



Home, Together: Tompkins

The CoC's homeless response plan for ending unsheltered homelessness and enhancing service delivery for people with severe service needs.

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Table of Contents

| | |
|---|-----------|
| Table of Contents | 1 |
| Letter from the CoC | 3 |
| Introduction | 4 |
| Background | 6 |
| The History of the Encampment | 6 |
| Housing as a Public Health Measure | 7 |
| Home, Together | 7 |
| Policies to End Homelessness | 8 |
| Tompkins County Homeless and Housing Needs Assessment | 10 |
| Definitions of Target Populations | 12 |
| The New Homeless Definition | 12 |
| Severe Service Needs | 13 |
| Other Relevant Definitions | 14 |
| Housing-First | 14 |
| Trauma-Informed Care | 15 |
| Harm Reduction | 16 |
| Racial Equity | 16 |
| Housing Surge | 17 |
| Temporary Housing Assistance (THA) | 18 |
| Cold Weather Policy/Code Blue | 18 |
| The Home, Together: Tompkins Plan | 19 |
| 1. A commitment to building 100 studio and 1-bedroom units of PSH | 20 |
| 2. Low-barrier shelter that uses a trauma-informed approach to safety. | 20 |
| 3. A “housing surge” strategy and by-name list | 23 |
| 4. Mitigation funds for business owners and landlords | 25 |
| 5. Other incentives such as a shopping cart exchange and cash for trash program | 25 |
| 6. Low-barrier move-in packages and assistance for moving from homeless to housed | 26 |
| 7. Three enhanced, centralized housing navigator positions | 27 |
| 8. Paid board positions for people with lived experience | 29 |
| 9. Professional development opportunities for people with lived experience | 29 |
| Planning and Implementation | 31 |
| Opportunities for the City of Ithaca | 34 |
| Opportunities for the Tompkins County Legislature | 34 |
| Other Complementary Interventions | 35 |
| References | 38 |

| | |
|---|-----------|
| Appendices | 42 |
| Appendix A: Funding Options | 42 |
| Appendix B: Needs Assessment Graphic | 46 |
| Appendix C: Home, Together Tompkins Outcome Metrics | 47 |

Letter from the CoC

We are incredibly grateful to work with and for this community in our efforts to build a homeless response system that will ultimately make homelessness rare, brief, and one-time. The CoC recognizes that our current system creates suffering for people experiencing homelessness by posing the issue of for-profit housing as a personal failing for every unhoused individual in our community. With this plan, we reject this belief and advocate for a radical culture shift to create a system that adequately serves people with severe service needs in our community.

When describing the solution to ending homelessness, people are often surprised that the answer is permanent, low-cost, supportive housing. There is usually an assumption that, as experts in this field, we must be aware of some new groundbreaking solution to homelessness that no one has considered before, but that is incorrect. The only thing radical about our solution is the insistence that every individual should have a human right to housing in our homeless response system because housing is a fundamental necessity for people to find stability and meet their long-term goals. It is also a fundamental necessity for health.

We have seen system change translate into transformative culture change in other systems. Notably, the recovery and treatment field has intentionally shifted away from punitive abstinence-only treatment models and has embraced the harm reduction model, medication-assisted treatment, and person-centered care. As recently as the mid-2000s, local treatment providers used a fully abstinence-only approach to treating addiction. It wasn't working, people were "failing" at treatment, and the heroin epidemic was in full swing. Researchers began to examine alternative treatment models and better track data to tackle the failing treatment sector. They learned that addiction is a progressive, fatal brain disease and that relapse is a natural part of the disease. Armed with that evidence and data, the harm reduction treatment model appeared. Providers began to modify their systems, practices, and, ultimately, the service delivery model. Before the shift, access to medication-assisted treatment was limited to people who could practice complete abstinence. When people relapsed, they risked losing their life-saving medication and trust was eroded between client and provider. Adopting a more person-centered system improved clients' recovery outcomes, and lives were saved. The larger community began to see the humanity in people with addiction.

The CoC intends to make a similar cultural shift in how we think about housing and homelessness. Our community currently lacks safe, habitable spaces where people can stabilize themselves and live indoors for low or no cost. *Home, Together: Tompkins* plans to address this while also acknowledging the obvious; this plan cannot be successful without all stakeholders- including legislators, service providers, outreach workers, community members, and people with lived experience of homelessness- coming together and creating the systems change necessary to alleviate our county's homeless crisis.

Simone Gatson, CoC Staff and Coordinated Entry Lead

Liddy Bargar, Director of Housing Initiatives and CoC Coordinator

Introduction

The Continuum of Care (CoC) is a program by the United States Department of Housing and Urban Development (HUD) dedicated to organizing community-wide involvement in preventing and ending homelessness. Ultimately the goal of the CoC is to rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness. The Continuum of Care does this by promoting access to supportive housing and other supportive services for individuals experiencing homelessness through our Coordinated Entry (CE) process, as well as organizing community planning and education regarding building a more trauma-informed, housing-first homeless response system.

Following the findings of our most recent Homeless and Housing Needs Assessment, the Continuum of Care believes that the only way to end homelessness is by expanding access to housing opportunities in our continuum. The CoC is committed to doing precisely that to meet the demonstrated needs of people experiencing homelessness through our plan: ***Home, Together: Tompkins***.

In alignment with the federal strategic plan to end homelessness published by USICH¹, ***Home, Together: Tompkins*** integrates evidence-based best practices to end homelessness for people with severe service needs in our Continuum of Care. This plan aims to build the low-cost housing necessary to resolve the current bottleneck in our existing homeless response system and increase accessibility through targeted programming. In addition, the Continuum of Care believes that implementing coordinated, time-limited strategies to exit people from unsheltered homelessness will ultimately lead to better health outcomes for everyone.

In addition to expanding the permanent housing options available in our community, the Continuum of Care also recommends easing community tensions through the implementation of several incentive programs, including a mitigation fund for business owners and landlords, a shopping cart exchange program, a cash for trash redemption program, and move-in funds for people entering housing from homelessness. By implementing these initiatives, the CoC hopes to provide opportunities for everyone in our community to heal from the rise in unsheltered homelessness through engagement.

The last component of ***Home, Together: Tompkins*** is expanding the capacity of the human services sector. Many organizations within our continuum struggle to hire for positions that serve the people most in need of direct service in our community. The Continuum of Care wants to expand these organizations' hiring pools by implementing a professional development track for people with lived experience to act as peers in those positions. The CoC also recommends adding three enhanced housing navigator positions as a centralized resource for warm, rapid

¹ United States Interagency Council on Homelessness. 2018. "Home, Together: The Federal Strategic Plan to Prevent and End Homelessness." United States Interagency Council on Homelessness (USICH). https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf.

progress toward entering and maintaining permanent housing. The final recommendation is to develop a paid board of individuals with lived experience to integrate their voices and experiences into CoC decision-making.

Our staff is committed to introducing diversion and prevention methods into our current homeless response system through trauma-informed planning. The CoC intends to use this plan to better serve individuals with severe service needs regardless of their housing status. While the Continuum of Care designed *Home, Together: Tompkins* with the goal of ending unsheltered homelessness, this plan will also introduce prevention resources through dedicated housing specialists and incentive programs for people with severe service needs who need help to stay in their housing.

Overall, the *Home, Together: Tompkins* plan covers three clear domains needing coordinated response following the COVID-19 pandemic by providing routes to permanent housing, meaningful employment, and better relations with local business owners, landlords, and neighbors for people with severe service needs. The Continuum of Care would monitor and assist the projects in this plan using our existing database and Coordinated Entry process to ensure that we meet the goals outlined in this plan.

Background

The History of the Encampment

Ithaca's West End has been home to unhoused people dating back to the 1920s when the area was home to a neighborhood of temporary structures and tents occupied by a group known as "The Rhiners".² The city first cleared the Rhiner community in 1927.³ However, despite ongoing efforts to suppress the encampment throughout the decades, there has been a known encampment community in the West End Inlet area ever since.

The Continuum of Care attempts annually to determine the numbers and specific service needs of people living in the encampment space through our Point in Time Count. Before 2020 there had been small, loosely organized groups of agency staff and private citizens performing street outreach services. These services ranged from relationship building and meeting basic needs to linkages with existing services and light case management. At the onset of the COVID-19 public health crisis, the Continuum of Care assembled the Enhanced Street Outreach Team. This team included members from all existing groups performing street outreach services and added REACH medical, Loaves and Fishes, and other critical partners. The team began meeting weekly to address the health and safety needs of people residing in the encampment.

As public spaces shut down, it became nearly impossible for people living outside to reasonably meet many of their essential needs. The first initiative of the Enhanced Street Outreach Team was to secure permission from the City of Ithaca and Park Foundation funding to provide several porta-potties and handwashing stations within the encampment. Additional flexible funding came from Robert Wood Johnson Foundation, allowing the team to quickly develop responses and pilot projects. These included daily prepared meal delivery from Loaves and Fishes, facilitated telehealth appointments with REACH medical, the installation of a Mutual Aid food pantry on-site, distribution of hundreds of masks and other PPE, and a fire safety partnership with the Ithaca Fire Department that included providing more than 25 fire extinguishers. The Enhanced Street Outreach Team continues to coordinate services and connect people with coordinated entry and permanent housing.

Currently, the Continuum of Care estimates that there are approximately 40 people living in the West End Inlet area, with up to 20 people living in other unsheltered areas throughout the county. These numbers are seasonal, as many individuals move into shelter during cold weather policy at our emergency shelter, when barriers to entering the shelter are lower. As cold weather policy generally lasts from October to April, outreach workers tend to see fewer individuals sleeping in unsheltered locations during this time, and more unsheltered individuals between May and September. This gives us an estimated total of about 60 individuals experiencing unsheltered homelessness in Tompkins County during the May to September period of time.

² Marteau, Erin. "Ithaca Children's Garden: Then and Now." Tompkins Weekly, 15 January 2018, <https://www.tompkinsweekly.com/articles/ithaca-childrens-garden-then-and-now/>. Accessed 29 November 2022.

³ Kammen, Carol, and Jane Marsh Dieckmann. Ithaca: A Brief History. Charleston, SC, The History Press, 2008.

