

Permanent Supportive Housing in the District of Columbia: Taking Stock and Looking Forward

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Highlights

It is increasingly clear that a critical aspect of ending homelessness in America is giving precedence to ending chronic homelessness. Permanent supportive housing (PSH) has proven to be an effective approach to reaching this goal. This report describes the PSH currently available in the District of Columbia and what will be needed to develop enough PSH to help all long-term homeless people leave homelessness for good.

Numbers

- The District had a total 2,741 permanent supportive housing (PSH) beds, or around 2,320 PSH units, during June–September 2008 (the time covered by our survey), virtually all of which are occupied by formerly homeless people.
- Increases since that time:
 - As of August 7, 2009, through its Housing First Initiative, The Department of Human Services (DHS) had housed and is providing supportive services for an additional 475 chronically homeless, highly vulnerable single adults and 62 families, and is housing more every day.
 - In summer 2008, District homeless assistance providers reported having over 1,600 more units of PSH in some stage of development.

Costs

- The 2,320 existing PSH units cost on average about \$8,500 each to operate *every year*. These costs are paid for mostly by U.S. Department of Housing and Urban Development (HUD)/housing authority subsidies (55 percent), D.C. Department of Mental Health (DMH) contracts (30 percent), and tenant contributions to rent (8 percent).
- We estimate that each resident of a PSH unit is supported by about \$7,200 in *annual* costs for supportive services; Medicaid payments for services cover most of these costs.
- *One-time* development costs for complete units (with kitchen and bath) averaged about \$127,000 per unit; Single Room Occupancy (SRO) units were considerably cheaper to create, but tenants much prefer complete units, and stay longer in them. DMH also used \$14 million in District Capital Improvement funds to renovate some of the 985 scattered site beds in its HomeFirst program.

Housing Characteristics

- Housing type—74 percent of the beds were scattered site, 90 percent of tenants hold their own lease
- Tenant households—77 percent were single adults, 23 percent were families

- Requirements for entering the PSH currently operated by District providers—78 percent of beds require being a DC resident, 73 percent require a serious mental illness, 48 percent require sobriety, 35 percent require one to be chronically homeless, 50 percent require a willingness to participate in services
- Reasons for eviction—destroying property and not paying rent are the most common reasons; 25 percent will evict for refusing to participate in services
- Subsidies for PSH beds—35 percent Shelter Plus Care, 28 percent HUD/SHP, 27 percent DMH HomeFirst, 6 percent Local Rent Supplement Program (LRSP), 5 percent Housing Opportunities for Persons with AIDS (HOPWA)

Tenant Characteristics

- 51 percent were chronically homeless; 40 percent were homeless but their length of homelessness was not known
- Disabilities—79 percent had a serious mental illness, 41 percent had addiction problems, 29 percent had both, and 28 percent had a physical disability
- Income sources—45 percent received SSI, 17 percent had earned income, and 6 percent had no income source
- Time in PSH is long—79 percent were in PSH at least one year, and 62 percent were in PSH at least two years
- Post-PSH destinations—28 percent went to their own unit for which they had a rent subsidy, 7 percent went to their own unit without any subsidy, 8 percent went to a residential treatment facility, 7 percent died in PSH, and the destination of 18 percent who left was unknown to PSH staff

The Future

- Provider involvement—70 percent are very likely to be involved in providing PSH in the future; 19 of 23 homeless assistance agencies have long histories of doing PSH and expect to continue
- Biggest inducements to continue—money, especially confidence that the funding for operations (rents) and supportive services will continue from year to year
- Needed for maximum effectiveness in ending homelessness—careful targeting to the most vulnerable, multiply disabled, longest-term homeless single adults and parents in homeless families
- Needed for adequate PSH production—more resources and an effective strategy for streamlining PSH funding of new projects that assures providers that all the pieces will come together and stay together over time.

Permanent Supportive Housing in the District of Columbia: Taking Stock and Looking Forward

1. Introduction

It is increasingly clear that a critical aspect of ending homelessness in America is giving precedence to ending chronic homelessness. Permanent supportive housing (PSH) is being promoted by many cities, housing specialists, and advocates as the “silver bullet” for ending chronic homelessness. A unit of permanent housing whose tenant is supported by a comprehensive set of services, it is argued, is the long-awaited answer to one of the more difficult and persistent policy problems a city or country can face—how can we stabilize a community’s most unstable citizens?

Evidence from an increasing number of cities supports this argument for PSH development. Cities such as Denver, San Francisco, New York, and Portland, Oregon, have shown dramatic reductions in chronic homelessness after launching extensive PSH development strategies.

The data are in: housing supported with permanent subsidies combined with such services as physical and mental health care, substance abuse treatment, and general housing stabilization and case management can indeed stabilize chronically homeless individuals and families. Many are able to reach the point where they break free from the revolving door of shelters, emergency rooms, detoxification centers, incarceration, and other emergency services that can be so costly for municipalities and continuums of care.

What is also clear, however, is that for many cities, **effectiveness depends on supply and focus—the issue is, where do we get these units and whom do we house?**

For the District of Columbia, the process of establishing and targeting PSH has already started. As part of *Homeless No More*, an ambitious 10-year plan to end chronic homelessness promulgated in late 2005, Mayor Adrian Fenty and DC DHS Director Clarence Carter are working to fulfill a commitment to create 2,500 new units of PSH by 2014. In addition, the District has used a survey of close to 3,000 homeless people to ascertain which are the most vulnerable; has identified almost 4,000 homeless people as highly vulnerable, based on their survey responses; and is targeting new units to house this most vulnerable segment of the homeless population. To ensure the success of this plan, though, the District needs to know more about its current stock of PSH, the current PSH tenant base, and the willingness of District PSH providers and other housing developers to step up to the task of developing new projects and supporting their tenants with appropriate services.

To that end, with the generous support of the William S. Abell Foundation, the Urban Institute (UI) surveyed District PSH agencies and specific PSH projects, asking their staff to detail current projects and future ambitions. What follows is an analysis of the stock of PSH in the District as of early fall 2008, demographic information on PSH tenants at that time, and a look at how the District might move forward toward fulfilling its commitment to create 2,500 new units of PSH and ultimately eliminating chronic homelessness.

METHODS

Two surveys were developed, one for agencies that offer PSH and one for their individual PSH projects. Survey protocols used in previous studies in other communities were augmented with the help of DHS staff to obtain information that DHS needs for planning purposes. UI staff administered these surveys between June and September 2008.

The *Agency surveys* addressed the mission and makeup of agencies currently offering PSH in the District. Questions centered around four sections:

- Section 1: PSH agency characteristics
- Section 2: Currently open and occupied PSH projects, and agency involvement with PSH components (development, housing operations, and/or services) now and in the past
- Section 3: PSH projects/units in development, including expectations for new scattered-site projects
- Section 4: Future plans and possibilities

Project surveys asked for detailed information on how specific PSH projects are administered, what services are provided to what types of clients, and specific funding sources. Sections included:

- Section 1: PSH project characteristics
- Section 2: Services linked directly to the PSH project, the agencies providing them, and policies related to continued tenancy
- Section 3: Characteristics of tenants in residence at the time of the survey
- Section 4: Funding sources for capital/development/pre-development
- Section 5: Funding sources for housing management/operating expenses
- Section 6: Funding sources for services for PSH project tenants

Using HUD's 2008 housing inventory chart (HIC), UI researchers identified 28 separate agencies listed as providing PSH in the District of Columbia. After discussion with the directors of 5 of the 28, we determined that their projects were not, by their own description and belief, PSH. Rather, they were various forms of transitional or affordable housing, or special needs housing for people with disabilities who are not coming from homelessness. Appendix A, table A.1, provides details of the housing these five agencies offer and the reasons for removing them from the PSH inventory.

We completed interviews with all of the remaining 23 agencies in the District that offer PSH. Two of these, the Department of Mental Health (DMH) and The Community Partnership (TCP), administer large numbers of units through subcontracts with core service agencies (CSAs) and other nonprofits. Because of time restrictions, UI staff administered surveys only to DMH and TCP staff, the agencies controlling the distribution of these units, relying on them for information specific to different CSAs and PSH tenants.

The 23 agencies offering PSH provided data on 25 of their PSH projects through the project survey. A project in this study is sometimes different from a "project" in the HIC. For instance,

several agencies in the District offer PSH in several buildings, each built at a different time and each showing as a distinct project in the HIC. The agency administers all the buildings as if they were a single project, placing the next tenant in whichever unit in whichever building becomes available first and providing similar services in a similar manner to all the tenants of all the buildings. Under these circumstances, we counted all the buildings managed as a single program as one “PSH project.” We did the same when an agency administered two scattered site projects that differ only in their funding sources. Agency staff were the ones to determine which of their activities should be considered one project.

This approach allowed researchers to collect information on almost all the PSH beds in the District without having to ask agency staff to fill out multiple, time intensive surveys. Even with this consolidation, some agencies completed two surveys because they offer very different forms of PSH. In general, UI researchers used purposive sampling to target the largest PSH project or combination of projects within a given agency for surveys. Of the 2,741 beds that our research identified as PSH in summer 2008, 2,589, or 94 percent, were accounted for in the PSH project surveys.¹ Because of the unusually high response rate, weighting the survey data was deemed unnecessary. One may assume that the remaining 6 percent of beds do not differ significantly from the beds included in our analysis.

We designed and administered both surveys using an online survey tool, Checkbox®. To increase accuracy and response rate, UI researchers conducted the surveys in person or over the phone, entering answers directly into the online template with both the interviewer and interviewee following along on a computer or printed-out version.²

REPORT STRUCTURE

This report provides information on the number of PSH beds in the District during a period from June to September 2008, as well as new insight into the current population of tenants and the future plans of District agencies offering PSH. The information is meant to assist District officials and agency staff in understanding the current stock of PSH and how to move forward to a shared goal of 2,500 new units.

