ANNUAL EVALUATION REPORT

JULY 1, 2024 – JUNE 30, 2025

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

CONTENTS

About Gateway Center

HISTORY

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 for individuals and families experiencing homelessness.

SERVICE APPROACH

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 actively participate in our service delivery model, which increases the likelihood of achieving self-sufficiency, obtaining sustainable employment (for those who can return to the workforce), and securing stable permanent housing. Our emphasis on providing services rooted in justice, equity, inclusion, and collaboration allows us to provide holistic, supportive services that effectively assist individuals and families experiencing homelessness in transitioning to stable housing.

COMMITMENT

GWC is committed to eliminating barriers, improving equitable outcomes, and creating opportunities in underserved and under-resourced communities by supporting individuals and families experiencing homelessness on their journey to safe and stable housing. Our ultimate goal is to provide multiple pathways that allow individuals and families to obtain stable housing, breaking the poverty cycle for those we serve, while improving health outcomes.

MISSION

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

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.**

BIG GOAL

ACHIEVED

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

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 analysis for that section and reflects the number of individuals for whom there was data for a given measure. Sample sizes vary due to missing or incomplete data (i.e., the guest did not provide the data). The symbol ~ is used when there is a 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, starting on page 39.

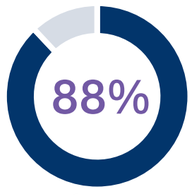
This report was written and designed by research and evaluation consultants, Michelle Ediger, Ph.D. and Christyl Wilson Ebba, Ph.D. in collaboration with GWC staff.

Executive Summary

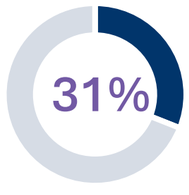
From July 1, 2024 through June 30, 2025 (FY25), Gateway Center (GWC) served 4,336 guests:

- **84%** of guests were previously living in the City of Atlanta
- **89%** of guests were from Fulton County; **4%** were from DeKalb County
- Based on VI-SPDAT scores, Permanent Supportive Housing or Housing First was the recommended housing solution for **46%** of Coordinated Entry guests
- **898** individuals were served in a case managed residential program
- On average, GWC case managed programs operated at **91%** of maximum residential capacity, and the average length of stay was **6 months**

Among Case Managed Residential Guests



African American

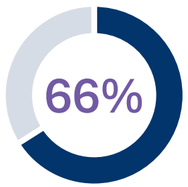


51 Years or Older

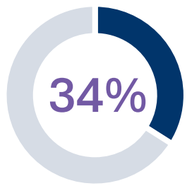
Completed a High School Diploma or Less

Veterans

Chronically Homeless



Disabling Condition

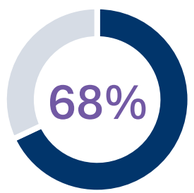


Substance Abuse-Related Special Need

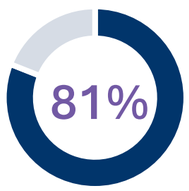
Mild to Severe Depression

Mild to Severe Anxiety

Symptoms of PTSD

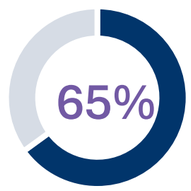


Criminal Background



Unemployed at Intake

No Cash Income at Intake



Stayed at Place Not Meant for Habitation Night Prior

Temporary Assistance Needed to Obtain or 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 (45% → **57%**)
- Health insurance (42% → **49%**)
- Employment[1] (19% → **37%**)

Wellness

- **77%** of guests had improvement in **depression symptoms**
- **73%** of guests had improvement in **anxiety symptoms**
- **70%** of guests had improvement in **PTSD symptoms**
- **68%** of guests had improvement in their **overall wellness**

Discharge

- **65%** were discharged to **housing**
- **63%** were discharged to **permanent** destinations
- **24%** were discharged to **temporary** destinations
- **60%** of guests were discharged for **positive** reasons
- **25%** of guests were discharged for **negative** reasons

[1]28% of guests reported being unable to return to the workforce. Percentages reported are among guests able to work.

Feedback & Community Engagement

Guest Feedback

- **82%** of guests would recommend GWC to others
- **79%** of guests reported being satisfied with services received

Volunteer Feedback

- **1,631** volunteers worked 21,286 hours supporting GWC
- **100%** of volunteers rated their experience as 'Excellent' or 'Good'
- **95%** reported that volunteering at GWC helped them have a greater understanding of homelessness

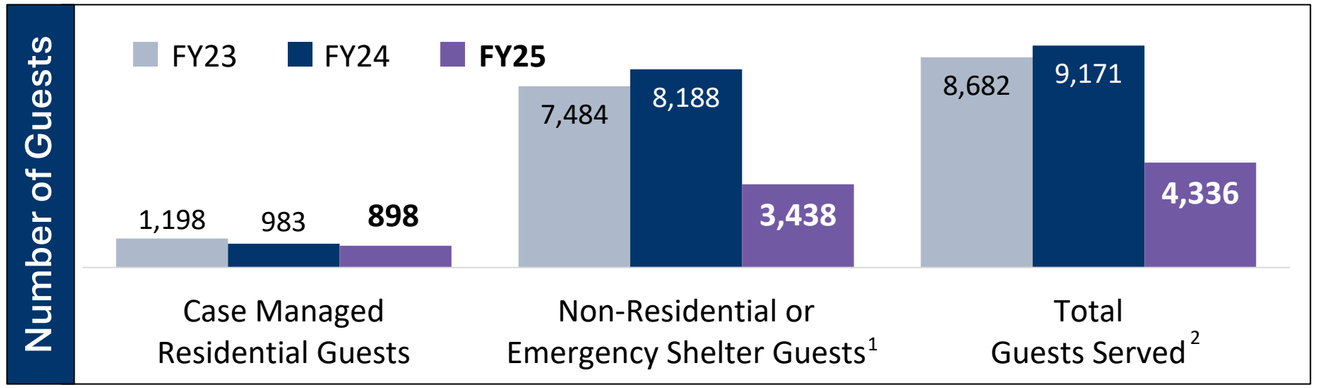
Community Engagement

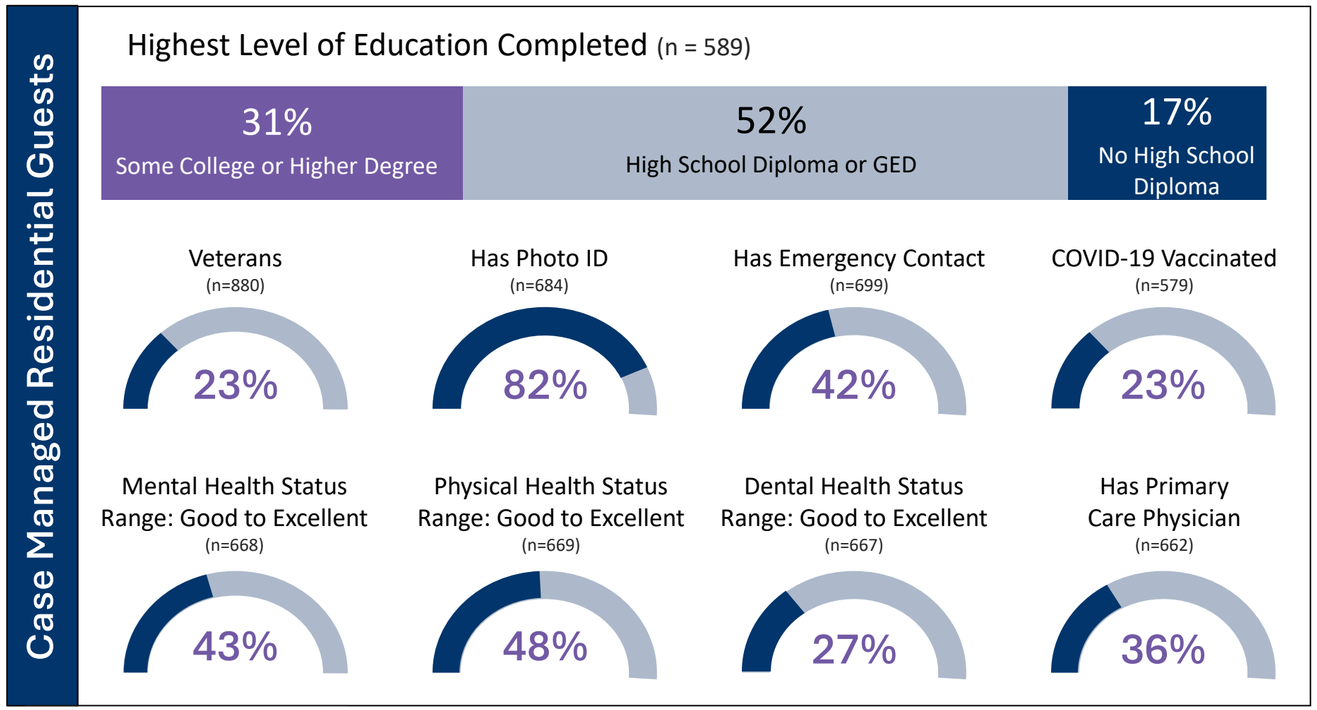
- Gateway Center staff participated in **224** community engagements and interacted with approximately **5,667** individuals through these engagements

GUESTS SERVED

Demographics at Intake

In FY25, Gateway Center Served 4,336 Guests

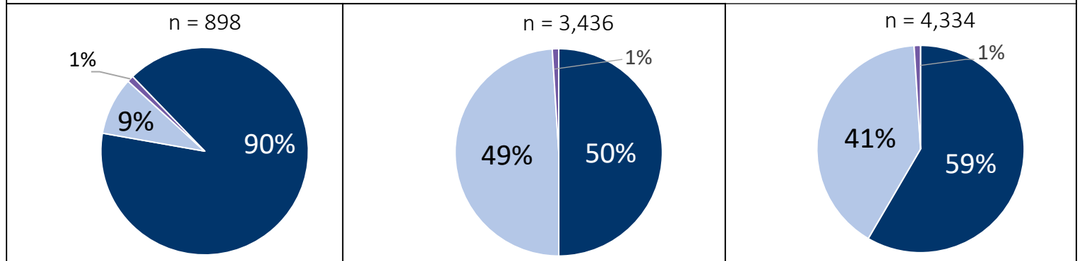




Case Managed Residential Guests	Non-Residential or Emergency Shelter Guests	All Guests

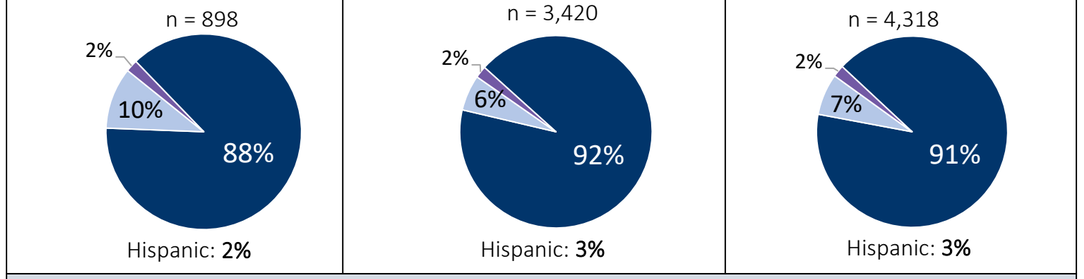
Gender

Male · Female · Gender Non-Conforming



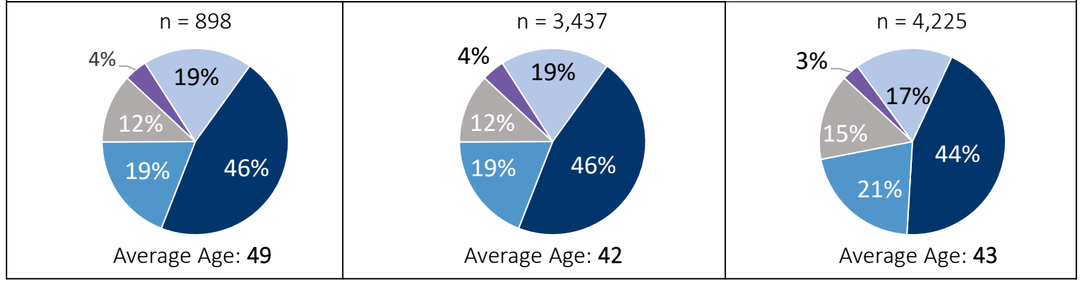
Race

Black/African American · White/Caucasian · Multi-Racial or Other Race[3]



Age

0 - 17 · 18 - 30 · 31 – 50 · 51 – 60 · 61 or older



[1] Non-Residential or Emergency Shelter guests did not enroll in a case managed residential program.
[2] The total number of guests served this year is lower than in previous years, primarily due to staffing shortages in the Coordinated Entry team and the reduction of diversion services.
[3] '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 Guests on Average...

stayed for

6.3

months

operated at

91%

of maximum residential capacity

	Number Served & Length of Stay (LOS)[2]			FY 25 Mean Nightly Occupancy and Capacity		
	FY24 # Served	**FY25 YTD # Served**	**FY25 YTD Mean LOS** (m: months; d: days)	**Mean Nightly Occupancy**	**Capacity** (avg. # of available beds)	**Occupancy ÷ Capacity**
All Case Managed Residential Programs[1]	**983**	**898**	5.0 m	174.7[3]	201.7[3]	86.7%[3]
GWC Case Managed Residential Programs	**778**	**685**	**6.3 m**	**138.0[3]**	**151.7[3]**	**91.0%[3]**
Downtown Rising (began 5/5/2025)	--	18	27.0 d	10.9	20	54.5%
New Beginnings	51	75	5.3 m	20.6	22	93.5%
Rapid Rehousing (RRH) LIFT[4]	102	83	17.2 m			
Stabilization	24	8	2.3 m	2.7	3	90.0%
The Evolution Center	388	306	4.8 m	92.2	100	92.2%
Trinity Women's Center[5] (ended 10/31/24)	46	3	9.0 m	3.7	7	52.9%
Upward	50	42	7.6 m	19.5	21	92.7%
Veterans: Contract Beds (VACB)[6]	16	16	3.7 m			
Veterans: Bridge to Housing[6]	5	10	2.0 m			
Veterans: Low Demand[6]	13	53	3.4 m			
Veterans: Transitional Housing (VAGPD)[6]	78	92	4.7 m			
Partner Case Managed Residential Programs	**258**	**239**	**2.0 m**	**36.7**	**50**	**73.4%**
ADID—Project ASSIST	19	19	2.7 m	4.5	6	75.0%
Hospital to Home	14	18	4.4 m	4.4	5	88.0%
Outreach / PATH Teams	93	76	2.1 m	11.3	20	56.5%
Recuperative Care by Mercy Care	140	131	1.5 m	16.5	19	88.7%

GWC Emergency Shelter Programs

	FY24 # Served	FY25 # Served	FY25 Mean LOS
Bridge Response Shelter (ended 11/30/24)	230	101	3.4 m
Family Shelter	33	11	4.8 d

GWC Non-Residential Services

	FY24 # Served	FY25 # Served
Behavioral Health Specialist (BHS)[7]	247	127
Career Resource Center	364	276
Coordinated Entry	6,151	3,293
Diversion	1,079	252
Engagement Center	1,329	1,215
Navigation Services	52	8
Outreach	515	387

[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. This applies to Downtown Rising and Trinity.
[4] RRH LIFT guests are housed in apartments, not at GWC.
[5] Children and significant others are not included in occupancy rates at Trinity Women's Center.
[6] Guest placement into VA beds has been delayed by the VA, making the occupancy rates beyond the control of GWC.
[7] Guests served by a BHS via a group or individual counseling session.

