12 MONTH EVALUATION REPORT
July 1, 2022 – June 30, 2023

Written by Michelle Ediger, Ph.D., & Christyl Wilson Ebba, Ph.D.

Contents

About Gateway Center

- Gateway Center (GWC) began serving Metro Atlanta's homeless community on July 27, 2005. Led by Atlanta Mayor Shirley Franklin, Jack Hardin, and Horace Sibley, Gateway Center opened its doors to serve as a beacon of hope.

- GWC strives to improve outcomes for individuals and families experiencing homelessness by utilizing a holistic collaborative approach that reduces and eliminates barriers while creating opportunities. The individuals and families we serve contribute to our service delivery model, which increases the likelihood of achieving self-sufficiency, securing sustainable employment (for those who can return to the workforce), and obtaining stable permanent housing.

- Our emphasis on providing services that are rooted in justice, equity, inclusion, and collaboration allows us to provide wraparound support that effectively assists individuals and families experiencing homelessness.

- GWC remains committed to eliminating barriers, improving equitable outcomes, and creating opportunities in underserved and under resourced communities by supporting individuals and families on their journey to safe and stable housing. Our ultimate goal is to provide multiple pathways that allow individuals and families to become stably housed, break the cycle of poverty, and improve health outcomes.

VALUES

- We believe in the worth and dignity of every person in our community.
- We operate with transparency.
- We use resources efficiently.
- We achieve measurable, lasting impact.

VISION

To live in a community where homelessness is **rare, brief, and non-recurring.**

MISSION

To **connect** people experiencing homelessness with the support necessary to become **self-sufficient and find a permanent home**.

BIG GOAL

By 2025, GWC will achieve an annual average of **65% of guests** transitioning to a **positive housing placement** upon discharge.

5 Keys to Success

Housing Placement & Stability

Health & Wellness

Family & Community Engagement

Job Skills Training & Placement

Adult & Financial Literacy

About This Report

This report was written and designed by Michelle Ediger and Christyl Wilson Ebba.

Homeless Management Information Systems

Gateway Center collects data via two electronic management information systems, Client Track by Eccovia Solutions and Apricot by Social Solutions. Demographic data is collected via interviews with guests and therefore is self-reported.

Sample Sizes

Throughout the report, n denotes the sample size for the analysis for that section and reflects individuals for whom there was data for a given measure. Sample sizes vary due to missing or incomplete data (i.e., guest does not provide the data). The symbol ~ is used when there is slight variation in the sample size for the items in a given measure.

Programs

Detailed descriptions of all Gateway Center programs can be found at the end of the report, beginning on .

Executive Summary

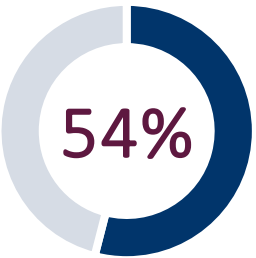From July 1, 2022, though June 30, 2023 (FY23), Gateway Center (GWC) served 8,682 guests:

- 86% of guests were previously living in the City of Atlanta.
- Based on VI-SPDAT scores, Permanent Supportive Housing or Housing First was the recommended housing solution for 41% of Coordinated Entry guests.
- 1,198 individuals were served in a case managed residential program.
- On average, GWC case managed programs operated at 93% of maximum residential capacity, and the average length of stay was 3 months.

Among Case Managed Residential Guests:
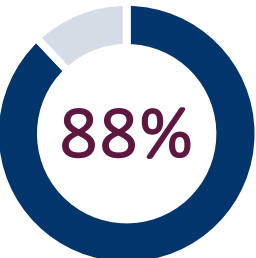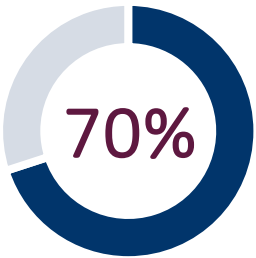
88% African American	**54%** Over 51 Years Old	**70%** High School Diploma or Less	**20%** Veterans	**30%** Chronically Homeless
67% Disabling Condition	**33%** Substance Abuse	**41%** Mild to Severe Depression	**39%** Mild to Severe Anxiety	**26%** PTSD Symptoms
68% Criminal Background	**89%** Unemployed at Intake	**60%** No Cash Income at Intake	**27%** Stayed at Emergency Shelter Night Prior	**79%** Assistance Needed to Obtain/Maintain Housing
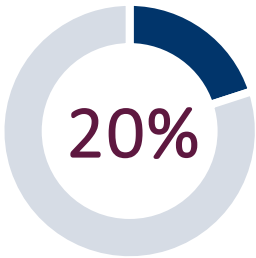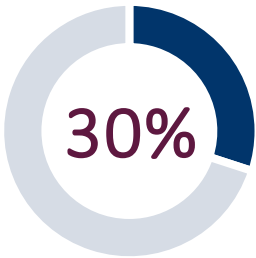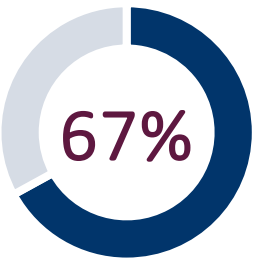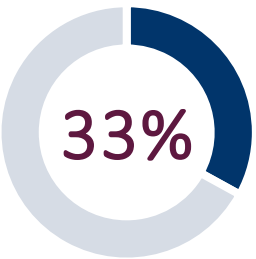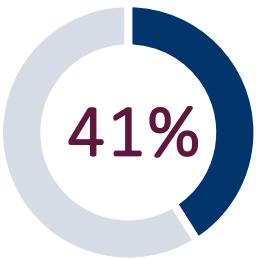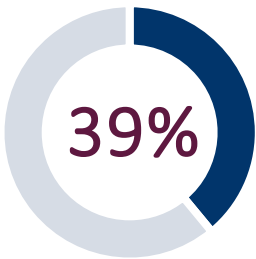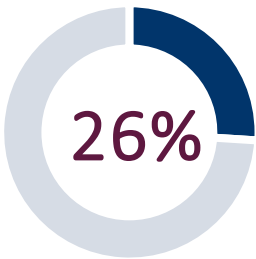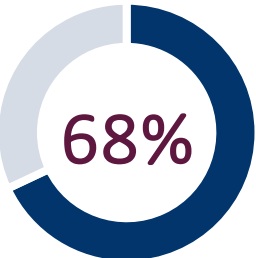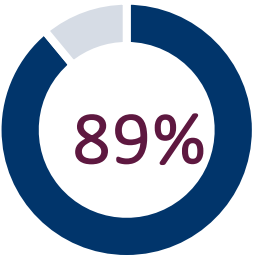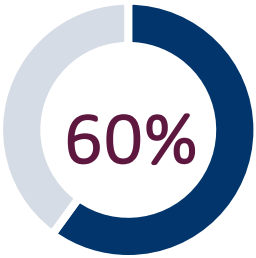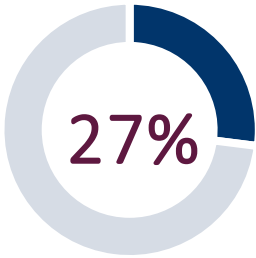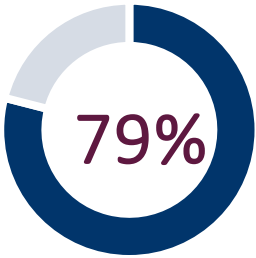
Executive Summary

Outcomes for GWC Case Managed Residential Programs

Statistically significant increases from intake to exit include:

Percent of guests with:
- Cash income (40% → **56%**)
- Health insurance (46% → **53%**)
- Employment[1] (23% → **55%**)
- Savings at exit (**43%**)

Wellness
- **75%** of guests had improvement in **depression symptoms**
- **74%** of guests had improvement in **anxiety symptoms**
- **74%** of guests had improvement in **PTSD symptoms**
- **68%** of guests had improvement in their **overall wellness**

Discharge
- **96% discharged to housing**
- **49%** were discharged to **permanent** destinations
- **40%** were discharged to **temporary** destinations
- **64%** of guests were discharged for **positive** reasons
- **31%** of guests were discharged for **negative** reasons

Feedback & Community Engagement

Guest Feedback
- **81%** of guests reported being satisfied with services received
- **82%** of guests would recommend GWC to others

Volunteer Feedback
- **6,178** of volunteers served at GWC in FY23
- **92%** of volunteers rated their experience as 'Excellent' or 'Good'
- **100%** reported that volunteering at GWC helped them have a greater understanding of homelessness

Community Engagement
- Gateway Center staff led **193** community engagements and interacted with approximately **3,297** individuals through those engagements
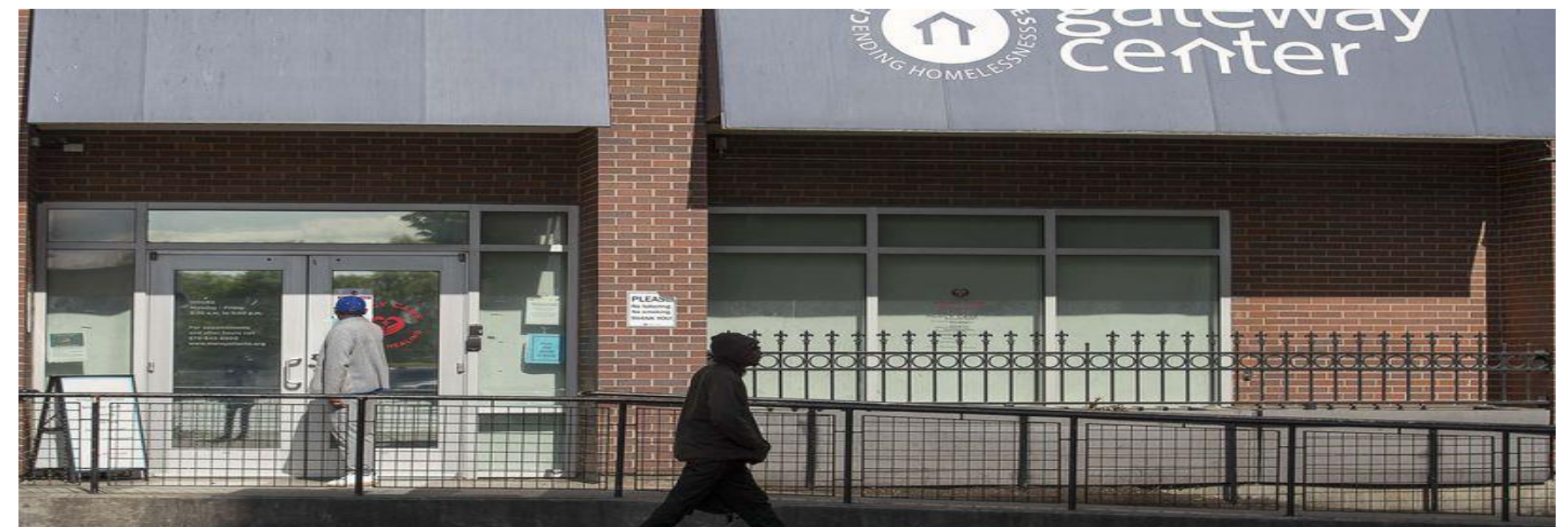
[1] Among guests able to return to the workforce.

Guests
Served

Demographics at Intake

In FY23, Gateway Center served 8,682 guests

Number of Guests

Legend: FY21, FY22, FY23

	Case Managed Residential Guests	Non-Residential Guests	Total Guests Served
FY21	1,087	6,525	7,426
FY22	901	6,086	7,080
FY23	1,198	7,484	8,682
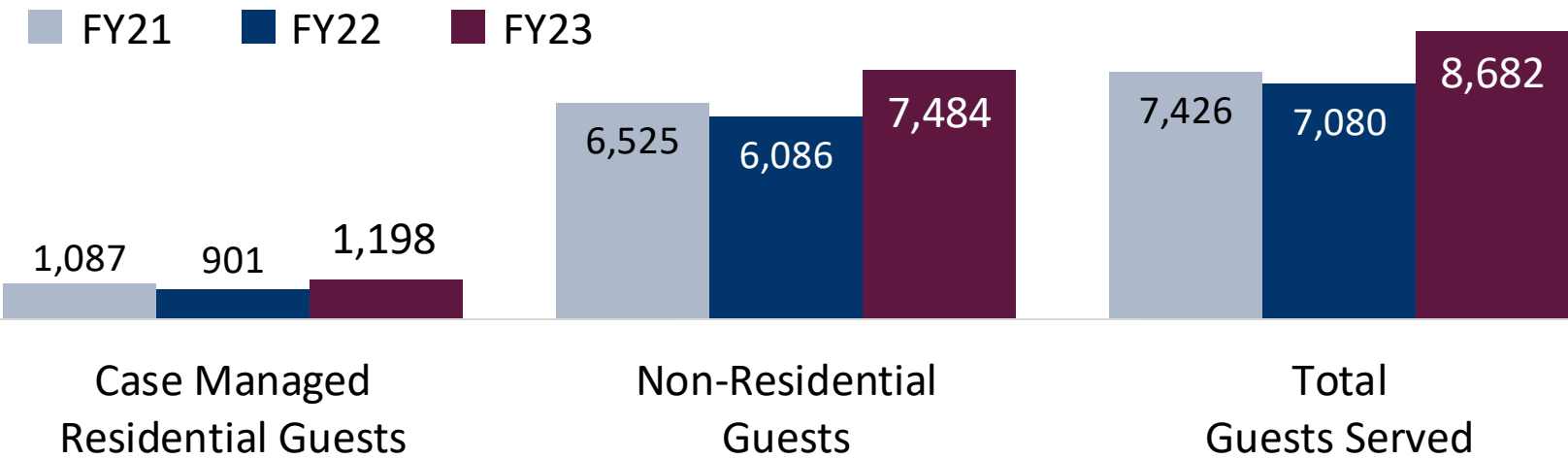
Case Managed Residential Guests

Highest Level of Education Completed (n = 712)

30% Some College or Higher Degree	48% High School Diploma or GED	22% No High School Diploma

Veterans (n=1,032)	Has Photo ID (n=972)	Has Emergency Contact (n=1,028)	COVID-19 Vaccinated (n=803)
20%	77%	33%	29%

Mental Health Status Range: Good to Excellent (n=832)	Physical Health Status Range: Good to Excellent (n=937)	Dental Health Status Range: Good to Excellent (n=938)	Has Primary Care Physician (n=934)
43%	45%	38%	30%

	Case Managed Residential Guests	Non-Residential Guests	All Guests
Gender			
	Male, Female, Gender Non-Conforming		
	n =1,198	n = 7,164	n = 8,362
	92% Male, 7% Female, 1% Gender Non-Conforming	48% Male, 52% Female	54% Male, 45% Female, 1% Gender Non-Conforming
Race/Ethnicity			
	Black/African American, White/Caucasian, Multi-Racial or Other Race[2]		
	n =1,198	n = 7,124	n = 8,321
	88% Black/African American, 10% White/Caucasian, 2% Multi-Racial	93% Black/African American, 6% White/Caucasian, 1% Multi-Racial	92% Black/African American, 7% White/Caucasian, 2% Multi-Racial
	Hispanic: 3%	Hispanic: 3%	Hispanic: 3%
Age			
	0 - 17, 18 - 30, 31 – 50, 51 – 60, 61 or older		
	n = 1,198	n = 7,363	n = 8,561
	4% (0-17), 10% (18-30), 32% (31-50), 29% (51-60), 25% (61 or older)	32% (0-17), 18% (18-30), 31% (31-50), 12% (51-60), 7% (61 or older)	28% (0-17), 17% (18-30), 31% (31-50), 14% (51-60), 10% (61 or older)
	Average age: 48	Average age: 31	Average age: 33

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[1] Non-Residential guests were never enrolled in a case managed residential program.

[2] 'Other Race' includes individuals who identify as American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.

Program Enrollment

Gateway Center Case Managed Residential Programs

Average length of stay:

3 months

93%

occupancy for residential for residential programs

	Number Served & Length of Stay (LOS)[2]			FY23 Mean Nightly Occupancy and Capacity		
	FY22 # Served	FY23 # Served	FY23 Mean LOS (m: months, d: days)	Mean Nightly Occupancy	Capacity[3] (avg. # of available beds)	Occupancy ÷ Capacity
All Case Managed Residential Programs[1]	901	**1,198**	3.1 m	220.4	244.5	90%
GWC Case Managed Residential Programs	783	**972**	**3.3 m**	**174.3**	**188.5**	**93%**
New Beginnings	28	80	5.0 m	15.0	16	94%
Rapid Rehousing (RRH) LIFT 1.0[4]	35	21	21.2 m			
Rapid Rehousing (RRH) LIFT 2.0[4]	NA	54	NA			
Stabilization	49	46	6.1 m	15.8	16.5	96%
The Evolution Center	441	517	2.5 m	94.3	97	97%
Trinity Women's Center[5]	43	77	3.6 m	5.0	7	71%
Upward	45	51	8.6 m	18.7	20	94%
Veterans Contract Beds (VACB)	20	18	5.0 m	5.7	7	81%
Veterans Low Barrier Shelter	125	111	21.7 d	6.4	10	64%
Veterans Transitional Housing (VAGPD)	45	46	5.5 m	13.4	15	89%
Partner Case Managed Residential Programs	218	**272**	**2.3 m**	**46.1**	**56**	**82%**
ADID—Project ASSIST[6]	40	22	1.9 m	4.0	5	82%
Hospital to Home	73	62	2.2 m	11.2	12	93%
Outreach / PATH Teams	79	99	2.7 m	17.3	20	87%
Recuperative Care by Mercy Care	73	94	2.0 m	13.6	19	71%

GWC Emergency Shelter Programs			
	FY22 # Served	FY23 # Served	FY23 Mean LOS
Family Shelter	22	49	6.4 d
Hotel—Emergency Shelter Lodging	183	234	31.7 d
Hotel—Encampment to Hotel	NA	285	4.2 m
Hotel—Isolation / Quarantine	685	335	8.5 d

GWC Non-Residential Services		
	FY22 # Served	FY23 # Served
Behavioral Health	106	185
Career Resource Center	355	464
Coordinated Entry	3,968	5,359
Engagement Center	1,567	1,124
Diversion	315	1,531
Navigation Services	102	109
Outreach	172	243
Rapid Exit	167	373

[1] Case Managed Guests are either case managed by GWC staff or partner staff.
[2] Individuals may be enrolled in more than one program.
[3] Average number of available beds is calculated based on the percentage of the year the beds were available.
[4] RRH LIFT guests are housed in apartments, not at GWC. There is no average LOS for LIFT 2.0 as only 1 person has exited.
[5] Children and significant others are not included in occupancy rates at Trinity Women's Center.
[6] ADID began 10/6/2022.

Last Permanent Zip Code & Prior Night's Stay

Gateway Center guests come from various locations.
- **99%** of all guests were previously living in Georgia
- **85%** of residential guests were at an Emergency Shelter or a place not meant for habitation the night before arriving at Gateway Center

Last Permanent Zip Code Location (among *all* guests)[1]

94% of guests were previously living in a county served by United Way's Regional Commission on Homelessness:

Fulton County	91.1%
DeKalb County	2.5%
Clayton County	1.3%
Gwinnett County	0.8%
Rockdale County	0.4%
Cobb County	0.3%
Douglas County	0.1%

Location of Residence the Night Before Arriving at Gateway Center[2]
(n = 1,009 residential guests)

Category	Location	%
Homeless 59%	Place not meant for habitation	58.7%
Temporary 31%	Emergency shelter, incl. hotel/motel paid for w/ ES voucher	26.5%
	Transitional housing for homeless persons	0.5%
	Hotel or motel paid for w/o E.S. voucher	0.9%
	Host home	0.2%
	Staying with family	1.9%
	Staying with a friend	1.4%
Institutional 9%	Foster Care home or foster care group home	0.1%
	Hospital or other residential non-psychiatric medical facility	5.2%
	Jail, prison, or juvenile detention facility	2.0%
	Psychiatric hospital or other psychiatric facility	0.2%
	Substance abuse treatment facility or detox center	1.1%
Permanent 1%	Rental by guest	1.1%
	Owned by guest	0.2%

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[1] n = 4,446: all GWC guests with known last permanent zip codes.
[2] For residential guests with more than one enrollment record during the report window, only data from the earliest enrollment is included.

