

Governor's Ten Year Chronic Homelessness Action Plan – **DRAFT**

Introduction

The State of California is committed to the prevention and significant reduction of chronic homelessness. In 2005 Governor Arnold Schwarzenegger launched his Chronic Homeless Initiative which included the creation of an Interagency Council comprised of the leaders of eleven Agencies and Departments with responsibility for housing and services for citizens who are at risk of or already chronically homeless. The Interagency Council initiated the process of a collaboratively developed Ten Year Chronic Homelessness Action Plan and created a Vision Statement and Guiding Principles.

Vision Statement:

California will exercise leadership, vision and innovation to prevent and significantly reduce chronic homelessness.

Guiding Principles:

- 1. California will aggressively pursue strategies to implement this vision through integrated prevention, intervention and support services.**
- 2. The California Chronic Homelessness Initiative will expand access to safe, permanent, affordable housing and coordinated treatment and support services.**
- 3. Actual service delivery is primarily local (public and private) and local input and participation is critical for success in preventing or alleviating homelessness.**
- 4. Results matter. Fund what works.**
- 5. The State must maximize and leverage funding opportunities from all other sources.**

On June 21-23, 2006, a conference was held at the Asilomar Conference Center, Pacific Grove, California that was attended by more than 110 representatives from Federal, State and local governments, non-profit organizations, the private sector and statewide interest groups. From that session came the following five goals which form the basis of California's Ten Year Chronic Homelessness Action Plan:

1. Establish as a statewide priority the prevention and significant reduction of chronic homelessness,
2. Increase the supply of housing affordable for those who are chronically homeless or at-risk of chronic homelessness,
3. Promote early identification of those at-risk of chronic homelessness and establish policies and programs to prevent its occurrence.
4. Enhance the availability, accessibility and integration of support services needed by those who are at-risk or chronically homeless.
5. Promote financial stability of the At-Risk and Chronically Homeless Population.

In addition to the five goals of the Plan, conference participants recommended a number of strategies and action steps to achieve these goals. Not all of those recommendations have been included in the plan at this time as some of the recommendations went beyond the scope and focus of the Chronic Homelessness Initiative, some were not consistent with the Plan's Vision Statement and Guiding Principles, and some were consolidated into other comparable recommendations. Although a number of thoughtful suggestions and recommendations have not been included at this time, it is envisioned that the Plan be viable and responsive to changing circumstances.

Goal 1: Establish As a Statewide Priority the Prevention and Significant Reduction of Chronic Homelessness

Implementation of the State's Ten Year Chronic Homelessness Action Plan will require State leadership, coordination and oversight. The State's role will include enacting state level policy to support solutions to chronic homelessness; advocacy for federal policy and funding to support State efforts; public education to generate broad-based support for this effort; and data collection and analysis to guide policy and program efforts and identify best practice interventions. Much of this work will be carried out through the Interagency Council and by relevant State departments and agencies which will work toward preventing and significantly reducing chronic homelessness as a central goal and will adjust their policies and programs accordingly.

Best Practice Spotlight

Regional Homeless Information Network Opportunity (RHINO)

All 11 Bay Area Counties

Following a Congressional mandate in 2004, communities throughout the country began to implement a Homeless Management Information System (HMIS). As defined by HUD's original mandate, HMIS is a computerized data collection tool designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness.

In response to this mandate, the Continua of Care within the eleven counties of the greater San Francisco and Monterey Bay Area have come together as the Bay Area Counties Homeless Information Collaborative (BACHIC) group to leverage learning and expertise across the multiple communities, and to facilitate the creation of RHINO, a "Regional HMIS" system that brings county HMIS data together for a composite picture of the homeless population and services across the BACHIC region.

The RHINO project, once fully implemented, will:

- enhance collaboration and data collection capabilities
- be a rich repository of information that will provide data utilized to analyze trends, gaps in services, mobility patterns among homeless people, and inform homeless funding and policy
- bring together a consolidated unduplicated picture of homelessness across the region in order to better understand the characteristics and mobility patterns of the homeless population
- identify the prevalence of chronic homelessness across county boundaries
- provide funders of homeless service agencies a better regional picture of the needs of homeless individuals and families, and the ability to better target their investments in housing and homeless services.
- allow for better planning and resource management and an increased ability to address the present and future needs of homeless people in the BACHIC region
- allow public policy makers to address homelessness issues on a regional basis.

STRATEGIES:

Strategy 1.1: Establish policies and procedures to guide and facilitate statewide efforts to prevent and significantly reduce chronic homelessness.

Key to the State's role in advancing the effort to significantly reduce chronic homelessness will be creation of a policy environment that supports the development of effective solutions. This includes advocacy for changes in federal and state policy, regulations and federal funding to better advance efforts to address chronic homelessness, as well as public education and outreach to put a spotlight on the issue of chronic homelessness and galvanize widespread support from the private sector. The State's commitment to preventing and significantly reducing chronic homelessness will be carried out in large part through the State agencies and departments who have contact with this population. As such, in order to make the State's commitment real, these agencies and departments must incorporate this goal into their work by developing outcome measures that monitor their effectiveness in serving people who are chronically homeless or at-risk.

