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Hilton Foundation Project to End Homelessness for People with Mental Illness in Los Angeles:

Changes in Homelessness, Supportive Housing, and Tenant Characteristics Since 2005

Prepared for the Corporation for Supportive Housing
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Acknowledgements

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Inquiries

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The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

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INTRODUCTION

In 2005, the Hilton Foundation gave CSH a five-year grant to launch an initiative in Los Angeles County to reduce the number of long-term homeless people, with a special focus on reducing homelessness among people with serious mental illness. To promote these outcomes, CSH has been using grant money to: fund predevelopment work on various permanent supportive housing (PSH) projects, invest in building the capacity of supportive housing providers, work with public officials and other key stakeholders in the county and selected cities (Los Angeles, Long Beach, Santa Monica, and others) to stimulate increased commitment to PSH, support the Special Needs Housing Alliance, and pursue other activities with City and County of Los Angeles officials and agencies.

CSH contracted with the Urban Institute to help evaluate this initiative. A first evaluation report (Burt 2005a) served two purposes - it presented an evaluation plan to address the research questions posed by the Foundation, and documented baseline levels of the target population and activities in Los Angeles County focused on ending long-term homelessness. The second evaluation report examined the extent of systems change in the first two years of grant funding and the extent to which it could be attributed to CSH activities under the grant or connected to it (Burt 2007a). This third report is an update of the first one, focusing on changes in baseline levels of the target population and PSH availability in Los Angeles County. A fourth report, expected in late summer 2008, will update the policy impact/systems change information with activities and their effects in 2007.

Key Research Questions for This Report

This evaluation is designed to answer a number of research questions, using either existing data or data collected specifically for this evaluation. This report provides information to answer the first three questions (the fourth report will focus on answers to the fourth question):

1. Have the efforts of CSH and their local partners led to an increase in the units of permanent supportive housing in Los Angeles?
   - How many PSH units exist in Los Angeles at baseline (end of 2004)?
   - How many PSH units are being created in Los Angeles over the life of Hilton's grant (five year period)?
   - How many PSH units are "in the pipeline"?
2. Who is being served by permanent supportive housing? Are chronically/street homeless people getting into supportive housing units?
   - What percentage of PSH units is occupied by people most in need of PSH (i.e. those who are chronically homeless with disabling conditions, and especially those with serious mental illness)?
   - How did formerly homeless tenants get into PSH (i.e. from the streets, from shelters, transitional housing programs, institutions, etc.)?
   - Are there procedural and outreach practices that either inhibit or facilitate housing receipt and stability for those who have been chronically homeless?
3. Has there been a reduction in the number of street homeless people in Los Angeles, or at least of people with severe mental illness living on the streets?

4. How have state and/or local public agencies and funding streams made changes to better accommodate the development and operation of permanent supportive housing units and the services that tenants need to achieve stability?
    - Are more, or different, public agencies and actors on board (e.g., mayors, agencies in specific cities, new county council support, etc.)
    - Are public agencies better coordinating their efforts to serve chronically/street homeless people?
    - Has any additional funding been committed at the local or state level to **develop and operate** supportive housing (e.g., more funding in the same streams, new streams)?
    - How have local agencies and providers been able to leverage additional state and federal resources to **deliver services** to PSH tenants?

Assumptions and Predicted Outcomes

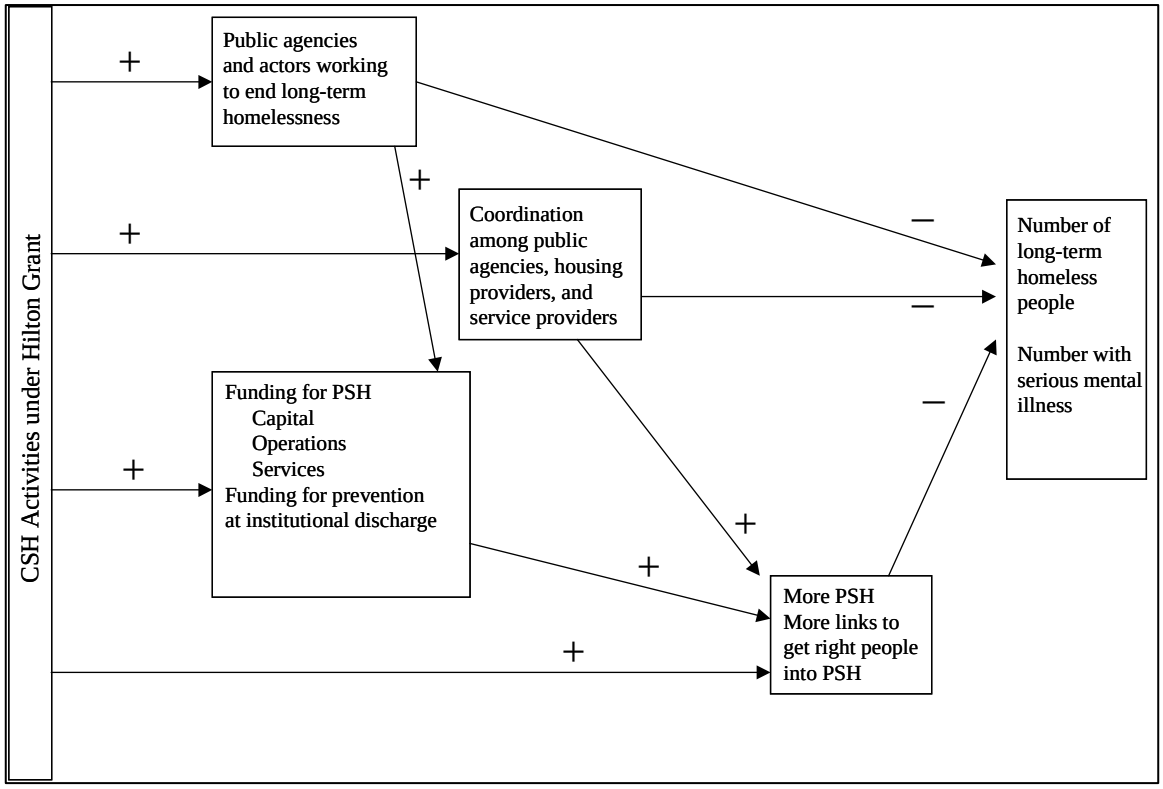
Based on the research questions just described, we summarize the outcomes of interest as:

1. Significantly increased numbers of PSH units in 2010, compared to 2005;
2. A higher proportion of PSH units occupied by the hardest-to-serve formerly homeless people, especially those with serious mental illness;
3. Fewer people with serious mental illness in the county's shelters and on its streets;
4. Increased public funding of PSH and other mechanisms to help long-term homeless people with serious mental illness and others leave the streets, including more federal dollars, more/new state and local dollars, greater leveraging of existing state and local dollars, and more efficient and effective uses for existing resources; and
5. Increased coordination at every level of the system, among funding agencies and funding mechanisms, providers, referral sources and pathways to PSH, and policy makers.

CSH has been working under its Hilton Foundation grant to increase (1) the number of public agencies and public officials knowledgeable about long-term homelessness and committed to working to end it; (2) the level of coordination among these agencies, and also among the organizations able to develop PSH and offer supportive services to keep people in housing; and (3) funding for PSH, and also for relevant homelessness prevention activities. Increases in these areas should lead to more PSH, and also to better linkages among those with housing to offer and those in contact with the neediest potential tenants. Changes in all the factors just described should result in less long-term homelessness, including fewer people with mental illness who become and remain homeless.

We graphically depict our assumptions about how CSH activities might influence the various outcomes of interest in Figure 1. The arrows in Figure 1 show the relationships we expect to see as CSH proceeds with its work under its Hilton grant. We have designed data collection and analysis for this evaluation to assure that we have the information needed to evaluate whether these predicted relationships have indeed come to pass. We will be able to see whether, at the end of the grant, we observe lower levels of long-term homelessness and homelessness among people with mental illness. We will also be able to identify the ways in which CSH activities stimulated public agencies and actors, and PSH providers, to change in ways that contributed to reduced levels of homelessness.

Figure 1: Predicted Relationships Among CSH Activities, Intermediate Steps and Changes, and Reduction of Long-Term Homelessness



DATA SOURCES USED FOR THIS REPORT

Much of the information in this report describing Los Angeles agencies and their partners offering PSH, PSH projects, units, and policies, and PSH tenants comes from reports on a large CSH initiative called Taking Health Care Home (THCH). THCH began in 2003 with a grant from the Robert Wood Johnson Foundation. Through THCH, CSH has worked with states and localities to demonstrate how they can create supportive housing that ends homelessness for people with chronic health conditions including mental illness, alcohol and chemical dependency, and HIV/AIDS, and how that experience can be replicated on a national scale. THCH's primary focus was on systems change at the state and local levels. The goal was to create systems and government infrastructure within state, county, and/or city governments to produce supportive housing in a more integrated and coordinated way.

An evaluation of THCH has been in place from its inception. The evaluation has produced two policy reports, one describing system changes in THCH communities during the initiative's first two years (Burt and Anderson 2006) and the second describing developments, expansions, and extensions of early systems change work during the initiative's last two years (Burt 2008c). Another two reports focused on the details of PSH creation and availability in THCH communities and the pipeline of projects stimulated by THCH (Burt 2005b and Burt 2008a).[1] As the first report on the Hilton Foundation Project to End Homelessness for People with Mental Illness in Los Angeles

[1] All reports are available on the CSH website (www.csh.org/resources/publications).

relied on Burt 2005b for much of its description of PSH in Los Angeles at baseline, so this report relies on information from Burt (2008a) for its descriptions of PSH agencies, projects, and tenants in Los Angeles three years later.

