SYSTEM CHANGE EFFORTS AND THEIR RESULTS, LOS ANGELES, 2005–2006

HILTON FOUNDATION PROJECT TO END HOMELESSNESS AMONG PEOPLE WITH SERIOUS MENTAL ILLNESS

Martha R. Burt

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Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
mburt@ui.urban.org

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INTRODUCTION

For anyone interested in ending homelessness, the greater Los Angeles area presents the supreme challenge. Los Angeles leads the nation in both the estimated total number of people homeless on a single day (almost 90,000) and the seriousness of the problem as measured by the ratio of homeless people to total population (about 1 homeless person for every 112 county residents). And most of Los Angeles's homeless people are unsheltered (about 1 for every 137 county residents), which is quite different from the situation in many other communities.[1]

We can bring these figures into stark contrast by comparing them with similar data from New York City, the only other jurisdiction in the country of roughly the same size (8.1 million versus Los Angeles County's 9.9 million). About 38,000 people were homeless on a single day in New York City in 2005 (about 1 homeless person for every 213 residents), but very few were unsheltered (about 1 for every 2,100 residents).[2]

A brief review of other differences between Los Angeles and New York City will help to set the stage for understanding the scope of the undertaking being requested by the Conrad N. Hilton Foundation when, in October 2004, it gave the Corporation for Supportive Housing (CSH) a five-year grant and a Program Related Investment to launch an initiative in Los Angeles County to reduce the number of long-term homeless people, with a special focus on ending homelessness among people with serious mental illness. First and most obvious is the weather—it is easier and less life-threatening to be homeless in Los Angeles, especially in the winter. Other, less obvious, differences are far more important with respect to ending homelessness:

- New York City is a single city-county jurisdiction, with the authority to make decisions for its entire territory and for a very large portion of the resources needed to address homelessness. As such, it can make plans and follow through on them. It can think big and long-term as well as in strategic steps, and make them happen. It has a mayor now in

[1] Based on the only data available for Los Angeles, which date from the Los Angeles Homeless Services Authority's first-ever effort in January 2005 to determine how many people are homeless in the county. Los Angeles Homeless Services Authority. 2005. 2005 Greater Los Angeles Homeless Count. Los Angeles, CA. Accessed March 26,2007 at http://www.lahsa.org/homelesscount2005/pdfs. There is a good chance that this 2005 estimate is too high, due to a number of methodological problems that are not surprising in the first attempt at a task as huge and complex as counting homeless people throughout the entire county. Even if the estimate is too high by 10,000 or even 20,000 people, however, Los Angeles would still have the highest rate of homelessness per capita in the nation.

[2] New York City unsheltered figures taken from Homeless Outreach Population Estimate Results, 2005, accessed March 26, 2007 at http://www.nyc.gov/html/dhs/downloads/pdf/hope_presentation-final.pdf. Average daily shelter occupancy data were accessed March 26, 2007 at http://www.nyc.gov/html/dhs/downloads/pdf/histdata.pdf.

his second term who has long been determined to reduce homelessness by two-thirds before he leaves office and has directed his cabinet officials to do what it takes.

- In contrast, Los Angeles County contains 88 cities with their own governments, a number of unincorporated areas, and county government. Responsibilities related to homelessness are split among city and county governments and no single entity has authority over the whole. As a policy issue, homelessness has barely been on the radar screen for local elected officials and public agencies until the last few years. The desire *not* to take responsibility for homelessness on the part of Los Angeles County and the City of Los Angeles, and also not to become entangled in lawsuits and countersuits, led to the creation of the Los Angeles Homeless Services Authority (LAHSA) in 1993 as a joint powers authority that was given as little scope as possible, to do little more than help draw down federal homeless dollars.

- New York City has considerably more flexibility to raise the money it needs through taxes, whereas every Los Angeles jurisdiction is hamstrung by the effects of almost 30 years of Proposition 13 and related legislation.

- New York City government has been legally responsible for sheltering homeless people since the mid-1980s, which accounts for the roughly 34,000 people (including children) in shelters in that city daily in 2005. This is triple the number sheltered in Los Angeles County (10,000-11,000), where only a few smaller city governments have taken serious steps to address the problem.[3]

- New York City spends $1.7 billion a year on homeless services, compared to $600 million for Los Angeles County and the City of Los Angeles combined.

- New York state and city mental health departments have been jointly funding permanent supportive housing in New York City for homeless people with mental illness since 1991; somewhat similar but less extensive funding (AB 2034, see below) has been available to California counties only since 2000.

- While public agencies in both communities are large and bureaucratic, those in New York City mostly work, while many in Los Angeles have long been troubled.

As with many big cities and their surrounding counties, relations between Los Angeles County, the City of Los Angeles, and to a lesser extent other cities in the county, have a long history of strain. Everyone interviewed for this report felt that at the personal level, staff at city and county agencies have developed extremely supportive and effective relationships during the past several years of joint work on homeless issues. But the structure of government in the county, with 88 cities, the balance of the county, county supervisors and city council members with their own power bases, and split powers and resources (housing largely under city control while supportive services must come from county agencies) has historically made it very difficult to resolve major issues affecting multiple county districts and jurisdictions.

[3] Shelter Partnership has recently completed a full inventory of emergency shelter in the county: "2006 Short-Term Housing Directory of Los Angeles County." Available at http://shelterpartnership.org/studies.htm.

The work of many stakeholders has come together in the last few years to stimulate and shape the movement toward developing solutions to homelessness that we report below. These include CSH and its direct partners such as Shelter Partnership; all the county agencies participating in the Special Needs Housing Alliance; local elected officials on the County Board of Supervisors, Los Angeles City Council, Los Angeles's mayor, and officials of several smaller cities within the county; foundations, including the Weingart Foundation, Conrad N. Hilton Foundation, and The California Endowment; and the many housing and service providers participating in one or more aspects of planning for and actually making changes.

The timing of the Hilton Foundation's funding to CSH for its initiative occurred just as some long-watched pots were almost beginning to simmer. CSH opened its Los Angeles office in early 2003, in the hope that it could serve as a catalyst for change. Receiving the support of the Hilton Foundation in 2004 was in some ways a statement that enough initial movement was visible one year later for the foundation to invest its resources in its home community to give a boost to the "end long-term homelessness" agenda. While much planning is finally being done, a heroic effort will still be needed to make the various plans coherent and orchestrate multi-jurisdictional efforts to turn their visions into reality.

To promote the outcomes of its Hilton initiative (reducing homelessness, especially among people with serious mental illness), CSH tries to use its status as a non-governmental, non-provider neutral third party to bring people together, facilitate planning and implementation, provide expert advice, and help span the boundaries of different systems that have long stood separate and apart. CSH has also been working with public officials and other key stakeholders at the state level and in the county and selected cities to stimulate increased commitment to joint actions on supportive housing as a big piece of the approach to ending homelessness.

Through its Hilton initiative resources, CSH continues to support county agencies in the Special Needs Housing Alliance and Los Angeles city agencies developing a Permanent Supportive Housing Plan, and interacts in other ways with City and County of Los Angeles officials and agencies. Some of Los Angeles's biggest foundations have also become part of these processes. CSH staff are actively involved at the state level also, in helping to design and implement major state funding opportunities affecting homelessness such as the Mental Health Services Act, housing bond financing, opportunities for integrated primary care-mental health-substance abuse funding and service delivery. CSH also uses Hilton grant and loan money to promote permanent supportive housing (PSH) directly, by offering training to potential PSH developers, funding predevelopment work on various PSH projects, providing technical assistance to new providers.

APPROACH

CSH has contracted with the Urban Institute to help evaluate this initiative. The first evaluation report, completed in October 2005, 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. This second report describes system change efforts that CSH has undertaken with foundation grant monies (often in conjunction with other stakeholders and partners), and what results they appear to have

stimulated as of early 2007. A third report will be completed by fall 2007 to examine changes since baseline in the size of the target population, growth in the number of permanent supportive housing units that are open and occupied and also in the pipeline, and any changes that may have occurred in the population occupying PSH units.[4]

CSH and the Hilton Foundation identified a number of research questions for the evaluation to answer. This report addresses one of those questions:

- How have state and/or local public agencies 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 Board of Supervisors support, etc.)
    - Are public agencies better coordinating their efforts to serve chronically/street homeless people?
    - Are new and/or expanded sources of funding available, and/or is existing funding being used in more effective ways?
        - Has any additional funding been committed at the local or state level to **develop and operate** supportive housing and **provide supportive services** to its tenants (e.g., more funding in the same streams, new streams)?
        - How have local agencies and providers been able to leverage these additional state and federal resources for PSH tenants?

To answer these questions, we looked for evidence that new stakeholders had become committed to participating in one or more aspects of PSH development or that existing stakeholders had expanded or changed their commitment in positive ways. We also focused on ways that coordination changed at different levels of the system, among funding agencies and funding mechanisms, providers, referral sources and pathways to PSH and other services, and policy makers. Finally, we have tried to identify investment of additional federal dollars, more/new state and local dollars, greater leveraging of existing state and local dollars, availability of private resources, and more efficient and effective uses for existing resources.

In our first evaluation report we presented a graphic representation of how we think the system change process works, which we repeat here as figure 1. The arrows in figure 1 show the relationships we expect to see as CSH proceeds with its work under its Hilton grant, and for which we have been looking as we conducted the interviews and examined the documents on which we base the findings reported below. We have been looking for the ways in which CSH activities stimulated public agencies and actors, and PSH providers, to change in ways that are expected to contribute to reduced levels of homelessness. 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

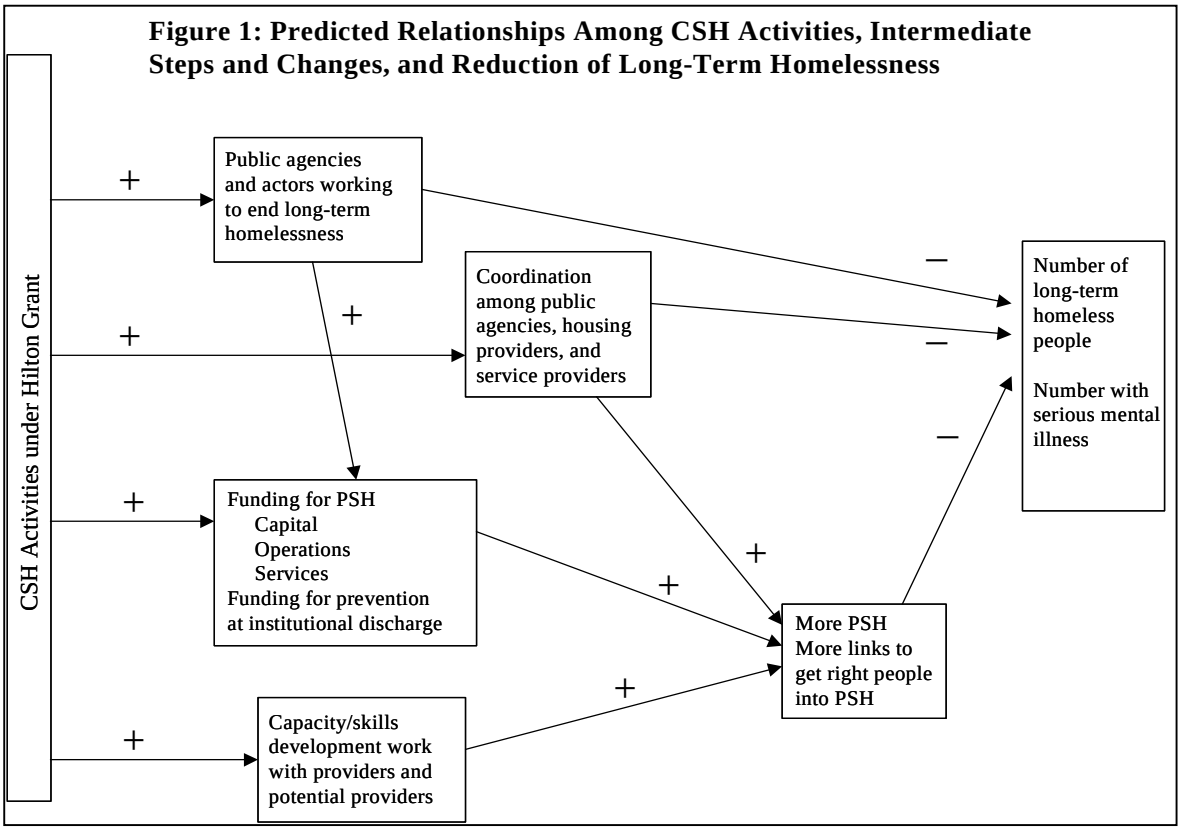
[4] The material for the third report will not be available until summer 2007, and will include the results of LAHSA's second countywide assessment of the size and characteristics of the homeless population, as well as the results of a second wave of PSH agency and project surveys. We did not want to delay delivery of the system change findings until fall, so we are presenting findings in two separate reports.

long-term homelessness, including fewer people with serious mental illness who become and remain homeless.

