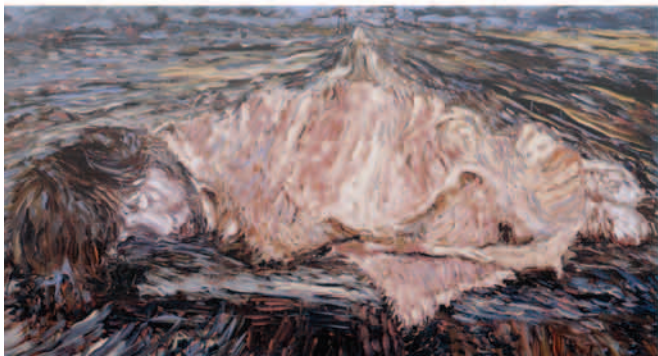
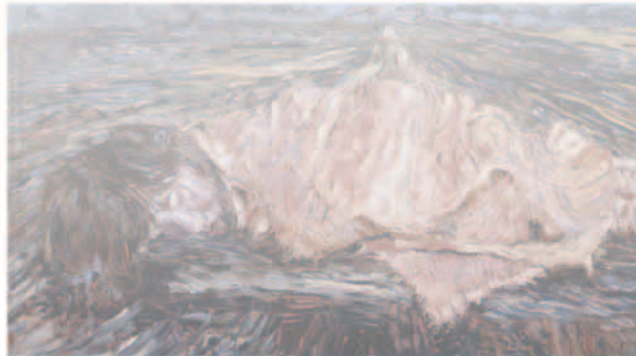


THE SAN FRANCISCO PLAN TO ABOLISH CHRONIC HOMELESSNESS



Marco Sassone, Home on the Streets, 1994 Oil on Canvas, 100 x 70in

The San Francisco Plan To Abolish Chronic Homelessness



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Dear Mayor Newsom,

On behalf of the members of the Ten Year Council, I submit this report entitled "San Francisco's Ten Year Plan" to end chronic homelessness.

The last five months have been an incredible education for all of us. We have the most incredible City, bar none, and yet, as you know, we have one of the worse homeless crisis in the nation. We have some of the most incredible human beings who give so unselfishly of themselves to help the poor and yet we remain unable to take the poor off of the streets and into housing. We have the most lauded and successful plans in the nation and yet again, we lead the nation in people without homes. These are stark realities, and this Ten Year Planning Council faced them head on. The plan we present to you is a no non-sense plan, "lets house people now" plan, that I firmly believe is the key that will unlock the door to the homes our people so desperately need.

The focus of the plan is permanent supportive housing for the 3000 or so chronically homeless, out of the 15,000 general homeless populations. When you effect the 3000 chronically homeless, indeed, you dramatically effect the general homeless population. The plan is a redirection of our resources, our attitudes and our strengths. Never easy, I know. But this Council of amazing people has given the City a plan that is courageous and necessary to end this disgrace. Now we need to implement it. The completion of the Plan is merely the beginning of the work.

For the first time in the twenty years that I have been in public life, I feel the united excitement, the electric energy, the profound intelligence, and the strong will to end chronic homelessness in our great City. I credit a lot of that to you, Mr. Mayor, for having the courage to make homelessness a priority in your administration. On behalf of the Council and me, we thank you!

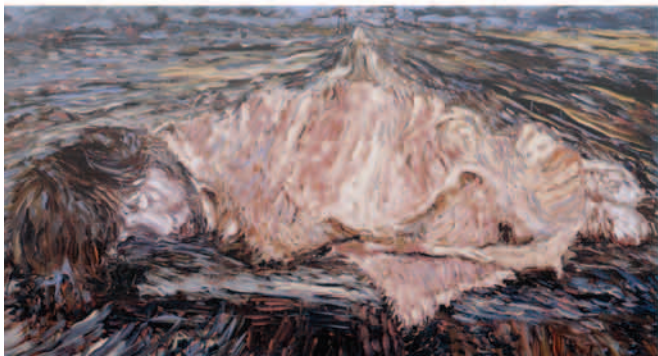
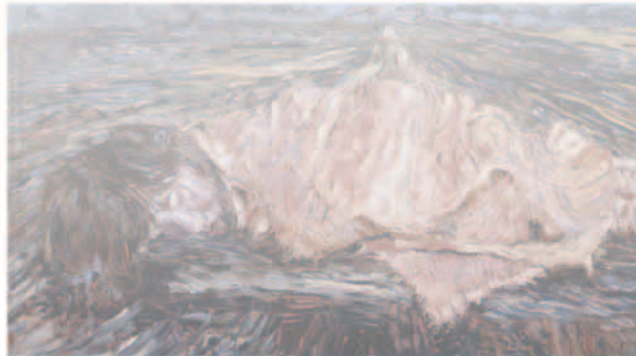
It's time to roll our sleeves up, and get to work on what will be one of the most rewarding accomplishments of anyone's life. I certainly look forward to this particular "victory party!".

Sincerely,

A handwritten signature in black ink that reads "Angela Alioto". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

Angela Alioto
Chairwoman of the Ten Year Planning Council

San Francisco Ten Year Planning Council



San Francisco Ten Year Planning Council

Angela Alioto, Esq. Chair
Reginald Smith, Project Director
Tim Guzzetta, Project Assistant

Mayor Gavin Newsom took the oath of office on January 8, 2004. One of the first acts of his new administration was his appointment of former Board of Supervisors President Angela Alioto to Chair a committee to write a plan to end homelessness in San Francisco in ten years.

Chair Angela Alioto recruited a diverse, non-partisan working group for appointment by Mayor Newsom to the Ten Year Planning Council.

The Council wishes to thank Philip F. Mangano, the Executive Director of the United States Interagency Council on Homelessness. As the founding Executive Director of the Massachusetts Housing and Shelter Alliance and as the formulator of the front door/back door paradigm of advocacy response that has been adopted by the National Alliance to end Homelessness, Mr. Mangano has been at the forefront of innovation regarding chronic homelessness. His insightful theories and unbridled enthusiasm for ending homelessness has been inspiring, and we in city of Saint Francis, thank you.

Finance Committee

Mike DeNunzio** - S.F. Commission on Aging and Adult Services
Chair, S.F. Republican County Central Committee
Fred J. Martin, Jr.* - Bank of America, Retired
John Hutar - Nikko Hotel, S.F. Hotel Council
Pamela Berman - Small Business Owner
Cassandra Benjamin - Charles & Helen Schwab Foundation
Gayle Orr-Smith - San Francisco Police Commission
Leon Winston - Local Homeless Coordinating Board, Swords to Plowshares

Prevention and Discharge Planning Committee

Dr. Suzanne Giraudo** - California Pacific Medical Center (CPMC)
Ed Jew* - San Francisco Coalition for Fair Rate Increases
Brian Cahill - Catholic Charities
Dr. Richard Kunin - Society for Orthomolecular Health Medicine
Ann Marks - San Francisco Progressives
Carol Lamont - The San Francisco Foundation

Mainstream Health and Employment Committee

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Steve Fields* - Progress Foundation
Anne Kronenberg - S.F. Local Homeless Coordinating Board,
Deputy Director Department of Public Health
Ruth Dewson - Mrs. Dewson's Hats, Small Business
Arthur M. Jackson - CEO, Jackson Personnel
John Hanley - San Francisco Firefighters, Local 798

Outreach, Assessment and Behavioral Health Committee

Honorable Chris Daly** - Supervisor, City and County of San Francisco
Father John Hardin, OFM* - St. Anthony's Foundation
Dr. Robert Okin - San Francisco Department of Public Health
Chris Cunnie - Walden House
David Heller - Geary Street Merchants Association
George Wesolek - Archdiocese of San Francisco
Liam Shy - San Francisco Youth Commission
Mel Beetle - Senior Advocate, Homeless

Permanent Supportive Housing Committee

Ramon Romero** - San Francisco Redevelopment Commission President
Lauren Hall* - Corporation for Supportive Housing
Paul Boden - S.F. Coalition on Homelessness
Bobby Jones - Wealth Management Group
Daryl Higashi - Permanent Supportive Housing Finance Director
Francis Rigney, M.D. - Chief of Staff, CPMC, Retired
Chip Conley - Joie de Vivre Hotels
Bok Pon - Cathay House # 384, American Legion

** Denotes Committee Chair; * Denotes Committee Vice-Chair

The Ten Year Planning Council, and committees of the Council, met eighty-five (85) times, beginning on March 19, 2004 and ending on June 30, 2004, when the Plan was presented to Mayor Gavin Newsom. Public hearings were held at San Francisco City Hall on May 26 and May 27, 2004.

More than 785 individuals representing over 400 organizations participated in one or more of these eighty-five meetings, and provided valuable contributions of information, funding, meeting space, and time toward the creation of this report.

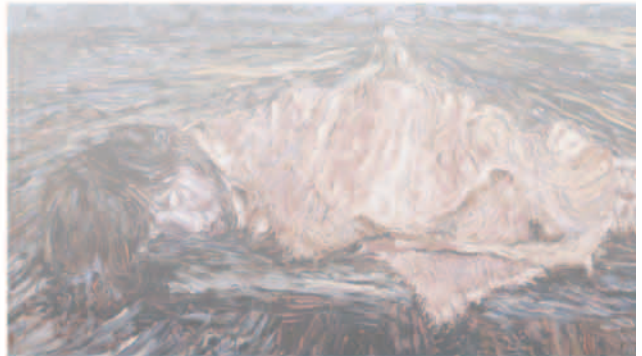
The San Francisco Foundation provided fiscal sponsorship of the Council's work, and contributed accounting services to facilitate payment of expenses.

As of the printing of this report, generous contributions to support the work of the Council had been received from: The San Francisco Hotel Council, Pacific Gas & Electric Corporation, the Gap Inc., Plumbers and Pipefitters Union Local 38, the Levi Straus Foundation, the McKesson Corp, Charles Schwab Corporation, the San Francisco Foundation, the San Francisco Restaurant Association, JP Morgan Chase, the Bank of America, Providian Financial Corporation and Mr. Larry Nibbi.

A writing committee, lead by Barbara Meskunas, met for several weeks to organize the committee recommendations. The writing committee included council members Mike DeNunzio, Fred Martin, Ann Marks, Paul Boden, Dr. Francis Rigney and Chair Angela Alioto. A special word of thanks to Lauren Hall of the Corporation for Supportive Housing for her contribution to the final document.

The Council offers its sincere gratitude to our donors, who share our compassion and commitment to ending the crisis of chronic homelessness in San Francisco.

“Changing Direction” Executive Summary



“Changing Direction” - Executive Summary

The "Housing First" model is a radical departure from the Continuum model in use for almost two decades in San Francisco.

San Francisco is Everyone's Favorite City. But San Francisco also has the dubious distinction of being the homeless capital of the United States.

There are estimated 15,000 people who are homeless in the city and county of San Francisco and 3,000 of them meet the definition of chronically homeless. New York, a city many times our size, has 2,700. This plan is directed at the 3000 chronically homeless.

It is a crisis that must be addressed immediately. We need change now.

San Francisco spends approximately \$200 million annually on homeless direct and related services, yet the numbers of homeless continue to rise alarmingly.

San Franciscans consistently identify homelessness as the number one problem in San Francisco. San Francisco voters have repeatedly sent a clear and overwhelming message to City Hall that they want change, and are willing to try any and all new approaches that look promising and do not perpetuate the status quo.

Mayor Gavin Newsom began his administration with the appointment of the Ten Year Council to End Chronic Homelessness in San Francisco. He asked former President of the Board of Supervisors Angela Alioto, to Chair the council and steer its agenda.

Our mandate is clear.

Our task begins with the admission that the city's focus to date -- based on *Continuum of Care* strategies, i.e. separating the provision of services from the provision of housing -- has not worked, as evidenced by the highest per capita number of homeless people in the United States.

We must have the courage to set aside our failed policies and change direction.

We must have the courage to say that we will no longer tolerate, as the compassionate City of St. Francis, human beings living in abject misery and sleeping in our streets.

The "Chronically Homeless"

The U.S. Department of Housing and Urban Development defines a "chronically homeless person" as "an unaccompanied disabled individual who has been sleeping in one or more places not meant for human habitation or in one or more emergency homeless shelters for over one year or who has had four or more periods of homelessness over three years."

An estimated 20% of San Francisco's homeless population meets the definition of "chronically homeless," yet these 3,000 individuals, including families, consume 63% of our annual homeless budget, comprising both City, State, and Federal funding.

The Ten Year Council targeted the 3,000 chronically homeless with this Ten Year Plan to the exclusion of other homeless populations because the chronically homeless are the most in need, they consume the lion's share of dedicated resources and, if their needs are met, the city will save money. The money we save can then be redirected to the remaining general homeless population.

Our focus is the 3,000 individuals who are the most visible reminders of our failure to find solutions. We do not imply hereby that the needs of the other 12,000 should be neglected, but rather, that the resulting efficiencies of our targeted effort would result in more assistance for the general homeless population.

Permanent supportive housing has been proven to be the most effective and efficient way to take the chronically homeless off the streets. San Francisco has its own successful versions of permanent supportive housing, one of which, Direct Access to Housing, is regarded as a national "best practice."

We must build upon our successes and phase out programs that do not work.

Statistics show that the care of one chronically homeless person using Emergency Room services, and/or incarceration, cost San Francisco an average of \$61,000 each year. On the other hand, permanent supportive housing, including treatment and care, would cost \$16,000 a year. The \$16,000 in permanent supportive housing would *house* the person, as opposed to the \$61,000 in care and services that leaves the person living on the streets.

Logic and compassion dictate that moving our 3,000 chronically homeless into permanent supportive housing would be cost effective, saving the taxpayers millions of dollars each year. Doing so would also provide the chronically homeless with their best opportunity to break the cycle of homelessness that controls their lives.

Permanent Supportive Housing

The recommended goal of the Ten Year Council is a simple one: create 3,000 units of new permanent supportive housing designed to accommodate the chronically homeless. The "Housing First" model is a radical departure from the Continuum model in use for almost two decades in San Francisco. Under the Continuum model, homeless individuals try to find space in a shelter. The next step is often transitional housing before eventual placement in permanent housing. The goal has been to stabilize the individual with a variety of services *before* permanent housing placement.

The "Housing First" model emphasizes immediate placement of the individual in permanent supportive housing, and then provides the services, on site, necessary to stabilize the individual and keep them housed.

This model has been endorsed by the Federal U.S. Interagency Council on Homelessness (USICH), the National Alliance to End Homelessness (NAEH), and by most other cities that have already written their Ten Year Plans.

San Francisco's Direct Access to Housing program has been honored nationally as a model of permanent supportive housing. Established in 1998, the San Francisco Department of Public Health's Direct Access to Housing (DAH) program provides permanent housing with on-site supportive services for approximately 400 formerly homeless adults, most of who have concurrent mental health, substance abuse, and chronic medical conditions. The DPH's reason for starting this program: "Without access to a stable residential environment, the trajectory for chronically homeless individuals is invariably up the 'acuity ladder' causing further damage and isolation to the individual and driving health care costs through the roof."

DAH has 360 units of permanent supportive housing in five single room occupancy (SRO) hotels and 33 units in a licensed residential care facility. The units have private baths and shared cooking facilities; three meals daily are prepared for the residents. DPH acquires the building through "master leasing," which has the added benefit of renovating buildings in troubled neighborhoods.

All six DAH sites have between three and five on-site case managers as well as a site director. Case managers assist residents to access and maintain health benefits, provide substance use, mental health, life skills and family counseling, assist in accessing medical and behavioral health (mental illness and substance abuse) treatment, assist with accessing food and clothes, and interface with property management in preventing evictions.

All six sites have access to a roving behavioral health team, which can place residents off-site in mental health or substance abuse programs when appropriate. All sites have access to medical care.

DAH residents are recruited into the program if they are high users of the public health system and have on-going substance abuse, mental illness and/or medical problems. Over two-thirds of the chronically homeless in the DAH program have remained housed since the program began in 1998, an astonishing success given the dismal recidivism rate of other programs.

Another successful local model is the Community Housing Partnership (CHP), which owns and operates housing for formerly homeless individuals and families. On Treasure Island, CHP provides us with a supportive model for replication.

It is the goal of the Ten Year Council to replicate the successes of Direct Access to Housing, Community Housing Partnership, and other successful permanent supportive housing national models, for the 3,000 chronically homeless individuals living on our streets and in our doorways.

Our model will be carefully refined to target the chronically homeless, (enhanced with a number of excellent suggestions from the Ten Year Council's research), and the money will be found to pay for additional master leasing and new housing production sufficient to meet San Francisco's goal.

