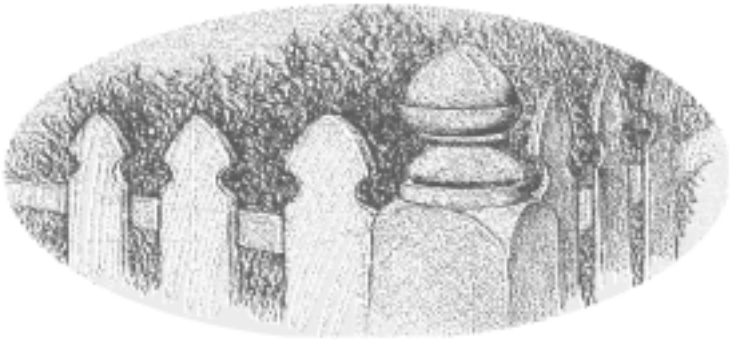
STATE OF GEORGIA

HOMELESS ACTION PLAN TO END HOMELESSNESS IN TEN YEARS



December 2002

GEORGIA DEPARTMENT OF
COMMUNITY AFFAIRS

Laura J. Meadows
COMMISSIONER

December 10, 2002

The Honorable Governor Roy E. Barnes
Office of the Governor
Georgia State Capitol
Atlanta, Georgia 30334-0900

Dear Governor Barnes:

On September 11, 2001 the State of Georgia applied to participate in the nation's first federally sponsored Homeless Policy Academy. The State of Georgia was selected and assembled a team of state officials and nonprofit homeless service providers to develop an action plan for the State to End Homelessness in Ten Years.

The action plan begins with a Vision Statement that states our desire for persons who are homeless to be restored to the mainstream of society. There are six strategic goals and accompanying action steps to guide the State in the realization of this vision. The Georgia Homeless Policy Team also offers our recommendation for "The First Steps" to be taken by the Office of the Governor on this path of human restoration.

The attached report is presented to the Office of the Governor for consideration. On behalf of all the members of the Georgia Homeless Policy Team, we wish to thank you for the opportunity to serve the State of Georgia in this effort.

Sincerely,

Paul D. Bolster
Co-Chair, Homeless Policy Team
St. Joseph's Mercy Care Services

Sincerely,

Terry E. Ball
Co-Chair, Homeless Policy Team
Department of Community Affairs

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December 10, 2002

The Honorable Governor Elect Sonny Perdue
Office of the Governor
Georgia State Capitol
Atlanta, Georgia 30334-0900

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State of Georgia
Homeless Action Plan To End Chronic Homelessness in Ten Years

On September 14, 2001 the State of Georgia submitted an application to participate in the first federally sponsored Policy Academy for State and Local Policymakers on Improving Access to Mainstream Services for Persons Who Are Homeless. The application included a letter from Governor Barnes who pledged his support for the application and expressed his conviction that the multi-disciplinary, public and private sector membership of the policy team would be able to develop state actions plans to address homelessness in Georgia.

The Bush Administration has made ending chronic homelessness in the next decade a top objective of the U.S. Department of Housing and Urban Development (HUD). The Administration has announced that it will continue to sponsor additional homeless policy academies for states that have not yet participated. The Administration has also reactivated the federal Interagency Council on Homelessness after a six year lapse and recently announced the proposed pooling of $35 million in new federal dollars to provide supportive housing and critical services to States implementing plans developed through the homeless policy academies.

The contents of this report outline the goals and action steps that the Georgia policy team believes will enable the State to fully access the federal resources that will be necessary to end chronic homelessness in Georgia in the next decade. The goals are lofty, the action steps ambitious and the resources needed to accomplish these objectives will require the allocation of scarce additional state funding.

The heart of this proposal is, however, quite simple. A relatively small number of all the individuals who are homeless are unable find their way back to a stable life. They suffer from physical and mental illnesses, alcoholism and drug addictions. They are homeless for extended periods of time, interrupted only by short confinements in public hospitals, jails and mental health institutions. These individuals are often referred to as “chronically” homeless. Institutional care at hospitals, jails and treatment facilities carries a very high, largely uncompensated cost to the State. Using national models we have estimated that 1,600 chronically homeless individuals are living on the streets of Georgia.

There is a solution that has proven to work in other States. Supportive housing that is affordable to the individual combined with services that are available to meet his or her ongoing supportive living needs. One will not work without the other. Housing without appropriate services, or services without stable, secure housing is doomed to fail.

The national leader in the provision of supportive housing is The Corporation for Supportive Housing. The Corporation has developed partnerships and programs throughout the nation, including a limited demonstration program in Georgia during 1995-1998 period. Three reports published by the Corporation for Supportive Housing (see appendix for copies of the studies) document the experiences of supportive housing initiatives in New York City, San Francisco and the State of Connecticut. All three studies report that individuals participating in the program experienced decreased utilization of restrictive and expensive health services, decreased hospitalization, decreased incarceration, decreased incidents of homelessness and increased residential stability by the program participants.

A report presented to the California State Legislature by the California Health and Human Services Agency in May 2002 on the evaluation of the Community Mental Health Treatment Program reported that significant savings to the State was achieved through a three-site pilot program. The state funded program combined supportive housing with outreach programs, mental health services, medications, substance abuse services and vocational rehabilitation. The study evaluated the 4,720 individuals who participated in the program over a twelve-month period. The evaluation reported:

66% decline in hospitalization
82% decline in incarceration
79% decline in homelessness
169% increase in employment

Most impressive was the reported $23 million dollar calculated savings to the State from decreased hospitalization and incarceration. The study did not include potential savings from other public funded systems of care such as shelters and substance abuse treatment facilities. (The full report is included in the appendix)

There are few examples of supportive housing and service program in Georgia. One of the facilities is the Welcome House Residence. The following story about Kenneth C. bears witness to the success of this model.

Kenneth C. is a resident of Welcome House on Memorial Drive just four blocks from the State Capitol. Kenneth lives in a supportive housing facility and has achieved a level of independence and self-sufficiency previously thought unattainable. Kenneth spent five years of his youth in Georgia Mental Health Institute. As an adult, Kenneth lived a transitory lifestyle, staying with friends for brief periods and on his own for other periods when he could maintain some form of steady employment. His continuous bouts of depression and repeated suicide attempts resulted in 58 separate admissions to Georgia Regional Hospital for treatment.

As with many individuals haunted by untreated mental illnesses, Kenneth turned to alcohol in his own attempts to cope with life. When he could no longer stay with friends he lived on the streets and the City of Atlanta public parks for five years. Life on the streets as a homeless, mentally ill individual with only alcohol and drugs to provide any sense of relief is a life of isolation, degradation and despair.

At his last stay at Georgia Regional Hospital, Kenneth was assigned a caseworker from Community Friendship, Inc. Upon his release from Georgia Regional Hospital, the caseworker was able to get Kenneth admitted into a Shelter Plus Care housing unit at Welcome House. Kenneth has his own place to live. Kenneth participates in the Twelve Step Recovery Programs offered at the facility. Through his Community Friendship caseworker Kenneth has been able to receive assistance from the Meals on Wheels Program and in-home nursing care services because of the advance stages of his Diabetes and Burgeons Disease.

Kenneth is no longer homeless. He has his own apartment and is responsible for his own well being. While he will likely require some supportive services for the rest of his life, Kenneth will never have to live on the streets again, or go to jail, or be admitted Georgia Regional Hospital for the 59th time.

It is obvious that supportive housing has worked for Kenneth C. What are also obvious are the potential public cost savings that can be realized through this approach. Kenneth's monthly rent at Welcome House is $375, of which he pays $159 from his social security disability benefits. The federally funded Shelter Plus Care Program pays the difference, $216 a month, or $7.20 a night. In comparison:

- The daily adult rate at the Atlanta Regional Hospital is $287;
- The daily rate at the Grady Psychiatric Ward is $630;
- The daily rate at the City of Atlanta Jail is $54.

The federal homeless policy academies and the Bush Administration initiative to end chronic homelessness in the next decade are based on a model that promotes four principles:

(a) Plan for Outcomes – collect the data necessary to measure and evaluate successful outcomes;
(b) Close the Front Door – develop policies for discharge planning from public institutions that connect individuals with housing and services;
(c) Open the Back Door – construct supportive housing with critical services for the chronically homeless; and
(d) Build the Infrastructure – recognize that for most individuals, eliminating the threat of homelessness is a function of affordable housing, adequate incomes and available services.

The Action Plan for the State of Georgia is based on these principles. It is our belief that individuals, like Kenneth C., who are chronically homeless can be housed and provided appropriate services at costs significantly less than the public is now incurring for their periodic institutional care. Our Goals and recommended Action Steps propose a broad, inter-departmental strategy to address needs, provide housing and services and measure the fiscal impact of these programs.

Intuitively, the State of Georgia ought to be able to realize an overall cost savings from this approach; however, it unclear how much cost savings could be realized, in which areas, and at what initial start-up cost. The members of the State of Georgia Homeless Policy Academy Team recommends that the first step in the implementation of the following Action Plan should be a thorough review of the costs and benefits of the limited number of current supportive housing sites in Georgia.

Instead of asking for the allocation of additional state funding on the hope and expectation that the overall cost savings experiences from New York, Connecticut and California can be realized in Georgia, we are proposing that we look at our own limited experiences first. We are confident that the measures proposed in the following Action Plan can end chronic homelessness in our State and can be accomplished at an overall savings level to the State. The evaluation of our own experiences will ensure that when a recommendation is presented for additional state appropriations for one program that we will also be able to demonstrate where the State can expect to achieve corresponding cost savings in other areas.

The First Steps
Homeless Action Plan To End Chronic Homelessness in Ten Years

1. Assign the Office of Planning and Budget the responsibility to conduct a cost / benefit analysis of the current supportive housing programs in Georgia and prepare a projection of the overall costs and benefits of implementing the Ten Year Homeless Action Plan.

2. Re-affirm the functions of the Georgia Interagency Homeless Coordination Council by Governor's Executive Order. The Council should be directed to complete the following tasks by June 30, 2003.

   - The Georgia Interagency Homeless Coordination Council should continue to be co-chaired by the Department of Human Resources and the Department of Community Affairs and should be composed of representatives from the various state departments and other homeless coordination service agencies.

   - The Council should be directed to pursue all available federal funding to support the implementation of the Georgia Action Plan, including the proposed $35 million federal pool of funds to be made available through the federal Homeless Interagency Coordination Council.

   - Ensure that the Office of Planning and Budget has access to all necessary program information and reports to conduct the cost / benefit analysis of the current supportive housing programs in Georgia.

   - Review and recommend measures to improve access to state administered Mainstream Service Programs (Medicaid, TANF, SSI, CHIP, Workforce Investment Act, Food Stamps and Veteran's Health Care and Benefits) by homeless individuals and families.

   - Review and recommend measures to establish State policies that require affected agencies to assure appropriate housing and community treatment for individuals with disabilities discharged from institutional settings.

   - Review the State of Georgia Homeless Action Plan to End Chronic Homelessness in 10 Years and present recommendations on the implementation strategy.

3. Direct the Commissioner's of DHR, DCA and DCH to reconvene the members of the Georgia Homeless Policy Team by June 30, 2003 to review the results of the cost / benefit analysis conducted by the Office of Planning and Budget and the actions of the Georgia Interagency Homeless Coordination Council.

State of Georgia Homeless Policy Team Vision Statement

Homeless persons have increased their independence and been restored to the mainstream of society because state and local resources have ensured optimal opportunities through the creation of an integrated and seamless system of quality services. As a result of these actions, the State of Georgia will have the resources to end chronic homelessness within ten years.

To accomplish this vision the State of Georgia Homeless Policy Team offers the following six goals and accompanying activities as a Plan of Action.

Goal One: Expand access to and use of the federal mainstream support service programs by the chronically homeless. The federal mainstream service programs are Medicaid, TANF, SSI, CHIP, Workforce Investment Act, Food Stamps, and Veterans Health Care and Benefits.

Action Step 1.1

Utilize the recently authorized 75 Medicaid Eligibility Workers to expand their scope of work to include Social Security eligibility and other mainstream entitlements.

- **Schedule a technical assistance visit from the Maryland Demonstration SSI Eligibility Program to develop implementation and training programs for Georgia.**
- **Provide training for the 45 Medicaid Eligibility Workers at the existing Community Service Board sites to begin screening and eligibility preparation for Social Security benefits.**
- **Explore the assignment of the 45 Medicaid Eligibility Workers at homeless service centers on "out station days".**
- **Utilize the 30 vacant eligibility worker slots at positions in the field including at major homeless service centers and shelter facilities, local and state correctional institutions, and indigent care trust hospitals.**
- **Identify sources of the fifty (50%) matching funds required for the 30 vacant Medicaid Eligibility Workers slots.**

Action Step 1.2

Review existing protocols for determination of benefits through existing mainstream services programs and develop universal, easy-to-use, web-based accessible, eligibility determination programs for in-take workers.

- **Examine the State Portal Project to determine the feasibility of adding intake eligibility for Medicaid and SSI to the scope of functions.**
- **Review present DHR SUCCESS project on TANF and Food Stamp eligibility qualification to determine the applicability of the project to also determine eligibility for Medicaid, SSI and other mainstream programs.**

Action Step 1.3

Recommend measures to improve access to Mainstream Service Programs by homeless individuals and families.

- **Review federal guidelines on improving homeless access to mainstream services for applicability to the State of Georgia.**

- **Review the Pathways Compass Homeless Management Information System (HMIS) to establish mainstream service eligibility factors as a basic component of the general in-intake processing fields.**

- **Assign the Georgia Homeless Interagency Council the responsibility to conduct a critical pathway study for access to basic homeless services.**
  1. **Outline the steps involved for admissions by a homeless individual to a mental health crisis treatment center.**
  2. **Outline the steps involved for admissions by a homeless individual to an alcohol or drug abuse treatment center.**
  3. **Outline the steps involved for admissions by a homeless individual to Shelter Plus Care residential housing program.**
  4. **Outline the steps involved for admissions by a homeless individual to community or public health program.**

Goal Two: Provide housing for chronically homeless individuals and families that is both affordable and appropriate for the delivery of supportive services and that fosters a transition or placement into permanent supportive housing.

Action Step 2.1

Execute a Memorandum of Agreement between key state agencies (DHR/DCH/DCA) that: 1) identifies common policies and principles; 2) establishes an annual production goal for creation of permanent supportive housing units; and 3) assigns evaluation responsibilities to OPB.

- **Prepare draft Memorandum of Agreement outlining responsibilities and annual production goals.**

- **Establish a standard template outlining costs of development, operation and delivery of supportive services for the proposed supportive housing units.**

Action Step 2.2

Establish a contractual coordination obligation between the network of DCA funded transitional housing and emergency homeless shelter programs with other state and federal funded homeless supportive service programs. Examples include Assertive Community Treatment (ACT) Teams and Community Courts.

- **Review existing directory of transitional housing providers and emergency shelter providers funded by the Georgia Department of Community Affairs and the Georgia Department of Corrections.**

- **Establish protocols and formal contractual agreements for the referral of homeless consumers of public services at state funded institutions (including public hospitals, prisons and regional mental health facilities) and state funded nonprofit organizations providing shelter and services for homeless individuals.**

- **Establish and provide training programs for staff and volunteers at transitional housing and emergency shelter providers that will work with individuals enrolled in community supportive service programs.**

Goal Three: Develop and adopt state policies to end the discharge of institutionalized individuals directly to homeless facilities unprepared and unable to meet the supportive service needs of the individual.

Action Step 3.1

Establish State policies that require affected agencies to assure appropriate housing and community treatment for individuals with disabilities discharged from institutional settings in compliance with the *Olmstead* U.S. Supreme Court ruling.

- **Assign OPB the responsibility to oversee the development of appropriate discharge planning guidelines by affected state agencies.**

- **Assign the relevant state agencies the task of enumerating both the existing census of institutionalized residents that should be offered services in community settings consistent with the *Olmstead* decision and the number of individuals "at-risk" of institutionalization due to inadequate or an insufficient inventory of community supportive housing.**

- **Require that OPB and the designated advisory groups named in the Governor's Executive Order to oversee the State's efforts to address *Olmstead* include consideration of institutional discharge procedures and availability of community supportive housing in their oversight.**

Action Step 3.2

Develop homeless recuperative centers for post-hospitalization discharge of homeless individuals with immediate primary care health needs.

- **Assign the Department of Community Health the responsibility to prepare a report that identifies the estimated need for post-hospitalization homeless facilities by community and the potential savings to the State.**

- **Require that Indigent Care Hospital Plan participants address the need for homeless post-hospitalization facilities and the use of funds to support homeless health care initiatives in the Indigent Care Trust Fund Plans submitted to the Department of Community Health.**

- **Issue a joint Request for Proposals (RFP) by the Georgia Department of Community Health and the Georgia Department of Community Affairs to support the replication of the J. C. Lewis Homeless Health Care Project of Savannah in other communities with local public safety net hospitals.**

Goal Four: Develop a local collaborative planning model of how integrated housing and homeless service delivery strategies can be implemented at the community level based on the Savannah-Chatham County Behavioral Health Collaborative Model.

Action Step 4.1

Prepare a model outline for the creation of a community collaborative including the identification of critical collaborative partners. Typical collaborative partners would include nonprofit homeless shelter and transitional housing providers, community Indigent Care Trust Fund hospitals, DHR Mental Health, Developmentally Disabled and Addictive Disorders Program Staff, community treatment court staff, local housing authorities, and local public and private mental health and substance abuse treatment providers.

Action Step 4.2

Prepare a model outline for outcome based measurements for program evaluation. Outcome measurements could include: (a) tracking the reduction in homeless incidents of admissions to hospitals, jails, and crisis treatment facilities; (b) measuring the decrease in the length of stay at these facilities; and (c) monitoring the decrease in the period of homelessness by individuals receiving services through a collaborative model program.

Action Step 4.3

Develop and conduct training workshops for other communities to promote the replication of community integrated homeless supportive service programs with supportive housing programs.

Action Step 4.4

Develop a recognition process to reward communities that have implemented a local collaborative planning in the future award of homeless assistance funding, including the placement of eligibility case workers, the selection of supportive housing developments and the awarding of post-hospitalization recuperative center funding.

Goal Five: Engagement of the State leadership (Department Heads, Legislature and Governor's Office) in the adoption of strategies, allocation of resources and the implementation of the recommendations of this report.

Action Step 5.1

Present recommendations of the Policy Team to the Governor's Office for adoption and implementation.

- **Preview the recommendations of the Policy Team with the Commissioner's of the Department of Human Resources, Department of Community Affairs and the Department of Community Health.**

- **Develop an implementation support strategy that would identify the expected public and private support for the adoption of the recommendations by the Governor and the recommendation for the identification of additional homeless support funds.**

Action Step 5.2

Re-affirm the functions of the Georgia Interagency Homeless Coordination Council by Governor's Executive Order.

- **Develop an outline of the proposed responsibilities, duties and membership of the Interagency Council.**

- **Direct the Commissioners of DHR and DCA to provide oversight for the Georgia Homeless Interagency Coordination Council and appoint members, delegate responsibilities, and assign initial tasks.**

Action Step 5.3

Develop a comprehensive, statewide, homeless data collection and analysis reporting capacity.

- **Conduct an analysis on the existing methodologies that are used to report on housing and services provided to homeless individuals. The review should include database systems maintained through the homeless Pathways Community, Inc. network, the local and state homeless Continuum of Care Plans, the U.S. Veterans Administration, the Georgia Department Corrections, and the various systems with the Georgia Department of Human Resources.**

- **Prepare a model for the aggregation of all the available data reports and assign the Georgia Interagency Council the responsibility to issue an annual Georgia Homeless Status Report.**

Action Step 5.4

Assign the Office of Planning and Budget the responsibility for developing a cost – benefit evaluation program to measure the impact of implementing the recommendations of the report.

- **Review the evaluation models used by the Corporation for Supportive Housing and the State of California and make modifications to establish an evaluation program for the State of Georgia.**

- **Secure written authorization from the various state and local governments necessary to identify and report homeless services and costs for program participants over a three-year review period.**

- **Develop a report projecting the cost of providing 1,600 units of permanent supportive housing target for the chronic homeless in comparison to the cost of continuing to treat the chronic homeless in the state public institutions (jails, prisons, hospitals, detoxification centers and crisis centers).**

Goal Six: Take the necessary actions to fully utilize the available federal and other funds available to address the needs of the homeless and to meet the goal of ending chronic homelessness in ten years.

- **Increase the financial capacity of the State Housing Trust Fund for the Homeless to support the development of 1,600 units of permanent supportive housing in ten years.**

- **Identify resources to provide the fifty- percent (50%) match associated with 15 of the 30 vacant slots for the Medicaid eligibility case workers and to establish case management teams to provide community support services directly to 750 chronically homeless individuals.**

- **Identify resources to continue the Department of Community Health development of homeless recuperative centers for post-hospitalization discharge of homeless individuals with immediate primary care health needs.**

- **Challenge local and state public housing authorities to award project based Section 8 Rental Assistance to developments providing supportive housing units in the State.**

- **Challenge local and state HUD Homeless Continuum of Care Plans to propose Shelter Plus Care applications that will provide rental assistance support to developments proposing supportive housing units in the State.**

- **Aggressively pursue all available funding through the federal homeless assistance programs including the HUD McKinney Homeless Supportive Housing Programs, the HUD Section 8 Rental Assistance Programs and the mainstream service programs administered by the U. S. Department of Health and Human Services (HHS) and the U. S. Veteran's Administration.**

- **Aggressively pursue funding partnerships with the private sector engaged in providing support for the nonprofit, faith-based homeless service community. Such partnerships shall include Homeward, Inc. of Atlanta, the Affordable Housing Program of the Federal Home Loan Bank, and the HomeAid America Program with the National Homebuilders Association.**

Appendices

1. **State of Georgia Policy Academy Team Members**

2. **Reports published by the Corporation for Supportive Housing**

   - **Impact of Supportive Housing for Homeless Persons with Severe Mental Illness: The New York / New York Initiative.**
   - **Supportive Housing and Its Impact on the Public Health Crisis of Homelessness.**
   - **Executive Summary, Connecticut Supportive Housing Demonstration Program.**
   - **Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness, State of California Health and Human Service Agency.**

3. **Characteristics of the Homeless Populations**

4. **Calculation of the Need and the Cost of Permanent Supportive Housing in Georgia**

5. **A Plan: Not a Dream. How to End Homelessness in Ten Years. The National Alliance to End Homelessness.**

6. **State of Georgia Application to participate in the Policy Academy.**

Georgia Department of Community Affairs

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If you are disabled and would like to receive this publication in an alternative format, please contact the Georgia Department of Community Affairs at 404.679.4915 or 1.800.736.1155 (TDD).

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The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals

A Summary of:

The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York/ New York Initiative Conducted by Dennis P. Culhane, Stephen Metraux and Trevor Hadley Center for Mental Health Policy and Services Research, University of Pennsylvania

Corporation for Supportive Housing

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Forthcoming in Housing Policy Debate, a journal of the Fannie Mae Foundation

Study facilitated by the Corporation for Supportive Housing

Funded by the Fannie Mae Foundation, the United Hospital Fund of New York, the Conrad N. Hilton Foundation, the Rhodebeck Charitable Trust, and the Corporation for Supportive Housing

Summary written by Ted Houghton
for the Corporation for Supportive Housing

May 2001

The Author

Ted Houghton is a consultant to nonprofit organizations working in homelessness, employment, and related human services. Previously, he oversaw housing placement and helped to develop policy at the New York City Department of Homeless Services and at the Coalition for the Homeless. He also works in music and film.

The Corporation for Supportive Housing

Founded in 1991, the Corporation for Supportive Housing (CSH) is a national financial and technical assistance intermediary dedicated to helping nonprofit organizations develop and operate service-enriched permanent housing for homeless and at-risk families and individuals with special needs, including mental illness, HIV/AIDS and substance use issues. CSH currently carries out its programs in eight states and localities with offices in: California, Connecticut, Illinois, Michigan, Minnesota, New Jersey, New York, and Ohio. As a local intermediary, CSH convenes community-based stakeholders, brings relevant research and data to the table, works with networks of providers and government from planning through implementation and makes grants and loans. Its goals are to expand the supply of supportive housing, build new constituencies and local capacity for reform, help networks take advantage of funding opportunities, and provide assessment of the efficacy of new initiatives.

I. Introduction

A research team from the Center for Mental Health Policy and Services Research, University of Pennsylvania, has published the most comprehensive study to date on the effects of homelessness and service-enriched housing on mentally ill individuals' use of publicly funded services. Five years in the making, the study measures for the first time the full extent of homeless mentally ill individuals' dependence on an array of publicly funded emergency service systems. The study also ascertains the degree to which this dependence is reduced by placement into service-enriched housing. And by comparing precise measurements of the cost of the service use to that of the housing, the study has determined exactly how much the public saves by placing homeless mentally ill people into service-enriched housing, and how little this housing ultimately costs.

The study tracked 4,679 homeless people with psychiatric disabilities who were placed into service-enriched housing created by the 1990 New York/New York Agreement to House Homeless Mentally Ill Individuals, a joint initiative between New York City and New York State that created and continues to maintain 3,615 units of affordable housing supported with clinical and social services. The researchers first examined these individuals' use of emergency shelters, psychiatric hospitals, medical services, prisons and jails in the two years before and in the two years after they were placed into the housing. They then compared their service use in these two time periods to the service use of control groups of homeless individuals with similar characteristics who had not been placed into NY/NY housing. Collaborating with eight different government agencies, the researchers were able to establish the cost of each type of service use, as well as the cost of constructing, operating and providing services in NY/NY housing. The researchers completed the study by comparing these costs and savings to determine the true cost to the public of providing service-enriched housing to homeless mentally ill individuals.

II. Key Findings

The study found that:

- A homeless mentally ill person in New York City uses an average of $40,449 of publicly funded services over the course of a year.*
- Once placed into service-enriched housing, a homeless mentally ill individual reduces his or her use of publicly funded services by an average of $12,145 per year.

* All figures are stated in 1999 dollars.

- Accounting for the natural turnover that occurs as some of the residents move out of service-enriched housing, these service reduction savings translate into $16,282 per year for each unit of housing constructed.
- The reduction in service use pays for 95% of the costs of building, operating and providing services in supportive housing, and 90% of the costs of all types of service-enriched housing in New York City.

Closely examining these service reductions in detail, the study also found that:

- $14,413 of the service reduction savings resulted from a 33% decrease in the use of medical and mental health services directly attributable to service-enriched housing.
- Much of these savings resulted from NY/NY residents' experiencing fewer and shorter hospitalizations in state psychiatric centers, with the average individual's hospital use declining 49% for every housing unit constructed.
- On average, shelter use decreased by over 60%, saving an additional $3,779 a year for each housing unit constructed.
- The cost of supportive housing, the most common model of NY/NY housing, was considerably less than that of other models created by the initiative, requiring an annual outlay of just $995 per unit.

III. NY/NY Housing

The study used as its initial data set the 4,679 individuals who had been placed into housing created by the New York/New York Agreement to House Homeless Mentally Ill Individuals in the period between July 1, 1989 and June 30, 1997. The NY/NY Agreement was the most visible and significant attempt to alleviate the enormous increase in demand for emergency shelter and psychiatric treatment services that had occurred in New York City over the previous ten years. The original Agreement was signed by representatives of the city and state governments in 1990, although the term of the Agreement was backdated by a year to account for housing development that had already been initiated by both sides while negotiations were still under way.

Working with over 50 nonprofit groups in all five boroughs of New York City, the state and city governments created 3,615 units of service-enriched housing for homeless mentally ill individuals over a nine-year period. The NY/NY Agreement funded the construction of 3,092 units of both permanent and transitional housing models with different levels of clinical and social

services, as well as 523 rental subsidies in existing housing. Permanent housing models included *supportive single room residences*, or *supportive SROs*, and scattered-site *supportive housing* apartments, all of which offered voluntary on-site or community-based case management, clinical and social services; as well as 18-month transitional housing programs licensed by the State Office of Mental Health called *community residences* that provide more intensive, mandated clinical and rehabilitative services. A licensed hybrid model called the *CR/SRO* provides single room apartments in permanent housing with a higher level of on-site mandated services than that found in the supportive SRO model, while at the same time offering more independence than what is usually found in the community residences.

In order to be eligible for NY/NY housing, residents must have a diagnosis of severe and persistent mental illness, defined as schizophrenia, major depression or bipolar disorder. Residents must also have spent a recent period of time homeless in municipal shelters or on the street.

IV. Comparison of Service Use Before and After Housing Placement

The researchers relied on data that had already been collected by the government agencies that provide the majority of specialized services to homeless mentally ill individuals, beginning with data on the 4,679 individuals placed into NY/NY housing collected by the New York City Human Resources Administration (HRA) Office of Health and Mental Health Services. These data were merged with other administrative data collected by seven other government agencies. The researchers then compared the service use records of the 4,679 individuals in the two years before they were placed into NY/NY housing, when they were homeless, to their records of service use in the two years after they had been placed into housing. This comparison recorded the effect only of the placement into NY/NY housing; the actual length of stay of each individual placement is unknown, as is whether, upon moving, the individual retained stable housing. Data from HRA shows that over 70% of the individuals placed remain in NY/NY housing after one year, and that the average length of stay is 17.9 months over two years.

Reviewing the service use records of the 4,679 individuals during the two years before and the two years after their placements into NY/NY housing, the researchers observed sharp reductions in the individuals' use of an array of services. The study found that after the homeless mentally ill individuals were placed into NY/NY housing:

- Use of emergency shelters dropped 85%, from an average of 68.5 days per year per person, to less than 10 days per year.

- Use of state psychiatric centers decreased 60%, from an average of 28.6 days per year per person before placement into housing, to less than 12 days after the placement.
- Use of publicly funded acute hospitals, for both psychiatric and medical treatment, dropped from 8.25 days to just 1.65 days per person per year.
- Hospitalization in Veterans Administration and private voluntary hospitals also dropped after placement into housing, by 59% and 39.9%, respectively.
- Use of Medicaid-reimbursed outpatient services almost doubled as a result of housing placement, from an average of 31.1 days per person per year to 60.8 days annually.
- Use of state prisons and city jails, while involving only a small portion of those placed into NY/NY housing, both dropped precipitously, by 74% and 40%, respectively.

V. Reductions Analyzed and Adjusted with Control Groups and Regression Analysis

While these results document real reductions experienced by actual individuals, not all of the reductions in service use can be attributed solely to placement into NY/NY housing. To obtain a more accurate, more conservative estimate of the effect of the housing placements, the researchers constructed a control group of homeless shelter users with similar characteristics to those placed who for one reason or another did not move into NY/NY housing.

Each individual who was placed into NY/NY housing was matched to an individual from the control group on the basis of three factors. First, they were paired on the basis of demographic similarities, matching gender and race, as well as ensuring that ages were within five years of each other. Secondly, they were matched on the basis of having similar mental illness and substance abuse diagnoses. Finally, the matched pairs were also required to have similar patterns of service use in the two-year period in which they were both homeless.

By comparing the changes in service use that occurred among the NY/NY residents before and after housing placement to changes in service use experienced by the individuals in the control groups, the researchers were able to estimate the portion of the reductions that can be ascribed solely to NY/NY housing. Even after accounting for service reductions unrelated

to the housing, these adjusted reductions follow a similar pattern to the raw reductions enumerated above, with some changes. The researchers found that:

- Placement into NY/NY housing is alone responsible for reducing emergency shelter use by 60%, from an average of 68.5 days per person per year to 27 days per person per year.
- NY/NY housing alone reduces use of state psychiatric centers by 50%, from an average of 28.6 days per person per year to 14.5 days per person per year.
- Adjusted reductions in the use of publicly funded hospitals were considerably more modest than actual reductions, but still substantial, showing a 21% drop due to housing placement.
- Adjusted reductions of both voluntary and Veterans hospital use were 24%.
- Adjusted use of outpatient services showed a 75% increase attributable solely to housing placement.
- Adjusted use of jails remained virtually the same as the raw reductions, with a 38% reduction, while state prison use declined further when other factors were taken into account, showing that NY/NY housing reduces use of prisons by 85%.

While the service reductions experienced by those individuals who were actually placed are concrete, these adjusted measurements of service use changes represent a more accurate estimate of the reductions that could be expected if the NY/NY housing program were to be expanded further.

VI. Cost Savings Associated with Reductions in Service Use

After measuring precisely the extent to which use of emergency services is reduced by placement into NY/NY housing, the researchers collaborated with government agencies to establish the per diem costs of providing these services in order to determine the cost savings associated with the housing. Using these figures, the study shows that before placement into NY/NY housing, a homeless mentally ill person spent an average of four and a half months in a variety of institutional settings over the course of a year, at a cost of $40,449 annually. The study breaks down the service usage and costs in the table on the following page.

Summary of Mean Two-Year Pre-NY/NY Intervention Period Services Use Across Seven Service Providers

Data Set	Mean Days Used- (2 Yrs Pre-NY/NY)	Per Diem (1999 $)	Cost (2 Yrs)	Annualized Cost
Dept. of Homeless Services	137.0	$ 68	$ 9,316	$ 4,658
Office of Mental Health	57.3	$ 437	$ 25,040	$ 12,520
Health & Hospitals Corporation	16.5	$ 755	$ 12,458	$ 6,229
Medicaid – Inpatient	35.3	$ 657	$ 23,192	$ 11,596
Medicaid – Outpatient (visits)	– 62.2	$ 84	$ 5,225	$ 2,612
Veterans Administration	7.8	$ 467	$ 3,643	$ 1,821
Dept. of Correctional Services	9.3	$ 79	$ 735	$ 367
Dept. of Correction	10.0	$ 129	$ 1,290	$ 645
TOTAL			**$ 80,898**	**$ 40,449**

These figures are based on an average; many of the homeless mentally ill individuals tracked by the study spent twice as many days, or more, in any one of the service systems than is indicated by the average.

Applying the same per diem costs to the adjusted service reductions calculated in Section V, and assuming year-round occupancy of the housing, the study then determined the amount of public funds saved as a direct result of a NY/NY housing placement. The reductions are itemized in the following table:

Cost Reductions by Service System

Service System	Annualized Cost Reductions Per Housing Unit
Dept. of Homeless Services	$ 3,779
Office of Mental Health	$ 8,260
Health & Hospitals Corporation	$ 1,771
Medicaid – Inpatient	$ 3,787
Medicaid – Outpatient (visits)	– $ 2,657
Veterans Administration	$ 595
Dept. of Correctional Services	$ 418
Dept. of Correction	$ 328
TOTAL	**$ 16,282**

The vast majority of the service use reductions were in health services, which accounted for 72% of the cost reductions. Approximately 23% of the cost reductions resulted from a decline in shelter use; another 5% came from reduced incarcerations. The reductions resulted from not only a reduced incidence of hospitalizations and other temporary stays, but also a significant reduction in the average length of stay during these episodes.

VII. Comparing Service Reduction Savings to Housing Costs

The substantial savings associated with placement into NY/NY housing confirm that the housing significantly reduces formerly homeless mentally ill residents' dependence on emergency services. The increased reliance on outpatient services also suggests that mentally ill individuals are better able and more inclined to use mainstream medical and mental health services on a regular basis once placed into the housing.

But NY/NY housing requires public funding to construct and operate, as do the supportive and clinical services necessary to make it effective. Working with the city and state agencies responsible for funding the development of NY/NY housing, the researchers were able to determine the total costs associated with creating, maintaining and serving the housing. They then compared these costs to the savings directly attributable to the housing, to establish the true cost to the public of the NY/NY Agreement.

The study found that, on average, the debt service, operating and social service costs of NY/NY housing equal $18,190 per unit per year. Development costs and service programs vary greatly from project to project, with some housing models costing more to build and maintain than others. Variations of the community residence model, which comprise 38% of the NY/NY housing units created, cost on average $19,662 a year per unit. The supportive housing models used for the remainder of the housing are less expensive, costing an average of $17,277 per unit per year to build and operate.

Subtracting the savings in service use reductions that the NY/NY housing makes possible from the cost of constructing, operating and providing services in the housing, the study found that:

- On average, a unit of NY/NY housing costs the public $1,908 per year.
- The average NY/NY supportive housing unit costs $995 per year.
- The 3,615 units of housing created by the NY/NY Agreement together cost $6.9 million annually.

VIII. Costs and Savings Calculated Per Placement

Calculating the savings from service use reductions and the costs of creating NY/NY housing on a per unit basis is useful to government administrators who must allocate funding for housing construction and provide contracts for services to those residences. But it is also useful to measure the costs and savings of the NY/NY Agreement as it affects each individual placed into and served by the housing. Using the same adjusted service reduction numbers and housing costs, but calculated on a per placement basis, the study found that:

- The service reductions resulting from NY/NY housing save the public $12,145 annually for each individual placed.
- NY/NY housing costs $13,570 per placement per year, meaning that, on average, it costs $1,425 to place one homeless mentally ill individual into NY/NY housing for a year.
- A homeless mentally ill person placed into *supportive* housing built by the NY/NY Agreement costs an average of $744 per year.

IX. Policy Implications

Although policy-makers and administrators of social service agencies have long known that homelessness seriously impacts state and local government spending for all types of emergency and acute care services, the NY/NY cost study is the first research that has documented these costs using the real service utilization records of actual homeless people, and then integrated those records across multiple service systems. The University of Pennsylvania research confirms that the price of homelessness is very high—$40,449 per homeless person per year, primarily in expenditures for psychiatric hospital care, inpatient hospital care, and emergency shelter care.

