, 2020). Below is a summary of their evidence-based best practices for engaging homeless individuals:

Best Practices in Engagement

- San Jose, Minneapolis, and San Francisco each develop short promotional videos to engage civic, corporate volunteers and partners.
- San Francisco partners with volunteer agencies and uses the web to advertise and recruit. Each team lead trains volunteers.

Best Practices in Site Selection & Staging

- San Jose implements mobile Project Homeless Connect in city areas where consumers have not been engaged.

Best Practices in Delivery

- Providing “mobile hospitality,” that is, the pairing of volunteers with homeless people to navigate the space and the resources, is vital to the consumers’ sense of welcome and comfort.

Best Practices in On-Site Consumer Engagement

- Establish ample intake capacity to reduce or eliminate waiting in lines for homeless consumers.
- Offer on-site entertainment and restaurant-style meal service.

Community Input

- Need for increased support and information dissemination on the status of homelessness to non-engaged social service organizations
- Need for increased training on basic information regarding homelessness and the benefits of permanent housing for persons experiencing homelessness.
- Need for ongoing increased community engagement with impact neighborhoods and communities.
- Need for increase community education through social media outlets on homelessness in Sangamon County.
- Need for a shared data system that tracks service delivery and status of client referrals.

Time Specific Recommendations

By Month 12

- Identify and remedy gaps in coordination in the system and remedy.
- Identify and remedy gaps in cross system communication.
- Provide internal and external homeless system of care training regarding trend, current issues and basic education and skill development that is promoted community wide.

5. INTEGRATION OF EQUITY MEASURES, BENCHMARKS, AND OUTCOMES

Organizations are increasingly being pressed to measure and report their outcomes and demonstrate investments of resources, time, and efforts, as well as, demonstrated results in improvements in the lives of people experiencing homelessness and/or reductions in rates of homelessness. Furthermore, the United States Department of Housing and Urban Development has required Continuums of Care to implement management information systems to evaluate characteristics of homeless persons, their service usage and service outcomes (Crook et al., 2005). In order to assess outcomes, especially some aspects of programs that cannot be quantified, the use of both quantitative and qualitative approaches is encouraged (Crook et al., 2005).

Equity measures also need to be established. Health disparities continue to disproportionately affect people of color, and physical and mental health conditions can contribute to homelessness by interfering with income and social ties. The racial demographics of homelessness has received little attention from policy makers, suggesting that more research should be conducted to identify the link between structural racism and homelessness and to develop effective policy and practice solutions (Olivet et al., 2021). There is a need to invest more in communities in color, and to expand the social safety net to make housing more affordable and equitable. Additionally, people of color with lived experiences should be engaged in interventions that address racism at local, state, and federal levels (Olivet et al., 2021).

Benchmarks are essential for providing a complete picture of a community's response to homelessness and can be used as an indicator of whether and how effectively that system is working. The United States Interagency Council on Homelessness suggests that communities need robust, coordinated systems that are focused on the same shared outcomes. This ensures those visions are clearly defined, and all efforts are aligned to provide long-term solutions to eliminate homelessness (U.S. Interagency Council on Homelessness, 2016).

BEST PRACTICES – Integration of equity measures, benchmarks, and outcomes

1. **Implement strategies outlined in the Housing and Urban development Racial Equity Plan**

- Partner with United States Interagency Council on Homelessness (USICH) and other agencies to reduce entries into homelessness from foster care criminal justice and other institutions (U.S Department of Housing and Urban Development, n.d).
- Improve the collection of gender identity data and race and ethnicity data. The goal is to collect data in a culturally sensitive and trauma-informed way and ensures data are not used to disenfranchise people. Improved data collection will enable greater awareness of barriers and effective actions (U.S Department of Housing and Urban Development, n.d).

