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The Benefits of and Need for a Low-Barrier, Housing First Homeless Shelter in Grand Forks, North Dakota

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by

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Abstract

The prevalence of substance use and mental illness are significant factors to consider when attempting to effectively resolve homelessness in the United States. By providing stable shelter or housing, individuals experiencing homelessness have a better capacity to address these obstacles that have historically caused them to lose, or prevented them from maintaining, their housing or shelter situation. Many homeless shelters in the United States have taken an abstinence-based approach that has left many homeless individuals unsheltered, and this can reduce the capacity of these individuals who may be trying to engage in services to address their other concerns. Low-barrier homeless shelters are increasing in number across the nation, as Housing First, person-centered, and harm reduction principles have been shown to successfully assist individuals to obtain and maintain housing. Grand Forks, North Dakota, is one city that would greatly benefit from a low-barrier homeless shelter to address the homeless population in Grand Forks and the surrounding region. This paper presents the rationale for the need, as well as a grant proposal with details for establishing a low-barrier shelter in Grand Forks, North Dakota.

Keywords: Homelessness, Low-Barrier Shelter, Housing First, Substance Use, Mental Illness Grand Forks, North Dakota

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The Benefits of and Need for a Low-Barrier, Housing First Homeless Shelter in Grand Forks, North Dakota

Introduction

Substance use and mental illness are very prevalent among people experiencing chronic homelessness. A majority of homeless individuals with these behavioral health conditions are also unsheltered (Technical Assistance Collaborative, 2019) Grand Forks, North Dakota, has only one shelter available for single men and women. Other agencies host homeless shelters, including Community Violence Intervention Center's (CVIC) shelter for victims of domestic violence and Red River Valley Community Action's shelter for homeless women and children, but the Northlands Rescue Mission is the only option available to single individuals. Barriers to access any of these shelters primarily include substance use, alcohol use, justice system involvement, and history of behaviors at the shelter. Low-barrier shelters who follow Housing First and harm reduction principles are meant to accept individuals into their services regardless of their ability to pass a drug test, present sober, or other requirements. They intend to provide shelter without prerequisites or mandatory services (United States Interagency Council on Homelessness, 2016). A low-barrier homeless shelter abiding by Housing First and harm reduction principles would be of great benefit to the Grand Forks community by providing another option to individuals who cannot access other options due to sobriety, behaviors, or other conditions.

North Dakota has been identified as one of the top five states in the United States with the lowest homeless population (U.S. Department of Housing and Urban Development, HUD, 2019). However, much of North Dakota can be considered a resource desert; as a result, homeless individuals tend to migrate to larger cities seeking services. Grand Forks is a city of

refuge for the rural communities surrounding the area. Consequently, these larger cities, like Grand Forks, are often tasked with triaging homeless individuals who typically tout intense levels of need including substance use, mental illness, transience, involvement in the justice system, and so on. In 2017, North Dakota's Point in Time Count, an annual count of sheltered and unsheltered homeless individuals required by the U.S. Department of Housing and Urban Development, identified 1,089 homeless individuals. This resulted in an estimated $1.35 million expense to North Dakota taxpayers because of service utilization by individuals experiencing homelessness (North Dakota Interagency Council on Homelessness, 2018). This can be attributed to costs such as emergency services, law enforcement services, and incarceration. Unfortunately, this count has been identified as likely inaccurate due to homeless definitions, mobility, rurality, the cycle of homelessness, and challenges identifying individuals experiencing homelessness (North Dakota Interagency Council on Homelessness, 2018). In their report (North Dakota Interagency Council on Homelessness, 2018), it is suggested to explore implementation harm reduction practices into homeless shelters and allowing onsite consumption of alcohol and substances or entry while under the influence.

The use of harm reduction in housing and shelter services is backed by many research studies and government publications as a successful method in addressing homelessness (HUD, 2019; Newman & Donley, 2017; North Dakota Interagency Council on Homelessness, 2018; Technical Assistance Collaborative, 2019, United States Interagency Council on Homelessness, 2016). Harm reduction and Housing First programming became prioritized with the Obama Administration's passage of the HEARTH Act in 2009, which allocated resources towards Housing First and harm reduction models from traditionally used "Treatment First" models (Newman & Donley, 2017). Treatment First models generally require sobriety prior to service

access and provision. Conversely, harm reduction models are stated to be "nonjudgmental, non-coercive provision of services and resources" (National Harm Reduction Coalition, 2020) to individuals who participate in alcohol or substance use The U.S. Department of Housing and Urban Development continues to recognize and support the effectiveness of Housing First and harm reduction principles for both housing and shelter services (HUD, 2019). Grand Forks, North Dakota, has an opportunity to take an initiative to further develop their service sector and to offer a choice in shelter options available to best meet the needs of all homeless individuals.

The following grant proposal will illustrate the rationale for the need for a low-barrier homeless shelter as well as a plan for implementation in Grand Forks, North Dakota. The author will explore various resources that display the benefits offered by having low-barrier shelters in other communities and translate these to the community of focus. The intent of this grant proposal is to be used as framework for any future grant proposals for further development of a low-barrier, Housing First homeless shelter in Grand Forks, North Dakota.

Background and Overview

On one night in 2020, 580,000 people across the United States experienced homelessness (HUD, 2020). About 61% of this population occupied emergency or transitional shelter beds. This means that over 226,000 people experienced unsheltered homelessness that same night. Out of the total 580,000 people, 408,891 people experienced homelessness as individuals, with 51% experiencing unsheltered homelessness. For the first time since data collection has been completed, more individuals experiencing homelessness have been unsheltered than have been sheltered (HUD, 2020). To understand these growing rates, it is important to understand the source of homelessness and efforts to address the problem. A current picture of homelessness in North Dakota will also be provided for context.

History of Homelessness in the U.S.

The concept of homelessness has been present in U.S. society since the 1800s. However, the modern concept of homelessness developed in the late-1970s (National Academies of Sciences, Engineering, and Medicines, 2018). During this time, there was a massive increase in the amount of people experiencing homelessness, which can be attributed to a variety of social and political developments in the United States, such as gentrification, deinstitutionalization, a rise in unemployment, the HIV/AIDS epidemic, lack of affordable housing, budget cuts to HUD and other social service agencies, and increased housing costs without a raise in wages (National Academies of Sciences, Engineering, and Medicines, 2018). Deinstitutionalization has been indicated as the most prominent contributor to this increase in homelessness (National Academies of Sciences, Engineering, and Medicines, 2018).

