

**Housing Ingham**  
**The 10 Year Plan to End Homelessness**  
**In**  
**Ingham County**



**The Greater Lansing Homeless Resolution Network**  
**The Power of We Consortium**  
**2006**

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## **Introduction**

Ingham County, Michigan consists of a unique blend of rural and urban areas, a diverse population, and a comprehensive service delivery system. Despite tremendous effort, Ingham County is still home to as many as 700 homeless people each night. Many individuals and families have escaped homelessness with the help of the wide variety of services in Ingham County, but many more enter, and systematic barriers are prohibiting some from moving into permanent housing. This plan illustrates a community wide effort to break down these barriers, create new opportunities, and strengthen the community by building stability into the lives of every citizen.

Ingham County has a great number of resources and an especially talented and committed group of people who are dedicated to the implementation and success of this plan. This plan will act as a road map that will lead Ingham County on the path to housing for all.



## **Executive Summary**

### **The Problem**

Like communities across America, Ingham County continues to face the struggle of homelessness. As the homeless population rises, affordable housing stock decreases, leaving more people fewer options. Unlike other communities, Ingham County also struggles with a declining job market as major automotive employers close factories and relocate jobs to other states and countries. In July 2006, Michigan had the highest unemployment rate in the country, next only to hurricane ravaged Louisiana. Ingham County, as one of the leaders in automotive production, has been hit hard by the decline in manufacturing jobs and revenue.

### **Our Vision**

A healthy, stable, housed Ingham County is within our reach. The process of creating this plan has demonstrated the ability of this community to pull together and address any issue that threatens the welfare of its citizens. Our vision includes formally adopting a housing first model, where no one will spend any length of time without a home, and providing all necessary supportive services to prevent homelessness and support individuals and families to sustain housing. The strength of our community depends on everyone having a place to belong.

### **Our Response**

Ingham County has been preparing to create a plan to end homelessness for more than two years. Initial efforts focused on gathering and analyzing quantitative and qualitative data on the homelessness in our community. The Continuum of Care for Homeless Services, The Greater Lansing Homeless Resolution Network, partnered with the Power of We Consortium, the Multi-Purpose Collaborative Body, to lead the process of creating the plan. To make the effort a community driven process, two community dialogues were held, with community leaders in service and business, care providers, homeless and formerly homeless individuals, local educators, hospital representatives, police departments, city officials, and religious leaders invited. More than 100 people representing more than 60 organizations gathered to discuss the characteristics of the homeless population, the contributing factors on the homeless situation in Ingham County, and the strategies needed to end homelessness. This plan is a result

of that process, partnered with the work done in the community since 2004 with data collection, discharge planning, and community collaboration.

Nationwide, the primary cause of homelessness is a lack of affordable housing. The federal government is taking steps to address this shortage, including committing to provide 150,000 units of supportive housing and promoting legislation that provides services to those at risk of becoming homeless. States are developing plans to end homelessness, bringing together mainstream resources and housing services to facilitate the implementation of housing first approaches, and working with local communities to strengthen service systems and enable housing first modalities.

**The following organizations contributed to the development of this plan.**

ACORN  
Advent House Ministries &  
Greater Lansing Homeless  
Resolution Network  
American Red Cross Emergency  
Services Dept.  
Black Child and Family Institute  
Capital Area Community Services,  
Inc.  
Capital Area Literacy Coalition  
Capital Area Michigan Works  
Capital Area United Way  
Capital Area Youth Alliance  
Care Free Medical, Inc.  
Christian Services  
City of East Lansing  
City of Lansing - Dept. of  
Planning & Neighborhood  
Development  
City of Lansing - Development  
Office  
City of Lansing - Human Relations  
and Community Development  
City Rescue Mission of Lansing  
Closing the Digital Gap  
Community Mental Health of CEI  
Counties  
Cristo Rey Community Center  
Debbie Stabenow's Office  
Department of Family and Child  
Ecology MSU  
Department of Human Services  
Eaglevision Ministries  
End Violent Encounters, Inc.  
(EVE)  
Greater Lansing Convention &  
Visitors Bureau  
Greater Lansing Homeless  
Resolution Network  
Haven House  
Ingham County Health Department  
- Maternal Infant Outreach  
Program  
Ingham County Health Department  
Ingham Regional Medical Center  
Ingham ISD & Power of We Birth  
to Five Subcommittee  
Justice In Mental Health  
Organization  
Lansing Affordable Homes, Inc.  
Lansing Area AIDS Network  
Lansing Community College  
Lansing Community College  
Peace Education Center  
Lansing Police Department  
Lansing School District  
LCC - Health and Human Services  
Careers Dept.  
Legal Services of South Central  
Michigan  
Loaves and Fishes Ministries  
Michigan Economic Development  
Corporation  
Michigan Prisoner Re-Entry  
Initiative  
Michigan State Housing  
Development Authority  
Michigan State University College  
of Human Medicine  
National Council on Alcoholism -  
Lansing Regional Area  
Okemos Presbyterian Church  
Open Door Ministry of Downtown  
Lansing

Physicians Health Plan of Mid-  
Michigan Family Care  
Power of We Consortium  
Pre-Medical Achievement  
Program MSU  
Presbyterian Church of Okemos  
RSVP  
School of Social Work MSU  
Sparrow Emergency Department  
St. Casimir Church

St. Michael Catholic Church  
St. Vincent Catholic Charities  
The Chronicle and Michigan  
Bulletin Newspaper  
The Ward Church of Lansing  
Thomas M. Cooley Law School  
Tri-County Office on Aging  
Volunteers of America Michigan  
YWCA of Greater Lansing

## **The Scope**

### **National Data and Trends**

According to the National Alliance to End Homelessness, between 700,000 and 800,000 people are homeless in the United States on any given night. That totals between 2.5 and 3.5 million people per year. Half of those experiencing homelessness in a year are families, and 38% are children. The effects of homelessness on children are devastating, and include greater rates of involvement in the child welfare system, higher rates of foster care placement, greater likelihood of mental health and behavior problems, and lower academic achievement. Of those in families, finding affordable housing is often cited as the main reason for their homelessness. For larger families, this is an especially daunting barrier.

Of the single homeless adults, most, (81%) enter and exit the service system quickly. 9% enter and exit repeatedly over the course of a year, and 10% spend the majority of the year in shelters. This group is often called the “chronically homeless”. Federal guidelines stipulate that a chronically homeless person

“is an unaccompanied disabled individual who has been continuously homeless for over one year”

-[www.hud.gov](http://www.hud.gov)

Research has shown that in many communities, this small percentage of the homeless population uses a majority of the resources. One tactic that has shown some success in dealing with the chronically homeless is permanent supportive housing. The housing is provided, with no limit on the amount of time the person can remain, and accompanied by intense supportive services that help the individual maintain in the housing. This strategy is supported by the Housing First Theory, which stipulates that individuals are not to be prepared for housing before they are housed, but that housing comes first and services immediately follow. Part of the definition of chronicity is a disabling condition, which means that many of the chronically homeless will not be able to work. Fortunately, public opinion and public policy have begun to turn away from assigning blame to individuals for their circumstances and focusing on the need for every person to have a place to live.

## **Local Data**

In Ingham County, the implementation of the Homeless Management Information System (HMIS) has started to reveal some of the characteristics of the homeless population. Since its inception in 2004, the system has recorded more than 4,000 unique individuals in Ingham County that have sought homeless or housing services. Preliminary analysis of the incomplete data set thus far derived indicates a similarity with national trends, including a large portion of the homeless population being comprised of families. Previous strategies to address homelessness, including emergency shelters, are not designed to deal with families and chronically homeless individuals. In addition to the HMIS system, each month a point in time count is taken recording how many people sought out services in the county. There are consistently more than 450 requests on a given day, half of which come from families.

Census data released on August 29, 2006 showed that Lansing residents living at or below the federal poverty line comprise 24.4% of the population of the county. The median income in Ingham County has dropped more than \$5000 since 2000, more than \$3500 lower than the state average. Ingham County now has the fourth largest concentration of poverty in Michigan. These changes are in sharp contrast to the national averages, which increased this year for the first time since 1999. The median income nationally rose by 1.1%, and the rate of people living in poverty dropped to 12.6%, about half of the rate in Lansing.

## **The Costs**

The costs of homelessness are often hidden and vary from individual to individual. Many service systems are not designed to accommodate the needs of the homeless, but are forced to due to inadequate housing services and poor collaboration between community entities. According to the New England Journal of Medicine, homeless people spend on an average 4 days more in the hospital than do comparably ill non-homeless people, at an average cost of \$2,414 per hospitalization. Homeless people have a rate of psychiatric hospitalization of more than 100 times that of non-homeless counterparts. Homelessness both causes and is caused by serious health and

mental health issues. The dangers of living out of doors and in places not meant for human habitation partnered with the emotional stress of instability and uncertainty leaves homeless individuals at greater risk for hospitalization and serious illness and injury. Unfortunately, health care and mental health care systems are often ill equipped to handle this tremendous need.

Homeless people have higher rates of incarceration, usually in jails, than does the general public. Usually they are arrested for minor crimes such as panhandling and loitering. One study showed that homeless individuals cost taxpayers \$14,480 per year, primarily for overnight jail stays. Many homeless people wind up in state prisons, often for repeated minor offenses, where the annual cost to house them is around \$20,000. Emergency shelters, at an annual cost of around \$8,000 per person, while less expensive than jails and prisons, are still more costly than Section 8 vouchers.

## **Past Efforts**

Historical efforts to alleviate homelessness in Ingham County have followed an emergency shelter model, where emergency shelter served as the entry point for services, and clients were prepared for permanent housing. The community realized that current efforts were uncoordinated and not yielding the results for clients that were hoped for. In 1994, the Greater Lansing Homeless Resolution Network was formed to bring the community of service providers together for purposes of strategic planning and compliance with new HUD mandates. Since then, the Network has worked toward increasing community involvement, client participation, and public awareness.

In February 2004 a group of concerned agency representatives were convened by the Power of We to critically assess the ways that people were discharged into the community from institutions such as correctional facilities, hospitals, substance abuse treatment programs, and other extended care facilities. This group met repeatedly over the course of a year, visiting with facilities and programs in the community and discussing the ways in which discharge planning could end the practice of releasing people into homelessness. The group assembled a set of recommendations in January 2005, which was presented to and endorsed by the Power of We.

Responding to a call to assist individuals and families displaced by Hurricane Katrina, the Greater Lansing Homeless Resolution Network and the Power of We Consortium, the Multi-Purpose Collaborative Body for Ingham County, held a series of meetings to make plans for housing people during the emergency. A tremendous amount of support and resources were devoted to this project, which illustrated the capabilities of the community. The Power of We and the GLHRN continued to meet, to strategize around continuing this passion and applying the lessons learned to the homeless population in Ingham County. This series of meetings lead to a resolution by the Power of We consortium to work cooperatively with the GLHRN on addressing the homeless problem.

The Power of We, the GLHRN and other community partners, including the Department of Human Services and Michigan State University, continue to be dedicated to the resolution of homelessness in Ingham County. The

process that has been established to create this plan to end homelessness also has created commitments from community partners to implement the plan.

## **Contributing Factors**

### **Unemployment**

The high rates of unemployment continue to cause homelessness and keep people homeless in Ingham County. The continuing loss of manufacturing jobs, coupled with the loss of service sector jobs that were associated with this economy, contributes in a major way to the high poverty rates in the county.

### **The Shifting Job Market**

This loss of manufacturing jobs has also lead to a need for different types of employees for the shifting job market. To change the work force in Ingham County, new training programs and educational opportunities will be needed. A string workforce with diverse capabilities and comprehensive skill sets will draw new business to our community and sustain people in their housing.

### **Continuing Stereotypes**

Stereotypes surrounding homelessness and the homeless population continue to challenge the service system in creating community support and private funding. Although the population of homeless people in Ingham County and the United States continues to shift away from the stereotypical single male substance abuser, and now incorporates more families, unaccompanied youth, and seniors than ever before, the public perception of a homeless person remains consistent. Public awareness and education is needed to alter these ideas.