We look at changes in the four boxes toward the left of figure 1, as well as the ways that CSH activities (leftmost box) have influenced those changes. We organize this report around:

- Changes at the state level, including planning and training for implementing the Mental Health Services Act (MHSA), work on the state affordable housing bond issue, and set-asides for permanent supportive housing.
- Changes within and among Los Angeles City and County agencies related to evolution of the Special Needs Housing Alliance, its strategic plan, and related funding and activities; MHSA plan development and implementation; development of the city's Permanent Supportive Housing Program; and LAHSA; and
- Changes involving providers, including
    - Work on the Skid Row Collaborative and involvement in its future,
    - Work to increase the efficiency and effectiveness of primary health and mental health care in Skid Row—the Skid Row Homeless Healthcare Initiative (SRHHI) and its Mental Health Group, and
    - Opening New Doors—work with housing developers and supportive services providers to increase relevant skills and capacities to produce and operate PSH and support its tenants.

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



In the course of preparing this report, more than 25 people kindly consented to share their experiences and their perceptions of what is changing and what still needs to happen. They represent every type of stakeholder in the change processes going on in Los Angeles County. This report focuses more on the role of CSH because the project being evaluated is a CSH project, but we in no way mean to downplay the crucial contributions made by the many interacting stakeholders who are helping to move the county forward.

STATE PUBLIC AGENCY AND FUNDING CHANGES

WORKING WITH THE DEPARTMENT OF MENTAL HEALTH

The California Department of Mental Health (CDMH) has presided over some important developments addressing homelessness among people with serious mental illness. Beginning in 1999, the state legislature passed Assembly Bill (AB) 34, which provided $10 million for pilot programs through the mental health departments in Los Angeles, Sacramento, and Stanislaus counties. Based on the success of that effort,[5] funding increased dramatically in FY 2000–2001 under AB 2034. AB 2034 provided the resources necessary to expand existing pilots and create additional programs statewide. Currently, there are 53 programs operating in 34 counties (19 in Los Angeles County, 2 in Sacramento County, and 1 in each of the remaining counties). One key to that success was the housing strategies developed by AB 2034 programs, which CSH did much to promote through extensive training opportunities with the California Institute of Mental Health (the training arm of the California Mental Health Directors Association) and CDMH itself.

The success of programs funded under AB 2034 in preventing or ending the homelessness of people with serious mental illness laid the groundwork for passage in November 2004 of a ballot initiative—Proposition 63—to provide the resources for significantly more extensive mental health services throughout the state. A very broad coalition of stakeholders worked to assure passage of this ballot initiative, whose provisions were subsequently formalized into law in 2005 as the Mental Health Services Act (MHSA). MHSA adds hundreds of millions of dollars to the state's community mental health system each year. Funding is targeted to vulnerable groups that existing systems have not served adequately or at all—including people with serious mental illness who are homeless, insufficiently housed, or returning to communities from the jail system.

As it did for AB 2034, CDMH contracted with CSH in January 2005 to help with several aspects of MHSA implementation. With CDMH, CSH worked to develop guidelines for the housing part of MHSA, including working out technical and legal issues that framed these guidelines. To draw down money from MHSA, each county in the state was going to have to develop its own

[5] The California Department of Mental Health reported pilot program results that in their first year of participation, AB 34 enrollees decreased their number of psychiatric hospitalization days by 66 percent, their incarcerated days by 82 percent, and their days homeless by 80 percent, compared to the year before they enrolled in an AB 34 program. California Department of Mental Health. 2000. *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature as Required by Assembly Bill (AB) 34 Chapter 617, Statutes of 1999.* Sacramento, CA: Author.

MHSA plan and have it approved by the state. As the funding was already available, it was desirable that these plans be developed quickly, and that they meet the requirements set out by CDMH. To this end CSH held 11 regional training events around the state. Invitations went to county departments of mental health, but to attend they had to bring teams representing all the agencies and providers relevant to helping homeless people with serious mental illness and, most likely, co-occurring substance abuse. These would include housing, substance abuse, corrections, and possibly other public agencies, plus private providers. CSH worked with county departments to decide which people in each county would be the most appropriate to include.

The trainings were oriented toward housing issues and especially toward the need for and appropriateness of permanent supportive housing as a strategy for ending homelessness. They covered basics such as "What is PSH?" and "Why PSH for this population?" They explained the concept, provided examples, and documented the proven effectiveness of PSH even with very disabled, difficult-to-serve, long-term homeless people. Other parts of the trainings focused on helping counties develop plans that maximized their use of MHSA dollars for housing, and teaching *how* to develop PSH, helping to build local teams of collaborating agencies to produce housing and link tenants to supportive services.

EVOLUTION OF THE HOUSING INITIATIVE WITHIN MHSA

In spring 2005, shortly after the legislature enacted the MHSA as the first step in implementing Proposition 63, Daryl Steinberg began talking with people in Sacramento about the increasing displacement of SRO accommodations in downtown Sacramento as a consequence of downtown development. Half of the tenants in these SROs are mental health consumers, so the potential disruption of their housing was an issue for the county mental health agency and the providers that help tenants sustain housing. The discussion focused on how to help tenants preserve their housing and their link to services, and especially how to use MHSA resources for this purpose.

The first idea that developed was to have county mental health agencies, which would receive the MHSA funding from the state, take part of their MHSA allocation and transfer it to their Redevelopment Authorities. These funds would serve as leverage for Redevelopment Authority bond issues and the money raised would be earmarked to provide capital for developing permanent supportive housing. As this idea developed, it became clear that it would be more efficient to do this at the state level, which would also have the advantage of assuring that every county got some capital resources.

At this point Steinberg began talking to CSH about the details of the plan, looking for an assessment of how much money it would take and how the overall program should be shaped. CSH arranged with Fannie Mae to hold a meeting in Sacramento in summer 2005 to begin the process of thinking through appropriate financial models. Many stakeholders were invited to a series of ad hoc meetings, including Lehman Brothers, which had experience doing similar financial modeling.

Discussion of options continued at the October 2005 meeting of the MHSA Oversight and Accountability Committee, which took place in Los Angeles. CSH accompanied committee members on a tour of some PSH projects in Skid Row, and Jonathan Hunter and Lehman Brothers staff did presentations on housing options. The basic plan presented would use MHSA

monies to leverage $2 billion in bond financing over 20 years, and produce about 13,000 new units of PSH.

The idea caught people's interest. Theresa Parker of the California Housing Finance Agency (CalHFA—which would have responsibility for issuing the bonds and running the program) got very involved, becoming committed to turning this idea into reality. Housing California, the state's largest affordable housing advocacy organization, was also committed to the idea. In December 2005, Housing California held the first statewide mental health housing conference that introduced the idea, strongly urging advocates all over the state to get involved.

A setback occurred in February 2006, when the state Attorney General's office wrote a letter saying that authority to commit MHSA funds for housing bonds was not clear, and that it might have to go back to the voters before it could become policy. Alternatives were sought, as no one wanted to repeat the ballot initiative process. At that point the CalHFA director began working with the governor's office to promote a statewide Chronic Homelessness Initiative and to be sure that it incorporated a commitment to capital financing for PSH. Her involvement and support raised the issue of capital financing to the right level of attention, offering the financial instruments and capacity of CalHFA as the agency that had the interest and capacity to make the plan work. After considerable effort to articulate how the plan would be implemented, it was incorporated into the Governor's Executive Order of May 2006 as the MHSA Housing Initiative, which designated up to $75 million of MHSA funds per year for housing, for the next 20 years. The stated goal of the Initiative is to produce 10,000 new units of PSH for people receiving MHSA services.

Announcement of the Housing Initiative produced initial resistance from county mental health directors, whose agencies would otherwise be receiving the funds proposed to be set aside for housing. But very quickly these same directors realized that homelessness and housing were very important components of their own MHSA plans, and opposition dwindled. During summer 2006, CSH staff and others worked with CalHFA and relevant legislators to develop a new lending category—special needs housing—within CalHFA's authorizing legislation. The legislation passed and was signed in August 2006.

With enabling legislation in hand, the CalHFA director assembled a technical work group to determine the details of implementation, as many issues had to be worked out before a viable program could be mounted. This state-level work group included CalHFA, the Department of Housing and Community Development, the Department of Mental Health, the Tax Credit Allocation Committee, the California Mental Health Directors Association, Housing California, several PSH developers, representatives of three county mental health departments, and CSH.

Among other issues, an important one was how putting money into the state-level MHSA Housing Initiative would affect counties' ability to spend resources on capital facilities, which (along with technology infrastructure and workforce development) is limited to 20 percent of a county's annual MHSA allocation. County representatives ultimately agreed to support the plan if the state-level resources did not count against their 20 percent limit. Referring back to the MHSA legislation, it was noted that the list of "services" that should be provided as needed to recipients of MHSA "Community Services and Supports" includes housing. Taking the cue

from the legislation, housing is now included as a service rather than a capital facility expenditure. Thus, all housing expenditures fall within the basic allocation of funds to counties and are not subject to the 20 percent limitation.

The final program description includes $75 million per year for capital and $40 million for 20-year capitalized operating subsidies, to provide 10,000 of the 13,000 units of housing. After signoff from the Mental Health Directors Association and DMH, and comments from the MHSA Stakeholders review process, CalHFA will need to develop an application package. The state is expected to issue the first notice of funds availability no later than June 2007, and funds should actually become available in July 2007 for award to projects that have their county's approval. An initial five years of funding have been committed and all 58 counties in the state will receive a proportional allocation of funds. Eight percent of the funds have been set aside specifically for the state's small counties (under 200,000 population).

KEEPING THE PSH FOCUS IN THE PROPOSITION 1C AFFORDABLE HOUSING BOND ISSUE

In 2006 it became apparent that the $2.1 billion in funds from Proposition 46, the landmark housing bond that California voters passed in November 2002, were rapidly being expended. At the same time, housing advocates foresaw little likelihood of creating a permanent funding source for affordable housing development, given the political climate of the state. However, the governor and the legislature had embarked on a bipartisan effort to place a series of major infrastructure bond measures on the November 2006 ballot. Housing advocates worked closely with Senator Pro Tem Don Perata to include a new housing bond in the package. Proposition 1C (of 1A-1E) called for $2.9 billion of new funding for a variety of housing needs.

When housing advocates originally introduced Proposition 1C, it called for a two to three year extension of Proposition 46 funding. Proposition 46 had included just under $1 billion of funding for new rental housing construction and just under $200 million for construction of PSH. Supporters had expected the Proposition 46 funding to last for five years, but after four years it was virtually all committed. Proposition 1C originally called for $1 billion of new rental housing construction and $200 million of new PSH, to cover two to three years of development activity. During last-minute negotiations between the governor and the legislature, the rental housing funds were reduced to $400 million (the balance was shifted to first time home buyer assistance). In spite of this major reduction in rental housing funds, the amount designated for PSH actually increased with the last minute addition of $50 million for development of housing for Transition Age Youth. The notable aspect of this decision is its reflection of the degree to which PSH is now seen by leadership throughout the state as an essential public investment for addressing the most difficult problems of homelessness.

POLICY AND FUNDING CHANGES AT THE COUNTY LEVEL

This section and the two that follow cover developments since fall 2005 among county agencies, city agencies, and city-county joint activities related to addressing homelessness and homelessness reduction efforts throughout the county. The final section focuses on changes among service providers during the same period. CSH has been consistently present and active as these changes have developed—sometimes as a primary player and sometimes as only a presence in the background. We have tried to describe all the relevant players in each

development, as it is usually the case that what emerged owes a lot to the synergy that happens when interested and energetic parties put their heads together. When CSH has played a specific role, we indicate what it was. In these sections we have gone well beyond changes in which CSH played a major role because the many small changes under way are all necessary to move Los Angeles in a productive direction, regardless of which organizations and people may have helped to make them happen.

