Solutions Beyond Shelter:

A vision to end homelessness

Solutions Beyond Shelter

CSH Community Planning Charrette with Lafayette, West Lafayette and Tippecanoe County

Presented to the community by the Corporation for Supportive Housing on June 18, 2012

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About the Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness.

Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, including Indiana, please see www.csh.org/contactus. For more information about CSH's consulting and training services, please contact the CSH Consulting Group at consulting@csh.org.

Acknowledgements

CSH wishes to acknowledge all those who participated in conversations and discussions that helped to shape this document and the Charrette process. Most especially, CSH thanks the Charrette Core Group for all their time and energy before and during Charrette week.

Inquiries

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Tippecanoe Charrette: Solutions Beyond Shelter

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Introduction

The Corporation for Supportive Housing (CSH) is pleased to present this report to Solutions Beyond Shelter partners and stakeholders. We commend you for committing to conducting a thorough, thoughtful and intentional exploration of implementation strategies to end and prevent homelessness. Through this inclusive community process, CSH witnessed a high level of authenticity and we hope that the same authenticity comes through in this document. CSH also appreciates the willingness of the Charrette Core Group to undertake the Charrette process as a method of analyzing, discerning, and ultimately making difficult decisions about moving forward on complicated and complex issues.

Tippecanoe County has been working hard on addressing homelessness and the Charrette process has demonstrated that while there has been great work accomplished; there is more that can be done to be more effective in ending homelessness and supporting the housing needs of the residents of the County. This work, as the recommendations outline, will mean looking at opportunities for realigning services and funding, for working more collaboratively and for ensuring that services offered lead people from homelessness to housing. It will mean breaking down barriers that keep people from getting services they need, focusing the approach on the perspective of people relying on the homeless service system, and working to support people to help them move toward self-sufficiency and self-directed goals. This report is intended to inform the body of work under the six issue areas identified and examined through this process; to lay a framework for the work to be done by the Solutions Beyond Shelter team; and to increase the success of the work of Lafayette, West Lafayette and Tippecanoe County Indiana for its citizens – with and without housing.

Tippecanoe County

Tippecanoe County is home to 172,780 residents, with 67,140 living in Lafayette and 29,596 in West Lafayette. It is home to Purdue University with more than 39,000 undergraduate and graduate students. The most recent Point In Time (PIT) count identified 167 people experiencing homelessness on a cold night in January 2012. This snapshot shows the number of people found, though we know that many people were not found on this one evening. Below is an overview of the homeless system and resources in Tippecanoe County.

- **Shelter:** If a person has no permanent residence, they can stay at the at the Lafayette Urban Ministries (LUM) shelter that houses up to 44 individuals. During the day, a person can go to Mental Health America for meals, case management, and a place to spend time. Lafayette Transitional Housing Center also provides meals, case management, and basic needs during the day. Families experiencing homelessness can stay at the Salvation Army (18 beds) or Family Promise of Greater Lafayette (14 beds). If a woman is a survivor of domestic violence, she can stay at the YWCA Domestic Violence program (24 beds) along with her children.

- **Transitional and Permanent Supportive Housing (PSH):** Lafayette Transitional Housing Center provides 22 transitional and 24 PSH for singles as well as 15 units for families. Mental Health America has 8 units of PSH, and the City of Lafayette has funding for 20 Shelter Plus Care PSH units in the community. Domestic violence survivors and their children can move from the shelter to Fresh Start (5 units), a transitional housing program that works with families for one year. There is also housing for targeted populations, including up to 30 units of transitional housing for ex-offenders through the City of Lafayette, housing for veterans experiencing homelessness through the Indiana Veterans Home, group homes for those with a developmental disability through Wabash Center, and supportive housing for individuals with a severe mental illness through Wabash Valley Alliance.

- **Supportive Services:**
    - Riggs Community Health Clinic provides health care, behavioral health care, dental care, and specialist referrals as well as assistance filling prescription medications
    - Wabash Valley Alliance offers addiction and mental health services.
    - St. Elizabeth Hospital provides inpatient and outpatient mental health services and has a psychiatric program that provides inpatient care.
    - Aspire provides services for those with HIV/AIDS, including a HOPWA program.
    - Food Finders supplies food to local food pantries.
    - Area IV Agency provides utilities assistance, self-sufficiency counseling, and other services, including programs for seniors and those with disabilities.
    - Lafayette Adult Resource Academy provides literacy and GED education as well as employment assistance.
    - CityBus provides public transportation including half fare for persons with a disability.
    - Employment services are provided by WorkOne (education testing and job preparation), EA staffing (temp agency targeting people with high barriers) and Vocational Rehabilitation (also targeting those with barriers to employment)

- **Affordable Housing:** There are a number of subsidized housing complexes, most with waiting list. The Lafayette Housing Authority has 1200 Housing Choice Vouchers, but is not currently accepting applications and has a waiting list with an approximate wait time of two years.

- **Addiction services:** Addictions services are provided by Wabash Valley Alliance for those with Medicaid. Bauer Counseling provides a fee for services program called Living in Balance. Family Services also has recovery programs. Organizations such as the SURF Center are home to a number of Alcoholics Anonymous, Narcotics Anonymous, and other support groups that are free to participants. There are no local detoxification facilities, and many people requiring this service find themselves in the county jail or in the hospital emergency room.

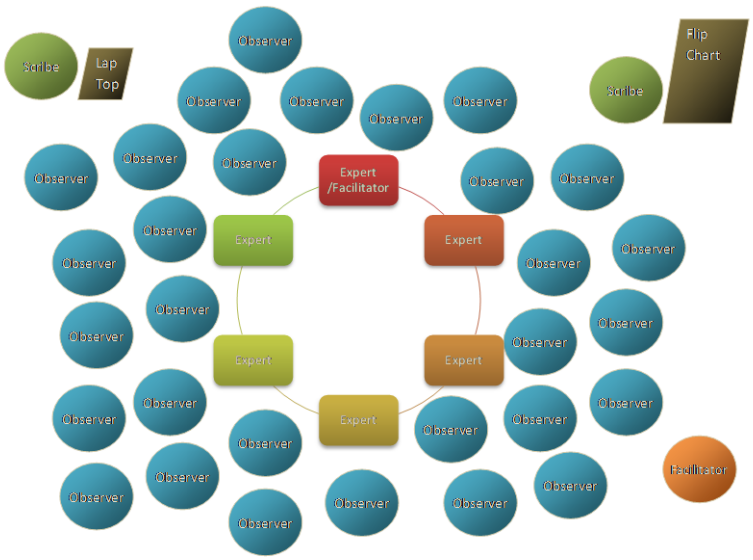
- **Homelessness Prevention:** Homelessness Prevention and Rapid Re-housing (HPRP) funding was effective, though the program has ended. Bauer Counseling offers a program, Community Partners, which helps keep their housing as a way to maintain custody of the children. This program offers case management as well as financial assistance. Homestead Consulting is the primary foreclosure prevention agency. The Fairfield Township Trustee works with many families in crisis to help households maintain their housing. A number of local agencies and faith-based organizations will help a family with limited financial support including LUM, LOVE Inc., Salvation Army, and various congregations.

The Charrette Process

What is a CSH Charrette?

To ensure robust participation and feedback from the community, the Core Group Members led by the United Way, Tippecanoe County, City of Lafayette, City of West Lafayette, and Greater Lafayette Commerce, decided to engage CSH to organize and deliver a condensed community process, known as a CSH Community Planning Charrette. The CSH Charrette takes what is typically a long-term planning process, and focuses community-wide energy on key issue areas. There are three phases to this process that are detailed below. With guidance from the Core Group, CSH worked closely with the community to identify key issue areas, review data, and prepare for the Charrette week. Two community meetings were also held to narrow down the issue areas and gather feedback, and over 100 people participated. As well, CSH staff members met with leaders from six agencies who provide emergency shelter, transitional housing, supportive housing, and/or supportive services to become more familiar with local programs and learn from providers. Following these meetings, CSH and the Core Group held two meetings with consumers that took place at the Mental Health America Day Shelter and Lafayette Transitional Housing Center to hear and learn from the perspective of people who are either currently experiencing homelessness or have in the past. Community conversations and the development of recommendations took place during the intensive Charrette week, resulting in this final report.

- **Expert Fishbowls:** Fishbowls are issue-focused panels that were open to all constituency groups and stakeholders in Tippecanoe County. National and local experts engaged in a dialogue to encourage thinking of new systemic and programmatic responses to ending homelessness in their particular topic area. The community observed the panel during this process. Once the panel completed its discussion, the community reacted and provided their input on the issue area. Note takers recorded the results of the conversations. The fishbowls were on



June 12th and June 13th and all were strongly encouraged to attend as many sessions as possible.

- **Feedback Process:** After the fishbowls, CSH staff compiled the information and feedback into initial recommendations. These recommendations were refined with the Core Group members on June 14 and based on their input were presented to the broader community at the Community Feedback Session on June 15. The feedback from this session was used to refine and reframe the final recommendations in this report.

- **Final Charrette Week Report**: This report on the action plan for Solutions Beyond Shelter is being presented to the Community on June 18. The next steps beyond this report will be determined by the Lafayette, West Lafayette and Tippecanoe County communities as they work to implement the recommendations outlined in this report.

Charrette Core Group Members: A core group of 12 members supported the work of the Charrette. Two community meetings were held where six key themes were selected for the focus of the Charrette. The core group also identified and invited participants to the process, recommended local experts; and provided ongoing guidance and participation in the process. The group met regularly from March 23 through June 8, 2012 before convening more than 120 stakeholders for the Charrette itself (*See Appendix A for list of Core Group Members and Appendix B for list of Charrette Participants).*

Charrette Week kicked off on June 12, 2012 with two full days of intense dialogue at Jefferson Park High School. The conversation focused on six issue areas:

1. Housing—From Homelessness to Permanent Housing
2. Interagency Coordination and Access
3. Health—Physical Health, Mental Health and Addictions
4. Homelessness Prevention
5. Re-entry—Ex-Offenders Facing Homelessness
6. Employment, Education, & Training

Each conversation occurred in a "fishbowl" setting with a group of experts sitting in a circle surrounded by community stakeholders. For the first hour the local and external experts engaged in a dialogue that encouraged thinking of new systemic and programmatic responses in the issue areas. Experts from diverse communities and organizations drew from their experiences and expertise to exchange views and craft suggestions for moving forward. *(See Appendix C for a full list of Experts and CSH staff biographies).*

While the expert dialogue occurred, the rest of the Charrette participants observed the discussion without comment. Half way through, the conversation among the experts ended and CSH facilitated audience observations and feedback. During this time, the experts were not allowed to respond, and community

members were given ample opportunity to agree with or challenge the experts and to offer other suggestions on the issue areas. The purpose of this part of each session was to engage the community members in the discussion and benefit from their expertise and experiences.

Following this intensive public process, CSH distilled the information into draft recommendations for each issue area as well as specific recommendations for the community. This was presented at an open community meeting on June 15 from 2:00 p.m. to 4:00 p.m. at Jefferson High School. At this session CSH heard input on how well the recommendations did or did not reflect the learning from the Charrette. The feedback session also tested the recommendations to gauge the likelihood of their implementation. CSH then incorporated the feedback into this final report which was presented at two meetings on Monday June 18, one to elected officials from 10:00 a.m. to noon and one at a public meeting from 2:00 p.m. to 4:00 p.m. at Jefferson High School.

