

# **A Ten Year Plan to End Chronic Homelessness**

**Prepared For**

**The Citizens of Kern County**

**By**

**United Way of Kern County**

**&**

**The Kern County Homeless Collaborative  
10-Year Plan Steering Committee**





City of Bakersfield  
California  
Office of Mayor Harvey L. Hall



May 2008

Dear Friends,

It is my pleasure to present *Home First: Kern County's Plan to End Chronic Homelessness*, a 10-year action plan created by the collaborative efforts of the nonprofit, business, faith and public sector communities to address the challenging issue of homelessness at its core.

Far too many Bakersfield and Kern County residents are walking a financial tightrope, barely making ends meet from one month to the next and living in fear that a job loss or unexpected expense could cause them to lose their homes. Others, who suffer from chronic problems such as poor health, mental illness, or substance abuse, are unable to maintain stability in employment and housing to meet their basic needs. Still others experience domestic violence or age out of foster care, or are released from prison or jail with no job skills, life skills or support system. These are the homeless among us. The more fortunate among them will regain stability in a short time with a modest degree of assistance. But for others, homelessness becomes a chronic condition.

*Home First* focuses on breaking the cycle of chronic homelessness by providing permanent, supportive housing solutions for this most challenging homeless population. Eliminating chronic homelessness is not only the compassionate thing to do; it is the smart thing to do for the greater good of our communities. Ensuring the availability of affordable housing, effective medical and behavioral health treatment, family supports, and opportunities for work and other meaningful activities are both more humane and cost effective than maintaining an ever-expanding homeless service system.

*Home First* includes both prevention and intervention strategies. With this plan, our community makes a commitment to change its approach from managing homelessness to ending it once and for all. It is not a simple task. It is not a task that can be accomplished by government or by any single sector alone. It will take a focused, collective effort of all segments of the community.

I know the people of Bakersfield and Kern County have great compassion for the less fortunate among us. Time after time, I have seen them extend a helping hand. They support faith-based and nonprofit groups in providing meals, clothing, temporary beds, shelter and services for people who are homeless and at risk of becoming homeless. City county, state and federal agencies spend millions of dollars on social services, law enforcement and health care to respond to the needs of the homeless. Still, on any given night, more than 1,500 of our neighbors are homeless.

It is my strong belief that every individual and family deserves safe, affordable housing. I know the caring and compassionate people of Bakersfield and Kern County share this goal. It can be achieved through proactive, coordinated action and investments in cost-effective initiatives that solve homelessness.

We have developed the plan. Now the real work begins. I am asking that you please join us now in ending homelessness in our community.

Sincerely,



Harvey L. Hall  
Mayor

## Table of Contents

PREFACE.....	4
Chronic Homelessness Initiative.....	4
A Housing First Approach.....	5
The 10-Year Plan Committee .....	8
INTRODUCTION .....	13
The Homeless.....	13
Causes of Homelessness .....	13
Defining Homelessness.....	14
Kern County’s Response to Homelessness.....	16
The Extent and Nature of Homelessness in Kern County .....	17
The Hidden Costs of Chronic Homelessness.....	21
The Costs of Chronic Homelessness to Kern County.....	22
Identifying Gaps and Impediments.....	23
THE PLAN .....	27
Objective #1 .....	27
Objective #2.....	41
Objectives #3 .....	52
FUNDING STRATEGIES.....	61
Greater Integration and Coordination of Existing Resources.....	61
Leveraging Resources from Every Segment of the Community .....	61
Redirecting Major Resources to Permanent Supportive Housing .....	62
New Funding Sources.....	64
IMPLEMENTATION.....	71
Step #1 – Homeless Coordinator .....	71
Step #2 – Oversight Committee.....	72
Step #3 – Marketing.....	72
Step #4 – Engagement .....	73
Step #5 – Funding.....	73
Step #6 – Integration.....	73
Step #7 – Rooms and Residences .....	74
Step #8 – Sustain and Update the Plan .....	74
Step #9 – Tracking.....	74
Glossary & Abbreviation Chart .....	78
APPENDICES .....	83
Appendix A.....	83
Appendix B.....	85
Appendix C.....	87
Appendix D.....	90
Appendix E.....	91
Appendix F.....	94
Appendix G.....	96
Appendix H.....	99
Appendix I .....	105

## **PREFACE**

### ***Chronic Homelessness Initiative***

The *Chronic Homelessness Initiative* is a nationwide campaign coordinated by the United States Interagency Council on Homelessness (ICH), to target federal, state, and local homeless assistance and other resources to people who meet the federal definition of "chronically homeless." This initiative was undertaken in response to research findings in cities like New York showing that while the chronically homeless comprise a smaller portion of the total homeless population, they use an inordinate amount of available services and resources. Also known as the "street" or "hard core" homeless, the chronically homeless frequently cycle through emergency rooms, jails, hospitals and detoxification programs at enormous cost to taxpayers, and are also a disturbing presence around businesses and neighborhoods where they gather.

The goal of ending chronic homelessness has achieved national prominence in a very short time. It was first articulated in July 2000, when the National Alliance to End Homelessness included it as part of its 10-year plan to end homelessness altogether. President Bush made "ending chronic homelessness in the next decade a top objective" in his FY 2003 Budget. The U. S. Conference of Mayors adopted it, and by 2004 more than 100 cities and many states committed themselves to this goal.

*Instead of serving homeless  
people endlessly, our  
mission is to end their  
homelessness.*

**Philip F. Mangano, Executive  
Director, Interagency Council  
on Homelessness**

In late 2005, Bakersfield Mayor Harvey Hall convened a committee of service providers and local government agency representatives to begin work on a 10-Year Plan to End Chronic Homelessness (TYP). With assistance from United Way of Kern County (UWKC), and the Kern County Homeless Collaborative (KCHC), the committee has expanded to include more than 35 partners from the nonprofit, government, faith and business communities. The 10-Year Plan Committee (TYPC) has been designated as a committee of the Kern County Homeless Collaborative, although its membership reaches well beyond the service providers who make up the Collaborative.

Initially, a representative from the United States Department of Housing and Urban Development (HUD) was contacted and through HUD's engagement the Kern County 10-Year Plan was provided grant-funded facilitation to begin the process. The first step in the process involved establishing a model to follow in developing the 10-Year Plan. The plan required a model based on a fundamental shift in how all sectors of the community thought about homelessness, and how all responded to meeting the needs of chronic homeless people. Based on the recommendation and urging of the Interagency Council on Homelessness, the 10-Year Plan Committee adopted a "Housing First" approach (for a full timeline see Appendix A).

### **Why a 10-year plan?**

- Homelessness is unacceptable to us as a community.
- Reaching the goal of truly ending chronic homelessness in our county requires a new mindset and a new degree of collaboration involving all sectors of the community including city and county government, nonprofit service programs, churches and temples, local businesses, and concerned citizens.
- Having a concrete plan for ending chronic homelessness positions the community to take maximum advantage of federal resources for homelessness. Since 2000, when the federal government declared that its goal was to end chronic homelessness within 10 years, federal funding has been increasingly targeted toward this goal.
- A plan provides the framework for aligning all efforts throughout the community, and a starting point to work together on determining how we will carry out this system-wide change.

### ***A Housing First Approach***

It is widely accepted that the homeless service network in the United States, while working admirably to provide services and shelter to the homeless population, is not doing enough to permanently end homelessness.

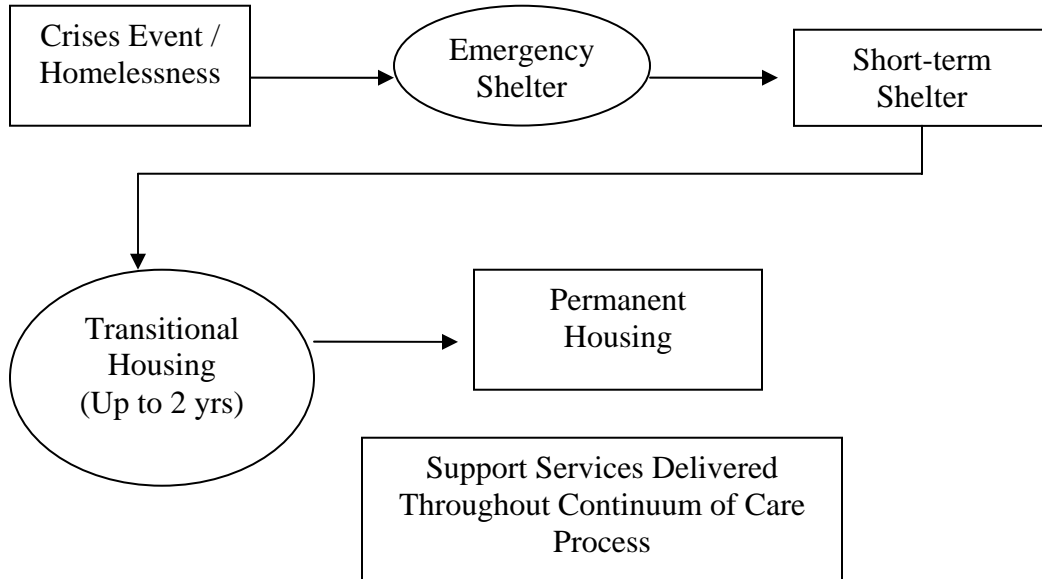
The current system – which moves people from emergency shelters, to short term shelters, to transitional housing, to permanent housing – works well for some in the homeless population, but for others it sends them back out to the streets and ultimately back through the same system again. This process is costly, ineffective for meeting and managing the special needs of the chronically or permanently homeless, and generally inefficient.

Much of the current spending on homelessness is aimed at providing emergency services and shelter to the homeless with less emphasis on developing permanent housing solutions. The resultant cycle of shuffling people from service to service leads many into chronic or permanent homelessness. New innovative solutions are needed to transition the homeless away from emergency and transitional housing to permanent supportive housing, from a *housing readiness* model to a *housing first* approach.

In the *housing readiness* model, people move along the Continuum of Care when they are “ready” or “eligible” for a specific type of housing, usually by articulating a desire for change or agreeing to comply with eligibility requirements. The chronically homeless do not move along the continuum, because they are never “ready.” The housing readiness model requires compliance with service and treatment plans, and services are only available as long as a person lives at the program site. The mentally ill chronically homeless are focused on surviving from one day to the next, often not realizing the existence of their illness. They cannot move along the Continuum, off the street, into

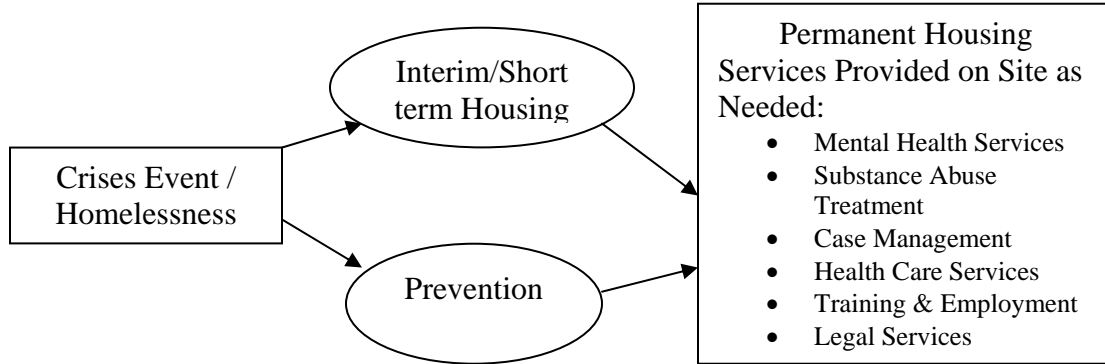
transitional or permanent housing using the traditional components of the Continuum of Care with their high demand for cooperative, goal-oriented, and consistent behaviors. A different service delivery model has to be utilized to house the chronically homeless population.

*Housing Readiness Model*



A *housing first* approach seeks to assist persons to exit homelessness as quickly as possible by placing them in permanent housing and giving them access to needed services (service-enriched supportive housing). This approach assumes that the factors that have contributed to a person's homelessness can best be remedied once the individual is housed rather than in emergency shelters or transitional settings. It also accepts that for some lifelong support may be required to prevent the reoccurrence of homelessness. Hence it seeks to maximize utilization of mainstream resources. The model also seeks long-term self-sufficiency, promoted through a wraparound service philosophy.

## *Housing First Model*



A research team from the Center for Mental Health Policy and Services Research, University of Pennsylvania, has published the most comprehensive study to date on the effects of homelessness and service-enriched housing on mentally ill individuals' use of publicly funded services.

The study tracked 4,679 homeless people with psychiatric disabilities who were placed into service-enriched housing in New York. Researchers examined these individuals' use of emergency shelters, psychiatric hospitals, medical services, prisons, and jails in the two years before and in the two years after they were placed into housing. Then the researchers compared client service use in these two time periods to the service use of control groups of homeless individuals with similar characteristics who had not been placed into housing.

Key findings from the study were:

- A homeless mentally ill person in New York City uses an average of \$40,449 of publicly-funded services over the course of a year.
- Once placed into service-enriched housing, a homeless mentally ill individual reduces his or her use of publicly-funded services by an average of \$12,145 per year.
- Accounting for the natural turnover that occurs as some residents move out of service enriched housing, these service reduction savings translate into \$16,282 per year for each unit of housing constructed.
- The reduction in service use pays for 95 percent of the costs of building, operating and providing services in supportive housing, and 90 percent of the costs of all types of service-enriched housing in New York City.
- \$14,413 of the service reduction savings resulted from a 33 percent decrease in the use of medical and mental health services directly attributable to service-enriched housing.

- Much of these savings resulted from New York City residents’ experiencing fewer and shorter hospitalizations in state psychiatric centers, with the average individual’s hospital use declining 49 percent for every housing unit constructed.
- On average, shelter use decreased by more than 60 percent, saving an additional \$3,779 per year for each housing unit constructed.

Source: NY/NY Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals. By D. Culhane, S. Metraux, T. Hadley, Center for Mental Health Policy and Services Research, University of Pennsylvania

### ***The 10-Year Plan Committee***

In order to successfully launch a Housing First initiative the 10-Year Plan Committee with the help of United Way of Kern County and the Kern County Homeless Collaborative began the process by developing buy-in and establishing a mindset among service providers that prioritized permanent housing as an essential first step in assuring that homeless individuals and families gain stability. The 10-Year Plan Committee committed to building community and political consensus on policies and plans which reflected a community-wide commitment to ending homelessness. It also began developing a range of housing solutions including affordable housing (rental and owned), permanent supportive housing, transitional housing, and shelter spaces.

The 10-Year Plan Committee continued the process by collaborating and dividing into workgroups to address specific issues surrounding the housing first strategy. Based on input from various stakeholders, the 10-Year Plan Committee appointed nine workgroups. Each workgroup had a specific mandate and work plan that was independent but interdependent.

Eventually, a tenth workgroup (Branding) was commissioned to develop a logo and motto for the 10-Year Plan. Ultimately, the motto *Home First! Kern County’s Plan to End Chronic Homelessness* was selected.

As the 10-Year Plan Committee solidified and advanced its platform, permanent supportive housing for the chronically homeless was the priority goal, but the 10-Year Plan’s ultimate objective was to ensure that all individuals and families in our County have access to safe, decent and affordable housing (for a complete list of 10-Year Plan Committee members and their subcommittee assignments see Appendix B).

### **Guiding Principles Subcommittee:**

This subcommittee was charged with collaboratively developing an appropriate set of principles to guide the full committee and the community at-large in the development of the 10-Year Plan to End Chronic Homelessness. Upon development, the guiding principles were submitted to the steering committee for review and approval. Following approval of the guiding principles, the subcommittee continued to evaluate whether the planning process adhered to them.

## **Guiding Principles**

**Solving chronic homelessness is the morally correct thing to do and will improve the quality of life for the entire community.** This overriding principle provides the basis for moving forward with setting goals and objectives and taking the actions necessary to be successful.

**Chronic homelessness has a significant financial cost to the community and a detrimental effect on business.** It is difficult to quantify the cost to our community; however, other communities have estimated the financial cost at between \$40,000-\$50,000 per year per chronically homeless individual.

**Solving chronic homelessness will require a variety of housing and integrated services.** Housing First strategies (housing and integrated services) now being offered in other communities are showing significant achievements in reducing, preventing and eliminating chronic homelessness and result in significantly reduced costs to the community.

**Leadership and commitment from all sectors of the community are necessary to prevent and eliminate chronic homelessness.** A collaboration of individuals and organizations from all sectors of the community who believe in these principles and are willing to devote time and energy to work on the goals and objectives established will be necessary to be successful.

## **Government & Community Relations Subcommittee:**

The duties of this subcommittee included coordinating activities of the full 10-Year Plan Committee in order to gain traction within the city and county governments and the community at-large. They were also charged with advising the full committee on matters of policy, and to serve as a liaison with government entities for consultation and advice; considering the effects of significant policy changes on government and community relations. An additional responsibility involved seeking to meet with the relevant city and county elected officials and city/county staff leadership at least quarterly and consult with other members of the government or community on an on-going basis.

## **Data/Cost Subcommittee:**

This subcommittee was charged with studying, quantifying, and reporting on cost conditions within any sector of the community, that were in its judgment, related to the costs of managing the chronically homeless. Particular emphasis was placed on institutional spending (City/County Departments and Divisions, Hospitals/Health Care, Public Safety/Jails, etc.) on the chronically homeless in Kern County. The subcommittee's ultimate goal was to identify a per capita number, or what our community spends per homeless individual a year. Once the processes in the 10-Year

Plan are initiated, the subcommittee is to continue to evaluate cost data and benchmark our community's performance against prior spending levels.

### **Project Cost and Funding Strategies Subcommittee:**

This subcommittee was charged with studying, quantifying and reporting on the estimated costs associated with developing the housing stock and solutions the full committee recommended. Once the cost of projects has been estimated the subcommittee was to develop funding strategies to bring these projects to fruition.

### **Housing Strategies Subcommittee:**

This subcommittee was to study best practices from other regions and recommend the housing solutions and types of development needed to complete the goals laid out in the 10-Year Plan. The subcommittee was to coordinate nonprofits involved in the process and/or currently receiving Continuum of Care funding to ensure that they are focusing their housing strategies on targeted solutions and populations. The subcommittee was to also identify potential private sector stakeholders and private-public partnerships that could be utilized to develop housing solutions.

### **Discharge Planning Subcommittee:**

The subcommittee was to recommend and research implementation strategies for broad-based policy changes designed to: provide adequate and accessible resources to conduct appropriate discharge planning; and attempt to hold institutions accountable for discharging people to housing and other related support services.

### **Outreach and Consumer Awareness Subcommittee:**

This subcommittee was created to oversee and implement coordination among homeless and other service systems, implementing best practice standards for outreach and engagement to help move homeless individuals into permanent housing. The subcommittee was to also solicit consumer feedback on barriers to accessing housing and services.

### **Prevention Subcommittee:**

This subcommittee was to oversee and implement coordination among homeless and other service systems, advising on best practices and policy strategies to prevent at-risk populations from falling into homelessness. The subcommittee was to liaise with the Government & Community Relations subcommittee to ensure communication of recommendations to the appropriate public, private, and nonprofit partners.

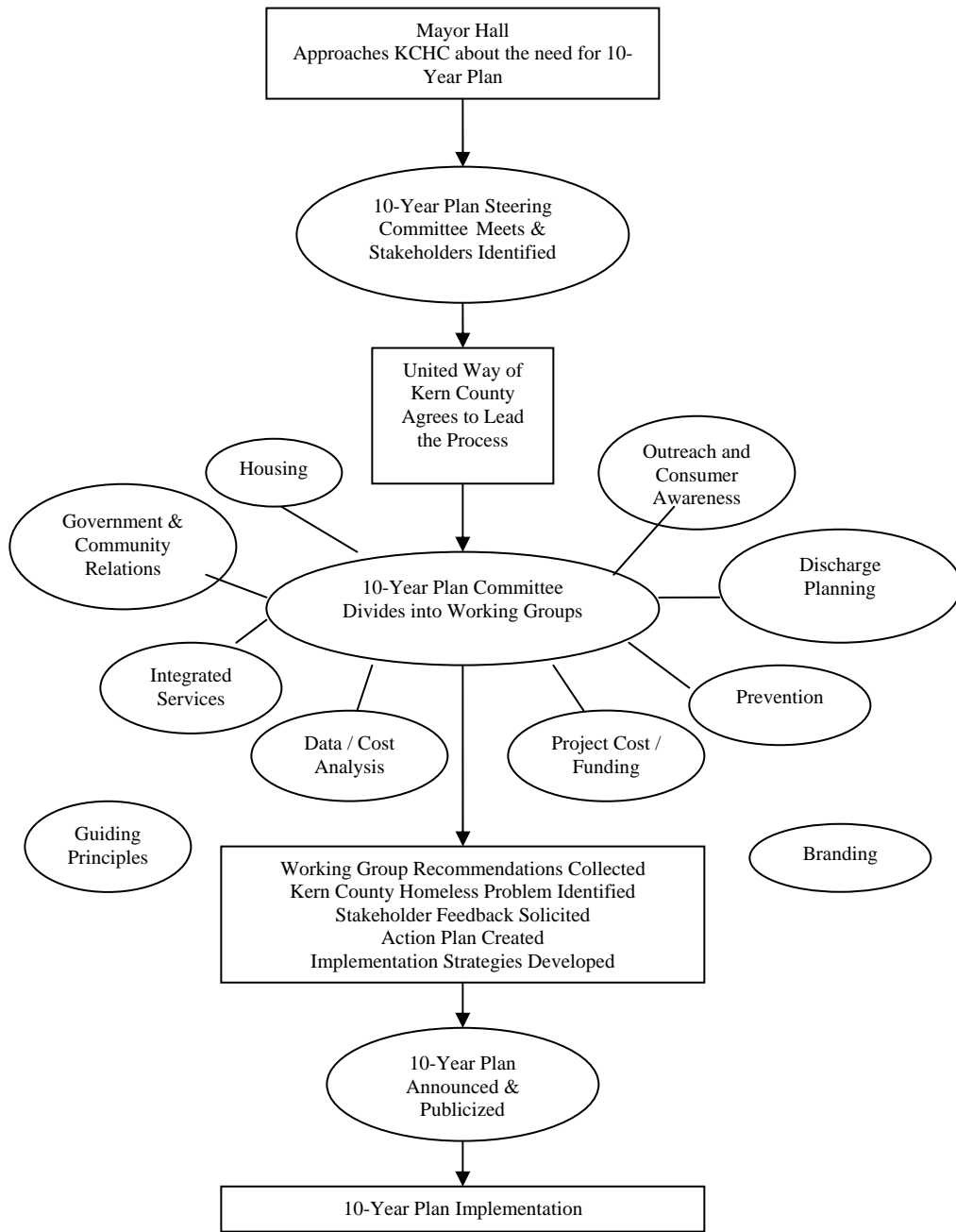
### **Integrated Services Subcommittee:**

This subcommittee was to oversee and implement coordination among homeless and other service systems, advising on best practices and policies to ensure that homeless

individuals have the greatest access to vital services. The subcommittee was to develop implementation strategies for ensuring that the permanent housing solutions borne out of the plan will have the resources to be truly “service-enriched”.

What follows in this document is the fruition of the work performed by the various Subcommittees and their vision for ending chronic homelessness in Kern County.

## How the TYP Process Developed



# **INTRODUCTION**

## ***The Homeless***

The homeless population of today is diverse and includes people from all walks of life. They are individuals and families, men, women and children of every age and ethnic background.

Families with young children (typically involving single mothers) are the fastest growing subgroup, accounting for 35% to 40% of homeless people nationwide, according to the US Conference of Mayors. Children under 18 comprise up to 25% of the homeless population.

Single men account for 40% to 50% and single women account for 10% to 15% of the homeless population.

The average age of the homeless population is 35 years, but seniors over 55 years range from 2% to 19%. In rural areas, the proportion of families is much higher.

Poor people are most at risk of becoming homeless, and demographic groups who are more likely to experience poverty are also more likely to experience homelessness. People of color are a large proportion of people in poverty and thus account for over half the numbers of homeless people nationwide.

People suffering from substance abuse account for one-third of the homeless, mentally ill people account for one-fourth to one-third.

One-third of the male homeless population are veterans.

A significant number of the homeless people lived in foster homes as children.

Battered women who live in poverty are often forced to choose between abusive relationships and homelessness.

Nationally, between one and two million people may become homeless each year. Most manage to find income supports and housing, but a small but visible proportion of the homeless population, perhaps 10% to 15%, are chronically homeless people. Typically, this group is made up of single adults with disabilities, including people with serious mental health, substance abuse, medical or physical problems, who have been homeless for long periods of time, or have been repeatedly homeless.

## ***Causes of Homelessness***

Two issues largely responsible for homelessness are poverty and the shortage of affordable rental housing. Homelessness and poverty are inextricably linked.

*Lack of Income.* The poor are frequently unable to pay for housing, transportation, food, childcare, health care, and education. Many people exist in a state of “crisis poverty,” and are literally a paycheck away from living on the streets. According to the Federal Government the current poverty line for a family of four is \$20,650.

*Affordable Housing Gap.* The gap between the number of affordable housing units and the number of people needing them has created a housing crisis for poor people. The housing bubble caused rents to soar, putting housing out of reach for the poorest Americans. Nearly two-thirds of all poor families are cost burdened and cannot afford the housing in which they live. Housing costs escalate faster for poor people than for any other group. This has led to high rent burdens, overcrowding, and substandard housing. These phenomena, in turn, have forced many people to become homeless, and have put a large and growing number of people at risk of becoming homeless.

*Other Factors.* There are multiple reasons why people become homeless. Among the most common precipitating factors are: substance abuse; mental illness; financial crises related to unemployment, medical problems or other unforeseen events; and domestic violence.

### ***Defining Homelessness***

Just as there are many causes of homelessness there are also many categories of homelessness. This Plan distinguishes between three types: transitional, episodic, and chronic. It also addresses other sub-types of homelessness that do not fit neatly into the three major categories.

*Transitionally Homeless:* Almost 90% of those who experience homelessness each year are experiencing a first or second episode of homelessness which typically lasts less than one year. An estimated two-thirds of this sub-population live in family households. Typically, a job loss, illness or eviction causes them to lose their housing. Unable to find other housing that is affordable and/or resolve their lack of income, they become homeless.