More important to public policy, the study shows for the first time how remarkably effective service-enriched housing can be for this population. In the before-and-after housing comparison conducted by the researchers, the net costs to taxpayers of the overall New York/New York housing program were found to be no more than $1,908 per unit per year, and in 62% of the units less than $1,000 per unit per year. The results of the study have clear implications for the implementation of homeless services and affordable housing programs in the future: For almost the same amount of public funds spent every year on psychiatric and medical care, emergency shelter, and other services for severely mentally ill homeless people, these individuals can be placed into service-enriched housing.

The study also provides clear evidence that the NY/NY Agreement improved the quality of life of the people who were placed into the housing by measuring the steep reductions in their use of episodic emergency services and recording their increased use of case management services and mainstream medical and psychiatric care.

The type of service-enriched housing pioneered by the participating providers of the NY/NY Agreement is now found in urban and suburban areas across the country. "Supportive housing" is changing the way government officials, service providers, neighbors and advocates for homeless people think about solutions to homelessness. The results of the University of Pennsylvania's cost study of the NY/NY Agreement should stimulate a cross-system perspective among policy-makers and taxpayers and give encouragement to those working on behalf of homeless people with severe mental illness. As this study demonstrates, service-enriched housing is a cost-effective response to homelessness. It therefore presents a powerful argument for executives at all levels of government to coordinate with each other in targeting increased resources to continue the all-important task of providing supportive housing for homeless mentally ill individuals.

X. The Study Partnership

The New York/New York cost study is the result of a partnership between the researchers, the government agencies that provided data, and a group of five funders, including the Corporation for Supportive Housing (CSH), which also played a role in bringing the partnership together and facilitating its activities. The principal investigator for the research is Dennis P. Culhane, Ph.D. Coauthors of the study are Stephen Metraux, M.A., and Trevor Hadley, Ph.D. The research team is based at the Center for Mental Health Policy and Services Research, University of Pennsylvania, where Dr. Culhane and Dr. Hadley began formulating a study of the cost of homelessness nearly a decade ago. CSH worked with them throughout the development and implementation of the NY/NY cost study, helping to raise funding, establish data use agreements with the government partners, and make the findings available.

The participating government agencies are:

- The New York City Human Resources Administration (HRA) Office of Health and Mental Health Services, which monitors and facilitates placements into NY/NY housing;
- The New York City Department of Homeless Services (DHS), which operates the New York City emergency shelter system and maintains individual records of shelter use;

- The New York State Office of Mental Health (OMH), which operates state psychiatric hospitals and maintains records of individuals' admissions and stays in state psychiatric centers;
- The New York State Department of Health (DOH), which administers the state's Medicaid program and maintains individually identifiable records of Medicaid-reimbursed inpatient and outpatient health care claims;
- The New York City Health and Hospitals Corporation (HHC), which operates the city's public hospitals and maintains records of individuals' inpatient hospital stays;
- The U.S. Department of Veterans Affairs (VA), which operates hospitals nationwide and maintains individual records of inpatient stays in the VA hospital system;
- The New York State Department of Correctional Services (DCS), which operates state prisons as well as the probation and parole systems for the state corrections system and maintains individual records of prison stays, probation and parole utilization, criminal arrests and convictions; and
- The New York City Department of Correction (DOC), which operates the city's jail system and maintains individual records of people incarcerated.

The New York City Department of Housing Preservation and Development (HPD) was also an important partner in this study. HPD funded and oversaw development of much of the permanent housing created under the NY/NY Agreement, and provided essential information about the cost of building and operating the city's NY/NY housing. OMH, which oversaw the state's share of NY/NY housing development, also provided housing construction and operating cost information. The City Department of Mental Health, Mental Retardation and Alcoholism Services also provided service cost information.

Funding for the New York/New York Agreement cost study was provided by the Fannie Mae Foundation, the United Hospital Fund of New York, the Conrad N. Hilton Foundation, the Rhodebeck Charitable Trust, and the Corporation for Supportive Housing.

CSH Publications

In advancing our mission, the Corporation for Supportive Housing publishes reports, studies and manuals aimed at helping nonprofits and government develop new and better ways to meet the health, housing and employment needs of those at the fringes of society.

Family Matters: A Guide to Developing Family Supportive Housing *Written by Ellen Hart Shegos. 2001; 346 pages.*
Price: $15 or download PDF files for FREE at www.csh.org.
This manual is designed for service providers and housing developers who want to tackle the challenge of developing permanent supportive housing for chronically homeless families. The manual provides information on the development process from project conception through construction and rent-up. It also discusses alternatives to new construction such as leased housing. It contains practical tools to guide decision making about housing models, picking partners and service strategies.

A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals
Written by Ted Houghton. 2001; 61 pages.
Price: $5 or download PDF file for FREE at www.csh.org.
This document provides a description and history of the New York/New York Agreement to House Homeless Mentally Ill Individuals, signed in 1990 by the City and State of New York.

The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals *Written by Ted Houghton. 2001; 14 pages.*
Price: $5 or download PDF file for FREE at www.csh.org.
A Summary of: *The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York/New York Initiative*. Conducted by Dennis P. Culhane, Stephen Metraux and Trevor Hadley, Center for Mental Health Policy and Services Research, University of Pennsylvania. This document summarizes the cost analysis of the New York/New York Agreement.

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing – National Edition
Commissioned by CSH. Prepared by the Law Offices of Goldfarb & Lipman. 2001; 226 pages.
Price: $15 or download PDF files for FREE at www.csh.org.
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolving common dilemmas.

Keeping the Door Open to People with Drug Problems – Volumes I, II and III *Written by Wendy Fleischer, Juliane Dressner, Nina Herzog and Alison Hong. 2001; 180 pages.*
Price: $5 Each or download PDF files for FREE at www.csh.org.
This three-part guide offers employment program managers and staff encouragement, strategies and tips for serving people with drug problems. The guide is divided into three volumes to make it easy to read for busy practitioners. Volume I is written with managers in mind. It focuses on the systems needed to train, manage and support staff in a program serving people with drug problems. Volume II is targeted to employment program staff. It covers basic information about drug addiction and treatment, and offers tips for working with people, including sample dialogues and forms. Volume III is focused on employment programs operating in public housing. It discusses the related housing policies and regulations, and some of the challenges and opportunities provided by the public housing context.

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir. 2000; 191 pages.* **Price: $5 or download PDF file for FREE at www.csh.org**
This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving health, housing and integrated services tenants where they live.

Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel *Written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez. 2000; 65 pages.*
Price: $5 or download PDF file for FREE at www.csh.org
Evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engaging them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community, developed by the Center for Urban Community Services with first-year funding from the Corporation for Supportive Housing, is one pioneering effort to help mentally ill long-term shelter residents obtain housing.

Forming an Effective Supportive Housing Consortia; **Providing Services in Supportive Housing**; and **Developing and Managing Supportive Housing**
Written by Tony Proscio. 2000; 136 pages.
Price: $5 Each or download PDF files for FREE at www.csh.org.
These three manuals are designed to assist local communities and service and housing organizations to better understand the local planning consortium, service delivery and funding, and supportive housing development and financing.

Landlord, Service Provider…and Employer: Hiring and Promoting Tenants at Lakefront SRO
Written by Tony Proscio and Ted Houghton. 2000; 59 pages.
Price: $5 or download PDF file for FREE at www.csh.org
This essay provides a close look at Lakefront SRO's program of in-house tenant employment, as a guide for other supportive housing programs that either hire their own tenants or might want to do so. The lessons of **Landlord, Service Provider...and Employer** are also of potential interest to affordable housing programs whose tenants could become valuable employees given sufficient encouragement, training and clear policies.

The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the *Next Step: Jobs* Initiative
Written by Wendy Fleischer and Kay E. Sherwood. 2000; 73 pages.
Price: $5 or download PDF file for FREE at www.csh.org
The ***Next Step: Jobs*** initiative tested the premise that a range of employment services targeted to supportive housing tenants can help them access employment. It used supportive housing as the focal point for deploying a range of services to address the multiple barriers to employment that tenants face. It also capitalizes on the residential stability and sense of community that supportive housing offers.

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing – California Edition
Commissioned by CSH. Prepared by the Law Offices of Goldfarb & Lipman. 2000; 217 pages.
Price: $15 or download PDF files for FREE at www.csh.org
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolving common dilemmas.

Supportive Housing and Its Impact on the Public Health Crisis of Homelessness *Written by Tony Proscio. 2000; 40 pages.*
Price: $5 or download PDF file for FREE at www.csh.org
This publication announces the results of research done between 1996 and 2000 on more than 200 people who have lived at the Canon Kip Community House and the Lyric Hotel in California. It also looks at pre-occupancy and post-occupancy use of emergency rooms and inpatient care.

Vocationalizing the Home Front: Promising Practices in Place-Based Employment
Written by Paul Parkhill. 2000; 79 pages.
Price: $5 or download PDF file for FREE at www.csh.org
Accessibility; inclusiveness; flexibility; coordinated, integrated approach to services; high-quality, long-term employment; and linkages to private and public sectors are hallmarks of a new place-based strategy to help people with multiple barriers to work find and keep employment. The 21 place-based employment programs featured in this report represent some of the most comprehensive and innovative approaches to employing persons who are homeless, former and current substance abusers, individuals with HIV-AIDS, those with physical and psychiatric disabilities and other challenges.

Connecticut Supportive Housing Demonstration Program – Program Evaluation Report *Commissioned by CSH. Prepared by Arthur Andersen LLP, University of Pennsylvania Health System, Department of Psychiatry, Center for Mental Health Policy and Services Research, Kay E. Sherwood, TWR Consulting.*
1999; Executive Summary, 32 pages. Complete Report, 208 pages.
Executive Summary Price: $5 Complete Report Price: $15
This report evaluates the Statewide Connecticut Demonstration Program which created nearly 300 units of supportive housing in nine developments across the state in terms of tenant satisfaction, community impact—both economic and aesthetic—property values and use of services once tenants were stably housed.

The *Next Step: Jobs* Initiative Cost-Effectiveness Analysis
Written by David A. Long with Heather Doyle and Jean M. Amendolia. 1999; 62 pages. **Price: $5**
The report constitutes early findings from a cost-effectiveness evaluation by Abt Associates of the ***Next Step: Jobs*** initiative, which provided targeted services aimed at increasing supportive housing tenants' employment opportunities.

Under One Roof: Lessons Learned from Co-locating Overnight, Transitional and Permanent Housing at Deborah's Place II *Commissioned by CSH, written by Tony Proscio. 1998; 19 pages.* **Price: $5**
This case study examines Deborah's Place II in Chicago, which combines three levels of care and service at one site with the aim of allowing homeless single women with mental illness and other disabilities to move towards the greatest independence possible, without losing the support they need to remain stable.

Work in Progress 2: An Interim Report on *Next Step: Jobs*
Commissioned by CSH, written by Tony Proscio. 1998; 22 pages. **Price: $5**
Work in Progress 2 describes the early progress of the ***Next Step: Jobs*** initiative in helping supportive housing providers "vocationalize" their residences—that is, to make working and the opportunity to work part of the daily routine and normal expectation of many, even most, residents.

A Time to Build Up *Commissioned by CSH, written by Kitty Barnes. 1998; 44 pages.* **Price: $5**
A Time to Build Up is a narrative account of the lessons learned from the first two years of the three-year CSH New York Capacity Building Program. Developed as a demonstration project, the Program's immediate aim is to help participating agencies build their organizational infrastructure so that they are better able to plan, develop and maintain housing, with services for people with special needs.

Next Door: A Concept Paper for Place-Based Employment Initiatives *Written by Juliane Dressner, Wendy Fleischer and Kay E. Sherwood. 1998; 61 pages.* **Price: $5**
This report explores the applicability of place-based employment strategies tested in supportive housing to other buildings and neighborhoods in need of enhanced employment opportunities for local residents. Funded by the Rockefeller Foundation, the report explores transferring the lessons learned from a three-year supportive housing employment program to the neighborhoods "next door."

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing *Written by Sue Reynolds in collaboration with Lisa Hamburger of CSH. 1997; 146 pages.* **Price: $15**
Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles.

Work in Progress…An Interim Report from the *Next Step: Jobs* Initiative *1997; 54 pages.* **Price: $5**
This report provides interim findings from CSH's ***Next Step: Jobs*** initiative, a three-city Rockefeller Foundation-funded demonstration program aimed at increasing tenant employment in supportive housing. It reflects insights offered by tenants and staff from 20 organizations based in Chicago, New York City and the San Francisco Bay Area who participated in a mid-program conference in October 1996.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults *Commissioned by CSH, written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez of the New York State Psychiatric Institute. 1996; 103 pages.* **Price: $15**
This evaluation examines low-demand interim housing programs, which were developed by nonprofits concerned about how to help homeless people living on the streets who are not yet ready to live in permanent housing. Funded by the Conrad N. Hilton Foundation, this report is a 15-month study of six New York interim housing programs.

In Our Back Yard *Commissioned by CSH, directed and produced by Lucas Platt. 1996; 18 minutes.* **Price: $10 nonprofits/$15 all others.**
This educational video is aimed at helping nonprofit sponsors explain supportive housing to members of the community, government representatives, funders and the media. It features projects and tenants in New York, Chicago and San Francisco and interviews a broad spectrum of supporters, including police, neighbors, merchants, politicians, tenants and nonprofit providers.

Design Manual for Service Enriched Single Room Occupancy Residences *Produced by Gran Sultan Associates in collaboration with CSH. 1994; 66 pages.* **Price: $20**
This manual was developed by the architectural firm Gran Sultan Associates in collaboration with CSH and the New York State Office of Mental Health to illustrate an adaptable prototype for single room occupancy residences for people with chronic mental illnesses. Included are eight prototype building designs, a layout for a central kitchen, recommendations on materials, finishes and building systems, and other information of interest to supportive housing providers, architects and funding agencies.

Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services *Commissioned by CSH, written by Basil Whiting. 1994; 73 pages.* **Price: $5**
Funded by the Rockefeller Foundation, this report explores the advisability of implementing a national employment demonstration program for the tenants of supportive housing. The paper is based on a series of interviews with organizations engaged in housing, social service and employment projects in New York City, the San Francisco Bay Area, Washington, DC, Chicago and Minneapolis/St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

Miracle on 43rd Street *August 3, 1997 and December 26, 1999.*
60 Minutes feature on supportive housing as embodied in the Times Square and the Prince George residences in New York City.
To purchase VHS copies, call 1-800-848-3256; for transcripts, call 1-800-777-8398.

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Mission Statement

The Corporation for Supportive Housing supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance use, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy and dignity, and reach for their full potential.

We work through collaborations with private, nonprofit and government partners, and strive to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.

Cover photo upper left corner
Tenant, Ivan Shapiro House
Liana Miuccio, photographer

Cover photo upper right corner
Ivan Shapiro House
Liana Miuccio, photographer

Cover photo lower left corner
Gouverneur Court
James Shanks, photographer

Cover photo lower right corner
Tenant, Holland House
Rigo Diaz, photographer

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Supportive Housing and Its Impact on the Public Health Crisis of Homelessness

CSH
Corporation *for* Supportive Housing

Tony Proscio is the author of this publication. Mr. Proscio is a writer and consultant to foundations and nonprofit organizations. In the mid-1990s he was deputy commissioner of homeless services in New York City, and previously worked in various positions on community development, affordable housing finance, and social welfare policy. He was associate editor of The Miami Herald and a member of its editorial board from 1990 to 1995.

CORPORATION *for* SUPPORTIVE HOUSING

Dear Colleague,

We are pleased to be able to share interim results from an evaluation of the Corporation for Supportive Housing's *Health, Housing Integrated Services Network*, an initiative of the California Program. The HHISN brought together nonprofit, government and consumer agencies to develop and operate a new way to both deliver and finance integrated support, health and employment services with affordable housing so that very poor individuals who also face health and mental health issues can live with dignity and stability in the community.

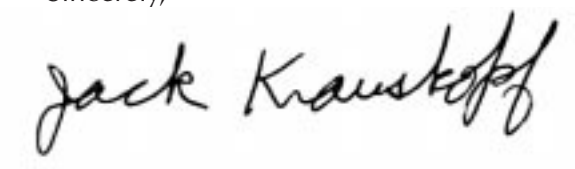
These early results from a study conducted by independent researchers from the Goldman School of Public Policy at the University of California at Berkeley, show a significant relationship between supportive housing and its effects on tenants' health and attendant health care costs. The study tracked HHISN participants' use of San Francisco General Hospital's emergency room, inpatient stays and psychiatric health care costs for one to two years prior to tenancy and compared it to costs incurred one year after moving in.

This report shows that for the more than 250 tenants who were given the opportunity to move from the streets or shelters to Canon Kip Community House and the Lyric Hotel in San Francisco, emergency room use decreased by 58 percent. For those residents who stayed housed at least one year, the number of days in the hospital decreased by 57 percent. For a smaller data set, the only tenants for whom complete information is available, use of residential mental health care went from an average of 2.69 days per person for the year prior to move-in to zero one year after becoming tenants in HHISN buildings.

These results also have significance in that they show that better than 81 percent of the 253 tenants, all of whom had histories of homelessness and nearly all of whom were dually diagnosed with mental illness and chronic substance abuse, were able to stabilize in housing for at least a full year.

While we expect to have a complete report by the end of 2000, we wanted to share these extremely promising early findings as soon as they became available. We hope you find them useful.

Sincerely,



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Executive Summary

Nonprofit and government agencies have been experimenting for nearly 20 years on ways to address the most persistent and disturbing forms of homelessness: people with mental illness, chemical addictions, and chronic illnesses or disabilities, living in public spaces, cycling through jails and prisons, receiving sporadic, emergency care, and incurring enormous public expenses with little or no long-term benefit.

Research now being conducted at the University of California at Berkeley suggests that these experiments have in fact led to an effective solution, combining two key elements. The first is supportive housing — affordable homes and apartments that offer social and mental health services to help residents remain stable and deal with the problems that led them to homelessness. The second is a more recent elaboration on the supportive housing model: the integration and coordination of resident services from several specialized provider agencies working as a team, so that each resident has access to the particular support he or she needs to stay housed, with the greatest possible level of independence. In this combination, supportive housing provides a stable alternative to life on the streets; and integrated services provide an economical alternative to the emergency or fragmented care that most long-term homeless people tend to receive.

Among several promising experiments with supportive housing and integrated services in California is the San Francisco Bay Area's *Health, Housing and Integrated Services Network*, or HHISN. Two of the supportive housing programs served by HHISN — the Lyric in San Francisco's Tenderloin, and Canon Kip Community House in the South of Market neighborhood — are the subjects of the current research, which is still under way. Well over one-third of the residents of the two programs came directly from living on the streets. The remainder were previously in shelters or transitional residences. All were homeless, and more than 95 percent are struggling with mental illness, chemical addictions, or most often, both.

Preliminary results of that study are beginning to be compiled. The first available results compare homeless people's use of emergency rooms, hospitals, and residential mental health programs before and after moving into a supportive residence served by HHISN. The results are dramatic.

For example, within 12 months of moving into supportive housing . . .

- **Use of emergency rooms falls by 58 percent**,
- **Use of hospital inpatient beds falls by 57 percent**, with another 20 percent decline the next year,
- **Use of residential mental-health programs virtually disappears** — from an average of more than 2½ days per person per year to zero, within 12 months.

These findings are based on data from San Francisco General Hospital and Community Mental Health Services. They include all the tenants in the two programs for whom complete data are available at least 12 months before and after moving in — between 95 and 253 people, depending on the database. Some missing records in each database are still to be filled in, and additional data from private hospitals, the criminal justice system, and other programs are likewise still being sought.

The addition of information from more institutions and systems will also make it possible to assemble a nearly complete picture of the cost of *not* providing supportive housing and integrated services. By examining how government and public institutions currently spend money trying to serve homeless people, often with little result, it will be possible to determine exactly how economical, and how effective, supportive housing and integrated services can be.

At this point, the early information is both encouraging and alarming. It tells a story of extraordinary accomplishment and opportunity — but one that today applies only to a small minority of all Californians living on the streets, in emergency facilities, and along the social margin.

Part I: Not a Treatment — a Solution

In California, as across the United States, the debate over homelessness has lately split in two, dividing the issue into distinct, and partly unrelated, fields of concern. On one path is a discussion largely about poverty, in its severest form. Many homeless people — in fact, most of those who are homeless at any given time — are like other very poor people, except that they have lost their housing and have been unable to replace it. Especially in high-cost housing markets like the San Francisco Bay Area, this group can be disturbingly large, but these people tend not to stay homeless for long. Solutions to their crisis usually are comparatively straightforward (even if not always easy to come by): A voucher, a job, subsidized housing, public assistance, or some combination tends to work for them sooner or later.

On the other track, however, is a quite different debate about a smaller but even more disturbing subset of homeless people: those who do not, in the main, find their way out of homelessness with routine or short-term help. Frequently mentally ill, or with long-term addictions, in poor health, and distrustful of programs and institutions, they live in public places, frequently end up in the hospital and are sometimes imprisoned, or cycle through the lives of anxious relatives and friends. Harmful to themselves and disturbing to others, they represent a steadily mounting cost, both economic and social, to people and public systems that try (and usually fail) to help them. When charities and public officials come under intensifying pressure to "do something" about homelessness, this is generally the group at issue.

For this more chronic, chaotic form of homelessness, the following pages offer not just a theory or a treatment, but a *solution* — tested, measured, effective, and economical. The solution consists of two parts: decent, affordable housing, and a carefully managed network of focused medical, social, and psychological services, aimed at preventive care and timely, effective response. In the Bay Area, one way this combination has been carried out is through the Health, Housing and Integrated Services Network (HHISN), whose accomplishments are described in detail in this paper.

The two parts of this equation, the housing and the integrated medical and social supports, are inextricably linked. More than an affordable apartment

but substantially less restrictive than institutional care, supportive housing and HHISN provide a home and essential supportive services — all in a single package, in a combination that vastly reduces the odds of physical or psychiatric emergencies, institutional care, or renewed life on the streets.

The Effects of Housing with Services: Results of New Research

A new, wide-ranging study of homelessness and public health costs in San Francisco, conducted by researchers at the University of California at Berkeley, has begun to document, in growing detail, the benefits of supportive housing and integrated services, not just for homeless people and those who care for them, but for the city's public institutions, government, and residents as a whole. Among the early findings of this research, described more fully in this paper, three stand out as especially significant:

- Supportive housing with integrated services reduces residents' use of San Francisco General Hospital's **emergency room** — *down well over half* in a single year. San Francisco General is the primary source of emergency and hospital care for uninsured and low-income people in the city.
- **Inpatient stays** at SF General fall just as sharply once a person enters supportive housing: a *nearly 57 percent* drop in the first 12 months, and another 20 percent in the following year.
- The need for r**esidential mental-health care** is virtually eliminated in the first year of supportive housing — with average utilization dropping to zero within 12 months, from an average of more than 2½ days per person per year.

Together, these results demonstrate that supportive housing is not only a more stable, decent solution for homeless people with long-term disabilities. Nor is it merely an effective way of taking people from a chaotic life on the sidewalks to a sustainable life in a place of their own. It is also a substantial relief to public hospitals and over-burdened crisis treatment programs, and a smart investment for the state and local governments that pay for them. As it turns out, the humane solution is also fiscally smart.

The research on which these findings are based is still in progress, with likely completion in the late fall of this year. We present here only the preliminary results: a comparison of people's use of emergency health care, hospital services, and specialized residential psychiatric or detoxification

programs, before and after entering supportive housing. The findings are part of a wider study by researchers at the University of California at Berkeley that will eventually include more data on psychiatric and hospital services, plus new information from private hospitals and the criminal justice system.

Although preliminary, the results are bolstered by other research that points to similar trends. In particular, an earlier study of HHISN by the Vanderbilt Institute for Public Policy Studies, using data from 1996–97, found a significant improvement in residential stability and some evidence of reduced use of hospital emergency services. Current research in Alameda County, though less far along, is also finding evidence of reduced utilization and costs for behavioral care services, particularly in locked facilities and hospital care for psychiatric emergencies, based on just a small sample so far. Studies under way in other states — most prominently Minnesota, Connecticut, and New York — are finding comparable trends in health and psychiatric costs. The results of the Alameda and New York research, like the complete version of the Bay Area study, are expected later this year.

Along with academic affirmation of the findings presented here comes a less formal, but equally exacting, review by the people who know the facts best: those who have lived in streets and shelters, and who are now living in supportive housing. The progress of this research, and the findings that emerge from it, are regularly reviewed by HHISN's governing board, which includes tenants as well as service providers and managers. Their approval is an additional sign — in some ways, perhaps the most reassuring one — that the analysis is based in reality, and that it tells a true story about real lives.

Supportive Housing and Integrated Services: Managing the Solution

For the most severely troubled and longest-term homeless people, life on the streets is not just a housing problem, and not just a problem of physical, mental, or behavioral health. These are all inextricably linked: Behavioral problems lead to a loss of housing — especially in a tight housing market where tenants are easy to replace — and life without a home quickly leads to deepening physical and psychological disorder. To break the spiral, the solutions have to be as linked as the causes. That is what supportive housing accomplishes.

The idea has evolved over two decades, beginning with experiments in various kinds of supportive housing in the 1980s. Most of the early efforts, though, were designed for tenants who were already considered "housing ready" — they had recently completed treatment programs, were fully stabilized on medication, clean and sober for at least several months, and willing to participate in a regimen of mandatory services. For this group, supportive housing was quickly recognized as a giant step forward. It provided a way of preserving the effects of treatment and reinforcing the recovery process, by supplying a long-term residence for people who might otherwise have had nowhere to live, or who may otherwise have found themselves back in a harmful environment.

But by the mid-1990s, it was also becoming clear who was *not* being reached by the first generation of supportive housing. Left behind in the public health-care safety net, especially public hospitals and mental health programs, or in penal institutions or simply on the streets, was a smaller group of chronically homeless people who were not yet fully "housing ready" by the prevailing standards. Care and services for this group were not only ineffective, they were alarmingly expensive.

Administrators of health systems and public institutions, under mounting pressure to control costs, began to zero in on the enormous cost of treating medical or psychiatric emergencies for this hardest-to-serve population — particularly homeless people with chronic addictions and mental illness, who were receiving no ongoing community treatment. For them, treatment in institutions or episodic programs was having little long-term effect amid the chaos of life on the streets. The same people, often with the same conditions, were showing up for treatment and re-treatment, time after time, with the severity of their problems deepening year by year. Neither the old methods of short-term treatment and release nor the new approach of supportive housing seemed to hold much hope for them.

Starting in 1994, the Corporation for Supportive Housing, a national nonprofit organization with offices throughout California, convened a group of supportive housing agencies and local public health officials in San Francisco, to look for solutions to chronic homelessness and its crushing effect on public health costs. They determined that supportive housing does, in fact, offer a way of reaching people with current or recent problems of addiction and those reluctant or unready to participate consistently in mental health treatment. It could, at a minimum, provide a safer place for them to live, with constant exposure to opportunities for better health and recovery. And in the process, it could at least reduce, if not eliminate, the high costs associated with ineffectual treatment and re-treatment, arrest and release, hospitalization and discharge, and on and on.

To put an end to life on the streets, this new, more expansive approach to supportive housing offers a place to live on terms that long-term homeless people can accept and live with. It says, in essence: *We'll offer you the help you need to be a good tenant and you can stay as long as you need to*. It builds opportunities for recovery into the stability of a permanent, independent dwelling. For each new tenant, the need for services will be different. Some will need medication, others counseling, others merely patience and opportunities to reintegrate into the wider community. But most, especially those with long-term problems and years of street life, will need a wider mix of specialized support services able to respond promptly or preventively to signs of trouble.

Planning and delivering this mix of responses, and tailoring them to each person's changing needs, requires a collaboration of housing managers with providers of various kinds of support services — those with expertise in addiction recovery, mental-health care, and the integrated treatment of the two together; those specialized in outreach or case-management; in vocational and employment services, and in building skills for independent living. Taken together, this combination of services, both on-site and off, would replace the costly, fragmentary treatment of momentary conditions with a sustained, preventive, and permanent solution to chronic homelessness.

That is the contribution of the Health, Housing and Integrated Services Network — the management and coordinating system that weaves these various specialties into an effective whole that works both economically and clinically, for each person it serves.

Other communities in California also provide integrated services linked to housing using variations on this model, adapted to local needs. What these various approaches have in common is that they combine an effective response to homelessness — that is, the basic elements of supportive housing — with a broad-based, carefully integrated solution to the complex needs of the hardest-to-serve homeless people. Together, they represent the most consistent, tested breakthrough in dealing with chronic homelessness anywhere in the United States.

Assessing the Benefits

The current research examines data from San Francisco General Hospital on inpatient and emergency-room care, and from San Francisco Community Mental Health Services on mental-health care. The analysis

compares people's use of emergency health care, hospital services, and specialized psychiatric programs, before and after entering supportive housing. It is based on a total population of up to 253 people[1] in two supportive housing programs whose services are coordinated through HHISN. Using all available data on this group through March 2000, the research shows *a dramatic reduction in both the instances of trouble and the costs of treatment*.

The data under examination cover people who moved into Canon Kip Community House and the Lyric, two supportive housing programs in San Francisco, at least 12 months before the start of the most recent data analysis (that is, by March 1999). The great majority of those studied — 94 percent — had formerly been living in the margins between institutional care and public crisis, moving between emergency shelters, hospitals, jail cells, detoxification or residential-treatment programs, and life on the streets. In an earlier study of residents at Canon Kip in 1996–97, researchers from the Vanderbilt Institute for Public Policy Studies found essentially the same thing: that 88 percent had moved into the building directly from the streets (25 percent) or shelters (63 percent). When the current study added in tenants from the Lyric, the percentage coming directly from the streets rose to 30 percent, but the percentage from shelters remained about the same.

Before entering supportive housing, most residents in both the Vanderbilt study and the more recent research at Berkeley had placed extraordinary demands on hospitals and emergency services — at an annual public cost that, according to the Berkeley analysis, sometimes amounted to more than $15,000 a year in mental-health programs alone. Across all the residents, the costs for mental-health care alone, for example, averaged some $8,000 per person per year in the two years before they came into the HHISN orbit.[2]

What happened after that is both striking and important: Once people found themselves in a supportive environment, where hygiene, nourishment, shelter, and routine health care were not a daily challenge, *their need for hospital or other 24-hour or emergency care either disappeared or plunged dramatically* — as the numbers cited earlier illustrate. Some, with counseling or peer support or medication, found their way to a completely ordinary life like anyone else's: a job, friends and family connections, and freedom from drugs or other addictive substances. But even when the result was less ideal, supportive housing still produced a substantial, measurable improvement for both the tenant and the public: Life on the street was over. The emergency room was not a routine source of treatment for chronic illnesses. Treatable problems did not fester and grow into medical or psychiatric crises requiring days of hospitalization.

Of those who moved in at least one year ago, 81 percent remained at Canon Kip or the Lyric for at least one year. (And of those who moved in at least two years ago, 62 percent have stayed for at least two years.) Here again, the most recent Berkeley findings are consistent with those in earlier work by Vanderbilt. Among residents of Canon Kip, the Vanderbilt team found a striking improvement in residential stability: In a population of which 88 percent had previously lived in shelters or on sidewalks, the majority were well into their third year of continuous residence at Canon Kip, and nearly 80 percent had been there for at least two years, when the survey was taken in 1996–97. Once in supportive housing, they increasingly used the medical, mental-health, and other supportive services on site — with the vast majority using mental health, case management, or medical services at Canon Kip (between 71 and 92 percent, depending on the service), rather than relying on public or emergency systems.

Preliminary results of studies in other states — most prominently Minnesota, Connecticut, and New York — are finding comparable trends. These studies, like the complete version of Berkeley's research, are expected later this year.

HHISN and Supportive Housing: How It Works

Any given supportive housing site in the HHISN network — for example, the Lyric in San Francisco's Tenderloin, or Canon Kip Community House in the South of Market neighborhood — is the responsibility of a team of housing managers and service organizations working in concert, through their membership in HHISN. The particular partnership at each site is different. The social-service staff and mental health specialists at the site normally have expertise with the primary day-to-day needs likely to arise among the tenants. The housing owner and managers make sure the building runs effectively and provides quality housing for the residents, and the service providers make sure that residents always have somewhere to turn either for reinforcement or to prevent or respond to problems.

Behind these front-line agencies and employees is a still broader array of HHISN specialists, a citywide team of diverse agencies with a wide spectrum of experience and specialties: for example, comprehensive medical services, addiction treatment and recovery support programs, money management, vocational, and employment services. Together, the on-site and off-site programs ensure that each tenant in supportive housing has clear, easy access to whatever mix of services will help keep

that tenant housed, stable, healthy, and independent. The key is to provide *as much* service as needed, but *only* the service that's needed.

The point of that combined goal is not just to minimize costs (though, as we will show, it seems to be working very effectively to that end). Just as important, its purpose is to ensure that tenants are supported, not enveloped, by services — that their environment is as independent and unrestrictive as possible, but never without ready help when required.

HHISN, which began in San Francisco and nearby Oakland, now consists of more than 30 nonprofit housing and service agencies from across six counties of the San Francisco Bay Area. Within the HHISN structure, members organize themselves into smaller Integrated Service Teams, responsible for each of 15 supportive housing sites in San Francisco, Oakland, Berkeley, San Mateo, and Santa Clara Counties, and more than 100 residents of Contra Costa and Marin Counties. Together, the teams have reached more than 1,100 people living in more than 1,000 affordable housing units. HHISN membership in San Francisco includes leading government and nonprofit service agencies like Baker Places, Conard House, Episcopal Community Services, and the San Francisco Department of Public Health's Tom Waddell Clinic, and affordable housing providers like Mercy Housing California and Chinatown Community Development Corporation.

Integrated Service Teams normally consist of staff from three member agencies at each supportive housing site, providing some combination of medical care, case management, mental health or substance-abuse treatment, help with housing retention and independent-living skills, and vocational and employment services. The mix depends in large part on the particular needs of tenants in different locales. The teams combine organizations with long histories of serving homeless people alongside others that deal with broader populations: providers of managed health care, for example, or job-training programs.

Each Team member also comes from a public or private agency with its own wider-ranging referral network, through which the particular needs of individual tenants can be met responsively and efficiently. The result is a program that addresses both the specific needs of long-term homeless people and the general needs of anyone grappling with poverty, disability, chronic illness, addiction, recent crisis, or some combination — all while maintaining a natural housing environment where residents enjoy the same privacy and independence that would come with any apartment anywhere else.

At a given building, the typical pattern would include a group of case managers for day-to-day counseling and referrals, an on-site clinic

for part-time medical services, as well as the property management staff. The three groups meet often to coordinate their work with tenants, resolve potential problems or conflicts, or seek referrals from one another when needed. The result is an on-site blending of specialties that mirrors the larger, region-wide coalition of HHISN.

In San Francisco, HHISN is sponsored jointly by the City's Departments of Public Health and Human Services. Marc Trotz, DPH's director of housing development, says his department particularly values HHISN's versatility and ability to assemble different combinations of agencies and services under different circumstances:

> It allows us to experiment with qualified organizations in a range of buildings. We're able to learn more quickly what works and what doesn't with a number of providers participating in the process. It helps to define the landscape and lets us apply that knowledge to the next project in a way we would never be able to without the Network.

The members of HHISN, the locations of the various supportive housing sites, and other details about the Integrated Service Teams are attached in Appendix B.

Part II: Evidence of a Breakthrough

The study now under way by researchers from U.C. Berkeley, sponsored by the Corporation for Supportive Housing, shows that the HHISN formula is producing substantially better results for the most difficult-to-reach homeless people, at significantly lower cost to state and local government and public institutions. Most significantly, supportive housing appears not merely to have *relieved* homelessness for its residents, but for a substantial majority of them, it has *put an end* to life on the streets and in shelters — a life harmful to them and disturbing to other residents of the community.

Treating the consequences of that life in the usual ways, with episodic emergency services in hospitals and other institutions, has been enormously costly without producing lasting benefits. That was how public programs and institutions dealt, for example, with Derrick Randall[3] during the two years he spent living on San Francisco sidewalks, shelters, and parks, or occasionally crashing with his sister. In the year before he moved into supportive housing, Mr. Randall spent an average of 2½ days *every month* in San Francisco General Hospital for one crisis or another. He'd been treated in the emergency room 10 times that same year. The cost of his mental-health services alone — everything from crisis intervention to medication monitoring to individual therapy — came to nearly $15,000 in just 12 months.

A college graduate and Vietnam veteran diagnosed with major depression and Post-Traumatic Stress Disorder, Mr. Randall had been taking cocaine intravenously for two decades — knowing full well, he says, that he was committing a slow, public suicide. "I was bouncing in and out of hospitals," he says. Relying on drugs "helps sometimes, but then you come down. You wake up and all you think about is where my next hit is coming from." As medical and psychiatric problems mounted and prescriptions went unfilled or unfollowed, the crashes grew worse. Each physical and emotional trough demanded another relief from drugs and drink, until another round of hospitalization, detoxification, or arrest brought a moment of unwelcome clarity. And then it started again.

