How To Be A "Player" in the Continuum of Care

Tools for the Mental Health Community

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Introduction

This guidebook is designed to provide the mental health community with the necessary tools to be active participants in the Continuum of Care process in their community or state. Through participation in the Continuum of Care process, the mental health community can expand and improve housing and supports for people who are homeless and have serious mental illnesses.

However, it should be noted that there is no guarantee that the Continuum of Care process will continue to be the main vehicle for distributing federal HUD McKinney Homeless Assistance funds. There have been ongoing discussions between Congress and homeless advocates exploring the idea of distributing these funds as a formula grant to states and localities – similar to the model utilized to distribute Projects for Assistance in the Transition from Homelessness (PATH) funds. If this change in federal policy occurs in the future, states and localities receiving McKinney Homeless Assistance funds would be responsible for developing a method for distributing these funds to local governments and non-profit organizations.

Regardless of how the McKinney Homeless Assistance funds are distributed, at the local level there will continue to be efforts to organize, streamline, and coordinate homeless programs and systems as part of an overall effort to capitalize on all existing funding opportunities and advocate for change. Thus, no matter what the future holds, the mental health community has a lot to gain by assertively and actively participating in the Continuum of Care system.

For further information about the fundamentals of the Continuum of Care model, refer to the *Guide to Continuum of Care Planning and Implementation* published by the US Department of Housing and Urban Development (HUD). This guide was prepared for all prospective participants in the Continuum of Care process, and is available by calling HUD's Customer Services at (800) 998-9999 or online at www.hud.gov/cpd/cont/gcoc.html.

Definitions

This guidebook uses some terms that may be unfamiliar or have various meanings depending on the context. To facilitate the reader's understanding, these terms are defined below.

Continuum of Care Plan

According to HUD, a Continuum of Care plan is:

> A community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.[1]

Mental Health Community

This guidebook is aimed at assisting the mental health community to increase affordable housing options and expand the availability of supportive services for people who are homeless

[1] *Guide to Continuum of Care Planning and Implementation.* U.S. Department of Housing and Urban Development, 1999. p. 7.

and have serious mental illnesses. In this context, the term mental health community refers to people with serious mental illnesses, service providers (including PATH providers), advocates, and families. For convenience, this guidebook will often use the general term "you" to refer to the mental health community as a whole.

Balance of State

For Continuum of Care purposes, *Balance of State* refers to those geographic areas that are not included in local Continuum of Care planning efforts. In many states these areas are linked together through one statewide Continuum of Care planning process.

Homeless Person

HUD Continuum of Care resources can be used to serve only people who are considered homeless according to the McKinney Act. Based on HUD regulations, a homeless person is someone who is:

- Living in places not meant for human habitation (streets, cars, parks);
- Living in an emergency shelter;
- Living in transitional or supportive housing but originally came from the streets or shelter;
- Living in any of the above but spending up to 30 consecutive days in an institution;
- Being evicted within a week and has no subsequent residence;
- Being discharged within a week from an institution (e.g. mental health or substance abuse facility or jail/prison) in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing; or
- Fleeing a domestic violence situation and no subsequent residence has been identified.

Chapter 1
Continuum of Care Overview

A. History of the Continuum Of Care

To address the growing problem of homelessness in the US, in 1987 Congress passed the Stewart B. McKinney Act (Public Law 100-77). One of the many purposes of this Act was to authorize funding for Homeless Assistance programs administered by federal agencies, including and most notably the US Department of Housing and Urban Development (HUD). These resources (collectively referred to as McKinney Homeless Assistance funds), and the programs funded by them, have formed the backbone of systems designed to address the many needs of homeless individuals and families in states and communities across the nation.

When first introduced, McKinney Homeless Assistance funds were distributed directly to governments and community agencies through a national competition. Through this funding scheme, individual non-profit agencies and local governments could apply to HUD on their own for Homeless Assistance funding to implement and manage their own specific housing and service programs for people who were homeless.

No strategic planning was necessary to receive these funds, leading to duplication and fragmentation of homeless services in many communities. For example, two separate non-profit organizations in the same community could receive HUD Homeless Assistance funding to implement transitional housing programs for people with serious mental illnesses without any requirement that they coordinate their efforts. The resulting array of shelter and services available was often the result of an individual provider taking the initiative to meet a need independent of, or in isolation from, other providers.

In 1994, with input from stakeholders throughout the country, HUD introduced the Continuum of Care model to encourage communities to address the problems of housing and homelessness in a more coordinated, comprehensive, and strategic fashion. Unlike previous HUD planning documents established by an act of Congress, the Continuum of Care was created through HUD policy and governed by HUD-established rules and regulations. With the introduction of Continuum of Care planning, communities were encouraged to envision, organize, and plan comprehensive and long-term solutions to address the problem of homelessness in their community. This comprehensive approach encourages communities to: identify and prioritize gaps in the housing and services available for people who are homeless; and develop long-term strategies and action plans to address these gaps using HUD Homeless Assistance funds as well as other resources, such as the PATH program. The strategic planning conducted through this process also forms the basis of a Continuum of Care plan and application to HUD for Homeless Assistance funds.

B. Purpose of the Continuum of Care

The Continuum of Care serves two main purposes:

1. It is a **strategic plan** to address the use of HUD resources and their interface with other funding sources, developed through a community-based process to address homelessness based on: the identified needs of homeless individuals and families; the availability and accessibility of existing housing and services; and the opportunities for linkages with non-homeless mainstream housing and services resources. Through the Continuum of Care planning process, a community can:

    - Identify the size and scope of the homeless problem;
    - Inventory the resources available in the community to address the problem of homelessness, including both homeless resources and non-homeless targeted housing and service resources (referred to as "mainstream" resources);
    - Rank the community's needs in order of priority;
    - Strategically plan the range of services and housing that should be implemented to address homelessness; and
    - Identify available leveraging resources that can be used to address homelessness.

2. It is an **application** to HUD for McKinney Homeless Assistance resources. These resources are invaluable in providing housing and supportive services for people who are homeless. These funds are made available through a national competition announced each year in HUD's Notice of Funding Availability (known as the HUD SuperNOFA). Chapter 2 provides more details about HUD's application process.

C. Fundamental Components of a Continuum of Care System

An ideal effective homeless system is seamless and coordinated. It includes not only the fundamental components described below but also the necessary linkages and referral mechanisms among these components to facilitate the movement of individuals and families toward permanent housing and independent living. It is balanced with available capacity in each of the key components of the system, and it is responsive to changing needs.

The fundamental components of a comprehensive Continuum of Care system should include:

- Prevention[2]: Stabilization services and activities that assist those individuals and families at risk of homelessness to maintain their housing.

    Examples: One-time emergency funds to keep families housed; crisis intervention services for people with mental illness living in the community.

[2] Although prevention is an integral part of a community's Continuum of Care, McKinney Homeless Assistance funds available through the Continuum of Care application can not be used to provide homelessness prevention services.

- Outreach, intake, and assessment: Services to identify and address a person's immediate needs, such as food, clothing, or shelter, and to provide a link for the individual to ongoing support (often involving going out to the streets, cars, etc.). These services target the most vulnerable of the homeless population who are unable or unwilling to accept emergency shelter services.

  Examples: Street outreach to people who are homeless and have mental illnesses residing in parks, campgrounds, and places not fit for human habitation; mobile health care workers.

- Emergency shelter: A safe, secure, temporary place for individuals with mental illnesses and their families to reside while they seek other more permanent housing or supportive services in order to facilitate access to more permanent housing options.

  Examples: Emergency shelter for families with children; emergency shelter for homeless single adults.

- Transitional housing: Longer-term (generally up to 24 months) supportive housing with varying degrees of support services that provide a needed period of stability to enable people who are homeless to successfully transition to and maintain permanent housing.

  Examples: 24 month housing program with support services provided on-site, including recovery services, life skills training, and mental health counseling for men who are homeless and have co-occurring serious mental illnesses and substance abuse issues; specialized supportive housing for "hard to reach" people with available on-site services.

- Permanent Housing and Permanent Supportive Housing: Long-term safe, decent, and affordable housing for individuals and families.

  Examples: The rehabilitation of existing rental housing into affordable housing units for families; and the use of tenant-based rental assistance to lease one-bedroom units in scattered sites for veterans who are homeless and have co-occurring substance use and mental illnesses.

- Supportive Services: Those support services needed for a person to move towards self-sufficiency and independent living.

  Examples: Employment education and job readiness training to assist individuals with serious mental illnesses who are homeless in locating and maintaining employment; medication management and budgeting workshops to assist families in maintaining housing.

D. HUD McKinney Homeless Assistance Programs Funded through the Continuum of Care Application

HUD McKinney Homeless Assistance resources can be used to create many of the components of a Continuum of Care system targeted to meet the unique needs of people who are homeless. More specifically, there are 3 (three) Homeless Assistance programs that can be accessed through a competitive Continuum of Care application and these include:

1. Supportive Housing Program (SHP): Provides supportive housing and/or supportive services to people who are homeless.

2. Shelter Plus Care (S+C): Provides rental assistance funding for people with disabilities who are homeless.

3. Section 8 Moderate Rehabilitation Program (Section 8 Mod Rehab) for Single Room Occupancy Dwellings (SROs): Provides rental assistance for the development of SROs for individuals who are homeless.

These programs will be described in further detail in Chapter 2.

E. History of McKinney Homeless Assistance Funding

In fiscal year (FY) 2000, Congress appropriated $850 million for McKinney Homeless Assistance funds. The funding chart below illustrates the funding history for McKinney homeless programs that are part of the Continuum of Care:[3]

FEDERAL FISCAL YEAR	FUNDING AVAILABLE THROUGH THE CONTINUUM OF CARE (IN MILLIONS)
FY 1995	$900
FY 1996	$708
FY 1997	$625
FY 1998	$640
FY 1999	$750
FY 2000	$850

The number of Continuum of Care groups seeking these funds has increased over the years. Escalating demand has resulted in intense competition for the limited McKinney Homeless Assistance funds. As a result, many local Continuum of Care groups that used McKinney Homeless Assistance resources early on to fund projects have experienced a decrease in new funding in their communities.

[3] HUD McKinney homeless funds also include Emergency Shelter Grant (ESG) funds. ESG funds are distributed through the Consolidated Plan process – not the Continuum of Care process – and are not reflected in this chart. For more information on ESG funds and the Consolidated Plan process, see *Seizing the Moment*: *Using HUD's Consolidated Plan to Identify Affordable Housing Opportunities for Homeless People with Serious Mental Illnesses* available online at www.prainc.com/nrc/papers/seizing/intro.htm.

Many Continuum of Care groups are also facing a renewal crisis. These experienced groups have projects that have completed their initial grants with HUD and are faced with the difficult decision of whether to use limited McKinney Homeless Assistance funds to renew these existing programs or to fund new programs needed by the community. The situation is particularly difficult for those Continuum of Care groups that relied on McKinney Homeless Assistance funding to form the foundation of the community's homeless system. Fortunately, the FY 2001 budget (which began on October 1, 2000) set aside over $100 million in funding to renew existing eligible Shelter Plus Care programs. This set-aside will relieve some pressure on those communities struggling to sustain existing permanent supportive housing programs.

Emphasis on Permanent Housing

Over the past few years there has been a growing dependence on HUD McKinney Homeless Assistance dollars to fund supportive services for people who are homeless. Congress has become increasingly concerned about this trend and about the need to continue to expand permanent housing for people who are homeless. To address this, in 1999 and 2000, Congress directed HUD to ensure that at least 30 percent of the McKinney Homeless Assistance funds awarded through the Continuum of Care process be utilized for permanent housing. To ensure this outcome, over the past two years HUD awarded a bonus of $250,000 to those Continuum of Care applications that ranked a new permanent supportive housing project as the first priority for funding.

F. The Continuum of Care and Discharge Planning

Beginning fiscal year 2001, Congress stipulated that any government entity applying for Homeless Assistance funds must agree "to develop and implement, to the maximum extent practicable and where appropriate, policies and protocols for the discharge of persons from publicly funded institutions or systems of care (such as health care facilities, mental health institutions, and jails) to prevent such discharge from immediately resulting in homelessness for such persons". Congress is concerned that there is little relationship between state health and human service agency discharge planning and federal policies that affect the delivery of housing and services for individuals who are homeless. Improvements in this area would reduce the incidence of homelessness among people with disabilities.

It is important to remember that HUD's Homeless Assistance programs controlled by the Continuum of Care are part of a "safety net" to address the problems that result after people with disabilities become homeless, and cannot be used for homeless prevention. For this reason, they should not be the foundation of a comprehensive state plan to ensure that people in institutions who are ready for discharge have affordable housing made available to them.

G. Continuum of Care Planning

A community can use the Continuum of Care process for more than the application to HUD for McKinney Homeless Assistance funds. A community also can use the Continuum of Care process to plan and facilitate access to a variety of other mainstream housing and service

programs, including PATH-funded programs. For example, the Continuum of Care process could result in:

- A formalized referral and intake process between PATH-funded outreach providers and local emergency shelters;
- Creation of a preference for people who are homeless or people with disabilities in the local Public Housing Agency's (PHA) Section 8 program;[4]
- Development of permanent affordable housing targeted to people who are homeless using mainstream housing resources such as Community Development Block Grant or HOME funds;
- More emergency shelter beds targeted to people who are homeless with serious mental illnesses;[5] or
- Increase in access to job training services for people who are homeless.

