



Hope for the Homeless

Effective Programs that Promote Real Change

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and the

Continuous System Improvement Committee

for the

California Mental Health Planning Council

January 21, 2016

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Introduction:

In September of 2015, Los Angeles declared a “state of emergency” to address the city’s homeless population, the largest in the United States. Homeless counts have revealed that 26,000 people live on the streets of Los Angeles on any given night. City officials have asked for 100 million dollars to provide relief.¹ Before the funding has even been approved there is debate about how it should be spent. Critics say that with past funding the city has prioritized law enforcement efforts to issue citations and remove homeless encampments at the expense of providing more permanent supportive housing (PSH) which is a proven and more sustainable approach to the problem.

This report will highlight promising behavioral health efforts which serve the homeless population in California. Providing effective services such as adequate housing and behavioral health treatment is a significant part of the state’s goal to end homelessness by 2020. California is home to the largest number of homeless youth and adults in the nation. Many programs have been instituted over the past 50 years but the numbers can’t be ignored. Homelessness continues to elude our efforts, strain our healthcare resources, and infuse discouragement in our large cities, suburbs, and rural communities. This report will focus on programs that provide effective behavioral health services for youth and adults. These programs are some of the critical building blocks in the construction of a system that works to keep the most vulnerable sub-groups of homeless Californians safe, secure, and healthy.

In June and October of 2015 the California Mental Health Planning Council (CMHPC) conducted panel presentations involving advocates, consumers, and stakeholders who are connected to the issues of behavioral health and homelessness. The report highlights those discussions and builds upon them by providing examples of other efforts around California and the nation which appear to be promising components in ending homelessness for those with severe mental illness and substance use disorders.

Definition:

The federal government has an official definition of homelessness which was finalized in January of 2012. It states that a person or family is homeless if they fall into one of four categories. The categories are: **Literally homeless:** they lack a fixed, regular, nighttime residence which includes living in a car or temporary shelter program; **imminent risk of homelessness:** an individual who will lose their residence within 14 days; **homeless under other federal statutes:** unaccompanied adults, youth, or families with children who have not had permanent housing for the past 60 days; **fleeing or attempting to flee domestic violence.**²

There is an effort underway to create a single definition of homelessness between government agencies. H.R. 5186 would create one definition of homelessness. The rationale for such action would

¹ World Socialist Website. *Los Angeles Officials Declare “state of emergency” over Homelessness*, September 2015.

² Housing and Urban Development. *Hunger and Homeless Coalition of Collier County*. January 2012. www.collierhomelesscoalition.org.

be to ensure that families with children and unaccompanied youth who are at imminent risk of homelessness have the same access to Housing and Urban Development (HUD) funds as other defined homeless persons. In the past, homeless counts conducted by HUD compared with those conducted by the Department of Education show very different numbers. The Department of Education has a higher count of homeless children under their definition than under HUD's. A consistent definition would increase access to HUD funding for children and unaccompanied youth.

Homelessness Statistics:

While it is difficult to obtain an accurate count of the number of people in our country and state who are experiencing homelessness, it is estimated that in the United States 578,424 people lack permanent shelter on a given night. Up to 31% of the total number of homeless lacks any type of shelter or roof over their heads. California has the highest population of homeless at 114,000. This number represents 20% of the nation's homeless.³

Statistics gathered by the Substance Abuse and Mental Health Services Administration (SAMHSA) from January 2010 found that 26.1% of those being sheltered had a severe mental illness compared to 4-6% in the general population. Those with chronic substance use issues represent 34.7% of the homeless population.⁴ It is widely reported that up to 40 percent of homeless youth identify as LGBTQ. Youth typically move to the streets due to conflict with their families, disagreements with foster families, or because they have aged out of the foster care system. The National Alliance to End Homelessness estimates that each year 550,000 single youth and transition age youth have experienced a homeless episode of up to one week.⁵ California has the largest number of veterans experiencing homelessness at 12,096. This number makes up 24% of the nation's total number of homeless veterans.⁶

The statistics demonstrate California's unique challenge, but it also presents the opportunity to provide leadership in the effort to bring an end to homelessness for youth and those with mental illness or substance addiction.

History of Homelessness:

According to John Foran of Praxis Housing we can find references to the homeless as far back as the book of Amos in the Old Testament. Most Western religions speak of the homeless and encourage followers to feed the hungry and clothe the naked. For the first 1300 years AD, the homeless were largely cared for by the church. But in 1349, the plague changed people's thinking about their interactions with the homeless for fear of becoming sick. It was at this time that people avoided those who wandered from town to town. This is when laws regarding the homeless came into effect and

³ Housing and Urban Development. *Homeless Statistics: 23 Facts to Know Before You Sleep Tonight*. January 2014.

⁴ Substance Abuse and Mental Health Services Administration. July 2011.

⁵ National Alliance to End Homelessness, <http://www.endhomelessness.org/pages/youth>.

⁶ Department of Housing and Urban Development. *Annual Homeless Assessment Report to Congress*. October 2014.

different definitions for the homeless emerged i.e. “unemployed, lusty rogues, shiftless beggars, jugglers, minstrels, and thieves.” For the next 500 years the government took on the responsibility of helping the homeless. In England they had work houses which you read about in Dickens’ books, Oliver Twist, and Hard Times. There were often small servings of food, poor conditions, and limited help for those housed there.