Other data used in this report include:

- Street and shelter count data - the Los Angeles Homeless Services Authority (LAHSA) conducted the county's first countywide point-in-time homeless count in 2005 and repeated it in 2007 (LAHSA 2005, 2007). LAHSA's reports of results include information from similar counts conducted in Long Beach, Glendale, and Pasadena.
- Data on housing outcomes for chronically homeless people participating in the Skid Row Collaborative, a federal demonstration project funded by HUD, the Department of Health and Human Services, and the Department of Veterans Affairs, and being run by a partnership of the Skid Row Housing Trust, Lamp Community, and JWCH Institute with participation from the Los Angeles County Department of Mental Health (DMH), the Housing Authority of the City of Los Angeles (HACLA), and the Greater Los Angeles Veterans Healthcare System, reported in Burt (2007).
- Data on housing and employment outcomes for chronically homeless people participating in LA's HOPE, a federal demonstration project funded by HUD and DOL, and being run by the City of Los Angeles's Community Development Department (CDD) and its partners, DMH, and HACLA, reported in Burt (2008b).

CHANGES IN OUTCOMES BETWEEN BASELINE AND 2007

Homeless, Chronically Homeless, and Mentally Ill Homeless Counts

In January 2005, LAHSA conducted the first-ever count of homeless people in Los Angeles County; it repeated that count, with considerably improved methodology, in January 2007. Thanks to the 2005 survey, in the first report for this evaluation we reported a baseline number of homeless people in the county in 2005, including the numbers of single adults, long-term homeless people, and homeless people with serious mental illness, alone or with a co-occurring substance abuse disorder.

We can now also report the results of LAHSA's 2007 survey. Methodological improvements for the 2007 effort were so substantial that we believe it may not be appropriate to interpret the differences between some aspects of the 2005 and 2007 estimates or population characteristics as improvements in the status of homelessness in Los Angeles County. Some of them at least, are probably the result of methodological rather than substantive changes. So we report the two sets of results and discuss what they might mean. LAHSA will conduct a third countywide survey in 2009, using the more refined techniques applied in 2007. At that time we will have more confidence that major changes in the level of homelessness and population characteristics between 2007 and 2009 reflect true change, including differences in the number of long-term homeless people in the county and those with serious mental illness.

Table 1 shows a 16 to 17 percent reduction in the estimate of people homeless during a single day in late January between 2005 and 2007. For the LAHSA areas, some part of this decrease is probably due to improvements in the design of the count, especially in the way that the researchers treated census tracts where there was a very high probability of encountering homeless people (these were

known as "must enumerate" tracts). But a parallel and almost identical decline in Long Beach, Pasadena, and Glendale, which have done their own counts and surveys for several years, indicates that some part of the decline, and perhaps a large part, is real.

Table 1: Los Angeles County One-Day Homeless Counts, 2005 and 2007

	2005	2007	Percent Change
Los Angeles County Total[a]	88,300	73,700	- 16.5
In LAHSA Continuum of Care (CoC) [b]	82,300	68,700	- 16.4
In Long Beach, Pasadena, or Glendale CoCs	6,000	5,000	- 16.7
Disabilities Experienced by Homeless People—LAHSA Survey Only			
Serious Mental Illness	31%	31%	
Chronic Substance Abuse Disorders	43%	42%	
Physical Disabilities	35%	35%	
At Least One Disability	46%	74%	
Three or More Disabilities	55%	57%	
Chronically Homeless—LAHSA Count Only[c]	35,000	22,400	-36.0%
As Proportion of All Homeless People	43%	33%	
As Proportion of Single Adults	64%	49%	

Sources: "2007 Greater Los Angeles Homeless Count," accessed at www.lahsa.org on October 15, 2007, and "2005 Greater Los Angeles Homeless Count," accessed at www.lahsa.org on January 8, 2007.

[a] Rounded to nearest 100.

[b] Differences in estimates of population size between 2005 and 2007 must be interpreted with great caution, because changes in sampling and weighting strategies greatly affected the 2007 results.

Data on population characteristics for the areas of the LAHSA survey come from interviews conducted with homeless people shortly after the night of the count. Table 1 also shows that there has been essentially no change in the prevalence of serious mental illness, chronic substance abuse disorders, physical disabilities, or multiple disabilities among homeless people in Los Angels County between 2005 and 2007. However, there does appear to be a substantial increase in the proportion of homeless people reporting that they have at least one disability.

Table 1 also reveals a substantial drop in chronic homelessness as a proportion of the entire homeless population (from 43 to 33 percent) and of single adults, who are the group to which the "chronically homeless" definition applies (from 64 to 49 percent). Some of the same methodological improvements that account in part for a lower overall count undoubtedly also account for most of this reported decrease. Chronically homeless people are least likely to be found in homeless shelters and most likely to be found in the "must enumerate" census tracts - these tracts are identified in large part on the basis of their continuing presence. The two methodological differences most likely to be contributing to reported changes in population characteristics between 2005 and 2007 are changes in how "must enumerate" census tracts were handled and changes in where post-count interviews were conducted.

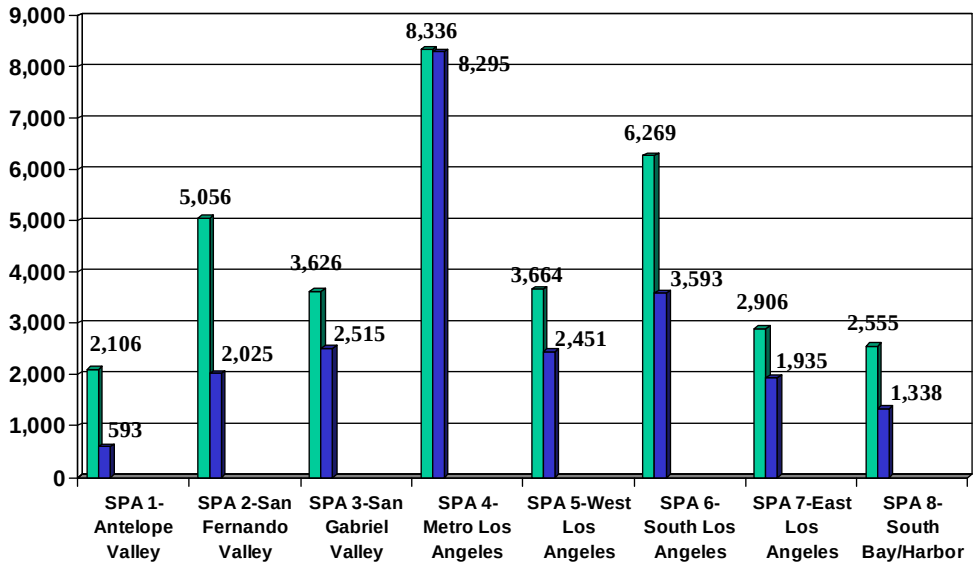
Because Los Angeles County is so huge and it would be impossible to cover every inch of it during a three-night count, the LAHSA surveys take a sample of the 1,886 census tracts in its survey area and go only to these tracts to do their counting. Selected census tracts were of two types - "must enumerate" and "sampled." A "must enumerate" tract represented only itself; 235 "must enumerate" tracts were identified and included in the 2007 count. Each "sampled" tract, of which there were 270 in 2007, represented about 6 of the remaining 1,651 tracts, on average.

When researchers developed their 2005 and 2007 estimates of the total number of homeless people in Los Angeles County, they used a procedure known as "weighting," which "blows up" the actual count in the 270 sampled tracts to make them represent all 1,651 tracts from which they were selected. The results of the actual count - the number of homeless people actually seen in a sampled tract - will then be multiplied by the weight, which for illustrative purposes we will say is 6, to estimate the total number of homeless people in the several tracts represented by the sampled tract. So if searchers saw 10 people on the night of the count, these 10 people would be "blown up" to 60 people for the final estimate. A "must enumerate" tract receives a weight of 1, so when one multiplies the number of people observed by the weight (1), you get just the number of people observed. Thus if searchers saw 375 homeless people in a "must enumerate" tract, that tract would contribute 375 people to the final estimate.

It is easy to see that it would make a big difference to the final count if researchers failed to identify a census tract with large numbers of homeless people as a "must enumerate" tract but left it in the group of tracts from which random tracts were sampled. Then that hypothetical tract with 375 observed homeless people and a presumed weight of 6 would contribute not 375 but 2,250 homeless people to the count, and a very large proportion of them would be chronically homeless people. This is what happened in 2005, when the procedures for identifying "must enumerate" tracts were far less well developed than they were for the 2007 count. In 2005, several tracts that each included hundreds of homeless people were found among the sampled tracts, having not been identified as "must enumerate" tracts. Therefore their hundreds of people were "blown up" in the manner described above, becoming thousands of homeless people during the process of developing a final estimate rather than just being counted as themselves.

Data on people's length of homelessness and presence of disabilities - the two factors that together determine whether the person should be considered chronically homeless - come from the post-count interviews. In 2005 these interviews were conducted only in shelters and in "must enumerate" census tracts, but not in randomly selected tracts. Further, they were not allocated in relation to the proportion of homeless people found in each type of location. The information they yielded on population characteristics cannot therefore be considered representative of the whole population of people homeless in Los Angeles in January 2005. In 2007, interviews were conducted in every type of tract and shelter, and *were* allocated in proportion to where people were counted. The information collected in 2007 is thus more likely to provide an accurate picture of population characteristics than the 2005 approach.