H. Continuum of Care Best Practices

HUD recently released a compendium of Continuum of Care "best practices" used by communities across the nation.[6] HUD found that these "best practices" all shared certain elements of success including:

- Leadership and buy-in from influential people in the community;
- Strong financial and in-kind support from local governments;
- Representation from a broad range of players including private businesses and corporations;
- Dedication to a year-round planning effort;
- Strategies that are updated regularly and stem from community-based planning;
- Clear ways to communicate among Continuum of Care members – such as monthly meetings, newsletters, speakers' bureaus, promotional literature, and effective working committees;
- Involvement of local Public Housing Agencies;
- Dedicated full-time staff to coordinate data collection, projects, and other activities;
- Participation by homeless citizens;
- Active education and advocacy about local homelessness; and
- An effective Continuum of Care infrastructure (such as a management information system) that provides sound data.

HUD cited the Maricopa County (Arizona) Continuum of Care group as a "best practice." In this community, the Maricopa Association of Governments (MAG) coordinates the process. MAG uses funding from a local foundation to support the Continuum of Care planning activities. Maricopa County has a wide range of stakeholders involved in the Continuum of Care process including advocacy groups, health care organizations, city officials and staff (from 4 cities), over

[4] The Section 8 Housing Choice Voucher program provides a rent subsidy paid by HUD through a PHA to a landlord on behalf of a program participant. When new participants receive a Section 8 voucher, they may pay no more than 40 percent of their income towards rent. The amount of the Section 8 rent subsidy is based on the HUD Fair Market Rent for the area.

[5] Emergency shelter operations are not funded via HUD's Continuum of Care funds. HUD's ESG funds – which are distributed as a formula grant to all states and certain localities – may be used for this purpose.

[6] *Continuum of Care Sustainability Best Practices*. Work Volf Consultants, LLC and Tonya, Inc., June 2000.

70 homeless providers, private developers, foundations, private charities, local commerce associations, local newspapers, and homeless individuals.

Through the Continuum of Care process, individuals and families have accessed a variety of new programs and funding sources. For example, local Public Housing Agencies have set aside Section 8 vouchers for people who are homeless; state housing trust funds have been used to match federal dollars in grant applications; and the regional behavioral health agency uses over $1.6 million of state-appropriated funds to house individuals with serious mental illness or those who are dually diagnosed. PATH funds also play an integral role in the support of the Maricopa homeless system through the provision of homelessness prevention services. It is clear that in Maricopa County, the mental health community is an active player in the Continuum of Care process and the needs of people who are homeless with serious mental illnesses are well represented.

Chapter 2
HUD's Continuum of Care Resources and Application

Each year HUD announces the availability of McKinney Homeless Assistance resources through a Notice Of Funding Availability (NOFA) published in the Federal Register.[7] This announcement is referred to as the SuperNOFA. By responding to this SuperNOFA and developing a Continuum of Care application, government agencies and non-profit organizations can apply for funding for new projects or to renew existing projects to serve homeless individuals and families.

This chapter provides an overview of HUD's Homeless Assistance resources and the application process – including how to develop an application and how HUD determines funding awards. Information is based on HUD's SuperNOFAs and requirements for 1999 and 2000. There are a few key issues to keep in mind when reading this chapter: 1) the application and the process for scoring applications may change from year-to-year; and 2) Congress and HUD each have the ability to change both the application and the mechanism for distributing Homeless Assistance funds. Thus, the application process described in this chapter may be different in the future. With this in mind, it is important for you to read the SuperNOFA, the application, and accompanying guidance and regulations carefully.

Part I. McKinney Homeless Assistance Resources

There are three programs that are included in the Continuum of Care Homeless Assistance resources. Together, these programs are effective ways for a Continuum of Care group to address those identified needs of individuals and families who are homeless in the community.

A. Supportive Housing Program

The Supportive Housing Program (SHP) promotes the development of supportive housing and services that help people transition from homelessness to living as independently as possible. Both government entities and non-profit organizations are eligible to apply for SHP funds. SHP funds are awarded in 1-3 year contracts. The SHP program is governed by HUD regulations located at 24 CFR Part 583.

Each project requesting SHP funds as part of a Continuum of Care application must be classified as one of the following program components:

- **Transitional Housing**: Temporary housing with support services to facilitate the movement of individuals and families to permanent housing within 24 months. Supportive services – which enable individuals and families to move towards more independent housing – may be provided by the organization managing the housing or coordinated by that organization and provided by other public or private agencies. Transitional housing can be provided in one structure, or several structures at one site, or in multiple structures at scattered sites.

[7] The Federal Register can be located on-line at www.access.gpo.gov/su_docs/aces/aces140.html.

- **Permanent Housing for Persons with Disabilities**: Long-term housing for people with disabilities. Basically, this program is community-based housing and supportive services, designed to enable people who are homeless with disabilities to live as independently as possible in a permanent setting. Permanent housing can be provided in one structure, or several structures at one site, or in multiple structures at scattered sites.
- **Supportive Services Only**: These projects provide services designed to address the special needs of people who are homeless. Projects are classified as *Supportive Services Only* if the project sponsor is not also providing housing to the same people receiving services. Eligible activities for this component are acquisition, rehabilitation, leasing, and supportive services. Applicants cannot request funds for new construction or operations. *Supportive Services Only* may deliver services at a central site, or at the scattered sites where people live; or services such as street outreach may be delivered independently of a structure.
- **Safe Haven**: A form of supportive housing in which a structure, or a clearly identifiable portion of a structure, meets the following criteria: 1) serves hard-to-reach people who are homeless with serious mental illnesses, are on the streets, and have been unable or unwilling to participate in supportive services; 2) provides 24-hour residence for an unspecified duration; 3) provides private or semiprivate accommodations; and 4) has overnight occupancy limited to 25 people. A Safe Haven may also provide supportive services on a drop-in basis to eligible people who are not residents. Safe Havens can serve as an entry point to the service system and provide access to basic services such as food, clothing, bathing facilities, telephones, storage space, and mailing addresses.

1. Eligible SHP Activities

- Acquisition of structures for supportive housing or to provide supportive services;
- Rehabilitation of structures for supportive housing or to provide supportive services;
- New construction of buildings for supportive housing where there is a lack of appropriate units that could be rehabilitated or where new construction costs substantially less than rehabilitation;
- Leasing of structures for supportive housing or to provide supportive services;
- Operating costs of supportive housing;
- Supportive services including those services not provided in conjunction with a SHP funded project (i.e., *Supportive Services Only*).

2. Examples of SHP funded Projects

Transitional Housing Program: In 1996, a local non-profit organization that had successfully operated emergency shelters participated in the development and submission of a Continuum of Care application. As part of this application, the organization requested a total of $500,000 in SHP funds to develop a transitional housing program for individuals with serious mental illnesses who were homeless and currently residing in the emergency shelter. The Continuum of Care application scored well and the non-profit organization was successful in obtaining $200,000 from HUD in SHP rehabilitation dollars to renovate an old school building and $300,000 in SHP service funds to support the cost of services available to residents in the program. The organization met HUD's matching requirements with $200,000 in rehabilitation funds from the state housing agency. Rehabilitation started in early 1997 and was completed by June 1999. In July 1999, residents moved into the transitional housing program and the organization began providing services funded with its HUD SHP funds. Operating

costs for the program were funded through private fundraising and resident fees. In May 2000, the organization's application for renewal funds for the service component of its program was included in the community's Continuum of Care application.

Safe Haven: As part of its needs assessment, a Continuum of Care group in a rural area identified an emerging trend of individuals with serious mental illnesses who were homeless and unwilling to participate in the array of services offered by the community, including shelter, transitional housing, mental health counseling, and medication management. In an effort to engage these individuals, the community decided to develop a small Safe Haven that would target their needs. A local church active in Continuum of Care planning agreed to take the lead in developing this specialized program.

Through the Balance of State Continuum of Care application, the church requested a total of $440,000 in HUD SHP funds: $100,000 to renovate a vacant parish house into a six-unit Safe Haven; $30,000 per year for three years in SHP operating funds to cover the costs of a part-time superintendent, utilities, and building supplies; and $250,000 in SHP supportive services funding to cover the cost of 24-hour staffing at the Safe Haven, transportation, and a street outreach worker. The state housing agency provided $150,000 in resources to cover additional renovation costs. In addition, through funds it raised privately, the church contributed an additional $10,000 to cover appropriate operating costs, and through a contract with the State Department of Mental Health, the group received an additional $84,000 to cover supplemental supportive service costs.

Permanent Supportive Housing: A Continuum of Care strategic plan identified a need for permanent supportive housing for women with mental illnesses who had custody of their children. Through the Continuum of Care planning process, the community realized that none of the other supportive housing programs in the area adequately served this population and, as a result, the women often lost custody of their children or continuously returned to the family shelter.

A non-profit organization was asked to develop a permanent supportive housing program that would target their needs. In 1999, the group successfully competed for $730,000 in SHP funds as part of the community's Continuum of Care application to HUD. Of these SHP funds, $430,000 were used to locate and lease 10 apartments in privately owned buildings throughout the community. Participating families would pay 30 percent of their income for rent and the SHP leasing funds covered the balance of the rent. The remaining SHP funds ($300,000) were used to cover supportive services costs, including the cost of a social worker, childcare, and transportation. The organization also received a commitment from the community mental health authority to provide $25,000 in PATH funds to cover the cost of a part-time mental health counselor.

Supportive Services Only: The emergency shelters located within a Continuum of Care community did not have the capacity to serve individuals during the day, and consequently, residents of the shelters had to leave the facilities by 8 a.m. each morning. Homeless providers in the community recognized that this was problematic and wanted to design a program that would provide a safe place where information and

referrals to community-based services would be available in addition to some on-site services.

The provider of an evening soup kitchen worked closely with local shelter providers and other members of the Continuum of Care work group to develop a proposal for a drop-in center that would provide: a hot meal; GED training; job coaching; and information and referrals on housing, substance abuse treatment, job training, and mental health counseling. Since the day program would operate out of the same space as the soup kitchen, the non-profit organization required primarily service funding to support on-site staff. Through the development and submission of a competitive Continuum of Care application to HUD, the organization received $40,000 per year in SHP service funding and $14,000 in funds from a private foundation to cover the service costs of the day program.

B. Shelter Plus Care Program

The Shelter Plus Care (S+C) is a permanent supportive housing program that provides rental assistance to people with disabilities, primarily those with serious mental illnesses, chronic problems with alcohol and/or drugs, and AIDS or related diseases. The funds provided for rental assistance must be matched dollar-for-dollar with funding for supportive services to help participants maintain their housing.

Only government agencies and Public Housing Agencies (PHAs) are eligible to apply for S+C and become grant recipients. However, non-profit agencies often serve as sponsors for S+C projects and work closely with the government agency (i.e., grant recipient) to administer the project and provide services. The program is governed by HUD regulations located at 24 CFR Part 582.

1. Types of S+C Programs

- **Tenant-based rental assistance** (TRA) provides grant funding for a 5-year contract term. Participants reside in housing of their choice, though grant recipients may require participants to live in a specific area in order to facilitate coordination of supportive services. With this model, if the tenant moves to another unit, he or she may use the voucher in the new unit. This model enables people who are homeless with mental illnesses to select rental housing consistent with their individual preferences and needs.
- **Sponsor-based rental assistance** (SRA) provides grant funding for a term of 5 years through contracts between a grant recipient and a sponsor organization. Sponsors may be non-profit organizations or community mental health agencies established as a public non-profit. Participants reside in housing owned or leased by the project sponsor.
- **Project-based rental assistance** (PRA) provides grants for a term of either 5 or 10 years through contracts between grant recipients and owners of existing structures with units that will be leased to participants. Rental assistance grants are for 10 years only if the owner agrees to complete rehabilitation on the units to be leased within the first year of the contract agreement.

  Project-based rental assistance provides rental vouchers that are tied to a specific unit in a building. Anyone who resides in that unit and meets eligibility requirements

can utilize the project based voucher and pay only a portion of the rent. When the tenant moves out of that unit, he or she loses access to that housing voucher.

- **Single Room Occupancy Dwellings** (SRO) provides grants for rental assistance for a term of 10 years in connection with moderate rehabilitation of single room occupancy housing units. Old hotels or rooming houses are often renovated through this program. Since the housing units in these types of buildings are singles or studios, this program is targeted to individuals who are homeless. As with other types of S+C, these rental assistance funds are matched with appropriate supportive services.

2. Examples of S+C Projects

Tenant-based: A community recognized a logjam in its efforts to help families from transitional to permanent housing. Families were ready to live independently in the community with limited support services but were unable to leave the transitional housing program because they could not afford the cost of housing in the community. The community submitted an application to HUD through the Continuum of Care process for 20 units of tenant-based S+C subsidies. The project was successful in receiving a $1.4 million HUD S+C award to fund the 20 family units over a five-year period. Through this program the community worked with three different non-profit service providers to assist the families to find apartments and to provide ongoing case management. To provide the required service match ($1.4 million over the 5 year period), the non-profit sponsors received funding from the State Department of Family and Children Services, the City Department of Human Resources, and Medicaid reimbursement.