Last Permanent Zip Code & Prior Night's Stay

- **98%** of all guests were previously living in Georgia
- **86%** 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]

95% of guests were previously living in one of the 7 counties served by United Way's Regional Commission on Homelessness:

Fulton County	88.5%
DeKalb County	3.7%
Clayton County	1.3%
Cobb County	0.7%
Gwinnett County	0.8%
Douglas County	0.2%
Rockdale County	0.2%
Outside the Region	4.6%

Location of Residence the Night Before Arriving at Gateway Center[2]

(n = 759 residential guests)

Homeless 65%	Place not meant for habitation	65.2%
Temporary 25%	Emergency shelter, incl. hotel/motel paid for w/ ES voucher	20.9%
	Transitional housing for homeless persons	0.7%
	Hotel or motel paid for w/o E.S. voucher	0.3%
	Safe Haven	1.3%
	Staying with family	1.1%
	Staying with a friend	0.8%
Institutional 9%	Hospital or other residential non-psychiatric medical facility	3.5%
	Jail, prison, or juvenile detention facility	2.5%
	Psychiatric hospital or other psychiatric facility	0.8%
	Substance abuse treatment facility or detox center	1.8%
Permanent 1%	Rental by guest	1.0%
	Owned by guest	0.1%

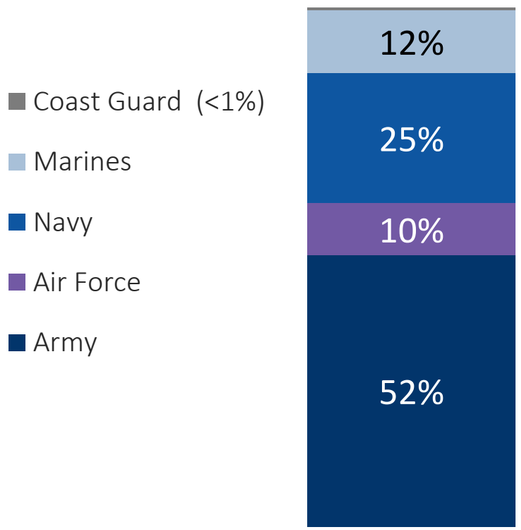
[1] n = 3,709: all GWC guests with known last permanent zip codes.
[2] For residential guests with more than one enrollment record during the report window, only data from the earliest enrollment is included.

Veterans

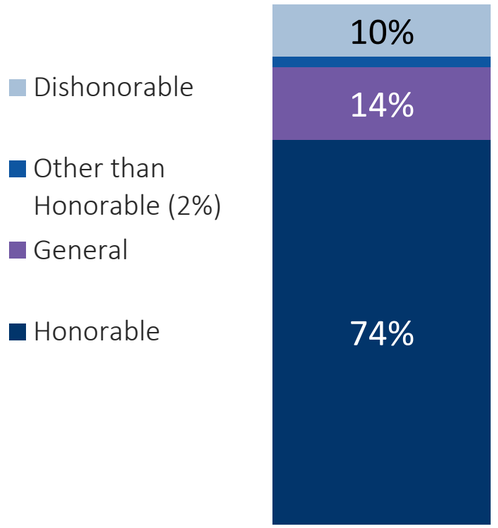
- In FY25, **23%** of case managed residential guests were Veterans
- On average, Veterans served for **4 years** (Range: 1 – 15 years)

Case Managed Residential Guests	Non-Residential or Emergency Shelter Guests	All Guests
Veterans[1]		
n = 199/880	n = 100/3,003	n = 299/3,883
23%	3%	8%

Military Branch (n=193)



Discharge Status (n=193)



[1] Veterans percentage are among those 18 years or older.

Case Managed Residential Guests	Non-Residential or Emergency Shelter Guests	All Guests
Veteran Gender		
Male Female		
n = 199 1% 99%	n = 100 22% 78%	n = 299 8% 92%
Veteran Race		
Black/African American White/Caucasian Multi-Racial or Other Race[3]		
n = 199 4% 11% 85% Hispanic: **3%**	n = 100 6% 94% Hispanic: **1%**	n = 299 2% 10% 88% Hispanic: **2%**
Veteran Age		
18 - 30 31 – 50 51 – 60 61 or older		
n = 199 2% 25% 29% 44% Average Age: **56**	n = 100 7% 33% 19% 41% Average Age: **53**	n = 299 4% 8% 25% 43% Average Age: **55**

NON-RESIDENTIAL & EMERGENCY SHELTER GUESTS

Vulnerability Index & Coordinated Entry

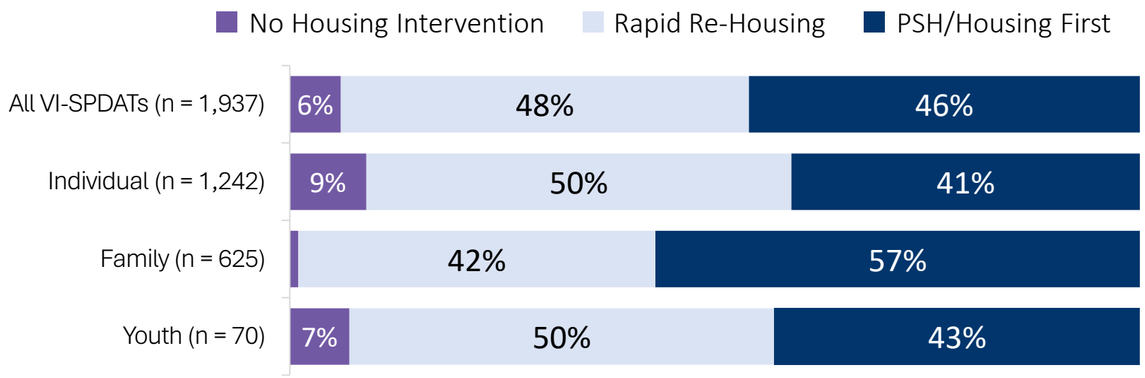
- **1,937** VI-SPDATs[1] were completed at Gateway Center[2]
- Based on their VI-SPDAT score, Permanent Supportive Housing (PSH) or Housing First was the recommended housing solution for **46%** of guests
- **14%** were chronically homeless and received a VI-SPDAT score recommending Permanent Supportive Housing (PSH) or Housing First
- CE provided **3,344** referrals for **1,857** households (including emergency shelter, lodging assistance, rental assistance, job placement, legal support, etc.)
- CE provided homeless verification letters for **1,225** individuals

Administering the Assessment

Assessments occurred on **242 days**.
On average, **8 assessments were conducted per day** (range: 1–28).

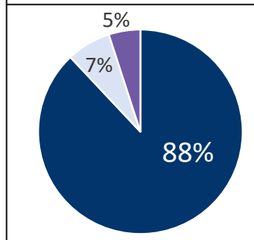
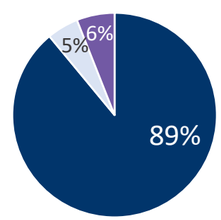
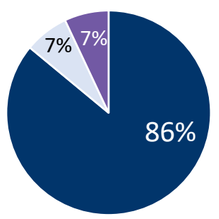
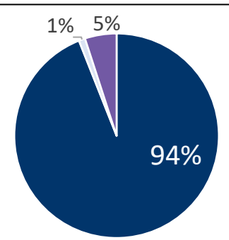
- **224** guests who presented for an assessment were **ineligible** due to not being homeless (n= 194) or not experiencing homelessness in the City of Atlanta or Fulton (n= 30).
- **15%** of guests completed an assessment over the phone; **85%** were in-person.
- **208** assessments were completed for eligible guests with an online appointment request.
- Average wait time for in-person assessments was **65 minutes** (same as FY24).
- Average assessment completion time was **30 minutes** (31 minutes in FY24).

Recommended Housing Solution Based on VI-SPDAT Score



3,293 Guests Served through Coordinated Entry (CE)

Atlanta CE: **1,594** Assessments	Fulton County CE: **343** Assessments

Adult Males (n = 1,088)	**Adult Females** (n = 1,004)	**Adult Gender Non-Conforming** (n = 16)	**Children** (n = 1,185)
Average Age (Years)			
45	39	36	8
Race			
Black/African American	White/Caucasian	Multi-Racial or Other Race[3]	
			
Ethnicity (% Who Identify as Hispanic/Latino)			
1%	1%	0%	1%

[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 assisting 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.
[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. One VI-SPDAT is completed per family, and all assessed guests are enrolled in the Coordinated Entry (CE) program.
[3] 'Other' includes individuals who identify as American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.

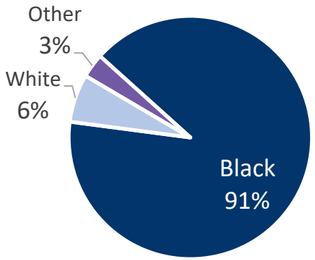
Outreach

Outreach served 387 individuals; 220 enrolled in the Outreach program.

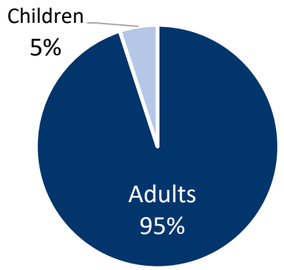
Total Enrolled	Households Served	Avg. Adult Age (Years)
220	**205**	**46**

Demographics

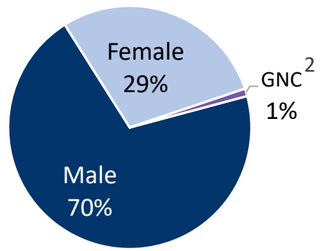
Race[1]



Adult/Child



Adult Gender (n=208)

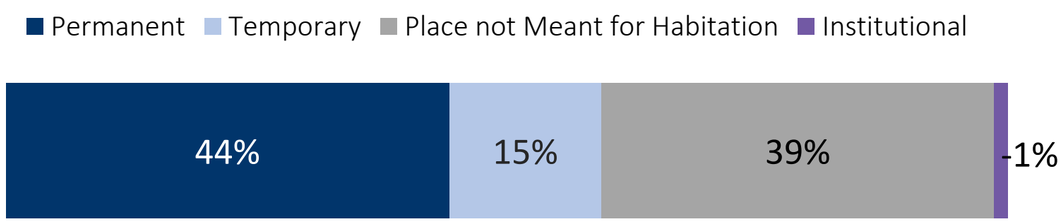


7% Veterans[3]

46% Chronically Homeless

52% Disabling Condition

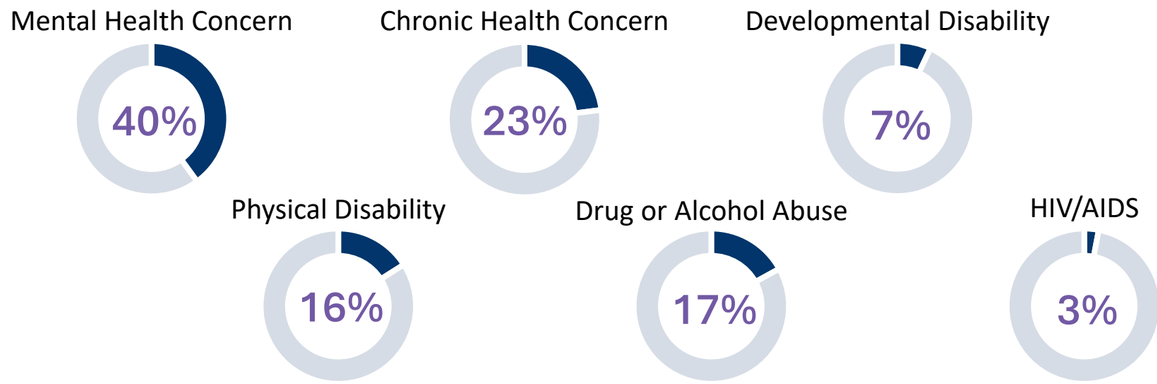
Discharge Destination[4] (n= 138)



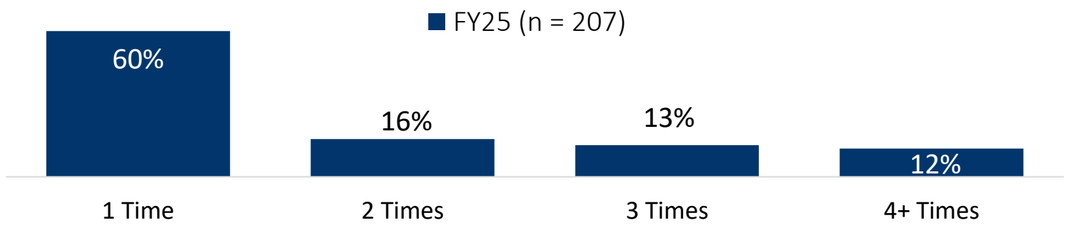
[1] 'Other' includes individuals who identify as Multi-Racial, American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.
[2] GNC = Gender Non-Conforming.
[3] Veteran status among adults only.
[4] For guests with multiple enrollments, only data from the most recent enrollment is 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.