Now, in two years of supportive housing (and counting), the emergency room visits and inpatient hospitalization have stopped. Community Mental

Health services continue — at nearly half the prior expense, under $8,000 a year — but now the services are preventive and sustaining, not rescue missions. And most of those are case-management services delivered routinely at the residence where Mr. Randall lives. He has not spent a single night in any public place or emergency room — no more benches and shelters, no more gurneys, no more jails. Now, at the first sign of trouble, an emotional low, a bout of nightmares, a craving for drugs, and help is no farther than the lobby.

Here is how a case manager in his supportive housing program describes Mr. Randall's life now: "He has a room that's his sanctuary, so he doesn't need to go to the emergency room just to be safe and off the streets. And if his mental illness escalates, and he begins to decompensate, there's a lot of people he can go to talk to. A lot of times, that's all people want, someone to talk to."

"The good thing about this place," says Mr. Randall, referring to his supportive apartment building, "is that I don't go to the hospital any more — voluntary or involuntary. I was snatched off the bridge once. Now, just being able to come down [to the building's offices and common areas] and talk about stuff makes the difference. Here, we can work it out." These days, Mr. Randall is increasingly part of the solution for other people, one of the peer counselors and resident leaders who encourage and support other residents in their rough spells.

Dealing with Reality

By itself, Mr. Randall's is merely an encouraging story, life-saving for him and inspirational for others. What makes it important for local, state, and national policy is that it is not a story of just one man's struggle against the odds. The turnaround in Mr. Randall's life came from two crucial factors quite apart from his own determination to change his life. One was the stability of an affordable place of his own to live. The other was the steady, carefully coordinated reinforcement of HHISN's constellation of services — available when needed, unobtrusive when not, but always prepared for timely intervention before difficulties become dangerous, costly, and hard to reverse.

In fact, it is essential not to confuse HHISN's achievements with the solitary heroism of some individuals fortunate enough to have overcome addictions or other disabilities on their own. What makes the performance of HHISN and its supportive housing partners remarkable is that it *does*

not depend on people first conquering their behavioral problems. You do not have to be "clean and sober" to enter HHISN's supportive housing programs. Many residents have yet to finish wrestling with the emotional, substance-abuse, or other problems that led them into homelessness. In 1996-97, for instance, the Vanderbilt Institute for Public Policy Studies found that 74 percent of the residents of Canon Kip had arrived with some substance-abuse problems. Of that group, some were already in recovery, and others were just beginning the lifelong struggle against addiction. But experience plainly suggests that the majority were still abusing drugs or alcohol, at least to some extent.

Transitional programs for people committed to recovery from addiction are extremely valuable, but they are not new. What's new, in HHISN, is a solution that also embraces those who are not yet in recovery — who are, for the moment, still among those whose crises land them in public places, receiving ineffectual care often at enormous public expense. Decades of experience with homelessness, mental illness, addiction, and other untended disabilities has shown that it is not enough for public policy to say, "get yourself together and we'll help you." That is a formula for the kind of public failure that a *New York Times* headline recently labeled "Bedlam on the Streets."

The residents of HHISN's supportive housing programs have not all navigated their own way into addiction recovery or developed completely effective strategies for dealing consistently with their mental illness other disabilities. What they have done, in many cases, is begun to get help managing the problems that led them into homelessness, in an environment that encourages and supports their recovery over the long term — beginning wherever they happen to be on the day they move in.

An example is Simon Delgado, son of alcoholic parents who, in middle age, still struggles with alcoholism after 2½ years of life on the streets of San Francisco. Those years, before he moved into supportive housing in 1997, took an enormous physical and emotional toll: "My heart is bad, I couldn't see, I was having blackouts, everything was breaking down." Of the last 12 months when he was on the streets, Mr. Delgado spent 15 days in psychiatric hospitals, racking up nearly $14,000 in Community Mental Health Service expenses.

His first encounter with HHISN came even before he could get a supportive apartment. Through a program at Episcopal Community Services, he started to get counseling for the spiraling effects of combined depression and substance abuse, and was introduced to the city's Tom Waddell medical clinic. "I have a whole lot of respect for Tom Waddell," he says, "because they care, they have patience. Even the office workers and the security guards there treat homeless people well." The atmosphere

of welcome and encouragement — soon followed by a stable place to live where these supports were close to hand — brought Mr. Delgado's drinking and medical problems steeply down from where they had been a year before. Even his weight, which had grown dangerously out of control, is now back nearly to normal — down more than 100 pounds.

Mr. Delgado has not eliminated alcohol from his life. He does not consider his problems "solved." But there is no question that he and the people who used to pass him on the streets are both profoundly better served now than they were three years ago, when he was bouncing between sidewalks and shelters, and suffering with sporadically medicated psychiatric problems, uncontrolled drinking, and disintegrating physical health. It was a slow, frightening death on a public stage. That, at the very least, is over.

Since entering supportive housing, Mr. Delgado has had no further need of psychiatric hospitals. The bill for his Community Mental Health services is down more than 85 percent, to $2,000 a year from $14,000. Meanwhile, the support from HHISN continues. Referring to the agency that supplies HHISN's on-site mental health specialists, Mr. Delgado says, "Baker Places has helped me with my psychiatric problems, with my [medications] . . . they give me reminders, notes, until it became habit. I now go to court, welfare, wherever, on my own. They also made me understand my alcohol use and how to control it better. [A Baker Places case manager] has helped guide me through all my goals, including conquering my alcoholism. I mean, now, I don't want to drink every day."

Reflecting on the same issues, Derrick Randall put the whole argument into one sentence: "I ain't what I want to be" he said, "but at least I ain't what I was."

Quantifying the Effects

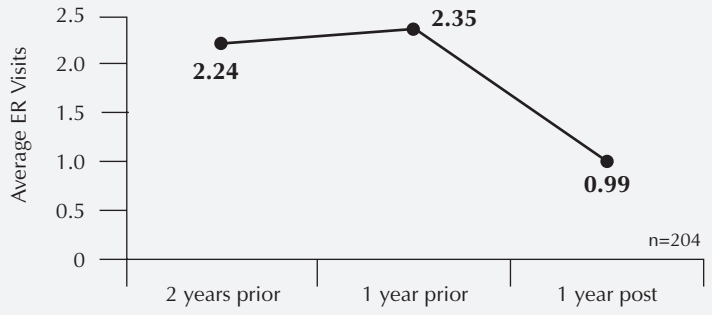
The combination of supportive housing and HHISN's integrated services is now proving itself in the lives of hundreds of San Franciscans for whom other forms of service, shelter, and care weren't working. To examine what happens when people go from public crisis to stable housing with HHISN's supportive services, researchers from U.C. Berkeley compiled medical care data on 253 residents of Canon Kip and the Lyric, and mental health-care data on a smaller subset of those residents, between 1992 and March 2000.[4] Thus far, the data show a steep drop in all major categories of service.

1. A 58 percent decline in emergency room use

Treatment in emergency rooms is a good measure not only of the incidence of crisis in someone's life, but of the likelihood that such crises are being dealt with inconsistently or belatedly, and at great cost. Among the 253 people who had entered Canon Kip or the Lyric as of March 1999, the average resident had previously been treated in the emergency department of San Francisco General Hospital on more than two occasions in each of the two years before moving in (2.08 visits and 2.11, respectively). Within one year of entering supportive housing, the average ER use fell to 1.01 per person per year, and the total number of emergency room visits for this group had declined from 535 in the year before supportive housing to 255 visits in the year after move-in.

When we look more closely at those tenants who remained in supportive housing for at least one year (204 of the 253 people, or 81 percent of those who entered supportive housing), the results are even more dramatic. The average number of emergency room visits for each person dropped from 2.35 in the year before moving in (and 2.24 in the preceding year) to less than one visit (0.99) per person per year in the first year of living in supportive housing — *a 58 percent decrease*. For those tenants who have remained for two years or more, the dramatic reductions in emergency room use during their first year in supportive housing are sustained during the following year.

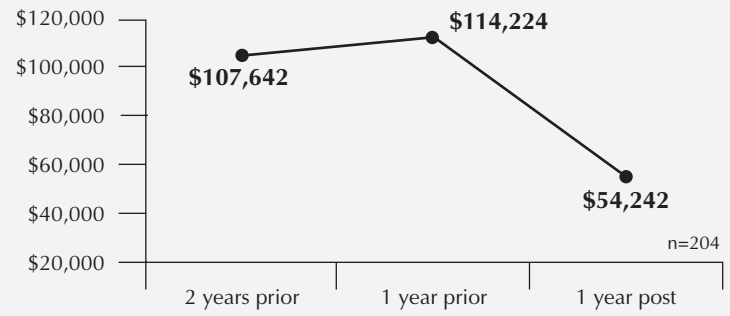
Table 1: Average Annual Visits to SFGH Emergency Room



The cost of a typical emergency room visit is $182, though for a psychiatric emergency the average cost rises to $550. That is only the *hospital* cost — it does not include the costs of medical procedures and tests, doctors' fees,

or any costs for an inpatient admission that may follow the emergency room visit. Focusing just on the hospital ER cost for those who remained in supportive housing for a full 12 months (204 people), the following graph shows the magnitude of the savings:

Table 2: Hospital Emergency Room Costs

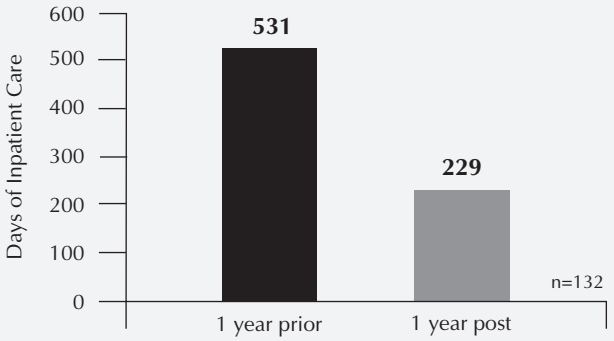


The benefit of this drop is not only in relieved demand on San Francisco General's emergency facilities; the longer-lasting benefit is that people are *healthier*, and being treated consistently, preventively, and without the costly infrastructure of emergency care. These are benefits that accumulate over time.

2. A 57 percent reduction in hospital inpatient days

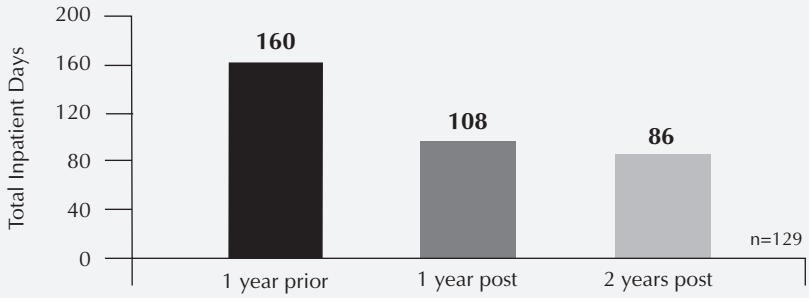
A similar pattern emerges when the study moves from the emergency room to the inpatient wards. Here, because of missing data in San Francisco General's database, it was possible to look at only one year of prior hospitalizations before moving in to supportive housing. Even then, hospital records on some patients were not complete enough to supply information on one full year before and after each patient entered supportive housing. Of the total population of 235 people, 204 had remained in supportive housing for a full 12 months. Of those, it was possible to obtain information on prior hospitalizations for only 132 people. Nonetheless, judging from this smaller group, the reduced demand on the hospital is as dramatic as the decline in ER use. The number of hospital days was down nearly by 57 percent in a single year, to 229 days from 531.

Table 3: Total Hospital Inpatient Days



Of all the tenants included in this study, 129 stayed in Canon Kip or the Lyric for at least *two* full years — long enough to examine the effect of a second year on their inpatient hospital use (even if, for some of these people, the data on inpatient hospital use *before* they entered supportive housing is still incomplete). For this group, the second year in supportive housing brought a further 20 percent decline in hospitalization days.

Table 4: Inpatient Days after a Second Year in Supportive Housing



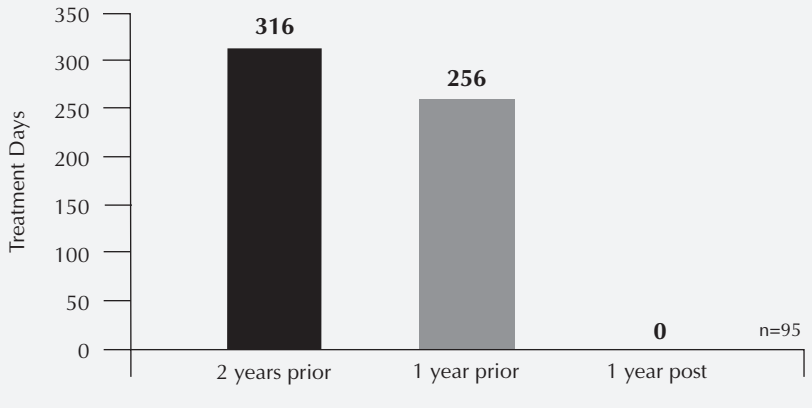
For those tenants who used hospital inpatient services, both the number of admissions and the number of days they were hospitalized each year dropped dramatically. Looking just at the people who had at least one inpatient stay during the year before or after moving into supportive housing (38 people out of 129), the number of hospital admissions declined from 79 to 36, and the average number of days of hospitalization dropped from 13.79 days before to 5.88 days after.

3. A *near total elimination* of residential mental-health care outside of hospitals

Data on mental-health services are subject to particular legal safeguards of confidentiality requiring, among other things, that the data may not be released for study unless each individual in the study first consents in writing. Of those living at the Lyric and Canon Kip during two rounds of recruitment for participation in this study, 157 provided the written authorization that would allow their data to be included in this analysis. Of those, however, some or all of the data on services is missing from the Community Mental Health Services database for many residents. (Researchers and CMHS staff are currently working to correct the problem wherever possible.) Complete information on mental health care during the 12 months after entering supportive housing is therefore available for only 95 of the tenants in these two programs. And for nearly half of these tenants, information is incomplete about inpatient hospitalizations during the 12 months before they moved into supportive housing.

Yet despite the limitations on the data, the results are dramatic. Total use of residential treatment programs among this sub-group fell *to zero* once people entered supportive housing. In the year before entering supportive housing, total use declined somewhat — possibly because some people were on waiting lists for the Lyric and Canon Kip, and thus receiving some amount of advance service from HHISN providers at those sites. Even then, however, their use of these 24-hour treatment programs one year before entering supportive housing had averaged 2.69 days per person per year, for a total of 256 days. One year later, both the average and the total utilization had fallen to zero.

Table 5: Days of Residential Mental Health Treatment



The total costs eliminated in this process are equally dramatic. For just this sub-group of 95 people, the aggregate cost of treatment two years before supportive housing was $39,195. A year later, the slight reduction in total use brought the cost to $28,388. A year later, it had been eliminated entirely.

There are several possible explanations for such a pronounced decline, and the next stages of analysis are likely to shed more light on these. The sharp drop in residential treatment may, for example, be associated with a reduction in the number of inpatient psychiatric hospitalizations. It may also be the result of a quicker return home following a short-term hospitalization, given that many of the supports provided in residential treatment programs are routinely available in supportive housing.

Although complete data on psychiatric hospitalizations are not yet available for analysis (they will be included in the next stages of research), these results on residential treatment programs give some clues about trends in the use of psychiatric hospital beds. In San Francisco, residential treatment is frequently used in conjunction with an inpatient psychiatric hospitalization. During an acute psychiatric crisis, consumers are often transferred to residential treatment after a few days in the hospital, to continue intensive treatment and prepare to return to more independent community living. A reduction in residential treatment would therefore be likely to signal some corresponding reduction in hospitalizations.

A Closer Look at Two Supportive Housing Residences

The Lyric Hotel and Canon Kip Community Residence, where these results were achieved, serve similar populations of formerly homeless people using a combination of federal, state, and local funds.

The Lyric is a 58-unit residence, one of six operated by Conard House, a nonprofit organization specializing in mental-health services. Apartments at the Lyric are tailored to people who have a psychiatric diagnosis — typically paranoid schizophrenia, post-traumatic stress disorder, major depression, or borderline personality disorder — plus one other form of disability, such as HIV, a physical impairment, or an addiction. At the Lyric, Conard House provides core on-site case management, and Baker Places supplements the on-site staff with case-management and social work specialists, besides providing connections to off-site treatment. The building opened in 1997.

Canon Kip, with 104 apartments, opened in 1994. It is the first of two supportive residences developed by Episcopal Community Services of San Francisco (ECS). More than 70 percent of the tenants at Canon Kip have two or more disabilities, including mental illness, HIV and AIDS, or a history of substance abuse. As at the Lyric, ECS's on-site staff are supplemented by employees of Baker Places, which also provides outside treatment as needed.

The average tenant at Canon Kip and the Lyric pays 30 percent of his or her income in rent. The residence collects a federal supplement paid through the Shelter-Plus-Care program to make up the difference between the cost of providing the supportive apartment and the rent each tenant is able to pay.

Both programs welcome people still struggling with the problems that led them to life on the streets. Based on a model known as "harm reduction," these programs start with the goal of reducing tenants' more self-destructive behavior, particularly the harmful use of drugs or alcohol — even if that behavior can't be stopped altogether. Yet at the same time, the program continually offers a vision and opportunity for an ordinary, independent life: training and employment services, opportunities for participating in community life, environments for socializing away from addictive substances.

HHISN reinforces this approach to supportive housing by making available a wide range of social, medical, and training services that meet tenants' needs wherever they happen to be. For example, the Supportive Housing Employment Collaborative, a specialized network within HHISN, operates a skills center that gives tenants and case managers in supportive housing a broad choice of training and job paths for people who are looking for employment or want to improve on their current job. The city's Tom Waddell clinic, in addition to its regular walk-in services, provides an on-site physician or nurse practitioner at both residences to deliver basic medical care and health education, and to help residents manage their psychiatric or other medication. Addiction-recovery programs conduct support groups on site or nearby and generally reinforce those who are trying to end their substance abuse. Baker Places and other service organizations help train peer counselors, provide clinically trained case managers on-site who can help tenants address mental-health or substance-abuse problems, and provide access to detoxification and treatment programs for residents who lapse into more severe substance abuse.

In short, HHISN gives each supportive residence an arsenal of different responses for all the different needs and levels of functioning that tenants present from day to day. One agency could never supply all the forms of experience and staff specialty that this requires. Relying on HHISN, the front-line staff at each supportive residence can concentrate on the particular

tenants at that place, knowing that whatever particular expertise may be needed from day to day is available from the network, no farther than a phone call — or, in many cases, a walk down the hall, or down the street.

Meanwhile, the specialized staff in the various medical and service agencies rely on supportive housing to give them access to people they might never reach otherwise. Said one staff member at the Tom Waddell clinic:

> Harm reduction creates a climate of trust where we can talk honestly to people, often for the first time, about problems they would never admit to in an office or a clinic. When I talk to someone at Canon Kip, I learn things about their drug use or their prior life on the streets that I would never have learned in my office. Suddenly, from that point on, the whole medical relationship is based on *reality*, and we actually start to accomplish something.

Conclusion

The study from which these early findings are drawn is still in progress. Eventually, it is expected to include information from the criminal justice system and from other public support and service programs. By later this year, it will be possible to make a straightforward comparison between the costs of supportive housing with HHISN's services, and the cost of "treating" chronic homelessness in the usual ways: by responding to its emergency side effects, by arresting and jailing people, or by simply ignoring it. All these responses have a cost. Some, like those described in this preliminary report, are enormous. All, it seems, can be reduced by coordinating housing, services, medical and psychiatric care, and addiction treatment in a carefully managed package.

The full test of that assertion will come over the next several months. For now, at least, the initial evidence seems encouraging, often dramatically so. The opinion of supportive housing residents, while less quantitative, reinforces the message of the numbers. Said one resident, on reviewing an early summary of this report: "When I look at those charts, I see my life. That's my story, and I know it's right."

Appendix A

Residents of the Lyric and Canon Kip: Behind the Numbers

This appendix presents profiles of just a few of the residents of the two supportive housing developments whose work is described in the main paper. As in other instances, the names have been changed and the specific place of residence concealed, but all other details are true. The experiences of each of these three people are included among the statistics in the current research.

Edwin Marshall is 48 years old. In the 1980s he was a happily married father of three, a Vietnam veteran with a home and a business of his own. Although he suffered, even then, from Post-Traumatic Stress Disorder (PTSD), the condition was medicated and seemed manageable. In the late '80s, however, a painful disease of the joints made it necessary for him to have both hips replaced. Unable to work, he watched his business suffer and eventually had to sell it. As he struggled with chronic pain, which prescribed medication had failed to control, he began to abuse the prescription drugs and to "self-medicate with alcohol."

After his surgery, the forced idleness and pain, aggravated by substance abuse, drove him deeper into depression and desperate behavior, including more drugs in more volatile combinations. As he lost control of his finances, and the cost of his drug habits deepened, he was forced to sell the family home. His wife, unable to recognize the man she married, soon left him. With his family gone, the last anchor holding him to a stable life disappeared.

"At that point," he says, "I fell into drug use full on." Between 1989 and 1992 he was convicted six times on felony charges of possession and selling drugs. Meanwhile, as he took worse and worse care of himself, his physical condition worsened and one of the hip replacements became infected. In 1992, walking on two canes, Mr. Marshall went to prison again, this time for 22 months, on drug-related felonies.

Although the stay in prison largely ended his drug use, upon release he again found himself homeless. With barely $300 in his pocket, he eventually landed a bed in an emergency shelter in San Francisco.

The shelter was run by an agency that is a member of HHISN. Seven months later, Mr. Marshall was moving into a supportive apartment.

Mr. Marshall is now recovering from his tangle of addictions — even foregoing pain medication, for fear of again becoming dependent. "I've learned to live with a certain amount of pain," he says. "I can't take drugs any more; I have to know what's going on in my body. I'm familiar with my pains, and I need to know when there's a new one. The human body is an amazing thing. It can get used to anything."

Mr. Marshall's next challenge is to re-establish himself in a new career, one that won't require heavy use of his fragile joints. HHISN's employment partnership — the Supportive Housing Employment Collaborative — provided some basic preparation in computer, office, and management skills, and he has since gone on to more extensive training through San Francisco Vocational Services. He uses, and values, the case-management and psychiatric services available on-site, which he says have helped him weather the occasional tough spells that still surface from time to time.

Not long ago, the management and other tenants of Mr. Marshall's supportive housing program surprised him with a lifetime achievement award, presented in person by the mayor of San Francisco.

Ray Vasquez had been living in a privately owned SRO hotel in San Francisco whose owners were about to sell the building. They gave him a referral to another SRO and a sizable cash settlement to terminate his lease. Unfortunately, Mr. Vasquez was a heavy user of crack cocaine at the time, and "I partied real good on that money. For about a week." With his money gone and his habit badly escalated, Mr. Vasquez was back on the streets, or doubled-up in the apartments of other friends with addictions. It wasn't long, though, before he ended up in Vacaville State Prison for six months on a drug-related felony.

Released on parole, he came into contact with a HHISN member agency, where he began to establish a relationship. Over time, the agency placed him on a waiting list for supportive housing, and continued working with him on his drug problem. "They asked me if I was active, if I was smoking crack," he says, still with a tone of amazement. "And I said yes. And they let me in!"

As a condition of his parole, Mr. Vasquez was required to attend regular meetings of Narcotics Anonymous. But his substance abuse continued. The agency managing his supportive residence believed — correctly, it turns out — that there was more hope for Mr. Vasquez if he had a safe place to live and the steady influence of people who could help him recover, than if he returned to the street.

The staff continually engaged Mr. Vasquez at every opportunity, talking about anything he wanted to talk about — baseball, politics, or every so often, his addiction. "They always had something else I could do instead of cracking it up," he recalls, "and every now and then, I'd do it: watch a movie, go on a trip to the zoo, or go to a ball game."

In time, some of his days were drug free. As his periods of lucidity became longer, and he could think more clearly about his situation, he began to talk with staff about the consequences of continuing drug use. "I was going to jail 18 months here and 18 months there, and by the time I was facing the new three-strikes law, I was going on five strikes."

The key to recovery for Mr. Vasquez came from a hobby: He likes to repair bicycles. When a counselor from the Supportive Housing Employment Collaborative saw him fixing bikes near the program's offices, the SHEC Skills Center helped Mr. Vasquez buy tools and start a repair business.

After a little more than a year in supportive housing, Mr. Vasquez stopped using crack. "I did everything I could to keep myself busy," he says. "I worked on bikes. I lifted weights. They have a movie marathon every month on the first, when [benefits] checks come and people get high. I went every time." Today, he is a member of the tenants' council and a peer counselor for those still struggling with addictions.

"I like it here," Mr. Vasquez says. "It's my home. I don't like to see it abused. I like [tenants] to pick up the trash, and I like for the case managers to come up and talk to the tenants. They really can help."

Morgan Cantrell was thrown out of his family's home in 1990 because of crack and alcohol addictions, and because of psychiatric problems that had become profoundly aggravated by drugs and drinking. For years, he lived in shelters and single-room hotels, and worked long hours driving trucks to support his habit. "One night I would be in my own hotel room smoking crack," he remembers, "then when the money ran out I would go to a secluded spot near Twin Peaks where I would camp out. I was so ashamed, I didn't want to be around anybody."

A short incarceration led him to a halfway house operated by one of the agencies in HHISN. That group, in turn, led him into a work-therapy program sponsored by the Veterans' Administration. In the rest of his time, he participated in the halfway-house's drug-free self-help program, where he attended (and still attends) meetings for people with dual diagnoses — that is, with mental illness combined with addiction. After two years in the halfway-house, the HHISN member agency arranged a place for him in supportive housing.

"I've been clean and sober for six years," Mr. Cantrell says now. But that victory came neither easily nor fast. "It took me four or five times of wanting to get off drugs before I did it." The next challenge he has set for himself is to move on from supportive housing because, as he puts it, "there are plenty of homeless people trying to get in." He is working, training, saving money, and planning a future.

Appendix B

Members of the Health, Housing and Integrated Services Network

San Francisco

San Francisco Department of Human Services
    Shelter-Plus-Care Program
San Francisco Department of Public Health
    Tom Waddell Health Center
    Housing Services
Baker Places
Episcopal Community Services
Conard House
Mercy Charities Housing California
Chinatown Community Development Corporation
Community Housing Partnership

Alameda County

Alameda County Health Services Agency
Alameda County Department of Housing and Community Development
Oakland Housing Authority
    Shelter-Plus-Care Program
Lifelong Medical Care
East Bay Community Recovery Project
Building Opportunities for Self Sufficiency
Bonita House
City of Berkeley Mental Health
Alameda County Network of Mental Health Clients
Jobs Consortium
Resources for Community Development
Mercy Charities Housing California
Oakland Community Housing, Inc.

Contra Costa County

Contra Costa County Health Services Department
Contra Costa County Housing Authority
    Shelter-Plus-Care Program
Rubicon Programs
Phoenix Programs
Mental Health Consumer Concerns
Shelter, Inc.

Marin County

Marin Housing Authority
    Shelter-Plus-Care Program
Marin County Department of Health & Human Services
    Division of Community Mental Health
Buckelew Programs
Ritter House
Homeward Bound of Marin

San Mateo County

San Mateo County Human Services Agency
    Office of Housing
    Shelter-Plus-Care Program
San Mateo County Health Services Agency
    Mental Health Services Division
Mental Health Association of San Mateo County
Mid Peninsula Housing Coalition

Santa Clara County

Palo Alto Housing Corporation
Alliance for Community Care
Department of Veterans Affairs Medical Center

Appendix C

Residents of the Lyric and Canon Kip: Basic Demographics

Demographic and prior living situation data are available for 244 individuals. Length of stay and retention rate data are available for 253 residents.

Characteristic	n	(%)
Age at Move-in		
Mean:		45.3
Median:		41.9
Range:		31-75
Gender		
Male	174	71.3
Female	69	28.3
Transgender	1	0.4
Race		
Black	136	55.7
White	77	31.6
Native American	12	4.9
Latino	15	6.1
Asian	4	1.6
Veteran	55	22.5
Mean Income		530.85
Living Situation at Intake		
Shelter	155	63.5
Street	74	30.3
Transitional housing or residential treatment program	15	6.1
Diagnosis		
Severe Mental Illness (SMI)	216	88.5
Substance Abuse (CD)	235	96.3
AIDS/HIV	34	13.9
Length of Stay		
All residents	mean	863 days
Residents who exit	mean	589 days
Retention Rate		
Residents that stay>= 365 days		81.6%

References

1. The research draws from multiple databases maintained by San Francisco General Hospital (SFGH) and San Francisco Community Mental Health Services (CMHS). In some cases, hospital or program data are missing or incomplete for some residents. These gaps are greatest during the years before the earliest HHISN tenants entered supportive housing, largely because of changes in billing systems and in the way publicly funded health services were reimbursed by state and local governments during those years. Therefore, depending on the service being analyzed, the population size may vary, and the variations are explained in the text of this report each time they occur.

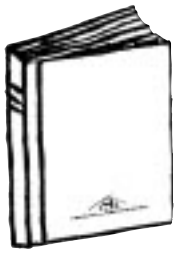
   Data regarding services provided by SFGH are available for a total of 253 individuals who agreed to be included in the study or who provided consent for this information to be provided as part of the Shelter Plus Care Program. Data describing the use of mental-health services are also subject to more restrictive legal safeguards to protect confidentiality, and may be used only with the individual consent of each person to be studied. Written consent to obtain this information was provided by 157 of those who were living at the Lyric and Canon Kip when researchers recruited participants for this component of the study, and records were located for 120 of these people, but not all the data on these 120 people were complete. Consequently, some analysis of mental-health services is based on a population size smaller than 120, and these variations are likewise described in this report each time they occur. Efforts to correct the data deficiencies wherever possible are under way. The final version of this analysis is therefore likely to be based on larger population sizes.

2. Because of the way billing data were maintained prior to 1995, this number does not include mental health care in private hospitals in the earliest year of the study. Nor does it yet include mental health care provided in jails and prisons — a figure expected to be made available in later stages of research. In short, the $8,000 average is almost certainly an underestimate.

3. Throughout this report, residents' names have been changed, and their current residence concealed, to protect their privacy.

All other facts are true, and are being reported with each person's full consent and participation. Other stories of tenants in supportive housing appear in Appendix A.

4. Two hundred seventy-eight people moved into Canon Kip or the Lyric as part of the Shelter-Plus-Care program between October 1994 and December 1999. Of those, 253 had moved in by March 1999 — allowing at least one full year of data to be collected by March 2000. Emergency Room data from San Francisco General Hospital are available for this full group for the full period being studied, but inpatient data are complete on only 132 of this group for 12 months before and 12 months after they entered supportive housing. As in other cases, hospital administrators are working with researchers to correct the problem.



CSH Publications:

In advancing our mission, the Corporation for Supportive Housing publishes reports, studies and manuals aimed at helping nonprofits and government develop new and better ways to meet the health, housing and employment needs of those at the fringes of society.

Under One Roof: Lessons Learned from Co-locating Overnight, Transitional and Permanent Housing at Deborah's Place II *Commissioned by CSH, Written by Tony Proscio. 1998; 19 pages.* **Price: $5**
This case study examines Deborah's Place II in Chicago which combines three levels of care and service at one site with the aim of allowing homeless single women with mental illness and other disabilities to move towards the greatest independence possible, without losing the support they need to remain stable.

Work in Progress…An Interim Report from the Next Step: Jobs Initiative *1997; 54 pages.* **Price: $5**
This report provides interim findings from CSH's ***Next Step: Jobs*** initiative, a three-city Rockefeller Foundation-funded demonstration program aimed at increasing tenant employment in supportive housing. It reflects insights offered by tenants and staff from 20 organizations based in Chicago, New York City, and the San Francisco Bay Area who participated in a mid-program conference in October, 1996.

Work in Progress 2: An Interim Report on *Next Step: Jobs* *Commissioned by CSH, Written by Tony Proscio. 1998; 22 pages.* **Price: $5**
Work in Progress 2 describes the early progress of the ***Next Step: Jobs*** initiative in helping supportive housing providers "vocationalize" their residences—that is, to make working and the opportunity to work part of the daily routine and normal expectation of many, even most, residents.

A Time to Build Up *Commissioned by CSH , Written by Kitty Barnes. 1998; 44 pages.* **Price: $5**
A Time to Build Up is a narrative account of the lessons learned from the first two years of the three-year CSH New York Capacity Building Program. Developed as a demonstration project, the Program's immediate aim is to help participating agencies build their organizational infrastructure so that they are better able to plan, develop, and maintain housing with services for people with special needs.

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing *Written by Sue Reynolds in collaboration with Lisa Hamburger of CSH. 1997; 146 pages.* **Price: $15**
Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults *Commissioned by CSH, Written by Susan M. Barrow, Ph.D. and Gloria Soto of the New York State Psychiatric Institute. 1996; 103 pages.* **Price: $15**
This evaluation examines low-demand interim housing programs, which were developed by nonprofits concerned about how to help homeless people living on the streets who are not yet ready to live in permanent housing. Funded by the Conrad N. Hilton Foundation, this report is a 15-month study of six New York interim housing programs.

In Our Back Yard *Commissioned by CSH, Directed and produced by Lucas Platt. 1996; 18 minutes.* **Price: $10, nonprofits/ $15, all others.**
This educational video is aimed at helping nonprofit sponsors explain supportive housing to members of the community, government representatives, funders and the media. It features projects and tenants in New York, Chicago and San Francisco and interviews a broad spectrum of supporters, including police, neighbors, merchants, politicians, tenants, and nonprofit providers.

Design Manual for Service Enriched Single Room Occupancy Residences *Produced by Gran Sultan Associates in collaboration with CSH. 1994; 66 pages.* **Price: $20**
This manual was developed by the architectural firm Gran Sultan Associates in collaboration with CSH and the New York State Office of Mental Health to illustrate an adaptable prototype for Single Room Occupancy residences for people with chronic mental illnesses. Included are eight prototype building designs, a layout for a central kitchen, recommendations on materials, finishes and building systems, and other information of interest to supportive housing providers, architects and funding agencies.

Next Door: A Concept Paper for Place-Based Employment Initiatives *Written by Julianne Dressner, Wendy Fleischer and Kay E. Sherwood. 1998; 61 pages.* **Price: $5**
This report explores the applicability of place-based employment strategies tested in supportive housing to other buildings and neighborhoods in need of enhanced employment opportunities for local residents. Funded by the Rockefeller Foundation, the report explores transferring the lessons learned from a three-year supportive housing employment program to the neighborhoods "next door."

Understanding Supportive Housing *1997; 58 pages.* **Price: $5**
This booklet is a compilation of basic resource documents on supportive housing, including a chart which outlines the development process; a description of capital and operating financial considerations; tips on support service planning; program summaries of federal funding sources; and a resource guide on other publications related to supportive housing.

The *Next Step: Jobs* Initiative Cost-Effectiveness Analysis *Written by David A. Long with Heather Doyle and Jean M. Amendolia. 1999; 62 pages.* **Price: $5**
The report constitutes early findings from a cost-effectiveness evaluation by Abt Associates of the ***Next Step: Jobs*** initiative, which provided targeted services aimed at increasing supportive housing tenants' employment opportunities.

Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services *Commissioned by CSH, Written by Basil Whiting. 1994; 73 pages.* **Price: $5**
Funded by the Rockefeller Foundation, this report explores the advisability of implementing a national employment demonstration program for the tenants of supportive housing. The paper is based on a series of interviews with organizations engaged in housing, social service, and employment projects in New York City, the San Francisco Bay Area, Washington, D.C., Chicago, and Minneapolis/ St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

Connecticut Supportive Housing Demonstration Program — Program Evaluation Report *Commissioned by CSH, Prepared by Arthur Andersen LLP, University of Pennsylvania Health System, Department of Psychiatry, Center for Mental Health Policy and Services Research, Kay E. Sherwood, TWR Consulting. 1999; Executive Summary, 32 pages. Complete Report, 208 pages.*
Executive Summary Price: $5 Complete Report Price: $15
This report evaluates the Statewide Connecticut Demonstration Program which created nearly 300 units of supportive housing in nine developments across the state in terms of tenant satisfaction, community impact — both economic and aesthetic, property values, and use of services once tenants were stably housed.

Miracle on 43rd Street *August 3, 1997 and December 26, 1999.*
60 Minutes feature on supportive housing as embodied in the Times Square and the Prince George in New York City. **To purchase VHS copies, call 1-800-848-3256; for transcripts, call 1-800-777-8398.**

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - California Edition
Commissioned by CSH. Prepared by the Law Offices of Goldfarb and Lipman. 2000; 217 pages.
Price: $15 or download for FREE at www.csh.org
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Landlord, Service Provider…and Employer: Hiring and Promoting Tenants at Lakefront SRO *Written by Tony Proscio and Ted Houghton. 2000; 59 pages.*
Price: $5 or download for FREE at www.csh.org
This essay provides a close look at Lakefront SRO's program of in-house tenant employment, as a guide for other supportive housing programs that either hire their own tenants or might want to do so. The lessons of **Landlord, Service Provider...and Employer** are also of potential interest to affordable housing programs whose tenants could become valuable employees given sufficient encouragement, training, and clear policies.