Sponsor-based: A non-profit organization operating an emergency shelter recognized that a number of individuals with serious mental illnesses residing in their shelter could live independently in the community with affordable housing and some supportive services. The group approached the local PHA to see if they were willing to partner in the creation of a 10-unit scattered site program for individuals with serious mental illnesses who were homeless. Together the non-profit and the PHA worked with the other members of the Continuum of Care group to apply for and receive a $300,000 5 year, sponsor-based, S+C program for people who were homeless with serious mental illnesses. The S+C grant provided up to $600 per month in rental subsidies for 10 units over a 5-year period. The non-profit organization became the sponsor and was responsible for renting apartments and signing leases with landlords for the 10 apartments. The sponsor then sublet those apartments to individuals who paid 30 percent of their income for rent. The PHA administered the rental subsidy and paid the landlords. The sponsor received a contract from the state Department of Mental Health and Addiction Services in the amount of $60,000 per year in PATH funds to provide case management services to the tenants.

Project-Based: One community had very limited available affordable housing. The community and non-profit organizations decided, that in order to meet the permanent supportive housing needs of individuals with disabilities who were homeless in the community, it would need to develop its own housing. The local Community Development Corporation (CDC) had access to a vacant house that could be converted into 10 individual studio apartments. The local CDC obtained funding from the state to

renovate the building. Before the renovation was complete, the community applied through the Continuum of Care process for 10 project-based S+C subsidies for the property. Since the property was going to be rehabilitated, the community was able to apply for 10-year subsidies. Based on HUD's Fair Market Rent for studio apartments in that community, the community was able to obtain an award of $600,000 in S+C subsidies for the 10 units for a 10-year period. The local CDC worked with a group of local service providers to develop a comprehensive supportive services package for the individual residents.

C. Section 8 Mod Rehab Program

The Section 8 Mod Rehab program provides grants to PHAs and non-profit organizations they contract with to develop SROs for individuals who are homeless. SRO projects are awarded Section 8 project-based rental vouchers for up to 10 years – a long-term commitment which helps the project sponsor obtain other financing necessary to develop the project. SRO projects must select tenants who qualify as homeless under HUD rules. The Section 8 Mod Rehab program is governed by HUD regulations located at 24 CFR Part 882.

Although this program is similar to the Shelter Plus Care SRO program, it does not require that participants be provided with supportive services.

1. Example of a Section 8 Mod Rehab Program

An old 10-unit lodging house had been vacant for several years. A non-profit organization purchased and renovated the building using a combination of city grant funds, state low-interest loan financing, and foundation resources. To ensure that the 10 studio apartments would be affordable, the organization applied for and received Section 8 Mod Rehab project-based subsidies from HUD. These funds provided the organization with steady operating funds that enabled it to cover operating costs and pay the mortgage payments on the state low interest loan. Individuals who moved into the building pay 30 percent of their income for rent, and the project based subsidy pays the difference between the tenant's share and 120 percent of the local Fair Market Rent.

Part II. The HUD Continuum of Care Application

Because all Continuum of Care systems should be unique and tailored to local circumstances, there is no one model of a competitive application. HUD has released the SuperNOFA at varying times in prior years (typically late winter/early spring), but could issue it considerably earlier. Also, HUD has revised the application from year-to-year to reflect new initiatives and new legislation. There is also no guarantee that this year's application will be identical to the application from the prior year.

In the past, HUD's application has been comprised of two major parts:

1. The community's Continuum of Care strategy, including a description of the process used to create that strategy, and a list of the projects requesting funding, in order of priority. Together, these comprise the Continuum of Care plan narrative and have been collectively referred to as Exhibit 1; and

2. All of the individual project proposals seeking HUD McKinney Homeless Assistance funding – including both new projects and projects seeking renewal funding – referred to as Exhibit 2 (SHP funds); Exhibit 3 (S+C funds); and Exhibit 4 (Section 8 Mod Rehab funds).

Specifically, within the Exhibit 1 narrative, HUD has requested Continuum of Care groups to include:

- **Abstract of Your Continuum of Care** – brief overview of your Continuum of Care highlighting key aspects of the system including the principal organizations involved and the types of funding requested.
- **Your Community's Planning Process for Developing a Continuum of Care Strategy** – the lead entity for the planning process; the planning structure; the dates and topics of the planning meetings held since the last HUD application and planned for in the future; and a diagram of how the entities in the planning structure relate to each other.
- **Specific Names and Types of Organizations Involved in the Continuum of Care Planning Process** – state and local government agencies, non-profit organizations, banks, neighborhood groups, housing developers, businesses, foundations, service providers, and people who are, or were, formerly homeless, the subpopulations each organization represents, and each organization's level of participation in the planning process.
- **Your Community's Continuum of Care System under Development** – this includes the vision for combating homelessness; the long-range strategies; and specific action steps to achieve that vision.
- **Fundamental Components of Your Continuum of Care System** – this means both those already in place and those your community is working toward including: prevention, outreach/assessment, emergency shelter, transitional housing, permanent supportive housing, and permanent housing.
- **Gaps and Priorities** – comprehensive needs and inventory assessment that identifies gaps in the existing system and prioritizes these gaps (including a description of how the needs and inventory data were gathered and how the priorities were established).
- **Supplemental Resources** – ways that the Continuum of Care process is linked to other planning processes and mainstream resources in the community including specific descriptions of how these resources are used in the Continuum of Care.
- **Project Leveraging** – documenting resources that are leveraged by the projects applying for Homeless Assistance funds. Leveraged resources are documented by written agreements – such as signed letters, memoranda of agreement, and other clear evidence of a commitment – and may include resources that will be used towards the cash match requirements in the project, as well as any written commitments for buildings, equipment, materials, services, and volunteer time. A written agreement indicating a formal commitment of PATH funds can demonstrate a leveraged resource.

Several new charts were included in Exhibit 1 of HUD's 2000 application, which made it easier for Continuum of Care groups to include these specifics.

A. Types Of Continuum Of Care Applications

There are three ways to submit an application to HUD:

1. Consolidated Application is developed from a single Continuum of Care plan for a geographic area and contains proposals for all the projects within that system. In a consolidated application there is usually one main agency that serves as the applicant and administers all funded projects through project sponsors or multiple applicants.
2. Associated Application is also developed from a single Continuum of Care plan, but project proposals in a Continuum of Care region request funding through individual applications and the applicant and project sponsor are the same entity. Each individual application includes an identical copy of the Continuum of Care plan (i.e., Exhibit 1) with their application.
3. Solo Application is not connected to the Continuum of Care plan for the jurisdiction and the applicant and the project sponsor are the same entity.

Consolidated and associated applications are developed from a single Continuum of Care strategy. They are considered equally competitive and are not substantially different. The primary difference is that in a consolidated application only **one** application is submitted with one Continuum of Care plan, while in an associated application, several applications may be submitted using the identical plan. Solo applications generally receive few points when scored by HUD because they are not part of a single Continuum of Care plan.

B. Renewals

Many mental health providers applied directly for HUD's McKinney Homeless Assistance funds in the late 1980s and early 1990s, before the Continuum of Care approach was introduced. These grantees have been extremely successful at meeting the varied and complex needs of people who are homeless with serious mental illnesses. Now, as they seek funds to renew these programs, it is important to be aware of how funds can be renewed. Under HUD's Continuum of Care policies, you may be forced to compete with other providers in the community who may also want to renew programs or implement new ones.

1. Renewing SHP Projects

According to HUD's most recent guidance, existing SHP projects must be included in the community's Continuum of Care process in order to be refunded. This means that many existing SHP projects will be competing with new projects for the limited HUD money made available through the Continuum of Care. In some communities, there is not enough funding to support both the existing and new projects. Many Continuum of Care groups now struggle with the dilemma of whether to use the valuable Homeless Assistance resources to sustain their existing system or to create new programs to meet the additional needs in the community. HUD's recent policy of awarding a $250,000 bonus to those applications that prioritize new permanent housing (as noted in Chapter 1) has allowed many communities to both renew SHP projects and create new permanent housing opportunities.

Over the past several years HUD has changed its requirements for how much renewal funding SHP projects can request. For example, in 1999 HUD revised its policies such that providers seeking to renew SHP funds for the operation of programs for people who are homeless with serious mental illnesses could now get up to 75 percent of needed

operations costs.8 For those providers seeking to renew SHP funds for supportive services, you would be required to provide 25 percent of the cost of the supportive services each year. It is important that you are aware of these requirements and stay informed of any changes.

2. Renewing S+C Projects

Since many S+C projects receive contracts for only 5 years of rental assistance funding, some of the projects that were funded in the early to mid 1990's are now in need of renewal funding. Many of these projects were initially funded before HUD introduced the Continuum of Care model. S+C projects are expensive, and until recently, Continuum of Care groups may have been forced to choose between using all their McKinney Homeless Assistance resources towards renewing S+C projects or creating new programs.

This renewal burden has resulted in a crisis for some communities across the nation and has put the housing of countless people with disabilities in jeopardy. For example, in 2000, across the country there were approximately $138 million in S+C grants that were in need of renewal funding. Recognizing the extent of this crisis, Congress set aside $100 million to provide one-year of funding for those S+C projects that would need renewal funding in fiscal years 2000 and 2001. Although it is not clear that Congress will continue to set aside funds for this purpose, advocates are hopeful that this trend will continue in the future. Since this is not yet a permanent solution, S+C grant recipients and sponsors need to continue planning for how funding for S+C projects will be sustained.

3. Renewing Section 8 Mod Rehab Projects

Existing Section 8 Moderate Rehabilitation programs do not have to compete through the Continuum of Care application process to obtain renewal funds. These programs are automatically renewed from HUD's Section 8 budget.

C. Pro-Rata Need

To encourage communities to develop a Continuum a Care strategy, HUD publishes the estimated funding amounts each community may receive if it submits a competitive application. This amount is referred to as the "pro-rata need" and is helpful in determining an estimated amount of funding.

In practice, a community may receive much more (or much less) than the pro-rata need amount depending on how well it completes the Continuum of Care application and how many projects are seeking renewal funds. This "pro-rata need" is only an estimate. The actual amount of funds a Continuum of Care plan receives depends on several factors including:

- The amount of renewals being requested as part of the application;
- The amount of Homeless Assistance funds requested nationally; and
- How well the application scores.

[8] In the past, for the third year of the SHP grant for operating funds, HUD would only award up to 50 percent of the operating costs.

To learn more about pro-rata need, contact your local HUD Field Office or HUD's Office of Special Needs Assistance Programs at (202) 708-4300.

D. HUD Scoring of Applications

HUD's Continuum of Care scoring of applications has been an evolving, and sometimes complicated, process. HUD conducted two types reviews on the 2000 Continuum of Care applications. The first was a review of the applicants' Continuum of Care narrative, and the second was a review of each project requesting funding. For each project proposal included in the application, HUD also conducted a threshold review to ensure that it meets the criteria for funding as described in the SuperNOFA. Projects that didn't pass the threshold review were eliminated from the competition.

For the year 2000 Continuum of Care application, HUD awarded:

1. Up to 60 points for an Exhibit 1 Continuum of Care narrative. These 60 points comprise the majority of an application's overall score. To receive a high score it is imperative that you clearly and comprehensively answer HUD'S questions and describe the Continuum of Care planning process in your community; and
2. Up to 40 points for each project requesting funding. This score is dependent on: the pro-rata need amount for the jurisdiction; the number of projects seeking renewal funding (referred to as the "renewal burden"); and how high the project is ranked by the Continuum of Care group in its list of priorities for Homeless Assistance funding.

HUD also awards up to two bonus points to Continuum of Care applications that propose one or more projects located within the boundaries and/or will principally serve the residents of a federal Empowerment Zone (EZ), Enterprise Community (EC), urban enhanced enterprise community, or strategic planning community (EZ/EC)[9], if the applicant states in the application that priority will be given to people who were homeless prior to their residing in the EZ/EC.

Those projects that are conditionally selected for funding by HUD are required to provide additional information (in the form of a "Technical Submission") some time after they have been notified of the award.

The most important point to remember is that HUD's scoring process places more weight on the Continuum of Care process than on individual project proposals. Thus a creative project may not receive funding if the Continuum of Care process – and the description of that process in the application's Continuum of Care plan – does not meet HUD's standards

E. Helpful Hints For Completing The Application

The best application is one with a good Continuum of Care plan including a clear and comprehensive description of the planning process. Here are some additional things to keep in mind to ensure that your Continuum of Care application is competitive:

[9] More information about HUD's Enterprise Community and Empowerment Zone programs can be found at www.hud.gov/cpd/ezec/ezeclist.html

- **Read SuperNOFA and application requirements carefully**. Make sure you understand what HUD is asking.
- **Start early**. The application is lengthy and requires a lot of hard work.
- **Make sure the application is well written**. Your application must clearly describe your Continuum of Care planning process to people who may never have been in your community.
- **Be specific**. Make sure that you answer questions clearly and follow their order.
- **Don't skip anything**. Explain to HUD what efforts have been made to address any deficiencies in your Continuum of Care process or system.
- **Make sure you are proposing to use funds in an eligible way**. HUD will not award funds for ineligible activities.
- **Plan to finish a few days ahead of time**. Use the extra time to allow another stakeholder to review the application to ensure it is complete and easy to understand. Mail the requested number of copies to HUD via registered mail and obtain a receipt to verify that it arrived.
- **Get help**. Read HUD's Question and Answer section (distributed with the SuperNOFA) and attend HUD's teleconferences to learn more.

