# Coalition of Housing and Homeless Organizations (COHHO)

**September, 2000**

**POSITION:** To impact the issue of homelessness – and the lives of those caught in it – is an imperative that requires a three-pronged approach:

1. systems reform
2. system/service coordination
3. shelter/service provision

**OVERVIEW:** People who are homeless have been isolated out of the general population. This isolation has necessitated the creation of a parallel service system to address their various needs. Currently, homeless organizations offer child care, mental health and substance abuse treatment, employment services, education/training, and so on.

Mainstream systems/services in the District are in disarray. People who rely on the public system receive limited services. People who are homeless receive services in the shelters because mainstream services are not accessible. With the elimination of many of the safety net mainstream programs, increased numbers of District residents have entered the homeless ranks.

**HISTORICAL BACKGROUND:** In the late 1970s and early 1980s homelessness exploded in the District. Early efforts to provide shelter and services faltered as the numbers continued to grow and the need for coordination and systems reform was ignored.

Generally, in the 1980s homelessness was attributed to the lack of affordable housing. However, Department of Public and Assisted Housing (which then ran the public housing program) was not the only system that did not work. The Department of Housing and Community Development's approach to economic development excluded very low income people. The emphasis has been on home ownership rather than the development of affordable and sustainable rental housing. The Commission on Mental Health failed to develop a community-based system of care for those who had been deinstitutionalized. Addiction, Prevention and Recovery Administration continued to cut back on services even as the drug problem in the District escalated. Adult Protective Services was absent. Child Welfare failed to see the connection between foster care and homelessness, and abuse and neglect and homelessness. MRDDA ignored many in the population we call homeless who needed their services. The Department of Education eliminated programs which addressed the literacy needs of adult District residents. The Department of Health was unresponsive to the medical needs of those who were homeless. Health Care for the Homeless (Unity Health Care) was established as a parallel system to provide primary health care for persons who are homeless. The Department of Corrections discharged people to the streets without support or a discharge plan. Employment services were out of reach for those who were homeless.

With the 1993 inception of the D.C. Initiative – a partnership between HUD and the District government – an integrated, coordinated approach to homelessness was to be developed. The

original commitment to the D.C. Initiative by the District government was $14.3 million. That amount was never realized. With the inception of the D.C. Initiative, the Department of Human Services turned over the responsibility for programs for people who are homeless to The Community Partnership for the Prevention of Homelessness. Motivation on the part of government officials for developing a coordinated approach to homeless services approach waned. The District government no longer appears willing to maintain mainstream services for homeless men, women, and children.

Although The Community Partnership has improved existing services, the continuum of care with which it is charged remains incomplete largely due to the lack of a comprehensive and integrated approach by the District government to the issue of homelessness and to its lack of commitment to appropriating adequate funds. Since the onset of the District's fiscal crisis the DHS budget has been ravaged. Not only have services for people who are homeless suffered but all the safety net programs which keep folks out of homelessness have been decimated. As the past few years have shown, there is a direct connection between poverty and homeless. People who are poor and have little or no support systems and are the most likely candidates for homelessness.

**CURRENT STATUS:** The Community Partnership, despite being limited by the lack of local funding, has accessed approximately $8 million annually from HUD through the SuperNofa process. That funding, though exceedingly useful, does not address emergency services – its focus is transitional and permanent supportive housing. Federal funding is not flexible and comes with many restrictions. In most cases, federal dollars do not fund emergency services. Emergency services are the essential entry point to the continuum of care, as they provide low-barrier, minimum expectation services to the most fragile of the population. Emergency services need to remain as a core component of the continuum of care. By limiting access to emergency services (e.g. limiting the number of beds available), many persons in need of the most basic and vital forms of assistance will be lost to the system.

In the summer of 1998, at the initiative of the Chief Management Officer, government entities, and private providers were brought back to the table together in an attempt to address again the need for coordination among government agencies. The goal of these meetings was to develop a Strategic Plan that all city agencies, as well as private providers, would sign off on, thereby committing themselves to work towards effective and long-lasting change. However, since that time, efforts to create a strategic plan for homeless services have stalled as thoughtful communication between the District government and homeless service providers has broken down. The MOU between HUD and the District government expired in March of 1999, as does HUD's financial commitment (of $7 million every three years) to the D.C. Initiative.

With the Continuum of Care approach, transitional and permanent housing options have increased while emergency services/shelter have decreased. Services which should be provided by mainstream systems have relied on homeless dollars for funding, thus reinforcing the dual system and isolating people who are homeless out of the general population.