The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the *Next Step: Jobs* Initiative
Written by Wendy Fleischer and Kay E. Sherwood. 2000; 73 pages.
Price: $5 or download for FREE at www.csh.org
The ***Next Step: Jobs*** initiative tested the premise that a range of employment services targeted to supportive housing tenants can help them access employment. It used supportive housing as the focal point for deploying a range of services to address the multiple barriers to employment that tenants face. It also capitalizes on the residential stability and sense of community that supportive housing offers.

Vocationalizing the Home Front: Promising Practices in Place-Based Employment *Written by Paul Parkhill. 2000; 79 pages.* **Price: $5 or download for FREE at www.csh.org**
Accessibility; inclusiveness; flexibility; coordinated, integrated approach to services; high quality, long-term employment; and linkages to private and public sectors are hallmarks of a new place-based strategy to help people with multiple barriers to work, find and keep employment. The 21 place-based employment programs featured in this report represent some of the most comprehensive and innovative approaches to employing persons who are homeless, former and current substance abusers, individuals with HIV/AIDS, those with physical and psychiatric disabilities and other challenges.

Supportive Housing and Its Impact on the Public Health Crisis of Homelessness *Written by Tony Proscio. 2000; 40 pages.*
Price: $5 or download for FREE at www.csh.org
This publication announces the results of research done between 1996 and 2000 on more than 250 people who have lived at the Canon Kip Community House and the Lyric Hotel. It also looks at pre-occupancy and post-occupancy use of emergency rooms and inpatient care.

COMING SOON:

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - National Edition
Commissioned by CSH. Prepared by the Law Offices of Goldfarb and Lipman.
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel *Written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez.*
Evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engage them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community, developed by the Center for Urban Community Services with first year funding from the Corporation for Supportive Housing, is one pioneering effort to help mentally-ill long-term shelter residents obtain housing.

Guide to Developing Family Supportive Housing *Written by Ellen Hart Shegos.*
This manual is designed for service providers and housing developers who want to tackle the challenge of developing permanent supportive housing for chronically homeless families. The manual will provide information on the development process from project conception through construction and rent-up. It also discusses alternatives to new construction such as leased housing. It contains practical tools to guide decision making about housing models, picking partners, and service strategies.

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir.*
This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving Health, Housing and Integrated Services tenants where they live.

Forming Local Consortia to Develop Supportive Housing Projects *Written by Tony Proscio.*
These three related guidebooks are for those interested in forming local consortia and developing supportive housing projects. Guidebook I discusses the formation and management of the supportive housing consortium. Guidebook II sets out the necessary building blocks for designing and organizing services in developments. Guidebook III provides information on designing, financing, building, and managing housing for people who need ongoing services.

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Mission Statement…

CSH supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance use, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy, and dignity, and reach for their full potential.

We work through collaborations with private, nonprofit and government partners, and strive to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.

EXECUTIVE SUMMARY

In the early 1990's, Connecticut was one of many states across the country that experienced a phenomena that stimulated the search for new housing solutions and new community-based services. Homeless shelters were at capacity, hospitals around the State were treating numerous episodes of illness and injury among indigent, often homeless, abusers of alcohol and drugs, and the State of Connecticut had been progressively discharging long-term patients from its three large mental health hospitals for several years.

The State of Connecticut (the "State") and the Corporation for Supportive Housing (CSH"), a national, nonprofit intermediary organization whose mission is to expand the quantity and quality of service-supported, permanent housing for individuals with special needs who are homeless or at risk of becoming homeless, joined forces in June 1992 to design and implement a demonstration program to address the housing issues facing homeless and at-risk populations. The understanding between the parties was that the State would identify the necessary financing and, if this were accomplished, CSH would dedicate $900,000 of its own national funds to the initiative, raise matching funds locally, make equity investment proceeds available to the project, and staff the development of the Program. The production target was 400 units of housing to serve the intended population by bringing together multiple forms of public and private financing, by working through community acceptance and approvals for specific supportive housing projects, by managing the project planning, construction and "rent up" of buildings, and by providing for effective, coordinated operation of both the building properties and the service programs for tenants. The joint initiative became the Connecticut Supportive Housing Demonstration Program ("the Program"), which ultimately produced 281 units of service-enriched permanent housing for homeless and at-risk populations.

The concept of supportive housing had been tested on a relatively large scale in New York City, Chicago, and the San Francisco Bay Area by 1992 when the Melville Charitable Trust funded CSH to assess the feasibility of a supportive housing demonstration program in Connecticut. But the concept had not been tested to the same extent in mid-size cities like New Haven and Hartford, or in towns the size of New Britain and Middletown. Although there was a "model" for supportive housing, it would require adaptation to Connecticut's governmental structures and interests and to local conditions and needs. This study is an objective evaluation of that adapted model for supportive housing.

The purpose of this study is to perform an objective evaluation of the Program in a number of key areas. One of the primary purposes of the study is to determine if stable housing reduces the need for expensive health and social services over time, enhances the quality of life of its residents, and allows residents to attend to their employment and vocational needs. This determination is being made through an analysis of data on the residents and their service usage over a three-year period. In addition, the study is intended to evaluate the financial stability of the projects participating in the Program over a three-year period. This report is the second of three reports that address these two key areas of tenant outcomes and project financial stability. The first Program evaluation report, issued in

October 1999, also included a financial analysis of the Program's costs and its cost effectiveness, an assessment of the aesthetic and economic impact of the siting process, and an analysis of the development phase of the Program.

Organization of Study

This year's study is divided into three components. The first component, the "Executive Summary", details the highlights, conclusions, and recommendations of the other components of the report. The second component of the study, entitled "Effect of Supportive Housing on Tenants", analyzes data derived from surveys that were completed by tenants, property managers, and social services providers. It also analyzes data regarding the use of social services by the tenants and the costs of Medicaid services rendered. The third component of the study, "Project Financial Stability", evaluates the financial stability of the individual projects using defined and developed methodologies.

The Consultants

This year's evaluation was performed by two separate consultants: Arthur Andersen LLP and The Center for Mental Health Policy and Services Research of the Department of Psychiatry at the University of Pennsylvania Health Care System ("UPENN").

The Center for Mental Health Policy and Services Research of the Department of Psychiatry at the University of Pennsylvania Health Care System was engaged to produce a detailed description of the Program and to determine if the provision of stable housing reduces the need for expensive health and community social services over time. UPENN used both data derived from surveys and secondary data. The survey data came from two sources, tenants and service providers, including property (building) managers, social services directors or supervisors, and case managers/case workers. There were four survey instruments for tenants that were administered at six-month intervals by case managers/case workers as interviews. Property managers, social service supervisors, and case managers completed written survey instruments. Secondary data were obtained from two governmental agencies, the Department of Social Services, Medicaid Unit, and the ABBY client tracking system of the Connecticut Department of Mental Health and Addiction Services. Based on the data obtained, staff at UPENN prepared the chapter entitled "Effect of Supportive Housing on Tenants."

Arthur Andersen LLP, a multidisciplinary professional services firm, was engaged to collect and analyze data from project sponsors, property management, and social service providers and from CSH, local municipalities, and the State. The data were collected from the projects' Statements of Cash Flow, submitted to the Connecticut Housing Finance Authority ("CHFA") and the State of Connecticut Department of Economic and Community Development ("DECD"); from audited financial statements; and from interviews with Program participants. Those data were used by Arthur Andersen to write the chapter of the report entitled "Project Financial Stability".

The Connecticut Supportive Housing Demonstration Program

Statistics related to homelessness and persons at risk bear out the need for supportive housing that the State of Connecticut recognized during the early 1990's. Forty-one shelters receiving State funding reported that about 15,600 different people used the shelters between October 1992 and September 1993. Approximately half of the shelter residents had been evicted by landlords or family and friends. Data from two years later showed that ninety-two percent of the single-person shelter population was concentrated in three counties - Fairfield, Hartford, and New Haven - although the shelters within the Connecticut Coalition to End Homelessness network were scattered across 25 towns. At the end of 1993, Connecticut had an estimated 25,000 cases of HIV / AIDS and the sixth highest per capita rate of AIDS cases in the nation. Furthermore, over the previous decade, the State had been progressively discharging long-term patients from its three large mental health hospitals, reducing beds in the facilities from 2,358 in 1983 to 1,186 in 1993, a decline of 62%.

The Program was designed to provide supportive housing, which is a non-institutional form of housing for people who have special needs but who are able to live independently if they have some assistance. In supportive housing projects, tenants have their own apartments, they enter into rental agreements and pay their own rent, and the housing is intended to be permanent as long as the tenants abide by the terms of their leases. In most supportive housing projects, there is common space for tenants' social activities and security systems to keep tenants safe and to control access to the project buildings. Although counselors are present during daytime and some evening hours, tenants are not required to obtain assistance from the social services providers – i.e., the utilization of case management services by the tenants is completely voluntary.

Unlike the development of most residential programs for people with special needs, the development of supportive housing involves bringing together multiple forms of public and private financing, obtaining community acceptance and approvals for specific supportive housing projects, managing project planning, construction and "rent up," and providing effective, coordinated operation of both the property and the service program. In addition to the usual housing development tasks of financing and siting, owners and property managers confront, with the advice of the on-site service providers, questions of tenant qualifications and tenant mix (both in terms of ability to pay rent and special needs); structural and other building accommodations for special needs; tenant screening procedures; on-site staffing; security; eviction policies that would support the revenue needs of the buildings and the needs of vulnerable tenants; and protocols for communication between property managers and service providers.

The Program Partners

There are various partners that are participating in the Program. The following chart lists all of the Program partners and, where applicable, their financial investments in the Program or the projects with which they are associated:

Public Funders of the Program

Providers of Capital Financing

- Connecticut Department of Economic and Community Development (DECD) - $62,500 per developed unit
- Connecticut Housing Finance Authority (CHFA) – $12,500 per developed unit (also administrator of Low Income Housing Tax Credits)

Provider of Annual Service Funding

- Connecticut Department of Mental Health and Addiction Services (DMHAS) – $5,000 per year per special needs unit
- Connecticut Department of Social Services (DSS) – $2,500 per year per special needs unit

Provider of Project-based Rental Subsidies

- U.S. Department of Housing and Urban Development (HUD) – $7,947,000 Program Grant

Policy Coordinator

- Connecticut Office of Policy and Management (OPM)

Private Funders of the Program

Provider of Predevelopment Loans, Technical Assistance, Capacity-Building Grants

- Corporation for Supportive Housing (CSH) – $2,381,364 total of loans, grants and technical assistance

Funders of CSH

- Ford Foundation, Pew Charitable Trusts, Robert Wood Johnson Foundation
- Connecticut philanthropy, including: Community Foundation for Greater New Haven, Ensworth Charitable Foundation, Fairfield County Foundation, Fisher Foundation, Greater Bridgeport Area Foundation, Hartford Courant Foundation, Hartford Foundation for Public Giving, George A. and Grace L. Long Foundation, and Melville Charitable Trust

Investors in Projects for Operating Reserves and Capital Costs

- National Equity Fund (NEF) – $28,000,000 (approximate Program total)

CONNECTICUT SUPPORTIVE HOUSING DEMONSTRATION PROGRAM – PARTICIPANTS

Projects	Lead Sponsor	Service Provider	Property Management
Liberty Commons 8 Liberty Street Middletown	The Connection Fund	St. Vincent DePaul Place	Community Housing Management
Hudson View Commons 525 Hudson Street Hartford	Broad Park Development Corp	Chrysalis Center	Broad Park Development Corp
Crescent Apartments 431 Washington Street Bridgeport	Central CT Coast YMCA	YMCA, Bridge House, Family Services Woodfield, Regional Network of Programs	Community Housing Management
Colony Apartments 41 Ludlow Street Stamford	St. Luke's LifeWorks	St. Luke's LifeWorks	St. Luke's LifeWorks Community Housing Management
Brick Row 25 Vermont Drive Willimantic	United Services, Inc.	United Services, Inc.	Community Housing Management
Mary Seymour Place 2197 Main Street Hartford	My Sisters' Place	My Sisters' Place	Greater Hartford Realty Mgmt. Co.
Cedar Hill Apartments 1465 State Street New Haven	HOME, Inc.	Columbus House	HOME, Inc.
Fairfield Apartments 1062 Fairfield Avenue Bridgeport	Central CT Coast YMCA	YMCA, Bridge House, Family Services Woodfield, Regional Network of Programs	Community Housing Management
Atlantic Park 658 Atlantic Street Stamford	St. Luke's LifeWorks	St. Luke's LifeWorks	St. Luke's LifeWorks Community Housing Management

Given that many State agencies changed names and functions between 1992 and the end of 1995, the remainder of this report will refer to these agencies by their present names and acronyms, except when historic accuracy is called for:

DECD - Department of Economic and Community Development – the agency that was created when the Department of Housing and the Department of Economic Development were consolidated into one agency;
CHFA - Connecticut Housing Finance Authority;
DMHAS - Department of Mental Health and Addiction Services – the agency that was created when the Addiction Services Division of the Department of Public Health and Addiction Services and the Department of Mental Health were consolidated into one agency;
DSS - Department of Social Services – the agency that was created when the Department of Human Resources and the Department of Income Maintenance were consolidated into one agency; and
OPM - Office of Policy and Management- the State agency responsible for policy coordination.

In April 1994, a Memorandum of Understanding ("MOU") was entered into between CSH and six State agencies – OPM, DECD, DMHAS, DSS, CHFA and the Department of Public Health and Addiction Services, which at the time was the State agency responsible for services to people with addictions. In the Memorandum of Understanding the State agreed to provide financial resources through CHFA and DECD for the Program to develop the project sites. DMHAS and DSS agreed to provide annual grants to the Program for on-site supportive services. CSH agreed to provide predevelopment financing to project sponsors and to provide grants to individual sponsors on an as-needed basis for core operating support. An interagency Taskforce chairperson was chosen to facilitate the overall coordination among Taskforce members, to convene meetings of the Taskforce, and to serve as the point person on press issues.

The project sponsors are community-based, nonprofit organizations that developed the projects and that serve as the general partners of the partnerships that own the projects. The selection of sponsors began in early 1993 with the publication of a request for qualifications (or "RFQ") from not-for-profit organizations interested in the development and management of housing and the provision of supportive services to homeless, at-risk and low income individuals. Of the 28 applicants responding to the RFQ, ten organizations were selected to develop a total of 12 projects, two each in Bridgeport, Hartford and Stamford, and single projects in Bristol, Meriden, Middletown, New Britain, New Haven, and Willimantic (Windham). Project sponsors then chose property management companies to operate the projects and nonprofit social service providers to provide on-site support services to the tenants.

Other partners include the national foundations (Ford Foundation, Pew Charitable Trusts, Robert Wood Johnson Foundation) and Connecticut philanthropy that fund CSH's efforts to provide predevelopment loans, technical assistance, and capacity-building grants. The U.S.

Department of Housing and Urban Development provides project-based Shelter Plus Care rental subsidies that are administered by DMHAS. Federal Low Income Housing Tax Credits ("LIHTC") are administered by CHFA and distributed to the projects to stimulate corporate investment. Corporate investment in the projects for operating reserves and capital costs is provided through the National Equity Fund.

Interagency Collaboration

The Connecticut Supportive Housing Demonstration Program represented a unique arrangement to accomplish a State objective in 1992. It entailed partnerships, collaborative work, and consensus decision-making of many types and at many levels. Among the organizational features that marked the Program as pioneering at the time were:

- The involvement of six state agencies in a single initiative with the objective of providing coordinated, simplified, and expedited development and oversight of the initiative.

- A substantial role for private entities in the initiative - including coordination and leadership on some aspects. Specifically, the Corporation for Supportive Housing was a partner with the State in developing the Program, and was the primary source of money for pre-development costs of supportive housing projects and of technical assistance to the projects. Also, the National Equity Fund played a key role in Demonstration Program project financing.

- A collaborative grant-making initiative by nine Connecticut foundations to finance CSH's work in the State and to create a pool of funds for CSH to lend and re-grant to supportive housing sponsors to cover predevelopment and "soft" costs of the projects.

- Formal structures and agreements to join local housing developers and social service providers in the same projects as well as parameters for project design and service program implementation that encouraged and facilitated a collaborative approach to the day-to-day operation of housing with services.

- Agreements and procedures for one state agency (DSS) to transfer funds for services in the Demonstration projects to another State agency (DMHAS) and the authority to administer those funds; and agreements and procedures for a single quasi-governmental organization (CHFA) to oversee the development of projects that were financed with its own resources and with the resources of a State agency (DECD).

These unprecedented ways of doing business in the Supportive Housing Demonstration Program were intended to make possible a type of housing that most Program partners believed could only be created by bringing together different professions, different sources of funding, and different regulatory and oversight authorities under an integrated system of some type. To some partners, these new ways of doing public business constituted part of the

model for supportive housing generally, or for the Connecticut Demonstration Program specifically.

Development of projects was expected to begin in January 1993, with the whole process of site selection, design, bidding and construction to take from 12 to 30 months after that, depending on the specific plans for each project. The nine projects of Connecticut's Supportive Housing Demonstration Program that were built and occupied actually opened their doors between June 1996 and June 1998. Because the development of supportive housing is extraordinarily complex in the best circumstances, and it was untested in Connecticut at the beginning of the Program, the first project opened its doors almost 2 ½ years later than was originally planned.

The Financing and Development of Program Projects

In the MOU entered into in April 1994, DECD agreed to provide a total of $20 million in taxable bond financing and CHFA agreed to provide a total of $4 million in loan funds from the proceeds of its Investment Trust Fund for the projects developed under the Program. DECD and CHFA provided capital financing in the form of construction and permanent loans at an interest rate of one percent annually. Loan principal is due as a balloon payment upon the earlier of sale or refinancing of the projects or at the end of 30 years.

Based on the funding amounts authorized by DECD and CHFA, DECD provided $62,500 in financing per Program unit and CHFA lent $12,500 per unit. Two of the projects received DECD's financing under the Affordable Housing Program, a third project received its financing through the Community Housing Development Corporation financing program, and the remaining six projects received their DECD funding from the PRIME financing program.

In addition to providing the capital financing, the State has incurred the costs of funding on-site supportive services. DSS and DMHAS agreed in the MOU to provide an annual, pooled support service grant of $7,500 per unit reserved for persons with identified special needs. DMHAS disburses the funds and is required to examine the total on an annual basis and to budget additional funds, if needed and available, to cover inflationary escalations in project service costs. The State intends for the grants to be renewed annually during the term of the DECD and CHFA mortgage loans, unless the MOU is terminated. Currently, the cost to the State of funding the on-site supportive services is $1,071,944 per year.

The projects were also financed using the Low Income Housing Tax Credit program (LIHTC), which is a Federal program that provides dollar-for-dollar tax credits to owners and investors in low income rental housing. Each project created a fund to finance shortfalls in revenue (which were expected, given the low incomes of the intended tenants) by "selling" the tax credits allocated to the projects by CHFA. The tax credits were syndicated by the National Equity Fund to yield a 15-year stream of investment income for corporate investors, who in turn provided cash to capitalize the operating reserves of the projects and to cover development costs above the $75,000 per unit limit of the loan terms. NEF effectively became a limited partner in the projects, representing the tax credit investors, and the tax credit market tapped by NEF eventually produced about $28 million for this purpose, ranging from

$1.3 to $3.2 million per project, depending on the number of project units. CSH administers the operating reserve funds for the projects, disbursing payments on the basis of DECD- and CHFA-approved budgets.

DMHAS administers project-based rental subsidies on behalf of the Program projects for units reserved for people qualified under the U.S. Department of Housing and Urban Development's Shelter Plus Care program. (These are 5 to 10-year federal subsidies requiring a match of state funds.) The total value of the subsidies to the Program reached approximately $8 million for 138 of the 281 units developed under the Program.

Funds to cover predevelopment costs, including fees associated with site control, accounting, appraisal, architectural, engineering, environmental, legal, real estate and other services, insurance, property taxes, and other costs incurred prior to construction loan closing, were provided by CSH to projects through a line of credit averaging $100,000 per project. CSH was repaid by project sponsors out of construction loans (for mortgageable costs) or equity investment proceeds (for non-mortgageable costs such as developers' fees).

Some of the project sponsors incurred predevelopment costs that could not be included within the overall costs that were mortgaged by CHFA and DECD. Therefore, those costs were deducted from the sponsors' developer fees. Furthermore, most of the project sponsors provided or obtained some type of additional financial assistance for the development and operation of the projects.

The Program Projects

Nine housing projects were developed and are currently in operation under the Program. Each project consists of a single site with 25-40 housing units, generally efficiency and one bedroom apartments, along with common meeting rooms and staff offices. The first project that was developed is in Middletown, two are in Hartford, one is in Willimantic, two are in Bridgeport, one is in New Haven, and two are in Stamford. One of the project sponsors in Hartford, as well as the project sponsors in New Haven and Stamford, serve as managers of the properties, in addition to their roles as the project sponsors. The project sponsors in Willimantic, Bridgeport, Stamford, and one of the Hartford sites also provide the social services at those six locations.

Appendix A contains a complete listing and brief description of each of the Program projects.

The Program Tenants

The tenants participating in the Connecticut Supportive Housing Demonstration Program are all single people with low incomes (at least fifty percent below the median annual income, as determined by HUD). At least seventy percent of the projects' apartments are reserved for occupancy by individuals who were formerly homeless or at risk of homelessness, and approximately fifty percent are reserved for individuals with identified special needs, such as serious mental illness, chronic substance abuse problems, or HIV / AIDS.

The Demonstration Program was designed specifically to serve a population with a high level of need, and it does. Four hundred one people enrolled as tenants between the opening of the first project in June 1996 and January 1, 2000. Of the enrolled tenants, UPenn reported demographic data in this report on the 167 individuals who entered the housing by January 1, 1998 and who responded to an initial survey. Over sixty-nine percent of these surveyed tenants reported having been homeless at some point in their lives. Only forty-five percent had lived independently in the time immediately before settling into the housing. Twenty-eight percent had lived in a "doubled up" situation, such as camping on a sofa in a friend or relative's house, in the two years before tenancy in the Program. Eighty-two percent reported having moved at least twice in those two years.

Over one in ten survey respondents had been in foster care as a child, and over 19% had been a victim of violence before the age of 18. Twenty-three percent reported spending some time in jail or prison in the two years prior to entering the housing, and 37% percent reported having been hospitalized for health reasons during that same time period. Over thirty-six percent reported receiving mental health treatment in the two years prior to entering the housing, and over 35% percent received detox services during that time.

UPENN also found that almost a fourth (24%) of the survey respondents had spent an average of 17 months prior to entry into this housing in a homeless shelter or living on the streets. Another 3% percent lived in settings that are temporary in nature, such as hospitals and treatment programs. Ten percent of the tenant respondents lived in congregate housing and another 10% lived in other or unknown situations immediately before settling into the housing.

Of the tenant respondents, 73% are men, over 43% are African-American, a third are European-American, and close to 15% are Hispanic. The average age on entry into the housing is approximately 43 years.

Staffing at the Projects

Project management in each of the nine projects generally has at least one staff person on-site during the day and someone on beeper during evenings and weekends. The on-site staff person may be either the property manager, an assistant to the property manager, or a maintenance superintendent. At least one case manager is also on-site during the day and sometimes on Saturday. Like property management, the social services staff is accessible by beeper at night and on weekends.

Generally, property managers make the decisions about who is accepted for tenancy. There is an application process to get into the housing, which includes an interview and credit check. To be considered for tenancy, applicants must have some housekeeping and cooking skills, must be able to look after themselves, and must have income adequate to pay at least a minimal rent. Reasons for rejecting an applicant include a history of violence, fire setting, and certain drug-related criminal activities.

As in most congregate residential settings from condominiums to cooperatives, all of the projects have house rules. Rules about overnight visitors vary from site to site, with most

sites allowing overnight visitors for a limited number of nights. Only one site reported not allowing overnight guests at all. The enforcement of the house rules falls to the property managers. Rule violations may result in verbal or written warnings or in Notices to Quit.

All projects have case management services available to all tenants. Case management services include linkage with other service providers, help with grocery shopping, and just "being there" as a supportive, caring person. One of the most important roles of the social service providers is to act as an advocate or interested party when a tenant is in danger of being evicted or is facing legal action for nonpayment of rent or for violation of another lease provision. When a tenant is in danger of facing legal action that will affect their housing, social service staff will talk to the tenant to determine the reason(s) why the tenant is not abiding by the provisions of the lease. Social service staff will then attempt to work with the tenant and with property management to remedy the issue.

Case managers / case workers all reported having at least an associate degree and several reported having Master's degrees. At the time of UPENN's study, the number of tenants using case management services varied from 100 percent in one project to less than 50 percent in other projects. Caseloads varied from nine to twenty-eight people, with most caseloads being eighteen or less. Nurse visits and housekeeping services were also delivered on site.

Results of UPENN'S Analysis *(Chapter 1)*

This chapter of the evaluation focused on three aspects: 1) descriptions of the tenant population and its subgroups, 2) analysis of tenants' healthcare service utilization and related costs prior to and following tenancy, and 3) tenants who have left the housing. UPenn performed its analysis by focusing on a subgroup of 213 tenants who entered the housing prior to January 1, 1998, with particular focus on the 167 tenants who filled out surveys and signed consent forms allowing access to secondary data. This subgroup was chosen because the data for this group allow sufficient follow-up and meaningful information. Within the subgroup, UPenn analyzed survey and secondary data for three samples: 1) the Full Medicaid sample, consisting of 125 tenants for whom Medicaid information was available; 2) a subset of the Full Medicaid group called the Long-Stay Sample, consisting of 98 tenants who stayed in the housing for at least two years; and 3) a subset of the Full Medicaid group consisting of 68 tenants who were part of the Shelter Plus Care Program. Seven major findings highlight the results of this evaluation.

First, **the Program serves the intended population**. As intended, a very large proportion of the tenants have a history of residential instability including being homeless or at risk of homelessness, having moved a great deal and doubling up with others. Smaller, but material proportions of the tenants have significant disabilities, including mental illness, substance abuse or serious physical disabilities that meet the eligibility criteria for the Program.

The second major finding is that, as a group, **the tenants decreased their utilization of restrictive and expensive health services,** mostly inpatient services. The decrease in use of medical inpatient services was true for most subgroups. Inpatient costs for the Full Medicaid sample were reduced 38%, for the Long-Stay Medicaid sample 58%, and for the more disabled Shelter Plus Care sample 18%.

Thirdly, there was a **marked increase in tenants' utilization of necessary on-going health care and support**. Utilization increased in two major areas: services, such as homecare, outpatient mental health and outpatient substance abuse, that enabled tenants to remain in the community; and medical and dental services to address previously unmet physical and oral health needs. The Program has been successful in linking its tenants to needed care, which accounted for the increased utilization.

The fourth finding revealed that while the average cost of healthcare service utilization decreased (e.g., inpatient) or increased (homecare, dental care), the number of service users tended to increase (with the exception of inpatient care). These findings point to **greater efficiency and the spreading of healthcare resources over larger numbers of people**.

A very important finding revealed **positive outcomes**. Tenants functioned at high levels, were able to develop goals and direction for themselves, progressed toward greater independence, and were satisfied with most aspects of the Program. While tenants expressed awareness of and concerns about social isolation, overall, the finding suggest that **being in the housing is beneficial for the people** it is designed to serve.

Comparisons of the tenant subgroups identified the Shelter Plus Care tenants as a most disabled group with the most troubled history. The small number of Shelter Plus Care users of specific services made some comparisons difficult. Overall, however**, some utilization (e.g., of home healthcare) was substantially higher for this group**.

Furthermore, there were substantial differences among the three subgroups of Full Medicaid, Long-Stay and Shelter Plus Care tenants. Comparing the total Medicaid reimbursement for all services provided to the Full Medicaid group two years prior and two years post-tenancy, reveals a 43% increase ($547,468). That increase, however, was the product of a significant (38%) reduction in inpatient costs ($126,528) coupled with a 72% increase ($682,991) in costs for services that enabled tenants with disabilities to remain in the community and those services, such as dental care, that addressed neglected and on-going needs.

A similar partitioning of the data for the Long-Stay and Shelter Plus Care groups reveals a more striking pattern. The reduction in Medicaid reimbursement of inpatient care for the Long-Stay group amounted to 58%. The increase for all other services for the same group was 81%. A more extreme pattern is reflected in the Medicaid reimbursed services for the Shelter Plus Care tenants. The reduction in reimbursement for inpatient medical care of the Shelter Plus Care group was only 18%, but the increase in Medicaid reimbursement for their all other services was 140%. Evidently, the Shelter Plus Care sample, two thirds of the size of the Long-Stay and half of the Full Medicaid samples, accounted for a large proportion of

the changes observed. Being the most disabled and in need of services, Shelter Plus Care tenants experienced the least reduction in need for inpatient care and the largest increase in utilization of all other services.

Finally, about 17% of the tenants exited the housing and over a third (38%) of those who departed left under negative circumstances. Although not unique to the Program, this is a matter of concern, because, as reported above, staying in the housing is related to substantive improvements in a variety of areas for the tenants.

Results of Project Stability Analysis *(Chapter 2)*

This chapter of the study analyzed the financial stability of the nine projects financed by the Program: Liberty Commons in Middletown, Hudson View Commons in Hartford, Crescent Apartments in Bridgeport, Colony Apartments in Stamford, Brick Row in Willimantic, Mary Seymour Place in Hartford, Cedar Hill Apartments in New Haven, Fairfield Apartments in Bridgeport, and Atlantic Park in Stamford. As of December 31, 1999, all nine of the projects had been operating for at least eighteen months.

Overall, the nine projects appear to be financially stable. Although all but one of the projects have operating reserve balances that are lower than projected, six of the eight are trailing their projections by minimal amounts that are most likely due to the investment activities of the operating reserve accounts. The other two projects behind their projections (Colony Apartments and Atlantic Park) have incurred much greater security expenses than anticipated, which has had a more significant effect on their operating reserve accounts. The financial stability of those two projects should not, however, be impaired as long as future expenses are monitored and annual sources of revenue (such as rental income) are sufficient to offset the higher expenses.

As with last year's evaluation of Liberty Commons, Hudson View Commons, Crescent Building, and Colony Apartments, the performance of parties who affect the financial stability of the nine projects has been commendable. Tenants are still not vacating the units in significant numbers, but when they do, the associated financial impact does not adversely affect the projects' financial stability. As of December 31, 1999, all nine projects have performed satisfactorily on a financial basis and the parties involved in managing the success of the projects have continued to do so while under tight budgetary constraints.

Some of the key findings of this year's financial analysis are the following:

Turnover and Occupancy Rates

An analysis of turnover rates has demonstrated that, like last year, the projects have been able to retain a majority of the tenants. While the turnover rates were not as low for Liberty Commons and Colony Apartments as they were in 1998, only two additional units turned over at Liberty Commons in 1999 and a new property manager at Colony Apartments had to stabilize tenancy by evicting tenants in 1999 who had breached lease covenants in 1998. Hudson View Commons and Crescent Apartments experienced decreases in turnover rates

in 1999 because tenancy stabilized at Hudson View and one unit less turned over at Crescent Apartments.

Of the projects included for the first time in this year's study, the turnover rates were generally low and ranged from 5.9 percent at Fairfield Apartments to 37 percent at Atlantic Park. Atlantic Park's high turnover rate can likely be attributed to the fact that the project will need to operate for longer than a year to 18 months before the turnover rate stabilizes. The need for a sufficient time to be operating, as was the case in last year's evaluation of both Hudson View Commons and Crescent Apartments, is due to the uniqueness of both the projects' tenant makeup and the Shelter Plus Care screening process..

The analysis of occupancy rates, which ranged from 91.97 percent at Atlantic Park to 98.47 percent at Mary Seymour Place, shows, like it did in last year's evaluation, that even when a tenant vacates a unit, management is able to fill the unit in a short period of time. The low turnover and high occupancy rates indicate that the projects have continued to keep tenancy stable and the flow of tenant rental income steady. The projects are still not losing significant income due to vacancy and significant costs have not been incurred to prepare units for new tenants because the number of tenants vacating the units continues to be reasonable.

Impact of Social Service Staffing on Financial Performance and Project Stability

Although there now seems to be a relationship between the number of hours that case managers spend onsite and the retention of tenants, no definitive conclusion can be reached with regard to onsite case managers and the turnover rates at the projects. While Colony Apartments and Atlantic Park have the greatest turnover rates with case managers onsite for the least number of hours per week, there are other factors that have influenced those two projects' turnover rates. Those other factors influencing Colony Apartments and Atlantic Park's turnover rates include unstable tenancy during the first 12 to 18 months of occupancy (due to poor initial screening of tenants) and the lack of solid property management at the two sites until December 1998.

In addition, of the remaining seven projects, Liberty Commons had case managers onsite for the least number of hours per week, and its turnover rate was lower than other projects that had social service providers onsite for 50 or more hours per week. Although no conclusion can be reached with regard to the relationship among onsite social service providers, property management, and tenant stability, there is a consensus that having social service providers onsite has proven to be a valuable resource that assists in addressing tenant issues and tenant retention.

Operating Performance

As of December 31, 1999, seven of the nine projects had exceeded their original operating projections and assumptions on a cumulative basis. The cumulative net operating income exceeded projections by as little as $6,375 at Liberty Commons and by as much as $131,569 at Brick Row Apartments. Colony Apartments and Atlantic Park were behind their original cumulative operating projections by $26,629 and $36,056, respectively. Both projects had

lower net income than their original cumulative operating projections due to the greater costs of providing adequate security at the sites.

With regard to operating reserve balances, only one project, Mary Seymour Place, had a balance that was higher than projected by NEF. Of the other eight operating reserve balances, six were lower than projected due most likely to the amount of interest that was paid or the investment activity of those operating reserve accounts. As with the cumulative operating projections and assumptions, Colony Apartments and Atlantic Park had operating reserve accounts that were significantly lower than NEF's projections due to the annual costs of security at the two sites.

Capital Improvements

Although the replacement reserves for all nine projects continue to be adequately funded, none of the nine projects have as yet budgeted the use of those funds for specific capital improvements. Each project had had sufficient funds from the operating reserve withdrawals to cover to-date capital expenditures.

Future Trends

The comparison of each project's actual performance in 1999 to the 2000 operating budgets revealed that property management at all nine projects are creating annual budgets that take into consideration the financial circumstances and needs at each of the sites. Management at each project made adjustments to the 2000 operating budgets so that the budgeted income and expenses reflect the historical trends and current financial needs at the sites.

The 2000 budgets were also compared to the original NEF projections to determine if future budgets are consistent with the original projections. The 2000 budget for each of the nine projects differs from the original projections due to various circumstances. Some projects have projected greater revenues because there are Section 8 subsidies contributing to their revenues or tenants are paying greater portions of their monthly rents than was originally anticipated. Expenses at all of the projects are typically budgeted to be greater than what was projected because projects have had to provide greater security measures than originally anticipated, along with other expenses that are greater than projected by NEF.

While the security costs have been greater than expected and projected by NEF, those costs have not had adverse effects on the future operating reserves of seven of the nine projects and property management have been able to adjust those projects' budgets to accommodate the increased security costs. Colony Apartments and Atlantic Park are the only two projects that are behind their cumulative NEF projections due to the amounts that have been withdrawn from their operating reserve accounts to fund security at its current levels. Although the project sponsor is subsidizing security costs at both sites using the projects' DMHAS grants in 2000, additional sources of future funding will be necessary so that the operating reserves will not be depleted faster than anticipated. Furthermore, for all of the projects, additional future resources will be needed to provide adequate 24-hour security measures and adequate building services and amenities.

Final Thoughts and Conclusions

As further expressed and illustrated in the following chapters, the Connecticut Supportive Housing Demonstration Program has been found to reduce the utilization of restrictive and expensive health services, enhance the quality of life of its tenants, and allow tenants to attend to their employment and vocational needs. Overall, the average reimbursement costs for the most expensive Medicaid services (medical inpatient) provided to Program tenants have decreased significantly from 18 months prior to tenants' entry into the housing to 24 months post-entry, the levels of tenant satisfaction with all aspects of the Program are high, and the number of tenants employed at least 10 hours a week has remained steady. Tenant utilization of on-going health care and other support services that enable them to remain in the community increased markedly after entry into the housing, as the Program successfully linked tenants to needed care. Occupancy rates are high and turnover rates are low at all nine projects that were analyzed in 2000, and property management and social service staffs have been working to ensure that the projects are run efficiently while not compromising the level of services and amenities provided to the tenants.

EFFECTIVENESS OF INTEGRATED SERVICES

FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS

A Report to the Legislature as Required by Division 5, Section 5814,
of the California Welfare and Institutions Code

Governor Gray Davis

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Secretary
California Health and Human Services Agency

Stephen W. Mayberg, Ph.D.
Director
California Department of Mental Health

May 2002

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LEGISLATIVE REPORT

Executive Summary

This report, required by Assembly Bills (AB) 34 and 2034 (Steinberg, Chapter 617 and 518, Statutes of 1999 and 2000, respectively), presents current results of the Department of Mental Health's administration and implementation of programs at county and city levels serving homeless adults with serious mental illness.