Housing as a Public Health Measure

Providing safe and stable housing for everyone in our county is a vital intervention to address the public health emergency faced by our unsheltered population. The National Health Care for the Homeless Council makes this case very clearly in their 2019 Article “Homelessness & Health: What’s the Connection?” where they note that “living on the street or in crowded homeless shelters is extremely stressful and made worse by being exposed to communicable disease (e.g. TB, respiratory illnesses, flu, hepatitis, etc.), violence, malnutrition, and harmful weather exposure. Chronic health conditions such as high blood pressure, diabetes, and asthma become worse because there is no safe place to store medications properly. Maintaining a healthy diet is difficult in soup kitchens and shelters as the meals are usually high in salt, sugars, and starch (making for cheap, filling meals but lacking nutritional content). Behavioral health issues such as depression, alcoholism, or other substance use disorders can develop and/or are made worse in such difficult situations, especially if there is no solution in sight. Injuries that result from violence or accidents do not heal properly because bathing, keeping bandages clean, and getting proper rest and recuperation isn’t possible on the street or in shelters. Minor issues such as cuts or common colds easily develop into larger problems such as infections or pneumonia. Numerous health conditions among people who are homeless have higher rates of illness and die on average 12 years sooner than the general U.S. population... Poor health, high stress, unhealthy and dangerous environments, and an inability to control food intake often result in frequent visits to emergency rooms and hospitalizations”.⁴

While many professionals recognize housing as a social determinant of health, the Continuum of Care asserts that access to stable housing is more than that. Housing is a prerequisite to achieving and maintaining health in our county for the reasons listed above by the NHCHC. The growth of our population experiencing unsheltered homelessness is a growing public health crisis. The solution is to create more indoor options for people to meet their basic needs with dignity and support. This relationship between housing and health is the central tenet of our plan. The Continuum of Care wants to shift the culture of managing encampment spaces towards meeting the needs of people experiencing unsheltered homelessness as a public health measure in and of itself.

Home, Together

Home, Together: Tompkins is modeled after the “Home, Together” Federal Strategic Plan to Prevent and End Homelessness from USICH, which incorporates evidence-based strategies to end homelessness. This plan follows the guiding principles of home: providing safe and stable places to live and together: strengthening our community by providing opportunities for people to collaborate on this issue. This plan integrates these best practices to meet the following goals:

- Quickly identifying and engaging people at risk of and experiencing homelessness.

⁴ National Health Care for the Homeless Council. “Homelessness & Health: What's the Connection?” National Health Care for the Homeless Council, 08 2019, <https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf>. Accessed 29 November 2022.

- Intervening to prevent people from losing their housing and divert people from entering the homelessness services system.
- Providing people with immediate access to shelter and crisis services without barriers to entry if homelessness does occur.
- Quickly connecting people experiencing homelessness to housing assistance and services tailored to their unique needs and strengths to help them achieve and maintain stable housing.

The CoC integrates the best practices included in the plan; having a by-name list of people experiencing homelessness, coordinating outreach and housing services, expanding capacity of the human services sector, supporting policies that reduce the criminalization of homelessness, providing access to low barrier shelter, and expanding access to safe, low-cost, adequate housing with supports.⁵ These are the suggested practices to end homelessness in any community and are especially relevant to our own.

Policies to End Homelessness

In addition to their Home, Together Federal Strategic Plan, USICH is consistent in their findings that any plans that criminalize homelessness, or ban sleeping outside in several locations, are **not consistent with any plan to end homelessness**. They assert that⁶

1. Criminalizing homelessness is expensive. It can cost three times more to enforce anti-homeless laws than to find housing for people who don't have it.
2. Criminalization fills jails up with people who are more likely to be victims of violent crime than perpetrators and with people who need treatment (which jails are not equipped to provide) for mental and substance use disorders. And, most importantly,
3. **Criminalization does not reduce the number of people experiencing homelessness. It breaks connections people have made with providers trying to help and exacerbates homelessness and the conditions that lead to it—such as health problems and racial disparities.**

While some policy-makers may understand criminalization as actually arresting people for sleeping in certain areas, in actuality any policy that increases interactions between people experiencing unsheltered homelessness and law enforcement will lead to increased court involvement and ultimately a longer length of time living in a homeless situation as people work to make appointments and pay fines related to that court involvement. These discriminatory laws are not effective. They put governments at risk of expensive civil-rights lawsuits and distract from implementing programs and strategies that are both effective and cost-effective.

⁵ United States Interagency Council on Homelessness. "Home, Together: The Federal Strategic Plan to Prevent and End Homelessness." United States Interagency Council on Homelessness (USICH), 18 July 2018,

https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf. Accessed 29 November 2022.

⁶ Olivet, Jeff. "Collaborate, Don't Criminalize: How Communities Can Effectively and Humanely Address Homelessness." United States Interagency Council on Homelessness (USICH), 26 October 2022, <https://www.usich.gov/news/collaborate-dont-criminalize-how-communities-can-effectively-and-humanely-address-homelessness>. Accessed 29 November 2022.

Programs like Permanent Supportive Housing and Housing First, treat homelessness as a housing and health crisis—not a problem for the criminal justice system to solve.⁷

Our plan will only be effective if the City and County shift their focus to building additional set-aside, supportive units for people experiencing homelessness. The Continuum of Care believes that increasing the stock of available rental units and shelter for this population must happen before the City of Ithaca attempts to close any existing camps. Without building adequate housing for people living outside, any policy that forces people to "move along" would put people living in these situations on a road to nowhere. Clearing camps without available housing will cause people to cycle between institutions and homelessness unless adequate housing is available to meet their needs.⁸ The CoC would advocate for a continuance of the tacit acceptance approach until housing to meet this community's needs is created in alignment with this plan.

The CoC would also recommend using inclusive public space management to respond to the West End Inlet area. As discussed in the research report "Alternatives to Arrest and Police Responses to Homelessness" published by the Urban Institute in October 2020, inclusive public space management avoids punitive measures for homelessness.⁹ Instead, it provides resources that act as a public benefit to anyone using the space, including people experiencing unsheltered homelessness.¹⁰ These are an alternative to restrictive public space management, such as performing encampment sweeps, providing citations, or using restrictive furniture and other public architecture to discourage sleeping. Restrictive public space management seeks to gain control over an area without addressing the root causes of homelessness: a lack of permanent, affordable, supportive housing, and the associated public health crisis: an inability for people to meet their basic needs with dignity. Some examples of inclusive public space management that the City could implement in the west end include picking up trash regularly, providing access to drinking water, building and maintaining public restrooms, showers, and other hygiene and sanitary options, as well as ways to dispose of and exchange needles safely. These practices do not only benefit the people using these public facilities but also benefit the larger surrounding community:

- in Santa Barbara County, California—where 27 percent of the homeless population lives in cars—the Safe Parking Program provides 133 cars with a designated place for sleeping, access to hygiene resources, and connection to rapid re-housing services (Arnold Ventures 2020c). The program serves more people than any year-round shelter in the Santa Barbara area.

⁷ Ibid.

⁸ National League of Cities. "An Overview of Homeless Encampments for City Leaders." National League of Cities, January 2022, <https://www.nlc.org/wp-content/uploads/2022/01/Overview-of-Homeless-Encampments-Brief.pdf>. Accessed 29 November 2022.

⁹ Batko, Samantha, et al. "Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices." Urban Institute, Oct. 2020, <https://www.urban.org/sites/default/files/publication/103158/alternatives-to-arrests-and-police-responses-to-homelessness.pdf>.

¹⁰ Ibid.

- Portland, Oregon, experienced a decline in reports about encampments after the start of a program that connects people in encampments to housing services (Arnold Ventures 2020b; Metraux et al. 2019)

Tompkins County Homeless and Housing Needs Assessment

Before developing a plan to assist people with severe service needs, a report titled the “Tompkins County Homeless and Housing Needs Assessment” (TCHHNA) was commissioned by the CoC, the Tompkins County Legislature, and the City of Ithaca Council in 2022. This report, written by Lisa Horn, revealed current areas in our homeless response system that need support and recommendations for providing that support. The CoC Governance reviewed this report and assembled a list of critical takeaways included in this proposal. While this plan offers a summary, Continuum of Care staff recommend that stakeholders review the entire report as it contains a more detailed analysis of additional findings.¹¹

The key findings of the TCHHNA include that:

1. **Length of time homeless is increasing in our continuum**, up to 90 days on average as of 2020.
2. **Returns to homelessness in Tompkins County are the highest of comparable CoCs** at 32%, or close to a third of all individuals who exited to a permanent destination in 2020.
3. **Chronic homelessness is increasing**, with 45% or almost half of our current population experiencing homelessness.
4. The **outcomes for other populations, such as couch surfers, youth, and people of color**, indicate a need for more purposeful engagement and referral to permanent housing destinations.

The factors contributing to these worsening outcomes include a lack of low-cost, supportive beds in our continuum and difficulty accessing and maintaining housing and services without additional case management and support. The TCHHNA provided recommendations to address these factors based on real-time data from our community. These interventions are evidence-based solutions to address the recent trends of increasing homelessness and worsening conditions for people with severe service needs in our community.

Key recommendations from the TCHHNA, as identified by our Governance Committee, are as follows:

1. **Building more Permanent Supportive Housing (PSH)**. Households leaving to temporary destinations were much more likely to return to homelessness (35%) than those exiting to permanent destinations. While this trend held across every group, it was most pronounced for Black and African-American Households.

¹¹ Horn, Lisa. “Homeless and Housing Needs Assessment for Tompkins County.” Horn Research LLC, June 2022, <https://hsctc.org/wp-content/uploads/2022/06/Tompkins-County-Needs-Assessment-Homelessness-and-Housing-Final-Report.pdf>.

2. **Building more low-cost single-unit housing.** This recommendation supports the outcomes of single, adult-only households that comprise the bulk of our homeless population (473 single households versus 53 family households in 2020).
3. **Enhanced Housing Navigation.** Both stakeholders and interview participants mentioned agency rules and requirements and the difficulty of navigating the social services system as key reasons people live in the encampment instead of going to the emergency shelter. This intervention allows us to target the growing unsheltered population.
4. **Heightened outreach to youth, people of color, and couch-surfers in our community.** Although our current system implicitly requires couch-surfing, there are little to no funded diversion efforts to keep this population from becoming homeless. Targeted outreach addresses the accessibility of services for a large and growing number of people at-risk of homelessness.
5. **Expand the capacity of our emergency shelter.** The emergency shelter in Tompkins County is insufficiently sized to meet the needs of our unhoused population. Our community has 29 emergency shelter beds to serve 80 households typically experiencing homelessness at any time throughout the year. This bed shortage requires using overflow beds from nearby hotels since they are convenient, non-congregate settings for people experiencing homelessness. Despite their convenience, hotel rooms present several barriers to our homeless response system, including cost, transportation barriers, and lack of on-site case management. Increasing shelter capacity would allow for more consistent, site-based case management and contribute to better outcomes for individuals utilizing the shelter.