**DESCRIPTION OF THE PROBLEM:**

In the District there are between 9,000 and 15,000 people who are homeless (counting people who are homeless is difficult and imprecise so these numbers are merely estimates). This is not a static number; as some people move out of homelessness, new people find themselves in need of the system's support. About one-third of those who are homeless are children. One out of every 200 family households in the District requested shelter from May 1996 through June 1997 according to a report by Dennis Culhane, Ph.D., University of Pennsylvania.

Families and individuals fall into homelessness for the following reasons:

- lack of affordable housing
- domestic violence
- under-education
- unemployment and underemployment
- lack of childcare
- substance abuse
- inadequate/non-existent discharge planning from institutions
- poor health care
- lack of emergency assistance
- lack of general public assistance
- lack of services for immigrant communitites
- privatization

***Lack of Affordable Housing***

The lack of affordable housing in the District is a major contributing factor to homelessness. In 1999, the National Low Income Housing Coalition ranked the District of Columbia fourth worst amongst all states with respect to housing affordability. A report last year by the U.S. Department of Housing and Urban Development showed that fair market rent in the District, as a percentage of average income of assisted households, had hit 111.7%, placing D.C. second only to Newark among 20 large U.S. cities surveyed.

In 1999, the National Low Income Housing Coalition found that thirty percent (30%) of all D.C. renters cannot afford a one-bedroom apartment, and thirty-five percent (35%) cannot afford a two-bedroom apartment (estimated to be $840/month). A renter would need to work 103 hours per week at the District's minimum wage to afford a two-bedroom apartment in D.C., paying the recommended 30% income for housing costs.

These high costs force many to turn to the subsidized housing market for assistance, but few find help there. Approximately 18,000 households are on the D.C. Housing Authority waiting lists for subsidized housing (according to the D.C. Housing Authority in May of this year, approximately 8,000 households were on the public housing list; nearly 13,000 were on the Section 8 list), waiting, on average two years for public housing and four years for Section 8.

Safety-net programs, such as emergency assistance and general public assistance, which traditionally have helped low-income individuals and families remain stable in their housing,

have been eliminated. The District's own rental housing subsidy program, the Tenant Assistance Program, as been virtually eliminated.

The housing crisis stands only to worsen, as contracts covering about 7,000 private units being used for Section 8 housing are set to expire over the next three years. With the Administration's focus on economic development activities encouraging the gentrification of neighborhoods, there is a serious concern that landlords will choose to "opt out" of this subsidy program, leading to an even greater scarcity of affordable units. At the same time, as the D.C. Housing Authority moves out of receivership, we will see approximately 2000 fewer conventional public housing units in its stock, as a result of the disposition of a number of scattered site properties and the reconfiguration of several large public housing communities through Hope VI development.

In addition, in 1999 the District sought out and received a waiver allowing its Community Development Block Grant (CDBG) funds to be used for programs serving a higher income population than would otherwise be permissible under Federal law. Few of these dollars are used to support rental housing for our lowest income neighbors.

The lack of affordable housing is a major contributor to homelessness. If there were adequate housing, mainstream systems could provide services to people while they were housed. But without adequate housing and functioning mainstream service systems, homelessness continues to be a problem.

***Domestic Violence***

The District has two safe houses for victims of domestic violence. The capacity of 28 does not accommodate a family with a male child 14 years or older, and does not come close to meeting the number of safety requests in a given year.

According to the Institute for Children and Poverty, seventy percent of parents who are homeless experience physical, sexual and/or emotional abuse from a parent or relative as a child, and sixty-three percent report involvement in violent relationships with friends or partners as adults. In all, 80% of parents who are homeless experience family violence at some point in their lives. Economics play a large part in driving victims into homelessness.

***Under-Education***

The public school system in D.C. has failed many. At least 50% of residents of shelters are illiterate. Cuts to adult education programs, specifically those directed to pre-GED or remediation, make it impossible for individuals who are homeless to secure the education necessary to enter the workforce.

***Unemployment and Underemployment***

As of June 2000, the rate of unemployment in the District is 5.1% as compared to 2.1% in the suburban ring. Many District citizens are unable to secure employment at a living wage largely due to a lack of education and training. According to the Self-Sufficiency Standard adopted by the District for workforce development, a single parent with one preschooler and one school-age child would need to earn $22.69 per hour (or $3,993 per month) to live independently, without public or private assistance. In contrast, the District's minimum wage is $6.15 per hour, or

$1,066 per month. The same single-parent family receiving job training and assistance through TANF and food stamps has a total benefit grant package of only $872 per month.