Governor Gray Davis provided $55.6 million in the state budget for Fiscal Year 2000-2001 to expand services for Adult System of Care programs directed particularly at serving homeless persons, parolees, and probationers with serious mental illness. This funding provided for the expansion from 3 AB 34 pilot programs to a total of 34 AB 2034 programs. While an additional $10 million was provided for these programs in Fiscal Year 2001-2002, this report only addresses program results for the 4,720 individuals enrolled through February 2002, prior to the award of the additional $10 million.

The Department continues to find, both through documented outcomes and anecdotal information, that the effects of intensive, integrated outreach and community-based services enable the target population to reduce symptoms that impaired their ability to live independently, work, maintain community supports, care for their children, remain healthy, and avoid crime. This report describes the approaches to services and strategies that were helpful in identifying and engaging clients and that may serve as guidelines and/or standards for future projects. Key among these approaches continues to be a very close collaboration at the local level among core service providers, including mental health, law enforcement, veteran's service agencies, and other community agencies.

The tables in Appendix 4 present program information collected from all county and city programs from implementation through February 28, 2002. The data show that days spent homeless or incarcerated and days of inpatient psychiatric hospitalization have been substantially reduced for enrollees.

Important fiscal impacts also appear to result from this service model. The $55 million in grant awards for this program provide an approximate average of $13,000 annually per client statewide. The report shows that an annual expenditure of approximately $55 million for these programs has been offset by an estimated savings or cost avoidance of nearly $23 million from reduced inpatient hospital days and reduced incarcerations.

Based on findings included in this report, the Department makes the following recommendations.

1. These programs should continue to be included in the spectrum of programs designed to meet the needs of homeless Californians.

2. Counties should be held accountable for meeting contractual and data reporting requirements as a condition of future funding.

3. Training activities for new and ongoing programs should continue with a specific focus on both housing and employment strategies to help counties and cities improve their integrated service activities and resulting client and system outcomes.

4. The Advisory Committee should continue to assist the Department in the evaluation of these programs with particular attention to housing and employment service delivery.

DATA ANALYSIS AND OBSERVATIONS

Data Summary

The data presented here on 4,720 individuals, were collected from all programs beginning with each county's start date (as early as November 1, 1999) through February 28, 2002, and is summarized below.

- Clients are mostly men (59%).
- 29.7% are African-American, 1.5% are Asian, 52.9% are Caucasian, and 11.3% are Hispanic.
- Clients are mostly between 25 and 59 years of age (86.2%).
- 3.1% of all enrollees are over the age of 59.
- 10.6% of enrollees are between the ages of 18 and 24.
- The percentage of clients choosing to leave the program since inception is 16.4%.

The outcomes presented here for post-enrollment have been annualized by county, based on the number of months of data available from each county, as compared to the twelve months prior to enrollment.

- The number of days of psychiatric hospitalization since enrollment dropped 65.6%.
- The number of days of incarceration dropped 81.5%.
- The number of days spent homeless dropped 79.1%.

The following table summarizes statewide data for three key factors by comparing data reported for the twelve months before services began to the data collected since.

Statewide Data at a Glance (Annualized)

	12 months Prior to Enrollment	**Since Enrollment (Annualized to Represent 12 months)**
Number of Days Hospitalized	34,184	11,765
Number of Days Incarcerated	206,087	38,014
Number of Days Homeless	944,201	197,342

Issue Statement

Governor Gray Davis provided approximately $55 million in the Fiscal Year 2001-2002 state budget for Adult System of Care programs directed particularly at serving homeless persons, parolees, and probationers with serious mental illness. The Adult and Older Adult Mental Health System of Care Act, specifically those provisions established pursuant to Assembly Bills (AB) 34 and 2034 (Steinberg, Chapter 617 and 518, Statutes of 1999 and 2000, respectively), governs the implementation and administration of the services and provides for their establishment at the local level as resources become available. These funds permitted the Department of Mental Health (DMH) to make permanent the pilots that tested this model and to expand these services to other county and city programs, for a total of 34 programs. The statutory provisions also require an annual report on program results by May 1 of each year. This report is in response to that requirement.

Background

In the state budget for Fiscal Year 1999-2000, Governor Davis provided $10 million for community mental health services to fund Adult System of Care programs directed particularly at serving homeless persons, parolees, and probationers with serious mental illness. A cooperative effort between the Legislature and the Governor resulted in legislation that authorized pilot programs with an integrated services approach intended to target specific individual needs. The legislation required the DMH to select counties in which to implement pilot programs, develop and perform an extensive monitoring and evaluation of the pilots, establish an advisory committee to assist in developing selection criteria and outcome measures for future programs, and report the results of the pilot programs and recommendations to the Legislature by May 1, 2000. The Department met the requirements of the legislation within the funds provided and submitted the required legislative report on time. That report concluded that the three pilots conducted under this effort were indeed successful and should be expanded.

Funding these pilots represented the Legislature's and Governor's continued interest in addressing community mental health needs which have largely gone unmet for persons whose illness leads them to being homeless or incarcerated, often repeatedly so. These individuals frequently either avoid contact with mental health services, or are without Medi-Cal benefits and/or do not meet Medi-Cal medical necessity. Many of these persons who do not have access to needed mental health services have contacts with the criminal justice system for minor crimes often leading to citations or arrests. This population also experiences high cost inpatient hospitalizations because their mental health needs are addressed only when they reach crisis levels. Thus, hospitalizations

are for longer periods of time and, since no resources are available for these individuals upon their release, the likelihood of relapse is higher

The pilots were themselves based on earlier models that demonstrated success in providing integrated services. These earlier efforts also consisted of three large pilots for adult systems of care that were established in 1989 pursuant to earlier legislation (Chapter 982, Statutes of 1988) to test the success of integrated services across all human service needs in the recovery and rehabilitation of adults with serious mental illness. An extensive evaluation conducted by an independent evaluator (Lewin and Associates, Inc.) concluded after three years of service that the integrated approach to serving this population was successful, and on some measures such as employment and housing, dramatically so. Despite the likelihood of eventual cost effectiveness, most counties could not access or divert the large sum of funds required to initiate this service model and train staff in its operation. Some that did succeed in doing so served to create an interest by Governor Davis and Assembly Member Steinberg in taking a new approach to adult mental health services.

The programs that are the subject of this report provide comprehensive services to adults who have severe mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or the state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. State funds for this program provide for outreach programs and mental health services along with related medications, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and other non-medical programs necessary to stabilize this population. The goal is to get them off the street and into permanent housing, into treatment and recovery, or to provide access to veterans' services that also provide for treatment and recovery. As these programs reduce recidivism, both in inpatient hospitalization and incarceration, significant cost avoidance is realized primarily at the local level. Further, as these programs increase the number of clients able to gain and keep employment, they may influence other less promising programs serving adults with serious mental illness to migrate to this service model as resources allow.

Objectives

Amendments and additions provided pursuant to AB 2034 further clarify objectives for California's adult system of care serving adults with serious mental illness. Objectives now include the following:

1. Develop programs in response to the needs of the target population and in concert with statutory standards, including services to young adults under 25 years old, outreach to adults hospitalized either voluntarily or involuntarily as a result of severe mental illness, and services responsive

to the needs of women from diverse cultural backgrounds, with supportive housing that accepts children and other supportive assistance.

2. Identify additional standards to ensure that members of the target population are identified and that appropriate services are provided, including services to persons who had an untreated severe mental illness for less than one year and who do not need the full range of services but who are at risk of homelessness unless a comprehensive individual and family support plan is implemented. (The addition to the target population of persons who had an untreated severe mental illness for less than one year only took effect January 1, 2002, pursuant to AB 334, Chapter 454, Statutes of 2001.)
3. Promote the development of integrated outreach and comprehensive services to enable the target population to: reduce symptoms, live independently, work, maintain community supports, care for their children, remain healthy, and avoid crime.
4. Provide funds for counties to establish outreach programs and related services for the target population.
5. Maintain funding for existing adult system of care programs that meet contractual goals as models and technical assistance resources for other counties.
6. Provide training, consultation, and technical assistance to counties preparing to operate these programs and to counties seeking improvements in their existing operation of these programs.
7. Establish a methodology for awarding future adult system of care grants.
8. Establish evaluation and reporting protocols and procedures for county programs funded by adult systems of care.
9. Report program results as required by statute.
10. Establish an advisory committee to assist in the development of award criteria, training and oversight conditions for continued receipt of funds, county reporting requirements, and to assist in reporting results to the Legislature.

Implementation Approach and Study Methodology

Selection Process

As required by earlier statute, the selection of the first three counties for the initial grants beginning in October of 1999, was based on the availability of existing programs able to provide integrated services with extensive experience in serving similar target populations. Typically, these programs employ psychosocial rehabilitation and recovery principles and consist of: outreach for identification, assessment, and diagnosis of target clients; mental health treatment including provision of medications and medication education and monitoring; and service coordination to ensure development of a plan with access to services that meet the client's expressed needs. Factors included in

these considerations were the counties' working agreements with other providers such as law enforcement, alcohol and drug services, medical and dental health practitioners, rehabilitation services, and housing providers. As statutorily required, funding for programs in these three counties was maintained for Fiscal Year 2000-2001, based on the significant success of results demonstrated and reported in the previous year.

Expansion of additional programs in these three counties and the funding of new county and city programs was based on several factors, including those specified in statute and the amount of funds remaining for Fiscal Year 2000-2001 after earlier, successful programs were maintained. Primary among these factors was the ability to develop integrated adult service programs that meet the statutory criteria for an adult system of care, even if such programs do not currently exist within the county system. The following readiness criteria were developed, with advisory committee consultation, to judge such capacity within each applicant county.

1. Ability to assess service capacity and approximate the number of homeless persons with serious mental illness in the county who could receive services.
2. Established community partnerships with law enforcement, veteran's services, probation, housing coalitions, city officials, businesses, etc. These relationships should be past the "sign-on" stage.
3. Joint outreach with law enforcement, veterans service agencies, former homeless clients, etc. to identify clients for enrollment.
4. Providers that can provide culturally competent, recovery-based services for this population, including psychosocial and psychiatric rehabilitation services.
5. Capacity to meet immediate housing needs, including temporary housing, at time of enrollment.
6. Ability to develop and provide permanent housing resources, relationships with landlords, and supported housing services.
7. Ability to develop jobs and related job resources, work with the Department of Rehabilitation, and enable clients to find and keep employment.
8. Ability to meet medical, dual diagnosis, and unanticipated expenses for basic needs of enrollees.
9. Direct support staff (e.g. personal service coordinators) that approximates a 12 to 1 staffing ratio or less.
10. Ability to submit requested data in a timely manner.

Based on the criteria identified, each applicant county or city submitted a proposal for the Department to evaluate from which an operational work plan could be formulated later if funded. If the written proposal adequately met these criteria, the applicant was invited to present details of their proposed program to department staff for further analysis. The funding awards were based upon these results. Continued refinement of this process, including the development of high performance criteria, is ongoing and will be utilized in selecting programs eligible for expansion funding.

Allocation of Funds and Conditions for Allocation

Funds are now awarded to 34 county and city programs. Two types of awards were made. Awards to operate new and/or expanded programs on an ongoing basis were granted to 26 local programs. One-time awards permitting services to begin in the year of the award and continue into the following year, were granted to 8 local programs. For the latter, no further funding commitment was made. Applicants whose proposal demonstrated they fully met the applicable readiness criteria and/or high performance criteria discussed above were granted continuous awards. Those proposals that did not entirely meet these criteria, but instead contained elements that could lead to a fully integrated system, were awarded one-time funding, with the possibility to apply for ongoing support in the next funding cycle if additional resources became available. The recipients of both types of awards are presented in Appendix 1.

Conditions of the awards require that local programs ensure that all funds provided are used to provide new service in integrated adult service programs and ensure that none of those funds are used to supplant existing services to adults with severe mental illness. Each local program was required to submit a work plan for approval by the state. In addition to a complete description of the program, the work plans identify the amount of contract funds to be expended and for what period, the total number of unduplicated clients to be enrolled, the maximum number of clients to be served at any one time, the outreach methods to be used, and the portion of funds used for that purpose. Assurances also were required that state and federal requirements regarding tracking of funds would be met and that patient records would be maintained in such a manner as to protect privacy and confidentiality, as required under state and federal law.

Advisory Committee

Advisory Committee membership conforms to statutory requirements. The committee initially consulted with the Department in establishing the process for awarding funds to new county and city programs. It also examined and critiqued much of the materials and methods used in providing training and consultation to the programs both as they began implementation and as part of the ongoing challenges met in continuing services. With this work completed, the committee has not met nearly as frequently as in the first year of its formation. Instead, the Department has focused its efforts on the award of funds and the training and technical assistance required by new programs. A recommendation included in this report suggests that the Advisory Committee continue to assist the Department with the evaluation of these programs with a specific focus on the delivery of housing and employment services. Please refer to Appendix 2 for a roster of committee membership.

Data Workgroup and Reporting Mechanisms

A data collection workgroup consisting of staff from the first three program counties, representatives from some of the more recently funded local programs, the evaluation consultants, and the Department, continues to refine the reporting methodology required to meet legislative reporting requirements. The topic-oriented data tables established at the inception of this program continue as the basis for all data collection and reporting, with refinements identified on an ongoing basis by the workgroup. Data is reported monthly by all county and city programs for clients enrolled in AB 2034 programs. These data are presented in Appendix 4. No data are available from local programs newly funded during this fiscal year as there has not been time to initiate local data collection efforts.

Study Methodology

The data displayed in Appendix 4 are in a set of tables organized by topics pertinent to the completion of this report. The data are divided into two groups, 1) data collected at enrollment (service entry) that provides information about the client for the twelve months prior to enrollment, and 2) data collected subsequent to enrollment that tracks outcomes after service is initiated. In addition to age and ethnicity, the baseline data for the twelve months prior to enrollment for each new service enrollee include:

- the number of hospitalizations and days of hospitalization;
- the number of enrollees with co-occurring substance abuse disorders;
- the number of other service contacts with local mental health plan services;
- the client's veteran status and benefits, if any;
- the number of arrests;
- the number of days incarcerated;
- the number of days spent homeless;
- various income sources of the client, if any;
- the number of days employed full time and part time, and
- whether the enrollee had been on probation or parole.

Ongoing data include:

- the number of enrolled persons being served;
- the number of enrolled persons who are able to maintain housing;
- the number of enrolled persons who receive extensive community mental health services;
- the number of enrolled persons on probation, parole, and the number of arrests and days incarcerated;
- the number of enrolled persons hospitalized and the number of days hospitalized;
- the number of enrolled persons employed full time and/or part time, competitively employed, in supported employment, and in vocational rehabilitation;

- the number of persons disenrolled;
- the number of persons referred to and served by local mental health programs; and
- the number of enrollees newly qualified for third party payments or receiving veteran's benefits.

In addition to these data, Department staff obtained information through selective program site visits, client and staff interviews, and exchange of information pertinent to program implementation, as indicated below.

Onsite Monitoring, Training, and Program Review

The purpose of the site visits is to provide statutorily required monitoring, oversee local efforts during the implementation phase, provide technical assistance on an ongoing basis, and generally become familiar with the operation of the local programs. The visits include observing service activities, interviewing clients, meeting with local staff and collaboration partners, and accompanying outreach teams. In the prior legislative report, the Department noted the slower pace at which local implementation proceeded for the then newly funded counties. One factor that appeared to contribute most to this pace were that new local programs did not have the existing services in place upon which to build program capacity like the three pilot counties did. Contracting and hiring processes to expand service capacity in the newly funded programs, generally proved to be much slower, leaving new programs unable to accomplish what the pilot counties could do at startup within their existing service agencies.

Another major factor contributing to the slower pace of implementation was that new programs simply did not have staff with adequate experience in the service models required by statute. To help bridge this gap as rapidly as possible, the Department undertook a substantial training effort to provide local staff with the necessary techniques and materials for outreach and client engagement appropriate for this population. Without such training, many local staff without prior experience in these techniques would otherwise have had no resource from which to learn these new service models. Subsequent to training and technical assistance during the early implementation of local services, the Department finds that most local programs have been able to increase the pace and quality of implementation. Even with such training, however, it still takes time for local systems to change earlier service approaches so that newer concepts can be employed. Appendix 3 contains a sample of program implementation and operation highlights for a few of the local programs funded under these statutes.

In continuing to monitor progress, Department staff note that with such training and consultation, newly funded programs are generally able to gradually increase the pace of implementation with concomitant results in client improvement. Significant contributions to this training effort come not only from Department staff, but consultants from the first three funded counties, the California Institute for Mental Health, the Village Integrated Service Agency, and the training

materials produced by consultants to the Department of Mental Health among other sources. The programs themselves confirm that access to these training and consultation resources has been instrumental throughout the implementation process. In fact, they seek similar resources as new problems emerge in the course of service operations.

Development of Program Standards

Progress on developing program standards in addition to those already identified in statute continues to be relatively slow. As more details become known about current programs, more issues emerge that increase the complexity of identifying a single set of standards applicable to a wide variety of local service environments. Nonetheless, progress in identifying widely applicable characteristics is underway. The development of the "best practice", high performance criteria discussed earlier contributes to this effort. As part of their site visits, Department staff also identify approaches to services and strategies for engaging clients that seem to be most effective and could serve as guidelines to be shared with other projects now and in the future. As in the first year of program operation, it is expected that future efforts of the Advisory Committee will also eventually contribute to identifying and developing "best practice" guidelines.

Findings

The tables in Appendix 4 present program information collected from all county and city AB 2034 programs from implementation through February 28, 2002.

Tables 1, 2, and 3 display demographic information about gender, ethnicity, and age, respectively, for each of the county and city programs.

Table 4 contains information about the budgeted cost per enrollee and the level of outreach effort expended to achieve current enrollment levels. The average annual grant cost per enrollee is approximately $13,000, which remains very near the average cost projected in last year's report for implementation of these services in a typical local program.

Table 5 contains information about hospitalizations prior to, and since, the client's enrollment. As with other tables presenting prior and post service information, the prior data is for a 12 month period. An adjustment for each county for 12 months of post data is provided. Comparing hospital days after enrollment to the 12 months prior to enrollment yields an estimated 65.6% decrease in hospitalization days statewide.

Table 6 contains information about incarcerations, probation, and parole. Again, an adjustment by county for 12 months of post data is provided. Thus,

comparing incarceration days after enrollment to the 12 months prior to enrollment yields an estimated 81.5% decrease in incarceration days statewide.

Tables 7, 8, and 9 contain information about income, housing, and employment, respectively. Using the data adjusted for a 12 month post period, the number of homeless days (excluding days spent in homeless shelters) has decreased 79.1% statewide since program inception.

Similar to last year's report, employment results tend to come later in typical client service patterns, since the most pressing needs related to housing, health, and stabilization are usually addressed first. Table 9 permits the comparison of adjusted data for the number of days employed full and/or part time prior and post enrollment. A statewide comparison shows that the number of days employed full time actually fell 28% and part time employment similarly fell 19.4%. However, if employment data is viewed for clients who have received services in programs with established employment service components for 24 months, i.e., twice as long as clients enrolled in most of the local programs newly funded last year, substantially different results may be found. As an example, the table below presents 24 months of post service employment data collected for the 305 clients in Los Angeles County AB 34 programs who accepted services for at least 24 months. (To determine whether this is true for the other two programs operating for 24 months would require special analysis due to the data collection and reporting mechanism used by these two programs.)

Number of Days Employed as reported by LA County	12 Months Prior to Enrollment	First 12 Months Since Enrollment	Increase	Second 12 Months Since Enrollment	Increase
Full Time	1,835	4,940	169%	5,340	191%
Part Time	6,075	10,980	81%	14,637	141%

For these clients, the table shows that results for the second 12 months of 24 months of services surpassed those of the first 12 months when compared to employment levels prior to enrollment. It is expected that similar improvements in employment efforts will be achieved by newer county and city programs as: (1) their employment programs mature; and (2), clients' immediate needs are addressed sufficiently to permit the focus of services to shift to employment.

Table 10 contains information about the number of persons with substance abuse issues at the time of enrollment and/or who had contact with mental health in the 12 months prior to enrollment. This table also identifies those without health insurance at enrollment and those who obtained health insurance since enrollment. Finally, this table contains information about disenrollments from the program. Of interest is the few number of clients that have qualified and obtained health insurance, including Medicaid, since enrollment. All clients are encouraged and assisted to apply for federal benefits, i.e. Supplemental Security Income (SSI), Social Security Disability, and/or Veterans Administration benefits.

However, because substance abuse is widely prevalent among this population (60% of enrolled clients as of February, 2002), programs report that this factor presents barriers to obtaining SSI and/or Medi-Cal. In fact, only 15.7% of enrolled clients have been able to qualify for health insurance such as Medi-Cal since enrollment. Since it appears that frequently persons are denied eligibility more than once, before successfully qualifying for SSI and/or Medi-Cal, continued tracking and analysis of this information will occur.

Nearly 83.6% of clients continue with this program once they are enrolled, as can be determined if the 1,118 clients (reported in Appendix 4, table 10) who chose to drop out of the program are compared to the 6,812 from table 4 who were enrolled statewide.

Program/Fiscal Impact

Results continue to indicate that this model has substantial implications for improved client and system outcomes including cost savings/avoidance associated with this population at the local level. Integrated services offer an expanded array of service components, such as housing, employment, life skills coaching, and social support in addition to treatment. In addition to these program improvements, the model offers the capacity to respond quickly with an extensive service package suited to individual client needs and preferences. Clients are more likely to engage with provider efforts that they can easily recognize as being directly related to their own priorities. They also benefit from immediate efforts to establish a relationship of trust and respect that they value as part of their own efforts towards recovery. The goal shared by the staff and each client is not just maintenance in a community setting, but continual improvement enabled by the client's own abilities to manage recovery.

Important fiscal impacts also appear to result from this service model. With daily jail costs approximately $70 for an average county or city's general jail population, and a range of $350 to over $500 for the medical/psychiatric jail population, the decrease in the number of jail days among these clients produces an important local savings and/or cost avoidance. If incarceration costs are calculated at $70 per day, excluding booking and classification costs, 168,073 fewer days (adjusted by county so that 12 months of service results are compared to the 12 months prior to services) yield $11.8 million annually. For hospitalization costs, a daily hospital cost of $500 (using an average of recent costs in Los Angeles) applied to the decrease of 22,419 in the number of hospital days over twelve months (similarly adjusted) yields $11.2 million. This is a total annual cost savings/avoidance of an estimated $23 million. It should be noted that we are continuing to refine our analysis of costs and cost savings/avoidance associated with this program.

Recommendations

1. These programs should continue to be included in the spectrum of programs designed to meet the needs of homeless Californians with serious mental illness.

2. Counties should be held accountable for meeting contractual and data reporting requirements as a condition of future funding.

3. Training activities for new and ongoing county and city programs should continue with a specific focus on both housing and employment strategies to help counties and cities improve their integrated service activities and resulting client and system outcomes.

4. The Advisory Committee should continue to assist the Department in the evaluation of these programs with particular attention to housing and employment service delivery.

Appendix 1

FY 2001-2002
AB 2034 Awards by Program

COUNTY	CLIENTS TO BE SERVED	ANNUAL AWARD	ONE TIME AWARD	Date of Grant Award
BERKELEY CITY	100	$1,000,000	$0	11/13/2000
BUTTE	50	$750,000	$0	11/13/2000
CONTRA COSTA	40	$0	$550,000	6/29/2001
EL DORADO	50	$800,000	$0	11/13/2000
FRESNO	150	$2,000,000	$0	11/13/2000
HUMBOLDT	30	$0	$800,000	1/17/2001
KERN	150	$1,350,000	$0	11/13/2000
LOS ANGELES	1,440	$18,255,000	$0	11/1/1999
MADERA	50	$650,000	$0	11/13/2000
MARIN	100	$1,500,000	$0	11/13/2000
MENDOCINO	30	$0	$800,000	1/17/2001
NAPA	20	$0	$261,052	6/29/2001
ORANGE	100	$1,200,000	$0	11/13/2000
PLACER	75	$850,000	$0	11/13/2000
RIVERSIDE	200	$1,750,000	$0	11/13/2000
SACRAMENTO	300	$5,200,000	$0	11/1/1999
SAN BERNARDINO	150	$1,125,000	$0	11/13/2000
SAN DIEGO	250	$3,750,000	$0	11/13/2000
SAN FRANCISCO	120	$2,300,000	$0	11/13/2000
SAN JOAQUIN	120	$1,000,000	$0	11/13/2000
SAN LUIS OBISPO	120	$1,000,000	$0	11/13/2000
SAN MATEO	75	$0	$1,500,000	1/17/2001
SANTA BARBARA	100	$1,500,000	$0	11/13/2000
SANTA CLARA	40	$0	$600,000	3/17/2001
SANTA CRUZ	30	$420,000	$0	11/13/2000
SHASTA	60	$850,000	$0	11/13/2000
SOLANO	100	$0	$1,250,000	1/17/2001
SONOMA	75	$1,250,000	$0	11/13/2000
STANISLAUS	250	$3,500,000	$0	11/1/1999
TEHAMA	75	$800,000	$0	11/13/2000
TRI CITY	83	$1,000,000	$0	11/13/2000
TUOLUMNE	12	$50,000	$0	11/13/2000
VENTURA	65	$1,000,000	$0	11/13/2000
YOLO	30	$0	$800,000	1/17/2001
Total	**4,640**	**$54,850,000**	***$6,561,052**	

*Initial awards in fiscal year (FY) 2000-01 totaled $48.3 million based on 8.5 months operations, yielding $6.5 million for one-time awards in FY 2001-02.

Appendix 2

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Appendix 3
AB 2034 Program Implementation and Achievements

Background

The county-specific outcome data included with this report clearly documents the success of the three initial pilot programs (Los Angeles, Sacramento, and Stanislaus), and specific information in the body of the report is provided about the success Los Angeles has demonstrated with employment efforts. However, since the previous two legislative reports on this program focused solely on the three pilot programs established pursuant to AB 34, we have chosen to highlight the more recently funded AB 2034 programs in the narrative and program descriptions that follow. There were 31 new programs funded pursuant to AB 2034, 23 with ongoing funding and 8 with one-time funding. Almost none of the local mental health agencies who received AB 2034 grant awards had significant experience delivering the types of comprehensive, integrated services required to serve homeless persons with serious mental illness. They were not as well prepared as the initial three pilot programs to implement and demonstrate immediate success.

The services necessary to move individuals from homelessness to stable housing and employment are not typically the responsibility of or provided by mental health agencies. Generally mental health professionals are educated and trained to provide traditional mental health services such as therapy, case management and medication supports. Staffing programs to provide outreach and engagement, housing and employment services and the intensive supports associated with those efforts was a challenge for most of the new programs established pursuant to AB 2034. Many of these programs have contracted with non-profit agencies whose staff typically have more familiarity or already provide housing and employment services in the community. These partnerships appear to have been critical factors for some program's success. Statewide, AB 2034 programs are staffed in various ways, some utilizing only county/city staff, some using only contract staff with county staff administering the program, and some utilizing both county/city and contract staff.

Toward the goal of developing staff and promoting "best practices" in AB 2034 programs, the Department has developed and/or contracted for training for local programs in outreach and engagement and housing and employment services. Additionally, another training activity, known as the "Village Immersion Training" has contributed significantly to helping new local program staff understand the values and principles associated with client directed services and the "whatever it takes" approach necessary for success in providing integrated, comprehensive services to persons with serious mental illness. The Village Integrated Service Agency in Long Beach is one of the Los Angeles AB 2034 programs sponsored by the Mental Health Association of Los Angeles. As a result of documenting significant positive outcomes for their members for over 10 years, this

internationally recognized program has been consistently identified as a model for “best practices” in delivering comprehensive, integrated, community-based services. To date, the Village has provided intensive “immersion training” to 366 staff from AB 2034 programs statewide. This training involves 3 days of both didactic and field experience and has been lauded by new programs as essential in helping staff conceptualize the non-traditional program services required in AB 2034 programs. Without this hands-on experience, many programs and program staff, would have no frame of reference for what is expected in terms of non-traditional approaches to service.

Highlights and Consumer Vignettes from Selected Counties

Review of the outcome data reported for AB 2034 programs statewide indicates that all programs have demonstrated some degree of success. Even though enrollment was initially slow in certain programs, their success in providing housing and meeting other immediate needs that enable persons to get off the street, has exceeded expectations. Given these outcomes, we could have provided narrative on each and every program and been able to talk about their success in at least one service area. We could have included vignettes about specific client successes from each and every program. Instead, what follows is a description of a few program efforts that reflect what is occurring statewide in these programs. These descriptions may include any or all of the following: implementation strategies, program values, services delivered, success with specific services, and/or vignettes about consumer successes.

Report from San Diego County:

San Diego has become one of the most expensive cities in which to live; rents have skyrocketed; the population has increased; the rental and housing shortfalls are of crisis proportion. San Diego’s Regional Task Force on the Homeless estimates there are as many as 3,750 homeless persons living in San Diego’s urban downtown center. Of these, approximately 30% suffer from serious mental illness and as many as 60% of these individuals have a dual diagnosis of substance abuse. Homeless persons with mental health and substance abuse problems are a highly visible problem in San Diego County. The largest concentration of this population is in the city of San Diego’s downtown area. Finding solutions for this population has been the focus of broad-based county, city and private collaboratives looking at housing and innovative treatment interventions.

Having the right people at the table together to develop a strategic plan was the first step. San Diego recognized that homelessness is a shared problem, and the synergy of working together is what makes this project successful. The City of San Diego, San Diego Housing Commission, Center City Development Corporation, Corporation for Supported Housing, San Diego County Probation Department, San Diego Police Department, Homeless Outreach Team, non-profit

service providers, primary care medical service providers, and consumers identify mutual challenges and solutions to impact homeless people with severe mental illness living in the community.

Because this population is generally difficult to serve, the service model also depends on an integrated collaborative effort involving the Health and Human Services Agency (Mental Health Services, County Medical Services, The Central Region's Family Resource Center and Alcohol and Drug Services), the Probation Department, the Sheriff, the San Diego Police Department/Homeless Outreach Team, mental health service providers, non-profit homeless providers, housing and homeless shelter providers, local law enforcement agencies, and primary care medical service providers.

Outreach, engagement and enrollment are essential components of the Integrated Service Program, Reaching out, Engaging to, Achieve Consumer Health (ISP/REACH). For those clients who are difficult to engage and hesitant to accept services, the engagement teams follow and work with the client, develop a trusting relationship and provide client determined services. Over 1,520 outreach engagement contacts were made to enroll 258 REACH members. The range of contacts needed to enroll one client has been from a minimum of one to a maximum of 35. A case manager is assigned to each client enrolled and the case manager works very closely with each client to ensure basic needs are met via wraparound services. The case manager ratio of 1:18 allows for enhanced individual services. Services are available 24 hours a day, 7 days a week. Case managers also work very closely with landlords to ensure that clients are not returned to the streets for behavior issues.

REACH is committed to placing members in housing immediately, at the time of enrollment. A Client Fund is used to subsidize rents, as the market rate for a single room at the YMCA is $600 per month, not including cooking facilities. REACH has also aggressively applied for client entitlements, increasing the number of clients currently receiving benefits by 35%.

REACH was fortunate to receive 100 Project-Based Section 8 certificates and 15 Tenant-Based Section 8 certificates from the San Diego Housing Commission. With these vouchers, REACH is able to place members in designated Single Room Occupancy (SRO) units and some apartments. REACH members must apply for Section 8, which includes a criminal background check (provided gratis through the San Diego County Probation Department). Once approved for Section 8, if the client has zero income, the REACH Client Fund pays $50 per month. Clients with entitlements are responsible for paying 30% of their income towards rent, per HUD regulations. REACH members also sign an agreement to reimburse the agency as they await the award of disability benefits or other entitlements. In the months of January and February 2002, REACH clients reimbursed over $14,000 to the program.

As of February 28, 2002, the REACH program has enrolled 251 members, 55% of whom have a dual diagnosis of a major psychiatric disability and substance abuse. The diagnostic distribution of these members is: 131 with thought disorders such as schizophrenia, and 120 with mood/affective disorders such as bi-polar and major depression. This program is currently maintaining 203 persons in housing. In general these clients have been the hardest to reach, and prior to these services have generally been "lost " in the streets.

Consumer Stories:

- One of the first individuals enrolled in the San Diego AB 2034 program had been homeless for 5 years. Since the client did not have an income he was offered a room, paid for by the City of San Diego through AB 2034. He was very suspicious of being around other people and reluctant when first approached by his case manager about living at a Single Room Occupancy (SRO) hotel. Over time his case manager was able to gain his trust and he agreed to move into the Metro Hotel. When he was handed the key to his room, he fingered it as if it were a valuable coin, his eyes welled up with tears and he remarked that he did not know how long it had been since he had a key of any kind. Upon moving in he remarked that he may not sleep on the bed in the room because he was used to sleeping on concrete. His case manager assured him that if he wanted to sleep on the floor of the room he could until he felt comfortable trying the bed. He recently celebrated his first year of being off the streets and has remained at the Metro Hotel.

- Another client was well known by the Homeless Outreach Team of the San Diego Police Department. He was approximately 50 years old and would frequent the area of Broadway and 8th Avenue in downtown San Diego. He was well known because of his bizarre behavior that would scare or intimidate others due to his severe mental illness. The REACH outreach worker met with him almost every day. Through this familiarity the worker gained the client's trust and was able to take the client for a psychiatric evaluation. The client was prescribed medication and began taking it. Within 2 weeks the client agreed to accept housing offered by his case manager. This client has made a remarkable change in the months since joining REACH. He has maintained his housing for nearly a year, is an immaculate housekeeper, and continues to participate in REACH activities. Last October he was featured in a local TV news segment about the success of the REACH program. In his own words, "They found me on the streets sitting by a tree, hungry. I've had amnesia and had been out there for a long time. I know I was attacked, and I only have partial memory. I don't remember a mother or father. I needed a place with an address, and so forth, some food. They kept coming by for a month or so and giving me food. I didn't talk to them till later. Now I have a room at the Metro Hotel, some food money and so forth. I'm glad to have a home address now."

- After 3 months of intense outreach and on site psychiatric care at a parking lot in downtown San Diego, a homeless man with mental illness who lived at the parking lot agreed to get off the streets and accept a room offered by the REACH case manager. As time grew near for him to move he became reluctant and backed away from the offer and remained at his usual spot. A few days later the client agreed to try another housing option offered by the case manager and eventually moved in to that place. Although provided with a room, the client chose to sleep in the parking lot at night because that was what he was used to. His case manager was able over time to get the client to spend more time inside of his room and eventually to sleep overnight there. Since enrollment this client has received medical services, assistance in obtaining benefits and rehabilitation services at the REACH office site.

Report from Madera County:

A shift is occurring in the way services to individuals with serious mental illness are provided in Madera County. This shift has been noted by consumers, family members, and mental health staff in the Madera County Mental Health Department and the contract provider (Kings View) programs. Although subtle at first, the changes began with the opening of the Recovery Resource Center (RRC), a program developed with AB 2034 funding in Fiscal Year 2000-2001. Based on the Recovery Model and the values and beliefs of the adult system of care framework, the RRC program promotes consumer-driven services that are strength-based and provided in a community that promotes interpersonal relationships and an emphasis on consumer rights, dignity, and respect.

In August 2000, Madera County submitted an application to the State Department of Mental Health (DMH) to provide integrated services for homeless adults with serious mental illness and those at risk of homelessness or at imminent risk of incarceration. Many consumers and agency/program representatives contributed to developing the original AB 2034 proposal. The Adult Interagency Coordinating Council (AICC) consisting of representatives from Social Services, health, and law enforcement programs, not only provide valuable guidance for the proposal, but agreed to serve in an advisory capacity once the program was funded. This group meets quarterly and has provided on-going feedback regarding services provided and new services that are needed.

In November 2000 the county was notified by DMH that its proposal would be funded to serve 50 individuals with an annualized grant of $650,000. The County contracted with Kings View Counseling Centers of Madera County to provide direct services and a building was secured by December 2000. The facility was named Recovery Resource Center to emphasize the reliance on the Recovery Model. By January 1, 2001, the majority of staff were hired and on February 1, 2001, the program began receiving referrals and making outreach contacts.

By the end of June 2001, the program had enrolled more than 50 individuals, and identified an additional 51 eligible persons who were placed on a waiting list for "deferred" enrollment. By developing relationships with the local Rescue Mission, Food Bank, Department of Social Services, and other private and public resources, staff was able to refer "deferred" persons for assistance with food, shelter, utilities, health care, and mental health services. Enrollees and "deferred" persons were welcome to use the facilities of the RRC including the laundry, showers, and kitchen. Food baskets donated by the Rescue Mission and the Food Bank were available at the RRC for distribution to enrollees and potential enrollees shortly after the program was opened.

A half-time Housing Coordinator works with consumers to obtain adequate housing as soon as possible. At least 80% of enrollees are provided with housing as soon as they are enrolled in the AB 2034 program. Another 20% of difficult to house enrollees are provided with housing within weeks of enrolling. The program staff has worked with local motels to establish pre-rented rooms that may be used to immediately house someone. Buy paying rent monthly, costs are reduced significantly. In some instances emergency housing is also provided to individuals who are not yet enrolled in the program. This is especially true for eligible individuals who have children living with them. To provide transitional and permanent housing, staff have developed relationships with managers of several local apartment complexes. By being available to these managers 24 hours a day, 7 days a week, staff have secured 12 apartments. By maximizing consumer contributions for rent, the RRC has been able to make housing dollars last longer. The long-term goal, whenever possible, is to have the consumer contributing 100% of housing costs. To date, 5 enrollees have been placed in a board and care facility, 31 have been placed in transitional apartments, 2 have been housed in parole designated housing, and 14 have received Section 8 vouchers to obtain their own apartments. Currently, 48 persons are being maintained in housing.

