Core Service Report

Homeless Drop-in Centers

Consumer Category:
Basic Needs

Primary Consumer Group:
Persons or Households that are Housing Insecure

February 2007

TABLE OF CONTENTS

Companion Reports ii

Acknowledgements ii

Snapshot iii

I. Foreword 1
- Introduction 1
- Methodology 1

II. The Core Service Environment 3
- Core Service Environment 3
- Public Policy Issues 6

III. The Core Service Consumers 9
- Definition Of Target Population 9
- Demographic Characteristics 10
- Realized Access To Service 17

IV. Core Service Delivery 19
- Core Service Definition 19
- Background On Core Service 19
- Funding Of Core Services 26
- Identified Revenues 29
- Reimbursement/Cost 30

V. What Works; What Doesn't 31
- Impact On Individuals/Families 31
- Impact On Community 32
- Accreditations/Standards/Certifications 32

VI. Gap Analysis 33

VII. Summary 35

References 37

Attachments 39
- Attachment 1: Researcher Team 39
- Attachment 2: Technical Notes 40
- Attachment 3: Actual Consumer Demographics 48
- Attachment 4: Actual Consumer Zip Codes 50
- Attachment 5: Profile Of Core Service Providers – 2005 52
- Attachment 6: Providers And Functions – 2005 54
- Attachment 7: United Way - First Call For Help Requests – 2000-2004 55
- Attachment 8: United Way - First Call For Help Requests – 2000-2004: Unmet Need 57

COMPANION REPORTS

In addition to the information included in this report, a report of the other core services (80 in total), community leader key informant interviews, United Way - First Call for Help staff focus groups, consumer snapshots, and e-survey of United Way funded executive directors, board presidents, and United Way Community Investment staff are available at http://www.uws.org.

ACKNOWLEDGEMENTS

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SNAPSHOT

AIRS Code Level I: Basic Subsistence (B)
AIRS Code Level II: Housing (BH)
Core Service: Homeless Drop-in Centers (BH-180.350)

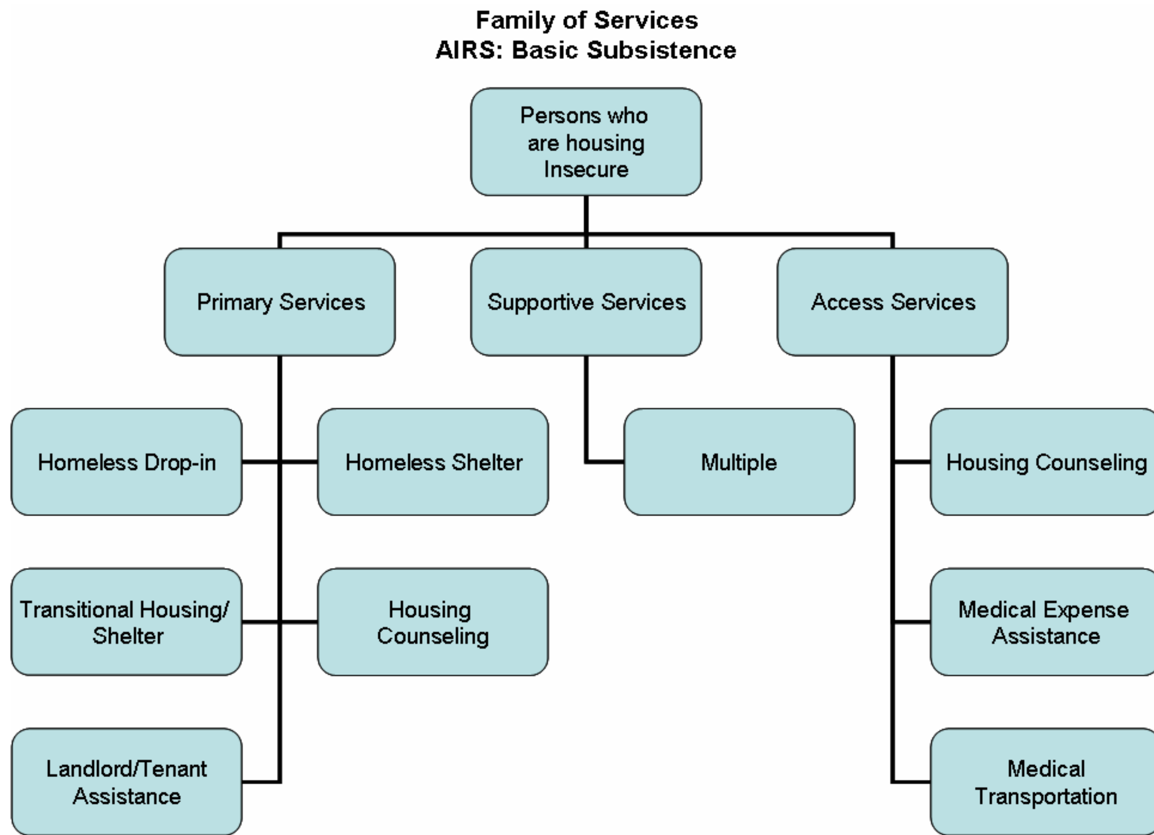
Investment Committee: Strong Families = Successful Children
Cluster: Basic Needs

AIRS Definition: Programs that provide a center where homeless people can spend time during the day. The center may provide counseling and/or medication, monitoring on a formal or informal basis; facilities for showering, napping, laundering clothes, making necessary telephone calls or attending to other personal needs; and/or other basic supportive services. Some centers may also provide food or facilities for cooking.

Special Note: There are three reports that deal with homeless services. The consumers of each are distinguished as follows:

- **Homeless Drop-in Centers**: the unsheltered homeless.
- **Homeless Shelters**: sheltered homeless persons of all ages who have no permanent housing and need a temporary place to stay.
- **Transitional Housing/Shelter**: sheltered homeless persons needing extended shelter (longer than two weeks but typically sixty days or more) and who indicate a willingness to participate in developing and implementing a case plan with a goal of eventual independent living.

The Homeless Drop-in Center Program is part of a family of services for persons who are housing insecure. It is one of five services targeting this consumer group. In addition, there are three services that help this consumer group access needed services. (See figure below.)



Core Service Environment
Along with street outreach teams, health care for the homeless networks, stationary (soup kitchens), and mobile (vans) food programs, drop-in centers are a primary service entity that caters to unsheltered homeless persons, The U.S. Department of Housing and Urban Development (HUD) estimates that one-quarter to one-third of the homeless are unsheltered.

As a funder and policy maker, the federal government drives much of what takes place with homeless services at the local level. With the enactment of the Stewart B. McKinney Homeless Assistance Act of 1987, Congress recognized the need to supplement "mainstream" federally funded housing and human services programs with funding specifically targeted to assist the homeless. Because of the complexity of providing services for homeless individuals and families, the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council, was established. It consists of the Departments of Housing and Urban Development (HUD), Health and Human Services, Veterans Affairs, Agriculture, Commerce, Education, Energy, Justice, Labor, and Transportation as well as the Social Security Administration and the Federal Emergency Management Agency.

As a primary funder of homeless services, the strategic direction established by HUD is of utmost importance. HUD's FY 2006 to FY 2011 strategic plan's objective is to end chronic homelessness and move homeless families and individuals into permanent housing. This plan has driven the local

agenda and has resulted in a joint effort with a ten year plan to prevent homelessness and expand affordable housing in Cleveland and Cuyahoga County.

Deinstitutionalization policies that pervaded the United States from the mid-1960s to mid-1980s resulted in the closure of many state-supported mental hospitals. These patients were discharged into local communities where the mental health infrastructure was ill-equipped to care for them. Some of these persons are now among the chronically homeless. Ohio's elimination of general assistance programs in the 1990s further exacerbated economic challenges for populations at risk of homelessness.

Core Service Consumers
The target population addressed in this core service is the unsheltered homeless, an estimated 31 percent of the total homeless population. According to HUD, an unsheltered homeless person resides in a place not meant for human habitation—cars, parks, sidewalks, or abandoned buildings ("on the street").

Despite the almost ten-year time lag in new data for the National Survey of Homeless Assistance Providers and Clients (NSHAPC), it is still considered to be the most comprehensive data set available on the homeless population. A look at the NSHAPC findings illustrates (McCarty, 2005):

- Homeless are predominantly male (68 percent), non-white (53 percent), and never married (48 percent).
- Veterans represent 23 percent of the homeless population.
- Over one-third had not received their high school diploma.
- Homeless families, defined as a client with one or more children, accounted for 34 percent of those served in homeless assistance programs.
- The homeless defined their top needs as finding a job (42 percent) and finding affordable housing (38 percent).

In 2003, Cleveland State University's Maxine Goodman Levin College of Urban Affairs estimated that approximately 16,000 persons were homeless at some time during the course of a year in Cuyahoga County. The Northeast Ohio Coalition for the Homeless (NEOCH) estimated that nearly 26,000 people are homeless in Cuyahoga County every year and that 3,900 are homeless on any given night. This includes the shelter population of 2,100 people, along with approximately 1,800 sleeping on the streets, staying under bridges and overpasses, or living in abandoned buildings (Heading Home, 2005).

In January 2005, a point-in-time count of homeless persons in Cuyahoga County suggests there were over 2,208 homeless persons (Cuyahoga County Office of Homeless Services, 2005). Of these, 1,208 were in emergency shelters, 776 were in transitional housing, and 224 were unsheltered and living on the street. Eighty-seven percent of the un-sheltered emergency homeless who are potential users of Homeless Drop-ins are considered chronically homeless and close to four out of five have a chronic substance use disorder. More than half are severely mentally ill and more than a third are veterans (Cuyahoga County Office of Homeless Services, 2005).

Core Service Delivery
The definition of homeless drop-in centers for this report is: programs that provide a center where unsheltered homeless people can spend time during the day. The center may provide counseling and/or medication, monitoring on a formal or informal basis; facilities for showering, napping,

laundering clothes, making necessary telephone calls or attending to other personal needs; and/or other basic supportive services. Some centers may also provide food or facilities for cooking.

Along with homeless shelters and transitional housing, homeless drop-in centers are part of the continuum of services that provide a comfortable, safe, and non-threatening place where homeless persons can find mutual support and advocacy on behalf of their needs. Generally open seven days a week, the centers offer a variety of social and educational opportunities for its members. There are typically a few paid staff, some stipend positions, and volunteers.

A recent Substance Abuse and Mental Health Service Administration (SAMHSA) (2003) study pointed out a number of service system challenges, primarily focusing on homeless persons with serious mental illness and/or co-occurring substance use disorders. These issues include funding restrictions and preference of service providers to institutional locations for service delivery, and the complexities of navigating a fragmented funding and service delivery system.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 6 homeless drop-in center program providers operating from 7 different sites, 1 of which is government and 5 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded one provider. FCFH call data shows a substantial decrease in the total number of requests for homeless drop-in center programs in the county: from 1,063 in 2000 to 156 in 2004 (85 percent decrease). Over the same five-year period, FCFH had 2,650 requests for information about homeless drop-in center programs. Of these requests, they were able to make referrals to 99 percent of callers.

The major sources of government funding for homeless drop-in centers are: the Emergency Shelter Grant Program, FEMA's Emergency Food and the Shelter National Board Grant Program. No Cuyahoga County general revenue funds go to supporting drop-in centers.

As of May 11, 2006, $291,469 in revenues for homeless drop-in center programs has been identified countywide. This includes information from foundations; federated fundraising organizations; regional, county, and municipal government; and United Way of Greater Cleveland. Thirty-six percent of the revenues are from foundations. United Way of Greater Cleveland significantly contributes to this core service through Investment Committee allocations and designations (57 percent).

An Internet search showed that most drop-in centers charge between $0 and $5 per visit. Much of the actual cost is offset through donations.

What Works; What Doesn't

The National Alliance to End Homelessness' "Sourcebook on Family Homelessness" states that drop-in centers are effective at engaging homeless men and women who would not ordinarily access the shelter system (National Alliance to End Homelessness, 2005).

A study by Tsemberis et al. (2003) conducted two experimental studies of programs meant to reduce homelessness for persons with mental illness and often substance abuse. Homeless participants were randomly assigned to programs that emphasized consumer choice or to the usual continuum of care in which housing and services are contingent on sobriety and progress in treatment. They found that a drop-in center that eliminated barriers to service access was more successful than the control programs in reducing homelessness. However, after 24 months only 38 percent of participants had moved to community housing. A subsequent apartment program that placed the experimental group individuals in subsidized apartments directly from the street, with services

under their control, had 79 percent in stable housing (compared to 27 percent in the control group) at the end of 6 months. Groups in this study did not differ on substance abuse or psychosocial outcomes.

In a New York City study, homeless people were found to spend an average of four days longer per hospital visit than their non-homeless counterparts, with extra costs totaling over $2,400 per hospitalization (Salit, Kuhn, Hartz, Vu, and Mosso, 1998). The National Alliance to End Homelessness cited prison and jail expenses as a further cost of homelessness, with typical cost of a prison bed in a state or federal prison at roughly $20,000 per year. In addition, the emergency housing of homeless men and women is expensive. The cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants program was over $8,000 in 1994, which was more than the average annual cost of a federal housing subsidy (National Alliance to End Homelessness).

Gap Analysis

An estimated 4,960 homeless persons need homeless drop-in center programs and, based on available information about actual consumers, approximately 6,366 persons have realized access to homeless drop-in center programs. This suggests that 1,086 persons more than the estimated number in need are being served.

I. FOREWORD

INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community's safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of "safety net" services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn't work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve dare located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

For purposes of clarity in these reports, the consumers of homeless drop-in centers are the *unsheltered* homeless.

Since the colonial era, there has always been a segment of the American population living without permanent dwelling. After the Civil War in the 1860s, discharged war veterans and immigrant laborers swelled the number, especially during the Great Depression in the 1930s. In the main, this population was referred to as "hobos," tramps or transients. The term "homeless" first entered the mainstream lexicon in the late 1970s, when America observed a startling increase of people forced to live on urban streets. The phenomenon was seen as a shocking aberration, garnering media attention and causing public outcry. Today, many Americans are resigned to it as an unchanging feature of the social landscape.

A single definition of homelessness is not available. However, most federal programs define a homeless individual as someone who lacks a fixed and night-time residence, or whose primary residence is a supervised public or private shelter designed for temporary living, an establishment accommodating persons intended to be institutionalized, or a public or private place not designed for—or ordinarily used as—a regular sleeping accommodation for human beings.

