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June 16, 2009

To: Supervisor Don Knabe, Chairman
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Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
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From: William T Fujioka
Chief Executive Officer

LOS ANGELES COUNTY HOMELESS PREVENTION INITIATIVE STATUS REPORT

According to the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County has the highest concentration of homelessness in the nation (74,000 people). Various social and economic factors, as well as gaps in available housing and social services have contributed to the crisis. In response to this crisis, on April 4, 2006, the Los Angeles County Board of Supervisors made an investment toward addressing and preventing homelessness with the approval of the \$100 million Homeless Prevention Initiative (HPI). The Chief Executive Office continues to implement specific key HPI programs in partnership with County Departments of Children and Family Services, Community Development Commission, Health Services, Mental Health, Probation, Public Defender, Public Health, Public Social Services, the Sheriff, LAHSA, and various cities. Through December 2008, the HPI has been tremendously successful in implementing 26 programs and serving over 21,000 individuals and 10,000 families (some programs may serve the same participants). The initiative focuses on reaching the following two goals through the six strategies shown below:

Goal 1 – Preventing Homelessness

- Housing assistance
- Transitional supportive services

“To Enrich Lives Through Effective And Caring Service”

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Goal 2 – Reducing Homelessness

- Community capacity building
- Regional planning
- Supportive services integration linked to housing
- Innovative program design

Three attachments are included with this memo:

1. Executive Summary of Fiscal Year (FY) 2008-09, Second Quarter;
2. HPI Status Report (Attachment A): The FY 2008-09 Second Quarter HPI status report includes information on program participants, services provided, and associated outcomes; and
3. Index of Programs (Attachment B): A table presents key performance indicators and budget information on each program. Following the table, each program's performance measures are included with a description of successes, challenges, an action plan, and a client success story.

This HPI report provides information about the progress of your Board's investment to decrease homelessness and inform future planning efforts. If you have any questions, please contact me or your staff may contact Miguel Santana, Deputy Chief Executive Officer at (213) 974-4530, or via e-mail at msantana@ceo.lacounty.gov.

WTF:MS:KH
VKD:hn

Attachments (3)

- c: Sheriff's Department
- Department of Children and Family Services
- Department of Community Development Commission
- Department of Health Services
- Department of Mental Health
- Probation Department
- Department of Public Defender
- Department of Public Health
- Department of Public Social Services
- City of Santa Monica
- Los Angeles Homeless Services Authority
- Public Counsel
- Skid Row Housing Trust



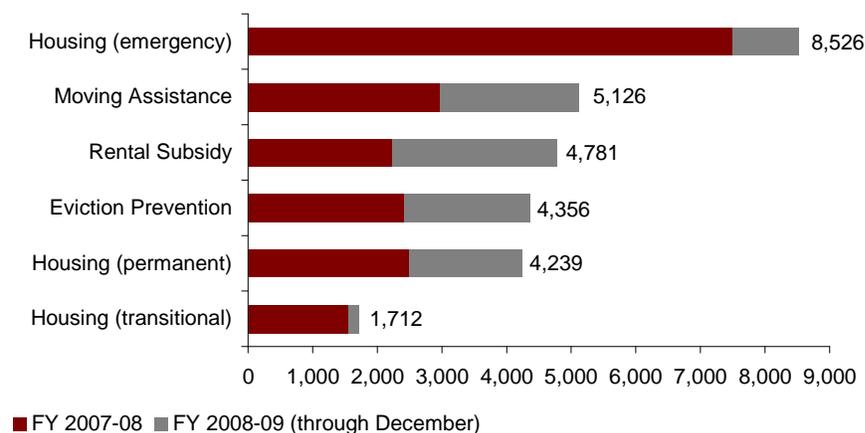
Los Angeles County HOMELESS PREVENTION INITIATIVE (HPI)

FY 2008-09, OCTOBER – DECEMBER, SECOND QUARTER EXECUTIVE SUMMARY

Los Angeles County has the highest concentration of homelessness in the nation.¹ The Los Angeles County Board of Supervisors invested resources to address and prevent homelessness with the approval of the \$100 million Homeless Prevention Initiative (HPI). With this crisis worsening as a result of the downturn in the economy, the Chief Executive Office (CEO) continues to implement specific key HPI programs in partnership with County departments,² the Los Angeles Homeless Services Authority (LAHSA), Community Development Commission (CDC), and various cities. To date, the HPI has been tremendously successful in implementing 26 programs and serving over 21,000 individuals and 10,000 families.³ The initiative focuses on reaching the following two goals through six strategies shown below:

Goal	Strategy
Preventing Homelessness	<ul style="list-style-type: none"> • Housing assistance • Transitional supportive services
Reducing Homelessness	<ul style="list-style-type: none"> • Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

HPI Participants Receiving Housing/Housing Assistance



¹ Estimated 74,000 persons; LAHSA 2007 Greater Los Angeles Homeless Count.

² Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff.

³ Participants across programs may include a duplicated participant count.

The HPI has served over 21,000 individuals and 10,000 families. For each strategy, specific outcomes and a combined total of actual and estimated expenditures are listed. For both the Housing Assistance and Supportive Services Integration and Linkages to Housing strategies, cumulative results are shown.

GOAL 1: PREVENTING HOMELESSNESS

HOUSING ASSISTANCE

Eviction Prevention \$9,622,540
 Moving Assistance
 Rental Subsidy

Through housing assistance, individuals, youth, and families maintain permanent housing.

- **3,249 individuals and 7,316 families received housing assistance, which prevented homelessness.**

Note: A participant who received more than one type of housing assistance was counted once.

TRANSITIONAL SUPPORTIVE SERVICES

Access to Housing for Health \$7,381,343
 Homeless Release Projects
 Jail In-Reach Program
 Recuperative Care

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

- **2,588 clients received public benefits.**
- **53 clients placed into permanent housing.**
- **93% decrease in inpatient days and 85% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING

City and Community Program (CCP) \$25,644,929
 Revolving Loan Fund

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

- **For CCP, 13 service contracts (60%) have been executed, and nine capital projects are scheduled to begin construction in 2009.**

REGIONAL PLANNING

Homeless Services \$3,250,000
 Long Beach Vets

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

- **Gateway Cities and San Gabriel Valley Council of Governments (COGs) and Long Beach Homeless Veterans implemented.**

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING

Case Management \$11,505,541
 Housing Locators
 Multi-disciplinary Team/Access Center

Provide clients with integrated supportive services and housing. Supportive services include case management, health care, mental health services, and substance abuse treatment.

- **9,481 individuals and 3,443 families placed into emergency, transitional, and permanent supportive housing.**
- **9,342 linkages to integrated supportive services enhanced participants' well-being.**
- **5,620 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN

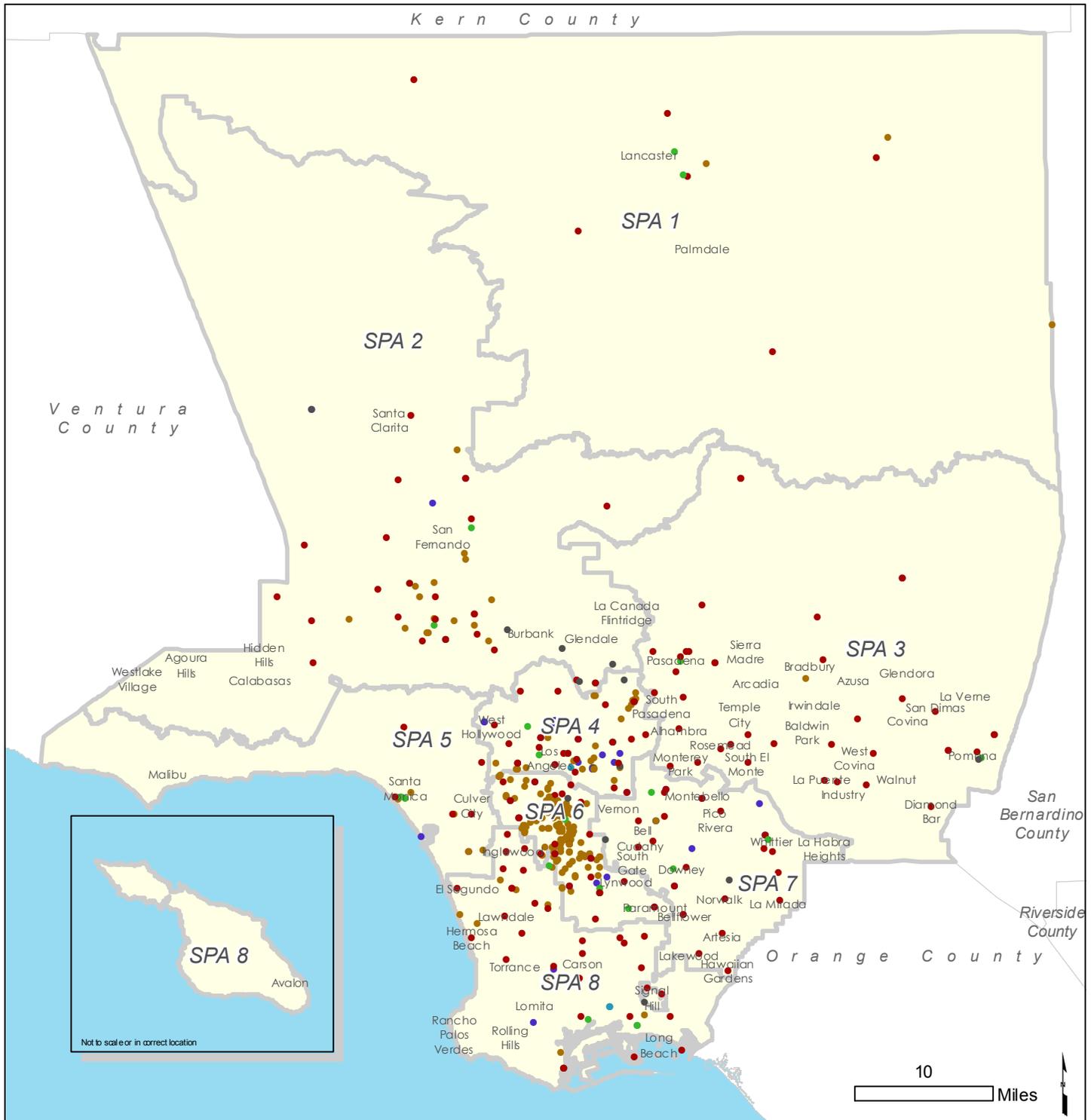
Project 50 \$17,569,753
 Skid Row Families Demonstration Project
 Homeless Court
 Housing Resource Center
 Santa Monica Service Registry

Provide access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

- **50 chronic homeless individuals placed into permanent supportive housing.**
- **236 Skid Row families placed into permanent rental housing.**
- **Citations and warrants dismissed for 717 individuals.**
- **Over 2 million housing searches conducted.**

County of Los Angeles Regional Homeless Prevention Initiative

Housing Placement and Service Locations by Service Planning Area (SPA)



Strategy

- 1 - Housing Assistance
- 2 - Transitional Supportive Services
- 3 - Community Capacity Building
- 4 - Regional Planning
- 5 - Supportive Services Integration and Linkages to Housing
- 6 - Innovative Program Design

Notes:

i) The following HPI programs are offered Countywide:
 General Relief Housing Subsidy and Case Management Project
 Los Angeles County Homeless Court
 Los Angeles County Housing Resource Center
 Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program
 Project Homeless Connect

ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

iii) Rental subsidies were provided to transition age youth who moved to cities in other counties, including: San Bernardino, Riverside, Kern, Orange, San Diego, Ventura, and Santa Barbara.

THE RECOVERY ACT: OPPORTUNITIES FOR FURTHER PREVENTING HOMELESSNESS

In response to the current economic crisis, President Barack Obama signed the American Recovery and Reinvestment Act into law on February 17, 2009. The Recovery Act includes \$1.5 billion to the Department of Housing and Urban Development (HUD) for the Homelessness Prevention and Rapid Re-Housing Program (HPRP). Los Angeles County is to receive \$12 million.

With the County's unemployment rate at 10.9% in February 2009 and foreclosures up 69% from the previous month, more residents are at-risk of becoming homeless.¹ Through the HPRP, the County proposes to prevent homelessness by closing the assistance gap for low-income residents who are at or below 50% Area Median Income (AMI) (between \$16,452 and \$39,650 for a family of four; below \$27,750 for individuals). Specifically, the County would provide homelessness prevention assistance to residents who are at-risk for homelessness and who can demonstrate a sustained living situation upon program completion. The County plan will utilize all resources available through the Recovery Act in order to provide a comprehensive menu of services to assist eligible program participants.

Building on the HPRP mandates, the success of existing homeless prevention programs, strengthening the network of service providers, and applying lessons learned from the HPI, the County proposes to invest \$12 million to further prevent and reduce homelessness by the following four strategies: 1) Expansion of housing assistance programs; 2) Development of rapid re-housing programs; 3) Development of a seamless support system; and 4) Enhanced coordination of services. The County is responsible for providing HPRP assistance to residents of unincorporated areas and 47 cities with a population of less than 50,000. In order to create a seamless Countywide system, strengthening the network among providers in all 88 cities would further prevent and reduce homelessness. By creating an extensive support system with shared resources, more can be achieved for residents. For more information, contact Vani Dandillaya at vkumar@ceo.lacounty.gov.



Left: An HPI participant holds a certificate of achievement at the quarterly client appreciation celebration for her continued participation in the Special Services for Groups (SSG) Co-Occurring Disorders Court program; *Right:* Homes for Life Foundation completed Vanowen Apartments in March 2009. Located in Van Nuys, Vanowen Apartments provides a total of 24 permanent, affordable, service-enriched housing units. Vanowen Apartments receive service funds from the HPI City and Community Program. The building has a secured entry, community room, laundry room, courtyard and garden, and parking.

¹ www.foreclosures.com



Homeless Prevention Initiative (HPI)
FY 2008-09, Second Quarter Status Report

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HOMELESS PREVENTION INITIATIVE (HPI) STATUS REPORT FY 2008-09, Second Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 26 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during October-December of FY 2008-09. The Chief Executive Office (CEO) continues to implement specific key HPI programs in participation with the Community Development Commission (CDC), the Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff. Representatives from these County agencies, departments, and several partner organizations meet frequently to ensure consistent communication and integration of services and facilitate successful implementation of HPI programs serving the County's homeless population.

HPI funding has allowed for greater access to housing and supportive services for the homeless and at-risk population. This HPI status update highlights results achieved through program strategies that have served over 21,000 individuals and 10,000 families.¹ This report features components of the HPI, associated outcomes, and opportunities to further enhance and integrate the network of providers.

Goals and Strategies

As mentioned in the Executive Summary, the Chief Executive Office continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), CDC, and various cities. The initiative focuses on meeting the following two goals through six strategies shown:

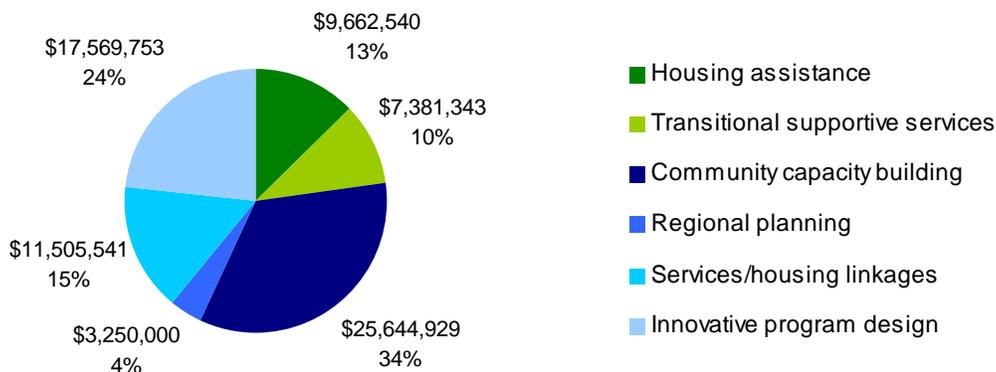
Goal	Strategy
Preventing Homelessness	<ul style="list-style-type: none"> • Housing assistance • Transitional supportive services
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Actual and Estimated Expenditures by Strategy

In this report, total expenditures include FYs 2006-07 and 2007-08 actual expenditures and estimated expenditures for FY 2008-09. The total expenditures for the HPI programs in this report are \$74,974,106. Chart I shows that 23 percent of all expenditures have or will be spent on the initiative's first goal to prevent homelessness. Seventy-seven percent of all expenditures have or will be spent on the HPI's second goal to reduce homelessness. In addition, the amount expended by each strategy is shown in Chart I. For the community capacity building strategy, 34 percent of all expenditures are designated for housing development and supportive services in 21 communities via contracts with local housing developers and service providers.

¹ Currently, a standardized data system is not in place to determine if any client is shared across programs, therefore, the total number of participants may include a duplicate count.

Chart 1: Estimated Actual Expenditures
Total: \$75,014,106*



*Actual expenditures are approximately \$78.3 million. Additional expenditures include: 1) Board approved operational support at \$1.9 million (FY 2006-07); and 2) operational support, administrative, and evaluation costs at approximately \$1.4 million. *From upper right (clockwise) beginning with Housing Assistance.*

The Recovery Act: Opportunities for Further Preventing and Reducing Homelessness

In response to the current economic crisis, President Obama signed the American Recovery and Reinvestment Act (ARRA) into law on February 17, 2009. The Recovery Act includes \$1.5 billion to the Department of Housing and Urban Development (HUD) for the Homelessness Prevention and Rapid Re-Housing Program (HPRP). Funding for the HPRP is being distributed based on the formula used for the Emergency Shelter Grants program, and Los Angeles County is to receive \$12 million.

Los Angeles County has the highest concentration of homelessness in the nation.² With the County's unemployment rate at 10.9% in February 2009 and foreclosures up 69% from the previous month, more residents are at-risk of becoming homeless.³ Through the HPRP, the County proposes to prevent homelessness by closing the assistance gap for low-income residents who are at or below 50% Area Median Income (AMI) (between \$16,452 and \$39,650 for a family of four; below \$27,750 for individuals). Specifically, the County would provide homelessness prevention assistance to residents who are at-risk for homelessness and who can demonstrate a sustained living situation upon program completion. The County plan will utilize all resources available through the Recovery Act in order to provide a comprehensive menu of services to assist eligible program participants. Additionally, in a recent survey, providers of the Homeless Prevention Initiative (HPI) noted opportunities for enhanced service coordination and sharing of resources. They expressed significant interest in improving access to child care, employment support, and law enforcement. Efforts to link families with existing child care facilities would increase family income by allowing more parents to work full-time.

Building on the HPRP mandates, the success of existing homeless prevention programs, strengthening the network of service providers, and applying lessons learned from the HPI, the County proposes to invest \$12 million to further prevent and reduce homelessness by the following four strategies:

² An estimated 74,000 homeless persons, according to the LAHSA 2007 Greater Los Angeles Homeless Count.

³ www.foreclosures.com

1. **Expansion of Housing Assistance Programs:** Programs for low-income families who are not eligible for CalWORKs, and adults, including seniors and veterans, would offer emergency assistance to prevent eviction, moving assistance, housing relocation, and rental subsidies.
2. **Development of Rapid Re-Housing Programs:** Rapidly re-housing residents would provide stability and the opportunity to focus on employment and/or needed health and social services.
3. **Development of a Seamless Support System:** Individuals and families would retain housing and achieve greater self-sufficiency through case management and linkages to such supportive services as: household budgeting, landlord-tenant counseling, and assistance with leasing agreements.
4. **Enhanced Coordination of Services:** The Los Angeles County Housing Resource Center website (<http://housing.lacounty.gov/>) would act as an on-line pre-screening tool that would assess an applicant's eligibility and provide referrals to appropriate HPRP programs for intake. This screening tool would assist Information and Referral from 211 L.A. County, the Department of Consumer Affairs, and other agencies.

The County is responsible for providing HPRP assistance to residents of unincorporated areas and 47 cities with a population of less than 50,000. In order to create a seamless Countywide system, strengthening the network among providers in all 88 cities would further prevent and reduce homelessness. By creating an extensive support system with shared resources, more can be achieved for residents.

The report provides an overview of HPI participants, the initiative's six strategies and associated outcomes, and opportunities to strengthen the overall system of care.

II. PARTICIPANTS

During the second quarter of FY 2008-09, 23 of 26 implemented HPI programs⁴ directly served the County's homeless and near-homeless. While several programs served more than one population, participants in 19 programs corresponded to one of five categories: homeless individuals (seven programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless families (three programs), and at-risk families (two programs). Appendix B provides an overview of programs. To date, Table 1 shows HPI touched the lives of 21,712 individuals and 10,295 families.⁵ From the first to the second quarter, the number of families and individuals served increased by 24 and 20 percent, respectively.