Definitions of Target Populations

The New Homeless Definition¹² (effective 1/4/2012 under the HEARTH act) has four categories:

Category 1 – Literally Homeless: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- I. An individual or family with a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- II. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
- III. An individual who is exiting an institution (e.g., jail, hospital)
 - A. where he or she resided for 90 days or less **AND**
 - B. resided in an emergency shelter or place not meant for human habitation immediately before entering the institution

Category 2 – (Homeless) Within 14 days of losing home: An individual or family who will imminently lose their primary nighttime residence, provided that:

- I. The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
- II. No subsequent residence has been identified; **AND**
- III. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing

Category 3 – (Homeless) Youth/Children: Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

- I. Meet the homeless definition under another federal statute; **AND**
- II. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; **AND**
- III. Have experienced persistent instability as measured by two moves or more during the sixty-day period immediately preceding the date of application for homeless assistance; **AND**
- IV. Can be expected to continue in such status for an extended period of time because of chronic disabilities, OR chronic physical health or mental health conditions, OR substance addiction, OR histories of domestic violence or childhood abuse (including

¹² United States Department of Housing and Urban Development. "HUD's Definition of Homelessness: Resources and Guidance." HUD Exchange, 8 March 2019, <https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/>.

neglect), OR the presence of a child or youth with a disability, OR two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment

Category 4 – (Homeless) Fleeing Domestic Violence: Any individual or family who:

- I. Is fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
- II. Has no other residence; **AND**
- III. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

Severe Service Needs are defined by the United States Department of Housing and Urban Development as any combination of one or more of the following factors:¹³

- facing significant challenges or functional impairments, including any physical, mental, developmental or behavioral health disabilities regardless of the type of disability, which require a significant level of support in order to maintain permanent housing (this factor focuses on the level of support needed and is not based on disability type)
- high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities
- experiencing a vulnerability to illness or death
- having a risk of continued or repeated homelessness
- having a vulnerability to victimization, including physical assault, trafficking, or sex work
- currently living in an unsheltered situation or having a history of living in an unsheltered situation

¹³ "Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness." U.S. Department of Housing and Urban Development, 22 June 2022.

Other Relevant Definitions

As the NY-510 Continuum of Care presents how best to integrate these recommendations into our existing homeless response system in this plan, there are several best practices that are important to define and cite here.

Housing-First

Housing First is an approach to providing housing assistance that prioritizes placing individuals in permanent housing to end their homelessness as a basic need to work on any larger personal goals. This is guided by the belief that people need to have their basic needs such as food and housing met before being able to work on other less critical objectives such as employment or addressing substance use issues. Providing permanent housing is seen as the base or platform from which people can begin to address other issues in their lives, rather than the uphill incentive of addressing those issues first. Through this belief, there is an underlying understanding that there is no such thing as “housing ready”, because everyone is ready for housing. Housing is a basic need for people to be able to take care of other issues, however many providers view housing as something that people need to earn by taking care of these other issues in advance of having that basic need met. Housing First is also founded on the idea of client choice. This understanding sees client choice in housing selection and service participation as essential to the success of these interventions to their current experience of homelessness.

Housing First is not only a philosophy, but an approach that is substantiated by data from other communities.

- A 2004 random assignment study found that homelessness programs that eliminated barriers to services, like Housing First, were more successful in reducing homelessness than programs where housing and services were contingent on sobriety and progress in treatment. When individuals were provided access to stable, low-cost housing, with services under their control, 79% remained stably housed at the end of 6 months, compared to 27% in the control group.¹⁴
- A 2004 long-term study found that participants in the Housing First model obtained housing earlier, remained stably housed after 24 months, and reported higher perceived choice than participants in programs where housing and services were contingent on sobriety and progress in treatment.¹⁵
- Canada conducted a significant evaluation, encompassing five cities – Vancouver, Winnipeg, Toronto, Montreal, and Moncton – and over 2,000 participants, making it the world’s largest study on Housing First. The study found: Participants in Housing First rapidly obtained housing and retained their housing at a much higher rate than the treatment as usual group. After two years, 62% of the Housing First participants were

¹⁴ Tsemberis, Sam & Moran, Linda & Shinn, Marybeth & Asmussen, Sara & Shern, David. (2004a). Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program. *American journal of community psychology*. 32. 305-17. 10.1023/B:AJCP.0000004750.66957.bf.

¹⁵ Sam Tsemberis, Leyla Gulcur, Maria Nakae, “Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis”, *American Journal of Public Health* 94, no. 4 (April 1, 2004b): pp. 651-656.

housed the whole time compared to 31 percent of those who were required to participate in treatment prior to the receipt of housing.¹⁶

- A 2010 study of data from the Collaborative Initiative to Help End Chronic Homelessness (CICH) established by The United States Interagency Council analyzed the outcomes of 709 participants across 11 communities (Chattanooga, TN; Chicago, IL, Columbus, OH; Denver, CO, Fort Lauderdale, FL; Los Angeles, CA; Martinez, CA; New York, NY; Philadelphia, PA; Portland, OR; and San Francisco, CA). These participants were assessed every 3 months for 2 years on housing outcomes, community adjustment, work and income, mental and physical health, and health service costs. Clients who received immediate, independent housing had more days in their own place, less days incarcerated, and reported having more choice over treatment; but no differences on other clinical or community adjustment outcomes. This study found no clinical advantages for clients who had residential treatment or transitional housing prior to entry into community housing, but did find that they incurred higher substance abuse service costs.¹⁷
- The National Alliance to End Homelessness provides an interactive database of the available literature on Housing First here:
<https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/>

Please visit the peer-reviewed studies and fact sheets below to learn more about Housing First.

- <https://nlihc.org/sites/default/files/Housing-First-Research.pdf>
- https://endhomelessness.org/wp-content/uploads/2022/08/Housing-First-Fact-Sheet_Aug-2022.pdf
- <https://www.huduser.gov/portal/publications/hsgfirst.pdf>
- <https://shnny.org/uploads/Florida-Homelessness-Report-2014.pdf>
- <https://doi.org/10.1002/casp.723>
- <https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/>
- https://www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf

Trauma-Informed Care

Trauma-Informed care is an approach that recognizes the traumatic experiences of people receiving services, and provides service providers with the knowledge and skills to prevent the re-traumatization of these individuals, especially individuals with SSNs, in the provision of supportive services. Trauma-informed care supports stability and healing through understanding and support of each individual's needs. This includes focusing on that individual's experience

¹⁶ Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry (2014). National At Home/Chez Soi Final Report. Calgary, AB: Mental Health Commission of Canada. Retrieved from: <http://www.mentalhealthcommission.ca>

¹⁷ Kresky-Wolff, M., Larson, M. J., O'Brien, R. W., & McGraw, S. A. (2010). Supportive housing approaches in the collaborative initiative to help end chronic homelessness (CICH). *The Journal of Behavioral Health Services & Research*, 37(2), 213–225. <https://doi.org/10.1007/s11414-009-9206-y>

through person-centered care, understanding their needs for safety, and working with them to address areas of support that they identify.

Please visit the peer-reviewed studies and fact sheets below to learn more about Trauma-Informed Care:

- https://www.air.org/sites/default/files/SHIFT_Service_and_Housing_Interventions_for_Families_in_Transition_final_report.pdf
- <https://www.air.org/sites/default/files/downloads/report/Americas-Youngest-Outcasts-Child-Homelessness-Nov2014.pdf>
- https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
- https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf

Harm Reduction

SAMHSA defines harm reduction as “an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services”.¹⁸ When serving people with SSNs in our continuum, especially those with Substance Use Disorder (SUD), harm-reduction methods can not only improve provider relationships with this population, but also help to expedite their entry into the housing they need to stabilize and exit their current homeless crisis.

Please visit the peer-reviewed studies and fact sheets below to learn more about Harm-Reduction Practices:

- https://harmreduction.org/wp-content/uploads/2020/08/Resource-HarmReductionBasics-Homelessness_HR.pdf
- <https://files.hudexchange.info/resources/documents/HOPWA-Factsheet-Housing-First-and-Harm-Reduction.pdf>
- <https://doi.org/10.2105%2Fajph.94.4.651>
- https://nhchc.org/wp-content/uploads/2020/05/Healing-Hands-Harm-Reduction_FINAL2.pdf

Racial Equity

Equity refers to proportional representation (e.g., by race, class, or gender) of opportunities in housing, healthcare, employment, and all indicators of living a healthy life. When talking about equity, it is helpful to distinguish it from equality. Equality is typically defined as treating everyone the same and giving everyone access to the same opportunities. The assumption is that everyone will benefit from the same support and services. This is not true. Some populations are situated differently because of historical and current discrimination against them. Equity addresses those differences. Equality is about sameness; it focuses on making sure everyone

¹⁸ “Harm Reduction.” SAMHSA Substance Abuse and Mental Health Administration, 16 Aug. 2022, <https://www.samhsa.gov/find-help/harm-reduction>.

gets the same thing. Equity is about fairness; it ensures that each person gets what the person/population needs. To achieve equity, policies and procedures may result in an unequal distribution of resources, but will lead to equitable outcomes for everyone.¹⁹

Please visit the articles and fact sheets below to learn more about integrating Racial Equity into discussions about housing and homelessness:

- https://housingmatters.urban.org/articles/applying-racial-equity-lens-housing-policy-analysis?trk=organization-update-content_share-embed-video_share-article_title
- <https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Prevention-to-Promote-Equity.pdf>
- https://www.macfound.org/media/files/hhm_research_brief_-_poor_black_women_are_evicted_at_alarming_rates.pdf
- <https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Equity-Driven-Changes-to-Coordinated-Entry-Prioritization.pdf>
- https://c4innovates.com/wp-content/uploads/2019/10/CES_Racial_Equity-Analysis_Oct12019.pdf
- <https://www.enterprisecommunity.org/blog/improving-housing-stability-prevent-evictions-and-end-racial-disparities-0>

Housing Surge

HUD defines a housing surge as a concentrated, time-limited community effort through which key stakeholders collaborate to connect a targeted group of households to a pre-identified pool of housing subsidies and units as well as other resources and services in order to house a large number of people in a short time frame.²⁰ Housing surges have been used to quickly rehouse people during and after natural disasters, to quickly deploy large amounts of new resources, and to target groups or people experiencing homelessness that may require special considerations, such as veterans, older adults, or youth.²¹ The housing surge expedites the housing process by streamlining procedures and creating temporary mechanisms (such as a pool of vacant units, pre-inspections, and same-day application processing) that break through common procedural delays in rehousing (e.g. unit identification, inspections, check processing, etc.).²²

Please visit the articles and fact sheets below to learn more about the concept of a “Housing Surge”:

- <https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Housing-Surges-Special-Considerations-for-Targeting-People-Experiencing-Unsheltered-Homelessness.pdf>

¹⁹ “Homeless System Response: Part 1: Equity as the Foundation.” US Department of Housing and Urban Development, June 2020.

