

Alameda Countywide Homeless and Special Needs Housing Plan

April 2006

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Alameda County Behavioral Health Care Services

Alameda County Housing and Community Development Department

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Alameda County Social Services Agency

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Index to Selected Key Terms and Topics

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Housing First	18: Objective H-4	8, 12, 14, 39	6.6, 11.8

Selected Key Terms and Topics	Associated Recommendations	References in Plan Document	References in Companion Materials
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Companion Materials: Table of Contents Summary

Note: The following is an overview of the content that is included in the *Companion Materials* for the plan, which comprise a separate document.

1. Planning Participants
2. Overview of the Planning Process
3. Next Steps for the Homeless Continuum of Care System
4. Next Steps for the Behavioral Health Care System
5. Next Steps for the HIV/AIDS System
6. Local and National Context for Planning: Expanded Version
7. Housing in Alameda County: Expanded Version
8. Homelessness in Alameda County: Expanded Version
9. Behavioral Health in Alameda County: Expanded Version
10. HIV/AIDS in Alameda County: Expanded Version
11. Consumer Focus Groups
12. Housing and Services Needs: Populations Working Groups
13. Housing Needs and Estimated Costs
14. A Review of Literature on Outcomes in Supportive Housing
15. Executive Summary from the 2003 Alameda Countywide Shelter and Services Survey
16. Mental Health System Housing Report: Front Door Project
17. Glossary of Related Terms

Executive Summary

As many as 16,000 people are homeless during the course of a year in Alameda County, and more than 5,000 are homeless on any given night. Many people experiencing homelessness have disabilities. Thousands more with serious and persistent mental illness and/or HIV/AIDS are living in precarious or inappropriate situations. This plan outlines a reorientation of housing and service systems to end chronic homelessness within ten years and significantly reduce housing crises for these vulnerable populations in Alameda County over fifteen years.

Alameda County has a history of innovative and successful programs *to address homelessness and special needs housing*. While these programs have significantly assisted the people they serve, the Sponsors and Stakeholders who developed this plan acknowledge that *simply* continuing with the current approaches will not lead to ending homelessness. Achieving this vision will require dedicating approximately 15,000 units of housing to the plan's target populations, but housing alone is not enough. In order to prevent and end homelessness for the plan's target populations, the plan establishes five goals:

- **Prevent homelessness and other housing crises.** The most effective way to end homelessness is to avoid it in the first place, by making appropriate services accessible when needed. Exiting foster care, hospitals, or a jail or prison, should not be an expressway to homelessness.
- **Increase housing opportunities for the plan's target populations.** This plan identifies a need for 15,000 units of housing for people who are homeless or living with HIV/AIDS or mental illness, and estimates the cost of developing and operating housing and services over the next fifteen years at \$2.1 billion.
- **Deliver flexible services to support stability and independence.** Culturally competent, coordinated support services must accompany housing; for some, access to clinical services will also be important. Service systems must coordinate in order to make the greatest difference in people's lives and to make the most of their limited resources.
- **Measure success and report outcomes.** Evaluating outcomes will allow systems and agencies to identify successful programs and target resources toward best practices.
- **Develop long-term leadership and build political will.** These goals can only be achieved with a long-term leadership structure that can sustain systems change activities. Building and sustaining political and popular support for its vision and activities will also be required.

Homelessness and housing crises are damaging to the physical, mental, and economic health of individuals and families, and leave them vulnerable to violence and exploitation. But homelessness and housing crises have serious costs to the community as well. For example, when children and adults are homeless or in a precarious housing situation at risk of becoming homeless, they cannot participate to their greatest potential in school, at home, at work, and in the community. Other costs to the community include the costs of providing emergency housing, mental health crisis services, emergency medical care, criminal justice and judicial system involvement.

Alameda County has already made a significant investment in affordable housing and services related to homelessness, behavioral health (including both mental health and substance use), and HIV/AIDS. There are more than 20,000 units of affordable housing, and services are provided to more than 20,000 people annually in these three systems. Still, too many low-income people experience homelessness and housing instability.

This plan envisions a housing and services system that partners with consumers, families and advocates; provides appropriate services in a timely fashion to all who need them; and ensures that individuals and families are safely, supportively, and permanently housed. As the sponsors and community stakeholders of this plan, we envision a future in which there are sufficient resources, political will, and community support to effect the changes necessary to make this vision a reality.

Not only is this Alameda County's plan to end chronic homelessness—and similar in intent to plans being developed across the country—but also it builds on those efforts by engaging the mental health and HIV/AIDS service systems to forge a comprehensive approach to increasing supportive housing. Prior to embarking on this shared planning process, each of the sponsoring agencies had in the past undertaken housing plans specific to their target populations.

This plan represents the culmination of more than a year of collaboration between Alameda County government representatives and community stakeholders. Dozens of housing and service providers, consumers, and stakeholders participated in interviews, focus groups, and ad hoc working groups to develop the plan. Successful implementation of this plan will require the support and participation of many more individuals, organizations, sectors, and jurisdictions. The plan was sponsored and funded by:

- Alameda County Behavioral Health Care Services
- Alameda County Housing and Community Development Department
- Alameda County Public Health Department Office of AIDS Administration
- Alameda County Social Services Agency
- Alameda Countywide Homeless Continuum of Care Council
- City of Berkeley Housing Department
- City of Berkeley Health and Human Services Department
- City of Oakland Community and Economic Development Agency
- City of Oakland Department of Human Services

Starting in 2005, the Sponsoring Agencies and community stakeholders will seek adoption, endorsement, and support of this plan from key stakeholders reflecting the diversity of the county. Civic and faith-based groups, businesses, housing and service providers, consumers and their advocates will all be asked to endorse the plan. Elected officials, localities, and the County will be asked to formally adopt the plan, participate in its implementation, and consider what steps they can take to forward the plan's goals.

The Sponsoring Agencies will also initiate the development of an Advisory Council that includes the participation of community leaders with diverse backgrounds. Together, by 2007, they will create a permanent Governing Board composed of influential community leaders responsible for overseeing the plan's implementation.

The Sponsoring Agencies and Advisory Council will also create a countywide Inter-Agency Council that includes funders and key housing and service providers from the homeless, HIV/AIDS, and mental health systems, as well as the leadership of mainstream housing and service systems. The Inter-Agency Council will support and advise the work of the Governing Board, develop detailed implementation plans, and incorporate the strategies of this plan into a revised service delivery system. The Inter-Agency Council will solicit consumer input on programs and priorities through a Consumer Advisory process.

During the next fifteen years, these three groups will work together to implement the plan's recommendations in order to ensure these outcomes by 2020:

- More than 35,000 individuals and families in Alameda County who have experienced homelessness or are extremely low-income and living with serious and persistent mental illness and/or HIV/AIDS in inappropriate or precarious housing situations will achieve long-term, appropriate housing situations.
- People experiencing a crisis or in need of basic medical, behavioral health and/or social services are able to access user-friendly and up-to-date information and obtain assessment services through any provider of such services in the county.
- People throughout Alameda County, including elected officials, community leaders, and the general public demonstrate, through their charitable contributions, volunteer service, funding decisions, and state and federal advocacy, an accurate understanding of how to prevent homelessness and a solid commitment to remedy the complex social and health issues faced by extremely low-income people living with HIV/AIDS, serious and persistent mental illness, chemical dependency, and other disabling conditions.

Plan Adoptions and Endorsements

The Sponsoring Agencies and interested stakeholders will be seeking endorsement of this plan from elected officials, agencies, and community groups throughout Alameda County.

Introduction

In Alameda County, an estimated 16,000 people experience homelessness over the course of a year. Many homeless youth and adults are living with mental illness, substance use issues, HIV/AIDS, and/or other disabilities. More than one in four homeless individuals countywide is a child younger than the age of 18.

Homelessness is a symptom of a wide range of challenges and characteristics in people who happen to share the problem of lacking a permanent residence. The high cost of housing in Alameda County both increases homelessness here, and is itself a barrier to preventing and ending homelessness. According to the National Low Income Housing Coalition, Alameda County is one of the ten least affordable counties in the nation.

Both homelessness and HIV/AIDS affect people of color disproportionately. In particular, African Americans constitute a higher proportion of people living with HIV/AIDS and people who are homeless than of the general population of Alameda County. Nationally, people of color have been shown to have less access to health care and worse health outcomes than Caucasians, due to factors such as poverty and racism.

Homelessness is detrimental to physical and mental health, and leaves people vulnerable to violence and exploitation. Homelessness also deprives the community of the full participation of adults and children in school, at home, at work, and in the community. However, a number of local and national programs have demonstrated successful interventions to assist people in achieving and maintaining stable housing and improving their quality of life.

A substantial body of research documents that the costs to tax payers of providing intensive and crisis services such as emergency rooms, medical and mental health hospitals, jails and prisons to chronically homeless, seriously disabled people primarily because they do not have stable housing are substantially higher than providing modest housing linked to appropriate support services.

This plan addresses the housing needs of persons who are homeless today, and those who are among the most likely to be homeless tomorrow. The sponsors and stakeholders who developed this plan recognize that people who are chronically homeless on our streets form the most visible and seemingly intractable part of the homeless population. This plan outlines reorienting Alameda County's housing and service systems to reduce and end chronic homelessness over the coming decade. In addition, by creating safe, decent, and affordable housing options for extremely low-income people living with serious and persistent mental illness and/or HIV/AIDS who are inappropriately or precariously housed, Alameda County can prevent future homelessness.

Without an effort of this magnitude to change Alameda County's housing and service delivery systems and to address the underlying causes of homelessness—not just react to its victims—the chronically homeless on the streets today will be replaced by those who become homeless tomorrow.

How this plan got started

The groundbreaking approach of this plan—combining three systems and sponsored by nine agencies—has not been undertaken by any other community in the nation, despite widespread acknowledgement of the importance of systems integration.

Prior to this plan, the Alameda Countywide Homeless Continuum of Care Council had completed homeless plans that also addressed HIV/AIDS and mental illness with a homelessness focus. The Alameda County Housing and Community Development Department (HCD) had combined the use of both local formula funds through the U.S. Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) program and national HOPWA technical assistance resources to create a multi-year HIV/AIDS housing plan in 1996 that was updated in 1998. The Office of AIDS Administration's annual Ryan White Title I planning activities have been tracking housing and service issues over the years. Alameda County Behavioral Health Care Services (BHCS) had examined housing issues of its clients internally and identified the need to undertake a community plan in partnership with housing and homelessness agencies.

In 2004, all of these agencies and the Alameda County Social Services Agency, together with the cities of Oakland and Berkeley, initiated the *Alameda Countywide Homeless and Special Needs Housing Plan*, each contributing funds to support this unique effort. The collaboration creatively leveraged knowledge, funding, passion, and expertise to address countywide multidimensional issues.

The plan's sponsors came together to develop this plan because they shared:

- A recognition that many people who are homeless and/or have disabilities have difficulty finding and keeping housing in Alameda County, both due to the high-cost of market-rate housing and the relatively limited amount of housing affordable to those who rely on disability incomes.
- A recognition that the homeless, mental health, and HIV/AIDS systems serve people with many similar needs, and in many cases, the same individuals.
- A recognition that many people, including those with HIV/AIDS or a mental illness, exit other systems, such as foster care, criminal justice, and hospitalization, into homelessness.
- A desire to build on successful interdisciplinary programs in Alameda County and elsewhere that have proven to stably house and increase the quality of life for many people, including those with long histories of homelessness and multiple disabilities.
- A desire to bridge the historical division between housing and service systems, and to seek innovative ways of combining resources in order to more effectively serve populations in need.
- A desire to maintain and increase resources that are dedicated to serving people who are homeless or are living with serious and persistent mental illness and/or HIV/AIDS, and a desire to increase political and popular support for these and related issues.

For more information about the people who participated in developing this plan and the planning process, see *Companion Materials, 1. Planning Participants* and *2. Overview of the Planning Process*. For notes from the consumer focus groups, please see *Companion Materials, 11. Consumer Focus Groups*.

A multi-dimensional problem requires multi-faceted solutions

As the Sponsoring Agencies and community stakeholders who developed this plan, we recognize that safe, decent, and affordable housing benefits the entire community, not only the residents of such housing. Ending homelessness and greatly decreasing the risk for homelessness in Alameda County, among people living with serious and persistent mental illness and/or HIV/AIDS, is a regional problem requiring regional solutions. These households face multi-dimensional challenges, so what is needed are multi-faceted solutions that integrate county health, housing, criminal justice, and human service delivery systems to a degree not yet realized.

With this plan, many jurisdictions, agencies, service delivery systems, funding sources, and sectors of our community are both pulling together in new, creative ways and building on past successes to prevent and end homelessness in Alameda County. For example, by utilizing multi-agency teams of public and private nonprofit organizations that deliver integrated services to residents, the Alameda Health, Housing and Integrated Services Network (HHISN) has demonstrated the effectiveness of affordable, long-term supportive housing in reducing systems-level costs, while improving client outcomes for homeless individuals living with multiple diagnoses.

Similarly, Alameda County's strong HIV/AIDS housing and services programs, funded primarily by the Housing Opportunities for Persons with AIDS (HOPWA) program and Title I of the Ryan White CARE Act, will be enhanced through greater collaboration with homeless services and behavioral health care programs. These expanded partnerships will ultimately assist more people living with HIV/AIDS to achieve and maintain housing stability, increase access to care and services, and help prevent homelessness.

As schools, faith-based and civic groups, and a broad array of community members learn more about issues affecting people with special needs in the county, new initiatives and ideas will emerge. Everyone can play a role in ending homelessness in Alameda County.

Ending homelessness starts with preventing it

Homelessness, highly unstable housing, and health crises harm the physical, mental, and/or economic health of individuals and families and should be prevented for these reasons alone. From a systems perspective, housing and service crisis responses are often more costly than prevention approaches. The National Alliance to End Homelessness refers to prevention as "closing the front door" on homelessness. While some emergency interventions will always be needed to respond to truly unforeseeable events, many of the circumstances that force people into homelessness are, in fact, foreseeable.

Many of those who are homeless were discharged from institutions, such as jails, prisons, or hospitals, or they have aged out of the foster care system. For example, one in five homeless adults in Alameda County was in foster care or a group home when younger than 18. There are high personal and financial costs associated with discharging people into homelessness rather than directly into appropriate housing. As the Sponsoring Agencies and stakeholders who developed this plan, we recognize that it is critical that housing and service systems throughout the county work well together to address complexities of timing, availability of options, and admission criteria in order to develop alternatives to discharging people into homelessness.

In addition to discharge planning, homelessness prevention strategies include benefits advocacy, to ensure people receive benefits such as SSI for which they are eligible, short-term rental assistance for emergencies, and employment training and job placement.

Ending homelessness requires connecting housing and services

In Alameda County, a formerly homeless woman with a disability described housing without services, or services without housing as “trying to make a cake without the eggs.” With access to housing assistance and linked services, she is now living stably in her own home for the first time in her adult life. For many people, particularly those with disabilities, neither housing assistance nor services alone is effective, but together they can have remarkable results. Housing and services, whether preventative, or provided over the short- or long-term, must be physically accessible and convenient to public transportation, so that additional barriers are not created.

Ending homelessness requires learning from successful innovations

We are committed to improving the effectiveness and efficiency of existing delivery systems and implementing new approaches. Realizing this vision requires maintaining the housing and services Alameda County has now. Many aspects of the existing housing and service delivery systems have value and can be strengthened through closer coordination to maximize positive outcomes for the low-income, multiply challenged populations they serve.

At the same time, we are encouraged and energized by the movement nationally toward developing new, integrated approaches that have been proven to increase housing stability, decrease risk of homelessness, and increase access to services for people who are homeless, living with HIV/AIDS, have a mental illness and/or other disabilities. These approaches bring together multiple systems, combine services and housing in new ways, and emphasize the importance of permanent housing options that are affordable to households with extremely low incomes.

Alameda County community-based organizations and the government agencies that fund them have developed effective, innovative, and nationally recognized approaches to serving people who are homeless, living with HIV/AIDS, and/or mental illness, including 2,300 units of permanent supportive housing now dedicated to the plan’s three target populations. Examples include the HOPWA-funded Project Independence Program; the Health, Housing, and Integrated Service Network (HHISN); and Berkeley Mental Health’s AB 2034 program serving homeless, mentally ill adults.

Our vision

We envision a system that partners with consumers, families and advocates; provides appropriate services in a timely fashion to all who need them; and ensures that individuals and families are safely, supportively, and permanently housed. We envision a future in which there are sufficient resources, political will, and community support to effect the changes necessary to make this vision a reality.

~

"The moral test of a society is how that society treats those who are in the dawn of life—the children; those who are in the twilight of life—the elderly; and those who are in the shadow of life—the sick, the needy, and the handicapped."

Hubert Humphrey,
former Vice-President of the
United States

We're in it for the long haul

As the sponsors and stakeholders who developed this plan, we recognize that as we complete this document, federal and state resources for housing and services have been decreasing, local governments are experiencing serious budget problems, and our local economy is still struggling to recover. However, homelessness, HIV/AIDS, and mental illness will not go away on their own. We cannot afford to wait until the "right" time to start working together to address these issues. Now, more than ever, we need to make sure that we are making the most effective use of resources.

We know that the goals of ending chronic homelessness within ten years and reducing housing crises for extremely low-income people living with serious and persistent mental illness and/or HIV/AIDS are ambitious. We know that these goals cannot be accomplished overnight, or even in the first years of this plan. Change will come slowly, as we expand existing relationships, create new relationships, identify new resources, and implement new approaches. As new strategies are implemented, we will see progress towards our goals of ending homelessness in Alameda County and supporting people living with HIV/AIDS or mental illness to stay stably housed and able to participate in their families and in our community to the greatest extent possible.

~

"It takes as much energy to wish as it does to plan."

Eleanor Roosevelt

~

Guiding principles

- Housing and service needs must be addressed as a **region-wide social and economic issue**, and must engage **broad participation** from both traditional and new partners in implementing solutions.
- A primary goal of the system should be to **prevent homelessness** and other foreseeable life crises, and to avoid or reduce further negative impacts when crises do occur.
- **Permanent housing that is affordable and accompanied by adequate supportive services** is essential to the effort to eliminate chronic homelessness, and requires **project-based rental subsidies** to ensure affordability for those with extremely low or no income.
- The entire system should be **accessible and responsive to all** who are in need of assistance, regardless of how, when, or where they first enter the system; regardless of their age, culture, language, or disability; and regardless of their changing needs. Services should be consumer-centered, building on each consumer's strengths toward their own wellness and recovery goals rather than the needs of the service delivery system.
- To ensure balance and continued success, the system should furnish housing and service providers with the **necessary resources and training** to ensure excellence in service delivery and provide individuals and families with **choices** to determine their own course, while requiring **accountability from all**—consumers, family members, providers, policymakers, and the community at large.
- Initiatives to change the system should include **realistic and measurable outcomes** and the necessary **data collection and reporting** to assess the effectiveness of those changes.

Recommendations

This plan's Sponsoring Agencies and stakeholders developed recommendations in support of five major goals. Each goal is critical to ending homelessness and preventing housing crises for the plan's populations. The five goals are:

- **Prevent homelessness and other housing crises.** The most effective way to end homelessness is to avoid it in the first place. Prevention requires making appropriate services accessible at the time they are needed, which is why this plan envisions a “no wrong door” approach to services. In particular, people leaving institutions including foster care, hospitals, jails and prisons need interventions that prevent their exiting into homelessness.
- **Increase housing opportunities for the plan's target populations.** People who are homeless need affordable and supportive housing. Increasing housing opportunities requires creative use of existing resources, developing new resources, and using effective models of housing and services. A detailed estimate of the housing needed and the cost of providing it appears later in the plan in the chapters entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* and *Housing Goals and Cost Estimates*.
- **Deliver flexible services to support stability and independence.** Culturally competent services, particularly services coordination, must accompany housing. Access to clinical services will be important for a segment of the population. Direct service providers in all systems throughout the county must have a degree of knowledge about and access to a range of housing resources and complementary support services.
- **Measure success and report outcomes.** Evaluating outcomes will allow systems and agencies to identify successful programs and target resources toward best practices.
- **Develop long-term leadership and build political will.** The other recommendations can only be achieved by developing a long-term leadership structure that can sustain systems change activities. Implementation of this plan will also require building political and popular support for its vision and activities and sustaining it for the next fifteen years.

The following pages present each goal with its associated objectives and strategies. For initial action steps, please see the accompanying document, *Action Plan (2006–2007)*. Additional steps for each system appear in the following chapters in the plan's *Companion Materials: 3. Next Steps for the Homeless Continuum of Care System; 4. Next Steps for the Behavioral Health Care System; and 5. Next Steps for the HIV/AIDS System*.



**Take a look at....
Sustaining and expanding
housing options**

**Partial Rent Subsidy Programs in Alameda County:
HOPWA Project Independence and BHCS 20% Program**

Partial rent subsidy programs are often operated as tenant-based rental assistance, like Section 8, but with a critical difference. While tenants with Section 8 pay a fixed 30 percent of their income for housing costs, with Section 8 making up the difference between that amount and the actual cost, partial rent subsidy programs pay a fixed amount per month to help augment what the tenant can pay.

Alameda County has had a partial rent subsidy program for people living with HIV/AIDS since 1996. **Project Independence**, which provides partial rent subsidies, support service coordination, and accessibility improvements to people living with HIV/AIDS who are at risk of homelessness, was recommended in the 1996 *Alameda County Multi-Year AIDS Housing Plan*. The program's funding, from the U.S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons with AIDS (HOPWA) Special Projects of National Significance (SPNS) program, has subsequently been renewed twice, once in 1999 and again in 2002, each time for a three-year period.

Rent subsidies ranging from \$175 to \$425 a month depending on income, household size, and unit size stabilize participants' housing situations. These subsidies are for use in permanent housing, and there is no time limit for participation.

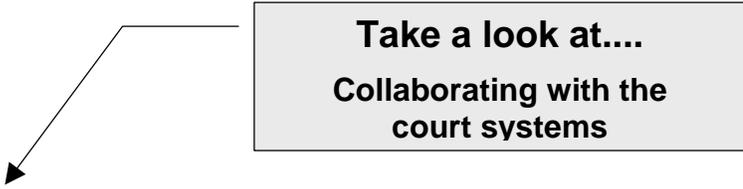
Alameda County Behavioral Health Care Services (BHCS) also operates a short-term partial rent subsidy program referred to as "**20% Rental Subsidies**." This program is piloting the use of rental subsidies to help people with mental illness move from homelessness to stable housing. It can provide 20 percent of monthly rent for consumers, up to a maximum of \$160 per month for up to two years. Initially, this program was funded with a roll-over of SAMHSA funds in FY 2004-2005.

Goal (P): Prevent Homelessness and Other Housing Crises

Placing a redoubled emphasis on homelessness prevention will be a key component of ending homelessness in Alameda County. The experience of homelessness itself has a detrimental effect on individuals and families, and returning from homelessness to stable housing is difficult. Generally, the longer an individual or family is homeless, the longer the transition to stable living will take. Preventing homelessness in the first place is better. At the same time, prevention can be less costly and simpler for a service delivery system than addressing homelessness and human service needs at a time of crisis. Homelessness prevention interventions should be available to all low-income households. Preventing homelessness at the time of discharge from an institution, whether foster care, hospitalization, jail, or prison will be required to stop the flow of people into homelessness.

Objective P-1: Ensure that all households at risk of homelessness, including households in affordable or public housing, can find complete information about prevention programs, and can access assistance in time to prevent homelessness.

- Strategy P-1-A:** Establish a “no wrong door” policy and practices, meaning that information on all systems will be available from many points of access 24 hours a day. Ensure that points of access are physically accessible so that disability is not a barrier to finding or receiving assistance, and ensure that systems have sufficient cultural competency to serve their target populations so that language and culture do not become barriers. Once information systems are coordinated, explore options for a unified referral process.
- Strategy P-1-B:** Offer in-service trainings and presentations to affordable housing and other property managers, including public housing property managers, about the information and referral resources and system entry points that exist, so that they can refer at-risk households, as appropriate.
- Strategy P-1-C:** Collaborate with the Social Security Administration and other mainstream systems to increase enrollment in Supplemental Security Income (SSI), Medi-Cal, Food Stamps, and other benefits programs for those who are eligible. Full utilization of benefits will help stabilize eligible households and can prevent homelessness and other housing crises.



**Take a look at....
Collaborating with the
court systems**

Alameda County's Homeless Court Project

In Alameda County, the Continuum of Care Council and the Superior Court of California's Community-Focused Court Committee co-sponsor and jointly operate a Homeless Court.

