Best, Promising and Emerging Practices to End Homelessness

Purpose and Definition

This document provides a sample listing of best, promising and emerging practices to inform and provide guidance in planning, developing and implementing homeless programs and systems. It is important to note that best practice often changes over time but is based on what has been documented to be effective to date. A **Best Practice** is an intervention, method or technique that has consistently been proven effective through the most rigorous scientific research (especially conducted by independent researchers) and which has been replicated across several cases or examples. An intervention is considered to be a **Promising Practice** when there is sufficient evidence to claim that the practice is proven effective at achieving a specific aim or outcome, consistent with the goals and objectives of the activity or program. **Emerging practices** are interventions that are new, innovative and which hold promise based on some level of evidence of effectiveness or change that is not research-based and/or sufficient to be deemed a 'promising' or 'best' practice.

A variety of sources informed the choice of practices including research conducted by ECONorthwest for the OHCS Housing State Plan; briefs and conference presentations/materials from the U.S Department of Housing and Urban Development, U.S. Department of Health & Human Services, U.S. Interagency Council of Homelessness, U.S. Dept. of Veterans Affairs, and National Alliance to End Homelessness; conversations and materials collected from other states and communities that have ended Veteran homelessness (i.e. Virginia, Connecticut, Delaware, Multnomah County), and published research or studies from sources that included SAMHSA (Substance Abuse and Mental Health Services Administration), Center for Social Innovation, and Homeless Hub. Selection of practices was also informed by the work of our CAA grantees, partners and Continuums of Care who are currently implementing best, promising and emerging practices.

System Best, Promising, Emerging Practice

Housing First

The Housing First model encourages clients to create and implement their own goals while immediately housing clients with no preconditions (except complying with a standard lease agreement). Research has shown that Housing First programs increase housing stability for clients served, are cost effective compared to traditional services that impose sobriety perquisites to housing and increase client utilization of other services.
https://endhomelessness.org/resource/housing-first/
http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf
https://www.usich.gov/solutions/housing/housing-first/

Rapid Rehousing

Rapid re-housing is another intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Permanent housing is provided without or minimal preconditions and services tailored to the unique needs of each individual household.
https://www.usich.gov/solutions/housing/rapid-re-housing/
https://www.hudexchange.info/resources/documents/Rapid-Re-Housing-Brief.pdf

Diversion

Diversion assists households in finding housing outside of an emergency shelter while providing services to stabilize their housing or help them move into permanent housing. As a result, this best practices strategy helps individuals who are seeking shelter to identify immediate alternate housing arrangements.
https://endhomelessness.org/the-three-cs-of-diversion/
https://www.usich.gov/tools-for-action/closing-the-front-door/

By Name Lists

The use of by name lists for homeless veterans and chronically homeless individuals allows providers to track and regularly review the list and focus on intervention strategies that enable service providers to find housing more quickly. It also provides real time progress of those on the list as well as system progress in functionally ending homelessness.
https://www.community.solutions/name-list-recommendations-practice

Coordinated Entry and Assessment

Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have a single or coordinated point of entry and equal access to the homeless delivery system. This type of entry allows homeless and at-risk of homeless to be quickly identified, assessed for, referred, and connected to the appropriate housing and assistance. It also facilitates the ability to prioritize the most vulnerable individuals and households for housing.
https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

Low and No Barrier Policies

Low and no barrier policies allow homeless individuals and households to access shelter, housing and services without preconditions such as sobriety, compliance with treatment plans, no pets, or agreement to participate in specific programs, activities or classes. These policies allow the most in need to have access to shelter and housing.
https://www.usich.gov/resources/uploads/asset_library/emergency-shelter-key-considerations.pdf

Targeted, Performance-Based Contracting

Federal and state funders are increasingly implementing performance-based initiatives as a means of distributing funds and increasing accountability for not only delivered services but the results of those services. Incorporating performance measures into the contracting process gives service providers more flexibility in the delivery of services, provides data to help discern what interventions are working, and can transform homeless systems to be meet system-wide needs, be person-centered, evidence-based and racially equitable.
https://govlab.hks.harvard.edu/files/siblab/files/seattle_rdc_policy_brief_final.pdf
https://www.nigp.org/docs/default-source/New-Site/global-best-practices/performancebased.pdf?sfvrsn=4