#### **Did You Know?**

- According to the Kern County Department of Human Services, 16,900 families in Kern County receive Cash Aid.
- 18% of Kern County families are living on incomes below the poverty level.
- In Kern County approximately 53% of all renter households are cost burdened, meaning they spend over 30% of their monthly income on housing.
- According to the 2007 NAHB/Wells Fargo Housing Opportunity Index, Bakersfield/Kern County ranked 21<sup>st</sup> in the *nation* in housing unaffordability.
- According to a new study commissioned by Housing California, a minimum wage earner in Kern County would have to work 106 hours a week to afford a Fair Market Rental (FMR) apartment in our area.
- According to RealtyTrac, as of January 2008, the city of Bakersfield ranks number nine in the nation in home foreclosures.

*Episodically Homeless:* The episodic homeless tend to be younger and shuttle among various institutions including jail, detoxification centers, residential treatment and hospitals. Episodic homeless need enriched transitional housing providing treatment for alcohol or drug dependency, medical and mental health issues.

*Chronically Homeless:* This category is estimated to include about 40% of the population that is homeless on any given night and slightly more than 10% of those who experience homelessness over the course of a year. They are severely disabled with a mental health condition, physical illness or substance abuse problem, and they have been homeless for a year or longer or have had at least four episodes of homelessness in the last three years. They are the most visible segment of the homeless population and the focus of community frustration due to their ongoing habitation of public places and their non-conforming behavior. Though a small percentage of the overall yearly homeless population, chronically homeless people use the majority of resources within the homeless service system and are costly to mainstream systems because of frequent interactions with hospitals, mental health crisis services, detox programs, and the criminal justice system. Because the services they receive tend to be fragmented and accessed only in crisis, their high service usage does not translate into long term gains in stability, but often reinforces their alienation and distrust of the service system. (Source: U.S. Interagency Council on Homelessness [ICH])

**A chronically homeless person is defined by HUD is:**

"...an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years."

While the primary focus of the 10-Year Plan is on chronic homelessness, the plan will secondarily address those who are at-risk of homelessness. HUD considers the following persons to be at-risk of homelessness. Those who are:

- paying an excessive amount of their monthly income (50% or more) for their housing
- living in substandard housing in need of repair
- living in housing that is crowded (such as instances when more than one household shares a single-family dwelling due to economic hardship)
- living in a long-term (greater than 30 days) temporary arrangement with relatives or friends
- being discharged from a public or private system of care with no subsequent housing identified and lacking the resources and support networks needed to obtain housing
- living in a Board and Care, Adult Congregate Living Facility, or similar place
- living as wards of the state, including youth in foster care or juvenile detention facilities

*Home First!* will include prevention plans that address specific areas to ensure that those who are at-risk do not become homeless. Two of those areas involve the precariously or marginally housed and those who are discharged into homelessness.

*Precariously or Marginally Housed:* These are individuals or families who lack a permanent residence and are most often living doubled-up or tripled-up with other family members or friends, and who are subject to having to leave that housing in the very near future. Others are living more or less independently on extremely limited income, often in substandard housing, with a high potential for eviction due to non-payment of rent, utility cutoff, or condemnation of the property due to the condition of the property.

Many low income families reside in weekly motels, often considered de facto homeless shelters, which are more expensive monthly than apartments. Households reside in these motels due to numerous factors, which include low wage earnings, poor credit history and/or inability to save enough for move- in expenses. Many households reside in motels until their money runs out, and then reside in shelters as a monthly cycle of homelessness.

*Discharged Into Homelessness:* Many people are released from public institutions directly into homelessness, to the streets or to shelters. These institutions include the foster care system, jails and prisons, mental health programs, drug and alcohol programs, and hospitals. Too often these systems do not engage in pre-release permanent housing planning to ensure that those discharged have stable housing and are linked to necessary services to ensure their ongoing stability and facilitate their transition back into the community. Individuals who have serious disabilities and who are discharged without receiving appropriate assistance often become part of the costly chronic homeless population.

Homelessness is an ongoing problem that affects a diverse group of people. It has many causes that require a comprehensive solution. Different types of homelessness can be broadly categorized into three groups. In addition to those who are already in a state of homelessness, there are those who are at risk of becoming homeless. *Home First: Kern County's Plan to End Chronic Homelessness* will address their needs as well.

### ***Kern County's Response to Homelessness***

There have been two major community-wide efforts to address the problems of homelessness in Bakersfield and Kern County.

*Kern County Homeless Coalition Task Force.* In 1986, the Bakersfield City Council and Kern County Board of Supervisors jointly appointed the Kern County Homeless Coalition Task Force, consisting of elected officials, public agencies and private nonprofit organizations, local businesses and homeless people, "to recommend solutions to the problems of homelessness both with regard to better assisting the homeless and to alleviating its adverse effect on the Community" with a special emphasis on the Baker Street corridor.

The Task Force, which met for about two years, arrived at a set of recommendations, chief among which was to establish a homeless day center that would be a full service, one-stop center for the homeless population. It also recommended that the day center include an overnight shelter, run by a lead agency appointed by the City - a recommendation that led to the creation of the Bakersfield Homeless Center. Another recommendation that was not implemented was a reception center/detox facility for public inebriates.

*Kern County Homeless Collaborative.* The Kern County Homeless Collaborative was formed in 1998, following a town hall meeting to discuss gaps in the homelessness Continuum of Care (CoC). On January 18, 2005 the Kern County Homeless Collaborative officially adopted by-laws. Its

Over the past 20 years, nonprofit housing and service agencies, the City of Bakersfield, the County of Kern, and the outlying cities have built a homeless service network comprised of more than 44 housing and service programs. This includes many outstanding programs that have shown some success in *managing* the problem of homelessness. Now, however, we seek to *end* chronic homelessness in our community.

membership consists of representatives from government agencies, community-based organizations, faith-based groups, advocacy groups, and businesses, as well as homeless consumers and those who are formerly homeless, community residents, and others who have an active interest in the problems faced by the homeless population. Its mission is "To put an end to homelessness in Kern County through collaborative planning and action." Members meet in committees to share information, identify gaps in services and develop projects to address them. The Kern County Homeless Collaborative is also responsible for coordinating the HUD Continuum of Care planning process, and submitting the city and county's annual associated application to HUD for McKinney-Vento funds for housing and services.

Major Kern County Homeless Collaborative accomplishments include: establishment of a nationally recognized homeless court; sponsorship of housing development workshops; coordination of river sweeps with local law enforcement to link homeless people with services and preserve their property; sponsorship of a biannual countywide homeless census and a sample survey of chronic homelessness; improvement of transportation services for the homeless; co-sponsoring the Veteran's Stand Down and the creation of a website to allow for easy access to information about the homeless care provided in Kern County.

Kern County receives approximately \$1.5 Million annually through the Continuum of Care to operate several homeless programs.

### ***The Extent and Nature of Homelessness in Kern County***

There are several local surveys that reflect on the extent and nature of homelessness and/or chronic homelessness in Bakersfield and Kern County. Taken together, they suggest that the local homeless population, at least in Bakersfield, is similar in nature to that found in other Metropolitan areas. Nationwide trends, such as the increase in the

numbers of single women and families with children, are also evident locally. Some of these surveys include:

- *Northcutt Baker Street Study*. This study was an extensive survey of homeless people in the Baker Street area, done for the City by Northcutt & Associates in 1987.
- *Kern County Mental Health 2001 Shelter Survey*. In February 2001, Kern County Mental Health (KCMH) compared nightly rosters from two emergency shelters against its client database to identify residents with a history of serious mental illness.
- *Kern County Homeless Collaborative 2003 Point-in-Time Census*. The Kern County Homeless Collaborative sponsored a countywide shelter and street count of unduplicated homeless people on January 30, 2003.
- *Kern County Homeless Collaborative 2004, 2005 Sample Surveys*. In March 2004, the Kern County Homeless Collaborative surveyed 180 sheltered and unsheltered homeless in Bakersfield to identify the percent who were chronically homeless. In 2005 a survey was conducted by Gil Garcia and the Collaborative.

**Kern County Homeless Collaborative 2006, 2007 Point-in-Time Censuses.** In 2006 a point-in-time (PIT) census along with a demographic and background survey was conducted in the metro Bakersfield area, while the 2007 point-in-time census was conducted county-wide.

#### January 26, 2006 Metro Bakersfield Homeless Census

Three methods were used to count and collect information about the homeless population in Metro Bakersfield: Sheltered counts, unsheltered counts and background information.

*Sheltered Count.* A two-page occupancy survey was mailed to 28 local emergency shelters and transitional housing programs, including hotel/motel voucher and vendor payment programs. The survey, called the Shelter Occupancy Report, asked providers to count and report the numbers of unduplicated adult individuals and families staying overnight in their facilities on the night of January 25.

#### **Did You Know?**

On any given night there are over 1,500 homeless people in Kern County, including almost 200 children. It is estimated that there are over 300 chronically homeless individuals.

*Unsheltered Count.* A two-page Unsheltered Survey Questionnaire was developed to screen for, identify and count homeless people who did not use shelters or transitional housing on the night of January 25 using the definition of “homeless” given by HUD, under the Stewart McKinney Act. The estimated chronically homeless count was 309.

*Background Information.* In addition to the screening questions, the Unsheltered Survey Questionnaire included questions designed to elicit demographic and background information from the homeless population. Identical questions were included in a Sheltered Survey Questionnaire administered in-house by facility staff to residents of 27 emergency shelter and transitional housing programs. The data collected was entered into a computer database to be displayed and analyzed.

**Summary:**

The final tally of the 2006 PIT census found 1,020 unduplicated homeless persons. All but 19, or 1,001, of these persons were counted in the Metro Bakersfield area. Of the 1,020 persons counted, 690 (68%) were sheltered, 330 (32%) were unsheltered; 795 (78%) were unaccompanied adults, 225 (22%) were family members, representing 67 separate families. Of the 795 unaccompanied adults surveyed, 603 (76%) were adult males, 190 (24%) were adult females, and two were transgender persons. No unaccompanied youth were counted in the survey. Of the 225 family members counted, 146 (65%) were children, 79 (35%) were adults. Seventy-five percent (75%) of family members, 62% of unaccompanied males, and 58% of unaccompanied females had lodging on the night in question (see Appendix C for complete survey results).

2006 Survey Facts

- 56% of the homeless adults were between age 18 and 44, 28% 45-54, 15% 55 or older; 43% had been homeless less than a year, 57% a year or more; 61% reported having been homeless at least two times in the past 3 years
- 18% reported being military veterans
- The most common reasons given for being homeless were: high housing/rent costs (48%), lost job/unemployment (49%), alcohol/drug problems (33%), mental/emotional disorders (26%), break up/divorce/separation (23%), physical disability (21%), lost/can't obtain welfare or disability benefits (21%). Some respondents checked multiple reasons, so the categories are overlapping.
- Of the unsheltered homeless surveyed (285), 70% reported living outdoors/streets/campsite, 14% car/van/vehicle, 13% abandoned buildings
- 41% of women (vs. 16% of men) reported having been a domestic violence victim in their life; 24% of women (vs. 7% of men) indicated family violence was a reason for their homelessness.
- More men (24%) than women (15%) indicated physical disability as a reason; more women (30%) than men (20%) reported Break Up/Divorce/Separation as a reason for homelessness; more women (26%) than men (7%) reported housing evictions

### January 25, 2007 County-wide Point-In-Time Census

The 2007 Homeless Census took place on January 24/25<sup>th</sup> involving both shelter and street counts. This effort was undertaken by the Kern County Homeless Collaborative and conducted by almost 100 dedicated volunteers from the service agencies that make up the Collaborative. Partial funding for was provided by a grant from Catholic Healthcare West.

In Metro Bakersfield, 11 mobile teams operated and 8 teams were sent to fixed sites. In the rural areas of the County, teams were deployed in Arvin, Lamont, Wasco, Shafter, Delano, McFarland, Kern River Valley, Ridgecrest, Rosamond, Boron, and Mojave.

#### **Summary:**

The final tally of the 2007 census found 1,537 unduplicated homeless persons countywide, including 905 sheltered, 632 unsheltered. Of this number, there were 89 families with 289 members, including 97 adults (mostly single moms) and 192 children. All but 11 families were sheltered. Unsheltered families, found in Bakersfield, Taft and Shafter, typically were living in autos.

In the metro Bakersfield area the unsheltered count was up over 60%, 535 people compared to 312 people in 2006. In the rural areas the numbers were down over the last time a rural count was attempted (2003). This decrease was attributed to tighter restrictions by HUD regarding who can and cannot be counted during homeless censuses and undercounting related to rural coverage and logistics. It is estimated that there were 316 chronically homeless individuals (see Appendix D for Census results).

2007 Point-in-Time County-wide Census Facts
<ul style="list-style-type: none"><li>• 59% were sheltered at the time of the count (emergency shelter + transitional housing), 41 % unsheltered</li><li>• 1,248 (81%) were single adults, including 972 men (63%) and 268 women (17%)</li><li>• 289 (19%) were family members in families with children, including 97 adults (7%) and 192 children under 18 (12%). There were 89 families total.</li></ul>

## *The Hidden Costs of Chronic Homelessness*

The true cost of chronic homelessness is much greater than the sum total of homeless programs – and more difficult to measure. People who are chronically homeless access healthcare, mental health and family support resources in their most expensive forms: in our hospital emergency rooms, Emergency Medical Services (EMS), law enforcement, mental health services and other crisis intervention venues.

A number of communities across the U.S. have measured some of the costs of chronic homelessness. The results are staggering. Taking into account the costs of emergency room care, mental health services, law enforcement response, and traditional shelter services, these communities have documented annual costs in the tens of thousands of dollars per homeless individual, with several cities reporting total costs of more than \$40,000 per homeless individual per year, some more than twice that amount.

**Table 2.1 – The Costs of Chronic Homelessness**

<b>City</b>	<b>Study Facts</b>	<b>Cost Facts</b>	<b>Other Factors</b>	<b>Avg. Costs per Person*</b>
<b><u>San Diego</u></b>  Source: Serial Inebriate Program	Costs/Services tracked for 227 individuals over 18 months	Subjects accrued \$6 million in health care costs	1745 trips by ambulance  2358 hospital visits	\$26,431 (health care costs only)
	Costs/Services tracked for a subset of 15 highest utilizers over 18 months	Subjects accrued \$3 million in health care costs		\$133,333 (health care costs only)
<b><u>Boston</u></b>  Source: Massachusetts Housing & Shelter Alliance Study by Dr. David Foster	Utilization of Medical Services by 119 homeless individuals 1999 – 2003	Total Medicaid costs \$13 million	18,384 ER visits  871 Medical hospitalizations  831 Respite admissions	\$25,000 (does not include detox, ambulance, other health care costs)
<b><u>King County, WA.</u></b>  Source: 2003 High Utilizer Study, King County Mental Health, Chemical Abuse and Dependency Division	Tracked homeless individuals with SAMH to determine service utilization & costs in 2000 & 2003	In year 2000 20 individuals accrued costs \$1,090,842	(Includes jail days, ER, Inpatient stays, detox & SA treatment)	\$54,542
		In year 2003 24 individuals accrued costs \$1,187,746	Highest utilizers cost \$100K/yr pp in ER/hospital services alone	\$49,489

<b>Asheville N.C.</b>  Source: Asheville's 10-Year Plan	Tracked costs in three areas (Jail, Hospital/EMS, Emergency Shelter) of 37 chronic homeless people over a three year period	Total accrued cost \$1.45 million per year	*Jail/Court – \$17,514  *Medical – \$14,730  *Shelter – \$7,200	\$39,444 (legal, medical, shelter)
*Costs are reflected as an average per person, per year.				

### ***The Costs of Chronic Homelessness to Kern County***

Determining the exact cost of maintaining services to the chronically homeless in Kern County is difficult since complete numbers are not available. However, based on national figures from the previously mentioned studies, it is reasonable to assume that the community is spending between **\$40,000 and \$50,000 per person per year** on services. Some figures are available to provide insight into costs to the county.

**Law enforcement.** The cost of law enforcement response calls involving the chronically homeless in Metro Bakersfield in 2005 was estimated to be **\$123,420**. Looking at calls to just two of the city's homeless service providers shows that the police department responded to **270** calls for services. In addition, **862** arrests were made of subjects listing the shelters as their home address.

**Ambulance transport.** Homeless patient transport costs over a two year period were **\$416,000**. **One chronic homeless individual alone led to \$171,000 in costs**. Since most costs are not reimbursable this debt has to be written-off by the service provider.

**Table 2.2 – Bakersfield Homeless Ambulance Transport Costs**

<b>Homeless Transport Costs</b>		
	<b>2006</b>	<b>2007</b>
Bakersfield Homeless Center	37	30
Transports	\$43,441.99	\$33,312.43
Unpaid Charges		
Jane/John Doe		
Transports	29	80
Unpaid	\$32,729.98	\$91,040.80
Rescue Mission		
Transports	21	21
Unpaid Charges	\$19,436.65	\$25,828.34
One Homeless Patient		
Transports	66	87
Unpaid Charges	\$73,857.82	\$97,204.95
Total Transports	153	218
Total Unpaid Charges	\$169,466.64	\$247,383.52

*Hospitalization.* Kern County Mental Health tracked 151 chronically homeless individuals enrolled in the AB2034 program over the course of a year. **In the 12 months prior to enrollment these 151 individuals spent 1,397 days in the hospital at an estimated cost of \$1,397,000 to the County. These same individuals also spent 2,072 days incarcerated at an estimated cost of \$186,480 to the County.**

These costs are remarkably similar to those in other 10-Year Plan Communities. In terms of resources, the chronically homeless account for roughly 10-15% of a community's total annual homeless population; yet consume over 50% of the resources dedicated to serving the entire homeless population. Ultimately, this means fewer resources for families and children affected by homelessness, and homeless individuals like transitioning/emancipating foster youth.

These costs also reflect the need to do more than just manage the problem. The success that Kern County Mental Health has had working with the AB2034 (see Appendix E) indicates that an emphasis on innovative approaches to chronic homelessness can be successful here locally (unfortunately, AB2034 has been discontinued). The planning committee hopes to see similar results with the implementation of *Home First! Kern County's Plan to End Chronic Homelessness*.

### ***Identifying Gaps and Impediments***

Any effective plan to end chronic homelessness has to take into consideration the existing resources within a community. Kern County has some very important resources that will be helpful in implementing the 10-year plan. However, in order to implement *Home First! Kern County's Plan to End Chronic Homelessness* the committee also needs to identify gaps in existing services and housing so that the 10-year plan can be most effective.

#### ***Services***

In looking at services rendered by the many fine provider organizations in Kern County, an inventory of services was developed, with a specific emphasis on those services which focused on helping those who *are* homeless or may be *at-risk* for homelessness. The survey catalogued services based on three categories listed in the HUD Continuum of Care application: prevention, outreach, and supportive services. (Appendix F).

#### ***Impediments in Services***

While Kern County has done a good job of providing homeless services to the community, there are several impediments to providing well-rounded and comprehensive services. These impediments stand in the way of the community's ability to end chronic homelessness.

*Inadequate prevention measures.* While prevention services are available in Kern County, they are insufficient to meet the estimated need. The workgroups have identified several areas where prevention can be improved. These areas involve integrated and standardized rental and mortgage assistance, foreclosure counseling, income and asset development, money management and general efforts to increase financial stability.

Major impediments to abolishing homelessness in Kern County include:

- Inadequate Prevention Measures
- Incomplete Coordination in Discharge Planning
- Lack of System Integration
- Inconsistent Outreach and Linkage
- Low Public Awareness
- Insufficient Funding
- Scarcity of Affordable Housing

*Incomplete coordination in discharge planning.* There are numerous institutions in Kern County that discharge individuals each day, including, hospitals, mental health facilities, foster care programs and jails or prisons. Each institution has its own policy and protocol for releasing individuals to the streets. Sometimes, institutions have no choice but to discharge an individual into homelessness or to an emergency shelter. This is counterproductive and prolongs the cycle of homelessness. A coordinated discharge plan is needed so that no individual is released into homelessness and only to an emergency shelter as a last resort.

*Lack of systemic integration.* While the homeless services system is functional, the system itself can be and must be improved. Through the efforts of the Kern County Homeless Collaborative there has been a real effort to connect the various service providers to each other and to communicate with each other on a county-wide level. However, if Kern County is going to truly be successful in ending chronic homelessness the system must move beyond collaboration toward real integration and coordination.

*Inconsistent outreach and linkages.* To be successful in reaching out to the chronically homeless, there must be a more aggressive and coordinated approach to outreach. It takes time to build relationships with the chronically homeless so that they will begin to trust those seeking to link them to housing and services. Having recently lost the HELP + program, Kern County lacks a *team* of individuals available to invest the time necessary to build those trusting relationships.

*Low Public Awareness.* As a whole, Kern County needs to more effectively and consistently communicate program needs and available resources to the community. Since an informed public is an engaged public, a focus on community outreach will be necessary to help move forward the goal of ending chronic homelessness.

### **Housing Needs Assessment and Market Analysis**

In 2007, *Kern County Mental Health* (KCMH) commissioned *Transforming Local Communities* (TLC) to perform a county-wide Consumer Housing Needs Assessment and Market Analysis that gave a broad picture of the housing needs in the County (the TLC report can be accessed at the KCMH website <http://www.co.kern.ca.us/KCMH>).

*Insufficient Funding.* With the increased emphasis by HUD on funding permanent housing projects, programs such as homeless transportation and mobile medical services to rural areas have lost funding. This trend is likely to continue in the future. It is essential for Kern County to find ways to support these types of services in order to effectively provide a full array of services to the homeless

*Scarcity of Affordable Permanent Housing.* If the availability of affordable permanent supportive housing is the key to ending chronic homelessness and reducing costs to the local community then more must be done to increase the supply of available affordable housing.

### ***Housing***

In addition to the need for more affordable permanent housing units, surveys of available *supportive housing* have revealed several gaps (see for example the Kern County Behavioral Health Board's Consumer Housing Inventory). If not filled, these gaps will continue to hinder the progress toward eliminating homelessness in Kern County.

### **Identified Gaps in Housing**

*Rural Housing:* There is a definite need to focus more on a range of housing projects in the rural areas. Of the seven emergency shelters in Kern County, only two are located outside of the metro Bakersfield area and both of these are domestic violence shelters. All transitional housing beds are located in metro Bakersfield. Of the eight permanent supportive housing projects in Kern County, only one is outside of Bakersfield.

*Transitional Housing:* In early 2008 the Continuum of Care reported the loss of 112 transitional housing beds, including 36 family beds, when Restoration Village closed its doors. Another facility, Tabitha's Houses, is scheduled to end its homeless programs later this year resulting in the loss of another 76 beds.

*Specialized Centers:* Kern County is lacking both a Public Inebriate Reception Center and a One Stop Drop-in Center. While there is a drop-in center in development serving the Baker Street area (Saint Vincent de Paul), it has been determined based on census results that there is a need for a large scale drop-in center in an alternate Lakeview/Cottonwood area.

### **GIS Mapping**

The *Kern County Network for Children* (KCNC), partnering with the Kern County Homeless Collaborative, plotted the results of the 2007 Census on a GIS map with the results shown in Appendix G.

The results of the GIS mapping indicate that the Lakeview/Cottonwood area has the single highest concentration of homeless people in Kern County (159 homeless adults), and accounts for almost 30% of the total Bakersfield unsheltered count. The area is greatly underserved and may be an appropriate location for a one-stop center, emergency shelter or transitional housing programs. Surveyors noted high use of crack cocaine here. Any project located in this area should also offer drug services.

*Preservation:* HUD and the California Housing Partnership have identified 708 Section 8 housing units that are at risk and at least 353 affordable housing units at high-risk of being lost in Kern County.

## THE PLAN

*Home First! Kern County's Plan to End Chronic Homelessness* focuses on three big ideas, or three overarching objectives. The first objective is one of prevention. It focuses on closing the front door to homelessness by preventing it whenever possible.

The second objective is one of stability and security. This objective focuses on housing stability and rapid re-housing through a housing first model. The goals under objective number two are designed to help the homeless find security and experience opportunity while abiding in permanent supportive housing. Wraparound services are provided to help build on the security of permanent housing and to promote self-sufficiency.

The third objective involves building up the infrastructure so that there is an appropriate amount of beds and housing stock available in the community. The goal in this objective is to increase the stock through the purchase of existing housing, through new construction and through the preservation of at-risk affordable housing. This objective will require the development of partnerships with affordable housing developers as well as the creation of new affordable housing entities. It will also require the integration of the housing plans of various service providers, stakeholder groups, developers and government planners.

Given the scope of these three objectives, the 10-Year Plan Committee has identified several desired outcomes or goals related to each objective, possible strategies for reaching the desired goals, and action steps to implement the strategies. In addition, each strategy has a target population identified, a timeframe established for implementation and a suggested partner agency to take the lead in implementation and follow-through. Finally, each goal is accompanied by a table reflecting an estimated cost analysis along with possible funding resources for implementation.

### ***Objective #1 – Close the front door to homelessness by preventing homelessness whenever possible.***

Since Kern County has the third highest poverty rate in the State of California and since 53% of all renter households in the County are cost burdened (meaning over 30% of income goes to housing expenses), it makes sense for the plan to start with prevention. The most effective way to end homelessness is to prevent it from happening in the first place. Homelessness prevention not only minimizes the disruption in people's lives, but also saves taxpayers money. Understanding the various possible causes of homelessness *Home First! Kern County's Plan to End Chronic Homelessness*, seeks to address these causes before they might occur, and when primary prevention is not possible the plan seeks to have secondary systems in place so as to minimize the length of time an individual or family spends in homelessness.

## ***Goal #1 – Reduced evictions***

In most cases, low-income families and individuals face homelessness only after a long struggle to remain housed. They are in crisis long before they actually become homeless. By identifying as early as possible at-risk families and individuals whose housing situations are deteriorating – before they suffer full-blown housing emergencies – we can minimize both the disruption they experience and the costs of assisting them.

Individuals and families facing homelessness usually request food packages, emergency cash assistance, or help with accessing benefits, healthcare or other problems before they request shelter. They may be late paying rent, or threatened with eviction. Most households facing the immediate or eventual threat of homelessness can be identified and assisted at any one of these junctures. An effective intervention will specifically address housing along with other needs. Followed up with an appropriate level of case management support, these early interventions can make the difference between becoming homeless or staying housed.