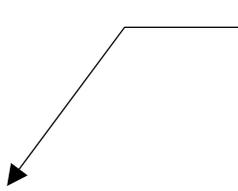
Many people who are homeless have at some point received a ticket for a misdemeanor charge such as jaywalking or carrying an open container. If they can't pay the fine, it becomes a bigger fine, and then it becomes a bench warrant. These warrants can prevent people from getting a job, housing, or public assistance.

The Homeless Court convenes periodically throughout the county at locations such as homeless shelters. Homeless people whose misdemeanor charges have turned into warrants come to the Homeless Court to have their cases dismissed. Before appearing in court, participants work with staff from participating provider organizations and a public defender to evaluate their cases and to review their efforts to turn their lives around. This information, along with a letter of support from staff, is presented to the presiding judge during the court session.

By bringing court to the people, and not giving additional fines to people who cannot pay them, the Homeless Court helps people who are moving toward greater independence and stability but who are unable to obtain employment, disability benefits, or housing because of outstanding warrants for non-violent offenses. The Homeless Court Project provides a new beginning for people by lifting significant barriers to exiting homelessness.

The majority of defendants seen by this court are chronically homeless. By May 2005, four successful court sessions had been held, serving more than 80 chronically homeless people. The courts adopted this system because it was clear that a different approach was needed for this segment of the population.

Objective P-2:	Ensure that no youth become homeless as a result of family violence or when exiting state or local care, including the foster care system and institutional settings (treatment or corrections).
Strategy P-2-A:	Target intensive services, such as family counseling, parenting classes, and youth activities to families who face disruption due to violence. Educate schools, recreational programs, and churches, on the warning signs and impact of family violence and the availability of community resources to support youth and families to maintain stability.
Strategy P-2-B:	Increase the availability of age-appropriate services for youth exiting state or local care, including basic life skills development, job training, services coordination, legal representation and advocacy, mental health and substance use treatment, and access to medical care.
Strategy P-2-C:	Implement or strengthen independent living plans for every youth in the county exiting foster care, treatment, and corrections. Transition planning should begin at least one year prior to the anticipated emancipation date and should incorporate a wide range of supports, as needed on an individual basis, in order to prepare youth as much as possible to successfully re-enter the community, and their families, as appropriate.
Objective P-3:	Link community-based housing and services with institutions, including hospitals, foster care, and incarceration, so that people do not become homeless when discharged.
Strategy P-3-A:	Convene the key policymakers and administrators in each system that is responsible for discharge planning to: (1) identify the optimal timing for pre-release or pre-discharge access and engagement; (2) begin negotiations to increase access by community-based case management; and (3) establish discharge protocols that result in people having stable, affordable places to live upon exit.
Strategy P-3-B:	Create a housing retention fund to provide one-time partial rent assistance for people in short-term crisis hospital stays.



Take a look at....
Exploring innovative and successful models in other communities

Kerner-Scott House (Seattle, WA)

In Seattle, the Downtown Emergency Service Center (DESC) offers a “Safe Haven” housing program for homeless people with serious mental illness who are not connected to or seeking mental health services. Kerner-Scott House was developed based on the idea that people would feel more comfortable and safer in low-barrier housing, rather than in a crowded and noisy shelter for their first step off the street.

There are limited requirements for residents, and staff can be very flexible. For example, one resident stayed on a chair in the hall for months before she felt comfortable to move into her own room. Active substance users can live at Kerner-Scott House as long as they do not use inside the facility.

DESC’s mental health outreach workers identify potential participants for the program. When a vacancy becomes available, the most vulnerable potential participant is invited to live there. Outreach workers bring the potential resident to visit the program, and s/he usually has about a week to think it over, although this can be extended up to three weeks if progress is being made. Residents sign a rental agreement when they move in. Sometimes a resident will leave the program, often because they are paranoid or delusional. If that happens, outreach workers follow up with the person to find out why they left and whether they will come back. If they do not want to come back, then they will be exited from the program. The outreach worker may work with the resident for up to a month about returning, and will continue to work with the person if they do leave Kerner-Scott House.

Kerner-Scott House provides 24-hour staffing and an integrated approach to support services, including clinical case management 7 days a week to engage with residents and develop service plans, two free meals a day, and activities such as games, groups, and field trips. Outreach workers stay involved with residents once they move in.

These intensive services and investment of time have yielded remarkable outcomes for the participants, who are among the most vulnerable members of the homeless population and have often been homeless for a long time. Residents can stay as long as they want. Most leave to go to another DESC supportive housing program, while some move into their own apartment with Shelter Plus Care. In a three-year period, 83 percent of residents either stayed at Kerner-Scott House 24 months or more, or exited to permanent housing.

For more information about DESC and Kerner-Scott House, visit www.desc.org/supportive_housing.html.

Goal (H): Increase Housing Opportunities for Targeted Populations

While Alameda County already has many types of affordable and supportive housing, the number of people in each of the populations targeted by this plan who need housing and related services is much greater than the existing housing dedicated to serving them. Increasing the amount and variety of types of housing for the plan’s populations will be essential to ending homelessness in Alameda County.

Preferably, people who are homeless should be offered a housing opportunity as quickly as possible, and have some choice in where they live. Whenever possible, consumers should be offered housing without any preconditions of service participation. In supportive housing, the level of property management and supportive services available to residents should be carefully planned, sufficiently intensive, and appropriately targeted to ensure that the housing is a success for consumers, providers, and the community at large. Because people who have been homeless are more likely to have chronic health conditions and physical disabilities, it is particularly important that housing options of many kinds be physically accessible. Finally, any changes to the housing system must not result in homelessness for current residents.

“I just love (my apartment) because it is mine and I have a key and I can come and go.”

~

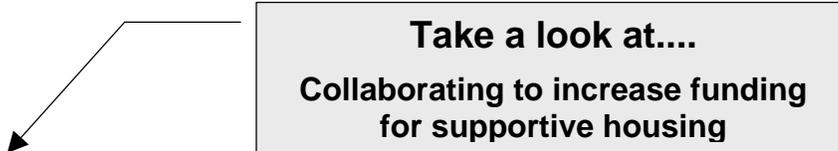
“An apartment that I can afford and I can’t beat it. A place I can call my own and it feels great. I love my place.”

~

“It will take an act of God to get me out.”

Formerly homeless adults in Alameda County, on their permanently affordable housing

Objective H-1:	Using existing resources, increase and sustain the amount of housing for the targeted populations in Alameda County.
Strategy H-1-A:	Within existing programs, work with each jurisdiction in the county, especially Community Development Block Grant and HOME entitlement communities, to target state and federal housing funds to extremely low-income, vulnerable populations at or below 30 percent of area median income (AMI), and below 15 percent of AMI in particular.
Strategy H-1-B:	Collaborate with jurisdictions and developers to explore mechanisms for coordinating and pooling funding for supportive housing development, operations, and services. <i>(See program model on page 14.)</i>
Strategy H-1-C:	Encourage housing development that exceeds minimum requirements for physical accessibility, to accommodate the higher than average rate of physical disability and chronic illness among the homeless population as well as the anticipated needs of an aging population.
Strategy H-1-D:	Maintain funding and identify new sources for partial- and graduated-rent subsidy programs for those households who don’t need a long-term deep subsidy to gain or maintain housing. <i>(See program models on page 8.)</i>
Strategy H-1-E:	Negotiate unit set-asides or master leasing for the plan’s populations in new and existing developments of nonprofit housing developers.



Community Shelter Board's Rebuilding Lives Funder Collaborative (Columbus, Ohio)

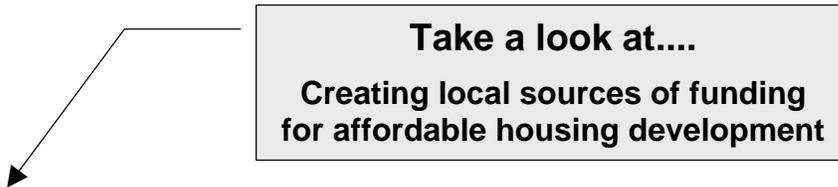
Coordination between funders and alignment of priorities can help housing developments and related programs assemble needed funding more quickly. The Community Shelter Board's Rebuilding Lives Funder Collaborative is one example of funder coordination.

The Community Shelter Board is a nonprofit organization in Columbus, Ohio that coordinates Continuum of Care and other homeless planning and administers Continuum of Care, City of Columbus, Franklin County, and United Way funding in the City of Columbus. The Rebuilding Lives initiative is a strategic plan developed by that community to address homelessness by building supportive housing.

The Funder Collaborative is comprised of public and private organizations, which provide funding and other resources for supportive housing projects. Participants include foundations, the county behavioral health agency, the mayor's office, city council, and the city health department. Together, the members of the Collaborative jointly develop strategy, program guidelines and standards, underwriting criteria, program evaluation, outcome measurement, and reporting requirements.

For more information about the Community Shelter Board, visit www.csb.org.

Objective H-2:	Work with Public Housing Authorities (PHAs) throughout the county to enhance and increase the availability of subsidized vouchers and units for the target populations.
Strategy H-2-A:	Project-base Section 8 vouchers in new and existing housing, and combine project-based Section 8 and local funding applications to expedite and streamline the development process.
Strategy H-2-B:	Link housing and services using partnerships and formal agreements between PHAs and community service providers.
Strategy H-2-C:	Advocate for rental assistance and support service programs for people with substance use issues and/or who have histories of felony convictions.
Strategy H-2-D:	Seek waivers from the U.S. Department of Housing and Urban Development to allow households to move between Section 8, Shelter Plus Care, and other similar programs as their service needs change over time.
Strategy H-2-E:	Collaborate in pursuit of regulatory changes that would increase PHAs' ability to house formerly homeless and special needs populations.
Strategy H-2-F:	Negotiate unit set-asides or master leasing for the plan's populations in new and existing developments.



City of Seattle Affordable Housing Levy

Affordable housing development, particularly in high-cost areas like Alameda County, requires piecing together many sources of funding. The funding that most localities use to support affordable housing development, such as HOME and CDBG, originate at the federal level and come with federally established restrictions. Some communities have created local sources of funding for affordable housing development that both increase the total amount of funding available—thereby increasing the total amount of housing that can be developed—and create a more flexible source that can fill in gaps left by other funding types.

City of Seattle residents have voted to levy property taxes for housing four times in the past, in 1981, 1986, 1995, and most recently in 2002. The 2002 levy will result in \$86 million for affordable housing over 7 years, and is anticipated to assist more than 2,000 households during that time. Planned uses of the levy funds include:

- \$63 million for rental housing production
- \$7.8 million for an operating and maintenance program to ensure that a portion of the rental production program housing is affordable to extremely low-income households (households with incomes at or below 30 percent of median income)
- \$7.8 million for homebuyer assistance for approximately 326 households with incomes up to 80 percent of median income)
- \$2.8 million for rental housing payment assistance for homelessness prevention
- \$4.3 million for administrative costs

The housing levy is administered by the City of Seattle's Office of Housing.

For more information on the Seattle Housing Levy, visit www.seattle.gov/housing/Levy.htm.

Objective H-3: Through advocacy efforts, maintain and increase the resources necessary to develop, operate, and preserve appropriate and affordable housing options for single adults, youth, and families whose incomes are at or below 30 percent of the area median in Alameda County.

Advocacy within the county is an ongoing responsibility to assure that both community members and leaders are aware of the benefits of widely dispersing affordable housing and offering appropriate housing options to all segments of Alameda County's diverse communities. Operating subsidies are needed to make up the difference between the cost of operating housing and the amount of rent very-low income households can pay.

- Strategy H-3-A:** Advocate at the federal level to preserve and expand funding, including supporting initiatives to preserve housing development and operations funding from the U.S. Department of Housing and Urban Development and establish a National Housing Trust Fund.
-
- Strategy H-3-B:** Support the establishment of a California Housing Trust Fund, advocating for inclusion of development and operating funds for units at the targeted income range.
-
- Strategy H-3-C:** Explore the possibilities for creating a local or regional source for housing development, support services, and housing operating costs, examining examples of permanent local funding streams in other communities, such as Seattle's Affordable Housing Levy (*see program model on page 16*) and Albuquerque's criminal justice initiative.
-
- Strategy H-3-D:** Develop new strategic partnerships with the private sector, including engaging business leadership in promoting and supporting affordable housing resources for low-income households. (*See program model on page 32.*)
-
- Strategy H-3-E:** Support "green building" initiatives and incentives that can reduce the monthly utility cost to residents or the total operating costs through greater energy efficiency in affordable housing developments.
-
- Strategy H-3-F:** Provide community organizing, education, and ongoing support to ensure acceptance of permanent supportive housing and other affordable housing models throughout Alameda County.

Objective H-4: Expand and sustain the range of housing models operating in Alameda County to include options ranging from intensely supported to fully independent affordable housing.

Housing options should include service coordination, where appropriate, to ensure that residents are linked to needed services, through both on-site and community-based providers.

Housing assistance should be available to people in their home community, with models appropriate for active substance users and people with physical disabilities.

Mechanisms should allow residents to move from one type of housing to another and to increase or decrease their service utilization as their need for support services changes.

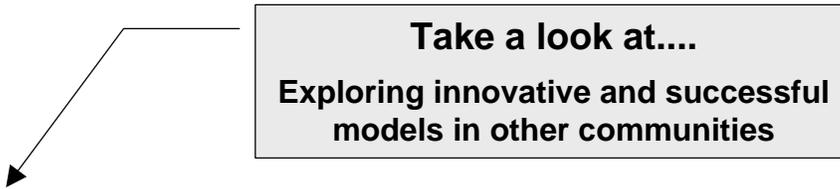
Elected officials, as well as faith- and community-based groups and business leaders, should take steps to educate Alameda County residents on the benefits of providing housing for all segments of society and to involve them in creating an atmosphere of welcome and inclusion of affordable and special-needs housing countywide.

- Strategy H-4-A:** Ensure that services are closely connected to housing, and for the long-term through:
- creating opportunities for longer-term (i.e. three or more year) services funding commitments and streamlining the process for combining multiple housing and services funding streams; and
 - requiring cross-training programs for case managers and other workers in mainstream service systems, so that they can better understand the role of housing case management and collaborate more effectively in addressing residents social and health issues.

(See program model on page 26.)

- Strategy H-4-B:** Preserve and enhance the quality of licensed Board and Care homes by collaborating with statewide partners and working with the State of California Department of Social Services Community Care Licensing Division to:
- enhance the reimbursement rate for homes serving the adult mentally ill population;
 - refocus services around principles of wellness and recovery; and
 - assist residents to transition to more independent housing, as appropriate.

- Strategy H-4-C:** Preserve and improve the quality of unlicensed boarding homes through:
- providing trainings and incentives to operators for improving the quality of both the housing and the care;
 - addressing residents’ grievances quickly and appropriately;
 - collaborating with code enforcement entities to prevent boarding home closures and loss of this affordable housing stock;
 - assisting unlicensed homes to become licensed, as appropriate, and
 - developing interagency protocols and agreements to prevent homelessness and other housing crises for residents when boarding home closure is necessary due to quality problems.
-
- Strategy H-4-D:** Create medical respite options for people with medical needs who do not need a skilled nursing facility but need more care than emergency shelter, transitional housing, or independent housing allows.
-
- Strategy H-4-E:** Analyze successful, innovative supportive housing models in other communities in greater depth, in order to determine how they can be implemented in Alameda County. New models should include some housing for people in the pre-contemplative stage of recovery from which they cannot be evicted due to behaviors related to their disability or for substance use alone. Implementation should start with pilot projects that use innovative but proven strategies to address needs identified in Alameda County, drawing on this community’s experience with housing and services. (*See program models on pages 12, 20, and 22.*)



Direct Access to Housing Program (San Francisco, CA)

The San Francisco Department of Public Health's Direct Access to Housing (DAH) Program has received national recognition since its establishment in 1998. DAH is a low-barrier permanent supportive housing program for people who are frequent users of mental and physical health care services. DAH accepts residents directly from the streets, shelter, hospital, and long-term care facilities. The program's main goal is to provide housing to a group of people that have rarely, if ever, maintained stable housing as adults.

Residents are recruited for DAH if they are frequent users of the public health system and have substance abuse, mental illness, and/or medical problems. They do not need to be recipients of Supplemental Security Income (SSI) or general assistance. The emphasis is on "screening in" prospective tenants rather than looking for reasons to deny housing. Felony convictions, active substance use, and undocumented status are not reasons to exclude people.

By 2004, the program included nearly 500 units of housing in seven single room occupancy (SRO) hotels, ranging from 33 to 92 units each, and a licensed Board and Care facility. Buildings are master-leased from private owners, which allows the Department of Public Health to open sites more quickly. In many cases, DAH involvement stabilized buildings that had previously been a problem for the neighborhood.

All sites have on-site case managers and a site director. Case managers assist residents to access and maintain benefits, medical and behavioral health treatment, and food and clothing; provide one-on-one substance use, mental health, life skills and family counseling; and work with property management to help prevent eviction. All sites have some access to medical care and a roving behavioral health team. DAH holds residents' rooms while they are in residential treatment, so they have a place to return.

The City's General Fund is the primary funding source. Other sources include AB 2034, the Ryan White Care Act, the Substance Abuse and Mental Health Services Administration (SAMHSA), and reimbursement through the Federally Qualified Health Center system for a portion of the medical- and mental health-related expenses. Approximately 80 percent of DAH residents receive SSI and Medi-Cal benefits. Residents pay 50 percent of their income towards rent.

Residents in the DAH program have had significant housing successes. Between January 1999 and January 2003, a four-year period, 91 percent of residents remained housed for six months or more. By 2004, two-thirds of DAH residents were still in the program. Of the one-third who left, half went into other permanent housing.

For more information about the Direct Access to Housing (DAH) Program, visit <http://www.endhomelessness.org/best/directaccess.htm>.

Goal (S): Deliver Flexible Services to Support Stability and Independence

For many people who are homeless and/or have a mental illness and/or are living with HIV/AIDS, affordable housing alone is not enough to ensure housing success. They will need support services at times. Rather than inducing or requiring dependence, the service delivery system should support consumers to adapt and/or recover and reach their greatest potential. For most this means living, working, learning, and participating fully in community life; for some it will entail eliminating, or simply reducing, the symptoms they exhibit related to mental illness or addiction. Services should also be culturally appropriate for Alameda County’s diverse populations—including those who have experienced long-term homelessness—and delivered in partnership with consumers’ families and social-support networks. Achieving these goals will require both the capacity to deliver services of varying intensities and over varying durations and a sincere commitment to promoting excellence in support service delivery through appropriate levels of training and compensation for program staff.

Objective S-1:	Expand the availability of needed clinical services that can provide culturally- and age-appropriate care to Alameda County’s diverse populations.
Strategy S-1-A:	Create a substance abuse detoxification facility in Alameda County and connect it to appropriate treatment and housing opportunities.
Strategy S-1-B:	Make medical and behavioral health clinical services, including both mental health and substance abuse treatment, readily available to all chronically homeless people who need them, regardless of their ability to pay or to meet SSI/MediCal eligibility criteria.
Strategy S-1-C:	Expand access to mental health services in South and East County through co-locating services in local one-stop assistance centers and establishing mobile service teams that provide seamless coverage for all communities.
Strategy S-1-D:	Build the capacity of community-based organizations working with the target populations of this plan to screen consumers and link them with Alameda County Behavioral Health Care Services (BHCS) for assessment.
Strategy S-1-E:	Expand mental health resources to serve those who have diagnoses that are not currently eligible for BHCS reimbursement, including people with post-traumatic stress disorder, mood disorders, and chemical addictions.
Strategy S-1-F:	Explore and pilot models of the provision of care and services by community-based providers to members of the plan’s target populations whose mental health or substance use conditions negatively impact housing stability but whom BHCS is unable to serve due to funding or eligibility restrictions.



Project H.O.M.E. (Philadelphia, PA)

Philadelphia's Project H.O.M.E., recognized as a national leader in providing comprehensive and effective services to people who are chronically homeless, has documented positive outcomes in serving a population that is usually considered very difficult to serve. Project H.O.M.E. offers comprehensive social services and housing options, including low-barrier "Safe Haven" housing, supportive transitional housing, and supportive permanent housing. Their approach is designed to deal with the complex issues of people with special needs such as mental illness and substance use.

Support services emphasize helping residents to achieve self-sufficiency. These services, which are tailored to the specific goals and needs of each resident, include comprehensive case management, on-site health care, an Adult Learning Program, employment counseling and training, and access to mental health and recovery services.

Project H.O.M.E.'s residential programs include:

- Safe Haven supportive housing – 65 beds for chronically homeless, mentally ill adults coming directly off the streets, with few requirements for entry. This program provides housing for "hard-to-reach" homeless men, many of whom are older, physically frail, and resistant to programs and services, and women who have a serious mental illness and a history of homelessness.
- Transitional supportive housing – 62 units for chronically homeless adults with serious mental illness and/or substance use issues. The program provides specialized behavioral health services and includes 36 Single Room Occupancy (SRO) units for men and women with a primary diagnosis of serious mental illness, and 26 SRO units for men who are homeless and have a substance use disorder with or without a co-occurring mental illness.
- Permanent supportive housing – 145 affordable SRO units for individuals and families who require regular, but not around the clock, supportive services and supervision. Residents pay 30 percent of their income for rent and have already lived in transitional housing situations for approximately one year. These units are subsidized primarily through the U.S. Department of Housing and Urban Development's Section 8 or Shelter Plus Care programs.

Project H.O.M.E. and its co-founder and Executive Director, Sister Mary Scullion, have played a pivotal role in reducing the number of chronic homeless in Philadelphia. In partnership with the City, Project H.O.M.E. reaches out to more than 3,800 people each year, with the goal of placing them in a stable housing situation. In 2003, of the 159 residents who left Project H.O.M.E. residences, half moved on to permanent housing, 10 percent moved into transitional housing, and 11 percent moved into a health institution (e.g. hospital, inpatient treatment, nursing home). Ninety-five percent of the men and women who live in Project H.O.M.E.'s permanent, supportive housing are successful in staying off the streets.

For more information about Project H.O.M.E., visit www.projecthome.org.

Objective S-2: Ensure coordination and accessibility of services.

- Strategy S-2-A:** Retain and expand mobile outreach and assistance teams that can assist households at-risk of or experiencing homelessness. Ensure that these outreach teams are highly-trained, interdisciplinary, mobile, and able to offer access to a range of needed resources and, thereby, help reduce geographic and physical barriers to maintaining stable and independent living for people throughout the county.
- Strategy S-2-B:** Engage consumers and family members to develop and assess the effectiveness of housing plans.
- Strategy S-2-C:** Create a “learning network” that offers ongoing cross-training and information exchange possibilities for staff and supervisors in the housing, social services, behavioral and physical health, and criminal justice agencies. This network should allow systems to build on their existing knowledge and expertise, and to universalize Alameda County’s best practices.
- Strategy S-2-D:** Combine resources and improve service coordination among programs that currently exist, with the goal of improving the comprehensiveness of services, eliminating unnecessary duplication, and reducing costs.

Objective S-3: Prepare consumers for tenancy and support them to maintain their housing over the long term.

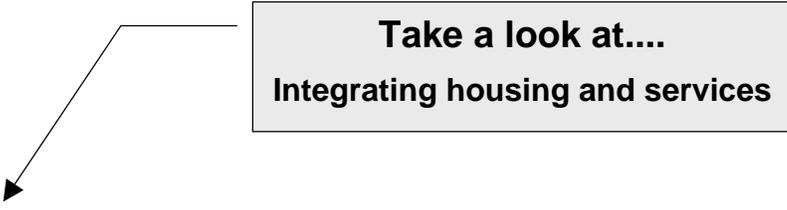
- Strategy S-3-A:** Make payee services widely available, particularly but not only to the HUD-defined chronically homeless population, in order to improve their housing stability and quality of life.
- Strategy S-3-B:** Develop peer-mentoring programs to assist consumers to recover, reduce harm to self and others, and move towards independent living.
- Strategy S-3-C:** Develop a network of service providers prepared to step in when tenants with Section 8 are at risk of losing their housing assistance.
- Strategy S-3-D:** Increase the service systems’ capacity for increasing tenancy skills for housing search, dealing with a poor credit history, and maintaining housing through the use of individualized counseling and group trainings.

Objective S-4: **Ensure that culturally appropriate, long-term services are offered to individuals and families experiencing homelessness and/or living with disabilities so that they can retain stable housing over the long-term, increase their independence, and have improved quality of life.**

People with long-term disabilities and health concerns may require some measure of support services throughout their lives.