Deinstitutionalization has deep roots in the civil rights movement with the aim to provide better quality of life to people living in institutions, as institutions were viewed as cruel and inhumane (National Academies of Sciences, Engineering, and Medicines, 2018). With developments in antipsychotic medications and the promise of community-based services and housing to provide support for this population once released, the hope was to promote the physical, social, and mental wellbeing of people with mental illness. Unfortunately, the funding for housing and community-based services was severely inadequate, and the medications available, while useful, were not sufficient in stabilizing those who struggle with severe mental illness (National Academies of Sciences, Engineering, and Medicines, 2018; Yohanna, 2013). Furthermore, cuts made to funding for housing assistance within HUD and cuts to social programs such as SSI and the tightening of eligibility requirements created a critical loss of

income and lack of access to housing (National Academies of Sciences, Engineering, and Medicines, 2018).

Several pieces of legislation have been a part of the federal response to address homelessness over the years. The Housing and Community Development Act of 1974 developed the Community Development Block Grant program and the Housing Choice Voucher, also known as Section 8, program allowing for the private sector to receive federal funding to provide housing to low-income individuals (National Academies of Sciences, Engineering, and Medicines, 2018). The 1977 Stewart B. McKinney Homeless Assistance Act provided definitions of homelessness in addition to federal funding for homeless shelters to support individuals experiencing homelessness. The 1997 Stewart B. McKinney Act authorized the development of the U.S. Interagency Council on Homelessness, or USICH, with membership from all federal agencies involved in homelessness, to better coordinate homeless services across the country National Academies of Sciences, Engineering, and Medicines, 2018). In 2002, USICH requested that every state and community developed a ten-year plan to address homelessness, specifically aimed at chronic homelessness. In 2009, the Obama Administration signed the HEARTH Act into law which reauthorized the McKinney-Vento Act, aimed at addressing family homelessness, as well as providing new definitions for homelessness and simplified access to HUD funding for Continuums of Care to address homelessness (National Academies of Sciences, Engineering, and Medicines, 2018). This legislation also provided a great deal of support for Housing First methods and permanent supportive housing facilities for those experiencing chronic homelessness (Newman & Donley, 2017). North Dakota has made efforts to engage these pieces of legislation in their methods to address homelessness across the state.

Homelessness in North Dakota

In 2008, the State of North Dakota developed their Ten-Year Plan to End Homelessness with the support of Governor John Hoeven. North Dakota's Interagency Council on Homelessness identified that at least 800 people experienced homelessness on any given day in the state, with approximately 20% experiencing long-term homelessness, meaning they have been without a permanent place to live for a year or more, or they have experienced at least four episodes of homelessness in the last three years. The report identified the main barriers to self-sufficiency experienced by this population include mental illness, substance use, extreme poverty, poor job skills, and poor physical health conditions. The report identified the need for permanent supportive housing and other support services for those experiencing long-term homelessness (North Dakota Interagency Council on Homelessness, 2008).

In 2018, the State of North Dakota provided a conclusion to this plan. The Interagency Council on Homelessness identified that the state is still experiencing insufficient availability of low-income housing opportunities for those in need. North Dakota was able to develop three permanent supportive housing facilities, but these were not sufficient to address the issue of homelessness in its entirety. Those most challenging to house and shelter continue to be those with severe mental illness and substance use. The Interagency Council on Homelessness in North Dakota provided a variety of recommendations including developing more facilities that follow Housing First methods, as well as the exploration of implementing shelters that utilize a harm reduction approach, meaning shelter consumers can use alcohol or substances onsite or are allowed access to shelter while under the influence (North Dakota Interagency Council on Homelessness, 2018).

Demographics of homelessness are an important consideration in the development of methods to address the issue. Every year, North Dakota participates in the national Point in Time Count, as instructed by HUD, to count the numbers of people experiencing sheltered and unsheltered homelessness on a single night of the year. These numbers are used to receive funding from HUD for the following year. In 2020, on a single night in January, North Dakota counted 371 people experiencing homelessness, of which 87 were identified as chronically homeless (North Dakota Coalition for Homeless People, 2021). Of this total, 337 experienced sheltered homelessness, while 34 experienced unsheltered homelessness. As for racial demographics, 231 people experiencing homelessness identified as White, 48 identified as Black, 75 identified as American Indian or Alaska Native, and 30 identified as Hispanic or Latino. Additionally, there were 15 people, who identified as white, who experienced unsheltered homelessness, three people who identified as Black, 16 people who identified as American Indian or Alaska Native, and four people who identified as Hispanic or Latino. When comparing these counts to the 2019 population and demographic estimates for North Dakota (United States Census Bureau, 2019), it can be found that Black and American Indian or Alaska Native individuals are nearly six times as likely to experience homelessness in the North Dakota.

The North Dakota Housing Finance Association has previously identified that North Dakota's Point in Time Counts are likely inaccurate due to the constrictive definitions of homelessness, mobility, rural isolation, non-identification, and the cycle of homelessness (North Dakota Interagency Council on Homelessness, 2018). Many reports are unable to provide information on the numbers of people experiencing homelessness who also struggle with substance use or mental illness. However, a Ten-Year Plan to End Homelessness developed in Grand Forks, North Dakota, identified that approximately two-thirds of the homeless population

in Grand Forks has a diagnosis of either a serious mental illness, substance use disorder, or both (City of Grand Forks, 2008). Additionally, other studies have highlighted the prominence of substance use and mental illness across the homeless population as a barrier to stable housing (Henwood et al., 2012; Newman & Donley, 2017; Mancini et al, 2008; Pauly, et al., 2018; Polcin, 2015; Young & Manion, 2017). These studies illustrate the importance of providing easier access to housing and shelter to individuals who struggle with substance use and mental illness.