The sections that follow address the following questions:

- PSH Stock
 - What units should “count” as PSH?
 - How many PSH beds does the District have?
 - What does the District’s PSH look like?
 - What types of people are served by agencies offering PSH?
 - What types of services are provided?

¹ In addition to the beds removed from the PSH list because entire projects were really transitional housing or affordable housing, we also corrected the PSH bed counts for 14 other agencies, adding some beds for nine agencies and subtracting some for five agencies according to what agencies reported they had. Appendix A, table A.2, gives the details.

² After an initial discussion of the project with UI staff, some respondents elected to fill out the survey on their own. UI staff checked these surveys for completeness and accuracy, contacting the respondents to clarify their answers when necessary.

- Who PSH projects work with as partners?
- What restrictions do agencies place on the types of tenants they will accept?
- PSH Tenants
 - What types of tenants are staying in PSH?
 - What sources of financial support do current PSH tenants have?
 - Where were tenants living just before moving into PSH?
 - How long are tenants staying in PSH?
 - If PSH tenants leave, where do they go?
- PSH Finances
 - What do agencies see as the scarcest type of resource—funding for development (capital), operations, or services?
 - What PSH components (development, operations, services) do investors support in the District?
 - Which investors contribute most to each component of PSH?
 - What have been the specific sources of funding for development, operations, and services for District PSH?
 - How much do PSH units cost, in one-time development and in annual operating and service expenses?
- Moving Forward
 - Do agencies offering PSH plan to continue or expand?
 - What projects are currently in development?
 - What do agencies plan for the future?
 - What would make PSH agencies more likely to take on new PSH projects?
- Implications and Conclusions

2. PSH Stock

WHAT UNITS SHOULD “COUNT” AS PSH?

For the purposes of these surveys and the overall enumeration of the stock of PSH that existed in the District of Columbia in 2008, UI researchers used the formal U.S. Department of Housing and Urban Development (HUD) definition of Permanent Supportive Housing provided by HUD’s Supportive Housing Program. Specifically, PSH beds are those that *are intended and expected to be their tenants’ permanent homes*, and that:

- (1) Are for persons homeless at move-in, by HUD’s definition, and who have one or more qualifying disabilities,
- (2) Have supportive services attached, and
- (3) Have no limit on the length of stay.³

³ This criterion, as worded but without remembering the “permanent home” part of the PSH definition, is responsible for some of the projects included in the 2008 HIC that we dropped as not being PSH. Some of these projects, such as medical respite, have no pre-determined length of stay, and a policy that people may stay as long as they need to. Thus they seem to meet criterion 3. Nevertheless, they are not intended for or expected to be a person’s permanent home, and are set up more like nursing homes or hospital wards. Similarly, some substance abuse treatment agencies offer transitional residences that do not have time limits, but where the strong expectation is that

As explained above, and in more detail in Appendix A, after initial interviews with agency directors, we removed from the inventory some District housing and services programs listed as PSH in the 2008 HIC because they fell outside of the above definition. We also adjusted the total number of PSH beds in various agencies based on their responses to our surveys.

HOW MANY PSH BEDS DOES THE DISTRICT HAVE?

Table 2.1 shows the 23 PSH providers we identified in the District, which offered 2,741 PSH beds as of summer 2008, spread over 25 distinct projects.⁴

Table 2.1: PSH Projects and Beds in Washington (from January 2008 HIC, with updates based on UI surveys)		
		Type of information
Agencies	23	Based on the 2008 HIC, adjusted to eliminate agencies that only offer something other than PSH. Core Service Agencies (CSAs) are combined under the agency providing the PSH operations funding. <ul style="list-style-type: none"> • TCP is the administrating agency for the operating money (rents) for the S+C units, allocating them to 10 CSA service partners that provide the supportive services. • For DMH's Home First program, we count only DMH, not the 19 CSAs that DMH funds to provide services for the tenants using these housing subsidies.
Projects	31 on HIC 25 combined	31 is all PSH projects, 25 is after combining some HIC entries based on respondent information that they are managed as a single project
Beds	2,741 beds	Estimate as of summer 2008, based on 25 project survey responses, the 23 agency survey responses, and the 2008 HIC

We use PSH *beds* as our unit of analysis. Each bed represents one person living in PSH. If survey responses gave units for PSH for homeless families, the number of units in a given project was multiplied by three to give a total bed estimate, unless the project was able to tell us exactly how many family members were in residence at the time of the survey.

WHAT DOES THE DISTRICT'S PSH LOOK LIKE?

Surveys asked about the way that PSH is configured (e.g., scattered site, single project, mixed use), its affordability to its tenants, supportive services and leasing arrangements, and whether units accommodate single adults or families.

For the housing *configuration* of PSH beds, we determined whether all of a project's beds were in a single building or scattered throughout the city in conventional units owned by private landlords. Housing configuration was grouped into four possibilities:

people will move on to their own residences after solidifying their recovery. In both these situations, agency staff felt their beds were not PSH.

⁴ Note that after the Urban Institute administered this survey, DHS created more than 400 additional beds to move highly vulnerable homeless people into PSH, at the same time it closed Franklin School Emergency Shelter, and continues to move more highly vulnerable people into supportive housing. Our estimate of PSH beds/units does not include these new beds.

- **Scattered site:** there are no more than one or at most a few project units in a building; this includes one-unit buildings. With rare exceptions, tenants lease the units from private landlords.
- **Clustered-scattered:** the project operates two or more small buildings, all units are occupied by project participants, with project buildings usually on different blocks.
- **Single site, building dedicated to PSH:** the project operates in only one building, usually of many more than 8 units; all units are occupied by project participants.
- **Single site, mixed use:** the project operates in only one building or apartment complex, in which project participants occupy some but not all of the units—this can be accomplished through set-asides, master leasing, or other arrangements.

As table 2.2 displays, scattered site housing is the most common configuration in the District of Columbia. Of the 2,589 beds covered by our survey respondents, 74 percent were in scattered site projects, 20 percent were single site, and 6 percent were clustered scattered. Only 1 percent were in single site mixed-use buildings.

Table 2.2: Proportion of PSH Beds in Washington, D.C., Projects with Various Housing Configurations, 2008 (N=25 projects covering 2,589 beds)			
Single site, all PSH	Single site, mixed use	Scattered -site	Clustered-scattered
20	1	74	6

All PSH beds in the District require tenants to pay a share of their rent, generally on a sliding scale. From table 2.3 one can get a sense of the affordability as well as the service levels for PSH beds in the District. Ninety-six percent of beds set their rates at no more than 30 percent of a tenant's income, and 4 percent require either 31–50 percent of a tenant's income or some other payment arrangement, ranging from a fixed rent to individual payment plans.

Table 2.3: Affordability and Service Levels of PSH Beds in Washington, D.C., PSH Projects, 2008 (N=25 projects covering 2,589 beds)				
	Affordability		Service level	
	< or = 30% of income	31-50% of income or some other arrangement	Services more than on request	On request
Percent	96	4	97	3

Tenants in the majority of beds receive services *more frequently than on request*. They might receive anything from simple monthly check-ins by a case manager, to having access to a range of services available on-site or, in the case of scattered-site projects, delivered to tenants in a variety of setting that include home visits. In these circumstances, the intensity of services is flexible but there is regular contact with tenants that supportive services staff initiate. Only 7

percent of beds make case management available only on request. In these situations, case management services are available to all PSH tenants, but tenants must initiate contact.

Table 2.4 shows that the majority of PSH tenants (90 percent) hold the lease to their unit in their own name and the project or agency is not on the lease. Four percent indicated that there is a sublease arrangement between the program agency and the tenant, and 5 percent indicated that there is no lease of any kind.

Table 2.4: Proportion of Washington, D.C., PSH Beds with Different Leasing Arrangements, 2008 (N=25 projects covering 2,589 beds)				
Percent of Beds for Which:				
Tenant holds lease	Joint lease	Tenant has sublease	No lease	Lease arrangements were reported
90	0	4	5	99

Finally, we looked at the types of household that occupy PSH, which can also be thought of as the types of household that agencies have designed their PSH to serve. Table 2.5 shows that more than three-fourths of PSH beds, 77 percent, are occupied by single adults. The remaining 23 percent of the beds are in units occupied by families. Homeless couples without children were rare in PSH, occupying less than 1 percent of PSH beds. In terms of *units* rather than beds, single adults occupy about 91 percent of units while families occupy the remaining 9 percent, assuming that each homeless family includes one adult and two children (three beds).