- Strategy S-4-A:** For people with mental illness, increase peer support programs and support the development of independent living skills.
-
- Strategy S-4-B:** For people with physical disabilities, address physical access to housing and services in all service systems, because many people in the target population have multiple disabilities and/or chronic illnesses. Accessibility issues include siting and transportation as well as building design.
-
- Strategy S-4-C:** For immigrants and people who are monolingual in a language other than English, increase the availability of linguistically appropriate services in all systems.
-
- Strategy S-4-D:** For people of color—recognizing that racial disparities persist throughout our society and that cultural competence is an essential ingredient of quality care—develop cultural competency standards, provide ongoing cultural competency training to program staff countywide, and encourage the hiring and leadership development of people of color in both front-line and management positions.
-
- Strategy S-4-E:** For seniors, support and increase the ability of community-based organizations to provide culturally competent services and to assist consumers to access mainstream resources for seniors. As the general population ages, the number of seniors in this plan’s target populations will increase as well, making this a quickly growing segment of the population.
-
- Strategy S-4-F:** For veterans, ensure that they are receiving benefits for which they are eligible and that appropriate support and services, including employment programs, are available.
-
- Strategy S-4-G:** For families, increase the availability of related support services for all family members, and seek opportunities to link services with affordable housing for families. Services should include culturally appropriate affordable childcare, youth after-school recreation programs, family and mental health counseling, domestic violence support, health education, and parenting services, as well as access to GED and continuing education programs for parents.

-
- Strategy S-4-H:** In cases of domestic violence, reduce the likelihood that an abused partner—and her/his children—become homeless as a result of abuse.
-
- Strategy S-4-I:** For people who come into contact with Alameda County’s court systems, establish and expand working relationships with the adult and juvenile court systems in order to deal with homelessness, disabilities, and criminal justice issues appropriately and in a coordinated way. (*See program model on page 10.*)
-
- Strategy S-4-J:** For people who have been incarcerated, work with private-sector businesses to develop employment opportunities. Successful experiences with paying work can be an incentive to avoid re-incarceration, and having a steady source of income can help to prevent homelessness.
-
- Strategy S-4-K:** Create service-enriched housing/shelter opportunities that offer an age- and developmentally-appropriate setting that will attract and retain participation by out-of-home youth and young adults who are at risk of or experiencing homelessness.



**Take a look at....
Integrating housing and services**

Alameda County's Health, Housing, and Integrated Services Network (HHISN) Pathways Project

The Health, Housing, and Integrated Services Network (HHISN) Pathways Project in Alameda County has demonstrated the effectiveness of affordable, long-term supportive housing in reducing systems-level costs, while improving client outcomes for homeless individuals living with multiple diagnoses. HHISN links housing to flexible social and health services, including comprehensive primary health care, client-centered mental health and substance use treatment, independent living and personal health skills, and employment services.

A total of 494 permanent supportive housing units at seven sites in Oakland and Berkeley are linked to supportive services through HHISN. Multi-agency teams of public and private nonprofit organizations deliver integrated services to residents. Lifelong Medical Care and Bonita House provide primary health care and mental health and substance use treatment, while Resources for Community Development, Oakland Community Housing, Inc., and Mercy Housing provide housing units. Other HHISN partners have included the City of Berkeley Mental Health, East Bay Community Recovery Project, Catholic Charities of the East Bay, Building Opportunities for Self Sufficiency, Alameda County Health Care for the Homeless Program, and West Oakland Health Council. These partnerships facilitate residents' access to off-site services, as well as the referral of multiply diagnosed homeless service users into supportive housing.

An evaluation of outcomes for formerly homeless and multiply diagnosed individuals who moved into supportive housing units served by HHISN found that the service-enriched housing improved access to care and reduced total public costs by 15 percent. After placement in supportive housing, residents' use of services generally shifted toward less expensive service categories. Demand for day treatment decreased by 84 percent, and inpatient psychiatric hospital days fell 48 percent, from 60 to 31 days per year. These decreases were accompanied by increases in the use of ongoing and preventative care, as well as crisis intervention services, which more than doubled, and crisis residential days and psychiatric emergency services. Although psychiatric emergency services were comparatively expensive, the cost was more than offset by cost reductions from decreased inpatient and day treatment services.

The most dramatic reductions in service costs came among the top quadrant of previous users of behavioral health services, who, before moving into supportive housing, had been responsible for the vast majority of service costs. At the same time, service use increased among the bottom half of service users, suggesting that HHISN increased access to services for individuals with previously untreated mental health issues.

(Source: The Benefits of Supportive Housing: Changes in Residents' Use of Public Services, prepared by Harder + Company Community Research for the Corporation for Supportive Housing, February 2004.)

Goal (M): Measure Success and Report Outcomes

Mechanisms for measuring and analyzing outcomes are necessary in order to both identify successful strategies and target resources to best-practice models of prevention, housing, and supportive services. Outcomes should be meaningful, measurable, and realistically within the capacity of both providers and consumers to achieve. In addition, systems and programs should be regularly assessed through collecting and analyzing data that measures effectiveness and efficiency in achieving stated outcomes.

Because the homeless, behavioral health, HIV/AIDS, and social services systems are all in the process of upgrading or adding new functionality to their respective data collection and reporting systems, now is the time to coordinate data collection and reporting and address the many practical and ethical considerations—as well as legal restrictions—that govern how confidential information is captured, recorded, and shared. Cross-system coordination will need to be phased in over time.

Objective M-1: Coordinate collection of client data between systems.

- | | |
|------------------------|--|
| Strategy M-1-A: | Convene a working group representing data teams from medical and behavioral health care (including both mental health and substance use), social services, homeless agencies, and HIV/AIDS housing and service providers who will identify common data needs, goals, and requirements; create a work plan to establish common collection and reporting protocols; and develop the budget needed to fully achieve cross-system data collection and reporting compatibility. |
| Strategy M-1-B: | Upon formation of the Governing Board (outlined later in these Recommendations), this working group should become a subcommittee of the Inter-Agency Council. |
| Strategy M-1-C: | Ensure that the Sponsoring Agencies Group and later the Inter-Agency Council remain involved in data collection issues, since the types and quality of data collected determines the extent to which outcomes can be measured. |

Objective M-2: Track outcomes to measure program and system success, and develop a plan to publicize positive outcomes and target resources to support best practice models.

Strategy M-2-A: Identify meaningful and measurable outcomes to track, starting with but not limited to, the biennial homeless count mandated by HUD’s homeless programs. Community input should inform the data points to be measured. Outcomes should assess significant changes in people’s lives and well being, be reasonable within the systems’ influence, and be consistent across systems. Outcomes should also correlate with legislated mandates for outcomes. Common data collection elements for systems should focus on maintaining housing stability, improving quality of life, and increasing self-sufficiency.

Strategy M-2-B: Establish baseline data.

Strategy M-2-C: Report and analyze outcomes regularly and use data to update action plans. Ensure that each component of the system, as well as the system as a whole, is accountable for its outcomes.

Strategy M-2-D: Funding should be tied to a program’s performance. Outcomes will help demonstrate whether each program and each system is meeting the real needs of its consumers.

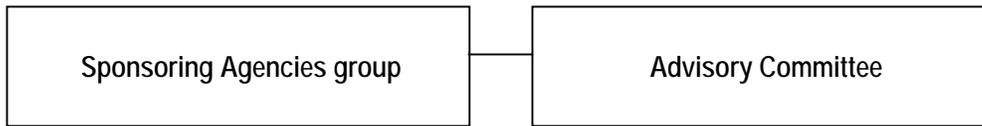
Strategy M-2-E: Develop a plan to communicate both specific positive outcomes and overall progress towards goals to stakeholders and the community at large, as well as to encourage understanding of—and participation in—efforts to prevent and end homelessness in Alameda County.

Goal (L): Develop Long-Term Leadership and Build Political Will

The recommendations outlined above represent a substantial shift from a focus on managing homelessness to a focus on ending it. Implementing these recommendations will require an unprecedented level of communication and collaboration between systems and jurisdictions. That communication and collaboration has begun with the development of this plan, but it can only continue and increase through the development of leadership that will guide and promote the plan's implementation for the next fifteen years. Making a break with "business as usual" requires skilled and dedicated leadership. Political will and community support are equally vital to realizing the plan's vision.

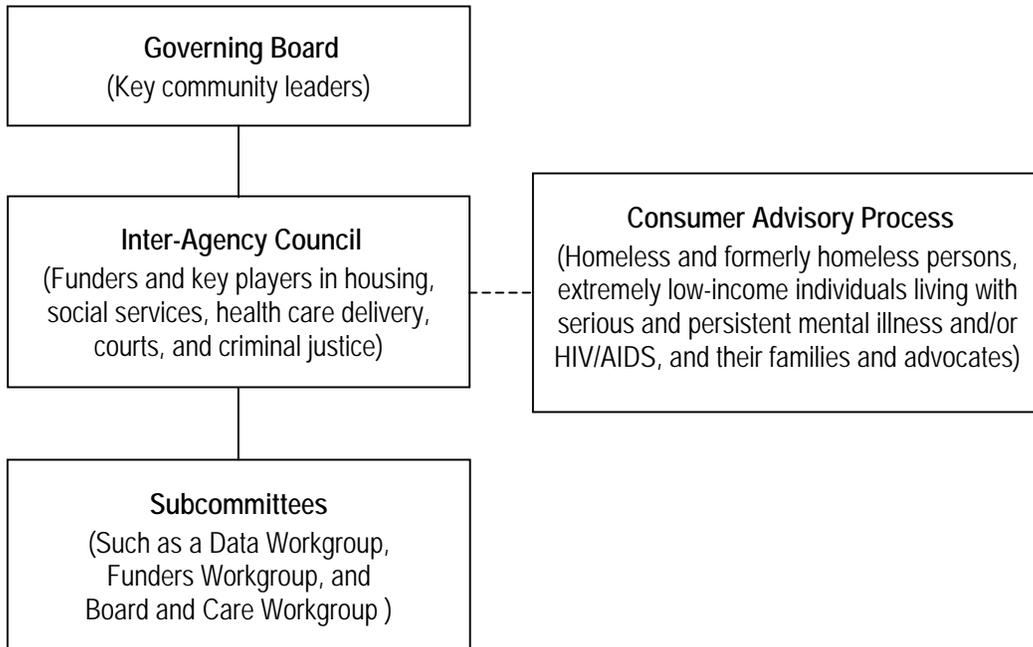
Objective L-1:	In consultation with civic, faith, and community leaders from throughout Alameda County, the Sponsoring Agencies will create an Interim Leadership Structure that can initiate plan implementation immediately through outreach and engagement with the many partners who are essential to the plan's ultimate success.
Strategy L-1-A:	The Sponsoring Agencies will initiate implementation activities by determining and securing the funding and staffing required for short-term leadership and plan implementation oversight activities, and by soliciting plan endorsements from all jurisdictions in the county.
Strategy L-1-B:	The Interim Leadership Structure will consist of the plan's Sponsoring Agencies group augmented by an Advisory Committee. The Sponsoring Agencies and Advisory Committee will meet together quarterly to help define and create the Governing Board for the plan's implementation, financing, and oversight.
Strategy L-1-C:	Advisory Committee members should include representatives from elected officials, the Courts, criminal justice agencies, health departments, Stakeholders Steering Committee, consumers and family members, public housing authorities, housing developers, schools, unions, and the faith and business communities.
Strategy L-1-D:	Ensure ongoing coordination among Sponsoring Agencies and policy-level participation from related agencies, by establishing management-level liaison positions at each agency. Liaisons will represent their agencies in the Interim Leadership Structure (precursor to the Inter-Agency Council) to initiate plan implementation and coordinate activities.
Strategy L-1-E:	The Sponsoring Agencies group and Advisory Committee will dissolve once a Governing Board is established. Their respective responsibilities will inform which, if any, leadership entity those members join for the future.

Interim Leadership Structure



<p>Objective L-2:</p>	<p>The Interim Leadership entity, consisting of the Sponsoring Agencies group and the Advisory Committee, will establish the Governing Board that is responsible for guiding and financing the plan’s implementation.</p>
<p>Strategy L-2-A:</p>	<p>Form a Governing Board comprised of key community leaders with representation from all regions and sectors of the county. The Governing Board will hold ultimate responsibility for the implementation of the plan’s recommendations in a direct, cost-effective, and problem-solving manner through guiding changes in policy, setting funding priorities, promoting systems change, and monitoring outcomes that assess progress towards achieving the plan’s goals. This Governing Board will likely include some members of the Sponsoring Agencies group as well as others representing, or recruited by, the Advisory Committee.</p>
<p>Strategy L-2-B:</p>	<p>Convene a countywide Inter-Agency Council that includes funders and key housing and service providers from the homeless, HIV/AIDS, and behavioral health systems, as well as the leadership of mainstream service systems (social services, youth, aging, courts, criminal justice, health care, public housing authorities, etc.) The Inter-Agency Council will support and advise the work of the Governing Board, identify major barriers to implementing plan recommendations, develop phased implementation plans, and incorporate the strategies of this plan into a revised service delivery system.</p>
<p>Strategy L-2-C:</p>	<p>Convene a Consumer Advisory process that ensures active participation by consumers and their advocates and families. Consumer participation must reflect the ethnic, age, and geographic diversity of Alameda County. Consumer Advisory participants will advise the Inter-Agency Council in program development and policy setting.</p>
<p>Strategy L-2-D:</p>	<p>Develop biennial action plans regularly, starting in the first year of plan implementation, and report on accomplishments.</p>

Long-Term Leadership Structure





Silicon Valley Leadership Group (Silicon Valley, CA)

In some communities, business leaders have become very involved with affordable housing and homelessness. One example is Columbus, Ohio, profiled elsewhere in this section. There, the Community Shelter Board, the community's lead organization for coordinating the response to homelessness, is guided by a board of trustees made up almost entirely of business leaders.

Another more local example is the Silicon Valley Leadership Group (SVLG). Formerly the Silicon Valley Manufacturers' Group, SVLG is a membership organization representing 190 Silicon Valley firms and supporting industries including software, systems, manufacturing, financial services, accounting, transportation, health care, defense, communications, education, and utilities. SVLG's mission is to involve member companies to work cooperatively on "major public policy issues affecting the economic health and quality of life in Silicon Valley."

SVLG has identified affordable housing as one of five core issues, with a focus on housing for the workforce. SVLG has helped raise money for the Santa Clara Housing Trust Fund, which includes funding specifically for homeless programs, and is working to establish a permanent funding source. SVLG is also supporting efforts to establish a Housing Trust Fund for San Mateo County and works continually on outreach and education related to affordable housing, including regular luncheons with public officials and the Silicon Valley Affordable Housing Week activities.

For more information about the Silicon Valley Leadership Group, visit www.svlg.net.

Objective L-3:	Build new relationships and partnerships by developing and implementing a communications plan to increase public awareness and endorsement of the Alameda Countywide Homeless and Special Needs Housing Plan.
Strategy L-3-A:	Engage elected officials, City and County agencies, business leaders, and civic, faith, and community groups to endorse the plan and participate in its implementation through outreach, advocacy, and regular updates. Once plan implementation has begun, continue outreach and education activities.
Strategy L-3-B:	Educate elected officials, City and County agencies, business leaders, and civic, faith, and community groups about extremely low-income Alameda County residents who have significant housing and support service needs as a result of experiencing, or being at risk of, homelessness and/or living with HIV/AIDS, chemical dependency, and mental illnesses, as well as about programs successfully serving these populations in Alameda County.
Strategy L-3-C:	Communicate how all Alameda County residents can play a role in ending homelessness and ensuring that appropriate housing and support services are available for all in the communities where they live. Invite people to participate in plan implementation, utilizing local and regional media. Once plan implementation has begun, continue outreach and education activities.

Outcomes

One of the primary tasks for the Sponsoring Agencies, their Advisory Committee, and other key community stakeholders is to define outcomes that are directly related to the year-by-year specific activities undertaken, according to the time lines they establish. This chapter outlines the three broad outcomes anticipated by 2020 as a result of implementing this plan's overarching recommendations.

These specific measurable outcomes are ambitious but achievable. Subsequent sections develop a detailed description of the target populations and their needs, quantify housing goals, and articulate cost projections and the next steps that will need to be taken to achieve these outcomes.

By 2020...

- 1. More than 15,000 individuals and families in Alameda County who have experienced homelessness or are extremely low-income and living with serious and persistent mental illness and/or HIV/AIDS in inappropriate or precarious housing situations will achieve long-term, appropriate housing situations.**

Year	Households Achieving Stability in Permanent Housing
2007	2,000
2009	4,000
2011	6,000
2013	8,000
2015	10,000
2017	12,500
2020	15,000

The housing targets established for this plan are ambitious, but achievable. Increasing by 5,000 units the stock of housing that is safe, decent, and affordable to people with extremely low incomes—and linking them to the services they need—is the single most important element in reducing and preventing homelessness. This increase will be supplemented by adding ten thousand housing subsidies for units throughout the county that are available in the rental market over the next fifteen years. It is impossible to provide all of the needed housing and support services overnight. Housing developments that are selected for funding will be ready for occupancy approximately four years later. The broad numeric targets for achieving housing stability are shown in the table above. These housing goals are described in further detail—showing the housing type, unit configuration, associated support services, and quantified for each of the plan’s target populations in the following two chapters entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* and *Housing Goals and Cost Estimates*.

Additional measures of progress and achievement towards housing goals might include:

- Annual reductions in the number of people found on the street year-to-year
- Annual increases in the number of long-term homeless and other plan target populations who have moved into permanent, affordable housing

- Increased rate of securing housing following discharge/release from a jail or other institution
 - Reductions in the number of school-age children who change schools or drop out as a result of unstable housing or homelessness
- 2. People experiencing a crisis or in need of basic medical, behavioral health and/or social services are able to access user-friendly and up-to-date information and obtain assessment services through any provider of such services in the county.**

Breaking through the barriers that have historically segmented service delivery is the primary service-related change initiated by this plan. To the extent possible, service systems will develop and utilize consistent definitions of the populations targeted in this plan, and at a minimum clearly articulate eligibility criteria for services in each system. Through establishing consistent quality of care standards, implementing approaches that treat the whole person, and developing joint funding mechanisms, mainstream and specialized housing, income support, and human service systems will offer the appropriate level of assistance to extremely low-income households in need wherever they live, throughout the county.

Measures of progress and achievement might include:

- Reductions in the length of stay for families and individuals living in shelters
- Reductions in the number of teens leaving foster care who end up homeless
- Reductions in days someone is homeless
- Decreased lag time in receiving financial and/or medical benefits upon release from jail
- Reductions in the number of people in need of emergency health, mental health, and shelter services
- Increases in the number of TANF recipients linked to housing assistance

- 3. People throughout Alameda County, including elected officials, community leaders, and the general public demonstrate, through their charitable contributions, volunteer service, funding decisions, and state and federal advocacy, an accurate understanding of how to prevent homelessness and a solid commitment to remedy the complex social and health issues faced by extremely low-income people living with HIV/AIDS, serious and persistent mental illness, chemical dependency, and other disabling conditions.**

Measures of progress and achievement regarding improved system performance and community commitment might include:

- Increases in the number and type of formal interagency/inter-jurisdictional agreements
- Degree of blended funding and increases in the number of joint activities between and among providers
- Extent to which staff from participating agencies are trained in each other's disciplines
- Degree to which program planning and development incorporates the participation of key community stakeholders, including consumers
- Increases in the number of volunteer hours dedicated to ending and preventing homelessness through faith- and community-based agencies across the county

Local and National Context for Planning

The *Alameda Countywide Homeless and Special Needs Housing Plan* takes the unprecedented approach of combining housing planning efforts for three distinct and overlapping populations: individuals and families who are homeless, living with HIV/AIDS, and/or mentally ill. Substance use issues affect a substantial portion of each of these three populations, and play a significant role in the provision of housing and services. Substance use issues are addressed in the context of each of three primary populations. Similarly, physical disabilities are addressed with each population.

This planning process drew on previous local and national initiatives to address the housing and services needs of these populations. This chapter provides the context for this plan. (Please refer to *Companion Materials, 6. Local and National Context for Planning: Expanded Version* for an expanded version of this chapter, which includes more detail and local history.)

Origins of the Countywide Homeless and Special Needs Housing Plan

In 2004, agencies representing the homeless services, mental health, and HIV/AIDS services systems in Alameda County came together in 2004 to develop a plan to address housing and related services needs of their respective target populations. These populations frequently face the same issues and are often the same households. Although each system had previously developed housing plans, undertaking a plan of this scope is unprecedented, both in Alameda County and nationally.

The Sponsoring Agencies¹ recognize both the similarities between the population(s) served by each system and the similarities between the activities of each system. The Sponsoring Agencies also recognize that substance abuse and the availability of alcohol detoxification, ongoing treatment, and related housing are major factors for each of the three systems. This plan builds on previous successful multi-system programs nationally, as well as locally. Local examples of collaboration include the Health, Housing, and Integrated Services Network (HHISN) providing supportive housing and the City of Berkeley's AB 2034 program for people who are homeless and mentally ill.

Each system has existing plans that formed the basis for this process. For example, a previous comprehensive homelessness system plan, called the *Alameda Countywide Homeless Continuum of Care Plan*, was completed in April 1997. This award-winning plan has guided activities in Alameda County since then. By 2004, the Continuum of Care (CoC) Council was ready to develop a ten-year strategic plan to end homelessness. Alameda County Behavioral Health Care Services (BHCS) has been increasingly attentive to the issue of housing since the completion of the *Front Door Report* in 2000. The HIV/AIDS system has an ongoing planning function in the form of the Ryan White Planning Council. Meanwhile, the last HIV/AIDS housing plan for guiding HOPWA was a 1998 update to the 1996 *Alameda County Multi-Year HIV/AIDS Housing Plan*, which was due to be updated.

¹The Sponsoring Agencies for the *Alameda Countywide Homeless and Special Needs Housing Plan* include Alameda County Behavioral Health Care Services, Alameda County Housing and Community Development Department, Alameda County Public Health Department Office of AIDS Administration, Alameda County Social Services Agency, Alameda Countywide Homeless Continuum of Care Council, City of Berkeley Health and Human Services Department, City of Berkeley Housing Department, City of Oakland Community and Economic Development Agency, and City of Oakland Department of Human Services.

Context for Preventing and Ending Homelessness

Alameda County's Homeless Housing and Service System Today

Alameda County's homeless housing and services activities are coordinated primarily through the Alameda Countywide Homeless Continuum of Care Council (Council). The Council has a number of initiatives:

- Coordinate strategic planning and priority setting for the homeless system.
- Prepare the annual Continuum of Care application to the U.S. Department of Housing and Urban Development (HUD) by bringing together proposals from throughout the county. In 2004, Alameda County organizations received approximately \$22 million in federal McKinney-Vento funding for homeless programs in response to the application submitted.
- Identify and document the county's homeless populations and their related housing and service needs. In 2004, the Council released the *Alameda Countywide Shelter and Services Survey*.
- Implement a Homeless Management Information Strategies data system (HMIS), as required by HUD for McKinney-Vento programs. Generally, HMIS is intended to collect and report information about the homeless population and its patterns of service utilization.

The Council has convened year-round since 1997 to facilitate the coordination of homeless services countywide. The Council is comprised of 45 designated and elected seats, including seats for each local government, consumers, service providers, funders, housing developers, and representatives of the faith community, labor, business, and education. Two co-chairs (one jurisdictional and one community-based organization) jointly lead the Council. The Alameda County Housing and Community Development Department (HCD) acts as fiscal agent for the Council and provides office space and other in-kind support to the Council. This reflects the historical relationship that HCD has had with related programs. The Council's activities are funded by a mixture of funding from the County, every city in Alameda County, foundation funding, and some support from HUD.²

If a community-based organization decides to pursue funding through Alameda County's Continuum of Care, it can submit a proposal once annually, during the Continuum of Care application process administered nationally by HUD. All proposals in the county are brought together, ranked according to established criteria, and the top ranked proposals are combined into a single submittal to HUD from the Council.

An important role of the Council and a major goal of the 1997 *Alameda Countywide Homeless Continuum of Care Plan* is to coordinate housing and support services. Coordination between providers had always been an interest in Alameda County, but collaboration was generally on an ad hoc basis prior to the *1997 Continuum of Care Plan*.

²Alameda Countywide Homeless Continuum of Care Council, 2004 Continuum of Care application, Exhibit 1: Application Summary.