### **Funding for Supportive Services**

Funding for supportive services for homeless people consistently lags far behind the need, especially for people recently housed or people at risk of entering homelessness. While service coordination and the development of an Inter-Agency Service Team will undoubtedly address some issues of efficiency and funding limitations, transitioning to a housing first approach will require the shift of funding to accommodate differing methods of providing services.

## **Benefits of Pursuing our Vision**

One of the most anticipated benefits of implementing this plan will be actually reducing homelessness, and assisting people with creating stability and certainty in their lives. Each member of this planning process has continually and consistently focused on the overall goal of housing people based on the principle that every person needs and deserves a stable place to live.

### **Efficiency**

Implementing our plan will also create more efficiency in the service delivery system, allowing for resources and effort to be focused in areas with the greatest and most urgent need. The plan will create a framework and a roadmap for the community to follow, and indicators of appropriate points for evaluation and realignment. Helping the system to work better will result in better services and outcomes for homeless clients.

### **Strengthening our Workforce**

Strengthening our workforce, though not a direct goal of the process, will be an exciting and long term result. Increasing the diversity of skills and workers in the community will be an attractive force for new industry and business, and a precursor for long term employment, and therefore housing, security. Stable housing diminishes many of the barriers to long term employment faced by homeless and precariously housed people, enabling them to work more consistently move forward on career paths.

### **Reinvesting in Prevention**

With increased employment and more efficient service delivery, the community's ability to invest resources in homeless prevention will increase dramatically. Ingham County's vision includes reaching a point when homeless services are replaced by homeless *prevention* services, and interruptions in stable housing will be minimal.

## **Strategic Response**

### **Allies in the Planning Process**

Initial commitments for participation were outlined in the Memorandum of Understanding signed earlier this year. Community partners include the GLHRN, Department of Human Services, Capital Area United Way, Michigan State University, Community Mental Health Authority of Clinton, Eaton and Ingham Counties, Ingham County Health Department, and Mid South Substance Abuse Commission. These partners have been active in the planning process, and have committed to remaining active throughout the implementation of the plan. The members of the GLHRN and the Power of We have resolved and formally committed to the plan. There is also expectation that new partners will be discovered as the initial implementation is begun.

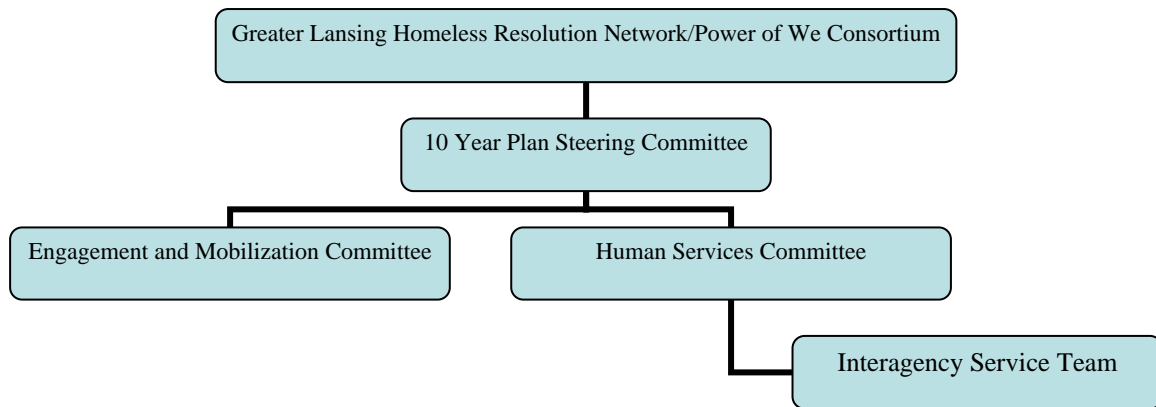
### **Planning in the Community**

The first step taken in beginning the planning process was to create a structure and assign initial tasks. It was decided that the lead group would be the Steering Committee, which was illustrated in the Memorandum of Understanding, and which includes:

- the Co-Chairs of the GLHRN,
- The Co-Chairs of the Power of We,
- The Director of the Ingham County Department of Human Services,
- The Director of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties,
- The Director of the United Way, and
- The Director of Mid-South Substance Abuse Commission.

Two committees were also formed. The Human Service Committee was assigned the tasks of creating the Housing First Plan, and creating and overseeing the Inter-Agency Service Team. The Engagement and Mobilization Committee was assigned responsibility for planning and holding the community dialogue sessions, and drawing new partners in to the planning process.

Several steps have been taken to include all community partners in the creation of this plan. The recommendations generated from the discharge planning group have been incorporated. The Human Services Committee met on several occasions and drafted a Housing First plan for Ingham County as well as a document charting the available services and current service providers in the community. A series of two community dialogues were held to identify the needs and goals of the community. An amazing amount of effort went into coordinating community involvement and data driven best practice into a comprehensive plan unique to our community and specific to the needs of the homeless in Ingham County.



**Ingham County  
Housing First Plan  
2006**

In an effort to contribute to the success of Ingham County's 10 Year Plan to End Homelessness, it is necessary to formalize the Housing First Plan for Ingham County. This plan is based on two premises:

- The goal for every client seeking services for homeless or housing related issues in Ingham County is adequate, safe and appropriate housing; and
- The focus is to reduce the length of time that clients spend in homelessness.

We believe to achieve this goal three components must be utilized, which are:

- Housing Crisis Management, which includes assessment, the provision of emergency services, and appropriate, individualized planning
- Housing Services, which include eviction prevention, rental assistance, housing placement, and housing provision; and
- Supportive Services, which include case management, that are accessible and individualized to the client, and that support the client in reaching and sustaining housing.

To implement this plan, Ingham County recognizes that a strong focus on eviction prevention must be maintained throughout the continuum of care. It is also noted that a transition in place model is accepted as the preferable method to assist people in maintaining their housing and stability by limiting the number of residential disruptions an individual or family must endure. The backbone of this plan is individualized assessment and planning that incorporates the skills, strengths and challenges of each unique person or family that seeks services, and the continuing supportive services that are accessible and customized.

## Ingham County Service Chart

### A. Income

#### I. Public Assistance

<u>Resource</u>	<u>Provider</u>
Unemployment	Michigan Works
Social Security	Social Security Administration
State Disability, Emergency Assistance, Medical Assistance, etc.	Department of Human Services
Food Stamps	Department of Human Services, Advent House
Veterans Benefits	Veterans Administration
Public Housing	MSHDA, Housing Commissions, HUD (Program Based), Department of Human Services, Advent House

#### ii. Employment

<u>Resource</u>	<u>Provider</u>
Short Term Disability, Long Term Disability, Worker's Compensation, Private Wage, Self Wage Subsidized	Private Insurance Private/Self Employment Peckham, CACS, Work First, Work Study, Michigan Works, CMH.

### LINKS

Advent House Ministries  
Michigan Works  
Michigan Rehabilitation Services  
Labor Ready

### GAPS and ISSUES

More transitional employment programs are needed.  
Longer term emergency stay is needed.  
Minimum income and rent requirements need to be lowered.  
Peckham needs to be invited to participate.

## **B. Housing**

<u>Resource</u>	<u>Provider</u>
Shelter + Care	LHC/CMH
Section 8 TBRA	MSHDA/LHC/ICHC
Section 8 PBRA	LHC/ICHC
Section 8 Subsidized	Private Companies
Commercial Properties	Commercial Landlords
Private Properties	Client Owned
PSH Projects	Salvation Army, GLHC, VOA, Haven House, NCA,
TH Projects	Haven House, Loaves & Fishes, Addiction Relief and Supported Recovery, Advent House, Ballentine Stepping Stones, JIMHO, VOA, NCA, LCRM, Rahab's House, Gateway
SRO's	Private/Commercial
Room and Boards	Private/Commercial
Adult Foster Care	Private/CMH
Residential Treatment	St. Vincent, NCA, Private Nursing Homes
Emergency Shelter	American Red Cross, LCRM, EVE, Inc.,
Haven House,	JIMHO, Loaves & Fishes, VOA

## **GAPS and ISSUES**

The range of services is sufficient, but not the quantity.  
 Funding for supportive services is inadequate.  
 Affordable private rentals needed.  
 Lack of resources/housing for large families.  
 No way of pairing up potential housemates.  
 Policies restrict communal living (eligibility requirements).  
 SRO's are of poor quality, and none for women.

## **C. Services**

<u>Resource</u>	<u>Provider</u>
Case Management	CACS, CMH, Shelters, TH, PSH, NCA, LAAN, TSA, VOA
Transportation	CATA, SpecTran, Agencies (Through rides and bus tokens)
Employment	See Income

Health	ICHD, Carefree Medical, Hospitals, Cristo Rey, Veterans Affairs, Medicaid, Medicare
Legal	Legal Services, Access to Justice, 60+, Christian Legal Services, Rental Housing Clinic at MSU, Elder Law, North Network, Code Compliance, Immigration Legal Services, Courts
Substance Abuse	NCA, CDRS, Cristo Rey, Insight, C&FS, Sparrow, AA, NA, Veterans Affairs, VOA, CMH
Financial-payee	DHS, CMH, Insight, Mid-Michigan Guardianship, Payee Resources
Financial-Housing (Rent deposit, etc)	CACS, DHS, CMH, TSA, VA, Churches, TCOA, ARC
Mental Health	CMH, St. Lawrence, MSU, VA, Cristo Rey, St. Vincent, C&FS, Gateway, Lutheran Social Services, Private Providers
Child Care	DHS, After school programs, churches, private providers, YMCA
Life Skills	Gateway, Advent House, MSU
Food	DHS, Food Bank, TSA, LCRM, Farmer's Market, CACS, Churches, Shelters, TCOA
Education (ESL, GED)	Michigan Works, School Districts, LCC

### **GAPS AND ISSUES**

Lack of funding for prescription medications.

Lack of funding for eviction prevention.

Strict eligibility requirements of programs leave some out.

Lack of Child Care assistance/resources.

Lack of individualized life skills training.

Limited access to perishable food.

Case managers are tied to specific agencies.

Adult Education, summer school programs have been eliminated.

Tenancy skills and responsibilities are needed

CATA needs to extend times, routes.

Limited/no transportation outside city of Lansing.

More outreach is needed for Ingham Health Plan.

Lack of resources for oral health, vision, hearing.

**Human Services Advisory Committee  
Ad Hoc Committee on Discharge Planning  
Draft Recommendations**

January, 2005

**Background**

Since February 2004, an Ad Hoc Committee constituted by the Human Services Advisory Committee (HSAC) has been reviewing the current process whereby people are discharged from public institutional systems such as Corrections, Mental Health and Substance Abuse Treatment, and Foster Care. On December 16, 2004, twenty-three participants in this process met to review the findings from their previous sessions, and to develop recommendations to the Human Services Advisory Committee. Doak Bloss facilitated the session.

The recommendations were developed in response to the following Focus Question: *“Given the gap between the current reality and the reality we want to create, what do we need to do, collectively, to help people make the transition from institutional care more successfully?”*

This report summarizes the findings from the session in two ways. First, an attempt has been made to describe the key discussion points made in the “Open Dialogue” portion of the session, particularly as they relate to the current reality and what has been shown to support successful discharge planning. This portion of the report should be viewed in conjunction with a two-page document produced by the committee, entitled “Community Strategies Summary,” which in essence describes the reality that the committee is seeking to create. As background material, the committee also has documentation of each of the meetings held throughout 2004, which describe the current reality and strategies for improvement for each of the individual institutions considered.

The second part of this report describes the Draft Recommendations of the committee that were produced at the December 16 session and revised on January 10, 2005. The committee will present the recommendations to the Human Services Advisory Committee at their January 2005 meeting.

## **I. Open Dialogue: “The Current Reality, What Works and What Does Not”**

The following discussion points were made about discharge planning processes during the Open Dialogue portion of the session. Although these points are organized by system, many issues were found to apply consistently across several of the systems.

