The Need for & Feasibility of Low-barrier Options in Sheltering People Who are Experiencing Homelessness

City of Indianapolis
Office of Public Health & Safety

Report to the City-County Council

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This report was prepared by Planning Plus, LLC.

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SECTION 1: Executive Summary

As the year 2020 began, no one could have imagined a world-wide pandemic was about to test, challenge and push every aspect of our community in ways never seen. The impact of the pandemic has forced communities across the nation to revisit and reconstruct systems related to a variety of social problems that have been in place for decades. The homeless population in particular has experienced unique and devastating consequences.

In response, the federal government is investing billions of dollars across the country in the form of pandemic recovery and stimulus funds for a variety of purposes, including preventing homelessness. In our own community, the most visible indication of this impact was the increase of unsheltered people who established homeless camps in and around the downtown area. Public health and safety concerns dramatically increased. The City of Indianapolis and community partners have an opportunity to create long-lasting changes that could not have been imagined prior to the pandemic, especially when addressing the rising numbers of people who are unsheltered.

On February 21, 2021, the City-County Council passed Proposal 76 (Prop 76) that directed the Office of Public Health and Safety (OPHS) to commission a study on the feasibility of establishing a permanent homeless encampment site near downtown Indianapolis. While this report includes this possibility as a solution, the primary focus was on evidenced-based best practices that are long-term solutions.

Consequently, this report embraces the “Housing First” philosophy that has been endorsed by national experts and adopted by the Indianapolis community. The Housing First model does not mean “Housing Only.” As the series of local plans to end homelessness in Indianapolis reflect in their priorities and data, robust support services are vital to the success of any type of shelter This report reviews the current shelter system, analyzes who is homeless and identifies gaps and weaknesses in the homeless infrastructure in Indianapolis.

The data shows a notable increase over the last two years in people experiencing unsheltered homelessness and an inadequate number of low-barrier shelter beds available to meet the need. Providing a shelter bed alone will not adequately address this gap, as there are reasons shared by people with lived experiences why they decline shelter, and this report is influenced by their voices.

Best practices research shows access to low-barrier shelter beds is an important component of a community’s infrastructure to end homelessness. This report examines the specific, must-have features of a low-barrier shelter as well as considers lessons learned from the recent Crowne Plaza Hotel initiative launched as a response to keep homeless people safe during the pandemic. There are also particular aspects of managing a low-barrier shelter that both the City and providers will need to commit to in order to ensure long-term success. The research, interviews, and data analysis

culminate in offering five broad recommendations using national best practices while also capitalizing on the assets of Indianapolis:

- **Recommendation #1**: Increase number and type of shelter beds that are low-barrier, which will require a new physical space as the current shelter system does not have enough beds nor the right type of beds.
    - Ensure full utilization of current shelter beds within the system.
    - Create additional low-barrier shelter beds
    - Create additional shelter beds that are specialized

- **Recommendation #2**: Fund and train staff to appropriately support the features of the new low-barrier shelter.
    - Staffing to keep the shelter open 24/7 (need for 3 shifts to cover the 24-hour operations)
    - Staff capacity to provide security, both internal and external
    - Staff to guest ratios are reasonable and follow best practices
    - Staff to provide case management, links to services, links to permanent housing
    - Staff to provide on-site support services, including counseling, clinical behavioral health services, health care services, and other social services (Social Security, IDs, applications for assistance, etc.)
    - Staff to manage the overall operations and administration

- **Recommendation #3.** Create a “Navigation Center” rather than just a standalone low-barrier shelter.
    - Design physical space to accommodate a variety of family and individual needs for shelter
    - Design the physical space to embrace Housing First principles to enhance service provision and culture

- **Recommendation #4.** Increase availability and access to safe, supportive, and permanent Housing.
    - Entice affordable housing developers and landlords to build more affordable units
    - Build the capacity of permanent supportive housing providers to develop more units.

Expansion of shelter beds should be implemented as part of a broader system of housing designed to quickly move people from the streets and into stable housing, with support services built into all stages of the system. The report is designed as a widely applicable guide for the effort to expand shelter bed types and enable Indianapolis to more effectively move people out of homelessness.

SECTION 2: Focus of This Study

As the year 2020 began, no one could have imagined a worldwide pandemic was about to test, challenge, and push every aspect of our community in ways never seen. While the impact of the pandemic has been felt across Indianapolis, the homeless population has experienced unique and devastating consequences. The Mile Square and downtown area have been particularly impacted by the issue of homelessness on multiple levels, causing alarm among businesses, civic leaders, and community partners while, more concernedly, increasing the harm done to people struggling with homelessness.

The most significant indication of this impact was the increased visibility of unsheltered people who established homeless camps in and around the downtown area. In response, the City-County Council passed Proposal 76 (Prop 76) on February 21, 2021, which directed the Office of Public Health and Safety (OPHS) to commission a study on the feasibility of establishing a permanent homeless encampment site near downtown Indianapolis.

Prop 76 required the OPHS to submit a report to the City-County Council on how such an encampment would be organized and administered. Research (provided later in this study) indicates such an approach raises valid concerns and, more importantly, is not a long-term solution to reduce homelessness. However, there are evidenced-based solutions and best practices learnings that should be considered by the City of Indianapolis (City) to achieve the goal of ending homelessness, particularly for the unsheltered.

The pandemic has forced communities across the nation to revisit and reconstruct systems that have been in place for decades to deal with social problems. In response, the federal government is investing billions of dollars across the country in the form of pandemic recovery and stimulus funds for a variety of purposes, including preventing homelessness. This is a rare opportunity for the City and community partners to create long lasting changes to achieve many of the community goals to end homelessness, particularly for the rising numbers of people who are unsheltered.

In 2017, the Coalition of Homelessness Intervention and Prevention (CHIP) commissioned a study that assessed the broad scope of services provided by the Indianapolis shelter system at that time.[1] Based on a review of primary data and research on best practices, one of the recommendations from this study was to ***establish a low-barrier shelter*** to address the issue of homelessness over the long-term. The overall focus of this study will be to revisit this specific recommendation in the

[1] Refers to the Indianapolis Homeless Shelter Assessment commissioned by CHIP in 2017. This assessment was completed by consultant Christie Gillespie, who is now a Principal with Planning Plus LLC. This study is referenced many times throughout this report as the "2017 study".

context of the environment today, current data, changes in providers' policies and the latest research and lessons learned in the community.

As with the 2017 study commissioned by CHIP, the overall orientation of this report will follow the *Housing First* model, a philosophical shift away from the traditional "housing ready" approach, which the U.S. Department of Housing and Urban Development (HUD) and other housing policy experts have determined to be more effective. The model functions under the concept that everyone is ready for housing, regardless of the complexity or severity of their needs.

Additionally, this report further explores how best to support the unsheltered by examining the following:

- Analysis of current barriers for homeless people to enter the current shelter system against the Housing First model principles and components.
- Research of the latest thinking and best practices about how to design a low-barrier shelter or similar solution that best serves homeless people.
- Case studies that demonstrate successful implementation of best practices.
- Provides estimated costs and recommendations of what needs to be in place for a low-barrier shelter or similar solution in Indianapolis to be successful.
- Analyzes the attributes and criteria of the entity that would be the best match to administer and manage the low-barrier shelter or similar solution.

SECTION 3: Housing First Model and Plans to End Homelessness

It is critical to acknowledge Indianapolis has been working diligently for decades to end homelessness through the adoption of the Housing First philosophy and creation of community wide planning documents. For many years, CHIP has served as the entity to convene providers, policy makers, advocates, and people who are homeless to conduct research, gather data, coordinate services, and provide a community forum. With each year, the community continues to improve the homeless prevention system, implement new learnings, and improve the use of data for goal setting. This report builds upon these efforts by referring and incorporating this community work throughout this document and in the development of the recommendations.

Housing First Approach

For at least the last decade, federal housing agencies have moved to officially adopt the Housing First approach in order to receive federal funding. Housing First is a philosophical shift from the traditional "housing ready" approach. The model functions under the concept that everyone is ready for housing, regardless of the complexity or

severity of their needs. Housing First is not a "program," it is a system-wide orientation and response. [2] HUD offers the following principles that communities need to embrace in order to execute a Housing First approach:

- ✓ *Homelessness is first and foremost a housing crisis and can be addressed through the provision of safe and affordable housing.*
- ✓ *All people experiencing homelessness, regardless of their housing history and duration of homelessness, can achieve housing stability in permanent housing.*
- ✓ *Everyone is "housing ready." Sobriety, compliance in treatment, or even criminal histories are not necessary to succeed in housing. Rather, homelessness programs and housing providers must be "consumer ready."*
- ✓ *Many people experience improvement in quality of life, in the areas of health, mental health, substance use, and employment, as a result of achieving housing.*
- ✓ *People experiencing homelessness have the right to self-determination and should be treated with dignity and respect.*
- ✓ *The exact configuration of housing and services depends upon the needs and preferences of the population.*

"Homelessness is first and foremost a housing crisis..."

Plans to End Homelessness

In 2000, the National Alliance to End Homelessness (Alliance) was a key leader in challenging communities and the nation to develop specific plans with goals to end homelessness. In time, the federal government adopted this approach and substantially increased resources to implement these plans. Key elements of the planning strategy that are now considered best practices and must-have elements of addressing homelessness include:

- Permanent supportive housing,
- Rapid re-housing,
- Systematic collection and use of data,
- Coordinated assessment and entry,
- Local systems to end homelessness, and
- Outcome focused crisis systems.[3]

[2] National Alliance to End Homelessness. Fact Sheet: Housing First. April 2016, p 1.

[3] National Alliance to End Homelessness. Retrieved from https://endhomelessness.org/who-we-are/our-mission-and-history/.

In 2002, Indianapolis embraced this planning approach and began incorporating the principles of Housing First through the inception of the first Blueprint to End Homelessness - a formal plan to create community wide goals around homelessness. The Blueprint planning continued through the development of Blueprint 2.0, which guided the community's work from 2013 - 2018 with the intentional focus to make homelessness rare, short-lived, and recoverable.[4]

From this plan, the Indianapolis Continuum of Care (ICoC) organized its governance structure around CHIP to serve as the support entity. Significant systems-change efforts that were included in this plan were: 1) a focus on special populations like those experiencing chronic homelessness, 2) changing the community funding process, 3) and shifting the focus to increasing permanent housing options.

This community wide collaboration continues today with the current plan to end homelessness that sets out the strategies and goals from 2018 – 2023. This plan is the most ambitious yet with specific goals and, more than ever, the use of data to track progress towards those goals. This plan outlines six strategic priorities that challenge providers, funders, government, and other partners to accelerate impact through use of data, evidenced based practices and community-driven concepts described in this plan. While this plan is intended to address all people experiencing homelessness, operational plans were developed to focus on special populations that have the highest rates of homelessness in order to meet their unique challenges.[5]

For the first time, nine key values are included in the plan that all partners and systems should apply when determining their strategies and tactics to address homelessness.[6] These values, found in Addendum A, reinforce, and set the expectations of how Indianapolis will address homelessness. Of relevance to this study are the values of ***housing first*** and ***individualized and client-driven services***.

However, no plan could have anticipated the COVID-19 pandemic of 2020,which continues as of this writing. The impact of the pandemic on the City's homelessness coupled with the unprecedented strain placed on the human services network that supports the homeless has been dramatic. This impact is reflected in the most recent Point in Time (PIT) Count conducted in January 2021.

[4] "Indianapolis Community Plan to End Homelessness 2018-2023". Retrieved from https://www.indycoc.org/community-plan/community-plan-overview p 4.
[5] "Indianapolis Community Plan to End Homelessness 2018-2023". Retrieved from https://www.indycoc.org/community-plan/community-plan-overview p 17-18.
[6] Ibid, p 7.

SECTION 4: People Who are Homeless in Indianapolis

The PIT Count is mandated by HUD and reports the number of people experiencing homelessness across the United States on a single night in January. In 2021, there were 1,928 homeless individuals identified in the Indianapolis PIT Count[7]. This represents a 21% increase from 2020's count of 1,588 and the highest number counted during the past 10 years. Both sheltered and unsheltered numbers increased from the previous year, with 1,665 individuals staying in sheltered locations and 263 being unsheltered. Changes in PIT Count methodology, due to COVID-19 concerns, allowed for an increase in time permitted for participants to conduct the count and likely impacted the data.