Recent Changes in the Response to Homelessness

A decade after the introduction of the Continuum of Care policy, Alameda County faces a reality common to nearly every community in the nation. That is, despite the infusion of targeted homeless assistance funding over the past ten years and the establishment of a plethora of new housing and service programs, the high cost of housing, static or decreasing state and federal resources, local resistance to siting of housing and service facilities, as well as changing political support severely impact the County's ability to stem the tide of growing numbers of homeless persons and assist them to find permanent housing. In addition, a strong overlay of other issues, including domestic violence, substance use, and involvement in the criminal justice system continues to contribute to homelessness.

Communities and policy makers across the nation are looking at new approaches for addressing homelessness. These approaches include:

- **Permanent supportive housing, Housing First, and “evidence-based models.”** Providers and communities are increasingly creating permanent supportive housing for people who have been homeless and have disabilities, rather than more emergency shelter and transitional housing. Many are moving toward a “Housing First” model, which is an approach that takes people directly from homelessness into permanent housing with services, without waiting for them to become “housing ready.” It is based on the idea that people can utilize services more effectively and successfully when stably housed. Across the country, programs are documenting successful outcomes, even with populations such as chronically homeless adults and active substance users.
- **Long-range planning.** In 2003, President Bush and the Interagency Council on Homelessness announced a ten-year goal of ending chronic homelessness, and many communities have embarked on the development of **ten-year plans** to create long term strategies for integrating systems of care, growing resources, and engaging mainstream programs. In support of this planning focus, HUD now requires all jurisdictions with McKinney-Vento funding to have a homeless management information strategies (**HMIS**) system.
- **Systems integration.** More communities are working towards integrating housing and service delivery systems to address the complexities of homelessness by reconfiguring the management and policies of the often-disconnected health, human service, and housing delivery systems.

These issues helped the Continuum of Care Council to determine that Alameda County's ten-year plan to end homelessness, while including all the elements recommended by HUD, would take a different approach that would work better in Alameda County. Specifically, community-based organizations and local government staff wanted to ensure that the ten-year plan would include both the population HUD defines as chronically homeless, adults with disabilities who have been homeless frequently or for a long period, as well as single people without disabilities and families who have been homeless for a long time.

Context for Behavioral Health Care and Housing

Alameda County's Behavioral Health Care System Today

California state law delegates responsibility for mental health service provision to counties. Alameda County is one of two exceptions in the state in which city-based public mental health programs are also statutorily authorized and funded. In Alameda County, the primary agency responsible for mental health services is Alameda County Behavioral Health Care Services, (BHCS), a department of the Alameda County Health Care Services Agency. In Berkeley, the Mental Health Division of the Health and Human Services Department provides public mental health services to residents of the cities of Berkeley and Albany and coordinates these services with the larger county system.

BHCS is mandated to provide psychiatric crisis or emergency care, inpatient care, outpatient/day care, case management, conservatorship, administration, and evaluation. Some services are provided directly by the BHCS, while others are provided by community-based organizations under contract with BHCS. State legislation also establishes standards for staffing, quality assurance, reporting and other general practices. Alameda County has used discretionary funding to develop additional programs, such as housing support services and community-based organization stabilization.³

The City of Berkeley is one of two city-based public mental health jurisdictions in California. Berkeley Mental Health (BMH) provides a broad range of mental health and support services and consumers receive acute inpatient, conservatorship, long-term care and some additional services from Alameda County.

Consumers enter the BHCS system through a single screening point, a toll-free telephone referral point called Acute Crisis Care and Evaluation for System-wide Services (ACCESS). When consumers call ACCESS, they are screened for eligibility and may be referred to a community-based organization. Berkeley and Albany residents may also access services directly through Berkeley Mental Health, where they are screened for service eligibility and admitted or appropriately referred in coordination with the Alameda County ACCESS program.

BHCS is also responsible for substance use treatment services in the county, although the two branches of the agency that address mental health and substance use are distinct. Most substance use treatment services are provided by community-based organizations under contract with BHCS. In FY 2003-2004, BHCS had contracts with 39 community-based organizations for a total of nearly \$28 million for alcohol and other drug programs.⁴

In FY 2004-2005, BHCS was responsible for a budget of more than \$220 million and for more than 450 FTE employees combined for both mental health and substance use programs.⁵ In 2004, BHCS allocated about \$11 million to housing programs, including approximately \$5 million in various

³ Alameda County Behavioral Health Care Services website. Available online: www.co.alameda.ca.us/health/behavior/behav.htm (Accessed: April 29, 2005).

⁴ Alameda County, FY 2004-2005 Final Amended Budget, pp. 533-535. Available online: www.co.alameda.ca.us/budget/budget_2005_final_amended.pdf (Accessed: May 12, 2005).

⁵ Alameda County, FY 2004-2005 Final Amended Budget. Available online: www.co.alameda.ca.us/budget/budget_2005_final_amended.pdf (Accessed: May 12, 2005).

mental health housing programs and approximately \$6 million in 16 residential alcohol and other drug programs.

BMH has an annual budget of \$7.2 million with 65 FTE employees. This includes a \$1.1 million program to provide integrated services to the homeless mentally ill (AB 2034) of which a significant portion is allocated to direct housing subsidies. BMH currently provides supportive services to consumers in more than 80 units of dedicated housing, many of which leverage HUD's Section 8, Shelter Plus Care and SHP programs. This includes both AB 2034 and state-funded services.

Recent Changes in the Response to Mental Health Housing and Services

The mental health system is in the midst of a transformation influenced by major changes at the federal and state levels. Important recent factors include:

- The **Mental Health Services Act** (MHSA, or Proposition 63), a landmark legislative initiative passed by California voters in November 2004, providing an ongoing source of funding for mental health programs and proposing a reorientation of the mental health system. BHCS and BMH are in the midst of implementing the MHSA, bringing together traditional and new partners to rethink housing and services for people with mental illness in Alameda County. An initial implementation plan, which drew on recommendations in this plan, was drafted in 2005.
- **Assembly Bill (AB) 2034**, California legislation that supported housing and service programs for mentally ill people homeless or at risk of homelessness or incarceration, demonstrated success with the populations, and set a precedent for the MHSA. BMH operates an AB 2034 program that has engaged over 150 seriously mentally ill homeless adults previously unable or unwilling to receive public mental health services. More than 70 percent have become housed, with dramatically reduced rates of hospitalization and incarceration. The vast majority of these clients were also approved for SSI and Medi-Cal benefits as a result of the 2034 services. Many were previously too disabled to navigate the eligibility and application process; for most, this is their first experience of receiving and benefiting from voluntary mental health services.⁶
- The **Olmstead decision**, a U.S. Supreme Court case which found that states may be violating the Americans with Disabilities Act (ADA) if they provided care to people with disabilities in institutional settings when they could be appropriately served in a community-based setting.
- The **President's New Freedom Commission on Mental Health**, which envisions a transformation in the mental health care system to focus on consumer- and family-centered care, and a shift to emphasize a recovery of symptoms, and addresses the importance of housing.

Alameda County also has a major initiative to create cost-effective, comprehensive, and coordinated health care delivery for people who are among the most frequent users of health care services, originally called the **Frequent Users of Health Services Initiative**.⁷ The Alameda County Access

⁶ Berkeley Mental Health, e-mail communication with AIDS Housing of Washington staff, June 3, 2005.

⁷ Corporation for Supportive Housing, Press release: The Alameda County Access to Care Collaborative Receives Grant to Reduce Health Care Costs and Use of Emergency Medical Services. Available online: www.csh.org/index.cfm?fuseaction=Page.viewPage&pageID=3482 (Accessed: January 10, 2005). Funded by the California Endowment and the California Health Care Foundation, working in collaboration with the Corporation for Supportive Housing, the initiative features the collaboration (Alameda County Access to Care Collaborative) of many organizations in Alameda County, including: Alameda Health Consortium, Homeless Action Center, LifeLong Medical Care, Alameda County Medical Center, Alameda County Health Care Services Agency, Alameda County Social Services Agency, Alameda County Community

to Care Collaborative received a \$900,000 grant to address avoidable or unnecessary emergency room utilization at Alameda County Medical Center’s Highland Hospital Campus in Oakland during a three-year period.⁸

In March 2004, Alameda County voters approved **Measure A**, which adds a half-cent sales tax to maintain emergency and trauma medical services throughout the county and to provide primary, preventative and mental health services to indigent, low-income, and uninsured children, families and seniors. The Board of Supervisors is allocating a portion of the funds (up to twenty-five percent) throughout the county to hospitals, clinics, and community-based organizations to pay for medical, mental health, substance abuse services and uncompensated emergency care.

Context for HIV/AIDS Housing and Services

Alameda County’s HIV/AIDS Housing and Service System Today

The HIV/AIDS services system has an ongoing planning function in the form of the Collaborative Community Planning Council (CCPC). The HIV/AIDS housing system last formulated a comprehensive HIV/AIDS housing plan in 1996 with the *Alameda County Multi-Year HIV/AIDS Housing Plan*, and completed an update to that plan in 1998. As a part of the successful implementation of that plan, Alameda County developed two new programs, Project Independence and the AIDS Housing Information Project, and received a “Best Practice” award from HUD.

Alameda County’s current HIV/AIDS housing and service system is supported primarily by two federal programs: HUD’s Housing Opportunities for Persons with AIDS (HOPWA) program and the Ryan White CARE Act, a program of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).

Alameda County is a part of the Oakland metropolitan area, which has received a HOPWA grant annually since 1992. HOPWA funds are awarded to the largest city in a metropolitan area to administer for the region; in this case, funds go to the City of Oakland, and the City of Oakland has contracted with Alameda County’s Housing and Community Development Department (HCD) to administer funds in Alameda County. HCD has used these HOPWA funds for the development of emergency, transitional, and permanent housing, as well as related support services, following the recommendations and strategies of the *HIV/AIDS Housing Plan*.

In 2004, Alameda County received \$1.8 million in HOPWA funding. Project sponsors annually apply to Alameda County HCD for HOPWA funds through a competitive RFP process. Alameda County has an additional HOPWA grant that supports Project Independence, which provides partial rent subsidies, support service coordination, and accessibility improvements to people living with HIV/AIDS who are at risk of homelessness.

Development Agency, City of Oakland Human Services Department and Oakland Police Department, Alameda County Sheriff’s Office, and Alameda County Behavioral Health Care Services.

⁸ Ibid. In 2002–2003, the most common diagnoses for this population were alcohol-related mental illness, cellulitis related to injection drug use, pain, chronic illnesses (such as diabetes, epilepsy, asthma), and injuries. Two-thirds of these patients received treatment in the Emergency Department (ED) for a psychiatric or drug/alcohol-related illness. Over a three-year period, 84 percent had been admitted for inpatient care, 33 percent had used the psychiatric emergency department, and 20 percent had been admitted for inpatient psychiatric services.

The Ryan White CARE Act represents the largest dollar investment made by the federal government specifically for the provision of services for people living with HIV/AIDS. The CARE Act is intended to help communities and states increase the availability of primary health care and support services, in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic.

Federal guidelines require that the use of CARE Act Title I funds locally be guided by a Ryan White planning council comprised of consumers, providers, and advocates. CARE Act programs are required to complete regular needs assessments to determine the current needs of the community, and the planning council must set priorities and allocate resources based on the needs assessment and Ryan White guidelines.⁹ In Alameda County, the Collaborative Community Planning Council (CCPC)¹⁰ is the body that determines priorities and allocations for CARE Act Title I, and the Alameda County Public Health Department Office of AIDS Administration (OAA) supports the Oakland EMA HIV Services Planning Council (HSPC) and administers the funding. In program year **2004-2005, Alameda County received \$6.6 million in Ryan White Title I funds.**

Recent Changes in the Response to HIV/AIDS Housing and Services

Several changes at the national level influence the current context for HIV/AIDS housing and services in Alameda County. These include:

- **Changes in Uses of Ryan White and HOPWA.** In 1999, HRSA clarified that Ryan White funds could be used for housing referral services, and short-term or emergency housing that is necessary to gaining access to medical care, but not permanent rental or ownership housing. HOPWA funds may be used for a range of housing activities, but HUD has indicated that the use of HOPWA for services should be limited to 35 percent of the total grant amount.
- **Integration of Planning Efforts.** In recognition of the similarity in issues and programs between various federal programs, including HOPWA, Consolidated Plans, Continuum of Care, and Ryan White, HUD has placed a renewed emphasis on integrating local planning efforts.

The 1996 *Alameda County Multi-Year HIV/AIDS Housing Plan* was a success in terms of reorienting and increasing AIDS housing resources. However, some of the systems change that it contemplated for cross-departmental cooperation between related branches of local government has not yet been achieved, especially the coordination of housing resources. Housing funding continues to be handled separately in both OAA and HCD, though progress has been made in sharing information and developing common monitoring protocols.

In addition, the HIV/AIDS housing and service system in Alameda County, like other communities in the country, faces a growing population with stable or declining resources. Since the introduction of anti-retroviral medications in 1996, people living with HIV/AIDS are leading longer and healthier lives. As new infections continue, though, lengthening life spans mean there are greater numbers of people living with HIV/AIDS than ever before. Other complicating factors affecting people living with HIV/AIDS locally as well as nationally include the co-occurrence of

⁹ HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), *Ryan White CARE Act Needs Assessment Guide*, p. I-16, Fall 1999. Funded by HRSA HIV/AIDS Bureau with John Snow, Inc. and assistance provided by MOSAICA under contract #240-96-0037.

¹⁰ CCPC is a new name starting in 2005. The CCPC combined the Health Services Planning Council, which had addressed service categories including housing, with the HIV Prevention Planning Council.

homelessness, mental illness and/or substance use issues, and involvement with the criminal justice system.

African Americans in particular continue to be disproportionately affected by the HIV/AIDS epidemic nationwide, as well as in Alameda County. The prevalence of HIV/AIDS among African Americans is exacerbated by disparities in access to health care and health outcomes. In 1998, the Alameda County Board of Supervisors unanimously passed a resolution declaring a State of Emergency due to the prevalence of HIV/AIDS in its African American community. It was the first time a local government in the United States has declared a regional disaster due to HIV.

Overarching Issues Facing Plan's Populations in Alameda County in 2005–06

In meetings related to the plan, consumers, providers, and government representatives consistently raised similar overarching issues facing the plan's populations. Many of these issues had been identified by the sponsors previously, and were part of the motivation to start the plan. The main issues are as follows:

1. **Costs and availability of housing.** Existing market rate housing is not affordable for people with low incomes, especially people with disability incomes (SSI), which is just \$812 per month in 2005. Although vacancy rates have increased in the past few years, apartments renting at the lowest price ranges are still too expensive for many people with extremely low incomes. Even in a softer housing market, many people in the three target populations are screened out by landlords due to bad credit and histories of incarceration.
2. **Amount of dedicated housing.** There is not nearly as much housing dedicated to serving people who are homeless, mentally ill, and/or living with HIV/AIDS as there are people in need. Waiting lists are very long and often closed.
3. **Prevalence of substance use.** At least a third of each population has active substance use. There are few housing and service programs working with active substance users, and no detox facility in Alameda County.
4. **Information about existing programs.** Despite some centralized resources, information often seems inconsistent, unavailable, and/or overwhelming for consumers and service providers.
5. **Complex eligibility requirements.** Even basic assistance usually has many eligibility requirements. Eligibility criteria are set at the federal, state, and local levels and when combined, can seem complicated and mutually exclusive.
6. **Limited collaboration and communication between systems.** Providers in different systems may not be collaborating, even when working with the same issue or consumer population. Providers often have difficulties getting consistently updated information about the resources in other systems. Eligibility criteria of other systems are not always clear, often because they require technical knowledge of another issue area.
7. **Institutional discharge.** Exiting hospitalization, jail or prison, and foster care leads to homelessness for many. There are few options for people at discharge. Having a criminal history affects a person's eligibility for housing and services for years.
8. **Distribution of help.** Although Oakland and Berkeley are home to the majority of the county's homeless population, homelessness, HIV/AIDS, and mental illness occur all over the county. However, housing and services are not available proportionately throughout jurisdictions, with residents of South and East County often needing to travel greater distances to access assistance.

9. **Tightening public sector budgets.** Due to budget problems at the local, state, and federal government levels, systems and providers are struggling to maintain what they have. They face additional difficult cuts.
10. **Inconsistent political and popular support.** Although many people are involved with trying to end homelessness and assist people who are homeless, living with a mental illness, and/or living with HIV/AIDS, these issues do not have as much political and popular support as will be needed to take care of them.

Context for Implementation of the Plan's Recommendations

Each system has evolved over time in response to the issues, regulations, and resources available to address its primary issue. The distinction between systems manifested themselves in this planning process, starting with estimating the populations involved and the resources available to them. In trying to answer the question “who is homeless?”, the Sponsoring Agencies found that each system tracks housing and homeless status differently. The homeless services system actually maintains two different homeless definitions: “chronic” homelessness among single adults has been defined very specifically by HUD, which requires jurisdictions receiving federal homeless funding to complete a count every two years, and more broadly, “community-defined” homelessness. The HIV/AIDS and behavioral health systems, on the other hand, usually only record this information once—at the first service contact of the year, or if it comes up as a service-related issue during the year—and base it on a working, rather than technical, definition of homelessness. Therefore information between the systems is neither directly comparable nor uniformly available.

These differences extend to housing and services activities as well. For example, in the HIV/AIDS system, HOPWA funds “transitional housing,” based on a definition established by HUD’s Office of HIV/AIDS Housing, while the Ryan White program funds “short-term housing” using the definition established by the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA). While these housing programs are similar in intent and function—and in many cases HOPWA and Ryan White fund the same providers—they are not the same. As a result, even within a single system, programs are using different concepts, names, and regulations for similar activities. This is just one among many gaps and inconsistencies between systems that confuse consumers and make systemic collaboration the exception, at this point, rather than the rule.

The plan’s sponsors recognized that even after nearly two decades of interagency coordination and proactive planning, housing and services in Alameda County for the plan’s populations are still largely fragmented. Although many jurisdictions and their local provider organizations routinely communicate and collaborate effectively, each jurisdiction in Alameda County sets its own priorities, establishes its own policies, and makes independent funding decisions. In addition, although most joint planning efforts have been programmatic collaborations, each system and its individual provider organizations have different eligibility criteria, points of entry, and waiting list policies. As a result, from the perspective of consumers, there appears to be no “system,” but rather an array of potential services that individuals must get into largely on their own and which are usually full. Addressing these service system gaps and barriers was a primary motivation in developing the *Alameda Countywide Homeless and Special Needs Housing Plan*.

Factors shaping the context for implementation include:

- **Increasing need and decreasing resources.** As the population increases and the gaps between incomes and housing costs in Alameda County increase, the amount of funding at the local, state, and federal levels available for related issues is for the most part stagnant or decreasing. The Mental Health Services Act represents one significant new source of new funding, but itself has been offset by reductions in mental health services funding in previous years.
- **Long-range planning in a short-term environment.** This is a ten-year plan for ending homelessness, but many types of funding are only available one-year at a time and may be subject to sudden changes. Elected officials are often oriented toward their term in office. The three- to five- years required to develop affordable housing and the required long-term periods of affordability of up to 59 years are at odds with the shorter timelines of service commitments.
- **Ensuring long-term leadership for implementation.** Implementing the changes identified in this plan will require consistent long-term leadership and working with many people who represent the diversity of Alameda County, including all jurisdictions and all sectors—for many years to come.
- **Regional solutions required.** Homelessness and permanent housing for people with disabilities are regional issues that cannot be solved by one jurisdiction, program, system, or funding source. What happens in one city or county affects other cities and counties, yet local government is not structured to approach issues regionally.
- **Creating new funding mechanisms.** Existing resources may be re-deployed in the implementation of this plan, and creative combinations of existing funding should yield greater impacts. However, making significant changes will require securing new resources and making long-term investments in the strategies and solutions outlined in this plan.

Housing in Alameda County

The high cost of housing in Alameda County combined with the extremely low incomes of many people with disabilities leaves many people vulnerable to homelessness and housing instability. Alameda County has affordable and supportive housing resources for the plan's populations, but unmet needs for housing and services still exist. This chapter presents background information about market-rate and subsidized housing in Alameda County. (Please refer to *Companion Materials, 7. Housing in Alameda County: Expanded Version* for a more comprehensive overview of information related to this chapter.)

Please see the chapter entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* for a detailed estimate of the amount and types of housing needed for the plan's three target populations.

Income and Poverty in Alameda County

Many people with disabilities depend on Supplemental Security Income (SSI) as their sole source of income. Although SSI is a crucial source of support, people with SSI have extremely low incomes; this impacts their ability to provide for their basic needs without additional assistance.

The median family income established by HUD in 2005 for a four-person household in Alameda County was \$82,000, which is 40 percent more than the national median income of \$58,000.¹¹ In comparison, in 2005 SSI pays a maximum of \$812 per month to a disabled single person under 65 living independently in California.¹² This is equivalent to just \$9,744 per year, or 17 percent of Alameda County's median income for an individual. SSI payments leave recipients near poverty level, which was \$9,570 per year in 2005.¹³ In 2002, the most recent year for which data is available, 10 percent of Alameda County's residents were living in poverty.¹⁴

The federal poverty level was developed in the 1960s and has been adjusted only for inflation since then. The poverty standard implies a two-parent family with a stay-at-home mom, which does not reflect the reality of many of today's families, and does not vary based on a family's location. A more realistic standard called the "Self-Sufficiency Standard," which takes the costs of childcare, housing, transportation, and health care into account, is being used in 35 states.¹⁵

¹¹ U.S. Department of Housing and Urban Development, "Estimated Median Family Incomes for Fiscal Year 2005," February 11, 2005. Available online: www.huduser.org/datasets/il/il05/ (Accessed: March 28, 2005).

¹² Social Security Administration, "Supplemental Security Income (SSI) in California," January 2005. Available online: www.ssa.gov/pubs/11125.html#pay (Accessed: March 28, 2005).

¹³ U.S. Department of Health and Human Services, "The 2005 HHS Poverty Guidelines." Available online: aspe.hhs.gov/poverty/05poverty.shtml (Accessed: May 12, 2005)

¹⁴ U.S. Census Bureau, "Small Area Income & Poverty Estimates, Estimates for California Counties: 2002." Available online: www.census.gov/hhes/www/saiep/county.html (Accessed: March 28, 2005).

¹⁵ United Way of the Bay Area, *The Bottom Line: Setting the Real Standard for Bay Area Working Families, 2004*. A collaborative project of the United Way of the Bay Area, Center for Women's Welfare at the University of Washington, the National Economic Development and Law Center, and Wider Opportunities for Women. Available online: www.uwba.org/uw_impact/Fact_Sheets/BottomLine_final.pdf (Accessed: February 2, 2005).

In 2004, the Self-Sufficiency Standard for Alameda County was calculated as:

- \$23,240 annually for a single adult
- \$50,907 annually for an adult with a preschooler and a school-age child
- \$59,328 for two adults with an infant and school-age child¹⁶

Thus, a single disabled person surviving on SSI earns only 41 percent of Alameda County's Self-Sufficiency Standard income, and as described in the next section, this is only 86 percent of the average "fair market rent" for a studio apartment.

Housing Market in Alameda County

The Bay Area is widely acknowledged to have a serious housing affordability problem. One commonly cited issue behind the lack of affordability is the jobs and housing imbalance; according to the Association of Bay Area Governments (ABAG), between 1990 and 2000 the Bay Area added 500,000 jobs but only 200,000 units of housing.¹⁷ Although the area has lost many jobs in the economic downturn since then, the jobs-housing imbalance persists. The housing affordability crisis is so acute that it affects households in almost every income range to some extent; however, the households in the lowest income ranges are both the most impacted and the least able to compete in this housing market.

Alameda County has one of the highest-cost housing markets in the country. This can be measured in many ways:

- 43 percent of the 518,471 households in Alameda County are renter households, and 48 percent of all renter households had a housing cost burden in 2003, up from 47 percent in 2002 (meaning that they paid more than 30 percent of their gross income for rent and utilities).¹⁸
- The rent affordable to a household earning the median renter's income of \$41,864 was \$1,042 per month, \$63 lower than the median rent of \$1,105.¹⁹
- Alameda County is in the top 10 least affordable housing markets in the country.²⁰
- A person earning minimum wage would need to work 126 hours (more than 3 full-time jobs) every week in order to afford a modest two-bedroom apartment.²¹
- If a single disabled adult spent their entire monthly SSI income in 2005 on housing, it still would not be enough to afford a studio apartment renting at Fair Market Rent; SSI is \$812, while the FMR for a studio is \$945.

¹⁶ Ibid.

