An aerial photograph of the Los Angeles skyline at sunset. The sky is a mix of orange, pink, and light blue. The city buildings are silhouetted against the sky, with the tallest building, the US Bank Tower, standing out prominently in the center. The overall tone is hazy and atmospheric.

# **AN ASSESSMENT OF LOS ANGELES COUNTY'S EMERGENCY SHELTER SYSTEM**

**Prepared by  
Shelter Partnership, Inc.**

**For the  
County of Los Angeles**

**August 2005**

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## **I. EXECUTIVE SUMMARY**

### **A. Background**

Beginning in the late 1980's, the Los Angeles region expanded its focus and commitment in the establishment of emergency shelters. Largely the result of the highly publicized deaths of several homeless individuals during the inclement weather months, a system was created to add several hundred and ultimately nearly 2,000 additional shelter beds in the winter months. The emergency shelter system is an integral part of the Continuum of Care, as defined by the U.S. Department of Housing and Urban Development (HUD), which includes prevention, outreach, assessment, emergency shelter, transitional housing, permanent affordable housing, permanent supportive affordable housing, and supportive services.

In 2003, the City of Los Angeles increased its funding to expand the Winter Shelter Program toward a year-round shelter system, converting many of the shelter beds to year-round, largely overnight beds. A year later, the Los Angeles County Board of Supervisors attempted to do the same and chose to add an additional component that would provide shelter 24 hours a day, seven days a week (i.e., 24/7). However, when the Los Angeles Homeless Services Authority (LAHSA) requested interested sponsors to apply to operate these programs, few responses were forthcoming.

Concurrently, the County was also exploring applying underutilized funds from the County's Department of Public Social Services (DPSS) General Relief Emergency Housing Voucher program to the LAHSA-administered emergency shelter system. During 2004, an average of 15.4% of the applicants for General Relief, or 24,214 individuals, requested a program voucher. However, emergency voucher utilization rates are down, resulting in \$1.3 million in unspent funding.

### **B. Purpose of the Assessment**

In light of these policy concerns, the County of Los Angeles commissioned Shelter Partnership in January 2005 to provide them with an assessment to address the following items:

- challenges associated with developing emergency shelters throughout the County;
- the integration of the GR Emergency Housing Voucher program and the LAHSA-administered emergency shelter system; and
- improvements and enhancements needed in the emergency shelter system and the Continuum of Care, with particular focus on regional and subregional needs.

As far as we are aware, this is the first comprehensive study on the emergency shelter system that the County has undertaken.

## **C. The Emergency Shelter System in Los Angeles County**

LAHSA has administered the Winter Shelter Program (WSP) for the past 10 years, but it was not until 2001 that additional social services were added to the program. With a high tolerance program design, the WSP generally does not require clients to follow certain programmatic rules, other than those standards necessary to ensure the safety of all clients and an alcohol and drug-free environment.

In 2004-2005, there were eight WSPs with 928 beds and eleven Year Round Programs (YRPs) with 899 beds. Yet, throughout Los Angeles County, there are 116 emergency shelters with 5,240 emergency shelter beds. This study provides a breakdown of these beds by supervisorial district, as follows:

- District 2 has the most number of shelters with 44 programs, accounting for 38% of the emergency shelters and 39% of all emergency shelter beds.
- Following the Second District is Supervisorial District 1, with 26 shelters with 22% of the countywide emergency shelter programs and 24% of all emergency shelter beds.
- District 3 has 20 shelters with 17.2% of all emergency shelter programs and 13.7% of all emergency shelter beds.
- District 4 has 16 programs, or 13.8% of all programs and 15.3% of all beds.
- District 5 has 10 emergency shelter programs, comprising 8.6% of all programs and 8.2% of all beds.

One central point of access for the emergency shelters is the 11 Access Centers, which are primarily funded by LAHSA, but also by the cities of Glendale and Long Beach. In 2004-2005, 26.6% of Access Center clients were referred to emergency shelters. Another potential referral source is the more than 20 outreach teams in Los Angeles County. The LAHSA-operated Emergency Response Team is the largest, and contacts between 350 to 400 unduplicated homeless people monthly despite no formal linkages with the emergency shelters.

## **D. Populations Served in Access Center, Winter Shelter, and Year Round Programs**

### **1. Countywide**

#### **a. Demographics**

The most recent program reports for the Access Center, Winter Shelter, and Year Round programs indicate that 29,472 people were served annually, although this number likely includes duplicate clients. The data includes 12,112 Access Center participants, 8,045 WSP clients, and 9,315 YRP clients.

Of the WSP and YRP clients, about two-thirds are male, however, males comprise only about 52% of the Access Center clients. The majority of participants in the WSP and

YRP were 24-44 years old (58.2% and 60.9%, respectively). The same is generally true for the Access Center participants, where 54.1% of the client population is 31 to 50 years old.

The data on clients' income sources show a large proportion of shelter clients with no income at all (39.3% and 31.5%, respectively). Approximately 25% of the shelter clients receive disability insurance or pension benefits and 5% of the shelters' population is comprised of individuals who are employed.

General Relief benefits accounted for the income of 22.3% of the population. Of the percentage of participants reporting that they no longer received General Relief, 51.2% indicated that this was because of receiving a sanction from the county.

### **b. Special Needs**

Although different categories were used to report the prevalence of special needs populations in the Access Centers and shelters, some comparisons can be made. In general, the shelter providers reported larger proportions of clients with special needs. Almost half (46.5%) of the WSP and YRP clients either have a substance abuse problem (18.7%) or a co-occurring disorder (27.8%). Substance abuse is also prevalent in the Access Centers with 15.5% of clients struggling with alcohol abuse and 25.4% with drug abuse.

The providers estimate that 51.7% of their clients have a mental illness (23.9% with a mental illness only and an additional 27.8% with a co-occurring disorder), whereas the Access Centers report that 19.7% of their clients are mentally ill.

The WSP and YRP providers estimate that 18.1% of their clients have a chronic health condition, while the Access Centers report that 13.1% of their clients have a physical disability.

### **c. Experiences**

The most common prior living situation for both shelter and Access Center participants is the street (34% to 40.3%). However, this figure is down from a high of 54.2% of emergency shelter participants in 2001-2002 who identified the streets as their most recent living situation.

An additional 14.3% to 16.7% of clients had previously lived with friends/relatives and 10.8% to 13.8% were living in rental housing prior to becoming homeless.

The shelters report that 10.6% to 12.6% of their clients enter directly from institutional care, with approximately 4% coming from jail or prison and 1.8% to 2.5% coming from the hospital.

Also of note, 15.2% of the emergency shelter participants most recently came from another emergency shelter, which may indicate that there are inadequate permanent and transitional housing opportunities.

## **2. District-specific Analyses**

### **a. District 1 (Molina)**

- Females comprised more than six of ten Access Center clients, and nearly two-thirds (65.8%) in Boyle Height's Access Center;
- A significant percentage of Access Center clients (33.5%) were under the age of 30, including 41% of Boyle Height's clients;
- On average among WSP and YRP clients, 19% have a mental illness (only), 15% a substance use disorder (only), and 22% are affected by co-occurring disorders;
- Thirty-eight percent (38%) of Access Center clients reported some form of independent housing as their most recent living situation, greater than any other situation;
- Two emergency shelter providers, East San Gabriel Valley Coalition for the Homeless and SRO Housing Corporation, report large numbers of recently incarcerated clients (14% and 13%, respectively), far more than reported countywide (4%); and
- Placements from Access Centers into emergency shelters (14%) are close to one-half the countywide norm (27%).

### **b. District 2 (Burke)**

- Nearly one-quarter (24.6%) of Access Center clients are over the age of 50. Moreover, one provider reported that more than 7% of its client population is over the age of 62;
- Two-thirds of WSP and YRP clients have either a substance use disorder, mental illness, or both;
- Close to six in ten WSP and YRP clients are coming from the streets, including at least 85% of the clients in three programs; and
- On average, more than one-third (35.4%) of Access Center clients are placed into transitional housing programs, while one-fifth (21%) are able to obtain an emergency shelter bed.

### **c. District 3 (Yaroslavsky)**

- Some 40% of shelter users are considered to have a substance abuse disorder only;
- Access Center clients most notably identify emergency shelters (41%) as their most recent living situation;
- Twice as many Access Center clients are leaving substance abuse facilities than reported countywide;

- Sixty-six percent (66%) of incoming shelter participants are leaving other emergency shelters, roughly four times the average across the county; and
- More than one-half (54%) of clients receiving Access Center services report emergency shelters as their destination, which is double the countywide average. At the same time, only 6% move into transitional housing.

#### **d. District 4 (Knabe)**

- With the exception of alcohol abuse, Access Center clients in District 4 are less likely to report special needs in comparison to other districts in the county;
- Nearly two-thirds (65.4%) of Access Center clients identify the streets as their most recent living situation prior to receiving program services;
- Only 11% of these clients report leaving some form of independent housing, in contrast to nearly 30% of the Access Center clients countywide; and
- Though a significant percentage (40%) of Access Center clients on average report leaving the program for destinations unknown, certain providers in this region report above-average placement rates into permanent (subsidized and non-subsidized) housing and emergency shelters.

#### **e. District 5 (Antonovich)**

- The number of females among Access Center clients (60%) is akin to District 1 and is noticeably higher than what was reported countywide (48%);
- Interestingly, 18% of the clients receiving services through Antelope Valley's Access Center live with a developmental disability;
- Across all shelter programs, at least one-fifth of clients are considered to have either a substance abuse disorder only (20%), a mental illness only (25%), or live with a co-occurring disorder (26%);
- Overall, the percentage of Access Center clients leaving some form of independent housing is high (39%), which includes 26% of the overall clientele identifying rental housing as their most recent living situation;
- Lancaster's YRP reports an extremely high level of clients (60%) leaving other emergency shelters, as well as jail or prison (10%);
- Three-quarters of the clients in Santa Clarita's WSP left some sort of independent housing, including 70% from friends/relatives, prior to entering the shelter;
- This district has shown some success in assisting their Access Center clients to obtain (or remain with) their own permanent housing arrangements, particularly a non-subsidized unit (8%) or with family or friends (8%). In comparison to the county, however, fewer clients are able to access transitional housing (11%) or emergency housing (19%).

### **E. Winter Shelter Program Trends**

In the last five years (from 2000-2001 to 2004-2005), there has been a decrease in the proportion of WSP participants who were homeless for seven to 12 months, from 41.1%

to 16.6%. However, during the same period the proportion of persons homeless for 12 months or longer was about the same, at 24.4% and 24.7%, respectively.

## **F. Barriers to Care**

### **1. Siting**

Some federal and state laws, including the Federal Fair Housing Act and The California Fair Employment and Housing Act, require that individuals with disabilities receive fair housing protections. Furthermore, the Federal Americans with Disabilities Act, Title II, prohibits discrimination against individuals with disabilities by state and local governments.

California Housing Element Law requires local cities and counties to adopt a general plan that includes a housing element. The housing element must include an analysis of any special needs housing, including families and persons in need of emergency housing as well as a review of potential and actual governmental constraints for persons with disabilities. Beginning in 2002, local governments must develop a program to remove such identified constraints or provide reasonable accommodations. Most housing elements in Los Angeles County will need to be submitted to the State in 2007.

Unfortunately, practice has not kept up with legislation, making it very difficult for providers to develop emergency housing for the population. Additionally, there is a dearth of long-term funding for these new programs.

Only two jurisdictions, the City and County of Los Angeles, explicitly allow emergency shelters by right in specific zones. Across the county, twenty-five jurisdictions (28%) require a conditional use permit, which necessitates a public hearing, a delay of anywhere from a few to several months, often the payment of a significant fee, and the imposition of conditions on their operation. In addition, 61 cities, or more than two-thirds of all local jurisdictions in Los Angeles County, make no provision for emergency shelters or transitional housing in their zoning ordinances.

### **2. Service Variation**

The delivery of emergency shelter services varies considerably. As currently operated, the emergency shelter system appears more like a patchwork of different programs and service philosophies than a coordinated and efficient entry point into the network of services and housing known as the Continuum of Care. The types of services available vary considerably, at least through the WSP and YRP contractors, as do the manner in which case management services are offered and the ratio of case managers to clients. Of particular concern, 75% of the YRP providers indicated a lack of formal linkages with transitional housing and/or permanent housing providers.

### **3. Data Collection**

There is arguably no more useful a tool for public systems of care than reliable and comprehensive data. As part of this study, Shelter Partnership reviewed various data sets collected from LAHSA and the many emergency shelter providers, the bulk of which is offered and analyzed in Section III.G. Upon reviewing these data reports, two general themes began to emerge: (1) the information that is being collected is not being analyzed sufficiently; and (2) there are many questions about these programs left unanswered because contractors have not been asked to record, track, or submit certain data.

The disparities surrounding what information is tracked or not reiterates the need for the emergency shelter system to establish clear goals and expectations for its contractors, with measurable outcomes tied to performance.

### **4. Client Specific**

Unlike the barriers described above, which are more systemic in nature, there are other barriers that are more unique to the clients and play an important role in their ability to access emergency shelter, achieve stability once placed there, and move forward through the Continuum of Care. These homeless subpopulations, which are later described in greater detail, include the chronically homeless, individuals with mental illness, individuals with substance use disorders, individuals with co-occurring disorders, women, families, veterans, and parolees.

### **G. Best Practices**

Shelter Partnership reviewed ten jurisdictions around the nation to identify best practices that might prove helpful to Los Angeles' Continuum of Care and its emergency shelter component. These jurisdictions included Boston, Chicago, Columbus, El Paso, New York, Philadelphia, Portland, San Francisco, San Jose, and Washington D.C.

Many of these jurisdictions have adopted a "Housing First" approach, which is an attractive strategy. However, the sheer size of the homeless population in Los Angeles and the extent of chronic homelessness create serious challenges to fully implementing such a strategy. A number of our recommendations on rental assistance, services that need to be offered, length of stay in shelters, the need for clinical staff, and more have been implemented in these jurisdictions.

### **H. General Relief Emergency Housing Voucher Program**

The report finally evaluates the feasibility of leveraging existing County Department of Public Social Services (DPSS) General Relief Emergency Housing Voucher program funding with resources allocated to the LAHSA-administered emergency shelter program.

The GR program serves as the final government safety net for individuals facing extreme poverty. GR applicants who identify as homeless are provided with an emergency housing voucher generally for one to 14 days. DPSS contracts with both shelters and vendor hotels to provide as many as 1,342 emergency housing beds throughout the county. Nonetheless, there is a significant lack of beds in certain communities, including the Antelope Valley and the East San Gabriel Valley.

The study reviews the respective program requirements of both the GR Emergency Housing Voucher program and LAHSA's WSP and YRP programs, with specific focus on length of stay, bed access, hours of operations, referral process, reporting process, client/population needs, rates of reimbursements, and lack of capacity.

## **I. Recommendations**

Based on the above analyses and subsequent findings, this study offers numerous recommendations on how to improve and expand the emergency shelter system and the Continuum of Care. Generally, the recommendations address the need for increased financial investment, leadership, and system enhancements.

The recommendations are organized into six general focus areas, as follows:

- Integration of the General Relief Voucher Program
- Siting of Emergency Shelters
- Development Strategies for Emergency Shelters
- Oversight, Standardization and Services in Emergency Shelters
- Development of Affordable, Permanent Housing
- Data Collection and Analysis.

The recommendations are also divided according to three time frames in which they should be implemented: (1) short-term (can be done in six months or less); (2) medium-term (can be done in six to 18 months); or (3) longer-term (will take 18 months or longer).

## II. INTRODUCTION

In 2004, the Los Angeles County Board of Supervisors made available \$2.5 million in general funds to expand and enhance the Los Angeles Homeless Services Authority (LAHSA)-administered emergency shelters to operate as a year-round program and to be modified from an overnight program to one that would be open “24/7.” At that time, county officials became concerned as there were so few applications to operate these year-round programs.

Concurrently, there were discussions with the County’s Chief Administrative Office (CAO), the County Department of Social Services (DPSS), the LAHSA, and others about the possibility of transferring \$1 million in underutilized funding from DPSS to LAHSA for emergency shelter use. This funding had been set aside originally under the General Relief (GR) Emergency Housing Voucher program, which assists homeless applicants who are waiting approval to receive General Relief.

These issues led to the commission of this study by Shelter Partnership to evaluate the barriers to the development of emergency shelters and the feasibility of using DPSS resources for the emergency shelter system. Additionally, Shelter Partnership was requested to evaluate how well the emergency shelter system was operating and make recommendations for improvements.

This study was undertaken from February 1, 2005 to May 31, 2005. It involved interviewing the LAHSA team that administers the program, as well as securing and analyzing several sources of data collected by LAHSA, including information on the LAHSA-funded Year Round Programs (YRPs) and Winter Shelter Programs (WSPs) and the Access Centers. (Shelter Partnership also secured information from the cities of Glendale and Long Beach, as this project was a countywide planning effort.) LAHSA staff also helped sponsor a focus group with their emergency shelter providers so that we could learn directly from the providers their opinions on the program. Shelter Partnership also conducted surveys of the providers, conducted site visits, and engaged in extensive follow-up conversations. We held six focus groups with YRP participants at two of the emergency shelters to learn directly from participants about their program impressions.

We interviewed key staff at all of the board offices to learn about their perceived interests and also updated them monthly on our progress. Through these interviews, the staff members also identified other key informants for us to interview.

To learn more about the practices for permitting the siting of emergency shelters of the 89 local jurisdictions in the county, we reviewed all of the housing elements that had been submitted to the California Department of Housing and Community Development (HCD). In some cases, we followed up that effort with personal interviews and a review of their respective zoning ordinances.

Finally, we reviewed the 10-Year Plans to End Homelessness and other written materials and conducted interviews of ten other metropolitan areas in the nation to discern best practices that could inform this effort.

The emergency shelter system is an integral part of the community's Continuum of Care, which includes prevention, outreach, assessment, emergency shelter, safe havens, transitional housing, permanent supportive housing, permanent housing, and supportive services. As far as we are aware, this is the first comprehensive assessment of the emergency shelter system. This system experienced its first major expansion in the late 1980's when it came to the attention of our community that people were dying on the street because of exposure to inclement weather. Additional beds were brought on-line to address this issue by both the city and the county. In fact, a major impetus for the creation of the Joint Powers Authority (JPA) was the integration of the city and county's Winter Shelter Program.

The report is comprised of five sections. Section III includes a review of the County of Los Angeles' Emergency Shelter System, including an analysis by supervisorial district of emergency shelter beds and programs, as well as an analysis of populations by supervisorial district served by Access Centers, WSPs, and YRPs. Section IV reviews various barriers to care, including siting constraints as well as client-specific challenges. Section V is a review of how other regions are addressing this challenge and innovations that might inform Los Angeles' efforts. Section VI contains an analysis of the county's General Relief Emergency Housing Voucher program and how it can be integrated with the LAHSA –funded emergency shelters.

The last chapter contains the recommendations and are identified as to whether they are short-term (can be done in six months or less); medium-term (can be done in six to 18 months), or longer-term (will take 18 months or longer). The recommendations are organized as follows:

- Integration of the General Relief Voucher Program
- Siting of Emergency Shelters
- Development Strategies for Emergency Shelters
- Oversight, Standardization and Services in Emergency Shelters
- Development of Affordable, Permanent Housing
- Data Collection and Analysis

### III. THE COUNTY OF LOS ANGELES EMERGENCY SHELTER SYSTEM

#### A. Emergency Shelter and the Continuum of Care

Established by the United States Department of Housing and Urban Development (HUD), the Continuum of Care (CoC) model recognizes that homelessness is not caused simply by a lack of shelter, but involves a variety of underlying, unmet physical, economic, and social needs. As a result, the CoC system is designed to address the critical problem of homelessness through a coordinated community-based process of identifying needs and building a system to address those needs. Recognized components of the CoC include: prevention, outreach, assessment, emergency shelter, safe havens, transitional shelter, permanent supportive housing, permanent housing, and supportive services.

Due to its expansiveness and the disparities of its communities, Los Angeles County is home to four separate CoCs: Los Angeles, Long Beach, Glendale, and Pasadena.<sup>1</sup> The Los Angeles CoC (LACoC) is the largest of them all, including 34 entitlement cities and all areas of Los Angeles County, except for the cities of Long Beach, Glendale and Pasadena. The CoC is coordinated by the Los Angeles Homeless Services Authority (LAHSA), which also serves as the independent governmental entity created for the purpose of addressing the problems of homelessness in the county. As an administrative entity, LAHSA contracts with community-based nonprofit agencies to provide homeless services throughout Los Angeles County.

Emergency shelter programs play an important role in the CoC. The Los Angeles County emergency shelter system has many layers. The thrust of the county's emergency shelter efforts are focused on the Winter Shelter (WSP) and Year Round (YRP) programs, but there are also other emergency shelter programs, some of which are funded outside of the CoC (e.g., Emergency Shelter Grants), or through specialized sources (e.g., Housing Opportunities for Persons With AIDS program), and others through faith-based resources.

Not only are emergency shelters effective in getting persons off the street and meeting their basic needs, they also offer an entry point into the CoC. Once a homeless person has entered the emergency shelter system, the goal is to refer them to a more stable and permanent housing situation, such as transitional or permanent housing, and provide them with services and referrals to increase their self-sufficiency and well-being.

In Los Angeles County, homeless clients are able to access emergency shelter from a variety of places, such as through outreach and numerous LAHSA-funded Access Centers. Though there are some twenty outreach programs for homeless persons within the Los Angeles CoC, one central means of identifying and engaging homeless persons

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<sup>1</sup> These cities administer their own Continuums of Care, and thus apply individually for their own targeted homeless assistance grants each year from HUD.

occurs through the LAHSA Emergency Response Team (ERT). The ERT operates countywide, responding to requests by elected officials, businesses, and community members, to assist homeless persons on the streets to obtain emergency housing and other needed services. The ERT serves the dual purpose of moving homeless persons living in urban and rural encampments into emergency shelter before they are removed more forcibly, perhaps by law enforcement, while also providing them important access to physical and mental health care.

Other outreach programs are operated by homeless service providers, law enforcement, the Department of Mental Health (i.e., AB 2034 Program), the Department of Children and Family Services, HIV/AIDS organizations, and providers of domestic violence housing and services. Like the ERT, these outreach teams identify clients within their communities and work to bring them into the emergency shelter and homeless service system.

There are also 12 homeless Access Centers with outreach teams that focus on rapid and intensive intervention for individuals and families that are homeless (See Appendix A for a complete list of the Access Centers). Clients are assessed in the field and on-site at these Access Centers, and referred and/or transported to appropriate services including emergency housing, health and mental health care, crisis counseling, legal services, and job development. The Access Centers are designed as a “one stop shop” to reduce the number of barriers a person might face when entering the CoC.

## **B. Overview**

The purpose of this section is both to articulate the structure of the emergency shelter system as it functions within Los Angeles County, while also describing in greater detail the types of clients that are served within it. At the same time, there is a very limited scope to this study and its audience. Ultimately, Shelter Partnership decided intentionally to concentrate on programs and resources that are administered by LAHSA, despite the existence of other regions of the county (namely Long Beach, Pasadena, and Glendale) that have developed more unique and finite approaches to addressing homelessness within their boundaries.

For this reason, the following narrative begins with an overview of the two primary emergency shelter programs in the county, the Winter Shelter Program (WSP) and the Year Round Program (YRP), followed briefly with a description of other emergency shelter programs within the CoC. The section then proceeds with a presentation of the spatial distribution of emergency shelters in Los Angeles County, both countywide and by each supervisorial district, by using ArcGIS software.

Afterwards, this section shifts to a detailed description of the various characteristics and needs that shape the homeless population in the county, or at least those that have come into contact with a publicly funded Access Center and/or emergency shelter. This section also describes specific homeless subpopulations (e.g., chronically homeless) whose needs are not yet fully understood but may require more specialized interventions on the part of

the homeless delivery system. Finally, the section concludes with a summation and analysis of specific population trends that have become evident in the recent decade.

## **C. Winter Shelter Program**

### **1. Background**

The LAHSA Winter Shelter Program (WSP) is the largest temporary emergency shelter system in the county, providing 2,000 seasonal beds with services.<sup>2</sup> LAHSA has coordinated the WSP since its inception in 1994. The purpose of the WSP is to provide homeless individuals and families with temporary emergency shelter and entry into the CoC system for housing and services. The program was established to address the basic shelter and service needs of homeless persons during the time in which Los Angeles usually experiences its most inclement weather.

The WSP generally operates between December 1<sup>st</sup> and March 15<sup>th</sup>. Historically, homeless service providers have used existing shelter facilities, California National Guard Armories, faith-based facilities, leased commercial space, and public facilities to provide shelter during the winter season.

The WSP is funded by a variety of sources, including Los Angeles City and County general funds, Emergency Shelter Grants, and Community Development Block Grants, as well as the California Emergency Housing Assistance Program, and the federal Emergency Food and Shelter Program.

### **2. Contracting**

For the 2004-2005 WSP, LAHSA contracted with eight shelter providers (see Table 1). The providers were awarded WSP contracts through a Request For Proposal (RFP) process, which was released in August 2003. WSP providers were awarded contracts for two Winter Shelter seasons, with renewals for the second and third seasons contingent on performance, available funding, demonstrated need, and continued available space (usually specific to armory sites).

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<sup>2</sup> LAHSA officially counts the Year Round Shelter beds as Winter Shelter beds during the winter shelter months. Technically, there were 928 Winter Shelter beds and 899 Year Round beds in the 2004-2005 program year.

<b>Table 1: LAHSA Winter Shelter Program Providers (2004-2005)</b>				
<b>Provider</b>	<b>SPA</b>	<b>Sup. District</b>	<b># of Beds</b>	<b>Configuration</b>
Covenant House	4	2	8	Open area
ESGV Coalition for the Homeless	3	1	120	Open area
New Image – San Pedro	8	4	200	Open area
Pomona Neighborhood Center	3	1	100	Open area
Santa Clarita Community Development Corp.	2	5	40	Open area
VOA – Culver Blvd.	5	2	150	Open area
VOA – Federal Ave.	5	2	160	Open area
YMCA of Glendale	2	5	150	Open area
<b>Total:</b>			928	

WSP providers are reimbursed at a rate of \$15 per night/per client for utilizing donated shelter space or California National Guard Armories, and at a rate of \$18 per night/per client for utilizing owned or leased shelter space. The maximum number of reimbursable shelter nights is 106.

### **3. Accommodations and Services**

LAHSA has administered the WSP for ten years, though it was just in 2001 that additional social services were added to the program to meet more than the basic need for food and shelter. With a philosophy of high tolerance, the WSP does not require clients to follow certain programmatic rules, other than those necessary to ensure the safety of all the clients and those creating an alcohol and drug free environment. However, the program offers several avenues, through case management, mental health counseling, and visits by primary medical personnel, for all clients to become engaged in moving towards self-sufficiency.

Due to the new Winter Shelter Mobile Health Program<sup>3</sup> that was added in 2004, clinicians performed 2,910 patient evaluations at the shelter sites, treating mild illnesses and conditions, stabilizing chronic health issues, providing treatment for previously undiagnosed illnesses, and conducting screening, testing, and counseling for HIV/AIDS, tuberculosis, and substance abuse.

All WSP providers offer shelter, intake services, case management, meals, and roundtrip transportation to the shelter from pick-up sites when mandated. All of the WSP providers use open space to house clients (see Table 1).

<sup>3</sup> Established through a grant from The California Endowment in 2003, the Winter Shelter Mobile Health Program provides on-site health care services as well as referrals and/or transportation to appropriate medical facilities for follow-up or more extensive care when needed.

By nature the WSP does not target certain populations, unlike other emergency shelter programs. Thus, program admission is not dependent upon a specific need or disability (e.g., mental illness). The only homeless population that the WSP does not serve is victims of domestic violence, since the WSP locations are published.<sup>4</sup>

In order to accommodate families and individuals for whom the mass shelter environment is inappropriate, LAHSA makes available hotel voucher funds. Contractors must express a need for such vouchers during the competitive bid phase, and must provide meals and referrals to appropriate services for all persons while “vouchered” to hotels.

## **D. Year Round Program**

### **1. Background**

In 2003, the City of Los Angeles allocated funds to LAHSA for the purpose of extending the WSP throughout the year, therefore formalizing the Year Round Overnight Emergency Shelter Program (YRP). In 2004, Los Angeles County also allocated funds for this purpose. Through this continued funding commitment, the program is offered, though on a smaller scale than the WSP, year round between March 16<sup>th</sup> and March 15<sup>th</sup> of the following year. The YRP is funded by the same sources as the WSP.

The purpose of the YRP is to provide homeless individuals and families with temporary emergency shelter, meals, showers, facilities, transportation, and case management, as well as access into the CoC. The YRP has established a goal to place a minimum of thirty percent of clients in 24-hour emergency shelters, transitional housing, or permanent housing. Although there is no predetermined time limit on residence in the YRP, providers are encouraged to use a 90-day time frame.

### **2. Contracting**

In 2004, LAHSA contracted with nine shelter providers countywide (see Table 2). Like the WSP, YRP contracts are awarded through an annual RFP process. Contracts are awarded for one year, but LAHSA can renew contracts for an additional year if the contractor is in good standing, adequate funding is available, and there is a demonstrated need.

YRP providers are reimbursed at a rate of \$15 per night/per client for utilizing donated shelter space and at a rate of \$18 per night/per client for utilizing owned or leased shelter space. Case management costs are included in the per diem rate.

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<sup>4</sup> The reality is that domestic violence victims occasionally end up in the WSP for reasons independent from domestic violence. Once they are identified, however, they are referred out to more appropriate shelter as soon as possible.

<b>Table 2: LAHSA Year Round Shelter Program Providers (2004-2005)</b>					
<b>Provider</b>	<b>SPA</b>	<b>Sup. District</b>	<b># of Beds</b>	<b>Configuration</b>	<b>Length of Stay</b>
IURD – Long Beach*	8	4	59	Open area	90 days
IURD – Project Achieve (Pomona & El Monte)	3	1	60**	Hotel rooms	90 days
LA Family Housing	2	3	80	Semi-Private rooms	90 days
Lancaster Community Shelter-Catholic Charities	1	5	10	Semi-Private rooms	90 days
MJB Recovery	6	2	85	Open area	90 days
New Image	6	2	350	Open area	90 days
People Helping People	6	2	110	Open area	90 days
Proyecto Pastoral	4	1	45	Open area	90 days
SRO Housing	4	1	100	SRO type	90-120 days
<b>Total:</b>			899		

\* Program is not operational yet due to delays in the issuance of the use permit and rehabilitation of the facility.

\*\* The 60 beds serve 15 families.

### **3. Accommodations and Services**

All YRP providers must offer shelter, intake services, case management, meals, and roundtrip transportation to the shelter from pick-up sites when mandated. While these basic services are required, many shelters offer additional resources and services depending on other housing and service programs they operate and the strength of their relationships with other mainstream services. Like the WSP, the YRP serves homeless persons, does not distinguish between certain populations, and does not serve victims of domestic violence.

### **E. Other Emergency Shelter Programs in Los Angeles County**

The previous two sections briefly described the two largest emergency shelter programs in the county, the WSP and the YRP. However, numerous additional emergency shelter programs operate independently within the county. According to LAHSA, for instance, there are at least an additional 97 programs besides the WSP and YRP, which offer over 3,300 emergency housing beds to homeless individuals and families throughout Los Angeles County.

Generally these programs can be grouped into three categories: (1) LAHSA-administered programs that serve general homeless populations; (2) programs administered and/or funded by other public systems of care that serve specific homeless

subpopulations; and (3) others that serve general or specific homeless populations, but are funded privately.

The first category includes programs that are administered by LAHSA, like the WSP and YRP, but are funded separately, mostly from federal block grant resources (e.g., Emergency Shelter Grants). Both the Shelter and Services Program and the New Emergency Housing Program fall within this grouping.

Additionally, there are publicly-funded emergency shelter programs that are often administered by specialized systems of care, financed entirely with targeted resources and designed to address the unique needs of specific segments of the homeless population. Some examples include the:

- Los Angeles County Department of Mental Health Specialized Shelter Bed Program (homeless persons with mental illness);
- Independent Living Program Emergency Shelter Program (homeless youth who have emancipated from foster care); and
- HOPWA Emergency Housing and Meal Voucher Program (homeless persons living with HIV/AIDS).

Finally, though beyond the scope of this study, there are other emergency shelter programs that are funded outside the CoC, but still play a vital role in the delivery of emergency shelter services to the homeless in the county. Typically, these programs are funded through private or religious entities, where program access is contingent upon participation in activities that are consistent with the philosophy or principles of the sponsoring agency.

## **F. Geographic Distribution of Emergency Shelters in Los Angeles County**

The following section presents the geographic distribution of emergency shelters in each of the five Los Angeles County Supervisorial Districts. The shelters were mapped according to type – Winter Shelter, Year Round Shelter, and other emergency shelters – and bed numbers. All shelter addresses were provided by LAHSA, and the mapping was prepared by the University of California of Los Angeles’ Center for Neighborhood Knowledge<sup>5</sup>. The entire emergency shelter list is included as Appendix A.

Countywide, 116 emergency shelters were mapped (see Figure 1 for Countywide Map). As shown by Table 3, eight were WSP providers, 11 were YRP providers, and 97 were other emergency shelters. The supervisorial district (SD) with the most shelters was SD 2, which had 39% of all emergency shelters in the county. SD 5 had the least emergency shelters with 8% of all emergency shelters in the county.

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<sup>5</sup> While the maps are an excellent representation of the locations of emergency shelters, they are not an exact depiction. The address list provided by LAHSA mostly represented only LAHSA-funded emergency shelters so those shelters outside of the LAHSA system might not have been catalogued and mapped.

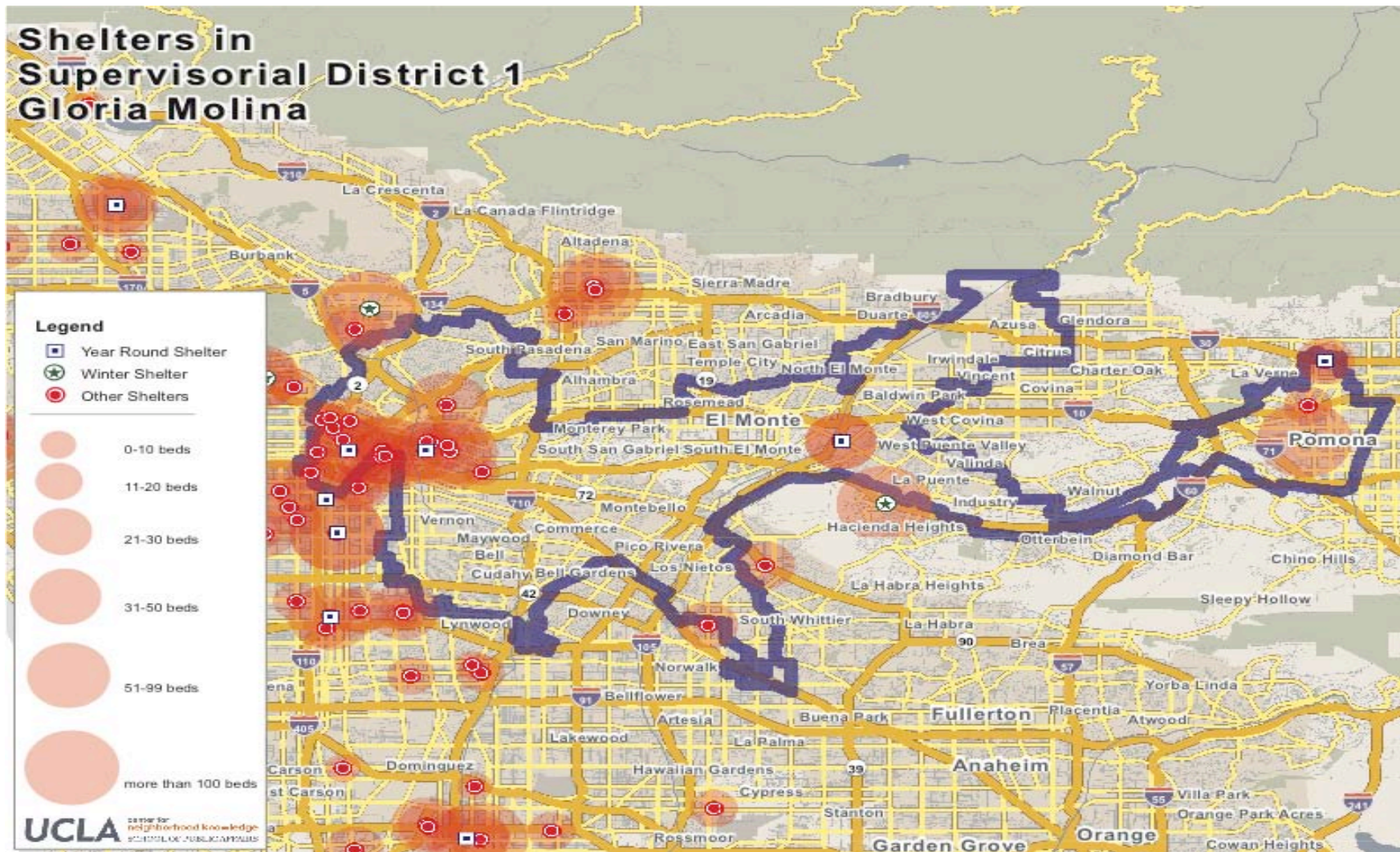
<b>TABLE 3: Emergency Shelters by Supervisorial District</b>				
<b>Supervisorial District</b>	<b>Total # of Shelters</b>	<b>% of County Total</b>	<b>Total # of Beds</b>	<b>% of County Total</b>
1	26	22.41%	1,268	24.20%
2	44	37.93%	2,023	38.61%
3	20	17.24%	720	13.74%
4	16	13.79%	801	15.29%
5	10	8.62%	428	8.16%
<b>Countywide:</b>	116	100%	5,240	100%



## **1. Supervisorial District 1, Gloria Molina**

Supervisorial District 1 (SD 1) has one Winter Shelter, four Year Round Shelters, and 21 other emergency shelters, representing 22.41% of the emergency shelters in the County. It is important to note that many of these shelters lie in the Los Angeles Central City Area, and much of SD 1 lacks the appropriate amount of beds. This is especially true of the eastern portion of the district where there are few programs (see Figure 2).