***Childcare***
Lack of affordable and accessible childcare remains a challenge for parents who are trying to move off the welfare rolls and into work programs. Over the past several years, the number of childcare facilities has been decimated, leaving many parents struggling with how to achieve gainful employment and take care of those children.

***Substance Abuse***
Access to meaningful treatment is a major hurdle to long-lasting recovery from substance abuse. There are between 65,000 and 100,000 persons in the District who need treatment for substance abuse. In the first 11 months of FY 1999, the Addiction Prevention and Recovery Administration served only 5,700 clients. No statistics are available regarding whether these individuals were successfully treated. Since 1993 both inpatient and outpatient capacity for substance abuse treatment has been dramatically cut.

The human costs of substance abuse are pervasive and devastating. Sixty-seven percent of recent offenders in DC tested positive in at least half of all drug tests. Eighty-five percent of child protection cases, 75% of foster care cases, and 35% of AIDS cases are related to drug abuse. Moreover, one in seven mothers delivering babies test positive for drug use; 38% of emergency room visit patients are under the influence of alcohol; and 50% of perpetrators of domestic violence have substance abuse problems. It is estimated that 60% of those in the population we call homeless suffer from addictions. Existing services fail to meet the treatment needs of youth, the elderly, pregnant and parenting women, and the immigrant communities.

***Inadequate/Non-existent Discharge Planning From Institutions***
In the 1960s and 1970s (and continuing today), there has been a movement to decrease the hospital beds for those who are mentally ill. Providing services in the least restrictive environment is and should be the goal. However, the District does not have a functioning community-based mental health system. Consequently, many people who are mentally ill are homeless and without mental health services, and therefore rely on help from the shelter system. The percentage of those suffering from mental illness in the District approximates 40%.

Prisons, jails, hospitals and the foster care system regularly discharge to shelters. Research by the National Alliance to End Homelessness showed that of 1,134 homeless individuals interviewed, 36.2% were in the foster care system. Furthermore, 77% of those who were parents and had been in foster care had at least one child in foster care. Overwhelming caseloads make efficient, effective discharge planning impossible. Many young people age out of foster care and end up on the streets and homeless.

A recent review of inmates in the D.C. Jail's Acute Mental Health Unit revealed that 1/3 of the inmates are also homeless. In a study conducted among 200 homeless mentally ill people in LA, 75% reported having been incarcerated at some point in their life. In 1991, the National Alliance for the Mentally Ill polled over 1,400 of its members and found that 40% reported having been arrested at lest once.

Plans for life beyond the institution are left to the individual who has little in the line of resources to develop a plan that will keep him/her in the community. Without the necessary resources and supports, people cycle between the streets to institutions and shelters.

***Poor Health Care***

Low-income and homeless District residents face several obstacles to obtaining primary care. A 2000 report by the Children's Defense Fund ranked the District's ability to find, enroll, and retain children in Medicaid 40th out of 47 states. According to the report, D.C. CHIP has a potential population of 16,0000 children. Enrollment at its peak was 3,029 after 12 months of operation; meaning 13,000 kids remained to be enrolled.

Other major barriers to health care are: geographic access to care and lack of transportation, lack of insurance, and cultural and linguistic barriers. Only 14.8% of all physicians, and 16.7% of primary care providers who practice medicine in the District actually provide services in the 151 shortage areas.

The District's homeless population is especially vulnerable to health problems that require uninterrupted, continuous care, such as tuberculosis, HIV/AIDS, diabetes, hypertension, upper respiratory infections, addictive disorders and mental disorders. All of these conditions are exacerbated by exposure and a lack of adequate nutrition.

Another fundamental need among the homeless and low-income population is access to medicines. Individuals often find themselves choosing between their medicines and basic living expenses like rent and food.

***Lack of Emergency Assistance***

The emergency assistance program provided rental and utility assistance to people who had fallen behind in paying their bills. It was eliminated in 1995. In 1996, the year after the program ended, the number of evictions that took place in the District increased by over 1000 households. From October 1998 to November 1999, the FEMA Board's Rent, Mortgage and Utility (RMU) program documented 457 individuals and 698 families turned away from RMU assistance due to lack of program assistance funds.

Furthermore, in FY 1999, 9% of the 10,151 calls to the HDS social service information and referral hotline, "Answers, Please!" were for Emergency Assistance. From Oct. 1, 1999 to February 9, 2000, 10% of the 11,705 calls to "Answers, Please!" were for Emergency Assistance.