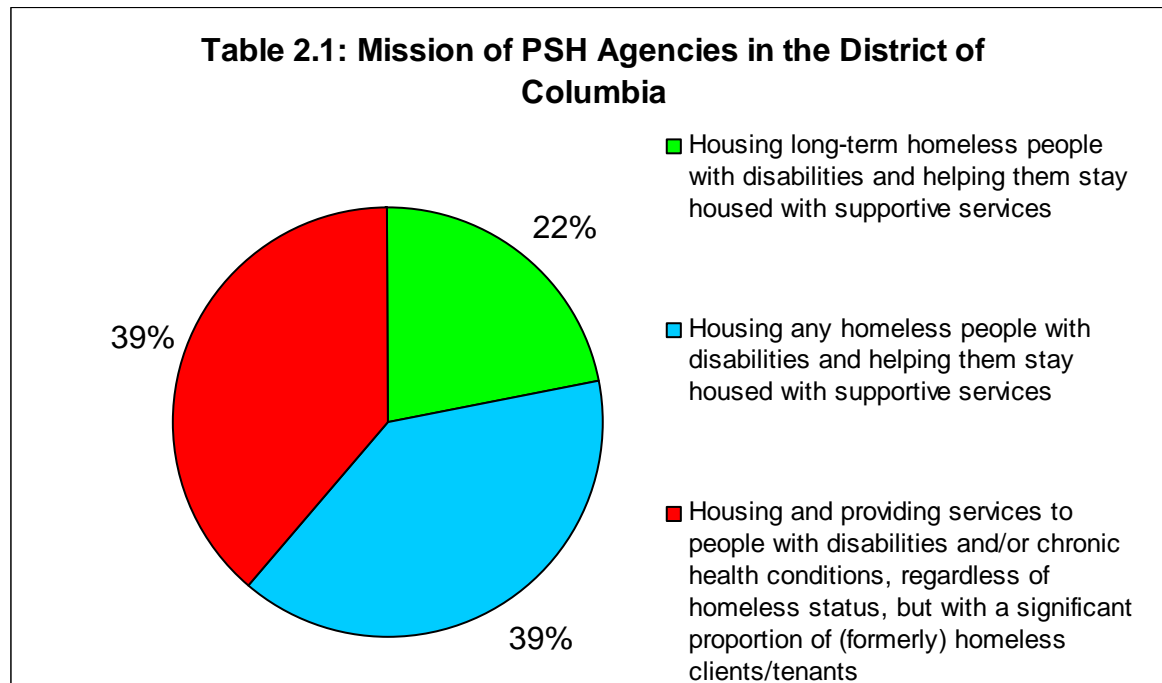
Table 2.5: Proportion of Washington, D.C., PSH Beds Occupied by Different Types of Households, 2008 (N=25 projects covering 2,589 beds)			
Single adult	Couple (two adults, no children)	Families (children present)	No household type reported
77	<1	23	0

WHAT TYPES OF PEOPLE ARE SERVED BY AGENCIES OFFERING PSH?

Many agencies offering PSH also provide a range of other services; they also serve housed as well as homeless people. Considering all agency clients, whether in PSH or not, homeless or not, 91 percent of the 23 District agencies offering PSH serve clients with serious mental illnesses (SMI), substance abuse disorders, dual diagnoses, and physical disabilities; 74 percent serve at least one individual with HIV/AIDS; and 48 percent serve at least one individual with no disabilities (table 2.6).

Table 2.6: Proportion of Washington, D.C., Agencies That Currently Serve Single Adult Clients with Various Disabilities, Whether in PSH or Not, 2008 (N=23 agencies)					
SMI	Substance abuse	Dual diagnosis	HIV/AIDS	Physical disabilities	No disability
91	91	91	74	91	48

Figure 2.1 shows how respondents categorized the mission of their entire agency. Only 22 percent felt their mission was primarily to provide housing with supportive services to chronically homeless people with disabilities. The others had broader missions, with 39 percent providing housing for any disabled homeless people, not just the chronic population. Another 39 percent described their mission as providing housing and services to people with disabilities, regardless of their homeless status.



In addition to the commitments and experiences of the agencies offering PSH, specific projects may have a mission to serve people with certain disabilities. The survey asked project directors about these missions, with most directors identifying more than one disability group that their project was committed to serving. Table 2.7 shows the proportion of PSH beds found in PSH projects reporting a mission to serve various disability groups. Proportions sum to more than 100 because many PSH projects reported a mission to serve more than one population.

Table 2.7: Proportion of Washington, D.C., Beds Found in Projects with a Mission to Serve Groups with Various Disabilities, 2008 (N=25 projects covering 2,589 beds)					
Disability Group					
SMI	Substance abuse	Drug abuse	Dual diagnosis	HIV/AIDS	Physical disabilities
88%	44%	44%	50%	38%	15%
SMI but no substance abuse		Substance abuse but no SMI		Both SMI and substance abuse	
38%		2%		50%	

Eighty-eight percent of the District's PSH beds are in projects with a mission to help people with serious mental illness, of which 38 percent are in projects that serve those with SMI but no co-occurring substance abuse disorder. Fifty percent of the beds are in projects with a mission to serve people with co-occurring mental illness and substance abuse. Given the relatively small proportion of PSH beds actually occupied by persons with HIV/AIDS (see below, table 14), a surprising number of beds—38 percent—are in projects saying they have a mission to serve those with HIV/AIDS. Only 2 percent of beds were in projects saying they target people with addictions only and do not consider it their mission to help those who also have a mental illness.

WHAT TYPES OF SERVICES ARE PROVIDED?

Ninety-five percent of District agencies provide case management for their PSH tenants, while 82 percent provide mental health, substance abuse, and other treatment services, and the same proportion provide recreational/community building services (table 2.8). Far fewer agencies hold leases for tenants or serve as representative payees; about three-fourths (73 percent) either provide assistance gaining employment themselves or have mechanisms to link tenants to employment services.

Table 2.8: Proportion of Washington, D.C., Agencies Offering Certain Services for Their PSH Tenants, 2008 (N=22 agencies)					
Agency holds lease	Serves as rep payee	Provides case management	Provides recreational educational, community-building services	Provides mental health, substance abuse, health, other treatment services	Provides employment assistance
37	32	95	82	82	73
Based on 22 agency surveys; TCP did not complete this question because it does not provide direct services.					

Where table 2.8 shows general categories of services available from *agencies* offering PSH, table 2.9 focuses on PSH *projects*. At the project level, we inquired about 13 service types, determining whether they were available to PSH tenants and if yes, whether they were part of the services offered directly by the project or if another agency provided them. If another agency was involved, we also asked whether that agency came to the tenants (on-site service delivery) or whether the services were offered at one or more other locations. For services provided by a different agency, we also asked whether there were clear partnering arrangements that assured tenants of getting the service, or if the service was only “by referral,” without a commitment of the other agency to serve the tenants. In these latter cases, we do not list the service as part of the PSH project.

Table 2.9 shows the 13 services we asked about, from tenant stabilization through representative payee services. The table's first row shows the proportion of District PSH beds for which project staff or the sponsoring agency provides each service. For the most part these are provided at the project location or, if the project uses scattered site housing, in the tenant's home. However, it may also include services provided at a central location of the project's sponsoring agency—for instance, tenants of S.O.M.E.'s (So Others Might Eat) various projects come to S.O.M.E.'s central location for case management, health care, and other services, while residents in Catholic Charities' several PSH projects come to a centralized location for specialized services such as

employment supports. The second row of table 2.9 shows the proportion of beds with services delivered on site, which may be offered by staff of the PSH project or by another agency coming to the project site.

Table 2.9: Proportion of Washington, D.C., PSH Beds with Services Provided by the Project or Its Sponsoring Agency, and Whether Services Are Delivered on Site		
(N=24^a projects covering 2,002 beds)		
	Project or its sponsoring agency provides the service	Service is provided on site, whether by the project or a partner agency
Tenant stabilization	100	100
Building support systems	92	80
Basic needs	80	85
Case management	84	87
Employment-related services	32	24
General health care	68	61
Mental health	75	73
Substance abuse	26	22
HIV/AIDS	11	13
Legal services	9	7
Veterans services	4	4
Housing-related services	83	77
Representative payee services	13	13
^a TCP did not complete this question because it does not provide direct services.		

All survey respondents indicated that they provided tenant stabilization services with their own staff, using staff to help tenants learn to live in housing, perform activities of daily living, and to get along with their landlord and other tenants. Most also used their own staff to help tenants to build support systems (92 percent), meet basic needs such as food and clothing (80 percent), and link to needed programs and services through case management (84 percent). Few programs offered veterans, HIV/AIDS, legal, or representative payee services using program staff or by having staff of other agencies come to project clients, choosing instead to refer tenants to other providers and facilities.

WHAT OTHER PROVIDERS WORK WITH PSH PROJECTS AS PARTNERS?

Partner arrangements for District PSH projects centered largely on service provision, with 22 of the project survey respondents indicating that on average, they partnered with 4 or 5 other agencies to provide services (table 2.10). This mean number of partners for services is skewed upward because two agencies TCP and DMH, work with 20 and 19 CSA service providers, respectively, for their S+C and HomeFirst resources. We did not count a parent agency as a partner (e.g., SOME for its various buildings; Catholic Charities for its four PSH projects or for Anchor MH), nor did we count a response of “we refer” as indicating a partnership relationship.

The number of partners identified for operations (building maintenance, rent collection, etc.) and development is much smaller, much of which can be explained by the fact that 77 percent of

PSH beds in the District are in scattered site projects and thus did not involve development, nor are the PSH agencies involved in operations. Only five programs indicated that they worked with even one partner for operations, and none worked with a partner for development. In all, we see extensive partnering for various services but very little for operations or development.

Table 2.10: Organizations Named by Washington, D.C., PSH Projects as Partners for Development, Operations, or Services, 2008

(N=25 projects covering 2,589 beds)

Partners for:	Number of Projects:		For projects naming at least one partner:		
	With surveys	Naming at least one partner	Number of partner agencies mentioned by at least one project	Number of mentions	Average number of partners mentioned
Development	25	0	0	0	0
Operations	25	5	5	6	1.0
Services	25	22	66	83	4.5*

Note: We did not count a parent agency as a partner (e.g., S.O.M.E. for its various buildings; Catholic Charities for its 4 PSH projects or for Anchor MH), nor did we count a response of "we refer" as indicating a partnership relationship.

*The mean number of partners for services is skewed upward due to the way that TCP and DMH manage their S+C and HomeFirst resources; both agencies act as central allocation points for rent subsidies across many CSAs and other nonprofits.

WHAT RESTRICTIONS DO AGENCIES PLACE ON THE TYPES OF TENANTS THEY WILL ACCEPT?