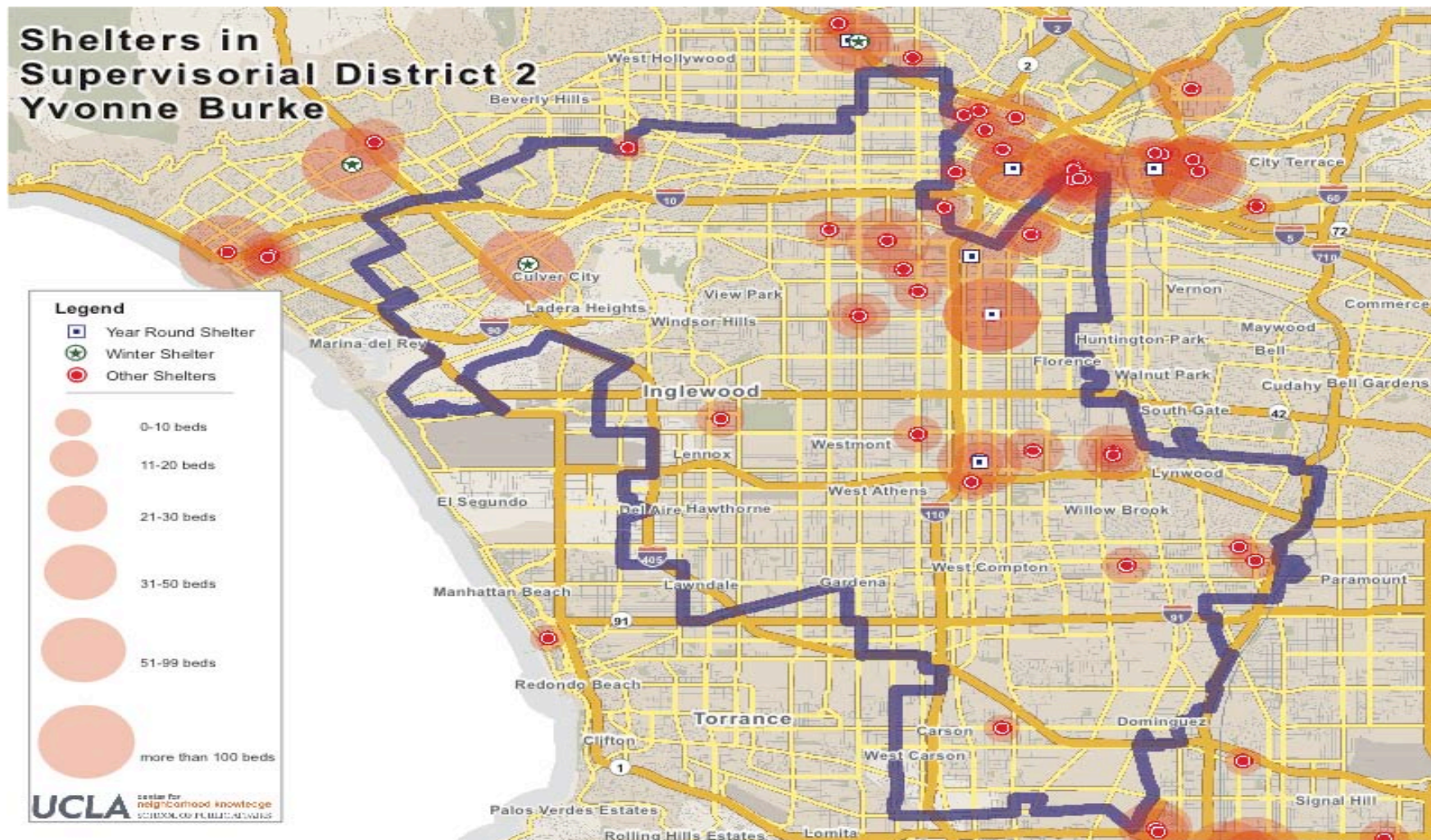
FIGURE 2



## **2. Supervisorial District 2, Yvonne Burke**

Supervisorial District 2 (SD 2) has one Winter Shelter, three Year Round Shelters, and 40 other emergency shelters. Compared to the other districts, SD 2 holds the largest amount of emergency shelters (37.93%). Like SD 1, the majority of the emergency shelters in SD 2 are within the Los Angeles Central City Area (see Figure 3).

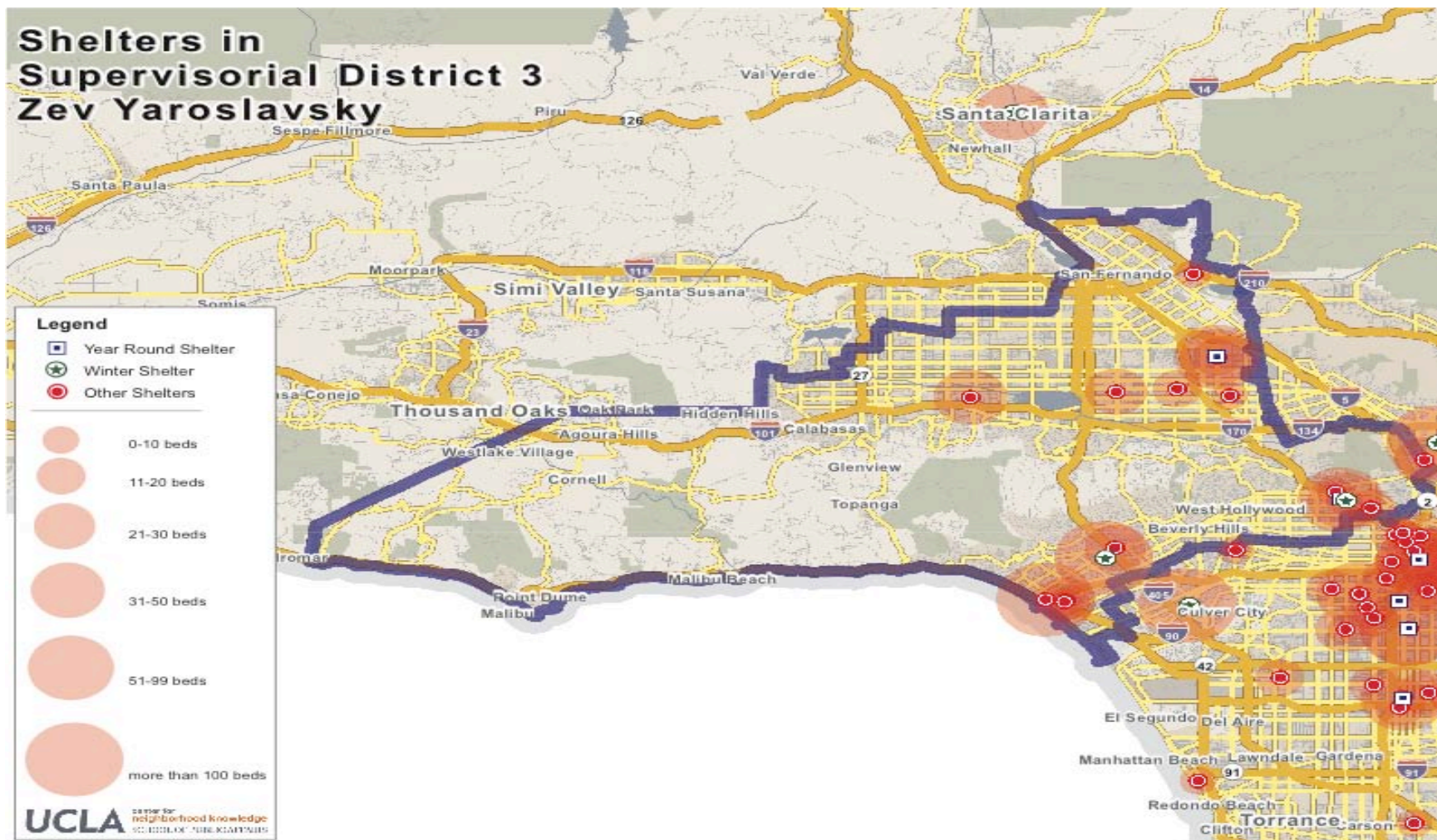
FIGURE 3



### **3. Supervisorial District 3, Zev Yaroslavsky**

Supervisorial District 3 (SD 3) has two Winter Shelters, two Year Round Shelters, and 16 other emergency shelters, representing 17.24% of the total emergency shelters in the County. As shown by Figure 4, the northern portion of the district, which represents parts of the San Fernando Valley, has few emergency shelter programs.

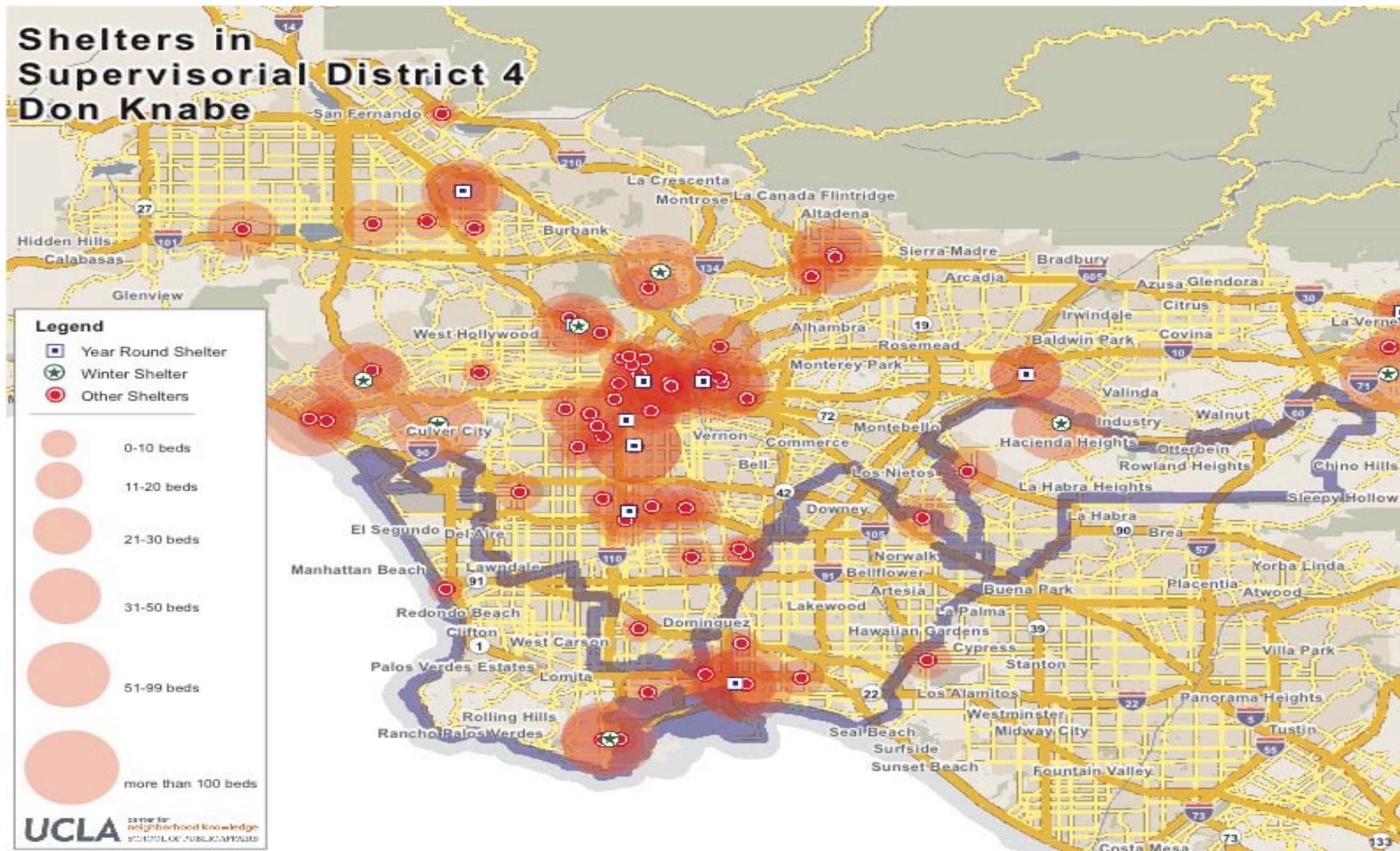
FIGURE 4



#### **4. Supervisorial District 4, Don Knabe**

Supervisorial District 4 (SD 4) has two Winter Shelters, one Year Round Shelter, and 13 other emergency shelters, representing 13.79% of the total emergency shelters in the County. As shown by Figure 5, the majority of shelters in SD 4 are situated in and around Downtown Long Beach.

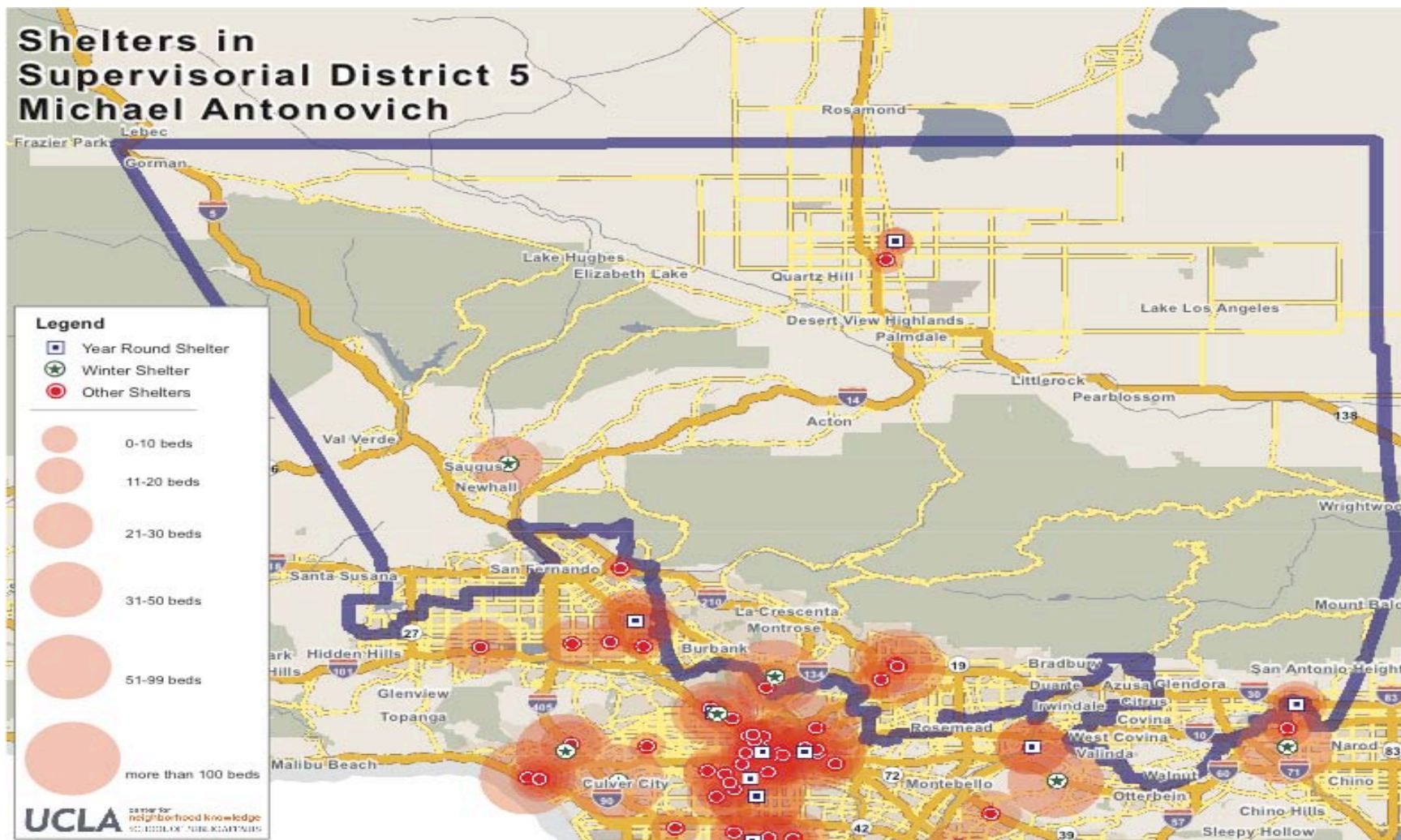
FIGURE 5



## **5. Supervisorial District 5, Michael Antonovich**

Supervisorial District 5, (SD 5) has two Winter Shelters, one Year Round Shelter, and seven other emergency shelters. As evidenced by Figure 6, SD 5 has the least amount of emergency shelters in the County (8.62%).

FIGURE 6



## G. Populations Served in Access Center, Winter Shelter, and Year Round Programs

### 1. Overview

This section discusses the populations served in Los Angeles County’s Access Center, Winter Shelter, and Year Round Programs. Data was culled and analyzed in order to present a vivid description of clients utilizing services and provide a context for the emergency shelter system as a whole, thus informing the study’s recommendations. Due largely to the different reporting mechanisms that were used, the methodology for this section was fairly complicated, and therefore has been described in detail and included as Appendix C.

Overall, this section focuses on the demographics and experiences that define the homeless populations served through the Access Center and emergency shelter components of the Continuum of Care. Shelter Partnership opted to concentrate on specific statistical categories for the analysis, such as: number of persons served, age, gender, race and ethnicity, income source, special needs, prior living situation, and destination. This section commences with a review of these figures across the county, and then follows with specific analyses per each supervisorial district. Lastly, since there are such differing special needs among these client populations, the section closes by discussing the various special needs subpopulations represented within the larger homeless population.

### 2. County of Los Angeles

#### a. Number of Persons Served

The most recent program reports for the Access Center, Winter Shelter, and Year Round programs indicate that 29,472 people were served annually, although this likely includes duplicate clients.<sup>6</sup> The data corresponds to 12,112 Access Center participants, 8,045 WSP clients, and 9,315 YSP clients (see Table 4).

	<b>Persons Served</b>
Access Centers (2003-2004)	12,112
Winter Shelter Program (2004-2005)	8,045
Year Round Program (2003-2004)	9,315
<b>Total</b>	<b>29,472</b>

<sup>6</sup> The different reporting mechanisms prevented this analysis from presenting a uniform reporting year. For instance, Access Center data is generally taken from 2003-2004 annual reports, with the exception of one provider that could only provide data as recent as the 2002-2003 program year. In other cases, such as the Winter Shelter Program, data runs through March 2005.

## b. Gender

Roughly two-thirds of WSP and YRP clients are male, corresponding with national and local trends (see Table 5).

<b>Table 5: Gender of WSP and YRP Clients</b>		
	<b>WSP</b>	<b>YRP</b>
Male	69.9%	66.6%
Female	29.3%	32.5%
Transgender	0.8%	0.9%

The Access Centers, however, report that females make up almost one-half of their clients. This fact can likely be explained by the fact that the Centers serve families in addition to single adults, and homeless families tend to be headed by women (see Table 6).

<b>Table 6: Gender of Access Center Clients</b>	
	<b>Access Centers</b>
Male	51.8%
Female	48.2%
Transgender	Not reported

## c. Age

Although the emergency shelters and Access Centers use different ranges to report the age of their clients, a limited comparison can be made. The data shows that the most common age range of clients is comparable across systems – 31 to 50 year olds for the Centers (54.1%) and 24 to 44 year olds for the shelters (58.2% - 60.9%). The Access Center clients, however, appear to be younger, with 27.6% of them 18-30 years old, compared to only 7.1% - 8.4% of the emergency shelter clients in the 18-23 age range (see Tables 7 and 8).

<b>Table 7: Age of WSP/YRP Clients</b>		
<b>Age Range</b>	<b>WSP</b>	<b>YRP</b>
0-17	0.2%	0.1%
18-23	8.4%	7.1%
24-44	58.2%	60.9%
45-54	23.4%	22.3%
55-69	8.5%	8.3%
70+	1.3%	1.2%

<b>Table 8: Age of Access Center Clients</b>	
<b>Age Range</b>	<b>Access Centers</b>
0-17	0.5%
18-30	27.6%
31-50	54.1%
51-61	14.4%
62+	3.9%

#### **d. Race and Ethnicity**

The statistics on race and ethnicity are somewhat limited due to how Hispanic/Latino is considered an ethnicity only, and not a race. This distinction likely accounts for the large percentage of respondents who reported their race as Other (14.0% - 22.6%). The potential confusion over the Hispanic/Latino category may also skew other racial categories, such as White or Black/African American. Nonetheless, the data does reveal that there is a sizable Hispanic/Latino homeless population of between 23.0% - 24.9% of the shelters' and Centers' clients. Comparing Black/African American to White populations, the WSP providers report similar proportions of these groups (35.4% and 34.7%, respectively), and the YRPs and Access Centers report a larger African American population (46.0% versus 29.4% White for the YRPs, and 54.1% versus 21.4% White for the Centers) (see Tables 9 and 10).

<b>Table 9: Race and Ethnicity of Access Center Clients</b>	
<b>Ethnicity</b>	
Hispanic or Latino	24.6%
Non-Hisp. Or Non-Latino	75.4%
<b>Race</b>	
Amer. Indian/Alask.Nat.	1.7%
Asian	1.4%
Black/African American	54.1%
Nat. Hawaiian/Pacific Isl.	0.6%
White	21.4%
Amer. Indian + White	3.9%
Asian + White	0.1%
Black + White	2.3%
Amer. Indian + Black	0.7%
Other	14.0%

	WSP	YRP
<b>Ethnicity</b>		
Hispanic or Latino	24.9%	23.0%
Non-Hisp. Or Non-Latino	75.1%	77.0%
<b>Race</b>		
Amer. Indian/Alask.Nat.	1.2%	0.8%
Asian	3.3%	2.5%
Black/African American	35.4%	46.0%
Nat. Hawaiian/Pacific Isl.	1.2%	0.9%
White	34.7%	29.4%
Amer. Indian + White	0.2%	0.2%
Asian + White	0.0%	0.0%
Black + White	0.8%	0.7%
Amer. Indian + Black	0.5%	0.3%
Other	22.6%	19.3%

#### e. Income Source

The data on clients' income sources shows a remarkably large proportion of shelter clients with no income at all (39.3% and 31.5%). Also noteworthy is the approximately 25% of shelter clients who receive relatively large disability insurance or pension benefits, but are still forced to stay in a shelter. Furthermore, approximately 5% of the shelters' population is comprised of individuals who work (see Table 11).

	WSP	YRP
<b>Disability Insurance</b>		
Private Disability	0.1%	0.0%
SDI	0.8%	0.4%
SSDI	4.5%	6.9%
SSI	11.9%	13.4%
<b>Pension</b>		
Other Pension	0.2%	0.1%
SS Retirement	2.0%	1.4%
VA Pension	3.6%	3.5%
<b>Public Benefits</b>		
General Relief	22.3%	28.3%
TANF	5.9%	5.7%
<b>Unemployment</b>		
	1.9%	3.5%
<b>Work</b>		
	5.5%	5.0%
<b>Other Income</b>		
	2.0%	0.2%
<b>No Income</b>		
	39.3%	31.5%

## f. Special Needs

Although different categories were used to report the prevalence of special needs populations in the Access Centers and shelters, comparisons can be made. In general, the shelter providers reported larger proportions of clients with special needs. Almost half (46.5%) of WSP and YRP clients have either a substance use (18.7%) or co-occurring disorder (27.8%).

Substance use is also prevalent in the Centers with 15.2% of clients struggling with alcohol abuse and 25.3% with drug abuse (these categories are not mutually exclusive). The proportion of clients with a mental illness is high in the shelters as well. The providers estimate that over half (51.7%) of their clients have a mental illness (23.9% with a mental illness only and an additional 27.8% with a co-occurring disorder). The Access Centers report that a smaller, yet still sizable, 19.7% of their clients are mentally ill.

Individuals with physical health conditions are another noteworthy population in the emergency shelter and Access Center programs. The WSP and YRP providers estimate that 18.1% of their clients have a chronic health condition. Clients with a physical disability represent 13.1% of Access Center clients. Access Centers additionally report that 29.4% of their clients are categorized as disabled. Persons with HIV/AIDS comprise 3.8% of the Access Center and 1.5% of the shelter clients served (see Tables 12 and 13).

<b>Special Need</b>	<b>% of Total Persons Served</b>
Alcohol Abuse	15.2%
Drug Abuse	25.3%
Developmental Disability	1.9%
HIV/AIDS & related diseases	3.8%
Mental Illness	19.7%
Physical Disability	13.1%
Domestic Violence	5.2%
Other	2.7%
Disabled	29.4%

<b>Special Need</b>	<b>% of Total Persons Served</b>
Substance Use Disorder Only	18.7%
Co-occurring Disorder	27.8%
Developmentally Delayed	5.0%
HIV/AIDS	1.5%
Mental Illness Only	23.9%
Chronic Health Condition	18.1%
Mobility Impaired	3.2%
Other	5.9%

### g. Prior Living Situation

The most common prior living situation for shelter and Access Center clients is the street (34.0% - 40.3%). A notable 10.8% - 13.8% of clients were living in rental housing prior to becoming homeless. An additional 14.3% - 16.7% of clients previously had been living with friends or relatives. The shelters report that 10.6% - 12.6% of their clients enter directly from institutional care, with approximately 4% coming from jail or prison and 1.8% - 2.5% from the hospital. This data illustrates the lack of adequate discharge planning in both systems. Also noteworthy is the number of clients entering both the shelter and Access Center programs from another shelter (12.2% - 22.3%) (see Tables 14 and 15).

<b>Table 14: Prior Living Situation of Access Center Clients</b>	
<b>Independent Housing</b>	27.5%
Rental Housing	10.8%
Friends/Relatives	16.7%
<b>Institutional Care</b>	3.8%
Jail/Prison	0.3%
Psychiatric Facility	0.2%
Hospital	0.5%
Substance Abuse Facility	2.8%
<b>Streets</b>	34.0%
<b>Shelter</b>	26.7%
Emergency Shelter	22.3%
Transitional Housing	4.4%
<b>Unknown/Other</b>	5.9%
<b>Domestic Violence Situation</b>	2.0%

	WSP	YRP
<b>Independent Housing</b>	29.7%	27.6%
Rental Housing	13.8%	13.3%
Friends/Relatives	15.9%	14.3%
<b>Institutional Care</b>	10.6%	12.6%
Jail/Prison	4.0%	4.3%
Psychiatric Facility	0.7%	0.8%
Hospital	2.5%	1.8%
Substance Abuse Facility	3.4%	5.7%
<b>Streets</b>	40.3%	39.7%
<b>Shelter</b>	12.2%	16.7%
Emergency Shelter	12.2%	16.2%
Domestic Violence Shelter	0.6%	0.5%
Transitional Housing	2.4%	2.6%
<b>Unknown/Other</b>	4.2%	1.0%
<b>Domestic Violence Situation</b>	Not reported	Not reported

## h. Destination

The housing destination is known for approximately 70% of the clients who exited the Access Center programs. Only 9% of clients who left the Access Centers entered permanent housing – 3% moved to unsubsidized rental housing and 4.9% moved in with family or friends. Less than one-quarter (21.8%) of clients entered transitional housing programs. Additionally, a significant number of Access Center clients entered an emergency shelter (26.6%) (see Table 16).

<b>Table 16: Destination of Access Center Clients</b>	
<b>Permanent</b>	
Rental house/apt. (no subsidy)	3.0%
Public Housing	0.4%
Section 8	0.3%
Shelter Plus Care	0.1%
HOME subsidized house/apt.	0.1%
Other subsidized house/apt.	0.2%
Homeownership	0.0%
Moved in w/ family or friends	4.9%
<b>Transitional</b>	
Transitional housing	21.8%
Moved in w/ family or friends	3.0%
<b>Institution</b>	
Psychiatric hospital	0.1%
In-patient alcohol/drug treatment	4.3%
Jail/prison	0.1%
<b>Emergency Shelter</b>	
Emergency Shelter	26.6%
<b>Other</b>	
Other supportive housing	0.2%
Street	2.8%
Other	2.4%
Unknown	29.7%

### 3. District 1

#### a. Gender

Access Center clients in District 1 are overwhelmingly female, over 60% on average. For example, the L.A. Family Housing Access Center, in the Boyle Heights neighborhood of East Los Angeles, shows an even higher level of females among its clientele, almost two-thirds (65.8%) of the total population served (see Table 17).

<b>Gender</b>	<b>District Average</b>	<b>Project Achieve (El Monte)</b>	<b>L.A. Family Housing (Boyle Heights)</b>	<b>Pomona Inland Valley</b>
<b>Male</b>	39.5%	43.0%	34.2%	43.3%
<b>Female</b>	60.5%	57.0%	65.8%	56.7%

These findings seem consistent with increased reports from District 1 stakeholders of homeless families requiring homeless services. The percentage of women served through District 1 Access Centers is also significantly higher than the 48% reported throughout the Los Angeles Continuum of Care and the approximately 30% served through the WSP and YRP.

#### b. Age

Individuals ages 31-50 predominate across all program sites in the district, representing over half (55.1%) of the client population on average. Significant numbers (33.5%) of young adults ages 18-30 are also accessing these programs, especially in Boyle Heights, where 41% fall within that age range. In comparison to the overall countywide average (3.9%), there are far fewer older adults, specifically those ages 62 and over (2.2%), in these programs (see Table 18).

<b>Age Range</b>	<b>District Average</b>	<b>Project Achieve (El Monte)</b>	<b>L.A. Family Housing (Boyle Heights)</b>	<b>Pomona Inland Valley</b>
<b>0-17</b>	0.1%	-*	0.3%	-*
<b>18-30</b>	33.5%	32.1%	41.0%	32.1%
<b>31-50</b>	55.1%	56.6%	51.0%	56.6%
<b>51-61</b>	9.1%	10.0%	5.1%	10.0%
<b>62+</b>	2.2%	1.3%	2.7%	1.3%

\* Not reported under single adults

### c. Race and Ethnicity

Clients receiving Access Center services in District 1 are primarily Hispanic or Latino (63.4%), including more than eight of ten clients (83.4%) in the Boyle Heights Access Center which fall into this category (see Table 19).

Racial data in District 1 also reflect substantial concentrations of Black clients, especially in the easternmost sections of the district, where they represent more than one-third (37%) of overall clients. Yet, on average, Blacks are underrepresented among the client population when compared to the countywide average (54%). In Pomona and El Monte, Whites account for well over one-half of overall clients. Persons identified as “Other” are sizable on average, particularly in Boyle Heights, where their percentages match the ethnic reporting for Hispanics or Latinos (see Table 19).

<b>Table 19: Race/Ethnicity of Access Center Clients (District 1)</b>				
	<b>District Average</b>	<b>Project Achieve (El Monte)</b>	<b>L.A. Family Housing (Boyle Heights)</b>	<b>Pomona Inland Valley</b>
<b>Ethnicity</b>				
Hispanic or Latino	63.4%	63.5%	83.4%	31.8%
Non-Hispanic Or Non-Latino	36.6%	36.5%	16.6%	68.3%
<b>Race</b>				
American Indian/ Alaskan Native American	1.5%	1.0%	0.8%	3.3%
Asian	0.5%	0.8%	0.5%	0.3%
Black/African American	17.1%	8.3%	11.7%	37.0%
Native Hawaiian/Pacific Islander	0.4%	0.8%	0.2%	0.3%
White	42.2%	76.4%	3.3%	59.3%
American Indian + White	0.1%	0.4%	0.0%	0.0%
Asian + White	0.0%	0.0%	0.0%	0.0%
Black + White	0.0%	0.0%	0.0%	0.0%
American Indian + Black	0.0%	0.0%	0.0%	0.0%
Other	38.2%	12.5%	83.5%	0.0%

### d. Special Needs

#### i. Access Centers

With the odd exception of the Boyle Heights Access Center, clients receiving services through the Project Achieve or Pomona Inland Valley Access Centers are likely to have a mental illness (35% and 21% respectively), but these same programs report lower rates of drug and alcohol abuse than indicated on average countywide. Victims of domestic violence also account for a large percentage of Access Center clients in the district. Moreover,

according to Project Achieve, at least half of their clients meet the federal definition of disabled, far greater than the 29% reported countywide (see Table 20).

<b>Table 20: Special Needs of Access Center Clients (District 1)</b>				
<b>Special Need</b>	<b>District Average</b>	<b>Project Achieve (El Monte)</b>	<b>Pomona Inland Valley</b>	<b>L.A. Family Housing (Boyle Heights)</b>
Alcohol Abuse	5.9%	12.3%	6.3%	0.5%
Drug Abuse	8.4%	14.6%	13.5%	0.2%
Developmental Disability	2.4%	5.8%	1.8%	0.0%
HIV/AIDS & related diseases	0.5%	1.0%	0.8%	0.0%
Mental Illness	17.1%	35.1%	20.8%	0.0%
Physical Disability	8.3%	11.9%	16.5%	0.2%
Domestic Violence	7.1%	8.4%	8.0%	5.5%
Other	0.1%	0.4%	0.0%	0.0%
Disabled	17.0%	50.5%	-*	0.2%

\* Not reported

## **ii. Winter Shelter and Year Round Programs**

In District 1, there are highly contrasting degrees of special needs among clients served by WSP and YRP providers, which is most likely the product of vastly different programs across the district. SRO, for instance, reports that over half (52%) of its clients have a mental illness, while 54% have a co-occurring mental health and substance use disorder. Both of these figures are twice as high as those reported across the county (24% and 28%, respectively). SRO also indicates an extremely high number of persons living with chronic health conditions, nearly three-quarters of their total population (74%). Surprisingly, 25% of ESGV’s clients are developmentally delayed, which is five times greater than the average in the county.

IURD and Proyecto Pastoral report extremely low numbers of clients with special needs, all of which are below the countywide averages (see Table 21).

<b>Table 21: Special Needs of WSP and YRP Clients (District 1)</b>					
	<b>District Average</b>	<b>ESGV</b>	<b>SRO</b>	<b>IURD</b>	<b>Proyecto Pastoral</b>
Program Type		WSP	YRP	YRP	YRP
Mental Illness (Only)	18.5%	15.0%	52.0%	6.0%	1.0%
Substance Use Disorder (Only)	14.8%	15.0%	36.0%	6.0%	2.0%
Co-occurring Disorder	22.3%	32.0%	56.0%	0.0%	1.0%
Developmentally Delayed	6.6%	25.0%	1.0%	0.0%	0.5%
HIV/AIDS	1.5%	1.0%	4.0%	0.0%	1.0%
Chronic Health Condition	27.0%	25.0%	74.0%	6.0%	3.0%
Mobility Impaired	3.3%	10.0%	2.0%	0.0%	1.0%
Other	.3%	0.0%	0.0%	0.0%	1.0%

## **e. Prior Living Situation**

### **i. Access Centers**

As one would expect, large percentages of the clients in District 1 receiving Access Center services are coming from the streets (31%) or shelters (14.3%). However, compared to the rest of the county where 26.7% of Access Center clients had resided in shelters most recently, fewer clients in District 1 are coming from shelters. Also, the greatest number of clients identify as having lived in some form of independent housing (38.7%), whether with friends/relatives (24%) or rental housing (14.7%).

L.A. Family Housing’s Boyle Heights Access Center is unique in that half of its clients (50.3%) come from some sort of independent housing, primarily friends and relatives (34%), more than double the number countywide (16.7%). This fact is likely connected to fewer clients identifying the streets (19%) or emergency shelter (11.4%) as their prior living situation, the latter of which is half the amount (22.3%) that is reported across the county (see Table 22).

<b>Table 22: Prior Living Situation of Access Center Clients (District 1)</b>				
	<b>District Average</b>	<b>Project Achieve (El Monte)</b>	<b>Pomona Inland Valley</b>	<b>L.A. Family Housing (Boyle Heights)</b>
<b>Independent Housing</b>	38.7%	30.3%	31.0%	50.3%
Friends/Relatives	24.0%	21.3%	11.5%	34.0%
Rental Housing	14.7%	9.0%	19.5%	16.3%
<b>Institutional Care</b>	1.8%	3.1%	1.0%	1.1%
Hospital	0.3%	0.2%	0.0%	0.6%
Jail/Prison	0.1%	0.2%	0.0%	0.0%
Psychiatric Facility	0.0%	0.0%	0.0%	0.0%
Substance Abuse Facility	1.4%	2.7%	1.0%	0.5%
<b>Shelter</b>	14.3%	14.6%	13.3%	11.4%
Emergency Shelter	12.9%	14.6%	13.3%	11.4%
Transitional Housing	1.4%	1.5%	2.3%	0.8%
<b>Streets</b>	31.0%	37.0%	42.0%	19.0%
<b>Unknown/Other</b>	13.8%	12.9%	9.5%	17.2%
<b>Domestic Violence Situation</b>	0.5%	0.6%	1.0%	0.2%

## ii. Winter Shelter and Year Round Programs

In comparison to the Access Centers, there are more WSP and YRP clients coming from the streets (44%) on average, but a similar percentage is coming from other shelters (13%). Significant numbers of shelter clients are also coming from some sort of independent housing (23.9%), and hotels or motels (non-vouchered) (10.3%). Approximately four times as many clients most recently resided in institutional care (7.4%) than was reported on average with the Access Centers (1.8%) in this district.

Table 23 illustrates the disparities of circumstances and living situations that define the incoming shelter population in District 1. IURD clients, for instance, are for the most part either leaving independent housing (49%), which includes 41% from friends and relatives, or other non-subsidized hotels or motels (31%). Subsequently, there are relatively few from the streets (15%). SRO Housing, on the other hand, and Proyecto Pastoral predominately serve street populations (40% and 74%, respectively).

Of important note is the amount of clients who have left institutional care, particularly jails and prisons. Both ESGV and SRO identified larger percentages of recently incarcerated clients (10% and 5%, respectively) than reported countywide (4%).

	<b>District Average</b>	<b>ESGV</b>	<b>SRO</b>	<b>IURD</b>	<b>Projecto Pastoral</b>
Program Type		WSP	YRP	YRP	YRP
<b>Independent Housing</b>	23.9%	23.5%	10.0%	49.0%	12.8%
Friends/Relatives	17.8%	20.0%	3.0%	41.0%	7.1%
Rental Housing	6.1%	3.5%	7.0%	8.0%	5.7%
<b>Institutional Care</b>	7.4%	14.0%	13.0%	1.0%	1.4%
Hospital	1.5%	2.0%	4.0%	0.0%	0.0%
Jail/Prison	4.2%	10.0%	5.0%	1.0%	0.7%
Psychiatric Facility	0.5%	1.0%	1.0%	0.0%	0.0%
Substance Abuse Facility	1.2%	1.0%	3.0%	0.0%	0.7%
<b>Motel/Hotel (no voucher)</b>	10.3%	10.0%	0.0%	31.0%	0.0%
<b>Shelter</b>	13.0%	11.0%	11.0%	3.0%	11.0%
Emergency Shelter	11.0%	10.0%	25.0%	3.0%	11.0%
Domestic Violence Shelter	0.5%	1.0%	1.0%	0.0%	0.0%
Transitional Housing	1.5%	1.0%	4.0%	1.0%	0.0%
<b>Streets</b>	44.0%	40.0%	40.0%	15.0%	73.8%
<b>Unknown/Other</b>	0.1%	0.5%	5.0%	0.0%	0.0%

### **g. Destination**

Clients receiving services through District 1 Access Centers do not necessarily obtain more stable or permanent living arrangements as a result of program services. Of persons whose destination is known, about 47% of the population on average, 13.9% tend to move on to emergency shelter, and to a lesser extent permanent, non-subsidized rental housing (9.8%). Significant numbers also report moving in with family or friends (8%). In comparison to countywide figures, it appears that the average numbers of clients in District 1 being placed in emergency shelter (13.9%) and transitional housing (1.5%) is drastically lower than the countywide averages (26.6% and 21.8%, respectively).

Within specific programs, however, Pomona reported that close to 15% (14.8%) were assisted to move into permanent housing (non-subsidized), which is equal to five times that number countywide (see Table 24).

<b>Table 24: Destination of Clients Served through Access Centers (District 1)</b>				
	<b>District Average</b>	<b>Project Achieve (El Monte)</b>	<b>Pomona Inland Valley</b>	<b>L.A. Family Housing (Boyle Heights)</b>
<b>Permanent Housing</b>				
Rental house/apt. (no subsidy)	9.8%	9.7%	14.8%	8.1%
Public Housing	0.4%	0.0%	0.0%	0.7%
Section 8	0.8%	0.0%	0.0%	1.5%
Shelter Plus Care	0.2%	0.3%	0.5%	0.0%
HOME subsidized house/apt.	0.3%	0.0%	0.0%	0.6%
Other subsidized house/apt.	0.0%	0.0%	0.0%	0.0%
Homeownership	0.1%	0.0%	0.5%	0.0%
Moved in w/ family or friends	3.3%	5.2%	9.5%	0.0%
<b>Transitional Housing</b>				
Transitional housing	1.5%	2.1%	3.7%	0.4%
Moved in w/ family or friends	4.7%	11.2%	0.0%	2.4%
<b>Institutional Care</b>				
Psychiatric hospital	0.3%	0.6%	0.5%	0.0%
In-patient alcohol/drug treatment	0.8%	1.8%	1.6%	0.0%
Jail/Prison	0.2%	0.6%	0.0%	0.0%
<b>Emergency Shelter</b>				
Emergency Shelter	13.9%	11.5%	7.4%	17.7%
<b>Other</b>				
Other supportive housing	0.4%	0.0%	2.1%	0.0%
Street	7.4%	10.6%	21.2%	0.6%
Other	2.8%	0.0%	12.2%	1.3%
Unknown	53.2%	46.4%	25.9%	66.8%

## 4. District 2

### a. Gender

In District 2, Access Center service recipients were primarily male (56.2%), including three programs where they represented at least 60% of the total clientele. This percentage is just slightly higher than the countywide norm (52%). In almost direct contrast, however, some 62% of persons seen by WLCAC were female (see Table 25).

	<b>District Average</b>	<b>Bridge of Hope</b>	<b>PATH</b>	<b>Weingart</b>	<b>WLCAC</b>
<b>Male</b>	56.2%	64.5%	60.4%	63.1%	38.0%
<b>Female</b>	43.8%	35.5%	39.6%	36.9%	62.0%

### b. Age

On average, the age disparities among clients receiving LAHSA-funded Access Center services in District 2 are akin to those reported countywide. Nearly half (48.2%) of the clients are between the ages of 31 and 50.

There are, however, some interesting findings concerning other age ranges, including slightly more (20.3%) adults ages 51-61 in this District than the countywide average (14.4%). Almost half (44%) of WLCAC's clients are under 30, while over one-third (35%) of Weingart's Access Center clients are over 50 (see Table 26).