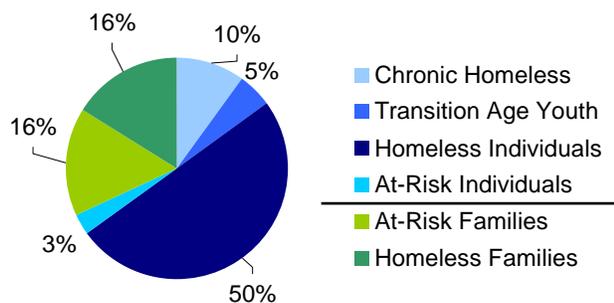
Table 1: Number of Contacts by Participant Category
FY 2008-09 Year to Date through Second Quarter (December 2008)

	FY 2008-09* Year to Date	FY 2007-08**	Cumulative	Second Qtr. Increase
Homeless Individuals	3,877	12,204	16,081	16%
Chronic Homeless Individuals	791	2,440	3,231	15%
Transition Age Youth	471	1,121	1,592	9%
At-Risk Individuals	808	-	808	100%
Total for Individuals	5,947	15,765	21,712	20%
Homeless Families	1,294	3,946	5,240	6%
At-Risk Homeless Families	2,568	2,487	5,055	50%
Total for Families	3,862	6,433	10,295	24%
Total	9,809	22,198	32,007	21%

*FY 2008-09: Returning participants from FY 2007-08 have been subtracted for an unduplicated count.

**FY 2007-08: Participant count has been adjusted to include LAHSA contracted programs.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 68 percent were individuals and 32 percent were families. According to LAHSA, 24 percent of the total homeless population lives in families,⁶ and homeless families made up 16 percent of all HPI participants. Of all individuals, 50 percent were homeless adults, and five percent were transition age youth. Approximately one-third of the homeless in the County are chronically homeless,⁷ while these individuals made up 10 percent of all participants.

⁴ While Housing Locator and Housing Specialists programs are included, these programs are funded by CalWORKs Single Allocation and DMH Mental Health Services Act (MHSA), respectively.

⁵ Note most programs provided an unduplicated participant number; however, four programs included a duplicated participant count during FY 2007-08. Housing Locators/Housing Specialists are included in total participant count.

⁶ LAHSA 2007 Greater Los Angeles Homeless Count.

⁷ Ibid.

Participant Characteristics

During the second quarter of FY 2008-09, a total of 18 programs provided demographic information for program participants. Demographic information included gender, age, and race/ethnicity of participants. To obtain data on HPI participants, demographic information from new participants served during this past quarter was included. Gender information from LAHSA contracted programs was added from FYs 2007-08 and 2008-09. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

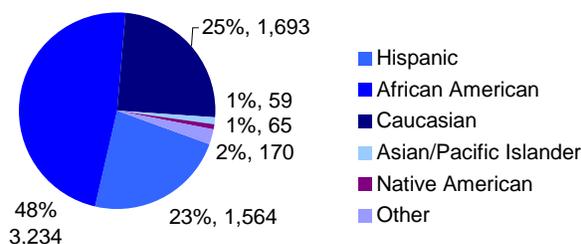
Gender

Approximately 59 percent of the homeless population in Los Angeles County consists of adult men.⁸ Of the 13,209 participants whose gender was provided, 60 percent (8,007) were male, nearly 40 percent (5,188) were female, and less than one percent (14) was transgender.

Race/Ethnicity

The total homeless population in Los Angeles County is about 55 percent African American and 19 percent Caucasian. Chart 3 shows 48 percent of HPI participants were African American and 25 percent Caucasian. Representing the total homeless population, 23 percent of participants were Hispanic. The remaining four percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

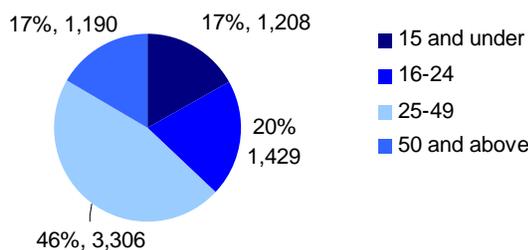
Chart 3: Race of HPI Participants (n=6,785)



Age

Compared to an average age of 45 years for homeless individuals in the County, 46 percent were between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 20 percent of participants were between the ages of 16-24, 17 percent were children less than 15 years of age, and 17 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=7,133)



⁸ LAHSA 2007 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy ① Housing Assistance \$9,622,540

Through housing assistance, individuals, youth, and families maintain permanent housing.

Eviction Prevention • Moving Assistance • Rental Subsidy

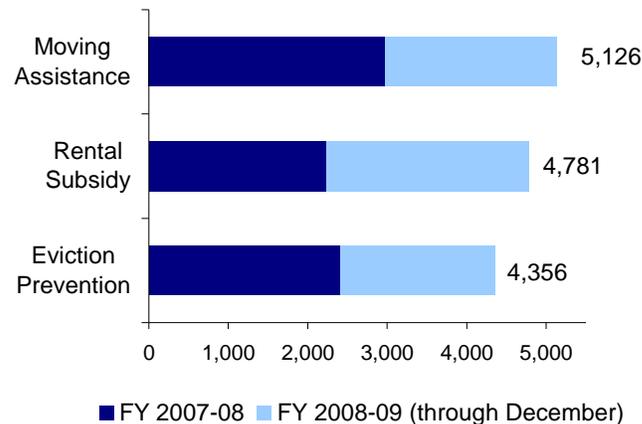
Most HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies, and five programs focused on these services. Through December 2008, a total of 10,565 participants received housing assistance to secure permanent housing. Table 2 shows 69 percent of participants who obtained housing assistance were families, 23 percent were individuals, and eight percent were transition age youth. Table 2 illustrates that a greater proportion of individuals and transition age youth received rental subsidies, whereas significantly more families received eviction prevention. Chart 5 shows the number of participants who received each type of housing assistance through December 2008. Through the HPRP, additional funds will be invested into housing assistance to prevent homelessness for families and individuals, including seniors and veterans.

In the last quarterly report, the total number of participants who received housing assistance included a duplicated count. In this report, a participant who received more than one type of housing assistance was counted once.

Table 2: Through December 2008	Housing Assistance		Moving Assistance	Rental Subsidy	Eviction Prevention
Individuals	2,447	23%	1,860	3,543	23
Transition Age Youth	802	8%	479	725	-
Families	7,316	69%	2,787	196	4,333
Total	10,565	100%	5,126	4,464	4,356

This service was not grouped by population type: 317 participants received rental subsidy/housing assistance.

Chart 5: HPI Participants Receiving Housing Assistance



Strategy ② Transitional Supportive Services	\$7,381,343
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Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

Access to Housing for Health (AHH) • Recuperative Care • Homeless Release Projects (DPSS-DHS and DPSS-Sheriff) • Jail In-Reach Program

Discharge Planning for Hospital Patients

The Access to Housing for Health (AHH), Recuperative Care, and DPSS-DHS Homeless Release programs provided discharge planning for hospital patients at-risk of becoming homeless. A discharge plan connected these patients to needed services that helped them attain stable housing and a better quality of life. Both the AHH and Recuperative Care programs have shown improvements in health outcomes, such as reductions in Emergency Room (ER) visits and inpatient hospitalizations.

- **Improved Health Outcomes:** Eight AHH clients reached their one-year mark during the October to December 2008 quarter. They had a combined total of 20 ER visits during the 12 months prior to AHH enrollment. *Post enrollment, the clients only had a combined total of three ER visits for an 85% reduction.* The eight AHH clients were hospitalized for a combined total of 88 days prior to AHH enrollment. These same clients only had six inpatient days post AHH enrollment. *The number of inpatient days was reduced by 93%.*
- *A six month pre/post analysis for Recuperative Care patients reported a 29% reduction in ER visits, a 65% reduction in hospitalizations, and a 42% reduction in the number of inpatient days.*
- **Linkages to Public Benefits:** A total of 436 individuals received public benefits, including SSI, Medi-Cal, and General Relief.
- DHS-DPSS Homeless Release project made 304 connections to public benefits for 94 individuals who had been discharged from County hospitals.
- **Housing Stability:** AHH program placed 53 individuals into permanent housing. Thirty-five have continued to live in housing for six months, and 18 individuals have retained housing for 12 months.

Discharge Planning for Individuals Released from Jails

The Jail In-Reach and DPSS-Sheriff Homeless Release projects connected individuals to services and benefits prior to release from jail to help support steps towards building a better future, including stable housing and employment.

- **Linkages to Public Benefits:** The Jail In-Reach and DPSS-Sheriff Homeless Release projects have served 4,065 individuals and made 2,152 connections to public benefits, including General Relief, Food Stamps, SSI/SSDI, and Veteran's benefits.
- **Transition Back to Communities:** Housing locators have assisted 244 individuals with housing placement. The majority of housing has been emergency and transitional housing.
- By offering case management to all Jail In-Reach clients and focusing on education/job opportunities, 180 individuals received job related/education services, and 88 percent (245 of 280) have not returned to jail.

Goal 2: Reducing Homelessness

Strategy ③ Community Capacity Building

\$25,644,929

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

City and Community Program (CCP) • Revolving Loan Fund

City and Community Program (CCP)

- As of December 2008, six programs served 1,253 individuals and 154 families. Of these individuals, 808 were at-risk of becoming homeless, 116 were chronically homeless, and eight were transition age youth. A total of 320 participants were placed into permanent housing. To date, the CDC has executed 13 of the 15 service contracts (87 percent) that are ready to be implemented.
- The State's current inability to fund previously committed loans has brought a number of developments that include HPI, City of Industry or other CDC funding to a virtual standstill. Construction lenders will not fund or "roll over" to permanent financing without viable commitments from all permanent lenders. The CDC and Housing Authority are reevaluating disbursing loan funds. This has an impact on some HPI projects where funding for both capital and service funding will be delayed until the economic downturn is halted. CDC is working with the State, local jurisdictions and housing advocates to promote new collaborative and risk sharing policies. The failure of the propositions (1A through 1E) on the ballot of May 19th, could adversely impact the State's ability to sell bonds. The bond sales are needed to provide previously committed loan funds made available under Propositions 1C and 46. Many projects funded through HPI, City of Industry, and the CDC's other housing funding also receive Propositions 1C and 46 funding.

Revolving Loan Fund

- Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.
- LACHIF has an estimated \$22 million in loans to provide funding for 508 affordable housing units.

Strategy ④ Regional Planning

\$3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

Gateway Cities Council of Government (COG) • San Gabriel Valley COG • Long Beach Homeless Veterans

- San Gabriel Valley Council of Governments (COG) presented a draft report on a Regional Homeless Service Strategy; final recommendations will be discussed in the next status report. The report provides valuable information about the region, and its recommendations focus on three main strategic objectives to build regional capacity, resources, and will.
- PATH Partners' Gateway Cities Homeless Strategy will also be issuing a report with important recommendations, and details will be provided in the next status report. Eleven recommended actions are organized in these four areas: leadership, engagement, collaboration, and implementation. Four actions for implementation are outlined, including homeless prevention services, a first responders program, interim housing, and permanent supportive housing.

- Long Beach Homeless Veterans was implemented during the second quarter, and 79 veterans have been referred to case management services. Program participants are connected to services, housing, and benefits.

Strategy 5 Supportive Services Integration and Linkages to Housing \$11,465,541

Clients receive integrated supportive services and housing.

Case Management • Recuperative Care • Housing Locators • Multi-disciplinary Team/Access Center
• Project Homeless Connect

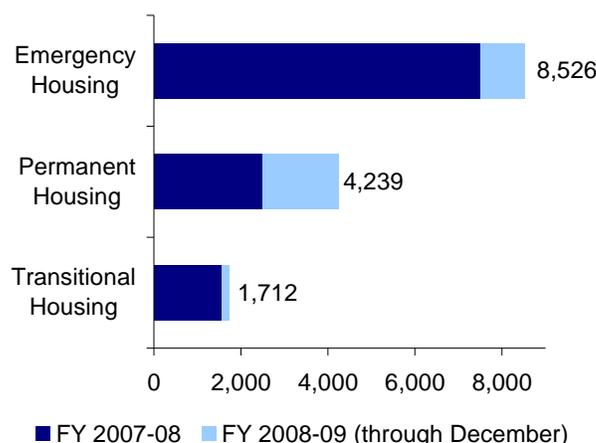
Linkages to Housing – Of all HPI programs, a total of 3,784 participants received permanent housing with 61 percent being families, 16 percent transition age youth, and 23 percent individuals. In contrast, 87 percent of individuals received emergency/transitional housing placement. Chart 6 shows a significant increase in the number of participants who received housing during this fiscal year. The number who received emergency housing during FY 2007-08 has been adjusted with the addition of LAHSA’s programs. This quarter, 15 programs placed participants into transitional or emergency housing. Participants in these programs spent an average of 42 days in temporary housing prior to permanent or transitional housing. Participant stay in temporary housing ranged from 2-122 days.

Five programs will focus on supportive services integration and linkages to housing. Two programs will be launched early in FY 2009-10 and will serve as service integration models. The Weingart Center Association in partnership with JWCH Institute and the County of Los Angeles will operate a state-of-the-art, 20,000 square foot Community Health Center in downtown Los Angeles. In addition, the SSI Advocacy program will increase the number of early SSI approvals by coordinating efforts between DPSS and DHS to utilize existing County medical records and improve the overall SSI application process.

Table 3: Housing Placement through December 2008	Emergency/ Transitional		Permanent Housing	
Individuals	7,817	85%	864	23%
Transition Age Youth	175	2%	625	16%
Families	1,148	13%	2,295	61%
Total	9,140	100%	3,784	100%

These FY 2007-08 services were not categorized by population: 455 permanent housing; 1,098 transitional housing.

Chart 6: HPI Participants Receiving Housing



Supportive Services Integration – Participants received supportive services in three categories: 1) employment/education, 2) benefits advocacy and enrollment assistance, and 3) health and human services.

Employment/Education Services and Support

Through December 2008, eight HPI programs reported a total of 876 participants received job and/or education related supports (Table 4). Sixty percent of these participants received job training, referrals, or related resources. Participants in these programs included transition age youth, chronic homeless individuals and families on Skid Row, and participants with co-occurring disorders. As programs continue to make linkages to job and education related services and build infrastructure for data collection, these numbers are expected to increase. Knowing that 90 percent of the homeless in Los Angeles are unemployed,⁹ providing them with the support to overcome barriers in obtaining and maintaining employment will assist them in attaining greater self-sufficiency.

Table 4: Jobs/Education	FY 2008-09, YTD	Cumulative	Percent
Job training/referrals/resources	484	528	60%
Job placement (employment)	211	221	25%
Education (course, class, books)	106	127	15%
Total number of services provided:	801	876	100%

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 16 HPI programs reported enrolling homeless individuals and families. This quarter, four times as many participants enrolled into General Relief, which had the greatest increase from the first quarter. Table 5 shows that through December 2008, 3,563 homeless individuals were enrolled into General Relief, which consisted of 75 percent of all benefit enrollments. Eight percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and nine percent received Shelter Plus Care or Section 8 to secure permanent housing.

Table 5: Benefits	FY 2008-09, YTD	Cumulative	Percent
General Relief (and Food Stamps)	1,380	3,135	66%
General Relief only	174	428	9%
SSI/SSDI	335	383	8%
Shelter Plus Care	208	241	5%
Section 8	96	192	4%
Medi-Cal or Medicare	79	153	3%
CalWORKs	81	109	2%
Food Stamps only	43	83	2%
Veterans	19	20	1%
Total number of benefits provided:	2,415	4,744	100%

⁹ Bring L.A. Home: The Campaign to End Homelessness; LAHSA 2005 Homeless Count.

Supportive Health and Human Services

For the current fiscal year to date, 20 programs made 9,342 linkages between participants and supportive health and human services. These programs served homeless and chronic homeless individuals, homeless families, and transition age youth. Table 6 shows 28 percent (2,644) of these HPI participants received case management, which was the most frequently reported supportive service. Followed by case management, 17 percent (1,580) acquired life skills, and 16 percent (1,530) received mental health care.

Knowing that 74 percent of the homeless population have a physical or mental disability, depression, alcohol or drug use, or chronic health problems,¹⁰ linking these individuals and families with health care, mental health care, and substance abuse treatment is critical. Additionally, with the forthcoming HPRP funding, the County plans to expand services to assist families and individuals with credit repair, legal assistance, and money management. In a recent HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Fifteen programs reported providing case management services, and 10 programs selected the most intense level of case management. The HPI Report Form asked about the level of case management provided, with level one assessing the client and level three assisting with supported referrals and counseling.¹¹ Hours provided to each participant per month ranged from 3-168 hours (average of 30 hours) with an average caseload of 19 cases per case manager.

Table 6: Supportive Services through December 2008	FY 2008-09 YTD	Percent	FY 2007-08*
Case management	2,644	28%	2,257
Life skills	1,580	17%	676
Mental health care	1,530	16%	182
Transportation	733	8%	615
Health care	719	8%	183
Alternative court	657	7%	286
Tenant rights/responsibilities	317	3%	-
Food vouchers/food	306	3%	414
Social/community activity	287	3%	51
Substance abuse treatment	279	3%	130
Recuperative care	134	1%	45
Other**	55	1%	5
Legal services	53	1%	15
Clothing/hygiene	48	1%	80
Total number of services provided to participants:	9,342	100%	4,939

* For FY 2007-08, this report includes LAHSA contracted programs that provided referrals to mental health care (including domestic violence counseling) and substance abuse treatment.

**Other services include: detox, auto insurance, pet care.

¹⁰ LAHSA 2007 Greater Los Angeles Homeless Count.

¹¹ Post PA. Developing Outcome Measures to Evaluate Health Care for the Homeless Services. National Health Care for the Homeless Council. May 2005.

Strategy 6 Innovative Program Design

\$17,569,753

Provides access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

Project 50 • Santa Monica Service Registry • Skid Row Families Demonstration Project • Homeless Courts • Housing Resource Center

The HPI Report Form requested for programs to report on three outcome areas for participants receiving services for six, 12 and 18 months. The three outcome areas were: 1) housing stability, 2) education and employment status, and 3) health and well-being. Nine programs that served chronic homeless individuals, transition age youth, and homeless individuals and families reported on these longer-term outcome areas.

Longer-term outcomes for this past quarter include (at 6, 12, or 18 months post enrollment):

- **Housing Stability:** A total of 1,338 participants continued to live in permanent housing and 1,200 continued to receive rental subsidies.
- **Employment/Education:** A total of 109 participants obtained employment, 174 maintained employment, and 102 enrolled in an educational program.
- **Health and Well-Being:** The following number of participants continued to receive these services for six months or more: 867-case management; 401-health care; 197-mental health services; and 105- substance abuse treatment.

Examples of outcomes from innovative programs are highlighted:

- **Project 50** – The project is a successful collaboration that includes over 24 government and non-profit agencies. Based on Common Ground's *Street to Home* strategy, Project 50 integrates housing and supportive services for vulnerable, chronic homeless individuals living near downtown Los Angeles on Skid Row. A year after its launch, the pilot successfully moved 50 vulnerable, chronic homeless individuals off of Skid Row with an impressive housing retention rate of 88 percent. Moreover, significant decreases in hospitalizations and emergency room visits indicate improved health and behavioral health outcomes. In addition to improving the quality of life for these 50 individuals, estimates show considerable cost savings as a result of fewer days spent in ERs, hospitals, and jails.
- **Skid Row Families Demonstration Project** – A total of 235 families have been placed into permanent housing, and 124 families maintained housing for seven to 12 months, and 68 families have maintained their permanent housing for 12 months or more. For the first six months in permanent housing, the family is offered home-based case management. Consistent contact has enabled the Housing First Case Managers to develop positive relationships based on trust. Case management has included linking families to various supportive services, including: community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families receive follow-up phone calls to ensure they are doing well and are not in crisis.

- **Homeless Courts** – A total of 717 individuals have had their warrants or citations dismissed as a result of successful completion of mental health and/or substance abuse treatment requirements of the Los Angeles County Homeless Court and Santa Monica Homeless Community Court. In addition, three individuals have graduated from the Co-Occurring Disorders Court to have charges dismissed. As a result of having outstanding warrants, citations, or charges resolved, these individuals have been able to move forward by securing employment, reconnecting with their families, and planning for their future. For example, one participant obtained his GED, became a certified cook and hopes of owning his own restaurant. Another participant said that the program has changed his life by helping him achieve sobriety for over 17 months and reunite with his family.
- **Los Angeles County Housing Resource Center (LACHRC)** – The online database provides information on housing listings for public users, housing locators, and caseworkers. Over 2 million searches have been conducted by users to receive listings. The LACHRC is an excellent example of using technology to make information more accessible, and clients are very grateful for this service. Plans for adding a pre-screening feature to determine HPRP program eligibility will further improve system navigation for clients.