Pay for Success (PFS) Contracting

Pay for Success is an innovative contracting model that drives government resources toward high-performing social programs. PFS contracts track program effectiveness over time to ensure that funding is invested in effective service delivery through documented, measurable improvement in the lives of the intended individuals and communities. This model entails private funders (foundations, banks, businesses, etc.) to provide upfront funding to a high-performing service provider who is serving a government targeted population. The service provider delivers services to reach or exceed predetermined outcomes for success. Outcomes are rigorously measured to ensure that the service provider has achieved the desired impact. Government repays the initial

investment made by the private funders only when the service/program successfully achieves the desired outcomes.
https://www.thirdsectorcap.org/what-is-pay-for-success/ .

Targeting

Targeting individuals and families and providing only what homelessness prevention assistance is absolutely necessary to stabilize housing for the critical time is a core best practice. Targeting is based on local HMIS or other data, or risk factors used by similar communities. The shorter and more limited an intervention, the more households a program can serve.

In many communities, the supportive housing opportunities that have been created have unfortunately not been well targeted. In fact, national data shows that only about 29% of existing supportive housing is targeted to individuals experiencing chronic homelessness. The impact of existing supportive housing can be maximized by targeting and prioritizing individuals experiencing chronic homelessness for any newly created units, and for any units that become available through turnover.

Targeting in conjunction with established ambitious monthly, quarterly, or 100-day housing placement efforts break down the larger goal of ending homelessness into focused blocks of time and effort for a single subpopulation, while pushing systems to perform with maximum efficiency and better outcomes. The majority of states and local communities who have functionally ended homelessness identified a specific target population, frequently veteran or chronic homelessness, in alignment with national targeting goals.
https://www.mayorsinnovation.org/images/uploads/pdf/Homelessness_Prevention_-_Key_Principles_and_Best_Practices.pdf

Service Integration

Service Integration comes in different theoretical frameworks (Collective Impact, Wraparound Services, System of Care, etc.) but share the common elements of people-centered, collaborative partnerships, and intentional infrastructure. Service integration is particularly relevant for populations whose needs span multiple systems, i.e. health, housing, disability, employment. Homeless populations are best served through a service integration approach that involves a variety of sectors including criminal justice, child welfare, health care, education, housing and homelessness services. To establish and sustain a service integration approach, research suggests that successful collaborative partnerships require thoughtful strategy and support by a sturdy infrastructure.
https://www.hudexchange.info/resource/3257/improving-homeless-access-to-mainstream-benefits-and-services/
https://www.collaborationforimpact.com/collective-impact/
https://nwi.pdx.edu/NWI-book/Chapters/Bruns-5a.2-(implementation-essentials).pdf

Homeless System Governance and Infrastructure

Successful system infrastructures targeted to homeless include state interagency councils on homelessness, regional continuums of care and cross-departmental partnership agreements. States are uniquely positioned to be a convening partner for statewide planning and shared goal attainment in reducing and ending homelessness. Several states of relied on the state-level Interagency Council on Homelessness model to provide leadership and alignment of multiple regional and local homeless initiatives and efforts.
https://www.usich.gov/resources/uploads/asset_library/Guide-Developing-State-ICH.pdf
https://www.tn.gov/behavioral-health/mental-health-services/housing---homeless-services/housing---homeless-services/tennessee-state-plan-to-end-homelessness.html
http://www.cceh.org/about/history-successes/

https://www.mass.gov/orgs/interagency-council-on-housing-and-homelessness

Supporting Partnerships for Anti-Racist Communities (SPARC)

SPARC is an initiative of the Center for Social Innovation an entity who partners with HUD to identify and promote homeless and housing evidence-based practices through organizational consultation, and training and technical assistance to homeless services providers. The first phase of the SPARC Initiative involved a study conducted in six communities to determine the rates of homelessness for people of color, identify the pathways into homelessness and experiences of people of color within the homelessness response system and barriers to exiting homelessness. The study confirmed that racial inequity exists in homelessness and identified multiple organizational change, research, policy and individual recommendations to address this inequity. A detailed list of these recommendations and the study research can be accessed http://center4si.com/sparc/ . Information regarding Portland's involvement in the SPARC Initiative can be accessed at http://ahomeforeveryone.net/sparc/ .