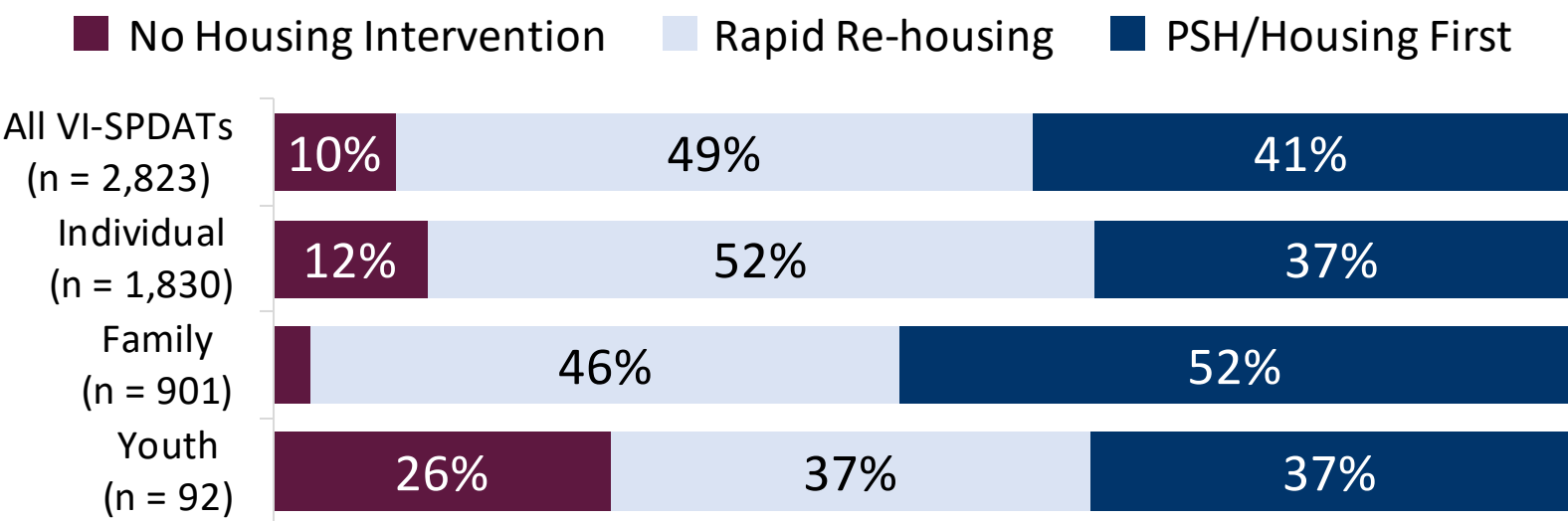# Non-Residential & Emergency Shelter Guests

Vulnerability Index & Coordinated Entry Services

- 2,823 VI-SPDATs[1] were completed at Gateway Center[2]
- Permanent Supportive Housing (PSH) or Housing First was the recommended housing solution for 41% of guests
- 11% were chronically homeless and received a VI-SPDAT score recommending Permanent Supportive Housing (PSH) or Housing First
- CE provided 1,116 referrals for 772 households (including emergency shelter, lodging assistance, rental assistance, employment placement, legal support, etc.)
- CE provided 1,517 homeless verification letters to 1,501 households

Administering the Assessment

- Assessments occurred on **251 days**.
- On average, 11 assessments were conducted per day (Range: 1 − 26)

- **1,107** guests were **ineligible for an assessment** due to not being homeless (n= 660) or not experiencing homelessness in the City of Atlanta (n= 447)

- **91%** were completed in-person; **9%** were completed over the phone
- **149** online appointment assessments completed

- Average wait time for in-person assessments was **1.2 hours** (1.5 hours in FY22)
- Average assessment completion time was **36 minutes** (42 minutes in FY22)

Recommended Housing Solution Based on VI-SPDAT Score

Legend: ■ No Housing Intervention ■ Rapid Re-housing ■ PSH/Housing First

Category	No Housing Intervention	Rapid Re-housing	PSH/Housing First
All VI-SPDATs (n = 2,823)	10%	49%	41%
Individual (n = 1,830)	12%	52%	37%
Family (n = 901)		46%	52%
Youth (n = 92)	26%	37%	37%

5,359 Guests Served through Coordinated Entry (CE)

Atlanta CE: 3,805 Assessments	Fulton County CE: 1,641 Assessments

Adult Males (n = 1,775)	Adult Females (n = 1,612)	Adult Gender Non-Conforming (n = 23)	Children (n = 1,949)
Average Age (Years)			
44	38	33	8
Race			
■ Black/African American ■ White/Caucasian ■ Multi-Racial or Other Race[3]			

Adult Males: 88% Black/African American, 11% White/Caucasian, 1% Multi-Racial or Other Race
Adult Females: 90% Black/African American, 8% White/Caucasian, 2% Multi-Racial or Other Race
Adult Gender Non-Conforming: 92% Black/African American, 4% White/Caucasian, 4% Multi-Racial or Other Race
Children: 97% Black/African American, 2% White/Caucasian, 1% Multi-Racial or Other Race

Ethnicity (% Who Identify as Hispanic/Latino)			
4%	3%	13%	3%

[1] The VI-SPDAT (Vulnerability Index—Service Prioritization Decision Assistance Tool) is a validated survey used across the US to determine risk and prioritization when providing assistance to individuals and families experiencing homelessness. It is rooted in leading medical research that determines the chronicity and medical vulnerability of individuals experiencing homelessness. There are three versions of the VI-SPDAT—one for individuals, one for families, and one for youth. One VI-SPDAT is completed per family, and all assessed guests are enrolled in the Coordinated Entry (CE) program.
[2] Some guests were assessed more than once. All assessments are included. If a Family VI-SPDAT was conducted, the questions pertain to the guest AND anyone in their family.
[3] 'Other' includes individuals who identify as American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.

Outreach & Navigation Services

Outreach: engaging individuals where they are sleeping in unsheltered areas or places not meant for habitation
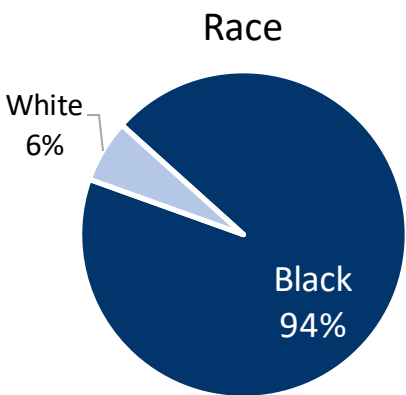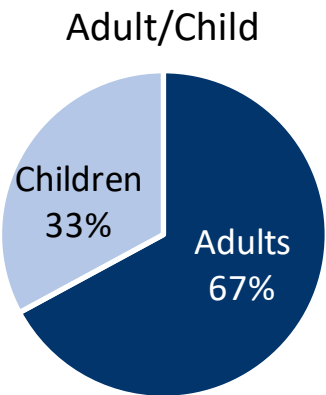
Total Served	Served in Fulton	Served in Atlanta
243	**150**	**93**

Demographics

Average Adult Age = 45 years old

Race
- White 6%
- Black 94%

Adult/Child
- Children 33%
- Adults 67%

Adult Gender (n=163)
- Female 49%
- Male 51%

6% Veterans[1]

32% Chronically Homeless

45% Disabling Condition

Discharge Destination[2] (n=92)

■ Permanent ■ Temporary ■ Place not Meant for Habitation ■ Institutional (1%)

| 58% | 34% | 8% | |

Navigation: case management services to assist guests with securing documents needed to obtain permanent housing

Total Served[3]	Crisis Response & Navigation	Atlanta COC Housing Navigation
109	**79**	**40**

Demographics

Average Adult Age = 49 years old

Race[4]
- Other 6%
- White 15%
- Black 79%

Adult/Child
- Adults 92.7%
- Children 7.3%

Adult Gender (n=101)
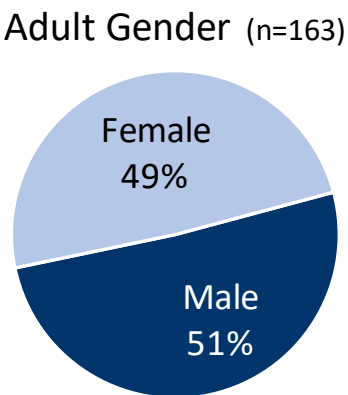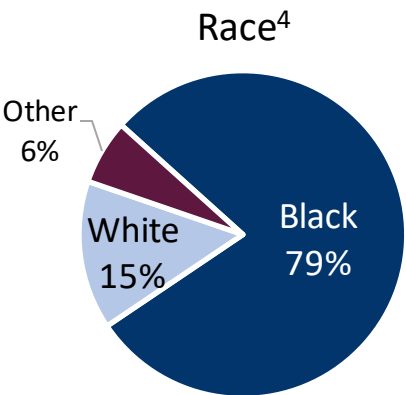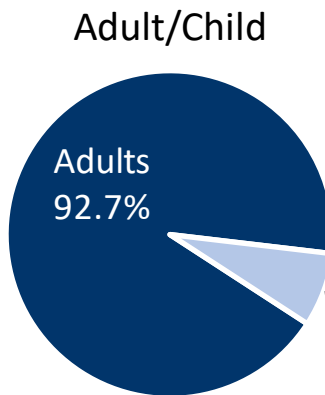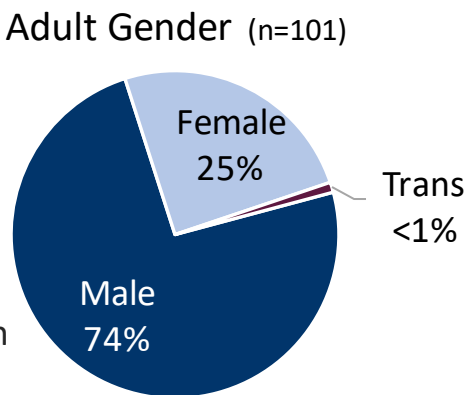- Female 25%
- Trans <1%
- Male 74%

6% Veterans[1]

59% Chronically Homeless

71% Disabling Condition

Discharge Destination[2] (n= 51)

■ Permanent ■ Temporary ■ Place not Meant for Habitation (2%) ■ Institutional (4%)

| 26% | 69% | | |

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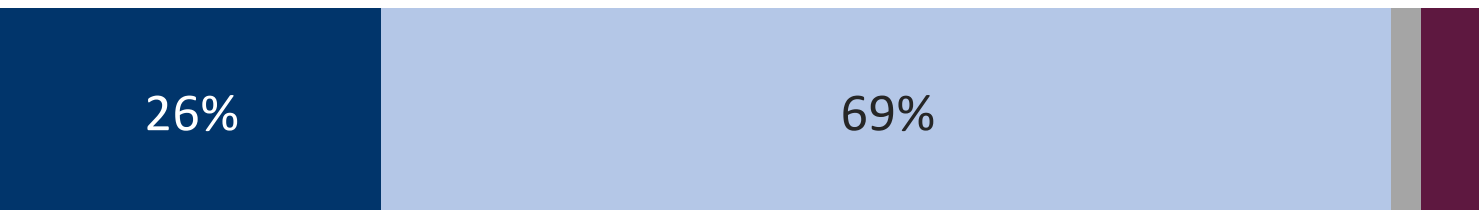
[1] Veteran status among adults only.

[2] For guests with multiple enrollments, only data from the most recent enrollment is included. Unknown discharge destinations were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other.

[3] Total served is number of unduplicated guests. 10 guests were enrolled in both navigation programs.

[4] 'Other' includes individuals who identify as Multi-Racial, American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.

Diversion & Rapid Exit

Diversion: prevents homelessness by helping individuals identify immediate alternative housing options, connecting them with services to return to permanent housing

Rapid Exit: reduces time spent in shelters by helping individuals identify alternative housing options, connecting them with services to return to permanent housing

Total Served	Avg. Adult Age (Years)	Avg. Child Age (Years)
1,531	**39**	**8**

Total Served	Avg. Adult Age (Years)	Avg. Child Age (Years)
373	**43**	**7**

Demographics

Race[2]
Other 2%
White 6%
Black 92%

Adult/Child
Children 30%
Adults 70%

Adult Gender (n=163)
Female 46%
Trans 1%
Male 53%

4% Veterans[1]

6% Chronically Homeless

27% Disabling Condition

Demographics

Race[2]
Other 2%
White 12%
Black 86%

Adult/Child
Children 28%
Adults 72%

Adult Gender (n=269)
Female 42%
Male 58%
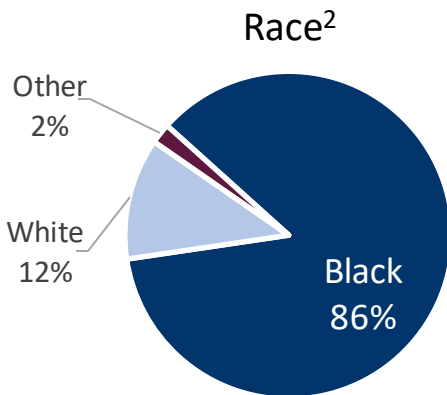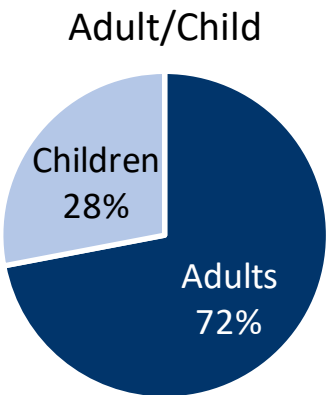
5% Veterans[1]

16% Chronically Homeless

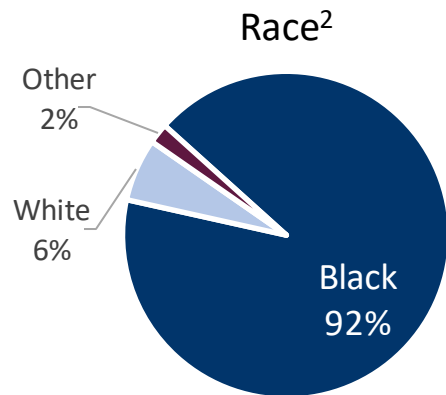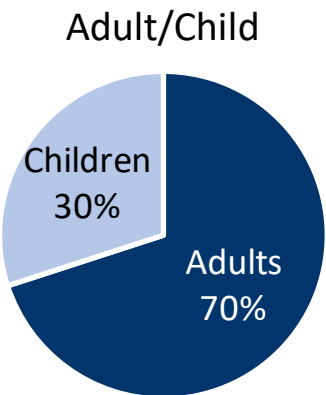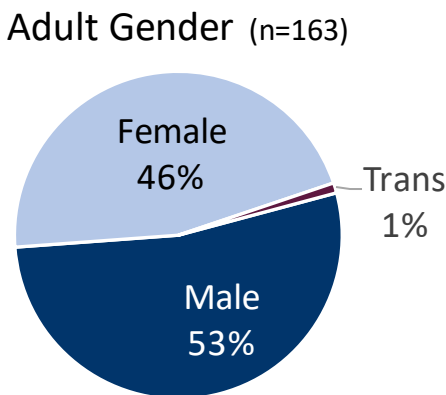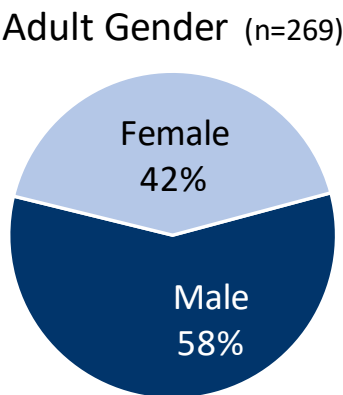**35%** Disabling Condition

Discharge Destination[3] (n=889)

■ Permanent   ■ Temporary   ■ Place not Meant for Habitation

Permanent	Temporary	Place not Meant for Habitation
95%	4%	1%

Discharge Destination[3] (n=214)

■ Permanent   ■ Temporary   ■ Place not Meant for Habitation

Permanent	Temporary	Place not Meant for Habitation
92%	7%	1%

[1] Veteran status among adults only.

[2] 'Other' includes individuals who identify as Multi-Racial, American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.

[3] For guests with multiple enrollments, only data from the most recent enrollment is included. Unknown discharge destinations were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other.

Emergency Shelter Hotels

Emergency Shelter Lodging Hotels: temporary hotel stays for those experiencing homelessness

Total Served	Avg. Length of Stay (Days)	Avg. Adult Age (Years)
234	**32**	**39**

Demographics

Race[2]

Other 1%
White 2%
Black 97%

Adult/Child

Children 49%
Adults 51%

Adult Gender (n=119)

Female 69%
Male 31%

7% Veterans[1]
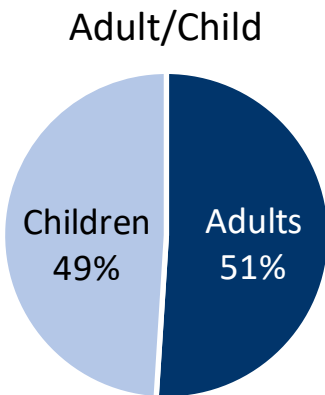
6% Chronically Homeless
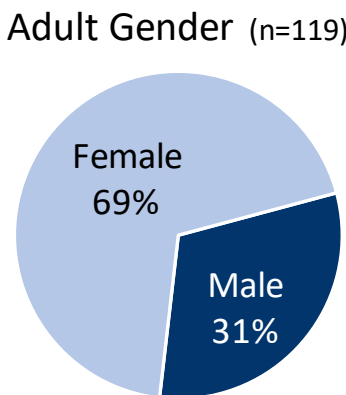
20% Disabling Condition

Discharge Destination[3] (n=219)

■ Permanent   ■ Temporary   ■ Place not Meant for Habitation (3%)

22%	75%	
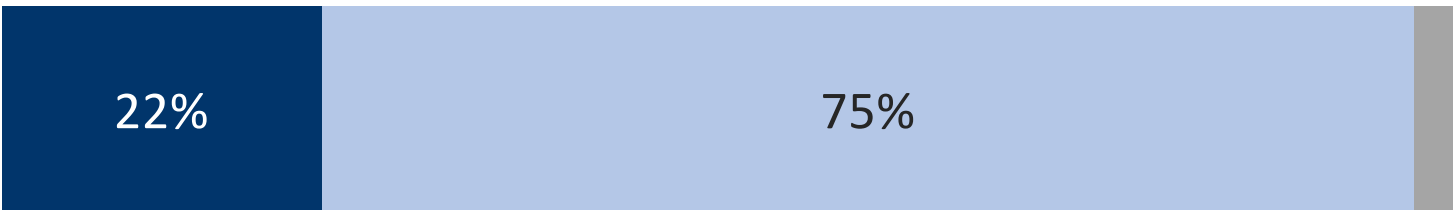
Encampment to Motel: temporary hotel stays for those sleeping in encampments in Atlanta

Total Served	Ang. Length of Stay (Months)	Avg. Adult Age (Years)
285	**4.2**	**50**

Demographics

Race[2]

Other 1%
White 16%
Black 83%

Adult/Child

Children 0.4%
Adults 99.6%

Adult Gender (n=284)

Female 29%
Trans 3%
Male 68%
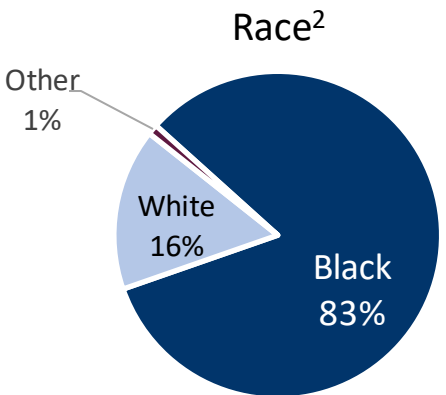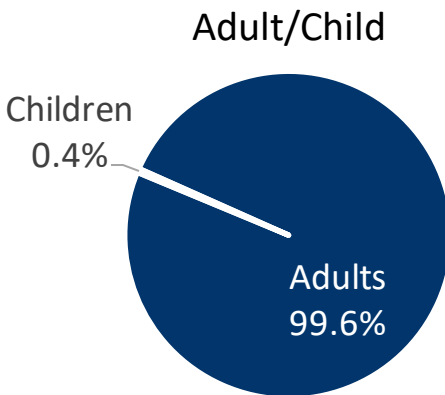
7% Veterans[1]

41% Chronically Homeless
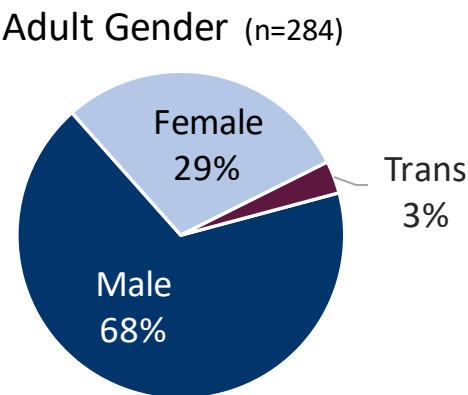
49% Disabling Condition

Discharge Destination[3] (n= 196)

■ Permanent   ■ Temporary   ■ Place not Meant for Habitation   ■ Other (1%)

73%	17%	9%

---

[1] Veteran status among adults only.

[2] 'Other' includes individuals who identify as Multi-Racial, American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.