2. **Project Homeless Connect best practices for measuring outcomes**

- Some jurisdictions partner only with those that provide tangible resources wanted by consumers and identify one person accountable for each reportable result (Charlesworth & Metzger, 2020).
- Streamline and standardize reporting by using the United States Interagency Council's PHC reporting tool.
- Use exit interviews to assess and record individual results and cross-check partner-reported results for quality control.

https://www.usich.gov/resources/uploads/asset_library/2009-1_NPHCToolkit2pt1.pdf

3. **Invest in organizations that are trusted within racial/ethnic communities**

Organizations known, respected, and trusted within communities of color are well situated—and often, best suited—to serve families of color experiencing a housing crisis. Families of color trust these organizations enough to approach them for help and

share their stories. Funders need to reward and return that trust by investing in those organizations to deliver homeless services (Building Changes, 2021).

Community Input

- Need for increased support and information dissemination on the status of homelessness to non-engaged social service organizations
- Need for increased training on basic information regarding homelessness and the benefits of permanent housing for persons experiencing homelessness.
- Need for ongoing increased community engagement with impact neighborhoods and communities.
- Need for increase community education through social media outlets on homelessness in Sangamon County.
- Need for a shared data system that tracks service delivery and status of client referrals.

Time Specific Recommendation

By Month 12

- Develop an education campaign on homelessness in Sangamon County that is inclusive of status, possible solutions and "asks" – activities for community members.
- Promote the user-friendly database as a community resource for dashboard data.
- Implement strategies and messages to large scale community education using social media.

References

Ashwood, J. S., Patel, K., Kravitz, D., Adamson, D. M., & Burnam, M. A. (2019). Evaluation of the Homeless Multidisciplinary Street Team for the City of Santa Monica. RAND Corporation. https://www.rand.org/pubs/research_reports/RR2848.html

Balagot, C., Lemus, H., Hartrick, M., Kohler, T., & Lindsay, S. P. (2019). The Homeless Coordinated Entry System: the VI-SPDAT and other predictors of establishing eligibility for services for single homeless adults. *Journal of Social Distress and the Homeless*, *28*(2), 149-157.

Building Changes. (2021). Lessons in family homelessness: Making homeless systems more equitable and effective. Retrieved from https://buildingchanges.org/wp-content/uploads/2021/02/2021_FHIBrief_RacialEquity.pdf

Charlesworth, L. W., & Metzger, J. (2020). Scaffolding Student Learning: The Project Homeless Connect Model. *Journal of Social Work Education*, *56*(sup1), S142-S149.

Choi, K. R., Castillo, E. G., Seamans, M. J., Grotts, J. H., Rab, S., Kalofonos, I., ... & Starks, S. L. (2021). Mental health conservatorship among homeless people with serious mental illness. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.202100254

Connecticut Coalition to End Homelessness. (2015). Coordinated access in Connecticut. Retrieved from https://cceh.org/work/coordinated-access/

Corporation Supportive Housing. (2015). Supportive housing scattered-site ownership. Retrieved from http://www.csh.org/wp-content/uploads/2015/12/IL_Toolkit_Model_Scattered-Site-Owned.pdf

Crook, W. P., Mullis, R. L., Cornille, T. A., & Mullis, A. K. (2005). Outcome measurement in homeless systems of care. *Evaluation and Program Planning*, *28*(4), 379-390.

Curry, S. R., Baiocchi, A., Tully, B. A., Garst, N., Bielz, S., Kugley, S., & Morton, M. H. (2021). Improving program implementation and client engagement in interventions addressing youth homelessness: A meta-synthesis. *Children and Youth Services Review*, *120*, 105691.

Felton, M. C., Cashin, C. E., & Brown, T. T. (2010). What does it take? California county funding requests for recovery-oriented full service partnerships under the Mental Health Services Act. *Community Mental Health Journal*, *46*(5), 441-451.

Fraino, J. A. (2015). Mobile nurse practitioner: a pilot program to address service gaps experienced by homeless individuals. *Journal of Psychosocial Nursing and Mental Health Services*, *53*(7), 38-43.