Substance Use, Mental Illness, and Homelessness

Substance use and mental illness are both prominent characteristics within the chronically homeless population. In a 2014 study (Newman & Donley, 2017), 48% of homeless, single men identified that mental illness and substance use are two major barriers to exiting homelessness. The same study further states that substance use is much higher in populations of homeless individuals versus the general population, and behavioral health disorders pose as the largest risk for an individual to experience homelessness in their lifetime. These factors contribute to homelessness by causing social and economic challenges for those who are afflicted. The rates of mental illness and substance use are disproportionately high amongst the homeless population (North et al, 2004).

People with dual diagnoses present an additional challenge, as these are the individuals most likely to have trouble finding and maintaining stability. For example, Mancini et al (2008) describes that these individuals are resistant to treatment-first approaches, and they are more likely to return to the street and continue to use when exposed to “highly structured, abstinence-only programs”. Furthermore, individuals with dual diagnoses, also known as co-occurring disorder, often experience rejection when seeking treatment for their mental health because of

their challenges with sobriety (Padgett et al, 2016). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) identified in 2010 that 26.2% of individuals in shelter had a serious mental illness, and 34.7% of sheltered individuals had a substance use disorder. Within the chronically homeless, 50% of the population has a dual diagnosis. Additionally, mental health problems are present in about 60% of chronically homeless individuals, and alcohol or substance use is present in 80% of the population (SAMHSA, 2011). In Grand Forks, approximately two-thirds of the chronically homeless population have a mental illness or substance use disorder (City of Grand Forks, 2008).

Homeless individuals with a dual diagnosis, serious mental illness, or substance use disorder are less likely to engage in services (Sun, 2012). Unfortunately, homelessness inhibits recovery from substance use and mental illness (Henwood et al, 2012), and people who struggle with serious mental illness and substance use disorders are persecuted by society, though these negative attitudes are only intensified when they also experience homelessness (Padgett et al, 2016). When considering the disproportionate number of dually diagnosed individuals experiencing homelessness (Padgett et al., 2006), homeless shelters may pose as a barrier by limiting access for homeless individuals, which results in higher rates of unsheltered homelessness across this population (USICH, 2017). By adhering to treatment first principles in homeless services, people experiencing homelessness, who also have a dual diagnosis, are set up to fail by being barred from services if they are unable to adhere to the stringent requirements in these programs (Padgett et al., 2006).

Harm reduction and Housing First principles have received a great deal of attention since the Obama Administration passed the HEARTH Act in 2009, as these approaches reject the requirement of sobriety or program compliance. Many areas across the United States have

adopted policies of harm reduction into their shelters, and they have observed significant reductions in their homeless rates. Oregon has made great strides in implementing a harm reduction approach to their entire homeless shelter system.

Oregon's Shelter Study

In 2019, Oregon Housing and Community Services, with the assistance of the Technical Assistance Collaborative, conducted a study on gaps in shelter services for homeless families with children and homeless individuals. Their goals were to strengthen policy and practice for homeless shelters, identify barriers to implement systemic change and approach, gain information and tools to strengthen their shelter provider network, and incorporate recommendations to form a stronger approach across the state to address homelessness. Through focus groups, surveys, and interviews, Oregon Housing and Community Services examined current shelter services from both Point in Time (PIT) Count data, shelter staff, and people with lived experience (Technical Assistance Collaborative, 2019).

In their 2018 PIT Count, the State of Oregon found 29% of homeless individuals self-identifying as having a serious mental illness (SMI), and 27% self-identified as having a substance use disorder (SUD). However, individuals with SMI or SUD account for one-third of unsheltered individuals across the state. Approximately 70% of individuals with a SMI are unsheltered while 67% of individuals with a SUD are unsheltered in Oregon. From a provider standpoint, they feel that there are too few funds and not enough staff to provide best practice homeless services to this population (Technical Assistance Collaborative, 2019). Individuals with lived experience identified five barriers in their ability to access shelter including: personal safety concerns, personal privacy concerns, restrictive check-in and check-out times,

overcrowding within the shelter, and unsanitary shelter conditions (Technical Assistance Collaborative, 2019).

This study allowed Oregon to develop and publish their recommendations for best practices in homeless service provision, specifically related to homeless shelters and emergency warming centers. They recommend the use of Housing First and low barrier principles, meaning everyone who needs shelter should be able to access shelter without prerequisites, including treatment completion or compliance. Services should not be mandated within any program. Shelters who follow best practices should make an effort to lower sobriety standards, loosen pet restrictions, and avoid restrictions based on proof of identification, income, and background. Homeless shelters should be accommodating to homeless couples. Furthermore, these programs should offer on-site services to engage shelter users to access housing, but it is important to remember that this should not be mandated. The Technical Assistance Collaborative provided recommendations for staffing including teaching staff to be trauma-informed and ensuring staff are culturally responsive and representative of the populations served by the shelter. They also suggest hiring a combination of paid professionals and paid peer providers for ongoing support (Technical Assistance Collaborative, 2019). These recommendations have been identified as an integral part of effectively addressing homelessness, and Grand Forks should be mindful of these suggestions in their efforts to end homelessness within the city. A low-barrier homeless shelter abiding by these principles would be one way to act based on these recommendations.

Proposal for a Low-Barrier Homeless Shelter in Grand Forks, North Dakota

Grand Forks, North Dakota, would greatly benefit from a low-barrier homeless shelter. With a low-barrier homeless shelter, individuals experiencing homelessness would not be turned away due to their alcohol use, substance use, challenging behaviors due to their mental health

diagnoses, or other factors that generally prohibit shelter access in many communities. The following section will outline the need statement, project description, plan for evaluation, and the budget request.

The Need Statement

Homelessness in North Dakota is known to be severely underreported year after year. As previously mentioned, this is due to the rurality of the state, prevalence of couch-surfing, and cyclical homelessness. The most prominent barriers preventing individuals experiencing homelessness from accessing shelter are substance use disorders and mental illnesses. Grand Forks does not currently have a homeless shelter able to accommodate these barriers. As a result, many individuals go without having their basic needs met and resort to existing in unsafe and unstable situations. Individuals experiencing unsheltered homeless contribute to high rates of emergency service use, with an estimate of a $1.35 million cost to North Dakota taxpayers in 2017 (North Dakota Housing Finance Agency, 2018). Homelessness is financially costly to taxpayers, and it is emotionally, mentally, and physically costly to those who experience it. Prohibiting access to services is not a solution. The establishment of a low-barrier homeless shelter is an evidence-based approach towards the effort to end homelessness in the United States.