<b>Age Range</b>	<b>District Average</b>	<b>Bridge of Hope</b>	<b>PATH</b>	<b>Weingart</b>	<b>WLCAC</b>
<b>0-17</b>	0.7%	-*	1.9%	-*	0.4%
<b>18-30</b>	26.5%	18.2%	21.9%	21.1%	43.1%
<b>31-50</b>	48.2%	61.3%	56.1%	44.1%	39.6%
<b>51-61</b>	20.3%	18.0%	16.3%	32.0%	9.5%
<b>62+</b>	4.2%	2.5%	3.9%	2.8%	7.3%

\*Not reported under single adults.

### c. Race and Ethnicity

Ethnic disparities among Access Center clients in District 2 are in stark contrast to District 1, where Hispanics and Latinos represented the overwhelming majority. Here, Non-Hispanics or Non-Latinos represent close to 87% of the overall client population, significantly higher than the 75% identified countywide among Access Center users.

It is not surprising, therefore, that over 70% of these clients identify as Black/African American. Only at PATH's Access Center, at the northern edge of the district, are Blacks

below that percentage (52%), as Whites assume a larger portion (21%) of the overall racial composite. PATH also reports a substantial percentage of service recipients who identify as American Indian + White (17%) (see Table 27).

<b>Table 27: Race and Ethnicity of Access Center Clients (District 2)</b>					
	<b>District Average</b>	<b>Bridge of Hope</b>	<b>PATH</b>	<b>Weingart</b>	<b>WLCAC</b>
<b>Ethnicity</b>					
Hispanic or Latino	13.5%	16.0%	17.7%	10.0%	12.0%
Non-Hispanic or Non-Latino	86.5%	84.0%	82.3%	90.0%	88.0%
<b>Race</b>					
American Indian/Alaskan Native	1.2%	2.2%	0.9%	2.0%	0.1%
Asian	1.8%	3.6%	1.5%	3.0%	0.1%
Black/African American	71.7%	71.0%	52.2%	73.0%	97.6%
Native Hawaiian/Pacific Islander	0.5%	0.2%	0.1%	1.0%	0.2%
White	12.9%	4.5%	20.9%	15.0%	0.8%
American Indian + White	6.0%	0.7%	17.3%	0.0%	0.0%
Asian + White	0.1%	0.2%	0.2%	0.0%	0.0%
Black + White	2.6%	0.4%	1.9%	5.0%	0.6%
American Indian + Black	0.2%	1.1%	0.4%	0.0%	0.0%
Other	3.1%	16.0%	4.7%	1.0%	0.5%

#### **d. Special Needs**

##### **i. Access Centers**

District 2 Access Centers serve significant numbers of clients with special needs, particularly those with substance use disorders and HIV/AIDS. Clients of the PATH and Weingart Access Centers, for instance, are affected by substance use disorders (67% respectively) to a far greater degree than the average countywide (40.5%). Rates of mental illness (36% and 27%, respectively) are also higher at these two facilities than the countywide average (20%).

HIV/AIDS prevalence among Access Center clients in this district is also notable. Almost 9% of PATH's clients and 7% of persons served at Weingart's Access Center report HIV or AIDS (or related diseases). In light of the severe special needs among their client populations, it is unsurprising that over half of the clients from these two programs meet the federal definition of disabled (see Table 28).

	<b>District Average</b>	<b>Bridge of Hope</b>	<b>PATH</b>	<b>WLCAC</b>	<b>Weingart</b>
Alcohol Abuse	16.6%	11.7%	21.8%	4.5%	21.0%
Drug Abuse	34.5%	10.8%	45.1%	9.1%	46.0%
Developmental Disability	1.2%	2.7%	0.0%	0.0%	27.0%
HIV/AIDS & related diseases	5.5%	0.2%	8.6%	1.9%	6.0%
Mental Illness	24.5%	21.3%	36.3%	4.9%	27.0%
Physical Disability	17.5%	14.4%	23.1%	0.9%	24.0%
Domestic Violence	6.0%	2.7%	9.1%	1.3%	7.0%
Other	3.2%	0.0%	0.0%	0.0%	9.0%
Disabled	40.9%	14.8%	60.7%	0.9%	54.0%

### **ii. Winter Shelter and Year Round Programs**

Based on responses from WSP and YRP providers in District 2, an alarming two-thirds of program clients have a substance use disorder, mental illness, or both. Covenant House, for instance, reported that 67% of their clients are affected by mental illness alone, nearly triple the level reported countywide. This provider also identified a significant number (5%) of clients with HIV/AIDS, as did MJB Recovery. The number of clients with chronic health conditions also appears particularly high among clientele of People Helping People (25%) and MJB Recovery (30%) (see Table 29).

	<b>District Average</b>	<b>VOA (Culver)</b>	<b>VOA (Federal)</b>	<b>People Helping People</b>	<b>Covenant House</b>	<b>MJB Recovery</b>
Program Type		<b>WSP</b>	<b>WSP</b>	<b>YRP</b>	<b>WSP</b>	<b>YRP</b>
Mental Illness (Only)	28.4%	5.0%	5.0%	40.0%	67.0%	25.0%
Substance Use Disorder (Only)	16.6%	10.0%	10.0%	20.0%	3.0%	40.0%
Co-occurring Disorder	34.0%	50.0%	50.0%	10.0%	30.0%	30.0%
Developmentally Delayed	2.6%	0.0%	0.0%	5.0%	7.0%	1.0%
HIV/AIDS	2.0%	0.0%	0.0%	0.0%	5.0%	5.0%
Chronic Health Condition	13.0%	2.0%	2.0%	25.0%	6.0%	30.0%
Mobility Impaired	1.6%	1.0%	1.0%	0.0%	1.0%	5.0%
Other	13.2%	33.0%	33.0%	0.0%	0.0%	0.0%

## e. Prior Living Situation

### i. Access Centers

On average, the previous living situation of Access Center clients in District 2 is somewhat evenly divided among independent housing (27%), shelters (29%), and the streets (34%). Twice as many clients appear to be receiving Access Center services after having lived most recently in shelters than was the case in District 1, where only 14% had been receiving services. Within the programs, however, there are some notable areas of comparison.

For example, Bridge of Hope’s clients are overwhelmingly from the streets (71%), whereas PATH’s clients seem to be living with friends and relatives (24%) or in their own apartments (23%). Weingart, on the other hand, appears to be serving some of the least stable of the homeless population, with nearly half (49%) from shelters and another 37% from the streets. Also, there is a large percentage of their clients who are accessing services after fleeing a domestic violence situation (7%) (see Table 30).

	<b>District Average</b>	<b>Bridge of Hope</b>	<b>PATH</b>	<b>Weingart</b>	<b>WLCAC</b>
<b>Independent Housing</b>	27.2%	2.0%	46.6%	4.0%	40.4%
Friends/Relatives	17.4%	1.1%	24.0%	4.0%	31.9%
Rental Housing	9.8%	0.9%	22.6%	0.0%	8.5%
<b>Institutional Care</b>	2.8%	0.0%	4.6%	3.0%	0.6%
Hospital	0.3%	0.0%	0.9%	0.0%	0.0%
Jail/Prison	0.0%	0.0%	0.0%	0.0%	0.0%
Psychiatric Facility	0.2%	0.0%	0.4%	0.0%	0.2%
Substance Abuse Facility	2.3%	0.0%	3.3%	3.0%	0.4%
<b>Shelter</b>	29.2%	26.7%	14.4%	49.0%	22.0%
Emergency Shelter	23.1%	26.5%	12.2%	39.0%	14.4%
Transitional Housing	6.1%	0.2%	2.2%	10.0%	7.6%
<b>Streets</b>	34.0%	71.2%	22.6%	37.0%	35.6%
<b>Unknown/Other</b>	3.7%	0.0%	10.9%	0.0%	8.5%
<b>Domestic Violence Situation</b>	3.1%	0.0%	0.9%	7.0%	1.5%

### ii. Winter Shelter and Year Round Programs

Close to six in ten WSP and YRP clients are coming from the streets in District 2, though two WSP providers and one YRP provider indicate that at least 85% of their clients fit this category. It is anticipated that large numbers of incoming shelter users would be from the streets, but these District 2 numbers are well above the 40% average countywide.

Perhaps more importantly, 14% of these program clients are most recently leaving institutional care, including 4% post-incarcerated, over 5% leaving psychiatric facilities, and another 3% leaving substance abuse treatment programs. An astonishing 45% of MJB Recovery’s clients are leaving these facilities, including 25% from psychiatric facilities. On another note, more than one-third of Covenant House’s service recipients identified friends or relatives (25%), or rental housing (9%), as their most recent living situation (see Table 31).

<b>Table 31: Prior Living Situation of WSP and YRP Clients (District 2)</b>						
	<b>District Average</b>	<b>VOA (Culver)</b>	<b>VOA (Federal)</b>	<b>People Helping People</b>	<b>Covenant House</b>	<b>MJB Recovery</b>
<b>Program Type</b>		<b>WSP</b>	<b>WSP</b>	<b>YRP</b>	<b>YRP</b>	<b>YRP</b>
<b>Independent Housing</b>	15.2%	1.0%	1.0%	10.0%	34.0%	30.0%
Friends/Relatives	11.4%	1.0%	1.0%	5.0%	25.0%	25.0%
Rental Housing	3.8%	0.0%	0.0%	5.0%	9.0%	5.0%
<b>Institutional Care</b>	14.0%	7.0%	7.0%	0.0%	11.0%	45.0%
Hospital	1.8%	1.0%	1.0%	0.0%	2.0%	5.0%
Jail/Prison	4.0%	5.0%	5.0%	0.0%	5.0%	5.0%
Psychiatric Facility	5.4%	5.0%	5.0%	0.0%	2.0%	25.0%
Substance Abuse Facility	2.8%	1.0%	1.0%	0.0%	2.0%	10.0%
<b>Motel/Hotel (no voucher)</b>	1.0%	0.0%	0.0%	0.0%	0.0%	5.0%
<b>Shelter</b>	3.8%	0.0%	0.0%	0.0%	9.0%	10.0%
Emergency Shelter	2.0%	0.0%	0.0%	0.0%	5.0%	5.0
Domestic Violence Shelter	1.0%	0.0%	0.0%	0.0%	0.0%	5.0%
Transitional Housing	0.8%	0.0%	0.0%	0.0%	4.0%	0.0%
<b>Streets</b>	59.4%	85.0%	85.0%	90.0%	27.0%	10.0%
<b>Unknown/Other</b>	5.6%	2.0%	7.0%	0.0%	19.0%	0.0%

#### **f. Destination**

On a positive note, and as one would expect given the structure of the Continuum of Care, clients receiving services through District 2 Access Centers are moving on to more stable living arrangements. On average, almost one-third (35%) are being placed in transitional housing programs, while one-fifth (21%) are able to obtain a bed in an emergency shelter. Weingart, for instance, reports that more than half (55%) of its clients are placed into transitional housing. WLCAC, on the other hand, assists half of its clients to move in with family or friends, either transitionally (20%) or permanently (30%).

PATH appears successful at assisting its clients, some 11%, into in-patient alcohol or drug treatment programs, which is significant given the large number of their population that is affected by drug or alcohol addictions. For some reason, Bridge of Hope indicated the greatest percentage of Access Center clients in the district moving on to permanent non-subsidized housing, but more than three-quarters of their clients left for reasons unknown (see Table 32).

<b>Table 32: Destination of Clients Served through Access Centers (District 2)</b>					
	<b>District Average</b>	<b>Bridge of Hope</b>	<b>PATH</b>	<b>Weingart</b>	<b>WLCAC</b>
<b>Permanent</b>					
Rental house/apt. (no subsidy)	1.6%	3.6%	0.5%	1.2%	3.2%
Public Housing	0.5%	0.8%	0.0%	0.0%	2.3%
Section 8	0.2%	1.6%	0.0%	0.0%	0.0%
Shelter Plus Care	0.1%	0.0%	0.2%	0.0%	0.0%
HOME subsidized house/apt.	0.0%	0.0%	0.0%	0.0%	0.0%
Other subsidized house/apt.	0.2%	0.4%	0.4%	0.0%	0.0%
Homeownership	0.0%	0.0%	0.0%	0.0%	0.0%
Moved in w/ family or friends	5.8%	0.0%	0.3%	0.1%	30.1%
<b>Transitional</b>					
Transitional housing	35.4%	0.2%	37.7%	54.9%	10.1%
Moved in w/ family or friends	3.6%	13.3%	0.0%	0.0%	19.6%
<b>Institution</b>					
Psychiatric hospital	0.0%	0.0%	0.0%	0.0%	0.0%
In-patient alcohol/drug treatment	5.2%	3.2%	11.4%	0.0%	2.3%
Jail/prison	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Emergency Shelter</b>					
Emergency Shelter	20.5%	0.0%	21.2%	24.1%	24.7%
<b>Other</b>					
Other supportive housing	0.0%	0.4%	0.0%	0.0%	0.0%
Street	0.4%	0.0%	0.0%	1.1%	0.0%
Other	3.6%	0.0%	0.0%	11.3%	0.0%
Unknown	22.9%	76.5%	28.2%	7.3%	7.8%

## 5. District 3

### a. Gender

Unlike the gender figures for District 1 (and to a lesser extent District 2), clients receiving services in L.A. Family Housing’s Access Center in the San Fernando Valley are primarily male, more than two-thirds of the overall population (see Table 33).

<b>Table 33: Gender Disparities of Access Center Clients (District 3)</b>	
	<b>L.A. Family Housing</b>
<b>Male</b>	67.4%
<b>Female</b>	32.6%

### b. Age

Most clients (60%) served through L.A. Family Housing’s Access Center were between the ages of 31-50, though more than one-quarter (29%) of clients were younger than age 31. Individuals over the ages of 50 (11%) represent a much smaller percentage of overall clients in the district in comparison to the county average (18%) for this age range (see Table 34).

<b>Table 34: Age Disparities of Access Center Clients (District 3)</b>	
<b>Age Range</b>	<b>L.A. Family Housing</b>
<b>0-17</b>	0.1%
<b>18-30</b>	28.7%
<b>31-50</b>	60.0%
<b>51-61</b>	9.6%
<b>62+</b>	1.3%

### c. Race and Ethnicity

The ethnic composition of Access Center clients in the San Fernando Valley is similar to the countywide averages. Close to one-third (29%) identify as Hispanic or Latino.

In terms of race, there appears to be significantly less Black clients (31%) than there are countywide (54%), and a greater percentage of Whites (27% versus 21% in the county). A significant number of clients also identify as biracial, including almost 4% who are Black and American Indian (see Table 35).

<b>Table 35: Race and Ethnicity of Access Center Clients (District 3)</b>	
	<b>L.A. Family Housing</b>
<b>Ethnicity</b>	
Hispanic or Latino	28.9%
Non-Hispanic or Non-Latino	71.1%
<b>Race</b>	
Amer. Indian/Alaskan Native American	3.1%
Asian	1.2%
Black/African American	30.7%
Nat. Hawaiian/Pacific Islander	0.7%
White	27.4%
American Indian + White	1.2%
Asian + White	0.3%
Black + White	2.7%
American Indian + Black	3.7%
Other	29.0%

#### **d. Special Needs**

The extent of special needs among Access Center clients in this district is relatively lower than reported elsewhere in the county. For instance, only 8% of clients are considered disabled, compared to 30% countywide. Slightly less than one-fifth (17%) report abusing substances, 12% abuse alcohol, and 13% are affected by a mental illness (see Table 36).

Among clients of the Year Round Program, however, substantial numbers have special needs. Most visibly, some 40% of shelter users are considered to have a substance use disorder only, which is double the countywide average (19%). The percentages of persons with a mental illness only, a co-occurring substance use disorder and a mental illness, or HIV/AIDS are on par with those rates across the county (see Table 36).

<b>Table 36: Special Needs of Access Center and YRP Clients (District 3)</b>			
	<b>L.A. Family Housing</b>		<b>L.A. Family Housing</b>
<b>Program Type</b>	<b>AC</b>		<b>YRP</b>
Alcohol Abuse	11.9%	Substance Use Disorder Only	40.0%
Drug Abuse	17.4%	Co-occurring Disorder	25.0%
Developmental Disability	2.8%	Developmentally Delayed	5.0%
HIV/AIDS & related diseases	3.4%	HIV/AIDS	2.0%
Mental Illness	13.0%	Mental Illness Only	20.0%
Physical Disability	5.3%	Chronic Health Condition	2.0%
Domestic Violence	3.0%	Mobility Impaired	6.0%
Other	0.0%	Other	0.0%
Disabled	8.0%		

#### **e. Prior Living Situation**

District 3 experiences relatively large numbers of Access Center clients who identify emergency shelters (41%) as their most recent living situation. Together with persons leaving the streets (20%), there are over 60% coming from one of these two places, which is average when compared to the rest of the county. There are also twice as many clients (7.6%) leaving substance abuse facilities than reported countywide (3%) (see Table 37).

Data from L.A. Family Housing’s Year Round Program, on the other hand, show much contrast in relation to the countywide averages. Far fewer clients are leaving independent housing (6%), institutional care (2%), or the streets (20%). Conversely, some 66% of incoming shelter participants are leaving other emergency shelters, roughly four times the average reported across the county (see Table 37).

<b>Table 37: Prior Living Situation of Access Center and YRP Clients (District 3)</b>		
	<b>L.A. Family Housing</b>	
<b>Program Type</b>	<b>AC</b>	<b>YRP</b>
<b>Independent Housing</b>	17.5%	6.0%
Friends/Relatives	13.6%	5.0%
Rental Housing	3.9%	1.0%
<b>Institutional Care</b>	9.8%	2.0%
Hospital	1.5%	1.0%
Jail/Prison	0.4%	0.0%
Psychiatric Facility	0.3%	0.0%
Substance Abuse Facility	7.6%	1.0%
<b>Motel/Hotel (no voucher)</b>	N/A	5.0%
<b>Shelter</b>	41.2%	66.0%
Emergency Shelter	39.0%	65.0%
Domestic Violence Shelter	N/A	0.0%
Transitional Housing	2.2%	1.0%
<b>Streets</b>	19.8%	20.0%
<b>Unknown/Other</b>	12.7%	1.0%

#### **f. Destination**

In District 3, a majority (54%) of Access Center clients report emergency shelters as their destination. This finding is double the countywide norm, well exceeding such statistics for Districts 1 and 2, and suggests that the district has been successful at moving clients on to more stable living situations within the Continuum of Care. At the same time, there are very few clients (6%) who are receiving Access Center services and obtaining a bed in a transitional housing program. More than one-third (35%) of client destinations in District 3 are unknown (see Table 38).

<b>Table 38: Destination of Access Center and YRP Clients (District 3)</b>	
	<b>L.A. Family Housing</b>
<b>Permanent</b>	
Rental house/apt. (no subsidy)	0.9%
Public Housing	0.2%
Section 8	0.0%
Shelter Plus Care	0.0%
HOME subsidized house/apt.	0.0%
Other subsidized house/apt.	0.1%
Homeownership	0.0%
Moved in w/ family or friends	1.6%
<b>Transitional</b>	
Transitional housing	6.3%
Moved in w/ family or friends	0.0%
<b>Institution</b>	
Psychiatric hospital	0.1%
In-patient alcohol/drug treatment	0.7%
Jail/prison	0.1%
<b>Emergency Shelter</b>	
Emergency Shelter	53.8%
<b>Other</b>	
Other supportive housing	0.1%
Street	0.3%
Other	0.5%
Unknown	35.3%

## 6. District 4

### a. Special Needs

#### i. Access Centers

With the exception of alcohol abuse, Access Center clients in District 4 are less likely to have special needs in comparison to persons receiving such services in other districts throughout the county. The number of persons reported with mental illness (9%), for instance, is less than half the countywide average (20%). Only 5.5% of clients are physically disabled, which is well below the 13% reported across the county. Even the number of persons considered disabled across the district, slightly less than 10%, is but a third of the 30% reported in the entire county.

Nonetheless, the level of alcohol abuse is comparatively higher than elsewhere in the county, though not drastically. On average, more than one-quarter (26%) of Access Center clients in District 4 are reported as alcohol abusers, versus 15% of the client population countywide. This finding may simply be the result of Substance Abuse Foundation's programs, which target persons with substance abuse disorders. Yet, even Beyond Shelter reports that close to half of its client population is affected by alcohol (42%) or drug abuse (50%) (see Table 39).

	<b>District Average</b>	<b>Beyond Shelter</b>	<b>Substance Abuse Foundation</b>	<b>New Image</b>	<b>City of Long Beach</b>
Alcohol Abuse	26.3%	42.3%	84.3%	13.6%	3.6%
Drug Abuse	19.1%	50.0%	50.0%	21.2%	4.9%
Developmental Disability	0.0%	0.0%	0.0%	0.0%	0.0%
HIV/AIDS & related diseases	0.5%	0.0%	0.9%	0.0%	0.4%
Mental Illness	9.3%	0.0%	6.0%	1.5%	12.0%
Physical Disability	5.5%	3.8%	5.1%	0.0%	6.4%
Domestic Violence	2.0%	23.1%	0.5%	1.5%	1.7%
Other	0.4%	0.0%	0.0%	1.5%	0.4%
Disabled	9.5%	3.8%	5.1%	0.0%	12.8%

## ii. Winter Shelter Programs

The special needs of clients served through New Image’s Winter Shelter Program in San Pedro are quite different in at least three cases than those found on average throughout the rest of the county. For one, the extent of the population with chronic health conditions is extremely high (42%), more than double the countywide average. New Image’s figures also reflect a substantial percentage of clients with substance abuse disorders only (38%) and HIV/AIDS (3%), both of which far surpass their statistical counterparts throughout the county (19% and 1.5%, respectively) (see Table 40).

<b>Table 40: Special Needs of WSP Clients (District 4)</b>	
	<b>New Image WSP</b>
Mental Illness (Only)	12.0%
Substance Use Disorder (Only)	38.0%
Co-occurring Disorder	25.0%
Developmentally Delayed	2.0%
HIV/AIDS	3.0%
Chronic Health Condition	42.0%
Mobility Impaired	4.0%

## b. Prior Living Situation

### i. Access Centers

Access Center providers in District 4 report that nearly two-thirds (65%) of their clients identify the streets as their most recent living situation prior to accessing program services. Among some programs, such as those operated by New Image or the City of Long Beach for example, this figure is closer to three-quarters. Only Beyond Shelter indicated otherwise, instead reporting large percentages of clients leaving transitional housing (62%), substance abuse facilities (15%), or domestic violence situations (12%), and oddly none coming from the streets.

Other living situations appear at or below average, especially forms of independent housing. Though 28% of Access Center clients in the entire county identified such housing as their most recent living situation, only 11% did so on average in this district (see Table 41).

	<b>District Average</b>	<b>Beyond Shelter</b>	<b>Substance Abuse Foundation</b>	<b>New Image</b>	<b>City of Long Beach</b>
<b>Independent Housing</b>	10.9%	0.0%	8.8%	12.1%	12.0%
Friends/Relatives	8.0%	0.0%	8.8%	12.1%	7.5%
Rental Housing	2.9%	0.0%	0.0%	0.0%	4.5%
<b>Institutional Care</b>	7.0%	15.4%	17.6%	1.5%	3.0%
Hospital	0.2%	0.0%	0.0%	0.0%	0.4%
Jail/Prison	3.1%	0.0%	5.6%	1.5%	2.4%
Psychiatric Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Substance Abuse Facility	3.7%	15.4%	12.0%	0.0%	0.2%
<b>Shelter</b>	15.2%	73.0%	13.9%	10.6%	13.5%
Emergency Shelter	10.1%	11.5%	6.0%	0.0%	12.9%
Transitional Housing	5.1%	61.5%	7.9%	10.6%	0.6%
<b>Streets</b>	65.4%	0.0%	57.4%	75.8%	70.5%
<b>Unknown/Other</b>	0.7%	0.0%	1.9%	0.0%	0.4%
<b>Domestic Violence Situation</b>	0.8%	11.5%	0.5%	0.0%	0.6%

## ii. Winter Shelter Programs

Clients in New Image’s WSP are overwhelmingly from the streets (70%). Significant percentages of clients identify other shelters (17%) as well as different types of institutional care (12%) as their most recent living situations. A relatively low percentage of clients, on the other hand, report some form of independent housing (7%) in relation to the rest of the county (30%) (see Table 42).

	<b>New Image WSP</b>
<b>Independent Housing</b>	7.0%
Friends/Relatives	4.0%
Rental Housing	3.0%
<b>Institutional Care</b>	12.0%
Hospital	3.0%
Jail/Prison	3.0%
Psychiatric Facility	1.0%
Substance Abuse Facility	5.0%
<b>Motel/Hotel (no voucher)</b>	2.0%
<b>Shelter</b>	17.0%
Emergency Shelter	10.0%
Domestic Violence Shelter	2.0%
Transitional Housing	5.0%
<b>Streets</b>	70.0%
Unknown/Other	2.0%

### c. Destination

Overall, clients receiving services through Access Center programs in District 4 seem on average most likely to obtain beds in transitional housing (18%) or emergency shelter (17%) programs, even though fewer clients do so than reported countywide (22% and 27%, respectively). A large percentage of clients were reported to be leaving for destinations unknown (40%).

Among specific programs, however, there are differences. In stark contrast to the others, Beyond Shelter’s clients have been very successful in obtaining permanent non-subsidized housing (19%) and rental housing through the federal Section 8 program (63%).

New Image and the City of Long Beach, on the other hand, are placing close to half their clients (42% and 59%, respectively) into emergency shelters, close to double the countywide average for such placements. Also of note, New Image’s clients, if not seeking emergency shelter, are primarily moving back with family and friends on a permanent basis (39%) (see Table 43).

	<b>District Average</b>	<b>Beyond Shelter</b>	<b>Substance Abuse Foundation</b>	<b>New Image</b>	<b>City of Long Beach</b>
<b>Permanent</b>					
Rental house/apt. (no subsidy)	1.3%	18.8%	0.5%	0.0%	0.0%
Public Housing	0.0%	0.0%	0.0%	0.0%	0.0%
Section 8	3.2%	62.5%	0.0%	0.0%	0.0%
Shelter Plus Care	0.0%	0.0%	0.0%	0.0%	0.0%
HOME subsidized house/apt.	0.0%	0.0%	0.0%	0.0%	0.0%
Other subsidized house/apt.	0.0%	0.0%	0.0%	0.0%	0.0%
Homeownership	0.0%	0.0%	0.0%	0.0%	0.0%
Moved in with family or friends	8.7%	6.3%	1.0%	38.5%	12.5%
<b>Transitional</b>					
Transitional housing	17.5%	0.0%	20.6%	5.8%	25.0%
Moved in with family or friends	2.3%	6.3%	2.4%	0.0%	3.1%
<b>Institution</b>					
Psychiatric hospital	1.0%	0.0%	1.4%	0.0%	0.0%
In-patient alcohol/drug treatment	7.8%		11.0%	1.9%	0.0%
Jail/prison	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Emergency Shelter</b>					
Emergency Shelter	16.8%	0.0%	5.3%	42.3%	59.4%
<b>Other</b>					
Other supportive housing	1.9%	0.0%	2.9%	0.0%	0.0%
Street	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown	39.5%	6.3%	55.0%	11.5%	0.0%

## 7. District 5

### a. Gender

The percentage of females among Access Center clients in District 5 is very akin to the figures for District 1, where they represent approximately 60% of the population served, and is noticeably higher than the countywide average (48%). Within the district, however, there appear to be more females (63%) accessing services in the eastern areas, such as West Covina, compared to a more equitable distribution in the Antelope Valley (see Table 44).

	<b>District Average</b>	<b>West Covina</b>	<b>Antelope Valley</b>
<b>Male</b>	39.8%	36.9%	46.4%
<b>Female</b>	60.2%	63.1%	53.6%

### b. Age

On average, Access Center clients in District 5, regardless of location, are for the most part (48%) between the ages of 31 and 50. Otherwise, age figures are generally similar to the countywide averages, with a few minor exceptions. Slightly more clients are under 30 (32% versus 28%), and over 51 (21% versus 18%), especially in West Covina, where a notable 8% of clients are above the age of 62 (see Table 45).

<b>Age Range</b>	<b>District Average</b>	<b>West Covina</b>	<b>Antelope Valley</b>
<b>0-17</b>	0.0%	0.0%	0.0%
<b>18-30</b>	32.1%	30.5%	31.1%
<b>31-50</b>	48.3%	47.3%	50.7%
<b>51-61</b>	14.9%	14.4%	16.1%
<b>62+</b>	6.1%	7.8%	2.0%

### c. Race and Ethnicity

Just over two-thirds of clients (67%) receiving services through Access Centers in District 5 identify as Non-Hispanic or Non-Latino, which is slightly less than reported Countywide (75%). Antelope Valley's ethnic composition however appears nearly identical to countywide figures.

Approximately one-third of clients on average identify as Black/African American and/or White (36%). Again, there is an evident disparity between the different regions of District 5. Antelope Valley clients, for instance, are almost entirely Black or White, whereas West Covina's suggest more diversity, given that some 36% are identified as "other" (see Table 46).

<b>Table 46: Race and Ethnicity of Access Center Clients (District 5)</b>			
	<b>District Average</b>	<b>West Covina</b>	<b>Antelope Valley</b>
<b>Ethnicity</b>			
Hispanic or Latino	32.7%	35.9%	25.7%
Non-Hispanic or Non-Latino	67.3%	64.1%	74.3%
<b>Race</b>			
American Indian/ Alaskan Native	2.8%	2.8%	2.7%
Asian	0.1%	0.0%	0.3%
Black/African American	32.0%	26.8%	43.5%
Native Hawaiian/ Pacific Islander	1.5%	2.0%	0.3%
White	36.0%	29.6%	50.0%
American Indian + White	0.0%	0.0%	0.0%
Asian + White	0.0%	0.0%	0.0%
Black + White	3.0%	2.8%	3.3%
Amer. Indian + Black	0.0%	0.0%	0.0%
Other	24.7%	35.9%	0.0%

#### **d. Special Needs**

##### **i. Access Centers**

The special needs of clients in the two District 5 Access Centers show significant levels of persons with alcohol use (15%) or drug use (8%) disorders, or affected by mental illness (11%), although all of these figures fall at or below what has been reported countywide in these areas. Antelope Valley appears somewhat unique in that 18% of its clients have a developmental disability, a very high level, while roughly one-quarter is physically disabled (see Table 47).

<b>Table 47: Special Needs of Access Center Clients (District 5)</b>			
	<b>District Average</b>	<b>Antelope Valley</b>	<b>West Covina</b>
Alcohol Abuse	15.2%	12.4%	17.8%
Drug Abuse	8.3%	10.4%	8.1%
Developmental Disability	5.6%	18.3%	0.3%
HIV/AIDS & related diseases	0.3%	0.3%	0.3%
Mental Illness	10.9%	22.2%	6.8%
Physical Disability	10.1%	24.6%	4.3%
Domestic Violence	3.0%	6.5%	1.6%
Other	9.3%	0.0%	14.3%
Disabled	32.8%	Not reported	32.8%

## ii. Winter Shelter and Year Round Programs

The differentiation of special needs among WSP and YRP clients in District 5 is very similar to the countywide averages. Across all programs, at least one-fifth are considered to have either only a substance use disorder (20%) or a mental illness (25%), or live with both conditions (26%). Clients of the YMCA of Glendale WSP are also likely to live with a chronic health condition (40%) or have a mobility impairment (15%) (see Table 48).

	<b>District Average</b>	<b>Lancaster</b>	<b>Santa Clarita</b>	<b>YMCA of Glendale</b>
Program Type		WSP	YRP	WSP
Mental Illness (Only)	25.0%	20.0%	20.0%	35.0%
Substance Use Disorder (Only)	20.3%	20.0%	10.0%	31.0%
Co-occurring Disorder	25.7%	20.0%	32.0%	25.0%
Developmentally Delayed	6.7%	0.0%	8.0%	12.0%
HIV/AIDS	1.0%	2.0%	0.0%	1.0%
Chronic Health Condition	20.0%	20.0%	0.0%	40.0%
Mobility Impaired	5.0%	0.0%	0.0%	15.0%
Other	0.0%	0.0%	0.0%	0.0%

## e. Prior Living Situation

### i. Access Centers

On average, Access Center clients in District 5 identify some form of independent housing (39%) or the streets (36%), and to a less extent a type of shelter (19%), as their most recent living situation. The percentage of clients leaving rental housing (26%), for example, is particularly high (more than two times that reported on average countywide), especially in West Covina, where more than one-third (34%) of persons served had resided most recently.

In contrast, IURD's figures indicate their programs are serving mostly street-based and shelter-based populations (see Table 49).

	<b>District Average</b>	<b>Antelope Valley</b>	<b>IURD (SA)</b>	<b>IURD (HEP)</b>	<b>IURD (MH)</b>	<b>West Covina</b>
<b>Independent Housing</b>	39.3%	46.4%	9.0%	0.0%	12.6%	44.5%
Friends/Relatives	13.8%	27.5%	3.6%	0.0%	7.0%	10.3%
Rental Housing	25.5%	18.9%	5.4%	0.0%	5.6%	34.2%
<b>Institutional Care</b>	1.9%	0.6%	5.4%	0.0%	7.0%	2.0%
Hospital	0.7%	0.0%	1.8%	0.0%	2.8%	0.8%
Jail/Prison	0.2%	0.3%	0.0%	0.0%	0.0%	0.3%
Psychiatric Facility	0.3%	0.0%	0.0%	0.0%	0.0%	0.5%
Substance Abuse Facility	0.7%	0.3%	3.6%	0.0%	4.2%	0.4%
<b>Shelter</b>	19.3%	21.0%	3.6%	85.3%	47.9%	10.8%
Emergency Shelter	18.1%	18.6%	1.8%	85.3%	46.5%	10.1%
Transitional Housing	1.2%	2.4%	1.8%	0.0%	1.4%	0.7%
<b>Streets</b>	35.5%	29.6%	82.1%	13.2%	26.8%	37.6%
<b>Unknown/Other</b>	2.8%	0.0%	0.0%	0.0%	4.2%	4.5%
<b>Domestic Violence Situation</b>	1.2%	2.4%	0.0%	1.5%	1.4%	0.7%

## **ii. Winter Shelter and Year Round Programs**

Consistent with the previous table, WSP and YRP clients are most likely to come from some form of independent housing (38%), but also the streets (26%), or shelters (25%). The percentage of persons leaving institutional care (7%) is lower than the countywide average (11%), although Lancaster’s YRP reported 10% of its clients leaving jail or prison, more than double the average reported among other shelter providers in the county.

Specifically, Lancaster reports an extremely high level (60%) of clients leaving other emergency shelters. It is also worth noting that three-quarters of clients in Santa Clarita’s program left some sort of independent housing, including 70% from friends or relatives, prior to entering the shelter (see Table 50).

	<b>District Average</b>	<b>Lancaster</b>	<b>Santa Clarita</b>	<b>YMCA of Glendale</b>
<b>Program Type</b>		YRP	WSP	WSP
<b>Independent Housing</b>	38.3%	20.0%	75.0%	20.0%
Friends/Relatives	30.3%	10.0%	70.0%	11.0%
Rental Housing	8.0%	10.0%	5.0%	9.0%
<b>Institutional Care</b>	7.0%	12.0%	0.0%	9.0%
Hospital	1.3%	1.0%	0.0%	3.0%
Jail/Prison	4.0%	10.0%	0.0%	2.0%
Psychiatric Facility	0.7%	1.0%	0.0%	1.0%
Substance Abuse Facility	1.0%	0.0%	0.0%	3.0%
<b>Motel/Hotel (no voucher)</b>	0.3%	0.0%	0.0%	1.0%
<b>Shelter</b>	25.3%	60.0%	0.0%	16.0%
Emergency Shelter	24.3%	60.0%	0.0%	13.0%
Domestic Violence Shelter	0.3%	0.0%	0.0%	1.0%
Transitional Housing	0.7%	0.0%	0.0%	2.0%
<b>Streets</b>	26.0%	8.0%	25.0%	45.0%
<b>Unknown/Other</b>	1.7%	0.0%	0.0%	5.0%

#### **f. Destination**

In District 5, Access Center programs have demonstrated success at assisting their clients to obtain (or remain with) their own permanent housing arrangements, particularly a non-subsidized unit (8%) or with family or friends (8%). Yet, two of IURD’s programs, those serving persons with substance abuse disorders and mental illness, report above average figures for the percentages of clients moving on to subsidized housing, such as Shelter Plus Care (4% and 11%, respectively). This district also shows a relatively large percentage of clients (10%) moving on to in-patient alcohol or drug treatment programs

In comparison to countywide figures for client destinations, District 5 appears to place fewer clients into transitional housing (11%) and emergency housing (19%). West Covina also indicated that close to one-third (30%) of its clients return to the streets after accessing program services. Unfortunately, almost half (46%) of those using Antelope Valley’s services leave for destinations unknown (see Table 51).

<b>Table 51: Destination of Access Center Clients (District 5)</b>						
	<b>District Average</b>	<b>Antelope Valley</b>	<b>IURD-(SA)</b>	<b>IURD-(HEP)</b>	<b>IURD-(MH)</b>	<b>West Covina</b>
<b>Permanent</b>						
Rental house/apt. (no subsidy)	8.3%	7.1%	8.0%	23.1%	15.9%	6.9%
Public Housing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Section 8	0.2%	0.0%	0.0%	0.0%	4.5%	0.0%
Shelter Plus Care	0.9%	0.0%	4.0%	0.0%	11.4%	0.0%
HOME subsidized house/apt.	0.2%	0.0%	4.0%	0.0%	0.0%	0.0%
Other subsidized house/apt.	0.5%	0.5%	2.0%	0.0%	4.5%	0.0%
Homeownership	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Moved in with family or friends	8.0%	14.8%	12.0%	17.9%	6.8%	4.3%
<b>Transitional</b>						
Transitional housing	6.7%	13.2%	2.0%	17.9%	15.9%	3.1%
Moved in with family or friends	3.9%	4.9%	2.0%	10.3%	2.3%	3.3%
<b>Institution</b>						
Psychiatric hospital	0.7%	1.1%	2.0%	0.0%	0.0%	0.6%
In-patient alcohol/drug treatment	10.3%	2.9%	50.0%	2.6%	0.0%	11.2%
Jail/prison	1.0%	0.0%	0.0%	0.0%	0.0%	1.4%
<b>Emergency Shelter</b>						
Emergency Shelter	19.0%	8.2%	6.0%	5.1%	6.8%	26.5%
<b>Other</b>						
Other supportive housing	0.5%	1.1%	2.0%	0.0%	2.3%	0.0%
Street	18.3%	1.1%	0.0%	0.0%	0.0%	29.6%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown	21.5%	46.2%	6.0%	23.1%	29.5%	13.1%

## **8. Special Needs Populations**

### **a. Individuals with Mental Illness**

Individuals struggling with a mental illness can be a very visible segment of the homeless population. Studies show that they represent roughly 25% of homeless adults in Los Angeles County, a number consistent with the national estimate of 23% (Institute for the Study of Homelessness and Poverty, 2004; U.S. Conference of Mayors, 2004). However, these rates are disproportionately high compared to the prevalence of severe mental illness in the overall adult population, estimated at 2.6% - 5.4% (National Alliance for the Mentally Ill).

Based on surveys from thirteen WSP and YRPs in Los Angeles County, the prevalence of mental illness is consistent with the national and county averages of the homeless. These shelters reported that almost 24% of their client populations have a mental illness only and almost 28% have a co-occurring mental illness and substance use disorder. Data from County Access Centers indicates that 20.1% of their participants, slightly less than average, are mentally ill.

### **b. Individuals with Substance Use Disorders**

As with homelessness in general, it is difficult to arrive at an exact figure to represent the prevalence of substance abuse disorders in the homeless population. A commonly cited estimate places 20–35% of homeless individuals as having such a disorder (Milby et al, 1996 as cited in Zenger, 2002). Within Los Angeles County, estimates of substance abuse among single homeless adults range from one-third to two-thirds of the population as a whole (Institute for the Study of Homelessness and Poverty, 2004). YRP and WSP providers in Los Angeles County estimate that 18.7% of their clients have a substance use disorder only and an additional 27.8% are dually diagnosed, thereby falling within other studies' ranges. Data on Access Center participants is also consistent with the trends, as 15.2% of clients struggle with alcohol abuse and 25.3% with drug abuse (these categories are not mutually exclusive).