The RRC has had remarkable success during its first year of operation. Consumers not only worked actively on their own personal services plans, but they have also joined together to organize a consumer action group that meets weekly. A room in the RRC has been equipped with a computer, a typewriter, telephones, and office supplies for consumer use. They gather there to work on projects, practice with equipment, or socialize with each other. "Giving back" has been a strong commitment of consumers. They are doing that by serving on advisory committees, helping other consumers move into apartments, sorting food at the Food Bank, staffing the distribution of food at the RRC, and sharing their stories with potential enrollees and others.

Consumer Stories:

As described by Madera County mental health staff, the following vignettes demonstrate the commitment and bravery of their enrollees.

- Mr. S came to the RRC with a forty-year history of multiple psychiatric hospital admissions and incarcerations in detention facilities. His early years in a rough neighborhood in Oakland set the stage for a life of trauma and pain. When he was first enrolled in the RRC, Mr. S was placed in a small motel room where he was able to live independently. He chose to attend some anger management groups and other groups designed to enhance empowerment and self-esteem. He is now living in his own apartment and is employed in a supported work setting. He has continued to work on controlling expressions of anger and was elected as the first President of the consumer action group. He is now experiencing his longest period of independent living – outside a prison or psychiatric hospital.

- D. is a 45 year old male raised in the Central Valley. He is a high school graduate and is one semester from completing a Bachelor of Arts degree. When first contacted by outreach workers, D. had been on the streets for five years. A self-proclaimed "certified alcoholic", he survived by using food stamps and collecting recyclables from dumpsters. After 3 to 4 months of contacts by outreach workers, D. came to the RRC and asked for help getting into a detoxification program. RRC staff immediately made arrangements with a contract residential treatment program to admit him. Following a severe physical reaction to withdrawal, D. completed 5 days of detoxification and a 30 day residential treatment program. He is actively involved in recovery and has taken an active role in his recovery group. He has secured employment through the Department of Rehabilitation and is participating in a Certified Forklift Driver Training program at the local Food Bank. He is applying for a Section 8 housing voucher and has a goal of achieving long term, full time employment in the community. He now talks about a home, a job, a wife, and a community with hope.

- C. is a 34 year old Latina from the San Jose area. She arrived in Madera eight months ago after leaving an abusive relationship. Four of her five children live with her. One child is severely disabled. She quickly found that she could not live with relatives and that her limited income would not pay the rent and buy food. She experienced depression and despair. Staff assisted her to find immediate shelter and buy food. She was linked to the mental health clinic where she received help with her mental health problems. She and her family were moved to one of the program's transitional apartments and she placed her children in school for the first time in months. She is very involved with the school and also assists other enrollees by helping with housework or babysitting. C. has now received a Section 8 housing voucher and has moved into her own apartment. RRC assisted with a deposit for the apartment and payment of an outstanding utility bill. She remains drug free and deeply dedicated to her family.

- J. is a 56 year old Cuban refugee who left Cuba eight years ago in a small inner tube bound for Florida. He had been imprisoned previously and given electroconvulsive therapy for depression and anxiety. He came to California hoping to find work and affordable housing. After living a short time with extended family, he and his family (wife, 5 children, mother-in-law, and sister-in-law) had to move to the Rescue Mission. Because the family had to be separated at the Mission, J. became more and more distressed. After J. was enrolled in the RRC, staff began an intense effort to locate suitable housing. Following many inquiries, a four-bedroom apartment was located for them. He has been linked to the mental health clinic and has received help for his illness. He has submitted a Section 8 housing application with the assistance of staff. He has a job at a local restaurant, but is seeking other employment that will provide more income for his family.

Report from Fresno County:

There were many challenges faced when starting the AB 2034 program in Fresno County. It was important to have staff embrace the recovery philosophy when providing services to consumers. To support this goal, all contract provider and county staff were sent to Fresno County's Department of Adult Services, Community Integration Division's, Peer Support and Recovery training. This training program provides all the coordination, training, education and mentoring of consumer providers and volunteer advocates who work throughout the Department of Adult Services. The goal of this training is to break down the stigma of mental illness, provide support and encouragement and let consumers, family members and volunteers know that recovery is possible.

It was extremely important for the partners who would be providing service to this homeless population to know each other, their services, contacts, etc. The AB 2034 Partner meetings included representatives from:

Information Technology Services
Department of Employment and Temporary Assistance, General Relief
Mental health services at the county jail
Department of Adult Services Job Options Program
United Consumer Advocacy Network (UCAN)
Department of Adult Services Housing Coordinator
Peer Support and Recovery staff
Turning Point of Central California, Inc. (contract provider)
Department of Adult Services, AB 2034 program staff analyst
Division Manager, Department of Adult Services and
Other services/programs as necessary

Through these meetings a partnership between Turning Point, the Department of Adult Services and the Department of Employment and Temporary Assistance was formed. The AB 2034 grant paid for an Eligibility Worker to assist consumers with General Relief monies and food stamps. The partners providing

AB 2034 services developed a questionnaire to be given to General Relief recipients who were homeless and suspected of having a mental illness. All of the General Relief Eligibility Workers were trained to administer the questionnaire. A staff person from Turning Point was out-stationed at the General Relief office to provide an immediate assessment and admittance to the AB 2034 program for those determined to be eligible.

These meetings also resulted in staff setting up a quick referral and intake process for homeless individuals with serious mental illness residing in jail. The county staff arranged for passes at the jail so Turning Point was able to assess these potential consumers immediately. Turning Point was able to work with the Probation Department, the courts, etc., so the individual was able to receive mental health services, housing, food, clothing, and other necessary assistance upon release from jail.

A partnership was also developed between Turning Point and the Fresno City Police Department. Turning Point staff was able to go on "ride-alongs" with the police to locations where homeless individuals were known to congregate and admit them to program services immediately.

The Fresno AB 2034 program currently has 150 individuals on a waiting list for service. The results of the program have been favorable and the word on the street among homeless individuals is that the program is trustworthy and good. Fresno attributes their success to two primary factors. First the foresight of the Governor and Assembly Member Steinberg, in funding programs that encourage a "whatever it takes" approach to services for the homeless population. Second, Personal Services Coordinators who are professional, energetic, creative, compassionate and willing to tailor services to address the needs, desires and talents of the enrollees. The trust built with their clients makes all things possible.

Consumer Stories:

On July 10, 2001, the following message was received by Adult Services: "Two homeless people have established two cardboard shelters under the Freeway 41 bridge. The second one to arrive is a woman, and she has been living there for approximately two or three weeks. The male has been there a little longer. Can your department assist these two persons to find appropriate shelter?" The Homeless Outreach Multiservice Effort (HOME) center was notified and the Personal Services Coordinators (PSCs) made the initial contact on July 12. The PSC found the man and woman living in cardboard houses at the base of the freeway pillars and a third man living inside a railroad boxcar nearby. Each looked after the other as they survived life on the streets during the hot summer months in Fresno. Miguel, Susan and Stephin have graciously allowed us to share their stories.

- Miguel is 55 years old and had been homeless for 15 years. He had not been in a car for 9 years, was estranged from family and drank every day while on the streets. Miguel enrolled in the HOME program on July 12. On July 20, he agreed to give up his grocery cart and bedroll and moved into a hotel. He changed residence once in October to move to another room at the same site. Miguel has reestablished contact with a cousin and is willing to accompany any of the PSCs from the HOME Center. He reduced his drinking from every day to once or twice a week. On November 27, Miguel was one of the first enrollees to move into Park Place, a 30-unit apartment complex that has been leased by Turning Point for the HOME program. Since moving into Park Place he has stopped drinking. Miguel was featured by the "Fresno Bee" on November 29 in a front-page article entitled "Fresno County Program Aids Homeless".

- Susan is 36 years old, had been homeless for over two years and was estranged from her family. She spent five months in a mental health program and dropped out. The first contact was made on July 12 and Susan enrolled in the HOME program the same day. She was placed at a motel on July 19, one week later. Since enrollment she has established contact with her aunt who visits her once a month. Susan moved into her own apartment on November 21.

- Stephin is 32 years and was born in Kenya. Stephin came to the United States to attend college. He has been living on the streets since 1989. The initial contact was made by the PSC on July 19 and he enrolled in the HOME program the same day. He was placed at a room and board facility and has remained at that housing site. Recently the PSC learned that he has a grandmother living in Fresno. He allowed the PSC to make contact and reunited with his grandmother on December 17. Recently, he allowed his PSC to make contact with his mother in Kenya. He has started writing a letter to her. Stephin plans to enroll at Fresno City College in January. He has an appointment with Job Options, a program of the Department of Adult Services, to develop his job skills. He also feels ready to move into his own apartment. He is currently on the waiting list for Park Place.

- Arnold is 57 years old and served in the U.S. Army as a medic from 1966 through 1968. Arnold was employed at state psychiatric hospitals as a licensed psychiatric technician for ten years following his discharge from military service. A serious accident in 1978 changed the course of his life. Following his three-week hospitalization, he lost his driver's license; he let his professional license expire; and began a journey of homelessness. At one time, he lived in a coastal town for four years under a bramble bush covered by a tarp. Arnold enrolled in the HOME program on May 7. He accepted placement at a room and board facility. Although there were problems at this facility, he stayed knowing he was on the waiting list for an apartment at Park Place. Arnold moved into his apartment on November 26. He loves plants

and plans to help with a garden and a horseshoe pit. For the first time Arnold is attending a day treatment program at the Veteran's Administration (VA). He attends group sessions five days a week. His goals for this year are to complete the VA program, gain employment skills and find work.

- Gina is 18 years old. Gina's personal journey and triumph over adversity is a testimonial to her strength and courage. During her short life she has experienced:

- The death of her father by suicide at age 2
- The death of her boyfriend at age 16
- Being a runaway at age 16
- Struggling to live independently in another state by working two jobs

- Suffering her first mental health break and a two-week hospitalization at age 17
- An arrest for petty theft and five months in juvenile hall due to substance abuse
- three months in a group home as a term of her probation
- aging out of the group home on her 18th birthday
- losing Social Security benefits

Gina enrolled in the HOME program on June 25 and was assigned to a PSC. She was placed at a room and board facility on July 6. One hour later, she contacted her PSC and stated she did not like this placement. Working together with her PSC, a new facility was located and she moved in the following day. She remains at this placement today and is on a waiting list for her own apartment. Gina completed all required courses for high school graduation in July 2001 and plans to attend commencement ceremonies in May. She is currently attending Narcotics Anonymous meetings and has been drug free since July 12. She has reunited with her mother and speaks warmly of their close relationship. When asked how she feels about HOME Center, she replied, "They saved my life. I would have been homeless." Gina states that she was not prepared to handle the responsibilities of turning 18. She believes that transportation, housing and counseling sessions tailored to transition age youth are needed.

Report from Humboldt County:

Humboldt County, located on the Highway 101 corridor, claims Eureka/Arcata as the largest population mass between Santa Rosa, California and Eugene, Oregon – a distance of over 750 miles. Eureka is also the largest coastal city between San Francisco and Seattle. The relatively mild climate and the mountainous terrain lend themselves to attracting large numbers of veterans, primarily Vietnam-era, desiring to drop out of mainstream society. The county also contains the largest Native American Indian reservation in the state.

Humboldt County has over 130 Lanterman-Petris-Short (LPS) conservatees, nearly twice the per-capita average of other counties in the state. Their County Department of Health and Human Services – Mental Health Branch currently provides service to over 2000 adult consumers, roughly one of every 45 adult residents of the county. A conservative estimate of the number of homeless persons with mental illness in the county is 800.

Prior to receiving AB 2034 funding, Humboldt County had provided case management outreach services to homeless persons with mental illness for over 10 years. This was accomplished with one case management position. That case manager now functions as the supervisor for the 7-member AB 2034 Team, which received immediate acceptance in the homeless communities throughout the county. Persistent, non-threatening personal/personable contacts are attempted until there is movement either positive or negative, toward engagement and trust. Enrollment occurs when an appropriate diagnosis is determined and both the potential enrollee and the AB 2034 team are comfortable that services can be provided that are advantageous to the potential enrollee. In the first year of the program Humboldt enrolled 33 consumers (30 persons was their target) and have housed 30 to date.

Because of the pockets of homeless persons living in remote areas of the county, this program was constantly confronted with the dilemma of how to provide adequate services to those choosing to live outside the urban circle of Eureka/Arcata. Accessing the consumers living 50-70 miles from all services presents their greatest challenge. Humboldt's experience taught that outreach services are more easily provided, more readily accepted, and outcomes more positive because of the trust built when they met consumers in their own environment. As a result, they intend to purchase and customize a 39-foot RV and take their AB 2034 services to the hertofore unserved consumer population in the most remote areas of the county. With this mobile unit they can provide on-the-spot assistance to those who, until now, felt they would have to relocate to the city to get help. In addition to a full array of services to be offered by staff of the mobile unit, the RV also offers showers and washers and dryers for use by the homeless population. The RV also has bag phones and FAX capability to begin enrollment processes for General Relief, SSA, SSI, Medi-Cal, etc.

Although Humboldt County was a trusted presence in the homeless community for many years, they cite the availability of the Village Immersion Training for new staff as very effective in showing what can be accomplished with hard work, grant funding and vision. As reported "It allowed our team to realize there are no limits as to what is possible, even with severely and chronically mentally ill homeless consumers. We would hope the training will continue to be available for all AB 2034 programs, as it sets standards of service to be offered to consumers on a statewide basis."

Consumer Stories:

- The Hoopa Indian Reservation is located 70 miles northeast of Eureka. Ms. S., is a 25 year old native American female who was living in bushes and doorways, under bridges and/or in abandoned structures in and around the town of Hoopa, in the heart of the Reservation. She suffers from paranoid schizophrenia, and because of her life situation and vulnerability, has been sexually and physically abused from early childhood to recently. She had been hiding from the community since graduation from high school when her illness first presented. Ms. S. had presented at the mental health crisis unit several times over the past two years and been brought in twice for mental health evaluations by her family. Although medication was prescribed, her paranoia resulted in non-compliance. Due to the distance from the agency, staff were unable to provide medication case management or education. For the doctor to monitor her medications would have required her to return to Eureka regularly. With the implementation of the AB 2034 program, staff made 8 visits to the Hoopa area and met with Ms. S. each time. As trust was established, Ms. S. returned to Eureka to apply for General Relief, food stamps and county medical coverage, all in one day. She has received aid and assistance, applied for SSI and is in stable housing in Hoopa for the first time in 3 years. She is interested in attending a local community college extension program in Hoopa and is talking about employment for the future. She is currently taking medications and is monitored by AB 2034 program staff. The ability to bring a full spectrum of services to her regularly, in her community, will be possible when the intended Mobile AB 2034 Therapeutic Team is fully functional.

Appendix 4

Data Tables

Integrated Services for Homeless Adults Programs (All Funded Programs)

November 1, 1999, through February 28, 2002

- **Table 1: Enrollments and Demographics-Gender**
- **Table 2: Enrollments and Demographics- Ethnicity**
- **Table 3: Enrollments and Demographics- Age**
- **Table 4: Outreach Efforts**
- **Table 5: Psychiatric Hospitalization**
- **Table 6: Incarcerations, Probation and Parole**
- **Table 7: Income**
- **Table 8: Housing**
- **Table 9: Employment**
- **Table 10: Benefits, Disenrollments and Other**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Enrollments and Demographics-Gender								
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9
	Number of contracted consumers	Number of consumers currently enrolled	Number Male	% Male	Number Female	% Female	Number Other / Trans gender	% Other Transgender	Date of Grant Award
Berkeley	100	98	72	73.5%	26	26.5%	0	0.0%	11/13/2000
Butte	50	49	41	83.7%	8	16.3%	0	0.0%	11/13/2000
Contra Costa	40	39	23	59.0%	16	41.0%	0	0.0%	06/29/01
El Dorado	50	46	32	69.6%	14	30.4%	0	0.0%	11/13/2000
Fresno	150	155	101	65.2%	54	34.8%	0	0.0%	11/13/2000
Humboldt	30	29	18	62.1%	11	37.9%	0	0.0%	1/17/2001
Kern	150	133	61	45.9%	72	54.1%	0	0.0%	11/13/00
Los Angeles	1,440	1,536	976	63.5%	559	36.4%	1	0.1%	11/01/99
Madera	50	56	36	64.3%	20	35.7%	0	0.0%	11/13/00
Marin	100	99	54	54.5%	45	45.5%	0	0.0%	11/13/00
Mendocino	30	55	38	69.1%	17	30.9%	0	0.0%	01/17/01
Napa	20	6	4	66.7%	2	33.3%	0	0.0%	06/29/01
Orange	100	108	74	68.5%	34	31.5%	0	0.0%	11/13/00
Placer	75	123	54	43.9%	69	56.1%	0	0.0%	11/13/00
Riverside	200	183	118	64.5%	65	35.5%	0	0.0%	11/13/00
Sacramento	300	299	153	51.2%	146	48.8%	0	0.0%	11/01/99
San Bernardino	150	116	64	55.2%	50	43.1%	2	1.7%	11/13/00
San Diego	250	251	143	57.0%	106	42.2%	2	0.8%	11/13/00

San Francisco	120	123	85	69.1%	37	30.1%	1	0.8%	11/13/00
San Joaquin	120	119	50	42.0%	69	58.0%	0	0.0%	11/13/00
San Luis Obispo	120	124	86	69.4%	38	30.6%	0	0.0%	11/13/00
San Mateo	75	68	44	64.7%	23	33.8%	1	1.5%	01/17/01
Santa Barbara	100	101	50	49.5%	51	50.5%	0	0.0%	11/13/00
Santa Clara	40	30	17	56.7%	13	43.3%	0	0.0%	03/17/01
Santa Cruz	30	29	18	62.1%	10	34.5%	1	3.4%	11/13/00
Shasta	60	68	26	38.2%	42	61.8%	0	0.0%	11/13/00
Solano	100	91	52	57.1%	39	42.9%	0	0.0%	01/17/01
Sonoma	75	76	41	53.9%	35	46.1%	0	0.0%	11/13/00
Stanislaus	250	277	136	49.1%	140	50.5%	1	0.4%	11/01/99
Tehama	75	42	25	59.5%	17	40.5%	0	0.0%	11/13/00
Tri-City	83	87	54	62.1%	33	37.9%	0	0.0%	11/13/00
Tuolumne	12	8	7	87.5%	1	12.5%	0	0.0%	11/13/00
Ventura	65	64	36	56.3%	28	43.8%	0	0.0%	11/13/00
Yolo	30	32	16	50.0%	16	50.0%	0	0.0%	01/17/01
Total	**4,640**	**4,720**	**2,805**	**59.4%**	**1,906**	**40.4%**	**9**	**0.2%**	

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Enrollments and Demographics-Ethnicity															
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	2.11	2.12	2.13	2.14	2.15	2.16
	Number of contracted consumers	Number of consumers currently enrolled	Number African American	% African American	Number Asian American	% Asian American	Number Caucasian	% Caucasian	Number Hispanic	% Hispanic	Number Native American	% Native American	Number Pacific Islander	% Pacific Islander	Number Other	% Other
Berkeley	100	98	46	46.9%	2	2.0%	43	43.9%	3	3.1%	1	1.0%	0	0.0%	3	3.1%
Butte	50	49	3	6.1%	0	0.0%	45	91.8%	1	2.0%	0	0.0%	0	0.0%	0	0.0%
Contra Costa	40	39	7	17.9%	0	0.0%	24	61.5%	5	12.8%	2	5.1%	0	0.0%	1	2.6%
El Dorado	50	46	2	4.3%	0	0.0%	40	87.0%	2	4.3%	0	0.0%	0	0.0%	2	4.3%
Fresno	150	155	38	24.5%	1	0.6%	62	40.0%	35	22.6%	2	1.3%	0	0.0%	17	11.0%
Humboldt	30	29	1	3.4%	0	0.0%	26	89.7%	0	0.0%	2	6.9%	0	0.0%	0	0.0%
Kern	150	133	19	14.3%	2	1.5%	90	67.7%	17	12.8%	2	1.5%	1	0.8%	2	1.5%
Los Angeles	1,440	1,536	799	52.0%	11	0.7%	485	31.6%	188	12.2%	12	0.8%	7	0.5%	34	2.2%
Madera	50	56	6	10.7%	0	0.0%	29	51.8%	20	35.7%	0	0.0%	0	0.0%	1	1.8%
Marin	100	99	18	18.2%	4	4.0%	72	72.7%	5	5.1%	0	0.0%	0	0.0%	0	0.0%
Mendocino	30	55	1	1.8%	1	1.8%	44	80.0%	4	7.3%	4	7.3%	0	0.0%	1	1.8%
Napa	20	6	0	0.0%	1	16.7%	5	83.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Orange	100	108	18	16.7%	9	8.3%	67	62.0%	12	11.1%	2	1.9%	0	0.0%	0	0.0%
Placer	75	123	3	2.4%	1	0.8%	103	83.7%	6	4.9%	8	6.5%	0	0.0%	2	1.6%
Riverside	200	183	48	26.2%	1	0.5%	92	50.3%	34	18.6%	3	1.6%	0	0.0%	5	2.7%

Sacramento	300	299	84	28.1%	5	1.7%	173	57.9%	18	6.0%	7	2.3%	3	1.0%	9	3.0%
San Bernardino	150	116	27	23.3%	2	1.7%	61	52.6%	24	20.7%	1	0.9%	0	0.0%	1	0.9%
San Diego	250	251	76	30.3%	7	2.8%	144	57.4%	16	6.4%	3	1.2%	4	1.6%	1	0.4%
San Francisco	120	123	49	39.8%	7	5.7%	54	43.9%	10	8.1%	1	0.8%	0	0.0%	2	1.6%
San Joaquin	120	119	23	19.3%	3	2.5%	71	59.7%	12	10.1%	3	2.5%	0	0.0%	7	5.9%
San Luis Obispo	120	124	6	4.8%	0	0.0%	105	84.7%	4	3.2%	8	6.5%	0	0.0%	1	0.8%
San Mateo	75	68	7	10.3%	4	5.9%	45	66.2%	7	10.3%	1	1.5%	0	0.0%	4	5.9%
Santa Barbara	100	101	13	12.9%	0	0.0%	74	73.3%	13	12.9%	1	1.0%	0	0.0%	0	0.0%
Santa Clara	40	30	3	10.0%	2	6.7%	16	53.3%	8	26.7%	1	3.3%	0	0.0%	0	0.0%
Santa Cruz	30	29	1	3.4%	0	0.0%	23	79.3%	4	13.8%	1	3.4%	0	0.0%	0	0.0%
Shasta	60	68	1	1.5%	0	0.0%	61	89.7%	1	1.5%	5	7.4%	0	0.0%	0	0.0%
Solano	100	91	40	44.0%	0	0.0%	41	45.1%	5	5.5%	2	2.2%	2	2.2%	1	1.1%
Sonoma	75	76	3	3.9%	3	3.9%	63	82.9%	3	3.9%	3	3.9%	0	0.0%	1	1.3%
Stanislaus	250	277	29	10.5%	2	0.7%	191	69.0%	43	15.5%	5	1.8%	1	0.4%	6	2.2%
Tehama	75	42	0	0.0%	0	0.0%	35	83.3%	2	4.8%	3	7.1%	1	2.4%	1	2.4%
Tri-City	83	87	23	26.4%	3	3.4%	41	47.1%	18	20.7%	2	2.3%	0	0.0%	0	0.0%
Tuolumne	12	8	0	0.0%	0	0.0%	8	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Ventura	65	64	3	4.7%	0	0.0%	42	65.6%	12	18.8%	6	9.4%	0	0.0%	1	1.6%
Yolo	30	32	4	12.5%	0	0.0%	24	75.0%	3	9.4%	1	3.1%	0	0.0%	0	0.0%
Total	**4,640**	**4,720**	**1,401**	**29.7%**	**71**	**1.5%**	**2,499**	**52.9%**	**535**	**11.3%**	**92**	**1.9%**	**19**	**0.4%**	**103**	**2.2%**

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through February 28, 2002

County Programs	Enrollments and Demographics-Age											
	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	3.10	3.11	3.12
	Number of contracted consumers	Number of consumers currently enrolled	Age 0 to 17	% Age 0 to 17	Age 18 to 24	% Age 18 to 24	Age 25 to 45	% Age 25 to 45	Age 46 to 59	% Age 46 to 59	Age 60+	% Age 60+
Berkeley	100	98	0	0.0%	9	9.2%	43	43.9%	41	41.8%	5	5.1%
Butte	50	49	0	0.0%	5	10.2%	21	42.9%	21	42.9%	2	4.1%
Contra Costa	40	39	0	0.0%	1	2.6%	24	61.5%	12	30.8%	2	5.1%
El Dorado	50	46	0	0.0%	4	8.7%	21	45.7%	20	43.5%	1	2.2%
Fresno	150	155	0	0.0%	16	10.3%	88	56.8%	47	30.3%	4	2.6%
Humboldt	30	29	0	0.0%	5	17.2%	11	37.9%	11	37.9%	2	6.9%
Kern	150	133	0	0.0%	17	12.8%	87	65.4%	25	18.8%	4	3.0%
Los Angeles	1,440	1,536	0	0.0%	149	9.7%	910	59.2%	437	28.5%	40	2.6%
Madera	50	56	0	0.0%	6	10.7%	35	62.5%	15	26.8%	0	0.0%
Marin	100	99	0	0.0%	6	6.1%	43	43.4%	44	44.4%	6	6.1%
Mendocino	30	55	0	0.0%	5	9.1%	27	49.1%	22	40.0%	1	1.8%
Napa	20	6	0	0.0%	0	0.0%	4	66.7%	1	16.7%	1	16.7%
Orange	100	108	0	0.0%	4	3.7%	61	56.5%	36	33.3%	7	6.5%
Placer	75	123	0	0.0%	18	14.6%	71	57.7%	34	27.6%	0	0.0%
Riverside	200	183	0	0.0%	33	18.0%	106	57.9%	42	23.0%	2	1.1%

Sacramento	300	299	0	0.0%	20	6.7%	181	60.5%	88	29.4%	10	3.3%
San Bernardino	150	116	0	0.0%	13	11.2%	66	56.9%	33	28.4%	4	3.4%
San Diego	250	251	0	0.0%	9	3.6%	131	52.2%	92	36.7%	19	7.6%
San Francisco	120	123	0	0.0%	15	12.2%	78	63.4%	30	24.4%	0	0.0%
San Joaquin	120	119	0	0.0%	3	2.5%	74	62.2%	35	29.4%	7	5.9%
San Luis Obispo	120	124	0	0.0%	16	12.9%	56	45.2%	45	36.3%	7	5.6%
San Mateo	75	68	0	0.0%	12	17.6%	27	39.7%	19	27.9%	10	14.7%
Santa Barbara	100	101	0	0.0%	7	6.9%	54	53.5%	37	36.6%	3	3.0%
Santa Clara	40	30	0	0.0%	2	6.7%	19	63.3%	8	26.7%	1	3.3%
Santa Cruz	30	29	0	0.0%	3	10.3%	13	44.8%	13	44.8%	0	0.0%
Shasta	60	68	0	0.0%	7	10.3%	38	55.9%	21	30.9%	2	2.9%
Solano	100	91	0	0.0%	9	9.9%	52	57.1%	29	31.9%	1	1.1%
Sonoma	75	76	0	0.0%	10	13.2%	37	48.7%	27	35.5%	2	2.6%
Stanislaus	250	277	1	0.4%	79	28.5%	139	50.2%	55	19.9%	3	1.1%
Tehama	75	42	0	0.0%	8	19.0%	19	45.2%	15	35.7%	0	0.0%
Tri-City	83	87	0	0.0%	7	8.0%	46	52.9%	33	37.9%	1	1.1%
Tuolumne	12	8	0	0.0%	0	0.0%	8	100.0%	0	0.0%	0	0.0%
Ventura	65	64	0	0.0%	4	6.3%	37	57.8%	23	35.9%	0	0.0%
Yolo	30	32	0	0.0%	0	0.0%	15	46.9%	16	50.0%	1	3.1%
Total	**4,640**	**4,720**	**1**	**0.0%**	**502**	**10.6%**	**2,642**	**56.0%**	**1,427**	**30.2%**	**148**	**3.1%**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Outreach Efforts									
	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	4.10
	Number of contracted consumers	Total contract funds	Average budgeted cost per consumer	Unduplicated number of outreach consumers	Number of outreach contacts	Number of consumers enrolled to date (Including Dropouts)	Number of consumers currently enrolled	Number of incarcerated consumers identified for AB 334 program (Subset of all outreach consumers)	Number of consumers identified and enrolled in AB334 programs	Number of months reporting Data
Berkeley	100	$1,000,000	$10,000	484	610	116	98	0	98	12
Butte	50	$750,000	$15,000	172	240	70	49	0	49	11
Contra Costa *	40	$550,000	$13,750	52	52	42	39	0	39	4
El Dorado	50	$800,000	$16,000	178	184	102	46	0	46	10
Fresno	150	$2,000,000	$13,333	342	455	247	155	2	157	12
Humboldt *	30	$800,000	$17,778	698	1,206	33	29	0	29	11
Kern	150	$1,350,000	$9,000	542	882	188	133	0	133	12
Los Angeles	1,440	$18,255,000	$12,677	6,740	17,087	2,251	1,536	0	1,536	28
Madera	50	$650,000	$13,000	325	417	91	56	0	56	12
Marin	100	$1,500,000	$15,000	320	1377	106	99	0	99	12
Mendocino *	30	$800,000	$17,778	144	201	100	55	0	55	11
Napa*	20	$261,052	$13,053	11	11	6	6	0	6	1
Orange	100	$1,200,000	$12,000	693	911	135	108	0	108	12
Placer	75	$850,000	$11,333	237	254	150	123	0	123	12

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

Riverside	200	$1,750,000	$8,750	602	602	324	183	0	183	12
Sacramento	300	$5,200,000	$17,333	2,007	3,167	529	299	0	299	28
San Bernardino	150	$1,125,000	$7,500	422	540	198	116	0	116	12
San Diego	250	$3,750,000	$15,000	584	1,617	340	251	0	251	12
San Francisco	120	$2,300,000	$19,167	343	741	156	123	1	124	12
San Joaquin	120	$1,000,000	$8,333	293	341	142	119	0	119	12
San Luis Obispo	120	$1,000,000	$8,333	310	440	147	124	0	124	12
San Mateo *	75	$1,500,000	$13,333	246	1,814	78	68	19	87	10
Santa Barbara	100	$1,500,000	$15,000	412	810	131	101	0	101	12
Santa Clara *	40	$600,000	$12,000	59	102	30	30	0	30	4
Santa Cruz	30	$420,000	$14,000	110	129	33	29	0	29	12
Shasta	60	$850,000	$14,167	267	336	102	68	0	68	12
Solano *	100	$1,250,000	$8,333	357	924	126	91	0	91	12
Sonoma	75	$1,250,000	$16,667	262	829	89	76	0	76	12
Stanislaus	250	$3,500,000	$14,000	1646	5955	413	277	0	277	28
Tehama	75	$800,000	$10,667	306	1,666	86	42	27	69	12
Tri-City	83	$1,000,000	$12,048	109	126	117	87	0	87	12
Tuolumne	12	$50,000	$4,167	10	38	14	8	0	8	12
Ventura	65	$1,000,000	$15,385	507	517	84	64	0	64	12
Yolo *	30	$800,000	$17,778	132	531	36	32	1	33	11
Total	**4,640**	**$61,411,052**	**$12,839**	**19,922**	**45,112**	**6,812**	**4,720**	**50**	**4,770**	
Total	**9,180**	**$121,822,104**	**$13,270.38**	**39,360**	**89,614**	**13,508**	**9,342**	**100**	**9,442**	
Total	**18,310**	**$242,894,208**	**$13,265.66**	**78,548**	**178,988**	**26,946**	**18,635**	**200**	**18,835**	

*** Programs given one-time awards (One-time awards total $6,561,052)**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 though February 28, 2002

County Programs	Psychiatric Hospitalizations							
	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8
	Number of consumers currently enrolled	Number of unduplicated consumers hospitalized in 12 mos prior to enrollment	Number of hospitalizations in 12 mos prior to enrollment	Number of hospital days in 12 mos prior to enrollment	Number of unduplicated consumers hospitalized since enrollment	Number of hospitalizations since enrollment	Number of hospital days since enrollment	Column 5.7 Adjusted for 12 mos. Data
Berkeley	98	39	105	1,876	18	28	614	614
Butte	49	20	34	237	8	16	86	94
Contra Costa	39	7	9	406	3	3	34	102
El Dorado	46	10	13	296	0	0	0	0
Fresno	155	30	43	971	12	16	80	80
Humboldt	29	5	6	100	5	6	154	168
Kern	133	29	40	913	10	14	80	80
Los Angeles	1,536	282	441	11,182	245	447	5,659	2,425
Madera	56	4	6	389	1	2	10	10
Marin	99	35	76	574	32	51	517	517
Mendocino	55	8	9	397	3	6	22	24
Napa	6	1	1	71	0	0	0	0
Orange	108	44	60	2,009	40	68	1,936	1,936
Placer	123	31	39	712	4	5	69	69
Riverside	183	21	32	673	15	24	222	222
Sacramento	299	63	121	1398	28	56	536	230

San Bernardino	116	35	60	1,004	23	50	419	419
San Diego	251	83	162	2,568	59	91	1,628	1,628
San Francisco	123	51	88	1,433	27	37	678	678
San Joaquin	119	16	16	327	3	3	11	11
San Luis Obispo	124	19	31	341	6	12	244	244
San Mateo	68	44	70	2,053	12	24	483	580
Santa Barbara	101	15	15	308	9	13	165	165
Santa Clara	30	10	13	382	1	2	17	51
Santa Cruz	29	10	11	213	8	12	198	198
Shasta	68	11	11	124	3	3	20	20
Solano	91	12	14	285	3	3	46	46
Sonoma	76	30	44	773	14	14	189	189
Stanislaus	277	79	137	987	51	96	849	364
Tehama	42	9	9	223	12	21	356	356
Tri-City	87	16	21	578	4	5	144	144
Tuolumne	8	5	7	115	1	1	1	1
Ventura	64	17	22	173	6	9	75	75
Yolo	32	6	8	93	2	2	23	25
Total	**4,720**	**1,097**	**1,774**	**34,184**	**668**	**1,140**	**15,565**	**11,765**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Incarcerations, Probation and Parole									
	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9	6.10
	Number of consumers currently enrolled	Number of consumers on probation at any time in 12 mos prior to enrollment	Number of consumers on parole at any time in 12 mos prior to enrollment	Number of unduplicated consumers incarcerated in 12 months prior to enrollment	Number of incarcerations in 12 months prior to enrollment	Number of days incarcerated in 12 months prior to enrollment	Number of unduplicated consumers incarcerated since enrollment	Number of incarcerations since enrollment	Number of days incarcerated since enrollment	Column 6.9 adjusted for 12 months Data
Berkeley	98	11	2	47	84	3,421	20	31	810	810
Butte	49	6	2	11	18	703	4	6	112	122
Contra Costa	39	0	1	9	11	764	1	1	78	234
El Dorado	46	7	2	11	12	2,100	1	1	23	28
Fresno	155	36	26	67	81	9,440	36	46	4,462	4,462
Humboldt	29	2	0	9	11	560	2	2	53	58
Kern	133	13	2	42	46	2,664	8	9	241	241
Los Angeles	1,536	214	181	721	857	119,650	312	423	30,520	13,080
Madera	56	8	12	29	35	4,516	13	16	1,510	1,510
Marin	99	15	12	21	39	1980	16	36	1141	1,141
Mendocino	55	10	2	17	29	1,770	9	9	1,138	1,241
Napa	6	0	1	0	0	0	1	1	1	12
Orange	108	0	0	24	29	2,075	13	21	1,287	1,287
Placer	123	23	4	35	39	3,744	2	2	190	190
Riverside	183	13	7	40	40	5,026	8	9	1,027	1,027
Sacramento	299	73	4	118	216	4407	72	133	1637	702

