

Charles Francis:

... Center. I want to welcome you to our webinar today: Building Effective Partnerships with Continuums of Care to Increase Housing Options for People Leaving Prisons and Jails. As you all know, connections with safe and affordable housing are an absolutely essential component for successful re-entry, and one of the most fundamental steps towards making connections with that housing is building partnerships between the criminal justice and the housing systems, and we're focusing on Continuums of Care today because that is one of the most important partners for you to start with in doing this work. Next slide.

Charles Francis:

So, just a quick note that this meeting is being recorded and it will be archived on NRRC's website after the event for your perusal. Next slide. So, the Council of State Government Justice Center. Who are we? We're a national non-profit, nonpartisan organization that combines the power of a membership association serving state officials in all three branches of government with policy and research expertise to help develop strategies that increase public safety and strengthen communities. So, an outline of our webinar today. After a brief welcome and some introductions, I will go over some of the basics, what is a continuum of care? Why are they such important partners for people who work in criminal justice and what are some important strategies for building partnerships with CoCs?

Charles Francis:

Afterwards, we'll hear from two different communities who have used the resources and partnerships available through the CoC system to meet the housing needs of people in reentry in two very different contexts. In Albany, New York, you'll be hearing about how the team there is meeting the housing needs of people on parole whereas in Cuyahoga County, Ohio, you'll be hearing about how they work with the CoC and other community partners to design a program that serves people who were frequently cycling between jails and other public systems, and then hopefully at the end, we'll have some time for questions and answers, but in addition to that, I want to encourage you to use the Q&A function in Webex throughout the presentation. You can pose questions to myself or any of the other panelists and we'll do our best to get you some answers. Next slide.

Charles Francis:

So, our presenters today, besides myself, we are joined by Liz Hitt, the executive director of the Homeless and Travelers Aid Society in Albany, New York, and we also have Meghan Patton, a specialty court administrator for the Cuyahoga County, Ohio, Common Pleas Court. Thank you both so much for joining us today and we can't wait to hear about your work. Next slide. So, there's a lot of us here today, but if you would, go ahead and introduce yourself using the Webex chat function. Just give us your name, what agency you're from and the jurisdiction city state or what have you. We'd love to know who is with us today. Next slide.

Charles Francis:

All right, so I will start by talking about some strategies for working with CoCs to prioritize people in reentry. So, next slide, what is a continuum of care? Some of you may know and some of you may not. So, it's very important to HUD. HUD provides the majority of homeless assistance funding that's available in most communities and it's really important to HUD that this funding is deployed in the most strategic way possible that it's really responsive to what are the greatest needs in each community. So, HUD has required that communities develop what's called the continuum of care, and a continuum of care can... It can be at the state level. It can be at the regional level or it can be at the local or municipal level depending on where you live, but nearly every area of the U.S. is under the jurisdiction of the CoC, and a CoC is at its heart, it's a planning body and what they do is they coordinate local responses to homelessness.

Charles Francis:

What that means is part of their responsibilities is to each year when HUD releases homeless assistance funding, they work to set priorities for how that funding will be deployed into new housing and homeless assistance projects. Things like rental assistance, moving costs, homeless prevention resources. The other major function of CoCs is to help assess people's needs for housing and services in the community and to create a system that prioritizes them for assistance because, unfortunately, there are far more people that need assistance than there are resources available. So, in addition to deciding which projects get funded, which projects get built, CoCs also are charged with prioritizing people for assistance on a community-wide basis, and they control... I'm talking about the homeless assistance resources they control.

Charles Francis:

The best examples of that are programs such as that tend to be permanent housing for people who are experiencing or at risk of homelessness. Probably the best known program is permanent supportive housing. So, these are permanently affordable housing units that also have supportive services closely attached. So, supported employment, case management, behavioral health treatment, things like that, but CoCs also control another resource known as rapid rehousing, which is a different type of program, which is generally a short-term package of assistance and supports. So, it might be help finding housing, assistance with moving costs, short-term, rental assistance, but the idea is to really catch people at the point of homelessness or risk of homelessness, and sorry. I think something is happening with my camera. Hopefully, everyone can still hear me to prioritize that rapid rehousing is a short-term package of assistance, designed to really help people who become homeless quickly, exit that experience of homelessness and be able to connect and be stabilized in permanent housing.

Charles Francis:

So, engaging with CoCs really involves two main things. It involves at the most fundamental level partnership building. So, each CoC is governed by a CoC board, and we really encourage folks who sit within the criminal justice system to join this board because really decisions about resource allocation and prioritization for resources

are made over the long term and these relationships are absolutely essential and the other way to really engage with CoCs is to get involved with the coordinated entry assessment process, which is the actual mechanism that CoCs use to assess people's housing needs and prioritize them for assistance, and I'm going to go more into both of these strategies on the next slide. So, coordinated entry assessment. What does that mean? So, coordinated entry has four key elements, access. So, connecting people with the systems to get their housing needs assessed, the assessment itself, prioritization for housing and then referrals to housing programs.