### **c. Individuals with Co-Occurring Disorders**

Individuals with co-occurring disorders are those who have both a diagnosed mental illness and a substance use disorder. Depending on the circumstances, one disorder may precipitate the other. A person may begin using alcohol or drugs to self-medicate the symptoms of a mental illness or, alternately, use of a substance may itself trigger a mental illness disorder.

Studies show that individuals with co-occurring substance abuse and mental health disorders account for 10-20% of the homeless population (Zenger, 2002). Approximately 50% of homeless mentally ill adults also have a co-occurring substance use disorder (Fischer and Breakey, 1991 as cited in SAMHSA, 2003). The Downtown Mental Health Center, a County Department of Mental Health clinic serving the downtown/Skid Row area of Los Angeles, reports that 47% of its clients have co-occurring disorders (USC, 2004). County emergency

shelters estimate that 27.8% of their clients have co-occurring disorders, a proportion significantly higher than the national average.

**d. Chronically Homeless**

As defined by the U.S. Department of Housing and Urban Development, a chronically homeless person is an unaccompanied adult with a disabling condition who has either been homeless continuously for at least one year or has experienced at least four episodes of homelessness in the last three years.

According to preliminary estimates of the Greater Los Angeles Homeless Count conducted in 2005, 83,347 individuals are homeless on any given night in the county, and 34,898 of them, over 42%, meet the definition of chronically homeless (Bring LA Home, 2005).<sup>7</sup> LAHSA shelter providers report that 24.7% of WSP clients and 17.8% of YRP clients are individuals who have been homeless for longer than 12 months. Although the above estimates do not meet the exact federal definition of chronic homelessness due to the lack of knowledge about the number of these individuals who are disabled, these figures remain noteworthy. The Access Centers appear to serve a relatively low proportion of chronically homeless clients (7.8%).

Countywide, there are an estimated 38,209 chronically homeless people, representing 41.3% of the homeless population (see table 57 in Section V). Other metropolitan areas with a high percentage of chronically homeless individuals are San Francisco and New York, with 20% and 23%, respectively.

The preliminary estimates of the Greater Los Angeles Homeless Count reveal high rates of special needs among the chronically homeless (see Table 52).

Mental Illness	48%
Substance Use Disorder: Alcohol	47%
Substance Use Disorder: Drugs	43%
Physical Disability	47%
Health Condition	35%

Similarly, Access Center data shows that chronically homeless clients experience higher rates of special needs than does the general client population. Most notably, the rate of alcohol abuse for chronically homeless clients is nearly double that of all clients (30.5% versus 15.5%). Drug abuse is also substantially higher for chronically homeless clients (43.6% versus 25.4%) (see Table 53).

<sup>7</sup> Excludes the Cities of Glendale, Pasadena, and Long Beach.

<b>Table 53: Special Needs of Access Center Clients</b>		
	<b>All Clients</b>	<b>Chronic Clients</b>
Mental Illness	20.1%	29.5%
Alcohol Abuse	15.5%	30.5%
Drug Abuse	25.4%	43.6%
HIV/AIDS	3.7%	3.9%
Developmental Disability	1.9%	0.6%
Physical Disability	13.0%	15.3%
Domestic Violence	5.2%	4.3%
Other	2.8%	6.9%

#### **d. Families**

Families with children are a homeless subpopulation that has been growing over recent years. The U.S. Conference of Mayors estimated that families with children represented 36% of the homeless population in 2000, and 40% in 2004 (U.S. Conference of Mayors, 2000; 2004). In Los Angeles, estimates of families range from 20% to 43% of the overall homeless population (Institute for the Study of Homelessness and Poverty, 2004). Compared to other poor, but housed, families, those who are homeless are poorer, younger, more likely to be an ethnic minority, and are less likely to have a housing subsidy (Culhane, 2004, as cited in National Alliance to End Homelessness, 2004).

A report prepared by the Los Angeles County Department of Public Social Services examining homeless families receiving CalWORKS, California's version of TANF, provides specific information on those families receiving benefits. The report found that between September and November 2004, 7% of all CalWORKS cases, approximately 13,000 families or 44,800 people, were homeless. African-American and Hispanic adults headed the majority of homeless families, at 43.6% and 40.7%, respectively. The homeless parents had younger children than non-homeless parents; in fact, they were four times more likely to have a child under one year old. Based on a sample of the CalWORKS families, 50% were 28 years old or younger, and 93.2% were headed by women (Bono, Toros, Mehrtash, & Moreno, 2005).

#### **f. Women**

Historically, the homeless population in Los Angeles has been predominantly comprised of men. Over the past several years, however, the number of homeless women has increased. Nationally, it is estimated that single women comprise 14% of the homeless population, and that families with children, most of which are headed by women, comprise 40% (U.S. Conference of Mayors, 2004). In Los Angeles County, the estimates of women in the larger homeless population range from one-third to one-half (Institute for the Study of Homelessness and Poverty, 2004).

As with all homeless subpopulations, women have varied histories. According to a 2004 study of homeless women living in the Skid Row area of downtown Los Angeles, 62.8% had been homeless for one year or more during their lifetimes, with 23.7% having been homeless for five years or more. Thirty-six percent of the studied homeless women had a mental illness, and 27.2% reported current substance abuse, recovery, or both. The study additionally found that 55.4% had been victims of domestic violence at some point in their lives. Of these women, 34.3% had experienced domestic violence in the past year (Dennison, Mendizabal, White, 2005).

#### **g. Veterans**

Nationally, it is estimated that 33% of the male homeless population are veterans, and that approximately 2% of all homeless veterans are women (National Coalition for Homeless Veterans website). According to the U.S. Conference of Mayors, 10% of the general homeless population are veterans (U.S. Conference of Mayors, 2004). In Los Angeles County, veterans represent 14% to 20% of the homeless population, compared to only 9% of the general population (Institute for the Study of Homelessness and Poverty, 2004). During the 2003/04 year, 2,172 new veterans were served in Los Angeles County's WSP system, and 3,317 in the YRP system (clients may be duplicated across shelter systems). Los Angeles County Access Centers report that veterans represent 6.2% of their client population, significantly lower than the national and county homeless averages.

#### **h. Parolees**

In 2003, the national adult parole population increased by 3.1% to a total of 774,588 individuals, with California having the largest parole population in the nation (DOJ, 2004). In the first quarter of 2005, California's parole population totaled 113,768 people. Over 35,000 of these parolees lived in Los Angeles County. In fact, of all California counties, Los Angeles is home to the most parolees, with 31% of the state's total parolee population (CDC, 2005).

Individuals on parole oftentimes exit prison into homelessness. Many people are discharged from the prison system with no housing in place and little social support to assist them. WSP and YRP intake data indicate that roughly 4% of clients entered the shelters directly from jail or prison. Furthermore, shelter providers report that approximately 11% of their clients are on parole.

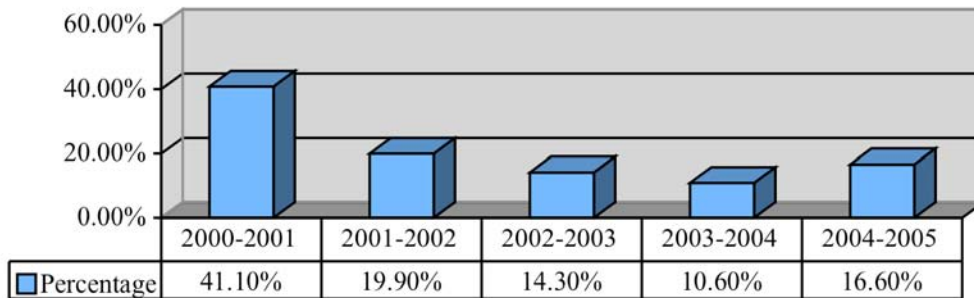
## H. Winter Shelter Program Trends

Shelter Partnership reviewed information collected by LAHSA’s winter shelter program for a four-year period, from the 2000-2001 program year to the 2004-2005 program year. While we are unable to establish with certainty why some of the changes occurred, we do speculate on a probable cause where possible. For purposes of analysis, we reviewed the percentage of people in various situations. We utilized percentages rather than raw numbers because the number of unduplicated individuals using the winter shelters is significantly different due annual program funding and the recent advent of the year round shelter program.

The data includes length of homelessness, use of the winter shelter program, self-reported causes of homelessness, previous living situation, and current income.

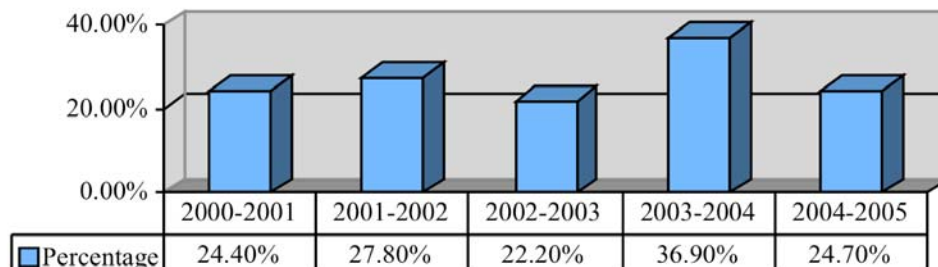
One significant improvement is that people entering the homeless shelter system who had been homeless for seven months to twelve months is decreasing. In 2000-2001, the proportion of people who had been homeless before entering the emergency shelters for seven months to twelve months was 41.1% of all participants. During the 2004-2005 winter shelter program, the proportion of people who had been homeless for this period had decreased significantly to 16.6% (see Figure 7).

**Figure 7: Percentage of Participants Homeless for Seven to Twelve Months**



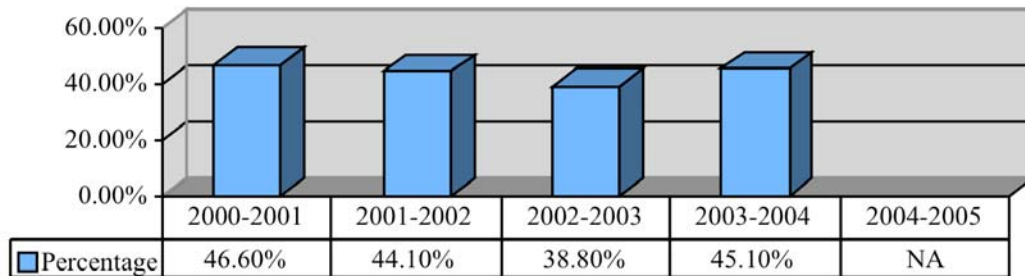
However, the number of those who had been homeless for 12 months or more was approximately the same for 2000-2001 and 2004-2005 program years at 24.4% and 24.7%, respectively (see Figure 8).

**Figure 8: Percentage of Participants Homeless for Twelve Months or More**



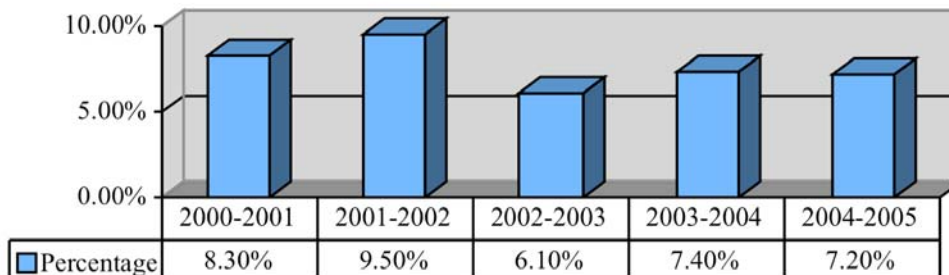
Furthermore, the proportion of participants who had used the winter shelters for two or more years was relatively stable, indicating that there is a chronic homeless population that is dependent on these shelters. In 2000-2001, 46.4% had used the shelters for two or more years, remaining about the same in 2003-2004, with 45.1% of all participants having used the shelters for two or more years (see Figure 9).

**Figure 9: Percentage of Participants Participating in Winter Shelter for Two or More Years**



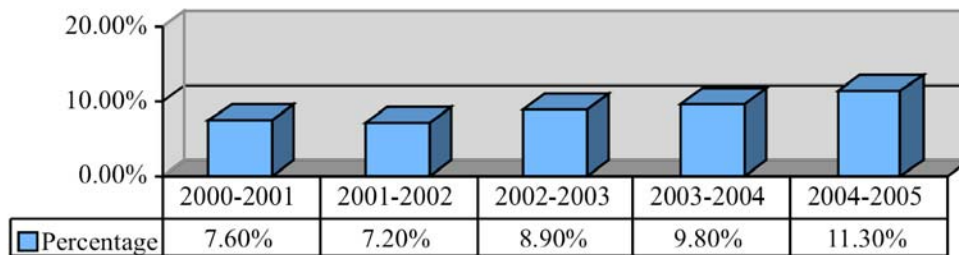
We were interested in reviewing those individuals who had some form of reported poor health as a reason for their homelessness, including those released from a hospital, and those who had an illness, injury, or other health problems. In 2000-2001, 8.3% of the individuals using the shelters indicated that they fell into one of these categories, whereas in 2004-2005, 7.2% of the individuals reported poor health as the cause of their homeless status (see Figure 10).

**Figure 10: Percentage of Participants Homeless for Health Related Issues**



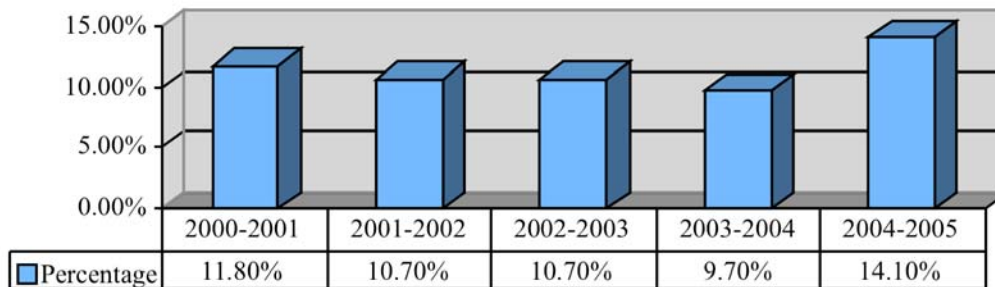
A significantly higher proportion of people in the shelters indicated that a move was responsible for their homelessness, up from 7.6% in 2000-2001 to 11.3% in 2004-2005 (see Figure 11).

**Figure 11: Percentage of Participants Homeless Caused by a Move**



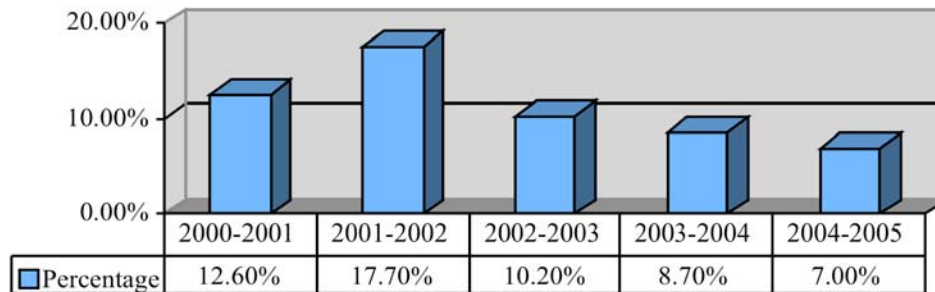
Individuals whose family/friends asked them to leave increased from 11.8% in 2000-2001 to 14.1% in 2004-2005, indicating a reduction in the ability of family/friends to assist unstably housed individuals (see Figure 12).

**Figure 12: Percentage of Participants Homeless Due to Moving From Family/Friends Homes**



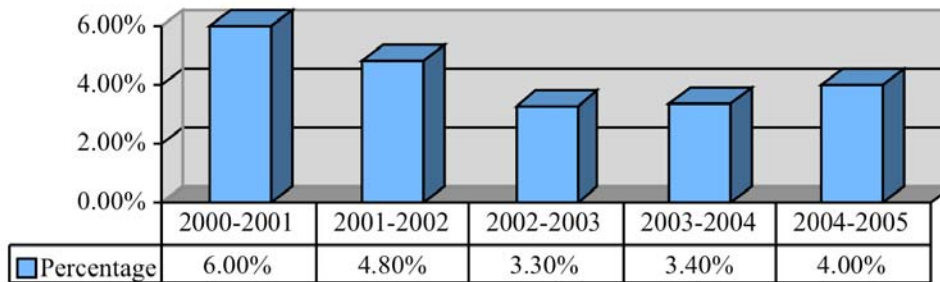
A positive finding is that individuals reporting drug/alcohol use as a precursor to becoming homeless decreased from 12.6% in 2000-2001 to 7% in 2004-2005 (see Figure 13).

**Figure 13: Percentage of Participants Homeless Due to Drugs/Alcohol Use**



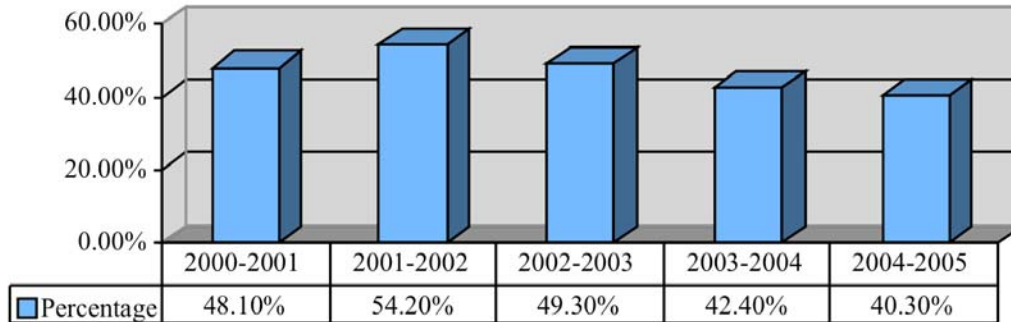
Persons whose prior living situation was reported as jail/prison actually decreased slightly from 6% in 2000-2001 to 4% in 2004-2005 (see Figure 14).

**Figure 14: Percentage of Participants Previously In Jail/Prison**



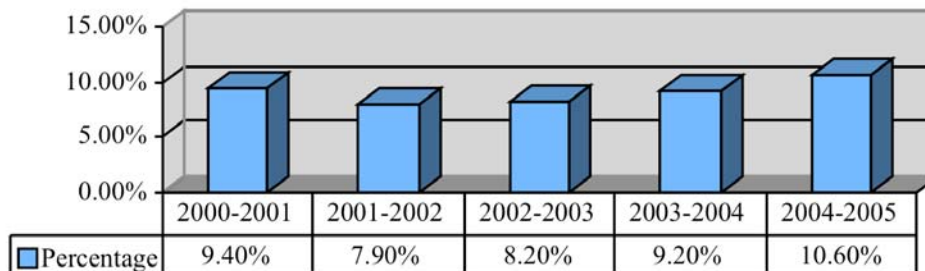
There was a decrease in the proportion of participants who previously had lived on the streets before going to the shelter from 48.1% in 2000-2001 to 40.3% in 2004-2005 (see Figure 15).

**Figure 15: Percentage of Participants Who Previously Lived on the Streets**



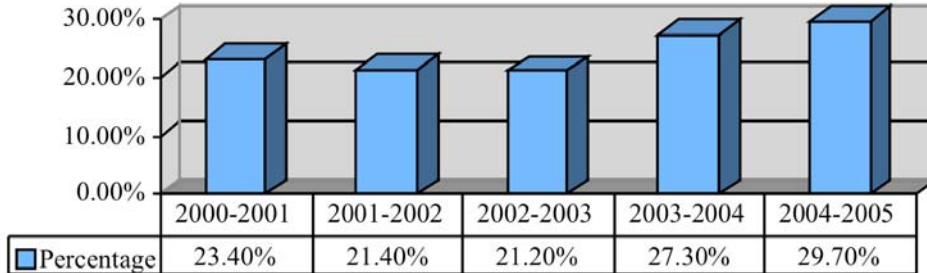
Conversely, the proportion coming from an institutionalized setting (jail/prison, psychiatric facility, hospital and substance abuse facility) increased slightly from 9.4% to 10.6% of all participants during the periods examined (see Figure 16).

**Figure 16: Percentage of Participants Previously in Jail/Prison, Psychiatric Facility, Hospital, or Substance Abuse Facility**



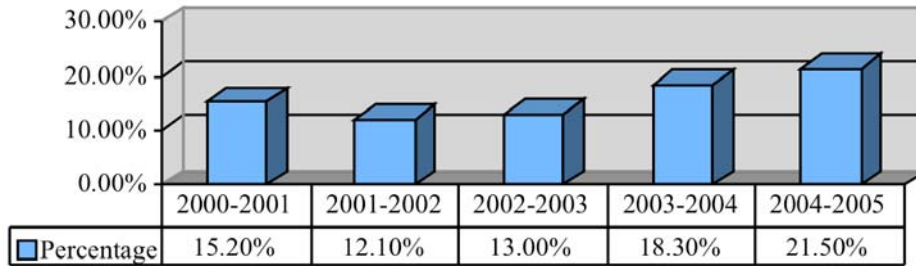
The proportion who came from their own or a friend's/relative's place of residence increased from 23.4% to 29.7%. As stated earlier, there is an apparent reduction in the "safety net" for vulnerably housed people (see Figure 17).

**Figure 17: Percentage of Participants Previously on Their Own or from a Friends/Relatives Place of Residence**



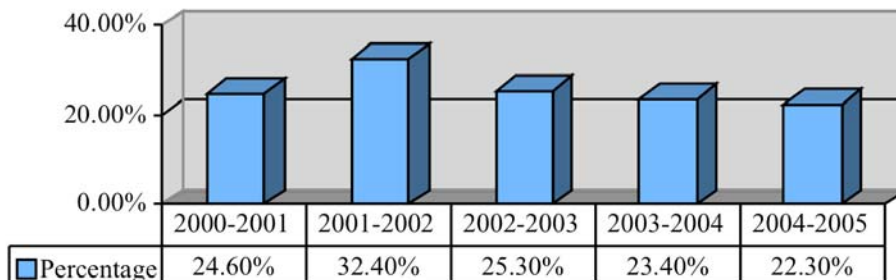
Persons with monthly incomes of \$501 to \$1,000 increased from 15.2% in 2000-2001 to 21.5% in 2004-2005 (see Figure 18).

**Figure 18: Percentage of Participants With Monthly Incomes of \$501 to \$1,000**



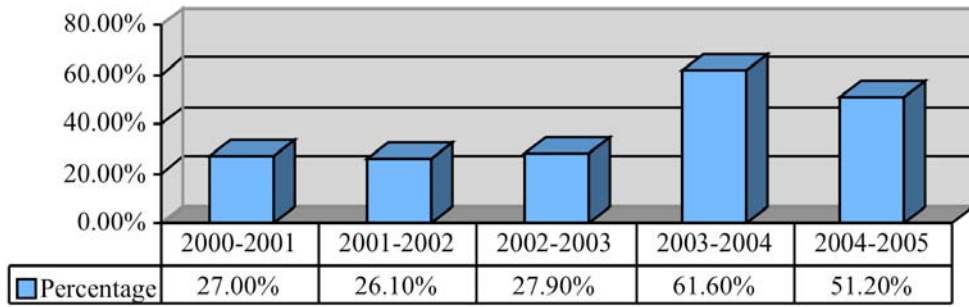
Approximately the same number of persons reported receiving General Relief in 2000-2001 as in 2004-2005, 24.6% and 22.3%, respectively (see Figure 19).

**Figure 19: Percentage of Participants Receiving General Relief**



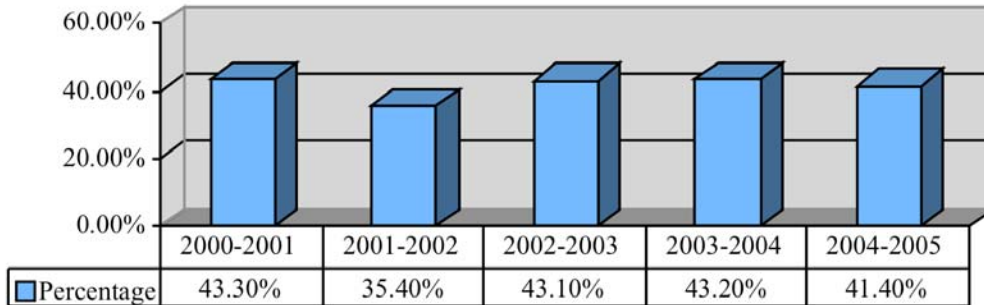
Between 2000-2001 and 2004-2005, nearly twice as many (27% compared to 51.2%) of those clients with no income who had received General Relief in the last 12 months reported that the reason they no longer earned GR was because of a sanction (see Figure 20).

**Figure 20: Percentage of Participants No Longer Receiving General Relief Because of a Sanction**



There was no significant change in the proportion of participants who reported receiving “no income”, which were 43.3% and 41.4%, respectively (see Figure 21).

**Figure 21: Percentage of Participants Receiving No Income**



## **IV. BARRIERS TO CARE**

### **A. Background**

In Los Angeles County, the ability of homeless individuals to access emergency shelter, or sufficiently stabilize themselves once there, is dependent upon a number of factors, both structural and client-specific. Structural concerns are those that are imposed by policymakers or program administrators, whether intentional or less direct in their consequence, while the latter refers to the unique needs and circumstances that shape and define the various segments of the homeless population.

Although structural barriers are less visible in terms of their negative impact on an individual, they clearly play a major role in the emergency shelter system's ability to effectively serve the intended population. During the course of this study period, Shelter Partnership's research has discovered specific areas of concern that are systemic in nature, including, but not limited to, the following:

- tremendous difficulty siting emergency shelter programs throughout the county;
- the variation of service delivery among emergency shelter operators; and
- insufficient client tracking and data collection.

Beyond these structural barriers, there are others that are more specific to the client but still warrant attention. For the most part, these barriers include the various special needs (e.g., mental illness, substance abuse, etc.) that are common among the homeless, as well as issues that are not usually considered special needs, such as lack of financial resources, or previous contact with the criminal justice system.

### **B. Structural**

#### **1. Siting**

Despite recent year advances in both federal and state fair housing protections, special needs populations continue to encounter considerable discrimination and stigma that create major impediments to accessing housing and services. This is especially true for the siting of short-term housing – emergency shelters and transitional housing for people who are homeless.

This section begins with a brief review of neighborhood and political opposition to housing for disabled persons, including persons who are homeless, which is followed by a brief description of federal and state fair housing protections. The section closes by reviewing the status of zoning ordinances of each jurisdiction within Los Angeles County, as they relate to the siting of emergency shelter and transitional housing programs.

#### **a. Neighborhood and Political Opposition**

The practice of opposing housing developments serving low-income, disabled, and/or homeless persons—so-called NIMBYism (Not In My Backyard)—endures as one of the most pervasive manifestations of communities' unwillingness to assist individuals with the

greatest needs in their neighborhoods. It is therefore hardly surprising that the NIMBY mentality and the inability to garner community support for special needs housing, including emergency shelters and transitional housing, is cited frequently—by program administrators, housing developers, advocates, and researchers—for its potential to stymie affordable housing production for the neediest members of society.

To this day, the NIMBY issue remains at the forefront of the siting difficulties for emergency shelters and transitional housing, and represents one of the greatest challenges for both consumers and developers of housing for disabled populations. Even the most benign development projects encounter this form of opposition for a variety of reasons, including lack of information, fear, conflicts of interest, issues unrelated to the proposal itself, or discriminatory attitudes.

Neighborhood concerns that affordable housing for homeless persons or those with disabilities decreases local property values, increases crime rates, and attracts “undesirable” tenants also fuels the NIMBY mentality, despite research that indicates the contrary. These fears reflect economic concerns and the substantial investment in their homes held by homeowners, as well as the notions they have about temporary housing and affordable housing.

Beyond the more overt forms of discrimination conveyed through landlords and neighborhood opposition, the aversion of local government to pursue special needs housing in their jurisdictions can also play a pivotal, if less visible, role in its development. In some respects, local government—both the elected officials and the agencies that serve them—is at the forefront of the debate about housing discrimination for persons with special needs because it represents the confluence of interests and policies that surround this issue. Local government support can make a tremendous impact. Local officials who appreciate homeless housing and service developments as community assets can advocate to increase funds for homeless services and initiate changes in local housing policies, making it easier to gain approval for needed developments.

The various government agencies that are charged with fulfilling the directives of these elected officials are integral as well, since they must approve or deny permit applications. Altogether, local government has tremendous authority to improve access to safe, decent, and affordable housing for persons with special needs, despite the lack of a demonstrated commitment to make it a priority.

Shelter Partnership can recall at least four emergency shelters in the last 18 months that were discouraged from siting in neighborhoods because of the privately expressed negative positions of the locally elected city officials.

Since the 1990s, when the federal government began to devolve federal housing funding decisions to state and local government, local policymakers have witnessed increased

authority over how federal housing funds are used in their jurisdictions.<sup>8</sup> These decisions influence both the types of low-income communities (e.g., elderly, disabled, etc.) that will benefit or have priority from federally funded housing activities and the types of activities (e.g., housing production versus rental assistance) considered for expenditure.

According to one technical assistance provider, the ability of policymakers and elected officials to endorse housing development proposals is often a product of their participation in molding the proposal and/or their awareness of existing examples of high-quality housing and services for homeless persons in their communities. In certain cases, the official may have little direct exposure to these types of programs, leaving them with piecemeal impressions and stereotypes. In the end, these assumptions can be blown out of proportion and greatly undermine potential support for the proposal (Community Acceptance Strategies Consortium et al., p. 7).

Therefore, local government is integral to a development's success and must respond to the interests of other stakeholders in the community, including its residents and business owners. The proposed 20-bed expansion of Union Station's homeless shelter in Pasadena, for example, demonstrates the intense criticisms frequently directed towards these developments and their operators. The business community, including the local Kiwanis Club, insisted that Union Station police the area surrounding its headquarters, including Pasadena's Central Park, for litter and any problems being caused by its clients.

Meanwhile, the City of Pasadena denied Union Station's expansion request, despite acknowledging that the venture was for a portion of the program whose client population (homeless women) has not been recognized as problematic by local businesses. Only after an incredible outreach effort by the program operator, and negotiations encouraged by City Hall planners and the City Council, were local stakeholders able to consent to the proposal.

Other recent cases also reflect a trend of prohibitive land use decisions by local government as they relate to establishing short-term housing programs within their boundaries. The City of Long Beach, for instance, insisted on round-the-clock security for a new 59-bed shelter, proposed in an industrial area of Long Beach, even though shelter participants would not be allowed to stay at the shelter during the day. The City of Santa Clarita, in a much publicized example of NIMBYism, contended that there was no location anywhere in their jurisdiction for a shelter, so instead proposed to transport its homeless into the City of Los Angeles. Fortunately, as a result of the leadership of Supervisor Michael Antonovich, a county-owned site was identified and made available for a short period to address the need in the winter months. Finally, the East San Gabriel Valley Homeless Shelter has to move its operations every two weeks and convince the local churches, officials, and communities to allow them to use various churches on a short-term basis.

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<sup>8</sup> For instance, state and local government housing officials and PHAs must now develop and submit strategic housing plans to HUD each year. Both the Consolidated Plan and the PHA Plan include specific housing strategies and activities that will be implemented in the jurisdiction to meet affordable housing needs.

## **b. The Federal Fair Housing Act and The California Fair Employment and Housing Act**

The federal Fair Housing Amendments Act of 1988 extends fair housing protections to individuals with disabilities in virtually every housing activity or transaction.<sup>9</sup> The Act protects an individual with a physical or mental impairment that substantially limits one or more major life activities; anyone who is regarded as having any such impairment; or anyone who has a record of having such impairment.<sup>10</sup> The Act prohibits local governments from making housing opportunities unavailable to people with disabilities through discriminatory land use and zoning rules, policies, practices, and procedures. Furthermore, cities and counties have an affirmative duty to provide reasonable accommodation in land use and zoning rules, policies, and practices where it may be necessary to provide individuals with disabilities equal opportunity in housing.<sup>11</sup>

Moreover, in a May 15, 2001 letter, the State Attorney General Bill Lockyer wrote to local governments to advise them to not rely simply on their land use procedures to evaluate developments serving the disabled. Specifically, and as the problem is demonstrated in the forthcoming analysis of land use requirements in Los Angeles County, the Attorney General stated:

*Thus municipalities relying upon these alternative procedures have found themselves in the position of having refused to approve a project as a result of considerations which, while sufficient to justify the refusal under the criteria applicable to grant of a variance or conditional use permit, were insufficient to justify the denial when judged in light of the fair housing laws' reasonable accommodations mandate....Further, and perhaps even more importantly, it may well be that reliance on these alternative procedures, with their different governing criteria, serves at least in some circumstances to encourage community opposition to projects involving desperately needed housing for the disabled. As you are well aware, opposition to such housing is often grounded on stereotypical assumptions about people with disabilities and apparently equally unfounded concerns about the impact of such homes on surrounding property values. Moreover, once triggered, it is difficult to quell. Yet this is the very type of opposition that, for example, the typical conditional use permit procedures, with its general health, safety and welfare standard, would seem rather predictably to invite, where a procedure conducted pursuant to the more focused criteria applicable to the reasonable accommodation would not. (Italics added for emphasis)*

Enacted in 1994, California's fair housing legislation prohibits discriminatory "public or private land use practices, decisions, and authorizations" including, but not limited to, "zoning laws, denials of permits, and other (land use) actions...that make housing opportunities" unavailable to people with disabilities.<sup>12</sup>

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<sup>9</sup> 24 C.F.R. 100.70 (a) (1994).

<sup>10</sup> 42 U.S.C. 3602(h); 24 C.F.R. 100.201.

<sup>11</sup> 42 U.S.C. 3604(f)(3)(B).

<sup>12</sup> Cal. Govt. Code 12955(1).

Both intentional discrimination and zoning rules and regulations that have the effect of discriminating against housing for people with disabilities is prohibited by federal and state law.

### **c. Federal Americans with Disabilities Act**

Title II of the Americans with Disabilities Act (ADA) prohibits discrimination by state and local governments against individuals with disabilities.<sup>13</sup> With broad scope and complementary of the federal Fair Housing Act, this provision of the ADA covers certain non-traditional housing, such as government-operated homeless shelters, as well as social services offices and treatment programs.<sup>14</sup>

### **d. State Housing Element Law**

State law requires each city and county to adopt a general plan containing at least seven elements including housing. As differentiated from the other mandatory elements, the housing element is subject to detailed statutory requirements and must be updated every five years. It is also subject to mandatory review by the California Department of Housing and Community Development (HCD). As part of the housing element, jurisdictions must include an analysis of any special needs housing, including families and persons in need of emergency housing. This analysis must include a review of potential and actual governmental constraints for persons with disabilities.

Beginning in 2002, a new law became effective requiring much more specificity in the housing element as it relates to persons with disabilities. As part of this governmental constraints analysis, the element must analyze potential and actual constraints upon the development, maintenance and improvement of housing for persons with disabilities, and demonstrate local efforts to remove governmental constraints that hinder the locality from meeting the need for housing for persons with disabilities. Also, the element must include programs that remove constraints or provide reasonable accommodations for housing designed for persons with disabilities.

This legislation goes much further than previous law. Prior to 2002, local governments had been required to include an analysis of special needs in their housing element, but now housing elements must evaluate the potential government constraints and must develop a program to remove such constraints or provide reasonable accommodations (see above quotation from Attorney General Bill Lockyer). Beginning in 2007, local jurisdictions in Los Angeles County will need to submit their new housing elements to the State of California.

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<sup>13</sup> 42 U.S.C. 12101 et seq. (Americans with Disabilities Act, title II).

<sup>14</sup> Bay Area Addiction Research and Treatment, Inc. v. City of Antioch, 179 F. 3d 725 (9<sup>th</sup> Cir. 1999).

### **e. Housing Elements in Los Angeles County**

Following is an analysis of the status of the current plans and policies of the 88 cities of Los Angeles County based on their most recently submitted housing element. Shelter Partnership also conducted a phone survey to determine the status of local governments that had indicated in their housing element that they were committed to amending their zoning ordinances to allow for emergency shelters and transitional housing. In other cases, we undertook an analysis of their zoning ordinance using Internet resources.

Unfortunately, the results are not promising and explain in large part the inability of community-based agencies to site emergency shelters in their jurisdictions. Only two jurisdictions, the City and County and Los Angeles, explicitly allow emergency shelters by right in specific zones, both subject to a limit of 30 beds or less. Twenty-five jurisdictions (28%) required a conditional use permit, which necessitates a public hearing, a delay of anywhere from a few to several months, often the payment of a significant fee, and the imposition of conditions on their operation. And most disturbing, 61 cities, or more than two-thirds of all jurisdictions in Los Angeles County, made no provision for emergency shelters or transitional housing in their zoning ordinances.

While transitional housing is most like a standard rental unit in that individuals and families pay rent, the vast majority of communities do not identify this housing specifically in their zoning ordinances. It is unclear as to whether or not they consider transitional housing the same as rental housing. In most cases we presume that they do not (see Table 54).

<b>Table 54: Status of Zoning Ordinance Provisions for Emergency Shelters and Transitional Housing in Los Angeles County by Jurisdiction<sup>15</sup></b>		
<b>Jurisdiction</b>	<b>Status of Zoning Ordinance</b>	<b>Description of Ordinance Provisions</b>
Agoura Hills	Approved	CUP to allow ES in commercial zones & TH in residential zones.
Alhambra	None	
Arcadia	None	
Artesia	None	
Avalon	None	
Azusa	Approved	UP like a CUP to allow ES & TH in industrial zones.
Baldwin Park	None	
Bell	None	
Bell Gardens	None	
Bellflower	Approved	CUP for community-care facilities including transitional care facilities in general commercial facilities.
Beverly Hills	None	
Bradbury	None	
Burbank	None	
Calabasas	None	
Carson	Adopted	CUP ES & TH in commercial zones, requires 300 foot distance between programs.
Cerritos	None	

<sup>15</sup> Notes: CUP stands for Conditional Use Permit; UP stands for use permit; ES stands for Emergency Shelter; and TH stands for transitional housing. The determination was based on review of Housing Elements submitted to the California Department of Housing and Community Development viewed at their Sacramento headquarters in May 2005. "None" applies where the jurisdiction either (1) stated their intention to not develop an ordinance or (2) where the jurisdiction stated their intent to develop an ordinance but had not done so based on telephone surveys during May 2005, as well as internet research on [www.lexisnexis.com/municipal](http://www.lexisnexis.com/municipal) codes and [www.amlegal.com/online\\_library.htm](http://www.amlegal.com/online_library.htm) May 2005.

<b>Jurisdiction</b>	<b>Status of Zoning Ordinance</b>	<b>Description of Ordinance Provisions</b>
Claremont	None	
Commerce	None	
Compton	None	
Covina	None	
Cudahy	None	
Culver City	None	
Diamond Bar	None	
Downey	None	
Duarte	None	
El Monte	Approved	CUP for TH in any zone.
El Segundo	None	
Gardena	None	
Glendale	None	
Glendora	None	
Hawaiian Gardens	None	
Hawthorne	None	
Hermosa Beach	Adopted	CUP in any area of the city.
Hidden Hills	None	
Huntington Park	Approved	CUP ES in one commercial zone.
Industry	None	
Inglewood	Approved	CUP for Community-Care Facilities of over 6 beds if “no detriment to property values.”
Irwindale	None	

<b>Jurisdiction</b>	<b>Status of Zoning Ordinance</b>	<b>Description of Ordinance Provisions</b>
La Canada Flintridge	None	Note: Planning Director determines if development fits in with current uses.
La Habra Heights	None	
La Mirada	None	
La Puente	None	La Puente
La Verne	Approved	CUP for ES & TH in some commercial zones in Foothill Blvd. Specific Plan.
Lakewood	None	
Lancaster	Adopted	CUP TH in some commercial zones.
Lawndale	None	
Lomita	None	
Long Beach	Approved	CUP ES some commercial zones, high density residential and institutional zones where owned/operated by govt. agency.
Los Angeles	Approved	By right, 30 beds or less for emergency housing (up to six months stay) allowed in high density residential and commercial zones. Subject to a discretionary permit (not CUP) in some manufacturing zones. Allows for reduced parking requirements.
Los Angeles County	Approved	Subject to Director's review and approval not to exceed 30 beds in high density Residential zones, commercial zones, and manufacturing zones.
Lynwood	Approved	CUP ES & TH in some commercial and industrial zones.
Malibu	None	Note: Planning Director determines if development fits in with current uses.
Manhattan Beach	Approved	CUP ES & TH in some high density residential and commercial zones.
Maywood	Approved	CUP ES and TH in some commercial zones based on following: management plan; 30 or fewer beds; one parking space/employee; and other provisions.
Monrovia	None	

<b>Jurisdiction</b>	<b>Status of Zoning Ordinance</b>	<b>Description of Ordinance Provisions</b>
Montebello	Approved	CUP the same as for other residential uses except parking requirements are one space per two employees.
Monterey Park	None	
Norwalk	None	
Palmdale	Approved	CUP for homeless shelter in C-3, M-1, and PF zones.
Palos Verdes Estates	None	
Paramount	Approved	CUP ES & TH in any area zoned for multifamily housing.
Pico Rivera	None	
Pomona	None	
Rancho Palos Verdes	None	
Redondo Beach	None	
Rolling Hills	None	
Rolling Hills Estates	None	
Rosemead	None	
San Dimas	Approved	CUP for TH in public semi public zone.
San Fernando	Adopted	CUP for ES and TH in some manufacturing zones.
San Gabriel	None	
San Marino	None	
Santa Clarita	Adopted	CUP/MUP (Minor Use Permit) depends on zone development is in.
Santa Fe Springs	None	
Santa Monica	Adopted	CUP ES in all but one multifamily residential district and in all non-residential districts. TH allowed by right in all multifamily residential and commercial zones.

