County of Los Angeles
New Directions Task Force

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Child Care

October 11, 2005

The Honorable Board of Supervisors
County of Los Angeles
383 Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

A STRATEGIC HOUSING PLAN FOR SPECIAL NEEDS POPULATIONS IN LOS ANGELES COUNTY (ALL AFFECTED)
(3 VOTES)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Accept and endorse the attached *Strategic Housing Plan for Special Needs Populations in Los Angeles County* (Plan), which provides a proactive strategy to guide County efforts to provide housing, operational subsidies, and supportive services for the County's special needs populations.

2. Approve the eight recommendations identified by the Special Needs Housing Alliance (Alliance) as critical to serve as the initial focus for efforts to implement the Plan and, with the exception of the Housing Trust, direct the Alliance to provide the Board with an implementation plan including action steps and timelines within 90 days.

3. Direct the Chief Administrative Office (CAO) to develop a proposal to establish a Housing Trust Fund that provides dedicated, ongoing revenue sources to fund operating and supportive service costs associated with housing for special needs populations, and report back to the Board as part of the Fiscal Year 2006-07 Proposed Budget.

4. Recognize the New Directions Task Force's (NDTF) Alliance as your Board's advisory body for the multi-departmental review of housing policy and program issues, including review and development of recommendations on proposals for the use of the Housing Trust Fund.

5. Direct the NDTF to expand Alliance membership to include appropriate representation from the City of Los Angeles and the County's other 87 cities as may be appropriate.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On November 4, 2003, ten NDTF member departments and agencies (Attachment A) executed a Collaborative Agreement that included forming the Alliance and directing it to develop a strategic plan for guiding the County's efforts to establish an interdepartmental infrastructure for addressing housing for special needs populations. The Plan (Attachment B) complies with the NDTF direction and was approved by the NDTF on May 10, 2005. The purpose of the Plan, and the eight critical first round recommendations, is to lay the foundation for establishing a Countywide interdepartmental housing infrastructure for coordinating the capital, service, and operational resources needed to enhance the production of housing with support services for the County's special needs populations. The Plan, taken in combination with other County actions directed by your Board, also represents a strategic direction to effectively approach the homelessness crisis.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The Plan and its recommendations are in compliance with the County Strategic Plan, Goal 5, Strategy 2, Objective 1, approved by your Board on March 15, 2005, that calls for the completion of an *implementation plan for the County's Special Needs Housing Strategic Plan that addresses the needs of children and families with special needs.*

FISCAL IMPACT/FINANCING

The fiscal/financial impact of the individual recommendations will accompany the submission of the Implementation Plan within 90 days of Board approval of the recommendations.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Alliance, co-chaired by the Community Development Commission (CDC) and CAO, determined the Plan should initially focus on the three special need population groups: youth emancipated from the dependency and delinquency systems; homeless persons with mental illness; and persons living with HIV/AIDS. However, the scope of the collaborative agreement establishing the Alliance includes all "special needs populations" and the vulnerable clients (including persons who are homeless or at-risk of homelessness) served by the County's health and human service departments.

The Alliance and Shelter Partnership, Inc., serving as technical consultants through funding provided by the Corporation for Supportive Housing, developed the Plan, which establishes the common framework for departments to collaboratively address the housing and service needs of special needs populations.

The Plan contains more than 60 recommendations designed to put in place the policy, programmatic, financial, and staffing resources necessary to ensure the production of housing with support services. In recognition of the significant quantity and magnitude of the recommendations, the Alliance prioritized the recommendations according to what would produce the most significant, tangible results in meeting the needs of the three special needs populations, and enhancing the County's interdepartmental housing infrastructure. As a result of the prioritization, the Alliance recommends that your Board approve the following eight priority recommendations for immediate Phase I implementation (Attachment C includes a brief description of key recommendations):

- Each Alliance member shall identify a housing and homeless prevention coordinator within their respective department. *(Plan Objective: A.2)*
- Request the Board to adopt a formal policy establishing the Alliance as the body for addressing housing policy/program, funding, and County funded/supported project opportunities for vulnerable health and human services populations in Los Angeles County. *(Plan Objective: A.6)*
- Establish a Countywide Special Needs Housing Operating and Supportive Service Trust Fund that can maximize access to funding opportunities for the targeted populations, such as Proposition 46, Proposition 63, Hilton Foundation funds, and City of Industry resources. *(Plan Objective: B.1, merged with Objective D.2)*
- Create and cultivate the political will to address special needs housing concerns and development. *(Plan Objective: B.2)*
- Create more permanent housing resources for emancipated foster youth through the development of new housing. *(Plan Objective:C.2)*
- Ensure a broader array of housing options to respond to the disparate, evolving needs, and circumstances of homeless persons with mental illness. *(Plan Objective: D.1)*
- Establish dedicated housing specialist teams in each Service Planning Area (SPA). *(Plan Objective:D.9)*
- Increase the number of permanent supportive housing units targeted to people living with HIV/AIDS. *(Plan Objective:E.3)*

The Plan's recommendations align and corroborate other housing efforts your Board has directed County staff to participate in, including:

- December 14, 2004 Board motion that resulted in a Department of Public Social Services led interdepartmental action plan (pursuant to a zero tolerance policy for homeless families on Skid Row) for enhancing services to homeless families aided

through the CalWORKs program and diverting them away from Skid Row. Collaborating departments and agencies included: Children and Family Services, Mental Health, CDC, Los Angeles Homeless Services Authority (LAHSA), and the Public Counsel Law Center.

- January 4, 2005 Board motion to review and enhance the various County agencies' policies for discharging persons from County institutions to ensure that appropriate planning is in place so persons are not discharged to homelessness.
- June 20, 2005 Board motion that allocates significant resources for enhancing, and more effectively administering, the County's homeless services systems; and, requires the identification and evaluation of dedicated revenue sources for homeless programs.
- *The Bring Los Angeles Home! (BLAH)* effort, a blue ribbon panel composed of more than 60 political and civic leaders staffed by LAHSA and the Coalition to End Hunger and Homelessness that is developing a blueprint to end homelessness in the County.
- The Emancipation Program Partnership convened to ensure that emancipation services are unified and comprehensive and adequately prepare 14 to 21 year old youth – who are or have been in foster care under the County's dependency or probation systems – for successful adulthood.
- The Mental Health Services Act *(Proposition 63),* approved during the 2004 General election to increase resources to counties for the expanded provision of mental health services to children, adults, and seniors. Services covered under the Act include reducing "negative mental health outcomes, such as suicide, incarceration, homelessness, school failure, unemployment, and foster care."

As part of the implementation plan development process, the Alliance enlisted participation and subject matter expertise from other County and non-County stakeholders, such as the County's Regional Planning Department, LAHSA, and the City of Los Angeles Housing Department's Housing Opportunities for People with AIDS program. Outreach to other Alliance stakeholders (e.g., other departments, cities, unincorporated areas, communities, housing developers, etc.) is occurring on an ongoing basis. This process has highlighted the significant overlap among the housing related County efforts listed above.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Endorsement of the Plan and approval of the eight critical recommendations will provide a County strategic direction regarding the creation of permanent, affordable, housing with support services for our most vulnerable client populations. Housing with necessary health and human support services will be enhanced as coordination increases, and duplication is reduced through coordinated implementation efforts undertaken by the Alliance and its member agencies. Additionally, addressing the long-term housing and comprehensive service needs of clients will, in the long-term, reduce

the cost to the County's health and human services infrastructure associated with recidivism.

CONCLUSION

The Alliance's recommendations will support the goals of multiple County initiatives and efforts, and enhance their effectiveness through a coordinated and strategically cohesive interdepartmental infrastructure for overseeing the implementation of policy/programmatic, financial, and staffing aspects associated with the production and preservation of housing with support services.

Respectfully submitted,

BRYCE YOKOMIZO
Chair, New Directions Task Force

CARLOS JACKSON
Co-Chair, Special Needs Housing Alliance

BY:CJ:LS:CP

Attachments

c: County Counsel
Auditor-Controller
New Direction Task Force Members

Special Needs Housing Alliance Member Departments and Agencies

Community Development Commission, Co-Chair

Chief Administrative Office, Co-Chair

Children and Family Services

Community and Senior Services

Health Services

Mental Health

Public Social Services

Los Angeles County Office of Education

Los Angeles Homeless Services Authority

Probation

A STRATEGIC HOUSING PLAN FOR SPECIAL NEEDS POPULATIONS IN LOS ANGELES COUNTY

Prepared by:
Shelter Partnership, Inc.

For the:
County of Los Angeles
New Directions Task Force
Interagency Operations Group
Special Needs Housing Alliance

September 2005

ACKNOWLEDGEMENTS

Author

This Plan was prepared by Marc Tousignant, Senior Project Manager, at Shelter Partnership, Inc., with guidance from Ruth Schwartz, Executive Director. Many thanks are also due to Meg Barclay, Project Manger, who provided invaluable support in the development of Sections IV-VI.

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Special Needs Housing Alliance

This Plan certainly would not be possible without the support and information provided by the Special Needs Housing Alliance. With such an intensive amount of data and program information contained in this Plan, each Alliance member departments deserves credit for their cooperation, patience, and perseverance throughout the last year. These members consist of the Departments of Children and Family Services, Community and Senior Services, Health Services Office of AIDS Programs and Policy, Mental Health, Public Social Services, as well as the Community Development Commission, Los Angeles Homeless Services Authority, Office of Education, and the Probation Department.

Appreciation is extended to Los Angeles County Chief Administrative Officer David E. Janssen, and Lari Sheehan of the Chief Administrative Office-Service Integration Branch (CAO-SIB) for supporting the work of the Alliance. Specific thanks also go to CAO-SIB staff Kathee Saito, Carlos Pineda, and Michael Castillo. They had the dubious tasks of coordinating this strategic planning process, securing program data from Alliance members, soliciting their feedback, and ensuring that each Alliance member was comfortable with the final product.

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I. EXECUTIVE SUMMARY

A. Introduction

In October 2003, the New Directions Task Force (NDTF) approved the Special Needs Housing Alliance's (Alliance) Business Plan to serve as a vehicle to build on the Alliance's previous accomplishments and facilitate its transition into an operational phase. A major goal of the Alliance's Business Plan is the development and implementation of a two-year strategic plan for increasing the availability of special needs housing.

With the generous support of the Corporation for Supportive Housing and the Robert Wood Johnson Foundation, Shelter Partnership, Inc. was commissioned to provide staff support and technical assistance to the Alliance, including drafting the Strategic Housing Plan (Plan). The Plan focuses on the following three special needs groups:

- Youth emancipated from the dependency and delinquency systems;
- Homeless persons with mental illness; and
- Persons living with HIV/AIDS.

The Plan contains the following five sections: *Trends and Considerations, Barriers to Accessing and Maintaining Housing, Availability of Special Needs Housing, Public Funding for Housing and Supportive Services,* and *Recommendations*. To varying degrees, each section utilizes information from various sources, such as public planning documents, reports, academic journals, news articles, conference and workshop materials, and an abundance of caseload information made available by Alliance member departments.

The implementation of this Plan (anticipated to begin in July 2005), the Alliance's engagement of non-County agencies/entities, and the opportunities created by current and upcoming legislation serve to produce a hopeful and proactive environment in the County of Los Angeles with regard to housing for the three targeted special needs populations.

B. Trends and Considerations

The *Trends* section provides a recent composite of each special needs population in the County. It utilizes information from numerous sources, including public planning documents, reports, academic journals, news articles, conference materials, and a wealth of caseload information made available by Alliance member departments. Some notable characteristics of these populations include:

Emancipated Foster Youth

- As of January 31, 2004, DCFS reported 38,825 cases, the majority of which (27,897) were served in out-of-home care. As of October 2004, Probation reported a total of 1,560 youth in placements—group homes, foster care, or relative care—though the total number of youth with placement orders approximates 2,400.

- DCFS estimates that approximately 1,800 foster youth emancipate from foster care each year. This estimate is based on the assumption that the majority (i.e., 90%) of older youth (ages 18 and up) and a small number (i.e., 25%) of youth aged 17 and older will emancipate each year.
- Unlike the dependency system, where African American children represent more than half of the children, the juvenile justice system is predominately Hispanic.
- As of January 31, 2004, emancipating foster youth, ages 14 and older, were primarily concentrated in SPA 3 (23.39%), SPA 8 (19.79%), and SPA 6 (18.21%).
- According to the Probation Department, the experiences and backgrounds of youth entering the delinquency system in Los Angeles County do not differ significantly from their counterparts in the dependency system. Instead, the primary distinction concerns their involvement with criminal or delinquent activity that warrants their removal to ensure the safety of the community and comply with court orders.

Homeless Persons with Mental Illness

- Local studies conducted in the City and County of Los Angeles have found that severe mental illness, such as schizophrenia, major depression, or bipolar affective disorder, affects anywhere from 30-50% of the homeless population.
- Approximately 32% (70,966) of the 220,528 clients served through DMH in FY 2003 were without medical insurance. Of those uninsured, 7% (4,613) were homeless.
- Among homeless DMH clients served in 2002, schizophrenia and other psychotic disorders (42.8%) and mood disorders (42.2%) appeared most common, though substance-related and adjustment disorders were also evident in smaller numbers.
- The U.S. Department of Justice reports significant levels of homelessness and mental illness among inmates in federal prisons (19%), state prisons (20%), and local jails (30%) across the country.

Persons Living with HIV/AIDS

- One-third of all AIDS cases in California are found in Los Angeles County, where persons living with HIV/AIDS (PLWH/A) represent approximately 5% of AIDS cases in the entire country.
- African Americans are the most disproportionately impacted population, comprising 9% of the population but accounting for nearly one-quarter (22%) of AIDS cases, and an estimated one-third of HIV incidence.
- Case data from the County of Los Angeles HIV Epidemiology Program (HEP) continue to identify SPA 4 (Metro) as the largest epicenter of the disease, with SPA 8 (South Bay), SPA 2 (San Fernando), and SPA 6 (South) also assuming large roles in the epidemic.
- The Los Angeles estimates that between 30-40% of PLWH/A do not have health insurance. Among insured respondents from the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, most (52%) relied on Medi-Cal, and a quarter (26%) on Medicare as their primary source of health coverage, more than double the level (13%) of respondents who reported private insurance.
- Of the 1,046 Tuberculosis cases reported by DHS in 2001, 12.4% were co-infected with HIV. Approximately 21% of the homeless cases were also HIV co-infections.

There are also significant trends within these populations that are important considerations for policymakers, such as:

- Year-end figures from DCFS illustrate a general decline in the number of youth in out-of-home care between 1998 and 2002, including a 40% drop between 1999 and 2002.
- African American males had the highest AIDS case rate in Los Angeles County in 2002, more than double the rates for Latinos and Whites. The case rate among Latino men, on the other hand, surpassed that of White men in 1998.
- Significant regional patterns have emerged over the course of the last decade, which underscore increasing percentages of AIDS cases in South Los Angeles County, particularly the South Bay-Long Beach area, where rates have accelerated the most since 1995.

After describing the characteristics and trends of each special needs population, the Plan describes significant subpopulations within these groups that warrant further attention and study. Some highlights include:

- Despite a reduction in the number of children that are born nationally to teens, adolescent parenting remains common and presents certain challenges to the dependency and delinquency systems.
- Recent research has also documented a close relationship between homelessness and foster care and that a substantial number of emancipated foster youth have endured homelessness since their discharge.
- Many homeless persons in the U.S. grapple with both mental illness and substance abuse issues, both of which can be seen as a predictor and consequence of homelessness. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), roughly 50% of homeless persons with serious mental illness are affected by substance abuse.
- Persons living with HIV or AIDS are constantly challenged to manage their own health and well-being, even in light of tremendous medical advances that have proven to mitigate symptoms or forestall the onset of full-blown AIDS. In certain instances, however, they must also struggle with other issues and needs, such as substance abuse or homelessness, which ultimately have a compounding and debilitating effect on their ability to cope with the epidemic.
- Substantial numbers of undocumented immigrants live with HIV/AIDS, while many rely on the County's publicly-funded systems of care for medical care and housing.

C. Barriers to Accessing and Maintaining Housing

The pursuit of affordable housing remains tenuous at best for the County's special needs populations despite concentrated local efforts to increase the stock of dedicated and affordable housing for them, and efforts to provide them with housing placement assistance services. Housing policies that concern them therefore must address the various barriers they encounter during their pursuit of appropriate housing.

Some of these barriers, such as the scarcity of affordable housing and pervasive discrimination, can be considered universal to all special needs populations engaged in the process of securing or retaining housing. Others appear unique to the special needs

of the County's clientele. This section also includes responses from the series of County-sponsored focus groups conducted with program administrators, nonprofit housing and service providers, and consumers of County services.

1. Housing Affordability

The overall lack of affordable housing endures as much as a national concern as a local one, yet it remains a significant barrier that pervades every aspect of the housing relationship, from searching for a suitable home to maintaining that home and meeting the requirements of tenancy. Below are some key figures:

- Vacancy rates for both the City and County of Los Angeles have declined since 1990 and remain low, at 4.6% and 5.3% respectively. The County reports twice as many low-income households than affordable units.
- Nearly 23% of renter households in the County are severely cost-burdened, meaning they pay more than 50% of their monthly income to housing expenses.
- Close to one-fifth (18.8%) of all households in the County are considered overcrowded.
- Persons receiving SSI income need to more than triple (341%) their income to afford a decent one-bedroom unit in 2004; and increase their incomes by close to 600% to afford even the average rent Countywide.

2. Discrimination

Despite advances in both federal and state fair housing protections in recent years, the considerable discrimination and stigma encountered by special needs populations persists as a major impediment to accessing affordable housing and appropriate services. Often, this opposition is directed at the prospective renter due to their special need or disability. In other instances, communities or local government can resist the siting or development of programs in their neighborhood or jurisdictions that may benefit special needs populations.

a. Landlord Opposition

- One common perception among landlords is that persons with a history of foster care, probation, mental illness, homelessness, or HIV/AIDS will need 24-hour supervision.
- Another concern of landlords is the perceived threat to building and personal safety because of criminal activity on the part of special needs tenants. There is substantial stigma and fear associated with housing for emancipated foster youth and homeless persons with mental illness because landlords associate these populations with violent behaviors.
- Based on the findings of several focus groups with County departments, participants noted that property managers express concern that their clients are associated with gang activity.

b. Neighborhood Opposition

- The practice of opposing housing development serving low-income, disabled, and/or homeless persons—so called NIMBYism (Not In My Backyard)—endures as one of the most pervasive manifestations in which communities across the country display their unwillingness to assist individuals with the greatest needs.
- NIMBYism appears driven by multiple concerns on both the part of homeowners and local businesses that supportive housing programs will have an adverse impact on the property values of proximate homes, on the incidence of violent and property crimes, and on the quality of life in their communities.

c. Local Government Resistance

- The aversion of local government to pursue special needs housing can also play a pivotal, if less visible, role in the development of affordable housing for these populations. Their support, however, can make a tremendous impact, such as increasing funds for homeless services, initiating changes in local housing policies, and making it easier for developers to gain approval for needed projects.
- Examples of local government resistance include changing zoning codes, denials of zoning variance or conditional use permit requests, or failing to comply with state-mandated housing element law.

3. Client-Specific Barriers

Aside from these more general barriers, there are other barriers that impact housing access and retention and that present unique challenges to each of the special needs populations under review in this Plan. These are described in greater detail in the Plan, but are listed below:

- Preparation for Independent Living;
- Housing Placement Assistance;
- Lack of Awareness of Available Resources;
- Support Networks;
- Lack of Financial Resources;
- Previous Involvement with the Criminal Justice System;
- Access to Federal Rental Subsidies;
- Access to Supportive Services;
- Health and Employment; and
- Appropriate Housing.

D. Availability of Special Needs Housing

This section presents an inventory of housing in Los Angeles County that is targeted to each of the three special needs populations. It begins with a general overview of the housing landscape across all populations, then focuses on each population and the housing types targeted to them. Finally, the section concludes with an analysis of the geographic distribution of these resources throughout the County.

- Approximately 8,642 beds in targeted housing facilities or programs targeting our three special needs populations are distributed throughout the County as follows: emergency shelter (333 beds), transitional housing (1,963 beds), and permanent housing (6,346 beds).
- Permanent housing comprises nearly three-quarters (73%) of the housing provided Countywide to the three special needs populations. Transitional housing represents roughly one-fifth (23%), while emergency shelter represents only 4% of the available beds.

For emancipated foster youth:

- 93% of the housing available to this population is transitional housing.
- Approximately half of the County's transitional housing for emancipated foster youth is divided almost equally between SPA 2 and SPA 4.

For homeless persons with mental illness:

- Eight out of ten (80%) beds that are targeted to this population are considered permanent housing.
- Countywide, the majority of permanent housing (3,394 beds or 82%) targeting persons with mental illness has been secured through long-term rental assistance provided through the HUD Shelter Plus Care and Section 8 programs.
- Seventy-five percent of the 180 emergency shelter beds targeting homeless persons with mental illness are located in SPA 6 (42%) and SPA 4 (33%). SPA 3 does not have any such beds.
- SPA 4 has roughly two-thirds (66%) of the 1,017 permanent supportive housing beds for homeless persons with mental illness. The next largest concentration of such beds are found in SPA 8 (10%).

For persons living with HIV/AIDS:

- 88% of the 2,193 beds targeting this population are considered permanent affordable housing.
- HOPWA and Section 8 Homeless programs account for providing 61% (1,190 beds) of the permanent housing stock through long-term rental assistance for this population.
- Eighty-seven (87) emergency shelter beds are located primarily in SPA 4 (66%), but also in SPA 2 (17%), SPA 8 (13%), and SPA 6 (4%).
- The permanent housing inventory for this population is almost entirely located within SPA 4 (76%).

E. Public Funding for Housing and Supportive Services

This section highlights the various public funding programs that are available for providing housing and supportive services to special needs populations in Los Angeles County. Generally, there are two types of public funds—**formula grants** and **competitive grants**—accessible to local government and nonprofit organizations, as follows:

Over time, legislators at various levels of government have established funding programs to provide for programs that target specific groups of people, including special needs populations.

Only one source of funding, the **Independent Living Program (ILP)**, targets public resources towards youth who have been discharged from these systems.

- According to DCFS, Los Angeles County received $18,286,552 in ILP funding for FY 2003-2004, of which roughly $4 million was eligible for housing-related purposes. Nearly half of this money ($1,975,386) was committed for LAHSA's contracted ILP housing providers. The remainder was allocated to the Room and Board Assistance program ($916,888), and also to support the County THP/Bridges program ($1,000,000), funded primarily through HUD's Supportive Housing program.

Two public funding programs target persons with serious mental illness who are either homeless or at risk of becoming homeless: the **California Integrated Services for Homeless Adults with Serious Mental Illness (AB 2034)** and **Projects for Assistance in Transition from Homelessness (PATH)** programs.

- Currently, DMH administers AB 2034 contracts with 19 grantees (including other County agencies and private organizations) across the County. Collectively, these programs serve 1,694 clients or 34% of all the State's enrollees.
- For FY 2004-2005, the State was awarded $6,741,000 in PATH funds, with Los Angeles County receiving $1,850,087, or roughly 27% of the total statewide allocation.

There are only two public funding programs specifically targeted to support the housing and supportive services needs of persons living with HIV/AIDS. These programs include the federal **Ryan White Comprehensive AIDS Resources Emergency (CARE) Act** and **Housing Opportunities for Persons Living with AIDS (HOPWA)** programs.

- For the CARE Act Year 14 beginning on March 1, 2004, Los Angeles County was awarded $39,927,199 in Title I and Title II funds combined. This represents an 8.2% ($3.3 million) decrease in the Title I award for the current year and an increase in Title II funding in the amount of $304,489.
- For the 2004-2005 Program Year, HOPWA program expenditures have been directed primarily (54%) towards rental assistance, which includes the Short-Term Rent, Mortgage, and Utility Assistance Program (STAP) (17%), as well as long-term rental assistance (37%).
- The bulk (69%) of HOPWA rental assistance funding is designated for long-term rental assistance, both tenant-based rental assistance (TRA), which functions similar to the Section 8 Housing Choice Voucher program, and project-based rental assistance (PRA).

In Los Angeles County, there is a unique public resource, the **City of Industry Fund Special Needs Housing Program**, that specifically targets all three of the three populations under review in this Plan.

- Typically, approximately $5 million in Industry funding is available annually for Special Needs housing and another $5 million is available for Affordable (single-family, multifamily, and senior) projects.
- Currently the Special Needs program has provided $41,395,973 in capital financing, and leveraged an additional $129,374,089 from other funding sources. Program funding has assisted in the development of 1,143 units of housing, of which 959 are for special needs.

After reviewing public funding programs that allow grantees to target programs to specific populations, this section outlines other non-targeted funding sources along with the types of activities and expenses that are generally considered eligible.

- **Development or capital costs** are those costs associated with establishing the physical structures associated with a housing project. Housing development activities consist generally of four principal activities: 1) predevelopment; 2) acquisition; 3) rehabilitation; and 4) new construction. Development funding can be provided in the form of loans. A more detailed outline of housing development sources is included in Table 38.
- **Operating sources** are defined as those that provide for the costs of operating or maintaining the physical structure of a housing development. These expenses include but are not limited to: maintenance, insurance, security, property management, debt service, and operating and replacement reserves. In some cases, operating sources will cover leasing expenses for project sponsors that provide either single site or scattered-site affordable housing. A more detailed outline of operating sources is included according to the type of subsidy as Table 39.
- **Supportive services** are provided to participants in affordable housing programs to enhance their ability to obtain or remain in stable housing and live as independently as possible. For this reason, they are considered the "support" in supportive housing programs. Services provided in conjunction with special housing programs are very diverse in nature due to the various circumstances and needs of persons accessing these programs. A more detailed outline of supportive service sources is included as Table 40, according to the level of government at which they originate, eligible uses of funds, and grant type (i.e., formula or competitive).

F. Recommendations

The plan concludes with recommendations that offer specific strategies that the County and the Special Needs Housing Alliance should pursue to best address the housing and housing-related needs of their clients. They are divided into five sections, beginning with those that directly concern the Alliance, followed by those that are more general in nature (i.e., not specific to any one special needs group) and a section each for the three special needs populations included in this Plan.

At its February 28, 2005 meeting, the Alliance agreed to narrow its immediate focus and came to consensus to prioritize the following recommendations:

Objective A.2 Each Alliance department shall identify a housing and homeless prevention coordinator within their respective departments.

Objective A.6: Adopt a formal Board policy establishing the Alliance as the body for addressing housing policy/program, funding, and project opportunities for vulnerable health and human service populations in Los Angeles County.

Objective B.1: Establish a Countywide Health and Human Service Housing Operating and Supportive Service Fund.

Objective B.2: Create and cultivate the political will to address special needs housing concerns and development.

Objective C.2: Create more permanent housing resources for emancipated foster youth through the development of new housing.

Objective D.1: Ensure a broader array of housing options to respond to the disparate and evolving needs and circumstances of homeless persons with mental illness.

Objective D.2: Establish a Mental Health Services and Operating Fund for supportive housing for homeless persons with mental illness.

Objective D.9: Establish dedicated housing specialist teams in each SPA.

Objective E.3: Increase the number of permanent supportive housing units targeted to PLWH/A.

II. INTRODUCTION

A. Background

The Los Angeles County Special Needs Housing Alliance (Alliance) was created by the New Directions Task Force (NDTF) on June 10, 2001, to identify housing requirements for special needs populations; proactively pursue legislation and funding to address the identified needs; develop and implement strategies to increase the availability of geographically disbursed, service-enriched housing for special needs populations through an integrated community approach in partnership with local government, community-based organizations, and non-profit entities. Six special needs populations were identified in the context of the Alliance, including: individuals with mental health issues, victims of domestic violence; persons living with HIV/AIDS; youth emancipating or emancipated from the dependency and delinquency systems; teen mothers; the frail elderly; and the developmentally disabled.

In October 2003, NDTF approved the Alliance's Business Plan to serve as a vehicle to build on the Alliance's previous accomplishments and facilitate its transition into an operational phase. A major goal of the Alliance's Business Plan is the development and implementation of a two-year strategic plan for increasing the availability of special needs housing. With the generous support of the Corporation for Supportive Housing and the Robert Wood Johnson Foundation, Shelter Partnership, Inc. was commissioned to provide staff support and technical assistance to the Alliance, including drafting the Strategic Housing Plan.

B. Content and Methodology

Conversations held by the Alliance in early 2004 about the development of the Strategic Housing Plan (Plan) illustrated the complexity of planning strategically for the six special needs populations previously selected by NDTF. In order to expedite the development of the Plan and still provide a thorough planning document, the Alliance narrowed the Plan's scope to the following three special needs groups: youth emancipated from the dependency and delinquency systems; homeless persons with mental illness; and persons living with HIV/AIDS.

The Plan contains the following five sections: *Trends and Considerations, Barriers to Accessing and Maintaining Housing, Availability of Special Needs Housing, Public Funding for Housing and Supportive Services, and Recommendations*.

The *Trends* Section provides a recent composite of each special needs population in the County utilizing information from numerous sources, including public planning documents, reports, academic journals, news articles, conference materials, and a wealth of caseload information made available by Alliance member departments.

The *Barriers* Section outlines issues and circumstances that impact the three identified special needs populations as they search for and attempt to maintain housing. It begins with a discussion of two universal barriers—housing affordability and discrimination—that pervade every aspect of the housing relationship, from development to tenancy. The Barriers Section then builds on information from the *Trends* Section to describe more client-specific concerns, such as an overall lack of preparation for independent living and financial resources. This Section also incorporates responses generated through a series of County-sponsored focus groups held in April 2004 with County program administrators, nonprofit housing and service providers, and special needs clients.

The *Housing Availability* section offers an overview of affordable housing—emergency shelter, transitional housing, and permanent housing—in the County that targets any of the three special needs populations. Analysis is provided both in terms of housing type and the geographic distribution of such housing. The *Public Funding* section describes the public grant making process and the financial resources available to the County that target special needs groups. Both the *Housing Availability* and *Public Funding* sections relied heavily on public information accessed by Shelter Partnership and on budget data provided by member departments.

The *Recommendations* consist of specific strategies that the County and the Alliance should pursue to best address the housing and housing-related needs of their special needs clients. Like all the sections, the recommendations were developed through the collaborative efforts of Alliance members.

C. Next Steps

This Plan fulfills an objective under Goal 5, Children and Families Well-Being, of the County Strategic Plan. This Strategic Housing Plan will assist the Alliance in transitioning from its current role as a planning body into a more active, project-based, policy-driven implementation body. An example of this shift is the Alliance's oversight in identifying services and the development of a protocol to facilitate access to those services for clients housed at Mason Court, a 12-unit apartment building for DCFS at-risk certified families, being developed in the unincorporated Willowbrook area of Los Angeles County.

Given the Alliance's transition from planning to implementation, its membership composition will be revisited in the near future with the intent of including other key cities and community based-organizations within the County that create housing, with a special focus on the City of Los Angeles. The City, under the leadership of Mayor James K. Hahn, recently established an Affordable Housing Trust Fund that has assisted in the creation of approximately 3,000 new affordable housing units since 2002. Mayor Hahn is also working to put a $500 million housing bond before voters, which could happen as soon as 2006.

The Strategic Housing Plan also requires the Alliance to leverage its resources to secure additional State financing for special needs housing in the County. For

instance, the Alliance is committed to assisting special needs housing developers/providers in the County in the aggressive pursuit of capital financing through the California Housing and Emergency Shelter Trust Fund Act (Proposition 46 of 2002), a $2.1 billion bond measure passed by California voters in November 2002. Proposition 46 funds are administered by the State's Department of Housing and Community Development for the purpose of supporting the construction, rehabilitation, and preservation of affordable rental housing, emergency shelters, and homeless facilities.

In addition to facilitating the local pursuit of Proposition 46 funds, this Plan also presents strategies for the Alliance to take advantage of the Mental Health Services Act of 2004 (Proposition 63), which was approved on the November 2004 ballot. These funds provide for substantial new resources to address a number of the most pressing and enduring challenges of treating persons with serious mental health disorders in California, and can play a vital role in addressing the housing-related needs of homeless persons with mental illness. The Alliance is acutely aware that Proposition 63 funds, if applied properly, could leverage affordable housing funds, including those generated by Proposition 46.

The implementation of this Strategic Housing Plan, the Alliance's engagement of non-County agencies/entities, and the opportunities created by current and upcoming legislation serve to produce a hopeful and proactive environment in the County of Los Angeles with regard to housing for the three targeted special needs populations.

III. TRENDS AND CONSIDERATIONS

A. Characteristics of Youth Emancipating from the Dependency and Delinquency Systems

Youth emancipating from the dependency and delinquency systems share a common experience: through either parental neglect or abuse, or perhaps as a result of their own actions, their care and safety have become a public responsibility. In Los Angeles County, this responsibility falls respectively upon the Department of Children and Family Services (DCFS) and the Probation Department, which administer these two systems. Though the relationship between the two systems is close and dynamic—many youth enter the delinquency system after several foster care placements while some enter foster care after leaving the delinquency system—there are important distinctions, such as the circumstances upon which clients access these systems.

The dependency system, a complex system of overlapping programs and services, represents a "safety net" for neglected or abused youth.[1] Because their own families are unable or unwilling to care for them, foster care provides them with 24-hour out-of-home care, acting essentially as a form of substitute, or in some cases, long-term parenting. The purpose of the dependency system is to keep children safe while child welfare services are provided so they can be reunited with their families.[2]

The County is also responsible for youth in the delinquency system. Probation youth, many of whom have come from the same backgrounds as those in the dependency system, have committed an offense and are entering foster care to protect communities, comply with the court order for placement and receive the support, guidance, education, and structure they need to change their behavior.

Since there has been insufficient research conducted on the subtle differences between the two populations, the following discussion concentrates more generally on their similarities and most often describes them as one group. The bulk of this discussion moreover is dedicated to older youth (i.e., 14 years of age and above) who are currently in out-of-home care and preparing for emancipation. Despite the Plan's focus on emancipated foster youth as a distinct special needs population, this emphasis allows for a greater understanding of the foster youth population that will soon be achieving independence in the years to come.

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[1] This Plan at times refers to the dependency system as the foster care or child welfare system.

[2] It is important to note that child welfare services and foster care are not synonymous. In fact, the vast majority (80%) of children in the child welfare system is not in foster care (Foster, p. 7). Instead, it is the child welfare system that acts as the primary entryway into foster care.

1. Demographics

a. Number

Nationally, the number of children in foster care has fluctuated over the last few decades, the result primarily of a convergence of environmental factors and policymaking. Sharp increases in the 1960's and 1970's abated somewhat in the 1980's, only to rebound in the last part of that decade. Significant growth persists to this day. According to the U.S. Department of Health and Human Services (HHS), the number of children in foster care in March 2000—approximately 580,000—was in fact more than double the number (276,000) in care in 1984 (Barbell & Freundlich, p. 2).

On July 1, 2003, there were reportedly 89,309 children under age 19 in child welfare supervised foster care in California, mostly those who have been removed from their parents and home due to abuse or neglect (State of California Department of Social Services, April 2004).

As of January 31, 2004, DCFS reported 38,825 total cases, the majority of which (27,897) were served in out-of-home care (DCFS, May 2004a) (see Table 1).

Table 1. Number of DCFS Cases, as of January 31, 2004

DCFS Cases	In-Home Cases	Out-of-Home Cases	Total
	10,928	27,897	**38,825**

Though Los Angeles County does not collect data on the actual number of youth emancipating each year, DCFS estimates that close to 1,800 foster youth emancipate annually from foster care services (County of Los Angeles Design Team for Emancipation Services, p. A-2). This calculation assumes that the majority (i.e., 90%) of older youth (ages 18 and up) and a small number (i.e., 25%) of youth aged 17 and older will emancipate each year.

The Probation Department serves anywhere from 22,000-24,000 youth annually. As of October 2004, Probation reported a total of 1,560 youth in placements—group homes, foster care, or relative care—though the total number of youth with placement orders approximates 2,400 (Probation Department, January 2005).[3]

b. Reason in Foster Care

The primary reason that children enter foster care is because of a substantiated report of abuse or neglect. According to HHS, the prevalence of parental abuse or neglect of children placed in foster care varies dramatically from state to state, ranging from 2.3% to 62% (Barbell & Freundlich, p. 1). Foster care placement is due more often to neglect than physical abuse.

[3] The disparity between "in placement" and "with placement orders" occurs since, at any given time, not all youth with placement orders are residing within their placement.

In California, more than one-third of dependent children are removed due to parental neglect (Foster, p. 3). Similar to the level of neglect found among foster youth in California, slightly more than one-third of DCFS-placed children, ages 14 and above, have been removed from their families due to neglect. Other reasons for removal include caretaker absence or incapacity (26.2%), conversion (18.75%), physical abuse (10.58%), sexual abuse (4.21%), and emotional abuse (2.21%) (DCFS, May 2004a) (see Table 2).

Table 2. Children Age 14 and Above in DCFS Placement by Removal Reason

Removal Reason	No. of Children	Percent (%)
Caretaker Absence/Incapacity	2,267	26.20%
General Neglect	1,708	19.74%
Conversion	1,623	18.75%
Severe Neglect	1,299	15.01%
Physical Abuse	916	10.58%
Sexual Abuse	364	4.21%
Emotional Abuse	191	2.21%
Other[4]	286	3.30%
Total	**8,654**	**100%**

According to the Probation Department, the experiences and backgrounds of youth entering the delinquency system in Los Angeles County do not differ significantly from their counterparts in the dependency system. Instead, the primary distinction concerns their involvement with criminal or delinquent activity that warrants their removal to ensure the safety of the community and comply with court orders.

c. Gender

Of the 8,654 children ages 14 and above in DCFS placement as of January 31, 2004, approximately 52% (4,499) were female while 48% (4,153) were male (DCFS, May 2004a).

Probation youth, on the other hand, are overwhelmingly male. Of the 1,560 youth reported in placement by October 2004, less than one-quarter (348 or 22%) was female (Probation Department, January 2005).

d. Race and Ethnicity

More than half (50.9%) of these youth in DCFS placement were African American, while almost one-third (32.75%) were Hispanic. The remainder were White (13.97%) for the most part, followed by Asian/Pacific Islanders (1.73%), American Indian (0.47%), and Alaskan Native (0.12%) (DCFS, May 2004a) (see Table 3).

[4] Other reasons consist of the following: relinquishment (1.39%), child's disability/handicap (0.77%), law violation (0.37%), voluntary placement (0.32%), mental health/Kin-Gap (0.23%), exploitation (0.12%), status offense (0.08%), and disrupted adoptive placement (0.02%).

Table 3. Children Age 14 and Above in DCFS Placement by Ethnicity

Ethnicity	No. of Children	Percent (%)
African American	4,405	50.9%
Hispanic	2,834	32.75%
White	1,209	13.97%
Asian/Pacific Islanders	152	1.73%
American Indian	41	0.47%
Alaskan Native	10	0.12%
N/A	3	0.03%
Total	**8,654**	**100%**

The figures in Table 3 underscore a less than positive reality for ethnic children within the County's dependency system, which continues to serve more than would suggest through local demographic data. African American children, for instance, continue to represent only 10% of the County's child population, but 45% of the children in foster care. Such ethnic disparity is also evident among American Indian children, who have the second highest rate of children in foster care at 20.2 (per 1,000 children), more than double the rate for Hispanic (8.2) and White (8.3) children (Los Angeles County Children's Planning Council, pp. 3, 14).

Unlike the dependency system, where African American children represent more than half of the children, the juvenile justice system is predominately Hispanic. In fact, the ratios of African American (33%) and Hispanic (53%) youth on Probation as of October 2004 reflect nearly the opposite of their representation in the dependency system. Other Probation youth were mostly White (11%) or Asian (2%) (Probation Department, January 2005).

e. Age

The vast majority of older youth in DCFS placement, as of January 31, 2004, were between the 14-18 years of age, with relatively equal numbers of youth in each of those age categories (DCFS, May 2004a) (see Table 4).

Table 4. Age Range of Older Foster Children in Los Angeles County

Age Range	Number of Foster Children	Percent (%)
14	1,960	22.65%
15	1,870	21.61%
16	1,767	20.42%
17	1,729	19.98%
18	957	11.06%
19	304	3.51%
20	62	0.72%
21	5	0.06%
Total	**8,654**	**100%**

Unlike youth in the foster care system, probation youth are typically much older than their foster care counterparts; most are ages 16-18 (Foster, p. 17; Watson, 2003, p. 7).

f. Service Planning Area

As of January 31, 2004, emancipating foster youth, ages 14 and older, were primarily concentrated in SPA 3 (23.39%), SPA 8 (19.79%), and SPA 6 (18.21%), and to a lesser extent in SPA 7 (12.71%) (DCFS, May 2004a) (see Table 5).

Table 5. Foster Youth Ages 14 and Above in DCFS Placement by SPA, as of January 31, 2004

Location	Number of Placements	Percent
SPA 1	540	6.83
SPA 2	583	7.38
SPA 3	1,848	23.39
SPA 4	408	5.16
SPA 5	515	6.52
SPA 6	1,439	18.21
SPA 7	1,004	12.71
SPA 8	1,564	19.79
N/A	753	7.60
Total	**8,654**	**100%**

g. Health Status

As the number of children in foster care has grown recently, there has been a parallel increase in the prevalence of health problems among this population, particularly developmental delays, and mental and physical health disabilities. According to recent studies, access to health care for these youth has proven inadequate, while lack of reimbursement for services, poor medical record-keeping, and a failure to coordinate health care remain additional concerns (Ensign, p. 19).

i. Health Insurance

Though federal and state law requires that foster children receive comprehensive physical, mental, developmental, and dental care, both emancipating and emancipated foster youth have suffered historically from health problems more than those not in foster care. The vast majority (82%) of Americans ages 18-44 have medical coverage, in contrast to recent studies which found as many as 30% of foster care alumni lack coverage (Pecora et al, p. 39; Guinn, p. 406; Institute of Medicine, 2001). This is of serious concern, given that young adults (ages 19-34) typically are the most likely to be uninsured, and insurance coverage has proven to mitigate the transmission and progression of fatal illnesses.

Fortunately, children in foster care in California, and former foster youth, are eligible for Medi-Cal until age 21. Yet, despite legal protections and Medi-Cal, being in foster care often does not improve access to adequate health care (Foster, p. 13). Routine

assessments for health conditions have not translated into timely address of medical recommendations and appropriate follow-up, leading to adverse outcomes such as unwanted pregnancies and unnecessary emergency intervention (Ensign, p. 22).

The health issues among foster children are compounded by a patchwork of programs that are often too confusing or poorly coordinated. Red tape and low Medi-Cal reimbursement rates have left only a small number of health care providers with enough incentive to serve this population. Many of these providers are ill-equipped to deal with the complexity of health conditions experienced by today's foster youth. Additionally, research has illustrated insufficient maintenance of medical records, especially among youth-serving shelters, due primarily to staff capacity and frequent placement moves (Foster, p. 14). Negative outcomes include a lack of or excessive immunizations, misdiagnosed symptoms, and lengthy and unnecessary delays in follow-up care (Ensign, p. 22).

ii. Mental Health

The relationship between foster care and mental health has been the subject of increasing research over the years, as both researchers and practitioners grapple with the reality that many children enter foster care with significant mental health problems. For example, a recent assessment of foster care effects conducted by Casey Family Programs reported that over half (50.6%) of the foster youth alumni surveyed as part of the study had been professionally diagnosed with a psychological disorder at some point in their childhood (Pecora et al., p. 19). Indeed, to some extent, the foster care system exacerbates their problems, leaving them worse off upon emancipation and less prepared for independent living. There are several reasons behind the connection between foster care and mental health.