Action Step 1.1.1

Identify chronic homeless and housing related outcome measures and implement measures appropriate for each agency or department function. These measures should include the housing status of clients at intake and exit; homelessness-related services provided, both directly or through referral; and entitlements applied for and received. Measures should be developed to be consistent with and to complement outcomes measures currently in place and required by federal and local governments.

Action Step 1.1.2

Identify and aggressively pursue additional federal housing and services funding.

Action Step 1.1.3

Identify and advocate for the removal of barriers to providing services to the at-risk and chronically homeless population to include changes in policy and regulations to allow integration and blending of funding streams to facilitate the efficient use of resources.

Action Step 1.1.4

Develop a statewide public education campaign to provide information about effective solutions to chronic homelessness.

Action Step 1.1.5

Conduct outreach to the business community, faith-based organizations and community organizations to garner support and resource commitments.

Strategy 1.2: Collect and analyze data on chronic homelessness and client outcomes to monitor implementation of the state action plan and guide ongoing policy and program development.

In order to be most effective, the State's efforts to address chronic homelessness should be grounded in data about the characteristics and needs of this population and about the effectiveness of the policy and program interventions being used. Statewide data collection

will allow tracking of overall progress in substantially reducing chronic homelessness and monitoring of client outcomes and program effectiveness. Based on data analysis, best practices can be identified and disseminated, policy and programs can be adapted to facilitate improved outcomes, cost savings can be redirected to support effective interventions, and data can be used to lobby for changes in policy, programs and funding.

Action Step 1.2.1

Establish a Statewide Data Clearinghouse that collects data on chronic homelessness that:

- can be used to track statewide progress in meeting the goal of preventing and substantially reducing chronic homelessness,
- can identify what portion of the homeless population is comprised of families and advocate that the federal government should include this population in the federal definition of chronically homeless,
- can demonstrate that prevention and other best practices are cost effective,
- can be utilized as a basis for program funding decisions,
- and can monitor program effectiveness and client outcomes.

Action Step 1.2.2

Develop data to demonstrate that prevention and other best practices are cost-effective in ending chronic homelessness.

Action Step 1.2.3

Develop data that can be utilized as a basis for funding decisions regarding successful and cost effective programs.

Goal 2: Increase The Supply of Housing Affordable For Those Who Are Chronically Homeless Or At-Risk Of Chronic Homelessness

First and foremost, what people who are chronically homeless need in order to end their homelessness is housing that is affordable. Housing provides a base of stability and security that is essential to other efforts to resolve health, mental health, addiction and income issues that caused or were exacerbated by their homelessness. Without housing, people continue to cycle from one service to another, without gaining any ground. However, with housing, they have a chance to regroup and heal, and begin to address the complicated issues that left them so vulnerable and marginalized. *Housing First* is an approach to addressing chronic homelessness, which recognizes the importance of housing and thus, works to rapidly re-house people, without requiring that they achieve interim measures such as sobriety or spend extended time in transitional stages or programs. Then, once they are in housing, it works to link them with services and supports to address other needs. For some people, transitional services for a limited time period are all they need, while for others, long-term support through community-based agencies is necessary.

Housing First Is Proven In Its Effectiveness.

An evaluation of New York City's Pathways to Housing program which places homeless people with mental illnesses and addictions directly from the streets into supportive housing found that 88% of the program's tenants remained housed after 5 years.

Tsemberis, S. and Eisenberg, R. "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities". *Psychiatric Services*, pp 487-492, April 2000.

This type of services support linked to permanent housing is a nationally recognized "best practice" in serving people who are chronically homeless or at-risk. Known as *supportive housing*, this *Housing First* strategy has been proven effective at helping people achieve long-term residential stability, health and maximum self-sufficiency. It is also a cost effective approach: *a recent study documents a reduction in service use of \$16,281 per housing unit per year by homeless people with severe mental health disabilities who are placed in supportive housing.*¹

However, in order to implement a *Housing First* approach to addressing chronic homelessness, California must address its severe deficit of housing affordable for those who are chronically homeless or at-risk. It is currently estimated that the state backlog of affordable home production is over 651,000 units.² This problem is even more pronounced for housing affordable to people with extremely low incomes, those whose incomes are less than 30% of the area median, which includes people who are chronically homeless or at-risk. Because their incomes are so low, this housing requires very deep subsidies, and so is not only expensive to build, but very complicated to finance. Effectively addressing this crisis requires State leadership. The State must actively signal

¹ Culhane, Dennis P., Metraux, Stephen and Hadley, Trevor. (2002). Public Service Reductions Associated With Placement of Homeless Persons With Severe Mental Illness in Supportive Housing. *Housing Policy Debate* Vol 13, Issue 1, pp 107-163. Fannie Mae Foundation.

² "Expanding Opportunity: New Resources to Meet California's Housing Needs". A PolicyLink Report for Housing California, Executive Summary, Winter 2005.

through policy and administrative mechanisms that the development of housing for people who are chronically homeless is a priority and foster and support local action to develop new units. The State can also provide leadership in addressing barriers to housing access through education and outreach to landlords, funding for programs that assist with move-in costs, and advocacy for changes in policies that limit access to subsidized housing by needy sub-populations.