***Lack of General Public Assistance (GPA) for Newly Disabled Residents***

Eliminated in 1997, General Public Assistance (GPA) was the only income support for over 2,500 adults (per month) awaiting determination for federal social security disability benefits. Without this interim support, many of these individuals became homeless or turned to other, more expensive emergency services. As a result of losing their stability and a place to stay, many also lost track of their disability applications, further delaying the receipt of their federal benefits.

Legislation to create a new Interim Disability Assistance (IDA) program was introduced in the D.C. Council in January of 2000 (D.C. Council Bill 13-550). IDA will provide income assistance from the time a newly disabled resident submits a federal benefit application until the application receives a final denial or approval. Due to streamlined administration and eligibility determination, an estimated forty (40) to fifty (50) percent of IDA's annual costs will be reimbursed by the federal government.

Despite vigorous support from over ninety (90) neighborhood, consumer, faith, labor, social service, and advocacy groups from across the District, the $4.3 million needed to fund IDA's first year was not included in the Fiscal Year 2001 D.C. operating budget sent to Congress.

***Lack of Services for Immigrant Communities***

Conservative estimates approximate that 100,000 Latinos and 17,000 Asian Americans live in Washington, D.C. The immigrant communities experience all of the same systemic barriers to opportunity experienced by the English-speaking population. Similarly, the immigrant communities have been subject to the consequences of neighborhood gentrification as evidenced by the construction and revival of Mt. Pleasant. However, the District government has not responded to this increasing need for multi-lingual services caused by the displacement associated with gentrification.

Only within the last 18 months has any kind of transitional housing been developed to serve the Hispanic population, and this has been created with private dollars. There is only one domestic violence shelter with bilingual services which has very few units and is just initiating services for Hispanic women and children. Again, they cannot meet the need.

The problems of substance abuse in the Latino community are mostly alcohol, crack and marijuana. Assuming a 10% addiction incidence rate in the population, there are an estimated 10,000 Latinos in the District requiring treatment for alcoholism. At this time there are no in-patient substance abuse facilities that are culturally and linguistically competent to serve the Hispanic population. Various outpatient centers have been developed by the Hispanic service providers but without inpatient treatment, the most chronic abusers cannot be appropriately served.

Finding culturally sensitive and competent service providers for the immigrant population is an ongoing problem. Government facilities have few, if any, bilingual professionals to properly treat immigrant populations, e.g., Spanish-speaking or Asian-speaking residents. Mental health facilities rarely have bi-lingual counselors or therapists.

Of the four Mobile Community Outreach Treatment Team (MCOTT) Centers in D.C., only one has ONE Spanish-speaking case worker. Hispanic clients in St. Elizabeth Hospital are often medicated but receive only minimal therapy as they have few bilingual professionals to give them proper treatment. If released, there is no follow-up or medical supervision. Consequently, in a very short time, patients are often picked up on the street again and sent back to be medicated and subdued for another period of time, until the cycle of release and readmission is repeated. There are no supervised housing programs for immigrants who struggle with mental illness or are dually diagnosed. Hospitals in general often scrounge to find an interpreter for

patients, often relying on receptionists or maintenance staff to translate, with total disregard for confidentiality.

A large percentage of the immigrant population is not eligible for any kind of public benefits. Those that are in the process of applying for legal residence or citizenship cannot show any "burden to the state," and therefore are ineligible for any public assistance. New welfare reform and strict immigration laws have made it almost impossible for any immigrant of any legal status to apply for benefits.

Because of these laws, it is increasingly harder for immigrants to obtain proper work authorization. Moreover, penalties against employers are higher, therefore causing many of them to be more suspicious of documentation and less willing to hire immigrants. Immigrants are forced to take the most menial jobs, and are often exploited by employers who give them less wages, no overtime or benefits, with little possibility of upward mobility, forcing them to work 2 or 3 jobs at a time. Individuals are scared to complain, in fear of immigration problems and deportation, despite the fact that they may be completely "legal."

Hispanic inmates are often incarcerated for periods much longer than actually required, as there are few, if any, half-way houses or programs that have the bi-lingual staff to treat them and who are willing to take them. In jail, medical and mental health problems are most often left unattended, as there are no staff to properly deal with them, and no recourse for the inmates to make their complaints heard. Substance abuse and mental health treatment is minimum or non-existent for these inmates.