Gordon, A. J., Montlack, M. L., Freyder, P., Johnson, D., Bui, T., & Williams, J. (2007). The Allegheny initiative for mental health integration for the homeless: integrating heterogeneous health services for homeless persons. *American Journal of Public Health*, *97*(3), 401-405.

Greysen, S. R., Allen, R., Lucas, G. I., Wang, E. A., & Rosenthal, M. S. (2012). Understanding transitions in care from hospital to homeless shelter: a mixed-methods, community-based participatory approach. *Journal of General Internal Medicine*, *27*(11), 1484-1491.

Guerrero, E. G., Henwood, B., & Wenzel, S. L. (2014). Service integration to reduce homelessness in Los Angeles County: Multiple stakeholder perspectives. *Human Services Organizations Management, Leadership & Governance*, *38*(1), 44-54.

Guild. (2021). What does homeless outreach mean? Retrieved from https://guildservices.org/blog/what-does-homeless-outreach-mean/

Lacobucci, G. (2022). Multi-agency approach is needed to improve services for homeless people, says NICE. *The BMJ*, 376. doi: https://doi.org/10.1136/bmj.o706

National Project Homeless Connect. (2008). Project Homeless Connect: A step-by-step guide. Retrieved from https://www.usich.gov/resources/uploads/asset_library/2009-1_NPHCToolkit2pt1.pdf

Olivet, J., Wilkey, C., Richard, M., Dones, M., Tripp, J., Beit-Arie, M., ... & Cannon, R. (2021). Racial inequity and homelessness: Findings from the SPARC Study. *The ANNALS of the American Academy of Political and Social Science*, *693*(1), 82-100.

Parker, R. D., & Albrecht, H. A. (2012). Barriers to care and service needs among chronically homeless persons in a housing first program. *Professional Case Management*, *17*(6), 278-284.

Pottie, K., Kendall, C. E., Aubry, T., Magwood, O., Andermann, A., Salvalaggio, G., ... & Tugwell, P. (2020). Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience. *Cmaj*, *192*(10), E240-E254.

Resler, M. (2017). Facing the facts: Trauma informed practices in homeless intervention services. *Family & Children's Trust Fund of Virginia*. Retrieved from https://www.fact.virginia.gov/wp-content/uploads/2017/11/FACT-ISSUE-BRIEF-TRAUMA-INFORMED-Homeless-Intervention-FINAL.pdf

Stergiopoulos, V., Schuler, A., Nisenbaum, R., Deruiter, W., Guimond, T., Wasylenki, D., ... & Dewa, C. (2015). The effectiveness of an integrated collaborative care model vs. a shifted outpatient collaborative care model on community functioning, residential stability, and health service use among homeless adults with mental illness: a quasi-experimental study. *BMC Health Services Research*, *15*(1), 1-12.

Su, J. J. (2020). Health services for homeless people in California. California State University, Northridge. Retrieved from https://scholarworks.calstate.edu/downloads/w6634840n

United States Department of Health and Human Services. (2007). Strategic Action Plan on Homelessness. Retrieved from https://www.hhs.gov/programs/social-services/homelessness/research/strategic-action-plan-on-homelessness/index.html

United States Department of Housing and Urban Development (n.d). Equity Action Plan. Retrieved from https://assets.performance.gov/cx/equity-action-plans/2022/EO%2013985_HUD_Equity%20Action%20Plan_2022.pdf

United States Department of Housing and Urban Development. (2010). Strategies for improving homeless people's access to mainstream and services. Retrieved from https://www.huduser.gov/portal/publications/strategiesaccessbenefitsservices.pdf

United States Interagency Council on Homelessness. (2016). Criteria and Benchmark for Achieving the Goal of Ending Chronic Homelessness. Retrieved from https://files.hudexchange.info/resources/documents/Criteria-and-Benchmark-for-Achieving-the-Goal-of-Ending-Chronic-Homelessness.pdf

Wilkins, C. (2015). Connecting permanent supportive housing to health care delivery and payment systems: Opportunities and challenges. *American Journal of Psychiatric Rehabilitation*, *18*(1), 65-86.