The National Context

Federal Plan to End Homelessness

In 2010, the U.S. Interagency Council for the Homeless (USICH) published Opening Doors: Federal Strategic Plan to Prevent and End Homelessness and can be accessed by visiting www.usich.gov. Opening Doors notes that while communities across the country have made significant progress, homelessness continues to be a problem that we must begin approaching differently to effectively prevent and end homelessness in our communities. As the plan states, "no one should be homeless – no one should be without a safe, stable place to call home". The goals of the plan are to:

- Finish the job of ending chronic homelessness in 5 years;
- Prevent and end homelessness among Veterans in 5 years;
- Prevent and end homelessness for families, youth, and children in 10 years, and;
- Set a path to ending all types of homelessness.

It is important local plans to end homelessness align with the Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. (See Appendix F to identify how local plans to end and prevent homelessness can align with Opening Doors.) It is essential to remember that the Solutions Beyond Shelter plan is part of the larger national context of plans to end homelessness and these documents should help guide your implementation as you move forward in turning the recommendations of this plan into an action plan for Tippecanoe County.

HEARTH Act Legislation

In 2009 the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) was signed into law at a federal level and significantly changes the manner in which resources for homelessness can be used and how communities performance is evaluated. The HEARTH Act requires local agencies and key stakeholders to work closely together to share data and coordinate services to prevent homelessness and move households experiencing homelessness into permanent housing rapidly. Additionally, communities will be evaluated on reducing the overall number of people experiencing homelessness, reducing the recidivism of people returning to homelessness, and reduce the length of time that people remain homeless (i.e. length of time living in places not meant for human habitation, staying at a shelter and/or transitional housing). Communities will be required to have a coordinated and/or centralized intake and assessment process to connect the households at-risk and experiencing homeless to the most appropriate housing intervention, i.e. prevention, shelter, permanent supportive housing, affordable housing, etc. It is important that the Solutions Beyond Shelter plan contain HEARTH Act required measures (length of time homeless; recidivism (subsequent return to homelessness); access/coverage (thoroughness in reaching persons who are homeless); and overall reduction in number of persons who experience homelessness. Under the HEARTH Act competitiveness for funding will be determined by the strength of the community outcomes and performance and not just on individual agency performance so it is imperative that there is a focus on increased performance, outcomes and collaboration among all partners in the local homeless system. The HEARTH Act requires communities to have a Plan to End Homelessness, which reinforces the importance of the work of the Charrette and the work the community will be doing to move this effort forward to ensure that Tippecanoe County is competitive for federal funding.

Recommendations

These recommendations represent ideas presented in the Fishbowl sessions that will have the most impact on ending homelessness in the communities of Lafayette, West Lafayette and Tippecanoe County through Solutions Beyond Shelter. Each issue area has a short introduction, followed by suggested action items. Additionally, recommendations have been prioritized and quick win opportunities have been identified with an asterisk (*).The report concludes with recommendations on implementation.

Issue Area Action Items

1. Housing – From Homelessness to Permanent Housing

Every year approximately 900 individuals in Tippecanoe County who face homelessness are served by agencies that provide shelter, transitional housing, permanent supportive housing, or supportive services to these households. Although the individuals and families served face unique situations and barriers such as mental and physical health challenges, substance use disorders, and unemployment or underemployment, they all share a common need to obtain and maintain permanent housing. In its efforts to meet this need as efficiently and effectively as possible, Tippecanoe County is joining communities across the nation who are working to ensure that the housing opportunities available match the needs of the population. "Right-sizing" the system in this way will require both creating additional units of housing and examining whether existing housing should be repurposed to better meet community needs.

1.1 *Use local data to determine need, number and types of permanent supportive housing units needed in the community Include point-in-time, current housing inventory, and HMIS data and identify specific housing needs for target populations such as homeless families, veterans, ex-offenders, medically vulnerable people, survivors of domestic violence, and others.

1.2 *Map current housing resources and eligibility requirements and identify barriers and gaps within the homeless resource system (Align with Recommendation 2.2). Based on the system-wide map, create a plan and timeframe to repurpose and right-size the housing resources to meet the needs of those experiencing homelessness. Repurposing examples include, converting temporary housing resources (shelter and/or transitional housing) to rapid re-housing and/or permanent supportive housing (PSH).

1.3 Create a community-wide intake, assessment and triage system to connect households experiencing homelessness and those at-risk to the most appropriate type of housing and level of support services needed (rapid rehousing, PSH, etc.) to assist them in maintaining housing. (Align with Recommendation 2.1).

1.4 Identify and pursue opportunities to increase behavioral health and primary health care services connected to permanent supportive housing to engage and provide long-term support to those individuals who are experiencing long-term homelessness and cycling throughout crisis response systems (i.e. hospitals, jails, prisons, detox).

1.5 Right-size the existing system of housing options by creating additional permanent supportive housing units targeted for the most medically vulnerable households and those cycling in and out of emergency systems who are not likely to obtain and maintain housing if not for this resource.

1.6 *Maintain and continue to build on and explore opportunities to increase project based rental subsidies for permanent supportive housing including working closely with the Lafayette Housing Authority, IHCDA, the Veterans Administration and other opportunities that arise.

1.7 Improve and further develop a rapid rehousing approach for households with fewer barriers and shorter-term needs including increased community capacity to provide case management services and pooled financial resources from organizations providing emergency and short-term rental assistance.

1.8 Work closely with the Lafayette Housing Authority and private landlords to identify and reduce barriers (i.e. credit and criminal background screenings) and create strategic partnerships between property management and service providers.

1.9 Create a landlord registry to share landlord contacts across programs. A registry will help build awareness of landlords to better understand local resources, how to access them, and the important role service providers can play in helping those who otherwise might be screened out because of poor credit history, previous evictions, lack of rental history and other similar barriers. Find opportunities to outreach and increase communication with landlords across the county and to develop strategies to address their concerns, such as creating a common fund for property damage to address concern that tenants who have experienced homelessness may damage their units. As well as partner with landlords to ensure that they distribute information regarding homeless prevention resources to those who are at risk of eviction to prevent this outcome. (Align with Recommendation 2.8).

1.10 Align existing support services with housing, identify gaps, and create new funding opportunities to fill the gap for services tied to housing. As households transition from homelessness to housing, supportive services and housing based case management is imperative in creating stable housing opportunities. Currently a lack of funding for non-Medicaid eligible services as well as limitations on which agencies can bill Medicaid Rehabilitation Option for services is a challenge for the existing Shelter Plus Care program. These funding issues will continue to be a barrier to seeking new rental assistance for those who are medically vulnerable and experiencing homelessness or for those with fewer barriers who just need shorter term assistance. Prioritizing the development of a funding stream for services not paid for through existing sources will assist in leveraging housing resources, reduce recidivism and provide care for those who are medically vulnerable and without housing and support will continue to use costly emergency systems of care. Target case management services to identify "hot spots" in the community where the greatest number of households fall into homelessness.

1.11 Explore opportunities to implement a peer support system and partnering with the faith based community in leveraging additional social support networks. Fostering natural supports and using the expertise of people who have experienced homelessness will strengthen support systems to assist people with accessing and maintaining housing while assisting them in meeting their goals.

2. Interagency Coordination and Access

For communities, coordinated or centralized access can help to reduce duplication of services and provide a clear picture of the entire scope of housing need. For consumers, having a clear access point or points can take the luck out of the system and facilitate their ability to access needed housing or services. Coordinating intake and assessment can also ensure that all consumers are treated equally in the system regardless of the agency or case manager with which they work and reduce the impact of barriers such as access to transportation. Under the HEARTH Act, communities will be required to have a coordinated and/or centralized intake and assessment process to connect the households at-risk and experiencing homeless to most appropriate housing intervention, i.e. prevention, shelter, permanent supportive housing, affordable housing, etc The following recommendations are provided to best meet the goal of creating a coordinated system and that removes the 'luck' of access to the appropriate services and housing.

2.1. Create and implement a coordinated intake, assessment, and triage system to connect people experiencing homeless or at-risk to the most appropriate resources based upon by agreed upon standards across the system and individual programs. The overall goal is to create a system that has 'no wrong door' meaning that it does not matter where a person enters the system; they have access to the same services and housing. Current tools available in the community such as 211, the Indiana Housing Options Planner and Evaluator tool (IHOPE), and the Homeless Management Information System (HMIS) should be utilized where appropriate. Based on a number of best practices and models around the country, there are a variety of ways that a coordinated system can be implemented in Tippecanoe County including the creation of a Housing Resource Center that households can access housing resources and a virtual, coordinated intake and assessment system with real-time availability of resources (i.e. shelter, transitional housing,

and permanent supportive housing beds, prevention and rapid rehousing resources). (See Appendix E for Examples of Best Practices).

2.2. **Map the current homeless response system** (to build on Recommendation 1.1 Housing Mapping). Through system mapping identify homelessness prevention, rapid re-housing, shelter, transitional housing, and permanent supportive housing resources; identify target populations and eligibility requirements; identify opportunities to remove/reduce barriers to access resources thereby reducing the number of hoops households have to jump through to access housing (i.e. are people being screened out of housing?); highlight duplication of services and utilize local data to identify gaps in services and housing resources. Based on map and duplication in services, explore and pursue opportunities to repurpose, align, and coordinate resources in a strategic and systematic manner to make the services easier to navigate. Repurposing examples can include – converting shelter resources to prevention and rapid re-housing resources; converting transitional housing to PSH or rapid re-housing resources; moving from site based case management to community based case management; and exploring potential opportunities to co-locate day and night sheltering with standard, consistent case management to assist households in moving to permanent housing as rapidly as possible.

2.3. **Develop and distribute clear and consistent messaging and marketing** on how to access services for households that are at-risk or experiencing homelessness.

2.4. ***Coordinate a Funder Collaborative consisting of homeless system funders** to align and leverage homeless assistance funding streams in the community including developing funding opportunities based on agreed upon community-wide metrics, performance measurements, outcomes, reporting requirements, and data requirements. Recommended funders include the Cities of Lafayette and West Lafayette, Tippecanoe County, United Way, Community Foundation, North Central Health Services, Indiana Housing and Community Development Authority, Division of Mental Health and Addiction, other possible State Agencies and the Indiana HUD field office.

2.5. **Assess capacity of current organization(s) to apply for and provide rental assistance** such as that funded through the Emergency Solutions Grant (ESG), Supportive Services for Veteran Families (SSVF), and HUD Continuum of Care Program and have this organization(s) coordinate and/or collaborate on securing and providing rental assistance for the community.

2.6. **Work with IHCDA to expand access to and use of HMIS, train front line staff to access shared data, access community-wide data and reports, and explore opportunities to simplify data entry** and upload documents such as birth certificate, social security information, homeless verifications, etc to speed up housing process. Explore opportunities to simplify and streamline data collection and documentation process including working with the Indiana HUD Field Office to move forward a paper-less system.

2.7. **Utilize best practices and national models to develop community-wide standards for homeless and housing based case management** to ensure consistency across agencies in the delivery of services provided and offer intensive training, capacity building, and networking opportunities for case managers. Working toward improving the quality of case management services offered across programs will result in better outcomes for people at-risk and/or

experiencing homelessness, along with additional learning and networking opportunities for service providers. In addition to focusing on ensuring that all case managers are able to appropriately connect clients with services, training should also focus on understanding the stages of change, motivational interviewing, strengths based approaches, harm reduction, trauma informed practices, and exploring relationship building techniques that will allow staff to best build relationships of trust with those which they work. Lastly, the importance of self-care for case management staff should be incorporated in any standards and related trainings. To begin establishing local standards, case managers from various agencies could be surveyed electronically to identify core components of case management and any improvements they would like to see across the community in case management services.