Figure 2: Location of Chronically Homeless Single Adults,
by Service Planning Area, 2005 (green) and 2007 (blue)



The effects of these methodological changes can be seen dramatically in figure 2, which shows the distribution of chronically homeless single adults by Service Planning Area (SPA). In addition to showing that chronic homelessness is not evenly distributed among the county's eight SPAs, figure 2 also shows substantial drops in estimates of chronic homelessness between 2005 (green columns) and 2007 (blue columns) for every SPA except SPA 4 - the SPA containing Skid Row in downtown Los Angeles. Of all the possible census tracts in Los Angeles County that might have been identified as "must enumerate," in 2005, researchers were least likely to miss those in downtown Los Angeles. Since almost all the same tracts in SPA 4 were identified as "must enumerate" in both years, the estimates of chronic homelessness did not change. In the remaining seven SPAs, better identification of "must enumerate" tracts and more appropriate allocation of post-count interviews contributed to the reduced estimates of chronic homelessness.

PSH Units in Los Angeles County in 2007 and 2004

For CSH's Taking Health Care Home (THCH) initiative, an evaluation estimated the number of PSH units in Los Angeles County in 2004 and 2007 (Burt 2008a). We use the results of surveys in these two years as the baseline for the Hilton project and as an indication of progress in the project's first three years. (We will repeat this survey in Los Angeles in 2009 to provide data on PSH status at the end of the Hilton project.)

5,455 PSH units	2004 estimate, based on surveys of 38 PSH projects in Los Angeles County, weighted to represent all PSH in the county.[2]
6,030 PSH units	2007 estimate, based on surveys of 45 PSH projects in Los Angeles County, weighted to represent all PSH in the county.
2,200 PSH units	Pipeline for the future - at least this many PSH units are currently in development.

Comparing the count of chronically homeless single adults - 35,000 in 2004 and 22,000 in 2007 - to the number of PSH units available in those years gives some idea of the size of the gap that must be filled before the county will reach the goal of eliminating chronic homelessness. Almost 600 new units opened and housed formerly homeless tenants in those years; pipeline figures show that at least another 2,200 are actively in development and should come on line within the next one to three years. These 2,200 pipeline units are ones in which the CSH Los Angeles office has some involvement, using Hilton Foundation and other resources to stimulate development. Others are probably also on the drawing boards, but without CSH involvement. Even so, to reach the goal, the county will need about *14,000 more PSH units* or other strategies for ending chronic homelessness.

Los Angeles's existing PSH projects are mostly single-site - 88 percent in 2007 and 91 percent in 2004. Most of these projects (82 percent in 2007 and 78 percent in 2004) are in buildings completely occupied by formerly homeless individuals - what we call "dedicated" buildings. The rest are in buildings whose tenants include some never homeless people, or at least people who did not come to the units directly from homelessness. We refer to this latter configuration as "mixed use," indicating that it accommodates both formerly homeless and never homeless individuals and families. Non-PSH units in these mixed use buildings are almost always "affordable," meaning that tenants pay no more than 30 percent of their income toward rent. Adding units in mixed-use buildings occupied by never homeless people to the PSH units already noted brings the estimated total number of units in buildings used for PSH up to about 6,300 in 2007. Only about 9 to 12 percent of PSH projects used a scattered site configuration - these were mostly units associated with agencies using McKinney-Vento Shelter Plus Care certificates to help their clients obtain apartments in the community.

PSH Occupants in Los Angeles County

THCH project surveys asked about the types of people occupying PSH units, and where those people were staying immediately before moving into PSH.

[2] In 2004 we received completed surveys from 38 projects offering about 2,100 beds; in 2007 we received completed surveys from 45 projects offering about 2,250 PSH beds. Responding projects were sampled, according to their size, from the much larger number of projects in Los Angeles that were open and occupied at the time of the surveys and offered PSH for formerly homeless people with disabilities (118 in 2004 and 142 in 2007). Each sampled project represented a stratum defined by project size—1-9 units, 10-19 units, etc. To get these estimates of PSH units, as well as those for all the tables in this report based on THCH, we weighted the data from the surveys we received so they represent all PSH beds, units, and projects in Los Angeles County. Weights for projects were calculated using the following formula: (number of beds in a stratum/number of beds in the project)/number of projects in the sample from that stratum.

Homeless Single Adults and Homeless Families

For the first time in 2007, the survey asked about the household status of PSH occupants. Los Angeles projects reported that 89 percent of their units were occupied by single adults and 5 percent were occupied by families (an adult with at least one child present). Household status was not known or not reported for 6 percent of the units.

Homeless, Chronically Homeless, or Not Homeless

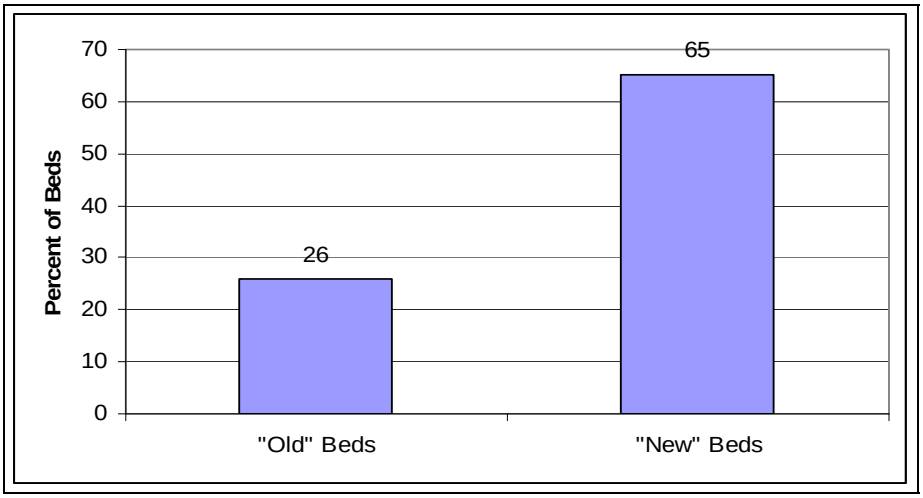
The most important question, from the point of view of ending chronic homelessness, is whether current PSH occupants had been chronically homeless before moving into PSH, as one would hope that PSH is being reserved for people whose long-term homelessness indicates limited ability to obtain or retain housing without the substantial assistance offered by PSH. The results for open and occupied PSH units in Los Angeles County for which former homeless status is known are:

- 32 percent in 2007 and 22 percent in 2004 were occupied by people who were chronically homeless at move-in.
- 62 percent in 2007 and 54 percent in 2004 were occupied by formerly homeless people whose pattern of homelessness at move-in did not qualify them as chronically homeless.
- 6 percent in 2007 versus 10 percent in 2004 were occupied by people who were never homeless, including low-income people in need of affordable housing, ex-offenders, and people at high risk of homelessness.
- Projects were more knowledgeable about their tenants' homeless status in 2007 than they had been in 2004, but the increased information did not significantly change the proportion reported in each category (chronically homeless, other homeless, not homeless).

Looking at all PSH in Los Angeles County together, we can see a slight increase in the proportion of all PSH units occupied by people who had been chronically homeless. This statistic may not reflect recent developments, however, because such a large proportion (90 percent) of all PSH beds in 2007 were already in existence in 2004 and the characteristics of occupants presumably have not changed very much. Older projects with established eligibility requirements are probably replacing departing tenants with others with similar characteristics. Therefore we compared the proportion of beds *opened after 2004* that were occupied by formerly chronically homeless people to the same proportion in beds that were already open in 2004. If the recent policy push toward targeting new beds on the longest-term homeless people is having an effect, we should see it in beds that came on line after the baseline 2004 survey.

These figures tell a very different story - 65 percent of *new* PSH beds were occupied by chronically homeless people, compared to only 26 percent of *old* PSH beds. Figure 3 displays these differences, which indicate that agencies developing new PSH projects are heeding the policy priorities of housing chronically homeless people.

Figure 3: "New" Beds Are More Targeted to Chronically Homeless People



Disabilities Present Among Current PSH Tenants

Another critical question about PSH occupants is what disabilities they have. It may be that many, even though they do not have a history of chronic homelessness, would be highly likely to become and remain homeless without the supports offered by PSH. People with serious mental illness might fall into this category, as might some people with chronic substance abuse, HIV/AIDS, physical disabilities, or chronic health problems.

Table 2 shows what we learned about Los Angeles PSH tenants from THCH project surveys in 2004 and 2007. The first set of columns shows the average proportion of all units in PSH projects in Los Angeles County that are occupied by people with particular disabilities.[3] These figures are not mutually exclusive, so tenants may be counted in more than one category. It is clear that in both years, serious mental illness was the disability most common among PSH tenants, and that a significant proportion of tenants also had problems with addictions. We know that PSH is intended to serve people with disabilities, so we would expect that *every* tenant has at least one disability. It is possible that the same person was counted under alcohol abuse and drug abuse, and someone could have been counted as having HIV/AIDS or physical disabilities and any of the other categories. As we saw in the LAHSA data reported above, the majority of homeless individuals have three or more such disabling conditions.