<https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Rehousing-Activation-and-Racial-Equity-Part-1-Equity-as-the-Foundation.pdf>

²⁰ “Homeless System Response: Planning a Housing Surge to Accelerate Rehousing Efforts in Response to COVID-19.” US Department of Housing and Urban Development, June 2020.

²¹ Ibid.

²² Ibid.

- <https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Planning-a-Housing-Surge-to-Accelerate-Rehousing-Efforts-in-Response-to-COVID-19.pdf>
- https://endhomelessness.org/wp-content/uploads/2022/02/Progressive-Engagement-Fact-Sheet_Feb-2022.pdf
- <https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Rehousing-Activation-and-Racial-Equity-Part-1-Equity-as-the-Foundation.pdf>
- <https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Rehousing-Activation-Planning-and-Implementation-Tips.pdf>

Temporary Housing Assistance (THA)

As described in the official compilation of codes, rules and regulations of the state of New York, specifically 18 CRR-NY 352.35, “Temporary Housing Assistance is a public assistance benefit provided temporarily for an eligible homeless individual or family to meet an immediate need for shelter”.²³ All individuals seeking emergency housing through the shelter are required to attain, and stay in compliance with their Temporary Housing Assistance, or THA, in order to stay in the emergency shelter and pay for their emergency housing. This regulation (18 CRR-NY 352.35) describes the various rules that people experiencing homelessness must follow in order to maintain their emergency housing. Many of these regulations as mandated by New York State law mirror and uphold the same barriers that stakeholders have identified as preventing people with severe service needs from accessing shelter. That mandate can be reviewed here:

- <https://govt.westlaw.com/nycrr/Document/I50c3e46fcd1711dda432a117e6e0f345?>

Cold Weather Policy/Code Blue

In 2016, New York State created the code blue policy, known locally as cold weather policy. Code blue policy directs local social service districts to work with shelter providers to extend their hours of operations and staff capacity to ensure that people experiencing homelessness can remain indoors when the temperature is 32 degrees or lower, including windchill. The state fully reimburses our Department of Social Services for these shelter stays, which means that individuals seeking shelter during nights with below freezing temperatures are not required to comply with Temporary Housing Assistance requirements (see above).

[https://govt.westlaw.com/nycrr/Document/I1f0386b55f29f11e6848bebc42a960167?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/nycrr/Document/I1f0386b55f29f11e6848bebc42a960167?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

²³ Thomson Reuters. “18 CRR-NY 352.35.” New York Codes, Rules, and Regulations, Thomson Reuters, 30 April 2021, <https://govt.westlaw.com/nycrr/Document/I50c3e46fcd1711dda432a117e6e0f345?> Accessed 5 January 2023.

The Home, Together: Tompkins Plan

The *Home, Together: Tompkins Plan* (HTTP) is a series of progressive opportunities to better serve people experiencing homelessness following an analysis of the existing gaps and needs in our system and the work of several committees of the CoC. Many of these projects don't currently exist in our system due to dwindling service provider capacity and funding to pilot novel solutions to end homelessness. The Continuum of Care believes that locating funding opportunities, coordinating these projects, and expanding sector capacity under a shared goal will allow us to see this plan through to completion. The HTTP will require engagement from a wide array of partners, including an endorsement from the City and County government, to be successful. CoC staff would oversee and track the outcomes of the projects listed to ensure the plan meets the goals outlined in Appendix C.

The Continuum of Care recognizes the systemic harm our country has caused BIPOC and how that harm is reflected in the proportion of BIPOC represented in our homeless response system. While BIPOC represent less than 9% of our local population, there are 50% BIPOC utilizing emergency shelter in our homeless response system, and 20% BIPOC living in unsheltered locations. BIPOC are traditionally underserved in our community and underrepresented in the human services sector. *Home, Together: Tompkins* is committed to monitoring who this project is serving and how BIPOC experiences compare to that of their white counterparts.

Along with targeted outreach and incorporating the feedback of BIPOC leaders in our community, Continuum of Care staff have integrated metrics into each component of this plan to ensure equitable distribution of resources and power to BIPOC participants. These metrics were decided based on the current representation of BIPOC in a particular subset of people experiencing homelessness listed in this document. For example, if a particular component prioritizes people sleeping in unsheltered locations, such as the low-barrier shelter, 20% BIPOC is used as an equity indicator. If another component focuses on the overall homeless population including shelter stayers, such as permanent supportive housing, 50% BIPOC is used as an equity indicator. Please do not hesitate to contact CoC staff at sgatson@hsctc.org or lbargar@hsctc.org with any questions.

Home, Together: Tompkins consists of the following components. Each of these components are described in more detail beginning on the following page:

1. A commitment to building 100 studio and 1-bedroom units of PSH.
2. Low-barrier shelter that uses a trauma-informed approach to safety.
3. A "housing surge" strategy and by-name list to better serve people living in unsheltered locations.
4. Mitigation funds for business owners and landlords.
5. Other incentives such as a shopping cart exchange and cash for trash program.
6. Low-barrier move-in packages and assistance for moving from homeless to housed.
7. Three enhanced, centralized housing navigator positions.
8. Paid board positions for people with lived experience to monitor and approve *Home, Together: Tompkins*.
9. Professional development opportunities for people with lived experience.

1. A commitment to building 100 studio and 1-bedroom units of PSH

PSH, or Permanent Supportive Housing, has proven to be the most effective intervention for lowering returns to homelessness within 24 months in our continuum.²⁴ PSH is housing set aside for people experiencing literal homelessness that is affordable, permanent, and offers supportive services without requiring participation in these services. Most of the PSH in our current system also includes a mechanism for residents exiting the housing after one year to exit with a section 8 voucher for securing private market housing. This form of housing is a critical intervention in our system because it increases the number of existing beds available for people experiencing homelessness in Ithaca's competitive housing market. The Continuum of Care would also prioritize funding to ensure 20 of these units are located in rural locations, where housing is often low-cost but substandard. The CoC believes that providing access to safer permanent supportive housing with enhanced support, such as transportation and preventative medical care, would help to address health and service delivery disparities in these areas of the county. Along with the commitment to building this housing, this commitment would include finding a partner to provide these enhanced supports for PSH in rural areas.

Anticipated Date of Completion: Q4 2025

Needs for Success: Staffing, Coordination, Funding

Racial Equity Metric: At least 50 new units of PSH occupied by BIPOC households.

2. Low-barrier shelter that uses a trauma-informed approach to safety.

Many people currently living outside in the "jungle" area are not eligible for or willing to navigate the high threshold of our current emergency shelter system. In addition, our local shelter, funded through the Department of Social Services (DSS), can be difficult for people with severe service needs to access and maintain. Here are some of the prerequisites that prevent easy access to emergency shelter when people need it:

1. All people who live in our emergency shelter and receive income through employment must contribute 50%-75% of their paycheck towards their shelter stay.
2. Clients of our emergency shelter must record and submit at least five housing contacts per week to comply with THA and stay in the shelter.
3. Most beds in our shelter are offered through local hotels, which are at least a 30-minute bus ride away from most of the centralized housing resources.
4. Our current emergency shelter sanctions individuals with known or suspected substance use disorder from the shelter for diversion to recovery services before entry when cold weather policy is not active. This implicitly requires individuals with substance use disorder to engage in treatment before they can access stable housing. Failure to continue to engage in treatment can lead to THA ineligibility and no access to shelter.
5. Clients must go to DSS in person, fill out the necessary paperwork, and stay for hours to wait and find out if they were approved for shelter that night.

²⁴ Horn, Lisa. "Homeless and Housing Needs Assessment for Tompkins County." Horn Research LLC, June 2022, <https://hsctc.org/wp-content/uploads/2022/06/Tompkins-County-Needs-Assessment-Homelessness-and-Housing-Final-Report.pdf>.

6. The THA application requires that people fill out contacts for the last three places they stayed. DSS staff call these contacts and ask if the person asking for emergency shelter cannot stay there any longer. If one of those contacts says that the person can stay there for even one night, that person is diverted from the shelter and required to apply again the next time they need a place to stay. This process also diverts people whose landlords have yet to execute a warrant of eviction because that person can technically remain in the unit for at least one more night.
7. Our county requires young adults ages 18-21 and minors to pursue child support from their caregivers before accessing shelter. Not only does this create an additional step for young adults who have identified a need for emergency housing to access it, but it requires the young adult to choose between living on the streets or affecting their parents' income and benefits. For minors, the shelter is additionally required to contact their parents who ultimately decide whether or not they can stay home another night. Understanding these complex power dynamics, and that emotional/physical abuse at the hands of parents does not qualify minors for domestic violence services or shelter, this process makes youth more vulnerable and susceptible to sleeping outside, returning to an abusive home setting, or trading housing for sexual exploitation.

There are currently two examples of low-barrier shelters in our homeless response system. However, they are both not site-based and limited in their capacity to serve individuals with severe service needs. Despite these limitations, both have been able to stably shelter individuals who would otherwise be living outside or in other unsafe conditions.

The first is the NYS cold weather policy, which allows anyone between October and April (when the weather is below freezing) to have a warm space to spend the coldest parts of the night. The CoC's Homeless Management Information System or HMIS data shows that many people experiencing unsheltered homelessness enter the shelter during this time to access warm beds, showers, bathroom facilities, and other centralized services. When the weather is consistently above freezing in April, there is migration back out of the shelter for individuals who aren't willing to pay for their stay, apply for Temporary Housing Assistance (THA), or maintain that THA. This trend is evidence that if there were a low-barrier emergency shelter where people could get their basic needs met with dignity, similar to how our emergency shelter operates under the cold weather policy, it would be utilized by many of the encampment residents and reduce the number of people experiencing unsheltered homelessness in unsafe conditions.

The second is low-barrier shelter through the LEAD (Law Enforcement Assisted Diversion) program locally. Through this, REACH Medical funds shelter stays for people who have failed to comply with shelter requirements and have a history of interactions with law enforcement. While a more recent addition to our homeless response system, this program has been a successful intervention to house people who would otherwise be sleeping outside.

The Continuum of Care recommends the formation of a site-based low-barrier shelter that prioritizes people sleeping outside. Low-barrier shelter does not mean there are no rules, but instead that these rules are expectations instead of barriers to entering or maintaining a shelter

stay. The goal is to get as many people off of the streets as possible without some of the requirements preventing people from entering our OTDA-funded emergency shelter, like identification, sobriety, payment, or strict curfews, with an emphasis on safety through harm reduction.