Permanent Supportive Housing (PSH)

Permanent Supportive Housing is a proven intervention to address long-term homelessness by combining affordable housing assistance with voluntary support services. Services are designed to stabilize chronic homeless people through connection with needed services (i.e. treatment, health care, employment, income subsidies, community support, etc.). Studies have shown that PSH not only ends a person's homelessness but also can improve health and well-being.
https://endhomelessness.org/ending-homelessness/solutions/permanent-supportive-housing/

Permanent Housing Homeless Preferences

Housing choice vouchers, public housing, private multifamily housing units, and other affordable housing resources are key to preventing and ending homelessness. Setting aside housing units for homeless households, prioritizing homeless populations to receive housing subsidies and creating landlord incentives for housing homeless people are successful practices to expand access to stable housing. HUD has identified seven planning and implementation steps to provide more housing opportunities for homeless households: 1. Create a multifamily planning and implementation team;
2. Examine and understand the community needs and multifamily resources; 3. Identify and engage service providers; 4. Engage multifamily property owners 5. Formalize agreements between service providers and owners; 6. Support owners' implementation of a homeless preference and; 7. Refine the process.
https://endhomelessness.org/ending-homelessness/solutions/permanent-supportive-housing/
https://www.hudexchange.info/resources/documents/Opening-Doors-Through-Multifamily-Housing-Toolkit-for-Implementing-a-Homeless-Preference.pdf
https://www.oregon.gov/ohcs/Pages/supportive-housing-workgroup.aspx

Frequent Users Systems Engagement (FUSE)

FUSE (Frequent Users Systems Engagement) is a proven model identifying frequent users of jails, shelters, hospitals and/or other crisis public services and then improving their lives through supportive housing. Supportive housing is an evidence-based solution that leads to better health and other good outcomes for people homeless and disabled. Tenants are provided affordable housing with wraparound support services, which stabilizes their lives and significantly reduces returns to jail and homelessness, reliance on emergency health services, and improves overall quality of life.
https://www.csh.org/fuse/
http://www.sheltercare.org/2017/08/community-partnerships-are-central-to-fuse-sucess/

Rural Homelessness

The U.S Interagency Council on Homelessness convened multiple states (did not include Oregon) in September 2017 to share and discuss rural strategies for ending homelessness. This convening along with the assistance of Collaborative Solutions (national training/TA entity in supportive housing systems) developed a report that contains promising practices and considerations in developing systems to end rural homelessness. Several practices were identified in the report including: innovative leadership and governance that includes a regional approach, leadership "pipeline"/development, outsourcing to build capacity; leveraging poverty mainstream systems and resources including strengthening partnerships with faith-based partners; development of rural outreach and engagement practices including utilization of nontraditional community partners; development of coordinated entry across large geographies that may include multisite centralized access, assessment hotline, and robust network of referral sources; and creative ways to provide crisis housing (motels, churches, etc.).
https://www.usich.gov/resources/uploads/asset_library/Strengthening-Systems-for-Ending-Rural-Homelessness.pdf

Two-Generation Model

Two-generation models target low-income children and parents from the same families in hopes of interrupting the cycle of poverty. This approach focuses on creating opportunities for and addressing needs of both children and the adults in their lives together. Outcomes are identified and tracked for both children and adults simultaneously. There are five key components to this approach: postsecondary education and employment; early childhood education and development; economic assets; health and well-being; and social capital.
http://ascend.aspeninstitute.org/two-generation/what-is-2gen/
https://www.urban.org/research/publication/theoretical-framework-two-generation-models

Client Service Best, Promising, Emerging Practice

Trauma Informed Care

Research shows that individuals who are homeless are likely to have experienced some form of previous trauma; homelessness itself can be viewed as a traumatic experience, and that being homeless increases the risk of further victimization and re-traumatization. A trauma-informed organization has four key elements: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs/symptoms of trauma in those involved (clients, staff, family, etc.) with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices and; seeks to actively resist re-traumatization.
https://traumainformedoregon.org/wp-content/uploads/2016/01/What-is-Trauma-Informed-Care.pdf
https://www.centerforebp.case.edu/practices/trauma
https://www.samhsa.gov/nctic/trauma-interventions