Children placed in foster care have been removed from their family of origin, which creates a sense of isolation and traumatization that is not always adequately or sufficiently addressed during care, largely because of the relatively limited amount of time that they are placed and can access therapeutic services. The removal is often preceded by sexual or physical abuse and leaves youth vulnerable, resulting commonly in disruptive behavior, delinquency, hyperactivity, and aggression (Foster, p. 14).

While in foster care, children are often exposed to different living arrangements and adults responsible for their well-being. These so-called "placement changes" have the potential to negatively affect these youth, and have been cited as precursors for an increasing sense of transience. Ultimately, this familiarity and comfort with a transient lifestyle creates an aversion to the stability upon which the foster care system is designed to promote. Moreover, these multiple placements have a profound impact on emotional development, educational achievement, appropriate developmental milestones being met, and general preparedness for adulthood (County of Los Angeles Design Team for Emancipation Services, p. A-10).

At the same time, foster youth typically lack a network of support systems (or the tools to establish one), a circumstance which may have precipitated their removal from their

family of origin by the child welfare or juvenile justice systems. Their frequent inability to rely on such a network directly impacts their independence, as they feel stigmatized and pathologized as a result of their childhood. This compromise of self-worth is a significant barrier to accessing help. Similarly, the lack of support they experienced as a youth creates an over-reliance on public systems of care to meet their needs. Over time, this reliance simply cannot be fulfilled, as youth often are unable to receive help when they believe they will (Ibid, p. A-10).

The prevalence of mental health issues among youth emancipating from the dependency and delinquency systems can be understood in one sense by viewing mental health services usage rates among the population.[5] Overall, these rates are higher in comparison with other children, including those receiving public assistance. Accordingly, mental health service expenditures are also higher comparatively, as foster youth with mental health issues are more likely to receive outpatient mental health services and be hospitalized for a mental health condition (Foster, p. 14).

An analysis of foster youth in California from 1997 indicated that most youth in foster care receive some kind of mental health services, including 62% of emancipating child welfare youth and 63% of the emancipating probation youth (County of Los Angeles Design Team for Emancipation Services, p. A-11; Needell, pp. 27-29). Data from the Children and Family Bureau of Los Angeles County Department of Mental Health suggest that foster children occupy 40% of the child mental health inpatient beds on a given day (Stone, p. 3).

More recent information from DMH, however, suggests a lower utilization rate, with approximately 20% of the Los Angeles County foster youth receiving mental health services from January to December 2002 (Needell, pp. 27-29). According to DMH, older foster youth aged 17 and 18 have been more likely to receive mental health services from DMH during this same time period. DMH provided mental health services to 1,162 foster youth (ages 17 and 18) in 2002, representing approximately 30% of older DCFS and DCFS/Probation youth (out of 3,833 foster youth in total) (County of Los Angeles Design Team for Emancipation Services, p. A-12).

iii. Emotional and Physical Health

There is additional concern about the high incidences of emotional, behavioral, and developmental problems among children in foster care, which have been documented in some cases to be three to six times greater than the incidence of these problems among children not in out-of-home care (Barbell & Freundlich, p. 6). Though estimates range about the extent, most agree that at least 30% of children in foster care have such problems. Researchers in Texas found that, of 300 children assessed upon entry into foster care, 60% of the children under age 7 exhibited developmental delays or behaviors that warranted specialized interventions or additional evaluation.

[5] It is important to note that mental health service utilization does not fully illustrate the extent of mental illness among this population, as many youth with mental illness(es) do not seek or receive services for such conditions.

Furthermore, of the older children and adolescents assessed, 22% reported very severe posttraumatic stress symptoms and 50% had academic problems (Perry, 2000).

Children in foster care are also more likely to suffer from acute and physical health problems, including upper respiratory infections, dermatologic disorders, dental caries, malnutrition, and poor vision (Barbell & Freundlich, p. 6). The 2003 Casey Family Programs Alumni Study for instance found that while in foster care more than one in ten (11.3%) youth were diagnosed with a physical or medical illness or chronic condition of some kind (Pecora et al., p. 19). The prevalence of HIV and other sexually transmitted diseases among the population is also greater than in the general adolescent population (Barbell & Freundlich, p. 12).

h. Economic Well-Being

Numerous studies have highlighted a reciprocal connection between the economic well-being of families and foster care. Researchers conclude that youth that have had some involvement in the foster care system are more likely to encounter a life of poverty. Moreover, a life of poverty, in turn, correlates with several adverse conditions, such as: an increased likeliness to quit school, unemployment, receipt of welfare benefits, mental health problems, becoming unwed parents, involvement with the criminal justice system, and becoming victims of violence and other crimes (Guinn, p. 409).

In general, the economic well-being of former foster youth, at least two to four years after emancipation, appears adequate at best, and more closely resembles those 18 to 24 year olds living below the poverty line than those in the general population. Though it is unreasonable to expect 21 year olds to be self-supporting, the majority of the Westat sample could not be categorized as such as the term is usually understood. Less than one-fifth (17%) of the Westat youth were completely self-sufficient, while 51% were totally dependent on multiple sources of support and did not have a job. This figure includes 7% of the sample that reported that welfare (e.g., AFDC, Food Stamps, Medicaid, or General Assistance) was their only source of income (Westat, p. 4-6; Guinn, p. 406).

On the other hand, families living in poverty are more likely to be sources of child abuse or neglect, both precursors to foster care placement. This is not to say that low-income families will abuse their children, but that most children living in foster care are from low-income families that are eligible for public assistance (Foster, p. 18). In California, where the poverty rate is higher than the national rate, especially for children of color, this issue is particularly significant.

A principal reason for this connection is that families living in poverty struggle to meet their daily needs—food, shelter, clothing, health care, transportation to school and needed services—all of which are factors contributing to stress and an environment that can lead to parental abuse or neglect. In contrast, parents of higher income levels can avert these stresses though increased access to private resources and services independent of the dependency system (Foster, p. 18).

i. Educational Attainment

The educational achievements of foster youth, both while in care and after emancipation, remain lower than their counterparts in the general population. In large part, the stability provided to most youth in a school setting is elusive for youth who have been subject to maltreatment or multiple placements during their involvement with the foster care system. Repeated transfers to different schools, coupled with broken social relationships at these institutions and adjustments to different curricula, standards and rules in each school, have led many youth on the path to poor academic success, including failure and being kept back a grade. As studies have shown, low educational achievement may have the most adverse effect on long-term adjustment and future life success (Pecora et al., p. 26).

The disproportionate educational status of youth emancipating from the dependency and delinquency systems is also a product of the educational system as well. Though school districts are responsible for providing an appropriate education and funding to foster children, like all children, their ability to serve such youth remains a challenge.

Special education classes are common in large public schools, where teachers are often overloaded with students and cannot dedicate appropriate time to meet the special education needs (both developmental and emotional) common among foster youth. Often times, the "enhanced" efforts needed to effectively educate these youth are compromised by insufficient resources or concern that they will move on to another school soon enough, thereby justifying a reluctance to meet their individual needs (Foster, p. 15). This is a legitimate concern for school districts since nearly half of the children in group care qualify for special education services (Ibid, p. 15).

One measure of educational achievement is high school completion. The Westat evaluation reported that approximately 78% of the 18-24 general population had completed high school, notably higher than the 54% of former foster youth who had, and the 53% among former youth living below the poverty line (Westat, p. 4-12). Another study, perhaps evidencing the positive impact that the federal Independent Living Program has had on youth emancipating from foster care, indicated that a remarkable 87% of foster youth who were not involved in ILP did not complete high school at the time of discharge (Scannapieco et al., p. 388).

In Los Angeles County, high school completion rates among foster youth are remarkably similar. A profile of youth aging out of foster care in 1996 showed that 54% had completed high school. However, the completion rate among youth enrolled in the Bridges to Independence program from 1996 to 1999 was significantly higher (88%) (Kellam, p. 25). This disparity supports the notion that ILP services, supported though integrated social work, education case management, and continuous monitoring of education outcomes, are yielding positive results.

2. Environmental Trends

Three notable trends have emerged within the past two decades that have had a direct impact upon youth emancipating from the dependency system and ultimately play a role in their ability to achieve independence and self-sufficiency.

First, an increasing number of children are being removed from their families because of abuse and neglect, and in turn, are entering the dependency system with severe emotional or behavioral problems.

Second, as the dependency system evolves, it is forced to respond to numerous smaller dynamics both internal and external. As the foster care system has matured over time, the number of children entering and re-entering foster care has shifted also, while the length of stay in foster care has increased as well for some youth. Moreover, the dependency system has had to adapt to changes within other systems of care, such as the mental health and delinquency systems, which have become reliant upon it as an alternative safety net.

Finally, foster youth are staying in care for longer periods of time and are experiencing multiple placements, both of which are factors that affect a child's well-being while in care and ability to manage independently in adulthood.

a. Child Abuse and Neglect

As stated in the previous section, one of the primary reasons that children enter into foster care is due to abuse or neglect. These precursors to foster care represent some of the many challenges to the future of the foster care system and reflect a growing need to ensure that emancipation and independent living services, including housing assistance, provide appropriate support for youth with these experiences.

Over the last few decades, dating from the 1960's, there has been a profound rise in the number of substantiated reports of child abuse and neglect in the U.S. Between 1980 and 1999, these figures nearly tripled, with almost three million reports of child abuse and neglect documented at the close of the century (Barbell and Freundlich, p. 1).

Child abuse and neglect referrals in Los Angeles County have fluctuated in recent years, at least between 1998 and 2002. In similar fashion, the number of these referrals during this period that were substantiated also varied, with less substantiated reports documented in 2002 than four years previously (DCFS, May 2004b) (see Table 6).

Table 6. Number of Child Abuse and Neglect Referrals in Los Angeles County, 1998-2002.

Year	Child Abuse/Neglect Referrals	Substantiated Child Abuse/Neglect Referrals
1998	157,062	26,785
1999	146,583	29,860
2000	151,108	28,303
2001	147,352	29,076
2002	161,642	26,555

Fortunately, the number of victims of child maltreatment while in the child welfare system continues to decline, which probably reflects concerted efforts by state and county child welfare agencies, in partnership with the federal government, to ensure the safety of all children in out-of-home care.

Nevertheless, children in Los Angeles County, who are not under the county's care, are still experiencing high rates of abuse and neglect, and are reported to be twice as likely to suffer from repeated abuse and neglect as children nationwide. For those in foster care, the rate is triple the national average and nearly doubles the rate in California (DCFS, May 2004b; Fox, February 18, 2004).

b. Number of Children in Foster Care

Nationally, the number of children in foster care has risen steadily in recent decades and despite a decline in this number in the 1980's, this rate of growth persists today. As of March 2000, the number of children in foster care (588,000) was more than twice the number (276,000) of children in care in 1984 (Barbell & Freundlich, pp. 1-2).

Year-end figures from DCFS illustrate a general decline in the number of youth in out-of-home care between 1998 and 2002, including a 40% drop between 1999 and 2002 (DCFS, May 2004b) (see Table 7). Yet the number of youth in foster care is still remarkably high. The County is home to 29% of the State's children, though DCFS oversees approximately 38% of the California's foster care population (Los Angeles County Children's Planning Council, 2004, p. 13).

Table 7. Number of Youth in Out-of-Home Care in Los Angeles County, 1998-2002

Year	No. of Foster Youth
1998	42,293
1999	48,613
2000	38,273
2001	33,591
2002	29,224

According to a foster care study conducted by Casey Family Programs, there are three primary forces that have helped shape the increasing number of children in foster care: higher rates of entry into foster care than of exit from care; high rates of re-entry into care; and placement of children in foster care through other systems.

i. Entry into Foster Care vs. Exit from Foster Care

A significant reason for increased foster care placements has been simply that more children are consistently entering care than leaving care. This has been affirmed through national and state-based analyses of foster care caseloads, where annual admissions and discharge rates, which up until 1986 remained fairly equal, highlight a widening disparity. In the U.S., what was a mere 5,000 gap among the number of children entering and exiting out-of-home care in 1986 ballooned to 20,000 by FY 1998 (Barbell & Freundlich, p. 3).

This disparity has been less evident in California, where caseloads increased slightly during FY 1998 and FY 1999 (by approximately 3-4,000 cases), only to drop again by nearly 5,000 in FY 2000 (U.S. Department of Health and Human Services, 2002, p. IV-34).

ii. Re-Entry Rates into Foster Care

Another significant reason for the increased number of children in foster care has been the contribution of high re-entry rates. This figure measures the number of children entering foster care that previously have been in foster care. National data from FY 1998 indicate that approximately 17% of children entering into foster care fall into this category. Local data from state reporting, nonetheless, remain inconsistent. Illinois and New York, by example, reported rates as high as 20% during that same year (Barbell & Freundlich, p. 3).

Re-entry rates in California are similar to national rates, and even illustrate a slight increase from FY 1998 (78%) to FY 2000 (80%) among the percentage of children entering foster care who are doing so for the first time (U.S. Department of Health and Human Services, 2002, p. IV-36). In other words, averages of 20% of children entering foster care in the state have had a prior placement. Of these children who had had a prior placement, twice as many were re-entering the foster care system within 12 months of a prior placement.

iii. Foster Care Placements from Other Systems

Researchers have concluded that increasing number of foster children, at least nationally, originate in other systems of care, specifically the mental health and juvenile justice systems. Though the amount of research to support this assertion remains modest, clearly more and more foster youth who have traditionally been the clients of mental health programs and correctional facilities now find themselves in the dependency system (Barbell & Freundlich, p. 3).

The high rate of mental illness and emotional disturbance among today's foster youth, estimated by some to be one-half to two-thirds of the children who enter foster care, perhaps invites the mental health system to look increasingly to child welfare agencies so that residential treatment arrangements can be provided to them (Gilberti, 1999; Barbell & Freundlich, p. 3). Other researchers have found a rising number of youth entering foster care after committing status and delinquent offenses (Tatara, 1993).

Though children continue to be placed in out-of-home care in Los Angeles County from other systems of care, available data reflects generally a downward trend, specifically among those youth placed by the Probation Department and the California Youth Authority.[6] Between 1996 and 2000, the number of children placed in out-of-home care decreased by 28% at the Probation Department and 38% at the California Youth Authority (County of Los Angeles, April 2004, p. 31). More recent data from the Probation Department however suggests that this trend is abating somewhat. Between 2003 and 2004, for instance, there was only a 6.7% decrease in the number out-of-home placements by the Department (Probation Department, January 2005).[7]

Contrary to these declines, however, out-of-home placements by DMH increased significantly (56%) during this same period and serve to further underscore the high prevalence of mental illness(es) among the foster youth population (County of Los Angeles, April 2004, p. 31).

c. Length of Time in Foster Care

The dependency system is not intended to be a long-term arrangement for foster youth. Nonetheless, a significant percentage of foster youth remain in care for substantial periods of time. According to HHS, the median length of stay for children in foster care on March 31, 2001 was 21 months, a duration that is far lower than in a number of states across the country.

There are several factors that contribute to a child's duration in foster care. Missed reunification and permanency timeframes can extend the amount of time a child is in care, but certainly more complicated issues, such as parental substance abuse, are difficult to quickly resolve and thereby prolong placement.

The duration of time in foster care has serious implications for a child's stability and well-being. Extended stays for children in foster care are directly related to the number of placements they are likely to have during their time in care. In California, the vast majority (78%) of foster children in FY 2000 with two or fewer placements were those who had been in care less than 12 months (U.S. Department of Health and Human Services, 2002, p. IV-37). The percentage of children with two or fewer placements dropped significantly as the amount of time in care increased.

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[6] The Probation Department noted it is far easier and more likely for DCFS foster youth to be placed in Probation programs than it is for their youth to access and be placed in the dependency system.
[7] According to Probation, slight increases over the last few years in the number of youth in placements has been offset by aggressive departmental efforts to get these youth out of placement.

Conversely, nearly half of the state's foster care population, who had been in care more than 48 months, were placed three or more times. Only 22% of the foster youth during this year in foster care who were in care less than 12 months were placed three or more times (Ibid, p. IV-37). As a point of comparison nationally, of the foster children in FY 1998 who had experienced multiple placements, 21% had three or more placements, 8% had five or six placements, and 8% had seven or more placements (Barbell & Freundlich, p. 4).

Of the County's foster youth population who had entered foster care for the first time in FY 2002, approximately three-quarters had no more than two placements within that 12-month period. More recently and inclusive of all foster youth placed in out-of-home care in FY 2003, nearly 87% were reported with two or fewer placements (DCFS, May 2004b).

Increased time in foster care also raises concerns for the overall health and well-being of children. Multiple placements preclude children from developing the nurturing bonds and support networks that facilitate the transition to independence, self-sufficiency, and adulthood. They also severely inhibit the achievement of educational and training goals for foster youth, which can lead to economic malaise, depressed salaries, and ultimately homelessness.

The familiarity of "drifting" for youth, especially older ones, who have experienced multiple out-of-home care placements, is a common and real concern. As a result, relationships with others become superficial, as intimacy with others, including caseworkers and foster families, are avoided as a coping strategy. Foster youth in these situations begin to identify with a lifestyle of transience while feeling powerlessness with their fate. For these reasons, there is an urgency to regain what has been lost by reclaiming some strength and control through running away or by refusing to stay in a new placement. Ironically, these attempts to regain power are illusory since increased resistance usually leads to more stringent supervision and less control.

3. Support Networks

Children in foster care are supported through a network of supports and living arrangements, all of which provide different levels of structure and services. The placement of children in various settings is done according to the needs of the child, with the primary goal to provide the least restrictive or family-like setting to best address these needs. The task of "appropriately" placing children in foster care remains extremely challenging for the county's social workers and Probation officers; in many cases placement is based more on the availability of a bed than on the specific needs of the child (Foster, p. 20).

Youth in out-of-home care in Los Angeles County are placed in a variety of settings, including emergency shelters, kinship care, foster family placements, and group care. Of the out-of-home cases in DCFS placement as of January 31, 2004, most were placed with relatives (42.57%), foster family agency (FFA) certified homes (24.86%) and foster

family homes (15.01%). The remaining youth were primarily placed in guardian homes (8.10%) and group homes (7.73%) (DCFS, May 2004a) (see Table 8).

Table 8. Number of DCFS Out-of-Home Cases by Facility Type, as of January 31, 2004

Facility Type	No. of Children	Percent (%)
Relative Home	11,877	42.57%
FFA Certified Home	6,935	24.86%
Foster Family Home	4,186	15.01%
Guardian Home	2,260	8.10%
Group Home	2,156	7.73%
Small Family Home	223	0.80%
Court Specified Home	61	0.22%
County Shelter/Receiving Home	1	0.00%
Medical Facility	1	0.00%
N/A	197	0.71%
Total	**27,897**	**100%**

a. Emergency Shelters

According to state estimates, nearly 20% of the youth removed from their home are placed in emergency shelters as their first placement (Foster, p. 20). These are short-term arrangements, licensed, no more than 30 days in length, and are utilized until children are returned to their homes or placed in a more appropriate facility. Shelters also serve as a transition placement when children moved from one placement to the next. The Probation Department also oversees 20 emergency shelter beds through its Status Offender Detention Alternative (SODA) program, which primarily serve youth whose offense (e.g., truancy) does not warrant placement in Juvenile Hall.

b. Kinship Care

In some cases, children are placed with a relative or someone emotionally close to the child who can assume responsibility for their parenting. Kinship homes must adhere to the same health and safety codes as licensed homes. There has been an increasing trend to place children in kinship care, in part a product of the prevailing perception that relatives and family care, in the sense of the wider family circle, are preferable to non-kin settings. Moreover, kinship caregivers provide a culturally sensitive environment relative to other placement arrangements.

Among arrangements in the foster care system, kinship care presents certain challenges for its caregivers. They tend to be older, single, African American, have less education and income, receive public benefits, and require help assisting children to receive education, health, and mental health services. Often times, they are grandmothers and require respite care, emotional support, or childcare. According to the state, they are less prepared for their roles as caregivers and appear less informed by the dependency system about their duties and responsibilities under this arrangement (Ibid, p. 21).

c. Foster Family Placements

There are two types of non-relative family home placements: foster family homes (FFH) and certified homes (CH) of a treatment foster family agency (FFA). Both settings strive to meet the primary goals of the foster care system to provide a family setting for the best development of the child. Foster family homes are licensed residences that provide 24-hour care for no more than six children (or eight if a sibling group). These placements are used particularly as an intermediary placement until reunification or adoption.

As there has been a rising focus on kinship care in the foster care system, there has been a parallel decline in the number of foster families both statewide and nationally (Ibid, p. 22). Foster family homes are even more absent among families of color or those who are willing to accept children with special needs. Insufficient reimbursements to foster families for their care, or communication and support from the dependency system to address the specialized needs of today's foster children have contributed to this trend. Increasingly, foster families are opting to provide foster care through a foster family agency that can provide additional support for themselves and the youth.

Foster family agencies are licensed nonprofit agencies that recruit and certify family homes for its exclusive use. They tend to serve as alternative placements for children heading to group homes and thus are designed to provide not only support to foster parents, but care and treatment for the many emotional, behavioral, developmental, or behavioral needs experienced by foster youth.

d. Group Homes

A group home is also a licensed, 24-hour care facility, though it is a distinctively more structured environment than kinship or foster family settings. This option is pursued for youth in the delinquency system because of its restrictive environment, and is frequently used as an alternative to juvenile hall. Although Probation also looks at kinship care and foster care as the first placement options, the child's behavior (at the point he/she enters the system) may warrant a more structured setting, such as a group home.

In fact, while Probation youth make up less than 10% of California's foster youth, they make up 40% of the group home population (Foster, p. 23). In Los Angeles County, nearly 70% of Probation foster youth reside in group homes, in contrast to 17% of DCFS teen-aged youth (Watson, p. 5).

Facilities can range dramatically in size; provide intensive services, as is the case in residential treatment centers; and target specific populations, such as pregnant or parenting teens or youth with mental illness(es). The structured, supervised setting found in group homes exists because of the characteristics of the children placed there. Children placed in group homes are likely to be older than age 12, have been placed multiple times, be prone to aggressive behavior, and have trouble complying with rules.

Because of these issues, it is difficult to retain qualified, educated persons to staff these facilities and as a result, turnover is common.

4. Significant Subpopulations

a. Minors with Children (Adolescent Parents)

Despite a reduction in the number of children that are born nationally to teens, adolescent parenting remains common and presents certain challenges to the foster care system. Teen mothers are often disadvantaged in comparison to other older mothers. They face higher rates of pregnancy complications (e.g., premature delivery), are less likely to have obtained prenatal care, and tend to have attained less academically (completion of high school) and economically (lower incomes) than mothers in their 20's (Barbell & Freundlich, p. 11). These experiences can be seen as risks that place children of adolescent parents in environments that harbor maltreatment, which has been shown to predict entry into out-of-home care.

A recent foster care alumni study conducted by Casey Family Programs reveals a significant number (17.2%) of female alumni who had at least one live birth while in foster care (Pecora et al., p. 23). This figure stands markedly higher than the percentage (8.2%) of similarly-aged, unwed teen mothers across the U.S. who had ever given birth (Ibid, p. 23).

In California, emancipating females are also quite likely to be parenting or pregnant either in care or soon thereafter. Results of a statewide study on the foster care population indicated that approximately two-thirds of emancipating child welfare females had at least one birth within five years of leaving foster care. Twenty percent (20%) of these births occurred while in care or during the first year after leaving care (Needell, p. 35). Among emancipating probation females, nearly 85% had given birth at least once within five years of leaving care. Six percent (6%) of these births occurred while in care, 11% during the first year following care, and 24% between one and two years following emancipation (Ibid, p. 36).

The County of Los Angeles reports that more than 50 minors in the care of DCFS are currently pregnant, with an additional 100 DCFS youth with children in DCFS care (DCFS Communication, March 12, 2004). An estimated 12% of emancipated foster youth participating in the Independent Living Program (ILP) Transitional Housing program are teen mothers (Community Development Commission, March 2004).

The Probation Department also reports pregnant or parenting youth in placements. As of April 2004, there were 38 males with children, 20 males with pregnant girlfriends, 44 females with children, and 14 pregnant females (Probation Department, January 2005).

The reality of adolescent parenting and its relationship to foster care raise systemic concerns, especially as affordable housing remains a major hurdle for emancipating mothers. Recent legislative findings state that dependent teen parents lose their

parental rights at a faster and higher rate than non-dependent teen parents, as the foster care system fails to provide them with adequate resources (DCFS, March 2004).

b. Homeless Youth

The relationship between foster care and homelessness has been increasingly the subject of academic research and policy debates in recent years. Heightened awareness of this connection arose primarily as both foster care placements and homelessness have risen dramatically during the 1980s, coupled with anecdotal reports from homeless service providers that attest to a disproportionate number of homeless persons with a foster care history. Studies have also revealed that a substantial number of emancipated foster youth have endured homelessness since their discharge. Moreover, research confirms that homeless persons with a foster care history are more likely than other homeless persons to have their own children in foster care.

The causes of homelessness among youth emancipating and emancipated from the dependency and delinquency systems are inseparable from the interrelated set of socioeconomic and psychosocial factors that have been highlighted over the past two decades to be responsible for the rising presence of homelessness in America. The lack of affordable housing and supportive services (especially primary care), a decrease in incomes for poor families, general instability for poor families, and substance abuse and domestic violence all contribute to this trend (Roman & Wolfe, p. 2).

According to the National Alliance to End Homelessness, homeless persons are much more likely to have been in foster care than the general homeless population. In the 1990s, they conducted a modest study to assess this relationship. Data collected from both homeless service/housing providers and homeless persons revealed that no less than 9%, and as many as 37% of homeless individuals had a foster care history (Roman & Wolfe, pp. 9-10).

Conversely, several longitudinal studies have documented an increased likelihood of homelessness for youth emancipating from the dependency and delinquency systems. The seminal Westat study found that approximately 25% of former foster youth had spent at least one night without a place to live. Of the youth reporting a homeless episode, 19% had spent the night in a public shelter, while 36% had slept in a car or on the street (Westat, p. 4-11). The majority (55%) of youth with homeless episodes had to rely on resources or the street for shelter, indicating that homelessness was primarily the result of a lack of personal resources in a time of crisis (Ibid, p. 4-11).

According to a survey of people who are homeless or living in temporary housing programs in Minnesota, more than two-thirds (69%) of homeless adults in 2003 had lived in institutional arrangements. Though the majority of these adults had left a correctional facility, 48% had recently left some other form of institution, including 58% who had recently left foster homes (Wilder Research Center, p. 20). Of the homeless youth interviewed as part of the study, over half had lived in a foster home (Ibid, p. 24).

Researchers at the University of Pennsylvania also examined the prevalence and associated factors of shelter use among young adults who were placed in out-of-home care or received preventive dependency services without out-of-home placement in New York City. This study highlighted the increasing concern among policymakers and researchers of the status and well-being of children who have exited the dependency system.

Within ten years of emancipation, nineteen percent (19%) of the study participants had entered public shelters, with an average of 38 months between emancipation to shelter admission (Culhane et al., 2003a, p. 11). Former youth with out-of-home placement histories were twice as likely (22% vs. 11%) to enter shelters during this time than youth who received preventive dependency services only. Moreover, among youth who had been placed in out-of-home care, there were substantial differences among the rate of shelter use.

For instance, youth who exited the dependency system through "running away" had the highest rate (34%) of shelter use, compared to those discharged to independent living (26%) and those discharged to reunification (19%) (Ibid, p. 11). On a different note, this same study asserts that those who had experienced homelessness during childhood were associated with a 25% increase in the risk of public shelter use as an adult (Ibid, p. 14).

There is also strong evidence of an intergenerational aspect to the relationship between foster care and homelessness. Homeless families can do little to resist the removal, either voluntarily or involuntarily, of their children as a result of their situation. In 1988, for instance, homelessness was a factor in 40% of foster care placements in New Jersey and the sole reason for 18% of those placements (Barbell & Freundlich, p. 10).

Other research efforts have reached similar conclusions about this connection and the chance of homeless children becoming involved with the dependency system. One study, which tracked a one-year Philadelphia birth cohort[8] for five years, indicated that more than one-third (37%) of ever-homeless mothers became involved in dependency services, as compared to 9% among low-income residents, and 4% among all others (Culhane et al., 2003b, p. 8). Also, children born into families with a history of homelessness were placed in foster care at a significantly higher rate (62%) than both low-income residents (39%) and all others (39%) (Ibid, p. 9).

Another study asserts that housing instability is twice as likely to be responsible for foster care placement than for those families without housing problems (Barbell & Freundlich, p. 10). Removal is compounded when homeless shelter policies and services do not assist families to stay unified, or to the same effect, court judgements are made which determine the inability of families to keep their children.

[8] The housing status of the mothers was divided into three populations: ever-homeless, other low-income neighborhood residents, and all others.

Similarly, risk factors that predispose youth to becoming homeless include being in foster care, group homes, juvenile detention, or other institutional settings, as well as problems related to special education or mental health (Hagedorn, p. 34). Indeed, the potential for current and former foster youth to become homeless is a serious concern and perhaps a reflection of the inadequacy of the foster care system. There are several explanations for this.

First, studies suggest that foster care placements strongly predict homelessness, though they cannot be considered causes of homelessness (Piliavin et al., p. 64). The Westat study affirmed the impact of multiple placements on homelessness. Almost one-third of former foster youth had lived in five or more places since discharge. Moreover, thirty-seven percent (37%) of the youth had five or more living arrangements while in care as well as since discharge (Westat, p. 4-11).

Second, there is doubt that the foster care system effectively addresses the predictors of foster care placement, such as neglect, physical and sexual abuse, and parental substance abuse to name a few. At the same time, the mental health and/or substance abuse needs of foster youth are often unmet or neglected, which in some cases are further compounded by the placement of foster youth into abusive situations. Achieving educational and work-related goals are very important as well; in their absence, emancipated youth are more likely to live in poverty and ultimately without a home.

Third, as stated earlier, multiple placements lead to increased time in foster care and inhibit the development of nurturing relationships and support networks that have been shown to be critical during adulthood. The internalization of "drifting" as a norm assumes significance too, as does the reliance upon the dependency system for subsistence. Children, therefore, are not adequately equipped for a transition to independence, and revert back to what is familiar, which has been a pattern of transience and social disaffiliation.

B. Characteristics of Homeless Persons with Mental Illness

Persons who are both homeless and mentally ill represent the intersection of two extremely vulnerable populations that struggle with a multitude of problems related to their condition and environment. In fact, many see mental illness as the "face" of homelessness, and to a certain extent, the homeless mentally ill have come to symbolize the growing presence of homelessness in the U.S., certainly here on the streets of Los Angeles, where the so-called "chronic homeless" are so visible.[9]

This group tends to have major psychiatric disorders, co-occurring substance abuse disorders, frequent health problems, and a range of social needs that include employment, income, food, clothing, personal safety, and of course, housing. These issues are further compounded by the stigma associated with homelessness and mental illness, and a suspicion and distrust of housing providers and service professionals that can lead to resistance to treatment or other forms of assistance. Altogether, these factors make it difficult to serve this population and leaves them continually underserved in the homeless and mental health service delivery systems.

The U.S. Department of Housing and Urban Development (HUD) considers a person **homeless**[10] when he or she resides in **one** of the following places:

(1) in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings;
(2) in an emergency shelter;
(3) in transitional or supportive housing for homeless persons who originally came from the streets or emergency shelter;
(4) in any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution;
(5) is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing; or
(6) is being discharged within a week from an institution in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks to obtain housing.

Because there are such high rates of mental illness even among the general population, both locally and nationally, this section concentrates on those persons in Los Angeles County that experience both homelessness and mental illness. For those who are fortunate to have a stable housing arrangement despite living with mental illness, the

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[9] According to HUD, a person who is "chronically homeless" is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for more than one year, OR has had at least four (4) episodes of homelessness in the past three (3) years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter. A disabling condition is defined as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability including the co-occurrence of two or more of these conditions.

[10] Per HUD's *Questions and Answers: A Supplement to the 2003 Continuum of Care Homeless Assistance NOFA and Application*.

challenges of tenancy or homeownership are difficult enough. For those who find housing and mental stability to be elusive however, as is often the case with homeless mentally ill persons, securing and maintaining housing can be a lifelong pursuit with little sense of success.

Considerable research has been done on the nexus of these two worlds. As a result, the public sector has attempted through various methods, both advocacy and policymaking, to respond by appropriating state-level funding for demonstration programs. Statewide legislation for homeless persons with mental illness include the Integrated Services for Homeless Adults with Severe Mental Illness (otherwise known as AB 34/2034/334)[11] program and the Supportive Housing Initiative Act (SHIA).[12]

The following section highlights some of the more notable characteristics of homeless persons with mental illness, particularly adults, though additional focus is placed on persons with co-occurring substance use disorders[13] as a significant subpopulation. Also, information on the homeless mentally ill is at times presented through analyses of data from the county's AB 34/2034/334 program since it provides numerous opportunities to look locally at one segment of this population from both demographic and environmental perspectives.

1. Demographics

a. Number

Efforts to enumerate the homeless population have yielded varying results. Yet, the federal government estimates that despite two decades of support, statewide planning, and local initiatives, there are 637,000 adults in the U.S. who are homeless in a given week, with 2.1 million adults experiencing homelessness over the course of a year (Burt et al., 2001; Substance Abuse and Mental Health Services Administration, 2003a).

Statewide data prepared by the Department of Housing and Community Development (HCD) have placed this figure at roughly 361,000 homeless persons on any given day, or about 1.1% of the state's total population (State of California, pp. 7-8). In Los Angeles County, it has been accepted for nearly a decade that there are as many as 84,000 homeless persons on any given night and up to 236,400 in the course of a year.

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[11] Signed into California law by Governor Davis on September 17, 2000, AB 2034 provides comprehensive services to mentally ill persons who are homeless, recently released from county jail or state prison, or others who are untreated, unstable and at a significant risk of incarceration or homelessness unless treatment is provided to them.

[12] Created in 1998 and amended two years later (SB 1593), SHIA is managed jointly by the State Departments of Mental Health (State DMH) and Housing and Community Development (HCD). The program promotes affordable housing devleopment linked to accessible mental health, substance addiction, employment, and other support services. During the first two years of SHIA, DMH awarded 31 three-year grants for projects serving approximately 5,100 clients.

[13] Substance abuse disorders refer to alcohol abuse as well as use or misuse, dependence, and addiction to legal and illegal drugs.

There is a significant number of persons with mental illness within the homeless population, although similar to the inconsistencies found among homeless counts, there are discrepancies concerning the prevalence of mental illness throughout the homeless population. Even among the general public, mental illness, which is more common than diabetes, cancer and heart disease, affects nearly one in five Americans (County of Los Angeles Department of Mental Health, March 2001). A subpopulation of about 5.4% of adults in the U.S. are considered to have a "serious" mental illness (SMI), a term defined by federal regulations that generally applies to mental disorders that interfere with some area of social functioning.[14] Nearly half (2.6%) of those with SMI have been identified as having severe mental illness, which includes schizophrenia, bipolar disorder, and other severe forms of depression (HHS, 1999a, p. 46).

The National Council on Disability estimates that approximately 150,000 people with severe mental illness are homeless on any given day, living on the streets or in public shelters (National Council on Disability, p. 42). In relation to the overall number of homeless persons in the nation, this figure suggests that close to one-quarter of all homeless persons are affected by mental illness. Other calculations from the U.S. Conference of Mayors (19%), HHS (39%), and the Interagency Council on Homelessness (45%) affirm this estimate and provide a baseline assertion that mental health problems impact between one-fifth to one-half of homeless persons in America (SAMHSA, 2002).

Local studies conducted in the City and County of Los Angeles have found the prevalence of severe mental illness, such as schizophrenia, major depression, or bipolar affective disorder, to range from 30-50%. In California, such estimates appear lower. The State DMH estimates that approximately 14% of California's homeless have a severe mental illness (State of California, p. 9).

b. Age

There is little evidence to suggest that age demographics among homeless mentally ill persons are disproportionate to the general population. Documentation appears more widespread for the adult population relative to children, adolescents, and the elderly. Nonetheless, according to HHS, about 20% of the U.S. population (including these three age groups) is affected by mental disorders during a given year (HHS, 1999a, p. 46).

Of the 6,344 homeless clients served by DMH from July 2002 through June 2003, the overwhelming majority were adults (92.1%) ages 22-61, followed by transitional age youth (4.0%), older adults (3.1%), and children less than 16 years of age (0.8%) (DMH, 2004b) (see Table 9).

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[14] For the purpose of this Strategic Plan, "serious mental illness" refers to having one or more of the following: diagnosed mental illness, diagnosable mental illness, condition attributable to a mental illness or co-occurring health conditions that include mental illness. The disorder is associated with significant limitations in the performance of one or more major life activities, including but not limited to the following: basic activities of daily life (e.g., bathing, eating, care for health condition), instrumental activities of daily life (e.g., domestic activities or managing money), interpersonal relations (e.g., regulating aggressive behavior), or school or work. The disorder has endured or can be expected to endure continuously or with major episodes for at least one year.

Table 9. DMH Homeless Clients by Age Group, FY 2002

Age Group	Clients	Percent of Total Homeless Clients
Adults (22-61)	5,842	92.1%
Transition Age Youth (16-21)	251	4.0%
Older Adults (62+)	199	3.1%
Children (<16)	52	0.8%
Total	**6,344**	**100.0%**

Information from the County's AB 2034 program also offers some insight on age characteristics among the homeless mentally ill, despite the program being limited to adults with serious mental illness who are homeless or at-risk of homelessness. As of January 31, 2004, the program was serving 1,669 clients, of which 9% were ages 18 to 24; 53% were between 25 and 45 years of age; 35% were ages 46 to 59; and 3% were 60 and over (DMH, 2004a). Age-specific information from the county's AB 2034 program is nearly identical to statewide program figures.

c. Gender

There is also a dearth of literature that identifies gender proportions throughout the homeless mentally ill population and thus it is difficult with any certainty to estimate the extent to which males and females are represented as subpopulations. According to the Interagency Council on Homelessness however, women comprise approximately 32% of homeless persons in the U.S. (Burt et al., 1999).

Research shows a high risk of mental illness and substance abuse among women nationally and greater prevalence than homeless men (Ibid, 1999). Moreover, homeless women are more likely to suffer from depression, post-traumatic stress disorder, and substance abuse than low-income women (Bassuk et al., 1998). Especially among single, homeless women, for instance, there is a greater presence of severe mental illness, such as schizophrenia and bipolar disorder (Buckner et al., 1993).

A survey of homeless clients conducted through DMH in 1997 however indicates an overwhelming number of males (84%) relative to females (16%) (DMH, 1997). In contrast, a random consumer housing preference survey, also conducted by DMH at the same time, found results that reflect more the breakdown of males and females in the general population; 52% were male, 48% were female (Ibid, 1997).

The most recent data provided by DMH Homeless and Housing Division indicates gender disparities somewhere in between those reported through those two data sets. DMH clients served during FY 2002-2003 were 55% male, with a disproportionately higher representation of males among homeless clients served during that year (DMH, 2004b; DMH, 2004c) (see Table 10).

Table 10. Gender of General and Homeless DMH Clients (1997 & 2002)

Data Source	Male	Female
DMH Homeless Survey 1997	84%	16%
DMH Housing Consumer Preference Survey 1997	52%	48%
DMH Clients FY 2002	55%	45%
DMH Homeless Data FY 2002	63%	37%

The most current reports from Los Angeles County's AB 2034 program again offer a reference point. In this case, close to two-thirds (61%) of program clients were male, reflective of the amount (60%) of male program clients throughout the state (DMH, 2004a; California Department of Mental Health et al, p. 7). According to the state's most recent evaluation of the program, the amount of males is not surprising since a large number of AB 2034 consumers come directly out of jails or prisons with their disproportionately high numbers of males (California Department of Mental Health et al., p. 8).

One research effort that focused on homeless women living in metro Los Angeles indicated that they are more likely to meet the definition of chronic homeless and experience mental health problems. A needs assessment of homeless women in the Skid Row/Central City East area of downtown Los Angeles, for instance, found nearly 60% to have experienced homelessness for more than one year. Close to 26% of the sample had been homeless for five years or more, and a significant portion (40.5%) were reported to be affected by mental illness (Shelter Partnership, 2001).

d. Race and Ethnicity

In 1999, the U.S. Surgeon General documented profound disparities for minorities in mental health services. The report found that racial and ethnic minorities share a disproportionate burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity. Furthermore, this study concluded that minority groups are less likely than whites to access services, and they receive poorer quality mental health care despite similar prevalence. Together, these factors substantiate that minority communities have a higher proportion of individuals with unmet mental health needs (HHS, 1999b, p. 3). This burden is further compounded by minority overrepresentation among high-risk populations, such as the homeless and incarcerated.

Similar to the impact that race and ethnicity plays upon mental health and services, racial and ethnic minorities remain dramatically over represented among the homeless population. Though percentages vary across other racial lines, research illustrates that people of color comprise a disproportionate share of the homeless population in their communities (Burt at al., 1999; SAMHSA, 2003a, p. 15).

i. African Americans

Racial disparity among the homeless is no less evident than among African Americans, identified in the 2000 U.S. Census as approximately 12% of the country's population.[15] Among the general population, epidemiological surveys have not offered any evidence that the rates of mental illness are greater among African Americans than whites. Yet, African Americans are estimated to represent no less than 40% of the homeless population (Burt et al, 1999). Or proportionally, there are 3.5 times as many African Americans as whites are homeless.

County data from DMH's homeless survey affirm the overrepresentation of African Americans among the homeless mentally ill. Findings from this survey identified almost half (49%) of respondents as African American, nearly one-quarter as Hispanic, 19% white, and 5% American Indian (with very small percentages of other racial groups). Unlike the DMH homeless survey, the department's random consumer housing preference survey did not generate data that reflects this disparity. Instead, random survey respondents were primarily white (54%), with similar amounts of Hispanic (21%) and African American (18%) respondents (DMH, 1997).

More recent departmental data from FY 2002 indicates that African Americans represent close to one-quarter (26.1%) of their total clients, and roughly 38% of homeless clients served during that year (DMH, 2004b; DMH, 2004c) (see Table 11).

Of the nearly 1,700 clients served by the county's AB 2034 program as of January 31, 2004, the largest number of clients were African American (55%), followed by Caucasian (29%) and Latino (12%) (DMH, 2004a).

ii. Latinos

Unlike African Americans, Latinos are underrepresented among the homeless population despite the fact that many experience high rates of poverty, which is closely associated with homelessness (Burt et al., 1999; HHS, 1999b, p. 139). Moreover, researchers have not been able to draw substantial distinctions between the rates of mental illness among Latinos relative to whites, though more narrowly-focused studies have proven that among Latinos, especially Mexican Americans, factors associated with living in the United States are related to an increased risk of mental disorders.

Lower representation of Latinos among the mentally ill and homeless populations is also reflected in statewide data for the AB 2034 program. Approximately 5 out of 6 AB 2034 consumers are either Caucasian or African American while Latinos represent about 12% of program participants (California Department of Mental Health et al, p. 8). The same percentage (12%) of Latinos is represented in the County's program reports. The relatively low number of Latinos seems to be consistent with the under

[15] This percentage is likely to be higher since African Americans are over represented among people who are difficult to reach through the census, including the homeless and incarcerated.

representation of Latinos in mental health programs at large and possibly suggests the need for more targeted outreach to the Latino community.