- **46%** of outreach guests were referred for additional services
- **60%** of outreach guests had at least one special need (n= 187)

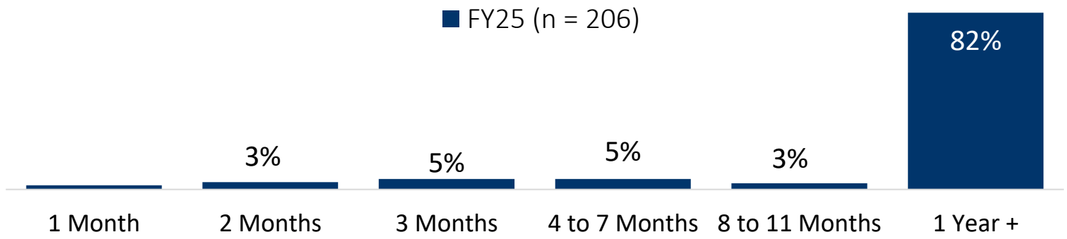
Percent of Outreach Guests with Special Needs



Number of times homeless in the last three years



Total number of months homeless in the last three years



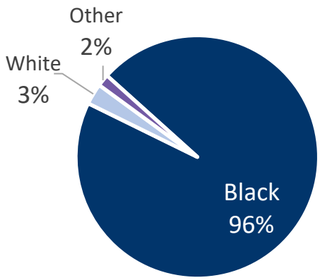
Diversion & Essential Services

Diversion

Total Served	Households Served	Avg. Adult Age (Years)
252	**113**	**38**

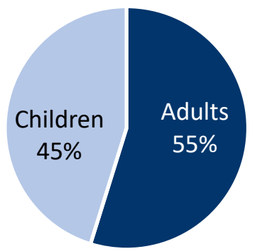
Demographics

Race[1]



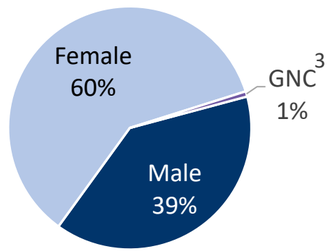
2%
Veterans[2]

Adult/Child



6%
Chronically Homeless

Adult Gender (n=138)



27%
Disabling Condition

Engagement Center

Total Served	Total Services Provided	Number of Days Served
1,215	**2,254**	**176**

On average, guests received 2 services (range 1-26 services).
The most frequent services provided were:

- **Showers** (n=863)
- **Homeless Verification Letters** (n=295)
- **Clothing or Hygiene Kit** (n=129)

Mercy Care Clinic

Provided 4,625 Encounters[4]:

- 2,269 **Medical Encounters**
- 2,356 **Behavioral Health Encounters**

[1] 'Other' includes individuals who identify as Multi-Racial, American Indian/Alaska Native, Asian, or Native Hawaiian/Other Pacific Islander.
[2] Veteran status among adults only.
[3] GNC = Gender Non-Conforming.
[4] Encounters are discrete interactions; these numbers may have duplicates (i.e., a person may have been served more than once).

Emergency Shelter Programs

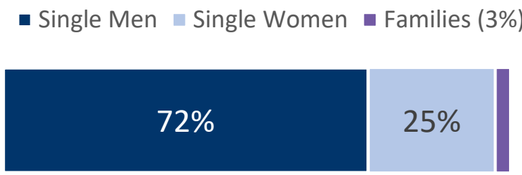
Winter Warming Shelter

On cold nights, GWC supported the community through 6,668 winter warming encounters[1], providing shelter or transportation to shelter at a partnering agency.

Winter Warming Shelter (temperature below 40 degrees)

Encounters[1]: **3,389**

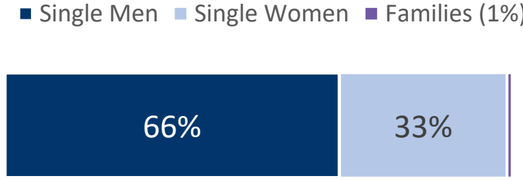
Days: **50**



Winter Warming Transportation (temperature below 32 degrees)

Encounters[1]: **3,279**

Days: **27**



Family Shelter

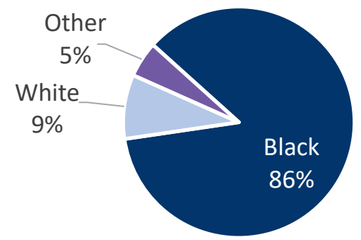
In limited situations, GWC provided emergency shelter for **families with children** as they awaited placement at local family shelter providers.

Total Families Served:	Total Children Served:	Avg. Length of Stay (Days):
4	**7**	**5**

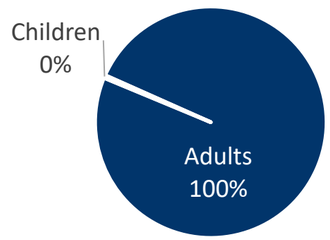
Bridge Response Shelter

Total Served	Avg. Length of Stay (Months)	Avg. Adult Age (Years)
101	**3.4**	**53**

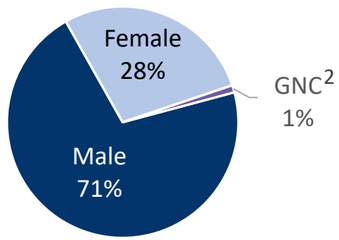
Demographics



9%
Veterans[1]



43%
Chronically Homeless



61%
Disabling Condition

Discharge Destination[3] (n=94)

[1] Encounters are discrete interactions; these numbers may have duplicates (i.e., a person may have been served more than once).
[2] GNC = Gender Non-Conforming.
[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.

RESIDENTIAL GUESTS

Characteristics At Intake & Services Provided

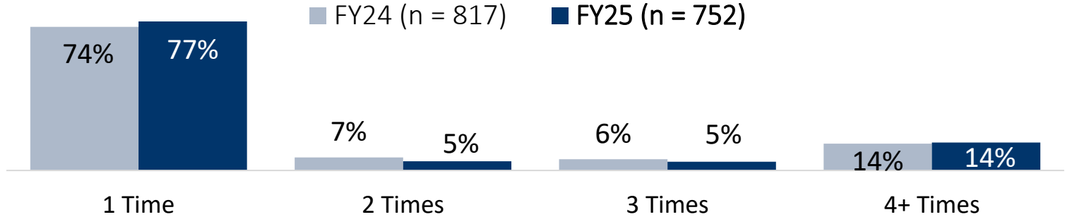
Chronic Homelessness

The U.S. Department of Housing and Urban Development (HUD)[1] defines a chronically homeless individual as someone who:

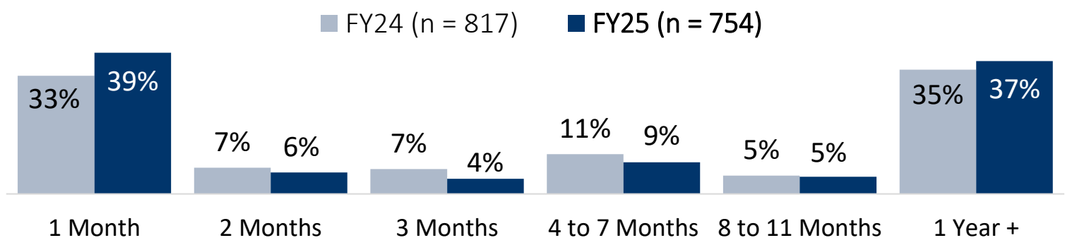
(1) has a **disabling condition**,
(2) lives in a **place not meant for human habitation** *or* in an **emergency shelter**, and
(3) has been living as described in **#2 continuously for at least 12 months** or on at least **four separate occasions** in the last 3 years, where the combined occasions total a length of at least 12 months.

of Guests Were **Chronically Homeless[2]** (n = 776)

Number of times homeless in the last three years



Total number of months homeless in the last three years



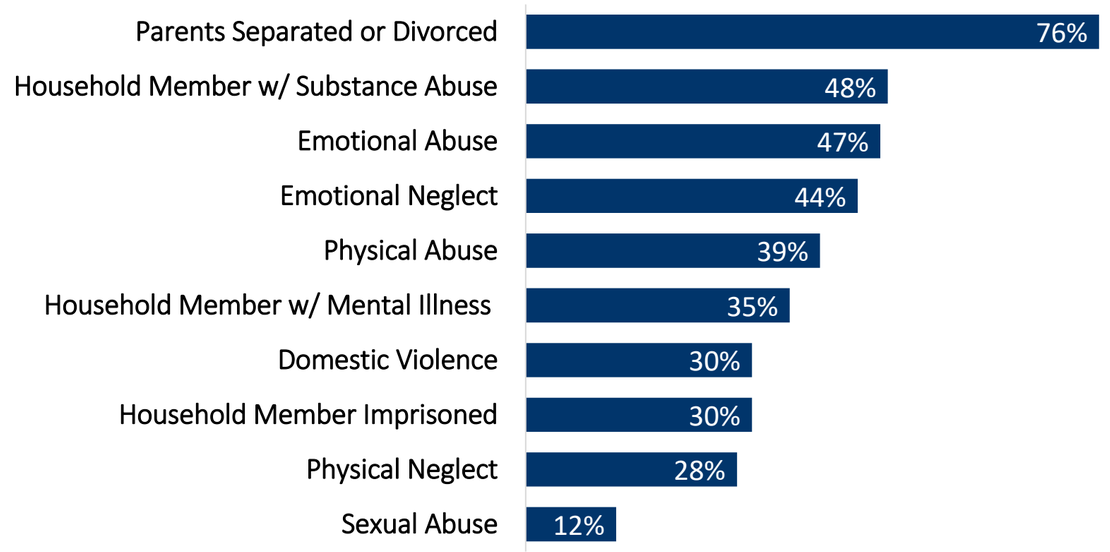
[1] For the full definition visit: https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf
[2] For guests with more than one enrollment record during the report window, only data from the most recent enrollment is included.
[3] https://www.cdc.gov/violenceprevention/aces/index.html

Adverse Childhood Experiences

- **92** residential guests completed the Adverse Childhood Experiences form, which assesses exposure to traumatic events as a child
- On average, guests experienced **4 traumatic events** as a child

of Guests Experienced at Least One **Traumatic Event[2]**

Percent of guests who indicated 'Yes' to experiencing the following events during the first 18 years of life (n = 92)



Housing Barriers

- 652 residential guests **completed** the Barriers to Housing Stability Assessment[1]
- 84% needed temporary assistance and 71% 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 – 16 barriers).

89% had 1 of these **employment barriers**

- **88%** did not have reliable transportation to get to work
- **9%** reported English as a second language

79% had 1 of these **credit history barriers**

- **43%** had poor credit history
- **51%** had no credit history
- **21%** had unpaid rent or utility bills in their name

74% had 1 of these **rental history barriers**

- **45%** never had a lease for an apartment/home in their name
- **41%** never had utilities in their name
- **26%** have been evicted from housing
- **12%** would receive a bad reference from a prior landlord

66% had 1 of these **criminal history barriers**

- **55%** had been convicted of 1 or more misdemeanors
- **15%** were on probation
- **46%** had been convicted of a felony
  - **39%** involved drugs, weapons, or a sex crime

12% had 1 of these **mental health barriers**

- **10%** lost housing because of their mental health issues
- **7%** had mental health challenges that currently impact ability to obtain housing

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

- **8%** lost housing because of their physical abilities or physical health
- **7%** had physical health challenges that currently impact ability to obtain housing

14% had 1 of these **substance use barriers**

- **13%** 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**

- **4%** lost housing because of domestic violence or abuse
- **2%** had domestic violence or abuse challenges that impact ability to obtain housing

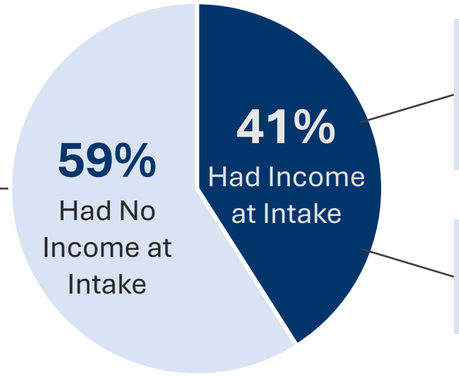
2% had 1 of these **family composition barriers**

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

[1] http://www.ndo.org/Downloads/HPRP/Forms/pdf/Barriers%20to%20Housing%20Stability.pdf. Only the most recent Barriers to Housing Stability forms per guest completed during the report window are included.

