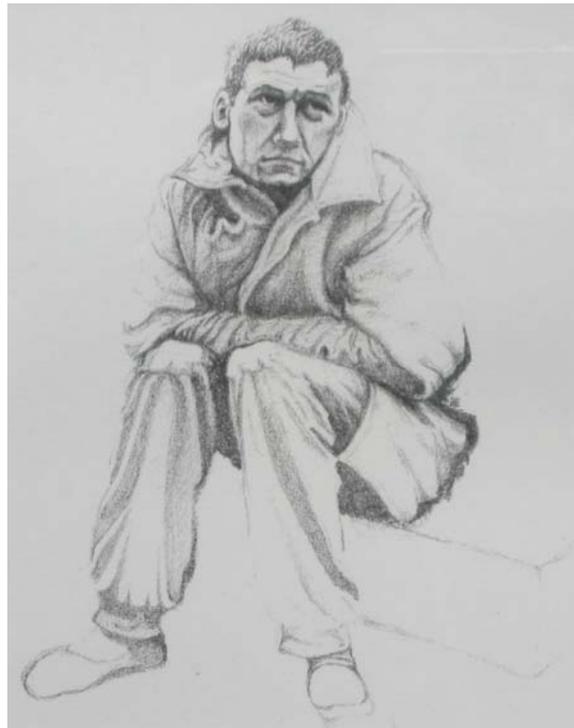


BRINGING OUR COMMUNITY HOME:



*Santa Barbara County-wide 10-Year Plan
To End Chronic Homelessness*

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Acknowledgments

It is with great pleasure that we present to you the 10-Year Plan to End Chronic Homelessness throughout Santa Barbara County, *Bringing Our Community Home*. This Plan represents an unprecedented collaboration of over one-hundred community leaders throughout Santa Barbara County who focused on one of the most troubling, expensive and difficult societal challenges faced in this country: preventing and ending homelessness in our communities. *Bringing Our Community Home* is one more Plan to add to the more than 220 Year Plans to End Chronic Homelessness throughout the United States.

This 10-Year Plan focuses on one segment of the homeless population, known as the chronically homeless. National studies show that while this population makes up only 10% to 15% of the total homeless population, it consumes 50% or more of local resources spent on homeless services. These resources include emergency room care, shelter services, detoxification services, and psychiatric care. It also includes millions of dollars in our police and fire department budgets and the jail system: dollars spent that do not eradicate the root causes of homelessness, do not provide adequate housing and needed social services to the individuals involved, and dollars that could be better spent on other forms of public safety.

A major goal of *Bringing Our Community Home* is that by focusing on ending chronic homelessness, its results will have a positive ripple effect in regards to better coordinated services and additional funding towards ending all forms of homelessness.

We can not continue along the same path of managing chronic homelessness; instead, we must change course and eradicate chronic homelessness by implementing *Bringing Our Community Home*, which will move people away from the revolving doors of jail time, emergency room care, temporary shelters and crisis centers into permanent supportive housing and self sufficiency.

Our success requires moving beyond our jurisdictional and political boundaries and instead, working collaboratively and cooperatively. It is our combined political will and ongoing commitment to ensure that homelessness becomes a rare and preventable situation for the people in our community. It will be our combined political will and ongoing commitment that will take the *Bringing Our Community Home* Plan from the written document to effective implementation. It is incumbent upon us to work smarter, not harder. We cannot afford to do otherwise, not in our budgets, not for the wellbeing of those affected by homelessness, and not in our overall community role as providers of the public's health and safety.

We invite you to read this summary booklet, the entire *Bringing Our Community Home* Plan, and become engaged in the implementation process. To view the entire plan, visit www.bringsbhome.org.

Sincerely,

Helene Schneider
Leadership Committee Co-Chair

Sylvia Barnard
Leadership Committee Co-Chair

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Introduction

Santa Barbara County-wide 10-Year Plan To End Chronic Homelessness

Homelessness affects all Santa Barbara County residents; whether they are in danger of becoming homeless, are homeless, or are concerned for and support homeless family, friends, co-workers, and community members. Each year more than 6,300 people in Santa Barbara experience homelessness; on any given night, over 4,000 people are homeless.

Of the people who are homeless, 10-15%, or as many as 945 people, are chronically homeless. Santa Barbara County's chronically homeless population is composed of single adults and families with children who have either been continuously homeless for a year or more or have had at least four episodes of homelessness in the past three years, have a disabling condition¹ and have been sleeping in a place not meant for human habitation (e.g. living on the streets) or in an emergency shelter during that time.² Many of these individuals have serious mental illnesses; two-thirds of all people with serious mental illness have been homeless or have been at risk of being homeless at some point in their lives.³ People with untreated mental illness often lose their housing due to problems with neighbors; because they present a threat to themselves or others; miss rent, utility, or mortgage payments; or neglect their house keeping.⁴

Chronically homeless people consume more than 50% of all the services provided to homeless people due to their continued movement through the service system without obtaining the help they need. Chronically homeless individuals are also frequent users of other costly public services, such as hospital emergency rooms, psych emergency wards and the criminal justice system. Every year it costs Cottage Health Systems an estimated \$7,212,400 to provide services to homeless individuals, \$350,400 for Marian Medical Center to provide services to homeless individuals, and \$154,643 for Lompoc Hospital to provide services to homeless individuals.⁵ The Sheriff's Department estimated it costs \$4,708,500 to house homeless individuals who have violated some law or ordinance (but most likely would not have with appropriate intervention).⁶ Similarly, it cost Santa Maria Park Service \$20,040 to issue 334 citations to 76 homeless people from May 2004-July 2005; 10 individuals received 50% of the citations.

Chronic homelessness is expensive, but these costs can be reduced and chronic homelessness eradicated through the provision of permanent supportive housing. Studies have demonstrated that providing people with permanent supportive housing is the most humane and cost-effective way to end chronic homelessness. One study documented a savings of \$16,281 per year for individuals

¹ Santa Barbara defines a disabling condition the same way HUD defines it: a "diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions"

² The HUD definition of chronically homeless is identical to the definition Santa Barbara has adopted except HUD's definition is limited to unaccompanied homeless individuals and does not include families.

³ Tessler, R.C. & Dennis, D.L. *A synthesis of NIMH funded research concerning persons who are homeless and mentally ill*. Rockville, MD: National Institute of Mental Health. 1989.

⁴ SAMHSA. *Blueprint for Change: Ending Chronic Homelessness for Persons With Mental Illnesses and/or Co-Occurring Substance Use Disorders*. 2003.

⁵ Heroux, Roger. "A Report on Homelessness Services in the County of Santa Barbara." 2006.

⁶ Id.

placed in permanent supportive housing.⁷ Another study in Minnesota documented a reduction of crisis costs of \$6,200 per family for one supportive housing complex.⁸ Santa Barbara County demonstrated the same type of savings when it supplied housing and services through intensive case management teams to people with serious mental illness and housing instability; the total cost of higher care services dropped 76%.⁹ In Santa Barbara County it costs an estimated \$86 per day to house an individual in jail, \$800 to house a person in a private health care facility, and \$1600 to house a person at a hospital, but it only costs \$28 per day to house a person in permanent supportive housing.¹⁰ Thus, this Plan to secure the amount of permanent supportive housing necessary makes sense from both a financial and humanitarian standpoint.

Although communities are often concerned about developing services and housing because they fear that their community will become a “magnet” for homeless individuals from other areas, this Plan recognizes that homeless people do not move to communities for services and housing. Homeless people move to areas for the same reasons as non-homeless people: to be closer to family, for new jobs, etc. Studies have shown that 75% of people remain in the city where they become homeless.¹¹ Santa Cruz, Santa Barbara County’s coastal neighbor to the north, which shares Santa Barbara County’s combination of high-priced housing and significant number of low-wage jobs, found that more than two-thirds of its homeless population’s last permanent home was in Santa Cruz and that more than half of its homeless population had lived in Santa Cruz for over ten years.¹² Service providers in Santa Barbara can attest to similar statistics for the homeless population they serve.

Recognizing the need for a coordinated effort to address homelessness, Santa Barbara County commissioned, “A Report of Homelessness Services in the County of Santa Barbara.”¹³ The study described the causes of homelessness in Santa Barbara County, examined the coordination between housing and service providers, and calculated the costs of homelessness to the cities and County. The Report is based on thorough interviews of homeless individuals and service providers, and well-documented data collection. The Report ultimately recommended greater coordination in the provision of services and collaboration among community stakeholders. It also recommended creating a 10 year plan to end chronic homelessness.

As a result, stakeholders from all sectors of the community came together to create this Plan to house Santa Barbara County’s chronically homeless individuals and families in a coordinated,

⁷ Culhane, Dennis P., Metraux, Stephen and Hadley, Trevor. Public Service Reductions Associated With Placement of Homeless Persons With Severe Mental Illness in Supportive Housing. *Housing Policy Debate* Vol 13, Issue 1, pp 107-163. Fannie Mae Foundation. 2002.

⁸ “Ending Long-Term Homelessness in Minnesota: Report and Business Plan of the Working Group on Long-Term Homelessness.” Minnesota Department of Human Service, Department of Corrections Housing Financing Agency. 2004.

⁹ See Prevention Appendix A.

¹⁰ Heroux, Roger. “A Report on Homelessness Services in the County of Santa Barbara.” 2006.

¹¹ Martha Burt, “What We Know About Helping the Homeless and What it Means For HUD’s Homeless Programs” Testimony presented to the Housing and Community Development Subcommittee of the Banking and Financial Institutions Committee of the U.S. House of Representatives 1. March 5, 1997.

¹² Community Action Board of Santa Cruz, Inc. “Housing and Homelessness in Santa Cruz County – 2005.” *available at* <http://www.cabinc.org/Research/housing-and-homelessness-2005-report.htm>

¹³ Heroux, Roger. “A Report on Homelessness Services in the County of Santa Barbara.” 2006.

humane, and relationship centered manner. Over the course of several months, these individuals met repeatedly to devise solutions that build on the strengths of Santa Barbara County's community, and that incorporate well-researched, innovative best practices and models. This Plan is a realistic yet ambitious approach to accomplish the Community's most important goal: ensuring that every chronically homeless individual in Santa Barbara County has a place to call home.

Mission Statement

We will enhance the quality of life for all county residents as chronic homelessness is eradicated through a focus on services, treatment, supportive housing, and healthy relationships for all chronically homeless people.

Vision Statement

The communities of Santa Barbara County join together to creatively build on “what works” to end chronic homelessness by 2017.

Guiding Principles

Values

Working to end chronic homelessness is our responsibility. As moral human beings living in a civil society, we have the obligation to assist those in dire need.

Intervening to end chronic homelessness is our focus. This problem has emerged in our lifetime, and we are a community that is the “right size,” with resources to make a difference.

Ending chronic homelessness makes sense: the negative impact on our public and private institutions is expensive. Efforts to manage the problem have proliferated experiences that we can now capture and shape into effective programs.

Ending chronic homelessness is now possible: we have successful programs upon which to build; we have a clear analysis of the waste in resources as well as human potential that will continue if we do nothing; we have the experience of our agencies and peers around the nation participating in a paradigm shift on this issue; and we have the will and the motivation to see this Plan implemented.

Leadership and Focus

This Plan will guide the many efforts underway in Santa Barbara County and will provide leadership to galvanize unified action.

This Plan will “stay on course” with a focus on chronic homelessness; implementation will hold attention to strategies that will respond to the particular circumstances of this population. We will focus on a set of strategies that are narrowly designed to impact this problem, and invest in their success.

Coordination and Collaboration

All programs and agencies intervening in the lives of chronically homeless people must coordinate and collaborate their efforts in order to improve client outcomes. Even those whose primary focus

is elsewhere must coordinate their response when working with a chronically homeless person. The cities, the County, and the community-based organizations will all make a significant difference by working together to end this problem.

Involvement of Mainstream Programs

Mainstream housing, services, health care, and employment programs can prevent chronic homelessness by intervening early. These agencies must attend to prevention strategies throughout their programs as the most humane and cost effective approach.

Outreach and Access

Services and treatment should be provided at locations where chronically homeless people spend their time in a community based, proactive response.

Resources Support a Return to Mainstream Society

We will have a focus on education, training, and work for those who are able in order to improve lives and afford the means to sustain independent living. Meaningful activity and participating in community will support re-integration.

Access to Sufficient Housing is Fundamental to our Success

Homelessness is an indicator of the housing crisis in our county and country. Housing is a basic necessity, a place to be safe, stable, and from which to grow into one's fullest potential. We must generate the political will to produce a full spectrum of housing opportunity.

Demonstrate Success

Several communities in Santa Barbara County have program models that work; we need to expand them county-wide.

Through this Plan we must accomplish results. We must end homelessness for those who currently have a chronic condition and prevent homelessness from becoming chronic for any other person.

Data is important. Implementing this Plan will include collecting the information we need.

Executive Summary

How We Will Accomplish Our Goal of Ending Chronic Homelessness

We have adopted a comprehensive approach to ending chronic homelessness within ten years that includes:

- Enhancing prevention efforts through early interventions and outreach to individuals in institutions,
- Reaching out to individuals on the streets and providing them with the services and treatment they need and want to support their transition from homelessness into permanent supportive housing,
- Developing enough supportive housing for every chronically homeless Santa Barbara County resident to have a permanent home in a stable environment,
- Building a strong system of income reinforcing supports so that each chronically homeless person has enough income to subsist upon,
- Devising a financing plan that will fund the programs, staff, teams, and Centers that will engage in this work, and
- Creating an implementation structure to ensure that the Plan gains the political support, financing, and oversight it needs to succeed.

Taken together, our strategies allow us to “close the front door” through which people become chronically homeless, and “open the back door” to provide housing for those who now are chronically homeless. Some strategies will result in a permanent new way to respond to basic human needs, so that no one need become nor remain homeless again.

Intervening in Chronic Homelessness Before it Repeats and in Homelessness Before it Becomes Chronic

Prevention is a key strategy in ending chronic homelessness in Santa Barbara County. Our prevention efforts will focus on providing the services and treatment chronically homeless people need in order to be successful in their housing, and intervening early if they are in danger of losing housing. Additionally, prevention efforts will focus on ensuring that no chronically homeless individuals are discharged from public institutions without the housing, services, and treatment they need. This will prevent an increase in the number of people becoming chronically homeless. *Transitions Teams* will do outreach with institutions of custodial care and will interface with discharge planners to accomplish this goal. The *Transitions Teams* will be composed of a social worker and a benefits specialist and will rely upon institutional staff for diagnosis, medications list, medical treatment, and assessments. These Teams will work out of *Transitions Centers*, places for people exiting hospitals, jails, residential treatments, foster care, and detox to access *basic housing assistance* until they can obtain permanent supportive housing. *Basic housing assistance* is short-term housing supported by services and treatment that is provided in the interim while permanent supportive housing is being secured.

Reaching Out, Engaging, Serving, and Treating Chronically Homeless People

We will also outreach among currently homeless people and foster youth without next-step housing arrangements and chronically homeless people living in the open (streets, parks, beaches, and in vehicles) through *Street Outreach Teams*. The *Street Outreach Teams* will have an Outreach Worker who will assist in access to income subsidies, benefits programs, and entitlements and a Field Worker who will respond to medication, mental health, and substance abuse issues. *Street Outreach Teams* will be mobile, going where chronically homeless people are, but will operate out of *Community Centers*. Similar to the Transitions Centers, the *Community Centers* will provide *basic housing assistance*. This will reduce the number of people who remain homeless for lengthy periods of time.

The *Outreach Teams* will coordinate with the *Integrated Services Teams* as chronically homeless individuals are placed in permanent supportive housing. The *Integrated Services Teams* will ensure that services and treatment are provided as needed to chronically homeless individuals in permanent supportive housing. The *Integrated Services Teams* will provide person centered case management, relationship building, life skills counseling, money management, access to benefits and employment, and peer support. Treatment shall include mental health services, substance use management counseling based on a harm reduction philosophy, medication management, and assistance with getting physical health and primary care needs met.

Ending Homelessness Through Supportive Housing

The availability of housing to be secured for our chronically homeless population will drive the success of this entire effort, and dictate the number of people who can be assisted to end their homelessness. In order to end chronic homelessness in Santa Barbara, we will develop 500 beds in housing units or shared/individual sleeping rooms in permanent housing in the first 3 years and 750-1200 beds in housing units or shared/ individual sleeping rooms in permanent housing over the next 10 years. Housing will be leased, rents subsidized, in rehabilitated buildings, or new construction and will be located in South County, Santa Maria, and Lompoc. Housing will be provided based on a Housing First approach; chronically homeless people will not be required to utilize services or treatment before housing is provided.

Ending Chronic Homelessness by Increasing Incomes to Sustain Housing and Reach Self-Sufficiency

Another important component of the Plan is increasing the incomes of chronically homeless people so that each person has a stable, adequate source of income. We will adopt an “employment first” approach and will assist every individual who can work obtain and maintain a job that fits that person’s skills and abilities. All employment opportunity will be cultivated and pursued through job programs and developers, and will be supported by the Teams. The Teams will interface with the *Job Developer* who will help locate and create job opportunity, the *Employment Specialist* who will help match clients to a job and prepare them for securing a job, *Industrial Relations Staff* who will support employers who hire chronically homeless people, and a *Job Coach* who will support employment after it is obtained.

We will also assist everyone who qualifies for benefits to receive them. We will cross-train and cross-locate staff from community-based organizations and public agencies to increase the number of successful applications. Additionally, the Teams will start seeking benefits/entitlements within

institutions before individuals are discharged to ensure that people exiting institutions have a stable source of income.

Financing a Comprehensive System of Housing, Services, and Treatment

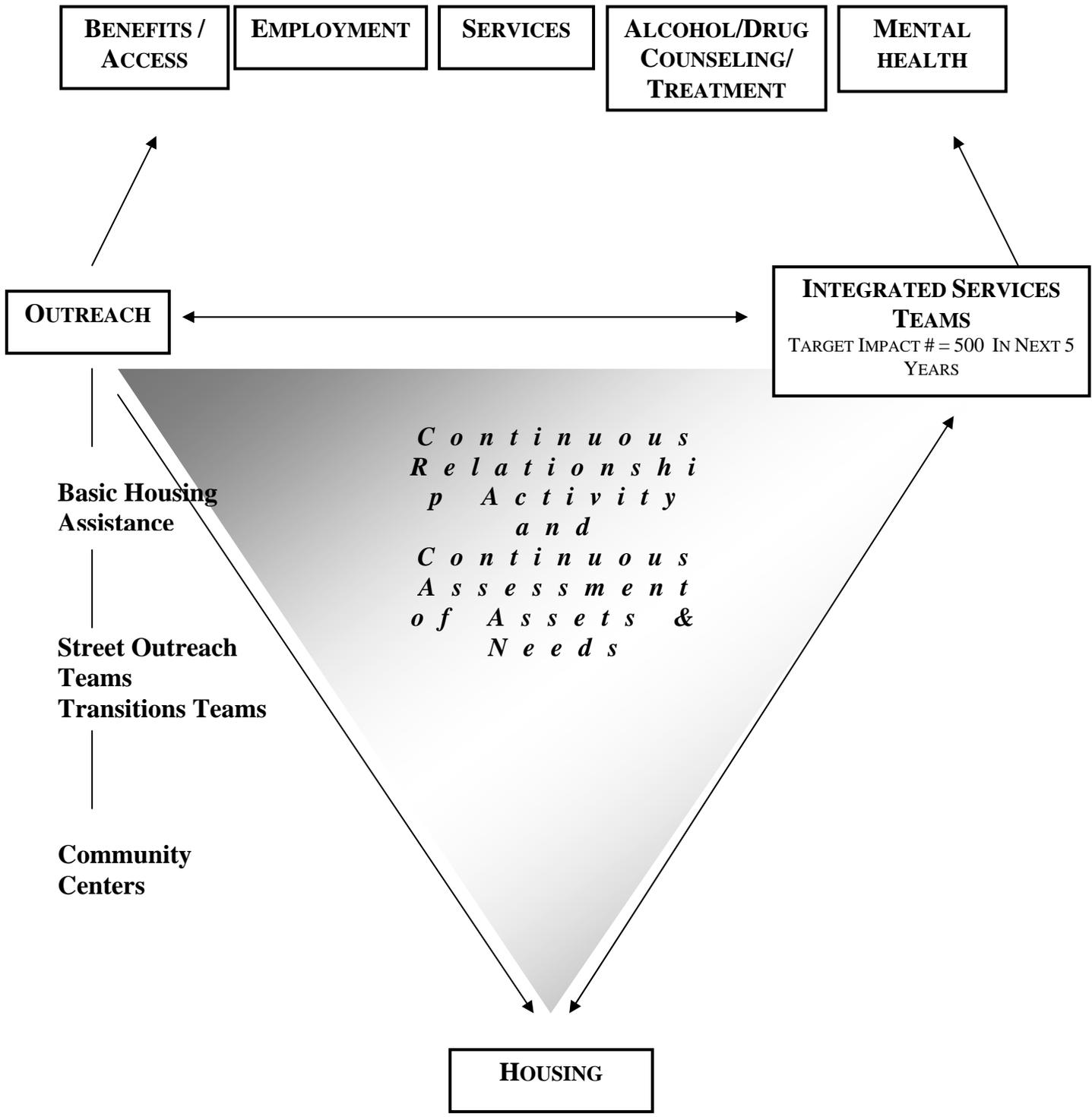
The Plan will be financed by a variety of mechanisms. Existing resources will be redirected to this target population. New resources will be allocated by governments in next fiscal year and will meet at least 50% of the need. Private resources will be immediately solicited and contributed to launch the Campaign to cover the other half of the Plan's immediate financing costs. Private resources will be evenly split between philanthropic donations and business and corporate donations.

Plan Administration, Coordination, and Implementation

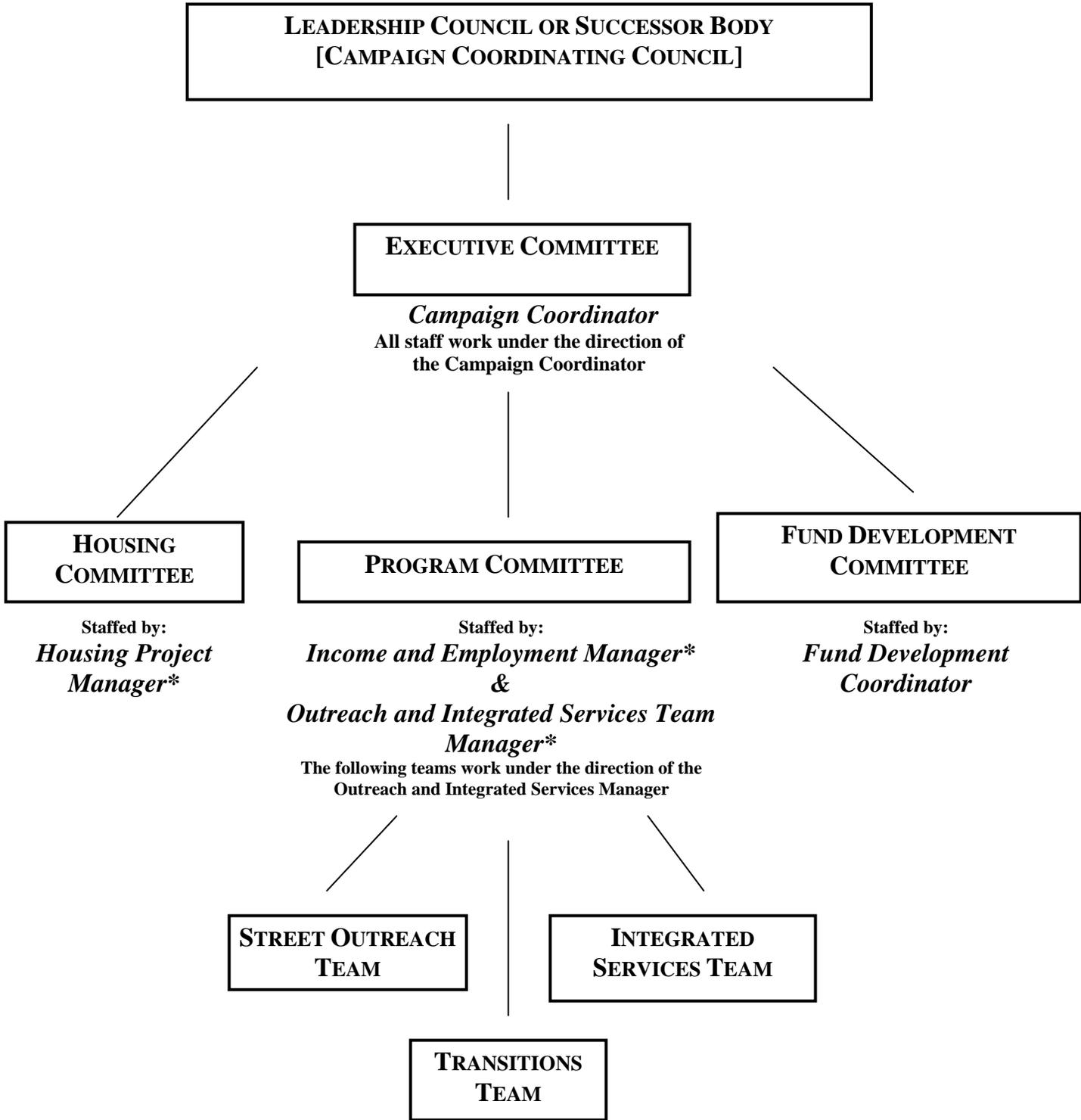
The "Campaign" will be implemented by a nonprofit entity that will be formed in the first three years and will work with Committees that are charged with overseeing this Plan. The nonprofit entity will be staffed with dynamic coordinators who will oversee the daily implementation of the Plan. The *Chronic Homeless Campaign Coordinator* will oversee all aspects of Plan implementation, coordinate and supervise staff, convene the Campaign Management Team, staff the Leadership Council, work with the Leadership Council in support of proposals and funding requests, and function much as a Chief Administrator/ Executive Director. The *Housing Project Manager* will secure access to all housing necessary, including *basic housing assistance* and permanent supportive housing, work to secure housing capacity, arrange for property management, and act as a liaison to services and treatment. The *Outreach and Integrated Service Teams Manager* will pull together personnel from separate agencies into functional teams; retain Team Leader services; create the model of care, protocols, and procedures for Teams; manage the schedules and resources Teams require; and convene case conferencing and Team coordinating sessions. The *Income and Employment Manager* will identify appropriate entities to carry out strategies and action steps; link the benefits access and employment activity to Teams and to housing; and monitor progress and outcomes in this area. Finally, the *Fund Development Coordinator* will identify and cultivate resource opportunities; draft the Annual Finance Plan; convene agencies to develop programs that fit funding possibilities; and handle public relations and the media effort.

We have the vision, resources, and ability to eradicate chronic homelessness in the next ten years. Under the guidance of this Plan, we will end chronic homelessness, both by preventing individuals from becoming chronically homeless, and by ensuring that people who are currently experiencing chronic homelessness are able to achieve supportive housing. Within ten years, every chronically homeless individual in our community will have a place to call home.

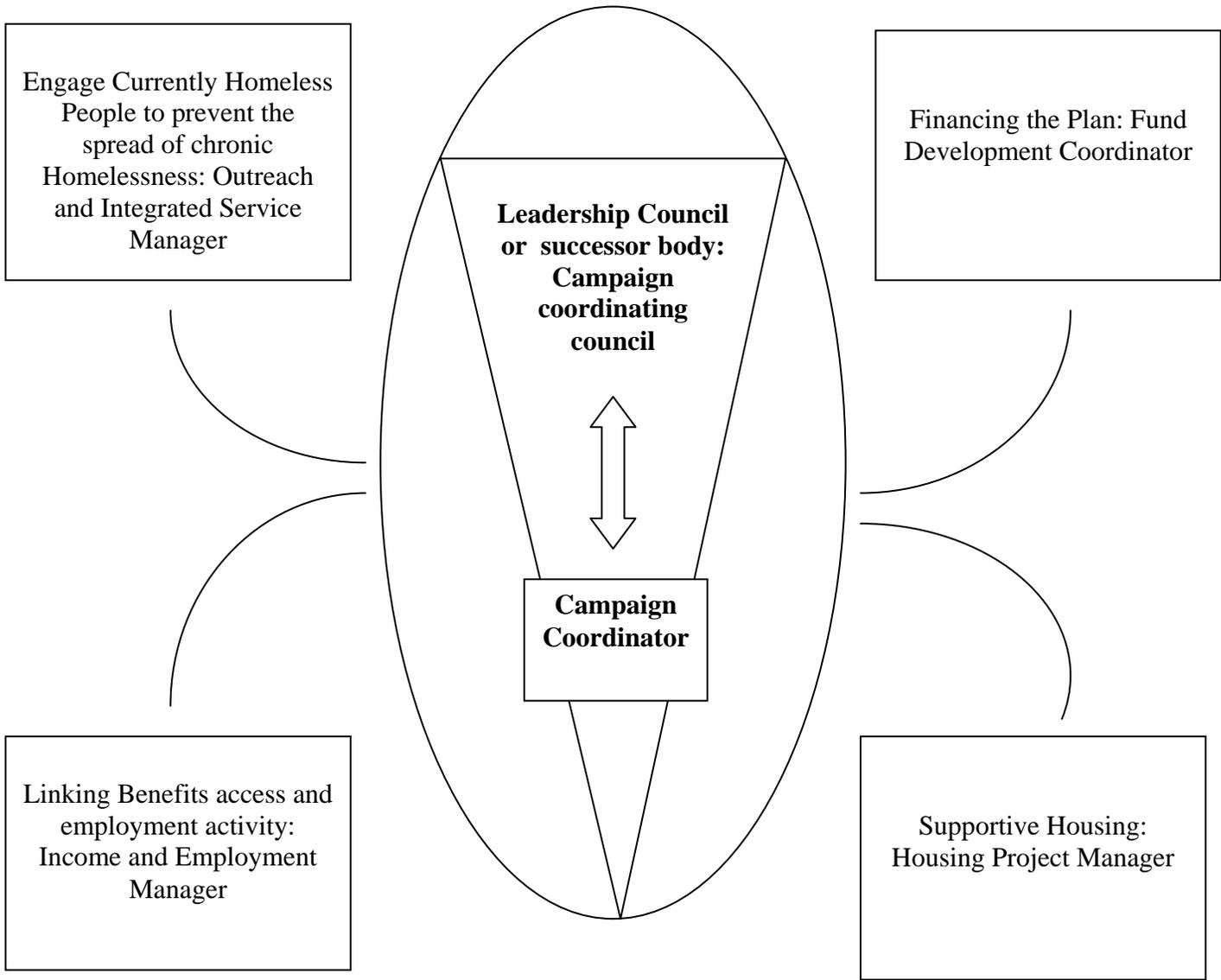
Bringing Our Community Home: Housing-Services-Treatment Nexus



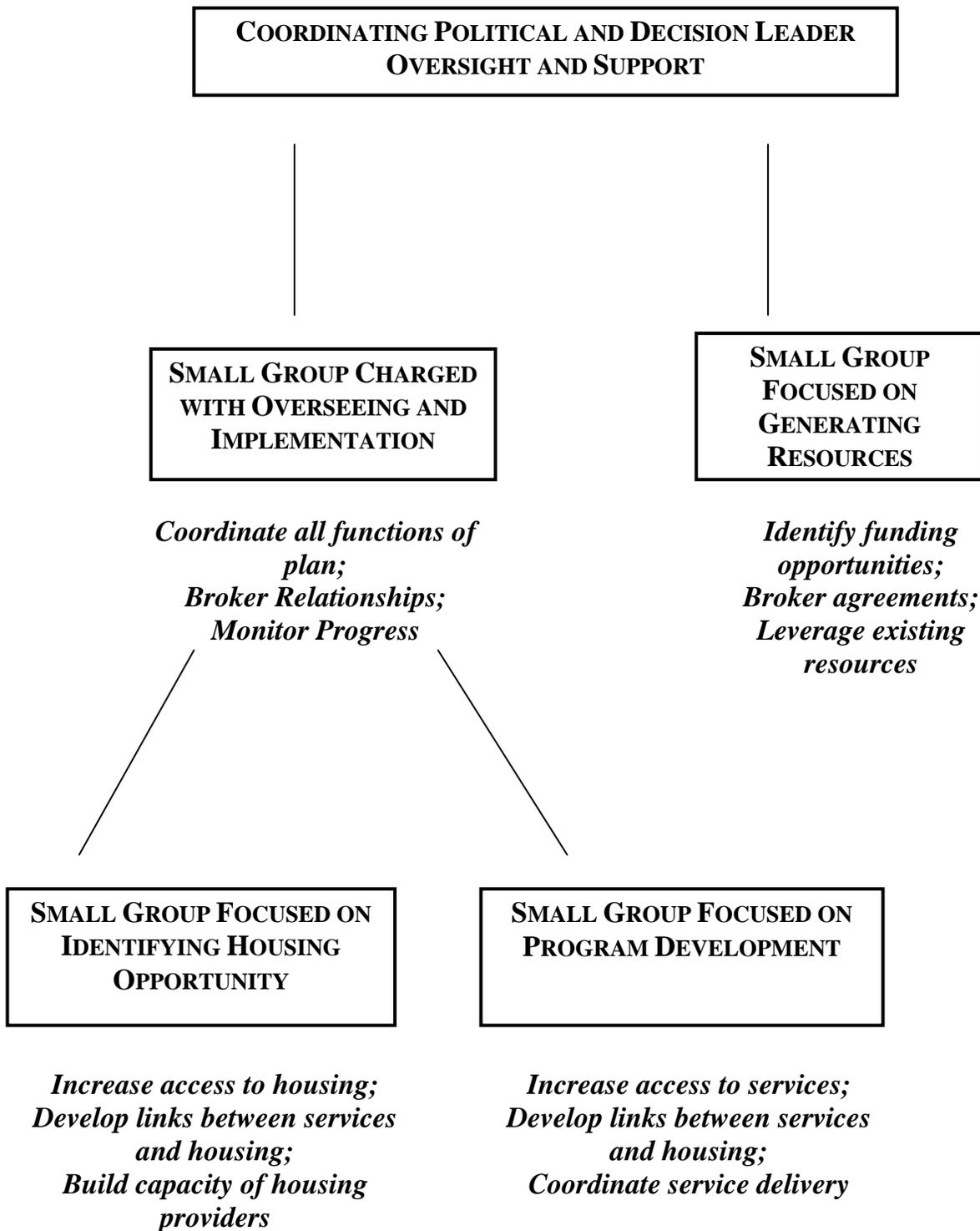
Bringing Our Community Home: Organization Chart [Linear]