2.8. ***Coordinate with local landlords and supportive service providers system-wide** including developing a landlord registry; sharing landlord contacts across programs; building awareness of landlords to better understand local resources, how to access them, and the important role service providers can play; opportunities to breakdown current barriers to access housing such as credit and background checks, previous evictions, with the support of service providers; and explore opportunities to reduce risk of providing housing to households with high barriers to including rental damage pools. Additionally, IN Housing Now, a website rental housing database, could possibly serve as a resource to list and identify available housing units.

3. Health – Physical Health, Mental Health and Addictions

People who face homelessness frequently report significant health problems. Locally 66% report either substance abuse and/or mental health problems while 46% report chronic health conditions such as high blood pressure, diabetes or cancer. The stability of housing assists people with health conditions in their efforts to work toward achieving a greater level of wellness. For example, those who require a refrigerator

to store their medication are more likely to be able to be medically compliant if they have a home where they can access proper storage for their medications. Some health issues are also exacerbated by weather related conditions such as frostbite or pneumonia, and people living outside are subject to inclement weather and the negative effects on health that it brings. There are opportunities under the Affordable Care Act to coordinate services in the community to serve those who are the most medically

vulnerable. It is important that the community determines how to best address the needs of those who are medically vulnerable and who require housing to work toward recovery. Peer support can also play a critical role improving the health of others and should be utilized and strengthened at every opportunity. The recommendations below outline approaches that will assist the community in improving the system's ability to support the health of people who are experiencing homelessness and formerly experienced homelessness.

3.1 Explore establishing a centralized referral system across hospitals to standardize the admission process for Crisis Intervention Teams (CIT) for medical and psychiatric crises. There are three hospitals with referrals and beds being filled unevenly and unpredictably by emergency services, police, and emergency walk-ins. This makes coordinating mental health and medical aftercare for individuals experiencing homelessness more expensive and difficult for the homeless service agencies. This can help simplify coordinating admission, discharge planning, and arranging alternatives to hospitalization.

3.2 Create a peer run detoxification and respite center with an on-call doctor for support and a small amount of medical training for peer mentors to take blood pressure and other simple diagnostic procedures in support of the doctor on call with videoconference support. Currently the county does not have a detoxification program and providers drive people to other counties when this service is needed. Not having access to any services often results in the loss of housing, increased use of law enforcement and jails, and accidents that lead to emergency care. This is expensive for the county, while non-medical models are cheaper and are used with great success. There is often less resistance on the part of those requiring this service with the use of peers and an informal center can save a housing placement by giving a landlord and tenant an alternative time out during a time of crisis. The State of Georgia has developed a substance use recovery specialists curriculum and may provide good models for these programs. (See Appendix E for Examples of Best Practices).

3.3 Review the unmet and current need for psychiatric inpatient hospitalization and other alternatives to help people maintain housing. Chicago (the Living Room) has established peer run alternatives to the psychiatric hospital. Boston has a nationally recognized Peer Recovery Support Specialist Training that could provide certification and assist in creating a peer recovery support center and respite as an alternative to psychiatric hospitals. These can be used more flexibly in helping people to reduce symptoms during a crisis as medication is adjusted helping a person to maintain housing**.** Tippecanoe County will find this service cost effective to fund as it will give law enforcement and health care officials more flexibility in using longer term services at a relatively low cost allowing people to maintain housing and entitlements while stabilizing symptoms.

3.4 Work with Riggs (FQHC) and Wabash Valley (CMHC) to aggressively pursue mutually beneficial partnerships to serve those most in need. If either is unable to make services available we encourage the Homeless Prevention and Intervention Network (HPIN) to seek other partners who will, potentially via an RFP process. It has been very beneficial across the country to have a partnership formed between the local community mental health centers (CMHC) and the federally qualified health centers (FQHC). Clinical medical services and some psychiatric services are more profitably delivered by the FQHC while the community mental health center

claims all ongoing case management and additional support services. This helps to offset and lessen risk to both agencies while serving the most difficult, most treatment resistant, most expensive persons in the community who most benefit from long term consistent case management.

3.5 *Partner with IDOC and the jail to sign people up for Medicaid prior to being released and ensure that people are released with proper medication (if needed) and a plan for continued mental health and or addictions services. The Reentry Team should accept community reports of problems with the release of medication and explore gaps in medication provided upon release and develop solutions for any difficulties in the system.

3.6 Create opportunities for care coordination. The Affordable Care Act (ACA) will provide tremendous opportunities to position care coordination in the community and to explore ways to provide cost effective services to people experiencing homelessness. Tippecanoe County should seek opportunities and realign services to improve access and resources in the community.

3.7 Increase training of staff and the community about mental wellness and substance abuse disorders. Enlist the National Alliance for the Mentally Ill (NAMI) and Mental Health America (MHA) to offer training for supportive services staff so that those working with people experiencing homelessness understand mental wellness and substance abuse disorders and how to best work with people who suffer from one or both. Develop a consumer panel to help educate the community about mental health and substance abuse. (See Appendix E for Examples of Best Practices).

3.8 Train volunteers, peers, and paraprofessionals in primary care settings to help screen and collect information and a case history for a psychiatrist. There is a great deal of medical care that does not need to be provided by clinical staff. This is a cost effective way to collect additional intake data and background information into the record. They can assist in creating a triage system where brief screens can prioritize current needs, screen for additional preventative services, or assist in completing applications for government benefits.

3.9 Expand videoconferencing in Tippecanoe County. This technology needs further exploration in linking scarce medical professionals to hard to reach populations. Allowing easy access to a doctor on weekends is important in extending the reach and effectiveness of community support. Telemedicine, Tele-Case Management, and family services are all very important services for this group.

4. Homelessness Prevention

Experiencing homelessness is a very traumatic experience. Once a family or individual enters shelter, not only is it difficult to move out with a positive outcome, it is also an expensive intervention. Often times providing small amounts of prevention financial assistance, case management, and mediation can keep a household in their current housing and prevent homelessness and the associated trauma that is sustained while not having a permanent home. While many in the community are experiencing poverty, not all households in poverty are at imminent risk for homelessness and it is imperative that homelessness prevention resources are targeted at those that 'but for' the assistance will enter the

shelter system and/or live on the streets. There are a number of factors that cause a household to be at imminent risk including previous homeless episodes, young families, pregnant women, etc. Understanding who is at imminent risk of homelessness and designing strategies to respond to the needs of these households are both critical steps. Strategically offering resources to households that would otherwise fall into homelessness is a cost effective solution that involves the least amount of trauma for the household. The recommendations below outline approaches that will assist the community in reducing the number of people who become homeless and working to identify those who are the most at-risk of homelessness.

4.1. **Develop and implement a common, system-wide assessment for homelessness prevention resources** that is built into the coordinated intake, assessment and triage system and train front line case managers on how to access the system. (Align with Recommendation 2.1)

4.2. *** Analyze local data of current people experiencing homeless and their associated characteristics** to best identify the characteristics of the most imminently at-risk (such as presence of a disability and/or health related issues, young families, substance use issues, previous episodes of homelessness, encountered with jails/prisons, etc**)** and to best identify and target prevention resources for the most at-risk. Additionally, current prevention resource eligibility requirements should be mapped and compared to the needs to identify gap and opportunities to streamline.

4.3. **Explore and pursue opportunities to pool (some or all) homelessness prevention resources** to streamline these resources, reduce the difficulty in navigating the system, and create flexibility in mixing and matching resources to best benefit the client.

4.4. **Coordinate faith based homelessness prevention efforts** including opportunities to provide informal social support networks for households, coordinating transportation needs, assistance with moving, participation in pooling of prevention resources, and other activities that support preventing homelessness.

4.5. **Develop system-wide strategy to market homelessness prevention resources** and eligibility requirements to effectively reach households at-risk, landlords, employers, postal workers, school corporations, etc.

4.6. ***Educate and build capacity of local homelessness prevention providers and front line case management staff on various strategies and resources to prevent homelessness** through

diversion, conflict resolution, providing needed resources (food, cribs, etc), budgeting, and case management, in addition to financial assistance.

4.7. ***Create opportunities for case managers across agencies and programs to work collectively with shared clients** to streamline services provided, de-duplicate services, and ease the demands on the clients with multiple case managers, service and housing plans, employment requirements and explore utilizing HMIS to identify shared clients across providers, shared case notes and individual service and housing plans.

5. Re-Entry

Approximately 390 persons return from incarceration to Tippecanoe County every year. Many struggle to find employment because of their criminal record and other barriers. As well, over 8,000 arrests are made in Tippecanoe County per year involving some period of jail time. Those who are discharged from prison or jail who are unable to secure employment and housing often return to their same criminal situation that existed prior to their arrest or worse. Those who have the stability of housing and are able to secure an income are less likely to re-offend, making this solution both positive for the individual and the community. With such a large proportion of the re-entry population that faces homelessness battling mental illnesses and/or substance abuse disorders, enhanced discharge planning will greatly help those who require medication, Medicaid, and connections to behavioral health care. Such coordination begins with local and state agency partnerships and includes productive in-reach. The recommendations below outline approaches that will assist the community in addressing the housing and service needs of ex-offenders to assist in reducing recidivism to the correctional systems.

5.1. ***Establish a Tippecanoe Re-entry team to coordinate connecting people with a criminal background to housing, employment, and necessary services.** State Partners involved in this team may include the Department of Corrections, Indiana Housing and Community Development Authority, Department of Mental Health and Addictions, and Department of Workforce Development. Local partners could include probation and parole officers, recently released parolees and probationers, the Cities of Lafayette and West Lafayette, and providers representing social services needs, employment, and housing. In order to most effectively connect people with housing, employment, and services, in-reach will need to be conducted to begin the process of discharge planning prior to the person's discharge date.

5.2. ***Create a Tippecanoe County ecumenical task force to develop a coordinated faith based response for those in prison or jail.** The task force can work with the IDOC Chaplaincy Program to participate in mentoring, additional training, and discharge support for those persons returning to Tippecanoe County. This may include in-reach, outreach, community preparation, and ongoing community support for individuals leaving corrections.

5.3. **Coordinate discharge planning between IDOC, Court Services, and Tippecanoe County**. Tippecanoe County, Court Services, and IDOC should partner to work to share information on when people will return to Tippecanoe County and coordinate discharge planning in order to ensure access to housing. A small workgroup will explore IDOC errors in current out date

calculations and advocate for the changes needed to increase the accuracy and timeliness of current date calculations for the purposes of effective discharge planning.

5.4. **Increase housing opportunities by partnering with landlords and applying for targeted housing resources** from the Lafayette Housing Authority, the Indiana Housing and Community Development Authority and Continuum resources for this population in the community. Use data from system mapping process to make the case. Without targeted resources, this group does not always gain access to resources and a second chance. Prior to Tippecanoe County receiving resources, the Reentry Team needs to develop a strong group of assertive wrap-around services for any proposed target population with a plan for long term access to emergency and ongoing support services in order to make the case for the allocation of additional resources.