Chapter 3
Continuum of Care Framework

The best way to have a competitive application is to have a strong framework for Continuum of Care planning. Across the nation, there are many different approaches used by Continuum of Care planning groups. The approach adopted by a particular community may be a reflection of the geographic region, the number and capacity of providers, the underlying philosophy of the players in a community, or the way homeless services are organized and delivered. Unlike other HUD planning processes – such as the Consolidated Plan and the PHA Plan – there are no regulations on how a Continuum of Care process should be organized.

To determine if there is an established Continuum of Care process in your community, contact the local emergency shelter, homeless service provider, or homeless advocacy agency. If you are unsure of whom to contact, often organizations such as the United Way or the Salvation Army can help you locate the appropriate agency.

If you are unable to determine if there is an existing Continuum of Care planning process in your community, contact staff at the Community and Planning Development Department of your local HUD Field Office. They should be able to tell you if a Continuum of Care application for McKinney Homeless Assistance funds has ever been submitted to HUD and, if so, who the contact person was for that application.

A. Different Approaches to Implementing the Continuum of Care Model

Remember, HUD introduced the Continuum of Care model as an inclusive process to get planning and decisions accomplished locally. As such, the way the Continuum of Care process is organized and led – its "approach" – must be able to legitimately reflect this local decision-making responsibility. All approaches must be able to balance a widespread inclusive planning process with the ability to maintain accountability. Some examples of Continuum of Care approaches are:

- Government led
- Homeless coalition led
- Non-profit organization led

Keep in mind that there may be more than one Continuum of Care process in your service area. For example, a city may have a Continuum of Care process that is separate from the process in the rest of the county (see Figure 1). A city Continuum of Care might be led by city government officials while the county Continuum of Care could be led by a coalition of service providers.

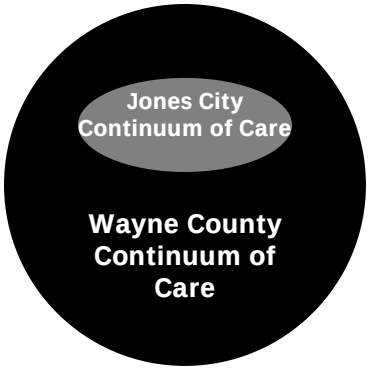


Figure 1

1. Example of Government Led Continuum of Care Approach

In a government led Continuum of Care, staff from government agencies take a leadership role in organizing the planning process and implementing the Continuum of Care. Government staff typically coordinate all data collection activities, including an annual census of street and sheltered people who are homeless. They also facilitate meetings with key stakeholders in the community – including homeless shelter and service providers, advocacy organizations, housing providers, veterans groups, people who are, or were, previously homeless, and leaders from the business community – to inventory the system, identify gaps, set priorities, and develop strategies and action steps. When necessary, subcommittees focus on particular subpopulations or discrete system issues. These activities are accomplished through an ongoing process in order to get input from a broad range of players and build consensus on priority activities and strategies. Government staff would also be responsible for monitoring the implementation of the Continuum of Care plan and making policy recommendations to local and state officials.

Advantages of this Approach

- Government agencies are usually able to contribute staff and/or resources towards the Continuum of Care effort. You will be able to participate without feeling over-burdened by the workload.

- Government agencies have the power and ability to hold people accountable for gathering data, implementing action steps, and accomplishing other planning related tasks. The mental health community will be able to see direct results from their involvement.

Disadvantages of this Approach

- As part of local or state government, government agencies coordinating the Continuum of Care process may be subject to the political agenda of local officials. Local officials may not be supportive of the needs of people who are homeless with serious mental illnesses and it may be difficult for you to access resources or advocate for change.

- Coordination by government can lead to the process being **controlled** by the government. This domination by one entity may create a more rigid and less creative process and make it difficult for you to get new and innovative ideas heard.

2. Example of Homeless Coalition Led Continuum of Care Approach

In this approach, a coalition of homeless providers coordinates the Continuum of Care process. The planning group is made up of representatives from not only coalition members, but also local foundations, corporations, and people who are, or were, formerly homeless. Both city and county government officials may have a seat at the table and support the process, but they do not lead.

As a group, the coalition conducts a comprehensive needs assessment and planning process over the course of the year to develop a Continuum of Care plan. Committees are organized to address specific aspects of the Continuum of Care process, including membership development, research and information, advocacy, and interagency planning. The coalition leverages resources – such as researchers from a local university – to assist with the Continuum of Care needs assessment and other activities. Overall responsibility for developing the plan and

monitoring its implementation is usually provided by the member agencies, through committee assignments.

Advantages of this Approach

- Promotes broad-based participation in the Continuum of Care process. With a wide range of players involved, you may establish creative partnerships and learn about new funding opportunities and programs.

- Facilitates data collection by involving more agencies to contribute in the effort. The mental health community can easily identify any emerging trends or changing needs among people with serious mental illnesses.

Disadvantages of this Approach

- The coalition has no staff dedicated to the Continuum of Care effort. Thus it may be more difficult for planning activities to be accomplished, and you may have to share a large portion of the workload.

- There is no mechanism inherent in this Continuum of Care approach that ensures accountability from the parties involved. You may be frustrated by the lack of follow-through on strategies and action steps.

3. Example of Non-Profit Led Continuum of Care Approach

In this approach, a non-profit agency takes the leadership role in organizing and implementing the planning process. In some communities, a non-profit organization may be formed for the sole purpose of coordinating and monitoring the Continuum of Care plan. The organization must have staff with the capacity, resources, and organizational skills to coordinate meetings. When the non-profit has programs funded through the Continuum of Care process, it must separate its role as facilitator and leader of the planning process from its role as a funded agency.

Advantages of this Approach

- As with the government led process, a non-profit organization may be able to dedicate staff and resources to the Continuum of Care planning effort. Consequently, less of the burden for arranging logistics (such as meeting space, distributing information, gathering materials, etc.) will fall on the mental health system.

- A local non-profit organization may be very aware of the community's needs. This knowledge will enhance the qualitative portion of the needs, inventory, and gaps analysis and will facilitate legitimacy in the community. The mental health community benefits in establishing relationships with the other community players involved in the planning process.

Disadvantages of this Approach

- This approach has the potential for perceived or actual bias in decision making and allocation of funding since the non-profit organization coordinating the efforts may also be receiving funding obtained through the Continuum of Care process. You may find it difficult to get support for new projects if the decision making is not fair. By creating a new non-

profit organization with the sole purpose of facilitating the Continuum of Care process, this bias can be avoided.

- Although the non-profit organization may have staff and resources that can be used by the Continuum of Care group, this staff – and the agency as a whole – may be over-burdened and unable to accomplish many of the action steps. You may therefore, perceive a lack of leadership and experience frustration at the inability to get things done.

B. "Balance of State" Continuum of Care Approach

Many states also have created "Balance of State" Continuum of Care plans. HUD creates incentives for states to put together Balance of State Continuum of Care plans to cover communities without their own Continuum of Care process. These plans typically include small communities and rural areas.

For example, in fiscal year 2000 there were 20 Continuum of Care applications that were submitted to HUD for McKinney Homeless Assistance funds from the state of Massachusetts. These Continuums of Care used a variety of planning approaches, and included a Balance of State Continuum of Care application (representing 91 communities) developed by the state human service agency.

Advantages of this Approach

- A Balance of State Continuum of Care process may have access to staff and resources from the state to coordinate the process and planning activities. You may also use the state PATH coordinator as a liaison between the local mental health providers and players involved in the Continuum of Care planning at the state level. In fact, many state mental health agencies have taken the lead in establishing a Balance of State Continuum of Care process.

- Based on HUD's funding policies, a Balance of State Continuum of Care plan may be able to obtain more HUD McKinney Homeless Assistance funding since it claims the "share" of many smaller communities. As a result, you may be able to access more funding to develop programs for people who are homeless with serious mental illnesses.

Disadvantages of this Approach

- Given the size of the geographic region, it may be difficult to gather meaningful data for each community covered by a Balance of State Continuum of Care. You will have to make an extra effort to ensure that the needs of people who are homeless with serious mental illnesses are accurately reflected in the Continuum of Care plan.

- It is difficult to develop an effective statewide homeless system that encompasses all communities and ensures that the needs of all people who are homeless are addressed. You may therefore have difficulty ensuring that resources to meet the needs of people who are homeless with serious mental illnesses are dedicated in your community.

C. Initiating the Continuum of Care Process

In many communities, there is no existing Continuum of Care planning process. Given the housing crisis currently facing people who are homeless with serious mental illnesses across the nation, you may want to explore establishing a Continuum of Care process in your community. Key questions to ask when establishing a new Continuum of Care process are:

- **What role do you want to play in the process? Will you organize and coordinate the planning process?** By taking a leadership role, you are well positioned to address the needs of people who are homeless with serious mental illnesses. However, the agency that coordinates the Continuum of Care process can *dominate* the process – leading to only one subpopulation of people who are homeless receiving assistance. Furthermore, in all communities, the agency that coordinates the process assumes a large amount of the administrative workload (e.g., arranging meeting logistics, minutes, agenda, etc.).

- **What resources are available within your agency to devote to the planning process? How much time can be devoted to the planning process?** When determining what role to play in the Continuum of Care process, be realistic about what resources your agency is able to contribute, such as staff time, space, and materials. Remember, there is usually no financial compensation.

- **What is the capacity of your agency to be involved? What skills or knowledge do you need to gain in order to be an active participant?** It is important to capitalize on the knowledge that you have – such as the provision of support services to people with serious mental illnesses – and use the Continuum of Care process as an opportunity to learn about other resources – such as federally subsidized housing programs.

- **What do you want to gain from the process?** Most importantly, your agency should determine what the desired outcomes are. Do you want to use this opportunity to:

  - ❒ Access more housing resources for people with serious mental illnesses who are homeless? If so, how many units of housing? What type of housing (e.g., transitional, permanent, etc.)?
  - ❒ Identify alternative sources for funding the services you are currently providing to people with serious mental illnesses? For example, if the mental health system is currently subsidizing housing for people with serious mental illnesses, could Section 8 vouchers be utilized instead? If so, how much funding would you need?
  - ❒ Establish partnerships with other providers in the community – such as job training programs or transitional housing providers – in order to better serve people who are homeless with serious mental illnesses?
  - ❒ Preserve those resources that you already have? Many providers already receiving HUD McKinney Homeless Assistance funds will have to demonstrate to the Continuum of Care group how these funds have been used to help people who are homeless with serious mental illnesses – highlighting program outcomes and establishing justification for additional funding in the future.

D. Start-up Activities

Before beginning a new Continuum of Care process, you should have a clear understanding of all the activities involved in establishing and maintaining this process.[10] To start a Continuum of Care process you will need to take the lead to accomplish many of those activities described in other chapters of this guidebook. For example, understanding how HUD McKinney Homeless Assistance resources can be used; compiling data on the needs of people who are homeless and resources available to them as a way of identifying gaps; and seeking assistance when needed, as well as the activities described below about involving stakeholders.

1. Involving Stakeholders

The first step in starting a new Continuum of Care process is to identify stakeholders in the community who could help address the needs of people who are homeless. HUD encourages broad participation in the Continuum of Care process. Given this, you may want to contact agencies in the community that may not be directly involved in assisting people who are homeless, but may have resources that could contribute to the overall effort. For example, colleges and universities may have graduate students who can help with the data collection activities. These students could benefit from participating in the process by using the data to complete a research project or publish a paper. Examples of stakeholders in your community who could participate in the Continuum of Care process include:

- Local homeless coalitions/networks
- Homeless service providers
- Non-profit housing developers
- Local government representatives (city and county)
- Key civic leaders
- People who are, or have been, homeless
- Homeless advocates
- Public Housing Agencies
- Mental health funders and other service providers
- Local job councils
- Colleges and vocational education institutions
- Veterans service agencies
- Persons representing special needs populations such as people with mental illness, people with addictions, people with HIV/AIDS, and families fleeing domestic violence
- State government representatives (community development, veterans, welfare, human services, employment, education, transportation, etc.)
- Religious leaders
- Business community
- Police officers and staff from correctional facilities

Think creatively about ways to engage those players that do not typically serve people who are homeless, such as banks and businesses. There are many different methods of "participating" in the Continuum of Care process. For example, agencies can participate in the process by:

- Attending core working group meetings;
- Joining an issue-related task force or subcommittee;
- Sponsoring activities that benefit and facilitate input from people who are homeless;
- Financially supporting Continuum of Care activities;

[10] In addition to the material in this guidebook, HUD's *Guide to Continuum of Care Planning and Implementation* provides a comprehensive overview of the planning process.

- Commenting on written materials;
- Providing input on specific strategies or action steps;
- Collecting data;
- Reviewing data to ensure these are accurate and realistic; and
- Reviewing proposals for funding.