Phasing Down Shelters and Transitional Housing

Our City shelters and most transitional housing programs will be phased out as new permanent supportive housing units are brought on line.

In most cases, there is no exit from our shelter system. Available shelter space is insufficient, but the system itself is more problematic than its lack of funding for capacity expansion. New York City spent \$4.6 billion dollars over ten years to expand its shelter system only to find that the shelter system is a dead end street. New York is now dramatically shifting its financial priorities to prevention and housing, and so should we.

Transitional housing programs are of limited duration, providing only a temporary respite from the condition of chronic homelessness, after which the individual usually returns to the streets.

We recommend preparing a plan to phase out traditional shelters within four to six years. We propose to replace the shelters with 24-hour crisis clinics, and sobering centers similar to the McMillan Stabilization Pilot Project. McMillan has saved the city considerable money by diverting intoxicants from emergency rooms. According to the McMillan Stabilization Center May 2004 report, 69% of the chronic homeless population is "either heavy alcohol or drug users." The average age of a homeless person who dies on the streets of San Francisco is 41 years, and 70% of them die intoxicated. San Francisco General's emergency room sees an average of 74 inebriates every two days. A recent study in Seattle calculated that only 123 public inebriates cost the city \$12.3 million in one year; our costs are similar if not worse.

We can use the emergency room cost savings from operating more sobering centers to fund staffing of the crisis clinics.

We propose phasing out most transitional housing programs, and reinvesting those resources in creative and proven models that will place the chronically homeless in permanent housing with appropriate treatment services. Many of the facilities currently in use for transitional housing programs also could easily be reconfigured and adapted to the preferred permanent supportive housing model.

Jails are San Francisco's most widely used version of supportive housing, and shelters are our best example of permanent non-supportive housing. Neither of them is serving its intended purpose.

New Service Delivery Model - Treatment Innovations

We must move personnel and funding away from homeless services that are not linked to housing.

The Corporation for Supportive Housing recommends in a 12/03 report:

'To make supportive housing work for people who really have been homeless for the long term will require far greater coordination among programs. For example, there should be a focused effort to ensure that long-term homeless people who enter the hospital emergency room are discharged as quickly as possible to housing, or community-based treatment as appropriate, and prepare them for supportive housing placement. Treatment programs should be closely linked to housing placement with housing placement set as an outcome measure, and housing slots made available as long-term homeless people exit treatment. Permanent housing outcomes should also be set as a goal for all pro-

grams serving homeless people including hospitals and jails. Freestanding service programs targeting homeless people should be assessed for their connection and value in relation to housing outreach, placement and retention."

San Francisco currently has over 1000 homeless service programs (according to USF Institute for Nonprofit Organization Management). Yet recent research consistently finds that services are maximized when received in a permanent housing setting. We are wasting money if we ignore these findings.

The treatment model currently in use by the DAH program will be enhanced to include valuable contributions made by Ten Year Council members and participants.

Nutrient Support

The Ten Year Council was fortunate to have the participation of noted orthomolecular psychiatrist Richard Kunin M.D., who has had 35 years of experience working with homeless and quasi-homeless patients. His research concludes, "almost all are well served by sensible use of nutrient support." Further, "This is especially important with alcoholic and drug addicted patients. In fact, almost all homeless people are at high risk of malnutrition. Supplementation and dietary support and encouragement will help some to regain their mental and emotional functions and increase their chances for some sort of goal-directed activity. Some will recover entirely. How many? No one knows. Therefore a pilot project is strongly indicated."

The permanent supportive housing environment would provide an opportunity for such a pilot project, which could significantly contribute to the decrease of recidivism.

Prevention and Intervention Innovations

We know that approximately 90% of our 3,000 chronically homeless individuals rotate through the jail system on a weekly or monthly basis. At any given time, approximately 40% of the jail population is homeless people.

Our jails are overcrowded because a homeless person cannot qualify for early release.

Jails have become permanent supportive housing for San Francisco's chronically homeless.

If case managers can be assigned to prisoners before release, and if permanent supportive housing slots can be assigned immediately upon release, we could cut the chronic homeless number dramatically.

If we can apply the same intervention model to San Francisco General Hospital releases we will have, for the most part, solved our problem.

We recommend expanding the use of designated rent receivers, to discourage evictions from permanent supportive housing for non-payment of rent.

We recommend requiring that city-funded housing providers first notify a designated city agency before initiating eviction proceedings for non-payment of rent by or behavior difficulties of the chronically homeless. We recommend the creation of a new Housing Court (Eviction Court) to arbitrate and decide eviction matters.

Every effort must be made to reunite the chronically homeless with their families, wherever they might be located. Isolation only exacerbates the loneliness and despair of drug or alcohol addiction, and the life threatening challenges of living of the streets.

Coordination of City Resources

Seven City departments directly spend our homeless money: Department of Public Health; Department of Human Services; Mayor's Office of Community Development; Department on the Status of Women; Department of Children, Youth and Their Families; Mayor's Office of Housing; and the San Francisco Redevelopment Agency.

The San Francisco Housing Authority must expand its role as a working partner and asset contributor. In other cities local Housing Authorities have worked in partnership with non-profit housing providers to set-aside units for behavioral health treatment and other programs targeting the homeless. Authority eligibility lists and placement priorities should be redesigned to reflect the goal of the Ten Year Plan.

The creation of a master intake database must be a priority. City departments must have current and accurate placement data available 24 hours a day.

The Mayor's continued dedication to ending chronic homelessness will insure the interdepartmental coordination and cooperation necessary for successful implementation of this Ten Year Plan to End Chronic Homelessness in San Francisco.

Redirection of Homeless Dollars

New ideas are as important as new funding, but we must proceed with crafting a solution in any event, *new funding or not*.

This strategy will require a dramatic reprioritization of how our homeless, health and housing dollars are spent.

If chronic homelessness is recognized as the crisis it is, then eradicating chronic homelessness must take precedence over traditionally funded housing and service programs until our goal is met.

Toward that end:

- The Consolidated Plan should be updated to emphasize production of permanent supportive housing;
- The City's inclusionary zoning requirements should be amended to provide incentives for market-rate developers to build permanent supportive housing; competition could substantially lower our production costs;
- The SF Redevelopment Agency should amend its project area planning to produce permanent supportive housing with tax increment monies already earmarked for affordable housing;
- MOH, SFRA and the SF Housing Authority should include permanent supportive housing in all proposals for new affordable housing, and should identify opportunities where empty apartments could be converted for such use.

Of course, any and all new resources will be sought for new funding to help us to achieve our goal as quickly as possible.

Finally, we believe there will be a meaningful role for philanthropy in this effort, once public confidence in our ability to do the job properly has been restored. The SF Foundation recommends joining with the Bay Area Foundation Advisory Group to End Homelessness to champion a high profile campaign to increase philanthropic contributions from the community, local foundations, businesses, and residents to join together to "end this plague on people and our community." We agree.

Employment Opportunities

We recognize the importance of employment and training in ending chronic homelessness. We recommend changes to the mainstream employment service system that will specifically address the needs of the chronically homeless. Thus we recommend the following:

Examine the potential to increase the employment and training of homeless individuals in the construction or rehabilitation and operation of supportive housing sites.

Examine current programs such as Section 3 Plus Program to ensure that federally funded projects are adhering to the practice of hiring low-income individuals.

Determine strategy to increase the community's ability to train homeless individuals to increase their ability to access employment.

This strategy can be implemented immediately by DHS and MOH/MOCD. Cost would be determined by the findings. Existing employment and education programs may be able to increase their ability to provide training and employment services pending funding.

Ten Year Plan Oversight

We recommend that the Mayor appoint a seven-member Planning & Implementation Council who will be accountable for the results, timelines, and public reporting requirements of the Ten Year Plan.

These seven individuals will be results-oriented, and have no financial or political investment in the outcomes of implementing the Plan.

The Council should have the authority, acting on behalf of the Mayor and his office, to recommend programmatic and operational changes to department heads to keep the goals and objectives of the Plan on track.

Conclusion

This Ten Year Plan is a bold admission that the City of St. Francis can do a better job taking care of its own.

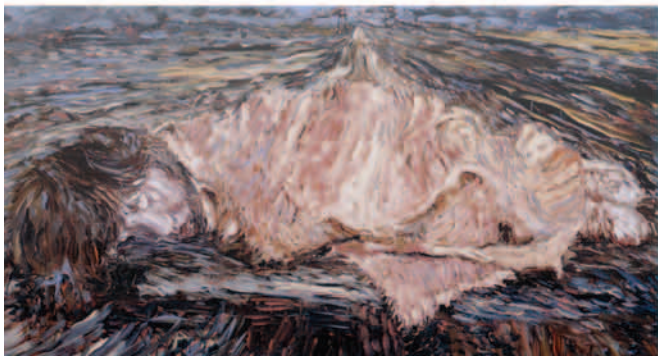
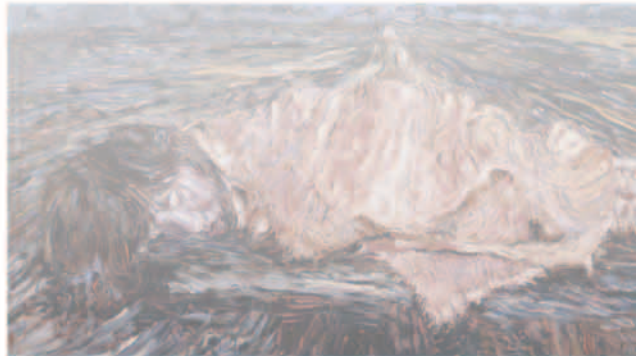
Never have so many diverging interests, of all political parties, sat down at the same table to chart a new course, working together to solve a crisis that has beset our beautiful city for decades.

Despite the best intentions of those who have tried to solve the problem before us, and despite the hundreds of millions of dollars we have spent seeking a solution for the homelessness pervading every corner of San Francisco, the answer has alluded us. Until now.

This Ten Year Plan recommends a number of profound departures from the status quo.

The goal of this Ten Year Plan is not to manage homelessness, but to effectively *end* chronic homelessness in San Francisco in ten years.

Continuum



San Francisco's Current Homeless Assistance Delivery Model

San Francisco has had large numbers of homeless people on its streets for almost two decades. Past administrations have attempted to deal with the problem with a number of variations on the same theme, i.e. providing a vast array of services and housing options, the number and quality to be determined by available funding.

The federal McKinney-Vento Act of 1987 officially recognized that there is "no single, simple solution to the crisis of homelessness." San Francisco opened its city-operated shelters shortly thereafter, and continued to grow a system of services to assist shelter occupants that is both vast and diverse.

Following is the Service Activity Chart contained in San Francisco's 2003 McKinney Application. It is an amazing list.

Fundamental Components in CoC System -- Service Activity

Component: Prevention

Homeless prevention is an essential element of San Francisco's continuum of care, where early intervention includes eviction prevention, grants for security deposits to move individuals into permanent housing, in-home support services, legal services and money management. The San Francisco *Chronicle's* annual Season of Sharing campaign is a major contributor to the eviction prevention program. The City has aggressively pursued other resources as well. The Department of Human Services (DHS) contributes General Fund moneys and leverages over \$1 million in non-local funds for eviction prevention services, providing over 1,300 interventions annually. Likewise, the Mayor's Office of Community Development (MOCD) and Mayor's Office of Housing (MOH) provide funding for anti-eviction programs. Since 1995, the funding pool has grown from \$410,000 to over \$1.3 million through private donations, government grants, CDBG and HOME funds, and other resources. DHS also manages an eviction prevention program for CalWORKs (TANF) families in public housing.

Services in place: (Please arrange by category (e.g., rental/mortgage assistance), being sure to identify the service provider.) The Family Eviction Prevention Collaborative (FEPCO; Catholic Charities is lead agency, others are the Eviction Defense Collaborative, St. Peter's Housing Clinic, and the Volunteer Legal Services Program of the Bar Association of San Francisco) provides direct back rent assistance, tenant education, case management and legal services. Additional funding goes to the Eviction Defense Collaborative to help defend tenants who are served with an eviction notice. As part of that program, RADCo (rental assistance disbursement component) disburses funds for back rent. The San Francisco Housing Authority-a partner in the Family Eviction Prevention Collaborative-focuses on families in Housing Authority units who are at risk of eviction for nonpayment of rent. This fund can pay back rent and provide ongoing case management to help families continue to be able to pay rent and keep their housing. The Homeless Advocacy Project provides legal representation to prevent evictions as well as landlord-tenant counseling.

The Department of Human Services' Division of Family and Children's Services works in concert with CalWORKs and the Division of Housing and Homelessness to support family stability to prevent homelessness for families. They provide mental health and substance abuse services and they can help providing funding for first and last month's rent and move-in costs. Their current caseload (as of May 2nd) was 3,024 children, all linked to court cases.

Services planned: \$200,000 of the City's State Tobacco Tax Initiative funds (Prop 10), which target families who have children younger than five, are directed toward existing programs for additional move-in and eviction prevention grants.

We have recently created a formal group of all the programs that receive Department of Human Services funds to provide direct rental assistance; this Direct Rental Assistance Work Group meets to discuss various issues that impact on the program's effectiveness, e.g., strategies, leveraging additional funds.

Fundamental Components in CoC System -- Service Activity (continued)

How persons access/receive assistance: Season of Sharing Program: Access to eviction prevention services is through approximately 80 community agencies, including Homeless Resource Centers, which are trained to take applications from eligible clients who are at risk of eviction or need to move from temporary to permanent housing. Applications are reviewed biweekly at the Department of Human Services, which coordinates the program, and then submitted to a review board. If approved, a check is issued directly to the landlord on behalf of the client.

The Family Eviction Prevention Collaborative (FEPCO) has 15 agencies that can do intakes and forward the information to FEPCO. RADCo gets referrals from agencies that make up the Eviction Defense Collaborative, as well as from a number of other service agencies, including tenant rights groups (e.g., Bay Area Legal Aid, Asian Law Caucus, Tenderloin Housing Clinic, San Francisco Tenants Union), and even from landlords seeking assistance with tenants who are behind in their rent.

Component: Outreach

Outreach in place: (1) Please describe the outreach activities for homeless persons who are *living on the streets* in your CoC area and how they are connected to services and housing. (2) Describe the outreach activities that occur for other homeless persons.

Outreach activities to people living on the streets are carried out by outreach teams from the Department of Public Health and by the San Francisco Community Clinic Consortium (part of Healthcare for the Homeless), both of which go to where the people are on the streets, as well as at scheduled clinics in shelters and other places where formerly homeless people live. In addition to outreach workers, outreach teams include physicians, nurses, and medical assistants. The San Francisco Community Clinic Consortium now offers monthly veterinary services to the pets of homeless people on the streets, finding this an important service as well as a way to establish rapport with people who may not seek help for themselves. Caduceus Outreach Services conducts outreach to severely mentally ill persons who are unable or unwilling to utilize institutional treatment services.

Veterans: The Veterans Administration operates a Comprehensive Homeless Center, which provides outreach, assessment, and treatment services. Outreach is conducted twice weekly at A Man's Place (shelter) and at detox centers. Outreach also occurs through Outreach Health Fairs. The VA goes to Treasure Island, where veterans reside in several transitional housing programs. Swords to Plowshares, which has been serving homeless veterans since 1974, conducts outreach in shelters, hospitals, jails and drop-in centers. Swords is part of the City's Emergency Response Teams to fires in SROs so that displaced veterans can access housing and health care. The VA's Health Care for Homeless Veterans has been working more closely with Swords to Plowshares on collaborative outreach efforts in the two San Francisco jail facilities; both work closely with public defenders and alternative sentencing programs, as well as treatment programs. This year the VA started outreach to the Tom Waddell Clinic where they go twice a month. Both the VA and Swords outreach to chronically homeless veterans.

Seriously mentally ill persons on the streets come into the system of care through the MOST team (Mobile Outreach, Support and Treatment) of the Department of Public Health. Caduceus Outreach Services offers additional outreach to seriously mentally ill persons, working with them on the streets, providing case management and care, for the purpose of helping them move into the system of care. Both of these efforts target chronically homeless people.