The District has ignored the educational needs of immigrant children. For example, one of the primary High Schools serving the Hispanic community, Bell Multi-Cultural High School, has no science/chemistry laboratory. They have no auditorium, or gymnasium. They have no cafeteria. Despite years of making their needs known, the situation continues to be the same. In addition, few schools are able to offer the necessary bi-lingual services to integrate the immigrant population into the general curriculum, one of the primary reasons kids drop out, feeling frustrated and humiliated because they cannot fully participate.

A hidden impact of the lack of multi-lingual services is the impact on children who are pulled out of school for days at a time to serve as translators for heads-of-household seeking services for themselves and other members of their families. Having immigrant children serve as translators for their families not only deprives the children of components of their education, but also thrusts children into adult roles of negotiating complex systems that are difficult for even English speakers to understand.

***Privatization***

The switch from government operated programs to privately run ones has created new challenges. Responsibility for the dissemination of information and responsibility for policy making should continue to reside with the government. The direct result of privatization of the shelter system has been a severe decrease in funding and reduced government investment in social service programs, a decrease in accessible information about programs and services and an abdication of policy making functions.

**GUIDING PRINCIPLES:** COHHO recommends the following set guiding principles to underlie the development of homeless services policy. These principles reflect the value and dignity of every person.

- **People who are homeless should have access to services in the most appropriate setting for their circumstances.** People who are staying in shelters and who also suffer from chronic mental illness, chronic substance abuse or both should receive services in settings that addresses those specific issues, **if they want those services**.

- **People who are homeless should determine for themselves the type of care they should receive.** For example, people who are staying in the shelters and who also suffer from chronic mental illness should be encouraged to seek services for their condition, but should not be forced into such settings.

- **People only seek shelter when they have a need for it.** All reasons for seeking shelter are legitimate. For example, a person who is thrown out of his house may have a need for shelter, even if it is only for a few nights.

- **Emergency shelter services should be provided in a clean and safe environment that communicates respect and dignity for people.** This includes providing trained staff gifted with engaging people to begin building a trust relationship.

- **Housing and services for people with special needs, e.g., people suffering from chronic mental illness and/or addiction, are not the exclusive domain of the homeless community.** Therefore, every effort must be taken to create partnerships with CMHS, APRA, DCHA and other entities to develop alternative placements for people in the shelters with special needs. Because of the extent of the cross-agency jurisdictional issues, the Mayor's office should take a leadership role in creating these partnerships.

**RECOMMENDATIONS:**

1) Create a Cabinet-level position that has the responsibility of developing and maintaining an integrated and coordinated approach to homelessness. The focus of services should be on the prevention of homelessness, and work with persons at their point of entry into the system. The position would be responsible for ensuring a coordinated system of care across the spectrum perhaps following up on the work begun in the CMO's office this summer.

2) Charge DHCD and DCHA with expanding affordable housing options

3) Eliminate the dual system of service for people who are unhoused by making mainstream services accessible to all citizens of the District of Columbia, particularly the most vulnerable.

4) Commit adequate local dollars to address the issue of homelessness.

5) Develop a continuum of care that adequately provides for emergency services. At a minimum this amount would be originally committed dollars of 14.8 million.

6) Mandate each agency providing services to low income residents of the District to secure all federal funding available.

7) Explore a regional approach to solving homelessness. Traditionally the District has provided more services, with fewer expectations, than the surrounding districts. A metro area response to homelessness should be created.

This document was prepared by the Coalition of Housing and Homeless Organizations of which the member agencies are listed below.

For further information, please contact Linda Plitt Donaldson, Director of Advocacy and Family Services, 797-0701 x108.

**COHHO Members as of September, 2000**

Cheryl K. Barnes
Calvary Shelter
Capital Hill Group Ministry
Catholic Charities
Coalition for the Homeless
Community Council For The Homeless at Friendship Place
Community Family Life Services
Community for Creative Non-violence (CCNV)
Community Partnership for the Prevention of Homelessness
D.C. Tenants' Advocacy Coalition (TENAC)
Dinner Program for Homeless Women
Downtown D.C. BID
For The Love of Children (FLOC)
Yvonne Keyes
My Sister's Place
N Street Village, Inc.
National Coalition for the Homeless
Neighbor' Consejo
New Endeavors By Women
Rachael's Women's Center, Inc.
Salvation Army
Sasha Bruce Youthwork, Inc.
So Others Might Eat (SOME)
Temporary Living Communities Corporation
U. S. Veterans Initiative, Inc.
Washington Legal Clinic For The Homeless