Goals, Objectives, and the Implementation Plan

The goal of a low-barrier homeless shelter is to provide support to people experiencing homelessness through optional services and programming to connect to stable housing options. This service is meant for individuals who cannot access other shelter options in the Grand Forks community. Research shows that Housing First principles, a harm reduction approach, and person-centered care are integral to reducing the number of individuals experiencing

homelessness. Lack of shelter access for those experiencing homelessness leads to higher emergency service usage, heightened levels of substance use, and poorer mental and physical health. For this proposal, refer to "Appendix A" for the full logic model. The main objectives for this project include:

1. Provide shelter to consumers who have no other shelter options in the Grand Forks community.
2. Support and educate chronically homeless individuals with empathy and dignity to help them sustain their housing upon exit from the shelter.
3. Collaborate with community service providers to offer onsite substance use, mental health, skill-building, and employment services to individuals experiencing homelessness.
4. Decrease the impact of the costs of emergency service use by individuals experiencing homelessness in the Grand Forks community.
5. Participate in and advocate for systemic change for homeless policy at the community, state, and national levels.

Inputs and Resources

This project will require both human resources and material resources. The shelter will require staffing resources including support staff, one social worker to provide case management, and a shelter director, who will be committed to grant writing and shelter management. The shelter will also require counselors, therapists, employment specialists, and other program staff. These will be obtained through partnerships with other community service providers. The goal is for the providers to be able to bill their services to insurance, if applicable, or they may choose to provide their time spent in-kind to the shelter. Shelter clients will also be needed to utilize the

shelter. This population will be obtained via referral from Northlands Rescue Mission in Grand Forks, North Dakota. Regarding building space, the shelter would have approximately 15 beds in dormitory style rooms, a large common area for opportunities related to social activity and recreation, two offices for staff, an accessible storage area for consumer belongings, and three meeting rooms for medical, mental health, or substance use visits.

There will need to be thorough training for all staff at the shelter. Staff will be cross trained to be harm reduction advocates to provide an additional level of service. Meals will not be provided at this shelter, as the goal is to partner with Northlands Rescue Mission as a meal provider for consumers. Activities for consumers, such as books, board games, movies, art supplies, etc., will be sought via community donations. Any itinerary for group work completed by service providers will be provided by the agency where the provider originates after first receiving approval from the shelter director.

Activities

Staff education is integral to the way this shelter will operate and to achieving the desired outcomes. Staff training includes, but is not limited to, trainings on harm reduction, person-centered care, Housing First principles, motivational interviewing, trauma-informed care, Homeless Management Information System (HMIS), and mental health first aid. These trainings, and adherence to these trainings by staff, are integral to this shelter operation. These trainings will be delivered via online platforms and other community service providers with experience in the specific area of training. Completing these trainings will be part of each staff's orientation period, and they will receive continuing education on a yearly basis. Support staff will receive weekly supervision from the social worker on staff. This time will be used to staff consumer and policy concerns, questions, updates, and so on. The social worker will receive weekly

supervision from the shelter director related to questions, concerns, and barriers in their work with the consumers.

Shelter staff and the social worker will conduct street outreach on a bi-monthly basis to ensure shelter and services are offered to any individuals found to be doubled-up or unsheltered. Additionally, the social worker and shelter director will allocate time as needed to educate other community service providers on the infrastructure, policies, and functionality of the low-barrier shelter. This will include the intake process, policies and procedures for consumers and referrals, and ongoing activities within the shelter. Additional community education and public relations will be conducted on an as needed basis, such as community events, parades, community service provider meetings, and so on.

Consumers will participate in an intake process upon entry into the shelter. They may divulge as little or as much information as desired related to their identity, demographic information, substance use, and any other pertinent information. They will be asked to sign releases of information for CARES and HMIS for data tracking related to their entry, exit, and services provided. If they are new to the shelter, they will be provided a handout with the facility rules and policies, as well as a facility tour. They will be asked to store any weapons, drugs, or alcohol in a locker in the storage area. This area will be accessible to them when accompanied by staff. The consumers will not receive any urine screens, breathalyzers, or other drug tests prior to entry. Any threats or violence committed by consumers will be addressed by support staff via de-escalation techniques or law enforcement involvement, if necessary. The consumers will receive their bed assignment, and a weekly itinerary for activities will be posted in the common areas. The consumers will have complete access to bathrooms, showers, and laundry facilities within the building. There will be no limit on length of stay for consumers. They are not required to

receive services and attempts at engagement should be completed by staff daily. Use of alcohol and substances onsite will be prohibited, but consumers are educated not to use alone in the event of a potential overdose.

Activities within the shelter will include the opportunities for substance use, mental health, employment, and medical services. Once a week, there will be an onsite medical provider to see consumers for any medical concerns. This provider will be obtained through a partnership with local medical hubs such as Altru, Spectra Health, or the University of North Dakota. Substance use and mental health providers will be present twice a week to provide substance use and mental health counseling when needed. These providers will be obtained through a partnership with agencies like Northeast Human Service Center, Spectra Health, Agassiz Associates, Altru, or any other behavioral health provider in the Grand Forks area. They may choose to run groups or individual counseling. Employment services will be available two times each week and rendered through partnerships with agencies such as Vocational Rehabilitation, Job Service, Community Options, and so on. These services will be monitored on an ongoing basis to determine whether less or more services are needed. The space for these services will be provided by the shelter, but any practice materials and content will be provided and developed by the incoming provider. They will be scheduled in a way to avoid running out of space within the shelter.