County actions to address homelessness, including those of the Board of Supervisors and of county agencies, have expanded considerably in the period since fall 2005. They still have a long way to go, however, before it would be possible to describe the county as having a *system* to reduce or end homelessness. We focus on three developments—follow-through on Special Needs Housing Alliance (SNHA) activities, local response to the Mental Health Services Act (MHSA), and efforts to prevent homelessness at exit from jail. The beginnings of SNHA and MHSA were described in the fall 2005 evaluation report; activities related to jail release and community re-entry are described here for the first time.

DEVELOPMENTS RELATED TO THE SPECIAL NEEDS HOUSING ALLIANCE

In our first evaluation report we reviewed the activities of the Special Needs Housing Alliance (SNHA, or "the Alliance") and the contributions that CSH and Shelter Partnership were able to make in moving its agenda forward. To review briefly, when CSH opened its Los Angeles office in March 2003, only one largely-public entity in the whole county—the Special Needs Housing Alliance—had as its focus housing vulnerable populations, one of which was homeless people. The Alliance was created in June 2001 as an offshoot of activities related to housing conducted by the Los Angeles County New Directions Task Force. The Alliance has two purposes: (1) to provide an ongoing forum through which county departments, service providers, housing agencies, developers, and other stakeholders might meet, learn, and plan together to address the unique housing and service needs of specific special needs populations; and (2) to serve as a conduit and catalyst to unite housing and program interests in Los Angeles County and to be proactive in securing funding for special needs housing.

By September 2002, the SNHA's work plan included the following tasks: (1) identifying the populations, service needs, and housing resources and supply for special needs populations; (2) quantifying housing demand; (3) enhancing planning and coordination; (4) formalizing and expanding Alliance partnerships; and (5) developing a county-wide strategic plan for special needs housing. By March 2003 progress on the first of these objectives was stalled, and no other activity was under way.

CSH invested resources in the SNHA from its Robert Wood Johnson Foundation Taking Health Care Home grant, paying Shelter Partnership to provide staff to help the Alliance complete its first task—an inventory of special needs housing in the county. In 2004, following release of this inventory, the county's Chief Administrative Officer became the Alliance's co-chair, giving the Alliance some much-needed standing and signaling that its actions and plans would receive serious attention.

To move forward, the Alliance worked on developing a strategic plan to address homelessness and homelessness prevention among three populations—transition-age youth, persons with a

mental illness, and persons with HIV/AIDS. Shelter Partnership again provided staff to help this happen, with financial support from CSH using funds from this Hilton initiative. The final plan included about 90 recommendations; Alliance members agreed on the top 8 or 9 recommendations and worked with County Board of Supervisors members to support these recommendations.

A major milestone was achieved in October 2005 as the Board of Supervisors unanimously adopted the Strategic Plan and initial goals of the Special Needs Housing Alliance. The Board instructed the Alliance to report back in 90 days with implementation plans for this initial set of goals. CSH again engaged Shelter Partnership to provide technical support to the Alliance in drafting these implementation plans. In April 2006, the Board of Supervisors took the unprecedented step of approving $100 million for a Homeless Prevention Initiative (HPI) that incorporates many of the recommendations in the SNHA's Strategic Plan. This $100 million is in addition to the $20 million the Board approved in June 2005 for transforming wet-weather shelters to year-round shelters.

The $100 million consists of two different pots of mostly County General Fund dollars. One-time dollars in the amount of $80 million, known as the Housing and Homeless Program Fund (HHPF), are being used to support a number of innovative demonstration programs that, it is hoped, will receive ongoing funding if the pilot projects demonstrate effectiveness in preventing or ending homelessness. Approximately $20 million in ongoing funds ($16 million County General Funds and $4 million program-restricted funds) support a variety of ongoing programs.

The Special Needs Housing Alliance, expanded to include additional county departments, continues to meet regularly to do the work needed to implement the HPI and take on other work related to the SNHA Strategic Plan. Over the past few months its members have been heavily engaged in developing requests for proposals for the projects that will be contracted out to community providers, and detailing plans with its member agencies for the projects that will be performed by county agencies. The level of communication and cooperation among county agencies in pursuit of a shared goal has never been higher—all respondents agreed that before the Alliance, and indeed even for much of its history before developing the strategic plan, member agencies were not in the habit of talking with each other, let alone undertaking joint or coordinated tasks.

In addition, the CAO's office has become the central coordinating office for county activities around homelessness. Staff people have been assigned solely to housing and homelessness issues for the last two years, and a new position has been created to supervise these functions. Several departments (Health Services, Public and Social Services, and the Sheriff) have appointed homelessness coordinators or at least a point person for their department's homeless-related activities, and the Department of Mental Health has reorganized and consolidated its homelessness and housing activities within its countywide adult systems of care.

Some of the specific projects that are or may be funded as part of the Board's action in June 2005 and it approval of the HPI in 2006 are:

- Capital may be provided for one or two safe havens through the HHPF's City/Community Program, with MHSA expected to contribute the service dollars. Capital dollars will be provided if one or more communities submits a proposal to construct the safe havens;
- The Board's June 2005 action provided capital dollars to transform the cold/wet weather beds in the five supervisorial districts to year-round beds;
- The HHPF's City/Community Program will result in additional supportive services by nonprofit providers;
- The HHPF provides partial funding for a demonstration homeless community court in Santa Monica;
- The HHPF also provides support for the following programs being implemented by county agencies:
    - Establishing a revolving pre-development loan fund for agencies intending to develop affordable and supportive housing;
    - Outreach and collaborative strategies;
    - Rental, moving, and eviction prevention resources to assist homeless families, General Relief recipients, transition age youth, and persons being released from county jail, county hospitals, and child dependency and delinquency systems, including
        - A contract with Beyond Shelter to move to move 500 homeless families out of Skid Row. Funding for the contract covers Beyond Shelter staff to locate housing and case manage the families as well as funds for extended motel stays and shallow rental subsidies for 150 of the families. In addition, 300 Section 8 vouchers have been secured from HACLA and 50 from HACoLA to house 350 of the families.
        - The HHPF will provide $2 million for a contract to expand SSI advocacy to help people qualify for benefits, including developing a liaison relationship with local SSA offices;
        - Funding for expanding the number of recuperative beds for homeless persons being discharged from hospitals (see next section of this report for details);
        - Funding for Access to Housing for Health to provide short term motel stays and case management for homeless persons discharged from county hospitals; (see next section of this report for details).

In addition, ongoing General Fund dollars have been allocated to several county departments (1) to provide rental subsidies for 900 General Relief clients at a time, (2) to establish DPSS outreach to the county jail and medical centers to determine eligibility and complete applications for benefits for people about to be released, (3) to create a housing database to aid housing placement specialists, (4) to provide housing locator services for CalWORKS families served by DPSS, and (5) to create DMH housing locator positions in each service planning area.

For the past few months, it appeared that the CAO was going to retire, and the staff person who has been the key coordinator of Alliance and other homeless-related matters was going to change departments. These changes augured no good for continued forward movement on homeless-related matters at the county level, as both had been central to the success of activities to date.

But the CAO has agreed to stay on if he is given more flexibility to do his job, and his assistant administrative officer is staying also, so the county has another year or two to institutionalize a dynamic approach to homelessness that will be less dependent on the presence of particular people. By that time the habit of working together may have become so ingrained in county staff from different agencies that a change in leadership would not have negative consequences.

Next steps for HPI/HHPF Alliance-related activities are to get all the money out the door and to set up some evaluative procedures for documenting its impact. Alliance members know well that if they hope to see these one-time dollars renewed they will have to be able to show first their own department heads and then the CAO and the Board of Supervisors that the projects and approaches have had desirable effects.

ACTIVITIES WITHIN THE DEPARTMENT OF HEALTH SERVICES

As critical as the Special Needs Housing Alliance has been in bringing together county departments to focus on addressing the issues they have in common, equally important is work *within* departments to move department-specific issues related to homelessness in complementary directions. If the within-department work to reduce homelessness is to get done, it is essential that a department have someone on staff (a homeless liaison) whose responsibility is to look at homeless-related issues, develop plans, and promote solutions. We use the activities of the Department of Health Services (DHS) homeless liaison as an example of what can be accomplished.

In 2006 two departments, the Department of Health Services and the Department of Public Health (DPH), were created out of a previous department that housed them both. DHS is responsible for all the public hospitals and comprehensive health clinics that are either directly operated by DHS or are contracted with DHS as public private partners. DHS facilities are directly affected by homelessness—homeless people are many of their frequent service users.[6]

DHS has a very active homeless liaison, who has filled this role since 2004, before the departmental division. She has participated in the Special Needs Housing Alliance from the beginning, and helped shape its strategic plan. As an extension of Alliance work she arranged for the leadership council of DHS to hear a CSH presentation on the importance of permanent housing. She perceives a major increase in communications around homelessness within county departments, and also some enhanced access to resources. Much has been happening both within and beyond the scope of the Alliance's strategic plan.

With respect to continuity of care for homeless people, for instance, the DHS homeless liaison has participated since 2004 in the Skid Row Homeless Healthcare Initiative that local foundations have been supporting (see below). In November 2005, DHS and DPH began a joint strategic planning process for homeless health care providers throughout Los Angeles County, seeking to develop a single voice of such providers that could impact local, state, and federal policy and local service delivery issues. This effort developed into the United Homeless

[6] Other health service providers with primarily homeless clients are the three Health Care for the Homeless grantees with their 20 service sites throughout the county. These are funded directly by the federal Health Resources and Services Administration in DHHS.

Healthcare Partners (UHHP). UHHP obtained a grant from the Green Foundation to pay a policy analyst to develop feasible ways to coordinate the work of DHS, DPH, the Health Care for the Homeless providers, and the Federally Qualified Health Centers (FQHC) throughout Los Angeles County. UHHP has submitted applications to the Kaiser Foundation and The California Endowment to support an executive director and other staff for UHHP. The ultimate goal, through the Alliance strategic plan and UHHP efforts and beyond, is to try to improve and coordinate homeless health care service delivery for the whole county by organizing around geographic areas where services exist and bringing many additional providers into these regional networks. UHHP is seeking foundation funds for symposium to identify best practices and to begin discussing how to improve homeless health care service delivery in all regions of Los Angeles County.

Access to Housing for Health (AHH) is another activity initiated by DHS. In 2004 the DHS homeless liaison went to the county's Community Development Commission (CDC) to see if some housing resources could be made available for DHS clients with Axis II diagnoses and substance abuse disorders that made them unlikely to be able to sustain housing on their own. The CDC agreed to provide 15 public housing units and 50 Section 8 vouchers. AHH was also able to secure 50 Section 8 vouchers from the City of Los Angeles. As part of the HPI's $100 million, AHH received $1.5 million to fund temporary housing to cover the 30–90 days between submission of a Section 8 application and the time it is approved, intensive case management, and housing location services. DHS was able to hire a program coordinator for this activity.

Another challenge being addressed within the county's new spirit of seeking solutions to long-standing issues of access to health care for homeless people is increasing recuperative care opportunities for homeless people. People leaving hospitals often need a period of recuperative care before they can get back on their feet, but homeless people have nowhere to go for this care and no one who will supply it. The private hospitals throughout the county were among the strongest proponents of doing something about this need. The Hospital Association of Southern California brought together the obvious players—its own members, DHS, Kaiser, Neighborhood Legal Services, the National Health Foundation, JWCH and LA Health Action—all of whom agreed that more recuperative care beds were needed. The Hospital Association took on the task of organizing a planning effort to bring the private and public hospitals together on this with a planning grant from Kaiser. The Recuperative Care Coalition determined that 45 new recuperative care beds added to the 43 such beds currently available would better meet the overall need. Thirty new beds are planned for south Los Angeles, and 15 are being considered in the San Fernando Valley. The plan also indicates the importance of case management services to accompany these beds, to help their occupants move to the most relevant type of housing once they are ready to leave. CSH staff is scheduled to do a presentation to this group in April on options for permanent supportive housing. HHPF resources will fund the first 15 new recuperative beds, to be located at the Bell Shelter in south Los Angeles. JWCH will operate these beds.