¹⁷ Association of Bay Area Governments, *The Regional Housing Needs Determination for the San Francisco Bay Area: 2001-2006 Housing Cycle*, p. 13. Available online: www.abag.ca.gov/planning/housingneeds/pdf/RHND_Plan/RHND_Plan-Chapter_1C.pdf (Accessed: July 21, 2004).

¹⁸ National Low Income Housing Coalition, *Up Against A Wall: Housing Affordability for Renters, An Analysis of the 2003 American Community Survey, November 2004*. Available online: www.nlihc.org/pubs/uaw04/UpAgainstAWall.pdf (Accessed: March 28, 2005).

¹⁹ Ibid.

²⁰ National Low Income Housing Coalition, *Out of Reach 2004, California*, Available online: www.nlihc.org/oor2004/data.php?getstate=on&getcounty=on&county%5B%5D=185&state%5B%5D=CA (Accessed: January 27, 2005).

²¹ Ibid.

Affordable Housing in Alameda County

Many local and regional organizations develop affordable housing in Alameda County; in 2005, there are nearly 20,000 units of subsidized housing. Public housing authorities own and operate about 20 percent of these units, while nonprofit and private organizations own and operate the rest.

Although these units are a vital resource for low-income individuals and families, many of them are still not affordable to people who are homeless, mentally ill, or living with HIV/AIDS. Rents for affordable housing developed by nonprofits are typically set with a formula to be affordable to renters at certain income levels. Nonprofit housing is usually affordable to people earning 30 to 60 percent of median. Although new developments include more units affordable at or below 30 percent of median, the majority of existing housing is affordable at 50 percent to 65 percent of the median income. Because the monthly cost of operating housing typically costs more per unit per month than an extremely low-income person can afford to pay, and there are few subsidies that can make up the difference, most nonprofits are unable to set rents that are affordable to people earning lower incomes. All types of affordable housing in the county are difficult to access because waiting lists tend to be very long, up to several years, because more people need and qualify for housing than there are units available.

In contrast, public housing authorities can provide housing to extremely low-income people through the public housing and Section 8 programs, in which tenants pay rent based on their income. This housing is much more affordable for people with very low incomes, including people with disability income. The six housing authorities in Alameda County administer a combined total of nearly 21,000 Section 8 vouchers and 3,700 units of public housing.²² Because of the great need for the types of assistance that housing authorities provide, they typically have very low vacancy rates and lengthy, or closed, waiting lists. Recent changes in the regulations that guide public housing authorities and current budget priorities at the national level are encouraging housing authorities to link work requirements to housing assistance and seek increased revenue through serving households with higher income levels. Both of these directions will make it difficult for this plan's target populations to access this housing unless the housing authorities take specific actions to establish local priorities.

Housing Dedicated for the Plan's Three Primary Populations

Alameda County contains emergency, transitional, and permanent housing for people who are homeless, living with HIV/AIDS, and/or mentally ill. Unlike affordable housing in general, housing that is dedicated to one of these populations typically connects with services. The service connection may range from a service coordinator, who can make referrals to services off-site, up to more intensive on-site services.

One particular type of housing that is particularly important to the mental health system is Board and Care homes, or Adult Residential Care Facilities (ARFs). These provide 24-hour non-medical care, including assistance with daily living activities and dispensing medications, for adults with

²² U.S. Department of Housing and Urban Development, Public and Indian Housing (PIH) Information Center, "Housing Authority Profiles." Available online: <https://pic.hud.gov/pic/haprofiles/haprofilelist.asp> (Accessed: May 11, 2005).

physical, mental, or developmental disabilities and are licensed by the State of California Department of Social Services Community Care Licensing Division.²³

Because many supportive housing programs rely on funding from multiple sources in multiple systems, many of the emergency and transitional beds, as well as permanent housing units, appear in the inventories of more than one system. An unduplicated count of housing resources in the three systems includes:

- 747 emergency shelter beds for single individuals and 73 emergency shelter units for families that can accommodate 485 people in families.
- 543 transitional housing beds for single individuals and 326 transitional units for families that accommodate 1,077 people in families.
- 1,369 permanent housing beds or units for single individuals plus 650 beds for individuals in Board and Care homes and 10 beds in a residential care facility. For families, the unduplicated permanent housing inventory includes 358 permanent housing units that can accommodate 1,022 people in families.²⁴

Please see the chapter entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* for a detailed estimate of the amount and types of housing needed for the plan's three target populations.

²³ The majority of Board and Care residents have Supplemental Security Income (SSI), and SSI payments inform the rate structure at Board and Care homes. In 2004, the monthly payment for someone in non-medical Board and Care was \$991 per month. Board and Care homes are important in the context of housing because they provide housing for many very low-income people in Alameda County.

²⁴ AHW calculation based on inventory information from each system.

Homelessness in Alameda County

A 2004 survey sponsored by the Alameda Countywide Homeless Continuum of Care Council found that 6,215 people, including 1,755 children, met the community's definition of homelessness at a point in time. The homeless population is diverse and experiences issues that span many service delivery systems. This chapter presents an overview of data regarding the homeless population in Alameda County and the supportive housing dedicated to this population. (Please refer to *Companion Materials, 8. Homelessness in Alameda County: Expanded Version* for a more comprehensive overview of information related to this chapter.)

Based on the 2005 update to the 2004 survey, this plan estimates that 1,883 chronically homeless single adults and 10,869 community-defined homeless adults and children in Alameda County, comprising approximately 5,264 households, will need long-term housing assistance. The 2005 process updated certain population totals only, not the more detailed attributes of the population. Therefore, this plan utilizes detailed information from the 2004 survey report in the background sections on homelessness, but uses the updated 2005 counts to project the amount of housing needed. Please see the chapter entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* for a detailed estimate of the amount and types of housing needed for the plan's three target populations.

Who is Homeless in Alameda County?

Describing people who are homeless requires first defining who is homeless. There are four definitions of homelessness being used in Alameda County and for which data is available. This plan deals primarily with the broadest definition, community-defined homelessness, and a subset of that population meeting the most specific definition, HUD-defined chronic homelessness. When not specified, this plan uses the community definition of homelessness.

The **community definition of homelessness** is probably very close to how most people in Alameda County understand homelessness. It includes people staying in emergency shelters or transitional housing, living on the street or in a car, and people who will lose their housing within a month and have nowhere to go. The **HUD definition of chronically homeless** includes only single adults with a disability, who have been homeless for a long time or frequently.²⁵ For more detail about all four definitions, please refer to *Companion Materials, 8. Homelessness in Alameda County: Expanded Version*.

The Alameda Countywide Homeless Continuum of Care Council sponsored an extensive count and survey of people utilizing shelter and services in Alameda County, the *Alameda Countywide Shelter and Services Survey: County Report* (ACSSS), which it released in 2004. (See *Companion Materials, 15. Executive Summary from the 2003 Alameda Countywide Shelter and Services Survey*.) This survey found that **6,215 people in Alameda County are homeless at a point in time**, and that 1,604 people in Alameda County meet HUD's definition of chronic homelessness at a point in time. Since people become homeless and then housed again throughout the year, the

²⁵ Specifically, to meet HUD's definition, they must have been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

number of people homeless during the course of the year is higher than the number at a single point in time. The Continuum of Care Council estimates that **16,000 people are homeless in Alameda County over the course of a year.**²⁶

Nearly half of the homeless population at the point in time of the survey was in Oakland, while 20 percent were in South and East County, 13 percent in Berkeley, and 17 percent in other Mid- and North County locations. The survey found an unexpectedly large portion of HUD-defined chronically homeless adults at a point in time in Berkeley, at 41 percent of the entire chronically homeless population.²⁷ Generally, the homeless population in Oakland and Berkeley includes more single adults and people with disabilities, while South, East, Mid-, and North County have higher proportions of homeless families with children.

The following information highlights some demographics of the homeless population:

- **Families.** The survey found that 43 percent of the community-defined homeless were in a family with children. At the point in time of the survey, the total included 936 adults with children, and 1,755 children.²⁸
- **Gender.** The homeless population countywide was almost evenly split between men (53 percent) and women (47 percent), although women were more highly represented in areas with more families, and men are more common in areas with more single adults.²⁹
- **Race and ethnicity.** In the community-defined homeless population, Blacks/African Americans, American Indians, and Alaska Natives were over-represented when compared to Alameda County's population as a whole.³⁰
- **Youth and young adults.** At a point in time, there were 364 community-defined homeless people in Alameda County aged 24 or younger, including effectively emancipated youth younger than 18.³¹
- **Seniors.** At a point in time, Alameda County had 2,296 people aged 55 or older, including 1,195 people aged 55 to 64 and 1,101 aged 65 and older. This population is anticipated to grow as the proportion of Americans aged 55 and older grows.³²
- **Duration of homelessness.** At the point in time of the survey, about a quarter of homeless adults had been homeless for less than a year, while 16 percent had been homeless for 10 years or more or had never had their own place to live.
- **Education.** More than 40 percent of homeless adults had completed high school or earned a GED.³³

²⁶ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, pp. 1-12 to 1-13.

²⁷ *Ibid.*, p. 3-15.

²⁸ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, p. 3-9.

²⁹ *Ibid.*, p. 4-2.

³⁰ See Table CM-9 on page 8.6 of this plan's *Companion Materials* for detail on race/ethnicity in the community-defined homeless population. For the population of Alameda County as a whole in 2002, population estimates are: American Indian/Alaska Native (<1%); Asian and Pacific Islanders (23%); Black/African American (14%); Hispanic/Latino, any race (20%); White/Caucasian (39%); Other (1%); and Multiracial (4%). Metropolitan Transportation Commission (MTC) and Association of Bay Area Governments (ABAG), "Selected Census 2000 data for the San Francisco Bay Area," Alameda County 2002 ACS Estimates. Source: Census 2000 SF1, SF3, DP1-DP4, American Community Survey 2002 Summary Tables. Available online: www.bayareacensus.ca.gov/counties/AlamedaCounty.htm (Accessed: December 14, 2004).

³¹ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, p. 2-3.

³² *Ibid.*, p. 2-3.

- **Employment.** The survey also included people who utilize homeless and/or food services but had housing. Homeless respondents were slightly more likely to report having worked in the past 30 days than housed service users (35 versus 31 percent), but homeless people were more likely to have temporary or marginal work, and to work 15 or fewer hours weekly.³⁴
- **Income.** 88 percent of homeless people had an income; the average homeless family income was just \$727 per month.³⁵
- **Health insurance.** Three-quarters of homeless adults reported having “health insurance or access to publicly-supported treatment services” at that point in time. Homeless people averaged one hospitalization every two years, which is more than double that of housed extremely low-income service users.³⁶
- **Medical care.** About one-third of homeless respondents reported an emergency room as the location of their most recent medical care, and 36 percent delayed or did not receive medical care they thought they needed.³⁷
- **Food security.** Almost half of homeless respondents reported having gone hungry in the past 30 days, and 18 percent of adults with children reported that their children go hungry.³⁸
- **Domestic violence.** The survey found that more than 600 people who met the community definition of homelessness had been injured or threatened by a family member within the 12 months prior to the survey.³⁹
- **Veterans.** Almost 1 in 5 homeless adults had served in the United States military (at least 853 people at a point in time); just 17 percent of those reporting military service history also reported a Veterans Administration benefit or pension.⁴⁰

Homelessness in Combination with HIV/AIDS, Mental Illness, and Substance Use

Local and national data indicate that HIV/AIDS, mental illness, and substance use are common among people who are homeless, and that each of these issues affects a person’s experience while homeless and the duration they remain homeless. For example:

- **HIV/AIDS.** According to Dr. Dennis Culhane, a researcher who has worked extensively on homelessness, approximately 3 percent of the adult homeless population nationally is living with HIV/AIDS.⁴¹ Applied to the 4,460 adults homeless at a point in time in Alameda County, this would yield an estimate of 134 people living with HIV/AIDS who are homeless at a point in time.
- **Mental illness.** Data from the *Alameda Countywide Shelter and Services Survey: County Report* (ACSSS) and BHCS indicates that there are close to 1,000 people with a mental illness who are homeless in Alameda County at a point in time.

³³ Ibid, p. 4-7.

³⁴ Ibid, p. 7-1

³⁵ Ibid, p. 7-3.

³⁶ Ibid, p. 10-3.

³⁷ Ibid, pp. 10-6, 10-16.

³⁸ Ibid, p. 6-3.

³⁹ Ibid, p. 9-3.

⁴⁰ Ibid, pp. 4-16, 7-9.

⁴¹ Dr. Dennis Culhane, personal communication with AIDS Housing of Washington staff, October 14, 2004.

- **Substance use.** The ACSSS found that 30 percent (1,736 adults at a point in time) of community-defined homeless adults had alcohol dependence or drug abuse, as did 50 percent (799 adults at a point in time) of the HUD-defined chronically homeless.

Institutionalization: Foster Care, Hospitals, and Jails or Prison

Nationally and locally, there is growing documentation and understanding that many people become homeless upon leaving an institution such as foster care, hospitals, and jail or prison, and that ending homelessness requires ensuring that people do not exit institutions to homelessness. For example, in the ACSSS survey, 12 percent of all respondents (864 people at a point in time) said that they became homeless most recently when they were “released from jail, prison, or a hospital.”⁴² Further detail follows:

- **Foster care.** 1 in 5 homeless adults (20 percent) in Alameda County reported having been in an institution before age 18, including 14 percent who had been in foster care.⁴³ The proportion of community-defined homeless adults younger than age 30 in Alameda County who reported being in an institution before age 18 was even higher, at 37 percent.⁴⁴ The California Department of Social Services estimates that 65 percent of the 219 youth who exit foster care *every year* need housing assistance.⁴⁵
- **Formerly Incarcerated.** More than two-thirds of the community-defined homeless population in Alameda County had been in either jail or prison at some point in the past. This includes 4 percent who had last been released a month to a year prior to the survey, and 16 percent who had been released within the 30 days prior to the survey.⁴⁶
- **Hospitals.** 11 percent of community-defined homeless adults and 16 percent of HUD-defined chronically homeless reported having been hospitalized two or more times in the previous year.⁴⁷ Nine percent of the community-defined homeless and 21 percent of the HUD-defined chronically homeless reported having been in a psychiatric hospital within the past year.⁴⁸

⁴² Ibid, p. 5-3.

⁴³ Ibid, p. 4-9.

⁴⁴ Ibid, p. 8.

⁴⁵ California Department of Social Services, *Report of the Survey of the Housing Needs of Emancipated Foster/Probation Youth*, p. 1. Available online: www.childsworld.ca.gov/res/PDF/RptontheHousingNeeds.pdf (Accessed: March 8, 2005).

⁴⁶ Ibid, p. 4-11.

⁴⁷ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, p. 10-10.

⁴⁸ Ibid, p. 10-12.

Housing Inventory for Homeless Population

The 2005 Alameda Countywide Continuum of Care application, Exhibit 1 included the following inventory of existing housing resources, presented in **Table 1**. The inventory includes all beds that are available year-round, separated by individuals and families. Some of the beds included in the Continuum of Care inventory are dedicated to serving people who are both homeless and have a mental illness or people who are homeless and are living with HIV/AIDS.

Table 1:
**Continuum of Care Housing Inventory Summary,
Year-Round Beds 2005**

	Family Units	Family Beds	Individual Beds
In operation:			
Emergency Shelter	131	454	538
Transitional Housing	292	1,023	565
Permanent Supportive Housing	252	761	1,232
In development:			
Emergency Shelter	0	0	0
Transitional Housing	0	0	32
Permanent Supportive Housing	48	82	57

Source: Alameda Countywide Homeless Continuum of Care Council, 2005 Continuum of Care application, Exhibit 1.

Homeless Count: 2005 Update

In the last week of January 2005, the Alameda Countywide Homeless Continuum of Care Council performed a full-week count of homeless people who were using a wide range of services, in order to update homeless population counts from the *Alameda Countywide Shelter and Services Survey: County Report (ACSSS)*, which was published in 2004. By combining the 2005 point-in-time count of service users with the 2004 ACSSS data, a research firm determined the numbers of people who were homeless in Alameda County as of January 28, 2005 and who should be counted among this plan's three target populations. The update applied to certain population totals only, not the more detailed attributes of the population. Therefore, this plan utilizes detailed information from the 2004 ACSSS report in the background sections on homelessness, but uses the updated 2005 counts to project the amount of housing needed.

On January 28, 2005, there were 3,010 homeless individuals, and 2,119 homeless adults and children in 684 families, for a total of 5,129 people who were homeless in Alameda County at a point in time. Segments of the total homeless population included:

- 1,506 adults meeting HUD's definition of chronic homelessness
- 719 homeless adults with serious mental illness
- 93 homeless adults living with HIV/AIDS
- 1,746 homeless adults with chronic substance abuse
- 355 homeless youth

NOTE TO READER: Additional information about the homeless system and related issues can be found in the following chapters in this plan:

Local and National Context for Planning, Context for Preventing and Ending Homelessness (p. 38)
Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs (p. 71)

Please also see the following chapters in the *Companion Materials* for this plan:

3. Next Steps for the Homeless Continuum of Care System
8. Homelessness in Alameda County: Expanded Version
11. Consumer Focus Groups
12. Housing and Services Needs: Populations Working Groups
13. Housing Needs and Estimated Costs
15. Executive Summary from the 2003 Alameda Countywide Shelter and Services Survey
17. Glossary of Related Terms

Behavioral Health in Alameda County

People with behavioral health issues, including mental illness and/or substance use, face substantial challenges obtaining and maintaining stable housing, a fact that has been documented from both a behavioral health and a homelessness perspective. In Alameda County, there are 30,581 adults and children with a serious mental illness or serious emotional disturbance who are in a household with an income at or below 200 percent of poverty. Alameda Behavioral Health Care Services (BHCS) served more than 18,000 adults during 2002, and of these, 3,920 adults were assigned to Service Teams, which indicates that they had more intensive service needs. Available data suggests that 866 adults with mental illness are homeless at any given time in Alameda County, and the HIV/AIDS service system identified at least 23 percent of its annual clients (644) as having a mental illness. In 2004, local funding for housing for people with mental illness totaled approximately \$7 million.

Substance use issues are a major complicating factor for each of the plan's three target populations, and must be taken into account. In the twelve-month period ending June 2004, more than 9,000 people participated in publicly funded substance use treatment services in Alameda County. The 2004 homelessness survey in Alameda County found more than 1,736 homeless adults with substance abuse or dependence at a point in time, and 500 to 900 people living with HIV/AIDS who are estimated to have substance use issues.

This chapter presents information about people with mental illness and/or substance use issues in Alameda County and the resources dedicated to meeting the housing and services needs of this population. (Please refer to *Companion Materials, 9. Behavioral Health in Alameda County: Expanded Version* for a more comprehensive overview of information related to this chapter.)

This plan estimates that housing assistance is needed for 17,819 people with a serious and persistent mental illness who have extremely low-incomes and are at risk of becoming homeless, as well as 443 people with serious mental illness who are in the chronically homeless population and 1,095 people with serious mental illness in the community-defined homeless population. Please see the chapter entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* for a detailed estimate of the amount and types of, housing needed for the plan's three target populations.

Mental Health

In October 2004, the State of California Department of Mental Health (DMH) released estimates of the total number of people with serious emotional disturbance (SED) and serious mental illness (SMI) statewide by county, then estimated how many of them also had incomes below 200 percent of poverty (\$38,700 for a family of four).⁴⁹ For Alameda County, the estimate was a total of **30,581 people**, including **9,805 youth** ages 0 to 18 and **20,775 adults** ages 18 and older.⁵⁰

⁴⁹ Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375. Available online: www.aspe.hhs.gov/poverty/05poverty.shtml.

⁵⁰ DMH advises using 200% of poverty as the upper income limit for planning for publicly funded mental health services. State of California Department of Mental Health (DMH), "Statistics & Data Analysis: Prevalence Rates of Mental Disorders, Updated October 2004," Prevalence Table 2: "Prevalence Estimates for Persons in Households <200% of Poverty For 2000 Census and Updated to July 2004, Estimates of Prevalence of Persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) in Alameda County." Available online: www.dmh.cahwnet.gov/SADA/docs/Prevalence%20Rates/Alameda/Table2.pdf (Accessed: December 2, 2004).

In 2002, the most recent year for which complete data is available, Alameda County Behavioral Care Services (BHCS) served **18,024 adults** over the course of the year. Berkeley Mental Health (BMH) operates a separate mental health system. However, the majority of BMH clients are also in the County mental health system because certain types of mental health care, particularly hospitalization, are available only through the County system. For that reason, Berkeley Mental Health estimates that BHCS data includes about two-thirds of their clients.⁵¹

Consumers with the most acute service needs are assigned by BHCS to Service Teams for care. In general, adult residents of Alameda County who have a serious and persistent mental illness which causes substantial impairment in their community functioning, and who have no other appropriate source of mental health treatment available to them, will be accepted as meeting criteria for Service Team assignment. In July 2004, there were **4,074 adults on Service Teams**.

BHCS collects data on the housing status of clients. However, because data is collected at the first contact of the year, and for many people this contact occurs at a time of crisis, data is not consistently available for all clients. For example, housing status data was not available for 31 percent of clients in 2002. Still, it is clear that homelessness and housing stability are issues for many. In 2002, more than **1,000 BHCS clients were reported as homeless** during the course of the year, equivalent to 6 percent of all clients for the year and including 6 percent of service team clients. Nearly **1 in 5 clients served in 2002 entered services while in jail**, or more than 3,000 people.⁵²

In its initial AB 2034 grant proposal, Berkeley Mental Health estimated that roughly 450 of the City's adult and transition age youth homeless populations were seriously mentally ill and eligible for AB 2034 services. This number is consistent with the findings of the Alameda Countywide Shelter and Services Survey, which noted a disproportionately high number of single adults with mental disabilities in Berkeley's homeless population. Berkeley's AB 2034 program contracts with the State Department of Mental Health to serve 95 individuals and 107 are currently enrolled, thus demonstrating a significant gap in the availability of this type of service to those in need in Berkeley and across Alameda County. Berkeley's non-AB 2034 teams serve an estimated additional 150 homeless adults.

The needs of transition-age youth, including youth emancipating from foster care, are increasingly a concern in Alameda County. Approximately 220 youth emancipate from foster care in Alameda County every year, and two-thirds need housing assistance.⁵³ An analysis of California Department of Social Services data found that statewide **63 percent of foster youth received publicly funded mental health services prior to emancipation**.⁵⁴

A particular challenge for Alameda County's Social Services Agency is people receiving General Assistance who have behavioral issues but who may not qualify for mental health services.

⁵¹ Berkeley Mental Health, e-mail communication with AIDS Housing of Washington staff, June 6, 2005.

⁵² Alameda County Behavioral Health Care Services handout, "BHCS Data on Homeless Populations in SMI and General BHCS Populations," August 25, 2004.

⁵³ Amanda Richards, *Housing, Services, and Support: A Comprehensive Housing Continuum for Youth Aging Out of Foster Care in Alameda County*, May 2004, p. 8.

⁵⁴ Barbara Needell, Stephanie Cuccaro-Alamin, Alan Brookhart, William Jackman, and Aron Shlonsky, *Youth Emancipating from Foster Care in California: Findings Using Linked Administrative Data*, Center for Social Services Research, University of California at Berkeley, May 2002, pp. 27-29.

Mental Illness in Combination with Homelessness, HIV/AIDS, and Substance Use

National and local data indicate substantial correlation between the plan's three populations: people experiencing homelessness, people living with HIV/AIDS, and people with mental illness. Statistics regarding the correlation of mental illness with homelessness and with HIV/AIDS follows.

- **Homelessness.** A recent homelessness survey in Alameda County found 866 adults at a point in time who were homeless and had a mental illness; nearly half of them had co-occurring substance use issues.⁵⁵ BHCS reports that more than 1,000 of its clients served during 2002 were reported as being homeless that year.⁵⁶
- **HIV/AIDS.** The Office of AIDS Administration reports that 637 people in FY 2003–2004 (about a quarter of all clients served that year) entered Ryan White services with mental illness as a presenting issue, and 313 participated in Ryan White mental health therapy or counseling during the year.⁵⁷ BHCS mental health programs do not track information related to HIV/AIDS, and use different eligibility criteria than Ryan White.
- **Substance use.** Substance use issues have been estimated to affect 35 percent of people with serious mental illness nationally.⁵⁸ During the 12 months ending June 30, 2004, 1,648 clients receiving in mental health services were also served by providers of substance abuse services.⁵⁹ A recent homelessness survey found more than 400 people at a point in time in Alameda County who were homeless, mentally ill, and had alcohol or other drug dependence.⁶⁰

This plan estimates that housing assistance is needed for 17,819 people with a serious and persistent mental illness who have extremely low-incomes and are at risk of becoming homeless, as well as 443 people with serious mental illness who are in the chronically homeless population and 1,095 people with serious mental illness in the community-defined homeless population. (Please see the chapter, *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs*, for more detail.)