[3] This analysis concentrates on projects, showing the average proportion of beds per project that are occupied by people with various disabilities. This approach treats similarly a project with 10 beds and a project with 100 beds that both say 100 percent of their beds are occupied by people with serious mental illness – both reported 100 percent regardless of the number of beds involved. Another way of thinking about this analysis would be to focus on beds, asking what proportion of all the PSH beds in a community are occupied by people with various disabilities. We chose to focus on projects because we were concerned with project policies and whether project specialties or exclusionary policies resulted in increased or decreased access to PSH for people with particular disabilities. We also ran the analysis using beds rather than projects – for the most part the two analyses tell the same story. The differences worth noting include (1) the percent of beds dedicated to tenants with serious mental illness, which was slightly smaller than the analysis illustrated in table 2 (by around 6-7 percentage points in both 2004 and 2007), and (2) the change in the percent of beds occupied by tenants with a dual diagnosis between 2004 and 2007, which was also smaller than the analysis illustrated in table 2 (a 4 percentage point change rather than the 8 percentage point change).

Table 2: Los Angeles PSH Project Information Regarding Tenant Disabilities						
Disability	Average Proportion of Units Occupied by People with this Disability, Across All Projects		Percent of Projects with No Units Occupied by People with this Disability		Percent of Projects whose Funding Requires that they Serve People with this Disability	
	2004	2007	2004	2007	2004	2007
Serious Mental Illness	55	67	2	1	31	32
Alcohol Abuse	28	29	15	27	18	17
Drug Abuse	49	51	29	11	18	17
Dual Diagnosis	23	41	4	8	20	17
HIV/AIDS	15	12	35	50	20	16
Physical Disabilities	8	9	25	4	14	3

The second set of columns in table 2 shows the proportion of projects that do not have any tenants with each type of disability. These proportions in several categories increased considerably between 2004 and 2007. One might read these differences as indicating that PSH projects have gotten more specialized in the years between the two surveys, but we think the more likely explanation is that for 2004 only 9 agencies participated in the survey, and most of them were large agencies that developed large hotel conversion projects. Thus we had surveys for 38 projects but most were very similar to each other and, being large, tended to have a relatively diverse tenant base. For 2007 we made a point of including a greater number of smaller agencies and agencies that ran smaller projects, so we received surveys from 13 agencies and 45 projects. The smaller projects *are* more specialized than the larger ones, with the result that a higher proportion of projects in 2007 reported having no tenants with certain disabilities. Missing data from certain projects is another factor that may be influencing these results. Several of the "new since 2004" small projects did not report client characteristics. We also did not get surveys back in 2007 from one agency with an HIV/AIDS specialization that contributed two project surveys in 2004, which accounts for much of the change in units and projects whose tenants do not have HIV/AIDS and/or physical disabilities.

The final set of columns in table 2 indicates one of the reasons why PSH projects serve people with certain disabilities - these are the populations they were designed to serve, and most have funding that requires them to serve people with these disabilities. People with serious mental illness are the most "supported," with 31 to 32 percent of projects having funding that requires they be served. Physical disabilities are the least-supported, in the sense that project funding does not require that they specifically be served. The prevalence of mental illness and substance abuse among the population requiring PSH is probably the factor driving the proportion of units occupied by people with these disabilities, however, as occupancy rates mostly exceed what might be expected based solely on funding requirements.

From the data in table 2 we can conclude that even if current PSH projects are not occupied primarily by people who were once chronically homeless, they *are* mostly occupied by people who have homeless histories, albeit not long-term homelessness, and whose disabilities and conditions would place them at high risk for long-term homelessness if PSH were not providing them with stable housing.

Pathways to PSH

There is much controversy about the right recruitment strategies for PSH. The "housing first" approach argues that PSH should be recruiting tenants directly from the streets or emergency shelters, without requiring a stay in transitional housing first. This argument rests on the belief that it is impossible to address the many clinical issues of chronically homeless people unless they are first in stable housing situations. Other approaches argue that chronically homeless people are not ready for, nor are they capable of sustaining, permanent housing until they have addressed their clinical issues, stabilizing their mental illness through medication and gaining some control over their substance use. In the world of mental health services, transitional housing programs are one possible venue for acquiring this stability and becoming what providers consider "housing ready." In the homeless services world, however, transitional housing programs more usually function as places where people acquire employment or parenting skills that will let them function in housing on their own, without need of the continuing supportive services one finds in PSH.

Many Los Angeles PSH projects use a combination of these approaches, as table 3 shows. Taking PSH tenants from transitional housing projects is most common, with only 10 percent of projects in 2007 having no tenants who came to them directly from transitional housing (up from none in 2004). Direct tenancy from streets or emergency shelters is the route taken by 35 percent of PSH occupants, with 84 to 89 percent of PSH projects having some tenants who came to them directly from these venues. Other venues include jails, hospitals, and residential treatment facilities. Finally, it appears that in 2007, projects did not, and perhaps could not, report the route to PSH taken by 26 percent of their tenants - up from only 7 percent in 2004. Many more projects in 2004 were able to report their tenants' pathways to PSH, as only 7 percent of projects had tenants whose prior living situation was reported as unknown. In 2007, only 38 percent of projects reported tenant pathways for all their tenants.

Table 3: Los Angeles PSH Project Information
Regarding Tenant Living Situation Immediately Before PSH

Disability	Percentage of Units Across All Projects Occupied by People who Came from this Location		Percent of Projects with No Units Occupied by People who came from this Location	
	2004	2007	2004	2007
The Streets	20	12	13	15
Emergency Shelters	15	23	19	21
Either the Streets or Emergency Shelters	35	35	11	16
Transitional Housing	24	28	0	10
Other Venues	33	11	9	66
Don't Know	7	26	92	38

Funding for PSH in Los Angeles

Data on PSH funding in Los Angeles come from THCH (Burt 2008a) and was weighted as explained in footnote 2. Along with projects in other THCH communities, each Los Angeles project sampled in 2007 completing a survey was asked to report the sources of capital, operating, and services funding for the past year. In the case of capital resources, many projects were able to go back to their original development funding. We report capital, operating, and services funding separately, looking for the largest/most important sources, average number of sources per project, and total dollar amounts. Total dollar amounts for capital go back to project beginnings, while total dollar amounts for operating and services are just for the reporting year. For surveys completed in 2007 this would most often be calendar year 2006 or fiscal year 2007. In what follows, we present information for projects in the 2007 THCH sample for Los Angeles and compare it to parallel data collected in 2004. For more detail on funding sources and levels in other THCH communities, please see Burt (2008a).

Capital Funding

Capital funding data are available from Los Angeles THCH surveys for 35 of 43 2007 projects and 31 of 37 2004 projects that had development costs. Los Angeles projects identified 22 sources of operating funds in 2007 and 14 in 2004, including foundations, congregations, businesses, and miscellaneous public sources (e.g., CDBG, and state or local rental assistance programs). In 2007, these projects reported receiving a total of $558.9 million in capital investment since their inception. In 2004, projects reported $395.8 million in capital funding. About 40 percent of this difference is accounted for by capital for projects that opened since 2004; better data collection in 2007 is likely to account for most of the rest. Projects reported an average of 4.5 different capital funding sources in 2007 (4.7 different sources for 2004).

Per-unit costs for capital construction in Los Angeles come from the surveys received in 2007, which we judge to most completely account for capital costs. For all PSH units involving capital investment that were open in 2007, the average per-unit capital used in their construction or rehabilitation was about $97,400. Since units open in 2004 were often constructed many years ago under less expensive construction circumstances, we also calculated per-unit costs for units open in 2004 and those that opened after 2004. These costs are: $90,500 for units open in 2004, and $160,000 for units that opened in 2005, 2006, or 2007.

Table 4 reveals the major sources of capital funding for PSH in Los Angeles in 2004 and 2007. LIHTC is far and away the biggest contributor (41–43 percent of all capital funding). The Redevelopment Authority contributed 17–19 percent and housing finance agencies contributed 6–9 percent of capital funding for PSH in Los Angeles. These three biggest capital funding sources contribute 65 to 69 percent of all capital resources. Housing trust funds, CDBG, and commercial banks also make important contributions to PSH in Los Angeles.

Table 4: Comparing Proportional Contributions of Different Capital Sources in Los Angeles in 2004 and 2007		
Sources	2004	2007
LIHTC	41.2	42.8
Redevelopment Agency	19.3	16.5
Housing Finance Agency	8.6	5.5
Housing Trust Fund	8.0	6.4
CDBG	4.6	5.6
Commercial Bank	4.7	4.7
Other Local	4.4	3.9
Mainstream Service Agencies[a]	0.7	3.6
HOME	1.9	3.5
Public Housing Authorities (including Section 811)	3.4	<0.1
McKinney-Vento (SHP and SRO Mod Rehab)	0.9	1.6
Other/Other Private	1.1	1.4
Federal Home Loan Bank	1.0	0.6
Total Dollars from Major Sources (Weighted, Millions)	$395.5	$555.5
Proportion from Major Sources	99.9	96.2
[a]Mainstream agencies reported as contributing capital funds included mental health and housing and community development health agencies.		

Funding Sources for Operating PSH

In 2007, PSH projects in Los Angeles reported receiving $28.6 million in operating resources during their most recent project year, which in most cases would have been calendar year 2006 or FY 2007. This translates into approximately $7,000 per unit per year ($28.6 million/4,063 units, including scattered-site units, in 35 projects). This is a considerable increase in reported operating revenues compared to 2004, for which $25.7 million were reported (about $5,700 per unit per year). This 11 percent increase corresponds pretty closely to the 12 percent increase in PSH beds during the same period.