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

San Bernardino	116	23	6	32	38	4,695	15	24	912	912
San Diego	251	33	13	47	52	4,251	23	27	2,026	2,026
San Francisco	123	24	4	54	86	4,948	13	16	1,244	1,244
San Joaquin	119	16	4	15	15	1,467	3	3	220	220
San Luis Obispo	124	20	5	38	47	3,591	8	11	1,047	1,047
San Mateo	68	4	1	13	15	1,126	7	8	373	448
Santa Barbara	101	10	5	25	30	2,900	14	24	894	894
Santa Clara	30	3	0	8	9	548	1	1	84	252
Santa Cruz	29	2	0	7	23	199	5	6	41	41
Shasta	68	6	1	19	20	1,088	3	3	237	237
Solano	91	7	3	25	27	3,214	8	10	189	189
Sonoma	76	5	1	17	19	2,719	6	8	415	415
Stanislaus	277	66	17	76	144	4,419	74	176	3,428	1,469
Tehama	42	28	7	37	45	3,573	19	27	1,695	1,695
Tri-City	87	12	7	15	17	2,232	5	6	236	236
Tuolumne	8	4	1	5	5	305	4	4	157	157
Ventura	64	1	0	15	18	1,285	9	10	282	282
Yolo	32	6	3	15	21	707	4	7	96	105
Total	**4,720**	**701**	**336**	**1,664**	**2,178**	**206,087**	**739**	**1,117**	**57,806**	**38,014**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Income										
	7.1	7.2	7.3	7.4	7.5	7.6	7.7	7.8	7.9	7.10	7.11
	Number of consumers currently enrolled	Number of unduplicated consumers receiving GA/GR at enrollment	Number of unduplicated consumers receiving SSI / SSDI at enrollment	Number of unduplicated consumers receiving TANF at enrollment	Number of unduplicated consumers receiving VA benefits at enrollment	Number of unduplicated consumers receiving wages at enrollment	Number of unduplicated consumers receiving GA/GR since enrollment	Number of unduplicated consumers receiving SSI / SSDI since enrollment	Number of unduplicated consumers receiving TANF since enrollment	Number of unduplicated consumers receiving VA benefits since enrollment	Number of unduplicated consumers receiving wages since enrollment
Berkeley	98	3	22	0	2	4	8	73	0	3	6
Butte	49	4	14	4	1	2	15	23	4	2	15
Contra Costa	39	2	10	0	0	0	3	20	0	0	3
El Dorado	46	2	15	1	1	2	3	16	1	1	8
Fresno	155	59	11	2	2	3	88	17	4	2	12
Humboldt	29	6	11	0	0	1	11	14	0	0	2
Kern	133	5	21	4	0	1	10	61	5	0	3
Los Angeles	1,536	332	285	17	4	77	624	617	30	14	327
Madera	56	3	11	7	0	2	4	14	8	0	8
Marin	99	18	47	0	0	7	40	83	1	0	20
Mendocino	55	3	32	0	4	7	5	34	0	6	9
Napa	6	0	3	0	1	0	0	4	0	1	0
Orange	108	2	50	0	4	1	5	65	0	4	19
Placer	123	12	38	9	0	16	16	45	11	0	15
Riverside	183	4	45	4	0	15	6	51	4	0	30
Sacramento	299	91	92	4	1	6	74	162	2	0	13
San Bernardino	116	2	35	2	2	6	3	55	4	2	8

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

San Diego	251	17	88	3	5	8	26	126	3	11	13
San Francisco	123	25	52	0	0	1	27	62	0	0	5
San Joaquin	119	5	60	4	0	7	11	78	5	0	18
San Luis Obispo	124	5	44	0	1	5	9	47	0	1	9
San Mateo	68	4	16	0	2	5	5	30	0	2	19
Santa Barbara	101	12	52	0	10	6	25	72	1	12	17
Santa Clara	30	2	17	0	1	0	3	20	1	2	0
Santa Cruz	29	3	13	1	0	4	6	20	1	0	8
Shasta	68	10	30	6	2	1	11	36	8	2	4
Solano	91	2	17	1	0	10	15	27	3	2	31
Sonoma	76	1	40	0	1	4	3	52	0	1	7
Stanislaus	277	10	67	19	2	29	23	94	33	3	66
Tehama	42	8	23	6	0	5	7	8	0	0	12
Tri-City	87	23	15	6	0	5	40	23	8	0	10
Tuolumne	8	1	2	0	1	3	2	2	1	1	4
Ventura	64	1	15	1	0	4	1	34	1	0	14
Yolo	32	1	20	2	0	0	4	13	1	0	1
Total	**4,720**	**678**	**1,313**	**103**	**47**	**247**	**1,133**	**2,098**	**140**	**72**	**736**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

Housing													
8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	8.10	8.11	8.12	8.13	8.14
			Summary	Sub1	Sub2	Sub3	Sub4						
Number of consumers currently enrolled	Number of unduplicated consumers homeless during 12 mos prior to enrollment	Number of homeless days during 12 mos prior to enrollment	Number of consumers homeless at enrollment	Number of consumers on the street at enrollment	Number of consumers in jail at enrollment	Number of consumers in a shelter at enrollment	Number of consumers in a treatment facility at enrollment	Number of homeless days since enrollment (INCLUDING SHELTER DAYS)	Number of unduplicated consumers becoming homeless since enrollment (INCLUDING CONSUMERS IN SHELTERS)	Number of consumers currently maintaining housing (EXCLUDING CONSUMERS IN SHELTERS)	Number of homeless days since enrollment (EXCLUDING SHELTER DAYS)	Number of consumers currently maintaining housing (INCLUDING CONSUMERS IN SHELTERS)	Column 8.12 adjusted for 12 months Data
98	96	30,465	91	77	3	10	1	9,323	37	61	7,378	69	7,378
49	47	9,836	38	24	1	12	1	786	9	47	527	47	575
39	38	8,803	28	7	0	21	0	1,381	9	25	734	29	2,202
46	41	5,164	36	33	2	0	1	891	3	41	866	41	1,039
155	119	29,966	59	40	11	8	0	5,812	52	130	4,947	133	4,947
29	28	8,281	21	16	1	4	0	1,937	10	21	1,536	23	1,676
133	95	19,605	40	28	0	10	2	2,151	13	119	1,496	122	1,496
1,536	1,251	305,914	827	445	252	109	21	124,179	457	1,250	101,703	1,307	43,587
56	43	9,298	17	6	3	8	0	2,241	17	47	1,887	48	1,887
99	99	27324	106	70	1	33	2	15520	0	60	15144	64	15,144
55	48	12,479	45	31	1	13	0	7,604	18	41	6,836	42	7,457
6	6	803	5	5	0	0	0	128	1	0	106	1	1,272
108	97	25,523	74	60	2	4	8	10,168	59	69	8,921	75	8,921
123	94	16,500	63	48	4	5	6	5,578	15	89	5,076	91	5,076
183	151	34,815	113	87	6	19	1	14,076	27	114	12,816	125	12,816
299	299	66,476	237	175	1	48	13	13,162	169	266	12,673	267	5,431
116	83	12,805	71	53	4	13	1	7,712	33	99	3,784	101	3,784
251	230	55,446	195	116	5	61	13	19,352	34	186	13,314	203	13,314
123	123	35,481	100	50	21	20	9	6,941	21	86	5,267	95	5,267

119	64	8,174	37	17	1	19	0	1,467	2	116	463	119	463
124	111	30,443	99	75	5	18	1	15,624	13	53	12,258	66	12,258
68	51	10,470	38	22	0	8	8	2,173	18	59	1,669	60	2,003
101	82	17,746	60	38	1	21	0	7,838	38	65	4,824	73	4,824
30	25	4,023	17	6	1	8	2	960	2	18	484	25	1,452
29	29	9,063	23	16	0	7	0	3,117	17	22	2,090	26	2,090
68	59	10,192	43	30	0	13	0	2,299	8	47	1,428	54	1,428
91	87	22,805	78	68	4	6	0	5,133	24	64	4,520	70	4,520
76	66	17,318	52	38	2	10	2	4,320	32	60	3,573	62	3,573
277	224	47,548	200	144	3	41	12	21,871	70	208	20,912	211	8,962
42	52	9,374	33	31	0	1	1	5,271	58	31	5,064	48	5,064
87	64	15,442	41	29	5	7	0	4,505	19	74	3,610	77	3,610
8	11	3,298	14	9	0	5	0	663	4	6	640	6	640
64	59	15,046	46	37	0	9	0	2,411	22	52	2,144	54	2,144
32	33	8,275	24	20	0	0	4	955	3	24	955	24	1,042
4,720	**4,005**	**944,201**	**2,971**	**1,951**	**340**	**571**	**109**	**327,549**	**1,314**	**3,650**	**269,645**	**3,858**	**197,342**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Employment														
	9.1	9.2	9.3	9.4	9.5	9.6	9.7	9.8	9.9	9.10	9.11	9.12	9.13	9.14	9.15
	Number of consumers currently enrolled	Number of consumers with no employment in 12 mos. prior to enrollment	Number of consumers employed full time (32+ hours) in 12 mos. prior to enrollment	Number of days employed full time (32+ hrs) in 12 mos. prior to enrollment	Number of consumers employed part time (< 32 hours) in 12 mos. prior to enrollment	Number of days employed part time (< 32 hrs) in 12 mos. prior to enrollment	Number of consumers employed full time since enrollment	Number of days employed full time since enrollment	Number of consumers employed part time since enrollment	Number of days employed part time since enrollment	Number of consumers in competitive employment since enrollment	Number of consumers in supported employment since enrollment	Number of consumers referred to Dept. of Rehab	Column 9.8 adjusted for 12 months Data	Column 9.10 adjusted for 12 months Data
Berkeley	98	91	0	0	7	1,635	0	0	6	724	2	1	0	0	724
Butte	49	37	3	66	9	1,347	2	227	15	2,522	1	15	2	248	2751
Contra Costa	39	35	2	233	1	273	1	15	3	278	0	3	0	45	834
El Dorado	46	27	2	544	17	3,440	3	334	6	957	7	3	1	401	1148
Fresno	155	131	16	2,310	7	959	4	454	7	701	11	0	21	454	701
Humboldt	29	28	0	0	1	31	1	88	1	297	0	2	0	96	324
Kern	133	111	10	1,297	12	1,521	1	295	2	158	1	1	0	295	158
Los Angeles	1,536	1,349	50	8,177	140	24,829	102	23,236	263	66,841	178	203	30	9,958	28,646
Madera	56	50	0	0	6	1,489	3	229	5	1,076	2	6	0	229	1,076
Marin	99	70	19	2680	25	2064	11	1097	21	1438	19	14	1	1,097	1,438
Mendocino	55	44	3	657	9	2,321	4	474	7	1,198	5	3	0	517	1,307
Napa	6	6	0	0	0	0	0	0	0	0	0	0	0	0	0
Orange	108	104	0	0	4	720	6	930	14	1,194	15	2	0	930	1,194
Placer	123	78	6	642	42	8,507	5	705	12	2,736	12	3	0	705	2,736
Riverside	183	155	19	3,694	11	1,624	17	1,318	19	2,304	15	15	0	1,318	2,304
Sacramento	299	220	43	5,485	41	3,602	41	5,588	62	3,246	56	45	8	2,395	1,391
San Bernardino	116	108	0	0	8	1,102	3	663	5	640	7	2	6	663	640
San Diego	251	218	5	630	27	4,128	1	260	12	2,200	4	9	0	260	2,200
San Francisco	123	111	5	688	7	1,413	0	0	8	1,449	2	6	1	0	1,449

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

San Joaquin	119	106	8	1,826	5	450	8	693	12	854	11	4	0	693	854
San Luis Obispo	124	112	2	371	10	2,274	2	162	8	1,377	7	2	0	162	1,377
San Mateo	68	47	11	1,496	12	2,295	5	382	14	1,845	7	4	0	458	2,214
Santa Barbara	101	85	6	865	12	1,192	6	829	12	2,085	10	9	0	829	2,085
Santa Clara	30	26	0	0	4	620	0	0	0	0	0	0	0	0	0
Santa Cruz	29	17	3	182	11	1,578	1	125	8	806	5	3	0	125	806
Shasta	68	56	3	776	9	1,239	1	171	3	109	1	2	0	171	109
Solano	91	75	11	2,221	6	1,826	17	2,080	16	1,677	21	13	13	2,080	1,677
Sonoma	76	67	2	190	7	1,718	2	75	6	452	2	5	9	75	452
Stanislaus	277	212	35	4754	33	3452	39	8009	41	6095	59	17	5	3,432	2,612
Tehama	42	58	7	382	18	2123	5	723	7	1248	4	3	11	723	1,248
Tri-City	87	66	6	897	15	1,375	4	284	6	734	6	4	0	284	734
Tuolumne	8	11	1	110	2	68	2	408	2	126	5	0	0	408	126
Ventura	64	48	3	243	14	1,664	7	830	10	1,396	10	3	0	830	1,396
Yolo	32	33	0	0	2	41	0	0	1	93	1	0	4	0	101
Total	**4,720**	**3,992**	**281**	**41,416**	**534**	**82,920**	**304**	**50,684**	**614**	**108,856**	**486**	**402**	**112**	**29,881**	**66,812**

Integrated Services for Homeless Adults (All Funded Programs)
November 1,1999 through February 28, 2002

County Programs	Benefits, Disenrollments and Other												
	10.1	10.2	10.3	10.4	10.5	10.6	10.7	10.8	10.9	10.10	10.11	10.12	10.13
							Summary	Sub1	Sub2	Sub3	Sub4	Sub5	Sub6
	Number of consumers currently enrolled	Number of consumers with co occurring alcohol or substance abuse at enrollment	Number of consumers with at least 1 mental health contact in 12 mos prior to enrollment	Number of consumers without health insurance (e.g. Medicaid, Medicare, HMO, Vet Health) at enrollment	Number of consumers obtaining health insurance (e.g. Medicaid, Medicare, HMO, Vet Health) since enrollment	Number of consumers having served at any time in the U.S. armed forces	Number of consumers disenrolled to date	Number of disenrolled consumers who died since admission to the program	Number of disenrolled consumers found not to meet minimum program qualifications	Number of disenrolled consumers who dropped out of program	Number of disenrolled consumers who moved out of area or graduated	Number of disenrolled consumers leaving program for OTHER reasons	Number of consumers disenrolled due to Incarceration (Post-anniversary)
Berkeley	98	46	72	44	21	3	19	1	1	11	5	1	0
Butte	49	21	40	10	8	14	21	1	1	12	7	0	0
Contra Costa	39	31	29	7	0	4	3	1	1	0	0	1	0
El Dorado	46	30	27	18	2	5	60	1	6	21	24	8	0
Fresno	155	71	75	125	3	14	92	2	16	63	11	0	0
Humboldt	29	12	10	9	3	5	4	0	0	1	3	0	0
Kern	133	103	112	100	29	5	57	1	11	27	18	0	0
Los Angeles	1,536	1,108	720	895	246	56	717	33	26	406	111	23	118
Madera	56	32	40	16	6	1	36	0	0	21	15	0	0
Marin	99	45	69	30	38	15	7	1	3	0	2	1	0
Mendocino	55	19	51	15	13	10	45	4	8	18	10	5	0
Napa	6	2	5	2	0	0	0	0	0	0	0	0	0
Orange	108	39	64	52	8	17	31	1	2	20	6	1	1
Placer	123	75	60	52	1	5	29	0	6	8	11	4	0

Riverside	183	99	176	107	16	10	141	0	1	96	37	7	0
Sacramento	299	189	209	210	179	54	205	10	31	110	39	15	0
San Bernardino	116	68	74	66	21	0	82	5	2	45	25	5	0
San Diego	251	121	173	135	37	16	92	1	16	51	19	4	1
San Francisco	123	80	65	57	9	7	33	1	4	21	7	0	0
San Joaquin	119	46	74	36	8	5	23	1	5	2	14	1	0
San Luis Obispo	124	68	53	43	4	18	23	1	0	19	3	0	0
San Mateo	68	28	40	30	5	11	10	2	0	5	3	0	0
Santa Barbara	101	55	57	43	17	6	32	5	0	18	9	0	0
Santa Clara	30	10	24	10	0	0	0	0	0	0	0	0	0
Santa Cruz	29	14	6	14	6	0	4	0	0	2	1	1	0
Shasta	68	23	37	11	2	0	34	0	5	11	13	5	0
Solano	91	55	39	32	4	22	36	0	0	32	3	1	0
Sonoma	76	31	48	14	3	0	13	1	4	5	2	1	0
Stanislaus	277	165	178	129	8	17	136	6	9	50	63	3	5
Tehama	42	44	62	38	18	6	40	1	9	12	11	7	0
Tri-City	87	41	32	53	4	0	30	1	0	18	8	3	0
Tuolumne	8	10	13	5	9	4	6	0	1	1	4	0	0
Ventura	64	27	60	39	14	7	19	1	2	12	2	2	0
Yolo	32	22	19	14	0	4	4	0	4	0	0	0	0
Total	**4,720**	**2,830**	**2,813**	**2,461**	**742**	**341**	**2,084**	**82**	**174**	**1,118**	**486**	**99**	**125**

Characteristics of the Homeless Population

From the Martha Burt, Urban Institute Report: Homeless Families, Singles and Others: Finds from the 1996 National Survey of Homeless Assistance Providers and Clients.

For all Homeless Populations:Family Status by Sex Subgroups:

60% single men **15%** single women **12%** women with children
5% men with other men 5% women with other women
3% men with children.

	Single Male	**Single Female**	**Female With Children**
Only One Homeless Experience	47%	60%	48%
Current Homeless Period			
1-3 months	22%	25%	61%
6-12 months	24%	18%	43%
13-24 months	19%	9%	34%
25+ months	35%	38%	5%
Current Type of Residence			
Emergency Shelter	30%	27%	37%
Transitional Housing	28%	48%	44%
Room or Apartment w/ Other	16%	14%	18%
Place not meant for housing	26%	11%	2%
While Homeless			
Subject to thief of property	42%	43%	23%
Physically assaulted	24%	28%	13%
Sexually assaulted	4%	16%	9%
Reason Left Last Residence			
Could not pay rent	13%	20%	20%
Lost job / job ended	17%	9%	
Abusive household violence		10%	16%
Drinking	7%		
Drugs	7%	13%	
Landlord eviction			8%
Types of Income			
AFDC / TANF			58%
General Assistance	10%	9%	8%
SSI	8%	13%	3%
Food Stamps	30%	40%	74%
Funds from Parents	7%	7%	15%
Funds from Friends	11%	17%	13%
Panhandling	10%	6%	1%

	Single Male	Single Female	Female With Children
Alcohol, Drug or Abuse before 18			
First started drinking to get drunk	53%	31%	36%
First started using drugs regularly	29%	19%	14%
Abandoned by age of 18	12%	12%	12%
Physically abused by age of 18	19%	30%	24%
Sexually assaulted by age of 18	8%	27%	23%
Out-of-Home Experiences			
Placed in foster care, group home or institution before age of 18	23%	28%	25%
Placed in foster care, group home or institution before age of 13	14%	18%	13%
Juvenile Detention before 18	18%	10%	11%
Length of time lived away from home			
1-6 months	21%	15%	1%
7-12 months	8%	10%	20%
One year or more	71%	75%	64%
Ran away from home before 18	28%	34%	37%
Forced to leave home before 18	20%	23%	29%
First time became homeless occurred before the age of 18	19%	22%	29%

Calculation of the Need and the Cost of Supportive Housing Units

Defining the Population: The first and most important group to address when seeking to end homelessness is the group that lives in the shelter system --- the chronically homeless. They represent 10% of the single homeless population, which itself represents 50% of the homeless people over time. National Alliance to End Homelessness

Chronically Homeless in Georgia: Every county of the State of Georgia was included in a 2000 HUD Homeless Continuum of Care Plan. Each Continuum of Care Plan included a Homeless Gaps Analysis Chart, which reported estimated needs, present supply and unmet gaps. This is the first time that estimates of homeless were submitted for all of the state and accepted by units of government, as opposed to advocate estimates or projections. Following are the Estimate of Homeless Need for the State, by Continuum of Care Plan Jurisdiction. ***Based on the formula by the National Alliance to End Homelessness and these estimates of need, the State of Georgia chronically homeless population is estimated to be 1,623 individuals***. Almost 30,000 individuals were estimated to be homeless in the State for the same period.

Estimated Need for Shelter for Homeless Individuals (Total = 16,234)

Athens	Atlanta	Augusta	Cobb	Columbus	Gwinnett	Macon	Savannah	Other
123	8,250	876	604	1,700	530	340	425	3,811

Estimated Need for Shelter for Homeless Persons in Families & Children (Total = 12,711)

Athens	Atlanta	Augusta	Cobb	Columbus	Gwinnett	Macon	Savannah	Other
132	2,750	750	604	1,200	1,615	290	671	4,663

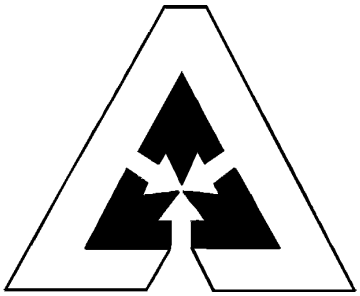
Cost of Providing Permanent Supportive Housing: The cost of developing and operating permanent supportive housing is based on three cost categories: development costs, annual operating costs for the housing, and supportive service costs for the residents. Following is a chart providing estimates or averages for these three categories from different sources.

Source of Estimate	**Development Cost per Unit**	**Annual Operating Cost per Unit**	**Annual Service Cost per Unit**
National Alliance to End Homelessness	$50,000 to $100,000	$8,500	$3,000 to $8,000
NY/NY Study by Corp. Supportive Housing			$6,500 to $9,000
DCA 1997 Multifamily Housing Developments	$65,000	$2,500* no debt service	

Source of Estimate	Development Cost per Unit	Annual Operating Cost per Unit	Annual Service Cost per Unit
Rosalyn Center 200 Units / DeKalb	$51,500	$4,343	
Hope House 70 Units / Proposed	$37,700	$10,000	$7,150
Millennium Center 20 Family Units	$110,000	$5,500	$20,000
Proposed Planning Model for Georgia	**$65,000**	**$5,000**	**$7,000**

Annualized Cost Projections: The projected cost for 160 units of permanent supportive housing is significant: $10,400,000 for development, $800,000 (annually) for operating costs and $1,120,000 (annually) for the supportive services. A significant portion of these funds could be secured through non-state resources. A typical permanent supportive housing development could be financed through a combination of public and private financing. A reasonable model for a permanent supportive housing development would estimate 40% in public, low-or-no interest debt, 30% in market rate private financing, and 30% in equity through the syndication of federal and state low income housing tax credits. The state funded portion of the development costs requirement for 160 units would be 40%, or $4,160,000.

The operating costs of $6,000 per unit could be covered through a combination of federal housing subsidies including Section 8 Vouchers or the Shelter Plus Care Grants. Both federal subsidies pay a fair market rent, less the 30% of income contribution required of the resident. One bedroom fair market rents for Atlanta is $500 - $700 per month and $350 - $500 per month in the other urban market areas. $500 a month in rents generates operating revenue of $6,000 per year. No additional state dollars would be required if Section 8 or Shelter Plus Care subsidies are secured through HUD or the local public housing authority.



A Plan: Not a Dream

How to End Homelessness in Ten Years

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Executive Summary

Twenty years ago there was not wide-spread homelessness in America. Tonight nearly a million people will be homeless, despite a two billion dollar a year infrastructure designed to deal with the problem. Can homelessness be ended?

While the seeds of homelessness were planted in the 1960s and 1970s with deinstitutionalization of mentally ill people and loss of affordable housing stock, wide-spread homelessness did not emerge until the 1980s. Several factors have affected its growth over the last two decades. **Housing** has become scarcer for those with little money. **Earnings** from employment and from benefits have not kept pace with the cost of housing for low income and poor people. **Services** that every family needs for support and stability have become harder for very poor people to afford or find.

In addition to these systemic causes, social changes have exacerbated the personal problems of many poor Americans, leading them to be more vulnerable to homelessness. These social trends have included new kinds of illegal drugs, more single parent and teen-headed households with low earning power, and thinning support networks.

These causes of homelessness must be addressed. People who are homeless must be helped, and the current system does this reasonably well for many of those who become homeless. But the homeless assistance system can neither prevent people from becoming homeless nor change the overall availability of housing, income and services that will truly end homelessness.

Mainstream social programs, on the other hand, do have the ability to prevent and end homelessness. These are programs like welfare, health care, mental health care, substance abuse treatment, veterans assistance and so on. These programs, however, are over-subscribed. Perversely, the very existence of the homeless assistance system encourages these mainstream systems to shift the cost and responsibility for helping the most vulnerable people to the homeless assistance system. This dysfunctional situation is becoming more and more institutionalized. Can nothing be done?

Ending Homelessness in Ten Years

The Board of Directors of the National Alliance to End Homelessness believes that, in fact, **ending homelessness is well within the nation's grasp**. We can reverse the incentives in mainstream systems so that rather than causing homelessness, they are **preventing** it. And we can make the homeless assistance system more **outcome-driven** by tailoring solution-oriented approaches more directly to the needs of the various sub-populations of the homeless population. In this way, homelessness can be ended within ten years.

To end homelessness in ten years, the following four steps should be taken, simultaneously.

Plan for Outcomes

Today most American communities plan how to manage homelessness – not how to end it. In fact, new data has shown that most localities could help homeless people much more effectively by changing the mix of assistance they provide. A first step in accomplishing this is to collect much better **data** at the local level. A second step is to create a **planning process that focuses on the outcome** of ending homelessness – and then brings to the table not just the homeless assistance providers, but the mainstream state and local agencies and organizations whose clients are homeless.

Close the Front Door

The homeless assistance system ends homelessness for thousands of people every day, but they are quickly replaced by others. People who become homeless are almost always clients of public systems of care and assistance. These include the mental health system, the public health system, the welfare system, and the veterans system, as well as the criminal justice and the child protective service systems (including foster care). The more effective the homeless assistance system is in caring for people, the less incentive these other systems have to deal with the most troubled people – and the more incentive they have to shift the cost of serving them to the homeless assistance system.

This situation must be reversed. The flow of **incentives** can favor helping the people with the most complex problems. As in many other social areas, investment in **prevention holds the promise of saving money** on expensive systems of remedial care.

Open the Back Door

Most people who become homeless enter and exit homelessness relatively quickly. Although there is a housing shortage, they accommodate this shortage and find housing. There is a much smaller group of people which spends more time in the system. The latter group – the majority of whom are chronically homeless and chronically ill – virtually lives in the shelter system and is a heavy user of other expensive public systems such as hospitals and jails.

People should be helped to exit homelessness as quickly as possible through a **housing first approach**. For the chronically homeless, this means **permanent supportive housing** (housing with services) – a solution that will save money as it reduces the use of other public systems. For families and less disabled single adults it means getting people very quickly into permanent housing and linking them with services. People should **not spend years in homeless systems**, either in shelter or in transitional housing.

Build the Infrastructure

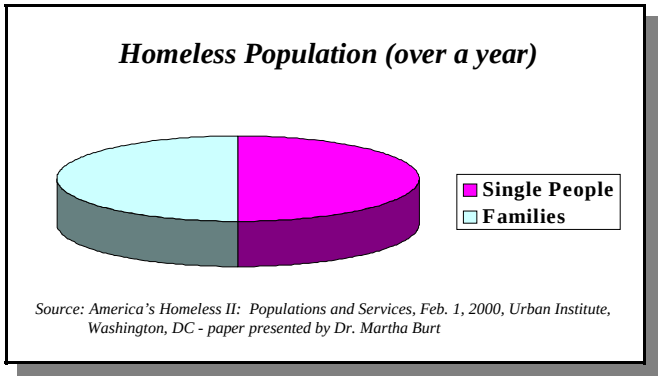
While the systems can be changed to prevent homelessness and shorten the experience of homelessness, ultimately people will continue to be threatened with instability until the supply of affordable **housing** is increased; **incomes** of the poor are adequate to pay for necessities such as food, shelter and health care; and disadvantaged people can receive the **services** they need. Attempts to change the homeless assistance system must take place within the context of larger efforts to help very poor people.

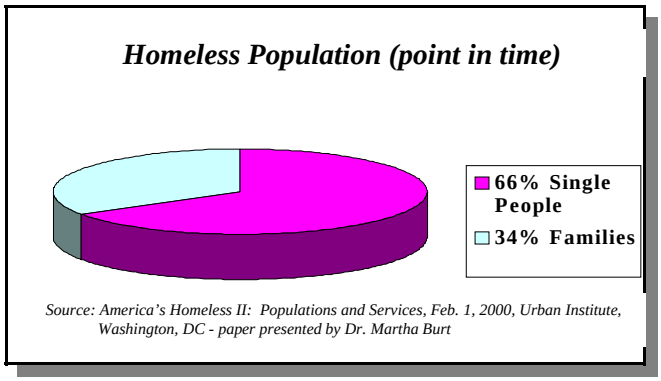
***

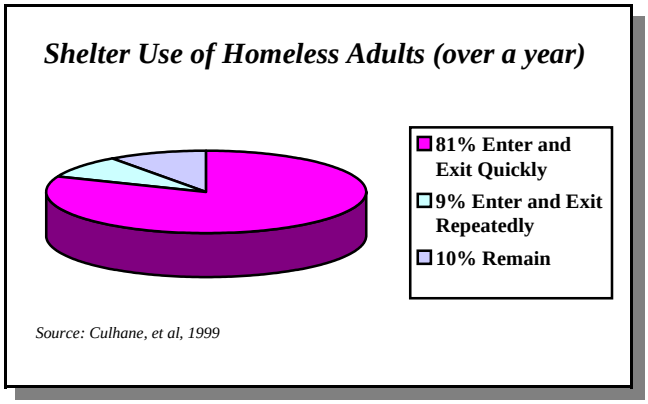
Taking these steps will change the dynamic of homelessness. While it will not stop people from losing their housing, it *will* alter the way in which housing crises are dealt with. While it will not end poverty, it *will* require that housing stability be a measure of success for those who assist poor people. The National Alliance to End Homelessness believes that these adjustments are necessary to avoid the complete institutionalization of homelessness. If implemented over time, they can lead to an end to homelessness within ten years.

A Snapshot of Homelessness

Between 700,000 and 800,000 people are homeless on any given night. Over the course of a year between 2.5 and 3.5 million people will experience homelessness in this country.[1] In order to end homelessness, it is necessary to understand the needs and characteristics of the sub-populations of this large group. The most significant sub-groups are people who experience homelessness as part of a family group, and those who are single adults.







Families

Most families become homeless because they are having a housing crisis. Their primary, immediate need is for housing. Certainly they are likely to have other needs -- for services and to increase their incomes. However, these needs are best met, once the family is in permanent housing – not while they are temporarily housed in shelter or transitional housing. Most homeless families get themselves back into housing as quickly as they can after they become homeless.

- About half of the individuals who experience homelessness over the course of a year live in family units.[2]
- About 38% of people who are homeless in the course of a year are children.[3]
- Most people in homeless families have personal problems to overcome, but these problems are not appreciably different from those of poor, housed families.[4]
- Services delivered in the homeless system seem to have little effect on eventual stability of these families in housing.[5]
- Homeless families report that their major needs are for help finding a job, help finding affordable housing, and financial help to pay for housing. The services they most often receive, however, are clothing, transportation assistance, and help in getting public benefits. Only 20% of families report that they received help finding housing.[6]

In cases in which a family is fleeing from a domestic violence situation or in which the head of household has been in residential treatment or detoxification for drug or alcohol abuse illness, a transitional period may be required prior to housing placement.

Single Homeless People

About half of the people who experience homelessness over the course of a year are single adults. Most enter and exit the system fairly quickly. The remainder essentially live in the homeless assistance system, or in a combination of shelters, hospitals, the streets, and jails and prisons.

- 80% of single adult shelter users enter the homeless system only once or twice, stay just over a month, and do not return. 9% enter nearly five times a year and stay nearly two months each time. This group utilizes 18% of the system's resources. The remaining 10% enters the system just over twice a year and spends an average of 280 days per stay – virtually living in the system and utilizing nearly half its resources.[7]
- The main types of help homeless single adults felt they needed were help finding a job, help finding affordable housing, and help paying for housing. The major types of assistance they received were clothing, transportation and help with public benefits. Only 7% reported receiving help finding housing.[8]

There are also single homeless people who are not adults – runaway and throwaway youth. This population is of indeterminate size, and is often not included in counts of homeless people. One study that interviewed youth found that 1.6 million had an episode of homelessness lasting at least one night over the course of a year.[9]

The Cost of Homelessness

For mayors, city councils and even homeless providers it often seems that placing homeless people in shelters, while not the most desirable course, is at least the most inexpensive way of meeting basic needs. This is deceptive. The cost of homelessness can be quite high, particularly for those with chronic illnesses. Because they have no regular place to stay, people who are homeless use a variety of public systems in an inefficient and costly way. Preventing a homeless episode, or ensuring a speedy transition into stable permanent housing can result in a significant cost savings.

- *A recent study of supportive housing in Conecticut compared Medicaid costs for residents for six-month periods prior to and after their move into permanent supportive housing. Reimbursements for mental health and substance abuse treatments decreased by $760 per service user while reimbursements for inpatient and nursing home services decreased by $10,900.*[10]

Following are some of the ways in which homelessness can be costly.

Hospitalization and Medical Treatment

People who are homeless are more likely to access costly health care services.

- *According to a report in the New England Journal of Medicine, homeless people spent an average* ***of four days longer per hospital visit*** *than did comparable non-homeless people. This extra cost, approximately $2,414 per hospitalization, is attributable to homelessness.*[11]

- *A study of hospital admissions of homeless people in Hawaii revealed that 1,751 adults were responsible for 564 hospitalizations and $4 million in admission cost. Their rate of psychiatric hospitalization was over 100 times their non-homeless cohort. The researchers conducting the study estimate that the* ***excess cost for treating these homeless individuals was $3.5 million*** *or about $2,000 per person.*[12]

Homelessness both causes and results from serious health care issues, including addictive disorders.[13] Treating homeless people for drug and alcohol related illnesses in less than optimal conditions is expensive. Substance abuse increases the risk of incarceration and HIV exposure, and it is itself a substantial cost to our medical system.

- *Physician and health care expert Michael Siegel found that the average cost to cure an alcohol related illness is approximately $10,660. Another study found that the average cost to California Hospitals of treating a substance abuser is about $8,360 for those in treatment, and $14,740 for those who are not.*[14]

Prisons and Jails

People who are homeless spend more time in jail or prison -- sometimes for crimes such as loitering -- which is tremendously costly.

- *According to a University of Texas two-year survey of homeless individuals, each person* ***cost the taxpayers $14,480 per year****, primarily for overnight jail.*[15]

- *A typical cost of a prison bed in a state or federal prison is* ***$20,000*** *per year.*[16]

Emergency Shelter

Emergency shelter is a costly alternative to permanent housing. While it is sometimes necessary for short-term crises, it too often serves as long-term housing. The cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants program is approximately **$8,067,**[17] **more than the average annual cost of a federal housing subsidy** (Section 8 Housing Certificate).

Lost Opportunity

Perhaps the most difficult cost to quantify is the loss of future productivity. Decreased health and more time spent in jails or prisons, means that homeless people have more obstacles to contributing to society through their work and creativity. Homeless children also face barriers to education.

Dr. Yvonne Rafferty, of Pace University, wrote an article which compiled earlier research on the education of homeless children, including the following findings:

- *Fox, Barnett, Davies, and Bird 1990: 79% of 49 homeless children in NYC scored at or below the 10th percentile for children of the same age in the general population.*

- *1993: 13% of 157 homeless students in the sixth grade scored at or above grade level in reading ability, compared with 37% of all fifth graders taking the same test.*

- *Maza and Hall 1990: 43% of children of 163 homeless families were not attending school.*

- *Rafferty 1991: attendance rate for homeless students is 51%, vs. 84% for general population.*

- *NYC Public Schools 1991: 15% of 368 homeless students were long-term absentee vs. 3.5% general population.*[18]

Because many homeless children have such poor education experiences, their future productivity and career prospects may suffer. This makes the effects of homelessness much longer lasting than just the time spent in shelters.

Elements of a Plan to End Homelessness*

Plan for Outcomes

Localities can begin to develop plans to end, rather than to manage, homelessness. There are two components. Every jurisdiction can collect **data** that allows it to identify the most effective strategy for each subgroup of the homeless population. Second, jurisdictions can bring to the **planning** table those responsible for mainstream as well as homeless-targeted resources.

Close the Front Door

Homelessness can be **prevented** by making mainstream poverty programs more accountable for the outcomes of their most vulnerable clients and wards.

Open the Back Door

Where homeless people are already accommodating the shortage of affordable **housing**, this should be facilitated and accelerated. Where there is no housing, particularly for those who are chronically homeless, an adequate supply of appropriate housing should be developed and subsidized.

Build the Infrastructure

Ending homelessness can be a first step in addressing the systemic problems that lead to crisis poverty:

- shortage of affordable **housing**
- **incomes** that do not pay for basic needs
- lack of appropriate **services** for those who need them.

***These steps should be undertaken simultaneously**

Planning for Outcomes

Since the demographics of homelessness, and therefore its solutions, vary in every locality, ending homelessness will require the development of local plans to systematically and quickly re-house those who lose their housing. The replacement housing should be permanent -- having no artificial limits on how long a person can stay. If an individual or family requires some type of temporary housing such as residential treatment (for illness) or residential separation (for victims of domestic violence, for chronically homeless people, for people in recovery) such interim housing should be firmly linked to eventual placement in permanent housing.

In order to develop local systems that do not tolerate homelessness, two things must happen. Accurate administrative data must be developed to understand the nature of homelessness and its solutions, and long range planning must take place with the goal of ending homelessness (defined as getting people into permanent housing).

Data

Every jurisdiction needs solid information on who is homeless, why they became homeless, what homeless and mainstream assistance they receive and what is effective in ending their homelessness. This information is needed on a city- or state-wide basis, not just a program-by-program basis. This allows trends to be monitored to determine what is causing homelessness, to assess what types of assistance are available to address homelessness, and to fill the resulting gaps.