At a systemic level, the shelter will be a participant in the North Dakota Continuum of Care, as well as a participant in the regional Coordinated Access, Referral, Entry, and Stabilization (CARES) group. As a result, the shelter and staff will use HMIS to document consumer entries and exits with the shelter, services provided to consumers, coordinated entry assessments, and so on. The shelter director will be tasked with attending meetings related to

homeless service provision and ensure staff are committing to evidence-based practice as it develops. The shelter director will also be involved with grant writing to pursue homeless funds, program funds, and other applicable financial resources. Ongoing partnerships and collaboration with major service providers in the community, such as Altru, Spectra Health, Northlands Rescue Mission, Northeast Human Service Center, The Salvation Army, Red River Valley Community Action, Community Violence Intervention Center, and so on, are integral to achieving change and promoting the health, welfare, dignity, and overall recovery of individuals experiencing homelessness.

Outputs

The outputs based on the previously mentioned activities are as follows:

- Onsite medical provider once per week
- Onsite employment specialist, counseling, and therapy twice per week
- Shelter staff provide harm reduction education to consumers
- Shelter staff will at least engage with each consumer daily
- Street outreach conducted twice per month
- Consumers will not be turned away due to intoxication, history of behaviors, having a pet, wanting to stay with their partner, etc.
- Staff are person-centered, trauma-informed, knowledgeable in harm reduction and Housing First principles
- Consumers will have their basic needs met
- Consumers will gain access to onsite services and housing resources
- Consumers actively participate in the Continuum of Care
- Number of homeless on the street and doubled-up in Grand Forks is reduced

The outcomes for a low-barrier homeless shelter in Grand Forks include:

- Number of homeless on the street and doubled-up in Grand Forks is reduced
- Increased knowledge of the needs and characteristics of the homeless population
- The community will see a reduction in costs associated with emergency service use after two years
- Grand Forks becomes an example of a community with a more efficient homeless response system

Evaluation Plan

The central outcomes of this project are to reduce the number of people experiencing homelessness in the Grand Forks community, to assist this population by providing resources to maintain their housing, and to reduce the community costs associated with emergency service provision to this population. This will be attained by providing an approach combining Housing First, harm reduction, trauma-informed, and person-centered care. The indicators of success related to these outcomes include:

- Reduced number of individuals who are unsheltered or doubled-up in the community
- Lowered community costs related to emergency service use after two years
- 80% of consumers maintain housing stability for three years following shelter exit
- 75% of consumers will be employed or receiving some type of income one year after exiting the shelter
- 95% of consumers are discharged into a positive housing situation

This information will be gathered and analyzed from data from the Homeless Management Information System, qualitative data from surveys and interviews, staff notes and observations, and agency reports from hospitals, law enforcement, and jails. Similar data points will be

examined at a baseline period, such as the client entry into the shelter, discharge from the shelter, and after exit from the project. Ideally, follow-up should be conducted very six months post-discharge. Data will be collected through partnerships with local stakeholders and by shelter staff and analyzed by the shelter director. Anticipated barriers to effective data collection will be the inherent transience with much of the homeless population, lack of response, and inability to locate former clients.

Budget Request

Low barrier homeless shelters are aimed at providing shelter for those who face the most challenges in accessing services. This project would ease access by providing a variety of voluntary services onsite for individuals experiencing homelessness, along with a multitude of other challenges. Supported by partnerships with local mental health agencies, medical facilities, and employment agencies, this shelter aims to reduce the number of homeless individuals in the Grand Forks community. This funding will assist this population by providing comforting accommodations and effective services to effectively transition individuals out of homeless seamlessly. The funds requested will sustain this shelter for 12 months. The total amount being requested is $477,558.60. Please see “Appendix B” for a detailed chart of the budget request.

Budget Justification

Personnel

- **Executive Director**: The agency executive director will be responsible for supervising the facility including the case manager, support staff, programming staff, and program content held at the shelter. They will also be tasked with managing finances and operations, writing grants, and facilitating community partnerships. They will spend 40 hours each week dedicated to these job duties (1.0 FTE) for a total of $73,000 a year.

- **Social Work Case Manager**: The social work case manager will be tasked with providing case management to shelter consumers including working with consumers to connect to housing and applicable community resources. They will also oversee shelter support staff. They will spend 40 hours each week dedicated to these job duties (1.0 FTE) for a total of $42,000 a year.
- **Shelter Support Staff**: Shelter support staff will be tasked with providing the most direct service to consumers including completing check-in and checkout procedures for the shelter, providing social interaction for consumers, connecting consumers to resources, and providing harm reduction information where applicable. The shelter will require 6.5 FTE at $12 per hour. This will account for a yearly expense of $149,760.
- **Employment Support Staff**: The shelter aims to have eight hours (0.2 FTE) of time with an onsite employment support staff. They will be asked to help interested consumers apply for employment, develop resumes, and develop job skills. The goal is to develop a partnership where this is an in-kind service from a community partner, such as Community Options or Job Service. This would be an in-kind donation of an estimated $7,800 per year.
- **Mental Health and Substance Use Professionals**: The shelter aims to have 32 hours (0.8 FTE) of time with onsite substance use and mental health professionals to engage with consumers and provide optional counseling to interested consumers. They will have space available for individual sessions, and they can also conduct group work. The goal is to develop a partnership where this is an in-kind service from a community partner, such as Northeast Human Service Center or Agassiz Associates. This would be an in-kind donation of an estimated $64,000 a year.

- **Medical Provider**: The shelter will have an onsite medical provider for eight hours each week (0.2 FTE). They will provide routine medical care for interested consumers. The goal is to develop a partnership where this is an in-kind service from a community partner, such as Spectra Health, Altru, or the University of North Dakota. The in-kind donation would be an estimated $20,000 a year.
- Employee benefits have been calculated at 20%, including FICA and Federal Withholding, Social Security, State Withholding, Medicare, Worker's Compensation, and Health Benefits. The total benefits for this project are $52,952.

Operating Expenses

- **Communications**: Communications expenses include two wireless internet networks, one for staff and one for consumers, six landline phones, and email licenses for all staff. The budget for communications will be $700 each month, adding up to $8,400 a year.
- **Rent**: There is an ideal location for the shelter in downtown Grand Forks at 414 University Avenue. They are leasing 2,955 square feet at $10 per square foot per year, adding up to $29,550.
- **Staff Training**: The budget for staff training and professional development will be $5000 annually, or $416 per month. These funds can be spent on travel reimbursement and costs of certain trainings.
- **Office Supplies**: The budget dedicated to office supplies will be $500 per month, or $6,000 annually. Office supplies to be purchased include notepads, pens, file folders, locking file cabinets, copier ink and printer toner, and desk supplies.
- **Consumer Activities/Recreation**: This proposal includes an allocated line item for consumer activities and recreation. $200 per month will be dedicated to conducting

consumer recreational activities. These expenses could include movie nights, birthday parties, bingo, trivia nights, and so on.