Many low-barrier shelters, while not requiring sobriety, prohibit possessing and using drugs, alcohol, and weapons in their facilities. They also set an expectation that people obey the law and behave respectfully towards other people using the shelter. Any behaviors that risk other residents' safety are typically not tolerated. Other typical rules and regulations may be expected but not enforced. For example: In our emergency shelter funded through DSS, someone could arrive past curfew and fall out of compliance with the shelter, ending up back on the street when their THA is denied. In a low-barrier shelter, there may be a recommended curfew with softer rules, such as not acting in a disruptive manner during quiet hours rather than having to be in a shelter bed after a certain hour. This allows people to more easily maintain their shelter stay and adjust to the culture of having neighbors in a brick-and-mortar facility. Staff in these spaces are also typically trained in de-escalation, trauma-informed care, mental health first aid, addiction sensitivity, and well-being and wellness as they interact with clients in crisis.

The Continuum of Care asserts that a refocus on safety and clear behavioral standards as opposed to compliance with funding regulations will be a key component in creating these spaces. Having a culture that focuses on trauma-informed safety for the shelter space is not only important for those residents that struggle to stay in compliance with their temporary housing assistance, but also for those with whom they share the space. Individuals with severe service needs, especially youth, have reported feeling uncomfortable and vulnerable in the emergency shelter. This has, for example, contributed to the overrepresentation of youth in the couch-surfing community as noted in the Homeless and Housing Needs Assessment as they seek out alternate options for emergency housing. A new shelter space or expansion of the existing shelter needs to address these conditions and ensure that existing and new spaces are safe for the most vulnerable and exploited members of our community. A trauma-informed culture shift for our existing emergency shelter spaces, especially as they add additional beds, will be essential to ending unsheltered homelessness for youth and others with severe service needs.

While compliance-based rules have been clearly identified as barriers to entering shelter or maintaining a shelter stay, many of the same rules cited by clients and providers as being barriers are Office of Temporary Disability Assistance (OTDA) requirements that must be met to reimburse shelters for the cost of an individual's stay. The most recent publication by the USICH, "ALL IN: The Federal Strategic Plan to Prevent and End Homelessness", supports the "removal and reduction of programmatic, regulatory, and other barriers that systematically delay or deny access to housing for households with the highest needs".²⁵ It suggests building

²⁵ United States Interagency Council on Homelessness (USICH). "ALL IN: The Federal Strategic Plan to Prevent and End Homelessness." United States Interagency Council on Homelessness (USICH), 1 December 2022,

programs like low-barrier shelter that work to meet the needs of the people utilizing emergency shelter, as opposed to requiring people to “fit” or be “ready” for entering a bed. Following this recommendation, CoC staff would advocate reexamination of the need for the above barriers to ensure they align with federal, state, and local policy. In order for a low-barrier shelter to be successfully implemented in our community, the organization taking on this project would need to ensure that their funding source is flexible enough to fund and operate a shelter without the barriers THA compliance presents outside of cold weather policy season. Funding options could include some of those listed in Appendix A, philanthropy, or other opportunities that become available over the course of the planning year.

The CoC recommends the following articles, fact sheets, and real examples below to learn more about the concept of low-barrier shelter, and how to implement it:

- <https://media.graphassets.com/xCfY2vIQCeVXUG15y7Mn>
- <https://cceh.org/wp-content/uploads/2018/05/Making-the-Shift-to-a-Low-Barrier-Housing-Focused-Shelter-5.17.18-Final.pdf>
- https://endhomelessness.org/wp-content/uploads/2017/04/ES-Webinar-2-Keys-to-Effective-Low-barrier-Shelter_Webpage.pdf
- <https://www.crossroadsri.org/about/our-work-team/about-us>

Anticipated Start: Q1 2024

Needs for Success: Staffing, Coordination, Funding

Racial Equity Metric: At least 20% of low-barrier shelter beds occupied by BIPOC.

3. A “housing surge” strategy and by-name list to better serve people living in unsheltered locations.

COVID-19 has presented new and urgent health and safety needs that necessitate expedited and efficient processes to rehouse people experiencing homelessness swiftly. In addition, the pandemic has generated a combination of political will, unprecedented collaboration within communities, and an influx of resources, all of which create an ideal environment for deploying a strategy that has proven successful in similar situations: the “housing surge.”

A “housing surge” is a concentrated, time-limited community effort through which key stakeholders collaborate to connect a targeted group of households to a pre-identified pool of housing subsidies and units as well as other resources and services in order to house a large number of people in a short time frame. Housing surges have been used to rehouse people quickly during and after natural disasters, to quickly deploy large amounts of new resources, and to target groups or people experiencing homelessness that may require special considerations, such as veterans, older adults, or youth. The housing surge expedites the housing process by streamlining procedures and creating temporary mechanisms (such as a pool of vacant units, pre-inspections, and same-day application processing) that break through

https://www.usich.gov/All_In_The_Federal_Strategic_Plan_to_Prevent_and_End_Homelessness.pdf. Accessed 5 January 2023.

common procedural delays in rehousing (e.g., unit identification, inspections, check processing, etc.).

HUD has laid out a plan (attached below) for the execution of a housing surge and other communities in which this has been an effective intervention. The Continuum of Care would incorporate this into our current system through the Coordinated Entry list, which already has a process to prioritize the most vulnerable individuals and distribute resources equitably. In alignment with HUD's operational steps and other materials, our first step would be to convene partners such as rapid re-housing providers, permanent supportive housing providers, street outreach, landlords, elected officials, service providers, and people with lived experience. Our second step would be to identify the available housing resources and work with providers to set aside those resources to ensure the housing stock meets the needs of the households interested in housing. The third step would be to set a target length of time for the surge and identify a target population which in this case would be people experiencing unsheltered homelessness in the encampments. Step four would be to conduct outreach to landlords to use rapid re-housing vouchers and create a pool of vacant units available to surge participants. These would include single units, family units, and single-room occupancies (SROs) for people interested in living in a communal space with roommates. For those individuals who indicate their interest in having a roommate, there could be roommate matching made available to ensure compatibility in those spaces.

Finally, through step five, housing surge providers would map out the expedited process and organize a pop-up destination for people to identify housing and work on the next steps with service providers on site. Throughout steps one through five, we would work closely with our enhanced street outreach team to **develop a by-name list** of everyone experiencing unsheltered homelessness and their interest in participating in the surge. This by-name list would allow us to better track households' outcomes and better understand the needs of the community experiencing unsheltered homelessness. The Continuum of Care would work on updating this list throughout and between each surge. The sixth and final step would be to track outcomes for households interested in participating in the surge, addressing any issues or barriers that prevent households from entering or maintaining the housing. This will be especially important for households receiving one-time or time-limited funding through emergency rapid re-housing support. In these cases, a housing stability plan for maintaining funding after one-time funding sunsets would be an additional seventh step for these households. The Continuum of Care would include equity checks throughout each step of this process to ensure that each housing surge serves all households in a way that supports their individual needs. The equity checks will also ensure that the demographics of housing surge participants reflect and attempt to mitigate the existing racial disparity in our system. Providers will be held accountable through their signed MOU with HSCTC to provide information for these equity checks and respond quickly to identified concerns.

An ongoing issue with HUD-funded resources, and our local coordinated entry process, is the exclusion of couch-surfers and preventative resources for people at-risk of homelessness. While the Continuum of Care is referencing the HUD framework for structuring the housing surge, this

activity would not solely depend on HUD-funded services. To follow Lisa Horn's findings that point out the need for outreach and designated resources for couch-surfers, CoC staff will set aside at least five spots per housing surge for couch-surfers with severe service needs.

Anticipated Start: Q2 2023

Needs for Success: Coordination, Policy Considerations

Racial Equity Metric: At least 20% of housing surge participants will be BIPOC.

4. Mitigation funds for business owners and landlords

At the Human Services Coalition of Tompkins County (HSCTC), the Rental Resolutions program supports Tompkins County landlords to build better tenant/landlord relationships to stave off evictions. The Human Services Coalition has a landlord liaison who helps landlords navigate conflicts with tenants, complete paperwork to comply with Section 8, and advocate for the landlord in times of uncertainty. One of the biggest draws of this position, in addition to the work of the liaison, is the mitigation fund available to landlords to cover potential damages to the unit as a consequence of renting to a tenant with severe service needs. In the *Home, Together: Tompkins* plan, the Continuum of Care proposes expanding this fund and liaison position into a mitigation fund entitled the Happy Neighborhood Program. Business owners or landlords approved by the *Home, Together: Tompkins* lived experience board would be eligible for financial support up to a certain amount in case of damages or theft incurred while serving people with severe service needs. The goal of the Happy Neighborhood Program would be to ease tensions, especially for small business owners, in our community following the years of hardship post-pandemic. The Continuum of Care has heard the West End Business Partners' concerns and wants to help rebuild lines of communication around issues related to the encampments. Not only would this program provide mitigation funds to businesses affected by the aftermath of the pandemic, but the neighborhood liaison position would act as someone to respond to the concerns of these community members and ensure their voices are heard in the encampment response without harming or harassing members of the encampment. This position would increase community engagement with issues related to the encampments and help to center the emotional recovery of the west end as all stakeholders work together to end unsheltered homelessness.

Anticipated Start: Q1 2024

Needs for Success: Community Engagement, Staffing, Funding

Racial Equity Metric: Business owners and landlords approved by the lived experience board will require unanimous approval by BIPOC members of the board.

5. Other incentives such as a shopping cart exchange and cash for trash program

There are other, smaller incentives that the Continuum of Care believes would help us engage all community members in ending unsheltered homelessness. The first is a shopping cart exchange program. The CoC would provide outreach workers with reliable, collapsible, easy-to-repair carts to exchange with their clients in return for stolen shopping carts. The enhanced street outreach team would return these and other discarded carts to the associated business, restoring thousands of dollars in value. Our primary goal is to understand the

community's need for the carts that have been stolen and provide alternatives to meet that need. These carts would also provide functionality that stolen shopping carts do not: portability for taking on the bus, easy repairs, and less stigma when navigating the community. The CoC would work closely with our enhanced street outreach team to pick the ideal carts to meet this need and disperse them among the community. Home, Together: Tompkins would also have a mechanism to track how many carts are returned and understand the effectiveness of this program.

Anticipated Start: Q1 2024

Needs for Success: Coordination, Funding

Racial Equity Metric: Outreach through BIPOC community centers to ensure access for clients

The second smaller incentive would be a cash-for-trash program. This program would follow the redemption model for recycling but for trash! An organization would provide bright-colored bags, grabbers, and PPE, such as gloves, for people to pick up trash and return full bags for cash. This initiative would be open to any community members who want to give back or engage with sanitation efforts. One of the biggest complaints about the encampment spaces is the amount of trash and its environmental impact. Cash-for-trash would help to address that and put much-needed cash in people's pockets for spending at local businesses.