Income Barriers

- The median household income in Atlanta, GA is $6,828 monthly[1]
- In July 2025, the average rent for a one-bedroom apartment in Atlanta was $1,628 per month[2]
- The monthly entitlement benefit for someone with SSI in 2025 is $967[3]



Average Monthly Income[4]:
$1,246
(Range: $139- $4,700)

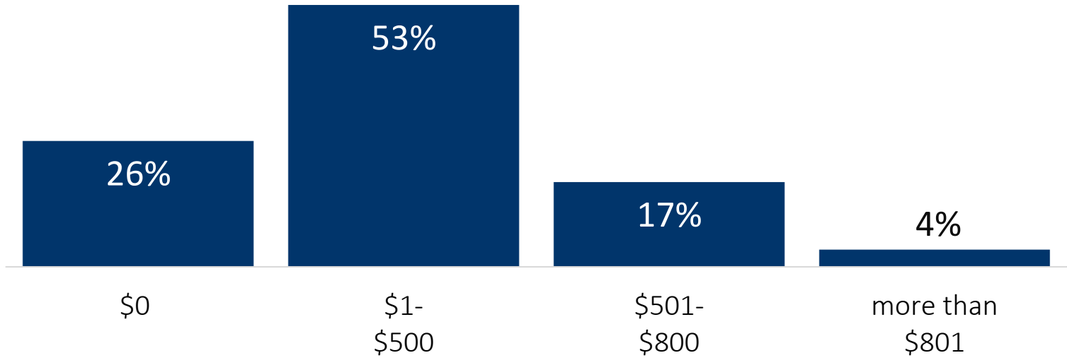
14%
Had Employment Income at Intake

Monthly Income at Intake for Residential Guests (n = 759)

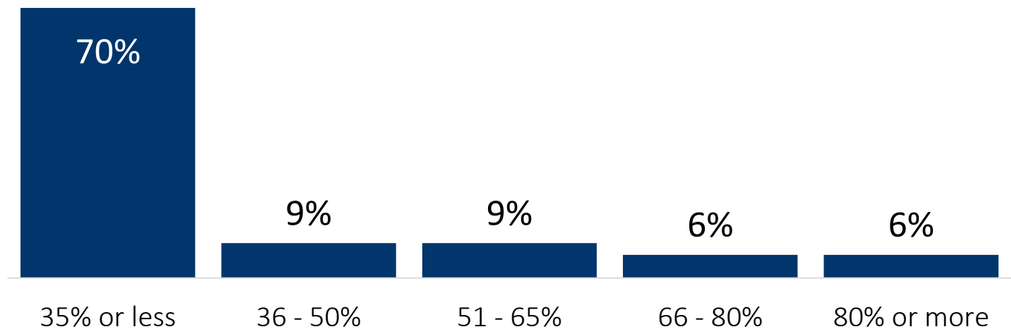
87% of guests were below the 2025 federal poverty line at intake.

Federal poverty line[5]: $1,304 monthly

If you are not living in your own house or apartment, how much money can you spend on housing each month? (n = 565)



When you were living in a house or apartment, what percent of income did you spend on housing (rent/mortgage AND utilities)? (n = 583)

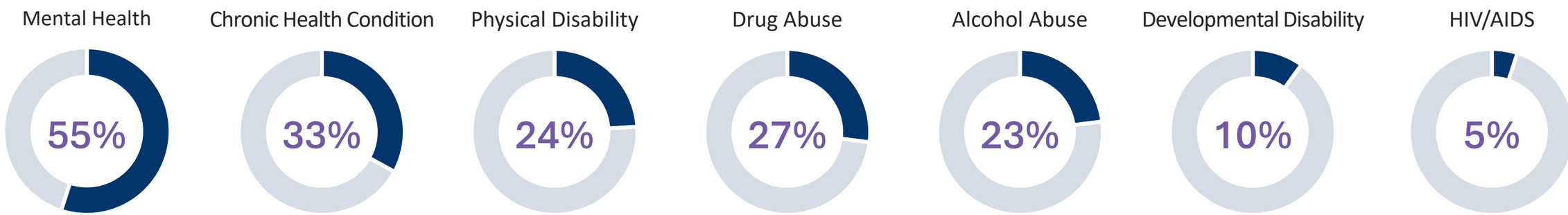


[1] https://www.census.gov/quickfacts/fact/table/atlantacitygeorgia/INC110221. Estimate is from 2023.
[2] https://www.apartments.com/rent-market-trends/atlanta-ga/
[3] https://www.ssa.gov/oact/cola/SSI.html
[4] For guests with more than one enrollment record, only data from the earliest enrollment date is included above. Only guests with income are included in the average monthly income.
[5] https://aspe.hhs.gov/poverty-guidelines. The single-person-in-household guideline is used. The 2025 federal poverty line is $15,650 annually.

Special Needs

- 66% 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)
- 34% of guests had a substance abuse special need (drug or alcohol abuse)
- 27% experienced a co-occurring mental health and substance abuse special need

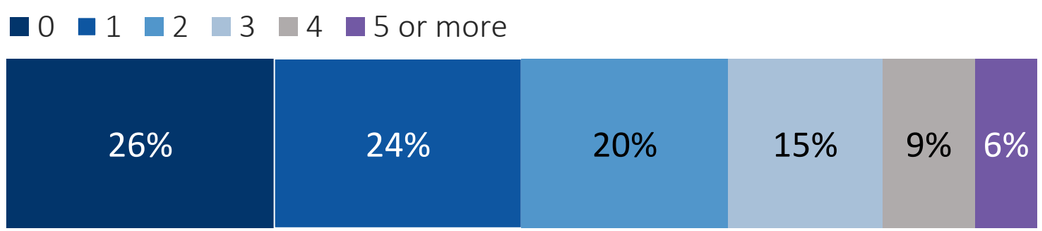
Percent of Residential Guests With Special Needs (n ~ 775)



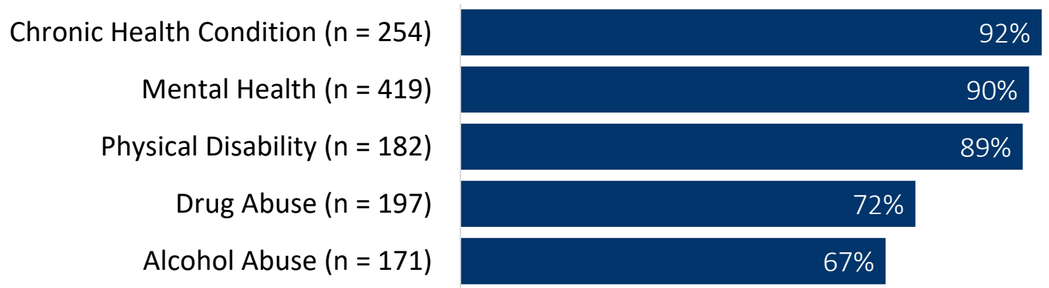
- 74% had at least one special need
- 50% had more than one special need

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

Number of Special Needs Per Guest (n = 776)



Guests With Indefinite and Impairing Special Need



Behavioral Health and Well-Being

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

73% of guests experienced at least one of the five challenges below.

Mild to Severe Depression

Mild to Severe Anxiety

PTSD

Low Resilience Copers

Low Resilience

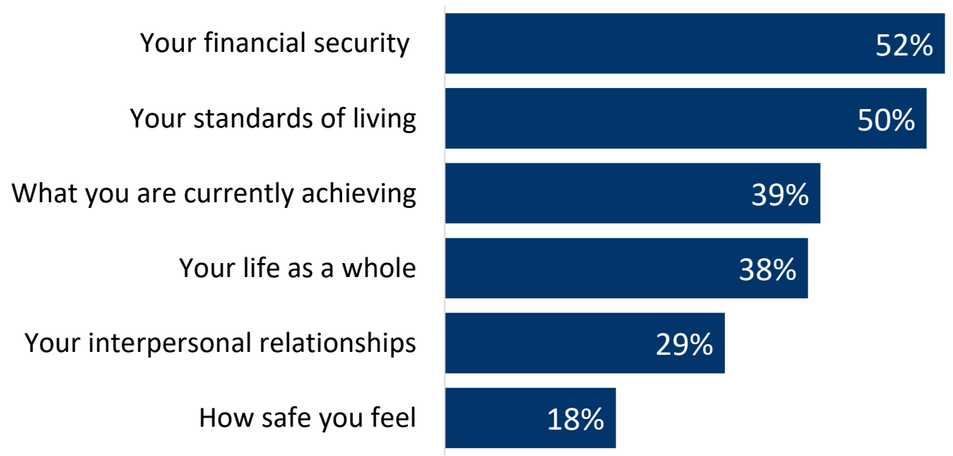
Depression (PHQ-9)	n = 560
No or minimal depression	47.7%
Mild depression	20.7%
Moderate depression	14.5%
Moderately severe depression	9.1%
Severe depression	8.0%
Anxiety (GAD-7)	
No anxiety	48.4%
Mild anxiety	22.7%
Moderate anxiety	15.0%
Severe anxiety	13.9%
Post Traumatic Stress Disorder (PCL-5)	
May benefit from PTSD treatment	38.0%
Coping Skills (BRCS)	
Low resilient copers	38.6%
Medium resilient copers	31.8%
High Resilient copers	29.6%
Resilience (BRS)	
Low resilience	28.0%
Normal resilience	65.5%
High resilience	6.4%

Personal Wellness Index

GWC case managed residential guests responded to 6 questions about their perceptions of their wellness from the Personal Wellness Index (PWI).

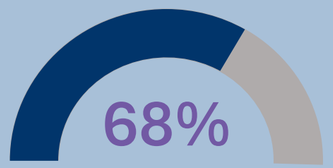
- Response options were on a scale of 1 to 5: 1=Extremely unsatisfied; 3=Neutral; 5=Extremely satisfied
- The average guest score on all items was **3.0**, indicating that guests tend to feel neutral about their wellness

Percent of guests who indicated that they are 'Unsatisfied' or 'Extremely Unsatisfied' with the following (n = 560)



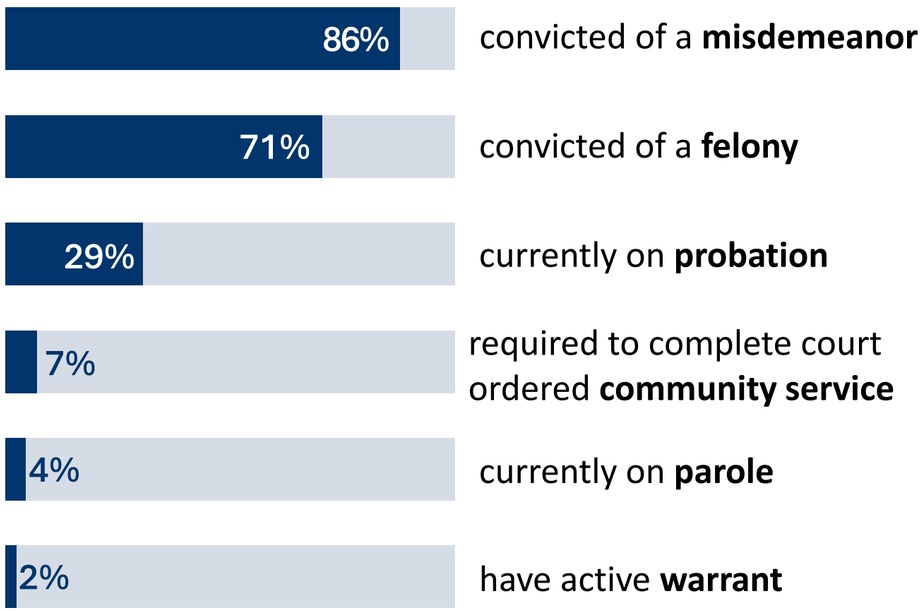
[1] Behavioral Health Assessments are conducted at intake, during enrollment, and at exit. The earliest assessment during a FY25 enrollment is included. Only 1 assessment per guest is included.

Criminal Background



of Residential Guests Have a Criminal Background (n=384/567)

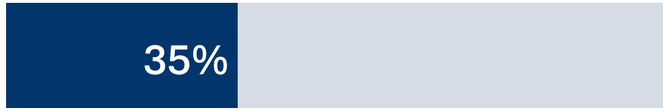
Among those with a criminal background, on average, guests had 2 of the following six criminal background indicators:



Child Support

of Residential Guests are Required to Pay Child Support (n=51/593)

Among those who were required to pay child support, the average amount was $459 per month (range: $20 - $1,200).



Treatment Sessions

Behavioral Health Sessions

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

1-on-1 Behavioral Health Sessions[1]: 178

92
Guests Had a 1-on-1 Session With a BHS

On Average, Guests Met With a BHS **2 times**
(Range: 1 – 9 sessions)

Average Session was **37 minutes**

Group Behavioral Health Sessions: 58

66
Guests Attended a Group session

Guests Attended an Average of **5 group sessions**
(Range: 1- 17 sessions)

Substance Abuse Sessions

42 guests attended a substance abuse treatment group[2]

Substance Abuse Sessions:

183
Morning Check-Ins

172
Didactic Sessions[2]

Upward Guests Attended an Average of **106** Substance Abuse Group Sessions
(Range: 2 – 334 Sessions)

[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

The Career Resource Center (CRC) assists guests with obtaining economic stability through job training and placement while bridging the digital divide by providing computer skills education.

In FY25, the CRC served 276 guests.

Individual Employment Plans

The CRC Manager develops Individual Employment Plans (IEPs), which include goal-setting, with residential guests.

- 145 IEPs were created
- 150 IEP goals were completed
- 111 guests completed at least one IEP goal

CRC Impact

- 69 guests obtained employment because of engaging with the CRC
- 847 CRC services were recorded

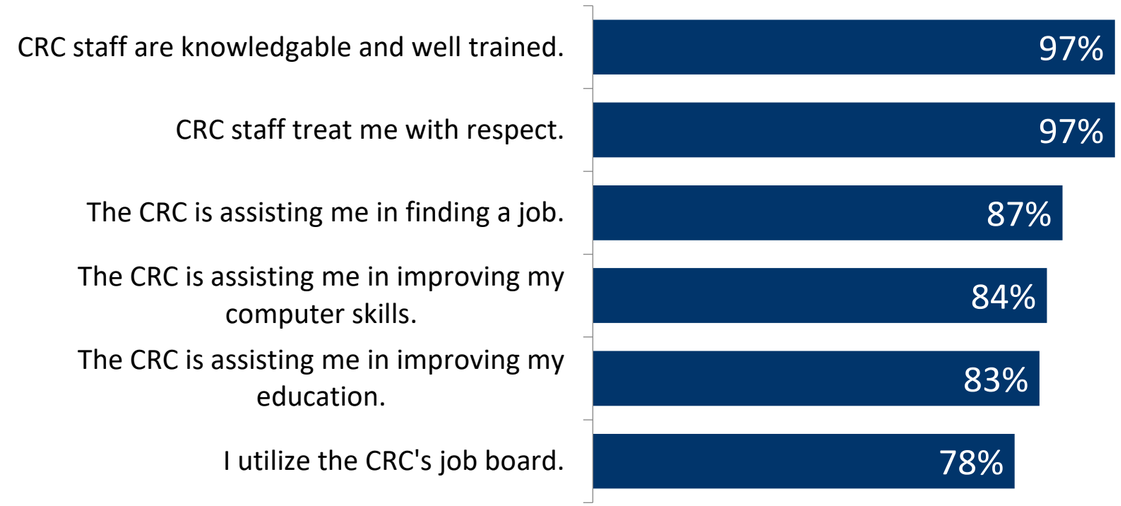
- The most frequent CRC services were:

Computer Use
248 services

Job Search Assistance
231 services

- 129 guest feedback surveys were completed about the CRC[1]
- Among those who completed the surveys, 97% are satisfied overall with CRC's services

Percent of Guests Who 'Agree' or 'Strongly Agree' (n ~ 123)



What is most helpful about services at the CRC?