In the 1900s the United States became an industrialized nation until the 1970s. The time of heavy industry was economically strong but it was also unstable and there were several periods of economic depression and job loss which led to homelessness. In this period of time, homeless people with mental or developmental disabilities were hospitalized against their will. In 1967, California Governor Ronald Reagan signed into law the Lanterman-Petris-Short Act. This law ended commitment of the mentally ill to state hospitals except in the case of criminal sentencing. Some believe that this decision led to a sudden increase in homelessness for people with mental illness as state hospital staffing was drastically cut and no increase in funding for community-based programs occurred. Homeless persons were often blamed for their own plight. It wasn’t until 1975 that people began to recognize that homelessness could happen to anyone. Although the phrase “pull yourself up by your own bootstraps” remained popular throughout the 1980’s.⁷

As the United States moved from an industry economy to a service economy many people experienced unemployment. At this time, the homeless were introduced to drug use which became both a cause and result of homelessness as it is today. In 1975, journalist Geraldo Rivera investigated Willowbrook, a New York mental hospital for children and adults. The conditions were sub-standard and his report gained the attention of the American people. Hugh Carey, the NY state governor, took action and began to set up supportive housing in communities. While the idea was a good one, thousands of people were released from mental hospitals without secure housing. Implementation of the housing component was slow and resulted in 25,000 people becoming homeless.⁸

The McKinney-Vento Homeless Assistance Program was enacted in 1987. The Act which was named after Representatives Stewart B McKinney and Bruce Vento includes a set of homeless programs administered through the Department of Housing and Urban Development (HUD). The McKinney-Vento Act was the first federal response to homelessness. The act was created after the public demanded that homelessness be acknowledged on a national level. The original Act included fifteen programs that addressed issues such as job training, emergency shelter, health care, and some permanent housing. The Act has been amended several times since 1987. In 1990 it was amended to include two vital programs, Shelter Plus Care which provides housing assistance to people with disabilities, and Projects for Assistance in Transition from Homelessness (PATH). In 2009, Congress

⁷ “Pulling Yourself Up By Your Own Bootstraps” : An Etymology of an American Dream, May 2011.

⁸ Foran, John. Praxis Housing CEO. [The history of homeless](#), March 2008.

passed, and President Obama signed, the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH) which amended and reauthorized the McKinney-Vento Act.⁹

In 2004, California voters passed Proposition 63, called the Mental Health Services Act (MHSA). This law has generated over 14 billion dollars since its inception. The funds are provided to enhance the mental health services in California. The MHSA program provides Permanent Supportive Housing to homeless persons who have serious mental health disorders. This report will highlight the MHSA Housing programs in California and how they benefit homeless people who have mental illness.

For the past 30 years there has been significant movement toward finding solutions for homeless youth and those with mental illness. However, the number of people experiencing homelessness in California is substantial and can no longer be ignored. Innovative and effective programs that target specific homeless populations will be highlighted here in order to further the conversation about what is working and what California could implement going forward.

Critical Components:

Programs that serve homeless youth and homeless persons with behavioral health disorders consist of four critical components that, when integrated, can produce effective results. These four components are prevention, outreach, permanent or transitional housing, and reintegration.

1. Prevention:

Can homelessness be prevented? According to the US Interagency Council on Homelessness, assistance with rental housing is the most direct and effective tool to prevent homelessness in adults with behavioral health issues and their families.¹⁰ Emergency Solutions Grants (ESG), through the HEARTH Act, provides funding to subsidize rent payments for no income or very low income individuals and families. Permanent supportive housing has been demonstrated as effective in reducing the number of people who return to homelessness by providing mental health and substance use services along with subsidized housing. For adults with behavioral health disorders, connection to Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) is a critical service that can prevent chronic homelessness by providing a steady, albeit modest, income to individuals deemed to be disabled. In California it has been recognized that many homeless persons are not taking advantage of Medi-Cal eligibility which could improve their health through management of chronic diseases such as diabetes, asthma, or heart disease.¹¹ Connecting homeless individuals with these necessary financial and healthcare resources is an important step in improving the overall health of those who are homelessness.

⁹ National Coalition for the Homeless. McKinney-Vento Act. Fact Sheet. June 2006. www.nationalhomeless.org/publications/facts/McKinney.pdf

¹⁰ United States Interagency Council on Homelessness., *Explore the Solutions Database*. January, 2013.

¹¹ California Healthline, "Many California Homeless Not Taking Advantage of Medi-Cal Eligibility", March 2014.

For homeless youth the most effective prevention method is family reunification services with on-going support. Runaway and homeless youth (RHY) ages 14-18 typically end homelessness by returning to their families. “Family conflict and abuse are consistently identified by unaccompanied homeless youth as the primary reason for their homelessness.”¹² Because of this, effective programs address these family systems issues and provide support to all family members in order to ensure that it is safe for youth to return. The primary goal is to return youth to their families or extended families before pursuing longer term youth housing programs.

“Teachers must be alert to the signs that a child is homeless, since these youth face a variety of challenges and experiences that put them at risk for a range of physical, mental, and academic problems.”

Schools can play a vital role in early intervention efforts. “Teachers must be alert to the signs that a child is homeless, since these youth face a variety of challenges and experiences that put them at risk for a range of physical, mental, and academic problems.”¹³ For high risk homeless youth, those who are 18-24 years of age or who have serious behavioral health issues, the best methods to prevent chronic homelessness is to connect them with permanent supportive housing which can address their mental health, substance abuse, and life skills development in one location. According to the National Alliance to End Homelessness, “it would be important that these programs have limited barriers to entry and minimize rules that would result in ejecting youth from the program in order to keep them off of the streets.”¹⁴ This is a “harm reduction” strategy. The prevention of homelessness starts with getting and keeping youth off of the streets. If programs have a black or white, inflexible, or judgmental view towards drug use, youth who are using drugs will fail in these programs and not receive the help they need.

The California Fostering Connections to Success Act (AB12) went into effect in January 2012. The Act was designed to address the growing number of aged out foster youth who were experiencing homelessness at a much higher rate than other youth. This program allows foster youth to remain in extended foster care from 18-21 years of age if they are finishing high school, enrolled in college or trade school, working part time, in a program to train for work, or they have a medical condition that would not allow them to meet the criteria. This program prevents homelessness in former foster or probation youth by allowing them additional time to finish schooling or obtain the skills necessary for independence.

¹² *Ending Youth Homelessness Before it Begins: Prevention and Early Intervention Services for Older Adolescents*, August 2009.

¹³ *Homeless Youth In Our Schools, Identifying and supporting a marginalized and victimized population*, Poland, March 2010.

¹⁴ National Alliance to End Homelessness. *An emerging Framework for Ending Unaccompanied Youth Homelessness*. March 2012.