Los Angeles projects identified 14 sources of operating funds in 2007 and 12 in 2004, including foundations, congregations, businesses, and miscellaneous public sources (e.g., HOPWA, CDBG, and state or local rental assistance programs). Projects reported an average of 2.5 sources for 2007 and 2.2 for 2004. Table 5 shows the proportional contribution of major sources of operating funds for PSH projects in Los Angeles in 2007, 2004, or both.

In 2007, the single biggest source of operating revenues for PSH in Los Angeles was Shelter Plus Care, a McKinney-Vento program. Shelter Plus Care contributed 46 percent, a substantial increase from the 38 percent reported for 2004. Some small Los Angeles programs have their own Shelter Plus Care grants, but the bulk of Shelter Plus Care in Los Angeles comes through the Department of Mental Health (DMH). DMH routinely applies for additional Shelter Plus Care certificates every year, and has increased its pool from 338 in 2004 to 464 in 2007, making this a substantial housing subsidy resources for homeless people with serious mental illness.

Table 5: Comparing Proportional Contributions of Operating Revenue Sources in Los Angeles in 2004 and 2007		
Source	Los Angeles	
	2004	2007
Shelter Plus Care	38.3	46.3
Tenant Payments	30.2	30.9
McKinney-Vento (SHP and SRO Mod Rehab)	12.3	11.5
Section 8	4.2	3.8
Commercial Rents	3.4	2.4
Special State or Local Appropriations	--	1.5
Redevelopment Agency	5.2	0.6
Mainstream Service Agencies[a]	4.7	0.3
Total Dollars from Major Sources (Weighted, Millions)	$25.1	$27.8
Proportion from Major Sources	98.3	97.2
[a]The mainstream agency reported as contributing operating funds was the mental health agency.		

Tenant contributions to rent were next most important in both 2007 (31 percent) and 2004 (30 percent). The McKinney-Vento SHP and SRO Moderate Rehabilitation programs contributed about 12 percent in both years. Section 8 subsidy certificates supported about 4 percent of PSH units in 2004 and 2007. Some of the big residential hotel providers have many more units supported by Section 8 than these figures reflect, but these units are not necessarily occupied by formerly homeless people nor do they have significant amounts of services attached to them. They fall into the category of "affordable" units rather than PSH.

The information available to describe operating revenues is a bit more confusing than for capital sources, because projects sometimes gave a funding program (e.g., Section 8) and sometimes a funding agency (e.g., public housing authority) in their survey responses. However, it is clear that federal housing resources contribute a great deal to PSH operating revenues. In this category we include Shelter Plus Care, McKinney-Vento (SHP and SRO Mod Rehab), and Section 8. In Los Angeles, these sources taken together invested about $17.6 million in the 2006-2007 operations of PSH projects - an amount equal to about 62 percent of all operating revenues reported. Corresponding figures for 2004 for Los Angeles were $13.6 million and 55 percent.

Funding Sources for Providing PSH Supportive Services

The final funding component of PSH is the resources available for supportive services. Before commenting on levels or changes in services funding, a few caveats about the data are important to understand. For capital resources, some projects were not able to attach dollar figures to every source they reported. For the most part these lapses were random rather than systematic, and are to be expected. For services, however, (and a somewhat lesser extent for operations), the extent of missing information is sufficiently important and potentially large enough to skew anything we might say about access to services dollars.

We decided to compensate for this lack of information related to Medicaid funding where we could, to get a better picture of services funding for 2004. We made some assumptions about Medicaid funding for projects that were in both surveys and reported Medicaid funding in one year but not the other. If funding was reported for 2004 but not for 2007, we attributed the 2004 amount to the

same project in 2007, augmented by the average increase of 1.03 for the same funding source that we calculated from projects for which we did have two years of data. If the funding was reported for 2007 but not for 2004, we attributed the 2007 amount to the same project in 2004, diminished by the same average difference of 1.03. After doing this, we had service funding information for 58 percent of projects submitting a survey in 2007 and 82 percent of projects reporting in 2004.[4]

In 2007, 26 PSH projects in Los Angeles, representing (after weighting) about 2,500 units, reported receiving $8.6 million in supportive services funding resources during their most recent project year, which in most cases would have been 2006 or FY 2007. This translates into approximately $3,500 per unit (including scattered site units) per year. The corresponding per-unit supportive services estimated cost for 2004 was $4,000, as reported by 30 projects representing almost 3,900 units.

Table 6 shows the nine biggest sources of funding for supportive services in the reporting PSH projects. First, total reported funding for services was down a substantial 45 percent between 2004 and 2007. The end of federal funding for the Skid Row Collaborative, one of 11 federal Chronic Homeless Initiative demonstration projects, accounts for part of this decline. Ideally this funding would have been replaced by local service resources; but this has not happened to date.

Table 6: Comparing Proportional Contributions of Supportive Services Funding in Los Angeles in 2004 and 2007

	2004	2007
McKinney-Vento (SHP and SRO Mod Rehab)	14.0	57.0
Medicaid	4.6	9.5
Mainstream Service Agencies[a]	47.3	9.1
Tenant Payments	2.1	7.5
Other Private	1.6	5.3
Special State or Local Appropriations	0.2	2.6
HOPWA/Ryan White	11.3	0.6
Federal Chronic Homeless Initiative Funding	15.3	--
Veterans Affairs	1.0	--
Total Dollars from Major Sources (Weighted, Millions)	$15.6	$8.6
Proportion from major sources	97.4	91.7

[a] Mental health agencies were the mainstream agencies contributing services funds to PSH projects in Los Angeles.

More important is greatly reduced contributions that flow through mental health agencies. Reductions in revenues from state programs account for this difference. In 2004, 19 projects reported receiving about $7.5 million in services funding from mental health agencies (not counting funding for the Skid Row Collaborative through the federal Chronic Homeless Initiative). This funding came largely through the California Department of Mental Health, and consisted of funding from the Supportive Housing Initiative Act (SHIA) and one or two other state funding streams. All such funding had ended in 2006, either because the state did not renew the program (SHIA) or because it changed its approach to paying for services in ways that resulted in withdrawal of supportive services from PSH projects. It is clear that projects have not been able to find alternative funding sources to compensate for the loss of these state funds.

[4] For operating dollars, 82 percent of Los Angeles projects submitting a survey in 2007 reported at least some funding. For 2004, 74 percent of surveys received contained information on at least some operating resources.

The combination of fewer resources flowing through mental health agencies and the end of Chronic Homeless Initiative funding would have raised the proportion of services funding attributable to McKinney-Vento programs in any case, but it is also true that the amount of this type of funding reported by surveyed projects more than doubled between 2004 and 2007, from $2.2 million to $5.4 million.

Finally, the Los Angeles County Department of Mental Health reported an increase between 2004 and 2007 of about $200,000 to provide services to tenants using DMH Shelter Plus Care Certificates. During those years DMH continued to apply for Shelter Plus Care resources to house more of its homeless clients - the number of certificates under DMH control grew from 338 in 2004 to 464 in 2007. A good part of the services funding increase is linked to providing services for these additional tenants, but there is also a per-tenant increase of about 4 percent. Even with this small increase, the service resources DMH reports for these Shelter Plus Care tenants are extraordinarily low, at about $1540 a unit in 2007 compared to about $1480 in 2004. In 2007, Medi-Cal paid for about 70 percent of these services with DMH making up the difference; in 2004 Medi-Cal covered about 67 percent of the costs.

PSH Partnerships, Collaborations, and Policies

We wanted to understand the history, motivations, and policies of agencies offering PSH and the projects they sponsor, and how they might have changed between 2004 and 2007, including:

- The odds that the agencies currently involved in PSH will continue to help develop more PSH units;
- The collaborations and partnerships that agencies develop to support one or more aspects of PSH—development, operations/management, and services;
- What types of people they are likely to serve; and
- Any policies that make it more or less likely that PSH will attract and retain tenants who were once homeless.

Most agencies offering PSH in Los Angeles see themselves as "in it for the long haul." They have been involved in PSH in the past, are involved now, and expect to be involved in the future. In 2007, 44 percent of agencies were involved in all aspects of PSH, including development, operations, and service delivery. This proportion is an increase from the 34 percent of agencies that were so extensively involved in 2004; these agencies may be less inclined to enter into collaborations, as they see themselves as covering the necessary components of PSH.

Another 47 percent of agencies in 2007 did two out of three PSH activities - most of these (37 percent) did the development and building management/operations aspects and partnered with other agencies to provide services, but about 10 percent did the management/operations and service delivery and had either partnered with another agency that did the development or ran scattered-site projects that needed no development. Finally, by 2007 only a few agencies (5 percent) were new to PSH or had no future intentions, whereas in 2004 about 1 in 4 agencies (27 percent) were not sure of their commitment to continue producing and running PSH projects.

Collaborations and Partnerships

We gathered information about collaborations and partnerships from the agencies offering PSH and also from the projects that actually house its tenants. Neither source (agencies or projects) reported much change between 2004 and 2007 in their collaborations and partnerships. In 2007, fewer than half (6 of 13) of the agencies surveyed named at least one partner for development, operations, or services, whereas in 2004 7 of 9 agencies named such a partner. However, the average number of partners per agency increased slightly at 1.8 development partners in 2007 (1.4 in 2004), 0.5 operations partners in 2007 (0.4 in 2004), and 1.3 service partners in each year (0.7 in 2004).