Bringing Our Community Home: Staff Organization Chart (Free Flow)



Bringing Our Community Home: Functions to Implement



Initial Timeline: Top Ten Steps for Years 1-3

TIME	STEPS	STRATEGIES
Year 1 (1 st Quarter and ongoing thereafter)	Develop Leadership. Strong leadership with a shared, relationships-oriented vision will be developed at every level. A new nonprofit entity will be created that will generate political support for the Plan and its strategies and ensure its successful financing and implementation. The nonprofit will initially be staffed by a Chronic Homelessness Coordinator, who will oversee the daily implementation of the Plan, and a Fund Development Coordinator, who will develop a plan to raise the funds necessary to support full implementation of the Plan. The Campaign Coordinating Council, Executive Committee, Housing Committee, Program Committee, and Fund Development Committee will direct and advise the implementing entity in the first three years.	<i>1.6, 2.8, 3.6, 3.7, 4.9, 5.8, 6.1, 6.2, 6.3, 6.4, 6.5, 6.7, 6.9</i>
Year 1 (1 st Quarter and ongoing thereafter)	Raise Revenue. Successful implementation of this Plan will require raising adequate funds to finance effective programs that are currently operating, innovative new programs, and the staff necessary to support both. Funds will be raised in a coordinated manner from a number of private and public sources. A fiscal agent will host the effort while a new nonprofit is formed. Sources that experience savings as a result of the Plan's success will be re-allocated to fund homeless services and housing.	<i>1.6, 2.8, 3.7, 4.1, 4.9, 5.1, 5.2, 5.3, 5.4, 5.5, 5.6, 5.8, 6.9</i>
Year 1 (2 nd Quarter)	Create Inter-Agency Agreements. Santa Barbara has a wealth of experienced and capable public and private organizations working on chronic homelessness issues. These organizations will come together in the next three years to create agreements that synchronize their work and enhance their efforts to end chronic homelessness through the staffing of teams, cross-trainings, and the development of a model of care the community accepts and adopts as its own.	<i>1.1, 1.2, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 3.2, 3.3, 3.5, 4.1, 4.3, 4.6, 4.7</i>
Year 1 (2 nd Quarter and ongoing thereafter)	Create Teams and Staff to Support the Teams. Santa Barbara will outreach, engage, and provide services and treatment to all chronically homeless people in a coordinated and effective manner. Outreach teams will be created to provide services to chronically homeless individuals on the streets and in institutions. Integrated Service Teams will be created to help individuals in permanent supportive housing access the services they need and want so that they can retain their homes and stability.	<i>1.1, 1.4, 2.2, 2.3, 2.4, 3.2, 4.1, 6.2</i>

Year 1 (2 nd Quarter)	Access Services and Treatment. In order to ensure that chronically homeless people are able to succeed in their new homes, wrap-around services will be provided from the time of the first contact with each chronically homeless person. Chronically homeless individuals will receive all the services they need, such as client-centered case management, income increasing activities, medical and psychological services, alcohol and drug treatment, etc., as they are willing and able to receive them.	<i>1.1, 1.2, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.6, 3.2, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8</i>
Year 1 (3 rd Quarter and every quarter thereafter)	Train Teams. The new Outreach and Integrated Services Teams will be composed of staff from many of the nonprofit and public agencies that currently provide outreach, services, and treatment to chronically homeless individuals. These newly formulated cross-agency teams will be trained to enhance their abilities to provide services in a way that embraces the new model of care and ensures that services are provided in a coordinated, effective manner.	<i>1.1, 2.1, 2.3, 2.4, 3.5, 4.1</i>
Year 1 (4 th Quarter)	Adapt a Model of Care. Santa Barbara will continue to develop a “relationships first” attitude that encompasses providing services and housing in a non-judgmental, supportive manner where housing is provided first, and services and treatment are tailored to the individual’s needs and wishes.	<i>2.1, 2.4, 2.6, 3.2, 3.5, 4.3</i>
Year 2 (1 st Quarter)	Locate Center Sites. Chronically homeless individuals will receive basic housing assistance, interim housing with services, at the Community Centers and Transitions Centers. The locations for these Centers will be determined based on accessibility, community resources, and cost-effectiveness. The Centers will be operating within the first three years of the adoption of this Plan.	<i>1.2, 2.5, 3.3, 5.7</i>
Year 2 (1 st Quarter)	Access Housing Units. The Plan calls for the development of 500 units of supportive housing for chronically homeless people in the first three years of the plan. These units will be acquired, constructed, rehabilitated, and leased. Housing will be provided based on a housing first model.	<i>3.1, 5.7</i>
Year 2 (1 st Quarter)	Establish Data Systems. The Plan is based on well-researched models and best practices. As these new models are integrated and developed, the implementation body will design data systems and outcome measurements to evaluate new and established programs to ensure that the Plan’s outcomes are met.	<i>6.6, 6.8</i>

Goal 1: Intervening In Chronic Homelessness Before It Repeats And In Homelessness Before It Becomes Chronic

“To be homeless literally means that you have no home to live in, that you are without the reference point to which you instinctively turn to define who you are in relation to the larger order of things; that you are deprived of your sense of place and privacy, your sense of belonging, of rootedness and community, of being part of a social configuration that gives context to your aspirations and purpose to living -- all essential elements of identity, of self-worth, all inextricably related to the functioning of the psyche and the meaning of life.

To lose your home is to lose part of yourself, of the meaning in your life; it induces a profound sense of loss and the grieving that inescapably accompanies loss.”

-- Padraig O'Malley, New England Journal of Public Policy [1992, Vol. 8, No.1]

Homelessness is a devastating occurrence that undermines a person’s health, mental health, and ability to function and contribute in society. For children, the loss of stability and security can irrevocably undercut their growth and development, and limit their future potential. For people with serious health, mental health, or substance abuse disabilities, homelessness all too often deteriorates into a chronic condition that only further undermines their health and distances them from the services they need to recover. In addition, homelessness, in particular chronic homelessness, places a costly burden on public service systems, including hospitals, psych emergency rooms, and the criminal justice system. Given both the individual damage and the high societal costs it wreaks, the most humane and cost-effective strategy for addressing homelessness is *prevention*.

The societal costs of homelessness are very high: a study of homeless people with severe mental illnesses found that they used an average of \$40,451 worth of publicly-funded services per year. The majority (86%) of these costs were for health and mental health services.¹

In Santa Barbara County, homelessness is a very real threat for many low-income residents. Santa Barbara County families earning 30% of the area median income (\$19,110) can afford no more than \$478 for monthly rent.² However, median rent for the City of Santa Barbara is \$960, for Lompoc it is \$639, and for Santa Maria it is \$675.³ The high priced rental market and limited supply of subsidized housing means that many residents are forced to assume high housing cost burdens that place them at-risk of homelessness in the face of any unexpected emergency, such as job loss, eviction, or a health care crisis.

For people suffering from health, mental health, and drug and alcohol disorders, the threat of homelessness is even more pronounced, especially when their illnesses are untreated. In addition, once homeless, they are at high risk of becoming chronically homeless, as the combination of the stresses of homelessness, their illnesses, and the lack of available and accessible services can result in a downward spiral of continuing or repeated homelessness. Such chronic homelessness, involving as it does, extended time periods lived marginalized from society without the stability and security of housing, causes serious health and emotional damage and thus, is more difficult and costly to resolve.

Given the difficulty of locating affordable units and the danger of an episode of homelessness becoming chronic, *early intervention* strategies that prevent homelessness in the first place are the best approach. Such strategies include landlord mediation to resolve disputes and prevent eviction, as well as linkages with community-based services to provide the supports needed to facilitate ongoing health and stability.

For many people, homelessness occurs when they are released from public institutions, such as hospitals, mental health facilities, prisons and jails, and the foster care system. “*In-reach*” strategies in which service teams begin working with residents at-risk of homelessness, long before their discharge, to address health, mental health, and addiction service needs and to provide assistance in accessing entitlements and housing are an effective way to prevent discharges into homelessness (See Prevention Appendix A). For people who are ready for discharge, but are still too ill to move directly into housing, *recuperative care or respite care facilities* provide short-term housing and services to help them recover and prepare to move into permanent housing.

“*In-Reach*” Strategies Working in California: New Directions in Santa Clara County
New Directions is the product of a pilot study that initiated community case management for frequent emergency department users. Strategies were tested and refined during the pilot. The intervention was composed of three core parts: intensive case management, interdisciplinary and inter-agency case conferencing, and linkage to primary care and continuity of physician. As a result of project, there has been a 31% reduction in emergency department visits and a 53 % decrease in inpatient hospital days for clients. Additionally, the cost of emergency department, inpatient, and outpatient clinic services provided to clients declined by almost half after just one year of enrollment (and was even greater for clients who completed two years of enrollment), and hospital inpatient days declined after nine months of case management for the one group of clients for whom data is available. (See Prevention Appendix A).

In order to prevent additional cases of homelessness, and to prevent homelessness from turning into a chronic condition for those who are already homeless, the Santa Barbara County-Wide Ten Year Plan lays out a two-pronged approach focusing on early intervention to support people in retaining their housing and enhanced discharge planning for chronically homeless people being released from public institutions.

→ Early Intervention to facilitate housing retention will be carried out through landlord mediation efforts, linkages with community-based services and supports, and exploration of strategies aimed at ensuring health and stability for people once they regain their housing.

→ Enhanced Discharge Planning for those being released from public institutions will be accomplished through the creation of *Transitions Teams* and *Transitions Centers*. The *Transitions Teams* will be multi-disciplinary; focus on working with people who are chronically homeless and currently in hospitals, mental health facilities, foster care homes or facilities, or prisons and jails; engage with clients to assess needs as early as possible; and work to identify housing, access entitlements, and forge linkages with community-based services to provide ongoing support. *Transitions Centers* will be developed to provide interim housing, needed services, and medically-appropriate respite care for people in need of immediate health, mental

health, or substance abuse services so they can recuperate, become stable, and successfully obtain and retain permanent housing.

Building on Community Strengths...

- Santa Barbara County has enacted a policy that prohibits discharges into homelessness from publicly-funded institutions and is in the process of implementing a requirement that all institutions which provide residential care, treatment, or custody provide staff assistance in locating housing and ensure that residents have accessed all available entitlement programs (such as TANF, GR, Medi-Cal, SSI) prior to discharge.
- The Re-Entry Program is a new county-wide pilot program that will fund a Transitional Coordinator (TC) to provide intensive case management to parolees being released out of prison six months before release and then will follow the parolee through case management after release and into self-sufficiency. The TC will connect them with necessary services to prevent recidivism (i.e. substance abuse treatment, mental health treatment, housing, clothing, food, employment, etc.). The program will be administered by Good Samaritan Shelter, Inc.
- Santa Barbara County already has one recuperative care facility in place: the Hotel de Riviera, which offers 12 recuperative care beds for men.

Ultimate Objectives

As a result of this work, in ten years the quality of life for all county residents will be enhanced as:

- Every chronically homeless person exiting an institution will move directly to permanent supportive housing.
- No one will be evicted into chronic homelessness.

Table 1-1: Projected # of Chronically Homeless Single Individuals and Individuals in Families Transitions Teams Will Provide with Services (Cumulative)

Year	South County Coast (60%)				Santa Maria (25%)	Lompoc (15%)	Total
	City of Santa Barbara (35%)	Unincorporated South Santa Barbara County/Isla Vista (10%)	Goleta (10%)	Carpinteria (5%)			
2007	21	6	6	3	15	9	60
2010	175	50	50	25	125	75	500
2013	263	75	75	37	188	113	750
2016	420	120	120	60	300	180	1200

Strategies/Action Steps

Strategy 1.1: Link Housing, Services, and Treatment at Discharge.

Create Transitions Teams to engage with chronically homeless people who are identified within custodial care/institutions, and provide services, treatment and housing through continuously sustained relationships until independence is achieved.

Action Step 1.1.1. The Transitions Teams will do outreach within institutions of custodial care, interfacing with discharge planners to intervene with people at risk of becoming chronically homeless in preparation for discharge and release.

The Transitions Teams will also work with chronically homeless people who are repeatedly evicted from housing.

The Transitions Teams will engage in discharge planning activity, including working with institutions and others to identify those most at risk as early as possible, and forge linkages for community based relationships to be the locus of response. The more people who know a client by name, * the greater the success.

Action Step 1.1.2. Transitions Teams will be mobile, going where chronically homeless people have been identified by hospitals, jails, treatment programs, group homes, psychiatric centers, residential care facilities, residential treatment facilities, foster care houses/facilities, landlords, and others.

- The Transitions Teams will work with adults and with transition aged youth.

* Santa Barbara will develop terminology that is consistent with its model of care (Action Step 2.1.2), however, for the purposes of clarity, chronically homeless individuals will be referred to as clients throughout this Plan.

- The Transitions Teams take services and engagement to where the clients are to be found, and will not require chronically homeless people to come to a location to be engaged.

Action Step 1.1.3. Through case conferencing and other techniques, the Transitions Teams are to share efforts to end homelessness for each person the Transitions Teams engage. The Transitions Teams are to work with discharge planners within each institution to streamline access to chronically homeless people and integrate efforts to meet their needs. Teams will forge partnerships with the target population, offering services such as money management to assist in attaining residential stability.

Action 1.1.4. At a minimum, the Transitions Teams will include a social worker who relies upon existing institutional staff for diagnosis, medications lists, medical treatment, assessments, benefits access, and family reunification. Case managers and peer workers may be on Teams as well.

Strategy 1.2: *Engagement Teams will work out of Centers of Operation and Assistance.*

Establish Transitions Centers in Santa Barbara, Isla Vista, Santa Maria, and Lompoc to support recovery from chronic homelessness.

Action Step 1.2.1. Transitions Centers will serve as bases of operations for Transitions Teams, providing office space, parking for mobile vans, technology centers, and meeting space. The Transitions Centers will provide a connecting place for Team staff, personnel at numerous agencies, and clients.

Website and other technologies will support intensive and continuous communication.

Action Step 1.2.2. Transitions Centers will provide Basic Housing assistance as short-term housing opportunity on-site or nearby in individual rooms and shared space to meet the needs of chronically homeless people in immediate transition from the streets or custodial care to permanent housing. This is intended as very short term (3-30 days), to accommodate the time it takes to process apartment rental applications and similar paperwork (see Strategy 3.3).

Action Step 1.2.3. Transitions Centers may serve as Safe Havens, providing for the basic living needs of chronically homeless people with on-site service centers to provide a range of support services.

Action Step 1.2.4. Medically adequate respite care will be available to chronically homeless individuals at the Transitions Centers. The Centers will provide mental health and/or addiction services over a period of time in order to sustain the housing stability of chronically homeless individuals while they recuperate, recover, and prepare to enter

permanent housing. The Centers will use mainstream programs to provide treatment and services.

Action Step 1.2.5. Transitions Centers can be established at existing facilities, and may build upon the co-location of services work now underway. The Transitions Centers, wherever located, must embrace all the nuances that the focus on Housing First entails, including breaking the cycle of homelessness and preventing a fall into the chronically homeless lifestyle. A recovery focus must be included for those who need support in their recovery process, but this cannot block participation in a Transitions Center by those actively under the influence. Accommodating the needs of both groups as and where needed will be part of the program design work in implementing this Plan.

Strategy 1.3: *Intervene to retain housing.*

Encourage early mediation for all providers of housing to chronically homeless people to prevent repeat homelessness.

Action Step 1.3.1. Provide liaison, mediation, and asset management assistance, as well as a damages/repair fund, to sustain availability of housing stock for chronically homeless people.

- Support landlord training and education, inclusive of civil rights requirements. “Provide value and security to property owners.”
- Support 24/7 intervention with tenant when landlord or neighbors call with issues.
- Create a reserve fund that accommodates the expected higher level of wear/tear and turnover with this tenant group.

Action Step 1.3.2. Provide tenancy training and support to relearn what it means to be part of the whole community. This may include basic living skills and social skills, development of self-esteem and self-worth.

Strategy 1.4: *Enhance Transition Services.*

Require Transition Teams to work with all publicly funded institutions providing residential care, treatment, or custody to secure all entitlements/benefits, services, treatment, and housing for which residents are eligible prior to discharge.

Action Step 1.4.1. Assess the capacity of these institutions to provide the linkages needed, with or without the assistance of the Transitions Team.

Action Step 1.4.2. Create a coordinated system of benefits, entitlements, and housing linkages to monitor the applications and outcomes.

Strategy 1.5: *Mainstream Program participation in preventing Chronic Homelessness.*

Create an early warning system to flag those at risk of chronic homelessness and provide appropriate interventions. This includes repeat users of the shelter system, those in the youth systems who have had repeated housing problems, and those who repeatedly face eviction.

Action Step 1.5.1. Establish points of contact with the youth system, hospitals, landlords, and the police through the restorative policing program. Talk about the path to chronic homelessness, and the need to intervene early. Seek the assignment of caseworkers to monitor and assist the person at risk. Link to the Transitions Team as a last resort.

Action Step 1.5.2 Adopt strengths-based model of assessment.

18 BED PROJECT FOR TRANSITIONAL AGE YOUTH (LA MORADA)
Department of Social Services and Housing and Community Development
Contact: Mike Sederholm

A high percentage of people transitioning out of the foster care system end up homeless. La Morada was developed because Santa Barbara County has no local program that provides emergency temporary housing for transitional age youth and children in need of immediate removal from the foster care system due to abuse. La Morada will be located at a rehabilitated County-owned property, which will provide emergency temporary housing for these youth. The project is expected to be complete in the beginning of 2007. Once completed, La Morada will be staffed by social workers who will work with youth to assist them with obtaining permanent housing and avoiding homelessness. It will provide food, clothing, and shelter 24 hours a day. Additionally, it will provide medical screenings; therapeutic activities; transportation; psychiatric, psychological, educational, and medical evaluations; and educational opportunities on site. (See Prevention Appendix A).

Strategy 1.6: Systems Change

Engage in State and federal advocacy to support prevention strategies.

Action Step 1.6.1. Support legislation and changes in State and federal practices to encourage better planning and services for individuals being discharged from federal/State correctional institutions into the community.

Action Step 1.6.2. Advocate for the adoption of strategies and action steps in California's 10 Year Plan to End Chronic Homelessness that will support our Plan, particularly strategies and action steps that will lead to increased funding for prevention strategies, including discharge planning.

SUPPORTIVE HOUSING INITIATIVE ACT PROJECT
Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Contact: Elodie Patarias

In 2001, five Santa Barbara County agencies and nonprofits were awarded California Supportive Housing Initiative Funds to create two intensive case management teams, one in each geographic region of the County. The teams were created based on the PACT model and were responsible for enabling at least 106 adults with serious mental illness and

ENDNOTES

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

2 National Low Income Housing Coalition, "Out of Reach," 2005.

3 *United States Census Data, 2000.*

Goal 2: Reaching Out, Engaging, Serving, and Treating Chronically Homeless People

"The wonderful thing about that place was they hung in there with me... What I really needed, and what that place gave me, was someone to tell me I was worth something and then to be around when I felt myself falling. That made all the difference. Made me want to try... What most people don't know is that a lot of us just need someone to hold our hands, to give us a chance."

– formerly homeless person cited in the *San Francisco Chronicle*, "Shame of the City."
May 9, 2004

At any given time over 4,000 people, including individuals and family members, are homeless in Santa Barbara County. Most of them (72%) are unsheltered and are not living in any of the County's emergency or transitional housing. This includes over 500 people who are chronically homeless and many others at-risk of chronic homelessness due to a disabling health, mental health, and/or substance abuse condition. An estimated 30% of the homeless population has a severe mental health disorder and 16% has a history of chronic substance abuse. The reasons for the high percentage of unsheltered homeless people are varied, but include the County's lack of shelter and housing capacity to meet the needs of its homeless residents, as well as reluctance by many members of this population to interact with a service system that has failed them. The latter is especially true for those suffering from mental health, substance abuse, and co-occurring disorders.

Reaching those outside the County's housing and service system requires *outreach*, whereby trained staff visit encampments and other locations where homeless people congregate to begin the process of *engagement*. *Engagement* involves making contact, gaining trust, and offering preliminary services, such as warm clothing, basic medical care, and medications. As trust develops, over time and through repeated contacts, outreach staff encourage clients to accept more detailed assessments and support them in accessing the assistance they need to regain housing and health. Given that many homeless people, especially those who are chronically homeless, have multiple inter-related needs, outreach is best conducted through multi-disciplinary teams. These teams facilitate access to the full range of services needed by the client population, and ensure coordinated care.

Multi-disciplinary outreach teams are an effective strategy for linking homeless people with housing and services: studies show that even individuals with the most severe disorders, and who are the most reluctant to accept treatment, will enroll in services and show improved outcomes when served by an outreach team.¹

Studies show that ACT and other intensive case management models reduce hospitalization, decrease substance use and psychiatric symptoms, and increase community tenure for people who are homeless and have mental health and/or substance abuse disorders.²

Another essential feature of outreach teams is "*intensive case management*," an approach in which staff do "whatever it takes" to assist clients in accessing the full range of services that they need and work aggressively to maintain contact with clients for as long as it takes them to regain stability. *Assertive Community Treatment (ACT)* is a proven intensive case management model in which service

teams with a high staff-to-client ratio place a heavy priority on the development of trusting, therapeutic relationships with clients. The teams provide intensive support both to ameliorate clients fears and distrust of the service system, and to help clients successfully obtain the housing and other services they need to facilitate long-term stability.

Even after they are housed, most homeless people who have been chronically homeless will need ongoing services and supports to help their transition from homelessness to housing. *Intensive case management* is an effective model used by integrated service teams for addressing this population's multiple needs. Under an intensive case management model, an individual service plan is developed with the team's case manager; housing and the full range of services needed are provided as one coordinated package of care that evolves over time based on client needs. This type of service provision is known as *wrap-around services*, as it encompasses the client in the full range of support they need to successfully transition out of homelessness and regain their health and stability for the long term. Typically, integrated service teams include staff from both mainstream and homeless services and focus on linking clients with community-based services and supports.

Integrated service teams are effective in helping clients retain their housing and health: a study of two supportive housing projects using integrated service teams found high rates of residential stability, with 81% of clients remaining in their housing for a year and 62% for two years. In addition, after one year, client use of emergency rooms fell by 58%; use of hospital inpatient beds fell by 57%; and use of residential mental health programs disappeared.³

Intensive Case Management Working in California: Project Coming Home, Contra Costa County
Project Coming Home is a collaborative, inter-agency effort to end homelessness for chronically homeless individuals with a disabling mental health, substance abuse, or physical condition funded by the Collaborative Initiative to Help End Homelessness. Project Coming Home includes multi-disciplinary outreach and services to the target population, the creation of a homeless-dedicated detox and residential treatment capacity, access to affordable housing, and comprehensive, integrated support services attached to the housing. In two years the project has housed 168 people, assisted 50 veterans in obtaining veteran benefits, developed a strong relationship with the local emergency room and the police so that chronically homeless people are immediately referred to Project Coming Home's outreach team, and worked with the housing authority to streamline the process for getting tenants into the Shelter Plus Care Program. (See Outreach Appendix A).

In order to better engage and serve people who are chronically homeless or at-risk of chronic homelessness, the Santa Barbara County-Wide Ten Year Plan seeks to enhance existing outreach capacity and effectiveness; provide comprehensive, wrap-around services linked to housing; and expand availability of key services and treatment for this population.

→ Enhanced Outreach Capacity and Effectiveness will be achieved by expanding the number of outreach teams, as well as their hours and coverage; developing a concrete philosophy of care based on the ACT intensive case management model; improving coordination within teams and between teams; and streamlining access to interim housing, permanent housing, and services for

clients referred by outreach teams. In addition, *basic housing assistance* will be provided through scattered site community centers.

→ Comprehensive, Wrap-around Services Linked To Housing will be provided through *Integrated Service Teams* involving both homeless and mainstream agencies, using an intensive case management approach and maintaining contact with clients until ongoing stability is attained.

→ Expanded Availability of Key Services and Treatment will be achieved through review and analysis of current service dollar usage to identify greater efficiencies in resource allocation, support of agencies in developing capacity to bill for Medi-Cal, and reallocation of mainstream system savings due to implementation of Plan strategies to fund additional services.

Building on Community Strengths...

Santa Barbara has already begun integrating services among providers.

- Mental Health staff and outreach workers hold weekly “Team 4” meetings to discuss the status of homeless clients in the system, to fill unoccupied beds, and to identify unstable homeless individuals.
- Linkages are in place between the Vet Center and other homeless outreach workers to ensure veterans are enrolled in all the County programs available to them.
- The Board of Supervisors created and funded a central contact person for all homeless questions and concerns in the County. This single contact position works with each of the numerous County departments serving the homeless population, directs those people seeking services to the appropriate County department, and identifies any duplicative services provided by the County.

Ultimate Objectives

As a result of this work, in ten years the quality of life for all county residents will be enhanced as:

- 100% of chronically homeless people in Santa Barbara County will be engaged and on the path to self-sufficiency.
- 100% of chronically homeless people in Santa Barbara County will be participating in services, treatment, and housing.

Chart 2-1: Estimated Number of Chronically Homeless Single Individuals and Individuals in Families to Receive Outreach Assistance (Cumulative)

Year	South County Coast (60%)				Santa Maria (25%)	Lompoc (15%)	Total
	City of Santa Barbara (35%)	Unincorporated South Santa Barbara County/Isla Vista (10%)	Goleta (10%)	Carpinteria (5%)			
2007	63	18	18	9	45	27	180
2010	525	150	150	75	375	225	1500
2013	788	225	225	112	563	337	2250
2016	1260	360	360	180	900	540	3600

Strategies/Action Steps

Strategy 2.1. Relationships First Model of Care.

Articulate a model of care concerning “outreach” that builds upon existing professional terminology and the experience of Santa Barbara County with chronically homeless people.

Action Step 2.1.1. The agencies providing services and treatment to chronically homeless people throughout Santa Barbara County will work together to develop a model of care for use by the Teams. This model will adapt the ACT model; focus on healthy relationships as a core value; develop relationships between individuals as an operating paradigm, making available what they need to become self sufficient; support clients in developing trust and feelings of self worth, and working through fears, challenges, and barriers. Central to the philosophy is a continuous relationship with clients once they have been placed in housing/programs, or a structured hand-off to another team that continues the trust that has been built.

Action Step 2.1.2. In developing a standard for this work, the collaborative effort will strive to develop a way of interacting with the target population that includes the following:

- Consider adapting stages of change model
- Consider using “assets” focused model that Casa Esperanza is now adapting for this group (40 Developmental Assets found at searchinstitute.com)
- Engender hope; the belief that something different is possible and is going to happen; build trust; caring about self
- Foster inter-dependence as it supports re-integration into community
- “Meet clients where they are at” attitude
- Outreach that is nimble, flexible, and relationship focused; with services that follow and flow; integrated and naturally occurring relationships are supported; relationship as the service

- Select terminology that reflects attitude and culture: client vs. member, guest; case manager vs. care coordinator, mentor, life coach. Adapt to the language of the people we are seeking to engage, so they can participate in determining the path forward for their lives
- Determine how to have a system that uses staff and volunteers
- Interact with the business community to make connections along the street where people are found and secure help with the effort
- Have an “any door is the right door” attitude throughout the system of response, including access at regular community locations

Action Step 2.1.3 Disseminate the model community-wide. Prepare a statement of the model including a description of all of its elements. Create a training packet and use it to train staff. Integrate the model into RFP’s and contacts for agencies to do this work.

Strategy 2.2. *Establish Street Outreach Capacity.*

Build relationships with people on the street through Street Outreach Teams.

Action Step 2.2.1. Street Outreach Teams will be parallel in function to the Transition Teams of Goal 2, who work in accordance with Assertive Community Treatment principles suited to Santa Barbara County. Street Outreach Teams will be multi-disciplinary and collaborative, building upon national and local models. Street Outreach Teams will be composed of existing outreach teams and outreach workers, field workers and others currently touching the lives of this population. Numerous volunteers will be recruited to participate on the Teams. An inventory of existing work will support this extensive collaboration.

Action Step 2.2.2. Street Outreach Teams will be mobile and will go where chronically homeless people have been identified by libraries, businesses, parks staff, and others. Street Outreach Teams will take services and engagement to locations where chronically homeless people are and will not require chronically homeless people to come to a location to be engaged. Service connection points for the Street Outreach Teams shall include many existing facilities/programs, such as the Community Kitchen lunch program in Isla Vista or the public library, the Farmer’s Market, coffee shops; places not meant for homeless people specifically, but used by them, “indigenous to community.” Relationships will be built in these locations.

Action Step 2.2.3. Have at least 2-person Street Outreach Teams that are on call 24/7. The Street Outreach Teams retain daily contact until a chronically homeless person has become “engaged.” Contact then shifts as needed. Street Outreach Teams may be composed of volunteers, and may be faith-based efforts. Teams will be supported with vans, laptops, cell phones, and engagement resources.

Action Step 2.2.4. Street Outreach Teams will work to engage people (Outreach Worker), assisting in access to income subsidies, benefits programs, and entitlements. Street Outreach

Teams (Field Worker) will respond to medication, mental health, and substance abuse issues. Team contacts are estimated at 180 in Year 1.

Strategy 2.3. *Establish Integrated Services Teams.*

Support Integrated Services Teams linked to housing, who continue the relationship and work of the Transitions Teams (Goal 1) and Street Outreach Teams, and coordinate with employment services providers for chronically homeless people placed into housing.

Action Step 2.3.1. Integrated Service Teams will be formed to support housing retention, formation of community relationships, access to employment and volunteer opportunity, and to provide care-giver support to the newly housed for as long as it is needed.

Action Step 2.3.2. Integrated Service Teams will intervene to prevent repeat homelessness and will work to keep people connected once they are linked to housing/services/treatment/support. Any housing transitions will be carefully managed to assure continuity of housing.

Action Step 2.3.3. Integrated Services Team will include the capacity to handle, directly or through linkages, co-occurring disorders, mental health, substance abuse, physical health, and primary care needs.

Action Step 2.3.4. Integrated Service Teams will include the capacity to handle, directly or through linkages, benefits/income and employment issues, including legal system entanglement.

Strategy 2.4. *Coordinate Team Work.*

Coordinate the work of all the outreach teams and the Integrated Services Teams.

Action Step 2.4.1. Centralize responsibility for developing each of the Teams to cover the geography of the County to reach the target population. Centralize the function of coordinating Teams, increasing/decreasing the caseload of each as needed to provide clients with the attention and relationships needed. Centralize responsibility for determining the configuration and composition of the Team membership, including the role of a Personal Care Coordinator/Coach (reclaimed from case management lingo) who will schedule appointments, maintain paperwork, monitor progress, identify assets, assist in building self-esteem, report out to the Team, act as a caregiver, and have the longest sustained relationship with the chronically home-less person on behalf of the Teams.

Action Step 2.4.2. Co-convene the Teams for case conferencing on common clients, and develop protocols and techniques to assure smooth interface between Teams when clients shift from institutions or the streets to Centers and/or housing and employment.