- **Copier Lease**: The copier can be leased for $119 per month, adding up to a $1,428 annual cost. The copier will be used to print client forms, flyers, applications, and other information.
- **10 HMIS Licenses**: There will be 10 staff who hold HMIS licenses in the facility. The HMIS licenses will be required to effectively participate in the Coordinated Entry system. Each license costs $225, adding up to $2,250 annual cost. These licenses will need to be renewed each year.
- **Utilities**: Utilities in commercial buildings are calculated at $2.14 per square foot per year. With the identified location, at 2,955 square feet, this results in $6,324 annually.
- **Cleaning Supplies**: Cleaning supplies will have an allocated $500 per month budget, resulting in a $6000 annual cost. This will include laundry detergent, sanitary solutions, household cleaning supplies, mops, brooms, vacuums, dustmops, and so on.
- Indirect costs are charged to this project at 15% of the total, meaning $57,939.60 is allocated to any indirect costs.

One-Time Facility Furniture Expenses

- **15 Single, Bed-Bug Proof Beds**: Allowing for $250 per bed, the total cost will come to $3,755. The beds will be used for clients. They will be bed-bug proof to avoid and/or help control any infestations. Bedding will be attained by community donations.
- **Surveillance System**: There will need to be a surveillance system for safety reasons within the shelter. Staff will be tasked with monitoring the system. The system will consist of two outdoor cameras, priced at $100 each; four dome cameras inside of the

facility, priced at $150 each; and the installation costs of an estimated $1,000. The total expense for the surveillance system will be approximately $1,800.

- **2 Laundry Machine Sets**: The laundry machine sets will be used to wash client clothing, bedding, and other facility washing needs. The machine sets are priced at an estimated $1,500 per set, allowing for a $3,000 expense.
- **Office and Consumer Furniture**: This expense will include three large desks, five office chairs, and six consumer chairs for staff offices. There will also need to be a table and four chairs for the staff breakroom. This shelter will also have some comfort furniture for consumers including a sofa and two accent chairs. The allocated budget for this furniture will be $8,000.
- **2 Outdoor Tables with Chairs**: The outdoor tables with chairs will be used for consumers to have a smoking and seating area outside, and they will serve as a potential meeting spot for consumers with case managers or other professionals. Priced at about $750 each, this will consist of a total $1,500 cost.
- **5 Indoor Folding Tables**: These will be used for consumer gatherings such as group work for professionals, larger consumer meetings, staff meetings, consumer advisory board meetings, and so on. They will cost approximately $150 each, adding up to a $600 total.
- **Games, Recreational Items, Activities for Consumers**: These activities will be used to provide a sense of purpose and participation for consumers at the shelter. Items included are board games, decks of cards, coloring books and pages, art supplies, movies, and books. The budget allocated for these items will be $1,000.

- **20 Folding Chairs**: Folding chairs will be used for larger consumer gatherings, extra seating, outdoor events, and so on. Each chair costs about $25 each, meaning a $500 total expense.
- **Lockers**: Lockers will be used to store consumer belongings. They will be fully accessible to consumers throughout the day. They will be asked to store any items such as alcohol, drugs or other substances, weapons, and so on, upon entry into the facility. They will be allowed to access these items, but they will have to take them offsite once they have the items. One locker set, with six units, costs about $500. Three sets will be needed to meet the needs of staff and consumers, adding up to a $1,500 expense.
- **Two Refrigerators**: One refrigerator will be used in the staff breakroom for staff items. The other refrigerator will be used for clients to keep food, drink, medications, and so on. Each refrigerator costs approximately $700, adding up to a $1,400 expense.
- **10 Laptop Computers**: Six laptop computers will be allocated for staff use. Four laptop computers will be designated for consumers to use. The staff laptops will be used for completing intakes and discharges, consumer case management, communication, monitoring the surveillance system, and completing trainings or meetings. The consumer laptops will be used for job searching, attending appointments, and communication. At $1,000 each, the laptop expense will be about $10,000 total.
- **Two Microwaves**: One microwave will be in the staff breakroom, and one microwave will be available for consumer use. Each microwave will cost about $150 each, allowing for a $300 total expense.

Total furniture expenses are totaled at $33,355. This cost will be a one-time cost to the facility and will not recur every year. These items will only be replaced as needed.

Plan for Sustainability & Future Funding

This project aims to serve 50 individuals within the first year. Partnerships will be developed with other agencies that will provide in-kind funding, and the shelter director will be tasked with applying for additional grants, including grants through the U.S. Department of Housing and Urban Development (HUD), to provide operational sustainability. As services are established, there will be continuous assessments taking place on how to expand service delivery and possibly provide additional services, if needed. Other avenues of funding will involve community engagement to partake in fundraising, HUD, and partnerships with other homeless shelters in other parts of North Dakota.

Sustainability will be contingent on the effectiveness of service delivery and programming, ensuring the provision of a variety of services that are trauma-informed and culturally aware, and focusing on the development of person-centered, Housing First, and harm reduction principles and practice. Establishing trust and rapport with consumers to build the capacity to help them with their identified needs in the best way possible is so important to the effectiveness and sustainability of this program. The hope is that consumers will refer other individuals in need of this type of services to this establishment to maintain a steady flow of program participants.

Applicant Capability & Partnerships

This project is committed to providing exemplary services to individuals who experience great challenges when trying to access services. By providing stability in shelter, this population has an opportunity to feel empowered to take steps to resolve their homelessness with the assistance of passionate community staff members. Building trust and meeting individuals where they are at are integral in effectively addressing their homelessness. Through advocacy,

partnership, empathy, and compassion, the plan is to provide Housing First, harm reduction, and person-centered services to the homeless population in the effort to end homelessness in Grand Forks.