[3] For guests with multiple enrollments, only data from the most recent enrollment is included. Unknown discharge destinations were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other.
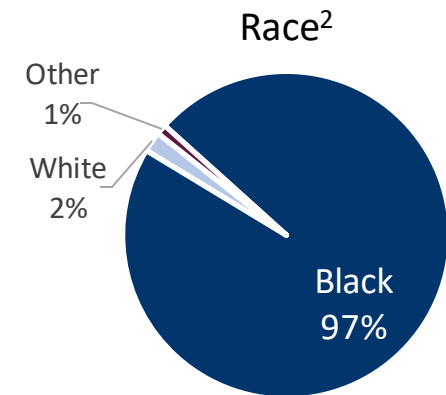
Emergency Shelter Programs

Isolation/Quarantine Hotels: temporary hotel for those diagnosed with COVID-19 or other highly contagious diseases

Total Served	Avg. Length of Stay (Days)	Avg. Adult Age (Years)
335	**8.5**	**50**
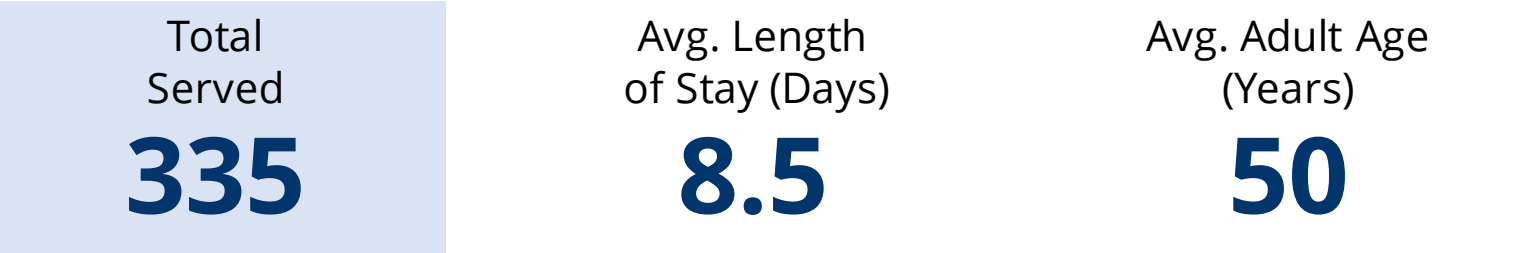
Cold Weather Shelter & Transportation:
GWC provided shelter or transportation to shelter at a partner agency when the temperature **dropped below 40 degrees**

Cold Weather Shelter		Cold Weather Transportation	
Encounters:	Days:	Encounters:	Days:
1,537	**36**	**611**	**11**

■ Single Men ■ Single Women ■ Families (7%)   ■ Single Men ■ Single Women ■ Families (3%)

74%	19%		69%	28%	
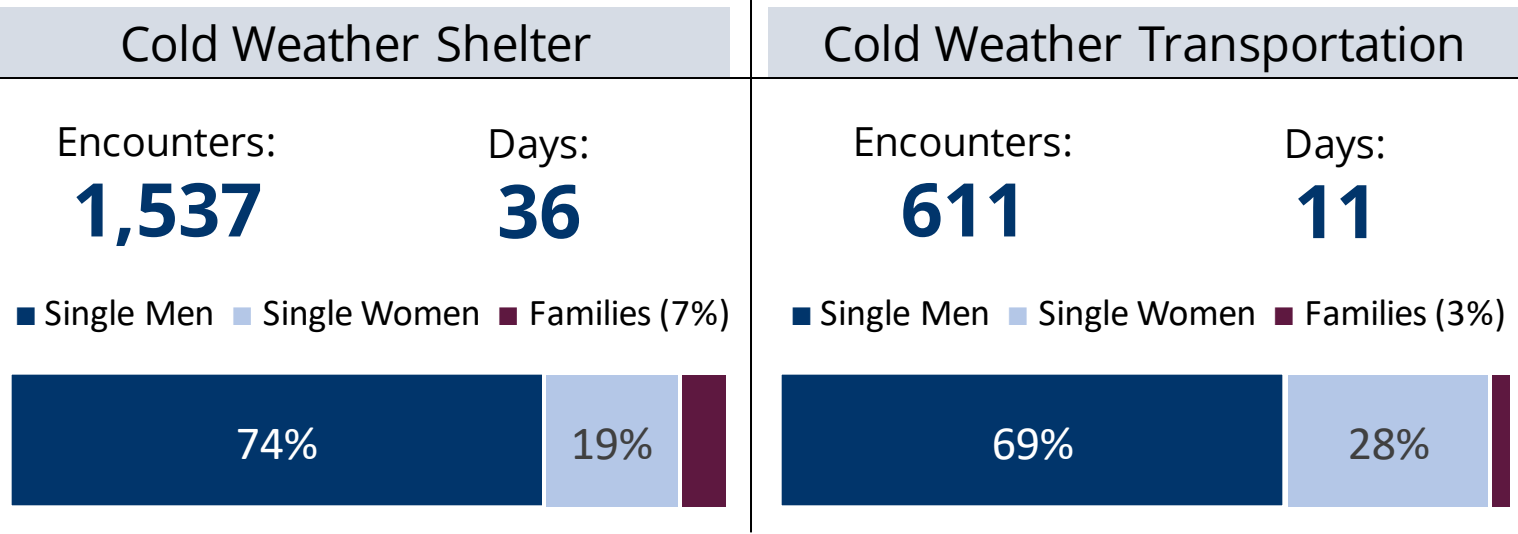
Family Shelter: in limited situations, GWC provided emergency shelter for **families with children** as they awaited family shelter placements

Total Families Served:	Total Children Served:	Avg. Length of Stay (Days):
13	**36**	**6**

Essential Services

Engagement Center: provides access to basic human services

Total Served	Total Services Provided	Number of Days Served
1,124	**2,731**	**224**

On average, guests **received** 2.4 services (Range: 1-105 services). The most frequent services provided were:

Showers (n=1,959)	Homeless Verification Letters (n=533)	Clothing (n=140)

Mercy Care Clinic: uses an integrated health care model to provides onsite medical services

Provided 3,864 Encounters:

1,902 Medical Encounters	1,457 Behavioral Health Encounters	505 Dental Encounters

Residential Guests:
Characteristics at Intake and Services Provided

Chronic Homelessness

The U.S. Department of Housing and Urban Development (HUD)[1] defines a chronically homelessness individual as someone who:
(1) has a **disabling condition**,
(2) lives either in a **place not meant for human habitation** or in an **emergency shelter**, *and*
(3) has been living as described in #2 **continuously for at least 12 months** or on at least **four separate occasions** in the last 3 years, where the combined occasions total a length of time of at least 12 months.

30% **Chronically Homeless** (n=1,073)

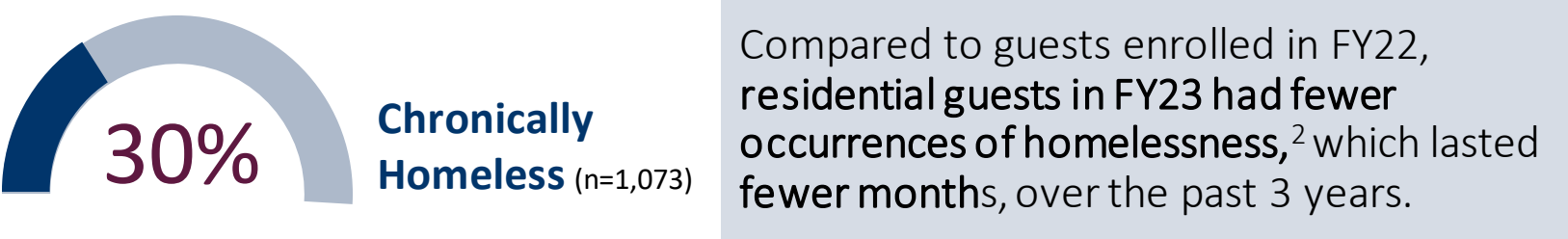Compared to guests enrolled in FY22, **residential guests in FY23 had fewer occurrences of homelessness,**[2] which lasted **fewer months**, over the past 3 years.

Number of times homeless in the last three years

■ FY22 (n = 825) ■ FY23 (n = 1,025)

	1 Time	2 Times	3 Times	4+ Times
FY22	40%	17%	10%	33%
FY23	61%	10%	8%	21%
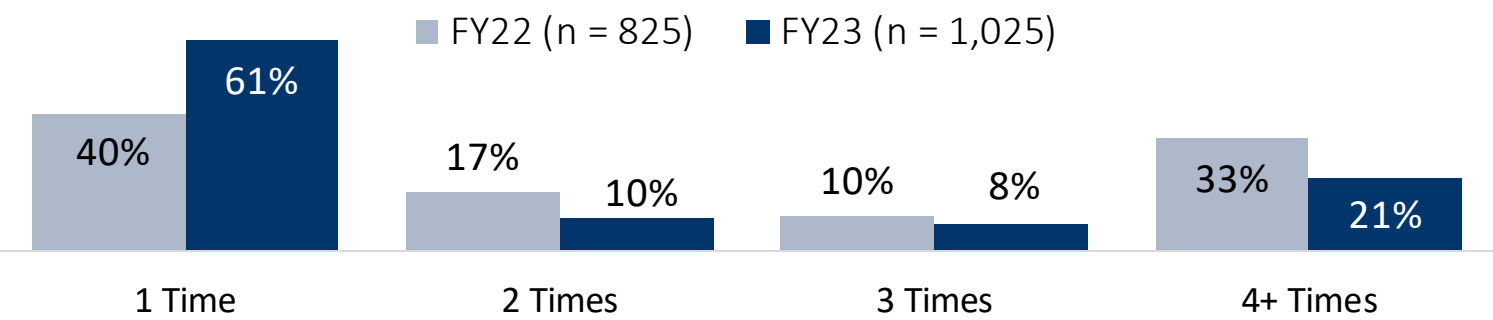
Total number of months homeless in the last three years

■ FY 22 (n = 824) ■ FY23 (n = 1,025)

	1 Month	2 Months	3 Months	4 to 7 Months	8 to 11 Months	1 Year +
FY22	21%	10%	8%	14%	9%	38%
FY23	30%	7%	5%	12%	5%	41%
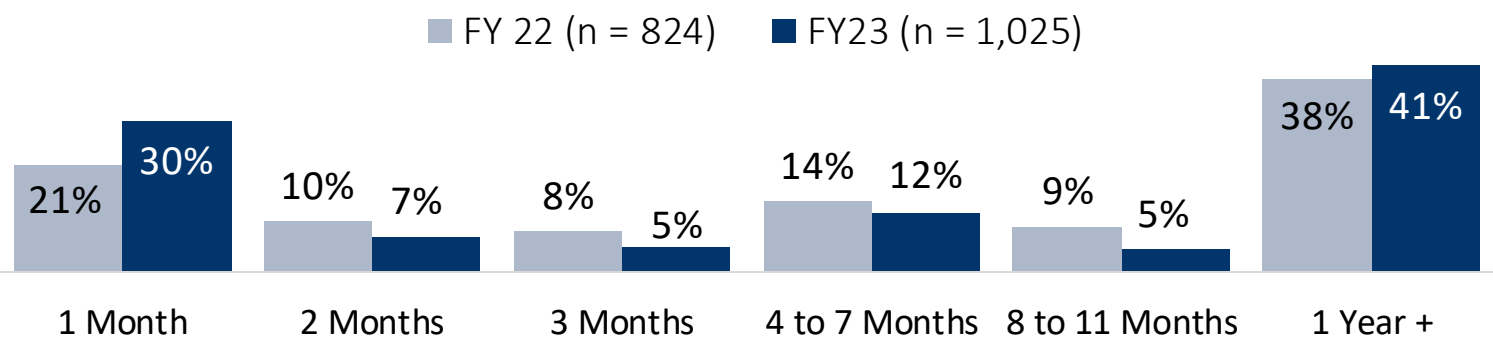
[1] For the full definition visit: https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf
[2] Statistically significant difference at p <.05.
[3] https://www.cdc.gov/violenceprevention/aces/index.html
[4] For guests with more than one enrollment record during the report window, only data from the most recent enrollment is included.

Adverse Childhood Experiences

- **135** residential guests completed the Adverse Childhood Experiences form[3], which assesses exposure to traumatic events as a child.

- On average, guests experienced **4 traumatic events** as a child

88% **Experienced at Least One Traumatic Event**[4]

Percent of guests who indicated 'Yes' to experiencing the following events during the first 18 years of life (n = 135)

Event	Percent
Parents Separated or Divorced	62%
Emotional Abuse	49%
Household Member w/ Substance Abuse	48%
Emotional Neglect	46%
Physical Abuse	39%
Household Member Imprisoned	37%
Domestic Violence	29%
Physical Neglect	27%
Household Member w/ Mental Illness	26%
Sexual Abuse	19%
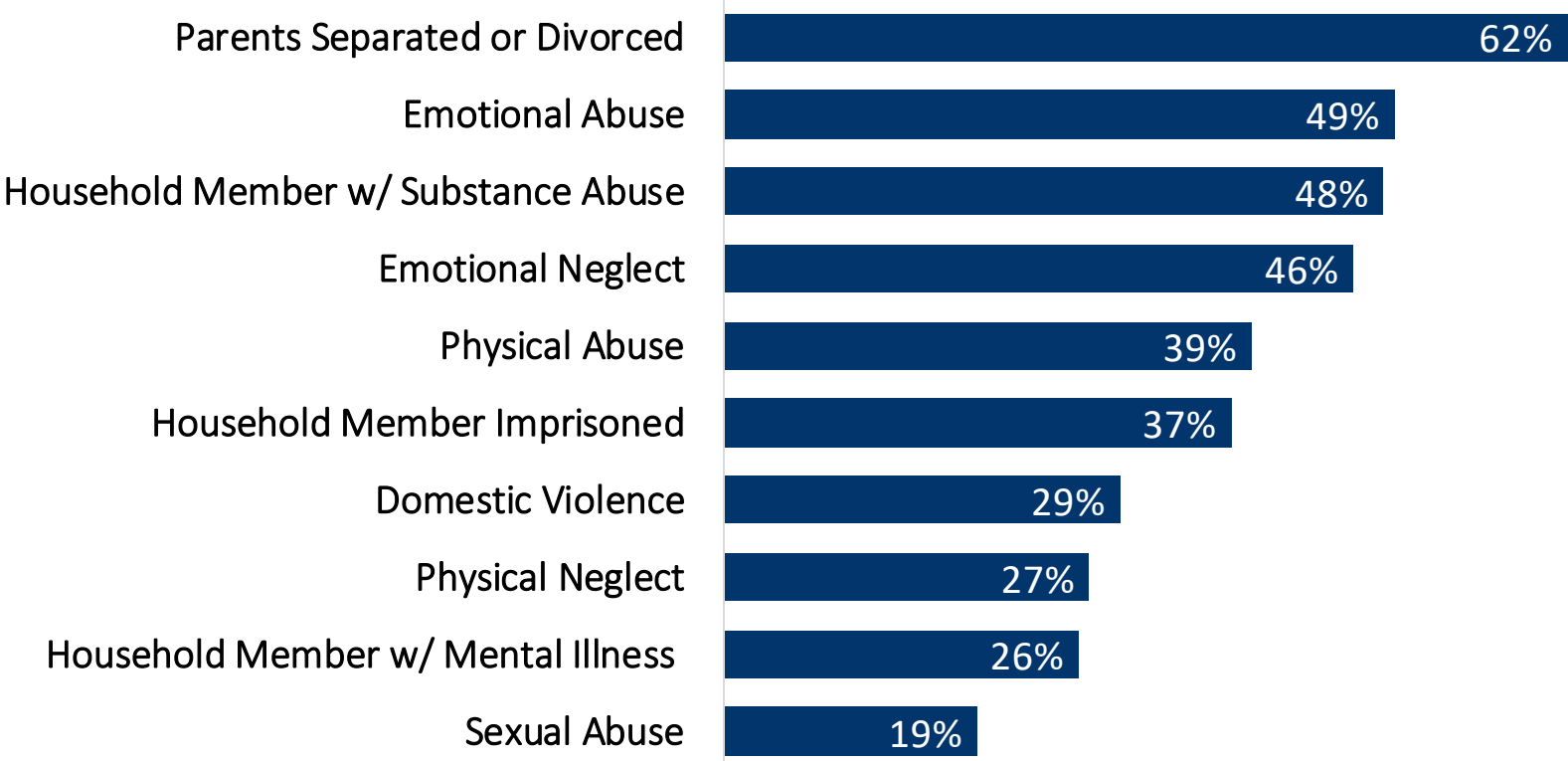
Housing Barriers

- **980** residential guests completed the [Barriers to Housing Stability Assessment](#)[1]

- **79%** needed temporary assistance and **77%** needed permanent assistance to obtain or maintain housing

The most common housing barriers were **employment** and **credit history**. On average, guests had **5 barriers** to housing (Range: 0 – 13 barriers).

88% had 1 of these **employment barriers**

- **87%** did not have reliable transportation to get to work
- **10%** reported English as a second language

83% had 1 of these **credit history barriers**

- **46%** had poor credit history
- **51%** had no credit history
- **23%** had unpaid rent or utility bills in their name

73% had 1 of these **rental history barriers**
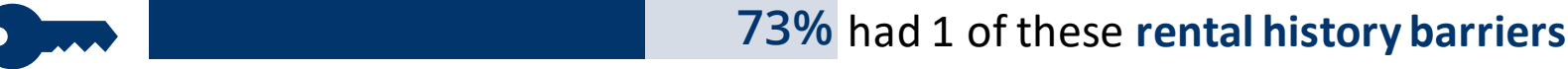
- **45%** never had a lease for an apartment/ home in their name
- **39%** never had utilities in their name
- **27%** have been evicted from housing
- **9%** would receive a bad reference from a prior landlord

61% had 1 of these **criminal history barriers**

- **49%** had been convicted of 1 or more misdemeanors
- **44%** had been convicted of a felony
  - **37%** involved drugs, weapons, or a sex crime
- **11%** were on probation

13% had 1 of these **physical health barriers**

- **9%** lost housing because of their physical abilities/physical health
- **7%** had physical health challenges that currently impact ability to obtain housing

11% had 1 of these **mental health barriers**

- **9%** lost housing because of their mental health issues
- **6%** had mental health challenges that impacted ability to obtain housing

12% had 1 of these **substance use barriers**

- **11%** lost housing because of their substance use
- **5%** had substance use problems that currently impact ability to obtain housing

4% had 1 of these **domestic violence barriers**
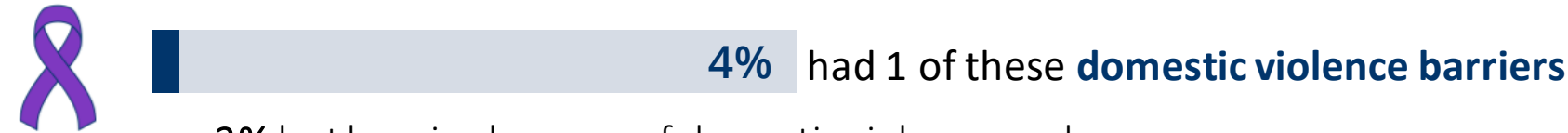
- **3%** lost housing because of domestic violence or abuse
- **1%** had domestic violence or abuse challenges that impact ability to obtain housing

3% had 1 of these **family composition barriers**
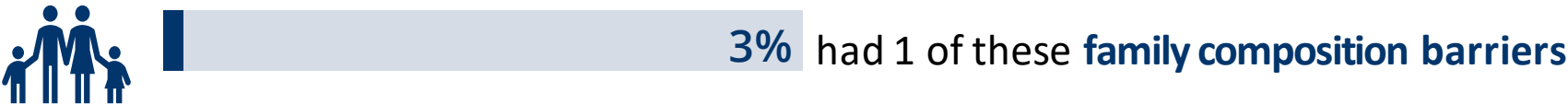
- **2%** had more than four individuals in their household
- **1%** had a male between 12 and 18 years of age in their household

Income Barriers

- The median household income in Atlanta is $5,764 monthly[1]
- In June 2023, the average rent for a one-bedroom apartment in Atlanta was $2,127 per month[2]
- Monthly entitlement benefits for someone with SSI in 2023 is $914[3] (less than half the cost of an average one-bedroom rental)

61% Had No Income at Intake

45% Had Income at Intake

Average Monthly Income[4]:
$1,080
(Range: $100 - $3,568)

Among Those With Income
28%
Had Earned Income

Monthly Income at Intake: Residential Guests (n = 1,022)

$0	$1 - 750	$751 - $1,133	>$1,133
61%	8%	20%	11%

89% of guests were <u>below</u> the 2023 federal poverty line at intake.