TABLE 1. Marion County Point-in-Time Count (2017–2021)[7]

	2017	2018	2019	2020	2021	Change 2020-2021
Low Temp	37°F	27°F	-11°F	18°F	27°F	9°F
Sheltered	1657	1546	1462	1402	1665	18.8%
Unsheltered	126	136	105	186	263	41.1%
Total	**1783**	**1682**	**1567**	**1588**	**1928**	**21.4%**

TABLE 2. Reported race and ethnicity of individuals experiencing homelessness by location.[8]

	Emergency Shelter	Transitional Housing	Safe Haven	Unsheltered	2021 Total	% of total population
American Indian or Alaskan Native	7	1	0	5	13	0.7%
Asian	13	2	1	5	21	1.1%
Black or African American	764	190	16	70	1040	53.9%
Multiracial	47	12	0	7	66	3.4%
Native Hawaiian or Pacific Islander	5	1	0	0	6	0.3%
White or Caucasian	482	98	26	176	782	40.6%
Hispanic/Latinx ethnicity	53	22	1	10	86	4.5%
Total	**1318**	**304**	**43**	**263**	**1928**	**100%**

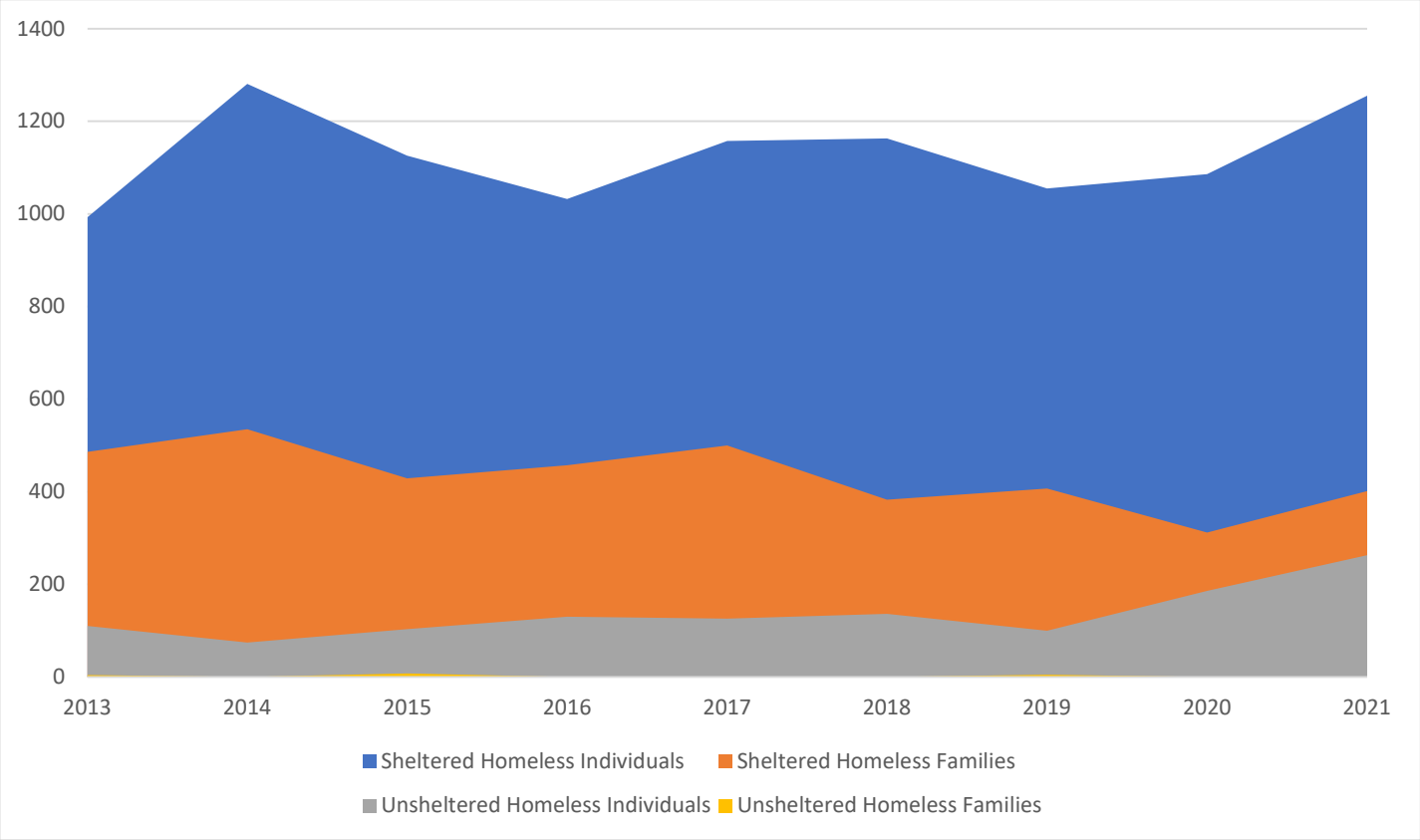
Of those who were sheltered, 304 stayed in transitional housing and 43 were in a safe haven. This indicated a decrease in the percentage staying at both types of shelters compared to 2020. Additionally, 1,318 individuals stayed in emergency shelters in 2021. This includes 222 people who stayed in non-congregate shelters managed by the City

[7] "Homelessness In Indianapolis: 2021 Marion County Point-in-Time Count". IU Public Policy Institute, Center for Research on Inclusion and Social Policy, July 2021, p 2.
[8] Ibid, p 5.

and individual hotel rooms paid for by Supportive Services for Veteran Families. Additional non-congregate shelter beds were managed by traditional emergency shelter providers. However, individuals staying in those beds were not distinguished in the data from individuals staying at traditional emergency shelter facilities. The number of people staying in transitional housing dropped from 2020, while all other locations increased or maintained their populations in experiencing homelessness – they are sleeping in temporary shelters, transitional housing, or on the street.

People enduring unsheltered homelessness are, on average, older, white men who have been homeless for a large part of their lives, however, the current plan to end homelessness indicates special populations such as women and LGBT individuals are increasingly vulnerable to becoming unsheltered. People who are Black and Latinx are experiencing unsheltered homelessness at disproportionately higher rates.

CHART 1. Sheltered and Unsheltered Trends 2013 – 2021.[9]



Note: The PIT data reflects (4) Unsheltered homeless families in 2013, (8) unsheltered homeless families in 2015, and (5) unsheltered homeless families in 2019.

[9] 2021 Point-In-Time Count, Indianapolis Continuum of Care, retrieved from https://www.indycoc.org/coc-dashboards-pit-count.

SECTION 5: Housing the Unsheltered

The Indianapolis community uses best practices and continues to improve the current systems to address homelessness such as permanent supportive housing and rapid re-housing programs. However, these programs still don't address the full scale of our issue . Since at least 2017, various reports and plans have identified the need for housing the unsheltered and have made recommendations.

HUD defines the term "homeless" as individuals living in places not meant for human habitation, shelters, transitional housing, and exiting an institution they lived in for up to 90 days. While most experiencing homelessness can find shelter at local emergency and transitional housing facilities, or with family and friends, the number of unsheltered individuals and families living in cars, on the streets, and in abandoned areas is increasing.

People living in unsheltered places have been very visible, particularly throughout the pandemic and within the Mile Square of downtown. Not surprisingly, the business community and downtown residents have intensified concern and scrutiny about the real and perceived negative impacts of unsheltered homelessness, demanding attention from civic leaders.

TABLE 3. HUD 2020 CoC Homeless Assistance Programs Housing Inventory Count

	Family Units	Family Beds	Adult-Only Beds	Child-Only Beds	Total Year Round	Seasonal	Overflow / Voucher
Emergency Shelter, Safe Haven, and Transitional Housing	**113**	**418**	**829**	**11**	**1258**	**278**	**289**
Emergency Shelter	85	323	480	11	814	278	289
Safe Haven	0	0	51	0	51	n/a	n/a
Transitional Housing	28	95	298	0	393	n/a	n/a
Permanent Housing	**270**	**955**	**1318**	**0**	**2273**	**n/a**	**n/a**
Permanent Supportive Housing	131	415	889	0	1304	n/a	n/a
Rapid Re-Housing	89	367	177	0	544	n/a	n/a
Other Permanent Housing	50	173	252	0	425	n/a	n/a
Grand Total	**383**	**1373**	**2147**	**11**	**3531**	**278**	**289**

Per HUD and section 578.7 of the Continuum of Care Program interim rule, all Continuums of Care (CoCs) must conduct a homeless person's Point In Time (PIT) count every two years that spans the CoC geographic service areas to qualify for program funding. As part of an annual funding process, HUD also highly encourages and recommends that each CoC perform an annual PIT count as well as a Housing Inventory Count (HIC) identifying the total number of homeless program beds for all programs serving homeless persons and receiving federal funding associated with HUD. The data in the chart above identifies the total number of beds in the ICoC, including both emergency shelter and permanent housing.[11]

When the data is compared between the annual PIT count numbers and the HIC, there is a clear gap between the number of identified homeless individuals and available emergency shelter beds within the Indianapolis CoC.[12]

TABLE 4. 2007-2020 HIC Counts by Indianapolis CoC

	2017	2018	2019	2020	2021
PIT Count	1783	1682	1567	1588	1928
HIC ES SH TH Beds	1750	1307	1440	1258	1597
Identified Bed Gap	**-33**	**-375**	**-136**	**-330**	**-331**

The deficits of the current shelter system, including insufficient numbers of shelter beds; restrictions that prevent partners, children, or pets from remaining together; shelter rules; concerns about personal safety and safety of belongings; and barriers to entry, including sobriety requirements, have launched new discussions about how actionable steps can be taken and how the political will can be solidified to address these gaps.

Feedback from People with Lived Experiences

This report relies heavily on research, data, and evidence-based approaches. However, the thoughts and feedback of people with lived experiences of homelessness provide critical information to incorporate when developing recommendations that will directly impact their lives. Both the 2017 shelter assessment report and this report incorporates feedback from people with lived experiences to further confirm, explain, or question the data.

Other research across the country that collected feedback from people with lived experiences has found the availability of assistance is certainly a factor in the number of unsheltered individuals*, but even communities with almost enough shelter beds have individuals, especially chronically homeless individuals, who remain unsheltered*. There

[11] Notice: CPD-18-080 Notice CPD 18-08 2019 HIC and PIT Data Collection Notice (hudexchange.info)
[12] PIT and HIC Data Since 2007 - HUD Exchange

are several reasons individuals may avoid shelter, but research suggests there are *some policies that make shelter less desirable*, such as not allowing access for couples, pets, or those facing challenges with substance use or mental health.[13]

Interviews with people experiencing homelessness in Indianapolis align with this research. As a part of the shelter assessment study conducted in 2017, homeless individuals surveyed identified the following barriers to accessing shelter services:

- ∅ Shelter policies against serving people with a **criminal history**
- ∅ Shelter policies against **drug and alcohol use**
- ∅ **Feeling unsafe** as shelter locations
- ∅ Not having the **proper documentation to qualify** and receive services
- ∅ **Limited access** and transportation **for those with physical disabilities**
- ∅ Shelter **hours of operation**
- ∅ **Customer service** issues amongst the staff at shelters

The Corporation for Supportive Housing (CSH) shared feedback collected during the summer of 2021 from people experiencing homelessness. In addition to the above barriers in accessing shelter, CSH also found the following themes emerged as important considerations:

- Desire for a physical place where they have access to overnight shelter, but they would also like to be able stay during the day.
- Importance of onsite access to the necessary resources, services, providers, and recreational activities in order to avoid having to travel around the city.
- Need for trauma-informed care that extends to the space design and culture of the organization managing the shelter/programs.

Low-barrier Shelters

To address the crisis of homelessness, the type of shelter, and how it is managed must be considered. Shelters can provide immediate safety and security, but they also must quickly pivot to create paths to permanent housing. Both the 2017 shelter assessment study and the most recent plan to end homelessness specifically recommend the need to implement a low-barrier shelter in some way. This recommendation is supported by national and local research as well as the feedback from people with lived experiences.

[13] "Unsheltered Homelessness: Trends, Causes, and Strategies to Address". National Alliance to End Homelessness. Retrieved from https://endhomelessness.org/resource/unsheltered-homelessness-trends-causes-strategies-address/

However, the way in which a low-barrier shelter is implemented and managed determines if it successfully addresses the needs of the unsheltered. This section will outline the philosophy and management criteria that are considered best practices.

The U.S. Interagency Council on Homelessness (USICH) advises there are four areas to examine and evaluate to identify gaps and improvements needed for a community shelter system:

- ✓ Ensure emergency shelters are playing a vital role in Housing First approaches to ending homelessness.
- ✓ Strengthen models of emergency shelter by embracing innovation and change.
- ✓ Create many pathways out of homelessness that are person-centered.
- ✓ Lead a larger community response end homelessness.[14]

While all four areas are important, for the purpose of this study, the focus will be on ensuring emergency shelters play a vital role in Housing First approaches. USICH Regional Coordinator Katy Miller summed up what this means: "Shelters must be low-barrier, focus on assessment and triage, and intentionally link to permanent housing resources so that people move through to housing quickly — this is *Housing First* at its best."[15]

The shift to being a low-barrier shelter requires changes in philosophy, operations, and physical space. Depending upon how much an organization has already adopted the Housing First approach will dictate how fast such a transition can be completed. Some shelters may need to start this shift by targeting/prioritizing certain populations, such as those that have been in shelters the longest, for permanent housing placements.

> *"Shelters must be low barrier, focus on assessment and triage, and intentionally link to permanent housing resources so that people move through to housing quickly — this is 'Housing First' at its best."*
>
> Katy Miller, Regional Coordinator, U.S. Interagency Council on Homelessness. "Using Shelter Strategically to End Homelessness", 2016.

As the agency profiles found in *Addendum D* indicate, most shelters report unique rules for entry, even those that self-describe as "low-barrier." Most rules coincide with the sub-population that the shelter seeks to specialize in serving. It is important to note, however, that when the agency profiles were updated for this study from 2017, some shelters have modified their entry rules to move closer to "low-barrier."