According to HUD, drop-in centers are a primary service entity that caters to unsheltered homeless persons, along with street outreach teams, health care for the homeless networks, and stationary (soup kitchens) and mobile (vans) food programs. An unsheltered homeless person resides in a place not meant for human habitation—cars, parks, sidewalks, or abandoned buildings ("on the street"). HUD estimates that one-quarter to one-third of the homeless are unsheltered.

Two major and influential studies on the homeless population have been conducted. The first was the 1996 National Survey of Homeless Assistance Providers and Clients study (NSHAPC, 1999). It was designed and funded by 12 federal agencies that comprise the Interagency Council on the Homeless and was analyzed by the Urban Institute. The second study was done by the U.S. Conference of Mayors in 2004.

Despite the almost ten-year time lag in new data for the NSHAPC, it is still considered to be the most comprehensive data set available on the homeless population. A look at the NSHAPC findings illustrates (McCarty, 2005):

- Homeless are predominantly male (68 percent), non-white (53 percent), and never married (48 percent).
- Veterans represent 23 percent of the homeless population.
- Over one-third had not received their high school diploma.
- Homeless families, defined as a client with one or more children, accounted for 34 percent of those served in homeless assistance programs.
- The homeless defined their top needs as finding a job (42 percent) and finding affordable housing (38 percent).

The National Survey of Homeless Assistance Providers and Clients (NSHAPC, 1999) identified roughly 40,000 homeless assistance programs in 21,000 service locations throughout the United States, including food pantries (9,000); emergency shelters (5,700); transitional housing programs (4,400); soup kitchens (3,500); outreach programs (3,300); and voucher distribution programs (3,100). Nonprofit agencies predominantly operated the homeless assistance programs (85 percent)—51 percent of these were run by secular nonprofits, 34 percent by faith-based nonprofits, and 14 percent by government agencies (McCarty, 2005).

Both practice and public policy have changed, reflecting new models of service delivery for the chronically homeless based on a premise of "Housing First," and addressing sobriety and mental health second. Research has tested and confirmed these assumptions. The new Housing First approach is driven by consumer preference and has become the cornerstone of the U.S. Department of Housing and Urban Development's (HUD) policy on homeless services. For some time, according to Tsemberis et al. (2004), the predominant service delivery model utilized with the chronically homeless population, was called the continuum of care. It begins with outreach, includes treatment and transitional housing, and ends with permanent supportive housing. According to the model, outreach and transitional residential programs were the first steps in the process aimed at:

> …enhancing clients' "housing readiness" by encouraging the sobriety and compliance with psychiatric treatment considered essential for successful transition to permanent housing. This approach assumes that individuals with severe psychiatric disabilities cannot maintain independent housing before their clinical status is stabilized. Furthermore, the model presumes that the skills a client needs for independent living can be learned in transitional congregate living. Research in psychiatric rehabilitation indicates, however, that the most effective place to teach a person the skills required for a particular environment is within that actual setting (Blanch, 1989).

According to Tsemberis et al. (2004), consumers had a different and less positive perspective on the continuum of care model:

> Consumers experience the Continuum as a series of hurdles—specifically, ones that many of them are unable or unwilling to overcome. Consumers who are homeless regard housing as an immediate need; yet access to housing is not made available unless they first complete treatment. By leveraging housing on participation and treatment, continuum program requirements are incompatible with consumers' priorities and restrict the access of consumers who are unable or unwilling to comply with program terms. In addition, most consumers prefer to live in a place of their own rather than in congregate specialized housing with treatment services on-site (Carling, P.J., 1993; Ridgeway, 1990). Most programs have rules that restrict clients' choices and that when violated are used as grounds for discharging the consumer from the program. For example, despite having attained permanent housing, clients who relapse and begin to drink mild or moderate amounts of alcohol, may be evicted if the program has strict rules about sobriety maintenance. The chronically homeless population is characterized by its frequent inability to gain access to existing housing programs. Individuals in this group often have multiple disabling conditions, especially psychiatric conditions and substance abuse (Kuhn, 1998). Most programs are poorly equipped to treat people with dual diagnoses, let alone

prepared to address their housing needs (Hurlburt, 1996). Treatment requires time and commitment and is often not available if a program is under pressure to move clients along a continuum (Minkoff, 2001).

The loss of control over one's life resulting from housing instability, frequent psychiatric hospitalizations, and intermittent substance abuse treatment leaves some consumers mistrustful of the mental health system and unwilling to comply with demands set by providers (Howie, 1990). Others prefer the relative independence of life on the streets to a fragmented treatment system that inadequately treats multiple diagnoses or addresses housing needs (Asmussen, 1994; Osher, 1996). Paradoxically, consumers' reluctance to use traditional mental health and substance abuse services as a condition of housing only confirms providers' perceptions that these individuals are "resistant" to treatment, not willing to be helped, and certainly not ready for housing (Lowell, 1998).

The Housing First model was developed by Pathways to Housing to meet the housing and treatment needs of this chronically homeless population. The program is based on the belief that housing is a basic right and on a theoretical foundation that includes psychiatric rehabilitation and values consumer choice (Tsemberis, et al., 2003). Pathways is designed to address the needs of consumers from the consumer's perspective (Shern, et al., 2000). Pathways encourages consumers to define their own needs and goals and, if the consumer so wishes, immediately provides an apartment of the consumers' own without any prerequisites for psychiatric treatment or sobriety. In addition to an apartment, consumers are offered treatment, support, and other services by the program's Assertive Community Treatment (ACT) team. ACT is a well defined community based interdisciplinary team of professionals that includes social workers, nurses, psychiatrists, and vocational and substance abuse counselors who are available to assist consumers 7 days a week 24 hours a day. The Pathways program has made two modifications to the standard ACT model: a nurse practitioner was included to address the considerable number of health problems, and a housing specialist was added to coordinate the housing services. Although housing and treatment are closely linked, they are considered separate domains, and consumers in the program may accept housing and refuse clinical services altogether without consequences for their housing status. There are two program requirements: tenants must pay 30 percent of their income (usually Supplemental Security Income [SSI]) toward the rent by participating in a money management program, and tenants must meet with a staff member a minimum of twice a month. These requirements are applied flexibly to suit consumers' needs. (Tsemberis, 1999)

Consistent with the principles of consumer choice, Pathways uses a harm-reduction approach in its clinical services to address alcohol abuse, drug abuse, and psychiatric symptoms or crises. At its core, harm reduction is a pragmatic approach that aims to reduce the adverse consequences of drug abuse and psychiatric symptoms (Inciardi and Harrison, 2000). It recognizes that consumers can be at different stages of recovery and that effective interventions should be individually tailored to each consumer's stage (Prochaska, 1992). Consumers are allowed to make choices—to use alcohol or not, to take medication or not—and regardless of their choices they are not treated adversely, their housing status is not threatened, and help continues to be available.

Continuum of care supportive housing programs subscribe to the abstinence-sobriety model based on the belief that without strict adherence to treatment and sobriety, housing stability is not possible. But studies examining the model's effectiveness report only modest results in achieving housing stability for individuals who are chronically homeless and mentally ill (Lipton et al., 2000). Alternatively, the approach used by the Pathways program assumes that if individuals with psychiatric symptoms can survive on the streets then they can manage their own apartments. The program posits that providing a person with housing first creates a foundation on which the process of recovery can begin. Having a place of one's own may—in and of itself—serve as a motivator for consumers to refrain from drug and alcohol abuse.

PUBLIC POLICY ISSUES

NATIONAL

Federation Regulations

McKinney-Vento Act

Congress enacted the Stewart B. McKinney Homeless Assistance Act in 1987 in response to the homelessness crisis that had emerged in the 1980s. This act recognized the need to supplement "mainstream" federally funded housing and human services programs with funding specifically targeted to assist homeless people. Over $11 billion in McKinney funds have been appropriated since then, and billions more have been provided through other federal, state, and local programs and benefits. Renamed the McKinney-Vento Act in 2000, the act authorizes funds for a small set of federal homeless assistance programs, including four administered by HUD: Emergency Shelter Grants (ESG); Section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings for Homeless Individuals (SRO); Shelter Plus Care (S+C); and the Supportive Housing Program (SHP). Collectively, these programs are known as HUD McKinney-Vento Homeless Assistance Programs and are the key source of federal funding for homeless assistance programs (National Low Income Housing Coalition, 2006). SRO, S+C, and SHP are known collectively as the Continuum of Care Homeless Assistance under HUD's Super NOFA (notice of funds available) grant process, a consolidated process for awarding grants that stresses local coordinated plans and the development of comprehensive assistance. Homeless drop-in centers meet the criteria to receive grants from HUD McKinney-Vento Funds only through the Emergency Shelter Grant program.

In 2000, HUD realigned its funding policies to focus on permanent housing. As a primary funder of homeless services, the strategic direction established by HUD is of utmost importance. HUD's FY 2006 to FY 2011 strategic plan's objective is to end chronic homelessness and move homeless families and individuals into permanent housing.

> HUD is committed through its Continuum of Care to ending chronic homelessness. HUD's working definition of a person experiencing chronic homelessness is an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has had recurring episodes of homelessness. Estimates of the number of persons experiencing chronic homelessness range from 150,000 to 200,000. Even when housing is available, disabilities sometimes make it difficult for chronically homeless persons to remain in that housing for long periods unless they also have supportive services, including case management and regular healthcare.

While those experiencing chronic homelessness are often the most visible of the homeless population, there are also substantial numbers of families and individuals who experience a more temporary crisis, such as loss of employment or eviction, and become homeless. HUD's approach to replacing homelessness with housing stability relies on three coordinated efforts:

- Preventing homelessness;
- Developing permanent and transitional housing for both those persons experiencing chronic homelessness and the growing numbers of homeless families;
- Coordinating housing assistance with supportive services.

Given the variety of individual needs and locally available resources, communities are in the best position to design strategies to help each homeless person and family achieve permanent housing and self-sufficiency. HUD's homeless assistance programs will continue to foster local initiatives by providing flexibility while providing incentives to meet important national objectives, including ending chronic homelessness.

HUD allocates the federal government's largest amount of targeted homeless assistance under the McKinney-Vento Homeless Assistance Act through its annual Continuum of Care (CoC) competition and by formula through the Emergency Shelter Grants program. Communities also address homeless needs through the use of CDBG, HOME, and HOPWA programs and through the use of HUD's other mainstream housing programs, such as Housing Choice Vouchers and the public housing program.

Cuyahoga County's Office of Homeless Services, which manages the HUD Super NOFA funding process at the local level, is also focusing its grant applications on permanent housing, although other types of programs such as transitional housing continue to be renewed at flat rates.

Specifics of HUD McKinney-Vento Funds are addressed in Section IV of the report.

National Initiatives

<u>National Alliance to End Homelessness</u>

For many decades, the American public has assumed that homelessness is a problem to be managed, not solved. Building on the Housing First philosophy, the National Alliance to End Homelessness, a nonprofit organization whose mission is to mobilize society's nonprofit, public and private sectors in an alliance to end homelessness has proposed another perspective: homelessness can end. It has developed a plan to end homelessness in ten years that includes the following elements:

Plan for Outcomes

Localities can begin to develop plans to end, rather than to manage, homelessness. There are two components. Every jurisdiction can collect data that allows it to identify the most effective strategy for each sub-group of the homeless population. Second, jurisdictions can bring to the planning table those responsible for mainstream as well as homeless-targeted resources.

Close the Front Door
Homelessness can be prevented by making mainstream poverty programs more accountable for the outcomes of their most vulnerable clients and wards.

Open the Back Door
Where homeless people are already accommodating the shortage of affordable housing, this should be facilitated and accelerated. Where there is no housing, particularly for those who are chronically homeless, an adequate supply of appropriate housing should be developed and subsidized.

Build the Infrastructure
Ending homelessness can be a first step in addressing the systemic problems that lead to crisis poverty:

- shortage of affordable housing
- incomes that do not pay for basic needs
- lack of appropriate services for those who need them.

LOCAL

County Initiatives

Plan to Prevent Homelessness and Expand Affordable Housing
Driven by HUD's Housing First policy, a joint local effort conducted by the Cleveland mayor's office, Cleveland City Council, and the Cuyahoga County Board of Commissioners, with the support of the St. Luke's Foundation of Cleveland, The Cleveland Foundation, and the Sisters of Charity Foundation of Cleveland, has resulted in a "Ten Year Plan to Prevent Homelessness and Expand Affordable Housing in Cleveland and Cuyahoga County." The plan's strategies for preventing homelessness include:

- Adopting a community-wide Housing First policy that emphasizes stabilizing individuals and families in permanent housing with supportive services as soon as possible before addressing issues of employment or other recovery goals.
- Creating an infrastructure for preventing homelessness rather than ameliorating its effects.
- Holding shelters accountable for transitioning shelter residents into permanent housing as quickly as possible.
- Creating over 3,000 additional units of permanent supportive housing.
- Improving the transition process between prison and re-entry into the community.
- Improving the discharge options for youth who age out of the foster care system.
- Making safety net programs more effective so that homelessness does not become a reality.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

For counting purposes, the U.S. Department of Housing and Urban Development (HUD) distinguishes between sheltered and unsheltered homeless (HUD, 2004):

> A person is considered homeless **only** when he/she resides in one of the places described below at the time of the count:
>
> An *unsheltered* homeless person resides in:
> - a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).
>
> A *sheltered* homeless person resides in:
> - an emergency shelter,
> - transitional housing or supportive housing for homeless persons who originally came from the streets or emergency shelters.

According to HUD (2004), along with street outreach teams, health care for the homeless networks, stationary (soup kitchens), and mobile (vans) food programs, drop-in centers are a primary service entity that caters to unsheltered homeless persons. HUD estimates that one-quarter to one-third of the homeless are unsheltered.

> HUD's definition of an episode of homelessness is:
>
> A separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter. (HUD's Chronic Homelessness Fact Sheet)
>
> HUD's definition of chronic homelessness is:
>
> An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in emergency shelter during that time. (2004 Continuum of Care application)
>
> Note that HUD's definition of chronic homelessness *does not* include families. In addition, to be identified as chronically homeless, an individual must have a *disabling condition,* defined as follows:
>
> A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. (2004 Continuum of Care application)

The chronically homeless can be sheltered or non-sheltered homeless.