Substance users/abusers come into the system of care through the Mobile Assistance Patrol's (MAP) First Response Team. This is the entity that is called when someone wishes to report someone on the street who needs assistance/intervention. The First Response Team is in communication with the MOST team (above), so coordination takes place at the time of the initial intervention to ensure the most appropriate response. MAP is operated by Community Awareness and Treatment Services under contract with the Department of Public Health. The Department of Human Services collaborates with the MAP First Response Team and the MOST Team in efforts to provide street-based, client-driven case management services. These efforts link homeless single adults to community services such as addiction treatment (including medical detox referral, methadone programs and social model treatment programs), to benefit and entitlement programs (including county cash aid, Food Stamps, SSI advocacy, etc.), to emergency shelter services and stabilization units in local SROs and to supportive housing programs.

Fundamental Components in CoC System -- Service Activity (continued)

Persons with HIV/AIDS: Primary care outreach is through the Tom Waddell Health Clinic at its clinic site or through any of its other 29 sites in shelters, SRO hotels, and other homeless-specific sites. Tom Waddell Clinic conducts street outreach and care four half-days a week and HIV outreach and care three mornings a week. This outreach targets chronically homeless people.

Domestic violence: Outreach to victims of domestic violence is generally through the domestic violence (DV) shelters or the Police Department's DV Response Unit, which hands out resource cards when it goes out on DV calls. The San Francisco Domestic Violence Consortium conducts training with shelter, hospital and clinics staff, informing them of screening protocols and providing them with the resource cards. The Department on the Status of Women requires its subcontractors to report regularly on how and where they conduct outreach, as well as the numbers who are reached in each instance. California state law requires all hospitals to have a domestic violence protocol that includes screening and providing information on resources. Hospitals have recently begun giving out the resource cards as well.

Youth: Outreach to youth is carried out by a number of youth-serving agencies, generally neighborhood-based. There are two homeless youth drop-in centers and many more mainstream youth centers where homeless youth also come. These mainstream centers often make referrals to Larkin Street Youth Services, which serves as a triage point for shelter and housing resources. There is a program of peer-based outreach to youth of color, and there has been an expansion of service options for youth ages 18 and older. These outreach efforts include chronically homeless youth and those at risk for chronic homelessness.

Outreach planned: San Francisco seeks to continue to achieve greater coordination, collaboration and effectiveness in our outreach activities to bring more people on the streets into care settings and toward residential safety and security and ongoing case management. HIV and hepatitis health education, as well as case management, are areas designated for further attention.

Veterans: The VA and Swords to Plowshares plan to continue to seek areas for further collaboration and coordination; one such future effort is in identification and treatment for veterans on the VA's Hep C project (hepatitis C). Swords will be doing more aggressive outreach to veterans to move them into Shelter Plus Care housing.

Seriously mentally ill persons and substance users/abusers: The Department of Public Health's MOST (Mobile Outreach Support and Treatment) and Tom Waddell Health Center's HOPE (Homeless Outreach Projects) workers work in partnership with the Department of Human Services' Homeless Services Team and MAP First Response to address the complex needs of individuals living on the streets who have multiple diagnoses. The pilot for a standard interagency referral form designed by this collaboration is now electronically implemented in San Francisco's HMIS, called C.H.A.N.G.E.S. (Coordinated Homeless Assessment of Needs and Guidance through Effective Services, see project #2). Using this electronic, centrally organized method, these teams will avoid duplication of services, and the efficacy of assisting individuals will constantly improve. The Department of Human Services Homeless Services Team is presently involved in providing social work services to homeless individuals currently enrolling in the HMIS who need assistance in transitioning to this type of service coordination and delivery.

Persons with HIV/AIDS: San Francisco's Health Department continually seeks out new funding to augment and enhance services, and they are currently working in a new collaborative to capture Title III funds for primary health care. Other mechanisms for augmenting and enhancing services include efforts to work smarter, and the Department of Public Health is seeking a planning grant to increase collaboration and coordination for HIV/AIDS services. The Department is continually assessing needs and activity at the different outreach sites to ensure that services are adequate and appropriate.

Domestic violence: The Department on the Status of Women is currently engaged in a six-month strategic planning process; they are looking into consolidating the various DV hot lines into one city-wide line, and they are working on outreach to populations not currently being reached.

Fundamental Components in CoC System -- Service Activity (continued)

Youth: Efforts will continue toward removing barriers for youth to access substance abuse and mental health treatment services. The United Way has provided \$100,000 in seed funding for a Foster Care Initiative in concert with local public and nonprofit agencies focusing initially on housing.

Component: Supportive Services

Services in place: The Gaps Analysis Chart compiled in 2002 shows an inventory of 3,420 supportive services slots available for homeless families and 20,564 for individuals, not including health care services. These include job training, case management, substance abuse treatment, mental health care, housing placement, life skills training, advocacy and legal services, money management, and child care. Nearly all the services are provided through contracts with nonprofit agencies. The City spends over \$104 million annually for homeless-related housing and services (\$18.7 million for capital projects and nearly \$73 million for direct services), with \$53.7 million coming from the City's General Fund. Relatively new state mental health funds, which the City has obtained in two competitive grant cycles, have allowed us to provide intensive case management, including housing services, to homeless severely mentally ill people who have not connected with the system. The City obtained funds in 2001 to provide services for 120 new cases, as well as a new 34-bed long-term licensed care facility that will be fully accessible to homeless persons with medical, physical and psychiatric disabilities who need this level of care. The expanded outreach teams work to move people from the streets into appropriate care situations, although they are constituted to be able to provide services to people on the streets who may not yet be ready to move into housing or a shelter situation. The Department of Public Health's Housing and Urban Health unit, which master leases SRO hotels, has added 139 units in the last year, bringing the total of that program to nearly 400 units. This Housing unit has taken over management of the HIV / AIDS Housing Wait List. Activities focus particularly on services for injection drug users through its Post-exposure Prevention project and the Action Point Adherence Project, a storefront, community based program to assist HIV infected persons to adhere to regimens associated with antiretroviral therapy. Case management services are available throughout the continuum in San Francisco. The Inventory developed for the Gaps Chart showed 36 agencies providing case management services for up to 1,132 families and 54 agencies able to provide up to 4,812 individuals with case management at any one time. Additional case management is available at mainstream programs that homeless clients may utilize, e.g., San Francisco AIDS Foundation, Family Service Agency, as well as with the City's own case management staff for CalWORKs (TANF) and the County Adult Assistance Program (CAAP, which is part of San Francisco's general assistance program).

Life Skills training is accessed through employment and vocational programs, as well as through many of the housing and services providers. The Inventory reports 18 family service providers able to offer up to 377 slots at a time for Life Skills; for individuals, 49 agencies/programs offer up to 4,182 slots at any one time.

Alcohol and drug abuse treatment is available through 13 agencies/programs for families and 30 that serve individuals, offering 232 and 2,278 slots for families and individuals respectively. Counseling and support groups are included in individual service plans in emergency, transitional and permanent housing programs, which either offer residential treatment or can make coordinated referrals to treatment. Treatment is also available for veterans through the Veterans Administration Medical Center, and AA/NA programs are available all over San Francisco, including on Treasure Island.

Mental health treatment: Mental health care is available at 13 sites for families (180 slots) and 26 sites for individuals (1,699 slots). As with substance abuse treatment, homeless people can access mental health services on site in shelters, transitional and permanent housing programs, or through referrals to the various outpatient programs in the city. A number of the programs have psychotherapists on staff.

AIDS-related care and other primary care services are available through 13 City health centers, four youth-focused health centers, one senior-focused health center, two family-focused health centers, two women-focused health centers, and one Native American health center. Tom Waddell Clinic, the main Healthcare for the Homeless provider, outstations medical clinicians and social workers regularly at 29 homeless program sites (at 49 scheduled times during the week), including shelters, hotels, Treasure Island, and with the Day Labor Program; two of the sites are specifically for targeting HIV-positive persons. In addition, Tom Waddell Clinic conducts street outreach and primary care four half-days a week and HIV outreach and care three mornings a week.

Fundamental Components in CoC System -- Service Activity (continued)

Education: Throughout San Francisco's continuum of care, educational services are made available to clients in the programs. Education services include GED classes, literacy classes, resume writing, grammar assistance, and links to City College and the San Francisco Unified School District's adult education programs. Both City College and the School District have staff assigned to homeless students. Some of the shelters and transitional housing programs offer educational services as well.

Employment assistance: According to the 2002 inventory of homeless services, there are 13 job training programs that serve homeless families and 37 for individuals, with a capacity of 174 and 1,885 slots at any one time. The City partners with City College, the State Employment Development Department and its One Stop Centers, the Workforce Investment Board, Goodwill Industries and others to provide a range of employment training programs and services for homeless adults along the continuum of care. In addition, the city, in partnership with HUD, funds the Supportive Housing Employment Collaborative (SHEC), which provides direct employment assistance on site in ten permanent supportive housing buildings. HUD McKinney funds also help support the Homeless Employment Collaborative, the San Francisco Training Project, and HomeWORC, all projects up for renewal in this application. Access to these services is through most of the programs that provide supportive services to homeless people.

Child care services for homeless families are available through Tenderloin Childcare Center, Holy Family Day Home, and Catholic Charities Child Care Voucher Program (the last two are part of this application) for families who meet eligibility criteria. Access is through the San Francisco Children's Council, which coordinates all child care programs in the City, including all the child care associated with CalWORKs/TANF.

Transportation: The Mobile Assistance Patrol (MAP) provides 24-hour transportation to outreach teams and as part of the coordinated referral system during the evening hours for taking people to shelters where there are beds available. MAP also operates a Monday-Friday family transportation system from Connecting Point to shelters and from shelters to destination points. All the City-funded programs provide fast passes, tokens, and cab vouchers. On Treasure Island, which is accessible only by bus or car, the transitional housing programs all have vans for transporting their residents, to augment the public bus service, which runs every half-hour.

Services planned: Greater attention is being given to training staff in both content and service delivery methods to ensure that services are appropriate and effective. The Department of Public Health is in the process of merging substance abuse, mental health and primary care services. This will have the effect of increasing significantly the number of access points for these services in the near future.

How homeless persons access/receive assistance: Except for primary health care services, which are provided in clinics and on the street, most services are provided by nonprofit agencies. Most providers focus on a particular kind of service, a particular population, and/or a particular neighborhood. Service providers make referrals for services that they do not offer. For families, the network of family services opens up once they register with Connecting Point, the Homeless Family Resource Center. Individuals tend to enter the services system through outreach teams, the shelter system, or through agencies that focus on particular subpopulations (e.g., veterans, ex-offenders, persons with HIV/AIDS). The Treatment Access Program (substance abuse treatment) operates multiple access points for treatment on demand, at detox centers, two drop-in centers, and shelters. Additionally, they are now in the courts and at the Hall of Justice as a result of State Proposition 36 which opens up treatment alternatives for drug-related crimes. This is an expansion over last year, and the number of access points will continue to expand as the Department of Public Health further integrates substance abuse, mental health and primary care services (see above under Services planned).

Through outreach, engagement and assessment, homeless individuals are linked to services. But only a lucky few are linked to housing, the only thing that will truly end their homelessness.

San Francisco has an extensive network of shelters and transitional housing. The McKinney narrative explains:

"For San Francisco, 'emergency shelter' is temporary housing (generally up to six months) that provides homeless people with a place to stay where they will be safe and assisted in obtaining the services that will help them to exit homelessness. 'Transitional housing,' on the other hand, is temporary housing (generally up to 24 months) that has a full array of services, again, designed to assist people to exit homelessness. Some shelters operate more like transitional housing, with mandatory case management in a service-enriched environment. Due to insufficient permanent housing options, people sometimes stay in the emergency shelter and transitional housing programs longer than the six-month and 24-month periods; for this reason our shelter system is working to strengthen its ability to provide supportive services, either directly or through collaborative arrangements. Transitional housing programs, as compared with shelters, tend to focus more on education and vocational activities and generally target specific populations, as the program of services is tailored to that specific group, e.g., families, veterans, women who have been abused, women with mental illness, ex-offenders."

In 2003 there were 1,910 emergency shelter beds for homeless individuals and 528 beds for families with children; 1,467 transitional housing slots for individuals and 184 for families with children; and 389 permanent supportive housing beds for homeless individuals, 74 for families with children. Given that San Francisco's homeless population numbers approximately 15,000, it is no wonder that most have no alternative but to sleep on our streets, in our doorways, and in our neighborhood parks.

The 3,000 chronically homeless, the focus of the Ten Year Plan, are more likely to be found on the streets, jails, mental health wards and emergency rooms, than in shelters or transitional housing.

Permanent supportive housing, housing which provides services designed to support populations with special needs, is cited as a primary strategy to end chronic homelessness in the McKinney Application list of goals:

Goal: End Chronic Homelessness ("What" are you trying to accomplish)	Action Steps ("How" are you to go about accomplishing it)	Responsible Person/Organization ("Who" is responsible for accomplishing it)	Target Dates (mo/yr will be accomplished)
Goal 1: Permanent housing – Acquire, build or lease 345 units of permanent affordable housing for special populations.	The Departments of Human Services and Public Health are continuing to expand their master lease programs (200 units added in 2002-3); 88 additional units have been proposed through a recent initiative of the Interagency Council on Homelessness. In addition, with MOH and SFRA, 664 new units in 10 sites have been added to the supply of permanent supportive housing.	Mayor's Office of Housing (MOH), Redevelopment Agency (SFRA), Department of Human Services (DHS), Department of Public Health (DPH)	2004-06

Goal: End Chronic Homelessness ("What" are you trying to accomplish)	Action Steps ("How" are you to go about accomplishing it)	Responsible Person/Organization ("Who" is responsible for accomplishing it)	Target Dates (mo/yr will be accomplished)
Goal 2: Prevention – Improve discharge planning	The Department of Public Health created a discharge planning committee consisting of professionals in the area of substance abuse, mental health, primary care and homelessness. The group is staffed by a highly qualified social worker who is also the Chair of the SRO Task Force, and she holds a Masters in Public Health. This committee reviews every discharge from the hospital to determine the best placement. Every attempt is made to place an individual at the appropriate level of aftercare. If a person is homeless, rooms subleased in SRO hotels may be used as aftercare units. If a person has a substance abuse or mental health diagnosis, staff attempts to connect the individual with the appropriate program prior to discharge. Though much progress has been made in the last year, additional efforts need to continue. Some of the challenges include a limited amount of SRO housing stock.	DHS, DPH, Sheriff's Department	6-30-04
Goal 3: Housing – Increase units in Direct Access to Housing program	Develop at least 100 Direct Access to Housing units each year.	DPH	Ongoing, on track
Goal 4: Emergency shelters – Ensure access for people with special needs	Accommodations are in place for working people, disabled people, and those with pets. Next Door homeless shelter has respite beds for seniors. Over the course of the next year, DHS will focus efforts on increasing linkages for seniors and mentally ill persons.	DPH	6-30-04, ongoing
Goal 5: Integrated services – Increase capacity and improve access to substance abuse services	Link detox beds to residential treatment. Sobering Center on track to be opened in Summer 2003. The Sobering Center will provide links to long-term detox and then to housing.	DPH	6-30-04
Goal 6: Integrated services – Increase capacity and improve access to methadone treatment	Advocate for change in state law to allow for 26-week methadone detox. In process. Budget cuts have not side-railed this goal; while some substance abuse services have been cut, methadone services are being increased. Pilot project utilizing private physicians and a mobile methadone van.	DPH	6-30-04
Goal 7: Integrated services – support all Treatment on Demand recommendations	Implement social model detox services. DPH has supported annual Treatment on Demand recommendations, which are the basis of substance abuse planning.	DPH	6-30-04, ongoing
Goal 8: Integrated services – expand capacity to provide Medi-Cal and SSI advocacy	Add additional capacity to serve 100 clients	DPH	6-30-04, ongoing

Unfortunately, the city's goal of creating 100 more units of Direct Access to Housing units each year means that it will be thirty years before we reach our goal of taking 3,000 chronically homeless from our streets.

Oversight and Successes

San Francisco's Continuum of Care Plan is overseen by the Local Homeless Coordinating Board, the lead entity for San Francisco's Continuum of Care planning and implementation process. "This 34-member board includes 11 seats appointed by the Board of Supervisors and 15 seats appointed by the Mayor; eight of the Mayor's seats are assigned to heads of the main city departments involved with issues of homelessness. Among the Board of Supervisors' and Mayor's appointees, there are designated seats to represent targeted populations and needs (e.g., youth, veterans, domestic violence, substance use, mental health, shelter services, neighborhood seats, education, foundations, labor, large and small business, legal). The Local Board has four standing committees that meet monthly: Steering (serves as the executive committee of the Board, can take action on behalf of the Board, hears committee reports, sets the agenda for Board meetings, serves as membership committee), Policy, Funding (coordinates the McKinney application) and Oversight (monitors CoC plan implementation)."