[14] Using Shelter Strategically to End Homelessness. U.S. Interagency Coalition for Homeless. Retrieved from https://www.usich.gov/news/using-shelter-strategically-to-end-homelessness/.

[15] Ibid.

Examples of unique rules for entry within the Indianapolis shelter system, as reported when updating the agency profiles include:

- ∅ IDs required
- ∅ children only
- ∅ children with specific special needs only
- ∅ families (same sex accepted) only
- ∅ veterans only
- ∅ previous history of violence
- ∅ not fleeing domestic violence
- ∅ at least one child under 18
- ∅ criminal histories (active warrants)
- ∅ no admission from psychiatric facilities
- ∅ child molestation convictions prohibit entry
- ∅ active drug use/intoxication prohibited
- ∅ must be victim of domestic violence
- ∅ willingness to participate in screens for drug/alcohol use
- ∅ referral required from a mental health professional or law enforcement
- ∅ individuals on the sex or violent offender registry not accepted (most shelters)
- ∅ requirement to participate in work programs
- ∅ only single women with children or pregnant
- ∅ couples must be married to seek shelter as a family
- ∅ domestic violence victims only

The pandemic provided the urgency for the Indianapolis community to step back and better align resources to ensure continued movement in resolving homelessness. For example, through the Crowne Plaza initiative (see case study in *Addendum B*), many partners and resources were pooled together in order to provide a safe, quality place to be sheltered while quickly moving them to a permanent housing situation through the housing placement team.

According to the USICH, when a housing crisis cannot be immediately resolved, ***people will assess and choose options most consistent with their needs and preferences***. If guests perceive that an emergency shelter stay requires conforming to rules or expectations that seem unreasonable, punitive, or that divide them from their defined family, they will choose alternatives that meet those needs. In their August 2017 brief, the USICH provides the following guidelines when creating low-barrier access to shelter.[16]

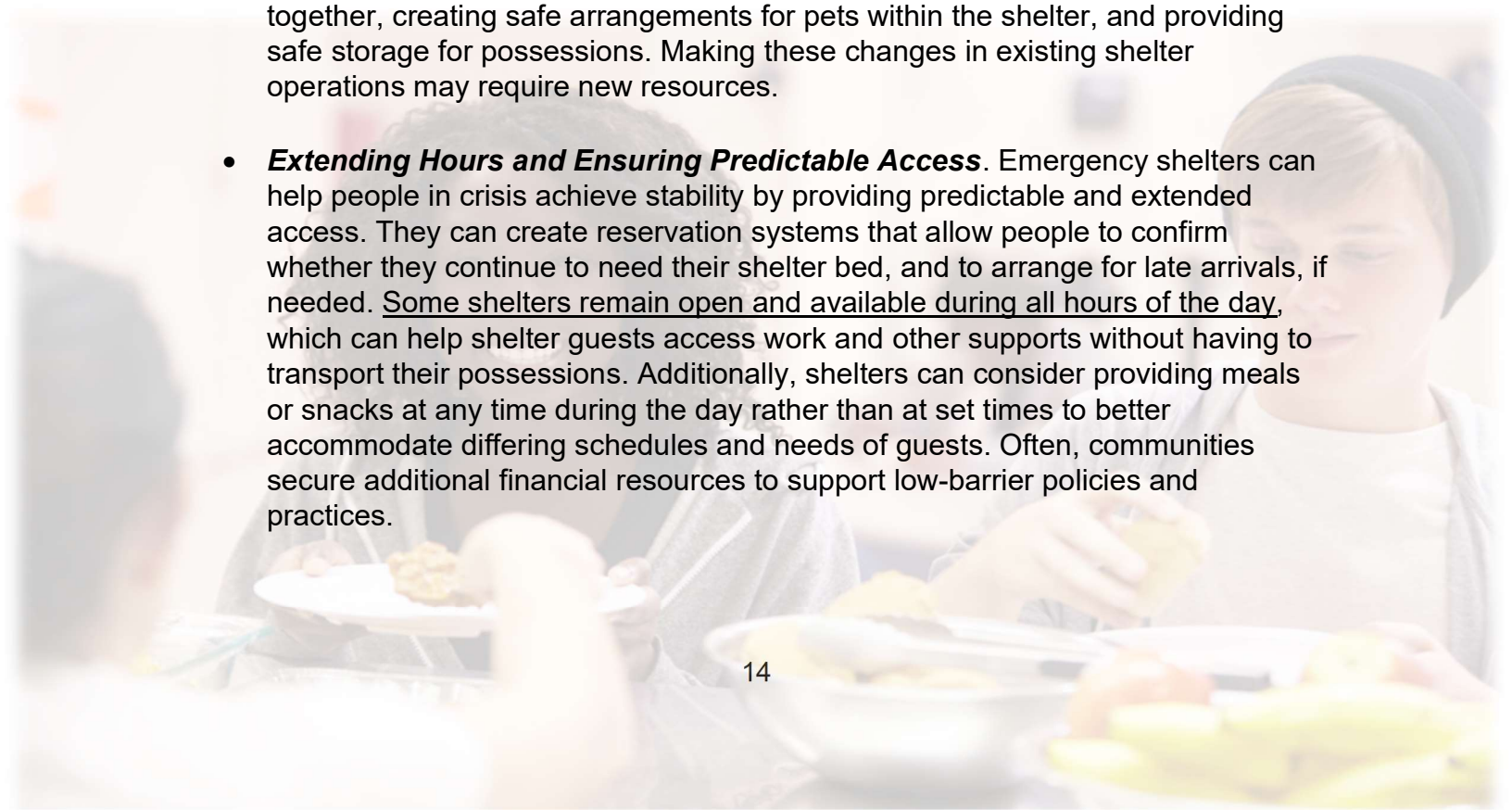
[16] "Key Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System". U. S. Interagency Council on Homelessness. Retrieved from emergency-shelter-key-considerations.pdf (usich.gov). August 2017, p 5.

- ***Providing Low-Barrier Access*.** For emergency shelters, using Housing First approaches means removing as many preconditions to entry as possible and responding to the needs and concerns of people seeking shelter. Historically, concerns about safety have prompted many shelters to limit access to people using substances or living with substance use disorders. Innovative shelter programs across the country have been able to design their approach to accommodate people regardless of substance use or other perceived barriers to entry. Low-barrier shelters emphasize welcoming guests in as they are, while having clear and simple behavioral expectations that apply to anyone residing in the shelter. These expectations are narrowly focused on maintaining a safe environment for all. Staff are trained in trauma-informed care and de-escalation techniques in order to help residents understand and conform to these expectations. Some programs are also integrating restorative justice principles into their methods for ensuring that behavioral expectations are met.

- ***Engaging People with Barriers to Accessing Housing****.* Emergency shelters should also work closely with outreach teams to specifically and intentionally outreach to and engage people who are reluctant to access shelter or have high barriers to permanent housing. This will likely involve seeking to understand the reasons for their reluctance and, if possible, addressing those concerns through shelter and engagement policies.

- ***Accommodating Partners, Pets, and Possessions****.* Many people seeking shelter report that being separated from their relatives, partners, friends or chosen family, pets, or possessions leads them to remain unsheltered. In some communities, new shelter models are identifying ways to reduce these barriers, inviting self-defined groups of friends and family to access and stay in shelter together, creating safe arrangements for pets within the shelter, and providing safe storage for possessions. Making these changes in existing shelter operations may require new resources.

- ***Extending Hours and Ensuring Predictable Access***. Emergency shelters can help people in crisis achieve stability by providing predictable and extended access. They can create reservation systems that allow people to confirm whether they continue to need their shelter bed, and to arrange for late arrivals, if needed. Some shelters remain open and available during all hours of the day, which can help shelter guests access work and other supports without having to transport their possessions. Additionally, shelters can consider providing meals or snacks at any time during the day rather than at set times to better accommodate differing schedules and needs of guests. Often, communities secure additional financial resources to support low-barrier policies and practices.



Again, this national research aligns with the local community planning efforts that outline the priorities and strategies set out by the most current plan to end homelessness.

Programs—including crisis shelter and housing—address barriers to different degrees, but typically have some configuration of the following features:

- ✓ Operations that use **alternatives to extensive rules** and an overbearing security presence
- ✓ **Relaxed sobriety and curfew** measures
- ✓ **Accommodations** provided **during the day**
- ✓ Accommodations **allow companions, including partners and pets**
- ✓ **Personal belongings can be stored**, so they are safe and readily accessible
- ✓ **Housing assistance** and **case management services** are available
- ✓ Accommodations are **safe, geographically convenient, and reasonably sized**
- ✓ **Community-building activities are encouraged** (but not mandated) through such measures as group activities, therapeutic services, participation in facility governance, and emphasis on mutual respect, among other means

The next iteration of the low-barrier shelter being conceived by many cities across the US are **Navigation Centers**, described as low- barrier and service-enriched shelter that specifically target high-need homeless adults. The Navigation Center concept embodies the Housing First philosophy and incorporates all elements described above. Based on a review of several Navigation Centers located across the country, the big difference from a low-barrier shelter appears to be the design of both program and structure incorporate the Housing First principles from the beginning.

Low-barrier Shelter Management

While there can be agreement in principle about embracing the Housing First philosophy within the context of the emergency shelter system, it is the day-to-day operations and management that determine if a shelter successfully transitions to be a low-barrier and Housing First entity. This section provides guidance on how to organize criteria and expectations for an entity to manage a low-barrier shelter.

Philosophy and Values: **The foundation of operating a low-barrier shelter is based on the organizational philosophy and culture of the entity**. Questions to consider about the philosophy and values an organization:

1. Does your emergency shelter consistently implement practices to meet people where they are and provide person-centered care that focuses on personal strengths?

2. What policies or value statements convey clear expectations that guests will be treated with dignity and respect, and how does the shelter monitor adherence to these expectations?

3. Are expectations of guests clearly communicated and easily accessible for review by guests?

4. What specific practices help ensure that the shelter exhibits cultural competency and provides appropriate protections for shelter seekers across demographic differences?

5. Does the shelter set only minimal and reasonable requirements for guests, and does the shelter enforce these requirements in a fair and transparent way?

6. Does the shelter involve guests in governance and operations?

Program Principles: Below are a series of questions to **help assess how an entity *operationalizes* the Housing First philosophy and what the entity is currently doing to embrace low-barrier access**.[17] These questions also open dialogue with organizations to have honest discussions about what prevents them from implementing low-barrier practices.

1. Does your emergency shelter have minimal expectations or requirements of people seeking shelter?

2. Does your emergency shelter focus on addressing disruptive or dangerous behaviors rather than compliance to rules or case plans?

3. Does your shelter welcome self-defined family and kinship groups to seek shelter together?

4. Can your emergency shelter identify financial resources that can support the adoption of low-barrier policies and practices and support extended or flexible hours and adapted service-delivery models?

5. Does your shelter accommodate pets and belongings?

6. Does your shelter intake process and housing navigation services coordinate closely with community-based outreach services and coordinated entry?

7. Does your shelter create flexible and predictable access for people seeking shelter?

[17] "Key Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System". U. S. Interagency Council on Homelessness. Retrieved from emergency-shelter-key-considerations.pdf (usich.gov). August 2017.

Operating Culture: For most people experiencing homelessness, particularly those who are unsheltered, have a history of trauma, crisis, and stress. **Leadership and staff of shelters need specialized training in homeless population, trauma informed care, MSW degrees, and continual staff training.**

1. Does your staff receive training in trauma-informed care and support to work effectively and nonjudgmentally with people facing these crises?

2. Does the organization set staff expectations that reflect a commitment to promoting dignity and respect?

3. How does the organization engage people experiencing homelessness on a routine basis?

4. Does the organization involve people with lived experiences in homelessness in the development of policies and program attributes?

5. Does the organization partner with permanent housing providers to create a pipeline of housing opportunities for those in shelter?

6. Does the organization have MOUs or referral agreements in place with substance abuse programs, mental health, primary health care, job placement, and other needed services in ways that are reduce accessibility barriers?

Administration Strength: As with any selection process, the administrative management and oversight of the organization is the **foundation for executing impactful programs, attracting talent, and sustainability over the long term**.

1. Does the organization have strong financial management policies, balance sheet, and audited financial statements?

2. Does the organization have a human resources infrastructure that evaluates performance, attracts, and develops talent, and maintains a values-based culture?

3. Does the organization value diversity of staff and management staff, and in what ways is this demonstrated?

4. Does the organization have strong board leadership that regularly engages in strategic planning and appropriate oversight of the chief executive officer?

5. Does the organization have a reputation of collaboration and partnership among funders, public officials, other providers, and people experiencing homelessness?

Cost Estimates

Low-barrier shelters and Navigation Centers operate differently from traditional emergency shelters. These shelters are designed to serve the most vulnerable households who may have extensive behavioral and medical issues, and as a result, may face significant barriers to housing. Therefore, low-barrier shelters require more extensive staffing than traditional shelters especially regarding general management and security services. The staffing model also requires more intensive levels of program supervision, case management services and 24/7 staffing needs.

Although it is not feasible to provide exact costs without a chosen site and operational needs, there are many examples across the country that provide city policy makers a range of cost estimates to expect. Some of these examples are listed below.

It should be noted, however, these costs are prior to the pandemic before the increase in building materials and construction costs. The current labor shortage will also increase staffing costs as the starting wage in Marion County has reached $15 per hour.[18] Filling staff positions that will be needed to run a low-barrier shelter will require competitive salaries.