### *Jail*

- For those who are held in the jail but who are not sentenced, there is too little time to have significant impact, and no thought given to aftercare or how best to prepare for re-entry into the community. Many leave the jail without even a plan for how they will get from Mason to Lansing.
- For those who are sentenced, who may reside at the jail up to a year, there is also little or no practical planning for re-entry, and little or no aftercare. There *are* opportunities to help inmates plan for their return to the community, and to develop skills that will help them do so, but many of these opportunities are missed. Michigan Works provides assistance in a number of ways to help them secure a job placement, working both with the employees and prospective employers. Information about the program is regularly given out to jail staff, inmates, and the community organizations (such as shelters) with which are likely to interact after they leave the jail.
- One reason why education and employment programs are unsuccessful in engaging some people is the sense of pride and independence they seek to maintain upon re-entering the community. If such programs feel like they represent dependency or neediness, they will probably not appeal to many who need them most.
- Because of the strong need to be independent, even many who participate in education and employment programs offered to them in the jail may do so only cursorily. Once they are out, this sense of pride is also very quickly shattered. Even if they apply for jobs enthusiastically at first, a few rejections are likely to result in pessimism about their chance of ever succeeding.

## *Prison*

- As with people emerging from the jail, parolees typically want to be independent by showing that they do not need help getting employment. They quickly distribute poorly done applications all over town, and just as quickly give up when they are rejected for employment, which subsequently leads to substance abuse, crime, or other negative behaviors.
- The important lesson to be gained here is that people will not be helped if they feel that they are being treated like a child or an inferior; they need to have some sense that they are in charge of their own lives, especially after emerging from a system that restricts their sense of self-worth and self-control. In order to engage successfully with such a client, we need to help them recognize personal strengths; otherwise they will not work together with us to achieve employment, housing, etc.
- Parolees, before and after release, need continuity in their connection once they find someone whom they trust. Personal advocacy on their behalf, as may be provided by a community volunteer, is also a powerful tool in creating hope after having been treated like a “nobody” by the system.
- The Governor’s current Michigan Prison Re-entry Initiative will help prepare parolees in advance of their release. Assistance will be provided with housing, mental health issues, and employment assistance in facilities closer to their homes (i.e. Carson City rather than Marquette). New staff will be hired by New Way Inn to help with resumes and other employment-seeking skills, and with getting an I.D. card. Mentoring services will also be provided, both to the parolee and his/her children.
- The biggest obstacle to finding employment for parolees is convincing employers to hire them, even if they have been adequately prepared to assume the responsibilities of work, and even if Michigan Works offers to provide bonding insurance to the employer. As a marketing tool, bonding is not effective with many employers because they are

not bonded to begin with. The stigma and fear of risk associated with hiring a parolee remains very high.

- Volunteers of America often receives letters from people with criminal sexual conduct convictions in advance of their parole, asking whether the shelter will be a viable option for them. There is a critical need for longer-term transitional housing for these parolees, whose options are severely restricted.
- Funding from Public Act 511 could be of assistance in securing residential treatment for parolees. The criteria for getting this assistance are complex and difficult, however, and it is not the practice in Ingham County to pursue these funds.

### *Mental Health – Adults*

- Community Mental Health is mandated and fiscally able only to serve people with Severe and Persistent Mental Illness (SPMI). The current system is more successful in treating those who have a *severe* mentally illness; where it often fails is in meeting the needs of those with a *persistent* mental or emotional problem which is not evaluated as severe. These are people who, due to a variety of traumatic life circumstances, have tremendous difficulty functioning in the world. This population is able to get access to limited medications and some services in the community, but what they really need is case management: someone to assess their needs in a holistic way, link them to resources, and broker access to services. This is not generally available to them.
- There is fragmentation within the service systems in treating the dually diagnosed. Even within Community Mental Health, the two treatment systems—mental health and substance abuse—are somewhat separated from one another. Cross-training and some case conferencing occurs, but what is needed is a more unified approach to treating both the mental health and addiction issues of the client simultaneously.
- Michigan Rehab collaborates with CMH in the delivery of supportive employment services. These services are effective, but are being

eroded by funding cuts that result in the elimination of case management services by CMH. Michigan Rehab is prohibited from providing on-going long-term case management directly. Consequently, it can get a person employed, work with employers, and provide income that supplements or replaces Social Security benefits-but without long-term CMH case management the arrangement often falls apart.

- For the underserved people who have persistent but not severe mental or emotional problems, management of medications is a huge issue. Volunteers of America sees this problem daily: guests at the shelter don't know how to correctly take their medications, don't know what their medications are, or have run out of meds because they took them improperly. Case managers often have to investigate with providers to sort out these issues and, once sorted out, find it necessary to lock up medications for the client in order to ensure they are properly administered.
- For dually diagnosed clients of National Council on Alcoholism emerging from institutional care, the inability to get mental health services and needed medications is a consistent problem. It takes time to get clients connected to health care and mental health services, and the need for medications is immediate. Such clients are also at times caught in limbo between the public health and mental health systems because it is not clear which is responsible for covering needed medications.
- A consistent barrier to adults emerging from mental health treatment is the length of time it takes to get public entitlements (Social Security Insurance or Social Security Disability Insurance). A second barrier is the amount of funding that can be accessed via this route, since many have very limited work histories. It is usually well below what is needed to pay for rent.
- Statewide, due to a lack of supports and gaps in social services and mental health services, many who have mental health needs have been adjudicated into the criminal justice system. In a sense, correctional facilities are becoming the new mental health facilities.

## *Substance Abuse – Adults*

- Virtually everything that has been said about adults exiting jail or prison applies to adults entering and emerging from substance abuse treatment, since substance abuse is so common among ex-offenders. Employment, housing, and health care are all difficult to attain, for the same reasons cited above. Expanded capacity to provide case management is needed, as are a more complete array of appropriate substance treatment options (residential, detox, etc.). Clients referred to aftercare following treatment do not necessarily attend it. Lack of availability and mismanagement of medications is also an enormous problem.
- The health care needs of the substance abusers can be severe, due to the strain on the body of a long history of abusing substances. Some who have been through three or four cycles of substance abuse treatment exhibit limited liver functioning, or may experience seizures three or four times a month. At the same time, many of these clients do not access health care services. It is not clear whether this is due to lack of awareness of local health care options, lack of interest in enrolling or simply bad decision-making. Some are described as simply preferring to use the ER, where they attempt to get Vicodin or other pain medication.
- Lack of thoughtful coordination between the FIA and Court systems creates a setup for failure for many clients. From the point of view of the parent, FIA may be called in to investigate because the house is dirty, which leads to a discovery of substance abuse, physical abuse of children, etc. This in turn leads to removal of children and court involvement. Rather than supply supports in a way that are likely to strengthen parents and families, the court orders the parent to attend an overwhelming number of programs (parenting, substance abuse, etc.) which only add to their stress and their sense of self-control.
- There is a need for education of the court system of the consequences of imposing unrealistic expectations on clients. Steps should be taken to assure that families are not assigned to multiple case managers, each with its own set of appointments to schedule. A move toward coordinated case management and use of community supports, built

around the family's own perception of strengths and problems, would be better than the current reality.

- Housing is a tremendous problem for many who have cycled through the substance abuse system. After receiving multiple felony convictions, clients are unable to get affordable housing other than in locations where the chances of succeeding (i.e. avoiding substances, crime, etc.) are slim.

### *Mental Health – Children and Youth*

- See first bullet point under *Mental Health – Adults*. This description of the gap in service to patients who are not evaluated as having a severe mental illness is also applicable to children and youth.
- For older adolescents, about to turn 18 or 19, it is very difficult to get mental health services as an adult. Many of these youth have an emotional development on par with a 13- or 14-year-old, and consequently find it impossible to fend for themselves. Without stable family support, many become homeless because they cannot find anyone who will rent to them.
- Juvenile offenders as young as 13 may receive blended sentences that place them for eight years in an institution like Maxey Boys Training School. Those who receive blended sentences are not eligible for aftercare. This means that such an offender could emerge at age 21 after eight years in Maxey with no community support and no services whatsoever.
- Many younger minors within the mental health treatment system come from families characterized by extreme emotional problems—families with limited or no structure. Success with these youth, when it occurs, is usually the result of one trusted adult who made a difference by staying with them, providing consistent support over time. The experience at Crossroads transitional living program also bears this out.

- The largest component of people currently served by shelters in the Capital Area is children under the age of five years (members of homeless families). Some of these families are seen repeatedly over the years. Some move from agency to agency with no consistent support or plan for establishing stability.
- Statewide, due to a lack of supports and gaps in social services and mental health services, many who have mental health needs have been adjudicated into the criminal justice system. In a sense, correctional facilities are becoming the new mental health facilities.

### *Substance Abuse – Children and Youth*

- A big problem with substance abuse treatment for adolescents is that it mirrors the model for treatment for adults, i.e. an office-based approach, 12-step programs predicated on abstinence, etc. Youth substance abuse is different from adult substance abuse because of where youth are in their development, and because the act of substance abuse can have a different and varied function in the youth's life. Substance abuse by youth often correlates with substance-abusing parents; it can be a form of attention-seeking or risk-seeking behavior; and, for youth, the choice of moderation can be viable in ways that it is not for a chemically dependent adult.
- Effective programming for youth during and after their involvement in substance abuse treatment has a strong mentoring component, and focuses on coping and decision-making skills. Programs are also more likely to succeed if labeled with a term other than "substance abuse," and if they are provided in the community rather than in an office setting. In other words, programming should be integrated with other aspects of the youth's life; it should go to where youth are, rather than requiring youth to come to it.
- The way systems and families think about a youth's substance abuse problem often encourages denial and a non-integrated approach. Schools, parents, and treatment approaches treat the youth as the "identified problem" rather than deal with the broader community or family context in which the substance abuse has occurred. Many

youth who undergo substance abuse treatment also have underlying mental health problems that may or may not get addressed.

- Schools are largely in denial of substance abuse issues as they affect the broader culture of the school. School representatives have not participated in the Ad Hoc Committee's work, and they really should be at the table if we are going to change our approach across systems.
- A family systems approach is essential to resolving substance abuse issues among children and adolescents. Family Independence Agency workers see families where children from a very young age witness substance abuse daily within the home, and may begin smoking marijuana themselves as young as age six. Children are emotionally on their own at a very young age because their parents are not emotionally present. "Parenting classes" are not effective for the parents in such families, because in reality the parents believe themselves to be *good* parents and perceive the classes as "talking down to them." Mandated parenting classes are also seen in a context of punishment for a wrong that the parent does not recognize having committed. Contrarily, a family systems approach views the family, not the youth, as the client, and provides appropriate supports for the parent.
- Continuity and a long-term approach are also needed. As systems, we often go away from families at the birth of the child, and then return when he or she enters school—missing the most critical years in the child's development. A long-term, prevention-oriented approach to families at risk due to low incomes, substance abuse, etc., would likely result in savings across all systems (education, law enforcement, corrections, health, etc.).

### *Foster Care – Children and Youth*

- The community has good treatment models, like Families First, but there is a need to do much more to prevent kids from getting into the foster care system in the first place. Too often, one bad decision leads to long-term involvement in the system, with ultimately tragic consequences for the family.

- There is a need for educations of some foster care and protective services staff—especially younger ones—of the unintended negative consequences that can result from unilateral decisions to involve families in the system. This must begin with the training that these professionals receive. Newer case workers, appropriately, tend to have a single-minded focus on protection of the child, which prompts removal from the home when in fact a more coordinated intervention with a focus on the entire family system might be more appropriate.
- To community-based service providers such as shelter providers, there appears to be inconsistency or illogic in Child Protective Services' application of its protocols. One worker may come to a shelter and remove a child from the parent's care for seemingly minor reasons, whereas another may leave a child with a parent who is literally living in the park and subject to great danger.
- There is also a lack of follow-through by Child Protective Services at times. For example, it appears to shelter workers that once a family is taken to a shelter, they're considered safe and no further action is taken. One explanation for this is that FIA workers are tremendously overburdened and able only to respond to the most severe cases they encounter.
- Mentoring is an important component of treatment for families in foster care. Mentors should be drawn from racial/cultural/ethnic communities that match the families to be served. It should become part of the philosophy of treatment that we value a deeper understanding of the cultural norms of the families we're serving, and bring cultural expertise onto the care team.