- **Computer skills training**
  - "Everything. I didn't even know how to turn on a computer."
- **Job opportunities**
  - "Knowledge of various job opportunities."
  - "The CRC helped me get a job and stay focused on keeping it."
- **Resume building:**
  - "Helping with my resume so I can get a better job."

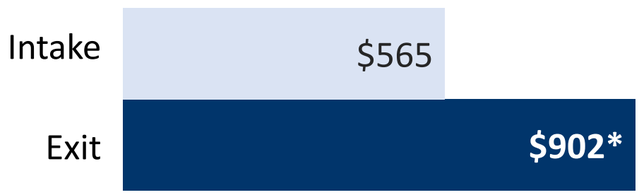
[1] Guests completed the CRC Feedback survey anonymously. It is possible that the same guest answered the survey more than once. All surveys are included in the above results.

Outcomes of 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 Earned Income and Supplemental Security Income (SSI)

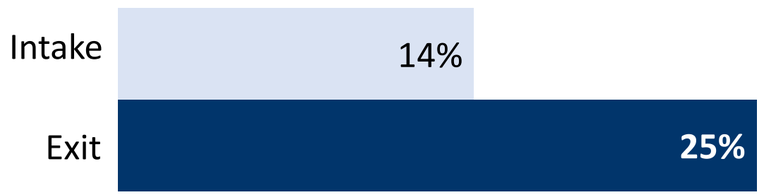
Average Monthly Income (n = 475)



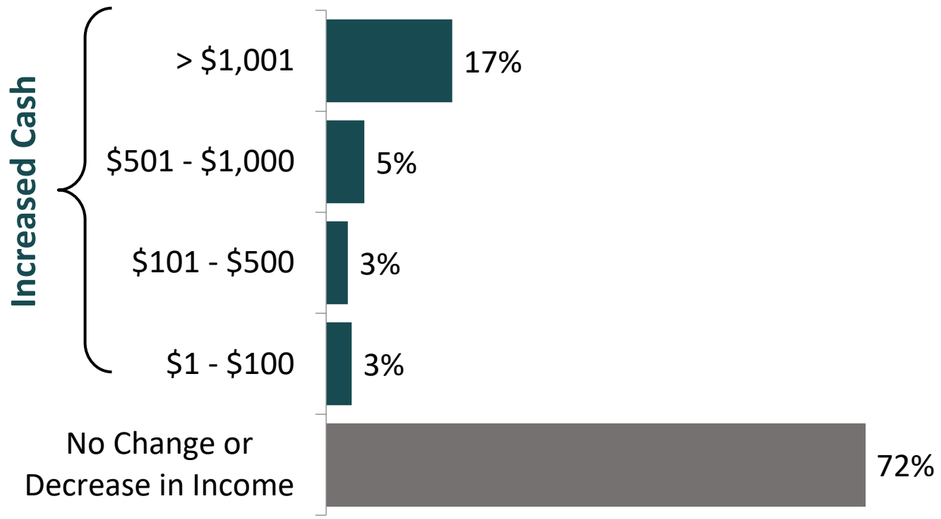
On average, income increased by

↑ $336

Guests with Earned Income (n = 475)



Change in Monthly Income from Intake to Exit (n = 475)



Cash Income Sources[1]	Intake	Exit
Earned Income	14.1%	25.3%
Supplemental Security Income (SSI)	14.1%	16.0%
Social Security Disability Insurance (SSDI)	9.7%	10.3%
Veterans Disability Payment	9.5%	9.5%
Retirement from Social Security	2.3%	2.5%

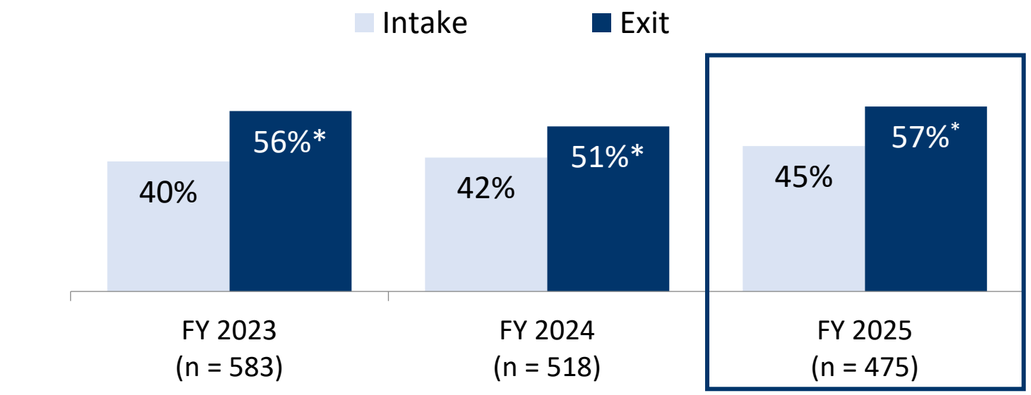
*Indicates a statistically significant changed at $p < .05$.

[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

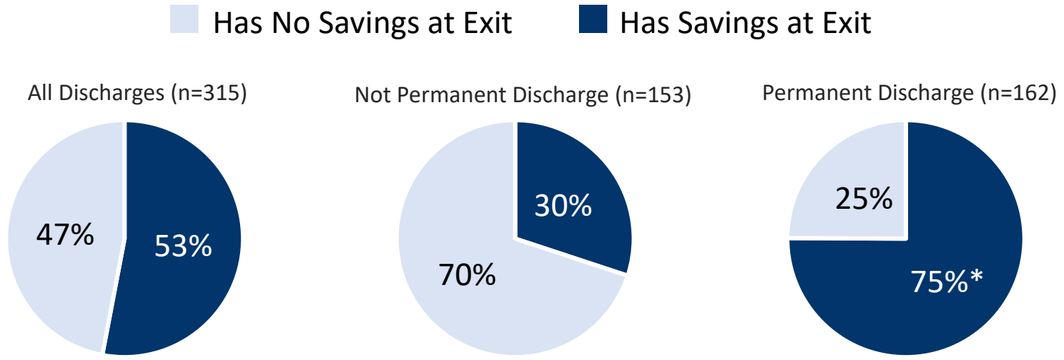
- From intake to exit, there was a significant increase* in the number of residential guests with cash income
- Guests with a permanent discharge were significantly more likely* to have savings at exit (as compared to all other discharge types)

Cash Income[1]

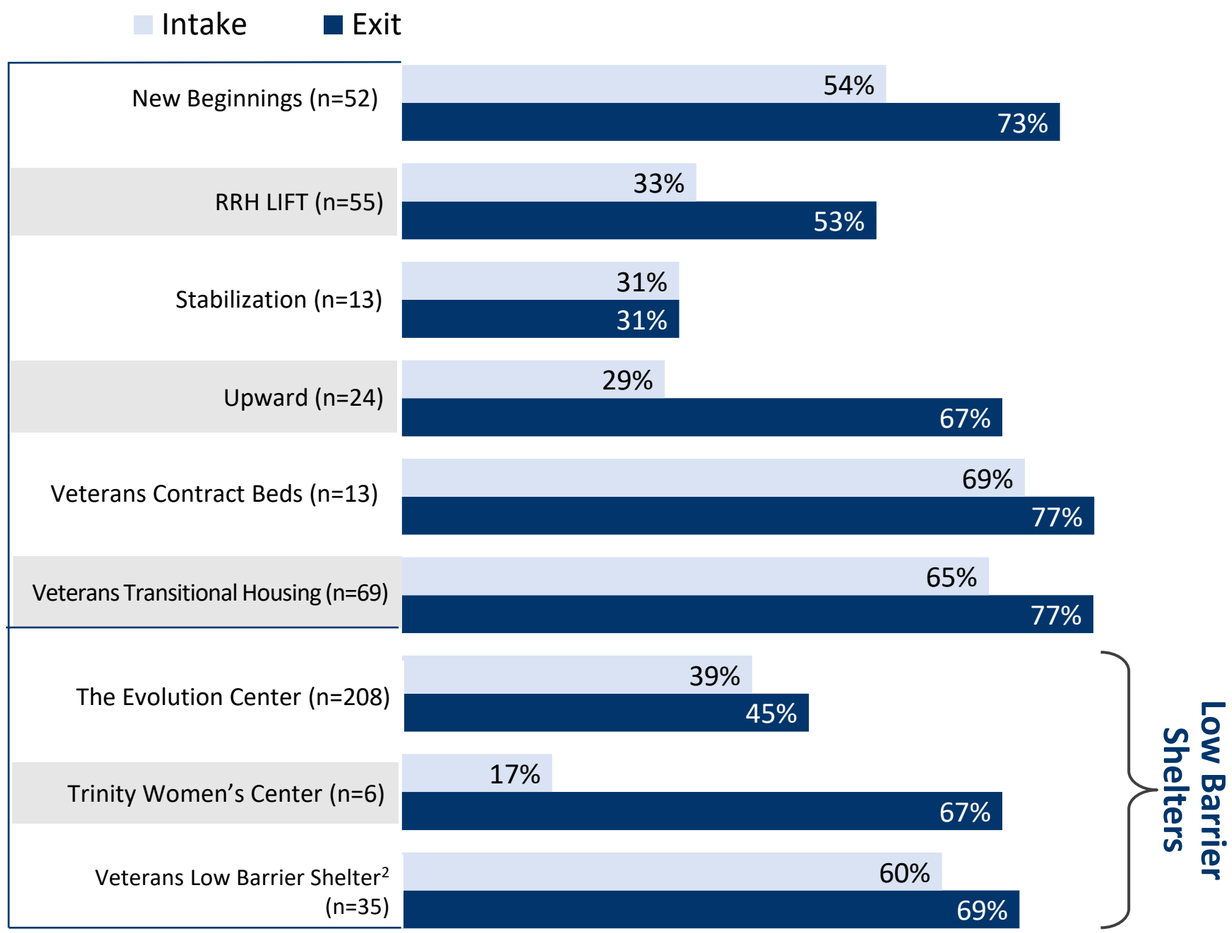


Savings at Exit

Among those with savings, the average amount was $2,040 (Range: $50—$10,000).



Cash Income by Program[1]



*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.

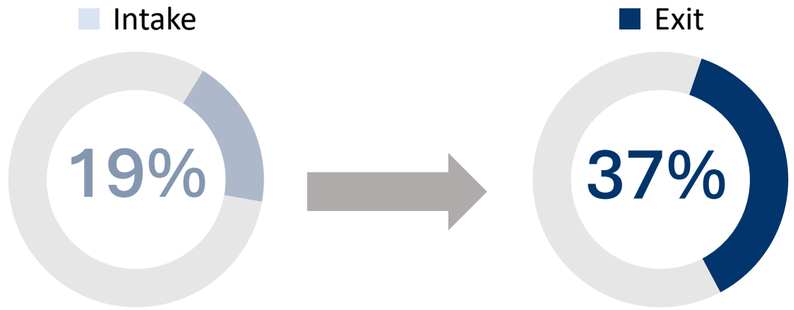
[2] Veterans Low Barrier Shelter includes those in Veterans Bridge to Housing and Veterans Low Demand.

Changes in Employment & Identification

From intake to exit, there were significant increases* in the number of guests with jobs and with different forms of identification

Employment[1]

- 28% of guests were unable to work (n = 136/487)
- Among guests who were able to work, 37% were employed at exit (n = 129/351)

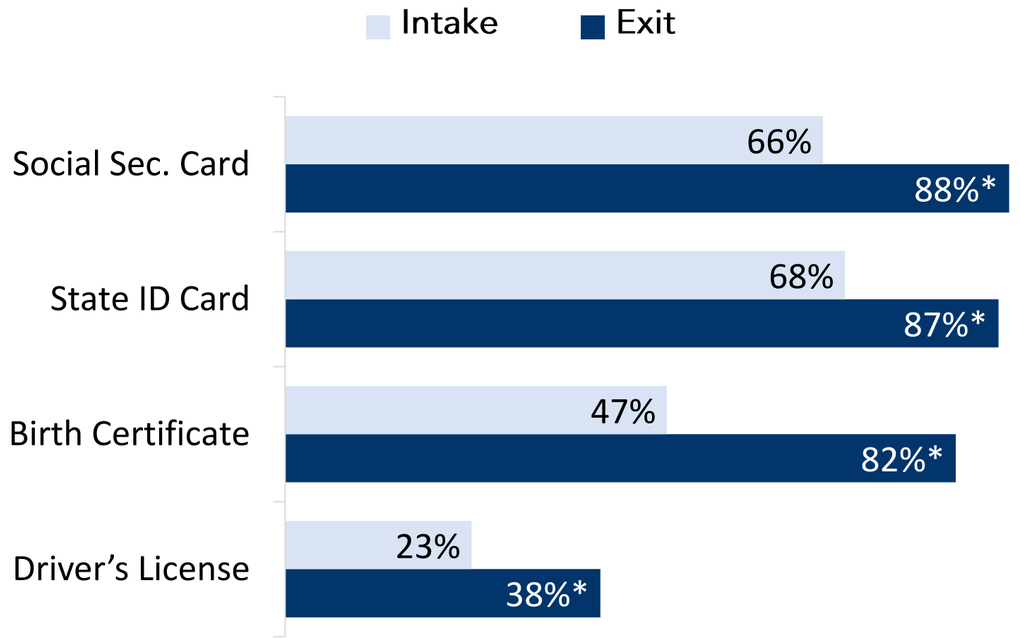


The average hourly rate of a guest's employment was $16 (Range: $8 – $42; n = 109).