It is estimated that people with untreated psychiatric illnesses make up one-third of the homeless population.¹⁵ For people with serious mental illness, prevention efforts must begin at the first sign of psychosis. While schizophrenia or bi-polar disorder may not be avoidable conditions, it is possible to prevent deterioration in those who suffer with these diagnoses. If symptoms are recognized in the early stage, young people can be engaged in mental health support services which could prevent them from becoming homeless. Psychotic symptoms are generally first recognized in people between 18 and 22 years of age.¹⁶ For this reason, former Senate Pro Tempore Darrell Steinberg has recently shed light on the issue by encouraging more funding for mental health services in the UC, State, and community college systems.¹⁷ This is a good start and at some point it will be helpful to explore how employers, military personnel, and trade school representatives could be informed about the symptoms of early psychosis so that services could be delivered to the approximately 35% in this age group who are not in college but have gone to work, trade school, or the military.

2. Outreach:

“Outreach seeks to establish a personal connection that provides the spark for the journey back to a vital and dignified life.”¹⁸ For homeless adults with mental illness and youth who may have grown to mistrust others, outreach and engagement services may be difficult and perplexing. The following are just some of the components of successful outreach and engagement services to the homeless.

- Designed to treat the whole person
- Respect for the client is critical
- Relationship building is of utmost importance
- Respect for culture
- Meeting basic needs such as food, shelter, and clothing
- Coordination of services
- Involvement of consumers or formerly homeless
- Safety, boundaries, and ethics
- Designed to serve people who have difficulty accessing services
- End goal is integration into the community¹⁹

Outreach takes place in many different settings i.e. emergency rooms, the streets, and homeless encampments. Workers typically move out in pairs to make initial connections and bring essentials like food, water, socks, sleeping bags, and information about local services. If done well, rapport is built over time and services are delivered in a respectful and non-judgmental way. It is important to

¹⁵ Nieves.E. *Fed Up, Berkeley Begins Crackdown on Homeless*. New

Ohlemacher S. Study: 744,000 homeless in U.S. Associated Press archives, January 10, 2007, <http://www.ap.org/>, last accessed March 28, 2011. York Times, November 3, 1998, p. A19

¹⁶ NIH, News In Health. *Recognizing Schizophrenia*, May 2011.

¹⁷ Steinberg, D. *Time to adjust California's Mental Health Services Act*. September 2015 <http://www.sacbee.com/opinion/oped/soapbox/article36452658.html>

¹⁸ Bassuk, The Open Health Services and Policy Journal. *Definitions of Outreach and Engagement*. 2010.

¹⁹ Homeless Resource Center. *Assessing the Evidence: What We Know About Outreach and Engagement*. 2007.

consider the reasons why some homeless people with mental illness refuse any type of assistance with shelter. A review of several articles found varied reasons for shelter refusal:

- Psychosis which creates paranoia toward helpers
- They want to bring all of their belongings but are told they can't
- They see "home" as an unsafe place where they were previously abused or mistreated
- Past experiences of physical abuse in shelter programs
- Prevalence of theft in shelters
- Burdensome shelter rules
- Past experiences with sexual assault in a shelter
- They can't bring their animals
- They have a drug/alcohol dependence and think that the shelters won't allow it
- They prefer isolation
- The shelter itself represents the shame of their situation
- Contagious disease, bed bugs and lice in shelters
- There aren't enough beds available in local shelters
- Shelters become targets for drug sellers
- Too much fluorescent light
- They're treated like children by shelter staff
- People try to persuade them to adopt their religion
- They'll be separated from their homeless friends who support one another

In San Francisco, these issues were considered and the Navigation Center was launched. The goal of the Navigation Center was to create a different kind of shelter with fewer barriers. People are welcome to bring their "three Ps" with them; pets, personal belongings, and partners.²⁰ So far the plan is working.

Another hurdle to overcome in regards to service delivery is the criminalization of homelessness. Because the homeless have been arrested for sleeping or resting in public areas there exists a certain degree of mistrust and fear. Outreach is an important step in the effort to de-criminalize homelessness. Furthermore, the United States Interagency Council on Homelessness recommended that police officers be involved along with outreach workers in the effort to connect the homeless to services.²¹ Youth can be difficult to engage in outreach efforts because they fear being arrested for running away or eventually returned to a home that may have been abusive. For this reason youth outreach workers practice consistency and patience without judgement in order to see results. In September of 2015 the Department of Housing and Urban Development stated that they will now consider a community's efforts to prevent the criminalization of the homeless when they award \$1.9 billion in new homeless assistance grants later this year.

²⁰ KQED. San Francisco Hopes New Shelter Program Impresses Tech Sector. July 2015 ww2.kqed.org/.../san-francisco-hopes-new-homeless-shelter-impresses.

²¹ United States Interagency Council on Homelessness. *Searching Out Solutions, Constructive Alternatives to the Criminalization of Homelessness*. 2012.

In fully integrated health care outreach, clinicians, physicians, nurses, and program staff are involved on the teams to bring critical health care services to the homeless. This model increases penetration rates for the homeless into health care programs. It is difficult to quantify outreach efforts. As a result, it becomes difficult to keep them funded. Highlighting the financial benefits of outreach would increase the feasibility of such programs and ensure that they remain a vital component of the larger plan to end homelessness.

3. Housing First and Permanent Supportive Housing:

Programs that provide disabled individuals and/or families with the rights of tenancy in a long term housing unit of their own are referred to as Housing First or Permanent Supportive Housing (PSH). In other words they are free to stay as long as they want if they are able to fulfill the terms of their lease, i.e. paying their rent on time. The program includes supportive services which are voluntary and offered on site. This is a “housing first” approach which delineates itself from other programs that offer support services but do not offer housing. A housing first approach is defined as “an approach that centers on providing homeless people with housing quickly and then providing services as needed.”²²

The greatest challenge to a “housing first” approach is the lack of available supportive housing units. Waiting lists often require people who are homeless to call in each day to check in and secure their place on the list. For clients who experience severe mental illness or substance use disorders, this requirement can become too burdensome and can create a barrier to assistance. The “Housing First-San Diego” three year plan seeks to dramatically grow the number of affordable housing by renovating a 72 unit downtown hotel, awarding 30 million dollars to programs that will grow permanent supportive housing, and by utilizing 1,500 federal government vouchers for rental housing.²³ This type of plan has promise because if cities and counties have housing units available, they can successfully implement a “housing first” model.