MHSA Planning and Implementation

Just as CSH worked with the state Department of Mental Health to help develop its overall approach to MHSA and assure adequate provision for homeless-related services and housing, and conducted trainings throughout the state to assist counties to develop their own plans, CSH

staff, the director of the Mental Health Association of Greater Los Angeles, and Shelter Partnership's Executive Director worked more extensively with the Los Angeles County Department of Mental Health (LACDMH) on the local level of the same activities. As a result, Los Angeles County was one of the first counties to submit a plan to the state, and one of the first to have its plan approved, in spring 2005.

MHSA planning in Los Angeles County was done through a "stakeholder" process, with over 60 official stakeholders appointed to represent various interests. Shelter Partnership's Executive Director was an appointed stakeholder as the "homeless representative." In that position she chaired the Housing Committee and advocated strongly for housing opportunities to be included in the MHSA Community Services Support Plan. An important result was the inclusion of funding for housing specialists throughout the county to help homeless people with serious mental illness to secure housing, rental assistance, and supportive services.

MHSA implementation has not gone swiftly, owing to delays at the state level in completing implementing guidelines and regulations and to LACDMH's historic approach to distributing its funding. The plan was approved by the state DMH in February 2006, but LACDMH did not convene the Housing Advisory Group to develop final guidelines for PSH funding until February 2007, and the guidelines were not finalized until late March. The final guidelines owe much to the active participation in the Housing Advisory Group of both Shelter Partnership and CSH.

Adding further to delays is DMH's lack of capacity to process requests for proposals and the resulting review and contracting activities. Until MHSA, DMH rarely did requests for proposals—two were issued in the 10 years before MHSA. In 2006 alone, 14 requests were issued under MHSA. Each request must go through the County Counsel before it can be issued, and the proposal review and final selection must also receive legal scrutiny before a final contract can be issued. County Counsel has not received any additional staff to handle this many-fold increase in work, so its part in the process has become a serious bottleneck.

LACDMH staff have been very involved with the Special Needs Housing Alliance. The MHSA plan was in place before the Alliance's strategic plan was completed, and every effort was made to see that the two plans were complementary. LACDMH did not receive any allocation for service delivery under the strategic plan because with the MHSA if was not felt necessary. But the expectation is that county capital resources under the strategic plan will be combined with MHSA resources to create complete packages for permanent supportive housing for homeless people with serious mental illness.

Simultaneous with MHSA development and implementation, LACDMH is undergoing a combination of severe budget pressures, restructuring, and "transformation." Staff positions that would otherwise have been lost are being closed out and their occupants reassigned to new positions in newly created or "transformed" activities. For instance, caseworkers who once handled 150 people at DMH clinics may move to casework positions in full service partnerships (an MHSA activity) with 10 clients. Or they may move to new "Wellness Centers" that will handle clients whose situation is stable and who only need medication management. An especially important, and difficult, aspect of "transformation" is change in attitudes and values. DMH policies have all been about boundaries—keeping the boundary between staff and patients,

adhering strictly to job descriptions, and hierarchy. A central idea of transformation is to convince both staff and clients that the power is in their hands, for them to take control and improve their lives, as workers and as consumers. After more than a year of transformation work, some district offices have thrived on this new orientation while others have not made much headway. As an environment in which to try to observe the impact of MHSA's influx of resources and new ideas, LACDMH has been a challenge.

REDUCING HOMELESS RISK FOR PEOPLE LEAVING THE COUNTY JAIL

People leaving jail or prison have a relatively high risk of becoming homeless, especially if they have disabilities or a prior homeless history. Every month, more than 13,000 people enter the Los Angeles County Jail. Most are convicted of petty drug charges or theft, although those with serious mental illness are most likely to be charged with "quality of life" crimes. At intake, 1,700 to 1,800 of those 13,000 say that they are homeless. Every month, about 13,000 people are released from jail. We can assume that their risk of becoming homeless at release is at least the same as it was at imprisonment, comprising around 15 percent of all releasees.

Most people leaving the Los Angeles County Jail go out on parole, which means they have some structure of supervision in the community. That supervision has historically been geared to assuring compliance with parole conditions rather than supporting former inmates to achieve stable living arrangements and adequate income. In 2000 the Sheriff's Department, cognizant of the high rates of return to jail among releasees, established the Community Transition Unit (CTU) to aid inmates who needed help with the transition to civilian life if they were to avoid committing new crimes. Funded by the Inmate Welfare Fund (which gets its resources from inmate purchases of candy, cigarettes, and similar items), the CTU was staffed by 18 "custody assistants" acting as case managers. All custody assistants were sworn officers and supervised by a lieutenant, but an effort was made to select staff who had or could develop a social services/support orientation. The CTU focused on reducing jail recidivism, not on preventing homelessness. But to the extent that it reduced recidivism it probably had some effect on lowering the risk of homelessness as well, since the route to reduced risk of recidivism, stable housing and employment, clearly implies less homelessness.

In establishing the CTU in 2000, the Los Angeles County Sheriff's Department became part of a national movement among criminal justice agencies to do something new about recidivism. Hundreds of thousands of people imprisoned during the "war on drugs" were being released from prisons every year. The approach to corrections that imprisoned them during the 1980s and 1990s had perceived the goal of prisons and jails to be punishment, not rehabilitation. It focused on determinate sentencing, "paying your debt to society," reduced or no parole, and little by way of preparation for release or support once released. Systems of quarter-, half-, and three-quarter-way housing that had once been an integral part of corrections agencies had been dismantled. Prisoners were often completely on their own once the prison doors closed behind them. The effects of these policies began to be felt within corrections systems themselves, as about one-third of all released offenders returned to prison within the first year after release, with two-thirds returning within three years. Prison time is expensive time for public coffers, and corrections systems eventually felt the pinch of so much recidivism. In their own interest, corrections officials started to explore options for increasing the odds that inmates could succeed in their return to the community.

At about the same time, service providers and advocates in the homeless arena were becoming increasingly aware of two things. First, emergency shelters were admitting significant numbers of people coming directly from prisons and jails; in fact, some parole officers *told* releasees to go to specific shelters, and that they would be looking for the releasees at those shelters as their *assigned residence* upon release. So jails and prisons were using the homeless system programs as their new "halfway houses," without having to support any facilities from their own budgets. Second, it appeared that jails, especially, were serving as makeshift shelters for some of the most severely disabled homeless people. Chronically homeless street dwellers with serious mental illness, chronic addictions, or both were being jailed for "quality of life" offenses such as sleeping in public places—infractions that affect only homeless people.

Corrections officials were of course well aware of this second fact as well—the Los Angeles County sheriff often remarks that he runs the largest mental institution in the world, as he estimates that half of his daily population suffers from a serious mental illness. The risk of homelessness upon release is particularly severe for this disabled population. The Los Angeles County Department of Mental Health maintains a presence at the county jail to work on discharge planning for its own clients. Both agencies received important assistance in this task through state funding for the AB 2034 program (see above). Los Angeles County received one of the first three pilot programs under AB 34 in 1999 (funding has been continuous since then). The Los Angeles program, originally and still, focuses largely on preventing homelessness among people with serious mental illness exiting the county jail.

Recent Developments: National and State

At the national level, a broad coalition of advocates and other stakeholders have been working for several years to achieve passage of legislation known as the "Second Chance Act," and will be working to pass it in the new Congress. CSH staff has participated in this effort by helping to shape the supportive housing elements it contains, and educating public officials and other partners about the positive impact that statewide re-entry programs would have in many states. Passage of the Second Chance Act, along with subsequent appropriations, would establish a mechanism for creating statewide re-entry housing programs that would include supportive housing initiatives.

Additionally, on the administrative level CSH has engaged with senior HUD officials to discuss options for refining the current definition of chronic homelessness to include people who meet the current definition based on the longevity or frequency of their homelessness, but who are excluded because they cycle between homelessness and incarceration. A revised definition would let supportive housing providers "catch" otherwise chronically homeless people as they leave jail or prison and end the costly cycle of homelessness and incarceration.

At the state level, CSH is working closely with key partners, including Housing California, and with key legislators and legislative staff to build support for a statewide re-entry supportive housing demonstration program for homeless, mentally ill parolees from state prisons. CSH is working closely with Senator Lowenthal, Chair of the Senate Transportation and Housing Committee, Senator Steinberg, and other members of the Assembly and Senate to build support

for the program, and doing similar work with California Department of Corrections and Rehabilitation officials and members of the governor's staff.-

Recent Developments: Los Angeles County.

Several interrelated things have been happening in Los Angeles pertaining to jail inmates returning to the community. All show promise of being able to help returning inmates avoid homelessness.

CTU Adopts Homelessness Prevention Focus. In April 2006 the Community Transition Unit (CTU) took on the additional goal of reducing homelessness on release from jail, and for the first time a civilian was hired to run this aspect of the program. As two programs with a focus on people with serious mental illness already existed, people coming through the CTU mostly do not have a mental illness. The new director's goal is to incorporate evidence-based practices for case management into the CTU, starting with identifying and incorporating a well constructed, preferably web-based, assessment tool. "Web-based" is important because the county's jail system is far-flung—with seven facilities, sometimes the caseworker's biggest job is simply finding people. It is important that the case manager be able to access an inmate's record in whatever location the inmate and caseworker are able to meet. With an assessment tool in place, caseworkers would use its results to assemble a package of supports to help each inmate be emotionally and financially prepared for life on the outside. CTU staff also recruit and work with landlords who are willing to house returning prisoners (assuming appropriate supportive services are available), and even to wait a few weeks to receive their first rent payment until the tenant gets a first paycheck. CSH is helping the CTU develop this focus by analyzing the resources that exist to help people with shallow rent subsidies (either short-term or less than FMR) and transitional services. CSH is also working with LASD using some of its discretionary money to provide short-term rental assistance to the 100 "neediest" people leaving jail at a time.

CSH Work with Housing Authorities. CSH has supported advocacy by Shelter Partnership directed toward the Los Angeles City and County Housing Authorities (HACLA and HACoLA) to take a somewhat more flexible approach to their criteria for accepting people with criminal records as recipients of public housing or rental assistance. In 2005, HACLA had proposed major changes to its admissions policy to be more restrictive than required by federal guidelines with respect to admission in Section 8 housing. Shelter Partnership organized a number of interested parties to oppose these changes and was successful in these efforts. HACLA ultimately agreed to waive some of its criteria for time since incarceration for people convicted of substance abuse offenses if they can show proof that they have successfully completed a substance abuse treatment program. Shelter Partnership also reviewed nonprofit developer practices in screening potential tenants to exclude persons with criminal background histories, and made recommendations for policy changes. If public housing authorities cannot be flexible on this issue there is little hope that returning prisoners can secure these very important housing resources. It is hoped that these negotiations can be expanded to the other public housing authorities in the county, once tenants using HACLA and HACoLA resources have some track record of success.[7]

[7] There are at least six more public housing authorities in the county: Glendale, Inglewood, Long Beach, Pasadena, Santa Monica, and Torrance.

Opening New Doors and the Creation of Relevant Housing. Later in this report we describe Opening New Doors, an extensive training package that CSH is offering to teams of developers and service providers interested in helping to expand the supply of PSH. In the current (second) round of Opening New Doors, two of the provider teams are planning to develop housing targeted specifically for jail inmates returning to the community. CSH is helping with technical assistance and with linkages to the jail's Community Transition Unit.

Returning Home Initiative. In spring 2006, CSH received a grant from the Robert Wood Johnson Foundation to mount the Returning Home Initiative, with additional support from the Conrad N. Hilton and JEHT Foundations. Primary sites include Los Angeles, New York, and Chicago, with additional work occurring in five other states. This initiative is designed to establish the role of supportive housing as an essential component of systems to assure a successful return to the community for people leaving jails and prisons. In Los Angeles, Returning Home is a partnership of CSH and the Community Transition Unit of the Los Angeles County Sheriff's Department. Returning Home is still in its initial implementation phase in Los Angeles; the next report will include more detail about how it has developed.