Federal poverty line[5]:
$1,215 monthly
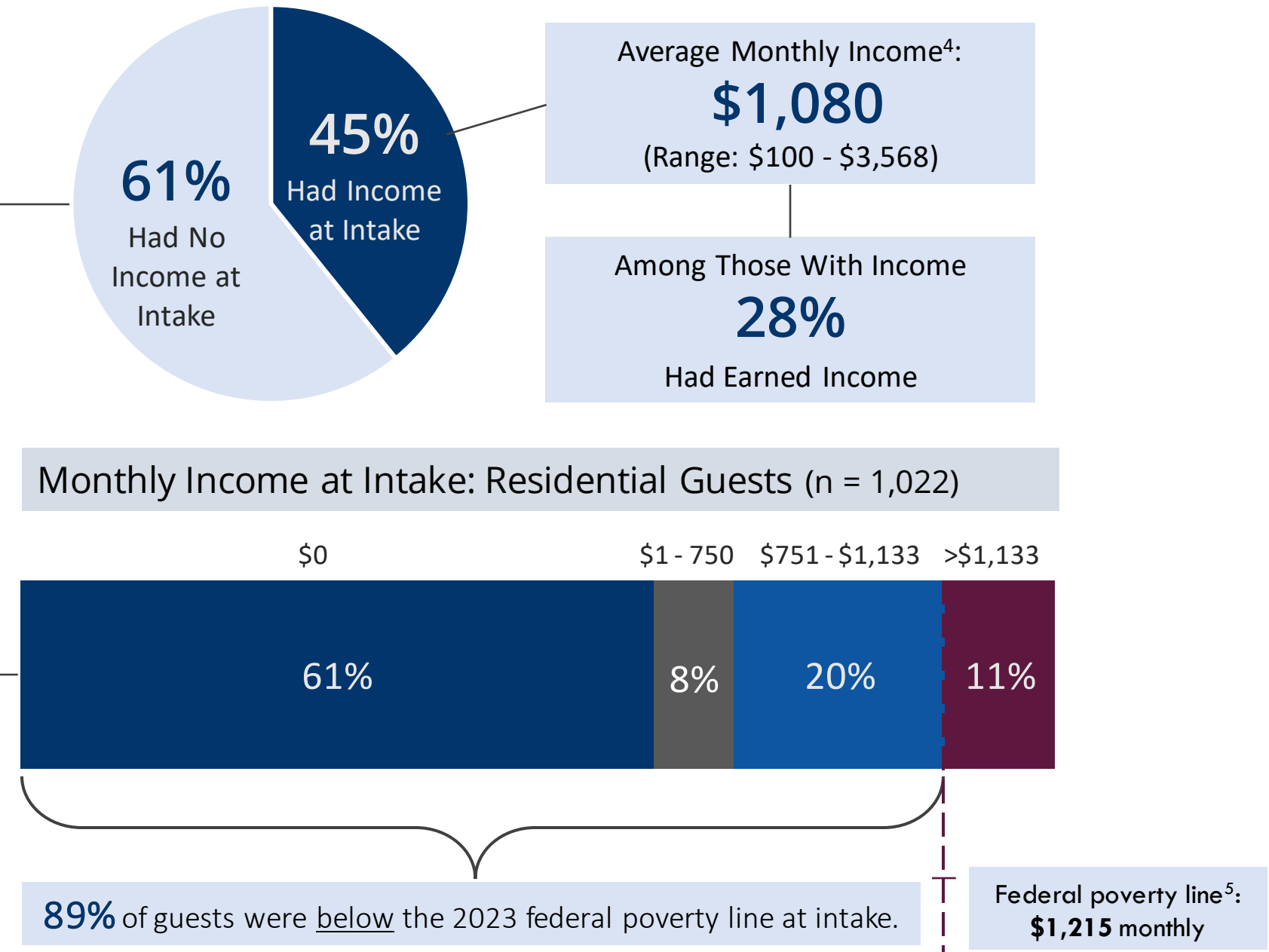
If you are not living in your own house or apartment, how much money can you spend on housing each month? (n = 488)

$1-$100	$101-$200	$201-$300	$301-$400	$401-$500	$501-$600	$601-$700	$701-$800	more than $801
10%	10%	18%	17%	14%	9%	7%	6%	8%
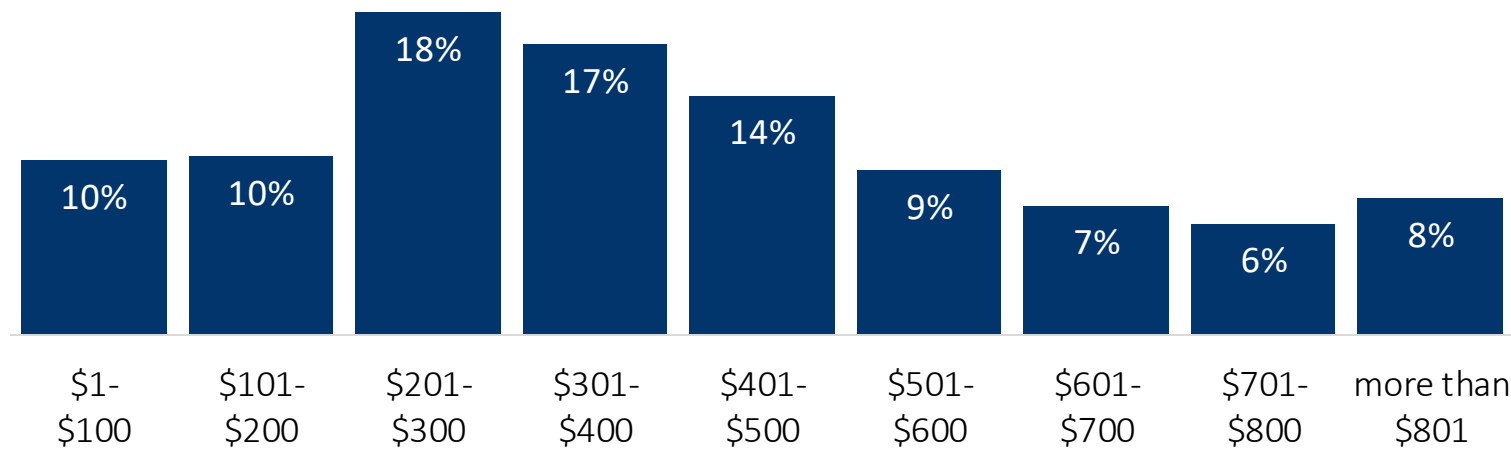
When you were living in a house or apartment, what percent of income did you spend on housing (rent/mortgage AND utilities)? (n = 966)
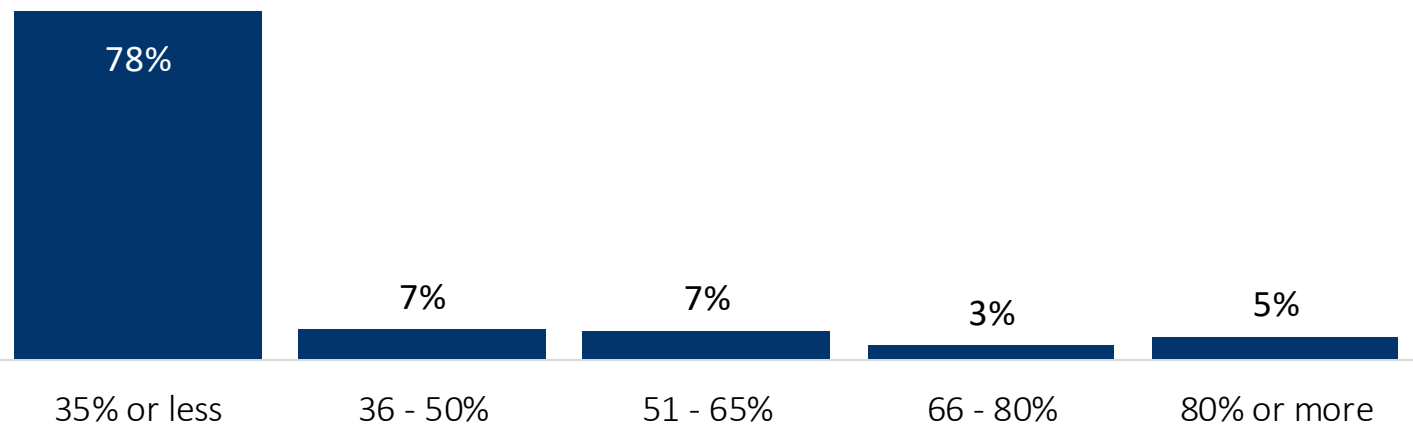
35% or less	36 - 50%	51 - 65%	66 - 80%	80% or more
78%	7%	7%	3%	5%

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[1] https://www.census.gov/quickfacts/fact/table/atlantacitygeorgia/INC110221. Estimate is from 2021.
[2] https://www.apartmentguide.com/blog/apartment-guide-annual-rent-report/
[3] https://www.ssa.gov/oact/cola/SSI.html
[4] For guests with more than one enrollment record, only data from the earliest enrollment date is included above. Only guests with income included in the average monthly income.
[5] https://aspe.hhs.gov/poverty-guidelines. The single person in household guideline is used. The 2023 federal poverty line is $14,580 annually.

Special Needs

- **67%** of residential guests had a disabling condition (a special need that is expected to be of long-continued duration, and substantially impairing one's ability to live independently, i.e., is *indefinite* and *impairing*).
- **33%** of guests had a substance abuse special need (drug or alcohol abuse).
- **21%** experienced a co-occurring mental health and substance abuse special need.

Percent of Residential Guests with Special Needs (n ~ 1,073)

Mental Health	Chronic Health Condition	Physical Disability	Drug Abuse	Alcohol Abuse	Developmental Disability	HIV/AIDS
45%	34%	34%	25%	22%	18%	6%
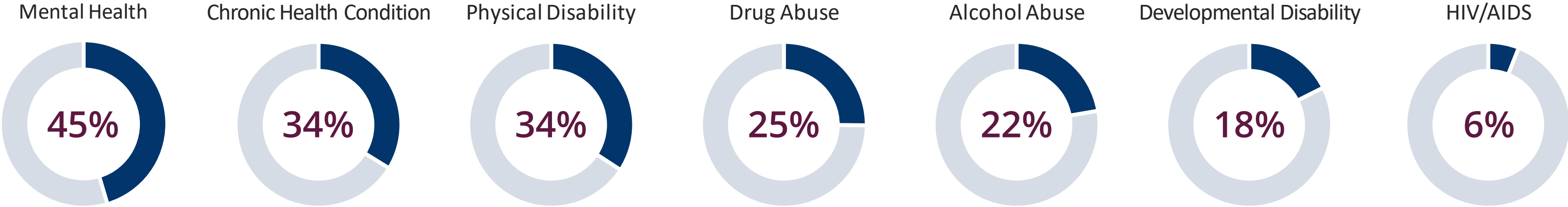
- **73%** had at least one special need.
- **53%** had more than one special need.

- Among guests with a chronic health condition, **92%** reported this condition is *indefinite* and *impairing*.

Number of Special Needs Per Guest (n = 1,073)

Legend: ■ 0 ■ 1 ■ 2 ■ 3 ■ 4 ■ 5 or more

27%	20%	21%	15%	9%	8%
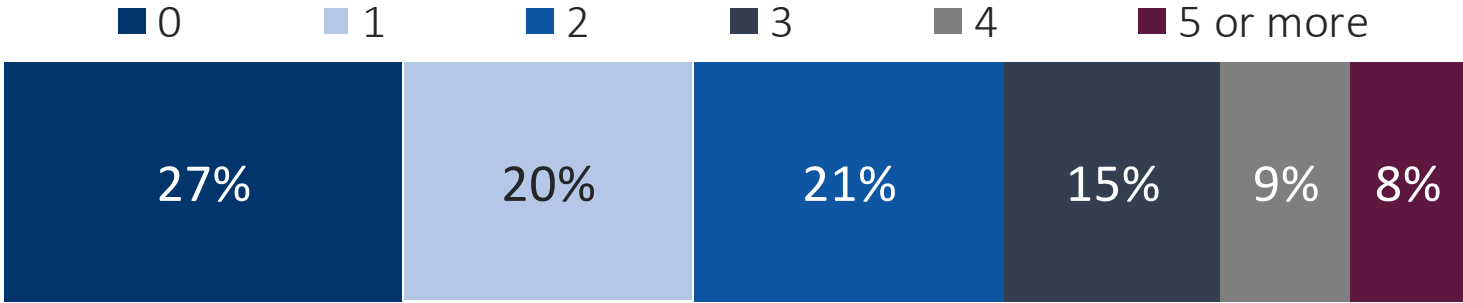
Guests With Indefinite and Impairing Special Need

Chronic Health Condition (n = 354)	92%
Mental Health (n = 476)	90%
Physical Disability (n = 356)	86%
Drug Abuse (n = 264)	75%
Alcohol Abuse (n = 235)	69%
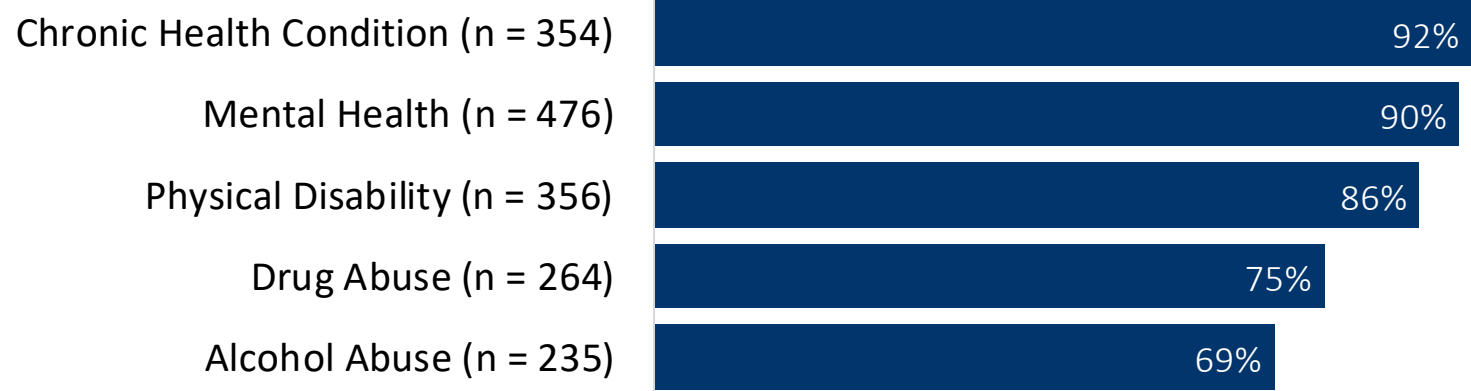
Behavioral Health & Well-Being

Gateway Center case managed residential guests complete a battery of behavioral health assessments[1] to assess their level of depression, anxiety, PTSD symptoms, coping skills, and perceptions of wellness.

60% of guests experienced at least one of the five challenges below:

41% — Mild to Severe Depression

39% — Mild to Severe Anxiety

26% — PTSD

28% — Minimal Coping Skills

21% — Low Resilience
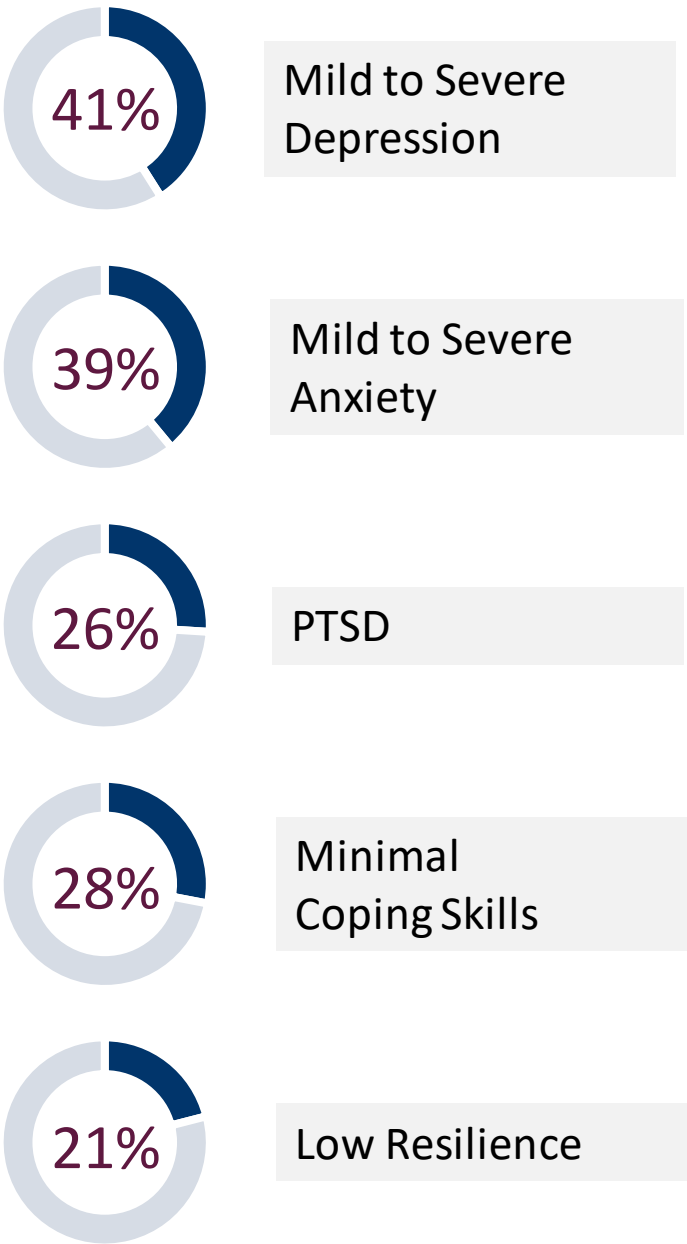
Depression (PHQ-9)	n = 659
No or minimal depression	59%
Mild depression	20%
Moderate depression	13%
Moderately severe depression	6%
Severe depression	2%
Anxiety (GAD-7)	**n = 659**
No anxiety	61%
Mild anxiety	21%
Moderate anxiety	11%
Severe anxiety	7%
Post Traumatic Stress Disorder (PCL-5)	**n = 458**
May benefit from PTSD treatment	26%
Coping Skills (BRCS)	**n = 658**
Minimal coping skills	28%
Moderate coping skills	31%
High coping skills	41%
Resilience (BRS)	**n = 658**
Low resilience	21%
Normal resilience	67%
High resilience	12%

Personal Wellness Index

Guests responded to 6 questions about their perceptions of their wellness from the Personal Wellness Index (PWI).

- Response options were on a scale of 1 to 5:
  - 1=Extremely Unsatisfied; 3=Neutral; 5=Extremely Satisfied

- The average guest score on all items was **3**, indicating on average guests feel *Neutral*.

Percent of guests who indicated that they are 'Unsatisfied' or 'Extremely Unsatisfied' with the following (n = 659):

Your financial security	58%
Your standards of living	51%
Your life as a whole	39%
What you are currently achieving	38%
Your interpersonal relationships	24%
How safe you feel	15%

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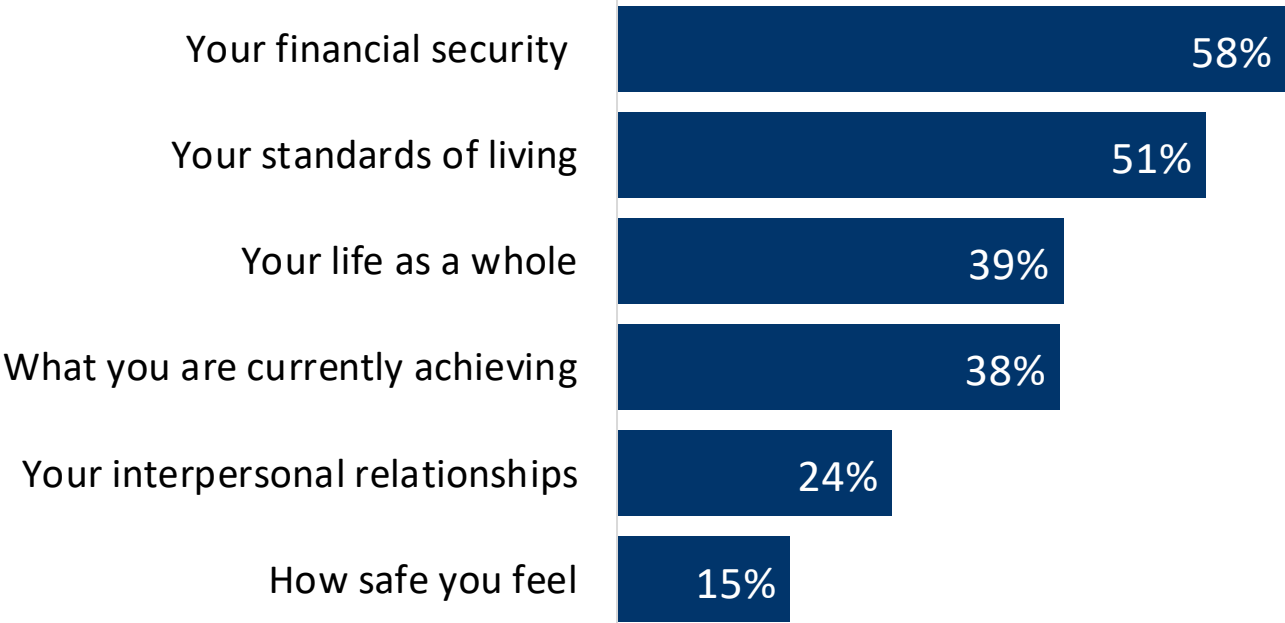
[1] Behavioral Health Assessments are conducted at intake, during enrollment, and at exit. The earliest assessment during FY23 enrollment is included. Only 1 assessment per guest is included.