> Chronically homeless people are more likely than other homeless people to have one or more disabilities. Serious mental illness, drug and alcohol abuse, and chronic and acute physical illnesses are common and often co-occurring. Many people with serious mental illness are afraid of both shelters and street areas where other homeless people congregate. Instead, persons with serious mental illness are frequently found along major roads and transportation corridors at the fringes of downtown areas. Further, some people who are new to homelessness may not use shelters.

The newly homeless, could become chronically homeless if appropriate interventions are not available.

For this report, the targeted population for drop-in centers is the unsheltered homeless, an estimated 31 percent of the total homeless population.

DEMOGRAPHIC CHARACTERISTICS

National

Because of their transient nature, it is difficult to acquire data on the homeless population. There is no good estimate of the number of homeless people currently in the United States. However, based on sample research studies, it is believed that there are probably anywhere from 600,000 to 2.5 million homeless persons (Lowe, 2004). Better data will become available once the new Homeless Information Management System is implemented.

Contrary to what many may believe, most homeless persons are without a place to live for only a short period of time (SAMHSA, 2003):

> They usually become homeless as a result of an unexpected event such as an eviction, natural disaster, or house fire, and tend to have more social and economic resources to draw on than those who remain homeless for longer periods of time. A much smaller group of homeless people either is episodically homeless (i.e., have many episodes of homelessness but each for short periods of time) or is chronically homeless (i.e., have few episodes of homelessness but each for long periods of time). One study of shelter users in two large cities found that 80 percent were temporarily homeless, 10 percent were episodically homeless, and 10 percent were chronically homeless (Kuhn and Culhane, 1998 in SAMHSA, 2003).
>
> The estimated 200,000 people who experience chronic homelessness tend to have disabling health and behavioral health problems. Recent estimates suggest that at least 40 percent have substance use disorders, 25 percent have some form of physical disability or disabling health condition, and 20 percent have serious mental illnesses (Culhane, 2001 in SAMHSA, 2003). Often individuals have more than one of these conditions. These factors contribute not only to a person's risk for becoming homeless but also to the difficulty he or she experiences in overcoming it. People who experience chronic homelessness also tend to be slightly older than those who experience shorter homeless

episodes, are non-white, and male (Culhane and Kuhn, 1998 in SAMHSA, 2003). Families and youth experience chronic homelessness, as well.

According to a recent report by SAMHSA entitled "Blueprint for Change, Ending Chronic Homelessness in Persons with Serious Mental Illness and Co-occurring Substance Use Disorders" (2003), the major societal risk factors of homelessness, especially for persons with mental illness, are:

- *Poverty*

  > People with serious mental illnesses are among the most impoverished in our Nation … Because many are unable to work full-time, they must rely on public benefit programs, such as SSI. For many individuals with serious mental illnesses, such benefits provide their only means of support.

  However, people with substance use disorders are not eligible for Supplemental Security Income (SSI) based on substance-related disability alone. And even when persons qualify for SSI, which is only provided by fewer than half the states, incomes are well below the federal poverty level. "Lack of benefits frequently leads to homelessness and the inability to exit homelessness."

- *Lack of Affordable Housing*

  > A dearth of appropriate, accessible, and affordable housing is considered by many to be the number one barrier to residential stability for people with serious mental illnesses and/or co-occurring substance use disorders. Not one housing market in the United States exists in which an individual receiving SSI benefits can afford to rent a modest efficiency or one-bedroom unit.

- *Housing Barriers for People with Serious Mental Illnesses*

  Many people with serious mental illnesses qualify for federal housing choice (formerly Section 8) vouchers where they need only 30 percent of their income for rent and utilities. However, many people are on waiting lists for years before they receive a subsidy. These vouchers are not helpful in communities with a shortage of affordable housing options. The result is that many very low income persons with mental illness live in overcrowded or substandard living environments or live with aging parents or relatives, many of whom themselves are living on fixed, low incomes. Many are one crisis away from becoming homeless.

  > Further, many mainstream affordable housing providers are reluctant to serve people with serious mental illnesses, especially those who have been homeless. That reluctance in part is because of the misperception that people with mental illnesses need supervision or round-the-clock support, and in part because of their low incomes and lack of credit history. Research, however, provides strong evidence that people with mental illnesses neither need to nor want to live in such settings (Carling, 1993 in SAMHSA, 2003).

- *Housing Barriers for People with Substance Use Disorders*

  > Housing is especially problematic for people with substance use disorders, particularly for those with co-occurring mental illnesses. Their behaviors place them at high risk for eviction, arrest, and incarceration. Once homeless, they are

unlikely to succeed in treatment without the availability of safe, sober housing (Baumohl and Huebner, 1991; Stark, 1987 in SAMHSA, 2003). Few housing landlords (public or private), mental health agencies, and nonprofit developers will rent to people who are actively abusing alcohol or other drugs. Use of illegal drugs may be cause to deny admission or evict a person from federally assisted housing (Federal Register, 2001 in SAMHSA, 2003). Individuals who have engaged in drug-related criminal activity must be denied admission to public housing and most other federally assisted programs (Federal Register, 2001 in SAMHSA, 2003).

- *Discrimination and Stigma in Housing*
  Despite statutes such as the Fair Housing Amendments Act, allegations of housing discrimination based on mental illnesses are common (HHS, 1999 in SAMHSA, 2003). Stigma and discrimination can be overt, such as vocal community opposition to group living situations, or they can be less obvious, such as steering public funds away from housing initiatives that serve controversial populations.

- *Lack of Employment*
  People who are homeless want and need to work, but few are employed in jobs that can help them escape homelessness. A recent nationwide survey of homeless assistance providers and clients found that 44 percent of homeless people were working, but most were employed in short-term jobs with low pay and no benefits (Burt et al., 1999 in SAMHSA, 2003).

  There are frequently barriers to employment by persons with mental illness and substance abuse disorders.

In addition, there are a number of individual risk factors:

- *Mental Illness*
  Though only about five percent of people with serious mental illnesses are homeless at any given point in time, as many as two-thirds of all people with serious mental illnesses have experienced homelessness or have been at risk of homelessness at some point in their lives (Tessler and Dennis, 1989 in SAMHSA 2003 in SAMHSA, 2003).

- *Alcohol and Drug Use*
  Substance use is both a precipitating factor and a consequence of being homeless (Zerger, 2002 in SAMHSA, 2003). Notes McCarty (1990, p.1): “Researchers estimate that as many as half of all people who are homeless have diagnosable substance use disorders at some point in their lives (McMurray-Avila, 2001; Baumohl and Huebner, 1991 in SAMHSA, 2003). Alcohol abuse is more common, occurring in as many as 30 percent to 40 percent of people who are homeless (Stark, 1987; Baumohl and Huebner, 1991 in SAMHSA, 2003). Indeed, there still exists a cadre of older, white male, skid row alcoholics (Koegel and Burnam, 1987 in SAMHSA, 2003). Increasingly, however, individuals who are homeless and have substance use disorders are younger and include women, minorities, poly-drug users, and individuals with co-

occurring mental illnesses (McMurray-Avila, 2001 in SAMHSA, 2003). They have less education and fewer skills than their older counterparts.

- *Co-occurring Disorders*

  Substance use problems are a complicating factor for many people who have serious mental illnesses. An estimated 50 percent of adults with serious mental illnesses who are homeless have a co-occurring substance use disorder (Fischer and Breakey, 1991 in SAMHSA, 2003). Among veterans who are homeless, one-third to nearly one-half have co-occurring mental illnesses and substance use disorders (Kasprow, Rosenheck et al., 2002 in SAMHSA, 2003).

  Once homeless, people with co-occurring disorders have more problems, need more help or are unable to benefit from services, and are more likely to remain homeless than other groups of people (Winarski, 1998 in SAMHSA, 2003). They are more likely to be older, male, and unemployed; to be homeless longer and living in harsher conditions; and to suffer greater distress, demoralization, and alienation from their families. They tend to be isolated, mistrustful, and resistant to help (Dixon and Osher, 1995 in SAMHSA, 2003). Lack of appropriate treatment for co-occurring disorders means that even individuals who are motivated to get help may be unable to find it or have to face long waits.

- *Physical Health Problems*

  People with serious mental illnesses and/or co-occurring substance use disorders often have significant co-morbid medical conditions, including malnutrition, diabetes, liver disease, neurological impairments, and pulmonary and heart disease. Homeless people with alcohol disorders are in especially poor health; they experience both the deleterious effects of alcohol and of homelessness (Wright and Weber, 1987 in SAMHSA, 2003). Further, life on the streets makes it difficult for individuals to receive appropriate care for chronic conditions and often leads to such acute problems as upper respiratory infections, skin conditions, and serious dental health problems. In addition, people who are homeless, particularly those with serious mental illnesses or co-occurring disorders, are at risk for life-threatening infectious diseases such as tuberculosis, Hepatitis B and C, and HIV/AIDS. (Federal Task Force on Homelessness and Severe Mental Illness, 1992; McMurray-Avila, 2001 in SAMHSA, 2003)

- *Victimization*

  The relationship among homelessness, mental illness, substance use, and victimization—including physical and sexual abuse—is multidimensional. People who have been abused are more vulnerable to ongoing stresses that may lead to mental illness, substance use, and homelessness. While the association between childhood abuse, mental illness, and substance use is increasingly recognized, a number of studies have found high rates of childhood physical and sexual abuse in adults who are homeless, as well (Fischer, 1992 in SAMHSA, 2003). Indeed, research points to high prevalence rates of sexual abuse and other trauma in the lives of people with serious mental illnesses and substance use disorders who are homeless, particularly women (Goodman et al., 1995; Herman et al., 1997 in SAMHSA, 2003).

In studies that ask about lifetime abuse, between 51 and 97 percent of women with serious mental illnesses report some form of physical or sexual abuse, with a significant portion suffering multiple traumas (Goodman et al., 1997 in SAMHSA, 2003). Forty-one percent to 71 percent of women in treatment for drug or alcohol disorders report being sexually abused as children or adults, and more than one-third have been victims of violent crimes (Alexander, 1996 in SAMHSA, 2003).

Abuse in childhood may leave individuals vulnerable to ongoing abuse in adult relationships. For some women, domestic violence precipitates homelessness. Mental health providers may treat women who have experienced physical and sexual abuse inappropriately by using such techniques as physical restraints or forced medication that may remind the women of the original abuse they suffered (National Association of State Mental Health Program Directors [NASMHPD], 1998 in SAMHSA, 2003). These women require trauma-sensitive services to help them regain psychiatric and residential stability.

Finally, people who are homeless may become victims of further assault on the streets and in shelters. Those individuals who have fewer resources and skills to overcome the effects of trauma—especially people who have serious mental illnesses, including post-traumatic stress disorder (PTSD)—are particularly likely to be victimized while homeless, and to suffer more severe consequences of ongoing abuse (Fischer, 1992 in SAMHSA, 2003).

- *Minority Status*

  Racial and ethnic minorities are dramatically overrepresented among homeless populations. Nationally, compared to all U.S. adults in 1996, individuals who were homeless were disproportionately Black non-Hispanics (40 percent versus 11 percent in the general population) and American Indians (8 percent versus 1 percent in the general population) (Burt et al., 1999). Though these percentages vary around the country, research shows that people of color comprise a disproportionate share of the homeless populations in their communities (Burt, 1999 in SAMHSA, 2003).

- *Sexual Minorities*

  Homeless sexual minorities, especially youth, also are at increased risk for negative outcomes. Forty-two percent of homeless youth identify as lesbian, gay, or bisexual (Orion Center, 1986 in SAMHSA, 2003). Researchers comparing gay, lesbian, bisexual, and transgender (GLBT) homeless youth with their heterosexual counterparts found that GLBT adolescents left home more frequently, were victimized more frequently, used highly addictive substances more frequently, had higher rates of psychopathology, and had more sexual partners than heterosexual homeless youth (Cochran et al., 2002 in SAMHSA, 2003).

  Transgender individuals are especially stigmatized. They may become homeless as a direct result of job or housing discrimination. Researchers report that as many as 60 percent have been victims of harassment or violence, and 37

percent have experienced economic discrimination (Lombardi, 2001 in SAMHSA, 2003).

- *Diminished Social Supports*
  People with mental illnesses who become homeless have less contact with their families and are more likely to have poor family relationships than those who are not homeless … Likewise, people with substance use disorders who are homeless have less social support than people who are not homeless. Yet, interestingly, among homeless groups, people who drink tend to report more support than people who don't drink, in part because drinking can be a social activity (Fischer and Breakey, 1987 in SAMHSA, 2003). Severing the bonds with their "friends" who use alcohol or drugs may compound feelings of social isolation among people who are homeless (McMurray-Avila, 2001 in SAMHSA, 2003).

- *Foster Youth*
  Numerous studies of homeless youth have found experiences of physical and sexual abuse, parental drug or alcohol use, childhood homelessness, foster care, and juvenile detention. Neglect and lack of emotional and financial support from their families can also cause youth homelessness. Homeless youth also have special needs (National Alliance to End Homelessness, 2004). Youth aging out of foster care are particularly vulnerable. Within 2-4 years of exiting foster care, 25 percent of youth experienced homelessness (Annie E. Casey Foundation, 2004).

- *Criminal Justice System Involvement*
  Homeless people, especially those with mental illnesses and/or co-occurring substance use disorders, come into frequent contact with the criminal justice system both as offenders and as victims. Often, homeless people are arrested for minor offenses, including trespassing, petty theft, shoplifting, and prostitution … A person's contact with the criminal justice system may be even more likely following the enactment of "anti-homeless" legislation, including anti-begging, sleeping, and vagrancy ordinances, which is occurring in many of the country's largest cities (National Coalition for the Homeless [NCH] and National Law Center on Homelessness and Poverty, 2002 in SAMHSA, 2003).

Ohio

Much like national estimates, it is difficult to determine the true number of homeless people residing in Ohio. The Coalition on Homeless and Housing in Ohio (COHHIO) applied national estimates to Ohio's total population and estimated that over 179,000 Ohioans experienced homelessness in 2001. For the point-in-time estimate, COHHIO also applied national estimates to surmise that roughly 27,000 Ohioans experienced homelessness on any given night in 2001 (COHHIO).

Cuyahoga County

There have been several estimates of the number of persons in Cuyahoga County who are homeless within a year. They range from 16,000 to 26,000 persons. In addition, between 2,208 and 3,900 persons are estimated to be homeless on any given night. While these numbers are not exact, they paint a picture of the county's overall problem.