Contrary to these assertions, the percentage of Latino consumers responding to both the County DMH random consumer housing preference survey and the homeless consumer housing preference survey indicates a greater representation among consumers of county mental health services. Findings from these two surveys show that 21% of random survey respondents were Hispanic, slightly higher than African Americans (18%), while 26% of the homeless survey respondents were identified as Hispanic.

Service statistics from FY 2002 still illustrate that both the overall number of DMH clients who are Latino (30%) and the number of homeless Latino clients (14%) remain far below their proportion of the County's general population (45%) (U.S. Census Bureau; DMH, 2004c; DMH, 2004b) (see Table 11).

Table 11. Race/Ethnicity of DMH Total and Homeless Clients (1997 & 2002)

Race/Ethnicity	Homeless Clients (1997)	Consumer Housing Preference Survey Respondents (1997)	Total Client Population (2002)	Homeless Clients (2002)
African American	49%	18%	26.1%	37.8%
White	19%	54%	27.2%	38.3%
Latino	26%	21%	29.8%	13.8%
API	-	-	5.5%	2.2%
Native American	5%	3%	0.5%	0.8%
Other	-	-	1.0%	0.1%
Unknown	-	-	10.0%	7.1%

e. Health Status

i. Physical Health Problems

Homeless mentally ill persons, especially those with co-occurring substance use disorders, are more likely to have serious medical problems, including malnutrition, diabetes, liver disease, neurological impairments, and pulmonary and heart disease (SAMHSA, 2003a, p. 14). The experience of alcohol addiction and/or a life on the street further compromises the ability of homeless mentally ill persons to access appropriate primary care for chronic conditions. Frequently, these experiences result in more acute (e.g., upper respiratory infections, skin conditions, and serious dental health problems) and long-term conditions (tuberculosis, Hepatitis B and C, and HIV/AIDS) (McMurray-Avila, 2001; SAMHSA, 2003a, p. 14).

ii. Diagnosis

More research needs to be undertaken to further understand and document the nature of mental illness among the homeless population. The reluctance or inability of many

homeless persons to access quality health care certainly presents a barrier for gaining a better understanding of the types of mental disorders that affect homeless persons. Regardless, diagnoses data are available for the general mentally ill population, homeless clients served by DMH in 2002, and AB 2034 program consumers, all of which lead to some interesting findings.

According to HHS, anxiety disorders are the most common mental disorders in adults and have been shown to affect twice as many women as men (HHS, 1999a, p. 225). Anxiety disorders are broad, but include panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder among others. Mood disorders are also common and can greatly impact suffering and productivity, and ultimately lead to suicide. Major depression and bipolar disorder are the most frequent forms of mood disorders, the causes of which tend to be triggered by stressful life events (e.g., loss of family member) or burdensome social conditions, such as poverty and discrimination. Anxiety disorders affect nearly 16% of the general population; slightly less than one-half that number (7%) is affected by mood disorders (Ibid, p. 228).

Among homeless DMH clients, at least those served in 2002, schizophrenia and other psychotic disorders (42.8%) and mood disorders (42.2%) appeared most common, though substance-related and adjustment disorders were also evident in smaller numbers (DMH, 2004b) (see Table 12).

Table 12. Admission Diagnoses among DMH Homeless Clients, FY 2002

Diagnosis	Homeless Clients	% of Total Homeless Clients
Schizophrenia and Other Psychotic Disorders	2,715	42.8%
Mood Disorders	2,676	42.2%
Substance-Related Disorders	345	5.4%
Adjustment Disorders	226	3.6%
Anxiety Disorders	120	1.9%
Other	39	0.6%
Personality Disorders	16	0.3%
Delirium Dementia and Other Cognitive Disorders	28	0.4%
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	27	0.4%
Impulse Control Disorders Not Elsewhere Classified	9	0.1%

iii. Health Insurance

Health insurance remains one of the most important factors influencing access to health and mental health services. According to the U.S. Surgeon General, in 1996 approximately 63% of the U.S. population had private insurance, 13% had Medicare as a primary insurer (with about 7% also having supplemental private insurance), 12% had Medicaid (2% were dual Medicare/Medicaid), and 16% were uninsured (HHS, 1999a, pp. 418-419).

Individuals with severe and persistent mental illness, not to mention the homeless, are typically uninsured and require an intensive amount of services and resources for effective mental health treatment. SAMHSA attributes several reasons for the obvious gaps in coverage for the homeless mentally ill.

For one, outreach and engagement remain difficult while treatment is often not a reimbursable service since clinic and institution-based care endure as more favorable settings than shelters or streets. The homeless are also victims of high case management caseloads, which limits staff contact and monitoring. Furthermore, providers are simply reluctant to serve uninsured persons, despite the fact that they are often eligible for benefits they are not accessing. Even clients receiving Medicaid or Medicare are "unattractive" to providers that receive less reimbursement than they would under a fee-for-service arrangement (SAMHSA, 2003a, p. 18).

Approximately 32% (70,966) of the 220,528 clients served through DMH in FY 2003 were without medical insurance. Of those uninsured, 7% (4,613) were homeless. The homeless uninsured DMH clients tended to be almost entirely adults (92%), and primarily African American (38%), White (36%), and male (80%) (DMH, 2004c).

Due to their low incomes and the high cost of psychiatric and other health services, most insured persons with severe mental disorders rely on Medicare, Medicaid, and other government programs to cover their health needs. Of the 1,110 consumers who were without health insurance upon enrollment in the County's AB 2034 program, 535 (48%) had applied for and received health insurance either through Medicaid, Medicare, HMOs, or VetHealth (DMH, 2004a).

f. Income and Employment

The association of poverty, homelessness, and mental illness has already been noted and is documented throughout numerous studies. Whether as a result of hospitalization or some other circumstance, there is a strong reliance among this population on public assistance as a source of income and coverage.

This fact is understandable since conventional sources of income (i.e., wages through employment) are often unattainable for homeless persons with mental illness. Many are unable to work consistently, if at all, due to their illness, while the jobs they do qualify for are frequently low-paying and without benefits, leaving them likely to return to a life of transience and homelessness (SAMHSA, 2003a, p. 25). Recent research has continued to dispel the myth that employment alone equates to sufficient income and in turn affords other basic necessities, such as housing. Unsurprisingly, among persons with serious mental illnesses, the rate of unemployment hovers at 90% (Ibid, p. 25).

There has been a substantial decline as well in the purchasing power of the poorest of Americans, including the homeless, whose economic stability remains tempered through modest increases in public benefits over recent years. In many instances, these

public assistance programs either continue to be stagnant relative to inflation, trimmed altogether as a result of policymaking, or create disincentives to pursue employment, as has been the concern with Supplemental Security Income (SSI).

Responses from the DMH homeless consumer survey support the notion that homeless mentally ill clients are heavily reliant upon government assistance for income. More than half (56%) of respondents identified public benefits as their income source. Of the entitlement programs accessed by respondents, the county's General Relief (GR) program was most common (37%). Others consisted of SSI/SSA (15%) payments, "other benefits" (e.g., SSDI) (3%), and approximately 1% through the federal Aid to Families with Dependent Children (AFDC) program, now referred to as the Temporary Assistance to Needy Families (TANF) program.

Twenty-two percent of homeless survey respondents reported employment as their source of income, compared to less than 1% who were unemployed and 7% who reported no source of income at all. More than two-thirds (67%) of survey respondents were earning less than $700 monthly, which is well below the federal poverty line (DMH, 1997).

Participants in the county's AB 2034 program also depend on government assistance and demonstrate an increasing utilization of SSI payments for subsistence. Of the 1,669 clients enrolled in the program on January 31, 2004, 25% were receiving GR; 23% were receiving SSI; 2% were participating in TANF; and less than 1% (0.3%) were receiving VA benefits at the time of enrollment.

Since enrollment, however, the amount of AB 2034 participants receiving SSI increased 150% while there was a 79% rise in the number of GR recipients. These are two notable outcomes that indicate that the program is assisting the homeless mentally ill to access available entitlement programs. The program has also shown a dramatic increase in the number of employed participants, which have jumped from 4% to 26% (DMH, 2004a).

g. Criminal Justice System Involvement

Homeless persons with serious mental illness and/or co-occurring substance abuse disorders are frequently in contact with the criminal justice system. In fact, researchers have shown that a person with a mental illness has a far greater chance of being arrested for committing the same offense as a person who does not have a mental illness (SAMHSA, 2003a, p. 16). In Chicago, a review of police encounters found that 47% of people with a mental illness were arrested, while only 28% of individuals without a mental illness were arrested for the same behavior (Teplin, 2000; Bazelon Center for Mental Health Law, pp. 4-5).

Many times legal problems arise through "aesthetic" or "quality of life" misdemeanors (e.g., panhandling, sleeping, public urination, etc.) that result more from a lack of access to adequate housing or mental health services than efforts to ensure public safety. The adoption of "anti-homeless" ordinances is increasing in many of the country's largest cities, as business owners and policymakers look for legislative solutions to

homelessness. However, not all forms of contact with the criminal justice system are as offenders; it is common for homeless persons with mental illness to be victims too, particularly since they are vulnerable to attack and less capable of overcoming the effects of trauma.

Statistics from the U.S. Department of Justice indicate that persons with mental illness accounted for nearly 284,000 inmates in jails and prisons across the country in 1998. This same study found that in the year prior to arrest, there were high levels of homelessness among incarcerated persons with mental illness in the federal prisons (19%), state prisons (20%), and local jails (30%) (Ditton, 1999).

Inmates with mental illnesses are more than just over represented among the corrections system. Besides higher rates of homelessness, they tend to embody many of the factors that place people at risk, such as growing up in foster care; living with a substance-abusing parent; being under the influence of drugs or alcohol at the time of arrest; being the victim of physical or sexual abuse while younger; and being unemployed at the time of arrest (National Council on Disability, p. 44). All of these factors create a tremendous burden on the criminal justice system, where adequate and appropriate treatment models are antithetical to the therapeutic environment required for inmates with mental illness.

One approach to the alarming number of incarcerated persons with mental illnesses or co-occurring substance use disorders has been to divert them to treatment or provide treatment services while in jail or prison. The County's AB 2034 program represents an example of a program that targets persons at-risk of homelessness by intervening and providing mental health services during incarceration. Of the 1,669 participants enrolled as of January 31, 2004, 15% had been on probation at any time in the twelve months prior to enrollment, while 11% had been on parole during this time. Nearly half (45%) of those enrolled had been incarcerated in the preceding twelve month period, in contrast to the 35% who had been previously incarcerated statewide (DMH, 2004a).

2. Environmental Trends

Probably the most notable trend surrounding this population has been the role of psychiatric hospitalization over recent decades. Since the 1960's, stemming from public awareness of the abusive and costly conditions of institutional care, patient dependency, and patients' loss of connection to the community, the locus of care for people with serious mental illness has shifted from the state hospital to community-based alternatives (Bachrach, 1996). The landmark decisions in the cases of *Wyatt v. Stickney*[16] in the early 1970's and *Olmstead v. L.C.*[17] in 1999 remain emblematic of the

[16] With this major impetus for "deinstitutionalization," the Supreme Court established a constitutional right for people confined in state mental institutions to receive treatment for the condition that led to their confinement, rather than merely being warehoused.
[17] The 1999 *Olmstead* decision affirmed that unjustified segregation occurs when persons with mental illness are institutionalized when they can handle and benefit from community settings. The Court stated that this form of confinement constituted a violation of civil rights and diminished daily activities (e.g.,

drive among national policymakers to insist that treatment (and not confinement) for persons with mental illness be provided in the least restrictive setting.

As the public sector attempted to realize "deinstitutionalization" through court orders and legislation, the priorities of psychiatric hospitalization began to reflect the need to mitigate the risk of danger to self and others, and embraced a push to rapidly return patients to the community. Inpatient programs were restructured to focus on those who were too dangerous or unresponsive (e.g., homocidal, suicidal or decompensating) for community-based care. Accordingly, inpatient services emphasized safety measures, crisis intervention, acute medication, reevaluation of ongoing medications, and reestablishing the client's links to other supports and services (HHS, 1999a, p. 288).

Such interest in addressing the mental health needs for persons who are homeless or incarcerated through community-based approaches precipitated state legislation for the Integrated Services for Homeless Adults with Serious Mental Illness program (AB 34/2034/334). Homeless persons with mental illness are frequently in contact with the criminal justice system and experience high levels of psychiatric hospitalizations and emergency room visits because their mental and physical health needs are only addressed when they reach crisis levels (California Department of Mental Health et al., pp. 1-2). The program's objective is to reduce the number of homeless days, jail days, and psychiatric hospital days experienced by this population, and thus far success and funding for the program have ensued.

Post-enrollment program data through January 31, 2003 indicates tremendous achievement in reducing hospitalization among consumers. Statewide there were significant reductions in the number of consumers hospitalized (42%), the number of hospitalizations (28%), and the number of hospital days (56%) (Ibid, p. 9). Los Angeles County reported a greater decrease in the number of hospital days (63%) despite a slight increase in the number of hospitalizations since enrollment (DMH 2004a) (see Table 13).[18]

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work, education, family relations, etc.), thereby imploring public systems of care to eliminate this needless perpetuation of segregation and its harmful effects.

[18] In response to this local rise in hospitalization rates, the state's annual program report to the California Legislature in May 2003 suggested that the program was enabling some consumers to be hospitalized more than they were, but that program staff were able to limit the length of those hospitalizations through effective discharge planning.

Table 13. Annualized Psychiatric Hospitalizations, Hospitalization Episodes, and Hospitalization Days among AB 2034 Consumers in California and Los Angeles County, by January 31, 2003

Psychiatric Hospitalizations, Hospitalization Episodes, and Hospitalization Days	Number of Consumers: California	Number of Consumers: Los Angeles County
Unduplicated Consumers Hospitalized in 12 Months Prior to Enrollment	1,130	286
Unduplicated Consumers Hospitalized Since Enrollment	652	175
Percentage Increase/Decrease	**-42%**	**-39%**
Number of Hospitalizations in 12 Months Prior to Enrollment	1,837	410
Number of Hospitalizations Since Enrollment	1,316	427
Percentage Increase/Decrease	**-28%**	**4%**
Number of Hospital Days in 12 Months Prior to Enrollment	37,938	12,505
Number of Hospital Days Since Enrollment	16,778	4,600
Percentage Increase/Decrease	**-56%**	**-63%**

3. Support Networks and Evolving Needs

Multiple efforts have been developed in the public sector to address the many needs of homeless persons with mental illness. Mobile crisis services for example, with a multidisciplinary team approach, emerged as one means of providing immediate, comprehensive, and client-centered crisis services and evaluation. Though the goal to minimize the use of hospital resources drove this development, the efficacy of such an approach relied on close coordination among team members and ready linkages to sufficient community programs. Assertive Community Treatment (ACT) represents one example of this type of a "one-stop" approach. This model began in the late 1970's and features practitioners from the mental health, substance use, and social service fields who can address each client's clinical, housing, and rehabilitation needs. Caseloads are kept to a minimum (e.g., 10 to 1) and services are provided around the clock.

Over time, as the need to reduce unnecessary and involuntary institutional care for persons with mental illness became paramount, more innovative approaches arose in conjunction with the evolution of the homeless service delivery system. These support networks include outreach and engagement, supportive housing, consumer self-help and advocacy, consumer-operated programs, family self-help and advocacy, and other "essential" services.

a. Outreach and Engagement

The primary goal of outreach efforts is to connect individuals with long-term services, such as housing, as well as health, mental health, substance abuse, and social services. In another sense, they reduce the need for involuntary services. Outreach services are

now considered to be a linchpin of any supportive service network. Typically, homeless persons with mental illness or co-occurring substance use disorders are in need of intensive services and are reluctant to seek them out. Outreach workers must meet these individuals on their own terms, be flexible, and engage them over extended periods of time before they feel comfortable accessing services and treatment voluntarily. Recent studies have highlighted dramatic success with this type of intervention. Even the hardest-to-reach, most reluctant to accept treatment, with the most severe disorders, have been able to be successfully engaged through outreach, enroll in services, and demonstrate improved outcomes (SAMHSA, 2003a, p. 60).

b. Supportive Housing

Contrary to popular assumptions about the need for more structured living environments for persons with mental illness, there is increasing evidence that providing housing and supportive services is effective in achieving residential stability and improving mental health and recovery from substance abuse (Culhane et al., 2001; Tsemberis and Eisenberg, 2000; SAMHSA, 2003a, p. 61). The success that has been documented is twofold: appropriate housing provides for the safety and stability necessary for adherence and retention in treatment; and well-designed, flexible services provide the support necessary during the delicate transition from homelessness to housing and self-sufficiency.

c. Consumer Self-Help and Advocacy

Consumer self-help groups are also critical forms of support for persons with mental illness or co-occurring substance use disorders. This type of service however is unique in that it is peer-led and based on the benefit that two-way interaction provides for individuals coping with these issues. Self-help groups are proven strategies—an estimated 2-3% of the general population is involved in some self-help group at any one time—that are more noteworthy for the individual empowerment, mutual support, and knowledge they impart on participants (HHS, 1999a, p. 289). Yet these methods are also very effective in decreasing inpatient treatment and hospitalization, reducing substance abuse and mental health distress, and assisting clients to better adjust to their communities (SAMHSA, 2003a, p. 66).

d. Consumer-Operated Programs

Consumer-operated programs extend beyond self-help groups to include drop-in centers, case management programs, outreach programs, businesses, employment and housing programs, to name a few. This approach is built upon the notion that homeless persons with mental illness are more likely to be reached and assisted by a peer than through professional workers. Perhaps it is the immeasurable value of trust and shared experience that propels this approach and explains its increasing presence among support strategies for this population. Either way, the knowledge of the "system" and the "streets," combined with the flexibility and creativity common among peer workers, continues to be an asset in the design and implementation of programs to address a client's crisis and long-term needs.

e. Family Self-Help and Advocacy

Family self-help supports assist families to cope with the strain—interpersonally, socially, and economically—that is placed upon them as a result of the symptoms and behaviors of persons with serious mental illness or co-occurring substance use disorders. Research has shown that such factors can negatively impact a family's resources, thereby creating the need for other family members to be supported so they do not experience additional stress and possibly homelessness.

These types of programs work with family members to educate them about the cyclical nature of mental illness, the possible side effects of medication, and how best to handle symptoms when they become disruptive and troubling. Family self-help models can be more informal, such as those similar to the self-help approach, or more professional and organized, as the case with the National Alliance for the Mentally Ill (NAMI), which has more than 1,200 local self-help groups (affiliates) across the country (HHS, 1999a, p. 292; SAMHSA, 2003a, pp. 74-75). Besides the important role family members play as caretakers, they often devote time, energy and resources to push for better services, increased funding, and more opportunities to improve the lives of family members with mental disorders.

f. Other Services

In addition to these types of supports, homeless persons with mental illness require a host of other supportive services to prevent and minimize the disruptive and distressful elements associated with their disorder(s). It is important to note that some of these services, such as psychosocial rehabilitation, were designed for persons with serious mental illness, while others catered to the homeless population and have been adapted since to accommodate people who have serious mental illnesses and/or co-occurring substance use disorders.

For those who are homeless (or at-risk of homelessness) and live with a mental illness or substance use disorder, the following services are considered "essential" and comprise the backbone of a comprehensive system of care for this population: primary health care, alcohol and drug abuse services, mental health and counseling services, psychosocial rehabilitation, crisis services, income support and entitlement assistance, employment support, and education.

4. Significant Subpopulations

a. Persons with Co-Occurring Disorders (Mental Illness and Substance Abuse)

Homelessness is understandably connected to socio-economic factors, such as sufficient income, poverty, and lack of adequate and affordable housing. It is also influenced by problems of mental illness and substance abuse, which together define a substantial number of homeless persons in the U.S. Those with co-occurring disorders[19], or the "dually diagnosed" as some have labeled them, must deal simultaneously with their compounding and debilitating effects. Often times, people with these conditions use substances to cope with the effects of mental illness, or complicate their mental disorder through substance abuse.

Recent studies have identified substance abuse as both a predictor and consequence of homelessness; it confuses a homeless person's life but also makes it more bearable. This relationship is evident in the high prevalence of substance abuse even among homeless persons without a mental illness. As many as half of all people who are homeless have diagnosable substance use disorders at some point in their lives, though it appears that alcohol abuse is more common (30-40%) than drug use among the homeless (McMurray-Avila, 2001; SAMHSA, 2003a, p. 13). Substance abuse remains a significant barrier for housing stability and is frequently cited by both housing and service providers and consumers as an issue and barrier for homeless persons seeking affordable housing.

Roughly 50% of homeless persons with serious mental illness are affected by substance abuse (Fischer and Breakey, 1991; SAMHSA, 2003a, p. 13). This statistic contrasts sharply with prevalence rates among other populations. Of the estimated 14.8 million adults in the U.S with SMI in 2001, approximately 20% were dependent on abused alcohol or illicit drugs.[20] Among adults without SMI, this rate dropped to 6% (SAMHSA, 2002, p. 5).

In Los Angeles, a study of the utilization of mental health and substance abuse services among the homeless supports the assertion that there is substantial overlap between homeless persons with mental illness and substance dependence. Two-thirds of the more than 1,500 homeless individuals interviewed as part of the study met the criteria for chronic substance dependence, whereas 22% met the criteria for chronic mental illness. Seventy-seven percent (77%) of those with chronic mental illness were also chronic substance abusers (Policy Research Associates, 2001).

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[19] This Plan defines "co-occurring disorders" consistent with the definition used by SAMHSA. Persons with co-occurring disorders are individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other. These disorders must occur within a 12-month period.

[20] According to the National Comorbidity Survey, about 15% of adults with a diagnosable mental disorder have a co-occurring substance abuse disorder, suggesting that persons with serious mental illness are more afflicted than those whose mental illness is not categorized as "serious."

Co-occurring disorders vary widely and can include any combination of two or more substance abuse disorders identified in the Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV). For instance, combinations could include major depression with cocaine dependence, alcohol abuse with panic disorder, multiple drug use with schizophrenia, or even those that are not found on the diagnostic landscape (e.g., binge drinking by people with mental health disorders) (SAMHSA, 2002, p. 3).

There are certain risk factors associated with one disorder that result in adverse outcomes for the other. Researchers have explored these impacts and conclude that there is an increased risk for people with one disorder to develop a co-occurring disorder or become homeless. Homeless persons with co-occurring disorders tend to deny their condition. Furthermore, the abuse of alcohol and street drugs leads to symptom exacerbation and relapse, noncompliance with mental health or substance abuse treatment, higher overall treatment costs, and significantly worse social and occupational functioning (DMH, March 4, 2004). In excess and left untreated, these factors are precursors to suicidal behavior and ideation (SAMHSA, 2003a, p. 13).

Homeless persons with co-occurring disorders are more likely to require intensive treatment and assistance accessing and maintaining a stable living environment. According to SAMHSA, they are more often male, unemployed, and older; experience homelessness for longer durations; and suffer greater distress, demoralization, and isolation from their families (Ibid, p. 14).

The population's comorbidity presents tremendous challenges (and incentives) for the public sector to coordinate care. Their myriad health and social problems cut across multiple systems of care—substance abuse, mental health, primary health care, homeless, criminal justice, and others—which are organized and financed separately. No single system of care is prepared adequately to address singularly the many needs of people with co-occurring disorders. Though this Plan will discuss in further detail some of the systemic barriers to care and housing for this population later in the section titled *Barriers to Accessing and Maintaining Housing,* the need for combined interventions (e.g., integrated treatment) that respond simultaneously to both conditions has received increasing attention in recent years.

C. Characteristics of Persons Living with HIV/AIDS

Persons living with Acquired Immune Deficiency Syndrome (AIDS) confront a deadly disease that is caused by Human Immunodeficiency Virus (HIV), a retrovirus that kills certain infection-fighting cells in the body. HIV is transmitted between people through numerous means, including sexual transmission, sharing injection drug paraphernalia, direct contact with infected blood, perinatal transmission (from an infected woman to her fetus), or neonatal transmission (from infected breast milk to an infant). An individual may be infected with HIV for as long as 10 years before opportunistic infections and/or cancers begin invading the body, or before its effects on the condition of the individual can be observed. Throughout this entire period, the infected individual can transmit the disease to others.

Despite more than twenty years of response to the HIV/AIDS epidemic, it continues to be one of the most serious public health challenges facing California today, according to the State Department of Health Services (SDHS). AIDS diagnoses in California remain second only to New York, and since 1981, when the first cases of the disease were reported, more than 75,000 Californians have died as a result (State Office of AIDS, February 2002).

Two decades of policymaking have certainly mitigated the epidemic's impact, in part because of intense epidemiologic research that has been conducted on this subject. For one, the development of effective drug therapies over time has reduced the number of AIDS-related deaths and slowed the progression from HIV infection to AIDS. As a result new needs have emerged among the population, as a growing number of HIV-positive individuals look to receive treatment and prevention along with other longer-term, non-medical services, such as housing and employment. Indeed, the landscape of AIDS has changed with the epidemic and the responses of the public sector.

This Plan benefits from the wealth of data collection and reporting that have helped to delineate and monitor the extent of this epidemic.[21] Because HIV reporting is relatively new, this section at times presents HIV-specific data, particularly to distinguish between HIV and AIDS, but also to highlight the epidemic's transmission and impact in the County.

The following section therefore discusses HIV/AIDS in Los Angeles County, with respect to race/ethnicity, gender, age, mode of transmission and geographic distribution. These types of estimates provide a basis for further analysis of notable trends in HIV in recent years. Additionally, this discussion concentrates on the epidemic's relationship to health status and economic well-being, as well as other subpopulations—persons with co-occurring mental health or substance use disorders, homeless persons, and undocumented individuals—in which HIV prevalence is of particular concern.

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[21] Primary sources of information used in this section of the Plan include the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, the HIV/AIDS Reporting System database, the Supplemental HIV/AIDS Study (SHAS), and OAPP service utilization data.

1. Demographics

a. Surveillance Rates

According to the State's Office of AIDS (OA), only the State of New York reports more AIDS cases each year than does California (State OA, February 2002). As of December 31, 2003, a cumulative total of 133,858 AIDS cases had been reported statewide. Of these, 79,073 had died, leaving a case-fatality rate of 59%. California accounts for approximately 14% of all presumed living AIDS cases in the United States and Puerto Rico (County of Los Angeles HIV/AIDS Epidemiology Program, January 2004a, p. 1).

One-third of all AIDS cases in California are found in Los Angeles County, where persons living with HIV/AIDS (PLWH/A) represent approximately 5% of AIDS cases in the entire country. The County of Los Angeles HIV Epidemiology Program (HEP) reports 47,628 cumulative AIDS cases in the County, including 28,531 deaths and 19,097 living cases. Accordingly, the case-fatality rate (60%) is nearly identical to state and national figures (Ibid, p. 1) (see Table 14).

In addition to the number of living cases, Los Angeles County estimates another 26,458 diagnosed HIV (non-AIDS) cases, creating a baseline assertion that there are at least 46,500 cases of HIV prevalence. There are an estimated additional 10,000 individuals who are currently infected with HIV but unaware of their infection.

Table 14. AIDS Prevalence in the United States, California, and Los Angeles County (2003)[22]

AIDS Surveillance Figures	U.S.	California	Los Angeles County
Cumulative AIDS Cases	886,575	133,858	47,628
Cumulative Deaths	501,669	79,073	28,531
Living Cases	384,906	54,785	19,097
Cumulative Case-Fatality Rate (%)	58%	59%	60%

b. Race and Ethnicity

National, California, and County of Los Angeles HIV infection and AIDS case reporting show that people of color continue to be disproportionately affected by the epidemic. In 1982, for instance, people of color accounted for less than one-third of all AIDS cases in the country. By 2002, however, studies indicated that people of color (representing close to one-third of the overall U.S. population) accounted for 62% of all PLWH/A (Body Health Resources Corporation, 2002; Shelter Partnership, 2003). Through a closer look at the racial and ethnic divisions of the population, it is apparent that HIV/AIDS is increasingly an epidemic among people of color even if it has affected these groups differently.

[22] Includes all cases reported to the HEP or OA as of December 31, 2003. National figures are reported by the Centers for Disease Control and Prevention AIDS Surveillance Report 2002 (Vol.14) and do not represent enumerations of actual cases for the respective categories. They are point estimates that have been adjusted for reporting delays and for redistribution of cases in persons initially reported without an identified risk, but not adjusted for incomplete scoring.

i. Whites

Demographic shifts in California in recent years have resulted in Whites, for the first time in 2000, comprising less than 50% of California's general population. At the same time, according to the State OA, Whites have represented less than 50% of new annual AIDS cases every year since 1997. In fact, in 2000 and 2001 they accounted for less than 40% of new AIDS cases (State OA, December 2002, p. 12).

This statistic has been true in Los Angeles County as well, where Whites have represented less than 40% of PLWA in 2000 (39%), 2001 (38%), 2002 (37%), and 2003 (37%) (County of Los Angeles HEP, January 2004a, p. 22).

ii. African Americans

The disproportionate impact that HIV/AIDS has placed on communities of color is most evident among African Americans, and can be viewed particularly through cumulate case reports and infection rates. At the end of 2002, for instance, the Centers for Disease Control and Prevention (CDC) estimated that 42% of all persons living with AIDS were African Americans, more than any other racial/ethnic group (Centers for Disease Control and Prevention, p. 14). Moreover, in the United States, African Americans account for more than half (54%) of the 40,000 new HIV infections estimated to occur each year (Ibid, p. 4).

In California, AIDS prevalence among African Americans more than doubles their representation in the state's general population. For example, as of December 31, 2003, there were 133,858 cumulative reported AIDS cases; of that, 23,596 were African Americans. This represents over 17% of all AIDS cases, yet African Americans constitute only 7% of California's population. Prevalence is even greater among all living AIDS cases. The state's most recent estimate is that African Americans represent over 19% (10,656) of all PLWA in California (State OA, December 2002).

In Los Angeles County, African Americans are the most disproportionately impacted population, comprising 9% of the population but accounting for nearly one-quarter (22%) of AIDS cases, and an estimated one-third of HIV incidence (OAPP, 2002, p. 23).

iii. Latinos

The Latino population also continues to be substantially affected by HIV/AIDS, but according to OAPP, they are not disproportionately impacted in relation to their representation among the general population. In terms of absolute numbers, Latinos comprise the largest portion (38%) of PLWH/A in Los Angeles County, but account for nearly half (46%) of the County's residents (County of Los Angeles HEP, January 2004a, p. 19; Los Angeles County Commission on HIV, p. 1-26).

AIDS diagnoses rates in 2002 for Latinos however show similarity to their representation among the general population. Forty-three percent (43%) of AIDS

diagnoses in 2002 occurred among this group, nearly one-third more than the number (30%) of whites diagnosed during that year (County of Los Angeles HEP, January 2004a, p. 19).

Nearly half of all Latinos living with AIDS in the state were diagnosed with AIDS in Los Angeles County (OAPP, 2002, p. 24). For the first time in 1999 Latino representation among new AIDS cases exceeded their representation in California's general population (State OA, December 2002, p. 12).

iv. Asian/Pacific Islanders

To a greater extent than Latinos, Asian/Pacific Islanders (APIs) are also under represented among the HIV/AIDS population. They represent close to 12% of the general population in Los Angeles County—making them the third largest ethnic/racial community in the county—but only 3% of all PLWH/A in Los Angeles County (Los Angeles County Commission on HIV, p. 1-26).

Statewide representation among the general population has continued to incline steadily in recent years, from about 6% in 1981 to over 11% in 2000. Over this same period, however, the percentage of APIs annually diagnosed with AIDS has hovered at roughly 2% (State OA, December 2002, p. 12).

Notably, the State Office of AIDS reports that APIs were the only racial/ethnic group with more AIDS cases in 2001 than in 2000 (Ibid, p. 12). In 2002, APIs accounted for 4% of all AIDS diagnoses in the County (County of Los Angeles HEP, January 2004a, p. 19) (see Table 15).

Table 15. Impact of HIV/AIDS Epidemic on Racial/Ethnic Communities in Los Angeles County

Race/Ethnicity	AIDS Diagnoses (2002)	Cumulative AIDS Cases	PLWA	PLWH[23]
White	30%	47%	37%	19%
African American	22%	20%	22%	31%
Latino	43%	30%	38%	44%
Asian/Pacific Islander	4%	2%	3%	3%

c. Gender

The AIDS epidemic in California and Los Angeles County continues to be predominately among men. Comparisons of statewide and national case data illustrate that the proportion of cumulative AIDS cases among women in California is smaller (7.7%) than in the United States (19.4%) (State OA, December 2002, p. 7).

[23] The percentages of persons living with HIV are from the Commission on HIV's HIV/AIDS Comprehensive Care Plan (2002).

In Los Angeles County, the number of females living with AIDS has remained relatively unchanged in recent years. Since 1994, the proportion of female PLWA has increased slightly from about 9% to 10% in 2001. Males continue to represent about 90% of PLWA (Los Angeles County Commission on HIV, p. 1-23).

Limited information is available regarding the number of transgender PLWH/A given their inability or unwillingness to seek care, due to perceptions of fear of judgment and insensitivity of providers. Yet according to the Commission on HIV, transgenders living with HIV/AIDS may be the most severely impacted subpopulation, with extremely high numbers and rates of co-morbidities. Of an estimated 10,500 transgenders in Los Angeles County, approximately 5% (565) live with AIDS, while another 905 (8.6%) live with HIV (OAPP, 2002, p. 119).

d. Age

The age distribution of persons diagnosed with AIDS in California is similar to that of the nation, where most cases are found among persons 30-39 years of age (State OA, December 2002; County of Los Angeles HEP, January 2004a, p. 19) (see Table 16).

Table 16. National, State, and Los Angeles County AIDS Diagnoses by Age[24]

Age Group (Years)	National	California	Los Angeles County
<13	1%	<1%	<1%
13-19	<1%	<1%	1%
20-29	17%	15%	12%
30-39	45%	45%	39%
40-49	26%	27%	32%
50+	11%	12%	16%

Contrasting the age disparities among recent (i.e., 2002) AIDS diagnoses, cumulative, and living cases in Los Angeles County presents some interesting results. In 2002, AIDS diagnoses occurred predominately among persons ages 30-39 (39%) and 40-49 (32%). There is slightly less parity between these age groups with respect to cumulative cases, where persons ages 30-39 and 40-49 account, respectively, for 44% and 26% of all cumulative cases in the county.

This relationship appears reversed when viewing these disparities from the perspective of living AIDS cases, perhaps an indication of the increased longevity of PLWA since the advent of anti-retroviral therapies in the last decade. Of this group, 28% are between the ages of 30 and 39, while 43% are between 40 and 49 years of age (County of Los Angeles HEP, January 2004a, p. 19) (see Table 17).

[24] National figures are from the Centers for Disease Control and Prevention. Data includes all states but California and runs through 6/30/2001. State figures are from the OA's State of the State Report, 2001 and include diagnoses reported by April 1, 2002. Los Angeles County data is reported in the *HIV/AIDS Semi-Annual Surveillance Summary*, January 2004, p. 19, and includes diagnoses as of December 31, 2003.

Table 17. Age Disparities among AIDS Cases in Los Angeles County

Age Group (Years)	AIDS Diagnoses (2002)		Cumulative AIDS Cases		Persons Living with HIV/AIDS	
	No.	%	No.	%	No.	%
<13	<5	-	246	1	42	<1
13-19	13	1	223	<1	60	<1
20-29	182	12	7,718	16	737	4
30-39	616	39	21,141	44	5,410	28
40-49	501	32	12,376	26	8,170	43
50-59	185	12	4,397	9	3,570	19
60+	62	4	1,527	3	1,108	6

e. Mode of Transmission

Though HIV transmission can occur through different means, infected persons are exposed primarily through sex between men (MSM), heterosexual contact, injection drug use (IDU), and MSM/IDU. The epidemic both in California and Los Angeles however has been consistently confined to MSM. Between 3-10% of California residents are gay men, according to the California HIV Prevention Plan, yet generally, MSM constitute nearly three-quarters (69% and 70% respectively) of cumulative AIDS cases (OAPP, 2002, p. 25). Statewide cumulative reports through December 31, 2001 also indicate transmission through IDU (10%), MSM/IDU (9%), and heterosexual contact (5%) (State OA, December 2002, p. 14). Los Angeles County follows a similar pattern (County of Los Angeles HEP, January 2004a, p. 19) (see Table 18).

Table 18. AIDS Case Rate Percentages and Exposure Categories, Reported by December 31, 2003, Los Angeles County

Exposure Category	Year 2002 Cases	Cumulative Cases	Living Cases
Male-to-Male Sex	52%	70%	64%
Injection Drug Use	7%	7%	7%
MSM/IDU	5%	6%	6%
Male-to-Female Sex	7%	5%	7%

f. Regional Variation

The geographic profile of HIV/AIDS in Los Angeles County offers policymakers the opportunity to target resources to specific regions of the county where infected persons must have proximate services. Case data from the county's HEP continues to identify SPA 4 (Metro) as the largest epicenter, with SPA 8 (South Bay), SPA 2 (San Fernando), and SPA 6 (South) also assuming large roles in the epidemic. The large concentration of PLWH/A in these areas confirms that the epidemic's impact remains far from equally distributed throughout the County (County of Los Angeles HEP, January 2004a, p. 15) (see Table 19).

Table 19. Geographic Profile of AIDS in Los Angeles County

Service Planning Area	AIDS Diagnoses (%) in 2003	Cumulative AIDS Cases (%)	Living Cases (%)
SPA 1 (Antelope Valley)	1	1	1
SPA 2 (San Fernando)	13	14	14
SPA 3 (San Gabriel)	8	7	7
SPA 4 (Metro)	34	39	39
SPA 5 (West)	5	6	6
SPA 6 (South)	11	10	10
SPA 7 (East)	7	6	7
SPA 8 (South Bay)	20	15	17

Note: Percentages may not total 100% due to rounding

Two areas of the county, San Fernando Valley and San Gabriel Valley, display an under representation of PLWA in relation to the general population. SPA 2 (San Fernando) and SPA 3 (San Gabriel) each possess approximately 19% of County's residents, but only 14% and 7% respectively of the its AIDS population. On the other hand, PLWA are significantly over represented in Metro Los Angeles. SPA 4 (Metro), for instance, has nearly 40% of PLWA in the County but only 13% of its population. OAPP notes that in most SPAs, the percentage of PLWA is similar to the percentage of persons living with HIV (Los Angeles County Commission on HIV, p. 1-27).

g. Income and Poverty

Considerable research has been pursued to understand the burden that poverty places upon households that struggle to meet basic subsistence needs, such as food, housing, and health care. As will be discussed later, HIV/AIDS, both the transmission and management of the disease, can be seen as one of many barriers experienced by impoverished households. In Los Angeles County, PLWH/A are disproportionately impacted by poverty, a threshold that is defined each year, at least statistically, by the U.S. Department of Health and Human Services.

According to federal poverty guidelines for FY 2003, the poverty level was $8,980 for a one-person household; $12,120 for a two-person household; and $15,260 for a three-person household. Census data further indicates that this threshold defines a substantial number of households in California and Los Angeles County, where reports show respectively that 20% and 18% of residents live below this level.

Because these guidelines have long been considered too low to truly define poverty, researchers and policymakers often frame this issue in terms of the percentages of household income that are above or below (e.g,. 200% or 300%) the federal poverty thresholds (or FPL) to more accurately describe the economic well-being of the general population. With this approach, clearly a large number of households in Los Angeles County can be considered "poor." Some 39% of the general population in the county earn 200% or less of FPL (Los Angeles County Commission on HIV, p. 1-34).

The Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey of PLWH/A in Los Angeles County affirms the notion that HIV and AIDS follow poverty, with 52% of respondents reportedly living below the poverty level. Combined with data from OAPP's client database, it is estimated that over 90% of the PLWH/A who receive Ryan White CARE Act-funded care live below 300% FPL, which represents the typical baseline income level for clients eligible to receive CARE Act-funded services (Ibid, p. 1-34).

h. Health Status

Persons living with HIV/AIDS are severely challenged to maintain their health during the progression of the disease. It is not surprising therefore that health outcomes among this population are persistently lower than counterparts in the general population. This discussion looks at medical insurance rates, but also how impacted the population is by other HIV-related diseases—sexually transmitted diseases, tuberculosis, and hepatitis C—that commonly afflict them.

i. Health Insurance

Health coverage has been linked to increased access to health care and serves as an important indicator of whether people are connected to a health care system that can address their health needs. In fact, among families in Los Angeles County with incomes below 300% FPL—an eligibility determinant for participation in the Medi-Cal or Healthy Families programs—nearly 25% are uninsured at any point in time, the highest uninsured rate in the state. Even in California, merely 57% of low- and moderate-income non-elderly adults and children who lack insurance for the entire year report having a usual source of care for which to rely on for medical purposes (Brown et al., p. 2).

In addition, studies have proven that children and adults who are uninsured during part or all of the year are more likely to use community, public, and hospital-based clinics for care than those with continuous coverage. In Los Angeles County, more than 350,000 low-income people (most with little or not health insurance) use these facilities for their health needs despite that the county has fewer free and community clinics per 100,000 people than anywhere in the state (OAPP, 2002, p. 35).

Since CARE Act-funded programs serve as a "payer of last resort," service utilization data provided by the Commission on HIV provides great insight into understanding health insurance rates among low-income PLWH/A. OAPP estimates that between 30-40% of the population does not have insurance. Among insured respondents from the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, most (52%) relied on MediCal, and a quarter (26%) on Medicare as their primary source of health coverage, more than double the level (13%) of respondents who reported private insurance (OAPP, 2002, p. 35; Los Angeles County Commission on HIV, p 1-35).

The geographic profile of persons without health insurance in the county appears concentrated in SPA 6 (South) (47%) and SPA 4 (Metro) (43.5%), followed by SPA 7

(33%), all areas with a high prevalence of AIDS and a large proportion of Latinos. Indeed, the lack of coverage has adversely impacted communities of color. Of the uninsured, 49% are Latinos, 25% are APIs, 19% are African Americans, and 18% are Whites (Los Angeles County Commission on HIV, pp. 1-34,35).

ii. Sexually Transmitted Diseases

Because HIV is progressive in nature and is associated with an increased risk of contracting sexually transmitted diseases (STDs), TB, and other morbidities, PLWH/A are likely to suffer from more than simply HIV or AIDS. The following section reviews briefly a few of the common illnesses among the population.

Since the AIDS epidemic began, researchers and health practitioners have documented a close epidemiologic relationship between HIV/AIDS and STDs, which generally are considered an indicator of high-risk unprotected sexual behavior. In turn, numerous studies have affirmed that persons engaging in high-risk unprotected sexual behavior are at an increased risk of HIV infection.

These concerns are especially acute in Los Angeles County, where STD rates are among the highest in the nation. According to OAPP, in 2002, the total rate per 100,000 of the population per year was 14.5 cases of syphilis (an increase of approximately 200% since 1999), 79 cases of gonorrhea and 332 cases of chlamydia (both showing approximately 20% increases since 1999) (OAPP, 2002, p. 28).