IV. SYSTEMS CHANGE SURVEY RESULTS

Twenty-six HPI programs completed the online Systems Change Survey in February 2009. To better understand the impact of HPI upon the greater system of housing and supportive services, questions were asked about: service integration/coordination; leveraging funding; service access and quality; and changes in service delivery.

Overall, program managers and staff who participated in the survey agreed that through HPI, they have been able to serve more homeless and at-risk clients. Although HPI funding has appeared to increase service access and quality, findings suggest that connections between partners could be strengthened. For instance, the HPRP proposal addresses this need by planning for the development of an online assessment tool to determine an applicant's eligibility and provide referrals to appropriate programs.

1) Service Integration/Collaboration

Chart 7: Does your program coordinate or collaborate with other departments or agencies in any of the following ways? n=26

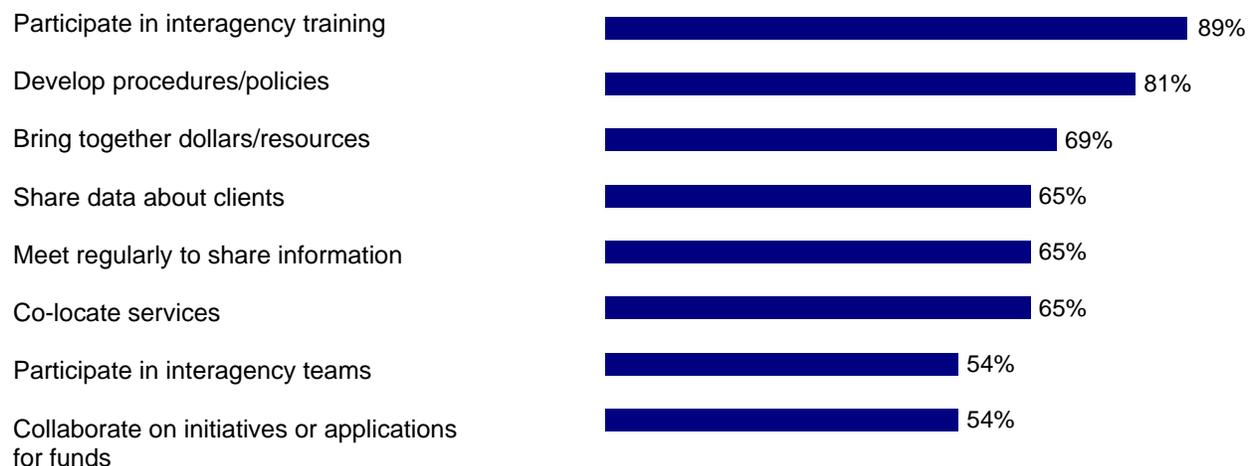
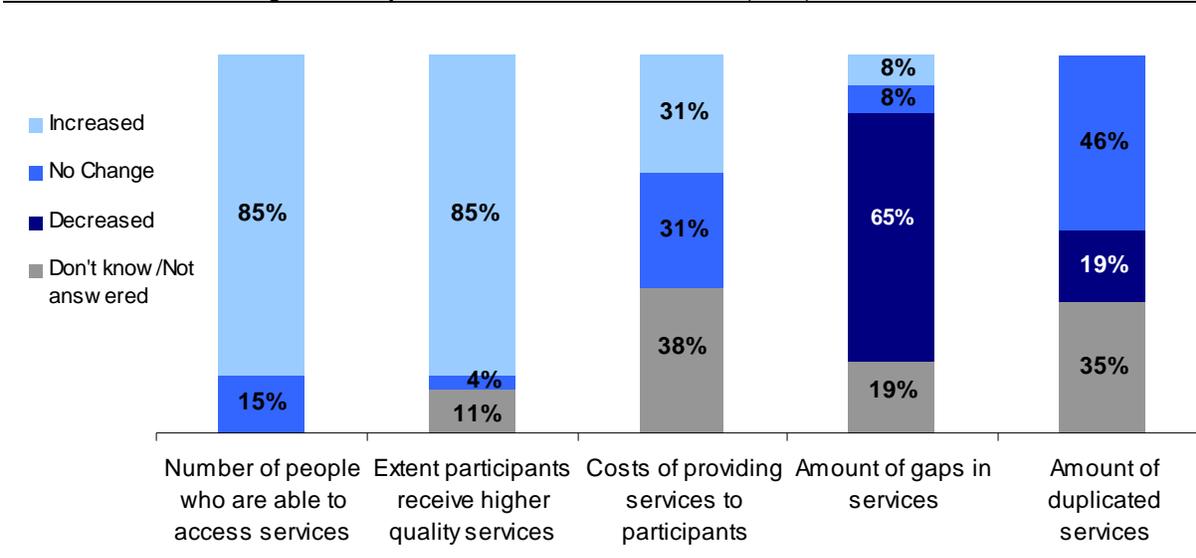


Chart 8: Percent of Programs - Impact of Collaborative Activities (n=26)

To what extent has participating in any of the above collaborative activities affected the following?

- **Access and quality:** Eighty-five percent of programs reported that collaborative activities increased both access and quality of services.
- **Cost:** Thirty-five percent of programs either did not know nor respond to the impact of HPI on cost. Cost avoidance studies conducted by the CEO's Office have begun to investigate the impact of specific HPI programs on cost, and this upcoming research will provide more information. Thirty-one percent of programs each reported that costs either increased or did not change.
- **Service gaps:** Sixty-five percent of programs indicated that the HPI decreased the amount of gaps in services, and 20 percent of programs did not know the impact on service gaps.
- **Duplication of services:** Forty-six percent of programs reported that HPI has not changed duplication of services, 19 percent believe that the initiative decreased duplication, and 35 percent did not know. This suggests that more communication across programs would be helpful, such as a tracking system that captures information about shared clients.

2) Leveraging Funding (n=26)

- Seventy-one percent reported that the HPI has not enabled funding from other sources. While 21 percent indicated receiving funds from other sources, eight percent did not provide a response. This suggests that building capacity to raise additional funding could be beneficial.
- Sixty-three percent of programs have not identified sources of support that can sustain services currently funded by HPI, 33 percent do not know/did not answer this question. Only four percent of programs have identified additional sources of support, and this also indicates the need to plan for sustainability and leveraging of funds.

3) Impact on Service Access and Quality

Program respondents indicated that the HPI created new access to housing and housing assistance, with 28 percent of programs noting development of permanent housing. Programs reported that the initiative most improved the access and quality of case management, mental health, substance abuse treatment, and transportation. According to these service providers, the top three service areas that the current system has no or limited availability are: child care, law enforcement, and employment support services.

Table 7: HPI Impact on Service Access and Quality (n=28)

No or Limited Availability	New Access	Improved Access	Improved Quality
<ul style="list-style-type: none"> • Child Care (56%) • Law enforcement services (48%) • Employment support (44%) 	<ul style="list-style-type: none"> • Permanent housing (28%) • Transitional/Emergency housing (24%) • Housing assistance (20%) 	<ul style="list-style-type: none"> • Case management (48%) • Mental health services (44%) • Substance abuse treatment (44%) • Transportation (44%) 	<ul style="list-style-type: none"> • Case management (32%) • Mental health services (24%) • Substance abuse treatment (20%)

4) Changes in Service Delivery Over 12 Months

Chart 9 shows providers’ responses to three indicators of quality and access to services. An average of 69 percent of respondents felt that the quality and access of services within programs increased, and an average of 66 percent thought that some or most of this increase could be attributed to the HPI. Chart 9 also illustrates that an average of 60 percent reported increased information sharing. Chart 10 similarly shows positive changes in referrals. For these four questions, an average of 62 percent of programs indicated such increases, and about half of programs felt that such changes were due to the HPI.

Chart 9: Changes in Service Delivery – Quality, Access, and Information Sharing (n=28)

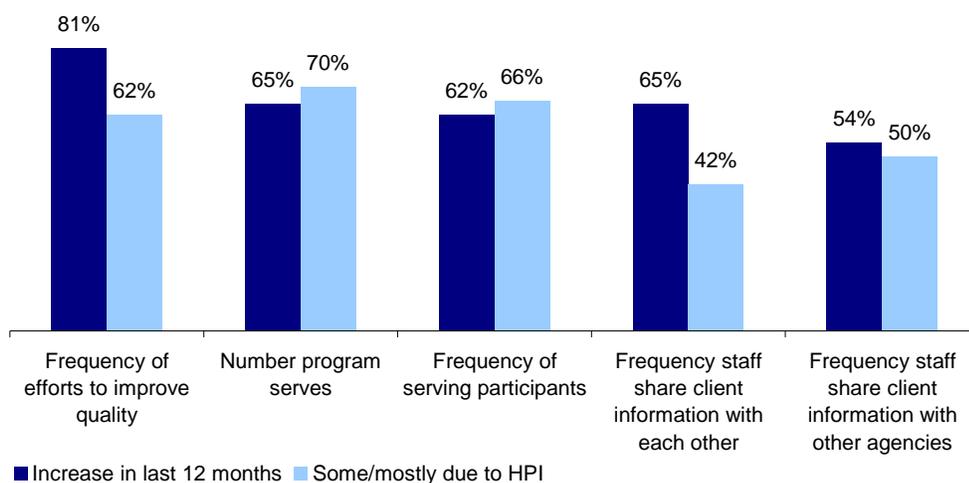
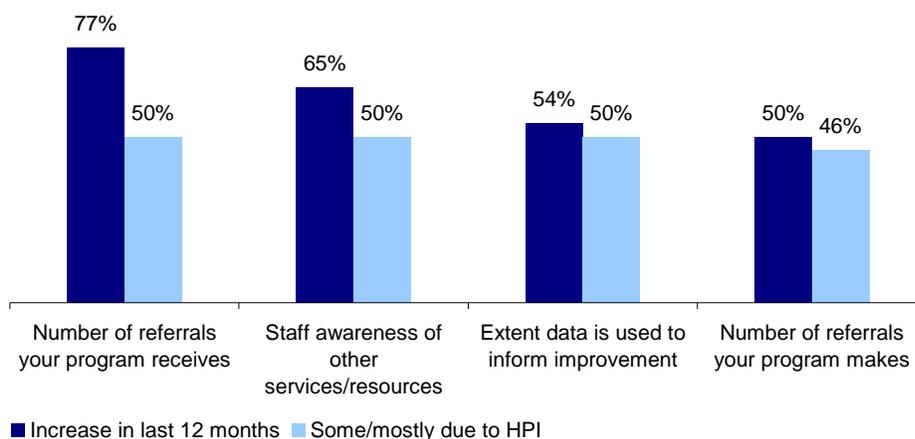


Chart 10: Changes in Service Delivery – Referrals (n=28)



V. PROGRAM NARRATIVE (included in Attachment B)

Program Successes, Challenges, and Action Plans

Each quarter, programs provide information on successes, challenges, and action plans. A review has identified four common themes in implementing strategies to reduce homelessness: collaborative partnerships, innovative processes, outreach strategies, and leveraged funds.

1. Develop and strengthen **collaborative partnerships** between County departments and community-based agencies to ensure a seamless and integrated service system.
2. Support **innovative processes** that promote information sharing between service providers to better meet clients' housing and service needs.
3. Expand **outreach strategies** and education efforts to provide specialized supportive services and housing to more homeless and at-risk individuals and families.
4. **Leverage funds** to expand access to housing and services for more homeless and at-risk individuals and families.

Client Success Stories

Words directly from participants illustrate the impact HPI has made—

SSG came into my life when I needed a program. I was facing five years in State Prison, so I took the program instead of prison. And how has it changed my life! It has taught me how to live my life clean and sober. By going to the groups they have also showed me how to deal with people. By having holiday parties, we were not alone. This year was the first year I got to spend with my family. SSG made this possible. They helped me pay for the trip so I could see my family. How is my life now? I have my own place and I have 17 months sober. That's with the help of SSG staff. –Co-Occurring Disorders Court participant

I am elderly and disabled and just lost my home due to foreclosure. I have called agencies throughout Los Angeles County looking for housing. I can't find anything that I can afford. I was at my wit's end last night and called 2-1-1. They gave me your number. I am so pleased to have been helped so promptly. You gave me pricing and direct contact numbers. Now I am able to still live in the areas I prefer, off my own income! You gave me more help than any agency located in my city, I am so pleased. I don't know how to use a computer, but I'm going to learn. I need to start a blog about this wonderful service, I am surely going to pass this number on to help others. – Tenant/LACHRC client

A few examples from program staff –

Incarceration followed by homelessness led Client V to apply at one of A Community of Friends (ACOF) permanent housing apartments. With stable housing V was able to become stable, obtain benefits, and regain full custody of her children. V went through the vocational training through DMH's Health Advocacy Training Program and obtained full time employment upon completion of the program. By obtaining housing, employment, and remaining stable, V is a true success story! – ACOF staff

Client R was so thankful for having a stable place to live, and this greatly improved his chances of being hired. The client was a very active participant in his assigned GROW activities, and three weeks after being placed in housing, he found a job as a handyman. – General Relief Housing Subsidy project staff

Previously denied SSI for failure to respond to appointments or notices, the General Relief and Housing Subsidy project enabled three participants to have permanent housing and a mailing address. As a result, they were able to keep appointments, respond to notices, and received effective case management services from our Homeless Case Managers. – General Relief Housing Subsidy project staff

VI. RECOMMENDATIONS

Through December 2008, the HPI offered hope to many homeless and at-risk individuals and families living in Los Angeles County. As we apply lessons learned to inform future planning efforts, we will continue to make a greater impact on the lives of many residents who need the support to achieve and sustain a safe, stable place to live. The lessons learned make it clear that:

- More linkages between various supportive services as well as housing is critical to create self sustainability for the homeless;
- Greater availability of affordable and subsidized housing would move more homeless residents into safe housing;
- Information sharing and improved data collection would enable more learning about clients' needs and program progress; and
- Opportunities for joint problem solving among partners would build on existing strategies and overcome service delivery barriers.

With the economic recession increasing unemployment and foreclosure rates, more residents are at-risk of becoming homeless. In these difficult times, the County is experiencing a dramatic rise in requests for public assistance. Unfortunately, many of those who apply for assistance are simply not eligible due to income requirements. Therefore, the County is making a commitment to assist these residents by investing \$12 million from ARRA HPRP funding to expand housing assistance and rapid re-housing services. Moreover, the County plans to develop a seamless service system to further support individuals and families through case management and linkages to other supportive services, including household budgeting and tenant-landlord counseling. By building on the success of HPI programs, the County will target resources towards preventing homelessness as well as strengthening network connections among providers.

Through lessons learned from the HPI, HPRP funding will focus on enhancing coordination of services. Recently, the HPI providers indicated the need for greater awareness of other services and resources, such as child care and employment support. By knowing more about the broader network of available services, HPI providers could make more direct referrals and linkages for clients. In response, the HPRP proposal includes plans to add an online pre-screening feature to the LACHRC website to determine program eligibility, assist with making referrals, and improve overall system navigation.

In summary, the CEO will continue to develop public private partnerships with cities and communities throughout the County to create regional solutions to address and reduce homelessness. To ensure the greatest return on the County's investment, the CEO holds monthly Board briefings and homeless coordination meetings that include staff from Board offices, County Departments, LAHSA, CDC, and various cities to provide updates on the HPI budget and programs. The forum is an opportunity to discuss various homeless issues. These monthly meetings are chaired by Deputy Chief Executive Officer, Miguel Santana. Each of these efforts and the Board's continued investment will ensure that the initiative to reduce homelessness throughout Los Angeles is successful.

Table of Homeless Prevention Initiative (HPI) Programs

	Program	Indicator (to date)	Target	Funding	Budget
	Families (I)				
3	① 1. Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	4,309 families received eviction prevention to prevent homelessness	2,079	One-Time	\$500,000
	① 2. Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	2,589 families received moving assistance and permanent housing	1,305 450	One-Time	\$1,300,000
	① 3. Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	153 families received rental subsidies to prevent homelessness	1,475	One-Time	\$4,500,000
4	⑤ 4. Housing Locators	573 families placed into permanent housing	n/a	DPSS	\$3,000,000
5	⑥ 5. Skid Row Families Demonstration Project	235 families placed into permanent housing	300	Board Approved	\$9,212,000
	Transition Age Youth (II)				
7	① 6. Moving Assistance/Rental Subsidies for TAY – DCFS	332 TAY received rental subsidies	335 3yr	One-Time	\$1,750,000
7	① 7. Moving Assistance/Rental Subsidies for TAY – Probation	306 TAY received rental subsidies 11% recidivism rate (compare to 30%)	335 3yr	One-Time	\$1,750,000
	Individuals (III)				
9	② 8. Access to Housing for Health (AHH)	53 clients placed into permanent housing 93% decrease in inpatient days; 85% in ER visits	115 cap	Board Approved	\$1,500,000
11	⑥ 9. Co-Occurring Disorders Court	37 individuals placed into transitional housing	n/a	Ongoing	\$200,000
13	⑤ 10. DPSS General Relief Housing Subsidy & Case Management Project	1,195 homeless GR participants received moving assistance	900 time	Ongoing I	\$4,052,000
15	② 11. DPSS-DHS Homeless Release Project	304 potentially homeless individuals received benefits	n/a	Ongoing	\$588,000
15	② 12. DPSS-Sheriff's Homeless Release Project	2,101 potentially homeless individuals received benefits	n/a	Ongoing	\$1,097,000
17	② 13. Homeless Recuperative Care Beds (DHS)	140 patients admitted to recuperative care beds 65% decrease in hospitalizations; 29% in ER visits	490/2yr	One-Time	\$2,489,000
19	⑤ 14. Housing Specialists (most clients are individuals)	476 placed into permanent housing	n/a	DMH MHSA	\$923,000
20	② 15. Jail In-Reach Program	51 individuals received public benefits	Individuals 400/2 yr	One-Time	\$1,500,000
22	⑥ 16. Long Beach Services for Homeless Veterans (new program)	79 veterans referred to case management services	n/a	Ongoing	\$500,000
24	⑥ 17. Los Angeles County Homeless Court Program	615 individuals with citations or warrants dismissed	n/a	Ongoing	\$379,000
26	① 18. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	136 single adults received moving assistance to prevent homelessness	until 2,000	One-Time	\$1,100,000
27	⑥ 19. Project 50	50 chronic homeless individuals placed into permanent housing	50	One-Time	\$3,600,000
29	⑥ 20. Santa Monica Homeless Community Court	102 individuals with citations or warrants dismissed	90	Board Approved	\$540,000
31	⑥ 21. Santa Monica Service Registry	36 chronic homeless individuals have participated	n/a	3 rd District	\$1,178,100
	Multiple Populations (IV)				
35	⑥ 22. Los Angeles County Housing Resource Center	Over 2 million housing searches conducted	n/a	Ongoing	\$202,000

Table of Homeless Prevention Initiative (HPI) Programs

	Program	Indicator (to date)	Target	Funding	Budget
36	⑤ 23. Pre-Development Revolving Loan	Loans totaling \$22 million to provide 508 housing units	n/a	One-Time	\$20,000,000
37	⑤ 24. Project Homeless Connect	8,848 participants were connected to services/benefits	n/a	One-Time	\$45,000
38	③ 24. City and Community Program -CCP(V)	\$11.6 m capital, \$20.6 m City Community Programs	Multiple	One-Time	\$32,000,000
45	③ 25a. Gateway Cities Homeless Strategy -COGs (VI)	Final report due in Spring of 2009	n/a	Ongoing	\$135,000
47	④ 25b. San Gabriel Valley Council of Governments	Final report due in Spring of 2009	n/a	Ongoing	\$200,000
48	⑤ 26. LAHSA contracted programs	6,614 placements into emergency housing	n/a	One-Time	\$1,735,000
	⑤ 27. Leavey Center	Program to be launched	n/a	Ongoing	*\$186,000
	⑤ 28. PATH Achieve Glendale	Program launched 12/09; data to be in next report	n/a	One-time	\$150,000
	⑤ 29. SSI and Other Benefits Advocacy Program	Program to be launched	Individuals	One-Time	\$2,000,000
	HPI Funding Total (excludes Board approved operational support (FY 2006-07), administrative and evaluation costs)				\$98,125,100
	*Ongoing costs expected to be \$76,000				

	City and Community Program (CCP) Funds	Service (\$)	Capital (\$)
38	③ A Community of Friends – Permanent Supportive Housing Program	\$1,800,000	
	Beyond Shelter Housing Dev. Corp. – Mason Court Apartments		\$680,872
	Catalyst Foundation for AIDS Awareness and Care – Expansional Supportive Services Antelope Valley	1,800,000	
	Century Villages at Cabrillo, Inc. – Family Shelter EHAP I & II		1,900,000
	City of Pasadena – Nehemiah Court Apartments	102,685	858,587
	City of Pomona – Community Engagement & Regional Capacity Building	913,975	
	City of Pomona – Integrated Housing & Outreach Program	1,239,276	
	CLARE Foundation, Inc. – 844 Pico Blvd., Women’s Recovery Center		2,050,000
	Cloudbreak Compton LLC – Compton Vets Services Center	322,493	1,381,086
	Homes for Life Foundation – HFL Vanowen	369,155	369,155
	Nat’l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley	900,000	
	Nat’l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Long Beach	1,340,047	
	Ocean Park Community Center (OPCC) – HEARTH	1,200,000	
	Skid Row Housing Trust – Skid Row Collaborative 2 (SRC2)	1,800,000	
	So. California Housing Development Corp. of L.A. – 105 th and Normandie	200,000	600,000
	So. California Alcohol & Drug Programs, Inc. (SCADP) – Homeless Co-Occurring Disorders Program	1,679,472	
	Special Services for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program	1,800,000	
	The Salvation Army – Bell Shelter Step Up Program		500,000
	Union Rescue Mission – Hope Gardens Family Center	756,580	646,489
	Volunteers of America of Los Angeles – Strengthening Families	1,096,930	
	Women’s and Children’s Crisis Shelter	1,000,000	
	Women’s and Children’s Crisis Shelter	300,000	
	Total for Service and Capital	\$18,620,613	\$8,986,189
	Grand Total for CCP	\$27,606,802	

For this report, unless specified: Year to date (YTD) refers to the first and second quarters of FY 2008-09 (July 1-December 31, 2008). Cumulative refers to the number of clients served to date.