Charles Francis:

So, coordinate and entry access points, they can be a lot of different things, but typically people will connect with the system through a homeless shelter, another social service provider agency, maybe a community wide hotline, but one thing that we particularly encourage for folks who sit within the criminal justice system is to establish access points to coordinated entry within the system itself. In particular while people are still in jail and prison and that's why we have call out in reach as a strategy here because it can be difficult to staff those efforts because doing that assessment takes time. Some places might use their own staff. Some places may contract with outside agencies, but that's a real best practice to connect people to the system while they're still in prison or jail to help to prevent them falling through the cracks in those critical early days of the reentry process.

Charles Francis:

Another great way to connect to coordinated entry too, which I'm not going to focus on today, is through law enforcement or community-led homeless outreach teams. It's just another way to meet people where they're at and make an immediate connection to housing, and in terms of the assessment process, HUD mandates that there's a standardized assessment process used throughout the entire jurisdiction of the CoCs. So, throughout the whole state, locality or region that they cover, but HUD does not mandate what that assessment process actually looks like. So, communities have used different tools for this. The most common that we see is what's called the VI-SPDAT, and if I remember the acronym, I think it's the Vulnerability Index Service Prioritization Decision Assistance Tool. Try to say that three times fast, but there are a number of other tools out there too including in Austin, Texas, they developed a new tool called the Austin Prioritization Index, which is a really great emerging practice that I believe HUD has featured recently and really centers racial equity in the assessment process and the process of connections to housing. Next slide.

Charles Francis:

So, the third part of coordinated entry, the all-important prioritization. Again, HUD requires that a CoC has a set of uniform written standards that it uses to prioritize people for assistance under the different programs that the CoC funds, but again, HUD does not mandate what those written standards look like. So, there's significant flexibility that communities have in terms of who they prioritize and so again that's why I'm going to keep driving home the point that it's so important for people who sit within the criminal justice system, as well as other partner systems like behavioral

health, to connect with the CoC meet with them, join the CoC board, because that's how over the long term you get input into these written standards, and I think you'll see from both of our presenters today that these partnerships over the longer term, like having these partnerships is what actually allowed them to launch new initiatives, meeting the needs of people in reentry.

Charles Francis:

HUD does have a few basic requirements for priorities. The most important of which is housing resources, particularly permanent supportive housing resources are prioritized for people who are what's called chronically homeless, and there's a very complicated definition for that, but the bottom line is that they've been homeless for a year straight or four or more times in three years. So, hopefully, I didn't mix that up, but it's not that people can't qualify for assistance if they don't meet that definition, but particularly within PSH, HUD is trying to prioritize folks who have been homeless for the longest amount of time and who have the highest needs. Next slide.

Charles Francis:

Oh, and just another note about prioritization, but there's local communities can really within HUD's basic framework set their own priorities in a lot of different ways. They may prioritize veterans for example. They may prioritize people who have a certain level of need as expressed through their assessment tool or as which ties directly into Cuyahoga's presentation today, they may prioritize folks who have had frequent contact with different public crisis systems. So, jails, emergency rooms, and shelters. Now, again, the ability to prioritize people in reentry can be limited by some of HUD's own policies, and in addition to the chronic homelessness issue, to qualify for most CoC programs, you do actually have to be literally homeless. That's not true for every program. There're certain programs you can also qualify by being at risk of homelessness and that's an important strategy that people have used to serve the justice-involved population.

Charles Francis:

But HUD's definition of literally homeless, you're not literally homeless if you have been in a publicly funded institution for over 90 days and actually there's a waiver out there right now that increases that to 120 days, but this can be particularly challenging for the prison population, folks who've been incarcerated for an extended period of time and so we'll talk a little bit more about that and some kind of strategies to address it there, but one other very important point about prioritization is that it's important to really meaningfully integrate people with lived experience of homelessness and with the justice system. HUD has a minimum requirement that at least one person who's experienced homelessness beyond the CoC board, but HUD also encourages communities to go beyond that minimum requirement and really make this participation meaningful.

Charles Francis:

For example, I think it's in Baltimore. Their CoC board actually has a standing lived experience committee that's made up of several folks and their decisions and recommendations have real weight in terms of the COC's written standards and other decisions. So, we really encourage communities to be thinking about how can you be learning from the real experts in deciding how to prioritize these scarce resources. Next slide, and HUD is here to help. Despite some of the policy obstacles that I was talking about on the previous slide, HUD has also taken a number of actions to help communities in this area. They began in 2016 by issuing some guidance around applying the Fair Housing Act to admissions decisions and how landlords can... landlords and HUD assisted housing providers can really follow best practices there, only utilizing criminal histories for issues that have a direct impact on safety or fitness as a tenant and not utilizing arrest records.

Charles Francis:

But HUD has actually recently expanded on this foundation just a couple weeks back, so after we made these slides, has announced a department-wide initiative where over the next six months, every HUD program office is going to be conducting a comprehensive review of their regulations, guidance, and other program documents and making recommendations for change to better serve people with justice involvement and to reduce their barriers to participation in HUD programs. So, those two things are not directly related to prioritization, but they are a huge step in terms of reducing barriers to housing, but in terms of prioritization, HUD Secretary Fudge also put out some guidance last year focused on the emergency housing vouchers made available under the American Rescue Plan Act.

Charles Francis:

These are 70,000 vouchers nationwide that are really targeted towards people at the highest risk of homelessness, and the important thing about the ARP vouchers is that they... while they are allocated through CoCs, they don't have the same requirements around the definitions of homelessness or priorities for chronic homelessness. So, Secretary Fudge has really called that out as a place where communities can prioritize people with justice involvement. Next slide.