The belief behind PSH is that people with behavioral health issues will not benefit from services until a safe, steady place to sleep each night is acquired. Once the basic needs of safety, warmth, and health care are met the important supportive services can begin. “The difference is that they can access, at their option, services designed to address their individual needs and preferences. These services may include the help of a case manager or peer counselor. They receive help in building independent living and tenancy skills, assistance with integrating into the community, and connections to community-based health care, treatment, and employment services.”²⁴ The use of peer counselors in these programs is vital to its effectiveness. When people recover, they are often times the most effective resources to provide outreach services and keep others engaged in recovery.

²² National Alliance to End Homelessness. What is Housing First? November 2006

²³ San Diego Housing Commission. Housing First-San Diego. November 2014. www.sdhc.org/Special-Housing-Programs.aspx?id=7616

²⁴ United States Interagency Council on Homelessness, *SAMHSA 2010 Annual Report*. 2010.

It costs \$16,282 per person in a housing unit year round. When all the costs of supportive housing and public services are considered, it costs the public only \$995 more a year to provide supportive housing to a mentally ill individual than it does to allow him or her to remain homeless. University of Pennsylvania

Cost Effectiveness:

The cost of providing PSH units may seem exorbitant. However, the National Alliance to End Homelessness in a 2015 report cited a University of Pennsylvania study which found that PSH provided a major reduction in costs associated with caring for homeless persons with mental illness. “It costs \$16,282 per person in a housing unit year round. When all the costs of supportive housing and public services are considered, it costs the public only \$995 more a year to provide supportive housing to a mentally ill individual than it does to allow him or her to remain homeless.” Living on the streets deteriorates the physical and mental condition of homeless individuals and leads to the inefficient and costly use of public health, mental health, and law enforcement services.²⁵ In 2009, Michael Cousineau of the Keck School of Medicine of USC conducted the “Homeless Cost Study” which found that placing four chronically homeless persons in PSH saved taxpayers \$80,000 per year.²⁶ When the most vulnerable homeless are permanently housed, significant cost savings are found in the areas of health care, emergency room visits, overnight stays in hospital beds, and law enforcement expenditures. According to Daniel Flaming of the Economic Roundtable, “The key finding from our study is that practical, tangible public benefits result from providing housing and supportive services to vulnerable homeless individuals. Public costs are reduced by 79 percent and the quality of life for homeless persons is improved.”²⁷

Housing for Youth:

Housing for youth ages 16-24 requires a different approach. Homeless youth often reunite with families, but when they don’t and they end up experiencing chronic homelessness, the housing approaches must adjust to meet the specific needs of youth. In the United States, 50,000 youth sleep on the streets for 6 months or more.²⁸ Effective youth housing programs not only house youth but also provide Positive Youth Development (PYD). For youth who are chronically homeless we can assume that they have no supportive family or friend network willing to take them in and lead them toward successful adulthood. Because of this, PYD provides much needed guidance in the areas of cooking, relationships, school attendance, paying bills, caring for children, and establishing goals. PYD is strength-based in that the programs don’t focus on the problems a youth may have but on their unique abilities. PYD is trauma informed as it recognizes the significant emotional, social, and physiological effects of trauma on the lives of people and is aware of the high rate of trauma experiences in this age group. Successful programs not only recognize trauma, but have services

²⁵ National Alliance to End Homelessness, *Permanent Supportive Housing*, 2015.

²⁶ Lewit, M. *Sheltering Homeless Saves Money, Study Says*. 2009.

²⁷ Examiner.com. *Housing Homeless People reduces costs for Los Angeles taxpayers*. 2010.

²⁸ National Alliance to End Homelessness, Youth, www.endhomelessness.org/pages/youth

available for depression, anxiety, drug and alcohol use, chronic health conditions, and past physical/emotional abuse.

Youth housing options are provided in steps, depending on the age and independence level of the youth. These housing level options are emergency shelter, community-based group home, shared houses, supervised apartments, and scattered-site apartments. At each level there is an effort to assess needs, provide services, and implement PYD approaches.²⁹ Within these layers of housing exists programs to assist transition age youth (TAY). These programs are called Transitional Housing Programs (THP) or Transitional Living Programs (TLP).

The more information we obtain about homeless youth the better we'll be able to address specific needs with the most effective approach. It wasn't until 2013 that HUD asked communities to count unaccompanied homeless youth. In their 2014 Annual Homeless Assessment report, a point-in-time snap shot count across the country found 194,302 homeless youth on a single night. 45,205 of those youth were unaccompanied and represented 8% of all homeless people on that night in January 2014.³⁰ It is likely that the reported number of unaccompanied homeless youth is lower than the actual number. This is because youth on the streets avoid police contact and find places to shelter i.e. friend's houses, and cars. A Government Accounting Office (GAO) report estimated that only 1 in 12 unaccompanied youth ever come into contact with a shelter system. Obtaining accurate reports will help us to design housing options for the most vulnerable homeless youth.

4. Reintegration:

Webster's defines reintegration as: "to integrate again into an entity, to restore to unity." Reintegration of people who are experiencing homelessness assumes that those people have been removed from an entity or community, and need to be re-connected to that community. This final component of reintegration is critical. If those who are homeless, and living with mental illness, have been separated out and are not reconnected back into their local communities, they run the risk of isolation while the community at large runs the risk of remaining uninformed about their potential contributions to the community.

For homeless people who are young or who have a serious behavioral health issue, reintegration is a thread that can run through the other critical components; prevention, outreach, and housing. The goal of effective reintegration efforts is to assist consumers as they recover and then re-enter the larger community. The Center for Reintegration describes it as "the process by which a person with a mental illness finds meaningful work, restores his or her relationships, and moves toward independent living".³¹ Often times, relationship breakdown and loneliness precede homelessness. Whether a divorce, job loss, family conflict, or untreated mental illness, these events can become the catalyst to

²⁹ Ibid.

³⁰ Department of Housing and Urban Development. *Annual Homeless Assessment Report to Congress*. October 2014.

³¹ The Center for Reintegration. *Back to Work, Back to Life, Definition of reintegration*, 2003.

isolation and eventual homelessness. Loneliness and isolation can also be the cause of failed re-housing efforts. “Crisis”, a national charity for single homeless people, claims “Isolation and loneliness are also commonly experienced after people have been re-housed into permanent housing and are often linked to tenancy breakdown and repeated episodes of homelessness. One in four formerly homeless people find themselves unable to sustain a tenancy, with loneliness and isolation the main causes of this.”³²

“The obstacles and difficulties the mentally ill face builds courage, strength and endurance. It is the resilience of survivorship. This group remarkably and unexpectedly did well after the tragedy of 9/11 as compared to other groups. Its members exhibited remarkable strength and courage based on the very difficulties they have encountered because of their illness.” Walder, N. *The Ghettoization of the Mentally Ill*. 2012.