Action Step 2.4.3. The Teams will develop record-keeping, training, and the infrastructure needed for a smoothly functioning effective program with a minimum of administrative requirements. To this end, the Campaign Staff will:

- Create a uniform intake and assessment application for all services and benefits.
- Support cooperative work through tools and technology, such as electronic note taking that updates files, universal assessments, and case files with common access components. The Teams will have the capacity for information sharing and case management through HMIS so that a data monitoring system is in place and activity can be reported by geographic areas.
- Work to be sure the 211 system and its paper guides are integrated to provide support to the Teams.
- Train teams and cross-train agency staff in a model and philosophy of care.
- Maintain data system to track all contacts, differentiate urban/rural, client characteristics and linkages created.

Action Step 2.4.4. Form the Teams, as is feasible, from new funding sources and from existing agencies and outreach workers, building capacity from existing people already doing components of this work. Connect various existing outreach workers around this client group, exploring what is already being provided. The new P. 63 funded workers in the CARES program will be included in this networking effort.

Action Step 2.4.5. All the Outreach and Integrated Services Teams will have access to the range of next step placements needed. This will include working to prepare the “system silos” (such as detox, residential treatment, employment programs) to receive and welcome the clients being brought forth from outreach activity.

Strategy 2.5. *Create Community Centers.*

Establish Community Centers in the South County Coast, Santa Maria, and Lompoc to support recovery from chronic homelessness.

Action Step 2.5.1. Community Centers will serve as the bases of operations for Transition Teams and Street Outreach Teams, providing office space, parking for mobile vans, a technology center, and meeting space. These Centers will provide environments tailored to the stage of recovery achieved by the individual, be small scale and personable, and support forward progress on the path to self sufficiency for the engaged persons.

Action Step 2.5.2. Community Centers will provide Basic Housing assistance as short-term housing opportunity on-site or nearby in individual rooms and shared space to meet the needs of chronically homeless people in immediate transition from the streets or custodial care to permanent housing. This is intended as very short term to accommodate the time it takes to process apartment rental applications and similar paperwork (see Strategy 3.3).

Action Step 2.5.3. Community Centers will serve as Safe Havens and using a harm reduction model, will provide for the basic living needs of chronically homeless people. The on-site

service centers will provide a range of support services. The Community Centers will balance acceptance with boundaries that work.

Action Step 2.5.4. Community Centers may be virtual centers: mobile, temporary, rotating, using existing facilities.

- Consider youth model, adapting a 4-bedroom house to sleep 8 at a time in shared rooms.

Action Step 2.5.5. When Community Centers are no longer needed, convert the property into permanent affordable housing or other special needs community use.

Strategy 2.6. *Provide Services and Treatment.*

Support the availability of sufficient units of services and treatment needed by chronically homeless people, and make them immediately available upon demand.

Action Step 2.6.1. Treatment provided shall include mental health services, substance use management counseling based on a harm reduction philosophy, and healthcare.

Action Step 2.6.2. Services provided shall include person centered case management, relationship building, life skills counseling, money management, access to benefits and employment assistance, and peer support.

Action Step 2.6.3. Fast track access shall be provided at hospitals, residential treatment facilities, prisons and jails, and facilities for children in foster care to those clients connected through one of the Outreach Teams or the Integrated Services Teams.

Action Step 2.6.4. Develop Santa Barbara County's Homeless Court. Teams will support chronically homeless individuals as they work to clear their police and court records.

Structure a relationship between the homeless and mental health courts, the P. 63 Court Liaison, and the Outreach and Integrated Service Teams.

Action Step 2.6.5. Enhance capacity of key mainstream services by reviewing use of existing federal and state service dollars in the County and reallocate them to achieve greater efficiency.

Action Step 2.6.6. Document cost savings to mainstream systems from strategies such as supportive housing and reapply savings to fund more services.

Strategy 2.7 Increase resources available to agencies through Medi-Cal and Medicare billing for treatment and services.

Action Step 2.7.1 Create Integrated Services and Outreach teams to document activity that will support reimbursements.

- Consider coordinated activity and billing.

- Consider even regional configuration.

Action Step 2.7.2 Work with CBO's to become certified for reimbursement.

- Provide training in documentation.
- Develop billing strategies to maximize resources (look at ADMH new program at Casa where staff will do case notes and ADMH will do MediCAL billing), particularly at sites where children and families, the populations most likely to be on MediCAL, are served.

Strategy 2.8. *Instigate Systems Change.*

Engage in State and federal advocacy to support outreach strategies.

Action Step 2.8.1. Advocate for state change on MediCAL billing requirements to streamline billing process.

Action Step 2.8.2. Advocacy to increase MediCAL and NNA (net negotiated amount) funds available for non-covered services and treatment needed by this population.

Action Step 3.8.3. Advocate for the adoption of strategies and action steps in California's 10 Year Plan to End Chronic Homelessness that will support our Plan, particularly strategies and action steps that will lead to increased funding for services and treatment for chronically homeless individuals.

SOUTH COUNTY RESTORATIVE POLICING TEAM

Contacts: Dana Gamble and Officer Robert Casey

Before the start of this program in 2004, people who were homeless, or at risk of homelessness, and coping with mental illness and/or substance abuse issues, traditionally faced significant barriers in accessing treatment and finding support necessary for long-term recovery. These obstacles often lead to a perpetual cycle of arrest, jail time, and minimal treatment without long-term supportive services, resulting in a relapse leading to further arrests. The Santa Barbara Police Department wanted to increase the level of collaboration between agencies and decided to begin working with people trapped in this cycle. Community leaders implemented an innovative and hopeful approach by forming a Restorative Policing Team. This team, made up of local agencies, including law enforcement officers and service providers, come together to help people dealing with these issues link with appropriate support and treatment services, one person at a time.

South County Restorative Policing Team assisted Sam, who for years made his home on the streets of Isla Vista. Mentally ill and an alcoholic, numerous disturbance calls were made about him to the Isla Vista police. Although not a real danger, Sam surrounded himself daily with magazines that he had collected, and had conversations with the images on the covers. These conversations turned into shouting matches, with both the magazine covers and the people walking by on the street. After many arrests, the South County Restorative Policing Team worked with the Alcohol and Drug Mental Health Services (ADMHS) to get Sam the help he needed. ADMHS encouraged him to see a therapist, and Sam was diagnosed with bipolar disorder. Sam also obtained help for his alcohol dependence; he graduated from a detox program and entered a sober living center for those with co-occurring disorders. Sam is sober

COORDINATING COMMITTEE FOR THE HOMELESS

Facilitated by Cottage Health System and the Department of Social Services

Contacts: Ken Williams, Roger Heroux, and Sam Leer

The Coordinating Committee for the homeless started 20 years ago as a mechanism to coordinate the delivery of services and treatment to homeless patients prior to a hospital discharge. Before the Committee formed, this population of homeless people was discharged to the streets or bounced around from shelter to shelter, and didn't receive the necessary services and treatment needed. The Committee meets every Monday to discuss the needs of each patient and coordinate resources to help homeless individuals, or individuals at risk of homelessness. Services and treatment follow-up are assigned to the appropriate service organization. The Committee is also concerned with assuring that the shelter's medical and respite beds are available and utilized in the most effective way. The Committee is composed of individuals representing a continuum of services like Cottage Hospital, Catholic Charities, Casa Esperanza Homeless Shelter, Veterans Administration, Department of Social Services, Public Health Department, Salvation Army, Council on Alcoholism and Drug Abuse, Alcohol, Drug and Mental Health, Telecare, State Department of Rehabilitation, New Beginnings Counseling Center, and Department of Housing and Community Development.

The Coordinating Committee for the Homeless approached Shelly a number of times over the years before she decided to accept its services. Shelly was a full-fledged alcoholic for 13 years of her life. Shelly uses a wheelchair and has a significant physical disability. She lived on the streets for many years and amassed over 100 hospital visits throughout her time on the streets. She received an even greater number of police citations for being drunk in public. She bounced in and out of shelters and hospitals, refusing repeatedly to stop drinking. The Coordinating Committee on the Homeless never gave up on Shelly. After numerous contacts, Shelly finally agreed to be placed in a shelter by the Committee. She has been living a clean and sober life-style in this shelter for the past 4 months, and is finally receiving treatment for her disability.

ENDNOTES

- 1 Lam, J.A., Rosenheck, R. Street outreach for homeless persons with serious mental illness. *Medical Care* 37(9): 894-907. 1999
- 2 SAMHSA. Blueprint for Change: Ending Chronic Homelessness for Persons With Mental Illnesses and/or Co-Occurring Substance Use Disorders. 2003.
- 3 Proscio, Tony. "Supportive Housing and Its Impact on the Public Health Crisis of Homelessness," Corporation for Supportive Housing. 2000.

Goal 3: Ending Chronic Homelessness Through Supportive Housing

Housing “is at the core of one’s social and personal life, determining the kinds of influences and relationships one has and access to key opportunities and services (education, employment, healthcare).” -- Chester Hartmann, Executive Director, Poverty and Race Research Action Council

Any serious effort to end homelessness must address, front and center, the need for *permanent affordable housing*. Local experience throughout Santa Barbara County mirrors that of communities across the nation which have found that access to housing is an essential first step in helping people get off the streets and back on the road to self-sufficiency. The vital second step is linkage to a broad range of services and supports that help to foster ongoing residential stability and a sense of community belonging, thus preventing homelessness from re-occurring.

“*Housing First*” is an approach to ending homelessness that places a priority on helping people quickly attain permanent housing without imposing any requirements on accessing services or achieving sobriety. It recognizes that people are in a better position to address health, addiction, lack of education and job skills, and other issues that cause poverty and homelessness, once they have the stability of a safe and secure place to live. In addition, assisting individuals rapidly regain housing minimizes the physical and emotional damage caused by homelessness, facilitating their ability to recover. Even the most service needy populations - people who have been chronically homeless and have a disabling health, mental health or substance abuse disorder - have demonstrated significant gains in health, stability and quality of life, once they obtain permanent housing.

“Housing First” is proven in its effectiveness: an evaluation of New York City’s Pathways to Housing program, which places homeless people with mental illnesses and addictions directly from the streets into supportive housing, found that 88% of the program’s tenants remained housed after 5 years.¹

“Housing First” Working in California: The Skid Row Collaborative

The Skid Row Collaborative aims to provide 62 chronically homeless individuals with stable housing, mental health and substance abuse services, primary healthcare, and veterans’ services using an integrated multidisciplinary team and a housing first approach. It focuses on matching each individual with the type of permanent housing best suited to individual need: low demand Safe Haven, community enriched project-based, or scattered site housing. The project began in December 2003 to great success; 56 of the 67 participants enrolled in the program are actively receiving housing and

services, inter- and intra-agency systems have been improved to give participants direct access to services between partnering agencies, and many crises that could have led to loss of housing and a return to homelessness have been mitigated. (See Housing Appendix A).

Once in housing, residents are linked with the services and supports that they need and want, including case management, healthcare, mental health services, substance abuse treatment and relapse prevention support, benefits advocacy, vocational services, money management, and life skills. This type of integrated housing and services is known as *supportive housing*. It is designed to promote long-term residential stability by providing residents with the supports they need to maintain health and recovery, develop relationships and connections with the community, and realize maximum self-sufficiency. An additional benefit is that *supportive housing* is also associated with diminished use of costly public emergency services, such as homeless shelters, hospitals, and psych emergency wards, and involvement with the criminal justice system by its residents.

Permanent Supportive Housing is a cost-effective approach: a recent study documents a reduction in service use of \$16,281 per housing unit per year by homeless people with severe mental health disabilities who are placed in supportive housing.²

Recognizing the central importance of stable housing in its efforts to end homelessness, the Santa Barbara County-Wide Ten Year Plan seeks to both facilitate rapid re-housing for people who have been chronically homeless, and to foster long-term residential stability and community connection. Both objectives will be met by building on the significant base of effective programming that is already in place and that is under development in Santa Barbara County (See Housing Appendix B).

→ Rapid Re-Housing will be accomplished through the transformation of the existing Continuum of Care into a set of programs with the shared goal of ending chronic homelessness. *Basic housing assistance* (short-term housing with supportive services) will be developed for chronically homeless people to provide a place off the streets while facilitating rapid access to permanent housing. *Community Centers* and *Transitions Centers* will be created to provide assistance in accessing housing and services appropriate to people's needs. Over the next ten years, the cities, the County, and their partners will continue to construct, rehabilitate, acquire, and lease enough units to fully house Santa Barbara's chronically homeless population. Along with housing, chronically homeless people will be provided with services and treatment that transition over time based on client needs.

In addition, a concerted effort will be undertaken to expand the supply of affordable housing stock available to people who are chronically homeless or at-risk of repeat homelessness. This will involve maintaining the existing stock of affordable housing, including the 519 permanent supportive housing beds for single adults and the 80 beds for families (See Housing Appendix B). It will also involve creative use of existing housing stock and the development of new affordable housing through a variety of program models and configurations designed to meet the full spectrum of need throughout the County (See Housing Appendix C).

→ Long-Term Residential Stability & Community Connection will be fostered through the integration of services, treatment, and other community-based supports with housing. Residential stability will be a core goal for all agencies, homeless and mainstream, working with

chronically homeless people. In addition, all services and treatment will be provided with a “relationships first” philosophy that prioritizes the development of healthy relationships by and with clients, and which promotes client engagement in activities that enhance their connections and sense of belonging to the community.

Building on Community Strengths...

- In Santa Barbara County, there are currently 89 permanent housing units dedicated for housing chronically homeless individuals.
- In 2005, 77% of people housed in transitional housing in Santa Barbara County moved into permanent housing.
- In Santa Barbara County, there are currently XX units of permanent housing under development. (See Housing Appendix B).

Ultimate Objective:

As a result of this work, in ten years the quality of life for all county residents will be enhanced as one hundred percent of Santa Barbara County’s chronically homeless population will be housed in permanent supportive housing.

- 500 beds in housing units or shared/individual sleeping rooms in permanent housing will be added in the first 3 years.
- 750 (low end)-1200 (high end) total beds in housing units or shared/individual sleeping rooms in permanent housing will be added over the next 10 years.

The number of beds that must be secured reflects the needs of the chronically homeless population in Santa Barbara. The availability of housing to be secured for our clients will drive the success of this entire effort, and dictate the number of people who can be assisted to end their homelessness. Existing need, based on best-available anecdotal data from enumeration and the Report on Homelessness Services in the County of Santa Barbara is:

Chart 3-1: Projected # of Chronically Homeless Single Individuals and Individuals in Families Achieving Stability in Permanent Housing (Cumulative)

Year	South County Coast (60%)				Santa Maria (25%)	Lompoc (15%)	Total
	City of Santa Barbara (35%)	Unincorporated South Santa Barbara County/Isla Vista (10%)	Goleta (10%)	Carpinteria (5%)			
2007	21	6	6	3	15	9	60
2010	175	50	50	25	125	75	500
2013	263	75	75	37	188	113	750
2016	420	120	120	60	300	180	1200

*This will be updated bi-annually based upon enumeration process involving community representatives.

**Bed space will be secured in units where funding is available and community infrastructure exists. Work will be done by agencies now working in the community.

Strategies/Action Steps

Strategy 3.1: Provide Housing Units

Move chronically homeless people into housing that suits their needs and abilities.

Action Step 3.1.1. Construct, acquire, rehabilitate, or lease a combination of housing units and shared/individual sleeping rooms in permanent housing that will accommodate 60 beds for chronically homeless individuals and families in the first year of this Plan.

In creating housing opportunity, consider:

- Dedicated Section 8 vouchers for this population.
- Utilizing single-family houses that can accommodate 6-8 roommates.
- Supporting the development of scattered site and small-scale units, as well as any units needed for chronically homeless families with up to 8 children.
- Debt-free housing, or putting funding streams together to accommodate debt and use of tax credits.
- Master-leasing existing units as a transitional strategy that does not add to the existing stock of affordable housing, and is only available as long as private landlord is willing to lease.

Action Step 3.1.2. Through attention to architecture, creative use of space, and program design, foster the development of naturally occurring community among tenants and program participants. Establish tool kit of methods by which this can take place; develop design parameters or training materials and deliver to appropriate agency leadership.

Strategy 3.2: Connect Housing to Services and Treatment

Coordinate, integrate, and link the delivery of services and treatment with the provision of housing. (See Goal 2 for Integrated Services Teams who will do this work)

Action Step 3.2.1. Provide Housing First for chronically homeless people. This means providing housing without conditions concerning receipt of services or treatment, which will be continuously offered.

Action Step 3.2.2. Provide access to services, treatment, or other supports as needed, at the level needed, to chronically homeless people placed into housing.

Action Step 3.2.3. Establish a security deposit and utilities assistance program.

Action Step 3.2.4. Establish several community warehouses where furniture and furnishings can be donated for chronically homeless people to obtain for free to create their new homes when they move inside.

Strategy 3.3: Provide Basic Housing Assistance

Basic Housing Assistance will be made available through the Outreach Teams to chronically homeless people.

Action Step 3.3.1. Provide, as part of the system of human services in the community, Basic Housing Assistance (service enriched shelter) opportunity. Basic housing assistance is immediate and short-term (3-30 days) while housing applications are being processed.

Action Step 3.3.2. Continuously have 50 spaces available in these programs for people who are chronically homeless. Basic Housing Assistance will encompass the sleeping units available on site at the Community Centers (see Action Step 2.5.2) and Transitions Centers (see Action Step 1.2.2), motel vouchers or dedicated motel rooms, dedicated beds at emergency shelters, dedicated Section 8 rental subsidies, master leased units, or community based organization's owned/operated housing units.

Strategy 3.4: Foster Residential Stability.

Retain existing housing for chronically homeless people, once placed into housing. (See Strategy 1.3)

Action Step 3.4.1. Provide liaison, mediation, and asset management assistance, as well as a damages/repair fund, to sustain availability of housing stock for chronically homeless people.

- Support landlord training and education, inclusive of civil rights requirements. "Provide value and security to property owners."
- Support 24/7 intervention with tenant when landlord or neighbors call with issues.
- Create a reserve fund that accommodates the expected higher level of wear/tear and turnover with this tenant group.

Action Step 3.4.2. Provide tenancy training and support to relearn what it means to be part of the whole community. This may include basic living skills and social skills, and development of self-esteem and self-worth.

Action Step 3.4.3. Provide continuity of housing, support and care to sustain relationships and community connections through relapses and crises.

Action Step 3.4.4. Where suitable, an on-site case worker may assist in access to supportive services (including accessing employment and mainstream benefits) and treatment.

Strategy 3.5: Model of Care

Create collaboration among agencies providing housing to chronically homeless persons to share model of care. (See Strategy 2.1).

Action Step 3.5.1. Through leadership and training, work with agencies and staff to foster permanent housing residential stability as a common goal and the primary desired outcome of all housing, services, and programs working with chronically homeless people. Develop a training curriculum to support this effort.

Action Step 3.5.2. Services and treatment coordinated with housing provision will operate under this Plan with a “relationships first” philosophy.

- Building healthy relationships with people who have experienced chronic homelessness is the fundamental key to lasting success.
- Supporting people to people linkages, a sense of being at home and belonging to a community, and the ability to engage in healthy relationships is an emerging model that will be documented through work under this Plan.

Strategy 3.6: Systems Change.

Change the regulatory environment and resource pool to accommodate the immediate creation of more housing for chronically homeless people.

Action Step 3.6.1. Advocate for changes in local planning and zoning regulations to streamline the process of providing units for this population. An outreach effort should take place with the Planning Commissions and their staff concerning chronic homelessness and the kinds of housing needed to implement this plan.

Action Step 3.6.2. Encourage developers to use the incentives for developing affordable housing with supports for this population.

Action Step 3.6.3. Partner with the local housing trust fund to support the housing needs of this population.

Strategy 3.7: Systems Change.

Engage in State and federal advocacy to support housing strategies.

Action Step 3.7.1. Support the local Continuum of Care in obtaining McKinney Vento funds for new and renewal projects serving homeless people.

Action Step 3.7.2. Create an advocacy team to lobby Congress to increase funding for the Section 8 Housing Choice Voucher program.

Action Step 3.7.3. Advocate at the state level for MHSA funds for programs that will serve severely mentally ill chronically homeless people.

Action Step 3.7.4. Advocate for the adoption of strategies and action steps in California's 10 Year Plan to End Chronic Homelessness that will support our Plan, particularly strategies and action steps that will lead to increased funding for permanent supportive housing.

VIDA NUEVA PERMANENT SUPPORTIVE HOUSING

Contact: Jeannette Candau

The Governor's Homeless Initiative provides funding for permanent supportive housing for chronically homeless people with severe mental illnesses. Vida Nueva for Adults and Older Adults will take advantage of this funding to house and offer supportive services to the mentally ill population in Lompoc. Vida Nueva will serve 120 adults and 5 older adults with severe mental illness in need of housing. Nineteen units in the newly constructed apartment building will be devoted to transitioning mental health clients. Vida Nueva is the first Assertive Community Treatment (ACT) program in Lompoc and its in-house staff will include 10 mental health professionals working 7 days a week. Vida Nueva will provide housing assistance, supported employment and education, vocational skills enhancement, medication support, counseling support, peer support, and social skills development. (See Housing Appendix A).

GOOD SAMARITAN SHELTER, Inc.

Contact: Sylvia Barnard

Good Samaritan's Shelter, Inc. (GSSI) originally started in January 1988 out of a need to have a single shelter (as opposed to multiple churches offering a rotating system of shelters in the area) to provide wrap-around services for the homeless population. In December 2004, the Homeless Shelter Campus began operating with the goal of diminishing the number of homeless individuals and families living on the streets. The Homeless Shelter Campus offers several housing options including emergency shelter housing, transitional housing, and detox beds. One of the most unique facets of the Homeless Shelter Campus is the large number of partnerships it has with other agencies. These partnerships allow the program to offer homeless people an on-site supportive services model, and various options for those people not admitted into the Campus for reasons such as alcoholism or drug abuse. (See Housing Appendix A).

Teri first arrived at Good Samaritan Services through the homeless shelter in January 2003. She was 2 months pregnant and alone. Teri moved to the women's clean and sober home in Tanglewood, until November 2003, when she moved to the T.C. House where she gave birth to a healthy baby boy. She stayed there for 6 months until the Family Transitional Shelter opened in April 2004, at which time Teri moved in, sharing a room with another single mother and her child. Teri began working closely with the case manager and developed a plan to attend Allan Hancock College, where her son attends the child center on site. In June 2005 Teri attained permanent housing and moved into her own apartment. Teri will be graduating Allan Hancock College in June 2007, with plans to continue on to a University to become a therapist.

THE SAFE PARKING PROGRAM

New Beginnings Counseling Center
Contact: Shaw Talley

The Safe Parking Program provides safe nightly parking without a time limit for clients that have both proof of insurance and a valid driver's license. The program offers clients relief from the concerns associated with living on the streets, while also connecting them with services so that they can find permanent housing and/or employment. The program currently serves 28 participants in ten locations provided by local churches and non-profit agencies.

After spending her childhood suffering through difficult family problems, Jackie came to the Safe Parking Program with only an old truck to her name. The Safe Parking Program offered her the kind of support system that had been absent from her life for so long. Jackie spent a number of years living out of her truck in the Safe Parking Program, while also working tough hours as a security guard. The program's case manager helped Jackie move towards finding affordable housing. The program also gave her a loan to help fix her vehicle. Jackie currently lives in a mobile home that she shares with another man for \$200 per month. Although she misses the freedom of living out of her truck, Jackie is forever grateful to the Safe Parking Program for offering her the chance to be part of a community. She no longer lives with the stigma of being homeless!

EL CARILLO PERMANENT HOUSING Santa Barbara City Housing Authority Contact: Rob Pearson

El Carrillo was designed to offer low-income residents the opportunity to move from homelessness and transitional housing situations to permanent stable housing. El Carrillo was born out of the recognized need for a collaborative relationship between the City of Santa Barbara Housing Authority and local service providers. Expected to be completed in August 2006, El Carrillo will provide 61 units of clean, safe housing to very low-income, single individuals, many of whom are presently homeless. Selection preferences will be given to those individuals who are disabled or who have graduated from a transitional housing program. Support Services will be provided by Work Training Program and will include mental health counseling, job placement assistance, employment training, health screenings, and financial and budgetary counseling. (See Housing Appendix A and Increasing Incomes Appendix A).

Endnotes

- 1 Tsemberis, S. and Eisenberg, R. "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities". *Psychiatric Services*, pp.487-492, April 2000.
2. Culhane, Dennis P., Metraux, Stephen and Hadley, Trevor. Public Service Reductions Associated With Placement of Homeless Persons With Severe Mental Illness in Supportive Housing. *Housing Policy Debate* Vol 13, Issue 1, pp 107-163. Fannie Mae Foundation. 2002.

Goal 4: Ending Chronic Homelessness by Increasing Incomes to Sustain Housing and Reach Self-Sufficiency

"I was homeless, helpless and toothless... They provided me with housing and supported employment until I could find my own. They helped me until I could help myself... I have a mission again. I look forward to going to work each day. I wake up with gratitude for a roof over my head. I have friends... I am starting to see the positives in life instead of the negatives" -- Dave Schwing, quoted in *Anchorage Free Press*, "From Hopeless to Hopeful" Vol.6 Ed. 35 , Sept. 4 -11, 1997

While the provision of housing is essential to ending homelessness, long term housing stability depends on access to a stable income stream that is adequate to cover the costs of housing and basic necessities, and which allows for the accumulation of savings as a cushion against unexpected emergencies. In Santa Barbara County, the combination of high housing and land costs, and an economy made up of a significant percentage of low wage jobs in the service and agricultural sectors, results in a serious gap between housing costs and wage levels. This gap puts many people at risk of homelessness, especially those who struggle with health, mental health, and addiction disorders.

Given the employment opportunities available in the County, accessing employment that pays a housing wage is difficult. It is even more difficult for homeless people who often face additional barriers, including stigma due to their homelessness, history of mental health or substance abuse disorders, limited or non-existent employment history, limited education and job skills, lack of transportation, and difficulties working mainstream employment without additional support.

The "Housing Wage" in Santa Barbara County, the hourly wage needed to afford housing if working 40 hours/week, is \$19.94 for a two-bedroom apartment. This is 295% of the minimum wage and 147% of the average wage of renters in the County.¹ in

Addressing the need for employment that will allow people to achieve housing stability requires a variety of different strategies, some focused on improving the employment skills of homeless people, and others focused on developing additional employment and training opportunities. It also requires significant collaboration between the public, private, and nonprofit sectors. Customized employment is an effective model which involves individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs, and interests of the person with a disability, while simultaneously employing strategies designed to meet the requirements of the employer. Examples of customized employment approaches include: supported employment; supported entrepreneurship; individualized job development; job carving and restructuring; use of personal agents (including individuals with disabilities and family members); development of micro-boards, micro-enterprises, cooperatives and small businesses; and use of personal budgets and other forms of individualized funding that provide choice and control to the person and promote self-determination.

Customized Employment Working in California: Hope House, San Francisco

Under the leadership of the Private Industry Council of San Francisco, Inc., this “vocalized housing” program provides housing, case management, and employment program services to chronically homeless people. This effort seeks to better combine and coordinate the multiple services and agencies that deliver vocalized housing in an effort to improve both the involvement of the area’s workforce development system, including the area One Stop Career Centers, and the employment options for the chronically homeless. Participants receive: career counseling and assessment, assistance with developing a resume and preparing for interviews, access to computers, internet, and other office equipment, job search assistance, job coaching, and employment follow-up. In 2006, 90% of clients were engaged in work-related activities or employed within 12 months of move in. (See Increasing Incomes Appendix A)

Also important are strategies aimed at enhancing access to benefit programs by those who are eligible, including Food Stamps, SSI/SSP, Veterans Benefits, and General Relief. Though many homeless people suffering from health, mental health, and addiction disorders are eligible for benefits, too often they do not receive them due to lack of identification and other documentation, inability to complete the application and follow through with necessary appointments, and lack of assistance and understanding by benefits program eligibility workers.

Over half (56%) of homeless people exiting HUD SHP-funded programs in Santa Barbara in 2005 had no source of income.

Enhancing homeless people’s access to these entitlement programs can be accomplished through changes in service provision to better accommodate the special needs of homeless people, and through specialized staffing in homeless programs to provide individualized assistance to homeless people to help them through the application process.

In order to address the need for stable income streams to sustain housing and allow self-sufficiency, the Santa Barbara County-Wide Ten Year Plan focuses on enhancing access to employment for chronically homeless people, supporting their success at employment, and enhancing access to benefits by those who are eligible.

→ Enhanced Access to Employment will be accomplished by linking housing with employment services, increasing access to mainstream employment services, development of targeted training and work opportunities through public and nonprofit service agencies and private businesses, and development of micro-enterprises.

→ Supporting Success at Employment for chronically homeless people will be accomplished by linking support services to employment, including child care, transportation, mentors, and people skills workshops, and by facilitating customized adaptations of employment to accommodate employee needs.

→ Enhanced Access to Benefits by chronically homeless people will be achieved through outstationing of Certification Application Assistors at key locations, including Certification

Application Assistors on the Outreach and Integrated Service Teams, inter-agency collaboration to document diagnoses, developing procedures to allow presumptive eligibility and streamlined approvals, and the development of a local income subsidy to help chronically homeless people retain their housing.

Building on Community Strengths...

Santa Barbara already has a number of strong employment assistance programs targeted at serving chronically homeless and homeless individuals including:

- The Salvation Army operates a Job Club to assist homeless persons develop resumes, prepare applications for employment, and practice interview skills. This program also helps with job placement, career planning, and vocational training.
- Good Samaritan operates an employment opportunity service and casual labor registry for homeless persons in Santa Maria.

Additionally, the County Department of Social Services has homeless outreach workers who visit shelters, encampments, and other locations to enroll homeless persons in income support programs including GR, THA, CalWORKS, Supplemental Security Income, Social Security, and other programs. (See Increasing Incomes Appendix C)

Ultimate Objectives

As a result of this work, in ten years the quality of life for all county residents will be enhanced as:

- 100% of chronically homeless individuals who are able to work will be employed.
- 100% of the chronically homeless individuals who obtain work will continue to receive support for their employment, including having an individual service plan, and will be able to retain employment after 6 months.
- 100% of chronically homeless individuals who qualify will receive benefits.
- The incomes of chronically homeless individuals in Santa Barbara will increase by 50%.

Chart 4-1: Estimated Number of Chronically Homeless Single Individuals and Individuals in Families to Receive Employment Assistance (Cumulative)

Year	South County Coast (60%)				Santa Maria (25%)	Lompoc (15%)	Total
	City of Santa Barbara (35%)	Unincorporated South Santa Barbara County/Isla Vista (10%)	Goleta (10%)	Carpinteria (5%)			
2007	11	3	3	1	8	4	30
2010	88	25	25	12	63	37	250
2013	114	33	32	16	81	49	325
2016	210	60	60	30	150	90	600

Chart 4-2: Estimated Number of Chronically Homeless Single Individuals and Individuals in Families to Receive Benefits for Which They Qualify (Cumulative)

Year	South County Coast (60%)				Santa Maria (25%)	Lompoc (15%)	Total
	City of Santa Barbara (35%)	Unincorporated South Santa Barbara County/Isla Vista (10%)	Goleta (10%)	Carpinteria (5%)			
2007	70	20	20	10	50	30	200
2010	252	72	72	36	180	108	720
2013	336	96	96	48	240	144	960
2016	420	120	120	60	300	180	1200

Strategies/Action Steps

Strategy 4.1: Access Mainstream Benefits.

Increase immediate benefits access for chronically homeless people in all programs for which they are eligible.

Action Step 4.1.1. Outstation Certification Application Assistors (CAA) at clinics, hospitals, Community Centers, homeless programs, and other locations with a significant number of chronically homeless people. Include an eligibility worker as a member of all Outreach and Integrated Services Teams. {Look at Santa Cruz inclusion of a worker on the Health Care for the Homeless Team, half of the costs being repaid by Medi-Cal.}

Action Step 4.1.2. Provide fast track or hot desk at mainstream agencies. Expand outstationing of benefit program staff to additional locations including a mobile benefits team. In year 1, benefits applications will be processed in 30 days; by year 3, benefits applications will be processed in 15 days.

Action Step 4.1.3. Mainstream agencies empower staff throughout chronic homeless programs to complete applications for determining eligibility.

Action Step 4.1.4. Provide identification and records needed to support applications.

Action Step 4.1.5. Create a volunteer benefits ombudsman effort, with appointed advocates.

Action Step 4.1.6. Explore the CalWIN Uniform Benefits Application for County, State, and federal benefits use in the field with chronically homeless people in interactive interviews. Determine the suitability of 1-e.app or an application that will achieve the same results and is affordable for the County.