LTHC located in Lafayette, IN

The total cost for the Engagement Center and Low-barrier Shelter was approximately $12 million and feasible only with private grants and tax credits. With over $2.3M raised for 5 years of operating expenses (approximately $460,000 per year), LTHC is now working towards establishing endowments to keep the essential services funded in perpetuity.

Currently staffed with approximately 50 employees, LTHC partners with several local agencies to deliver critical services for the individuals that arrive at its doors. On any given day you will find up to 3 partner agencies working with homeless individuals on site.

The Low-barrier Shelter/Non-Congregate Shelter at LTHC is open 24 hours a day, seven days a week. They currently have 10 emergency shelter overflow beds that are only available if, and when, all other shelter beds in the system are full or someone has been banned from another facility. LTHC also provides 17 interim housing pods that are for clients connected to case managers and are within 45 days of a housing placement. This has been found to be a successful measure in helping clients work and maintain their permanent housing plan.

[18] Huang, Binghui. "$15 is Becoming the New Staring Hourly Wage in Indiana", August 19, 2021. https://www.indystar.com/story/money/2021/08/19/indiana-jobs-minimum-wage-companies-paying-15-hour-fill-jobs/8108833002/.

In addition to the 10 emergency shelter beds and 17 interim housing pods, LTHC has also invested in providing four medical respite pods for those homeless individuals that required a place for medical recovery after release from a hospital or medical facility. These individuals must be able to do all daily activities and provide self-care. They may stay up to six weeks after entering LTHC.

The Second Avenue Commons located in Pittsburgh, PA

Announced in August 2020, the groundbreaking for this new low-barrier shelter took place in June 2021. The building will be a brand new 45,000-square-foot, five-floor facility in the downtown corridor of Pittsburgh. The Commons is scheduled to open in early 2022, pending the completion of construction. The $21 million project was supported by contributions of $10 million from the PNC Foundation, $6.75 million from Highmark and Allegheny Health Network, and $6.75 million of in-kind services from UPMC. Grants from the Hillman Foundation, Heinz Endowments, R.K. Mellon Foundation, and the Pittsburgh Foundation were also part of the fundraising.

The new building will house four complementary services that do not currently exist elsewhere in Allegheny County:

- A 24/7, 52-bed Low-Barrier Shelter with space to add 40 additional beds when needed
- A daytime Drop-in Center
- A clinic staffed and operated by University of Pittsburgh Medical Center that provides routine physical and behavioral health services
- 45 Single Room Occupancy (SRO) units, which are a type of permanent housing that offers small, private, furnished rooms along with shared bathroom and kitchen facilities
- No sobriety requirements, pets will be allowed

Buena Park Navigation Center located in Buena Park, CA

Opened in early 2020, the navigation center cost $8 million to construct the 15,000 sq. ft center and $2.5 million annually to operate. Mercy House, a nonprofit organization, operates the center.

The Center has 149 beds in addition to offices, classroom, medical, outdoor, and meeting spaces. The facility serves as transitional housing for those living on the streets in Buena Park and provides a stable setting with healthcare and other services. The long-term goal is to provide clients with the resources they need to permanently transition off the streets. Referrals to the shelter are typically made by the City's homeless outreach workers or Police Department liaison officers.

Sanctioned Homeless Encampments

Cities across the country have seen the rise of encampments, defined as a group of people experiencing unsheltered homelessness together. Although their existence is not unprecedented, reports suggest that the number of encampments has increased sharply in recent years.[19]

Addressing the needs of people experiencing unsheltered homelessness is an issue that often generates contentious, emotional debates across communities and Indianapolis is no different. While there have been encampments around the City for many years, most were invisible to the public. In recent years, however, controversies have erupted when landowners evict people living in the encampments and the City is charged with enforcing the law to ensure they vacate the land. In each these situations, the City and landowner worked with social service providers to help transition those living in the encampments, it was still emotionally difficult since many had lived there for several years.

Understandably, leaders and housing and services providers within such communities want to find ways to address both the immediate safety and living conditions of people who are unsheltered and the concerns of other community members.

As an alternative solution, some communities have created, or are considering creating, "sanctioned encampments," "safe zones," or other similar settings with a goal of helping people stay in safer and more sanitary environments, without the risk of being arrested or cited. Sometimes these settings feature sheds, or other structures, or provide areas for people to stay in their cars or RVs. Others simply provide places for people to sleep in their own tents or on mats. Some communities have created these environments as a voluntary option for people living in unsafe situations. In other cases, people living outside may be compelled to move to the designated locations through the threat of citation or arrest.[20]

People experiencing unsheltered homelessness may perceive staying in an encampment as a safer option than staying on their own in an unsheltered location or in an emergency shelter; however, encampments can create both real and perceived challenges for the people who stay in them as well as for neighbors and the broader community. As community leaders seek to develop and deploy a response, they often are called on to balance multiple, sometimes competing priorities and demands from a

[19] Tent City, USA: The Growth of America's Homeless Encampments and How Communities are Responding. National Law Center on Homelessness and Poverty, 2017, p 24.

[20] Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones". U. S. Interagency Council on Homelessness. Retrieved from Caution_Sanctioned_Encampments_Safe_Zones_052318.pdf. May 2018, p 1.

diverse group of stakeholders, including community residents, business owners, public health and safety officials, and advocates for disadvantaged populations—as well as the people living in the encampments.

The U.S. Interagency Council on Homelessness makes the following recommendations to cities as they weigh the costs and consequences of sanctioned encampments. Additionally, consideration of the impact on the community's systemic efforts to end homelessness must be evaluated.

- **People staying within such settings are still unsheltered, still living outside, and remain homeless.** Creating these environments may make it look and feel like the community is taking action to end homelessness on the surface—but*, by themselves, they have little impact on reducing homelessness*. Often, these settings are not providing them with a truly safe, healthy, and secure environment. It is also important to note that the intended target population may not decide to enter these settings. Additionally, if there is not adequate planning and resources devoted to help people exit these settings on a path out of homelessness, creating these settings alone does not reduce homelessness in communities.

- **Creating these environments can be costly in money, staff time, and effort.** Creating and then operating such settings typically requires significant funding, energy, and staff time from both public and private agencies devoted to locating and arranging for the use of sites, educating, and engaging neighbors, addressing any permitting requirements, providing a secure and hygienic environment, setting up and maintaining any structures, providing adequate services and supports, and many other planning and operational details. It is *critically important to discuss the opportunity costs of pursuing these efforts, and whether critical resources would be better focused on other strategic activities—or used directly for permanent housing and services interventions—that could have a greater impact on ending people's homelessness.*

- **These environments can prove difficult to manage and maintain**. For example, communities often find that temporary sheds (which are sometimes referred to as "tiny homes") or other structures that may have been put up in these settings do not hold up over time and require significant upgrades and/or repairs. Maintaining a hygienic environment can prove challenging if there are not adequate sanitation facilities at the sites. And there often need to be *significant investments in security to be able to ensure the safety and well-being of people staying in these settings,* as many people may be vulnerable to victimization and such communities can become targets for illegal activities, such as drug sales and human trafficking.

- **Although often proposed as "temporary" approaches, these programs prove difficult to close once they open**. While a community may intend for these settings to be a temporary part of its response to homelessness, they can prove difficult to close, especially if there are not adequate plans and resources dedicated to helping people exit these settings and end their homelessness.[21]

In 2018, a study was conducted to expand and increase the body of knowledge around homeless encampments.[22] This research indicates at the root of all encampments is a *need for greater investment of resources to address severe shortages of affordable housing*. This study found a consistent set of factors that contribute to people's decisions to stay in encampments rather than in shelters or in other, unsheltered locations. These reasons include:

- Shortages in the availability of shelter beds,
- Shelter policies that create barriers to entry,
- Undesirable conditions inside shelters such as providing for safety, sense of community, and the freedom to come and go at will.

Local jurisdictions are pursuing a variety of strategies to address encampments and the challenges they pose to health, safety, and well-being. The most rudimentary of those approaches is to "sweep" encampments, the primary goal of which is clearing out the people staying in them. Preliminary evidence suggests that this response of clearance without support results in disruption and trauma for inhabitants of the encampments but does little to resolve the problem. Encampments are quickly reestablished in a new location or even back on the recently cleared site.

[21] Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones". U. S. Interagency Council on Homelessness. Retrieved from Caution_Sanctioned_Encampments_Safe_Zones_052318.pdf. May 2018, p 1-2.
[22] Ibid.

SECTION 6: Recommendations

The recommendations below were developed based on extensive review of national research from the leading experts on ending homelessness. Equally important, local research and data informed these recommendations, including the most recent plan to end homeless published by the ICoC. The COVID-19 pandemic offered lessons learned through the Crowne Plaza hotel initiative that are woven into these recommendations. Finally, incorporating the thoughts and feedback from people with lived experiences influenced these recommendations.

Over the last few years, the Indianapolis community has made great strides in improving the system to reduce and end homelessness. While some of the elements listed below are still a work in progress and are continually evolving, these are important evidenced-based best practices already underway:

- A collaborative and community governed CoC, with a dedicated support entity to implement a true collective impact model.
- Dynamic HMIS system with system-wide performance dashboards available for homeless providers, funders, and the public to view and analyze, and hold each other accountable.
- Coordinated Entry System providing a comment assessment process and increased access to engage individuals and families in programs and services.
- Professional Blended Street Outreach Team that brings a collaborative team approach to addressing the needs of those unsheltered individuals.
- Re-examine and revise policies and practices that create barriers to housing access.

Like many cities, the COVID-19 pandemic increased the number of unsheltered residents in Indianapolis by 21.4 percent from 2020 to 2021, bringing the plight of the unsheltered to the forefront in visible ways. Cities across the country are grappling with similar challenges and have implemented many strategies with varying success, including establishing city-sponsored safe encampments. Based on both academic studies and experiences of other cities across the country, which can be found in Section 5 of this report, safe encampments are not a long-term solution to ending homelessness. In fact, this approach creates more issues than it solves and utilizes precious resources that could be used to support evidenced based approaches.

Instead, cities of all sizes have recognized the systemic weakness in their effort to address homelessness is the *lack of low-barrier shelter beds*. There are either not enough shelter beds or, in cases where there are shelter beds available, people who are unsheltered make the choice to not utilize those beds.

The recommendations below are built on the conclusion that a critical element missing from Indianapolis' system to end homelessness are bona fide low-barrier shelter beds

as defined by the best practices research, particularly for the unsheltered. Secondly, these recommendations affirm implementation of low-barrier shelter beds by adhering to the Housing First approach through incorporating these principles to provide homeless households with the most direct route to permanent housing with no "housing readiness" requirements that impede receiving a housing placement. Based on this philosophical assumption, the recommendations are:

Recommendation #1. Increase number and type of shelter beds that are low-barrier, which will require a new physical space.

As referenced in Table 1 (p. 9), the PIT count found 268 people who were unsheltered, with a range of between 105-268 unsheltered individuals over the last five years and generally trending upward. As noted on page 13 of this report, there is a clear gap between the number of identified homeless individuals on any one give night and available emergency shelter beds within the current ICoC homeless system. Strategies to increase the number of ***low-barrier*** shelter beds should include the following:

a) Ensure full utilization of current shelter beds.

The City should confirm there are no opportunities left within the current shelter system to move more beds to be low-barrier. As the agency profiles indicate, there are a variety of rules for entry based on many reasons. Some organizations target certain populations, require participation in religious-specific programming, or may have marriage requirements for couples seeking shelter as a family. Since the 2017 study, some shelters have relaxed their rules for entry but are there opportunities to go further to create more low-barrier beds?

City officials should have discussions with shelters that have a utilization rate lower than 95 percent if there are still unsheltered people.[23] These discussions can determine if entry rules are preventing people from accessing the shelter and if the shelter is willing and able to make changes for entry. There may be financial reasons for the entry rules that can be addressed through providing funding incentives to entities who provide low-barrier beds or at least designate isolated beds as low-barrier.

b) Create additional low-barrier shelter beds.

While ensuring the current shelter system is being fully utilized for low-barrier beds, the deficit cannot be overcome by full utilization alone. The creation of **new** shelter beds that are **low-barrier** will be needed. Assuming the shelter system is being fully utilized, the data in Table 4 on page 10 of this document shows a

[23] "Would Adding More Emergency Shelter Help Reduce Unsheltered Homelessness? It's Complicated…", National Alliance to End Homelessness, August 21, 2018. Retrieved https://endhomelessness.org/adding-emergency-shelter-help-reduce-unsheltered-homelessness-complicated/

deficit of approximately 20 percent when comparing the number of unhoused people against the available shelter beds across a 5-year average from 2017-2021. Based on this data, at least 100+ of additional low-barrier shelter beds should be created as soon as possible. Given the number of beds recommended, the *creation of a new physical building will be needed.*

The subsequent recommendations address the components that must be present for this new building to truly be a low-barrier shelter. Secondly, the recommendations emphasize the importance of integrating support services as well as permanent housing paths to insure a maximum flow-through of these beds.

c) Create additional shelter beds that are specialized. So often, there are special circumstances which unsheltered people need to be immediately housed. Medical issues, the need for respite, or similar issues are such examples where being sheltered in a more private setting will impact health outcomes. The LTHC housing organization located in Lafayette, IN, created these specialized beds or "interim pods" (case study can be found in Addendum C p. 35).