Best Practice Spotlight

Supportive Housing Initiative Act (SHIA) – Flexible Funding For Housing Linked With Services California

The Supportive Housing Initiative Act funded housing (leasing and operating costs) for disabled people with low incomes and support services to help them maintain their housing and live independently, including health care; mental health services; drug and alcohol treatment; employment, training and education; life skills and peer support; and housing assistance. SHIA was designed to serve local needs and so proved flexible funding that supported a broad array of housing and service models. Between 2000 and 2003, a total of 46 projects were funded throughout California for approximately \$48.2 million.

Outcomes for program participants include the following:

- Residential stability: 86% maintained stable housing
- Improved Quality of Life: after 6 months, significant improvements in satisfaction reported in general quality of life, daily activities and functioning, family and social relationships, safety, living situation and health
- Increased Income: of those who had no income upon program enrollment, 64% increased their income, and of those who reported only SSI at enrollment, 65% maintained that income and 20% increased it
- Improved Functioning: improvement reported in dealing with daily problems (84%), ability to control their lives (83%), ability to deal with crisis (79%) and dealing in social situations (73%)

STRATEGIES:

Strategy 2.1: Increase the supply of housing for those who are at-risk or chronically homeless through a combination of new development and removing barriers to accessing existing housing units.

Expanding housing opportunity for people who are chronically homeless will require the development of new units to expand supply. This should include low-threshold housing linked to services for those unable to adapt to more structured environments as well as housing to meet the needs of youth transitioning to independence. Also important in the effort to expand housing opportunity for this population are efforts to enhance access to the existing housing supply. Often times, this population, even when they have housing vouchers, is unable to find housing due to reluctance of private sector landlords to rent to people with unattractive tenant profiles,

including poor housing histories, credit problems and indebtedness, low income to rent ratios, and histories of homelessness and/or health problems. In addition, lack of money to pay for security deposits and other move-in costs can pose an insurmountable barrier, and for those people who have a criminal convictions, federal policy prohibiting their access to federally subsidized housing effectively locks them out of the housing market. Addressing these barriers requires a combination of landlord education, funding of programs to assist with one time move-in costs, and changes in housing policy and regulations.

Action Step 2.1.1

Develop a supportive housing program to produce at least 10,000 units utilizing \$75 million annually from the Mental Health Services Act (Proposition 63).

Action Step 2.1.2

Develop low-demand permanent housing options, such as Safe Havens, which offer low-threshold, low structure environments with access to services. Dedicate some units for clients referred by outreach teams.

Action Step 2.1.3

Target housing funds for the development of age-appropriate housing opportunities for transition age youth and those existing foster care.

Action Step 2.1.4

Organize a statewide education and outreach campaign to encourage state affordable housing fund recipients and all landlords to rent to people who are chronically homeless or at-risk, including those who have Section 8 vouchers. Highlight incentive programs; effectiveness of community-based rent guarantee programs and crisis intervention services in helping tenants maintain stability; background on homelessness, mental illness and addiction; and fair housing laws.

Action Step 2.1.5

Provide state and federal funding for local security deposit and rental guarantee programs in order to both eliminate barriers to access caused by one-time move-in costs and address concerns of rental property owners by insuring them against loss from property damage or non-payment of rent.

Action Step 2.1.6

Work with appropriate levels of government to obtain waivers or change regulations to allow greater access to housing for chronically homeless people and those at-risk who are prevented from accessing subsidized housing due to criminal convictions. Target state rental subsidies to meet the housing needs of people who are chronically homeless who are unable to access federally supported units.

Strategy 2.2: Support and foster the creation of more housing for chronically homeless people through state policy and administrative mechanisms.

Given the tremendous costs of chronic homelessness on state-funded systems of care and the State's interest in ensuring that all of its residents have access to adequate housing, the State has an important leadership role to play in promoting and facilitating action by local jurisdictions to develop housing to meet the needs of people who are chronically homeless. This role includes strengthening and enforcing state policy and regulations relating to the planning and development of affordable housing; making appropriate government-owned property available for housing development for this population; providing support and technical assistance to local jurisdictions in reforming zoning and planning processes and supporting local developers in developing housing for this population; and streamlining access to state housing monies in order to help reduce the costs of development.

Action Step 2.2.1

Strengthen Housing Element law to require that local jurisdictions incorporate chronically homeless-related needs and strategies identified in local ten year plans and other homeless planning documents in their Housing Elements. Promote development of permanent affordable housing for people who are chronically homeless in state housing and homeless legislation, regulations and funding streams.

Action Step 2.2.2

Inventory available publicly owned property throughout the State that would be suitable for developing housing for the chronically homeless and make it available to be developed for that housing.

Action Step 2.2.3

Provide support, assistance and incentives to encourage local jurisdictions to make zoning and planning process changes to facilitate and streamline the development of affordable housing for people who are chronically homeless. Provide technical assistance to local jurisdictions and developers and facilitate the development of partnerships and other collaborations in order to enhance capacity for developing housing for people who are chronically homeless or at-risk.

Action Step 2.2.4

Improve access to state funding by consolidating and streamlining funding applications for services, treatment, operations and capital to develop housing and conduct outreach and technical assistance to local jurisdictions about available state housing and services funding and resources.