Action Step 4.1.7. Facilitate inter-agency collaboration in assisting people to access benefits – cross train homeless program and benefits program staff and promote interagency collaboration in documentation of diagnoses and assessments. Train staff to help clients maintain benefits once they are obtained.

Action Step 4.1.8. Work with the Santa Barbara County Board of Supervisors to adopt a presumptive eligibility policy for County-funded benefit programs. Advocate to State and federal agencies to adopt a presumptive eligibility policy for county-administered benefit programs.

Action Step 4.1.9. Take specific action targeted to 100% SSI/SSDI enrollment for chronically homeless people for whom eligibility can be established.

Action Step 4.1.10. Take specific action targeted to 100% Food Stamps enrollment for chronically homeless people for whom eligibility can be established.

Action Step 4.1.11. Take specific action targeted to 100% Dept of Veterans Affairs benefits and assistance enrollment for chronically homeless people for whom eligibility can be established.

Action Step 4.1.12. Take specific action targeted to 100% educational enrollment for those chronically homeless people for whom eligibility can be established, and financial assistance for education and employment.

Action Step 4.1.13. Develop and locally fund an income subsidy for chronically homeless people that supports housing access and retention.

Action Step 4.1.14. Utilize any available mainstream discretionary funding sources for homeless housing and services.

- Utilize TANF funds to administer holistic assessments of TANF clients.
- Utilize TANF funds to provide housing vouchers and rental assistance.

Strategy 4.2: Assess Assets.

Conduct assessments that include past work history, educational background, and social and skills assessments every 6 months. Include attention to supports that exist for employment and expectations that run counter to holding a job.

Action Step 4.2.1. Assessments should begin at the first encounter with the Outreach Teams and continue with Integrated Services Teams.

Action Step 4.2.2. Use assessments to determine what level of training and supports job seekers will need.

Strategy 4.3: Provide Jobs.

Provide employment after stabilizing housing that will support ability to sustain the job attained.

Action Step 4.3.1. Take a Work Fast “standing offer of work” approach that mirrors the “readiness not required” Housing First model of care.

Action Step 4.3.2. Link housing with job assessments and development programs through the Outreach and Integrated Services Teams (see Goal 2).

Action Step 4.3.3. Have a services plan wrapped around the job from the outset; everyone with a job will have a service plan. Integrate social services with employment using a holistic approach. Use workshops, after hours evening programs, peer work, and volunteer efforts.

Strategy 4.4: Foster Volunteerism.

Develop community service and insular job volunteer opportunity as part of social work/service agencies (not limited to homeless programs).

Action 4.4.1. Create time-limited volunteer positions that include a graduation certificate and internships at minimum wage; allow a relationship to develop that fosters self-worth and identity beyond the experience of homelessness.

Action 4.4.2. Support added agency costs of volunteer coordination and supervision as needed.

Strategy 4.5: Support Employment.

Provide a spectrum of support for employment. Supported employment is integrated, choice driven, flexible, not contingent on treatment, and is not time limited.

Action Step 4.5.1. Include pre-employment, volunteer opportunities, training, job placement, direct job task training or adapting, and continuity of employment services.

Action Step 4.5.2. Support employees. Address their needs for childcare and transportation. Provide mentors to help them deal with job challenges and any stigma resulting from their homeless status.

Strategy 4.6: Utilize Existing Resources.

Access all available employment programs, including those available through the Department of Rehabilitation.

Action Step 4.6.1. Adapt mainstream programs, including the Workforce Resource Center, to more effectively serve homeless people including changing its performance measures to allow it to provide additional services and time to this population.

Action Step 4.6.2. Utilize Disability Program Navigators through the Department of Rehabilitation to assist chronically homeless clients with disabilities to learn to use assistive technology, obtain reasonable accommodations in the workplace, and facilitate their entrance back into the workforce. Advocate for more funding for the program.

Action Step 4.6.3. Link to the Senior Community Employment program for re-entry to workforce stipend opportunity for chronically homeless people.

Action Step 4.6.4. Support flexibility within mainstream employment programs to accommodate this population.

Action Step 4.6.5. Support a job developer to work with this group, customizing employment to the individual. This position may be a portion of an existing position in each geographic area where chronically homeless people are concentrated.

Action Step 4.6.6. Support an employment specialist to help develop resumes and other aspects of preparation for employment and support once employed. This position may be a portion of an existing position in each geographic area where chronically homeless people are concentrated.

Action Step 4.6.7. Reduce barriers to access to all employment programs for this population.

Strategy 4.7: Tailor Work to Client.

Develop targeted sector job opportunity and support with tailored training programs.

Action Step 4.7.1. Identify businesses with niche needs suitable to the skills of clients, such as landscape maintenance, food service, tile setting, building maintenance services, linen service, automotive mechanics, computer lab, agriculture, hospitality, sanitation, and construction. Conduct outreach to encourage the hiring of chronically homeless people.

Action Step 4.7.2. Work with unions, nonprofits, and government agencies to develop job opportunities for clients, such as peer advocates, the Transitions Mental Health Garden Project, the Conservation Corps, and the Housing Authority resident employment program. Access the Federal Home Loan Bank grant opportunity {now being considered for a job link program at the El Carrillo through the Housing Authority application}. Secure

commitments from government agencies to prioritize the hiring of chronically homeless people.

Action Step 4.7.3. All agencies seeking to assist chronically homeless people to get jobs should have access to a database that describes each chronically homeless person's skills.

Action Step 4.7.4. Support employers through "industrial relations staff;" attend to the real and perceived extra burden of engaging this population, such as Worker's Comp costs.

Action Step 4.7.5. Training programs will include people skills needed for interpersonal relationships and appropriate responses to authority. Provide job coaches and mentors.

Strategy 4.8: *Create Jobs.*

Support the development of Social Enterprise.

Action Step 4.8.1. Look at the DC Kitchen, Rubicon Enterprises Inc. (Contra Costa County, California), Pioneer Human Services (Seattle, Washington), Good Samaritan, ARC, Salvation Army, Catholic Charities and Delancy Street (San Francisco, California) as examples of volunteer, job training, and paid employment within activity run by a CBO. Consider a Ben & Jerry's franchise (Larkin Street, San Francisco, California).

- Consider "Ag Programs for Recovery from Chronic Homelessness" agriculture or connecting with land focus, like the Lompoc recovery farm, and Transitions Mental Health in Santa Maria, Casa Maria Healing Grounds.
- Consider the "community kitchen" model linked to housing, like Bethel House, ILP and Good Samaritan.

Strategy 4.9: *Support Systems Change.*

Engage in State and federal advocacy to support increasing income strategies.

Action Step 4.9.1. Support efforts to increase the state and federal minimum wage.

Action Step 4.9.2. Convey to local jurisdictions the benefits in cost savings and community improvements of enacting "hire homeless first" policies.

Action Step 4.9.3. Advocate for reducing the eligibility requirements for food stamps.

Action Step 4.9.4. Advocate for changes to the SSI eligibility process including eliminating the practice of rejecting an applicant's first application for benefits.

Action Step 4.9.5. Advocate for the adoption of strategies and action steps in California's 10 Year Plan to End Chronic Homelessness that will support our Plan, particularly strategies and action steps that will lead to increased incomes for chronically homeless individuals.

WORK TRAINING PROGRAM

Contact: Jennifer Newbold

The Work Training Program (WTP) was started to “provide independent living and employment services to people with disabilities or disadvantages that enable them to live and work as productive members of their community.” Started in 1964, and later expanded in 1980 to also target the mentally ill, WTP works with people with developmental and physical disabilities, mental illness, and seniors who are homeless. WTP offers a variety of employment and living services to help clients assimilate into community living. WTP will provide services at the El Carrillo project (scheduled to be completed in Fall 2006) including medical support, life skills education, support around co-occurring disorders, and employment support. All residents of El Carrillo will be able to access services through WTP, however, only the 18 individuals in units funded by Shelter Plus Care grants will be required to obtain services. (See Increasing Incomes Appendix A).

ENDNOTES

1 National Low Income Housing Council, “Out of Reach,” 2005

Goal 5: Financing a Comprehensive System of Housing, Services and Treatment

The Santa Barbara Countywide Ten Year Plan is a proactive effort to truly bring about the end of chronic homelessness in ten years by helping chronically homeless individuals back into housing and providing them with the supports they need to maintain it, and by preventing new cases of chronic homelessness from occurring. As such, it will require aggressive and creative efforts to identify the financing necessary to carry out the plan. Current funding for Santa Barbara’s homeless housing and services comes from the following sources:

Funding Type	Examples
1. Public funding targeted for homelessness	<ul style="list-style-type: none"> • Federal Level: HUD homeless assistance programs, Health Care for the Homeless, VA Homeless Housing programs • State Level: Housing and Emergency Trust Fund Act of 2002, Services for Homeless Adults with Serious Mental Illness, EDD’s program for homeless veterans
2. Mainstream Public funding – not targeted specifically for homelessness	<ul style="list-style-type: none"> • Federal Level: SSI/SSDI, TANF, Medi-Cal, Food Stamps, Veterans Healthcare, Community Development Block Grant (CDBG) and HUD’s housing development programs, including HOME Investment Partnership, HOPWA, and Supportive Housing for People with Disabilities • State Level: Mental Health Services Act • Local Level: GR, redevelopment funds
3. Private Funding	<ul style="list-style-type: none"> • Foundation grants, corporate donations, and faith based giving

In order to finance the comprehensive system of housing, services, and treatment needed to end homelessness, the Santa Barbara County-wide Ten Year Plan lays out the following strategies:

→ Generate an Annual Finance Plan that identifies the annual costs of each of the Plan’s strategies and identifies potential funding sources.

→ Expansion of Funding, both through enhancement of existing funding streams and development of new funding sources. This will include exploration of strategies to recapture savings by mainstream agencies due to implementation of Plan strategies, a concerted effort to tap all federal, State and local government and private resources, development of a voluntary giving campaign, imposition of new fees and taxes, and creation of a local housing subsidy fund.

→ Analysis of Current Service Provision and Spending to identify strategies for increasing efficient use of resources through greater collaboration in program development, operation and fundraising, and establishing ending chronic homelessness as a priority activity for all public and nonprofit service agencies in the County.

Ultimate Objectives

As a result of this work, in ten years the quality of life for all county residents will be enhanced as:

- The plan is fully financed at each step of its roll-out and chronically homeless people are assisted at the levels needed.
- Institutions of custodial care have a cost savings from reduced expenditures on chronically homeless people when the housing-services-treatment nexus is in place for this population.

Strategies/Action Steps

Strategy 5.1: Create Fiscal Management Tools.

Generate an Annual Finance Plan and appropriate Budget to support “The Campaign to End Chronic Homelessness.”

Action Step 5.1.1. Outline the direct costs incurred and potential funding sources to meet each of the strategies of this Plan on an annual basis. This Finance Plan will guide all participating agencies in seeking resources, and will serve as a report-out framework on the success of the fund development efforts.

Action Step 5.1.2. Target the Finance Plan sources at 50% government resources, 25 % corporate/business, and 25% philanthropy/individual giving.

Action Step 5.1.3. The Finance Plan can include contributed resources including volunteer time (to be valued following the HUD rules for CoC leverage submission), increased client resources secured through Plan implementation efforts, community-based and faith-based agency resources supporting implementation activity, and direct cash contributions to underwrite Plan costs.

Action Step 5.1.4. Develop a budget for each component of Plan implementation. In Year 1-3, budget for the Chronic Homeless Campaign Coordinator, and estimate the costs/sources of funds for strategies and action steps. Include contributed sources, existing resources, and % of positions. This document should respond to the inquiry “What is it going to Cost?”

Strategy 5.2: Establish Financial Analysis Methods.

Establish a mechanism to track expenditures on chronic homelessness, noting sources and uses by agency, program, and activity.

Action Step 5.2.1. Capture spending data from all public and private sources, looking for leverage points to redirect resources for effective Plan implementation.

Action Step 5.2.2. Inventory funding, especially discretionary funding and private funds: What do we have now? What do we spend? What resources can we capture and target to alternate use? Aim to present in the Plan: What do we need? What do we have? Where will the resources come from?

Action Step 5.2.3. Review materials on Financing a Comprehensive System of Care found in *Blueprint for Change, Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders*, www.samhsa.gov (and additional supplementary materials provided to Roger at May meeting).

Strategy 5.3: Demonstrate Cost Effective Efforts.

Foster effective spending and recapture savings for spending on the response to chronic homelessness.

Action Step 5.3.1. Increased effectiveness and savings will be realized through coordinated effort. No agency working with chronically homeless people should work alone; all should be part of a network of response. Forge this network, centered on activity with clients.

Action Step 5.3.2. Explore viability of HMIS to support coordinated efforts, including billing and on-line progress notes.

Action Step 5.3.3. Look at data and financial systems partnerships with community-based organizations, business and government -- cooperating to create an infrastructure in which all participate.

Action Step 5.3.4. Consider a government-wide resolution to make “The Campaign to End Chronic Homelessness” a priority activity across all departments that should be reflected in budget requests. Establish a “comprehensive homeless response” budget that includes a strong focus on chronic homelessness. These government resources can be reflected in the Annual Finance Plan.

Action Step 5.3.5. Identify leverage points, and how to recapture spending from hospitals, jails, and mental health. Seek up to 50% of the funds saved, or costs no longer incurred, to be re-directed to homeless work. Develop MOU’s to direct transfer.

- Institute among hospitals, the sheriff, the police, and others a cost-sharing plan to support the delivery of housing-services-treatment at transition.
- This cost-sharing plan can include a shift in role for different agencies (for example, law enforcement provides an outreach team member from community affairs; hospital

provides a nurse or health care worker for the outreach team, or creates the Community Center on-site at the hospital).

Action Step 5.3.6. Track cost-savings that result from implementing the new housing-services-treatment nexus called for elsewhere in this Plan. Use data to document success, and convey results once/twice a year to “investors” (businesses, the public, government, nonprofit, and faith-based agencies).

Strategy 5.4: Secure Resource from all Sources.

Tap all federal/national, State, and local government and private (corporate, business, philanthropic, and individual) resources.

Action Step 5.4.1. Identify resource opportunities systematically, both homeless targeted and mainstream, pertinent to carrying out the strategies in this Plan. The information could be put into a calendar of what is due/when and what the requirements are for submission.

Action Step 5.4.2. On behalf of “The Campaign to End Chronic Homelessness,” applications shall be submitted for every possible funding opportunity for housing, treatment, and support services that would implement the strategies of this Plan. Administrative costs, matching funds, and required leverage shall be identified to support said applications.

Action Step 5.4.3. Cooperatively engage community- and faith-based organizations for program design work targeted to funding opportunities well in advance of submission deadlines. Convene organizations to develop program designs that fit resource opportunities, as well as to inform the design of RFP’s and other funding disbursement mechanisms.

Action Step 5.4.4. Advocate on behalf of the potential new funding for permanent supportive housing and affordable housing at all opportunities, particularly through the Governor’s Chronic Homeless Initiative and the Affordable Housing Bond.

Action Step 5.4.5. Form a partnership with the Downtown Organization, Chamber of Commerce, Kiwanis and other service clubs to engage in supporting Plan implementation and resource contributions.

Action Step 5.4.6. Add a donation icon to every webpage of the Campaign’s website to ease access to electronic contributions.

Strategy 5.5: Partner with Philanthropy.

Engage philanthropy leadership and donors to support Plan implementation.

Action Step 5.5.1. Create pooled funding to underwrite Plan implementation. Review materials “Ending Bay Area Homelessness: The Philanthropic Role” at <http://www.homelessphilanthropy.org/index.php/articles/downloads/100>

Action Step 5.5.2. Increase current foundation payout rates, contributing the net increased amount of resources so generated to “The Campaign to End Chronic Homelessness.”

Action Step 5.5.3. Invest in efforts to generate new funding streams and permanent sources of funding for Plan implementation activity. Consider developing or supporting the development of:

- A voluntary giving campaign, which can include direct cash contributions, underwriting the costs of a housing unit, adopting a program, and a rent/deposit/repairs fund.
- A new fee or add on contribution to regular payments; best idea will have connection to the housing-treatment-services nexus that is at the core of this Plan (alcohol surcharge or developer fee are in lieu of fees ideas raised by committee).
- A gap subsidy fund to pay the difference between client’s income and private market rental costs.

Action Step 5.5.4. Support approaching estate planners for inclusion of “The Campaign” in gifting efforts of buildings, land, and other valuable items that can be converted to use for implementing Plan Strategies.

Strategy 5.6: *Be Resourceful.*

Identify resources and action that could reduce Plan implementation costs in each of the County’s geographic areas most impacted by chronic homelessness.

Action Step 5.6.1. Inventory government owned land, FBO and CBO space that can be adapted for chronic homeless housing space.

Action Step 5.6.2. Use HUD, SHP, CDBG, HOME, and Redevelopment Agency funds to support housing development for this population.

Action Step 5.6.3. Discern locations for developing housing and Centers that will be cost-effective.

Action Step 5.6.4. Locate buildings that can be creatively reused to meet the needs of this Plan’s strategies. Seek seized and forfeited properties, such as the houses used for meth manufacture that the sheriff seizes.

Strategy 5.7: *Support Systems Change.*

Engage in State and federal advocacy to support funding for housing, services, and treatment for chronically homeless individuals.

Action Step 5.7.1. Utilize McKinney Vento funding to implement the Plan.

Action Step 5.7.2. Tap State and federal resources to implement housing, services, treatment, income, and engagement goals.

Action Step 5.7.3. Re-allocate existing resources.

Action Step 5.7.4. Advocate for the adoption of strategies and action steps in California's 10 Year Plan to End Chronic Homelessness that will support our Plan, particularly strategies and action steps that will lead to increased financing for permanent supportive housing, services, and treatment.

CASA ESPERANZA

Contact: Mike Foley

In 1999, Santa Barbara City and County were informed that the Winter Homeless Shelter would not be available that winter due to seismic retrofitting. As a result, a broad base of community members – religious, business, government, and civic leaders –formed the Coalition to Provide Shelter and Support to Santa Barbara Homeless. The Coalition raised money to acquire a large old furniture warehouse and then worked with the community to renovate the building in a way that met the needs of Santa Barbara's homeless population and the community. The building was opened in December 1999, but continued to be renovated and improved. By 2002, a second story had been added that housed social service providers. The Coalition raised 3.9 million dollars through its capital campaign, and raised an additional 2.1 million dollars from the Redevelopment Agency of Santa Barbara and Santa Barbara County. (See Financing Appendix A).

Goal 6: Plan Administration, Coordination and Implementation

In order to ensure effective administration, coordination and implementation of the Santa Barbara County-wide Ten Year Plan, the Oversight and Implementation Committee outlined the following strategies to ensure that proper staffing, structures and mandates are in place:

- Staffing: A full time Chronic Homeless Campaign Coordinator staff position will be established to oversee all aspects of plan implementation and to coordinate the staffing that will carry out the Plan and the committee structures that will provide oversight. In addition, the Plan calls for the creation of staff positions to carry out the strategies outlined in the Plan: Housing Project Manager, Outreach and Integrated Service Teams Manager, Income and Employment Manager, and Fund Development Coordinator. The Chronic Homeless Campaign Coordinator and Fund Development Coordinator are new positions, however, the other three positions may be filled by people who already exist at a County agency or nonprofit organization.
- Oversight and Implementation Body: During the first three years of the Plan, the Leadership Council will be retained to oversee Plan implementation, set policy, foster interagency collaboration, and obtain necessary resources to support implementation. During this time period, the legal entity will continue coordinating Plan implementation and the county-wide response to homelessness in subsequent years will be developed. In addition, an annual Plan Implementation Matrix will be produced to guide implementation efforts.
- Chronic Homelessness Community-Based Organization: A new community-based organization devoted solely to working on chronic homelessness will be created to launch all housing and service related efforts called for in the Plan.
- Leadership Cultivation and Public Relations: The Plan calls for concerted efforts to identify and cultivate leadership to champion the Campaign to End Chronic Homelessness and the implementation of the Plan, including elected officials, the business community, the philanthropic community and local foundations, as well as representatives from city and County government, health and service departments, police departments, education, nonprofit service providers, faith-based organizations, and homeless and formerly homeless individuals. In addition, a media and public relations effort to build public support for the implementation effort will be carried out. Information and resources will be provided about homelessness and hot-button issues such as the magnet theory.¹⁴

¹⁴ Information on magnet theory is available at the following sources:

- Martha Burt, “What We Know About Helping the Homeless and What it Means For HUD’s Homeless Programs” Testimony presented to the Housing and Community Development Subcommittee of the Banking and Financial Institutions Committee of the U.S. House of Representatives 1. March 5, 1997.
- ¹⁴ Community Action Board of Santa Cruz, Inc. “Housing and Homelessness in Santa Cruz County – 2005.” *available at* <http://www.cabinc.org/Research/housing-and-homelessness-2005-report.htm>
- HomeBase. “Building Inclusive Community: Tools to Create support for Affordable Housing.” 1996 www.homebaseccc.org

- Outcomes Monitoring: Plan benchmarks and outcomes will be established to continuously monitor progress and impact, and to guide ongoing program and policy improvements.

Ultimate Objective:

As a result of this work, in ten years the quality of life for all county residents will be enhanced because a nonprofit entity will exist that successfully generates political support for the Plan’s public policy objectives and oversees the successful financing and implementation of the Plan.

Strategies/Action Steps

Strategy 6.1: Develop Structure

Create Oversight and Implementation Body with power to command resources and determine policy.

Action Step 6.1.1. Evolve from the plan development phase a Leadership Council and Committee structure for Years 1-3 to launch The Campaign. The Committees formed to develop the Plan may restructure around core aspects of The Campaign, and may form subcommittees and work groups as needed. Leverage existing forums to integrate implementation activity and communication. Invite stakeholder groups now active in Plan development to participate in the Implementation structure.

Possible Committee Structure for Phase 1 of Implementation

Campaign Coordinating Council	(bi-annual meetings)
Executive Committee	(quarterly meetings)
Supportive Housing Committee	(bi-monthly meetings)
Program Services Committee	(bi-monthly meetings)
Development Committee	(bi-monthly meetings)

Representatives of each Plan goal (Housing, Program, Fund Development) committee should have a liaison to the Coordinating Council. The 3 City-County Homeless Advisory Committees will each name a liaison to the Campaign Coordinating Council.

Action Step 6.1.2. Develop in Year1- 3 the non-profit legal entity to carry out the Campaign and coordinate the response to all homelessness county-wide. Incubate this new organizational structure from the newly formed and realigned agency and governmental relationships forged in launching the Campaign.

In the start-up phase of Implementation, incubate the Campaign within an existing support (not service provider or housing group) agency, to act as a fiscal agent and employer of

record. The agent must have capacity, as well as credibility, in the community, sound fiscal management, office space, and staff.

Action Step 6.1.3. Define job of Implementation body to include:

- Keep people focused on goals of the Plan
- Bring resources towards implementing action
- Utilize homeless persons count to allocate funds by geography
- Oversee the development of a Homeless Management Information System (HMIS) in the County to measure program outcomes
- Decide policy
- Create power to command action
- Align the Plan with homeless services report and all homeless efforts
- Report back to jurisdictions appointing authority
- Convene to foster fund development
- Distribute funds to support building and managing housing and programs
- Sustain effort with turnover of personnel and attention
- Foster flexibility across systems

Action Step 6.1.4. The community and faith-based organizations that secure resources to carry out this Plan are to participate in a minimum of 2 of the Committees and Subcommittees charged with Plan implementation.

Action Step 6.1.5. Staff the Implementation Body with the right leaders:

Public Sector

- City representatives
- County representatives
- Housing Authorities
- Education liaisons
- Law enforcement

Private Sector

- Business
- Community-based organizations
- Faith-based organizations
- Foundations
- Members of the Continuum of Care

Consumer Constituents

- At least 2 persons who are experiencing or have experienced homelessness
- Relatives of individuals experiencing homelessness

Liaisons

- Housing Committee

- Program Committee
- Fund Development Committee
- 1 Representative from each of the 3 City-County Homeless Advisory Committees

Strategy 6.2: Staff Plan

Provide full-time staffing to support Plan Implementation.

Action Step 6.2.1. Create position of **Chronic Homeless Campaign Coordinator** who will: oversee all aspects of Plan implementation; coordinate and supervise staff; convene Campaign Management Team; staff the Leadership Council; work with the Leadership Council in support of proposals and funding requests; function much as a Chief Administrator/Executive Director.

Action Step 6.2.2. Fund specific positions that will manage the core housing-services-treatment nexus of this Plan, such as:

Fund Development Coordinator: identify and cultivate resource opportunities; draft the Annual Finance Plan; convene agencies to develop program that fits funding possibilities; handle public relations and media effort. (See Finance Goal, Strategies 1, 4, 6; Implementation Goal, Strategy 5)

Housing Project Manager: secure access to all housing required, including basic housing assistance and permanent supportive housing. Work to create the housing capacity, arrange for property management, liaison to services and treatment (See Housing Goal, Strategies 1, 2, 3, 4; Prevention Goal, Strategy 2)

Outreach and Integrated Service Teams Manager: pull together personnel from separate agencies into functional teams; retain Team Leader services; create the philosophy, protocols, procedures for Teams; manage the schedules and resources Teams require; convene case conferencing and Teams coordinating sessions (See Prevention Goal, Strategies 1, 4; Outreach, Services, and Treatment Goal, Strategies 1, 2, 3, 4; Housing Goal, Strategy 2)

Income and Employment Manager: identify appropriate entities to carry out strategies and action steps; link the benefits access and employment activity to Teams and to Housing; monitor progress and outcomes in this area (See Incomes Goal, Strategies 1, 2, 3, 4, 5, 6, 7, 8)

Strategy 6.3: Cultivate Leadership

Support leadership in championing the Campaign at all levels.

Action Step 6.3.1. Support locally elected officials in championing The Campaign.

Action Step 6.3.2. Support the business community, corporations, and philanthropy in taking a lead role to sustain the Campaign.

Strategy 6.4: *Develop Structure*

Develop and adhere to public reporting schedule on Plan development, implementation, and progress.

Action Step 6.4.1. Keep jurisdictions and public abreast of efforts.

Action Step 6.4.2. Determine a report structure and reporting schedule.

Strategy 6.5: *Public Outreach*

Plan implementation is to be supported by a Media and Public Relations effort.

Action Step 6.5.1. Launch Plan with media effort, and conduct media messaging activity every 6 months. Educate the public about homelessness.

Action Step 6.5.2. Have a communications strategy in support of the Plan and engage PR professionals, paid or as volunteer advisors. Consider public TV series with a “how to take action” component for the audience. Align with “PR and Public Education” efforts of affordable housing.

Action Step 6.5.3. Develop materials in response to hot-button issues to support integrity in campaign communication (issues such as the magnet theory, ending vs. reducing).

Action Step 6.5.4. Develop a website that is dynamic and frequently updated. Include a key statement from jurisdictional leadership, stories or profiles of homeless people, a list of donors, how to get involved, measuring progress, statement of values, statement of the problem, and a donation option on every page.

Strategy 6.6: *Effective Action*

Measure outcomes and continuously apply lessons learned to improve the Plan and programs launched through the Campaign.

Action Step 6.6.1. Define what shall be measured and monitored, develop an evaluation design, and work on research to document progress in implementing the Plan on reducing chronic homelessness.

Action Step 6.6.2. The outcomes for every strategy are to be carefully and continuously measured from the start of any activity under this Plan. Data collection and analysis systems will be established as part of start-up programmatic activity.

Action Step 6.6.3. A standard instrument will be selected to track progress made with each person served to deliver measurable outcomes. Consider adapting tools from other efforts, such as AB2034, SHIA, CHI. Team members with a host agency will use the standardized instruments that the agency requires. An effort will be made to collect parallel information across teams and an overlay instrument for common use by all Teams may be developed to supplement the tools in use in providing support to chronically homeless people.

- Allow a 360 perspective of knowledge and circumstances, including addiction, mental health, and hygiene.
- Look at needs, eligibility, and what people are receiving; update periodically.
- Assure HIPAA compliant.
- Review examples of such instruments now in use in the County, such as the Telecare version.

Action Step 6.6.4. The Teams and their partners shall meet annually to review lessons learned and discuss mid-course corrective steps taken.

Action Step 6.6.5. The Subcommittee shall meet annually with all providers and agencies providing any aspect of the housing-services-treatment nexus under this Plan to discuss total quality improvements.

Action Step 6.6.6. County Departments that come into contact with chronically homeless people will identify the person, contact the Street Outreach Team or Transitions Team, as well as report on the housing status of clients at intake and exit.

Action Step 6.6.7. In Year 5, focus on what lessons have been learned on chronic homelessness that should be applied to the county-wide response to all homelessness.

Strategy 6.7: *Update the Plan*

Update the Plan annually to ensure that it remains focused and responsive to the community's needs.

Action Step 6.7.1. Require that all programs implementing this Plan coordinate data systems, contribute common data to be used in generating reports, or utilize HMIS.

Action Step 6.7.2. Staff shall present to the Campaign Coordinating Council an annual Plan Implementation Matrix to identify the next year's focus area and action steps. This Plan should be updated every 5 years.

Action Step 6.7.3. Success under the Plan shall be reported each year by reporting measurable achievements. Barriers encountered shall be reported as well, and the Leadership Council shall share in efforts to overcome obstacles.

Strategy 6.8: *Cultural Shift*

Generate a system-wide cultural shift within organizations working with chronically homeless people to target efforts towards ending chronic homelessness.

Action Step 6.8.1. Encourage and support agencies to spend resources more effectively, position for new projects, and engage in capital projects.

Action Step 6.8.2. Structure a research study to show improvement in residential stability with the housing-treatment-services nexus called for in this Plan vs. offering only shelter or transitional housing to this population. Develop a data collection mechanism and support collecting and analyzing data. Engage the University to participate in study design and implementation. Seek County Public Health Dept and philanthropic resources to underwrite costs.

Strategy 6.9: *Systems Change*

Engage in State and federal advocacy to support implementation strategies.

Action Step 6.9.1. Advocate to restore federal funds to the Housing Choice Vouchers program.

Action Step 6.9.2. Advocate for State resources to implement this Plan.

Action Step 6.9.3. Advocate on behalf of the potential new funding for permanent supportive housing and affordable housing at all opportunities, particularly through the Governor's Chronic Homeless Initiative and the Affordable Housing Bond.

Action Step 6.9.4. Advocate for the adoption of strategies and action steps in California's 10 Year Plan to End Chronic Homelessness that will support our Plan, particularly strategies and action steps that will lead to increased funding for supportive housing.

PREVENTION APPENDIX A:

MODELS, BEST PRACTICES, AND RESEARCH THAT INFORMED THE DEVELOPMENT OF THE SANTA BARBARA COUNTY-WIDE 10 YEAR PLAN TO END CHRONIC HOMELESSNESS

In determining how to shape the strategies and action steps that will facilitate the end of chronic homelessness in Santa Barbara, the Prevention Committee studied prevention models, including models developed in Santa Barbara, as well as research on effective prevention strategies. The strategies and actions steps that the Committee developed incorporated their research and analysis.

Prevention Model: Supportive Housing Initiative Act Project, Santa Barbara County, CA

Activity Description

Why: High needs, complex clients with serious mental illness and multiple risk factors for housing instability were getting lost in the system, were not getting well, and were recidivating through all aspects of service delivery, resulting in higher costs.

What: Two intensive case management teams, one in each geographic region of the County, were created to enable at least 106 adults with serious mental illness and multiple risk factors for housing instability to obtain and maintain permanent, stable, affordable housing in the community. Permanent housing units affordable to extremely low income and homeless people were provided through Section 8 vouchers.

Partners: Five County departmental and nonprofit agencies working as a collaborative:

- Santa Barbara County Alcohol Drug and Mental Health Services (ADMHS)
- Work Training Program (WTP)
- Transitions Mental Health (TMHA)
- Sanctuary Psychiatric Center of Santa Barbara (SPCSB)
- Santa Barbara Mental Health Association (SBMHA)

Significant Program Design Features:

Service Delivery

- consumer driven
- based on the accepted PACT model
- provide “wrap-around” services
- available 24/7
- provide *in vivo* in the tenant’s apartment or community
- caseloads no larger than 10
- 3 weekly contacts per client; multiple daily contacts if client need demands

Housing

- TMHA provides 20 units of permanent housing
- WTP/ SPCSB provide 12 units housing
- no limit on length of stay in the housing units
- participation in services not a condition of occupancy
- clients do not lose housing unless they do not fulfill their tenancy obligations as outlined in their lease

Funding

Originally:

- Federal Section 8 Vouchers¹⁵
- State of California Supportive Housing Initiative Act Funds
- State of California AB 34 Funds
- Santa Barbara Mental Health Association down payment loan program (HAP)

Post-expiration of SHIA grant:

- Federal Section 8 Vouchers
- Medi-Cal Reimbursements: a distinguishing mark of this project is that it was able to supplant SHIA funding and support its budget through Medi-Cal reimbursements for care provided to clients.