Criminal Background
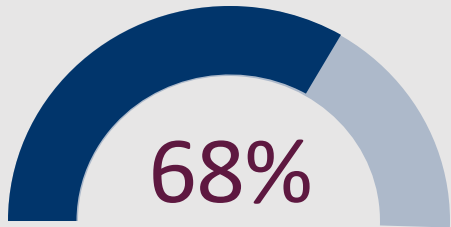
68% **Criminal Background**
(*n*=456/676)

Among those with a criminal background, on average, guests had 2 of the following six criminal background indicators:

85%	convicted of a **misdemeanor**
76%	convicted of a **felony**
20%	currently on **probation**
4%	currently on **parole**
4%	required to complete court ordered **community service**
2%	have active **warrant**
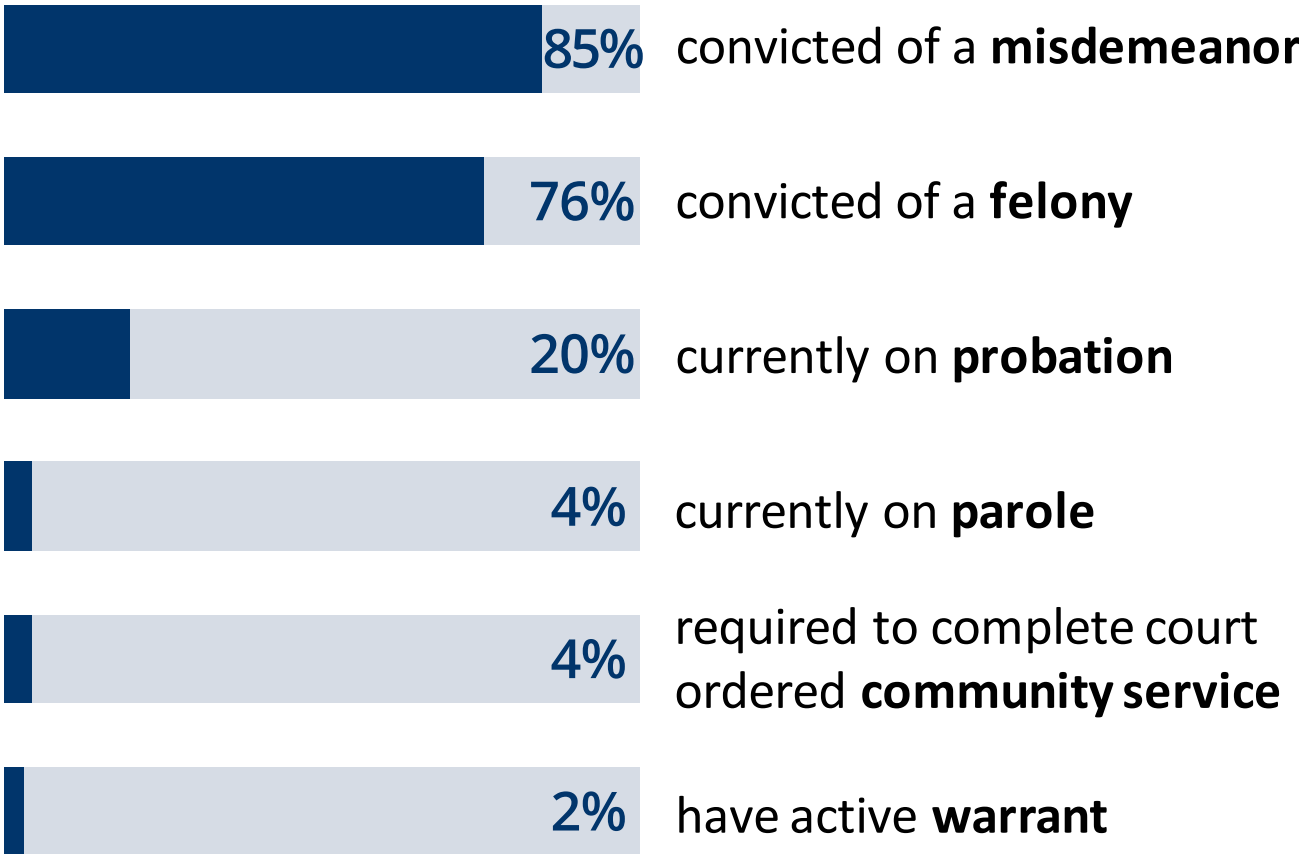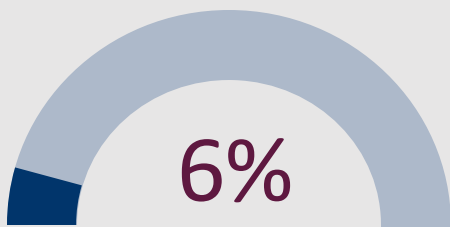
Child Support

6% **Required to Pay Child Support** (*n*=43/696)

Among those who were required to pay child support, the average amount was $312 per month (Range: $20 - $1,200).

43%	are in good standing with paying child support
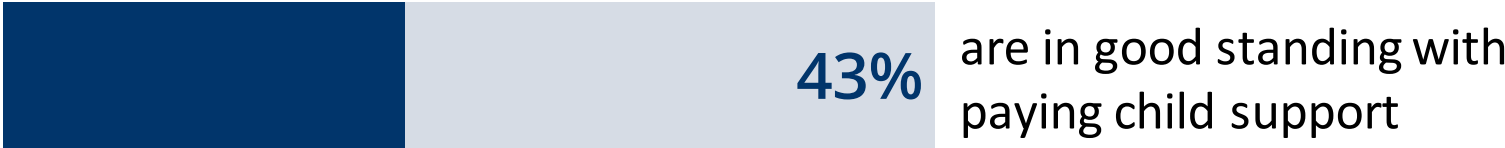
Treatment Sessions

Behavioral Health Sessions

185 met with a Behavioral Health Specialist (BHS) via a group or individual session at least once

1-on-1 Behavioral Health Sessions[1]: **282**

134	2	42 minutes
attended individual sessions	average BHS sessions attended (Range: 1-15)	average session duration

Group Behavioral Health Sessions: **97**

86	7
attended group session	average group sessions attended (Range: 1-30)

Substance Abuse Sessions

52 guests attended a substance abuse treatment group[3]

Substance Abuse Sessions: **308**

123	185	88
morning check-Ins	didactic sessions[2]	average substance abuse group sessions attended (Range: 5-302)

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[1] Guests may have attended more than one session.
[2] Guests learn about their triggers and practice recovery strategies while sharing with and learning from others in the Upward program.

Career Resource Center (CRC)

- The Career Resource Center (CRC) assisted 464 guests with obtaining economic stability.

- 122 guest surveys were completed about the CRC[1]
- Among those who completed the surveys, 98% are satisfied overall with CRC's services

Individual Employment Plans

The CRC Manager develops Individual Employment Plans (IEPs) with residential guests.

- 217 IEPs created
- 136 IEP goals completed
- 116 guests completed at least one goal

Impact

- 118 guests obtained employment after engaging with the CRC
- 1,221 services recorded
- The most frequent CRC services were:

Computer Use
554 services

Job Search Assistance
403 services

Computer Education
34 services

Percent of Guests Who 'Agree' or 'Strongly Agree' (n ~ 109)

CRC staff treat me with respect	98%
The CRC is helping me improve my computer skills	90%
The CRC is helping me find a job	86%
I utlize the job board at the CRC	82%
The CRC is helping me improve my education	82%

What is most helpful about the CRC's services? (n = 85 comments)

30%	25%	25%	20%
CRC Staff	Job Search Assistance	Accessibility of Services	Computer Skills

"The [CRC manager] is consistent and dedicated to seeing the guests grow. Very good listener and communicator. Impactful and helpful."

"The peaceful atmosphere to complete my job search."

[1] Guests completed the CRC Feedback survey anonymously. It is possible that the same guest answered the survey more than once. All surveys are included in the above results.

Outcomes for GWC Case Managed Guests

Changes in Cash Income

- From intake to exit, there was a significant increase* in the amount of monthly cash income for residential guests[1]
- The most common sources of income were Supplemental Sec. Income (SSI) and Veterans Disability
- 53% of guests with a permanent discharge destination had an increase in cash income

Average Monthly Income (n = 583)

Intake	$433
Exit	$768*

On average, income increased by
↑ $335
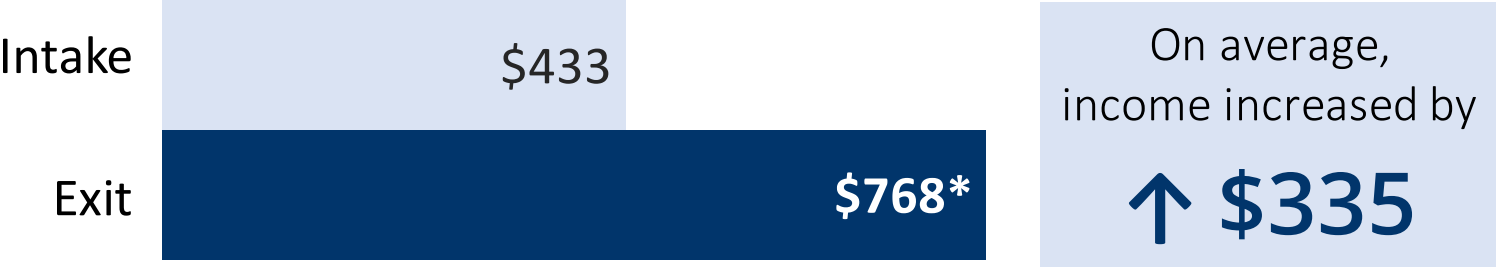
Guests with Earned Income (n =583)
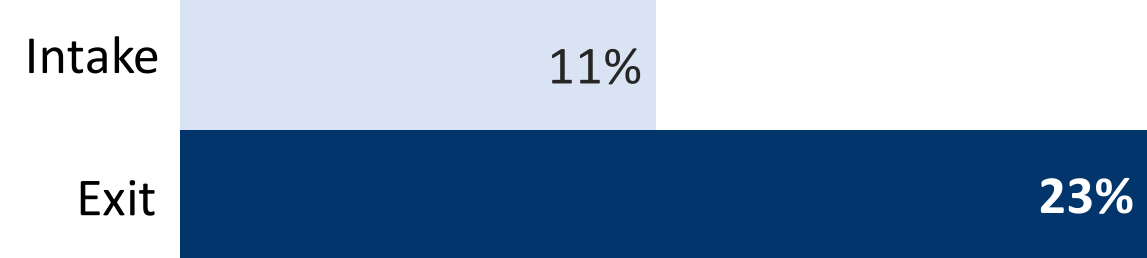
Intake	11%
Exit	23%

Change in Monthly Income from Intake to Exit (n = 583)

Increased Cash

> $1,001
- 14%
- 9%
- 34%

$501 - $1,000
- 6%
- 4%
- 3%

$101 - $500
- 5%
- 3%
- 8%

$1 - $100
- 3%
- 2%
- 4%

No Change or Decrease in Income
- 72%
- 82%
- 47%

■ All Guests (n=583)
▨ Not Permanent Destination (n=421)
■ Permanent Destiantion (n=162)
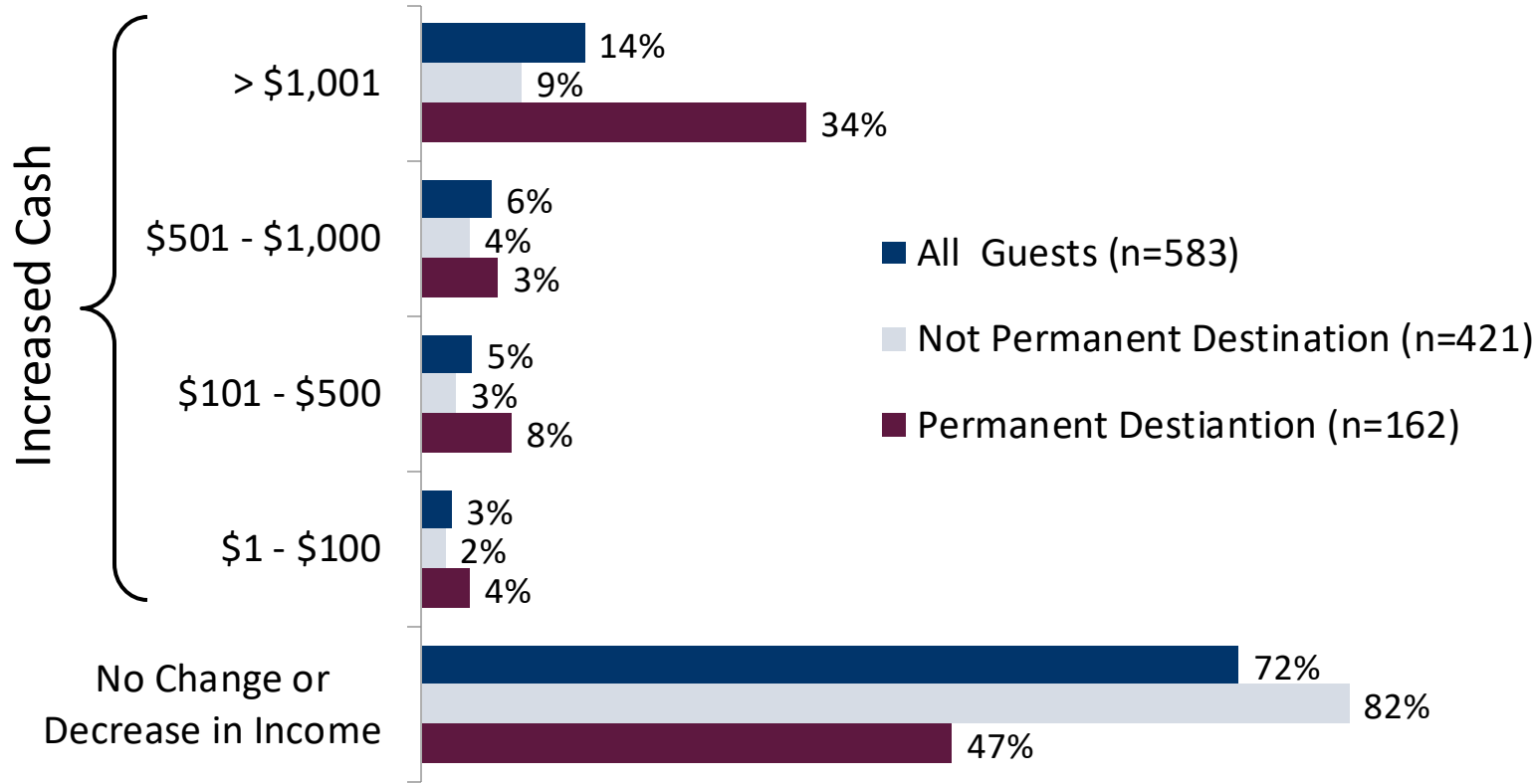
Cash Income Sources[1]	Intake	Exit
Supplemental Security Income (SSI)	13%	18%
Veterans Disability Payment	4%	7%
Earned Income	11%	23%
Social Security Disability Insurance (SSDI)	13%	15%
Retirement from Social Security	2%	3%

* Indicates a statistically significant change at p <.05.
[1] Only guests with data at intake and exit are included. For guests with more than one enrollment record, only data from the most recent enrollment is included.

Changes in Income & Savings

- From intake to exit, there was a significant increase* in the number of guests with cash income

- Guests with a permanent discharge destination were significantly more likely* to have savings at exit (as compared to all other discharge types)

Cash Income[1]

Intake   Exit

FY 2021 (n = 284)	FY 2022 (n = 198)	FY 2023 (n = 583)
47% → 60%*	52% → 61%*	40% → 56%*
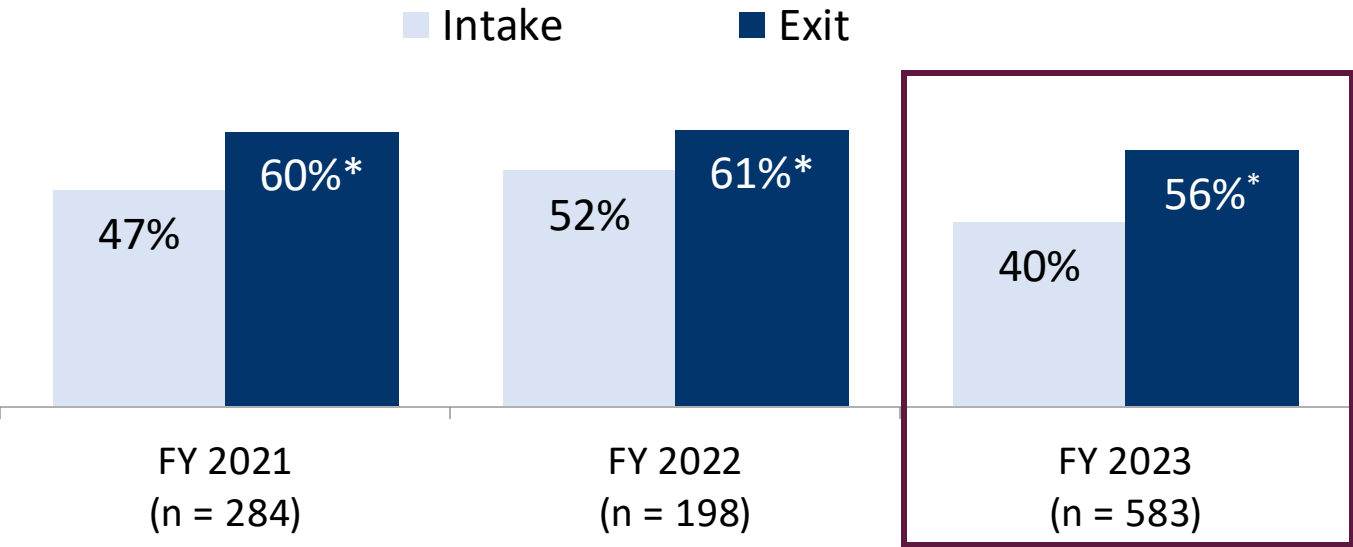
Savings at Exit

Among those with savings, the average amount was $2,210.
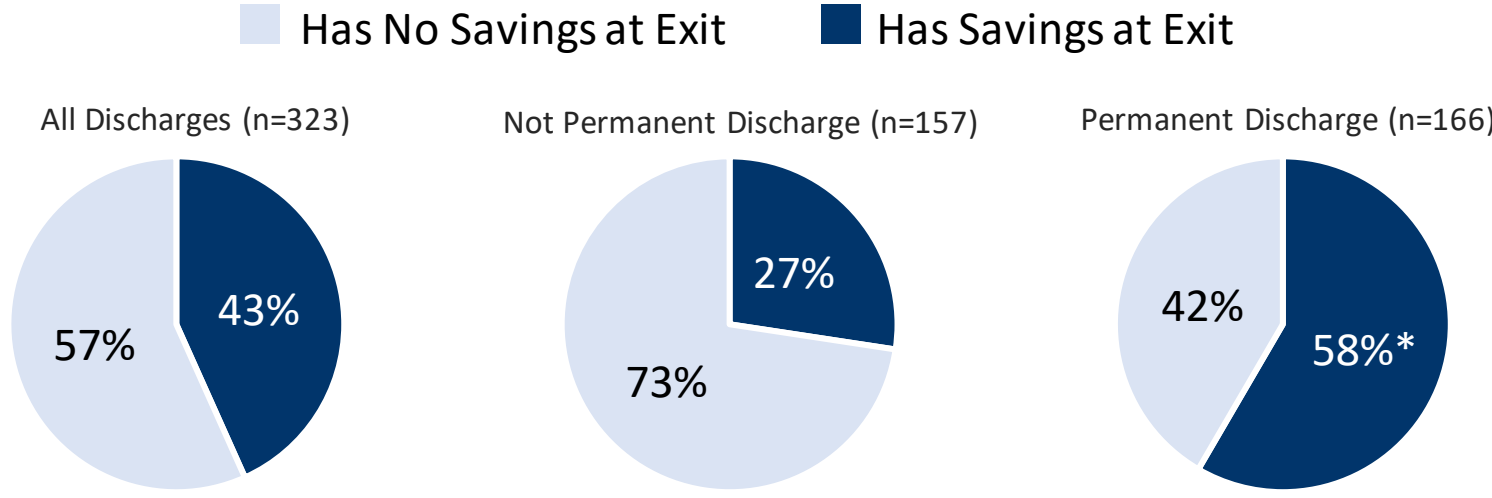
Has No Savings at Exit   Has Savings at Exit

All Discharges (n=323): 57% / 43%

Not Permanent Discharge (n=157): 73% / 27%

Permanent Discharge (n=166): 42% / 58%*

Cash Income by Program[1]

Intake   Exit

Program	Intake	Exit
New Beginnings (n=61)	48%	75%
RRH LIFT 1.0 & 2.0 (n=14)	50%	57%
Stabilization (n=16)	44%	56%
Upward (n=31)	39%	55%
Veteran Contract Beds (n=14)	57%	93%
Veterans Transitional Housing (n=34)	44%	77%
The Evolution Center (n=318)	38%	50%
Trinity women's Center (n=27)	33%	44%
Veterans Low Barrier Shelter (n=68)	41%	52%

Low Barrier Shelters (bracket for The Evolution Center, Trinity women's Center, Veterans Low Barrier Shelter)