In 2003, Cleveland State University's Maxine Goodman Levin College of Urban Affairs estimated that approximately 16,000 Cuyahoga County residents were homeless at some time during the course of a year. The Northeast Ohio Coalition for the Homeless (NEOCH) estimated that nearly 26,000 people are homeless in Cuyahoga County every year and that 3,900 are homeless on any given night. This includes the shelter population of 2,100 people, along with approximately 1,800 sleeping on the streets, staying under bridges and overpasses, or living in abandoned buildings (Heading Home, 2005).

In January 2005, a point-in-time count of homeless persons in Cuyahoga County suggests there were over 2,208 homeless persons (Cuyahoga County Office of Homeless Services, 2005). Of these, 1,208 were in emergency shelters, 776 were in transitional housing, and 224 were unsheltered and living on the street. Eighty-seven percent of the un-sheltered emergency homeless who are potential users of Homeless Drop-ins are considered chronically homeless and close to four out of five have a chronic substance use disorder. More than half are severely mentally ill and more than a third are veterans (Cuyahoga County Office of Homeless Services, 2005). (See Table 1.)

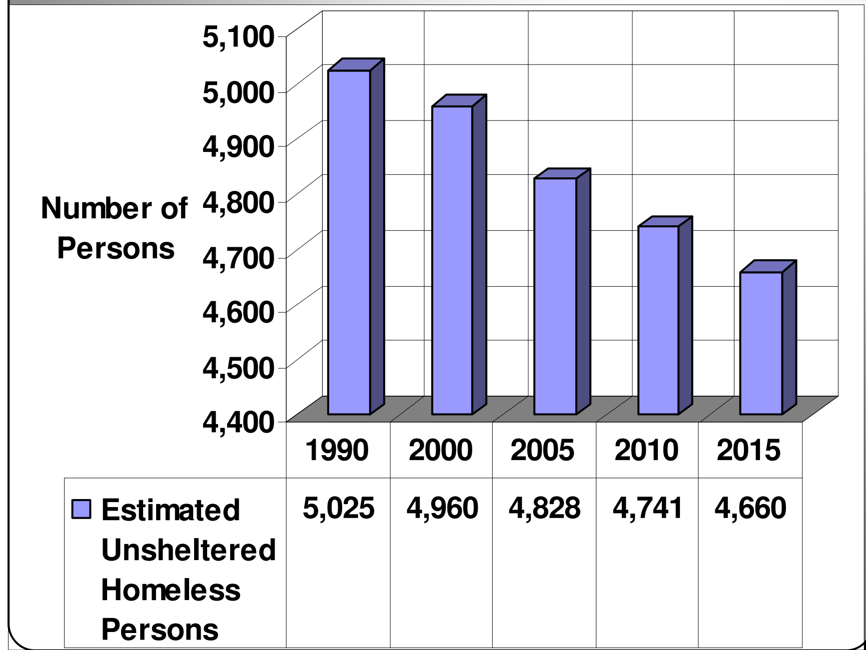
Table 1: Profile of Un-Sheltered Homeless Persons in Cuyahoga County from 2005 'Point in Time' Count

Contributing Factor	#	%
Chronically Homeless	195	87%
Chronic Substance Abuse	178	79%
Severely Mentally Ill	123	55%
Veterans	80	36%
Victims of Domestic Violence	27	12%
Persons with HIV/AIDS	23	10%
Youth (Under 18 yeas)	0	0%
Total Un-Sheltered	**224**	**100%**

Cuyahoga County Continuum of Care Point in Time Count of Homeless Services, 2005. (Cuyahoga County Office of Homeless Services, February, 2006).

Estimated Persons in Need

As stated previously, 16,000 individuals in Cuyahoga County were estimated to be homeless in 2000. It is estimated that 4,960 (31 percent) of them are in need of homeless drop-in centers. This is based on the National Survey of Homeless Assistance Providers and Clients (1996) findings that, nationally, 31 percent of the homeless slept on the streets or in other places not meant for habitation within the last week, which is reflective of HUD's definition of the unsheltered. The number of individuals estimated to be homeless is projected to decrease to 4,660 by 2015 because of projected decreases in the population. (See Figure 1.)



Sources:

* U.S. Census 1990, SF1 (P1); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).

**Based on the National Survey of Homeless Assistance Providers and Clients (1996) findings that, nationally, 31 percent of the homeless slept on the streets or in other places not meant for habitation within the last week, which is reflective of HUD's definition of the unsheltered.

It is recognized that drop-in centers can also be used for homeless prevention purposes and as an access point for other mainstream services. However, this estimate only focuses on persons who are already known to be homeless. It begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the numbers of consumers actually served. It includes the actual number of consumers reported by agencies funded by United Way and by government funders from which it was possible to obtain data. Thus, it could be an underestimate of actual numbers of consumers receiving service.

In FY 2004, United Way funded 6,366 persons for homeless drop-in center programs. It is assumed that many of these persons are working poor and not homeless. Thus, drop-in centers may be used for homeless prevention purposes also. (See Attachment 3.) In CY 2004, the Office of Homeless Services funded 768 actual annual consumers. These are not noted in Attachment 3 because they

represent services funded by multiple funders. Duplication with United Way funded consumers is assumed.

While 47 percent of the county's total population is male and 53 percent female, United Way funded consumers were primarily males (69 percent) versus females (31 percent).

In 2000, according to the U.S. Census, 67 percent of the county's total population was Caucasian, 28 percent African American, and 2 percent Asian. Consumers funded by United Way were 22 percent Caucasian, 68 percent African American, and less than 1 percent Asian.

Approximately 5 percent of UW-served homeless drop-in centers consumers were Hispanic compared to 3 percent of the county's population.

Ninety-seven percent of those funded by United Way reported annual household income below $15,000. Three percent reported incomes between $15,000 and $19,999.

Agencies funded by United Way report that almost all consumers resided in two City of Cleveland zip codes (44114 and 44115), more than likely in homeless shelters. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of homeless drop-in center programs for this report is: programs that provide a center where homeless people can spend time during the day. The center may provide counseling and/or medication, monitoring on a formal or informal basis; facilities for showering, napping, laundering clothes, making necessary telephone calls or attending to other personal needs; and/or other basic supportive services. Some centers may also provide food or facilities for cooking.

BACKGROUND ON CORE SERVICE

Along with homeless shelters and transitional housing, homeless drop-in centers are part of the continuum of services that provide a comfortable, safe, and non-threatening place where homeless persons can find mutual support and advocacy on behalf of their needs. Generally open seven days a week, the centers offer a variety of social and educational opportunities for its members. There are typically a few paid staff, some stipend positions, and volunteers.

Drop-in centers are often one component of a "continuum of care" model that serves mentally-ill and chemically-addicted men and women. The services offered in this model range from providing a great deal of assistance—such as street outreach and drop-in centers, to allowing clients increasing independence—including temporary housing and long-term supportive housing. Twenty-four hour drop-in centers offer adults access to meals, clothing, showers, and rehabilitation and recovery programs. They can also provide on-site medical, mental health, and substance abuse assessments. In addition, by utilizing a strong case management approach, the centers provide individual counseling, entitlement assistance, banking facilities, vocational training, money management, and instruction in other independent living skills, all of which help clients successfully transition to housing.

As the major funder of services for homeless persons, HUD is the driving force behind the direction of services for homeless persons, as was discussed previously in this report (HUD, 2006). Its current strategic plan has spelled out its agenda for ending chronic homelessness and addressing the needs of other homeless households. More specifically, the goal is "to provide both flexible and targeted resources to communities, as well as to encourage planning and coordination to maximize the impact of these resources."

> HUD annually allocates over $1.1 billion in McKinney-Vento Act funds through 450 local Continuum of Care (CoC) planning jurisdictions. A Continuum of Care is a broadly representative public-private planning process that assesses local needs, determines local priorities for funding within national goals, and assesses local performance in ending chronic homelessness and moving homeless families and individuals to permanent housing. In order to target funds to serve the chronic homeless, HUD has developed a "Samaritan Initiative" that provides bonus funding for CoCs submitting a permanent housing project dedicated to serving chronically homeless persons. In the 2005 national competition, HUD funded 4,940 projects totaling $1.1 billion

in 452 CoCs. Of these, 611 were new projects. There were 233 “Samaritan bonus” projects that received a total of over $100 million in funding.

HUD will continue to seek tighter coordination and integration of its 10-year planning efforts to end chronic homelessness through standardizing homeless and chronic homeless planning components contained in its two resource-driven local planning structures: (1) the Consolidated Plan with homeless and chronic homeless elements that are submitted by states and 1,128 jurisdictions that receive over $5.8 billion in CDBG, HOME, HOPWA, and ESG program funding; and (2) the annual plan for addressing homelessness and ending chronic homelessness submitted by over 452 CoC planning jurisdictions. HUD is actively seeking to coordinate these jurisdictional CoC and Consolidated Plans with other 10-year plans.

HUD will continue to work directly with other federal agencies, and through the U.S. Interagency Council on Homelessness, on collaborative efforts to address homeless needs and to end chronic homelessness. One tangible result of this effort is the $35 million Chronic Homeless Initiative between HUD and the Departments of Health and Human Services (HHS) and Veterans Affairs that weaves together housing and social services for homeless people with addictions, mental illness, prisons histories, and other root causes of persistent homelessness. Another is the jointly funded initiative between HUD and Department of Labor for $13 million focusing on the housing and employment needs of chronically homeless persons.

HUD also recently funded a new initiative, “Housing for Persons Who Are Homeless and Addicted to Alcohol,” to assist chronically homeless individuals who have a long-term addiction to alcohol. The initiative funds 12 pilot programs in 11 cities that serve approximately 555 persons. These programs received two-year grants totaling $10 million in funding, and were developed in collaboration with the U.S Interagency Council on Homelessness.

As homeless families and individuals obtain better access to the mainstream services they need, and as the coordination between HUD and other federal agencies coalesces, HUD is working to reduce the proportion of HUD homeless funds used for the provision of social services and to increase the proportion used for housing.

A key tool for ending chronic homelessness will be to provide permanent supportive housing–housing combined with services. The Department will continue to ensure that at least 30 percent of all available homeless funding is awarded for permanent housing. Providing permanent supportive housing will significantly reduce the cost of medical, mental health, and criminal justice resources that are used for persons experiencing chronic homelessness. In fact, recent research has demonstrated that providing permanent supportive housing costs about the same as leaving an individual on the streets and having him or her cycle through the various disconnected healthcare, correctional, mental health, and substance abuse treatment institutions.

HUD will scrutinize the policies of its mainstream housing programs to determine whether additional mainstream housing resources can be brought to bear on the problem of homelessness, including both persons experiencing chronic homelessness and homelessness among families.

HUD is also collaborating with other federal agencies in efforts to better connect HUD program recipients with resources made available to address health, human services, job development, education, and other services that are needed by persons with special needs. The results of these efforts should help ensure that HUD recipients achieve their housing mission with improved access to the related social services provided by other federal programs.

Finally, HUD will continue to:

- Assist communities in developing congressionally mandated Homeless Management Information Systems (HMISs) to track homeless persons moving through emergency shelter, transitional housing, and into permanent housing. HMISs will identify the characteristics of homeless persons and track milestones, including access to benefits, educational opportunities, and employment. In doing so, HUD will take steps to ensure adequate legal protections for privacy and confidentiality of homeless clienteles, particularly victims of domestic violence.

- Encourage states and communities to improve discharge planning from their healthcare, foster care, youth facilities and criminal justice programs, so that, upon discharge, people move to stable permanent housing rather than becoming homeless.

- Provide extensive technical assistance to applicants and potential applicants for the Department's homeless assistance programs. In addition to a continuation of the local, regional, and national technical assistance resources already in place, HUD will inaugurate targeted technical assistance specifically tailored to faith-based organizations. Existing targeted technical assistance efforts under way to veteran service organizations will also be expanded.

- Research methods to measure and optimize the cost of achieving housing stability for various populations.

In its strategic plan, HUD has spelled out specific performance measures to be achieved by 2011:

- The percentage of formerly homeless persons who remain housed in HUD permanent housing projects for more than 6 months will be 75 percent by 2011.
- By 2011, HUD will create 40,000 new units of permanent housing for chronically homeless individuals.
- By 2011, 65 percent of households leaving transitional housing will directly move to permanent housing.

- By 2011, 25 percent of homeless persons will be employed upon exiting HUD homeless assistance projects.

Issues with the Service System

The recent SAMHSA (2003) study referenced previously points out a number of service system challenges, primarily focusing on homeless persons with serious mental illness and/or co-occurring substance use disorders. These issues include funding restrictions and preference of service providers to institutional locations for service delivery, the complexities of navigating a fragmented funding and service delivery system, and the timing of assessments.

<u>Funding Restrictions and Preference for Institutional Service Delivery Locations</u>

> Payers who fund mainstream mental health and substance abuse treatment services favor clinic and institution-based care (Post, 2001 in SAMHSA, 2003). Though Medicaid has instituted some outreach efforts, it is not specifically targeted to homeless people (GAO, 2000a). When case management is available to people who are homeless, caseloads are usually high, permitting little more than office-based contact and infrequent monitoring. Providers struggle to pay for services provided in atypical settings, such as shelters and on the streets, or non-medical services, such as social model substance abuse treatment programs. Further, providers may be reluctant to serve people with no health insurance coverage, which is the case for many people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. Many are eligible for, but unable to access, these benefits. Those covered by Medicaid or Medicare often are not attractive to providers in managed care systems that receive less reimbursement than they would under a fee-for-service arrangement (Bianco and Milstrey-Wells, 2001 in SAMHSA, 2003).
>
> Homeless people who have substance use disorders are less likely than those with serious mental illnesses or co-occurring disorders to be receiving Federal disability benefits (Baumohl and Huebner, 1991 in SAMHSA, 2003). This is in large part because individuals with substance use disorders, no matter how severe, are not considered disabled under Social Security Administration guidelines for the purpose of receiving SSI, unless they have other disabling health conditions not attributable to their substance use.