A pressing issue for many PSH programs is under what circumstance they would evict a tenant. Table 2.11 displays the response from program staff on the various reasons a tenant might be evicted from their unit. Seventy-one percent of respondents noted that destroying property and not meeting individual rent requirements could result in eviction. Far fewer beds in the District (28 percent), were in projects that would not tolerate multiple relapses into substance use, and 23 percent would not tolerate any substance use at all. It should be noted that these circumstances would not always result in an automatic eviction; program staff often dealt with these issues on a case by case basis and gave tenants numerous chances before eviction became a reality.

One of the biggest potential issues for District public agencies working to bring many long-term homeless people with numerous disabilities into housing is the willingness of providers to include people with these characteristics in their PSH projects.

Table 2.11: Proportion of Washington, D.C., PSH Beds in Projects that Would Evict a Tenant for Various Reasons, 2008

(N=25 projects covering 2,589 beds)

Reason	2008
Fails to maintain complete abstinence	23
Multiple relapses	28
Fails to participate in required service	25
Disruptive/aggressive behavior	35
Destroying property	71
Not paying rent	71

We asked project directors about many different criteria that they might use to decide whether someone seeking a PSH unit in one of their projects would be accepted. Providers had the option

of saying that a particular characteristic was *required*, meaning that someone without the characteristic would be turned away, that it was *acceptable*, meaning that a person might be accepted whether or not the characteristic was present, or that it was *not acceptable*, meaning that a person with the characteristic would be turned away. Table 2.12 displays the results.

Table 2.12: Entry/Screening/Acceptance Criteria for D.C. PSH programs? (N=25 projects covering 2,589 beds)			
Criterion	Required	Acceptable	Not acceptable
Was D.C. resident when became homeless	78	22	0
Was D.C. resident just before entering your program	61	39	0
Homeless (living in a shelter, transitional housing, or in a place not typically used for sleeping such as on the street, in a car, in an abandoned building, or in a bus or train station)	44	56	0
Meets HUD "chronically homeless" definition or, if family, a parent would meet that definition	35	65	0
Diagnosis of severe and persistent mental illness (SPMI)	73	25	2
SPMI plus a co-occurring diagnosis (substance abuse or major medical)	23	74	3
Active substance abuser	0	45	55
Clean and sober	48	52	0
Has HIV/AIDS	25	75	0
Has felony criminal record	0	98	1
Has sexual offender criminal record	0	82	17
Has history that includes own violence against or abuse of children or adults	0	84	15
Able to participate in developing and carrying out an appropriate service plan	53	47	0
Willing to participate in developing and carrying out an appropriate service plan	50	50	0
Physical disabilities requiring accommodation (e.g., wheelchairs, ramps, sign language interpretation)	2	96	1
Note: Due to rounding, not all percentages add to 100.			

Forty-eight percent of PSH beds were in projects that required tenants to be clean and sober upon entering the program. Slightly more beds, 55 percent, were in projects that said they would not accept an active substance abuser. Some of the projects requiring sobriety did not require much sobriety time, as long as prospective tenants committed themselves to remaining clean and sober once they were in housing.

For the most part, PSH providers in the District appeared to be open to accepting individuals with felony criminal records (98 percent found it acceptable), a history of violent behavior (84 percent found it acceptable), and sexual offender criminal records (82 percent found it acceptable). Projects offering 73 percent of all PSH beds indicated that they require tenants to

have a severe and persistent mental illness (SPMI) diagnosis. In many cases this requirement on the projects' part reflects project funding, which comes at least in part from DMH.

3. PSH Tenants

WHAT TYPES OF TENANTS ARE STAYING IN PSH?

Table 3.1 indicates the proportion of PSH tenants in the District who were chronically homeless before moving into PSH, those who were homeless but known not to be chronic, those known to be homeless but whose length of homelessness is not known, and those for whom homeless status itself is not known. A fair number of respondents could not readily report the proportion of their tenants who had been chronically homeless, leaving us without determination of chronicity for tenants in 40 percent of PSH beds. Two circumstances might explain this lack of information. These may be tenants who have lived in their units for many years, moving in before HUD began to require projects to assess length of homelessness. Alternatively, they may live in projects that do not receive HUD funding and would never have been required to assess for chronic homelessness.

Table 3.1: Formerly Homeless Status of Washington, D.C., PSH Occupants, 2008 (N=25 projects covering 2,589 beds)			
Formerly homeless			Don't know homeless status
Chronic	Not chronic	Do not know chronicity	
51	7	40	2

Whether or not we know about chronic homelessness, however, it is very clear that the vast majority of PSH units *are* occupied by people who had been homeless just before moving into PSH. For PSH tenants where length of homelessness is known, almost 9 of every 10 tenants had been homeless for more than a year. As table 3.2 shows, 79 percent of District PSH beds house people with a serious mental illness. Drug and alcohol abuse is also prevalent, with 41 percent of District beds reportedly inhabited by homeless individuals with a substance abuse problem. Those who are dually diagnosed, with both substance abuse and mental health problems, make up 29 percent of the District PSH tenants. Fourteen percent of District PSH beds are occupied by formerly homeless individuals with HIV/AIDS, while 28 percent of PSH tenants have at least one physical disability.

Table 3.2: Proportion of Washington, D.C., PSH Beds Occupied by Formerly Homeless Tenants With Various Disabilities, 2008 (N=25 projects covering 2,589 beds)	
Disability	Proportion of beds ^a
Serious mental illness	79
Substance abuse	41
Dual diagnosis	29
HIV/AIDS	14
Physical disability	28

^a Categories are not mutually exclusive

WHAT SOURCES OF FINANCIAL SUPPORT DO CURRENT PSH TENANTS HAVE?

We inquired about three aspects of tenants' economic circumstances—what types of income, rent subsidy, and health insurance they have. Response categories always included “none.” Information about tenants' income and health insurance sources proved more difficult for PSH project staff to provide than information about housing arrangements or tenant disabilities. Indeed, responses regarding some types of income dropped below 80 percent for current tenants. Therefore table 3.3 shows the number of beds for which respondents were able to report about each income type, then the proportion of all surveyed beds this represents, and finally, in the last column of table 3.3, the proportion of tenants who have this income source.

Income Source	Number of beds accounted for	Percent of all beds surveyed	Percent of tenants with income source
SSI—Supplemental Security Income	2459	95	45
Earned income—from job of any type or length	2379	92	17
TANF (families only)	1988	77	7
Social Security—regular payment after retirement	1893	73	6
Tenants with no income source	2044	79	6
IDA—Interim Disability Assistance—the District's own disability payments, while people wait to get into SSI	2060	80	3
Veterans Affairs payments, either disability or regular military pension	1913	74	2

By far the most commonly reported income source was SSI, which 46 percent of tenants received. Reporting on only 80 percent of PSH beds, respondents indicated that another 3 percent were getting the District's Interim Disability Assistance while waiting to be approved for SSI. Following SSI, the next most common income source was earned income, reported for 17 percent of the tenants in 92 percent of PSH beds. Of the remaining income sources, reflecting tenants of between 73 and 79 percent of PSH beds, 7 percent received TANF and 2 percent received cash benefits from the Department of Veterans Affairs. Only 6 percent of tenants (in 79 percent of PSH beds) were reported as not having any income at all.

Project representatives were much more able to report on the various rent subsidies used for their PSH beds (only 3 percent were missing information), mostly because all beds in a particular project usually received the same type of subsidy and the agency offering the PSH was well aware of its source. Not surprisingly, federal programs supported the majority of PSH tenants. As table 3.4 shows, 35 percent of all PSH beds in the District receive Shelter Plus Care (S+C) subsidies, and another 28 percent are subsidized by HUD Supported Housing Program (SHP) grants. District public agency funds provided some level of subsidy for 30 percent of PSH beds, with DMH monies funding around 650 PSH beds.

Table 3.4: Proportion of Tenants in Washington, D.C., PSH Projects with Various Housing Subsidies (N=2,453 beds reporting—97%)	
Subsidy type	Proportion of beds reporting that receive each subsidy type
Shelter Plus Care—tenants pay 30 of income	35
HUD Supported Housing Program pays for most of their housing cost—but PSH tenants pay a share	28
DMH funding (HomeFirst) as contract to PSH agency	27
Some other type of subsidy or rent reduction	6
DCHA spending locally appropriated money—Local Rent Supplement Vouchers	5
HOPWA or other HIV/AIDS-related subsidy	1
HUD Supported Housing Program pays for their housing—PSH tenants pay nothing	<1
They live in units owned and run by DCHA—including Section 202 and 811 housing	<1
No subsidy	<1

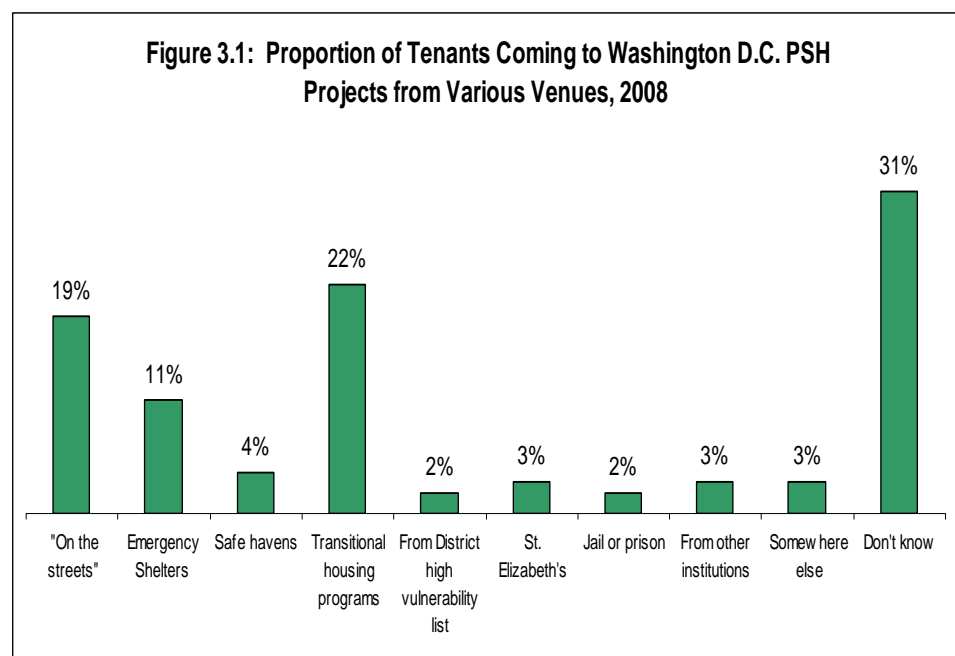
Few respondents were able provide answers to questions regarding the health insurance their tenants received, with the exception of Medicaid use. Respondents representing 90 percent of the District's PSH beds reported that 69 percent of their tenants were Medicaid beneficiaries. Information on other sources of health insurance garnered response rates too low to report.