Anticipated Start: Q1 2024

Needs for Success: Community Engagement, Supplies, Staffing, Funding

Racial Equity Metric: Outreach through BIPOC community centers to ensure access for clients

6. Low-barrier move-in packages and assistance for moving from homeless to housed

The Continuum of Care has convened a housing stability committee to understand and mitigate issues related to maintaining housing. One of the gaps identified is the need for smaller goods besides furnishings, such as trash tags, cleaning supplies, shower curtains, toiletries, linens, and kitchen utensils. While these goods may seem inconsequential for people with the resources or stability to shop for them, our committee has found that they can make or break someone's housing stability when entering a new unit from homelessness, especially for individuals with severe service needs. For example, a lack of cleaning supplies can lead to bad smells or infestations, which can lead to lease violations and nuisance allegations, leading to eviction. The Continuum of Care wants to ensure that people have access to the items they need to stay stably housed and already have a model for how to do this within our community. Catholic Charities of Tompkins and Tioga Counties runs a small transitional housing program called A Place to Stay, which helps to transition participants into permanent housing. To assist with the transition from their housing into a new unit, CCTT has a flexible fund to support these smaller, additional needs on move-out. These include many of the goods that our housing stability committee identified as barriers to maintaining housing. In addition, CCTT has a small pilot program with ReUse to assist with moving help, including movers and moving trucks.

ReUse also partners with the CoC to furnish many of our PSH projects. It has been a valuable partner in keeping our site-based projects comfortable and affordable.

The CoC would suggest expanding these pilots to provide low-barrier move-in packages and assistance for individuals moving from homeless to housed. Our housing stability committee is confident that a program like this is key to helping reduce high returns to homelessness within our county.

Anticipated Start: Q1 2024

Needs for Success: Staffing, Coordination, Funding

Racial Equity Metric: 50% of move-in package and assistance recipients will be BIPOC.

7. Three enhanced, centralized housing navigator positions

Page 34 of the TCHHNA describes the nature of support services in Tompkins county. While there are many services, they are decentralized. The most frequently mentioned barrier to entering and maintaining housing and shelter in the report is navigating the paperwork and understanding the rules of the many programs and services available. One stakeholder said, "I see Tompkins County as being very service rich. There are a lot of opportunities to get services. The barrier is more a fear or reluctance to access services because of distrust with the system. There is a difficulty of accessing services without an advocate. It's so decentralized. You have to go to a different place for different things – clothing, food, health care, to apply for services, and you're constantly jumping through hoops. It causes frustration and people give up. It's easy for services to say 'they didn't follow through,' but it's literally impossible. Either have one location where service providers can be in one space, or have a case manager that can either transport and do everything from A to Z to help someone through the whole process. Doing it alone is completely overwhelming and next to impossible." This salient quote points to the need for our first project- a team of case managers who can transport and help everyone at each stage of our continuum, from homeless to housed.

Our case management team would consist of three housing specialists; one serving people experiencing literal homelessness, one serving people recently housed from homelessness, and another serving people who are housing unstable. Each housing specialist would have a small caseload of 10-12 individuals with severe service needs for situations where long-term assistance navigating barriers to housing is needed. They would each receive training in de-escalation, trauma-informed care, mental health first aid, addiction sensitivity, well-being and wellness, and cultural competence by local providers. This training would ensure that the team is prepared to serve clients with various backgrounds and needs. They would also receive training from all agencies in our continuum, be ready to fill out any program application, and understand eligibility requirements. Aside from their small caseload, they would act as a mobile resource to provide light-touch services for other situations that arise in our community. Essentially, these positions would work as a team of direct service generalists who are housing-focused and trauma-informed for those who fall through the cracks in our existing homeless response.

The housing specialist serving people experiencing literal homelessness would assist these individuals in accessing housing-related services and locating appropriate housing based on their needs. Some tasks would include helping clients fill in applications for shelter, apply for other county services, stay in compliance with the shelter, help people in unsheltered situations get into the shelter, and assist with housing search. The success of a role like this has been demonstrated in Salvation Army's program "Homeless to Housed", in which 10 out of 15 participants receiving services from a case manager like this role were able to find and maintain housing.

The housing specialist serving people who are recently housed from homelessness would be assisting these individuals in understanding the expectations of their housing and navigating any conflicts or needs that arise after move-in. Some tasks would include assisting clients in navigating local resources, staying in compliance with section 8, navigating relationships with the landlord and other tenants, providing other appropriate referrals to ensure that people do not return to homelessness, and using their relationship with landlords to act as a housing search resource. Our enhanced street outreach team has demonstrated the effectiveness of a role like this as they support their clients' moves into new housing. Although their assistance has helped people navigate the novelty of being recently housed, these outreach workers have voiced the need for a warm hand-off with the capacity to support these clients' ongoing needs.

The housing specialist serving people experiencing housing instability would help divert people from homelessness by preventing avoidable evictions and displacement through advocacy and referrals to local resources. The pipeline for referrals to this housing specialist would include high-priority calls from our local 2-1-1 line for people at risk of losing their housing, referrals for diversion from emergency housing staff at DSS, eviction court, and local legal services such as LawNY and the Tenants Legal Hotline. High-priority calls through 2-1-1 will include people in couch-surfing situations, and act as a pipeline for prevention in our continuum. In addition, this role would assist with Emergency Rental Assistance applications, complete intakes for local legal services, and connect clients with other supports. The current 2-1-1 Housing Specialist position at the Human Services Coalition has demonstrated the effectiveness of a role like this. Through these efforts, this Housing Specialist has helped to divert 53 people from their 63 person caseload from homelessness to maintain their current housing or end their couch-surfing. Unfortunately, this position expires in September of 2023. The Continuum of Care asserts that continuing a role like this with a special focus on preventing homelessness for people with severe service needs could reduce entries to homelessness from couch-surfing situations by 50%.²⁶

Each of these positions and their role in the community would require approval from the lived experience board. The lived experience board would also be directly involved in the hiring of the individuals themselves, and organizations with a housing specialist position would be required to report out to the lived experience board at least once every two months with an update on the progress of this position. While CoC staff hope that three of these specialists will meet the

²⁶ Also noted in Appendix C

needs of our community, our community will reassess to ensure that there are an adequate number of housing navigators employed in our system by Q1 2026.

Anticipated Start: Q1 2024

Needs for Success: Staffing, Coordination, Funding

Racial Equity Metric: Housing Navigators will receive training to be culturally competent and trusted providers for BIPOC. At least 50% or 300 of their contacts per year will be for BIPOC.

8. Paid board positions for people with lived experience to monitor and approve *Home, Together: Tompkins*

The Continuum of Care wants to ensure the inclusion of people with lived experience of unsheltered homelessness in all *Home, Together: Tompkins* projects and programs through paid board membership. Our homeless response system has a Youth Advisory Board that advises and monitors projects funded through our Youth Homelessness Demonstration Project. The CoC would apply that existing model to compose and fund a similar advisory board for adults with lived experience. The board would advise and approve *Home, Together: Tompkins* projects. All participating agencies would be highly encouraged to consult with the board throughout the planning stage of their projects. Once approved, these projects would also send quarterly reports to the board to track progress toward set goals.

Board positions would be paid per hour of engagement. Board members would be tasked with consulting on *Home, Together: Tompkins* projects, brainstorming solutions to issues in project roll-outs, and monitoring participant outcomes. This group will offer leadership and guidance to the project. In addition, the board would be given professional development opportunities for any desired skills they would like to learn during their board membership, as well as access to additional support (transportation, childcare) to help members participate to their fullest ability. Two board members would also hold seats in the CoC's Governance committee as the Continuum of Care works to better integrate the valuable perspectives of people with lived experience into its membership.

Anticipated Start: Q1 2024

Needs for Success: Community Engagement, Coordination, Funding

Racial Equity Metric: At least 5 of 10 seats on the lived experience board will be BIPOC.

9. Professional development opportunities for people with lived experience

In response to the workforce crisis in our community, the Continuum of Care suggests offering professional development opportunities for people with lived experience of homelessness who are interested in filling these roles. This would involve a different path to employment in human services for people with lived experience who might lack other higher education requirements or experience in the field. Through professional development, a program like this could offer work experience for resume building and assist completion of a certification program or associate degree through one of our local universities. The Human Services Coalition would engage

directly with human services employers to work on building these professional development opportunities as well as capacity and funding to better support these roles.

Anticipated Start: Q1 2024

Needs for Success: Community Engagement, Coordination

Racial Equity Metric: Providers participating in professional development opportunities will also express a commitment to diversity and inclusion with personalized metrics and monitoring for success.

Planning and Implementation

The first step of implementing this plan involves seeking buy-in from critical stakeholders, including the city and county legislature, service providers, people with lived experience of homelessness, and city planners. While some components of this plan are feasible without community buy-in, the goal is to have a coordinated homeless response across Tompkins County. This step is necessary to shift our continuum of care culture to one that is person-centered and housing-first. During this stage, the CoC staff will also work to convene a lived experience board for implementing *Home, Together: Tompkins*.

The next step will be to formalize relationships with service providers or other organizations interested in taking on leadership roles in the planning. The Continuum of Care lead agency, the Human Services Coalition of Tompkins County (HSCTC), will formalize these relationships through memorandums of understanding (MOUs) with these organizations. These MOUs must receive unanimous approval from the lived experience board to be executed by HSCTC.

Once we have identified the organizations interested and committed to pursuing this work, we will enter the planning phase of *Home, Together: Tompkins*. Planning will involve seeking funding for projects through some or all of the opportunities listed in Appendix C. Organizations who apply for funding will ultimately be responsible for determining the design of the project, hiring staff, reporting, and day-to-day operations of the project. Each *Home, Together: Tompkins* partner will meet with the lived experience board at least once every two months. The topics of these discussions will include relevant trends in their project of focus and feedback for their organization's project. This process will allow for an ongoing conversation between service providers and people with lived experience and a better understanding of how to build programs that work for their target populations.

These meetings will continue once partners receive funding to begin their projects. Building the projects themselves will include adding equity checks in both the structure and monitoring of the program. Equity checks will integrate the lived experience board and real-time data in the performance evaluation of a *Home, Together: Tompkins* project.

Continuum of Care staff will advise, lead, and support identified partners in acquiring funding, structuring their projects, and monitoring participant outcomes. CoC staff will also oversee the implementation of the *Home, Together: Tompkins* plan and ensure that partners and projects are aligned in their culture and outcomes.