Persons who have STDs are at higher risk, ranging from a twofold to fivefold chance, of HIV infection. For example, by 2002 Los Angeles County had identified a total of 217 cases of syphilis, 57% of whom were co-infected with HIV (Ibid, p. 29). STDs appear most endemic among men who have sex with men (MSM).

iii. Tuberculosis

County DHS reports that TB is the single most common opportunistic infection for people with HIV. Fortunately, the overall rate of tuberculosis in Los Angeles County has steadily decreased since 1996 despite slower declines among undocumented and immigrant communities. As persons living with HIV/AIDS are generally more susceptible to TB, those in the county who are foreign-born, persons of color, or low-income appear the most affected. Nearly three-quarters of TB cases reported in 2001 in Los Angeles County were foreign-born.[25]

In 2001, Los Angeles County comprised 32% of all TB cases in California (3,332 cases) and 6.6% of TB cases in the U.S. (15,991 cases). Furthermore, TB rates in the county are double those of the nation (OAPP, 2002, p. 30).

[25] Mexico was the most frequently identified country of birth (33.9% of foreign-born cases), followed by the Philippines (18.3%), China (6.9%), South Korea (6.8%), and Vietnam (6.3%). TB rates appear to be decreasing among Latin American immigrants despite increases among Asian immigrants (OAPP Title I Application, 2003, p. 30).

County TB rates are most common among Latinos (47%) and Asians (36%) while rates among African Americans (9%) appear to be steadily declining (nearly 40% between 2000 and 2001) (Ibid, p. 31). Geographically, TB prevalence varies by SPA but SPA 4 (Metro) accounted in 2000 for more than one-quarter of cases, followed equally (15%) in SPA 3 (San Gabriel Valley) and SPA 6 (South) (Los Angeles County Commission on HIV, p. 1-38). TB rates also have been notably high among homeless persons, which account for roughly 7% of total cases.

Of the 1,046 TB cases reported by DHS in 2001,12.4% were co-infected with HIV. Approximately 21% of the homeless cases were also HIV co-infections (OAPP, 2002, p. 31).

iv. Hepatitis C

Both HIV and the hepatitis C virus (HCV)[26] are transmitted through blood to blood contact (e.g., injection drug use, sharing drug paraphernalia, sexual intercourse, etc.) and are viruses that can successfully evade the immune system. Though about 1 million individuals have HIV in the U.S., nearly 4 million individuals have HCV, equivalent to nearly 2% of the population. It is undetermined the precise number of persons who are co-infected with HIV and HCV, but various studies estimate that approximately 300,000 people with HIV are co-infected with HCV (30%) (National AIDS Treatment Advocacy Project, p. 6).

According to the National AIDS Treatment Advocacy Project (NATAP), HCV progression appears to be more rapid, as much as 2-5 times faster, in HIV-infected individuals compared to those who are only infected with HCV (Ibid, p. 6). In fact, the longer a person has had HIV/HCV, the more likely it is that HCV has progressed. The relationship between these two morbidities still requires more targeted research efforts, as HIV remains better understood and funded than HCV.

Nonetheless, SDHS estimates that approximately 2% of Los Angeles County residents are living with hepatitis C. Infection rates are significantly higher for persons co-infected with HIV or AIDS. The Commission on HIV's Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey indicates that about 15% of PLWH/A have had hepatitis C, though among IDUs, this rate was 50% (Los Angeles County Commission on HIV, p. 1-37).[27] OAPP estimates that roughly one-quarter of recently incarcerated and PLWH/A with a history of homelessness report having had hepatitis C.

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[26] HCV is a liver disease caused by infection with the hepatitis C virus. HCV is spread by contact with the blood of an infected person, and can cause liver inflammation and scarring (fibrosis). Disease progression can result in increasing inflammation and scarring.

[27] Intravenous drug use seems closely connected to HIV and HCV since both can be transmitted through dirty needles. It is estimated that 60-90% of people who contracted HIV from intravenous drug use also have HCV (NATAP, p. 6).

2. Environmental Trends

The emergence of the AIDS epidemic more than two decades ago has wrought a number of significant shifts among the populations and locations it has affected. Many of these trends can be understood through the same types of demographic and population characteristic analyses that were presented in the previous section. Indeed, each of these criteria (e.g., surveillance rates, race/ethnicity, gender, mode of transmission, etc.) illustrates significant and varying impacts of the epidemic.

a. Surveillance Rates

i. Case Reports and Death Rates

The State OA indicates that reported AIDS cases have continued to decline each year since 1993, including a 14.4% decline from 2000 to 2001 and a 8.1% drop during the year after (State OA, December 2002, p. 9).

Los Angeles County has also experienced declining AIDS case reporting over the last decade.[28] According to HEP, the number of AIDS diagnoses decreased by 55% (1,935 cases) between 1995 and 2002, while the number of AIDS fatalities decreased by 83%. The AIDS case-fatality rate also declined substantially during this time, from 78% in 1995 to 29% in 2002 (County of Los Angeles HEP, January 2004a, p. 3) (see Table 20).

Table 20. Cases, Deaths, and Case-Fatality Rates of AIDS by Year Reported by December 31, 2003, Los Angeles County

Year	Cases Diagnosed	Deaths Occurred	Living Cases	Case-Fatality Rate (%)
1995	3,497	2,722	11,029	78
1999	1,778	711	15,472	40
2002	1,562	454	18,480	29

ii. Race/Ethnicity

Despite encouraging trends for case reports and death rates, these declines have not been equal among all racial/ethnic groups. With respect to newly diagnosed cases, OAPP reports that the AIDS rate among Whites has fallen more quickly than among communities of color. Between 1994 and 2001, for example, the AIDS rate among Whites declined more than 75% while the decline among communities of color has been smaller for African Americans (65%), Asian/Pacific Islanders (58%), Latinos (52%), and Native Americans (41%) (Los Angeles County Commission on HIV, p. 1-11).

[28] In February 2004, the Director of the county's HEP expressed caution about the declining trend in HIV incidence in Los Angeles County. This admonition was based upon HEP's observance that the annual number of new AIDS cases diagnosed in the county rose 0.5% between 2001 and 2002, primarily among White and API men. Though this counters declining incidence rates for several years, the Director cited the improvement in AIDS reporting in July 2002 as one possible explanation for the apparent increase in AIDS diagnoses in 2002 and urged restraint in basing conclusions or suggesting tends on this rise.

The rate of decline in AIDS-related mortality has also been unequal, particularly for African Americans. For instance, since 1998, death rates have stabilized for all racial and ethnic populations, but African American death rates continue to be three to five times higher than for Whites and Latinos. The Los Angeles County Commission on HIV attributes this disparity to the disproportionate impact of HIV/AIDS in the African American community and continually high numbers of new cases (Ibid, p. 1-9).

As diagnoses and deaths appear to be decreasing steadily in Los Angeles County, conversely, the number of persons living with HIV/AIDS (or so-called living cases) continues to rise each year. Between 1995 and 2002, the number of living cases increased 67%, from 11,029 cases to 18,480 cases over this period (see Table 19).

Analyses of the racial profile of persons living with AIDS in recent years also yield some notable shifts. In 1996, HEP reports that PLWA were predominately White and to a lesser extent Latino. By 2002, however, the number of White PLWA dropped at a similar rate as the increase in the number of Latino PLWA. Thus, the most recent estimates from the county indicate nearly equal numbers of White and Latino PLWA, while African American PLWA continue to represent a little less than one-quarter of the overall population. The proportion of Asian and American Indian/Native Alaskan PLWA has remained relatively constant (County of Los Angeles HEP, January 2004a, p. 22) (see Table 21).

Table 21. Racial Profile of PLWA in 1996, 1999, and 2002, Cases Reported by December 31, 2003, Los Angeles County

Year	White	African American	Latino	Asian	American Indian/ Native Alaskan
1996	45%	21%	32%	2%	1%
1999	40%	22%	35%	2%	1%
2002	37%	22%	38%	2%	1%

iii. Gender

As stated previously, males continue to represent about 90% of PLWH/A in Los Angeles County, yet recent incidence rates reveal an increasing presence of females among the newly diagnosed. Females living with AIDS have increased by more than 40% since 1994, according to OAPP, compared to a 20% increase among men during this period (Los Angeles County Commission on HIV, p. 1-23). Furthermore, HEP reports that in 2002 women represented only 8% of cumulative cases, but 11% of living cases and 13% of cases reported that year (County of Los Angeles HEP, January 2004a, p. 19). These figures bolster the assertion that HIV/AIDS is increasingly affecting females in the county (see Table 22).

Table 22. Gender Profile of AIDS Cases, Reported by December 31, 2003, Los Angeles County

Year 2002	Males (%)	Females (%)	Total Cases (%)
Diagnoses	1,362 (87%)	200 (13%)	1,562 (100%)
Cumulative	43,891 (92%)	3,737 (8%)	47,628 (100%)
Living	17,083 (89%)	2,014 (11%)	19,097 (100%)

Moreover, there have been underlying trends within each gender type, specific to race/ethnicity, that reflect the overall demographic transformations of the County's HIV/AIDS population.

According to the State Office of AIDS, African American males and females continued to have the highest annual AIDS incidence rate among all racial/ethnic groups in 2001. The incidence rate for African American females was triple that of Native American females, six times higher than among Latinas, and over ten times that of White and API females (State OA, December 2002, p. 10). Since 1997, in fact, over 20% of all African American AIDS cases in California have been female, eclipsing the percentage of females among all other races/ethnicities (Ibid, p. 12). Otherwise, Latino males continue to report higher incidence rates statewide than men who are White (at least since 1997), Native American, or API (Ibid, p. 11).

Turning to Los Angeles County, and based upon HEP case reports from 2002, it is also clear that there are discrepancies in prevalence and incidence rates among race/ethnicity figures for each gender, especially African Americans. The absolute numbers of AIDS cases among women remain relatively small, with roughly equal numbers of Latinas and African American women, demonstrating the severely disproportionate impact on African Americans (OAPP, 2002, p. 23). In 2002, for instance, African American females accounted for 34% of all diagnoses, 37% of cumulative cases, and represented 36% of female PLWA in the county (County of Los Angeles HEP, January 2004a, p. 19) (see Table 23).

Table 23. 2002 Female AIDS Rates by Ethnicity, Cases Reported by December 31, 2003, Los Angeles County

Race/Ethnicity	Year 2002			Cumulative		Living		
	No.	%	Rate	No.	%	No.	%	Rate
White	32	16	2	848	23	387	19	25
African American	67	34	13	1385	37	724	36	140
Latino	92	46	4	1389	37	844	42	38
Asian	8	4	1	85	2	40	20	6

Notably, African American males had the highest AIDS case rate in Los Angeles County in 2002, more than double rates for Latinos and Whites (Ibid, p. 19) (see Table 24). The case rate among Latino men, on the other hand, surpassed that of White men in 1998 (Ibid, p. 6) (table not included).

Table 24. 2002 Male AIDS Rates by Ethnicity, Cases Reported by December 31 2003, Los Angeles County

Race/Ethnicity	Year 2002			Cumulative		Living		
	No.	%	Rate	No.	%	No.	%	Rate
White	432	32	29	21662	49	6704	39	443
African American	281	21	63	8342	19	3406	20	763
Latino	585	43	26	12665	29	6395	37	282
Asian	56	4	9	921	2	446	3	72

iv. Mode of Transmission

While MSM remains the most frequent mode of exposure, the percentage of AIDS cases attributable to this method of exposure is declining state and countywide. Among this risk group, AIDS prevalence rates continue to outpace incidence rates in Los Angeles County, where the percentage of MSM living with AIDS has decreased from 68% in 1994 to 64% in 2002 (County of Los Angeles HEP, p. 22; Los Angeles County Commission on HIV, p. 1-22). Despite this downward trend, MSM are expected continue to represent the vast majority of PLWA for the foreseeable future. MSM, like others in the epidemic, are increasingly represented by communities of color (County of Los Angeles HEP, January 2004a, p. 22).

The proportion of heterosexual IDUs has also remained constant in recent years, though the proportion of heterosexual (non-IDU) living with AIDS has increased from 5% in 1994 to 7% by the end of 2001. In terms of sheer cases, the number of heterosexual PLWA has risen by 60%, representing one of the largest increases in PLWA of any risk group over the past three years (Los Angeles County Commission on HIV, p. 1-23).

v. Regional Variation

The disparate impact of HIV and AIDS across geographic lines in Los Angeles County has already been described, but there are significant regional patterns that have emerged over the course of the last decade. These trends underscore increasing percentages of AIDS cases in South Los Angeles County, particularly the South Bay-Long Beach area, where rates have accelerated the most since 1995. Conversely, there has been a lower percentage of annual AIDS diagnoses in SPA 4 (Metro) and SPA 5 (West), though this decline has tapered in the last few years (County of Los Angeles HEP, January 2004a, p. 15) (see Table 25).

Table 25. Percentage of Annual Cases of AIDS, 1995-2002, Reported by December 31, 2003, Los Angeles County

Service Planning Area	1995	1999	2002	Cumulative
1 – Antelope Valley	1%	1%	1%	1%
2 – San Fernando	13%	12%	14%	14%
3 – San Gabriel	7%	7%	9%	7%
4 – Metro	37%	34%	33%	39%
5 – West	6%	4%	3%	6%
6 – South	9%	13%	11%	10%
7 – East	7%	7%	7%	6%
8 – South Bay	16%	18%	20%	15%

3. Support Networks

Persons living with HIV/AIDS are supported through a variety of housing and supportive service networks in the County of Los Angeles. The federal Ryan White CARE Act provides financing for at least a portion of nine special needs housing programs, administered by OAPP, that specifically target this population. The following section provides an overview of these programs, which are predicated on HIV status and specific housing or service needs, as well as housing supports available through the federal Housing Opportunities for Persons with AIDS (HOPWA) program, administered locally by the City of Los Angeles Housing Department (LAHD).

a. Licensed Residential Housing Programs

The OAPP administers six licensed residential housing programs for PLWH/A, as follows: Adult Residential Facilities, Congregate Living Health Facilities, Substance Abuse Inpatient Detoxification Facilities, Substance Abuse Residential Rehabilitation, Substance Abuse Transitional Housing, and Residential Care Facilities for the Chronically Ill.

Adult Residential Facilities (ARFs) are state-licensed residential programs that provide 24-hour non-medical care and supervision[29] to adults with symptomatic HIV disease or AIDS. These facilities are geared towards indigent individuals, including persons who are homeless or at-risk of homelessness, and generally accept individuals from county health facilities, other public or private health facilities, and contracted case management agencies.

Congregate Living Health Facilities (CLHFs) are also state-licensed residential programs that provide 24-hour care to persons with symptomatic HIV disease or AIDS residing in Los Angeles County. Yet CLHFs are inpatient programs for persons who

[29] Care and supervision have been defined by OAPP as the ongoing assistance with activities of daily living without which a resident's physical health, mental health, safety, or welfare would be endangered.

have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both.[30] Services provided to CLHF inpatients include residential services, medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, and social/recreational services. Providers are certified as a nursing facility in order to comply with Medicare and Medi-Cal regulations.

PLWH/A with chemical dependencies can access **HIV/AIDS substance abuse inpatient detoxification services** to assist indigent individuals with an HIV or AIDS diagnosis with the physiological removal of the noxious or intoxicating chemicals on which he/she is dependent. In accordance with federal and state standards, these programs are state-licensed as Chemical Dependency Recovery Hospitals. Participants in the program are allowed to reside in the facility for a maximum of ten days.

The County also administers an **HIV/AIDS Substance Abuse Residential Rehabilitation** program to assist individuals to achieve and maintain a lifestyle free of substance abuse. Service are provided in a 24-hour residential setting within a structured program of no less than six hours of planned treatment activities per day under the supervision of trained staff. These programs are state-licensed as Adult Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities. Programs are for indigent persons, diagnosed with HIV or AIDS, who require a structured, controlled treatment environment because of the severity of the impairment caused by their substance abuse. Though most residents participate in the program for less than six months, the maximum length of stay is eighteen months.

Persons with HIV/AIDS and substance use disorders are also able to access the county's **HIV/AIDS Substance Abuse Transitional Housing** program. These services are designed to facilitate the ongoing recovery from substance abuse impairment, so that the client can move toward more independent and permanent housing. The program targets indigent, homeless (or at-risk) residents of the county, who have successfully completed a substance abuse detoxification and/or rehabilitation program. Residency is limited to four months.

Residential Care Facilities for the Chronically Ill (RCF-CI) provide 24-hour care and supervision to adults, family units, and/or emancipated minors who have symptomatic HIV disease or AIDS.

b. Non-Licensed Residential Housing Programs

In addition to these licensed residential programs, OAPP administers two residential housing programs for PLWH/A—the Residential Emergency Housing program and the Residential Transitional Housing program—both of which are operated by contracted nonprofit organizations.

[30] OAPP defines terminal illness as a life expectancy of six months or less. A life-threatening illness is one that can lead to a possible termination of life within five years or less.

The **Residential Emergency Housing** program provides emergency housing of no more than one month to HIV+ persons who have no form of housing and require immediate placement. Participants may be homeless due to a loss of public benefits (e.g., General Relief), discharge from a hospital or prison with no identified residence, or eviction from other housing. Lengths of stay range from one night to four weeks to stabilize clients so that they can effectively seek more permanent living arrangements. Housing can be provided in SRO hotels or through nightly vouchers. Homeless persons, persons with TB, persons with mental illness, substance abuse disorders (or both), families with children, and the post-incarcerated are all targeted through the program.

The **Residential Transitional Housing** program also provides short-term housing, between two and four months, along with case management and counseling services to ensure that residents progress towards permanent housing.

c. HOPWA Programs

Aside from the CARE Act-funded programs identified above, there are several forms of support provided to the county's HIV/AIDS population through the HOPWA program. If the CARE Act can be seen as the primary funding source for "service-oriented" programs for this group, such as outpatient medical services, the HOPWA program can be conceived as the principal source of housing-related subsidies that are targeted to the population. HOPWA is administered by LAHD on behalf of the entire County of Los Angeles, otherwise referred to by HUD as the Los Angeles-Long Beach Eligible Metropolitan Statistical Area (EMSA).

The following components currently comprise the Los Angeles HOPWA program: housing information and referral services, emergency housing and meal vouchers, short-term rent, mortgage, and utility assistance (STAP), move-in grants, housing case management services, lease, operating, and supportive services in emergency and transitional housing, supportive services (both within and independent of affordable housing programs), and TB control and risk mitigation.

More information on CARE Act- and HOPWA-funded programs is provided in Section VI.

4. Significant Subpopulations

Persons living with HIV or AIDS are constantly challenged to manage their own health and well-being, even in light of tremendous medical advances that have proven to mitigate symptoms or forestall the onset of full-blown AIDS. Certain PLWH/A, however, must also struggle with other issues and needs, such as substance abuse or homelessness, which ultimately have a compounding and debilitating effect on their ability to cope with the epidemic.

In some instances, as is the case for persons with mental illness, the sobering reality that an HIV diagnosis can bring can be enough to create an emotional or mental imbalance. In other circumstances, behaviors such as substance abuse can itself be the source of

HIV transmission. So, the connection is dynamic between HIV/AIDS and these other experiences. The following discussion sheds light on their reciprocal nature.

a. Persons with Substance Use Disorders

Substance abuse remains a common co-occurring disorder among PLWH/A. Injection drugs, such as heroin or crystal methamphetamine (meth), define a very vulnerable population often found to be poor, homeless, mentally ill, and/or have HCV or STDs. As discussed previously, these experiences and/or morbidities place individuals at far greater risk for HIV exposure. But the relationship between substance abuse and HIV also includes non-injection drugs, such as marijuana and party drugs (e.g., ecstasy and poppers), that create risk through their relation to unsafe sexual practices.

Yet beyond transmission, this relationship also encompasses complications that emerge when substances inhibit effective HIV/AIDS medication regimens. Alcohol and drugs, including methadone, have a high probability of interacting with most anti-viral medications and subjecting their therapeutic properties to extremes.[31] Drug interactions also compromise the efficacy of anti-viral medications by interfering with stomach absorption, altering the metabolism in the liver or kidney, or causing unnecessary side effects (Falkner & Kosel, p. 1).

Data from the Los Angeles County Commission on HIV indicate that the IDU rate among PLWH/A ranges from 10-26%, with nearly double (21-42%) that many reported to use other, non-injection drugs (Los Angeles County Commission on HIV, p. 1-33). A recent Shelter Partnership study affirms these estimates, as 38% of survey respondents reported some type of active substance abuse, mostly alcohol (40.6%), but also crack (8.1%) and crystal meth (7.8%) (Shelter Partnership, 1999, p. 26).

b. Persons with Mental Illness

Increasingly, research has evidenced a relationship between mental illness and HIV, both in its effect on the course of HIV disease and as a longstanding affliction that can contribute to the high-risk behaviors that lead to HIV infection.

The *Los Angeles County HIV/AIDS Comprehensive Care Plan* documents a substantial presence of mental illness among consumers of OAPP services. Nineteen percent (19%) of clients in the OAPP service utilization data report a history of mental illness, while nearly 33% of respondents to the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey were identified as severely mentally ill (Los Angeles County Commission on HIV p. 1-114). As a comparison, sixteen percent (16%) of respondents in Shelter Partnership's 1999 study indicated that they had a mental illness (Shelter Partnership, 1999, p. 25).

[31] For example, the anti-viral medication may reduce the effects of methadone, which would lead to symptoms of withdrawal, or increase the effects of methadone and promote sleepiness.

Within the mentally ill, HIV/AIDS population, the Los Angeles County Commission on HIV has been able to delineate some notable trends along demographic and geographic lines. Based upon findings from the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, SMI persons living with HIV/AIDS were more likely to be male (76.5%), older than other PLWH/A, White, IDUs (40%), and reside in SPA 4 (Metro) (Los Angeles County Commission on HIV, pp. 114-115).

Additionally, this group tended to be poor (97% earn 300% of FPL each year), have less than a high school education (53%), live alone, report higher rates of medical insurance than other PLWH/A, and have lived with HIV or AIDS for longer than 12 years. Unsurprisingly, SMI are likely to report higher substance use than other PLWH/A, primarily alcohol and/or marijuana, though more than one-quarter (26%) report using crystal meth, close to double the rate (14%) of other PLWH/A (Ibid, pp. 115-117).

c. Homeless Population

Like its relationship to substance abuse and/or mental illness, HIV can also be a precursor or a consequence of homelessness. Yet regardless of whether a person was diagnosed with HIV before or after becoming homeless, undoubtedly, the ability to manage the illness and achieve housing stability is complicated by the dual and adverse impact of each condition. These intersecting problems are visibly reflected through estimates of homelessness, as well as the presence of poor health outcomes (including TB prevalence), substance use disorders, and mental illness among PLWH/A.

i. Number

Statistics from OAPP and the Los Angeles County Commission on HIV certainly provide a numerical basis for the connection between HIV and homelessness, where figures from different data sets suggest that the homeless comprise between 10-20% of the county's HIV/AIDS population. Most recently, an estimated 14% of all PLWH/A in the county are considered homeless (Shelter Partnership, 2003, p. 17).

In Los Angeles County, the following data sources confirm these estimates: 1) SHAS interviews identified 10% of PLWA as either homeless at the time of diagnosis or have become homeless since learning of their diagnosis; 2) OAPP service utilization data showed that about 10% of PLWH/A have a history of homelessness; 3) according to the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, 20% have been homeless sometime in the last two years; and 4) 2003 Countywide Risk Assessment Survey (CRAS) responses, collected from clients of HIV prevention providers, indicated that 12.6% were homeless (Los Angeles County Commission on HIV, pp. 1-37; OAPP, March 2004).

Among the newly diagnosed, homelessness is reportedly higher. In 2000, fifteen percent (15%) of the individuals newly diagnosed with AIDS were homeless. More than one-quarter of CARE Act clients (26.3%) were homeless at intake (OAPP, 2002, p. 40). The Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey affirms this trend and indicates that among the PLWA diagnosed in 2000 or

later, 19% are currently homeless and an additional 37% report living in some form of transitional housing (Los Angeles County Commission on HIV, p. 1-40).

Shelter Partnership's 1999 study also confirmed a strong relationship between HIV and homelessness. Based on its findings, 65% of survey respondents had been homeless at some point in their lives. For respondents who had reported being homeless at one point in time, nearly half (46%) were currently homeless. Moreover, up to 50% of the respondents who were not currently homeless believed they were at imminent risk of becoming homeless (Shelter Partnership, 1999, p. 27).

The *Los Angeles County HIV/AIDS Comprehensive Care Plan* described some other characteristics of the population that emerged from recent planning and research efforts. Accordingly, homeless PLWH/A are more likely to: have had HIV for less than one year (13%), live in SPA 4 (36%) or SPA 8 (22%), be male (78%), identify as African American (39%), have some college degree or higher (40%), have been incarcerated in the last two years (52%), and be unemployed (33%) compared to the general HIV/AIDS population (Los Angeles County Commission on HIV, pp. 1-110,111).

More updated homeless demographic information was also available through OAPP's service utilization data. As of March 2004, there were approximately 25,000 individuals accessing CARE Act services, including 1,546 (6%) individuals identified as homeless.[32] Together, they present a snapshot profile of homeless PLWH/A within the county. These clients were more likely to be male (77%), African American (47%), between the ages of 40-49 (39%), HIV+ (51%) but not AIDS-diagnosed, and earn annual incomes below 100% FPL (83%).

Significant numbers of homeless clients reported through OAPP service utilization data also had histories of substance abuse (62%, with 42% with active use in the last year), mental illness (39%, with 11% active within the last year), and incarceration (37%, including 23% within the last 24 months) (OAPP, March 2004).

ii. Health Status

The pivotal role that housing stability assumes among health concerns for persons living with HIV/AIDS has been the subject of intensive research and recently caught the attention of federal policymakers attempting to model innovative interventions to break the cycles of homelessness for certain PLWH/A.[33] Despite these ongoing efforts to investigate and document their mutual impacts, there is little question that without stable housing, the benefits of comprehensive health care, including HIV treatment, are severely limited, if present at all.

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[32] OAPP noted that the number of homeless clients is likely higher since this figure relies on client self-reporting.

[33] In January 2004, the federal government officially launched a multi-site, multi-agency (HUD and CDC) research collaboration to examine the impact of providing housing for homeless or unstably housed people living with HIV on their disease progression and their risk of transmitting HIV. Approximately 1,000 people living with HIV will be recruited across three national project sites, including Los Angeles, to participate in this 18-month study.

Indeed, the poor health outcomes common among homeless PLWH/A are in many ways related to their housing instability. Homeless men and women face a variety of barriers to accessing health care, including the following: lack of awareness of services and resources, lack of medical insurance, competing subsistence needs, lack of transportation, suspicion of health care institutions, and resistance from providers due to the stigma of homelessness (Shelter Partnership, 2003, p. 18).

Other health concerns, such as tuberculosis (TB), hepatitis, and STDs appear closely related to HIV and homelessness. High TB rates among homeless persons are often attributed to the conditions found in many homeless facilities, where overcrowding and poor ventilation can be common (Ibid, p. 19). Persons confronted with AIDS or HIV, whose immune systems are further compromised, can be particularly susceptible to TB infection.

Studies nationwide suggest that latent TB prevalence can be extremely high among homeless PLWH/A, ranging from 32-67%, whereas others have documented active TB prevalence between 5-50% (Song, p. 20). Based on the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, homeless PLWH/A in Los Angeles County have the highest rates of reactive TB tests (29%, compared to 16% of the general PLWH/A) and active TB (6%) (OAPP, 2002, p. 116).

Approximately one-quarter of respondents to the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey had been diagnosed with hepatitis A, B, or C in the last two years. In the two years prior to the survey, seventeen percent (17%) had yeast infections, 10% had syphilis or chlamydia, and 4% of the homeless report having been diagnosed with gonorrhea (Los Angeles County Commission on HIV, p. 1-112).

iii. Substance Abuse

Substance abuse has been a longstanding concern among HIV/AIDS and homeless providers since active substance abuse has been linked with the lack of access to HIV care and poor adherence to anti-retroviral therapy (Song, p. 8). Forty percent (40%) of the respondents in Shelter Partnership's 1999 study who had been homeless at some point in their lives reported some type of substance use, primarily alcohol (42%). Over 56% of the homeless PLWA from the SHAS interviews reported substance use (Los Angeles County Commission on HIV, p. 1-39). These rates are consistent with the presence of large numbers of homeless PLWH/A in SPA 4, a region characterized by severe poverty, HIV infection, injection and non-injection drug use and severe alcohol abuse.

There are substantial numbers of homeless clients utilizing OAPP services who have reported using substances within the past six months. The county estimates that that 40% of homeless PLWH/A are addicted to both alcohol and drugs (OAPP, 2002, p. 117). Recalling the previous discussion about modes of HIV transmission, the risk of exposure through injection drug remains a primary concern for homeless PLWH/A.

Nearly one-fifth (19%) of homeless consumers of OAPP services feel they contracted HIV through their injection drug use history (Ibid, p. 1-112). Moreover, according to the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, twice as many (44%) homeless respondents said they had injected drugs in their lives in comparison to the total PLWH/A sample. Both crystal meth (44%) and crack (25%) were the most frequently used substances among the homeless sample (Ibid, p. 1-112).

In terms of non-injection drug use, nearly half (46%) of the homeless respondents had consumed alcohol within the last six months, with 10% drinking once a week or more. Thirty-eight percent (38%) had used marijuana during the last six months, while close to one-fifth (17%) reported its use at least once a week (Ibid, p. 1-112).

iv. Mental Illness

Homeless PLWH/A are also more apt to have been diagnosed with mental illness than other PLWH/A, according to OAPP, which again confirms the high degree of co-morbidity among this segment of the population. Between 25-50% of the total homeless population is severely mentally ill with conditions such as schizophrenia, depression, and/or bipolar affective disorder (OAPP, 2002, p. 117).

Homeless PLWH/A, at least since their HIV diagnosis, are also frequent consumers of mental health services. OAPP reports that 56% of the homeless have received mental health services since their diagnosis: thirteen percent (13%) had received inpatient mental health services, 42% had received group counseling or professional therapy, and 50% had received individual counseling or therapy with a professional (Los Angeles County Commission on HIV, pp. 112-113).

d. Undocumented Population

According to the Immigration and Naturalization Service (INS), of the 5 million undocumented immigrants estimated to reside in the U.S. each year, nearly half (2 million) are found in California (Los Angeles County Commission on HIV, p. 1-120). Conservative estimates place the County's undocumented immigrant population at roughly one-third to one-half that of California's. Yet enumeration efforts are hampered because undocumented immigrants with HIV/AIDS are unlikely to reveal their immigration status, an unwillingness that is compounded by the fear and stigma associated with HIV (Ibid, p. 1-120).[34]

Nevertheless, clearly there are substantial numbers of undocumented immigrants with HIV/AIDS that rely on the CARE Act- and HOPWA-funded systems in the County for medical care and housing. One CARE Act-funded agency serving mostly Latinos reported that 30-40% (about 350 individuals) of their clients is undocumented, while another agency serving the Asian community reported that undocumented clients represent 20% of their caseload (OAPP, 2002, p. 129).

[34] Most studies have shown that the incidence of HIV for foreign-born adult residents is lower than for the U.S. born (OAPP, 2002, p. 128).

Most of the regional demographic data on undocumented PLWH/A comes from the Los Angeles County Commission on HIV's Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, which included 18 undocumented respondents. With this limited sample of participants, no generalizations can be made. However, despite the small sample size, the responses reveal significant information about a population that has been largely ignored in most demographic and epidemiological profiles.

For instance, sixteen respondents identified as Latino, including twelve as Mexican. Other findings indicate that undocumented PLWH/A tend to be: younger (mean age 35) than other PLWH/A (mean age 43), have no medical coverage, have less formal education, have annual earnings below 100% FPL, identify as heterosexuals, and reside in either SPA 4 (Metro) or SPA 8 (South Bay) (Los Angeles County Commission on HIV, p. 1-120).

With respect to housing stability among these respondents, undocumented PLWH/A appeared more vulnerable to homelessness than other types of respondents. Twenty-eight percent (28%) had been homeless in the past two years, compared to 20% among all PLWH/A. Undocumented respondents were also less likely to report stable, secure, or habitable housing. Only 55% of the undocumented PLWH/A felt that their current housing situation was stable, in contrast to 87% of all PLWH/A (Ibid, p. 1-120).

IV. BARRIERS TO ACCESSING AND MAINTAINING HOUSING

A. Overview

The pursuit of affordable housing for persons with special needs remains extremely challenging despite concentrated local efforts to increase the stock of dedicated special needs housing and ensure sufficient access to housing placement assistance services. Even for individuals fortunate enough to have succeeded during the housing search phase, the ability to live independently and maintain that housing can be equally difficult. Housing policies that concern the special needs populations under review in this Plan must therefore account for the many barriers they face while searching for and living in decent, safe, and affordable housing.

Regardless of need, there are barriers, such as the scarcity of affordable housing and pervasive discrimination, that can be considered universal to all special needs populations engaged in the process of securing or retaining housing. There are other common barriers that compromise housing access, some of which are specific to the individual while others are systemic. These include adequate marketing and awareness of housing resources, previous contact with the criminal justice system, and the limited number and capacity of affordable housing developers that serve these populations.

The process of maintaining one's housing can also be a struggle, primarily because housing expenses are increasingly out of reach for low-income and special needs individuals. The devotion of precious energy and resources (e.g., security deposits and move-in expenses) in just securing housing leaves tenants, even those with stable employment, with minimal income to afford the ongoing costs of rent and utilities, at least without modest financial public assistance.

Beyond these financial barriers, housing stability can be tenuous for special needs populations without access to supportive services, including case management, mental health care, primary medical care, and vocational training. Individuals with special needs are also in need of legal assistance to protect themselves from undue discrimination or unjust evictions and generally to educate them about their roles and responsibilities as tenants.

The purpose of the following section, therefore, is twofold: 1) to discuss two common barriers—housing affordability and discrimination—that appear universal to all special needs populations; and 2) to highlight some of the more notable barriers that have a unique impact on each of the three populations under review. In no way does the following discussion attempt to provide an exhaustive list of all the barriers—some are more subtle than others—that limit access to or retention in housing. With this in mind, the reader should be aware that certain barriers affect both housing access and retention, while others are more situated towards clients searching for housing. Where possible, these distinctions are made to further the reader's comprehension.

B. Universal Barriers

1. Housing Affordability

For the thousands of low-income persons living with disabilities and special needs in Los Angeles County, the pursuit for safe, decent, and affordable housing[1] is unattainable simply because of the burgeoning housing crisis that impacts nearly every housing market in the region. This is a crisis of national proportion, fueled by extreme poverty and ballooning rent levels, that further distances those most in need, such as the subjects of this Plan, from the one asset that can help them to achieve stability and a sense of belonging: a home.

The issue of housing affordability is far from novel and in fact dates back several decades. During the 1970's, there was little consideration evident in federal housing policy to avert this looming crisis, precipitated in large part from the substantial reconversion of the nation's affordable housing stock, steady decline in federal affordable housing expenditures, and increased demand for such housing, particularly from persons with disabilities (Technical Assistance Collaborative, 2003). Over time, these factors, along with the rise in rental costs and population growth connected with the region's strong economy in the previous decade, have continued to define the affordable housing crisis as a widening gap between the County's vibrant housing market and the incomes of its poorest residents.

The lack of affordable housing has therefore created a number of other housing problems for households within the County, such as low vacancy rates, cost burdens, and overcrowding. Vacancy rates for both the City and County of Los Angeles have declined since 1990 and remain low, at 4,6% and 5.3% respectively, while the County reports twice as many low-income households than affordable units (Wotapka, 2004; City of Los Angeles, 2003; Riches, 2002). In addition, nearly 23% of renter households in the County are severely cost-burdened, meaning they pay more than 50% of their monthly income to housing expenses (Community Development Commission of the County of Los Angeles, 2003). The squeeze in the local housing market has also meant more people living in housing units across the County, where a reported 18.8% of all households in the County are considered overcrowded (Ibid, p. 3-35).

One illustrative means to view the affordable housing crisis more closely is through a comparison of monthly income provided through the federal Supplemental Security Income (SSI) program and the median rent levels determined annually by HUD. The use of SSI in this case is important because a significant number of Los Angeles County residents (6%) receive their income through this program, which is often identified as the federal "safety net" program for low-income people with disabilities.[2] Using HUD's annual Fair Market Rents (FMRs) as a general benchmark for median rents in the County, it is clear that even modest rental housing remains unaffordable to this population.

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[1] For the purposes of this Plan, "affordable housing" refers to housing that costs no more than 30% of a household's annual gross income.

[2] This statistic was obtained using the information from the 2000 U.S. Census (*see* www.census.gov).

In 2004, continuing a trend beginning two years earlier across the county, the average rent for a one-bedroom unit in Los Angeles County exceeded (102%) the amount of income provided to SSI recipients. Using the 30% benchmark for affordability, therefore, persons with disabilities who are receiving SSI but not any long-term rental assistance were effectively priced out of the rental housing market, as they would need to dedicate their entire income to afford modest rental housing. This burden is also exacerbated when you consider that at least half of the rents in the County exceed HUD's FMR determinations.

Moreover, the County is witnessing disproportionate increases in incomes relative to rental costs. Between 1999 and 2004, SSI benefit amounts in California rose by 23% while local one-bedroom FMRs increased by 37%. Figure 1 shows the local FMRs for both efficiency and one-bedroom units and the amount of income a SSI recipient would need to pay to afford this housing at 30% of monthly gross income.

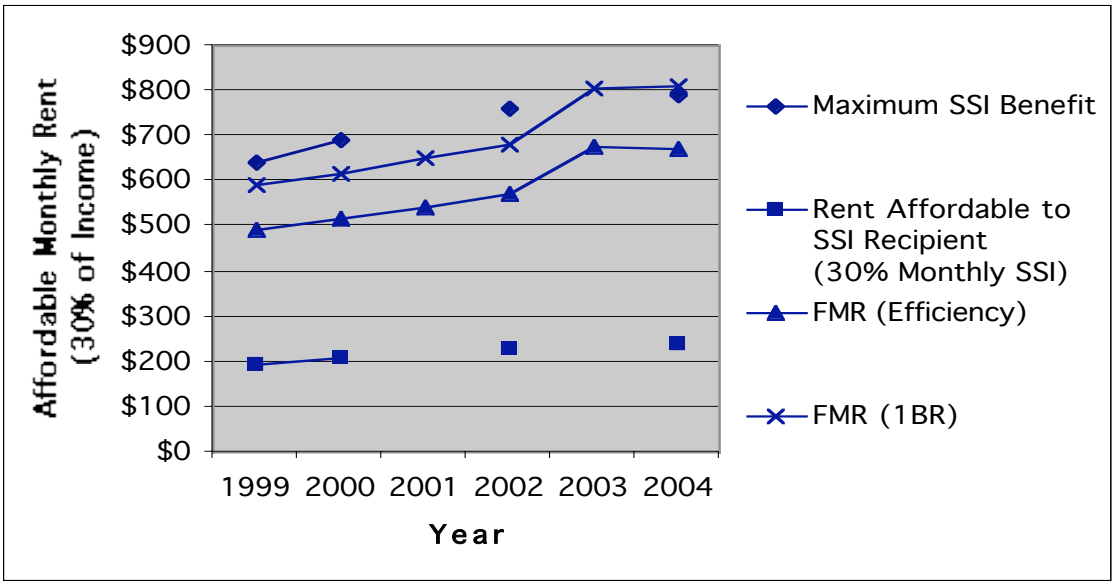

Figure 1. Maximum SSI Benefit and HUD FMR's (2000-2004)

As noted earlier, persons with special needs, including those accessing SSI income, are at the lowest rungs of the economic ladder. According to HUD, the 2004 area median income (AMI) for a one-person household in Los Angeles County ($53,500) is more than five times as much as the annual income for a SSI recipient ($9,480). Even households earning 30% ($16,050) or 50% of AMI ($26,750), considered respectively by HUD to be extremely low-income or very low-income, earn far more than those on SSI.

These disparities have serious implications for the portions of income that these groups need to dedicate to limit housing expenses to 30%. Figure 2 shows that aside from SSI recipients, even persons at 50% of AMI still cannot afford the one-bedroom FMR in the County. Yet, even FMRs are not truly reflective of the bulk of rents found throughout the County, which further underscores the degree to which housing is out of reach for

special needs populations. Even a household earning 100% of AMI would barely meet HUD's affordability benchmark to afford the average market rent ($1,337.50) in Los Angeles County (Wotapka, 2004). Or, put another way, half of the County's residents are unable to afford average rents (see Figure 2).

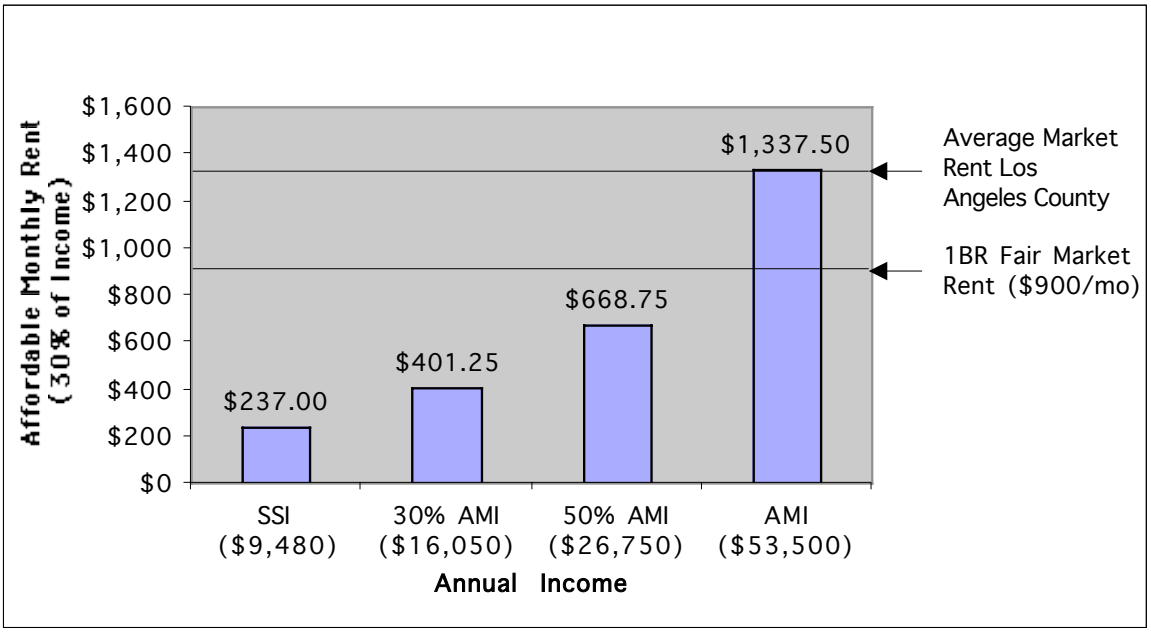

Figure 2. Rents Affordable to Households at Median Income and Below in Los Angeles County

Additional comparisons of SSI income and local rents indicate that persons receiving SSI income need to more than triple (341%) their income to afford a decent one-bedroom unit in 2004; and increase their incomes by close to 600% to afford even the average rent countywide. This finding is derived from the housing wage, which measures the amount of income per hour that full-time workers must earn to have their rental housing costs be affordable (see Table 26).