I. PROGRAMS FOR FAMILIES

1, 2, 3) DPSS Programs: Moving Assistance, Eviction Prevention, and Rental Subsidy

Goal: Assist families to move into and/or secure permanent housing.

Budget: (One-Time Funding)

1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	\$500,000
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	\$1,300,000
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	\$4,500,000

**Table A.1: DPSS Services for Families by Program
FY 2008-09, First and Second Quarters**

Program (unduplicated count)	Year to Date (YTD)	Cumulative
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	1,901 received eviction prevention	4,309 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	1,103 received moving assistance and permanent housing	2,589 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	73 received rental subsidies for permanent housing	153 received rental subsidies for permanent housing

**Table A.2: DPSS Measures by Program
FY 2008-09, First and Second Quarters**

Program (unduplicated count)	Number of applications received		Percent of applications approved		Average amount of grant	
	YTD	To date	YTD	To date	YTD	FY 07-08
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	2,658	6,318	72%	68%	\$588	\$589
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	1,427	3,718	77%	70%	\$612	\$629
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	77	155	95%	99%	\$400	\$150

Each program reported an average of three business days to approve an application.

1) Moving Assistance (MA) for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families

Successes: A total of 614 families received benefits through the Moving Assistance program. Of this total, 611 families were CalWORKs non-Welfare-to-Work and three families were non-CalWORKs.

Challenges: Due to the current economic crisis, a large number of families are applying for services. Funding is very scarce. A second challenge is receiving success stories for the program.

Action Plan: DPSS continues to work on identifying funding to preserve the program beyond June 30, 2009.

Client Success Story: Efforts are underway to obtain success stories for these programs for the next quarterly report.

2) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families

Successes: A total of 42 families received assistance through the 12-month Rental Subsidy Program. Of the 42 families, 41 were on CalWORKs and one was a non-CalWORKs family.

Challenges: One of the challenges has been that not many non-CalWORKs families have requested the subsidy. Although many efforts have been made to increase usage, the response has been extremely minimal.

Action Plan: DPSS continues to inform partnering agencies of this program at various monthly meetings.

3) Emergency Assistance to Prevent Eviction (EAPE) for CalWORKs Non-Welfare-to-Work Homeless Families

Successes: A total of 1,037 families received assistance through this program.

Challenges: A large number of families are applying for EAPE. The influx of requests/approvals has reduced available funding.

Action Plan: DPSS continues to work on identifying funding that will preserve the program through and beyond June 30, 2009.

4) Housing Locators - DPSS

Goal: Assist families to locate and secure permanent housing.

Budget: \$3 million (DPSS CalWORKs funding)

Table A.3: Housing Locators Measures
FY 2008-09, First and Second Quarters

(unduplicated count)	YTD	Cumulative
Homeless Families	471	1,685
Housing (permanent)	210	573
Number of referrals to Program	471	1,685
Average time to place family (days)	60-180	60-180

Successes: Through the assistance of the Housing Locators, 210 families were placed into permanent housing during October-November 2008. No placements were made in December 2008.

Challenges: Due to budget constraints, the Housing Locators contract has been officially terminated effective December 15, 2008. Referrals to the Housing Locators program ended effective October 15, 2008.

Action Plan: The Housing Locator's program contract was terminated effective December 15, 2008.

5) Skid Row Families Demonstration Project

Goal: Locate 300 families outside of Skid Row and into permanent housing.

Budget: \$9,212 million (Board Approved Funding)

Table A.4: Skid Row Families Demonstration Project Participants and Services
FY 2008-09, First and Second Quarters

(unduplicated clients)	Cumulative (12/31/08)		YTD	FY 2007-08
Homeless Families (individuals)	300 1,084	Moving Assistance	47	123
Female	273	Eviction Prevention	20	-
Male	27	Housing (emergency/transitional)	23	278
		Housing (permanent)	*235	123
		Rental subsidy	19	14
Hispanic	68			
African American	187	Education	3	2
White	12	Job training/referrals	31	25
Asian/Pacific Islander	3	Job placement	6	6
Native American	-	Section 8	11	65
Other	30			
		Case management	204	254
15 and below	619	Life skills	337	254
16-24	80	Mental health/counseling	25	17
25-49	295	Transportation	213	410
50+	15	Food vouchers	190	390
Program Specific Measures			YTD	FY 2007-08
Number of families enrolled in project			300	300
Number of families relocated from Skid Row area within 24 hours			-	-
Number of families placed into short-term emergency housing			-	300
Number of adults received referrals to community-based resources and services			319	420
Number of children received intervention and services			571	850
Number of families received monitoring/follow up after 6 months case management			213	64
Number of families no longer enrolled (termination or dropped out of program)			56	50
Number of families received an eviction notice during the last 3 months			15	-
Number of families who lost their permanent housing during the last 3 months			4	-
Emergency Housing/Case Management			Second Quarter	
Average length of stay in emergency housing:			89 days	
Most frequent destination (permanent housing):			8 families	
Case management (level 2)				
Average number of case management hours for each participant per month:			35 hours	
Total case management hours for all participants during current reporting period:			2,784 hours	
Number of cases per manager:			10 cases	
Longer-term Outcomes			6 mo	12 mo
Continuing to live in housing			124	68
Receiving rental subsidy			19	2

*A total of 235 families have received permanent housing since the beginning of the program.

Additional measures to be provided after close of program:

- Gainful Employment - (Number of individuals who obtained employment)
- Access to appropriate and necessary Mental Health or substance abuse treatment - (Number of individuals who received mental health services, Number of individuals who received substance abuse treatment)
- Educational stability for children - (Number of children)
- Socialization/recreational stability for children - (Number of children)
- Services to assist domestic violence victims - (Number who received domestic violence services/counseling)

Successes: The total number of families enrolled in the Skid Row Families Demonstration Project (SRFDP) is 300. **The total number of families relocated from Skid Row to permanent housing since**

the beginning of SRFDP is 235, with eight of those families placed into permanent housing during this quarter. Of these 235 families, 68 families have successfully maintained their permanent housing for 12 months or more, 124 families have been in permanent housing for seven to twelve months, and 43 families are in their first six months of permanent housing. Nine families are still in the process of being placed into permanent housing. The Housing First Case Manager conducts an evaluation of each family's intensity level just prior to moving into permanent housing. For the first six months in permanent housing, the family receives home-based case management based on needed intensity level. The client's participation in case management is completely voluntary after they move into permanent housing.

Consistent contact has enabled the Housing First Case Managers to develop good relationships based on trust. Case management after moving into permanent housing has included linking families to community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families are receiving follow up phone calls to ensure they are doing well and are not in crisis. While most families stabilize after living in permanent housing for six months, approximately 23% (28 of the 124 clients in housing for that length of time) were in need of crisis intervention services during the second half of their first year in permanent housing.

Challenges: The issue of unemployment remains a serious problem for undocumented adults in participant families (13 families had undocumented heads-of-household). The limited incomes of many of these families have prevented them from moving into permanent housing or maintaining permanent housing without an ongoing rent subsidy. In order to increase income, these families are referred to the Beyond Shelter Employment Department for assistance in obtaining employment; however, legal issues related to their undocumented status are a challenge. Nevertheless, 9 of 13 undocumented families were able to obtain permanent housing.

Action plan: Ongoing case management services assist families with emotional support and community referrals during their housing search. Creative planning with property owners, including weekly rent installments, will continue to help. Future plans are in development to link undocumented, homeless families with faith-based resources to provide additional support.

Client Success Story: Client L is a 24-year-old single parent with two young daughters. Homeless with her young daughter after relocating to Los Angeles from Nevada, and without family or friends in Los Angeles, Client L sought emergency shelter in Skid Row, when she was unable to continue to pay for a motel room. The family was referred to Beyond Shelter by the Midnight Mission and was enrolled immediately into the Demonstration Project. The mother and child were relocated to a motel outside the downtown area within 24 hours and crisis case management was provided. After the client became pregnant with her second child in late November 2007, she was severely beaten by her boyfriend at the time and was hospitalized. The client's daughter was temporarily placed in foster care after the domestic violence situation, but she was returned upon Client L's release from the hospital. Client L was then assisted through the Section 8 application process by Beyond Shelter's Housing Relocation Specialist. Meanwhile, she was moved from the motel to a Master Leased Apartment and was provided with home furnishings including beds, a couch, sheets and cleaning supplies. After giving birth to her second daughter in July 2008, she and her daughters moved to a two-bedroom apartment subsidized by her Section 8 voucher - and her life began to finally stabilize. Prior to becoming pregnant with her oldest daughter, she had completed her freshman year at the University of California, Berkeley. Once back in permanent housing, she was planning to continue her education. Unfortunately, she was recently diagnosed with breast cancer and began radiation therapy in October 2008. The Housing First Case Manager meets with the family on a regular basis to help this young mother with her current ordeal. She has remained very positive during this time, however, and with close case management, continues to meet her obligations to pay her bills on time and to maintain her permanent housing. She continues to demonstrate amazing strength and is receptive to case management, which is basically her only support system at this time.

II. PROGRAMS FOR TRANSITION AGE YOUTH

6 and 7) Moving Assistance for Transition Age Youth

Goal: Assist Transition Age Youth (TAY) to move into and secure permanent housing.

Budget: \$3.5 million (One-Time Funding)

Table B.1: Moving Assistance for Transition Age Youth Participants					
FY 2008-09, First and Second Quarters					
	Total YTD	Probation		DCFS	
		YTD (new)	Cumulative	YTD	**Cumulative
Transition Age Youth	361 (100%)	* 103	306	258 (all)	332
Female	235 (65%)	46	135	189	-
Male	126 (35%)	57	171	69	-
Hispanic	98 (23%)	31	78	67	-
African American	243 (74%)	68	215	175	-
White	12 (2%)	-	8	12	-
Asian/Pacific Islander	7 (1%)	4	5	3	-
Native American/Other	-	-	-	-	-
16-24	361 (100%)	103	306	258	-

*During the First Quarter of FY 2008-09, 68 new TAY were enrolled; 35 TAY enrolled in the Second Quarter..

**FY 2007-08 DCFS demographic participant data was duplicative. 79 TAY enrolled in the Second Quarter.

Table B.2: Moving Assistance for Transition Age Youth Services					
FY 2008-09, First and Second Quarters					
(unduplicated count)	Total YTD	Probation		DCFS	
		YTD	Cumulative	YTD	Cumulative
Moving Assistance	192	121	242	71	126
Rental Subsidy	341	138	306	203	332
Housing (permanent)	190	128	306	41	174
Any supportive service ⁺	67	48	101	19	64
Education	38	9	-	29	39
Job training, referrals	31	-	-	31	35
Job placement	39	39	81	-	-
Case management	455	197	306	258	332
Life skills	8	-	-	8	8
Mental health	1	-	-	1	1
Transportation	26	-	-	26	43
Food vouchers, clothing	28	-	-	28	52
Auto insurance	5	-	-	5	5

⁺Probation does not break down supportive service by type, except for job placement.

Table B.3: Longer-term Outcomes for Transition Age Youth		
(6 or more months), FY 2008-09, Second Quarter		
	Probation	DCFS
Continuing to live in housing	147	131
Continuing to receive rental subsidy	n/a	44
Obtained employment	39	29
Maintained employment	130	75
Enrolled in educational program/school	9	47
Received high school diploma/GED	-	-

Table B.4: Program Specific Measures for Transition Age Youth FY 2008-09, First Quarter				
	Probation		DCFS	
	YTD	Cumulative	YTD	Cumulative
Number of new approvals	103	390	128	264
Average cost per youth	\$5,423	*\$3,815	\$1,913	*\$2,663
Number of program participants satisfied with program services	129 (of 131)	216 (of 218)	66	135
Number of pregnant/parenting youth placed in permanent housing	37	90	10	71
Number exited housing	21	48	148	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	41	78

*FY 2007-08 average cost per youth.

Probation – Moving Assistance for TAY

Successes: **Eighty-six percent of the young adults** placed in housing through this program are either in the same housing (76%) or have moved (10%) with a plan to remain in permanent housing.

Challenges: Many of the 306 youth placed in housing since the inception of the program may lose their housing should they lose their jobs due to layoffs. The employment referral sources used to place these young adults are reporting that re-employment is made more difficult for this population that often have arrest histories, limited education, and no real work history. Available positions are now being taken by the abundance of newly unemployed with no arrest histories, higher education, and some work history.

Action Plan: The program is directing efforts towards youth already placed in housing to help them keep their housing. Such efforts include: working with landlords to encourage rent reductions where possible, encouraging youth to consider taking in roommates, and working to develop additional job placement connections.

Client Success Story: A young woman with two children, initially placed in a one-bedroom apartment, became a career development intern with DCFS and moved into a two-bedroom apartment in a safer neighborhood. Currently, she is attending community college to study child development.

DCFS – Moving Assistance for TAY

Successes: The program continues to have great success. The program approved 55 youth for assistance this quarter. Twelve youth secured permanent housing and 62 youth received rental subsidies during this reporting quarter. The average spending this quarter was \$59,000 per month.

Challenges: Maintaining contact with the youth continues to be a barrier. The youth utilize prepaid cell phones and frequently change telephone numbers which continues to present challenges in maintaining contact with them and conducting follow-up reviews.

Action Plan: DCFS will attempt to conduct more frequent follow-up with the youth. In addition, we are also obtaining email address as another avenue to maintain contact. Program staff is attempting to obtain an email address or the contact number of a family member or friend.

Client Success Story: A 22 year-old male residing with his girlfriend in an apartment. His girlfriend had to assume custody of her 16 year-old sibling and one year-old niece due to parental instability. The youth and his girlfriend were unable to continue residing in their apartment due to limited space, but they did not have sufficient financial resources to move into a larger apartment. DCFS provided move-in expenses, furniture, and this prevented the family from becoming homeless. The youth is also receiving six months of rental assistance.

III. PROGRAMS FOR INDIVIDUALS**8) Access to Housing for Health (AHH)**

Goal: To provide clients discharged from hospitals with case management, housing location and supportive services while permanent housing applications are processed.

Budget: \$1.5 million (Board Approved Funding)

Table C.1 : Access to Housing for Health Participants and Services					
FY 2008-09, First and Second Quarters					
(unduplicated count)	YTD	Cumulative		YTD	Cumulative
Homeless Individuals	-	4	Education	-	2
Chronic Homeless	19	77	Job training	-	1
Homeless Families	-	4	Job placement	-	2
Female	10	36			
Male	8	56	General Relief	12	59
Transgender	1	1	Food Stamps only	-	1
Hispanic	1	21	Medi-Cal/Medicare	3	32
African American	7	40	Section 8	7	37
White	11	30	Public Housing Certificate	3	10
Asian/Pacific Islander	-	1	SSI/SSDI	5	28
Native American	-	-		YTD	FY 07-08
Other	-	1	Case management	65	66
			Health care	65	66
15 and below	-	7	Life skills	65	66
25-49	9	36	Mental health/counseling	58	15
50+	10	50	Substance abuse (outpat.)	9	15
Moving Assistance	10	48	Transportation	64	66
Housing (emergency/transitional)	27	93	Recuperative care	4	-
Housing (permanent)	10	53			
Rental subsidy	10	48			
Program Specific Measures				YTD	Cumulative
Number of referrals				108	498
Number admitted to program (enrolled)				18	84
Pending applications				8	8
Number that did not meet eligibility criteria				82	326
Number of exited clients				6	26
Of the current AHH enrollees, number of inpatient days*				18	23
Number of ER visits after program enrollment				13	26
Number of new AHH enrollees that have a primary healthcare provider				18	84
Transitional Housing/Case Management					
Average stay at emergency/transitional housing:				122 days, 47 into permanent housing	
Level 3 Assisted/Supported Referral and Counseling case management services					
Average case management hours for each participant per month:				16 hours	
Total case management hours for all participants during current reporting period:				780 hours	
Number of cases per case manager:				10 cases	

*This measure was previously, "number of inpatient admissions."

Successes: The AHH Program has been able to significantly reduce monthly expenditures for temporary housing. New relationships with shelters have been formed to allow for clients to remain in shelter placement until they are ready to move into permanent housing. This keeps the cost of temporary housing considerably reduced.

There are eight AHH clients that reached their one year mark during the October to December 2008

quarter. They had a combined total of 20 Emergency Department visits during the 12 months prior to AHH enrollment. **Post enrollment, the clients only had a combined total of three Emergency Department visits for an 85% reduction.**

The eight AHH clients were hospitalized for a combined total of 88 days prior to AHH enrollment. These same clients only had six inpatient days post AHH enrollment. **The number of inpatient days was reduced by 93%.**

Challenges: There continues to be challenges in finding suitable clients for the program. Many of the referrals do not possess the skills for independent functioning. Many clients present with severe physical and psychiatric conditions and are unwilling to access treatment.

Action Plan: The AHH staff has engaged in an active plan of promoting the program with current referral sources and developing new sources. Information has been updated and attractively displayed. A film featuring a client is played at each presentation, so that referrers can view a client's course in the program. Referrals have significantly increased more than 50%. The staff plans to continue to reconnect with referral sources on a regular basis.

Client Success Stories: Mr. M is a 64 year-old white male who has been homeless for four years. He had been very successful until he lost his job as a copy writer, thus not being able to pay rent. Even though he has been homeless, Mr. M has been able to maintain a website where he critiques classical music. In 2008, he was admitted to LAC+USC for issues relating to hypertension and chronic venous insufficiency. Mr. M was discharged to the JWCH Recuperative Care program and later enrolled in the AHH program in June 2008. He was approved for a Section 8 voucher through the City of Los Angeles and moved into an apartment a couple of weeks before Christmas. Throughout his homeless episode, he has been very isolated and withdrawn. Now housed, he has gained insight into his homelessness. He continues to attend the weekly AHH support group and maintain his website.

Table C.2: Longer-term Outcomes
FY 2008-09, Second Quarter, Cumulative

	6 mo.	12 mo.
Continuing to live in housing	35	18
Receiving rental subsidy	35	18
Obtained employment	-	-
Maintained employment	-	2
Enrolled in educational program	1	-
Case management	33	37
Health care	29	32
Substance abuse treatment (outpatient)	6	2
Reunited with family	3	5

9) Co-Occurring Disorders Court

Goal: Assist dually diagnosed adult defendants in receiving comprehensive community-based mental health and substance abuse treatment.

Budget: \$200,000 (HPI On-going Funding; pass through for DMH)

Table C.3: Co-Occurring Disorders Court Participants and Services					
FY 2008-09, First and Second Quarters					
(unduplicated count)	YTD	Cumulative		YTD	Cumulative
Chronic Homeless	23	58	Education	4	14
Homeless Individuals	1	1	Job training/referrals	6	15
Transition Age Youth	1	1	Job placement	-	1
			CalWORKs	-	1
Female	19	36	General Relief (GR,FS)	8	11
Male	6	24	Food Stamps only	2	3
			Medi-Cal/Medicare	5	28
Hispanic	2	6	SSI/SSDI	1	26
African American	21	51	Shelter Plus Care	4	2
White	2	3			
		2	Alternative court	24	33
16-24		36	Case management	24	33
25-49		22	Health care/medical	15	19
50+			Life Skills	23	31
Housing (emergency)	4	8	Mental health/counseling	24	33
Housing (transitional)	17	37	Social/community activity	11	16
Rental Subsidy	17	24	Substance abuse (outpatient)	42	51
			Substance abuse (residential)	8	11
			Transportation	24	33
			Clothing/hygiene	21	30
Longer-term Outcomes			6 mo.	12 mo.	18 mo.
Continuing to live in housing			-	2	2
Receiving rental subsidy			1	1	1
Enrolled in educational program, school			1	2	2
Case management			4	4	5
Health care			4	4	5
Good or improved physical health			4	3	4
Mental health/counseling			4	4	5
Good or improved mental health			4	3	4
Substance abuse treatment (outpatient)			4	3	4
Substance abuse treatment (residential)			-	-	1
No drug use			3	2	2
Reunited with family			1	1	1
Emergency Housing/Case Management					
Average level III case management hours for each participant per month:				6 hours	
Total case management hours for all participants during current reporting period:				810 hours	
Number of cases per case manager:				7 cases	

Successes: In October 2008, the CODC program graduated its first clients. Of the three clients who graduated, two have successfully transitioned to lower levels of care while they remain in contact with other CODC clients and SSG staff. Six clients are scheduled for graduation in late February, and it appears that they will transition to lower levels of care following dismissal. All CODC clients – even those who were granted court permission to leave Los Angeles to be with family – tested clean after both Christmas and New Year weekends. Those working in the substance treatment field will acknowledge the enormous success of getting a large group of clients at various stages in their sobriety through the holiday season. In addition, the Alcohol and Drug Program Administration (ADPA) received a three-year annual grant of \$300,000 from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the creation and support of residential treatment services for this program.