Goal 3: Promote Early Identification Of Those At-Risk Of Chronic Homelessness And Establish Policies And Programs To Prevent Its Occurrence

The advent of homelessness in someone's life is a devastating crisis that can be deeply damaging, both physically and emotionally. It undermines people's health and mental health and their ability to function and contribute in society. For people with serious health, mental health or substance abuse disabilities, this crisis all too often deteriorates into a chronic condition that only further undermines their health and distances them from the services they need to recover. Such chronic homelessness, involving as it does extended or repeated time periods in which people live marginalized from society and without the stability and security of housing, is generally much more difficult to resolve. In addition, it places a costly burden on public service systems, including hospitals, psych emergency rooms, and the criminal justice system. Given both the individual damage and the high societal costs it wreaks, the most humane and cost-effective strategy for addressing chronic homelessness is *prevention through early identification and intervention*.

The State's public systems have a key role to play in this effort as most people who are chronically homeless or at-risk are in touch at some point or other with at least one of these systems, including the foster care system, the corrections system, hospitals, mental health programs, drug and alcohol treatment facilities, and benefits programs. As such, these programs and systems are in a prime position to be able to identify members of this population and prevent their homelessness through the provision of *discharge planning and transition services*. These services are designed to link people with housing and provide additional support and service linkages to ensure that they are able to maintain health and stability over the long term. Typically, *discharge planning and transition services* are provided in three phases: 1) Pre-Release Phase– comprehensive assessments that identify housing, service and income needs and provision of services while the individual is still in the program or facility; 2) Transition Phase – intensive case management and services to facilitate health, housing stability, and maximum self-sufficiency; and 3) Ongoing / Community Linkage Phase – less intensive services and supports on an as-needed basis and provided through community-based providers.

Also important in the effort to prevent chronic homelessness is supporting community efforts to develop the range of prevention services and supports needed both to address emerging crises so as to avoid housing loss and to rapidly rehouse those already homeless. Key among these are *eviction prevention services and rapid rehousing assistance*.

California already has many effective programs in place that work to prevent chronic homelessness. These proven practices must be replicated and expanded to fully meet the need across the State.

Homelessness Is Expensive!

A study of homeless people with severe mental illnesses found that each used an average of \$40,451 worth of publicly-funded services per year. The majority (86%) of these costs were for health and mental health services.

Culhane, Dennis P., Metraux, Stephen and Hadley, Trevor. (2002). Public Service Reductions Associated With Placement of Homeless Persons With Severe Mental Illness in Supportive Housing. *Housing Policy Debate* Vol 13, Issue 1, pp 107-163. Fannie Mae Foundation.

Best Practice Spotlight

New Directions: Hospital Discharge Planning Targeted at Frequent Users Santa Clara County

New Direction is designed to assist frequent users of hospital emergency rooms to achieve greater health and housing stability and to reduce their use of hospital emergency services. A comprehensive range of discharge and transition planning services are provided to clients through an inter-disciplinary service team using an intensive case management approach and inter-agency case conferencing to effectively coordinate care. Services include housing assistance, benefits advocacy, health care, mental health, drug and alcohol treatment, employment and training, budgeting and other life skills, and transportation assistance.

Evaluation of the New Directions pilot study documented the following outcomes:

- 31 percent reduction in emergency department visits
- 53 percent decrease in inpatient hospital days for clients
- Almost 50 percent reduction in cost of emergency department, inpatient, and outpatient clinic services provided to clients, after just one year of enrollment with greater reductions for clients who completed two years of enrollment.

STRATEGIES:

Strategy 3.1: Establish state policy and guidelines to promote effective discharge and transition planning practices by state-operated, funded and regulated agencies and institutions in order to identify people who are chronically homeless or at-risk of chronic homelessness and intervene to address their housing and service needs.

A significant percentage of people who are chronically homeless or at-risk of chronic homelessness due to ongoing health, mental health and addiction disorders are in contact with public agencies and institutions which provide residential and custodial care, including the corrections system, foster care, hospitals, mental health programs and drug and alcohol treatment facilities. Too often, they are released without adequate discharge and transition planning, ending up on the streets or in emergency shelters. Effective discharge and transition planning by these institutions can identify those at-risk of chronic homelessness upon release and facilitate linkages to housing and other supports needed to avoid homelessness and end costly recycling through these service systems.

Action Step 3.1.1

Establish policy that state-operated, funded and regulated institutions providing custodial and residential care develop and implement effective and appropriate discharge and transition planning practices that promote ongoing residential stability by:

- reviewing existing protocols, procedures, contractual obligations, licensing and accreditation standards, services and funding related to discharge and transition planning,
- making necessary revisions in their policies, regulations, contracts and practices so as to require and enable the development of sustainable and culturally competent discharge and transition planning practices that connect clients to housing, services and income prior to release.

Action Step 3.1.2

Promote and facilitate state level inter-agency and inter-departmental collaboration and coordination with discharge planning and implementation by streamlining the linkage of discharging clients to housing, income and services; creation of financial incentives (cost-sharing, savings sharing, fee for service) to encourage collaboration around discharge planning; co-location of mainstream services at large state institutions to facilitate access to services and benefits; and sharing of data to expedite access to benefits and services.