Housing for People with Mental Illness

In 2004, the BHCS budget for housing programs for people with mental illness was \$5.4 million. Programs included purchased shelter beds, access to Single Room Occupancy apartments, transitional housing, partial rent subsidies, and the Supplemental Rate Program for Board and Care homes.⁶¹ Each of these programs and a detailed inventory appear in *Companion Materials, 9. Behavioral Health in Alameda County: Expanded Version*. Other sources of funding specific to

⁵⁵ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, pp. 8-18, 10-12.

⁵⁶ Alameda County Behavioral Health Care Services handout, "BHCS Data on Homeless Populations in SMI and General BHCS Populations," August 25, 2004.

⁵⁷ Data provided to AIDS Housing of Washington by the Office of AIDS Administration, prepared December 7, 2004.

⁵⁸ Alameda County Behavioral Health Care Services, personal communication with AIDS Housing of Washington staff, March 30, 2005.

⁵⁹ Alameda County Behavioral Health Care Services, e-mail communication with AIDS Housing of Washington staff, October 8, 2004.

⁶⁰ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, pp. 8-18, 10-12.

⁶¹ Data provided to AIDS Housing of Washington by Alameda County Behavioral Health Care Services, September 23, 2004; e-mail communication with AIDS Housing of Washington staff, September 7, 2004.

housing people with mental illness are the City of Berkeley’s AB 2034 program and related general funds, and a SAMHSA grant to Bonita House. These sources totaled \$1.6 million in 2004.⁶²

Table 2 summarizes the units of housing for people with mental illness in Alameda County. The count of family beds represents the number of individuals who can be accommodated in the family units; these cannot be added together. With the notable exceptions of residential care facilities and licensed Board and Care homes, nearly all of these units also appear in the homeless housing inventory.

Table 2:
Inventory of Housing Units for People with Mental Illness, by Housing Type

Housing Type	Family Units	Family Beds	Individual Beds
Residential and 24-hour Care Facilities	—	—	375
Emergency Housing	—	—	50
Transitional Housing	4	10	83
Permanent Housing – Solely for people with mental illness	2	6	140
Health, Housing, and Integrated Services Network (HHISN)*	—	—	118
Licensed Board and Care Homes	—	—	650
Total	6	16	1,416

Sources: Inventory was compiled for use in this plan. See detailed inventory tables in *Companion Materials, 9. Behavioral Health in Alameda County: Expanded Version*, for complete sources.

*The HHISN sites are permanent housing. While not exclusively for people with mental illness, they are a substantial resource for people with mental illness. The number above is an estimate of the number of mentally ill tenants in 2004, representing 20% of total units.

Board and Care Homes

No discussion of housing for people with mental illness in Alameda County would be complete without a discussion of Board and Care homes, also called Adult Residential Care Facilities (ARFs), and unlicensed boarding homes. Board and Care homes (ARFs) provide 24-hour non-medical care, including assistance with daily living activities and dispensing medications, for adults with physical, mental, or developmental disabilities. They are licensed and regulated by the State of California Department of Social Services Community Care Licensing Division. Boarding homes can provide room and board, but it is illegal for them to provide the non-medical care that Board and Care homes do. Boarding homes are unlicensed and unregulated.

Many people are not aware that there are two different types of facilities, and that one type is licensed and regulated, while the other is not. However, it is very important to distinguish between the two, because the laws and policies affecting them are so different. Throughout this plan, “Board and Care home” is used to indicate licensed facilities, and “boarding home” is used to indicate unlicensed facilities.

⁶² City of Berkeley Health and Human Services, Division of Mental Health, e-mail communication with AIDS Housing of Washington staff, October 4, 2004. Bonita House and Corporation for Supportive Housing: Health, Housing, and Integrated Services (HHISN) proposal, p. 2.

A number of concerns related to Board and Care homes have been identified in this process:

- The **number of Board and Care homes for people with mental illness has been steadily decreasing**, due to the retirement of aging owners, and demand for the real estate the homes occupy. Most importantly, the state's reimbursement rates for serving people with developmental disabilities are up to five times higher than for serving people with mental illness, leading to the conversion of many ARFs to serving people with developmental disabilities.⁶³
- There is **no mechanism in place to assist residents to develop independent living skills and move on** from Board and Care homes to more independent living.
- Because Board and Care homes are affordable on SSI income, and few other affordable housing options are available for people with mental illness, **some residents who might be successful in a more independent setting remain in Board and Care homes**. This both limits their potential and prevents people appropriate for a Board and Care homes from accessing the resource.

Unlicensed boarding homes are subject to many concerns about the quality of life for their residents and the surrounding communities. These homes can be attractive to residents because they leave residents with more discretionary income than licensed facilities.⁶⁴ In 2002, for example, a resident of a licensed Board and Care home paid their entire SSI payment, \$918, while a resident of an unlicensed boarding home paid \$500 to \$750 and had \$168 to \$418 for incidental expenses.⁶⁵ Legally, independent boarding homes can provide room and board, but are prohibited from providing care, but some boarding homes provide illegal care without appropriate oversight. There are no regulations about staffing or care, which can create an unstable situation for residents and the surrounding community.

In addition, some boarding homes are improperly maintained and have unsafe and/or unsanitary conditions that can endanger residents. Despite the quality concerns, a substantial portion of people with mental illness live in unlicensed boarding homes. Although a complete count of boarding homes is not available, Oakland had 86 in 2002, compared to about 100 Board and Care homes.⁶⁶ Because of their extremely low incomes and disabilities, unlicensed boarding home residents would otherwise be at high risk of homelessness.

⁶³ Michele Byrnes, Mandy Folse, Ruth Genn, and Michael Thompson, Richard and Rhoda Goldman School of Public Policy, University of California at Berkeley, *Substandard Board and Care: Addressing Inadequate Facilities in Oakland*, May 2002, p. 6. Sponsored by Daphne Markham, Oakland Police Department in collaboration with Calvin Wong and Leslie Gould, City of Oakland Community and Economic Development Agency.

⁶⁴ Ibid, p. 5.

⁶⁵ Ibid, p. 5, Table 1. SSI recipients who are residents of non-medical board and care receive a larger monthly payment than people with an "independent living status." For example, in the second half of 2005, a disabled person with an independent living status receives \$812 per month, while a person living in a non-medical board and care receives \$991. Source: Social Security Administration, "Supplemental Security Income (SSI) in California," January 2005. Available online: www.ssa.gov/pubs/11125.html#pay (Accessed: June 29, 2005).

⁶⁶ Byrnes, p. 3.

Substance Use

According to federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates, 21.6 million people in the United States, or 9 percent of the population aged 12 or older, were classified with substance dependence or abuse in 2003. Approximately 3.3 million people in the United States (1 percent of the population) received treatment for a problem related to substance use during 2003.⁶⁷ However, many people—even a majority of people who need treatment for substance use issues—do not receive it,⁶⁸ due to a lack of perceived need for services, insurance barriers, lack of publicly funded treatment openings, and/or stigma related to services.⁶⁹

In FY 2003-2004, community-based providers of substance use-related service with contracts with BHCS provided services to 9,357 clients over the course of the year. Nearly half of service contacts (44 percent) were provided in Oakland, while Newark (17 percent) and Hayward (16 percent) had the next largest numbers of contacts.⁷⁰ Of the total, 591 contacts (6 percent) were provided in Berkeley.

Substance Use in Combination with Homelessness, HIV/AIDS, and Mental Illness

Both national and local data confirm that substance use issues affect many people who are homeless and/or living with HIV/AIDS. Ensuring housing stability for Alameda County's homelessness population and for people living with HIV/AIDS can only be accomplished by addressing substance use as well. Population estimates are:

- **Homelessness.** The ACSSS survey found that 30 percent (1,736 adults at a point in time) of community-defined homeless adults had alcohol dependence or drug abuse, as did 50 percent (799 adults at a point in time) of the HUD-defined chronically homeless.
- **HIV/AIDS.** Estimates of the extent of substance use issues among people living with HIV/AIDS are limited by current data collection and by the documented tendency people have to underreport substance use. BHCS substance use treatment and recovery programs do not track information related to HIV/AIDS. However, some information is available from Ryan White services. Based on local and national data, a conservative estimate is 500 to 900 people living with HIV/AIDS with substance use issues in Alameda County.
- **Co-Occurring Disorders.** It is estimated that 35 percent of people with a serious mental illness also have alcohol or other drug dependence.⁷¹ Among people who are homeless with a serious mental illness, co-occurring substance use disorders are even more prevalent, perhaps in as

⁶⁷ Substance Abuse and Mental Health Services Administration, "Overview of Findings from the 2003 National Survey on Drug Use and Health," 2004. Available online: www.drugabusestatistics.samhsa.gov/nhsda/2k3nsduh/2k3Overview.htm#toc (Accessed: February 16, 2005).

⁶⁸ Child Welfare League of America, "The Child Protection/Alcohol and Drug Partnership Act (S. 484/H.R.1909) Will Help Keep Children Safe and in Permanent Families," June 2001. Available online: www.cwla.org/advocacy/aodfactsheet.htm (Accessed: February 16, 2005).

⁶⁹ Substance Abuse and Mental Health Services Administration, "SAMHSA's Latest Survey Provides the Prevalence of Substance Use, Serious Mental Illness, Related Problems, and Treatment in the U.S." Available online: www.oas.samhsa.gov/NHSDA/2k3NSDUH/2k3results.htm#ch7 (Accessed: February 15, 2005).

⁷⁰ Alameda County Behavioral Health Care Services, Office of Management Services, December 31, 2004. Includes adults over age 18 who received one or more claimed outpatient services during the 12 months ending June 30, 2004. Excludes office-based services of MediCal Level 3 Provider Network.

⁷¹ Alameda County Behavioral Health Care Services, personal communication with AIDS Housing of Washington staff, March 28, 2005.

many as half of all people.⁷² Nationally, the differing approaches and separate histories of the mental health system and the substance use treatment and recovery systems have meant that people with co-occurring disorders have often been underserved. A SAMHSA study found that nationally more than half of adults with co-occurring disorders had received neither specialty mental health treatment nor specialty substance use treatment in the past year (2002).⁷³

NOTE TO READER: Additional information about housing for people with mental illness and related issues can be found in the following chapters in this plan:

Local and National Context for Planning, Context for Behavioral Health Care and Housing (p. 40)
Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs (p. 71)

Please also see the following chapters in the *Companion Materials* for this plan:

4. Next Steps for the Behavioral Health Care System
9. Behavioral Health in Alameda County: Expanded Version
11. Consumer Focus Groups
12. Housing and Services Needs: Populations Working Groups
13. Housing Needs and Estimated Costs
16. Mental Health System Housing Report: Front Door Project
17. Glossary of Related Terms

⁷² Substance Abuse and Mental Health Services Administration, The Center for Mental Health Services, National Resource Center on Homelessness and Mental Illness, "Get the Facts: Question #3, Why are so many people with serious mental illness homeless?" Available online: www.nrchmi.samhsa.gov/facts/facts_question_3.asp (Accessed: July 1, 2004).

⁷³ Substance Abuse and Mental Health Services Administration, "The National Survey of Drug Use and Health Report: Adults with Co-Occurring Serious Mental Illness and a Substance Use Disorder," June 23, 2004. Available online: www.oas.samhsa.gov/2k4/coOccurring/coOccurring.cfm (Accessed: July 1, 2004).

HIV/AIDS in Alameda County

At the end of 2003, there were 2,720 people living with AIDS who had been diagnosed in Alameda County. HIV case reporting was implemented in July 2002, so comprehensive data is not yet available. However, at the end of 2003, 1,162 people had been diagnosed with HIV but not AIDS and reported in Alameda County. African Americans make up nearly half of people living with AIDS in Alameda County, despite being just 14 percent of the total population in 2002.

Alameda County receives funding dedicated for housing and services for people living with HIV/AIDS from both the U.S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons with AIDS (HOPWA) program and the Health Resources and Services Administration's (HRSA) Ryan White CARE Act program. For the current year, this funding totals more than \$8 million combined. This funding supports services for nearly 3,000 people as well as more than 200 units of housing.

This chapter presents information about the population living with HIV/AIDS in Alameda County, and the resources dedicated to meeting the housing and services needs of people living with HIV/AIDS. (Please refer to *Companion Materials, 10. HIV/AIDS in Alameda County: Expanded Version* for a more comprehensive overview of information related to this chapter.)

This plan estimates that housing assistance is needed for 4,890 people living with HIV/AIDS who have extremely low incomes and are at-risk of becoming homeless, as well as 46 people living with HIV/AIDS in the chronically homeless population and 168 people living with HIV/AIDS in the community-defined homeless population. Please see the chapter entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* for a detailed estimate of the amount and types of housing needed for the plan's three target populations.

Population Living with HIV/AIDS in Alameda County

As of December 31, 2003, there were 2,720 people living with AIDS in Alameda County. Because California implemented HIV-reporting changes in 2002, HIV data is not considered complete. A total of 1,162 HIV (non-AIDS) cases had been reported to Alameda County between the start of reporting and December 31, 2003.

The majority of people who have been diagnosed with AIDS in Alameda County since 1980 are men, at 87 percent of the total. Since reporting began in 1980, 41 percent of AIDS diagnoses were in adults aged 30 to 39, and 30 percent were in adults aged 40 to 49. The majority of people diagnosed with AIDS in Alameda County from 1980 through 2003, 58 percent, were living in Oakland at the time of diagnosis. Nine percent were living in Berkeley at the diagnosis, followed by 8 percent in Hayward, 6 percent in San Leandro, and 5 percent in Alameda.

Blacks/African Americans make up nearly *half* of all people living with AIDS in Alameda County, despite being just 14 percent of Alameda County's total population in 2002. African Americans as a group have less access to health care and more negative health outcomes than most other racial/ethnic groups and the population as a whole in relationship to HIV/AIDS and many other health conditions. In late 1998, the Alameda County Board of Supervisors unanimously passed a

resolution declaring a State of Emergency due to the prevalence of HIV/AIDS rates in its African-American community. It was the first local government in the United States to declare a regional disaster because of HIV. The declaration was aimed to draw attention to the seriousness of the issue and to help develop new resources to address the situation.⁷⁴

In 1999, the Board of Supervisors declared a State of Emergency regarding the transmission of HIV/AIDS and hepatitis via the use of contaminated needles. In the 12 months prior to that point, injection drug users represented nearly half of new HIV infections at public health test sites. This State of Emergency made a needle exchange program possible. From 1980 to the end of 2003, 20 percent of the people living in Alameda County who were diagnosed and reported as living with AIDS had injection drug use as a mode of transmission.

This plan estimates that housing assistance is needed for 4,890 people living with HIV/AIDS who have extremely low incomes and are at-risk of becoming homeless, as well as 46 people living with HIV/AIDS in the chronically homeless population and 168 people living with HIV/AIDS in the community-defined homeless population. (Please see *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* for more detail.)

Dedicated Funding for Housing and Services for People Living with HIV/AIDS

There are two primary federal programs that fund programs for people living with HIV/AIDS in the United States: Housing Opportunities for Persons with AIDS (HOPWA), a program of the U.S. Department of Housing and Urban Development (HUD), and the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, a program of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. Both of these programs provide a significant amount of support to housing and service programs in Alameda County.⁷⁵

The Alameda County Housing and Community Development Department and Alameda County Public Health Department Office of AIDS Administration both contributed funding to support the development of the Alameda County Homeless and Special Needs Housing Plan. In addition, funding from HUD's National HOPWA Technical Assistance Program supported this effort.

Housing Opportunities for Persons with AIDS (HOPWA)

HOPWA was established in 1992 to address the specific housing-related needs of people living with HIV/AIDS and their families. HOPWA is a cornerstone for the HIV/AIDS housing continuum available in most communities; as such, sound program management is essential and integration with local planning efforts, such as HUD's Consolidated Plan and the Continuum of Care, a requirement. The primary projected outcomes of the HOPWA program are increased housing stability, decreased risk of homelessness, and increased access to care for persons living with HIV/AIDS.

⁷⁴ "Alameda County Takes Bold Steps: Declaring a State of Emergency in the African American Community to combat the AIDS epidemic," *District 5 News*. Available online: www.co.alameda.ca.us/board/district5/news/2000/aids.htm (Accessed: April 7, 2005).

⁷⁵ The Alameda County Housing and Community Development Department and Alameda County Public Health Department's Office of AIDS Administration both contributed funding to support the development of the *Alameda Countywide Homeless and Special Needs Housing Plan*. In addition, funding from HUD's National HOPWA Technical Assistance Program supported this effort.

As the largest city in the metropolitan area, which includes both Alameda and Contra Costa Counties, the City of Oakland serves as the local HOPWA grantee and contracts with the Alameda County Housing and Community Development Department for HOPWA administration in Alameda County. The Oakland eligible metropolitan area (EMA) has received a HOPWA formula allocation since 1992. The grant for the two-county area was \$1.8 million in FY 2005, a decrease from the approximately \$2 million in FY 2003 and FY 2004. HOPWA (HIV/AIDS) funds for the Oakland EMA are allocated between Alameda County and Contra Costa County proportionally based on the percentage of HIV/AIDS cases reported in the two counties for the Oakland EMA. The City retains two percent of the grant to cover costs of grant administration and reporting. The balance of the grant (98 percent) is divided between Alameda and Contra Costa Counties based on the percentage of AIDS cases in the two counties (which averages out to lower 20 percentile for Contra Costa County and higher 70 percentile for Alameda County).

The Alameda County Housing and Community Development Department solicits proposals through an annual Request for Proposals process. By 2004, HOPWA had provided funding for the development of 71 units of permanent supportive housing for families and 120 units of permanent supportive housing for individuals.⁷⁶ HOPWA also funded emergency shelter capacity for 1 family and 18 adults, as well as transitional housing for 9 families and 24 single adults and 10 residential care facility beds.⁷⁷ During the FY 2003-2004 fiscal year, HOPWA also funded the AIDS Housing and Information Project (AHIP) at Eden I & R, which answers phone inquiries about housing and services, provides housing-search related trainings to providers countywide, and produces bimonthly housing availability updates. In FY 2003-2004, AHIP provided housing information and referral to 290 people with HIV/AIDS and their family members in response to more than 275 phone calls.⁷⁸

In addition, Alameda County also has a HOPWA Special Projects of National Significance (SPNS) grant for Project Independence, now in its second renewal, which the Alameda County Housing and Community Development Department applied for and administers. The Project Independence program provides case management and a partial rent subsidy for permanent housing for people living with HIV/AIDS. The total budget for FY 2003-2006 is about \$1.2 million.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

The Ryan White CARE Act, enacted in 1990, was named after Ryan White, an Indiana teenager whose courageous struggle with HIV/AIDS and against AIDS-related discrimination helped educate the nation. It represents the largest dollar investment made by the federal government specifically for the provision of services for people living with HIV/AIDS. Ryan White funds are intended to help communities and states increase the availability of primary health care and support services, and increase access to care for underserved populations.

The Alameda County Public Health Department Office of AIDS Administration administers Ryan White Title I funds in Alameda County, and the Collaborative Community Planning Council

⁷⁶ *Alameda Countywide Homeless and Special Needs Housing Plan: Companion Materials, 10. HIV/AIDS in Alameda County: Expanded Version*, Table CM-40: "Permanent Housing for People Living with HIV/AIDS in Alameda County," p. 10.21.

⁷⁷ *Alameda Countywide Homeless and Special Needs Housing Plan: Companion Materials, 10. HIV/AIDS in Alameda County: Expanded Version*, Table CM-39: "Emergency and Transitional HIV/AIDS Housing in Alameda County," p. 10.20; Table CM-41: "Residential Care Facility for People Living with HIV/AIDS in Alameda County," p. 10.22.

⁷⁸ City of Oakland, CAPER Narrative 2003/2004; HOPWA Program Narrative.

(CCPC) guides the priorities and uses for funding. The Oakland metropolitan area has received Ryan White funds since 1991. The CCPC (known at that time as the HIV Services Planning Council) established multi-year goals and objectives for the period November 1, 2003 to October 31, 2005. The goals address: (1) the continuum of services provided by Title I; (2) ensuring access, outreach, and eliminating disparities; (3) linkage, coordination, and collaboration; and (4) new technologies, emerging developments, and evaluation goals.

In FY 2004-2005, Alameda County received a total of \$6.6 million in Ryan White CARE Act funding. Of this total, about \$800,000 went into funding three types of housing programs: short-term housing (STH), emergency housing assistance (EHA), and housing referral services (HRS). More than \$400,000 went into mental health services and substance abuse treatment services each.⁷⁹ During the 2003-2004 program year, 2,781 people were served by Ryan White-funded programs.

Minority AIDS Initiative

The Minority AIDS Initiative (MAI), established in 1998, is a federal funding source aimed at reducing the impact of HIV/AIDS on racial and ethnic minority communities. In fiscal year 2003-2004, the Title I MAI award received locally was \$472,460.⁸⁰ The lead contractor is California Prevention and Education Project (CAL-PEP), a community-based organization located in Oakland, which provides psychosocial case management, peer advocacy, and short-term transitional housing assistance. In fiscal year 2002-2003, 41 clients were assisted and 31 clients were enrolled in MAI case management at the end of the year. Challenges to success identified by the program were the prevalence of substance use issues and the lack of appropriate and affordable housing.⁸¹

Inventory of HIV/AIDS Housing in Alameda County

There are several types of dedicated HIV/AIDS housing resources available to people living with HIV/AIDS in Alameda County that are funded by Ryan White and HOPWA. They are: housing referral services; emergency housing assistance; dedicated emergency, transitional, and permanent housing units; a residential care facility; and tenant-based rental assistance. People living with HIV/AIDS may also access subsidized housing resources that are not HIV/AIDS-specific; however, there are typically very long waiting lists, and this housing is not necessarily linked with needed services.

⁷⁹ Alameda County Public Health Department Office of AIDS Administration, Preliminary Finding of Funding Coming into Alameda County, August 11, 2004.

⁸⁰ Alameda County Public Health Department Office of AIDS Administration, MAI Final 03 spreadsheet, e-mailed to AIDS Housing of Washington, April 2004.

⁸¹ Alameda County Public Health Department Office of AIDS Administration, Minority AIDS Initiative, Final Progress Report, May 12, 2003.

Table 3 presents an inventory of HIV/AIDS-dedicated housing units in Alameda County. The column entitled “family beds” quantifies the number of people that can be accommodated in the “family units.” These two numbers cannot be added together. Nearly all of these units also appear in the homeless housing inventory.

Table 3:
Inventory of HIV/AIDS Housing in Alameda County

Sponsor/Owner	Family Units	Family Beds	Individual Beds
Emergency Housing	1	3	18
Transitional or Short-Term Housing	10	28	48
Permanent Housing (operating)	22	65	112
Permanent Housing (in development)	—	—	8
Residential Care Facility	—	—	10
Total	33	96	196

Sources: See detailed inventory in *Companion Materials, 10. HIV/AIDS in Alameda County: Expanded Version*.

Other HIV/AIDS-dedicated housing programs are:

- **Eden Information and Referral Services’ AIDS Housing Information Project (AHIP)** funded by HOPWA. AHIP has phone line attendants who answer inquiries, provide housing search training to providers countywide, and produce a bimonthly update/newsletter for the community. In FY 2003-2004, AHIP provided housing information and referral to 290 people with HIV/AIDS and their family members in response to more than 275 phone calls.⁸²
- **Housing Referral Services (HRS)** funded by Ryan White Title I. In the 2003–2004 fiscal year, 152 people received housing referral services at the AIDS Project of the East Bay.⁸³
- **Emergency Housing Assistance (EHA)** funded by Ryan White Title I, a tenant-based rental assistance program for eviction prevention and move-in costs up to \$750 per household per year.⁸⁴ In the 2003–2004 program year, 310 unduplicated clients were served in the EHA service category.⁸⁵
- **Project Independence**, funded by a HOPWA SPNS grant, prevents homelessness by providing a partial rent subsidy to people living in permanent housing. In FY 2003-2004, Project Independence served 198 people in 159 households; a total of 139 households were being served at the end of the year.⁸⁶

⁸² City of Oakland, CAPER Narrative 2003/2004; HOPWA Program Narrative.