<u>Complexities of Navigating a Fragmented Funding & Service Delivery System</u>

> Categorical funding—which requires that providers offer only a specific type of service with funds from a particular source (federal, state, local, private, etc.)—may make it difficult to tailor services to individual needs. In its report, "Ending Chronic Homelessness: Strategies for Action," the U.S. Department of Health and Human Services (HHS) uses the phrase "funding silos" to describe this problem, which arises in part because most mainstream programs administered by HHS were created to respond to a unique need or population (HHS, 2003 in SAMHSA, 2003). The same is true for categorical programs in other federal agencies, as well as in state and local programs.
>
> People with serious mental illnesses and/or co-occurring substance use disorders who are homeless require a broad range of housing, health and

mental health care, substance abuse treatment, and social services, all of which typically are provided by separate agencies with separate funding streams. The burden of coordination falls on the individual, but people with serious mental illnesses or co-occurring disorders, especially those who are homeless, are ill-prepared to negotiate a fragmented service system unaided.

Service system fragmentation is especially evident in the transition from an institution, such as a hospital or jail, to the community. Some people with serious mental illnesses may be released from a hospital before their symptoms are stabilized adequately, especially if their health insurance plan specifies a predetermined length of stay. Others are released without adequate discharge plans. People with substance use disorders may be discharged from detoxification programs back to the streets … Nationally, only one-third of inmates with mental illnesses in jails and prisons receive any discharge planning services. Frequently, they are released with bus tokens, a few pills, and the address of a mental health center (Bazelon Center for Mental Health Law, 2001 in SAMHSA, 2003). They are subject to further arrest or to unnecessary hospitalization as they attempt to cope with their mental illnesses and life on the streets. Likewise, individuals with substance use disorders who are not connected to appropriate community services are more likely to cycle repeatedly between jail or prison and the community.

There is a lack of integrated treatment for co-occurring mental illnesses and substance use disorders. People who are homeless also interact with the homeless service system. People with co-occurring disorders who are homeless frequently are excluded from mental health treatment programs because of their substance use disorder, from substance abuse treatment programs because of their mental illness, and from homeless service programs because of their mental illnesses and substance use disorders. Those who do receive care may get treatment for their substance use or their mental illness, but the vast majority of individuals do not receive treatment for both (Watkins et al., 2001). More recent models emphasize the integration of mental health and substance abuse treatment for people with the most serious disorders, but few such programs are available (SAMHSA, 2002b in SAMHSA, 2003).

Timing of Assessment

Screening and assessment of homeless people is also complicated.

Outreach workers may conduct an initial assessment, which often has to be short and unobtrusive to avoid frightening away potential clients. A more complete assessment may be possible when clients have developed a greater degree of trust and comfort with outreach staff (Interagency Council on the Homeless, 1991 in SAMHSA, 2003). Adequate initial assessment of persons with serious mental illnesses or co-occurring disorders is made more difficult by the fact that shelter staff may lack the training or time to conduct a thorough psychiatric assessment, and there are few reliable screeners for co-occurring disorders. There are, however, some agreed upon early assessment tools for substance use disorders. A study of different assessment methods in Boston's Long Island Shelter found that case managers could identify substance use

problems by using a set of open-ended questions that include information on consumption patterns and personal problems associated with drinking (Garrett and Schutt, 1987 in SAMHSA, 2003).

People who are homeless and have serious mental illnesses and/or co-occurring substance use disorders are eligible for a host of mainstream health, social service, and income support programs that are intended to meet the needs of all low-income people, not only those who are homeless. Though such programs are a valuable resource for providing needed services and supports, people who are homeless often face significant enrollment barriers (Post, 2001 in SAMHSA, 2003).

United Way - First Call for Help Call Data

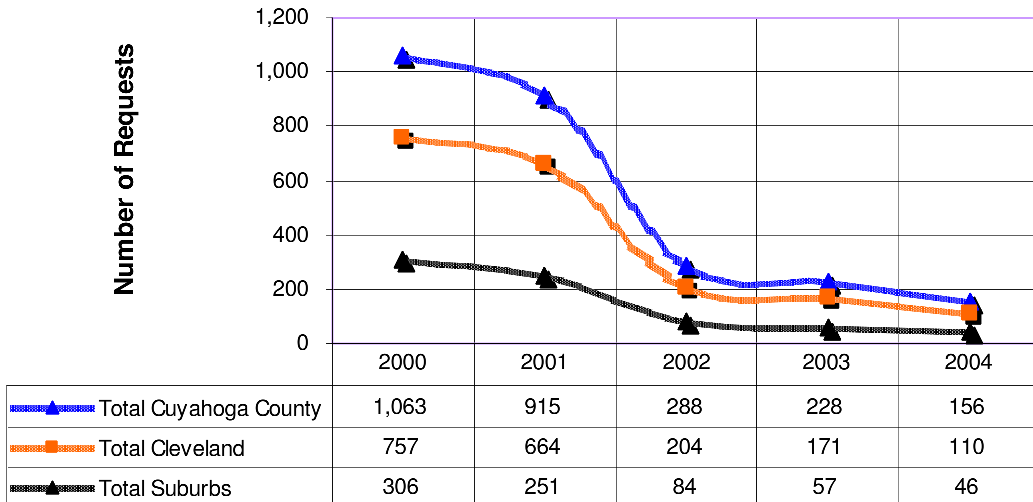
Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 6 homeless drop-in center program providers operating from 7 different sites, 1 of which is government and 5 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded one provider. (See Attachments 5 and 6.)

United Way - First Call for Help call data shows a substantial decrease in the number of total requests for homeless drop-in center programs in the county: from 1,063 in 2000 to 156 in 2004 (85 percent decrease) with an 85 percent decrease in Cleveland (757 to 110 requests) and an 85 percent decrease in the suburbs (306 to 46 requests). (See Figure 2.) Calls came from about one-third of Cuyahoga County zip codes with the following experiencing the highest average number of calls from 2000-2004:

- 44105 (Cleveland/Newburgh Hts/Garfield Hts) – 45 calls
- 44112 (East Cleveland/Cleveland) – 36 calls
- 44108 (Cleveland/Bratenahl) – 33 calls
- 44106 (Cleveland/Cleveland Hts) – 32 calls
- 44120 (Shaker Hts/Cleveland) - 30 calls
- 44104 (Cleveland) – 27 calls

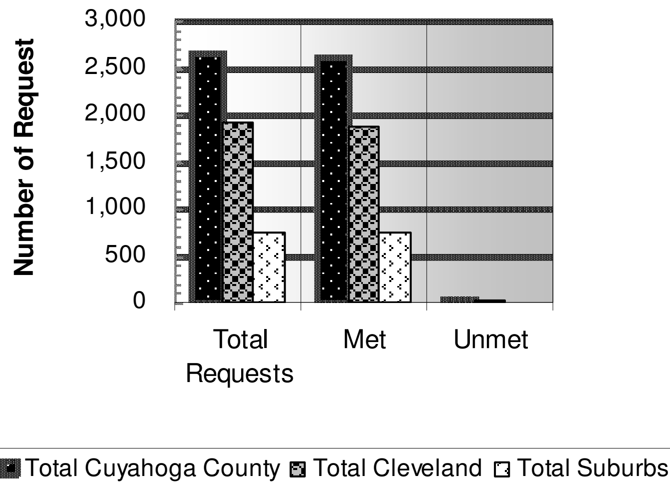
(See Attachment 7.)

Figure 2: Homeless Drop-In Center
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)



	2000	2001	2002	2003	2004
Total Cuyahoga County	1,063	915	288	228	156
Total Cleveland	757	664	204	171	110
Total Suburbs	306	251	84	57	46

Over the same five-year period, United Way - First Call for Help had 2,650 requests for information about homeless drop-in center programs. Of these requests, they were able to make referrals to 99 percent of callers; however, 1 percent of all Cuyahoga County callers (35) had an unmet need, meaning there was no agency to which to refer the caller. Callers from the City of Cleveland and from the suburbs each had a 1 percent unmet need. The largest unmet need was 28 requests in Cleveland to 7 requests in the suburbs over the five-year period. The largest numbers of unmet needs were in zip codes 44105 (Cleveland/ Newburgh Hts/Garfield Hts), 44112 (East Cleveland/Cleveland) and 44115 (Cleveland). (See Figure 3 and Attachment 8.)



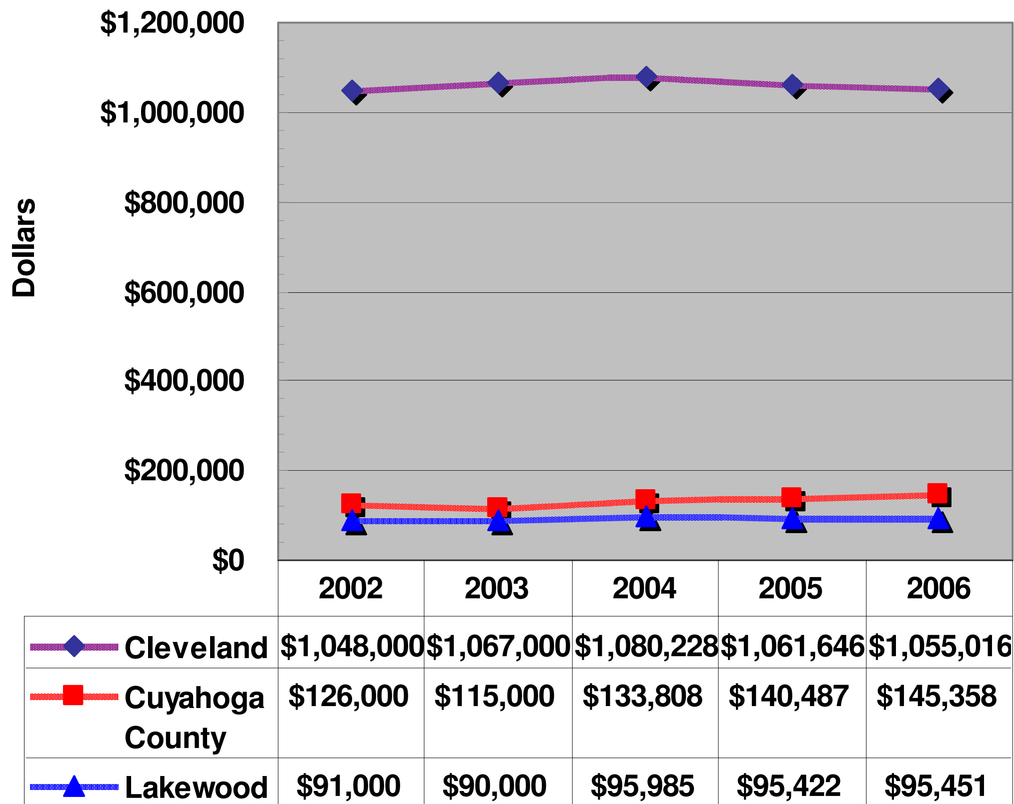
FUNDING OF CORE SERVICES

Major Government Funders
The major sources of government funding for homeless drop-in centers are the following:

- Emergency Shelter Grant Program
- FEMA's Emergency Food and Shelter National Board Grant Program
- Community Development Block Grant (CDBG)
- Ohio Housing Trust Fund

NATIONAL

Emergency Shelter Grants
Homeless drop-in centers meet the criteria to receive grants from HUD McKinney-Vento Funds only through the Emergency Shelter Grant program. Emergency Shelter Grant funds are made to states, metropolitan cities, urban counties, and territories based on the CDBG formula for emergency shelters and homeless prevention. Cuyahoga County, the City of Cleveland, and the City of Lakewood receive ESG funding. Cleveland's ESG funds were rolled into the City of Cleveland's Community Development Block Grant (CDBG) beginning in 2003. ESG is relatively stable, though there is some small fluctuation. (See Figure 4.)



Source: Department of Housing and Urban Development Community Planning and Development Program Formula Allocations for 2002, 2003, 2004, and 2005 Information by State.

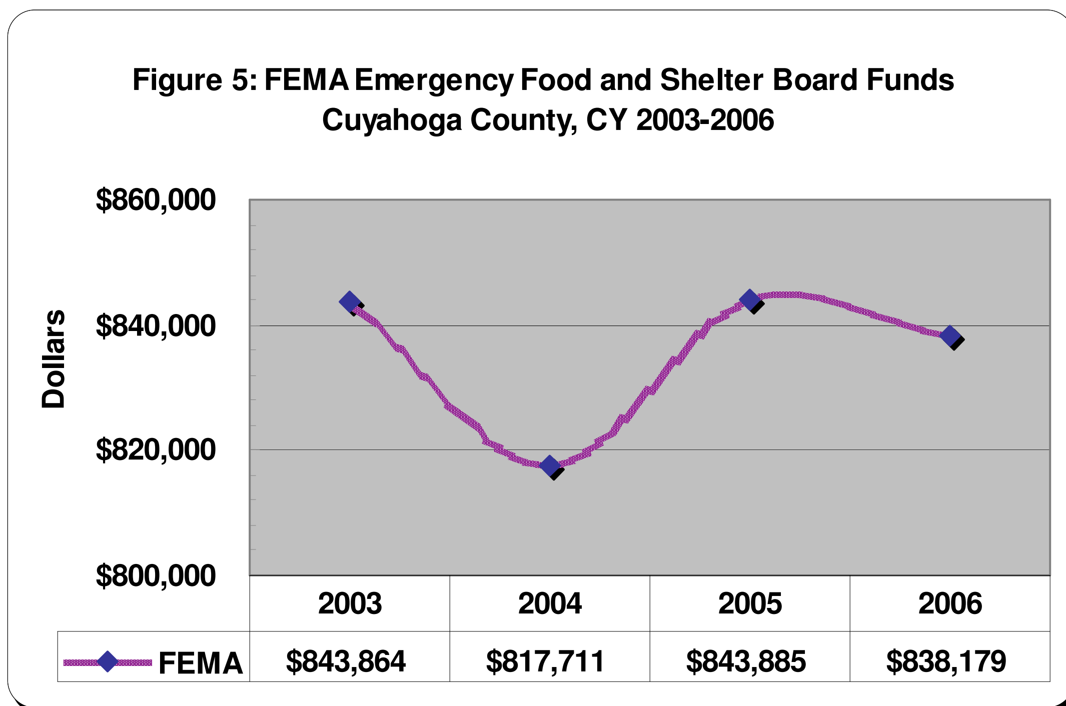
Typically, HUD allocates approximately 15 percent of Homeless Assistance Grant funds to ESG (National Low Income Housing Coalition, 2006). The Bishop Cosgrove Center receives $35,000 annually in ESG/CDBG funds for its drop-in center. No other drop-in centers receive ESG/CDBG funding.