POLICY AND FUNDING CHANGES AT THE CITY LEVEL

City of Los Angeles housing agencies, along with their county counterparts, have long contributed resources to develop and operate housing for homeless people, much of it in Skid Row. After the Low Income Housing Tax Credit, agencies running permanent supportive housing projects in Los Angeles list CDBG dollars and funding from redevelopment authorities as their biggest sources of capital for developing housing. Redevelopment authorities also contribute significantly to annual operating expenses, as do housing authorities through their Shelter Plus Care and other housing subsidy programs. These resources have all been generated by individual PSH developers applying to and negotiating with the relevant departments, one project at a time. Until recently, however, the City of Los Angeles has not developed any type of plan for either permanent supportive housing or affordable housing in general.

CITY DEVELOPMENT OF A PERMANENT SUPPORTIVE HOUSING PLAN

When the current mayor took office in July 2005, his administration hired a consultant and undertook a strategic planning process with the eight deputy mayors and three senior advisors. The results contained no content related to homelessness, and barely touched on housing. Most of the City of Los Angeles budget is consumed by the public safety activities of the police and fire departments, but the city does have three agencies with responsibilities related to housing and development—the Housing Department (LAHD), the Housing Authority of the City of Los Angeles (HACLA), and the Community Redevelopment Agency (CRA).

Responding to the recent interest in homelessness occasioned by the results of the 2005 homeless count, activities around creating a 10-year plan for the county as a whole, and a hard-hitting series of articles about Skid Row appearing in the *Los Angeles Times*, the mayor's office began to concern itself with homelessness. To promote permanent supportive housing, in October 2005 the mayor pledged $50 million in HOME, CRA, HOPWA, and the Department of Water and Power resources for capital development, and HACLA committed $3 million in Project Based Section 8 for operating expenses (equivalent to a $26 million, 10 year commitment). A second

$50 million for capital followed the next year. No services funding attaches to these housing dollars, as the city does not control those service dollars, but the hope in announcing the housing commitment was that the county would follow through with supportive services funding. The mayor also proposed a $1 billion bond issue for affordable housing. The bond issue failed, though it drew a surprising 62+ percent of the vote. The mayor and other city leaders are considering reintroducing this bond issue in 2008.

The Los Angeles Housing Department was given the task of turning the city's initial $50 million commitment into a Permanent Supportive Housing Program (PSHP). LAHD approached CSH and asked for technical assistance; together with LAHD, CSH approached the California Community Foundation (CCF) to help support this work. A grant from CCF coupled with Hilton funds available to CSH let CSH engage Jean Butzen, former Executive Director of Lakefront SRO Housing from Chicago and former member of the CSH Board of Directors, to help design the PSHP. CSH convened two focus groups with housing developers and Skid Row service providers. Subsequently, a joint presentation by LAHD and CSH made to over 100 stakeholders from Skid Row announced the basic elements of the program. Having developed a program description that focused on housing chronically homeless people in mixed population buildings, CSH was then asked to draft the first funding notice. At the same time, the mayor announced a second $50 million investment for a second round of funding for the PSHP.

The first funding notice contained some challenges for project developers. LAHD very intentionally worked to increase the expectations for the quality of the housing to be developed. Among the key challenges for Skid Row developers was the call for private baths in every unit and for central heat and air conditioning. A challenge for some of the non-Skid Row developers who tended to develop smaller projects was the call for 24 hour front desk coverage. CSH and LAHD have held subsequent meetings with developers to explain the city's efforts to increase the quality of PSH in Los Angeles and to ensure that projects are able to successfully house chronically homeless people.

During the process of developing the program guidelines for PSHP, CSH helped facilitate joint meetings between LAHD and key county agencies to explore possibilities for committing services funds to the city's housing program. Unfortunately, the talks did not succeed in producing a commitment of county funds. Part of the problem is that county agencies are not clear about the mechanism(s) to use to make such a commitment, even if they had the funding to devote. The Special Needs Housing Alliance has agreed to review the service plans in the individual projects submitted for the first round of PSHP funding, to determine what supportive service resources their member agencies would be able to offer.

Despite the lack of service funding, one of the breakthroughs in the development of the PSHP is that the city's commitment includes both capital funds and project based operating subsidies. This is the first time in Los Angeles that a single funding announcement has included both elements. The first funding notice was released in October 2006. In early March 2007, the city announced five successful bidders; CSH had provided some form of financial or technical assistance to four of the five. LAHD has asked CSH to work with department staff to adapt the funding notice for round two to address some of the concerns raised by sponsors during the first round and to make the funding more accessible for smaller projects.

The growth of the city's commitment to address chronic homelessness can be traced in personnel devoted to the task. One of the mayor's senior advisors served as the city's point person on homelessness, along with other assignments, until fall 2006. At that time, recognizing the amount of work to be done in this area and the need for a dedicated staff person to support it, the mayor created a full-time position of homelessness policy coordinator. Less than one year later, the mayor's office is in the process of creating two more staff positions—a housing policy analyst and a community development policy analyst—who will work side-by-side with the homelessness policy coordinator to address the complexity of issues involved.

LAHSA

The mayor's office and the county's Board of Supervisors also recognize the need to have a strong Los Angeles Homeless Services Authority. LAHSA was created in 1993 to settle lawsuits between the city and the county over responsibility for homelessness. Neither the city nor the county wanted the responsibility, and they created in LAHSA a joint powers authority that was given the least authority and scope possible that would still sidetrack the lawsuits. For years LAHSA labored under a cumbersome legal and financial structure that gave it virtually no leeway to become a true center and guide for developing countywide responses to homelessness. Nor did any other entity fill this need, leaving homeless assistance providers struggling along in the trenches with no place to turn for leadership that would or could bring public agencies and local elected officials together to create a coherent countywide approach to addressing homelessness.

Although serving as little more than a pass through agency for federal dollars earmarked for local projects, in early 2006 LAHSA ran into accounting problems that ultimately occasioned the resignation of its long-time director. The LAHSA board (half of whom are appointed by the County Board of Supervisors and half by the Los Angeles mayor) took this opportunity to do some rethinking about LAHSA's role, especially given the spotlight that was then shining on the lack of public action to reduce the county's enormous homeless population. No changes have yet been made to LAHSA's charter, and it is not clear whether any changes are contemplated. But at least the board selected someone as the new director who has a history of effective management in very difficult organizational circumstances, and gave her to understand that there would be support for taking LAHSA in the direction of becoming the strategic planning and implementation agency on homelessness for the whole county. To this end, LAHSA has submitted a proposal to the City of Los Angeles as part of the city budget that would allow it to draw down matching county dollars that have been waiting since 2005 for a city commitment. These funds will give LAHSA some administrative resources that it can devote to planning and working with the many city, county, and private entities that will have to be involved in a comprehensive approach.

For the City of Los Angeles's part, it needs LAHSA. The city has no services dollars of its own, nor does it have adequate planning capacity to take on homelessness. It needs LAHSA to help organize, synchronize, and integrate the many plans currently competing for attention, and better yet, establish a coherent overall approach to planning and implementation. If LAHSA can supply the leadership, the city would be happy to have it take over planning functions.

LAHSA's relationship to county agencies is a bit less certain—the mayor's office knows it needs LAHSA, but it is not yet clear whether county authorities will come to feel the same way. Although some say they want LAHSA to be able to assume leadership on homeless issues, the county has chosen to administer all of the new HPI and HHPF funding through its own agencies, including the components that are intended to go out for bid to nonprofit agencies and could easily, and perhaps most appropriately, be administered through LAHSA. LAHSA will also have to earn the faith of city and county elected officials if it is going to function smoothly as a countywide leader.

The new LAHSA leadership is being careful not to take on tasks until it can be sure that it can "deliver," so as not to destroy any budding belief that it is on a new path and can be trusted to do what it says it will do. An attempt to create a unified plan of action for downtown Los Angeles, including the Skid Row area, is a case in point. LAHSA began this effort, hiring a consultant whose assignment was to draft a plan that would be able to bring together the overlapping activities and plans for the Skid Row area.[8] But not all existing activities and planning efforts are compatible, and some are quite controversial in both their concept and their execution. In addition, it was hard to plan for a specific geographical area without having a larger structure of services and supports in place. So the draft integrated plan has been pulled back for further study. An interesting development is that, even in its draft state, the plan is receiving active consideration from some County Supervisors' deputies. In the next section of this report we describe LAHSA's strategy for working toward a position of leadership.

CITY-COUNTY JOINT ACTIVITIES

As noted in the introduction to this report, relations between many big cities and their surrounding counties are often strained; Los Angeles is no exception. A framework sometimes used to describe levels of system integration includes isolation, communication, coordination, collaboration, and coordinated community response.[9] Up until the last several years, few would have argued with a description of city and county agencies as operating in isolation, even within the same government structure as well as across city-county boundaries. Whether the issue was homelessness or something else, the same lack of communication and interaction prevailed. Even worse, because no communication could be simple ignorance or neutrality, the interactions that inevitably took place contained elements of distrust, suspicion, and occasionally active hostility. This was certainly the situation that prevailed with respect to action regarding homelessness in the early 1990s, when LAHSA was established, and not much had changed over the next decade.

[8] In Skid Row alone, there are, at least, the city's Permanent Supportive Housing Plan, the primary care group's plan under the SRHHI, a plan and some implementation for the United Homeless Healthcare Providers to do mobile medical care in Skid Row and connect to hospitals plus run a downtown urgent care center once it is funded, DMH's Transformation plan, the SPA 4 MHSA plan as well as MHSA's countywide parts, Special Needs Housing Alliance strategic plan elements that pertain to Skid Row, possibly soon also plans for the SRHHI's mental health and dental components, and the police department's "safer cities" plan.

[9] See Burt, M.R. and Spellman, B.E., 2007, Changing Homeless And Mainstream Service Systems: Essential Approaches To Ending Homelessness. Washington, DC: Review paper presented at the Second National Symposium on Homelessness Research, and 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.

CSH stepped into this situation in early 2003, when a grant from the Robert Wood Johnson Foundation for a project called "Taking Health Care Home" allowed CSH to open an office in Los Angeles. An evaluation of Taking Health Care Home, conducted by the same evaluator currently assessing progress on the Hilton initiative, began quickly thereafter and is still ongoing. Reflections of key informants interviewed in early 2004 and late 2005[10] were helpful in describing the situation when CSH staff arrived and what happened during its first three years of trying to serve as a catalyst for change.

In 2003, city and county elected officials and government agencies were well known for holding each other responsible for failures to resolve problems while not taking action themselves. Homelessness was not part of anyone's "portfolio," in part due to the district system of elections for both City Council and County Board of Supervisors that left no one with a citywide or countywide constituency. Numerous informants said that "homeless people and homelessness were not big enough in anyone's electoral district to 'matter.'" The Special Needs Housing Alliance had already been formed and had developed a reasonable agenda, but its slow initial progress in moving that agenda forward suggested that county agencies and LAHSA lacked the experience to take the necessary steps despite the serious intention to do so. City of Los Angeles agencies and representatives from the many independent civil jurisdictions in the county, meanwhile, were not even at the table—although some had created "tables" of their own.

All informants spoke of how important it was to have the CSH presence in Los Angeles. CSH is seen as playing a crucial "catalytic" and matchmaking role as it serves on, provides staff for, or offers technical assistance to various committees, taskforces, and efforts in the community. Early on, the effects of this role were visible with respect to the Special Needs Housing Alliance, the Skid Row Collaborative, and implementation of the Mental Health Services Act at the state and county levels. CSH worked with partners in many of these efforts (e.g., Shelter Partnership for the Special Needs Housing Alliance, the Mental Health Association of Greater Los Angeles for MHSA), as well as with the key stakeholder agencies and organizations. CSH staff abilities as facilitators and relationship builders were identified as important, especially their talents in keeping people focused and working together despite some fundamental differences among partners. More than one person spoke of CSH's ability to be a strong partner because it does not come with a lot of local political baggage, can carry off the neutral role, has a lot of relevant expertise stemming from work in California and many other states and communities that it shares liberally, and is a national organization that carries some clout. Informants also felt that CSH was good to work with because it is about "getting things accomplished without bureaucracy and red tape." CSH is also seen as an organization that seeks out partners; works well in collaborative arrangements; and brings people, organizations, and agencies together to work on developing common approaches to shared goals.