Recommendation #2. Fund and train staff to appropriately support the features of a low-barrier shelter.

Appropriately staffing a low-barrier shelter is critical to successfully implementing the Housing First philosophy. Hiring the right talent who have the skills to build trusting relationships with people experiencing homelessness and are aware of the need for compassion towards those living unsheltered is also key to a shelter's success. Understanding reasons for homelessness and the local homeless assistance system is paramount. Professional development and continuing education around trauma-informed care, Housing First philosophy and features of low- barrier shelters must be integrated. Below are the staffing considerations that must be included as a normal part of operations:

a) Staffing to keep the shelter open 24/7 (need three shifts to cover the 24-hour operations)
b) Staff capacity to provide security, both internal and external
c) Staff-to-client ratios are reasonable
d) Staff to provide case management, links to services, links to permanent housing
e) Staff to provide onsite support services, including counseling, clinical behavioral health services, health care services, and other social services (Social Security, IDs, applications for assistance, etc.)
f) Staff to manage the overall operations and administration

Recommendation #3. Create a "Navigation Center" rather than just a low-barrier shelter.

Navigation Center refers to a Housing First, low-barrier, service-enriched shelter focused on moving homeless individuals and families into permanent housing. In the interim, a Navigation Center provides temporary living facilities while case managers connect individuals experiencing homelessness to basic needs, income, public benefits, health services, shelter, and housing.

Navigation Centers have shown strong signs of success in helping people exit homelessness, and they are different from traditional shelters in a number of ways. They have few barriers to entry and provide intensive case management to connect people to the unique care and housing solutions they need. They provide community space and *welcome people with partners, pets, and possessions*. Clients receive personalized support to help address housing barriers such as a lack of personal identification documents, employment opportunities, or histories of eviction. Navigation Centers represent an effort to provide a higher level of coordinated care in a managed environment, focused on working with service partners to help end chronic homelessness for people with the highest needs.

These centers are focused on providing services to long-term unsheltered individuals and couples that are often fearful of accessing traditional shelters, in partnership with a Coordinated Entry System. Because they are designed with Housing First principles from conception to implementation, this allows the opportunity for purpose-built structures that can accommodate various types of households including singles, families, partnered couples, those with pets, and those with limited possessions. The design can also include ways to encourage interaction between staff and guests.

Recommendation #4. Increase Availability and Access to Safe, Supportive, and Permanent Housing.

The above recommendations are directly related to reducing barriers for shelter entry for those residents who are unsheltered, including the philosophical and programmatic requirements for success. However, it is imperative to recognize a well-run low-barrier shelter only works if residents can quickly be moved to some type of permanent housing. The current plan to end homelessness is very clear about the critical need to create affordable, permanent housing options as identified in Strategic Priority #2 in the plan.[24] The specific strategies include working with affordable housing developers, landlords, and building the capacity of permanent supportive housing providers to develop more units with less barriers.

[24] Indianapolis Community Plan to End Homelessness. Pg. 12.

SECTION 7: Acknowledgments

Thank you to the following agencies that participated in this study during the summer of 2021 by updating the agency profiles* that were compiled for the 2017 report:

- Holy Family Emergency Shelter
- Children's Bureau Rachel Glick Courage Center
- Children's Bureau Gene B. Glick Family Support Center
- Dayspring
- Family Promise of Greater Indianapolis
- Gennesaret Health Recovery Program for Women
- Gennesaret Health Recovery Program for Men
- Good News Ministries Men's Shelter
- Stopover Emergency
- Salvation Army Shelter for Women and Children
- Wheeler Shelter Women and Children
- Wheeler Shelter for Men
- Reuben Engagement Center
- Shepherd's Pathway
- Queen of Peace (*note: partially complete*)
- Salvation Army DV Component
- VOA Contract Emergency Residential Services
- Julian Center
- HVAF Respite Program

**Please note there are differences in the 2017 agency profiles to the profiles provided in this report, which include:*

- *The Reuben Engagement Center is now called the Assessment and Intervention Center and has moved to the Community Justice Campus. There are no longer any beds dedicated specifically for people who are homeless.*
- *Stopover is no longer operating its RHY Emergency Shelter grant as of September 2021 and consequently appears in the 2017 report but not in this report.*
- *Homeless Initiative Program (HIP) participated in the Crowne Plaza project as a key partner and does not appear in this report.*

Thank you to IFF and Corporation for Supportive Housing for sharing their data collected from People with Lived Experiences during the summer of 2021 for this report.

Thank you to Jennifer Layton of LTHC, David Canavan, Professional Street Outreach Team and the Crowne Plaza staff for sharing their expertise and experiences for this report.

Thank you to Coalition for Homelessness Intervention and Prevention (CHIP) staff for providing data for this report. Additionally, this report draws heavily on previous and current community plans published by CHIP.

ADDENDUM A: Indianapolis Community Plan to End Homelessness 2018-2023 Values

On any given night in the City of Indianapolis, nearly 1,600 of our most vulnerable neighbors are experiencing homelessness.

OUR VALUES

AS WE REALIZE THIS VISION TOGETHER, COMMUNITY MEMBERS HAVE IDENTIFIED NINE KEY VALUES THAT WILL BE ESSENTIAL IN DRIVING OUR COLLECTIVE WORK:

CLIENT CHOICE
We must treat all individuals and families experiencing homelessness with dignity and respect, allowing for self-determination in making decisions about their lives.

QUALITY
We must provide quality housing and services, measuring all programs against common metrics of success.

COMMUNITY-LEVEL APPROACH
We believe that the best solutions come when we work together to find solutions as a collaborative community rather than individually as separate entities.

SYSTEM INTEGRATION
We prevent and end homelessness by working collaboratively with other systems that impact our ability to end homelessness, including health care, education, corrections, the Balance of State Continuum of Care, and others.

HOUSING FIRST
We believe in quickly connecting individuals and families to permanent housing without preconditions or barriers and ensuring ongoing opportunities for engagement in services to support long-term stability.

TRANSPARENCY & CULTURAL COMPETENCE
We must assure that we make data-driven decisions, communicate openly, and provide services with dignity and respect by accommodating different cultures and beliefs.

INCLUSIVITY
We must seek to include stakeholders from every sector so that we can work collaboratively to reach our shared goals, with special emphasis on engaging those with lived experience.

TRAUMA INFORMED CARE
We must provide services that respond to all types of trauma and ensure safety while minimizing the risk of incidences of trauma.

INDIVIDUALIZED AND CLIENT-DRIVEN SERVICES
We recognize that all people experiencing homelessness are unique and we must provide services that respond to individual differences and needs, length of time for engagement, and types of services offered.

By extending these values beyond the daily work of social service providers and applying them to the shared approach of all intersecting systems that impact our neighbors, we can position Indianapolis, as a community, to effectively address the crisis of homelessness in our city.

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ADDENDUM B: USICH Brief on Strategically Using Shelters to End Homelessness

Below are key excerpts in their entirety from a brief prepared by the USICH about how to utilize shelters to end homelessness. This brief can be accessed by referring to footnote #21.

Emergency shelter has vital roles to play in Housing First approaches to ending homelessness. Shelters must be low-barrier, focus on assessment and triage, and intentionally link to permanent housing resources so that people move through to housing quickly — this is **Housing First** at its best. Some shelters start this shift by targeting/prioritizing "long-term stayers," or those that have been in shelters the longest, for permanent housing placements.

When we operate hundreds of individual shelters, transitional housing, and service programs, all targeting different populations, with different screening criteria and models, we create a maze that is impossible to navigate and slows our progress. What if we could deconstruct the complicated emergency shelter, housing, and service system that we have created over the last several decades so that shelter acts as an assessment and triage center to help people quickly get on with their lives?

It is important to step back and look at ways to synchronize up our current resources so that shelter is not a dead end or a distant hope that someone's homelessness will self-resolve. Many are doing this through **coordinated entry** and assessment systems, improving access to the housing and services people need. The questions to ask are: Do those who are living outside and in shelters have direct connections to the community's full array of diversion, rapid re-housing, affordable housing, and supportive housing resources? Or is it pure luck to land on the right referral, have access to all the application forms and the right case manager at the right time, in order to find a safe place to call home?

To strengthen our models of emergency shelter, we must embrace innovation and change. In order to get to better outcomes, some communities have shifted their model from sheltering people overnight (with late entry and early exit) to a model that provides a place for someone to be 24/7. This type of shelter provides a place for people to store belongings, access employment services and healthcare, and quickly move on to permanent housing. When shelter, hygiene centers, storage, food, and other survival services are scattered around town, it may seem preferable to stay in a tent under the freeway with your belongings, your friends, and your pet, then navigate the logistics of finding a place to be during the day.

San Francisco is testing this theory with its **Navigation Center**. They are finding that people who are living in encampments are willing to come inside when shelter is something that both allows you to come as you are and also leads to something better.

We must create many pathways — person-centered pathways — out of homelessness. On the other hand, there will be those who are not interested in moving

inside to shelter, even after consistent outreach. Therefore, shelter should not be the only access point for permanent housing. Someone can be diverted away from entering the shelter system all together. Coordinated outreach teams with diversion funds or flexible dollars to quickly move a person to stability, efficient coordinated entry processes that match them to the right housing intervention, and access to permanent housing resources can also be the answer.

Working with urgency to end homelessness for each person, each family, must be our goal. What works for one person or family will not necessarily work for the next. Creating a coordinated system that operates from the position of a Housing First approach, removing barriers to entry and based on the needs of each individual person and family, is key.

A larger community response must be brought to bear to end homelessness among our neighbors. In expensive housing markets, the lack of units and access to affordable housing contribute to the long timeframes that people remain unhoused — definitely true and absolutely hard. Neighborhoods cannot continue to hold contentious meetings about homelessness in their streets and parks without then stepping up to see what they can do to create solutions — be it via their faith communities, as private landlords renting to people exiting homelessness, as vocal supporters of new housing developments, as volunteers in effective Housing First programs, or through many other ways they can help.

Supported by such a broader community and neighborhood response, shelter can become a more effective and efficient part of a systemic response to prevent and end homelessness, no longer operating as individual or standalone programs, but functioning as part of a coordinated system of programs working together to provide everyone with permanent housing solutions quickly. [25]

[25] Using Shelter Strategically to End Homelessness. U.S. Interagency Coalition for Homeless. Retrieved from https://www.usich.gov/news/using-shelter-strategically-to-end-homelessness/.

ADDENDUM C: Case Studies & Best Practices

Crowne Plaza Hotel Initiative - Indianapolis

The City of Indianapolis, through the Office of Public Health and Safety, launched the Hotel Temporary Housing Program in 2020 to comply with the Marion County Public Health Department's (MCPHD) Public Health Order No. 8, which directs City and County authorities to provide non-congregate housing for individuals experiencing homelessness who are at high risk of the COVID-19 virus.

The Crowne Plaza Hotel located at 2501 South High School Road, Indianapolis, IN, was a Non-Congregate Shelter site for individuals experiencing homelessness. Those individuals had been matched to a permanent housing program through the Coordinated Entry System and needed a safe place to stay while working through the housing process. Individuals must be verified as meeting high-risk status for COVID-19 either through age or health conditions listed in the Marion County Public Health Order.

The shelter operated from May 2020 to September 2021, on a 24/7 basis. An additional location was operated by the Marion County Public Health Department at the Wingate by Windham Hotels located at 5797 Rockville Rd, Indianapolis, IN.

Program
In this 240-bed short-term program, participants completed their CES and housing assessment with a housing stability case manager. Based on the specific needs and challenges, a case manager helped individuals develop a plan to end their housing crisis. The plan includes a path to connect to mainstream resources, increase income when available and connect everyone to a housing opportunity they can sustain.

Project partners included Crowne Plaza Hotels, as laundry, weekly housekeeping, and 24/7 concierge service was provided by hotel staff. Wheeler Mission provided off-site program management, as well as provided on-site services such as meals for program participants as well as on-site security.

Numbers Served
As of August 2021, 160 individuals were housed and living at Crowne Plaza and 89 individuals were housed and living at the Windham location. At the end of the shelter lease, all unhoused individuals will be expected to return to Wheeler Mission Ministries if they have not been matched with an available permanent supportive housing unit. However, as of this writing, it is expected that no participants will return to being homeless. Similar to many other programs across the country, the HomeNow program

is challenged with housing with serious criminal histories and those with active warrants.

Lessons Learned

During the unprecedented 2020 pandemic, the Indianapolis community had a unique opportunity to safely and individual house our most vulnerable chronically homeless neighbors at the Crowne Plaza hotel. During this time, individuals who may normally only make sporadic use of homeless shelter or programming, where engaged in case management and housing navigation opportunities that previously had not been available. Because of the breadth and intensity of housing engagement and case management support, clients were able to combat many of the traditional fears and barriers that go along with ending their chronic homelessness. During this time, program participants are continuously encouraged to opt into case management and housing plan.