Charles Francis:

So, to sum up, partnering with your local CoC. At the end of the day, a really important point is to remember that the criminal justice and housing systems, they serve a lot of the same people. It might be people who have had the deepest experiences of homelessness, people with a particularly high level of behavioral health needs. There's a real common mission there and that is an important thing to keep in mind as you're building these partnerships. Another important thing to keep in mind is that unfortunately people who identify as BIPOC, Black, indigenous, and people of color, as we well know, are overrepresented both in the criminal justice system and among people experiencing homelessness, and if you are really building partnerships to work at that intersection, it's really a powerful move towards increasing racial equity. So, I think that's another important thing to keep in mind too when you're looking for reasoning to drive this work locally.

Charles Francis:

Also, for criminal justice partners, the CoC is a valuable resource, but resources are limited, and as you can see, there are policy barriers as well too. So, when you're partnering with your CoC, think about funding other resources you can bring to the table. For example, housing search assistance or financial resources, moving costs, short-term rental assistance. Those sort of things can really make a difference especially in the early phases of re-entry when people may have had their intake into the CoC system, but a housing assistance spot hasn't opened up for them, or for folks who under HUD's policies don't qualify for CoC assistance because they'll use the community-wide infrastructure of the CoC to connect those people with other assistants as well too, and you'll hear a bit more about that in Cuyahoga's presentation.

Charles Francis:

And finally, the last point I'll leave you with, and I know I've said this three times, but focus on long-term relationship building in partnership because over time, these relationships are really what lead to being able to prioritize people with justice involvement for housing resources locally. Next slide. So, now I'm very pleased to turn it over to Liz Hitt who is going to be talking about work that their CoC has done locally in Albany, New York to help meet the housing needs of people on parole. So, go ahead, Liz.

Lizz Hitt:

Thank you. I hope everyone can hear me. My name is Liz Hitt, and I'm the executive director for the Homeless and Travelers Aid Society here in Albany, New York. Next slide. So, we started working with people coming home from prison in 2014. We had an opportunity to be part of that continuum and it's one of the best things that we've ever done. We started learning things as soon as we hit the ground. Some of this we already knew because we've been working with homeless people for decades since the '60s, but being in that space and working every day with parole officers, mental health experts. People really living that reality taught us so much. One of the first things we observed that we didn't really have any hard data on how many people came home from a New York State prison to Albany County and were homeless.

Lizz Hitt:

It just had never been counted. Now, I know that New York State keeps some data, of course, lots of data, but here in Albany County, we did not have any specific data nor did we have a database for that program. So, that team assigned to re-entry did not have a specific database like we have in housing. So, our housing program uses HMIs, and of course, they've been doing that for a long time so that struck me as interesting that we weren't even trying to capture per se this information. So, we met as a team and we decided just to start asking people where they slept last night and to put all of that into an Excel grid and then we would organize that grid to see what it said per se, and it was pretty startling even for us.

Lizz Hitt:

So, having worked in this sector for decades, I was surprised that we were surprised, but I too thought, "Wow. That percentage of people that are homeless just having come home from a New York State prison and living in a shelter was just so high." So, as you can see well over 30%, that number fluctuates a lot. Quarter by quarter, it can be 50%. It's been as high as 60% in some quarters, but it does average about 35, 40%. Of course, this population, these are people that have just come home from prison. Now, they're in a homeless shelter, so they're already working with parole officers and struggling to reintegrate and now they're homeless. It has struck me that the largest shelter we have, the capital city rescue mission, which does a lot of good for a lot of people, that's not a publicly funded shelter.

Lizz Hitt:

So, all of our publicly funded shelters have case management goals and protocols. That's not true for this shelter and so during the day, people aren't mandated to meet with case managers. They're not assigned to a navigator. That's the term we actually prefer because people are cases and we don't manage them, but they're not assigned to a navigator from the time they arrive or during intake. So, they can often languish at that spot for much too long. Next slide. So, in 2018, we worked with our continuum of care to start a rapid rehousing program. I had no idea that this would be one of the few rapid rehousing programs in the country. We had been part of the rapid rehousing family since the early days of HPRP so we understood rapid rehousing.

Lizz Hitt:

Back then, it was about people that had a recent attachment to the workforce and that's not the case here. So, we flipped the narrative per se, started small, six beds, small budget. These funds as you can see came through reallocation. So, we're specifically looking for people that have been recently incarcerated and are in a homeless shelter, trying to get them out of those shelters and into their own unit. Next slide. So, certainly, of course, the partnership with the Albany Housing Authority. We set up a specific channel. We worked with the housing authority so that they would take a certain number of applications directly from this program. Of course, just like every other housing authority, there are regulations regarding criminal history and some other things, but that's been very helpful and that continues today.

Lizz Hitt:

Of course, we've had a great relationship with the Office of Parole. I will say over the years that we've educated them as much as they've educated us. We've pushed back on them per se over the years, very respectful, of course, but one of the first things I learned that a lot of the parole officers were really focused on employment and not housing and truth be told housing wasn't even a big part of the conversation. People had just become so used, so comfortable maybe with people being in homeless shelters that there didn't seem to be a lot of people advocating for that's just a ticket back to prison or that's possibly just a ticket back to jail. Not always the case,

of course, but certainly contributes to the likelihood that someone maybe returned or rearrested.