The double stigma of having a mental illness and being homeless is difficult to overcome. However, if housing programs make it a priority to get consumers connected to others, outside of the mental health arena, they may fare better and end the cycle of homelessness. Job assistance, friendship development, and community living skills are an important piece in the step by step process of recovery.

Funding Streams:

The funding of homeless programs for youth and those with serious mental illness comes from several different sources. Non-profit organizations and churches benefitting the homeless receive funding through fundraising efforts, federal, state, and local grants; while states and counties receive funding from federal and state government programs. Some of the major funding streams are the Department of Housing and Urban Development (HUD), Projects for Assistance in Transition from Homelessness (PATH), Mental Health Services Act, (MHSA Housing), and Substance Abuse Mental Health Services Administration (SAMHSA).

HUD:

HUD expends the funding from the McKinney-Vento homeless grants which are the federal government’s primary fiscal response to homelessness. This program consolidated three programs, Shelter + Care, Supportive Housing, and Section 8, into one Continuum of Care program. The program was reauthorized in 2009 through the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH). Shelter + Care is recognized as a promising program that works. In this model, people are not only sheltered, but they are provided with the support needed to find more permanent housing, employment, and benefits. Many homeless people with severe mental health issues do not have the skills necessary to complete forms, meet with landlords, and fully understand the rules and agreements around housing. Shelter + Care provides a warm hand-off to more permanent housing options while shelter is being provided.

³² Crisis, “Relationship Breakdown and Loneliness.” www.crisis.org.uk/pages/relationship-breakdown-and-loneliness.html. 2012.

The Homeless Prevention and Rapid Rehousing Program (HPRP) is also funded out of the HEARTH Act. “Rapid re-housing is a cost-effective strategy to help families successfully exit homelessness and maintain permanent housing by integrating three components: employment assistance, case management, and housing services.”³³ Rapid re-housing programs provide assistance to individuals or families with move in expenses such as first and last month’s rent, as well as rent subsidies which make housing affordable to low income families. The reauthorization simplified the fund matching requirements and consolidated the grant programs. Every year this funding serves one million people who are in emergency shelters, transition programs, or permanent supportive housing. In fiscal year (FY) 2014 California communities received 307.5 million dollars in HUD, Continuum of Care Homeless Assistance Grant funding.³⁴ In FY 2015 funding for the entire program was authorized at \$2.145 billion, and the FY-2016 proposed budget calls for \$2.48 billion.³⁵

PATH:

The California Department of Health Care Services (DHCS) administers the federal funding that comes through the SAMHSA/PATH formula grant. The PATH grant funds community outreach efforts, as well as mental health and substance abuse referral and treatment. It also funds case management services as well as housing services for the homeless who are mentally ill. In FY 12-13 42 California counties participated in the program which served 8,300 persons annually.³⁶ Not all counties elect to participate in the PATH Homeless grants.

MHSA:

The MHSA Housing Program is supported by two main funding streams within the Community Services and Supports portion of the act. The MHSA Housing funds offer permanent financing and subsidies toward the development of properties to be used for permanent supportive housing (PSH) programs. The support services such as case management, treatment, and peer support services are offered through the Full Service Partnership (FSP). FSP funds can also be used to fund outreach, engagement, and rent subsidies.

Since 2007, 400 million dollars has been provided to counties for the construction of permanent supportive housing units. Funding amounts received by counties was determined by population and represents the largest sum of money provided to California counties to successfully address the needs of the homeless who have a severe mental health challenge. Each county is provided additional MHSA funds each month for housing and support services.

PSH sites such as motels are redeveloped into several living units with community meeting rooms. The housing options are both rental and shared housing, and serve people who have serious mental illness, are homeless, or at risk of homelessness. Tenants must meet this MHSA Housing Program target

³³ National Alliance to End Homelessness. 2012. Rapid re-housing: Successfully ending family homelessness. Retrieved from: <http://www.endhomelessness.org/library/entry/rapid-re-housing-successfully-ending-family-homelessness>.

³⁴ Homeless Assistance grant money to California.

³⁵ HUD Exchange. HEARTH Act information. 2014. <https://www.hudexchange.info/homelessness-assistance/hearth-act>

³⁶ California Department of Health Care Services. PATH, www.dhcs.ca.gov › Services › Mental Health › Pages 2015.

population description. The program is administered by the California Housing Finance Agency (CalHFA) as well as DHCS under an interagency agreement. Other funding sources can be joined together with MHSAs Housing funds to maximize funding and subsidies. This is especially helpful in difficult economic times when people struggle to find affordable housing. MHSAs Housing had a goal for 2013 to produce 2,530 units.³⁷ As of March 2015, MHSAs has funded 1, 860 units.³⁸

The CMHPC talked with consumers, service providers, and developers of some of the MHSAs programs which are discussed later in this report.

SAMHSA:

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) provides Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSH). This fund supports the development of programs which treat drug and alcohol abuse as well as co-occurring disorders as a part of their overall homeless support services. It also funds permanent housing for veterans and other individuals who are experiencing homelessness. It is SAMHSA's goal to increase the number of individuals enrolled in permanent housing programs that support recovery from drug or alcohol abuse. Another goal is to support efforts to engage and connect clients who experience substance use or co-occurring substance use and mental disorders to the resources available to them through health insurance, Medicaid, and other benefit programs like SSI/SSDI.³⁹ This is an important component for funding because many homeless individuals and young adults with mental illness are not enrolled in the Medi-Cal program. California Health Line reports that many homeless individuals do not enroll in or use Medi-Cal coverage because of discomfort with medical settings, lack of understanding about how to sign on, and the difficulty they have in providing the required paperwork.⁴⁰

Veterans:

Veterans make up 11% of the homeless adult population in the United States. In California, 63% of the state's homeless veterans were living in unsheltered locations based on HUD's 2014 Annual Homelessness Assessment report.⁴¹ California is one of only five states where the majority of homeless veterans live without shelter. San Jose had the highest rate of unsheltered veterans at 71%.⁴² According to the US Interagency Council on Homelessness, about half of homeless veterans have a mental illness, typically PTSD or bi-polar disorder, 70 percent have substance use disorders.⁴³

³⁷ Mental Health Services Act Housing Program. [MHSAs Housing goal for 2013 www.dhcs.ca.gov/services/MH/Documents/MHSATermSheet.pdf](http://www.dhcs.ca.gov/services/MH/Documents/MHSATermSheet.pdf). 2011.