The inception and implementation of the *HomeNow Indy* staffing hub began at the Crowne Plaza Hotel Site. As stated on the Indy CoC website, *(HomeNow Indy — Indy CoC)* this initiative and community-driven program is working to connect individuals and families experiencing homelessness in Indianapolis, with rental assistance and services that will help them find housing and ***stay housed*** long-term. Created in response to the public health crisis caused by COVID-19, *HomeNow Indy* will address homelessness among individuals at highest risk for COVID-19. The program will utilize more than $7 million in CARES Act funding to house 500 households at high risk for COVID-19 by the end of 2021.

The collaborative and strategic effort is being led by Merchants Affordable Housing Corp., in partnership with the City of Indianapolis, CHIP, and Glick Philanthropies and aligns with Indianapolis' Five-Year Community Plan to End Homelessness

The program is designed to quickly house those experiencing homelessness using three key strategies: 1) housing, 2) rental assistance and 3) connections to services, including employment, to provide long-term solutions to homelessness.

Individuals targeted for this initiative may be residing in shelters (including the non-congregate shelters) or on the street, and they will be assessed for eligibility prior to entry.

LTHC | Fighting Tippecanoe County's Housing Crisis

Homelessness in the Greater Lafayette Area

LTHC Homeless Services started in 1989 by serving five homeless families. At that time, they offered six-month transitional apartments and there was no day shelter. Today the LTHC has evolved to help not only families but veterans and individuals to find permanent housing and manages a day shelter. They offer a variety of homeless prevention services that include assessments and case management, rapid re-housing, permanent supportive housing, services for veterans and engagement center. LTHC also serves as the coordinated entry point for Greater Lafayette area.

The housing wage in Greater Lafayette is the fifth highest in the state of Indiana. Combine this with our guests' lack of a safety net if they lose their job, and it's understandable why there's a housing crisis here. Along with financial issues, guests may struggle with addiction, physical health issues, or mental illness. These circumstances make it difficult to survive everyday life and find stability.

In 2012, LTHC CEO Jennifer Layton and her team brought in staff from CSH (formerly, Corporation for Supportive Housing) for a realistic community conversation around homelessness in Lafayette. After several hard discussions and realizing that something new needed to be done, LTHC shifted all Transitional Housing programing to Permanent Supportive Housing. There was a paradigm shift within the community that transitioned mindsets from managing homelessness to ending homelessness. Additionally, instead of selecting designated populations to "win the housing lottery," LTHC shifted from working with targeted populations to focusing on getting housing for everyone.

When meeting with Jennifer and her team, she clearly states, "We know our role. LTHC is not here to end poverty, but we can get everyone into shelter."

In addition to moving transitional housing to permanent housing, LTHC recognized the need to also create and operate a one-stop-shop solution for anyone that needed shelter and basic needs, an Engagement Center with a low-barrier shelter and temporary housing space. The Engagement Center facility opened on January 20,2020. In February 2020, one month before the pandemic, programing began, and the doors have been open since.

Homeless Services Program (HSP): Guests complete their assessment with a housing stability case manager and provide all resources and referrals based on specific needs and challenges. A case manager can help individuals, families, or veterans develop a

unique plan toward ending their housing crisis. These plans will include ways to increase income, connect to mainstream resources, and find a sustainable housing opportunity. Case managers will first try to divert or prevent all guests from becoming homeless with referrals to other resources. When that is not an option, the help the guests enroll in HSP and get connected with the services available at the Day Resource Center.

Rapid Re-Housing (RRH): Rapid Re-Housing (RRH) provides case management and financial assistance for families and individuals who are residing in shelters or other locations not meant for human habitation. LTHC also has a housing specialist who works to connect families and individuals with private landlords. In 2018, over 40 landlords partnered with LTHC to help guests quickly get back on their feet and back into housing.

Services for Veteran Families (SVF): A program specifically designed to provide housing resources for veterans and their families. The goal of this program is to help low-income veteran families achieve housing stability and have access to helpful services. SVF serves veteran families who live in Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, and White counties. To qualify, a guest must be a veteran, or a family member of a veteran; have low income; and be homeless or at risk of homelessness. SVF case managers will then help guests develop a personalized housing plan. Guests and case managers can work with landlords to find an affordable housing solution. Veteran families may also qualify to receive temporary financial assistance for housing stability.

Engagement Center: LTHC Homeless Services offers diversion, intake, and other services at the Engagement Center to help anyone experiencing homelessness stay as comfortable as possible while they explore housing opportunities. If a case manager can’t immediately divert a guest out of homelessness, the Engagement Center is available for those who need extra time and services to end their housing crisis once and for all.

Permanent Supportive Housing: Permanent Supportive Housing (PSH) through LTHC Homeless Services combines affordable housing and on-site case management to help our guests live more stable, productive lives. PSH is our most intensive service for guests who are chronically homeless with complex and long-term barriers to housing. In fact, 100 percent of individuals in PSH have a physical or mental health condition, and 50 percent of PSH families have experienced domestic violence. Because of this, we know that just putting a vulnerable guest in a shelter for a night will only manage their

homelessness. But we want to overcome it. So, we offer PSH units and services to these guests so they can find the safety and stability they might not have otherwise.

Each PSH facility has an onsite case manager to help residents with their housing stability plan and connect them with community resources. Each tenant signs a one-year lease and gets a rental subsidy through the Lafayette Housing Authority. LHTC have four facilities that offer long-term solutions for PSH guests: the Lincoln Center, the Eighth Street Commons, the Family Program, and the Engagement Center.

General Info: October ’17 – September ‘18
1,851 individuals served

1. Average Age: 28.5 yr. old
2. 533 of those were children, 94% increase from previous year
3. 277 families served, 57% increase from previous year

Data October 2017-September 2018

Program	# Of Guests	Housing Outcome	Income Outcome
Rapid Re-Housing	77 out of 78 families completed program	97% obtained housing	81% obtained income
Permanent Supportive Housing	71 adults	16 obtained housing	44% obtained income
Housing	1620 served (1072 adults, 429 children)		

ADDENDUM D: 2001 Updated Shelter Profiles

The following agency profile information was gathered either through interviews conducted via telephone and email or by reviewing agency websites for current data. The following data points were collected from each participating shelter:

- Key referral sources
- Current capacity for clients (bed count during normal operations and during winter contingency)
- Entry assessment questions and procedures
- Ability to participate in Coordinated Entry and HMIS
- Bed utilization rates for daily average and annual rates
- Average length of stay for clients
- Destination(s) at exit
- Funding partners (faith-based, public, private, foundation, etc.)
- Staff structure
- Restrictions or limitations on clients who access shelter (unique rules for entry)
- Other housing services offered (transitional, permanent, etc.)
- Case management services offered and the process to refer to permanent housing projects
- Other stabilization or non-housing services (childcare, employment/education support)
- Organizational definition of client success
- Key barriers to success and to permanent housing
- Key programmatic needs (infrastructure and service)

PROFILE 2021: Children's Bureau Rachel Glick Courage Center

Website: https://www.childrensbureau.org/our-services/residential-care/

Locations: Rachel Glick Courage Center
2115 Central Avenue
Indianapolis IN 46201

Children's Bureau Mission: Preserving families and protecting the future of Indiana's children.

Key Referral Sources: probation, CHOICES, DCS
Bed Count (normal): 18
Bed Count (winter contingency): 18
Participation in Coordinated Entry: Children's Bureau manages
Participation in HMIS: Children's Bureau manages
Average Daily Bed Utilization: 15
Annual Average Bed Utilization: 15
Average Client Length of Stay: 17-21 days
Destinations at Exit: family reunification, foster care, relatives
Funding Partners: Children's Bureau manages (UW, DCS)

Staff Structure/Case Management: Director, Assistant Director, Therapist, Case Manager, Coordinator of Access/Licensing, 4 Team Leaders, and 24 Full/Part Time Teaching Specialists (Direct Care)

Unique Rules for Entry: 8-to-18-year-old kids who have a high level of therapeutic needs

DIAGNOSES: ADHD • Disruptive Behavior • Mood Disorders • Anxiety Disorders • Depressive Disorders • Learning Disabilities

DEVELOPMENTAL: IQ > 70 (based on observation, referral source report, written evaluation when available)

MEDICAL: ambulatory children • common medical conditions (i.e., diabetes, asthma, blood pressure, special dietary needs, etc.

Other Housing Services Offered (transitional or permanent): referrals as appropriate to other agencies/services

Case Management Services Offered (process for referral to permanent housing): Treatment is a combination of the Teaching Family Model, Trauma-Focused Cognitive Behavioral Therapy, Motivational Interviewing and Dialectical Behavioral Therapy to address each youth's individual needs. Youth participate in both individual and group therapy. Courage Center also provides youth with increased access to learning through technology as well as regular on-site creative arts. Youth have access to training and equipment to develop increased independent living skills.

Other Stabilization (non-housing) Services Offered: The Teaching Family model drives daily interactions with youth. It is evidenced based, strength-focused, and optimistic in its approach. The goal is to teach youth to take personal responsibility for developing needed skills and to identify how those skills will benefit them now and in the future. All staff are trained in the Teaching Family model

Definition of Client Success: ability to manage the situation that led the youth to enter the facility; increase in learning and demonstrating pro social.

Key Barriers to Success: working with DCS to find permanent placement for the children.

Key Programmatic Needs (Infrastructure/Service): additional education opportunities

PROFILE 2021: Children's Bureau Children's Shelter at the Gene B Glick Family Support Center

Website: https://www.childrensbureau.org/our-services/residential-care/

Locations: 1575 Dr. Martin Luther King Jr. St.
Indianapolis, IN 46202

Children's Bureau Mission: Preserving families and protecting the future of Indiana's children.

Key Referral Sources: DCS (primary during COVID, respite, hospitals, schools, law enforcement)
Bed Count (normal): 24
Bed Count (winter contingency): same
Participation in Coordinated Entry: yes
Participation in HMIS: yes
Average Daily Bed Utilization: 15-18
Annual Average Bed Utilization: 23-24
Average Client Length of Stay: 20 days
Destinations at Exit: family, foster, group homes, residential
Funding Partners: United Way, DCS, private fundraising

Staff Structure/Case Management: Director, Assistant Director, Case Manager, Coordinator of Access/Licensing, 4 Team Leaders, and 24 Full/Part Time Teaching Specialists (Direct Care)

Unique Rules for Entry: ACCEPTED: Children newborn to 17 years old • Runaway children • Homeless children • Children who are victims of or witness domestic violence • Children who are at risk of abuse or neglect • Children whose parents are experiencing a housing crisis • Children whose parents are experiencing a mental health or medical crisis

NOT ACCEPTED: Children who are: • actively suicidal or homicidal • sexually acting out behaviors that could potentially put other children at risk or require specialized treatment • physically aggressive • in need of medical intervention requiring specialized training and/or equipment • seriously ill or have a contagious disease

Other Housing Services Offered (transitional or permanent): no

Case Management Services Offered (process for referral to permanent housing): extensive case management, referrals to CPCS, there is a CPCS staff person assigned to

Other Stabilization (non-housing) Services Offered: full range of access to social services opportunities

Definition of Client Success: varies by family; ability to maintain a home; decreased utilization of the center

Key Barriers to Success: substance abuse of parents: heroine epidemic (seeing an increase); criminal histories

Key Programmatic Needs (Infrastructure/Service): infrastructure (build another shelter); more education opportunities for parents; housing for families

PROFILE 2021: Children's Bureau Community Partners for Child Safety (Formerly NACS)

Website: www.childrensbureau.org/our-services/cpcs/

Locations: Fay Biccard Family Place
3801 N. Temple Avenue
Indianapolis, IN 46205

Children's Bureau Mission: Preserving families and protecting the future of Indiana's children.

Key Referral Sources
Bed Count (normal): not a sheltering facility – CPCS refers to other shelters
Funding Partners: United Way, DCS, Private Funding

Staff Structure/Case Management: 10-15 cases per case manager

Unique Rules for Entry: Families with children 0-17 years of age that reside in Marion County; Families not actively involved with the Department of Child Services or Healthy Families or the juvenile probation system.

Other Stabilization (non-housing) Services Offered: In-home visitation program; Community Liaisons (case managers) help families develop and meet specific family-centered goals; Liaisons help families discover and connect with local community support and services

PROFILE 2021: Dayspring

Website: http://dayspringindy.org/

Locations: Dayspring Center
P.O. Box 44105
Indianapolis, IN 46244-0105

Mission: "Lovingly meet the needs of homeless families with children and connect them with the resources needed to return them to self-sufficiency."
Motto: "Helping homeless families find their way home"

Key Referral Sources: word of mouth; self-referral/already know about the shelter; calls from 211; other agency partners
Bed Count (normal): 60 beds - 14 rooms; smallest room has 2 beds; 14 families max
Bed Count (winter contingency): Same as above
Participation in Coordinated Entry: Participates in the process but will not be a coordinated entry site. Working with CHIP to find a way for their clients to participate in this process. Shelter has reservations about agreeing to the Coordinated Entry MOU term that it will accept any person at any time.
Participation in HMIS: Yes
Average Daily Bed Utilization: Some beds may be empty due to family size (rooms are designed for families and may have vacant beds based on family size.); Room utilization is 99%.
Annual Average Bed Utilization: same as daily answer
Average Client Length of Stay: 22 days; at times can be closer to 30-40 days
Destinations at Exit: Goal is permanent housing (50-60% rate); others unknown
Funding Partners: Individuals; churches/congregations, foundations, corporate

Staff Structure/Case Management: 2 FTE case managers and 1 PTE case manager; divided by phases - in shelter average of 10; follow up case manager has 4 plus 30-40 cases that are seen between 1- 4 times a month; assessment of children/parenting, etc. connecting with school system, number depends upon children

Unique Rules for Entry: Self-described as low-barriers - no requirement to be married/same sex couples accepted. No screening for mental health, sub abuse, felonies are accepted. Cannot accept sex offenders. Families with children only. Previous violence behavior is reason for exclusion from re-entry to shelter.