As mentioned in the Homeless and Housing Needs Assessment, outreach to youth, couch-surfers, and people of color will be essential to ensure this plan serves these traditionally underserved communities equitably. A preliminary plan for outreach tailored to each of these specific groups would include, but not be limited to:

1. Outreach to Minors
 - a. Schools throughout the county
 - b. After-school programs and peer groups

- c. Social Media
- d. Youth Employment Programs, other youth-serving organizations
- e. Youth Action Board
- 2. Outreach to Young Adults
 - a. Youth Employment Programs, other youth-serving organizations
 - b. Social Media
 - c. Written Materials, Posters
 - d. Local colleges
 - e. Local employers
 - f. Peer groups, Youth Action Board
 - g. Community Events
- 3. Outreach to Couch-surfers
 - a. Written Materials, Posters
 - b. Social Media
 - c. Social Services Agencies
 - d. Community Events
 - e. 2-1-1 Information and Referral Hotline
- 4. Outreach to People of Color
 - a. Community Centers (e.g. Southside, Alliance for Family Justice)
 - b. Churches
 - c. Social Services Agencies
 - d. Emergency Shelter, Hotel Stays
 - e. Networking with community leaders
 - f. Peer groups and community events

CoC Staff will work closely with outreach workers to bolster and staff this outreach plan over the course of our planning year for *Home, Together: Tompkins*.

4
New Staff Positions
including three Housing Navigators and a Neighborhood Liaison Position to enhance and centralize communication across the Continuum of Care.

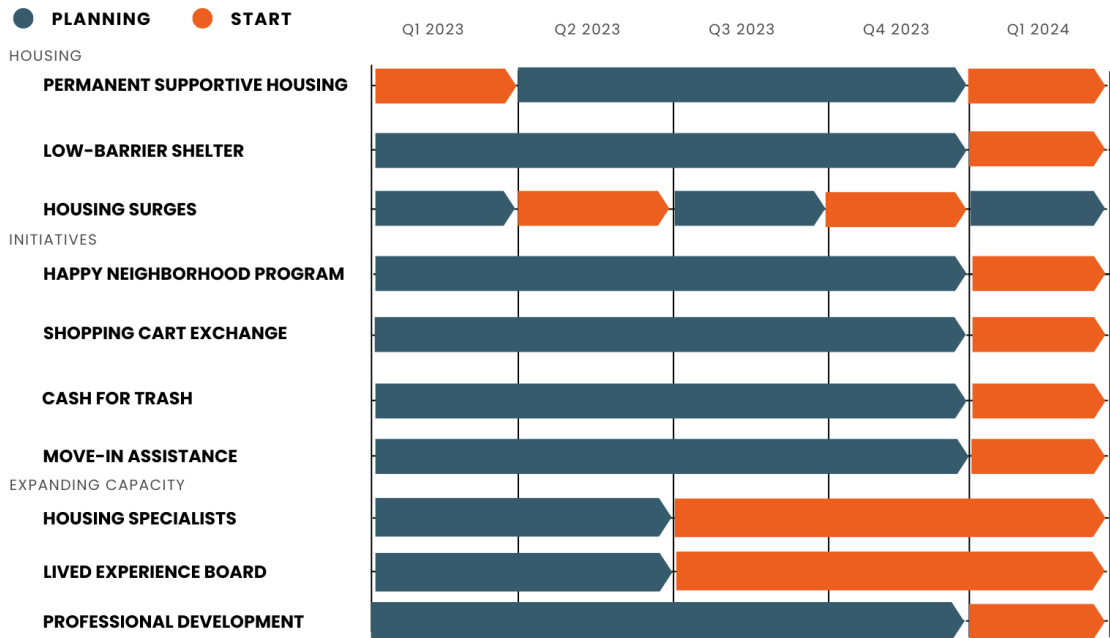
10
Paid Lived Experience Board Seats
for advising and approving projects

\$50,000
Cash for business and landlord partners
as mitigation funds for any theft or damages incurred by serving people with severe service needs.

Home, Together: Tompkins Outcomes

50
Low-Barrier Shelter Beds
with minimal pre-conditions to entering and maintaining shelter with an emphasis on safety through clear and simple expectations for residents.

100
Units of Permanent Supportive Housing
offering wrap-around services with a goal of sustaining housing through housing-first.



Opportunities for the City of Ithaca

This plan requires participation from the City of Ithaca to adopt a new outlook on its encampment spaces by working with the Continuum of Care to help address the health needs of its residents. As mentioned in the introduction of this plan, the earliest mention of clearing the same encampment spaces that our community is discussing today is from 1927. After nearly a hundred years of trying to manage this space through restrictions and clearance, CoC staff believe it is time to address the root causes of homelessness. In our community, that means addressing the lack of low-cost, permanent, safe spaces for unhoused people. Here are some opportunities for the City to engage with this issue as a part of the *Home, Together: Tompkins Plan*:

- Creating a mechanism for affordable units in new property developments to become PSH set-asides available through the CoC's Coordinated Entry process
- Considering ways the Community Housing Development Fund can be used to expand PSH units, as the CHDF is the major locally controlled funding source for expanding the supply of low-cost housing
- Performing regular inspections of city rentals and requiring property managers to address unsafe living conditions for tenants without negatively impacting current residents through forced displacement or condemnation. Many interviews with people with lived experience of homelessness revealed this is one of the main reasons people cite for leaving their homes. While the City Code does provide for payments (200% of rent) to tenants who are displaced due to failure by the landlord to comply with codes and housing standards, there may be an opportunity to ensure tenants and landlords are aware of this law and have access to legal counsel to enforce their rights.
- Continuing the tacit acceptance approach while incorporating inclusive management practices for the existing "jungle" space. These provide public utilities that benefit everyone whether or not they are currently experiencing homelessness.
- Integrating CoC staff into existing working groups to address encampment spaces.
- Working with the CoC to identify future funding priorities and screen projects for housing-first approaches and public health-centered practices.

CoC staff are available to discuss these and more opportunities for the City of Ithaca to engage in *Home, Together: Tompkins* in a way that is synergistic to the other initiatives outlined in this proposal. We invite interested legislators to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org.

Opportunities for the Tompkins County Legislature

The Tompkins County Legislature oversees the Department of Social Services, which provides many of the services our unhoused population needs, and the Community Housing Development Fund, which provides funding support for the diverse range of affordable housing needs in our community. Therefore, the engagement of the Tompkins County Legislature is essential to improving the delivery of services to our population with severe service needs. Here

are some opportunities for the County to engage with this issue as a part of our *Home, Together: Tompkins Plan*:

- Creating a mechanism for affordable units in new property developments to become PSH set-asides available through the CoC's Coordinated Entry process
- Considering ways the Community Housing Development Fund can be used to expand PSH units, as the CHDF is the major locally controlled funding source for expanding the supply of affordable housing
- Performing regular inspections of rentals outside of the city and requiring property managers to address unsafe living conditions for tenants without negatively impacting current residents through forced displacement or condemnation. Many interviews with people with lived experience of homelessness revealed this is one of the main reasons people cite for leaving their homes.
- Working with the CoC to identify future funding priorities and screen projects for housing-first approaches and public health-centered practices.
- Investigating OTDA requirements for the operation of resources through our local Department of Social Services. Many existing barriers to entering and maintaining emergency housing and other resources through DSS are mandated by law. The CoC would be interested in better understanding these statutes, especially as OTDA shifts to a low-barrier shelter model.
- Integrating CoC staff into existing committees and working groups to address housing and homelessness issues.

CoC staff are available to discuss these and more opportunities for Tompkins County's various departments to engage in *Home, Together: Tompkins* in a way that is synergistic to the other initiatives outlined in this proposal. We invite interested legislators to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org.

Other Complementary Interventions

The CoC invites anyone interested in partnering with *Home, Together: Tompkins* to reach out to us about projects and initiatives that may be aligned with this plan to end unsheltered homelessness and better serve people with severe service needs. Here are a few complementary interventions for which the CoC seeks partners with the capacity and interest to fill existing gaps in our system.

Community Spaces for Learning About Resources

The Continuum of Care would like to partner with community centers to discuss ways to better share resources for people experiencing homelessness in our continuum. This could include improved, more inclusive media campaigns or physical spaces to distribute some of the resources included in this plan. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model, especially partners who focus on serving BIPOC to disrupt the historical underserving of this community.

Lowering Barriers to Existing Shelter

The barriers to our current emergency shelter exist in shelters funded by the Department of Social Services across the state. While there are statutes that implicitly require some of these barriers, the CoC believes that understanding these statutes is vital to developing creative ways to lower barriers to shelter. Therefore, Continuum of Care staff invites interested advocacy groups to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this widespread issue across New York State.

Meeting Basic Needs with Dignity

In alignment with our goal of providing safe alternatives to the existing encampment as a health measure, *Home, Together: Tompkins* would support the creation of a site that allows people to **meet their basic needs with dignity without requiring engagement with services or clearance of other spaces**. The Continuum of Care believes that a site with trash services, safe needle disposal, groundskeeping, bathrooms, safe heating elements, benches, and access to clean water without security measures or policing would be the most effective health intervention for people who do continue to live outside, without increasing their interactions with law enforcement. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Mental Health Crisis Respite Center

Providing crisis respite for people experiencing a mental health crisis in an unsheltered location would be an essential and valuable addition to our existing continuum of care. This would be a space with voluntary crisis beds for people to stay in while experiencing a mental health crisis, prioritizing patients currently sleeping in unsheltered locations. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Opportunities for BIPOC Homeownership

Due to the enduring legacy of racism, discrimination, slavery, and genocide for Black and Indigenous people in our country, there has been a racial wealth gap for BIPOC perpetuated by a lack of rights to land and homeownership. The Continuum of Care would be interested in supporting a program that would help to provide a holistic, sustainable pathway to homeownership and landownership for BIPOC in our community. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

The “Paperwork Brigade”: Part-time Volunteer Positions with Stipends

A group of volunteers interested in helping people to maintain their housing stability by helping people with severe service needs fill out paperwork, understand the rules of their housing and their rights as tenants, and inform our centralized housing navigator team of any needs that come up within the first month of obtaining new housing would be a welcome addition to *Home, Together: Tompkins*. Continuum of Care staff invite interested partners to reach out to us at

sgatson@hsctc.org and lbargar@hsctc.org to talk more about how to integrate your group of volunteers into this framework.

Rehabilitating Rental Units in Substandard Condition

Many people entering our homeless response system are exiting naturally occurring low-cost rentals with substandard living conditions. An initiative focusing on rehabilitating these units while keeping their rents low-cost would be a welcome project to help prevent returns to homelessness in our continuum. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Transportation Assistance

Our system is in need of free shuttles to expand the existing capacity of the TCAT for people experiencing homelessness in rural areas of our County. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Trauma-Informed Training and Oversight for the Human Services Sector

Organizations interested in performing regular training for Continuum of Care partners in the human services sector should reach out to us at sgatson@hsctc.org and lbargar@hsctc.org. We are especially interested in integrating trauma-informed training with a focus on racial equity into direct training roles. The CoC would like to center an anti-racist perspective to ensure all direct service provision and management are trauma-informed for BIPOC participants.