5.5. **Develop increased linkages and resources for CIT officers.** CIT officers need simpler procedures with a single point of contact within each of the major social systems (mental health, substance abuse, Department of Child Services, etc.). There is a need to refresh and expand linkages and agreements.

5.6. **Increase medical coverage in the jail.** Add 1.5 FTE licensed clinical social work staff and additional nursing staff to allow for 24-7 on-site medical staff to meet the emergency medical and ongoing pro-active discharge planning needed for an increasingly medically complex and behaviorally disordered population in jail.

5.7. **Reduce use of correctional and emergency services** through a partnering with Access to Recovery, the Reentry Team, and the FQHC for the criminal justice population who are experiencing homelessness and suffering from co-occurring mental illness and substance abuse. Over 80% of the homeless reentry population has a co-occurring substance use problem. This population often is difficult to serve, lacks health care and entitlements, and is excluded from housing supports. Currently, the state of Indiana has an Access to Recovery (ATR) Program targeting traditional and non-traditional recovery supports to this population. Tippecanoe County is not currently a designated county for these services. Both county and state officials should request from DMHA that Tippecanoe County become an ATR eligible county. The program requires that the counties develop a plan for sustainability for this resource once the federal grant runs out in 2 years. This population will be eligible for health care under the American Care Act (ACA) and as a newly eligible population will be allowed to receive an enhanced reimbursement rate with a 90% match. This is an opportunity for the County to prepare for a Federal Innovation for health care while immediately reducing the burden of this population on emergency services.

5.8. **Divert people experiencing homelessness from the criminal justice system** by increasing affordable long term housing resources, strengthening assertive Community Outreach for those suffering from a mental illness and ensure access to alcohol and substance use detoxification (or places to go to keep housing during a crisis). A number of promising models exist to deliver these services including peer support.

5.9. **Improve notifications to the community of an imminent release at the jail.** The Re-entry Team should work to improve the community's response to all jail releases. This will require more timely notification to the community of an imminent release at the jail. Due to modification of sentences, procedures should be set up in the court to have court clerks phone the jail of an imminent release

from the jail so that jail discharge social workers can immediately contact community staff for a quick response for those that are homeless upon release

5.10. **Advocate for the upgrade of the IDOC prison data system**, the Corrections Offender Management System, to better integrate with other systems and to allow prison staff to enter the information needed to coordinate discharge planning. The Prison system has an RFP to upgrade their DOS system computers. The local community has to emphasize the importance of this upgrade so that it will not get delayed. An improved data system will help eliminate a bottleneck in improving service delivery and coordination.

5.11. **Advocate with IDOC that no one is released from Prison system to shelter unless a path to permanent housing within 48 hours has been pre-arranged.** This would improve discharge planning for individuals leaving prison while also ensuring that services are available when they return to the community to support their ability to re-engage in employment and to reduce their recidivism rates and the impact this has on taxpayers.

6. Employment, Education and Training

Employment, Education and Training are critically important to ensuring that people experiencing homelessness are able to secure and maintain employment to support their families and be able to participate more fully in the life of the community, however the barrier of poor or limited work histories coupled with low wage jobs presents a challenge to self-sufficiency. The United Way calculates a family sustaining income as 200% of the federal poverty level. The 2012 poverty level for a family of 4 is $23,050 which would make a sustaining income for a family of four $46,100. A sustaining income would provide enough money for a household to afford housing, utilities, clothing, food and all living necessities without a subsidy. In order to earn $46,100, a household with two wage earners earning $7.25 (minimum wage) would require both wage earners to work 61 hours 52 weeks of the year. It is unlikely that most families could both access and sustain this level of employment while also caring for children. This means that it is imperative that the focus isn't solely on entry level jobs, but also on career pathways. More than 20% of Tippecanoe residents live in poverty. Training and educational opportunities for those who struggle to connect to viable employment is needed, and these opportunities must be accessible to them. Increasing the income of residents experiencing homelessness will decrease the reliance on subsidies and ensure that families are able to be as self-sufficient as possible. Tippecanoe County has strong employment, education and training partners that can assist the homeless system in helping people in move up the career ladder to increase their

income and therefore their ability to be self-sufficient. The County is also in the unique position of having a strong manufacturing industry. These two strengths offer potential and hope to help offset the challenge of poverty in the community. The recommendations below outline approaches that will assist the community in expanding employment, education and training resources to increase the income of people experiencing homelessness in Tippecanoe County.

6.1. ***Establish community voicemail program in Tippecanoe County.** A community voicemail system would ensure that job seekers have a method for receiving phone calls related to their employment search. Lack of a regular phone number is a barrier to employment that this would eliminate.

6.2. **Add local employment training and access resources to the HPIN Network.** In recognition of the importance of employment, education, and training to moving people from homelessness to housing and self-sufficiency, adding more representatives from these agencies would support greater collaboration and access for people experiencing homelessness.

6.3. **Develop a collaborative approach to increase the employment of people who are experiencing homelessness** among homeless system agencies, WorkOne, Lafayette Adult Resource Academy (LARA), Ivy Tech, the Tecumseh Area Partnership (TAP), and the Wabash Center. This would enable the community to better benefit from the rich local resources available.

6.4. **Develop pilot project with initial goal of employing 30 people connected to LARA and WorkOne's 10 career pathways and Ivy Tech's advancingmanufacturing.com.** Staff in homeless programs and supportive housing would identify potential applicants and the project would be marketed directly to people experiencing homelessness so they can also self-identify interest. Training would focus on available career pathways and participant's interest and the project would work with employers to connect to jobs. Set implementation timeline to ensure project moves forward in a timely manner.

6.5. **Develop day sleeping space for third shift workers** who are experiencing homelessness and connect housing assistance with these individuals within 30 days to support their stability. Currently there is no daytime sleeping option for this group of workers and it is important to support their ability to maintain their employment to help them move toward self-sufficiency and out of the homeless system.

6.6. **Create a Life Coach network** to support individuals who are homeless while they train and search for employment. One of the roles of the Life Coach would be to help job seekers connect to social networks of support to assist them in maintaining their job.

6.7. **Develop an Employment Communication Strategy** that includes approaches to informing case managers and people who are homeless of employment opportunities, resources, and documents needed for successful job search; outreach strategy using businesses who have successfully employed people who are homeless to their peers in business community to increase community participation; and work with Greater Lafayette Commerce to create strategies for increasing

employment opportunities within the business community and to hold an informational event for employers to learn about services that providers can offer their employees.

6.8. **Increase access to entry level positions** by mapping out and creating strategies for including low skilled and unskilled positions in the employment database, using Job developer to recruit for entry level jobs and creating network of 'survival' jobs that people can use for income while they are pursuing career path training.

6.9. **Create a supported employment program** to assist people who have multiple barriers to access employment opportunities. For people with multiple barriers the existing resources may not be enough to assist them in moving toward employment. Supported employment has proven to be very effective in connecting to employment people who need more support than traditional employment training system provides.

6.10. **Create personal data website where people who are homeless can keep and control their own data** and determine who they want to share it with. Documents needed for employment search could be kept on their website. This would eliminate some of the difficulties with permissions for information sharing and would give individuals control and access to their own data. There is potential that this could also help eliminate the duplication of information gathering among homeless service providers.

6.11. **Increase transportation options to support access to employment.** Explore volunteer support from churches, car sharing among co-workers, micro-enterprise business to provide transportation to work. Focus should start with employment options that do not have public transportation options to ensure that people experiencing homelessness can access these work opportunities

6.12. **Develop resources for free or subsidized child care to support head of household's ability to work** and secure income to support their family. Child care is the key to enabling parents to work. Minimum wage jobs do not support paying for child care. To assist parents in entering the workforce there need to be resources created that will ensure their children are cared for while they are working.

6.13. **Determine number of people who are homeless and working and create strategy to move them into housing within 60 days.** People experiencing homelessness who have an income have the potential to move into housing more quickly and to maintain it once housed. The stability of housing will assist them in maintaining their job and not returning to the homeless system.

6.14. **Ensure that the participants in the HIRE employment program are linked to housing and services.** This employment program is an important resource for ex-offenders and connecting participants to housing and services will decrease the potential for them to recidivate to the corrections system and will therefore decrease their potential impact on taxpayers

Implementation Recommendations

Solutions Beyond Shelter is an ambitious Plan to Prevent and End Homeless that includes two cities and a county and offers a path to build on the impressive earlier work of the Tippecanoe County community. This report outlines recommendations for the community. The next step for the Solutions Beyond Shelter team will be to take these recommendations and craft an action plan that will outline how they will implement these ambitious goals. Below are recommendations to ensure that implementation of the Solutions Beyond Shelter Plan has the impact the community both desires and deserves.

- ***Create infrastructure to implement the Plan.** The Core Group should determine infrastructure, but CSH suggests that they consider the following:
    - **The Core Group becomes the Plan Steering Committee** that provides oversight and guides implementation of the Plan. The Steering Committee would meet regularly to provide oversight and accountability to the Plan and to review progress on implementation.
    - **Hire Plan Coordinator.** This would be a half-time position (at a minimum) whose job would be to lead the Solutions Beyond Shelter Plan. This position should be housed in an organization that does not have perceived or real conflicts of interest in the process. The Plan Coordinator would be authorized to lead the work of the Plan, under the guidance of the Steering Committee. Their responsibilities could include writing the plan, updating the plan, writing quarterly updates for the community, coordinating work of the Plan and HPIN committees, and serving as the public face and contact for the plan. Foundations that support systemic change and bigger impact work would be appropriate places to approach for seed funding for this position.
    - **HPIN and subcommittees work on Plan Implementation.** There needs to be a structure for working on Plan implementation and HPIN and its committees offer an existing structure for community involvement and participation. Work on Plan implementation could be tasked to these existing committees, with new committees created as needed, to ensure work is being done to meet the ambitious goals of the Plan. The Plan Coordinator would work closely with these committees on Plan implementation.

- **Use Memorandum of Understanding (MOU) to guide the work of the plan** (MOUs for the Steering Committee, MOU for the Plan Coordinator and MOUs among HPIN members). MOUs should outline the details on expectations, alignment, funding to ensure common goals in Plan implementation.

- **Analyze composition of the Plan Steering Committee** to ensure that there is leadership from areas crucial to the Plan's success. Add members as needed to Steering Committee to ensure strong leadership of the Plan, (but err on side of stability when unsure if necessary). A strong and consistent Steering Committee is needed to lead implementation of a successful Plan.

- **Involve Consumers throughout the Plan implementation process and consider creating a Consumer Advisory Council** comprised of homeless and formerly homeless persons to ensure they have a voice in the Plan's implementation. A council that is led and directed by people who understand the causes and solutions to homelessness is of tremendous value to any Plan implementation effort.

- **Ensure data is collected in a consistent, community-wide and comprehensive manner and used to measure performance of programs, providers, and the community.** Data is critical to determining progress on the Plan goals and for advocating for sustaining and increasing resources at a local, state and federal level. To be effective it is essential that it is being collected in an efficient and coordinated manner and that the community has defined what success means and how to capture that with quantitative and qualitative data.

- **Measure community progress on Plan Implementation.** Use HEARTH Act performance measurements, Federal Plan to End Homelessness goals, IHCDA Planning Council measures and other funding requirements as guide to select common set of community metrics to measure progress on plan implementation.