Other Housing Services Offered (transitional or permanent): None

Case Management Services Offered (process for referral to permanent housing): Partner with CHIP on housing when they are available; developed stand-alone housing program to work with landlords in community; 60% of families work but earn minimum wage or below and can't afford housing; Working relationship with Center township trustee relationship to provide some access to housing.

Other Stabilization (non-housing) Services Offered: Child development opportunities - assessments/parenting skills; life skill classes on site; financial planning assistance

Definition of Client Success: Continuing to work on the issues that led to homelessness regardless of final location.

Key Barriers to Success: domestic violence, children with behavioral issues; mental health issues; histories of evictions; lack of permanent housing options; lack of basic financial planning skills

Key Programmatic Needs (Infrastructure/Service): Additional funding for supportive services, particularly for clients who do not qualify for permanent housing options.

PROFILE 2021: Family Promise of Greater Indianapolis

Website: http://www.fpgi.org/

Locations: Private apartment model, works with any landlord partner. 6 apartments Newbridge (25th and Keystone) no barrier apartments other than national sex offender barriers bc of school location. 14 apartments Carriage House East, Glick apartments. Will secure another 10 units in a few weeks but plan to move 10 people into permanent units and will be back down to 20.

Starting in September: Will reopen one congregation a night for 20 +4 families a night.

Mission: "We are a partnership of congregations and community organizations responding to the crisis of children and their families who are homeless. We work to eliminate homelessness in Greater Indianapolis."

Key Referral Sources: 2-1-1 (30%); Search Engine (30%); referrals from other agencies (30%); word of mouth (10%)
Bed Count (normal): 100 beds for 12 months per year; (2.5 x apartment)
Bed Count (winter contingency): n/a
Participation in Coordinated Entry: yes
Participation in HMIS: yes
Average Daily Bed Utilization: rooms are designed for families, so bed utilization varies but rooms remain full
Annual Average Bed Utilization: full
Average Client Length of Stay: in HMIS
Destinations at Exit: apartment lease; private housing; PSH; transitional housing; Section 8 **Funding Partners**: congregations, public, individuals, foundations

10 family Diversion Program: staffed with Case Worker MSW, just for families with kids.

Staff Structure/Case Management:1 FTE Case Manager for the shelter (caseload: 8 families); 1 FTE Case Manager for aftercare (caseload: approx. 25 families)

Unique Rules for Entry: At least 1 child under age 18 in family (unborn, dependent over 18+, a child removed by DCS with reunification imminent; not fleeing DV; no registered sex offenders; ability to arrive at the center the day accepted; screen for heavy drug use; willing to consider criminal histories (with no active warrants); accepts same sex families

Other Housing Services Offered (transitional or permanent): option for permanent placement in apartment. Family assistance fund for barrier busters.

Case Management Services Offered (process for referral to permanent housing): case managers provide employment and housing services; offer a family assistance fund (matching rent savings, deposits, childcare, car repairs)

Other Stabilization (non-housing) Services Offered: referrals to Midtown, childcare, HIP nurse practitioner comes weekly to see families, we pay for birth certificates, coordinate child

immunizations with HIP, bus passes, work uniforms, etc. Whatever is needed to get the family going from day 1 when motivation is highest.

Definition of Client Success: Moving out to housing that was the mutual goal of the case manager and the “client.” Could be apartment with income to sustain it. Could be moving in with stable family temporarily while we all wait for the permanent supportive housing unit to open months later. Could be moving to transitional housing if appropriate.

Key Barriers to Success: Medical approvals for PSH (we often use the FSSA Medicaid waiver process instead of the CES PSH process to get permanent housing for adults with developmental or intellectual disabilities, but the process—even expedited—can take 9 months if someone doesn’t already have SSI for their disability b/c of the review process of health evaluations.

Key Programmatic Needs (Infrastructure/Service): N/A

PROFILE 2021: Gennesaret Health Recovery Program for Women

Website: www.gennesaret.org

Location: 2048 S. Meridian Street
Indianapolis, IN 46225

Mission: "For persons experiencing homelessness or lacking established health care, Gennesaret Free Clinics provided quality, accessible and compassionate patient centered healthcare."

Key Referral Sources: Hospitals
Bed Count (normal): 4
Bed Count (winter contingency): 4
Participation in Coordinated Entry: yes
Participation in HMIS: yes
Average Daily Bed Utilization: 100% in summer; varies at other times
Annual Average Bed Utilization: 75-100%
Average Client Length of Stay: Summer: 45 days
Destinations at Exit: Independent living, return to family
Funding Partners: ESG; Per diem with Health/Hospital; philanthropic grants; general donors

Staff Structure/Case Management: Director of HRH, Senior Resident Care Assistant, Nurse Case Manager, 24-hour Resident Care assistants

Unique Rules for Entry: No admission from psychiatric centers or SUD treatment facilities; must be continent; Must be able to manage ADL's, and not have an IV PICC line, Hospital must provide transportation from the hospital to the facility and bring 1-month of medications.

Other Housing Services Offered (transitional or permanent): Case manager assist with housing search

Case Management Services Offered (process for referral to permanent housing): Assistance in locating apartments (maintains good relationship with apartment complexes); assistance in accessing public assistance options

Other Stabilization (non-housing) Services Offered: Enroll clients in supportive services for which they may qualify (SNAP, mental health services, Social Security etc.); employment search; transportation

Definition of Client Success: Ideally: Discharge into stable housing or with family, mental and physical health challenges stabilized

Key Barriers to Success: mental health issues; addictions; lack of family support; criminal history; evictions; no income support

Key Programmatic Needs (Infrastructure/Service): Access to mental health care and SUD treatment. Need an additional facility to house men with long-term recovery needs and or interim housing for those awaiting permanent housing.

PROFILE 2021: Gennesaret Health Recovery Program for Men

Website: www.gennesaret.org

Locations: 2401 Central Avenue
Indianapolis, IN 46205

Mission: "For persons experiencing homelessness or lacking established health care, Gennesaret Free Clinics provided quality, accessible and compassionate patient centered healthcare."

Key Referral Sources: Hospitals **Bed Count (normal):** 8
Bed Count (winter contingency): 8
Participation in Coordinated Entry: yes **Participation in HMIS**: yes
Average Daily Bed Utilization: 100% in summer; varies at other times
Annual Average Bed Utilization: 75-100%
Average Client Length of Stay: Summer: 35 days
Destinations at Exit: Return to family, permanent housing
Funding Partners: ESG; Per diem with Health/Hospital; philanthropic grants; general donors

Staff Structure/Case Management: Director of HRH, Senior Resident Care Assistant, Nurse Case Manager, 24-hour Resident Care assistants

Unique Rules for Entry: No admission from psychiatric centers or SUD treatment facilities; must be continent; Must be able to manage ADL's, and not have an IV PICC line, Hospital must provide transportation from the hospital to the facility and bring 1-month of medications. No registered sex offenders.

Other Housing Services Offered (transitional or permanent): Case manager assist with housing search

Case Management Services Offered (process for referral to permanent housing): Assistance in locating an apartment (maintains good relationship with apartment complexes); assistance in accessing public assistance options

Other Stabilization (non-housing) Services Offered: Group counseling sessions; Enroll clients in supportive services for which they may qualify (SNAP, mental health services, Social Security etc.); employment search; transportation

Key Barriers to Success: Mental health issues; addictions; lack of family support; criminal history; evictions; no income support

Key Programmatic Needs (Infrastructure/Service): Access to mental health care and SUD treatment. Need an additional facility to house men with long-term recovery needs and or interim housing for those awaiting permanent housing.

PROFILE 2021: Good News Ministries Men's Shelter

Website: http://goodnewsministries.com/shelter-for-men/

Locations: 2716 E. Washington St.
Indianapolis, IN 46201

Mission: "Good News Mission is in the business of rebuilding broken lives."

Key Referral Sources: word of mouth
Bed Count (normal): 88
Bed Count (winter contingency): 128
Participation in Coordinated Entry: no
Participation in HMIS: no
Average Daily Bed Utilization: full most of the time
Annual Average Bed Utilization: full
Average Client Length of Stay: no limit, some stay for years, average for months
Destinations at Exit: Wheeler when they no longer want to work, places where they do not have to work, some limited permanent transitional house
Funding Partners: all funding from regional archdiocese

Staff Structure/Case Management: 1 director & 1 assistant cover all the hours and all the clients; one client manager helps in the evenings; 1 full time evening

Unique Rules for Entry: conviction of child molestation; won't turn them away for drug/alcohol use; will allow them to stay as an emergency guest for the night and then talk to them in the morning

Other Housing Services Offered (transitional or permanent): 4 permanent housing units

Case Management Services Offered (process for referral to permanent housing): Do "a little" but "not enough to talk about;" The focus is to provide them with faith-based counseling, etc.

Other Stabilization (non-housing) Services Offered: not

Definition of Client Success: Ability to function in society; training for a permanent career

Key Barriers to Success: self-motivation; making changes in their way of thinking

Key Programmatic Needs (Infrastructure/Service): due to a fire in late 2018, the facility suffered a significant amount of fire and smoke damage. This led to several facility upgrades and space reconfiguration for the men's shelter.

PROFILE 2021: Holy Family Emergency Shelter

Website: www.holyfamilyshelter.net

Locations: 907 N. Holmes Avenue
Indianapolis, IN 46222

Mission: "Helping Homeless Families Help Themselves"

Key Referral Sources: 211, other families, self
Bed Count (normal): 22 total rooms available for families
Bed Count (winter contingency): same
Participation in Coordinated Entry: yes
Participation in HMIS: yes
Average Daily Bed Utilization: rooms usually 100% full
Annual Average Bed Utilization: same
Average Client Length of Stay: 45 days
Destinations at Exit: usually rental housing paid by families
Funding Partners: United Way of Central Indiana, Emergency Food & Shelter Program, Summer Youth Program Funding,

Staff Structure/Case Management: director, case manager, shift supervisors, custodial staff, volunteer coordinator, kitchen manager

Unique Rules for Entry: 20-minute phone intake screening followed by in-person screening process; IDs for each family member requested; Family defined as: (1) married couple with/without children, (2) single parent with children, or (3) single pregnant female

Other Housing Services Offered (transitional or permanent): transitional housing services offered; families have access to onsite shelter facility services once they are placed in transitional or permanent housing

Case Management Services Offered (process for referral to permanent housing): comprehensive case management services offered based on the families' individual needs

Other Stabilization (non-housing) Services Offered: education-assistance, childcare assistance & children's services, job placement, healthcare (onsite medical clinic), life skills,

Definition of Client Success: engagement in case management services to address the issues that led to the homelessness; stable/permanent housing

Key Barriers to Success: lack of childcare options, criminal backgrounds/records, poor credit with evictions on record, severe lack of affordable housing and support services for homeless families requiring 3, 4,and 5 bedrooms.

Key Programmatic Needs (Infrastructure/Service): ongoing operations funding, supportive service funds, capital funding

PROFILE 2021: HVAF – Helping Veterans and Families

Website: http://www.hvafofindiana.org/

Location: 964 N. Pennsylvania Street
Indianapolis, IN 46204

Mission: HVAF of Indiana houses, supports, and advocates for all veterans and their families to help them achieve the best possible quality of life.

Key Referral Sources: Coordinated Entry System
Bed Count (normal): 121 transitional housing beds
Bed Count (winter contingency): Not Applicable
Participation in Coordinated Entry: Yes – Access point for veterans
Participation in HMIS: Yes
Average Daily Bed Utilization: 82% over past year
Annual Average Bed Utilization: 82% over past year
Average Client Length of Stay: 6 - 9 months
Destinations at Exit: At least 80% move into permanent housing
Funding Partners: Primarily VA funding (SSVF and GPD); State and City grants (TBRA and ESG); UWCI funding; Private donations

Staff Structure/Case Management: 45-50 FTE consists of case managers, employment specialists, housing specialists, and peer mentors

Unique Rules for Entry: Veterans

Other Housing Services Offered (transitional or permanent): Transitional housing, Rapid rehousing, and Permanent supportive housing

Case Management Services Offered (process for referral to permanent housing):
Case management includes proper referrals and connections with all programs and services

Other Stabilization (non-housing) Services Offered: Veterans Workforce Development (employment services, 11 FTE); Pantry consisting of food, clothing, and hygiene

Definition of Client Success: Permanent Housing; Income; Employment

Key Barriers to Success: Lack of housing subsidies; Disability claims processing time; Criminal backgrounds; Mental health; Substance abuse

Key Programmatic Needs (Infrastructure/Service): Reliable transportation

PROFILE 2021: Julian Center

Website: http://www.juliancenter.org/

Locations: 2011 N. Meridian St.
Indianapolis, IN 46202

Mission: "Working Today for a Safer Tomorrow"

Key Referral Sources: Crisis line advertised on website, print and partners - majority; word of mouth; 211; other partners (Centers for Hope); IMPD; hospitals; refer to each other in DV network
Bed Count (normal): 96 beds in units.
Bed Count (winter contingency): same
Participation in Coordinated Entry: yes; will be access point; have staff trained as navigators; key partner in this effort and involved from beginning
Participation in HMIS: yes for HMIS in perm supportive housing program but no for shelter
Average Daily Bed Utilization: 87% - 100%
Annual Average Bed Utilization: 98%
Average Client Length of Stay: 50-60 nights
Destinations at Exit: Permanent Housing, Temporary Destinations; Institutional Settings; Other
Funding Partners: VOCA/HUD Public - majority of public; lots of foundation support; UWCI

Staff Structure/Case Management: In shelter: 5 total FT case managers; case load ranges from 9-13 families (usually at max). Also have housing advocates that will help support clients.

