Cape and Islands Regional Network to Address Homelessness

REGIONAL PLAN TO ADDRESS HOMELESSNESSON CAPE COD AND THE ISLANDS

2012-2014

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EXECUTIVE SUMMARY

The Cape & Islands Regional Plan to Address Homelessness is the culmination of a ten month strategic planning process that brought together working groups across the region organized around five target populations: 1) the chronically homeless; 2) veterans; 3) families with children; 4) youth aged 18-24; and 5) seniors (60+). The plan updates the 2005 Ten Year Plan to End Homelessness, reflecting the community's experience over the intervening period, present conditions, and state and federal policy changes; it also aligns the region's goals and objectives with the 2010 Federal Strategic Plan to Prevent and End Homelessness. The three primary goals of the Regional Plan are to:

- Increase access to safe, stable, accessible, and affordable housing
- Improve health and stability of target populations
- Improve economic security

To achieve these goals, the Network has organized strategies and action steps around three broad themes of education, advocacy and facilitation. More specifically, the Network will:

Educate about the impact of homelessness in our community and how to access resources to preserve and/or obtain housing. Several action steps will serve this strategy including developing an on-line resource directory of local available housing; working with educators to help identify children in families at risk of homelessness and what resources are available to help them avoid homelessness; and, supporting increased access to available employment resources for homeless and at risk households. Most importantly, the Network will educate the community on how **prevention** helps individuals and families from ever experiencing homelessness.

Advocate for policies that promote affordable housing and funding for best practices to access and sustain housing. Action steps that will serve this strategy include advocating for additional Housing First subsidies and expanded eligibility criteria for this highly successful program; seeking funding opportunities to provide more units of permanent supportive housing; securing funding to expand the availability of case management and, advocating for prevention funds from the state and federal government.

Facilitate collaborations to optimize available resources and develop new ones.

Action steps that will serve this strategy include developing a work plan to address common barriers to accessing housing; helping connect potential employees to employment resources and job opportunities in the region; forming a landlord council to discuss needs and challenges and resources available for our target populations; investigating opportunities to partner with organizations to disseminate materials to youth about financial literacy, landlord tenant laws, and other consumer issues; supporting development of a mentoring program to help veterans increase housing and economic stability; and supporting development of a comprehensive regional map of services available to seniors.

The Regional Network recognizes that the best way to address homelessness is to prevent it from ever happening. When it does occur, we need to be able to provide a well-coordinated, compassionate response to help those experiencing homelessness move into stable, affordable housing and maintain that housing with appropriate support. The Network has assembled a strong continuum of services and housing in the region. With this plan, the Network commits to improving this continuum so that homelessness becomes a rare occurrence on the Cape & Islands.

Regional Network

The Cape and Islands Regional Network to Address Homelessness ("Regional Network") is a broad public-private partnership of agencies, governmental bodies, civic and business organizations, and other community stakeholders committed to identifying and implementing creative solutions to preventing and ending homelessness on Cape Cod, Martha's Vineyard, and Nantucket. The Network grew out of the region's HUD Continuum of Care and has been the coalition responsible for implementing the region's Ten Year Plan to End Homelessness. The Regional Network includes three counties: Barnstable, Dukes (Martha's Vineyard), and Nantucket comprising 23 towns (fifteen in Barnstable County, seven in Dukes County and Nantucket as one town only). The vision of the Regional Network is that:

> **All individuals and families on the Cape Cod and Islands will have safe, affordable housing with supports needed to maintain that housing**.

The Regional Network was created in 2009 out of the former Leadership Council to End Homelessness, as one of ten Regional Networks in the Commonwealth of Massachusetts to receive funding from the Interagency Council on Housing and Homelessness (ICCH). Funding was provided to create innovative programs to prevent homelessness; to increase the availability and sustainability of affordable housing and support services to maintain that housing; and to strengthen the networks of providers, public agencies and civic groups that are addressing the issues of homelessness in their communities. In 2009 and 2011,the Regional Network received two rounds of funding from ICHH which significantly helped prevent families and individuals from experiencing homelessness; supported a 24/7 homelessness crisis hotline; provided training to support the coordination of services; and enhanced the region's ability to track the outcomes of those who received assistance. Although funding from the state is currently not available to support Network activities, the Cape & Islands Regional Network remains committed to its mission to foster collaborations among its partner organizations and to address the root causes of homelessness.

The Cape Cod and Islands Regional Network also continues to be the entity that is identified as the region's HUD Continuum of Care (C of C). As an approved continuum, the Regional Network is eligible to apply for the U.S. Department of Housing and Urban Development (HUD) Continuum of Care McKinney-Vento funds for homelessness services and

programs. Since the early 1990s, over $20 million in HUD McKinney-Vento funds have been awarded to the region through this annual application process. Community Action Committee of Cape Cod and the Islands is the lead agency for the Continuum of Care and in that capacity oversees the writing of the HUD C of C grant application and the annual Point in Time count. The Regional Network Policy Board reviews all requests for funding (both renewals and new) prior to submission of the grant to HUD.

Over the last two years, the Regional Network has experienced a strengthening of political and community consensus evidenced by efforts to maintain prevention funds to the region and through collaborations like the Main Street Initiative. As a result of these significant strides in building bridges within the community, the Regional Network has expanded its membership base and strengthened its partnerships. This is reflected in the Regional Network's leadership role in working together with the larger community to update and implement this Regional Plan to Address Homelessness on Cape Cod and the Islands.

Demographics of Cape and Islands

Across Cape Cod and the Islands, there is both city-like density in the Mid-Cape area (notably Hyannis) to sparsely populated rural areas in Truro and parts of the Islands. Common to all areas is an economy that is primarily seasonal, an aging population, a small stock of affordable year round rental housing, limited public transportation system, and high rates of substance abuse and depression. These issues are part of being a resort economy, and increase the risk of homelessness for the individuals and families. The following data is from the 2010 U.S. Census unless otherwise noted:

Population Growth: A profile of demographics on Cape Cod and the Islands, shows after several decades of growth in the region, the Barnstable County population decreased by 2.9%, in comparison to the 2000 census data. Growth in Dukes and Nantucket Counties has slowed considerably. Dukes County increased by 10% and Nantucket County increased by 6.8% while the state increase was 3%. (See Appendix 2, Population Statistics)

Age: Since 2000, Cape Cod has lost more than a quarter of its population of young adults, Between 2000 and last year, the number of people between the ages of 25 and 44 living on Cape Cod fell 26 percent, from 55,577 to 40,658. Statewide, the population in that age range fell by

13 percent over the same period. At the same time, the number of Cape residents 80 or older jumped 21 percent, from 13,833 in 2010 to 16,759 last year. (Cape Cod Times, Aug. 18, 2011)

Median Income: Cape Cod median household income was **$55,294** compared to **$62,072** for households in Massachusetts. On Martha's Vineyard median household income is **$82,900** and **$101,900** for Nantucket. (See Appendix 2, Population Statistics)

Poverty Rate: Between the years 2006 to 2010 in Barnstable County, the percent of household in poverty almost doubled (6.2% to 12.0%); the percent of individuals in poverty more than doubled (5.1% to 11.3%); and the percent of individuals 65 and over in poverty almost doubled (4.4% to 8.7%). Although there was an increase in household and individual poverty levels for Massachusetts, the size of the change was larger for Barnstable County. (See Appendix 2, US Census Bureau, American Community Survey, 2006 to 2010).

Veterans: 25,686 veterans are currently living in Barnstable County; this represents 14% of the population compared to 7% statewide. 11% of these veterans are between 17-44 years of age; 29% are between 45-64 years; and 60% are 65 years and over. 93% of veterans in the region are male.

Race and ethnicity: According to the 2010 U.S Census, 92% of Cape and Islands residents report that their race is white alone. The region has two Native American tribes: the Aquinnah Wampanoag Tribe on Martha's Vineyard on Dukes County and the Mashpee Wampanoag Tribe in Barnstable County. In addition, the region has a Brazilian community and a Cape Verdean community. Dukes and Barnstable Counties have a Portuguese speaking population (mainly people from Brazil) and Nantucket has a Spanish speaking population.