There are many different mechanisms to promote meaningful participation in the Continuum of Care process by stakeholders in the community, including those who do not typically serve people who are homeless. Overall, it is important that providers and key stakeholders understand the Continuum of Care concept and why it is important. Some mechanisms to increase participation include:

- Provide a clear description of why a stakeholder should participate; the level and amount of participation; and the expected outcomes of this participation;
- Identify what the stakeholder will get from participating (e.g., improved public relations; resolution of problem; more funding; partnerships);
- Identify who specifically needs to be at which meetings (e.g., Executive Director or junior staff person). Ensure that the person is well-informed of his or her role in the process;
- Use political pressure – get a friendly elected official to request participation from specific stakeholders; and
- Use board members to convince other established community members to join the "effort."

Keep in mind that before asking a community player to be involved in the Continuum of Care process, it is important to know specifically what you are asking of that person. For example, would you like the bank to provide free checking for individuals who are homeless and working, or would you just like them to hang a poster in the bank window during homeless awareness week?

It also helps to indicate what that player has to gain from their involvement. For example, participation in the process can boost a bank's Community Reinvestment Act (CRA) rating, and help keep people who are homeless from sleeping in its ATM booths.

Much of the success of a Continuum of Care plan will ultimately rest on the cooperation and buy-in of policy makers and funders. If these stakeholders are not directly involved in the process, they should be kept informed of the ongoing Continuum of Care activities and the plans to address homelessness in the community.

2. Participation by People Who Are and Have Formerly Been Homeless

The input and knowledge of consumers of homeless and mental health services is critical to the development of a comprehensive, effective Continuum of Care. Creative strategies to engage consumers meaningfully in the process may include:

- Identify former consumers of homeless mental health services who are now active members of the Board of Directors, interested alumni, or staff from your agency or other agencies in the community.
- Sponsor regular focus groups with consumers to obtain information and data, review strategies and action steps, and prioritize needs and projects. To ensure participation at focus groups, try to identify barriers to participation and provide some incentives – whether

it is food or a small stipend – or other means to demonstrate appreciation. Report back to consumers on the results of the process.
- Conduct regularly scheduled surveys and interviews. These surveys can be conducted upon exit from mental health programs or at regularly scheduled intervals throughout the year (e.g., every six months).
- If your agency administers a Shelter Plus Care program, members of the Shelter Plus Care Advisory Committee could be asked to participate in the broader Continuum of Care planning process.

3. Ensure Representation of All Homeless Subpopulations

It is important that the Continuum of Care group include stakeholders representing the needs of the various segments of homeless subpopulations:

- People with serious mental illnesses;
- Youth;
- Elderly;
- Veterans;
- People with dual or multiple diagnoses;
- Victims of domestic violence; and
- People living with HIV/AIDS.

There is considerable interrelation and crossover among subpopulations that should be addressed through Continuum of Care planning. For example, in some communities there is a need for substance abuse and recovery services and supports for people who are homeless and have serious mental illnesses.

4. Define the Geographic Area

At the same time that you are identifying potential stakeholders, you should also be defining a logical geographic area for your Continuum of Care jurisdiction. HUD policies state that stakeholders from all parts of the Continuum of Care geographic areas should be involved in the planning process.

Factors for communities to consider when defining a geographic area include:

- The key agencies and providers involved in the delivery of homeless services and their service/planning areas to facilitate linkages and coordination;
- The jurisdiction of key resources needed to comprehensively respond to the needs of people who are homeless and facilitate linkages to mainstream resources; and
- How people who are homeless access services.

HUD provides a Geographic Area Guide of cities and counties to help Continuum of Care groups define their geographic area when competing for McKinney Homeless Assistance funding. A Continuum of Care application should be composed of one or more of the cities and counties listed in this guide. Current HUD policies state that one Continuum of Care system may not overlap with the service area of any other system.

5. Tie to Existing Planning Processes

Whenever possible, the Continuum of Care effort should be linked to other community plans (such as the State Comprehensive Mental Health Services Plan, Consolidated Plan, Public Housing Agency Plan, Ryan White Care Act, other mental health strategic planning, etc.). This is to ensure that priority activities and strategies to serve people who are homeless are consistent with a community's other housing, community development, and health and human services objectives. If priority activities are divergent, the Continuum of Care plan should include explicit strategies for influencing changes in the Consolidated Plan or other community plans.

By linking to other community planning efforts, the Continuum of Care group can share data; learn about other programs in the community; strengthen coordination among programs; eliminate fragmentation and duplication of services; and gain access to mainstream resources for people who are homeless with serious mental illnesses and other subpopulations.

6. Take the Time to Do Things Right

Considerable time, energy, and financial resources are needed to coordinate and improve the housing and services programs that make up the existing homeless system. When attempting to establish a new Continuum of Care process in your community, you should allow yourself time to lay the right groundwork in terms of community "buy-in", data collection and analysis, and the development of priority strategies. In the end, this hard work will earn legitimacy in the community and translate into material improvements in the homeless and mental health systems and the lives of people with mental illnesses who are homeless.

E. Joining an Existing Continuum of Care Process

Many communities and states already have established Continuum of Care processes. You, as a mental health provider, have a lot to gain – and a lot to lose – if you are not actively involved in the Continuum of Care process. For an existing Continuum of Care process, it is important to determine if the process: 1) truly incorporates the needs of people who are homeless with serious mental illnesses; and 2) addresses these needs through the development of long-range strategies and realistic action steps. Questions to ask to determine if the process is fair, inclusive, and representative of the community's needs, including the needs of people who are homeless with serious mental illnesses, are discussed below.

Keep in mind, there is no one answer to each of these questions. However, when assessing an existing Continuum of Care process, it is important to think about what your vision is for an ideal system for meeting the needs of people who are homeless with serious mental illnesses. This vision should encompass the quantity, quality, and type of housing and supportive services that are needed and preferred by consumers. You should evaluate the process by determining whether it moves the existing homeless system towards this vision.

1. Are the Interests of People Who are Homeless with Serious Mental Illnesses Adequately Represented?

Providing mechanisms for incorporating the voices of those directly affected by policies is imperative to the Continuum of Care process and the successful delivery of homeless services. Experiences of people with serious mental illnesses who have been, or are, homeless are

essential to learn what works, what does not work, and what is missing in the homeless services system.

2. Is the Mental Health Community Doing Its Part?

As a participant in the Continuum of Care process, you should be sharing some of the planning workload – such as arranging meeting logistics, assisting with the data collection activities, helping to implement action steps, and collaborating in the completion of the application to HUD. It is imperative that you are perceived as sharing some of this administrative burden.

Quality assurance is also important. You must ensure that existing HUD Homeless Assistance funded programs serving people who are homeless with serious mental illnesses are appropriately and efficiently utilized. By operating good quality housing and services, you improve your chances of receiving more HUD funding in the future.

Finally, you must play an active role in ensuring that the needs of all people who are homeless are met, not just people with serious mental illness who are homeless. This can be accomplished through broad membership and involvement by a wide range of stakeholders in the Continuum of Care process – including participation by those stakeholders who operate outside of the homeless system. A perception that the mental health community is receiving the majority of the available resources could lead to tension among the participants in the Continuum of Care process – making your participation less effective. You must be willing to lend your expertise and experience – including knowledge about resources, programs, and innovative solutions – to helping other people who are homeless.

3. Is the Mental Health Community Receiving Its Fair Share of Resources Based on the Needs of People Who are Homeless with Serious Mental Illnesses?

The needs, inventory, and gaps analysis is a key component in the Continuum of Care process since it is the basis for determining which unmet needs are the highest priority for the community and therefore should be addressed first. Given its importance, you should make certain that the process for completing this analysis is sound and allows the needs of people who are homeless with serious mental illnesses to be accurately represented. You should also ensure that this analysis encompasses the needs of all people who are homeless and not only the needs of those people who receive services from the most dominant provider.

4. Is the Mental Health Community Part of the Decision Making?

Countless decisions have to be made throughout the Continuum of Care process, including:

- What is the vision for the Continuum of Care system?
- What approach will be used?
- Who will take the lead?
- Who gets invited to the table?
- How will data be collected?
- How will data be analyzed?
- How will priorities be established?
- What are strategies and action steps?
- Who writes and reviews the Continuum of Care application to HUD?

- What criteria are used to review, analyze, and prioritize the projects for the HUD application?
- Who should be responsible for monitoring and implementation of the Continuum of Care plan?

No matter how well a Continuum of Care group plans for its decision making, problems will naturally arise. Many of the decisions – particularly those regarding funding and priorities – are difficult. It is also difficult to make decisions that may have a perceived negative impact on an agency or project. The best way to avoid tension is to plan ahead. Laying out a fair process in advance, before difficult decisions have to be made, will take the pressure off the actual decision making.

For those Continuum of Care groups that do not currently use a formal decision making process, you can take the lead in developing and implementing one. In groups with an established process, you can work collaboratively with other group members to identify shortcomings in the existing process and develop strategies to address these problem areas. For example, one Continuum of Care group determined that they had a fair process except in the event of a tie. In the past, the chairperson had broken all ties. However, last year the chairperson was forced to decide between his own agency's program and another in the community – compromising the fairness of the process.

The ground rules for participation and decision making should be clear to both newcomers and to veterans of the planning process. For example, how and what information will be presented; who will have input and how; and who can vote. The ultimate goal is that all involved stakeholders consider the decision-making process to be legitimate and fair. Some examples of decision making include:

- **Example 1:** Each individual or provider in the Continuum of Care group has one vote. The planning group may want to develop criteria that determine which planning members get the right to vote and ensure balanced participation from all stakeholders. For example, criteria could be based on number of meetings attended during a specific time period. The group could use a secret ballot to avoid any bias due to intimidation or the problem of voting against "friends."
- **Example 2:** The Continuum of Care group uses a proportional voting method in which each individual or provider is given a number of points – 100 for example. These points can be either placed on one item (e.g., 100 votes for Project A) or can be divided among the items (e.g., 45 for Project A and 55 for Project B). When an individual/provider assigns points to an item, there could be a minimum number of points (e.g., 30).
- **Example 3:** There are two votes. For the first vote, each individual/provider gets to vote for three different items. Once these are tallied, the top three items are then put up for a second vote. Each individual in the group gets to vote on these "finalists."
- **Example 4:** An objective committee is elected to make decisions such as the prioritization of gaps in the system or the ranking of project proposals. Persons or agencies that have any potential interest in any current funding proposal are prohibited from serving on the committee. The committee is democratically elected by all participants in the Continuum of Care process. The committee reviews pertinent information, all relevant data, and may interview stakeholders as part of the decision making process.

F. Joining A Balance of State Continuum of Care Process

Another way for the mental health community to access more resources is to strengthen its role in the Balance of State Continuum of Care process. As mentioned earlier, an existing Balance of State Continuum of Care covers those communities that have not developed a comprehensive process of their own. You may find that your community is involved in this Balance of State Continuum of Care process, but not in a meaningful way.

A Balance of State Continuum of Care has a lot to gain by involving mental health providers in the process and should welcome your participation. Given the large and diverse geographic area covered by a Balance of State Continuum of Care, it is often difficult for the planning group to gather accurate data from local communities about the needs of people who are homeless with serious mental illnesses and the resources available to them. Local mental health providers could partner with the Balance of State planning group to supply this information. Once this relationship is established, it will be easier to advocate with the Balance of State planning group to develop strategies to address these unmet needs of people who are homeless with serious mental illnesses.

To become more involved in a Balance of State process, contact your state PATH coordinator or the housing director in the state Department of Mental Health to discuss ways you can participate in the process.

Chapter 4
Continuum of Care Planning Process

In some communities, the Continuum of Care has been a successful model for both strategic planning and developing competitive applications for HUD McKinney Homeless Assistance funding. In other communities, the Continuum of Care process has been perceived as "one more bureaucratic requirement." There are also some communities that have never implemented the Continuum of Care.

This chapter provides an overview of the Continuum of Care process including a discussion of the four basic steps: organizing the process; collecting needs data and inventorying system capacity; determining and prioritizing gaps in the Continuum of Care; and developing long-term strategies and short-term action steps. It will also cover information on selecting and ranking projects, and what to do after the application is submitted.

A. Organizing the Process

The first step in organizing a Continuum of Care process is to establish a core working group. This working group can be small but, as indicated in chapter 3, should be representative of key stakeholders in the community and represent the interests of all homeless subpopulations, including people with serious mental illnesses.

The core working group takes responsibility for developing the structure for the planning process including: developing a vision and guiding principles; defining clear decision-making procedures; and establishing a timeline and desired outcomes.

B. Collecting Needs Data and Inventorying System Capacity

An essential part of a Continuum of Care process is the assessment of the extent and types of unmet need – for both housing and services – experienced by people who are homeless in the community. For the mental health community, this means: 1) documenting the number of people with serious mental illnesses in the community and determining what their needs are; and 2) inventorying the existing housing and services currently available to meet their needs. In the Continuum of Care plan, the difference between the needs and the inventory is referred to as the "gap."

Data synthesized through the Continuum of Care process serves as the foundation for establishing long-range strategies for a community. By documenting the gaps in the existing system, the mental health community can more effectively advocate for funding for programs – including HUD McKinney Homeless Assistance funding – to address these needs.