Table 26. SSI Benefits Compared to the Housing Wage

	Zero BR FMR ($674)	One BR FMR ($807)	Two BR FMR ($1,021)	Average Rent Countywide ($1,338)
Housing Wage	$12.96	$15.52	$19.63	$25.72
Housing Wage as Percentage of Minimum Wage[3]	192%	230%	291%	381%
Housing Wage as Percentage of AMI	50%	60%	76%	100%
Housing Wage as Percentage of SSI	284%	341%	431%	564%
Percentage of Population Able to Afford Housing	76%	71%	62%	50%

All of these different ways to view the issue of affordable housing in Los Angeles County substantiate the tremendous need for additional financial resources to help special needs populations access the housing they need. The primary source of federal rental assistance, the Housing Choice Voucher (or Section 8) program, despite its history of serving extremely low-income households, has been seen by HUD over the years as consuming too much of the agency's annual budget. Recent changes to the program, specifically those concerning funding formulas for public housing agencies (PHAs), have resulted in drastic shifts at the local level, including not issuing any new vouchers to eligible households and increasing the amount of rent that participating households must contribute to the total monthly rent.

With such a profound role in meeting the housing needs of thousands of households in the County, any change to the Section 8 program poses severe consequences for persons with special needs. For one, as the FMRs continue to lag behind the current rents charged in the private rental market, property owners participating in the program are compelled to "opt-out" of the program, knowing that they can receive significantly more rent on their own. Second, many of these Section 8 tenants cannot find comparable housing in their own neighborhoods and must move far away from their children's schools and friends and from the family's network of community support. This phenomenon actually counters HUD's policy of de-concentration of minority and low-income households, as these residents are forced to relocate to lower-income, minority neighborhoods to afford housing (City of Los Angeles, 2003, p. 33).

2. Discrimination

Despite advances in both federal and state fair housing protections in recent years, the considerable discrimination and stigma encountered by special needs populations persists as a major impediment to accessing affordable housing and appropriate services. Often, this opposition is directed at the prospective renter due to their special need or disability.

[3] For the purposes of this analysis, minimum wage equals the State of California minimum wage ($6.75/hr.).

In some cases, the landlord's discrimination is more overt, consisting of a simple denial of admission to an individual or family or an unjust eviction. In other instances, the community is vocal in resisting the provision of housing to special needs or homeless populations in their neighborhood.[4] Still, in other cases, this discrimination can be less obvious as policymakers steer funds away from housing initiatives that serve controversial populations (SAMHSA, 2003a, p. 24). Regardless of the source, all of these scenarios illustrate the potent level of opposition confronted by persons with special needs as they search for suitable housing and residential stability.

a. Landlord Opposition

The reluctance or refusal of landlords to lease available properties to special needs populations is a grave concern derived from several factors. One common perception among landlords is that persons with a history of foster care, probation, mental illness, homelessness, or HIV/AIDS, will need 24-hour supervision. This concern is reinforced by the notion that such individuals require intensive physical and behavioral health care. Only recently have housing providers begun to see that the benefits (both client-specific and cost-related) of supportive housing far outweigh the negative outcomes and long-term loss achieved through their longstanding insistence that more supervised, structured, and group-oriented arrangements are more appropriate placement for these clients.

Another concern of landlords is the perceived threat to building and personal safety because of criminal activity on the part of special needs tenants. There is substantial stigma and fear associated with housing for emancipated foster youth and homeless persons with mental illness because landlords associate these populations with violent behaviors. Certain studies have concluded that selective media reporting can contribute to the connection between violence and the homeless, mentally ill, though the risk of violence they pose is small (HHS, 1999a; Mulvey, 1994; SAMHSA, 2003, p. 26). In the focus groups with County departments, participants also noted that property managers express concern that their clients are associated with gang activity.

As agents responsible for lease-up and building operations, landlords are understandably quite concerned with the financial and physical security of their properties. Especially for the homeless, special needs populations have difficulty producing satisfactory credit reports or documenting sufficient income to meet security deposit, move-in, and rental expenses required in the current housing market. Any suggestion that a prospective renter might not be a good tenant—as evidenced through criminal histories, spotty or nonexistent records of tenancy, or limited income due to unemployment or public assistance—creates further disincentives for property managers to offer admission to these populations.

[4] This common practice, referred to as NIMBYism (Not In My Backyard), remains a significant force of resistance to housing homeless and disabled populations, especially as affordable housing developers seek to site and develop future special needs housing programs. The tremendous level of community opposition to such developments is enough to "kill" a project or leave special needs housing developers disinterested in pursuing similar projects.

The discrimination and stigma exhibited by landlords is circumscribed by regulatory barriers that further restrict access to appropriate and affordable housing. Few housing landlords (public or private) are willing to rent to persons who are actively using drugs or abusing alcohol. Recent adjustments to federal housing policy provide authority to housing providers to deny admission or proceed with eviction if a person is using illegal drugs. To the benefit of persons with histories of drug-related criminal activity, some local housing authorities (e.g., HACLA) have exercised discretion on this federal mandate, by conditioning admission upon participation in some intensive mental health and/or drug and alcohol-related treatment programs.

The complications that discrimination and stigma by housing providers bring to the challenge of securing suitable housing have a great impact on the client's willingness to pursue available resources. In the end, clients facing discrimination often internalize what they have experienced, leading to fear, mistrust, and the disinclination to seek the housing and supports they need (SAMHSA, 2003a, p. 26).

While the theme of landlord discrimination resonated throughout the numerous focus groups conducted for this Plan, other concerns were expressed by respondents about property management as follows: 1) client privacy is violated as property managers share personal information about other tenants; 2) program or building guidelines vary and are inconsistent across properties and property managers; 3) certain units are without cooking facilities or often in need of repairs that are rarely addressed; 4) families with children, especially large families, have difficulty with property managers; and 5) property managers tend to only see prospective tenants during a specific time that is often irrespective of the client's schedule or needs.

Participating youth also raised the issue of discrimination during their focus groups. They felt this discrimination was directed at them by both landlords and neighbors due to their status as emancipated foster youth and their participation in a "program;" their reluctance to "rock the boat" or call attention to themselves; and their age and lifestyles (e.g., music, noise, etc.).

b. Neighborhood 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 in which communities across the country display their unwillingness to assist individuals with the greatest needs. This issue remains at the forefront of the affordable housing crisis for special needs populations and represents one of the greatest challenges for both consumers and developers of special needs housing (Galster et al, 2000). 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 (Community Acceptance Strategies Consortium et al., 1999).

The NIMBY mentality and the inability to garner community support for special needs 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 (Federal Task Force on Homelessness, 1992; Conrad et al., 1993). The Los Angeles Housing Department, in its 1996 analysis of impediments to fair housing choice, cited NIMBY opposition and zoning barriers as significant barriers to securing sites for housing persons with disabilities in middle class communities (Savage, 2002). Likewise, NIMBYism was identified during the focus groups, especially among the County employees, as one of the principal systemic barriers preventing special needs populations from obtaining and maintaining permanent housing.

Although its roots have been described as longstanding, dating back to the colonial period when communities generally were averse to assisting transients and vagabonds, NIMBYism appears driven by multiple concerns on the part of both homeowners and local businesses: that supportive housing programs will have an adverse impact on the property values of proximate homes, on the incidence of violent and property crimes, and on the quality of life in their communities.[5]

In modern times, these stereotypes have manifested themselves in the form of local resident opposition to siting affordable, special needs developments in residential neighborhoods. Neighborhood residents and groups tend to be very well-organized and feel many times that affordable, special needs housing developers are working exclusively to pursue their objectives. They furthermore point to the subsidized housing that nonprofit community development corporations (CDCs) create as independent pursuits that are "developer-driven" rather than "neighborhood-driven" (Goetz et al., p.9). Their opposition can take the form of picketing, physical threats, and verbal harassment in public community meetings.

Community opposition to the development of the Positive Match Program, for instance, which serves homeless and marginally housed HIV-positive single mothers and their children in the Bernal Heights neighborhood of San Francisco, centered around the fear that client children would come into contact with neighborhood children and that disease would infect the neighborhood through water or sewage (Health Resources & Services Administration, 2001, p. 16).

Los Angeles County has also had its share of NIMBY battles in recent years. One contentious project, a planned residential facility for mentally disabled emancipated foster youth in the San Gabriel Valley, mobilized significant resident opposition during its development. Community members staged a community-wide protest, complete with lawn signs, incendiary rhetoric, and threats. To counter this resistance, a collaborative consisting of the CDC, DMH, DCFS, local jurisdictions, and a nonprofit housing developer/service provider, united and refused to capitulate. With a broadened outreach strategy in consultation with local officials, the situation was eventually diffused and the project moved forward. Yet the most notable outcome of this NIMBY battle was less the project's completion so much as the precedent it set that

[5] See Polis Consulting Group, Inc.'s *An Analysis of the Supportive Housing Development Capacity in Los Angeles County*, September, 2003, which offers historical insight on NIMBYism and its impact on local housing development.

community opposition to special needs housing may be extremely hostile, and in some cases illegal, but not insurmountable.

In some cases, gaining community acceptance for proposed affordable, special needs housing requires concessions on the part of the developer or project sponsor. Project New Hope's Jack H. Plimpton New Hope Apartments represents one example despite great local demand for permanent HIV/AIDS housing. The originally planned site of the project had to be abandoned after intense neighborhood opposition, leading the sponsor to identify the Silver Lake neighborhood on the east side of Los Angeles, where public reception would be stronger.[6] Project New Hope staff canvassed the new neighborhood, going to door-to-door to discuss the proposed site, and enlisted some residents to participate in plan modifications as the development design progressed. The final design included neighborhood requests for two additional off-street parking spaces, a pitched roof, a residential (not apartment) façade, and substantial landscaping. Ultimately, the neighborhood supported required zoning variances.

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 trepidations reflect economic concerns and the substantial investment in their homes held by homeowners and the notions they have about subsidized housing and what form that housing will take.

In 2000, the Urban Institute conducted research to further assess the impact of supportive housing on property values (e.g., sale prices of single property homes) and the rate of reported violent, property, and other crimes in a specific geographic area. This study, despite its concentration in Denver, found that among eleven supportive housing sites, the area within 1,001 to 2,000 feet of any site experienced both an increase in general level of prices and an upward trend in house prices relative to the prices of similar homes not near such facilities (Galster et al., p. 5-1). In fact, this finding highlighted a relative decline in housing prices (compared to elsewhere in the census tract) that existed in these areas prior to the presence of the supportive housing site. Regarding crime impacts during the same study period, the author did not find differences in the rates of any type of reported offenses between areas where supportive housing was developed and in other, "control" areas in Denver (Ibid, p. 5-2).

Other research efforts have affirmed that subsidized housing, including developments serving persons with special needs, can be a net plus to communities and can actually help improve the very concerns often cited by NIMBY proponents. One study in the central neighborhoods of Minneapolis found the following: proximity to nonprofit-developed subsidized housing actually enhanced property values at a rate of $0.86 per foot; less evidence of crime (police calls or criminal events) after the subsidized buildings were developed; and, contrary to popular assumption, improvements in

[6] This area of Los Angeles was chosen because it was in the same price range; the neighborhood has a history of supporting HIV/AIDS issues; several PNH staff, board members, and colleagues live in the neighborhood; it met the criteria of providing housing on the east side of Los Angeles; and the demand for HIV/AIDS housing in Silver Lake was a high regional priority (Health Resources and Services Administration, 2001).

indicators of neighborhood stability, as the tenants of subsidized nonprofit projects demonstrated less transience than other renters in the neighborhood projects and for the most part had already lived in Minneapolis prior to moving into their subsidized units (Goetz et al., 1996).

Two others are worth noting here. Professor George Galster at Wayne State University, has also found that prior studies have overestimated the negative impact federally assisted housing has on property values. His unique methodology measures property values both before and after the construction of affordable housing, which allows for a more comprehensive assessment that accounts for property values in the neighborhood that may have already been declining before the housing was built. Another study on Low-Income Housing Tax Credit developments in Madison, Wisconsin also challenges conventional wisdom by asserting that properties near LIHTC developments actually appreciated more rapidly.

c. Local Government Resistance

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 they represent the confluence of interests and policies that surround this issue. Their support however 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 (Community Acceptance Strategies Consortium, p. 7).

Elected officials must grapple with the urges of their constituencies—fears of declining property values, neighborhood instability, and decreases in the quality of life—and concerns about the impact of the Fair Housing Act on zoning and land use decisions. Local policymakers must also respond to an aging and deteriorating multifamily housing stock in the County's urban centers. But they also face the emerging consensus that supportive housing or community living is more beneficial and cost-effective than institutionalization or incarceration, and court decisions enforcing the rights of disabled persons under the Fair Housing Act.

Moreover, the various government agencies charged with fulfilling the directives of these politicians are integral as well, since they must approve or deny permit applications for subsidized or otherwise affordable housing. 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.

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.[7] 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.

During the last decade, these new laws altered dramatically the landscape of affordable housing development for special needs populations and granted increased flexibility for local policymakers to alleviate the challenges of obtaining and maintaining housing for persons with special needs. Yet with this profound shift in housing policy came an increasing tension among local officials to balance affordable housing production with the risk of facing controversy for serving special needs populations.

This conflict rests at the core of the struggle for cultivating more political will and sponsorship for special needs, if not simply affordable, housing. The worsening affordable housing crisis has increased awareness among constituents and public officials about the importance of building more affordable rental housing. At the same time, when it comes time to approve proposed projects, many are hesitant to offer consent because they fear they will lose the support of local citizens.

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 are 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 with 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).

According to the Technical Assistance Collaborative (TAC), which surveyed approximately 600 PHAs nationwide in 1999, the vast majority of state and local housing officials do not give a high priority to the housing needs of people with disabilities. Only 10% of state/local housing officials, 18% of PHAs, and 26% of state/local housing finance agencies have made housing for people with disabilities a "high priority" for funding in their communities (Technical Assistance Collaborative et al., 2000, p. 25).

Also as part of this same survey, TAC found that PHAs are not aggressively pursuing new housing initiatives that could expand affordable housing opportunities for persons with disabilities and/or special needs. Only 10% of the PHAs that administer the Section 8 program applied to HUD each year for additional vouchers appropriated by Congress through the Section 8 Mainstream Program for Persons with Disabilities (Ibid, p. 17). This finding was consistent with the relatively high number (33%) of surveyed

[7] 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.

PHAs who believe there is no need for additional affordable housing targeted to persons with disabilities within their jurisdiction (Ibid, p. 25).

The apparent unwillingness of local policymakers and officials to prioritize special needs housing can also be seen as a pragmatic response to a complicated issue. Both public perceptions and the overall lack of incentives for pursuing special needs housing continue to shape the public response to date. A recent poll of 1,000 residents in a six-county area in Chicago found that only a very small percentage of respondents express "strong opposition" to affordable housing, suggesting the presence of a "silent majority" of supporters of well-built and managed affordable housing. Yet the bulk of respondents, despite expressing relative support for affordable housing, are still convinced that low- and moderate-income housing is poorly maintained, contributes to crime, and decreases local property values (National Multi Housing Council, 2003, p.4). These concerns may be unfounded but still weigh heavily on the decisions of local government officials who are understandably quite concerned about public perceptions.

The difficulty engaging and obtaining the "buy-in" from state and local elected officials also reflects the direction of federal housing policy to concentrate their housing resources on the "working poor" and "moderate" income households. According to TAC, this leaves no built-in fiscal or policy incentives for government housing officials or affordable housing developers to collaborate on housing for households with the lowest incomes and/or special needs (Technical Assistance Collaborative, p. 14). The so-called "generic" affordable housing programs—CDBG, HOME, and LIHTC—which remain the cornerstones of affordable housing resources, do not target these groups, and thus inevitably attract developments serving higher income tenants whose stability and rental income can offset the low cash flows often associated with affordable housing developments.

Local government therefore 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 their 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.

Less direct examples of local government resistance include changing zoning codes, denials of zoning variance or conditional use permit requests, or failing to comply with state-mandated housing element law.

C. Youth Emancipated from the Dependency and Delinquency Systems

1. Preparation for Independent Living

Perhaps the most immeasurable but significant barrier to accessing housing for emancipating and emancipated youth is their general lack of preparation for and experience with independent living.[8] In fact, housing providers serving emancipated foster youth report increased housing tenure and lease compliance for youth with previous experience in independent living arrangements.[9]

This lack of preparation is compounded and mitigated by some of the same factors that have impacted youth before and during foster care, such as abuse, neglect, mental and emotional disturbances. For some former foster youth, these issues are exacerbated by an aversion to stable living hardened through a life of transience and multiple placements. Moreover, the transition to independent living, even if under some degree of supervision, means that youth can no longer rely on the dependency system to address activities of daily living, such as laundry, grocery shopping, etc.

As a barrier, a lack of preparation or experience with independent living can negatively affect both housing access and tenure. And although independent living services are not designed simply to address what is needed for an emancipating youth to succeed as a tenant, in more circumspect ways they provide the foundations and skills to allow that youth to respond to the challenges they will face while managing their own home.

Nationally, the U.S. General Accounting Office (GAO) reports that roughly 60% of all eligible youth received some type of independent living service in 1998 (GAO, 1999). However, despite access to emancipation services in both the Wisconsin and the Casey foster care alumni sample, the vast majority of the participants expressed concerns about or difficulty in independent living (Pecora et al., p. 20).

The pivotal Westat evaluation found that older youth discharged from foster care had generally not acquired some of the basic resources for future self-sufficiency, including driver's licenses, automobiles, auto insurance, credit cards, checking and/or savings accounts. As these items are less requirements of self-sufficiency than they are indicators, they still provide some insight into the preparation of emancipating youth upon leaving foster care (Westat, p. 4-26) (see Table 27).

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[8] The notion here is that independent living, as it relates to housing access and retention, represents the end of the housing continuum and housing arrangements in which the individual either rents or owns their home.

[9] Mark Kroner's presentation, titled "Foster Outcomes: Stable Housing as an Outcome of Foster Care," at the annual National Alliance to End Homelessness conference, Washington, DC, July 20, 2004.

Table 27. Percentage of Youth Who Had Acquired Basic Resources for Self-Sufficiency

Basic Resources	Percentage of Youth	
	Yes	No
Driver's License	48%	52%
Automobile	32%	68%
Automobile Insurance	65%	35%
Credit Cards	16%	84%
Checking Account	28%	72%
Savings Account	34%	65%

Fortunately for emancipating foster youth in Los Angeles County, DCFS has instituted systematic efforts to provide them a stable transition to independent living, both before and after their discharge from care. Prior to emancipation from foster care, a youth's housing needs, among other life skills needs, must be accounted for in their Transitional Independent Living Plan (TILP).[10] The importance of including housing needs in the completion of the TILP was highlighted in the Design Team for Emancipation Services most recent strategic housing plan. In this plan, caseworkers are recommended to use the TILP as an effective planning tool for housing success.

Subsequent to emancipation, the UFC/Bridges to Independence Transitional Housing Program (THP) serves as a focal point in Los Angeles County's support for this population. In fact, the Bridges program remains in many senses a paradigmatic approach for ensuring that emancipating youth are put on the right track to achieve career goals and housing stability. Of the 257 youth enrolled in Bridges from 1996 to 1999, there were significantly higher education and employment rates than the 710 foster children who emancipated from foster care in the county in 1996.

Bridges graduates were more likely to have completed high school (88% vs. 54%), be currently enrolled in an educational program (55% vs. 22%), be currently employed (55% vs. 32%), and have completed the Independent Living Program (70% vs. 62%) (Kellam, p. 25). Notably, three-fourths of Bridges participants secured stable housing before graduating from the program, with 33% securing their own apartment, 35% with roommates, and 7% in college dorms or military housing (Ibid, p. 20).

Despite these encouraging statistics, these programs are only able to reach a select few. Bridges youth, for instance, must not require psychiatric medications, face active delinquency cases in juvenile court, or have histories of violence or chemical addictions. Thus, the vast majority of emancipating youth in Los Angeles County, including many Probation youth not eligible for ILP serviecs, are left to rely on public- or nonprofit-provided housing placement assistance services or their own wherewithal to stave off the chronic housing instability experienced by many foster care graduates.

[10] Under State law, each foster youth is required to have a completed TILP for success upon emancipation.

2. Housing Placement Assistance

Though housing placement assistance is not defined as a set of specific services, it is nonetheless a common means to refer to the types of supportive services that enable an individual to find and stay housed. It is also an extremely unmet need among the county's emancipating foster youth population, who generally bring with them a host of existing barriers (e.g., early parenthood, victimization, substance abuse, etc.) into an unforgiving local housing market. Without the assistance of a knowledgeable and trained professional who can guide these youth through the housing search process, the likelihood that youth will be able to effectively access appropriate and affordable housing will remain tenuous.

As noted earlier, Los Angeles County does make efforts to account for the housing needs of its emancipating youth through the TILP, transitional housing programs, and alumni services. Yet ensuring their access to appropriate and affordable housing requires that emancipation services be very specific to the many components involved with securing and maintaining housing. This includes a range of assistance, from helping youth with applications for permanent or subsidized housing to educating them about their roles and responsibilities as tenants in a leased unit. Often times, these services are labeled as housing counseling or housing case management.

As a point of comparison, less than one-third of a sample of former foster youth in Illinois reported receiving these types of housing services as part of their overall participation with independent living services (Courtney et al., p. 29).[11] Less than one-quarter (23.8%) were assisted with finding an apartment, learned about security deposits and utilities (22.2%), were trained on tenants' rights and responsibilities (22.2%) or how to handle landlord complaints (17.7%), and assisted with completing apartment applications (15.0%) (Ibid, pp. 29-30).

It is difficult to gauge exactly how inadequate levels of housing placement assistance services limit housing access. Nevertheless, it is clear there is more to gain by carving out these types of services among the array of independent living programs currently available to youth, to provide the skills and tools necessary for housing stability. Both the Design Team for Emancipation Services housing plan and the 2002 Request for Proposals (RFP) for Independent Living Program (ILP) Housing Programs represent attempts to ensure that eligible ILP housing funds are being used for this purpose.

3. Lack of Awareness of Available Resources

One barrier that is pervasive among all special needs groups, but is certainly experienced by emancipating foster youth given their limited resources, is the lack of awareness of available housing. Without adequate knowledge of the housing resources available to them, emancipating foster youth are even less equipped to achieve success,

[11] This figure comes from the *Midwest Study*, a collaborative effort of the state public child welfare agencies in Illinois, Iowa, Wisconsin and the Chapin Hall Center for Children at the University of Chicago. The overall purpose of the project is to gather information about services provided to selected foster youth served in participating states and report on adult self-sufficiency outcomes achieved by youth.

especially during the housing search phase. Indeed, the issue of sufficient access to housing can be seen as beginning with broad access to available housing information, so that emancipating and emancipated foster youth can make educated decisions about which housing options to pursue.

For this purpose, the Design Team also embraced this concept among its recommendations. Their concerns emanated from the estimate that at least two-thirds of emancipating youth who emancipate annually will require some form of housing assistance to prevent homelessness or relocating several times over the first few years of independent living (County of Los Angeles Design Team for Emancipation Services, p. A-4). Promoting greater awareness of available housing resources, however, involves both improving marketing efforts concurrent with aggressively developing a more comprehensive understanding of the resources that exist.

At this time, the thrust of the County's marketing efforts are to ensure that information is accessible online, as well as in written formats (e.g., posters, flyers, mailings), and that marketing materials be accessible to youth where they reside and/or receive services. Moreover, the Design Team emphasized the need for centrally coordinated housing marketing services to more effectively assist youth and caseworkers in finding appropriate and affordable housing. The development and maintenance of a countywide housing program database, to provide detailed information on available beds in emergency shelter, transitional housing, and permanent housing programs, is currently being pursued, and can be used for referrals, planning, and tracking purposes.

The housing program database mentioned above undoubtedly will rely on the success of comprehensive and timely data collection, but will offer emancipating youth a much-needed point of reference for their housing needs. Its success is also somewhat dependent on the County's ability to identify available units and develop relationships with landlords and a pool of housing developers/owners willing to rent to these youth.

4. Support Networks

Another principal concern, related to self-sufficiency and independent living, is the extent to which emancipating foster youth have available to them a support system upon emancipation. Such a system can vary but should include at least a network of resources and strong, permanent relationships from which youth can draw concrete (e.g., finances, transportation, etc.) and emotional assistance.

According to the Westat study, a significant number of youth emancipating from foster care reportedly lack these forms of support. With respect to youth identifying people in their lives who provided strong, close relationships, only 14% indicated that they had such an individual (Westat, p. 4-16). On this note, some pre-emancipated foster youth participating in the focus groups stated that they "have no one to turn to" when they turn 21. Three of the five youth participating in this focus group expressed the need for such support "now," including someone to answer questions and "help sort out problems."

Yet adequate support for this population means more than individual relationships in times of need. It can extend to the very practical side of providing landlords willing to rent to this population with specific guarantees that the two paramount concerns of property managers/owners—the ability of tenants to pay rent and meet the obligations of tenancy—will be addressed. Housing and service providers serving this population have noted that landlords are often hesitant to rent to former foster or Probation youth unless there are supervisory policies in place, such as: access to crisis intervention services, daily visits with staff, limitations on the numbers of allowable guests each night, and weekly group meetings. In the worst of cases, youth service providers should have a back-up living arrangement for those youth who do not succeed in certain independent or transitional living placements.

The presence of a "social network" therefore for these youth can be quite important and is a focus that is appropriately reflected in the Los Angeles County's dependency system. Permanency efforts undertaken by DCFS for instance, and embraced in the Los Angeles Youth Permanency Initiative, are predicated on the integral role that family-like relationships assume in the growth and stability of youth in and leaving foster care. As Sharon Watson stated in her report on this topic, emancipated foster youth express their need for "lifelines as well as life skills," and that "the most important assistance they need to become successful adults is the support of a permanent family or a connection to a caring, committed adult" (Watson, 2004, p. 15).

The important role that a support network assumes for emancipating youth was highly reaffirmed in the consumer focus groups as a reason for success obtaining and maintaining permanent housing. Continued access to friends, families, and supportive services staff after housing placement was identified by both groups as a key resource to avoid the loss of housing.

5. Lack of Financial Resources

Another primary housing need for emancipating youth is access to financial resources, a challenge for any special needs population, but for youth especially. As noted previously, most children living in foster care are from low-income families that are eligible for public assistance. Additionally, they are likely to be unemployed or have poor financial management skills, leaving them with little if no resources as they search for suitable housing. Exacerbated by the typical lack of strong support networks available to emancipating youth to offset their modest economic standing, emergency or short-term financial assistance is in high demand.

This issue endures as a significant gap in the County's current housing assistance programs for emancipated foster youth. Even for students or entry-level workers, it is simply not possible to expect that youth will have secured, at least prior to searching for housing, all of the required rental, deposit, and move-in costs. For this reason, some housing and service providers assist youth, in addition to helping locate an apartment, with these expenses and even co-sign the lease to further alleviate the concerns of property managers.

It is no surprise that the youth focus groups identified poor credit, debts, the lack of money management skills, and no savings as reasons for other emancipated youth having failed to keep their housing. Similarly, certain youth respondents expressed their interest to live with roommates upon turning 21 as one means of alleviating housing costs.

Elsewhere in the country, there is also evidence of the need for financial assistance to ensure that emancipating youth can subsist independently. In the Illinois study, youth were asked if they had received an independent living subsidy that enabled them to live on their own. Of the total study population, under one-tenth (9.5%) reported having ever received an independent living subsidy, and even less (6.3%) indicated currently receiving a subsidy (Courtney et al., p. 29).

Discussions of the Los Angeles County Housing Roundtable for Transitioning Youth have also stressed the need for short-term or emergency financial resources to offset housing costs. Yet according to the Housing Roundtable, these youth need more than the assurance that this resource is available to them. They need it to be flexible and immediate—some advocates say within 72 hours of the request—as youth can suffer during the transition between housing arrangements (e.g., an emergency stay in a hotel or motel or before moving into permanent housing).

For the 20% of emancipating youth who need limited assistance in order to live independently, they may not require much more than this level of support to secure and maintain appropriate housing. Although this group can function without direct supervision, they face imminent risk of homelessness and require additional support to achieve self-sufficiency.

6. Previous Involvement with the Criminal Justice System

The Illinois study endorsed the high presence of delinquent behavior among its sample, and noted that three-fifths of the study youth had come into some form of contact with the juvenile justice system, including half with a history of arrest (Courtney et al., p. 48). Though the study describes lower conviction rates than arrest rates, the impact of a criminal record is severe for youth seeking to establish themselves as self-sufficient adults in the housing market.

D. Homeless Persons with Mental Illness

Historically, mental health systems of care have not prioritized a client's housing needs as part of an approach to effective treatment. But with the growing and documented success of supportive housing (and the cost-savings associated with this model) and the increasing focus by DMH on providing a more holistic, psychosocial level of care, the possibility of independent living for homeless clients has become an appropriate and desirable treatment goal. Accordingly, as this goal becomes realized, it is imperative to identify and alleviate barriers that prevent mental health clients from obtaining a home of their own.

Homeless persons with mental illness are confronted with numerous challenges in their pursuit of and retention of affordable housing. The following issues have been noted persistently by consumers and program administrators: 1) cost of housing; 2) lack of support and independent living skills; 3) lack of financial resources; 4) involvement with the criminal justice system; and 5) access to federal rental subsidies.

1. Cost of Housing

This Plan has already discussed how housing affordability impacts the ability of all special needs populations to access and maintain appropriate and affordable housing. But strong reliance of homeless persons with mental illness on public assistance for income and medical support, particularly SSI, means that housing in safe, pleasant neighborhoods is beyond their economic means. Moreover, persons with psychiatric illnesses, not to mention histories of homelessness, are simply not competitive in the eyes of landlords who are more likely to lease available units to someone who does not look or act "different" or live on a fixed income.

2. Lack of Support and Independent Living Skills

The ability to effectively maintain an apartment or house can depend largely on the presence of a support system, which generally is lacking for this population. Homeless persons with mental illness typically fear or mistrust public agencies and may be traumatized by the experience of homelessness rendering them unable to cope with anything other than basic survival needs. Their willingness to engage in services and to remain in treatment also reflects (and is affected by) the limited service options they feel are available to them and any negative experiences they may have had with previous treatment efforts. This issue of "client-centered" services continues to gain attention as providers strive for increased engagement and retention in treatment.

Their need for support is also a direct result of their mental health and other complications in their lives, such as substance abuse, inadequate hygiene, and poor heath. Homeless persons with mental illness are in need of comprehensive outpatient and residential mental health services, including crisis intervention, individual and group therapy, medication management, and other therapeutic methods that address multiple problems (SAMHSA, 2003a, p. 70).

Moreover, this population is highly susceptible to a range of both minor and life-threatening diseases, such as diabetes, liver disease, TB, hepatitis B and C, and HIV/AIDS. These risks associated with being homeless exacerbate the need for primary health care as part of a more holistic approach to providing clients with housing support. Finally, the significant number of homeless persons with co-occurring substance use disorders have been shown to fare better in clinical assessments if they are provided access to alcohol and drug abuse services. These include counseling and education, case management, day programs, detoxification, and self-help and peer support activities (McMurray-Avila, 2001; SAMHSA, 2003a, p. 68).

For these reasons, a competent and accessible resource in times of crisis is a critical form of assistance and can help to avoid decompensation and the possible loss of housing. There was an overwhelming sense on the part of both consumer and service provider focus group respondents that the retention of a service provider or a case manager throughout the housing search and occupancy phases greatly alleviates the concerns of property managers.

Homeless persons with mental illness also need a variety of services to mitigate the ways in which their ability to cope with the tasks of daily, independent living are impaired by their disability. These services include money management, finding and maintaining work and housing, and managing their physical and mental health (Federal Task Force on Homelessness and Severe Mental Illness, 1992). These skills can be absent or forgotten, especially by clients coming from more supportive or structured environments, such as Board and Care facilities, hospitals, incarceration, or even those having spent years living with family.

The need for aftercare or follow-up supportive services was commonly cited among the consumer focus groups as integral for housing retention and avoiding homelessness. Some respondents reiterated the importance of programs that "hand hold" and teach clients to be independent, noting that clients who do not continue to take advantage of available services, such as those that teach how to budget, cook, grocery shop, respect house rules, and comply with leasing agreements, after placement in housing are at risk of becoming homeless again. On this same note, respondents expressed concern that current program regulations and eligibility criteria limit the amount of time following housing placement that clients can receive these types of services.

3. Lack of Financial Resources

People who are homeless and mentally ill need adequate income to help them secure and maintain housing. With limited or non-existent work histories, a transition to independent living is nearly impossible without the supplemental income provided through federal income and entitlement programs. Acquiring enough money for today's housing costs—first and last month's rent, cleaning and/or security deposits, move-in costs—on a relatively fixed income leaves the population with little to address ongoing rental expenses and other basic personal needs.

The issue of sufficient financial resources to secure affordable housing also relates to the requirements placed on prospective renters by property management agents. Some

respondents in the consumer focus group noted that the credit check process disfavors them since most property managers will not provide clients with a copy of their credit report even though they are required to pay for it.

4. Involvement with the Criminal Justice System

The frequent contact that homeless persons with mental illness experience with the criminal justice system leaves them at an obvious disadvantage upon seeking access to public and other forms of subsidized housing. Yet research also suggests that incarceration creates other challenges for this population, specifically the level of mental health care received upon discharge and the ability to maintain eligibility for public assistance programs.

The California Research Bureau reports that approximately 70% of inmates received a lower level of mental health services upon release from prison than they received during incarceration (Nieto, p. 16). In addition, fifty percent (50%) of these inmates, upon release, do not live within range of Parolee Outpatient Clinics (POC's) where they could receive mental health services as part of their parole (Ibid, p. 16). As housing and social service providers struggle to meet the influx of homeless and post-incarcerated persons with mental illness in their communities, any progress or stability achieved during incarceration to address mental health issues is in jeopardy if the same or increased level of care is not provided to them immediately upon discharge.

Incarceration can also lead to the termination or suspension of public benefits, such as Medi-Cal. Such a loss can be devastating for homeless persons with mental illness, given that Medi-Cal provides medical assistance, including mental health and substance abuse treatment services. Upon release, these individuals may have to go through a re-application process in order to regain access to these benefits, which could take as long as two to three months.

As studies have indicated, the time period immediately following release is critical for an individual's ability to re-enter society, address immediate needs, and pursue housing resources. Any interruption, delay, limitation, or prevention of Medi-Cal benefits (e.g., community treatment services and psychotropic medication) can greatly impact whatever stability was gained while in jail. At worst, this could place the individual at risk of re-hospitalization and/or return to the criminal justice system (SAMHSA, 2002).

Despite the negative outcomes this presents to an individual striving to regain their benefits, the potential burden faced by public systems of care in these circumstances is arguably as significant. In certain systems where an individual's access to public mental health and substance abuse treatment services is not lost upon incarceration, it is the local city, county, or State agencies to which the full financial cost of these services is transferred (Ibid, 2002).

5. Access to Federal Rental Subsidies

Without some type of ongoing housing assistance, such as federally subsidized housing, persons with disabilities who have the lowest incomes have virtually no chance of finding a home of their own. Yet often times, the structure and operations of federal housing assistance programs, particularly those providing long-term rental assistance, work adversely to serve homeless persons with mental illness.

In the case of the federal Housing Choice Voucher (or Section 8) or Shelter Plus Care programs, lengthy wait lists and complicated application procedures pose a significant barrier to people with serious mental illness or co-occurring disorders who are homeless. Even local housing authorities, such as HACLA and HACoLA, that have been able to "set-aside" Section 8 subsidies for homeless clients continue to report excessive wait lists for applicants to receive a subsidy. If the client can afford to wait such a long time and be successful in receiving a Housing Choice voucher, they are still faced with the daunting task of searching for affordable housing that is in short supply and possibly located in distant areas of the County, with different cultural norms.

Based upon a recent local assessment of the rental assistance processes in Los Angeles County, federal rental assistance programs are cumbersome, lengthy, and poorly understood by those that they intend to assist. In Los Angeles County, the mental health clinics that refer clients to DMH are responsible for identifying eligible clients and assisting them to complete applications before their submission to DMH. The extensive documentation and the completion of several forms that are required in these applications take time and diligence. In some cases, as many as 65% of applications submitted to DMH Administration for processing are returned for revision (Shelter Partnership, 2004, p. 18). Mental health clinics participating in this assessment cited the following errors as the most common reasons for revision: 1) incomplete third party homeless verification; 2) inadequate case manager cover letter; 3) inadequate income verification; 4) technical issues (e.g., typographical errors or pages copied incorrectly); and 5) outdated time sensitive documents (Ibid, p. 13).

Specifically, the homeless status and income verification requirements have proven the most difficult since they depend on the client's willingness and ability to request them from a host of appropriate organizations (i.e., banks, shelters, past landlords or employers). Despite changes in the requirements to document homelessness, HUD has not changed their definition of homelessness. For homeless, mentally ill clients, obtaining third-party verification, in some cases from multiple emergency shelters, can be very difficult to attain. With respect to meeting income verification requirements, clinics reported that some clients have trouble understanding that they need a new SSI form from the Social Security office, not a copy of the form that is kept for their own records. Coordinating appointments and convincing employers to complete the required forms can also be burdensome. Moreover, clients expressed hesitation or reluctance disclosing income information (Ibid, p. 14).

E. Persons Living with HIV/AIDS

1. Overview

Many of the same factors that limit the ability of persons living with HIV/AIDS to access and maintain safe, decent, and affordable housing are endemic to some extent to all special needs populations. These include low incomes, housing affordability, housing discrimination, poor or no credit history, family status or size, criminal history (especially felony convictions), and a lack of independent living skills. Yet this population is also beset by unique experiences, such as the high cost and complexity of supportive services, resistance to certain AIDS drug treatments, an undocumented subpopulation, and the likelihood that consumers with multiple needs may have burned bridges with other public systems of care.[12]

These issues have been the subject of recent planning efforts in Los Angeles County to address the housing needs of this target population. Last year, the City of Los Angeles Housing Department, on behalf of the Los Angeles Countywide HOPWA Advisory Committee (LACHAC), released a countywide strategic plan for HIV/AIDS housing and supportive services. This document, developed under the guidance of LACHAC's Strategic Planning Task Force, included a review of the most common barriers experienced by PLWH/A, as reported by clients and other stakeholders.

The most common barrier cited by both PLWH/A and providers, as reported in a 1999 survey by Shelter Partnership, concerned the inability to afford housing costs, both rental and move-in expenses. Other common barriers involved the lack of appropriate housing options for PLWH/A, poor rental/credit history, cumbersome and lengthy applications for affordable housing, discrimination, and sobriety restrictions imposed by the housing provider. Surprisingly, a lack of knowledge of what housing resources are available or how to access them was also rated highly by consumers (Shelter Partnership, 2003, p. 29) (see Table 28).

Table 28. Top Seven Barriers to Accessing Housing per PLWH/A and LACHAC Strategic Planning Task Force

Persons Living with HIV/AIDS (1997)	Strategic Planning Task Force (2002)
Insufficient funds to pay for housing	Insufficient funds to pay for housing
Lack of knowledge of what is available or how to access available housing	Rental assistance not enough to obtain safe and affordable housing
Rental assistance not enough to obtain safe and affordable housing	Not enough appropriate housing options
Not enough appropriate housing options	Poor rental/credit history
Poor rental/credit history	Lack of knowledge of what is available or how to access available housing
Long or difficult application process	Long or difficult application process
Discrimination based on HIV/AIDS status	Not being sober

[12] These barriers were discussed during *The State of AIDS Housing: Current Trends and Future Directions*, a presentation at the annual Housing California conference , on May 7, 2002 in Sacramento, CA. Presented by Mariah Ybarra (AIDS Housing of Washington) and Katharine Gale (KGC Consulting).

2. Housing Placement Assistance

The lack of or inadequate levels of assistance locating and/or applying for affordable housing has continued to hamper efforts to connect low-income and special needs individuals and families with the resources they need to become self-sufficient and stable. Thus far, reports have indicated that housing assistance (i.e., assistance in finding or getting housed) services remain elusive for many PLWH/A.

In the Los Angeles County HIV/AIDS Comprehensive Care Plan Needs Assessment Survey, more than half (53.7%) of these respondents said that they needed this service in the past year, nearly one-half (43.9%) of the respondents said they had asked for this service, and less than one-third (30.9%) of the respondents received this service. This represents a substantial portion (13%) of the survey sample that asked for housing information services but did not receive it, an indication of so-called "unmet demand" (Los Angeles County Commission on HIV, p. 1-59). Among homeless survey respondents, the need for these services is much higher; nearly nine in ten (87.5%) indicated a need for these services (Ibid, p. 1-113).

Despite considerable resources being expended through both the HOPWA and CARE Act systems to provide PLWH/A with housing information and referral services, there is a common perception among consumers that these efforts are still falling short. According to the County's Supplement to HIV and AIDS Surveillance Project (SHAS) survey, nearly half (42%) of the respondents did not know of any groups or organizations in their communities that could provide them with assistance in finding shelter (County of Los Angeles HEP, June 2002, p. 9). Given that large numbers of consumers identify housing resources through "word of mouth," clearly public systems of care targeting this population must look more closely at ways to more effectively provide consumers with the information they need to make informed decisions and receive necessary care.[13]

3. Access to Supportive Services

As noted in the *Trends and Considerations* section, a significant and increasing proportion of the people accessing HIV/AIDS services and housing have histories of homelessness, mental illness, and substance abuse. Though planners and providers face the challenge of reconciling practical and philosophical approaches (e.g., harm reduction vs. zero tolerance) to meeting these disparate needs, clearly the provision of appropriate supportive services for this population is critical for their ability to obtain and maintain housing. Conversely, researchers have been working to further affirm that housing, as a structural intervention, assumes a positive role in the transmission and progression of HIV disease.[14]

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[13] Thirty percent (30%) of the respondents in Shelter Partnership's 1999 study found out about their current housing through family or friends, while another 30% indicated that case workers or managers had helped them to locate their housing.

[14] During FY 2003, HUD and CDC collaborated to provide competitive grant funding to three cities across the nation to examine the connection of housing and health among persons with HIV. The purpose of the study is threefold: 1) to study whether housing reduces HIV risk behaviors; 2) to study whether

Supportive services can assist PLWH/A to improve their economic standing, obtain or retain employment, access health insurance and other benefits, and generally enhance their quality of life. Services that affect entry into and retention in care include case management, self-help drug treatment, mental health services, and direct housing services. For homeless PLWH/A, transportation is also important.

Housing programs that offer readily available services to PLWH/A are showing impressive results in increasing access to medical insurance and primary care, participation in HIV medication therapies, and general health functioning, while decreasing emergency room visits and hospitalizations (Aidala et al., 2003). One study in New York, for instance, found that residents in a housing program were more likely to resolve problems (e.g., financial) and report taking combination drug therapies than PLWH/A that were not in housing programs (Aidala and Lee, 2000).

a. Persons with Co-Occurring Disorders

The high incidence of co-occurring disorders among the HIV/AIDS population necessitates a broad range of housing, health and mental health care, substance abuse treatment, and social services, all of which are typically provided be separate agencies with separate funding streams. Unfortunately, the onerous task of navigating these fragmented service systems falls on the consumer despite their inability and lack of preparation. The need to tailor services to individual needs is further hampered as a result of categorical funding, which requires that providers offer only a specific service with funds from a particular source.