Housing Units: Housing on the Cape & Islands is distinguished by the low percentage of year round occupied units compared to the rest of Massachusetts. In Barnstable County, only 59.7% of housing units are occupied; in Martha's Vineyard, 42.9%; and, in Nantucket, 36.4%. Of the occupied units, in Barnstable, 77.4% are owner occupied and 22.6% are renter occupied; in Martha's Vineyard, 66.5% are owner occupied and 33.5% are renter occupied; and, in Nantucket 58.5% are owner occupied and 41.5% are renter occupied. (See Appendix 2, US Census 2010, Housing Units).

Homeless Individuals: The Regional Network's annual Point in Time count of the homeless is conducted every January. In conducting the annual Point-in-Time count, the Regional Network utilizes HUD's definition of homelessness. This includes a count of unsheltered persons residing in a place not meant for human habitation, such as cars, parks, sidewalks or on the street, and sheltered persons residing in an emergency shelter or transitional or supportive housing for homeless persons who originally came from the street or emergency shelter. HUD's definition of homelessness excludes many who are at risk of homelessness and those doubled-up, living with family and friends due to the high cost of housing and low wages in the region. The Point in Time count identified homeless individuals, comprised of homeless on the streets, in motels, in emergency shelter programs, and in Transitional Housing. On January 26, 2011, **269** individuals were identified as homeless.

Homeless Families with Children: The Point In Time Count identified homeless persons in families, comprised of homeless on the streets, in motels), in emergency shelter programs and in Transitional Housing. On January 26, 2011, **80** families with children were identified as homeless. These families were composed of **211** adults and children. Two other sources of family homelessness data is collected by the Homeless Management Information System (HMIS) and by the McKinney-Vento School Districts. HMIS reports that in 2010 there were **248** homeless families on Cape Cod; the School Districts reported that there were **218** homeless teens and children on Cape Cod.

The Hidden Homeless: While the above information pertains to data gathered through the Regional Network's Point-in-Time count of those fitting the HUD definition of homelessness, the need extends beyond just these numbers, especially when noting that this definition does not include what might be considered the hidden homeless: those doubled-up not by choice or otherwise precariously housed.

According to survey data in the Human Condition Report, conducted in 2008, one Human Condition survey question, "Has any household member been homeless for more than a day or two in the past 24 months?" found that 7% of the respondents answered affirmatively. When extrapolating the survey results to the total population, this comes to 6,474 households. 22% of the households surveyed reported they did not have enough money to pay for housing. These

households were also two-and-a-half times more likely to report "having a lot of anxiety and stress in the household." The survey also found that 33% of renters paid month to month as they did not have a year-round lease. Of those who rented by the month, 53% earned less than $25,000. 6% of households reported that they received a private charity emergency money grant for housing in the past 24 months: extrapolated to the population this comes to 5,310 households (Barnstable County Department of Human Services 2009A).

Although the Cape and Islands has a comprehensive prevention system in place through an array of prevention programs, it is not able to keep up with the need due to the costs of housing in the region, the lack of affordable housing and adequate permanent supportive housing, along with the lack of adequate employment opportunities with sufficient year-round income, to provide long-term stability to the homeless population once housed. Coupled with this is the high cost of living in the area and lower than the state average median incomes.

The current system does not provide enough permanent supportive housing and affordable housing to move homeless persons from shelter and/or transitional housing into more stable housing. It also does not include enough long-term stabilization to prevent recidivism back into homelessness. On the Islands these shortages are even more acute: there is very little on-island support for very low income and/or transitional needs be they for housing or treatment needs.

The need for Housing First to include long-term stabilization for both individuals and families is evident. The Housing First model is based on the concept of first getting homeless persons into housing which in itself is a stabilizing factor, and then providing the necessary support services in order to maintain stabilization of the housing. Preventing someone from becoming homeless in the first place and/or limiting the time actually homeless is crucial.

Development of Regional Plan

HUD strongly encouraged regional Continuums of Care to develop and implement a Ten Year Plan to End Homelessness. The evolution of the development of the region's Ten Year Plan began in 2003 during the HUD SuperNOFA Continuum of Care application process when the Leadership Council was challenged to address this issue. This resulted in the 2005 Ten Year Plan to End Homelessness on Cape Cod and the Islands.

In 2011, the U.S. Interagency Council on Homelessness (USICH) encouraged the reassessment of progress towards the goals or objectives of the Ten Year Plan and suggested that

community leaders consider aligning their plans with Opening Doors, the 2010 Federal Strategic Plan to Prevent and End Homelessness. Challenged by the USICH, the Regional Network convened a subcommittee charged with the responsibility of updating the Ten Year Plan to End Homelessness for the region.

In February 2011, Regional Plan subcommittee members met with John O'Brien, the New England Regional Coordinator of the U.S. Interagency Council for the Homeless. The members concluded that the updated plan should be aligned with the federal plan and, given our regional demographics, specifically address homelessness among our senior population.

In March 2011, the Executive Committee of the Regional Network met and agreed that working groups would be formed to develop goals and objectives. The working groups were organized around five target populations: 1) chronically homeless individuals; 2) veterans; 3) families with children; 4) youth aged 18-24; and 5) seniors (60+). The working group chairs were charged with seeking out community members to participate. In addition to meetings of the five working groups, the Executive Committee organized meetings with community members on the islands of Martha's Vineyard and Nantucket.

The five working groups held meetings in May and June 2011 and each developed a Problem Statement, Goals and Objectives as part of each group's strategic planning. Additional meetings were held on the islands of Martha's Vineyard and Nantucket. In the Fall, the working groups reconvened to review their problem statements and action plans. This review included identifying responsible parties and setting time frames for each action step. The following are summaries of each group's discussions of population need and strategies to address the identified gaps in resources and services.

Statements of Need for Target Populations

Chronically Homeless Individuals

Nationally, there were almost one million homeless single adults accessing shelters and transitional housing over the course of 2009; two-thirds of these were men. About 10% of these individuals were chronically homeless. The Point-in-Time count for 2011 found 151 chronically homeless persons on Cape Cod that day.

A chronically homeless person is defined by the Federal government as 'either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition

who has had at least four episodes of homelessness in the past three years.' A disabling condition is defined as 'a diagnosable substance abuse disorder, a serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.' In addition, 'a disabling condition limits an individual's ability to work or perform one or more activities of daily living.' (*2006 Continuum of Care Homeless Assistance Notice of Funding Availability*).

The needs of those experiencing chronic homelessness are acute (Federal Strategic Plan to Prevent and End Homelessness, 2010):

- Despite disabling health conditions, most people experiencing chronic homelessness are not currently enrolled in Medicaid or other health insurance programs.
- This group has high rates of mental illness and/or substance use disorders. Chronic homelessness is associated with severe symptoms of alcohol abuse, schizophrenia, and personality disorder.
- Many have not been effectively engaged or retained in outpatient treatment and show increasingly high rates for chronic, disabling and/or life-threatening health conditions such as hypertension, asthma, HIV/AIDS, liver disease.
- For individuals experiencing chronic homelessness overall, there are high rates of abuse, violence and separation from families. Some have minor children who are not with them.

The causes of homelessness for individual adults are the same as for other populations that are experiencing homelessness: little or no income so they can't afford housing; insufficient subsidized housing; limited access to housing because of past criminal records; social support networks that are frail to non-existent; and high rates of behavioral health conditions and insufficient access to care.

On Cape Cod, the Chronic Homelessness work group of the Plan to Address Homelessness stated the problem as follows: All too often the chronic homeless individual has *lost hope and direction* in getting out of homelessness and is otherwise *disconnected from potential resources* available. We must develop a more effective approach to *build a working relationship* with them and subsequently *provide the resources* of supportive housing.