The McKinney narrative cautions that "according to the most recent street count, San Francisco has experienced a 76% increase in the number of homeless people overall since 2000; the homeless street population has increased by 123% during that time and the shelter population by 28%."

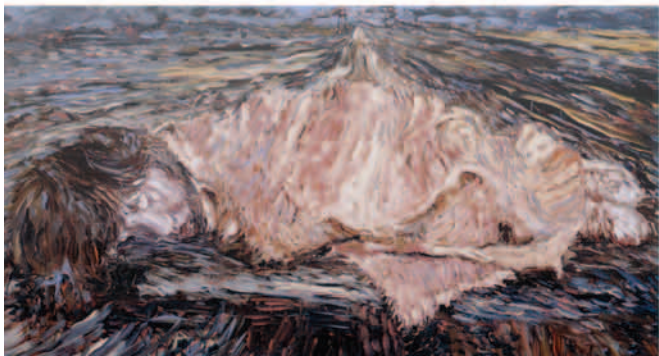
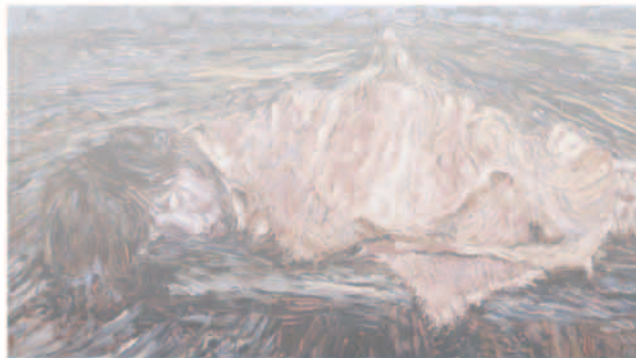
In response, in "the past year, our community has continued to expand permanent housing opportunities for chronically homeless individuals. The Department of Public Health's Direct Access to Housing program focuses on developing and operating service-enriched permanent housing for chronically homeless people with special needs. This program was begun in 1998 and has expanded by approximately 100 units per year, now housing nearly 400 individuals (another 88 have been proposed through a recent initiative of the Interagency Council on Homelessness). The Department of Human Services expanded its Master Lease Program, which provides permanent supportive housing for individuals, from 844 units to 938 units. Both programs utilize the mechanism of master leasing blocks of rooms, sometimes entire SRO hotels, and provide services ranging from on-site primary care to mental health and substance abuse services.

"In the past year, San Francisco has created 300 new slots in its Modified Payment Program. In this program, the formerly homeless person's benefits check goes directly to the program, which ensures that the person's rent is paid; remaining funds are provided to the client according to the contract that has been agreed upon between the client and the program. Finally, 50 new Shelter Plus Care units were brought on line at the Ambassador Hotel; all persons referred to this program will be formerly homeless with at least one special need relating to mental health, substance abuse and/or HIV/AIDS. Other supportive housing added during the year (864 units at 13 sites in all) also is open, but not necessarily restricted to chronically homeless persons."

Innovations in discharge planning from hospitals and jails are important and effective components of the Continuum of Care Plan, as are youth emancipating out of foster care. Preventive placement in both cases is limited by the limited stock of SRO housing.

San Francisco's Continuum of Care Plan is as good as any and better than most. Many of our programs are lauded as national examples. But it is clear that the priorities and focus of the Continuum of Care Plan is not the direction we need to take if we are to end chronic homelessness in San Francisco within ten years.

Document 1



Permanent Supportive Housing

The Primary Strategy for Ending Chronic Homelessness

The San Francisco Ten Year Planning Council to End Chronic Homelessness in San Francisco recommends shifting considerable homeless and housing resources from the existing shelter and transitional housing system of service delivery to the acquisition, production, and operation of permanent supportive housing.

In addition to maintaining funding levels for approximately 3,000 existing units, the recommended goal is to create 3000 new units of permanent supportive housing for chronically homeless adults and families by 2010.

Throughout the nation and here in San Francisco, the model of housing with on-site supportive services has proven to be most effective in housing persons who have been homeless and struggling with mental illness, substance abuse, and other issues. It is clearly more humane and cost effective to provide someone a decent supportive housing unit rather than to allow them to remain on the street, and/or ricochet through a high cost setting such as the jail system or hospital emergency rooms. Such institutions offer incarceration or treatment, but are no more than expensive revolving doors leading back to the streets.

San Francisco's system of homeless services delivery can maximize usefulness and success rates by adaptation to the new model.

The chronically homeless are the most in need of specialized services that can best be offered in a permanent supportive housing setting. The Federal Government definition is:

- Unaccompanied individuals in their early forties
- Homeless over one year, or multiple times
- Disabled by mental illness, addiction, or physical illness
- Frequently hospitalized, incarcerated, and unemployed

The chronically homeless comprise only 20% of San Francisco's homeless population, yet consume 63% of our homeless dollars.

Housing is only one piece of the permanent supportive housing solution. Supportive housing works when other systems fail because chronic homeless prevention and discharge planning innovations are in place to stop the chronically homeless from being discharged to the streets in the first place. Supportive housing works because of the carefully selected supportive services delivered to residents on site, linkages to physical and behavioral health services in the community, and the confidence that comes from no longer being threatened and isolated from living on the streets.

Prevention and Discharge Planning

Closing the Front Door to Chronic Homelessness

The Ten Year Council developed a set of principles to guide its recommendations for prevention and discharge planning:

Housing First

People must be stably housed before they can effectively deal with the other issues in their lives.

No Exit to Nowhere

No one should be discharged from programs, hospitals, prisons, or other systems to the streets.

No Wrong Door

No matter how people enter the system, they should not be prevented from getting the housing and services they need.

Continuity of Care

There should be no gaps in services; toward that end, clients should retain the same primary case manager over time.

Responsibility for Removal means Responsibility for Placement

If the state removes a child from their home and puts them into the foster care system, then the state is responsible for getting that young person stably housed before it takes away their services.

Integration of Services

Housing, mental health, substance abuse, and SSI advocacy services must be integrated through the Dept. of Human Services, Dept. of Public Health, and Dept. of Children, Youth and Families.

Discharge Planning

No one should be discharged from programs, hospitals, prisons, or other systems to the streets.

Data: The largest Mental Health facility in San Francisco is the Jail.

90% of the street population cycles in and out of county jail.

40% of inmates at any given moment are homeless.

16-20% of emergency room patients are homeless

Almost all patients placed in protective custody and brought to the hospital for psychiatric evaluation are homeless

San Francisco's homeless veteran population is estimated to number 3,000 individuals.

Penal System Discharge

The San Francisco Sheriff's Office describes the population going in and out of the county jail as the chronically homeless population, with 90% of the street population cycling in and out of county jail. The largest Mental Health facility in San Francisco is the Jail. In the past ten years, the mental health contacts in San Francisco jails have increased by 56% and the number of unduplicated prisoners requiring mental health treatment has increased by 77%. In 1998, 11% of inmates had a major mental illness diagnosis, and 43% of inmates required some mental health treatment.

There were 23,000 total bookings last year, indicating that potentially thousands of homeless persons passed through the jail system. About 40% of inmates at any given moment are homeless. Homeless persons cycle in and out of jail quickly; therefore it is reasonable to think that more than 40% of discharges are homeless persons. If the City and County of San Francisco is to perform outreach to the chronically homeless population, it needs to look no further than the gates of 850 Bryant, the County Jail.

Moreover, there are tremendous cost savings to housing chronically homeless in supportive housing rather than prison. Incarceration in jail costs over \$20,000 a year, and inmates lose their SSI benefits while incarcerated. If a prisoner were to maintain SSI funding by staying out of jail, that would be \$790 per month (\$9480 per year) coming into the City from Federal and State sources.

The cost of crimes committed must also be considered. Studies show that homeless people who receive services are less likely to recommit crimes, another cost saving to society. The Sheriff's Department anecdotally describes the offenses that homeless persons commit as intimately related to their being homeless, i.e. quality of life crimes. However, despite the cost efficiency of providing stable supportive housing for chronically homeless persons who cycle through the jail system, it is clear that these savings will not be directly reaped. For example, the \$34,000 annually saved by not incarcerating will remain in the Jail's budget, not cut and transferred immediately to the City's Supportive Housing budget.

The Ten Year Council recommends that San Francisco:

Create supportive housing options that are available to chronically homeless persons with criminal records.

We should create 100 units of supportive housing dedicated to homeless ex-offenders through a program similar to the Direct Access to Housing Program, with a focus on chronically homeless with special need. The program should be designed in consultation with criminal justice service providers as to whether this should be a scattered site housing program, co-op apartments, single site SRO hotel, etc., and must be designed to ensure that service provision is linked to existing criminal justice case management and outreach programs to decrease duplication.

A percentage of the new units created to address chronic homelessness should be set-aside for individuals with multiple diagnoses who are barred from other affordable and/or supportive housing programs due to their conviction records.

The City should encourage the Housing Authority and supportive housing sites to assist prospective tenants with navigating the appeal process for those excluded due to criminal backgrounds.

This design of this program should begin immediately, and should be budgeted as part of the city's plan for more permanent supportive housing units.

Prepare for discharge by identifying chronically homeless inmates, and available housing for them, prior to release.

The Sheriff's department should determine during the triage process for all bookings whether incoming inmates are chronically homeless, and whether they have mental disabilities or substance abuse disorders that contribute to their homelessness, and then begin to work on a treatment plan and an appropriate exit strategy to housing.

Preparation for release of prisoners identified to have a mental health diagnosis should include an effective discharge plan with mental health services in place; assistance to initiate or restart SSI benefits; and an assessment of job readiness, with appropriate interventions and referrals for post-release vocational services.

Local programs that have served or continue to serve the ex-offender population should be evaluated for effectiveness and applicability, e.g. the Supportive Living Program - Center on Juvenile and Criminal Justice; that part of the Bay Area Support Network serving state parolees with a history of substance abuse; the Sober Living social rehabilitation model, which offers 16 beds and a maximum two-year stay; the Mentally Ill Offender Program; Acute Diversion Units.

These policies and procedures should begin immediately. Two additional Criminal Justice Case Managers would aid this process, at an estimated cost of \$200,000 for salaries and benefits.

Initiate SSI advocacy and application/reinstatement for all inmates identified with mental health issues prior to release.

Link jail services directly to housing and homeless services.

Criminal justice case managers should be designated as a referral source for new supportive housing sites. Criminal justice case managers should be required to conduct outreach in the jail when housing waitlists are opened. This policy change would cost nothing and could begin immediately.

San Francisco should encourage all city-assisted housing providers to adopt tenant selection criteria with a way around the automatic bar against those with a previous criminal record.

Medical and Psychiatric Discharge

Sixteen to twenty percent of all emergency room patients are homeless.

Almost all patients placed in protective custody and brought to the hospital for psychiatric evaluation 5150's are homeless.

Current protective custody standards are inadequate and they are inconsistently applied. Only a third of the people brought to psychiatric emergency services are placed in treatment. Often homeless serious mentally ill people are released to the street without treatment only to be picked up later that day or soon thereafter, and 5150ed again.

There is also a real need to find ways to prevent people from losing their homes due to the symptoms caused by mental illness. Twenty-five percent of the homeless have been hospitalized for psychiatric disorders; often mental illness is accompanied by substance abuse.

Homelessness is in many ways a symptom of the failure of our mental health service delivery system. This is in part a result of our incomplete understanding - both medically and socially - of mental illness. As our understanding of mental illness more fully develops with additional research on genetics, brain physiology and the body's chemical functions, we will most likely find that the distinctions now made between mental and physical illness are arbitrary, and that substance abuse will be identified as a symptom of a mental or physical disability. Current inadequacies in the mental health system include its failure to adequately identify those at risk for mental illness; to protect those unable to care for themselves due to their mental disability; to accurately diagnose the specific psychiatric disorder within a short timeframe; to provide treatment and medication that is accepted without uncomfortable or harmful side effects; and to provide appropriate treatment and supportive services tailored to each individual's needs.

While we wait for science and public understanding to catch up to the needs of those suffering with mental disabilities, there are actions that can be taken to improve the interventions and services made available to stabilize those unable to care for or support themselves:

Medical and psychiatric discharge is an ideal and natural point at which to access the chronically homeless population. We also know that it is prohibitively expensive to house homeless persons in medical and psychiatric emergency services, but that to discharge a person to the street will exacerbate the problems and likely cause re-admission to emergency services.

Supportive housing for chronically homeless persons saves money by reducing hospitalization costs. A 1999 San Francisco study by the Corporation for Supportive Housing of over 200 formerly homeless and low income people who lived in supportive housing for at least one year compared their usage of emergency room and hospital inpatient care one year prior to entering the housing, and one year post entry. The study found a 57% decrease in emergency room visits and a 58% drop in the number of hospital inpatient days.

The Ten Year Planning Council recommends that San Francisco:

Expand housing options for mentally ill.

We should provide housing with intensive case management to help those with mental illness become and remain stable in housing. Some with mental illness need daily, not weekly, visits by case manager. Some need outreach by an RN to ensure medications are properly taken. Others need cleaning service, or other accommodations, to overcome the specific symptoms of their disability to enable them to maintain their housing.

This change can be immediately integrated into planning for the city's new supportive housing. Additional case management costs should be included in the supportive housing budget. Additional visiting RN costs are estimated as follows: if approximately 1000 (out of 3000 total) clients need medication, and an RN can make 50 client medication visits per day, then 28 FTE RNs will be required. Housekeeping costs (for weekly visits) can be estimated and projected based on similar costs in the Supportive Housing budget.

Separate housing placements should be arranged, when appropriate and in a manner that does not violate fair housing laws, for adults aged 18-23, and those 59 and over, because these groups tend to have different needs. This procedural change can be implemented immediately at no additional direct cost.

The Dept. of Human Services should take steps to expand the availability of board and care, residential treatment options, and other cooperative supportive housing, costs for which are reimbursable through Medi-Cal and SSI. There is no direct cost and the procedures can be put in place immediately.

As an interim measure, we should attempt to increase residential care or respite beds to help homeless people recover from medical issues, including episodes of mental illness, before returning to shelters. Ideally, these people should be placed in respite care until permanent housing is found. This procedure could begin immediately, but should be phased out as supportive housing becomes available. Costs are variable, depending on scope.

Keep mentally ill from losing homes due to symptoms

Improve interventions when patients brought to psychiatric emergency services for protective custody and treatment

Upon admittance for medical and mental health services, patients should be evaluated as to need and potential eligibility for SSI and medical benefits, and be connected to SSI Advocacy Services prior to discharge. Doctors should be required to prioritize providing SSI documentation. This procedure could begin immediately.

The Dept. of Public Health and Dept. of Human Services will meet to restructure their procedures to achieve coordinated case management across multiple services. Clients need to have one case manager that remains the same over time, or a seamless transition to another appropriate case manager. This procedure could be phased in within a year and has no direct costs.

Standards and training should be developed for to doctors, hospital personnel and the judges who make the decisions to retain patients in psychiatric emergency services for protective custody and appropriate medical intervention. There appears to be an inconsistent response among those currently making these decisions, and it is unclear whether it is because those entrusted with these decisions use different standards, or because they first consider the capacity of the hospital before considering the protective needs of the patient. Patients brought to the hospital in custody should be assessed to determine whether they are endangering themselves by not having treatment for severe mental illness. Those deemed endangered and unable to protect themselves should be held for protection and treatment, with appropriate safeguards. This procedure could begin the draft process immediately; there are no direct costs for implementation.

The 5150 protective custody rules should be amended to make it easier to retain patients, and for longer periods. The current system clearly does not work on the behalf of the disabled unable to care for themselves. In order to increase the success of medical intervention and to stabilize those with mental illness, protective custody with appropriate treatment can be an important process to break the cycle of harm, and repeat hospitalizations and homelessness. For those on the street who are mentally ill, harm may come both from an "immediate" threat, (which is the focus of the current standard), but may also come from long-term exposure to degrading conditions and untreated illness. Too often the current process is set to intervene to protect only those who are immediately, at that moment, a threat to themselves or others. The process does not consider the ongoing harm that these disorders have on people and their life expectancy. Better protective custody in a supportive medical setting with appropriate treatment should be society's response in these very difficult cases, with discharge to appropriate residential treatment or supportive housing.

We should also enforce the 5170 (substance abuse) provision for the same reasons, in order to retain chronically homeless clients in a safe setting until a connection with treatment and housing has occurred.