Table C.4: Program Specific Measures	YTD	Cumulative
Number of clients screened for enrollment	27	359
Number of clients accepted for observation	16	69
Total number of clients enrolled	18	60
Number of clients pending enrollment	10	13
Number of clients not meeting Program criteria	6	166
Number of clients rejecting/dropping out prior to enrollment	3	96
Number of clients lost during follow-up process	3	6
Number of participants in ER/crisis stabilization while enrolled in program	12	17
Average length of hospital stay (days)	5	9
Number of participants who have a primary healthcare provider while enrolled	7	38
Number of participants with new arrest(s)	13	17
Misdemeanor:	1	3
Felony:	12	10
Number of participants in jail	13	18
Average number of days in jail	32	36

(FY 07-08)

Challenges: The greatest challenges continue to be availability of residential beds and transportation. For clients who struggle with their sobriety in an outpatient setting, the program finds beds at residential treatment programs to provide more intensive substance treatment. Only a limited number of residential programs and Prop 36 beds for dually diagnosed clients make placement difficult. It frequently takes 2-3 weeks for a client to be placed, jeopardizing their success in the program. The recently awarded SAMHSA grant will provide clients with 16 permanent residential beds at Antelope Valley Recovery Center to address this challenge.

Through the Full Service Partnership program that clients are first enrolled upon acceptance into CODC treatment, there are funds available to help clients with public transportation and the (Special Services for Groups) SSG Case Managers transport clients as needed. However, as the SSG offices are located on Skid Row in Downtown Los Angeles, clients frequently express their struggle with sobriety given the access and availability of illegal substances as they travel to and from the office. SSG currently does not have the funding or staff availability to provide greater transportation and community supervision support.

The program faces growing employment needs as more clients progress through the program and are interested in education, volunteer work and/or paid employment. Clients are requesting more individual time with the SSG Employment Specialist and are in need of supportive employment assistance.

Action Plan: Currently, energy is focused on the new SAMHSA grant and ensuring that the collaborative efforts between SSG, Antelope Valley Rehabilitation Center, DMH, ADPA, Countywide Criminal Justice Coordination Committee (CCJCC) and the court are successful to address the need for residential care. SSG also has focused on discharge planning as a greater number of clients move toward graduation and need to have their own support system. Increased work by the SSG housing and employment specialists for clients in the final phase of the program have been a priority. Finally, the SSG development team is working with CCJCC on a new enhancement grant for the CODC program in order to expand funding to address the transportation and supportive employment needs.

Client Success Story (BY CLIENT): SSG came into my life when I needed a program. I was facing five years in State Prison, so I took the program instead of prison. And how has it changed my life! It has taught me how to live my life clean and sober. By going to the groups they have also showed me how to deal with people. By having holiday parties, we were not alone. This year was the first year I got to spend with my family. SSG made this possible. They helped me pay for the trip so I could see my family. How is my life now? I have my own place and I have 17 months sober. That's with the help of SSG staff.

10) DPSS General Relief (GR) Housing (Rental) Subsidy and Case Management Project

Goal: To assist the homeless GR population with a rental subsidy. In addition, coordinate access to supportive services and increase employment and benefits to reduce homelessness.

Budget: \$4.052 million (HPI On-going Funding)

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures					
FY 2008-09, First and Second Quarters					
(unduplicated count)	YTD		YTD		
Chronic Homeless	199		Education	16	
Homeless Individuals	527		Job training/referrals	250	
			Job placement	119	
Female	286				
Male	440		SSI/SSDI	41	
			Section 8	1	
Hispanic	89		Veteran's	1	
African American	482				
White	139		Case management*	885	
Asian/Pacific Islander	12		Health care	61	
Native American	2		Life skills	17	
Other	2		Mental health/counseling	121	
			Substance abuse (resident)	25	
16-24	26		Transportation	55	
25-49	288		<i>(Last quarter numbers for supportive services)</i>		
50+	75				
	YTD	FY 07-08			
Rental (housing) subsidy	1,609	1,535			
Moving assistance	335	860			
Case management*	885	1,535			
<i>*Number to be revised in next report with release of program evaluation report.</i>					
Longer-term Outcomes			6 mo.	12 mo.	18 mo.
Receiving rental subsidy			452	173	99
Obtained employment			40	9	1
Maintained employment			66	4	-
Enrolled in educational program, school			21	-	-
Case management			452	173	99
Health care			33	40	34
Mental health/counseling			51	46	15
Substance abuse treatment (outpatient)			16	6	7
Reunited with family			1	2	-

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures		
FY 2008-09, First and Second Quarters		
	YTD	Fiscal Year
Number of applications received	795	Not available
Average number of business days to approve	19	20
Average amount of rental subsidy	\$288	\$300
Number of individuals re-entering program	57	Not available
Number of SSI approvals	52	Not available
Percent of SSI approvals	9%	Not available
Number of individuals disengaged from program	233	Not available

Level 1 Case Management (assessment)

Average case management hours for each participant per month:	2 hours
Total case management hours for all participants during current reporting period:	8,724 hours
Number of cases per case manager:	60 cases

Successes: A total of 61 participants received jobs during October-December 2008. Thirty-four participants received SSI approval, and three individuals were reunified with their families.

Challenges: Challenges included: 1) maximizing the 150 allocations in all project districts; and 2) contacting difficulties for homeless participants on the project waiting list.

Action Plan:

- 1) Allow the General Relief Housing Case Managers (GR HCMs) to approve an additional 10 slots in each category. Continue communicating with Eligibility Workers and Social Workers (EWs/GSWs/SWs) about the benefits of providing housing to their homeless participants through this project.
- 2) Set up National Security Agency (NSA) training for the GR HCMs. Encourage GR HCMs to mentor challenging participants and become a supportive network between them and the outside world.
- 3) Encourage participants to provide valid contact numbers, and update the waiting list every month after the third Thursday of each month.

Client Success Stories: The combination of being enrolled in the GR Housing Subsidy and Case Management and the GR Opportunities for Work (GROW) programs have motivated individuals to seek/maintain employment. Below are a few examples.

Client R was so thankful for having a stable place to live, and this greatly improved his chances of being hired. The client was a very active participant in his assigned GROW activities, and three weeks after being placed in housing, he found a job as a handyman.

Client H, a homeless GR participant, was hired as a Reservation Sales Agent after completing her GROW components and placed in stable housing by the GR Housing Subsidy project.

Three other individuals, credit the GR Housing Subsidy project for the approval of their SSI applications. Previously denied SSI for failure to respond to appointments or notices, the General Relief and Housing Subsidy project enabled them to have permanent housing and a mailing address. As a result, they were able to keep appointments, respond to notices, and received effective case management services from our GR HCMs.

11 and 12) Homeless Release Projects (DPSS-DHS and DPSS-Sheriff)

Goal: Identify individuals scheduled for release who are eligible for DPSS administered benefits.

Budget: DPSS-DHS: \$588,000; DPSS-Sheriff: \$1.097 million (On-going Funding)

Table C.6 Homeless Release (unduplicated count) FY 2008-09, First and Second Quarters	Year to Date Total	DPSS-DHS		DPSS-Sheriff	
		YTD	Cumulative	YTD	Cumulative
Homeless Individuals	933	194	608	739	3,785
Female	393	45	*n/a	348	*n/a
Male	537	149		388	
Transgender	3	-		3	
Hispanic	294	44		250	
African American	439	92		347	
White	175	49		126	
Asian/PI	4	1		3	
Native American	3	1		2	
Other	16	5		11	
16-24	158	6	(second qtr.)	152	
25-49	542	52		490	
50+	139	42		97	
Housing (emergency)	225	42	61	63	164
Average stay (days)	9-14	14	14	9	9-12
CalWORKs (approvals)	35	-	1	9	34
General Relief (w/FS)	2,015	56	233	489	1,782
General Relief only	299	8	67	71	232
Food Stamps only	44	2	3	19	41
SSI/SSDI	9	-	-	9	9
Veterans' benefits	3	-	-	3	3

*Information not available for FY 2007-08.

Table C.7 Program Measures	Cumulative Total	DPSS-DHS		DPSS-Sheriff	
		YTD	Cumulative	YTD	Cumulative
Total referrals received	7,309	194	608	1,712	7,115
Total referrals accepted	5,041 (69%)	69	355	1,223	4,686
Of the total referrals accepted:					
Total approved	752	62	*62	690	2,082
Total denied	212	182	*182	30	116
Total pending release:	2,683	14	*14	2,669	3,256
Releases/discharges	372	94	239	133	133
Number of applications					
Food Stamps	35	-	1	7	41
General Relief	1,939	49	287	619	2,014
CalWORKs	26	-	1	10	29

Demographic information not provided for all participants

DPSS-DHS Homeless Release Project

Successes: Once patient is discharged, there is no further contact between the Project Eligibility Worker and the patient.

DPSS-Sheriff Homeless Release Project

Successes: During the Sheriff's Community Transition Unit (CTU) and DPSS bi-monthly meeting, an idea was presented by CTU. It was suggested to fax a weekly "priority list" on Fridays listing names of inmates likely to be released in the following week. This has increased the number of CTU referrals processed in the month of December due to DPSS staff interviewing these inmates just before their release.

Challenges: There is a limited number of hotel rooms available in the downtown area. Another challenge involves staffing as DPSS project staff reduced from five to four.

Action Plan: DPSS staff is communicating with CTU staff by updating referrals sent with annotations regarding eligibility and correcting any discrepancies.

13) Homeless Recuperative Care Beds

Goal: Homeless individuals from area hospitals receive recuperative care and are discharged to transitional or permanent housing.

Budget: \$2.489 million (One-Time Funding)

Table C.8 : Homeless Recuperative Care Beds Participants and Services			
FY 2008-09, Second Quarter			
(unduplicated count)	Quarter	FY 2008-09	Quarter
Homeless Individuals	70	*111	Housing (permanent) 11
			Housing (transitional) 11
Female	5	14	Housing (emergency) 6
Male	64	96	General Relief only 11
Transgender	1	1	Medi-Cal/Medicare 7
Hispanic	10	21	SSI/SSDI 7
African American	24	41	Case management 70
White	18	31	Health care 70
Asian/Pacific Islander	2	2	Life skills 12
Other	16	16	Mental health/counseling 1
16-24		3	Recuperative care 70
25-49		30	Transportation 70
50+		37	Substance abuse (outpatient) 2
			Quarter
			FY 2008-09
Number of patients referred for recuperative care beds			18
Number of patients admitted to recuperative care services			46
Number of patients who were discharged from recuperative care services			52
Number of patients who were assigned to a primary health care provider during recuperative care stay			70
Average length of stay for patients in recuperative care program (days)			30
Number of ER visits 6 months after being discharged from recuperative care			-
Number of inpatient admissions 6 months after receiving recuperative care			-
			142
			100
			72
			111
			30
			102
			285
Emergency Housing/Case Management			
Average stay at emergency/transitional housing:			30 days
Level 3 Assisted/Supported Referral and Counseling case management services			
Average case management hours for each participant per month:			160 hours
Total case management hours for all participants during current reporting period:			480 hours
Number of cases per case manager:			25 cases

* Combined total from previous fiscal year is 140. Cumulative data will be in next report.

Successes: One client was transitioned into the Access to Housing for Health (AHH) program. The intake paperwork was shortened and the processes were streamlined which has resulted in faster admissions into recuperative care. Several clients were transitioned into substance use treatment services.

A six month pre/post analysis shows a 29% reduction in ER visits, a 65% reduction in hospitalizations, and a 42% reduction in the number of inpatient days.

Challenges: Permanent housing resources are limited. Many clients are unhappy about being discharged to emergency shelter. Clients have difficulty following through with the paperwork and guidelines for aftercare resources.

Action Plan: The program is hoping for more permanent housing to become available and is working with the recuperative care provider to strengthen case management services.

Client Success Story: In July 2009, Client M entered the JWCH Recuperative Care Program in Bell Shelter. The client is a 43 year-old Hispanic male with diabetes who was referred by Rancho Los Amigos. Client M worked as a supervisor for a carpet company for 15 years. In December 1993, he was

diagnosed with facial cancer, and the news was devastating for him and his family. After he was treated in February 1994, he returned to work to support his wife and children. On November 1994, he was diagnosed with yet another cancerous tumor. The patient received several surgeries between March and June in 1995. Mr. M returned to work once again with the carpet company and eventually transferred to a computer company where he held a supervising position in data entry for seven years. In 2001, the computer company began to decrease the amount of work, and he began to work with a different agency. In February 2008, Mr. M stopped working due to the company's lack of business. In May 2008, Mr. M was diagnosed with gangrene on his right foot. Mr. M returned to the hospital due to complications from diabetes. Mr. M was transferred from hospital to hospital until he was discharged into the JWCH Recuperative Care Program in Bell Shelter.

Mr. M entered the program with no source of income, no history of mental health issues or incarceration. The patient was eager to attend school in the field of computers. The case manager provided Mr. M with referrals and steps required to take for income and placement. During this hard time, the patient was going through a divorce. In July 2008, the patient returned to Rancho Los Amigos due to complications of diabetes, and the patient was admitted with his right leg amputated from the knee down.

In August 2008, the patient was readmitted to Recuperative Care in Bell Shelter. Since then, Mr. M has looked forward to return to his normal life. By this time, Mr. M reunited with his son, and this brought happiness and hope to the client once again. During his stay, Mr. M succeeded with income from disability, received a diploma for computer operations, and partnered in business with professional photography. Mr. M enjoys editing and perfecting photos through his use of computer knowledge. The patient followed the advice provided by the JWCH nursing staff and case manager at Recuperative Care. His wounds began to progress, and so Mr. M was deemed medically stable. The patient was transferred to the Salvation Army Bell Shelter two-year program. The program is a transitional placement where he may save income and continue to follow through while waiting for housing. Since then Mr. M has continued to follow up with his goal plan and appointments.

Mr. M is grateful to the Recuperative Care program and has been dedicating his time to helping others. Although Mr. M encounters a few limitations, he is doing his best to share his life story, motivate and provide emotional support to other homeless patients. I would like to leave you with a quote by Mr. M, "If you really want something in life you can reach it."

14) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and transition age youth to obtain and maintain permanent housing. *Eighty-six percent of participants during FY 2007-08 were homeless individuals.*

Budget: \$923,000 (annually in MHSA funding)

Table C.9: Housing Specialists Program Specific Measures FY 2008-09, First Quarter and FY 2007-08		
(duplicated count)	Quarter	Fiscal Year
Number of referrals to program.	163	n/a
Number of property owners contacted.	330	898
Average time to place family.	n/a	n/a

Successes: The Department has been able to identify and utilize other funding streams to augment the Move-in Assistance component of the Countywide Housing Assistance Program for Fiscal Year (FY) 2008-2009. The Move-in Assistance component provides financial assistance to homeless individuals with a mental illness moving into permanent affordable housing. This program, funded through the Projects for Assistance in Transition from Homelessness (PATH) grant, had received a significant reduction in funding for FY 2008-09. By identifying other funding streams, the Department will not be forced to reduce the number of individuals and/or families served through this program.

Challenges: The Department will be challenged continuously to identify available funding streams that permit financial assistance for housing related expenses such as rental subsidies, move-in assistance and household goods such as basis necessities to start a new home.

Action Plan: The Department will continue to seeking other funding options to fund housing related expenses that permit these untraditional expenses.

Table C.10: Participants and Services FY 2008-09, First and Second Quarter s and FY 2007-08		
	YTD	Fiscal Year
Chronic homeless individuals	31	-
Homeless individuals	427	2,343
Homeless families	41	255
Transition age youth	6	142
<i>Demographic information not provided for all participants in families</i>		
Female	308	*n/a
Male	227	
Transgender	2	
Hispanic	171	
African American	160	
White	126	
Asian/Pacific Islander	19	
Native American	2	
Other	27	
16-24	6	
25-49	475	
50+	12	
	YTD	Cumulative
Moving assistance	50	198
Eviction prevention	5	10
Housing (emergency)	325	1,128
Housing (transitional)	123	426
Housing (permanent)	121	476
Rental subsidy	74	178
Mental health	458	*

*Information not available for FY 2007-08.

Client Success Story: Not available this quarter. The HPI reporting format has allowed the Housing Specialists to redesign data collection efforts.

15) Jail In-Reach Program

Goal: Engage homeless nonviolent inmates upon entry into jail. Develop a release plan that coordinates an assessment and links clients to supportive services, benefits, and housing options upon their release. Case management team works with clients to obtain employment and explore rental subsidy eligibility.

Budget: \$1,500,000 (One-Time Funding)

Table C.11 : Jail In-Reach Program			
FY 2008-09, First and Second Quarters			
(duplicated count)	Year to Date (YTD)		YTD
Homeless Individuals	118	Housing (emergency)	10
Chronic Homeless	162	Housing (transitional)	49
		Housing (permanent)	21
Female	78	Job training	163
Male	202	Job placement	15
		Education	2
Hispanic	86	General Relief (Food Stamps)	8
African American	236	General Relief only	22
White	103	Food stamps only	20
Native American	3	Veterans' benefits	1
Other	24		
<i>(not for all participants)</i>		Case management	167
16-24	33	Health care	2
25-49	205	Substance abuse, outpatient	12
50+	40	Substance abuse, residential	14
		Transportation	37
		Legal Advocacy	42
Program Specific Measures			YTD
Number of participants who received intake/enrollment			193
Number of participants who received intake/enrollment within 72 hrs of initial interview			155
Number of participants who did not complete program (exited prior to completing)			77
Number by violent crime			61
Number by non-violent crime			93
Number by area of residence prior to incarceration (most frequent residence)			79
Number by area of residence prior to incarceration (second most frequent residence)			17
Number of times in County jail			304
Number of times in State prison			44
Number of participants with a service plan			193
Number of participants with a service plan within a week from intake/enrollment			193
<u>Number of referrals provided to participants by type:</u>			
- Service(s): Case management, health/medical care, mental health, substance abuse treatment, transportation, and mentoring			128
- Benefit(s): CalWORKs, General Relief, Food Stamps only, Section 8 and/or Shelter Plus Care, SSI/SSDI, Medi-Cal, Veterans			113
- Job/education related service(s): Job training, employment referrals, education			44
Number of participants who do not return to jail			245
Emergency Housing/Case Management			
Average stay at emergency/transitional housing: (47 participants)			49 days
Level 3 Assisted/Supported Referral and Counseling case management services			
Average case management hours for each participant per month:			4 hours
Total case management hours for all participants during current reporting period:			2,046 hours
Number of cases per case manager:			32 cases

Successes: The Jail In-Reach Program (JIR) enrolled 83 clients of the 150 that were referred to by the Community Transition Unit (CTU) of the Los Angeles County Sheriff's Department. The 83 clients were determined to meet the criteria for the program and began receiving services. Services were continued to the prior quarter enrollees, and the program carries an average active roster of approximately 160 clients per month. Typically, staff meetings and trainings are held at least every two weeks on topics such as: housing advocacy, harm reduction, mediation and software management. We also receive technical and specialty assistance from our partners in the collaboration. This quarter, significantly more clients were released to stable housing. With more time progressing and an increased awareness of outcomes, the program is beginning to show more of an impact in these areas. As a result of outreach efforts, the program regularly receives letters from clients inquiring about the JIR program. This is credit to the JIR and CTU staff promoting the program as a worthwhile investment for the clients.

Challenges: The program continues to work through a dropout rate of over 25%. This is primarily attributed to the short enrollment time before release and the drop off of communication once the client leaves the jail. This will likely continue with a portion of clientele.

The operational requirements of JIR staff working within the jail system have improved with the increased familiarity between JIR and the CTU staff. JIR continues to slightly struggle with scheduling changes that occur within the jails but understand that it is usually a result of a safety requirements. JIR staff also face the challenge of finding an appropriate private space to work with their clients. Often staff meet in a hallway or speak to their client through windows which limits disclosure from clients. JIR staff will continue to work with the LASD to explore options in this area.