Outcomes

Client census through June, 2004: 117 (North Team: 61; South Team: 56)

Housing stability

- Once settled into independent living, most clients remained consistently in the same housing. Sixteen clients left housing due to: evictions (5), move to more restrictive care (1), relocations (3), deaths (2), transfer to Board and Cares awaiting transition to independent living (3), and homeless (1).

Treatment and satisfaction

- Clients appear to be more hopeful about their recovery and have created future-oriented goals. Consumer Satisfaction with Mental Health Surveys, case studies and observations showed an increase in the quality of life and satisfaction with services received. (However, it appears that clients may feel more comfortable reporting higher quality of life satisfaction as opposed to service satisfaction due to their past negative experiences with the system.)
- Many clients, once enrolled and settled into the SHIA program, appeared to engage successfully and consistently in appropriate services and activities. (Very few clients were discharged from SHIA to re-enter more restrictive levels of care or for medical necessity.)
- The careful planning of treatment and services for each client provides an opportunity for a sense of independence and responsibility for their recovery process. This also appears to reduce their dissatisfaction with care, and clients tend to remain in programs for longer periods of time.

¹⁵ In year three of the SHIA grant, the program experienced difficulty obtaining Section 8 vouchers from the Housing Authority that had been dedicated to the SHIA Project. Due to a freeze on vouchers, the Santa Barbara County Housing Authority was unable to fulfill their agreement with the SHIA program for a total of twenty vouchers for the North SHIA Team. The North SHIA Team received a total of sixteen vouchers from the County by grant ending. The program received 20 vouchers dedicated by the City Housing Authority for the South SHIA Team. The City Housing Authority was also able to extend five more vouchers towards the end of the grant due to the success of the program and clients in independent living.

Vocational rehabilitation

- Approximately 30% of clients enroll in various forms of vocational rehabilitation services and are at different stages in this process. (There is reluctance from clients to get involved in work related activities that could dramatically impact a client's SSI benefits, however, this gradually shifted over the last year.)
- Several clients are now interested in beginning with volunteer work and then gradually shifting into small part-time jobs.
- The program is looking to shift some clients into consumer run activities as a way to engage in the employment field. Clients who have made this shift have appeared more hopeful about their recovery and have maintained high levels of independence within their community.

Cost savings

- Over the course of the three years the program was able to provide significant cost savings to the County system. These clients were high utilizers of the system, especially the emergency/crisis system. They were also clients that were not being served appropriately by the current system. These data clearly indicate a dramatic decrease in the amount of admissions into higher care services. This reflects a 65.9% drop once SHIA began providing intensive case management services.
- These clients still access the higher care system, but not as frequently and they tend to enter short-term psychiatric units rather than residential emergency care units. During these admissions, SHIA clients experienced a significant reduction in the length of time they spent in higher care services. This significant drop of 90.7% has not only impacted the system financially, but has also allowed room for clients other than SHIA to receive much needed higher care services. The result for SHIA clients is that they have become confident about their recovery and self-symptom management, thus enhancing their quality of life.
- The total costs of higher care services also shows a significant drop of 76.1% once SHIA began providing services. Clients continued to need higher care services on occasion due to the cyclical nature of mental illness and the predictable relapses on the road to recovery. However, the length of stay for clients was reduced drastically due to the consumer involved supportive services, the discharge planning, and the continuity of care that the SHIA project provides.
- SHIA clients continued to benefit from a variety of outpatient services that were used to enhance the current SHIA services. Although SHIA clients receive more services and increased contact, there is still a cost savings to the County system. Clients are more likely to efficiently use the correct services because SHIA closely collaborates and monitors treatment plan development and subsequent services to match the individual needs of each client.

Systems Implications

- Initially, SHIA was viewed as an addendum to the Alcohol Drug and Mental Health service delivery system of care. In some instances, parts of the system became rejecting of the program. Over the life of the grant, the collaborative SHIA program worked patiently and persistently to achieve a full integration into the Mental Health system. This unique program has now become a centerpiece for future program planning in order to produce a system-wide transformation.
- The strong collaborative relationships derived from the SHIA grant are the impetus for the community's collective "whatever it takes" attitude to sustain and grow the program no matter what.

Places Where Similar Work is Underway:

Contra Costa County: Project Coming Home

San Francisco: Direct Access to Housing

Los Angeles: Skid Row Collaborative

Santa Clara County: Off the Streets Team and Navigator Project

Most AB 34-funded programs

Discharge Planning Model: New Directions (Hospital Council of Northern and Central California), Santa Clara County, CA

Activity Description

Why: In 2003, approximately 400 frequent user patients¹⁶, many of whom were “chronically homeless,” made almost 4,900 visits to five emergency departments, which together treat 85 percent of the frequent user patients in Santa Clara County. Many of these patients have complex psychosocial issues in conjunction with medical conditions and, in addition, they are often economically disadvantaged. During a pilot study of frequent user patients that began in 2002, the planning committee of New Directions found that many study participants had a history of mental illness or alcohol and other substance abuse, while 30 percent had co-occurring mental illness and substance abuse disorders. Sixty-two percent lacked stable housing, 51 percent had incomes of less than \$500 per month, and 23 percent were on probation or parole.

What: New Directions is a product of the pilot study, which initiated community case management for frequent user patients. Strategies were tested and refined during the pilot, with the result being an intervention composed of three core parts: intensive case management, interdisciplinary and inter-agency case conferencing, and linkage to primary care and continuity of physician.

Partners: County, City, Hospitals and Nonprofit Agencies:

- Santa Clara Valley Medical Center
- San Jose Medical Center
- Saint Louise Regional Hospital
- Regional Medical Center of San Jose
- O’Connor Hospital
- Santa Clara County Department of Alcohol and Drug Services
- Santa Clara County Department of Public Health
- Santa Clara County Social Services Agency
- Santa Clara County Department of Mental Health
- Santa Clara County Office of Affordable Housing
- Community Health Partnership
- Catholic Charities
- Corporation for Supportive Housing
- EHC LifeBuilders

¹⁶ A frequent user patient has made eight or more emergency department visits in the prior 12 months to one or more of the hospitals participating in the project.

- Gardner Family Health Network
- InnVision
- San Jose Police Department
- Santa Clara Family Health Plan
- Valley Homeless Health Care Program
- Valley Transportation Authority

Significant Program Design Features:

Component 1: Intensive Case Management

- Assertive case management model (build trust, flexible client-specific supports, ‘whatever it takes’)
- Focuses on helping clients achieve stability in key areas (for example, medical, behavioral, housing, food).
- Establishes the case manager as a continuous point of contact and support.
- Emphasizes gradual transition to increased independent self-care and employment.
- Low case loads
- Provides:
 - Assistance with furnishing and moving into apartments
 - Assistance and advocacy in maintaining good tenant-landlord relationships
 - Assistance with budgeting and other life skills
 - Access to financial assistance and health insurance
 - Assistance and advocacy obtaining mainstream benefits, including SSI, GA, Food Stamps, Medicare and Medi-Cal
 - Assistance in accessing employment and training services
 - Assistance with accessing and using transportation
 - Group programs in decreasing stress & anxiety, increasing coping mechanisms, managing money, and other topics as needed

Component 2: Interdisciplinary and Inter-agency Case Conferencing

- Multidisciplinary team that includes members from the Mental Health Department, Alcohol and Drug Services, and Primary Medical Care.
- Enables coordination of care across providers, and facilitates timely access to needed services at the right location.
- Team members assist in reviewing cases and finding solutions and options for clients with difficult issues.
- Team makes recommendations for changes in systems that create barriers to services for this population.
- New Directions also works with a community collaborative formed specifically for the New Directions program, including members from Public Health, Mental Health, Alcohol and Drug Services, hospitals in the community, several housing organizations, transportation systems, community health clinics, primary health care providers, and community-based support organizations. All of these members provide services needed by this population, and all members have actively participated in working with New Directions on issues and barriers to services for this population.

Component 3: Linkage to primary care and continuity of physician.

- Access to primary and specialty medical care with a specific primary care physician assigned
- Advocacy to move through barriers to service and health care access
- Assistance in accessing medical care including escorting participants to medical appointments and providing follow-up after appointments
- Assistance in filling prescriptions and being compliant with taking prescribed

A note on housing: New Directions soon recognized that lack of permanent housing is the biggest barrier to success for this population. Even when the client is motivated, it is extremely difficult to make improvements in chronic health conditions, mental illness, or substance abuse without stable housing. Therefore the project formed a partnership with a local homeless housing provider to develop permanent supportive housing, using a Housing First model, to provide permanent units for New Directions' clients.

Funding

- Frequent Users Initiative Program, a joint initiative of The California Endowment and the California HealthCare Foundation
- Applicant for HUD Continuum of Care-SHP Funds (with housing provider to provide permanent, supportive housing)
- In-kind and/or cash resources from each partner

Outcomes

Initial results from the pilot study show:

- 31 percent reduction in emergency department visits
- 53 percent decrease in inpatient hospital days for clients
- After just one year of enrollment, the cost of ED, inpatient, and outpatient clinic services provided to clients declined by almost half.
- This reduction was even greater for clients who completed two years of enrollment.
- Hospital inpatient days declined after nine months of case management for one group of clients for whom data are available.

Places Where Similar Work is Underway:

- Santa Cruz County—Santa Cruz County Health Services Agency (Project Connect)
- Alameda County—Alameda Health Consortium (Project RESPECT)
- Los Angeles County (San Fernando Valley)—Tarzana Treatment Centers (Project Improving Access to Care)
- Sacramento County—University of California Davis Health System (Sacramento Effective Medical Care Task Force)
- Tulare County—Kaweah Delta Hospital Foundation (Tulare County Frequent Users Project)

Prevention Program Under Development: La Morada 18 Bed Project for Transitional Age Youth with DSS and HCD, Goleta, CA

Activity Description

Why: A high percentage of people transitioning out of the foster care system end up homeless. La Morada was developed because Santa Barbara County has no local program that provides emergency, temporary housing for transitional age youth and children in need of immediate removal from the foster care system due to abuse. Historically, these youth have been placed in residential programs specifically setup for this population which, unfortunately, are located great distances from Santa Barbara County.

What: Santa Barbara County is in the process of rehabilitating a County-owned property which will provide emergency temporary housing for these youth. The project is expected to be complete in the beginning of 2007. Once completed, La Morada will be staffed by social workers who will work with youth to assist them in obtaining permanent housing and avoiding homelessness.

Partners:

- * Department of Social Services
- * Housing and Community Development
- * An outside contractor will eventually run the facility

Significant Design Features:

Service Delivery

- 24-hour admissions
- Immediate medical screenings
- Food, clothing, and shelter 24-hours a day
- Planned, therapeutic activities each day
- A complete physical examination
- Transportation to medical or other appointments
- Psychiatric, psychological, educational, and medical evaluations
- Educational opportunities at on-site class room

Housing

- 18 emergency beds for youth
- No official cut-off point for the number of days a youth can stay in La Morada
- Focus on getting older transitional aged youth into permanent housing

Funding

- CDBG grant of \$500,000 for building rehabilitation
- Expenses associated with providing housing and services for children in the foster care system are reimbursed by various government sources

Research on Effective Ways to Prevent Homelessness: Good Discharge Planning Policies

Good discharge planning policies that help prevent homelessness include:

1. **Prohibit discharges into homelessness** from all publicly funded institutions such as hospitals, treatment facilities, prisons and jails, and the foster care system. Invest in recuperative care facilities for patients without homes who require supervised medical care but are not ill enough to remain hospitalized. This policy is now in place.
2. **Require all publicly funded institutions providing residential care, treatment or custody** to secure all available entitlements for residents prior to discharge and to provide staff persons trained in housing placement assessment and assistance. This practice is now underway.
3. **Establish assisted living type recuperative care facilities** for homeless individuals who require medical, mental health and/or addiction services over a period of time in order to sustain their housing stability while they recuperate, recover, and prepare to enter permanent housing. The Hotel del Rivera is such a facility.
4. **Support legislation to encourage better planning and services** for individuals being discharged from correctional institutions into the community.
5. **Create sufficient jobs and incomes, affordable permanent housing, universal health insurance, accessible health care, and other community services** to meet the needs of all persons at risk of homelessness.

PREVENTION APPENDIX B:
CHRONICALLY HOMELESS IN SANTA BARBARA

The Prevention Committee considered statistics regarding the populations that are most likely to compose Santa Barbara’s chronically homeless population in developing strategies and action steps to prevent homelessness.¹⁷

- According to Santa Barbara County Department of Alcohol, Drug, and Mental Health Services (ADMHS), about 43% of Santa Barbara County’s mentally ill residents are not receiving services.
- Twenty-two percent of incarcerated individuals in Santa Barbara County have severe mental health issues (170 out of 775).
- Over 1/3 of jail clients who accessed services from Santa Barbara County Department of Alcohol, Drug, and Mental Health Services (ADMHS) received mental health and drug/alcohol services.
- Severely mentally ill Santa Barbara youth aging out of the probation, mental health, child welfare system, and school system named homelessness as their biggest problem. Youth also experienced economic limitations, insufficient education/vocational training, lack of family support, untreated mental health needs, alcohol and other drug abuse, domestic violence, and other problems.
- Adults with severe mental illness similarly reported homelessness, timely access to needed help, alcohol and drug problems, involvement with the law, getting a job, and access to self-help programs were their greatest challenges.

¹⁷ Mental Health Services Act Three Year Program & Expenditure Plan: Community Services and Supports, County of Santa Barbara, December 2005

**PREVENTION APPENDIX C:
PREVENTION PROGRAMS IN SANTA BARBARA**

Chart C1: Current Prevention Service Providers in Santa Barbara County*

Prevention Service Provided	Service Provider
<i>Mortgage Assistance</i>	<ul style="list-style-type: none"> • County Housing and Community Development Department • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • Catholic Charities • Family Services Agency
<i>Rental Assistance</i>	<ul style="list-style-type: none"> • Casa Esperanza Shelters, Inc. • CHANCE, Inc. • Santa Barbara Community Housing Corporation • City of Santa Barbara Housing Authority • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • Catholic Charities • Family Services Agency
<i>Utilities Assistance</i>	<ul style="list-style-type: none"> • Casa Esperanza Shelters, Inc. • CHANCE, Inc. • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • Catholic Charities • Family Services Agency
<i>Counseling/Advocacy</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • Domestic Violence Solutions • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Department of Human Services • County Department of Social Services • County Veterans Services Office • Pacific Pride

* This information is based on Santa Barbara’s 2006 Continuum of Care application for McKinney Vento funding.

	<ul style="list-style-type: none"> • Legal Aid Foundation • CHANCE, Inc. • Santa Barbara Community Housing Corporation • People’s Self-Help Housing Corporation • City of Santa Barbara Housing Authority • Phoenix of Santa Barbara • Planned Parenthood • Catholic Charities • Family Services Agency • Willbridge
<i>Legal Assistance</i>	<ul style="list-style-type: none"> • Transitions House • Domestic Violence Solutions • County Department of Social Services • Legal Aid Foundation • CHANCE, Inc. • Family Services Agency

Chart C2: Descriptions of Selected Early Intervention Programs in Santa Barbara

Santa Barbara has a number of programs that provide *early intervention* assistance to individuals and families who are at greater risk for eviction due to mental illness and/or drug and alcohol issues including:

- *Crisis and Recovery Emergency Services (CARES)* provides around the clock mental health, drug, and alcohol crisis services.
- *The Transition House* administers a program to offer homeless prevention services to at-risk homeless families who are marginally housed including low/no cost childcare, employment enhancement workshops, computer literacy, ESL, etc.
- *The City of Santa Barbara Housing Authority* provides assistance to Section 8 voucher holders to obtain and stay in the restrictive housing market and provides educational and informational outreach to landlords to encourage them to participate in the Section 8 Rental Housing Assistance Program.
- *The Center for Employment Training* provides comprehensive vocational and job placements services for low-income and homeless people.
- *The Community Action Commission* provides child care services, giving priority to homeless and at-risk families that are either working or are enrolled in a vocational training program or school.
- *The Legal Aid Foundation* and *RHMTF* conducts Fair Housing workshops for landlords in various parts of the County, and distributes information on tenant rights.
- *Shelter Services for Women* works to prevent family homelessness by conducting educational training on domestic violence at the local high schools.

Santa Barbara has also developed programs to assist low-income families at risk of eviction including:

- The *Temporary Homeless Assistance (THA)* program provides cash grants for families that are used for temporary motel stays (limited to 16 days), and for payment of security and utility deposits to acquire rental housing. The Department annually assists approximately 620 family households through the THA program, and an additional 4,300 GR cases, of which 600 identified themselves as being homeless.
- The County's *General Relief (GR)* program provides grants for individuals to cover housing-related costs. The number of SRO's has reduced over the past year due to the reformatting of the Faulding Hotel.
- *FEMA grants/loans* are available through a number of programs.
- *The Legal Aid Foundation* and the *City of Santa Barbara Rental Housing Mediation Task Force (RHMTF)* each offer free services to low-income tenants facing eviction and probable homelessness.

Chart C3: Planned Countywide Prevention Action

Under the Mental Health Services Act, Santa Barbara is currently developing the following programs to reduce the risk of homelessness to high-risk populations:

- *Vida Nueva* is a culturally competent Assertive Community Treatment program that will provide seriously mentally ill adults, older adults, and transition age youth who are homeless or are at risk for homelessness with wrap-around services 24 hours a day/7 days a week.
- *SPIRIT* will add culturally competent wrap-around teams to all ADMHS children's service sites.
- *CARES* will expand its services to include a mobile crisis response team.
- *Older Adult Response and Recovery Service* will have a 24/7 wrap-around team to provide psychiatric, medical and risk assessment to older mentally ill clients.
- *New Heights* will be a drop in center for youth providing mentoring, support groups, leadership development, vocational support, counseling, housing assistance, and benefits assistance targeting mentally ill youth at risk for homelessness.
- *Partners in Hope* serves adults with severe mental illness and their families by providing recovery activities.
- *Connections: Each One Reach One* will connect families with children with emotional/behavioral or alcohol/drug problems with services and provides community education on these issues.
- *Justice Alliance* will work with people identified through the criminal justice system as having mental health or co-occurring substance abuse problems with appropriate care.
- *Bridge to Care* will provide psychiatric medical evaluation, prescriptions, and medical monitoring to stabilize people being treated by drug/alcohol programs who have co-occurring serious mental illnesses or identified trauma that meets medical necessity.

OUTREACH, ENGAGEMENT, SERVICES, AND TREATMENT APPENDIX A:

MODELS, BEST PRACTICES, AND RESEARCH THAT INFORMED THE DEVELOPMENT OF THE SANTA BARBARA COUNTY-WIDE 10 YEAR PLAN TO END CHRONIC HOMELESSNESS

In determining how to shape strategies and action steps that support outreach, engagement, and the provision of services and treatment to homeless and chronically homeless individuals in Santa Barbara County, the Outreach, Engagement, Services, and Treatment Committee studied program models and analyzed research regarding successful practices. As a result, the strategies and actions steps that were adopted are based on successful, well-documented models and strong research.

Integrated Supportive Services Model: The Collaborative to Help End Chronic Homelessness

The Collaborative to Help End Chronic Homelessness was an Initiative to fund eleven projects that serve the chronically homeless by providing permanent housing linked to services. Funding was provided in 2003 by the Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Department of Veterans Affairs (VA).

In order to qualify for the funding, each prospective grantee had to develop a comprehensive plan to end or reduce chronic homelessness in their community through the development of partnerships with private and public sector providers.

The eleven collaborations have different structures and services. Philadelphia, Broward County, and Contra Costa County have local government lead agencies while Chattanooga, Columbus, and Denver have nonprofit lead agencies; New York City and Broward County have scattered site housing while Los Angeles and San Francisco have one housing site. However, all the projects share several elements. All use assertive outreach teams, move eligible participants into housing as quickly as possible, and provide a full range of integrated supportive services needed to sustain housing.

Components and Structure of CHI Funded Projects*	
Central City Concern Portland, OR	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • Community Engagement Team consists of 4 ACT teams. • Teams are composed of a team lead, case managers, benefits workers, nurses, mentors, housing representatives, employment/education specialists, a VA evaluator, and a VA social worker. <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Primary care, labs, meds, acupuncture

	<ul style="list-style-type: none"> • Addiction services • Parole transition assistance <p><i>Housing</i></p> <ul style="list-style-type: none"> • Housing First approach • 73 Shelter Plus Care Rental Vouchers <p><i>Employment</i></p> <ul style="list-style-type: none"> • Emphasis on “systems change” in Workforce Programs, customized employment through the One Stop system.
<p>Chattanooga Collaborative Initiative Chattanooga, TN</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • ACT team composed of a program supervisor, part-time psychiatrist, part-time nurse, 5 case managers, 2 peer case managers, a mental health therapist, a substance abuse counselor, and a program assistant. <p><i>Housing</i></p> <ul style="list-style-type: none"> • 50 units of permanent supportive housing
<p>Chicago Collaborative Initiative to Help End Chronic Homelessness Chicago, IL</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • ACT team composed of a team leader, case managers, a nurse, and a psychiatrist. • Reaches out to homeless people in shelters and public places where homeless people congregate. <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Primary health and dental care • Case management • Mental Health • Substance abuse • Veterans services <p><i>Housing</i></p> <ul style="list-style-type: none"> • Housing First Approach • 59 Shelter Plus Care Vouchers • 2 service-enriched housing clusters (approx. 20 vouchers) and scattered site options • Housing Units set aside by YMCA and Catholic Community Charities • ACT team works with participants’ landlords <p><i>Employment</i></p> <ul style="list-style-type: none"> • ACT team assists with finding jobs and obtaining benefits
<p>Denver Housing First Collaborative Denver, CO</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • ACT team composed of a clinical director, 2 dual diagnosis case managers, a medical social worker, 2 clinical case managers, a case manager, a clinic nurse specialist, a benefits and entitlement specialist, and a psychiatrist. <p><i>Services/Treatment</i></p>

	<ul style="list-style-type: none"> • Health care • Veterans services • Benefits acquisition • Transition to mainstream services providers <p><i>Housing</i></p> <ul style="list-style-type: none"> • Housing First Approach • 100 units – scattered site and supportive housing
<p>Direct Access to Housing, San Francisco, CA</p>	<p><i>Outreach</i></p> <p>Variety of access points:</p> <ul style="list-style-type: none"> • Health Care for Homeless Vets • Street Outreach Teams • Intensive Case Management Teams • Primary Care Clinics • Emergency Medical and Psychiatric Services <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Case management • Medical care • Primary care clinic • Behavioral health team • Property management • Third party rent payment • Money management assistance • Benefit advocacy services <p><i>Housing</i></p> <ul style="list-style-type: none"> • 90 units • Utilizes permanent housing and master leasing • On-site behavioral health and medical services
<p>Housing and Health Options Provide Empowerment Broward County, FL</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • 13 ACT Teams composed of a psychiatrist, clinical social worker/team leader, administrative aide, 2 employment specialists, 2 co-occurring treatment specialists, 2 peer mentors, and 3 intensive case managers. <p><i>Housing</i></p> <ul style="list-style-type: none"> • Housing First Approach • 51 Shelter Plus Care vouchers
<p>Home First Philadelphia, PA</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • ACT Teams • 1:10 staff to consumer ratio • 24/7 coverage • 80% of time spent in the community with consumers • Long term engagement model • Integrated case management model

	<p><i>Housing</i></p> <ul style="list-style-type: none"> • Housing First Approach • 80 units of permanent supportive housing
<p>In Homes Now New York, NY</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • ACT Model <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Health Services • Addiction Services <p><i>Housing</i></p> <ul style="list-style-type: none"> • Scattered site apartments <p><i>Employment</i></p> <ul style="list-style-type: none"> • Employment services
<p>Project Coming Home Contra Costa County, CA</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • Multi-disciplinary outreach teams do outreach, conduct assessments, and provide services to clients in the street and in encampments using a modified ACT model • Dedicated Veteran’s Outreach worker • Emergency room and police departments regularly call the outreach team when they encounter a chronically homeless person <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Wrap-around intensive case management • Benefits assistance • Health care • HIV services • Dedicated residential detox and treatment beds • Fast track to veterans services <p><i>Housing</i></p> <ul style="list-style-type: none"> • 48 Shelter Plus Care units <p><i>Employment</i></p> <p>Vocational assistance</p>
<p>Rebuilding Lives PACT Team Initiative Columbus, OH</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • Comprehensive mental health team <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Primary health care • Mental health and substance abuse treatment • Benefits linkage • Expedited benefits enrollment for homeless people with disabilities to receive SSI and other mainstream benefits • Integrated dual diagnosis treatment <p><i>Housing</i></p>

	<ul style="list-style-type: none"> • Housing First approach • 108 Supportive housing units
<p>Skid Row Collaborative Los Angeles, CA</p>	<p><i>Outreach</i></p> <ul style="list-style-type: none"> • Uses a multi-disciplinary team of mental health and substance abuse specialists, peer advocates, psychiatric and medical staff, and property management staff to provide outreach, engagement, case management, and supportive services • Outreach teams visit the streets, missions, shelters, Access Centers, and Health Clinics to do an initial screening for eligibility. • The Multi-disciplinary team enrolls and assesses participants, determines the most appropriate housing placement, and assigns a case manager. <p><i>Services/Treatment</i></p> <ul style="list-style-type: none"> • Case Management • Drug/Alcohol Recovery • Health Screening • Medication Management • Mental health assessment and treatment • Benefits advocacy • Money management, rep-payee service • Individual and group counseling • Crisis intervention • Recreation, educational and cultural activities • Transportation <p><i>Housing</i></p> <ul style="list-style-type: none"> • 62 units at four locations with supportive services • Interim/Safe Haven units to allow participants to stabilize while waiting for permanent housing <p><i>Employment</i></p> <ul style="list-style-type: none"> • Employment support

*The information provided in this chart is based on materials provided by each of the organizations for the Annual Grantee Meeting July 21-23, 2004.

Note Re Formatting:

Please insert a graphic or picture on pages where the text ends high on a page.

Successful Outreach Model: South County Restorative Policing Team, Santa Barbara County, CA

Activity Description

Why: Before the start of this program in 2004, people who were homeless, or at risk of homelessness, and coping with mental illness and/or substance abuse issues traditionally faced significant barriers in accessing treatment and finding support necessary for long-term recovery. These obstacles often lead to a perpetual cycle of arrest, jail time, and minimal treatment without long-term supportive services, resulting in a relapse leading to further arrests.

What: The Santa Barbara Police Department wanted to increase the level of collaboration between agencies and decided to begin working with people trapped in this cycle. Community leaders implemented an innovative and hopeful approach by forming a Restorative Policing Team. This team, made up of local agencies, including law enforcement officers and service providers, come together to help people dealing with these issues link with appropriate support and treatment services one person at a time.

Partners:

- * Santa Barbara Police Department
- * Santa Barbara County Alcohol, Drug and Mental Health Services
- * Santa Barbara County Public Health Department
- * Mental Health Association in Santa Barbara County
- * Santa Barbara County Public Defender
- * Santa Barbara County District Attorney
- * Santa Barbara County Sheriff’s Department
- * Santa Barbara County TeleCare
- * Department of Social Services
- * Santa Barbara County Probation Department
- * Santa Barbara County Treasurer-Tax Collector
- * California Highway Patrol

Significant Program Design Features:

<p>The Program begins when law enforcement has contact with a homeless individual and a recommendation is made that the person receive services through the Program.</p> <ul style="list-style-type: none">* If an individual is accepted into the program, a Release of Information is signed so the volunteer coalition can release health information to other members of the team at their bi-monthly meetings in order to coordinate case management.* The coalition meets and assesses the program participant’s situation and develops an action plan for getting the program participant the services and treatment needed.* The support service interventions include referrals and linkages to the health care system, housing, substance abuse recovery, and the mental health system.

Places Where Similar Work is Underway:

This program is modeled after the Mental Health Liaison Program in San Rafael, CA.

Unified Case Management System Model: The Chatham Savannah Authority for the Homeless (CSAH), Savannah, Georgia

The Chatham Savannah Authority for the Homeless (CSAH) established a unified case management system because up until that point each agency kept its own case files on clients, and often referred clients to other agencies; however, no single file was maintained of all services referred to, or accessed by, each client.

The CSAH has established reporting requirements and performance standards for both intake and assessment for agencies that are members of the homeless coalition. The purpose of the Unified Case Management Project is to help homeless individuals and families move to permanent housing and self-sufficiency to the greatest extent possible. The major responsibilities are as follows: coordinate case management service delivery; increase and strengthen linkages among agencies providing services; assure the availability of services and referral information; lessen the duplication of services and documentation; address system barriers to services; provide ongoing training and support to staff and evaluate the effectiveness through centralized data collection and analysis. Outreach services are included in this project to identify, engage, and develop a trusting relationship with homeless persons who are unsheltered and/or are living in places not meant for human habitation. Initial intake, referral, and linkage to shelters and/or community programs are provided.

The Unified Case Management Coordinator oversees:

- The Housing Support Team, which consists of a Life Skills Coordinator, Attorney, Single Adult Specialist Case Manager, Family Specialist Case Manager, and a Mental Health/Substance Abuse Case Manager. The purpose of the Life Skills Curricula implementation for homeless persons in emergency and transitional housing is to obtain the necessary life skills for self-sufficiency and independent living. The purpose of the Attorney is to inform, advise, and represent homeless persons and families as to their housing rights and responsibilities, as well as other legal matters pertaining to self-sufficiency. The Team also provides case management services to homeless persons in transitional housing such as Potters Place, Hacienda House, and the Greater Horizons Programs of Union Mission.
- The Savannah Area Behavioral Health Collaborative (SABHC), which maintains the contracts for adult mental health and substance abuse services for all in need throughout Chatham County.
- The Employment and Training Center (ETC), which tracks employment and wage information for all sheltered homeless persons in Savannah and seeks to improve coordination of employment efforts by service providers on behalf of their homeless clients through a central referral system. Through this collaborative project, all job-ready homeless persons will be given job search assistance to successfully compete for good-paying jobs that help them to move into stable, permanent housing. Those who are not job-ready will be provided the training and assistance required to help them become job-ready.
- Title 1 Program

Much of the information regarding this model was taken directly from the “2003-2007 Housing and Community Development (HCD) Plan”, Chapter IX Homelessness at <http://www.ci.savannah.ga.us/cityweb/webdatabase.nsf/livingIndex?OpenFrameset> and the “Chatham-Savannah Authority for the Homeless Strategic Plan” at <http://homelesscoalition.org/2003forum/michaelelliott/CSAH%20Presentation.ppt>

Aggressive Outreach Model: Project Homeless Connect, San Francisco, CA

Activity Description

Why: San Francisco concluded that data proves that when chronically homeless people are approached in a respectful and kind manner, and with available resources, they are eager to accept help towards self-sufficiency, dispelling the myth that they prefer to live on the streets. Further, citizen involvement is seen as essential to the City’s ability to end homelessness.

What: A bi-monthly services fair to consolidate available services under one roof and connect homeless individuals to benefits, medical care, substance abuse and mental health counseling, and a variety of social services which can help lead to housing. This effort is highly reliant on volunteers and the project also serves to engage the general public toward innovative solutions to homelessness.