Progressive Engagement

Progressive Engagement is an approach to helping households end their homelessness as rapidly as possible, despite barriers, with minimal financial and support resources. More supports are offered to those households who struggle to stabilize and cannot maintain their housing without assistance. In this approach, participants are initially offered "light-touch" assistance, regularly reassessed, provided assistance "as-needed" and exited from the program as soon as housing retention barriers are resolved.
https://buildingchanges.org/images/documents/library/2015_WhatIsProgressiveEngagement.pdf
http://cceh.org/progressive-engagement/

Harm Reduction

Harm reduction incorporates a spectrum of strategies from safer use, to managed use, to abstinence in order to meet drug users "where they are at", addressing conditions of use along with the use itself. This approach is particularly relevant to maintaining no barrier shelter and housing.
http://homelesshub.ca/about-homelessness/substance-use-addiction/harm-reduction
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1319346/

SOAR (SSI/SSDI, Outreach, Access, Recovery)

SOAR is an evidenced based intervention designed to increase access to disability income programs for eligible adults including homeless and at-risk of homeless adults with mental health and/or co-occurring substance abuse disorder.
http://homelesshub.ca/about-homelessness/substance-use-addiction/harm-reduction

Social Inclusion

Social inclusion offers opportunities to re-engage with the community and form positive relationships. Consumer involvement is the practice of integrating people with lived experience of homelessness into staff and leadership roles at homeless service agencies. Consumers may provide peer support as role models and resources for other services. Peer support creates a sense of belonging for both the individual providing the service and those receiving the support.
https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/social-inclusion
https://www.samhsa.gov/recovery/peer-support-social-inclusion

Critical Time Intervention

Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals, including veterans and homeless, during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.
https://www.criticaltime.org/cti-model/evidence/

Housing and Employment Navigators

Housing Navigators are designated staff members who are charged with finding and recruiting landlords willing to rent to homeless people. There is increasing evidence to support the importance of having housing navigators as part of the strategy to implement rapid re-housing and support homeless veterans in accessing housing.

Building Changes, a Seattle-based nonprofit, has supported a navigator cross-system model to address family homelessness. The model aims to help heads of homeless families find a job, keep a job and secure stable housing by improving collaboration between the workforce, housing and social service systems. Effects of the model have been demonstrated through a research project implemented in three regions of Washington State. Research results show that families with access to Navigators were more successful in finding and keeping a job and securing housing.
https://endhomelessness.org/resource/rapid-re-housing-toolkit/
https://www.va.gov/HOMELESS/nchav/docs/Housing_Navigator_Toolkit_PDF.pdf
https://buildingchanges.org/library-type/best-practice-reports/item/964-housing-and-employment-navigator-an-innovative-cross-system-model

Homeless Subpopulation Best, Promising, Emerging Practice

Veteran

The HUD-VA Federal 100-Day Workgroup surveyed four communities and conducted follow-up discussions to identify best practices that were implemented to meet the goals of ending Veteran homelessness. Three best practices were identified: Continuums of Care and Veteran Affairs Medical Centers collaboratively created an inclusive list of homeless Veterans; identified/developed prioritization instruments to target housing interventions to those most in need; and used interagency service planning and navigators to address individual veterans' needs.
https://www.usich.gov/goals/veterans/
https://www.usich.gov/resources/uploads/asset_library/Vet_Criteria_Benchmarks_V3_February2017.pdf

Families with Children

Studies have shown that there are emerging practices for successfully addressing family homelessness. These practices include: building relationships between homeless service agencies and early care and learning agencies at the state and local levels; integrating direct feedback of parents of children experiencing homelessness into their early care and learning system's efforts; providing cross-training for the staff of homeless service agencies and early childhood agencies; expanding on past efforts and lessons learned to connect children experiencing homelessness to early childhood development services; and sharing data among agencies that serve families with children age 0-5 who are experiencing homelessness.
https://www.usich.gov/resources/uploads/asset_library/Homeslessness_in_America_Families_with_Children.pdf
https://www.acf.hhs.gov/sites/default/files/ecd/final_promising_practice.pdf
https://www.acf.hhs.gov/sites/default/files/ecd/echomelessnesspolicystatement.pdf
https://www.theounce.org/wp-content/uploads/2017/03/CCDF-Homelessness-Guide.pdf