Thanks to much hard work by CSH and many other stakeholders over the past few years, there are indications that the historically stalemated relationships in Los Angeles might be beginning to change. For one thing, as revealed in a recent round of interviews with key stakeholders, people in different organizations, agencies, and jurisdictions know each other now, understand much more clearly what each other's organizations are able and not able to do, and have some experience designing joint actions to reach common goals. This is not to say that they did not

[10] Reported in Burt and Anderson 2006 (see footnote 8).

"know" each other before, since many had sat on committees together and seen each other in meetings and conferences. But hardly ever had they *really communicated* the things that people need to know if they are going to pursue shared goals together and are expecting their respective agencies to start changing standard operating procedures. Everyone interviewed for the present report felt that at the personal level, staff at city and county agencies have developed extremely supportive and effective relationships during the past several years of joint work on homeless issues. The quiet influence of several local foundations may also be a key to these changes, as may new leadership at LAHSA.

During 2006, several foundations worked to bring together the various Los Angeles stakeholders to see what could be done on a countywide basis. Two meetings have been held with officials from several foundations, representatives from the cities of Los Angeles, Santa Monica, and the three with independent Continuums of Care (Long Beach, Glendale, and Pasadena), the heads of DPSS, CDC, and HACoLA, and the CAO and his staff. It is not entirely clear whether these meetings will continue or what they might hope to accomplish, but one message from the four cities was crystal clear—the City of Los Angeles and Los Angeles County had to start working together. Some respondents said they had been worried about including the other cities in the meetings, but most agreed in hindsight that the presence of the other cities diffused the usual tension between Los Angeles city and county agencies and made it possible for the right people to hear the message.

LAHSA recently acquired a new director, has straightened out its accounting difficulties with the aid of a consultant, and that consultant has been hired as the deputy director to assure the smooth functioning of internal procedures. The new director recognizes the enormous task facing her, in changing the image of the organization and developing perceptions that it is competent and should be the seat of countywide leadership on homeless issues. The director and deputy director have met with representatives of most agencies and groups concerned with homelessness in most communities in the county to listen to their experiences, understand their missions and their constraints, and discuss the roles that LAHSA could and should play. One or both attend meetings of as many task forces, committees, advisory groups, alliances, planning councils, study groups, and initiatives as they can find, to accustom people to their presence, participate as much as possible, and discuss how LAHSA relates now and could relate in the future.

LAHSA has always been starved for staff resources, as described earlier in this report. Working with city and county officials, the new LAHSA leadership has submitted budgets to both city and county for resources to support realistic planning and administrative functions, and appears likely to get at least $2 million a year for this purpose ($1 million each from city and county).[11] Ideally the new staff will be able to renegotiate the ground rules under which LAHSA operates, as set out in the joint powers agreement. Virtually every respondent perceived that LAHSA had been "set up to fail," given as little responsibility as possible, hampered by extremely awkward financial arrangements, and micro-managed with respect to spending by city and county alike.

[11] The county has had $2 million earmarked for LAHSA administrative support since 2005, but has not been willing to transfer it to LAHSA until the city would match it. So the city's recent commitment of $1 million has triggered release of the same amount from the county. Thus there is a possibility of LAHSA receiving more administrative resources if either the city comes up with additional funding to match the county's or the county decides to commit some or all of its remaining funds without demanding a city match.

However, those same respondents are now "rooting for" LAHSA to get its financial house in order (pretty much done) and re-establish its legitimacy, after which they hope that LAHSA can become the source of the leadership that is needed countywide to bring the many Los Angeles stakeholders together.

One approach to regional planning that LAHSA and county officials are exploring is working through councils of governments (COGs). There are eight COGs in Los Angeles County, and all but two of the county's 88 cities are members of a COG. COG boundaries may be a meaningful way to think about regionalism within the county, in a way that supervisory districts or service planning areas do not seem to be. COG members are usually city council members in their home communities, so the COGs are organizations with some potential political muscle should they decide to move on homeless issues. The LAHSA director has been looking for ways to stimulate real sub-county regional planning and commitments around homelessness, and working with COGs might be feasible. CAO staff, county homeless deputies, and LAHSA representatives have been meeting with COGs and regional collaboratives around homeless programs and initiatives. There is potential that the COGs could form the basis for sub-regional plans and help to identify and work on the county's regional stabilization centers, for which county funding is available. Several COGs have also expressed interest in working to change cold/wet weather shelters to year-round facilities and at least one is ready to propose a site, but they want to see county dollars on the table before committing their own.

Representatives of the City of Los Angeles, Los Angeles County, and LAHSA recently spent a week together in Washington, DC. They prepared a joint City/County/LAHSA Federal Policy Agenda on homelessness as well as a brief for the Los Angeles Congressional delegation. Issues were McKinney appropriations and reauthorization, Section 8 reform, a National Affordable Housing Trust Fund, and service delivery issues associated with SSI and recuperative care beds for homeless people being discharged from the hospital. They met one on one with key Congressional leaders, presenting a united front for the first time. They also met with HUD program officials to develop a deeper understanding of HUD policy direction in general. They also wanted to learn about the Los Angeles Continuum of Care application process and how city and county agencies and officials can be more aware and supportive of this process, which LAHSA leads. Los Angeles recently learned that it would receive about $8 million less this year than last in federal Shelter Plus Care funding through its Continuum of Care; one of the possible reasons has to do with the performance of one or more public agencies. The participation of city and county agencies in fixing any poorly performing aspects of their own processes would greatly contribute to assuring that this is a one-time loss and is not repeated in years to come.

These city-county and countywide efforts are in their infancy. The direction being taken seems essential—the fragmentation and isolation of the county's various jurisdictions must be overcome and coherent and integrated regional strategies developed. LAHSA is the obvious entity to make this attempt, as the only entity whose primary mission is ending homelessness and the only one with any type of joint powers. The questions for the future are whether the LAHSA leadership is able to inspire the confidence, and whether public agencies and private organizations will finally provide the resources that LAHSA will need to fulfill its mission. At the same time, the joint work being done by city agencies with each other, county agencies with

each other, and city and county agencies together needs to continue, solidify, and ultimately result in truly new and stable structures that work effectively together to end homelessness.

ACTIVITIES AT THE PROVIDER-SERVICE LEVEL

Ultimately, policy changes at national, state, county, and city levels must "get down to the street" if homeless people themselves are to reap any benefit. This means that the providers who actually interact with homeless people on a daily basis have to have ways to participate, as they must understand any policy changes and their implications for clients if the changes are going to sift through to help clients. We focus in this last section of the report on three developments at the provider level, starting with the Skid Row Collaborative (the earliest, began in 2003) and then looking at the Skid Row Homeless Healthcare Initiative and Opening New Doors. As virtually everything happening in Skid Row in the last few years calls itself a collaborative, or even "the collaborative," we will keep our references straight using the following conventions: we will refer to the Skid Row Collaborative either by its full name or as SRC, to the Skid Row Homeless Healthcare Initiative as SRHHI, and to Opening New Doors by its full name.

SKID ROW COLLABORATIVE

The Skid Row Collaborative is one of the 11 projects funded under the federal government's Chronic Homelessness Initiative (CHI) in fall 2003. CSH was involved in the Skid Row Collaborative from the proposal stage, assisting with the project design and helping to bring the various partners together. Once SRC received funding, CSH staff were involved as facilitators for both the Oversight Committee of agency heads and the Operations Committee that had to set up collaborative arrangements among the most involved nonprofits (Skid Row Housing Trust, Lamp, and JWCH) and public (HACLA, DMH, and VA) agencies and basically make the project work. During its first year especially, when a CSH staff person was its chair, the Operations Committee was called on to resolve many issues of actual program functioning, often having to do with negotiating the relationships and responses of the various partners to each other and to the needs of the project's tenants/clients.

The Skid Row Collaborative has provided the first opportunity for local housing and service organizations to target resources and expertise toward the same goal—providing coordinated services and permanent housing to chronically homeless individuals. As this was the first time these organizations worked together, there were unique challenges to implementing the project. For example, each organization came to the project with separate service philosophies and processes. Regular meetings and organizational site visits helped to move separate systems into systems that incorporate the expertise of each partner and are coordinated through outreach, housing placement, and service delivery. There is some evidence that the effort spent on these negotiations and the resulting interactions and relationships are beginning to affect the actions of these agencies beyond the framework of the SRC itself.

SRC has developed a model that really works for the most long-term homeless, multiply disabled single adults who frequent Skid Row. It combines housing in efficiency units in two closely linked downtown hotels with intensive on-site services that include case managers but go well beyond the usual case management approach. From project inception, office space at the key project hotel has been provided for a psychiatrist and psychiatric nurse. The nurse is on site full-

time and the psychiatrist 20 hours a week. The VA devoted a full-time social worker to the project starting a few months after people began to move into housing, who also has an office in the building. All three of these staff have been with the SRC for its entire existence. Key informants who have had lots of experience with different models of permanent supportive housing attest to the difference it has made to have these staff on site, and that they have stayed with the program. Their physical presence in the building has promoted more interaction with tenants, which in turn allows staff to catch potential problems before they become full-blown crises. Having staff-tenant relationships lasting several years contributes to the same effect, in part due to increased staff knowledge and in part due to increased tenant trust and openness with staff. Tenant stability in housing has been one consequence, as has improved health conditions.

The Chronic Homeless Initiative projects received three years of federal funding. SRC has stretched its funding about six months past its original October 2006 end date, but April 2007 will see the last of any federal funding through the demonstration.[12] As a federally funded demonstration project, it has been clear from the start of the Skid Row Collaborative that it would have to secure funding from local government agencies if it was to have a future after its initial three years. The housing component, in the form of Shelter Plus Care vouchers, comes through the Housing Authority of the City of Los Angeles (HACLA), which is committed to continuing to supply them. So the project has secured ongoing support for the housing subsidies that are essential to keep project participants stably housed. But replacing the federal resources used for health, mental health, and veteran services proved to be much more difficult. To understand why it has been so difficult to secure these health and mental health resources to continue the SRC, it helps to know the challenges that characterized its first couple of years.

Among the 11 original Chronic Homeless Initiative projects, SRC is the only one that was initiated by service providers; a government agency was the lead in all 10 other projects. Skid Row Housing Trust and Lamp, the two provider agencies that developed the SRC idea and pushed it through the proposal stage, sought and received signoffs from the three main government agencies involved, HACLA, DMH, and the VA. But none of the public agencies had a serious institutional commitment to the project when it began. One part of the SRC plan was that JWCH, one of the primary health care providers in Skid Row, would apply to become a Federally Qualified Health Center (FQHC), and thus be able to supply medical and mental health care at rates high enough to support the types of staff that would be needed for the project once federal funds ran out. JWCH's application was rejected on its first submission, setting this part of the plan back at least a year (JWCH has recently qualified as an FQHC). The two

[12] As of this writing it appears that SAMHSA plans to issue a request for applications inviting the 11 original CHI sites to apply for $5 million in one-time additional services dollars, thanks to the vagaries of the Congressional funding process. The Skid Row Collaborative will undoubtedly apply if this offer becomes reality. CSH was very involved in efforts to convince SAMHSA to make this funding available. CSH provided technical assistance to CHI grantees on sustainability strategies through conference calls and, at grantee meetings, by facilitating the sustainability track. CSH representatives also met with SAMHSA staff to persuade them of the need for ongoing funding. CSH helped lead the advocacy campaign to convince Congress to add funding in the SAMHSA budget with language directing SAMHSA to use the money for grants for PSH, including sustaining the CHI projects. When the vagaries of the FY07 appropriations process left SAMHSA with some extra money but no clear direction from Congress, CSH worked with the National Alliance to End Homelessness to organize CHI grantees in a series of conference calls that led to a letter (drafted by CSH) to the SAMHSA Administrator and signed by all the grantees and other national advocacy groups.

organizations originally expected to provide substance abuse services (Behavioral Health Services and Homeless Health Care-LA) never became integrated into the SRC, in part because at the beginning the SRC was busy housing people and was not ready to use these services, and in part because the SRC never included any provision for paying for these services. Through its own resources, Lamp provides support for substance abuse recovery, including counseling by qualified substance abuse counselors and peer approaches such as Alcoholics and Narcotics Anonymous. But actual treatment, whether outpatient or inpatient, is still the missing link in the SRC, as well as in many other supportive housing projects.[13]

The local VA provided a social worker during the federal demonstration period, because it received a directive from the national level to do so, accompanied by funding for the position. But local VA officials do not consider the Skid Row area a safe place for veterans to live, and thus have not made a commitment to continue providing on-site staff at Skid Row housing programs. The VA still maintains its downtown clinic to serve any homeless veterans in the area who want health care, but clinic services do not have the same effect as an on-site social worker.