Among those **employed** at exit, 14% obtained a job promotion (n = 17/125).

Types of Identification (n ~ 289)[1]

On average, residential guests gained 1 additional form of identification by exit.

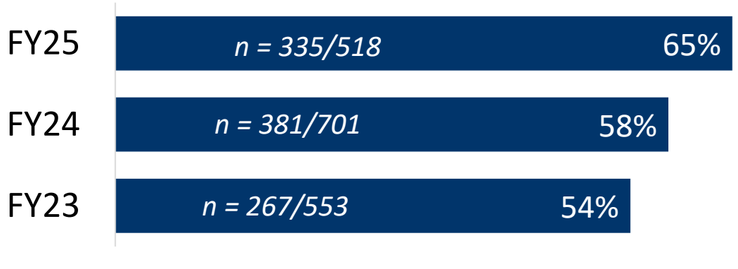


*Indicates a statistically significant change at $p < .05$.
[1] Only guests with data at intake and exit are included. For guests with more than one enrollment record, only data from the most recent enrollment is included.

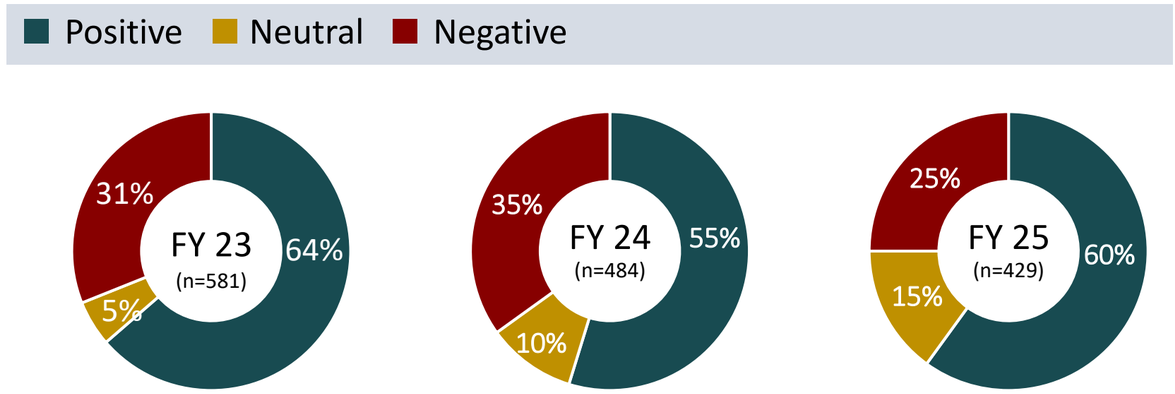
Discharge Summary

IN FY25, GWC ACHIEVED ITS BIG GOAL TO TRANSITION 65% OF GUESTS TO A POSITIVE HOUSING PLACEMENT UPON DISCHARGE BY 2025.

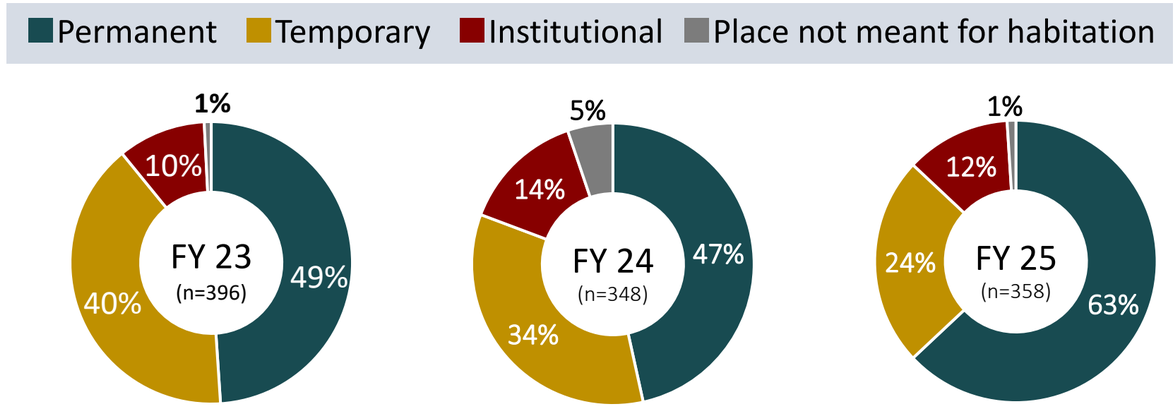
Percent of Guests Discharged to Housing[1,2]



Discharge Reason[3,4]



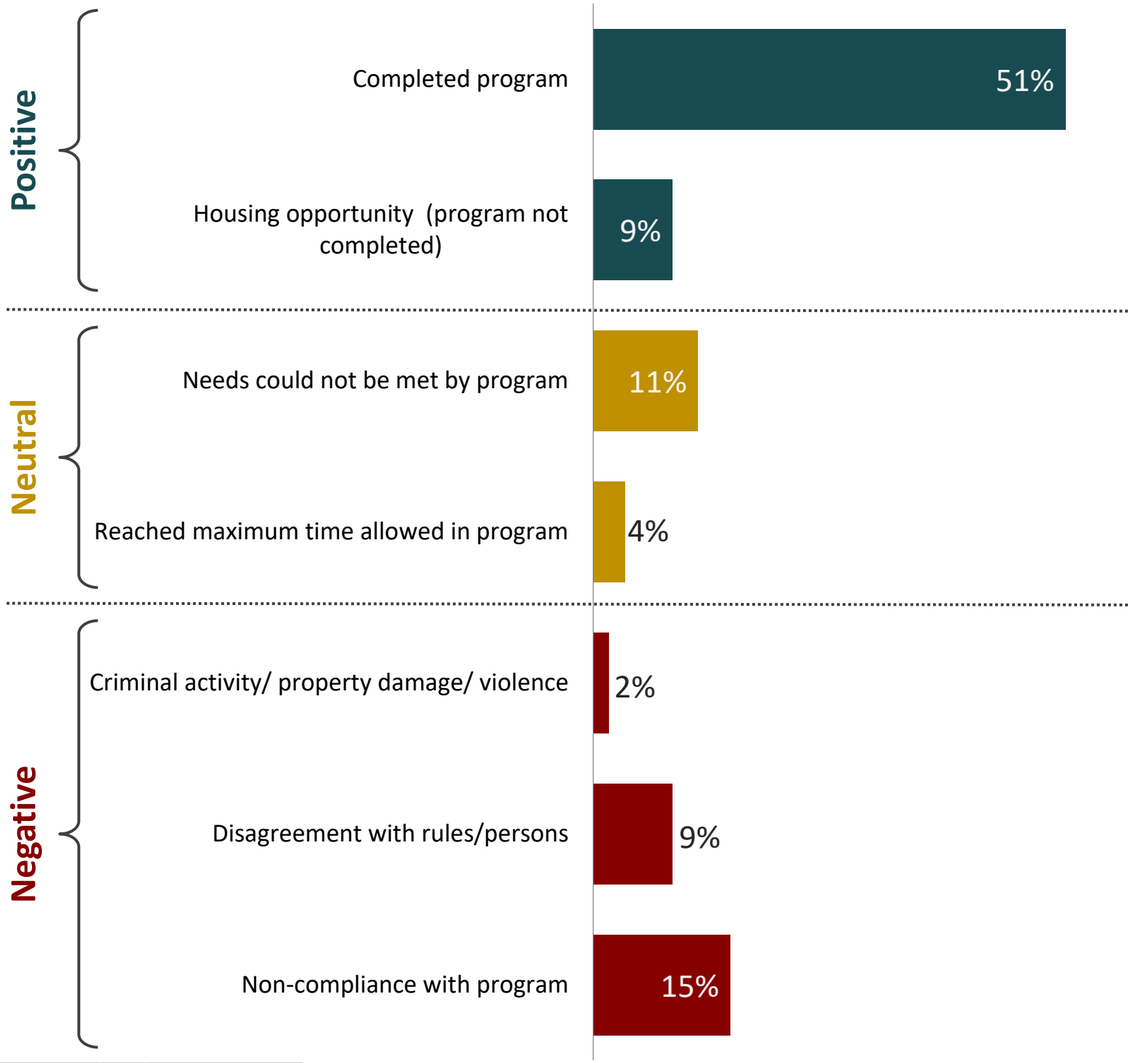
Discharge Destination[2,3]



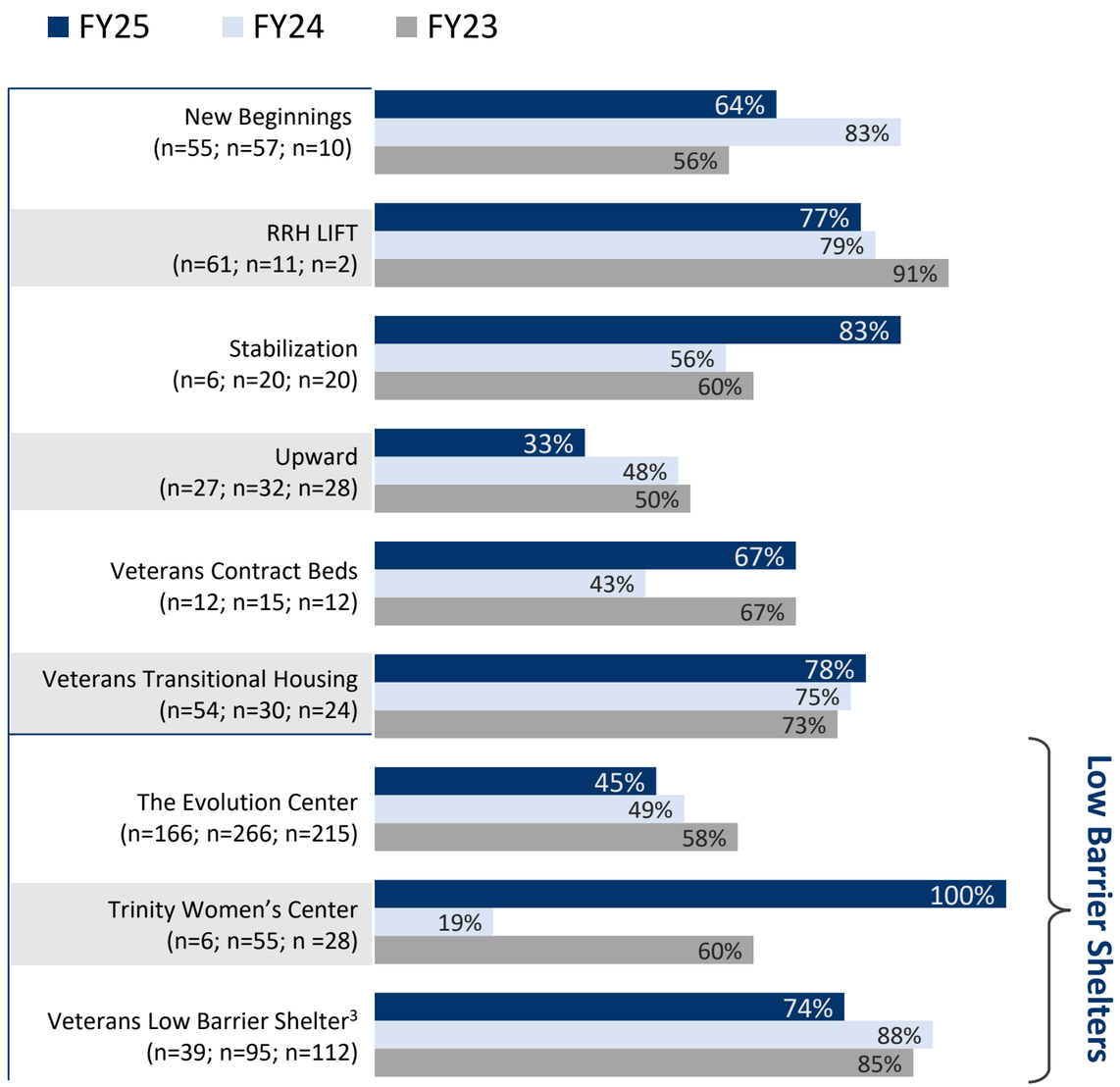
[1] Those discharged to housing include anyone NOT discharged to a place not meant for habitation, jail, or unknown destinations.
[2] For guests with multiple enrollments, only data from the most recent enrollment is included.
[3] Unknown discharge destinations and reasons were removed, including responses 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 = 429)



Positive Discharge Reasons by Program[1,2]