Unique Rules for Entry: screen for DV abusers; must be DV/sexual assault victim; screen for Baker 1 and sex offender; do not disqualify for mental illness or addiction or DCS engagement. Will admit a retaliatory victim who has charges pending. Will admit if someone is intoxicated but they must stop using.

Other Housing Services Offered (transitional or permanent): 71 permanent supportive housing units (23 designated for COC funding and an additional 4 self-funded; transitional housing currently (average stay of 9 months) - rapid rehousing in apartments offered - 34 North also have a section 8 project based

Case Management Services Offered (process for referral to permanent housing): internal and external referral process; COC and VOCA funds at 34 North; COC portion still submit apps to main COC pool (will become coordinated entry 23 units). VOCA is internal referral - decisions are made internal (mostly from JC clients, also will get CP clients applying); mental health services on site (variety of therapists); legal support; all advocates have access to training to complete other public supports

Other Stabilization (non-housing) Services Offered: employment services; financial planning; life skills; self-sufficiency coaching. Referrals to community partners for childcare; respite services; children's programming

Definition of Client Success: Individually driven/client based

Key Barriers to Success: substance abuse; mental health issues; issues related to abuse

Key Programmatic Needs (Infrastructure/Service): not enough in-house therapy due to financial constraint; not enough of quality, safe affordable housing available - not just unique to JC but across the city; access to support for mental health/addictions services.

PROFILE 2021: Queen of Peace

NOTE: Currently incomplete due to temporary closure of the shelter. Information below was gathered from Connect2Help.

Website: none

Locations: 2424 East 10th Street
Indianapolis, IN 46201

Mission:

Key Referral Sources:
Bed Count (normal):
Bed Count (winter contingency):
Participation in Coordinated Entry: no
Participation in HMIS: no
Average Daily Bed Utilization:
Annual Average Bed Utilization:
Average Client Length of Stay: 3 weeks
Destinations at Exit:
Funding Partners:

Staff Structure/Case Management:

Unique Rules for Entry: Only accepts single women with or without children; boy children are only permitted if they are under 5; pregnant women must be more than 2 months pregnant; must go through a phone screen; drug test may be required if drug use is suspected; must be able to climb stairs; must be willing to turn in cell phone to staff during night hours

Other Housing Services Offered (transitional or permanent):

Case Management Services Offered (process for referral to permanent housing):

Other Stabilization (non-housing) Services Offered:

Definition of Client Success:

Key Barriers to Success:

Key Programmatic Needs (Infrastructure/Service):

PROFILE 2021: Salvation Army Ruth Lilly Women & Children's Center

Website: http://salvationarmyindiana.org/need-help/ruth-lilly-women-and-childrens-center-2/

Locations: 540 N. Alabama St.
Indianapolis, IN 46202

Mission: "Doing the Most Good"

Key Referral Sources: walk in; word of mouth; referrals from churches, other social service agencies
Bed Count (normal): 111 beds; emergency bed space program (can go as high as 20 additional beds for people fleeing violent situation) - try to move them to shelter space or other partners for traditional beds
Bed Count (winter contingency): considered shelter for last resort - they typically use those beds for DV but will take people in Winter.
Participation in Coordinated Entry: yes
Participation in HMIS: yes
Average Daily Bed Utilization: 100% - the mild winter there were some beds open but quickly fill up
Annual Average Bed Utilization: 100% for most of the time; rooms are occupied but there may be beds open due to mismatch of family size and # of beds in rooms
Average Client Length of Stay: 2.5 mo. - 5 months
Destinations at Exit: most are going to independent private housing

Funding Partners: Ind. Criminal Just Inst; UWCI; Salvation Army City Fund (internal individual gifts)

Staff Structure/Case Management: 4 FTE case managers; plus 1 Lead Case managers; 2025 cases per case mgr.

Unique Rules for Entry: must present there is a homeless situation; victim of violence; will accept men with children who is victim of violence; will also accept LGBTQ who is victim of violence. Past behavior problems will bar them. Everything is a choice for clients (support groups, pastoral care, etc.); will accept clients with active intoxication but ambulance is called, and they are sent to ER.

Other Housing Services Offered (transitional or permanent): have three projects but they for certain populations due to the funding source

Case Management Services Offered (process for referral to permanent housing): when funds are available, they will help with deposits; first month rent etc.; have list of landlords and work with HIP navigators to help find housing for families.

Other Stabilization (non-housing) Services Offered: have children's services - work with them on education and medical needs for children and family. Advocate at schools for children; provide summer camp for kids; part of BPSOP (street outreach); do follow up case mgr. even after they are out of shelter.

Definition of Client Success: it varies per individual - funding applications dictate this - client defined.

Key Barriers to Success: mental health, trauma, and addictions; issue is keeping individuals housed; need support services to keep them perm housed.

Key Programmatic Needs (Infrastructure/Service): Mental Health wait list for services; funding beyond emergency care to provide the direct service (case mgr. and ongoing supportive services)

PROFILE 2021: Shepherd's Pathway

Website: http://shepherdspathway.com/

Locations: 5353 Raymond Street
Indianapolis, IN 46203

Mission: "Take time and pray."
"Giving a hand-up, not a hand-out."

Key Referral Sources: word of mouth; congregations
Bed Count (normal): 175
Bed Count (winter contingency): 450 (space in building is flexible; this is not a formal number)
Participation in Coordinated Entry: no
Participation in HMIS: no
Average Daily Bed Utilization: 110
Annual Average Bed Utilization: 110
Average Client Length of Stay: 2 months; no maximum length of stay
Destinations at Exit: varies; apartments; family; transitional housing
Funding Partners: no government assistance; fully funded by congregations

Staff Structure/Case Management: Informal structure; utilize volunteers primarily; utilize the staff and coaching opportunities for staff as learning opportunities

Unique Rules for Entry: Houses men, women, and children and families. Faith-based Christian nondenominational program. Does not accept registered sex offenders (previously had a separate facility); Will not accept individuals who will not participate in the work programs.

Other Housing Services Offered (transitional or permanent): none

Case Management Services Offered (process for referral to permanent housing): individual based on pastors and congregation volunteers

Other Stabilization (non-housing) Services Offered: none currently (have in past)

Definition of Client Success: breaking the cycle of homelessness; applying the Biblical principle of the classes to become successful; being responsible; being accountable; following directions; taking responsibility for yourself.

Key Barriers to Success: personal issues such as anger, addictions, criminal histories, domestic violence; varies

Key Programmatic Needs (Infrastructure/Service): equipment for the on-site job programs; facility upgrades

PROFILE 2021: VOA Contract Emergency Residential Services (Brandon Hall)

Website: www.voain.org

Location: Brandon Hall
611 N. Capital Avenue
Indianapolis, IN 46204

Mission: "Offer Hope, Restore Dignity, & Transform Lives"

Key Referral Sources: word of mouth, VA, Veterans Outreach Team, CHIP, others
Bed Count (normal): 24 Healthcare for Homeless VA Contract–
Bed Count (winter contingency): 24
Participation in Coordinated Entry: yes
Participation in HMIS: yes
Average Daily Bed Utilization: 100%
Annual Average Bed Utilization: 100%
Average Client Length of Stay: 5 to 6 months (program is 6 months max)
Destinations at Exit: primarily permanent housing due to SSVF, some to friends & family
Funding Partners: 100% Department of Veterans Affairs

Staff Structure/Case Management: 2 FTE case managers - 1 FTE program coordinator; 1 to 15 case-load per person

Unique Rules for Entry: must be a veteran with at least one day of active duty; history of mental health and substance abuse; must check eligibility with VA; operate on housing first model; felony convictions accepted, meet HUD definition of homeless.

Other Housing Services Offered (transitional or permanent): SSVF (covers deposits, etc.)

Case Management Services Offered (process for referral to permanent housing):
Maintains a group of landlords - SSVF helps establish landlord relationships -
Case managers staff the residences and work with landlords. Provide the landlord with expectations from all parties. Case Mgr. must go out and see the residence to inspect.

Other Stabilization (non-housing) Services Offered: link all residents to employment; SSVF provides supports; money management and budgeting assistance; nutrition workshops; social worker to organize other life skills; substance abuse groups NA, etc.

Definition of Client Success: Clients are assessed individually upon entry and evaluated every 90 days. Stable housing and income are considered.

Key Barriers to Success: Felony convictions; sex offender registry; literacy; substance abuse; mental health

Key Programmatic Needs (Infrastructure/Service): need better location of transitional housing (prefer stand-alone facility); locating housing for sex offenders; lack of resources for recreational/physical activities

PROFILE 2021: Wheeler Shelter for Men

Website: https://wheelermission.org/our-work/mens-services/

Locations: Shelter for Men (520 E. Market St., Indianapolis, IN 46204)
Men's Residential Center (245 N. Delaware St., Indianapolis, IN 46204)

Mission: "We provide Christ-centered programs and services for the homeless and those in need. Our services take a holistic approach to our local homelessness community by providing physical, mental, emotional and spiritual help."

Key Referral Sources: citywide; jails; probation departments; word of mouth; out of town
Bed Count (normal): 225-245; actual 200; 32 over-flow
Bed Count (winter contingency): average 2016-17: 375
Participation in Coordinated Entry: yes
Participation in HMIS: no
Average Daily Bed Utilization: 100%
Annual Average Bed Utilization: Always Full
Average Client Length of Stay: Summer: 10-14 Days; Winter: 3-4 Months
Destinations at Exit: 15% enter stable housing
Funding Partners: Primarily Individuals

Staff Structure/Case Management: 4 full-time case managers

Unique Rules for Entry: 1) On non-winter nights, entry is denied if the person is intoxicated; 2) no guns; 3) no families/women/men only 4) no one underage of 18; Limit of 10 consecutive nights/month

Other Housing Services Offered (transitional or permanent): Transitional housing program; addiction recovery program for 9 months; have STEPS program – once STEPS are completed, referrals can be made through the ACTS program

Case Management Services Offered (process for referral to permanent housing): Primarily refer to the VA, Adult & Child, and Horizon House

Other Stabilization (non-housing) Services Offered: Work Outreach; legal clinic; referrals for GED (Boner Center for example)

Definition of Client Success: Participation in a rehabilitative program or stable income or housing.

Key Barriers to Success: Drug and alcohol addiction; criminal record; poor rental history; lack of income

Key Programmatic Needs (Infrastructure/Service): Need additional staff to deliver services. Case Managers have an average client load of 50.

PROFILE 2021: Wheeler Center for Women and Children

Website: https://wheelermission.org/our-work/womens-services/

Location: 3208 E. Michigan St.
Indianapolis, IN 46201

Mission: "We provide Christ-centered programs and services for the homeless and those in need"

Key Referral Sources: self-referrals, outreach teams, IMPD, provider referrals
Bed Count (normal): 267 beds total: 67 are emergency shelter beds single women; 120 beds (30 units) for women with children; 80 transitional beds for women without children 6-12 months.
Bed Count (winter contingency): 100 additional beds
Participation in Coordinated Entry: yes
Participation in HMIS: no but works with CHIP on data dissemination
Average Daily Bed Utilization: 100%
Annual Average Bed Utilization: 100%
Average Client Length of Stay: Varies by program; ESS = 30 days, Transition Programs 3-8 mos.
Destinations at Exit: permanent housing
Funding Partners: primarily private; congregations/churches

Staff Structure/Case Management: Staff ratio is approximately 1:10 with case management/program assistant staff

Unique Rules for Entry: emergency very low-barrier; admit substance impaired but cannot continue to use; Variety of transitional programs available that vary with level of restriction i.e., willingness to return each evening by curfew, willingness to not use illegal substances; Higher Ground Addiction Recovery Program is a substance free non- smoking program where participants don't have the ability to be employed and the use of some medications is restricted

Other Housing Services Offered (transitional or permanent): see transitional housing info; no permanent housing

Case Management Services Offered: Yes, with other services provided by community partners

Other Stabilization (non-housing) Services Offered: life skills classes, internships, social enterprise participation, mentoring, group counseling, access to individual counseling, spiritual and social support

Definition of Client Success: Safe and affordable housing, sustainable income, improved social/community supports

Key Barriers to Success: safe and affordable housing access; severe mental health concerns; unaddressed addiction issues; appropriate elder care options

Key Programmatic Needs (Infrastructure/Service):consistent access to housing, mental health, physical health resources; affordable options for staff development to promote ongoing best practice