Partners: City Departments, and over 130 nonprofit agencies, businesses, labor unions, faith communities, health care providers and 1,000 individual volunteers including:

- | | |
|---|-----------------------------------|
| State of California Employment Development Department | SBC |
| San Francisco Department of Human Services | San Francisco Bar Association |
| San Francisco Department of Public Health | San Francisco Chamber of Commerce |
| San Francisco General Hospital | Sprint |
| San Francisco PAES Counseling (General Assistance) | Starbucks |
| San Francisco Public Defender’s Office | Subway |
| California Culinary Academy | Sysco |
| Cisco | Walgreens |
| Hotel Council | Hospital Council |
| Lenscrafters | Medical Society of San Francisco |
| Safeway | South of Market Health Center |
| | St. Francis Hospital |
| | St. Luke’s Hospital |
| | St. Marty’s Hospital |

Significant Program Design Features:

<p><i>Planning and Volunteers</i></p> <ul style="list-style-type: none"> • Team Leadership: Each week the Team Leads meet to discuss lessons learned, coordinate appropriately, plan, and update each other on activity status. • Volunteer Recruitment and Training: Volunteers submit their interest in volunteering with a particular team via email to that team’s lead. All prospective volunteers attend a one-hour training. • Mass Mobilization: Monthly “Mass Mobilization” to engage with new volunteers. These meetings provide an opportunity for feedback and offer volunteers a chance to interact with staff. • Wrap-up and Debrief: After the event, volunteers and organizers gather again to wrap-up and debrief about the event that day. Some of the initial numbers available are reported and there is an open discussion with the organizers and the Mayor to offer ideas and lessons learned. 	<p><i>Outreach</i></p> <p><i>Outreach to the Homeless:</i> On the day of the event, working in groups of three and four, the Street Outreach teams hit the streets to engage the homeless population and encourage them to visit the linkage station.</p> <p><i>At the Linkage Station:</i> Once at the Linkage Station, every person is greeted by a volunteer and directed to the Triage area.</p>	<p><i>Services/Housing Linkage</i></p> <p><i>Triage:</i> The triage teams greet the clients and interview them to help determine what services they need. Triage team members are available to help escort the client through the services as well.</p> <p><i>Getting the Services:</i></p> <ul style="list-style-type: none"> ○ Medical & Benefits (CAAP, GA, SSI) ○ Behavioral Health ○ Housing Information ○ Shelter Reservation ○ Veterans Assistance ○ Domestic Violence Counseling ○ Mental Health Counseling ○ Substance Abuse Treatment ○ Methadone Shots ○ Legal Assistance ○ Discharge Planning ○ Food, Activities & Giveaways <p>Each service station area is in communication with other service areas to help ensure this is as smooth a process as possible.</p> <p><i>Outreach Discharge:</i> The discharge volunteer teams check-in with each client before they leave to make sure that they visited all appropriate service stations.</p> <p><i>Gift Bags:</i> Each client is given basic necessary hygiene products.</p> <p><i>Follow-up:</i> Follow-up outreach with the clients after each event including help with making appointments.</p>
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Funding

- City and County of San Francisco
- 10,182 volunteers
- Private and/or in-kind donations:
 - Goodwill Industries
 - Green Leaf Produce
 - Kellogg's
 - Konica Minolta
 - Smart & Final
 - St. Marty's Medical Center
 - SMG & Bill Graham Civil Auditorium
 - Sysco
 - Waldeck's Office Supplies
 - Starbuck's Coffee
 - California Culinary Academy
 - Safeway
 - Hotel Council of San Francisco
 - Deloitte
 - SF Chamber of Commerce
 - Cisco Systems
 - Webcor Builders
 - Bechtel
 - SBC
 - Clif BarLocal 510
 - Give the Gift of Sight
 - Sprint
 - American Automobile Assn.
 - Subway
 - Park Hyatt San Francisco
 - Walgreens
 - LensCrafters
 - Savor Catering
 - Philippe Decker Design Inc.
 - Full Circle Fund
 - Fed Ex
 - Gap
 - Kinko's
 - Artists Build of San Francisco
 - Luxor Cabs
 - Slatkin Works
 - Parnassus Investment
 - SF Public Health Foundation

Outcomes

Since October 2004 Project Homeless Connect has served 5,506 homeless clients in the following ways:

- 5,000 received a meal, toiletries, sweatshirt, and/or socks
- 1,900 were counseled about housing options and individual housing plans
- 1,328 received medical and mental health care and behavioral health treatment
- 750 were assisted with income benefits (638 received county benefits)
- 427 were given counsel regarding legal issues
- 218 received vision care and glasses
- 509 individuals on the streets were given immediate shelter or stabilization housing with case management to support a path to permanent housing.

Places Where Similar Work is Underway:

This program is unique; the U.S. Interagency Council on Homelessness is encouraging cities around the country to begin similar programs and organized a December 8, 2005, "National" Project Homeless Connect. (Many cities from across the nation attended the August 2005, Project Homeless Connect in San Francisco to view first hand how the project operated.)

Best Practices: Health, Housing & Integrated Service Network Integrated Service Teams

Health, Housing and Integrated Service Network Integrated Service Teams (ISTs) are teams of professionals from homeless and mainstream agencies who work collaboratively to provide clients with the array of services and treatment they need, linked to their housing. ISTs offer clients a web of individually-configured services and support that are delivered at service sites throughout the community and in the home of the client. Flexible and consumer-centered, the services are designed to respond to client needs and to facilitate long-term housing stability, ongoing health and recovery, and maximum levels of independence and self-sufficiency. Typical staffing includes a clinical director, team leader, psychiatric nurse, housing specialist, co-occurring disorder specialist, peer counselor, and a money manager. The supportive services offered include client-centered case management and treatment services, health care, substance use management counseling based on a harm reduction philosophy, money management, life skills counseling, benefits and employment assistance, and peer support.

A study by independent researchers affiliated with the Goldman School of Public Policy at the University of California at Berkeley looking at two supportive housing projects using the HHISN IST model found high rates of residential stability, with 81% of clients remaining in their housing for a year and 62% for two years. In addition, after one year, client use of emergency rooms fell by 58%, use of hospital inpatient beds fell by 57%, and use of residential mental health programs disappeared.¹⁸

¹⁸ Proscio, Tony. "Supportive Housing and Its Impact on the Public Health Crisis of Homelessness", Corporation for Supportive Housing. 2000.

OUTREACH, ENGAGEMENT, SERVICES, AND TREATMENT APPENDIX B:

SERVICE AND TREATMENT CAPACITY IN SANTA BARBARA

Chart B1: Current Outreach Service Providers in Santa Barbara County*

Outreach Services Provided	Service Provider
<i>Street Outreach</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • County Alcohol Drug and Mental Health • County Public Health Department • CHANCE, Inc. • Family Services Agency • Willbridge • Telecare • Transitions Mental Health
<i>Mobile Clinic</i>	<ul style="list-style-type: none"> • Good Samaritan Shelters, Inc. • Transitions House • County Alcohol Drug and Mental Health • County Public Health Department • Family Services Agency • Willbridge
<i>Law Enforcement</i>	<ul style="list-style-type: none"> • Santa Barbara County Sheriff • City of Lompoc Police Department • City of Santa Maria Police Department • City of Santa Barbara Police Department • Santa Barbara County Probation Department • State of California Parole Department

* This information is based on Santa Barbara's 2006 Continuum of Care application for McKinney Vento funding.

Chart B2: Current Supportive Service Providers in Santa Barbara County*

Supportive Services Provided	Service Provider
<i>Case Management</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • Domestic Violence Solutions • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Department of Social Services • Mental Health Commission of Santa Barbara County • Sarah House • New House • Veteran’s Outpatient Clinic • Pacific Pride • Santa Barbara Community Housing Corporation • Pediatric Medical Group • Mental Health Association • Phoenix of Santa Barbara • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • Work Inc. • New Beginnings • Noah’s Anchorage • Family Services Agency • Willbridge • Telecare • Transitions Mental Health
<i>Life Skills</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • Domestic Violence Solutions • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Department of Social Services • Mental Health Commission of Santa Barbara County

* This information is based on Santa Barbara’s 2006 Continuum of Care application for McKinney Vento funding.

	<ul style="list-style-type: none"> • New House • Santa Barbara Community Housing Corporation • Mental Health Association • Phoenix of Santa Barbara • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • Work Inc. • New Beginnings • Noah’s Anchorage • Family Services Agency • Willbridge
<i>Alcohol & Drug Abuse</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Department of Social Services • Mental Health Commission of Santa Barbara County • New House • Veteran’s Outpatient Clinic • Pacific Pride • Santa Barbara Community Housing Corporation • Mental Health Association • Phoenix of Santa Barbara • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • New Beginnings • Noah’s Anchorage • Family Services Agency • Willbridge
<i>Mental Health Counseling</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • County Alcohol Drug and Mental Health • Mental Health Commission of Santa Barbara County • Sarah House • Veteran’s Outpatient Clinic • Santa Barbara Community Housing Corporation • Mental Health Association • Phoenix of Santa Barbara

	<ul style="list-style-type: none"> • New Beginnings • Noah’s Anchorage • Family Services Agency • Willbridge • Telecare • Transitions Mental Health
<i>Healthcare</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • County Alcohol Drug and Mental Health • County Public Health Department • County Department of Human Services • County Veterans Services Office • Mental Health Commission of Santa Barbara County • Sarah House • Veteran’s Outpatient Clinic • Santa Barbara Community Housing Corporation • Pediatric Medical Group • Mental Health Association • Phoenix of Santa Barbara • New Beginnings • Planned Parenthood • Noah’s Anchorage • Family Services Agency • Willbridge
<i>HIV/AIDS</i>	<ul style="list-style-type: none"> • County Public Health Department • Sarah House • Veteran’s Outpatient Clinic • Pacific Pride • Santa Barbara Community Housing Corporation • Pediatric Medical Group • Mental Health Association • Phoenix of Santa Barbara • New Beginnings • Family Services Agency • Willbridge
<i>Education</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Public Health Department

	<ul style="list-style-type: none"> • County Department of Social Services • County Public Schools Homeless Education/Liaison Project • Pacific Pride • Center for Employment Training • Santa Barbara Community Housing Corporation • People’s Self-Help Housing Corporation • Mental Health Association • Phoenix of Santa Barbara • Salvation Army of Santa Barbara • Salvation Army of Santa Maria • Salvation Army of Lompoc • Work Inc. • New Beginnings • Planned Parenthood • Noah’s Anchorage • Family Services Agency • Willbridge
<i>Employment</i>	<ul style="list-style-type: none"> • Casa Esperanza Day Center • Good Samaritan Shelters, Inc. • Transitions House • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Department of Social Services • County Veterans Services Office • Center for Employment Training • Santa Barbara Community Housing Corporation • People’s Self-Help Housing Corporation • Mental Health Association • Phoenix of Santa Barbara • Work Inc. • New Beginnings • Family Services Agency • Willbridge
<i>Child Care</i>	<ul style="list-style-type: none"> • Good Samaritan Shelters, Inc. • Transitions House • Domestic Violence Solutions • Mark’s House • Bridgehouse • County Alcohol Drug and Mental Health • County Department of Social Services • County Public Schools Homeless Education/Liaison Project • Mental Health Association

	<ul style="list-style-type: none"> • Noah’s Anchorage • Family Services Agency • Willbridge
<i>Transportation</i>	<ul style="list-style-type: none"> • Good Samaritan Shelters, Inc. • Transitions House • Domestic Violence Solutions • County Public Schools Homeless Education/Liaison Project • City of Lompoc Transportation (COLT) • Phoenix of Santa Barbara • Noah’s Anchorage • Family Services Agency • Willbridge • Phoenix of Santa Barbara • Noah’s Anchorage • Family Services Agency • Willbridge

Chart B3: Planned Countywide Action

<p>In response to the issues identified in the Mental Health Services Act (MHSA) community planning process, a new program, the following homeless-related services have been proposed for funding over the next three years (2005-2008):</p> <ul style="list-style-type: none"> • <u>Vida Nueva</u>: ACT multi-disciplinary service teams providing wrap-around care linked to housing for transition age youth with mental health disorders. • <u>Crisis and Recovery Emergency Services (CARES)</u>: 24/7 mobile crisis response by alcohol, drug and mental health professionals, including integration of crisis response to substance abuse and mental health emergencies. • <u>New Heights</u>: one-stop, hub of support drop-in center for services and social support; including peer mentoring, support groups, leadership development, vocational support, counseling, housing assistance, and benefits assistance, for transition age youth with a mental health disorder. • <u>Bridge to Care</u>: development of integrated treatment capacity for people with co-occurring mental health and substance abuse disorders.
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HOUSING APPENDIX A:

MODELS, BEST PRACTICES, AND RESEARCH THAT INFORMED THE DEVELOPMENT OF THE SANTA BARBARA COUNTY-WIDE 10 YEAR PLAN TO END CHRONIC HOMELESSNESS

In determining how to shape the strategies and action steps that will facilitate the end of chronic homelessness in Santa Barbara, the Supportive Housing Committee examined a variety of housing models, best practices, and research. The strategies and actions steps that the Committee developed incorporate their research and analysis.

“Housing First” Model: Skid Row Collaborative, Los Angeles, CA

Activity Description

Why: In the area of downtown Los Angeles called “Skid Row,” there is a large street homeless population, many of whom suffer from mental illness. Skid Row has a large presence of missions and social services agencies, and some single-room occupancy hotels, the City’s most “affordable” housing. However, there is a real lack of affordable housing, and of housing appropriate for chronically homeless people – permanent supportive housing. Service provision between providers was only informally coordinated until recently.

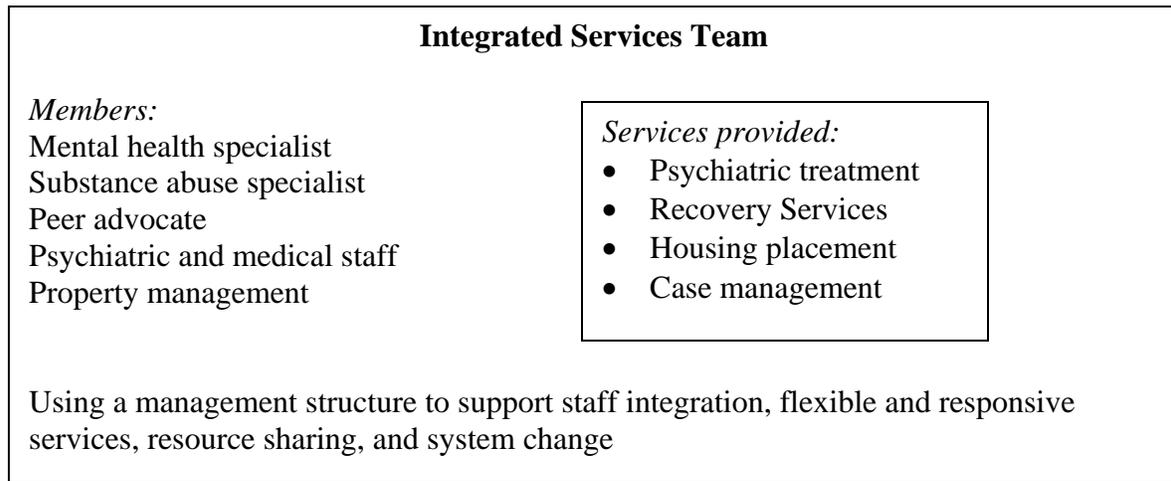
What: The Skid Row Collaborative is a community-wide strategy that addresses the needs of chronically homeless and disabled individuals with a collaborative approach to resolving the problems of Los Angeles’ most vulnerable citizens. The Collaborative aims to provide 62 chronically homeless individuals with stable housing, mental health and substance abuse services, primary healthcare, and veterans’ services using an integrated multidisciplinary team. The Collaborative focuses on housing placement that matches the individual with the type of permanent housing best suited to individual’s need: low demand Safe Haven, community enriched project-based or scattered site.

Partners: A partnership of 12 public and private non-profit agencies:

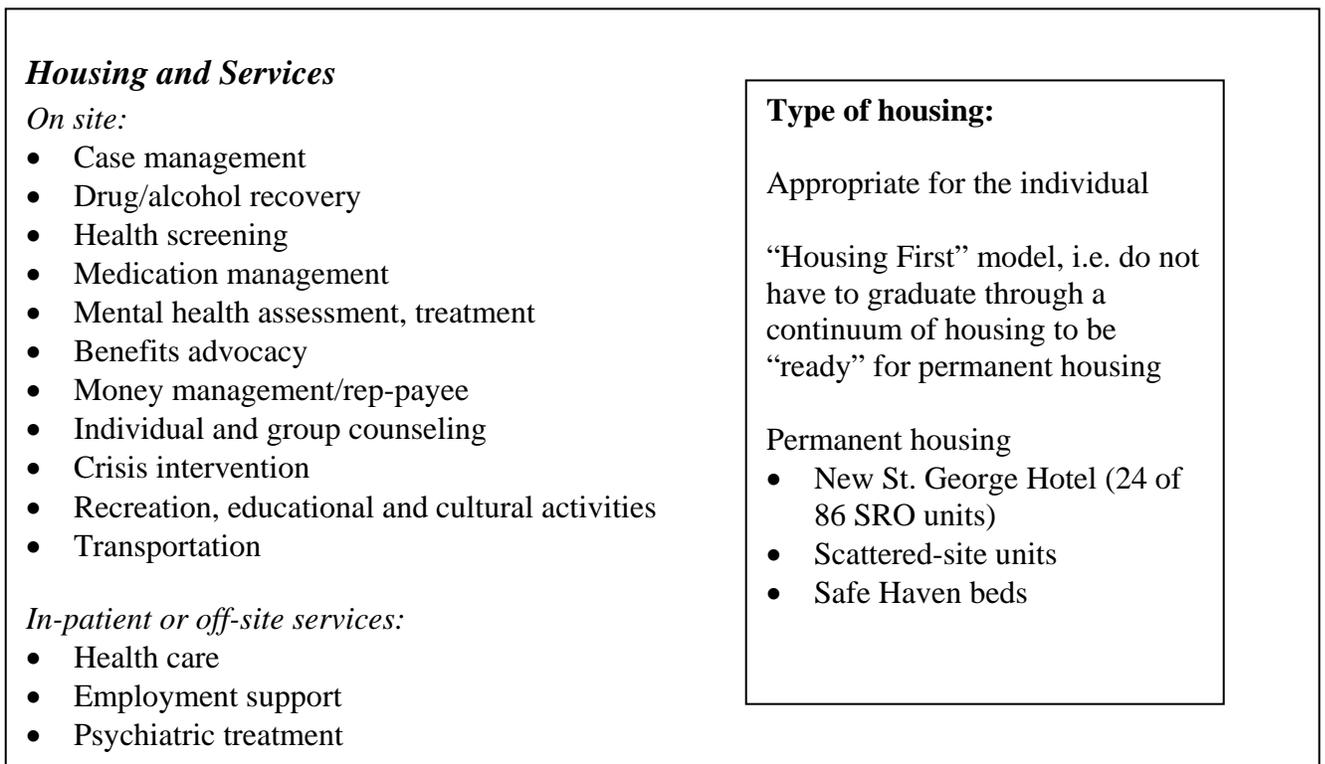
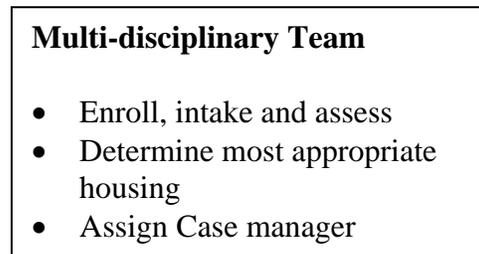
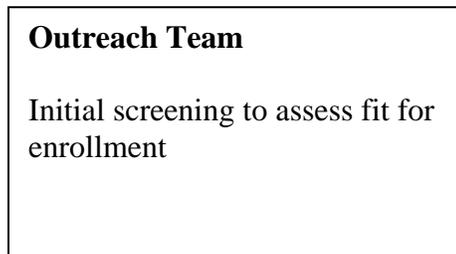
- Skid Row Housing Trust
- Lamp Community
- County of LA Dept. of Mental Health
- JWCH Institute
- Housing Authority of the City of Los Angeles
- Homeless Healthcare Los Angeles
- Behavioral Health Services
- Clinica Oscar Romero
- GLA Veterans Healthcare System
- Corporation for Supportive Housing

- Los Angeles Homeless Services Authority
- New Directions, Inc.

Significant Program Design Features:



Project Entry



Funding

- Collaborative Initiative to Help End Chronic Homelessness (HHS, HUD, VA) grant
- HUD Continuum of Care Shelter Plus Care program
- Medi-Cal reimbursements
- Local Mental Health Block Grant funds
- State of California AB 2034 funds
- In-kind contributions, Los Angeles County Department of Mental Health
- In-kind services
 - Homeless Health Care Los Angeles
 - Behavioral Health Services, Inc.
 - JWCH Institute
 - New Directions
 - Los Angeles Homeless Services Authority
 - Corporation for Supportive Housing
- Contribution of Safe Haven units and permanent studio units at Lamp Lodge from Lamp Community
- Equity from 9% low-income housing tax credit equity provided by the Enterprise Social Investment Corp.
- Community Development Commission of Los Angeles County
- Federal Home Loan Bank of San Francisco, Affordable Housing Program grant through Citibank
- General partner loan
- Deferred developer fee
- Los Angeles Housing Department
- General partners contribution
- Soft loan construction loan interest
- Private sources

Outcomes

Since project began in December 2003:

- Total of 67 participants have been enrolled; 11 no longer enrolled due to variety of circumstance including death, incarceration, and recidivism
- 56 participants are actively receiving housing and services (target is 62 participants)
- Inter- and intra-agency systems have been improved to give participants direct access to services between partnering agencies
- Many crises that could have led to loss of housing/return to homelessness have been mitigated

Places Where Similar Work is Underway:

San Francisco, Project Coming Home

Santa Clara County: Off the Streets Team and Navigator Project

Most AB 2034 Funded Programs

Frequent Users Initiative Programs, a joint initiative of The California Endowment and the California HealthCare Foundation (case management, wraparound services and housing for frequent users of the emergency rooms) in Santa Clara, Santa Cruz, Alameda, Los Angeles, Sacramento and Tulare Counties).

Interim Housing Model: Good Samaritan Shelter, Santa Maria, CA

Activity Description

Why: Good Samaritan's Shelter, Inc. (GSSI) originally started in January 1988 out of a need to have a single shelter (as opposed to multiple churches offering a rotating system of shelters in the area) to provide wrap-around services for the homeless population. In December 2004, the Homeless Shelter Campus began operating with the goal of diminishing the number of homeless individuals and families living on the streets.

What: The Homeless Shelter Campus offers a multitude of supportive services and housing options. Every year, the Campus takes in 1,000 homeless people.

Partners: One of the most unique facets of the Homeless Shelter Campus is the large number of partnerships it has with other agencies. These partnerships allow the program to offer homeless people an on-site supportive services model. It also offers and various options for those people not admitted into the Campus for reasons such as alcoholism or drug abuse. Partners include:

- Santa Barbara County Mental Health Department (outreach workers and referrals)
- Public Health (on-site health clinic and public health nurses)
- Sojourn (non-profit that offers mental health assessment and therapy for children 0-5)
- Transitions Mental Health (therapy for women/mothers)
- CAC (on-site HeadStart and job training for food preparation in kitchen)
- Department of Education (After School Program)
- Department of Social Services (on-site social worker)
- Santa Maria Valley Youth and Family (mental health therapy for children 6-18 years old)

Significant Program Design Features:

Service Delivery

- On-site Headstart center run by the Community Action Commission (CAC)
- After-school care program currently serving 35 children (Dept. of Ed.)
- Full-time social worker provided by HSS that helps with applications/paper work for food stamps, GR, etc.
- Savings program (savings for each individual can be tracked so that the program knows who is working/saving money and who is not)
- On-site homeless clinic (Public Health Dept.)
- Clothing vouchers (GSSI thrift store)
- AA, NA, Double Trouble meetings
- Hospitals and Institution (H&I) panels
- Churches or community services organizations provide nightly meals
- Detox program
- Case managers for both emergency shelter and family shelter

Housing

- 76 bed emergency housing unit (stays can last up to 90 days with a maximum of three extensions)
- 56 bed transitional housing unit for families (consists of 14 rooms, each of which is adopted by a community services group for holidays and birthdays)
- 12 bed detox center (3-21 day stays)
- Currently constructing a 40 bed overflow center, with a dining room and kitchen (CAC as partner on kitchen to provide job training).
- Working on creating a 16 unit permanent housing complex for homeless families, so that the Campus can provide all levels of housing.

Funding

- Federal
 - Community Development Block Grants (CDBG)
 - Emergency Housing Assistance Program Capital Development (EHAPCD)
 - FEMA Emergency Food and Shelter grant
 - SAMHSA
 - HOME
- State
 - Child Protective Services
 - Medi-Cal
- Local
 - Santa Barbara County Human Services
 - Santa Barbara County Mental Health Services

- Santa Barbara County Department of Education
- Income from services
 - Thrift store sales
 - Pay phone income
 - Reimbursed expenditures
 - Vending machine income
 - Rental income
 - Client fees
- Foundation grants
 - Fund for Santa Barbara
 - The Orfalea Foundation
 - Wood-Claeysens Foundation
 - United Way
- Fund raising
 - Wood-Claeysens Foundation
 - United Way
- Fund raising

Interim Housing Model: Safe Parking Program, Santa Barbara, CA

Activity Description:

Why: Started in 2003 by Catholic Charities, and currently run by New Beginnings Counseling Center, the Safe Parking Program came out of a need to balance County ordinances that say homelessness is a crime.

What: The program provides safe nightly parking without a time limit for clients that have both proof of insurance and a valid driver’s license. While offering clients a relief from the concerns associated with living on the streets, the Safe Parking Program’s case manager connects and builds relationships with clients, with the goal of helping them find more permanent housing or employment. The program currently serves 28 participants in ten locations provided by local churches and non-profit agencies.

Partners: Although the program has no official partners, it has close connections with Schools on Wheels out of Los Angeles, and various social agencies around Santa Barbara County.

Funding

The Safe Parking Program is funded more and more through private donors as its block grants from the federal government keep decreasing.

Places Where Similar Work is Underway:

There is a similar program in Eugene, Oregon.

Supportive Permanent Housing Under Development in Santa Barbara: El Carrillo, Santa Barbara, CA

Activity Description:

Why: El Carrillo was designed to offer low-income residents the opportunity to move from homelessness and other transitional housing situations to permanent stable housing. El Carrillo is an example of a project born out of the recognized need for a collaborative relationship between the City Housing Authority and local service providers.

What: El Carrillo is expected to be completed in August 2006. It will provide 61 units of clean, safe housing to very low-income single individuals, many of whom are presently homeless. Selection preferences will be given to those individuals who are disabled or who have graduated from a transitional housing program.

Partners: El Carrillo partnered with the Housing Trust Fund of Santa Barbara to obtain financing. The Housing Trust Fund, an important and relatively new local nonprofit, strives to expand the production, renovation and preservation of affordable housing within Santa Barbara County. The Housing Trust Fund accesses lines of credit from local banks that loan it money at lower interest rates and then brokers them to developers as construction funds. The Housing Trust Fund is currently providing \$1,000,000 in financing to El Carrillo at a below market interest rate.

El Carrillo will partner with the Work Training Programs, Inc. (WTP). WTP provides employment and living services including job skills assessment, job placement, and community independent skills to underserved populations, and will be the managing agent at El Carrillo.

Significant Program Design Features:

Service Delivery

- Consumer driven
- On-site supportive services include mental health counseling, job placement assistance, employment training, health screenings, and financial and budgetary counseling.
- An on-site Work Training Program advisor will serve as the day-to-day manager of the facility.

Housing

- 61 units of supportive housing
- Property designed to create a sense of community
- Participation in services not a condition of residency

Funding

- \$1,000,000 from the Housing Trust Fund of Santa Barbara
- The City Redevelopment Agency

- Garden Court, Inc.
- Santa Barbara Housing Assistance Corporation
- Apollo Capital (our tax credit investors)
- Low income housing tax credits
- Santa Barbara Bank and Trust
- Housing Authority of the City of Santa Barbara
- “Adopt a Room” donation drive: community members can contribute \$200 to help provide residents with everything needed to help make the transition into their new apartments.

Places Where Similar Work is Underway:

- Seattle, WA
- Denver, CO

Supportive Permanent Housing Under Development: Vida Nueva, Lompoc, CA

Activity Description:

Why: The Governor’s Homeless Initiative provides funding for permanent supportive housing for chronically homeless people with severe mental illnesses. Vida Nueva for Adults and Older Adults will take advantage of this funding to house and offer supportive services to the mentally ill population in Lompoc.

What: Vida Nueva will serve 120 adults and 5 older adults with severe mental illness in need of housing. Nineteen units of the newly constructed apartment building will be devoted to transitioning mental health clients.

Partners:

- * Developers: Transitions Mental Health Association and Santa Barbara Housing Assistance Corporation
- * Services provided by MHSA

Significant Program Design Features:

Service Delivery

- * Vida Nueva is the first Assertive Community Treatment (ACT) program in Lompoc.
- * The in-house staff includes 10 mental health professionals working 7 days a week.
- * Vida Nueva will provide housing assistance, supported employment and education, vocational skills enhancement, medication support, counseling support, peer support, and social skills development.

Housing

- * Vida Nueva has applied for funding for 39 units
- * 19 units will house mentally ill individuals
- * 6 units will house chronically homeless individuals
- * Residents will not be required to utilize services in order to retain their housing

Funding

(from <http://www.hcd.ca.gov/fa/ghi/>)

- The Governor's Homeless Initiative
- Permanent loans under HCD's Multifamily Housing Program (MHP)
- Construction, bridge and permanent loans from CalHFA
- Limited grant funds for rental assistance from DMH

Best Practices: Master Leasing

Under "master leasing," a nonprofit or public agency leases multiple units of housing (could be scattered site units or a whole apartment building) from a landlord, and subleases the units to homeless or low-income tenants. By assuming the tenancy burden, the agency facilitates housing of clients who may not be able to maintain a lease on their own due to poor credit, evictions, or lack of sufficient income. The landlord receives a certain monthly payment whether or not the units are occupied.

Elements of Master Leasing:

- Benefits the landlord, service provider, and client
- Reduces rental costs due to the size and long-term nature of the lease
- Provides an alternative for clients with poor credit or evictions
- Divides upkeep costs between master lessor and landlord (with landlord responsible for major maintenance)
- Includes on-site supportive services; property management can be subcontracted in larger master leases
- Creates a public-nonprofit-private partnership

- Works with many populations: chronically homeless, transitionally homeless, and homeless youth.

Research on Effective Ways to Prevent Homelessness: Housing Subsidies

Research shows that formerly homeless families, including those with histories of mental illness, substance abuse, health problems, and incarceration are significantly more likely to be able to remain in their housing if they have a housing subsidy.

- A study in New York City found that families that accessed subsidized housing upon exiting homelessness were 21 times more likely to be stably housed than comparable families five years following a homeless episode.¹⁹
- A study in the Boston area found that nearly 90% of families that exited homelessness with a housing subsidy remained stably housed 6-12 months later.²⁰

¹⁹ Shinn, M., et al., (1998). Predictors of homelessness among families in New York City: From shelter request to housing stability. *American Journal of Public Health*, 88(11), 1651-1657. [<http://www.nlihc.org/bookshelf/shinn.htm>]

²⁰ Friedman, D.H., Meschede, T. and Hayes, M. (2003). Surviving against the odds: Families' journeys off welfare and out of homelessness. *Cityscape: A journal of Policy Development and Research*, 6(2), 187-206

**HOUSING APPENDIX B:
HOUSING CAPACITY IN SANTA BARBARA**

Chart B1: Current Inventory of Housing*

Provider	Facility	Target Population	Units/Beds
Transition House	Transition House Homes	Families with children	26 units with 80 beds
Community Housing Corporation (CHP)	Casa de Mural	Single males & females	12 individual beds/ 12 beds for chronically homeless (CH)
Lompoc Housing Assistance Corp.	Gianni Apartments	Single males & females	22 individual beds/ 22 beds for CH
CHP	Via Vida	Single males & females	6 individual beds/ 6 beds for CH
Lompoc Housing Assistance Corp.	Arn Apartments	Single males & females	20 individual beds/ 20 beds for CH
Sanctuary	Sanctuary House	Single males	3 individual beds
Phoenix House	Phoenix House	Mixed populations	11 individual beds/ 11 beds for CH
Sanctuary	Arlington Apartments	Mixed populations	27 individual beds
Beet's Board & Care	Beet's Board and Care	Mixed populations	5 individual beds
Cornerstone House	Cornerstone House	Young males & females	6 individual beds
United Cerebral Palsy	Beachcourt Assisted Living Apartments	Singles males & females	10 individual beds
United Cerebral Palsy	Tumbleweed Assisted Living Apartments	Singles males & females	13 individual beds
CHP	Deveraux Group Home	Singles males & females	8 individual beds/ 8 beds for CH
Good Samaritan Shelter, Inc.	Permanent Clean and Sober Living	Singles males & females	16 individual beds/ 16 beds for CH
CHP	The Faulding Hotel	Singles males & females	81 individual beds/ 81 beds for CH

* This information is based on Santa Barbara's 2006 Continuum of Care application for McKinney Vento funding.