The program's external database administrator (DOMUS) has experienced changes that have adversely affected JIR's record keeping processes and reporting. JIR initiated several internal procedures including weekly file and case reviews to ensure accuracy as well as hard copy back-ups of the database. All information provided in reports can be documented, however, JIR had to redirect a few resources toward maintaining records. DOMUS has been able to work on this with JIR.

Action Plan: JIR staff will regularly meet and participate in quarterly administrator meetings to address collaborative issues. Continued dialogue and procedural implementation will alleviate operational challenges and maintain a functional level of communication between agencies and facilities.

JIR will increase the emphasis and impact of the mentoring component as it has been identified as a significant resource for the client's stability after release. JIR has identified and secured funds to increase the training for staff including outside consultation. LASD is on board with this direction. JIR will increase the amount of follow-up on clients that have been released and have secured some form of housing and/or employment. As clients reach this mark during the next quarter, JIR will have the opportunity to report this information. In addition, JIR has conducted some follow-up before the six month milestone, especially with high-risk clients.

Client Success Story: A 51-year-old male from the Twin Towers Correctional Facility was enrolled in the JIR program. During his case management sessions, it was determined that the most appropriate placement for this client was a Sober Living program. Staff worked within a short time frame as the client had an upcoming court date, and it was expected that he would have an appropriate placement. Staff located a Sober Living program in the area of the client's release. Moreover, staff had already built a positive relationship with the program administration and was able to secure a space for the client. JIR staff attended a court date, the JIR program was cited, and the client was released to the Sober Living Program. JIR will continue this case to monitor his progress.

16) Long Beach Services for Homeless Veterans

Goal: Assist veterans with housing, employment, SSI/SSDI, and legal issues such as child support. The program provides case management, outreach, and mental health services.

Budget: \$500,000 (Ongoing Funding)

Table C.12 : Long Beach Services for Homeless Veterans			
FY 2008-09, Second Quarter			
	Quarter		Quarter
Homeless Individuals	101	Housing (emergency)	9
Chronic Homeless	8	Housing (transitional)	1
		Rental subsidy	12
Female	9		
Male	100	Job training	2
		General Relief	6
Hispanic	19	SSI/SSDI	6
African American	41	Veterans' benefits	14
White	45	Case management	19
Asian/Pacific Islander	2	Mental health	17
Native American	2	Street outreach with mental health focus	79
16-24	6		
25-49	55		
50+	48		
Program Specific Measures			Quarter
Number of mental health coordination activities conducted.			-
Number of mental health assessments provided to homeless veterans by MHALA.			10
Number of meals provided to homeless veterans. (includes food/meal vouchers)			-
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK.			6
Number of outreach sessions conducted by U.S. Vets and DHHS.			8
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS.			79
Number of outreach sessions conducted with veterans recently returning from tour of duty.			3
Number of mental health educational pamphlets developed.			-

Successes: The partners of the Long Beach Homeless Veterans Initiative (Initiative) - the City of Long Beach (City), Mental Health America of Los Angeles (MHA), Single Parents United N Kids (SPUNK), and United States Veterans Initiative (US VETS) - are implementing a comprehensive service package to enhance specialized services for homeless veterans. The four partner agencies of the Initiative served 109 homeless veterans with housing and supportive services, including outreach, case management, child support debt reduction, and psychiatric services. As a part of the Initiative, the partner agencies continue to verify veteran status and benefits with the Long Beach Veterans Affairs Healthcare System.

Through the Initiative, two of the collaborative partners, MHA and SPUNK, are specifically targeting and serving homeless veterans in the community for the first time. MHA is currently providing case management, outreach, and psychiatric services to 17 homeless veterans. MHA was aware of the growing need to psychiatrically serve the veteran population in the Drop-In Center at the Village Integrated Service Agency (ISA), but was unable due to limited resources. SPUNK is now serving permanently and totally disabled veterans, many of them referred by US VETS. During the reporting period, SPUNK was able to close the cases of four clients for a total arrears savings of \$273,765. Additionally, SPUNK was also able to lower the monthly amount of current child support on two cases for a savings of \$421 per month total.

On December 16th, the first planning meeting for the Initiative was held. Attendees, including the City Homeless Services Officer, newly hired Mental Health Coordinator, the HMIS administrator for the Long

Beach Continuum of Care, Director of Outreach and Engagement for MHA, the President of SPUNK, the Site Director for the US VETS Villages at Cabrillo, and the County Homeless Coordinator discussed current progress of the Initiative and future steps for increased collaboration between the Initiative partners, as well as other agencies. An example of progress is the close collaboration between SPUNK and US VETS to educate the US VETS staff and clients about the services provided by the Initiative. Additional presentations about available resources are being scheduled with the partner agencies, including presentations on the City HOME, Section 8 programs, and the County DPSS housing programs for homeless clients.

Challenges: The Initiative was hindered by the delay in the hiring process of the Mental Health Coordinator and veteran-specific case manager. Despite a late start, the Mental Health Coordinator's knowledge and experience in the mental health profession have allowed her to implement resources and educational brochures quickly. To compensate for the delay in securing the case manager position, duties have been temporarily shifted to ensure continuity of service to the homeless veterans in the community.

Another challenge is to provide unduplicated client information in the quarterly report. While each of the partners are tracking and reporting the data for their clients, the collaborative is working to design a method to eliminate redundancy in the demographic information for the report.

Action Plan: The veteran specific case manager position delay has been resolved. The street outreach worker and case manager for the initiative have started collaboration regarding homeless veterans. The program will utilize the Homeless Count as a means to educate community volunteers and to outreach to homeless veterans. A brochure explaining the Initiative and the services provided was distributed to homeless veterans identified during the count process on January 29, 2009. In addition, the Initiative partners will:

- Implement a citywide mental health event, proposed for May 2009
- Host ongoing coordination meetings for the Initiative, including all of the partner agencies.
- Provide informational sessions to the collaborative partners about ancillary services available to homeless veterans.
- Utilize the Homeless Management Information System (HMIS) to track and share information between Initiative partners.
- Develop and distribute informational brochures about mental health issues.
- Seek additional funding for mental health and/or veterans services/housing.

Client Success Story: Client X is a permanently and totally disabled veteran who was living at the Villages at Cabrillo, and working with US VETS to achieve self-sufficiency. As a part of his case management plan, he was referred to SPUNK for help with his child support debt. Client X originally owed \$96,516 in child support, and after working with SPUNK, his case is now closed. He states that not having to worry about this bill helps him tremendously; he feels like he has his life back. With this debt being lifted, he no longer has to worry about his driver's license being taken, and he can better focus on his recovery.

17) Los Angeles County Homeless Court Program

Goal: Assist homeless individuals with clearing outstanding tickets, fines, and warrants upon successful completion of rehabilitation recovery programs for mental health, substance abuse and/or other issues.

Budget: \$379,000 (On-going Funding)

Table C.13 : Los Angeles County Homeless Court Program Participants					
FY 2008-09, First and Second Quarters					
(duplicated count)	YTD	Cumulative		YTD	Cumulative
Homeless Individuals	558	712	Hispanic	126	162
			African American	297	375
Female	191	242	White	107	141
Male	365	467	Asian/Pacific Islander	8	8
Transgender	2	3	Native American	2	3
			Other	18	23
			15 and below	-	-
			16-24	37	53
			25-49	383	474
			50+	138	185
Program Specific Measures				YTD	Cumulative
Number of Los Angeles County Homeless Court motions received.				1,216	1,550
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission.				1,216	1,550
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate.				35	50
Number of motions that are granted by Superior Court.				92%	
				1,182	1,505
Number of motions that are denied by Superior Court.				99%	
				-	-
Number of individual cases filed under the Los Angeles County Homeless Court.				1,881	2,281
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant.				523	677
Number of participants that have Los Angeles County citations or warrants dismissed upon program completion.				489	615
Number of participants who complete at least 90 days of necessary case management, rehabilitative, employment or mental health services before their first appearance in Court.				557	711
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources.				539	715

Successes: One of the program's great achievements this quarter was developing a subcontract with Volunteers of America (VOA) to provide transportation services. The transportation services were provided to and from Homeless Court sessions as well as between other courts and the mental health, substance abuse, housing, and case management service providers that play a crucial role in helping Homeless Court participants overcome the problems that led to or prolonged their homelessness. As part of this subcontract VOA will also administer the emergency hotel and food vouchers provided for through our contract with the County. The subcontract was executed on January 6, 2009 and the program looks forward to providing these additional services to clients.

Another success this quarter was the training of more than 350 case managers on the Homeless Court Program's benefits, requirements and process. Within two days, 130 General Relief Opportunities for Work (GROW) case managers from Department of Public Social Services (DPSS) offices throughout the County came together to learn about Homeless Court and how it can serve the clients with whom they work. We also attended Project Homeless Connect events in downtown Los Angeles, East Los Angeles, South Los Angeles, and Pomona on December 4, 2008, providing information on the Homeless Court Program to 383 prospective applicants and 42 case managers.

Extensive outreach has fostered greater awareness of the Homeless Court Program throughout the service provider community, resulting in a significant increase in the number of applications submitted. Despite this increase, the Homeless Court has succeeded in keeping up with the flow of incoming applications and continues to process applications in a timely manner.

Superior Court worked closely with Public Counsel and the Los Angeles City Attorney to recognize efficiencies in processing motions submitted on behalf of clients seeking relief from the Court on pending or previously resolved cases. These efficiencies include: 1) submitting motions that are both accurately completed, timely, and seek the appropriate relief, 2) developing techniques to complete court processing and 3) notifying the appropriate justice partners of the court's order. Superior Court recognized the need to include as many clients as possible in the monthly graduation ceremonies, hosted by the Honorable Michael A. Tynan. To that end, Superior Court and Public Counsel agreed to increase the number of clients that were invited to each ceremony. The ceremony was then divided into two or more smaller ceremonies each taking less time, while still providing sufficient time for Judge Tynan to provide individual client recognition for their achievements. This model will be further evaluated in the next reporting period.

Challenges: The success achieved in increasing the number of applications to Homeless Court has led to challenges to accommodate all of the clients at our bi-monthly Homeless Court sessions. As program staff work through the backlog of old cases and simultaneously process a growing number of new applications, a Homeless Court session regularly has more than 100 clients invited to appear before the Judge. This number of clients can be difficult to manage, not only for the Judge and those administering the session, but also for the agency that hosts the session and allows use of their space. As staff look into moving the sessions to other locations across the County, they are considering: accessibility for clients, availability of parking for volunteer attorneys, case managers and clients, the location's capacity, and restrictions on the use of an agency's space.

Action Plan: The program will work with Homeless Court partners to recruit additional judicial officers to preside over Homeless Court sessions so the burden does not fall entirely on a single judge. Staff will also reach out to other service provider agencies to identify session locations that can accommodate the growing number of clients while still being accessible to clients, case managers and volunteer attorneys. Finally, staff will investigate various options for reducing the number of clients invited to appear at a single session, such as splitting the invitees into two sessions on consecutive days.

Superior Court will continue to work with Public Counsel in providing case-related information to clients. In the next reporting period, Superior Court will begin providing written acknowledgment that the DMV has been appropriately notified of the Court's orders.

Client Success Story: Through his case management program, Client X received a wide range of services, including: shelter, mental health counseling, substance abuse prevention, employment resources, and money management assistance. In an effort to support Mr. X's commitment to improving his life and working towards his goals, his case manager applied to Homeless Court for him. The case manager explained to Client X that his outstanding tickets and warrants could be resolved, and the barrier these tickets posed could be eliminated. Mr. X has now obtained his GED and is a certified cook with hopes of owning his own restaurant.

18) Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program

Goal: Assist individuals to move into permanent housing.

Budget: \$1.1 million

Table C.14: Moving Assistance for Single Adults Program Measures
FY 2008-09, First and Second Quarters

(unduplicated count)	YTD	Cumulative		YTD
Homeless Individuals	202	380	Female	103
			Male	99
Number applications received	202	380		
Moving assistance approved	73	136	16-24	7
Rental subsidy approved	73	136	25-49	106
Percent applications approved	36%	51%	50+	89
	(2 nd Qtr.)	(1 st Qtr.)		
Average days to approve	11	*20	Hispanic	23
Average amount of grant	\$660	*\$575	African American	134
			White	35
			Native American	8
Number receiving rental	73	** n/a	Other	2
subsidy after six months				
General Relief (w/FS)	58	n/a		
General Relief only	3	n/a		
Food Stamps only	1	n/a		
Medi-Cal/Medicare	1	n/a		
SSI/SSDI	1	n/a		
Section 8	10	n/a		
Shelter Plus Care	1	n/a		

* FY 2007-08 average

**FY 2007-08 data not available

Successes:

Last quarter, the program received 67 applications, and this quarter 134 applications were received. Referrals have increased by 100%, which may be attributed to increased staff awareness of the program as well as increasingly difficult economic conditions.

Challenges:

- Low number of approvals despite the increase in referrals. In the first quarter, 51% of applications were approved, and only 35% were approved during the second quarter.
- Vendors/landlords refuse to provide their Tax ID numbers to participants.

Action Plan:

To reverse the number of low approvals:

- Continue providing refresher training to staff.
- Implement program enhancements, including: no time-limit for previously aided GR/FS participants, expand to include CAPI participants, and accept referrals from agencies working with the homeless population.

19) Project 50

Goal: To move 50 of the most vulnerable, chronically homeless individuals off of Skid Row and into permanent housing.

Budget: \$3.6 million (Board Approved Funding)

Table C.15: Project 50 Participants and Services					
FY 2008-09, Second Quarter					
(unduplicated count)	YTD	To Date		YTD	To Date
Chronic Homeless Individuals	20	60	Education	2	2
Female	3	9	Job training/referrals	-	2
Male	17	50	Job placement	2	2
Transgender	-	1	General Relief (GR,FS)	7	20
			General Relief only	4	7
Hispanic	5	11	Food Stamps	-	1
African American	12	43	Medi-Cal/Medicare	10	16
White	3	6	Section 8	-	1
Asian/Pacific Islander	-	-	Shelter Plus Care	6	49
Native American	-	-	SSI/SSDI	10	17
Other	1	1	Veterans	-	1
			Case management	38	49
25-49	8	24	Health care/medical	37	49
50+	12	37	Mental health/counseling	35	42
			Social/community activity	-	30
Housing (emergency)	15	36	Substance abuse (outpatient)	26	41
Housing (permanent)	15	50	Substance abuse (residential)	2	5
Rental Subsidy	-	33	Transportation	5	35
			Detox	1	9
			Legal Services	-	11
Longer-term outcomes (12 months)				Quarter	
Continuing to live in housing				36	
Receiving rental subsidy				36	
Obtained employment				2	
Maintained employment				1	
Enrolled in educational program				2	
Case management				36	
Health care				36	
Mental health/counseling				34	
Substance abuse treatment (outpatient)				26	
Substance abuse treatment (residential)				5	
No drug use				14	
Reunited with family				3	
Transitional Housing/Case Management				Quarter	
Average stay in transitional housing:				2 days	
Number into permanent housing:				3 participants	
Level 3 case management services					
Average for each participant per month:				5 hours	
Total hours for all participants:				95 hours	
Number of cases per case manager:				19 cases	

Program Specific Measures	Quarter	Cumulative
Number of participants who exited housing	4	11
Number of participants developing individualized treatment plans	6	48
Number of participants participating in a housing retention group	-	30
Number of Project 50 participants having arrests	6	12
Number of Project 50 participants having hospitalizations	3	12
Number of Project 50 participants having an emergency room (ER) visit	2	6
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	3	16

Successes: As of December 31, 2008, Project 50 maintained 35 participants in housing. Staff has been working on: policies/procedures, the P50-PHASE database by DPSS; and the building of community among participants. Staff are spending more time out in the field meeting with participants. Most of those participants who previously reported sobriety continue to maintain their sobriety. The majority of participants have received bus passes for transportation needs. In the next quarterly report, a one-year update will be provided on the program's successes.

Challenges: The outreach and engagement team has had limited success. Project 50 lost a counselor at the end of November and did receive two replacement staff. Not having a therapist from JWCH has been very challenging. The almost complete turnover in staffing has been very difficult on the participants, and there is need for staff to learn how to deal with the stress of working with the chaotic lifestyles of the participants. Policies regarding drug/legal issues have been further explored.

Action Plan:

- Utilize DMH Home Team for outreach and enrollment with P50 for two half days each week;
- Obtain two positions for CD counselor so the program will always have at least one at all times;
- Encourage staff stability, maybe have a process group for participants to deal with loss;
- Encourage creative solutions for JWCH to supply the needed therapist
- Develop policy/procedures for staff dealing with participants' certain drug/legal issues.

Client Success Stories: Client J was homeless for 12 years and turned to drugs. He was housed by Project 50 for the first time in 12 years. He has accepted mental health services and health services for a serious illness for which he has avoided treatment. He is willing to accept dental services and is happy and secure in his housing.

20) Santa Monica Homeless Community Court

Goal: Assist homeless individuals with clearing outstanding citations, warrants, and misdemeanor offenses upon successful completion of mental health, substance abuse and case management.

Budget: \$540,000

Table C.16: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – December 2008)

(unduplicated count)	Cumulative		*Cumulative
Chronic Homeless Individuals	142	15 and below	-
		25-54**	110
Female	46	55+	32
Male	96	Housing (emer/trans)	60
		Housing (permanent)	17
Hispanic*	17	Rental subsidy	11
African American	33		
White	92	Alternative court	142
Asian/Pacific Islander	3	Case management (level 3)	135
Native American	1	Mental health	60
Other	13	Substance abuse (outpatient)	5
		Substance abuse (residential)	32
Program Specific Measures			Cumulative
Total number of clients who have enrolled in Program			142
Number of participants who appear before the Court Pilot Project that engage in case management for at least three months after their first appearance at Court			110 (77%)
Number who participate that have citations or warrants dismissed upon completion			102 (72%)
Number who receive an emergency shelter bed and remain for two weeks or longer			26 (45%)
Number who enter residential treatment complete a substance abuse program of 90 days or longer			20 (63%)
Number of arrests for all Court participants that have been placed in an emergency, therapeutic, transitional or permanent bed (or some combination of bed-types) for 90-days or longer as compared to the 90 days prior to entering residential program			80% reduction
Number of permanently housed who continue to be housed after four months, or will still be housed at the end of the program periods (which may be less than four months after housing placement)			36 (97%)
Average length of stay in emergency housing: 14-160 days			

*Latino is not categorized as a distinct race by Santa Monica Homeless Community Court

** Age range is categorized differently by Santa Monica Homeless Community Court.

Successes: The most successful ongoing collaboration which the Homeless Community Court program is engaged in is its relationship with Edelman Mental Health Center. Every Thursday morning, the Edelman psychiatrist and social worker, provide in-office services at the St. Joseph Center Homeless Services Center and occasional outreach to Homeless Community Court clients. The primary benefit of this Edelman collaboration is giving clients easy access to psychiatric care, with medications administered at two area pharmacies. Given the limited mobility, organization and/or motivation of many Court clients, this is often a superior service option to conventional mental health clinics. Integrating these psychiatric services into the pre-existing relationship which clients have with their program Case Manager and Mental Health Specialist also provides context which can help overcome service barriers stemming directly from mental health symptoms. A secondary but lasting benefit of the Edelman collaboration is streamlining the eventual transfer of client services from in-office services at the Homeless Services Center to long-term mental health care at Edelman or other Department on Mental Health facilities.

Exodus Full Service Partnership has been another valuable collaborator with the Homeless Community Court Program. A dually diagnosed client referred to this program was rapidly entered into intensive services with an outreach case manager. Working in tandem with Homeless Community Court and Exodus staff, this client was able to access a full range of services including psychiatric care, substance abuse treatment, emergency shelter, and permanent housing at a sober living. The Full Service Partnership's collaboration with Exodus Mental Health Urgent Care Center accelerated the client's access to mental health services and dealt with acute mental health situations. This collaboration has also contributed to St. Joseph Center's familiarity with the services offered by Exodus Urgent Care, benefiting the agency more generally.

Building on the success of our Chronic Homeless Program (CHP) we have managed to link many of our CHP participants to the court which has resulted in the removal of barriers and has allowed for the successful transition by clients to the next phase of their lives.

Continued collaboration between our service providers, police and fire has allowed us to continue engaging clients in the field and seizing opportunities to refer them to the program when we think they will be receptive to services.

Our talented Public Defender is greatly appreciated not only by the Resource Coordinator but also by our service providers. She creatively strikes a balance between advocating for her clients and using her motivational interviewing techniques to help clients see the benefits of connecting to services.