The Supportive Housing Program is a competitive grant program funded through the Super NOFA continuum of care process and is administered through the county's Office of Homeless Services. Drop-in centers are not fundable thought the Supportive Housing Program. Services provided at drop-in centers (but not the drop-in center itself) can be funded through the Supportive Housing Program. Drop-in centers are often a component of "safe haven" programs of supportive housing services. Safe havens, which serve difficult-to-service populations such as those with severe mental illness, often provide drop-in centers where individuals can become familiar with staff and facilities before accepting other services. The Supportive Housing Program has been funded at about $10 million annually. Supportive Housing, which does not directly fund drop-in centers but does fund

some supportive services for homeless provided at drop-in centers, is being renewed only at a flat rate; no new programs are being funded as part of the HUD Super NOFA.

FEMA's Emergency Food and Shelter National Board Grant Program

FEMA's Emergency Food and Shelter National Board Grant Program, commonly referred to as FEMA, (a distinct funding source from HUD's Emergency Shelter Grant program) was created by Congress in 1983 to help meet the needs of hungry and homeless people throughout the United States by allocating funds for the provision of food and shelter. Homeless drop-in centers could be funded under this grant program. The program supplements the work of local agencies already providing such help at the community level, and funds are distributed through a collaborative planning and allocation process with local providers. The purpose of the program is to provide emergency food (in the form of served meals and/or groceries) and shelter (such as mass shelter, one month's rent, or mortgage payment). The FEMA Emergency Food and Shelter Board in Cuyahoga County splits allocations of funds between shelter and food. Historically, funding has been relatively stable. (See Figure 5.)



	2003	2004	2005	2006
FEMA	$843,864	$817,711	$843,885	$838,179

Source: United Way of Greater Cleveland.

Funding trends are expected to be flat to decreasing. FEMA grants are made to agencies, not to specific programs or services. Therefore, it is unknown how much funding went specifically to homeless drop-in centers.

Community Development Block Grant (CDBG) – County and City of Cleveland

Community Development Block Grant funds are intended to develop viable urban communities by providing decent housing and a suitable living environment and by expanding economic opportunities, principally for low- and moderate-income persons, and so homeless services are often funded from CDBG funds. The U.S. Department of Housing and Urban Development (HUD) determines the amount of federal funds that cities and counties are entitled to receive each year through a formula based upon population, growth lag, poverty level, age of housing, and

overcrowding. CDBG provides federal funding for neighborhood improvement projects that are locally initiated. City Council makes allocation decisions regarding the City of Cleveland's CDBG. CDBG can fund drop-in shelters; however, other than ESG funds, no competitive awards out of CDBG funds were made to homeless drop-in centers. CDBG funding has been somewhat stable though there has been some fluctuation.

STATE

Ohio Housing Trust Fund
The Ohio Housing Trust Fund (HTF) is another major source of state government funding for homeless services; it is a flexible state funding source that provides affordable housing opportunities, expands housing services, and improves housing conditions for low-income Ohioans. The HTF provides housing and housing assistance to Ohio's low and moderate income families and individuals. Nonprofit organizations, for-profit organizations, lenders, and certain units of local government are eligible to participate in the HTF programs. No grants from this key funding source for homeless services were made to drop-in centers

LOCAL

No Cuyahoga County general revenue funds go to supporting drop-in centers.

Trends of Identified Government Funders in Cuyahoga County
Government funding for homeless drop-in centers is very limited, primarily as a result of: a) the federal government's policy of emphasizing permanent housing; and b) program models which emphasize meeting specific participation requirements in order to receive services. Both direct sources of government funding for this core service (ESG and FEMA) are flat. Much of the funding available for homeless services is a competitive process, and no funds are set aside exclusively to be used for drop-in centers.

Foundation funding for drop-in centers has remained fairly level, with a total of $102,050 granted in 2002 and $104,800 in 2004.

IDENTIFIED REVENUES

As of May 11, 2006, $291,469 in revenues for homeless drop-in center programs has been identified countywide. This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland. (See Table 2.)

Thirty-six percent of the revenues are from foundations. United Way of Greater Cleveland provides 57 percent of identified revenues of this core service through Investment Committee allocations and designations. The remaining seven percent is from federated fundraising organizations.

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Homeless Drop-in Centers, 2003/2004.

		A		B	
Funder	Period	Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			**0.00%**	**14,000**	**3.83%**
Cleveland Foundation, The		1,500			
Gund Foundation, The George		50,000			
Murphy Foundation, The John P		3,000			
O'Neill Foundation, The William J. and Dorothy K.		30,300			
Other Private Foundations - Not Elsewhere Classified		19,500			
Sherwin-Williams Foundation, The		500			
Total - Foundations & Trusts		**104,800**	**35.96%**	**0**	**0.00%**
Catholic Charities Service Corporation				93,900	
United Black Fund of Greater Cleveland		21,000			
Total - Federated Fundraising Organizations		**21,000**	**7.20%**	**93,900**	**25.66%**
Other Federal Funders - Not Elsewhere Classified				22,000	
Subtotal Federal Government		***0***	***0.00%***	***22,000***	***6.01%***
Other City of Cleveland Funders - Not Elsewhere Classified				57,800	
Subtotal City of Cleveland Funding Sources		***0***	***0.00%***	***57,800***	***15.80%***
Total - Contracts/grants from government organizations		**0**	**0.00%**	**79,800**	**21.81%**
Total - All Other Revenue			**0.00%**	**12,500**	**3.42%**
Subtotal Non - UWGrCle Support		**125,800**	**43.16%**	**200,200**	**54.72%**
Total - UWGrCle investment committee allocation		**165,669**	**56.84%**	**165,669**	**45.28%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**165,669**	**56.84%**	**165,669**	**45.28%**
Total Support/Revenue		**291,469**	**100%**	**365,869**	**100%**

REIMBURSEMENT/COST

An Internet search showed that most drop-in centers charge between $0 and $5 per visit. Much of the actual cost is offset through donations.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

There is a lack of research specific to homeless drop-in centers; however, there are some time-tested programs worth highlighting. For example, Urban Pathways in New York City has worked with homeless men and women for over twenty-five years Through outreach, drop-in centers, and transitional and permanent supporting housing programs, Urban Pathways strives to reach the most isolated individuals in the community.

Urban Pathways' 24-hour drop-in centers provide comprehensive, on-site services to homeless men and women, many of whom have complex problems. Services such as meals, shelter, clothing, showers, medical and psychiatric treatment, and substance abuse counseling are provided to roughly 300 people daily at two locations (Urban Pathways, 2005).

The National Alliance to End Homelessness' "Sourcebook on Family Homelessness" states that drop-in centers are effective at engaging homeless men and women who would not ordinarily access the shelter system (National Alliance to End Homelessness, 2005).

Researchers, policymakers, and advocates who have examined the issue of using mainstream resources to prevent and end homelessness have developed a set of strategies useful both to homeless service providers and to those who administer and fund mainstream programs. Generally, these strategies fall into six main areas:

- Preventing homelessness among clients of mainstream programs.
- Improving access to mainstream resources for people who are homeless.
- Expanding the capacity of mainstream programs to serve people who are homeless.
- Promoting coordination and collaboration among mainstream programs.
- Building the infrastructure of housing and services that homeless people need.
- Creating public awareness about mental illnesses, substance use disorders, and homelessness.

What Doesn't Work

A study by Tsemberis et al. (2003) conducted two experimental studies of programs to reduce homelessness for persons with mental illness and often substance abuse. Homeless participants were randomly assigned to programs that emphasized consumer choice or to the usual continuum of care in which housing and services are contingent on sobriety and progress in treatment. They found that a drop-in center that eliminated barriers to services was more successful than the control programs in reducing homelessness. However, after 24 months only 38 percent of participants had moved to community housing. A subsequent apartment program that placed the experimental group individuals in subsidized apartments directly from the street, with services under their control, had 79 percent in stable housing (compared to 27 percent in the control group) at the end of 6 months. Groups in this study did not differ on substance abuse or psychosocial outcomes.

A study by Ball et al. (2005) evaluated the psychiatric symptoms, psychosocial problems, and treatment response of personality-disordered substance abusers receiving services at a homeless

drop-in center. Fifty-two homeless clients were assessed after program admission and randomly assigned to receive either individual psychotherapy focused on personality disorder and substance abuse relapse prevention (dual-focus schema therapy [DFST]) or standard group substance abuse counseling (SAC). Client functioning was assessed using measures of personality disorder, psychiatric symptoms, early maladaptive schemas, interpersonal problems, and addiction-related psychosocial impairment. Therapy retention (total weeks in treatment) and utilization (number of weeks in which sessions were attended) were the primary outcomes. Clients reported significant psychiatric symptoms, criminality, and psychosocial impairment, yet made limited lifetime use of mental health services. Overall, there was greater utilization of individual DFST than group SAC. However, clients with more severe personality disorder symptoms demonstrated better utilization of SAC than DFST.

IMPACT ON COMMUNITY

In a 1998 report published by the *New England Journal of Medicine,* it was found that homeless people spent an average of four days longer per hospital visit than their non-homeless counterparts in New York City. The study calculated the extra costs to be over $2,400 per hospitalization (Salit, Kuhn, Hartz, Vu, and Mosso, 1998).

The National Alliance to End Homelessness cited prison and jail expenses as a further cost of homelessness. Homeless men and women also tend to spend more time in prison than others, sometimes simply for loitering, which can be costly. The typical cost of a prison bed in a state or federal prison is roughly $20,000 per year. A two-year University of Texas survey of homeless individuals found that each homeless person cost the taxpayers over $14,000 per year, predominantly due to jail costs.

In addition, the emergency housing of homeless men and women is expensive. The cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants program was over $8,000 in 1994, which was more than the average annual cost of a federal housing subsidy (National Alliance to End Homelessness).

In 2004, the Office of Homeless Services reported that the $13 million provided by HUD leveraged more than $51 million in supplemental resources for homeless services in Cuyahoga County (Heading Home, 2005).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

The Council on Accreditation will accredit homeless drop-in centers.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Homeless Drop-in Centers:

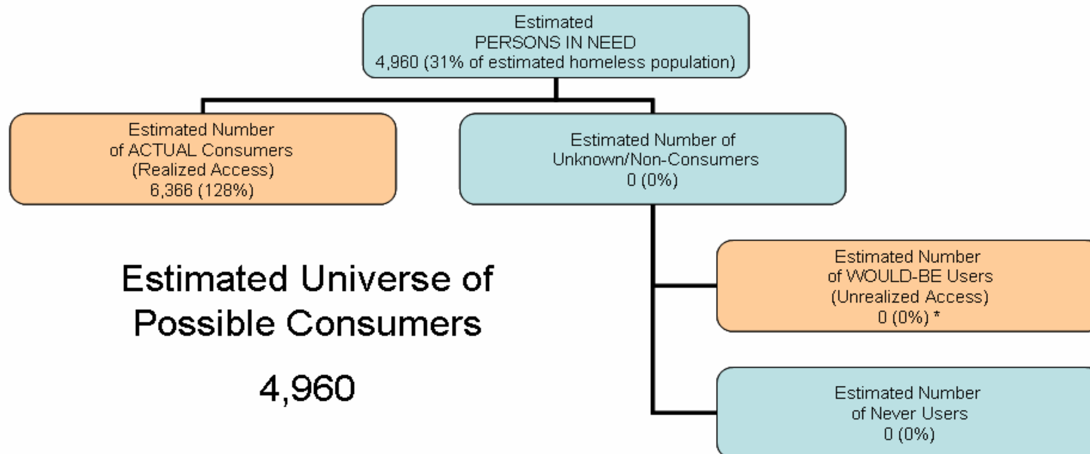
- An estimated 4,960 homeless persons need homeless drop-in center programs, which is 31 percent of the estimated number of homeless persons in Cuyahoga County (16,000). This is based the National Survey of Homeless Assistance Providers and Clients (1996) findings that, nationally, 31 percent of the homeless slept on the streets or in other places not meant for habitation within the last week, which is reflective of HUD's definition of the unsheltered.

- Based on available information about actual consumers, approximately 6,366 persons have realized access to homeless drop-in center programs. This is the sum of persons estimated to use homeless shelters funded by UW (6,366). It is assumed that the 768 persons funded by The Office of Homeless Services are included in United Way's figures.

- This suggests that 1,086 persons more than the estimated number in need are being served. This may be explained by the United Way-funded provider's service description, which stated that it served both homeless and working poor in its drop-in center. United Way is only funding one of six providers of homeless drop-in center services. This suggests that there is no unmet need for homeless drop-in center services in Cuyahoga County.

- The number of persons reported being served is also far in excess of the national survey's finding that 10 percent of the homeless used other homeless assistance programs (e.g., drop-in centers, food pantries, outreach programs, mobile food programs) within the last week. Application of this percentage to the estimated 16,000 homeless persons in Cuyahoga County would have 1,600 consumers of drop-in centers.

- And finally, the Cuyahoga County Office of Homeless Services reports only 224 unsheltered persons in 2005. This represents 10 percent of its total county of 2,208 persons. (See Figure 6.)



Service Site Index

Countywide, there are 7 service sites for homeless drop-in center programs. This is a ratio of 708 possible consumers (estimated 4,960 total) per service site countywide. No service site analysis by zip code was completed because of homeless persons' lack of addresses.