⁸³ Data provided to AIDS Housing of Washington by the Office of AIDS Administration, prepared December 7, 2004.

⁸⁴ Alameda County Public Health Department Office of AIDS Administration, telephone communication with AIDS Housing of Washington staff, December 21, 2004.

⁸⁵ Data provided to AIDS Housing of Washington by the Office of AIDS Administration, prepared December 7, 2004.

⁸⁶ Alameda County Housing and Community Development Department, Annual Progress Report (APR) for Housing Opportunities for Persons with AIDS (HOPWA), p. 4.

HIV/AIDS in Combination with Homelessness, Mental Illness, and Substance Use

While no single definitive data source is available, there is substantial evidence that people living with HIV/AIDS also experience homelessness, mental illness, and/or substance abuse in significant numbers:

- **Homelessness.** According to Dr. Dennis Culhane, a researcher who has worked extensively on homelessness, approximately three percent of the adult homeless population nationally is living with HIV/AIDS.⁸⁷ Applied to the 4,460 adults homeless at a point in time in Alameda County, this would yield an estimate of 134 people living with HIV/AIDS who are homeless at a point in time.
- **Mental illness.** The Office of AIDS Administration reports that 637 people (about a quarter of all clients) in FY 2003–2004 entered Ryan White services over the course of the year with mental illness as a presenting issue, and 313 participated in Ryan White mental health therapy or counseling during the year.⁸⁸ Alameda County Behavioral Health Care Services' mental health programs do not track information related to HIV/AIDS, and use different eligibility criteria than Ryan White.
- **Substance use.** Estimates of the extent of substance use issues among people living with HIV/AIDS are limited by current data collection and by the documented tendency people have to underreport this issue. Alameda County Behavioral Health Care Services' substance use treatment and recovery programs do not track information related to HIV/AIDS. However, some information is available from Ryan White services. Based on local and national data, a conservative estimate is that 500 to 900 people living with HIV/AIDS in Alameda County have substance use issues.

NOTE TO READER: Additional information about housing for people living with HIV/AIDS and related issues can be found in the following chapters in this plan:

Local and National Context for Planning, Context for HIV/AIDS Housing and Services (p. 42)
Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs (p. 71)

Please also see the following chapters in the *Companion Materials* for this plan:

- 5. Next Steps for the HIV/AIDS System
- 10. HIV/AIDS in Alameda County: Expanded Version
- 11. Consumer Focus Groups
- 13. Housing Needs and Estimated Costs
- 17. Glossary of Related Terms

⁸⁷ Dr. Dennis Culhane, personal communication with AIDS Housing of Washington staff, October 14, 2004.

⁸⁸ Data provided to AIDS Housing of Washington by the Office of AIDS Administration, prepared December 7, 2004.

Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs

This chapter outlines the estimate of need for housing that will help ensure that individuals and families who are homeless or extremely low-income and living with serious and persistent mental illness and/or HIV/AIDS are safely, supportively, and permanently housed. This plan estimates that 35,461 individuals in 30,846 separate households need housing assistance. These needs are further developed to estimate the need for different types of housing based on the kind and intensity of on-site services, if any, that targeted subpopulations may require. The goal for the creation of new permanent housing is 15,061 units.

The estimate and types of need were informed by a series of working groups focusing on certain subpopulations during December and January 2005. For notes from those groups, please refer to *Companion Materials, 12. Housing and Services Needs: Populations Working Groups*.

Projections of Housing Needs of Target Populations

Quantifying the amount of housing needed to prevent and end homelessness in Alameda County must begin with an understanding of Alameda County's housing market in general. There is a significant shortage of housing that is safe, decent, and affordable to the target populations of this plan: homeless individuals and families, as well as extremely low-income persons living with serious and persistent mental illness and/or HIV/AIDS, many of whom are precariously or inappropriately housed and could easily become homeless as a result of one missed paycheck, a medical emergency, or a family crisis.

The limited and shrinking supply of housing that is affordable to the lowest-income households is a primary factor increasing homelessness. Without a job that pays two or three times minimum wage, even full-time workers cannot afford most market-rate housing in Alameda County. About six percent (33,922) of Alameda County's 523,208 households are at severe risk of homelessness because they are extremely low-income renters paying more than 50 percent of their income on housing.⁸⁹ A large number are also living with a physical or mental health disability. Even with increasing vacancies in recent years, it remains a very competitive market for extremely low-income renters—especially for people who are receiving disability income (SSI), which is just \$812 per month in 2005. In contrast, an average studio apartment rents for more than \$900.⁹⁰ Due to the high costs and limited availability of affordable rental housing in Alameda County, existing market-rate housing is simply not available to many people with low incomes. These households are at serious risk of being pushed into homelessness.

In addition to not being able to afford market-rate housing, people who experience homelessness or are extremely low-income and living with serious and persistent mental illness and/or HIV/AIDS face other significant obstacles to securing housing. Many have criminal histories or poor credit, and substance use affects at least a third of these populations. Many have physical disabilities, and

⁸⁹ U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy (CHAS) 2000 Database. Available online: www.huduser.org/datasets/cp/chas/chas_opening_page.html (Accessed June 13, 2005).

⁹⁰ The 2005 Fair Market Rent amount determined by HUD is \$945.

may require physically accessible units. Further, there are very few options for people at discharge from hospitalization or aging out of foster care. This plan seeks not only to address the housing needs of those who are experiencing homelessness now, but also to reduce future homelessness through creating housing that is affordable and appropriate to the needs and preferences of this plan's target populations.

The 30,846 households identified above as needing housing assistance represent just 5.8 percent of all households in Alameda County and should be considered a conservative estimate—truly those most at risk of homelessness, not just anyone who might become homeless. To develop an estimate of the housing needed for the plan's three target populations, the population was divided into five distinct groups, based on the way the data was collected:

- Chronically Homeless Single Adults
- Community-defined Homeless Adults (Singles and Couples)
- Community-defined Homeless Youth and Young Adults (up to age 25)
- Community-defined Homeless Families
- Extremely Low-Income Single Adults and Heads of Family Households Living with HIV/AIDS
- Extremely Low-Income Single Adults and Heads of Family Households Living with Serious and Persistent Mental Illness

Some of these individuals and families will only require a short stay in emergency housing, or a short-term rent or mortgage subsidy, with appropriate support to get back on their feet. For many, the combination of low wages and high rents will keep them at high risk of homelessness even after their immediate crisis is resolved. Others, depending on the complexity of their lives and the severity of their disability or medical issues will need long-term—even life-long—housing assistance. Most of these households will require some degree of support services linked to their housing, provided either on-site or through agencies in the community.

Housing Needs of Chronically Homeless Single Adults

The U.S. Department of Housing and Urban Development has established the following as a working definition of chronic homelessness:

HUD-defined chronically homeless person: 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.⁹¹

In updating the 2004 *Alameda Countywide Shelter and Services Survey (ACSSS)*, the Continuum of Care Council reports that 1,506 people in Alameda County in 2005 met HUD's definition of chronic homelessness at a point in time.⁹² In order to estimate the total number of people who meet the definition of chronic homelessness during the course of a year, this point-in-time count was multiplied by 1.25, for an estimate of 1,883 people experiencing chronic homelessness during the

⁹¹ "Notice of Funding Availability (NOFA) for the Collaborative Initiative To Help End Chronic Homelessness," Federal Register, Vol. 68, No. 17, January 27, 2003, p. 4019. This definition is shared by the U.S. Department of Housing and Urban Development, the U.S. Department of Health and Human Services, and the U.S. Department of Veterans Affairs.

⁹² Richard Speiglmán and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, pp. 1-12 to 1-13; Alameda Countywide Homeless Continuum of Care Council, 2005 Continuum of Care application, Exhibit 1.

year. The chronically homeless are all single adults with disabilities who have been homeless for a long time or frequently. They all need permanent housing. The vast majority will also require long-term support services to help them gain and maintain housing stability.

Housing Needs of Community-Defined Homeless Single Adults, Couples without Children, Youth and Young Adults

The “community definition” of homeless is probably very close to how most people in Alameda County understand homelessness. It includes people staying in emergency shelters or transitional housing, living on the street or in a car, and people who will lose their housing within a month, and includes both people with or without disabilities. The definition also includes most people who meet HUD’s definition of “chronic homelessness.” The exception is for those whom HUD considers chronically homeless but who were living in permanent housing when the survey was undertaken.

For planning purposes, however, the following estimate of the community-defined homeless population excludes people who meet the HUD definition of chronic homelessness, as well as adults with dependent children and children, because their housing needs are estimated separately in this chapter. Youth and adults younger than 25 are discussed separately in this section. The following estimate includes both single adults and couples who meet the community definition of homelessness.

The *Alameda Countywide Shelter and Services Survey* published in 2004 and updated in 2005 found that 1,174 single adults or adults in couples without children in Alameda County met the community’s definition of homelessness at a point in time.⁹³ To estimate the number of people who meet the community definition of homelessness over the course of a year, this number was multiplied by three, and resulted in a total estimate of 3,522 community-defined homeless adults annually, in 3,212 households.

The ACSSS reported an additional 355 youth and young adults (defined as youth younger than 18 who are not accompanied by an adult, and young adults emancipated youths up to age 25) in Alameda County at a point in time who also met the community’s definition of homelessness. An estimated 7 percent (25) are either parents themselves or pregnant, and are accounted for with families later in this chapter, leaving 330 single youths and young adults. This number when likewise increased threefold yields 990 over the course of a year. However, community-based youth services providers indicated that, based on the number of youth served by their agencies annually, the actual total number of youth and young adults in Alameda County who meet the community definition of homeless in a year is closer to 1,500 over the course of a year.⁹⁴

⁹³ AHW calculation of ACSSS data. This figure is the total number of people meeting the community’s definition of homelessness, minus people who are HUD-defined chronically homeless, youth and young adults, adults with children, and children.

⁹⁴ *Alameda Countywide Homeless and Special Needs Housing Plan: Companion Materials, 12. Housing and Services Needs: Populations Working Groups*, Youth and Young Adults workgroup meeting notes.

Housing Needs of Community-Defined Homeless Families

The *Alameda Countywide Shelter and Services Survey* published in 2004 and updated in 2005 found that 41 percent of the community-defined homeless were members of a family with children. The total includes 684 households comprising 2,119 persons in homeless families with children at a point in time; an estimated 25 youth or young adults with dependent children are in this group.⁹⁵ This count includes people staying in emergency shelters or transitional housing, living on the street or in a car, and people who will lose their housing within a month.

In order to estimate the total number of individuals in families experiencing homelessness over the course of a year, these point-in-time numbers was multiplied by a factor of three for a total of 6,357 individuals in 2,052 households annually.

Housing Needs of Extremely Low-Income Single Adults and Families Living with HIV/AIDS

According to the Alameda County Public Health Department, 7,089 adults are estimated to be living with HIV/AIDS in Alameda County.⁹⁶ Approximately 72 percent (5,104) have low incomes, i.e. less than 50 percent of area median and are, therefore, included as a target population of this plan.⁹⁷

An estimated 75 percent (3,656) are single or in couples without children, and 25 percent (1,234) are parents in a household that includes one or more children. Another 214 people living with HIV/AIDS are included in the estimates of chronically and community-defined homeless above.

Housing Needs of Extremely Low-Income Single Adults and Families Living with Serious and Persistent Mental Illness

Approximately 20,000 adults living with serious and persistent mental illness in Alameda County are extremely low income, i.e. with incomes of less than 200 percent of poverty rate.⁹⁸ Of this total, 1,538 are included in the estimates of chronic and community-defined homeless above. An additional 644 are included in the HIV/AIDS estimates above. This leaves approximately 17,818 people with serious mental illness who are at risk of homelessness.

⁹⁵ Richard Speigman and Jean Norris, *Alameda Countywide Shelter and Services Survey: County Report*, prepared for the Alameda Countywide Homeless Continuum of Care Council, May 2004, p. 3-9.

⁹⁶ Alameda County Public Health Department, CAPE Unit, telephone communication with AIDS Housing of Washington staff, July 12, 2005. Data is for year-end 2003 estimated living with HIV and AIDS.

⁹⁷ Samuel Bozzette, Sandra Berry, Naihua Duan, Martin Frankel, Arleen Leibowitz, Doris Lefkowitz, Carol-Ann Emmons, Walton Senterfitt, Marc Berk, Sally Morton, Martin Shapiro, "The Care of HIV-Infected Adults in the United States," *New England Journal of Medicine*, Vol. 339, No. 26, December 24, 1998, pp. 1897-1904. Bozzette et al analyzed data from the 1996 baseline HCSUS survey and estimated that 72% of persons with AIDS had incomes below \$25,000 in the previous year. Estimate confirmed by MPR analysis of HCSUS data. Estimate was adjusted for inflation to 2002 dollars, approximately \$29,510 in 2002. Inflation estimate from the U.S. Department of Labor, Bureau of Labor Statistics. Available online: <http://www.bls.gov/cpi/home.htm>.

⁹⁸ DMH advises using 200% of poverty as the upper income limit for planning for publicly funded mental health services. State of California Department of Mental Health (DMH), "Statistics & Data Analysis: Prevalence Rates of Mental Disorders, Updated October 2004," Prevalence Table 2: "Prevalence Estimates for Persons in Households <200% of Poverty For 2000 Census and Updated to July 2004, Estimates of Prevalence of Persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) in Alameda County." Available online: www.dmh.cahwnet.gov/SADA/docs/Prevalence%20Rates/Alameda/Table2.pdf (Accessed: December 2, 2004).

The housing needs of the above populations, which are more fully detailed in the *Companion Materials* for this plan, are summarized in *Table 4*.

Table 4:
**Estimate of Individuals and Households within the
Target Populations Needing Housing Assistance**

Subpopulation*	Individuals	Households**
Chronically Homeless Single Adults	1,883	1,883
Includes: Chronically Homeless with HIV/AIDS	46	46
Chronically Homeless with Mental Illness	443	443
Chronically Homeless Other	1,394	1,394
Community-defined Homeless Singles (excludes chronic homeless)	3,522	3,212
Community-defined Homeless Youth (excludes chronic homeless)	990	990
Community-defined Homeless Families	6,357	2,052
Includes: Community-defined Homeless Living with HIV/AIDS	168	168
Community-defined Homeless with Mental Illness	1,095	1,095
Community-defined Homeless Other	7,626	7,626
Low-income Single Adults Living with HIV/AIDS (not homeless)	3,656	3,656
Low-income HIV/AIDS Head of Family Household (not homeless)	1,234	1,234
Low-income Single Adults with Mental Illness (not homeless)	11,741	11,741
Low-income Head of Family Household with Mental Illness (not homeless)	6,078	6,078
Estimated Total Needing Housing Assistance	35,361	30,846

* There is some degree of overlap between the populations living with serious and persistent mental illness and HIV/AIDS, but current reporting systems do not allow for an accurate count.

** Household totals include combinations of individuals, e.g. 3,212 households comprise 3,522 Community-defined Homeless Singles and 2,052 family households comprise 6,357 men, women, and children.

Note: This table uses HUD's definition of chronic homelessness. People in couples or accompanied by children do not meet HUD's definition of chronic homelessness regardless of the duration or frequency of homelessness, or presence of disabilities.

Housing Goals and Cost Estimates

This chapter establishes the goal of creating 15,061 units of supportive housing for people in Alameda County who are homeless or extremely low-income and living with serious and persistent mental illness and/or living with HIV/AIDS. It presents preliminary cost estimates broken out by subpopulations, individuals, and families. The housing goal assumes that roughly 10,000 units will be secured through renting or “master leasing” existing units in the rental market and another 5,000 units will be developed through new construction or acquisition and rehabilitation of existing housing stock. The projections include estimates for the costs of developing and operating the housing, as well as providing support services on-site where needed.

The chapter of this plan entitled *Housing Assistance Needs of People Who Are Homeless and/or Have Special Needs* estimated that 30,846 households in Alameda County need some type of housing assistance. These households need not just housing that is low in cost, but also housing that offers on-site services tailored specifically to the needs of residents. Housing accompanied by services is typically referred to as “supportive housing.” Because this plan is oriented toward permanent housing solutions, the estimates for units of needed housing refer to “permanent supportive housing” (with services on-site) and “permanent independent housing” (with no services on-site). No one model meets everyone’s needs; rather, a variety of housing and service models are required, including both single-site developments and scattered sites.

Currently, Alameda County has about 2,300 units of permanent supportive housing dedicated to people who have been homeless, people living with HIV/AIDS, and/or people with mental illnesses.⁹⁹ While this represents a significant historical investment in addressing the housing needs of this population, there are many fewer units than people in need. Some members of these target populations are undoubtedly accessing a portion of the 21,000 Section 8 rental assistance vouchers that are being utilized to subsidize rents in apartments and buildings all across Alameda County. As a result of the federal subsidy, they pay just 30 percent of their income toward their housing costs. Others occupy some of Alameda County’s nearly 20,000 affordable housing units,¹⁰⁰ but the level of subsidy in the vast majority of these units is not enough to make the units affordable to a person with only disability income. Thus, even though these units exist, they may not be affordable to, or offer the services need by, this plan’s target populations.

Components of Supportive Housing

Supportive housing offers tenants both long-term tenancy in safe, decent, and affordable housing and an appropriate level of on-site services tailored specifically to the needs of residents. Three interrelated components must be in place and financed or funded adequately to create and sustain permanent supportive housing: housing development, housing operations, and the availability of support services.

⁹⁹ AHW calculation based on inventory information from each system.

¹⁰⁰ See chapter entitled *Housing in Alameda County* for more information about subsidized housing in Alameda County.

Housing Development

Housing development activities for permanent supportive housing are generally the same as for any other housing development. Costs include buying the lot; constructing, rehabilitating, or renovating housing units; and other development costs such as architectural and engineering services, financing charges, and local planning and impact fees. The only difference between market-rate and subsidized housing development is the need to secure subsidized financing and other funding, such as deferred or very low interest rate loans and grants, since rental income typically cannot cover a conventional, market-rate mortgage.

Housing Operations

Expenses associated with operating and maintaining a housing development include property management, repair, maintenance, and funding reserves. Adequate income to pay for operations is essential to ensure that the property is well managed and maintained in good condition over a very long term of operation. In permanent supportive housing, there is typically a deficit between the cost of operating a housing development and the rents that tenants can afford. Thus nearly all supportive housing developments require ongoing rental assistance or operating subsidies.

Support Services

Support services can encompass a wide range of activities, such as case management, service coordination (assessing needs and coordinating services), health and mental health care, substance abuse treatment, employment counseling and training, and money management. Services are usually tailored to the needs of the housed individuals, and may be delivered on-site or through linkages to community-based agencies.

Goals for Supportive Housing and Long-Term Rental Assistance

Table 5 on the next page outlines both the quantity and types of housing assistance that the 30,846 households identified by this plan will need. It includes projections for the level of services, if any, which would be appropriate to provide on site. Permanent independent housing, with no support services provided on-site, represents approximately 17 percent (5,388) of the total housing units needed. Permanent supportive housing with low, moderate or a high level of services on site represents 9,673 units or 31 percent of the total need. And short-term assistance—in the form of rent, mortgage and/or utility subsidies—represents just over one-half (51 percent) of the total need. Note: Short-term housing assistance estimates are not included in the housing goals for this plan. Only the permanent independent and supportive housing projections are included in the plan's housing goal of 15,061 units.

Table 5:
Goals for Permanent and Short-Term Housing Assistance for Target Populations in Alameda County, Categorized by Length of Assistance and Level of Services Offered On Site

Plan Subpopulation	Permanent Independent Housing (With No On-Site Support Services)	Permanent Housing with Some Level of On-Site Support Services Offered			Short-term Rent, Mortgage or Utility Assistance Only*	Total Permanent Housing & Short-Term Assistance Needed
		Low Level of Services	Moderate Level of Services	High Level of Services		
Chronically Homeless Single Adults	NA	377	753	753	NA	1,883
Community-defined Homeless Youth	165	65	165	100	495	990
Community-defined Homeless Single Adults & Couples without Children	482	482	321	321	1,606	3,212
Community-defined Homeless Families	616	246	246	123	821	2,052
Low-income Single Adults Living with HIV/AIDS	914	366	366	182	1,828	3,656
Low-income Heads of Family Households Living with HIV/AIDS	494	197	197	99	247	1,234
Low-income Single Adults with Mental Illness	1,198	798	1,198	798	7,749	11,741
Low-income Heads of Family Households with Mental Illness	1,519	608	608	304	3,039	6,078
TOTALS	5,388	3,139	3,854	2,680	15,785	30,846
		9,673				

*Note: Short-term housing assistance estimates are not included in the housing goals for this plan. Only the permanent independent and supportive housing projections are included in the plan's housing goal of 15,061 units.

Financing Supportive Housing

Producing affordable housing linked with services is not an easy task. Financing permanent supportive housing for long-term homeless and special needs populations is complicated and expensive. For example, several funding sources must participate in order to complete a housing development; no one source of funding will pay for all of the housing development costs. Housing developers must leverage funding from conventional bank loans, federal, state, and local government loans and grants, and contributions from private foundations and organizations, and secure ongoing rental subsidies. It is not unusual for nonprofit housing developers to access ten to twelve financing sources per project. In Alameda County, local funding sources typically make up about a third of the total funding required to develop affordable and supportive housing.

While leveraging has some advantages—it decreases the amount of local funding required and spreads risks—it makes the development process more complex and increases costs. Every layer of financing adds different conditions, requirements, and monitoring criteria. Funds are usually targeted for specific types of projects (such as transitional or permanent housing), specific uses (such as housing development or support service delivery), and/or specific target populations. The applications themselves can be lengthy, there is intense competition for every source, and funding may be awarded based on small differences in the scoring of many excellent applications.

In addition, most major sources of funding for housing operations and support services are time-limited. There is the possibility, but not usually a guarantee, of renewal. Adding to the complexity, many lenders will require that all of the necessary financing be in place before committing any funds. To increase the complexity, funding applications are usually due and funds are awarded at different times during the year. The competition for funding and intricacies of timing complicate a usually complex process of local planning, zoning, and development reviews, approvals, and permits. Not surprisingly given this level of complexity, the housing development process is both labor-intensive and time-consuming. A development project can take anywhere from three to five years (or more) to complete, during which time construction costs are likely to have increased.

Typical challenges faced in financing permanent supportive housing include:

- **Limited rental income** and limited ability to support debt. As a result, developers need to access multiple sources to complete the financing for development and operating costs.
- **Higher operating costs.** Permanent supportive housing requires higher staffing levels to support tenants' long-term housing stability and provide an appropriate level of property management.
- **Operating shortfalls** that get larger over time. Rental income does not keep pace with rising operating costs; that means on-going rental subsidies will be needed.
- **Cost of services.** Rental income is insufficient to cover the costs of providing support services. Additional funding sources for services are needed.
- **Short-term funding.** Most funding, especially for services, is short-term; permanent supportive housing needs mid- to long-term funding sources. For example, the use of low-income housing tax credits requires a 55-year term of affordability, while services are usually funded for one to three years at a time.

Securing Resources for Supportive Housing

The federal government provides the major share of the funding for affordable housing but state and local financing and funding sources are important components as well. Federal and state agencies administer several programs that support permanent supportive housing. Federal and state funding is combined with local funding to finance permanent supportive housing projects.

The State of California also has a program that provides loans to develop supportive housing. Known as the Multifamily Housing Program (MHP), it was created by California Proposition 46, but will have been completely allocated by 2007.

On the local level, redevelopment agencies are one of the largest sources of funding after the federal government; state law requires that redevelopment agencies spend 20 percent of their property tax increment revenues on low- and moderate-income housing. In Alameda County, local funds from various sources typically comprise up to one-third of the total development financing. Local housing authorities can also be key partners in supportive housing, because they issue and manage Section 8 rental assistance vouchers. Most local housing authorities also own and manage public housing. Public housing authorities can set local preferences that target specific subsets of eligible populations, including those targeted in this plan.

County and city departments of health, behavioral health, and social services provide funding for the range of services needed by residents. Private foundations, corporations, individuals, and faith-based and service organizations also contribute funding and volunteers to support housing and service activities.¹⁰¹

Estimate of Funding Needed to Achieve the Plan's Supportive Housing Goals

Creating 15,061 units of affordable and supportive housing is an ambitious goal. As outlined in the section above, this goal will be achieved through a combination of development and rental subsidies, providing funding for ongoing operations and needed support services. Due to the limited availability of housing stock in Alameda County, we propose developing—through either new construction or acquisition and rehabilitation—one-third of the total units needed (4,970) and securing long-term master leases for the remaining two thirds (10,091) in the private rental market. Given the length of time it takes to secure units and the costs associated, we propose a timetable that stretches over 15 years, through 2020.