- **Seek opportunities to apply collaboratively for funding** that will assist in meeting the goals of the Plan. To move the Plan forward it is essential that the community is nimble and collaborative in applying for competitive funding. The strongest applicant must apply to ensure that Tippecanoe County has the strongest chance of bringing new resources into the community.

- **Integrate cultural competency and language access components into program development and Plan implementation**. Require that all housing programs funded with community resources integrate cultural competency and language access components into program development and implementation, (for example, do management and service delivery methods and structure support people served?).

- **Engage elected officials in Plan implementation.** Identify opportunities to include elected officials in the process, from invitations to meetings to ribbon cutting ceremonies and ongoing discussions about the success of these efforts.

- **Create early wins.** When prioritizing recommendations, identify 'early wins' or those that can be accomplished relatively easily and lead to success. This will keep providers, funders, and consumers engaged and interested in the continuing work of the Solutions Beyond Shelter.

- **Turn recommendations into action.** This plan includes many recommendations, which may initially seem overwhelming. The Core Group/Plan Steering Committee should prioritize the recommendations and create an Implementation Action Plan *(See Appendix D for an Implementation Action Plan template and example*) which outlines the tasks, timeline and responsible parties. It is important to remember that while not all of the work can happen immediately, a plan creates a structure for the community to see when the work will happen and to keep efforts moving forward to ensure full implementation.

- **Continue to engage the community and build momentum.** Consider holding periodic public events to engage the community and celebrate the completion of goals. Look for opportunities to tie the work in Solutions Beyond Shelter to other important community issues such as early education, literacy campaigns, hunger, etc. to ensure that it is part of the larger community conversation and structure.

- **Identify like-size and similar community(ies) implementing a Plan to Prevent and End Homelessness** and build relationships to promote knowledge sharing.

- **Create advocacy strategies for Solutions Beyond Shelter** and work with other statewide entities to advocate for resources necessary to the success of the Plan. There are a number of recommendations that require advocacy at a local, state, and federal level. The Core Group/Plan Steering Committee/HPIN should continuously work to identify opportunities for advocacy and engage with elected officials and administrators to sustain and increase needed resources.

- ***Continue important work on issues not covered in the Charrette. The Charrette** focused on six key issues areas; however, it is clear that there are other important areas where work must continue in order to end homelessness. Include work on Opening Door goals to ensure your plan is in alignment with the national plan. Likewise it is important to stay flexible and open to new opportunities that may arise for veterans, youth, seniors, families, and other special populations. This plan is meant to bolster this important work to increase the communities' success.

Conclusion

It is an honor to present this report to the Solutions Beyond Shelter partners, key stakeholders, and all Charrette week participants. Through this intensive and inclusive community process, CSH witnessed the many strengths, opportunities and challenges in Tippecanoe County and the recommendations of this Report outline a plan for capturing and addressing them to assist the community in preventing and ending homelessness. This Report, and the Implementation Plan that the community will develop as a result, should be treated as living documents that are flexible and responsive to community needs as well as tools to evaluate efforts moving forward. Coming together as a community to create a plan to prevent and end homelessness is an audacious goal that at times may feel overwhelming, however Tippecanoe County has thoughtful, passionate, and committed leaders from elected officials, agency staff, government partners, individuals experiencing and at-risk of homelessness and many others to undertake the task of providing housing and services to the most vulnerable in the community. CSH used the notes collected through the fishbowl discussions, community feedback and observations to create the "word cloud" below (created via www.wordle.net). Within the word cloud the larger the word, the more often that word appeared in the notes taken during Charrette week. For the Tippecanoe County Charrette, the word "people" was used most frequently of any word, serving as a great reminder that this work goes beyond creating plans, housing options, appropriate services, discharge planning, and many other tasks, but most importantly it involves touching people's lives to help them access and maintain housing.

Tippecanoe Charrette: Solutions Beyond Shelter

Appendices

Appendix A – Charrette Core Group

Appendix B – Charrette Participant and Organization List

Appendix C – Expert and CSH Staff Biographies

Appendix D – Implementation Action Plan Template

Appendix E – Best Practices

Appendix F – USICH Developing and Implementing Strategic Plans to End Homelessness

Tippecanoe Charrette: Solutions Beyond Shelter

Appendix A – Charrette Core Group Members

Laura Carson	United Way of Greater Lafayette	lcarson@uw.lafayette.in.us
Dale Dixon	City of West Lafayette	ddixon@westlafayette.in.gov
Roger Feldhaus	Tecumseh Area Partnership	rfeldhaus@tap.lafayette.in.us
Doug Fletcher	Community Member	Notthe600@yahoo.com
Steve Horne	United Way of Greater Lafayette	shorne@uw.lafayette.in.us
Aimee Jacobsen	City of Lafayette	ajacobsen@lafayette.in.gov
Jennifer Layton	Lafayette Transitional Housing Center	jlayton@lthc.net
Adam Murphy	City of Lafayette	amurphy@lafayette.in.gov
Kim Murray	Greater Lafayette Commerce	kmurray@greaterlafayettecommerce.com
Tom Murtaugh	Tippecanoe County	tmurtaugh@tippecanoe.in.gov
Joe Seaman	Greater Lafayette Commerce	jseaman@greaterlafayettecommerce.com
James Taylor	United Way of Greater Lafayette	jtaylor@us.lafayette.in.us

Tippecanoe Charrette: Solutions Beyond Shelter

Appendix B – Charrette Attendees
Participants

1. Alison Baeker
2. Anthony Baker
3. Kelli Barker
4. Michael Barnes
5. Nora Barnett
6. Joni Biesecker
7. Pam Biggs-Reed
8. Gail Brock
9. Dia Brown
10. Katy Bunder
11. Monika Burgos
12. Laura Carson
13. Lillie Carty
14. Suzanne Clifford
15. Chris Cohee
16. Russel Cooke
17. Lana Cooper
18. Rick Cornstuble
19. Earl Cox
20. Rick Crawley
21. Albert Davis
22. Jeri Deleon-Lara
23. Britney Dickey
24. Dale Dixon
25. Jasmine Dowd
26. Richard DuCharme
27. Ed Dunn
28. Beverley Ebersold
29. Randy Fairchild
30. John Fallon
31. Joyce Fasani
32. Roger Feldhaus
33. Doug Fletcher
34. Jennifer Flora
35. Tiffany Floyd
36. Dustin Folden
37. Kathy Foresman
38. Mikel Fuller
39. Chris Galbreth
40. Damien Galloway
41. Lindsey Bishop Gilmore
42. Amanda Glidden
43. Terence Goodman
44. Cheryl Harmon
45. Margaret Haywood
46. David Heffner
47. Ginger Hopper
48. Steve Horne
49. Vida Hoyer
50. Jennifer Ingle
51. Major Jim Irvine
52. Carole Jackson
53. Aimee Jacobsen
54. Anne Jarrard
55. Jennifer Layton
56. Don Johnson
57. Chris Jones
58. Christopher Jones
59. Joe Kellogg
60. Kerrie Kikendall
61. Andrew King
62. Cris King
63. Sheila Klinker
64. Andre Lucas
65. Craig Lamb
66. Lowell Landrum
67. Veronique LeBlanc
68. Kay Lewis
69. Joy Ley
70. Laurie Mann
71. Criselda Marquez
72. Anne Martin

73. Serena Matchett
74. Trish Maxwell
75. Anne Maynard
76. Colleen McCammon
77. Jane McCann
78. Stephanie Mercier
79. Teresa Meyers
80. Joe Micon
81. Jillian Miller
82. Jim Morgan
83. Marie Morse
84. Kim Motuliak
85. Rick Mummey
86. Adam Murphy
87. Kim Murray
88. Tom Murtaugh
89. Mindy Niehaus
90. Sue Niemczyk
91. Deb Parent
92. Sue Parkinson
93. Cassie Payne
94. Jason Philhower
95. Lori Phillips-Steele
96. Judy Rechberger
97. Danielle Roberts
98. Ashley Rogers
99. Julie Roush
100. Mike Roush
101. Joe Seaman
102. April Schmid
103. Stephanie Sideman
104. Martha Shane
105. Erin Smith
106. Lisa Smith
107. John Smuch
108. Ilz Solomon
109. John Staley
110. Rodney Stockment
111. Karen Sullivan
112. Sue Svensson
113. James Taylor
114. Amy Thayer
115. Jane Vanable
116. Joe Vanable
117. Jerry Vance
118. Katrina Van Valkenburgh
119. Joanne Vorst
120. Kim Walker
121. Mary Waltz
122. Catherine Went
123. Kim Westen
124. Dawna Whitus
125. Leah Whitus
126. Fred Williams
127. Stephanie Wilson
128. Janet Winters
129. Amy Wood
130. Sheila Zborek

Charrette Attendees
Organizations

1. Area IV Agency on Aging and Community Action Program
2. Aurora Evansville
3. Bauer Family Resources
4. City of Lafayette
5. City of West Lafayette
6. Corporation for Supportive Housing
7. Court Services
8. Covenant Church
9. Department of Corrections
10. EA Staffing
11. Ellsworth-Romig
12. Fairfield Township Trustee's Office
13. Faith Church
14. Family Promise of Greater Lafayette
15. Food Finders
16. Greater Lafayette Commerce
17. Green Meadows International School
18. Homestead Consulting Services
19. Indiana Housing and Community Development Authority
20. Indiana Department of Mental Health and Addictions
21. Indiana Department of Workforce Development
22. Indiana State Parole
23. Inspiration Corporation
24. Inspiring Transformations, Inc.
25. Ivy Tech
26. Lafayette Adult Resource Academy
27. Lafayette Crisis Center and 211 Hotline
28. Lafayette Housing Authority
29. Lafayette Transitional Housing Center
30. Lafayette Urban Ministries
31. Mental Health America of Tippecanoe County
32. National Alliance to End Homelessness
33. Region 4 WorkForce Board
34. Riggs Community Health Center
35. Salvation Army
36. State of Indiana
37. Sycamore Springs
38. Tecumseh Area Partnership
39. Tippecanoe County
40. Tippecanoe County Veterans Services
41. United Way of Greater Lafayette
42. United States Interagency Council on Homelessness
43. Veteran's Office
44. Vocational Rehabilitation Services
45. Wabash Center
46. Wabash Valley Alliance
47. Weed and Seed
48. West Lafayette Police
49. WorkOne
50. YWCA Domestic Violence Intervention and Prevention Program

Tippecanoe Charrette: Solutions Beyond Shelter

Appendix C – Expert and CSH Staff Biographies

Kelli Barker, Special Needs Analyst with the Indiana Housing and Community Development Authority, has spent most of her life in central Indiana and has held a strong interest on issues of homelessness as long as she can remember. She has spent the last five years with Indiana Housing and Community Development Authority managing the Emergency Solutions Grant and implementing the Homeless Prevention and Rapid Re-housing program (HPRP). In working with HPRP for the duration of the program, Kelli has assisted subrecipients in navigating the intrinsic rewards and challenges involved in developing effective prevention and rapid re-housing programs in their communities.