WHERE WERE TENANTS LIVING JUST BEFORE MOVING INTO PSH?

Transitional housing programs feed into PSH programs at the highest rate, with 22 percent of current tenants entering PSH from a transitional program. These transitional housing programs are often run by the same agency that offers the PSH.

A high proportion, almost 20 percent, came directly from the streets, indicating a significant level of outreach by PSH providers, and 11 percent came from District emergency shelters.

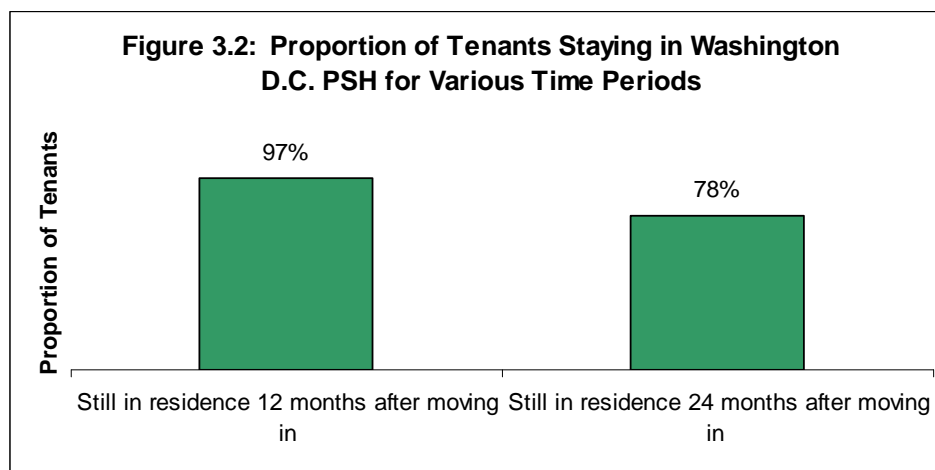
Only 2 percent of tenants in the PSH that existed in summer 2008 came from the list that



DHS has begun to maintain of people who have one or more conditions that make them highly vulnerable to dying on the streets. This is because the 475 new units of PSH that DHS has developed for people on the list, so far, were not available during the period covered by our surveys. All new PSH developed under DHS auspices will be offering their units to people from the list.

St. Elizabeth's Hospital, prisons and jails, and other institutions were each the source of 2 or 3 percent of PSH tenants. Given what we know about the risk of homelessness for persons leaving the DC jail,⁵ more collaboration to prevent homelessness upon institutional discharge for people with significant levels of disability and histories of homelessness would be highly advisable.

HOW LONG ARE TENANTS STAYING IN PSH?



Of all PSH tenants in residence at the time of our survey, 97 percent had been housed for at least a year and 78 percent had been in residence two years or more (figure 3.2).

PSH project staff attribute housing stability primarily to case management

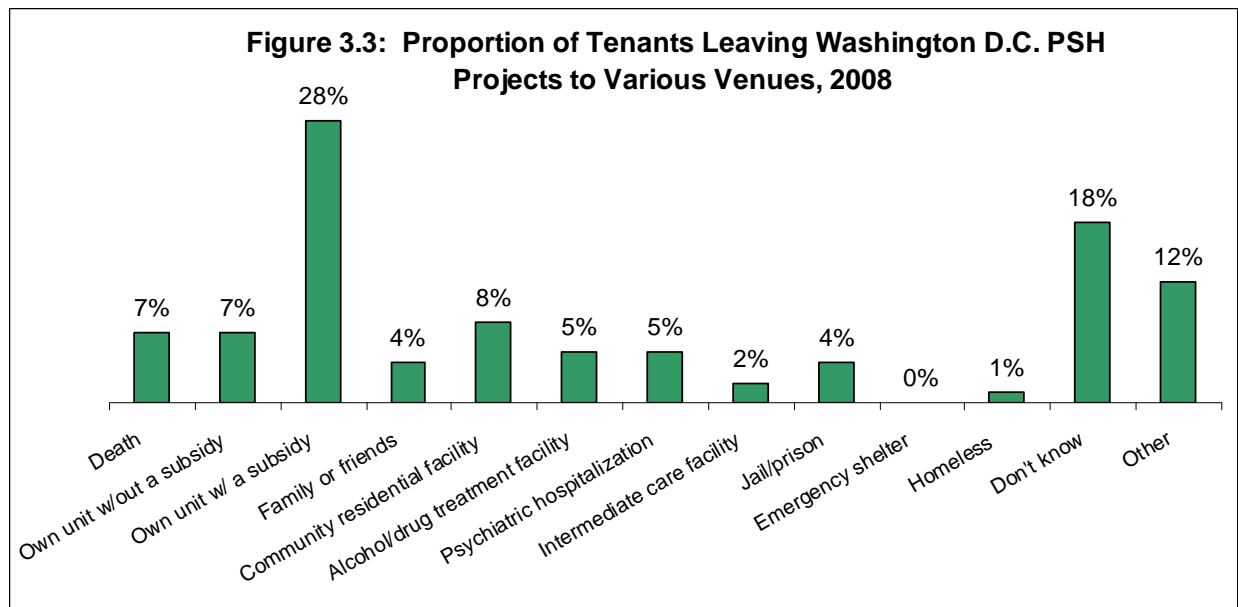
Table 3.5: Program Staff Opinion of Critical Factors That Keep Someone in Housing for a Year or More	
(N= 25 project surveys)	
	Number of projects
Case management, plus understanding and willingness to work on individual plans	19
Staff skills/relations and culture	10
Sobriety/personal characteristic selection	7
Quality/safety of unit (includes privacy)	6
Community	5
Location	4
General services	4
Lack of other options	2

based on individualized service plans, as shown in table 3.5. Nineteen of the 25 project respondents, or 76 percent, noted the importance of having clients understand their service plans and demonstrate a willingness to follow through with them. Along those lines, 40 percent of respondents mentioned that staff skill and staff-client relationships had the greatest effect on retention, claiming that if staff could create a comfortable environment and culture, tenants would stay.

⁵ Burt, M.R., S. Hall, C.G. Roman, and J. Fontaine. 2009. Reducing the Revolving Door of Incarceration and Homelessness in the District of Columbia: Population Overlaps. Washington, DC: Urban Institute. Available at <http://www.urban.org/publications/411859.html>.

IF PSH TENANTS LEAVE, WHERE DO THEY GO?

For tenants who do move out, the highest proportion, 28 percent, are moving into another unit of their own with a subsidy attached, while 7 percent were able to move into their own unit without a subsidy, as shown in figure 3.3. Another 7 percent died during their stay in PSH. It should be noted that no programs reported any PSH clients moving out of PSH and back into emergency shelters. In addition, only 1 percent of tenants leaving PSH in the District return to a homeless situation, as far as project staff are aware. Eighteen percent of leavers, however, were unaccounted for in our survey responses, so some of these may have become homeless again after leaving PSH.



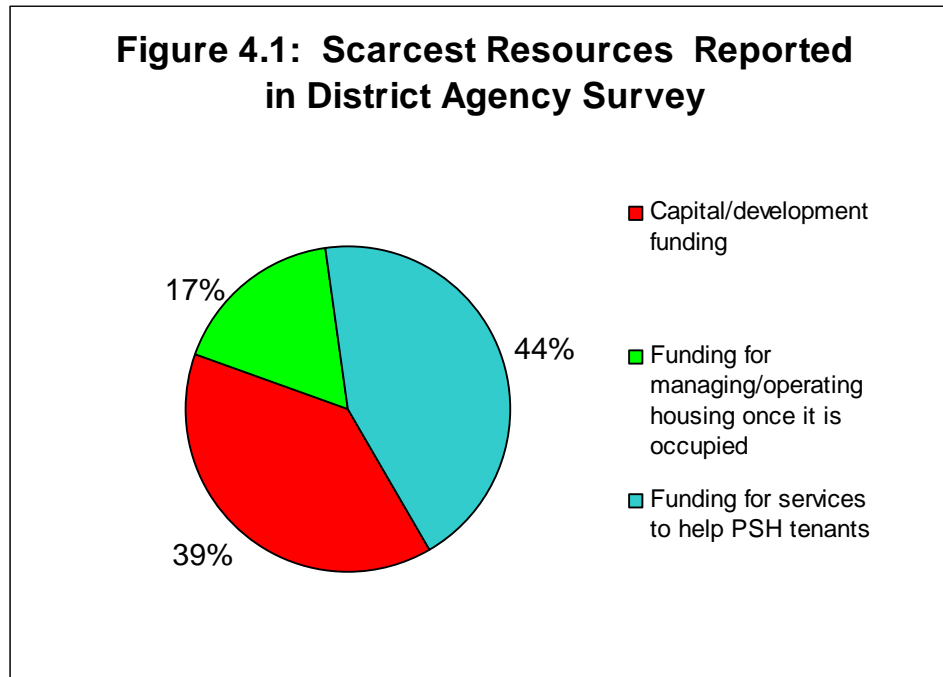
4. PSH Finances

It is always a challenge to assemble the funding for a PSH project. PSH needs money to pay the rent and to provide tenants with supportive services, and these funds are recurring and must be found year after year. If the PSH is offered in a specific building rather than using existing apartments scattered around the community, one-time resources for development (acquisition, renovation, construction, permitting, etc.) are also involved. In addition to the ever-present fact that there are never enough resources to meet the need, a good part of the battle to fund PSH involves knowing where to look for various types of funding and the different requirements that various funding agencies have for applying.