VII. SUMMARY

The primary findings from this report are as follows:

- Since the colonial era, there has always been a segment of the American population living without permanent dwelling. The term "homeless" first entered the mainstream lexicon in the late 1970s, when America observed a startling increase of people forced to live on urban streets. The phenomenon was seen as a shocking aberration, garnering media attention and causing public outcry. Today, many Americans are resigned to it as an unchanging feature of the social landscape.
- According to HUD, drop-in centers are a primary service entity that caters to unsheltered homeless persons, along with street outreach teams, health care for the homeless networks, and stationary (soup kitchens) and mobile (vans) food programs. An unsheltered homeless person resides in a place not meant for human habitation—cars, parks, sidewalks, or abandoned buildings ("on the street"). HUD estimates that one-quarter to one-third of the homeless are unsheltered.
- Both practice and public policy have changed over time and are reflective of new models of service delivery for the chronically homeless based on a premise of housing first and sobriety and mental health second. Research has tested and confirmed these assumptions.
- The Housing First approach is driven by consumer preference and has become the cornerstone of the U.S. Department of Housing and Urban Development's (HUD) policy on homeless services. The current goal is to end, not manage homelessness.
- The federal government is a primary actor in the area of homeland services. With the enactment of the Stewart B. McKinney Homeless Assistance Act of 1987, Congress recognized the need to supplement "mainstream" federally funded housing and human services programs with funding specifically targeted to assist homeless people.
- HUD's FY 2006 to FY 2011 strategic plan's objective is to end chronic homelessness and move homeless families and individuals to permanent housing. HUD's approach to replacing homelessness with housing stability relies on three coordinated efforts: prevention; development of permanent and transition housing for the chronically homeless and families; and coordination of housing assistance with supportive services.
- Driven by HUD's Housing First policy, a joint local effort under the Cuyahoga County Office of Homeless Services has resulted in a ten year plan to prevent homelessness and expand affordable housing in Cleveland and Cuyahoga County.
- As of May 11, 2006, $291,469 in revenues for homeless drop-in center programs has been identified countywide.
- The National Alliance to End Homelessness' "Sourcebook on Family Homelessness" states that drop-in centers are effective at engaging homeless men and women who would not ordinarily access the shelter system.
- Recent research found that a drop-in center that eliminated barriers to access to services was more successful than the control programs in reducing homelessness. However, after 24 months only 38 percent of participants had moved to community housing. A subsequent apartment program that placed the experimental group individuals in subsidized apartments directly from the street, with services under their control, had 79 percent in stable housing (compared to 27 percent in the control group) at the end of 6 months.
- An estimated 4,960 homeless persons need homeless drop-in center programs, which is 31 percent of the estimated number of homeless persons in Cuyahoga County (16,000). The number of persons reported being served is far in excess of the national survey's finding

that 10 percent of the homeless used other homeless assistance programs (e.g., drop-in centers, food pantries, outreach programs, mobile food programs) within the last week. Application of this percentage to the estimated 16,000 homeless persons in Cuyahoga County would have 1,600 consumers of drop-in centers. This suggests that there is no unmet need for homeless drop-in center services in Cuyahoga County.

- Countywide, there are 7 service sites for homeless drop-in center programs. This is a ratio of 708 possible consumers (estimated 4,960 total) per service site countywide.

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ATTACHMENTS

Attachment 1: Researcher List

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Thanks to ***The Center for Community Solutions*** for providing multiple sources of information.

Attachment 2: Technical Notes

Technical Notes:
Methodology, Caveats, Limitations of Data

The following provides descriptions, definitions, methodologies, caveats, or limitations of data for the following components of the core service reports:

- Unit of Analysis
- First Call for Help Data
- Funding Information for Core Services
- Consumer and Financial Data: Caveats
- Gap Analysis Methodology & Limitations
- Service Site Index

Unit of Analysis

The core service is the unit of analysis. United Way of Greater Cleveland either funds or could fund 80 core services. These are the object and subject of the research, specific to Cuyahoga County. A separate report has been developed for each service. It must be noted that the aggregate of any quantifiable data across all of the reports does not comprise a picture of the totality of health and human services in Cuyahoga County because there are many more than 80 services that comprise the community's safety net.

The unit of analysis for estimates of service consumers is the individual, the family, or the household.

United Way - First Call for Help Data

For most core services, United Way First Call for Help (FCFH), the community's resource and referral service data, was used in tables that show the number of service providers and service sites, the geographic location of service providers by zip code, the service area by zip code as reported by providers of the respective services, and to show unmet need and greatest increase/decrease in calls received by FCFH for a particular core service.

It is important to remember that FCFH receives calls from a variety of sources that include people calling on behalf of a prospective consumer such as social workers, provider agencies, relatives, etc. Not all calls come directly from a prospective consumer, so some of the zip codes are for hospitals and business addresses, although the numbers for these zip codes are relatively small.

Calls also may be from people who are not interested in receiving a service, but wish instead to make a contribution to a program such as clothing, household items, food, books, crafts supplies, etc.

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services, however,

seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

- Adolescent/Youth Counseling: A caller asking about help with their troubled teenager would be referred by the type of counseling rather than age. (Example: counseling for drugs, family, sexual abuse, etc.)
- Advocacy: FCFH does not receive calls from people about advocacy.
- Child Care: Calls are directed to Starting Point.
- Condition Specific Rehabilitation Services: FCFH would refer caller back to their primary care physician for a referral.
- Early Intervention for Mental Illness: FCFH does not receive calls for this, but if they did, they would refer to the county's Help Me Grow program.
- Family Support Centers: FCFH defines data by specific service rather than type of agency. Depending on the call, the caller may be referred to General Counseling or Early Intervention for Infants and Toddlers with Disabilities, and so on.
- Preschools: Calls are directed to Starting Point.

A different match was used for other services that had no crosswalk.

- Medical Transportation and Senior Ride: FCFH uses "Paratransit" as they do not differentiate between senior transportation, medical transportation, and transportation for the disabled.
- Outpatient Mental Health Facilities: FCFH uses "Mental Health Drop-in Centers."

It must also be noted that, for the most part, the FCFH database does not include for-profit agencies. In the case of home health care providers, we contacted the Long Term Care Ombudsman for a more complete list of provider agencies which includes for-profit organizations.

There were several instances where the FCFH database did not code a United Way-funded agency with the core service for which they were receiving funding. In these instances, the agency was added manually to the Service Provider Table along with their site locations. The core services with the respective United Way of Greater Cleveland agencies that were added are:

- Case/Care Management – Care Alliance, Cystic Fibrosis, Epilepsy Foundation, Golden Age Centers
- Comprehensive Outpatient Substance Abuse Treatment – The Covenant
- Disease/Disability Information – The Muscular Disease Society of Northeastern Ohio
- Early Intervention for Infants and Toddlers with Disabilities – United Cerebral Palsy
- Medical Expense Assistance – North Coast Health Ministry
- Medical Transportation (Paratransit in FCFH) – Kidney Foundation of Ohio
- Senior Centers – Catholic Charities Services Corporation, Jewish Community Center of Cleveland, Jewish Family Service Association of Cleveland, University Settlement House.
- Volunteer Development – Neighborhood Leadership Institute

It must also be noted that when numbers are low for trend data reported, the high percentages are slightly exaggerated.

Funding Information for Core Services

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

Foundation Funding

We attempted to obtain foundation funding amounts for each core service from the latest annual report or 990 PF (foundation tax return to the IRS) of each major foundation that funds social services in Greater Cleveland. Wherever a description of the grant purpose was given, we used our best judgment to match the grant to the appropriate core service. If the grant fell within more than one core service area, it was not listed. When no description was given, the grant was treated like a general operating grant and assigned to a core service only when the mission of the grant recipient fell mainly within one particular core service. In-kind donations, grants for capital and equipment expenses and administrative salaries were not used. When grants were $10,000 or greater, they were listed by name of the foundation. All others were placed under Other Foundations and not listed. Typically, we did not attempt to provide trend financial data for foundation funding of core services because of the changing nature of funded programs from year to year.

Federated Funding Sources

We approached the major federated funders of core services in Greater Cleveland for funding and consumer information. Some data provided was for a single point in time; others provided three years of trend data. We often had to do a cross walk of United Way of Greater Cleveland funded core services against those funded by federated agencies to agree on the services.

Government Funding

We approached every major government funder for funding amounts for each core service and also did Internet searches for some federal government sources. Due to the constant state of change in government funding, it is important to note that the data provided is a snapshot in time and that many of the programs funded in 2004 have changed definition, are funded through different revenue sources, or no longer exist at all due to a lack of funding. This is particularly true of Community Development Block Grant dollars which have decreased due to shifting federal priorities.

Every effort was made to appropriately match government funding data to the correct core service area; however, this was not always possible as frequently the service definitions were not a one-to-one match. It was necessary, in some instances, to take the closest match or use the sore service which represented a majority of the services being provided.

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases where Medicaid is a significant source of revenue, the data was entered as an aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

Every effort was made to include data from municipalities. However, many did not respond after repeated requests for information. We would like to thank those who took the time to help with this project.

Medicaid Funding

A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

Entered as Aggregate Total Under Appropriate AIRS Level

- Medicaid Service - Home Care ($17,787,703 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: daily living aids and home health care.
- Medicaid Service - CADAS ($8,522,183 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.
- Medicaid Service - Therapy ($2,257,394 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: condition specific rehabilitation, and speech & hearing.
- Medicaid Service - CMH ($67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and includes the following core services: supportive therapies, adolescent/youth counseling, children's residential treatment facilities, early intervention for mental illness, general counseling services (outpatient mental health facilities), and psychiatric day treatment.

Entered as Aggregate Total Under Third Party Payee/Direct Bill

- Medicaid Service - Inpatient Hospital ($188,329,269 in 2004) - Falls into two different AIRS 1 categories: Basic needs and health care. It includes the following core services: condition specific rehabilitation and medical expense assistance.
- Medicaid Service - Waiver ($128,921,354 in 2004) – This category included all PASSPORT services. Since we reported PASSPORT separately, in order to avoid duplication, we deducted the PASSPORT total of $52,676,048 from this number and reported the remaining $76,245,306. This total falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: adult day care, home-delivered meals, home health care and in-home assistance.
- Medicaid Service - Habilitation ($55,550,307 in 2004) - Falls into AIRS 1 Health Care and Individual & Family Life and includes the following core services: condition specific rehabilitation services, early intervention for infants and toddlers with disabilities/delays, and residential living options for people with disabilities.

United Way of Greater Cleveland Funding

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are

unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues
Annually United Way-funded agencies submit revenue budgets to United Way for each funded core service. This information for FY 2004 is reported. However, all of the agency data may not be included in the countywide data as agencies may have assigned dollars from unrestricted grants to a specific core service, or allocated a portion of grant monies that fell within two or more core service areas. It was not always possible to match countywide government or foundation funding with that reported by the agencies and that gathered from other funding sources.

Consumer and Financial Data: Caveats

The following applies to revenue sources on tables and graphs and their corresponding consumer data used in the consumer demographics and zip code tables.

All Core Services
Data was self-verified by the funder/provider. Whenever data provided by a funder appeared to be inconsistent or incorrect, an attempt was made to contact the funder. If the funder responded, the data was either adjusted according to their instructions, or the reason for discrepancies footnoted. If they did not respond, or if they said it was correct, the data was left as submitted.

Demographic and zip code data provided by the funder/provider is frequently taken from consumer intake forms which may have missing or incomplete data, or from provider agency databases which contain data entry errors or incomplete consumer intake forms. Whenever possible, the funder was asked for corrected data. In cases where a correction was not possible, the data was counted as either unknown or missing. The usage of these terms is footnoted at the bottom of each table and is explained more fully in the Gap Analysis section of this attachment.

It was not always possible to get information in the format requested as each funder tracks data differently, using different service definitions, terminology and variables. Wherever possible, data was matched to a consistent report format.

When a funder could not provide consumer demographics, but could provide an estimated percentage of consumers by category, we took the total number of consumers and applied the percentages to come up with estimated numbers for the consumer tables. For example, Medicaid tracks individual recipients throughout the year, entering new data if there is a change, each time a claim occurs. Thus, a consumer who has a birthday between claims will appear in the system for that year with two different ages.

To resolve this, the percentage of consumers in each age range was determined for the total number of duplicated consumer ages. Those percentages were then applied to the total number of unduplicated consumers for the year in order to reach a total number of unduplicated consumers for each age range.

The time periods for both revenue and consumers vary by funder/provider. United Way Program Report data is for FY 2004 (July 2003 to June 2004). Other funder/provider data is for either a January to December or July to June fiscal year.

Gap Analysis Methodology & Limitations

Based on Anderson's (1964) seminal needs assessment model, realized access is defined as the number of consumers who receive service while unrealized access is the estimated number of consumers who need and would utilize a service, but are not currently receiving it. This could be considered the service gap. Unrealized consumer access to services drives the need for change in the social service delivery system. Ensuring unrealized consumer access to services requires new models of service delivery related to access, effective use of resources, data management, and funding. There were multiple steps used to conduct a gap analysis:

- *Estimate of persons in need of the service*: Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
  - In some cases data was "unknown," defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
  - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, "missing" represents data funders/providers were unable to provide.
  - There was no check of the accuracy of data submitted by agencies.
  - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
  - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
  - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.
- *Estimate of number of "unknown/non-consumers":* This is the difference between the estimated number of actual consumers and the estimate of persons in need.
- *Estimate of number of "would-be users" (unrealized access)*: This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of "never users":* This is the difference between the estimated number of unknown/non-consumers and would-be users.

- *Estimate of "universe of possible consumers":* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

We recognize that this is not a perfect method for assessing either realized or unrealized access to core services. However, we opted to use an imperfect method rather than no method to demonstrate both the complexity and the usefulness of quantifying realized and unrealized access to services as a first step toward a more rigorous methodology. In the business sector this would be a form of market analysis. We also recognize that actual consumer numbers are not unduplicated across funders, or across core services. Thus, there is much work yet to be done to gain realistic estimates of needs.

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

Service Site Index

For many services a service site index was developed. It provides a ratio of estimated consumers per service site on a countywide level and for each zip code within the county. The ratio is based on the number derived from the gap analysis described in the previous section and on the number of providers who reported to United Way – First Call for Help whether a specific service site includes a given zip code in its service area. A provider site is located in a single zip code, but could serve multiple zip codes. The ratio is a measure of potential service accessibility by estimated universe of service consumers per zip code area. This measure does not include the capacity of providers to offer the service, for example, the number of consumers that can be served on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving service. The index also gives an indication of which zip codes have higher ratios which means that consumers have a lower probability of receiving a service as well as any patterns in zip codes that have high percentages of African Americans, Asians, or Hispanics. A map is also attached which provides a graphic picture of the estimated consumers by zip code.

Based on the numbers of providers that report to FCFH whether they serve a given zip code, we had assumed that there would be greater variability across zip codes. In reality, many report that they serve the entire county. Thus the variability across zip codes is often primarily because of differences in the population numbers rather than in service sites that offer service in a given zip code.

Specific Service Issues

Senior Services

"Senior Centers" was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from

senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

Senior Ride includes disabled individuals of all ages as well as seniors for most funders with the notable exception of Western Reserve Area Agency on Aging (WRAAA) that requires an individual to be 60 years of age or older in order to receive services. If the transportation service was not provided by a senior center, the number of consumers reflects the number of riders using the system and contains duplicates (e.g. paratransit).