The needs of persons who are chronically homeless were summarized by the work group:

- It was emphasized that when individuals are lost and disenfranchised, we have to find a way to reach them. Lack of engagement is an important issue to address.
- We need individualized resources that take into account each person's needs and behaviors. We need to be person directed. We tend to talk about peoples' deficits and not their strengths, with them and among ourselves. We need to stop categorizing those we are serving and treat them as individuals, avoid overlooking them as human beings.
- We need this to help build a relationship with someone who has behavioral issues. This is a population that is seldom asked what they need; we tend to tell them what to do.
- Homeless individuals tend to have health issues and multiple problems. They need a place to get off the street and stay in the daytime as well as at night.
- The individuals served are often in denial and not ready to make changes. They have a fear of change. Some may want to avoid being seen as having mental health or substance abuse problems. They are often disenfranchised, suffering, living and dying on the street.
- Not addressing homelessness brings significant public expense, including hospital and jail costs.
- Addiction is a major community issue, not just among persons experiencing homelessness.

Veterans

There are presently 150 - 200 veterans and their families on Cape Cod and the Islands who are homeless or not in stable housing and at risk of homelessness. Last year, eighty-nine (89) veterans stayed at the NOAH shelter; approximately thirty (30) veterans are currently living in veteran's housing programs. Some veterans are living in overcrowded condition, or are living with former spouses due to a lack of affordable housing options.

Physical and mental health issues are prevalent in the veteran population. Post-traumatic stress disorder (PTSD) is a significant problem. There are high suicide rates among veterans who served in Iraq and Afghanistan; lung disease has also been diagnosed in 15% of returning veterans from these engagements.

Employment issues arise for veterans who are repeatedly re-deployed to combat zones. They lose their job while overseas and find it hard to get a job here when they return. Sometimes there is a stigma with employers to hire these individuals.

There is a two-tiered problem on the Cape and Islands: returning veterans and their families, and older veterans from WWII and Korea. Many of the older veterans did not enter the VA health care system. After WWII, many were quickly discharged and did not sign up for access to the VA system nor make use of the GI bill. Now they need health care and housing, and they cannot survive on Social Security alone. Older veterans may not have enough income to maintain housing. Some cannot sell their homes to get into assisted living. Vietnam veterans still come into the VA for health care enrollment and claims assistance for PTSD and Agent Orange forty five years after being discharged from service.

Most women who have served do not identify themselves as veterans, and many male veterans do not consider the women as veterans. If we cannot locate and identify them we cannot provide them the benefits they have earned. There are particularly high suicide rates among female veterans who served in Iraq and Afghanistan.

It is difficult to create affordable housing for veterans that is acceptable to the community. Rental homes available for families are often in undesirable neighborhoods. It is hard to place those who have housing vouchers. Many landlords do not want to rent to voucher recipients because they experience too many problems around behavioral issues and maintenance of the property. Landlords need to know who their tenants are, and may want guarantees of maintaining the property condition beyond just obtaining a security deposit. However, many veterans do not even have the money for the security deposit.

A lot is happening to address the needs of veterans. Several groups are working in different ways, but they need to be connected in order to reduce gaps and duplication of services. We need to identify and coordinate services, and encourage collaboration among providers. Veterans' advocates need knowledge of and ways to access resources. Education and outreach to other veterans' organizations and the community are needed. Stabilization and case management are crucial to support veterans when they need to find stable, affordable housing.

Families with Children

Over 200 children on Cape Cod are considered homeless based on Point in Time counts and reports from McKinney-Vento school districts. However, the incidence of homelessness among school-aged children may be underreported. Many families may not be getting services because they are flying under the radar of educators and providers. The community and those we

are helping need to be better engaged and educated on the risks that lead to homelessness (i.e. what warning signs to look for) as part of a larger effort to prevent family homelessness.

Homelessness potentially harms children in several ways, including impacting their physical and mental health as well as their social development. We need to recognize and address the trauma on children created by homelessness, and the subtle ways they are affected. We need to increase children's resiliency to become healthy productive adults.

A lack of safe, affordable housing often leads to the deterioration of the family. A root cause is the lack of a sustainable economy to support families. Many families need financial assistance each winter due to the region's seasonal economy. Barriers to family self-sufficiency need to be addressed in order to end this cycle. Education about homelessness in the schools, along with financial literacy, budgeting and employment skills are important. Re-housing readiness and education should be extended to parents and children.

Community partners can be engaged in providing and improving job readiness training and employment opportunities for parents with children. Families at risk of homelessness should have access to job skills training programs. All social service providers need to be aware of job opportunities in the region.

The Families with Children subcommittee developed action steps focused on reducing homelessness by improving the region's housing, education and jobs.

Housing

- Create more options for safe, decent, affordable housing;
- Encourage communities to meet affordable housing law goals;
- Connect people with housing by improving access of information on available resources; and,
- Link all housing authorities with social service providers to provide stabilization and supportive services for at risk families.

Education

- Educate the community about the risks and impact of homelessness on children through a comprehensive community awareness program;
- Inform the community on the true costs of homelessness;
- Educate those at risk about options to prevent homelessness;
- Educate employers about the needs of those who are at risk of homelessness;

- Address barriers to self-sufficiency and learned helplessness in families at risk of homelessness.

Jobs

- Promote regional economic development which leads to job creation;
- Improve collaboration between all community partners, including social services providers, government and business to increase employment options;
- Improve employer willingness to work with families who are at risk of homelessness;
- Provide training to instruct people how to function effectively as part of the work force;
- Train people in areas that can lead to sustainable employment.

A system of service delivery to children who are homeless should be developed. We need to identify and address gaps in what is in place in specialized services for families and children. We need to develop a system that focuses on facilitating new collaborations and builds an integrated system of service delivery. Families should be able to access resources in the community and receive supportive services when in crisis and after being placed in stable housing.

Youth (18-24 Years Old) Homelessness

Youth become homeless for a number of reasons and they should not be stereotyped as all coming from dysfunctional homes. Reasons for homelessness include personal or family financial stressors, emotionally difficult and/or unsafe home situations, and incompatibility with others in the household. Substance abuse, mental health and dual diagnosis are primary issues. Some homeless youth are experiencing their first onset of mental health issues. Contributing factors include health care issues, violence, ageism, poverty, disparity of income and wealth. Particularly high risk groups are:

- Youth grappling with addiction: this leads to instability in relationships, schooling, employment, and housing. This is negatively impacted by a) the lack of substance abuse (and mental health) services that address the needs of youth and b) not adequately addressing delays in social development as a result of substance abuse. For instance, a 21 year old may be at the social developmental level of teenager depending on when misuse of alcohol and drugs began.

- Youth who identify as gay, lesbian, bisexual, transgender (GLBT): particularly when they experience implicit or explicit rejection by all or some combination of family, friends, community and have inadequate support for growth and transitions normal to their age group.
- Youth who turn 18 years old while in foster care: although they receive a small safety net subsidy until they turn 22 years old (or complete college if enrolled), this amount is insufficient to support their basic needs.
- Youth who are recent veterans of Afghanistan and Iraq wars.
- Youth with significant disabilities such as developmental, cognitive, and behavioral and those with serious and pervasive mental illness. Some observers reported an uptick in inappropriate discharges from residential settings, which may occur because the organization/agency can no longer care for a youth whose condition is worsening as they age, or staffing reductions that significantly compromise ability to care for the youth safely or both. These formal caregivers bring some youth to the hospital emergency department because they don't have the capacity to handle them.

Homelessness can result in feelings of hopelessness and despair for all age groups, regardless of life experience and resiliency. For youth, personal feelings can include isolation, vulnerability, anxiety, fear, and being overwhelmed. They can feel stigmatized, undervalued and unwelcome by those around them while thinking no one believes in them. Youth have yet to build adequate life skills to address housing and other crises. However, it is important to respect this population's resourcefulness for meeting basic needs (although some mechanisms may threaten their safety and well-being), as well as their capacity for problem solving and developing resiliency when provided appropriate guidance and support.

Feelings of fear and vulnerability result from couch surfing, living outside, or sleeping in campus hallways. Youth often have trust issues and do not know who to go to. Isolation can stem from not knowing about housing options-navigating a complex social service system is difficult and youth may feel worried by the lack of an apparent safety net. Even available housing options of which they are aware of can leave youth feeling unsafe, such as homeless shelters and sober houses that predominantly house older adults. Furthermore, youth may feel 'labeled' by classmates or employers if they do stay in shelters or sober houses.