Finally, The Ten Year Council recommends actively supporting the Mental Health Services Act, which will be on the November 2004 ballot in California. This is an opportunity to provide a comprehensive approach to solving instability and homelessness resulting from our inadequate mental health system. The initiative would: expand mental health care programs for children and adults; provide much more than mental health counseling and care, using an "integrated services" model to provide a range of services, including outreach, medical care, short and long-term housing, prescription drugs, vocational training, and self-help and social rehabilitation; and offer services to persons and families without insurance, or for whom insurance coverage of mental health care has been exhausted.

Foster Care Discharge

Foster Care Discharge is a homelessness prevention strategy. A 1994 study indicated that 39% of chronically homeless adults in Minnesota were in foster or institutional care as children.

The State of California, which is responsible for removing children from their families, must also be held responsible for discharging these children to positive outcomes. In the next few years there will be a huge spike in the number of foster youth emancipating from the system, due to the large number of babies who were put into foster care at birth in the 1980's. According to DHS statistics, over the next seven years 774 youth will age out of the foster care system, at a rate of between 100 and 175 youth a year

The Ten Year Council recommends that a direct linkage be established between youth services and homeless services in order to better prepare for, and deliver services to, these emancipated youths toward the end of preventing chronic homelessness.

San Francisco should establish 150 new housing slots for former foster and homeless youth. This housing should be multileveled housing with a range of options including: scattered site housing, transitional/permanent housing, independent congregate living, and 100 units of permanent supportive housing.

This housing stock should come online rapidly to respond to the spike in the number of youth who will be exiting the foster care system in the next four years, and subside after the spike has ended. To begin, 60% of this housing should be allocated to former foster care youth, with the remaining allocated to homeless youth. Mechanisms should be put in place to determine at the end of the year if the allocations should change. For example, if less foster youth need housing the allocation could change to 50% for the next year. First year operating and services costs for 50 units are estimated to be \$1.2 million. The budget for subsequent years is \$840,000, assuming 25 units each year until the goal of 150 units is met. Total cost for the recommendation is \$4.56 million total over five years

Homeless Veterans

San Francisco's homeless veteran population is estimated to number 3,000 individuals. An estimated 10% to 12% (300 to 360 individuals) of these are chronically homeless. San Francisco currently has only 100 veteran-specific Supportive Housing units.

There are insufficient referral destinations within the VA system and elsewhere for homeless veterans being discharged from acute care at the VA Medical Center. Veterans have difficulty accessing local Substance Abuse and Mental Health facilities due to the perception that they can get these needs met through the VA.

Studies of veterans receiving medical care at V.A. facilities have shown that a large percentage has co-occurring mental health issues, and has never received treatment for them. Rather, the V.A. has reduced its spending for mental health and addiction services by 8% over the past seven years, and by 25% when adjusted for inflation, and has not counteracted these cuts with complementary increases in community care.

The Ten Year Council recommends:

Identify veterans at all homeless service and mainstream health providers in order to connect them to veteran specific services. There should be no "wrong door."

Increase the VA's domiciliary capacity in San Francisco should be increased to allow stable housing and care while longer term housing assistance and or placement is identified and obtained. The VA has responsibility for this item, it should be instituted immediately, and there is no direct cost to the city..

Housing options must be increased for veterans.

San Francisco must increase the number of veteran-specific permanent supportive housing units. This priority should commence immediately. Costs for property conversion and supportive services should be included in the Permanent Supportive Housing budget.

Integration of Mental Health and Substance Abuse Treatment

Epidemiological studies suggest that two-thirds of chronically homeless adults meet criteria for substance dependence and approximately 25% meet criteria for chronic mental illness. These studies as noted also noted a substantial overlap between these two disorders. 77% of those with chronic mental illness were also chronic substance abusers and 55% -69% of substance abusers also suffer from mental illness. The net result is that the majority of the chronically homeless suffers from mental illness and substance abuse, and has a "dual diagnosis".

Currently, two distinct systems of care exist, the mental health treatment system and substance abuse treatment system. These systems of care often work in contradictory manners. This leaves patients suffering from a dual diagnosis to maneuver their way through two complex and disconnected systems of care.

Dr. Barbara Havassy's research argues that more African Americans enter the system through drug rehab and more Caucasians enter through mental health. Those who enter through mental health are more able to access services than those who enter through drug rehab; however, these people have the same co-morbid diagnosis.

There must be a wholesale rethinking of how services for people suffering from mental illness and substance abuse are organized and delivered. That is, there should be one system of care. All clinical sites in this "new" mental health/substance abuse treatment system should be competent to address a patient's mental health and substance abuse problems simultaneously.

This type of clinical organization is referred to as a "no wrong door" system. This new organization should be able to provide comprehensive and integrated bio-behavioral substance abuse and mental health treatment services to homeless individuals suffering from a dual diagnosis. This system would include, but not be limited to a long term, staged approach to treatment with assertive outreach and case management, motivational interventions and individual and group cognitive behavioral treatment integrated with state of the art medication treatment.

These newly designed services would only be effective if the chronically homeless adult with a dual diagnosis is living in an environment of supportive housing. The supportive housing environment should be staffed with case managers proficient in the intricacies of dual diagnosis treatment.

The Ten Year Council recommends reorganizing the current mental health and substance abuse treatment systems into one service. This needs to more than just a "paper" reorganization, it needs to begin immediately, and should cost nothing to implement.

This new system should be staffed with professional treatment providers that are fully competent in mental health and substance abuse. Staff whose only professional preparation is their own recovery from mental illness, substance abuse or being previously homeless will not be allowed to work in this new system without receiving adequate training in the fields of substance abuse and mental health. The most professionally trained staff should be assigned to the front end of the system. There are no costs associated with this recommendation, which should begin immediately.

Adequate detoxification services must be made available. These services should necessarily be medically supervised and address all substances including opiates. The current system of social model detoxification is often a detriment to patient engagement, as well as placing the patient at risk for serious medical complications. This change should result in no direct costs to the city and could be phased in over two years with new requirements for city-funded detox service providers.

Individuals with chronic mental illness and substance abuse are over represented among the chronically homeless. Their treatment should also be "chronic" in nature. That is, treatment services should not be time limited. Time limits should be removed over time as permanent supportive housing comes on line. There is no additional cost, other than a decreased capacity to serve the same absolute number of clients, as chronic clients are served for longer periods of time.

Treatment services should be designed in a step-wise fashion. That is, the most intensive treatment services should be offered at intake and tapered over time as dictated by the patient's progress. This recommendation has no associated cost.

The advantages of the clinical model and the peer model should be converged so as to achieve the highest benefits with cultural competency. Re-organization efforts must pay attention to the racial dynamics of the current system: African Americans are more likely to enter substance abuse programs and Caucasians are more likely to access the mental health system. While the cause of this split has not been identified, planners must make sure to put in mechanisms of cultural competency so that people are not inadvertently blocked from the system. This procedure can commence immediately at no additional cost.

Prevention

Closing the Front Door to Homelessness

*Data: 50% of homeless women and children are fleeing domestic violence
40% of homeless individuals in the US are school dropouts;
55% are either dropouts or had less than 7 years of formal education.
30-70% of homeless persons in San Francisco have a disability
5% of homeless persons with severe mental health problems are successful
in obtaining SSI on their own*

According to the Annual Eviction Report compiled by the San Francisco Rent Board in April 2004, evictions in the City have gone down since 2000 (from 2641 in 2000 to 1643 in 2003, almost 62% decrease). This number reflects in part the successful intervention of eviction prevention programs, because only 117 of the 1643 evictions reported were because of non-payment of rent. In 2003, eviction prevention programs served well over 1200 families, each of those potential evictions prevented.

Evictions average \$2000, including court costs, sheriff's services, and then additional costs to the community when families have to access the already overwhelmed shelter system. Eviction prevention services are very cost-effective. The average amount of back rent paid on behalf of families is \$808 in the current fiscal year to date (FY2004-2005). Of the almost \$800,000 rental assistance disbursed to date, 43% was paid by the families themselves. Eviction prevention programs, through intervention with the eviction and mediation with the landlord, stay the eviction and assist families in maintaining their housing.

As is true in many social services, it is more cost effective to fund prevention and early intervention programs than it is to serve members of our communities after the fact. Therefore, it is important to maintain this trend of decreasing evictions in the City by continuing to support eviction prevention programs.

The Ten Year Council recommends that San Francisco:

Expand eviction prevention funding.

The success of the eviction prevention programs Citywide demonstrate the ability of intervention to prevent a family from being evicted, thus preventing the need to access the overwhelmed shelter system. Funding opportunities should be developed with private foundations, corporations, as well as state, federal, local governments to fund the direct financial assistance, educational, legal and case management activities provided by eviction prevention programs.

It costs nothing to maintain eviction prevention programs; a \$95,000 increase in funding available for emergency rental assistance/eviction prevention is calculated as follows: \$808 (average amount of back rent paid on behalf of families) x 117 (number of evictions due to non-payment of rent last year) = \$95,000. The number will be adjusted downward each year as the number of evictions in the previous year decreases.

More funding opportunities for rental assistance/eviction prevention services to serve more families should be developed. Funding opportunities should be sought with private foundations, corporations, and state, federal and local governments to fund the direct financial assistance, educational, legal and case management activities provided by eviction prevention programs.

Improve outreach and linkages to eviction prevention services.

A Central Intake Point should be designed and implemented. This is a complex area, as a family or individual can easily get lost in the system. But a system that is centralized can help families and individuals navigate and access all available resources in the City. Various community based and City agencies should be brought together to strategize and explore the possibilities of creating a centralized intake system for anyone seeking eviction preventions services. Such a system may avoid duplication of services, and minimize a client's need for registration and intake requirements at different agencies. Any system created must protect clients' confidentiality. Such a system can be planned in the first year and implemented in following years, with costs to be determined.

We must design a system to solicit broader community responses. In the absence of adequate funding, when a family or individual is on the verge of eviction, a broader response from the community would be welcomed. Perhaps each Supervisor in each District could establish his/her own priorities, advocate for programs, and encourage religious communities to house or advocate for housing. Schools could act as information points, cultural and social centers to advocate and seek housing opportunities. The strategy would be to encourage community capacity building, and a unified integral response to eviction prevention in the community. We could begin designing this system immediately and it would cost nothing.

The eligibility requirements for emergency assistance must be changed to allow for repeat usage. Families that are seeking repeat assistance are ineligible; thus, a program component needs to be created to address the reasons why. Catholic Charities' CYO programs report that 82 of its 547 families, or 15%, are seeking repeat assistance. Catholic Charities was able to assist the families from other sources but the issues surrounding why a family finds themselves in a repeat situation needs to be addressed. This recommendation should be implemented in the first year and is cost neutral.

San Francisco should investigate implementation of a New York Housing (Eviction) Court model, which could be integrated, at no additional cost, into our overall planning process for prevention innovations.

Preventing Behavior-Related Evictions

Many tenants are evicted because of allegations about their behavior - including strange or threatening behavior - and hoarding of materials or poor housekeeping. Often, these problems arise because of the tenants' disabilities, especially mental health disabilities. Intervention by legal and social service professionals working together can often alleviate the problem and preserve the tenants' housing.

While most landlords who evict tenants in the City do so with the assistance of legal counsel, the vast majority of tenants who are defendants in these lawsuits are unrepresented. This often means that tenants who have valid legal defenses summarily lose their housing, or situations that could be resolved to the mutual benefit of landlord and tenant instead result in housing loss by the tenant. Provision of competent legal assistance to tenants is a very effective way to prevent homelessness.

Currently, many housing providers, even of housing purportedly intended for individuals who are disabled or homeless, have regulations that prevent actual homeless persons from qualifying for the housing. For example, these housing providers refuse to accept individuals who have one or more evictions on their record. This makes no sense, since nearly every homeless person has become homeless in the first place by the mechanism of eviction.

Similarly, these housing providers do not have adequate safeguards in place to assist individuals in retaining their housing. Individuals, particularly those with mental health disabilities who have been living outdoors, need assistance and support in adjusting to living indoors. If problems develop, procedures by which that help can be provided, either internally or from the outside, must be in place. Too often, individuals who have waited several years to obtain subsidized housing are unable to keep it, evicted because of issues related to their disabilities or their adjustment needs. This housing then becomes simply a revolving door, failing to actually remedy the problem by providing long-term stable housing to those who need it most.

The Ten Year Council recommends that San Francisco should:

Increase affordable housing options with support for people with mental health/behavioral problems so as to avoid behavioral issues.

Provide mediation and legal assistance to prevent evictions.

Increase the availability of eviction prevention assistance, both legal assistance and rental assistance payments, to both families and individuals. We must expand funding of projects that provide pro per assistance and representation, especially holistic legal assistance that includes a social service component to help resolve issues underlying the eviction threat. The policy could be implemented immediately. The projected annual additional cost is \$2,000,000.

We should fund groups that provide education and advocacy to tenants who are having difficulty keeping their housing, or who might be at risk of developing difficulties, and groups that provide trainings to housing providers and their staff about tenants rights and responsibilities, applicable disability laws, and working effectively with disabled and/or formerly homeless clients. The projected cost per year for 50 such training workshops would be \$15,000 and could start immediately.

The Tenant Selection Criteria of supportive housing programs must be more flexible in providing housing opportunities to individuals who are disabled and homeless. There must be effective and consistent rules in place to allow homeless people and families to obtain and retain housing. All housing developments that receive any subsidy by or through the City and County should be encouraged to adhere to a specific set of tenant selection criteria developed by the City. The criteria would include, but not be limited to, the following components:

- Applicants that can demonstrate they have a good rent payment record for six months or more, demonstrate their ability to pay. Meeting this rent payment standard should overcome poor credit history, and rent to-income ratios that would otherwise exclude them from occupancy.
- No tenant should be automatically excluded because they have one or more evictions on their record. Consideration must be given to circumstances, and accommodations made for those losing housing as a result of their disability.
- A prospective tenant who has a previous history of eviction will automatically be given the opportunity to provide an explanation and documentation addressing the issue(s) involved in the previous eviction(s).
- Other standards must be found to eliminate a bar against those with a previous criminal record or a poor landlord reference.

This policy change could be instituted as soon as it is written, and would carry no direct costs.

Domestic Violence

Fifty percent (50%) of homeless women and children are fleeing domestic violence. Another twenty percent says that domestic violence was the immediate trigger to homelessness.

Domestic violence shelters turn away four out of five people asking for assistance.

The Ten Year Council concludes that transitional housing is necessary for homeless domestic violence victims before permanent housing because of the unique needs of this population.

As general shelters are phased out, some of the existing shelters in the system could be converted into domestic violence shelters or transitional living situations, with special support systems designed for emotionally vulnerable women and their children. Planning would be a part of the phasing out of shelters at no additional cost.

Two legislative and policy changes are recommended:

1. Expand criteria for Eviction Prevention money to include instances where the batterer has left the home, but was the primary source of rent and/or had his name on lease.
2. Change Housing Authority Policy as needed to expedite relocation of people.

SSI Advocacy

It is estimated that 30-70% of homeless persons in San Francisco have a disability - physical, mental or both. A 1999 federal study indicated that about 40% of homeless people may be eligible for SSI (Supplemental Security Income, or Social Security Disability Insurance for those who have a sufficient work history), yet only 11% were receiving SSI. In our experience, many homeless persons in San Francisco should qualify for federal disability benefits. This is true even for those who have a co-occurring substance abuse or alcohol addiction.

Despite the fact that many persons who are homeless and disabled should qualify for SSI, it is very difficult for such individuals to obtain the benefits without assistance. This is especially true for people who are not stably housed, and who suffer from mental disabilities. According to one study, only 5% of homeless persons with severe mental health problems are successful in obtaining SSI on their own.

SSI benefits amounts for the totally disabled are inadequate to support life in San Francisco and increase the City's cost to provide housing and services. The maximum SSI benefits provided through the Social Security Administration of \$564 are the same nationwide and are not currently adjusted for high cost areas. The state augments SSI benefits in California by \$226, but it too does not make adjustments for high cost areas. It is cruel and unrealistic to expect someone who is totally disabled, which is what it takes for non-elderly persons to qualify for SSI, to live on \$790 monthly in San Francisco where this amount will barely cover the cost to rent the cheapest of rooms leaving nothing for other basic necessities, and it is well below HUD's 2004 fair market rent of \$1,084 for a studio apartment in the city. We will not be able to solve the panhandling problem in San Francisco even if we get more of the disabled off the street unless the Social Security Administration provides benefits that will support people's basic necessities.