Lizz Hitt:

So, it was all about employment and we sat with all of the POs in a great big room pre-COVID and said, "Please pause and let's focus on housing and employment, not just employment," and we advocated with them to make actually housing the priority because we simply said to them, "How do you get a job, keep a job if you're in a homeless shelter? That's just really difficult?" So, if we could shift and focus on housing, actually try and make that a priority, we would then commit to working with them to also make employment a top priority, but if it comes before housing, it's in our assessment not the right order of things. It should be housing and then employment and of course treatment, all of that happening together, so that's been very helpful. Next slide.

Lizz Hitt:

So, no ID. I'm sure we're all experiencing this and I see people from all over the country, which is amazing. So, I would love to hear as this goes on after the presentations what's it like in other places again. We just weren't collecting this data, but we started collecting it. 60% of the people we saw didn't come home with the documentation they needed to obtain state ID, and I remember parole saying to me, "But wait, we've made a lot of progress. They have their prison-issued ID, which says the name of their prison on it." It has their picture on it and I tried not to chuckle, but that's not ID. You're not showing that to a landlord. You're not showing that to an employer. I know I sure wouldn't and I know they wouldn't. So, that continues to be just a big obstacle that, of course, since 9:11 has gotten harder because they need so much paperwork in order to show whom they are.

Lizz Hitt:

That lack of transportation, I'm sure we all go through that. Here in Albany, we have a really good bus system, but they don't have bus passes. So, that's a huge part of what we do. We just give out bus passes. Substance abuse. A lot of people come home and it's been a long time since they've used any substances, but being in shelters without navigation and the support they need, certainly, they've expressed to us that they feel more vulnerable to possibly using again. So, that's always something that we're concerned about, and of course, that standard landlord reluctance. So, this has been a great program. I just found out not even a month ago that a private donor is going to help us double the number of beds that we have in this program. So, we're going to go from 6:00 to 12:00, but our goal is much more than that. 18 would be a nice number for this program and I'll stop there. Thank you.

Charles Francis:

Great. Thank you so much, Liz. Really great to hear about the work you've done in Albany to really help prevent people from falling through the cracks. Thank you so much for sharing that and now I'm going to [inaudible 00:30:28]. Next slide please. So, here's Liz's contact information in case you want to get in touch with her and



learn more about the great work they've done. Just note, yes, I am still off camera. I'm going to restart in a moment here to try to get all the devices on my computer working again, but in the meantime, I'd like to turn it over now to Meghan Patton to talk about how they work with the CoC in Cuyahoga to serve a completely different population, people who are high utilizers of jail and other public services. How they built partnerships over time to really meet their housing needs in a way that really involves the criminal justice housing and behavioral health systems. So, Meghan can't wait to hear from you.

Meghan Patton:

Hi. Everyone my name is Meghan Patton, and I am the special court administrator of Cuyahoga County Common Pleas Court, and if you are unaware, we are in Cleveland. So, we're right here on Lake Erie. It's a cold day even though it's the end of April. I would like to thank BJA and Council of State Governments for highlighting the work our team has done in this space and I'm excited to present today. I would be remiss if I didn't also introduce two of our folks from our CoC who are here with me and that is Melissa Erka who is the program director and also Alison Gill who is our program administrator and we welcome them here today and we wouldn't be here without the work of them and their agency. Next slide.

Meghan Patton:

So, in our county in 2017, we actually came together through our Court of Common Pleas that has a mental health and developmental disabilities court. We technically serve about 500 individuals who have a felony level offense and is moving through our probation system. We have five wonderful judges that oversee those offenders along with a great probation staff and community partners. With that, Judge Holly Gallagher who is the chair of the mental health and developmental disabilities court really championed the cause of trying to get everyone together if in our county to start talking about this stepping up initiative, which is a national initiative to reduce the number of severely mentally ill individuals in jails across our country and stepping up came online in the national scene about 2015, and in 2017, our state began to really push this and came up to our county and visited with our judge and other important leaders in our community and that really propelled us to do a sequential intercept mapping.

Meghan Patton:

And for those that may not be aware of what that is, it's really where we brought in facilitators to map out the experience an individual has from the time of arrest to booking to their experience in the court, possible diversion opportunities, all the way through sentencing and to probation and then eventually re-entry. So, one day in August, in 2015, about 65 leaders and stakeholders came together. Alison was one of those folks and we really mapped out someone's experience. We had behavioral health folks there, criminal justice, our prosecutor's office, defense counsel, judges, case workers that were working with individuals and our housing folks. Through that two-day experience, we prioritized five areas that we felt that we needed to improve on, and one of those of course was housing.

Meghan Patton:

Our other co-chairs were from the county executive's office, our ADAMHS board and then our Metro Health, which is our county hospital who also does our medical and behavioral health in our county jail. Next slide. So, today, we're going to focus on what came out of that housing group experience and so once we identified that housing was one of the key issues that our stakeholders wanted to work on, we quickly realized in that sequential intercept experience that the criminal justice folks in the room did not know much about housing and we were thankful that our CoCs and our behavioral health role was in that room with us to say, "Hey, there is housing available. There is access to housing, and let's work together to make sure we both understand this."