After obtaining her B.A. from Indiana University in journalism, she left for Phoenix, Arizona to pursue her interest in homelessness issues to start a new fair-labor temporary employment program at a large, urban homeless shelter for those seeking to reintroduce themselves back into the workforce. This experience led her to obtain her Masters in Social Work from The University of North Carolina at Chapel Hill, where she spent time working on issues affecting those with developmental disabilities and Olmstead Act implementation. She has since spent several years with for Indiana University establishing a public health outreach program for the homeless and uninsured. She feels very fortunate to be able to work on an issue so important and in a position to support new programs and strategies that effectively prevent and end homelessness. Her other joys in life are teaching and practicing yoga, gardening, cooking, traveling and Jack Russell terriers.

Pam Biggs-Reed, the Chief Executive Officer of Bauer Family Resources Inc., has served in her current position for two years, providing leadership for this not-for-profit social service organization. Prior to becoming the CEO, she was the agency Executive Director for ten years. Pam is both a Licensed Mental Health Counselor and a Nationally Certified Counselor. She chairs the Our Kids are Our Community network, is a member of the Board of Directors of the Indiana Youth Services Association, and provides training to professionals and para-professionals including Court Appointed Special Advocates, Volunteers in Probation, and staff of the Cary Home for Boys.

Beverley Ebersold currently serves as a Regional Coordinator at the United States Interagency Council on Homelessness (USICH), a principal representative and bridge between the work of the full Council and states and communities. In this role, she is responsible for facilitating the strategic implementation of Opening Doors specifically in the upper Midwest and Northwest regions. Regional coordinators convene stakeholders at every level of government and with the private sector, encouraging implementation of strategies that maximize the impact of Federal resources and supporting strategic planning efforts. Regional Coordinators also disseminate information about proven practices, bridge linkages among communities, and share practical resources to support community efforts and foster momentum through shared knowledge and cross-community collaboration.

Beverley has extensive experience in supportive housing development, service design, delivery and coordination, working with Continuums of Care, and building local partnerships to end homelessness. She is currently a field instructor for both the University of Michigan and Wayne State University and is a doctoral student in Wayne State University's School of Social Work. Her previous background includes

coordinating blended management for a supportive housing non-profit developer, serving as program director of a homeless shelter, and providing supported education for persons with psychiatric disabilities. Beverley was hired to the CSH Michigan team in April 2006 and worked on capacity building and technical assistance with HUD grantees, strategic planning and restructuring of Continuums of Care, and convening stakeholders to promote the alignment of resources for person experiencing homelessness, with an emphasis on permanent supportive housing. She has a Masters Degree in Social Work with a concentration in Community Organizing & Administration from Wayne State University.

Roger Feldhaus has served in a variety of roles in the field of workforce development in the Greater Lafayette area over the past 32 years. In 2006 he became the Regional Operator for the workforce investment system in Indiana Economic Growth Region 4, which incorporates the Greater Lafayette and Greater Kokomo areas. Since 2011, workforce development activities in Region 4 have been governed by a 31-member Workforce Investment Board (WIB) through an agreement with the 12-county region's locally elected officials. Region 4 is known for the richness of its educational, industrial, and agricultural resources, and the quality of its workforce.
Roger's passion is to influence the transformation of workforce development from its 1930's supply-side labor economics model to the demand-driven model required in today's economy. This transformation will require better business intelligence gathering; enhanced applicant screening, assessment, and pre-referral services for employers; and the alignment of workforce development and educational resources with economic development priorities.

Doug Fletcher is a local businessman in Lafayette, Indiana. He graduated from WLHS and then attended Harvard College, beginning a promising bicoastal career as a comedy writer before severe mental illness spiraled him into homelessness - like Peyton with a football. He is in recovery, running helps, and has taken a B.S. in mathematics from Purdue University. He still writes when he is not practicing photography or tutoring calculus.

Jennifer Flora has served Mental Health America of Tippecanoe County, Inc., a not-for-profit organization and a United Way partner agency, for twenty-one years. She passionately believes in its mission of "Achieving better mental health in Tippecanoe County" and is an advocate for those with mental health challenges.

During her eighteen years as MHA's Chief Executive Officer she has observed the organization's growth and impact in our community, as exemplified by the construction of the MHA Day Shelter facility in 1997, renovation of the historic Potter House in 2004 which today houses the MHA Supportive Housing program, and the construction of the MHA Community Building in 2005.

As CEO of a local Mental Health America affiliate and a certified mental health executive, Jennifer oversees program development and implementation, as well as monitors each program's outcomes. Jennifer is responsible for preparing annual budgets, writing grants, supervising staff, working with the MHA Board of Trustees, maintaining compliance with affiliate agencies, and implementing all procedural policies of the MHA. Jennifer also stays aware of systemic and legislative issues impacting mental health services in our community and values collaborative efforts created specifically to meet the difficult and unmet mental health needs existing here in Tippecanoe County.

Vida Hoyer worked for the Lafayette Housing Authority for 25 years and is currently the Deputy Director. She held other positions including Secretary, Section 8 Clerk, Housing Inspector and Operations Specialist.

Ms. Hoyer developed and implemented the Security Deposit Loan Program which was awarded the 2007 National NAHRO Award of Merit for Program Innovation. She was awarded the State NAHRO 2008 Staff Member of the Year Award for the state of Indiana, and was instrumental in seeing the Lincoln Center Project-Based Voucher Program become a reality. As well, Ms. Hoyer is a member of HPIN.

Margaret Haywood, Director of Workforce Development for the Inspiration Corporation**,** graduated from Lawrence University in 1985 with a bachelor's degree in anthropology and French. She studied public service at DePaul University while already working in the field of social work. She has been working in workforce development since 1987, beginning with a job developer position at Vietnamese Association of Illinois. Margaret then worked as the Associate Director of the Cambodian Association of Illinois becoming more involved with training and employment. Margaret has worked with Project JOBS and Jane Addams Resource Corporation, agencies that specialize in employment and training for low-income and homeless populations.

Margaret joined Inspiration Corporation in 2002 with a varied background in job training, project development, fiscal management, and employment for special populations. For ten years, she oversaw the development of Inspiration Kitchens, a food service training program that uses two social enterprise restaurants to prepare people for returning to work. Margaret now oversees both of Inspiration Corporation's workforce development programs: Inspiration Kitchens and The Employment Project, which brings employment preparation and training workshops to shelters and agencies throughout Chicago.

Margaret serves as a Commissioner with the Uptown Special Services Area and is an active leader in the Uptown community. She is a past president of Organization of the Northeast and serves on the Board of Directors of Jane Addams Resource Corporation.

Majors Jim and Pat Irvine were appointed as leaders of The Salvation Army in Tippecanoe County in July 2010. Under their leadership, The Salvation Army has enjoyed dramatic growth in its services to the public such as the Tools for Schools and Winter Warm Up programs as a result of launching public media awareness campaigns. Preferring not to draw attention to themselves, the Irvines have quietly worked behind the scenes to strengthen The Salvation Army's relationships with other organizations and service providers in the community. Recently they organized and hosted the first Food Distributors Network Summit which summoned 30 representatives of food banks in Tippecanoe County to begin dialogue on best practices to meet the needs of poor and working poor families in our communities.

Over their 18 years as commissioned officers and ordained pastors of The Salvation Army, the Irvines have served in a variety of assignments throughout the central United States. While most of their service has been in co-lead commands under the structure of The Salvation Army whereby husband and wife are assigned to co-lead an area of service, a few have been separate commands. Major Jim served as Divisional Financial Officer in the Metropolitan Chicago Division while Major Pat served as youth Bible Study and Leadership coordinator before they were both assumed responsibility for all youth programming for The Salvation Army in the Chicago metropolitan area. In another assignment Major Jim served as the Director of Human Resources for The Salvation Army Adult Rehabilitation Centers Command, responsible for 3,500 full time employees in 11 states while Major Pat coordinated ministry candidacy services for The Salvation Army Central Territory.

While the Irvines have a proven track record in administrative leadership, their hearts and passions are deeply rooted in service to local community ministries. Prior to joining The Salvation Army as officers and

pastors, Major Jim worked 15 years in international computer communications in a variety of roles from engineering to marketing and sales. Major Pat was an elementary and middle school music teacher.

Jennifer Layton has been the Executive Director of Lafayette Transitional Housing Center for eleven years. LTHC is a non-profit organization which provides housing and supportive services to people who are homeless or at-risk of homelessness in our community. Jennifer earned a Bachelor's Degree from Purdue in Journalism and she has been with LTHC for a total of 18 years, working in a variety of direct services positions prior to being promoted to Executive Director.

During her tenure, the agency has grown from serving 9 families in their family transitional housing program, to now serving 15 families and 23 men and women in their transitional housing units, 24 men and women at the Lincoln Center permanent supportive housing program, over 300 people a year at the Supportive Services Program, and they operate the largest Food Pantry in Tippecanoe County which served over 6,000 people last year!

She is the current Chair of the Regional 4 Planning Council for the Homeless (Homelessness Prevention and Intervention Network). Jennifer also serves as a member of the Indiana Planning Council and is on the funding and strategies sub-committee. And, she has held the Chair of the Homeward Bound walk for the last three years.

Jennifer is a graduate of Leadership Lafayette, and serves on the United Way Director's Association of Greater Lafayette. In 2009, she received the Distinguished Citizen Award from the City of Lafayette.

Jane McCann has been Director of the Lafayette Crisis Center since 2006. She is a trained crisis hotline and information and referral phone specialist and trainer. She holds a bachelors degree in Psychology & Sociology from Franklin College and a Master's in Management from Indiana Wesleyan.

Prior to the Crisis Center Jane worked in nonprofit substance abuse agency as director of a court based program and was the founding director of a women's residential treatment program.

Joe Micon is the Executive Director of the Lafayette Urban Ministry. LUM is an organization of 42 Greater Lafayette area churches that serves as a social safety net for at-risk children and low-income families. He has a Bachelor's Degree in Applied Sociology from Purdue University (1980) and a Master of Social Work Degree from Indiana University (1983).

Joe is our retired Indiana State Representative from West Lafayette – serving two terms from 2004 to 2008. While at the Statehouse Joe served as Vice Chair of the Indiana House Education Committee. He is also past President of the Warren County Council, serving from 1998 to 2002.

He currently serves on the Indiana Lobbyist Registration Commission, has been a member of St. Thomas Aquinas Roman Catholic Church Parish Council, the Greater Lafayette Chamber of Commerce's Third House, the West Lafayette Rotary Club, the National Association of Social Workers, the Board of Directors of the Purdue University Warren County Cooperative Extension Agency, the Indiana University School of Medicine Lafayette Advisory Board, the Advisory Board for St. Vincent's Hospital in Williamsport and the Indiana Farm Bureau, a Junior Achievement volunteer in his children's school, and a youth baseball coach. He served on the Benton Community School Corporation's Textbook Adoption Committee, the Vision 2020 Education Roundtable, and the Warren County Child Protection Team. He has served on the Editorial

Board of the Lafayette Journal and Courier, the Indiana Native American Commission and on the Indiana Family and Social Service Administration's Select Welfare Reform Advisory Council.

His wife Jo is the Human Services Department Chair at IVY Tech's Lafayette Campus. They have 2 children, Katie 21, a Senior Biochemistry student at Purdue and Jonathan 18, a Freshman studying American History at Purdue.