<b>Jurisdiction</b>	<b>Status of Zoning Ordinance</b>	<b>Description of Ordinance Provisions</b>
Sierra Madre	None	
Signal Hill	None	
South El Monte	None	
South Gate	None	
South Pasadena	Approved	CUP for ES in commercial business and business park zones.
Temple City	Adopted	CUP ES & TH in M-2 zone.
Torrance	Adopted	CUP temporary housing in commercial zones.
Vernon	None	
Walnut	None	
West Covina	None	
West Hollywood	None	
Westlake Village	None	
Whittier	Adopted	CUP ES & TH for R-4 zone.

## 2. Variation of Service Delivery

As it currently functions, the emergency shelter system in the county appears more like a patchwork of different programs and service philosophies than a coordinated and efficient entry point into the network of services and housing known as the Continuum of Care. This variation occurs for different reasons: (1) fairly broad parameters that are placed upon shelter operators by LAHSA, which allow these agencies to design their programs to be consistent with their mission and resources; (2) the evolution of specialized shelter programs that serve specific homeless subpopulations (e.g., persons with mental illness), are funded through targeted public funding programs, and typically operate independent of one another; (3) the support for and operation of shelter programs from faith-based organizations that do not rely on public funds and have tremendous flexibility with respect to program admission and design; and (4) a simple lack of a coordinated and coherent countywide approach to this issue.

Yet, this fragmented system is also the product of philosophical differences that place seasonal shelter programs (e.g, WSP), whose purpose is simply to get people off the streets during the winter months, in contrast with other shelter programs that are focused on and are better equipped to move clients into more stable and appropriate housing.

Findings from both selective site visits to certain LAHSA-funded shelters and surveys Shelter Partnership conducted with YRP and WSP providers in April 2005 underscore the degree to which these programs operate differently across the various sites. Although these shelters show less variation in their hours of operation and room configuration, clearly their programs are run differently. For example, though not indicated entirely in Table 55, approximately half of the surveyed YRP and WSP providers did not accept walk-ins without some sort of referral (see Table 55).

<b>Table 55: Service Variation in LAHSA Year Round and Winter Shelter Programs</b>				
<b>Program Criteria</b>	<b>SRO Housing</b>	<b>MJB Recovery</b>	<b>YMCA of Glendale</b>	<b>LA Family Housing</b>
<b>Supervisory District</b>	1	2	5	3
<b>Program Type</b>	YRP	YRP	WSP	YRP
<b>Hours of Operation</b>	24 hours	6:00 p.m. – 6:00 am	Overnight	24 hours
<b>Room Configuration</b>	SRO	Large open areas for men and women	Large Open areas for single women and men in an armory	Community Center/Semi-private rooms
<b>Walk-ins Allowed</b>	With referral only	No	Yes	Yes
<b>Client: Case Manager Ratio</b>	33:1	60:1	10:1	27:1
<b>Frequency of Case Management</b>	Required once per week	Required to participate on a monthly basis	Recommended but not required	Encouraged but not required
<b>Linkages with Transitional and/or Permanent Housing Providers</b>	No	None	Yes, with Project Achieve in Glendale	None
<b>Services On-Site</b>	CM, housing referrals, transportation, outreach, money management, support groups	None	CM and medical assessments	Medical and mental health assessments
<b>Client Tracking</b>	Yes	No	Yes, until the referral is accepted	No

CM = Case Management

The types of services available are areas where different programs vary the most. LAHSA requires that YRP and WSP providers provide access to case management services, but does not go so far as to mandate that clients participate in such services to continue residing at the shelter. Instead, providers must “advise each client that case management services are available,” and then work with the client to develop an individualized service plan (ISP) if the client expresses a desire to work with the case manager. Providers are therefore given the flexibility of devising a service staffing pattern and structure that they consider to be sufficient to meet LAHSA’s goal of ensuring at least minimal access to case management services for all clients.

This flexibility can lead to significant disparities in how case management services are delivered at the various WSP and YRP sites. Case managers in the YRP program, for instance, are required to identify mental and physical health needs, among other service needs for clients, but it is not clear how trained or equipped these personnel are to make those types of specialized assessments. In essence, the programs become heavily reliant on linkages to address the service needs of clients, but not all programs have access to the same services in their communities. Moreover, case management delivery is not standardized, so depending on the site or the contractor, clients may be receiving vastly different levels of care.

In certain cases, the case manager-to-client ratios are understandably high given available resources and the disparate needs of clients. However, they are still cause for concern since some programs are able to provide more intensive case management to their clients by keeping these ratios to a minimum. This fact was echoed in the provider focus groups, where the consensus was that the lower the ratio, the more attention the case manager can give the individual or family, and the higher probability that the client will be successful.

Yet, beyond case management services, the WSP and YRP programs, depending on the provider, can offer varying types and levels of services to clients, and arguably lead to different client outcomes. Certain contractors, such as SRO Housing Corporation, are fortunate to be able to offer an array of supportive services on-site. Others, such as Covenant House, MJB Recovery, and Catholic Charities, indicated very little in the way of services through their programs.

For instance, consider money management, a service that is universally recognized as an integral component of homeless services, but one that is also generally associated with longer-term programs, such as transitional or permanent supportive housing. SRO Housing requires that, when applicable, shelter residents save 85% of their GR benefit and 50% of SSI benefits each month in order to remain in the program. Project Achieve, on the other hand, appears to require that its participants save 80% of their income, regardless of the source. None of the other WSP or YRP contractors indicated making that service available or requiring a savings plan as part of program participation.<sup>16</sup>

The survey findings also suggest a possible connection between the comprehensiveness of client services and the resources and linkages available to the shelter provider. Project Achieve, for example, is able to assist their clients through their Access Center as well as existing relationships with service providers in the San Gabriel Valley. SRO Housing also relies on its infrastructure as an affordable housing provider and historic engagement in the Continuum of Care to ensure that its clients are assisted either on-site, or off-site, through the network of homeless service providers that populate SPA 4. In certain cases, SRO's shelter clients are given priority for their permanent housing beds or other, longer-term shelter beds

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<sup>16</sup> The purpose of this study is not to make interpretations as to why there is such variation in program design and delivery, despite clear differences here among LAHSA-funded emergency shelter programs. Nonetheless, past experience, the mission and resources of the organization, and needs of the clients all dictate to some degree what will be available to homeless clients.

as appropriate. Consistent with this finding, other respondents noted that available services are generally driven by what other programs they operate, or proximate service resources in their neighborhood.<sup>17</sup>

Another particularly alarming finding from these surveys was the relatively small portion of providers who indicated any formal linkages with transitional housing and/or permanent housing providers. Only two of the eight YRP respondents noted they had agreements with such organizations, and only one of those was with a permanent-housing provider.<sup>18</sup> Without such mechanisms, the “back door” of homelessness, which in this case means placement into a more independent living arrangement than emergency shelter, will remain closed. It is hardly surprising therefore that incoming individuals and families at these shelter programs are predominately from other emergency shelters, if not the streets.

Other facets of service delivery also warrant attention and further study, but are beyond the scope of this study and are not able to be assessed at this time. For one, the issues of program structure and house rules resonated throughout the various client focus groups conducted for this study. Such concerns may have less to do with service delivery than they do program operations, but participants expressed considerable distaste for shelter programs that applied too many rules or expectations without providing clients with the resources to comply. Many clients in the New Image YRP focus group were candid in admitting to cycling in and out of other emergency shelters, only to settle (or resettle) at New Image because the program remains more tolerant year-to-year and imposes fewer rules.

One other area of concern has to do with disparities in admissions criteria among the various LAHSA-funded emergency shelters. At one extreme, programs such as those operated by the Salvation Army have in the past required drug testing as part of their entry policies. Others may condition participation upon abstinence from drugs or alcohol, employment or some other regular source of income, and/or willingness to comply with a case management or money management plan. In contrast, certain providers apply more tolerance during their screening processes, such as discouraging, but not prohibiting active substance use. Regardless of these criteria, the overall lack of standards concerning admissions among the WSP and YRP programs has the negative potential to exclude shelter to those who need it most while indirectly creating incentives for the homeless to relocate to another shelter that has less onerous participation requirements.

### **3. Data Collection and Performance Measurement**

There is arguably no more useful a tool for public systems of care than reliable and comprehensive data. From a funding and planning perspective, policymakers and program administrators can measure and articulate the effectiveness of their programs, and make more

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<sup>17</sup> One provider for instance, noted that its YRP participants are able to receive case management services and employment assistance through its Drop-In Center.

<sup>18</sup> This response came from SRO Housing Corporation, which is in the unique position of being a YRP provider and an established provider of permanent supportive housing. Earlier this year, the contract that SRO had with LAHSA was awarded to the Salvation Army in downtown Los Angeles.

informed assessments as to whether these systems are in fact meeting the needs of those they intend to serve.

Through the course of this study, Shelter Partnership accessed numerous data sources made available by LAHSA. Much of this data is included in the previous chapter, where the populations accessing the WSP, YRP, and Access Centers are described. These figures were primarily derived from monthly or annual program reports submitted to LAHSA by these respective program contractors.

Upon reviewing these data reports, two general themes begin to emerge: (1) the information that is being collected is not being analyzed sufficiently; and (2) there are many unanswered questions about these programs because these contractors have not been asked to record, track, or submit certain data.

In one of the first tasks associated with this study, Shelter Partnership met with LAHSA staff to discuss their WSP and YRP and request any reports that had been submitted, which could be of use. When the annual WSP and YRP reports from 2000-2004 were received, which were compiled from intake data at the shelters, client duplication across the system was an initial concern. That is, a client could be counted as served in one WSP, only to access another WSP later in the season and be counted as a separate client served by that provider. From a researcher's perspective, this is extremely troubling. This issue becomes compounded as smaller reports are compiled into larger annual reports, skewing the overall picture of who is being served through the county's emergency shelter system.

Beyond the issue of client duplication, there is also concern that the information collected from WSP and YRP providers is not sufficient to make any educated decisions about the effectiveness of these interventions in the lives of the county's shelter users. The reasons for this concern are fairly simple: providers are essentially only asked to report on outputs, or the direct products of their program operation.<sup>19</sup> They do not address program outcomes, or how a program participant benefits through involvement with the program or agency.<sup>20</sup> This limitation may be easier for the providers, in the sense that it is less burdensome, but it represents a tremendous barrier to the system. It is also clearly inconsistent with the recent direction of the federal government, especially HUD and HHS, to move their reporting mechanisms to an outcome-based model that establishes baselines and target goals for communities to measure program performance.

The issue of client tracking and program outcomes was one of several topics discussed during the provider focus group conducted by Shelter Partnership and hosted by LAHSA. It was also addressed on the provider questionnaire. Client tracking is significant because it allows homeless service providers and program administrators to follow clients as they move along the Continuum of Care. Understanding the degree to which the county's shelter users

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<sup>19</sup> Outputs are measures of program activities, typically expressed as units of service. Examples of outputs include: referrals made, classes taught, counseling sessions, educational materials distributed, hours of service delivered, meals served, bed days, number of patient encounters, number of participants served, etc.

<sup>20</sup> Conversations with LAHSA contract staff revealed that they cannot even verify referrals that are being made by program contractors, which could mean that clients may never have made it to the receiving agency.

move on to more independent living arrangements, such as transitional and/or permanent affordable housing, is vital.

Based on the most recent RFPs for the LAHSA WSP, YRP, and New Emergency Housing (NEHP) programs, contractors are required to report on the following outputs (see Table 56).

<b>Program</b>	<b>Output</b>
<b>WSP/YRP</b>	Number of intakes completed
	Number of clients referred to case management
	Number of referrals made to supportive services, other emergency shelters, transitional housing, and permanent housing
<b>WSP</b>	Number of clients referred that remain in other emergency shelter, transitional housing, and permanent housing
<b>NEHP</b>	Place 20% of persons in transitional housing
	Place 15% of persons in permanent housing

Unlike the WSP, the YRP does embrace the goal of placing 30% of clients in 24-hour emergency shelters, transitional housing, or permanent housing. Yet, even this goal is modest (certainly if clients are just being placed in other emergency shelters), and it is not clear if contractors are being held accountable for failing to meet this benchmark.

In developing their 2004 New Emergency Housing Program RFP, LAHSA appears to have incorporated at least two program outcomes, although the program subscribes to a similar philosophy as that of the WSP and YRP:

- Ensure that 25% of persons placed in transitional housing remain housed for four months; and
- Ensure that 10% of persons placed in permanent housing remain housed for four months.

Based on findings from the WSP and YRP provider questionnaires, roughly 60% of the YRP contractors reported tracking clients into transitional and/or permanent housing, while only 20% of WSP contractors indicated doing so. These findings contrast sharply with LAHSA’s output requirements, which may simply be a matter of interpretation on the survey, and suggest a disconnect between what is being proposed at the time of application and what is being implemented during program operations. Focus group respondents indicated that either confidentiality concerns or the limitations of their program funding prohibited them from monitoring client progress after they left their care.

The disparities surrounding what information is tracked or not reiterates the need for the emergency shelter system to establish clear goals and expectations for its contractors, with measurable outcomes tied to performance. They also highlight inconsistencies about the purpose of the system and its components. If the county truly wishes to see more clients progress to greater self-sufficiency and stable housing, then the program designs and requirements need to reflect that goal and create incentives for providers to meet, if not exceed, such benchmarks. Client stability and progress must also be monitored after discharge, not only to avoid recidivism, but to ensure that the emergency shelter component

is doing its job to stabilize clients for their next move. As recognized in the provider focus groups, these goals and outcomes must be flexible enough to accommodate the different types of clients with varying needs who populate the county's emergency shelters.

At the same time, very useful data is being collected across the Continuum of Care, specifically the emergency shelter component, that need more attention. Even the brief time that Shelter Partnership was able to spend with LAHSA's WSP, YRP, and Access Center data underscored this need. Access Centers, for example, receive federal homeless assistance funds, and are therefore required by HUD to submit Annual Progress Reports (APRs). The APRs include specific responses about how their programs further HUD's broader goals of assisting clients to achieve residential stability, increase their skills and/or incomes, and obtain greater self-determination. It is not readily apparent how the county uses that information to learn more about the delivery system and make adjustments. Moreover, there were multiple inconsistencies in certain APRs (e.g., client totals not adding up across different areas of the report) that hampered further analysis and need to be resolved.

## **C. Client Specific**

### **1. Chronically Homeless**

Many chronically homeless individuals are familiar with the shelter and service delivery systems, often from first-hand experience. However, the nature of chronic homelessness can hinder individuals from accessing services and maintaining housing stability. Given the high rates of special needs within this population, it may be difficult for a chronically homeless person to find an appropriate housing program. Some individuals may have had negative experiences in shelters or other types of housing that impact their willingness to enter another program. Others may have acute health needs that cannot be addressed in existing shelter settings. In short, the difficult transition from chronic homelessness to being housed requires a myriad of supportive services in order to be successful.

### **2. Individuals with Mental Illness**

The relationship between mental illness and homelessness varies by individual. In some cases, mental illness may contribute to becoming homeless. Severe mental illness may prevent an individual from securing or maintaining employment. A mentally ill person may have difficulty managing their money or performing basic living skills. In many instances these individuals no longer have a support system of family or friends to assist them in a crisis situation. These scenarios can all lead to a mentally ill person becoming homeless. In other instances, the homeless experience may actually cause mental illness (USC, 2004). Living on the streets, in shelters, in a car, or a hotel can understandably lead to such disorders as severe depression or anxiety.

Although the homeless mentally ill are certainly not a homogenous group, they do share similar experiences and needs. Compared to other homeless populations, those contending with a mental disorder are more likely to remain homeless for longer periods of time; be in poorer physical health; have more interaction with the legal system; have a co-occurring

alcohol or drug addiction; and encounter greater obstacles in obtaining services (USC, 2004; NCH, 1999). While quality treatment would certainly improve the lives of the homeless mentally ill and help them successfully move into housing, the various systemic and programmatic barriers of the mental health system prevent many individuals from accessing these services (USC, 2004).

### **3. Individuals with Substance Use Disorders**

The relationship between substance abuse and homelessness is complicated and controversial. Substance abuse does not cause homelessness per se, but can be the causal factor for those already on the brink of homelessness. For others, the experience of being homeless may drive one to self-medicate with drugs or alcohol. Self-medication may also occur for those contending with an untreated mental illness.

Many homeless individuals are interested in treatment for their substance abuse disorder. Treatment options, however, are limited. The lack of health insurance is a significant barrier to accessing services. In-patient and out-patient programs that accept people without insurance do exist, but they are limited and generally have long waiting lists. The same can be said for programs that accept Medicaid. Additionally, transportation can serve as an obstacle to receiving treatment, as homeless people frequently lack the means to travel to an out-patient program on a regular basis. Finally, the prevalence of abstinence-only programs, as opposed to those based on other, more tolerant philosophies, can hinder some individuals from accessing treatment that meets their needs.

### **4. Individuals with Co-Occurring Disorders**

Individuals with co-occurring disorders encounter many obstacles that make it difficult to maintain stable housing and to access services to assist in moving out of homelessness. In contending with both a mental illness and a substance use disorder, people may experience more severe symptoms of mental illness, and may be less inclined to seek treatment and medication (SAMHSA, 2003). Compared to other homeless populations, those with co-occurring disorders are generally older, male, and unemployed; homeless for longer and in harsher conditions; and experience greater distress, demoralization, and isolation from their families (Ibid). Treatment itself is more complicated for this population as, generally, both disorders need to be addressed simultaneously. Homeless individuals with co-occurring disorders have unique needs and require services, including housing programs, tailored specifically to them.

### **5. Women**

Homeless women experience a number of barriers in accessing shelter and maintaining stability once in the shelter system. Many emergency shelters do not provide beds for women. Despite its high concentration of homeless services, the Skid Row area of Los Angeles has only one emergency shelter, the Union Rescue Mission, which houses women. However, all of the LAHSA-funded emergency shelters do provide beds for women and,

according to such providers as New Image, the demand for shelter among this population is sharply rising.

Although the shelters that do serve women generally have gender-specific sleeping areas, women are still at great risk for harassment. Additionally, women with histories of domestic violence may not be comfortable in a shelter setting in which men are in very close proximity. These women may be in need of specific services not available in the general shelter system.

## **6. Families**

The negative effects of homelessness on children and families can be enormous. Homeless children are more likely than housed children to be in poor health, to have developmental delays or mental health issues, to exhibit behavioral problems, and to have lower academic achievement (National Alliance to End Homelessness, 2004). Homelessness can also cause the separation of families due to emergency shelter rules or to parents placing children with relatives or in foster care as a last resort measure (Ibid.).

According to the recent DPSS CalWORKs Homeless Families report, over 20% of respondents had been turned away from either a shelter or transitional housing program in the previous month, indicating an absence of enough available and appropriate beds for homeless families. Additionally, affordability was the most frequently cited barrier to permanent housing, and lack of child care the most frequently cited obstacle to obtaining employment (Bono et. al., 2005).

## **7. Veterans**

The causes of homelessness for veterans are as varied as for all homeless individuals. However, the National Coalition for Homeless Veterans emphasizes that Post-Traumatic Stress Disorder (PTSD) uniquely impacts veterans and can be an important factor in causing homelessness. For people diagnosed with PTSD, an emergency shelter can be an inappropriate housing option due to the setting itself, such as the commonly open area configuration and noise level.

Although the Department of Veterans Affairs administers programs to assist homeless veterans, their reach is limited and not all veterans are eligible for these services. Fortunately, there are two major providers of emergency shelter and transitional housing for veterans in Los Angeles County with several hundred beds, New Directions and U.S. Veterans.

## **8. Parolees**

Individuals on parole, who are often released from prison into homelessness, encounter unique barriers when seeking housing upon their re-entry into the community. According to a 2001 study, up to one-half of parolees in Los Angeles are homeless upon discharge from

incarceration (Gudzowski, 2001). Given their experience in institutional care, some parolees may choose not seek an emergency shelter if they lack a place to live upon discharge. Exclusionary housing policies prevent those with criminal backgrounds from being eligible for publicly supported housing (Human Rights Watch, 2004). Furthermore, the Little Hoover Commission has found that although California puts a higher percentage of felons on parole than other states do, relatively little assistance is provided to them in the community (Little Hoover Commission, 2003).

## **9. Financial**

As with all homeless populations who are single, the income supports generally available, whether county-funded General Relief or some form of federal benefit (e.g., Supplemental Security Income), have declined relative to the cost of living, making it very difficult to afford the upfront and ongoing costs of rental housing. For instance, General Relief, an income source for many homeless people, offers only \$221 a month, which by itself leaves rental housing expenses, not to mention other subsistence needs, out of reach.

## **V. BEST PRACTICES**

### **A. Background**

Several jurisdictions throughout the country have been recognized for their successful approach to homeless services, shelter, and housing. Shelter Partnership identified ten jurisdictions to identify best practices that could potentially be adopted for implementation in Los Angeles County. The jurisdictions are:

- Boston, MA;
- Chicago, IL;
- Columbus, OH;
- El Paso, TX;
- New York, NY;
- Philadelphia, PA;
- Portland, OR;
- San Francisco, CA;
- San Jose, CA; and
- Washington, D.C.

The following descriptions are by no means a detailed account of each jurisdiction's homeless delivery system. Section V. C focuses on the notable aspects of each jurisdiction's homeless service and housing system, their homeless populations, and the role of emergency shelters and local innovations and strategies to end homelessness. This section concludes with a comparison of Los Angeles County's emergency shelter system with those of the other cities we reviewed.

### **B. Methodology**

Research for this section was conducted primarily through phone interviews with staff from these cities and their direct service providers. Information was also gathered through site visits and reviewing local Ten-Year Plans to End Homelessness and other documents (e.g., Shelter Standards and Policies) secured through the phone interviews.

### **C. Summary of Findings**

#### **1. Boston, MA**

##### **a. Homelessness and the Emergency Shelter System**

The State of Massachusetts annually provides \$30 million for homeless services, of which one-half is allocated to the City of Boston. The city itself provides an additional \$9.5 million annually. These funds are used to leverage additional state, national, and private funding.

The emergency shelter system is comprised of city-operated and privately operated shelters, which provide a total of 1,775 beds citywide. The city shelters have centralized intake, which are linked to the Department of Mental Health, providing almost 300 of the shelter clients with mental health services. Family shelters are operated separately from those shelters serving individuals and the central intake for families is done at the City Welfare Office.

### **b. Innovations**

Boston's Home Start program is a model program that focuses on placing individuals from the emergency shelters into housing. Housing Advocates (*job description included as Appendix F*) work with homeless clients in the shelters while they are being case managed by their shelter case managers. Housing Advocates generally have a caseload of 40 to 50 clients. Home Start also utilizes stabilization workers (*job description included as Appendix G*) to help the client adjust to living off the streets and in permanent housing. They generally have a caseload of 30 to 35 clients. This service is available to any shelter participant who requests it, and is required for the more "risky" clients (i.e., those dealing with substance addiction). Sixty percent of clients use the stabilization workers services, and 86% stay housed after two years.

## **2. Chicago**

### **a. Homelessness and the Emergency Shelter System**

There are an estimated 9,687 people homeless in Chicago at any given point in time. Of these, 7,156 are in temporary shelters and 2,531 reside on the streets or public spaces. Chicago estimates that 56% (1,417) of those living on the streets or in public spaces are chronically homeless. Additionally, of those who are homeless, 25% reported having a job in the last month and one-third have at least one child in their direct care. City-funded shelter beds have a 120-day time limit and account for approximately two-thirds of the 6,500 available shelter beds.

### **b. Innovations**

Chicago has instituted a series of Five Year Strategic Initiatives, which include:

- *Prevention:* Expand the range and availability of prevention strategies by increasing their immediate accessibility and improving their long-term effectiveness. This expansion includes the establishment of a 24-hour prevention hotline to be coordinated with 3-1-1, to provide assessments, transportation, and prevention assistance. This also comprises the improvement and expansion of mobile assessment capabilities to immediately identify appropriate shelter alternatives.
- *Housing First:* Expand the availability of affordable permanent housing, increase its accessibility, and transition the existing tiered shelter system into a Housing First

system. This includes the development of additional types of housing, such as Safe Haven and harm reduction programs for those who need permanent housing, but are resistant to traditional service models.

- *Community Linkages*: Provide transitional services that ensure linkage to community resources, and increase the availability and awareness of formal community supports.

The plan proposes that resources from the Continuum of Care (CoC) be allocated to prevention and permanent housing. In the 2004 SuperNOFA application, the competitive process for which CoC funds are applied for, Chicago proposed that 10% of the total supportive service line item from renewal budgets be shifted to fund permanent housing.<sup>21</sup> Furthermore, the 2004 Conversion Plan recommended that 35% of transitional units be converted to permanent units. Furthermore, the city allocated \$2 million of general fund and Supportive Housing Program funding for a long-term rental assistance program.

Overnight and emergency shelters will be kept in place as the safety net until there are adequate permanent housing units, or subsidies, to support the transition from shelters to housing. A key priority in this plan is to convert transitional housing to permanent housing with short-term supports or permanent supportive housing.

### **3. Columbus and Franklin Counties, OH**

#### **a. Strategies from the Ten Year Plan to End Homelessness**

In June 2002, Columbus and Franklin Counties released their Ten Year Plan to End Homelessness, which focused on two priority populations: families and individuals who have experienced long-term homelessness; and families and individuals who have experienced short-term homelessness. For each, they propose to close the “front door” by preventing homelessness, open the “back door” to provide opportunities out of homelessness, build the infrastructure, and manage for results.

Action steps for closing the front door to long-term homelessness include improving the access to employment programs, health care programs, and alcohol, drug, and mental health programs, as well as continuing to reduce referrals and discharge from the Ohio Department of Corrections and Rehabilitation Centers and other service systems to homeless shelters. Strategies for opening the back door include developing 800 units of permanent supportive housing for chronically homeless men, developing 200 units of permanent supportive housing for chronically homeless women, and developing 50 units of permanent supportive housing for chronically homeless families with children.

Strategies for building the infrastructure include increasing the supply of affordable housing, connecting homeless people to employment that meets basic needs, and increasing the availability of essential supportive services.

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<sup>21</sup> This did not occur due to technical reasons.

Strategies for managing for results include implementing the Homeless Management Information System (HMIS), determining extent and outcomes of mainstream public systems interaction with homeless persons, initiating dialogue to promote support for the 10 Year Plan, and issuing semi-annual reports to the community.

#### **b. Innovations**

The county stressed a heavy reliance on data matches across different systems of care, like corrections and mental health, to determine the incidence of homelessness and divert these clients away from emergency shelter.

### **4. El Paso, TX**

#### **a. Homelessness and the Emergency Shelter System**

In El Paso, approximately 10,000 individuals and families are homeless at some point during the year. A point-in-time count found that 1,177 individuals and families were housed in El Paso's 23 shelters, transitional living centers, and permanent supportive housing programs. Another 58 homeless individuals were counted on the street, bringing the total count to 1,235. During that point-in-time count, slightly less than 50% of those surveyed met the definition of chronically homeless, which contrasts with the statewide estimate of 27%.

El Paso has nine emergency shelters, 13 transitional living centers, and five permanent housing facilities with a combined capacity of 1,383. The local Public Housing Authority administers 80 Section 8 vouchers for emancipated foster youth.

#### **b. Strategies From the Ten Year Plan to End Homelessness**

The El Paso Coalition for the Homeless released their Ten Year Plan in 2004. The plan focused on the chronically homeless population and centered on the principles to prevent homelessness whenever possible, rapidly re-house people when homelessness cannot be prevented, and provide wrap-around services that promote housing stability and self-sufficiency.

El Paso's Ten Year Plan focused on three action steps: (1) engaging the chronically homeless population; (2) providing services to the chronically homeless population; and (3) establishing the chronically homeless in independent living or long-term supportive housing.

#### **c. Innovations**

Notable strategies outlined in the El Paso Ten Year Plan to End Homelessness include:

- Utilizing radio, print, and media outlets to educate the community about chronic homelessness;

- Homeless service providers, jails, hospitals, emergency shelter providers, and mental health facilities should develop Memorandums of Understanding (MOUs) to institute mechanisms for referrals and resource sharing;
- Increasing the level of mental health and substance abuse professionals in local emergency shelters;
- Developing a case management system that allows for one case manager to follow a client through the service delivery system regardless of where services are initiated;
- Developing appropriate facilities for the frail elderly and chronically homeless;
- Developing recovery houses to assist clients in transitioning to permanent supportive housing following detoxification treatment; and
- Providing medical services on-site at emergency shelter facilities.

## **5. New York, NY**

### **a. Homelessness and the Emergency Shelter System**

Between July 2003 and April 2004, there were 21,770 individuals in families with 16,572 children staying in the city's shelters. According to a February 2004 street count, there were an estimated 2,694 individuals on the streets in Manhattan, Brooklyn, and Staten Island. The City estimates that 27% of homeless families and 18% of homeless individuals are chronically homeless.<sup>22</sup>

Over the past decade, approximately \$4.6 billion has been spent building and maintaining a network of emergency shelters, which have served 416,720 individuals and 163,438 children. For every dollar spent by the city on homeless prevention, \$3.50 is spent on emergency shelter.

New York City has about 50 shelters and directly operates seven of these. In October 2003, nearly 40,000 singles utilized the city's shelters. Sixteen percent of the single adults in the shelter system use more than 50% of the resources. Some homeless individuals have been on the street for more than 20 years. The average family stays in shelter over 11 months, and 19% of families stay for more than a year and a half.

### **b. Innovations**

New York City's Ten Year Plan to End Homelessness focuses on the chronically homeless and families. Some of their more notable innovations include:

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<sup>22</sup> New York City defines a chronically homeless individual as any currently homeless individual (including single adults and adults in couples) who is disabled and has been homeless for at least 365 days of the last two years, not necessarily consecutively; or any homeless individual who has been homeless for 730 days of the last four years, not necessarily consecutively. New York City defines a chronically homeless family as a currently homeless family that has been homeless for at least 365 days of the last two years, not necessarily consecutively.

## Prevention

- Reworking the current system of family shelter intake to focus on prevention and other forms of emergency assistance. The service model has been instituted in six areas of the city with the highest amount of homelessness.
- Implement community-based prevention services, such as the Household Stability Initiative, a neighborhood based homeless prevention program providing rental assistance, anti-eviction services, and other prevention initiatives.
- Streamline and expand rental assistance options for families at risk of homelessness. Continue to explore viability of Federally Qualified Health Care Center status for services in housing.

## Outreach and Intake

- Reconfigure outreach services so that they are borough-based, multidisciplinary outreach teams, which will offer comprehensive integrated treatment. This approach includes a strong peer component and increased access to permanent and transitional housing options with minimal entry requirements.
- Due to overcrowding in the central intake center designated for single adults, they are redesigning the system to better serve the chronic homeless population and increase service sites.

## Emergency Shelter

- In shelters where there are a number of people staying nine months or more, the city sends out a team to identify the problem and develop a solution.

## Transitional Housing

- Expand transitional programs with low threshold requirements, many of which gradually are able to get their participants to engage in services for their drug and alcohol dependencies.

## Permanent Housing

- Entry into permanent supportive housing is city-administered and case managers have to submit their requests to the city. The city also provides technical assistance to the shelters and provides them with Housing Specialists.
- Expand and make mandatory aftercare initiatives for families and individuals with a history of re-experiencing homelessness.
- The city proposed to fund a \$58 million rental subsidy program using general funds. The rental subsidies would support homeless families, chronically homeless individuals, and homeless parents trying to reunite with their children. The rental subsidy would decline by 20% each year.

## Funding

- The city wants to enhance incentive programs to further shift the culture of shelters from one that focuses on providing services to one that focuses on returning clients to permanent housing. Under this proposal, shelters can receive one to three percent “bonuses” for exceeding expectations in the placement of people into housing. They would also get a \$2,000 bonus for getting a chronically homeless person into permanent housing.
- The New York City Continuum of Care requires that one-third of the transitional and permanent housing renewal and new project tenants be chronically homeless in order to get funding.
- Tie program evaluation to funding of services and housing delivery.

## **6. Philadelphia, PA**

### **a. Homelessness and the Emergency Shelter System**

Philadelphia has a very well-developed emergency shelter system, and several components of the system are detailed below.

#### Outreach and Intake

All outreach workers are contracted and coordinated by the city. They are funded through the Behavioral Health System and funding is set aside for substance abuse services. Outreach is conducted 24-hours a day, seven days a week. Outreach workers engage people on the street and take all individuals to the central intake location. There are two central intake locations in the city, one for men and one for women. One intake center stays open overnight and both centers are coordinated in their efforts.

When a homeless individual enters the intake center, they register with the HMIS system and the intake staff gathers basic information to determine if the person needs immediate behavioral health services, substance abuse services, or if they have any chronic health issues. Once a person finishes the intake procedure, they are referred to a contracted shelter. All client referrals and services are tracked using HMIS, helping shelter staff to know where clients have been and what services they have accessed. The city also offers Safe Haven placement to those that do not want shelter with mandatory services.

#### Emergency Shelter System

Philadelphia has 2,200 year-round beds and an additional 300 to 400 beds during the winter season. All shelters provide an array of services and case management. The 300 to 400 winter beds are offered by the year round shelter providers; there are no additional providers contracted for that seasonal program. The winter shelter locations are open nightly from 6:00 p.m. to 9:00 a.m. and clients are transported from the winter shelter sites to places they can stay during the day.

The city has circumvented siting issues by using its own resources and property. For example, the city uses municipal Recreation Department sites during the winter months when needed.

### Case Management

After a person arrives at a homeless shelter, they have seven days to meet with a social worker to create a case management plan. Case management activities include employment assistance, referrals to transitional and permanent housing, benefit establishment, and mental health and substance abuse services.

Philadelphia's Office of Emergency Shelter and Services mandates that all social workers and case managers abide by documented performance standards.

### Money Management

All clients pay 15% of their income directly to the shelters and these funds supplement the shelters' operational costs. All clients must place an additional 60% of their income into a savings account. This money management policy was created by the city and is incorporated into the shelter contracts. The shelter providers are responsible for the collection activities and the city monitors the accounts.

Once a person accesses their savings, the money does not have to be spent a certain way. For example, a person does not have to use their savings for a security deposit on an apartment. However, the person cannot re-enter the shelter system for 120 days after taking control of their savings. This policy promotes housing as the best option. When a person staying in emergency shelter moves on to transitional or permanent housing, their savings stay intact, but the payment and savings structure changes.

### Time Limits

People are allowed to stay in emergency shelter for 60 to 90 days, and there are no time limits for the individuals residing in the Safe Havens. The city has had some problems with moving some of the more chronically homeless men out of the shelter.

### Contracting for Shelter and Services

The city directly subcontracts with all providers. A city department is responsible for monitoring the contracts and the shelter facilities. This department does both announced and unannounced inspections.

The city has comprehensive shelter standards, agreed to by all contracted providers. They outline all the program guidelines and outcomes that bind shelter operators. The city also has a Quality Management Unit that ensures shelters are meeting their outcome requirements. The city provides technical assistance to the shelters and is flexible with its policies and contracts when needed.

## Data Collection

The city has implemented HMIS and the majority of shelters are participating. Philadelphia's HMIS system is unique because it allows agencies to view a client's case history, regardless of which agency provided services. There have been confidentiality issues, but the City Attorney was able to work on the shelter contract language so that if an agency receives funds from the city to operate services, the use of those services becomes public information.

The city also created a data sharing agreement and participation in HMIS is written into the shelter contract. The city believes in the cost savings benefits of implementing HMIS, as it reduces duplicative services and over-billing.

## **7. Portland and Multnomah County, OR**

### **a. Homelessness and the Emergency Shelter System**

In 2003, a reported 17,000 people slept on the streets, in cars, or in shelters within Multnomah County. A point in time assessment found that 20% to 25% of requests for emergency shelter went unmet. This amounted to 450 people, including 175 families with children. Additionally, there are an estimated 1,600 chronically homeless persons in the county.

The county's homeless demographics include:

- 30% with chemical addictions;
- 18% with mental illness;
- 14% were victims of domestic violence;
- 10% were physically disabled;
- 13% were veterans; and
- 32% had not completed high school.

The county's shelters were originally designed as safe places for people who needed temporary emergency housing. The average length of homelessness is more than five months, and the average wait to gain access to publicly funded shelters is four to six weeks. The wait can be up to ten months during the winter months.

Of homeless resources available, 54% are directed to emergency shelter and transitional housing programs and 12% are allocated to permanent housing.

### **b. Strategies From the Ten Year Plan to End Homelessness**

In 2004, the Citizens Commission on Homelessness released the Ten Year Plan, which was focused on the chronically homeless. The plan centered on streamlining access to existing services and concentrating resources on programs that offer measurable results. The following represents nine key strategies set forth in this document:

1. Move people into housing first;
2. Stop discharging people into homelessness;
3. Improve outreach to homeless people;
4. Emphasize permanent solutions;
5. Increase supply of permanent supportive housing;
6. Create innovative new partnerships to end homelessness;
7. Make the rent assistance system more effective;
8. Increase the economic opportunity for homeless people; and
9. Implement new data collection throughout the homeless system.

With the increase in chronic homelessness, shelters have ended up housing people for longer periods of time. Under the Ten Year Plan, shelters will focus as a point of access and rapid connection to permanent housing and other support systems. The plan promotes the Housing First model and encourages modification of their transitional housing to focus specifically on households needing short-term and intensive structured interventions.

### **c. Innovations**

Portland proposed a series of innovative approaches in its Ten Year Plan to End Homelessness. The most notable include:

- A new definition for chronically homeless families and individuals: “households with one or more children and the hardest to house adults with a disabling condition, and/or multiple severe barriers, who have experienced homelessness two or more times in a three year period, or living outside, doubled-up, or in shelters for six months or more.”
- Adoption and application of a universal discharge assessment to systemize effective discharge planning at hospitals, jails, and emergency shelters;
- Outreach workers are able to offer homeless people immediate access to permanent housing, using rental assistance, rather than waiting through a lengthy application process;
- All rental assistance funds will be transferred into one administrative entity with consistent program guidelines and outcomes;
- Increased support of Housing Connections, a locator service connecting people with affordable, accessible, and special needs housing in the Portland Metropolitan Area;
- The Joint Access to Benefits (JAB) program to ensure that all eligible recipients of SSI or SSDI coming out of jails obtain benefits immediately upon discharge;
- Create day/resource space that will provide immediate access to social services, housing placement services, lockers, showers, rent assistance, shelter reservations, and transportation;
- Ensure that all transitional housing programs include four key elements: case management; housing and assessment services; on-site psychological, alcohol and drug services; and life change support; and
- Program evaluation to be used for the funding of services and housing delivery.