Accordingly, individual service needs transgress service system boundaries and can limit compliance in treatment programs. For homeless PLWH/A with multiple diagnoses, this can be especially troubling. Mental health treatment may be disallowed because the individual has a substance use disorder, or they may be excluded from substance abuse treatment because of a mental illness. Even the homeless delivery system, where these types of disorders are prevalent, can fail to provide services because of these conditions. One notable example of this disconnect is that persons with a primary diagnosis of a substance use disorder are ineligible for federal SSI benefits. The gaps that result from this fragmentation ultimately prevent persons with co-occurring disorders from receiving the care they need. Equally as important, however, is that they also may not receive the support they need to succeed as tenants.

b. Medical Advancements and Drug Resistance

The advancements in HIV medication, particularly Highly Active Anti-Retroviral Therapy (HAART), are allowing the population to significantly improve their health, live longer, and re-evaluate their lives and consider re-employment. These developments have also lead to decreasing demands for AIDS-related hospitalizations,

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providing housing increases engagement with health care and adherence to HIV therapies; and 3) to study whether providing housing improves health outcomes (CD4 and Viral Load).

skilled nursing, and hospice care, and changes in occupancy and vacancy rates in HIV/AIDS housing programs (Shelter Partnership, 1999, p. 96).

At the same time, however, not all individuals are able to access promising HIV treatments. Those who do not have access to adequate health insurance or State-run AIDS Drug Assistance Programs (ADAP) are unlikely to benefit from these advancements, which according to HRSA run well over $10,000 (Health Resources & Services Administration, 2001). Moreover, data indicates that African Americans, individuals with annual incomes below $9,600, non-English speakers, and those who had not been college educated were less likely to be prescribed these expensive drugs. The homeless, too, are in this predicament, as physicians often view them as unable to follow complicated medication protocols.

Another concern that impacts health outcomes and housing stability is the resistance to AIDS drug treatments that affects a substantial and increasing portion of the population. A recent study conducted in nine cities in the U.S. and Canada studied drug resistance in newly infected people living with HIV. According to its findings, 14% of participants were drug-resistant to one or more anti-HIV drugs. In addition, 5.8% of cases have been found to be resistant to two or more of the three classes of anti-HIV drugs from 1999-2000, up from 0.4% from 1995-1998.[15]

4. Health and Employment

Altogether, housing instability is common for PLWH/A due to the constant fluctuation in health, ability to work, and income. On average, Shelter Partnership's survey found that respondents had to move at least twice since contracting HIV, mainly because they could not afford the rent (Shelter Partnership, 1999, p. 29). And given the instability of drug therapy, many PLWH/A work sporadically. They may work for a short period of time and then discontinue working for health reasons, only to resume employment searches when their health improves. This poses significant challenges for PLWH/A, considering the ability to pay rent is often dependent on the amount of income earned, which is typically affected by employment status.

Indeed, high rates of unemployment are common among this population. Eighty-six percent (86%) of Shelter Partnership's sample were unemployed, compared to 68% of the SHAS survey respondents (Ibid, p. 21). Significant numbers of both samples reporting employment were working part-time. Yet, even among those unemployed respondents, there is the desire to return to work despite major hurdles, such as a lack of or outdated job skills, affordable day care or transportation, histories of substance abuse, and criminal records. Perhaps the greatest impediment to pursuing work, though, is the concern that joining the workforce places in jeopardy the receipt of public assistance or health insurance.[16]

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[15] These figures were included in *The State of AIDS Housing: Current Trends and Future Directions*, a presentation at the annual Housing California conference, on May 7, 2002, by Mariah Ybarra (AIDS Housing of Washington) and Katharine Gale (KGC Consulting).

[16] This concern of "negative income" is significant, especially for individuals who have become accustomed to a consistent source of income through public assistance. The income earned by those

5. Appropriate Housing and Sustaining AIDS Housing

The evolution of the epidemic in the last two decades has had a direct impact on the types of housing accessible and needed by consumers as well as the ability of providers to address them. Where hospice and other "end of life" forms of congregate living once prevailed as feasible housing strategies, there has been the recent pursuit of independent living arrangements or private subsidized rental units deemed more appropriate for the housing needs of a population that is living longer. Moreover, as this Plan has illustrated, many people living with HIV/AIDS are also dealing with a combination of other issues and morbidities that require different housing approaches.

The focus of AIDS housing providers therefore has shifted from assisting clients at the end of their lives to facilitating their transition to living with HIV and AIDS (Health Resources & Services Administration, 2001, p. 35). Such a shift has wrought significant transformations in the landscape of HIV/AIDS housing, from the network of paid and volunteer care that characterized earlier AIDS housing to the more structured and contractual elements of permanent, supportive housing common today.

This new environment means more than building maintenance for program operators. Properties must be "managed" and operating subsidies and supportive services kept intact in response to the various funding and regulatory restrictions that shape their work. Even the physical design of the housing structure must accommodate residents with HIV and AIDS. Features such as private bedrooms to help ensure self-care, individual refrigerators for medication storage, and elevators for those with difficulty climbing stairs are all examples of unique designs that are recommended for this population.

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entering or re-entering the workforce is rarely enough to offset the benefits they would otherwise receive through Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI).

V. AVAILABILITY OF SPECIAL NEEDS HOUSING

A. General

In Los Angeles County, there are numerous forms of housing available to individuals with special needs. These forms of housing target different populations, have various lengths of stay and levels of services, and range in type from emergency shelter to permanent, independent housing.

For the purposes of this discussion, there are three housing types available to special needs populations: emergency shelter, transitional housing, and permanent housing. Each can be characterized by variations in lengths of stay and program designs.

Emergency shelter is available to individuals and/or families that have no housing of their own. Typically, these programs do not require that clients contribute any portion of their income upon intake or as a condition of program participation. These programs are designed to meet a person's most immediate needs and are provided through homeless shelters and/or hotel/motel vouchers. Stays vary from one night to a maximum of three months (or 90 days).

Transitional housing programs are also short-term housing programs, but are geared less towards stabilizing the individual than on providing adequate preparation for self-sufficiency and independent living. Accordingly, lengths of stay range from 90 days to 24 months (2 years) and provide or connect residents with supportive services to further their independence and address barriers to self-sufficiency. Such programs may require that clients pay some percentage of their income (generally no more than 30%) to participate.

Permanent housing represents the end of the housing continuum, where clients are able to live independently and do not require constant medical care. There is not a length of stay restriction in permanent housing programs, and clients are afforded the privileges and rights of tenants in a leasing arrangement. Yet, since many of these programs specifically target special needs populations, supportive services may be provided on- or off-site to ensure that clients can maintain their housing and address temporary or chronic barriers to self-sufficiency. Permanent housing also includes units that are assisted with federal rental subsidies, such as the HUD Housing Choice Voucher (Section 8) and Shelter Plus Care programs.

The following discussion utilizes these definitions to present an inventory of housing in Los Angeles County that is targeted to each of the three special needs populations included in this Plan.[1] Upon a general overview of this housing landscape across all populations, the discussion focuses on each population and the housing types targeted

[1] Based upon the plethora of legal issues that surround affordable and supportive housing and interpretations of housing providers there are considerable differences of understanding and opinion as to what housing beds or units can be considered "targeted" or "set-aside." For this inventory, the most consistent distinguishing factor was whether the documented unit or bed was supported by a specific public funding source, which often is limited to certain populations or housing types.

to them, and concludes with an analysis of the geographic distribution of these resources throughout Los Angeles County.

Despite the availability of other forms of housing for the special needs populations under review, such as licensed residential programs or group homes, this Plan concentrates instead on the three housing types defined above. A more detailed inventory of the housing data discussed in this section is included as Appendix D.

B. Overview

Together, all three special needs groups are provided with approximately 8,642 beds in targeted housing facilities or programs throughout Los Angeles County, distributed as follows: emergency shelter (333 beds), transitional housing (1,963 beds), and permanent housing (6,346 beds) (see Table 29).

Permanent housing comprises nearly three-quarters (73%) of the housing provided countywide to these special needs populations. Transitional housing represents roughly one-fifth (23%), while emergency shelter represents only 4% of the available beds (see Figure 3).

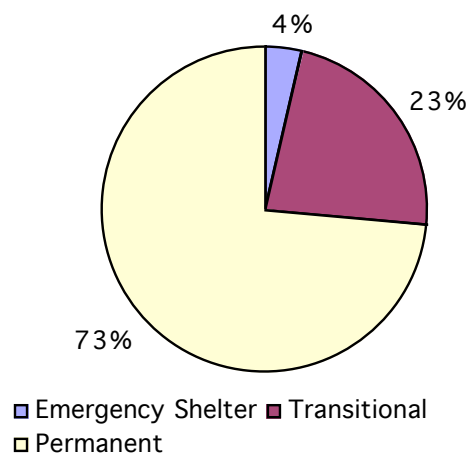

Figure 3. Special Needs Housing in Los Angeles County by Housing Type

Table 29 provides more detail with respect to the availability of these housing types to the three special needs populations considered in this Plan.

Table 29. Special Needs Housing Available by Population, Housing Type, and Beds in Los Angeles County

Housing Type	Youth Emancipated from the Dependency and Delinquency Systems	Homeless Persons with Mental Illness	Persons Living with HIV/AIDS	Total
Emergency Shelter	66	180	87	**333**
Transitional Housing	871	921	171	**1,963**
Permanent Housing	-	4,411	1,935	**6,346**
Total	**937**	**5,512**	**2,193**	**8,642**

C. Youth Emancipated from the Dependency and Delinquency Systems

1. Targeted Housing by Housing Type

Housing available to youth emancipated from the County's dependency and delenquency systems is concentrated entirely in the emergency and transitional housing types.

Between these two housing types, there are 937 beds targeted to the population, with transitional housing comprising nearly all (93%) of the targeted housing stock (see Figure 4).

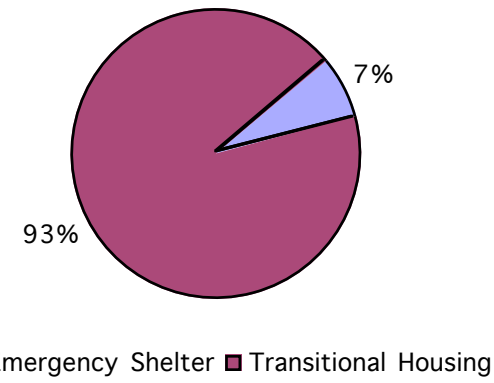

Figure 4. Housing for Emancipated Foster Youth by Housing Type

a. Emergency Shelter

There are 66 beds in the County that provide emergency shelter to emancipated foster youth (see Table 29).[2]

b. Transitional Housing

There are 871 transitional housing beds targeted to these types of youth throughout the County, nearly all of which are accessible to youth who are 18 years of age and older.[3]

c. Housing in Development

In addition to these existing beds, there are 108 beds that are in development and soon to be added to the current inventory of housing targeted to emancipated foster youth. Despite the lack of emergency shelter beds in development for this population, there are 69 transitional housing beds, and 39 are permanent housing beds in development (see Table D-3 in Appendix D).[4]

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[2] There are an additional 29 beds in the County that provide emergency shelter to pre-emancipated and/or homeless or runaway youth.
[3] An additional 160 transitional housing beds in the County are available to pre-emancipated and/or homeless or runaway youth.
[4] Eight (8) emergency shelter beds are currently in development in SPA 2 (San Fernando) for youth ages 13-17.

2. Geographic Distribution of Targeted Housing by Housing Type

a. Emergency Shelter

Youth emancipating from the dependency and delinquency systems can access 66 emergency shelter beds throughout two SPAs in the County.

These shelter beds are concentrated most heavily in SPA 4 (Metro), which contains 54 (82%) beds. The remaining 12 beds (18%) are located in SPA 1 (Antelope Valley) (see Figure 5).

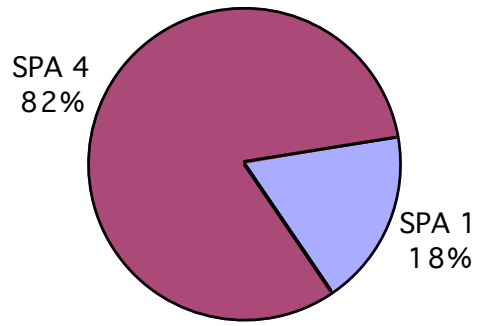

Figure 5. Emergency Shelter for Emancipated Foster Youth by SPA

b. Transitional Housing

In contrast to the limited geographic distribution of emergency shelter programs for former foster youth, the array of transitional housing programs available to this population is spread across all SPAs.

Close to half of the County's transitional housing for emancipated foster youth is divided almost equally between SPA 2 and SPA 4, where respectively 191 (22%) and 224 (25%) of the available transitional housing beds are located. Due to the unavailability of data reporting to make such a distinction, there were 69 beds (8%) that were not identifiable within a specific SPA (see Figure 6).

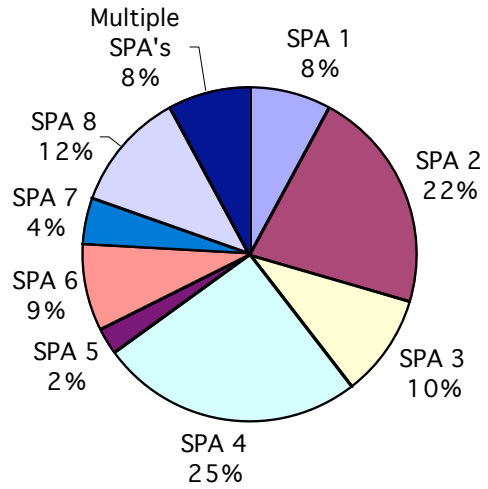

Figure 6. Transitional Housing for Emancipated Foster Youth by SPA

D. Homeless Persons with Mental Illness

1. Targeted Housing by Housing Type

Homeless persons with mental illness are targeted through the emergency shelter, transitional housing, and permanent housing types, which account for approximately 5,512 beds countywide.

Eight out of ten (80%) beds that are targeted to this population are considered permanent housing (see Figure 7).

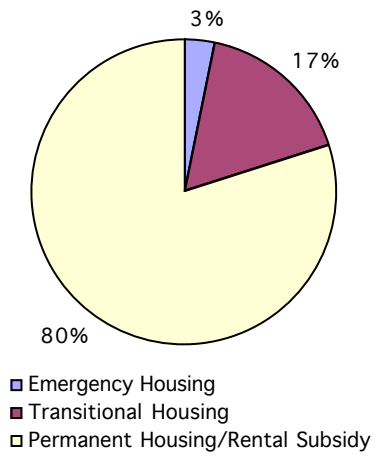

Figure 7. Housing for Homeless Persons with Mental Illness by Housing Type

a. Emergency Shelter

A relatively small portion of the available housing stock that is targeted to homeless persons with mental illness, only 180 (3%) beds, consists of emergency shelter (see Table 29).

b. Transitional Housing

The amount of transitional housing for homeless persons with mental illness in Los Angeles County represents approximately 17% of the overall housing stock targeted to this population. Thirteen nonprofit housing providers operate a combined 921 transitional housing beds (see Table 29).

c. Permanent Housing

As illustrated in Figure 6, the bulk of targeted housing for the homeless, mentally ill in Los Angeles County is comprised of permanent, supportive housing. The inventory of permanent housing available to homeless persons with mental illness can be further divided into programs that also target individuals with dual or multiple diagnoses, including a diagnosis of mental illness. Moreover, there are federal rental assistance programs, namely the HUD Section 8 and Shelter Plus Care (S+C) programs, that also provide financial support for independent living for this population.

There are 767 permanent housing beds specifically targeted to homeless persons with mental illness, located in affordable housing developments in which all or at least a portion of the building is dedicated for this purpose. Additionally, 250 beds are targeted to homeless persons with dual or multiple diagnoses (see Table 30).

The majority of permanent housing (3,394 beds or 82%) targeted to persons with mental illness in Los Angeles County has been secured through long-term rental assistance provided through the HUD S+C and Section 8 programs. Countywide, these two programs provide a combined 3,394 beds for homeless persons with mental illness.

The Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) both operate Section 8 Homeless programs. These programs support local homeless assistance strategies by providing long-term rental assistance to homeless persons and families living in emergency shelter and transitional housing. Currently, there are 1,706 beds for homeless persons with mental illness that are made affordable through Section 8 Homeless rental subsidies.

In Los Angeles County, the Shelter Plus Care program provides long-term rental assistance for 1,688 beds, distributed as follows according five local housing authorities that administer the assistance: HACoLA (256 beds), HACLA (1,251 beds), City of Long Beach (37 beds), the City of Pasadena (40 beds), and the City of Santa Monica (104 beds) (see Table 30).

Table 30. Permanent Housing for Homeless Persons with Mental Illness by Type

Housing Type	Total Beds
Supportive Housing	767
Supportive Housing (Targeting Dual or Multiple Diagnoses)	250
Supportive Housing Subtotal	**1,017**
Targeted Long-Term Rental Assistance	
Section 8 Homeless	1,706
Shelter Plus Care	1,688
Long-Term Rental Assistance Subtotal	**3,394**
Total	**4,411**

More specific information on each of these forms of permanent housing can be found in Section D.4 of Appendix D.

d. Housing in Development

In addition to these operational beds, there are 55 transitional housing and 664 permanent housing beds currently in development that will be targeted towards homeless persons with mental illness. It is important to note that twenty-five beds are being developed as part of a Safe Haven in Santa Monica (see Table D-15 in Appendix D).

2. Geographic Distribution Targeted Housing by Housing Type

a. Emergency Shelter

The 180 emergency shelter beds targeted to homeless persons with mental illness in Los Angeles County are provided in all SPAs but SPA 3. Three-quarters of these beds are located in SPA 6 (42%) and SPA 4 (33%).

The remaining beds are distributed between SPA 5 (8%), SPA 1 (8%), SPA 7 (4%), SPA 8 (4%), and SPA 2 (1%). (see Figure 8).

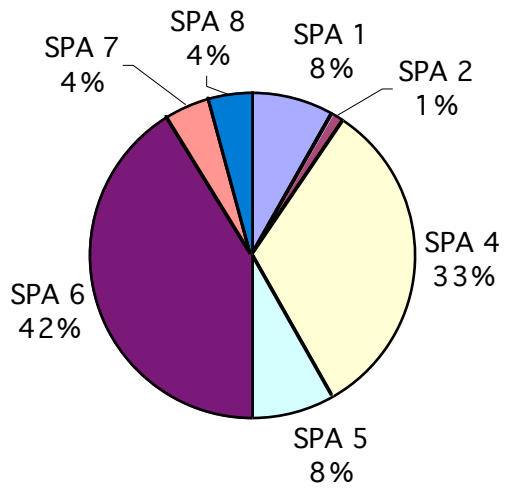

Figure 8. Emergency Housing for Homeless Persons with Mental Illness by SPA

b. Transitional Housing

Similar to the spatial distribution of emergency shelter beds for this population, transitional housing is provided in seven SPAs, including all but SPA 1.

More than a third (36%) of the 921 beds are located in SPA 7, with SPA 4 providing one-quarter (24%) of the transitional housing stock.

Other transitional housing beds targeted to homeless persons with mental illness in Los Angeles County are located in the following: SPA 2 (21%), SPA 6 (10%), SPA 3 (5%), SPA 5 (3%), and SPA 8 (1%) (see Figure 9).

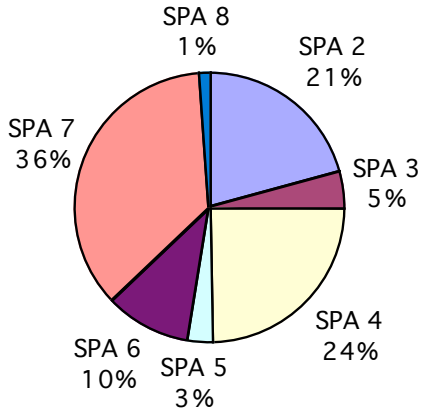

Figure 9. Transitional Housing for Homeless Persons with Mental Illness by SPA

c. Permanent Housing

The 1,017 beds of permanent supportive housing targeted to homeless persons with mental illness are scattered across Los Angeles County.

SPA 4 has roughly two-thirds (66%) of the overall permanent supportive housing beds for homeless persons with mental illness in the County. The remaining beds are distributed as follows: SPA 8 (10%), SPA 5 (7%), SPA 7 (7%), SPA 2 (4%), SPA 3 (4%), SPA 6 (2%), and SPA 1(<1%) (see Figure 10).

Figure 9 does not include the 3,394 beds provided through long-term rental assistance, as many of these beds are tenant-based and not site-specific.

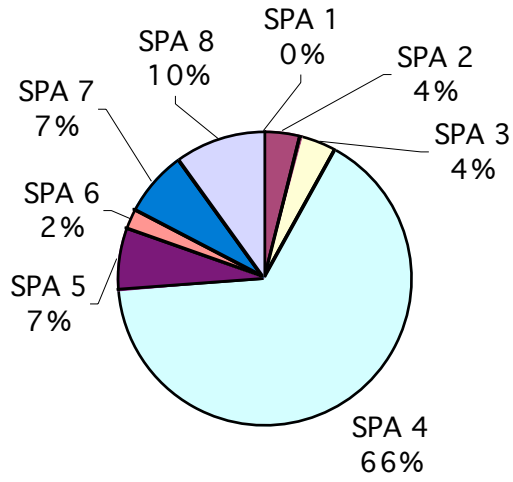

Figure 10. Permanent Housing for Homeless Persons with Mental Illness by SPA

E. Persons Living with HIV/AIDS

1. Targeted Housing by Housing Type

In Los Angeles County, persons living with HIV/AIDS are able to access targeted housing resources through all three housing types. They are currently targeted through 2,193 beds across the region, with close to nine-tenths (88%) of this stock considered permanent affordable housing (see Figure 11).

a. Emergency Shelter

Persons living with HIV/AIDS are targeted through 87 emergency shelter beds (see Table 29). Overall, emergency shelter represents 4% of the beds targeted to PLWH/A in the County (see Figure 11)

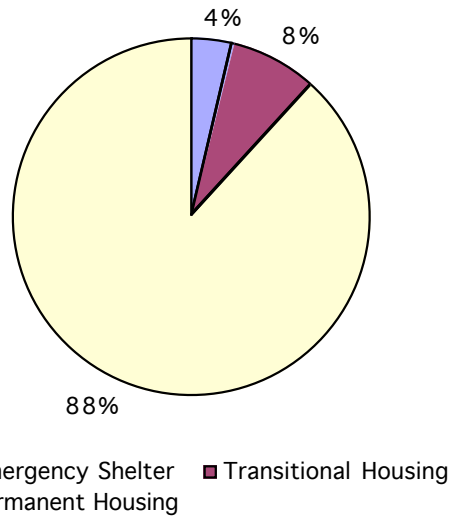

Figure 11. Housing for Persons Living with HIV/AIDS by Housing Type

b. Transitional Housing

There are 171 transitional housing beds targeted to PLWH/A, nearly twice the number of emergency shelter beds (see Figure 11).

c. Permanent Housing

There are 1,935 permanent housing beds targeted to PLWH/A in Los Angeles County, provided in supportive housing developments and through federal rental subsidies (see Table 29).

Approximately 39% (745 beds) of the total permanent housing stock for this population is made available through permanent supportive housing facilities in which all or a portion of the building is dedicated for this purpose.

Like housing resources for homeless persons with mental illness, permanent housing for PLWH/A in Los Angeles County is also provided through federal rental assistance subsidies. In this case, the HOPWA and Section 8 Homeless programs both serve as forms of long-term rental assistance for this population, providing 61% (1,190 beds) of the permanent housing stock.

Currently, there are 1,069 permanent housing beds provided through HOPWA tenant-based rental assistance, 46 beds financed with HOPWA project-based rental assistance. The City of Los Angeles Section 8 Homeless program also funds 75 beds through two nonprofit AIDS service organizations.

More information on these forms of permanent housing can be found in Tables D-18 through D-21 in Appendix D.

d. Housing in Development

Four affordable housing developers—Encore Hall Senior Housing, Hollywood Community Housing Corporation, Palms Residential Care Facility and Project New Hope—are in the process of developing an additional 204 units of permanent housing for persons living with HIV/AIDS in Los Angeles County (see Table D-22 in Appendix D).

2. Geographic Distribution of Targeted Housing by Housing Type

a. Emergency Shelter

The 87 emergency shelter beds are available to PLWH/A throughout the County, primarily in SPA 4 (66%), but also in SPA 2 (17%), SPA 8 (13%), and SPA 6 (4%). Four of the beds included in the SPA 6 total are provided through an emergency housing voucher program funded through the Ryan White CARE Act (see Figure 12).

The HOPWA Emergency Housing and Meal Voucher program includes 40 beds that could not be associated with any one specific SPA.

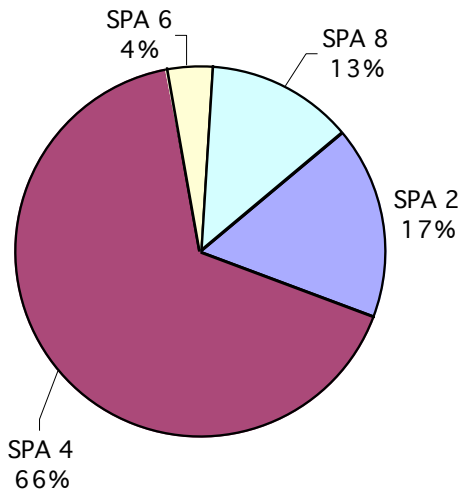

Figure 12. Emergency Shelter for PLWH/A by SPA

b. Transitional Housing

The 171 transitional housing beds targeted to persons living with HIV/AIDS are distributed more widely across the County, despite a lack of beds in SPA 1 and SPA 7. SPA 4 accounts for close to half (46%) of the transitional housing supply, followed by SPA 6 (18%), SPA 2 (14%), SPA 8 (12%), SPA 3 (9%) and SPA 5 (1%) (see Figure 13).

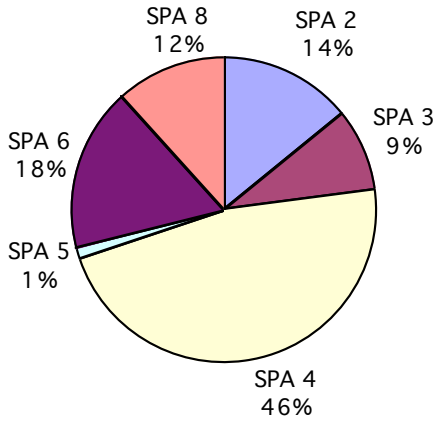

Figure 13. Transitional Housing for PLWH/A by SPA

c. Permanent Housing

In contrast to the slight degree of parity illustrated among the geographic distribution of transitional housing targeted to PLWH/A in the County, the permanent housing inventory is almost entirely located within SPA 4 (76%).

The remaining 24% is spread more evenly through the region, with smaller amounts of permanent housing located in SPA 2 (9%), SPA 8 (6%), SPA 5 (5%), SPA 6 (3%), and SPA 3 (1%) (see Figure 14).

Figure 13 does not include the 1,190 beds provided through long-term rental assistance, as many of these beds are tenant-based and not site-specific.

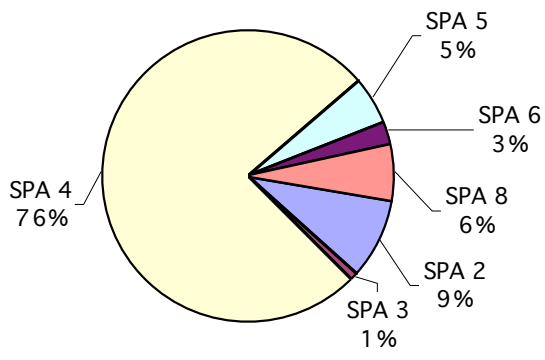

Figure 14. Permanent Housing for PLWH/A by SPA

VI. PUBLIC FUNDING FOR HOUSING AND SUPPORTIVE SERVICES

The purpose of the following section is to delineate the various public funding programs that are available for providing housing and supportive services to special needs populations in Los Angeles County. Through both an in-depth analysis of specific funding sources that target these populations, and a more general overview of others with the potential to benefit them, the following narrative serves as a resource for policymakers and practitioners to expand the supply of affordable housing options.

This section focuses exclusively on public sources of funding or financing that is made accessible through government. Thus, no private sources of funding (e.g., banks, corporations or foundations) are included here. This section is divided into the following six sections:

- Public Funding Landscape;
- Targeted Programs for Youth Emancipated from the Dependency and Delinquency Systems;
- Targeted Programs for Homeless Persons with Mental Illness;
- Targeted Programs for Persons Living with HIV/AIDS;
- City of Industry Fund Special Needs Housing Program; and
- Non-targeted Public Funding Programs.

A. Public Funding Landscape

The universe of public funding is a massive and complicated area of public policy that is filled with technicalities beyond the purpose and scope of this Plan. To simplify, this section attempts to provide the reader with a basic understanding of the types of public funds that are accessed by local government and nonprofit organizations. It also serves to discuss briefly some of the processes and requirements that shape how the majority of public funding is made available to local communities.

Public funding can be understood as one of two types of assistance: formula and competitive grants. Though they often serve similar purposes and pursue similar strategies, these types are still quite distinct in their own way. They also present their own opportunities and challenges, which is important as this Plan arrives at recommendations for their incorporation into countywide housing strategies.

1. Formula Grant Programs

Formula grants (sometimes referred to as block grants) are common mechanisms for the distribution of public resources from the federal government to more local levels of government, such as States, counties, and municipalities. As the title suggests, these types of grants are allocated through prescribed formulas, often determined by law or administrative regulation and reflect demographic and/or service need factors in a specific geographic locality (Bristol & Greiff, p. 2).

Unlike competitive grants, formula grant programs are not project-specific, but are instead provided to public entities on an ongoing basis to address housing and social service needs that continue from year to year. This characteristic is perhaps the most defining feature of formula funding: local jurisdictions are given broad flexibility to implement specific strategies that are consistent with the general eligibility guidelines established by the federal government. Funds are made available to local government entities contingent upon their ability to submit a planning document that provides the funding agency with periodic progress reports on the use of funds and documents the need for such funding to be sustained or augmented.

Local formula grantees are allowed to use funding to deliver housing or services directly, or to conduct a competitive bid process to solicit and identify project sponsors to implement the program. Some formula grantees, in turn, distribute their funding to more local units of government, such as States, counties or cities. This latter scenario is often how nonprofit organizations are able to access formula funds, either by applying directly to the grant recipient or the sub-recipient in a competitive process.[1]

Much of the formula funding accessed in Los Angeles County for special needs housing represent allocations from the U.S. Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS). HUD's formula grants are typically allocated to entitlement areas—sometimes these can be urban areas—based on factors such as poverty rates or total population. In the County, these are administered by agencies responsible for housing and community development oversight and implementation.

Formula grants for services usually flow from HHS, though they often are allocated to States before finding their way to more local units of government. These funds are generally administered by County Departments of Health (DHS), including the Office of AIDS Programs and Policy (OAPP), Mental Health (DMH), Community and Senior Services (CSS), Alcohol and Drug Programs Administration (ADPA), etc.

2. Competitive Grants

Competitive grants differ from formula funds in that they require interested applicants to apply directly to the relevant administrative agency. Funding is contingent upon a qualitative scoring process that evaluates the strength of the proposal and its ability to meet prescribed strategies and geographical or target population priorities. These types of grants are awarded for specific purposes, for fixed or known time periods, and are often not renewed, unless the funding source allows. Such grants are commonly used to implement best practices in a given field, and occasionally are titled Special Projects of National Significance (SPNS) (Ibid, p. 4).

[1] At the county or city level, federal formula grants are often combined with local funds (e.g., general funds or redevelopment funds) to create specific housing or service programs. Accordingly, nonprofit organizations seeking funding under these types of programs may not realize that the program is funded with formula funding. LAHSA's Winter Shelter program, for instance, represents an example of combined federal formula funding and local funding.

Competitive funding sources are usually discretionary "pots" of funding, and therefore are subject to the appropriations process. Funding availability can depend on the focus of the administrative agency (or Congress), which can vary in response to political pressures or programmatic shifts.

Many of the HUD funding sources that fund the development and operating expenses of affordable housing programs are considered in this category. The Continuum of Care program, which provides the bulk of federal homeless assistance grants to the County, can also be classified as a competitive grant.[2]

B. Targeted Programs for Youth Emancipated from the Dependency and Delinquency Systems

Los Angeles County provides youth in its dependency and delinquency systems with a variety of supports while in care and during their transition for independent living. Yet only one source of funding, the Independent Living Program (ILP), targets public resources towards youth who have been discharged from these systems.[3] As increasing research illustrates the many challenges experienced by this population upon emancipation, ILP has emerged as the principal source of both supportive service and housing-related financing to ensure that emancipated youth are equipped with the necessary tools to achieve and maintain economic and residential stability.

1. Independent Living Program (ILP)

a. Background

In 1999, Congress enacted the John H. Chafee Foster Care Independence Act to respond to the exceptional needs of youth who remain in foster care or Probation and are discharged to live on their own. This legislation permanently reauthorized the Independent Living Program, created in 1985 as a relatively limited service for youth in foster care, and doubled the level of funding for support services for youth aging out of these systems.

As noted earlier in the *Trends and Considerations* section, too often youth who leave foster care are unprepared to live on their own upon emancipation, as evidenced by poor employment and educational outcomes, as well as incarceration or homelessness. Chafee legislation therefore required states to provide youth ages 18 to 21 who were formerly in foster care with services to help them make the transition to self-sufficiency; offer education, training, and services so that they can obtain employment; provide personal and emotional support through mentors and dedicated adults; and provide

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[2] See the Corporation for Supportive Housing's *Supportive Housing Finances Guide* (2004) for more information about public grantmaking, including so-called "hybrid grants," which incorporate elements of both formula and competitive grants. This publication also provides a closer look at HUD-specific grants and the special processes (i.e., HUD SuperNOFA, Consolidated Plan, and Continuum of Care) that structure how the Departments's funding is distributed and accessed.

[3] ILP funding serves both pre- and post-emancipated foster and Probation youth, but was included here since the program provides substantial housing-related programs for emancipated youth.

financial, housing, counseling, and other supports and services to enhance their planning and preparation for independent living.[4]

Each year, through the U.S. Department of Health and Human Services' Administration on Children, Youth, and Families (ACYF) the State receives an allocation of ILP funds, and in turn allocates these funds to individual counties. In Los Angeles County, program funding is administered by DCFS, in partnership with other County departments, such as CDC, Probation, and LAHSA. These other departments are integral to the program's oversight and implementation.

b. Overview of Programs

Consistent with Congress' intentions upon establishing the Independent Living Program, States have implemented the program with minimum requirements and specifications. Counties therefore have broad discretion to design services to meet the disparate individual needs and circumstances for youth, though they must coordinate services with other federal, State, and local agencies whose efforts and resources are also directed to similar activities.

Accordingly, ILP occupies a major role in overall emancipation planning in Los Angeles County, as DCFS now ensures sufficient access to independent living services for any transitional youth in out-of-home care that is physically and/or mentally able to benefit from them. ILP services contain strong educational and vocational components, achieved through both public and private partnerships and community-based programs known as skill centers. Other emancipation services provided through the County's ILP include, but are not limited to, case management, transportation, health and mental health care, parenting classes, room and board assistance, and short-term housing.

c. Use of Program Funding for Housing

In 2002, the Los Angeles County Economy and Efficiency (E&E) Commission initiated, under the leadership of Dr. Sharon Watson, a review of the County's emancipation services and Independent Living Programs. This study reviewed the major housing programs in the County that serve both pre- and post-emancipated foster youth and provided the Department with several strategies to improve housing outcomes for emancipated youth (Watson, 2003, p. 4).

The Commission noted that even though up to 30% of each year's ILP allocation is eligible for housing assistance, the County had not fully obligated these funds since Chafee was passed in 1999. An important milestone therefore in realizing the Commission's recommendations in recent years has involved the complete dedication of ILP housing monies to enhance the continuum of housing resources available to the population.

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[4] The Act also heightened state accountability for positive outcomes for youth who leave foster care to live independently and requires states to track such outcomes as educational attainment, employment, avoidance of dependency, homelessness, non-marital childbirth, incarceration, and high-risk behaviors (Barbell & Freundlich, pp. 17-18).

Accordingly, through a partnership with the CDC, Probation, and LAHSA, the County released an RFP for ILP Housing Programs in October 2002 for the following three housing resources: 1) housing search and resource assistance; 2) emergency shelter; and 3) transitional housing.[5]

Funding commitments provided through this RFP helped to secure 140 transitional housing and 12 emergency shelter beds across all eight SPAs for high-need emancipated foster youth, with a focus on youth with mental health or substance abuse issues, pregnant or parenting youth, and gay/lesbian/bisexual/transgender subpopulations. Two contracts were also negotiated for housing apartment/locator services to identify and secure suitable, affordable rental housing.

Aside from the three ILP housing programs included as part of this competitive bid, the County also uses ILP funds to support transitional housing programs for youth with serious mental health problems. Sometimes referred to as the ILP Special Needs Housing program, this resource represents a collaboration with CDC, Probation, DCFS, and DMH to ensure access to affordable rental housing along with enhanced mental health and life skills services. Two transitional housing programs have been developed as a result. Athena, an 18-bed development in the San Gabriel Valley (SPA 3), opened in 2002, followed a year later by Step Out, a 20-bed program in the unincorporated area of Willowbrook (SPA 6).

ILP housing resources also fund the Room and Board Assistance program, which facilitates the transition to self-sufficiency by providing financial support to emancipated foster youth to offset their housing, food, and other necessary living expenses. This is an important housing option for youth ineligible for the Bridges to Independence Transitional Housing Program (THP), including many Probation youth, but also those who may be eligible for THP but are in college or employed outside of the County.

Finally, ILP resources have been used to provide match funding for the HUD-supported developments that comprise the County's THP.

d. Distribution of ILP Housing Funds

According to DCFS, Los Angeles County received $18,286,552 in ILP funding for FY 2003-2004, of which roughly $4 million was eligible for housing-related purposes. Nearly half of this money ($1,975,386) was committed for LAHSA's contracted ILP housing providers. The remainder was allocated to the Room and Board Assistance program ($916,888), and also to support the County THP/Bridges program ($1,000,000), funded primarily through HUD's Supportive Housing program.

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[5] Programs applying for ILP housing assistance funding under the LAHSA-administered RFP must provide at least six new or expiring beds that are dedicated to the EFY population. Under the terms of the RFP issued by LAHSA, ILP housing funds may be used for start-up, administrative and operating costs directly related to housing services provided to EFY's, and may not be used to finance supportive services or capital costs.

The proposed ILP housing budget for the current year ($4,874,739) dedicates significantly more funding for rental and move-in assistance to emancipated foster youth, while increasing the County THP/Bridges line item by nearly 60%. The three ILP housing programs administered by LAHSA remain the same from the previous year (see Table 31).

Table 31. Distribution of ILP Housing Resources in Los Angeles County (2003-2005)

Program	FY 2003-2004	FY 2004-2005 (Proposed)
LAHSA ILP Housing Contracts	$1,975,386	$1,975,386
Room and Board Assistance	$916,888	$1,303,746
County THP (Bridges)	$1,000,000	$1,595,607
Total	**$3,892,274**	**$4,874,739**

Source: County of Los Angeles Chief Administrative Office, September 2004.

C. Targeted Programs for Homeless Persons with Mental Illness

Two public funding programs target persons with serious mental illness who are either homeless or at risk of becoming homeless: the California Integrated Services for Homeless Adults with Serious Mental Illness (AB 2034) and Projects for Assistance in Transition from Homelessness (PATH) programs.[6]

The State AB 2034 program is an extremely flexible funding source that continues to garner the attention of the supportive housing community in part because of its unique reporting system and impressive program outcomes. The PATH program is another key source of financing for homeless persons with mental illness, though its focus is less broad and directed only towards eligible supportive service expenses. It is the only program created under the federal Stewart B. McKinney Homeless Assistance Act that limits assistance to persons with mental illness.

1. Integrated Services for Homeless Adults with Serious Mental Illness

a. Background

Assembly Bill 2034 (AB 2034), signed into law in 2000, resulted in the statewide expansion of a pilot program (AB 34) established to provide comprehensive services targeting the State's homeless population with severe mental illness.[7] The program

[6] Because AB 2034 provides an integral source of housing support for homeless persons with mental illness, it is included in this targeted funding section, even though it does serve persons at-risk of homelessness.

[7] In October 1999, the Governor of California approved AB 34 (Steinberg) with an initial budget of $10 million. The State Department of Mental Health (SDMH) selected Los Angeles County, Sacramento County, and Stanislaus County to administer the demonstration project through a Request for Information process. The projects were to demonstrate that with intensive outreach to the jail and homeless populations, the hardest to reach mentally ill would be provided with more services, including housing, resulting in decreased recidivism, homelessness, and psychiatric hospitalization. In Los Angeles, twelve agencies were selected to implement and demonstrate program success by May 1, 2000.

provides comprehensive services to mentally ill persons who are untreated, unstable, and at a significant risk of incarceration or homelessness unless treatment is provided to them.

Statewide, $175 million has been allocated to 34 county authorities across the State (including Los Angeles County) since the program's inception. Eligibility for program funding is limited to county mental health agencies or cities with independent mental health agencies. In addition to increasing the number of jurisdictions participating in the program, AB 2034 added specific sub-population groups (with a special emphasis on serving veterans, transition age youth ages 18-25, and women with children) and service standards to the bill's predecessor. Part of these changes required that service planning and delivery include provisions for housing for clients that are immediate, transitional, and/or permanent.

b. Program Philosophy

The program's principal focus is integrated outreach to the target population in either jail or the streets and "wrap around" intensive case management and services to forestall recidivism, chronic and episodic homelessness, and hospitalization. Program clients are provided with services in a comprehensive manner that promotes integration into the community. They are well supported as they are immersed in mainstream society, encouraged to develop their strengths and, to the greatest extent possible, develop strategies for living independently.

This legislation represents a shift from the previous strategy of providing this population with only Medicaid reimbursable services to the provision of comprehensive services, including housing. Housing assistance is one of the services funded by AB 2034, and both providers and consumers assert that the provision of stable housing results in consumer stability while assisting them to concentrate on improving other aspects of their lives (California Department of Mental Health et al., p. 2).

An important component of the AB 2034 program is its focus on performance and outcome monitoring. Statutorily, programs receiving AB 2034 funding are required to collect specific data for each of their clients at the time they enter the program and periodically over the course of their participation. Among other things, this information includes days of homelessness, incarceration, receipt of benefits and other information, all of which enable both the County and State Departments of Mental Health to assess program outcomes and cost effectiveness.

c. Local Program Implementation

On September 5, 2000, DMH released a Request for Information (RFI) to their contract agencies that were providing specialty homeless services, Adult Targeted Case Management, and/or PARTNERS/ISA services to high utilizers of mental health

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Most of the selected agencies were primarily "mental health" providers, with only two considered primarily "homeless" providers.

services, including homeless individuals. Based on the results of the RFI, AB 2034 services were provided by 16 agencies throughout Los Angeles County and by DMH in the Twin Towers facility of the Los Angeles County jail. Each contract agency has developed networks within their community with local law enforcement and social service agencies, substance abuse treatment programs, parole and probation officers, health care and housing providers, and inpatient psychiatric facilities.

Currently, DMH administers AB 2034 contracts with 19 grantees (including other county agencies and private organizations) across the County. Collectively, these programs serve 1,694 clients or 34% of all the State's enrollees (Ibid, p. 38). The program provides participants with an array of fifteen community-based supportive services, including the capacity of crisis intervention 24 hours per day, seven days per week (see Table 32).