Meghan Patton:

So, we created a subcommittee that had our CoC ministers, court administration, jail officials, shelter directors and staff, public defenders, behavioral health agencies, the coordinated intake staff, probation and parole, and we met once a month and we literally, I think the first six months, we educated ourselves with what the other systems were doing. We found out really quickly and I typically tell this story because I think it illuminates the issue at hand. As a mental health and developmental disability court, we are always working on safe healthy reintegration whenever we release any of the individuals in our court from jail during pre-trial back into the community.

Meghan Patton:

We work closely with our behavioral health folks. We put together plans, make sure they have doctor's appointments and try to divert them from shelter. If we can't, then we are going to send them to this altar and so we said we're going to do a soft hand off and take these individuals and drop them right off at the front door. What we learned out of this meeting is we were dropping them four blocks off too far because we didn't understand that they needed to go through a coordinated intake. So, here, the criminal justice folks thought they were doing a great job and we were trying to do healthy releasing and very quickly because of this committee learned those nuances that we all experienced and then obviously our clients were not being set up for success on release. So, that committee kept meeting monthly.

Meghan Patton:

At the same time, Stepping Up Ohio put out a technical assistance grant, and we applied for that and I'll go into that in the next couple slides. The other thing we did is we put together educational opportunities for each of our partners to understand each other, different opportunities throughout 2018 and 2019 to educate the housing community on how the criminal justice system works and they in return also educated us. Next. So, through all of those meetings, one of the programs that we learned about was working on the prison level in Ohio and that was called returning home and returning home, it started in the early 2000s out of prison where they were connected to a mental health agency here in our county and this was happening throughout the 88 counties in Ohio where individuals who had severe mental illness

or HIV and were being returned back to their county after their completion of their prison term and homeless could apply to be part of a program where they would receive permanent supportive housing.

Meghan Patton:

And when this was administered in the early 2000s, it was done as a pilot out of our Department of Rehabilitation, and what they quickly learned within a year is that it was working, that providing individuals with housing first, giving them the support that they need. They were less likely to return to the prison system. So, when we began those educations with our county leaders and our judges and our court administrators, we talked about this model working on the larger platform in our state and what about the possibility of doing this at the local level. Next slide. So, with that, we really leveraged the success of the program at the state level. We presented the problem and this solution to our mental health court judges and our administration and we identified the partners where we were going to pull our funding from and then we created our contracts and our MOUs.

Meghan Patton:

So, we essentially created the returning home on the local level where we would identify individuals that were cycling through our jails within our mental health court and provide them with wraparound behavioral health services and housing, and really, this is where the CoCs and those behavioral partners came in and really helped educate us so we could understand how HUD worked. We knew some of it just with our work of clients, but I don't think we understood the layering of it, the policy work of it and what the pros and cons are that CoCs have to work within a lot of the time. Next slide.

Meghan Patton:

So, when we created returning home on the local level, we were identifying clients that actively had a pre-trial case or a probation case in our Common Pleas Court and that they were frequently or had long-term stays in homeless shelters, crisis stays or hospitalizations, and they were coming in and out of our jail. What we often saw on the mental health court is that sometimes our most frequent clients that were coming into our court with cases every year, many times, they couldn't always achieve those HUD definitions of housing because of the cycling, the length of time they were staying in jail sometimes, that they couldn't always get high enough on the list before they got themselves back in jail. So, we knew we had to do something that was a little bit more outside the box and that's really where we utilized this program.

Meghan Patton:

So, we partnered with frontline service who is a mental health and behavioral health agency here in Cuyahoga County and they really have a niche population with working with individuals with severe mental illness and chronic homelessness. They also run our coordinated intake here at our county as well and then we also partnered with Eden Housing, which helps us to identify scattered sites that our clients can go into. We achieved funding for about 15 participants per year using the

housing first approach, and just to backtrack that, I will say this on the criminal justice end, we always had this thought process of get them into treatment, get them their meds, make sure that all that stuff is taken care of and then work with housing. So, this idea of housing first sometimes rubbed a little bit differently than what our judges and our professionals really thought we should do and so we're really thankful for all the education that did occur.

Meghan Patton:

So, our probation officers understood that the housing first motto works, that our judges understood that. So, when they were releasing people, they were thinking about that in mind and then of course we needed to wrap around with front lines or wraparound purposes. So, the behavioral health care team is made up of a care coordinator, a case manager and a peer specialist and then they obviously have access to this psychiatric care needs through that agency. One thing I will say in here, we also allowed for individuals in our MHD court who had sex offenses also to be a part of this. Obviously, the housing can be a little bit harder to find, but we were able because of the funding stream we were using, we could provide us services to that population. So, individuals with arson in their background and sex offenses in their background are able to be referred in.

Meghan Patton:

Next slide. So, this is our prioritization referral tool that we developed and so obviously we have 500 individuals at any one time in our mental health court, we wanted to make sure that we were prioritizing the right into visual. So, we worked with our community partners on this tool, making sure that we were looking at how often they were in jail, how much they cycled in jail in the prior year, their hospitalizations and then their homelessness. So, this helped us decide in that prioritization if they could move from the referral process to the eligibility and so our MHDD court coordinator and our probation team along with our partners meet once a month and always goes through these referrals and make sure that we're going through this prioritization tool and then if they are eligible, we move them on the process.