Agencies/facilities that do offer help can contribute to feelings of isolation and rejection if unwelcoming. For example, recreational facilities where homeless youth could experience positive social opportunities and physical activity may not perceive these youth as the 'right type'. Frustration can arise from long waitlists for completing the GED and without furthering their education youth feel undervalued in their community. Furthermore, when homeless and enrolled in educational opportunities, it is difficult to find a place to study, while stress and lack of sleep can distract concentration. In the area of seeking employment, career opportunity centers may lack competency to address the needs of homeless or at-risk youth.

While rental units may be available in some towns, there is an insufficient supply of safe, affordable, and convenient ones for youth. Moreover, because youth lack credit history and long-term stable income, landlords do not consider youth 'ideal' renters. Furthermore, landlords may be reluctant to rent to several youth in one unit for stereotypical reasons such as loud parties.

Housing security is entwined with factors such as education, job training, employment with a livable wage, reliable transportation, physical and mental health status, access to health care and health insurance. For example, life can easily spiral out of control when a youth's vehicle needs repair they cannot afford and there is no public transportation close to their employer. Hence, they cannot get to work reliably, lose their job and income, cannot pay the rent and eventually face eviction. Other factors in this mix include experiencing violence, ageism, and disparity of income and wealth.

During the process of developing goals and objectives, the Youth Homelessness Subcommittee discussed action steps that could contribute to success:

- Research best practice models for youth housing, such as cooperative housing where youth can learn from one another and mentors to build life skills and assess which designs might have a high success of transferability to the region. Provide integrated services connecting youth to education, work, and volunteer opportunities. Encourage involvement in community and neighborhoods with cross-generation activities.
- Research models for developing work skills, such as Jobs Corp, and assess what aspects might have a high success of transferability to the region. Build opportunities for youth to have hands on experience in places such as gardens, farms, shops, and thrift stores to gain job skills. Develop opportunities for internships and mentoring programs in

growing professions with a shortage of workers such as plumbing, electricity, and the environment.

- Engage the Workforce Investment Board, area businesses (e.g., banks, realtors, builders, store owners, restaurants, non-profit agencies) and other key stakeholders to support youth in achieving personal and economic success through education, training and jobs.
- Increase opportunities that resonate with youth to obtain GED certification, higher education, job skills, and life skills including managing finances.
- Develop a streamlined 'one-stop' shopping location that supports youth in meeting their basic needs, including housing, and building skills and competencies. It would provide guidance on how/where youth can access various social services and resources in the community, including information on accessing housing, food, physical and mental health care, health insurance, addiction treatment and recovery, educational advancement and job training.
- Increase access to substance abuse services that are youth appropriate and address misuse and addiction to prescription drugs, such as opiates which can permanently alter brain chemistry and hence mental and social well-being.
- Offer youth affordable, welcoming opportunities for healthy eating, physical activity, and peer interactions.
- Assist youth with development of their value structure and offer hope.
- Continue to pursue and support state and federal legislation to reduce homelessness and expand safe and affordable housing.

Seniors (60+)

There are numerous factors contributing to homelessness among the senior population. Key issues identified by the senior homelessness subcommittee are:

- Retirement and resulting loss of earned income, and transition to fixed income, coupled with a lack of individual retirement resources other than Social Security;
- Some are not quite poor enough to qualify for existing programs and benefits, or house rich and cash poor;
- Aging poor have never earned enough income to maintain stable, unsubsidized housing;
- Lack of affordable, accessible, community-based housing;
- Minimal family supports, with no one to take them in or care for them;

- Financial impact of chronic medical issues or disabilities, costs for upkeep of the home and credit card bills; and,
- Denial of problems; strong mindset to hold on to independence.

Circumstances that are unique to seniors put them at risk:

- The natural aging process often leads to need for increased assistance, dependency;
- A lack of formal and informal supports that is more pronounced among seniors;
- The need to make tradeoffs on where money is spent, such as prescriptions vs. utilities;
- Situational depression and substance abuse – alcohol and prescription drugs;
- Medication mismanagement;
- Difficulty getting around house, walking up stairs when there is no bedroom on first floor, and lack of funds for home modification;
- Decreased home sale values not providing enough money for assisted living or other alternatives;
- Predatory financial exploitation; and,
- No chance in employment pool and lack current job skills.

Seniors often feel physically isolated due to their home location and no transportation, and socially isolated due to lack of a network or group involvement. Loneliness results from having no co-workers, losing one's spouse, other friends and family dying. They may feel unneeded, seen as disabled or handicapped and unvalued; retired, but wanting to and able to work. Many seniors think they don't need help, and we should honor their independent choices and decisions.

It is important to emphasize the role played by the lack of infrastructure in the region. There is not enough social service agency staff to provide support services to our low and moderate income seniors. Currently 2,300 clients at Elder Services receive in-home services. Seniors do not have sufficient advocates. Isolation is a unique challenge affecting seniors caused in part by limited transportation options. We should aim for preventative measures to keep seniors in homes and engaged in the community.

There are adequate services for seniors who can afford them and for those who have no resources; there is not much available for those in between. We should consider tapping into volunteer networks along with other pooled resources that serve people. Service providers and

seniors in need don't realize the array of programs that are potentially available to them. There is a lack of understanding of resources available and limited coordination of services. We need to develop a regional picture of what services are available to provide a continuum of care.

Many seniors who are laid off or retired want to re-enter the workplace in order to receive health insurance. The recent recession and continued high unemployment rates have made this option difficult for most seniors. Ageism is not illness and we should focus on healthy aging and helping seniors find sustainable wages. Work opportunities, such as the Elder Services Mature Worker Program, and community volunteer efforts can help keep seniors stay involved and connected.

Elders experiencing homelessness and living on the streets should be helped to find appropriate housing and to use available safety nets in the community. Pilot House is available for those with substance abuse issues; permanent supportive housing for those who are disabled; and, Department of Mental Health assistance, for those with mental illness. Housing First has been successful for getting vulnerable seniors into housing. Multigenerational and blended households can be positive alternatives for some seniors. Local preference for seniors at housing authorities is also important to maintain.

To meet the needs of seniors, our community needs to expand available resources, including:

- Number of home care workers who can reach physically isolated seniors;
- More home health programs, in-home meals and services;
- More home modifications to increase mobility around the house (i.e. railings, ramps);
- Discharge planning to make sure seniors have appropriate housing after stays in the hospital and rehab facilities;
- Support for care giving; and,
- Sources of income to enable seniors to achieve self-sufficiency.

We can improve access to services by providing flexible transportation options, helping to identify home repair and accessibility problems, and connecting seniors to services. Developing a regional map of available services, coordinating services through an outreach workers group and convening a summit of senior service providers around homelessness will help give seniors options as they age.

To improve the range of affordable housing options, we can assist seniors in how to stay in their home on a reduced income, and evaluate other models besides the single family home for housing seniors such as congregate living, housing with support services, intergenerational housing, and a shared housing match service for seniors.

Organization and Implementation of Action Plan

The Action Plan is divided into six sections: one for each target population (chronically homeless, veterans, families with children, youth (18-24), and seniors (60+), and one global section for those goals and strategies that span at least three or more target populations. Each section is organized by the three primary goals of the plan: increasing access to safe, accessible and affordable housing; improving health through engagement and stabilization; and, improving economic security. The three broad strategies that the Network will use to achieve these goals are education, advocacy, and facilitation.

During the first three months of plan implementation, the Network entity (Executive Committee, Policy Board, or Client Coordination Council) that has been identified as responsible for an action step will designate a network member (non-profit, public agency, business, association, or coalition) to oversee completion of that action step. Each network member selected will in turn, identify a person (or position) who will be accountable for that action. This process may be postponed for actions that are not slated to begin until Year 2 or beyond.

The Regional Network will oversee the implementation and monitoring of the Regional Plan through monthly Executive Committee meetings and quarterly Policy Board meetings. The chairs of each working committee will continue to play a role in monitoring their components of the plan and will report to the full Regional Network on a regular basis.