This project has several desired partnerships within the Grand Forks community. Medical partnerships including Spectra Health, Altru, and the University of North Dakota's Medical School will be beneficial in assisting the homeless population to address their physical health needs. A partnership with Northeast Human Service Center will provide mental health and substance use services to the shelter, providing the groundwork for sustainability once they are housed. For employment support, partnerships have been identified with the local Vocational Rehabilitation services, Job Service, and Community Options. This will help this population to connect to sustainable employment with support services to help them maintain employment post-discharge from the shelter. All of the aforementioned agencies have significant experience working with individuals experiencing homelessness, mental health concerns, physical health concerns, and substance use disorders.

Staff within the shelter will be effectively trained to support consumers to assist them towards stability in their future housing situation. The main role of shelter support staff will be to engage with consumers and develop relationships in an attempt to build trust and rapport to make the likelihood of service participation increase. The social work case manager will be the main support in navigating connection to resources, housing, and other goals identified by consumers. The case manager will also be tasked with ensuring consumers are knowledgeable of available resources, or referred to support resources, upon discharge from the shelter. The shelter director will be tasked in pursuing funding opportunities, developing partnerships with local agencies, and advocating for political and social change in various contexts. This project developer is

confident that these services will effectively decrease homelessness in Grand Forks and increase housing retention with the identified population.

References

City of Grand Forks. (2008). Lighting the Way Home: Grand Forks 10 Year Plan to End Long-Term Homelessness. City of Grand Forks.

Henwood, B. F., Padgett, D. K., Smith, B. T., & Tiderington, E. (2012). Substance Abuse Recovery After Experiencing Homelessness and Mental Illness: Case Studies of Change Over Time. *Journal of Dual Diagnosis, 8*(3), 238-246. https://doi.org/10.1080/15504263.2012.697448.

Mancini, M. A., Linhorst, D. M., Broderick, F., & Bayliff, S. (2018). Challenges to Implementing the Harm Reduction Approach. *Journal of Social Work Practice in the Addictions, 8*(3). https://doi.org/10.1080/15332560802224576.

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Policy and Global Affairs; Science and Technology for Sustainability Program; Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals. (2018). *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*. Washington (DC): National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK519584/.

National Harm Reduction Coalition. (2020). *Principles of Harm Reduction*. National Harm Reduction Coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/.

Newman, R., & Donley A. (2017). Best practices for emergency shelters that serve male populations. *Journal of Social Distress and the Homeless, 23*(2). 97-103. https://doi.org/10.1080/10530789.2017.1332559.

North, C. S., Eyrich, K. M., Pollio, D. E., & Spitznagel, E. L. (2004). Are Rates of Psychiatric Disorders in the Homeless Population Changing? *American Journal of Public Health, 94*(1). https://doi.org/10.2105/ajph.94.1.103.

North Dakota Coalition for Homeless People. (2021). 2020 Point-in-Time Count ND-500 North Dakota Statewide CoC. https://static1.squarespace.com/static/5570a318e4b02d3071ca7d2b/t/609c031e9ac1b3442855de21/1620837151144/2020+-+PIT+Count+Summary.pdf.

North Dakota Interagency Council on Homelessness. (2008). *Housing the Homeless: North Dakota's Ten-Year Plan to End Long-Term Homelessness*. North Dakota Interagency Council on Homelessness.

North Dakota Interagency Council on Homelessness. (2018). *Housing the Homeless: North Dakota's Ten-Year Plan to End Long-Term Homelessness*. North Dakota Interagency Council on Homelessness.

Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing First Services for People Who Are Homeless with Co-occurring Serious Mental Illness and Substance Abuse. *Research on Social Work Practice, 16*(1). https://doi.org/10.1177/1049731505282593.

Padgett, D. K., Tiderington, E., Smith, B. T., Derejko, K., & Henwood, B. F. (2016). Complex Recovery: Understanding the Lives of Formerly Homeless Adults with Complex Needs. *Journal of Social Distress and the Homeless, 25*(2). https://doi.org/10.1080/10530789.2016.1173817.

Pauly, B., Barber, K., & Wallace, B. (2017). Sheltering risks: Implementation of harm reduction in homeless shelters during an overdose emergency. *International Journal of Drug Policy 53*. 83-89. https://doi.org/10.1016/j.drugpo.2017.12.011.

Polcin, D. (2015). Co-occurring substance abuse and mental health problems among homeless person: Suggestion for research and practice. *Journal of Social Distress and the Homeless, 25*(1). https://doi.org/10.1179/1573658X15Y.0000000004.

Sun, A. (2012). Helping Homeless Individuals with Co-occurring Disorders: The Four Components. *National Association of Social Workers, 57*(1). https:doi.org/ 10.1093/sw/swr008.

Technical Assistance Collaborative. (2019). *Oregon Statewide Shelter Study*. https://www.oregon.gov/ohcs/about-us/Documents/poverty/Oregon-Statewide-Shelter-Study.pdf.

United States Census Bureau. (2019). Quick Facts: North Dakota. https://www.census.gov/quickfacts/ND.

United States Interagency Council on Homelessness. (2016). *Housing First Checklist: Assessing Projects and Systems for a Housing First Orientations*. United States Interagency Council on Homelessness.