Meghan Patton:

Next slide. So, when you look at our data so far, we started in 2020 actually in March. I think I have a kickoff meeting March 1st, and then we all know it happened by about March 15th. Many of us were in lockdown. So, we did get off to a bumpy start because we were trying to transition, but the good thing is we were still able to move. When we looked at the seven-month time of the individuals that were participating, we had seven visuals at that time. In terms of their year prior, they had 15 total cycling episodes through our county jail. They had 616 total jail days in 2019, 23 prior hospitalizations, and four clients had experienced chronic homelessness where they were either living full-time in this shelter or on the street for a considerable length of time.

Meghan Patton:

At that seven-month mark, no one had experienced any incarceration episodes nor hospitalizations or went back through our shelter. Now, I do always caution our administrators, our judges and our team that this isn't what we're always going to see. We understand that with individuals with chronic and severe mental illness that they are very complex humans and they are going to have times in their life where they might cycle, but our goal is to make sure that we're always providing the wrap-arounds purposes and the safe housing to decrease those chances. Next slide.

Meghan Patton:

The next thing we did was on a bigger focus. So, we worked with our CoCs in that same housing committee with Stepping Up Ohio, and we knew that although we're doing a good job at identifying our most frequent flyers through our mental health and developmental disability court, there were lots of people obviously in and out of our jail that were also hitting other systems and it's important for us to really look at that larger policy. So, we developed a pilot's study over the last couple years where we worked with our CoCs to identify HMIS data that they had with our Ohio Mental Health and Addiction Services Agency to obtain some of their behavioral health, and then our jail data from 2012 into 2018, and then through this research, we were able to take all this data, obviously, remove names and any indicators of who they were and then be able to match them through the Ohio Housing Finance Agency's new data warehouse.

Meghan Patton:

So, we're the first county in the state of Ohio that is trying this. We're the guinea pigs for the state. We're really excited about this. They most recently received all the data that they needed to receive. Our hope is then they're going to cross reference the data on top of each other and try to fine-tune what themes, what issues, what they see in the data to help us with some of our policy moving into the future. Next slide, and the last thing I'll touch on is one of our... It's a companion initiative and so as we were going through the MHDD court, returning home initiative, again, we knew that not just people with chronic mental illness in the jail were homeless, that there were other individuals that were being released directly from our jail either during the pre-trial once they've received a bond, all the way to when they were released after doing any type of jail time that maybe they were ordered to.

Meghan Patton:

So, this program is our in-reach program. We partner with the Cleveland mediation center to create a jail diversion specialist and so this individual meets directly with inmates in the county jail who are either on pre-trial or anywhere along in their case that are homeless or reporting homelessness and our diversion specialist meets with them, reviews different avenues, maybe mediates with their family members. Part of this is able to also receive if it would be helpful for an individual to go back to mom's house and contribute some money through a gift card that that's a way that we can get them out of the county jail into safe housing and then also working with our shelters if we can't divert them, but doing a warm hand-off. So, this in-reach project again started in March of 2020.

Meghan Patton:

So, obviously, it was hard to meet one-on-one with individuals in the jail, but we use Zoom and behind glass in any way we could, and our diversion specialist meets with about 35 individuals each month multiple times and is really working with them and powers the client, tries to identify different housing possibilities and then provides discharge planning back to the court, back to the jail, back to the probation officer. One of the things we've recently worked with the jail is they provide us with a database of anyone that has reported homelessness upon hooking. So, we get that information on a daily basis and then our jail diversion specialist employs right out into the jail and starts meeting with them and working with them. Next slide.

Meghan Patton:

And here's my contact information. Always feel free to get to give me a call and if there's any questions, I'm happy to answer them.

Charles Francis:

Great. Thank you so much, Meghan. Really great to hear about how this program evolved over time and really meets the needs of people who are touching different systems. So, now, really encouraged to see of some lively discussion going on in the chat and we have some great time for Q&A for our panelists. I think I'll start with a question that I just saw coming from Natalie Saladino. How does the jail diversion center keep track of open beds? Is it a program or does the person just reach out to the shelter?

Meghan Patton:

So, the Cleveland Mediation Center is actually part of our coordinated intake, so they're embedded within that work and that agency as well. So, they can always rely on having that discussion of trying to divert someone from jail to shelter. You do bring up a good point though because we saw that issue going on. There's always different pots of money, everywhere different types of programs going on and not everybody's aware of it and so we saw that as a barrier to our jail shelter diversion specialist. So, it's not a center. It's an actual staff member that goes out to meet with the inmate or the client to try to divert them from shelter and develop a plan outside of the jail for housing, but we actually have an additional monthly meeting that we're holding with the health and human services department with Melissa at the CoC, our county executive's office to make sure along with our jail diversion specialist and his supervisor, to make sure that we are talking about what is the availability out there, what are the programs out there that criminal justice folks can be referred to or might be eligible because I think that is a space that sometimes we don't always know all the information or the programs.

Meghan Patton:

We're a big county and we have a wealth of behavioral health agencies and we're lucky for that, but that also means there's money coming in from different grants and foundations that we're not always well aware of. So, we began those meetings with

the intention of continuing to educate ourselves on the different ways to divert someone.