There are many other reasons why having good data is important including:

- **Funders rely on impartial statistics in making decisions**. They "trust" numbers.
- **Data are useful to measure the "success" of a program or service**. Outcome data can help reinforce why an existing program should continue to receive funding.
- **Data ensure that needs are clearly documented**. Unfortunately, in some communities the loudest or most articulate voice translates into greatest need.
- **Data can help forge partnerships**. Often, different subpopulations may have similar needs and the data can help with the creation of innovative collaborations (e.g., substance abuse treatment for individuals with serious mental illnesses who are homeless).
- **Data helps identify trends before they become epidemic problems**. Data on the characteristics of those people accessing services and housing can identify new trends or emerging subpopulations. For instance, data collected by shelter providers can demonstrate that many people accessing the shelter are being discharged from mental health institutions.

1. How to Collect Sound Data

Collecting and analyzing needs and inventory data are labor-intensive and time-consuming. It is important to be realistic about who has the capacity to follow through and what methods would be least taxing on providers and the system, while at the same time yielding reasonably accurate data. It is important to have an ongoing formal process with homeless providers and other key stakeholders regarding data. This "back and forth" should include some discussion before and/or during data collection to solicit ideas for, and cooperation on, methods and sources. There are certain principles to keep in mind when collecting data:

- **Clearly define homeless.** It is important to clearly establish who is being defined as homeless.
- **Do not reinvent the wheel.** Look first to existing sources of data, such as PATH data, mental health system data, the Consolidated Plan, or an annual homeless census.
- **Cast a broad net.** Make sure data collection captures all subpopulations identified among the homeless – especially people with serious mental illnesses who are not engaged in any service such as people living on the streets, in cars, in parks, and under bridges.
- **Decide on a methodology**. It is important to reach consensus early in the planning process regarding what type of methodology will be used to gather data, including deciding how often data will be collected, and how point-in-time data will be gathered.
- **Identify capacity for data collection.** There may be resources outside of the homeless provider network that can be tapped. For example, universities or metropolitan planning councils often have the capacity and interest to assist in data collection and analysis, though their assistance may not be pro bono.
- **Record the sources of your data.** Document the specific steps you took to identify the needs and inventory resources. For example, keep a list of all the agencies and programs counted in your inventory. Keep this information in a form that will be easy to update in the future.
- **Don't get lost in the data.** Reasonably accurate data are important – perfect data are not the goal. The goal is to have a sufficient quantitative and qualitative analysis of people who are homeless with serious mental illnesses in your community to guide decisions regarding resource deployment.

2. Needs Data You Already Have

Mental health providers, especially those that receive federal PATH funds, already gather useful data. Through intakes, assessments, and the development and updating of individual service plans, mental health providers collect a large amount of information about services and housing consumers regularly request and need. This information is vital to completing the community needs, inventory, and gaps analysis included in the Continuum of Care process. Needs data that you might collect include:

- **Incidence of Homelessness:** The number of people with serious mental illnesses who are currently living on the streets, in parks, or other places not fit for human habitation; the number of people with serious mental illnesses living in shelters; and the number of people with serious mental illnesses in transitional housing (and where they were living before entering that housing).
- **Service Needs:** Supportive services regularly requested or needed by consumers, as documented in intake forms, individualized service plans, and other assessment tools.
- **Housing Status:** The number of people with serious mental illnesses who were homeless prior to being housed; the number of people who are "at risk" of homelessness due to living in substandard housing or paying more than 50 percent of their income toward rent.
- **Housing Needs:** The type of housing needed and/or requested by people with serious mental illnesses who are homeless (i.e., congregate housing, scattered site, supportive housing); the number of people who are in restricted inpatient settings who would be discharged if affordable housing were available in the community.

3. Housing and Services Resources Currently Available

In addition to assessing the extent of homelessness, the Continuum of Care process includes an inventory of the existing capacity to meet the needs of people with serious mental illnesses who are homeless. As part of this assessment, it is important to look at all potentially available resources, including those that are not typically accessed by people who are homeless, referred to as "mainstream" resources. Specifically, mainstream resources are those housing and service resources that are available in your community and are not HUD McKinney Homeless Assistance funds. These include housing resources (such as conventional public housing, Section 8, and other rental subsidy programs), and service resources (such as mental health and substance abuse resources, Temporary Assistance to Needy Families [TANF], etc.). These are valuable resources that could be used to strengthen the overall Continuum of Care system.

As with the collection of mental health needs data, you should determine what data you already have about existing programs that could be included as part of the Continuum of Care inventorying process. Specifically, as part of this process you could examine:

- **Service Utilization**: What mental health services do people who are homeless with serious mental illnesses use? What other support services – such as job training, housing search, substance abuse counseling, and treatment - are accessed? How many people access these services? How many might access these services if they were more accessible?
- **Housing Supply**: What type of housing (transitional, congregate, etc.) and how many units of housing are available to people who are homeless with serious mental illnesses? Is any of this housing subsidized? If so, who provides the subsidy (HUD, Public Housing Agency, mental health authority, etc.)?

- **Housing Placement**: What type of housing do people with serious mental illnesses currently live in (transitional, permanent, supportive)? How many of these individuals were homeless before entering a particular housing situation?

4. FY 2000 HUD Exhibit: Needs and Gaps Analysis Chart

		ESTIMATED NEED	CURRENT INVENTORY	UNMET NEED / GAP	RELATIVE PRIORITY
		Individuals			
Example	Emergency shelter	115	89	26	M
Beds/Units	Emergency Shelter				
	Transitional Housing				
	Permanent Supportive Housing				
	Total				
Estimated Supportive Service Slots	Job Training				
	Case Management				
	Substance Abuse Treatment				
	Mental Health Care				
	Housing Placement				
	Life Skills Training				
	Other				
	Other				
Estimated Sub-Populations	Chronic Substance Abuse				
	Seriously Mentally Ill				
	Dually-Diagnosed				
	Veterans				
	Persons with HIV/AIDS				
	Victims of Domestic Violence				
	Youth				
	Other				
		Persons in Families with Children			
Beds/Units	Emergency Shelter				
	Transitional Housing				
	Permanent Supportive Housing				
	Total				
Estimated Supportive Service Slots	Job Training				
	Case Management				
	Child Care				
	Substance Abuse Treatment				
	Mental Health Care				
	Housing Placement				
	Life Skills Training				
	Other				
	Other				
Estimated Sub-Populations	Chronic Substance Abuse				
	Seriously Mentally Ill				
	Dually-Diagnosed				
	Veterans				
	Persons with HIV/AIDS				
	Victims of Domestic Violence				
	Other				

5. Completing HUD's Needs and Gaps Analysis Chart

The Needs and Gaps Analysis chart from HUD's Continuum of Care Homeless Assistance application (see previous page) can be used to organize the needs and inventory information you have gathered. It is supposed to represent a "snapshot" of your community's homeless system at one point in time. Many Continuum of Care groups choose a winter evening to complete this chart using point-in-time data. Some communities conduct more than one point-in-time assessment (i.e., summer and winter) to more accurately represent a picture of the homeless system. Before completing, make sure clear definitions of the categories are included in the chart. For example, are "dually diagnosed" those people who are homeless with substance abuse and mental illness? Or does "dually diagnosed" refer to an individual with multiple disabilities, regardless of the type of disability?

Many Continuum of Care groups find the Needs and Gaps Analysis chart a less than perfect tool for recording important data. Vague instructions make the chart difficult to complete and the categories on the chart and the point-in-time view do not always reflect the true homeless subpopulations and Continuum of Care components. These shortcomings can make it difficult for communities to complete comprehensive planning because they struggle with the details and forget the broader goals for data collection.

6. Reality-Test the Data

Once all the data are collected, there should be an opportunity to "reality test" it and fill in any missing data. You should try to facilitate honest discussion regarding potential errors or misrepresentations. Rely on your experience to assess if the data included in the needs, inventory, and gaps analysis are reflective of the actual situation facing people with serious mental illnesses who are homeless. Sometimes data do not reflect actual situations. For example, some communities have found that the number of people with HIV/AIDS is underrepresented due to stigma and fear.

Remember, the data do not have to be exact enough to pass statistical scrutiny, but the numbers should reflect reality and be useful in planning and program development. The goal is to ensure that the data collected are comprehensive and feasible; that all the parties involved in the Continuum of Care process agree with the methodology and picture they present; and that any shortcomings in the data are agreed upon as acceptable.

7. What Other Data Should be Collected

HUD requires that programs receiving McKinney Homeless Assistance funding complete an Annual Progress Report (APR) to document their progress towards meeting goals related to residential stability, self-determination, skills, and income. In addition to these goals, you should develop creative ways to document a program's success. Testimony from consumers is an effective means of documenting how services have affected their quality of life. Written referral agreements or Memoranda of Understanding (MOUs) with other agencies will demonstrate the ability to move people through the homeless system.

This information is particularly important when decisions are made about how to utilize future HUD McKinney Homeless Assistance funding. By consistently gathering outcome data to measure a program's success, you will have a stronger argument for why your programs should receive renewal funding.

In addition, outcome data can be useful when trying to obtain other funding (beyond McKinney Homeless Assistance resources) to sustain or expand programs serving people who are homeless with serious mental illnesses.

C. Determining and Prioritizing Gaps in the Continuum of Care

Using the data collected through the community assessment, the Continuum of Care group should work collaboratively to identify gaps in the system where the needs of homeless individuals and families are not being met. At its simplest, determining gaps in the homeless system involves a comparison between the amount of need and the current capacity (by component of the Continuum of Care system) to meet the need. The first step for determining gaps in housing and services is to quantify unmet need. This involves a calculation between the estimated amount of need (based on the needs data collected) and the current inventory by Continuum of Care component (based on the inventory) to meet the need. This calculation is demonstrated in the chart below.

		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	545	388	(545-388) = 157	
	Transitional Housing	250	212	(250-212) = 38	
	Permanent Supportive Housing	125	100	(125-100) = 25	
	Total	920	700	(920-700) = 220	

From: HUD's *Needs and Gaps Analysis Chart*

Decisions regarding the relative priority of these gaps (i.e., low, medium, or high) are the basis for developing strategies to deploy new resources or re-deploy existing resources within the Continuum of Care system. Most groups don't have enough resources to adequately address all the gaps identified through the needs, inventory, and gaps analysis. Given this shortage of resources, establishing the highest priorities of unmet need is a difficult task. However, the Continuum of Care process is designed to help communities decide what activities should be done first, given the limited resources available.

You may naturally feel that the unmet needs of people with serious mental illnesses who are homeless should be the highest priority, while other groups may want to prioritize other homeless populations. It is most important that the entire process for prioritizing gaps in the homeless system be fair and inclusive.

1. Qualitative Assessment

Priorities are not necessarily established solely on the basis of quantitative data. Qualitative information is also needed to capture contextual information. For example, if shelter census data were gathered on an unusually warm evening, emergency shelters may have lower than usual occupancy rates. Critical information on homeless subpopulations may not be reported or

may be under-reported. For example, people with co-occurring mental illness and substance abuse may under-report their substance use due to stigma or fear of losing access to housing or services.

Given the limitations of quantitative data, it is important to establish and build consensus on some qualitative criteria that will help the Continuum of Care group to prioritize gaps in the homeless system. There is a wide range of possible qualitative criteria including:

Housing Criteria

- How many units are needed for each homeless subpopulation?
- Is one homeless subpopulation more vulnerable than another with regard to age and/or diagnosis?
- Which homeless groups are "not yet served" versus those with some housing resources in place?
- Does one homeless subpopulation seem to be growing in size?
- Are there major gaps in a type of housing (SROs, multi-unit rental, larger bedroom sizes, transitional programs for subgroups, etc.) available or needed?
- Are there issues with how long people who are homeless are staying in certain housing programs?
- Are there linkages in place for persons in transitional housing or emergency shelter to facilitate access to permanent or permanent supportive housing?

Service and Systems Criteria

- What is the capacity of existing services to serve persons already in emergency shelter, transitional housing programs, or permanent housing?
- What services are essential to help people move to permanent housing or permanent supportive housing?
- Who are the high end users of services? What services are they using the most?
- Are there missing linkages among components of the system (i.e. outreach, intake, assessment, housing search, referral)?

These qualitative criteria should resonate with the vision and guiding principles articulated at the start of the Continuum of Care process. They should also focus on the ultimate goal of assisting people who are homeless to obtain and maintain permanent housing. For example, a community committed to permanent solutions to homelessness may not give a high priority to expanding emergency shelter capacity even if the (quantitative) unmet need is large. Instead, they might prioritize permanent supportive housing and engagement services to move people with serious mental illnesses who are homeless off the street and into housing.

2. The Process Used to Determine Relative Priorities

The Continuum of Care group is responsible for determining *relative* priorities – meaning priorities established that are *relative to one another*. A low priority does not mean that there is not an unmet need. Rather, it means that relative to other unmet needs or gaps, it is less of a priority. It may be helpful for Continuum of Care groups to have a discussion early on about common misconceptions such as:

- A "high" priority means that this group is more homeless than a "low" priority group; or
- All projects that are seeking HUD McKinney Homeless Assistance funds must be a "high" priority.[11]

Also, keep in mind that a high priority gap does not necessarily correspond with a high priority for HUD McKinney Homeless Assistance funding. Some high priority needs may be met through non-McKinney resources. For example, HOME tenant-based rental assistance funds could be used to create transitional (2-year) housing for people with serious mental illnesses who are homeless (identified as a high priority need through the needs and gaps analysis). [12]

Some Continuum of Care groups use only the quantitative data to determine the relative priority (i.e., the numbers documented in the "unmet need" column on the chart directly dictate the relative priority of that gap). As mentioned before, the quantitative assessment is limited and should be considered only part of the total process for determining the relative priority of unmet gaps.