Home improvement/accessibility data includes programs for low-income families and people of all ages with disabilities, as well as seniors.

References

Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior,* 36(1): 1-10.

Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis.* New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Homeless Drop-in Center BH-180.350				
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****
	Total Population (%)*	Estimated Homeless Persons (%)**	Estimated Unsheltered Persons (%)***	UW Program Report Data Cuy Cnty Only (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004
TOTAL	1,393,978	16,000	4,960	6,366
Percent		1.1%	31.0%	100.0%
GENDER				
Male	47.2%	N/A	N/A	69.0%
Female	52.8%	N/A	N/A	31.0%
Unknown Data*****				0.0%
Missing Data******				0.0%
RACE*****				
White alone	67.1%	N/A	N/A	21.5%
Black or African American alone/combination	27.9%	N/A	N/A	68.2%
Asian alone/combination	2.1%	N/A	N/A	0.3%
American Indian and Alaska Native alone/combination	0.7%	N/A	N/A	2.7%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	N/A	N/A	0.0%
Some other race alone/combination	2.1%	N/A	N/A	7.4%
Unknown Data*****				0.0%
Missing Data******				0.0%
HISPANIC******	3.3%	N/A	N/A	4.9%
AGE				
0-4	6.5%	N/A	N/A	0.0%
5-9	7.3%	N/A	N/A	0.0%
10-14	7.1%	N/A	N/A	0.0%
15-19	6.4%	N/A	N/A	1.1%
20-34	19.1%	N/A	N/A	23.1%
35-54	29.3%	N/A	N/A	38.8%
55-64	8.7%	N/A	N/A	27.9%
65-74	7.8%	N/A	N/A	8.6%
75+	7.8%	N/A	N/A	0.5%
Unknown Data*****				0.0%
Missing Data******				0.0%
INCOME*******				
Average Household Size	N/A	N/A	N/A	N/A
$0-$9,999	11.3%	N/A	N/A	82.8%
$10,000-$14,999	6.9%	N/A	N/A	14.1%
$15,000-$19,999	6.7%	N/A	N/A	3.0%
$20,000-$29,999	13.6%	N/A	N/A	0.0%
$30,000 and above	61.5%	N/A	N/A	0.0%
Unknown Data*****				0.0%
Missing Data******				0.0%
Totals	100.0%	N/A	N/A	100.0%

Attachment 3: Actual Consumer Demographics (continued)

*U.S. Census 2000, SF1(P1); SF4 (PCT 144)

**_Heading Home,_ The Cleveland/Cuyahoga County Ten Year Plan to Prevent Homelessness and Expand Affordable Housing: "A Five-Year Plan to Develop Supportive Housing for Long-Term Homeless Adults in Cleveland and Cuyahoga County." Prepared by the Corporation for Supportive Housing in collaboration with The Maxine Goodman Levin College of Urban Affairs, Cleveland State University, 2003 - estimated approximately 16,000 Cuyahoga County residents are homeless at some point in time during the course of a year. 1.1 percent total population

***This is based on the National Survey of Homeless Assistance Providers and Clients (1996) findings that, nationally, 31 percent of the homeless slept on the streets or in other places not meant for habitation within the last week, which is reflective of HUD's definition of the unsheltered.

****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.

*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.

******Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.

******* The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").

********Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.

*********The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multipled by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category which may result in more conservative estimates for children and the "old old" which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Homeless Drop-in Center - BH-180.350					
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****
	City/Town (% Cleveland)	Total Population (%)*	Estimated Homeless Persons (%)**	Estimated Unsheltered Persons (%)***	UW Program Report Data (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004
TOTAL		1,393,978	16,000	4,960	6,366
Percent			1.1%	31.0%	100.0%
44017	Berea	1.4%	N/A	N/A	0.0%
44022	Bentleyville	1.3%	N/A	N/A	0.0%
44040	Gates Mills/Mayfield Village	0.2%	N/A	N/A	0.0%
44070	North Olmsted	2.4%	N/A	N/A	0.0%
44101	Cleveland (100%)	0.0%	N/A	N/A	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	N/A	N/A	0.0%
44103	Cleveland (100%)	1.8%	N/A	N/A	0.0%
44104	Cleveland (100%)	2.1%	N/A	N/A	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	N/A	N/A	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	N/A	N/A	0.0%
44107	Lakewood/Cleveland	4.0%	N/A	N/A	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	N/A	N/A	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	N/A	N/A	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	N/A	N/A	0.0%
44111	Cleveland (100%)	3.1%	N/A	N/A	0.0%
44112	East Cleveland/Cleveland	2.4%	N/A	N/A	0.0%
44113	Cleveland (100%)	1.4%	N/A	N/A	0.0%
44114	Cleveland (100%)	0.3%	N/A	N/A	85.5%
44115	Cleveland (100%)	0.6%	N/A	N/A	14.5%
44116	Rocky River	1.5%	N/A	N/A	0.0%
44117	Euclid/Cleveland	0.9%	N/A	N/A	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	N/A	N/A	0.0%
44119	Cleveland/Euclid (50%)	1.0%	N/A	N/A	0.0%
44120	Shaker Hts/Cleveland	3.4%	N/A	N/A	0.0%
44121	University Hts/South Euclid	2.5%	N/A	N/A	0.0%
44122	Beachwood/Highland	2.5%	N/A	N/A	0.0%
44123	Euclid	1.3%	N/A	N/A	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	N/A	N/A	0.0%
44125	Valley View/Garfield Hts	2.1%	N/A	N/A	0.0%
44126	Fairview Park/Cleveland	1.2%	N/A	N/A	0.0%
44127	Cleveland (100%)	0.6%	N/A	N/A	0.0%
44128	Warrensville Hts/Cleveland	2.4%	N/A	N/A	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	N/A	N/A	0.0%
44130	Parma/Cleveland	3.8%	N/A	N/A	0.0%
44131	Independence/Seven	1.5%	N/A	N/A	0.0%
44132	Euclid	1.1%	N/A	N/A	0.0%
44133	North Royalton	2.0%	N/A	N/A	0.0%
44134	Parma/Cleveland	2.9%	N/A	N/A	0.0%
44135	Cleveland/Linndale (90%)	2.0%	N/A	N/A	0.0%
44136	Strongsville	3.1%	N/A	N/A	0.0%
44137	Maple Hts/Cleveland	1.9%	N/A	N/A	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	N/A	N/A	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	N/A	N/A	0.0%
44140	Bay Village	1.1%	N/A	N/A	0.0%
44141	Brecksville	1.0%	N/A	N/A	0.0%
44142	Brookpark/Cleveland	1.5%	N/A	N/A	0.0%
44143	Highland Hts/Richmond Heights	1.7%	N/A	N/A	0.0%
44144	Brooklyn/Cleveland	1.6%	N/A	N/A	0.0%
44145	Westlake	2.3%	N/A	N/A	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	N/A	N/A	0.0%
44147	Broadview Hts	1.1%	N/A	N/A	0.0%
44149	Strongsville	0.0%			0.0%
Unknown Cuyahoga County Zip Codes******					0.0%
Missing*****					0.0%
Unknown ******					0.0%
Total Cuyahoga County*******		100.0%	N/A	N/A	100.0%
Total Known Cleveland		30.5%	N/A	N/A	100.0%
Total Known Suburbs		69.5%	N/A	N/A	0.0%
Unknown & Missing					0.0%

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S.Census 2000, SF1 (P1)

**Heading Home,* The Cleveland/Cuyahoga County Ten Year Plan to Prevent Homelessness and Expand Affordable Housing: "A Five-Year Plan to Develop Supportive Housing for Long-Term Homeless Adults in Cleveland and Cuyahoga County." Prepared by the Corporation for Supportive Housing in collaboration with The Maxine Goodman Levin College of Urban Affairs, Cleveland State University, 2003 - estimated approximately 16,000 Cuyahoga County residents are homeless at some point in time during the course of a year, or 1.1 percent total population. Same ratio applied to each zip code.

***Based on the National Survey of Homeless Assistance Providers and Clients' (1996) findings that, nationally, 31 percent of the homeless slept on the streets or in other places not meant for habitation within the last week which is reflective of HUD's definition of the unsheltered.

**** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.

*****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.

******Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.

******* Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zipcodes because some zipcodes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS – 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	6	3
Number of Providers by Type		
Non-profit	5	3
For-profit	-	-
Government	-	-
Other	1	-
Total Number of Sites	7	11
Number of Service Sites per Provider		
1	5	1
2 – 5	1	1
6 – 10	-	1
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	-	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	-	-
44103 – Cleveland	1	-
44104 – Cleveland	-	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	-	-
44107 – Cleveland/Lakewood	-	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	-	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	-	-
44112 – Cleveland/East Cleveland	-	-
44113 – Cleveland	3	-
44114 – Cleveland	3	-
44115 – Cleveland	-	-
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	-	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	-	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	-	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	-	-
44125 – Valley View/Garfield Hts	-	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-
44128 – Cleveland/Warrensville Hts	-	-

Attachment 5: Profile of Core Service Providers – 2005 (continued)

PROFILE OF CORE SERVICE PROVIDERS – 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	-	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	-	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
Catholic Charities Health And Human Services - Emergency Assistance Services	Drop-In Center - Homeless Men And Women
Catholic Worker Community Of Cleveland	Drop-in Centers For Homeless
City Mission	Men's Homeless Drop In - Extreme Cold
Mental Health Services	Drop-in Center For Homeless Women And Children, Drop-in Center- Homeless Mentally Ill/Disabled
St. Paul's Community Church - United Church Of Christ	Drop-in Center/Clothing
West Side Catholic Center	Drop-in Centers For Homeless

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Homeless Drop-in Center Requests – 2000-2004: Greatest Increase/Greatest Decrease

BH-180.350 Homeless Drop-in Center								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44132	Euclid	1	3	1	1	3	200%	2
44140	Bay Village	0	0	0	0	1	N/A	N/A
44022	Bentleyville	1	1	1	0	0	(100%)	1
44139	Bentleyville/Glenwillow/Solon	3	0	0	1	0	(100%)	1
44017	Berea	4	1	0	1	0	(100%)	1
44141	Brecksville	1	0	1	1	0	(100%)	1
44147	Broadview Hts	1	2	0	0	0	(100%)	1
44144	Brooklyn/Cleveland	1	1	2	1	0	(100%)	1
44129	Brooklyn/Parma/Cleveland	2	4	1	1	0	(100%)	2
44142	Brookpark/Cleveland	1	3	2	0	0	(100%)	1
44101	Cleveland	2	1	0	0	0	(100%)	1
44181	Cleveland - PO Box	1	0	0	0	0	(100%)	N/A
44119	Cleveland/Euclid	2	5	0	2	0	(100%)	2
44126	Fairview Park/Cleveland	3	4	0	0	0	(100%)	1
44143	Highland Hts/Richmond Heights	5	4	0	0	0	(100%)	2
44070	North Olmsted	4	3	0	1	0	(100%)	2
44133	North Royalton	2	0	0	0	0	(100%)	N/A
44138	Olmsted Twp/Olmsted Falls	2	3	0	0	0	(100%)	1
44124	Pepper Pike/MayfieldHts/Lyndhurst	3	1	1	1	0	(100%)	1
44116	Rocky River	3	1	1	0	0	(100%)	1
44136	Strongsville	4	3	0	1	0	(100%)	2
44145	Westlake	1	0	1	0	0	(100%)	N/A
44110	Cleveland/East Cleveland	42	48	10	9	1	(98%)	22
44109	Cleveland/Brooklyn Hts	46	31	7	6	2	(96%)	18
44105	Cleveland/NewburghHts/GarfieldHts	109	78	14	19	7	(94%)	45
44120	Shaker Hts/Cleveland	57	54	22	11	4	(93%)	30
44128	Warrensville Hts/Cleveland	27	21	5	4	2	(93%)	12
44104	Cleveland	66	50	7	9	5	(92%)	27
44127	Cleveland	13	16	2	5	1	(92%)	7
44107	Lakewood/Cleveland	12	13	3	3	1	(92%)	6
44108	Cleveland/Bratenahl	71	63	16	7	6	(92%)	33

Attachment 7: United Way - First Call for Help Homeless Drop-in Center Requests – 2000-2004: Greatest Increase/Greatest Decrease (continued)

BH-180.350 Homeless Drop-in Center								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44106	Cleveland/Cleveland Hts	72	59	11	12	7	(90%)	32
44112	East Cleveland/Cleveland	76	64	19	12	10	(87%)	36
44146	Walton Hills/Oakwood/Bedford	15	9	2	1	2	(87%)	6
44135	Cleveland/Linndale	14	17	1	4	2	(86%)	8
44130	Parma/Cleveland	7	4	2	2	1	(86%)	3
****Total Cuyahoga County**		**1,063**	**915**	**288**	**228**	**156**	**(85%)**	**530**
****Total Cleveland**		**757**	**664**	**204**	**171**	**110**	**(85%)**	**381**
****Total Suburbs**		**306**	**251**	**84**	**57**	**46**	**(85%)**	**149**

* Extremely high percentages are due to low numbers.

** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.

Attachment 8: United Way - First Call for Help 2000-2004: Unmet Need

BH-180.350 Homeless Drop-in Center

United Way - First Call for Help Requests 2000-2004

Unmet Need

Zip Code		TOTALS 00-04			%
		Requests	**Met**	**Unmet**	**Unmet**
44117	Euclid/Cleveland	22	21	1	5%
44111	Cleveland	53	51	2	4%
44112	East Cleveland/Cleveland	181	176	5	3%
44103	Cleveland	117	114	3	3%
44105	Cleveland/NewburghHts/GarfieldHts	227	222	5	2%
44109	Cleveland/Brooklyn Hts	92	90	2	2%
44113	Cleveland	99	97	2	2%
44108	Cleveland/Bratenahl	163	160	3	2%
44102	Cleveland/Brooklyn	174	171	3	2%
44104	Cleveland	137	135	2	1%
44115	Cleveland	393	388	5	1%
44114	Cleveland	80	79	1	1%
44120	Shaker Hts/Cleveland	148	147	1	1%

	Requests	Met	Unmet	% Unmet
*** Total Cuyahoga County**	**2,650**	**2,615**	**35**	**1%**
*** Total Cleveland**	**1,906**	**1,878**	**28**	**1%**
*** Total Suburbs**	**744**	**737**	**7**	**1%**

FCFH DATA NOTES

Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)

Unmet = service request for which there was no referral.

Note: Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.

* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.

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