* Indicates a statistically significant change at p <.05.
[1] Only guests with data at intake and exit are included. For guests with more than one enrollment record, only data from the most recent enrollment is included.
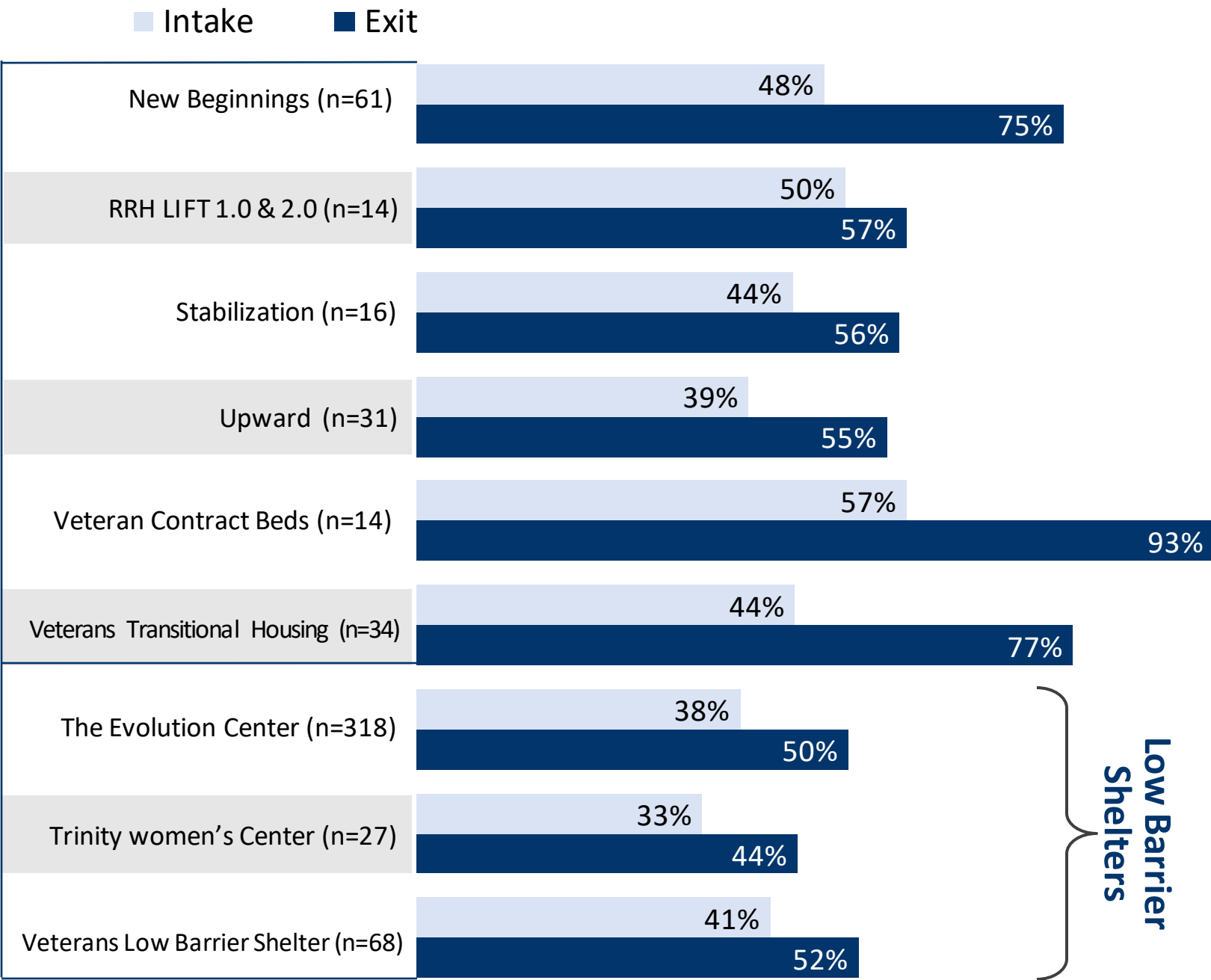
Changes in Employment & Identification

- From intake to exit, there was a significant increase* in the number of guests with employment and identification

Employment (n = 599)[1]

- **41%** of guests were unable to work
- Among guests who were able to work, **55%** were employed at exit

■ Intake   ■ Exit

23% → **55%***
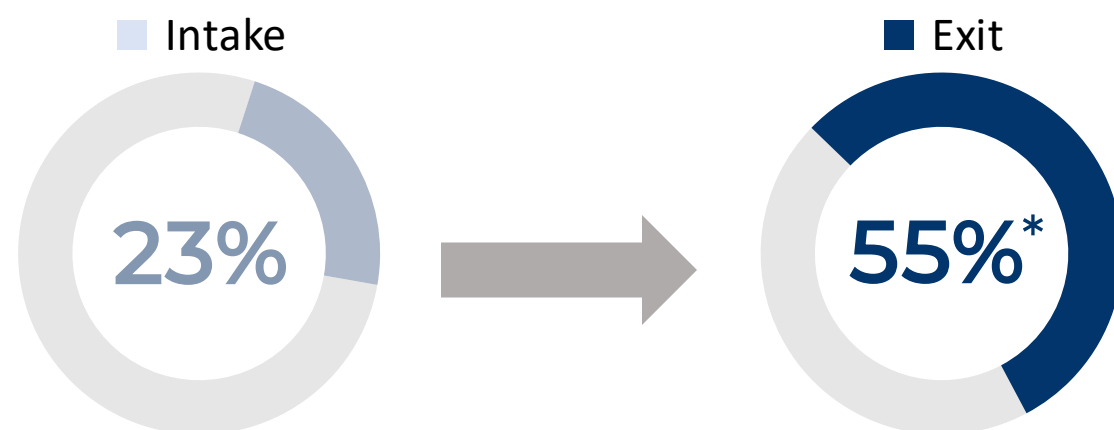
The average hourly rate of a guest's employment was $13.63 (Range: $7 – $28; n = 232).

Among those **employed** at exit, 7% obtained a job promotion (n = 13/193).

Among those able to work and unemployed at exit, 45% were actively looking for work (n = 70/155).

Types of Identification (n ~ 329)[1]

- On average, residential guests gained **1 additional form** of identification by exit
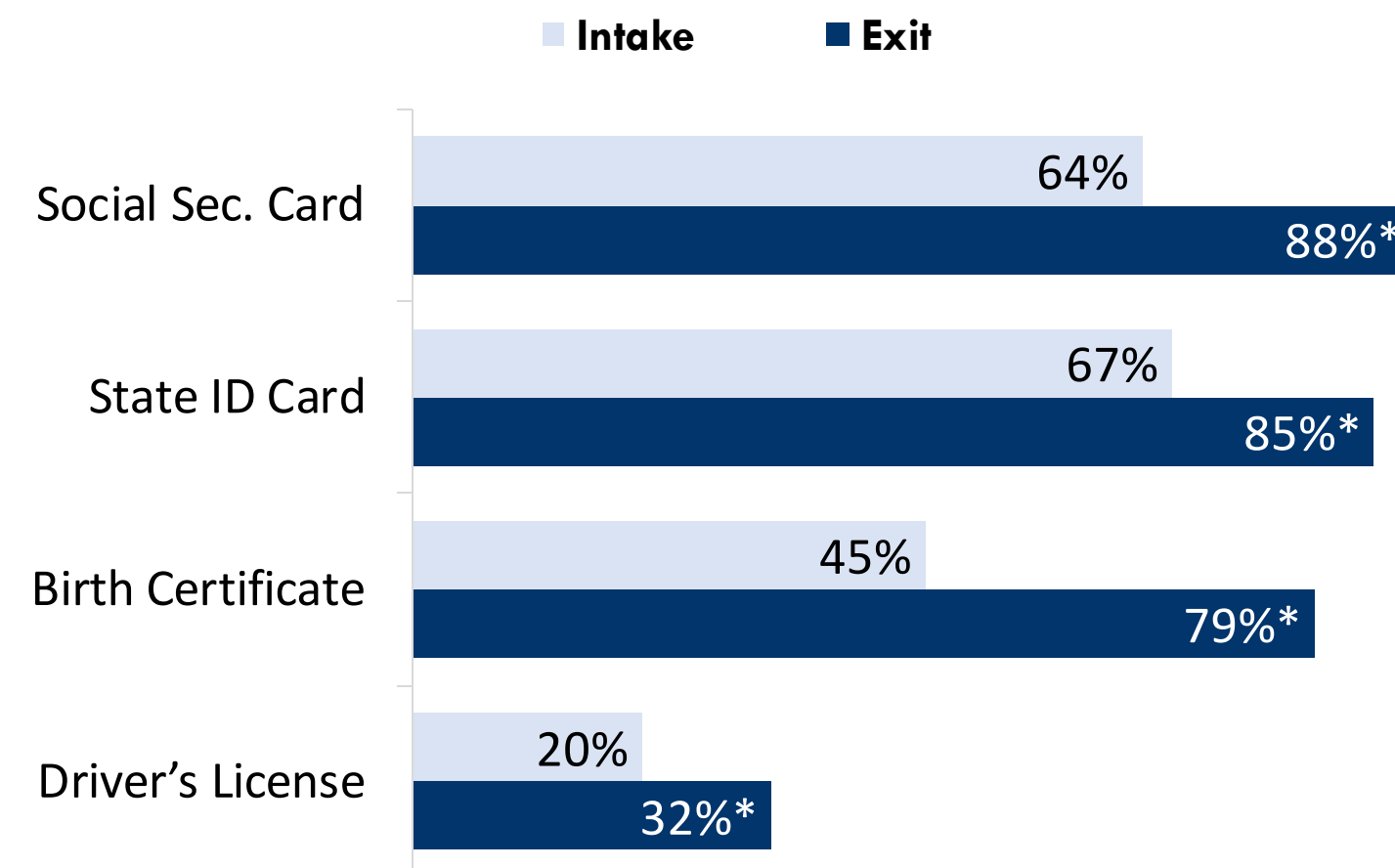
■ Intake   ■ Exit

Identification	Intake	Exit
Social Sec. Card	64%	88%*
State ID Card	67%	85%*
Birth Certificate	45%	79%*
Driver's License	20%	32%*

Discharge Summary

GWC's **Big Goal** is to achieve an annual average of **65%** of guests transitioning to a **positive housing placement** upon discharge by 2025.

Percent of Guests Discharged to Housing[1,2]

FY23	54%	n=381/701
FY22	48%	n=267/553
FY21	63%	n=274/436
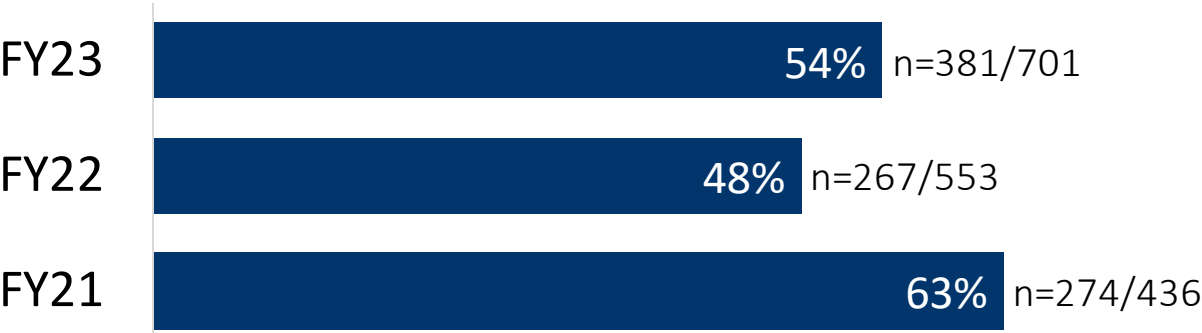
Photos of former GWC guests showing off keys to their new homes.

Discharge Reason[3,4]

■ Positive   ■ Neutral   ■ Negative

FY 21 (n=325): 70% Positive, 7% Neutral, 23% Negative

FY 22 (n=477): 62% Positive, 8% Neutral, 30% Negative

FY 23 (n=581): 64% Positive, 5% Neutral, 31% Negative
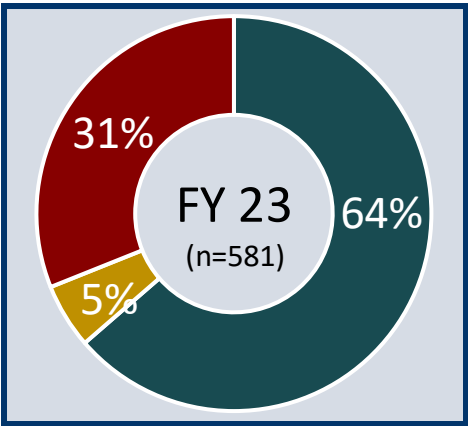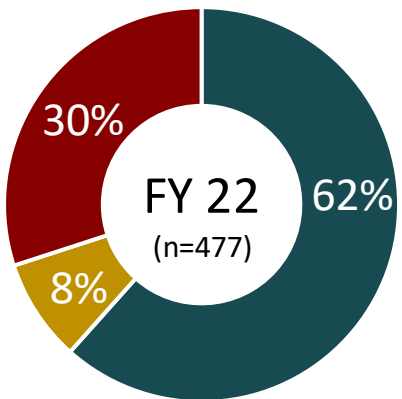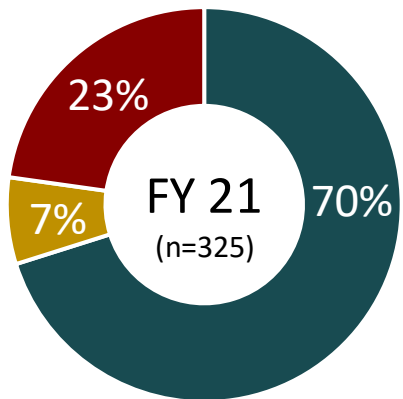
Discharge Destination[2,3]

■ Permanent   ■ Temporary   ■ Institutional   ■ Place not meant for habitation

FY 21 (n=294): 43% Permanent, 42% Temporary, 11% Institutional, 5% Place not meant for habitation

FY 22 (n=298): 35% Permanent, 46% Temporary, 12% Institutional, 8% Place not meant for habitation

FY 23 (n=396): 49% Permanent, 40% Temporary, 10% Institutional, 1% Place not meant for habitation

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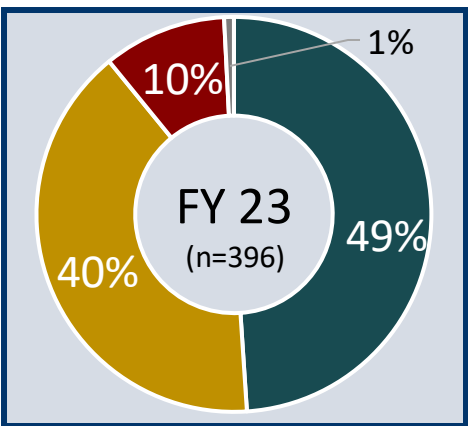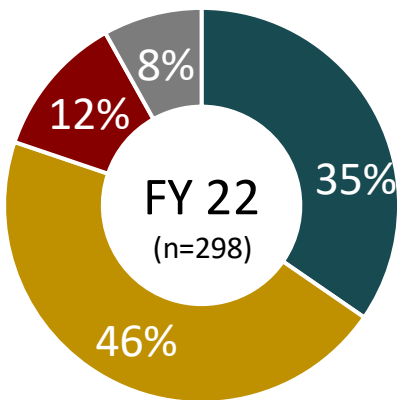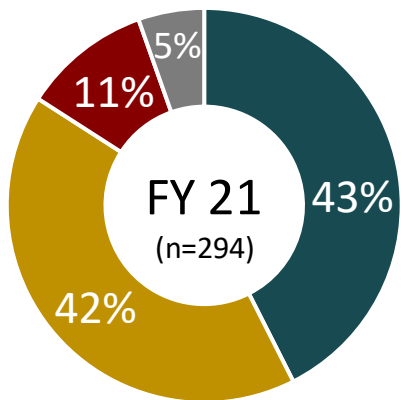
[1] Those discharged to housing includes anyone NOT discharged to a place not meant for habitation, jail, or unknown destinations

[2] For guests with multiple enrollments, only data from the most recent enrollment is included.

[3] Unknown discharge destinations and reasons were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other.

[4] Guests with multiple enrollments during the report period are included in the analysis more than once.

Discharge Reason

Discharge Reason[1] (n = 581)

Positive
- Completed program — 49%
- Housing opportunity (program not completed) — 15%

Neutral
- Needs could not be met by program — 4%
- Reached maximum time allowed in program — 1%

Negative
- Criminal activity/ property damage/ violence — 5%
- Disagreement with rules/persons — 4%
- Non-compliance with program — 22%
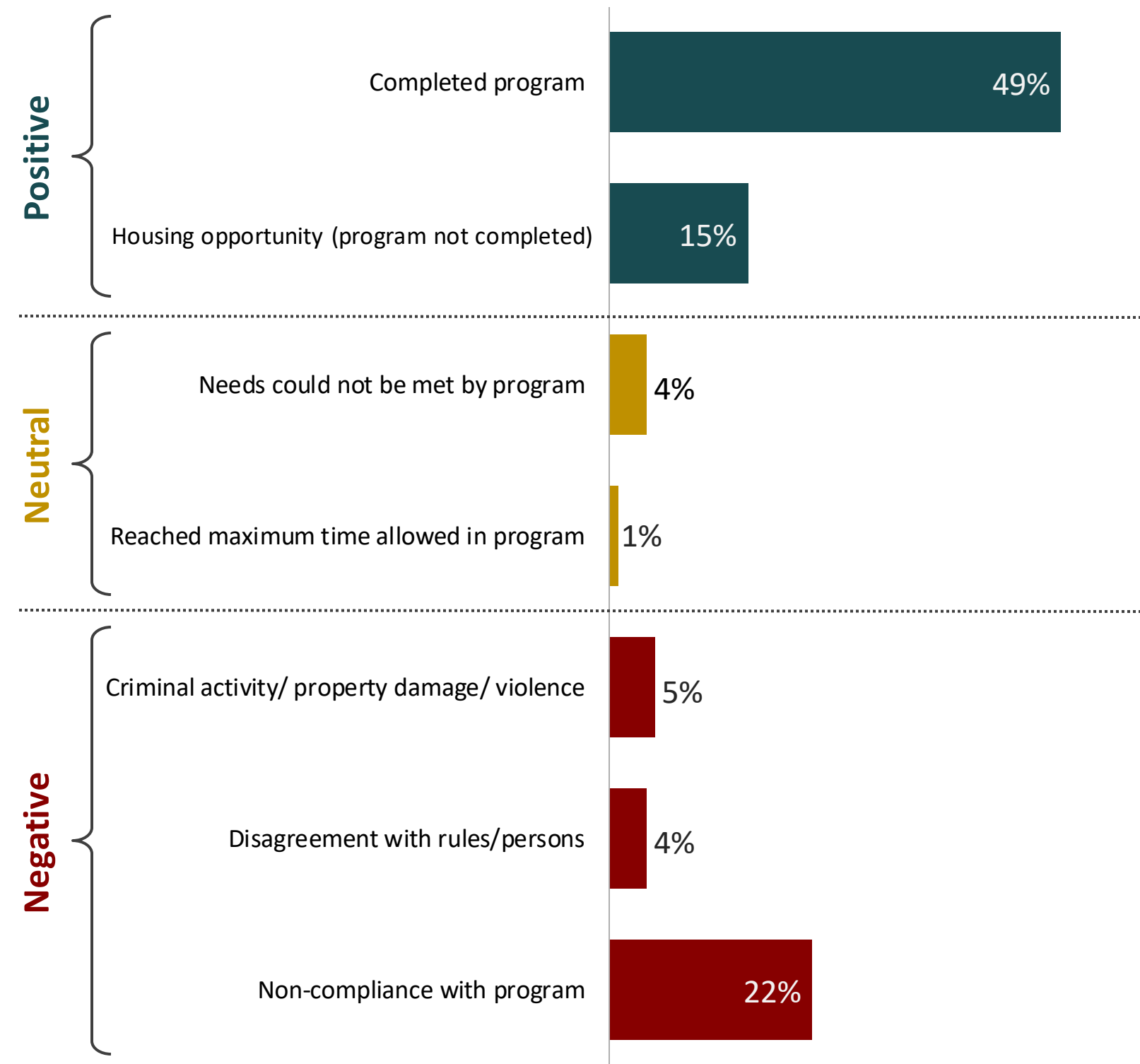
Positive Discharge Reasons by Program[1,2]

Legend: ■ FY23 ■ FY22 ■ FY21

New Beginnings (n=57; n=10; n=15)
- FY23: 56%
- FY22: 50%
- FY21: 100%

RRH LIFT 1.0 & 2.0 (n=11; n= 2)
- FY23: 91%
- FY22: 100%

Stabilization (n=20; n=20; n=19)
- FY23: 60%
- FY22: 60%
- FY21: 58%

Upward (n=32; n=28; n=35)
- FY23: 50%
- FY22: 43%
- FY21: 49%

Veterans Contract Beds (n=15; n =12; n=2)
- FY23: 67%
- FY22: 67%
- FY21: 50%

Veterans Transitional Housing (n=30; n=24; n=46)
- FY23: 73%
- FY22: 63%
- FY21: 83%

The Evolution Center (n=266; n=215; n=126) — Low Barrier Shelters
- FY23: 58%
- FY22: 41%
- FY21: 57%

Trinity Women's Center (n=55; n=28) — Low Barrier Shelters
- FY23: 60%
- FY22: 89%

Veterans Low Barrier Shelter (n=95; n=112; n=74) — Low Barrier Shelters
- FY23: 85%
- FY22: 96%
- FY21: 92%

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[1] Guests with multiple enrollments during the report period are included in the above analyses more than once. In FY23, 166 individuals discharged for an unknown reason. Unknown discharge reasons were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other.

[2] Under each program name, the first sample size (n=) provided is for FY23. The second sample size provided is for FY22. The third is for FY21.