### Recommended Strategies

*1. Establish an integrated system for identifying families and individuals who are at-risk for evictions.*

#### Action Steps:

- Develop an integrated service plan
- Identify agency or agencies to implement the plan
- Target consumers, landlords and service providers to promote usage of service plan
- Provide ongoing training and education to various plan participants (i.e. rights and responsibilities etc.)

*2. Provide improved mortgage/rental assistance programs.*

#### Action Steps:

- Identify and link various assistance programs to assist those at-risk of eviction
- Standardize education and training processes
- Identify new resources and grants for service providers
- Incorporate foreclosure counseling into processes

*3. Create and implement a community involvement program that targets prevention.*

#### Action Steps:

- Identify a program plan (i.e. “good neighbor“/ “adopt a family” etc.)
- Tap into existing programs and utilize current resources (i.e. Faith Based Community and community service organizations)
- Hold a Faith Based Community summit to garner support and participation

### **Adopt-A-Family**

*Adopt A Family of Marin [County]* is a community-based organization that believes that every family deserves respect, dignity and a place to call home. Through financial aid and emotional support they strive to prevent the homelessness of low-income families with dependent children, and to enable these families to preserve their status as stable and productive members of the community.

*Adopt A Family of Marin* is in a unique position to help since they are committed to also providing ongoing assistance where they feel it is both necessary and appropriate. Adopt A Family clients typically are parents whose lives are in turmoil due to circumstances often beyond their control such as an illness, an injury at work, a dramatic increase in monthly rent, spousal abuse or job loss that threaten their financial ability to stay in their homes.

Assistance from *Adopt A Family* takes many forms and may include food vouchers, help with rent, security deposits, utility bills, car repairs, and for some families, financial aid for academic or vocational programs that will lead to greater earning power.

Since its inception in 1989, *Adopt A Family* has provided emotional support as well as over \$3,000,000 in assistance to qualified families, helping more than 2,000 families and nearly 4,000 children avoid the devastating trauma of homelessness. Last year *Adopt A Family* helped 239 low-income families with 421 children survive financial and personal crisis.

Their mission remains, to increase their capacity to assist families in their move from crisis towards self-sufficiency. They have pursued these goals in partnership with the generous citizens of the Marin community and granting foundations. *Adopt A Family of Marin* does not ask for or receive any government funding.

*4. Increase benefits advocacy to ensure that at-risk individuals receive benefits for which they are eligible*

#### Action Steps:

- Identify all possible benefits available to those who are at-risk or who are homeless
- Collaborate with Department of Human Services, Social Security Administration, and other mainstream benefit providers to streamline benefit utilization
- Encourage benefit providers to provide access to printed materials detailing all available resources

## ***Goal #2 – Increased incomes and financial stability***

Since many people become homeless because they are paying too high a percentage of their income for housing, and lack the assistance needed to respond to a financial crisis, a renewed focus on providing tenants with the life-skills training necessary to retain their housing and manage their resources is needed.

The plan recommends that identified at-risk households be offered ongoing case management and supportive services to address the underlying causes of instability. A one-time reliance on emergency assistance can be enough to help some at-risk households successfully stave off homelessness. But many at-risk households have multiple barriers to stability and will require ongoing assistance to remain stable. Households that make repeated requests for financial or social service assistance, or are otherwise identified as being at high risk for homelessness, will be assessed and linked to supportive services and financial stability training. These individuals will be encouraged to utilize the services of the financial stability partnerships including Earned Income Tax Credit (EITC) services, Individual Development Accounts (IDA), asset development, credit counseling, budgeting and household management.

### Recommended Strategies

#### *1. Promote community impact programs & financial stability partnerships*

##### Action Steps:

- Provide financial stability education/training.
- Encourage participation in Individual Development Accounts (IDA) for savings and asset development
- Integrate financial stability programs and develop easier access to resources

#### *2. Eliminate systemic barriers to financial stability and mainstream resources and services*

##### Action Steps:

- Expand access to affordable childcare for those who are at-risk of becoming or who are homeless
- Expand transportation resources including bus passes and gas vouchers

#### *3. Develop customized employment options for those who are at-risk of becoming homeless or who are homeless*

##### Action Steps:

- Research and identify job development projects already being used (i.e. Community Garden)
- Adapt and implement identified programs to the needs of Kern County
- Expand job literacy, readiness and employment training resources

### **What are Mainstream Resources?**

“Mainstream” resources and services refer to the broad array of federally-supported safety net and community service programs, including:

- Public housing and Section 8/Housing Choice vouchers
- Benefits — Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), Food Stamps, and General Assistance (GA)
- Health care, mental health care and substance abuse treatment covered by MediCal or Medicare or funded through block grant programs
- Children’s services such as the Children’s Health Insurance Program (CHIP), child care and Head Start
- Employment and training services, such as those funded through the Workforce Investment Act, the New Freedom Initiative for people with disabilities, and Ready 4 Work for ex-offenders
- Services for special populations, such as for veterans or youth.

### ***Goal #3 – Coordinated discharge planning***

Whether it is because discharged individuals’ housing needs are not adequately addressed in their discharge plans, or whether it is because they may be ready for discharge or release before housing plans can be made. Clearly, there is more that can be done to minimize instances of individuals released to inappropriate housing, or released without adequate supplies of medication, prescriptions or insurance coverage. Most often responsibility for the successful implementation of discharge plans has not been clearly assigned. Sometimes recently discharged individuals require more intensive case management support than is now available in order to cooperate with and follow through on discharge plans Initiatives need to be undertaken to ensure that no one in Kern County is discharged into homelessness.

Every effort should be made to work with the Kern County Department of Human Services (DHS) to expedite discharged individuals’ applications for general-aid, Food

Stamps and other entitlements so that they do not experience gaps in coverage that can contribute to or exacerbate medical, psychiatric or financial crises and homelessness.

Efforts to prevent homelessness must also look beyond community-based solutions to systemic reform. Some system-wide policies promulgated at the State and Federal level adversely affect Kern County's ability to reduce and end homelessness. These policies achieve other worthy goals of the health, welfare, mental health and corrections systems; problems related to them reflect the sometimes conflicting missions of these systems when serving both homeless and mainstream populations. Kern County as a whole will work with State officials to review and in some cases reform administrative policies in order to increase housing placements and stability among homeless and at-risk populations.

### **The McKinney-Vento Act**

The McKinney-Vento Act requires that any governmental agency receiving funding may not receive HUD McKinney funds unless they "develop and implement, to the extent practicable, policies for the discharge of persons from publicly funded institutions or systems of care." These institutions and systems of care include health care facilities, mental health, foster care or other youth facilities, and corrections programs and institutions.

The purpose of developing and implementing a "Discharge Planning Program" is to prevent persons being discharged from publicly and privately funded institutions or systems of care into homelessness. Discharge planning prepares a homeless person while in an institution to return to the community and links that individual to essential housing and services, including enhancing and expanding their treatment options and effectiveness.

To reduce the number of people who become homeless upon leaving institutional care, the following strategies are recommended:

#### Recommended Strategies

- 1. Seek consensus agreement from hospitals, jails, foster care, mental health and other institutions that no individual will be discharged to the streets, and only to emergency shelters as a last resort.*

#### Action Steps:

- Hold private meetings with hospital administrators, State Office of Parole and Probation officials, the Sheriff Department, Bakersfield Police Department (BPD), DHS and elected officials to gain buy-in for no street discharge policy.
- Encourage Kern County Supervisors to enact a policy that prohibits publicly funded institutions from discharging into homelessness

2. *Develop a systematic discharge protocol whereby individuals to be discharged from a hospital, jail, youth authority, mental health facility, domestic violence shelter and/or foster care are linked to appropriate community services before discharge*

Action Steps:

- Establish MOUs between discharge institutions and service providers that allow agencies to share information, plan for and review discharges to the community.
  - Create principles of agreement that reflect the discharge community's desire for cooperation and communication while acknowledging the "dignity of risk" that comes from working with legal adults
  - health and jails/prisons
  - Incorporate oversight of discharge planning into homeless coordinator position
3. *Connect individuals who are homeless or at-risk of becoming homeless to permanent housing and a case manager prior to discharge.*

Actions Steps:

- Expedite benefit applications for individuals leaving institutional care
  - Provide access to "alternative level of care" transitional beds to provide a few days or weeks of intermediate medical care to disabled and medically frail individuals awaiting placement into permanent housing.
  - Provide interim transitional placements to allow for a few days lodging to recently discharged individuals while they await placement in transitional programs or permanent housing.
  - Create no-fail transitional housing for those who are prevented from using existing housing resources
  - Support and expand discharge preparation programs like the Independent Living Program (ILP) for those being discharged from Foster Care and other institutions
4. *Work with California Department of Corrections and the Kern County Jail to facilitate recently released individuals' transition from incarceration to community living*

Action Steps:

- Develop a re-entry pilot program that will provide intensive case management to parolees being released out of prison six months before release and that will involve follow-through case management after release and into self-sufficiency
- Divert people with mental illness from incarceration to alternative treatment arrangements
- Support and expand use of PACT meetings as a means of serving parolee population and preventing recidivism

## ***Goal #4 – Increased capacity and accessibility to no-cost/low-cost substance abuse treatment and mental health care services***

Both the mental health system and substance abuse treatment programs are essential to the success of any attempt to prevent homelessness. People with mental illness and/or substance abuse problems need easy access to no cost or low cost services so that they can continue to earn money and pay rent, and meet other responsibilities as tenants.

While Kern County has numerous substance abuse treatment facilities, very few are affordable without some type of insurance. Often, those who are most in need of treatment lack insurance or cannot afford to self-pay. Waiting times for treatment at publicly-funded clinics preclude effective help for those without stable housing.

*Home First!* has identified the need for a program that offers treatment to people who are homeless or at-risk of homelessness through the development of a first-step recovery service or sobering station. This can be accomplished without constructing any additional buildings through the dedication of beds/slots in existing licensed alcohol and drug treatment programs. Additionally, a first-step recovery program can provide linkages to other needed services, including health, mental health, and case management services.

### Recommended Strategies

*1. Develop a first-step recovery program or sobering station.*

#### Action Steps:

- Research best practices and identify model program
- Integrate with existing recovery services and seek pro-bono cooperation from Substance Abuse treatment programs

*2. Eliminate barriers to urgent substance abuse and mental health care services*

#### Action Steps:

- Research and identify systemic barriers i.e. Social Security Income & cost issues
- Work with service providers to streamline process

### **A First-step Recovery Program**

The purpose of a first-step recovery program is to stabilize homeless individuals who are under the influence of alcohol and/or other drugs so they can access other case management services in order to exit from their lives on the streets. This program would have beds available for law enforcement to utilize on a 24-hour basis.

A minimum stay would be required and extensions could be made on a case-by-case basis. All residents would work with highly-trained and experienced staff to establish a case management plan. Case management would include an intake and assessment process and access to 12-step meetings, alcohol and drug education, and a mentoring program.

Table 3.1 – Closing the Front Door

Objective – Close the Front Door to Homelessness by Preventing Homelessness Whenever Possible.				
Goal #1 – Reduced evictions				
Strategies	Action Steps	Target Pop. Served	Plan Timeframe	Lead Partners
Establish an integrated system for identifying families and individuals who are at-risk for evictions.	<p>Develop service plan for integration</p> <p>Identify agency or agencies to implement plan</p> <p>Target consumers, landlords and service providers to promote usage</p> <p>Provide ongoing training and education to various plan participants (i.e. rights and responsibilities etc.)</p>	<p>Precariously or marginally housed</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	Within Year 1	GBLA
Provide improved mortgage/rental assistance programs.	<p>Identify and link various assistance programs to assist those at-risk of eviction</p> <p>Standardize education and training process</p> <p>Identify new resources and grants</p> <p>Incorporate foreclosure counseling into process</p>	<p>Precariously or marginally housed</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	1-3 Years	Catholic Charities
Create and implement a community involvement program that targets prevention.	<p>Identify program plan (i.e. “good neighbor / adopt a family etc.)</p> <p>Tap into existing programs and utilize resources (i.e. Faith Based Community [FBC] and community service organizations)</p> <p>Hold FBC summit to garner support &amp; participation</p>	<p>Precariously or marginally housed</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	1-3 Years	Catholic Charities

Increase benefits advocacy to ensure that at-risk individuals receive benefits for which they are eligible	<p>Identify all possible benefits available to those who are at-risk or who are homeless</p> <p>Collaborate with DHS, SSA, and other mainstream benefit providers to streamline benefit utilization</p> <p>Encourage benefit providers to provide access to printed materials detailing all available resources</p>	<p>Precariously or marginally housed</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	1-3 Years	KCHC
<b>Goal #2 – Increased incomes &amp; financial stability</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Promote community impact programs & financial stability partnerships	<p>Provide financial stability education/training.</p> <p>Encourage participation in IDAs for savings and asset development</p> <p>Integrate financial stability programs and develop easier access to resources</p>	<p>Precariously or marginally housed</p> <p>Transitionally homeless</p> <p>Episodically homeless</p>	Within Year 1	IDA Network
Eliminate systemic barriers to financial stability	<p>Expand access to affordable childcare for those who at-risk of becoming or who are homeless</p> <p>Expand transportation resources included bus passes and gas vouchers</p>	<p>Precariously or marginally housed</p> <p>Transitionally homeless</p> <p>Episodically homeless</p>	3-5 Years	<p>KCHC</p> <p>KCHC</p>
Develop customized employment options for those who are at-risk of becoming or who are homeless	<p>Research and identify job development projects already being used (i.e. community garden)</p> <p>Adapt and implement programs to the needs of Kern County</p>	<p>Precariously or marginally housed</p> <p>Transitionally homeless</p>	1-3 Years	Goodwill

	Expand job literacy, readiness and employment training resources	Episodically homeless		
<b>Goal #3 – Coordinated discharge planning</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Seek consensus agreement from hospitals, jails, foster care and other institutions that no individual will be discharged into homelessness and only to emergency shelters as a last resort	<p>Hold private meetings with hospital administrators, Sheriff Department officials, BPD, KCDHS and elected officials to gain buy-in to no street discharge policy</p> <p>Encourage Kern County Supervisors to enact a policy that prohibits publicly funded institutions from discharging into homelessness</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	1-3 Years	GBLA, KCHC
Develop a systematic discharge procedure whereby individuals to be discharged from a hospital, jail, youth authority, mental health facility, domestic violence shelter and/or foster care are linked to appropriate community services before discharge	<p>Establish MOUs between discharge institutions and service providers that allow agencies to share information, plan for and review discharges to the community</p> <p>Create principles of agreement that reflect discharge institutions desire for cooperation and communication while acknowledging the “dignity of risk” that comes from working with legal adults</p> <p>Expand the Homeless Health Ombudsman project to include foster care, mental health and jails/prisons</p> <p>Incorporate management of discharge planning protocol into homeless coordinator position</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	2-4 Years	GBLA, KCHC

<p>Connect individuals who are homeless or at risk of becoming homeless to permanent housing and a case manager prior to discharge</p>	<p>Expedite entitlement applications for individuals leaving institutional care</p> <p>Provide access to “alternative level of care” transitional beds to provide a few days or weeks of intermediate medical care to disabled and medically frail individuals awaiting placement into permanent housing.</p> <p>Provide interim transitional placements to provide a few days lodging to recently discharged individuals while they await placement in transitional programs or permanent housing.</p> <p>Create no-fail transitional housing for those who are prevented from using existing housing resources</p> <p>Support and expand discharge preparation programs like ILP for those being discharged from Foster Care and other institutions</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	<p>3-5 Years</p>	<p>KCHC</p>
<p>Work with California Department of Corrections and the Kern County Jail to facilitate recently released individuals’ transitions from incarceration to community living</p>	<p>Develop a re-entry pilot program that will fund provide intensive case management to parolees being released out of prison six months before release and that will involve follow-through case management after release and into self-sufficiency</p> <p>Divert people with mental illness from incarceration to alternative treatment arrangements</p> <p>Support continued use of PACT meetings as a means of serving parolee population and preventing recidivism</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	<p>3-5 Years</p>	<p>GBLA, KCHC</p>

Goal #4 – Increased capacity and accessibility to no cost/low-cost substance abuse treatment and mental health care services				
Strategies	Action Steps	Target Pop. Served	Plan Timeframe	Lead Partner
Develop a first-step recovery program or sobering station.	<p>Research best practices and identify model program</p> <p>Integrate with existing recovery services and seek pro-bono cooperation</p>	<p>Episodically homeless</p> <p>Chronically homeless</p>	3-5 Years	KCMH, GBLA
Eliminate barriers to urgent substance abuse and mental health care services	<p>Research and identify systemic barriers (i.e. SSI, cost issues etc.)</p> <p>Work with service providers to streamline process</p>	<p>Episodically homeless</p> <p>Chronically homeless</p>	1-3 Years	KCMH, GBLA

***Objective #2 – Open the back door to housing stability by embracing a housing first model that focuses on rapid re-housing and provides security and opportunity along with wraparound services.***

Too often, homelessness, and chronic homelessness in particular, has not been seen as a problem that requires a coordinated response from the community as a whole. Rather, it has been viewed as something experienced by only a few individuals as a result of some failing of their own. In the past, non-profit agencies and faith-based organizations have valiantly tried to deal with the problem of homelessness while lacking the resources and public support needed to end it. Chronic homelessness within a community hurts all members of that community, having an impact on economic development, public safety, and, most importantly, community values. A community that does not work collaboratively to meet the needs of all of its residents cannot thrive.

Therefore, there is a need to involve all sectors of the community in ending chronic homelessness, including County and municipal policymakers, government agencies, law enforcement, community leaders, faith communities, business leaders, fraternal organizations, the academic community, local landlords, neighborhood associations, for-profit and non-profit housing developers, non-profit service providers, and homeless and formerly homeless persons. One of the objectives of this plan is to provide truly integrated services so that the system itself is streamlined and standardized.

The key to successfully meeting this objective is moving the entire community toward a housing first approach that centers on providing homeless people with housing quickly and then providing services as needed. What differentiates a housing first approach from traditional emergency shelter or transitional housing approaches is that it is “housing-based,” with an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing.

***Goal #5 – Implement a coordinated housing first model***

All shifts in paradigms require time to allow individuals and organizations to “catch-up” and embrace the new model. If Kern County is going to catch-up to the housing first approach and fully embrace the concept some time is going to be required. Unfortunately, there is the need to move forward as quickly as possible. In addition, in order to move forward as a community a great deal of coordination and focus is required.

To successfully achieve this goal the community of service providers will need to embrace the change in approach, establish a pilot project that allows for the group to gain experience in developing a project from start to finish. It will also require a heightened level of cooperation.

Recommended Strategies:

1. *Assist Kern County service providers in moving from a focus on shelter based homeless services to Permanent Supportive Housing (PSH) – Housing First focus*

Action Steps:

- Create working groups to define goals and establish timeline
- Establish a step by step process for transition from temporary housing to permanent housing
- Provide education, training and workshops on permanent housing development
- Identify and showcase Best Practice programs that have successfully moved from sheltered-based model to PSH model
- Develop interim funding stream for transition to PSH model

**Short Term Stabilization**

Although the crux of this plan is to end chronic homelessness by emphasizing permanent supportive housing through a Housing First model, it is important to recognize that housing development takes time. To address the void between leaving chronic homeless persons on the streets and stabilizing them in permanent, service enriched housing, consideration needs be given to modifying the existing housing systems to better provide interim stability.

While moving toward a Housing First model, in the absence of a sufficient stock of supportive housing options, there are two types of temporary housing programs that could be modified in some instances to get people off of the streets, provide greater opportunity for individualized assessment, and establish preliminary linkages with case management, social and community services: emergency shelters and transitional housing.

One solution may be to adopt a policy that eliminates turn-aways from emergency shelters except where admission might cause harm to others.

Another solution may be to increase the length of stay so as to afford some people an opportunity to achieve the level of sobriety required to enter residential treatment or transitional housing programs.

In addition, establishing a lower threshold entry requirement for some transitional housing programs may be a more cost effective measure than perpetuating the emergency shelter system, and savings in this area could be used to offset other costs.

*2. Establish a pilot permanent supportive housing (PSH) project*

Action Steps:

- Adopt KCMH's MHSa Permanent Supportive Housing Project as pilot program
- Encourage full support from Continuum of Care by making the pilot program its number one funding priority

*3. Identify partners to provide wraparound services for PSH projects*

Action Steps:

- Select service providers
- Identify operational resources
- Develop evaluation criteria and measure outcomes

***Goal #6 – Fully integrated array of wraparound support services***

Wraparound services refer to a comprehensive service provision model that guarantees that any and all services needed by an individual or family are integrated through a cohesive, individualized service plan that guides all service provision. Currently, service referral is a component of most homeless service provision, but in the absence of more active and integrated case management, referral-based case management often results in fragmented care. The implementation of a wraparound services approach will mean that case managers across agencies must work together to develop one plan of action for each client, with each agency contributing, according to its strengths and resources, to support the individual or family in achieving housing stability and long-term self-sufficiency. Because service intensity is determined based upon client need, this may also mean that initially an agency provides daily or weekly case management, which may shift to monthly or on-call assistance over an extended period of time. For some, services will always remain an integral part of the residential environment. For others, this support will be transitional, sufficient to ensure that employment and community-based resources, such as health care, schools, social services, civic organizations, and communities of faith, are secured.

Recommended Strategies:

- 1. Develop standardized Memorandums of Understanding (MOU) to be used among service providers*

Action Steps:

- Establish county-wide protocol for service providers establishing a streamlined & standardized intake/assessment /referral process

- Establish standardized service provider training
- Obtain buy-in and commitments from service providers
- Adapt HMIS MOU's or other Continuum of Care MOU's as a standard model

2. *Identify lead agency for centralized case management or homeless integrated service team (HIST) or a multidisciplinary integrated service team (MIST)*

Action Steps:

- Define responsibilities of lead agency
- Define target populations for consolidated case management (what are the parameters?)
- Identify resources
- Develop process for selecting lead agency

**Why Wraparound Services?**

Wraparound services give clients the full array of services they need to address the issues that caused their homelessness. Based on an individualized, client-driven service plan, housing, income and service needs are addressed as part of a coordinated package of care, thereby enhancing long term housing stability. Key to achieving the level of coordination needed for effective wraparound service provision is the integration of homeless and mainstream service programs into one comprehensive system. This system integration facilitates the ability of agencies to share client information, coordinate service provision, and engage in joint data collection.

3. *Encourage integration through Continuum of Care funding process*

Action Steps:

- Offer incentives to agencies seeking funding through HUD's Continuum of Care Competition who follow-through with certifications to integrate and coordinate mainstream resources with homelessness-specific programs
- Create measurement criteria to quantify integration and participation

4. *Fully utilize and maximize participation in Homeless Management Information System (HMIS)*

Action Steps:

- Continue regular training of agency staff.
- Continue coordination with KCMH in working toward full functionality.
- Use HMIS data to identify needs and design programs for various sub-populations

## ***Goal #7 – Coordinated county-wide outreach***

Outreach involves a two-pronged approach. The first approach involves promoting a greater awareness among the general public about the issue of chronic homelessness and its impact on the community. Too many people are only vaguely aware of the costs associated with chronic homelessness. They are even less aware of the resources that are available to help those who may be at-risk for homelessness. Outreach involves disseminating information. It involves taking the issue to the people through public relations and presentations, through the support of the media and community leaders and through cross-promotion and coordination with other kinds of services.

Primarily, outreach involves reaching out to the homeless population itself. This outreach involves trained staff visiting encampments and other locations where homeless people congregate to begin the process of engagement. Engagement involves making contact, gaining trust, and offering preliminary services, such as warm clothing, basic medical care, and medications. As trust develops, over time and through repeated contacts, outreach staff will encourage clients to accept more detailed assessments and support them in determining the assistance they need to regain housing and health. Using an approach sometimes referred to as “*intensive case management*,” outreach teams do “whatever it takes” to assist clients in accessing the full range of services that they need and work aggressively to maintain contact with clients for as long as it takes them to regain stability.

### **HELP+ Model**

*Help+* is a county-wide outreach service provided by Kern County Mental Health. The outreach team contacts and provides linkage and advocacy to individuals who are homeless living on the streets, in cars, parks, and river encampments, in shelters or other inadequate facilities. Initial screening of the individual's problems related to housing, food, financial stress, access to medical, mental health, and alcohol and or substance use is done in the field. The individual is then referred to appropriate services or is linked to an assessment with the Mental Health System of Care. Sometimes temporary housing is provided. *Unfortunately, HELP+ is losing its funding.*

Given that many homeless people, especially those who are chronically homeless, have multiple inter-related needs, outreach is best conducted through multi-faceted outreach teams. These teams will facilitate access to the full range of services needed by the client population, and ensure coordinated care.

Recommended Strategies:

1. *Develop a community education program to promote awareness of homeless problem and homeless resources*

Action Steps:

- Create media campaign “Homeless Prevention Week”
  - Develop “Homeless Prevention Resource Guide” for community distribution
  - Incorporate and utilize 2-1-1
  - Give presentations in churches and community groups
2. *Create a multi-faceted lay outreach team responsible for engaging the chronically homeless and directing them toward PSH.*

Action Steps:

- Define role of outreach team and scope of coverage (answer – who, when, what, how many)
  - Research best practices and adapt to Kern County (HELP+ model)
  - Build on and incorporate existing outreach programs and personnel
3. *Develop permanent supportive housing clearinghouse to identify and match homeless individuals with available housing*

Action Steps:

- Develop updated housing availability list
  - Incorporate management of housing availability list into duties of Homeless Coordinator
4. *Incorporate law-enforcement into outreach process as partners*

Action Steps:

- Coordinate sweeps with outreach teams
- Solicit feedback from law-enforcement in designing new outreach programs

***Goal #8 – Create the position of “Homeless Coordinator”***

Given the scope and magnitude of the recommendations made in the 10-Year Plan, and given the time and energy that it will take to implement *Home First*, it is critical that a full-time “Homeless Coordinator” be hired to manage its essential aspects. Many of the recommendations will need specific focus and attention. Their implementation will require the work of a strong leader and a capable manager. Important elements of the 10-Year Plan that will benefit most from a full time “Homeless Coordinator” are, *Discharge*

*Planning, Service Integration, Community Outreach, Housing Availability and New Housing Projects.*

Although the full-time “Homeless Coordinator” will be given managing responsibilities to help carry out the recommendations noted above, he/she will working closely with community representatives in continued collaboration. There are many representatives that are employed by homeless service providing agencies that include within their duties participation in the Network and subcommittees such as the “Discharge Planning Committee”. Representatives from these homeless service providing agencies simply do not have the time to carry out all of the responsibilities of each of the recommendations—a full-time “Homeless Coordinator” would.