When a community assigns relative priorities to needs, there can be tension surrounding that process and those decisions. The process and its results can get side-tracked into a discussion of "who is more homeless" or "who is more deserving" of services and housing. A well-planned and understood process can help to eliminate much of this tension. It is critical to ensure that there is a clear and unbiased process for making these decisions.

3. Renewals and the Prioritization Process

A Continuum of Care system may already include several programs funded with McKinney resources, and so the community faces the decision of whether to seek renewal funding for these projects in its application to HUD. Since HUD resources are limited, deciding to renew an existing project could directly reduce the amount of funding available for new projects.

In completing the needs, inventory, and gaps analysis process, Continuum of Care groups should be sure to consider the effect of *not* refunding existing projects. For example, if there is a 20 unit transitional housing project in need of renewal funding, the gap in transitional housing may increase by 20 units if this project is not renewed. Also, consider how renewals may impact the system as a whole. There may be several permanent housing programs up for renewal. If these programs are not refunded, what impact will that have on permanent housing, on transitional housing, and on the other components in the homeless system?

D. Developing Long-Term Strategies and Short-Term Action Steps

A comprehensive Continuum of Care plan should include strategies to address those priority gaps identified through the needs, inventory, and gaps analysis. In particular, it should include strategies to meet those gaps among people with serious mental illnesses who are homeless. These strategies can include activities such as: changes in mental health policies; advocacy

[11] Since the priorities are relative, a project that proposes to address a gap that is considered a low priority can still be included in the application to HUD for McKinney Homeless Assistance funds. However, the Continuum of Care group must be able to justify its rationale for including the project in the application.
[12] HOME funds are controlled by the Consolidated Plan process.

efforts within the mental health system; new partnerships or linkages between the mental health community and other systems; applications for funding for new mental health programs; or changes to the allocation of mental health resources. Strategies should be long-range and should include specific short-term action steps with identified responsible parties and deadlines.

Strategies are broad statements that articulate a goal for the future. Examples of strategy statements include:

- Foster creation of new permanent supportive housing for individuals with serious mental illness over the next two years;
- Expand economic development programs across the Continuum of Care to increase self-sufficiency and provide greater access to permanent housing;
- Facilitate the development of programs to address the specific needs of critically underserved homeless subpopulations, such as individuals with co-occurring diagnoses; and
- Integrate planning for housing and services for people who are homeless with serious mental illnesses with other mainstream planning processes within the mental health system.

There should be an established community-based process for developing strategies and action steps. This process should include "brainstorming" sessions where participants are encouraged to think creatively about potential activities that could help complete the long-range strategy. It is helpful to have a wide range of stakeholders involved in these brainstorming sessions since stakeholders may be aware of alternative resources or have innovative ideas for policy changes. For example, representatives from the business community may suggest creative ways to encourage local employers to hire job-ready people who are homeless with serious mental illnesses – such as the creation of a handbook of helpful tips for interested employers on how to build a supportive workplace environment.

1. Action Steps

To ensure that the Continuum of Care plan is outcome-oriented, each strategy should include action steps, point(s) of accountability, and a proposed timeframe for completion. These action steps will provide the community with a road map for implementing the Continuum of Care plan. Depending on the process used, these action steps can be developed and proposed by small groups, subcommittees, or the entire Continuum of Care group, and presented to the broader community for discussion and approval. Questions that can help facilitate the conversation in these brainstorming sessions and the development of action steps include:

- Is there an opportunity, project, or activity that will be lost if not begun immediately?
- Is there a timing issue where one action step is necessary before others can be taken?
- Is the amount of effort needed to undertake the activity reasonable? (Starting out with the most complex activities may not be a good strategy).
- How critical is this strategy?
- Is the proposed activity feasible?
- Are there major barriers to implementing the activity?

When developing action steps, remember to think creatively, but focus on what you can accomplish in the near future. Action steps can include:

- **Changes in policies** – Example: Meeting with the funders of mental health institutions and correctional facilities to discuss improvements to discharge planning to avoid people with serious mental illnesses leaving these institutions and entering the shelter system.
- **Re-allocation of resources** – Examples: 1) Reviewing the existing Consolidated Plan to determine how HOME funds are currently being utilized; and 2) proposing that HOME tenant-based rental assistance funds be used to address the transitional housing needs of people who are homeless with serious mental illnesses.
- **Creative linkages** – Example: Researching the programs currently funded through the Housing Opportunities for People with AIDS (HOPWA) program to determine if, through collaboration, they can be used to help people who are homeless with serious mental illnesses and HIV/AIDS.
- **Pursuing new funding opportunities** – Example: Meeting with the Executive Director of the local Public Housing Agency to explore the possibility of submitting an application for new Section 8 vouchers targeted to people with disabilities made available by HUD.
- **Advocacy** – Example: Researching how the state tobacco settlement funds are being used to determine if they can help people with serious mental illnesses who are homeless.

It is important to keep in mind that action steps do not necessarily involve the submission of an application to HUD for McKinney Homeless Assistance funds. With limited resources and an increasing burden to renew existing projects, Continuum of Care groups are struggling to find ways to fund new projects. Rather than rely on McKinney Homeless Assistance funds for all homeless services, efforts should be made to try to integrate programs for people who are homeless with serious mental illnesses into mainstream mental health and housing strategies.

Remember, the Continuum of Care model is a comprehensive community-wide strategic planning process that looks at *all* available resources when developing strategies and action steps to address any gaps in the system. Keeping this in mind, the application to HUD should be viewed as just one of many action steps that will help address these gaps.

Example of Strategy Statement and Action Steps

Strategy: Facilitate the transition to housing for people who are homeless with serious mental illnesses recently discharged from mental health institutions.

ACTION STEPS	RESPONSIBLE PARTY(S)	TIMELINE
Review existing discharge policies from state funded mental health institutions	*PATH providers and state PATH coordinator*	*January 2001*
Convene committee to analyze discharge planning	*Director of Inpatient Mental Health Services*	*March 2001*
Review utilization trends of existing shelter beds by people with mental illnesses	*Shelter providers*	*March 2001*
Explore targeting existing transitional housing units for people with serious mental illnesses being discharged from mental health institutions	*Shelter providers and mental health providers*	*May 2001*

E. Selecting and Ranking Projects to Be Included in the Continuum of Care Application to HUD

As part of the Continuum of Care process, communities have to select which projects will be included in its application to HUD for Homeless Assistance funding. In addition, as part of this application, Continuum of Care groups are required to rank these projects in the order they would like HUD to fund them.

There is no one way to make these difficult decisions. Some communities have developed clear and objective guidelines for making decisions (see chapter 3 for examples) while in other communities it is the most vocal person at the table who makes all the decisions. In less formal situations this selection and ranking process can be extremely difficult and can lead to tension among planning group members. To avoid some of this tension, the Continuum of Care working group should develop a clear process for making these difficult decisions. This process should demonstrate that decisions are logical and fair and should use established criteria to evaluate proposed projects. Some examples of selection and ranking criteria include:

- Degree to which the project fills a priority gap;
- Eligibility for McKinney Homeless Assistance funding;
- Experience of applicant in working with the target population;
- Cost effectiveness;
- Leveraging of other resources;
- Ability to articulate achievable outcome measures;
- Innovation of project;
- Quality of the application;
- Capacity of applicant to implement and manage the project; and
- Linkages with other parts of the Continuum of Care.

Finally, when selecting and ranking proposed projects, a Continuum of Care group should take into account the need to renew existing projects. Remember, any project that does not receive renewal funding may result in a gap in the Continuum of Care system in the near future.

F. What To Do After the Application is Submitted to HUD

Continuum of Care planning is a year-round process. Unfortunately, many Continuum of Care groups devote all their time and resources to the four-month period around the release of the HUD McKinney Homeless Assistance SuperNOFA. However, a comprehensive ongoing planning effort can reduce the burden often experienced during the SuperNOFA period; promote more comprehensive, proactive planning and assessment; and enable the process and the programs to be improved.

Some of the activities that should take place after the application is submitted include:

- **Follow-up on action steps.** The Continuum of Care group, in consultation with the broader community, must decide on how the Continuum of Care plan will be monitored. In communities where the city or county government has taken the lead in the planning

process, it will likely be city or county staff who are responsible for ensuring the implementation of the action steps in the Continuum of Care plan. This can occur with the advice and/or counsel of a formal (appointed) group of community stakeholders or through updates and input at regular community meetings. Other communities may use a lead homeless agency or may recruit community stakeholders to take responsibility for particular aspects of the implementation of the Continuum of Care plan. These volunteers may be expected to report to a nominated group of community stakeholders. Regardless of the mechanism adopted for monitoring the plan, roles and responsibilities should be explicit, and a regular meeting schedule should be established to ensure accountability for an ongoing year-long planning process.

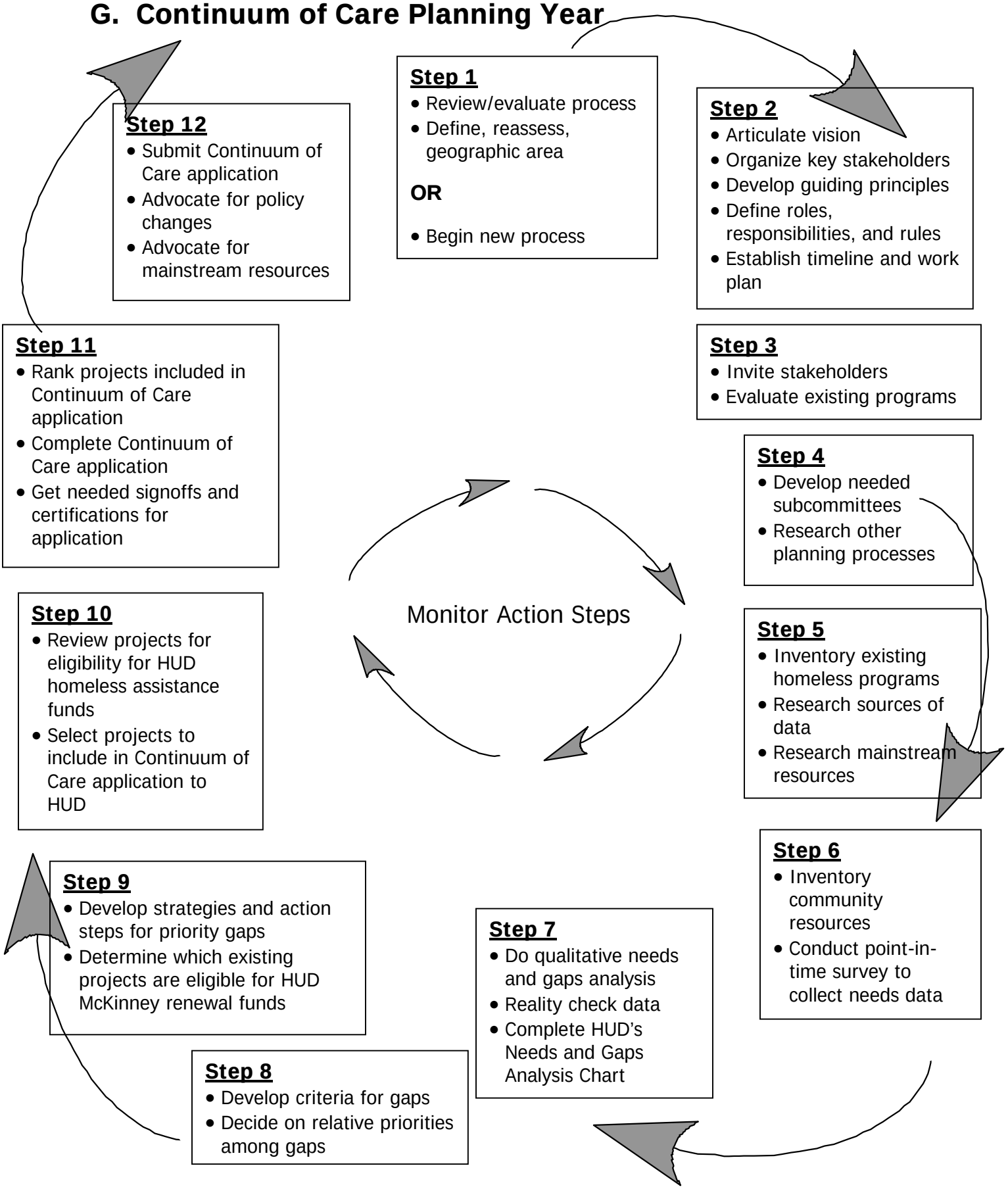
- **Evaluate next year's renewals.** Continuum of Care groups may need to start evaluating existing programs to determine if they are meeting the community's needs. An evaluation process can help a Continuum of Care group work with existing programs to improve their operations, establish additional linkages to the community, or seek more appropriate funding. Evaluating projects under consideration for renewal funding will help the Continuum of Care determine if the project is: 1) still viable; 2) meets identified needs and criteria; and 3) can access other funding. An evaluation should not be punitive, but rather serve as a means to improve a program's effectiveness and, identify and access other funding. For example, programs that receive poor evaluation ratings could be renewed for one year of funding with a list of areas to improve upon.