The benefits of moving disabled homeless persons on to SSI are many:

- The level of benefits, while inadequate, exceeds any other public benefit available for the disabled (with the exception of certain service-connected veterans benefits), with the current rate at \$790/month.
- Recipients automatically qualify for MediCal coverage, providing the opportunity for ongoing medical, mental health, and dental care, and substance abuse treatment.

The potential savings to the City and County of San Francisco by moving homeless persons on to federal income and medical benefits are huge. For example, in the past five years, HAP has moved more than 750 persons on to SSI. This represented an infusion of new federal dollars into San Francisco of over \$20,000,000 in cash payments alone. Reimbursement to the City from MediCal is harder to calculate specifically, but might very well exceed that.)

The value of effective assistance: with effective advocacy, the rate of SSI approvals for persons who are homeless and have severe mental health disabilities is much higher than the 5% success rate experienced by individuals who attempt to secure benefits on their own. At the Homeless Advocacy Project, the approval rate for clients who are assisted by our project is currently 89%.

The Benefit:

Assuming that 2500 persons could be moved onto SSI, what are the benefits to the individuals and to the City and County?

Federal/state SSI cash benefits

Monthly (assuming \$800/month benefit - some will get more, some slightly less, depending upon whether they have access to cooking facilities): \$2,000,000. This represents an annual infusion of \$24,000,000 into the San Francisco economy.

Medi-Cal Reimbursements:

Medi-Cal coverage is automatic for all SSI recipients. While the cost of medical care and the amount of MediCal reimbursement varies greatly by individual, some DPH estimates have put the costs for the most frequent uninsured users of City/County healthcare at as high as \$50,000 per person. Assuming even a very modest estimate of Medi-Cal reimbursement of \$2000 per person, MediCal reimbursement for 2500 individuals per year would total \$5,000,000.

Savings in County Assistance:

While not all homeless disabled persons receive County Adult Assistance, even if 1000 of the 2500 do, that would represent a savings to the City and County of \$5,400,000 per year in cash benefits.

Other Benefits:

Receipt of SSI and MediCal benefits also provides other benefits to both the individuals and the City/County that are less easily quantified but are nevertheless important.

A regular source of income and access to payment for medical/mental health care is an important component of a strategy to stabilize individuals and move them into more permanent housing. This benefits the individuals, and the City, which has an interest in moving people off the street, to make the City and its neighborhoods cleaner and more attractive to residents and tourists.

Federal cash benefits are most often infused into low-income neighborhoods, benefiting local businesses and helping to support the economy in depressed areas of the City.

The bottom line - For a cost of approximately \$3 million per year, 2,500 disabled homeless individuals can be moved on to Supplemental Security Income and Medi-Cal. This will bring an infusion of at least \$30 million in federal and state dollars to San Francisco, and save the City and County over \$5 million in County Assistance payments. The City and County comes out over \$30 million dollars ahead!

What is effective advocacy?

From years of experience, we have found that the most effective approach includes the following components:

- Assistance from the earliest stages of the SSI application process.
- Assistance by trained advocates who are familiar with the applicable laws and regulations.
- A specific and detailed approach to advocacy.
- The involvement of treating sources who can verify the applicant's disabilities, or the involvement of trained mental health and medical professionals who can provide consultative examinations to support the applications when no treating source is available.
- A supportive and accessible agency and staff, where clients feel comfortable and are more likely to return and follow through.
- The involvement of social services professionals who assist the applicant with other issues that are barriers to stability (such as housing and treatment), thereby helping to keep clients involved in the process, and better preparing them for a successful transition to stability when benefits are received.
- The use of well-trained and well-supervised volunteers can leverage resources.

The Homeless Advocacy Project (HAP) provides full-representation SSI advocacy to between 250 and 300 clients per year, focusing almost exclusively on individuals who are both homeless and have mental health disabilities. HAP's SSI advocacy component is currently funded through a combination of government grants, including HUD McKinney -Vento funding through the Department of Human Services and the Department of Public Health contracts described below; private foundation funding; and in-kind services provided by the Bar Association of San Francisco.

HAP/DPH projects: The Homeless Advocacy Project (HAP) has a long-standing relationship with the Department of Public Health to provide SSI Advocacy. They currently have two joint SSI projects with the Dept. of Public Health:

Disability Evaluation Assistance Program (DEAP) - DEAP provides SSI advocacy for clients through four in-house case managers. Medical staff, including two psychologists, primary care providers and a psychiatrist, have on-site office hours to help connect clients with medical care as well as help to document SSI claims. HAP provides training and technical legal advice regarding SSI issues to DEAP staff. HAP staff also provide SSI advocacy directly to over 100 clients per year through this project, and DEAP staff assist HAP in gathering local medical records and connecting our clients with psychological evaluations.

SSA "HOPE" project - recently funded by the Social Security Administration, the Homeless Advocacy Project will be the primary subcontractor with the Department of Public Health to provide SSI advocacy to the most difficult population of chronically homeless and mentally ill individuals.

The Healthcare Access Collaborative -a joint project between the Homeless Advocacy Project and Haight Ashbury Free Clinics, Inc. (HAFCI). HAP provides SSI advocacy (and handles certain other legal issues), and HAFCI provides a part-time psychologist placed in the HAP office who does consultative examinations and some treatment, as well as facilitates access to other HAFCI programs. The project was originally generously funded by the California Endowment. That funding has now ended, and the project continues in a scaled-back fashion with support from the California Wellness Foundation.

The Ten Year Council recommends that San Francisco fund SSI Advocacy in an immediate, large scale, and effective manner. SSI advocacy can be an incredibly effective way to help stabilize disabled homeless persons, providing both a source of income and healthcare. It is a particularly effective approach because it more than pays for itself by reducing the costs to the City and County, while at the same time bringing an infusion of federal dollars. Current resources for effective SSI advocacy are inadequate.

The city must increase funding for SSI advocacy to move 2,500 people onto the SSI roles. Because successful models exist, most notably the Homeless Advocacy Project, expanded SSI advocacy could be put into place fairly quickly.

A successful model requires at least three components:

1. Advocates to work with the clients, fill out the forms, assemble the evidence and provide representation to clients with the Social Security Administration (SSA), trained and supervised by legal experts.
2. Psychologists (or psychiatrists) to provide consultative examinations in support of the claims, who are familiar with applicable regulations, and have sufficient time to prepare adequate reports.
3. A method to gather applicable past medical records, from both local and other providers (often out-of-state.)

Estimates of the number of homeless persons who are severely disabled so as to potentially qualify for SSI vary widely. Even assuming that only 30% of the lowest estimate of homeless persons (8500) are potential SSI recipients, the number of homeless persons in need of SSI advocacy in San Francisco would be approximately 2500.

The ideal level of service to truly move approximately 2500 homeless disabled persons on to SSI would require approximately 50 full-time SSI advocates, located in, or regularly traveling to, a number of sites throughout the City, including existing medical and mental health clinics, homeless shelters, San Francisco General Hospital the jail, the County Adult Assistance Office, the offices of community based organizations, and doing some street outreach. The advocates would require training and ongoing technical assistance from legal experts who are completely familiar with the applicable

laws and regulations and the most effective advocacy approaches. Existing medical records would need to be gathered for all of the clients. Some clients would likely already be in existing treatment, while others would require consultative examinations. In either case, a provider would need to have the time to document the clients' disabilities. The estimates also assume only salary and benefit costs, or hourly rates for medical and mental health providers. It is assumed that the advocates would be able to make use of existing facilities.

There will be a systematic connection of SSI Advocacy, housing, and services for homeless persons. SSI advocacy and outreach, supportive housing, and discharge planning from all mainstream services will be integrated for efficiency.

Training for all staff providers will be improved and coordinated, with services interfacing with homeless persons, and those who are at risk for homelessness, to improve cross-referrals to services, housing and SSI advocacy. Need for payee services will be identified in clinical evaluations conducted for SSI application; payee services will be offered to ensure SSI benefits are used to cover basic necessities.

The total cost to implement this plan:

- 50 full-time advocates (salary and benefits): \$2,000,000
- 3 full-time Attorney Experts/Supervisors (salary and benefits): \$187,500
- 3 full-time medical records technicians (salary and benefits): \$112,500
- Psychologist/provider time for consultative exams or to prepare reports for 2500 clients (assumes 1500 need consultative examinations - 5 to 10 hours per client, depending upon the amount of testing needed - and 1000 need reports on ongoing treatment - 1 hour per client to write reports: \$612,500
- An undertaking of this magnitude would require some administrative support, some supplies, and the time of some kind of project director, at an additional cost of approximately \$54,125.

Total projected cost: \$2,966,625. (Compared to \$10 million that will be generated.)

Other potential costs/requirements:

Some non-invasive way by which clients could be tracked or notified when they access services, so that their SSI advocate can reach them if needed.

Ability by providers of consultative exams to make referrals to treatment.

Two legislative and policy changes are recommended:

1. To address the underlying structural problem, the federal government must provide incomes for those deemed unable to support themselves as a result of their disabilities that will cover the cost of basic necessities in San Francisco and other high cost areas
2. The State of California must provide cost of living adjustments in the benefit augmentation amounts it provides to those on SSI to help those with disabilities remain stable.

Family Reunification

Research indicates that the vast majority of chronically homeless individuals in San Francisco are from San Francisco. There are others, however, who come to San Francisco from other parts of the country. Reuniting homeless individuals with their family networks in other parts of the country can be the most effective tool to help the transition out of homelessness.

This is not to say that the city should seek to "ship off" homeless individuals with one-way bus tickets out of the county. However, when individuals genuinely want to reunite with their family, the City should support individuals with bus fair.

The Ten Year Council recommends that the city expand out-of-region reunification resources to all persons experiencing homelessness, as well as "at risk" persons who wish to be reunified with verified family social support systems. Increase city service provider skill in assessing and facilitating family reunification.

Provide chronically homeless individuals with the opportunity and the means to return home to their family or support network, by contracting with a service provider who will (a) establish the validity of homeless clients' connections to out-of-town family or other support, (b) provide counseling support and mediation for the connection between the client and their family, and (c) provide one-time transportation assistance, e.g. bus tickets, to reunite clients with their family. Examine the work of "Travelers Aid of Metropolitan Atlanta" and identify organizations in San Francisco that could offer similar supportive systems. Design and implement program offering support services.

Research can begin immediately. The program could begin operation upon selection of a provider and contracting, in approximately six months to one year. The program budget is estimated at \$275,000.

The City should direct all appropriate city funded programs to participate in professional training in assessing reunification needs, facilitating placements and accessing reunification financial assistance. There would be professional training costs, amount to be determined.

Behavior Health, Assessment and Outreach

Encouraging and Enabling Chronically Homeless People to Access and Maintain Themselves in Permanent Supportive Housing

Data: 40-50% of the chronically homeless population has serious mental illnesses.

40% have substance abuse or dual diagnosis disorders.

50% of patients who are admitted to psychiatric units are homeless on admission.

20% of the 1800 people released from jail each year have no place to live when they leave, no treatment available to them, and no source of financial support.

There are 16,000 opiate users and only 3,300 methadone maintenance slots.

Despite these barriers, the goal of The Ten Year Council is to encourage and enable chronically homeless people to access and maintain themselves in permanent supported housing. Toward that end, every chronically homeless person must be offered a long-term case manager unless otherwise determined. The case manager is the key to the client's success in obtaining and maintaining himself/herself in supported housing and in all other services.

Many chronically homeless people are already involved in services: mental health programs, jails, psychiatric units, detoxification programs, methadone maintenance programs, residential treatment programs, foster care programs and so on. These people do not need outreach, they need "inreach," i.e. they need a case manager who establishes a trusting, respectful relationship with them in the context of the services they are receiving and before they are released or discharged from these services. The case manager is the person who is responsible for helping them get access to supported housing, for sticking with them through their inevitable ups and downs, for helping them negotiate the city, state, and federal systems, and for serving as their single point of responsibility.

There are other chronically homeless people who are not connected to any service system. It is this subgroup that needs outreach. Through the gradual process of developing a trusting, respectful relationship with them, the outreach staff will be able to help them with their self-identified short term needs and ultimately connect them with a case manager who will then assist them in obtaining access to supported permanent housing and other services. For many chronically homeless people, being treated with respect is the precondition to developing trust and being willing to access services.

There is No Realistic Assessment of Necessary Services

There is no realistic assessment of services needed to fulfill the goals of the Ten Year Plan. This includes the required number of transitory and permanent housing units, of case managers, residential treatment centers, medically assisted detox units, and other substance abuse services, and the range of services needed by the chronically homeless elderly, families and youth, etc. Because of current limitations in the amount of resources available, the city necessarily prioritizes delivery of these services to those in the greatest need.

The present estimate of the number of opiate users in the city is 16,000. The current number of methadone maintenance slots is 2,600. The gap can and should be addressed either with additional opportunities to be treated with methadone or buprenorphine in specialized, self-contained opiate treatment programs, or alternatively in the primary health care system through the Office Based Opiate Treatment initiative.

The number of medically detox beds in the city is 40. The need exceeds this by multiples.

There are only a very limited number of assertive intensive case management programs in the city. In the last 31 days, the new outreach team has identified 400 unduplicated chronically homeless on the streets. Assuming, as most experts do, that these clients need case managers at a 1/12 staff to client ratio, the number of additional case managers needed for just this very limited population would be 33.

The city must annually, publicly, and accurately identify the gaps in services that are crucial to the implementation of the Ten Year Plan.

There is No Centralized Information System

There is currently no centralized information system relating to individual clients or to services, agencies, housing, etc. It is impossible for the city to effectively and efficiently identify and track all of the clients touching the service system, what they want, what they need, and what they've tried that has been successful and not successful. This client-specific information is crucial for a tailored, individually oriented service system that is attempting to significantly reduce chronic homelessness.

Similarly, there is no systematic method of coordinating the myriad services that exist in both the public and private systems. The need for this is obvious on its face. Clients will continue to have a totally fragmented experience with the service system if this problem is not solved. Some get less service than they need, some more. Others will get the wrong kind, and many will be subject to duplication of services. It needs to be stressed that although "duplication of services" has become a common criticism of the service system, a much more crucial problem is the absence of services for most clients. It is important that the notion of duplication not be used as a rationalization for stopping the financing and development of new or expanded services.

Finally, this information is needed to increase the efficiency and effectiveness of existing and new services. Currently, staff in all programs spends a great deal of time searching for available treatment or housing "slots." This practice is both inefficient and frustrating for the client and staff.

A centralized, computerized information system for both individual clients and coordination of services is critical to the success of any plan to reduce chronic homelessness. Unfortunately, a computerized system tends to take months and sometimes years in development. Many cities and states have had the experience of laboriously developing these systems only to discover that they are obsolete by the time they are completed. During the development interval, the city must develop a written, admittedly less efficient, mechanism. The need for client and service information is too vital to wait.

Staffing Problems

Staff who work with the chronically homeless population, as outreach workers, case managers, treatment personnel, residential counselors, peer counselors, and so on, require very special personal characteristics, experience and training. Many chronically homeless people have major problems in relationships. Many have been neglected and abused from childhood and carry this legacy into their current relationships; many others have been plagued by mental illness and substance abuse for most of their lives. Even the best trained staff can gradually burn out from the overwhelming tasks of helping people with such intense and complicated needs, from dealing with constant frustrations from clients and the service system, and from witnessing the chronic and pervasive trauma in their clients' lives.

Peer counselors are a critical component of the staffing of all services since they will have a prima facie credibility with certain homeless people and may inspire hope for people who have lost all hope that they could change their lives.

The staff and peer counselor recruitment and selection process must be changed to ensure that staff and peer counselors with the necessary skills, experience and training will be hired and retained, and that those for whom the work is not suitable be terminated. A significant percentage of staff must have clinical degrees or they will be unable to deal with the complexities of this population.

Chronically homeless people have multiple, complex psychosocial, biological and financial problems that interfere with their mental and physical health and prevent them from maintaining themselves in supported housing. We must hire and retain specialists capable of performing careful assessments of the multiple needs of people who are chronically homeless.

Good staff will make or break the effort to end chronic homelessness. The quality of the relationship between staff and clients is the foundation on which the client develops trust, consideration of the staff's recommendations, willingness to view the service system in a new way, inspiration to face challenges that he or she is anxious about, enhanced self-respect and self-confidence, reexamination of the impact of current life choices and behavior, and development of hope for the future.