The specific elements of the position will need to be worked out by following the action steps listed below. It is recommended that the position be accountable to the Kern County Homeless Collaborative and that the 10-Year Plan Committee act as an oversight board.

Recommended Strategy:

*1. Create Consensus among KCHC members for need and viability of a full-time coordinator*

Action Steps:

- Create job-description modeled after homeless coordinators in other communities (Pasadena, Glendale etc.)
- Identify organization of employment
- Define position authority
- Indentify and secure funding

Table 3.2 – Opening the Back Door

Objective – Open the Back Door to Housing Stability by Embracing a Housing First Model that Focuses on Rapid Re-housing and Provides Security and Opportunity Along with Wraparound Services.				
Goal #5 – Implement a coordinated housing first model				
Strategies	Action Steps	Target Pop. Served	Plan Timeframe	Lead Partners
Assist Kern County service providers in moving from a focus on shelter based homeless services to PSH – housing first focus	<p>Create working groups to define goals and establish timeline</p> <p>Establish a step by step process for transition</p> <p>Provide education, training and workshops</p> <p>Identify and showcase Best Practice programs that have successfully moved from sheltered based to PSH</p> <p>Develop interim funding stream for transition to PSH model</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	Within Year 1	KCHC
Establish a pilot PSH program (gain group experience in project development from start to finish)	<p>Adopt KCMH’s MHSA Permanent Supportive Housing Project as pilot program</p> <p>Encourage full support from CoC</p>	<p>Chronically homeless</p> <p>Episodically homeless</p>	2-4 Years	KCMH, KCHC
Identify partners to provide wraparound services for PSH projects	<p>Select service providers</p> <p>Identify operational resources</p> <p>Develop evaluation criteria and measure outcomes</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	2-4 Years	KCHC

Goal#6 – Fully integrated array of support services				
Strategies	Action steps	Target Pop. Served	Plan Timeframe	Lead Partner
Develop standardized MOUs to be used among service providers	<p>Establish county-wide protocol for service providers establishing a streamlined &amp; standardized intake/assessment /referral process</p> <p>Establish standardized service provider training</p> <p>Obtain buy-in and commitments from SP</p> <p>Adapt HMIS MOU's or other Continuum of CareMOU's as a standard model</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	Within Year 1	KCHC
Identify lead agency for centralized case management or integrated service team (i.e. MIST or HIST)	<p>Define responsibilities of lead agency</p> <p>Define target populations for consolidated case management (what are the parameters?)</p> <p>Identify resources</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	1-2 Years	KCHC
Encourage integration through Continuum of Carefunding process	<p>Offer incentives to agencies seeking funding through HUD's Continuum of Care Competition who follow-through with certifications to integrate and coordinate mainstream resources with homelessness-specific programs</p> <p>Create measurement criteria to quantify integration and participation</p>	<p>Chronically homeless</p> <p>Episodically homeless</p> <p>Transitionally homeless</p>	1-2 Years	KCHC
Fully utilize and maximize participation in HMIS	<p>Continue regular training of agency staff.</p> <p>Continue coordination with KCMH in working</p>	<p>Chronically homeless</p> <p>Episodically homeless</p>	2-3 Years	KCMH

	toward full functionality. Use HMIS data to identify needs and design programs for various sub-populations	Transitionally homeless		
<b>Goal #7 – Coordinated county-wide outreach</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Develop a community education program to promote awareness of homeless problem and homeless resources	Create media campaign “Homeless Prevention Week” Develop “Homeless Prevention Resource Guide” for community distribution Incorporate and utilize 2-1-1 Give presentations in churches and community groups	Precariously or marginally housed Episodically homeless Transitionally homeless Chronically homeless	1-2 Years	KCHC, UWKC
Create a multi-faceted outreach team responsible for engaging the chronically homeless and directing them toward PSH.	Define role of outreach team and scope of coverage (answer – who, when, what, how many) Research best practices and adapt to Kern County (HELP+ model) Build on and incorporate existing outreach programs and personnel	Chronically homeless Episodically homeless	1-3 Years	GBLA
Develop Permanent Supportive Housing clearinghouse to identify and match homeless individuals with available housing	Develop updated housing availability list Incorporate management of housing availability list into duties of Homeless Coordinator	Chronically homeless Episodically homeless Transitionally homeless	1-3 Years	KCHC

Incorporate law-enforcement into outreach process as partners	Coordinate sweeps with outreach teams Solicit feedback from law-enforcement in designing new outreach programs	Chronically homeless Episodically homeless	1-2 Years	GBLA
<b>Goal # 8 – Create the position of Homeless Coordinator</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Create Consensus among KCHC members for need and viability <i>Housing Availability</i> <i>Discharge Planning</i> <i>Service Integration</i> <i>Community Outreach</i> <i>CoC Application</i>	Create job-description modeled after homeless coordinators in other communities (Pasadena, Glendale etc.) Identify organization of employment Define position authority Identify and secure funding	Precariously or marginally housed Episodically homeless Transitionally homeless Chronically homeless	1-3 Years	KCHC, UWKC

***Objectives #3 – Build the infrastructure by focusing on construction, rehabilitation and affordable housing preservation.***

The key to making the 10-Year Plan work is to increase the amount of affordable housing. A housing first approach is only as effective as the number of supportive housing units that are available. The Housing Committee developed several recommendations to meet Kern County’s housing needs. Overall the committee elected to focus on expanding six types of housing, plus the need for preserving the affordable housing already in existence.

- Safe Haven/Low Demand Shelter Beds
- Permanent Supportive Housing
- Emergency Shelter for Rural Areas
- Transitional Supportive Housing
- Permanent Affordable Rental Housing (30% or less of AMI)
- Affordable Home Ownership

The committee believes that by addressing multiple points, pressure can be relieved in the affordable housing market overall.

***Goal #9 – Develop Public Inebriate/Safe Haven Center in Bakersfield***

**Safe Haven/Low Demand Shelter Beds**

Based on the 2007 Census results it was determined that Kern County needed some targeted low demand beds, particularly for the Southeast area of Bakersfield. The Committee felt approximately 30 beds were needed, 15 for both men and women.

A “Safe Haven” permanent supportive housing program provides residential units on a leased-basis. This housing is for chronically homeless, mentally ill individuals who are unable or unwilling, because of their illness, to comply with the rules of traditional shelters and transitional housing programs. Safe Havens are low-demand, high expectation programs with few initial requirements other than the clients abstain from alcohol and/or other drug use on the premises and not exhibit threatening behavior. High expectations reflect the probability that with time and appropriate, non-threatening services, clients will become more amenable to accepting medications and other stabilization services as a first step toward obtaining appropriate housing, services, and benefits.

Recommended Strategy

*1. Develop 20-30 bed Safe Haven/Public Inebriate Center in Southeast Bakersfield*

Action Steps:

- Identify potential site(s) for center

- Identify funding sources for development and operation of center
- Link with street outreach programs/law enforcement to insure utilization of resource

## ***Goal #10 – Create 520 new permanent supportive housing beds in Kern County***

### **Permanent Supportive Housing**

The Housing Committee recommends a goal of 520 units of permanent supportive housing, with 300 units devoted to the chronically homeless. This closely mirrors the Continuum of Care permanent housing unmet need of 517 units.

#### Recommended Strategies

##### *1. Expand availability of vouchers for permanent supportive housing*

###### Action Steps:

- Apply for additional Shelter Plus Care vouchers through the CoC
- Establish a limited preference for Section 8 vouchers for homeless receiving services

##### *2. Acquire and rehabilitate existing housing for use as permanent supportive housing*

###### Action Steps:

- Create a local Affordable Housing Trust Fund
- Establish a minimum percentage of City & County HOME funds to allocate to permanent supportive housing developments

##### *3. Construct new permanent supportive housing facilities*

###### Action Steps:

- Prioritize CoC and MHSA funds for the development of permanent supportive housing beds
- Identify and assist developers willing to develop permanent supportive housing

## ***Goal #11 – Create 20 new emergency shelter beds in the rural areas***

### **Emergency Shelter**

While Bakersfield does not need any more shelter beds, the rural areas of the county generally have none. One possible way to meet this goal is to develop a voucher system for motel rooms that could be administered in the outlying areas of the county.

## Recommended Strategy

### *1. Create vouchers for use in rural areas*

#### Action Steps:

- Identify funding source for emergency shelter vouchers
- Identify motels and other facilities willing to accept vouchers in rural areas
- Develop referral system to issue/administer emergency shelter vouchers

## ***Goal #12 – Develop 150 new transitional supportive housing beds for individuals and families***

### **Transitional Supportive Housing**

The committee felt that Transitional Housing is an opportunity mainly for single adults and mainly for substance abuse interventions. However, the bulk of transitional housing in Kern County is in a precarious position as it relates to funding. In addition, the community has lost or will lose by the end of 2008, 188 transitional housing beds. Therefore, the committee recommends the development of 75 units/beds targeted at individuals; 50 beds/units targeted at Transition-Aged Youth; 75 units/beds targeted to families.

## Recommended Strategies

### *1. Acquire and rehabilitate existing housing for use as transitional housing, focusing on needs of emancipated foster youth and prisoner re-entry*

#### Action Steps:

- To Be Determined

### *2. Construct new transitional housing facilities, focusing on needs of emancipated foster youth and prisoner re-entry*

#### Action Steps:

- To Be Determined

## ***Goal #13 – 500 new rental units countywide affordable to households earning less than 30% of AMI***

## **Permanent Affordable Rental Housing (30% or less of AMI)**

The committee believes that most families and homeless individuals who were in the first-time or episodic categories should be placed in this type of housing environment with minimal service supports on site, but a broad array of services available.

### Recommended Strategies

- 1. Expand availability of vouchers for housing serving households less than 30% of AMI*
- 2. Acquire and rehabilitate existing housing to serve households with income less than 30% of AMI*
- 3. Construct new permanent housing to serve households with income less than 30% of AMI*

### Action Steps:

- Apply for additional Section 8 vouchers if available
- Create a local Affordable Housing Trust Fund
- Establish a minimum percentage of City & County HOME funds to allocate to new housing serving households with income less than 30% of AMI

## ***Goal #14 – 50 new affordable homeownership units for households earning less than 60% of AMI***

### **Affordable Homeownership**

The committee believes that since the above three categories will be construction and development intensive, it is best to address the issue of affordable homeownership from a programmatic standpoint expanding the Habitat for Humanity homebuilding efforts and utilizing Self-Help Enterprises to create 50 new homeowners in 10 years.

### Recommended Strategies

- 1. Construct 50 new homes using the self-help approach*

### Action Steps:

- Expand Habitat for Humanity homebuilding efforts
- Collaborate with Self-Help Enterprises to create new affordable homes in Kern County

## ***Goal #15 – Preserve existing affordable housing in Kern County***

HUD sees preservation as a vital element of maintaining affordable housing. Based on the work done by California Housing Partnership Corporation, several properties in Kern County have been identified as being at high risk for conversion to market rate housing. As a part of the 10-Year Plan, the Kern County Homeless Collaborative is committed to assisting in the preservation of those affordable housing units.

### **Recommended Strategies**

*1. Create plan to identify and preserve existing affordable housing at-risk of converting to market rate housing*

#### **Action Steps:**

- Identify local housing entity to track at-risk affordable housing
- Authorize use of City/County HOME funds to assist in preservation of at-risk properties

**Table 3.3 – Building the Infrastructure**

<b>Objective #3 – Build Infrastructure Through the Construction, Acquisition, Rehabilitation and Preservation of Affordable Housing</b>				
<b>Goal #9 – Build a Public Inebriate/Safe Haven Center in Bakersfield</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners (Suggested)</b>
Develop 20-30 bed Safe Haven/Public Inebriate Center in Southeast Bakersfield	Identify potential site(s) for center  Identify funding sources for development and operation of center  Link with street outreach programs/law enforcement to insure utilization of resource	Chronically homeless  Episodically homeless	Year 1-5	Bakersfield Homeless Center
<b>Goal #10 – Create 520 New Permanent Supportive Housing Beds in Kern County</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Expand availability of vouchers for permanent supportive housing  Acquire and rehabilitate existing housing for use as permanent supportive housing  Construct new permanent supportive	Apply for additional Shelter Plus Care vouchers through the COC  Establish a limited preference for Section 8 vouchers for homeless receiving services  Create a local Affordable Housing Trust Fund  Establish a minimum % of City & County HOME funds to allocate to permanent supportive housing developments  Prioritize COC and MHSA funds for the development of permanent supportive housing beds	Chronically homeless  Episodically homeless  Transitionally homeless	Year 1-10	Housing Authority of the County of Kern  Housing Authority of the County of Kern  Housing Authority of the County of Kern  City of Bakersfield and County of Kern  KCHC, KCMH

housing facilities	Identify and assist developers willing to develop permanent supportive housing			KCHC
<b>Goal #11 – Create 20 New Emergency Shelter Beds in the Rural Areas</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Create vouchers for use in rural areas	Identify funding source for emergency shelter vouchers  Identify motels and other facilities willing to accept vouchers in rural areas  Develop referral system to issue/administer emergency shelter vouchers	Chronically homeless  Episodically homeless  Transitionally homeless	Year 1-3	KCMH  KCMH  KCMH
<b>Goal #12 – Develop 150 new transitional supportive housing beds for individuals and families</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead partners</b>
Acquire and rehabilitate existing housing for use as transitional housing, focusing on needs of emancipated foster youth and prisoner re-entry  Construct new transitional housing facilities, focusing on needs of emancipated	TBD	Chronically homeless  Episodically homeless  Transitionally homeless	Year 1-10	TBD

foster youth and prisoner re-entry				
<b>Goal #13 - 500 new rental units countywide affordable to households earning less than 30% of AMI</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
<p>Expand availability of vouchers for housing serving households less than 30% of AMI</p> <p>Acquire and rehabilitate existing housing to serve households with income less than 30% of AMI</p> <p>Construct new permanent housing to serve households with income less than 30% of AMI</p>	<p>Apply for additional Section 8 vouchers if available</p> <p>Create a local Affordable Housing Trust Fund</p> <p>Establish a minimum % of City &amp; County HOME funds to allocate to new housing serving households with income less than 30% of AMI</p>	<p>Marginally or precariously housed</p> <p>Transitionally homeless</p>	<p>Year 1-10</p>	<p>Housing Authority of the County of Kern</p> <p>Housing Authority of the County of Kern</p> <p>City of Bakersfield and County of Kern</p>
<b>Goal #14 – Create 50 New Affordable Homeownership Units for households earning less than 60% of AMI</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
<p>Construct 50 new homes using self-help</p>	<p>Expand Habitat for Humanity homebuilding efforts</p> <p>Collaborate with Self-Help Enterprises to create new</p>	<p>Marginally or precariously housed</p>	<p>Year 1-10</p>	<p>Habitat for Humanity, Self-Help Enterprises</p>

	affordable homes in Kern County			
<b>Goal #15 - Preserve existing affordable housing in Kern County</b>				
<b>Strategies</b>	<b>Action Steps</b>	<b>Target Pop. Served</b>	<b>Plan Timeframe</b>	<b>Lead Partners</b>
Create plan to identify and preserve existing affordable housing at-risk of converting to market rate housing	Identify local housing entity to track at-risk affordable housing  Authorize use of City/County HOME funds to assist in preservation of at-risk properties	Marginally or precariously housed	Year 1-10	HUD

## **FUNDING STRATEGIES**

The costs of homelessness are tremendous from both a personal and social perspective. Ending homelessness is not going to be easy or inexpensive. The solution is more than offering a cot and a hot meal. Therefore this plan is committed to identifying the probable costs and developing the funding resources necessary to implement the strategies recommended for achieving each of the fifteen goals. As *Home First!* developed, several realities related to costs and funding became apparent.

- Ending chronic homelessness will require a greater integration and coordination of existing resources
- Ending chronic homelessness will require leveraging resources from every segment of the community
- Ending chronic homelessness will require that major resources be redirected to focus on supportive housing
- The costs of ending chronic homelessness are greater than the current resources available

### ***Greater Integration and Coordination of Existing Resources***

Developing the appropriate funds for successful implementation presents definite challenges. However, as certain strategies are implemented, there will be cost savings and opportunities to shift resources to more pressing needs. Significant savings can also be expected in public systems from reduced use of services including hospital emergency rooms, ambulances, and law enforcement services. Savings in other services systems, including homeless shelters and medical services that can result from placement of individuals into supportive housing are also expected.

Various research projects in communities around the country have identified both cost effective and efficient ways of managing homeless needs. One study commissioned by the Department of Veterans Affairs focusing on homelessness issues, shows that cash assistance for rent and utilities helped 80 percent of recipients to avert eviction. The costs of this prevention assistance amounted to 15 percent of the cost to shelter a household in the emergency system for the typical length of shelter stay (Source: *The Road Home: Denver's 10-Year Plan to End Homelessness*). By making prevention an important aspect of the plan, *Home First!* asserts that these preventative investments will result in savings to a variety of other homeless expenditures over time. These savings will be used to help finance the costs associated with other elements of the plan.

### ***Leveraging Resources from Every Segment of the Community***

Since most federal and State funding resources are already utilized in Kern County, existing local resources must be leveraged and new local funding sources must be developed. It is important that the community as a whole understand its responsibility to

support the goals of *Home First!*. Implementation and funding will not only require the engagement of the local political leadership for support and new funding streams, but also the business and philanthropic communities as well. *Home First* also views the faith-based community as a crucial partner in resource development. Several elements of the plan are contingent on in-kind giving and private and public donations.

In the first two years of implementation, the city of Atlanta was able to raise \$17 million in private donations to support their plan. The city of San Francisco was able to raise considerable resources through existing sources of funds identified in the City's Consolidated Plan. A more organized and focused approach on how the city was spending funds allowed them to use resources from HOME, CDGB, and HOPWA for supportive housing and services.

San Francisco also identified and set aside local tax dollars for supportive housing development. Some local redevelopment agency tax increment funds already dedicated to affordable housing development were spent on supportive housing projects. A portion of the existing hotel tax which was formerly dedicated to serving people with physical disabilities and seniors was shifted to include a focus on those with mental illness and substance use issues. The city also passed a \$100 million general obligation bond to be used for affordable housing development including supportive housing and services.

These are just a few examples of local resources that have been leveraged to pay for elements of 10-Year Plans.

### ***Redirecting Major Resources to Permanent Supportive Housing***

The single greatest cost incurred in *Home First!* is the creation of 520 new supportive housing units. Over a 10 year period \$44 million must be raised in vouchers and funding for rehabilitation and new construction. While the timeframe of 10 years may seem unduly long, it is necessitated by limited availability of resources which have to be raised over a period of time. In the interim, existing resources must be redirected to support short-term stabilization, while new resources are being developed and new funding partnerships are formed.

The Continuum of Care must continue to refocus its efforts to fund supportive housing. This will require some very difficult decisions to be made about current services and programs. Implementation and funding for various elements of *Home First!* will hinge on the ability of the Continuum to meet the full funding threshold, especially for permanent supportive housing.

In order to develop new service-enriched supportive housing units, three areas must be financed: capital, operations and services.

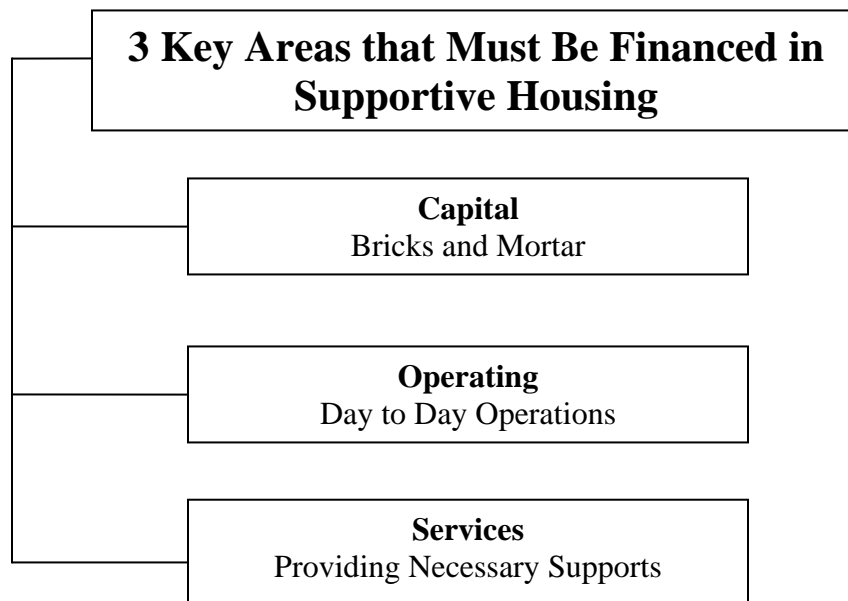
*Capital costs* are associated with acquiring, creating, and/or rehabilitating housing units, these costs are sometimes referred to as "bricks and mortar" costs.

*Operating costs* are the costs of operating and/or maintaining the housing or physical component of supportive housing. Operating costs in a project owned by a housing sponsor include all costs of maintaining the project once it is ready for occupancy, such as property management, utilities, maintenance, insurance, security, debt service or other loan payments, and operating and replacement reserves. In projects leased by the sponsor (either single site or scattered site), operating costs generally include the cost of leasing the units and any maintenance that is not covered by the owner/landlord.

*Services costs* are those costs related to providing supportive services either in supportive housing or stand alone supportive service projects.

The types of services that comprise the "support" in supportive housing emerge from the varied needs of the people who live in the housing. Tenants of supportive housing are individuals and families who face complex challenges – people who have been homeless, and who also have very low incomes and often serious, persistent health issues and/or disabilities or other barriers to housing stability. These challenges may include mental health issues, substance use issues, and HIV/AIDS.

Stand alone service projects are those that are not directly linked to supportive housing, but rather are provided by individual service organizations to homeless individuals, often at the street level.



For all new housing projects these three costs must be taken into consideration and funding for each will be critical.

Again, it is important to remember that much of the savings created by the implementation of a housing first model will generate funding to pay for other project costs. One study has identified annual savings of as much as **\$18,000** per person per year

for each unit of service-enriched, supportive housing built in place of emergency shelter beds (Source: *Accountability, Cost Effectiveness and Program Performance: Since 1998*; 2007 National Symposium on Homelessness Research; Culhane, Parker, Poppe, Gross and Sykes). If there are 316 chronically homeless persons in Kern County (estimating from the 2007 PIT Census), providing permanent supportive housing to them could save the County as much as **\$5,688,000**. That savings alone could pay for a large percent of the service enriched housing costs including operations and services. Even if a small portion of these back-end expenditures could be redirected toward homeless prevention, the community will see a large benefit.

### ***New Funding Sources***

The Mental Health Services Act (MHSA) provides funding for capital costs and operating subsidies to develop permanent supportive housing for MHSA-eligible homeless or at-risk consumers and their families. The program is authorized as an amendment updating the County's 3-year Community Supports and Services Plan, and must be consistent with the plan's priorities and goals. The State has set aside \$7,932,200 for Kern County over 3 years, (effective August 2007–August 2010), and possibly as much as \$2.5 million annually thereafter. Of the 3-year amount, up to \$2,644,100 can be used for capitalized operating subsidies. Services must be funded from other sources. Awards are not guaranteed but depend on satisfying MHSA Housing Program application requirements.

The California Department of Housing and Community Development, *Local Housing Trust Fund Program (LHTFP)* was created by action of the State Legislature resulting from a voter initiative and the passing of Proposition 46, Housing Emergency Shelter Trust Fund Act of 2002. The LHTFP makes one-time grants for the development of affordable multifamily rental housing. It is intended to support innovative local entities that have identified and committed sources of funds not traditionally utilized in the development and provision of affordable housing. Grants require a dollar-for-dollar match from a local entity such as the City of Bakersfield or the County of Kern.

For a comprehensive list of Federal, State and Local resources and brief descriptions of each, see Appendix H.

Funding recommendations for implementing *Home First! Kern County's Plan to End Chronic Homelessness*, are indicated in the tables that follow. Each table is focused on a specific goal in the plan. Each table also identifies the suggested strategies for accomplishing the goal, an estimated cost analysis for each strategy and funding recommendations in the form of possible funding sources. The implementation of some strategies may require funding from multiple sources. Each table also indicates whether costs are one-time (spread over 10 years), such as capital costs, or ongoing (annual) such as service costs. Finally, costs are identified as capital (C), operational (O) or service (S) costs where applicable.