## **DRAFT RECOMMENDATIONS TO THE HUMAN SERVICES ADVISORY COMMITTEE**

The structured exercise to answer the Focus Question generated seven recommendations, which are articulated below. Three of the recommendations are designated “catalytic,” meaning that if they were accomplished they would automatically advance most of the other recommendations as well. The seven recommendations are articulated on the following pages.

Generally speaking, the three catalytic recommendations are more generalized than the other four. Whereas the four non-catalytic recommendations describe specific changes or components for an improved approach to discharge planning, the three catalytic recommendations describe actions to be taken to promote and implement that approach. For this reason, the non-catalytic recommendations are presented first, to introduce the specific elements of an improved approach.

### **Overview of Recommendations:**

*Recommendation for an improved approach to:*

1. Coordinated Re-entry
2. Coordinated Case Management
3. Mentoring
4. Prevention

*Catalytic recommendations:*

5. Collaborative Oversight
6. Community Awareness and Involvement
7. Advocacy

*Recommendation for an improved approach to re-entry:*

**1. COORDINATED DISCHARGE PLANNING: Across all systems, for both adults and youth, re-engineer discharge planning procedures to assure that each person has a clear discharge plan in place that begins at the point of entry into the system, is geared to the client's natural strengths and supports, and engages community resources well in advance of discharge.**

Currently, discharge planning for adults is non-existent, haphazardly developed, or implemented in a way that diminishes the client's personal investment in participation. It is important to recognize that clients are living in an environment that intrinsically diminishes their sense of personal self-worth and self-control. Discharge planning and the programming that accompanies it must acknowledge this fact, and work to engage the client as a key member of the discharge planning team. Each client's existing family supports should also be incorporated into the discharge plan.

Discharge planning for children and youth must similarly adopt a family-systems approach, one that incorporates all available knowledge of the family's natural supports. Programming for youth must be appropriate to the emotional and social development of the youth rather than mirroring programming designed for adults.

Specific recommendations to be incorporated into a new approach to discharge planning:

- Ensure all clients have a clear discharge plan in place.
- Develop the plan immediately upon entry into the system, and engage relevant community resources early.
- Within the corrections system, ensure acquisition of ID cards well before release.
- Include strategies that prepare all parties to respond proactively to setbacks that may occur.
- Include strategies for highlighting successes as they occur.
- Teach life skills while still in institutional care, in ways that will attract and engage (rather than alienate) the client. Respect for the client's self-image and need for self-control is vital.

- Provide job skill training that is tied directly to client strengths and community need (i.e., practical careers likely to lead to job placement).
- Expand transitional living options in the community for youth, adults, and families.
- Incorporate case management, mentoring, and prevention into all plans (see the following three recommendations).

## **2. COORDINATED CASE MANAGEMENT: Realign case management services across all systems.**

Case management services are critical to the implementation of all discharge plans, for both adults and youth. When they are absent, regardless of the amount and quality of support services that are in place, clients are likely to fail. Case management services provided by different systems and agencies must be coordinated if not fully integrated. When case managers work independently of one another on the same case, the effect is often to overwhelm the client or, worse, deliver conflicting messages to the client.

Specific actions recommended for improving and expanding case management:

- Develop “best practices” for establishing individual goals for adult clients, and another for children and youth clients. In both cases, the goals should be consumer-led, realistic, involve an interdisciplinary team, and apply to all agencies serving the consumer.
- Develop a holistic, comprehensive assessment tool that can be applied across all systems.
- Encourage and support cross-system training on client-centered practice.
- Create a Re-entry Team for the client involving workers from each pertinent agency or system, led by a centralized case manager to whom all team members are accountable. The Re-entry Team and Case Manager should be unified in pursuing mutual goals for the client’s success.
- Develop strategies to reward incremental client success.

**3. MENTORING: Expand the community’s capacity to provide mentors to adults and youth emerging from institutions, and incorporate mentorship into discharge plans.**

The common element in nearly all cases where a youth successfully transitions from institutional care is the presence of a trusted adult who is willing to provide guidance, support, and encouragement to the youth over time, through serial setbacks. For adults, mentors offer a bridge between the personal goals of the client and the goals of the systems seeking to navigate the transition back to the community. They can build client trust and investment in the discharge plan, and serve as an empowering voice for the client in the development and implementation of the plan.

For both adults and youth, effective mentors should be drawn from the client’s own community. This requires that systems make a resolute effort to recruit, train, and support mentors from the neighborhoods where clients live, and from a range of racial and ethnic communities that is congruent with the demography of people emerging from institutional care. In recruiting mentors, it is also valuable to consider life experience, including the mentor’s own involvement with institutional systems, as a potential asset. Mentoring may also be a promising means of allowing those who have been involved with the system to give back to the community.

In the current reality, there is a severe shortage of mentors to meet the needs of people emerging from institutional care. To improve and expand the availability of mentors, it will be necessary to do the following:

- Include mentoring as a standard element of discharge plans.
- Within plans, include participation in the setting of goals that are relevant to the client as one of the responsibilities of mentors.
- Recruit mentors from neighborhood groups and organizations affiliated with communities of color or specific ethnic heritage.
- Mobilize the community to promote mentorship.
- Facilitate the development of community mentoring programs.

**4. PREVENTION: In addition to improving the process whereby people transition from institutional care, work “upstream” to prevent entry into the system in the first place.**

Although the focus of the Ad Hoc Committee’s inquiry was re-entry into the community, many of the insights generated in these dialogues also apply to resources that should be in place to prevent people from entering institutional care in the first place. Prevention efforts will be more effective if they are client-centered; employ a strengths-based, family-systems approach; coordinate client needs comprehensively and holistically, and link clients to trusted adults who can serve as long-term mentors.

Viewed holistically, prevention efforts should focus on ensuring that people have what they need to maintain themselves in a stable residence. While it is beyond the scope of these recommendations to outline a full range of prevention services, the following are offered as just a few examples of ways in which prevention efforts should be supported or expanded:

- Expand the availability of approaches that seek to prevent out-of-home placement, i.e. Wraparound, Families First.
- Expand the availability of support services to families with children between the ages of zero and five years.
- Educate foster care staff, protective services staff, and judges on the potential consequences of unilateral decision-making to remove children from homes.
- Encourage schools and their representatives to work in concert with other systems in confronting and preventing substance abuse.

*Catalytic Recommendations:*

**5. COLLABORATIVE OVERSIGHT: Continue the collaborative approach to improving discharge planning, aftercare, and community supports in Ingham County, through establishment of a permanent oversight body and a directive to extend collaboration to all levels of the systems.**

Enacting the strategies developed through the dialogue process will depend upon the establishment of an oversight body with the ability to commit resources and enforce changes in the way discharge planning is coordinated. The oversight body should include system decision-makers, direct service providers, and consumers. The oversight body's charge should include, but not be limited to, the following:

- Develop an Action Plan based upon the findings of the dialogue process, targeting current gaps in service and coordination, and establishing outcome objectives. To the degree feasible, the Action Plan should be consistent with the 10-year plan to end homelessness developed by the Greater Lansing Homeless Resolution Network, and outcomes should be tracked through the Homeless Management Information System (HMIS).
- Encourage and support collaborative approaches at all levels of the participating systems and organizations, from community engagement to case management to system reform.
- Share resources currently dedicated to institutional care, including staff, funding, and programming expertise, across all systems and agencies.
- Explore re-engineering current resources to better accommodate a coordinated approach to discharge planning, case management, mentorship, and prevention.
- Development of new resources in support of the Action Plan as the opportunity arises.

Note: In the above, the term *resources* should not be construed as synonymous with *funding*. The term *resources* is meant to include staffing, knowledge and skills, technology, and other assets that a system or agency could apply in a more coordinated and collaborative manner toward the common goal of improving successful re-entry to the community.

**6. COMMUNITY AWARENESS AND INVOLVEMENT: Develop a unified communication plan to describe to partners, consumers, policy-makers, and the community at large the benefits of new, integrated strategies for promoting successful re-entry to the community from institutional care.**

Community support is essential for new approaches to discharge planning to succeed. Without awareness and understanding of the issues in the community at large, there will be inevitable resistance to efforts to improve support, develop new housing alternatives, recruit mentors, etc. A unified communication plan is needed to engage the community (neighborhoods, community groups, participating agencies, policy-makers, etc.) in planning and participating in strategies for successful re-entry.

Some specific tasks to be included in the communications plan are:

- Identify key persons who need to be involved in this process and earn their buy-in to the new approach.
- Articulate the rationale for new approaches in ways that will be conducive to broad understanding of the need for change and the benefits that these changes will bring to the community (cost savings, expanded tax base, neighborhood stabilization, opportunities to give back to the community, etc.)
- Disseminate preliminary information on new approaches to both providers and consumers, and solicit input.
- Create “Discharge Resource Guides” for consumers that clearly describe the reason and purpose of new approach.

**7. ADVOCACY: Develop and implement an advocacy plan to promote legislative and policy changes needed to support successful re-entry into the community upon discharge from institutional care.**

Some of the changes needed to improve discharge planning processes in Ingham County are beyond the power of local authorities to enact. These changes should be clearly articulated and presented to legislative champions who can carry them forward.

Specific actions to be taken in the creation of a communications plan include:

- Identify key policy and legislative changes needed. Example: Prohibitions against discrimination in access to housing, employment, or education based on unilateral criteria such as having been in institutional care or having previously abused substances.
- Articulation of rationale for needed policy and legislative changes. Examples: The value of enabling people emerging from institutional care to become tax-payers in economically challenged communities; a cost/benefits analysis based on the consequences of recidivism vs. successful re-entry, etc.
- In partnership with community support, target legislators and appointed officials who are strategically and ideologically positioned to champion needed changes.
- In partnership with community support, assign and equip influential local partners to meet with targeted legislators and officials and make the case for needed changes.

# Ingham County End Homelessness Planning

## Report on Two Dialogues

August 28, 2006

On August 3, 2006, approximately 105 Ingham County residents participated in a facilitated dialogue focusing on the question, *“Considering all of the factors that contribute to homelessness, what needs to be in place to ensure that all Ingham County residents are in stable living environments and adequately supported in maintaining themselves?”* This report articulates the discussion points made in the early part of the dialogue, as well as the draft recommendations that resulted from a structured exercise to answer the focus question. A second dialogue was facilitated on August 24, 2006, to validate the draft recommendations and create more concrete action steps for each. More than 80 people participated in this dialogue, most of whom had also attended the August 3 session. The recommendations articulated in this draft of the report incorporate the input from both dialogues.

### PROCESS

Three pieces of “trigger” information were presented to the participants at the start of the session:

- *Data on Homelessness in Ingham County.* Doak Bloss presented preliminary data on the homeless collected by area agencies as part of the Homeless Management Information System (HMIS). Chuck Steinberg provided additional background on these data. Some basic information on the incidence of homelessness in Michigan was also provided.
- *Narratives of People who have been Homeless:* Doak Bloss read five first-person accounts of people’s experience of homelessness, which were adapted from case scenarios submitted by various members of the Homeless Resolution Network.
- *The “Housing First” Strategy:* Susan Cancro and Jerrie Lynn Gibbs gave an overview of the “Housing First” strategy that is driving much of the current interest in long range planning in Michigan. This strategy asserts that there are many different

factors contributing to homelessness, including inadequate living skills, low employability, domestic violence, mental illness, and substance abuse; and that it is impossible to address these issues successfully without first establishing a stable living environment. “Housing First” asserts that we must first create a stable living environment, and then provide the supports that will help people become reasonably self-reliant.

Following this “trigger” information, participants engaged in an *Open Dialogue* about homelessness in Ingham County, focusing primarily on three concerns: 1) people who are homeless, or at risk of homelessness; 2) services and supports to end homelessness; and 3) community awareness and attitudes toward homelessness.