Challenges: The voluntary nature of the program allows many of our most chronic, high users of police, fire and social services the opportunity to opt out of the program. These are the very people we had wished to engage in services using the authority of the court. Experience has shown us that many of our most chronic homeless do not want to access services and the voluntary nature of the program does not allow us to use the authority of the Court to connect individuals to much needed resources including mental health, psychiatric, medical, substance abuse and monetary assistance programs – all of which can be barriers to stabilizing clients, housing them and helping them maintain their housing.

Action Plan: The court will only accept participants cited with quality of life crimes – misdemeanors and infractions. The court will not accept felons or sex offenders. The very nature of the crimes, misdemeanors and infractions, prevent the court from following participant for extended periods of time and result in citations being dismissed with limited client progress. Greater oversight by the court could have a very positive influence on participants and result in better outcomes. Currently, participants average 2-3 court visits before their citations and warrants are dismissed. This impacts both our substance abuse treatment and housing placements. Indeed, because of Case Management initiated by the Court, some individuals may achieve outcomes months after their exit from the program.

Court participants would benefit from a more directive tone and more exact prescriptions from the Court. While this has improved, we continue to need progress in this area. The court appointed psychiatrist linked with the program supports this change in tone of court orders, and feels that it would result in greater client success. Furthermore, it would lend more objective finality to the process, taking out a great deal of ambiguity for the client.

21) Santa Monica Service Registry

A) Step Up on Second

Budget: \$ 518,000 (Board Approved – Third District)

Table C.17: Step Up on Second, Santa Monica Service Registry			
FY 2008-09, July – December 2008			
(unduplicated clients)	Quarter		Quarter
Chronic Homeless Individuals	9	Housing (transitional)	3
Female	3	Case management	9
Male	6	Mental health care	4
White	7	Social/community activity	9
Asian/Pacific Islander	1	Transportation	2
Other	1	Clothing	4
25-49	5	Case management level III	
50+	4	Average hours per case	5
		Total number of hours	378
		Caseload	3
Number of participants who have enrolled (entered) into program during the reporting period.			9
Number of participants who left the program during this period.			-
Total number currently enrolled in program.			9
Number of clients who received an assessment (if applicable).			5
Cost per participant			-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the <i>beginning</i> of the quarter.			n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the <i>end</i> of the quarter.			n/a

Successes: The HOME Team, fully-staffed as of November 1, 2008, has been successful in engaging nine chronically homeless adults. Three of these were placed into transitional housing and remained housed for the reporting period. The team has been successful in providing outreach and engagement services to individuals identified as “most vulnerable” by the City of Santa Monica. These individuals are traditionally resistant to mental health and supportive assistance.

Challenges: The list of priority names provided by the City of Santa Monica, as identified in their homeless survey process completed in February 2008, is largely out of date. Many of the individuals assigned to Step Up’s HOME Team are no longer staying in Santa Monica and are unable to be located through the City’s Police and Fire Departments. Due to this, the program has been unable to attain a full case load of 30 chronically homeless individuals. Additionally, we are working with individuals identified as “most resistant” to treatment and therefore require a great deal of time in engaging into services.

Action Plan: The City of Santa Monica has now opened the process for adding individuals to the Service Registry, thereby providing Step Up with the means to meet the program’s goal of providing services to 30 individuals. The program intends to perform surveys on all potentially qualifying homeless individuals contacted in the street and submit these for inclusion on the service registry. The timeframe for individuals to be added to the service registry has not been identified, but staff will continue to work toward the goal of providing services to 30 chronically homeless and mentally ill adults.

Client Success Story: In the short duration of this quarter (two months), staff successfully engaged nine individuals and assisted them into receiving supportive services at Step Up on Second. One individual, who has been living in the U.S. for over 20 years, has no evidence of his legal status here, despite the fact he worked for 11 years. Because he is originally from India and has been psychotic for many years, he has lost all forms of identification. In order to assist him in obtaining an income to support housing, the team spent many hours coordinating with the Indian Embassy and making phone calls to establish his identity. As of the reporting period, the team has not been successful in assisting him through all the barriers. However, the client has succeeded by learning to trust and accept the team’s support and overcoming his psychotic fear that people are out to harm him. Staff believes that this breakthrough will

open up new possibilities as their relationship progresses and will likely lead to greater housing opportunities.

B) OPCC Safety Net (Access Center)

Budget: \$ 660,000 (Board Approved, Third District)

Table C.18: OPCC Safety Net (Access Center)

FY 2008-09, July – December 2008

(unduplicated clients)	Quarter		Quarter
Chronic Homeless	27	Housing (emergency)	15
		Housing (transitional)	3
Female	6	Housing (permanent)	1
Male	21		
		Section 8	1
Hispanic	1	SSI/SSDI	1
African American	4		
White	21		
Asian/Pacific Islander	0	Case management	23
Native American	0	Health care	5
Other	1	Mental health care	6
		Substance abuse treatment (residential)	1
25-49	11	Substance abuse treatment (outpatient)	2
50+	16	Food and clothing	5
Number of organizations/agencies that your program has a formal collaboration for this project.			3
Number of times collaborative partners met each month.			2
Total amount (\$) of HPI funding leveraged for project.			n/a
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).			n/a
Number of participants who have enrolled (entered) into program during the reporting period.			27
Number of participants who left the program during this period.			1
Total number currently enrolled in program.			26
Number of clients who received an assessment (if applicable).			23
Cost per participant.			\$1,705
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.			n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.			n/a

Successes: OPCC Project Safety Net is becoming a dynamic and powerful program to establish hope and stability in the lives of the most challenging individuals to serve on the streets of Santa Monica. Our clientele are chronically homeless individuals who have established survival behaviors that ultimately hold them back from making progress toward housing and increased quality of life. Severe mental health issues, alcoholism and drug addiction are the norm in coping on the street, as well as extreme alienation from the larger community, society and authority figures – including the service providers who might be able to assist them in rebuilding their lives. There is an extreme lack of trust and often outright hostility toward service providers, and this is often the first challenge to address when outreaching.

A strong team has been established, with housing coordinator, outreach case manager, and team leader positions filled. The team is supported by the Access Center's adult outreach team, which often provides transportation and help with other tasks, such as locating hard to find clients. The Safety Net program has established its list of 40 targeted individuals, and 27 of these individuals have been located and engaged with intense case management and outreach; 23 have completed intakes and begun the road to recovery. That staff have been able to break through the mistrust, hostility and other factors with these individuals and getting them to play an active role in their own recovery from the street has been a tremendous success. The ability to stabilize clients through emergency housing in motel rooms has been a critical part of this process, and with the close support and case management provided, clients' attitudes have been shown again and again to change from hopelessness and animosity to hope and willingness to seek out and accept services of which they were previously very suspicious. Twelve clients have stabilized in emergency housing and three have entered into transitional housing. One client was already permanently housed in a local SNF when he was put on our list, and another we assisted in

placing the client in a Board & Care home. Staff continue working closely with housed clients – whether emergency, transitional or permanent – to encourage their stability and success. It has been found that this kind of support is imperative. As of the end of the second quarter, one client holds a housing voucher and is currently looking for an apartment with the assistance of our housing coordinator. Currently, five more housing voucher applications have been completed and submitted to the Santa Monica Housing Authority awaiting approval. Additionally, three more clients are in the process of finishing applications with their case managers, and one is in the process of applying for Shelter+Care housing through ACOF. Although these cases are at varied levels of completion, they all mark extreme progress with each of the clients, and indicate major steps toward stabilization and recovery using a 'housing first' methodology.

Challenges: The chronically homeless individuals eligible for OPCC Project Safety Net struggle with a multitude of issues from substance abuse and alcohol addiction to chronic and severe mental health issues and very poor physical health. Hostility, alienation, hopelessness and suspicion toward service providers are often initial challenges in establishing contact, and it is imperative to develop trust with the client to move forward at all. Many clients have a history of abuse, rape, and other traumas to contend with. Couples are a particular challenge; often co-dependent or abusive and exploitative relationships have developed on the street. The project has not yet been able to hire an LCSW to assist in the field with these issues. A part time psychiatrist has not yet started as well. As a result, it is often challenging to connect clients to mental health services with the alacrity desired.

In addition, the clients served by Safety Net tend to have burned many bridges among available programs, and it takes a great deal of advocacy to ensure programs understand the need for flexibility in dealing with their special needs. Life skills need to be constantly developed with clients, who often times have never lived alone and tend to fall into old patterns of behavior.

The absence of adequate low income housing in the Santa Monica community is also a profound challenge. The use of motel vouchers has been a tremendous factor in working to stabilize clients and develop life skills they will need to secure permanent housing, but it is difficult to locate available units for master leasing, as well as landlords willing to give the chronically homeless – who often have poor credit due to living on the street, and have many other special needs – a chance.

Bringing the list of clients up to 40 after targeting a set 40 from the registry also has posed specific challenges: often times, Safety Net clients are transient in lifestyle, or make an effort not to be found. Staff have worked closely with City of Santa Monica, including the Santa Monica police, to locate targeted individuals. Revising the list to create a total of 40 individuals who remain the most vulnerable on the street remains a challenge that Safety Net continues to collaborate with the City of Santa Monica to implement.

Action Plan: We will continue to actively recruit for an LCSW/LMFT to come on board and complete our staff team. In the interim we can consult with our clinical consultant who is on board at the Access Center in emergency situations. In addition, the psychiatrist for the team will be officially starting in January and will be able to provide clinical support to the team. Our housing coordinator will collaborate with other housing coordinators within our agency to come up with innovative and creative ways of finding landlords who will be willing to rent to our clients. Additionally, A Master leasing agreement has been pursued, and an agreement should be eminent in the next quarter. OPCC was notified this month by the Housing Authority of the City of Los Angeles of the availability of new Shelter Plus Care certificates to be reallocated to OPCC with a priority given to Project Safety Net.

Client Success Story: With a twenty-year history of homelessness in Santa Monica, Client E struggles with a learning disability and partial illiteracy and has had much experience with police, fire and paramedic services. He has often had difficulties coping with depression and anger, and has been picked up by the police with frequent hospitalizations. While he has been living on the streets, he has never been willing to go into shelters because of bad experiences in the past.

When OPCC Project Safety Net staff began working with him, he had poor adaptive living skills from years on the street, abrasive communication, and rarely managed to follow through on any task. Through an intensive team effort E has made amazing strides in all areas of his life. He is a typical Safety Net client, in that he was very suspicious of service providers and unwilling to work with staff to move forward;

he also has been unwilling to enter into the continuum of care. Staff were able to provide case management and support directly on the street, and through developing a bond of trust and mutual respect, E has become empowered to make significant changes in his life and behavior.

E became more flexible and willing to work with staff, following through on tasks needed for him to apply for a Section 8 voucher. His attitude has improved, where before his sense of hopelessness made him difficult to engage, now he collaborates with staff in his own recovery from the street. Since engagement with OPCC Project Safety Net, E has had no hospitalization or encounter with the police. He now addresses his personal hygiene and self presentation, which has enabled him to conduct an apartment search. With staff's guidance and support, and a housing voucher in hand, E recently met with a landlord who was interested in renting to him while he continues to repair his credit.

This is tremendous progress for E, and a great opportunity, which would have been impossible without the flexibility and creative persistence of the approach of the OPCC Project Safety Net team.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

22) Los Angeles County Housing Resource Center, (formerly known as the Housing Database)

Goal: Provide information on housing listings to public users, housing locators, and caseworkers.

Budget: \$382,000 (\$202,000 allocation from HPI funding and \$180,000 from CDC).

Table D1: LACHRC Program Measures	Cumulative	Year 1 6.1.07 - 6.30.08
FY 2008-09, Second Quarter		
Number of landlords registered on the site	3,999 <i>494 new</i>	3,505
Average monthly number of units available for rental	1,656	1,324
Total housing unit/ apartment complex listings registered on site (includes units that have been leased)	6,075 <i>904 new</i>	5,171
Total number of housing searches conducted by users that returned listing results	2,086,154 <i>495,329 new</i>	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	5,331	4,578
Number of collaborative efforts forged between 211 LA County, County Departments, Red Cross, Federal Emergency Management Agency, HUD and other stakeholder agencies	38 <i>8 new</i>	33

Successes: Several DMH Full Service Partnership organizations have received passwords and training to help housing locators search for special needs housing this past quarter.

Challenges: The national housing foreclosure crisis has increased the need to react more quickly with website information and resources related to homeownership. Additional marketing is also needed to County landlords to increase the number of rental listings to serve the growing demand for affordable rentals.

Action Plan: The website will be used to market foreclosed properties eligible for Neighborhood Stabilization Program funds. The CEO has recommended that the project administration be transferred solely to the CDC and a forthcoming Board Letter will request authority to transfer the contract, authorize the NSP funds, and authorize use of CEO-IT funds to expand the website functionality.

Client Success Story: Neighborworks America provided a logo and link to the StableCommunities.org website that is now displayed prominently on the HRC website as a "partner" organization. This website provides foreclosure resources and information on the Neighborhood Stabilization Program.

"I am elderly and disabled and just lost my home due to foreclosure. I have called agencies throughout Los Angeles County looking for housing. I can't find anything that I can afford. I was at my wit's end last night and called 2-1-1. They gave me your number. I am so pleased to have been helped so promptly. You gave me pricing and direct contact numbers. Now I am able to still live in the areas I prefer, off my own income! You gave me more help than any agency located in my city, I am so pleased. I don't know how to use a computer, but I'm going to learn. I need to start a blog about this wonderful service, I am surely going to pass this number on to help others."(Tenant)

23) Pre-Development Revolving Loan Fund (RLF)

Goal: Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.

Budget: \$20 million

Table D.2: Pre-development Revolving Loan Fund	Quarter/FY
Number of applications received that are eligible for the RLF.	6
Number of projects with a complete environmental review within 90 days.	6
Number of projects with environmental clearance.	6
Average amount of time from receipt of application to loan approval.	-
Dollar (\$) amount of loans distributed by LLC.	-
Average length of time from loan close to loan maturity date.	-
Average length of time from anticipated construction start to end date.	-
Number of loans approved.	-
Number categorized as predevelopment.	-
Number categorized as land acquisition.	6
Number of loans by Supervisorial District.	
Supervisorial District 1	2
Supervisorial District 2	2
Supervisorial District 3	-
Supervisorial District 4	-
Supervisorial District 5	2
Number of special needs households to be served by each loan.	187
Number of low-income households to be served by each loan.	321
Number of proposed total and affordable housing units.	321
Number of housing units to be developed at 60% or below AMI.	508
Number of housing units to be developed at 35% or below AMI.	-
Number of reports collected on time from LLC.	2
Number/percent of lost loans (live to date).	-

Successes: The LACHIF currently has an estimated \$22 million in loans to provide 508 affordable housing units awaiting funding.

Challenges: The United Methodist Church, the LACHIF investor, has temporarily suspended their participation in the fund due to lack of capital.

Action Plan: CDC and LACHIF staff have approached a number of lenders to replace the United Methodist Church.

24) Project Homeless Connect

Goal: Provide individuals and families with connections to health and human services and public benefits to prevent and reduce homelessness.

Budget: \$45,000

Project Homeless Connect (PHC) is designed to bring government, community-based, and faith-based service providers together, as well as other sectors of the local community, to provide hospitality, information, and connections to health and human services and public benefits to homeless individuals and families. PHC provides a unique opportunity for homeless individuals and families to access services in a supportive, community-based, "one-stop shop" setting. The Los Angeles County, Chief Executive Office participates as the lead organizer for local PHC Day events, which normally take place during the first week of December; however, recent need and popularity of PHC Day events have created a situation where the CEO's Office is being requested to plan events on an ongoing, year-round basis.

Successes: Between December 2006, which is the first year the County CEO served as the event coordinator, and February 2009, PHC Day events have served to connect/engage 8,848 homeless participants to public benefits, health and mental health screenings, dental services, voice mail service, substance and alcohol treatment and diversion services, food distribution programs, alternative courts and legal assistance, immunizations, vaccines and flu shots, domestic violence services and shelter, parenting classes, various types of housing, and other health and human services. On April 16, 2009, 115 clients attended the first annual Whittier Connect Day event; approximately 20% of the guests at the Whittier event were classified as "at-risk" of homelessness.

Challenges: Due to the current economy and the fact that families and individuals are losing their homes due to property foreclosures, future Connect events will need to continue to target the at-risk population.

V. CITY AND COMMUNITY PROGRAM (CCP)

Capital Projects

Successes: The CDC is in constant contact with all of the Capital Developers regarding the projects. The CDC has set up internal tracking systems to monitor project progress. Currently all capital projects (except Bell Shelter) are in the pre-development stages. The Bell Shelter project for acquisition should be executed within 60 days. County Counsel has approved the Loan and Deed of Trust agreement templates. The timeline for execution is being determined based on the need of each grantee. It is customary for grants to be executed near the start of construction.

Challenges: The State's current inability to fund previously committed loans has brought a number of developments that include HPI, City of Industry or other CDC funding to a virtual standstill. Construction lenders will not fund or "roll over" to permanent financing without viable commitments from all permanent lenders. The CDC and Housing Authority are reevaluating disbursing loan funds. This has an impact on some HPI projects where funding for both capital and service funding will be delayed until the economic downturn is halted. CDC is working with the State, local jurisdictions and housing advocates to promote new collaborative and risk sharing policies. The failure of the propositions (1A through 1E) on the ballot of May 19th, could adversely impact the State's ability to sell bonds. The bond sales are needed to provide previously committed loan funds made available under Propositions 1C and 46. Many projects funded through HPI, City of Industry, and the CDC's other housing funding also receive Propositions 1C and 46 funding.

Action Plan: The CDC is determining with each developer, whether or not to enter into the grant agreements soon or if it is best to wait until near the beginning of construction to avoid the necessity of several amendments. The CDC staff is providing technical assistance and will be conducting site visits to projects that are seeking funding for rehab of existing buildings.

Cumulative Expenditures to Date: \$406,046

Service Projects

Successes: To date, the CDC has executed 13 of the 15 service contracts that are ready to be implemented. The remaining agencies have successfully met all contract requirements and we expect to have the three outstanding contracts executed by the end of February 2009. While the execution of contracts has taken longer than originally anticipated, with our assistance, agencies have developed detailed, comprehensive budgets and systems that will enable them to effectively track costs once the projects are underway and ensure that funds are sufficient to continue the delivery of services over the entire contract period. We have worked extensively with our Risk Manager to facilitate the review and approval of insurance documentation for both the HHPF/CCP agencies and their subcontractors, while still meeting the County mandated requirements. We believe that this process will be greatly streamlined next year. Most agencies have begun the implementation of their programs by recruiting program staff and developing subcontract agreements with the identified collaborators. To that end, the CDC has assisted a number of agencies in the development of standard subcontract agreements that meet required County provisions.

Challenges: Our greatest challenge has been coordinating the submission of necessary information and documentation to meet all contract requirements. Most delays resulted from poor or lack of communication among different agency staff involved in the program and lack or responsiveness to our request for information. Meeting the County's stringent insurance coverage requirements was another major challenge that delayed the execution of contracts requiring us to work with external insurance brokers, various agency staff, the CDC Risk Manager and County Counsel. Agencies that have executed contracts faced the challenge of recruiting the proper staff to implement the enhanced programs. Some also experienced staff turnover with existing program and fiscal staff, which further delayed implementation and reporting of expenditures.

One service provider, United States Veterans Initiative, notified us that they would not be able to provide services to the Compton Vets Service Center after it is completed. The developer, Cloudbreak Compton,

LLC has provided some preliminary alternative options in their search for another service provider. We anticipate their submittal of revised plans in early March 2009 and will evaluate the proposal accordingly.

Action Plan: Our next challenge will be the implementation of the programmatic and financial monitoring of these projects. We are currently recruiting for one additional staff to assist in this process. We will continue to work closely with the funded agencies as we develop procedures and other resources to address the areas of technical assistance and guidance.

Cumulative Expenditures to Date: \$400,648

25. City and Community Program (CCP)

- a. A Community of Friends (ACOF) – Permanent Supportive Housing Program
- b. Ocean Park Community Center (OPCC) HEARTH
- c. Catalyst Foundation for AIDS Awareness and Care –Supportive Services Antelope Valley
- d. Southern California Alcohol & Drug Programs – Homeless Co-Occurring Disorders Program
- e. Volunteers of America Los Angeles – Strengthening Families
- f. Women’s and Children’s Crisis Shelter

25a) A Community of Friends (ACOF) - Permanent Supportive Housing Program

Budget: \$1,800,000 (City and Community Program)

Table D.1: ACOF			
FY 2008-09, July – December 2008			
(unduplicated count)	YTD		YTD
Homeless Individuals	169	Education	24
Chronic Homeless	36	Job training, referrals	18
Homeless Families	112	Job placement	21
Female	299	CalWORKs	73
Male	256	General Relief w/Food Stamps	40
Transgender	1	General Relief only	3
		Shelter Plus Care	19
Hispanic	140	SSI/SSDI	221
African American	207		
White	98	Alternative court	3
Asian/Pacific Islander	7	Case management	317
Native American	-	Life skills	317
Other	4	Mental health	278
		Health care	155
15 and below	114	Social/community activity	259
16-24	40	Substance abuse treatment (outpatient)	79
25-49	173	Substance abuse (residential)	5
50+	74	Transportation	158
		Residential management support	317
Moving assistance	10		
Eviction prevention	15	Case management (level II)	
Rental subsidy	317	Average hours per case:	6 hours
Housing (permanent)	317	Total number of hours:	6,005 hours
		Caseload:	15 cases

Successes: The HPI funding has led to a collaboration with the Housing Works Mobile Integrated Service Team (MIST), provided for case management services, additional supportive services through Resident Management support, and provided for some much needed repairs and maintenance. The MIST team and case management staff have played an integral role in preventing evictions for those residents in jeopardy of losing housing, and case management staff has been able to ensure that the majority of residents remain permanently housed in a safe and healthy environment.