The SRC's final government partner, LACDMH, has always treated the SRC as a *district* commitment, not a commitment of the entire county department.[14] The Downtown Mental Health Center (DTMHC), part of DMH's District 4, is available to serve people in Skid Row with serious mental illness. From its beginning, the SRC has benefited from the services of a psychiatrist assigned from DTMHC to work with its tenants on site at the St. George Hotel. As the federal project ends, the three nonprofit providers that form the nucleus of SRC—Lamp, JWCH, and Skid Row Housing Trust—have been involved in complex negotiations with DTMHC and District 4. CSH has also played an important role in reaching an interim solution.

At this time the SRC is regrouping with three primary nonprofit partners. Ultimately, the intent is for Lamp to supply expanded case management services to tenants in Skid Row Housing Trust buildings, and for JWCH to establish "medical homes" in three or four Skid Row Housing Trust buildings, through which all tenants in Skid Row Housing Trust's more than 1,000 units will receive primary care and mental health services and be linked to other services as needed. These medical homes will essentially be satellite locations for JWCH clinicians. To generate the resources to make this happen, JWCH will work during the next year to get federal approval for reasonable rates for psychiatric care under its FQHC status. Efforts will also be mounted to qualify more Skid Row residents for SSI (and hence Medi-Cal), or just Medi-Cal. There is also some discussion of negotiating with state Medi-Cal officials to make any indigent homeless

[13] The way that the county's Alcohol and Drug Programs Administration (ADPA) funds substance abuse treatment may have something to do with the problems with incorporating substance abuse treatment into housing programs or even into the type of primary care/mental health care/dental care structure envisioned by SRHHI. Most ADPA funds are disbursed through contracts with treatment providers, which might not be insurmountable except for the fact that the contracts are renewed repeatedly without new requests for proposals. As these contracts have not been re-competed since the late 1980s, there is no opportunity for new providers to apply, or for new approaches to treatment to gain support. Harm reduction and other approaches developed in response to changing circumstances and challenging populations have virtually no foothold among most providers with ADPA contracts.

[14] The county is divided into service districts, each with a district director and a budget to address client needs within the district. The overall departmental position on continuation funding for mental health services for the SRC has been "it's up to District 4, negotiate with them." This is a very different attitude from the one that DMH takes with respect to another federal demonstration, LA's HOPE, which it initiated along with the City of Los Angeles's Community Development Department.

person served by JWCH a "Medi-Cal equivalent" person, for whom JWCH could get reimbursed.

In addition, Lamp, which provides many case management/supportive services for PSH tenants, is developing the internal systems necessary to be able to bill Medi-Cal. To make this capacity meaningful, Lamp required DMH's participation *and* a DMH funding commitment, as the match for billing for mental health services under Medi-Cal comes out of the DMH budget. These negotiations were protracted but have recently been resolved by reallocating some funding that Lamp already has under a current DMH contract to become the required match, and DMH has agreed in principle to authorize this change.

It is anticipated that the JWCH and Lamp changes will take 12 to 18 months to bear full fruit in the form of adequate funding for the supportive services needed by SRC tenants. This leaves a substantial time period during which the program needs funding to continue its health and mental health services at the St. George (the SRC's primary hotel) and possibly expand services to the Rainbow and one or more other hotels. The SRC applied to CSH for a grant to help them bridge this time gap, and CSH is evaluating commitment of grants using a combination of Hilton Foundation and The California Endowment resources to help the SRC continue operations until the plans to use Medi-Cal resources can come to fruition. The final resolution is thus still a couple of years away.

The SRC has proved to be a successful model of housing plus services for the Skid Row population of chronically homeless multiply-disabled people. However, its status as nonprofit driven (as opposed to public agency driven) has left it in an awkward position with respect simply to its own continuation, let alone whether it might become a model for ending the homelessness of Skid Row's street homeless population. It will definitely need help if its model is to be adopted as an important one for public agencies to fund. That help may ultimately come through the work of the SRHHI, to which we turn next.

SKID ROW HOMELESS HEALTHCARE INITIATIVE

About five years ago, USC's Michael Cousineau published an assessment of homeless people's access to primary health care in the Skid Row area. He reported that care was scarce and that what existed was fragmented. Existing primary health care services did not communicate with each other. When they were desperate, which was the only time they sought care, homeless people went to whichever clinic was open that day, or where they thought they could get in. It was not uncommon for people to have been seen at all three primary care clinics in Skid Row, but no doctor ever knew what another doctor might have done for the patient sitting in the office now. Access to specialty care was very poor, and other problems abounded. He also reported the pervasiveness of physical health problems among the area's homeless population, including the proportion experiencing serious chronic and life-threatening conditions. From other data (e.g., Boston's Health Care for the Homeless client tracking), we know that death rates among street homeless people are 30 to 50 times higher than those for housed people of similar age.

The Cousineau report stimulated the Weingart, Annenberg, and Ahmanson Foundations to create a major initiative to improve access to care in Skid Row. They selected the Community Clinic Association of Los Angeles County to mobilize a Skid Row Homeless Healthcare Initiative, or

SRHHI, and committed about $1 million over three years to the process. The SRHHI began in January 2004 with a focus on primary health care and the intent to expand to mental health and dental care once primary health care goals were on their way toward achievement. The Community Clinic Association has supplied staff to convene and facilitate meetings; keep communications flowing; keep track of funding, organizational, regulatory, and other developments pertinent to the SRHHI mission and share this information at meetings; keep track of goals and progress; facilitate proposals for funding for various strategies developed by SRHHI workgroups; and report results.

The Primary Health Care Group

The experience of the primary health care group appears to have been excellent. Cousineau had provided a preliminary inventory of health services in Skid Row, most of which had little or no interaction at the start of SRHHI. Nineteen partners initially committed to participating in quarterly meetings of an overall guidance group and monthly meetings of specific workgroups. Their focus was on improving coordination of and access to primary health care. After making a more complete inventory of existing resources and capacity, the group produced a planning document that included 28 strategies plus a timeline for funding and implementation. Strategies covered capacity building (with a specific goal of increasing utilization by at least 500 additional clinical visits by patients a month), direct services, enabling services, and infrastructure development. The strategies were further divided by those the group expected to be able to fund almost immediately, those it felt could be funded by the end of the SRHHI's first year, and those to be funded by the end of the SRHHI's second year.

Strategies have included (1) expanded van services to accommodate 200+ additional riders a month and additional afternoon and evening hours; (2) assistance with benefits (mostly SSI), cutting approval time down from 12 to 4 months; (3) training and development for front line and case management staff; (4) projects focused on expanding radiology, specialty referral, and chronic disease treatment and services; (5) a "hospitalist" project to assure continuity of care for people referred to various hospitals for specialty treatment; (6) two expansions for dental care. All in all, at the end of the first two years the SRHHI had raised $7.1 million dollars to fund 14 projects growing directly out of its planned strategies. The California Endowment and a number of other local foundations contributed to this funding. In addition, the Conrad N. Hilton Foundation, through CSH, dedicated resources to the initiative's continued planning efforts. The Community Clinic Association continues to facilitate its ongoing work. Plans for 2006-2008 include transitioning from pilot projects to full implementation (with full funding); continuing to expand capacity; drawing in major public agencies, especially the county's Department of Health Services (most strategies funded so far have received support from private sources); and fully integrating mental health and dental services.[15]

These successful strategies are easy to explain and to see in action, and make it easy to point to the initiative's success. As important as these successful strategies are, however, they pale in comparison to the much less visible but overwhelmingly important accomplishment of the initiative—the three downtown primary care providers plus the Departments of Health Services

[15] Extensive material describing the history and progress of the SRHHI is available at the CCALAC website, www.ccalac.org.

and Public Health are now working together. Considering that none of them even talked with each other before the initiative, their current state of cooperative linkages must be seen as the initiative's stellar accomplishment. The next step is to get commitments of public dollars to accompany the investment of area foundations.

On the horizon is the potential for expanded options for the use of Medi-Cal funding for the services that SRHHI providers offer to homeless people. CSH staff provided some technical assistance to the SRHHI primary care group through a meeting that included city and county folks as well as the clinics, and a representative from the state's Medi-Cal program. This meeting not only identified options for SRHHI and other Los Angeles providers, but also highlighted some policy issues/obstacles that need to be addressed at the state level by the Medi-Cal program. Follow-up discussions were also held with California Department of Health Services staff who were interested in learning more. So there may be some opportunities through emerging state policies with respect to coverage of health services.

The SRHHI coordinator from CCALAC is now participating in an ongoing national workgroup launched by CSH in partnership with the National Health Care for the Homeless Council, to share program and financing models for the involvement of Health Care for the Homeless programs and community clinics in permanent supportive housing. Another activity related to funding may eventually bear fruit in Los Angeles—the state's Co-Occurring Joint Action Council, which grew out of a special federal Policy Academy in 2005. The Council is chaired by Dr. Marv Southard, the LACDMH director; a CSH staff member participates in the Council and chairs its Housing Subcommittee through support from its Hilton grant. The Council's basic task is to move its state plan for co-occurring disorders forward, which includes, among other things, funding recommendations for services and housing for people with both mental illness and substance abuse problems. Its success would link back to Skid Row to increase the chances of truly integrating care related to primary health, mental health, and addictions.

The Mental Health Work Group

Once the primary care group was under way, the SRHHI staff began to work on the mental health and dental aspects of the overall initiative. Networking with mental health providers in Skid Row began in January 2005 and the Mental Health Work Group was first convened in July 2005. This work group was expected to follow the same approach as the primary care group. As the Community Clinic Association staff had less experience with mental health issues and the original SRHHI funders were more focused on primary care, the Corporation for Supportive Housing was asked to facilitate the Mental Health Work Group. CCALAC and CSH provided contract funds to CSH to hire a consultant for this facilitation, and CSH also used Hilton funds to provide significant staff time and technical assistance to the effort.

The experience of the Mental Health Work Group did not follow the same smooth development track as the primary care group. This group encountered two major barriers. The first was the result of bringing new organizations into the conversation that had seriously divergent views on the purpose of the work group and its ultimate goal. The organizations with a long history of actively engaging people on Skid Row with the most serious mental illnesses were not part of the original SRHHI group. The original SRHHI organizations focused on some of the mental health

needs of residents in area shelters, which included dealing with stress, including post-traumatic stress, and the well being of children in the shelter networks.

However, when the Mental Health Work Group began its independent work, CSH and the consultant who facilitated the Mental Health Work Group began by assembling the organizations that were most concerned with serious and persistent mental illness, and particularly those people who are routinely screened out of existing shelters and programs or who resist taking advantage of these programs. Having first established a baseline goal of developing programs for this most difficult population, the Mental Health Work Group then expanded to include many of the initial SRHHI member organizations. A significant amount of time was then required to develop consensus and move forward.

The second barrier resulted from the development of proposals and strategies that were not a clear fit with the foundations that had so far committed the most resources to the SRHHI. Consequently, there was no single funder waiting in the wings to support initial efforts and to provide the seed money that would attract additional philanthropic investment. False starts absorbed considerable time and energy and left most participants feeling somewhat discouraged.[16]

The Hilton evaluator was able to attend a meeting of the Mental Health Work Group during a site visit for this report, after having interviewed many of the participants. The meeting was intended to be the last for the group, which was going to be incorporated into the primary care group and continue its work as an integrated part of the whole. Dr. Gregorson, chair of the primary care group, attended the meeting with that expectation in mind.

The meeting started with the stated issue of how to bring behavioral health care into primary care settings and primary care into behavioral health settings, and how to support both. The chairman of the Mental Health Work Group asked the providers at the meeting to describe the ways that their agencies integrated primary and behavioral health care. It soon became obvious that all providers had some level of co-located services and that all had plans or desires for more. But it was also clear that no system existed for making decisions about what was needed where, nor was a framework available to describe what might be needed or who might need it. If the Mental Health Work Group's first effort might be described as proposing things that were "too small," and the second as proposing something that was "too big," how was the group going to propose something "just right"—preferably by starting with an *overall* framework of current needs and how they might be met in incremental steps.