³⁸ DHCS. MHSAs Housing Program Semi-Annual Update. March 31, 2015.

³⁹ SAMHSA. *Grants for the Benefit of Homeless Individuals-Services in Supportive Housing*, 2015.

⁴⁰ California Healthline. *Many California Homeless not Taking Advantage of Medi-Cal eligibility*, 2014.

⁴¹ Department of Housing and Urban Development, *Annual Homeless Assessment Report to Congress*. 2014.

⁴² Ibid

⁴³ USICH. *Opening Doors: Homelessness among Veterans*, 2011.

The good news is that homelessness among veterans has declined dramatically in California since 2009. This may be due in part to two programs which directly benefit veterans, the Veteran's Bond Act (VBA) and HUD's Veteran's Affairs Supportive Housing (HUD VASH). Past efforts such as the VBA attempted to assist veterans in purchasing homes of their own. However, this was implemented in 2008 when the economy was in major recession and few veterans were able to take advantage of the program. In 2013, Proposition 41 allowed the VBA to be restructured to fund multi-family housing units.⁴⁴ Supportive housing options and housing-first programs are proven methods for addressing homelessness for veterans with mental illness, but where to put these units becomes an issue in some counties such as Santa Clara where land is very expensive.

In October of 2014, Phase I of the Mather Veteran's Village broke ground. When completed, the project will provide housing and supportive services for up to 160 veterans. Phase II of the project received funding from the Veteran's Housing and Homeless Prevention Bond Act or Proposition 41.⁴⁵ This project is unique in that it is being built within walking distance of the VA hospital at the former Mather Air Force Base. When all behavioral health support services are added, it will provide an integrated and comprehensive program to address the significant health needs of veterans who experience homelessness or at risk for becoming homeless.

In Phoenix, Arizona and Salt Lake City, Utah supportive housing programs for veterans have worked. In 2011, Phoenix counted 222 chronically homeless veterans with mental, physical or substance use disorders. In 2014, they announced that they had successfully housed the final 56 chronically homeless veterans in their city.⁴⁶ Salt Lake City followed shortly afterward declaring in December of 2014 that they had ended chronic homelessness for veterans. For these cities, the veteran population was the best place to start, considering that they often have co-occurring disorders, can draw from multiple sources of funding, and have significant public support, as most people find veteran homelessness unacceptable.

Older Adults:

Homelessness among older adults is rising and will continue to rise over the next 20 years due to a decrease in affordable housing and a growing elderly population. The population of homeless older adults in the United States is expected to double in size by 2050.⁴⁷ This often ignored population of homeless individuals will become more pronounced. Innovative approaches will become more necessary as we address the issue going forward. Research shows that when individuals lose their housing at an older age or have co-morbid conditions, they are far more likely to experience chronic

⁴⁴ Veteran's Housing and Homelessness Prevention Program. *Proposition 41 fact sheet*. Cal Vet. 2015.

⁴⁵ Sac County News. Mather Veteran's Village Phase I Celebrated. www.saccounty.net/news/latest-news/Pages/Mather-Veterans-Village

⁴⁶ Phoenix Becomes First City to End Chronic Homelessness. Think Progress. Scott Keyes. December 2013. Thinkprogress.org/economy/2013/12/23/3099911/phoenix-homeless

⁴⁷ Homeless Research Institute. Demographics of Homelessness Series: The Rising Elderly Population. M William Sermons and Meghan Henry. April 2010.

homelessness.⁴⁸ When older adults become homeless, they experience significant health related challenges that often go unmet. “Older adults who are experiencing homeless have three to four times the mortality rate of the general population due to unmet physical health, mental health, and substance use treatment needs.”⁴⁹

For this reason, it will be important to consider three factors in the discussion of homelessness of older adults. First, prevention efforts such as rapid re-housing will need to be available to the elderly population when they are not able to maintain their current residences. Second, as more funding becomes available for permanent supportive housing, the significant health needs of the elderly will need to be addressed in these settings by providing support services that focus on physical health. It may be necessary to designate more PSH reserved for and serving only seniors. Lastly, providing PSH to older homeless adults could result in tremendous cost savings, above and beyond any other age group, and should be factored into the community discussions and planning efforts.

Promising Programs:

While we seem to be on the cusp of some promising ideas in resolving the problem of homelessness, there is still much to consider. The issue is complex and will require innovation among California’s advocacy groups, consumers, mental health stakeholders, and legislators. Toward this goal, the California Mental Health Planning Council (CMHPC) held two separate panel discussions to identify what is working and to outline areas that need improvement. The panels consisted of the following representatives from non-profit organizations, county programs, and housing project members:

Ky Le, Director of Santa Clara County Office of Supportive Housing

Sparky Harlan, CEO of the Bill Wilson Center

Dr. Vitka Eisen, CEO of HealthRIGHT 360

Renee McRae, Personal Service Coordinator III from Turning Point

Richard Brown, Resident Services Coordinator from TLCS.

Holly Wunder-Stiles, Director of Housing Development, Mutual Housing of California

Michael Robinson, Turning Point/Wellspace MHSA Housing member

Regina Range, TLCS, MHSA Housing member

Santa Clara County Office of Supportive Housing

Mr. Le noted that there has always been a strong correlation between mental illness and homelessness. Some of the other major factors leading to homelessness are low income, no affordable housing and few supportive services. He has observed that many solutions and strategies

⁴⁸ Older Homeless Adults. Can We Do More?. Margot Kushel MD, November 2011.