Table 4.1 Reduced Evictions

Goal #1 – Reduced evictions		
Strategy	Cost Analysis	Funding Recommendations
Establish an integrated system for identifying families and individuals who are at-risk for evictions.	Negligible – Ongoing	In-kind, private donations
Provide improved mortgage/rental assistance programs.	\$100,000 – Ongoing	EHAP, FEMA, in-kind, private donations
Create and implement a community involvement program that targets prevention.	\$75,000 – Ongoing (50 families @ \$1500.00 Per Household Per Year)	In-kind, private donations, faith based community
Increase benefits advocacy to ensure that individuals receive benefits for which they are eligible	Negligible – Ongoing	Reallocation of existing funds

Table 4.2 Increased Income & Financial Stability

Goal #2 – Increased income & financial stability		
Strategy	Cost Analysis	Funding Recommendations
Promote community impact programs & financial stability partnerships	\$500,000.00 (over five years)	Federal Assets for Independence (AFI) grant, in-kind, private donations, business matching
Eliminate systemic barriers to financial stability	To be determined	In-kind, private donations
Develop customized employment options for those who are at-risk of becoming or who are homeless	\$50,000-\$100,000 – Ongoing	Workforce Investment Act (WIA)

Table 4.3 Coordinated Discharge Planning

Goal #3 – Coordinated discharge planning		
Strategy	Cost Analysis	Funding Recommendations
Seek consensus agreement from hospitals, jails, foster care and other institutions that no individual will be discharged into homelessness and only to emergency shelters as a last resort	Negligible – Ongoing	In-kind
Develop a systematic discharge procedure whereby individuals to be discharged from a hospital, jail, and foster care are linked to appropriate community services before discharge	Negligible – Ongoing	In-kind
Connect individuals who are homeless or at risk of becoming homeless to permanent housing and a case manager prior to discharge	To be determined	CoC, in-kind, reallocation of existing funds, private and philanthropic donations, faith based community
Advocate for a state plan concerning institutional discharge	Negligible – Ongoing	In-kind

Table 4.4 Access to Substance Abuse & Mental Health Services

Goal #4 – Increased capacity and accessibility to no cost/low-cost substance abuse treatment and mental health care services		
Strategy	Cost Analysis	Funding Recommendations
Develop a first-step recovery program or sobering station.	\$200,000 – Ongoing – O, S	EHAP, substance abuse prevention and treatment block grants, GBHI, in-kind
Eliminate barriers to urgent substance abuse and mental health care services	To be determined	MHSA, reallocation of existing funds, in-kind

Table 4.5 Implement a Coordinated Housing First Model

Goal #5 – Implement a coordinated housing first model		
Strategy	Cost Analysis	Funding Recommendations
Assist Kern County service providers in moving from a focus on shelter based homeless services to PSH – Housing First focus	Negligible – Ongoing	CoC, reallocation of existing funds
Establish a pilot PSH program (gain group experience in project development from start to finish)	\$3,750,000 – One time – C  \$158,000 annually for operation – O	MHSA, CoC, City/County HOME, tax-credits  S+C (for operational expenses), MHSA
Identify partners to provide wraparound services for PSH projects	\$50,000-\$100,000 – Ongoing – S	MHSA, CoC

Table 4.6 Fully Integrated Array of Support Service

Goal #6 – Fully integrated array of support services		
Strategy	Cost Analysis	Funding Recommendations
Develop standardized MOUs to be used among service providers	Negligible – Ongoing	In-kind
Identify lead agency for centralized case management or integrated service team (i.e. MIST or HIST)	Negligible – Ongoing – S	CoC, reallocation of existing funds, in-kind
Encourage integration through CoC funding process	Negligible – Ongoing	CoC, in-kind
Fully utilize and maximize participation in HMIS	\$80,000 – Ongoing	CoC

Table 4.7 Coordinated County-wide Outreach

Goal #7 – Coordinated county-wide outreach		
Strategy	Cost Analysis	Funding Recommendations
Develop a community education program to promote awareness of homeless problem and homeless resources	\$40,000 (for staffing, printing, website, supplies etc.) - Ongoing	In-kind, faith based community, private & philanthropic donations
Create a multidisciplinary assertive outreach (ACT) team responsible for engaging the chronically homeless and directing them toward PSH.	\$150,000 (3 member team) – Ongoing – S	MHSA, CoC, in-kind, reallocation of existing funds
Incorporate law-enforcement into outreach process as partners	Negligible – Ongoing	In-kind

Table 4.8 Create the Position of Homeless Coordinator

Goal #8 – Create the position of Homeless Coordinator		
Strategy	Cost Analysis	Funding Recommendations
Create Consensus among KCHC members for need and viability  <i>Housing Availability</i>  <i>Discharge Planning</i>  <i>Service Integration</i>  <i>Community Outreach</i>  <i>CoC Application</i>	\$50,000-\$70,000 – Ongoing – S	CoC SHP, private donations & Philanthropic support, faith based community

Table 4.9 Public Inebriate/Safe Haven Center

Goal #9 – Build a Public Inebriate/Safe Haven Center in Bakersfield		
Strategy	Cost Analysis	Funding Recommendation
Develop 20-30 bed Safe Haven/Public Inebriate Center in Southeast Bakersfield	\$750,000 - \$1,250,000 – One time – C	MHSA, SHP, CDBG, HOME, community donations

Table 4.10 Permanent Supportive Housing Beds

Goal #10 – Create 520 new permanent supportive housing beds in Kern County		
Strategy	Cost Analysis	Funding Recommendation
Expand availability of vouchers for permanent supportive housing – 100 vouchers	\$6,000,000 – Over 10 years – O	Incremental Housing Choice Vouchers from HUD
Acquire and rehabilitate existing housing for use as permanent supportive housing – 120 beds	\$8,000,000 – Over 10 years – C, O	HUD COC, Tax Credits, MHP, AHP, MHSA, City/County HOME, Governor’s homeless initiative
Construct new permanent supportive housing facilities – 300 beds	\$30,000,000 – Over 10 years – C, O	HUD COC, Tax Credits, MHP, AHP, MHSA, City/County HOME, Governor’s homeless initiative

Table 4.11 Emergency Shelter Beds

Goal #11 – Create 20 new emergency shelter beds in the rural areas		
Strategy	Cost Analysis	Funding Recommendation
Create vouchers for use in rural areas 15 vouchers	\$1,000,000 – Over 10 years – S	Mental Health funds, HUD COC, RHED

Table 4.12 Transitional Housing

Goal #12 – 150 new transitional supportive housing beds for individuals and families		
Strategy	Cost Analysis	Funding Recommendation
Acquire and rehabilitate existing housing for use as transitional housing, focusing on needs of emancipated foster youth and prisoner re-entry – 75 units	\$5,000,000 – Over 10 years – C, O	HUD COC, City/County HOME
Construct new transitional housing facilities, focusing on needs of emancipated foster youth and prisoner re-entry – 75 units	\$7,000,000 – Over 10 years – C, O	HUD COC, City/County HOME

Table 4.13 Affordable Housing Units

Goal #13 – 500 new rental units countywide affordable to households earning less than 30% of AMI		
Strategy	Cost Analysis	Funding Recommendation
Expand availability of vouchers for housing serving households less than 30% of AMI – 100 vouchers	\$6,000,000 – Over 10 years – O	Tax credits, tax-exempt bonds, MHP, AHP, City/County HOME funds, incremental vouchers from HUD
Acquire and rehabilitate existing housing to serve households with income less than 30% of AMI – 100 units	\$8,000,000 – Over 10 years – C, O	Tax credits, tax-exempt bonds, MHP, AHP, City/County HOME funds
Construct new permanent housing to serve households with income less than 30% of AMI – 300 units	\$29,000,000 – Over 10 years – C, O	Tax credits, tax-exempt bonds, MHP, AHP, City/County HOME funds

Table 4.14 Affordable Homeownership Opportunities

Goal #14 – Create 50 new affordable homeownership units for households earning less than 60% of AMI		
Strategy	Cost Analysis	Funding Recommendation
Construct 50 new homes using self-help approach	\$6,000,000 – Over 10 years – C	Private Funding, government agency donation of land

Table 4.15 Preserve Existing Housing

Goal #15 – Preserve existing affordable housing in Kern County		
Strategy	Cost Analysis	Funding Recommendation
Create plan to identify and preserve existing affordable housing at risk of converting to market rate housing	The plan itself won't cost anything. Actual preservation of units does cost – difficult to project at this time	

## **IMPLEMENTATION**

While the plan as presented in the previous section is a blueprint for implementation, there are nine additional steps that will need to be taken to ensure that *Home First! Kern County's Plan to End Chronic Homelessness* becomes a reality. Revolving around the acrostic HOME FIRST, these nine steps are critical to the success of the plan. The nine steps include:

- **H**omeless Coordinator – Hire a coordinator to manage and administer the plan
- **O**versight – Refocus the 10-Year Plan Committee on implementation
- **M**arketing – Sell the plan, promote the plan to the community
- **E**ngagement – Engage elected and appointed officials, services providers, business and philanthropic leaders in implementation of the plan
- **F**unding – Develop funding and resources to pay for the plan
- **I**ntegrate – Begin the process of integration and coordination of services to make the plan work
- **R**ooms and residences – Immediately begin the development of more housing units so the heart of the plan – housing – can be implemented
- **S**ustain and update the plan – Work toward full implementation and continue the process of updating and adapting the plan as necessary
- **T**racking – Begin tracking and measuring results of the plan

### ***Step #1 – Homeless Coordinator***

As soon as feasibly possible the position of Coordinator will be established. The Kern County Homeless Collaborative, along with the 10-Year Plan Committee will develop a job description for the position by following the strategies outlined in goal eight of the plan. Once the job description is established, funding has been secured, and an individual has been hired, the Coordinator can begin administrating and managing the implementation of the plan. Working alongside the suggested lead partner agencies the Coordinator will help support implementation in each specific plan area. Additionally, the Homeless Coordinator should:

- Develop a working list of available supportive housing units
- Aid the 10-Year Plan Committee in raising funds for implementing the plan
- Assist in the development and success of the pilot permanent supportive housing project
- Work with the Housing Committee to achieve goals nine through fifteen
- Facilitate the coordination of a unified discharge plan
- Assist service providers in integrating services
- Implement a community outreach program
- Assist the Continuum of Care with the development of the annual associated HUD application

## ***Step #2 – Oversight Committee***

The 10-Year Plan Committee will be re-commissioned to focus on plan implementation. The specific immediate focus of the 10-Year Plan Oversight Committee will include identifying an organization of employment for the Homeless Coordinator, creating a job description, identifying and securing funding for the position and creating points of accountability for plan implementation. In addition, the 10-Year Plan Oversight Committee should take the lead in the following areas:

- Develop engagement strategies for community support
- Participate in funding and resource development for 10-Year Plan in general
- Support and encourage a system-wide cultural shift within Kern County Homeless Collaborative organizations to fully embrace the 10-Year Plan and housing first emphasis
- Periodically update plan
- Monitor tracking and measuring results

## ***Step #3 – Marketing***

Along with the Homeless Coordinator, Mayor Harvey L. Hall, the 10-Year Plan Champion will announce the launch of 10-Year Plan with a press conference or other type of media event. Philip Mangano the Executive Director of the U.S. Interagency Council on Homelessness, or another high ranking Federal official should be invited to attend. Additionally, the following strategies will be employed:

- Meet with The Bakersfield Californian Editorial Board to gain an editorial endorsement of the plan
- Seek out radio and television interviews
- Begin making presentations to churches, faith-based groups and community service organizations
- Attend the Regional Community Collaboratives

The **Government and Community Relations Subcommittee** will take the lead in the following:

- Develop a communication strategy in support of the Plan
- Create fact sheets and talking points for public distribution
- Distribute copies of the Plan to local dignitaries and public officials
- Assist in the planning and promotion of a “Homeless Prevention” or “Homeless Awareness” week

## ***Step #4 – Engagement***

*Home First!* will not be a success without the full support of the local political and business communities. In order to gain their support engagement on the issue of homelessness must occur. A fundamental shift must take place in how the community looks at the problem of chronic homelessness and the facts regarding the costs must be made clear. In coordination with the Homeless Coordinator, the 10-Year Plan Champion, and members of the 10-Year Plan Oversight Committee, the Government and Community Relations Subcommittee will develop strategies to ensure that the following takes place:

- Meet with local elected officials to garner support & resources for homeless programs
- Meet with administrators and department heads of both public and private service providers to ensure full support of and cooperation in the implementation of the plan
- Meet with local business and philanthropic leaders to secure support

## ***Step #5 – Funding***

Resource development will be a key to the success of the 10-Year Plan. Utilizing the funding recommendations in the previous section, the Homeless Coordinator, the 10-Year Plan Oversight Committee and the Kern County Homeless Collaborative will work together to develop and access additional resources. Some of the strategies will require minimal new funding sources and in some cases can be addressed by a reallocation of existing resources. Others will require in-kind donations. Still others will require the financial involvement of the faith-based community. Access to large scale dollars will be critical for building the housing stock. Obtaining new housing vouchers through the Continuum of Care process will be essential as well. The Project Costs and Funding Strategies Subcommittee will be given the responsibility of locating and recommending possible new funding streams.

## ***Step #6 – Integration***

Although the details of integration as established in the Plan are very specific, there will need to be encouragement and oversight in this area. The Homeless Coordinator or the 10-Year Plan Oversight Committee will begin integration by creating standardized memorandum of understanding that describe service provider's commitments to plan implementation. This MOU can be patterned after the one developed for the Homeless Management Information System. Additionally, each provider should specify *current* services that their organization provides. Having an accurate list of current services will help to develop the official "protocol" regarding how the county officially "responds" to those who are homeless. This will also provide a big picture view of how services can be

integrated through the existing systems. Once there is a clear understanding of available services, coordinated intake assessment can begin and a system of case management can be incorporated into the process.

***Step #7 – Rooms and Residences***

Beginning with the development of an accurate and constantly updated housing availability list, the focus will be on placing as many people as possible in permanent supportive housing. Given the current shortage of supportive housing beds and the urgent need to create more units, the housing element of the Plan should take top priority. Working with the Housing Committee, the Homeless Coordinator and the 10-Year Plan Oversight Committee should place their full support behind the pilot project recommended in the plan (ideally the Mental Health Services Act project). It will continue to work toward creating additional permanent supportive housing through the Continuum of Care process as well. In its oversight role, the 10-Year Plan Committee should encourage and support agencies to spend resources more effectively, position for new projects, and engage in capital projects.

***Step #8 – Sustain and Update the Plan***

*Home First!* is meant to be a dynamic document that will require sustained support and updating as needed. It is recommended that the 10-Year Plan Oversight Committee look at the document on an annual basis and make adjustments to the plan when appropriate. Accordingly, the Oversight Committee should determine a report structure and reporting schedule so that a “State of the Plan” report can be issued annually. Additionally, the Oversight Committee should be actively involved in keeping jurisdictions and the public aware of progress.

***Step #9 – Tracking***

Critical to measuring outcomes will be the adoption of a data collection mechanism that can support collecting and analyzing all of the relevant homeless data. HMIS should be that mechanism to accomplish the task. Utilizing data from HMIS and supplementing it with information from other data gathering efforts such as AB2034, the 10-Year Plan Committee can make accurate predictions about results and make course corrections as needed.

Table 5.1 Implementation

Steps	Action Items/Responsibilities	Purpose
<u>Homeless Coordinator</u>	Begin immediate focus on: <ul style="list-style-type: none"> <li>○ <i>Housing Availability</i></li> <li>○ <i>Plan Funding</i></li> <li>○ <i>Pilot PSH Project</i></li> <li>○ <i>New Housing Units</i></li> <li>○ <i>Discharge Planning</i></li> <li>○ <i>Service Integration</i></li> <li>○ <i>Community Outreach</i></li> <li>○ <i>CoC Application</i></li> </ul>	Managing & Administering Implementation

<p><u>Oversight Committee</u></p>	<p>Re-commission TYPC to focus on overseeing the implementation of the TYP</p> <p>Define position of Homeless Coordinator</p> <ul style="list-style-type: none"> <li>• Identify organization of employment for Homeless Coordinator</li> <li>• Create job description modeled after homeless coordinators in other communities (Pasadena, Glendale etc.)</li> <li>• Identify and secure funding for Homeless Coordinator</li> <li>• Create points of accountability for Homeless Coordinator and plan implementation</li> </ul> <p>Additional areas of focus:</p> <ul style="list-style-type: none"> <li>• Assist in launch of marketing campaign</li> <li>• Develop engagement strategies for community support</li> <li>• Participate in funding and resource development for TYP in general</li> <li>• Support and encourage a system-wide cultural shift within organizations working with chronically homeless people to fully embrace TYP</li> <li>• Periodically update plan</li> <li>• Monitor tracking and measuring results</li> </ul>	<p>Ensuring Accountability &amp; Follow-through of Implementation</p>
<p><u>Marketing</u></p>	<p>Designate Mayor Hall as TYP Champion</p> <p>Launch TYP with Media event</p> <ul style="list-style-type: none"> <li>• Meet with Bakersfield Californian Editorial Board</li> <li>• Seek out radio and television interviews</li> <li>• Make presentations to churches, faith-based groups and community service organizations</li> <li>• Promote through the Regional Community Collaboratives</li> </ul> <p>Government &amp; Community Relations Subcommittee should:</p> <ul style="list-style-type: none"> <li>• Develop a communications strategy in</li> </ul>	<p>Creating Public Awareness and Promoting Implementation</p>

	<p>support of the Plan</p> <ul style="list-style-type: none"> <li>• Create fact sheets and talking points for public distribution</li> <li>• Distribute copies of the Plan to local dignitaries and public officials</li> <li>• Assist in the planning and promotion of a “Homeless Prevention” or “Homeless Awareness” week</li> </ul>	
<u>Engagement</u>	<p>Keys to Engagement:</p> <ul style="list-style-type: none"> <li>• Meet with local elected officials to garner support &amp; resources for homeless programs</li> <li>• Meet with administrators and department heads of both public and private service providers to ensure full support of and cooperation in the implementation of the TYP</li> <li>• Meet with local business and philanthropic leaders to secure support</li> </ul>	Cultivating Support for Implementation
<u>Funding</u>	<p>Suggested Actions:</p> <ul style="list-style-type: none"> <li>• Reallocate existing resources</li> <li>• Seek in-kind donations</li> <li>• Access faith-based dollars</li> <li>• Develop new funding streams</li> <li>• Leverage large dollars for new housing stock</li> <li>• Use the CoC Funding Process for new housing vouchers</li> </ul>	Developing Resources for Implementation
<u>Integration</u>	<p>Suggested Actions:</p> <ul style="list-style-type: none"> <li>• Create MOU’s that describe service providers’ commitments to plan implementation</li> <li>• Develop comprehensive list of available homeless services</li> <li>• Create coordinated intake assessment process</li> <li>• Develop integrated system of case management</li> </ul>	Coordinating & Integrating Services for Implementation
<u>Rooms &amp; Residences</u>	<p>Suggested Actions:</p> <ul style="list-style-type: none"> <li>• Develop accurate housing availability list</li> </ul>	Beginning the Implementation of

	<ul style="list-style-type: none"> <li>• Fully support pilot project</li> <li>• Increase PSH projects in CoC application</li> <li>• Encourage and support agencies to spend resources more effectively, position for new projects, and engage in capital projects.</li> </ul>	the Housing Element of the Plan
<u>Sustain and Update Plan</u>	<p>Suggested Actions:</p> <ul style="list-style-type: none"> <li>• Make adjustments as needed</li> <li>• Determine a report structure and reporting schedule</li> <li>• Issue an annual “State of the Plan” report</li> <li>• Keep jurisdictions and public aware of homelessness efforts</li> </ul>	Reviewing Plan Implementation & Progress
<u>Tracking</u>	<p>Suggested Actions:</p> <ul style="list-style-type: none"> <li>• Define what shall be measured and monitored, develop an evaluation design, and work on research to document progress in implementing the Plan</li> <li>• Utilize data from HMIS and supplement with information from other data gathering efforts such as AB2034</li> </ul>	Reporting Outcomes & Measuring Implementation Results

## **Glossary & Abbreviation Chart**

### **Definitions:**

**Assertive Community Treatment (ACT)** – A team treatment approach designed to provide comprehensive, community-based treatment, rehabilitation, and support to persons with serious and persistent mental illness.

**At-Risk of Homelessness** – On the edge of becoming homeless, often because of extremely low incomes and having to pay a large percent (typically 50 percent or more) of the adjusted gross household income for housing expenses.

**Case Management** – Services focused on identifying goals, developing action plans and coordinating resources to assist clients in attaining greater self-sufficiency.

**Chronic Homeless Person (HUD)** – An unaccompanied homeless individual with a disabling condition (see definition of "disability" below) who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years.

**Community Development Block Grant (CDBG)** - A federal block grant program administered by HUD and provided to local communities to support community development through acquisition, construction, rehabilitation and operation of public facilities and housing.

**Continuum of Care** – A comprehensive system for delivery of services to the homeless. HUD recommends a community's continuum of care include outreach and identification, emergency shelter, transitional housing, permanent housing and accompanying services.

**Disability** – A physical or mental impairment that substantially limits one or more major life activities, such as caring for oneself, speaking, walking, seeing, hearing, or learning.

**Discharge Planning** – Activities designed to facilitate and coordinate the release and aftercare needs of individuals from any publicly funded institutions or systems of care following any length of stay to prevent homelessness.

**Fair Market Rent (FMR)** – The amount determined by HUD per state, county, or urban area that determines the maximum allowable rent for HUD-funded housing programs.

**Emergency Shelter** – Any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless. (HUD definition)

**Homeless Management Information System (HMIS)** – A coordinated computerized system utilized to compile demographic data and track homeless clients through the service delivery system. HUD mandates all communities to implement an HMIS system by 2004 to be eligible to continue to receive HUD funding for homeless services.

**HOME Investment Partnership Program** – HOME is the largest Federal block grant to State and local governments designed exclusively to create affordable housing for low-income households. Each year it allocates more than \$1 billion to the States and hundreds of localities nationwide. HOME provides formula grants that communities use to: construct, acquire, and/or rehabilitate affordable housing for rent or homeownership; or, provide direct rental assistance to low-income people.

**Homeless Person (per HUD)** – A person sleeping in a place not meant for human habitation, in an emergency shelter; or transitional housing for homeless persons who originally came from the street or an emergency shelter or being released from an institutional situation having resided in the institution for more than 30 days and having no fixed permanent residence to which they can return. If being released from an institution and having stayed less than 30 days, they must have been homeless before entering the institution to be considered homeless upon release.

**Housing First Strategies** – Goals to immediately house people who are homeless. Housing comes first no matter what is going on in one's life, and the housing is flexible and independent so that people get housed easily and stay housed. Housing first can be contrasted with a continuum of housing "readiness," which typically subordinates access to permanent housing to other requirements. While not every community has what it needs to deliver housing first, such as an adequate housing stock, every community has what it takes to move toward this approach.

**Housing Opportunities for Persons With AIDS (HOPWA)** – HOPWA provides states and localities with resources and incentives to devise long-term comprehensive housing strategies for meeting the housing needs of low-income persons living with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

**Housing Subsidy** – Funds typically paid from federal or other sources to help make a housing unit affordable to a low-income household. The subsidy is the difference in the amount of the rent that is affordable to the tenant and the actual rent amount.

**Intensive Case Management** – Long term, time intensive services to assist in goal identifying and development of action steps leading to self-sufficiency through resource coordination.

**Mainstream Services** – Government-funded programs designed to meet the needs of low income people. Examples include Temporary Assistance to Needy Families (TANF)

**McKinney-Vento Funds** – The Stewart B. McKinney Homeless Assistance Act (PL100-77) was the first -- and remains the only -- major federal legislative response to

homelessness. The McKinney Act originally consisted of fifteen programs providing a range of services to homeless people, including emergency shelter, transitional housing, job training, primary health care, education, and some permanent housing.

**Project Based Section 8** – A federally funded housing program developed in the 1980s to increase the supply of units affordable to low income households. Developers were given low interest loans for housing development in exchange for setting aside a determined amount of units to be rented at household adjusted income affordable rates.

**Public Housing** – A federally funded housing program for low-income households administered by HUD and operated locally by Housing Authority of the County of Kern. Public housing units are owned and operated by the Housing Authority. The amount of rent paid by the tenant is determined by the affordability of the adjusted household income.

**Rural Housing and Economic Development Program (RHED)** – The RHED Program is designed to support innovative housing and economic development activities in rural areas. The program provides funding to local rural non-profit organizations, community development corporations, federally designated Indian tribes, state housing financing agencies, and state community and/or economic development agencies for the implementation of innovative housing and economic development activities in rural areas.

**Section 8 Voucher Program** – The Section 8 Voucher program is a subsidized housing program that helps poor, elderly and disabled people to rent decent housing.

**Service Enriched Housing** – Integrating services into existing rental housing for the low income population to preserve existing housing options and increase successful housing placements.

**Social Security Disability Insurance (SSDI )** – SSDI benefits go to you and certain members of your family if you are "insured," meaning that you worked long enough and paid Social Security taxes. The definition of disability under Social Security is different than other programs.

**Stakeholders** – The various groups with an interest in the quality, governance, and operation of a certification program, such as the public, employers, customers, clients, third party payers, etc.

**Supplemental Security Income (SSI)** – A Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

**Supportive Housing** – Permanent, subsidized housing that has on-site supportive services and flexible management that assists the tenant in overcoming barriers that previously led to homelessness.

**Supportive Housing Program (SHP)** – A competitive grant program that specifically funds homeless programs identified as permanent housing, transitional housing or supportive services.

**Temporary Assistance to Needy Families (TANF)** – Program that was created by the Welfare Reform Law of 1996. TANF replaced what was then commonly known as welfare: *Aid to Families with Dependent Children (AFDC)* and the *Job Opportunities and Basic Skills Training (JOBS)* programs. *Temporary Assistance for Needy Families (TANF)* provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs.

**Transitional Housing** – One type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing, It is housing in which homeless persons live for up to 24 months and receive supportive services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or coordinated by them and provided by other public or private agencies. (HUD definition)

**U.S. Department of Housing and Urban Development (HUD)** – Responsible for the implementation and administration of government housing and urban development programs including low-rent public housing, mortgage insurance for residential mortgages (FHA), equal opportunity in housing, energy-efficient mortgages, and research and technology.

**U.S. Interagency Council on Homelessness** – Congress established the Interagency Council on Homelessness in 1987 with the passage of the Stewart B. McKinney Homeless Assistance Act. The Council is responsible for providing Federal leadership for activities to assist homeless families and individuals.

**Workforce Investment Act (WIA)** – The WIA, which superseded the Job Training Partnership Act, offers a comprehensive range of workforce development activities through statewide and local organizations. Available workforce development activities provided in local communities can benefit job seekers, laid off workers, youth, incumbent workers, new entrants to the workforce, veterans, persons with disabilities, and employers.

**Abbreviation Key Organizations:**

AAFVSA – Alliance Against Family Violence & Sexual Assault  
AHP – Affordable Housing Program  
AMI – Area Median Income  
BRM – Bakersfield Rescue Mission  
BPD – Bakersfield Police Department  
BSA – Bakersfield Salvation Army  
BHC – Bakersfield Homeless Center (Bethany Services)  
CVAF – California Veterans Assistance Foundation  
CSC/ETR – Career Services Center/Employers Training Resource  
CC – Catholic Charities  
Clinica Sierra Vista – CSV  
Community Action Partnership of Kern – CAPK  
Covenant Community Services – CCS  
Golden Empire Affordable Housing - GEAH  
Golden Empire Transit – GET  
Goodwill Industries – GI  
Greater Bakersfield Legal Assistance – GBLA  
Housing Authority of the County of Kern – HACK  
Independent Living Center of Kern County – ILC  
Kern County Department of Human Services – DHS  
Kern County Homeless Collaborative – KCHC  
Kern County Mental Health Department – KCMH  
Kern County Sheriff’s Department – KCSD  
Mental Health Services Act (Prop 63) - MHSA  
Proteus, Inc. – PRO  
St. Vincent de Paul – SVdP  
Tabitha’s House Ministries, Inc. – THM  
United Way of Kern County – UWKC

## APPENDICES

### *Appendix A*

#### **Background and History:**

**1995** – After seven years of distributing McKinney Act Supportive Housing Program (SHP) funds through annual national competitions, HUD implements the competitive continuum-of-care (CoC) approach for deciding who receives SHP support for transitional and permanent supportive housing.