People's Self-Help Housing	The Victoria Hotel	Singles males & females	28 individual beds/ 28 beds for CH
SHIA Permanent Housing	SHIA Scattered Units	Single males	37 individual beds/ 37 beds for CH
Private Owner	Casa Juana Maria	Singles males & females	6 individual beds
Private Owner	Peterkin's Board & Care	Single males	8 individual beds
Private Owner	Flores	Single males	10 individual beds
Private Owner	Lyon's House	Single females	8 individual beds
Private Owner	Ada's Place	Singles males & females	12 individual beds
Private Owner	Chino's House	Singles males & females	16 individual beds
Private Owner	Transition Apartments	Singles males & females	12 individual beds
Private Owner	Freeman Place	Singles males & females	5 individual beds
Private Owner	Friendship Manor	Single males	6 individual beds
Private Owner	Heath House	Singles males & females	7 individual beds
Private Owner	Eleanor Apartments	Singles males & females	14 individual beds
Private Owner	Eden Bautista	Singles males & females	6 individual beds
Private Owner	Edith Caneth	Singles males & females	6 individual beds
Private Owner	Dodson	Singles males & females	6 individual beds
Private Owner	Dolete	Mixed populations	6 individual beds
Private Owner	Fesler House	Mixed populations	6 individual beds
Private Owner	Hobb's House	Mixed populations	6 individual beds
Private Owner	Hollister Apartments	Mixed populations	8 individual beds
Private Owner	Hollister Cottages	Mixed populations	4 individual beds
Private Owner	Jenny's	Singles males & females	6 individual beds
Private Owner	San Antonia	Singles males & females	6 individual beds
Private Owner	Susan's	Singles males & females	6 individual beds
Private Owner	Sonia Vea	Singles males & females	6 individual beds
Private Owner	Virginia Vea	Singles males & females	6 individual beds

Private Owner	Lifesteps Apartments	Singles males & females	4 individual beds
Private Owner	Casa Rosa	Singles males & females	22 individual beds
Private Owner	Casa Omega	Singles males & females	6 individual beds

Chart B2: County-Wide Capacity

In developing a full continuum of housing, Santa Barbara County has much in place to build upon:

- The City of Santa Barbara's Public Housing Authority (PHA) is working to counter the difficulties experienced by Section 8 certificate holders to obtain and stay in housing in the current restrictive rental market. This effort is targeted not only towards applicants, but also has educational and informational outreach workshops for local landlords in order to encourage participation in the Section 8 Rental Housing Assistance Program.
- Santa Barbara County has created a partnership between the Housing and Community Development Department and the Alcohol, Drug, and Mental Health Services Department. The County hired a full-time Housing Specialist to serve as a liaison between the two Departments who will be responsible for identifying funding sources for projects to house clients with disabilities, including permanent supportive housing.

- Santa Barbara has created a housing plan for clients with mental health disabilities. Elements include:
 - An inventory of existing housing units for people who are homeless and mentally ill.
 - An inventory of existing service providers for people who are homeless and mentally ill.
 - An updated survey to identify ADMHS consumer housing preferences.
 - A gaps analysis and needs assessment of current housing stock and services.
- The County's Housing Element encourages expansion, construction, and retrofit of projects into a variety of types that meet the needs of the County's chronically homeless population including:
 - Fast track permit processing for homeless facility projects and projects that house people with disabilities.
 - Emergency shelters, transitional housing, and SRO's are exempt from the Inclusionary Housing Program.
 - The County is supportive of, and works with, project proposals including housing for people with disabilities.

Chart B3: Housing Inventory Under Development

Provider	Facility	Target Population	Units/Beds	Anticipated Occupancy Date
Good Samaritan Shelter, Inc.	Casa de Familia	Chronically homeless families	16 beds	
Lompoc Housing Assistance Corporation	SRO in Lompoc	Youth	individual beds/ beds for CH	
Lompoc Housing and Community Development Corporation*	Casa del Desarrollo	Single males & females	19 individual beds/ 19 beds for CH	5/08
Santa Barbara City Housing Authority*	El Carillo	Single males & females	61 individual beds/ 61 beds for CH	8/06
Transitions Mental Health	SRO in Lompoc		individual beds/ beds for CH	

Additionally, 25 beds are planned at the Leon Hotel and 51 units are planned at 617 Garden Street. In response to the issues identified in the Mental Health Services Act (MHSA) community planning process, a new program, Vida Nueva, has been proposed for MHSA funding over the next three years (2005-2008) which will provide housing subsidies, supportive housing and other services for transition-age youth and adults with mental health problems who are homeless or-at-risk.

* This information is based on Santa Barbara's 2006 Continuum of Care application for McKinney Vento funding.

**HOUSING APPENDIX C:
HOUSING SPECTRUM**

Length of Stay	Type of Housing	Housing Program
Permanent	<i>Permanent Supportive Housing</i>	Affordable housing linked with an array of service supports, including case management, healthcare, drug and alcohol treatment, mental health services, self-help groups, and life skills where clients determine the range and intensity of services they will accept. Includes complexes with on-site 24-hour staffing, as well as scattered site models served by mobile service teams. Some services are provided on-site, in the client's home, and others through linkage with community-based services. Enables people with ongoing service needs to maintain housing stability and maximize their self-sufficiency.
	<i>Permanent Affordable Housing</i>	Housing with a rental cost that is no more than 30% of the client's total income. Includes housing with project-based and/or tenant-based (voucher) subsidies.
	<i>Adult Residential Facilities</i>	Provide 24-hour non-medical care and supervision for adults under 60 who are unable to meet their own needs.
	<i>Licensed Board and Care</i>	Residences for elderly people that offer meals and some level of personal assistance, but not skilled medical care.
	<i>Sober living</i>	Drug and alcohol free houses where residents recover through support from others, but are not compelled to participate in any type of treatment, before, during, or after their stay.
	<i>Group homes</i>	Provide 24-hour non-medical services and support to dependent children, juvenile wards, developmentally disabled, and seriously emotionally disturbed children in a structured environment.
	<i>Respite Care</i>	Provide shelter, health care, and supportive services for persons too ill to be on the street or in emergency shelters.

	<i>Safe Havens</i>	A form of low demand housing designed to meet mentally ill persons “where they are at,” allowing them to choose their own level of help when they are ready. Provides them with a 24 hour/day safe place indoors (in private or semi-private accommodations), access to a full range of support services, and assistance in accessing permanent housing. There is no limit on length of stay, and in some designs, can convert into permanent supportive housing. Serves hard-to-reach home-less persons who have severe mental illness, are on the streets, and have been unable or unwilling to participate in services.
0-2 years	<i>Transitional Housing</i>	Supportive housing with intensive case management and motel voucher wrap-around services, for an extended (up to 24 months), but not permanent time period. Designed to provide people with structure and support needed to address critical issues contributing to homelessness, and to teach skills necessary to maintain permanent housing and maximum self-sufficiency. Target populations include domestic violence victims, people in recovery from alcohol or drug abuse, youth transitioning from foster care, and others in need of intensive, time-limited support.
Short-term	<i>Emergency Shelter</i>	Emergency shelters include a range of crisis facilities designed to provide shelter for people who have lost their housing (also includes programs). Time limited with typical stays ranging from 30 to 90 days, sometimes as long as 6 months. Hours vary, ranging from all day to open only in the evening. Services provided range from those to address basic needs (bed, shower and food) to services aimed at assisting residents to exit homelessness, including case management, benefits assistance, housing assistance, mental health and substance abuse assessment, counseling and referrals, and healthcare.
Short-term	Interim Housing	Short-term housing program that rapidly re-houses persons who are homeless into appropriate permanent housing while providing supportive services to persons while they are housed. Program elements may include: <ul style="list-style-type: none"> • Housing assessment • Provision of or formalized partnership to housing referrals and placement services • Linkage to community supports and/or wrap-around system of services

		<ul style="list-style-type: none"> • Access to crisis intervention • Safety assessment particularly for youth • Public benefits screening and acquisition • Provision of or linkage to psychosocial assessment • Provision of or linkage to physical health assessment • Provision of or linkage to child focused assessment • Assistance in accessing housing relocation resources/ supports (security deposits, utilities) • 24-hour basic services (showers, beds, meals, laundry, hygiene products) • Time limits of 120-days is the goal
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INCREASING INCOMES APPENDIX A:

MODELS, BEST PRACTICES, AND RESEARCH THAT INFORMED THE DEVELOPMENT OF THE SANTA BARBARA COUNTY-WIDE 10 YEAR PLAN TO END CHRONIC HOMELESSNESS

In determining how to shape strategies and action steps that support increasing the incomes of homeless and chronically homeless individuals in Santa Barbara County, the Increasing Incomes Committee studied program models and analyzed research regarding successful practices. As a result, the strategies and actions steps that were adopted are based on successful, well-documented models and strong research.

Increasing Incomes Model: Ending Chronic Homelessness Through Employment and Housing

The Office of Disability Employment Policy (ODEP), the Veterans Employment and Training Service (VETS), the Employment and Training Administration (ETA), and the Department of Housing and Urban Development (HUD) funded 5 projects to increase and improve employment opportunities for chronically homeless individuals with disabilities in 2003. The demonstration grants began or expanded the delivery and implementation of “customized employment” strategies for homeless individuals with disabilities so that they may live, work, and fully participate in their communities.²¹

The Department of Labor, in conjunction with the Department of Housing and Urban Development, has promoted the customized employment model. This model is aimed at employment strategies for those with disabilities, including physical, mental, and developmental disabilities. Strategies include supported employment; supported entrepreneurship; individualized job development; job carving and restructuring; use of personal agents (including individuals with disabilities and family members); development of micro-boards, micro-enterprises, cooperatives and small businesses; and use of personal budgets and other forms of individualized funding that provide choice and control to the person and promote self-determination. These and other innovations hold the promise of dramatically increasing both employment and wages for people with disabilities, in part by increasing their choices for integrated, competitive employment, business ownership, micro-enterprise development, entrepreneurship, and other employment options that were previously seldom available.

²¹ Information regarding the grant and grantees was obtained at <http://www.dol.gov/odep/programs/homeless.htm> and www.csh.org.

Chronic Homelessness Project Sites

Worksystems, Inc., Portland, Oregon
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Overview:

Worksystems works primarily with 17 local organizations, including faith-based organizations, from the housing, disability, employment, employer, and veteran communities, to coordinate permanent housing with customized employment services in an effort to end the cycle of chronic homelessness for individuals within the Portland community. The key operational component of this project is the Community Services Team (CST), which uses a strengths-based assessment, treatment plans, and motivational interviewing to engage individuals in self-determined service planning. The CST delivers a full array of services in a facilitative manner, thus eliminating obstacles. Customized employment strategies such as job carving, micro-enterprise development, individual development accounts (IDA's), and peer mentors are the hallmarks of this effort.

Outreach:

ACT teams do outreach. The program also receives referrals from homeless providers.

Housing and Supportive Services:

The program utilizes a Housing First approach. The program has 89 Shelter Plus Care vouchers.

Participants are able to obtain services through partner organizations for drug and alcohol treatment, mental health services, and primary care services.

Employment Services:

Worksystems uses a person centered approach. Two of the five One Stops in the region serve homeless people. Participants have individualized service plans. The following services are offered to participants:

- Access to job listings
- Workshops
- Information, referrals, and coordination with other employment programs
- Resource room
- Career mapping

Intensive services include:

- Training
- Supportive services
- Case management
- Resource coordination
- Follow up and retention services

- Interview coaching
- Benefits advocacy and assistance
- Transportation assistance with getting to interviews, applying for jobs, and getting to One Stops
- On-going career planning
- Budget planning
- Mentoring

Primary Partners:

- Worksystems – runs One Stops
- Housing Authority of Portland – administers the Shelter Plus Care program
- Central City Concern – provides addictions, mental health and primary care services, housing, and employment services
- Outside In - Homeless youth agency contracting with CCC to provide staff position and youth expertise
- JOIN - Homeless outreach agency partnering with CCC to provide Outreach and support services

Note Re Formatting:

Please insert a graphic or picture on pages where the text ends high on a page.

Homeless Opportunity Providing Employment (LA's HOPE), Los Angeles, California

Overview:

Under the leadership of the Workforce Development Division of the Community Development Department and the City of Los Angeles, ten Los Angeles agencies representing the public and private, community-based, and faith-based sectors have joined together to better integrate the permanent housing, mental health, and other workforce development programs serving persons with disabilities who are both chronically homeless and mentally ill. All partners are committed to improving and enhancing the coordination of activities among agencies that operate emergency shelters, provide support services to the homeless, offer mental health and substance abuse treatment programs, provide permanent supportive housing and develop employment opportunities. Customized employment services are provided and coordinated with housing and other needed services in order to break the cycle of chronic homelessness.

All services are provided with sensitivity to the client's former homeless condition and current mental health and substance abuse issues, in a culturally appropriate manner, with the goal of providing continuous improvement in their housing and employment status.

Outreach:

Outreach workers from Portals, SCHARP, and SFVCMHC identify LA's HOPE's seventy-six homeless participants at three of the region's continuously operated overnight emergency shelters.

Housing and Supportive Services:

Participants are referred to the partners' existing wrap-around AB 2034 programs to stabilize their mental health issues and address other issues that they are experiencing (e.g. substance abuse, physical health issues, etc.).

Housing specialists from these agencies help the participants immediately secure permanent, affordable housing with supportive services in the private market using their federal housing certificate to pay the rent. Additionally, upon enrollment, LA's HOPE participants receive mental health services, including medication support, 24/7 crisis counseling, case management, and move-in assistance.

Employment Services:

Once the participant is living in their own apartment and has exhibited evidence of readiness to work, Goodwill's staff, in partnership with the participant's case manager, begins implementing the participant's customized job plan.

With their recognized expertise in providing employment support to individuals with disabilities, Goodwill assesses the participant's job readiness, work skills, work history, and areas of interest in relation to employment. When participants are ready to move

forward with their plans, Goodwill refers them to a One Stop center for case management services, job placement services, and follow-up. The Goodwill job developer continues to work with participants while the participants receive services from the One Stop. Participants are able to attend school, complete GED requirements, or participate in paid work experience, volunteer, or vocational training programs. Funding is available to provide both wages for paid supported employment, as well as vocational training for the participants.

Business service reps are working now with employers to find food service, retail, and administrative positions that will fit the population.

Partners:

A consortium of Los Angeles agencies representing the public and private, community-based and faith-based sectors:

- The City of Los Angeles Community Development Department (WIB)
- Housing Authority of the City of Los Angeles
- Goodwill Southern California, Inc. (Goodwill)
- Los Angeles County Department of Mental Health
- Los Angeles Homeless Services Authority
- Portals House, Inc.
- San Fernando Valley Community Mental Health Center, Inc. (SFVCMHC)
- Shelter Partnership, Inc.
- South Central Health and Rehabilitation Program (SCHARP)

Homework Program, Boston, Massachusetts

Overview:

The Boston Private Industry Council organized a coalition of local organizations from the housing, disability, employment, employer and veteran communities in a combined effort to coordinate permanent housing services with customized employment services so as to end the cycle of chronic homelessness for individuals within the Boston community. Through an extensive collaboration, the project creates a blend of housing and employment services that are presented in a seamless and coordinated fashion, providing ease of access to consumers. This effort increases connections and capabilities of the One Stop Career Centers and of other service systems to serve persons with disabilities who are chronically homeless.

Outreach:

Participant outreach is conducted through 5 partner contracted employment service agencies, through the Department of Mental Health Area offices and their Homeless Outreach Team, and in homeless shelters.

Housing:

Participants are allowed to choose from various housing options in the project's scattered site model.

- DND provides Shelter Plus Care Vouchers
- MBHP reviews eligibility and provide necessary documentation
- JRI and ABCD provides housing supports

Employment Services:

The project has a continuum of employment services.

Partners:

- Employment Agencies: Project Place, Victory Programs, Community Work Service, New England Shelter for Homeless Veterans, Bay Cove, JobNet
- Housing: Justice Resource Institute, Action for Boston Community Development
- Federal: Department of Labor, Department of Housing & Urban Development
- State: Department of Workforce Development, Department of Mental Health
- Local: Boston's Department of Neighborhood Development, Metro Boston Housing Partnership
- Local Evaluators: CommCorp
- Outreach: Department of Mental Health's Homeless Outreach Team
Long Island Homeless Shelter
- Employment: Bay Cove, Community Work Services, Project Place, New England

Shelter for Homeless Veterans, Victory Program, JobNet, Boston Private Industry Council

- Other Partners: Justice Resource Institute, Action for Boston Community Development, Metropolitan Boston Housing Partnership, Boston Department of Neighborhood Development, Mass. Housing & Urban Development, Mass. Department of Mental Health, Mass. Department of Workforce Development
- Technical Assistance: CHETA, CommCorp

The Threshold Project, Indianapolis, Indiana

Overview:

The Indianapolis Private Industry Council, Inc. created a new “System of Care” approach designed to combine and coordinate the various service delivery partners, including in the employment and housing areas, in a way which offers the consumer no wrong doors for entry into the system. The Threshold Project places homeless individuals in housing, provides support services, and helps them find employment.

Housing and Supportive Services:

The housing is subsidized; HUD’s Shelter Plus Care program requires tenants to pay 30 percent of their income toward rent. Furniture, household items, and utilities are furnished.

Employment:

Customized employment services identify an individual’s strengths, goals, vocational desires, and interests, and helps each individual find a job that uses them. The project teaches employers how to work with at-risk populations and guides them in making reasonable accommodations to allow an individual to succeed on the job.

The project coordinates services its participants need to become contributing members of the community, such as case management, medical services, legal assistance, and mental health services. It helps participants identify their strengths and skills, explore possible careers, plan their futures, get industry-specific training, tackle adult basic education, learn job-seeking and job-retention skills, and conduct job searches.

Partners:

- HealthNet’s Homeless Initiative Program
- Goodwill Industries of Central Indiana Inc.
- Easter Seals Crossroads Rehabilitation Center
- Luther Consulting LLC.

From Indianapolis Private Industry Council, Inc. website at <http://www.ipic.org/forcommunity.htm>

Overview:

Under the leadership of the Private Industry Council of San Francisco, Inc., this “vocationalized housing” program provides housing, case management, and employment program services to chronically homeless people. This effort seeks to better combine and coordinate the multiple services and agencies that deliver vocationalized housing in an effort to improve both the involvement of the area’s workforce development system, including the area’s One-Stop Career Centers, and the employment options for the chronically homeless. As a model program, the goals include a component of systems change to demonstrate ways to address chronic homelessness in collaborative efforts: stakeholders demonstrate an increase in their knowledge of employment strategies and resources for use with chronically homeless people, and identify and participate in policy changes to mitigate disincentives to work.

Housing and Supportive Services:

The project has 70 units of permanent housing at scattered sites. Participants have private bedrooms and shared common areas in multi-bedroom homes. Services are provided on-site and at other neighborhood locations.

Supportive services including case management are provided to assist with housing stability and promote increased self-sufficiency.

Employment:

Customized employment opportunities for chronically homeless adults focused on individual needs and skills and creating a culture of work with the hope of ending the cycle of chronically homeless individuals. Participants receive:

- career counseling and assessment
- assistance with developing a resume and preparing for interviews
- access to computers, internet, and other office equipment
- job search assistance
- job coaching and employment follow-up

Partners:

A Collaborative of nonprofit, community and government partners:

- San Francisco Department of Human Services, Housing and Homeless Programs Division and Workforce Development Division
- United Council of Human Services
- Young Community Developers
- Southeast Career Link One Stop
- Corporation for Supportive Housing

- Private Industry Council

Increasing Incomes Model: Work Training Program, Santa Barbara County, CA

Activity Description

Why: The Work Training Program (WTP) was started to “provide independent living and employment services to people with disabilities or disadvantages that enable them to live and work as productive members of their community.”

What: Started in 1964, and later expanded in 1980 to target the mentally ill, WTP works with people with developmental and physical disabilities, mental illness, and seniors who are homeless. WTP offers a variety of employment and living services to help their clients assimilate into community living. WTP will provide services at the El Carrillo project (scheduled to be completed in Fall 2006) including medical support, life skills education, support around co-occurring disorders, and employment support. All residents of El Carillo will be able to access services through WTP, however, only the 18 individuals in units funded by Shelter Plus Care grants will be required to obtain services.

Services offered by WTP:

- Case management
- Job development and placement
- Supported employment
- Work adjustment
- Computer skills training
- Instructional services
- Independent living services
- Assisted living services

Outcomes

- During Fiscal Year 2004-2005, 524 people received services in Santa Barbara County (www.wtpinc.org).

Funding

- California Endowment
- Contract with ADMHS
- Private pay

WTP has divisions in Santa Barbara County, San Luis Obispo County, Los Angeles County, and Ventura County.



Profiles of One Stop Career Centers Serving Homeless People

Below is a brief look at some of the strategies used by One-Stop Career Centers and their partners to serve individuals and families who are homeless. This list is not exhaustive—it was initially developed in 2003 and updated by the Chronic Homelessness Employment Technical Assistance Center (CHETA) in 2005 using information gathered through e-mailed and telephone surveys or on-site visits.

Throughout the country, Local Workforce Investment Boards¹ (LWIBs), One Stop Career Centers and Continuums of Care² (CoCs) serving those experiencing homelessness are responding to the significant program and systems challenges to addressing the employment needs of people who are homeless. Since 2003, many of the promising programs summarized in these profiles made strides to improve access and use of mainstream employment services. Some programs originally described have not continued to operate under their original funding auspices, but their work has set the stage for initiatives that succeeded and built upon their successes.

Profiles in this review include one stop career centers located in the following cities:

Tucson, Arizona	Portland, Maine
Mountain Home, Arkansas	Boston, Massachusetts
Glendale, California	Chattanooga, Tennessee
Irvine, California	Houston, Texas
Bridgeport, Connecticut	Washington, D.C.

CHETA found that most programs began with a modest, targeted effort (i.e.: obtaining community voice mail boxes for homeless One Stop users without phone access) and built

¹ Created by the Workforce Investment Act of 1998, Local Workforce Investment Boards are entities charged with meeting the needs of employers and job seekers in a jurisdiction and submitting plans to the state, which in turn submits a plan for approval to the US Department of Labor. Boards ensure that the workforce system is market-driven; is easily accessible to any individual who wants or needs a job, education, or training; supplies well-trained people for all employers; and delivers services through one stop career centers. There are 3,500 one stop career centers across the United States. Find a one stop career center at <http://www.servicelocator.org/>. Information about WIBs can be found at the National Association of Workforce Boards website, www.nawb.org.

² Continuum of Care (CoC) commonly refers to the entity that develops and carries out the Continuum of Care plan. The Continuum of Care plan is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness. There are nearly 500 CoCs across the United States. Find a Continuum of Care contact at <http://www.hud.gov/offices/cpd/homeless/programs/cont/coc/>.

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INCREASING INCOMES APPENDIX B: INFORMATION ABOUT CALWIN

CalWIN is an automated system that assesses benefit eligibility and calculates benefits for all assistance programs including:

- CalWORKS
- Welfare to Work
- Medi-Cal
- Food Stamps
- General Relief
- Foster Care/Adoption Assistance
- Child Care

Advantages to adopting CalWIN include:

- More accurate calculation of benefits
- Fewer forms for clients to fill out
- Increased staff productivity
- Improved public service

CalWIN was implemented in Santa Barbara in March 2006. Santa Barbara is the fourteenth county in California to adopt CalWIN.

INCREASING INCOMES APPENDIX C: INCOME ASSISTANCE IN SANTA BARBARA

Chart C1: Profiles of Selected Income Assistance Providers in Santa Barbara County*

Employment Assistance

- The Salvation Army operates a Job Club to assist homeless persons develop resumes, prepare applications for employment, and practice interview skills. This program also helps with job placement, career planning, and vocational training.
- Good Samaritan operates an employment opportunity service and casual labor registry for homeless persons in Santa Maria.
- Transition House, working in collaboration with Santa Barbara City College, has developed a job training and education program for homeless persons.
- The Private Industry Council administers a JTPA program with special outreach for homeless persons.
- In Santa Maria, the Center for Employment Training provides comprehensive vocational and job placement services for low-income and homeless persons.
- Job training is a major focus of the social service package funded with McKinney Vento Act dollars at the Hotel de Riviera.
- Both Work, Inc. and Work Training Programs operate day vocational programs serving several hundred persons.
- New Beginnings has a Vocational Training program that operates out of the Salvation Army Hospitality House for all homeless clients.

Income Supports/Benefits

- General Relief and Temporary Housing Assistance (THA) programs provide support for homeless families to access emergency shelter. The County's THA program also provides assistance to homeless families for utility and security deposits.
- The Public Guardian's Office provides money management for SSI recipients requiring such assistance.
- The County Department of Social Services has homeless outreach workers who visit shelters, encampments, and other locations to enroll homeless persons in income support programs including GR, THA, CalWORKS, SSI, Social Security, and other programs.

Educational Services

* This information is based on Santa Barbara's 2005 Continuum of Care application for McKinney Vento funding.

- The Transition House administers a program to offer homeless prevention services to at-risk homeless families (those who are marginally housed). These services include low/no cost childcare, employment enhancement workshops, computer literacy, ESL, etc.
- Good Samaritan Shelter, Inc. provides childcare through CAC's on-site HeadStart program and also provides job training and readiness through the One Mother to Another curriculum that focuses on improving the lives of single mothers and their children through higher education. The curriculum includes developing a support system, budgeting, job interviewing, resume development, resources, financial aid, etc.

Chart C2: Programs Under Development that Will Increase Santa Barbara Homeless Residents' Income

In response to the issues identified in the Mental Health Services Act (MHSA) community planning process, the following homeless-related services have been proposed for funding over the next three years (2005-2008):

- Vida Nueva: will provide a range of services, including vocational services, for transition age youth with mental health disorders
- New Heights: one-stop, hub of support drop-in center for services and social support for transition age youth with a mental health disorder. Services to include vocational support, supported employment, and benefits assistance.
- Bridge to Care: services for people with co-occurring disorders, including vocational services.

Additionally, there is work underway at several new projects that will support income increasing activities:

- El Carillo (for homeless mentally ill; will include WIB vocational services)
- Garden Street (Mental Health Association)
- Good Samaritan (includes vocational training)

FINANCING APPENDIX A:
MODELS, BEST PRACTICES, AND RESEARCH THAT INFORMED THE
DEVELOPMENT OF THE SANTA BARBARA COUNTY-WIDE 10 YEAR PLAN TO
END CHRONIC HOMELESSNESS

In determining how to shape the strategies and action steps that will facilitate the end of chronic homelessness in Santa Barbara, the Financing Committee examined a variety of funding sources. The strategies and actions steps that the Committee developed incorporate their analysis of which types of funding Santa Barbara should pursue.

State Funding

The majority of state funding for construction and rehabilitation comes from the *Housing and Emergency Trust Fund Act* of 2002. Passed by 58% of California voters in November 2002, this Act has allocated \$56,007,407 since its inception for new construction and substantial rehabilitation of supportive housing. In the three fiscal years that the program has been running, it has commenced or completed construction on 1,063 supportive housing units.

In addition, California's *Services for Homeless Adults with Serious Mental Illness Program* funds supportive services, including mental health, outreach, substance abuse services and vocational assistance. The Employment Development Department of California administers a veterans program that assists homeless veterans with mental health services, alcohol and drug rehabilitation, and employment development.

In November 2004, California voters passed the *Mental Health Services Act (MHSA)*. Under MHSA, the California Department of Mental Health (DMH) has been given increased funding to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults, and families. Under the new program, DMH will engage in prevention, early intervention, and service needs and provide infrastructure, technology, and training.

According to DMH, MHSA "imposes a 1% income tax on personal income in excess of \$1 million. Statewide, the Act was projected to generate approximately \$254 million in fiscal year 2004-05, \$683 million in 2005-06, and increasing amounts thereafter. Much of the funding will be provided to county mental health programs to fund programs consistent with their local plans. Any uncommitted funds during FY 2005-06 will be used to establish county prudent reserve accounts as required by the Act."

The Act specifies the following six funding priorities:

Percentage Funding Distribution by Component				
FY 2004/05	FY 2005/06	FY 2006/07	FY 2007/08	
Education/Training	45%	10%	10%	10%
Capital Facilities/Technology	45%	10%	10%	10%
Local Planning	5.0%	0.0%	0.0%	0.0%
State Implementation/ Administration	5.0%	5.0%	5.0%	5.0%
Prevention	0.0%	20%	20%	20%
Community Services and Support	0.0%	55%	55%	55%

Local Funding

State law requires that redevelopment agencies use 20% of all tax increment revenue generated from the project area for the purpose of increasing and improving low- and moderate-income housing in the area. As such, local redevelopment agencies provide a significant amount of the funding needed for the construction and rehabilitation of permanent supportive housing. Local housing authorities also control rental assistance vouchers. Some jurisdictions own permanent housing programs while others have set up local trust funds for affordable housing.

Local Funding Success: Casa Esperanza, Santa Barbara, CA

Activity Description

Why: In 1999, Santa Barbara City and County were informed that the Winter Homeless Shelter would not be available that winter due to seismic retrofitting. As a result, a broad base of community members – religious, business, government, and civic leaders – was formed called the Coalition to Provide Shelter and Support to Santa Barbara Homeless.

What: The Coalition acquired a large old furniture warehouse and then worked with the community to renovate the building in a way that met the needs of Santa Barbara’s homeless population and the community. The building was opened in December 1999, but continued to be renovated and improved. By 2002, a second story had been added that housed social service providers.

Significant Program Design Features:

Services

- The Day Center is open every day
- Services address physical and emotional needs, and empower homeless individuals
- 12 service providers on-site
- Public health nurses, employment and housing specialists, case managers, literacy aides, and substance abuse counselors available on-site

Housing

- 200 emergency shelter beds in winter
- Shelter services available to participants in recovery programs year-round

Outcomes

- In one year, 1500 individuals were served.
- In 2003, the Kitchen served 200 meals daily, and 106,000 meals total.
- Caseworkers see 300 individuals monthly.
- As of 2003, 300 people had been placed in permanent housing; 80% of those placed had remained in their units.
- The Center has created 12 full-time positions, many of which have gone to homeless individuals.
- Police calls to the area have decreased.

Funding

- Redevelopment Agency of the city of Santa Barbara – \$1.6 million
- Santa Barbara County - \$500,000
- Private contributions raised through capital campaigns - \$3.9 million

FINANCING APPENDIX B:

PROJECTED FUNDING GOALS AND COSTS FOR PLAN IMPLEMENTATION

PRELIMINARY PROJECTION OF COSTS ASSOCIATED WITH HOUSING:

Costs of Housing for the Chronically Homeless Population

	Units of Housing	Type of Unit	Cost Per Unit	Total Cost
CH Individuals				
Acquiring/Rehabilitating Housing				
Constructing Housing	550	SRO/Studio (250 sq. ft.)	\$159,000	\$87,450,000
Master Leasing				
Safe Haven or Shelter Plus Care				
CH Families				
Acquiring/Rehabilitating Housing				
Constructing Housing				
Master Leasing	50	2 bedroom	\$16,800	\$840,000 (per year)
Safe Haven or Shelter Plus Care				
Total Resources Needed				

Assumptions: The construction cost estimates are based on the costs for a project that is currently under construction in the City of Santa Barbara. Although the cost of construction (and in theory, for acquisition and rehabilitation) would be lower in Lompoc and Santa Maria, these numbers are a feasible estimate because the estimated costs above have not been adjusted for inflationary increases over the next ten years.

Data used to calculate numbers: These numbers were calculated by Santa Barbara County staff, staff from Santa Barbara City and County housing authorities, and local housing developers.

Costs of Providing Supportive Services in Supportive Permanent Housing

	Number of Persons in Permanent Housing	Total Cost of Providing Supportive Services*
2007	60	\$600,000
2010	500	\$5,000,000
2013	750	\$7,500,000
2016	1200	\$12,000,000

*Cost per person estimated at \$10,000 per year, using existing sources who will prioritize work with this population.

PRELIMINARY PROJECTION OF COSTS ASSOCIATED WITH PREVENTION:

Costs for Transitions Teams (projected as 2 person teams)

	Number of Teams Serving Each Area	Cost Per Team	Total Cost
Lompoc	1	\$180,000	\$180,000
Santa Maria	2	\$180,000	\$360,000
South County Coast	4	\$180,000	\$720,000
Total Cost			\$1,260,000

Costs for Transitions Centers

	Number of On-Site Sleeping Units	Total Cost*
Lompoc	8	\$650,000 - \$700,000
Santa Maria	8	\$650,000 - \$700,000
South County Coast	8	\$650,000 - \$700,000

*The projected costs are based on the costs for a similar program that serves youth. In the first 3 years of the Plan, we will assess the costs of the Centers, including the costs for sleeping units and services provided.

PRELIMINARY PROJECTION OF COSTS ASSOCIATED WITH OUTREACH:

Estimated Costs Associated with Expansion of Outreach and Services

	Number of Teams	Cost Per Team	Total Cost
Street Outreach Teams	6 2-person teams	\$180,000	\$1,080,000
Support Integrated Services Teams	3 2-person teams	\$180,000	\$540,000
Total Cost			\$1,620,000

*Outreach Teams projected as 3 in South County, 2 in Santa Maria, 1 in Lompoc. One SIST each in Santa Maria and Lompoc, and 2 in South County.

Estimated Costs for Community Centers

	Number	One-Time Cost	Annual Cost for	Total Cost
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	of On-Site Beds	for Building	Other On-Site Services	
Lompoc	8	\$1.2 million	\$650,000	\$1,850,000
Santa Maria	8	\$1.2 million	\$650,000	\$1,850,000
South County Coast	8	\$2 million	\$650,000	\$2,650,000
Total Cost				\$6,350,000

*Projection based on acquiring new space for each locality.