- **Data collection and assessment.** Use this time to identify new sources of data about the needs of people who are homeless – including people with serious mental illnesses – and to engage more participants in data collection activities. For example, determine what information police officers and hospital emergency room staff track, to see if it is useful for Continuum of Care planning.

- **Review previous year's process and recommend changes to that process.** Analyze any problems that arose with the previous year's Continuum of Care process – such as contentious decision making, limited attendance at meetings, weak participation in planning activities, or lack of involvement from some key stakeholders – and discuss ways to prevent these problems from occurring again. Determine what outcomes you want as a result of next year's Continuum of Care process

- **Advocate for increased housing and resources.** The mental health community needs to inform policy makers of the need for increased funding in McKinney Homeless Assistance resources. At the state and local level, providers need to ensure that people who are homeless with serious mental illnesses are getting their fair share of both homeless-targeted and mainstream resources.

G. Continuum of Care Planning Year



Conclusion

Frequently Asked Questions

This guidebook has described the Continuum of Care process and provides the mental health community with knowledge and tools to be successful players in a community's homeless planning activities. PATH funded providers may have more specific questions, however, regarding the interrelationship between HUD's Homeless Assistance programs and PATH. Some of these questions are addressed below.

Who Can PATH Funded Providers Serve?

Many PATH funded providers and Continuum of Care planning groups are confused by the differences between the McKinney definition of homelessness and the PATH reference to homelessness. PATH providers have the ability to serve a wider range of people who are homeless – including those people who cannot be assisted with McKinney Homeless Assistance funds. According to Part C of the US Public Health Service Act, PATH funds can be used to assist individuals who have serious mental illnesses and are homeless, or are at imminent risk of becoming homeless.

Many Continuum of Care planning groups have found it challenging to use HUD McKinney Homeless Assistance funds effectively due to the narrow definition of "homeless." For example, a person with a serious mental illness who is being discharged from a mental health institution is eligible for McKinney funded homeless programs only if it can be demonstrated that he or she: 1) has been a resident of the institution for more than 30 consecutive days; 2) is unable to locate subsequent housing; and 3) lacks the financial resources and support networks needed to obtain housing. Mental health providers often find it difficult, time-consuming, and burdensome to gather the documentation of these three facts.

Given these challenges presented by the narrow definition of "homeless," mental health providers should access a variety of funding resources – not just HUD McKinney dollars – when designing and implementing programs in the Continuum of Care for people with serious mental illnesses. By diversifying funding streams, mental health providers have the flexibility to create a program that more accurately meets the unique needs of the homeless individuals and families that they serve. For example, through the PATH program, mental health providers can make available prevention services to those individuals who are at risk of becoming homeless – such as those people who are paying over 50 percent of their income towards rent and utilities. The Homeless Assistance funds controlled by the Continuum of Care *cannot* be used to provide homelessness prevention services. It is important to be clear on the restrictions regarding eligibility for each funding source when designing programs to meet the needs of people who are homeless with serious mental illnesses.

How Can PATH Be Used to Meet the Match Requirements for HUD McKinney Funded Programs?

PATH funding is a valuable source of match for McKinney Homeless Assistance programs. It can be used to provide case management, mental health counseling, outreach, and other services that complement SHP and Shelter Plus Care funded activities – programs that require matching funds supplied by the grantee. By combining both PATH and McKinney funds, you have the flexibility to design programs that truly meet *all* the needs of people who are homeless with serious mental illnesses.

To use PATH as an effective match, you need to understand all of HUD's requirements for matching McKinney Homeless Assistance funds. These requirements have changed recently. For those grantees seeking SHP renewal funds to provide supportive services for people who are homeless with serious mental illnesses, HUD now requires that you produce *cash* funding to match HUD's SHP supportive services funding. [13]

How to Deal with Renewals?

To be in the best position possible to get renewal funding, you should have a complete understanding of HUD's renewal process and requirements. Make sure to be clear which year a program is eligible for renewal, according to HUD regulations. This information can be confusing and difficult to understand. Program eligibility for renewal funding is based on a date in HUD's computer system and not on how much funding is left in the grant.

In addition, as the demand for funding increases, it is important that Continuum of Care groups establish a mechanism for evaluating existing McKinney funded programs. Continuum of Care groups often do not have the resources to independently evaluate renewal projects. Some seek funding or staff from local foundations or corporations to assist with the evaluation of programs. The majority, however, rely on the grantee to supply data to document that the McKinney Homeless Assistance funds are being used effectively and efficiently. As discussed earlier, you should play a proactive role in gathering this type of data.

Some Continuum of Care groups may have implemented formal evaluation processes. Models that have been used include:

- **Evaluation Subcommittee.** This subcommittee can be made up of peer agencies and public organizations that evaluate all the programs seeking renewal funding. The evaluation committee can rely on annual progress reports, interviews, site visits, or a combination of these mechanisms.
- **Third Party Evaluator.** This evaluator can be a consultant paid to complete the work or a pro bono consultant (local college or university). You should be able to provide this consultant with all reports in a timely manner and be able to supplement his or her evaluation with outcome data and testimony from consumers.

Whichever evaluation process a Continuum of Care group adopts, it should be clear about what criteria will be used to evaluate a project and how the evaluation results will be used.

[13] Note that HUD's Shelter Plus Care match requirements do not call for cash dollars and can be met with in-kind resources, donations, etc.

Summary

For the past six years, HUD has mandated the Continuum of Care as the mechanism for obtaining HUD McKinney Homeless Assistance funding in a community. It is crucial that mental health providers be active players in this process in order to ensure that people who are homeless with serious mental illnesses get their "fair share" of these valuable resources.

But the Continuum of Care is more than just an application for HUD funds. Since it was first introduced, the Continuum of Care has served as an impetus for groups serving people who are homeless to come together to expand and strengthen the existing homeless system. When utilized to its fullest potential, the Continuum of Care is more than just a planning process; it is a means by which the mental health community: 1) creates linkages with other providers of housing and services; 2) works collaboratively with other key players to reduce fragmentation and duplication of services for people who are homeless with serious mental illnesses; 3) learns about other community resources, including new opportunities and mainstream funding sources; and 4) receives support and assistance in making its programs work more effectively.

The Continuum of Care is not a perfect process. There is only limited HUD guidance on how to implement and participate in the process. However, there are many positive elements inherent to the process, such as the flexibility given to a community to design an approach that addresses the unique dynamics of that area. The information in this guidebook, in combination with the publications listed in Appendix A, can assist the mental health community to be informed and assertive players in all strategic housing planning processes – including the Continuum of Care.

Appendices

Appendix A
How to Get Additional Assistance

After reading this guidebook, you may still have questions or need more "hands on" assistance to address the issues unique to your state or community – such as local politics or funding streams. Those mental health providers or Continuum of Care groups with access to resources may want to consider hiring an outside party to facilitate the process and/or write the HUD Continuum of Care application. An outside consultant may help to reduce any bias in the Continuum of Care planning. There is also some assistance available from HUD. However, funding for HUD technical assistance is very fragmented, and there are limits on how it can be used.

HUD Funded McKinney Homeless Assistance Technical Assistance

HUD makes available funding to provide technical assistance (TA) to those agencies involved in the Continuum of Care process and in the delivery of services and housing to people who are homeless, including people with serious mental illness. In fiscal year 2000, HUD made $4 million available to fund McKinney Homeless Assistance TA – formerly referred to as Supportive Housing Program (SHP) Technical Assistance. This funding is distributed to each HUD Field Office or region.

A HUD-funded TA provider can assist "prospective applicants, applicants, recipients, or other providers of supportive housing or services for homeless persons, for McKinney Homeless Assistance funded projects"[14] within the Field Office's jurisdiction. According to HUD regulations, the TA may include, but is not limited to, written information (such as papers, monographs, manuals, guides, and brochures), person-to-person exchanges, and training or related costs.

The actual type of TA available and the mode of delivery (e.g., workshop, teleconference, materials, etc.) depend on the skills, knowledge, and capacity of the TA provider and the decision of the HUD Field Office staff. TA providers work closely with the HUD Field Office to develop a plan for the types of TA activities to be delivered and the modes of delivery. Examples of TA activities that might be delivered include:

- A workshop for Continuum of Care groups to assist in gathering accurate data on the needs of people who are homeless and the services available to them;
- A booklet describing mainstream affordable housing resources – such as those controlled by the Consolidated Plan – and the mechanisms for accessing these resources for people who are homeless; and
- Individualized assistance in evaluating existing HUD funded programs to measure their successes, weaknesses, and assess linkages among Continuum of Care components.

[14] 24 CFR 583.140.

Limitations on Receiving HUD Funded Technical Assistance

The major problem with accessing HUD-funded TA is that TA providers *cannot* assist any organization or Continuum of Care group during the annual SuperNOFA competition (historically late winter to early summer), that would result in one Continuum of Care group or organization having an unfair advantage over another in the competition. For example, during the competition, HUD-funded TA providers cannot write or provide guidance on how to complete a Continuum of Care application for submission to HUD.

How the Mental Health Community Can Access HUD-Funded Technical Assistance

The first step to obtaining technical assistance is to make a request to the local HUD Field Office. Submit this request in writing and make sure to be clear about what the TA needs are. For example, do you need help strengthening your Continuum of Care process? Conducting a valid and accurate needs and gaps analysis? Understanding HUD's reporting and fiscal requirements?

Given the limitation to accessing HUD TA assistance described above, it is critical that mental health providers start to assess their needs for TA early on, and contact their local HUD Field Office to learn about any available TA as soon as possible.

At the local level, the mental health community should establish a working relationship with the HUD Field Office and ensure that available TA funds are used effectively to give mental health providers the skills needed. Historically, there are HUD Field Offices that, together with their TA providers, have provided effective assistance to Continuum of Care planning groups. Some HUD Field Offices may not yet have spent their allocation of TA funds. For more information about HUD funded technical assistance, contact Lyn Whitcomb in HUD's office of Community Planning and Development at (202) 708-3176.

Helpful Publications

In addition to HUD funded technical assistance, there are several publications that are helpful in providing the mental health community with the skills and knowledge to address the housing and service needs of people with serious mental illnesses. The following are a list of useful publications:

For more information about Continuum of Care planning:

- *Guide to Continuum of Care Planning and Implementation* – available at www.hud.gov/cpd/cont/gcoc.html or by contacting HUD Customer Services at (800) 998-9999 (item reference #05264).

For more information about HUD Requirements for Continuum of Care programs:

- *Supportive Housing Program Desk Guide* – available only online at www.hud.gov/cpd/shp/guide.html.
- *US Code of Federal Regulations (CFR), Part 24*. Available at your local library, online at www.hud.gov, or by contacting HUD's Customer Services at (800) 998-9999 or your local HUD Field Office.

For information about other affordable housing resources:

- *Seizing the Moment. Using HUD's Consolidated Plan to Identify Affordable Housing Opportunities for Homeless People with Serious Mental Illnesses* – available at

www.prainc.com/nrc/papers/seizing/intro.htm or by contacting the National Resource Center on Homelessness and Mental Illness at (800) 444-7415.

- *Opening Doors* publications – available at www.tacinc.org/OpeningDoors.html or by contacting the Technical Assistance Collaborative at (617) 742-5657.

Appendix B
How PATH Funds Fit into the Continuum of Care Process

When PATH was enacted, Congress intended that it would work in concert with HUD programs, including the Section 8 and public housing programs as well as the McKinney Homeless Assistance programs. With the introduction of the Continuum of Care approach, the emphasis on local strategic planning allows communities to take much more advantage of this linkage, including the use of PATH funds to complement HUD McKinney funds in meeting the needs of people who are homeless with serious mental illnesses.

PATH funds are an integral resource to addressing the needs of people with serious mental illnesses who are homeless or at risk of homelessness. Through creative programming, PATH funds have been an effective mechanism for filling many of the gaps in the existing mental health and homeless systems of care. PATH funds can be used for the following activities:

- Outreach services;
- Screening and diagnostic treatment services;
- Habilitation and rehabilitation services;
- Community mental health services;
- Alcohol or drug treatment services;
- Staff training (including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other service sites);
- Case management services including:
  - ❑ Preparing a plan for the provision of community mental health services and reviewing the plan not less than once every three months;
  - ❑ Providing assistance in obtaining and coordinating social and maintenance services including services related to daily living activities, personal financial planning, transportation services, habilitation and rehabilitation services, prevocational and vocational services, and housing services;
  - ❑ Providing assistance in obtaining income support services including housing assistance, food stamps, and Supplemental Security Income benefits;
  - ❑ Referrals for such other services as appropriate; and
  - ❑ Providing representative payee services;
- Supportive and supervisory services in residential settings;
- Referrals for primary health services, job training, educational services, and relevant housing services; and
- Other appropriate services.

PATH funds can also be used to support the following specific housing related services. However, not more than 20 percent of PATH funds can be used to provide these services. They include:

- Minor renovation, expansion, and repair of housing;
- Planning of housing;
- Technical assistance in applying for housing assistance;
- Improving the coordination of housing services;
- Security deposits;
- Costs associated with matching eligible individuals with appropriate housing situations; and one-time rental payments to prevent eviction.