We began our discussion of PSH funding with project sponsors by asking what they thought was the scarcest type of resource for PSH in the District, following that question with inquiries as to the sources and amounts of funding for their existing PSH, including development funding (if any), operating funds (mostly rent), and funds to provide supportive services. We combine the answers to the latter questions to show the most common sources of development, operations, and services funding for existing PSH in the District and the amounts invested by different levels of government and the private sector.

WHAT DO AGENCIES SEE AS THE SCARCEST TYPE OF RESOURCE?

A common answer to the survey question “What do you see as the scarcest resource for PSH in the District?” was “everything.” But when asked to choose, 44 percent of agencies saw *services* funding as the hardest to come by, followed closely by capital/development funding at 39 percent (figure 4.1). Only 17 percent found operations funding the hardest to obtain.



WHICH PSH COMPONENTS (DEVELOPMENT, OPERATIONS, SERVICES) DO INVESTORS SUPPORT IN THE DISTRICT?

We asked about funding in three categories—capital/development, operations, and services. Capital/development costs are one-time investments expected to create housing that will last for many years. Therefore they tend to be large for projects that have them. Operations and services costs were reported for “the most recently completed fiscal year,” and thus represent annual costs. The few projects that had not yet completed a full fiscal year were asked to report the budget projections for their first full year.

Currently operating PSH projects in the District reported a total of \$69.9 million in funding, slightly more than half of which was for capital outlays (\$39 million). One-year operating income was reported as \$19.1 million, while one-year services resources were reported as \$11.8 million for the survey respondents. The least complete of these reported amounts is the latter, for services, because many services that PSH tenants receive are paid for by other agencies and not through project budgets. We discuss this issue, and develop an estimate of true services cost, in conjunction with our discussion of table 4.5, which shows services funding sources and amounts. Table 4.1 shows these totals for District PSH in terms of capital, operations, and service dollars, and what level of government or private sector provides the funds. It also shows the distribution

of each source across capital, operating, and services as percentages that add to 100 as one reads down the columns.

Table 4.1: What PSH Components Do Investors Support in Washington, D.C.: One Year Period during FY06 – FY08 (N= 25 project surveys)				
Dollars, in millions		Percentage allocation by source across PSH components		
		Federal	Local	Private
Per source		\$27.0	\$27.3	\$15.6
Per component				
Capital	\$39.0 (56%)	37	68	66
Operating	\$19.1 (27%)	36	25	16
Services	\$11.8 (17%)	26	7	18
Total (percent)	\$69.9 (100%)	100	100	100

The total federal investment is fairly evenly split across capital, operations, and service funding, with a slightly lower portion going to services. Local public dollars are heavily invested in capital development (71 percent) but contribute very little to supportive services, with only 7 percent of local resources used by District PSH projects reportedly going to fund services. Both federal and private sources invest far more of their funding in service provision, at 26 and 18 percent, respectively.

WHICH INVESTORS CONTRIBUTE MOST TO EACH PSH COMPONENT?

At 39 percent each, federal and local dollars make up the highest proportion of the total reported funding (table 4.2). From the projects that involved capital development, encompassing 48 percent of PSH beds, we learned that just under half (48 percent) of capital development funding came from local government agencies—almost double the investment of federal funds. Both operating and services funding comes primarily from federal sources. Private funds, as shown in table 4.2, seem to be used to make up for a lack of local investment in services, with only 9 percent of the total services funding coming from local sources and 24 percent coming from private monies. On the other hand, fewer private funds are used for operating expenses while local funds are utilized to a greater extent.

Table 4.2: Which Investors Contribute Most to Each PSH Component for Washington, D.C., PSH Projects: One Year Period During FY06 – FY08 (N=25 project surveys)					
	Percent of beds reporting	Percentage Distribution, Type within Government Level/Private			
		Federal	Local	Private	Total Percent
Dollars, in millions		\$27.0	\$27.3	\$15.6	--
Percent of all funding		39	39	22	100
Capital	48	26	48	26	100
Operating	99	51	36	13	100
Services	96	61	15	24	100

WHAT HAVE BEEN THE SPECIFIC SOURCES OF FUNDING FOR DEVELOPMENT, OPERATIONS, AND SERVICES FOR DISTRICT PSH?

Table 4.3 shows the sources of capital reported for the projects that were involved in development. Capital Improvement funds provided the largest investment, followed by various grants and loans, capital campaigns, developer equity, and general fundraising by provider agencies. Section 811 funds as well as the Housing Trust Funds were also used to a large extent, with over 26 percent of capital funding coming from a combination of the two. Low Income Housing Tax Credits accounted for 6.3 percent of capital funding, while investments channeled through financial intermediaries contributed 4.5 percent. Noteworthy is the relatively insignificant role of tax credits in providing the capital for PSH projects, compared to 30 percent or more in a number of other communities.⁶

Table 4.3: Sources of \$1 million or More Capital Dollars for Washington, D.C., PSH Projects (N= 11 project surveys, including 1,316 beds)		
Major sources of capital	Dollars, in millions	Percentage of all capital dollars
Capital Improvement/District redevelopment funds	\$14.0	35.8
Developer equity, capital campaigns, general agency fundraising (includes some foundation support)	\$8.5	21.9
Section 811	\$5.7	14.6
Housing trust fund	\$4.6	11.6
Low Income Housing Tax Credits (LIHTC)	\$2.5	6.3
Financial intermediaries: Low income investment funds (loans), Cornerstone, Enterprise Community Partners, City First Bank	\$1.7	4.5
HUD special appropriation	\$1.5	3.7
Total from major sources	\$38.5^a	98.5^a
^a The remaining \$0.6 million (1.5%) includes funding from HOPWA, unidentified DHCD monies, McKinney Supportive Housing Program (SHP, direct or through CoC), and other District funds specially appropriated for PSH.		

DMH is the single largest funder for operations (rents) for PSH in the District through its HomeFirst Program, contributing \$5.66 million a year (29.5 percent of the total). Shelter Plus Care certificates from HUD supply almost as many resources (\$4.9 million a year), and are expanding every year. Other federal rent subsidies provide the next biggest share at \$3.14 million, or about 16 percent. Tenant contributions to rent make up 8 percent of the total operating resources, providing slightly more support than SHP funds.

⁶ Burt, M.R. 2008. Evolution of PSH in Taking Health Care Home Communities, 2004–2007: Tenants, Programs, Policies, and Funding at Project End. Oakland, CA: Corporation for Supportive Housing. Available at www.csh.org/publications.

Table 4.4: Sources of \$500,000 or More in Operating Dollars for Washington, D.C., PSH Projects: One Year Period During FY06 – FY08 (N = 23 projects covering 2,552 beds)		
Major source of Operating funds	Dollars, in millions	Percentage of all operating dollars
Department of Mental Health grants or contracts that cover rent	\$5.66	29.5
Shelter Plus Care (S+C)	\$4.90	25.6
Section 8 of any type (tba, pba, sponsor-based, SRO Mod Rehab)	\$3.14	16.4
Tenant contributions to rent, regardless of where tenants get the money from	\$1.55	8.1
McKinney Supportive Housing Program (SHP, direct or through CoC)	\$1.48	7.7
DCHA spending locally appropriated money for rent subsidies—Local Rent Supplement Vouchers	\$0.99	5.2
Fannie Mae and other foundation funding	\$0.57	2.9
Total from major sources	\$18.49^a	97.4^a
^a The remaining \$0.61 million (4.6%) includes additional funding from private fundraising, HOPWA, District appropriations/line items that cover rents or operating expenses, and Section 811.		

Among the sources of funds for supportive services that projects reported on surveys, Medicaid provided by far the largest amount of funding—\$4.17 million or over 35 percent of the total annual funding for services that projects reported (table 4.5). Much of these funds came through Shelter Plus Care matches for PSH tenants with serious mental illness. In all likelihood, a major reason why the District has such a high proportion of people with serious mental illness in its PSH is that most of them will qualify for SSI and hence for Medicaid, thus bringing with them this vital source of services funding that is mostly paid for from federal coffers.

Table 4.5: Sources of \$600,000 or More in Service Dollars Reported by Washington, D.C., PSH Projects: One Year Period During FY06 – FY08 (N = 25 projects covering 2,476 beds)		
Major sources of services funding	Dollars, in Millions	Percentage of all services dollars
Medicaid (“regular,” MRO) ^a	\$4.17	35.4
General fundraising by project sponsor	\$1.40	11.8
Foundation support and Fannie Mae	\$1.25	10.6
HOPWA	\$0.98	8.3
Any other DHS—not Medicaid, not Healthcare Alliance, not TANF	\$0.86	7.3
Other HIV/AIDS, Ryan White	\$0.77	6.6
McKinney Supportive Housing Program, including SSO monies (SHP, direct or through CoC)	\$0.64	5.5
DMH (local resources)	\$0.62	5.3
Medicare	\$0.60	5.1
Total	\$11.29^b	96.0^b
^a We calculate that Medicaid contributes an additional \$7.23 million for 1,104 PSH tenants who are Medicaid beneficiaries but for whom no Medicaid funding was reported.		
^b The remaining \$0.48 million (4.0 percent) includes tenant contributions through rent, special District appropriations/line items that cover services, Addiction Prevention and Recovery Admin (APRA), CDBG, DOH-Office of HIV/AIDS, and other District funds.		