At this point Dr. Gregorson, benefiting from the primary care group's experience, suggested that the group might want to talk about the *types of clients* that needed services and what they needed, plus what a *system* of care would look like, before worrying about the elements that would be

[16] Despite the difficulties experienced by the Mental Health Work Group, group members retain an emphasis on the central role of housing for the hardest-to-serve multiply disabled chronically homeless street dwellers, for its own sake and for its impact on clinical conditions. It is important to note that some members of the primary care group, including Dr. Gregorson, also share this vision of integrated housing, primary care, and behavioral health care for this population, so the coming integration of the primary and mental health groups of the SRHHI is likely to further this vision within the context of an integrated plan.

located at different venues. He suggested four types of clients for the group's consideration: (1) those well enough to access clinics on their own—whose medical/behavioral health home should be a clinic; (2) PSH tenants with multiple disabilities and a history of noncompliance—whose medical/behavioral health home would best be attached to housing; (3) people frequenting temporary housing sites, mostly emergency shelters and missions; and (4) people living on the streets. These latter two groups are likely to need outreach teams for engagement, and possibly mobile services until they are able or willing to become attached to a medical/behavioral health home by coming to clinics or getting into housing.

DMH has committed millions of dollars of new money to Skid Row, but it is all channeled through its own Downtown Mental Health Center. None of the nonprofit providers in Skid Row with experience and interest in working with the hardest-to-serve street population have received any part of the new funding. The fact that few of them played any active role in the MHSA stakeholder planning process surely meant that they did not influence DMH decision-making about how to allocate resources in Skid Row. But if the Mental Health Work Group could present a clear framework for building a system to serve homeless people, DMH would have something concrete to respond to. Further, there might be opportunities to convince the SPA 4 and Downtown Mental Health Center leadership to subcontract some full service partnership dollars to Skid Row providers who have experience connecting people with housing and also delivering wrap-around services for the population in greatest need.

Meeting participants proceeded to make plans for developing a full inventory of clientele, mental health services, and capacity in Skid Row (something the Mental Health Work Group had never completely done, but which was the starting point for the primary care group). DMH representatives volunteered to develop a formal survey instrument, which others volunteered to review to assure that it covered appropriate issues. Community Clinic Association staff offered support in the form of an intern to administer the survey and tally results, and the group set a timetable of two months for developing and completing the survey and discussing its implications. The meeting concluded with everyone agreeing that the group should convene separately at least once more to form a plan based on survey results before merging into the primary care group, and that it should look at the primary care group's structure and plans while making its own decisions. The prospect of completing this inventory, beginning a plan, and merging with the primary care group changed the tone of the meeting considerably; there was a feeling of renewed energy and direction as people left.

OPENING NEW DOORS

Los Angeles County and New York City are approximately equal in population, but Los Angeles County has only one PSH unit for every three or four in New York City although its population of chronically homeless people needing PSH may be twice as large. Assuming a population of about 30,000 chronically homeless people in Los Angeles County (per the 2005 LAHSA count) and an estimate of between 5,000 and 6,000 units of PSH (increasing the 4,600 estimate for the county in summer 2004[17] by 500 to 1,500 to account for growth in the past two years), there is only enough PSH presently to accommodate one in five or one in six people who need it. Los Angeles County has a long way to go to meet the challenge of creating PSH. Several current

[17] Burt and Anderson, 2006 (See footnote 8).

providers are continuing to develop PSH, but to meet the challenge it will be necessary to attract many more developers and service providers. Los Angeles County has about 85 nonprofit community development corporations that engage in a variety of neighborhood revitalization and construction activities. At present only about five participate in PSH development or operations. There is clearly room for expansion in PSH participation throughout the county.

After developing approaches to capacity-building through work with New York City developers and service providers funded by the Hilton Foundation,[18] CSH got into the capacity-building business in a big way through the work of its Southern New England office, which created a supportive housing development institute called One Step Beyond. The intent was to build provider capacity to serve chronically homeless adults and families through permanent supportive housing. The curriculum provides extensive training by CSH staff and others very experienced in developing PSH. It gets to the nitty-gritty of what it takes to develop PSH by training the agencies and people who will actually have to produce and operate it. Inspiration is also a part of this mix, as new players must be convinced to participate in PSH production if the goal of expanded PSH capacity is to be reached. The curriculum was designed in six bi-monthly sessions that started in March and went through November.

After two years of successful use in Connecticut and Rhode Island, CSH has made the curriculum available to all of its offices nationwide. Many, including the Los Angeles office, are adapting the curriculum and offering their own training academies. In Los Angeles the curriculum was heavily revised to local circumstances and its structure was changed to 10 monthly sessions. Under the title Opening New Doors, 11 teams participated in the first offering during 2006. After more work on the curriculum, a second group of teams recently began the 2007 round of training sessions.

Participants apply and are selected based on their seriousness and interest in creating PSH. The goal is for teams to have project plans and sites identified by the end of the training; even better is for them to have complete or near-complete project proposals. Participants learn from other providers during the sessions, so everyone feels they are both learning and contributing to others' learning, and sometimes developing new ideas together. Sessions are in-depth topic-focused seminars on issues such as team development, creating community support, and dealing with special populations. The entire effort is designed to foster partnerships among housing developers and service providers, so that more organizations will get into the PSH business and those already in it will expand their capacity to develop and operate PSH. Each plan being developed involves collaborations among several agencies.

Feedback from Some Los Angeles Opening New Doors Participants

The challenge in a lengthy training experience such as Opening New Doors is sustaining interest when almost everyone who comes is already an expert in some part of the proceedings.

[18] In 1994-1997, CSH received major support from the Hilton Foundation to help existing PSH developer/provider organizations to grow and sustain operations. Two reports that may be ordered through www.csh.org describe these efforts—"Sustainable Strength" and "A Time to Build Up." Lessons learned from these activities helped inform the work in Southern New England and beyond.

Experienced developers are encouraged to attend with new service partners, and experienced service providers are encouraged to attend with developers who have not previously done PSH. So almost everyone who attends could actually be teaching one part of the curriculum while they might have a lot to learn about other parts.

For this report we did not interview large numbers of Opening New Doors participants, but we did try to touch base with a some who were relatively new to PSH and with a new partner, some with an experienced developer working with new service partners one of which was relatively new to PSH, and an organization that expects to do both development and services but has never before sought government funding. As expected, people generally said that they found the proceedings elementary when they covered material related to their own past experience. The big payoff for most people came in the case study method and the application of general knowledge to their particular circumstances and partner arrangements.

The major thing that Opening New Doors seems to do for teams is give them the chance to understand where each is coming from, and to talk through all the details of how they will work together, how the things that need doing will get done, who will do what, and how conflicts will get resolved. People found it very valuable to take the time to understand each other's language, assumptions, organizational capacities and boundaries (i.e., what their bylaws or funding sources or board will and will not let them do), organizational structure and decision-making, past experience with different types of clients, and so on. Also praised was the specificity of the case studies, posing questions and challenges that the teams had to work out to their mutual satisfaction. One respondent said "I've done a lot of projects, but I've *never* been this far along in understanding and agreeing to who will do what. We don't even have a building yet, but we have a highly detailed plan and we know where we're going." Another respondent found the training useful because it had been many years since the agency had developed its first and only PSH. The funding and development environment had changed, and it was good to learn about the current situation. Another participant said his agency had done the real estate development part before so he did not get much out of those parts, but he found the case study approach really helpful for understanding systematic approaches to developing good property-management-service staff relationships.

A few agencies are back with new partners for the second round of Opening New Doors. But participants also indicated that they expected to extend their learning from the training to new horizons even if they did not return to the training itself. One said that his agency would return if it had a new service partner and the partner was committed to attending. He said he felt he would be able to pass on the information he learned to other partners without committing the time it takes to attend Opening New Doors, but he also spoke about the value added by participating if all partners actually attend the sessions.

CSH is also assisting some of the less experienced Opening New Doors teams with mentoring (for those who are really new to PSH), technical assistance, and publications such as an annually revised guide to funding sources for the different aspects of PSH. In addition, CSH has awarded pre-development loans and capacity building grants to a number of Opening New Doors teams, and has also assisted some teams with acquisition by offering backup (second position) loans for

acquiring properties. Funding for these loans comes from many contributors to CSH, including the Conrad N. Hilton Foundation.

IMPRESSIONS

We started this report with information intended to impress the reader with the great challenges posed by trying to end chronic homelessness in Los Angeles, to create a context for understanding what is changing, how far we have come, and how far there still is to go. Stakeholders in some communities have likened their efforts to make the system changes that will be needed to end chronic homelessness as "trying to turn the ocean liner." In Los Angeles, the more appropriate analogy would be "trying to herd cats." An ocean liner is, after all, a single entity pointed strongly in one direction. No one would ever describe the situation in Los Angeles that way. In thinking about how to categorize developments in Los Angeles County since fall 2005, one is impressed by two things. First, a lot is happening. Second, there is, as yet, no "system."

A LOT IS HAPPENING

Going back to the research questions posed for this system change part of the evaluation, we can say some things pretty clearly, even at this two-year mark:

Question	Answer
How have state and/or local public agencies made changes to better accommodate the development and operation of permanent supportive housing units and the services that tenants need to achieve stability?	More money, more coordination, more planning, more joint activities
Are more, or different, public agencies and actors on board (e.g., mayors, agencies in specific cities, new county Board of Supervisors support, etc.)?	Clearly yes. So far, mostly county agencies with each other, city agencies with each other.
Are public agencies better coordinating their efforts to serve chronically/street homeless people?	Some definitely are, and more coordination is poised to happen, but considerably more is still needed
Are new and/or expanded sources of funding available, and/or is existing funding being used in more effective ways?	Clearly yes, more resources from state and county; greater effectiveness is still in its infancy but starting in some ways
Has any additional funding been committed at the local or state level to **develop and operate** supportive housing and **provide supportive services** to its tenants (e.g., more funding in the same streams, new streams)?	Over the next 5 years, a total of about $400 million in new funds have been committed for capital and operating subsidies in Los Angeles County, including: State housing bonds, MHSA, MHSA $ for housing, $100 million one-time county funds with hope for renewal, and $100 million from the City of Los Angeles
How have local agencies and providers been able to leverage these additional state and federal resources for PSH tenants?	Will be addressed in next report, based on project and agency surveys

THERE IS, AS YET, NO "SYSTEM"

The historic fragmentation of government and provider communities in the county makes it very difficult to create and implement a coherent countywide plan. Efforts to develop *locally* coherent plans meet many obstacles because they cannot show that they fit into any larger plan, nor can they rely on county-controlled resources that must be available if their own plans are to work (such as health and mental health services). The communities that *are* working on their own plans (e.g., Skid Row, Santa Monica, and the three cities with their own Continuums of Care—Long Beach, Glendale, and Pasadena) are regularly frustrated by their inability to control essential county resources, and by the inaccessibility of those resources generally

At the same time, plans abound. There are too many plans, and too many groups meeting about plans. Group membership overlaps heavily, like a series of partially overlapping Venn diagrams. A few people are part of six or eight planning groups, most people are part of two or three. Yet there are still people and organizations that are not, have not been willing to be, or have not been invited to be, included in any.

Given the state of non-organization that existed in Los Angeles County as recently as four years ago, the amount of organizing is encouraging, even astonishing. Things do appear to be moving in directions that may ultimately make such a plan and its implementation possible, though, and no one should underestimate the level of accomplishment represented by what *is* happening throughout the county. However, the stage of plan proliferation will have to move to a stage of plan consolidation and actual organizational commitment and movement toward change before congratulations are in order. This is especially true for county and city agencies and local elected officials—the nonprofit and foundation communities have made most of the moves so far. As one respondent described the current scene, "It's like a high school dance. All the 'big men' are leaning against the walls, waiting for someone else to ask for the first dance." To that a number of respondents would add, "And they want to be able to refuse a few times just to show that they can, but to cut in and change the tune once others have started to dance." Others would also say "…and they only know the polka, while folks here are dancing the tango and the jitterbug." Things will not really start coming together until they push themselves off the walls, and possibly learn a few new dances.