Youth

Homeless youth program strategies incorporate a number of promising practices that align with the adult and family homeless system. Interventions are identified within the following framework of principles: immediate accessibility; individualized, flexible, and choice-based; developmentally appropriate for youth; culturally competent; trauma-informed; based on the Housing First approach; employ Positive Youth Development principles; and emphasize family reunification and resiliency strategies. Examples of promising practices include low or no barrier drop-in centers, strength-based case management, safety and harm reduction, rapid re-housing, and non-time-limited supportive housing.
https://www.hudexchange.info/resources/documents/Ending-Youth-Homelessness-Promising-Program-Models.pdf

Chronic Homeless

The federal definition of chronic homeless is *people with disabilities who also experience extended or repeated episodes of homelessness*. People with disabilities are disproportionately represented among all people experiencing homelessness and, according to point-in-time (PIT) counts conducted in January 2017 by communities across the country, it is estimated that on any given day nearly one-quarter (24%) of individuals experiencing homelessness are people with disabilities who met the federal definition of experiencing chronic homelessness. Permanent affordable housing combined with access to on-site or mobile services has proven effective in reducing episodes of homelessness among individuals with chronic patterns of homelessness. The use of the housing first model was the foundation to Utah's efforts in functionally ending chronic homeless.
https://www.npr.org/2015/12/10/459100751/utah-reduced-chronic-homelessness-by-91-percent-heres-how

http://www.evidenceonhomelessness.com/wp-content/uploads/2018/04/evidence-page-chronic-homelessness-April-2018.pdf
https://www.usich.gov/tools-for-action/10-strategies-to-end-chronic-homelessness/
https://www.usich.gov/resources/uploads/asset_library/Homelessness-in-America-Focus-on-chronic.pdf

Homeless Services Data Management Emerging Practice

Interoperability Agreements

Interoperability agreements between state agencies, local agencies, Continuums of Care, and/or other organizations working to prevent and end homelessness allow for data sharing and improved coordination among these entities. These agreements are generally key components of data warehouses and can also be integral to statewide or local efforts to provide better case management to people experiencing homelessness. For example, Lane County's FUSE program includes agreements between Lane County and community partners such as police departments, medical centers, municipal courts, and crisis centers, to identify the highest users of the hospital, jail, police, and other crisis services. This collaboration allows housing navigators and community partners to locate and engage people who qualify for services and provide improved case management.
http://www.sheltercare.org/2017/08/community-partnerships-are-central-to-fuse-sucess/https://www.lanecounty.org/UserFiles/Servers/Server_3585797/File/Government/County%20Departments/Health%20and%20Human%20Services/Human%20Services/HMIS%20ServicePoint/Fight%20Homeless%20wth%20Data%20handout%201.pdf
https://footholdtechnology.com/news-blog/new-jersey-governors-conference/

Data Warehouse

A data warehouse is the consolidation of multiple data sources from operational systems into one centralized database and can be a valuable way to support statewide policy decisions, improve coordination across agencies, and guide resource allocation. Data warehouses have proven effective in the study of regional homelessness and the use of mainstream systems. In a number of states, including Ohio, Michigan, and Washington, Continuums of Care bring their Homeless Management Information Systems (HMIS) client-level data into a data warehouse to create a comprehensive picture of the homeless population and services provided. This can assist CoCs and other agencies obtain unduplicated regional counts of homeless persons, identify the prevalence of chronic homelessness, understand client movement across continuum boundaries, and analyze service usage across continuums. In many cases, HMIS data warehouse also bring together client-level data from other state agencies, such as health, corrections, education, and human services. This allows for the ability to work with data at the statewide level to identify cross-system use of services, analyze trends, identify mobility patterns, and assess the impact of investments in housing and human services to inform funding and policy decisions on the state and local levels. This type of data warehouse also allows for the identification of system gaps, opportunities for cross-system collaboration, and identification of interventions to prevent and end homelessness.
https://www.hudexchange.info/resource/1696/hmis-data-warehousing-curricula/
https://www.commerce.wa.gov/serving-communities/homelessness/hmis/
http://ohiodatawarehouse.org/index.html