⁴⁹ Premature mortality in homeless population: A review of the literature. J. O’Connell. 2005. [Mortality rates for homeless older adults](http://www.nhchc.org/PrematureMortalityFinal.pdf)
<http://www.nhchc.org/PrematureMortalityFinal.pdf>

have been tried but these strategies have failed because they don't focus on housing. He believes that resources are often directed to affordable housing but not supportive housing. He recommends that resources should fund three main strategies:

- Residential care, and other options for Permanent Supportive Housing
- Rapid re-housing using temporary income supports
- Homelessness prevention.

Mr. Le supports the idea of MHSA Housing funds being used to develop more supportive housing units and highlighted the importance of the mental health departments reserving them for the serious mentally ill by controlling the wait lists.

The Bill Wilson Center

Ms. Harlan stated that the focus and vision of the Bill Wilson Center is to prevent poverty and homelessness through support of youth and families. They accomplish this by connecting them to supportive services. She stated that it is often the case that different homeless populations such as chronically homeless adults, veterans, and youth have competing needs and that the limited resources create a need to prioritize efforts. The BWC is a national trainer for Family Advocacy Services (FAS), a homelessness prevention program that includes caseworkers placed at schools to help families at risk of losing their homes. Many of the families are immigrants, some monolingual speaking languages other than English. The program measures outcomes by how the children perform in school, since homelessness, or the threat of homelessness, is known to lead to low attendance and poor grades. The Bill Wilson Center has intentionally focused on winning the trust of the community through outreach efforts as well as a practice of hiring peers as mentors. This has led to many individuals and families self-referring for assistance. Peer counselors are a vital resource for service delivery to the homeless population.

HealthRIGHT360

Dr. Eisen is the CEO of HealthRIGHT360, an agency which encompasses several entities, including Walden House and the Haight Ashbury Free Clinic. But, before she was CEO she was a client in the program which now provides services in 7 counties: Santa Clara, San Mateo, San Francisco, Los Angeles, Orange, Imperial and San Diego. The focus is on integration of services for substance abuse treatment, mental health care, and primary care. The agency runs four Federally Qualified Health Centers where 70% of the clientele are homeless. HealthRIGHT360 houses approximately 1000 people statewide, and provides services in jails and prisons as well. Many of the 800 employees are consumers, who inspire the clients through their own experience. Volunteers run a hotline that receives over 30,000 calls per year, as well as a Teen Chat line.

Thirty years ago the CEO was herself a client who received residential treatment for two years through public funding until she was stabilized, had income, and housing. Dr. Eisen stated that in this program, no one was transitioned until all 3 conditions were met. Today she stands as a great example of the effectiveness of peers as supporters and advocates. Dr. Eisen advocates for those with drug

dependence issues by highlighting that SUD has become criminalized, and as a result, those addicted to drugs are seeking treatment less often. This has led to clients becoming much sicker with chronic diseases, mental illness, unemployment, and are often incarcerated. While the Affordable Care Act has provided more people with Medi-Cal treatment, she believes that there is a major shortage of housing designed specifically to support those with SUD dependence.

Mutual Housing of California

Mutual Housing, the first organization in the state to apply for MHSA capital funding, developed Mutual Housing at the Highlands. This permanent supportive housing project has 33 studio and 1-BR apartments designated for people who have a mental illness and are homeless. The MHSA housing units are part of the larger apartment complex which has a total of 90 apartment homes. Holly Wunder-Stiles is the Director of Housing Development and shared information with the Council on the pre-opening planning process and the importance of ongoing communication between the property manager, property owner, social services coordinator, and tenant. The importance of this collaboration was said to be critical in the success of the program. Ms. Wunder-Stiles stated that *“Case management needs to learn about property management, and property management needs to learn about case management.”* The number of evictions due to behaviors stemming from mental illness is significantly decreased when there is on-going cross collaboration between these two entities. *“We don’t build housing and walk away.”* Property managers and case managers meet weekly to discuss any issues that may jeopardize the housing of a tenant. The economics of permanent supportive housing must also be considered. Ms. Wunder-Stiles believes that the program is working because of three important functions. Proposition 63 allowed for funding to complete the build out of properties, maintain the properties through operating subsidies, and to help residents recover through supportive services. If apartment owners are not provided with the subsidies needed to maintain their properties, the program would not survive.

TLCS:

Richard Brown, a Residential Services Coordinator with TLCS, remembers the struggle of opening the Folsom Oaks Apartments, an 18 unit complex with 5 MHSA designated apartments. *“Folsom didn’t want us here.”* But now, 5 years later, people come into the office to ask about renting an apartment. Richard has to explain to them that the complex is designated for the homeless. The CMHPC took a tour and quickly discovered why many would want to live there. The small complex has a playground for the children who live there, and large oak trees that canopy the property. One resident insisted that her apartment be toured, which was decorated with furniture and wall hangings donated from a local non-profit. While on the tour, another resident in her early twenties approached Richard and asked for some help because her car was acting up. He explained later that help with car trouble can be a big part of the “support” in permanent supportive housing. Transportation is an often overlooked need among his residents and has become an area of frustration when tenants need to get their children to school.

Regina Range is a tenant at Folsom Oaks. She became homeless six years ago after her mother died of cancer. She and her son lived in a car for months before she was referred to Folsom Oaks by an advocacy group in Sacramento. Regina raised a couple of important points before the Council. First, she felt that the local school district was not supportive to her children and grandchildren in that they were not taking their living conditions and past trauma into consideration. She has been frustrated hearing about her children's poor behavior or tardiness when she had no transportation and was just trying to survive. She believes that permanent supportive housing should come with support to homeless children as well, and that this support needs to come from the local school district. Secondly, Regina discussed how her LOCUS level has prevented her from receiving the help she has needed. LOCUS is the Level of Care Utilization System and it provides a measurement of needs in six areas, 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery status.⁵⁰ The concern for her was that the use of this system alone in determining her level of services has created what some call a "fail first model".