Action Step 3.1.3

Develop a uniform assessment tool to be used as part of initial intake by all appropriate state-operated, -funded and -regulated programs and facilities to screen for at-risk or chronic homelessness and identify related housing, health and social service needs. The assessment should be a guide to early intervention strategies to prevent chronic homelessness from occurring, whether from loss of housing or upon discharge or program exit, and to facilitate efforts to rapidly rehouse and provide service supports to those who are already chronically homeless. The assessment should be developed to be consistent with and complementary to assessment tools currently in place.

Action Step 3.1.4

Advocate for Federal agencies to develop and implement successful discharge planning practices, including Department of Homeland Security's INS programs, Department of Defense, Veterans Affairs and the Federal Bureau of Prisons.

Strategy 3.2: Facilitate the development of effective discharge planning and transition services to address the housing and service needs of people who are exiting public institutions and programs.

People who exit public institutions providing custodial and residential care often require certain services and support to achieve stability and self-sufficiency. These transition services include comprehensive assessments, case management, housing assistance and linkage with support services, such as health care, mental health, addiction treatment, benefits, and employment and training. Key sub-populations that can benefit from these services include:

Youth exiting foster care and transition age youth exiting other state systems are often at high risk of homelessness. They lack effective family support networks; often have poor educational attainment, limited employment skills, and ineffective social and coping skills; and may suffer from health or mental health problems. Without development of support networks,

education and training in job skills and life skills, and linkage with health and other needed services, they too often end up living on the streets headed towards chronic homelessness. Transition services targeted to this population can help develop the skills they need for ongoing independence and facilitate their becoming productive members of society.

Frequent users of publicly funded systems of care who often cycle repeatedly through these systems, bouncing from homeless shelters to hospitals to jails to treatment programs without ever getting the focused assistance they need to regain health and stability. The result is both continuing human suffering and a huge drain on public tax dollars. Targeting discharge planning and transition services, such as case management and housing assistance, to this frequent user population can help to break this unproductive cycle, resulting both in better client outcomes and more cost-effective use of public service dollars

Action Step 3.2.1

Support transition services for youth exiting foster care and transition-age youth exiting other state systems of care in order to facilitate housing stability and successful independent living.

Action Step 3.2.2

Identify frequent users of the corrections, health care, mental health and drug and alcohol treatment systems and target discharge case management and housing assistance services to this population. These transition services should begin while they are still residents of the system and continue until they achieve housing stability and are linked with community-based support services.

Strategy 3.3: Support efforts by local jurisdictions to provide temporary housing support and other services to prevent chronic homelessness.

Effective prevention of chronic homelessness requires putting in place a range of services and supports at the local level to prevent loss of housing, provide temporary assistance until permanent solutions are arranged, and facilitate rapid rehousing for those already homeless. Many communities are working to establish housing support centers that offer an array of easily accessible prevention and housing advocacy services under one roof. In addition, statewide eviction prevention policies and programs can help to eliminate unnecessary and unfair housing loss.

Action Step 3.3.1

Support local efforts to establish “Housing Support Centers” to provide prevention services and rapid re-housing assistance for those at-risk or chronically homeless.

Action Step 3.3.2

Strengthen enforcement mechanisms for policies restricting predatory evictions and support interventions with chronically homeless people through eviction prevention services linked to landlord-tenant court. Provide education activity about tenant rights in discharge planning and transition services offered by public institutions and programs.

Goal 4: Enhance The Availability, Accessibility And Integration Of Support Services Needed By Those Who Are At-Risk or Chronically Homeless

People who are chronically homeless or at-risk need access to a comprehensive and integrated system of support services in order to be able to exit homelessness and achieve ongoing residential stability, health and wellness, maximum self-sufficiency and community connection. This is a population suffering from health, mental health and addiction disorders, with a significant percentage struggling with co-occurring diagnoses. As such, they typically need access to multiple support services that are linked to their housing and available on an on-going basis.

Ensuring that services are in place to meet the needs of this population requires *expanding community-based service capacity*, in particular for health, mental health and addiction services. These services are part of the community's mainstream services safety net, a system of services established to meet the needs of people with low incomes. However, these mainstream service programs have often failed to successfully serve people who are chronically homeless and at-risk, due in part to failure to accommodate their special needs and situation. As such, it is also vitally important to implement strategies which *enhance access to mainstream services* by this population. Such strategies include streamlining eligibility and documentation requirements, sharing data to expedite applications, facilitating access to specialized services, outstationing efforts such as through regional one stop centers and mobile service units, fast track applications, access to legal assistance, and addressing issues of discrimination and stigma that impede service delivery.

In addition, since this population typically has multiple and concurrent needs for housing and a range of services, strategies to *integrate services at both the system and client levels* are necessary. *Integrated service teams*, composed of staff representing multiple agencies and service systems, have been

Best Practice Spotlight

**Project Coming Home – Outreach & Linkage With Mainstream Services Through Integrated Service Teams
Contra Costa County**

Project Coming Home (PCH) is a multi-agency collaborative effort to providing integrated outreach, treatment, housing and support services to chronically homeless individuals. Outreach teams are composed of a multi-disciplinary staff, use an intensive case management model, and work to rehouse people as quickly as possible. In addition, clients with substance abuse problems have access to dedicated treatment beds. Once in housing, integrated service teams provide ongoing case management and wraparound supports to ensure ongoing health and residential stability. PCH has entered into agreements with the regional VA office creating a fast-track for services and benefits for homeless clients and provides psychological and cognitive assessments through the outreach team psychologist to help document disability for applications for SSI/SSDI benefits.