Discharge Destination

Discharge Destination[1] (n = 396)

Permanent

Destination	Value
Rental by guest	25%
Staying with family permanently	13%
Staying with friends permanently	3%
Permanent housing (other than RRH) for formerly homeless persons	4%
Owned by guest	4%
Long-term care or nursing home	0.3%

Temporary

Destination	Value
Transitional housing	11%
Emergency shelter, hotel, or motel with E.S voucher	8%
Staying with family temporarily	9%
Staying with friends temporarily	8%
Hotel/motel without E.S. voucher	4%

Institutional

Destination	Value
Substance abuse treatment facility or detox center	3%
Hospital (non-psychiatric)	2%
Jail, prison, or juvenile detention facility	4%
Psychiatric hospital/facility	1%
Place not meant for habitation	1%

Permanent Discharge Destination by Program[1,2]

■ FY23   ■ FY22   ■ FY21

Program	FY23	FY22	FY21
New Beginnings (n=39; n=8; n=15)	74%	50%	60%
RRH LIFT 1.0 & 2.0 (n=10; n=11)	100%	91%	
Stabilization (n=16; n=15; n=18)	50%	60%	56%
Upward (n=25; n=18; n=32)	68%	56%	47%
Veteran Contract Beds (n=12; n=9)	83%	33%	
Veterans Transitional Housing (n=28; n=18; n=44)	71%	44%	73%
The Evolution Center (n=154; n=103; n=101)	45%	43%	51%
Trinity Women's Center (n=56; n=28)	50%	32%	
Veterans Low Barrier Shelter (n=56; n=75; n=79)	5%	3%	7%

The last three programs (The Evolution Center, Trinity Women's Center, Veterans Low Barrier Shelter) are grouped under "Low Barrier Shelters".

[1] For guests with multiple enrollments, only data from the most recent enrollment is included. In FY23, 303 individuals discharged to an unknown destination. Unknown discharge destinations were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other.
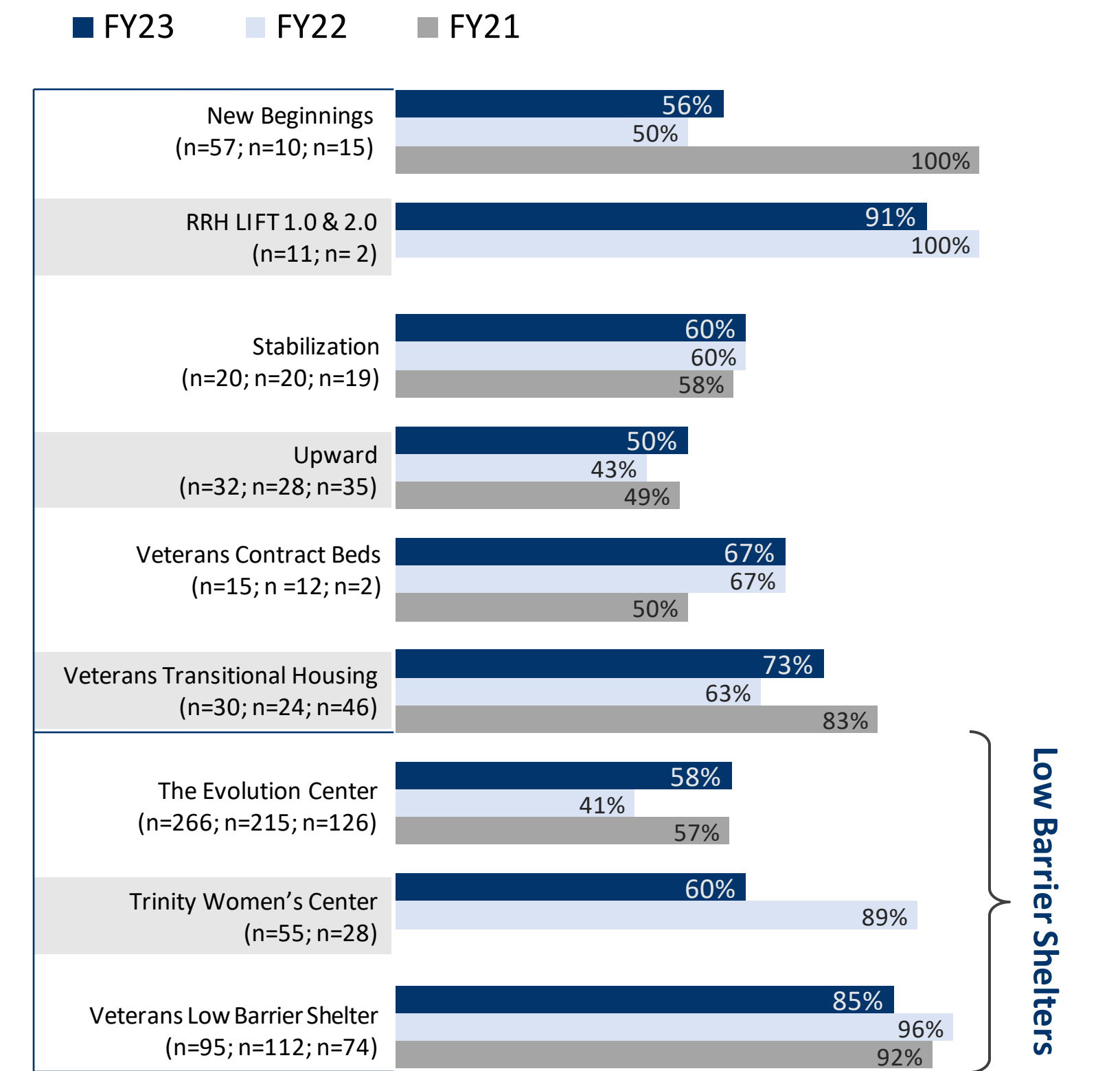[2] Under each program name, the first sample size (n=) provided is for FY23. The second sample size provided is for FY22. The third is for FY21.

Behavioral Health Assessments

- Residential guests complete a behavioral health assessment at intake, during program enrollment, and at exit[1]
- Among guests who engaged with a BHS, improvements in depression, anxiety, PTSD, and wellness from pre-test to post-test were statistically significant*
- 95% of guests improved on at least 1 of the 6 assessments

Assessment Name[2] (possible range of scores)	Average Score at **Pre-Test**	Average Score at **Post-Test**	Percent of Guests with **Improved Scores**[3] (n~92)
For the assessments below, **lower** scores are better.			
Depression (PHQ-9) (0 to 27)	6.6	4.7*	70%
Anxiety (GAD-7) (0 to 21)	6.7	3.9*	86%
PTSD (PCL-5) (0 to 80)	1.9	1.1*	70%
For the assessments below, **higher** scores are better.			
Wellness (PWI) (5 to 30)	16.7	20.6*	71%
Coping Skills (BRCS) (4 to 20)	14.1	14.8	54%
Resilience (BRS) (1 to 5)	3.2	3.3	47%

Mental Health & Coping Skills

- Guests who were enrolled for at least 14 days and engaged with a BHS were asked at exit about changes in their mental health and coping skills
- Approximately 57% of guests reported improvements

Legend: Much worse or somewhat worse | Stayed about the same | Improved or somewhat improved

Mental Health (n=84)

Much worse or somewhat worse	Stayed about the same	Improved or somewhat improved
5%	38%	57%

Coping Skills (n=84)

Much worse or somewhat worse	Stayed about the same	Improved or somewhat improved
7%	36%	57%

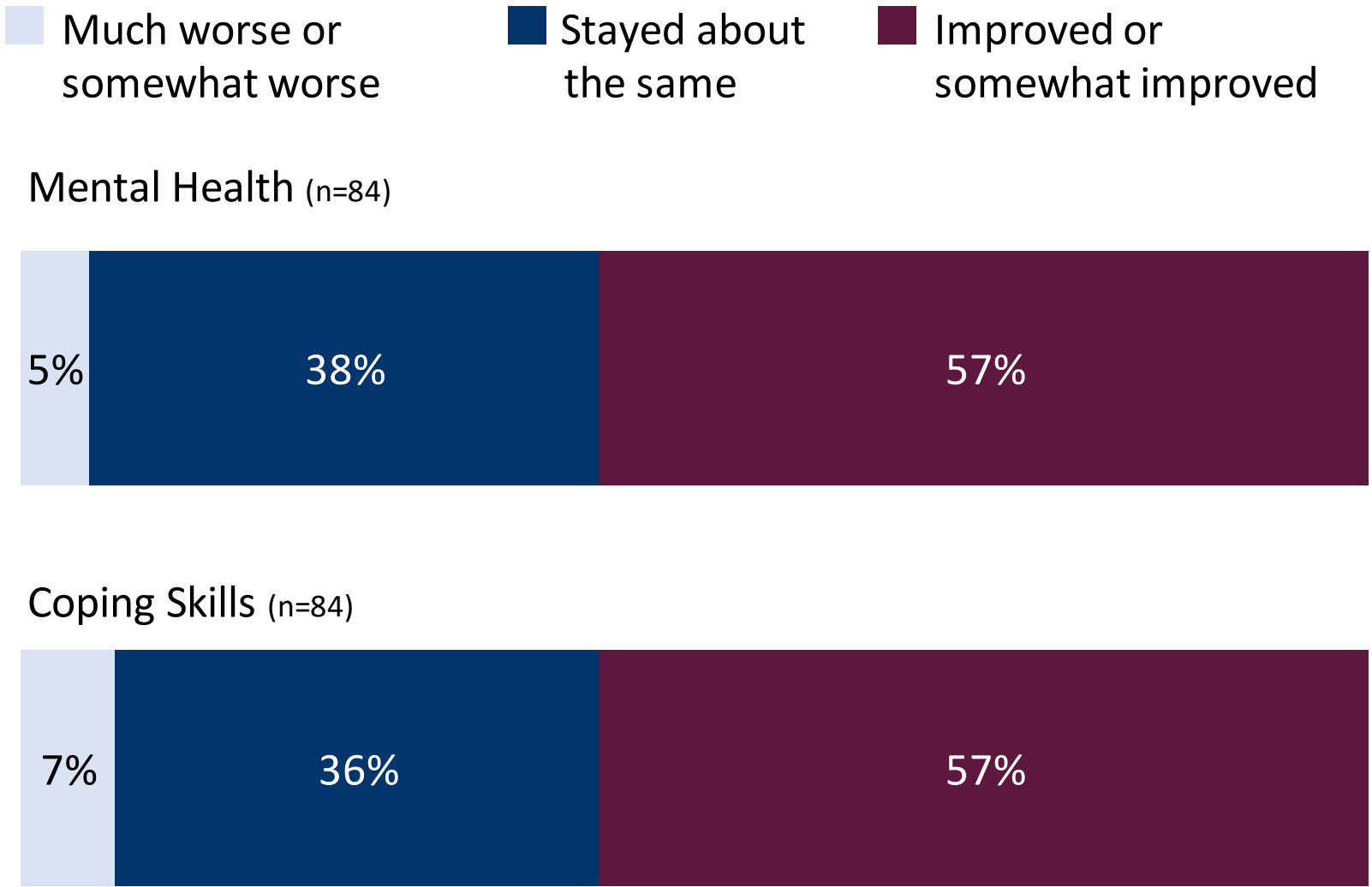* Indicates a statistically significant change at p <.05.

[1] Guests may be assessed for a post-test in as little as 30 days after enrollment, even while they are still enrolled at GWC, to assess their change over time.

[2] Only guests with a pre-test and post-test are included. The link to view each scale is provided in parentheses.

[3] These percentages also include those whose scores remained at the best possible score from pre-test to post-test. The best possible score for the Depression, Anxiety, and PTSD scales is 0. The best possible scores for the Wellness, Coping Skills, and Resilience scales are 30, 20, and 5, respectively.
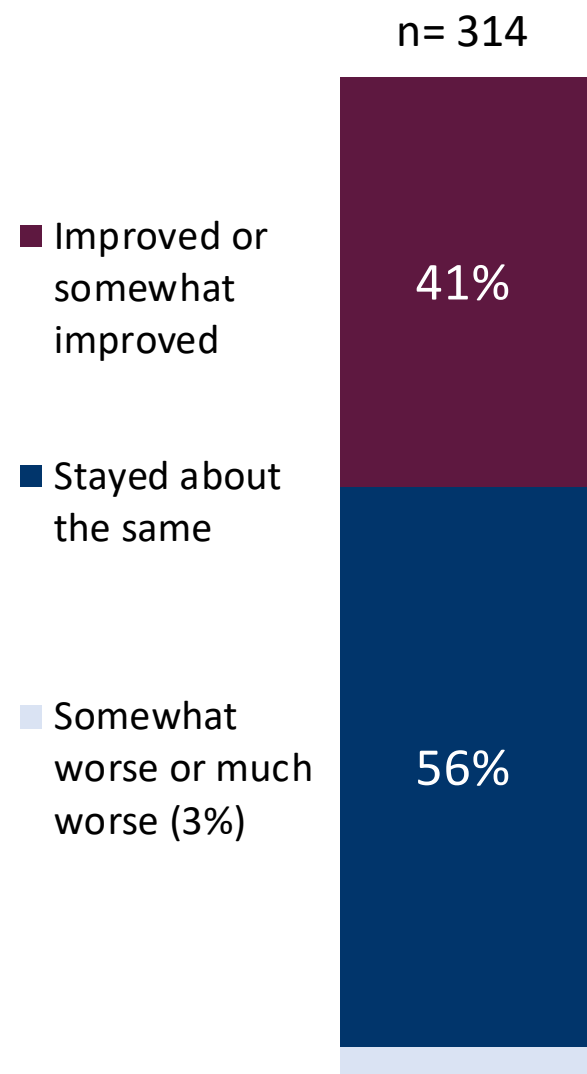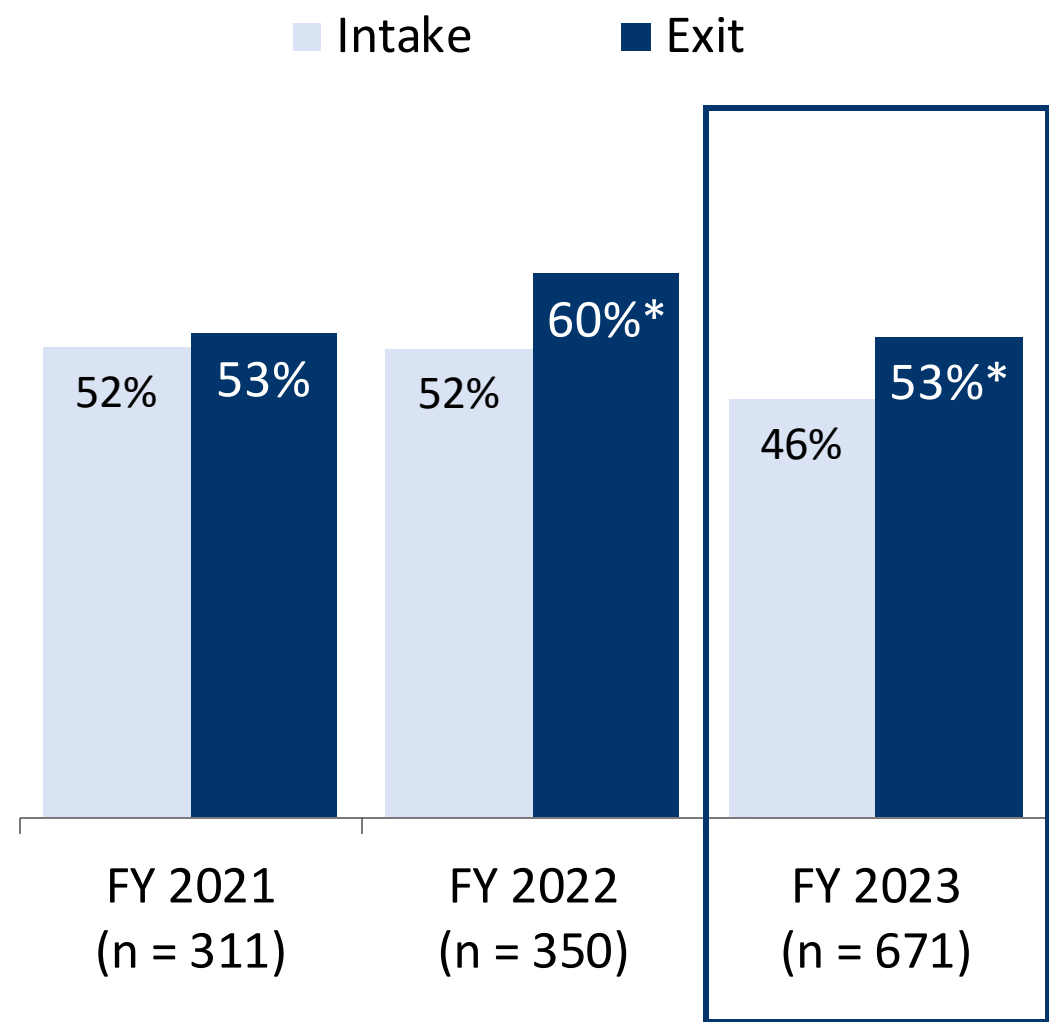
Changes in Health & Health Insurance

- Guests who were enrolled for at least 14 days were asked at exit about changes in their physical health.
- **41%** reported improvements.
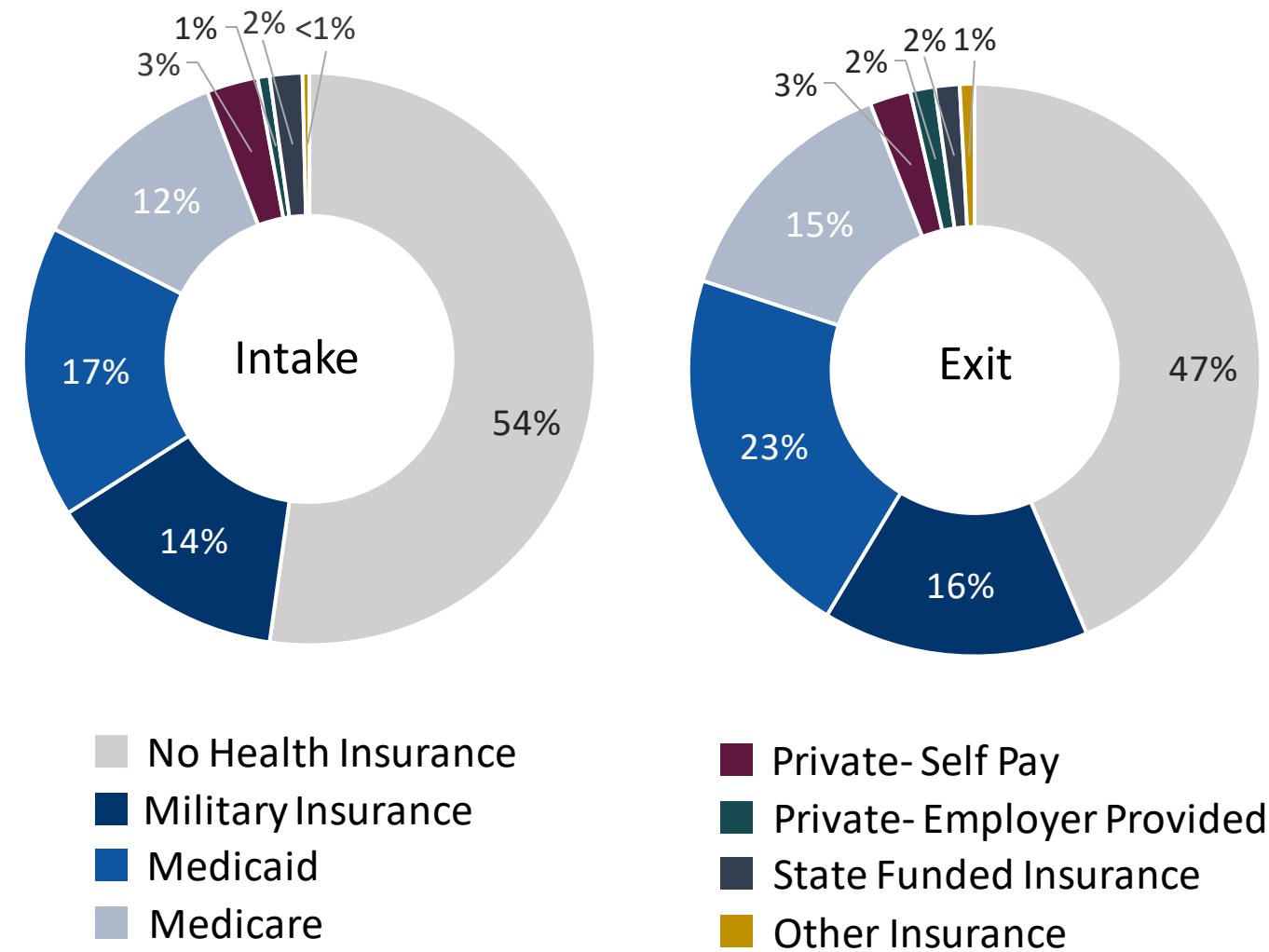- From intake to exit, there was a significant increase* in the number of residential guests with health insurance.

Changes in Physical Health

n= 314

- Improved or somewhat improved — **41%**
- Stayed about the same — **56%**
- Somewhat worse or much worse (3%)

Percentage with Health Insurance[1]

Legend: Intake, Exit

- FY 2021 (n = 311): Intake 52%, Exit 53%
- FY 2022 (n = 350): Intake 52%, Exit 60%*
- FY 2023 (n = 671): Intake 46%, Exit 53%*

Sources of Health Insurance[1,2] (n = 671)

Intake:
- No Health Insurance 54%
- Medicaid 17%
- Military Insurance 14%
- Medicare 12%
- Private- Self Pay 3%
- Private- Employer Provided 1%
- State Funded Insurance 2%
- Other Insurance <1%

Exit:
- No Health Insurance 47%
- Medicaid 23%
- Military Insurance 16%
- Medicare 15%
- Private- Self Pay 3%
- Private- Employer Provided 2%
- State Funded Insurance 2%
- Other Insurance 1%

Legend:
- No Health Insurance
- Military Insurance
- Medicaid
- Medicare
- Private- Self Pay
- Private- Employer Provided
- State Funded Insurance
- Other Insurance

---

* Indicates a statistically significant change at $p < .05$.
[1] Only guests with data at intake and exit are included. For guests with more than one enrollment record, only data from the most recent enrollment is included.
[2] Guests may have had more than one insurance type; therefore, the total may add to more than 100%.