Charles Francis:

Thanks, Meghan. Another question that might be a good one for our Cuyahoga team. A while back, we got a question as we were talking about coordinating entry itself and the need to use a tool to assess people's housing needs and prioritize them for assistance. Somebody asked, "How do you know which tools are evidence-based?" I guess I would expand that for our CoC folks. What are the things that you think about when you're selecting a tool? What are the things that communities should be thinking about? What are the pros and cons of different tools and what's the best way to use that information?

Alison Gill:

Well, I can jump in here, Alison Gill, program administrator with Cuyahoga County, Office of Homeless Services. Years ago, when we had HPRP homeless prevention and rapid rehousing, that's when we really started using tools to assess clients at coordinated entry. That's when CoCs were being asked to have an access point for individuals or families facing a housing crisis. So, I think the question is a good question because I think it's something we continue to look at and it's something we have to improve upon. Our CoC currently uses a set of custom tools that we've designed over the years. We feel like our providers are the subject matter experts and so they've weighed in heavily on what those tools look or how those have been updated over the years.

Alison Gill:

I think it's also important to mention that we are part of cohort number two for the Coordinated Entry Equity Initiative, which is a group of CoCs within the state of Ohio where we're really looking closely at coordinated entry and the tools that we're using. So, again, it's a work in progress, but I think it's something everybody is really focused on and we're looking forward to seeing how our tools will develop.

Charles Francis:

Alison. So, I want to now go back to Albany for a second. We had another really good question for Liz regarding rapid rehousing for individuals after release. So, were they prioritized on their own separate list or were they part of the larger coordinated entry list in general? How close to release did you start doing the coordinated entry assessments?

Lizz Hitt:

So, we were working with people once they had been released. So, people have been released and they've come home, which is a term that's unfortunate because oftentimes people come home to a homeless shelter. So, they're in shelter and then that CE form application gets completed. So, our largest shelter, they're not publicly funded. They're not what we would call an active member of the CoC, and we have a no wrong door policy here. So, we ourselves fill out the CE form for the person and

then it gets submitted. Of course, these are often people that tend to hover on the CE list for a really long time because they're not chronically homeless. They've been imprisoned for the past 10 years. They're not going to qualify as chronically homeless or really almost any other category that can quickly move you off the list.

Lizz Hitt:

So, by making these beds specifically for people that are formerly incarcerated and/or justice involved, then we can bypass that general list and say, "Let's give this voucher to this person or that person they've come home from prison. They're staying at the shelter," because that's part of the reason we started the program because this population for a traditional CE list can just hover somewhat at the bottom for a really long time and just be on that coordinated entry list for months and months. So, that's the other reason that we added these beds specifically for this population.

Charles Francis:

Thanks so much, Liz. I have another question really for anyone on the panel. The one that came up just a few minutes ago, I think it's a very important topic. Is consideration taken for domestic violence and no contact orders when finding placement and when you make referrals, how secure is the facility? I think either both sites, if you want to take this one, I think it's a really important consideration. I know it's something that's very important to HUD in terms of prioritization and connecting people with resources.

Lizz Hitt:

So, it's not something that we've historically dealt with about 97% I believe it is of the population that we deal with are men. These are single adult units. So, that's not something that we've historically interacted with. Oftentimes of course people are in these situations because they can't stay with the family member because they've had a prior incident of DV. So, they're in a homeless shelter because they can't stay maybe several different places. So, if there's anyone else on the panel that could better answer that.

Meghan Patton:

Sure. Within our mental health court, we do have individuals that have domestic violence charges and so we'll work really closely with our sheriff's unit and our prosecutors too around the victim safety piece of it. We're also really lucky to have a high-risk domestic violence court here within our county and so we'll use them as technical assistance as well. Most of the individuals that we are housing through returning home are single males. I think we've had two or three women so far and off the top of my head, I don't believe any of them had an instant offense of domestic violence, but it is something that on the jail shelter diversion side, we have to watch more closely because we have more individuals that might be reporting homelessness or unstable housing because of their current domestic violence charge or a past history.



Meghan Patton:

So, we work closely with our diversion specialist really to make sure he understands that part of it too because he's not in the criminal justice field. He's in the behavioral health field so that's been a learning curve. One of the things we've done is make sure to connect him really closely with our courts supervised, released supervisor. So, he provides all of that data to him or information. So, he knows what he's walking into and that seems to be helpful. In terms of housing, I would say it's always a challenge in order to find them placement and make sure it's appropriate.

Alison Gill:

I think to pick up on what Meghan has said, once the individual whether it's through Cleveland mediation or frontline service is connected with coordinated intake, we have a robust set of policies in place where coordinated intake really does their due diligence through those assessments to ensure that if someone indicates that they are a domestic violence victim, or if they have some sort of no contact order that the next placement is appropriate and safe for that individual as would be the housing plan. It has to be appropriate for that individual and so that again is just nodding at that coordination that's occurring between the justice system and the CoCs coordinated entry.