PRELIMINARY PROJECTION OF COSTS ASSOCIATED WITH INCREASING INCOMES

Estimated Additional Costs of Providing Employment Assistance

	Lompoc/Santa Maria	South County Coast	Total
Job Developer* (60,000 x 0.50 FTE x .40 fringe**)	36,000	36,000	72,000
Employment Specialist* (60,000 x 0.50 FTE x .40 fringe)	36,000	36,000	72,000
Industrial Relations Staff* (40,000 - 45,000 x 0.50 FTE x .40 fringe)	28,000 - 31,500	28,000 – 31,500	56,000 – 63,000
Job Coach* (36,000 x 0.50 FTE x .40 fringe)	25,200	25,200	50,400
Total			250,400 – 257,400

*The job developer position/employment specialist positions will be split, as will the industrial relations staff/job coach positions.

**Fringe benefits include payroll taxes, paid time off benefits, health benefits, etc.

PRELIMINARY PROJECTION OF COSTS ASSOCIATED WITH OVERSIGHT

(The Staffing for the Campaign to implement this Plan will be phased in as resources allow, and tasked to existing positions, where feasible. The Campaign Coordinator and Fund Development Coordinator are needed at the start of the first year.)

	Annual Salary/ Fringe*	Annual Overhead Costs**	Total
Chronic Homeless Campaign Coordinator	\$95,000/\$28,500	\$22,230	\$145,730

Fund Development Coordinator	\$80,000/\$24,000	\$18,720	\$122,720
Housing Project Manager	\$73,000/\$21,900	\$17,082	\$111,982
Outreach and Integrated Services Teams Manager	\$73,000/\$21,900	\$17,082	\$111,982
Income and Employment Manager	\$50,000/\$15,000	\$11,700	\$76,700
Administrative Support			
Total Cost			

*Fringe benefits are estimated at 30%. Fringe benefits include payroll taxes, paid time off benefits, health benefits, etc.

**The County has proposed incorporating these positions into existing governmental or nonprofit infrastructures so that overhead can be absorbed. The group needs to discuss this option with regard to how might impact the implementation structure the group has chosen.

**FINANCING APPENDIX C:
FINANCING CAPACITY IN SANTA BARBARA**

Chart B1: Private Resources Leveraged for McKinney Vento Homeless Programs

Application Year for McKinney Vento Funding	Amount of Leveraging
2006	\$1,629,110
2005	\$2,462,009
2004	\$1,738,638

Chart B2: Santa Barbara County Mainstreaming Statistics FY 2005*

Mainstream Resource	% Santa Barbara Homeless With Resource at Exit	% San Francisco Homeless With Resource at Exit
SSI	14%	19%
SSDI	2%	3%
Social Security	1%	2%
General Public Assistance	10%	25%
TANF	5%	4%
Children's Healthcare	0%	0%
VA Benefits	1%	5%
Employment Income	18%	25%
Unemployment Benefits	1%	2%
Veterans Healthcare	0%	7%
Medicaid	0%	11%
Food Stamps	95%	16%
No Financial Resources	56.3%	20%

*This information is based on Santa Barbara's 2006 Continuum of Care application for McKinney Vento funding.

**OVERSIGHT AND IMPLEMENTATION APPENDIX A:
MODELS, BEST PRACTICES, AND RESEARCH THAT INFORMED THE
DEVELOPMENT OF THE SANTA BARBARA COUNTY-WIDE 10 YEAR PLAN TO
END CHRONIC HOMELESSNESS**

In determining how to shape the body that will guide the implementation of this Plan, the Oversight and Implementation Committee examined a variety of implementation models. The structure of the implementation body the Committee ultimately selected reflects its understanding of Santa Barbara County's strengths and resources as a community.

Models for the Structure of the Oversight and Implementation Body

The Committee primarily considered the following models in determining the formation and organization of its implementation body.

Option A. Joint Powers Authority

What is a Joint Powers Agreement?

A Joint Powers Agreement (JPA) is an agreement between two or more local government agencies or bodies to collectively provide a service to a community. California Government Code Section 6500 grants authority to local governing bodies to join together to provide any service that either of them could provide on their own. To form a JPA, participating government agencies must mutually agree to specific conditions and terms that may limit each agency's ability to act independently, but it does not alter the basic structure of each agency's decision-making processes. Common examples of JPAs include: a sheriff's department agreeing to provide police services to a city, a county and a city agreeing to jointly run an emergency dispatch center, or multiple jurisdictions running a transit authority.

JPAs are designed to have separate boards of directors. The boards have the same power as the participating agencies. It is within the purview of participating agencies to limit the powers granted. As such, the powers can be general or specific, the term of the authority can be designated, and general administrative requirements can be made. Funding typically flows from the participating agencies. The JPA may have its own staffing and legal entity.

Examples of Joint Powers Authorities in a Homelessness Context

Los Angeles County Homeless Services Authority

In December 1993, the Los Angeles County Board of Supervisors and the Mayor and City Council created the Los Angeles Homeless Services Authority (LAHSA), a joint powers authority. A ten-member commission governs LAHSA with five commissioners appointed by the Board of Supervisors and five commissioners appointed by the Mayor

of the City of Los Angeles and confirmed by the City Council. In addition to the ten-member commission, a 39-member Advisory Board offers its perspectives and recommendations to the Commission on policy decisions. The Advisory Board represents diverse interests, including homeless persons, faith-based organizations, advocacy groups, and other government organizations.

The mission of LAHSA is “to support, create, and sustain solutions to homelessness in Los Angeles County by providing leadership, advocacy, planning and management of program funding.” Annually, LAHSA distributes about \$50 million to more than 150 programs, operated by about 75 different nonprofit agencies. LAHSA is also the lead agency of the Continuum of Care.

Solano County Safety Net Consortium

Formed in 1999, the Solano County Safety Net Consortium (SSNC) is a joint powers authority created to “address issues of homeless and safety net services on a coordinated and collaborative basis.” Authority for the SSNC flows from participating cities and the County of Solano. Member cities include Vallejo, Fairfield, Dixon, Suisun, and Benicia. To form the JPA, the Board of Supervisors and the city councils of the participating cities debated and adopted resolutions vesting authority with the SSNC.

The governing body of the SSNC is made up of local government officials from five cities and the County. The members meet every other month. Its mission is to set policy and provide oversight and technical assistance for the development of permanent supportive housing, the operation of homeless shelters, transitional housing, and homelessness assistance centers.

Like LAHSA, the SSNC has a sub-group whose members make policy recommendations and provide critical support to the SSNC. The sub-group, known as the Solano County Continuum of Care, is made up of 25 members from diverse interests, including formerly homeless individuals, service providers, faith-based nonprofit leaders, probation officers from corrections, and mental health directors.

Option B. Independent Nonprofit to Host All Efforts

Several communities have created a lead nonprofit organization to implement homelessness planning. These nonprofits can either operate as stand-alone organizations or in concert with a joint powers authority.

Under the existing federal McKinney Vento homelessness assistance program, communities are not eligible for funding unless the community has created what is known as a Continuum of Care. The structure of the Continuum of Care vary from region to region. Some Continuum are nonprofits with 501(c)(3) designation, while others are government agencies. New legislation known as the Reed Bill is currently under consideration and would replace the Continuum of Care with a new body known as the Collaborative Applicant (See Oversight and Implementation Appendix D). The Collaborative Applicant will not be too unlike a nonprofit entity.

Washington D.C. Community Partnership

The Community Partnership for the Prevention of Homelessness (The Community Partnership) is an independent, nonprofit corporation established in 1989. Its mission is to serve as a focal point for efforts to reduce and ultimately prevent homelessness in the District of Columbia. The Community Partnership does this by drawing upon and coordinating the resources of the District of Columbia community to improve services to the homeless and to prevent future homelessness.

The Community Partnership developed the City's Continuum of Care which provides prevention services, street outreach, emergency shelter, transitional housing, permanent supportive housing and supportive services in housing programs for homeless individuals and families facing barriers to independence.

Columbus, Ohio Coalition for the Homeless

The Columbus Coalition for the Homeless (CCH) was founded in 1986 and incorporated in 1988 by a group of Columbus shelter directors and service providers who recognized that homelessness could not be resolved by a single program or agency. CCH is a private, non-profit 501(c)(3) consortium of 50 service providers, homeless persons, and citizens which meets monthly to collaborate on strategies that will best serve the needs of people who are currently homeless.

Option C. Other Collaborative Body Models that Include Jurisdictions, Providers, Homeless People and Advocates

Chatham-Savannah Authority for the Homeless

In 1989, the Georgia State legislature created the Chatham-Savannah Authority for the Homeless to do the following: 1) develop a comprehensive plan for public and private agencies, 2) coordinate, evaluate, and provide administrative services and assistance in implementing the plan, 3) contract with public and private agencies to approve programs, 4) offer services, such as case management and employment training, and 5) provide uniform standards for organizations serving homeless people.

The governing body of the Chatham-Savannah Authority is unique in that it is comprised of representatives from key government agencies that have the necessary financial resources and political power to execute decisions of the Authority. Pursuant to its charter, the Board of Directors must be made up of appointments from the City of Savannah, Chatham County, the Georgia Department of Labor, the Board of Education, the Georgia Department of Community Affairs, the Georgia Department of Human Resources, the Housing Authority of Savannah and eight additional appointees elected by the Authority members, which must include homeless persons, service providers and community advocates.

Community-based organizations are encouraged to collaborate with the Chatham-Savannah Authority for fiscal and project management support. This collaborative approach, according to the Authority, has its benefits: "When problems surface

surrounding homelessness, they are brought to the attention of the authority by service providers, advocates for homeless people, local government, and homeless people themselves. To resolve the problems, the authority marshals resources to respond to needy parties and encourage joint decision-making.”

Alameda Countywide Homeless and Special Needs Housing Plan

The Alameda Countywide Homeless and Special Needs Housing Plan does not define the shape of its implementing body, and instead involves a two-step implementation process. Initially, during the planning phase, two committees determine how to implement the plan. The *Interim Leadership Committee* determines and secures funding and staffing for the short-term implementation of the plan. The plan's sponsoring agencies²² work with civic, faith, and community leaders to create the Interim Leadership Committee. Each sponsoring agency and related agency has a liaison to the Interim Leadership Committee. The Interim Leadership Committee meets quarterly with *The Advisory Committee* to define and create the Permanent Leadership Structure. The Advisory Committee is composed of elected officials, the courts, criminal justice agencies, health departments, Stakeholders Steering Committee, consumers and their family members, public housing authorities, housing developers, schools, unions, and the faith and business communities.

After the initial planning phase, the *Countywide Leadership Committee* will be created based on the recommendations of the Interim Leadership Committee and Advisory Committee. The Leadership Committee will be responsible for implementing the plan in a cost-effective and problem-solving manner. It will guide changes in policy, set funding priorities, promote systems change, and monitor outcomes.

Additionally, the *Interdisciplinary Council* will be created to support and advise the work of the Leadership Team, identify implementation barriers, develop phased implementation plans, and revise the service delivery system utilizing the plan strategies. The Interdisciplinary Council will be made up of key players in the system – funders; housing, social service, and health care providers; and the courts and criminal justice system.

The *Consumer Advisory Process* will include consumers, their advocates, and their families. The Consumer Advisors will advise the Interdisciplinary Council regarding program development and policy setting.

Additionally, *Subcommittees* (e.g., Data Workgroup, Funders Workgroup, and Board and Care Workgroup) will inform the implementation of the Plan.

²² Sponsoring members: Alameda County Behavioral Health Care Services, Alameda County Housing and Community Development Department, Alameda County Public Health Department Office of AIDS Administration, Alameda County Social Services Agency, Alameda Countywide Homeless Continuum of Care Council, City of Berkeley Housing Department, City of Berkeley Health and Human Services Department, City of Oakland Community and Economic Development Agency, and City of Oakland Department of Human Services.

Contra Costa County

As part of enacting its ten-year plan, Contra Costa County created a implementation and oversight body known as the Homelessness Inter-Jurisdictional Inter-Departmental Work Group (HIJIDWG). This body is composed of senior level representatives from City and County government, County Health and Social Service Departments, Police Departments, the Continuum of Care Advisory Board, nonprofit service providers and people who are homeless or formerly homeless. HIJIDWG has three charges:

- **First Charge:** It creates the Annual Implementation Blueprint that details the actions to be taken in the next year to carry out the Plan's five priorities. This involves fleshing out the Plan's action steps, determining costs, funding sources, expected outcomes, responsible agencies, and timelines.
- **Second Charge:** The HIJIDWG oversees the development of a Homeless Management Information System (HMIS) in the County to measure program outcomes.
- **Third Charge:** The HIJIDWG works with the Continuum of Care Advisory Board to oversee the development of public education and fundraising campaigns designed to enhance understanding of homelessness.

Santa Cruz County Homeless Action Partnership and Memorandum of Understanding

To implement its 10-year plan, the County of Santa Cruz (along with the cities of Santa Cruz, Watsonville, Capitola and Scotts Valley) expanded the leadership and powers of the local Continuum of Care. The Continuum of Care was renamed the Homeless Action Partnership and underwent the following structural changes: 1) two paid staff positions were created;

2) membership was broadened to include faith community, business, funders, law enforcement, and community and neighborhood groups; and 3) specific tasks were assigned, including annual evaluation of Plan progress, development of new programs, establishment of minimum quality assurance standards for the operation of homeless shelter, housing, and service programs, implementation of a public relations strategy to inform the public, and prepare a new plan at the expiration of the existing plan.

The ten-year plan also called for the creation of a formal Executive Committee comprised of jurisdictions and entities in the Partnership that control the resources needed to implement the Plan. The Executive Committee is composed of no more than ten persons who hold significant positions of relevant authority with the County, the cities, other funders of services, and housing. The Plan states that the following entities should be considered: 1) County Administrator's Office, 2) Human Resources Agency, 3) Health Services Agency, 4) Housing Authority, 5) City of Capitola, 6) City of Santa Cruz, 7) City of Scotts Valley, 8) City of Watsonville, 9) the United Way of Santa Cruz, and 10) Community Foundation of Santa Cruz.

The drafters of the Santa Cruz County Plan concluded that the best way to formalize partnerships was through a global *Memorandum of Understanding* between participating jurisdictions and entities with the resources needed for Plan. Therefore, high-level representatives from the County, cities, and other funders were asked to meet to develop a joint Memorandum of Understanding on Plan implementation and resolving homelessness. The MOU address all of the following critical needs for making the Plan a reality:

- The central role of the Plan in the community-wide response to homelessness, and in setting priorities for funding.
- Establishment of, and participation in, the Homeless Action Partnership.
- Participation in, and support for, the Homeless Action Partnership.
- Creation and joint funding of the two full-time staff positions to be headquartered at the County Human Resources Agency.
- A cost sharing formula bringing jurisdictions and funding entities together to pay for the two staff positions needed to create the Homeless Coordination Team, any services and consulting needed, emergency winter shelter, and other costs the participants deem appropriate.

New York City

In order to meet the goals outlined in the New York City 10-Year Plan, strong accountability and evaluation provisions were built into the plan. According to the Plan drafters, these provisions “allow stakeholders to track progress in real time, identify and replicate best practices, and ensure public resources are spent wisely to promote independence for those receiving services.”

As part of these accountability mechanisms, a first phase implementation schedule for the action plan’s 60 initiatives was prepared. Each of the 60 action steps has a schedule that includes key outcomes, dates for completion, critical partners, and targets and timeframes for reducing the shelter and street census. Projected goals are based on the impact of initiatives in advancing one or more of the following key indicators:

- Decrease in the number of individuals living on the streets and in other public spaces
- Increase in the number of people leaving shelter to stable housing
- Increase in the supply of affordable, service-enriched, and supportive housing
- Decrease in the number of applications for shelter
- Decrease in the length of stay in shelter
- Decrease in the total number of people in shelter

Chicago, Illinois

In January 2004, The Chicago Continuum of Care adopted a blueprint to implement its 5-year plan known as *Getting Housed, Staying Housed*. The task of developing the blueprint was given to a Conversion Task Group (CTG). Under the 5-year plan, the task group was given the following duties:

1. Develop Program Models to be supported under the Plan. The Program Models provide guidelines that will standardize program descriptions, outcomes and other details necessary to facilitate transforming the current system into one that will support ending homelessness;
2. Develop general conversion principles and strategies;
3. Examine the current homeless service delivery system;
4. Adopt assumptions about the number and profile of the homeless;
5. Project the number and types of housing units needed when the Plan is fully implemented; and
6. Make first set of conversion recommendations for the SuperNOFA application process.

Chicago recognized that the Conversion Blue Print and Program Models must be “living” documents that are meant to be revised and updated as more data becomes available through the Homeless Management Information System (HMIS) and through lessons learned from executing the Plan.

Questions the Committee Considered in Exploring the Application of the Different Implementation Models in Santa Barbara:

- Response to homelessness tends to be uncoordinated. Mental health, housing, government and community-based organizations do not work in concert. How do we coordinate all this work for an improved response?
- How do we bring in mainstream resources to implement Plan?
- What mechanisms must be in place to extend the authority of the Plan beyond the 10 years in the Plan? Once homeless persons are permanently housed, how will we ensure that they will be housed beyond the 10-year mark?
- How do we organize a structure to access state and federal funds?
- How do we bring in wealth from local philanthropy?
- What can we learn from successful implementation in other arenas -- local examples include RFP, ADMH and HCD?
- The communities of Santa Barbara County are motivated right now to effect change. How do we maintain this motivation beyond the planning stages?
- The Santa Barbara City Charter creates a budget document that defines the work plan of all sectors. How do we ensure that the Plan implementation links with the policy?
- This Plan deals with chronic homelessness only. What needs to be built into the implementation to coordinate the effort to end chronic homelessness with the effort to end all homelessness?
- Will the Plan be a living structure that can adapt to new ideas and changing populations?
- How do we assure homeless efforts in the government and the nonprofit sector will be well-linked?
- Will the new oversight body have authority over the CoC, Healthcare for the Homeless Program, ADMH, and DSS to impact policy and resources?

- Will the Plan seek to coordinate all groups around work suggested at the committee level?

OVERSIGHT AND IMPLEMENTATION APPENDIX B:

OVERSIGHT AND PROGRAM EVALUATION – WHY IT’S IMPORTANT

The Oversight and Implementation Committee will also be charged with developing a mechanism to measure program performance and outcomes. Program evaluation is the systematic effort by which a program knows if it is achieving its goals. Homeless services and housing programs aim to end homelessness for the people they are serving. Additionally, there may be other goals of particular homeless programs related to improvements in health, employment, child reunification, self-sufficiency, reduced recidivism to the criminal justice system, or other areas of well-being and stability. Because homeless programs are client-centered, there are a great variety of programs designed for particular groups of people who are homeless with like experiences, such as runaway youth, mothers with serious mental illness, or people in recovery for substance abuse. Each program will have its own set of unique goals, depending on target population and type of program.

The success of this wide range of programs is contingent on an array of factors, including internal factors such as program design, skill of staff, and collaboration with other programs, as well as external factors such as availability of affordable permanent housing. Program evaluation is a way to learn which factors are supporting or impeding client success. This information can be used to adapt programs to improve success rates.

Outcomes are commonly measured by categories of data known as performance indicators. For example, a transitional housing program may track its success in clients moving into permanent housing by measuring the number of program graduates who move into permanent housing. Alternatively, it may measure the number of clients who left the program (graduates and non-graduates) but remained in permanent housing for at least 2 years. These examples of performance indicators illustrate how widely performance indicators may vary. A performance indicator that may seem “difficult” to achieve, like whether a client has stayed in permanent housing for 2 years, may not necessarily be more rigorous than one that seems “easier,” such as placing a person into permanent housing. Depending on the complexity of the challenges facing the program’s clients, a seemingly “easier” performance indicator may, in fact, be appropriate.

Performance indicators are the lenses through which programs can measure their outcomes—both planned outcomes (success) and unexpected outcomes (failure). Regularly looking at outcomes can assist programs in identifying successful strategies within programs, so that they may be expanded or replicated. Further, pinpointing unexpected outcomes can provide clues about elements of a program that should be improved or barriers outside of a program that are preventing clients from succeeding.

Barriers to successful outcome measurement are multi-fold. Communities and service providers must determine which factors to measure to determine progress and how to quantify subjective measurements. Successful outcome measurement across programs is further challenged by questions about 1) how to develop and implement appropriate data

systems, 2) how to properly train staff, and 3) how to integrate data systems with other service providers.

OVERSIGHT AND IMPLEMENTATION APPENDIX C:

CURRENT ORGANIZATIONAL STRUCTURE IN SANTA BARBARA

Currently, the Santa Barbara County Board of Supervisors manages the process to develop the local Continuum of Care strategy. The Board of Supervisors, however, does not have the time or capacity to manage the full spectrum of issues arising in homelessness planning. In 2006, the Board of Supervisors created and funded a new position within the County government structure. This employee serves as a central contact person for all homeless questions and concerns in Santa Barbara County. This single contact works with each of the numerous County departments serving homeless populations.

The main planning committee for the Santa Barbara County Continuum of Care is the County Homelessness Committee. The County Homelessness Committee is a subcommittee of the County's Housing Advisory Committee which includes representatives from every city in the county.

The County Homelessness Committee makes direct policy recommendations to the County Board of Supervisors. These policy recommendations are vetted through the Housing Advisory Committee Steering Committee, which is made up of public officials from each city and the county.

Whereas the County Homelessness Committee has the responsibility to bring regional, long range Continuum of Care planning issues to the Board of Supervisors, there are three other committees focused on the three urban areas of the County. These three groups are the Santa Maria City/County Homeless Advisory Committee, the Lompoc City/County Homeless Advisory Committee, and the South Coast Homeless Advisory Committee. There is no overlap in planning efforts between these three committees, nor between these three committees and the County Homelessness Committee. The three separate City/County homeless coalitions serve as opportunities for local experts working in the homeless field to exchange specific information about the services they offer clients and what gaps in services exist in their areas.

OVERSIGHT AND IMPLEMENTATION APPENDIX D:

PROPOSED KEY CHANGE UNDER THE REED BILL REGARDING COLLABORATIVE APPLICANTS

The Community Partnership to End Homelessness Act of 2005 (S.1801) was introduced by Senator Jack Reed [D-RI] on September 29, 2005. With the support of 13 co-sponsors, the Act was read twice and then referred to the Committee on Banking, Housing, and Urban Affairs. On December 13, 2005, a fourteenth co-sponsor was added. S.1801 would reauthorize the McKinney-Vento Act, and would make major amendments to the Act. Some of the major changes proposed are those in Title IV, which authorizes all HUD homeless housing programs. If enacted, this Act would take effect within 6 months of enactment.

One of the major changes is that S.1801 defines a new entity called a “collaborative applicant,” that is:

- A representative community homeless assistance planning body
- Serves as the applicant for project sponsors who jointly submit a single application for a grant under the Homeless Assistance Program, in accordance with a collaborative process;
- If the CA is a legal entity and is awarded such a grant, the CA receives such grant directly from the Secretary;
- Notwithstanding requirements above, a CA may be a State or local government, or a consortium of State or local governments, engaged in activities to end homelessness.

Establishment or Designation of CA

CA’s could be established by the relevant parties within a given geographic area, or the Secretary of HUD could designate a CA for a particular geographic area, if, prior to enactment of this Act, the entity had engaged in coordinated, comprehensive local homeless housing and services planning and had applied for federal funding to provide homeless assistance.

Membership of CA

Each CA must include the following persons:

- At least 2 persons who are experiencing or have experienced homelessness,
- Persons who act as advocates for the diverse subpopulations of persons experiencing homelessness, persons or representatives of organizations who provide assistance to the variety of individuals and families experiencing homelessness,
- Relatives of individuals experiencing homelessness,
- Government agency officials, particularly those that are responsible for administering funding under programs targeted for persons experiencing homelessness, and other programs for which persons experiencing homelessness are eligible, including mainstream programs identified in 2 previously cited GAO reports,
- 1 or more local educational agency liaisons or their designees,

- Members of the business community,
- Members of neighborhood advocacy organizations,
- Members of philanthropic organizations that contribute to preventing and ending homelessness in the geographic area of the collaborative applicant.

Duties of CA

1. to design a collaborative process for evaluating, reviewing, prioritizing, awarding, monitoring projects and applications under Homeless Assistance Program, and for evaluating the outcomes of projects funded under ESG Program;
2. to review relevant policies and practices of private and public entities served by the CA, including priority review of:
 - discharge planning and service termination policies and practices of publicly funded facilities or institutions or other entities to ensure that such discharge or termination does not result in immediate homelessness,
 - mainstream access and utilization by homeless people,
 - local practices and policies on zoning and enforcement policies and practices to allow reasonable inclusion and distribution in the geographic areas of special needs populations and of families,
 - policies and practices relating to the school selection and enrollment of homeless children and youth,
 - local policies and practices relating to placement of children and youth in emergency or transitional shelters as close to their school of origin as possible;
 to correct policies and practices, as necessary; and, report to Secretary at least once every 3 years through Exhibit entitled, “Assessment of Relevant Policies and Practices, and Needed Corrective Actions to End and Prevent Homelessness.”
3. to design and carry out projects (if the CA runs projects);
4. to require outcome-based evaluation of grantees under the Homeless Assistance Program;
5. to request that state and local governments who distribute ESG funds to submit information and comments on administration of those activities to the CA;
6. to require outcome-based evaluation of the CA’s homeless assistance planning process;
7. to participate in the Consolidated Plan for the geographic areas served by the CA;
8. to require project sponsors to establish fiscal control and fund accounting procedures to ensure proper disbursement of Federal funds, including the conducting of annual reviews;
9. to ensure that project sponsors funded under the ESG and Homeless Assistance Programs participate in a Homeless Management Information System.

Note:

Conflict of Interest: No member of a CA may participate in decisions of the CA concerning the award of a grant, or provision of other financial benefits, to such member or the organization that such member represents.

Secretary may take remedial action against the CA if it is not meeting the requirements set forth. Remedial measures may include designating another body as CA, or permitting other eligible entities to apply directly for grants.

Legal and Non-Legal Entity CA's

CA's may be entities that are either legal or non-legal.

Under S.1801, a "legal entity" would be defined as:

- an entity that is tax-exempt under section 501(c)(3) of Internal Revenue Code, or
- an instrumentality of State or local government, or
- a consortium of instrumentalities of State or local governments that has constituted itself as an entity.

Legal entity CA's may apply for funds to fund HMIS under the Homeless Assistance Program.

Performance Reporting and Monitoring

CA's will submit an annual performance report regarding activities carried out with grant amounts received under ESG and Homeless Assistance Programs. These reports would include a number of specific outcome measures of numbers of people served and housed, numbers not served or housed, the accomplishments of the past year, strategies for the coming year, and consistency and coordination between programs funded and with the Consolidated Plan.

Each funded project sponsor funded through the Homeless Assistance Program will complete a performance evaluation, and will submit a report of sponsor's recordkeeping and reporting requirements.

Secretary may provide a waiver to any CA unable to provide information with a plan to submit information in future. Ongoing monitoring responsibility lies with CA for all sponsors.

Based on information obtained, the Secretary may adjust, reduce, or withdraw amounts made available (or that would otherwise be made available) to collaborative applicants, or take other action as appropriate.

Technical Assistance

Secretary shall make available effective technical assistance to project sponsors, potential projects sponsors, or CA's.

OVERSIGHT AND IMPLEMENTATION APPENDIX E: IMPLEMENTATION TOOLS

In the first three years of the Plan, we will coordinate an effort to gather accurate data about Santa Barbara’s chronically homeless population and its experiences so that we can create meaningful benchmarks for each strategy. We will update the charts in the Plan, and will create tools like those below to measure our progress.

Prevention Goal

Decrease the Number of Exits from Institutions that Result in Homelessness*

Year	Jails/Prisons	Hospitals/Residential Treatment Facilities	Foster Care	Total
2007				
2010				
2013				
2016				

*See Chart 1-1.

Decrease the Number of Evictions that Result in Homelessness*

Team	Lompoc	Santa Maria	South County Coast	Total
2007				
2010				
2013				
2016				

*See Chart 1-1.

Outreach Goal

Outreach Teams Goals for Chronically Homeless People in Santa Barbara County*

Chronic Homeless subpopulation	CH single adults	CH families	CH youth	CH with HIV/AIDS	CH with SMI
Total Contacts					
Street Outreach Teams Engagement					
Transitions Team outreach in institutions & among at-risk homeless					
Integrated Services Team linked to housing					
Total persons engaged in team care					
Income and Employment assistance					

*See Charts 1-1, 2-1, and 4-1.

**These goals will be created by Year 3 from the baseline numbers set in Year 1 and Team experience with the population.

Financing Goal

The costs associated with each Goal have been projected using available information in today’s dollar. It is anticipated that existing resources will be significantly tapped in order to do this work. Seed funds will be required to transition into this activity. To move through the first three years of implementation, it is anticipated that:

- Existing resources will be used
- Existing work will be reallocated
- New funds will be raised for key staff and activity, such as master leasing
- Lessons learned will be applied to subsequent action

To fully implement this plan, an investment in long-term resources will be required. A tool such as the following may be used to allow our community to chart its goals and progress.

	Source of Funding	Funding Goal for 2009	Funding Goal for 2012	Funding Goal for 2016
Housing				
___ Units for Individuals	McKinney-Vento			
	Community Development Block Grant			
	Supportive Housing for People with Disabilities			
	Supportive Housing for the Elderly			
	HOPWA			
___ Units for Families	McKinney-Vento			
Prevention				
Transitions Teams				
Transitions Centers				
Outreach				
Street Outreach Teams				
Integrated Services				

Teams				
Community Centers				
Increasing Incomes				
Job Developer Years 4-6		\$72,000		
Employment Specialist Years 4-6		\$72,000		
Industrial Relations Staff Years 4-6		\$56,000 – \$63,000		
Job Coach Years 4-6		\$50,400		
Implementation				
Chronic Homeless Campaign Coordinator Year 1	CDBG, etc ASIC HUD Private funding	\$123,500		
Housing Project Manager Years 4-6		\$94,900		
Outreach and Integrated Services Teams Manager Years 4-6		\$94,900		
Fund Development Coordinator Year 1		\$75,000 – \$90,000		
Income Benefits Coordinator Years 4-6		\$65,000		

Glossary

Assertive Community Treatment (ACT) is a proven intensive case management model in which service teams with a high staff-to client ratio place a heavy priority on the development of trusting, therapeutic relationships with clients. ACT teams provide intensive support both to ameliorate clients fears and distrust of the service system and to help clients successfully obtain the housing and other services they need to facilitate long-term stability.

Basic Housing Assistance is short-term housing that offers comprehensive services while individuals are assisted with obtaining permanent housing. Basic housing assistance centers may offer a variety of supportive services on a drop-in basis to homeless individuals and families including case management, food, showers, clothing, employment training, housing counseling, transportation, health care, educational programs, life skills programs, and information and referrals to substance abuse and mental health treatment.

Chronically homeless (CH) Santa Barbara defines chronically homeless as individuals and adults with children who have either been continuously homeless for a year or more or have had a least four episodes of homelessness in the past three years, have a disabling condition (diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions) and have been sleeping in a place not meant for human habitation (e.g. living on the streets) or in an emergency shelter during that time.

CBO – Community based organization

Discharge planning occurs before an individual leaves an institution (e.g., jail, hospital, foster care, detox, etc.) and involves creating links between the individual and the services and supports the individual will need upon leaving including housing, services, treatment, and benefits/employment.

FBO – Faith based organization

Housing First is a model where participants move directly into affordable rental housing in residential neighborhoods as quickly as possible. Participants are offered individualized, home-based social services support "after the move" to help them transition to stability, but participants are not required to accept treatments or services as a condition of housing.

Intensive case management is an approach to case management in which staff do “whatever it takes” to assist clients in accessing the full range of services that they need.

Staff work aggressively to maintain contact with clients for as long as it takes them to regain stability.

Master Leasing - Under “master leasing” a nonprofit or public agency leases multiple units of housing (could be scattered site units or a whole apartment building) from a landlord, and subleases the units to homeless or low-income tenants. By assuming the tenancy burden, the agency facilitates housing of clients who may not be able to maintain a lease on their own due to poor credit, evictions, or lack of sufficient income. The landlord receives a certain monthly payment whether or not the units are occupied.

Permanent supportive housing - Permanent supportive housing is a cost-effective combination of affordable housing with supportive services provided either on-site or off-site that enables people to live more stable, productive lives.

Section 8 Housing Choice Voucher Program subsidizes the rents paid by low, very low, and extremely low income individuals such that none pay more than 30% of their total income per month in housing expenses. Once an individual has qualified for the voucher, the individual rents an apartment on the private market, pays the individual’s 30% of the rent each month, and the housing authority pays the rest.

SMI – serious mental illness