Important as the reported Medicaid funding is, it represents only slightly more than one-third of the resources that Medicaid is probably contributing, due to underreporting of several types. First, respondents representing 955 beds knew that their tenants received Medicaid but did not report dollar figures for Medicaid on the survey's budget pages. Second, respondents representing an additional 149 beds reported that their tenants received SSI, which qualifies the tenants for Medicaid, but did not report that the tenants received Medicaid, and did not report any funding from Medicaid.⁷ Third, respondents for over 1,100 more tenants could not report their tenants' health insurance type, if any, nor did they indicate that the tenants received SSI. In addition, no respondent could estimate how many tenants received health care through the D.C. Healthcare Alliance, and none reported the Alliance as a source of services funding.

To compensate for the Medicaid underreporting and give a rough idea of how much more money Medicaid is contributing to the care of PSH tenants, we made the following calculations:

- \$4.17 million in *Medicaid funding* was reported for 635 of the 1,590 tenants reported to be *receiving* Medicaid. Using these figures we calculate that Medicaid supported \$6,567 in services costs for each of these 635 PSH tenants per year.
- Applying this per person per year cost of \$6,567 to the 955 tenants known to *receive* Medicaid but for whom *no Medicaid funding* was reported, we get an additional \$6.27 million in Medicaid expenditures per year to support PSH tenants in the District.
- Thus the total Medicaid funding for PSH tenants known to be receiving Medicaid is \$10.44 million, or about one and a half times as much Medicaid funding as the funding actually reported.
- There are also 149 tenants reported as receiving SSI, which makes them eligible for Medicaid, who were not reported as receiving Medicaid. If we assume that these 149 tenants are also Medicaid recipients and add \$6,567 for each of them to the total of \$10.44 just calculated, we get \$11.40 million in total Medicaid funds that support tenants in the District's PSH units—almost three times as much as actually reported.
- This brings the total annual dollars for supportive services in PSH to at least \$19.03 million, one and a half times the \$11.8 million reported in tables 4.1, 4.2, and 4.5.

Private funding sources such as foundations, Fannie Mae, and general fundraising and solicitations by provider agencies filled a gap in funding for services, providing close to 22 percent of the total annual funding known to and reported for PSH projects. The fact that general fundraising by project sponsors accounts for the second-largest source of reported services funding attests to the difficulty of relying on public sources to pay for services in PSH, reflecting back on the testimony of 44 percent of project directors who said that services funding is the hardest PSH component to obtain (see figure 4.1, above).

- In addition to the services funding reported in table 4.5 and the calculations we can make about unreported Medicaid funding, all of the PSH tenants not covered by Medicaid would be eligible to receive health care through the D.C. Healthcare Alliance. We do not know how many of these tenants avail themselves of Alliance services. Nor do we know

⁷ It is very common for PSH providers not to know how much their tenants are using in Medicaid and other funding for services that are delivered by other agencies, as these funds are not in the actual budgets of the PSH projects.

the per person cost of Alliance services for PSH tenants—although we do know that they are not likely to be as high as Medicaid outlays per person, because the services available through the Alliance are not as extensive as those allowed under Medicaid. What is clear, though, is that many PSH tenants receive health care through the Alliance and therefore the Alliance makes a contribution to the costs of maintaining tenants in PSH—we just do not know how much that contribution is.

5. Moving Forward

The District government's commitment to develop 2,500 net new units of PSH by 2014 makes it very important to know which agencies want and expect to continue developing new PSH. We asked about agency plans and intentions in several ways. First, we inquired about an agency's past, present, and expected future involvement in the three components of PSH—development, operations, and services, reasoning that agencies with long histories of involvement would be the most likely to continue. Then we asked about specific PSH projects they had in the pipeline, meaning that some money had already been invested in a new project and more was expected. These questions were followed by inquiries about partnering arrangements with other agencies.

DO AGENCIES OFFERING PSH PLAN TO CONTINUE AND EXPAND?

As table 5.1 shows, all 23 District agencies we surveyed plan to maintain at least some of their current involvement in PSH development, operations, and services. A very large majority—19 of the 23 agencies—had been involved in all three PSH components in the past, were involved at the time of the survey, and expected to continue that involvement. They appear as “DOS” in table 5.1. One agency had a long-time commitment to doing development and operations but no services (DO, no S), and one did services only. Two agencies had been involved with development and services for PSH in the past and present, and expected to be so in the future, but did not actually manage the PSH units they offered (DS, no O). No agency reported plans to offer *less* PSH in the future than it does now, although agencies receiving HOPWA funding for rental assistance did experience funding reductions in 2006.

Table 5.1: Washington DC Agencies' History of and Anticipated Future Involvement with PSH, 2008						
N=23 agencies	<i>Type of involvement (all are Past, Present, & Future; Past & Future, or Present & Future)</i>					
	DOS^a	DO, no S	OS, no D	DS, no O	S only	D only
Washington, D.C.	19	1	0	2	1	0
^a D=development, O=operating, S=services. In classifying agencies for this table, present and especially future orientation and commitment were deemed most important. Thus an agency could be without a present development project but have developed PSH in the past and intend to do so in the future, and still be classified as DOS.						

Some providers mentioned consolidation of projects within a larger program, but none reported a significant loss of beds. Rather, many agencies are already in the process of expanding.

WHAT PROJECTS ARE CURRENTLY IN DEVELOPMENT?

Survey questions asked agencies about PSH projects they were in the process of developing in the summer of 2008, when these interviews were done. Table 5.2 shows agency involvement as developers, managers, or service providers with 1,627 new units of PSH spread over 28 projects. These agencies are involved in development for 838 new units in 20 projects that, once completed, they will own as facility-based PSH (i.e., not scattered site). Another 10 projects, with 834 units, will be run as scattered site. Agencies offering PSH will provide the management and operations for 22 of the 28 projects, which include 938 of the 1,627 units. They will provide supportive services to tenants in another 22 projects, with 1,450 units.

Table 5.2: PSH Projects and Units that Washington, D.C., Agencies Reported as Being in Development as of Summer 2008 (N=23 agencies reporting)		
Once these projects are finished, your agency will:	Projects	Units
Be involved with them, in any way	28	1,627
Own/run them as facility-based	19	838
Run them as scattered site housing	10	834
Provide housing management/operations for them	22	938
Provide services for their tenants	22	1,450

WHAT DO AGENCIES PLAN FOR THE FUTURE?

Seventy percent of District PSH agencies describe themselves as “very likely” to be involved in the future in developing, operating, and/or providing services for tenants of PSH. Another 26 percent declared themselves “somewhat likely” to be involved; and only 4 percent said that they were “not at all likely” to be involved. When asked about expecting to be involved in the development of the mayor’s 2,500 new units of PSH in some way, 87 percent said they expected that they would be involved.

Agencies were asked in an open ended survey question to describe their plans or expectations to develop, operate, and/or provide services for more PSH in the next five years. Seven of the 23 agencies gave formal, specific plans to increase their units by a set number and in certain project areas, in addition to what is currently being developed (formal plan). Six additional agencies had plans that were specific as to numbers, meaning they had discussed the number of units they

Table 5.3: District Agency Plans or Expectations to Develop, Operate, or Provide Service for More PSH in the Next Five Years (N=23 agencies)			
	Formal plan	Specific informal plan	Nonspecific informal plan
Number of agencies	7	6	7

were interested in developing, but had no specific locations or buildings in mind (specific, informal plan). Another seven agencies said they had plans to expand their PSH, but could not provide target numbers of units or how they would proceed with this development (nonspecific informal plan). The remaining three had no plans or expectations for doing more PSH.

Even when they could not describe concrete plans for expansion, however, 11 of the 23 agencies were able to name possible partners for future PSH projects, as shown in table 5.4. These 11 agencies mentioned at least one possible partner for future projects—suggesting that more than half of D.C. agencies expecting to do more PSH were expecting to handle all aspects of it themselves. This is actually an increase, however, in the proportion of agencies expecting to form partnerships for future development, as 19 of the 23 agencies have done everything themselves in the past (table 5.1). Overall, agencies named 16 different organizations as possible partners for development, 9 possible partners for operating and managing PSH, and 6 possible partners for services.

Table 5.4: Anticipated Partners for Future PSH Projects, Washington, D.C., Agencies (N=23 agencies)

	Number of Agencies:		For agencies naming at least one partner, total (average) number of partners named as:		
	With Surveys	Naming at least one partner for future projects	Development partners	Operating/management partners	Service partners
2008	23	11	16 (1.78)	9 (1.125)	6 (1.2)
<p><i>Note:</i> Several agencies named funding sources (e.g., state housing finance agency) as partners for development. We use the concept of “partner” to mean actively working with another agency to create or run a project or serve its tenants rather than just contributing money. Therefore we did not count these funders as partners, although they do appear in the section 4 financial sources tables as capital funding sources.</p> <p>For the S+C units that are allocated to District CSAs, TCP is the administrating agency for the operating money and 10 CSA's are used as service partners. These partnerships are not included above. Similarly, DMH uses 19 CSAs to provide services for its Home First project.</p>					

WHAT WOULD MAKE PSH AGENCIES MORE LIKELY TO UNDERTAKE NEW PSH PROJECTS?

District PSH agencies were asked what steps could be taken that would ensure their continued or increased development of PSH. UI researchers coded responses to the open ended question, as shown in Table 5.5.