Adam Murphy is the Weed and Seed Site Coordinator for the City of Lafayette, Indiana. He has 8 years of non-profit housing and community organizing experience with a community development corporation and Habitat for Humanity of Lafayette, in addition to 4 years' experience with Weed and Seed. He currently works with three supportive housing programs in Lafayette, including Shelter Plus Care for chronically homeless individuals with co-existing mental illness, substance abuse and/or HIV/AIDS. Other programs serve ex-offenders returning from incarceration and domestic violence victims and their children. He is the housing coordinator for the ReEntry Problem Solving Court as well as prior experience with a sex-offender problem solving court. These projects have provided supportive housing for 210 persons since 2008. Current projects in motion include collaborating with local agencies to establish a furniture bank network. He is completing a Master's of Science degree in Community Economic Development at Southern New Hampshire University.

Mindy Niehaus is the Discharge Planning Coordinator for Vanderburgh County's Ten Year Plan to End Homelessness, and the program director for the Welcome Home 82 Initiative; a Re-Entry Plan for returning ex-offenders.
Mindy began her career working with people with a chronic mental illness in an inpatient setting at Mulberry Center. There she was able to work with Terry Kellogg and Marvel Harrison doing work with co-dependency. She also was trained and certified to use yoga and meditation to work with clients who had extreme anxiety. Mindy was the director of Mulberry Center Players a community education theater troupe. She also spent time working with Dr. John Lennon, and children with bonding and attachment disorders. She spent three years working with the Department of Child Services, working with children and families. She has extensive work in community outreach and education. She worked with Weed and Seed doing prevention and education in neighborhoods that were targeted as high crime, low income.
She has spent the last five years doing community outreach and coalition development to address the needs of individuals leaving institutions into homelessness. With the help of the Re-entry Coalition, Corporation for Supportive Housing, and Indiana Housing and Community Development Authority, she developed and implemented a Re-entry Project. She has Bachelors in Psychology from University of Southern Indiana.

Rodney Stockment is the Community Services Director at the Indiana Housing and Community Development Authority. In this capacity, he maintains oversight of a variety of federal and state housing programs. The Community Services Department has also designed a tenant-based rental assistance program for the Tippecanoe County Reentry Court. Rodney is the lead for the State's Balance of State McKinney Vento Homeless Assistance application to HUD for Supportive Housing Program funds and has oversight of the state Homeless Management Information System. In addition to these programs, Rodney serves on the state's Indiana Planning Council on the Homeless and the Division of Mental Health and Addiction's Transformation Work Group. These inter agency efforts work to improve the delivery of housing and services to homeless individuals and families. Recently, Rodney is the architect of the Indiana Permanent Supportive Housing Initiative, which aims to reduce long-term homelessness through the development of permanent supportive housing over the next six years. Working with the Corporation for

Supportive Housing and Technical Assistance Collaborative, Rodney is the project lead to develop a service delivery and finance model for permanent supportive housing and develop a state policy on supportive housing as a means to end long-term homelessness and prevent homelessness for individuals discharged from state operated facilities.

Prior to coming to IHCDA, Rodney was the Executive Director of ECHO Housing Corporation in Evansville and earned his master's degree in Public Service Administration from the University of Evansville.

James Taylor is the CEO of the United Way of Greater Lafayette a role he has held since 2004. Prior coming to Lafayette, he served with United Way in Hagerstown, MD Tampa, FL and Denver, CO. He is a native of Blacksburg, VA, a graduate of Wake Forest University and Louisville Presbyterian Theological Seminary and a former hospital chaplain. He and his wife, Amy, have twin sons, William and Wesley.

Jerry Vance is currently the Executive Director of Programs for the Department of Correction. He has served as the Substance Abuse Program Director, as well as the Director of Mental Health and Behavioral Management. He currently oversees all DOC Programs and is also responsible for overseeing all Substance Abuse related services provided by the Department, which include: Outpatient Treatment Services, Therapeutic Communities, and CLIFF Units (Clean Lifestyles is Freedom Forever), Methamphetamine Treatment Units. The Department currently has nearly 1700 Therapeutic Community treatment beds. The Department current averages about 3300 offenders in treatment on any given day. Mr. Vance has been with the Department of Correction for over twenty years.
Mr. Vance has been in the treatment/social services field for over 30 years. Prior to his tenure with the Department, he has worked in both for-profit and not-for-profit treatment organizations. This experience has included adults, juveniles, and family treatment agencies. He possesses both a Bachelor's Degree and a Master's Degree in Psychology from Ball State.

Kimberly Walker is a Capacity Building Associate with the National Alliance to End Homelessness. In this role, she works with the Center for Capacity Building to help communities create, implement, and evaluate plans to end homelessness based on their specific needs. She is the Center's point person on issues related to coordinated entry, prevention, and diversion, and has assisted in projects all over the country ranging from ten year plan to development to survey assessment of consumer needs. Prior to joining the Alliance in 2010, Kim worked for Beyond Shelter, a non-profit doing Housing First with homeless families in Los Angeles, and contracted with HUD's Office of Community Planning and Development. She received a Master's degree in Urban Planning with a focus on Community Development and Housing from UCLA in 2009 and a B.A. from the College of William and Mary in 2006.

Fred Williams has served Hoosiers with disabilities since 1978 through his work with Indiana Vocational Rehabilitation Services, first as a vocational rehabilitation counselor in Columbus, then as Area Supervisor in Lafayette since 1986. He holds a BA degree in Social Science from Olivet Nazarene University, a Master's degree in Human Development from Governors State University, and is a Certified Rehabilitation Counselor (CRC). Prior to joining Indiana Vocational Rehabilitation Services, Fred practiced rehabilitation counseling in several community-based agencies in Chicago and in Columbus, Indiana.

Corporation for Supportive Housing Staff:

Lindsey Bishop Gilmore is a Senior Program Manager at the Corporation for Supportive Housing - Illinois Program. Lindsey has been with CSH since 2008, starting in the CSH Michigan Program. At CSH, Lindsey is responsible for systems-level policy work with government partners to increase the creation of permanent supportive housing. Prior to joining CSH, Lindsey worked for the Washtenaw Housing Alliance in Ann Arbor, MI providing oversight to the 10 Year Plan to End Homelessness implementation, coordinating the local Continuum of Care, and building and maintaining key partnerships between the city, county, state, and local service providers. Additionally, Lindsey worked in the Supportive Housing and Homeless Initiatives Division at the Michigan State Housing Development Authority providing technical assistance and financial underwriting for supportive housing developments; developing and overseeing special projects targeted for homeless families with children, chronically homeless, homeless youth, homeless veterans, and individuals with special needs; and coordinated and facilitated state workgroups on 10 Year Plan to End Homelessness implementation. Lindsey has a Master in Social Work degree from the University of Michigan and Bachelor in Social Work from the University of Kentucky.

John Fallon, B.S., is a Program Manager in Illinois at the Corporation for Supportive Housing (CSH) working as part of the Returning Home Initiative. This is a twelve million dollar 7-year national study designed to extend and develop the model of permanent supportive housing for those persons who are homeless and disabled and frequently cycling through the criminal justice system. John comes to CSH after eighteen years at Thresholds directing two specialized teams working to place people from Cook County Jail back into the community. Typical members had a history of 50 arrests, 20 psychiatric hospitalizations and decades of homelessness in their history. The success of this project has resulted in the American Psychiatric Association awarding this project with the national 2001 Gold Achievement Award for small community based programs. John has 25+ years of experience in the mental health field which includes providing residential and outreach services to adolescents, children, persons who are homeless, as well as persons in correctional and health care settings with a wide range of co-occurring barriers in addition to their being diagnosed with a wide variety of specific psychiatric disorders.

Stephanie Mercier is a Senior Program Manager with the Consulting and Training Team of the Corporation for Supportive Housing. In that role, she provides training, facilitation and technical assistance to organizations working to end homelessness throughout the country. Prior to joining Consulting and Training, Stephanie worked with CSH in the Illinois, Michigan, and Washington DC offices. In Illinois, Stephanie worked closely with the Illinois Division of Mental Health to increase the availability of permanent supportive housing for persons with serious mental illness. She also collaborated in the development of the CSH Housing Options Tool, an online tool designed to streamline the process of connecting individuals with the housing options that best meet their needs. Before coming to CSH, Stephanie was the Housing Coordinator for the Shelter Association of Washtenaw County where she administered the agency's Shelter Plus Care program. She also worked in various capacities with the Washtenaw Housing Alliance on its efforts to implement the ten-year plan to end homelessness in Washtenaw County. Stephanie has a Bachelor's degree in Psychology from the University of Michigan as well as a Master's in Social Work and Master's of Business Administration from that University.

Lori Phillips-Steele, the CSH Indiana Program Director, provides a range of training, technical support, and policy advisement services to the local supportive housing industry and partners with local funders to better coordinate resources for supportive housing in the state. She has over twenty years of experience working for Indiana government and non-profit programs that serve underserved populations including

people experiencing homelessness and people with HIV/AIDS, with an emphasis on supportive and affordable housing programs and model development. Prior to joining CSH in 2007, Ms. Phillips-Steele served as Program Manager at the Coalition for Homelessness Intervention and Prevention (CHIP); and as Director of the Indiana State Department of Health Division of HIV/ Sexually Transmitted Diseases.

Stephanie Sideman is a Program Manager for the Corporation for Supportive Housing in Indiana. Prior to coming on board in July of 2010, Stephanie was a direct service provider for nine years in Chicago. She provided supportive services for people experiencing homelessness or at risk at the Franciscan Outreach Association emergency shelter and worked as a Housing Locator at the EZRA Multi-Service Center. Stephanie earned her Bachelor of Arts from the University of Illinois and a master's degree in Social Service Administration from the University of Chicago, where her focus was on policy and systems change work. Having worked for the Chicago Housing for Health Partnership, a research study examining the effects of housing people who have chronic health conditions, Stephanie is particularly interested in promoting housing as a preventative health care measure for vulnerable populations.

Katrina Van Valkenburgh is a Managing Director at the Corporation for Supportive Housing. She oversees the Illinois, Indiana, Minnesota, Michigan and Ohio offices as well as work in the in the center of the United States. She was the first Director of the Supportive Housing Providers Association, a trade association of not-for-profit supportive housing providers in Illinois from 1995 through 2000. Katrina worked at Deborah's Place as their Director of Project Development and was responsible for the development and rehabilitation of three permanent supportive housing projects. One of these projects was selected for inclusion on the website for Design Matters: Best Practices in Affordable Housing and another was the 2007 2nd place recipient of the MetLife Award for Excellence in Affordable Housing. Prior to this position, she was the Associate Director of Development, responsible for all public grants, and the Program Administrator of Marah's, the Transitional Housing Program of Deborah's Place. Katrina was the Program Manager of the Permanent Supportive Living Program and Transitional Housing Program of Housing Opportunities for Women from 1990 to 1991. Her direct service experience includes managing group homes for teenage wards of the state, for adults discharged from state mental hospitals in Massachusetts, and working with people who were homeless at the Women's Lunch Place in Boston. Katrina has a BA in Sociology from Kalamazoo College and a certificate in Urban Development from the University of Illinois at Chicago, the College of Urban Planning and Public Affairs. She currently serves on the Community Investment Advisory Council of the Federal Home Loan Bank of Chicago, the Advisory Board of the Law Project and as Secretary of the Deborah's Place II and Deborah's Place III boards. Katrina received the Gem of the Community Award from archi-treasures in 2009.

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Appendix D – Implementation Action Plan Template

The Action Plan, at a minimum, should identify action steps associated with each goal and strategy. The action steps should directly correspond to outcome statements that define when the action is successful. The plan should include details such as the entity with lead responsibility, names of participants, and the timeframe for accomplishments. As your community develops its Action Plan, remember that repurposing existing committees can be a good way of utilizing existing efforts without creating redundancies.