There is an Absence of Inreach to Chronically Homeless Populations in Programs or Institutions

Many people remain chronically homeless, despite the fact that they are or were engaged in specific programs or institutions. They want housing, but become or remain homeless because of the symptoms of their physical, mental or substance abuse disorders, lack of supported housing opportunities, the narrow focus of their programs, and/or a lack of staff who can help them negotiate the complex and inadequate array of services in the city. These chronically homeless people are already involved in the service system and do not need outreach. What they need is "inreach," i.e. assignment to case managers who can place them in supported housing. Examples of such people are: people with serious mental illness who are in treatment programs; people with debilitating health problems who frequent the city's emergency rooms and clinics; people in methadone maintenance or other substance abuse programs; patients who are discharged from PES or psychiatric inpatient units into shelters or other forms of transient housing; people being released from jail; kids who are aging out of the youth service systems; people who are being detoxed in various programs; people "graduating" from various substance abuse and mental health residential treatment programs.

These people primarily need "inreach," not outreach, and should be assigned a long term intensive case manager to engage them at the site of their programs, hospital units, jails, foster homes, etc. This engagement must occur before the point of discharge from the institutions in which they are living, confined or being treated.

The clinical supportive relationship inherent in case management is the key to encouraging mentally ill people to take their medications regularly, persuading people who abuse substances to accept treatment, helping dysfunctional people with the problems of everyday living, helping people with difficult behaviors to find and maintain housing, including negotiating with hotel or housing managers to avert evictions, connecting people with a variety of services, and helping them obtain financial entitlements.

Case management staff ensures continuity of care across all parts of the system. Case management is the crucial "support" mechanism in "supported" housing.

Intensive case managers should not be linked to a particular service or facility; clients lose the long-term benefits of the relationship when traversing one service to another. Moreover, when case managers are linked to particular treatment services, the importance of the relationship with the case manager sometimes serves as a disincentive for the client to make progress, for to do so would essentially end the relationship. Another advantage of not linking intensive case managers to particular services is that it prevents duplication of services and fragmented experiences for clients.

There is a Critical Lack of Dual Diagnosis Programs

Many clinical programs have historically viewed the chronically homeless through a narrow lens, treating them according to their own particular specialties and ignoring the other profound psychosocial and medical needs of their clients. A particularly egregious example of this is programs that treat either substance abuse or mental illness, but not both. The result is that people get fragmented care and are bounced among service providers until their frustration causes them to give up on the entire treatment enterprise.

The City must plan for and provide multiple diagnosis program slots adequate to meet demand.

There are Not Enough Treatment Slots

Chronically homeless people want mental health or substance abuse services but are required to wait weeks or months before receiving treatment. Even in certain clinics that have drop-in appointments, clients may be asked to return several times before staff finally begins to concretely help them. People must wait even longer to see a psychiatrist, even though they may have only a ten-day supply of medication following hospitalization. Many deteriorate while waiting for their medications to be refilled.

There is a dearth of available staff and psychiatrists. In addition to having concrete clinical consequences, these delays lead to frustration and distrust and increase the resistance of chronically homeless people to accepting housing and treatment.

In a system that is overburdened, there is a temptation to deal with the demands of new clients by displacing other clients. Sometimes the practice is clinically justified, but more often it simply transforms a stable population into an unstable one.

There are 16,000 opiate users in San Francisco and only 2,600 methadone maintenance slots. Many of the people who can't get methadone are chronically homeless because they spend all of their cash on drugs. If opiate treatment were more widely available, many more people could support themselves in housing.

San Francisco must make mental health and substance abuse treatment available on demand, when the client wants treatment. This is often the difference between whether a patient survives in housing or not.

When a client is seen by a clinician, the assessment must be done expeditiously, and treatment provided quickly with clear attention to the person's tangible problems. Each appointment could be the one and only opportunity that the treatment system has to engage the individual, and it should not be squandered by delays and irrelevant treatment approaches.

The availability of behavioral health services to the chronically homeless population must not be accomplished by pushing other vulnerable people out the back door. There must be an absolute prohibition against displacing one homeless population with another, whether in treatment facilities or housing.

Every opiate user who rests methadone maintenance or treatment with buprenorphine should have access to such treatment on demand. The Office Based Opiate Treatment program must be expanded so that people who are opiate users can be treated in the mainstream health care system, e.g. primary health care clinics.

There is No Plan for Jail Release of the Mentally Ill and Substance Abusers

Many people released from jail are mentally ill. Others have a history of substance abuse. They are often released without any means of financial support, no housing, no linkage to mental health or substance abuse treatment, and no case management.

A specialized case management team must be provided for mentally ill people who are being released from jail. The case manager should engage these people before their release, secure SSI funding (which would be effective upon their release), design a treatment regimen with them, and arrange for immediate supported housing.

A pilot program of this nature has been funded by the State of California, entitled The Forensic Case Management Project, and is operated jointly by the Department of Psychiatry and Jail Psychiatric Services. It has proven very successful in reducing the rate of re-arrests of mentally ill people by 37%, in reducing the rate of homelessness from 35% to 5%, and in placing 80% of the patients released from jail on SSI. Unfortunately, state funding is expected to end in June and the program will have to be curtailed unless the City picks up the funding, which it must plan to do.

People in jail whose opiate addiction was the direct or indirect cause of their arrests, and who were chronically homeless as a result, must have the opportunity to receive methadone maintenance in jail, and continue it when they are released to supported housing.

We Must Develop a System for Diverting Repeat Offenders into Treatment

Some chronically homeless people who are arrested repeatedly are very difficult to engage into treatment.

These individuals should be presented with the choice of going to jail or having their sentences suspended if they are willing to engage in treatment. Currently the Mental Health Court and Substance Abuse Court administer such a program, but they must be expanded to include immediate access to housing and treatment.

There is a Lack of Residential Treatment and Care Facilities

Many chronically homeless people cannot succeed in supported housing with only outpatient treatment. They will fail over and over again in housing because of their substance abuse problem or mental illness unless residential treatment programs are available to help them make the transition to permanent housing. There is currently a real dearth of these programs. Additionally, residential care (Board and Care) facilities, representing a dwindling but important resource for many mentally ill people who need around the clock supervision, have decreased by 50% over the last decade.

The city must invest in more residential treatment and care programs, with supported housing available when people exit from the programs.

There is a Lack of Crisis Intervention Resources

Certain mentally ill people who have been chronically homeless, but are then housed, have a variety of crises, often resulting from their failure to take their medications without which they begin to deteriorate, have psychotic symptoms, etc. These crises can be very disruptive for other residents and can result in a police escort to PES, the need for a psychiatric inpatient admission or jail, or may lead to an eviction. A crisis center may be able to handle the crisis if it happens to be open and adequately staffed, but the crisis is better handled on site, in the place where the person lives. In this way the entire living situation can be assessed, not simply the individual.

Expand the Crisis Resolution Team that is operated by the Department of Psychiatry to help formerly chronically homeless people when they have psychiatric crises in their homes.

As our system of shelters is phased out, some of these shelters could be converted to 24-hour crisis centers.

The Mentally Ill Chronically Homeless are Particularly Vulnerable

A large portion of the chronically homeless population has severe mental illnesses and is a particularly vulnerable subgroup. Chronic homelessness is both one of the causes and one of the effects of their illnesses. Concomitant substance abuse, inability to work, poverty, and social stigma add to the burdens of the mentally ill homeless population. Street life itself, with its physical and emotional stress and traumas, aggravates the symptoms of mental illness. Many people either can't or won't take their medications because of the emotional or physical side effects of the medications, or because needing to take the medications reminds them of how ill they are. Even those who try to take their meds have extreme difficulty doing so while living on the street; they lose them, have them stolen, or lose track of when to take them. Without medication, a large number of mentally ill people decompensate and require hospitalization, or behave in ways that result in arrests and jail terms.

The mentally ill among the chronically homeless population must be treated as a particularly vulnerable group when designing housing, treatment, and intervention programs.

Every mentally ill chronically homeless person must be provided with a case manager and supported housing. For those in hospitals and jails, assignment must occur before they are discharged or released.

A range of residential settings with varying degrees of supervision must be available. Access to psychiatrists and other clinicians must be efficient and flexible; service providers must be skilled in the treatment of both substance abuse and mental illness.

The city should pilot and carefully evaluate the implementation of Laura's Law, which provides involuntary outpatient treatment to a particularly vulnerable group of mentally ill people.

Families of mentally ill people should be provided with concrete help so that they can continue to provide care for their relatives and reduce the likelihood that they'll end up chronically homeless.

The Chronically Homeless Elderly Have Special Needs

The number of elderly among the chronically homeless is often minimized. This flies in the face of some epidemiologic data demonstrating that the homeless population is aging. The result of the failure to recognize this is that the city may fail to sufficiently plan for the specialized services that elderly people need: specialized medical care, wheel chairs, prostheses, transportation, specialized diets, help with blindness, deafness, diabetes, hypertension, and other infirmities that are more common in the later stages of life.

The elderly need to be viewed as a vulnerable and often overlooked group. Their numbers should be separately identified, and specific plans developed to address their needs.

Permanent Supportive Housing

The Best Model for Providing Housing and Support Services to the Chronically Homeless Population

San Francisco currently operates over 3,000 units of supportive housing in a variety of models. As we increase our investment in supportive housing, we must draw upon our expertise, while fostering innovations that are responsive to the needs of the chronically homeless. Research and evaluation has demonstrated the successes in supportive housing for housing retention and improved outcomes for residents. These strategies and programs can be built upon and replicated as we increase our commitment.

Increasing the stock of supportive housing will take an increased public investment of resources at the local, state and federal level, as well as an investment by the private sector. These resources are needed to pay for the initial capital costs, ongoing operating expenses and support services. At the same time, we must examine our current housing funding priorities as they relate to our new mandate, and determine whether we can contract our housing dollars more efficiently and effectively.

Priority planning and funding for supportive housing programs are divided across several city departments. In addition, several entities or working groups exist that impact supportive housing development. San Francisco should adopt a consistent policy for supportive housing development that ensures adequate oversight, community participation and budgetary commitments to achieve the goal of 3000 units by 2010. Within this effort, the City should assess the appropriate balance of master leased for-profit owned housing vs. non-profit owned, as well as the range of models to be supported.

The City of San Francisco has made a significant investment in supportive and affordable housing. Through this investment, we have learned how our own system can be flawed in its attempts to meet the overall goal of providing housing. The City must carefully examine the current processes related to access into supportive housing, and the processes related to keeping people housed. To eliminate these obstacles, the City must determine the most expedient manner for marketing and renting units, determining eligibility, targeting and access points, managing waitlists and assessing how to minimize evictions from supportive housing. This effort will include an examination of how organizations individually conduct these processes, the role of the San Francisco Housing Authority, and the standards that the City uses to guide these processes.

Maintaining the Investment

Once the supportive housing has been created, adequate oversight must occur to ensure that the support service provision and property management is of high quality and responsive to the needs of the tenants as well as the funders. This effort will include a review of current service provision, outcome measurements, service utilization, asset and property management processes, tenant satisfaction evaluations and compliance with housing quality standards.

Overcoming Opposition and Addressing Public Concerns

San Franciscans have identified addressing homelessness as a high priority. However, as solutions are presented, many communities are reluctant to endorse a particular supportive housing project in their neighborhood. In addition, some neighborhoods have hosted a high concentration of supportive housing and can play a role in ensuring that the site is an asset to the community. Key to this effort is the assurance that prioritizing supportive housing will be done in the City's overall planning efforts such as the Better Neighborhoods Plan and Consolidated Plan. This effort will include a public education campaign to promote permanent supportive housing as a solution to chronic homelessness

Protecting our Assets, Sustainability and Preservation

Maintenance of the existing inventory of supportive and affordable housing is threatened by actual or proposed cuts at the local, state, and federal levels. In order to prevent the loss of stability of individuals and families residing in these units, we must prioritize the preservation of the funding levels that sustain the current housing resources.

GOAL: Create an additional 3000 supportive housing units or beds for the chronically homeless by year 2010

Supportive Housing can be brought on line with a variety of methods: new construction, rehabilitation, master leasing, set asides in affordable housing and purchased or rented scattered site housing. Resources are primarily dedicated to higher density supportive housing that is non-profit owned and operated or master leased from private for-profit landlords. Master leasing represents a shorter-term strategy to secure sites quickly to ramp up the pipeline, while new development is a long-term strategy to increase the overall stock of permanently affordable supportive housing. Master leasing

requires minimal upfront public costs but requires ongoing lease payments to maintain the affordability of the housing. Non-profit owned housing requires an initial investment of capital and can take 3-5 years to bring the units on line. In the Direct Access to Housing Program, the Department of Public Health master leases sites, and tenants are selected directly from access points in systems that care for the chronically homeless. In non-profit owned housing, sites draw from wait lists that target the chronically homeless such as Shelter Plus Care to fill units.

Beyond the ownership structure and the leasing procedures, both models of supportive housing are very similar. Typical on site services include case management, life skills education, money management services, benefits advocacy, employment and education services, health, mental health and substance use services, and tenant leadership/community building activities. For family housing, a range of services for children and youth are provided which can include on site child-care, after school programs and child focused health and education services. Acceptance of services is voluntary. Tenants are expected to adhere to the terms of their individual leases and house rules. With the commitment to serving the chronically homeless in a "housing first" model, these tenancy standards are geared to accommodate for tenants who struggle with substance use and mental health issues while also maintaining a safe community. Support services, property management staff and tenants work together to ensure that the shared goal of maintaining stable housing is achieved.

In order to reach our ambitious goal of doubling our supportive housing inventory, San Francisco is utilizing both approaches. Dedicated local capital resources must be designated in order to create 1500 permanent supportive housing units/beds for individuals and families earning less than 20% of Area Median Income by 2010. The Mayor's Office of Housing and San Francisco Redevelopment Agency will administer the program. Supportive policies must be reflected in Consolidated Plan, Housing Element, Better Neighborhoods, and Redevelopment Plans. Total capital costs are estimated at \$339,000,000.

Local sources of funding for affordable housing development, (a portion of which can be prioritized to meet the unit production goal) are the Mayor's Office of Housing (HOME and CDBG), SF Redevelopment Agency Tax Increment Funds, and the Hotel Tax.

Acquire 1500 units in privately owned sites by 2007 through the Direct Access to Housing Program, SRO Housing Program or similar service enriched master lease program. Pending capital funding and availability, begin to purchase sites that have been master leased by 2010.

The annual cost to master lease 1500 units is \$23,892,000, or an average of \$16,000 per unit per year, administered by the Department of Public Health, Department of Human Services, and Mayor's Office of Housing. Sources of funding are the City's General Fund, and HUD McKinney funds.

To purchase master leased sites over time, the capital costs for acquisition will vary. The cost to acquire the 1,500 master leased units will range from \$37.5 million to \$67.5 million.

Set aside 75 units for the chronically homeless of the total number of supportive housing units currently in the development pipeline.

The cost would vary depending on current affordability levels and service funding dedicated to the project. The Mayor's Office of Housing could access DPH and HUD McKinney Shelter Plus Care Program funding.

Current projects in the pipeline may not have funding sources that allow for targeting of chronically homeless. This may raise the need to review compliance with fair housing laws.

Implement a demonstration project targeting 100 chronically homeless adults with criminal justice records that inhibit access to supportive housing. Examine the potential of creating access into the Direct Access to Housing Program through forensic case management programs. Utilize success of demonstration project to impact policies, which prohibit people with criminal justice histories from securing housing.

Implementation of the program should coincide with expansion of the Master Lease Program, and would be managed by DPH and the Sheriff's Department. Costs would be similar to expansion of master lease program. Depending on the model and service needs, anticipated cost would be \$1,000,000-\$1,500,000 per year. This cost would be offset by savings to the criminal justice system, as well as utilization of existing case management programs that work within the criminal justice system.

Examine the potential to increase the employment and training of homeless individuals in the construction or rehabilitation and operation of supportive housing sites. Examine current programs such as Section 3 Plus Program to ensure that federally funded projects are adhering to the practice of hiring low-income individuals. Determine strategy to increase the community's ability to train homeless individuals to increase their ability to access employment.

This strategy can be implemented immediately by DHS and MOH/MOCD. Cost would be determined by the findings. Existing employment and education programs may be able to increase their ability to provide training and employment services pending funding.

GOAL: Increase coordination and streamline efforts of city departments or committees responsible for the coordination of supportive housing funding, acquisition, leasing, development and monitoring.