Finally, participants were led through a structured exercise to answer the Focus Question. This began with a series of short-answer “summary” questions to help the group revisit the information they had heard thus far in the conversation. Each participant then brainstormed a personal list of good answers to the Focus Question. In small groups, participants shared and prioritized the items on their lists, submitting up to four answers as a group. These answers were clustered on the adhesive board, named, and further discussed in order to determine the preliminary recommendations of the group. Recommendations were not prioritized; however, the group designated several recommendations “catalytic,” meaning that if they were acted on, most or all of the other recommendations would be automatically advanced.

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Paula Young

Not all participants in the dialogue represented an agency or organization. However, participants identified affiliations with the following entities (62 in all):

ACORN	and Community	Justice In Mental
Advent House	Development	Health
Ministries	City Rescue Mission	Organization
American Red Cross	of Lansing	Lansing Affordable
Emergency	Community Mental	Homes
Services Dept.	Health of CEI	Lansing Area AIDS
Black Child and	Counties	Network
Family Institute	Cristo Rey	Lansing Community
Capital Area	Community Center	College
Community	Closing the Digital	Lansing Community
Services, Inc.	Gap	College - Health
Capital Area	Department of	and Human
Literacy Coalition	Human Services	Services Careers
Capital Area	Eaglevision	Dept.
Michigan Works	Ministries	Lansing Community
Capital Area United	End Violent	College - Peace
Way	Encounters, Inc.	Education Center
Capital Area Youth	(EVE)	Lansing School
Alliance	Greater Lansing	District
Care Free Medical,	Convention &	Legal Services of
Inc.	Visitors Bureau	South Central
Christian Services	Greater Lansing	Michigan
Chronicle and	Homeless	Loaves and Fishes
Michigan Bulletin	Resolution	Ministries
Newspaper	Network	Michigan Economic
City of East Lansing	Haven House	Development
City of Lansing -	Ingham County	Corporation
Development	Health Department	Michigan Prisoner
Office	Ingham County	Re-Entry Initiative
City of Lansing -	Health Department	Michigan State
Dept. of Planning	- Maternal Infant	Housing
& Neighborhood	Outreach Program	Development
Development	Ingham Intermediate	Authority
City of Lansing -	School District	Michigan State
Human Resources		University

Michigan State  
University -  
College of Human  
Medicine  
Michigan State  
University -  
Department of  
Family and Child  
Ecology  
Michigan State  
University - Pre-  
Medical  
Achievement  
Program  
Michigan State  
University - School  
of Social Work  
National Council on  
Alcoholism

Open Door Ministry  
of Downtown  
Lansing  
Physicians Health  
Plan of Mid-  
Michigan Family  
Care  
Power of We  
Consortium  
Power of We  
Consortium – Birth  
to Five  
Subcommittee  
Presbyterian Church  
of Okemos  
RSVP  
Sparrow Emergency  
Department  
St. Casimir Church

St. Michael Catholic  
Church  
St. Vincent Catholic  
Charities  
Thomas M. Cooley  
Law School  
Tri-County Office on  
Aging  
U.S. Representative  
Debbie Stabenow's  
Office  
Volunteers of  
America Michigan  
Ward Church of  
Lansing  
YWCA of Greater  
Lansing

## OPEN-ENDED DIALOGUE

For the open-ended dialogue, the facilitator urged participants to think about three different aspects of the Focus Question: 1) people who are homeless, or AT risk of homelessness; 2) services and supports to end homelessness; and 3) community awareness of and attitudes toward homelessness. Discussion points are presented below under these headings. Please note that most discussion points are the product of more than one participant's contribution, and that none necessarily reflects the will of the entire group.

### *People who are Homeless or at Risk*

- Among the homeless are elderly people and people with disabilities who are in nursing home facilities but who need to return to the community. There are funds available to help with this transition through Tri-County Office on Aging, but not everyone is aware of this.
- Lack of health insurance influences homelessness in at least two ways. People with a mental illness who cannot get the psychotropic medications that would enable them to stabilize are more likely to end up on the street or incarcerated, and more likely to do harm to themselves or others. And virtually any uninsured person could conceivably end up homeless after a catastrophic illness.
- In general, housing policy and the housing industry do not prioritize the homeless as a concern or as a population.
- The number of children who are homeless is startling, and would surprise many people who think they know who the homeless are. The state is allocating more funds to assist youth transitioning to foster care, and this is important. We need to invest in the life skills of young people, especially those who are not receiving this at home. And life skills needs to include helping young people think futuristically, creating hope and possibility that life can be more than what they have been shown thus far. Many young girls come to the conclusion that making a family themselves is the only way out of their current dilemma.

- One untapped resource for ending homelessness might be young people themselves, high school students who could be engaged to do the legwork of creating community interest and advocacy (letter-writing, fundraising, informing the community of who the homeless are).
- Life skills are need for more than just young people. What many of the homeless or at-risk people need is a way out of “relationship abuse.” Truly, many of the women and children seen at the mission do not know how to have a healthy relationship because it is something they have never experienced. Consequently, they are likely to return to relationships that are abusive.
- One path to the “change in thinking” that many need is through faith-based institutions and a new relationship with a higher power.
- When we think about women ending up homeless after leaving abusive, violent relationships, we shouldn’t forget about the guy who was abusing her. It’s wrong that police officers, judges, and landlords don’t address the batterer more effectively, through eviction and prosecution. Many participants in the dialogue felt that current systemic policies favor the male in these situations and don’t go far enough in protecting women and children. Others acknowledged that, from the law enforcement perspective, lack of time and resources—not indifference—prevents them from getting more involved and doing more to help victims of domestic violence. To the police officer, it appears to be a vicious circle: many of the homeless are passed along from one system to another, or in constant motion from one house to another, trying to survive, and there is no way to link all of these players together and do something that is coordinated and productive while they are in this state of constant transition. This is similar to the discovery that Michigan Works made when it became central to the prisoner re-entry initiative: in order to stabilize and assist people in a coordinated way, Michigan Works actually got into the housing business, becoming the landlord for ex-offenders. Once stabilized, coordinated services could be arranged.

## *Services and Supports to End Homelessness*

- Education is an important need, to enable people to get and maintain decent-paying jobs. Illiteracy escalates through the generations. Even those who receive a diploma may actually be reading at a third-grade level. Homeless children also face huge challenges in the intellectual development, because of the lack of continuity in school and lack of the stability needed to be able to learn. They are missing large chunks of their education, consequently. Lack of stability also impedes homeless adults from successfully focusing on acquiring their GED.
- While the Housing First strategy makes sense, because we want to get people into stable living environments, there are also funding consequences to HUD's shift in emphasis from support services to bricks and mortar. For many people, we still need to be able to provide support services once people are successfully placed in housing. Representatives of some church groups echoed this idea, telling the story of one woman who had been evicted from three different places. The church worked with her on basic things like budgeting and house cleaning so that she would be able to maintain herself. However, no one from the church was connected to the formal kinds of support services that exist to help the homeless.
- Work force development is an important component of ending homelessness. We should seek ways to use local education institutions to build skills that would increase the employability of people who are homeless or at risk. About 30% of the people served by Michigan Works now are homeless. All are welcome to come in and see the resources that the agency has to help with things such as budgeting, managing credit problems, and connecting to LCC.
- Families are an important source of support and stability. It is important to include family reunification as a goal whenever this is appropriate, and, when it is not, to explore a surrogate family arrangement. It was noted that 9% of the homeless and 10% of the Lansing's population are identified as "Hispanic." This seems to indicate that the Latino population is faring better than other population groups; it was speculated that this might in part be due to stronger extended family networks.

- Often the trigger of homelessness is inability to pay one's rent, at least from the perspective of one of the local churches. We should organize a way to help people in this situation pay their rent in order to keep them from landing on the street. It seems like, in Ingham County, there are several churches trying to help in this way, but there needs to be a more organized effort that links them.
- Landlord/tenant relationships are crucial. Some success has been achieved by agencies like Refugee Services in nurturing landlords who will rent to their clients with the reassurance that professional support is being provided to the new tenant. This support includes "training" on how to be a good tenant, and on-site support when this is challenging for the client.
- A five-part model for achieving the Housing First goal of stable living environments: 1) helping the person take responsibility for his or her own life, to the degree possible; 2) a peer support group; 3) a landlord who understands the situation and is encouraged to help through a worker who can vouch for the person in need of housing; 4) a professional support system (including that person who vouches for the client); and 5) employers who understand the challenges and are willing to employ, again with the professional support system in place.
- Two particular groups in need of employment assistance were singled out: 1) those losing factory jobs who are without computer skills and find themselves unable to get reasonably high-paying new jobs; and 2) women leaving domestic violence situations who need re-education and help overcoming age discrimination. In both of these groups, there are a great many people who want to work but find they cannot.
- The shift in emphasis from services to bricks and mortar needs also to acknowledge the costs of maintaining housing. Residential programs like Ballentine Stepping Stones must be supported through time in order to maintain current capacity.

*[Note: The following comment was not shared with the full group, but rather told to the facilitator by a gentleman who had seen the ad for the dialogue in the newspaper, and wanted to give his input. Although he was*

*invited to stay and become part of the dialogue, he declined, asking the facilitator to share this comment.]*

- Churches should open up their doors in the evenings and let homeless people sleep on the pews. Some pastors say that this wouldn't be sanitary, and that there might be damage to property. Security guards could be hired to make sure this wasn't the case. Since a church is God's house, it should be used to provide shelter those who don't have a home. For many of us who are homeless, we don't want services or someone to talk to. We just need a place to sleep at night.

### *Community Awareness and Attitudes*

- It's likely that many of the people who are homeless are not in the data base—specifically, women who are staying with one friend or another, serially, and trying to get their children back from Child Protective Services but unable to do so without a domicile of their own. The so-called “couch homeless” don't fit into the official homeless definitions, but they need to be recognized as a part of the population to be served.
- We won't be effective in ending homelessness unless we can get the broader community to own it as a significant problem that affects us all. Unfortunately, many of our community leaders have the attitude that the homeless are people who had their chance to lead a productive life but failed to take advantage of that chance. Why should we waste our money on people who weren't willing to step up for themselves? There is a need to create a sense of urgency around the issue. We tend to see this as an individual's problem, not a problem that has an impact on the whole community.
- People who apply for subsidized housing must remain on a waiting list for a long time, which presents many challenges in planning. Also, some subsidized housing does accept people with Section 8 vouchers. One policy action that could be pursued is a city ordinance requiring the acceptance of Section 8 vouchers because not doing so would constitute income discrimination.

- We need to convey to the community how impossible it is now for some who are at risk of homelessness to overcome the obstacles we put in their way. People who are in recovery from addiction, ex-felons working to return to the community from incarceration, and people with a bad credit history are all likely to be denied housing by property owners and/or denied serious consideration by potential employers. We can help overcome these obstacles by providing reassurance to property owners and employers that people will be supported in their transition to stable housing and stable employment. But we need to educate the entire community about the unfairness of the current obstacles—including the basic reality that a person can't afford \$500 a month for an apartment when they're only capable of earning \$600 a month. Even if the minimum wage is raised, many still cannot be expected to make ends meet.
- We need to remember that this is not just about fixing service systems or creating new models of care. It is about policy, and many of the people who make policy don't have a clue what we are talking about. We need to make a *business* case for addressing homelessness in this way. This became very clear a year ago when Volunteers of America announced the number of people who would be evicted if the VOA closed. This immediately got the attention of businesses in the area, who did not want to deal with the consequences of more homeless people on the streets and sidewalks downtown.
- While “mental health” is listed as the *primary* reason for homelessness in only about 3% of Ingham County cases, mental illness is a factor in many of the cases where something else—loss of job, eviction, underemployment—is the primary reason. There are many discrete obstacles for people with mental illness. In the court system, judges base many decisions upon one's “ability to make sound decisions.” Many people with mental illness could make sound decisions if they were not self-medicating and/or were receiving the medications they need in order to function well; unfortunately, this often isn't the case when they go before the judge. The mental health system is difficult to navigate, and limited resources prevent many people from getting assistance unless they are currently homicidal or suicidal. We need to create awareness of how these barriers play out in the lives of people who are not served well now, and its

consequences to the community. Important target audiences for this awareness are judges, legislators, and business community leaders.