The larger goal of the Regional Plan to Address Homelessness is to mobilize the community to address homelessness. The Regional Network will strive to maintain the existing seamless continuum of shelter, housing and supportive services while also continuously finding ways to improve the continuum of care with the ultimate long-term goal of preventing homelessness, particularly among chronically homeless individuals, veterans, families with children, youth and seniors.

ACTION PLAN

Regional Network Global Goal: Increase access to safe, stable, accessible, and affordable housing.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Educate/Advocate G. 1 Improve access to information about available housing options.	1.0 Develop an on-line resource directory of local available housing, including non-conforming and accessory apartments. Catalog housing options appropriate for chronically homeless, veterans, families, youth, and seniors and include contacts for informal housing options. 2.0 Improve capacity of regional network hotline in connecting to households at risk of homelessness to available housing opportunities through sustained funding of hotline and training of hotline staff**.**	Coordination Council Executive Committee	On-line Directory Dedicated funding source; increased number of calls	Year 1, ongoing Year 1, ongoing
Advocate/Facilitate G. 2 Expand the supply of affordable housing for the chronically homeless, veterans, families, youth and seniors.	1.0 Create and promote affordable, customized and subsidized regional housing options by obtaining additional permanent supportive housing units through the SuperNOFA. 2.0 Support policies and efforts to educate towns on Cape & Islands about need for and successful uses of affordable housing zoning by-laws. 3.0 Advocate for additional subsidized units or vouchers. 4.0 Advocate for affordable unsubsidized housing units.	Continuum of Care & Policy Board Policy Board Executive Committee	New units of supportive housing Increased number units qualified as affordable by town By-laws for accessory apts. in every town	Year 2 Years 1-3 Years 1-3

Regional Network Global Goal: Improve health through engagement and stabilization

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate G.3 Provide coordinated stabilization, case management and treatment services in the community.	1.0 Form landlord council to discuss needs and challenges and resources available for the chronically homeless, veterans, families, youth and seniors.	Coordination Council	LL Council formed; meets at least annually	Year 1, ongoing
Advocate G.4 Increase access to behavioral health services to target substance abuse and reduce suicide risks.	1.0 Advocate for treatment and resources on demand with addictions treatment providers	Policy Board	Decreased wait-times for treatment	Year 1, ongoing

Regional Network Global Goal: Improve Economic Security

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate/Educate G.5 Involve community partners in providing and improving job readiness, training, and employment opportunities.	1.0 Support increased collaboration between service providers and employers; connecting potential employees to employment resources and job opportunities in the region.	Workforce Advisory Group	Employment clearinghouse created	Year 2, ongoing
	2.0 Support increased access to available employment resources for homeless and at risk households	Workforce Advisory Group	Increase households with income	Year 2, ongoing

Target Population: Chronically Homeless

Problem Statement: All too often the chronic homeless individual has lost hope and direction in getting out of homelessness and is otherwise disconnected from potential resources available. We must develop a more effective approach to build a working relationship with them and subsequently provide the resources of supportive housing.

Goal 1: Increase access to safe, stable, accessible, and affordable housing for the chronically homeless.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate CH.1 Promote availability of housing options tailored to meet the needs of persons regardless of where they are in the 'stages of change'.	1.0 Form a short term work group of the policy board to define the array of housing models. 2.0 Develop a housing models chart that work or could be piloted on the Cape. 3.0 Explore 'sober house' model and community living for people with addiction disorders, and what supports are needed.	Policy Board Policy Board Coordinating Council	Chart of Housing Models New and well-functioning sober houses	Year 1 Years 2-3
Advocate CH.2 Expand the supply of affordable housing for chronically homeless.	1.0 Advocate for additional Housing First subsidies with the Massachusetts State legislature.	Executive Committee	Increased Housing First subsidies	Year 1, ongoing
Facilitate CH.3 Reduce barriers to accessing housing for the chronically homeless.	1.0 Identify barriers to access housing commonly faced by the chronically homeless 2.0 Develop a work plan to address these barriers.	Coordinating Council Coordinating Council	Work plan to reduce barriers	Year 1 Year 2, ongoing

Goal 2: Improve health and stability through engagement and stabilization.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate CH.4 Expand and coordinate outreach efforts across the region to reach the chronically homeless.	1.0 Create a subgroup that meets quarterly to discuss outreach needs in Towns and develops a plan to address emerging needs	Coordinating Council	Quarterly meetings; plan created	Year 1, ongoing
Facilitate/Advocate CH.5 Explore new ways to engage and provide for the basic needs of each chronically homeless individual in our community.	1.0 Form a subgroup of the Policy Board to research best practice models for engagement that impact willingness and build receptivity to services 2.0 Develop a chart of engagement models that work or will be piloted on the Cape. 2.0 Explore and seek additional sources of funding for engagement models.	Policy Board Policy Board Executive Committee	Subgroup formed Chart of engagement models New funding dedicated for engagement	Year 1 Year 2 Year 2, ongoing
Advocate CH. 6 Provide coordinated stabilization, case management and treatment services focused on health, home, purpose and community.	1.0 Secure funding and convert systems to expand the availability of case management. 2.0 Advocate for expanded eligibility for Housing First Case Management.	Executive Committee Executive Committee	Funding for case management Improved eligibility criteria for Housing First	Years 1-3 Year1, ongoing

Target Population: Veterans

Problem Statement: A lack of affordable housing options in many instances leads to veterans at risk of or homeless on the Cape and Islands. Many returning and older veterans, and their families, are in need of access to coordinated services and resources to maintain good physical and mental health, support stable housing outcomes and prevent them from falling into homelessness. Lack of information often hinders the ability of both male and female veterans to gain access to these needed resources.

Goal 1: Increase access to safe, stable, accessible, and affordable housing.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Advocate V.1 Expand the supply of affordable housing for veterans.	1.0 Seek funding opportunities to increase transitional housing options, including SPO and congregate facilities.	Policy Board	New transitional housing units	Years 1-3
	2.0 Seek funding opportunities to provide more permanent supportive housing for veterans.	Policy Board	New supportive housing units	Years 1-3

Goal 2: Improve coordination of services to address health and stability.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate/Advocate V.2 Promote housing stability for veterans.	1.0 Provide housing stabilization services to veterans at risk of homelessness.	Coordinating Council	Increased services	Year 1, ongoing
	2.0 Develop mentoring program to help veterans increase housing and economic stability.	Policy Board	Mentoring program	Year 2, ongoing
	3.0 Create a fund that will provide shallow rent subsidies, first and last month's rent and security deposits.	Policy Board	Subsidy fund created	Year 2, ongoing

Target Population: Families

Problem Statement: A seasonal economy and lack of affordable housing often leads to families with children being at risk of or homeless on the Cape and Islands. We often fail to address the unique needs of these families. The community does not adequately recognize the prevalence of families at risk of homelessness, nor the risks of harm to the physical health, mental health, social development and educational needs of children or the deterioration of the family unit.

Goal 1: Improve coordination of services to address health and stability.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Advocate/Educate F.1 Increase awareness of the impact of homelessness on families and children	1.0 Design a media campaign to inform public about impact of homelessness on families, including Op Ed pieces, feature stories, radio, etc. 2.0 Coordinate implementation of media strategy among agencies serving families at risk of homelessness and/or experiencing homelessness.	Executive Committee Policy Board	Media coverage of impact of family homelessness	Years 1-2
Facilitate/Educate F.2 Improve system for identifying families at risk of eviction, and providing appropriate interventions to prevent homelessness.	1.0 Work with educators to help identify children in families at risk of homelessness and what resources are available to help them avoid homelessness. 2.0 Advocate for prevention funds to at least pre-ARRA levels.	Coordinating Council Executive Committee	Increased number of at-risk children receiving services Increased funds for prevention	Year 1, ongoing Year 1

Facilitate/Educate F.3 Assure supportive services are provided for all families in crisis.	1.0 Collaborate with educators to develop a "guide" to help identify children in families at risk of homelessness and what resources are available to help them avoid homelessness	Coordinating Council	Increased number of at risk children receiving services	Year 2
	2.0 Link all housing authorities with social service providers to provide stabilization and supportive services.	Coordinating Council	Coordinated services with housing authorities	Year 1, ongoing

Target Population: Youth

Problem Statement: Youth likely to be homeless, or at risk for homelessness, may have aged out of foster care or left their home for a variety of reasons including family financial challenges or incompatible family circumstances. They are often disconnected from formal and informal social supports as well as resources that would help them locate safe, convenient, affordable housing. In addition to a low availability of suitable rental units, landlords are often reluctant to rent to young people. Last, we frequently fail to engage youth in a manner that builds on the strengths and resiliency they have already developed to support their basic needs.