Turning Point/Wellspace:

Renee McRae is a Personal Services Coordinator at the Boulevard Court Apartments in Sacramento. TP/Wellspace coordinated with Mercy Housing to build the complex which used to function as a motel. Renee completes two important functions at the program. She delivers support services and connects residents to needed services outside of the program, when necessary. She also coordinates with the Mental Health Court to assist residents in meeting their obligations in order to avoid confinement in jail. For clients who come to the program with no financial supports in place, the Sacramento Multiple Agency Resource Team (SMART) program is utilized to connect them to SSI/SSDI benefits. This SMART program is recognized as a national best practice model, and is operated by Capitol Community Health Network in partnership with Sacramento County Department of Health and Human Services. "The program expedites SSI/SSDI enrollment services by connecting community members who are disabled and homeless or at-risk of becoming homeless to Benefits Advocates."⁵¹

Michael Robinson is on his way to recovery and is now volunteering in the program that he says saved his life. Michael grew up in San Francisco, graduated from college, and joined the Marine corp. After leaving the military he started to use drugs and ended up on the streets. He got sober but then lost his wife to a brain tumor. Homeless again, he lived in his car, sleeping in the parking lot at the UC Davis Medical Center. He attempted suicide and was taken to the crisis residential program in Sacramento. Time ran out for him there but he was still receiving behavioral health services. Michael was grateful but stated, *"I got all the help I needed there but there was one thing I didn't have and that was a roof over my head."* He was eventually referred to Boulevard Court where he is now safe and sober. Michael expressed to the Council how exhausting it was to be homeless with nowhere

⁵⁰ LOCUS. Level of Care Utilization System. 2010. www.dhs.state.il.us/page.aspx?item=32545

⁵¹ Sacramento Steps Forward: Ending Homelessness, Starting Fresh. Success Saturday. 2012. <https://sacramentostepsforward.wordpress.com/tag/homeless>

to lay his head. He doesn't believe that he would have made it without this housing first approach. When Michael arrived at the program he had been prescribed several medications. *"Renee would come into my apartment and at the end of my coffee table would be 12 or 13 bottles of medication I was taking, now I'm down to 3 medications."* This is a striking example of just one area where supportive housing can bring real cost savings. Stable healthy people are able to reduce medications and stay out of the hospital.

Conclusion:

California has the highest number of homeless persons per capita in the United States. At 114,000 our homeless population is roughly the population of Fairfield, CA. They represent all ages, ethnicities, and backgrounds. Those who are homeless are five times as likely to have a mental health or substance use disorder. For generations we have made attempts to address the issue but the numbers keep growing. We are now beginning to understand that homelessness is not an issue of laziness or immorality, but an economic issue created by a lack of affordable housing. It is also an issue of civic responsibility to address the basic life needs of the most vulnerable in our communities. Homelessness, when coupled with a severe behavioral health issue, becomes nearly impossible to overcome.

Several funding sources are available but there isn't enough. Programs are often fragmented and hard to find when you're mentally ill and living on the streets. Coordination is needed among programs to ensure that funds are being spent on the programs that have been proven to work. Throwing more money at the problem will not work if these funds are not dedicated to the most proven, innovative, or evidence based approaches. For this reason several states have created an interagency council on homelessness to coordinate efforts, secure funding, and create better access to proven methods.

The Shelter + Care model is a paradigm that appears to work well in California, especially as it utilizes non-profit organizations with a consumer work force. Prevention efforts like rapid re-housing, Emergency Solutions Grants, school district coordination, and early detection of psychosis are very important tools. Outreach with the use of Peer Counselors offers an effective first step toward gaining the trust of the homeless. The reintegration and inclusion of those with mental illness into their communities helps to solidify the recovery process for those with mental illness and substance use disorders.

As with any life struggle, acknowledgement of a problem is the first step. California has a problem with homelessness. If we fail to address this issue with bold economic solutions, we run the risk of spending more capital on solutions that do not work. We will be economically stronger when we stop the revolving door of public expenditures that don't resolve the problem.

Michael and Regina's life stories inform us that recovery from mental illness, substance abuse and chronic homelessness is possible. As they told us about their path to recovery there was a strong sense of hope in the room. They have moved from hopelessness and dependence on expensive systems of care to becoming healthy contributors in their new communities. If California can increase its understanding of homelessness and mental illness, and adequately fund its systems of response, we will celebrate thousands of recovery stories across the state just like theirs.

Recommendations:

1. Programs that house the homeless should collect data for staying or leaving behaviors and evaluate this data at the county level to help guide efforts to decrease unsuccessful leaving of programs.
2. County Offices of Education should receive increased funding to ensure that a homeless liaison connects to all shelters, Permanent Supportive Housing, and Rapid Re-housing programs in their county to provide necessary supports to homeless children living with their parents in these programs.
3. Counties should receive increased funding so that they can ramp up and streamline programs like SMART which assists disabled homeless adults and youth in obtaining SSI and SSDI benefits.
4. California needs considerable new funding which should be used for Shelter + Care, bricks and mortar, and supportive services.
5. Counties should receive additional funding to create street outreach teams to guide homeless people with serious mental health disorders to permanent supportive housing options.
6. The California Interagency Council on Homelessness should be created to reduce fragmentation of service delivery and track federal funding opportunities.
7. Counties should assess for barriers to shelter use noted on page 8 of this report, and attempt to increase utilization and access to shelter services through removal or limitation of such barriers.
8. California should build the capacity and expertise of the homeless service workforce through passage of SB 614, the peer, family, parent, transition-age, support specialist certification program.

Acknowledgements:

This report would not have been possible without the help and dedication of the following people.

Jane Adcock, Executive Officer, CMHPC
Susan Morris Wilson, Chair, Continuous System Improvement (CSI) Committee of the CMHPC
Lorraine Flores, LMFT, Chair-elect, Continuous System Improvement Committee of the CMHPC
Linda Dickerson, PhD, Research Analyst II, CMHPC
Tamara Jones, Staff Services Manager I, CMHPC
Patricia Bennett, PhD, CSI Committee Member
Noel O'Neill, LMFT, CSI Committee Member
Raja Mitry, CSI Committee Member
Amy Eargle, PhD, CSI Committee Member
Walter Shwe, CSI Committee Member
Karen Hart, CSI Committee Member
Esmeralda Liberato, CSI Committee Member
Celeste Hunter, CSI Committee Member
Monica Nepomuceno, CSI Committee Member
Laura Leonelli, M.A., Analyst, CMHPC

A very special thanks to our panel members who brought the subject to life with their willingness to share their journey and expertise with the CSI Committee.

Ky Le, M.A., Director of Santa Clara County Office of Supportive Housing
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