## 8. San Jose, CA

### a. Homelessness and the Emergency Shelter System

In San Jose, there are an estimated 12,600 episodes of homelessness annually. On any given night, about 1,600 people find themselves homeless. Some notable population statistics include:

- Seventy-four percent were San Jose residents before becoming homeless.
- Each day, 75 people countywide are turned away from shelters.
- Approximately 10% of the homeless are mentally ill and 24% suffer from problems associated with substance abuse.
- Only 2% of the homeless say they are homeless by choice.
- About 20,000 to 30,000 households are at-risk of becoming homeless.
- Men significantly outnumber women by a ratio of nearly two to one (65% male and 35% female).
- The fastest growing segment of the homeless population is children. Twenty-five percent of the new homeless population between 1995 and 1999 were children under the age of 18.
- More than half of the city's homeless population earned less than \$6,000 per year, or roughly 8% of area median income for a family of one.

The city has nine emergency shelter providers, accounting for 678 shelter beds. Since 1999, the city has made available \$15 million in grant funding for homeless activities.

### b. Innovations

The City of San Jose has established a series of successful homeless policies and programs, which include:

- Housing and Homeless Fund: In 1993, the City Council approved the allocation of funding to establish a Housing and Homeless Fund (HHF). Projects applying for HHF must demonstrate that the grants will be used to improve, increase, or preserve the affordable housing stock, improve the living conditions of low- and very low-income households, or sustain homeless prevention and emergency shelter or transitional housing programs. Funding is available for one-time expenses, such as equipment and repairs to shelter facilities. Since 1993, more than \$5.8 million has been made available and over 100 nonprofit projects have been funded.
- Mayor's Homeless Families and Children Initiative: In 2001, this initiative was created with an initial appropriation of \$300,000 to support creative and collaborative programs that address the needs of homeless families and children. An additional \$300,000 was made available for this program in the FY 2002-2003 budget. This program is a special competitive funding opportunity for nonprofit organizations, and to date, 23 agencies have been funded. Initiative funds have been used for programs

providing hotel/motel assistance, rental assistance to prevent evictions, food purchase, job training programs, and intensive aftercare programs.

- Promoting Growth & Early Self Sufficiency (PROGRESS): In 1998, San Jose’s Redevelopment Agency Board allocated \$400,000 for a two-year pilot program to assist ten families and four individuals, for a total of 30 people. The people served were considered the “hardest to serve” homeless – those with chronic substance abuse and/or physical and mental illness – all of whom were unable to succeed in the traditional shelter system. The goal of the program was to stabilize the individuals and families, and provide them with decent and safe housing while they took care of their poor credit and acquired job skills. Since the program’s inception, it has expanded to serve 55 participants. In 2001, the City Council granted an additional \$400,000 to the program. Of the original pilot, six of the families and all four of the individuals are in stable housing.

The County of Santa Clara has also created a series of homeless policies and programs, including:

- Family Self Sufficiency (FSS) Program: Operated by the Santa Clara Housing Authority, the FSS program provides housing and supportive services to homeless families. Participating families must enter into a contract, and during the five-year period of the contract, the head of the family must seek and maintain suitable employment. The Housing Authority provides supportive services, such as child care, remedial education, job training and preparation, substance abuse treatment and counseling, homemaking and parenting skills, training in money management, and any other services necessary. The program mandates that families must be off all government assistance at the end of their five-year anniversary. This program allows for the families to establish escrow accounts, and at the end of the period, the family may take the money out of escrow and spend it on education, housing, or transportation. Since 1997, 57 families have become homeowners as a result of their participation in the program.

## **9. San Francisco, CA**

### **a. Homelessness and the Emergency Shelter System**

There are an estimated 15,000 people who are homeless in San Francisco, of which 3,000 (20%) meet the federal definition of chronic homelessness. According to the McMillan Stabilization Center May 2004 Report, 69% of the chronic homeless population are “either heavy alcohol or drug users.” San Francisco General’s emergency room sees an average of 74 inebriates every two days. The average age of a homeless person who dies on the streets of San Francisco is 41 years, and 70% of them die intoxicated.

San Francisco’s 3,000 chronic homeless people consume 63% of the annual homeless budget. Studies show that the care of one chronically homeless person using emergency room services and/or incarceration costs San Francisco an average of \$61,000 each year.

Ninety percent of the 3,000 chronically homeless people rotate through the jail system on a weekly or monthly basis. At any given time, approximately 40% of the jail population were previously homeless.

In 2003, there were 1,910 emergency shelter beds for homeless individuals and 528 beds for families with children.

### **b. Strategies from the Ten Year Plan to End Homelessness**

San Francisco's Ten Year Plan to End Homelessness focuses on the chronically homeless population. The main principles of the plan include:

- Refocusing funding and planning to promote permanent supportive housing and the Housing First model;
- Move personnel and funding away from homeless services that are not linked to housing; and
- Phase-out emergency shelters and transitional housing in four to six years.

### **c. Innovations**

The city is proposing to replace emergency shelters with 24-hour crisis clinics and sobering centers. The city will use the emergency room costs savings to fund staffing of the crisis clinics.

San Francisco has implemented the Care Not Cash program. Homeless persons receiving cash assistance from the city's County Adult Assistance Program (CAAP) were phased-into Care Not Cash from May through November 2004. CAAP is San Francisco's cash aid program for adults without dependent children. Under Care Not Cash, homeless CAAP clients are offered housing and associated amenities as a portion of their benefit package. Funding that would have otherwise been used for cash aid is being used to expand permanent housing and services for this population, including access to mental health, substance abuse, and other support services.

San Francisco's Direct Access to Housing (DAH) program has been recognized nationally as a model of permanent supportive housing. Established in 1998, the Department of Public Health's (DPH) DAH program provides permanent housing with on-site supportive services for approximately 400 formerly homeless adults, most of whom have concurrent mental health, substance abuse, and chronic medical conditions.

DAH has 360 units of permanent supportive housing in five single room occupancy (SRO) hotels and a 33-unit licensed residential care facility. The units have private baths and shared cooking facilities; three meals daily are prepared for the residents. DPH acquires the buildings through a master leasing arrangement, which has the added benefit of renovating buildings in troubled neighborhoods. All sites have between three and five case managers as well as a site director, access to a roving behavioral health team that can place residents off-site in mental health or substance abuse programs when appropriate, and access to medical

care. Some of the services are paid for through MediCal since they are offered by a Federally Qualified Healthcare Provider (FQHP).

## **10. Washington, D.C.**

### **a. Homelessness and the Emergency Shelter System**

In 2002 and 2003, an estimated 16,000 to 17,500 people were homeless at some point during the year, and as many as 2,000 meet the federal definition for chronically homeless. Since 2002, homelessness has increased by 10%.

Washington, D.C. has about 8,875 emergency beds. Annually, D.C. agencies spend over \$25 million in programs targeting the homeless, the United States Department of Housing and Urban Development contributes another \$15 million in McKinney-Vento Act funding, and philanthropies contribute more than \$5 million.

### **b. Innovations**

Washington, D.C. has recently redefined the role of emergency shelter. Emergency shelters will be replaced by easy-access, rapid-exit “homeless assistance centers” founded upon a new social contract. D.C. will institute a pilot program to offer rapid exit assistance to working people to leave the shelter sooner with cash assistance.

The city hopes to replace and upgrade some of their shelters, as well as expand the seasonal bed capacity by at least 265 beds. Washington D.C. is planning on converting one of their family shelters to a permanent housing facility.

## **D. Comparison and Analysis of Los Angeles and Other Cities**

Considering Los Angeles County’s tremendous geographical size, the multitude of governmental agencies and service providers serving the homeless, and the sheer number of the homeless population, there is no one-size-fits-all approach to addressing homelessness locally. Nonetheless, it is important to reflect on what other jurisdictions have proposed within their communities to determine what can be adopted and used in Los Angeles County.

This section compares Los Angeles County’s emergency shelter system with those of other jurisdictions reviewed in the previous section. Included below is a comparison of the jurisdiction’s homeless population, prevention activities, outreach and intake activities, emergency shelter, transitional housing, permanent housing, service coordination, data collection, and funding priorities.

Although Los Angeles has a draft framework for the Los Angeles County Ten Year Strategic Plan to End Homelessness, commonly referred to as *Bring LA Home*, this plan is still in development. Many of the recommendations do not include specific strategies, timelines, resources, or responsible parties. As a result, the plan was not specifically used for this

analysis. All suggestions regarding policy recommendations for Los Angeles County as a result of this assessment are included in the Recommendations section.

## **1. Homeless Population**

Compared to Los Angeles, several cities had notable differences and similarities for homeless demographics. For instance, where single adults reported staying prior to entering a New York City shelter in 2003 were quite different the previous living experiences reported among participants in Los Angeles County's LAHSA-administered shelters:

- Thirty-one percent (31%) had lived with family or friends, compared to 16% in Los Angeles YRP;
- Twenty-three percent (23%) came from the street/park, compared to 40% who came from the street in Los Angeles;
- Sixteen percent (16%) came from jail or prison, compared to 4% in Los Angeles;
- Eight percent (8%) came from their own home, compared to 13% in Los Angeles;
- Six percent (6%) came from hospital or detoxification programs, compared to Los Angeles where 2% came from hospitals and 4% came from substance abuse facilities;
- New York did not capture people coming from emergency, transitional, or domestic violence shelters. In Los Angeles these populations represented 16% of all individuals using the YRP.
- In New York, 10% of clients received SSI, compared to 13.4% in the Los Angeles YRP.

As shown by Table 57, Los Angeles has an extremely large homeless and chronically homeless population compared to the other cities.

<b>City</b>	<b>Number of Homeless Persons</b>	<b>Number of Chronically Homeless</b>	<b>% of Homeless that are CH</b>
Chicago, IL	9,687	1,417	14.6%
El Paso, TX	10,000	5,000	50%
Los Angeles, CA	92,519 <sup>23</sup>	38,209	41.3%
New York, NY	82,622 <sup>24</sup>	19,264	23%
Portland, OR	17,000	1,600	9.4%
San Francisco, CA	15,000	3,000	20%
Washington, DC	16,000	2,000	12.5%

## 2. Prevention Activities

Many jurisdictions are expanding the range and availability of their prevention strategies. Chicago is proposing to establish a 24-hour prevention hotline to provide assessment, transportation, and prevention assistance. Columbus, Ohio is advocating to ensure that there is no net loss of assisted housing units for low-income households in order to prevent displacement and homelessness. New York City is restructuring its current system of family intake to focus on prevention and other forms of emergency assistance to avert families from becoming homeless. New York City is also using family courts in specific communities.

Additionally, many jurisdictions are working with other systems of care, like mental health or corrections, to prevent those systems from discharging people into homelessness. For instance, Portland is working on the development of a universal discharge assessment to systemize effective discharge planning at hospitals, jails, and emergency shelters. Columbus is working with the Ohio Departments of Correction and Mental Health to reduce the amount of referrals into emergency shelters and homelessness.

Often, individuals and families that leave shelter re-experience homelessness after losing permanent housing. Aftercare services increase the likelihood for some to achieve stability in housing. New York City is proposing to expand their aftercare services and make it a requirement for those identified as harder to house.

Homeless prevention activities in Los Angeles County include numerous emergency rental assistance programs. Beyond Shelter operates several prevention programs funded through

<sup>23</sup> Shelter Partnership obtained this figure by compiling recent homeless counts from each of the four Continuums of Care in the county. The Los Angeles CoC counted 83,347 in 2005, the Pasadena CoC counted 1,217, the Glendale CoC counted 2,110, and the Long Beach CoC counted 5,845. The same was done for computing the number of chronically homeless, with the exception of Glendale.

<sup>24</sup> New York City does not report a total homeless figure, so this number was obtained using figures reported in the Cities *Uniting For Solutions Beyond Shelter* Action Plan. The Plan reported that there were 16,622 homeless families and 32,796 homeless individuals in FY 2003. In order to get an accurate homeless count, Shelter Partnership multiplied the number of homeless families (16,622) by three (3) to obtain an accurate number of individuals within each homeless family (49,866). Then 49,866 was added to the number of homeless individuals (32,796) to estimate the number of homeless individuals (82,662). The same methodology was used for computing the number of chronically homeless.

both public and private sources. Most of Beyond Shelter's prevention programs target families. In addition, DPSS administers two prevention programs, the Emergency Assistance to Prevent Eviction Programs (EAPEP) and the Moving Assistance Program (MAP). EAPEP provides financial assistance to CalWORKs families that are either facing eviction or are losing utility service. MAP provides financial assistance to CalWORKs families that are homeless, facing imminent eviction, or those that found more affordable housing. From April 2004 to April 2005, 2,773 families received aid through EAPEP and 1,499 received move-in assistance through MAP. Furthermore, one of the three active *Bring LA Home* working committees is focused on discharge planning activities to prevent homelessness.

### **3. Outreach and Intake Activities**

Some of the jurisdictions have coordinated all of their outreach activities and have created a single point of intake. Instead of having several outreach teams conducting outreach and referring homeless people to a single shelter or shelters, jurisdictions have started coordinating their efforts to make them less fragmented. In Philadelphia, all outreach workers are employed by the city, and outreach is conducted 24-hours a day, seven days a week. The outreach workers refer or transport people to one of two central intake locations, one for men and one for women.

In larger cities, there has been an effort to coordinate outreach and intake using a regional approach that takes into consideration communities' needs and resources. New York City is reconfiguring its outreach approach to be more borough-based and to offer more immediate services and housing. In New York City, they are increasing the locations of intake centers and redesigning the system to better serve the chronically homeless population.

Certain jurisdictions are increasing the resources that outreach workers can offer the homeless they engage on the streets. In Portland, outreach workers will have the ability to offer rental assistance to those who are homeless immediately upon moving them into permanent housing, rather than having them wait while the application is made to a rental assistance program.

In Los Angeles, there are more than 20 outreach programs for homeless persons operated by LAHSA, homeless service providers, law enforcement, the Department of Mental Health, the Department of Children and Family Services, HIV/AIDS organizations, and providers of domestic violence housing and services. These outreach teams identify clients within their communities and work to bring them into the emergency shelter and service system. In the case of the LAHSA outreach teams, which see 350 to 400 unduplicated clients monthly, they do not receive preference in the emergency shelters for their clients.

There are also 12 homeless Access Centers with outreach teams that focus on rapid and intensive intervention for individuals and families that are homeless. Client needs are assessed at the Access Center, and referred and/or transported to appropriate services including emergency housing, health and mental health care, crisis counseling, legal services, and job development (for extensive data on the Access Centers, see Section II). Additionally, other organizations, like Beyond Shelter, operate much like an Access Center on behalf of homeless families.

#### 4. Emergency Shelter

Most jurisdictions, supporting the transition to a Housing First model, are scaling down their provision of emergency shelter. As shown by Table 58, several jurisdictions do not have enough shelter beds to support their homeless population. Chicago has the most emergency beds for its homeless population, and San Jose the least. Los Angeles County has enough emergency shelter beds for less than 6% of the homeless population.

<b>City</b>	<b>Number of Emergency Beds</b>	<b>Emergency Beds as a Percentage of the Homeless Population</b>
Chicago, IL	6,500	67.1%
Los Angeles, CA	5,240	5.7%
San Francisco, CA	1,910	12.7%
San Jose, CA	678	5.4%
Washington, DC	8,875	55.5%

Certain jurisdictions, like El Paso, are proposing to develop appropriate emergency shelters for the chronically homeless population and the elderly population. El Paso is also developing “recovery houses” to better assist those clients with substance use issues. Similarly, San Francisco is hoping to phase out emergency shelters and replace them with “sobering centers” and crisis clinics.

In Philadelphia, no new shelter providers are contracted during the Winter Shelter season. Instead, the existing Year Round agencies that have the capacity to add more beds are expanded. Philadelphia also transports all of its Winter Shelter clients to places they can stay during the day, like drop-in centers.

In New York City, where people are staying in shelters for nine months or more, the city sends out a team to develop a plan of action to get people to move into other housing.

In Los Angeles, there has been a concerted effort to add more emergency shelter beds. Although many in the community are supportive of a Housing First approach, there are simply too many homeless people and not enough affordable permanent housing units.

#### 5. Transitional Housing

Of the jurisdictions reviewed, none seemed to focus on the expansion of transitional housing. This certainly reflects the growing trend among jurisdictions to embrace the Housing First model, thus downplaying the traditional role assumed by transitional housing programs. Of those cities that are pursuing transitional housing, namely Portland and New York, the goal was to add more comprehensive substance abuse and mental health services.

In 2000, Los Angeles had 9,475 transitional beds (i.e., length of stay between three months and two years) (Shelter Partnership, Inc., 2000). In recent years, very few new transitional housing beds have been developed since local CoC resources are directed primarily to support permanent housing developments.

## **6. Permanent Housing**

Several jurisdictions are embracing the Housing First Model. Housing First, developed locally by Beyond Shelter, promotes the rapid re-housing and provision of services to homeless individuals and families. Instead of transitioning through emergency shelter, then transitional housing, then permanent housing, Housing First proposes that a person move into permanent housing right away. Several studies have proven both the financial and housing stability success of Housing First. As a result, many jurisdictions like New York, Chicago, and Portland have shifted their funding priorities to favor permanent housing development as an avenue to expedite the provision of Housing First. Chicago's 2004 Conversion Plan recommended that 35% of the transitional units be converted to permanent units.

In addition to promoting Housing First, several jurisdictions have emphasized placing and maintaining individuals in permanent housing. For instance, Boston's Home Start program uses housing advocates to place individuals from emergency shelter into permanent housing. The program then uses stabilization workers to help clients adjust from living off the streets in permanent housing. Additionally, New York State operates a rental subsidy program for chronically homeless people in which they are eligible for \$500 to \$600 a month for five years. The rate decreases by 20% each year, so they can only enroll people who are employable.

In Los Angeles County, due to the high renewal burden, there is very little money available each year for new permanent housing developments. In the 2005 CoC, LAHSA had roughly \$1 million for new projects under the Supportive Housing Program. However, nearly 30% of the funding went to support rental subsidies in permanent housing with over 100 units for chronically homeless individuals.

## **7. Service Coordination**

Several Ten Year Plans to End Homelessness recognize the importance of coordinating care across different systems. El Paso proposes that homeless service providers, jails, hospitals, emergency shelter providers, and mental health providers develop Memorandums of Understanding (MOUs) to institute mechanisms for referrals and resource sharing. In addition, the majority of jurisdictions proposed increasing substance abuse, mental health, and medical health services in emergency shelters.

Some jurisdictions were altering their provision of case management services. El Paso was developing a case management system that allowed for a single case manager to follow a client through the service delivery system. In Philadelphia, all emergency shelter clients are required to engage in case management. Those who do not wish to participate are referred to Safe Havens.

In Los Angeles there has been some effort to integrate services, such as providing mental health services in the emergency shelters. Programs like the Los Angeles County Department of Mental Health's Integrated Services for Homeless Adults with Serious Mental Illness, or AB 2034, have proven successful in serving and housing people who are homeless with mental illness.

Also, LAHSA was awarded a two-year grant from The California Endowment in 2003, establishing the Winter Shelter Mobile Health Program. The program provided on-site health care services as well as referrals and/or transportation to appropriate medical facilities for follow-up or more extensive care when needed.

## **8. Data Collection**

The Columbus Ten Year Plan to End Homelessness places a reliance on data collection, specifically the implementation of HMIS and coordination of data matches across different systems of care to determine the incidence of homelessness. Data matching can also prove useful when trying to prevent homelessness. Philadelphia has implemented HMIS and this has proved very useful for their provision of services and housing. All contracted agencies must agree to the data sharing agreement.

In Los Angeles County, there is no strategic effort to conduct data matching across those various systems of care. Furthermore, Los Angeles has experienced some setbacks in the implementation of HMIS, but the program is expected to begin this summer with full implementation within the next year.

## **9. Funding Priorities**

As jurisdictions transition to a Housing First model, they are altering their funding priorities. In Chicago's 2004 SuperNOFA application, the city proposed that 10% of the total supportive service line item from renewal budgets be shifted to fund permanent housing.

Similarly, New York City is enhancing the incentives that providers are eligible for when they modify or succeed with their programs. New York City shelters can receive one to three percent "bonuses" for exceeding expectations in the placement of people into housing. They are also eligible to receive a \$2,000 bonus for moving a chronically homeless person into housing.

There has been an emerging trend for cities to focus on increasing the housing opportunities for the chronically homeless population. In New York City, the CoC requires that one-third of all the transitional and permanent housing renewal and new project tenants be chronically homeless in order to get funding.

There has also been an effort to only fund supportive service programs if they are linked to housing. In New York, most of the supportive services only projects (such as employment

projects) that were not linked to housing were not renewed in the 2004 CoC application. San Francisco is undertaking a similar effort.

There has been no comparable effort to date in Los Angeles County to modify the criteria for renewal project funding.

## **VI. FEASIBILITY OF LEVERAGING EXISTING GENERAL RELIEF FUNDS TO PROVIDE A MORE COMPREHENSIVE HOMELESS DELIVERY SYSTEM**

### **A. Background**

Currently, the Department of Public Social Services (DPSS) budget includes nearly \$4 million annually in county funds to provide emergency housing to homeless adults applying for General Relief (GR). DPSS makes available such housing through contracts with emergency shelter providers and agreements with vendor hotels throughout the county.

The Chief Administrative Office (CAO) was instructed to facilitate a workgroup to determine how existing county funds could be blended to provide a more effective, comprehensive, and streamlined homeless delivery system. Specifically, the CAO was instructed to address the feasibility of transferring DPSS funds utilized for the GR Emergency Housing Voucher Program to LAHSA to support the Year Round Shelter program.

In June 2004, the county identified \$1 million in program savings previously earmarked for GR emergency housing costs, which could be transferred to LAHSA for the purpose of attaining additional beds, services, and meals for homeless GR applicants.<sup>25</sup> DPSS committed to the transfer of the funds to LAHSA and identified the need for emergency housing in certain areas of the county, including the Antelope Valley, San Gabriel Valley, and South Los Angeles. In connection with other aspects of this report, Shelter Partnership was contracted to conduct such an assessment and prepare a detailed plan addressing the use of these program savings.

This assessment examines the viability of integrating the GR Emergency Housing Voucher Program and LAHSA's Year Round Shelter program to provide a seamless emergency shelter system and provide a higher level of care to those accessing GR emergency housing services. This section simply describes the aspects of the programs that would require modification. The Recommendations Section of this study will provide more specific strategies to address the concerns that are discussed in this section.

### **B. Methodology**

Several materials were used in this assessment, including the GR Handbook of Regulations, the DPSS Shelter Contract, the DPSS Vendor Hotel Acknowledgement, litigation relating to the program (i.e., the Paris Lawsuit), the Approved Vendor List, Monthly Usage Reports, communications between DPSS and the County Board of Supervisors, LAHSA's Minimum Shelter Standards, and LAHSA's Year Round Shelter Contract. Shelter Partnership also had meetings with LAHSA and DPSS and followed-up as necessary, mostly via email or telephone, on items related to those meetings and any materials that were provided.

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<sup>25</sup> DPSS notes that the increase of \$1.3 million to the budget was to cover the rate increase effective July 2003, and the increase of 40 beds at two contract shelters effective 9/1/03.

## **C. General Relief Emergency Housing**

The GR program serves as the final government safety net in Los Angeles County for individuals who are facing extreme poverty. GR is a State-mandated, county-funded welfare program with a current caseload greater than 65,000 people. GR provides a monthly cash grant of no more than \$221 that is usually accompanied by \$100 to \$135 in federally-funded Food Stamps. In addition, the program provides other services such as welfare-to-work (i.e., General Relief Opportunities for Work (or GROW), transportation assistance, and emergency housing assistance.

GR applicants who identify as homeless are provided with an emergency housing voucher for one to 14 days. If the GR application is not approved in 14 days, additional issuances may be issued until GR is approved. Vouchers are issued to a specific facility, either one of the contracted shelters or vendor hotels on the Approved Vendor List (*see* Appendix I). Only contracted shelter vacancies are controlled/coordinated by the DPSS Vendor Coordinator (VC). The VC obtains the shelter vacancies each day and in turn distributes this information to the various “feeder” districts located throughout the County. These districts will issue vouchers to the contracted shelters, then to the vendor hotels, if needed.

If the applicant accepts the voucher, a contracted emergency shelter or vendor hotel is contacted directly by DPSS district staff to reserve the room, or in the case of vendor hotels, to determine availability.<sup>26</sup> Generally, the housing is in a Single Room Occupancy (SRO) setting, but there is one dormitory-style facility for women only. All facilities must meet emergency housing standards for certification, as determined through periodic inspections by the Los Angeles County Department of Health Services.

### **1. Contracted Shelters**

DPSS contracts with three emergency shelter providers for a specified number of beds per night, exclusively for use by homeless GR applicants. Two of the contracted shelters (Weingart and SRO Housing) are in downtown Los Angeles and the third (L.A. Family Housing) is in North Hollywood. All of the contracted shelters provide GR applicants with a reserved single room where occupants have 24-hour access to the unit. There are 187 available beds on a daily basis at an annual cost of \$1,573,880 (*see* Table 59).<sup>27</sup>

### **2. Vendor Hotels**

DPSS also provides homeless GR applicants with emergency housing through “acknowledgements” with 38 hotels in Los Angeles County. The vendor hotels provide single rooms where occupants can access their room 24 hours a day. The length of time on a

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<sup>26</sup> Vendor hotels are not required to have a specific number of beds available to DPSS.

<sup>27</sup> Cost is based on the number of specific beds at \$24/night. The annual cost of \$1,573,880 is a projected cost, assuming every bed is occupied, every night.

voucher issued to a vendor hotel is the same as to a contract shelter. At a maximum, the vendor hotels supply a total of 1,155 additional emergency beds in the county, though unlike the contracted shelters, no predetermined number of rooms is required (see Table 59).

The majority of vendor hotels are located in the Los Angeles area, however there are hotels in Long Beach, San Pedro, Wilmington, Lynwood, El Monte, South Gate, Norwalk, Inglewood, Huntington Park, Pico Rivera, and Maywood. Vendor hotels are best able to accommodate small numbers of participants in outlying areas, such as the Antelope Valley, where no contracted shelters exist.

<b>Contractor/Location</b>	<b>Available Beds</b>	<b>% of Total Beds</b>	<b>Per Diem Rate</b>
SRO Housing Corporation	115	8.6%	\$24
Weingart Center Association	50	3.7%	\$24
LA Family Housing	22	1.6%	\$16
Vendor Hotels	1,155 <sup>28</sup>	86.1%	\$24*
<b>Total:</b>	1,342	100.00%	

\*One contracted vendor hotel is reimbursed at the dormitory rate of \$16.

### 3. Cost

DPSS reimburses the contracted shelters at the rate of \$24 per night for SRO setting and \$16 per night for dormitory setting. DPSS reimburses the vendor hotels at the rate of \$24 per night. When a GR applicant accepts an emergency housing voucher, \$4.53 is deducted from their monthly benefit for each night they stay in the shelter or hotel. This daily deduction is based on the maximum GR grant of \$221, allowing \$136 for housing over the course of one month. The emergency housing deductible portion is taken off the initial GR grant at approval (see Table 60).

<b>Number of Days</b>	<b>Total Deduction</b>
1	\$4.53
7	\$31.71
14	\$63.42
30	\$136.00

### 4. Usage

To arrive at a clearer understanding of the program’s utilization by homeless GR applicants, DPSS provided caseload data to Shelter Partnership for the last two calendar years. This

<sup>28</sup> This figure represents the total capacity of all vendor hotels combined. In meetings with DPSS, they noted that it would be highly unlikely that that number of beds would ever be available on any given night.

information included overall caseload totals, the number of GR applicants, and the number of applicants who requested a program voucher.

This data provided by DPSS presents some interesting findings. For one, there appears to be a slight increase annually in the number of overall GR participants. However, this is contrasted with relatively declining numbers of GR applications, which reached their lowest point during this two-year span in February 2005, when 11,580 applications for GR were received.

Yet despite the overall downward trend in applications, there appears since 2003 to be increasing numbers of GR applicants who sought emergency housing vouchers. More than twice the percentage of GR applicants requested such vouchers in March 2005 (17.8%) than did so in March 2003 (7.8%). This finding is particularly concerning in light of the limited bed capacity of the program and the identification of program savings in 2004 (see Table 61).

<b>Table 61: Emergency Housing Voucher Requests, March 2003-March 2005</b>				
<b>Month/Year</b>	<b>Total GR Caseload</b>	<b>Number of GR Applicants</b>	<b>Requested Housing Voucher*</b>	
			<b>Number</b>	<b>Percentage of Total Applicants</b>
March 2003	64,347	14,957	1,170	7.8%
April 2003	64,748	15,056	1,201	8.0%
May 2003	64,316	15,056	1,196	7.9%
June 2003	64,205	14,988	1,219	8.1%
July 2003	64,814	15,544	1,317	8.5%
August 2003	64,316	14,357	1,287	9.0%
September 2003	64,894	14,605	1,369	9.4%
October 2003	63,084	13,897	1,429	10.3%
November 2003	61,196	11,966	1,346	11.2%
December 2003	62,888	13,330	1,620	12.2%
January 2004	62,963	14,023	1,455	10.4%
February 2004	63,932	11,859	1,394	11.8%
March 2004	65,378	14,396	1,553	10.8%
April 2004	65,672	13,110	2,250	17.2%
May 2004	64,315	11,736	2,002	17.1%
June 2004	64,520	13,805	2,150	15.6%
July 2004	65,556	13,752	2,321	16.9%
August 2004	66,312	14,083	2,262	16.1%
September 2004	66,924	13,370	2,093	15.7%
October 2004	65,450	12,802	2,184	17.1%
November 2004	65,193	12,821	2,252	17.6%
December 2004	65,570	12,178	2,298	18.9%
January 2005	65,989	13,326	2,367	17.8%
February 2005	64,516	11,580	2,067	17.8%
March 2005	65,235	13,727	2,450	17.8%

\*This number indicates the number of vouchers requested, not actually used.

## **D. Summary of Findings**

The following section outlines some of the principal policy implications surrounding the possible integration of the GR Emergency Housing Voucher Program with emergency shelters funded by LAHSA. Overall, there are two types of implications: those raised generally by the county and others specifically by DPSS.

General concerns are aspects of the program that have been acknowledged as problematic by the Board of Supervisors, such as the overarching need to streamline the provision of emergency shelter in the county, the underutilization of emergency shelter resources, and the lack of supportive services that typically accompany emergency shelter.

Departmental concerns were expressed by DPSS to Shelter Partnership during the course of this study through meetings, literature review, and subsequent follow-up. Specifically, they consist of limitations in length of stay, bed access, hours of operation, referrals, reporting, client needs, and capacity.

### **1. General Concerns**

#### **a. Underutilization of Program Funds**

The total cost for emergency housing vouchers was estimated at \$2.4 million for Fiscal Year 2003-2004. To offset the GR vendor rate increase from \$16 per night to \$24 per night, an additional \$1.3 million was allocated. With the implementation of the Year Round Shelter Program in 2003, emergency housing voucher utilization is down, meaning that not all of the reserved beds are occupied nightly, and the additional \$1.3 million has gone unspent.

Each of the three contracted shelters experienced a decline in utilization between October 2003 and June 2004.<sup>29</sup> Most notably, SRO Housing Corporation's utilization fell by 11 percentage points during this period, from a 66% utilization rate in October 2003 to 55% in June 2004. The contrast between the apparent increase in emergency housing voucher requests, as shown in Table 61, and decreasing voucher utilization rates among contracted shelter providers is interesting and warrants further examination. Yet it is premature to draw conclusions from this contrast without reviewing utilization information from the various vendor hotels (see Table 62).

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<sup>29</sup> There were fluctuations in usage during this time, as program operators likely experienced more demand for shelter during the inclement winter months.

<b>Table 62: General Relief Contracted Shelter Utilization Rates, 2003-2004</b>			
<b>Month</b>	<b>LA Family Housing</b>	<b>Weingart Center</b>	<b>SRO Housing Corp.</b>
October 2003	63%	62%	66%
November 2003	50%	54%	69%
December 2003	57%	72%	76%
January 2004	61%	74%	74%
February 2004	61%	82%	74%
March 2004	44%	89%	61%
April 2004	73%	59%	56%
May 2004	60%	63%	61%
June 2004	60%	54%	55%
<b>Average</b>	<b>59%</b>	<b>68%</b>	<b>66%</b>

## **b. Lack of Services**

While DPSS encourages the provision of ancillary services as long as they are voluntary to participants and not funded through GR, they do not require contracted shelters or hotel vendors to provide any service except for shelter to homeless GR applicants. Despite the lack of ancillary services associated with GR Emergency Housing Voucher Program locations, applicants can benefit from additional services through DPSS. For instance, DPSS provides transportation (via bus tokens) for applicants to the emergency housing facility. If emergency/expedited Food Stamps cannot be issued immediately or the applicant is not eligible for Food Stamps, a meal voucher is issued. Substance abuse screening is also conducted at application as a condition of eligibility. In addition, County Department of Mental Health/Adult Protective Services staff are co-located at DPSS district offices to assist with mental health screenings for applicants/participants.

In contrast, LAHSA's Year Round Shelters are required to provide case management services, meals, and transportation to and from pick-up locations as needed. In the instance that case management services are not provided on-site, case management staff must refer participants to the appropriate services. Common referrals include mental health treatment and services, vocational training and/or counseling, life skills training, assistance in obtaining appropriate long-term housing, legal services, substance abuse counseling, support groups, and benefits counseling and advocacy.

## **2. Departmental Concerns**

To better understand these concerns and how they relate to LAHSA's Year Round Shelter Program (YRP), Table 63 provides a synopsis of the respective policies associated with the GR Emergency Housing Voucher Program and LAHSA's YRP (see Table 63).

<b>Table 63: Comparison of General Relief Emergency Housing and LAHSA's YRP Policies</b>		
<b>Concern</b>	<b>GR Voucher Program</b>	<b>LAHSA YRP</b>
<b>Length of Stay</b>	Fourteen (14) days, or until application is approved	Ninety (90) days
<b>Bed Access</b>	Contracted shelter vacancies are obtained and distributed by the VC to the designated feeder districts. Vendor hotel vacancies are not controlled, but are identified by the individual district office contact for availability.	First-come-first-serve basis
<b>Hours of Operation</b>	Twenty-four (24) hours a day	Only one shelter is 24-hours, the remaining are only open nightly
<b>Referral Process</b>	Vouchers are issued by district staff to a specific facility.	Clients are referred from Access Centers, Outreach Workers, and other shelters
<b>Reporting Process</b>	Contracted shelters provide monthly occupancy reports along with their invoice. Vendor hotels submit the housing voucher on a flow basis to the DPSS Fiscal Operations Section for reimbursement.	Monthly reports and nightly bed count
<b>Client/Population Needs</b>	Program is offered to all adults, does not include any special consideration for sub-populations	Program is offered to all adults, does not include any special consideration for sub-populations
<b>Rate of Reimbursement</b>	\$24 per night for SRO setting and \$16 per night for dormitory setting	\$15 per night for donated space and \$18 per night for owned or leased space
<b>Lack of Capacity</b>	East San Gabriel Valley (SD 1), the Antelope Valley (SD 5), and South Los Angeles (SD 2)	San Gabriel Valley (SD 1), Antelope Valley (SD 5), and South Los Angeles (SD 2 and SD 4)

**a. Length of Stay**

A homeless GR applicant is given an emergency housing voucher for 14 days, unless their application is still pending, at which point they would receive an additional seven days or until GR is approved. Once the voucher has expired, the unit must be vacated. Length of stay policies vary by LAHSA's contracted Year Round Shelter providers, but a 90-day maximum is fairly standard.

## **b. Bed Access**

Contracted shelter vacancies are obtained and distributed by the DPSS VC to the designated feeder districts. Vendor hotel vacancies, on the other hand, are not controlled, but are identified by the individual district office contact for availability. It is important to note that in either case the bed is available only for the period of issuance on the voucher, but additional vouchers may be issued pending GR approval. In contrast, LAHSA's contracted Year Round Shelter providers operate on a first-come-first-serve basis, meaning applicants are required to line up at a specific time of the day with no guarantee of a bed.

## **c. Hours of Operation**

All GR vendor hotels and contracted shelters operate 24 hours, allowing homeless GR applicants to access the room during the day. Conversely, the majority of LAHSA's Year Round providers operate nightly and occupants must leave the shelter during the day, usually around 7:00 a.m. and return around 6:00 p.m.

## **d. Referral Processes**

DPSS and LAHSA have different referral processes. Even within the GR Emergency Housing Voucher Program there are differences according to how bed availability is identified. Nonetheless, in both cases, district staff issue emergency housing vouchers to specific facilities. Conversely, LAHSA does not mandate a formal referral process or protocol. Contracted Year Round Shelters coordinate with other shelters and service agencies for client referrals.

## **e. Reporting Process**

DPSS requires the maintenance of complete and accurate records of occupancy and the submittal of monthly reports. Contracted shelters provide daily availability to the DPSS VC. Monthly occupancy reports are submitted along with the invoice. Vendor hotels submit the housing voucher (ABP 295) on a flow basis to the DPSS Fiscal Operations Section for reimbursement. LAHSA requires that contracted Year Round providers report a nightly count on a daily basis, keep a file on each client, and submit a monthly activity report to LAHSA.

## **f. Client Needs**

According to DPSS, women represent 38% of the GR caseload. Many women are concerned with their safety and may feel more comfortable in the DPSS contracted shelters and vendor hotels because they are given their own room and are allowed to stay throughout the day.

Homeless GR applicants are sometimes intoxicated and/or suffering from mental health issues. The contracted shelters and vendor hotels do not have the capacity to appropriately serve those with substance abuse and mental health needs.

### **g. Rate of Reimbursement**

Emergency housing vouchers are paid at the rate of \$24 per night for SRO setting and \$16 per night for dormitory setting. LAHSA Year Round providers are reimbursed at a rate of \$15 per night/per client for utilizing donated shelter space and at a rate of \$18 per night/per client for utilizing owned or leased shelter space. Case management costs are included in that per diem rate.<sup>30</sup>

### **h. Capacity**

Some GR emergency housing voucher recipients refuse to accept emergency housing due to geographic reasons. Many refuse to stay in the Skid Row area, and others want to stay in the community that they are familiar with or are fearful of crossing gang territories. For example, several young GR applicants refused emergency housing vouchers because they would have to leave the Hollywood area, where there is no contracted shelter or vendor hotel, to utilize the voucher.

DPSS has identified the greatest unmet need for emergency housing in the Antelope Valley (SD 5), the San Gabriel Valley (SD 1), and in South Los Angeles (SD 2). The Department has seen the demand for housing increase in SD 5 and SD 1, but has not been able to increase their available bed capacity there. These areas have no DPSS contracted shelters and one to five vendor hotels.

LAHSA is experiencing similar problems in the same areas. They have seen an increased demand for shelter and services, but have been unable to site additional shelters or increase bed capacity.<sup>31</sup>

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<sup>30</sup> Rates of reimbursement may vary due to the configuration of the emergency shelter facility. For example, LAHSA facilities are typically dormitory style, not single room occupancy. Moreover, LAHSA Year Round shelters operate on a first-come-first serve basis, unlike the bed reservation process found in the DPSS contracted shelters.

<sup>31</sup> See Section IV for more information on the siting of emergency shelter programs.

## **VII. RECOMMENDATIONS**

The preceding sections have provided information on the emergency shelter system and the people who use it, the structural and client-specific barriers affecting the system, the General Relief voucher program, and information about best practices in other urban areas in the nation. The following section now takes a step further to suggest specific strategies that the county should pursue to best address the emergency shelter needs and other housing needs of homeless people in the County of Los Angeles.

The recommendations have been divided into six sections. The first section describes how to integrate the General Relief voucher program with the LAHSA-funded emergency shelter system. The next section details some proposed actions to overcome the current obstacles of siting emergency shelters in cities throughout the region. The third group of recommendations is designed to drive the development of new emergency shelters in the county. The fourth section includes proposed program enhancements to improve, standardize, and increase the velocity of turn-over in the emergency shelters. The fifth group of recommendations details specific affordable permanent housing developments that are needed to enable many individuals to exit from the emergency shelters. The final section explains recommendations on data collection and analysis needed in order to move forward. Following the recommendations are both justifications for the recommendations and, in some cases, proposals on their implementation.

Overall, the recommendations address a need for the proactive involvement and leadership by the county departments and the board officers, the need for additional resources in the shelters, a new commitment by local cities and the development of new, specialized permanent housing.

We have identified the recommendations as short-term (can be completed in the next six months); medium-term (can be completed in the next six to 18 months) and longer-term (can be completed in the next 18 months or longer).