**2000** – The National Alliance to End Homelessness (NAEH) develops and disseminates a plan to end homelessness for the whole nation in 10 years.

**2001** – Secretary of Housing and Urban Development, Mel Martinez announces his agency’s acceptance of the NAEH goal in his keynote speech at the National Alliance’s 2001 Conference.

**2001** – The federal Interagency Council on Homelessness is revitalized and federal agencies are mobilized to do their share.

**2002** – The “Samaritan Initiative Act of 2004” (H.R. 4057) is introduced in the U.S. Congress to support local community efforts to end chronic homelessness. All communities seeking funds from the U.S. Department of Housing and Urban Development (HUD) through the McKinney-Vento Continuum of Care grant application process were strongly encouraged to develop a Ten-Year Plan to End Chronic Homelessness in their community.

**2003** – President Bush made “ending chronic homelessness in the next decade a top objective” in his 2003 Budget.

**2003** – The U.S. Conference of Mayors adopts the NAEH Goal.

**Late 2005** – Bakersfield Mayor Harvey Hall convened a committee of service providers and local government agency representatives to begin work on a 10-Year Plan to End Homelessness.

**February 2006** – The 10-Year Plan Committee begins meeting.

**March 2006** – Mayor Harvey Hall approaches United Way of Kern County Board about partnering on the 10-Year Plan. The United Way Board agrees to allow staff to take the lead in the process.

**June 2006** – A Press Conference is held with Philip Mangano of the U.S. Interagency Council on Homelessness and Mayor Hall. Mr. Mangano meets with 10-Year Plan Committee.

**August 2006** – Eduardo Cabrera from the U.S. Interagency Council on Homelessness made a brief presentation to the group of a video clip from the recent *National Summit for Jurisdictional Leaders: Moving From Good to Better to Great in Sustaining 10-Year Plans to End Chronic Homelessness*. The clip featured author Jim Collins discussing the new kind of thinking required to implement 10-Year Plans.

Miriam Krehbiel announced that Nicholas Ortiz has been hired as Self-Sufficiency Coordinator by United Way, with responsibility for coordinating activities of the Kern County Homeless Collaborative and the 10-Year Plan Committee. His start date is Sept. 11. The position is made possible in part by a grant from Kern County mental Health.

**September 2006** – Meeting held at St. Paul’s Episcopal Church to brief local faith leaders on the 10-Year Plan and solicit their involvement.

The Steering Committee approved a working list of subcommittees dedicated to providing input into the 10-year plan.

- Government/Community Relations which educates stakeholders and develops political will;
- Housing Strategies which quantifies the amounts and types of housing to address the need;
- Financing which analyzes and recommends funding sources and strategies;
- Cost Analysis which quantifies the cost of homelessness;
- Integrated Services which identifies the types of services needed in supportive housing developments and how to best deploy them; and
- Prevention which develops strategies to bolster at-risk individuals and families.
- Discharge Planning which will research current discharge methods and attempt to streamline them and strengthen the links between discharging institutions and service agencies.

**Throughout 2007** – Subcommittees meet to fulfill their assignments and make recommendations.

**October 2007** – Jim Wheeler is hired as Financial Stability Coordinator. He is tasked with completing the 10-Year Plan.

**February-March 2008** – Strategy planning meetings are held to finalize plan details.

**April 2008** – Completed Rough Draft is circulated for feedback and approval.

**May 2008** – Home First: Kern County’s 10-Year Plan to End Chronic Homelessness is approved by the 10-Year Plan Committee.

## ***Appendix B***

### **Committee Membership**

#### **Kern County's Ten-Year Plan to End Chronic Homelessness**

##### **Government & Community Relations:**

CHAIR: Dennis Wallace, Habitat for Humanity – Golden Empire  
Mayor Harvey L. Hall, City of Bakersfield  
Miriam Krehbiel, United Way of Kern County  
William Andrews, Assemblymember Nicole Parra  
Louis B. Gill, Bakersfield Homeless Center  
Sheryl Chalupa, Goodwill Industries  
Carmen Handy, Foundation for Success  
Juan Garcia, Clinica Sierra Vista  
Jonathan Webster

##### **Housing Strategies:**

CHAIR: Stephen Pelz, Housing Authority of the County of Kern (HACK)  
Jim Childress, Childress Construction  
George Gonzales, City of Bakersfield  
Gene Saint-Amand, Kern County Mental Health  
Maribel Reyna, City of Bakersfield  
Tricia Richter, City of Bakersfield  
Evelyn Danowitz, Corporation for Better Housing  
Louis B. Gill, Bakersfield Homeless Center  
David Press, County of Kern  
Bonita Steele, Community Action Partnership of Kern  
Tina Lerma, Independent Living Center of Kern County  
Carolyn Wade, County Mental Health  
Marie Wall, Clinica Sierra Vista

##### **Project Cost & Funding Strategies:**

CHAIR: Mike Blake, Union Bank of California  
Louis B. Gill, Bakersfield Homeless Center  
Miriam Krehbiel, United Way of Kern County  
Stephen Pelz, Housing Authority of the County of Kern  
Dennis Wallace, Habitat for Humanity – Golden Empire  
Bonita Steele, Community Action Partnership of Kern  
Mark Smith, Housing Authority of Wasco

##### **Guiding Principles:**

CHAIR: Fred Drew, Community Action Partnership of Kern  
Cristy Cortez-Sackrider, Kaiser Permanente  
Edith Gibson, Watson Realty  
Lisa Hammond, Greater Bakersfield Legal Assistance

David Strong, Corporation For Better Housing  
William Andrews, Office of Assemblymember Nicole Parra  
Father Rob Wenzinger, St Joseph's Church  
Della Hodson, United Way of Kern County

**Discharge Planning:**

CHAIR: Lisa Hammond, GBLA  
Marie Wall, Clinica Sierra Vista  
Kristin Reynolds, Mercy Hospital  
Jeanne Tripicchio, Mercy Hospital

**Data & Cost Analysis:**

CHAIR: Mark Smith, Housing Authority of Wasco  
Bonita Steele, Community Action Partnership of Kern

**Outreach & Consumer Awareness:**

CHAIR: Walter Williams, GBLA  
Tina Lerma, Independent Living Center of Kern County  
John Marshall, Senior Serve  
Nicholas Umholtz, His House of Refuge Church

**Prevention:**

CHAIR: Father Rob Wenzinger, St Joseph's Church  
Bonita Steele, Community Action Partnership of Kern  
Juan Garcia, Clinica Sierra Vista  
Tina Lerma, Independent Living Center of Kern County

**Special Acknowledgements for Historical Documentation:**

Gene Saint-Amand  
Della Hodson  
Miriam Krehbiel  
Nicolas Ortiz

## Appendix C

### 2006 METRO BAKERSFIELD QUESTIONNAIRE RESULTS

#### A. SHELTERED VS. UNSHELTERED HOMELESS SURVEY RESULTS

**1. Sleeping Places.** Unsheltered interviewees were asked to check only one answer to the following question: “Where did you sleep last night? Please check only one.”

Where Slept	Unsheltered Homeless 285	%	Sheltered Homeless 363	%	Total 648	%
Outdoors/Streets/Campsite	200	70%	--	--	200	31%
Abandoned Building/Structure	36	13%	--	--	36	6%
Car/Van/Other Vehicle	40	14%	--	--	40	6%
Other	9	3%	--	--	9	1%
Emergency Sheltered	--	--	236	65%	236	36%
Transitional Housing	--	--	127	35%	127	20%

**2. Age.** Interviewees were asked: “Which of the following age groups do you fall into?”

Age Ranges	Unsheltered 285	% Total	Sheltered 363	%	Total 648	%
Under 18 Years Old	2	1%	2	1%	4	1%
18 - 44 Years Old	140	49%	226	62%	366	56%
45 – 54 Years Old	98	34%	82	23%	180	28%
55 Years Old or Older	43	15%	53	15%	96	15%

**3. Domestic Violence.** Interviewees were asked: “Are you a victim of domestic or family violence? By that, I mean has a spouse/partner, parent or other family member ever physically or emotionally abused you?”

Domestic Violence Victim	Unsheltered 285	% Total	Sheltered 363	%	Total 648	%
Yes	49	17%	99	27%	148	23%
No	236	83%	264	73%	500	77%

**4. Length of Time Homeless.** Interviewees were asked: “How long has it been since you have lived in your own home, room, or apartment?”

Time Since Had Own Home	Unsheltered 285	%	Sheltered 363	%	Total 648	%
Less than a Year	99	35%	180	50%	279	43%
At Least a Year or More	185	65%	183	50%	368	57%

**5. Number of Times Homeless.** Interviewees were asked: “On how many separate occasions have you been without a regular place to live, staying on the streets or in a shelter, in the past three years?”

Times Homeless Past 3 Years	Unsheltered 285	%	Sheltered 363	%	Total 648	%

<b>Just Once</b>	92	32%	151	42%	243	37%
<b>Two to Three Times</b>	59	21%	123	34%	182	28%
<b>Four or More Times</b>	127	45%	88	24%	215	33%

**6. Veteran Status.** Interviewees were asked: “Are you a veteran of the U.S. military?”

<b>Military Veteran</b>	<b>Unsheltered</b> 285	<b>%</b>	<b>Sheltered</b> 363	<b>%</b>	<b>Total</b> 648	<b>%</b>
<b>Yes</b>	60	21%	58	16%	118	18%
<b>No</b>	225	79%	305	84%	530	82%

**7. Reasons for Homelessness.** Interviewees were asked: “Now, I’m going to read you a list of reasons some people don’t have housing. Please let me know if any of them apply to you?”

<b>Reason Homeless</b>	<b>Unsheltered</b> 285	<b>% Total</b>	<b>Sheltered</b> 363	<b>%</b>	<b>Total</b> 648	<b>%</b>
<b>High Housing/Rent Costs</b>	153	54%	159	44%	312	48%
<b>Lost Job/Unemployment</b>	137	48%	179	49%	316	49%
<b>Alcohol/Drug problems</b>	65	23%	148	41%	213	33%
<b>Physical Disability</b>	59	21%	80	22%	139	21%
<b>Mental/Emotional Problems</b>	56	20%	110	30%	166	26%
<b>Lost/Can’t Obtain Welfare or Disability Benefits</b>	51	18%	84	23%	135	21%
<b>Break-up/Divorce/Separation</b>	49	17%	98	27%	147	23%
<b>Released Jail/Prison</b>	34	12%	75	21%	79	12%
<b>Illness/Medical Problem</b>	32	11%	76	21%	108	17%
<b>Housing Eviction</b>	27	9%	66	18%	93	14%
<b>Family Violence</b>	19	7%	58	16%	77	12%
<b>Left/ran Away from Home</b>	15	5%	30	8%	45	10%
<b>Released from hospital</b>	10	4%	27	7%	37	6%
<b>Left Foster Care</b>	2	1%	14	4%	16	2%
<b>Other:</b>	43	15%	29	8%	72	11%

**B. MALE VS. FEMALE HOMELESS SURVEY RESULTS**

**1. Sleeping Places.** Unsheltered interviewees were asked to check only one answer to the following question: “Where did you sleep last night? Please check only one.”

<b>Where Slept</b>	<b>Male</b> 462	<b>%</b> 71%	<b>Female</b> 186	<b>%</b> 29%	<b>Total</b> 648	<b>%</b>
<b>Outdoors/Streets/Campsite</b>	163	35%	37	20%	200	31%
<b>Abandoned Building/Structure</b>	26	6%	10	5%	36	6%
<b>Car/Van/Other Vehicle</b>	21	6%	19	10%	40	6%
<b>Other</b>	8	1%	1	1%	9	1%
<b>Emergency Sheltered</b>	183	40%	53	28%	236	36%
<b>Transitional Housing</b>	61	13%	66	35%	127	20%

**2. Age.** Interviewees were asked: “Which of the following age groups do you fall into?”

<b>Age Ranges</b>	<b>Male</b> 462	<b>%</b>	<b>Female</b> 186	<b>%</b>	<b>Total</b> 648	<b>%</b>
<b>Under 18 Years Old</b>	3	1%	1	1%	4	1%

<b>18 - 44 Years Old</b>	228	49%	138	74%	366	56%
<b>45 – 54 Years Old</b>	143	31%	37	20%	180	28%
<b>55 Years Old or Older</b>	86	19%	10	5%	96	15%

**3. Domestic Violence.** Interviewees were asked: “Are you a victim of domestic or family violence? By that, I mean has a spouse/partner, parent or other family member ever physically or emotionally abused you?”

<b>Domestic Violence Victim</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Yes	72	16%	76	41%	148	23%

**4. Length of Time Homeless.** Interviewees were asked: “How long has it been since you have lived in your own home, room, or apartment?”

<b>Time Since Had Own Home</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Less than a Year	175	38%	103	55%	278	43%
At Least a Year or More	286	62%	82	44%	368	57%

**5. Number of Times Homeless.** Interviewees were asked: “On how many separate occasions have you been without a regular place to live, staying on the streets or in a shelter, in the past three years?”

<b>Times Homeless Past 3 Years</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Just Once	155	34%	88	47%	243	37%
Two to Three Times	124	27%	58	31%	182	28%
Four or More Times	175	38%	40	22%	215	33%

**6. Veteran Status.** Interviewees were asked: “Are you a veteran of the U.S. military?”

<b>Military Veteran</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Yes	112	24%	6	3%	118	18%

**7. Reasons for Homelessness.** Interviewees were asked: “Now, I’m going to read you a list of reasons some people don’t have housing. Please let me know if any of them apply to you?”

<b>Reason Homeless</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
High Housing/Rent Costs	207	45%	105	56%	312	48%
Lost Job/Unemployment	230	50%	86	46%	316	49%
Alcohol/Drug problems	150	32%	63	34%	213	33%
Physical Disability	112	24%	27	15%	139	21%
Mental/Emotional Problems	119	26%	47	25%	166	26%
Lost/Can’t Obtain Welfare or Disability	86	19%	49	26%	135	21%
Break-up/Divorce/ Separation	91	20%	56	30%	147	23%
Released Jail/Prison	77	17%	32	17%	79	12%
Illness/Medical Problem	86	19%	22	12%	108	17%
Housing Eviction	44	10%	49	26%	93	14%
Family Violence	32	7%	45	24%	77	12%
Left/ran Away from Home	28	6%	17	9%	45	10%
Released from hospital	30	6%	7	4%	37	6%
Left Foster Care	10	2%	6	3%	16	2%
Other:	55	12%	18	10%	72	11%

## *Appendix D*

### Kern County Homeless Collaborative 2007 HOMELESS CENSUS RESULTS

#### I. Homeless Count, by Sheltered/Unsheltered Status

Sheltered Status	Women	Men	Unknown	Subtotal Single Adults	Separate Family Units	Adults in Families	Children in Families	Subtotal Family Members	Total Homeless	Percent Total
Sheltered Homeless	147	499	0	<b>646</b>	83	86	173	<b>259</b>	<b>905</b>	<b>59%</b>
Unsheltered Homeless	121	473	8	<b>602</b>	6	11	19	<b>30</b>	<b>632</b>	<b>41%</b>
<b>Total</b>	268	972	8	<b>1,248</b>	89	97	192	<b>289</b>	<b>1,537</b>	<b>100%</b>
<b>Percent Total</b>	17%	63%	1%	<b>81%</b>	n/a	7%	12%	<b>19%</b>	<b>100%</b>	n/a

#### II. Sheltered Count, by Type Program, Night of January 24/25, 2007

Type Program	Women	Men	Subtotal Single Adults	Separate Family Units	Adults in Families	Children in Families	Subtotal Family Members	Total Homeless
Emergency Shelter	46	206	<b>252</b>	40	40	97	<b>137</b>	<b>389</b>
Transitional Housing Program	101	293	<b>394</b>	43	46	76	<b>122</b>	<b>516</b>
<b>Total Sheltered</b>	147	499	<b>646</b>	83	86	173	<b>259</b>	<b>905</b>

#### III. Unsheltered Homeless County, by Major Region, Day of January 25, 2007

Region	Women	Men	Unknown	Subtotal Single Adults	Separate Family Units	Adults in Families	Children in Families	Subtotal Family Members	Total Homeless
Metro Bakersfield	112	415	7	<b>534</b>	1	1	2	<b>3</b>	<b>537</b>
West Kern	2	37	0	<b>39</b>	5	10	17	<b>27</b>	<b>66</b>
East Kern	<b>7</b>	21	1	<b>29</b>	0	0	0	<b>0</b>	<b>29</b>
<b>Total Unsheltered</b>	121	473	8	<b>602</b>	6	11	19	<b>30</b>	<b>632</b>

## ***Appendix E***

### **AB 2034**

#### **Background**

In 1999 the State Legislature passed Assembly Bill (AB) 34 which provided \$10 million for pilot programs to provide services for homeless individuals in Stanislaus, Los Angeles, and Sacramento counties. (Experiences 1). Future funding for similar programs was dependent on the success of the three pilot programs as measured by positive client and system outcomes including cost effectiveness within that first year. (Leg. Report 1). The pilot programs were very successful in reducing the number of homeless days, jail days, and psychiatric hospital days experienced by enrollees. As a result of this success the legislature passed AB 2034 which expanded the pilot programs and created additional programs statewide directed at serving homeless persons, parolees, and probationers with serious mental illness. (Leg. Report 1). At the height of the program, AB 2034 funds were serving over 4,500 mentally ill homeless or incarcerated individuals (AB34.org) through 53 programs operating in 34 counties throughout California. (Experiences 1). AB 2034 funds allowed localities to provide comprehensive services “to adults who have serious mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them.” (Leg. Report 2). Due to the flexibility of funding provided under AB 2034, counties were able “to provide a comprehensive array of services including outreach, supportive housing and other housing assistance, employment, substance abuse, and mental and physical healthcare” to enrollees. (Leg. Report 2).

#### **Effectiveness of AB 2034 Programs**

##### What Worked

The AB 2034 programs were very effective at serving a variety of consumer needs. The success of these programs can be seen by comparing pre-enrollment information to post-enrollment information (data current as of January 31, 2003). There was marked improvement in several categories including hospitalizations, incarcerations, levels of homelessness, income, and employment. (Leg. Report 9-12).

##### Hospitalizations

- Number of consumers hospitalized decreased 42.3%
- Number of hospital admissions decreased 28.4%
- Number of hospital days decreased 55.8%

(Leg. Report 9)

##### Incarcerations

- Number of consumers incarcerated decreased 58.3%
- Number of incarcerations decreased 45.9%
- Number of incarceration days decreased 72.1%

(Leg. Report 10)

### Income

- The number of SSI recipients increased by 93.1%
  - The number of people receiving wages from employment increased by 279.8%
- (Leg. Report 11)

### Housing

- There was a 73.5% reduction in the number of consumers who were homeless
  - The number of consumers who became homeless since enrollment compared to the number of consumers who were homeless prior to enrollment decreased 71.3%
  - The overall number of homeless days experienced by consumers decreased by 67.3%
- (Leg. Report 11)

### Employment

- There was a 19.6% increase in the number of consumers who were employed full time with a 65.4% increase in the number of days of employment
  - There was a 14.4% increase in the number of consumers who were employed part-time, with a 53.1% increase in the number of days of employment
  - As of January 31, 2003, 13.3% of all consumers enrolled in the program were employed
- (Leg. Report 11-12)

### What Needs Improvement

While AB 2034 programs were very effective in serving the needs of enrolled consumers, improvement was needed in the level of participant retention. 22.7% of all consumers ever enrolled in AB 2034 programs disappeared or dropped out. (Leg. Report 13). A further 1.75% of consumers were disenrolled due to their death. (Leg. Report 13). This data indicates a need for more emphasis on the physical healthcare needs of participants as well as strategies to increase retention rates. The data also shows an under representation of Hispanic people relative to other racial/ethnic groups. Hispanic people represented only about 12% of the AB 2034 population. This lower representation suggests that AB 2034 programs may need to improve their outreach to the Hispanic community. (Leg. Report 8)

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[www.csh.org/index.cfm?fuseaction=Page.viewPage&PageID=3621](http://www.csh.org/index.cfm?fuseaction=Page.viewPage&PageID=3621)
3. Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness, Report to the Legislature 2003. California Department of Mental Health, Stephen W. Mayberg, Ph.D. Director. May 2003.  
[www.dmh.cahwnet.gov/AOAPP/Int\\_Services/docs/Leg\\_Report\\_2003.pdf](http://www.dmh.cahwnet.gov/AOAPP/Int_Services/docs/Leg_Report_2003.pdf)

(Source: <http://www.homebaseccc.org/PDFs/CATenYearPlan/CAHighlightOutreach.pdf>)

# Kern County AB2034 Program Results as of July 2007

**Kern County AB 2034 Program**

**July Numbers**

**Persons Served Summary as of July for FY 07/08**

Carry-over consumers from FY 05/06	151
First time admissions since FY 06/07	33
Return admissions since FY 06/07	2
Discharged FY	30
Current Enrollment	151

<b>Gender =</b>
Male = 65      Female = 86

<b>Disability =</b>
Mentally Ill = 46
Dually Diagnosed = 105

<b>Race Distribution =</b>	
Caucasian	103
Latino / Hispanic	20
African American	18
Asian American	3
Native American	3
Pacific Islander	1
Other	3

<b>Monthly Income at End of Period</b>	
No Income	= 41
\$1 - \$500	= 13
\$501 - \$1,000	= 74
\$1,001 - \$1,500	= 15
\$1,500 +	= 4

<b>Hospitalization:</b>	
Days of Hospitalization 12 months prior to enrollment	= 1,397
Hospitalization Episodes 12 months prior to enrollment	= 32
Days of Hospitalization since enrollment	= 224
Hospitalization Episodes since enrollment	= 32

<b>Employment</b>	<b>at en.</b>	<b>since en.</b>
Competitive Employment	9	2
Paid In-house		1
Non-Paid Work Exp.	1	6
Other Gainful/Employment	1	1
Transitional		
Unemployed	131	141
Other		
		<b>151</b>

<b>Incarceration</b>	
Incarceration days 12 months prior to enrollment	= 2,072
Incarceration Episodes 12 months prior to enrollment	= 52
Incarcerated days since enrollment	= 490
Incarceration Episodes since enrollment	= 15

<b>Education</b>	<b>at en.</b>	<b>since en.</b>
High School/Adult	1	0
Technical/Vocational	3	0
Community /4 year College	0	3
Graduate School	0	0
Not in school	146	146
Other	0	2
	<b>Total</b>	<b>151</b>

Homeless days 12 months prior to enrollment	= 20,263
Homeless Episodes 12 months prior to enrollment	= 180
Homeless days since enrollment	= 3,587
Homeless Episodes since enrollment	= 35

**Kern County AB 2034 Program**

**July Numbers**

Income	At Enrol	Since Enrol
Caregiver's Wages	1	0
P. Wages	7	6
Spouse/Sig. Other	1	1
Family	3	2
GA	6	11
Food Stamps	28	34
SSI/SSDI	14	18
SDI	2	3
Other	7	4
None	2	2

<b>Residence</b>	<b>at Enr.</b>	<b>since Enr.</b>
Unknown	0	
W/one or both parents	2	9
Family Members	14	5
Apartment	19	56
Single Room Occupancy	15	29
Emergency Shelter	19	2
Homeless	18	5
Unlicensed but Supervised	2	2
Unlicensed but Cong.	31	23
Licensed Board & Care	21	12
Acute Medical	1	1
Acute Psychiatric	3	3
State Psychiatric	2	0
Licensed Residential Treatment	2	0
Other	1	0
Jail	0	4

Numbers reflect currently enrolled consumers.