Charles Francis:

Yeah, thank you both for that insight. So, I want to pose another question to everyone. There's a bit of talk about this in the chat, but I think it's such an important question as we look at the big picture. We have been talking some about permanent supportive housing, which is really great for people with behavioral health needs who really need extended support, support tied with their housing, and a permanently affordable unit, but it's expensive and it's really reserved for people with the highest needs. So, whether we're thinking about PSH or other housing types, what do you all do to think about a continuum of housing options? Maybe some folks don't always need to stay in PSH. Maybe they move on. Maybe there are some folks you encounter who may not be a candidate for the rapid rehousing program, but they may need some other sort of assistance. Just curious how folks think about meeting the housing needs of the people you serve in the larger sense.

Alison Gill:

With respect to Cuyahoga County?

Lizz Hitt:

I-

Alison Gill:

Oh, I'm sorry, Liz. Did you want to-

Lizz Hitt:

Go ahead.

Alison Gill:

With respect to Cuyahoga County, we decided several years ago that we would take a progressive engagement approach towards housing and so initially what we try to do is look at rapid rehousing resources initially and so we want to provide the most basic level of financial support and services initially and then just continue to provide case management to those individuals and then after frequent check-ins with those individuals, seeing, "Do you need a little bit more support? Is permanent supportive housing a better option at this point?" So, thus far, that approach has been very successful both from the client perspective and from a continuum resources perspective.

Lizz Hitt:

We're in total agreement with what Alison just said. Often people in our rapid rehousing program, now we've got the time to do some assessments and people that once they have that paperwork needed to prove a disability, demonstrate a disability whether it's mental illness or something else, that's often the track used for PSH or some other type of more permanent housing assistance. So, rapidly housing gives us that opportunity to hit the pause button for a few months. So, you're not in shelter, but the majority of people that we have worked with since 2018, they really just needed those 7 months, 8 months, 10 months to get their ID, find the employment that works for them. It doesn't seem like lot of time, but it's a full housing voucher so they're not paying partial and then we're paying partial.

Lizz Hitt:

So, it's getting all of the rent paid. It includes the security deposit. It also includes the security deposit for when you move, so that's very helpful. That often comes from private funds, but once you find some place, we certainly want to help you be able to move into it. So, the bulk of the people we serve have said, "This was great. This was enough," but people that do need something else often now have a first chance at those PSH units and we actually just had those conversations. So, if we've got a PSH opening, [inaudible 01:08:31] has well over 100 PSH vouchers, should people in that rapid rehousing program get priority or do you need to go back to the CE list? So, we actually just had this conversation a couple of weeks ago and our feelings were this person's already in rapid rehousing and the CE people agreed with us that it wouldn't make any sense to make them start again when we've proven that they qualify for PSH.

Meghan Patton:

I would just add, we realize in our program we are only identifying a small minute portion of the population and what we're trying to do is identify those that are frequently cycling through all those systems and provide them with the permanent supportive housing. Now, we know we have 400 and 45 other individuals that might be receiving rapid rehousing or other assistance and that's we really rely on the continuum of care to help us with those individuals. Our focus here was to make sure that we were identifying the individuals that cost our county the most and make an impact on their lives with reducing their cycling, and in return, it's often less money

for the county to pay for their individual rent and their care versus the amount of money and time that's spent in the ERs and at the shelter and at the county jail.

Melissa Sirak:

Good afternoon all. I'm Melissa Sirak with Cuyahoga County. I would also just add to our area, along with the success of the progressive engagement model, if we've learned anything over the pandemic, it's also that we have a very creative and innovative continuum of care and we've made some tweaks along the way in the progressive engagement model that we offer. So, for instance, in regards to rapid rehousing, we've extended that assistance to 12 full months for individuals in our continuum to keep them housed. In addition, we've done some creative alternatives to housing, especially around the sexually oriented offenders that are hard to house. We've done transition in place programs where the nonprofit would hold a master lease and they would pay the landlord for up to a year, house individuals, allow them to transition in place and wrap those services around them while they're in housing to ensure that they have gainful employment or income coming in, get their benefits set up and are able to sustain that housing beyond that 12-month lease time.

Melissa Sirak:

So, I look forward to all the additional funding coming into our continuum. What a blessing? Because we really have some creative ideas that we're on the brink of and in addition, we've also utilized some of the cares' funding coming in during this time for landlord incentives. So, we've looked at repairs. We've looked at paying an additional security deposit for those landlords to incentivize affordable housing options for those that are within our continuum.

Charles Francis:

Thank you all for those great answers and I think that is a great way to finish this off. I'll just make one final comment on something. I'm seeing in the Q&A, what advice would you give to somebody creating a reentry program in 2022? There's lots of pieces of advice, but I think if you take anything away from today is really invest in building those partnerships between housing, criminal justice, and behavioral health over the long term, so you can really develop some shared buy-in to serve this population, set some goals about how to prioritize resources and really figure out what resources, financial, and otherwise that each system can bring to the table.

Charles Francis:

So, if we go to the next slide, please. I want to thank all our panelists today. I know I learned quite a bit, so thank you so much for being here and for all the work that you do. Thank you all for coming. We hope you got a lot out of this and please make sure to join the NRRC's distribution list and all of these slides and recordings will be posted there as well, including you can also find there under Second Chance Month Resources, we have a companion article to this webinar that gives some more information on building partnerships with Continuums of Care. So, thank you again, and we hope you have a great rest of the afternoon.