Questions that can be answered with such data include:

- With what mainstream public systems have homeless people interacted, and did this interaction result in homelessness (example: poor discharge planning, inadequate after-care, etc.)?
- How many units of supportive housing are needed to eliminate chronic homelessness?
- For those who enter and exit the system fairly quickly, what assistance is most effective in facilitating their re-housing?
- What mainstream services do families need after they are housed so that they do not become homeless again?

Columbus, Ohio faced the need to relocate two downtown shelters due to a redevelopment effort. The Community Shelter Board had developed a jurisdiction-wide data collection system which showed that some 300 men more or less lived in these shelters – the chronically homeless. Rather than relocate these individuals to new shelters, Columbus will create permanent supportive housing (housing with services) to house them. This will reduce the need for replacement shelter.

Surprisingly, very few places have this kind of fundamental data upon which to base decisions. Accordingly, the approach to homelessness is more often intuitive and general than strategic and outcome driven.

Planning

At present, there is very little local planning to end homelessness, utilizing the full range of resources that is available at the local and state levels. A first step toward such an effort, the Continuum of Care process of applying for funds from the U.S. Department of Housing and Urban Development, has succeeded in increasing the level of cooperation and analysis at the local level. But genuine planning efforts are still rare.

Local planning should go beyond the effort to create a full spectrum homeless assistance system which manages people's experience of homelessness. Local jurisdictions should develop long term plans whose goal is to immediately re-house anyone who becomes homeless. Such a system will involve agencies and programs far beyond the scope of the homeless assistance providers. The following agencies should be involved in local (and state) planning to end homelessness.

- State/local mental health department
- Mental health providers
- State/local public health department
- Health care providers
- State/local corrections department
- State/local veterans affairs department
- State/local labor or employment department
- Employment services providers
- Employers
- State/local substance abuse department
- Substance abuse providers
- Homeless assistance providers
- Governor's/Mayor's office
- County official(s)
- State/local public assistance department
- State/local housing department
- Nonprofit housing developers/operators
- For-profit housing developers/operators

The San Francisco/Oakland Bay Area has undertaken a major planning effort to coordinate the response to homelessness. Mental health, public health, housing and other agencies – both public and nonprofit sector – have been involved. An integrated strategy for addressing homelessness has resulted.

The Homeless Assistance Centers (HACs) in Miami/Dade County, Florida are replacing the area's shelter system. All homeless people go through intake and assessment in these large centers. Their immediate needs are met, but the goal is to assess and evaluate overall needs and re-house people immediately in either permanent housing or a residential service programs – to reduce the length of their homeless experience.

Closing the Front Door

The majority of people who enter the homeless assistance system receive help and exit the system relatively quickly. But no sooner do people successfully exit the system than they are replaced by others. This is why the number of homeless people does not decrease. If we are going to end homelessness we must prevent people from becoming homeless – we must close the front door to homelessness.

In the past, homelessness prevention focused primarily on stopping eviction or planning for discharge from institutions like jail or mental hospitals. These are important, but we must take a more comprehensive view.

Most homeless people are clients of a host of public social support systems, often called the "safety net." Others are the wards of programs in the criminal justice system or the child welfare system (foster care). Together these programs and systems are called the mainstream system. In a way, homelessness is a litmus test – it can show whether the outcomes of the mainstream system are positive or negative. Insofar as their clients or wards end up homeless, the programs have bad outcomes.

Generally speaking, these mainstream systems, while large in terms of scope and funding, are over-subscribed and under-funded relative to their responsibilities. It is not surprising, therefore, that they are quick to shift responsibilities and costs elsewhere, when they are able. The homeless assistance system provides one such opportunity. To the degree that homeless programs take responsibility for a whole host of very poor people, the mainstream system does not have to. However, the homeless system is not large and well-funded. It can meet immediate needs, but it cannot prevent people becoming homeless, and it cannot address their fundamental need for housing, income and services. Only the mainstream system has the resources to do this.

To end homelessness, the mainstream programs must prevent people from becoming homeless. A sample of the major programs that could be expected to help prevent homelessness follows:[19]

Temporary Assistance for Needy Families (TANF)
Mental Health Performance Partnership Block Grants
Social Services Block Grant
State Children's Health Insurance Program
Substance Abuse Prevention and Treatment Block Grant
Community Health Centers
Community Services Block Grants
Medicaid
Community Development Block Grant
Home Investment Partnerships Progra (HOME)
Public and Indian Housing
Section 8 Rental Certificate and Voucher Programs
Section 811 Supportive Housing for Persons with Disabilities Program
Job Training for Disadvantaged Adults
Welfare to Work Grants to States and Localities
Supplemental Security Income
Veterans Benefits
Veterans Medical Centers
Youth Employment and Training Program
Job Training for Disadvantaged Youth
Veterans Employment Program

Others with which poor people also interact, but which have a lesser impact are:

Ryan White Care Act
Emergency Food Assistance Program
Food Stamp Program
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Maternal and child Health Services Block Grant
Housing Opportunities for People With AIDS (HOPWA)

In order to Close the Front Door to Homelessness, we must prevent homelessness. This can be done in two ways. The first is to demonstrate that although shifting responsibility for homeless people to the homeless system may *seem* to be cost efficient, it is actually more costly over all. For example, sending parolees to shelters rather than half-way houses may seem cost efficient. However, it can increase recidivism, and result in use of other costly systems such as hospital emergency rooms.

The Illinois Department of Corrections has invested funds in housing for parolees under the theory that such stabilizing housing is less costly than recidivism.

Second, we can reward systems for improving their outcomes, as measured by homelessness. This could be done by providing incentives to programs which reduce the number of their clients or wards who become homeless. Conversely, it could be accomplished by penalizing these systems when a client becomes homeless.

The State Legislature of the Commonwealth of Massachusetts adjusted the contract of the State's managed care provider to require a reduction in discharges to shelters. Failure to reduce such discharges will result in financial penalties in the reimbursement scheme. Hospital social workers now seek housing for those being discharged from the hospital.

Opening the Back Door

A key step in ending homelessness is to quickly re-house everyone who becomes homeless – open the back door out of homelessness. Different subpopulations of homeless people require different housing strategies. The two major groups to consider are homeless families and homeless single adults. Both groups face system-based barriers to "getting out the back door."

Chronically Homeless People

The first and most important group to address when seeking to end homelessness is the group that lives in the shelter system – the chronically homeless. They represent 10%[20] of the single homeless population, which itself represents approximately 50%[21] of homeless people, over time. Applied to a national yearly estimate of 3 million homeless people,[22] there are thought to be some **150,000 chronically homeless people** in the nation.

Few people in this chronic group are likely to ever generate significant earnings through wages. While they may have *some* income from wages and/or public benefits, they will require long term subsidization of both housing and services because of their disabilities.

Permanent supportive housing -- housing with appropriate and available services and supports -- is highly successful in stabilizing this population. To end homelessness for chronically homeless people would take 150,000 units of permanent supportive housing. We estimate the cost of creating and sustaining 150,000 units of permanent supportive housing to be $1.3 billion per year at the end of ten years. It is important to consider this cost on the context of savings that will be generated in spending on homeless services, Medicaid, incarceration and the like. (See attached **The Cost of Permanent Supportive Housing**.)

Episodically Homeless Group

The people who use shelter repeatedly, often called the episodically homeless group, constitute approximately 9% of the homeless single population or around 135,000 people.[23] This group has a high public cost when housed in shelter because its members seem frequently to interact with other very costly public systems, particularly jails and prisons and hospitals. Many are active users of substances. They are young relative to the chronically homeless group.
This group requires a flexible strategy that addresses both their housing needs (both when in treatment and in relapse) and their need for treatment. When they are in treatment, or compliant with treatment regimens (i.e., clean and sober), supportive housing or private sector housing are good options. When they are unable to find acceptable treatment, or unwilling to partake in treatment or treatment regimens, other housing options must be found. Current policies in which episodically homeless people sleep in the street, in shelters, hospitals and penal institutions jeopardize public safety (primarily for them) and/or have high public costs.

There are different views about how best to address episodic homelessness. There are those who believe that many episodically homeless people are those currently unwilling to engage in treatment for addiction disorders. Therefore they believe that it is necessary to create a type of housing that recognizes the addiction, makes services available, but does not require sobriety. Models of so-called "low demand" housing exist, and it has further been suggested that low cost hostel or dormitory type housing with daily or weekly rental terms be developed. Others believe that most treatment available for addiction disorders is not appropriate for this group (too short term, no follow-up recovery or sober housing) and that the solution for the episodic group is a sufficient supply of appropriate treatment. Both options are probably needed, but further examination of this problem will be required before the most appropriate mix is identified.

Transitionally Homeless

Those who have relatively short stays in the homeless assistance system, exit it and return infrequently if at all, have been called by Culhane the "transitionally" homeless.[24] The majority of families and single adults who become homeless fall into this category. They have had a housing crisis that has resulted in their homelessness. Despite the near universal shortage of affordable housing for poor people, they will find a way to house themselves. Since the homeless system is unable to address the real cause of their problem – the overall national shortage of affordable housing – its best course of action is to facilitate their accommodation to this shortage and help them make it more quickly.

The Alliance recommends a HOUSING FIRST approach for most families. The focus is upon getting families very quickly back into housing and linking them with appropriate mainstream services – reducing their stay in housing to an absolute minimum. The components of such a plan are:

- Housing services: to clear barriers such as poor tenant history, poor credit history, etc.; identify landlords; negotiate with landlord; etc.
- Case management services: to ensure families are receiving public benefits; to identify service needs; to connect tenants with community-based services.
- Follow-Up: To work with tenants after they are in housing to avert crises that threaten housing stability and to problem-solve.

There are exceptions to this strategy for which an interim type of housing is necessary prior to placement in permanent housing. Families in which the head of household has a chronic and longstanding illness such as alcohol or substance abuse disorder or mental illness may require treatment, with housing for family members, followed by an intermediate level of supportive housing that has appropriate services attached. This would follow the model described above for chronically homeless, chronically ill single people.

For families fleeing an immediate domestic violence situation, a Housing First approach is also unlikely to be effective. Such families typically need a period of four to six months in a sheltered and secure environment in order to sever ties with the batterer. A major component of this transition, however, must be the identification of housing available at its completion.

Similarly for transitionally homeless single adults, the emphasis should be placed upon facilitating their move to permanent housing. Housing services, case management services and follow-up services can be effectively utilized to maximize housing stability.

California's Homeless Assistance Program (HAP) provided 30 days of hotel accommodation plus move-in costs (rent deposits) for newly homeless families which were receiving welfare income support. The philosophy of the program was to prevent families experiencing a housing crisis from entering the shelter by giving them the financial resources to get quickly back into housing. Accordingly, virtually no services or referrals were provided. The cost was low – about $700 per family, but more than 60% of families were stabilized after six months.

Dealing differently with these major components of the homeless population will drastically change the dynamic of homelessness.

The current orientation is to keep people in the system for long periods of time, either because there is no place for them to go (chronically and episodically homeless), or because it is assumed that people are homeless because of some set of personal problems that can be "fixed" by the homeless system (families, transitionally homeless single adults). To end homelessness, a different approach can be taken. People should be placed in housing as rapidly as possible and linked to available services.

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The Cost of Permanent Supportive Housing

Providing 150,000 units of permanent supportive housing for those who are chronically homeless will be costly. Providing such housing will require a long-term commitment from Federal, State, and local governments, and private providers. However, it also holds the promise of savings when total public investment is considered.

Currently, permanent supportive housing is financed through several federal funding programs combined with conventional financing. The major programs that have funded such housing are the Shelter Plus Care, Single Room Occupancy, and Supportive Housing (Permanent) programs at the US Department of Housing and Urban Development. To date around 50,000 units of supportive housing have been produced.[25]

We have estimated the cost of increasing this supply by 150,000 units of permanent supportive housing over ten years. We have calculated the cost of providing and sustaining this house using a project-based rent subsidy for supportive housing providers. This subsidy would include operating expenses such as maintenance, utilities, interest, and property management, and would also include principal payments.

The total cost the operating subsidies depends on the average per unit cost. The cost per unit of permanent supportive housing will vary widely depending on the cost of housing and services in a given geographic area. Based on the costs of similar housing programs, we estimate that the housing component of the units would average approximately $8,500 per unit per year.[26]The initial and renewal costs of the subsidies required to meet the 10-year goal, *including the costs of renewing the current stock of supportive housing*, are listed in the following table:

Cost of Supportive Housing Component of Ten Year Plan (millions)

Year	First Year Rent Subsidy	Renewal Cost	Total Cost	Total Units (New and Current)
1	$128	$300	$428	65,000
2	128	428	556	80,000
3	128	556	684	95,000
4	128	684	812	110,000
5	128	812	940	125,000
6	128	940	1,068	140,000
7	128	1,068	1,196	155,000
8	128	1,196	1,324	170,000
9	128	1,324	1,452	185,000
10	128	1,452	1,580	200,000

At the end of ten years, the annual cost of renewing the 150,000 units would be $1.3 billion, and the total cost of sustaining both the incremental and the existing subsidies would be approximately $1.58 billion.

Construction and Rehabilitation

In some localities, new supportive housing will have to be produced to meet this need, in others, existing housing can be rehabilitated, and in others, there may be adequate facilities already in place or tenant-based subsidies can be used in existing housing. The subsidy described above covers the amortized cost of constructing or rehabilitating units, but in some areas a rental subsidy may not be enough to ensure financing. In that case, several mechanisms for supporting financing are possible:

- FHA could insure financing for construction or rehabilitation.
- HUD could enter into a long-term contract with the provider to guarantee the subsidy, thus a financing agency would feel more confident in providing capital.
- Localities could use HUD funding from CDBG, HOME, or another program to help finance construction.
- The value of the subsidy could be increased in areas where construction financing is problematic.

An alternative to providing a single subsidy to cover all of the costs would be to provide separate financing for construction/ acquisition and operating expenses. The cost of producing a unit is between $50,000 and $100,000 depending on whether you acquire and rehabilitate an existing unit or construct a new one.[27] Funding the construction of 150,000 would require about $11.4 billion,[28] but the subsidy per unit would be reduced significantly. Any funding for construction could potentially be matched with funds from a variety of sources including private donations and State and local funding.

Supportive Services

The supportive services, which are crucial for properly serving this population, can be funded through traditional revenue streams for mental health, medical care, substance abuse treatment, education, and vocational rehabilitation and job training. Preferable would be an independent funding stream to support the cost of services in supportive housing, including case management. The cost of services will vary greatly depending on the geographic area and the individual needs of each resident. Current estimates from providers range from $3,000/year/person to $8,000/year/person for services.

> While the total cost of supportive housing appears high, it must be considered in conjunction with the fact that homeless services would be freed up for other homeless individuals and families, and there would be significant cost savings resulting from better service delivery and stability in housing.

Building the Infrastructure

A primary reason that wide-scale homelessness did not exist twenty-five years ago is that the infrastructure of housing, income and services that supports poor people has changed. Remedies to homelessness must take place within the context of re-building this infrastructure. Although we can stop people who lose their housing from spending lengthy periods of time homeless, ultimately we will not be able to stop people from having housing emergencies until we address their housing, income and service needs.

Housing

Most poor people rent housing, and a great many poor renter households are at an extremely high risk of homelessness. This is because so many of them, 12.3 million individuals or 5.4 million families,[29] have a housing affordability crisis. They pay more than half of their income for rent, and therefore have no buffer to deal with unforeseen expenses such as car breakdowns, the need to leave a job to care for a sick child, or school costs. Should such economic crises arise, they are vulnerable to losing their housing and becoming homeless.

Part of this problem is income-related, but there is also an extreme and growing shortage of affordable housing units in the country. In 1995, the number of low-income renters exceeded the number of low-cost units by 4.4 million.[30] This problem is getting worse. While the number of households needing housing support has increased, the number of units affordable to them has decreased. 370,000 unsubsidized units affordable to extremely low income renters were lost between 1991 and 1997.[31] Federal housing subsidy can help address the problem, but here again supply does not keep up with demand. The number of units receiving direct federal subsidies has dropped by 65,000 in the past four years.[32] Even where housing subsidy is available, it does not always solve housing problems. According to HUD, 1.3 million households that receive some sort of housing assistance still have a severe rent burden.[33]

In short, housing is a serious problem for lower income Americans including those who work. Yet stable housing is essential to achieve national goals of improved education, safety, health care and employment. There are existing housing programs to address these issues, but they are not adequate. Of those people who are eligible for housing assistance (based on income or status), as many do NOT receive assistance as DO receive it, because of inadequate funding.

People become homeless because of the lack of affordable housing. The supply of housing that is affordable and available to low income people should be increased. In addition, subsidies that allow people to achieve stability in decent housing should be regarded as good investments in a productive society.

Income

Work does not pay for housing. According to the National Low Income Housing Coalition, there is no community in the nation in which a person working at minimum wage can afford (using the federal standard of affordability) to rent a one-bedroom unit. Averaging across the nation, a full-time worker would have to make $11.08 per hour (215% of the minimum wage) in order to afford a two-bedroom rental unit. Alternatively, a person could work at minimum wage for an average of 86 hours per week.[34]

For the poorest Americans, reduced incomes are part of a long-term trend. Wages for the lowest-paid workers have gone down substantially in real terms over the past 20 years. The wage for a worker at the tenth percentile (i.e. with wages that were higher than ten percent of workers, and lower than 90 percent) was $6.52 per hour (in 1998 dollars) in 1979. By 1998 it had declined to $5.84, up from a low of $5.37 in 1996. This drop mirrors a drop in the purchasing power of the minimum wage, which declined from $6.29 in 1979 (1997 dollars) to $5.15 in 1997, where it has remained.[35]

The decline in real wages has gone along with an even greater deterioration in the availability and purchasing power of public benefits for the poorest and most afflicted people. In 1995, Congress amended the Supplemental Security Income program so that drug and alcohol addiction could not be considered grounds for disability. As a result, approximately 140,000 people, whose addictions and other disabilities were so severe that they made it impossible to work, lost benefits immediately. From the mid-1980s through the mid-1990s, many states eliminated programs of "General Assistance" or "General Relief," that provided minimal benefits to unemployed people who were not eligible for any

other benefit program. Then, in 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act, which affected food stamp allocations for many people, eliminated SSI eligibility for some children, and turned the administration of welfare programs for families over to the states, through the Temporary Assistance for Needy Families program.

While there has been much controversy about the overall impact of welfare reform, one fact that all concerned seem to agree on is that incomes of the very poorest families have gone down. Despite a superbly healthy economy, for example, the income of the poorest 20% of female headed families with children (six million people) fell $580 per family between 1995 and 1997.[36] The erosion of income was caused largely by sharp reductions in government cash and food assistance for poor families.

The rising tide of the strong economy is indeed lifting boats. However, poor people are experiencing far less benefit than those of higher incomes. Most importantly, any benefit they may experience is not adequate to meet the increasing cost of housing. We must continue to support efforts to create wage and benefits that allow households to pay for basic expenses, including housing, food and health care.

Services

People often need services, and low-income people must turn to public systems to secure the services they need. Some need services in order to work and earn the money to pay rent. Others need services, regardless of their income, in order to meet their basic responsibilities as a tenant and remain in housing.

Mental health treatment is essential so that people with mental illness can earn money and pay rent, and for those with the most severe illnesses, so they can meet other responsibilities as tenants. A great deal of current chronic homelessness can be traced to the lack of a system of community treatment, linked with housing, to replace the system of state hospitals that have been closed in large numbers in recent decades. The National Association of State Mental Health Program Directors estimated that 57,000 people were cared for in state psychiatric hospitals in 1997, down 37% from that number in 1990. This decline is part of a long-term trend that began in the 1950s. Community-based mental health treatment has not kept up with this decline.

The substance abuse treatment system is facing a severe treatment gap. The National Association of State Alcohol and Drug Abuse Directors indicates that 50% of those who need treatment receive it.[37] Waiting times for treatment at publicly-funded clinics preclude effective help for those without stable housing.

Child care is another important service. As welfare becomes less relevant to low-income communities, single parents must work in order to stay housed. Public child care is especially important for those at risk of homelessness – homeless parents are less likely to have functioning networks of social supports, such as family members or friends who could care for their children, than are poor parents in general. Nationally, however, only one out of ten children who is eligible for child care assistance under federal law receives any help.[38]

Everyone uses services. Those with the lowest incomes rely on public systems to supply medical care, job training, education, mental health treatment, child care, substance abuse treatment, transportation and many other services. Those systems are almost uniformly overburdened, and in many cases are not keeping up with new demands. These public systems require realistic funding and good policies to address new challenges.

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[25] Culhane et al, 1999.

[26] These units are, on the whole, subject to refunding every 3, 5 or 10 years, depending on the program. Because of the extraordinary process required to renew these units, relative to how most housing subsidy is renewed, units may be lost.

[27] This figure is based on the convergence of several estimates. The average cost of a HUD funded SRO unit is approximately $6,000. The average cost of other tenant and project based housing that HUD subsidizes is $7,000 to $10,000. The operating cost of public housing managed is approximately $4,500, and the amortized cost of construction (principal and interest) for an average rental unit is approximately $4,500 for a total of $9,000.

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STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Roy E. Barnes
GOVERNOR

September 11, 2001

Lynnette S. Araki, MPH
Office of Planning, Evaluation and Legislation
Health Resources and Services Administration
Parklawn Building, Room 14-36
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Araki:

Please be assured of my support for the application being made by the Georgia Department of Human Resources to participate in the initiative to improve access to mainstream services for homeless people. As Governor, I am committed to ensuring the accessibility of programs and services for all Georgians, particularly vulnerable populations and those with special needs. The policy-building forum jointly sponsored by the Departments of Health and Human Services (DHHS) and Housing and Urban Development (HUD) will provide valuable technical assistance and expert advice in developing state action plans to address homelessness.

As you know, the unique and complex problems of the homeless have eluded traditional solutions. The multi-disciplinary, public and private sector membership of the team that will represent Georgia reflects this understanding and the need to continue our intervention efforts on a variety of fronts. Our state has already engaged a diverse community in activities to aid the homeless and can certainly benefit from the feedback, guidance and innovative strategies offered through the policy academies.

Thank you for sponsoring this unique opportunity to improve the effectiveness of endeavors to assist homeless citizens. I hope you will give favorable consideration to the application from the Georgia Department of Human Resources.

Sincerely,

Roy E. Barnes

REB:lnr

State of Georgia Application for Policy Academy for State and Local Policymakers
Improving Access to Mainstream Services for Persons Who Are Homeless

Policy Academy #2: February or March, 2002
Chronically Homeless with an Emphasis on Persons with Mental Health and Substance Abuse Issues

The State of Georgia is applying for participation in the Policy Academy for Improving Access to Services for Chronically Homeless with an Emphasis on Persons with Mental Health and Substance Abuse Issues. Based on the 2000 National Census Bureau Report, the Georgia Task Force for the Homeless estimates the number of homeless persons in Georgia at 105,916. Georgia is one of the fastest growing states in the nation. As a result of this population growth and the rising cost of housing, the estimated number of homeless individuals in the state has doubled in four years. National estimates of the percentage of homeless individuals who suffer from chronic alcoholism, drug addiction, and/or mental illness vary from 36 percent up to 80 percent. These estimates would indicate that there are approximately 38,000 to 85,000 homeless individuals in Georgia with mental illness and/or addictive disorders. There are a number of health and human services available for this population but little to no coordination of service delivery. The State of Georgia is interested in participation in the Policy Academy because of the growing awareness of the need for policies that reduce duplicative services, maximize available resources, and integrate service delivery for this population.

Definition of the Problem

For many reasons, the homeless population of Georgia is growing. Georgia is a major thoroughfare to Florida, and Atlanta is the hub of the Southeast. Often, individuals, including many minorities, come to Georgia seeking employment opportunities.

Untreated mental illness and addictive disorders contribute to homelessness. For those who are at risk of homelessness, the onset or exacerbation of a mental illness or addictive disorder may be a precipitating factor to homelessness. Homeless individuals with mental illness and/or addictive disorders have multiple and complex needs and often do not know how to access the variety of services required. Service programs often lack the aggressive type of case management needed for this population. In addition, separate service delivery programs and approaches to the treatment of mental illness and addictive disorders complicate service delivery to homeless individuals with co-occurring disorders. Homeless individuals with mental illness and/or addictive disorders often have a multitude of physical health problems, including HIV and TB. Other issues complicating service delivery to this population are transportation, the stigmas associated with mental illness, substance abuse, and homelessness, increasing cultural diversity, policies and regulations that present barriers for individuals without a permanent home address, and other system barriers for accessing services.

Homeless people typically do not have health insurance, including Medicaid, and therefore are unable to pay for their own mental health or substance abuse treatment or physical health care. Research makes clear that housing stability is essential for successful treatment and/or recovery. However, the rising costs of housing further limits the ability of many individuals to access

affordable, safe housing. In Georgia, it currently takes 103 percent of SSI income to rent a one-bedroom apartment. The problem is even more pronounced in Atlanta where it takes 133 percent of SSI income to rent a one-bedroom apartment.

Although Georgia has never established a state vision for services to people who are homeless, there is clear commonality among the visions established by various state agencies, local governments, nonprofit agencies, religious organizations, advocacy groups, and numerous task forces and coalitions on homelessness. These visions support the provision of housing and essential services for homeless individuals and families and those at risk of homelessness to allow them to achieve independence, self-sufficiency and end their state of homelessness or risk of homelessness. The vision is there but what is missing is the high-level policy and direction to remove barriers to collaboration and service integration needed to improve access to services and achievement of the outcomes in the vision.

The percent of homeless individuals with mental illness and/or addictive disorders who are covered by Medicaid or have private insurance in Georgia is unknown. National estimates related to the homeless population suggest that 30 percent are covered by Medicaid and 55 percent have no medical insurance of any kind as compared to 16 percent for the general population. The Georgia Department of Community Health administers the Medicaid Programs for the State of Georgia. For homeless individuals with mental illness and/or addictive disorders who are covered by Medicaid, the implementation of the Medicaid Rehabilitation Option this year in Georgia opens a new service capacity by moving services out of the clinic and locating them where individuals are located, including the streets and shelters.

The Georgia Department of Human Resources administers federal and state funds for public mental health and substance abuse services, public health programs, and funds associated with the Temporary Assistance for Needy Family (TANF) Programs. The Department of Human Resources has a number of state funded and federally funded programs that are not tied to Medicaid eligibility or private health insurance. For example, Georgia has a total of $842,667 in the Projects for Assistance in Transition from Homelessness (PATH). The Georgia General Assembly in 2001 appropriated a total of $400,000 new state funding to develop specialized mobile teams in Fulton County to provide comprehensive community based treatment to homeless persons with intense levels of mental health and substance abuse problems. Fulton is the Atlanta metropolitan area's largest county and is also an area of great cultural diversity. In addition, a total of $247,000 federal Mental Health Block Grant funds are being used to develop a street based outreach team initiative to further the continuum of support services for homeless individuals with mental illness in Fulton County. An exciting new development that could serve as a model of how the state can improve both access to mainstream service and the impact of those services for homeless families is the Millennium Center which is being developed in Cuthbert, Georgia. The Millennium Center will provide a residential housing program for TANF families who are homeless and are in imminent danger of breakup due to reasons exasperated by alcohol and substance abuse. The program will provide a residential program for twenty families combined with day care, job training, alcohol and addiction counseling, family life skills and other supportive services as needed. The project is combining resources from the following federal and state funding sources: TANF, Medicaid, HOME, Section 8 Rental Assistance, State Housing Trust Fund for the Homeless, Technical and Adult Education and the Farmer's Home Administration.

Another critical resource need is housing. The Georgia Department of Community Affairs (DCA) administers the homeless assistance programs funded through the U. S. Department of Housing and Urban Development. The state annually appropriates over $3.0 million in funding to the DCA administered State Housing Trust Fund for the Homeless that is combined with the HUD funds and disbursed through a single, statewide application process. The Georgia Department of Community Affairs just announced the award of $7.3 million in combined federal and state funds to 176 homeless shelter and service providers located throughout the state. The Georgia Department of Community Affairs is a recipient of the HUD John J. Gunther Award for the State of Georgia 1998 Continuum of Care Plan. The Department administers twenty-two HUD Shelter Plus Care grant projects that combine affordable housing with supportive services for homeless individuals and families. The Georgia Department of Community Affairs also administers 15,000 units of Section 8 Rental Assistance and has recently secured authorization from HUD to implement a Project Based Voucher Program in conjunction with permanent supportive housing projects.

A significant barrier to accessing available housing has been the development of collaborative linkages for supportive services. To address this barrier, there has been an increasing commitment to collaboration between the Department of Community Affairs, the Department of Human Resources, and the Department of Community Health. This increasing collaboration is reflected in the special initiatives previously described and in the individuals who have committed to serve on the Policy Academy State Team.

The State of Georgia recognizes that additional resources are needed to address the needs of the growing population of individuals who are homeless or are at risk of homelessness. The current thinking, however, is that there is a critical need to identify all available resources in the state, maximize these resources, and eliminate duplication of efforts and system barriers to effective service delivery. There have been numerous initiatives in Georgia with significant investment of human resources towards addressing the issue of homelessness. Examples include the following:

1. The Georgia Interagency Coordination Council that was re-established in October 2000 at the request of the Commissioners of the Georgia Department of Human Resources and the Department of Community Affairs to focus on coordinated service delivery between council member agencies;

2. The Georgia Homeless Advisory Council that is composed of representatives from each of the State of Georgia HUD Continuum of Care Participating Jurisdictions that is the primary source for advice on provider comments on policies and procedures under consideration by the State Housing Trust Fund for the Homeless;

3. The Georgia Coalition to End Homelessness that is a statewide network of coalitions comprised of homeless individuals, service providers and homeless advocates who are committed to ending homelessness in a human fashion; and
4. The Georgia Family Connections Partnerships that is a nonprofit organization and the largest statewide network in the nation with 159 community collaboratives working to improve results for children and families.

The future investment in Georgia must be empowering actions already identified as needed in initiatives such as those listed above. Such empowerment comes from high-level, policy-

making state and local leaders. Georgia has assembled such a State Team for the Policy Academy grant application.

High-level Commitment

The Policy Academy represents an opportunity to facilitate needed policy development in Georgia. If selected to participate, the State of Georgia pledges to bring to the Policy Academy the following:

- A State Team composed of individuals knowledgeable of the barriers to service delivery to persons who are homeless and have mental health and substance abuse issues, and who possess the ability to impact and implement state-level policy changes in how services for homeless individuals are provided.

- A State Team that will dedicate the staff time and resources to attend the Policy Academy sessions to develop state-level policies to improve access to services for homeless individuals and to work with other stakeholders in the state to get the policies implemented.

- A State Team that will participate in the academy evaluation process and willingly share our experiences, strengths and hopes with other states throughout the process and at the concluding national forum.

Breadth, Depth, and Authority of Proposed State Team

The State of Georgia's Team for the Policy Academy is composed of persons with the ability to impact and implement state-level policy changes. The Georgia State Team has the knowledge and the authority to develop and implement a State Action Plan that removes barriers to collaboration and service integration needed to improve access to services and achievement of outcomes for persons who are homeless. The Georgia State Team members are listed in the attached document. This document also provides the rationale for each member's participation on the team.

ATTACHMENT

Georgia State Team for Policy Academy
Chronically Homeless with an Emphasis on Persons with Mental Health and Substance Abuse Issues

Representative from the Governor s Office**:**

Scott Frederking, Director, Human Development Division, Governor s Office of Planning and Budget, 270 Washington Street, Room 8052, Atlanta, Georgia 30334. Phone: 404-656-4395, Fax: 404-656-3828, E-mail: www.fgst@mail.opb.state.ga.us.
Mr. Frederking is responsible for reviewing the budget requests for the Department of Human Resources, the Department of Community Health and other state human development agencies and in coordination with the Governor develops the Governor s budget request for these departments.

Representative from the Georgia Department of Human Resources:

Debra Elovich, Assistant Commissioner for Policy and Government Services, Department of Human Resources, 2 Peachtree Street, NW, Atlanta, Georgia 30303. Phone: 404-651-6316, Fax: 404-651-6886, E-mail: www.dlelovich@dhr.state.ga.us. Ms. Elovich is the Department of Human Resources liaison to the Georgia General Assembly. She works closely on departmental policy issues with the Governor s Office.

Karl Schwarzkopf, Ph.D., **Contact Person for Georgia State Team**, Acting Director, Division of Mental Health, Mental Retardation, and Substance Abuse, Department of Human Resources, 2 Peachtree Street, NW, Suite 22.108, Atlanta, Georgia 30303. Phone: 404-657-2260, Fax: 404-657-1137, E-mail: www.khschwarzkopf.dhr.state.ga.us. Dr. Schwarzkopf is responsible for administration of public mental health and substance services, including the administration of the PATH program in the State of Georgia, other federal and state funded mental health and substance abuse services, and the development of new homeless mental health outreach programs in the state. He is responsible for setting state level policy and direction for public mental health and substance abuse services.

Juantia Blount Clark , Director, Division of Family and Children Services, 2 Peachtree Street NW, Suite 19.490, Atlanta, Georgia 30303. Phone: 404-651-8409, Fax: 404-657-5105, E-mail: www.jeblount@dhr.state.ga.us. DFCS is responsible for a number of programs that support and assist homeless families which include: the TANF Program, Food Stamps, Low Income Medicaid, Social Services for adults and children, Family Violence Shelters, and other cash benefits. Under Ms. Blount Clark s direction, TANF funds were targeted for homeless families.

Representative from the Georgia Department of Community Affairs:

Terry E. Ball, Director, Division of Community Services, Georgia Department of Community Affairs, 60 Executive Park, NE, Atlanta, Georgia 30329. Phone: 404-679-0569, Fax: 404-679-0669, Email: www.tball@dca.state.ga..us. Mr. Ball directs the supportive housing and homeless assistance programs administered by the Georgia Department of Community Affairs and the State Housing Trust Fund for the Homeless. These programs include the Emergency Shelter Grants Program, the Shelter Plus Care Program, the Section 8 Rental Assistance Program, the Housing Opportunities for Persons With Aids and the Permanent Supportive Housing Program. Mr. Ball is the co-chair of the Georgia Interagency Homeless Coordination Council.

Representative from the Georgia Department of Community Health:

Mark Trail, Acting Director, Division of Medical Assistance, Department of Community Health, 2 Peachtree Street, NW, 37th Floor, Atlanta, Georgia 30303. Phone: 404-657-1502, Fax: 404-463-2495, E-mail: www.mtrail@dch.state.ga.us. The Georgia Department of Community Health, Division of Medical Assistance administers the Medicaid Programs for the State of Georgia. For homeless individuals with mental illness and/or addictive disorders who are covered by Medicaid, the implementation of the Medicaid Rehabilitation Option this year in Georgia opens a new service capacity by moving services out of the clinic and locating them where individuals are located, including the streets and shelters.

Representative from the Veterans Administration:

Cindy Siegler, Acting Public Affairs Officer of the Atlanta Veterans Administration Medical Center, 1670 Clairmont Road, Decatur, Georgia 30033. Phone: 404-321-6111, Extension 2297, Fax: 404-728-1733, Pager: 404-722-2111, E-mail address: www.cindy.sieglar@med.va.gov. Ms. Siegler is Acting Public Affairs Officer and Regulatory Compliance Officer for the VA Medical Center. She is aware of the comprehensive services available to veterans and the need for collaborative support systems in Georgia for this population. She is a licensed clinical social worker with experience in serving individuals with mental illness and addictive disorders.

Representative from Primary Care Program Provider:

Paul Bolster, President, Saint Joseph's Mercy Care Services, 60 Eleventh Street, Atlanta, Georgia 30309. Phone: 404-249-8600, Fax: 404-249-8941, Email address: www.pbolster@sjha.org. Mr. Bolster is the President of the largest provider of primary care for homeless individuals in the Atlanta Region and has provided models of excellence for providing access to services to homeless individuals and their families. Mr. Bolster is also a past State Representative in the Georgia General Assembly.

Representative from Homeless Advocate Community:

Hunter Tison, President, Sewell Printing Services, Sewell Printing, 2697 Apple Valley, Atlanta, Georgia 30319. Phone: 404-237-2553, Pager: 770-747-0444, Fax: 404-233-3051, E-mail: www.sewellprinting.com. Mr. Tison has been active in developing housing alternatives for people with mental illness and substance abuse in recovery. He brings a faith-based approach to recovery and housing alternatives. Mr. Tison is a director of the Georgia Association of

Recovery Residences, Inc., and a director and managing partner of Soul Changers Recovery Foundation, Inc.

Representative from Regional Mental Health and Substance Abuse Service Planning

Earnestine Pittman, Executive Director, Fulton Regional MHMRSA Board, Citizens Trust Building, 75 Piedmont Avenue, 11th Floor, Atlanta, Georgia 30303-2507. Phone: 404-463-6367, Fax: 404-463-6369, E-mail: www.epittman@dhr.state.ga.us. Ms. Pittman is responsible for planning and contracting for public mental health and substance abuse services in Fulton County. Fulton is the Atlanta metropolitan area s largest county and is also an area of great cultural diversity. Forty percent of the homeless population in Georgia is located in Metro Atlanta. The Fulton Regional MHMRSA Board plans for over $1 million targeting services to individuals who are homeless and have mental health and substance abuse issues.