Projects were more likely than agencies to name partners in helping to support PSH tenants. In counting an organization as a "partner," we erred on the side of caution. If it appeared that the service provider had a significant commitment to serve PSH tenants, we counted that provider as a partner. But if it was apparent that the PSH project simply referred tenants to various places as the need arose, with no special commitment to serve on the part of the service provider, we did not count those providers as partners. Many PSH projects named the same collaborators, such that in 2007 the 45 projects for which we have surveys named 41 partner organizations, which received a total of 196 mentions. In 2004, the 38 projects with surveys named 26 partners and gave them a total of 144 mentions.

Of the 45 projects with surveys in 2007, two did not name any partners. Three named a partner for the development aspect of their projects, and all three named the same partner - A Community of Friends (ACOF). Three 2007 projects were scattered-site, and thus had no development activity. The remaining projects (37) were developed by the same agency that still ran them. In 2004, only one PSH project named a development partner.

Partnering for the operations aspect of PSH was a bit more common in 2007, with 12 projects naming operating partners. Eight of these, all developed by ACOF, used the John Stewart Company for operations. Four, all developed by Homes for Life Foundation, worked with a different operations management organization. Finally, the Los Angeles County Department of Mental Health relied on mental health service providers throughout the county to handle the operations/management aspects of housing subsidized through its Shelter Plus Care certificates. In 2004, 10 PSH projects named an operations partner, including one partner in addition to those named in 2007.

Most projects (41 of 45) named at least one partner for services in 2007; on average, projects named 5.1 partners that worked with project tenants to deliver one or more types of service. Partners receiving 15 or more mentions included the Los Angeles County Department of Mental Health and its various local centers and clinics, Chrysalis (for employment), the VA, and the JWCH Institute (for health care). In 2004, 32 of the 38 projects with surveys named at least one service partner, with patterns of collaboration very similar to what still existed in 2007. The average number of partners named was somewhat lower in 2004 than in 2007, at 3.8.

Mission to Serve

Between 2004 and 2007, the already high proportion of Los Angeles PSH projects that reported having a mission to serve people with serious mental illness went from 93 to 97 percent, while those with a mission to serve people with alcohol or drug addictions went from 59 to 52 percent. In Los Angeles the primary commitment of most PSH projects appears to be to those with a serious mental illness, as can be seen when one asks whether projects have a mission to serve those with mental

illness but not with addictions, those with addictions but not with mental illness, or those with both serious mental illness and a co-occurring substance abuse disorder. Hardly any PSH projects have a primary focus on substance abuse in the absence of a co-occurring mental illness - only 2 percent in 2007 and none in 2004. On the other hand, a substantial proportion of projects reported a mission to serve only people with a serious mental illness who do *not* also have a co-occurring substance abuse disorder - although more in 2007 than in 2004 (46 versus 34 percent).

Project Policies

We asked about a variety of project policies, from leasing arrangements to requirements that tenants have a representative payee to what might cause a project to evict a tenant.

- In the vast majority of units in Los Angeles PSH projects, tenants hold their own lease (92 percent in 2004 and 96 percent in 2007). Otherwise the lease is either jointly held with the project or the project subleases to the tenant. In only 1 percent of units in either year does the tenant live in a unit without a lease of any type.
- No Los Angeles PSH project in either 2004 or 2007 requires tenants to have a representative payee as a condition of rental. Nevertheless, agencies may be willing to serve as representative payee if a tenant wants that arrangement. Far fewer agencies in 2007 reported that they offer this service (30 percent) than did so in 2004 (74 percent).
- *Every* Los Angeles PSH project identified the same three circumstances that would cause them to evict a tenant - disruptive or aggressive behavior that threatened other tenants, destroying property, and nonpayment of rent. There was no change from 2004 to 2007. Even with these circumstances, projects usually try to work with a tenant to resolve the behavior, and only evict when it is clear that the tenant will not stop.
- Very few Los Angeles PSH projects insist on abstinence - only 6 percent in either year said they would evict for substance use, and not many more (12 percent in 2004 and 6 percent in 2007) said they would evict even after multiple relapses.
- A substantial, but shrinking, proportion of programs say that they condition tenancy on service participation - 40 percent of PSH projects in 2007 (down from 56 percent in 2004) said they would evict for failure to participate in services.

Conclusions

The information supplied by PSH agencies and projects has shed light on some important issues that may be useful for shaping policy. Before 2004 we did not have any of this information; now we have it for two different years that straddle the beginning of major efforts to stimulate PSH and change public policies about how to address chronic homelessness. In particular, we now have some meaningful idea of agencies' staying power and intent in the PSH arena, their mission, the populations they are willing and able to serve, and their policies with respect to preservation of tenancy. It appears that the large majority of PSH projects and agencies operate within the scope of what CSH considers appropriate for PSH - serving highly disabled people, not conditioning tenancy on service participation, and offering a range of supportive services. However, there still remain a sizable proportion of projects that do tie tenancy to service participation. Most agencies offering PSH in Los Angeles are "in it for the long haul," including most of the agencies that were new to our survey in 2007, and often new to PSH as well.

EVIDENCE FOR THE EFFECTIVENESS OF HOUSING AND EMPLOYMENT SERVICES FOR CHRONICALLY HOMELESS PEOPLE WITH MULTIPLE DISABILITIES

Los Angeles has been home to two demonstration projects supported by the federal government's Chronic Homelessness Initiative. The first of these, the Skid Row Collaborative, had the goal of recruiting and providing stable housing for the hardest-to-serve Skid Row residents. The second, *LA's HOPE*, had the same housing goal as the Skid Row Collaborative, but also had the mission to move tenants into employment. To qualify for either, a person had to be chronically homeless and have a serious mental illness; most also had a co-occurring substance abuse disorder and many had a wide range of other health problems. Evaluations are available for both (Burt 2007 for the Skid Row Collaborative, and Burt 2008b for LA's HOPE. Both show that substantial success may be achieved with even the hardest-to-serve long-term homeless people with a well-designed project that has the right kind of resources and enough of them.

The Skid Row Collaborative had three years of federal demonstration funding, which ended in June 2007. LA's HOPE is in its fifth and final year of federal funding, which ends in fall 2008. After describing the outcomes these demonstrations achieved, we conclude this section of the report with a discussion of their future, focusing on whether the local public agencies that were partners in the demonstrations have stepped forward with the resources needed for these projects to continue into the future.

The Skid Row Collaborative

An evaluation of the Skid Row Collaborative (SRC) completed in spring 2007 (Burt 2007b) focused primarily on process issues, but was able to use housing retention data for residents of the Collaborative and of other Skid Row Housing Trust (SRHT) buildings to assess the impact of participating in the Collaborative on housing retention.

The SRC structure of services integrated with housing has helped to keep small tenant lapses from becoming major ones. SRC tenants live in the St. George and three or four other nearby SRHT permanent supportive housing projects. Stationed at the St. George as part of the SRC were a psychiatric nurse, a psychiatrist and a VA social worker who remained in their positions throughout the entire demonstration. During the demonstration period the nurse was on-site full time, the psychiatrist half-time, the VA social worker was available full-time, and these three key staff were supported by several case managers with offices in the St. George. Some specialty staff were also sometimes available, such as a post-traumatic stress counseling specialist who joined the staff late in the demonstration as the need to address PTSD became very apparent. Staff saw tenants regularly. The nurse dispensed all medications and was thus the first to know that someone had stopped taking needed meds. She would ask the person to "drop by and see me." Most of the time this approach resulted in resumption of medications as well as discussion of what might have been going on that induced the tenant to think of stopping. If the nurse's intervention was not enough to resolve the issue, the nurse and psychiatrist were able to work together to develop an approach that was almost always successful.

The intensive supervision that results from this program structure has let the SRC staff help even people with potentially extreme behavior to keep their housing and deal with their issues. One example was a fire setter who always started out small (such as a piece of paper in her room). The minute matches started disappearing, the nurse and the psychiatrist knew the tenant was starting to

go off medications and took steps to get the tenant back on track. It was the staff's opinion, including that of the psychiatrist, that the SRC was able to house much sicker people successfully with the services in place than it could have done with less intense and less integrated services.

Documenting the SRC's Effectiveness

The primary goal of the SRC was to end the homelessness of chronically homeless, very disabled people with serious mental illness by providing housing and the supportive services that help them stay in housing. To assess the SRC's effectiveness, the evaluator looked at the project's own statistics on housing placement and retention and compared these to housing retention among disabled formerly homeless people living in the Simone and the Pershing (two other SRHT hotels) with subsidies from Shelter Plus Care housing certificates.

In interpreting the results, it is important for the reader to keep two things in mind - the SRC tenants were significantly more disabled than tenants in the comparison group, and they were homeless for considerably longer than the comparison group tenants before they obtained housing. Simone and Pershing Shelter Plus Care tenants had to be homeless and disabled to qualify for their housing unit. Their disabilities were HIV/AIDS, substance abuse, or mental illness. In contrast the SRC tenants had to be chronically homeless (either living on the streets or in an emergency shelter for over a year, or four episodes of homelessness in three years) and severely mentally ill, with or without a co-occurring substance abuse disorder. In reality the average length of homelessness for the SRC tenants was eight years before coming into housing, and almost all had co-occurring substance abuse disorders. The SRC staff believed the project's tenants to be much more ill and in need of much more direct and ongoing support than the Shelter Plus Care tenants in the Simone and Pershing hotels. As one senior SRHT staff person put it:

> We screen people applying for a unit in our hotels. The screening process allows us to "flag" a person's circumstances that we know from past experience mean the person will have trouble retaining housing. Too many flags and we don't take that person. For the SRC, everyone recruited had so many flags that we would never have offered them housing if we had followed our normal procedures. But we took them all into the SRC….and to my amazement, it has worked. We've done better with harder people. I've personally done a 180 on thinking that housing and services should be co-located.