The examples below are for the purposes of demonstrating the organization of an Action Plan only. Communities are encouraged to develop a plan for each goal in their 10 Year Plans. The Action Plan may include a higher level of detail or a greater number of action steps than the examples provided, but keep in mind that this is a summary document to be shared with multiple stakeholders. Detailed "to do lists" that evolve from the Action Plan can be maintained as separate documents. The Action Plan should be as clear and concise as possible in identifying the key actions and outcomes.

EXAMPLE – Based on Recommendations

Goal – Map the current homeless response system including homelessness prevention, rapid re-housing, shelter, transitional housing, and permanent supportive housing resources; identify target populations and eligibility requirements; identify opportunities to remove/reduce barriers to access resources (i.e. are people being screened out?, reducing the number of hoops households have to jump through to access housing); highlight duplication of services and utilize local data to identify gaps in services and housing resources. Based on map and duplication in services, explore and pursue opportunities to repurpose, align, and coordinate resources in a strategic and systematic manner to make the services easier to navigate.

Strategy	Lead	Key Participants	Time frame	Action Steps	Desired Outcome
Identify all the resources currently within the community for homelessness response to begin mapping the system	Plan Staff	Funders and providers of shelters, transitional housing, PSH, and prevention efforts Inclusion of people currently and formerly homeless to assist with mapping of resources	June 2012 – Sept. 2012	Identify all the funding resources in the community targeted to homelessness by surveying current providers.	Ensuring that all the funding sources and providers are at the table.
				Identify the uses of resources (financial assistance, case management, shelter, TH, PSH, etc) and funder restrictions	Identify what resources are currently in the community and rules/regulations that determine the use of funds to highlight opportunities for flexible uses.
				Share existing eligibility requirements and map applications and requirements	Identify barriers to access resources and initiate a community dialogue on program requirements and reducing eligibility requirements to funder minimum requirements
				Use information collected from steps outlined above to identify areas of duplication.	Identify areas of duplicate and opportunities to re-purpose community resources in a strategic manner

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Appendix E – Best Practices

Coordinated/Centralized Intake and Assessment

There are many resources and toolkits to assist think through the creation and implementation of a centralized/coordinated intake and assessment system. The NAEH has a Coordinated Assessment Toolkit with community examples that is very helpful in beginning local conversations and help guide a local decision making process.

NAEH Coordinated Assessment Toolkit www.endhomelessness.org/content/article/detail/4514 NAEH Coordinated Assessment Toolkit - Community Examples www.endhomelessness.org/content/article/detail/4532

Dayton-Montgomery County Coordinated Intake

Dayton-Montgomery County just recently went through a local decision making process and have been implementing a coordinated Front Door Assessment system for over a year. They serve as a good example of how to develop a system within a short period of time and using data to guide the process. Lastly, they have shared the lessons they've learned in moving toward a coordinated system that can inform the process locally.

Dayton-Montgomery County Front Door Assessment Presentation
http://www.slideshare.net/naehomelessness/210-joyce-probst-alpine-8637499

Kalamazoo Housing Resource Center

Housing Resources, Inc. was founded in 1982 as a non-profit corporation dedicated to finding housing solutions for individuals in the midst of a housing crisis as well as on behalf of the community at large. Their services are designed to stabilize homeless households and help those in jeopardy of losing their housing. Their website has sections to serve landlords as well as people who are experiencing homelessness or behind in their rent, or in the process of eviction, or are behind in their mortgage payments. Services offered include crisis intervention, housing stabilization, Rapid Re-Housing, Permanent Supportive Housing, Homeless Prevention and Affordable Housing Options. Landlords can use the site to connect to potential tenants, or to access their Eviction Diversion Program or Landlord-Tenant mediation services. Their Housing Stabilization Center helps people address problems that lead to their housing crisis. Professional case managers offer information, referrals and other homeless prevention services to renters and home-owners facing short-term crises. You can find out more about Housing Resources, Inc. at http://www.housingresourcesinc.org/i-am

Peer Respite Center

The Peer Support and Wellness Center, a project of the Georgia Mental Health Consumer Network was designed to fill an unmet need for ongoing ongoing peer support and wellness activities along with readily available respite stays during times of crisis. This model provides an alternative to jail and hospitalization. All Wellness Center services are provided at no cost to consumers, and admission to respite is contingent upon completion of the "Proactive Interview" to determine suitability for a stay and to begin developing a relationship. Respite guests stay in private rooms for up to seven nights. All peer staff are Certified Peer Specialists. Studies on the perceived benefits of peer-run support services have shown that participation in

these services yields improvement in psychiatric symptoms and decreased hospitalization (Galanter, 1988; Kennedy, 1990; Kurtz, 1988). In studies of persons dually diagnosed with serious mental illness and substance abuse, this intervention was found to significantly reduce substance abuse, mental illness symptoms, and crisis (Magura, Laudet, Rosenblum, Vogel, & Knight, in press; Magura, Laudet, Rosenblum, & Knight, 2002). Additional information about Peer Respite Centers as an alternative to hospitalization, along with a manual for creating hospital diversion programs like this one can be found at www.power2u.org.

Mental Health First Aid Training

Resources on providing Mental Health First Aid training is available on www.mentalhealthfirstaid.org/cs/become_an_instructor and can be very helpful in connecting staff to trainings on active listening, standardized case management training for agency, and peer support groups.

Jail InReach – Cook County

Trilogy, a behavioral healthcare agency, created an effective jail inreach model as part of the Frequent Users of Cook County Jail and Mental Health Services Project. As part of this project Trilogy placed a case manager in the jail who worked with targeted inmates with histories of cycling between homelessness, incarceration and the mental health system. The case manager engaged with inmates to develop a plan for post release services and linkages between inmates and participating mental health providers to support and guide their successful transition from jail to supportive housing. The case manager assessed targeted inmates personal, medical, social, emotional, and environmental status in order to plan for linkage and treatment course and provided individually-based motivational treatment to assist in their recovery from mental illness. Trilogy also offered a toll free linkage number as well as emergency phone triage to inmates to assist them in coordinating and linking with their identified follow-up provider. Housing is an essential part of the follow-up services.

Worcester, MA

Worcester, MA successfully tackled their goal of ending chronic homelessness within three years by moving the needle from 109 people to occasionally one or two. The Community Health Network and South Middlesex Opportunity Council worked collaboratively with the Home Again Planning Process of Worcester Task Force and the State Commission to End Homelessness. An additional partner included the Health Foundation of Central Massachusetts that funded the assessment center where the centralized intake process was conducted. This collaborative concluded that a paradigm shift to a Housing First/Rapid-Rehousing model was needed. The Home Again model included key strategies of (1) targeting individuals experiencing chronic homelessness through a centralized intake and assessment or triage system; (2) providing a 1:10 staff ratio in the early stages of individuals being housed and then increasing that number as clients began to stabilize; (3) fostering client choice in housing selection; (4) adapting the housing to the client's changing needs, and (5) ensuring timely access to treatment programs. The providers used a client-centered approach both in engagement and housing. As part of this process, the community repurposed existing resources for new needs and cost efficiencies. For example, a local organization transitioned from providing emergency shelter providing permanent housing solutions along with client centered services and linkages to resources. http://rootcause.org/documents/Homelessness-Issue.pdf

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Appendix F – USICH Developing and Implementing Strategic Plans to End Homelessness

United States Interagency Council on Homelessness

Preventing and Ending Homelessness in the United States

Developing and Implementing Strategic Plans to End Homelessness

The U.S. Interagency Council on Homelessness believes partnerships with local communities are more important than ever. There has been unprecedented collaboration among federal agencies to implement *Opening Doors.* We want to extend and support that strong collaboration to states and local communities.

This document is part of the USICH commitment to provide communities the support to develop and implement plans to prevent and end homelessness or realign their existing plans. It also helps define the roles key stakeholders, including Continuum of Care planning bodies, can play in such plans.

State and local officials, service providers, and local advocates are critical partners in achieving the goals in Opening Doors. Effective communities are implementing strategic plans to prevent and end homelessness tailored to their local needs. USICH strongly encourages the development and implementation of these plans; and they are a requirement of the HEARTH Act of 2009. Community-wide strategic planning is a pivotal step in ending homelessness and has been shown to demonstrably result in decreases in homelessness when the plans are well-crafted and implemented.

Many communities are familiar with Ten Year Plans, which have been advocated by local, state, and national organizations and the previous and current Administrations. For those who have established Ten Year Plans, Community Strategic Plans, or Continuum of Care Plans, USICH is encouraging them to both reassess their community's progress to the goals/objectives outlined in their plan and consider revisiting their plans to align with the subpopulations, goals, and timelines given in *Opening Doors* and with new opportunities outlined in the HEARTH Act. For those do not already have a Ten Year Plan, USICH calls on communities to develop a Community Strategic Plan to prevent and end homelessness guided by best practices and aligned with Federal goals.

USICH recognizes that each community has different strengths and resources, and that the planning process will vary by community. In some communities, Continuums are in the lead. In others, the community planning process will be led by jurisdictional leaders, in others the private sector. Whichever approach is used, all key community stakeholder leadership should be involved, including Continuum of Care and provider representatives. All should be important players in the process. Additionally, sharing data between the Continuum of Care, the Consolidated Plan jurisdictions (other jurisdictions) and other planning entities is strongly encouraged to have a more effective plan. There is no one right path to a comprehensive community plan.

Below, USICH provides some guidelines as a reference for your Community Strategic Plan leaders in development of the plan or in the review of your current Ten Year Plan. These guidelines emphasize the need in Community Strategic Plans for emphasis on all homeless populations, leveraging the use of mainstream resources, and including specific, measureable, and actionable goals in particular. The success of a Community Strategic Plan is found in collaboration between all stakeholders in the planning process to inform a plan for your specific community, no matter what the path is. With the participation of communities in Strategic Planning and in implementation, USICH envisions marked progress to preventing and ending homelessness in America. For those who have Ten Year Plans already in place and are beginning realignment, and for communities looking to begin development of a Community Strategic Plan, USICH encourages community plans to:

- Align with the Federal timelines for ending chronic homelessness and homelessness among Veterans by 2015 and homelessness among families, children and youth by 2020;
- Emphasize all homeless subpopulations – people experiencing chronic homelessness, Veterans, families with children and unaccompanied youth;
- Inform the plan by reviewing local Point In Time, HMIS, and other market/demographic data;
- Include strategies for leveraging the use of mainstream housing, services and funding to meet the needs of those who are homeless and on the brink of homelessness;
- Embrace strategies from *Opening Doors,* which are best practices/evidence-based practices
- Be informed by Continuum of Care leadership and providers and involve local government, political leadership, foundations, and the private sector;
- Invite action – with action plans that include specific steps, timelines, and responsible parties;
- Contain HEARTH Act required measures-- length of time homeless; recidivism (subsequent return to homelessness); access/coverage (thoroughness in reaching persons who are homeless); and overall reduction in number of persons who experience homelessness
- Include cost estimates and financing strategies;
- Contain measurable goals, performance indicators and targets that are reported on in accordance with HEARTH Act requirements; and
- Include a public relations/communications strategy to disseminate information on plan progress for education and advocacy proposes.

www.usich.gov