Challenges: The greatest challenge has been the reporting tool itself. While it may be effective to use one tool to collect data across programs, this sometimes makes it difficult to capture data outside the scope of the reporting tool. For example, spouses and adults in families are often not counted as having received a service, as they are not the "head of household". Challenges the tenants face include struggles with substance abuse, budgeting funds, managing medication, and improving life skills to a level which increases self sufficiency.

Action Plan: Case Management staff will continue to work with the MIST team to focus on those individuals most at risk of losing their housing. In addition, case management staff will work with Resident Managers on "best practices" to increase support when case management staff are unavailable on nights and weekends.

Client Success Story: Incarceration followed by homelessness led Client V to apply at one of ACOF's permanent housing apartments. With stable housing V was able to become stable, obtain benefits, and regain full custody of her children. She went through the vocational training through DMH's Health Advocacy Training Program, and upon completion of the program, she applied and obtained full time employment. By obtaining housing, employment, and remaining stable – Client V is a true success story!

	YTD
Number of organizations that your program has a formal collaboration for this project.	1
Number of times collaborative partners met each month.	25
Total amount (\$) of HPI funding leveraged for project.	\$1,775,550
Percent of HPI funding leveraged for project.	33%

	YTD
Number of participants who have enrolled into program during the reporting period.	23
Number of participants who left the program during this period.	9
Total number currently enrolled in program.	317
Number of clients who received an assessment (if applicable).	n/a
Cost per participant.	\$2,643
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.	29
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.	14
Program Specific Question:	
Number of participants who received benefits (as a result of the program).	317

25b) Ocean Park Community Center (OPCC) HEARTH

Budget: \$1,200,000 (City and Community Program)

Successes: OPCC Project HEARTH convened regular meetings with all project collaborators including Venice Family Clinic (VFC) Medical Director, Operations Director, Physician, Grants' Manager, OPCC Samoshel and Access Center directors, managers and project staff to ensure a smooth flow of services and to make any changes needed to procedures and protocols for intake and referral into the respite beds. The opening of the men's and women's respite beds opened in November (with a soft launch accommodating VFC referrals only), and seven beds were occupied this quarter. The VFC contracted with Central Pharmacy to provide narcotics medication to those patients that would need it while staying in a respite bed. Additionally, the VFC extended their on-site primary health care at the Access Center from three to five days a week in November. A subcommittee of all staff who work directly with the clients/patients at the Access Center and Samoshel was developed to ensure a smooth communication/collaboration process between OPCC and VFC during operating hours.

On December 18th, team members from OPCC Project HEARTH (from VFC, OPCC Access Center and Samoshel) provided an orientation of the Respite Bed Program to St. John's Hospital Emergency Room Department staff, attended by the Director of Social Services, Physician Department Head, discharge

nursing and social service staff. Referrals from St. John's Hospital begin on January 7, 2009. During the second quarter, OPCC Project HEARTH provided expanded five days a week of primary care medical services through VFC Physician and Clinic coordinator which served 71 individuals on-site at OPCC's Access Center. Additionally, 29 intake assessments were completed, seven respite beds were occupied, four clients were placed in emergency housing, and five clients were permanently housed.

Challenges: Combining the reports of different collaborators into one report has been a challenge. OPCC developed a computerized data tracking system for this grant; however, it is still a work in progress. It is anticipated that these problems will be resolved by next quarter. Challenges faced by our clients include a multitude of struggles with substance addiction, severe untreated and chronic mental health issues and very poor physical health conditions which impede their ability to become self sufficient. The absence of adequate low income housing in the Santa Monica community is also a profound challenge as it is difficult to locate landlords who are willing to give our clients – who often have poor credit due to living on the streets, and have many other special needs – a chance. Additionally, the process of assisting clients in obtaining a Section 8 voucher is a long and time consuming process.

Action Plan: OPCC will work closely with our IT consultant to ensure that the problems on the data tracking system will be completed by next quarter. Case management staff and the housing coordinator will continue to work on creative and innovative ways to find community housing alternatives for clients who have limited income. Case managers will also promote other types of permanent housing such as board and care, independent living, and they will look for additional resources out of the Santa Monica area. They will also continue to work on new landlord recruitment.

Client Success Story: AJ, a senior male, had been chronically homeless and sleeping behind an electrical unit in the City of Culver City. He became ill and began utilizing VFC services at the ACCESS Center for health services only. VFC referred the client to OPCC Project HEARTH case management, where he was able to work intensively with a HEARTH case manager and housing coordinator. Client was soon moved into permanent housing in Los Angeles. AJ continues to receive case management services and remains in permanent housing almost a month later.

Table D.2: OPCC HEARTH		
FY 2008-09, July – December 2008		
(unduplicated count)	YTD	YTD
Homeless Individuals	101	Education
Chronic Homeless	80	Job training, referrals
Transition Age Youth	8	Job placement
Female	60	
Male	129	General Relief w/Food Stamps
		Shelter Plus Care
Hispanic	27	SSI/SSDI
African American	52	
White	89	Case management
Asian/Pacific Islander	6	Life skills
Native American	1	Mental health
Other	14	Health care
		Social/community activity
		Recuperative care
15 and below	3	Substance abuse (residential)
16-24	8	Transportation
25-49	106	California identification
50+	68	
		Case management (level II)
Moving Assistance	1	Average hours per case:
Housing (emergency)	4	Total number of hours:
Housing (permanent)	3	Caseload:

	YTD
Number of organizations that your program has a formal collaboration for this project.	4
Number of times collaborative partners met each month.	4
Total amount (\$) of HPI funding leveraged for project.	\$386,770
Percent of HPI funding leveraged for project.	84%
Number of participants who have enrolled into program during the reporting period.	71
Number of participants who left the program during this period.	-
Total number currently enrolled in program.	189
Number of clients who received an assessment (if applicable).	29
Cost per participant.	\$326
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the <i>beginning</i> of the quarter.	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the <i>end</i> of the quarter.	n/a
Program Specific Question:	
Number of participants who received benefits (as a result of the program).	118

25c) Catalyst Foundation for AIDS Awareness and Care - Supportive Services Antelope Valley
 Budget: \$1,800,000 (City and Community Program)

Table D.3: Catalyst Foundation
 FY 2008-09, July – December 2008

(unduplicated clients)	Quarter	Quarter
At-risk Individuals	808	Eviction prevention 1
At-risk Families	15	Rental subsidy 1
Female	133	Education 298
Male	202	General Relief 1
Transgender	1	Medi-Cal/Medicare 1
Hispanic	86	Section 8 2
African American	123	Case management 20
White	127	Health care 826
Asian/Pacific Islander	8	Life skills 370
Native American	1	Mental health care 20
15 and under	-	Social/community activity 35
16-24	313	Transportation 41
25-49	101	Food 88
50+	42	Pet food/vet care 99
Longer-term outcomes (6 months)		
Continuing to live in housing		370
Receiving rental subsidy		1
Case management		20
Health care		192
Level 3 case management services		
Average for each participant per month:		5 hours
Total hours for all participants:		100 hours
Number of cases per case manager:		20 cases
Number of organizations/agencies that your program has a formal collaboration for this project.		28
Number of times collaborative partners met each month.		1
Total amount (\$) of HPI funding leveraged for project.		\$696,919
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).		46%
Number of participants who have enrolled (entered) into program during the reporting period.		808
Number of participants who left the program during this period.		-
Total number currently enrolled in program.		808
Number of clients who received an assessment (if applicable).		20
Cost per participant.		\$863
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.		n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.		n/a

Successes: The Catalyst Foundation was able to provide services to disenfranchised communities that are at high risk for homelessness. Services provided allow our clients to continue to live independently and self-sufficient. Clients mention that a major burden is relieved by the assistance provided; which allows them to focus on other aspects of their lives that require more attention.

Challenges: Some of the challenges experience by The Catalyst foundation during this reporting period has been the loss of our long time Director of Client Services in the month of November. She was involved in all aspects of the organization. Another challenge is that we lost our Case Manager assigned to us by Tarzana Treatment center. He left his position due to budget cuts at Tarzana Treatment Center. Most of our services were provided by our Supportive Services coordinator

Action Plan: The Catalyst Foundation Executive Director is in the process of interviewing candidates to fill the position of Director of Supportive Services. In addition, The Catalyst Foundation is in the process of re-institute the relationship with Tarzana Treatment Center to obtain a Case Manager on site. Once the Director of Supportive Services is hired that person will be responsible to interview and hire additional Case Managers.

Client Success Story: During this quarter, a woman came into the clinic who was very distraught and mentioned that she was having suicidal ideation and had a plan. The Medical Physician Assistant and other staff members provided the woman with support and advised her to go to the psychiatric hospital to obtain help. After several hours of being supported and convincing that she needed more help, the woman agreed to be hospitalized. Our staff worked passed their lunch hour and were very supportive to this woman. Several days later we obtained a call from the woman thanking everyone for helping her make the right choice, and she is now stable and feeling so much better.

25d) Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program

Budget: \$1,679,472 (City and Community Program)

Table D.4: SCADP

FY 2008-09, July – December 2008

(unduplicated clients)	Quarter	Quarter
Homeless Individuals	51	
Homeless Families	6	
(individuals)	13	Housing (transitional) 3
		Mental health care 48
Female	16	
Male	41	
Hispanic	28	Average length of stay for residents 45
African American	12	Residents discharged due to graduation 7
White	17	Discharge status for residents of transfer 1
		Discharge status for residents of walk-out 5
15 and under	7	Discharge status for residents, violated rules 8
16-24	3	
25-49	52	
50+	2	

Number of participants who have enrolled (entered) into program during the reporting period.	51
Number of participants who left the program during this period.	21
Total number currently enrolled in program.	30
Number of clients who received an assessment (if applicable).	47
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.	-

Successes: Services began on October 1, 2009. A full-time therapist is working at one of the men's programs. Psychiatric services began this past December.

Challenges: Current challenges do not involve the onsite service implementation. A major challenge this past quarter was getting approved a subcontractor contract.

Action Plan: For the upcoming quarter, we will be hiring the second therapist for this grant.

25e) Volunteers of America - Los Angeles, Strengthening Families

Budget: \$1,000,000 (City and Community Program)

Table D.5: VOALA			
FY 2008-09, July – December 2008			
(unduplicated clients)	Quarter		Quarter
Homeless Families	1	Eviction prevention	1
(individuals)	4	Housing (emergency)	2
At-risk Families	10		
(individuals)	54	Case management	15
		Life skills	1
Female	34	Mental health	4
Male	25	Health care	1
		Social/community activity	1
Hispanic	59	Substance abuse treatment (outpt.)	1
		Transportation	4
Education	2	Food pantry	2
Job training, referrals	13	Medi-Cal/Medicare	14
Job placement	-	CalWORKs	3
		General Relief w/Food Stamps	4
15 and below	32	General Relief only	-
16-24	5	Shelter Plus Care	1
25-49	20	SSI/SSDI	1
50+	2	Food stamps only	7
Number of organizations/agencies that your program has a formal collaboration for this project.			2
Number of times collaborative partners met each month.			2
Total amount(\$) of HPI funding leveraged for project.			\$1,000,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged).			50%
Number of participants who have enrolled (entered) into program during the reporting period.			11
Number of participants who left the program during this period.			-
Total number currently enrolled in program.			11
Number of clients who received an assessment (if applicable).			11
Cost per participant.			-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.			-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.			-

Successes: There are families with extreme need, and VOALA is currently building relationships with families.

Challenges: A large numbers of families are in need, but there are limited housing and employment resources.

Action Plan: Building partnerships and identifying resources.

Client Success Story: Program will report in the next quarterly report. It's too early in the program to report.

25f) Women's and Children's Crisis Shelter

Budget: \$300,000 (City and Community Program)

Table D.6: Women's and Children's Crisis Center			
FY 2008-09, July – December 2008			
(unduplicated clients)	Quarter		Quarter
Homeless Families (individuals)	11	15 and below	13
	24	16-24	4
Female	18	25-49	7
Male	6	50+	-
Hispanic	18	Housing (emergency)	22
African American	2	Housing (transitional)	2
White	2		
Asian/Pacific Islander	-		
Native American	-		
Other	2		
Program Specific Measures			Quarter
Number of hotline calls that are related to domestic violence issues.			47
Number of hotline calls that are related to homeless issues.			70
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.			33
Number of individuals reunited with their families.			-
Number of participants who have enrolled (entered) into program during the reporting period.			24
Number of participants who left the program during this period.			15
Total number currently enrolled in program.			7
Number of clients who received an assessment (if applicable).			-
Cost per participant.			-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter.			2
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter.			6

Successes: Three of our families continue to reside in our emergency shelter. One family continues to reside in our transitional shelter and is doing very well.

Challenges: It is very difficult to find transitional shelter for our clients residing in our emergency shelter due to the fact that there is limited availability.

Action Plan: Participants residing in our shelter programs will continue to receive individual counseling, domestic violence classes, parenting classes, as well as transportation.

Client Success Story: A family of two who was residing in our emergency shelter was accepted into a six month transitional shelter. She and her child entered the transitional shelter program along with a restraining order.

VI. COUNCIL OF GOVERNMENTS (COGs)

Lessons learned and recommendations from final reports will be included in the next status report. Below is information provided from earlier reports:

26a) San Gabriel Valley Council of Governments (SCVCG)

Budget: \$200,000 (On-going)

During the past quarter, SCVCG has engaged their consultant, Corporation for Supportive Housing (CSH), in a two-phased approach to achieve the following objectives: 1) population identification and needs assessment and 2) a consensus-building process for a proposed strategy and implementation plan to meet these stated needs.

During the first quarter of FY 2008-09, SCVCG has been working with CSH to:

- Complete the Draft Phase I Report;
- Present findings to various stakeholder groups including: COG Homeless Steering Committee, COG Housing Committee, COG Planner's Technical Advisory Committee (TAC), Key Service Providers, and COG City Managers TAC; and
- Revise the Phase I Report to incorporate stakeholder feedback.

An inventory of services was conducted, and the following was reported:

- Fourteen cities in the SGV reported a total of \$1,348,986 in local investments to provide homeless services and housing during the current fiscal year.
- The region has a total of 11 outreach teams and five access centers.
- Homeless population estimates were provided. A total of 10,911 homeless persons live in the region (based on LAHSA and City of Pasadena, 2007). A local estimated count of homeless persons is 5,034 (median 7,977).
- Six preliminary study areas/clusters of the region were provided with a breakdown by gender, race, and sub-population. Regional maps were used to illustrate findings.
- The location of housing by type as well specialized supportive services were shown on regional maps. Additionally, the ratio of short-term beds to homeless single individuals/family members/chronically homeless individuals in need of permanent housing was also shown by region.
- A service gap analysis showed the need for increased coordination and information sharing, short-term housing, permanent supportive housing, and increased/specialized mental health services.
- Recommendations for short-term strategies/long-term strategies will be addressed in Phase II of the study. Phase II will also include work with San Gabriel Valley leadership to: 1) develop consensus on these findings; 2) determine housing and service delivery models; and 3) identify federal, state and local resources for implementation of strategies.

26b) PATH Partners/Gateway Cities Homeless Strategy

Budget: \$135,000 (On-going)

During the first quarter of FY 2008-09, the following are highlights of specific tasks:

Task 1: Assess/Analyze Existing Services

- Confirmed 25 of the 27 cities to participate in the Gateway Cities Homeless Strategy. Secured City Manager designees for each of the 25 cities.
- Obtained homeless count data from LAHSA and the City of Long Beach. A preliminary analysis of the homeless count data was provided. Completed preliminary inventory and analysis of existing services and housing (emergency, transitional and permanent supportive housing) available to homeless persons.

Task 2: Identifying Underserved Regions and Populations

- Conducted 15 interviews with community stakeholders in over eight Gateway cities, including representatives from law enforcement, homeless services, faith groups, education, city departments

and senior housing. Through the interviews, groups are being asked about existing services, gaps in services, and challenges & opportunities for addressing homelessness on a local and regional level.

- Conducted one focus group with homeless individuals from the City of Long Beach, hosted by their Multi Service Center. Participants were both male and female, and had been homeless and were from Long Beach. Participants were asked a series of questions about where they have identified services, challenges to accessing services and areas of unmet need. Findings from the focus group are currently being analyzed and will be incorporated into the strategy along with findings from the stakeholder interviews.
- The *Community Survey on Homelessness* tool has been finalized. Dr. Christie Jocoy, Assistant Professor at California State University, Long Beach, provided support and expertise in finalizing the survey design. Additionally, she and her students will assist in analyzing the survey results. The survey is available in English and Spanish, and is available online and in print format. The survey was distributed to City Manager designees on October 20, 2008. The designees are assisting PATH Partners in forwarding the survey to a minimum of 10 respondents per city. Respondents will represent one of the following groups: business, City Housing office, other City office, faith group, healthcare provider, resident or service provider. The survey will be distributed to 300 respondents and the anticipated deadline for survey collection is Friday, November 7, 2008. California State University,

Task 3: Funding Plan

- The Funding survey was distributed to 25 cities to request information on city funds designated towards homeless services and housing. Twenty-two cities have completed and returned the funding survey. A preliminary assessment of the funding resources received by GCCOG cities was produced.

Task 4: Work with Local Governments (Gateway Cities and Los Angeles County)

- PATH Partners and GCCOG have proposed the division of the Gateway cities into four separate groups. The formation of these four groups will enable the collection of data/community feedback and will begin future planning for smaller, more localized, multi-city responses to homelessness.

Task 5: Develop "Gateway Cities Homeless Strategy"

- As data and community feedback are obtained from the previous task areas, the team will move forward in compiling the draft Gateway Cities Homeless Strategy.
- On Wednesday, November 12, PATH Partners facilitated four planning meetings that bring together cities and a diverse group of stakeholders groups, including law enforcement, faith groups, businesses, residents, providers and other community groups. The purpose of the meeting was to bring local stakeholders together to identify the needs and challenges of serving the homeless, and to provide leadership in planning for local approaches and solutions to address homelessness.

An inventory of regional services was conducted, and the following was reported:

- The Gateway Cities Council of Governments (GCCOG) region includes 27 cities.
- It is estimated that 14,000 homeless live in the region (based on LAHSA and City of Long Beach, 2007).
- Approximately 2,000 emergency and transitional beds and 750 permanent supportive housing units are currently located in the region.
- The numbers of programs that offer specific support services were: 7 street outreach/emergency response programs; 8 multi-service centers; 20 medical detoxification programs; and 10 community education programs.
- Percentages of emergency, transitional, and permanent supportive housing beds were shown by population.

Table E.1 Population	Emergency Housing Beds	Transitional Housing Beds	Permanent Supportive Housing
Single Adults	61%	53%	93%
Families	36%	36%	4%
Youth (ages 18-24)	3%	11%	3%

27) Los Angeles Homeless Services Authority (LAHSA) Contracted Programs

Goal: Emergency shelter and transitional housing are provided to families and individuals.

Budget: \$ 1,735,000 (One-Time Funding)

Of these nine programs, seven program will have ended as of March 15, 2009; and two programs will end on June 30, 2011.

Table E.2: LAHSA Participants and Services							
(unduplicated clients)	FY 2007-08	FY 2008-09	Total		FY 2007-08	FY 2008-09	Total
Homeless Families	483	114	597	Adult**	6,064	822	6,886
Homeless Individuals	3,162	554	3,716	Child	1,029	219	1,248
Chronic Homeless	2,206	120	2,326				
Female	1,938	216	2,154	Emergency housing	5,869	745	6,614
Male	3,931	581	4,512	Transitional housing	-	52	52
Hispanic*	1,385	305	1,690				
African American	2,838	336	3,174				
White	2,004	576	2,580				
Asian/Pacific Islander	151	41	192				
Native American	168	48	216				
Other	1,598	40	1,638				

*LAHSA uses the federal definition of Hispanic origin (which for the Feds includes all Spanish speaking nations in the Americas and Spain). There are two options: Hispanic or Non-Hispanic.

**LAHSA defines an adult as a person 18 years of age or older.