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Appendices

Appendix A: Funding Options

While the Continuum of Care staff is seeking endorsement of this plan, the goal of *Home, Together: Tompkins* is ultimately to have future planning within the continuum aligned with the goals, outcomes, and overall mission outlined in this document. This plan is not a proposal seeking funding from any particular group or entity, however this appendix includes a brief summary of potential funding sources that could support the projects.

City Set-Aside Funding for Addressing Encampment Spaces: The City of Ithaca tentatively voted to approve \$100,000 to set aside to support encampment responses. Eligible uses include; active management of City properties to address or prevent unauthorized encampments, including restoration of former encampments, reimbursement of out-of-pocket expenses to City Departments providing in-kind services to support development of facilities serving unsheltered homeless individuals on City-owned property, hiring an enhanced housing navigator in conjunction with Tompkins County or others. \$50,000 was approved to hire a part-time homeless outreach coordinator.

Community Development Block Grant (CDBG): The Community Development Block Grant (CDBG) Entitlement Program provides annual grants on a formula basis to entitled cities and counties 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. Ithaca is typically allocated about \$616,000 to spend on the following eligible project types, community facilities and improvements, public infrastructure and public services.

County Set-Aside Funding for Addressing Encampment Spaces: Tompkins County tentatively voted to approve \$100,000 to set aside to support encampment responses. Additional Information has not yet been provided to the public.

Department of Corrections and Community Supervision- Community Based Residential Programs (CBRP): Community Based Residential Programs (CBRPs) are housing initiatives that assist undomiciled individuals returning home from prison in attaining stability in the community. CBRPs provide food, counseling, and other services, such as substance abuse treatment, educational/vocational training, mental health and social services either directly or through referrals. They offer structured settings and services for a period of up to 120 days with extensions available on a case-by-case basis. REO awards and manages grant funds to eligible programs to support formerly incarcerated individuals with successful reintegration through a Continuous Recruitment Request for Application.

Emergency Solutions Grant (ESG): The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 amended to the McKinney-Vento Homeless Assistance Act, revised the Emergency Shelter Grants Program and renamed it to the

Emergency Solutions Grants (ESG) program. The program provides funding to: engage homeless individuals and families living on the street, improve the number and quality of emergency shelters for homeless individuals and families, help operate these shelters, provide essential services to shelter residents, rapidly re-house homeless individuals and families, and prevent families and individuals from becoming homeless.

HOME Investment Partnerships: The City of Ithaca has an annual HOME entitlement of \$304,000 in 2023. HOME funds are used for a wide range of activities including building, buying and/or rehabilitating low-cost housing for rent or homeownership or providing direct rental assistance to low-income people.

HOME American Rescue Plan Program: The American Rescue Plan (ARP) provides \$5 billion to assist individuals or households who are homeless, at risk of homelessness, and other vulnerable populations, by providing housing, rental assistance, supportive services, and non-congregate shelter, to reduce homelessness and increase housing stability across the country. These grant funds will be administered through HUD's HOME Investment Partnerships Program (HOME). Ithaca has been allocated \$1.2 million and will need to apply by March 31st, 2023 to be a Participating Jurisdiction or PJ.

The Homeless Housing and Assistance Program (HHAP): HHAP provides capital grants and loans to not-for-profit corporations, charitable and religious organizations, municipalities and public corporations to acquire, construct or rehabilitate housing for persons who are homeless and are unable to secure adequate housing without special assistance. HHAP has provided capital funding for a wide range of housing types for various homeless special needs populations, including but not limited to: emergency and transitional facilities for victims of domestic violence, transitional housing for adolescents aging out of foster care, programs for homeless and runaway youth, transitional programs for people in recovery, and supported housing for veterans, people living with HIV/AIDS, ex-offenders, substance abusers, the chronic homeless, and the severely and persistently mentally ill. In many instances, HHAP is the only state resource available to fund the capital development of these types of projects.

Medicaid Redesign Team (MRT) Permanent Supportive Housing Initiative:

Affordable/supportive housing for high frequency, high cost Medicaid beneficiaries who are homeless or precariously housed. MRT housing includes rental subsidies and other occupancy costs for apartments, program supervision, housing, and employment counseling.

The Neighborhood and Rural Preservation Program (NPP and RPP): For over 40 years the Neighborhood and Rural Preservation Program has provided financial and technical assistance to community-based not-for-profit corporations with a goal of providing safe, healthy, and affordable housing for families throughout New York State.

NYS Office of Addiction Services and Supports (OASAS): OASAS funds housing providers in several counties across New York State to assist individuals/families affected by addiction to locate and maintain permanent housing by providing rental subsidies and case management

services. Housing providers also assist in vocational training and employment counseling to help individuals in recovery lead self-sufficient lives.

They oversee the following brands of Permanent Supportive Housing:

New York/New York III (NY/NY III): Single-site and scatter-site housing for homeless, single adults who have completed some level of substance abuse treatment, as well as chronically homeless or at-risk families, in which the head of household suffers from a substance use disorder.

Upstate Permanent Supportive Housing: Housing which includes rental subsidies, case management, and employment services for individuals and families in recovery in rural communities, and small suburban regions of Upstate New York.

Re-entry Scatter-Site Permanent Supportive Housing: Rental subsidies, case management and employment counseling for persons with substance abuse problems, recently released on parole in New York City.

The NYS Office of Mental Health’s Empire State Supportive Housing Initiative (ESSHI):

The NYS ESSHI program provides service and operating funding for congregate supportive housing across the State. The eligible target populations to be served under this program are families or individuals who are both homeless and who are identified as having an unmet housing need as determined by the CoC or local planning entity, AND have one or more disabling conditions or other life challenges.

Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA's homelessness programs support many types of behavioral health treatments and recovery-oriented services. These services include:

- Outreach
- Case management
- Treatment for mental and/or substance use disorders
- Enrollment in mainstream benefits such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP)
- Peer support services
- Employment readiness services
- Programs primarily target people experiencing homelessness who have been underserved, or who have not received any behavioral health services. Most of these programs support people who experience chronic homelessness.

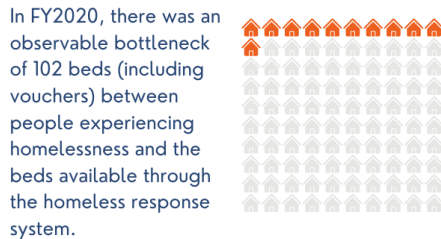
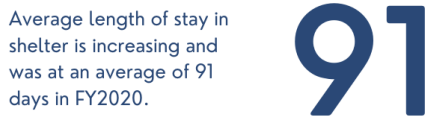
Tompkins County Community Recovery Fund: One-time funding of \$6.53 million that focuses on projects that will provide a “transformative” outcome in our community. Eligible types of projects that align with the Home, Together: Tompkins plan include public health/mental health, affordable housing, non-profit organizations, economic or community development

projects, and workforce initiatives. All funds must be obligated/awarded by December 31, 2024 and spent by December 31, 2026.

Appendix B: Needs Assessment Graphic

This appendix includes highlights from the Homeless and Housing Needs Assessment that the CoC Governance committee found to be most salient to understanding our homeless response system.

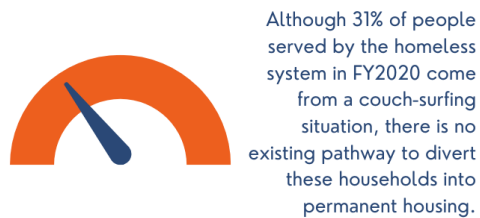
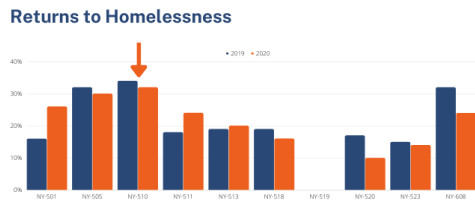
Needs Assessment: Data Findings



In FY2020, Tompkins County had the highest rate of returns to homelessness of all comparable CoCs at 32% of households returning to homelessness within 24 months.

Adult-only households have the worst outcomes in our continuum:

| FY2020 Adult- Only Households | FY2020 Adult and Child Households |
|-------------------------------|-----------------------------------|
| 473 Households | 53 Households |
| 87 days homeless on average | 71 days homeless on average |
| 8% returned to homelessness | 0% returned to homelessness |



Appendix C: Home, Together Tompkins Outcome Metrics

This appendix includes outcomes that CoC staff hope to achieve over the next five years following implementation of this plan. It includes specific metrics to track as well as interventions from the *Home, Together: Tompkins Plan* that would contribute to that goal.

Home, Together: Tompkins Outcomes

Reduce unsheltered homelessness by 70%:

- Recurring Housing Surges with rapid exits to permanent housing destinations
- Prioritization of people currently sleeping in unsheltered locations or otherwise banned from the OTDA-funded shelter in the low-barrier shelter
- 80 light-touch contacts from a HTT housing specialist to serve people experiencing unsheltered homelessness.

Decrease homeless entries from couch-surfing situations by 50%

- 200 new light-touch contacts assisting people at-risk of losing their housing
 - 80 contacts per year as high-priority referrals from 2-1-1
 - 40 contacts per year as referrals from eviction court
- Rolling intensive case management for a caseload of 10-12 clients with severe service needs to help people sustain their current housing or find new permanent housing
- 5 housing surge spots set-aside for couch-surfers with severe service needs.

Decrease the average length of time homeless by 30 days:

- Housing surges to serve households interested in housing with rapid, lower barrier exits to permanent housing
- Culture shift towards housing first as the basis for outreach
- 200 light-touch contacts and successful interactions with clients to end their homelessness as soon as possible
- Rolling intensive case management for a caseload of 10-12 clients with severe service needs throughout the year with rapid (within 30 days) exits from homelessness

Reduce returns to homelessness by 50%:

- 200 light-touch contacts assisting with new moves
 - 40 contacts assisting with landlord/tenant conflict within 6 months of move-in
- Rolling intensive case management for a caseload of 10-12 clients with severe service needs throughout the year with no returns to homelessness
- At least 200 clients served with move-in supplies and assistance
- Professional development for people with lived experience

Increased Community Engagement.

- Opportunities for engagement through initiatives such as cash for trash
- Paid lived experience board to enhance communication and understanding of the needs of people living outside
- Opportunities for professional development for people who lack other higher education requirements for employment in this field

Increased Accountability to Business Owners, Landlords, and Neighbors.

- \$50,000 per year going directly to business owner and landlord partners
- A neighborhood liaison to foster increased communication
- Returning stolen shopping carts through the cart exchange program.

Racial Equity Lens: Serve 50% BIPOC

- Proportional to current BIPOC representation in our homeless response system
- Commitment to equity through targeted outreach