The selection, review and approval process of supportive housing projects should be assigned to one entity, or a coordinated group of city departments overseeing capital, operating and services funding in conjunction with the Local Homeless Coordinating Board. Ensure that Mayor's Homeless Cabinet, or other City governing body mandates coordination of discharges from Transitional Housing programs, Criminal Justice system, Health care facilities and Foster Care with housing opportunities. This change can be implemented by the Mayor.

Reconstitute the Local Homeless Coordinating Board to incorporate the addition of state and federal representatives, adequate staffing (positions detailed out from the 2002 Controllers report: increase current one staff person to three full time including a policy and data analyst, grant writer and administrative assistant) and streamlined participation. Review original enabling legislation, 2002 Controller's report and current make up to determine appropriate seats and process. Ensure that at a minimum, one supportive housing development organization is represented and one tenant of supportive housing is represented on the committee to reflect the prioritization of permanent supportive housing.

Reorganization process should begin by the Mayor and Board of Supervisors once the 2004 McKinney application is submitted. Reorganization of the Board is cost neutral. Increases in staffing can be drawn from DHS or DPH, or the redirecting of existing staff.

Form a time limited working group to evaluate the current site selection process, and determine strategy to decrease timeline, maximize length of lease or options for purchase, minimize displacement and increase ability to competitively negotiate for master leased and purchased sites. Working group recommendations should also include review and documentation of current vacant or underutilized housing sites from SRO inventory report (Department of Building Inspections). Design a program for the City to market the housing program to private owners. Include in the task force a non-profit developer, SRO Collaborative representative, master lease housing provider, City Attorney's Code Enforcement Task Force, legal and private real estate experts.

The Working Group can be constituted by September 1, 2004 with a report completed by year-end. The Mayor's Office of Housing will coordinate the effort. Recommendations are cost neutral; engaging private sector experts may require payment of consulting fees.

GOAL: Develop Capacity Building Program to promote the development of high quality supportive housing.

Engage philanthropy, City Departments and technical assistance providers to craft a flexible grant funding program tied to the development of supportive housing units.

The program should begin in conjunction with the availability of capital funding through MOH. Competitive grants should be offered from \$25-50,000 depending on need of organization. Funding will be sought from private and corporate philanthropy and MOH.

Increase training opportunities for faith based groups, community based supportive housing providers and tenants. Explore partnerships with educational institutions to offer classes on services and management in supportive housing.

DHS and DPH could begin this program immediately with assessment, with expansion of training as the budget allows. Additional training may be provided through existing sources. A cost of expansion to educational institutions needs to be explored.

Outreach to faith based organization to assess feasibility of partnerships with non-profit organizations to increase their role in the development supportive housing. Develop workshops to ensure that the targeted organizations are successful in accessing funds for which they are eligible.

Timeline: The program will be administered through MOH and the SFRA in partnership with HUD, timed in conjunction with availability of capital funding through MOH.
Costs will vary depending on training needs.

GOAL: Eliminate unnecessary tenant selection criteria that impede the access of chronically homeless individuals and families into supportive housing.

We must examine the current barriers to existing supportive and affordable housing and determine strategies to alleviate. Ensure that evaluation includes assessment of credit, eviction history, and conviction barriers, as well as systemic issues such as wait lists, multiple certifications and access points. Establish a coordinated system for referring to supportive housing sites and marketing vacancies.

This goal can be accomplished by 2007 by DHS, DPH, and SFHA, and is cost neutral.

GOAL: Maintain high quality and cost effective supportive housing that is responsive to the needs of the residents.

Engage providers in assessment of the effectiveness of current performance outcomes and data collection methods. Assess if current measurements reflect stated goals of formerly homeless residents in housing and satisfy funding requirements. Ensure that ongoing asset management monitoring is conducted for capital funded sites. Perform independent audit of resident satisfaction to ensure that desired services are being provided.

Goal can be accomplished by 2007 by DHS, DPH, and MOH. Analysis is cost neutral. An Independent audit of satisfaction may be available through existing evaluations funded by philanthropy.

Institute eviction protocols in supportive housing to ensure that interventions such as case conferences are held prior to eviction proceedings. Determine and adhere to the best practices for providing reasonable accommodations. Incorporate effective protocols into contracting language. Goal can be accomplished by 2007 by the City Attorney's Office, and Mayor's Office of Disability.

Determine measurement of appropriate service needs with input from residents of supportive housing and providers. Ensure that appropriate services are made available such as health, education, employment and legal services. For sites serving families, ensure that a full range of services for children and youth are provided. Accomplished by DHS and DPH by 2007.

Strengthen and employ collaborative service models that maximize expertise and are cost effective. Utilize existing non-housing based programs to provide services in coordination with supportive housing providers to minimize duplication of services and stabilize recently housed individuals and families. DHS and DPH will implement.

GOAL: Increase efforts to engage the public in supporting solutions to chronic homelessness.

Strengthen community education campaign by developing consistent strategy and message on supportive housing as a solution to homelessness.

Increase effort for 2004 in support of housing bond with on-going media campaign to update the community on the successes of increased investment. The initial investment would be \$250,000, funded by private and corporate philanthropy, accountable to Mayor and Board of Supervisors.

Strengthen commitment to include supportive housing development in citywide planning processes including updates to the Consolidated Plan, Housing Element and the Planning Departments Better Neighborhoods process.

Implementation is concurrent with updates or adoption of plans, is cost neutral, accountable to MOH,

GOAL: Increase local, state and federal resources to sustain and increase San Francisco's investment in permanent supportive housing.

Actively support local, state and federal policies that increase resources for funding permanent supportive housing. Oppose proposed budget cuts to existing programs that are used to fund supportive housing.

LOCAL:

Support housing bonds for capital development. Such local sources would ensure that capital funds at the state and federal level could be leveraged to increase our total available resources.

Ensure that a proportion of the additional Tax Increment available to the Redevelopment Agency is dedicated to supportive housing development.

STATE:

Support ballot initiatives that fund mental health services.

Support all initiatives and legislation for affordable housing funding..

Support statewide efforts to increase funding from mainstream systems such as resources for youth aging out of foster care, Medi-Cal, and persons exiting the criminal justice system.

FEDERAL:

Support current Housing Choice Voucher Program (formerly Section 8) funding levels.

Support National Housing Trust Fund as a permanent revenue source for affordable housing development.

Support Samaritan Initiative to increase investment in supportive housing from Dept of Housing and Urban Development (HUD), Dept of Veterans Affairs and Dept of Health and Human Services.

Support Eliminating Long Term Homelessness Services Act (ELHSI) or similar increases in HHS budget for services for chronically homeless.

Support efforts to increase resources for the chronically homeless from the Department of Veteran's Affairs and Department of Labor.

National Trust: Encourage local leaders to work with federal representatives to re-engage in discussions with community groups on affordable housing.

The Mayor, Board of Supervisors, San Francisco Redevelopment Agency and Local Homeless Coordinating Board should work together to immediately begin implementing this goal. The strategy is cost neutral; on-going policy analysis may require increased staffing for entities such as the LHCB.

Create a working group to identify potential dedicated local revenue sources to cover the current and anticipated funding gaps for services and operating costs in supportive housing. Ensure that this local source utilizes private and public contributions. In order to alleviate the burden on the City's General Fund, these funds may be either redirected from a current use or as part of a revenue enhancement measure. In addition, services costs can be offset by other sources such as the ability to bill Medi-Cal for eligible residents.

The Working Group will meet from 9/1/2004 to January 1, 2005, making its recommendations at that time.

The Working Group will comprise representatives designated by the Mayor, Board of Supervisors and private/corporate Philanthropy.

The cost for supportive services and operations range from \$10-\$18,000 per unit per year. The higher end of the cost reflects incorporating a lease payment in the case of privately owned master leased sites and/or an enhanced service package. The current need can be calculated depending on the pace of development over the next five years. The annual total for this cost assuming 1500 of the units are leased and 1500 non-profit owned is approximately \$38,000,000 per year.

Funding sources for this effort could come from the General Fund, and private and corporate philanthropy could capitalize a fund for initial start up.

GOAL: Provide the linkage from the 3,000 chronically homeless to the estimated 15,000 total homeless population.

Chronically homeless people frequently have difficulty finding and keeping jobs, and are frequently unable to utilize existing employment and training services, which are often restricted to providing very basic services for a limited amount of time and do not allow for a customized approach that is frequently needed by chronically homeless individuals.

Replicate Hope House Model

The Department of Human Services, in partnership with the Private Industry Council, recently obtained funding from the Department of Labor and HUD for a multi-year Bayview community-based project to provide housing and employment services to the chronically homeless.

Subcontracts will be established with community based organizations and consultants to provide the housing, employment and other supportive services for the individuals to be housed and served through Hope House.

The population to be served will be identified in the neighborhood where Hope House will be located. Other recruitment will take place through jail and hospital discharge workers

Hope House will house and serve 70 individuals who have experienced chronic homelessness prior to coming into the program (perhaps as many as 90 will be housed over the three years of project funding).

Over half will be between the ages of 46-65, and 30% 36-45; nearly 80% will be African American and 80% male; 16% will be veterans of the U.S. military; 80% will have a history of substance abuse; 75% will have a criminal record.

Hope House will create a culture of work within the housing - sometimes referred to as "vocationalizing" the housing. Residents will be able to perform paid work within the housing and the resource center associated with the project.

The progress of Hope House should be carefully followed and analyzed, and other models replicated, adapted to the specifics of similarly unique communities

Analyze inclusion of sheltered and supported employment opportunities as one of the services provided in permanent supportive housing.

Policy changes would be adopted by department directors and could be implemented within the year.

Funding the New Strategy
A Business Plan to End Chronic Homelessness

Potential Cost Savings:

Preventing and ending chronic homelessness will ultimately save the government millions of dollars especially in very expensive systems like the criminal justice and health care systems. It may take several decades to fully realize these savings, however.

In the mid-term (next six to ten years), some funds will be able to be saved and shifted into permanent housing solutions, as shelter beds can be reduced when enough chronically homeless individuals are moved from the emergency system to permanent supportive housing. Potentially, the shelter system could be reduced by 33% six years from now, resulting in over \$6 million annually that might be able to be re-programmed toward operating and supportive service costs in permanent supportive housing programs.

Cost savings will not occur, however, in the very short-term horizon, as two systems will need to be operating - the existing homeless services system as well as the new housing first/permanent supportive housing system. Substantial numbers of chronically homeless people will need to be placed in housing and new folks will need to be prevented from entering the system in order to achieve real economies of scale and allow for the reduction in shelter, emergency room, etc. staff and services.

Fund an advocacy position:

Almost all of the committee recommendations include advocacy work around obtaining new and increased State and Federal resources. We recommended that the City hire an advocate specifically to work on increasing housing/homelessness funding from new government sources. This is a best

practice borrowed from the Los Angeles Homeless Services Authority. This position would cost approximately \$150,000 annually for salary, benefits, travel, and other operating costs and would more than pay for itself in terms of generating increased revenue for the City.

Advocacy recommendations:

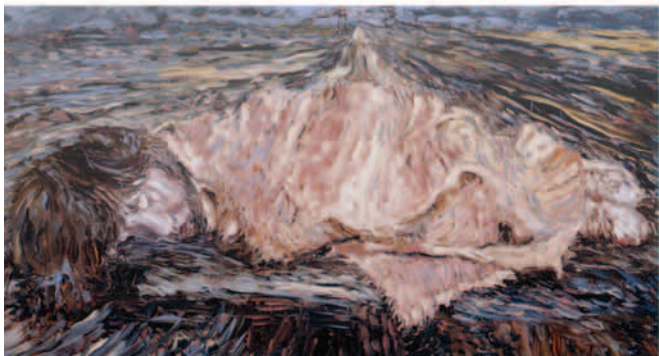
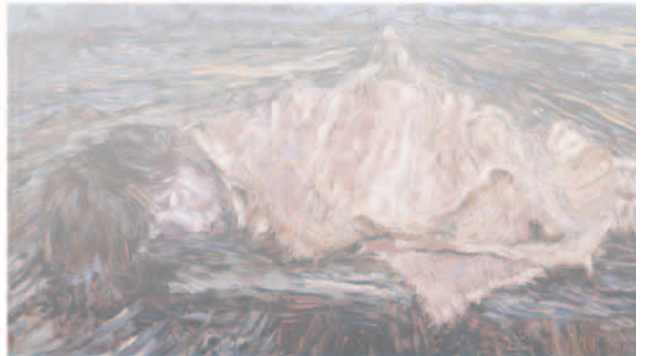
Specific issues for the aforementioned position to work on with 10 year Council Members, elected officials, city staff, nonprofit advocates and others include:

- Supporting the National Housing Trust Fund Campaign which is organized by the National Low-Income Housing Coalition and when enacted will result in billions of dollars of new federal funds for affordable housing.
- Advocating for the preservation and expansion of the Federal Housing Choice Voucher program (Section 8) which is key to providing operating subsidies for permanent supportive housing programs and preventing very low-income households from becoming homeless in the first place.
- Supporting the Permanent Source Campaign which is organized by Housing California in order to secure ongoing, permanent revenue for California's State Housing Trust Fund to be used for affordable and supportive housing.
- Supporting the State Mental Health Services Initiative which could generate over \$50 million per year for San Francisco for mental health services.
- Advocating for funding to be restored and increased to the State Supported Housing Initiative Act (SHIA) which funds services in permanent supported housing programs.
- Supporting the passage of a local Affordable Housing Bond which will include \$85 million for capital costs of permanent supportive housing.
- Increasing ongoing dedicated revenue to SF's Housing Trust Fund, which currently receives \$5 million per year in hotel taxes and a variable amount from Redevelopment Agency Tax Increment fees. Commercial linkage fees could be increased and other new taxes could be explored with a goal of generating an additional \$10 million per year in funding for the Trust Fund.

Fund a fund development and coordination position for homeless issues:

Currently the City utilizes staff from various departments and a wide range of consultants to access existing government and philanthropic dollars. Having a resource coordination office, as recommended in Newsom's campaign policy position papers, with dedicated staff to coordinate fund development activities could increase the amount of funding that the City is able to obtain from other sources. Finding and understanding government revenue streams, developing relationships with foundations and the business sector, and writing successful grant proposals are all time intensive activities that require a fair amount of knowledge and expertise. As with the advocacy position, spending approximately \$150,000 on this position and its related costs, could potentially yield millions of dollars in new revenue for the City.

A 1 2 3 4 5 6 7 8 9 10



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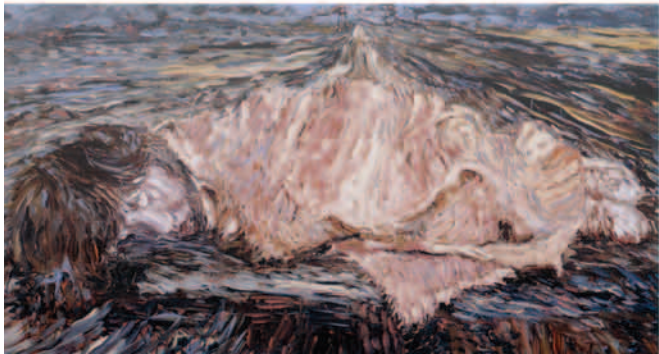
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Walden House
Wealth Management

Table 1



Subject

access point (referral source)
assessment
Acute Diversion Unit
affordable housing
affordable housing gap
at-risk person
available cash
behavioral health services
business scholarship
capitol development costs
court accountable case management &
Crime control IV:
Criminal justice system
debt
debt cash flow
debt equity financing
default
Department of Human Services (DHS)
Dept. of Pub. Health Clinic
development
direct access to housing
discharge planning
distaster
domestic abuse
drop-in center
Emergency Front-End Services
emergency shelter
employment
equity
eviction prevention
finance
formal vocational training
free food agencies
grant
gross effective income
harm reduction
Health Department (DPH)
homelessness
homelessness policies
intermediaries
loan
Local Homeless Coordinating Board
locked sub-acute facility

mainstream health
marginal housing I
mobile assistance patrol
mobile crisis services
medical - psychological care eligibility
medical -psychological services
medical -necessity
net cost per unit
net operating income
on the job training
Outreach services
permanent supportive housing
(physicians) private practitioner network
pre development
prevention
public finance
quality of life citation
rent
rent roll
residential treatment facility
San Francisco General Hospital
scattered site housing
self-sufficiency
serious mental illness
serious physical illness
single room occupancy
single-site housing
site control
San Francisco Redevelopment Agency (SFRA)
specific quality care
statutes for homelessness
street person
subsidy
substance abuse
suicide prevention
supportive services
support services cost
temporary homelessness
transitional housing
transitional services
unsafe practices
Youth Commission
Youth services