Thus if the SRC retention patterns are similar to those in the Simone and the Pershing, it means the SRC is achieving the same results for considerably more difficult clients. If the retention patterns are better for SRC tenants than for Simone and Pershing tenants, it means the SRC is doing better with harder clients. Either finding would speak well for the SRC.

Meeting Housing Retention Milestones

The SRC was able to house 62 people at one time, and has housed 101 people between January 1, 2004, the date its first tenant moved in, and May 31, 2007, the cutoff date used in the evaluation. During that same period 139 new Shelter Plus Care tenants moved into the Simone and 65 new Shelter Plus Care tenants moved into the Pershing. We treat these 204 tenants as a comparison group. We established a length of stay for each tenant by calculating the number of days between his or her move-in date and the date he or she moved out or May 31, 2007, whichever came sooner. In a few instances a tenant had more than one period of residency with a gap between during which

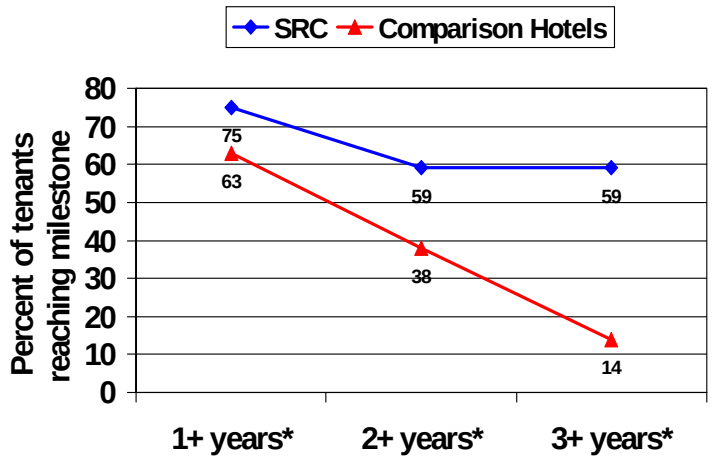
he or she was out of housing. When this happened the days of each residency were combined to calculate a total number of days in housing.

The first way of assessing the SRC's success in housing retention was to look at the average length of stay for SRC and comparison group clients. Results indicate that the average length of stay for SRC clients was 614 days, which was about 200 or 210 days longer than the average length of stay for Simone and Pershing Shelter Plus Care tenants - close to 7 months longer.

However, this approach fails to take into consideration when each tenant moved in, and therefore whether he or she had a chance to stay for a long time. A tenant moving in on January 1, 2004 had a chance to stay in housing for three years and five months, whereas a tenant moving in on January 1, 2007 only had a chance to stay for five months. The most appropriate, and revealing, way to examine housing retention is to look at those who achieved a specific milestone such as still being in housing after one year, assuming they were eligible for that milestone. To be eligible for consideration as having reached the one-year milestone, a tenant would have had to move in at least one year before May 31, 2007. To be eligible for consideration as having reached the two-year milestone, a tenant would have had to move in at least two years before May 31, 2007, and so on. Since the SRC only started a little more than three years before the evaluation took place, the number of eligible tenants for each milestone got smaller as the milestone involved longer housing retention.

Figure 4 displays the results in graphic form. Table 7 provides the relevant data, examining the milestone achievement of people who moved into SRC housing or the Shelter Plus Care-supported housing at the Simone and Pershing hotels from January 1, 2004, through May 31, 2007.

Figure 4: Housing Retention, SRC and Comparison Hotels



•Data points represent proportion of tenants reaching milestone, of all those moving into housing early enough that they *could* have reached milestone (I.e., at least 1 (2, 3) years before May 31, 2007.

Table 7 reports the number of tenants eligible for each milestone and the number and proportion of those eligible who reached the milestone. For the milestone of one-year housing retention, 92 SRC tenants were eligible, of whom 75 percent (69 tenants) met the milestone. This is significantly higher ($p < .05$) than the milestone achievement of people in the comparison hotels, among whom 155 were eligible and 63 percent (97 tenants) met the milestone. The difference in housing retention increases in favor of SRC tenants at each subsequent milestone. At the two-year milestone it is 59 percent for SRC tenants versus 38 percent for comparison hotel tenants ($p < .01$); at the three-year milestone the difference is 59 versus 14 percent ($p < .001$).

Table 7: Housing Retention for SRC Tenants Compared to Shelter Plus Care Tenants at the Simone and Pershing Hotels (Move-in on January 1, 2004 or Thereafter, through May 31, 2007)			
Client Group	Number of Eligibles--Tenants whose Move-in Date was at least 1, 2, or 3 Years before 5-31-2007	Number of Eligible Tenants who Reached the Milestone of 1, 2, or 3 Years in Housing	Proportion of Eligible Tenants who Reached the Milestone
Skid Row Collaborative Tenants			
One or More Years	92	69	75[a]
Two or More Years	69	41	59[b]
Three or More Years	32	19	59[c]
S+C Tenants in Comparison Hotels			
One or More Years	155	97	63[a]
Two or More Years	106	40	38[b]
Three or More Years	37	5	14[c]

[a] Percentages so marked are significantly different from each other at $p < .05$.
[b] Percentages so marked are significantly different from each other at $p < .01$.
[c] Percentages so marked are significantly different from each other at $p < .001$.

The level of staffing committed to helping SRC tenants retain housing was considerable. The SRC, staff-to-tenant ratio was 1 to 20. Case management ratios for the Simone and the Pershing were 1:82 and 1:67, respectively, and the specialized SRC staff (psychiatrist, nurse, VA specialist) were not available. One might look at the data in table 7 for one-year retention and think that performance of the Simone and Pershing was really not too bad. Considering the significantly lower availability of supportive services, their retention rate for the one-year milestone is only 12 percent lower than that achieved by the SRC (63 vs. 75 percent). However, the rates of those eligible for and reaching the two- and three-year milestones tell a different story. For those eligible for the three-year milestone, SRC retention is stable at 59 percent while retention at the comparison hotels has fallen to 14 percent. If both the SRC and Shelter Plus Care are programs intended to provide *permanent* supportive housing and to assure that people have the ability to remain in it, then the SRC model is clearly preferable.[5]

Also examined was the issue of differences *within* the SRC, specifically between tenants housed in the St. George Hotel where service staff have offices within the building and those housed elsewhere but served by the St. George-based support staff. That is, does being in the same building as supportive services staff do more for tenants than just having those staff available in a nearby location? The answer is "no" - there are no significant differences in housing retention between SRC participants housed in the St. George and those housed elsewhere, after taking into account each tenant's eligibility for reaching a retention milestone.

Tenants in both groups had episodes in the early months after move-in that threatened their continued residence; likewise those still in housing after a year or so faced possibilities of relapse, decompensation, and the like. The difference that made a difference was that SRC staff, with a ratio

[5] We do not have information about where people in SRC or in the comparison hotels went after leaving that housing. In stating that the SRC "did better," we are assuming that there are no differences in the proportions from each group that moved to equivalent or better accommodations or to less good situations or back to homelessness.

of 1 caseworker to 20 residents and the three on-site professional staff were in a position to observe the beginnings of such episodes and take steps to avert them, whereas staff at the Pershing and Simone, with caseworker ratios three and four times as high and no on-site psychiatric staff, could not do the same. The result was that comparison group tenants, although they may have had less intense or complex problems than SRC tenants, nevertheless lost housing at a higher rate.

LA's HOPE

LA's HOPE has the very concrete goals of housing its clients and helping them get and keep employment. The *LA's HOPE* demonstration is able to house 76 clients at one time using Shelter Plus Care certificates that came as part of the project's federal grant (they are renewable during future funding cycles in the same manner as for other Shelter Plus Care grants, so they represent net new units of PSH for Los Angeles). *LA's HOPE* had served 147 clients between its first intake in late winter 2003 and May 2007, the final month that could be included in the outcomes data to be analyzed for this evaluation.

LA's HOPE provides housing subsidies through the city's housing authority (HACLA) and delivers services through the workforce development (CDD) and mental health (DMH) systems. The latter two systems in turn have both policy and practice components - the city's Community Development Department and some of its One-Stops (known locally as WorkSource Career Centers), and the county's Department of Mental Health and three of the mental health agencies under contract to DMH that offer a special state funded program known as AB 2034. AB 2034 programs have the explicit goal of preventing or ending homelessness for people with serious mental illness (for a detailed description, see Burt and Anderson 2005). The three AB 2034 programs chosen to participate in *LA's HOPE* received extra AB 2034 resources to provide supportive services to *LA's HOPE* clients - that is, their AB 2034 caseloads increased by the number of *LA's HOPE* clients assigned to their program. *LA's HOPE* clients thus received "usual" AB 2034 services *and also* had access to Shelter Plus Care certificates reserved for *LA's HOPE* participants *and* extensive supports to prepare for, obtain, and keep a job.