**Incarceration**

Number of days incarcerated 12 months prior to enrollment	2,072x \$90 = \$ 186,480
Number of days incarcerated since enrollment	490x \$90 = \$ 44,100
Savings of	<u>\$ 142,380</u>

<b>Insurance Status</b>	
No Insurance at Enrollment	132
Obtained Insurance Since Enrollment	62
Had Insurance at Enrollment	19

**Hospital**

Number of days hospitalized 12 months prior to enrollment	1,397x \$1,000 = \$ 1,397,000
Number of days hospitalized since enrollment	224x \$1,000 = \$ 224,000
Savings of	<u>\$ 1,173,000</u>

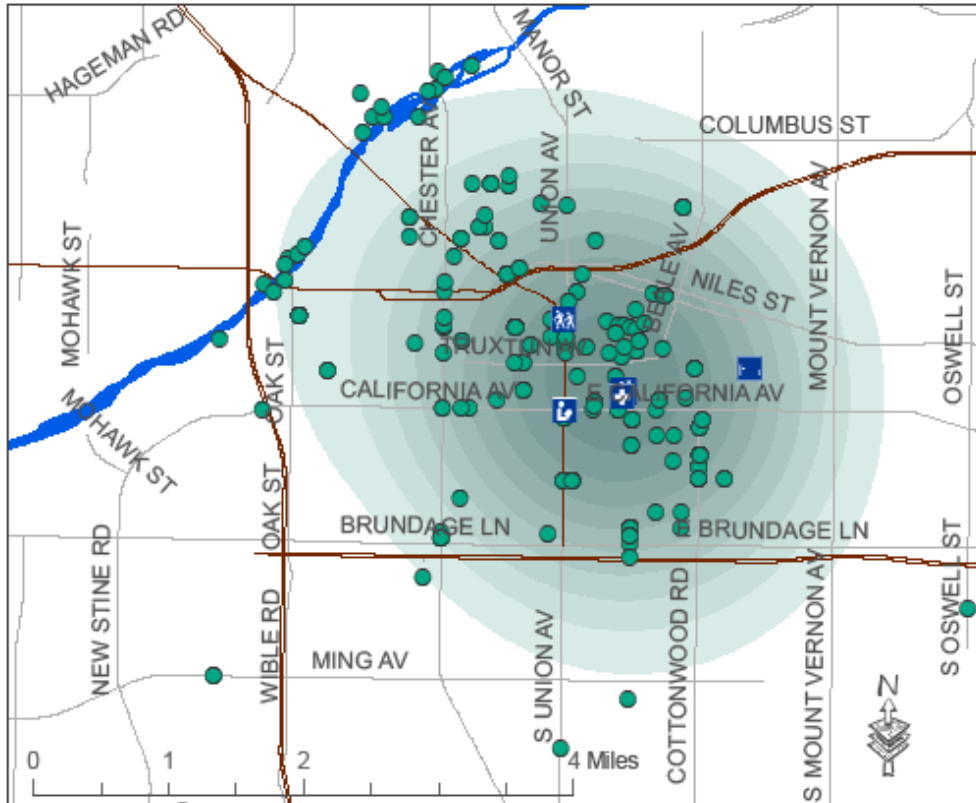
*Appendix F*  
**Homeless Service Resources**

(1) Provider Organizations	(2) Prevention					(3) Outreach			(4) Supportive Services									
	Mortgage Assistance	Rental Assistance	Utilities Assistance	Counseling/Advocacy	Legal Assistance	Street Outreach	Mobile Clinic	Law Enforcement	Case Management	Life Skills	Alcohol & Drug Abuse	Mental Health Counseling	Healthcare	HIV/AIDS	Education	Employment	Child Care	Transportation
AA/NA											X							
Alliance Against Family Violence		X	X	X	X				X	X					X			X
ALPHA House (Taft)				X														
Bakersfield Adult School															X	X		
Bakersfield AIDS Project				X					X	X				X	X			
Bakersfield Police Department								X										
Bakersfield Rescue Mission				X						X					X	X		
Bakersfield Salvation Army	X	X	X	X		X				X	X				X	X		X
Bethany Services (Bakersfield Homeless Center)	X	X	X	X					X	X	X		X		X	X	X	X
California Veterans Assistance Foundation		X		X					X	X	X				X	X		X
Career Services Center/Employers Training Resource															X	X		
Catholic Charities	X	X																
Clinica Sierra Vista		X		X		X	X		X			X	X	X	X			X
Community Action Partnership of Kern		X	X	X		X			X	X			X	X	X		X	X
Community Connection for Childcare				X													X	
Community Support Options (CSO)				X					X	X	X				X			X
Community Service Organizations				X														
Golden Empire Transit																		X
Greater Bakersfield Legal Assistance				X	X	X			X	X			X		X	X		
Griffin's Gate – Casa de Amigos				X					X	X	X				X			
Homeless Quarters		X	X												X			
Housing Authority of the County of Kern		X	X						X									

Provider Organizations	Mortgage Assistance	Rental Assistance	Utilities Assistance	Counseling/Advocacy	Legal Assistance	Street Outreach	Mobile Clinic	Law Enforcement	Case Management	Life Skills	Alcohol & Drug Abuse	Mental Health Counseling	Healthcare	HIV/AIDS	Education	Employment	Child Care	Transportation
Independent Living Center of Kern County		X		X		X			X	X					X			X
Jesus Shack				X		X			X	X								
Kern County Department of Aging & Adult Services		X		X	X				X	X		X		X	X			X
Kern County Department of Human Services		X	X						X	X					X	X	X	X
Kern County Department of Public Health		X		X					X	X			X	X	X			
Kern County Long Term Care Ombudsman				X														
Kern County Mental Health Department		X	X	X	X	X			X	X	X	X		X	X	X		X
Kern County Network for Children/Family Resource Centers		X		X														
Kern County Sherriff's Department								X										
Kern County Veterans Service Department				X														
Kern Medical Center (KMC)												X	X	X				
Kern Regional Center		X		X	X				X	X	X	X		X	X	X		X
Kern River Valley Family Resource Center		X		X														
N.E.E.D.S. Center (Taft)	X	X																
New Life Recovery & Training Center									X	X	X	X			X	X		
Proteus, Inc.		X		X											X	X		
Restoration Village Treatment Center		X	X	X						X	X				X		X	
Salvation Army (Bakersfield, Ridgecrest, Delano)	X	X	X			X					X					X		
St. Vincent de Paul	X	X	X															
Tabitha's House Ministries, Inc.				X							X							
Teen Challenge											X				X	X		
Women's Center High Desert (Ridgecrest)	X	X		X	X				X	X							X	

## Appendix G








### Density of Unsheltered Homeless Persons in Metro Bakersfield Homeless Census, January 24th-25th, 2007



**Data Sets:**  
 County of Kern  
 Road File 2007  
 Kern Homeless Collaborative,  
 Homeless Census Data 2007

**Mapping and Analysis:**  
 Kern County Network for Children,  
 Research and Evaluation Team, April 2007

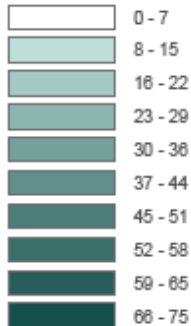
#### Service Providers

-  Bakersfield Homeless Center
-  Bakersfield Rescue Mission
-  Community Action Partnership
-  Department of Human Services
-  Homeless Healthcare Clinic
-  Kern Medical Center
-  St. Vincent DePaul

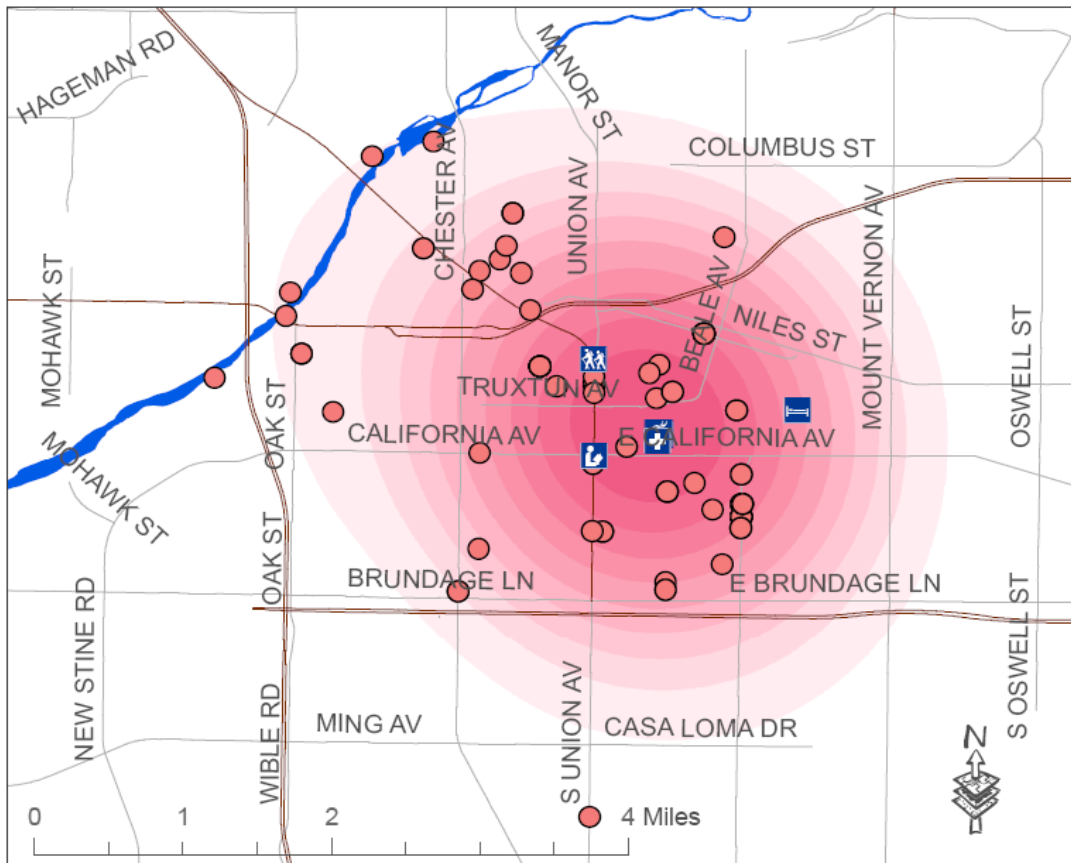
#### Known Unsheltered Homeless Persons

-  Males and Females

#### Density of Homeless Persons Per Square Mile






## Density of Female Unsheltered Homeless Persons in Metro Bakersfield Homeless Census, January 24th-25th, 2007



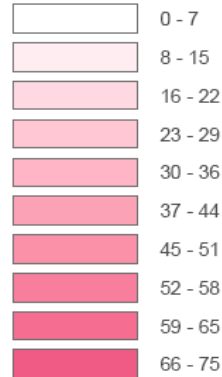
**Data Sets:**  
 County of Kern  
 Road File 2007  
 Kern Homeless Collaborative,  
 Homeless Census Data 2007

**Mapping and Analysis:**  
 Kern County Network for Children,  
 Research and Evaluation Team, April 2007

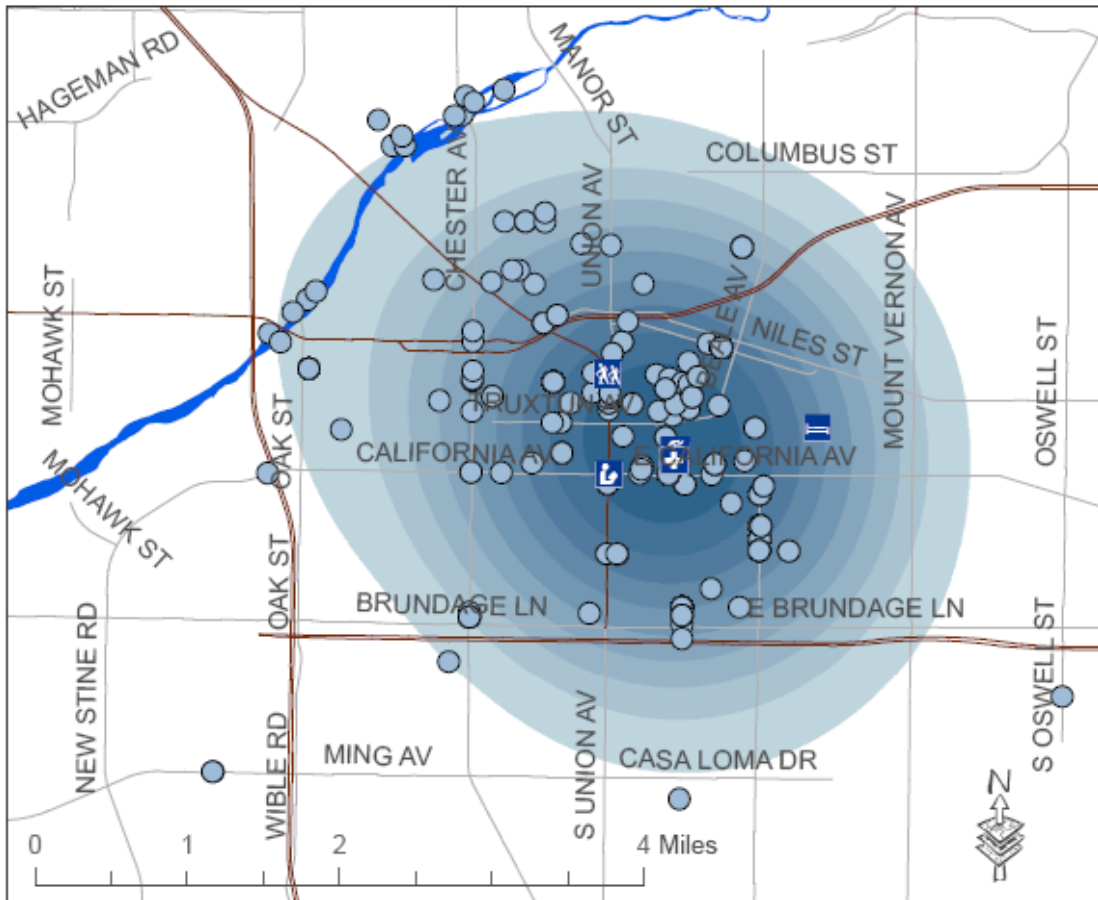
### Service Providers

-  Bakersfield Homeless Center
-  Bakersfield Rescue Mission
-  Community Action Partnership
-  Department of Human Services
-  Homeless Healthcare Clinic
-  Kern Medical Center
-  St. Vincent DePaul

### Density of Homeless Females Per Square Mile



## Density of Male Unsheltered Homeless Persons in Metro Bakersfield Homeless Census, January 24th-25th, 2007



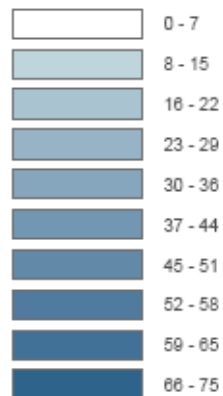
**Data Sets:**  
 County of Kern  
 Road File 2007  
 Kern Homeless Collaborative,  
 Homeless Census Data 2007

**Mapping and Analysis:**  
 Kern County Network for Children,  
 Research and Evaluation Team, April 2007

### Service Providers

-  Bakersfield Homeless Center
-  Bakersfield Rescue Mission
-  Community Action Partnership
-  Department of Human Services
-  Homeless Healthcare Clinic
-  Kern Medical Center
-  St.Vincent DePaul

### Density of Homeless Males Per Square Mile



## ***Appendix H***

### **Funding Resources**

#### **HUD Homeless Assistance Resources**

*Emergency Shelter Grants* are formula grants to states and local governments for the purpose of providing emergency and transitional housing, and are coordinated through the Consolidated Plan, a 5-year comprehensive housing plan required of communities to access HUD housing resources.

*Supportive Housing Program (SHP), Shelter Plus Care (S+C), and Section 8 Moderate Rehabilitation Single Room Occupancy (SRO)* program funds are awarded through an annual competition that requires communities to engage in a coordinated strategic planning process and to submit a comprehensive Continuum of Care plan to address homelessness.

- SHP funds may be used for the development and operation of transitional and permanent housing, and for supportive services.
- S+C funds may be used to provide rental assistance for permanent housing, with required matching funds for supportive services.
- Section 8 SRO funds can be used for rental assistance in single-room occupancy dwellings.

#### ***Housing for People who are Homeless and Addicted to Alcohol***

Approximately 10 two-year grants are expected to be awarded under a new \$10 million Housing for People who are Homeless and Addicted to Alcohol initiative created by Congress in PL 108-7. This initiative is designed to provide supportive housing assistance to chronically homeless persons who have been living on the streets for at least 365 days over the last five years and have a long term addiction to alcohol (serial inebriates). To be eligible for assistance under this program, clients must be living on the streets at the time of initial contact and will have no history of living in transitional or permanent housing over the last five years. Grantees will be expected to partner with local law enforcement, court systems and other relevant institutions to identify eligible clients for the program. To be eligible for funding consideration, a project must be located within a Continuum of Care that has at least 100 people who are chronically homeless and unsheltered as reported by the Continuum of Care or a recent official count. In addition, there are other HUD programs that are designed to expand affordable housing opportunities for low-income people or people with disabilities, including those who are homeless.

*Public Housing* is developed, owned, and managed by public housing agencies (PHAs) under contract with HUD. HUD provides a subsidy to cover operating and management costs of the units, and tenants generally pay 30 percent of their incomes toward rent. PHAs are allowed to establish local preferences for income targets and tenant selection

and must submit a 5-year plan that outlines these preferences and demonstrates their consistency with the local needs and strategies identified in the consolidated plan;

*The Housing Choice Voucher Program*, formerly referred to as the Section 8 program, is the largest Federal program targeted to very low-income households, including people with disabilities (TAC, 2002). Administered through state or local PHAs, the program offers four types of assistance: tenant-based rental assistance; project-based rental assistance; homeownership assistance; and down payment assistance. Tenant-based assistance is the most common form, offering subsidies that allow tenants to pay 30 percent of their income toward housing costs in a unit of their choice.

*The Home Investment Partnerships program (HOME)* is specifically designed to expand the supply of affordable housing for low and very low-income people. Program funds are controlled through the consolidated plan and awarded via formula grant to states and local jurisdictions. Partnerships among government and nonprofit organizations and private industry are required to develop and manage safe, decent, affordable housing. Funds may be used for homeownership, rental housing production, and tenant-based rental assistance, and are easily combined with funds from HUD's Homeless Assistance Programs;

*Housing Opportunities for Persons with AIDS (HOPWA)* supports the provision of both housing and services for people with HIV or AIDS. Funds are awarded by block grant to states and large metropolitan areas and can be used for a variety of activities, including housing information and coordination assistance; acquisition, rehabilitation, and leasing of property; rental assistance; operating costs; supportive services; and technical assistance (TAC, 1999);

*Community Development Block Grants (CDBG)* are formula grants to states and to "entitlement communities" (as defined by HUD) to provide decent housing and suitable living environments for moderate and low-income people. CDBG funds also are controlled through the consolidated plan and can be used for housing rehabilitation or construction, including shelters and transitional housing facilities, and for supportive services such as counseling, employment, and health care;

The *Section 811 Supportive Housing for Persons with Disabilities Program* awards funds competitively to community based nonprofit organizations to develop and operate supportive housing for people with disabilities. Funds may be used for new construction, rehabilitation, or acquisition; for project-based rental assistance; and for supportive services to address the health, mental health, or other needs of people with disabilities.

*Rural Housing and Economic Development Program (RHED)* provides funding to local rural non-profit organizations, community development corporations, federally designated Indian tribes, state housing financing agencies, and state community and/or economic development agencies for the implementation of innovative housing and economic development activities in rural areas.

## **Health and Human Services Homeless Assistance Resources**

*The Health Care for the Homeless (HCH)* program, administered by the Health Resources and Services Administration, awards grants to community-based organizations—including community health centers, local health departments, hospitals, and nonprofit community coalitions—to improve access to primary health care, mental health services, and substance abuse treatment. HCH funds support the provision of primary health care, substance abuse treatment, outreach, case management, provision of or referral to mental health services, and assistance in obtaining housing and entitlements (HRSA BPHC, 2001).

*The Projects for Assistance in Transition from Homelessness (PATH)* program, administered by SAMHSA's CMHS, awards formula grants to states and territories to support community-based services for people with serious mental illnesses and/or substance use disorders who are homeless or at-risk of homelessness. PATH funds can be used to support a range of services, including outreach, screening and assessment, case management, mental health services, and substance abuse treatment, provision of or linkage to supportive services, and a limited set of housing services.

*The Grants for the Benefit of Homeless Individuals (GBHI)* program, administered by SAMHSA's Center for Substance Abuse Treatment, provides funds to develop and expand mental health and substance abuse treatment services for people who are homeless. Grants are awarded to local public and nonprofit agencies to provide either substance abuse services, mental health services, or both, allowing communities the flexibility to provide the services they believe to be the most urgent. HHS also administers a number of mainstream resource programs, for which homeless people may be eligible that also can be used to provide services and supports.

*Community Mental Health Services Block Grant* funds are formula grants to states and territories to create comprehensive, community-based systems of care for adults with serious mental illnesses and children with severe emotional disturbances. Funds are used at the discretion of states to provide services such as health, mental health, rehabilitation, employment, housing, and other supportive services. Most states provide services specific to adults with serious mental illnesses who are homeless. In some cases, states have used block grant funds to provide services in supportive housing. Mental health block grant funds also may be used to provide services for individuals with substance use disorders within certain guidelines.

*Substance Abuse Prevention and Treatment Block Grants* also are formula grants to states and territories, in this case, to fund alcohol prevention and treatment activities, prevention and treatment related to other drugs, and primary prevention programs. All individuals who have alcohol or substance use problems are eligible for services, including people who are homeless, or persons with co-occurring substance use disorders.

*Community Health Centers*, supported by discretionary project grants, provide preventive and primary care services to medically underserved populations; many have specific programs designed to serve individuals who are homeless.

*Community Services Block Grants* are formula grants to states to support a range of services designed to address poverty and to promote self-sufficiency among low-income members of communities, including those who are homeless.

*Social Services Block Grants*, also formula grants to states, can be used to support a range of services to prevent, reduce, and eliminate dependency and increase self-sufficiency among community residents.

### **Veterans Administration Homeless Assistance Resources**

*The Domiciliary Care for Homeless Veterans* program provides funds to VA medical centers to support the delivery of health, mental health, substance abuse, and other social services in residential treatment settings for veterans who are homeless.

*The Homeless Chronically Mentally Ill Veterans* program supports mental health services, substance abuse treatment, case management, and other rehabilitative services in community-based residential treatment settings for veterans with chronic mental illnesses who are homeless.

*The Health Care for Homeless Veterans* program supports outreach and assessment, treatment, case management, and referral to community-based residential care for veterans with serious mental illnesses and substance use disorders who are homeless.

*The HUD-VA Supported Housing* program, administered jointly with HUD, provides permanent supportive housing and treatment for veterans with serious mental illnesses and substance use disorders who are homeless.

*Urban Homeless Veterans' Reintegration Program (HVRP)* are intended to address two objectives: (1) to provide services to assist in reintegrating homeless veterans into meaningful employment within the labor force, and (2) to stimulate the development of effective service delivery systems that will address the complex problems facing homeless veterans. Successful applicants will design programs that assist eligible veterans by providing job placement services, job training, counseling, supportive services, and other assistance to expedite the reintegration of homeless veterans into the labor force.

### **State and Local Resources**

#### ***State***

#### ***Emergency Housing and Assistance Program Operating Facility Grants***

The purpose of the grant is to provide facility operating grants for emergency shelters, transitional housing projects, and supportive services for homeless individuals and families. Eligible activities include providing direct client housing, including facility operations and administration, residential rent assistance, leasing or renting rooms for

provision of temporary shelter, capital development activities of up to \$20,000 per site, and administration of the award (limited to 5 percent).

*Emergency Housing and Assistance Program Capital Development*

The purpose of this source of funding is to fund capital development activities for emergency shelters, transitional housing, and safe havens that provide shelter and supportive services for homeless individuals and families. Eligible activities include acquiring, constructing, converting, expanding and/or rehabilitating emergency shelter, transitional housing, and/or safe haven housing and administration of the award (limited to 5 percent).

*Low Income Housing Tax Credits (LIHTC)*

Low Income Housing Tax Credits is a program administered at the state level that provides federal income tax credits for equity investors in low-income rental housing projects. Low-income rental housing projects that involve new construction, rehabilitation, or acquisition are eligible under the program.

*The Mental Health Services Act (Proposition 63)* MHSA Capital facilities funds can be used for capital costs (purchase of property or land, building or renovation) and for capitalized reserves (to fund the gap between actual operating costs of the facility or housing, and what clients can pay in rent) for operating costs of capital projects. MHSA Community Services and Supports funds can be used for rental subsidies to make housing affordable for clients and for services. It is also important to know that a commitment of MHSA funding for services in or linked to a facility or housing development may also make it easier for the project sponsor to get capital or operating funding from other sources.

There are also other sources of funding for capital, operating costs and services. In local planning for the use of MHSA funds, it will be important to identify these other sources and use the MHSA funds strategically to match or leverage these other sources. MHSA funds can fill gaps in other funding, making the facility or housing development project feasible and/or speeding up the development timeline. It should also be recognized that MHSA funds might also be used to create housing opportunities for clients who are not eligible or a priority population for other sources of capital, operating and services. For example, some funding that can be obtained from the federal Department of Housing and Urban Development (HUD) is restricted for use in housing that is targeted to people who have been homeless for the long-term, or those who are currently living in emergency shelters or “on the streets.”

***Local***

The California Department of Housing and Community Development, *Local Housing Trust Fund Program (LHTFP)* was created by action of the State Legislature resulting from a voter initiative and the passing of Proposition 46, Housing Emergency Shelter Trust Fund Act of 2002. The LHTFP makes one-time grants for the development of affordable multifamily rental housing. It is intended to support innovative local entities

that have identified and committed sources of funds not traditionally utilized in the development and provision of affordable housing. Grants require a dollar-for-dollar match from a local entity such as the City of Bakersfield or the County of Kern.

*Housing Opportunities Fund.* The Housing Opportunities Fund is used to provide financial assistance to construct, rehabilitate, acquire and preserve affordable housing units. For the current fiscal year, the revenue sources of the Fund consist of monies from the PCDC Low and Moderate Income Housing Trust Funds, Inclusionary Housing Ordinance funds (generated from in-lieu fee payments), California Housing Finance Agency HELP funds, California Department of Housing & Community Development Local Housing Trust Fund program, and Fannie Mae American Communities Fund.

*Appendix I*  
**Million-Dollar Murray**  
By  
**Malcolm Gladwell**

February 13, 2006  
Dept. of Social Services

*Why problems like homelessness may be easier to solve than to manage.*

Murray Barr was a bear of a man, an ex-marine, six feet tall and heavyset, and when he fell down—which he did nearly every day—it could take two or three grown men to pick him up. He had straight black hair and olive skin. On the street, they called him Smokey. He was missing most of his teeth. He had a wonderful smile. People loved Murray.

His chosen drink was vodka. Beer he called "horse piss." On the streets of downtown Reno, where he lived, he could buy a two-hundred-and-fifty-millilitre bottle of cheap vodka for a dollar-fifty. If he was flush, he could go for the seven-hundred-and-fifty-millilitre bottle, and if he was broke he could always do what many of the other homeless people of Reno did, which is to walk through the casinos and finish off the half-empty glasses of liquor left at the gaming tables.

"If he was on a runner, we could pick him up several times a day," Patrick O'Bryan, who is a bicycle cop in downtown Reno, said. "And he's gone on some amazing runners. He would get picked up, get detoxed, then get back out a couple of hours later and start up again. A lot of the guys on the streets who've been drinking, they get so angry. They are so incredibly abrasive, so violent, so abusive. Murray was such a character and had such a great sense of humor that we somehow got past that. Even when he was abusive, we'd say, 'Murray, you know you love us,' and he'd say, 'I know—and go back to swearing at us.'"

"I've been a police officer for fifteen years," O'Bryan's partner, Steve Johns, said. "I picked up Murray my whole career. Literally."

Johns and O'Bryan pleaded with Murray to quit drinking. A few years ago, he was assigned to a treatment program in which he was under the

equivalent of house arrest, and he thrived. He got a job and worked hard. But then the program ended. "Once he graduated out, he had no one to report to, and he needed that," O'Bryan said. "I don't know whether it was his military background. I suspect that it was. He was a good cook. One time, he accumulated savings of over six thousand dollars. Showed up for work religiously. Did everything he was supposed to do. They said, 'Congratulations,' and put him back on the street. He spent that six thousand in a week or so."