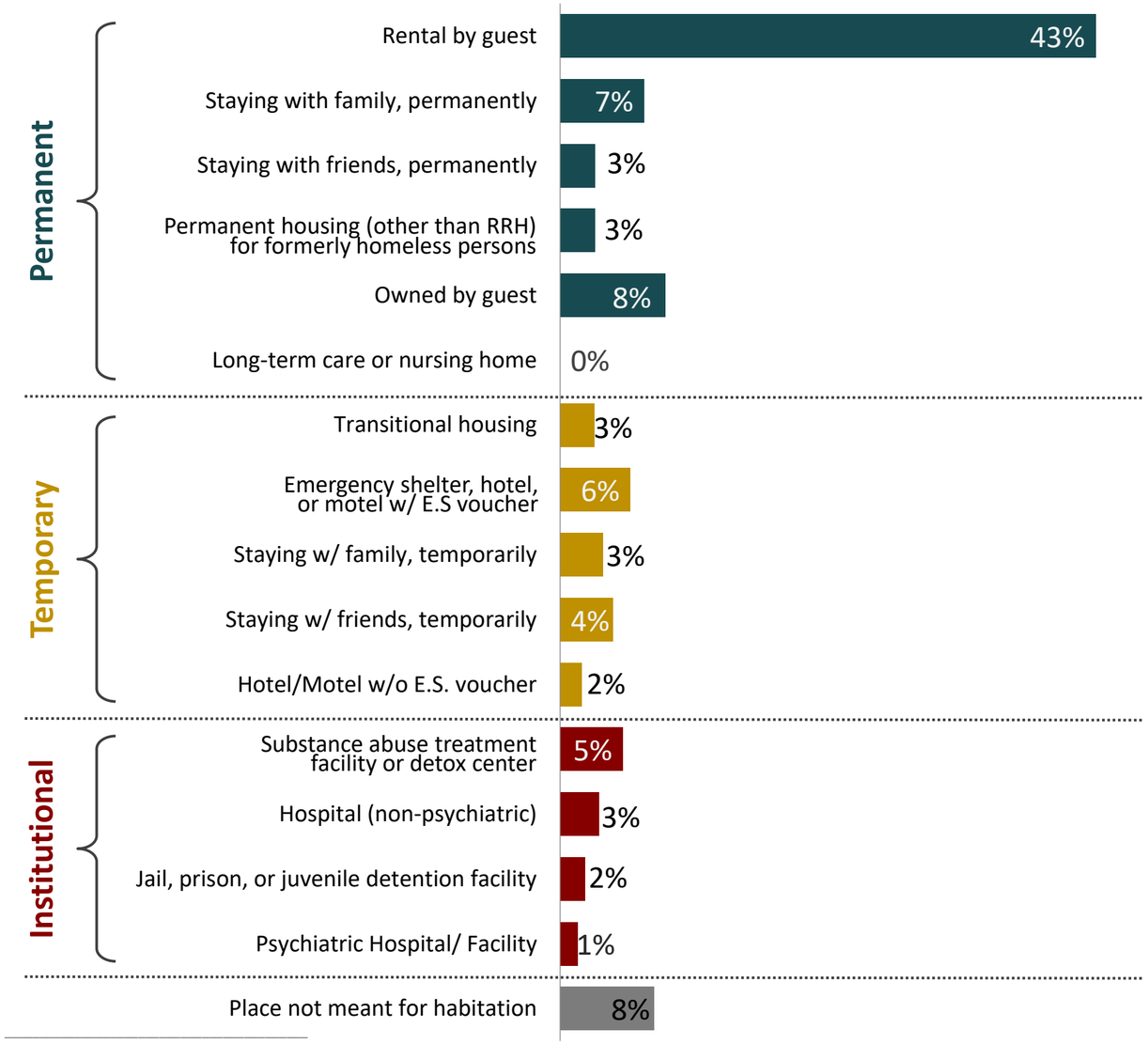
[1] Guests with multiple enrollments during the report period are included in the above analyses more than once. In FY25, 89 individuals discharged for an unknown reason. Unknown discharge reasons were removed, including responses in which no exit interview was conducted, the guest doesn't know, the guest refused to answer, or other. 5 guests passed away; these were removed.

[2] Under each program name, the first sample size (n=) provided is for FY25. The second sample size provided is for FY24. The third is for FY23.

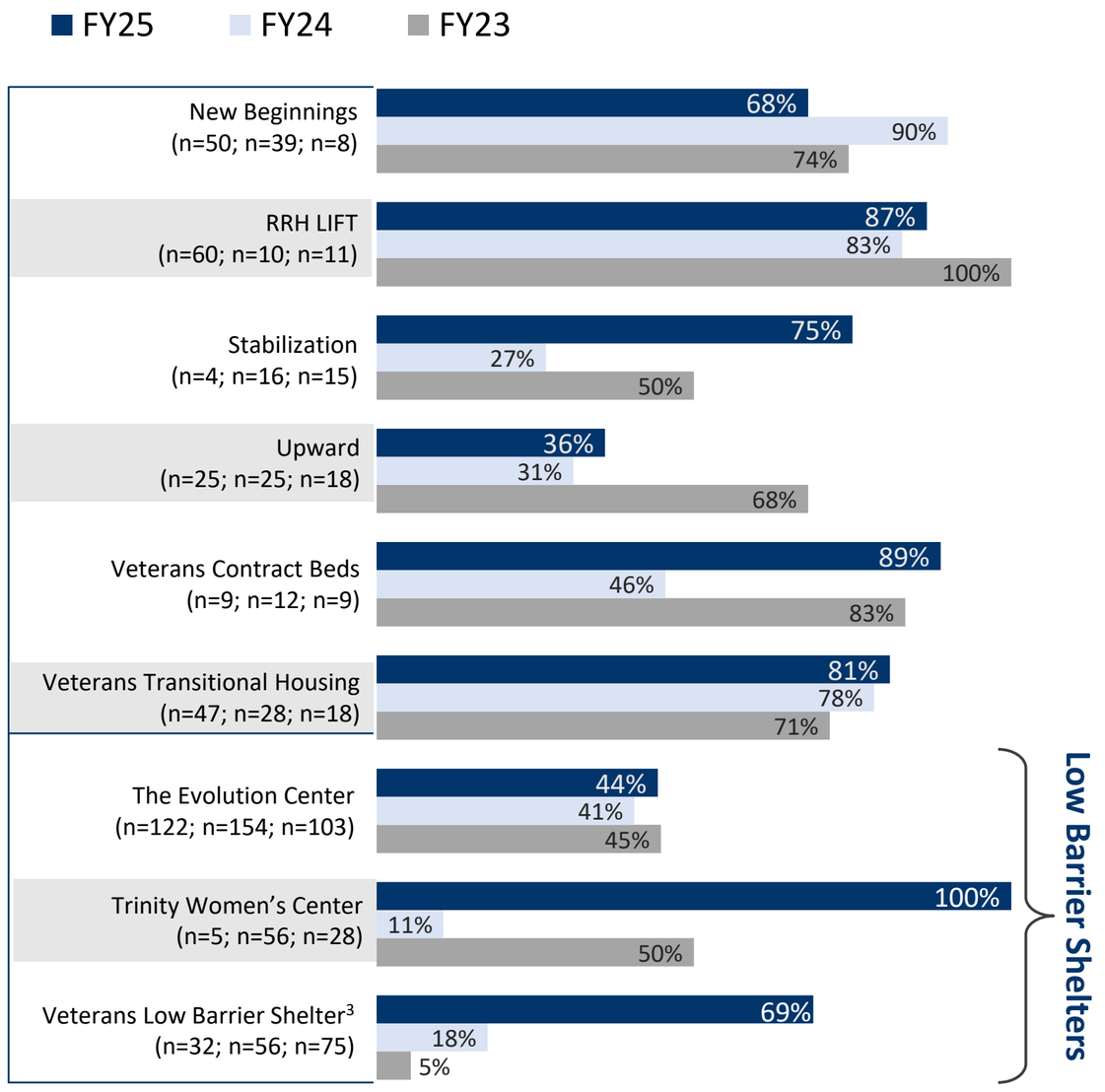
[3] Veterans Low Barrier Shelter includes those in Veterans Bridge to Housing and Veterans Low Demand.

Discharge Destination

Discharge Destination[1] (n = 358)



Permanent Discharge Destination by Program[1,2]



[1] For guests with multiple enrollments, only data from the most recent enrollment is included. In FY25, 142 individuals discharged to an unknown destination. Unknown discharge destinations were removed, including responses in which no exit interview was conducted, the guest didn't know, the guest refused to answer, or other. 5 guests passed away; these cases were removed.
[2] Under each program name, the first sample size (n=) provided is for FY25. The second sample size provided is for FY24. The third is for FY23.
[3] Veterans Low Barrier Shelter includes those in Veterans Bridge to Housing and Veterans Low Demand.

Changes in Mental Health (Among Guests who Interacted with a Behavioral Specialist)

Behavioral Health Assessments

- Residential guests complete a behavioral health assessment at intake, during program enrollment, and at exit[1]
- Improvements in depression, anxiety, PTSD, wellness and resilience from pre-test to post-test were statistically significant*
- 99% of guests improved on at least 1 of the 6 below 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=82)
For the assessments below, **lower** scores are better.			
Depression (PHQ-9) (0 to 27)	8.6	3.8*	77%
Anxiety (GAD-7) (0 to 21)	7.6	3.5*	73%
PTSD (PCL-5) (0 to 80)	24.9	13.6*	70%
For the assessments below, **higher** scores are better.			
Wellness (PWI) (5 to 30)	15.4	19.6*	68%
Coping Skills (BRCS) (4 to 20)	13.7	14.8	52%
Resilience (BRS) (1 to 5)	2.9	3.3*	59%

Mental Health and Coping Skills

- Residential guests who were enrolled for at least 14 days and who engaged with a Behavioral Health Specialist were asked at exit about changes in their mental health and coping skills
- Approximately 55% of guests reported improvements

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

Mental Health (n=276)

Coping Skills (n=276)

*Indicates a statistically significant changed 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.

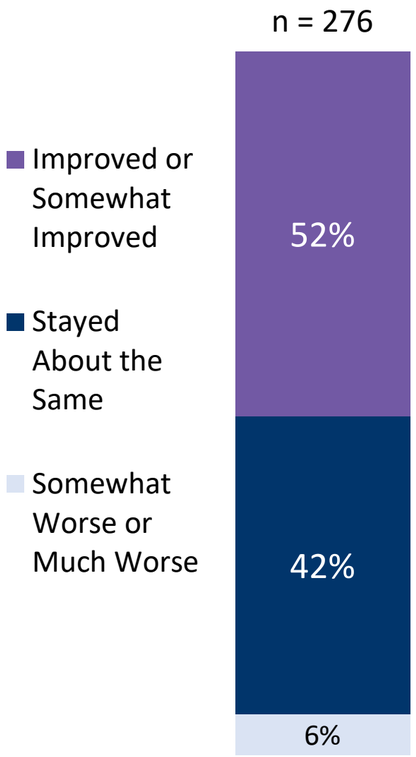
[2] Only guests with a pre-test and post-test are included. The link to view each scale is provided in parentheses.

[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.

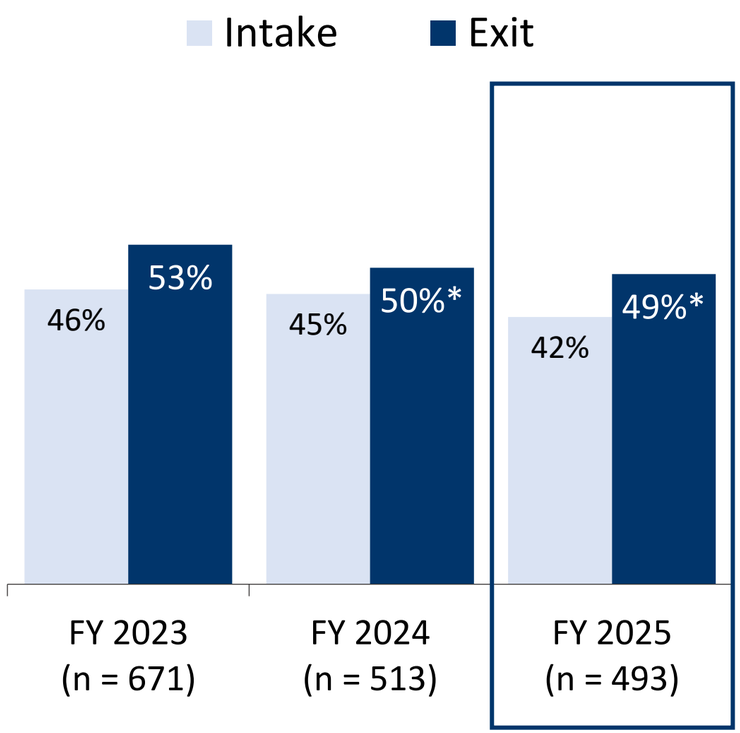
Changes in Health & Health Insurance

- Residential guests who were enrolled for at least 14 days were asked at exit about changes in their physical health
- 52% reported improvements in their physical health
- From intake to exit, there was a significant increase* in the number of residential guests with health insurance
- Among guests with health insurance, the most common types were Veterans Health Administration (VHA) insurance and Medicaid

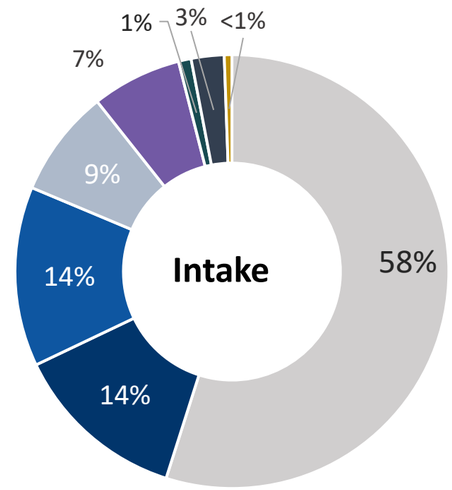
Changes in Physical Health

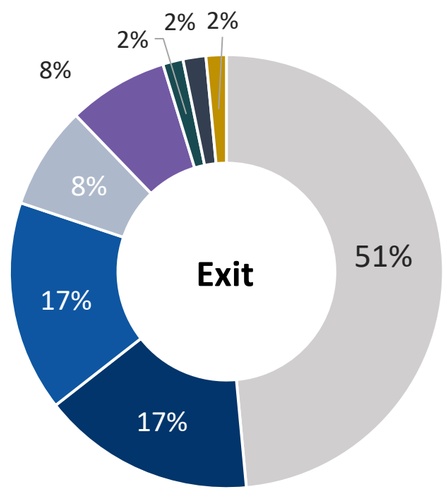


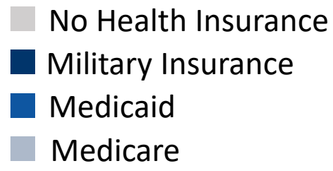
Percent of Guests with Health Insurance[1]