Table 32. Services Provided through Los Angeles County's AB 2034 Program

Provider	Service
DPSS	Benefits assistance
DCFS	Child Care/children's services
	Life Skills training
LACOE	Education/Instruction
CSS	Employment Services
DHS	Health related/Home health services
	Substance abuse treatment
HACoLA and HACLA	Rental Assistance
Private Nonprofit Organizations	Benefits assistance and advocacy
	Clothing
	Case management
	Counseling
	Employment services
	Food/meals
	Housing placement assistance
	Legal services
	Life skills training
	Transportation assistance (bus tokens)

d. Eligible Use of Funds

One of the main goals of the AB 2034 program is to assist program consumers in accessing and maintaining permanent housing. Program funding however is viewed more as a supplement to existing housing resources, and therefore funds allocated for housing are only expended when all other client resources are exhausted. Program funding can be used to finance a variety of housing-related activities, including housing production, and can be used for emergency shelter, transitional housing, and permanent housing, with a priority on permanent supportive housing.

Eligible capital costs include acquisition, rehabilitation, and new construction. AB 2034 funds can also be used for rental subsidies, assistance or first and last month's rent.

Supportive services costs are eligible, so far as they are associated with expanding the "adult system of (mental health) care," defined as encompassing an array of multidisciplinary services aimed at specific outcomes for clients (e.g., maximizing self-sufficiency) (Bristol and Greiff, p. 74). Supportive services include outreach, mental health services, substance abuse services, family support and consultation services, parenting support, peer support or self-help group support, personal service coordination, and other services deemed necessary to ensure housing stability.

e. Distribution of Program Funding in Los Angeles

Los Angeles County's AB 2034 program was allocated $55 million statewide in the FY 2003-2004 budget. Of this total allocation, DMH was awarded $17.5 million—or 30% of the State's AB 2034 budget—which represents a slight decline from the County's allocation in FY 2000-2001 (see Table 33).

Table 33. AB 2034 Program Allocations, Los Angeles County (FY 1999-2003)

Fiscal Year	Annual Allocation	Additional Fund
1999-2000	$4,800,000	
2000-2001	$18,255,000	
2001-2002	$18,255,000	
2002-2003	$17,448,000	$100,000
2003-2004	$17,548,825	

Precise reporting of expenditures per eligible activity was not available at the time of writing, in part because of the current reporting systems and the flexibility of program resources.[8] However, in 2003 the Special Needs Housing Alliance reported that the County opted to dedicate roughly 70% ($12,859,873) of its annual allocation toward supportive service expenses.

Of the remainder, DMH allocated approximately 21% ($3,753,647) of the funding toward housing/personal and incidental expenses, including capital, rental assistance, operating, food, clothing, vocational, and transportation costs. The remaining 9% ($1,641,480) account for the department's administrative costs and the DMH-operated AB 2034 program in Twin Towers. DMH reported no matching requirements as a condition to access program funding.

2. Projects for Assistance in Transition from Homelessness (PATH)

a. Background

In 1990, Congress amended the McKinney Act to create the PATH program as a formula grant that provides funding to States to provide numerous support services for homeless persons with mental illness or co-occurring substance abuse disorders. PATH funding differs from AB 2034 resources in that they are less flexible, focused instead on

[8] DMH reported that the State provided them with no specification as to the extent and amounts of program resources that can be used for housing purposes, only the number of clients to be served annually.

outreach, engagement, and transition to mainstream resources, and are distributed via formula based on the urban population of the State relative to the urban population of the entire United States.

Despite the general scarcity of public funds targeted to homeless persons with mental illness, the PATH program has emerged in recent years as a promising source of ongoing financing for affordable housing and supportive service providers seeking to serve this population. Steady increases in federal appropriations, at least over the past five years (i.e., $23 million in FY 1998 to $47 million in FY 2003), attest to this fact. Nonetheless, advocates express concern that the minimum allocation ($300,000) has not been raised since the program's inception in 1991 (National Alliance to End Homelessness, p. 27).[9]

b. Program Philosophy

PATH funds are used to ensure access for homeless persons with severe mental illness to the mainstream mental health system, affordable housing and treatment options for individuals with dual diagnosis. The three levels of service targeted by PATH funding and considered critical to assisting homeless persons with serious mental illness are: *outreach* to individuals not receiving mental health services; *engagement* of these persons in treatment and services; and *transition* to mainstream mental health treatment, housing and supportive services.

c. Eligible Use of Funds

PATH-funded services include outreach, referral services, case management, mental health services, staff training, rehabilitation, housing services, and supervisory services for clients in residential settings. These types of services comprise the vast majority (at least 80%) of the County's program expenditures.

Housing services as defined by this program include: minor renovations/repairs; housing planning; technical assistance in applying for housing assistance; improving coordination of housing services; providing security deposits; costs associated with matching eligible homeless individuals with appropriate housing situations; and one-time rental payments to prevent evictions. No more than 20% of a state's PATH allocation can be used to fund housing services. According to DMH, of the 20% eligible for housing services, the County has opted to designate roughly 14% of that amount (or $52,000 annually) for rental assistance purposes.

Funds may not be used to support emergency shelters or to construct housing facilities, for inpatient psychiatric or substance abuse treatment or to make cash payments to intended recipients of mental health or substance abuse services. The receipt of PATH

[9] Homeless advocates such as the National Alliance to End Homelessness argue that PATH funding continues to remain stagnant during the annual federal appropriations process. Under the formula, approximately 30 states share in the program's annual appropriations increases. The remaining states and territories (more than 20) receive the minimum grant of $300,000 for states and $50,000 for territories. They are seeking to double the minimum grant amounts to $600,000 since several states have received no increase in funding over the last several years even though the program has grown.

funds from the federal government requires a 25% County match. The DMH network of directly operated mental health clinics provides a comprehensive range of mental health services as the required in-kind match.

d. Local Program Implementation

DMH applies for and administers PATH money on behalf of Los Angeles County. The PATH grant is used to fund homeless programs operated by DMH-contracted agencies and the Department's directly operated programs. According to DMH, the slight increase in local PATH dollars from FY 2003 to FY 2004 enables them to enhance PATH funding in Mental Health Service Areas 1, 4, 6, and 8, where there is a strong need for additional program funds (DMH, April 8, 2004).

e. Distribution of Program Funding in Los Angeles

For FY 2003-2004, the State Department of Mental Health allocated a total of $2,046,731 in PATH funds to Los Angeles County. For FY 2003-2004, DMH's 25% match requirement was $682,244 for a total program cost of $2,728,975.

For FY 2004-2005, the State was awarded $6,741,000 with Los Angeles County receiving $1,850,087, or roughly 27% of the total statewide allocation (see Table 34).

Table 34. PATH Allocation, Los Angeles County (FY 2003 & FY 2004)

Fiscal Year	Amount
FY 2002-2003	$1,484,086
FY 2003-2004	$2,046,731
FY 2004-2005	$1,850,087

D. Programs Targeted to Persons Living with HIV/AIDS

There are only two public funding programs specifically targeted to support the housing and supportive services needs of persons living with HIV/AIDS. These programs include the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and Housing Opportunities for Persons Living with AIDS (HOPWA) programs.

For the most part, both these programs distribute funding to the region via formula allocations based on the cumulative AIDS cases within Los Angeles County. Though they are administered at the local level by separate entities, both programs provide the County with broad control of HIV/AIDS-related planning and service delivery.

1. Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

a. Background

The CARE Act was first enacted in 1990, with the intention of addressing unmet service and healthcare needs of persons living with HIV disease. It was subsequently amended

and reauthorized in 1996 and in 2000, respectively. This is the largest federal program specifically designed to provide care and services for persons living with HIV/AIDS.

Funds for this program originate with the U.S. Department of Health and Human Services, and are administered at the federal level by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB).

b. Program Philosophy

CARE Act funds are used to address medical and supportive service needs that are not met by other resources, such as Medicaid or private insurance. These funds are intended to act as the "payer of last resort," to supplement but not supplant funds already allocated for services to this population under local, state, and federal programs. For this reason, only low-income individuals with HIV/AIDS and their families/caregivers are eligible "users" of CARE Act services.

CARE Act services are intended to reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic. As HIV penetrates deeper into the most marginalized sectors of society, CARE Act programs are being called upon to provide care for traditionally underserved populations—the homeless, women who are dependent upon welfare, persons with substance use disorders, gay and bisexual men of color—and other communities that have been affected by the virus.

c. Overview of CARE Act Programs

CARE Act funding is distributed under five titles or parts, though the following discussion concentrates only on the Title I (Local Areas) and Title II (States) programs since they are the principal sources of CARE Act funding for housing assistance programs targeting PLWH/A in Los Angeles County.[10] While the costs associated with the development or operation of permanent or long-term supportive housing are not eligible under Titles I and II, these programs will fund housing-related services (e.g., emergency financial assistance) and supportive services to residents in supportive housing (Bristol & Greiff, p. 48).

The **Title I** program provides emergency relief grants to the country's largest metropolitan areas, referred to as eligible metropolitan areas (EMAs). Title I grants are awarded directly to local governments, and in turn, to providers based on service priorities established by the Title I planning council, convened by the EMA to carry out HIV/AIDS planning. Title I funds may be used for HIV/AIDS primary care and support services that enhance access to and retention in primary care. Funds may also be used for early intervention services to move PLWH/A into appropriate care.

The **Title II** program provides formula-based financial assistance to states and territories to improve the quality, availability, and organization of health care and

[10] CARE Act programs also consist of the following: Title III (Community-Based Programs); Title IV (Children, Youth, and Women with HIV Disease and Their Families); Special Projects of National Significance (Research Models) (SPNS); and the HIV/AIDS Dental Reimbursement Program.

support services for individuals and families with HIV infection. Title II funds may be used for all of the uses of Title I plus the establishment and operation of HIV consortia; continuity of insurance coverage; and pharmaceutical treatments through the AIDS Drug Assistance Program (ADAP).

Los Angeles County is one of several jurisdictions in the nation that receives CARE Act funds through both formula grant programs. For the purpose of local nonprofit housing and social service providers who seek (or have received) CARE Act funding, Title I and Title II formula grants are typically not distinguished as such by the County, but instead are administered together as CARE Act funds. Except where necessary, the following describes both formula grant components as one source of funding.

d. Uses of Title I and Title II Funding for Housing Assistance

There are two categories of housing-related expenditures to which CARE Act funds may be allocated: Housing Referral Services and Short-Term or Emergency Housing Assistance. Both types of costs are justified so long as they assist PLWH/A and their families or caregivers to gain and/or maintain access to HIV-related medical care or treatment.

i. Housing Referral Services

The HIV/AIDS Bureau defines housing referral services as assessment, housing search and placement, and advocacy services. They must be provided by case managers or other professionals who possess an extensive knowledge of local, state, and federal housing programs and how they can be accessed.

ii. Emergency or Short-term Assistance

Emergency assistance refers to programs that are of a very short duration and are intended to assist individuals or households in situations of immediate housing crisis. Examples of emergency assistance include hotel or motel vouchers, emergency shelter stays, homeless prevention assistance (e.g., one-time rent payments), assistance moving to a new location, or per diem payments in an emergency alcohol or substance abuse detoxification program.[11]

The HAB defines short-term housing assistance as programs or payments that are designed to promote housing stability, and to facilitate the transition to long-term sustainable housing that is independent of CARE Act funding. Short-term housing assistance includes transitional housing programs, short-term rental assistance, temporary living assistance, and short-term residential treatment.

As stated earlier, CARE Act funds are applicable mainly to emergency and transitional housing. However, providers or long-term or permanent supportive housing should take note that Ryan White funds, under the health and support services provisions, are

[11] Housing funds may be used for detoxification services if the provider requires payment for the housing portion of the program, and does not receive CARE Act funds from the substance abuse category for the expense.

able to finance many of the services that make up the "support" in these types of housing (Ibid, p. 49).

e. Local Planning Process

Federal legislation mandates the establishment of collaborative local planning bodies to determine the categories of use of CARE Act Title I and II funds. Title I grantees, in turn, must procure funds according to these set priorities.[12]

In Los Angeles County, the Commission on HIV (Commission) serves in this capacity. The Commission is broadly representative of the community, playing a critical role in establishing priorities for the allocation of funds. The Commission accomplishes this by working in partnership with the grantee to determine the size and demographics of the population with HIV disease, carrying out needs assessments, comprehensive planning, capacity development, and services evaluation activities.

The role of the planning councils in addressing housing needs of persons living with HIV/AIDS is critical. The CARE Act Amendments of 2000 expanded planning council members to include providers of housing and homeless services. Congress instituted this change to help strengthen the link between planning for HIV care and housing.

f. Program Implementation

OAPP administers local CARE Act funding and is responsible for implementing the priorities and allocations established by the Commission. As part of this responsibility, OAPP must conduct periodic needs assessments and utilize CARE Act funding to solicit services, negotiate contracts, and monitor services.

g. Distribution of CARE Act Funding in Los Angeles

Since 1991, the Los Angeles County Board of Supervisors has accepted in excess of $380 million in CARE Act funds. The Board has taken a number of actions to expend the grant funds primarily through contracts with community-based organizations.

For March 1, 2003 to February 29, 2004, $41,965,686 was allocated to the provision of direct services. The $41,965,686 was offset by $32,626,080 in CARE Act Title I funds; $2,268,225 in CARE Act Title II funds; $1,028,780 in California Department of Health Services (CDHS) – Office of AIDS (OA) funds; and $5,502,601 in Net County Costs (see Table 35).

[12] Funding allocations are based on an assessment of the needs of those with HIV (particularly those who are not in care), the cost effectiveness and outcome effectiveness of specific services, priorities of HIV-infected communities, and availability of other governmental and non-governmental resources.

Table 35. CARE Act Services Funding Allocations in Los Angeles County (2003-2004)

CARE Act Service	Funding Allocation
Ambulatory/Outpatient Medical Services	$17,284,251
Case Management Corrections Project	$751,880
Case Management/Psychosocial, Family Support *	$724,031
Case Management/Psychosocial Services	$3,785,606
Food Bank, Home Delivers Meals/Nutritional Supplements*	$689,700
Housing Assistance-Residential Emergency Housing	$126,983
Housing Assistance-Residential Facilities	$7,457,796
Housing Assistance-Residential Transitional Housing	$293,647
Legal Services	$414,713
Mental Health Services	$2,273,889
Oral Health Care	$607,958
Other Support Services, Child Care	$197,981
Other Support Services, Translation/Interpretation	$244,587
Psychosocial Support Services/HIV Support**	$570,492
Service Provider Networks/Program Support	$1,187,730
Substance Abuse Services-Methadone Maintenance	$184,507
Substance Abuse Services-Residential Detoxification/Residential Rehabilitation	$1,081,769
Substance Abuse Services-Residential Rehabilitation	$738,943
Substance Abuse Services-Transitional Housing	$219,403
Substance Abuse Services-Short Term and Emergency Counseling	$200,342
Training and Cross Training	$168,881
Transportation Services	$909,758
Treatment Adherence**	$1,550,729
Van Transportation**	$300,110
Total	**$41,965,686**

* Receives CARE Act Title I and Title II funding.
** Receives CARE Act Title II but not Title I funding.

For the CARE Act Year 14 beginning on March 1, 2004, Los Angeles County was awarded $39,927,199 in Title I and Title II funds combined. This represents an 8.2%, or $3.3 million decrease in the Title I award for the current year and an increase in Title II funding in the amount of $304,489.

The resulting $3 million deficit in funding to programs supported by CARE Act funds has been addressed by cuts to programs and services and the redirection of county funding not provided through the CARE Act to offset cuts to vital services. The Commission has developed a plan to cut non-direct services (administration, program support, etc.) by 8% and reduce funding to each direct service category by 3%. With a general fund contribution from the County (Net County Cost), funding for outpatient medical services was maintained at pre-reduction levels and offset by larger, 5% cuts to case management, housing assistance and hospice services that are funded by County resources.

2. Housing Opportunities for Persons with AIDS Program

a. Background

The Housing Opportunities for Persons with AIDS (HOPWA) program emerged as a response to intensifying housing crises among the HIV/AIDS population during the 1980's and early 1990's. These issues were illuminated in a report by the National Commission on AIDS in 1992, which found that housing is of vital importance as a foundation from which to receive care and access other support (HUD, 2003, p. 9).

These pressures compelled Congress to create a reliable and sustainable funding source through the National Affordable Housing Act of 1990, with broad flexibility for states and localities to develop comprehensive strategies in meeting the varying needs of persons living with HIV/AIDS. The HOPWA program is the federal government's primary targeted response to the pressing housing needs of persons living with HIV/AIDS and their families. At this time, the HOPWA program is administered at the federal level by HUD's Office of HIV/AIDS Housing.

b. Formula and Competitive Grants

The HOPWA program is designed to mix formula funding with competitive grants. Program funds are distributed under a formula that is based on AIDS surveillance information from the Centers for Disease Control and Prevention (CDC), for cumulative AIDS cases and area incidence. The formula allocates 90% of the appropriation to eligible States and cities on behalf of their metropolitan statistical areas (EMSA). The City of Los Angeles acts as the HOPWA formula grantee for the Los Angeles-Long Beach EMSA (otherwise known as the County of Los Angeles), with the Los Angeles Housing Department (LAHD) designated as the local program administrator.

HUD also appropriates 10% of HOPWA funding on a competitive basis. Competitive grants, for which applications are submitted directly to HUD, fall into two categories. Special projects of national significance (SPNS) are projects that, due to their innovative nature or potential for replication, are likely to serve as models in addressing the needs of persons living with HIV/AIDS. Competitive grants are also awarded to those states and units of local government that do not qualify for formula allocations but have developed long-term comprehensive strategies for the utilization of HOPWA resources.[13]

As part of the 2003 HUD SuperNOFA, the Department provided more than $3.5 million in rental assistance to persons with HIV/AIDS in connection with a collaboration with the CDC to study the impact of stable housing on the health of persons served. Los Angeles is one of three cities nationwide (along with Chicago and Baltimore) participating in the study, which will provide $1.2 million in long-term rental assistance to approximately 105 PLWH/A who are either homeless or at imminent risk of homelessness. *Connections* , as it is called in Los Angeles, represents the first

[13] Except for SPNS grants, nonprofit organizations are not eligible to apply directly to HUD for a HOPWA grant but may receive program funding as a project sponsor under contract with a formula grantee.

collaboration between HUD and CDC and demonstrates the Administration's interest to pursue multi-agency demonstration projects (e.g., *Collaborative Initiative to End Chronic Homelessness* and *Ending Chronic Homelessness through Employment and Housing*) to achieve housing goals in light of modest annual investment in HUD's discretionary funding.

c. National and Local Grant Levels

Since 1992, Congress has appropriated more than $2.2 billion to the HOPWA program. From 1992 to 2004, HOPWA appropriations increased nearly six times from $42,935,000 to $295,000,000. During the same time period, Los Angeles' share of the national allocation decreased from 6.8% to 3.6% (see Table 36).

Table 36. Annual HOPWA Appropriations, Los Angeles EMSA (1992-2004)

Fiscal Year	National Appropriation	Los Angeles-Long Beach Allocation	% of National Appropriation
1992	$42,935,000	$2,917,000	6.8%
1993	$90,000,000	$6,898,950	7.7%
1994	$140,000,000	$9,509,592	6.8%
1995	$153,900,000	$8,478,741	5.5%
1996	$153,900,000	$7,962,855	5.2%
1997	$176,400,000	$10,732,040	6.1%
1998	$183,600,000	$10,144,000	5.5%
1999	$225,000,000	$8,769,000	3.9%
2000	$232,000,000	$8,905,000	3.8%
2001	$258,000,000	$9,691,000	3.7%
2002	$278,000,000	$10,288,000	3.7%
2003	$292,000,000	$10,489,000	3.6%
2004	$295,000,000	$10,476,000	3.6%
Total	**$2,225,735,000**	**$115,261,178**	

d. Program Philosophy

The goal of the HOPWA program is to assist low-income persons with HIV/AIDS and their families to locate, stabilize, and maintain safe, decent, and affordable housing, which is consistent with the central mission of HUD to create such a living environment for all Americans. This goal is based partly on the belief that the alleviation of housing concerns of PLWH/A will better enable them to address their health-related needs, and when possible, pursue other life and career goals.

Yet while housing remains the primary mission of the HOPWA program, grantees report using HOPWA as a bridge to other supportive services with the program often addressing the immediate need of housing and working with clients to access other services (Ibid, p. 9). In this sense, the HOPWA program has successfully maximized program resources by leveraging funds with local, State, and federal agencies to provide services to clients. According to HUD's *National Evaluation of the HOPWA*

Program in 2000, 92% of grantees and housing providers report coordination with Ryan White CARE Act and HUD's Continuum of Care systems (ICF Consulting, 2000).

e. Local Planning Process

To best promote coordination and integration of HOPWA with other community-focused planning processes, eligible states and localities apply for their formula funding as part of a Consolidated Plan submission to HUD. The Consolidated Plan document represents a plan for the jurisdiction's application of resources for three of HUD's formula grant programs — Community Development Block Grant (CDBG), the HOME Investment Partnerships Program (HOME), and Emergency Shelter Grants (ESG) — in addition to HOPWA.[14]

Los Angeles has established the Los Angeles Countywide HOPWA Advisory Committee (LACHAC) to advise LAHD on program policy and design issues. This board is comprised of representatives from the community, with various expertise in HIV/AIDS housing and services, as well as persons with HIV/AIDS. LACHAC has established various subcommittees, such as the Strategic Planning Task Force, to provide assistance with long-term planning and needs assessment.

f. Program Implementation in Los Angeles

As the HOPWA formula grantee for the Los Angeles-Long Beach EMSA, the City of Los Angeles has the responsibility of establishing policy initiatives, and determining the process and direction of funding for housing and services to help meet the needs of persons living with HIV/AIDS in the county. The LAHD, in its role as the administrative entity for HOPWA funding in Los Angeles County, is responsible for the implementation of priorities established by the LACHAC, soliciting and negotiating contracts, as well as monitoring services.

g. Distribution of HOPWA Funding in Los Angeles

Currently, the HOPWA program funds a variety of housing programs and services for PLWH/A and their families in the Los Angeles area. The LAHD has disbursed program funding primarily through contracts with community-based organizations and local housing authorities.

For the 2004-2005 Program Year, HOPWA program expenditures have been directed primarily (54%) towards rental assistance, which includes the Short-term Rent, Mortgage, and Utility Assistance Program (STAP) (17%), as well as long-term rental assistance (37%). The remaining funds are distributed as follows: supportive services (20%), housing information and referral and housing case management (8%), emergency housing and meal vouchers (8%), capital development (7%), and grantee administration (3%).

[14] Plans are developed through a public process that involves consultations in assessing area needs, creation of a multiple year strategy and development of an annual action plan for use of federal funds in conjunction with other community resources, such as State, local and private funds.

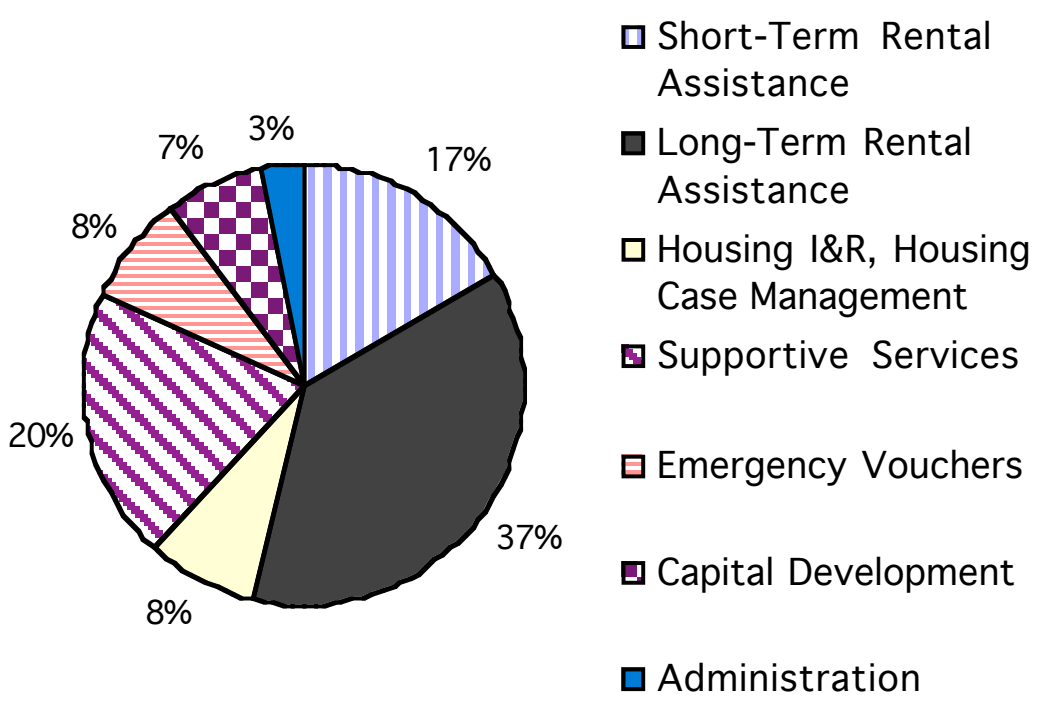

Figure 15. Distribution of HOPWA Funds in Los Angeles (FY 2004-2005)

The bulk (69%) of HOPWA rental assistance funding is designated for long-term rental assistance, both tenant-based (TRA), which functions similar to the Section 8 Housing Choice Voucher program, and project-based (PRA). Housing authorities for the City of Los Angeles (HACLA), County of Los Angeles (HACoLA), and City of Long Beach are under contract to administer the HOPWA TRA component, with HACLA responsible for the PRA component (see Figure 16).

Aside from long-term rental assistance, approximately one-third (31%) of the rental assistance funds are used for more time-limited purposes, such as the STAP (23%) and Move-In Grant programs (8%) (see Figure 16).

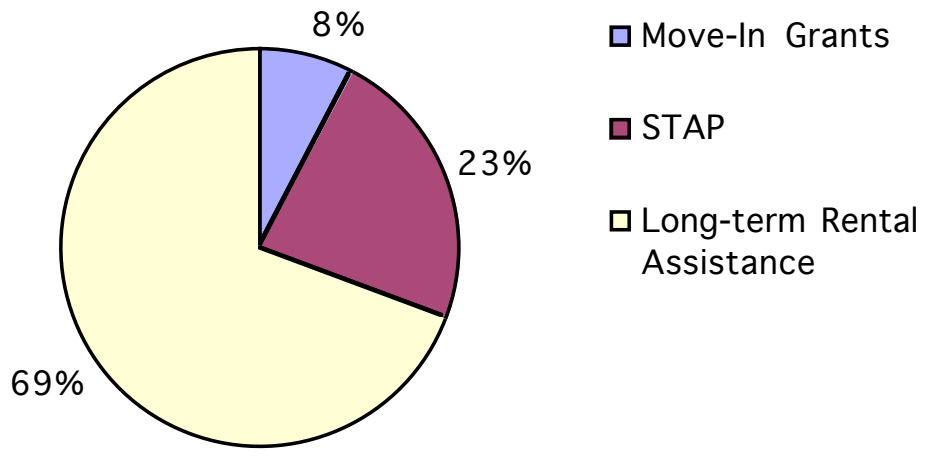

Figure 16. Distribution of HOPWA Rental Assistance Funds in Los Angeles (FY 2004-2005)

In January 2004, LAHD released an RFP for approximately $8.5 million in HOPWA program funding for ten program components.[15] This was the first time since 2001 that LAHD had conducted a competitive bid process to obligate their HOPWA formula grant funds. Relative to the 2001 HOPWA RFP, the current one made some adjustments to keep pace with federal policy and the increasing demand of the program to adapt appropriate responses to PLWH/A who have become homeless or who are at risk of homelessness.[16]

In addition to funding committed as a result of this competitive process, the 2004-2005 HOPWA program budget ($16,377,654) includes $6,085,849 for long-term rental assistance, $1.2 million for capital development, $170,000 for technical assistance (e.g., accounting), and $314,672 (3%) for the Department's administration of the program. This budget reflects more than $2 million in HOME program funding to support long-term rental assistance (see Table 37).

[15] Subsequent to this bid process, LAHD provided an additional $1 million to the *Housing Case Management* component to provide housing placement assistance to undocumented clients who are accessing long-term rental assistance but are unable to "roll-over" into the Section 8 program due to eligibility restrictions.

[16] *Move In Grants* had previously been available through the STAP program but were separated to comply with HUD's guidance. The *Other Supportive Services* category is also a new addition. It provides services funding for programs (e.g., legal services or food) that operate independently of HIV/AIDS housing programs. The *Housing Case Management* (formerly Housing Specialists) component was established to differentiate from traditional case management provided under programs which focus more exclusively on supportive and other services rather than housing.

Table 37. Los Angeles HOPWA Program Budget, FY 2004-2005

Program Component	Amount
Centralized Countywide Housing Information Services Clearinghouse	$191,640
Emergency Housing and Meal Vouchers	$1,300,056
STAP	$2,036,664
Move In Grants	$678,887
Housing Case Management	$1,155,455
Lease, Operating, and Supportive Services in Emergency Shelter and Transitional Housing	$1,515,435
Supportive Services in Permanent Housing	$806,735
Other Supportive Services	$582,261
Scattered-Site Master Leasing	$250,000
TB and Hepatitis B and C Risk Mitigation	$90,000
Subtotal (2004 RFP)	**$8,607,133**
Long-term Rental Assistance	$6,085,849
Technical Assistance	$170,000
Grantee Administration	$314,672
Capital Development	$1,200,000
Total	**$16,377,654**

E. City of Industry Fund Special Needs Housing Program

Every funding program discussed above targets resources towards specific populations that are considered to have special needs. In Los Angeles County, there is a unique public resource that specifically targets all three of the three populations under review in this Plan. By embracing the concept of affordable housing linked to supportive services, the City of Industry Fund Special Needs Housing program represents a very important source of capital funding for the County's special needs populations.

1. Background

In August 1992, California Senate Bill 1718 was enacted, authorizing and requiring the Industry Urban Development Agency to transfer 20% of all tax increment revenue derived from its redevelopment areas to the Housing Authority of the County of Los Angeles (HACoLA) for the development of low- and moderate-income housing. Pursuant to SB 1718, an administrative plan was submitted to the State Housing and Community Development Department (HCD) after approval by HACoLA's Board of Commissioners and ultimately the Los Angeles County Board of Supervisors on November 8, 1994.[17]

The administrative plan set aside 50% of the redevelopment funds to the development and preservation of affordable housing.[18] The remaining 50% of program funds are

[17] All rulings from various lawsuits challenging aspects of SB 1718 became final by October 15, 1998, allowing the transfer of Industry funds to HACoLA at that time.
[18] Affordable housing includes rental apartments for seniors, multifamily rentals, and for-sale housing to income-qualified buyers.

reserved for "special needs" housing. Funds for special needs housing must be spent in accordance with California redevelopment law, including resident income restrictions, rental and homebuyer payment limits, and duration of residence. Only persons with developmental disabilities, mental illness, HIV/AIDS, victims of domestic violence, and emancipated foster youth are eligible target populations.

2. Program Philosophy

This program responds to the pervasive lack of affordable housing in Los Angeles County and the large numbers of homeless individuals within its jurisdiction that have special needs. Combined with limited shelter and transitional housing capacity across the region, as well as budget curtailments at the State and local levels, the County felt compelled to respond with a coordinated, comprehensive, and longer-term solution to confront these exacerbating concerns.

In this context, the City of Industry Fund Special Needs Housing program occupies a central role in the County's efforts to increase the stock of affordable housing for disabled and special needs persons. To ensure that the program is directing its resources to those most in-need, the program has adopted a maximum affordability criterion of 50% of AMI. Moreover, there is a strong emphasis upon the housing provider's capacity and experience working with and developing and operating housing for the proposed target population.

Providers are also required to offer (either directly or through linkages) residents an array of supportive services to facilitate their transition to self-sufficiency and housing stability. To further demonstrate the long-term viability of the proposed development, applicants are evaluated on the degree and types of service funding committed to the project as well as the property management's experience and approach for serving these populations.

Since the program functions essentially as a source of "gap" financing, offering only limited funding, the program also strives to leverage funds from other public and private sources. In the past, Industry funds have leveraged public funding from numerous other public sources, such as: Low-Income Housing Tax Credits (LIHTC); the Affordable Housing Program; and HUD's Sections 202, 811, McKinney Homeless Asssistance, HOME, Supportive Housing Program, Shelter Plus Care, SRO Moderate Rehabilitation, CDBG, and HOPWA programs among others.[19]

3. Use of Funding

The City of Industry Fund Special Needs Housing program provides capital financing for the expenses incurred in the development of transitional and permanent housing for very low-income special needs populations. Through the "special needs component," only rental housing developments are eligible for funding, and eligible developments must commit to create at least four new or additional beds/units.

[19] See Section VI.F. for more information on these mainstream public funding programs that have been leveraged through the City of Industry program.

Requested funding can be used only for predevelopment (e.g., accounting, architect, etc.),[20] acquisition (with or without rehabilitation), new construction, and permanent financing. The maximum assistance per project is $1.8 million, available as loans only and not grants. All developments must be located within 15 miles of any point of the boundaries of the City of Industry and within the County of Los Angeles.
As stated earlier, the program only funds transitional or permanent housing developments for special needs populations. Emancipated foster youth are limited to transitional housing, while persons with developmental disabilities can only be provided with permanent housing.

4. Distribution of Funding

Each fall, Requests for Proposals (RFPs) are used to announce the availability of Industry funds for the development of special needs housing for very low-income persons with special needs. Typically, approximately $5 million in Industry funding is available annually for Special Needs housing and another $5 million is available for Affordable (single-family, multifamily, and senior) projects.

Currently in its eighth funding cycle, the Special Needs program has provided $41,395,973 in capital financing, and leveraged an additional $129,374,089 from other funding sources. Program funding has assisted in the development of 1,143 units of housing, of which 959 are for special needs.

F. Non-Targeted Funding Sources

The discussion of non-targeted public funding programs is categorized according to the type(s) of activity (or use categories) considered eligible, such as housing development, operating, or supportive service costs. Sources that may provide funding for multiple activities, like housing development and supportive services, are grouped in the category with which they are most commonly associated and then referenced in other sections.

Where applicable, the following information is also classified according to the level of government from which this funding originates, not necessarily the level at which it is accessed. This may include Federal, State, County, and City funding sources. Moreover, this section distinguishes between sources that fund permanent, transitional, and/or emergency shelter housing types.

1. Development Sources

a. Eligible Activities

Development or capital costs are those costs associated with establishing the physical structures associated with a housing project. Housing development activities consist generally of four principal activities: 1) predevelopment; 2) acquisition; 3)

[20] Predevelopment funds are limited to $50,000 until all funding commitments are in place.

rehabilitation; and 4) new construction. Development funding can be provided in the form of loans (may be deferred, low-interest, or residual receipts), grants or equity (Bristol & Greiff, p. 79).

These activities can be further categorized as either "soft costs" or "hard costs." Predevelopment expenses are often considered under the soft cost category, and can include but are not limited to items such as architectural services, appraisals, engineering, developer fees, legal costs, fees and permits, environmental reports, monitoring, and lease-up costs.

Hard costs are more narrowly defined. They consist of land or building site preparation, acquisition, construction, rehabilitation, as well as off-site improvements (sewers, utilities, etc.).

b. Use Restrictions

It is common for public housing development funding to limit use to individuals or households that meet specific income requirements, often determined by HUD, but occasionally at the State level. Each year, HUD publishes median income guidelines that are frequently incorporated into program regulations, though they perhaps are best understood for their use in federally subsidized housing programs such as conventional public housing or the Section 8 Housing Choice Voucher program.

The three income categories that impact the use of housing development funding are: 1) low-income (defined as <80% Area Median Income or AMI); 2) very low-income (30-50% AMI); and extremely low-income (<30% AMI). The Community Development Block Grant program (CDBG) also allows for moderate-income use as well, despite using the 80% of AMI threshold to define it.

In addition to these income limitations, project sponsors are frequently asked to "match" their funding request with a certain percentage of funds from other sources, either public or private. Depending on the source, this can be as much as a dollar-for-dollar commitment, as is the case with sponsors requesting capital funding through the HUD Supportive Housing Program.

c. Overview of Programs

Federal sources comprise the vast majority of public funding available for housing development for special needs populations, though the passage of Proposition 46 in November 2002 provided close to $2 billion in capital resources for affordable housing statewide. Development funding is typically distributed according to either formula grants or competitive grants (see Section VI.A. for more information on these types of grants).

Among capital sources provided through the federal government, most originate with HUD. The two federal programs that are not administered by HUD are the Federal Home Loan Bank's Affordable Housing Program (AHP), which provides low-interest loans to affordable housing development projects and Low Income Housing Tax

Credits (LIHTC), which facilitate private investment in low-income housing. Both of these grants are accessed through a competitive process. Outside of HUD's resources, the VA has limited capital funding through its Homeless Providers and Per Diem program.

The State of California, through its Department of Housing and Community Development (HCD) has also implemented several programs to finance the development of emergency shelter, transitional housing, and permanent affordable housing. The Emergency Housing Assistance Program (EHAP) provides capital development deferred loans for capital expenses associated with building, rehabilitating, or expanding emergency shelters, Safe Havens, and transitional housing for homeless persons.

The Multifamily Housing Program (MHP), on the other hand, provides low-interest loans to developers of multifamily rental and transitional housing through both a General and Supportive Housing component. The MHP-Supportive Housing component is particularly attractive to affordable housing providers because it allows for programs to target special needs populations.

Within the City of Los Angeles, the Affordable Housing Trust Fund and redevelopment funds represent the most local sources of capital financing for special needs housing. It should be noted, however that while the City's Affordable Housing Trust Fund is partially financed through the General Fund, other sources (e.g., federal HOME program) are also employed.

Regardless of the grant source, all housing development funding programs available through public entities are extremely competitive and require the applicant to demonstrate both the capacity and experience to perform the proposed work. In order to remain competitive for scarce housing development resources, projects must be both feasible (e.g., project readiness, secured additional funding commitments for development and/or supportive services, workable pro forma, etc.) and meet quality standards (e.g., proximate to services or public transit, appropriate types and levels of services, architectural design) (Ibid, p. 79).

d. Development Program Funding Summaries

A more detailed outline of housing development sources are included below according to the level of government at which they originate, eligible uses of funds, and grant type (i.e., formula or competitive), and matching requirement (see Table 38).

2. Operating Sources

Operating sources are defined as those that provide for the costs of operating or maintaining the physical structure of a housing development. These expenses include but are not limited to: maintenance, insurance, security, property management, debt service, and operating and replacement reserves. In some cases, operating sources will

cover leasing expenses for project sponsors that provide either single site or scattered-site affordable housing.[21]

Operating sources are fairly scarce, more so than capital development programs, and extremely precious for affordable housing programs that serve disabled and/or special needs populations. Unlike market rate housing, affordable (and supportive) housing rents are generally not enough to cover operating costs because they are kept intentionally low to ensure affordability for households with low or modest incomes. Affordable housing developments therefore must receive an ongoing source of operating funds, or in some cases rental subsidies, to ensure that project income at least meets expenses (Bristol & Greiff, p. 123).

Operating expenses can be further categorized according to three major categories: 1) Short-term Rental Assistance; 2) Long-term Rental Assistance; and 3) Conventional Operating Subsidies

a. Short-term Rental Assistance

Short-term rental assistance refers to two modes of assistance. *Eviction prevention* programs provide beneficiaries with funds to pay late or delinquent rent or utility bills. Programs that provide funds for *move-in assistance* offer cash grants to individuals to cover the cost of moving into permanent housing, including first and last month's rent, security and/or key deposits, cleaning fees, etc.

b. Long-term Rental Assistance

Long-term rental assistance programs function as operating subsidies for housing providers, as they allow them to meet the financial demands of providing housing and still make their units affordable to low-and very-low income tenants. Rental subsidies are paid to housing providers to offset the difference between what the consumer can afford to pay and what the market would allow for a particular size or rental unit in a particular locality, often referred to as the fair market rent (FMR), determined annually by HUD.

Long-term rental assistance can be accessed through both formula and competitive means, though they are all federal sources that must be administered by local housing authorities.

Tenant-based Rental Assistance (TRA) provides rental assistance that permits participants to choose their own housing. In this sense, the subsidy (sometimes called a voucher) is "attached" to the tenant. If and when the tenant decides to move during the course of their stay, the subsidy remains with them. Tenants receiving this type of assistance pay rent in an amount that is affordable to them, typically 30% of annual income, with the difference between this amount and the amount charged by the housing provider covered by the housing authority.

[21] Generally, operating sources that provide for leasing do not allow project sponsors to request funds for capital improvements to the leased building, though any maintenance that is not covered by a landlord is often considered eligible if detailed appropriately during the funding request process.

Project-based Rental Assistance (PRA) is dedicated to units in a specific project, unlike TRA which are "moveable." Project sponsors receive a subsidy defined by the difference between the 30% affordability benchmark and the fair market rent. These types of subsidies are usually used for single project sites, where either all or a portion of units receive the assistance.

Sponsor-based Rental Assistance (SRA) is provided through specific housing sponsors, typically a nonprofit housing developer. Sponsors administering this type of assistance can use vouchers to subsidize any units under their control, whether they are owned or leased. The subsidy is paid in the same manner as the other two assistance types, with the sponsor receiving payment in the amount of the difference between what a tenant can afford to pay and the fair market rent.

c. Use Restrictions for Long-term Rental Assistance

Since long-term rental assistance funding sources are federal programs, the primary restriction for their use is that they must first flow from HUD to local housing authorities, and then from there to individual tenants, housing developments, or housing providers. Though this path varies according to the type of assistance (e.g, TRA or PRA), local housing authorities are still the only public entities eligible to apply for these resources.[22]

Two other restrictions apply to federal long-term rental assistance programs, specifically the amount that tenants can pay for rental costs, and how prospective tenants are identified. For this first criteria, HUD requires that tenants pay 30% of their adjusted income for rent and utilities, while HUD pays the difference between the tenant's portion and their approved FMR. Furthermore, eligible clients must meet specific income benchmarks, to ensure that the assistance is going to those with the greatest housing needs.

For several reasons, least of which is the lack of affordable housing in the County, individuals wishing to access federal rental assistance must be willing to wait an extended period of time to receive a subsidy. Local housing authorities must place interested parties on a waiting list, which is maintained in strict adherence with federal guidelines. It is not uncommon for persons on these wait lists to wait several years before finally receiving a Housing Choice Voucher. Fortunately for households in Los Angeles, both HACLA and HACoLA have established preferences and set-asides (e.g., Section 8 Homeless program) for those that meet HUD-approved criteria, such as homelessness or specific disabilities, to expedite their receipt of long-term rental assistance.

[22] Through highly competitive processes, local housing authorities can in turn sub-grant out PRA and SRA subsidies. Often times, as is the case in Los Angeles, local housing authorities will sub-contract with local housing and service providers for client referrals and the provision of supportive services to ensure that clients are accessing supports that will keep them housed.

d. Conventional Operating Subsidies

Uses of funds categorized as operating subsidies include general operating costs and per diem payments. Conventional operating subsidies cover the costs of the day-to-day maintenance of the facility and usually are contingent upon an approved operating budget, as is the case with the HUD Supportive Housing Program.