Often, he was too intoxicated for the drunk tank at the jail, and he'd get sent to the emergency room at either Saint Mary's or Washoe Medical Center. Marla Johns, who was a social worker in the emergency room at Saint Mary's, saw him several times a week. "The ambulance would bring him in. We would sober him up, so he would be sober enough to go to jail. And we would call the police to pick him up. In fact, that's how I met my husband." Marla Johns is married to Steve Johns.

"He was like the one constant in an environment that was ever changing," she went on. "In he would come. He would grin that half-toothless grin. He called me 'my angel.' I would walk in the room, and he would smile and say, 'Oh, my angel, I'm so happy to see you.' We would joke back and forth, and I would beg him to quit drinking and he would laugh it off. And when time went by and he didn't come in I would get worried and call the coroner's office. When he was sober, we would find out, oh, he's working someplace, and my husband and I would go and have dinner where he was working. When my husband and I were dating, and we were going to get married, he said, 'Can I come to the wedding?' And I almost felt like he should. My joke was 'If you are sober you can come, because I can't afford your bar bill.' When we started a family, he would lay a hand on my pregnant belly and bless the child. He really was this kind of light."

In the fall of 2003, the Reno Police Department started an initiative designed to limit panhandling in the downtown core. There were articles in the newspapers, and the police department came under harsh criticism on local talk radio. The crackdown on panhandling amounted to harassment, the critics said. The homeless weren't an imposition on the city; they were just trying to get by. "One morning, I'm listening to one of the talk shows, and they're just trashing the police department and going on about how unfair it is," O'Bryan said. "And I thought, Wow, I've never seen any of these critics in one of the alleyways in the middle of the winter looking for bodies." O'Bryan was angry. In downtown Reno, food for the homeless was plentiful: there was a Gospel kitchen and Catholic Services, and even the local McDonald's fed the hungry. The panhandling was for liquor, and the liquor was anything but harmless. He and Johns spent at least half their time dealing with people like Murray; they were as much caseworkers as police officers. And they knew they weren't the only ones involved. When someone passed out on the street, there was a "One down" call to the paramedics. There were four people in an ambulance, and the patient sometimes stayed at the hospital for days, because living on the streets in a state of almost constant intoxication was a reliable way of getting sick. None of that, surely, could be cheap.

O'Bryan and Johns called someone they knew at an ambulance service and then contacted the local hospitals. "We came up with three names that were some of our chronic inebriates in the downtown area, that got arrested the most often," O'Bryan said. "We tracked those three individuals through just one of our two hospitals. One of the guys had been in jail previously, so he'd only been on the streets for six months. In those six months, he had accumulated a bill of a hundred thousand dollars—and that's at the smaller of the two hospitals near downtown Reno. It's pretty reasonable to assume that the other hospital had an even larger bill. Another individual came from Portland and had been in Reno for three months. In those three months, he had accumulated a bill for sixty-five thousand dollars. The third individual actually had some periods of being sober, and had accumulated a bill of fifty thousand."

The first of those people was Murray Barr, and Johns and O'Bryan realized that if you totted up all his hospital bills for the ten years that he had been on the streets—as well as substance-abuse-treatment costs, doctors' fees, and other expenses—Murray Barr probably ran up a medical bill as large as anyone in the state of Nevada.

"It cost us one million dollars not to do something about Murray," O'Bryan said.

Fifteen years ago, after the Rodney King beating, the Los Angeles Police Department was in crisis. It was accused of racial insensitivity and ill discipline and violence, and the assumption was that those problems had spread broadly throughout the rank and file. In the language of statisticians, it was thought that L.A.P.D.'s troubles had a "normal" distribution—that if you graphed them the result would look like a bell curve, with a small number of officers at one end of the curve, a small number at the other end, and the bulk of the problem situated in the middle. The bell-curve assumption has become so much a part of our mental architecture that we tend to use it to organize experience automatically.

But when the L.A.P.D. was investigated by a special commission headed by Warren Christopher, a very different picture emerged. Between 1986 and 1990, allegations of excessive force or improper tactics were made against eighteen hundred of the eighty-five hundred officers in the L.A.P.D. The broad middle had scarcely been accused of anything. Furthermore, more than fourteen hundred officers had only one or two allegations made against them—and bear in mind that these were not proven charges, that they happened in a four-year period, and that allegations of excessive force are an inevitable feature of urban police work. (The N.Y.P.D. receives about three thousand such complaints a year.) A hundred and eighty-three officers, however, had four or more complaints against them, forty-four officers had six or more complaints, sixteen had eight or more, and one had sixteen complaints. If you were to graph the troubles of the L.A.P.D., it wouldn't look like a bell curve. It would look more like a hockey stick. It would follow what statisticians call a "power law" distribution—where all the activity is not in the middle but at one extreme.

The Christopher Commission's report repeatedly comes back to what it describes as the extreme concentration of problematic officers. One officer had been the subject of thirteen allegations of excessive use of force, five other complaints, twenty-eight "use of force reports" (that is, documented, internal accounts of inappropriate behavior), and one shooting. Another had six excessive-force complaints, nineteen other complaints, ten use-of-force reports, and three shootings. A third had twenty-seven use-of-force reports, and a fourth had thirty-five. Another had a file full of complaints for doing things like "striking an arrestee on the back of the neck with the butt of a shotgun for no apparent reason while the arrestee was kneeling and handcuffed," beating up a thirteen-year-old juvenile, and throwing an arrestee from his chair and kicking him in the back and side of the head while he was handcuffed and lying on his stomach.

The report gives the strong impression that if you fired those forty-four cops the L.A.P.D. would suddenly become a pretty well-functioning police department. But the report also suggests that the problem is tougher than it seems, because those forty-four bad cops were so bad that the institutional mechanisms in place to get rid of bad apples clearly weren't working. If you made the mistake of assuming that the department's troubles fell into a normal distribution, you'd propose solutions that would raise the performance of the middle—like better training or better hiring—when the middle didn't need help. For those hard-core few who did need help, meanwhile, the medicine that helped the middle wouldn't be nearly strong enough.

In the nineteen-eighties, when homelessness first surfaced as a national issue, the assumption was that the problem fit a normal distribution: that the vast majority of the homeless were in the same state of semi-permanent distress. It was an assumption that bred despair: if there were so many homeless, with so many problems, what could be done to help them? Then, fifteen years ago, a young Boston College graduate student named Dennis Culhane lived in a shelter in Philadelphia for seven weeks as part of the research for his dissertation. A few months later he went back, and was surprised to discover that he couldn't find any of the people he had recently spent so much time with. "It made me realize

that most of these people were getting on with their own lives," he said.

Culhane then put together a database—the first of its kind—to track who was coming in and out of the shelter system. What he discovered profoundly changed the way homelessness is understood. Homelessness doesn't have a normal distribution, it turned out. It has a power-law distribution. "We found that eighty per cent of the homeless were in and out really quickly," he said. "In Philadelphia, the most common length of time that someone is homeless is one day. And the second most common length is two days. And they never come back. Anyone who ever has to stay in a shelter involuntarily knows that all you think about is how to make sure you never come back."

The next ten per cent were what Culhane calls episodic users. They would come for three weeks at a time, and return periodically, particularly in the winter. They were quite young, and they were often heavy drug users. It was the last ten per cent—the group at the farthest edge of the curve—that interested Culhane the most. They were the chronically homeless, who lived in the shelters, sometimes for years at a time. They were older. Many were mentally ill or physically disabled, and when we think about homelessness as a social problem—the people sleeping on the sidewalk, aggressively panhandling, lying drunk in doorways, huddled on subway grates and under bridges—it's this group that we have in mind. In the early nineteen-nineties, Culhane's database suggested that New York City had a quarter of a million people who were homeless at some point in the previous half decade—which was a surprisingly high number. But only about twenty-five hundred were chronically homeless.

It turns out, furthermore, that this group costs the health-care and social-services systems far more than anyone had ever anticipated. Culhane estimates that in New York at least sixty-two million dollars was being spent annually to shelter just those twenty-five hundred hard-core homeless. "It costs twenty-four thousand dollars a year for one of these shelter beds," Culhane said. "We're talking about a cot eighteen inches away from the next cot." Boston Health Care for the Homeless Program, a leading service group for the homeless in Boston, recently tracked the medical expenses of a hundred and nineteen chronically homeless people. In the course of

five years, thirty-three people died and seven more were sent to nursing homes, and the group still accounted for 18,834 emergency-room visits—at a minimum cost of a thousand dollars a visit. The University of California, San Diego Medical Center followed fifteen chronically homeless inebriates and found that over eighteen months those fifteen people were treated at the hospital's emergency room four hundred and seventeen times, and ran up bills that averaged a hundred thousand dollars each. One person—San Diego's counterpart to Murray Barr—came to the emergency room eighty-seven times.

"If it's a medical admission, it's likely to be the guys with the really complex pneumonia," James Dunford, the city of San Diego's emergency medical director and the author of the observational study, said. "They are drunk and they aspirate and get vomit in their lungs and develop a lung abscess, and they get hypothermia on top of that, because they're out in the rain. They end up in the intensive-care unit with these very complicated medical infections. These are the guys who typically get hit by cars and buses and trucks. They often have a neurosurgical catastrophe as well. So they are very prone to just falling down and cracking their head and getting a subdural hematoma, which, if not drained, could kill them, and it's the guy who falls down and hits his head who ends up costing you at least fifty thousand dollars. Meanwhile, they are going through alcoholic withdrawal and have devastating liver disease that only adds to their inability to fight infections. There is no end to the issues. We do this huge drill. We run up big lab fees, and the nurses want to quit, because they see the same guys come in over and over, and all we're doing is making them capable of walking down the block."

The homelessness problem is like the L.A.P.D.'s bad-cop problem. It's a matter of a few hard cases, and that's good news, because when a problem is that concentrated you can wrap your arms around it and think about solving it. The bad news is that those few hard cases are hard. They are falling-down drunks with liver disease and complex infections and mental illness. They need time and attention and lots of money. But enormous sums of money are already being spent on the chronically homeless, and Culhane saw that the kind of money it would take to solve the homeless problem could well be less than the

kind of money it took to ignore it. Murray Barr used more health-care dollars, after all, than almost anyone in the state of Nevada. It would probably have been cheaper to give him a full-time nurse and his own apartment.

The leading exponent for the power-law theory of homelessness is Philip Mangano, who, since he was appointed by President Bush in 2002, has been the executive director of the U.S. Interagency Council on Homelessness, a group that oversees the programs of twenty federal agencies. Mangano is a slender man, with a mane of white hair and a magnetic presence, who got his start as an advocate for the homeless in Massachusetts. In the past two years, he has crisscrossed the United States, educating local mayors and city councils about the real shape of the homelessness curve. Simply running soup kitchens and shelters, he argues, allows the chronically homeless to remain chronically homeless. You build a shelter and a soup kitchen if you think that homelessness is a problem with a broad and unmanageable middle. But if it's a problem at the fringe it can be solved. So far, Mangano has convinced more than two hundred cities to radically reevaluate their policy for dealing with the homeless.

"I was in St. Louis recently," Mangano said, back in June, when he dropped by New York on his way to Boise, Idaho. "I spoke with people doing services there. They had a very difficult group of people they couldn't reach no matter what they offered. So I said, Take some of your money and rent some apartments and go out to those people, and literally go out there with the key and say to them, 'This is the key to an apartment. If you come with me right now I am going to give it to you, and you are going to have that apartment.' And so they did. And one by one those people were coming in. Our intent is to take homeless policy from the old idea of funding programs that serve homeless people endlessly and invest in results that actually end homelessness."

Mangano is a history buff, a man who sometimes falls asleep listening to old Malcolm X speeches, and who peppers his remarks with references to the civil-rights movement and the Berlin Wall and, most of all, the fight against slavery. "I am an abolitionist," he says. "My office in Boston was opposite the monument to the 54th Regiment on the Boston Common, up the street

from the Park Street Church, where William Lloyd Garrison called for immediate abolition, and around the corner from where Frederick Douglass gave that famous speech at the Tremont Temple. It is very much ingrained in me that you do not manage a social wrong. You should be ending it."

The old Y.M.C.A. in downtown Denver is on Sixteenth Street, just east of the central business district. The main building is a handsome six-story stone structure that was erected in 1906, and next door is an annex that was added in the nineteen-fifties. On the ground floor there is a gym and exercise rooms. On the upper floors there are several hundred apartments—brightly painted one-bedrooms, efficiencies, and S.R.O.-style rooms with microwaves and refrigerators and central airconditioning—and for the past several years those apartments have been owned and managed by the Colorado Coalition for the Homeless.

Even by big-city standards, Denver has a serious homelessness problem. The winters are relatively mild, and the summers aren't nearly as hot as those of neighboring New Mexico or Utah, which has made the city a magnet for the indigent. By the city's estimates, it has roughly a thousand chronically homeless people, of whom three hundred spend their time downtown, along the central Sixteenth Street shopping corridor or in nearby Civic Center Park. Many of the merchants downtown worry that the presence of the homeless is scaring away customers. A few blocks north, near the hospital, a modest, low-slung detox center handles twenty-eight thousand admissions a year, many of them homeless people who have passed out on the streets, either from liquor or—as is increasingly the case—from mouthwash. "Dr. —Dr. Tich, they call it—is the brand of mouthwash they use," says Roxane White, the manager of the city's social services. "You can imagine what that does to your gut."

Eighteen months ago, the city signed up with Mangano. With a mixture of federal and local funds, the C.C.H. inaugurated a new program that has so far enrolled a hundred and six people. It is aimed at the Murray Barrs of Denver, the people costing the system the most. C.C.H. went after the people who had been on the streets the longest, who had a criminal record, who had a problem with substance abuse or mental illness.

"We have one individual in her early sixties, but looking at her you'd think she's eighty," Rachel Post, the director of substance treatment at the C.C.H., said. (Post changed some details about her clients in order to protect their identity.) "She's a chronic alcoholic. A typical day for her is she gets up and tries to find whatever's going to drink that day. She falls down a lot. There's another person who came in during the first week. He was on methadone maintenance. He'd had psychiatric treatment. He was incarcerated for eleven years, and lived on the streets for three years after that, and, if that's not enough, he had a hole in his heart."

The recruitment strategy was as simple as the one that Mangano had laid out in St. Louis: Would you like a free apartment? The enrollees got either an efficiency at the Y.M.C.A. or an apartment rented for them in a building somewhere else in the city, provided they agreed to work within the rules of the program. In the basement of the Y, where the racquetball courts used to be, the coalition built a command center, staffed with ten caseworkers. Five days a week, between eight-thirty and ten in the morning, the caseworkers meet and painstakingly review the status of everyone in the program. On the wall around the conference table are several large white boards, with lists of doctor's appointments and court dates and medication schedules. "We need a staffing ratio of one to ten to make it work," Post said. "You go out there and you find people and assess how 're doing in their residence. Sometimes we're in contact with someone every day. Ideally, we want to be in contact every couple of days. We've got about fifteen people we're really worried about now."

The cost of services comes to about ten thousand dollars per homeless client per year. An efficiency apartment in Denver averages \$376 a month, or just over forty-five hundred a year, which means that you can house and care for a chronically homeless person for at most fifteen thousand dollars, or about a third of what he or she would cost on the street. The idea is that once the people in the program get stabilized they will find jobs, and start to pick up more and more of their own rent, which would bring someone's annual cost to the program closer to six thousand dollars. As of today, seventy-five supportive housing slots have already been added, and the city's homeless plan calls for eight hundred more over the next ten years.

The reality, of course, is hardly that neat and tidy. The idea that the very sickest and most troubled of the homeless can be stabilized and eventually employed is only a hope. Some of them plainly won't be able to get there: these are, after all, hard cases. "We've got one man, he's in his twenties," Post said. "Already, he has cirrhosis of the liver. One time he blew a blood alcohol of .49, which is enough to kill most people. The first place we had he brought over all his friends, and they partied and trashed the place and broke a window. Then we gave him another apartment, and he did the same thing."

Post said that the man had been sober for several months. But he could relapse at some point and perhaps trash another apartment, and they'd have to figure out what to do with him next. Post had just been on a conference call with some people in New York City who run a similar program, and they talked about whether giving clients so many chances simply encourages them to behave irresponsibly. For some people, it probably does. But what was the alternative? If this young man was put back on the streets, he would cost the system even more money. The current philosophy of welfare holds that government assistance should be temporary and conditional, to avoid creating dependency. But someone who blows .49 on a Breathalyzer and has cirrhosis of the liver at the age of twenty-seven doesn't respond to incentives and sanctions in the usual way. "The most complicated people to work with are those who have been homeless for so long that going back to the streets just isn't scary to them," Post said. "The summer comes along and they say, 'I don't need to follow your rules.'" Power-law homelessness policy has to do the opposite of normal-distribution social policy. It should create dependency: you want people who have been outside the system to come inside and rebuild their lives under the supervision of those ten caseworkers in the basement of the Y.M.C.A.

That is what is so perplexing about power-law homeless policy. From an economic perspective the approach makes perfect sense. But from a moral perspective it doesn't seem fair. Thousands of people in the Denver area no doubt live day to day, work two or three jobs, and are eminently deserving of a helping hand—and no one offers them the key to a new apartment. Yet that's just what the guy screaming obscenities and swigging Dr. Tich gets. When the welfare mom's time on public assistance runs out, we cut her

off. Yet when the homeless man trashes his apartment we give him another. Social benefits are supposed to have some kind of moral justification. We give them to widows and disabled veterans and poor mothers with small children. Giving the homeless guy passed out on the sidewalk an apartment has a different rationale. It's simply about efficiency.

We also believe that the distribution of social benefits should not be arbitrary. We don't give only to some poor mothers, or to a random handful of disabled veterans. We give to everyone who meets a formal criterion, and the moral credibility of government assistance derives, in part, from this universality. But the Denver homelessness program doesn't help every chronically homeless person in Denver. There is a waiting list of six hundred for the supportive-housing program; it will be years before all those people get apartments, and some may never get one. There isn't enough money to go around, and to try to help everyone a little bit—to observe the principle of universality—isn't as cost-effective as helping a few people a lot. Being fair, in this case, means providing shelters and soup kitchens, and shelters and soup kitchens don't solve the problem of homelessness. Our usual moral intuitions are little use, then, when it comes to a few hard cases. Power-law problems leave us with an unpleasant choice. We can be true to our principles or we can fix the problem. We cannot do both.

A few miles northwest of the old Y.M.C.A. in downtown Denver, on the Speer Boulevard off-ramp from I-25, there is a big electronic sign by the side of the road, connected to a device that remotely measures the emissions of the vehicles driving past. When a car with properly functioning pollution-control equipment passes, the sign flashes "Good." When a car passes that is well over the acceptable limits, the sign flashes "Poor." If you stand at the Speer Boulevard exit and watch the sign for any length of time, you'll find that virtually every car scores "Good." An Audi A4—"Good." A Buick Century—"Good." A Toyota Corolla—"Good." A Ford Taurus—"Good." A Saab 9-5—"Good," and on and on, until after twenty minutes or so, some beat-up old Ford Escort or tricked-out Porsche drives by and the sign flashes "Poor." The picture of the smog problem you get from watching the Speer Boulevard sign and the picture of the homelessness problem you get from listening in

on the morning staff meetings at the Y.M.C.A. are pretty much the same. Auto emissions follow a power-law distribution, and the air-pollution example offers another look at why we struggle so much with problems centered on a few hard cases.

Most cars, especially new ones, are extraordinarily clean. A 2004 Subaru in good working order has an exhaust stream that's just .06 per cent carbon monoxide, which is negligible. But on almost any highway, for whatever reason—age, ill repair, deliberate tampering by the owner—a small number of cars can have carbon-monoxide levels in excess of ten per cent, which is almost two hundred times higher. In Denver, five per cent of the vehicles on the road produce fifty-five per cent of the automobile pollution.

"Let's say a car is fifteen years old," Donald Stedman says. Stedman is a chemist and automobile-emissions specialist at the University of Denver. His laboratory put up the sign on Speer Avenue. "Obviously, the older a car is the more likely it is to become broken. It's the same as human beings. And by broken we mean any number of mechanical malfunctions—the computer's not working anymore, fuel injection is stuck open, the catalyst 's not unusual that these failure modes result in high emissions. We have at least one car in our database which was emitting seventy grams of hydrocarbon per mile, which means that you could almost drive a Honda Civic on the exhaust fumes from that car. It's not just old cars. It's new cars with high mileage, like taxis. One of the most successful and least publicized control measures was done by a district attorney in L.A. back in the nineties. He went to LAX and discovered that all of the Bell Cabs were gross emitters. One of those cabs emitted more than its own weight of pollution every year."

In Stedman's view, the current system of smog checks makes little sense. A million motorists in Denver have to go to an emissions center every year—take time from work, wait in line, pay fifteen or twenty-five dollars—for a test that more than ninety per cent of them don't need. "Not everybody gets tested for breast cancer," Stedman says. "Not everybody takes an AIDS test." On-site smog checks, furthermore, do a pretty bad job of finding and fixing the few outliers. Car enthusiasts—with high-powered,

high-polluting sports cars—have been known to drop a clean engine into their car on the day they get it tested. Others register their car in a faraway town without emissions testing or arrive at the test site "hot"—having just come off hard driving on the freeway—which is a good way to make a dirty engine appear to be clean. Still others randomly pass the test when they shouldn't, because dirty engines are highly variable and sometimes burn cleanly for short durations. There is little evidence, Stedman says, that the city's regime of inspections makes any difference in air quality.

He proposes mobile testing instead. Twenty years ago, he invented a device the size of a suitcase that uses infrared light to instantly measure and then analyze the emissions of cars as they drive by on the highway. The Speer Avenue sign is attached to one of Stedman's devices. He says that cities should put half a dozen or so of his devices in vans, park them on freeway off-ramps around the city, and have a police car poised to pull over anyone who fails the test. A half-dozen vans could test thirty thousand cars a day. For the same twenty-five million dollars that Denver's motorists now spend on on-site testing, Stedman estimates, the city could identify and fix twenty-five thousand truly dirty vehicles every year, and within a few years cut automobile emissions in the Denver metropolitan area by somewhere between thirty-five and forty per cent. The city could stop managing its smog problem and start ending it.

Why don't we all adopt the Stedman method? There's no moral impediment here. We're used to the police pulling people over for having a blown headlight or a broken side mirror, and it wouldn't be difficult to have them add pollution-control devices to their list. Yet it does run counter to an instinctive social preference for thinking of pollution as a problem to which we all contribute equally. We have developed institutions that move reassuringly quickly and forcefully on collective problems. Congress passes a law. The Environmental Protection Agency promulgates a regulation. The auto industry makes its cars a little cleaner, and—presto—the air gets better. But Stedman doesn't much care about what happens in Washington and Detroit. The challenge of controlling air pollution isn't so much about the laws as it is about compliance with them. It's a policing problem, rather than a policy problem, and there is something

ultimately unsatisfying about his proposed solution. He wants to end air pollution in Denver with a half-dozen vans outfitted with a contraption about the size of a suitcase. Can such a big problem have such a small-bore solution?

That's what made the findings of the Christopher Commission so unsatisfying. We put together blue-ribbon panels when we're faced with problems that seem too large for the normal mechanisms of bureaucratic repair. We want sweeping reforms. But what was the commission's most memorable observation? It was the story of an officer with a known history of doing things like beating up handcuffed suspects who nonetheless received a performance review from his superior stating that he "usually conducts himself in a manner that inspires respect for the law and instills public confidence." This is what you say about an officer when you haven't actually read his file, and the implication of the Christopher Commission's report was that the L.A.P.D. might help solve its problem simply by getting its police captains to read the files of their officers. The L.A.P.D.'s problem was a matter not of policy but of compliance. The department needed to adhere to the rules it already had in place, and that's not what a public hungry for institutional transformation wants to hear. Solving problems that have power-law distributions doesn't just violate our moral intuitions; it violates our political intuitions as well. It's hard not to conclude, in the end, that the reason we treated the homeless as one hopeless undifferentiated group for so long is not simply that we didn't know better. It's that we didn't want to know better. It was easier the old way.

Power-law solutions have little appeal to the right, because they involve special treatment for people who do not deserve special treatment; and they have little appeal to the left, because their emphasis on efficiency over fairness suggests the cold number-crunching of Chicago-school cost-benefit analysis. Even the promise of millions of dollars in savings or cleaner air or better police departments cannot entirely compensate for such discomfort. In Denver, John Hickenlooper, the city's enormously popular mayor, has worked on the homelessness issue tirelessly during the past couple of years. He spent more time on the subject in his annual State of the City address this past summer than on any other topic. He gave the speech, with deliberate symbolism, in

the city's downtown Civic Center Park, where homeless people gather every day with their shopping carts and garbage bags. He has gone on local talk radio on many occasions to discuss what the city is doing about the issue. He has commissioned studies to show what a drain on the city's resources the homeless population has become. But, he says, "there are still people who stop me going into the supermarket and say, 'I can't believe you're going to help those homeless people, those bums.'"

Early one morning a year ago, Marla Johns got a call from her husband, Steve. He was at work. "He called and woke me up," Johns remembers. "He was choked up and crying on the phone. And I thought that something had happened with another police officer. I said, 'Oh, my gosh, what happened?' He said, 'Murray died last night.' " He died of intestinal bleeding. At the police department that morning, some of the officers gave Murray a moment of silence.

"There are not many days that go by that I don't have a thought of him," she went on. "Christmas comes— and I used to buy him a Christmas present. Make sure he had warm gloves and a blanket and a coat. There was this mutual respect. There was a time when another intoxicated patient jumped off the gurney and was coming at me, and Murray jumped off his gurney and shook his fist and said, 'Don't you touch my angel.' You know, when he was monitored by the system he did fabulously. He would be on house arrest and he would get a job and he would save money and go to work every day, and he wouldn't drink. He would do all the things he was supposed to do. There are some people who can be very successful members of society if someone monitors them. Murray needed someone to be in charge of him."

But, of course, Reno didn't have a place where Murray could be given the structure he needed. Someone must have decided that it cost too much.

"I told my husband that I would claim his body if no one else did," she said. "I would not have him in an unmarked grave."

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