Since March 2004, the following outcomes have been achieved:

- 160 people have accessed subsidized housing
- 52 people have accessed residential substance abuse treatment
- 50 veterans have begun receiving VA financial benefits
- Almost 100% of the cases submitted for SSI/SSDI disability evaluation have been approved
- Closer working relationships between the outreach team and the county hospital, the mental health department, and various police departments have been forged.

**Integrated Service Teams Are Effective
In Helping Clients Retain
Their Housing And Health.**

A study of two supportive housing projects using integrated service teams found high rates of residential stability, with 81% of clients remaining in their housing for a year and 62% for two years. In addition, after one year, client use of emergency rooms fell by 58%; use of hospital inpatient beds fell by 57%; and use of residential mental health programs disappeared.

Proscio, Tony. (2000). "Supportive Housing and Its Impact on the Public Health Crisis of Homelessness", Corporation for Supportive Housing.

found to be an effective client-level approach for coordinating services and enhancing both quality of care and client outcomes. This integrated service team approach has been effectively used both in outreach teams as well as in supportive housing, where teams are used to provide *wraparound services* linked to the client's housing.

Another important strategy for linking this population with the support services needed to access and maintain housing are *criminal justice diversion programs*. People who are chronically homeless or at-risk are often in contact with the criminal justice system, often for nuisance crimes related to their homelessness and/or to a mental health or substance abuse disorder. Diversion programs work to turn contact with the criminal justice system into an opportunity to address people's underlying needs by linking them with case management and support services to address their homelessness and/or mental health and substance abuse treatment needs.

Best Practice Spotlight

Serial Inebriates Program – Criminal Justice Diversion
San Diego City and County

The Serial Inebriates Program (SIP) is an intervention and treatment program which offers homeless chronic inebriates alcohol treatment and wraparound services with transitional living and permanent housing placement assistance in lieu of jail time with the goal of reducing the number of people cycling through detoxification centers, County jail, local emergency rooms and treatment. SIP is carried out through a collaboration of County, City and non-profit agencies.

Since 2000, the participant outcomes include the following:

- 32% completed treatment
- EMS contacts were reduced 88%
- Emergency room visits decreased 92%
- Hospital costs decreased 80%
- Arrests decreased 58%.

STRATEGIES:

Strategy 4.1: Expand community-based service capacity to support long-term housing stability for those who are at-risk or chronically homeless.

For people who are chronically homeless or at-risk, long-term housing stability depends on access to key services, including health care, mental health and addiction treatment. However, the community-based services on which they depend are under-funded and not able to meet the level of need that exists. Support for these crucial systems is needed so they can expand their capacity and quality of care and play a strong role in ensuring the ongoing housing stability of vulnerable members of the community.

Action Step 4.1.1

Facilitate the development of community-based treatment on demand and dedicated treatment capacity including a continuum of dependency interventions, sobering stations and detox facilities, peer-mentoring services, after-rehabilitation support, family counseling programs, and residential treatment facilities.

Action Step 4.1.2

Increase the scope and timely availability of mental health services, including assessments, counseling, medication management and peer-mentoring. Expand eligibility for services to include at-risk or chronically homeless people who have mental health problems but fall short of a seriously mentally ill diagnosis.

Action Step 4.1.3

Expand the availability and scope of health care treatment for people who are at-risk or chronically homeless with programs at locations such as neighborhood health centers, regional one-stop health centers and mobile service programs. Services should include primary health care, treatment of acute/chronic illnesses and communicable diseases (such as TB and HIV/AIDS), dental services, health education, case management, medications, foot clinics, vision services, pediatric services, and geriatric services.

Action Step 4.1.4

Improve the linking of clients to funding streams that will cover the costs of their services.

Strategy 4.2: Enhance access to state mainstream services by people who are at-risk or chronically homeless.

Despite the fact that mainstream service programs are funded to meet the needs of people with low incomes, they are often unsuccessful in meeting the needs of people who are chronically homeless or at-risk. Due to a variety of factors, including lack of understanding and sensitivity to the special needs of homeless people by staff, complicated and intimidating application and interview procedures, and inaccessible locations, many people who are chronically homeless or at-risk are not accessing services for which they are eligible. Other important barriers include program performance measures that are not calibrated to take into account the complications in serving this population and rules and regulations which prevent access, such as those which block

access to federally subsidized housing by those with a felony conviction or to SSI benefits by people whose disability is primarily due to drug or alcohol addiction. In order to better serve this population and assist them in regaining and maintaining health and residential stability, mainstream programs need to review and adapt their policies and operating procedures to enhance access by people who are chronically homeless or at-risk, such as through streamlining eligibility and documentation requirements, sharing data to expedite applications, facilitating access to specialized services, outstationing efforts such as through regional one stop centers and mobile service units, fast track applications, access to legal assistance, and addressing issues of discrimination and stigma that impede service delivery.

Action Step 4.2.1

Establish a no-wrong door policy for all state operated, funded and regulated programs to ensure that clients seeking services through any one agency have seamless access to the entire system of care and receive case management to provide them with referrals and assistance in accessing services.