- Lack of *accessible* housing is also a problem. People with disabilities sometimes find themselves unable to find housing even if they have a Masters Degree, because there is not adequate housing stock equipped to accommodate the needs that would allow them to live independently.

## **PRELIMINARY FINDINGS ON WHAT IS NEEDED**

In the structured exercise to answer the Focus Question, the participants generated ten needs that should be in place to ensure stable living environments for all. Five of the eleven needs were designated as *catalytic*, meaning that, if they were fulfilled, they would automatically help fulfill many of the other recommendations as well. The catalytic needs are listed first. No other attempt was made to prioritize the findings.

The five catalytic recommendations focused on:

- Affordable, Accessible Housing
- Supportive Services
- Policy Change
- Public Awareness and Education
- Clearing House for Resources

The other five recommendations concerned:

- Economic Development
- Life Skills
- Data
- Living Wage
- Health Care

Each of these findings was reviewed and revised at the second dialogue on August 24, 2006. Input from the second dialogue has been incorporated into this version of the recommendations.

## Catalytic Recommendations

- 1. AFFORDABLE, ACCESSIBLE HOUSING:** Through a variety of strategies that optimize the use existing resources, expand the availability of affordable housing to meet the needs of Ingham County residents who are homeless or at risk of homelessness.

Ingham County will embrace the “Housing First” strategy for ending homelessness; that is, it will reconfigure systems and community resources in a way that prioritizes the establishment of stable living environments for all who are homeless or at risk of homelessness. To achieve this in ten years, it is critical that additional housing stock be created to meet the wide-ranging housing needs of this population. Housing stock must be:

- *Affordable* to people earning low incomes
- *Accessible* to people with a wide range of physical and mental ability
- *Obtainable* by people who would otherwise be obstructed from housing due to criminal records, poor credit ratings, or physical, mental, or behavioral conditions
- *Diversified and mixed* in type, incorporating both Single Room Occupancy and units for intact families
- *Safe*, i.e. secure, conforming to reasonable standards of quality, and unlikely to be exposed to criminal activity
- *Sustainable* over time, through planned maintenance and whatever supportive services may be needed to enable the resident to maintain his or her home.

There is not necessarily a need to build additional housing to meet the current need for this type of housing. The foreclosure and eviction process as currently practice does not optimize the potential for rehabbing existing housing. Nor does the process of red-tagging houses operate in the interest of preventing homelessness and stabilizing neighborhoods. Furthermore, the economics of these processes do not motivate builders and landlords to support a strategy that would stabilize and sustain vulnerable individuals and families.

Examples of actions that might be taken toward fulfilling this need:

- Using the best available data, calculate the amount and nature of additional housing stock needed in Ingham County.
- Conduct a new “Healing and Housing” dialogue around the potential for rehabbing or maintaining existing housing stock:
  - Identify representatives of all entities who “touch” the process of red-tagging, foreclosure, and eviction. This must include landlords, code enforcement officers, realtors, utility companies, builders, service providers, and neighborhood organizations.
  - Collectively “tell the story” of what happens in this process, and how each group of stakeholders perceive their part of the story.
  - Facilitate the development of new policies and practices that would mutually benefit all parties, and support the stabilization and maintenance of persons at risk of homelessness.
  - Identify both monetary and non-monetary incentives that might be applied in support of new practice and policy, including:
    - Assurance to landlords of support for tenants in maintaining their homes. This will include both financial and human resources to help the tenant succeed, and the degree of support must correspond to the degree of risk represented by the client.
    - Application of community service time to the maintenance of properties, to create a better climate for the house and increased value to landlords and builders.
    - Tax incentives to support the personal and financial investment of tenants, landlords, and builders.
    - Incentives to builders and landlords tied to participation in the work of the GLHRN.
    - Location of social services in close proximity to residences; likewise, working toward close proximity with stores, employment, public transportation, etc.
  - Explore a regionalized approach to these policy and practice changes, in collaboration with Eaton and Clinton Counties.
- Institute more city and state tax credits for people on low incomes, to enable them to afford existing housing stock.
- Establish or acquire subsidies to build needed housing stock.
- Establish financial incentives for landlords to accommodate people who are homeless or at risk, and for builders and developers to create needed housing.

- Develop relationship with the Board of Realtors to explore options for creating access to homes that are on the market but not selling.

**2. SUPPORTIVE SERVICES: Establish the full range of supportive services needed to help people who are homeless or at risk of homelessness maintain stable living environments.**

Many challenging life circumstances and conditions contribute to homelessness in Ingham County. For many who are homeless or at risk of becoming homeless, maintaining housing will require the application of additional supports unique to each individual's challenges. These supports vary greatly in nature, and include all of the following:

- ***Practical assistance*** in the event of a crisis, such as financial aid for rent and utilities after a major illness or injury.
- ***Skill-building*** to increase one's ability to maintain a home, secure a job, manage a budget, etc.
- ***Social advocacy*** to reassure employers, landlords, and others that the person in question will be reliable and supported in his or her efforts to achieve stability.
- ***Individualized support*** in overcoming challenges related to conditions such as mental illness, recovery from chemical dependency, or physical or emotional disability.
- ***Child care and parenting*** support to families with young children.
- ***Access to life-changing relationships*** that can overturn a deeply held negative self-image and illuminate a pathway to empowerment for those who have experienced generational poverty, lifelong abusive relationships, long-term addiction, social ostracism, or exclusion from educational and employment opportunities. Mentors, life coaches, and spiritual supports are all possible avenues to this kind of assistance.

In addition to establishing the full range of services, mechanisms must be put in place to coordinate and facilitate access to them. Just as the level of need varies greatly among those who are homeless, the level of intensity of these coordinating mechanisms must vary as well, from basic information and referral to intensive case management services:

- ***The emerging 211 system*** will be critical in providing easy access to information on available services.
- ***Volunteer/paraprofessional Navigators*** are needed to “walk with” the person in need of services, helping overcome personal barriers to

seeking assistance. This type of help is especially necessary for the many people who have been trained to avoid certain agencies such as DHS because of past frustrations; also, for people who have developed a habit of living in crisis.

- ***Intensive Case Managers*** are needed to help those in greatest need coordinate the range of services needed. These case managers would ideally be located at various sites in the community, and be integrated into the entire system. All providers in the network would operate with common protocols for intake and assessment, avoiding duplication of processes.

Examples of actions that might be taken toward fulfilling this need:

- Using the best available data, calculate the amount and nature of support services needed in Ingham County. Data would include maps derived from the HMIS showing where supportive services are most needed, where landlords are amenable to renting to higher risk tenants.
- Identify existing programs that give practical assistance with financial needs, their current capacity, and the gap in unmet need.
- Identify existing programs that provide individualized support to people with challenging life conditions or disabilities, their current capacity, and the gap in unmet need.
- Inventory the community's current capacity to provide life skills training and relationship-building opportunities, looking beyond conventional human service programs to neighborhood and faith-based networks as well. Explore new linkages between these resources and the established homeless prevention network.
- Promote the strategy of "social advocacy" to reassure landlords and employers that homeless/at-risk persons will be supported in their effort to maintain their home and their jobs.
- Synchronize resource development for supportive services with the plan for expanding available housing stock over ten years.

**3. PUBLIC AWARENESS AND EDUCATION: Raise the community’s awareness and understanding of the causes and consequences of homelessness, and in so doing motivate key sectors of the community to do more to end homelessness.**

To bring about the policy changes described in Finding #3, decision-makers need to hear from a broad base of community members that the goal of ending homelessness is important, desired, and achievable. Therefore, we need a concentrated effort to convey the truth about homelessness to members of the general public and key players in education, business, faith organizations, and sectors of the community who will need to be part of the plan to end homelessness.

In framing the broad message about homelessness, our goal should be to create community ownership of the issue, by portraying common, universal community concerns. Today many people see homelessness as an issue of the *individual* rather than an issue for the *community*. We should think carefully about reframing the concern as part of the broader issue of *housing*—something that everyone cares about—rather than *homelessness*, which signifies a specific group of people who many would prefer to pretend do not exist in our community. Moreover, when trying to create interest and concern for the homeless, we should remain mindful of the universal need of social belonging. One way to connect individuals to the circumstances of homeless people is to recognize we all have the same basic needs, one of which is to belong in the world.

The objectives of this effort are:

- ***Awareness*** of the many conditions and circumstances that lead to homelessness, and the diverse population that is at risk of homelessness.
- ***Education*** on the barriers that prevent people from establishing stable living environments, and the social and economic consequences to our community.
- ***Dialogue*** among diverse community stakeholders that helps them identify their own course of action to assist in the effort to end homelessness.
- ***Action*** by many sectors of the community, including educational institutions, employers, faith organizations, and others.

Examples of actions that might be taken toward fulfilling this need:

- Engage professional “social marketing” expertise to generate a new frame for public awareness messages about homelessness: one that emphasizes universal concerns and helps people to see this as a broad community concern.
- Organize a public awareness campaign built around the above message frame, but one which also portrays a authentic but normalized picture of the homeless (including families, children, working men and women), and what is being done in our community to stabilize individuals, families, and neighborhoods. The campaign could include public service announcements and other communications tools.
- Organize large-scale community events that bring a cross-section of stakeholders to hear and learn about homelessness and what we are doing collectively to end homelessness. The first of these should be a community gathering to unveil the ten-year plan in the fall of 2006. Other examples of this type of event are a Prayer Week, the VOA Stand Down, etc. Involvement of people who are or have been homeless is desirable.
- Convene community dialogues where people have the opportunity to work through perceptions and attitudes toward homeless in a more intimate way, and come up with their own ideas for action.
- Create a Speakers Bureau to schedule presentations with business groups, service clubs, realtor groups, government entities, school classrooms, etc.
- Link these efforts to policy activities described under Finding #4.

**4. POLICY: Identify and advocate for revision of current local, state, and federal policies that perpetuate homelessness by creating unreasonable barriers to housing, employment, and needed supportive services.**

Some of the barriers to ending homelessness are embedded in policy, and can only be overcome by convincing elected officials, government administrators, and other community leaders that specific changes in policy are needed. The case to be made for these policy changes should be grounded in overall community well-being, including the promotion of economic development and safe, healthy communities. Work toward policy change must be integrated with awareness and education efforts seeking to deepen the general public's understanding of homelessness and how it affects all (see finding #3). Four specific policy targets emerged from the community dialogue process (there are most likely others to be identified):

- ***Broaden the official “homeless” definitions***, which currently restrict assistance to a limited segment of those who are in need of services. Many of the very needy are chronically homeless or consistently on the brink of homelessness by moving serially from one unstable housing situation to another.
- ***Develop and work toward red-tagging, foreclosure, and eviction procedures*** that benefit all parties. (One of the action steps for Recommendation #1 describes a process for changing policy and practice in this area.)
- ***Illuminate the injustice embedded in certain housing and employment policies, and modify them accordingly***. Criminal histories, credit histories, and income guidelines prevent many from being able to obtain housing and a reasonable income. While this information is obviously important to the decision-making processes of employers, landlords, and lending institutions, it can become an insurmountable barrier to someone who is ready and willing to assume a productive life. Safeguards should be put in place to prevent unreasonable discrimination in housing and employment on the basis of these considerations.
- ***Develop new standards for determining personal capacity that do not discriminate against people with mental/emotional disability***. In making decisions that have profound consequences for homeless and potentially homeless people, judges often use the standard of whether a person is capable of making sound decisions for themselves. For

- persons with mental illness who are not on needed medications or who are self-medicating, this is not a fair standard.
- ***Establish housing policy that does not discriminate on the basis of income, and that encourages stability rather than sequential moves based on changing incomes and housing availability.*** Some landlords and property managers will not accept recipients of Section 8 vouchers. This should be addressed through city ordinances, or policy action at the county or state level. In addition, when Section 8 housing becomes available for someone who is eligible for it, they will most likely move from their current housing arrangement, and then move again when their income increases above the eligibility cap. These sequential moves add to the instability of the living arrangement. Through state and national advocacy efforts, the GLHRN should help to illuminate this problem in the current implementation of Section 8 waivers.
  - ***Work toward improved navigation and/or reduced complexity in the Medicaid/SSI system.*** The current complexity of processes to access assistance through the Department of Social Services discourages many from even attempting to do so. For many people, this creates a lifestyle of poverty and living from crisis to crisis which some have characterized as an “addiction.” GLHRN should advocate for changes that would assist people in navigating the process, or toward changes in DHS policy and practice that would make services and assistance more accessible.
  - ***Encourage local educational institutions to adopt community-friendly strategies that would assist the homeless in attending school.*** There is a concern that some local college options are moving toward policies that disfavor the homeless. One participant in the second dialogue said that Lansing Community College will not consider homeless persons as “residents” in determining tuition; also, that transportation is not available to many of the education venues.
  - ***Encourage HUD to go further in allowing local community assessments of need to drive strategy, policy, and funding.*** In recent years, HUD has encouraged and empowered local community’s to define the Continuum of Care needs at the local level, and to direct resources accordingly. However, funding priorities and policies still sometimes supersede what the local stakeholders have determined. GLHRN should be a voice for greater flexibility in funding and strategy, driven by local information and insight.