Table 6 and **Table 7** on the following pages outline the various aspects of housing production and leasing, the number of units of various configurations, level of services offered, and estimated funding needed to develop and operate the housing, as well as offer on-site services. All cost estimates in the tables are stated in 2005 dollars and have not been adjusted for inflation.

¹⁰¹ California Research Bureau, *Addressing Long-Term Homelessness: Permanent Supportive Housing*, pp. 21-25. Available online: www.library.ca.gov/crb/03/12/03-012.pdf (Accessed June 13, 2005).

Table 6:

**Projected Annual Expenditures for the 15 Years of Plan Implementation:
New Leased and Capital Units Added Each Year, Annual Costs of Capital Additions,
and Annual Operating and Support Service Costs for Units in Service During the Year**

Year	New Units Added in Year thru Leasing	New as % Total	New Capital Units	Cumulative Total	Annual Costs for Capital Development	Annual Operating Costs for Units in Service	Annual Service Costs for Units in Operation	Annual Capital, Operating, and Service Costs
1	303	3%	149	3%	\$ 35,427,864	\$ 2,801,265	\$ 1,275,321	\$ 39,504,450
2	303	3%	149	6%	35,427,864	5,602,531	2,550,641	43,581,036
3	404	4%	197	10%	47,237,152	9,337,552	4,251,069	60,825,772
4	404	4%	197	14%	47,237,152	13,072,572	5,951,496	66,261,220
5	706	7%	348	21%	82,665,016	19,608,858	8,927,244	111,201,119
6	706	7%	348	28%	82,665,016	26,145,144	11,902,992	120,713,153
7	807	8%	398	36%	94,474,304	33,615,186	15,303,847	143,393,337
8	807	8%	398	44%	94,474,304	41,085,227	18,704,702	154,264,233
9	807	8%	398	52%	94,474,304	48,555,268	22,105,557	165,135,129
10	807	8%	398	60%	94,474,304	56,025,309	25,506,412	176,006,025
11	807	8%	398	68%	94,474,304	63,495,350	28,907,267	186,876,922
12	807	8%	398	76%	94,474,304	70,965,392	32,308,121	197,747,818
13	807	8%	398	84%	94,474,304	78,435,433	35,708,976	208,618,714
14	807	8%	398	92%	94,474,304	85,905,474	39,109,831	219,489,610
15	807	8%	398	100%	94,474,304	93,375,515	42,510,686	230,360,506
Total	10,091	100%	4,970	15,061	\$ 1,180,928,806	\$ 648,026,078	\$ 295,024,163	\$ 2,123,979,047

Table 7:
**Estimate of Housing Units Needed by Subpopulation,
 Indicating the Breakout between New Housing Development and the Use of Existing Housing Stock**

	Units of Housing	SRO/Cong	Unit Sizes Needed				Annual Costs When Fully Operational in 2020 (No inflation adjustment)		Total Capital Development Costs for 15,061 Units (No inflation adj.)	Cumulative Operating and Service Costs During Phase In (No inflation adj.)
			Studio	1 Bdrm	2 Bdrm	3 Bdrm	Services	Operating		
Use of Existing Housing (2/3 of total)										
<u>Individuals</u>										
Homeless Youth and Young Adults (to Age 24)	332	50	200	82	-	-	\$ 694,967	\$ 2,045,916	\$ 497,425	\$ 19,021,956
HUD-defined Chronically Homeless	1,261	150	700	411	-	-	4,141,500	5,835,750	1,891,913	69,242,115
Community-defined Homeless	1,076	300	500	276	-	-	2,087,842	6,472,309	1,614,062	59,407,445
Extremely Low-Income & Living with HIV/AIDS	1,225	50	700	475	-	-	1,645,115	8,496,806	1,837,045	70,384,925
Extremely Low-Income & Living with Mental Illness	2,675	150	1,500	1,025	-	-	5,588,645	16,087,313	4,011,848	150,431,144
<i>Subtotal Existing Housing - Individuals</i>	<i>6,569</i>	<i>700</i>	<i>3,600</i>	<i>2,269</i>	<i>-</i>	<i>-</i>	<i>\$14,158,068</i>	<i>\$38,938,126</i>	<i>\$9,852,293</i>	<i>\$368,487,585</i>
<u>Families</u>										
Community-defined Homeless	825	-	-	175	500	150	\$ 1,662,120	\$ 5,725,080	\$ 1,237,356	\$ 51,267,168
Extremely Low-Income & Living with HIV/AIDS	661	-	-	136	400	125	1,332,742	4,590,554	992,152	41,107,674
Extremely Low-Income & Living with Mental Illness	2,036	-	-	236	1,400	400	4,102,414	14,130,536	3,054,019	126,536,673
<i>Subtotal Existing Housing - Families</i>	<i>3,522</i>	<i>-</i>	<i>-</i>	<i>547</i>	<i>2,300</i>	<i>675</i>	<i>\$ 7,097,275</i>	<i>\$24,446,171</i>	<i>\$5,283,527</i>	<i>\$218,911,516</i>
Total Use of Existing Housing	10,091	700	3,600	2,816	2,300	675	\$21,255,343	\$63,384,297	\$15,135,820	\$587,399,101
Housing Production (1/3 of total) (Acquisition and Substantial Rehab or New Construction)										
<u>Individuals</u>										
Homeless Youth and Young Adults (to Age 24)	163	25	100	38	-	-	\$ 694,967	\$ 1,023,051	\$ 33,200,080	\$ 11,923,046
HUD-defined Chronically Homeless	621	75	350	196	-	-	4,141,500	5,835,750	129,094,000	69,242,115
Community-defined Homeless	530	150	250	130	-	-	2,087,842	3,485,089	105,197,734	38,676,142
Extremely Low-Income & Living with HIV/AIDS	603	25	350	228	-	-	1,645,115	2,836,206	128,770,076	31,100,361
Extremely Low-Income & Living with Mental Illness	1,318	75	750	493	-	-	5,588,645	8,662,399	280,157,609	98,902,244
<i>Subtotal Housing Production - Individuals</i>	<i>3,235</i>	<i>350</i>	<i>1,800</i>	<i>1,085</i>	<i>-</i>	<i>-</i>	<i>\$14,158,068</i>	<i>\$21,842,495</i>	<i>\$676,419,499</i>	<i>\$249,843,907</i>
<u>Families</u>										
Community-defined Homeless	406	-	-	81	250	75	\$ 1,662,120	\$ 1,908,360	\$ 113,511,040	\$ 24,779,131
Extremely Low-Income & living with HIV/AIDS	326	-	-	63	200	63	1,332,742	1,530,185	91,187,507	19,868,709
Extremely Low-Income & Living with Mental Illness	1,003	-	-	103	700	200	4,102,414	4,710,179	284,674,940	61,159,392
<i>Subtotal Housing Production - Families</i>	<i>1,735</i>	<i>-</i>	<i>-</i>	<i>247</i>	<i>1,150</i>	<i>338</i>	<i>\$ 7,097,275</i>	<i>\$8,148,724</i>	<i>\$489,373,487</i>	<i>\$105,807,233</i>
Total Housing Production	4,970	350	1,800	1,332	1,150	338	\$21,255,343	\$29,991,219	\$1,165,792,986	\$355,651,140
Total Production and Use of Existing Housing	15,061	1,050	5,400	4,148	3,450	1,013	\$42,510,686	\$93,375,515	\$1,180,928,806	\$943,050,241

The cost assumptions utilized in creating *Table 7* follow. Please note that all estimates are stated in 2005 dollars and have not been adjusted for inflation.

1. **Per unit capital development costs for rental housing production:** Capital costs for the production of affordable housing in Alameda County vary widely. This estimate assumes total development costs ranging from \$160,000 for a studio apartment to \$320,000 for a three- or four-bedroom unit. This estimate assumes that approximately one-third of all capital development financing will come from local government sources. State and federal programs, local lending, and private contributions will make up the balance.

New construction is often the most cost-effective means for creating supportive housing, especially when local governments are able to help nonprofit developers locate and secure additional sources of subsidy. The acquisition and rehabilitation of existing housing can be less costly than new construction, but depending on the location, condition, and configuration of the building and attractiveness of the neighborhood, it can also be equally expensive.

Investing in the development of permanently affordable housing owned by nonprofit organizations means that these units will be permanently affordable to people in need, regardless of future changes in the housing market or in resources available for affordable housing. Making deep capital investments in construction or acquisition and rehabilitation of permanently affordable housing reduces the amount of ongoing operating subsidies needed by the project, by reducing the debt needed. Even with deep capital investment, however, subsidies of operating costs or tenant rents will be needed for the life of the project when residents' incomes fall below 30% of the area median, which is the case for virtually all of the people targeted by this plan.

2. **Per unit capital development costs for master leasing** are estimated at \$3,000 per unit for modest repairs and accessibility accommodations.
3. **Annual operating cost subsidies** are estimated to be \$6,200 per unit per year. Please note, however, that this represents only the operator's costs. In the case of master-leased or other private-market units, the actual rental amount could be as much as double, based on unit size, age, amenities, and location. Tenant households are projected to pay 30 percent of their adjusted gross household income, the standard payment formula for Section 8 and supportive housing properties. These additional rental subsidies will have to come from a combination of local, state, and federal sources, such as the Housing Choice Voucher program (Section 8), which is administered by local public housing authorities, and the Shelter Plus Care program, which is administered by Alameda County Housing and Community Development, local city governments, and some housing authorities.
4. **Annual support services costs** are estimated to range from \$2,000 to \$6,000 per year for individuals and \$3,000 to \$9,000 for families, based on the level of services required on site. These estimates were derived from the experience of local area supportive housing providers and the Corporation for Supportive Housing.

This chapter of the *Alameda Countywide Homeless and Special Needs Housing Plan* presents permanent housing goals for the target populations and outlines the estimated costs to ensure housing stability for more than 15,000 of the Alameda County's most vulnerable citizens.

Supportive housing is a key strategy, and both existing and newly constructed units of various sizes will be needed to meet the needs of individuals and families. Due to the high costs of housing in the Bay Area, the vast majority of these units will be found in the private rental market, and will require long-term rent subsidies to assure affordability.

End Note: A New Beginning

The *Alameda Countywide Homeless and Special Needs Housing Plan* represents the culmination of a year of unprecedented communication and collaboration between systems, organizations, and jurisdictions. Despite past successes in Alameda County, planning participants acknowledge that continuing on the same path will not make ending homelessness possible. This plan itself, though, is only the beginning. In order to achieve the goals of this plan, these partnerships and the innovations they represent must continue.

Ending homelessness and reducing housing instability for extremely low-income people living with serious and persistent mental illness and/or HIV/AIDS will be accomplished through actions in support of this plan's five major goals:

- **Preventing homelessness and other crises.** Discharge from public institutions, such as hospitals and prisons or aging out of foster care, is the most predictable and frequent entry point into homelessness. Building on existing public sector involvement, implementing systems-wide discharge-planning guidelines, and ensuring housing availability upon exit will all significantly reduce future homelessness.
- **Increasing housing opportunities for the plan's target populations.** The costs of securing 15,000 units of affordable housing will be significant; the estimated total cost to eliminate homelessness for our County's most vulnerable populations is \$2.1 billion. Only one-third of these resources need to come from local sources; even so, realizing this vision will require new resources and new players.
- **Delivering flexible services to support stability and independence.** Culturally competent, coordinated support services must accompany housing; for some, access to clinical services will also be important. Direct service providers in all systems throughout the county must have a "no wrong door" philosophy and a degree of knowledge about—and immediate access to—a range of housing resources and complementary support services.
- **Measuring success and reporting outcomes.** Evaluating outcomes will allow systems and agencies to identify successful programs and target resources toward best practices.
- **Establishing a countywide leadership structure** to guide implementation of the plan will ensure that momentum for the plan's implementation is sustained over the fifteen years of effort that will be required to achieve these goals.

To accomplish this plan's ambitious goals, however, many new partners will also be needed. **Every person in Alameda County is invited to help make a difference** in ending homelessness by contributing their time, money, or support. Every contribution, no matter the size, will positively impact our community. The people of Alameda County can look forward to the day when each of us has safe, appropriate, and affordable housing.

Alameda Countywide Homeless and Special Needs Housing Plan

Action Plan (2006–2007)

April 2006

Prepared for and jointly funded by:

Alameda County Behavioral Health Care Services
Alameda County Housing and Community Development Department
Alameda County Public Health Department Office of AIDS Administration
Alameda County Social Services Agency
Alameda Countywide Homeless Continuum of Care Council
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Action Plan (2006–2007)

This is the first time that any County or State has developed a comprehensive and integrated housing and service plan for people who experience homelessness and/or are living with serious and persistent mental illness and/or HIV/AIDS. Realizing the vision outlined in this plan—ending chronic homelessness and reducing housing crises for extremely low-income people who are precariously or inappropriately housed—is going to require sustained and coordinated efforts on the part of multiple jurisdictions and service delivery systems.

The creation of an integrated, regional response offers a number of measurable, outcome-oriented alternatives to the current model. Alameda County has a history of collaborative efforts, but until now they have been focused primarily at the consumer or provider level—not the systems level. Making adjustments and changes at the systems level will require active participation by top community leaders and government representatives. Moving towards this preferred future requires that elected officials, as well as civic, business, and faith leaders recognize and commit to a regional approach that will include such outcomes as:

1. **Increased efficiency and effectiveness** of local and regional housing and supportive service programs through sharing of information, planning, clients, resources, and responsibility across the multiple systems that must work together to address common issues.
2. **More coordination** of government and philanthropic funding. National research has demonstrated that an integrated approach to long-term homelessness can significantly reduce expenditures on emergency medical and other services.
3. **Increased local capacity to attract competitive grants** from federal, state, and philanthropic sources that can augment existing housing and service systems and support the replication of emerging promising practice models.
4. **Increased public interest and support for creative solutions** to homelessness, excitement about and involvement in regional efforts, and willingness to support the creation of a new local or regional revenue stream for supportive housing.

2006–2007 ACTION STEPS: LEADERSHIP

For the first period of plan implementation, the top priority must be initiating the formation of long-term coordinated leadership. Developing an appropriate leadership structure and building momentum with collaborative work at the systems level are the necessary first steps toward implementing the rest of the plan's recommendations.

Leadership Objective L-1 proposes creating an Interim Leadership Structure that can engage and consult with the many partners who will be critical to the plan's ultimate success and immediately initiate plan implementation. Specifically:

- The Sponsoring Agencies will determine a host agency for, garner the necessary resources, and hire staff for implementation activities.
- The Sponsoring Agencies, with staff support, will recruit and convene an Advisory Committee that will begin meeting quarterly to help refine the implementation plan and, specifically, to develop the Governing Board for the plan's long-term implementation and oversight.
- Simultaneously, the staff lead will work with the Sponsoring Agencies and interested stakeholders to design the Consumer Advisory process.
- The key management-level liaisons from each major system will develop joint agreements for addressing service delivery system recommendations and overall plan implementation.
- The Interim Leadership and staff will identify major barriers to implementing plan recommendations and develop short- and long-term strategies to address them.
- The Interim Leadership and staff will develop an action plan for the next two- to three-years. Establish a schedule and process for developing updated action plans through the period of plan implementation. Action plans will identify areas where progress has been made and where more attention is needed.

2006–2007 ACTION STEPS: PREVENTION

Homelessness prevention is a primary goal of this plan because it is both the most humane and the most cost-effective approach to achieving the plan’s vision of an integrated system that ensures that individuals and families are safely, supportively, and permanently housed and provides appropriate services in a timely fashion to all who need them.

Prevention Strategy P-1-A establishes a “no wrong door” policy—meaning that information on all systems will be available from many points of access 24 hours a day and that assessment and referral for appropriate housing and services are available throughout the county. With full implementation of this strategy, an individual or family nearing crisis would be able to obtain the information or assistance they needed to remain in their housing and stabilize their household.

Action steps in 2006–2007 for **Sponsoring Agencies** include:

- Creating a complete inventory of current, relevant information systems.
- Mapping all related services in the county in the three systems.
- Comparing existing housing and service referral protocols and materials and identifying areas for standardization.
- Assessing the physical accessibility of points-of-access for information, referral, assessment, and services and where people experience barriers to finding or receiving assistance.

Prevention Strategy P-1-C calls for the **Sponsoring Agencies** to work toward increasing consumer enrollment in Supplemental Security Income (SSI), Medi-Cal, Food Stamps, and other mainstream programs among those who are eligible. Full utilization of benefits will increase the incomes of eligible households and, thereby, stabilize their housing and help prevent homelessness and other financial crises.

Action steps for 2006–2007 include:

- Initiating collaboration with the Social Security Administration and other mainstream systems regarding the assessment and enrollment in existing benefits programs. The focus will be on people who are homeless and have disabilities.
- Exploring strategies to increase and expedite enrollment used in other communities, such as Columbus Ohio’s expedited process for participants in the Rebuilding Lives Initiative, serving chronically homeless people.
- Documenting the best practices that benefits specialists in different parts of the system already use. Creating training protocols and reference materials that disseminate these practices to all caseworkers and benefits advisors throughout the various systems.

Prevention Strategy P-3-A discusses the **Sponsoring Agencies** convening the key policymakers and administrators that are responsible for discharge planning in each system—including hospitals, foster care, the courts, and incarceration—to collaborate on assuring that people do not become homeless upon exiting the system.

Action steps for 2006–2007 include:

- Identifying key participants in each system and establishing relationships.
- Beginning negotiations to increase access and engagement for community-based case managers, starting by identifying the optimal timing in each institution for pre-release or pre-discharge planning and coordination with by community-based providers.
- Initiate discussion of standard discharge protocols that result in people having stable, affordable places to live upon exit.

2006–2007 ACTION STEPS: HOUSING

One of the primary objectives of this plan is to create safe, decent, and affordable housing options for both individuals and families experiencing homelessness and extremely low-income people living with serious and persistent mental illness and/or HIV/AIDS who are inappropriately or precariously housed. This plan has a goal of creating more than 15,000 units of housing over fifteen years—ambitious, but achievable if approached systematically and with the full endorsement of jurisdictions and key community leaders throughout the county.

A number of interventions have been demonstrated, both locally and nationally, that successfully assist people in becoming and staying stably housed and improving their quality of life. These approaches bring together multiple systems, combine services and housing in new ways, and emphasize the importance of permanent housing options that are affordable to households with extremely low incomes. Ensuring affordability for those with extremely low or no income requires project-based rental subsidies; and assuring access to adequate supportive services, either on- or off-site, is essential to the effort to eliminate and prevent homelessness.

Strategy H-1-A calls for the **Sponsoring Agencies** to work with jurisdictions throughout the county to target local, state, and federal housing funds to extremely low-income, vulnerable populations at or below 30 percent of area median income (AMI) and particularly below 15 percent of AMI.

2006–2007 action steps include:

- Exploring mechanisms for coordinating and pooling supportive housing development, operating, and services resources—examples include the Oakland Pipeline Committee and the Community Shelter Board’s Rebuilding Lives Funder Collaborative in Columbus, Ohio.
- Determining the amounts within existing housing programs, especially Community Development Block Grant (CDBG) and the HOME program, that could be made available for this purpose.

Strategy H-1-B encourages collaborations among **jurisdictions and developers** to explore mechanisms for coordinating and pooling funds for supportive housing development, operations, and services.

2006–2007 action steps include:

- Exploring pilot jointly funded supportive housing developments, such as for youth transitioning out of foster care.

Strategy H-3-B underscores the necessity of establishing a state Housing Trust Fund to assure an ongoing stream of state funds for the development, operations, and preservation of appropriate and affordable housing options for this plan’s target populations.

2006–2007 action steps for **all stakeholders** include:

- Ensuring that Alameda County housing and services organizations are informed and engaged with the Housing Trust Fund campaign, “Homes 4 California,” which is gearing up for a ballot measure in 2006.
- Advocating for inclusion of development and operating funds for units at the targeted income range.

Strategy H-4-E proposes analyzing innovative and successful supportive housing models in other communities in greater detail and determining how they can be implemented in Alameda County. People with co-occurring mental illness and substance use issues, or other multiple disabilities, would benefit from new models that emphasize earlier access to permanent supportive housing.

2006–2007 action steps for **Sponsoring Agencies and other interested stakeholders** include:

- Researching evidence-based practices and lessons learned in other communities—such as San Francisco’s Direct Access to Housing Program, Philadelphia’s Safe Havens model, and Los Angeles-based Beyond Shelter’s housing-first model for families—and bringing those models and lessons to the table in Alameda County.
- Working closely with Alameda County Behavioral Health Care Services (BHCS) as they plan for and implement new housing activities funded through the voter-initiated 2004 Mental Health Services Act.

2006–2007 ACTION STEPS: SERVICES

A primary objective of this plan is to deliver flexible services to support residents' stability and independence. In so doing, the Sponsoring Agencies want to bridge the historical division between housing and service systems, and to seek innovative ways of combining resources in order to more effectively serve populations in need. Local innovations will build on successful interdisciplinary programs in Alameda County, and elsewhere, that have proven to stably house and increase the quality of life for many people. They will be based on the recognition that the homeless, mental health, and HIV/AIDS systems serve people with many similar needs, and in many cases, the same individuals.

The entire system should be accessible and responsive to all who are in need of assistance, regardless of how, when, or where they first enter the system; regardless of their age, culture, language, or disability; and regardless of their changing needs. Services should be consumer-centered, building on each consumer's strengths toward their own wellness and recovery goals rather than the needs of the service delivery system.

Strategy S-1-A advises creating a substance abuse detoxification facility in Alameda County and connecting this facility to appropriate treatment and housing opportunities. Plans to undertake this effort are substantially underway under the leadership of BHCS.

2006–2007 action steps for **Sponsoring Agencies** include:

- > Ensuring that the resources and endorsements necessary to complete this much-needed facility are available to expedite its operations
- > Assessing opportunities to link the detox facility with appropriate supportive housing, looking at models in other communities.

Strategy S-1-D, Strategy S-2-C, and Objective S-4 all are related to building the capacity and competence of community-based organizations in Alameda County to implement the housing and services work under this plan, including managing the complex requirements of multiple funding sources. Support will also be needed to assist community-based organizations in transitioning their focus from managing homelessness to ending it. Implementing the plan's strategies and achieving the goals of a seamless system will require a close partnership between government and community-based agencies.

2006–2007 action steps for **all stakeholders** include:

- Gather information on current outcomes and performance along with organizational capacity building needs related to data, financial and record-keeping infrastructure, and program management and oversight from community-based organizations, starting with those receiving funding from the HUD Supportive Housing Program. This should include collection and review of findings and/or other documented correction issues from funding or regulatory agencies, analysis of Annual Progress Reports for outcome and performance information, and other information to develop a summary of capacity building needs for each organization and to flag system-wide capacity issues.
- Compile and analyze this data and use it to design the capacity building program and identify best practices. The capacity building program is likely to include establishing a set of shared system-wide outcomes and objectives, organizational self and external assessment tools, development of materials and/or a ‘tool kit’ to assist organizations in developing capacity, and structured training and technical assistance sessions.
- Coordinate this broad organizational capacity building work with program-specific HUD training and technical assistance to be provided in conjunction with the release of HUD’s revised Desk Manual for the Supportive Housing Program.

2006–2007 ACTION STEPS: MEASURING SUCCESS AND REPORTING OUTCOMES

In order to identify successful approaches and target resources toward best practices, it will be essential to track consumer and program data and regularly analyze outcomes. Outcomes should focus on real change in people’s lives, and be meaningful, measurable, and realistically within the capacity of both the providers and consumers to achieve. In addition, systems and programs should be regularly assessed through collecting and analyzing data that measures effectiveness and efficiency in achieving stated outcomes.

Strategy M-1 recommends the coordination of data tracking and outcome measurement between systems. Because each system is in the process of upgrading or adding new functionality in its data collection system, now is the time to coordinate data collection and reporting and address the many practical and ethical considerations, as well as legal restrictions, regarding how confidential information is recorded and shared. Coordination will need to be phased in.

2006–2007 action steps for **key management-level liaisons from each major system** include:

- Developing a comprehensive understanding of data collection systems, reporting requirements, and ability to report on the same client-level data in the same way.
- Collaborating to develop memoranda of understanding between systems that outline work plans and time lines for establishing common data definitions and reporting functions.
- Establishing baseline data from which future changes will be measured.
- Identifying potential outcomes that are meaningful and measurable, reasonably within the systems’ ability to influence them, and consistent across systems.