Action Step 4.2.2

Identify policy, procedural, structural, cultural and attitudinal barriers to services by people who are at-risk or chronically homeless and develop strategies to enhance access by this population.

Action Step 4.2.3

Improve access to all state programs and services by training staff to assure appropriate interactions between state representatives and members of this population. Training topics can include: homeless sensitivity; services, eligibility requirements and referral protocols for other state programs; and crisis intervention techniques.

Strategy 4.3: Facilitate and improve inter-agency and inter-departmental integration and collaboration at the state level and between the state and local levels to enhance the quality of care for people with multiple needs.

Typically, people who are chronically homeless or at-risk have multiple needs for services that must be integrated across different agencies and service systems. Many have co-occurring mental health and substance abuse disorders. In order to effectively serve this population, services must be coordinated at the system level, through inter-agency and inter-departmental agreements to facilitate joint service provision, development of capacity for inter-agency case management and electronic referrals, and inter-agency blending of funding streams to support integrated service provision. At the same time, client-level service integration must be brought about through integrated service teams composed of staff from multiple agencies and through efforts to co-locate services from multiple agencies in easily accessible locations. Specifically, people who are chronically homeless and those at-risk are often involved with the criminal justice system, often for nuisance violations related to their homelessness, including public inebriation, sleeping in public places, etc. which is a costly and ineffective solution, as too often people cycle through the system repeatedly. A better approach is to divert these individuals from the criminal justice system through linkage with services and outreach teams and use of homeless, mental health and/or drug courts so they can access the services they need and reduce likelihood of future involvement with the

criminal justice system. To support service integration, strategies should be implemented to expand access to services by increasing the services funded by Medi-Cal and the capacity of community-based organizations to provide and bill for these services.

Action Step 4.3.1

Develop the agreements, capacity, systems, policies and integrated funding to allow for inter-agency and inter-departmental service coordination, including inter-agency case management, electronic referrals, client information-sharing, and other strategies to streamline linkage of clients to housing, income and services.

Action Step 4.3.2

Develop strategies for more efficient allocation of resources through integration of funding streams and administrative processes at the state level and by allowing new uses for funds in order to better respond to chronic homelessness. Identify legal and regulatory barriers preventing efficient use of funding and work with the federal Interagency Council on Homelessness and their respective federal agencies to create needed regulatory and policy change.

Action Step 4.3.3

Fund integrated service team models which increase access to services and coordination of services and housing for people who are chronically homeless or at-risk. Outstation state program staff with integrated service teams, at one-stop service centers and as part of other efforts to co-locate and coordinate service provision.

Action Step 4.3.4

Support the expansion of “diversion” programs to reduce the costly involvement of people who are chronically homeless with the criminal justice system for nuisance violations and ensure their access to needed support services.

Action Step 4.3.5

Facilitate the use of Medi-Cal for those at-risk or chronically homeless:

- Evaluate the possibility of a Medi-Cal waiver to include case management and other supportive services.
- Provide technical assistance and training to help community organizations and supportive housing providers develop the capacity to provide and bill for Medi-Cal eligible services.

Goal 5: Promote Financial Stability of the At-Risk and Chronically Homeless Population

Maintaining ongoing housing stability ultimately depends on having access to adequate income to cover housing costs and other basic necessities. Unfortunately, people who are chronically homeless or at-risk often have difficulties in obtaining decent employment because of the lack of opportunities in today's economy, their limited work history and experience, disabilities which interfere with their abilities to work, and reluctance by employers to hire them. However, the combination of *targeted employment and training services and development of customized employment opportunities* has been shown to be effective in helping this population to find and maintain employment. State leadership can help promote this effort by ensuring that a portion of state employment and vocational training resources are targeted to develop specialized programs for people who are chronically homeless or at-risk and by taking state action to encourage private businesses to offer employment opportunities to this population.

Best Practice Spotlight

Hope House – Customized Employment Linked With Housing And Other Support Services San Francisco, California

Hope House provides integrated housing, case management and employment services to chronically homeless people. Employment services are provided through a customized employment model which individualizes the employment relationship to meet the needs of both the job seeker and the employer.

Outcomes achieved as of September 22, 2005:

- 40 people with jobs, 15 full-time and 25 part-time
- Average hourly wage is \$10.39

Some people who are chronically homeless or at-risk are struggling with such serious health, mental health or addiction disabilities that it interferes with their ability to hold employment, and they must depend upon government benefit programs. However, the application processes and requirements for these programs, in particular for accessing Social Security's SSI/SSDI, are so complicated and intimidating that many eligible members of this population do not obtain them. However, when people are provided with assistance in filling out applications, helped to obtain supporting documentation and guided through the interview process, their rates of approval for these programs is much higher. In addition to funding benefits access programs that provide these types of support, the State can also review and revise state level policies to facilitate eligibility for Medi-Cal, and lobby for federal policy changes to improve access to federal benefit programs.

In addition to access to an adequate income stream, ongoing housing stability depends upon good fiscal management, and ideally, upon developing savings to provide a cushion against unexpected emergencies. The State can take action to minimize barriers faced by those with low incomes in accessing banking services and establish standards for representative payee services to protect against abuse. In addition, it can enact legislation providing some degree of amnesty for back taxes and child support, in order to help people get back onto a solid financial footing.