Subsequent to the development of this draft report and recommendations, Shelter Partnership provided the CAO and County Board of Supervisors offices with a menu of different emergency shelter program models for their consideration. This correspondence, included as Appendix J, also provides specific information on the supportive service costs associated with these models.

## **A. Integration of General Relief Voucher Program**

### **Objective A-1: Phase-In the General Relief Program with the LAHSA Emergency Shelter funded programs. (Medium-term)**

- DPSS should transfer a portion of its emergency shelter funding to LAHSA to provide 24-hour emergency shelter to homeless GR applicants. As homeless GR applicants request an emergency-housing voucher, they will be referred to a LAHSA-funded shelter program for a guaranteed bed for one to 14 nights.
- The following policy/program changes will need to occur in contracting, hours of operation, bed access, referral process, reporting process, the rate of reimbursement, and the cost to clients, as follows:
  - DPSS would need to cancel existing contracts and agreements with some of its contracted shelters, vendor hotels, and restaurant vendors. With administrative oversight, DPSS would transfer respective contracting duties to LAHSA. LAHSA would identify shelters in all areas of the county for which to contract for GR emergency homeless beds. With DPSS approval, LAHSA would then subcontract with shelters to provide a certain amount of beds designated for homeless GR applicants referred by DPSS.
  - The LAHSA contracted shelters would be required to offer beds and meals to homeless GR applicants 24-hours a day. In order to make this change, certain nightly programs will have to modify to a 24-hour model. This change will not be possible immediately for certain programs, such as IURD in Long Beach, since the City of Long Beach approved use permit does not allow for daytime occupancy. However, with the proper funding equivalent to the SRO voucher rate with the food allowance, other shelters such as MJB and People Helping People would be able to transition to a 24-hour model.
  - The LAHSA contracted shelters would be required to set aside a certain number of beds for homeless GR applicants, therefore modifying their first-come-first-served policy. However, if a set aside bed is not assigned to a homeless GR applicant by 6:00 p.m., the shelter may open that bed to its general clientele.
  - The LAHSA contracted shelters and DPSS would need to formalize a referral process enabling the shelters to coordinate daily with the Vendor Voucher Unit for bed referrals. This referral process will require DPSS to train the shelter staff on proper reporting procedures.
  - LAHSA and DPSS will need to coordinate the monthly reporting process. Shelters will report on monthly usage directly to LAHSA.
  - Currently, DPSS reimburses its contracted shelters at a rate of \$24 per night for SRO setting and \$16 a night for dormitory setting. DPSS also provides

\$6.45 a day for food vouchers when Food Stamps cannot be provided or expedited. Conversely, LAHSA reimburses its contracted Year Round shelters at \$18 per night for owned or leased space as long as they can document expenditures equivalent to this rate. DPSS would need to increase its rate of reimbursement to \$30.45 (equal to the \$24 SRO rate combined with the \$6.45 food voucher rate) per night for the LAHSA contracted shelters. This increase in reimbursement is necessary given the higher cost of operating 24-hour emergency shelters with case management services. We believe that this should be sufficient for most programs transitioning from an overnight shelter program to a 24-hour program. The cost savings from contracting at a lower rate for the \$24 SRO rate will offset the increased nightly reimbursement rate of \$30.45.

- Considering that all LAHSA-funded emergency shelter programs prohibit providers from charging their clients, DPSS would no longer deduct \$4.53 daily from a homeless GR applicant's check for utilizing an emergency housing voucher.

*[NOTE: DPSS does not concur with this recommendation to integrate the provision of GR emergency shelter with shelter provided through LAHSA. Despite their overall agreement that the creation of a single, integrated emergency shelter system in the county is beneficial, and reiterating that they are willing to continue to discuss how best to do so, they feel at this time that a plan to create such a system does not exist. Their concerns are multiple and include the following: (1) transferring funding to LAHSA does not at this time guarantee DPSS increased access to emergency housing in the underserved areas (as identified in Table 63 and Section VI.D.2.h.); (2) transferring funding to LAHSA would simply result in terminating existing DPSS contracts, only to have LAHSA enter into new contracts and/or subcontracts; and (3) no method has been articulated to ensure that LAHSA could track the actual usage of emergency housing by GR individuals to remain sure that emergency housing funds transferred by DPSS are utilized for their specified purpose.]*

**Objective A-2: Direct the \$1 million in General Relief savings that has been identified to fund a new emergency shelter in the East San Gabriel Valley. (Medium-term)**

## **B. Siting of Emergency Shelters**

**Objective B-1: The Board of Supervisors should identify their priorities for the general location and type of emergency and transitional housing that they want developed in their respective districts. (Medium-term)**

- Provide funding for the predevelopment costs of developing a site. Some of these costs include undertaking due diligence on site identification, securing other funding resources, and securing necessary governmental permits.
- Provide a commitment of ongoing funding needed to operate the program.
- Provide support for the siting of the development within the community.
- Supervisorial Districts 1, 4, and 5 must develop a coordinated approach for the development of programs in the San Gabriel Valley.

**Objective B-2: The Board of Supervisors and the county departments need to take a proactive role in the siting of programs for the homeless, including actively supporting developments that are well- operated and serve a vital community need. (Medium-term)**

- The County of Los Angeles should develop a model zoning ordinance for the siting of emergency shelters and transitional housing and request that all cities adopt the ordinance.
- The county should monitor all of the updates of the housing elements submitted by the cities to the California Department of Housing and Community Development. The county should officially comment to the state and the respective local governments on housing elements that do not make adequate provision for emergency and transitional housing pursuant to new state law.
- The county should develop an educational video on the positive aspects of establishing housing programs for the homeless in suburban communities.
- In communities that have no provision for emergency shelters in their zoning ordinance, or have a clearly identified policy of denying such programs, the county should exert its sovereign authority to site emergency shelters on county owned property without going through local zoning review.

**Objective B-3: All emergency shelters and transitional housing should adopt a “Good Neighbor Policy” on how they will work with their surrounding neighbors. (Short-term)**

## **C. Development Strategies for Emergency Shelters**

**C-1: The county should encourage and assist nonprofit sponsors to apply directly for funding from the California Department of Housing and Community Development (HCD) under the Emergency Housing Assistance Program (EHAP) for capital grants of up to \$1 million for the acquisition, rehabilitation, and construction of emergency shelters. (Short-term)**

- More emergency shelter beds are needed, since nearly 40% of WSP participants come from the streets. This need is particularly acute in Supervisorial District 4, where 70% of the WSP participants come from the streets, and in Supervisorial District 3, where 85% of the WSP participants (at Volunteers of America's two WSPs, serving Los Angeles' Westside) come from the streets.
- As a result of the November 2002 initiative, \$122 million in unallocated funding remains with nearly \$64 million of the bond funding issued. Developments in Los Angeles County have received commitments of \$15.2 million, or 23.4% of the total state funding, to be used for 273 "bed" units, including 224 new beds.
- Additionally, the cost of purchase and rehabilitation will often exceed \$1 million for a project, making additional capital funding necessary. Based on the limitations in federal funding such as CDBG, HOME, and ESG, General Funds or other categorical funds must be secured for these costs.

**C-2: The county needs to help identify ongoing operating funding for these emergency shelters. (Medium-term)**

- Developments for state EHAP funding are evaluated in large part by the strength of the nonprofit development and service team as well as a commitment for operating and supportive services dollars. Funding from the MHSA is the most appropriate source for housing for the mentally ill and those with a co-occurring disorder. Funding from the Department of Community Services and Seniors may be appropriate for the elderly while funding from the County Health Department and Medi-Cal should be investigated for persons with chronic health conditions.
- The McKinney-Vento (Continuum of Care) funding does not provide significant funding for emergency shelters, however, it is feasible that with additional services, programs could be reclassified as transitional housing.
- In order to secure the federal funding, some of the supportive services only or transitional housing programs that are currently funded through the Continuum of Care would not receive renewal funding when their one-year renewal funding is reviewed in spring 2006 by the Los Angeles Homeless Services Authority.
- Local cities should be requested to provide funding for these programs using their CDBG, ESG, or General Fund dollars.

- Some county General Fund or other categorical dollars may have to be used for this purpose.

**C-3: The \$1 million in savings from the county's General Relief underutilized voucher program should be used to provide funding for a two-year program in the East San Gabriel Valley for the development of a 24/7 year-round shelter. (Medium-term)**

- The East San Gabriel Valley has the greatest unmet need in the county for emergency shelter and is also an area that both DPSS and LAHSA have identified as a high need area.

**C-4: Develop Safe Havens for the mentally ill and persons with a dual diagnosis. (Medium-term)**

- The emergency shelters have effectively become the place of last resort for persons with mental illness because of the significant lack of mental health services in our community. It is estimated that more than half (51.7%) of the WSP and YRP shelter clients have a mental illness, with 23.9% having a mental illness only and an additional 27.8% having a co-occurring disorder, most often alcohol or drug abuse.
- These programs are relatively small, 25-50 beds, and recognize that recovery from mental illness is not a linear process. Lamp Village in downtown Los Angeles and OPCC in Santa Monica both operate Safe Havens.
- Additional Safe Havens, using the MHSA and other funding, need to be developed throughout the county, with priority given to Supervisorial District 2 because of the high incidence of reported mental illness and dual-diagnosis (62% of all participants) in the WSPs and YRPs in this district. This suggestion is complementary of recommendations contained in the Strategic Housing Plan.

**C-5: Develop Respite Centers for People with Health Conditions (Longer-term)**

- Of the winter and year round shelter population, 18.1% is identified as having a chronic health condition and 3.2% as having mobility impairments. During the 2004-2005 YRP, 2.5% of the users' most recent residence was a hospital.
- Some of these individuals need anywhere from one week to six months of medical respite care that could be provided by a Federally Qualified Health Center (FQHC) and thereby billed to MediCal.

## **D. Outreach and Assessment**

### **D-1: The Los Angeles County Department of Mental Health must play an integral role in the county's Emergency Shelter system. (Medium-term)**

- People with mental illness represent more than half of all shelter users.
- The Los Angeles County Department of Mental Health must play an integral role in the county's emergency shelter system.
- Currently, the Los Angeles County Department of Mental Health contracts with three community agencies to outreach to several of the city shelters and engage chronically homeless mentally ill people into permanent housing and employment. As additional funding is becoming available through the MHSA in early 2006, this type of commitment must be replicated in all of the community's emergency shelters.

### **D-2: An investigation is necessary to determine whether sufficient coordination exists between the Access Centers and Los Angeles County's Alcohol and Drug Programs Community Services Centers. (Short-term)**

- Of the 12,112 persons served by the Access Centers, 40.5% had a substance abuse problem.

## **E. Oversight, Standardization, and Services in Emergency Shelters**

### **E-1: LAHSA needs to hire clinical staff to assist in administering the program. (Short-term)**

- While LAHSA provides oversight to the shelters, they do not have any clinically trained staff to monitor and design service programs to assist clients.
- We would encourage the county to fund at least two positions immediately to begin to develop LAHSA's capacity in this area.

### **E-2: Official policies regarding the length of stay and case management requirements need to be developed. (Medium-term)**

- Currently, no official requirements exist detailing length of stay or case management in the year-round shelters.
- A new covenant needs to be developed between participants in the WSP and the YRP shelters and program operators, to ensure that shelter participants are working with the program to end their homelessness.
- A reasonable length of stay goal would be for people to stay in shelters for no longer than four months with two-month extensions possible.
- A LAHSA-contracted clinical team should evaluate individuals who have been in the emergency shelters for nine months or longer to develop a plan of action.
- Ultimately, all of the emergency shelters should require that individuals participate in case management services. Individuals unable to participate should be screened for a possible mental illness and if mentally ill, excused from participation in case management, and referred to programs serving this population. We would suggest that this recommendation be phased in at the shelters.
- The system should strive to become a 24/7 system. However, there are many obstacles including costs, conditions imposed by local governments on the siting of programs, reluctance of some providers to adopt or design such a model, and size of facilities. In the interim, we would encourage programs serving General Relief voucher clients, persons with mental illness, the physically challenged, and the frail elderly to provide this level of service.
- For long-term shelter residents, follow-up case management should be provided.

### **E-3 Minimum professional standards and required staffing patterns need to be established in the emergency shelters. (Medium-term)**

- Minimum professional standards need to be developed for the LAHSA-funded emergency shelter case managers. All case managers should be trained in a common curriculum.
- The ratio of professional staff to clients should not exceed 30 to 1, including a Substance Abuse Counselor, a Nurse Practitioner, and a Housing Relocation Specialist, as well as Case Manager(s).

**E-4: Additional Health Services as needed. (Medium-term)**

- Of the winter and year round shelter population, 18.1% were identified as having a chronic health condition and 3.2% as having a mobility impairment.
- One fairly cost-effective way of providing health services is for the shelters to hire a Nurse Practitioner that can provide care, diagnostic assistance, and specialty referrals.
- The need for health services is especially critical in SPAs 2,3, and 4 because of the high proportions of clients coming directly from the streets.

**E-5: Rental assistance and rental guarantee programs should be developed to help people leave the shelters more quickly. (Medium-term)**

- The program should be targeted to the 30% to 34% of the shelter clients who are disabled, elderly, retired, and working who receive some form of federal income assistance or other assistance, such as pensions, unemployment assistance, or wages from work.
- Some of the case managers should be specifically trained in housing relocation so that they can assist people in finding housing and help remove some of the barriers that cause difficulty for homeless individuals trying to locate housing. Consideration should be given to the establishment of a central cadre of relocation specialists.
- A rental assistance program for up to \$1,000 in first and last month's rent and security deposits should be established for persons with some income to quicken their entry into rental housing. Rental assistance could be provided so people are able to match at least 50% of the move-in costs. More clients would leave the shelter quickly, thereby increasing the shelter's ability to serve additional clients without necessarily increasing the shelter capacity.
- A rental guarantee program should be established for individuals who are having difficulty renting for three major reasons: (1) poor credit rating, (2) past evictions, and (3) criminal background. The fund would guarantee against any damages that might be caused or the cost of possibly evicting someone if they refused to pay the rent.

**E-6: The following services need to be established or enhanced in the shelters: (1) voice messaging; (2) bus tokens and bus passes; (3) computer lab access and training tied to regional WorkSource Centers; (4) storage; (5) money management; and (6) legal advocacy. (Medium-term and Longer-term)**

- The need for the first three services is fairly evident. People must be reachable by phone and e-mail and be able to travel to appointments unencumbered with their personal goods if they are to secure employment and establish relationships that can assist them.
- The WorkSource Centers provide critical linkages with employment-related services. An existing partnership between City of Los Angeles-funded Work Source Centers and New Image's YRP is a model for such collaboration and one that is beginning to show results.
- People who are homeless are often unwilling to part with their personal possessions because they are a source of normalcy. However, the costs associated with storing their possessions often requires a significant portion of whatever income they do receive.
- Money management is important to assure that people are using their scarce resources effectively so that they can move onto more permanent housing.
- The population has a high need for legal advocacy services because of their outstanding problems with issues such as child support, establishing or reestablishing benefits, outstanding warrants for tickets, etc. [*Some years ago, the Los Angeles County Bar Barristers group provided in-kind assistance to the seasonal emergency shelters, but that project no longer exists.*] These unresolved issues often become barriers to a client's ability to leave the shelter for months, if not years.

**E-7: Agencies that provide comprehensive , integrated services should be favored to operate WSP and YRP programs. (Short-term)**

- WSP and YRP programs show evidence of achieving more favorable outcomes than other programs.

## **F. Development of Affordable, Permanent Housing for Specific Subgroups**

### **F-1: The county should assist, where appropriate, nonprofit developers and service providers that are applying for funding for supportive permanent housing from the State of California. (Short-term)**

- As a result of the enactment of the Emergency Housing and Assistance Act of 2002, the California Department of Housing and Community Development is administering \$244 million in a bond act for supportive housing for homeless disabled individuals. To date, nearly \$64 million has been awarded to 114 developments, including 30 developments in Los Angeles County that have been awarded \$15.2 million. Los Angeles County developments have been awarded 23.8% of the funding and represent 26.3% of the developments.
- Half of the bond act, or \$122 million, remains to be awarded. Developments are strongly evaluated for the capacity of the sponsor as well as the funding secured for supportive services for the tenants. Funding for the mentally ill should be identified through the Mental Health Services Act, and for other populations, through the appropriate county departments. This plan is consistent with the county's Strategic Housing Plan proposal to develop a Housing Trust Fund for operating and supportive service costs.

### **F-2: The county should include provisions for permanent housing for people coming from emergency shelters into housing operated and funded by the county. (Medium-term)**

- The Housing Authority of the County of Los Angeles (HACoLA) should reserve at least 20% of their Section 8 rollover or additional vouchers for people who are homeless and living in emergency shelters. The more than 30 other housing authorities in Los Angeles County should be encouraged to do the same.
- The county provides capital loans to for-profit and non-profit developers for the development of permanent, affordable housing. As a condition of providing these loans, the county should require that at least 15% of the housing be reserved for people who are homeless and using the emergency shelter system. These developers should also waive any onerous rules for entry for those individuals who have shown progress during their stay in emergency shelters. The county will need to assure that these developments receive sufficient rental subsidies to provide housing to these individuals.
- LAHSA renewal funding of transitional and permanent housing developments should be contingent on sponsors providing at least one-third of the beds or units that become available to chronically homeless people in emergency shelters.
- Consideration should be given in the City of Industry Special Needs Set-Aside for funding for permanent housing for homeless older adults.

**F-3: Permanent housing developments for older adults should be established. (Longer-term)**

- Eighteen percent (18%) of Access Center clients are over 50 years old.
- Similar programs have been established in Boston and New York.
- We suggest developing a request for proposals to engage an appropriate nonprofit developer(s) and service operator(s) to take on this initiative.
- The first projects should be developed in Supervisorial Districts 2 and 5, given their higher predominance of persons in this age group (24.5% and 21%, respectively).

**F-4: Establish permanent housing developments for persons with chronic health conditions. (Longer-term)**

- Eighteen percent (18%) of winter shelter and year round shelter participants are identified as having chronic health conditions.
- We suggest developing a request for proposals to engage an appropriate nonprofit developer (s) and service operator(s) to take on this initiative.
- The priority areas should be Supervisorial Districts 1, 2 and 5.

**F-5: Permanent housing options need to be developed for persons unable or unwilling to abstain from alcohol.**

- Forty percent (40%) of the Access Center clients were identified as having an alcohol or drug abuse problem and 19% of the WSP and YRP clients were identified as having a substance abuse disorder.
- Look to the Pre-Recovery Housing Option, as developed in Seattle, Washington, as a model. This is low demand housing, meaning that the rules, expectations, and structure of the program are not so high and rigid that they constitute barriers.
  - The resident selection process is designed to screen in the sickest and most vulnerable.
  - The project is staffed 24 hours a day, seven days a week.
  - Engagement of residents into service/clinical relationships with the goal of reducing use and gradually extinguishing associated behaviors producing harm and chaos in the resident's life.

**F-6: An investigation is needed to determine if specialized housing is needed in Supervisorial District 5 for the developmentally disabled. (Short-term)**

- In Supervisorial District 5, there appears to be a higher proportion of developmentally disabled individuals using shelters than the countywide average, 5% as compared to 1.9%.
- In the Antelope Valley's Access Center, 18.3% of participants have a developmental disability. More dialogue with permanent housing developers for the developmentally disabled is needed to determine the necessary steps for creating a development for this population.

## **G. Data Collection and Analysis**

**Objective G-1: Develop a consistent method to avoid client duplication in LAHSA program reports.**

**Objective G-2: Assess all data collection instruments (e.g, shelter intake form) as to their effectiveness in capturing the information for which they are designed. Where necessary, modify these instruments, and possibly expand their scope to keep pace with the evolving needs and circumstances of the homeless.**

**Objective G-3: Further explore particularly notable findings that are highlighted throughout this study. The frequency of “shelter hopping,” for example, became quite evident during the client focus groups and data analysis phases of this study.**

- Countywide, 20% of YRP participants come from emergency shelter and transitional housing.
- This frequency is particularly acute in Supervisorial District 3 as two-thirds of the participants come from emergency shelters.

**Objective G-4: Ensure that all collected data is sufficient per program reporting requirements, and that mandated reports, such as the HUD Annual Progress Reports, are completed consistently, in order to ease future data analysis efforts.**

**Objective G-5: Where possible, institute and enforce data sharing agreements between LAHSA-funded contractors so that client progress and movement can be more effectively tracked and monitored.**

**Objective G.6: Establish specific personnel, via the creation of a program performance unit, whose sole function is to review and analyze the abundance of data received from program contractors.**

**Objective G-7: Utilize this new personnel to present periodic reports (e.g., biannually) to the LAHSA Commission, Board of Supervisors, and other stakeholders on population characteristics and trends as well as program performance (e.g., success at meeting outcomes) across the system.**

- Ensure that these reports can be divided according to program type, Service Planning Area, and supervisorial district. In this way, LAHSA can be more readily aware of any regional or subregional variation evident within their delivery system.
- Ensure that these reports allow for client data to be cross-analyzed, transcendent of different statistical categories. For instance, LAHSA should use its data to isolate certain segments of their clientele, such as persons receiving SSI, and be able to explore any unique characteristics or trends among that population.

- Provide these reports to other systems of care, or interdepartmental planning efforts, as they relate to their area of focus. For instance, information presented in this study concerning the extent of WSP and YRP clients who recently left institutional care could be of particular interest to the current workgroup in charge of standardizing discharge policies throughout the county.

**Objective G-8: Based at least in part upon the data collected and presented in this study, and future updates as they become available, establish baselines for units of service as well as measurable program outcomes.**

- Use collected data as an ongoing tool to modify these benchmarks, adjust program design, and eventually hold contractors accountable for failure to meet these outcomes. Use data as a gauge to provide incentives to contractors who exceed program expectations. Condition future funding and policy decisions upon previous experience on the part of the applicant or project sponsor in meeting these benchmarks.
- Remain aware, however, when using program outcomes to assess program performance, that agencies with an established infrastructure tend to demonstrate greater success at assisting clients to self-sufficiency and more stable housing.
- Use the competitive bid processes, conducted respectively for LAHSA-administered emergency shelter programs, to articulate specific program goals and outcomes for each program and its prospective contractors.
- Consider developing an outcome matrix, common for all LAHSA contractors, where providers can uniformly report on client progress towards meeting program goals. Ensure, however, that this matrix is flexible enough to accommodate the various circumstances and needs of the homeless population, which impact their ability to progress at the same rate.

# Appendices

**APPENDIX A**

**Winter Shelter Programs, Year Round Programs, Other Emergency Shelter Programs, and Access Centers**

**Winter Shelter Programs, 2004-2005**

SD	AGENCY NAME	PROGRAM NAME	ADDRESS	City	ZIPCODE	BEDS
1	Pomona Neighborhood Center	Winter Shelter Program	600 S. Park Ave.	Pomona	91766	100
2	Volunteers of America	Winter Shelter Program	10803 Culver Blvd.	Culver City	90230	150
3	Volunteers of America	Winter Shelter Program	1300 Federal Ave.	Los Angeles	90073	160
3	Covenant House California	Winter Shelter Program	1325 N. Western Ave.	Los Angeles	90013	18
4	East San Gabriel Coalition for the Homeless	Winter Shelter Program	1345 Turnbull Canyon Rd.	Hacienda Heights	91745	140
4	New Image Emergency Shelter	Winter Shelter Program	461 West 9th St.	San Pedro	90731	200
5	YMCA of Glendale	Winter Shelter Program	220 E. Colorado St.	Glendale	91206	150
5	Santa Clarita Community Development Corp.	Winter Shelter Program	21190 Centre Point Pkwy.	Santa Clarita	91350	40

**Year Round Programs, 2004-2005**

SD	AGENCY NAME	PROGRAM NAME	ADDRESS	City	ZIPCODE	BEDS
1	IURD-Project Achieve, Pomona	Year Round Shelter	310 E Foothill Blvd.	Pomona	91767	28
1	IURD-Project Achieve, El Monte	Year Round Shelter	13010 E Valley Blvd.	El Monte	91731	32
1	Salvation Army	Year Round Shelter	832 W. James M Wood Blvd.	Los Angeles	90015	76
1	Proyecto Pastoral	Year Round Shelter	171 S. Gless St.	Los Angeles	90033	45
2	New Image Emergency Shelter	Year Round Shelter	3804 Broadway Pl.	Los Angeles	90037	350
2	People Helping People	Year Round Shelter	5701 S. San Pedro St.	Los Angeles	90011	110
2	MJB Recovery	Year Round Shelter	11152 S. Main St.	Los Angeles	90061	90
3	PATH	Year Round Shelter	5627 West Fernwood Ave.	Hollywood	90028	65
3	L.A. Family Housing	Year Round Shelter	7843 Lankershim Blvd.	North Hollywood	91605	80
4	IURD-Long Beach	Year Round Shelter	1368 Oregon Ave.	Long Beach	90813	59
5	Catholic Charities/Lancaster Community Shelter	Year Round Shelter	44661 Yucca Ave.	Lancaster	93534	10

## Other Emergency Shelters, 2004-2005

SD	AGENCY NAME	PROGRAM NAME	ADDRESS	City	ZIPCODE	BEDS
1	Catholic Charities of Los Angeles, Inc	Brownson House	1307 Warren St.	Los Angeles	90033	8
1	Community Rehabilitation Services Inc.	Casa De Richard Chavez: ILS	3551 E. 4th St.	Los Angeles	90063	8
1	Jovenes, Inc.	La Posada	1320 Pleasant Ave.	Los Angeles	90033	6
1	Los Angeles House of Ruth	House of Ruth Emergency Shelter	605 N. Cummings St.	Los Angeles	90033	24
1	Los Angeles Mission	Overnight Beds for Men	303 East 5th St.	Los Angeles	90013	116
1	Proyecto Pastoral at Dolores Mission	Guadalupe Homeless Project	171 S. Gless St.	Los Angeles	90033	60
1	Special Service for Groups (SSG)	BACUP	1336 Wilshire Blvd.	Los Angeles	90017	20
1	The Salvation Army	Bell Shelter Relapse Prevention Program	5600 Rickenbacker Rd., Bldg 2-6	Bell	90201	63
1	Pomona Inland Valley Council of Churches	Our House Shelter	1753 N. Park Ave.	Pomona	91768	18
1	St. Vincent's Cardinal Manning Center	Men's Emergency Shelter	231 Winston St.	Los Angeles	90013	58
1	Filipino American Service Group, Inc.	FASGI Shelter Program	135 N. Park View St.	Los Angeles	90026	6
1	The Salvation Army	James M. Wood Site	832 W. James M. Wood Blvd.	Los Angeles	90015	66
1	Women's Village of Good Shepherd	Good Shepherd Emergency Shelter	267 N. Belmont Ave.	Los Angeles	90026	30
1	Angel's Flight At Risk Youth Services	Angel's Flight Shelter	357 S. Westlake Ave.	Los Angeles	90057	9
1	Los Angeles Family Housing	Comunidad Cesar Chavez	207 N. Breed St.	Los Angeles	90033	52
1	SRO Housing	Panama Hotel	403 East 5th St.	Los Angeles	90013	151
1	The Salvation Army	Booth Memorial Center	2670 Griffin Ave.	Los Angeles	90031	74
1	Casa de Rosas, Inc.	The Sunshine Mission	2600 S. Hoover St.	Los Angeles	90007	20
1	Catholic Charities of Los Angeles, Inc	Angel's Flight	357 S. Westlake Ave.	Los Angeles	90057	16
1	Center for Human Rights & Constitutional Law	Safe Haven Children's Center	252 S. Rampart Blvd.	Los Angeles	90057	18
1	Midnight Mission	Emergency Housing	396 S. Los Angeles St.	Los Angeles	90013	64
1	Los Angeles Family Housing Corporation	Chernow House	207 N. Breed St.	Los Angeles	90033	100
2	Emmanuel Baptist Mission of Los Angeles	Emergency Shelter	530 E. 5th St.	Los Angeles	90013	37
2	Emmanuel Baptist Mission of Los Angeles	Short-Term Lodging	530 E. 5th St.	Los Angeles	90013	33
2	People Helping People	People Helping People Shelter	5701 S. San Pedro St.	Los Angeles	90011	125

SD	AGENCY NAME	PROGRAM NAME	ADDRESS	City	ZIPCODE	BEDS
2	SRO Housing	Russ Motel	517 San Julian St.	Los Angeles	90013	118
2	Henderson Community Center	28 Shelter Bed for Women	911 E. 25th St.	Los Angeles	90011	28
2	Henderson Community Center	Shelter Henderson	911 E. 25th St.	Los Angeles	90011	16
2	LAMP, Inc.	Day Center/Shelter	627 S. San Julian St.	Los Angeles	90014	18
2	Missionaries of Charity	Casa San Juan Diego	1345 Alvarado Terr.	Los Angeles	90006	4
2	Akila Concepts, Inc.	Charlotte's House	542 East Carson St.	Carson	90745	6
2	Compton Welfare Rights Organization	Shelter for Homeless Women and Children	4513 E. Compton Blvd.	Compton	90221	18
2	Compton Welfare-Right Shelter	Emergency Housing	528 W. Almond St.	Compton	90220	15
2	Compton Welfare-Right Shelter	Emergency Shelter	528 W. Almond St.	Compton	90220	15
2	Didi Hirsch Community Mental Health Center	Excelsior House	1007 Myrtle Ave.	Inglewood	90301	14
2	Faithful Central Missionary Baptist Church	Kingdom Shelter	205 W. 118th St.	Los Angeles	90061	12
2	Faithful Service Outreach	Faithful Service Outreach	1416 W. 37th Dr.	Los Angeles	90018	20
2	Faithful Service Outreach	Per Diem Shelter	1412 West 37th Dr.	Los Angeles	90018	60
2	Faithful Services Outreach	Emergency Shelter Project	1412/1414 W. 37th Dr.	Los Angeles	90018	20
2	Health Promotion Institute	Agape House	3550 S. Arlington Ave.	Los Angeles	90081	12
2	His Sheltering Arms, Inc.	Homeless Assistance (60 Day)	11101 S. Main St.	Los Angeles	90061	12
2	Holy Temple Missionary Baptist Church	LA Community Outreach Center	10121 S. Vermont Ave.	Los Angeles	90044	19
2	JWCH Institute, Inc	HELP	566 S. San Pedro St.	Los Angeles	90013	3
2	MJB Transitional Recovery, Inc.	First Beginning	4151 Budlong Ave.	Los Angeles	90037	17
2	Parents of Watts	Parents of Watts (Site A)	19828 Lou Dillon Ave.	Los Angeles	90059	32
2	Parents of Watts	Parents of Watts (Site B)	10824 Lou Dillon Ave.	Los Angeles	90059	12
2	Parents of Watts	Parents of Watts (Site C)	10910 Lou Dillon Ave.	Los Angeles	90059	10
2	Testimonial Community Love Center	Job Training	5721 S. Western Ave.	Los Angeles	90062	30
2	Testimonial Community Love Center	TCLC Emergency Shelter Program	5721 S. Western Ave.	Los Angeles	90062	8
2	Testimonial Community Love Center	Transitional Housing Program	5721 S. Western Ave.	Los Angeles	90062	22
2	Watts Labor Community Action Committee	WLCAC Homeless Access Center	958 1/2 E. 108th St.	Los Angeles	90059	30
2	Skid Row Development Corporation	24 Hour Bed Slots at Transition House	543 S. Crocker St.	Los Angeles	90013	10
2	Skid Row Development Corporation	Transitional Housing	543 S. Crocker St.	Los Angeles	90013	10
2	Special Service for Groups (SSG)	People Helping People	4801 S. Vermont Ave.	Los Angeles	90037	20

SD	AGENCY NAME	PROGRAM NAME	ADDRESS	City	ZIPCODE	BEDS
2	Union Rescue Mission	Men's Emergency Shelter	545 S. San Pedro St.	Los Angeles	90013	320
2	Union Rescue Mission	Women's Emergency Shelter	545 S. San Pedro St.	Los Angeles	90013	110
2	Weingart Center Association	DPSS Vouchers	566 S. San Pedro St.	Los Angeles	90013	50
2	Weingart Center Association	LAHSA Emergency Six	566 S. San Pedro St.	Los Angeles	90013	6
2	Weingart Center Association	Supportive Residential Services	566 S. San Pedro St.	Los Angeles	90013	25
2	Truevine Community Outreach, Inc.	Per Diem Shelter	14513 S. Butler St.	Compton	90047	6
3	Catholic Charities of Los Angeles, Inc	St. Mary Center Outreach Team	4665 Willow Brook Ave.	Los Angeles	90029	16
3	Didi Hirsch Community Mental Health Center	Jump Street	1233 S. La Cienega Blvd.	Los Angeles	90035	10
3	Covenant House California	Crisis Shelter	1325 N. Western Ave.	Hollywood	90027	48
3	San Fernando Valley Friends of Homeless	Women's Care Cottage	12828 Victory Blvd. #294	North Hollywood	91606	15
3	Hillview Mental Health Center, Inc.	SFV Coordinated Homeless Svcs	12408 Van Nuys Blvd.	Pacoima	91331	4
3	Children of the Night	Children of the Night	14530 Sylvan St.	Van Nuys	91411	24
3	CLARE Foundation, Inc.	CLARE Detox Center	907 Pico Blvd.	Santa Monica	90404	16
3	CLARE Foundation, Inc.	Clarity Drug Court Program	1002 Pico Blvd.	Santa Monica	90405	30
3	CLARE Foundation, Inc.	Sober Inn	905 Pico Blvd.	Santa Monica	90404	7
3	Gay & Lesbian Adolescent Social Services, Inc.	Independent Living Program	11426 Calvert St.	North Hollywood	91606	2
3	Los Angeles Family Housing Corporation	General Relief Vouchers	7843 Lankershim Blvd.	North Hollywood	91605	45
3	Los Angeles Family Housing Corporation	Valley Shelter Sobering Station	7843 Lankershim Blvd.	North Hollywood	91605	12
3	Los Angeles Youth Network	Taft House	1754 Taft Ave.	Hollywood	90028	6
3	New Directions, Inc.	Regional Center for Homeless Veterans	11301 Wilshire Blvd., Bldg. 116	Los Angeles	90073	24
3	Tarzana Treatment Center, Inc.	Adult Residential Detox	18646 Oxnard St.	Tarzana	91356	38
3	The Salvation Army	SAMOSHEL	1533 4th St.	Santa Monica	90401	100

SD	AGENCY NAME	PROGRAM NAME	ADDRESS	City	ZIPCODE	BEDS
4	Southern California Alcohol & Drug Programs, Inc.	CIDER House Primary Care	11400 Norwalk Blvd., Bldg.209-211, 313	Norwalk	90650	25
4	Southern California Alcohol & Drug Programs, Inc.	CIDER House Detox Program	11400 Norwalk Blvd. #211	Norwalk	90650	25
4	1736 Family Crisis Center	Emergency Shelter for Adolescents	1736 Monterey Bl.	Hermosa Beach	90254	6
4	Beacon Light Mission	Shelter Program	525 N. Broad Ave.	Wilmington	90744	21
4	Harbor Interfaith Shelter	Family Shelter Program	663 West 10th St.	San Pedro	90731	60
4	Healthview, Inc.	Life Support	921 S. Beacon St.	San Pedro	90731	2
4	Hospitality House	Emergency Shelter	7950 S. Pickering Ave.	Whittier	90602	24
4	Boys and Girls Town of America	Boys and Girls Town	350 W. Wardlow Rd.	Long Beach	90806	4
4	Casa Youth Shelter	Casa Youth Shelter	10911 Reagan St.	Los Alamitos	90720	12
4	Catholic Charities	Elizabeth Ann Seton Residence	2241 Williams St.	Long Beach	90810	44
4	Long Beach Rescue Mission	Lydia House	1338 Pacific Ave.	Long Beach	90813	30
4	Long Beach Rescue Mission	Samaritan House	1338 Pacific Ave.	Long Beach	90813	110
4	SO. CA Alcohol and Drug Program	Baby Step Inn	1755 Freeman Ave.	Long Beach	90804	18
4	Veterans Affairs	Treatment Program	2001 River Ave.	Long Beach	90810	21
5	Union Station Foundation	The Family Shelter	825 East Orange Grove Blvd.	Pasadena	91104	50
5	Union Station Foundation	Raymond Street	412 South Raymond Ave.	Pasadena	91105	20
5	Ecumenical Council	Winter Shelter Program-Adults	539 North Lake Ave.	Pasadena	91101	100
5	Ecumenical Council	Winter Shelter Program-Families	539 North Lake Ave.	Pasadena	91101	10
5	Catholic Charities of Los Angeles, Inc	Transitional Living Program	44611 Yucca Ave.	Lancaster	93534	10
5	GLASS	Independent Living Program	43321 Gadsden Ave.	Lancaster	93555	8
5	Institute for Urban Research and Development	Project Achieve	437 Fernando Ct.	Glendale	91204	30

## **APPENDIX B**

### **Winter Shelter and Year Round Program Summaries**

#### **Winter Shelter Providers**

##### **Covenant House of California**

The Covenant House shelter is located in Supervisorial District 2 in a mixed high/low-density residential and commercial area. The shelter has eight beds and admits homeless and chronically homeless male and female youth. Men and women are housed separately on cots in large open areas. All clients must be transported in from pick-up locations, and walk-in clients are not allowed. The shelter provides case management, cots, blankets, meals, showers and referrals.

##### **East San Gabriel Valley (ESGV) Coalition for the Homeless**

The ESGV Coalition shelter rotates every two weeks utilizing churches located in Supervisorial District 1. The surrounding neighborhood is a mixed high/low-density residential and commercial area. The shelter has 120 beds and admits homeless and chronically homeless single men and women. Men and women are housed separately on cots in large open areas. Walk-in clients are allowed. The shelter provides cots, meals, showers and referrals, and case management services are available upon request.

##### **New Image Emergency Shelter – San Pedro**

New Image's WSP is located in Supervisorial District 4 in a mixed high/low-density residential and commercial area. The shelter has 200 beds and admits homeless and chronically homeless single men and women. Men and women are housed separately on cots in large open areas. Walk-in clients are allowed. The shelter provides cots, blankets, meals, showers and referrals. Participation in case management is not required.

##### **Pomona Neighborhood Center (PNC)**

The PNC shelter is located in Supervisorial District 1 in a mixed high/low-density residential and commercial area. The shelter has 100 beds and admits homeless and chronically homeless single men and women. Men and women are housed separately on cots in large open areas. Walk-in clients are allowed. The shelter provides cots, blankets, meals, showers and referrals. Participation in case management is not required.

##### **Santa Clarita Community Development Corporation**

The Santa Clarita WSP is located in Supervisorial District 5 in a low-density scattered commercial and residential area. The shelter has 40 beds and admits homeless and chronically homeless men, women and families. Men and women are housed separately in large bungalows. Walk-in clients are allowed. The shelter provides cots, blankets, meals, showers and referrals. Families are required to meet with a case manager on a daily basis. Individual clients are encouraged but not required to participate in case management.

### **Volunteers of America (VOA) – Culver Boulevard**

VOA's Culver Boulevard WSP is operated in an armory located in Supervisorial District 2. The surrounding neighborhood is a high-density residential area. The shelter has 150 beds and admits homeless and chronically homeless single men and women. Men and women are housed separately on cots in large open areas. Walk-in clients are allowed if referred by another agency. The shelter provides cots, meals, showers, referrals, and case management services are available upon request.

### **Volunteers of America (VOA) – Federal Avenue**

VOA's Federal Avenue WSP is operated in an armory located in Supervisorial District 2. The surrounding neighborhood is a high-density residential area. The shelter has 160 beds and admits homeless and chronically homeless single men and women. Men and women are housed separately on cots in large open areas. Walk-in clients are allowed if referred by another agency. The shelter provides cots, meals, showers and referrals, and participation in case management is not required.

### **YMCA of Glendale**

The YMCA of Glendale WSP is operated in an armory located in Supervisorial District 5. The surrounding neighborhood is a high-density residential area. The shelter has 150 beds and admits homeless and chronically homeless single men and women. Men and women are housed separately on cots in large open areas. Walk-in clients are allowed. The shelter provides cots, meals, showers and referrals, and participation in case management is recommended but not required.