A potential participant in LA's HOPE is first recruited and enrolled by an AB 2034 program, whose staff assist the person to find housing and offer other needed supportive and mental health services. Once housed, the person is expected to begin participating in employment-related activities. While enrollees did not have to sign an agreement to participate in employment, recruitment procedures clearly indicated that the purpose of the program was to help people to move toward employment and potential enrollees were screened for their stated motivation to work with the program to that end. Work-related activities usually began with work experience jobs in the mental health programs and then moved on to full- or part-time employment in the competitive job market. One-Stops were instrumental in helping *LA's HOPE* clients get some jobs of the latter type, but for the most part clients found their jobs on their own or with the help of *LA's HOPE* case managers.

Housing and Employment Outcomes of LA's HOPE

Because *LA's HOPE* participants are also AB 2034 clients and consistent information about clients of every AB 2034 program statewide is reported to a central database every month, evaluators were able to construct comparison groups of other AB 2034 clients in Los Angeles County to assess the success of *LA's HOPE* in getting its clients into permanent housing and employment. The results were impressive (see Burt 2008b for details):

- *LA's HOPE* clients were significantly more likely than other AB 2034 clients to engage in full-time employment, part-time employment, and competitive employment, and significantly less likely to have avoided employment altogether.
- *LA's HOPE* clients spent more than twice as many days in all types of employment than did other AB 2034 clients, and more than four times the days working in competitive employment.
- *LA's HOPE* clients spent many more days in PSH than did other AB 2034 clients, and far fewer days incarcerated or hospitalized.
- Multivariate analyses showed program differences (*LA's HOPE* vs. other AB 2034 clients) to be the only significant factor consistently affecting the employment outcomes. For housing, program differences were the strongest consistent factor. In addition, holding group membership constant, some personal characteristics consistently affected housing outcomes.
  - Compared to white AB 2034 clients, African-American and Hispanic clients were only about one-fourth as likely to have lived in PSH since enrollment, took about three times as long to move into PSH (for those who did make that move), and spent fewer days in PSH since enrollment.
  - AB 2034 clients with a co-occurring substance abuse disorder took only half the time to move into PSH as those without such a disorder and had spent an average of 10 or 11 more days in PSH since enrollment.

The Future of the Skid Row Collaborative and *LA's HOPE*

The assumption underlying the federal Chronic Homelessness Initiative demonstrations was that they would show their value to the local public agencies that participated in the projects as partners, to the extent that the public agencies would be willing, and able, to cover the costs of their continuation once federal funding expired. HACLA, the agency responsible for the housing subsidy component of both projects, is committed to continuing its involvement, but expectations that the agencies offering supportive services will devote local resources to maintaining these services have for the most part not been fulfilled.

For both demonstrations, the only secure ongoing financial commitments have come from HACLA, through which the projects' Shelter Plus Care certificates have run. Those certificates remain active after the other federal funding sources stop, so they continue to subsidize the rents of the people who were in both demonstrations. HACLA is also committed to keeping those certificates available to new recipients should the current recipients leave their housing and other people appropriate to the projects be selected to receive them.

DMH, which supplied a half-time psychiatrist for the SRC and AB 2034 funding for *LA's HOPE* has run into enormous budget crises of its own. It has not renewed its commitment to provide psychiatric care for the SRC, but it has been working with Lamp Community, the primary SRC service provider, to help Lamp qualify as an agency that can bill to Medi-Cal, and has allowed Lamp to use some of its DMH contract funds as the county match for such billing. These arrangements do not immediately benefit the SRC tenants (they only help other Lamp clients), but the additional resources generated by Medi-Cal billing may ultimately be useful in supporting these tenants. To help Lamp continue to support the SRC tenants until these arrangements begin to bear fruit, CSH has contributed about half a million dollars in grant funds it received from The California

Endowment to sustain this collaborative until Medi-Cal funding can begin to have an effect. CSH has also provided extensive technical assistance to help collaborative members increase their capacity to bill Medi-Cal for ongoing services.

With respect to *LA's HOPE*, Governor Schwarzenegger's line item veto in fall 2007 of state funding for the AB 2034 program has thrown the future of that program into grave doubt. No new clients are being accepted by any AB 2034 program anywhere in the state unless local funds can make up for the disappearing state dollars. In Los Angeles County DMH had a major budget shortfall even before the demise of AB 2034 funding, and is not in any position to compensate. Thus it is very unclear at this time what level of mental health care and supports will be available to existing AB 2034 clients (including *LA's HOPE* clients) after this year, and any expectation that new clients might be enrolled once the demonstration ends are likely to be disappointed.

Each demonstration has one more public partner that has made some commitment to ongoing activity. For the SRC, that partner is the VA, which is continuing to support the social worker who was part of the on-site SRC services team from the beginning. For *LA's HOPE*, the final player is CDD, which was responsible for managing the demonstration. CDD expects to continue to encourage its One-Stops to partner with mental health agencies to be able to improve its services to customers with mental disabilities. But it will not have the resources to support specialized employment case managers whose job it is to work solely with *LA's HOPE* clients or similar homeless or formerly homeless people. In addition, many of the mental health agencies with which the One-Stops might partner will be feeling the effects of losing AB 2034 funds and may not be in a position to pursue innovative arrangements with other agencies for some time to come.

CONCLUSIONS

There is definitely some good news in this report related to major goals for Los Angeles of CSH's Hilton Foundation Project to End Homelessness among People with Mental Illness. Permanent supportive housing development is in full swing, with about 600 new units already open and at least another 2,200 in the pipeline. New projects appear to be targeting chronically homeless people specifically, which will have the effect of moving more people with serious mental illness into housing. Federal demonstration projects have contributed solid evidence that PSH with substantial service levels and innovative approaches are very effective strategies to ending the homelessness of people with many disabilities who have not responded to other program structures or who quickly fail in them because they do not receive the types of attention they need. Philanthropy and local government are collaborating to help extend the life of these federal demonstration projects once the federal resources are withdrawn, but it remains to be seen whether the models will be adopted as local practice, with local resources devoted to them, despite their clear ability to achieve their goals. The sheer numbers of homeless and chronically homeless people in the county appear to be down, although some proportion of the decrease may be due to methodological changes in counting and interviewing procedures. All of these findings are in the direction that the Hilton Foundation Project is working to move the county.

The first evaluation report for this project (Burt 2005a) covered the issues of numbers (how many homeless people are there?); baseline estimates of available PSH; characteristics of PSH tenants in 2004; and sources and amounts of capital, operating, and services funding for projects open in 2004. For these issues that first report relied on the 2005 LAHSA point-in-time count of homeless people

in the county (LAHSA 2005) and the report done for THCH on the 2004 surveys of agencies and projects offering PSH (Burt 2005b).

That first report also contained a brief assessment of the policy environment and baseline organizational activities relating to ending long-term homelessness and PSH development. The present report does not update this information because separate reports are now being written that cover the policy environment and progress toward developing policies and resources that will help to end homelessness. The second report for this evaluation (Burt 2007a) presented this analysis of the policy developments and changes that had occurred between early 2005 (when the Hilton Foundation Project began) and early 2007. The fourth report for this evaluation, scheduled for summer 2008, will repeat that policy analysis, as will the final report, due in early 2010 and reflecting circumstances in 2009 after five years of project activity.

REFERENCES

Burt, M.R. 2008a. Evolution of PSH in Taking Health Care Home Communities, 2004–2007: Tenants, Programs, Policies, and Funding at Project End. Oakland, CA: Corporation for Supportive Housing. Available at www.csh.org/resources/publications.

Burt, M.R. 2008b. Evaluation of *LA's HOPE*: Ending Chronic Homelessness Through Employment and Housing, Final Report. Washington, DC: The Urban Institute. Available at www.urban.org.

Burt, M.R. 2008c. Pushing the Envelope: Deepening and Broadening Involvement in THCH Communities as Projects End. Oakland, CA: Corporation for Supportive Housing. Available at www.csh.org/resources/publications.

Burt, Martha R. 2007a. Hilton Foundation Project to Reduce Homelessness Among People with Serious Mental Illness: System Change Efforts and Their Results, 2005-2006. Oakland, CA: Corporation for Supportive Housing (second evaluation report). Available at http://www.urban.org/url.cfm?ID=411449.

Burt, M.R. 2007b. The Skid Row Collaborative—2003–2007: Process Evaluation. Washington, DC: The Urban Institute. Available at http://www.urban.org/url.cfm?ID=411546.

Burt, M.R. 2005a. Hilton Foundation Project To End Homelessness among People With Serious Mental Illness: First Evaluation Report. Oakland, CA: Corporation for Supportive Housing.

Burt, M.R. 2005b. Taking Health Care Home: Baseline Report on Tenants, Programs, Policies, and Funding. Oakland, CA: Corporation for Supportive Housing. Available at www.csh.org/resources/publications.

Burt, M.R. and Anderson, J. 2006. Taking Health Care Home: Impact of System Change Efforts at the Two-Year Mark. Oakland, CA: Corporation for Supportive Housing. Available at www.csh.org/resources/publications.

Burt, M.R. and Anderson, J. 2005. AB2034 Program Experiences in Housing Homeless People with Serious Mental Illness. Oakland, CA: Corporation for Supportive Housing.

Los Angeles Homeless Services Authority. 2007. Greater Los Angeles Homeless Count. Accessed at www.lahsa.org on October 15, 2007

Los Angeles Homeless Services Authority. 2005. 2005 Greater Los Angeles Homeless Count. Accessed at www.lahsa.org on January 8, 2007.