SSI Access Programs Are Effective.

Nationally, only 37% of Social Security disability applications are approved upon initial submission. However, provision of SSI/SSDI outreach and assistance, can result in initial approval rates of 60-95%, without necessity of appeals.

Soar Facts from the SSI/SSDI Outreach, Access and Recovery (SOAR) Website:
<http://www.pathprogram.samhsa.gov/SOAR/about/facts.asp>

STRATEGIES:

Strategy 5.1: Streamline and expand access to federal and state benefits for people who are chronically homeless or at-risk of chronic homelessness.

Many people who are chronically homeless or at-risk and suffering from serious health, mental health or addiction disabilities are potentially eligible for federal and state benefits that provide income and health services. Access to Social Security's SSI/SSDI benefits are particularly important for those with disabilities as the benefit level is high enough to allow people to achieve some measure of residential stability and receipt of SSI/SSDI also results in approval for Medi-Cal health benefits. Helping those who are eligible to access these supports is also beneficial for the State and for local jurisdictions since it gives these individuals an income stream that can support their care, helping to take some of the financial stress off over-burdened public systems of care. As such, strategies which remove barriers to accessing Social Security and other benefit programs make sense for both the individuals and the community at-large. Such strategies include application assistance, streamlining access to identifying documents and other supporting documentation, presumptive eligibility mechanisms and lobbying for needed policy changes and waivers.

Action Step 5.1.1

Support local efforts to help the chronically homeless access SSI/SSDI.

Action Step 5.1.2

Streamline the acquisition of identifying documents such as birth certificates, social security cards, driver's licenses or California State I.D. for people who are chronically homeless or at-risk. Ensure that those discharging from or exiting state institutions have all needed documents.

Action Step 5.1.3

Improve processing of Medi-Cal applications and determination of eligibility. Support local efforts to improve outreach programs to assist those who are at-risk or chronically homeless in completing applications and complying with recertification requirements. Identify best practices and distribute to all counties.

Action Step 5.1.4

Develop and implement strategies to facilitate applications and reinstate federal and state benefits for people who are being released from state custodial care.

Strategy 5.2: Develop targeted education and employment and training services to meet the needs of people who are chronically homeless or at-risk of chronic homelessness.

Although many people who are chronically homeless or at-risk are interested in employment and capable of working, mainstream education, training and employment programs are typically not successful in meeting their needs. They need specialized programs, including customized, transitional and supportive employment, designed to accommodate their needs and barriers. To accomplish this, employment and training resources must be targeted to serving this population and appropriate outcome measures developed that more accurately reflect their employment potential.

Action Step 5.2.1

Utilize a portion of state employment and vocational training resources for chronically homeless people and those at-risk living in supportive housing. Identify funding targeted at specialized employment and training programs, including development of customized, transitional and supportive employment, for people who are chronically homeless or at-risk by state and local employment services providers.

Action Step 5.2.2

The Department of Rehabilitation, in partnership with other state Departments and homeless service providers, will work collaboratively to recommend programs and protocols that would address the needs of those at-risk who are residing in a shelter or facility and homeless, through coordination and leveraging of existing resources. Ensure employment is linked with other supportive services that provide support.

Action Step 5.2.3

Develop integrated education and employment programs (including VA, WIA, EDD, etc.) and make them accessible to people who are at-risk or chronically homeless.

Action Step 5.2.4

Target training and employment services to people who are chronically homeless or at-risk in jails and prisons so that they are able to acquire “certificates of completion” to facilitate employment when they re-enter.

Strategy 5.3: Increase the education and employment opportunities available to people who are chronically homeless or at-risk of chronic homelessness.

Providing adequate employment opportunity to enable people who are chronically homeless or at-risk to enter the labor market requires support from private sector businesses. Offering incentives can help to encourage the hiring and training of this population by private employers.

Action Step 5.3.1

Develop incentives to private business for training and hiring people who are chronically homeless or at-risk, including those who are ex-offenders.

Strategy 5.4: Promote ongoing financial stability and savings opportunities for people who are chronically homeless or at-risk of chronic homelessness.

People with low incomes face barriers in accessing banking services and are often victimized by unscrupulous check cashing and payee services. They need access to secure money management and payee services that will allow them to achieve some measure of financial stability and to develop savings that provides a cushion against future unexpected emergencies. Also important to their getting back on their feet financially is addressing backlogs of unpaid child support and tax payments.

Action Step 5.4.1

Improve access for those at-risk or chronically homeless in securing fiscal management services (such as banking and payee services). Create standards and regulations for payee qualifications.

Action Step 5.4.2

Seek legislation that would reduce outstanding child support penalties and interest (not unpaid principal) for people who are chronically homeless or at-risk.

Action Step 5.4.3

Encourage the Franchise Tax Board to establish a program to enable employed chronically homeless individuals to re-establish themselves in the Tax system, including forgiveness of tax penalties and interest (not unpaid principal).

Conclusion

This Ten-Year Chronic Homelessness Action Plan has set forth the goals, strategies and action steps necessary to work towards its mission of preventing homelessness and shortening the length of time people remain homeless by focusing statewide efforts through an adequately resourced and well-coordinated system of housing, income supports, and collaborative services.