Eleven agencies mentioned that more funding options were needed specifically for development, while seven mentioned funding for both services and operations. In all, 68 percent said funding is a problem, whether for development, operations, or services. Twenty-one percent (five agencies) said that they would need greater assurance from the District that funding streams would be held constant—that is, that they could count on them from year to year. These five agencies talked extensively about the need for stability in funding streams,

Table 5.5: Factors Agencies Say Encourage Them to Undertake Development/Operations/Service Provision for More PSH Units in the Future

(N=23 agencies)	
	Number of agencies
Funding for development	11
Funding for support services	7
Funding to cover rents and operations	7
Confidence in the stability of funding streams	5
Address NIMBYism	2
Contractor quality	1
Technical skills for development	1
District government cooperation	1

mentioning that currently they lacked confidence that promised sources of funding are safe to rely on in the future. In their view, without confidence that monies will be around, few are willing to take on the risk of starting a project.

With respect to meeting the targets for housing that will accommodate chronically homeless people, mostly using a Housing First, low barrier approach, 43 percent of District agencies said they currently offer PSH that could be described as Housing First”—PSH that moves chronically homeless people directly into housing “as they are” and works with them to help them keep the housing, without requiring any immediate behavioral changes. Of the agencies that currently do not offer such low barrier housing, 50 percent would be willing to try a Housing First model if they had either more funding, more support services, more staff, or a scattered site set up. The other 50 percent would be unwilling to take on a Housing First model, explaining that it would violate their program’s philosophy.

Implications and Conclusions

HOW WELL DOES THE PSH THAT EXISTS MATCH THE MOST VULNERABLE PEOPLE WHO HAVE BEEN HOMELESS THE LONGEST?

The District has an unusually high proportion of chronically homeless people in its homeless population—65 percent, or more than 2,700 people, have been homeless for a year or more and have at least one disability that makes it difficult for them to achieve stable housing, according to the latest homeless counts. Thus although there were 2,741 open and occupied PSH beds (or around 2,320 units) in the District during June-September 2008, these represent only about half of what is needed to eliminate chronic homelessness in the jurisdiction. Hence the mayor’s goal of 2,500 net new PSH units.

Further, many of the District’s most vulnerable homeless people are not likely to move into housing that imposes many restrictions. Only about half of the existing PSH units in the District could be classified as “low barrier,” but “low barrier” is the only type of housing that is likely to be acceptable to the most vulnerable among the city’s homeless population. About half (48 percent) of existing PSH units require sobriety at entry, while 55 percent say they would not take an active substance abuser. Half require participation in services, and half of these (25 percent) would evict a tenant who would not participate in services.

When a PSH provider sets its mind to offer housing that *will* be acceptable to the District’s most vulnerable residents, those who are chronically homeless with multiple disabilities, the results have clearly been successful. Pathways-DC has engaged, housed, and sustained in housing over 150 people from this very challenging target population, and DHS has done the same with close to 500 similar people in less than a year. More of the same type of housing is needed. If the District hopes to end the homelessness of its most vulnerable residents, it would be wise to devote *all* of the resources it expects to invest in new units for single adults into those that provide low barrier housing with appropriate services and supports. Only such units are designed to accommodate the people that the District has targeted for its campaign to end chronic homelessness.

WHAT IS NEEDED TO COMPLETE THE PLAN?

From our surveys we have estimates that the District had a total 2,741 beds of PSH (around 2,320 PSH units) during June–September 2008. The number of PSH units has changed since we conducted these surveys, growing substantially with the closing of Franklin School Emergency Shelter and provision of 475 rental subsidies (as of August 7, 2009) with associated services to house long-term homeless people who have high scores on the District’s vulnerability index. What is more, we saw that a number of projects were already in development. Over 1,600 units of possible PSH were in some stage of development during June–September 2008, some of which opened soon after the information gathering portion of this project and are likely to be part of the 2009 HIC. Some of these will serve the target population of chronically homeless people, but some will not. Estimates from our survey, therefore, should be used merely as a point in time estimate for PSH beds in the District during a 4 month period—yet another marker to help in assessing progress toward the goal of 2,500 units of PSH by 2014.

Streamlined Access to Adequate Resources

- Each year, each PSH unit costs about \$8,500 to operate, paid for mostly by subsidies (55 percent), DMH contracts (30 percent), and tenant contributions to rent (8 percent).
- Each year, we estimate that each PSH tenant is supported by about \$7,200 worth of supportive services, of which Medicaid may be assumed to pay at least three-fourths.
- If new housing is to be created, rather than focusing entirely on accessing units of existing housing through rental agreements, capital resources will be needed. If only moderate rehabilitation is needed to create these units, the likely cost may be around \$75,000 or less, but if new construction is involved, the cost could easily exceed \$120,000 per unit.

It is best to be realistic about the task ahead of the District. Agencies offering PSH are willing to develop and offer more—enough to meet the goal of 2,500 net new PSH units. Further, there appear to be enough agencies willing to accommodate the longest-term, most disabled, most vulnerable, homeless people in the District with service models that will be attractive to those people. But they need:

- The resources to fund new projects—District decision makers should consider some of the existing funding sources that other communities have used, such as Low Income Housing Tax Credits, as well as examining mechanisms that other communities have used to increase funding for PSH;
- The assurance that the annually recurring resources—for operations and services—will be there in the future;
- A more streamlined way for agencies desiring to create new PSH to acquire the funds needed, through more coordinated requests for proposals from District agencies and, ideally, a consolidated funding structure that brings together District agencies responsible for services, rent subsidies, and capital development as well as private sector partners willing to fund the same (e.g., business associations, corporations, foundations, financial intermediaries, Fannie Mae, and the United Way). Models exist in other communities for this type of integrated funding structure.

Appendix A

Accounting for Differences between Our PSH Count and that In TCP's 2008 Housing Inventory Chart

One of the goals of doing the survey whose results we report above was to assess whether all the projects, units, and beds that were being counted as permanent supportive housing in the District's Housing Inventory Chart were really PSH, and if they were, whether the numbers reported were accurate. For us to count a bed/unit as PSH, it had to:

- House *tenants*, not clients or patients; the tenant should have a lease or a lease-like arrangement, and should be able to stay in his/her bed/unit as long as the conditions of the lease are being met;
- House tenants who came to the project *from homelessness* (i.e., not from an institutional setting or from conventional dwellings);
- Be permanent—no expectation should exist on the part of the project that tenants would move on after a period of time, whether the period was defined (e.g., not longer than 24 months) or indefinite;
- Be affordable—ideally, the tenant should not be paying more than 30 percent of income for rent, and certainly not more than 50 percent.
- Come with supportive services of sufficient intensity, frequency, and appropriateness to significantly affect the likelihood that the tenant, regardless of disabilities, will be able to retain the housing.

Given these expectations for what a bed/unit had to look like to count as PSH, we found quite a bit of the housing listed as PSH on the District's 2008 Housing Inventory Chart to be something else. This happened with five projects, which we removed from our estimates; table A.1 gives the details, showing how many beds were removed and why. We also sometimes found that projects had more or fewer beds than appeared in the inventory. When this happened we corrected the errors, adding beds in eight cases and subtracting beds in five cases. Table A.2 shows these additions and subtractions, noting the reasons for each, which included simple errors, tenants who did not meet HUD/SHP's definition of homelessness, some units that did not meet our definition of PSH, and projects that had been completely missed.

Table A.1: REMOVALS—Beds in TCP's 2008 Housing Inventory Chart as PSH that We Determined Not to Be PSH			
Agency/Project Name	Beds shown in HIC	Beds we removed from PSH category	Why removed (with agreement of sponsoring agency in all cases)
Coalition for the Homeless/Sherman Avenue SRO	6	6	Affordable housing—no subsidy, tenant pays full rent, no services attached to housing
Joseph's House/Joseph's House	9	9	End of life care, serves ~ 40 people a year in 9 beds.
L'Arch/Permanent Housing for the Disabled	12	12	Special needs housing for MRDD people who were not homeless at entry
Missionaries of Charity/Gift of Peace	49	49	Medical respite—could be classified as transitional housing, but even that is dubious, as it offers multi-bed nursing wards except for a few private rooms for patients with HIV/AIDS; patients must leave as soon as they are well enough and have any sort of income
Samaritan Inns/service-enriched housing	170	170	No limits on length of stay, but building provides housing for people in later stages of recovery; limited services and strong expectation that they should be moving on after about two years. Count as TH
The Community Partnership/Community Care Grant Program	94	94	Prevention program, recipients not literally homeless, not disabled, not permanent
TOTAL REMOVED	340	340	

Table A.2: ADDITIONS AND SUBTRACTIONS—PSH Agency Reports of More or Fewer PSH Beds than Appeared in TCP's 2008 Housing Inventory Chart

Agency	Beds added	Beds subtracted	
Additions			
Catholic Charities	21		New project
DMH	291		Counting S+C that were attributed to TCP in the HIC, plus Housing Choice Vouchers and Local Rent Subsidies (LRSP) not appearing in the HIC at all, of which DMH uses 90% for homeless people
N Street Village	4		Count was wrong
Pathways to Housing	124		New units
RIGHT, Inc.	25		Count was wrong
Safe Haven Outreach/ (Riley Cheeks)	20		Riley Cheeks was never included on the HIC but should have been, while a different Safe Haven Outreach project was included incorrectly (see below)
U.S. Vets Initiative	12		New units
TOTAL ADDITIONS	497		
Subtractions			
Anchor Mental Health		42	Some of Anchor's group homes are special needs housing for people with SMI but who were not homeless at entry
Building Futures		163	HOPWA-funded housing for people with HIV/AIDS, whose tenants meet HOPWA's definition of homelessness (imminent risk) but not the HUD-SHP definition
Safe Haven Outreach/ Haven House Cooperative (811)		71	Tenants of this 811 building are disabled but were not homeless at entry, don't systematically get supportive services, and are heading for cooperative ownership of the building in a few years
Marshall Heights CDC		6	Some tenants not previously homeless
SOME		26	Some units/buildings are affordable housing—no rent subsidy and no services
Woodley House		6	Count was wrong
TOTAL SUBTRACTIONS		314	