The following action is suggested toward fulfilling this need:

- Establish a policy work group or subcommittee to pursue policy changes needed to remove barriers to ending homeless.

## **5. CLEARING HOUSE FOR RESOURCES: Streamline access to housing and supportive services through a unified intake, assessment, and referral system.**

All of the resources that the community can apply to ending homelessness should be linked through a central clearing house and resource center. This centralized system should be the primary access point for data on homelessness and information on the entire range of services and assistance that the community has to offer to people who are homeless or at risk of becoming homeless. All of the resources linked through this system should adopt a “no wrong door” policy, using the clearing house or resource center to connect people to what they need, such as housing assistance, rent/utilities payments, employment, health care, child care, etc.

Components of the needed system:

- ***A 211 system*** through which information on available services can be accessed, in multiple languages.
- ***A Housing Resource Center***, staffed with people who can assist people more directly in accessing housing assistance and support services.
- ***A Housing Locator Resource***, to assist in identifying housing options in the community.
- ***A two-tiered system of intake, assessment, and referral***—one that eliminates duplicative processes. When all parts of the system are charged with completing the entire intake, assessment, and referral process, it is likely that people will be asked to go through the process more than once. Those agencies that serve as an initial contact with the network of services should therefore be charged to conduct a more streamlined, basic intake process, which leads to a complete intake, assessment, and referral by an agency capable of navigating the system more thoroughly.

The following action is suggested toward fulfilling this need:

- Continue to support the development and capacity of the Capital Area 211 system, operated by the Capital Area United Way.
- Develop a plan to re-establish a Housing Resource Center to provide more direct assistance in accessing resources and assistance.

- Advocate for continued development of the Housing Locator Service at the state level.
- Consider and develop a “two-tiered system” of intake, assessment and referral that will eliminate duplicate processes.
- Develop a plan or proposal to upgrade the technological capacity of programs that will be making use of electronic intake, assessment, and referral mechanisms.

Other (Non-catalytic) Recommendations

**6. LIFE SKILLS: Empower people at risk of homelessness to realize their own potential and worth, through personal growth opportunities, life skills training, employment training, and educational support.**

Many of the homeless and those at risk of homelessness have endured multiple traumatic conditions and situations—generational poverty, long-term abuse, chemical dependency, etc.—which have placed understandable boundaries on their ideas of what they can achieve for themselves. Others are limited by simply not having been given the opportunity to acquire practical skills that will help them be able to manage a home or acquire a job. The Ingham homeless initiative should apply a strategy of acknowledging each person’s assets within the context of whatever physical or mental limits he or she experiences, and building on those assets to help achieve a greater degree of self-reliance and stability. This strategy should encompass each of the following types of skill-building efforts:

- ***Realistic goal-setting and achievement*** that enables people to develop a sense of their own worth and value.
- ***Relationship building*** that reaffirms for people that they are not alone in working to achieve their goals.
- ***Practical life skills*** (budgeting, cooking, home maintenance)
- ***Employability training*** (interviewing skills, job shadowing, maintaining positive work relationships)
- ***Educational advancement*** (G.E.D. attainment, assistance in enrollment in vocational training or higher education)

Programming of this nature should not only be made available to adults who are homeless or at risk but also for children and adolescents, and in some cases for parents and children together. The incorporation of life skills training into school curricula is also desirable.

NOTE: In the ten year plan, this recommendation can be incorporated as an action step under Goal #2, “Supportive Services”.

**7. ECONOMIC DEVELOPMENT: Coordinate an integrated response to homelessness by financial partners, grounded in the economic value of investing in employment and stable housing for those who would otherwise be homeless.**

Employers, landlords, banks, other lending institutions, grant-makers, and local, state, and federal government all need to be engaged in the effort to end homelessness. Engagement of these stakeholders can be accomplished through:

- *Outlining the economic argument* of ensuring that all people are employed and living in stable environments—i.e., eliminating the high cost to the general public of providing health care, shelter, law enforcement, and other services to the homeless;
- *Articulating the economic benefit* of creating homes, entry-level jobs, and employment training to all Ingham County residents who would otherwise be homeless.

Potential actions to be pursued with economic stakeholders:

- Develop an organized response to the problem of predatory lending practices in Ingham County, via cash advance and check-cashing agencies. This would involve identifying all relevant stakeholders, identifying the nature and consequences of predatory lending practices, and developing through dialogue a set of recommendations for change in policy and practice.
- Communicate to grant-making institutions the value of flexible funding and shaping strategies for ending homeless in accordance with the local experience and insight.
- Exploration of the role Individual Development Accounts can play in helping people establish housing stability.

**8. DATA: Continue to refine data collection so that data on homelessness and services can validate and inform program development and demonstrate the long-term economic and social impact of our strategy.**

Considerable work is already underway to refine the capability of the Homeless Management Information System. We should continue to work toward a reliable system that creates and compiles data that can:

- *Increase community awareness and understanding*
- *Reveal the impact of specific programs and services*
- *Illuminate the impact of plan implementation on the community's overall well-being*, including both economic and social effects.

Action steps toward the achievement of this recommendation:

- **Dedicate time and energy to developing unified outcomes across the homeless resolution network.** One problem with the current system's ability to increase awareness and show impact is that different agencies define their desired outcomes in different terms. This is partially driven by the divergent expectations of multiple funders; however, as a network of providers with a common target population, it will be important to unify our desired outcomes as much as possible.
- **Develop a plan or proposal to upgrade the technological capacity of programs that participate in the HMIS.** (This action step is also included under Recommendation #5, "Clearinghouse.")
- **Augment data on homelessness through linkages to other information sources.** Data on health, mental health, substance abuse, and other service sectors that directly impact homelessness should be incorporated into our data through linkages to other data sources. Partnerships with MSU might advance this objective.
- **Work to resolve persistent data problems.** There are many concerns that impede the capture of good data about the homeless population today. These include the inability to include the "couch homeless," who are not included in current federal definitions, and the difficulty in obtaining certain information through self-reporting. It is assumed that issues like mental health, substance abuse, AIDS/HIV,

etc., are underreported because of the stigma one might feel in revealing them.

**9. JUST AND EQUITABLE INCOME: Work toward policy changes that would assure that homeless people and those at risk of homelessness can achieve an income that will enable them to acquire and maintain a stable living environment.**

Considering the income generated by lower-paying jobs in our community and the typical cost of living for anyone trying to maintain safe, stable housing, it is clearly impossible for some in our community to become economically self-reliant. This imbalance is compounded further for those whose work options are limited by physical or mental disability. There are two ways in which we should pursue the establishment of a reasonable living wage for all:

- ***Increased living wage standards.*** While the passage of ordinances and legislation guaranteeing a higher living wage to employees would on the surface correct the current problem, it would also create dire economic problems, by furthering the departure of businesses from Michigan and most certainly bankrupting most agencies that currently working to end homelessness. A true “living wage,” calculated at around \$17 per hour, is not a feasible goal.
- ***Income subsidies*** that “level the playing field” for those who are unable to secure full employment, or limited by physical or mental challenges in doing so.

Toward the goal of a “just and equitable income” for those who are homeless or at risk, the GLHRN should:

- Work with the business community and governmental bodies to create entry-level positions at a reasonably high level of compensation for people who are homeless or working to avoid becoming homeless.
- Work with MSHDA to establish subsidies to tenants that are sufficient to maintain them in quality affordable housing.

NOTE: In the ten year plan, this recommendation can be incorporated as an action step under Goal #4, “Policy”.

**10.HEALTH CARE: Ensure access to health care to all Ingham County residents.**

Ingham County’s Board of Commissioners has placed a priority on establishing health care coverage for all residents, through a variety of coverage strategies, including the Ingham Health Plan (IHP). Advocates for the homeless should work with area health care providers and the Ingham Health Plan Corporation to achieve the following:

- *Expanded enrollment of the uninsured* in IHP programs
- *Demonstrated effective utilization* of health care services through IHP programs
- *New incentives or strategies to increase employer-based health insurance*
- *New incentives or strategies to engage health care providers* to partner in assuring access to health care for the uninsured.
- *Expansion of services covered under IHP and other programs* to include dental care, substance abuse treatment, mental health services, vision care, and prevention services.
- *Expansion of the hours of operation of free and low-cost clinics* to accommodate the needs of those who are working in low-income jobs and cannot afford to take time off work to see a provider.
- *Patient advocates* who can assist and educate people for whom health care has not been a priority and who are likely not to access care because they do not understand the norms and language of the patient visit process. Patient advocates are a necessary but absent component of a working organized system of health care. Without them, many of the uninsured will not seek out health coverage through available programs, and many who have acquired coverage will not utilize health care services effectively.

Action steps toward the achievement of this recommendation:

- Communicate to the Ingham Health Plan Corporation and the Ingham County Health Department the unmet needs of Ingham County residents who are homeless or at risk of homelessness.
- Work toward establishment of patient advocates who can help people with difficulty understanding coverage and health care resources navigate such programs as Medicaid, SSI, and IHP; establish a

positive relationship with a primary care provider; and navigate the process of scheduling and completing health care visits.

NOTE: In the ten year plan, this recommendation can be incorporated as an action step under Goal #2, “Supportive Services”.

# GOALS

## Goal 1.

Coordination of Discharge Planning, Case Management, and Supportive Services.

### Lead Agent

Human Services Committee and Inter-Agency Service Team

### Objectives

1. Across all systems, for both adults and youth, re-engineer discharge planning procedures to assure that each person has a clear discharge plan in place that begins at the point of entry into the system, is geared to the client's natural strengths and supports, and engages community resources well in advance of discharge.
2. Realign case management services across all systems.
3. Establish the full range of supportive services needed to help people who are homeless or at risk of homelessness maintain stable living environments.

### Action Steps for Goal 1

- Ensure all clients have a clear discharge plan in place.
- Develop the plan immediately upon entry into the system, and engage relevant community resources early.
- Within the corrections system, ensure acquisition of ID cards well before release.
- Include strategies that prepare all parties to respond proactively to setbacks that may occur.
- Include strategies for highlighting successes as they occur.
- Teach life skills while still in institutional care, in ways that will attract and engage (rather than alienate) the client. Respect for the client's self-image and need for self-control is vital.
- Provide job skill training that is tied directly to client strengths and community need (i.e., practical careers likely to lead to job placement).
- Expand transitional living options in the community for youth, adults, and families.