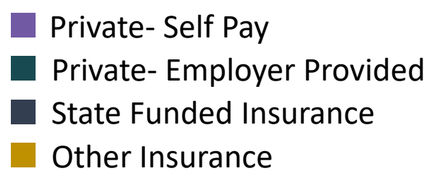


Sources of Health Insurance[1,2] (n = 493)









*Indicates a statistically significant changed 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

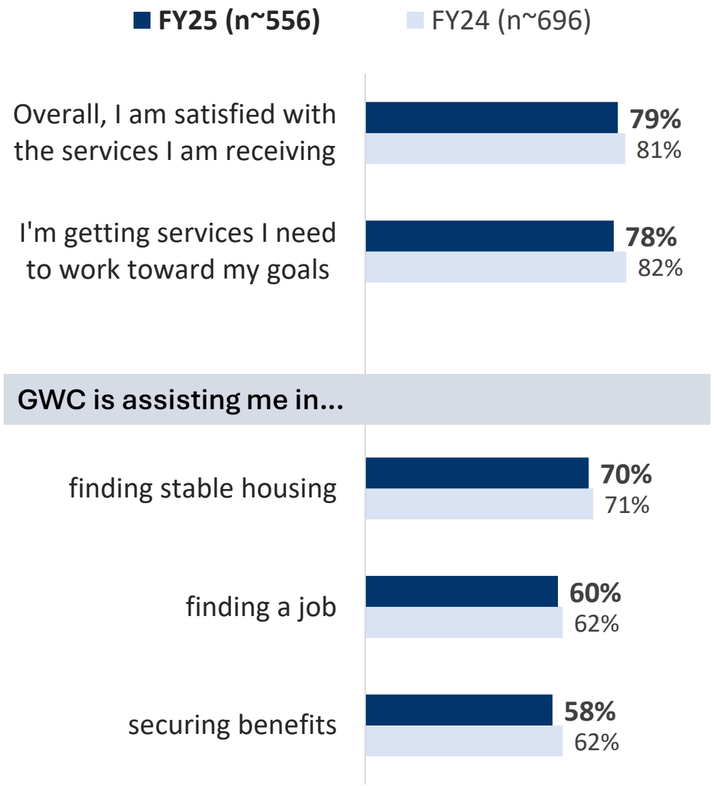
Guest Feedback

605
Total Guest Feedback Surveys Completed[1]

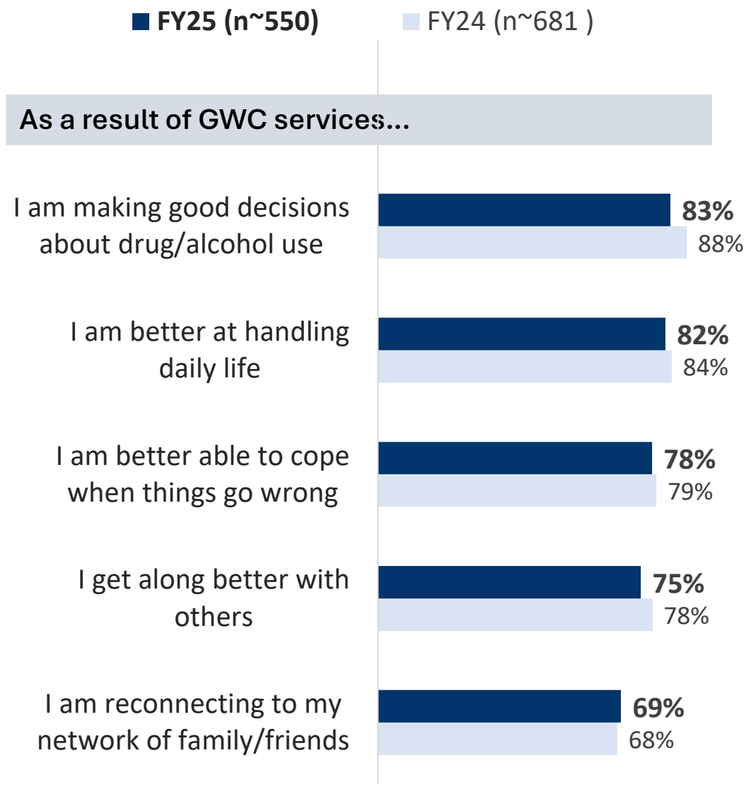
82%
Would Recommend GWC to Others

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

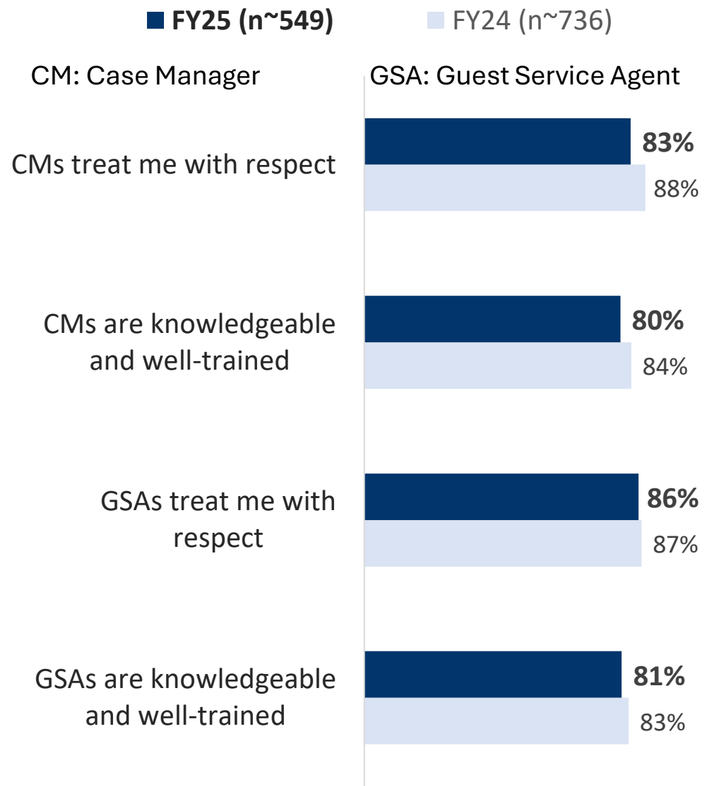
GWC Services



Outcomes



Staff

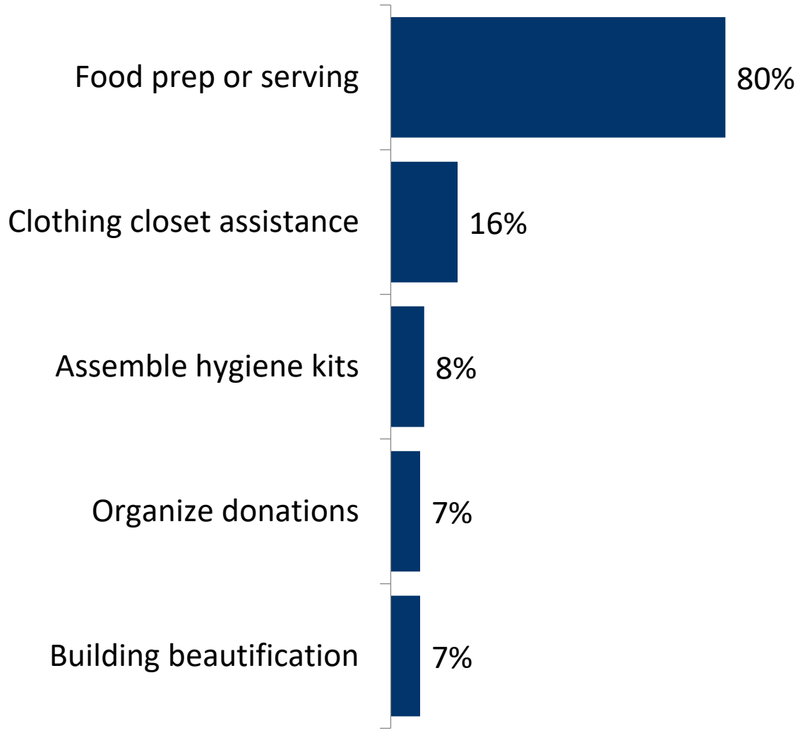


[1] Residential guests completed a survey to provide feedback about services, staff, and personal outcomes. Guests completed this survey anonymously. It is possible that the same guest answered the survey more than once. All surveys are included in the above results.
[2] Each survey question was rated on a scale from 1 = 'Strongly Disagree' to 5 = 'Strongly Agree'.

Volunteer Feedback

7,058	1,631	21,286	61	100%
Total Volunteer Encounters[1]	Volunteers[2]	Volunteer Hours	Volunteers Provided Feedback	Rated Volunteer Experience as 'Excellent' or 'Good'

Activities Performed While Volunteering[3] (n=61)



Volunteers 'Agree or Strongly Agree' (n=56)

98%

- I would recommend this volunteer experience.
- I was engaged in my volunteer experience.
- I enjoyed my volunteer experience.
- My time at GWC made an impact on my life.

96%

- My time at GWC was used efficiently.
- GWC staff were well informed about homelessness, poverty, and justice issues.
- I am more likely to be engaged with issues in the homelessness community.

95%

- I have a greater understanding of homelessness.
- My time at GWC made an impact on the lives of those served by Gateway Center.

Volunteers 'Agree or Strongly Agree' (n=38)

Among those who volunteered through their employer.

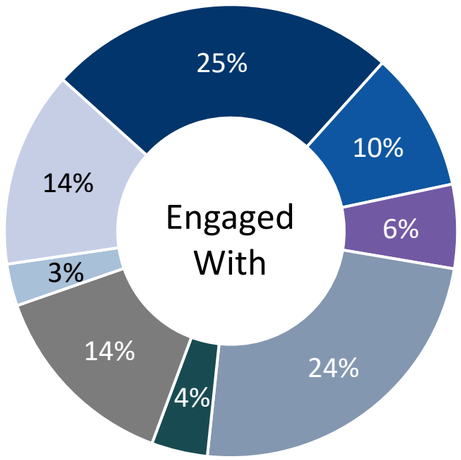
100%

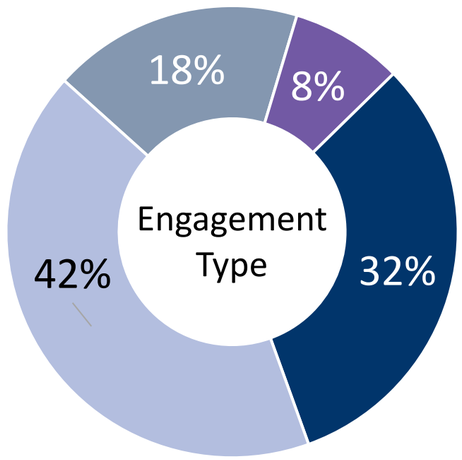
- I enjoyed collaborating with my co-workers outside the walls of my workplace.
- The service opportunity was a good team-building event for me and my fellow employees.
- It is important to me that my workplace culture is supportive of volunteering.
- I am grateful to my employer for this opportunity to serve my community.
- The service event exemplified my employers' desire to participate in serving our community.

[1] Encounters are discrete interactions; these numbers may have duplicates (i.e., a person may have volunteered more than once).
[2] This number is an approximation using volunteer sign-in sheets as well as volunteer appointments with groups that volunteer with Gateway Center on an ongoing basis. Therefore, these numbers may have duplicates (i.e., a person may have volunteered more than once) and are likely to be an underestimation of the total number of volunteers.
[3] Volunteers may have been involved in more than one activity.

Community Engagements

Gateway Center staff led **224** community engagements and interacted with **5,667** individuals through these engagements.





PROGRAM DESCRIPTIONS

Non-Residential Programs & Services

Behavioral Health Services

Provides onsite counseling services via 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 our 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 coaching services and employer linkages to help guests secure sustainable employment.

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 placement options available through the Housing Queue.

Diversion

A strategy to assist individuals and families who could benefit from family reunification, diversion assistance services will assist them in overcoming transportation barriers that have previously prevented reunification.

Non-Residential Programs & Services

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).

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 residential housing (shelter) or permanent housing options.

Navigation Services

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.

Cold Weather Transport

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

GWC Case Managed Residential Programs

Downtown Rising

The Downtown Rising initiative links individuals experiencing homelessness in downtown Atlanta with housing and essential resources, fostering long-term transformation.

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 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

Guests are screened using the VI-SPDAT. Guests are chronically homeless and most guests have 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.

Trinity Women's Shelter (TWC)

Provides low barrier short-term residential housing for women and children experiencing homelessness. TWC provides supportive services that include intensive case management, employment services, behavioral health and substance abuse support, and housing navigation services. The ultimate goal for the guests enrolled in this program is to move into a home they will maintain, breaking the cycle of poverty and homelessness for their families. This program ended 10/31/24.

Upward

Provides residential addiction recovery designed to support men experiencing homelessness 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 maintain their sobriety.

GWC Case Managed Residential Programs for Veterans

Veterans 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 Transitional Housing

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.

Veteran Low Barrier Programs

The two programs below are funded by the Department of Veterans Affairs and are combined in the outcome section of this report labeled as Veterans Low Barrier Shelter. Eligible veterans will be referred to these programs from Fort McPherson.

Veterans Bridge to Housing

Provides veterans with short-term transitional housing that provides temporary shelter for veterans while they are awaiting permanent housing, essentially acting as a bridge between homelessness and stable living.

Veterans Low Demand

These veterans have not been successful in traditional programs and harm reduction strategies are beneficial. For veterans enrolled in this program, there are no requirements to maintain sobriety or to comply with mental health treatment, but supportive services are in place to encourage compliance in both areas.

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 and Northside Hospitals. 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 & Other Partner Programs

Emergency Shelter Programs

Bridge Response Shelter

This program is a collaboration with the City of Atlanta and provides temporary emergency shelter to individuals experiencing homelessness when designated encampments (often below bridges) are closed. Guests receive case management, housing navigation, and rapid rehousing support to ensure a quick transition to stable housing. The program ended 11/30/2024.

Winter Warming Shelter

Provides daytime respite and overnight shelter to individuals when the “feels like” temperature is 40 degrees or below.

Family Shelter

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

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.

gateway center

FY25 Evaluation Report