Feedback & Community Engagement
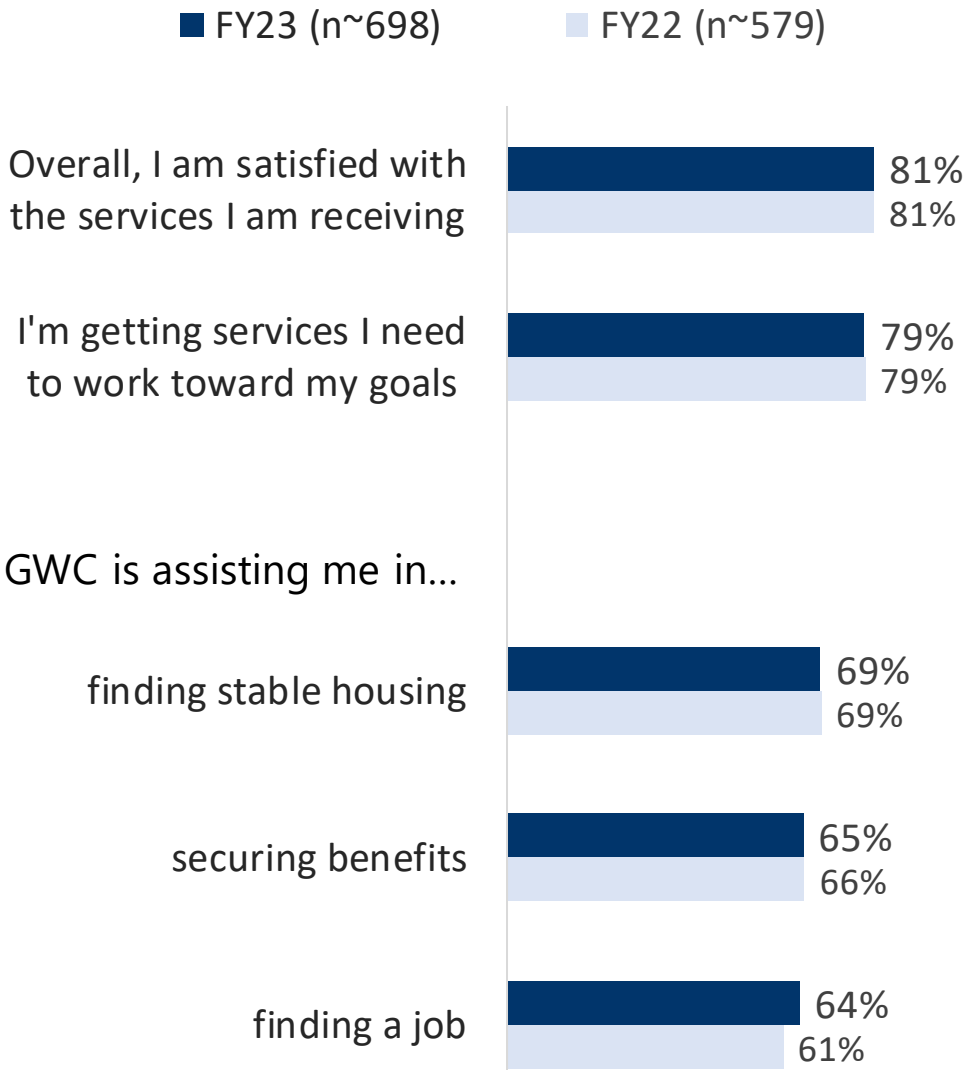
Guest Feedback

773
Total Guest
Surveys Completed[1]

82%
Would Recommend
GWC to Others

4.1
Average Cumulative Survey Score[2]
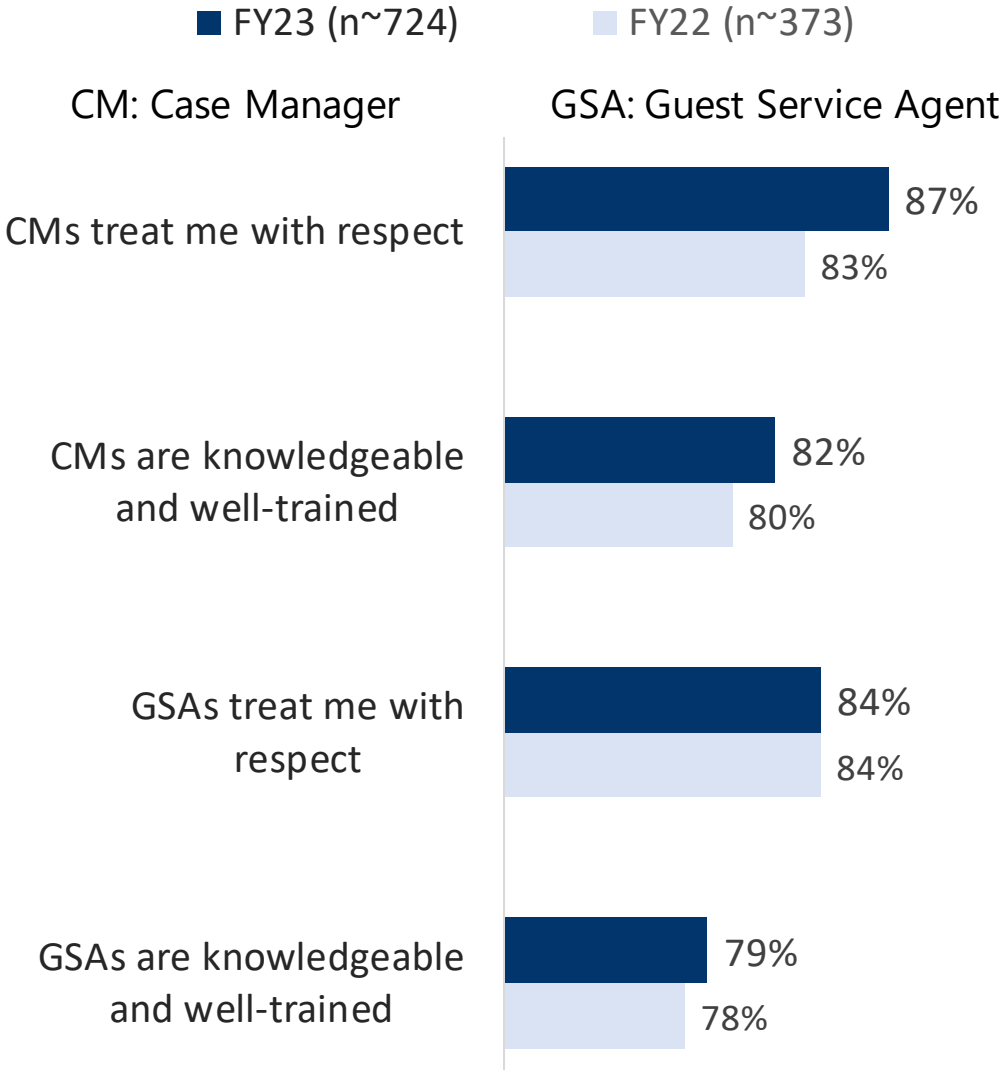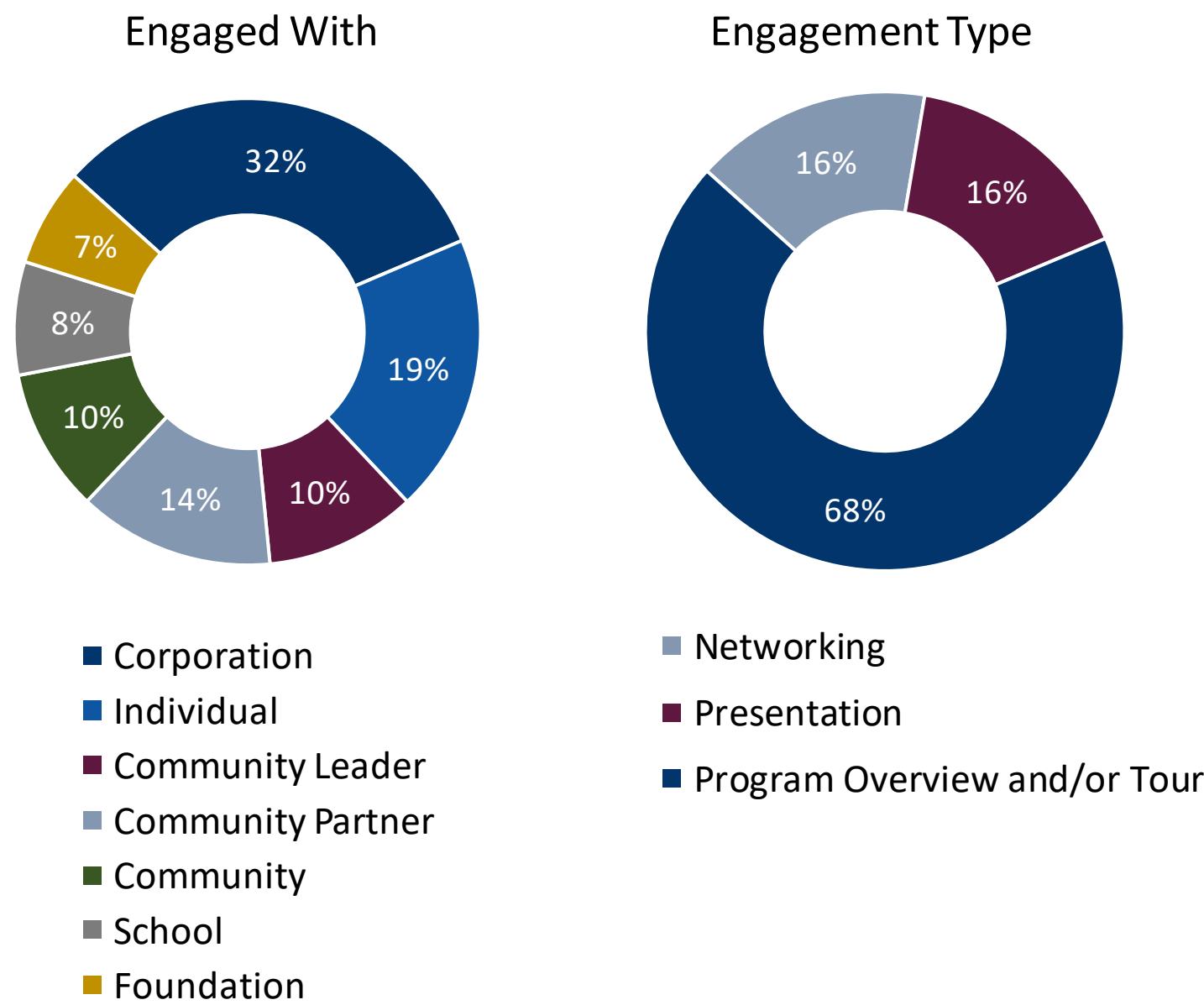(Indicates Agreement With Most Statements)

GWC Services

■ FY23 (n~698) ■ FY22 (n~579)

Overall, I am satisfied with the services I am receiving
- 81%
- 81%

I'm getting services I need to work toward my goals
- 79%
- 79%

GWC is assisting me in...

finding stable housing
- 69%
- 69%

securing benefits
- 65%
- 66%

finding a job
- 64%
- 61%

Outcomes

■ FY23 (n~693) ■ FY22 (n~581)

As a result of GWC services...

I am making good decisions about drug/alcohol use
- 88%
- 81%

I am better at handling daily life
- 82%
- 79%

I am better able to cope when things go wrong
- 79%
- 77%

I get along better with others
- 75%
- 71%

I am reconnecting to my network of family/friends
- 68%
- 68%

Staff[3]

■ FY23 (n~724) ■ FY22 (n~373)

CM: Case Manager   GSA: Guest Service Agent

CMs treat me with respect
- 87%
- 83%

CMs are knowledgeable and well-trained
- 82%
- 80%

GSAs treat me with respect
- 84%
- 84%

GSAs are knowledgeable and well-trained
- 79%
- 78%

Community Engagements

Gateway Center staff led **193** community engagements and interacted with **3,297** individuals through those engagements.

Engaged With

- 32%
- 19%
- 10%
- 14%
- 10%
- 8%
- 7%

■ Corporation
■ Individual
■ Community Leader
■ Community Partner
■ Community
■ School
■ Foundation

Engagement Type

- 16%
- 16%
- 68%

■ Networking
■ Presentation
■ Program Overview and/or Tour

Forever 404 Honoree
PRESENTED BY ❤ sharecare

An additional 16,000 individuals were engaged at the State Farm Arena when Gateway Center's CEO Raphael Holloway was named as a Forever 404 honoree. Raphael was also recognized by Atlanta Magazine in the 2023 Atlanta Magazine 500 Most Powerful Leaders.

Program Descriptions

Non-Residential Programs & Services

Coordinated Entry

Provides a coordinated access point to the City of Atlanta and Fulton County's Continuum of Care, which connects men, women, and families with the most appropriate housing resources to assist them in ending their homelessness. Coordinated entry provides individuals and families experiencing homelessness with housing assessments (VI-SPDAT), emergency shelter placements, housing navigation services, and linkage to long-term housing placements available through the Housing Queue.

Engagement Center

Serves as a resource center during the day and an emergency response center under special circumstances. While permanent housing is the end-goal for individuals experiencing homelessness, basic human services are critical in building relationships while meeting immediate needs. These services and resources include access to restrooms, showers, telephones, cell phone charging stations, clothing, laundry, hygiene supplies, healthcare (physical and behavioral) services, and referral services (i.e., Diversion, ID/Birth Certificate Assistance, and Employment Resources).

Behavioral Health Services

Provides onsite counseling services, both individual and group sessions, to assist guests in processing their trauma, increasing coping skills, and improving personal relationships. The individual therapy and psycho-educational groups address the impact Mental Illness and Substance Use Disorders have had on guests' ability to maintain stable employment and housing, adherence to healthcare, and maintain interpersonal relationships. Guests learn effective management of their mental health; gain coping skills to manage triggers; and ultimately become better equipped to be self-sufficient.

Career Resource Center

Provides essential tools and trainings to bridge the digital divide and improve financial and adult literacy while focusing on career coaching and employer linkages to help guests secure sustainable employment.

Non-Residential Programs & Services

Cold Weather Transport

Provides individuals with transportation to shelter at a partnering agency on nights when the temperature drops below 40 degrees.

Outreach

Works to build trusting relationships by meeting individuals where they are typically sleeping in unsheltered areas throughout Atlanta and Fulton county. The goal is to transition unsheltered individuals to short-term housing (shelter) or permanent housing options.

Navigation

Guests are provided case management services to assist them in obtaining the documents necessary to secure permanent housing. Case Managers also provide guests with referrals for behavioral health/substance abuse support, primary medical services, food stamps, employment, and emergency shelter placements as needed.

Prevention

A strategy to prevent households from becoming homeless using problem solving techniques to mediate, reunify with family, or connect to services and financial assistance to quickly and efficiently assist with maintaining their current housing.

Diversion

Provides services to an individual or family who is imminently homeless before they spend a night in a shelter or in a place not meant for habitation.

Rapid Exit

Individuals who cannot be diverted enter the homeless shelter system but are exited to a more permanent housing solution within 90 days. Safe alternative options for rapid exit include:

- A negotiated return to their previous housing
- Short-term, non-shelter accommodations
- Shared housing
- Family reunification

GWC Case Managed Residential Programs

New Beginnings

Provides beds for men needing housing and employment case management as they re-enter the workforce. This program addresses systemic factors that may have contributed to guests experiencing homelessness, including educational, legal, and critical life needs.

Rapid Re-Housing (RRH) LIFT 1.0 & 2.0

In December 2020, Gateway Center initiated our Rapid Re-Housing outreach and case management program. Case Managers assist guests in finding and maintaining housing for up to 24 months. Project Community Connections Inc. provides the rental subsidy during this time period.

Stabilization

Provides beds for chronically homeless men. Guests are screened for this program using the Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT). Most men enter the program with no identification. Case Managers work closely with guests to obtain identification and complete disability paperwork. Guests are connected to resources assisting with substance abuse, mental health, and physical health needs.

The Evolution Center (TEC)

Provides low barrier short-term residential housing (shelter) for men experiencing homelessness. TEC addresses the needs of Atlanta's chronically homeless men who need a low barrier shelter option. TEC is designed to provide rapid access to safe shelter 24 hours per day, 7 days per week. Shelter beds are provided to individuals who need it most, prioritizing those who have the highest needs.

GWC Case Managed Residential Programs

Trinity Women's Shelter (TWC)

Provides low barrier short-term residential housing (shelter) for women and children experiencing homelessness. TWC provides wraparound supportive services that include care coordination, intensive case management, employment services, behavioral health and substance abuse support, and housing navigation services. The ultimate goal for the households enrolled in this program is to move into a home they will maintain, breaking the cycle of poverty and homelessness for their families.

Upward

Provides a residential addiction recovery program designed to support men in obtaining and maintaining their sobriety. Guests develop a plan for implementing and sustaining substance abuse recovery and are connected to employment resources and stable housing. Through intensive case management and the utilization of a pre-treatment curriculum, guests remain clean and sober.

Veteran Contract Beds (VACB)

Provides short-term beds to veterans referred to Gateway Center by the Veterans Affairs Office located at Fort McPherson. This program is a collaborative project funded by the U.S. Department of Veterans Affairs. Veterans are provided case management and connected to available services, including medical, mental health, substance abuse support, income benefits, employment opportunities, and housing assistance.

Veterans Low Barrier Shelter

Provides short-term beds to veterans referred by the Veterans Affairs Office located at Fort McPherson. Eligible veterans transition to longer-term residential programs, rapid re-housing, or permanent supportive housing based on needs.

Veterans Transitional Housing (VAGPD)

Provides beds for a maximum of 2 years. This program is a collaborative project funded by the U.S. Department of Veterans Affairs. Guests must be referred by Atlanta's Homeless Veterans Program to be enrolled in this program. Veterans are provided case management and connected to available services, including medical, mental health, substance abuse support, income benefits, employment opportunities, and housing assistance.

Partner Case Managed Residential Programs

ADID – Project ASSIST

Provides case management to men referred from ADID's (Atlanta Downtown Improvement District) outreach team. Because most men enter the program with no identification, Case Managers work closely with guests to obtain identification and complete disability paperwork. Guests are connected to resources assisting with substance abuse, mental and physical health needs.

Hospital 2 Home

Provides temporary housing to men experiencing homelessness who frequently visit the emergency room and have presented in emergency rooms at Emory, Northside, or Grady Memorial Hospital. These guests are provided case management and are assessed to determine service needs.

Recuperative Care by Mercy Care

Provides short-term housing for up to 30 days to men experiencing homelessness who have been hospitalized, are ready for discharge, can function independently, but have no home for required recuperation. This program is intended to serve Grady Memorial, Saint Joseph's, and Piedmont Hospitals. By preventing unnecessary extended hospital stays, healthcare expenses that often burden communities are minimized.

Outreach/PATH Teams

The two programs below are combined throughout the report.

HOPE Atlanta Outreach

Assists men experiencing homelessness by engaging them where they are (e.g., the Atlanta Airport or MARTA train stations) and providing access to treatments for mental health, physical health, and/or substance abuse issues. When guests are engaged by the outreach team, they are offered beds at Gateway Center. HOPE Atlanta Case Managers work to connect individuals to needed resources.

Mercy Care PATH

Serves men experiencing homelessness who have severe and persistent mental illnesses. Short-term beds for guests are made available for up to 60 days by Mercy Care PATH (Projects for Assistance in Transition from Homelessness) team. Case Managers ensure individuals are connected to mental health services and resources. Guests and Case Managers work together to create housing plan goals that include, but are not limited to, mental health, medical care, income, employment, and stable housing.

Emergency Shelter Programs

Cold Weather Shelter

Provides shelter to individuals on nights when the temperature drops below 40 degrees.

Family Shelter

Provides emergency shelter for families in limited situations as they await placement in a short-term residential program offered by local family shelter providers.

Hotel- Emergency Shelter Lodging

Provides hotel stays to individuals and families experiencing homelessness in Fulton County. This program began in April 2021.

Hotel- Isolation/Quarantine

Provides temporary shelter at a hotel for individuals experiencing homelessness who have tested positive for COVID-19, have been exposed to someone who has COVID-19, or have tested positive or been exposed to highly contagious diseases. Length of stay at the hotel follows CDC guidelines for quarantine. This program began in April 2020, and it sunset in June of 2023.

Encampment Hotel

An initiative for guests enrolled in Street Outreach to access a hotel for temporary shelter as they work with Case Managers to obtain documents necessary to secure permanent housing. Case Managers assist guests with completing rental applications, providing Rapid Re-Housing financial assistance, and ensuring successful transitions to stable housing.

Other Partner Programs

Mercy Care Clinic @ Gateway Center

Uses an integrated health care model and provides onsite medical services (i.e., physical health, behavioral health, dermatology, and dental) to those experiencing homelessness.

GWC FY23 Evaluation Report