Goal 1: Increase access to safe, stable, accessible, and affordable housing.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Educate Y.1 Improve access to information	1.0 Make information more readily available by publicizing the homelessness hotline to groups connected to youth.	Policy Board	Increased volume of youth calls	Year 2, ongoing
Facilitate/Advocate Y.2 Increase supportive housing options for homeless youth/young adults	1.0 Compile existing local data to demonstrate need for supportive housing for youth 18-24 who are homeless.	Policy Board	Data compiled	Year 2
	2.0 Define supportive housing and share this information with regional network members and larger community.	Policy Board	Policy paper created	Year 2
	3.0 Improve integration/explore opportunities for collaboration with other planning efforts.	Policy Board	Youth subcommittee formed	Year 1, ongoing

Advocate/Facilitate Y.3 Expand the supply of affordable housing for youth	1.0 Seek opportunities to engage and educate legislators and funders on needs specific to this population 3.0 Increase participation of additional entities in SUPERNOFA Continuum of Care process when opportunities arise for additional funds for supportive housing	Executive Committee Continuum of Care & Policy Board	Meetings convened w/ legislators and funders Increased participation in CoC	Years 2 Year 1, ongoing

Goal 2: Improve coordination of services to improve health and stability.

Strategy	Action Steps Outcomes	Responsible		Time Frame
Facilitate Y.4 Identify opportunities & feasibility of developing a "drop in" center for youth with coordinated services that connects youth to housing, education, job opportunities, substance abuse and mental health treatment and other needed basic supports, in an appropriate, healthy, and welcoming environment.	1.0 Convene an ad hoc subcommittee of the Policy Board to explore options/promote collaboration to create opportunities for developing an actual and/or virtual drop in center.	Policy Board	Subcommittee formed Plan for "drop in" center created	Year 1 Years 2-3

Facilitate/Advocate Y.5 Improve integration of health, mental health and substance abuse treatment with homeless assistance programs that work with youth.	1.0 Encourage partnerships between providers and health care to co-locate or coordinate services and create better connections.	Policy Board	Increased services for youth.	Year 1,ongoing
	2.0 Develop policy statement regarding need for increasing availability of behavioral health services and connection to homelessness.	Policy Board	Policy statement	Year 1
	3.0 Model successful service delivery models that are targeted for outreach to youth populations and encourages opportunities for healthy eating, physical activity and peer interaction.	Policy Board	Increased health indicators for youth	Years 1 - 3

Goal 3: Improve economic security.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate/Advocate Y.6 Increase meaningful and sustainable employment & educational opportunities for youth.	1.0 Increase collaboration between providers, WIB and employers to develop strategies to build competencies to improve economic success using labor market, workforce shortage areas, and work skill development models i.e. Jobs Corp.	Workforce Advisory Group	Regular meetings scheduled	Year 1, ongoing
	2.0 Develop and disseminate statement to public and elected officials about funding needs for GED programs.	Policy Board	Policy statement created	Year 2
	3.0 Investigate opportunities to partner with other organizations to disseminate materials to youth about financial literacy, educational opportunities, lending rights and responsibilities, landlord tenant laws, and other consumer issues.	Policy Board	Meetings convened with partners	Year 2

Target Population: Seniors

Problem Statement: Seniors are at risk of homelessness due to a lack of formal and informal supports. This problem, while common for all at-risk people, is more pronounced among seniors as part of their natural aging process, transition to fixed income and increased need for in-home services. In addition, seniors face an inadequate supply of affordable, accessible housing and community based supports.

Goal 1: Increase access to safe, stable, accessible, and affordable housing.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate S.1 Increase housing options for seniors.	1.0 Form a task force to evaluate and consider other models besides the single family home for housing seniors such as congregate living, housing with support services, intergenerational housing.	Policy Board	Task force formed; report created	Year 2
	2.0 Develop a chart of housing models that work or could be piloted on the Cape	Policy Board	Chart of housing models	Year 2-3
Facilitate S.2 Expand supply of affordable housing options for seniors.	1.0 Support the development of a shared housing match service.	Policy Board	Housing match service created	Year 2

Goal 2: Improve health and stability.

Strategy	Action Steps	Responsible	Outcomes	Time Frame
Facilitate S.3 Increase coordination of existing services	1.0 Support development of a comprehensive regional "map" of available services	Coordinating Council	Service map created	Year 1, ongoing
	2.0 Convene a summit of senior service providers around homelessness for seniors.	Coordinating Council	Summit convened	Year 2
Advocate S.4 Increase access to services	1.0 Support the development of a policy statement regarding workforce development needs, including trained geriatric health workers (MDs, RNs, etc.)	Policy Board	Policy statement created	Year 2
	2.0 Support advocacy efforts for an enhanced geriatric workforce based on policy statement.	Policy Board	Increased geriatric workforce	Years 2 -3
	3.0 Support the development of a policy stance to improve transportation options for seniors.	Policy Board	Policy statement created	Year 1, ongoing

APPENDIX 1: List of Participants

Regional Network Policy Board

Sheila Lyons, Barnstable County Commissioner
Estella Fritzinger, Community Action Committee of the Cape and Islands
Elizabeth Albert, Barnstable County Human Services
Chris Austin, Homeless Prevention Council
Merrill Blum, Veteran's Outreach Center
Don Brown, Massachusetts Department of Transitional Assistance
Diane Casey-Lee, Cape Cod Council of Churches
Steve Jochim, Massachusetts Department of Mental Health
Heidi Nelson, Duffy Health Center
Allison Rice, Housing Assistance Corporation
Paula Schnepp, Sandwich Housing Authority
Brenda Swain, Falmouth Service Center
Connie Teixeira, Duke's County Associate Commissioner for Homeless Affairs
Susan Witte, Nantucket Planning Department
Janis Carriero, Nantucket Rental Assistance Program
Alan Trebat, Regional Network Coordinator
David Willard, Cape Cod Five Cents Savings Bank

Regional Plan Subcommittee Meeting

Beth Albert, Director, Barnstable County Department of Human Services
Christine Austin, Executive Director, Homeless Prevention Council
Stephanie Coxe, Office of Congressman William Keating
Estella Fritzinger, Executive Director, Community Action Committee of Cape Cod and the Islands, Inc.
Lee Hamilton, Continuum of Care Grant Writer
Mary LeClair, former Barnstable County Commissioner
Sheila Lyons, Barnstable County Commissioner
Heidi Nelson, Executive Director, Duffy Health Center
John O'Brien, New England Coordinator, U.S. Interagency Council for the Homeless
Allison Rice, Vice President, Housing Assistance Corporation
Paul Ruchinskas, Affordable Housing Specialist, Cape Cod Commission
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness
Paula Schnepp, Coordinator, Cape & Islands Regional Network to Address Homelessness

WORKING GROUPS:

Chronically Homeless Individuals
Heidi Nelson, Chair, Duffy Health Center
Billy Bishop, Homeless Not Hopeless
Rick Brigham, Housing Assistance Corp./NOAH Center
Tom Brigham, Massachusetts Housing & Shelter Alliance
Alan Burt, DMH Advisory Board
Gene Carey,VinFen

Bill Ferney, Gosnold
Maggi Flanagan, Homeless Prevention Council
Betsy Fontes, Community Action Committee of the Cape & Islands
Diane Munsell, Cape Cod Health Care
Louise Patrick, Duffy Health Center
Kathie Porteous, Barnstable County Sheriff's Department
Ed Ropulewis, Massachusetts Dept. of Mental Health
Connie Teixeira, Duke's County Associate Commissioner for Homeless Affairs
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness

Veterans

Allison Rice, Co-Chair, Housing Assistance Corp.
David Willard, Co-Chair, Cape Cod Five Cents Savings Bank
Merrill Blum, Veterans Outreach Center
Arlene Crosby, Duffy Health Center
Susan Pollard, Massachusetts Division of Employment and Training
Jeanne Smith, U.S. Dept. of Veterans Affairs
Billie Stewart, Veterans Outreach Center
Alan J. White, Veterans Outreach Center
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness

Families with Children

Chris Austin, Co-Chair, Homelessness Prevention Council
Estella Fritzinger, Co-Chair, Community Action Committee of the Cape & Islands
Dolores Barbati-Poore, Housing Assistance Corp
Melissa Carney, Community Action Committee of the Cape & Islands
Jane deGroot, Duffy Health Center
Mary LeClair, Community Representative
Mary Pat Messmer, Cape Cod Child Development
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness

Youth Aged 18-24

Beth Albert, Chair, Barnstable County Human Services
Caroline Coneana, , Barnstable County Human Services
Carol Dubay, Cape Cod Community College
Scott A. Fitzmaurice, GIGSYA
Paul Hebert, CHAMP Homes
Susan Howard, Massachusetts Dept. Of Children and Families
Terri Huff, UMass and Duffy Project for Young Adults 18-24
Tammy Schenk, Housing Assistance Corp./NOAH
Christine Stein, Facilitator, Barnstable County Human Services
Rose Warfield, Cape Cod Community College
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness

Seniors (60+)

Sheila Lyons, Chair, Barnstable County Commissioner
Beth Albert, Barnstable County Human Services
Caroline Coneana, Barnstable County Human Services
Caronanne Procaccini, Community Action Committee of the Cape & Islands
Leslie Scheer, Elder Services of Cape Cod and the Islands
Rose Warfield, Cape Cod Community College
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness

Martha's Vineyard

Beth Albert, Barnstable County Human Services
Estella Fritzinger, Community Action Committee of the Cape & Islands
Sheila Lyons, Barnstable County Commissioner
Connie Teixeira, Duke's County Associate Commissioner for Homeless Affairs
Jessica Burgoyne, The Community Builders (Morgan Woods)
Caroline Coneana, Barnstable County Human Services
Philippe Jordi, Island Housing Trust
Sarah Kuh, Vineyard Health Care Access
Russell Smith, Dukes County Manager
David Vigneault, Duke's County Regional Housing Authority
Kate Young, Surfside Motel
Sarah Young, Surfside Motel
Alan Trebat, Coordinator, Cape & Islands Regional Network to Address Homelessness

Nantucket

Beth Albert, Barnstable County Human Services
*Estelle Fritzinger***,** Community Action Committee of the Cape & Islands
Heidi Nelson, Duffy Health Center
Toby Brown, Veterans
Janis Carriero, Nantucket Rental Assistance Program
Caroline Coneana, Barnstable County Human Services
Bert Johnson, Nantucket Housing Authority
Pam Meriam, Nantucket Director of Human Services
Augusto Ramos, Human Services Council
James Richard, Veterans
Linda Roberts, Saltmash Senior Center
Milen Tsvetkof, Housing Nantucket
Susan Witte, Nantucket Planning Department

The Cape & Islands Regional Network to Address Homelessness would like to acknowledge **Lee M. Hamilton, Ph.D** for her work drafting the original Ten Year Plan to End Homelessness upon which much of the narrative is derived; **Alan Trebat**, former Coordinator for the Regional Network, who shepherded the focus groups and compiled the preliminary draft; and, **Paula Schnepp**, the current Network Coordinator, who helped shape the final document with great assistance from the Chairs of the Working Groups.

Appendix 2:

Population Statistics

Poverty Data

Housing Units

HUD Housing Inventory

Population Statistics for Cape Cod, Martha's Vineyard, and Nantucket, US Census 2010

Age, Household Size, Income

	Massachusetts (N=6,547,629)		Counties					
			Barnstable (Cape Cod)		Dukes (Martha's Vineyard)		Nantucket (Island of Nantucket)	
	N	%	N	%	N	%	N	%
Total population	6,547,629		215,888		16,535		10,172	
Age								
Median age in years	39.1		49.9		45.3		39.4	
Under age 18 years		21.7%	37,239	17.3%	3,175	19.2%	2,106	20.7%
18 - 24 years		10.2%	13,817	6.4%	992	6.0%	692	6.8%
25 - 34 years		12.9%	17,756	8.2%	1,856	11.3%	1,591	15.7%
35 - 44 years		13.6%	22,902	10.6%	2,177	13.1%	1,689	16.6%
45 - 64 yrs.		27.8%	70,005	32.5%	5,645	34.2%	2,921	28.7%
18 - 64 years (total %)		64.5%	124,480	57.7%	10,670	64.6%	6,893	67.8%
65 years and older		13.8%	53,879	25.0%	2,699	16.3%	1,227	12.1%
Total households	2,547,075		95,755		7,368		4,229	
Median household size	2.5		2.2		2.2		2.4	
Family households		63.0%	58,724	61.3%	4,221	57.3%	2,429	57.4%
Female, no husband present, with own children under 18 yrs.		6.8%	4,419	4.6%	387	5.3%	202	4.8%
Non-family households		37.0%	37,031	38.7%	3,147	42.7%	1,800	42.6%
Percent of households below 100% poverty rate		8.2%	10,820	11.3%				
Percent of Families below 200% poverty rate*			29,493	30.8%				

Compiled by Barnstable County Department of Human Services, December 19, 2011
Source: US Census Bureau, American Community Survey 2006 to 2010

Poverty Data in Barnstable County

The American Community Survey collects data from a sample of households and individuals. As such these data are estimates.

	2006		2007		2008		2009		2010	
	Barnstable County	MA	Barnstable County	MA	Barnstable County	MA	Barnstable County	MA	Barnstable County	MA
HOUSEHOLDS										
Households for which poverty estimated	98,466	-	97,560	-	93,027	-	99,904	-	93,576	-
Households in poverty	6,089	-	6,541	-	7,373	-	7,475	-	10,645	-
Percent in poverty	6.2%	10.6%	6.7%	10.5%	7.9%	10.6%	7.5%	10.6%	11.4%	12.0%
INDIVIDUALS										
Number for whom poverty estimated	220,372	-	219,275	-	217,210	-	214,953	-	212,042	-
Individuals in poverty	11,258	-	12,589	-	16,372	-	15,680	-	23,860	-
Percent in poverty	5.1%	9.9%	5.7%	9.9%	7.5%	10.0%	7.3%	10.3%	11.3%	11.4%
Under 18 years in poverty	3.4%	12.4%	6.5%	12.9%	9.8%	12.0%	10.2%	13.1%	17.8%	14.3%
18-64 years in poverty	5.9%	9.2%	5.4%	9.0%	7.6%	9.3%	7.4%	9.6%	10.7%	11.0%
65 years and over in poverty	4.4%	9.3%	6.0%	9.3%	5.6%	10.2%	5.1%	8.8%	8.0%	8.7%
Percent less than 200% poverty	18.0%	22.3%	15.4%	22.0%	19.2%	22.3%	18.7%	23.0%	25.3%	24.9%

Compiled by Barnstable County Department of Human Services, December 19, 2011
Source: US Census Bureau, American Community Survey 2006 to 2010

Notes on change in poverty 2006 to 2010:

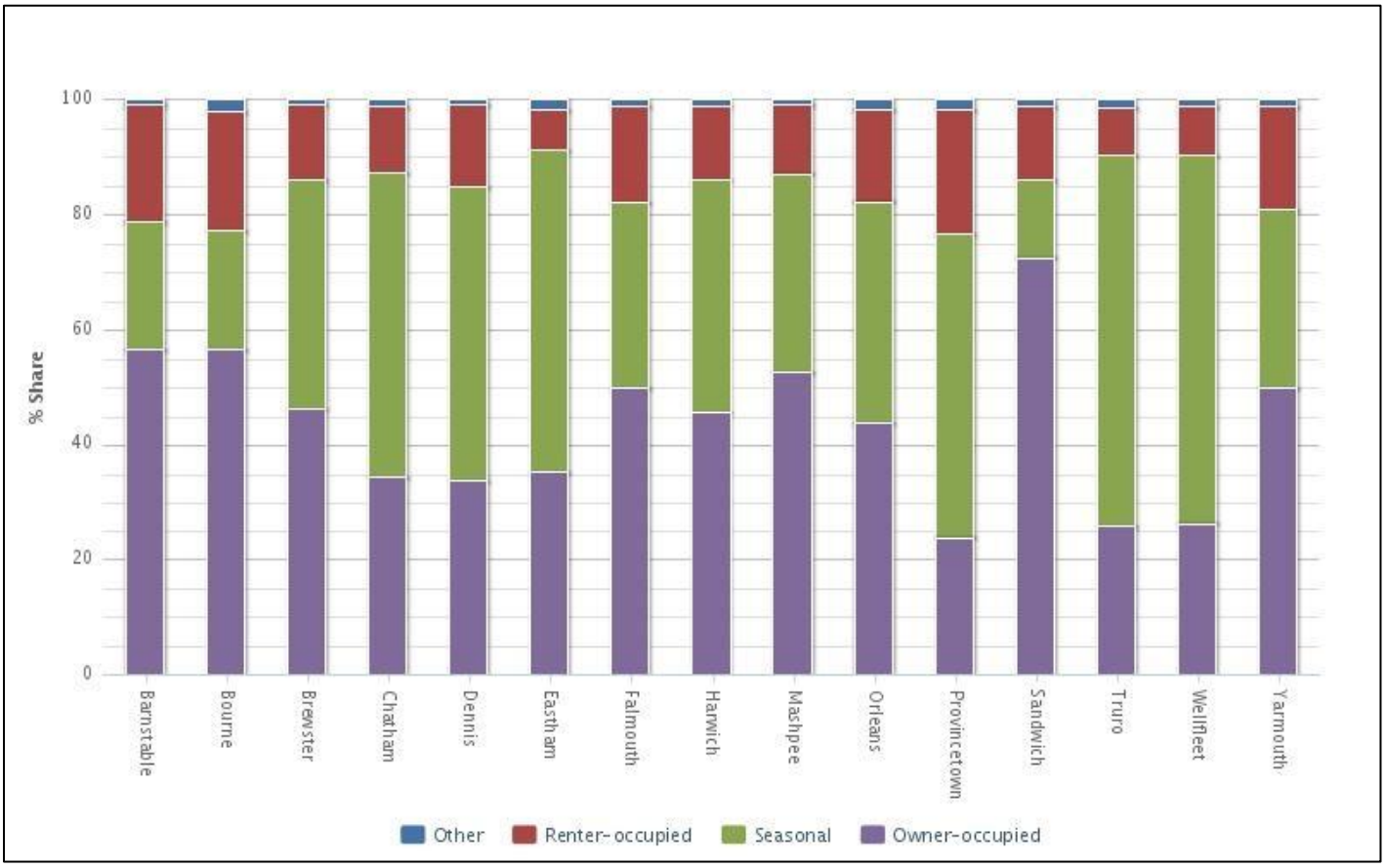
Although there was an increase in household and individual poverty levels for Massachusetts, the size of the change is larger for Barnstable County
For Barnstable County:
The percent of households in poverty almost doubled (6.2% to 12.0%)
The percent of individuals in poverty more than doubled (5.1% to 11.3%)
The change in the percent of individuals under 18 years in poverty is highly significant (3.4% to 17.8%)
The percent of individuals 65 and over in poverty almost doubled (4.4% to 8.7%)

Housing Units for Cape Cod, Martha's Vineyard, and Nantucket, US Census 2010

	Massachusetts		Counties					
			Barnstable (Cape Cod)		Dukes (Martha's Vineyard)		Nantucket (Island of Nantucket)	
	N	%	N	%	N	%	N	%
Total housing units	2,808,254		160,281		17,188		11,618	
Occupied units		90.7%	95,755	59.7%	7,368	42.9%	4,229	36.4%
Owner occupied		62.3%	74,110	46.2%	4,900	66.5%	2,475	58.5%
Avg. household size	2.5		2.3		2.3		2.4	
Renter occupied		37.7%	21,645	13.5%	2,468	33.5%	1,754	41.5%
Avg. household size	3.1		2.1		2.1		2.4	
Vacant units		9.3%	64,526	40.3%	9,820	57.1%	7,389	63.6%
For rent		2.4%	3,102	1.9%	225	1.3%	326	2.8%
For seasonal, recreational, or occasional use		4.1%	56,863	35.5%	9,253	53.8%	6,722	57.9%
All other vacant		1.6%	1,996	1.2%	147	0.9%	221	1.9%
Affordable units			5434	5.4%				

Table compiled by Barnstable County Department of Human Services and Chart by the Cape Cod Commission

HOUSING UNITS BY BARNSTABLE COUNTY TOWNS: PERCENT SHARE



HUD CoC FUNDED PROJECTS

(As of 6/10/11)

SUPPORTIVE HOUSING PROGRAM PROJECTS FOR BEDS ***(Total of 32 beds)***

- HAC, Cape Homes I (6 units of leased housing for chronically homeless individuals)
- HAC, Cape Homes II (9 units of leased housing for chronically homeless individuals)
- HAC, Cape Homes III (8 units of leased housing for chronically homeless individuals)
- Duffy, Welcome Home (3 units of leased housing for chronically homeless individuals)
- Duffy, Welcome Home II (2 units of leased housing for chronically homeless individuals)
- Duffy, Welcome Home III (2 units of leased housing for chronically homeless Individuals who are also Veterans – newly awarded and under development)
- Vinfen, Cape CBFS Leasing (2 units of leased housing for homeless individuals with mental illness (MI) – also newly awarded and under development)

SHP PROJECTS FOR SERVICES

- Housing For All, Support Services for CHAMP Homes II & III
- South Coastal Counties Legal Services, Outreach
- HAC/ HMIS (HUD requirement and also used for ICHH and HPRP)

SHELTER PLUS CARE (SPC) PROJECTS ***(total of 112 beds)***

- DMH, Cape Cod Supported Housing (20 units for homeless individuals with MI)
- DHCD/HAC, Cape Regional Housing Initiative (24 units for a total of 32 beds for families and individuals)
- BHA, Housing First (35 units for individuals some who have AIDS)
- BHA/CAC, Pilot Plus (5 beds for chronically homeless individuals)
- BHA /Duffy, Spring Street (8 units for chronically homeless individuals)
- Provincetown Housing Authority, Foley House (10 beds for homeless individuals with AIDS)
- BHA/DMH /Cape Cod Supported Housing Expansion (2 Units for individuals with MI)

OTHER PROJECTS FUNDED THROUGH THE HUD COC APPLICATION PROCESS FOR ACQUISITION, CONSTRUCTION OR REHAB ***(Total of 40 beds)***

- Falmouth Housing Corporation / Bridgeport = $289,000 toward construction (8 units)
- Housing for All Corporation /CHAMP Homes II & III = $250,000 toward construction and rehab (14 beds)
- HAC / Southside Village – construction for 4 units for 8 individuals provided for DMR homeless clients
- HAC –toward the purchase of the land for Community Green

HUD COC SECTION 8 SRO – MOD REHAB FUNDED PROJECTS ***(Total of 30 beds)***

- BHA/ HAC, Chase House (6 beds)
- BHA/ Nam Vets Association, Homestead (10 units)
- Orleans Housing Authority, Canal House (7 beds)
- Falmouth Housing Authority, Flynn House (7 beds)

TOTAL NUMBER OF BEDS DEVELOPED THROUGH THE CoC APPLIATION

HUD CoC funded beds (SHP = 32, SPC = 112) 2010 HUD Award for two new projects for new beds are under development (Duffy & Vinfen's applications with 2 units each)	144 beds (4 of these beds/units to be developed)
HUD CoC Section 8 Mod Rehab beds	30 beds
HUD Acquisition, Construction & Rehab beds (already developed) HAC beds at Community Green for the homeless individuals (under development)	30 beds 10 additional units to be developed
Total number of beds developed **Total of beds under development**	**200** **14**

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