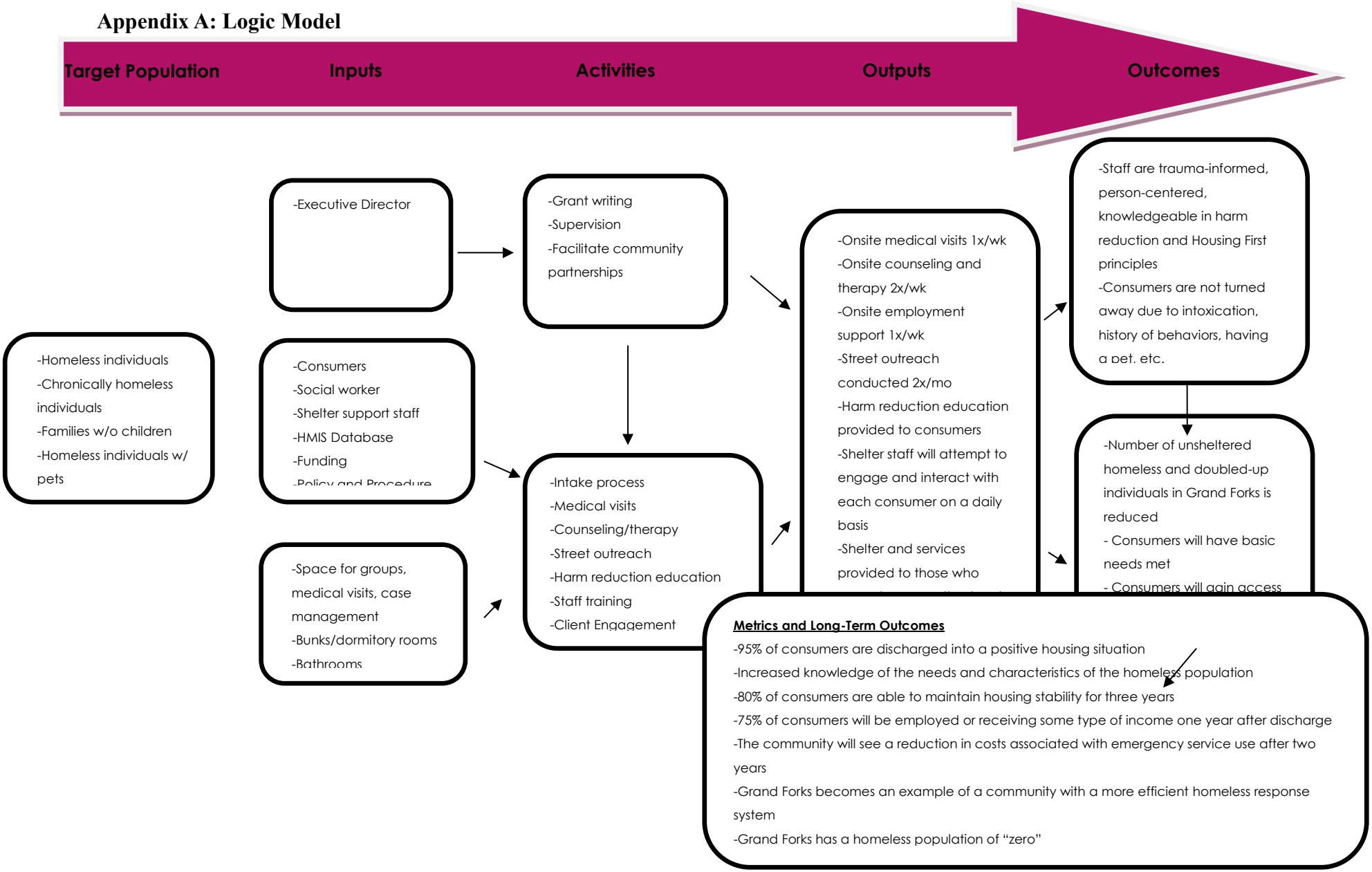
U.S. Department of Housing and Urban Development. (2019). *The 2019 Annual Homeless Assessment Report to Congress*. U.S. Department of Housing and Urban Development.

U.S. Department of Housing and Urban Development. (2020). *The 2020 Annual Homeless Assessment Report to Congress*. U.S. Department of Housing and Urban Development.

Yohanna, D. (2013). Deinstitutionalization of People with Mental Illness: Causes and Consequences. *American Medical Association Journal of Ethics, 15(10)*. 886-891. https://doi.org/10.1001/virtualmentor.2013.15.10.mhst1-1310.

Young, M. & Manion, K. (2017). Harm reduction through housing first: An assessment of the Emergency Warming Centre in Inuvik. *Harm Reduction Journal*. 14. 10.1186/s12954-016-0128-8.

Appendix A: Logic Model



Appendix B: Budget[1]

Personnel	FTE	Monthly Range	Partnership In-Kind	Monthly	Yearly
Executive Director	1	$61,000-$91,000	N/A	$ 5,600	$ 73,000
Social Work Case Manager	1	$40,000-$50,000	N/A	$ 3,230	$ 42,000
Shelter Support Staff	6.5	$11.50-$12.50/hr	N/A	$ 12,480	$ 149,760
Employment Support Staff	0.2	$35,000-$42,000	$7,800	N/A	N/A
Mental Health and Substance Use Professionals	0.8	$75,000-$90,000	$64,000	N/A	N/A
Medical Provider	0.2	$83,000-$180,000	$20,000	N/A	N/A
Subtotal Personnel					**$ 264,760.00**
Benefits @ 20%					$ 52,952
Total In-Kind Costs			**$91,800.00**		
Total Personnel					**$ 317,712.00**

Facility Furniture Expenses (One-Time)		
15 Single Beds (Bed Bug Proof)	$ 3,755	
Surveillance System	$1,800	
2 Laundry Machine Sets	$3,000	
Office and Consumer Furniture	$8,000	
2 Outdoor Tables and Chairs	$1,500	
5 Indoor Folding Tables	$600	
Games, Recreational Items, Activities for Consumers	$1,000	
20 Folding Chairs	$500	
Lockers	$1,500	
2 Refrigerators	$1,400	*One for employee breakroom; one for consumers*
10 Laptop Computers	$10,000	
2 Microwaves	$300	*One for employee breakroom; one for consumers*
Total Start-Up Costs	**$ 33,355.00**	

Operating Expenses	Monthly	Yearly
Communications (Email, Phone, Cell Phone)	$700	$ 8,400
Rent	$2,462.50	$29,550
Staff Training	$416	$5,000
Office Supplies	$500	$6,000
Printing	$100	$1,200
Consumer Activities/Recreation	$200	$2,400
Copier Lease	$119	$1,428
10 HMIS Licenses		$2,250
Utilities	$527	$6,324
Cleaning Supplies	$500	$6,000
Subtotal Operating Expenses	$5,525	$ 68,552.00
Subtotal Project Budget		**$ 386,264.00**
Indirect at 15% Subtotal		$ 57,939.60
One-Time Facility Furniture Expenses		$ 33,355.00
Total Project Budget		**$ 477,558.60**

[1] The total projected budget was configured by adding the total personnel costs, total start-up costs, subtotal operating expenses, and indirect costs.