### **Year Round Shelter Providers**

#### **Institute for Urban Research and Development (IURD) – Long Beach**

The IURD Long Beach shelter is not yet operational. LAHSA is hoping that it will come online in the summer of 2005. Once operational, it will be an overnight facility located in Supervisorial District 4, in a light industrial area. The shelter will have 59 beds and will admit homeless and chronically homeless single men and women. The shelter will operate from 4:00 p.m. to 8:00 a.m. daily.

#### **Institute for Urban Research and Development (IURD) – Project Achieve**

IURD operates Project Achieve in Supervisorial District 1 by utilizing scattered hotels located in mostly commercial areas. The program provides hotel vouchers for families to stay in local hotels and has the capacity to house 15 families for a maximum of 90 days. Project Achieve provides beds, meals and referrals. Participation in case management is highly recommended but not required.

#### **Lancaster Community Shelter (LCS) – Catholic Charities**

LCS is an overnight facility located in Supervisorial District 5 in a mixed high/low-density residential and commercial area. The program utilizes a community center space and has 10 beds. Homeless adults are admitted into the shelter and are housed separately

in semi-private rooms. Walk-in clients are allowed and residents are allowed to stay in the shelter for a maximum of 90 days. The shelter provides cots, blankets, meals, showers, case management and referrals. The hours of operation are 4:00 p.m. to 8:00 a.m. daily.

### **L.A. Family Housing**

LAFH's YRP is located in Supervisorial District 3 in a mixed high/low-density residential and commercial area. The program has 80 beds for homeless men and women who are housed separately in semi-private rooms. Walk-in clients are allowed and residents are allowed to stay in the shelter for a maximum of 90 days. The shelter provides cots, blankets, meals, showers and referrals, and participation in case management is recommended but not required.

### **MJB Recovery**

MJB's YRP is an overnight facility located in Supervisorial District 2 in a commercial area with mixed high/low density residential dwellings. The shelter has 85 beds and admits homeless/ chronically homeless single men and women who are housed separately in large open areas. Clients are allowed to stay in the shelter for a maximum of 90 days. Walk-in clients are not admitted into the shelter. The shelter provides cots, blankets, meals, showers and referrals, and participation in monthly case management meetings is required. The hours of operation are 6:00 p.m. to 6:00 a.m. daily.

### **New Image Emergency Shelter**

New Image's YRP is an overnight facility located in Supervisorial District 2 in a light industrial and scattered high-density residential area. The shelter is the largest YRP with 350 beds and admits single homeless men and women who are housed separately in large open areas. Clients are allowed to stay in the shelter for a maximum of 90 days. Walk-in clients are not admitted into the shelter. The shelter provides cots, blankets, meals, showers, case management and referrals. The hours of operation are 3:30 p.m. to 8:00 a.m. daily.

### **People Assisting the Homeless (PATH) – Hollywood**

PATH's YRP is not yet operational, but it is anticipated to open in the summer of 2005. The shelter is located in Supervisorial District 2 in a mixed high/low-density residential with commercial area. Once open, the shelter will have 65 overnight beds for homeless and chronically homeless single men and women. Clients will be allowed to stay in the shelter for a maximum of 90 days. Walk-in clients will not be admitted into the shelter. The shelter will provide beds, blankets, meals, showers and referrals, and clients will be required to participate in case management. The hours of operation will be 4:00 p.m. to 7:00 a.m. daily.

### **People Helping People**

The People Helping People YRP is an overnight facility located in Supervisorial District 2 in a single and multi-family residential area with scattered commercial space. The shelter has 110 beds and admits homeless and chronically homeless single men and women. Clients are allowed to stay in the shelter for a maximum of 90 days. Walk-in

clients are admitted into the shelter. The shelter provides cots, meals, showers and referrals, and clients are required to attend a weekly meeting with a case manager. The hours of operation are 4:00 p.m. to 8:00 a.m. daily.

### **Proyecto Pastoral**

The Proyecto Pastoral shelter is an overnight facility located in Supervisorial District 1 in a mixed high/low density residential area with scattered industrial use. The shelter has 45 beds and admits single homeless men who are housed in large open areas. Walk-in clients are admitted and all clients are allowed to stay in the shelter for a maximum of 90 days. The shelter provides cots, blankets, meals, showers and referrals. Clients are required to attend bi-weekly meetings with a case manager and the hours of operation are 4:00 p.m. to 8:00 a.m. daily.

### **SRO Housing Corporation**

The SRO Housing Corporation YRP is located in Supervisorial District 1 in a high-density residential area. The shelter has 100 private rooms and admits single homeless men and women for a maximum stay of 90 to 120 days. Walk-in clients who are referred by another agency are admitted into the shelter as space permits. The shelter provides beds, meals, support groups, case management and referrals. SRO Housing operates 24 hours a day and 7 days a week. The SRO Housing Corporation will no longer have a LAHSA YRP starting June 1, 2005.

### **The Salvation Army**

The Salvation Army was awarded a YRP contract in April 2005, and the site is anticipated to come online in June 2005. The shelter is located in Supervisorial District 1 in a mixed high/low density residential and commercial area. The shelter will be an overnight facility, but intake services will be performed throughout the day. The shelter will have 76 beds and will admit homeless and chronically homeless adults and families who are housed in semi-private rooms. Clients will be allowed to stay in the shelter for a maximum of 90 days. The shelter provides beds, blankets, meals, showers and referrals, and clients are required to participate in case management.

## **APPENDIX C**

### **Methodology of Section III.G.**

#### **Scope**

This methodology refers specifically to the data discussed in Section III.G., Populations Served in Access Center, Winter Shelter, and Year Round Programs.

#### **How Data Was Obtained**

In January 2005, Shelter Partnership requested data from LAHSA on their emergency shelter programs. LAHSA provided annual summaries of aggregate intake data for the WSP (FY2000/01, FY2001/02, FY2002/03, FY2003/04, FY2004/05) and the YRP (FY2002/03, FY2003/04). For the purposes of Section III.G., only data from the most recent program year program was utilized<sup>1</sup>.

Early in the process, the Board of Supervisors requested that the study include information and analysis specific to each of their districts. Given this request and the relatively limited scope of the LAHSA intake data (i.e. it did not include regional variation), Shelter Partnership prepared a survey instrument for the LAHSA shelter providers (see Appendix D). The survey's intent was two-fold: to collect district-specific shelter data that had been presented in aggregate on the intake report (i.e. prior living situation), and to acquire additional data on particular areas of interest to the study that were not captured in the reports that LAHSA provided (i.e. prevalence of special needs). The surveys were sent in late April 2005. All seven WSP surveys were returned, as were eight out of nine YRP surveys<sup>2</sup>.

Shelter Partnership ultimately chose to also examine Access Centers based on the important role that they play in feeding the emergency shelter system. The intent was to use this client data as a point of comparison with the Winter and Year Round Programs. Shelter Partnership asked LAHSA only initially for data on the Access Centers they fund. In April and May 2005, Annual Progress Reports (APRs) from the 2003/04 program year for the ten LAHSA-funded Access Centers were forwarded to Shelter Partnership<sup>3</sup>.

Given the countywide scope of this study, APRs for Access Centers in the Glendale and Long Beach Continuums of Care were next requested in May 2005<sup>4</sup>. A total of 17 APRs were received from Long Beach. Shelter Partnership chose not to use the 13 APRs that either covered a program year prior to 2003/04 or whose programs served clients beyond the scope of this study (i.e. child care centers). Eight Glendale Access Center APRs from 2003/04 were received. Due to the very specific nature of these programs, a representative from Project Achieve, the agency sponsor of all of Glendale's Access Center programs, recommended the use of three APRs

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<sup>1</sup> The WSP program year runs from December through March. The YRP program year runs from March through November, and thus 2004/05 data was not yet available.

<sup>2</sup> The WSP and YRP surveys for New Image were received late and only utilized for the District 4 analysis (Section III.G.6).

<sup>3</sup> The Pomona Access Center APR covers the 2002/03 program year.

<sup>4</sup> The Pasadena Continuum of Care does not have any Access Centers.

(Homeless Employment Program, Life Skills/Mental Health, and Substance Abuse Treatment) in an effort to minimize client duplication.

## **What Data Was Used**

Three data sets were examined in this analysis: Access Center APRs, LAHSA WSP and YRP intake data, and Shelter Partnership surveys of LAHSA WSP/YRP providers. Based on the differing information contained within the data sources, each source was used in the most appropriate of the seven areas of analysis: gender, age, race and ethnicity, income source special needs, prior living situation, and destination. With the exception of income source, the LAHSA Access Center data was analyzed across all statistical categories for both the countywide and district-specific analyses. The Glendale and Long Beach Access Center data was studied for the countywide and district-specific special needs, prior living situation, and destination categories. Shelter intake data was utilized for the countywide discussion of all areas except special needs and destination. The WSP and YRP survey responses were analyzed for the countywide and district-specific special needs category and the district-specific prior living situation section.

## **Nuances in How the Data Was Used**

### *Data Sources*

#### *Access Center APRs*

Due to the varying structure and function of Access Centers in the three Continuums of Care, each Continuum's data was used differently within the analysis. LAHSA-funded Access Centers are facility-specific. Each Access Center represents one distinct program and generally is funded singularly for the entirety of program services. In Long Beach, on the other hand, one facility, the Multi-Service Center, functions as the Access Center. Numerous agency programs are housed within this one site with each agency funded separately for that service, and therefore required to report distinctly on that particular service. In Glendale, IURD's Project Achieve sponsors the eight Access Center programs<sup>5</sup>, with each one providing a specific service.

The LAHSA Access Center data was utilized in all categories except income source. The Glendale and Long Beach Access Center figures, however, were not used for the basic demographic areas of gender, age and race/ethnicity. This decision was made because the Centers' various programs did not allow for an accurate picture of the composite client population due to potential duplication and the reporting on distinct client populations. Nonetheless, value remained in examining these clients' backgrounds (special needs), where they were coming from (prior living situation), and where they were going to upon leaving the program (destination).

Additionally, because the Glendale and Long Beach APRs were received later than those from LAHSA, time constraints necessitated prioritizing the analysis of areas most integral to the study's recommendations, rather than the basic demographics of the client population.

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<sup>5</sup> The eight programs were consolidated into one in September, but a combined APR was not yet available.

### *WSP and YRP Intake Data*

The LAHSA shelter intake data was provided in aggregate reports for the WSP and the YRP systems rather than by individual shelter. This data, therefore, could not be separated by district, and is only utilized in the countywide analysis.

### *Calculations*

#### *Access Centers*

The data in the Access Center APRs was presented in raw numbers. Shelter Partnership calculated percentages using these figures. Based on the APR's format, the total client population used to calculate the percentages consisted of adding the number of singles not in families to the number of adults in families. Countywide and district-specific averages were also calculated using the raw numbers. In the Prior Living Situation tables, the category totals were calculated by adding together the separate percentages.

#### *WSP and YRP Intake Data*

The shelter intake data provided both raw numbers and percentages. No averages needed to be calculated since the reports were presented in aggregate. In the Countywide Prior Living Situation table, the category totals were calculated by adding together the separate percentages.

#### *WSP and YRP Surveys*

The data for the Winter and Year Round Programs was combined for each area of analysis to arrive at a general emergency shelter figure. The survey data contained only percentages given by the providers, and not raw numbers. The countywide and district-specific averages were calculated based on these percentages. In the District-specific Prior Living Situation tables, the category totals were calculated by adding together the separate percentages.

### *Statistical Categories*

#### *Age*

In the Age tables throughout this section, the 0-17 category represents only those individuals considered a "single person" on the APR, and does not include those in that age range who are members of a family unit. For example, a 17-year-old unaccompanied individual would be factored into this table, but a 15-year-old child in a family would not. Children in families are not included in this table because they were only reported in the age and gender areas of the APR.

#### *Gender*

The transgender category was only offered on the WSP/YRP intake form, and not on the Access Center APR.

### *Income Source*

Income source data from the Access Centers was not used in this analysis because the categories presented on the APR were not mutually exclusive. The income source figures from the WSP and YRP intake data was used in the countywide section only since it could not be separated by supervisorial district. Some of the data was grouped into categories to facilitate analysis of the proportion of clients receiving similar incomes. For instance, private disability, SDI, SSDI, and SSI were all grouped under a “disability insurance” category. The pension category includes other pension, SS retirement, and VA pension. The public benefits category covers General Relief and TANF. Unemployment, work, and other income remained separate.

### *Special Needs*

Data from the Access Center APRs and WSP and YRP surveys were used to analyze the extent of special needs among program participants. Some of the special needs categories are different across data sources because the provider survey was created prior to receiving the APRs, and thus could not be used as a guide. The categories in the survey were included for specific reasons. Shelter Partnership felt it was important to separate mental illness only, substance use disorder only, and co-occurring disorder in order to accurately determine the prevalence of these common disorders. Chronic health condition was included to assess the prevalence of this specific population. Domestic violence was not included because the survey includes a domestic violence shelter as an option for prior living situation.

Access Center data on special needs was not used for the Supervisorial District 5 analysis because the three Glendale Access Center programs targeted very specific populations, such as substance users, that would have skewed the special needs categories.

### *Prior Living Situation*

The prior living situation options on the WSP and YRP survey were based on those from the intake form. To facilitate the analysis of data from the surveys and the Access Centers, the prior living situation responses were grouped into categories. The independent housing category consists of friends/relatives and rental housing because they both represent independent housing arrangements, as opposed to program-based housing. The institutional care category includes hospital, jail/prison, psychiatric facility, and substance abuse facility. Although these facilities vary widely in function, the intent of the category is to understand the larger issue of discharge planning. The shelter category contains emergency shelter, domestic violence shelter, and transitional housing; transitional housing was included with the more traditional shelters in order to differentiate it from independent housing. Also, the transitional programs tend to function differently across the county, and are oftentimes operated similarly to an emergency shelter. motel/hotel (no voucher), streets, unknown/other, and domestic violence situation remained as separate categories due to their unique natures.

Domestic violence was addressed differently by the Access Center APR and the WSP and YRP survey. The APR offers domestic violence situation as a prior living option, while the survey

offers domestic violence shelter. These categories are presented separately in the section's tables. Also, motel/hotel (no voucher) was a possible prior living choice on the survey only.

*Destination*

This category reflects the destination of those clients who left the program during the year. The destination question was only asked on the Access Center APR. The groupings on the destination tables mirror those on the APR itself.

**APPENDIX D**  
**Year Round and Winter Shelter Provider**  
**Questionnaire**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Program: \_\_\_\_\_

**CLIENT/POPULATION QUESTIONS**

1. At this point in time, what percentage of your clients have resided at your shelter for: *(Not applicable for Winter Shelter Programs)*

%	Less than 30 days
%	30 days – 60 days
%	60 days – 90 days
%	90 days –120 days
%	120 days –180 days
%	Six months – one year
%	More than one year
<b>100 %</b>	<b>Total</b>

2. Where are your shelter clients coming from (their most recent living situation prior to entering shelter)? Please provide a percentage next to the following situations:

Streets	%	Domestic Violence Shelter	%
Emergency Shelter (includes hotel/motel voucher)	%	Rental housing (apartment, house, single room)	%
Hotel/motel, not paid by voucher	%	Client owned housing	%
Transitional Housing	%	Permanent supportive housing (Shelter Plus Care, Supportive Housing Program, SRO, etc.)	%
Jail/Prison	%	Friends or Relatives	%
Psychiatric Facility	%	Foster Care	%
Hospital	%	Other:	%
Substance Abuse Facility	%	Do not know, client refused	%

3. Please estimate the extent to which your clientele have the following disabilities or special needs:

Mental Illness (only)	%	HIV/AIDS	%
Substance Use Disorder (only)	%	Mobility Impaired	%
Co-Occurring Mental Illness and Substance Use Disorder	%	Chronic Health Conditions (Diabetes, Hypertension, etc.)	%
Developmentally Delayed	%	Other:	%

4. Where are your clients going during the day?
5. What sort of changes have you seen in your clientele since you began operating? (For example, more people coming from the jails or prisons, more women, less elderly, etc.)
6. If you operate both a Year Round shelter and a Winter Shelter, do you notice any similarities or differences between the characteristics and needs of clients accessing each program? If so, please describe.
7. At this point in time, please estimate the number of clients on parole or probation.

8. On average, how many people do you turn away nightly?

**SERVICE QUESTIONS**

9. How many case managers does the shelter employ? What is your client to case manager ratio?

10. How often are clients required to engage in case management?

11. In what ways are your Case Managers available to their clients during the day?  
We have included an example.

Available	Method	Time Available (days/hours)
✓	<i>In-person – Walk-in</i>	<i>M, W, and F, 8 am to noon</i>
	Phone	
	In-person – Walk-in	
	In-person – By appointment	
	Other:	
	Other:	

12. Does your agency track a client once they have left your program, regardless of whether the move was for disciplinary reasons or not?

- a. If your agency does track clients:
  - i. What percentage obtained transitional housing?
  - ii. What percentage obtained permanent housing?

13. Does your agency have formal linkages (i.e., MOU) with transitional and/or permanent housing providers? If so, please describe.

14. Besides case management, please indicate which services are available to program clients, who provides them, and where they are provided (i.e., on- or off-site). We have included an example.

<b>Type of Service</b>	<b>Provider (i.e, program staff, or other agency-please name)</b>	<b>On- or Off-site</b>
<i>Vocational Training</i>	<i>Chrysalis</i>	<i>Offsite</i>

15. Please rank the top five service needs of your clients.

<b>Rank</b>	<b>Service</b>
1	
2	
3	
4	
5	

16. What is your policy on serving families? What happens when a family requests shelter and services?

## **SITING QUESTIONS**

17. What barriers did you experience siting your program? How did you address them?
18. What is needed to facilitate the siting of these programs?

## **INCOME/BENEFITS QUESTIONS**

19. As you know, the Los Angeles County Department of Public Social Services provides emergency housing vouchers for homeless General Relief (GR) applicants. For each night that a homeless GR applicant accepts an emergency housing voucher, a fee is deducted from their GR check. To your knowledge, do you think this policy discourages these individuals from accepting an emergency housing voucher, and in turn, encourages them to instead access your program at no charge?
20. Is there anything else you would like us to know about your program?

Thank you for participating!

Please return this questionnaire to:  
Flaherty Wright, Project Manager  
Shelter Partnership, Inc  
523 West 6<sup>th</sup> Street, Suite 616  
Los Angeles, CA 90014  
[fwright@shelterpartnership.org](mailto:fwright@shelterpartnership.org)  
213-689-3188 (fax)

APPENDIX E  
GOOD NEIGHBOR POLICY

*Whereas*, the City of Culver City (the "City") is the owner and operator of the property commonly known as the California National Guard Armory, located at 10808 Coombs Avenue, Culver City, County of Los Angeles, California (the "Armory");

*Whereas*, the Armory is leased from the City, by the California National Guard, for use as an armory;

*Whereas*, the California state legislature has designated the Armory be used as a cold weather shelter;

*Whereas*, state law and policy requires that cold weather shelters be operated in a manner consistent with a Good Neighbor Policy;

*Whereas*, the Los Angeles Homeless Services Authority ("LAHSA") is a joint powers authority under a Joint Powers Agreement between the City of Los Angeles and the County of Los Angeles and is thereby authorized to administer cold weather shelters at various locations, including a shelter at the Culver City Armory (the "Shelter");

*Whereas*, LAHSA contracts with a third-party agency to operate the Shelter (the "Operator");

*Whereas*, the City has created an Ad Hoc Committee whose primary purpose includes, but is not limited to, the development of a Good Neighbor Policy intended to guide LAHSA's operation of the Shelter;

*Now, therefore*, LAHSA hereby acknowledges and agrees to comply with the following terms and conditions in its operation of the Shelter:

1. LAHSA and the Operator shall each send at least one representative to all meetings of the Ad Hoc Committee.
2. At all times, LAHSA and the Operator shall operate the Shelter in compliance with the Good Neighbor Policy.
3. LAHSA shall formulate rules and regulations applicable to all clients of the Shelter (the "Rules") and submit the Rules to the Ad Hoc Committee, which shall have the right to provide comment and input thereto. Each year, LAHSA shall submit these Rules to the Ad Hoc Committee at least ten (10) days prior to the first day of Shelter operations.
4. LAHSA shall post copies of the Rules in all Armory bathrooms, on all Armory walls and at all Armory entrances.

5. LAHSA shall ensure that the Operator suspends or terminates the use privilege of any Shelter client who fails to comply with the Rules, uses alcohol or any controlled substance while in or immediately adjacent to the Armory, violates any law and/or disturbs the peace and quiet of the neighborhood immediately adjacent to the Armory.
6. To the extent possible, LAHSA shall ensure that the Operator obtains a signed acknowledgment from each Shelter client acknowledging that the client has been provided with a list of social service resources available to Shelter clients. Such written acknowledgment shall be obtained from each Shelter client at the time of each Shelter client's first visit of the season. LAHSA shall retain all of these signed acknowledgments until one (1) year after end of the season, and shall make these available to the City upon request.
7. LAHSA shall ensure that the Operator conducts outreach to all businesses and individuals who have been or are expected to be impacted by the operation of the Shelter. This outreach will consist of, but not be limited to, a description of the Shelter's operating dates and hours, its Rules and a contact list containing the names and telephone numbers of Shelter personnel to be contacted if impacted businesses or individuals wish to report violations of the Shelter's Rules or other problems or concerns relating to the operation of the Shelter. At a minimum, this contact list shall contain the name(s) and phone number(s) of the person(s) who can be contacted immediately at the time that any problem caused by Shelter clients or the operation of the Shelter is occurring, as well as the name(s) and phone number(s) of the LAHSA staff to whom the problem can be subsequently reported during normal business hours. This outreach shall be conducted to all residences located within six (6) blocks of the Shelter and to all businesses located within three (3) blocks of the Shelter. Each year, LAHSA shall ensure that the Operator completes this outreach no later than ten (10) days prior to the first day of Shelter operations. Each year, upon completion of this outreach, LAHSA shall promptly serve the City with written notification of its completion.
8. At least once every two weeks, LAHSA shall ensure the Operator shall allow representatives of the City to conduct presentations at the Shelter regarding the requirements of the Good Neighbor Policy.
9. As to any prospective client who cannot be housed at the Shelter on any given occasion, LAHSA shall ensure that the Operator provides such client with the following notification: "Veteran's Park closes at 10:30 PM. The Shelter Operator is obligated to notify the Culver City Police Department regarding any prospective client remaining at Veteran's Park after the park closes. Prospective clients remaining in Veteran's Park after it has closed or remaining adjacent to the Armory outside of the Shelter's operating hours shall be disqualified from using the Shelter for [ a period of time to be determined by LAHSA and/or Operator ]."
10. LAHSA shall ensure the Operator shall keep the exterior of the Armory free of litter, shopping carts, personal property and any other debris left by Shelter clients.

11. LAHSA shall ensure the Operator shall promptly notify the City's Housing Programs Administrator, or his/her designee, regarding any graffiti appearing on any Armory structure during the operation of the Shelter.
12. All Shelter clients shall be transported from off-site pick-up location(s) to the Shelter on transportation provided by LAHSA and/or the Operator.
13. To the extent possible, LAHSA shall ensure the Operator transports all Shelter clients from the Shelter each morning.
14. While Shelter clients are being admitted into the Shelter each night of its operation, LAHSA and/or the Operator shall line-up the prospective Shelter clients in a location designated for such purposes by the City.
15. No more than 150 Shelter clients shall be transported to the Shelter from off-site pick-up location(s) on any day the Shelter is in operation.

LOS ANGELES HOMELESS SERVICES AUTHORITY

  
\_\_\_\_\_  
MITCHELL NETBURN, EXECUTIVE DIRECTOR

1/31/05  
DATE

**APPENDIX F**  
**HomeStart**  
**Job Description**

**Housing Advocate**

**Job Responsibilities**

1. Assist homeless persons with all aspects of housing search and placement into permanent housing:
  - Work with clients to devise an appropriate housing search strategy;
  - Complete housing applications and prepare necessary documentation; negotiate with landlords, housing authorities, realtors, and the like;
  - Go with clients to housing appointments and to view apartments;
  - Assist clients with money management skills such as budgeting and setting up a savings plan.
  - Carry out related activities such as helping with furniture, moving services and back utility bills.
2. Coordinate housing search activity with related work of shelter and transitional program case managers.
3. Provide financial assistance from HomeStart's rental assistance fund, if appropriate, and help individuals access other financial resources to facilitate their housing placement.
4. Work with HomeStart's stabilization staff to coordinate stabilization once housing placement has been made.
5. Conduct housing search workshops and housing support groups for clients and other service providers, when appropriate.
6. Complete all paperwork, statistics, and data entry in a timely and thorough manner.
7. Remain up-to-date on regulations and programs relevant to client needs.
8. Coordinate housing search work through regular meetings with members of HomeStart's Housing Search Team.
9. Carry out other related duties as assigned.

**Required Skills**

1. One-to-three years housing search experience or related social service experience, preferably with single, homeless adults, and knowledge of relevant resources.
2. Knowledge of public, subsidized, and private housing resources preferred. Demonstrated ability to learn technical information (rules and regulations) necessary to conduct effective housing search.
3. Experience working with homeless adults and/or substance abuse/mental health population preferred.

4. Good problem-solving skills, patience and persistence in assisting people with the difficulties of housing search. Willing to be flexible according to client needs.
5. Good interpersonal skills and ability to work well with diverse groups of people.
6. Strong advocacy and outreach skills.
7. Dedication to helping homeless people gain self-confidence and setting goals that lead to moving out of the shelter system and becoming successfully integrated into the community.
8. Willingness to travel to shelter/transitional program sites and to accompany clients to housing appointments and to view apartments.
9. Ability to work independently and as part of team.
10. An ability to establish and facilitate groups or presentations.
11. Strong written, verbal and math skills necessary.
12. A familiarity with computers is preferred.
13. Some evening hours are expected as part of a 40 hour work week.

**APPENDIX G**  
**HomeStart**  
**Job Description**

**Stabilization Advocate**

HomeStart provides housing placement and follow-up stabilization services to homeless adults from shelters and transitional programs in Greater Boston. HomeStart's case management, housing search and stabilization staff work together as a coordinated team

The objective of stabilization services is to help formerly homeless adults achieve stable tenancies and become successfully integrated into their new communities.

**Job Responsibilities**

1. Work with a pool of clients who are in the process of moving or who have recently moved into scattered site housing.
2. Assist clients to develop good tenancies and to connect with resources in their new communities. Activities will include the following:
  - Maintain regular contact through home and office visits.
  - Develop individualized, goal-oriented service plans.
  - Establish and monitor recovery plans.
  - Assist with budgeting skills and other activities of daily living.
  - Serve as a liaison with landlords and property managers.
  - Make referrals as needed to substance abuse treatment centers, mental health agencies, health care providers, vocational/educational resources, legal services, public benefits, food pantries, etc.
3. Coordinate stabilization work through regular meetings with HomeStart staff.
4. Remain up-to-date on housing regulations and programs relevant to the housing in which your clients live.
5. Help clients access financial assistance from HomeStart's Housing Fund and from other resources to facilitate housing stabilization.
6. Complete all paperwork and statistics in a thorough and timely manner.
7. Provide housing search or case management services when necessary.
8. Carry out other related duties as assigned.

## **Job Qualifications**

1. Two years of case management or related social service experience strongly preferred.
2. Experience in working with persons in recovery from substance abuse strongly preferred.
3. A bachelor's degree in social work or a related field strongly preferred.
4. Experience working with mental health issues strongly preferred.
5. A willingness to conduct regular home visits in a variety of neighborhoods and to accompany clients to neighborhood services.
6. An ability to work closely with a team of direct service staff, as well as an ability to work with a diverse group of people, including formerly homeless men and women, landlords, social service agency representatives, and others.
7. A demonstrated ability to work independently.
8. A demonstrated ability to advocate effectively on behalf of clients to help them access benefits and services.
9. A dedication to working with people to move out of the shelter system and to become successfully integrated into the community.
10. Knowledge of homelessness issues and/or housing programs helpful.
11. An ability to work some evening hours as part of the 40-hour work week is required.
12. Good math skills.
13. Good verbal and written communication skills.
14. Computer proficiency preferred.

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**APPENDIX I**  
**Department of Public Social Services General Relief Hotel Vendors**

Name of Hotel	Address of Hotel	Zip Code
<b>Central City Vendors</b>		
Good Shepherd Center (Lang.)	267 N. Belmont, L.A.	90026
Adams Garden Hotel	4905 W. Adams Blvd., L.A.	90016
Sunshine Mission	2600 Hoover St., L.A.	90007
<b>Outlying Areas Vendors</b>		
Alhambra Inn & Suites	2451 W. Main St., Alhambra	91801
Aloha Motel	2860 Long Beach Blvd., Long Beach	90902
Anand Motel	10210 S. Western Ave., L.A.	90047
Barton Hill Hotel	246 N. Pacific Ave., San Pedro	90731
Bonnie Lee	543 N. Broad Ave., Wilmington	90744
Carlton Motel L.A.	10314 S. Figueroa, L.A.	90003
Clover Motel	12429 Long Beach Blvd., Lynwood	90262
Cornett Motel	6345 S. Crenshaw Blvd., L.A.	90003
Cozy Motel	10830 Atlantic Ave., Lynwood	90262
Crown Motel	2111 E. Imperial Highway, L.A.	90059
Econo Inn	12031 Garvey Ave., El Monte	91732
Fijian Motel	8420 S. Main St., L.A.	90003
Firestone Motel	4920 Firestone Blvd., South Gate	90280
Flores Motel	807 E. Manchester Blvd., L.A.	90001
4-Star Motel	7400 So. Figueroa St., L.A.	90003
Grand Ave. Center For Dignity	3833 S. Grand Ave., L.A.	90037
Greenleaf Hotel	63 Lime Ave., Long Beach	90802
Groomes Family Home I	235 W. 107th St., L.A.	90003
Groomes Family Home II	213 W. 108th St., L.A.	90061
Hoover Motel	9710 S. Hoover, L.A.	90044
Keystone Motel	11728 E. Imperial Hwy., Norwalk	90650
King's Lodge Motel	8618 Venice Blvd., L.A.	90034
Los Angeles Adventurer All Suites	4200 W. Century Blvd., Inglewood	90304
Lido Hotel	6523 Santa Fe Ave., Huntington Park	90255
Monterey Motel	1777 Cherry Ave., Long Beach	90813
Palos Verdes Hotel	1001 So. Palos Verdes St., San Pedro	90731
Poolside Motel	611 W. Pacific Coast Hwy., Long Beach	90806
Royal Pound Motel	9431 Whittier Blvd., Pico Rivera	90660
Searle Motel	6124 N. Long Beach Blvd., Long Beach	90805
Slauson Atlantic Hotel	4531 E. Slauson, Maywood	90270
Slumber Inn Motel	1770 Pine Ave., Long Beach	90813
Top-Hat Motel	7517 S. San Pedro St., L.A.	90003
Tropic Motel	4315 N. Sierra Hwy., Lancaster	93534
Tuk-U-In Motel	1626 W. Esther St., Long Beach	90813
Venice Hotel	8686 Venice Blvd., L.A.	90034
Victory Motel	11652 E. Garvey Ave., El Monte	91732
Wagon Wheel Motel	11167 S. Atlantic Ave., Lynwood	90262
Whittier Atlantic Hotel	5379 Whittier Blvd., L.A.	90022

**APPENDIX J**  
**Emergency Shelter Program Models and Associated Service Costs**

**PROGRAM TYPE #1: Single Adults (Medium)**

Target Population: Homeless Single Adults  
 Gender: Coed  
 Size: 60 beds  
 Hours: 24-hour  
 Length of Stay: 4 months (+2 months extension)  
 Configuration: Semi-private

**Service Budget**

Line Item	Cost (\$)
<b>Personnel</b>	
Program Manager 0.5FTE	20,000
Case Manager (Lead) 1FTE	35,000
Case Manager 1FTE	31,000
Case Manager 0.5FTE (\$10.5 x 22hrs/wk x 52wk)	12,000
Mental Health Therapist 1FTE	40,000
Substance Abuse Counselor 0.5FTE	16,000
Nurse Practitioner 0.5FTE	39,000
Employment Specialist 1FTE	27,000
Housing Specialist 0.5FTE	17,000
<i>Total (Salaries)</i>	<i>237,000</i>
Payroll Taxes/Fringe Benefits (25%)	59,250
<b>Total (Personnel)</b>	<b>296,250</b>
<b>Non-Personnel</b>	
Transportation (Bus Tokens) <sup>1</sup>	14,000
<b>Total (Personnel + Non-Personnel)</b>	<b>310,250</b>

**Services**

This program requires that shelter residents engage in case management.<sup>2</sup> Residents will also receive legal assessments and advocacy, benefits assistance, budget counseling, life skills training, health education, have access to a computer lab (with connections to WorkSource Center services), and be able to participate in social and other recreational activities.

<sup>1</sup> Assumes that approximately 13% of the population will qualify for disabled passes (\$12/mo.), while the remaining residents will access 1,000 bus tokens monthly at \$1.10 per token.

<sup>2</sup> With this overnight model, it is possible to offer case management services off-site, at a central location, where shelter residents could access such services during day hours.

**PROGRAM TYPE #2: Single Adults (Large)**

Target Population: Homeless Single Adults  
 Gender: Coed  
 Size: 250 beds  
 Hours: Overnight (4 p.m. – 8 a.m.)  
 Length of Stay: 4 months (+2 months extension)  
 Configuration: Warehouse

**Service Budget**

Line Item	Cost (\$)
<b>Personnel</b>	
Program Manager <sup>3</sup> 1FTE	40,000
Case Manager (Lead) 1FTE	35,000
Case Manager 7@1FTE	217,000
Mental Health Therapist 4@0.5FTE	80,000
Substance Abuse Counselor 2@0.5FTE	32,000
Nurse Practitioner 0.5FTE	39,000
Employment Specialist 1FTE	27,000
Housing Specialist 2@1FTE	68,000
<i>Total (Salaries)</i>	<i>538,000</i>
Payroll Taxes/Fringe Benefits (25%)	134,500
<b>Total (Personnel)</b>	<b>672,500</b>
<b>Non-Personnel</b>	
Transportation (Bus Tokens) <sup>4</sup>	44,500
<b>Total (Personnel + Non-Personnel)</b>	<b>717,000</b>

**Services**

This program requires that shelter residents engage in case management. Residents will also receive legal assessments and advocacy, benefits assistance, budget counseling, life skills training, health education, have access to a computer lab (with connections to WorkSource Center services), and be able to participate in social and other recreational activities.

<sup>3</sup> Assumes a full-time commitment given the presence of a Project Director who can fulfill administrative obligations of the program.

<sup>4</sup> Assumes that approximately 13% (33 residents) of the population will qualify for disabled passes (\$12/mo.), while the remaining residents will access 3,000 bus tokens monthly at \$1.10 per token.

### PROGRAM TYPE #3: Safe Haven

Target Population: Chronically Homeless Adults  
Gender: Coed  
Size: 25 beds  
Hours: 24-hour  
Length of Stay: As long as needed  
Configuration: Semi-Private

#### Service Budget

Line Item	Cost (\$)
<b>Personnel</b>	
Program Manager 0.5FTE	20,000
Licensed Clinical Social Worker <sup>5</sup> 1FTE	55,000
Outreach Specialist <sup>6</sup> 1FTE	26,000
Registered Nurse 0.25FTE	13,000
Peer Advocate <sup>7</sup> 0.75FTE	13,000
Psychiatrist 0.1FTE	16,000
<i>Total (Salaries)</i>	<i>143,000</i>
Payroll Taxes/Fringe Benefits (25%)	35,750
<b>Total (Personnel)</b>	<b>178,750</b>
<b>Non-Personnel</b>	
Transportation (Bus Tokens) <sup>8</sup>	4,000
<b>Total (Personnel + Non-Personnel)</b>	<b>182,750</b>

#### Services

The capacity and configuration of the Safe Haven depend heavily on the site, as some programs also provide supportive services on a drop-in basis to eligible persons who are not residents. The program is intentionally kept small, to provide for more intimacy and opportunity to engage with residents, and embraces a high-tolerance, low-demand service philosophy, often characterized as “harm reduction.” Due to the high levels of disability among the population, the program offers diverse, specialized services, and is flexible to address the

<sup>5</sup> The LCSW would have a background in “co-occurring disorders.”

<sup>6</sup> Outreach services could continue to identify prospective Safe Haven participants as well as engage and serve others who remain on the street and demonstrate unwillingness to access program services immediately.

<sup>7</sup> Peer advocates are chosen from formerly homeless Safe Haven residents who assist with program services. They conduct outreach, escort residents to appointments and services, assist case managers by following up on service plan activities, and participate in group activities and facilitate socialization at programs.

<sup>8</sup> Assumes that at least 50% of Safe Haven members will qualify for disabled Metro passes.

non-linear progression of mental illness and substance addiction. From a housing perspective, this program is focused on preparing for and moving clients into more appropriate forms of support, such as Shelter Plus Care, where they can benefit from permanent supportive housing. Safe Haven residents can stay indefinitely, although many move on within six months.

#### **PROGRAM TYPE #4: Family Shelter (Small)**

Target Population: Homeless Families  
Gender: Single Mothers with Children  
Size: 12 families (approximately 48 beds)  
Hours: 24-hour  
Length of Stay: 4 months (+2 months extension)  
Configuration: Individual Units

#### **Service Budget**

<b>Line Item</b>	<b>Cost (\$)</b>
<b>Personnel</b>	
Program Manager 0.5FTE	20,000
Therapeutic Counselor MFT 1FTE	45,000
Case Manager 0.5FTE	17,500
Housing Specialist 0.5FTE	17,000
Registered Nurse 0.4FTE	20,800
<i>Total (Salaries)</i>	<i>120,300</i>
Payroll Taxes/Fringe Benefits (25%)	30,075
<b>Total (Personnel)</b>	<b>150,375</b>
<b>Non-Personnel</b>	
Transportation (Bus Tokens) <sup>9</sup>	4,000
<b>Total (Personnel + Non-Personnel)</b>	<b>154,375</b>

#### **Services**

Due to the unique and diverse needs of homeless families, and because minor children are involved, case management participation is mandatory. Benefits and legal advocacy and assistance are also prominent aspects of service delivery. To this end, this program will seek the on-site presence or engagement of DCFS and DPSS to address issues related to permanency, reunification, and access to cash benefits and employment programs.

The housing specialist is present part-time to ensure that families are aware of available housing resources and actively assisted to pursue these options. On-site medical care is available twice a week, while parents with younger children will be assisted with childcare and other child-related services. This program also provides residents with various life skills training, such as budgeting, cooking, parenting, household management, and others associated with daily living.

<sup>9</sup> Assumes that certain residents (e.g., school-age children) may qualify for Metro passes.

**PROGRAM TYPE #5: Homeless Mentally Ill (Small)**

Target Population: Homeless Persons with Mental Illness<sup>10</sup>  
 Gender: Coed  
 Size: 12 beds  
 Hours: 24-hour  
 Length of Stay: 6 months (+3 months extension)  
 Configuration: Semi-Private

**Service Budget**

Line Item	Cost (\$)
<b>Personnel</b>	
Program Manager 0.5FTE	20,000
Psychiatrist 0.25FTE	40,000
Licensed Clinical Social Worker 1FTE	55,000
Registered Nurse 0.2FTE	10,400
Housing Specialist 0.25FTE	8,000
Peer Advocate 0.5FTE	8,000
<i>Total (Salaries)</i>	<i>141,400</i>
Payroll Taxes/Fringe Benefits (25%)	35,350
<b>Total (Personnel)</b>	<b>176,750</b>
<b>Non-Personnel</b>	
Van Lease (\$700/mo.)	8,400
Van Gas and Maintenance (\$225/mo.)	2,700
<b>Total (Non-Personnel)</b>	<b>11,100</b>
<b>Total (Personnel + Non-Personnel)</b>	<b>187,850</b>

**Services**

This is a small, manageable program that provides an array of on-site specialty services, including a psychiatrist available twice a week, specific to the mental health needs of its residents. Peer advocates are also available to offer credibility and improve communication between residents and staff. To ensure that it remains responsive to the changing needs of its residents, the program will also offer strong linkages with DMH-funded clinics, psychiatric facilities, operators of transitional and permanent supportive housing, and other community-based services. Other services include on-site medical care, substance abuse counseling and/or treatment, individualized entitlements planning, employment,

<sup>10</sup> It is anticipated that the program could serve residents coming from a variety of settings, including psychiatric hospitals, Institutions for Mental Disease, or be identified through street outreach or Access Centers.

life skills, budget development and management, and other social/recreational activities.