- Incorporate case management, mentoring, and prevention into all plans (see the following three recommendations).
- Develop “best practices” for establishing individual goals for adult clients, and another for children and youth clients. In both cases, the goals should be consumer-led, realistic, involve an interdisciplinary team, and apply to all agencies serving the consumer.
- Develop a holistic, comprehensive assessment tool that can be applied across all systems.
- Encourage and support cross-system training on client-centered practice.
- Create a Re-entry Team for the client involving workers from each pertinent agency or system, led by a centralized case manager to whom all team members are accountable. The Re-entry Team and Case Manager should be unified in pursuing mutual goals for the client’s success.
- Develop strategies to reward incremental client success.
- Using the best available data, calculate the amount and nature of support services needed in Ingham County. Data would include maps derived from the HMIS showing where supportive services are most needed, where landlords are amenable to renting to higher risk tenants.
- Identify existing programs that give practical assistance with financial needs, their current capacity, and the gap in unmet need.
- Identify existing programs that provide individualized support to people with challenging life conditions or disabilities, their current capacity, and the gap in unmet need.
- Inventory the community’s current capacity to provide life skills training and relationship-building opportunities, looking beyond conventional human service programs to neighborhood and faith-based networks as well. Explore new linkages between these resources and the established homeless prevention network.
- Promote the strategy of “social advocacy” to reassure landlords and employers that homeless/at-risk persons will be supported in their effort to maintain their home and their jobs.
- Synchronize resource development for supportive services with the plan for expanding available housing stock over ten years.

## **Goal 2.**

Affordable, Accessible Housing

### **Lead Agent**

Housing Task Force

### **Objectives**

1. Through a variety of strategies that optimize the use existing resources, expand the availability of affordable housing to meet the needs of Ingham County residents who are homeless or at risk of homelessness.
2. Embrace the “Housing First” strategy for ending homelessness; that is, reconfigure systems and community resources in a way that prioritizes the establishment of stable living environments for all who are homeless or at risk of homelessness.

### **Action Steps**

- Using the best available data, calculate the amount and nature of additional housing stock needed in Ingham County.
- Conduct a new “Healing and Housing” dialogue around the potential for rehabbing or maintaining existing housing stock:
  - Identify representatives of all entities who “touch” the process of red-tagging, foreclosure, and eviction. This must include landlords, code enforcement officers, realtors, utility companies, builders, service providers, and neighborhood organizations.
  - Collectively “tell the story” of what happens in this process and how each group of stakeholders perceive their part of the story.
  - Facilitate the development of new policies and practices that would mutually benefit all parties, and support the stabilization and maintenance of persons at risk of homelessness.
  - Identify both monetary and non-monetary incentives that might be applied in support of new practice and policy, including:
    - Assurance to landlords of support for tenants in maintaining their homes. This will include both financial and human resources to help the tenant succeed, and the degree of support must correspond to the degree of risk represented by the client.

- Application of community service time to the maintenance of properties, to create a better climate for the house and increased value to landlords and builders.
    - Tax incentives to support the personal and financial investment of tenants, landlords, and builders.
    - Incentives to builders and landlords tied to participation in the work of the GLHRN.
    - Location of social services in close proximity to residences; likewise, working toward close proximity with stores, employment, public transportation, etc.
  - Explore a regionalized approach to these policy and practice changes, in collaboration with Eaton and Clinton Counties.
- Institute more city and state tax credits for people on low incomes, to enable them to afford existing housing stock.
- Establish or acquire subsidies to build needed housing stock.
- Establish financial incentives for landlords to accommodate people who are homeless or at risk, and for builders and developers to create needed housing.
- Develop relationship with the Board of Realtors to explore options for creating access to homes that are on the market but not selling.

## **Goal 3**

Prevention

### **Lead Agent**

Prevention Task Group

### **Objectives**

1. In addition to improving the process whereby people transition from institutional care, and stable housing into homelessness, work “upstream” to prevent entry into the system in the first place.

### **Action Steps**

- Expand the availability of approaches that seek to prevent out-of-home placement, i.e. Wraparound, Families First.
- Expand the availability of support services to families with children between the ages of zero and five years.
- Educate foster care staff, protective services staff, and judges on the potential consequences of unilateral decision-making to remove children from homes.
- Encourage schools and their representatives to work in concert with other systems in confronting and preventing substance abuse.

## **Goal 4.**

Clearinghouse for Resources.

### **Lead Agent**

Human Services Committee

### **Objectives**

1. Streamline access to housing and supportive services through a unified intake, assessment, and referral system.
2. Establish a fully functional 211 system through which information on available services can be accessed, in multiple languages.
3. Create a Housing Resource Center, staffed with people who can assist people more directly in accessing housing assistance and support services.
4. Implement a Housing Locator Resource, to assist in identifying housing options in the community.
5. Design and implement a two-tiered system of intake, assessment, and referral—one that eliminates duplicative processes.

### **Action Steps**

- Continue to support the development and capacity of the Capital Area 211 system, operated by the Capital Area United Way.
- Develop a plan to re-establish a Housing Resource Center to provide more direct assistance in accessing resources and assistance.
- Advocate for continued development of the Housing Locator Service at the state level.
- Consider and develop a “two-tiered system” of intake, assessment and referral that will eliminate duplicate processes.
- Develop a plan or proposal to upgrade the technological capacity of programs that will be making use of electronic intake, assessment, and referral mechanisms.

## **Goal 5**

Collaborative Oversight

### **Lead Agent**

10 Year Plan Steering Committee

### **Objectives**

1. Continue the collaborative approach to improving discharge planning, aftercare, and community supports in Ingham County, through establishment of a permanent oversight body and a directive to extend collaboration to all levels of the systems.

### **Action Steps**

- Encourage and support collaborative approaches at all levels of the participating systems and organizations, from community engagement to case management to system reform.
- Share resources currently dedicated to institutional care, including staff, funding, and programming expertise, across all systems and agencies.
- Explore re-engineering current resources to better accommodate a coordinated approach to discharge planning, case management, mentorship, and prevention.
- Development of new resources in support of the 10 Year Plan as the opportunity arises.

## **Goal 6**

Public Awareness and Advocacy

### **Lead Agent**

Public Awareness and Advocacy Task Force

### **Objectives**

1. Raise the community's awareness and understanding of the causes and consequences of homelessness, and in so doing motivate key sectors of the community to do more to end homelessness.
2. Develop a unified communication plan to describe to partners, consumers, policy-makers, and the community at large the benefits of new, integrated strategies for promoting successful re-entry to the community from institutional care.
3. Develop and implement an advocacy plan to promote legislative and policy changes needed to support successful re-entry into the community upon discharge from institutional care.
4. Identify and advocate for revision of current local, state, and federal policies that perpetuate homelessness by creating unreasonable barriers to housing, employment, and needed supportive services.

### **Action Steps**

- Establish a policy work group or subcommittee to pursue policy changes needed to remove barriers to ending homeless.
- Identify key persons who need to be involved in this process and earn their buy-in to the new approach.
- Articulate the rationale for new approaches in ways that will be conducive to broad understanding of the need for change and the benefits that these changes will bring to the community (cost savings, expanded tax base, neighborhood stabilization, opportunities to give back to the community, etc.)
- Disseminate preliminary information on new approaches to both providers and consumers, and solicit input.
- Create "Discharge Resource Guides" for consumers that clearly describe the reason and purpose of new approach.
- Identify key policy and legislative changes needed. Example: Prohibitions against discrimination in access to housing, employment,

- or education based on unilateral criteria such as having been in institutional care or having previously abused substances.
- Articulation of rationale for needed policy and legislative changes. Examples: The value of enabling people emerging from institutional care to become tax-payers in economically challenged communities; a cost/benefits analysis based on the consequences of recidivism vs. successful re-entry, etc.
  - In partnership with community support, target legislators and appointed officials who are strategically and ideologically positioned to champion needed changes.
  - In partnership with community support, assign and equip influential local partners to meet with targeted legislators and officials and make the case for needed changes.
  - Engage professional “social marketing” expertise to generate a new frame for public awareness messages about homelessness: one that emphasizes universal concerns and helps people to see this as a broad community concern.
  - Organize a public awareness campaign built around the above message frame, but one which also portrays a authentic but normalized picture of the homeless (including families, children, working men and women), and what is being done in our community to stabilize individuals, families, and neighborhoods. The campaign could include public service announcements and other communications tools.
  - Organize large-scale community events that bring a cross-section of stakeholders to hear and learn about homelessness and what we are doing collectively to end homelessness. The first of these should be a community gathering to unveil the ten-year plan in the fall of 2006. Other examples of this type of event are a Prayer Week, the VOA Stand Down, etc. Involvement of people who are or have been homeless is desirable.
  - Convene community dialogues where people have the opportunity to work through perceptions and attitudes toward homeless in a more intimate way, and come up with their own ideas for action.
  - Create a Speakers Bureau to schedule presentations with business groups, service clubs, realtor groups, government entities, school classrooms, etc.

## **Goal 7**

Economic Development

### **Lead Agent**

Economic Development Task Force

### **Objectives**

1. Coordinate an integrated response to homelessness by financial partners, grounded in the economic value of investing in employment and stable housing for those who would otherwise be homeless.

### **Action Steps**

- Develop an organized response to the problem of predatory lending practices in Ingham County, via cash advance and check-cashing agencies. This would involve identifying all relevant stakeholders, identifying the nature and consequences of predatory lending practices, and developing through dialogue a set of recommendations for change in policy and practice.
- Communicate to grant-making institutions the value of flexible funding and shaping strategies for ending homeless in accordance with the local experience and insight.
- Exploration of the role Individual Development Accounts can play in helping people establish housing stability.

## **Goal 8**

Comprehensive Data

### **Lead Agent**

GLHRN HMIS/Data Management Committee and PWC Community Data Committee

### **Objectives**

1. Continue to refine data collection so that data on homelessness and services can validate and inform program development and demonstrate the long-term economic and social impact of our strategy.
2. Increase community awareness and understanding
3. Reveal the impact of specific programs and services
4. Illuminate the impact of plan implementation on the community's overall well-being, including both economic and social effects.

### **Action Steps**

- Dedicate time and energy to developing unified outcomes across the GLHRN.
- Develop a plan to upgrade the technological capacity of programs that participate in the HMIS.
- Augment data on homelessness through linkages to other information sources
- Work to resolve persistent data problems.

## **Goal 9**

Mentoring

### **Lead Agent**

Mentoring Task Force

### **Objectives**

1. Expand the community's capacity to provide mentors to adults and youth emerging from institutions, and incorporate mentorship into discharge plans.

### **Action Steps**

- Include mentoring as a standard element of discharge/case plans.
- Within plans, include participation in the setting of goals that are relevant to the client as one of the responsibilities of mentors.
- Recruit mentors from neighborhood groups and organizations affiliated with communities of color or specific ethnic heritage.
- Mobilize the community to promote mentorship.
- Facilitate the development of community mentoring programs.

## **Goal 10**

Comprehensive Health and Healthcare

### **Lead Agent**

Human Services Committee

### **Objectives**

1. Ensure access to health care to all Ingham County residents.

### **Action Steps**

- Communicate to the Ingham Health Plan Corporation and the Ingham County Health Department the unmet needs of Ingham County residents who are homeless or at risk of homelessness.
- Work toward establishment of patient advocates who can help people with difficulty understanding coverage and health care resources navigate such programs as Medicaid, SSI, and IHP; establish a positive relationship with a primary care provider; and navigate the process of scheduling and completing health care visits.

## **Next Steps**

### **Year One Overall Action Steps**

**Finalize Plan and Submit**      October 2006

**Present Plan to Community**    November 2006

The plan will be presented at a community forum to be held in conjunction with Homeless Awareness Week. Media coverage and participation in the event will help to announce the plan and the next steps to the community. It will also serve as an entrance point for community partners not yet engaged.

**Form Task Groups**                      November 2006

Task groups will be formed as indicated in the action steps outlined previously. Task groups will be made up of participants in the planning process, members from the community, and homeless and formerly homeless people with an interest in the process.

**Begin Work on Action Steps**    January 2007

Each task group will determine its leadership and initial strategy and begin to work on the goals assigned.

**Evaluate Progress**                      August 2007

The steering committee will lead a formal evaluation process that critically looks at initial action steps, progress, and changes in the community that may necessitate changes in approach or strategy.

### **Realignment and Begin**

**Year 2 Action Steps**                      October 2007

The steering committee will create a status report and realignment strategy which will be presented to the community during Homeless Awareness Week 2007.

Ingham County recognizes that our plan to end homelessness is a living document that will be adjusted according to the discoveries made during implementation and evaluation. The Steering Committee will continue to function as the oversight body for this process and maintain the focus on the overall goal of ending homelessness.

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