Per Diem payments, on the other hand, are oriented towards short-term housing programs or licensed residential programs. Operating payment is provided to a housing operator based upon an approved daily rate for the costs incurred in their provision of housing to an eligible client

e. Overview of Programs

Most of the operating subsidies included in this section are federal sources. The following provide long-term rental assistance: Section 8 Housing Choice Voucher Program, Section 8 Moderate Rehabilitation Single Room Occupancy (SRO ModRehab) program,[23] Shelter Plus Care (S+C), and the Mainstream Program Vouchers for Persons with Disabilities (Mainstream).

Rental assistance programs specifically targeting disabled populations, and thus of particular interest in the context of this Plan are the S+C and Mainstream programs.

The federal Temporary Assistance to Needy Families (TANF or CalWORKs in California) and the State EHAP programs also provide short-term rental assistance to homeless program participants. EHAP, in addition to providing capital financing, also offers grants for more conventional operating expenses.

Locally, the General Relief Emergency Voucher program, administered by DPSS, offers time-limited per diem payments to homeless applicants in need of nightly shelter.

f. Operating Program Funding Summaries

A more detailed outline of operating sources is included below according to the type of subsidy (see Table 39).

3. Supportive Service Sources

a. Types of Services

Supportive services are provided to participants in affordable housing programs to enhance their ability to obtain or remain in stable housing and live as independently as possible. For this reason, they are considered the "support" in supportive housing programs. Services provided in conjunction with special housing programs are very

[23] Section 8 Moderate Rehabilitation program operates similarly to the Section 8 program with the added requirement that rental assistance be applied to Single Room Occupancy (SRO) units that have undergone at least $3,000 each. Operators of SRO projects to which this assistance is applied receive an amount to cover debt service on loans incurred to make improvements in addition to the usual subsidy.

diverse in nature due to the various circumstances and needs of persons accessing these programs.

In the context of this Plan, supportive services represent integral forms of assistance that are directly responsive to the challenges special needs populations experience. For special needs populations residing in permanent supportive housing units, services often go hand-in-hand with rental assistance to help them meet the obligations of tenancy.

A homeless person with mental illness, for instance, may require multiple supportive services, such as case management, assistance accessing public benefits, primary health care, mental health and/or substance abuse services, and others that help alleviate the barriers to housing stability. For a higher-functioning emancipated foster youth, on the other hand, supportive services may be less intensive, or focused more on education, vocational attainment, and other independent living skills (e.g., money management).

The following services are commonly provided within supportive housing programs, either at the program site or through linkages with other providers:

- Case management and service coordination;
- Outreach and engagement;
- Benefits counseling and advocacy;
- Mental health counseling and treatment;
- Substance abuse counseling and treatment;
- Primary health care;
- Independent living skills;
- Education;
- Employment and vocational training;
- Child care and youth programs;
- Housing services;
- Food;
- Legal aid and client advocacy; and
- Transportation.

b. Use Restrictions

Like all activities for the use of public funds, there are certain restrictions that apply to the use of service funding. Service funding is generally limited to the following three areas: 1) the delivery of particular services; and/or 2) the utilization of a particular service strategy; and/or 3) addressing the needs of a particular population, as defined by its service needs.

Given the differing but sometimes overlapping criteria for the use of public service funding, the challenge rests with housing and service providers to effectively blend them to meet the disparate needs of their clientele (Bristol & Greiff, p. 11). Consistent with the use of public funds for housing development or rental assistance activities, service funding is usually limited to specific income levels, defined through either

HUD's AMI determinations or the federal poverty guidelines, published each year by HHS.

c. Overview of Programs

Supportive service funding sources emanate primarily from the federal government. They generally represent larger block grant programs, where resources "flow" to the local level through prescribed formulas based upon demographic and/or service need factors within a specific geographic area. Still, local entities at the County or municipal level, often supplement these federal funds with their own general funds, special taxes or bonds, or redevelopment funds, which together are packaged under one housing or service program title and purpose. LAHSA's Winter Shelter program and OAPP's residential facilities represent programs that have pursued such a mix to create local programs.

Several block grant programs originate with HHS and their key departments: the Substance Abuse and Mental Health Services Administration (SAMHSA); Centers for Medicare and Medicaid Services (CMS); Health Resources Services Administration (HRSA); and the Administration on Children, Youth, and Families (ACF). These programs include:

- Community Mental Health Services Block Grant (MHBG);
- Substance Abuse Prevention and Treatment Block Grant (SABG);
- Community Services Block Grant (CSBG);
- Social Services Block Grant (SSBG); and
- Child Care and Development Block Grant (CCDBG).

Despite the fact that most of SAMHSA's services funding is distributed through block or formula grants, the Department also uses discretionary funding to offer competitive grants for mental health services and substance abuse treatment.[24] These include:

- Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons who are Homeless;
- Grants to Expand Substance Abuse Treatment Capacity in Targeted Areas of Need; and

- Targeted Capacity Expansions Initiatives for Substance Abuse Prevention (SAP) and HIV Prevention in Minority Communities.

The federal MediCal and CalWORKs programs are also critical service resources that are managed at the State, and ultimately the County level. In the case of MediCal, the State has opted to dedicate a portion of its allocation to provide specialty mental health services. CalWORKs, on the other hand, provides numerous welfare-to-work

[24] Beginning in federal Fiscal Year 2004, SAMHSA announced and solicited proposals through these discretionary programs under the following four standard grant announcements: 1) Services Grants; 2) Infrastructure Grants; 3) Best Practices Planning and Implementation Grants; and 4) Service-to-Science Grants.

programs, in addition to the County's Homeless Assistance Program, administered by DPSS.

In the context of this Plan, homeless persons with mental illness can also receive primary health care (including mental health and substance abuse services) through HRSA's Health Care for the Homeless (HCH) program.

Additionally, there are federal employment and vocational training programs designed to assist persons with special needs, including homeless persons, to enter or reenter the workforce. In Los Angeles County, the Department of Labor provides formula funding for a network of WorkSource Centers (formerly known as One Stops), which are located throughout the City and County to streamline the delivery of these services to both job seekers and employers. The DOL also targets homeless veterans through the Homeless Veterans Reintegration Program, a competitive resource that expedites the entry of homeless veterans into the labor force.

With respect to State-funded service resources, the Proposition 36 program provides a comprehensive system of community-based drug treatment services through the collaboration of the courts and Probation systems, parole authority, the Board of Prison terms, and community-based providers.

d. Service Funding Summaries

A more detailed outline of supportive service sources is included below according to the level of government at which they originate, eligible uses of funds, and grant type (i.e., formula or competitive) (see Table 40).

Table 38. Summary of Funding Sources for Housing Development.

	Eligible Activities				Target Populations				Project Type						Grant Type		Matching Requirement
	Pre-Development	Acquisition	Rehabilitation	New Construction	Homeless	Special Needs	Very Low-Income	Low-Income	ES	TH	PH	HO	SH	NRF	Formula	Competitive	
FEDERAL																	
Affordable Housing Program		✓	✓	✓			✓ [1]	✓		✓	✓	✓				✓	
Community Development Block Grant		✓	✓	✓				✓ [2]	✓	✓	✓				✓		
Emergency Shelter Grant			✓		✓				✓						✓		
HOME		✓	✓	✓			✓ [3]	✓ [3]		✓	✓	✓			✓		25%
Low Income Housing Tax Credits			✓	✓			✓ [4]	✓ [4]			✓					✓	
Section 202	✓	✓	✓	✓			✓				✓					✓	0.50%
Section 811	✓	✓	✓	✓		✓ [5]	✓				✓					✓	0.50%
Supportive Housing Program		✓	✓	✓	✓	✓ [5]				✓	✓ [5]		✓	✓ [6]		✓	100%
VA Homeless Providers and Per Diem		✓	✓	✓	✓					✓						✓	Per Diem = 35%
VA Loan Guarantee		✓	✓	✓	✓					✓						✓	
STATE																	
EHAP- Capital Grants		✓	✓	✓	✓				✓	✓			✓			✓	
Multifamily Housing Program		✓	✓	✓	✓	✓	✓	✓ [7]		✓	✓			✓		✓	
California Special Needs Financing Program (CalHFA)		✓	✓	✓		✓	✓				✓					✓	
LOCAL																	
Affordable Housing Trust Fund		✓	✓	✓							✓					✓	
Redevelopment Set-aside	✓	✓	✓	✓			✓	✓			✓	✓				✓	

[1] Twenty Percent of units in projects using these funds must be affordable to this population.

[2] At least 70% of units in projects receiving these funds must be affordable to this population.

[3] At least 90% of benefiting families must have incomes no more than 60% of AMI, at least 20% must have incomes no greater than 50% AMI.

[4] At least 40% of households must have incomes no more than 60% of AMI, at least 20% of units must have incomes no greater than 50% AMI.

[5] Limited to persons with disabilities.

[6] Acquisition, rehabilitation or leasing of supportive services only facilties.

[7] Non-residential supportive service space connected to MHP funded housing developments.

ES = Emergency Shelter; TH = Transitional Housing; PH = Permanent Housing; HO = Home Ownership; SH = Safe Haven; NRF = Non-Residential Facilities

Table 39. Summary of Funding Sources for Operating Costs

	Long-term Rental Assistance			Short-term Rental Assistance		Operating Subsidies		Grant Type	
	TRA	PRA	SRA	Eviction Prevention	Move-in Assistance	General Operating Costs	Per-Diem Payments	Formula	Competitive
FEDERAL									
Emergency Food and Shelter Program				✓			✓	✓	
Community Development Block Grant				✓				✓	
Community Services Block Grant							✓	✓	
Emergency Shelter Grants				✓	✓	✓		✓	
Mainstream Housing Opportunities for Persons with Disabilities	✓							✓	
Section 202		✓				✓			✓
Section 8	✓	✓						✓	
Section 8 SRO Moderate Rehabilitation		✓							✓
Shelter Plus Care	✓	✓	✓						✓
Section 811		✓				✓			✓
HUD Supportive Housing Program					✓	✓			✓
CalWORKs									
Emergency Assistance				✓				✓	
Homeless Assistance Programs					✓		✓	✓	
Housing Relocation					✓			✓	
Transitional Living Program for Older Homeless Youth	✓					✓			✓
VA Homeless Per Diem Program						✓			✓
STATE									
Emergency Housing Assistance Program-Operating Grants				✓	✓	✓			✓
Proposition 36						✓			✓
LOCAL									
General Relief Emergency Vouchers							✓		✓

TRA = Tenant Based Rental Assistance; PRA = Project Based Rental Assistance; SRA = Sponsor Based Rental Assistance

Table 40. Summary of Funding Sources for Supportive Services

	Case Management	Outreach	Benefits Counseling	Mental Health Services	Substance Abuse Services	HIV Services	Health Care	Education	Employ-ment	Child Care	Housing Services	Formula	Competitive
FEDERAL													
HHS Block Grants													
MHBG	✓	✓		✓			✓	✓	✓		✓	✓	
SABG					✓							✓	
CSBG	✓		✓	✓			✓	✓	✓	✓	✓	✓	
SSBG	✓						✓			✓	✓	✓	
CCDBG										✓			
HHS Discretionary Grants													
Treatment Systems for Homeless Persons	✓			✓	✓						✓		✓
Substance Abuse Treatment Capacity Expansion					✓								✓
TCE (Prevention of Substance Abuse and HIV)					✓	✓							✓
CalWORKs	✓			✓	✓		✓	✓	✓	✓	✓	✓	
CDBG	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		
EFSP											✓	✓	
ESG	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	
General Relief Program	✓			✓	✓		✓	✓	✓		✓		
Health Care for the Homeless	✓	✓	✓	✓	✓		✓						✓
Homeless Veterans Reintegration program	✓	✓							✓				✓
HUD-VA Supported Housing Program	✓	✓			✓		✓				✓	✓	
Medi-Cal	✓	✓		✓			✓					✓	
HUD Supprtive Housing Program	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Transitional Living Program				✓			✓	✓	✓		✓		✓
VA Supported Housing Program	✓				✓		✓				✓	✓	
Workforce Investment Act									✓			✓	
STATE													
Proposition 36				✓	✓			✓	✓				✓
Proposition 10										✓			✓

VII. RECOMMENDATIONS

The preceding sections have served to provide the reader with a greater understanding of the environment that shapes and defines each of the three special needs populations under review in this Strategic Plan. The following section now takes a step further to suggest specific strategies that the County and the Special Needs Housing Alliance should pursue to best address the housing and housing-related needs of their clients.

In one sense, the following recommendations describe a series of actions that frame the direction of the Special Needs Housing Alliance in the years to come. At another level, however, not all of these objectives require their leadership or engagement. For these reasons, the recommendations have been divided into five distinct sections, beginning with those that the directly concern the Alliance. The remaining four sections include recommendations that are more general in nature, not specific necessarily to the Alliance or any one special needs population, followed by a section each for the three special needs populations included in this Plan.

These recommendations are presented within the context of extremely challenging fiscal times at the federal, State, and local levels, which certainly impact the ability of the County to use grant and discretionary funding to advance the following special needs housing agenda. These strategies were moreover intended to be as specific as possible, to provide the clearest direction for the County's approach to special needs housing. At the same time, they remain flexible enough to respond to changing political climates, policy priorities, different implementation strategies, and the evolving needs of the County's clientele.

As the County transitions to pursue their implementation in the coming months, these recommendations must not be seen from a linear perspective, primarily because the arena of special needs housing and the needs of its consumers are too complex and dynamic. Instead, they outline a series of steps that can and should be pursued concurrently, so as to afford the County and the Alliance the greatest ability to take advantage of available resources and opportunities as they exist now and arise in the future.

A. Special Needs Housing Alliance

Objective A.1: Instruct the Chief Administrative Office (CAO) and the Executive Director of the Community Development Commission (CDC), or their designees, to serve as co-chairs of the Alliance.

- Review the co-chairmanship designation within one year from the approval of this recommendation with the intention that the chairmanship and leadership responsibilities will vest solely with the Executive Director of the CDC as the County's premier housing specialist/agency.
- Provide Alliance members with a joint leadership plan to demonstrate how the CAO and CDC will best share the co-chair responsibilities.

Objective A.2: Each Alliance member shall identify a housing and homeless prevention coordinator within their respective departments.

Objective A.3: Ensure the immediate participation, respectively, of the Department of Health Services, the Commission on HIV, and the Office of AIDS Programs and Policy in all Alliance meetings and functions.

Objective A.4: Expand Alliance membership to more comprehensively reflect special needs housing stakeholders and resources in Los Angeles County.

- Ensure the immediate participation of the City of Los Angeles, particularly the Los Angeles Housing Department. Revisit the Alliance's composition over the next two years to possibly include other City agencies and other significant cities within the County.
- Consider this expansion as well to financial institutions, foundations or corporations, technical assistance agencies, local government associations, and nonprofit housing and service providers, perhaps convening them on an annual basis in an advisory capacity.

Objective A.5: Improve the ability of the Alliance to identify, advance, and monitor special needs housing opportunities in Los Angeles County

- Increase awareness by developing marketing materials (e.g., brochures, flyers, posters, etc.) that inform the community about the history, mission, and role of the Alliance with respect to special needs housing in the County.
- Sponsor a one-day fair to allow Alliance members to exhibit their programs and resources that could support special needs housing development and/or operations.
- Amend the Business Plan to clearly articulate the process through which special needs housing projects come to the attention of the Alliance.
- Ensure that the Alliance is represented in other planning efforts (e.g., Continuum of Care, DMH Stakeholder, Ryan White CARE Act priority- and allocation-setting processes, etc.) that address the housing needs of special needs populations.
- Develop strategies to engage property owners and managers in the community to pursue special needs housing, such as:

  - Creating a "How To" manual that instructs program administrators on how to develop and cultivate these relationships; and
  - Developing a fact sheet that describes how privately owned rental properties (and their owners) could be "enrolled" as part of a special needs housing program and what services could be "packaged" for such a program.
- Review and update existing information provided through the Special Needs Housing Alliance website. Enhance this information by including the following: :
  - Business Plan;
  - Alliance Report (2003);
  - Strategic Plan;
  - Meeting Information (e.g., agendas, minutes, etc.);
  - Links to all Member agencies; and
  - Opportunities for special needs housing providers to interact (electronically) with the Alliance, to inform them of project opportunities and to request assistance or funding for a specific special needs housing project.

Objective A.6: Adopt a formal Board policy establishing the Alliance as the body for addressing housing policy/program, funding, and project opportunities for vulnerable health and human service populations in Los Angeles County.

Objective A.7: Ensure that the developed Alliance protocols are readily understood and used to inform members of project opportunities, funding announcements, and legislative alerts.

- These interdepartmental instruments must be assessed for their effectiveness and use. Modify the protocols as necessary to ensure they are user-friendly and accessible to Alliance members.
- Direct the Alliance Chair to require and monitor their use.
- Require that the Alliance Chair be immediately notified of any changes in previously identified staff protocol contacts.

Objective A.8: Develop and maintain a geographic or SPA-based list of services provided by Alliance member departments that can be made available to special needs housing projects.

Objective A.9: Conduct a semi-annual forum at which Alliance member department managers share strategies they have developed for attaching service funding to housing resources, for using "mainstream" funding sources to cover the cost of services in supportive housing settings, and for blending funding from multiple sources to meet the needs of special needs tenants.

Objective A.10: Modify existing data collection mechanisms employed by Alliance members to more effectively capture available resources for special needs populations in the County.

- Provide Alliance members with an annual update of the inventory of special needs housing resources in the County.
- Provide an annual or biannual update of flexible funding sources controlled by Alliance members that have the potential to benefit special needs populations.
- Provide Alliance members with specific instruction to capture relevant data on special needs housing programs administered by their departments.
- Ensure that the Alliance commits to updating the Strategic Plan periodically.

Objective A.11: Coordinate with Alliance members to develop a shared legislative agenda. Explore ways in which this agenda can complement existing legislative advocacy mechanisms used by the County to address the needs and concerns of special needs clients.

B. General

Objective B.1: Establish a Countywide Health and Human Service Housing Operating and Supportive Service Trust Fund.

- Use the Trust Fund as a high-leverage source of operating and supportive service funding for special needs housing. The Trust Fund will assist affordable and special needs housing developers and operators to document operational and supportive service financing when applying for capital financing.
- Establish a benchmark that at least 75% of the Trust Fund is used for permanent housing.
- Conduct a thorough assessment of County resources that could be used to establish this fund, including but not limited to the following:
  - Mental Health Services Act funds;
  - County realignment funds;
  - AB 2034 funds;
  - Projects for Assistance in Transition from Homelessness (PATH) program funds; and
  - Sources not generally considered for affordable housing, such as Ryan White Care Act, Independent Living Program, County general funds, hotel tax, etc.

Objective B.2: Create and cultivate the political will to address special needs housing concerns and development.

- Educate Board offices, Commissioners, and department heads about the mutual benefit of pursuing affordable housing for special needs populations for both client outcomes and public savings.
  - Provide a *Housing 101* training for County department heads and Board deputies.
  - Provide them with ongoing opportunities for site visits to model supportive housing programs serving special needs populations throughout the County.
- Enlist the collective input of department heads to argue for more equitable distribution of special needs housing in each Supervisorial district.
- Continue to convene the department heads at least semi-annually at regularly scheduled Alliance meetings.
- Adopt a formal Board policy that embraces the comprehensive approach of affordable housing with supportive services as a unified approach to address special needs housing in the County.
- Commit to develop more mixed-use developments, as both a means to integrate different income levels and populations and create economic development and revitalization opportunities.
- Provide policymakers with a financial analysis to illustrate the extent of public savings achieved by pursuing supportive housing versus public emergency services (e.g., incarceration, psychiatric hospitalization, and emergency shelters).
- Per the Board's directive on March 5, 2002, establish or reconvene a task force, consisting of representatives from each Supervisorial district, to assist the County

and community-based housing providers to site shelter, transitional, and permanent housing for emancipating and emancipated foster youth throughout the County. Request that the Board broadens the scope of this motion to include this level of ongoing assistance for developments serving any special needs population.

Objective B.3: Increase the capacity of the nonprofit sector to produce affordable housing units targeted to the Alliance's priority populations.

- Leverage capital financing through financial intermediaries.
- Projects receiving capital financing commitments through the City of Industry Fund program should also receive funding commitments through the Special Needs Housing Operating and Supportive Service Trust Fund. In turn, consider establishing a scoring advantage in the City of Industry Special Needs competition for projects that demonstrate an early commitment of private funds.
- Expend the available resources to increase the number/capacity of affordable and special needs housing development consultants to better enable smaller housing providers or strictly service providers to develop this kind of housing.
- Solicit capacity building grants from private sources and foundations.

Objective B.4: Continue to assist the more experienced and capable special needs housing developers to pursue special needs housing development.

- Create incentives for these types of housing providers to enter into joint ventures and turn-key development projects.
- Provide resources to support community outreach and engagement efforts.
- Streamline the contracting process by developing a "preferred provider" arrangement with nonprofit housing development and service organizations that have been successful partners with the County.
  - Consider developing and issuing a Request for Qualifications (RFQ) to "pre-qualify" access to County resources for these types of providers.
- Increase staffing at special needs housing development agencies to provide them with the security and resources they need to accept traditionally underserved populations and those requiring more intensive supportive services (e.g., persons with co-occurring disorders).

Objective B.5: Encourage special needs housing providers to reconsider and where possible, modify admission policies that require prospective tenants to be "clean and sober" before entering supportive housing programs.

- Prioritize funding recommendations for projects that demonstrate willingness to "soften" their admissions and tenancy policies.
- Prioritize the use of non-HUD monies where possible to finance programs that accommodate this population.
- Promote housing developments that protect all fair housing rights and that use sound property management policies to ensure well-managed projects that fit into

communities while allowing for successfully housing people dealing with substance abuse issues.

Objective B.6: Promote special needs housing through additional uses of federal CDBG and HOME funds.

- Continue to reserve the right to use County CDBG monies as a supplement to the existing program allocations received by other participating jurisdictions, so long as these funds are used for homeless programs and the move is consistent with jurisdictional priorities identified during respective Consolidated Planning processes.
- Utilize CDBG funds for land acquisition as a means for the County to facilitate the development of specific special needs housing projects.
- Review the current limitation on the use of HOME funds for strictly housing production and rehabilitation. Consider utilizing HOME resources as a potential means to offset the current limitation of federal rental assistance resources (e.g., Section 8).

Objective B.7: Contingent upon the ability to spare such resources, direct local housing authorities to dedicate a portion of available Section 8 rental subsidies as project-based vouchers for specific use for special needs populations.

Objective B.8: Continue to utilize County-controlled properties for special needs housing development.

- Ensure that the Board of Supervisors and CAO Real Estate Division provide Alliance members with access to a comprehensive and updated list of such properties.
- Request that the Board of Supervisors prioritize the use of these properties for projects that have received the support of the Alliance.
- Enable special needs housing developers/providers to access these properties at no cost or below market value through a competitive bid process. This will allow developers to redirect their energies from having to buy and hold land/property to focus on design and funding strategies.

Objective B.9: Advocate for LAHSA's annual Continuum of Care priorities to be flexible enough to advance project opportunities that do not meet regional or population-specific criteria.

- Use this discretion judiciously, based upon the project's ability to address a documented community need and the degree to which the project has leveraged other mainstream public resources.
- Without such a provision, the scarce and decreasing amount of Continuum of Care resources that can be awarded to "new" projects will result inevitably in missed opportunities to leverage State and local resources to increase the stock of affordable housing targeted to special needs populations.
- Brief LAHSA Commissioners each year, in advance of the HUD SuperNOFA release date, on the current planning efforts and project priorities pursued by the Alliance.

Objective B.10: Ensure that interdepartmental agreements and collaborations utilize public funds within the broadest range of eligible uses permitted under the applicable regulations . Ensure that these agreements do not adversely impact special needs housing opportunities or development.

Objective B.11: Investigate the feasibility of issuing special needs housing finance bonds, including incorporating resources from other jurisdictions, as a means to generate non-federal revenue to facilitate housing production for special needs populations.

Objective B.12: Require that all County-administered systems of care that serve or have the potential to serve special needs populations direct their assistance to the most needy of each of these priority populations, as determined periodically through needs assessments and local planning processes.

Objective B.13: Conduct a comprehensive review of all County-administered housing programs that serve or have the potential to serve special needs populations. Ensure that new contracts include goals and objectives with measurable outcomes to assist the County to determine if these programs are serving the intended population, responsive to client needs, and addressing regional and other priorities.

Objective B.14: Ensure sufficient access to housing placement assistance and rental assistance resources for all special needs populations.

C. Emancipated Foster Youth

Objective C.1: Continue to support existing interdepartmental efforts that concentrate on addressing the housing needs of emancipated foster youth.

Objective C.2: Create more permanent housing resources for emancipated foster youth through the development of new housing.

- Pursue available capital financing to establish at least 200 units of affordable, permanent housing targeted to the population within the next three years.
- Support existing and pursue additional scattered-site master leasing models, where limited numbers of units in affordable housing developments are set-aside for emancipated foster youth.
  - Provide incentives under the City of Industry Fund program to allow affordable housing developers to set-aside a portion of their units for this population.
- Establish a dedicated fund in the Health and Human Service Housing Operating and Supportive Service Trust Fund for supportive services for permanent housing developments that target the population to spur traditional affordable housing developers to pursue such housing.
- Establish permanent housing for emancipated foster youth as an eligible program and housing type under the City of Industry Fund Special Needs Housing program.

Objective C.3: Create more permanent housing resources for emancipated foster youth through increased access to sources of long-term rental assistance.

- Ensure that County-controlled Section 8 Family Unification Program vouchers are being fully utilized and are serving youth aging out of foster care or Probation systems who lack adequate housing. Encourage the City to do the same.
- Require that DMH, DCFS, Probation, HACLA, and HACoLA coordinate annually to develop proposals for the maximum number of units available of Shelter Plus Care assistance (through LAHSA and/or the cities of Pasadena, Long Beach, or Glendale) for homeless emancipated foster youth with a mental illness or other disability.
- Establish a program for assisting emancipated foster youth in applying individually for Section 8, Shelter Plus Care, and Public Housing assistance, but also with benefits assistance, getting onto waiting lists, completing application forms, and contacts/staff available to assist individual youth through the various procedures.

Objective C.4: Strengthen the current short-term rental assistance program for emancipated foster youth.

- Ensure that assisted youth receive instruction on how to effectively prepare budgets and manage their finances.
- Connect youth with vocational services that will facilitate their ability to sustain themselves financially.
- Require that assisted youth generate income of at least two times their monthly rent.
- Establish greater flexibility in the criteria used to determine the disbursement amounts for assisted youth.

Objective C.5: Explore other avenues to increase the amount of transitional housing targeted to the population.

- Pursue necessary steps to access the State Transitional Housing Plus program and meet its match requirements.
- Advocate for the LAHSA Commission to prioritize new HUD SHP Transitional Housing funding commitments for projects serving homeless emancipated foster or Probation youth with additional special needs (e.g., mental illness).

Objective C.6: Preserve the current inventory of emergency shelter and transitional housing targeted to the population.

- Continue to dedicate available federal, State, and local resources to support these programs.
- Investigate the possibility of reducing this inventory over time, however, if the need for such housing decreases or as more permanent housing resources become available.

Objective C.7: Ensure broad access to informational resources that can assist emancipated foster youth to identify available housing options.

- Utilize a variety of marketing media.
- Promote awareness of the *ilponline* website, especially among caregivers and youth, through posters, flyers, mailings, etc.
- Pursue the development and maintenance of a housing program database for emancipated foster youth.
- Use it for referral purposes, and ensure that the information it contains is as accurate as possible.
- Ensure that the database will allow program administrators, providers, and caregivers to track client progress in various stages of their assistance.

Objective C.8: Continue to expend annually the full 30% allowable for housing under the Foster Care Independence Act/John H. Chafee Program.

Objective C.9: Pursue available grant funding through the U.S. Department of Justice to assist prevention strategies for youth at-risk of committing a criminal offense or returning to the delinquency system.

D. Homeless Persons with Mental Illness

Objective D.1: Ensure a broader array of housing options to respond to the disparate and evolving needs and circumstances of homeless persons with mental illness.

- Continue to utilize the City of Industry Fund Special Needs Housing program to provide capital financing for both transitional and permanent affordable housing targeting the population. Prioritize the use of program funding for permanent housing for this population.
- Consider prioritizing the use of Mental Health Services Act funding to provide permanent, affordable supportive housing for homeless individuals with co-occurring disorders.
- Commit to pursue the development of three Safe Havens over the next three years as a cost-effective means of serving the hard-to-reach homeless population that have a serious mental illness and meet HUD's definition of chronic homelessness.
- Concurrent with efforts to establish more tolerant (and culturally appropriate) housing programs for the population, explore more structured living arrangements for individuals who require more intensive support, under the consultation and advisement of DMH. These strategies could include developing:
  - Crisis/Respite housing that accepts "tougher" clients to avoid hospitalization;
  - At least 200 units of supportive housing , with a focus on the dually diagnosed, over the next three years;
  - At least three licensed Board and Cares (approximately 30 beds each) with augmented services for persons unable to live in permanent supportive housing but who are not appropriate for placement in IMDs. No less than one of these should serve transitional age youth (18-25) who have emancipated from the dependency and delinquency systems and are not able to be adequately served in existing adult Board and Care programs; and
  - Permanent supportive housing for the aging HMI population, with a commitment to at least one affordable housing development (or 50 units) for homeless seniors with mental illness and/or dual diagnoses during the next two years. Leverage additional funding by encouraging developers with senior projects in the development pipeline to dedicate a portion of their units for this population.

Objective D.2: Establish a Mental Health Services and Operating Fund for supportive housing for homeless adults with a mental illness.

- These funds should be intended for three purposes: (1) increasing the stock of supportive housing for the targeted populations; (2) persons experiencing the most difficulty in securing housing; and (3) leveraging other funding, such as the Conrad N. Hilton Foundation, as well as other federal and State supportive housing funds.
- Consider dedicating a significant percentage of Mental Health Services Act funds to establish this fund along with contributions from other Alliance partners in order to provide specialty services within their specific disciplines for the targeted populations.

- Use the fund for supportive housing developments coming on-line within a year from the commitment.
- Proposed housing projects that would be enhanced by the collaboration of the Alliance will be vetted with the Alliance for input and recommendations.
- Proposed funding would be accessed through a formalized application process that would be administered by the Department of Mental Health.

Objective D.3: Utilize a broader range of health care professionals to better address the primary health care needs of this population.

- Consider funding emergency mobile health teams, including nurse practitioners and psychiatric technicians, to rotate through different supportive housing developments throughout the County.
- Provide incentives to providers to hire licensed psychiatric technicians so that they are not lured into more lucrative positions in institutional settings.

Objective D.4: Continue to pursue the use of Shelter Plus Care (S+C) federal rental subsidies to increase the availability of permanent supportive housing for the target population.

- Ensure that DMH-sponsored (or nonprofit-sponsored) S+C projects, that receive a funding commitment through HUD, are prioritized for implementation, including any means necessary to expedite the project once the contract has been executed with HUD.
- Effectively track service commitments made in conjunction with S+C rental assistance awards so that HACoLA can quickly reallocate that funding if project sponsors fail to meet the program' s match requirement in the time permitted.
- Ensure that HACLA and HACoLA apply for at least 200 Shelter Plus Care certificates or Section 8 Housing Choice Vouchers annually for adults with mental illness.

Objective D.5: Assist homeless persons with mental illness to access and retain safe, decent, and affordable housing.

- Increase engagement of homeless persons with mental illness at LAHSA-funded Year Round Shelters.
- Ensure that DMH employees and/or contracted DMH mental health professionals are stationed at each of the Year-Round shelters to assist with the identification of HMI during intake. Ensure that HMI shelter clients are identified immediately and expedited to more appropriate living environments (e.g., permanent supportive housing, Board and Cares, etc.).
- Should additional resources become available, require that AB 2034 providers outreach aggressively to Year Round Shelters to identify prospective program participants. Incorporate the same strategy into the implementation plan for Mental Health Services Act funding.

- Expand DMH's homeless prevention efforts that are focused on housing retention for this population.

Objective D.6: Streamline the application process for homeless persons with mental illness to access federal rental assistance programs (e.g., Section 8 and Shelter Plus Care).

- Ensure the presence of dedicated staff at DMH clinics who understand the application requirements and are trained to assist HMI to access federal rental subsidies.
- Ensure that the service area's housing specialist "signs-off" on the application before its submission to DMH.
- Require that DMH administrators and housing authority administrators meet at least quarterly to review the status of participants and means to improve these programs.
- Provide a dedicated and secure website where information (updates, contact information, landlord database, FAQ's, application materials, etc.) is posted and maintained by DMH Division staff on a regular basis. Coordinate property and landlord listings with those provided through local PHAs.
- Provide training to housing authority personnel (e.g., line staff, managers, and supervisors) to ensure they are sensitive to the behavior and needs of homeless persons with mental illness when applying for rental subsidies.

Objective D.7: Mitigate the adverse impact that prior involvement with the criminal justice system places upon HMI seeking federally subsidized housing.

- Ensure that local PHAs adopt less restrictive admission policies that balance an adherence to federal admissions specifications with the security associated with a client's participation in a drug recovery or treatment program and/or the commitment of supportive service staff to remain available to the client and landlord after the initiation of tenancy.
- Expedite the amount of time required to perform necessary third party verification of criminal record status.

Objective D.8: Expand the Countywide Rental Assistance program for homeless persons with mental illness by including funding for rental deposits, utility costs, and furnishings.

Objective D.9: Establish dedicated housing specialist teams in each SPA.

- Consider modeling these teams after the SHIA HOME teams, previously operated by DMH through June 2004.
- Require that these teams stay engaged with the client from the beginning of the application process to the point at which they are stable in the community.
- Require that these teams perform minimally the following:
  - Development of individualized housing plans;
  - Developing and cultivating a network of landlords willing to rent to the population;
  - When necessary, providing referrals to other appropriate housing options;
  - Credit counseling;
  - Assisting clients in applying for housing assistance (e.g., Section 8);
  - Assisting clients to identify and remove barriers to accessing housing;
  - If operating within the City of Los Angeles, participating in rent stabilization training;
  - Educating clients about tenant rights and responsibilities;
  - Assisting clients in moving into housing;
  - Linking clients to stabilizing supportive services; and
  - Remaining accessible to the landlord and client once he/she has moved into the housing unit.

Objective D.10: Assist eligible providers to pursue MediCal reimbursement mechanisms (e.g., Federally Qualified Health Centers) to offset supportive service expenses in supportive housing developments.

Objective D.11: Continue to facilitate the transition of adults with mental illness from County/State hospitals and Institutions of Mental Disease (IMDs) to independent and supported living arrangements.

- Continue to augment Interim Fund (IF) funding as necessary in order to maintain the current capacity while accommodating persons ready to transfer but who remain in long-term care due to lack of funds.
- Continue to reimburse ACT contracted providers for IF expenditures they have incurred to house SSI ineligible clients.
- Ensure that the current IF program is modified by separating funding allocations into two categories: (1) persons pending SSI approval; and (2) a Specialized Housing Fund for persons who are considered SSI ineligible.
- Continue to assist those considered "SSI ineligible" to secure benefits assistance (i.e., become SSI eligible) and to explore other means of meeting their individual housing needs.
- Determine funding levels for the Specialized Housing Fund based upon the number of clients currently assisted that meet the above definition, those in long-term care waiting funding for community living, and the potential for clients to exit the program as a result of the availability of other resources.

- Adjust funding levels as necessary to remain consistent with resources available in upcoming fiscal years.

Objective D.12: Ensure that housing professionals understand and practice "fair housing" policies that protect individuals with disabilities during the screening, occupancy, and termination phases of the housing relationship.

- Direct training resources to all housing providers, with a particular focus on emergency shelters and transitional housing operators, as they are more likely to serve disabled populations and currently do not receive fair housing trainings or resources specifically geared towards them.
- Ensure that shelter programs funded through LAHSA and the Emergency Food and Shelter Program are required to participate in such training.
- Consider contracting with an experienced, capable technical assistance provider that can equip permanent housing developers with fair housing tools to address regulatory barriers, community opposition, screening concerns, and reasonable accommodation requests.

Objective D.13: Conduct exploratory research to learn more about the unique needs of the older adult homeless mentally ill population.

- Through the joint leadership of DMH's Older Adult Division, CSS, and LAHSA, conduct a series of focus groups to establish a composite of this population and determine their housing and supportive service needs. Coordinate these planning efforts with the Countywide Older Adults Work Group associated with DMH's Stakeholder process.
- Based upon these findings, develop a fact sheet or policy paper on the best way to address the needs of this population.

Objective D.14: Expand access to mainstream supportive services and public assistance.

- Ensure that outreach efforts do not deter the population from accessing mainstream housing and supportive services.
- Convene a group of staff from DMH-operated clinics and contracted agencies that have demonstrated success in securing benefits on behalf of their clients to develop a training curriculum targeted to line staff in the mental health delivery system. Ensure that the training is done on an ongoing basis.
- Provide a more effective and integrated treatment response for individuals with mental illness and co-occurring substance use disorder.
- Commit to pursue and secure federal housing and supportive service initiative grants (e.g., *HUD/DOL Ending Chronic Homelessness through Employment and Housing*) as a means of increasing resources for special needs populations.

Objective D.15: Increase access to federal Supplemental Security Income and State MediCal benefits.

- Consider additional out-stationing or co-locating County personnel in homeless service settings.
- Utilize SSI Outreach Project staff to identify and engage potentially SSI eligible clients in LAHSA-funded emergency shelters.
- Ensure cross-training for people who work with homeless individuals on the appropriate medical documentation needed to determine disability.
- Implement a quality assurance requirement to determine that there is both substantive and time-sensitive tracking of participants applying for SSI.
- Explore ways to assist pre-emancipated youth to access SSI prior to emancipation.
- Consider adopting a policy of presumptive eligibility for MediCal assistance to increase enrollment and lessen the period of time under which a prospective beneficiary must be observed for medical verification of their disability. Review existing models across the country that have demonstrated success in dramatically reducing the time necessary to complete eligibility determinations.

E. Persons Living with HIV/AIDS

Objective E.1: Expand the supply of emergency shelter beds targeted to the population

- Continue to utilize HOPWA's competitive bid process to encourage the re-designation of at least 50 emergency shelter bed spaces in appropriate existing shelters.
- Develop at least 50 new emergency shelter beds in the next two years through the collaborative efforts of the LAHD, OAPP, the Commission on HIV, LAHSA, and the Special Needs Housing Alliance.
- Continue to use the CARE Act and HOPWA systems to maintain the current level of emergency hotel/motel vouchers, but use this mechanism as a short-term strategy that may be gradually reduced or phased out as new permanent housing resources become available.

Objective E.2: Expand the supply of transitional housing beds targeted to PLWH/A.

- Continue to utilize HOPWA's competitive bid process to encourage the re-designation of at least 100 transitional housing beds for PLWH/A in appropriate transitional housing facilities.
- Develop at least 100 transitional housing units through the collaborative efforts of the CDC/HACoLA, LAHD, LAHSA, OAPP, the Commission on HIV, and the Special Needs Housing Alliance.

Objective E.3: Increase the number of permanent supportive housing units targeted to PLWH/A.

- Commit to creating at least 100 units (or two affordable housing developments) in the next two years targeted to PLWH/A through the collaborative efforts of the LAHD, CDC, LAHSA, OAPP, the Commission on HIV, and the Special Needs Housing Alliance.
- Continue to utilize the federal HOPWA and City of Industry Fund Special Needs Housing programs as capital financing mechanisms for the development of permanent supportive housing targeted to the population. Prioritize the use of Industry funds, however, for permanent housing for PLWH/A.

Objective E.4: Ensure sufficient access to quality housing placement assistance services for PLWH/A who lack adequate housing or are at imminent risk of losing their housing.

- Require that housing placement assistance be as comprehensive as possible, and include the minimum responsibilities:
  - Intake and assessment;
  - Development of individualized housing plans;
  - Establishing linkages and providing referrals with appropriate housing options;

  - Credit counseling;
  - Assisting clients in applying for housing assistance (e.g., HOPWA or Section 8);
  - Assisting clients to identify and remove barriers to accessing housing;
  - Educating clients about tenant rights and responsibilities;
  - Assisting clients with "move-in" activities;
  - Linking clients to stabilizing supportive services once housed; and
  - Remaining available to the client and landlord once the client has obtained housing.
- Focus housing placement assistance on persons exiting institutional care, emergency shelter, licensed residential facilities, and transitional housing, in addition to PLWH/A who have received a Section 8 voucher but cannot locate appropriate housing.
- Ensure that housing placement assistance services funded through the Ryan White Care Act and HOPWA systems are closely coordinated with the information and referral components of these systems.
- Review housing information and referral systems in other systems of care (e.g., City of Los Angeles Domestic Violence) and localities to improve the current delivery of housing outreach, information, referral, and placement services available to PLWH/A.
- Require that HOPWA Housing Case Managers possess a comprehensive knowledge of local, State, and federal housing programs and how they can be accessed.

Objective E.5: Improve the ability of PLWH/A to retain affordable housing by continuing to utilize HOPWA as the primary source for delivering emergency financial assistance to PLWH/A to prevent homelessness.

Objective E.6: Increase the coordination of HOPWA and Ryan White CARE Act resources to more efficiently respond to the prioritized needs of PLWH/A.

- Develop mechanisms for more effective communication and coordination between administrators of CARE Act and HOPWA resources.
- Explore the feasibility of joint priority-setting and decision-making between the local public agencies that administer funding targeted to PLWH/A.

Objective E.7: Increase the coordination of HOPWA and CARE Act programs with other mainstream public funding programs (e.g,. Continuum of Care) so that funding can be targeted to the prioritized needs of PLWH/A.

Objective E.8: Improve the ability of HIV/AIDS housing and service providers to integrate resources in order to provide comprehensive housing and supportive services to PLWH/A.

- Enhance provider awareness of existing public resources by expanding outreach, educational, and technical assistance efforts.

- Ensure that RFPs and NOFAs releases by Alliance member agencies continue to reward proposers who successfully document project resources leveraged from other mainstream systems of care.
- Encourage HIV/AIDS project sponsors to establish formal and informal interagency agreements (e.g., MOUs, mutual service agreements, or linkage agreements) with other providers of HIV/AIDS housing and/or supportive services.
- Establish standing grant review committees, modeled after the technical review process for the City of Industry Fund Program
- On behalf of HIV/AIDS housing and service providers, facilitate interagency, multidisciplinary trainings, opportunities for strategizing and sharing of best practices, and site visits. Extend these opportunities to a mixture of line staff and administrators.
- Ensure that HIV/AIDS housing and service providers are outreached to, and participate in ongoing planning efforts for mainstream systems of care.

APPENDICES (A – F)

APPENDIX A. BIBLIOGRAPHY

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APPENDIX B. GLOSSARY

ACT	Assertive Community Treatment
ACYF	U.S. Department of Health and Human Services Administration on Children, Youth and Families
ADAP	AIDS Drug Assistance Programs
ADPA	County of Los Angeles Department of Health Services, Alcohol and Drug Programs Administration
AHP	Affordable Housing Program
AHTF	Affordable Housing Trust Fund
AIDS	Acquired Immunodeficiency Syndrome
AFDC	Aid to Families with Dependent Children
API	Asian Pacific Islander
AMI	Area Median Income
ARF	Adult Residential Facility
CalHFA	California Housing Finance Agency
CalWORKs	California Work Opportunity and Responsibility to Kids
CAO	County of Los Angeles Chief Administrative Office
CARE	Ryan White Comprehensive AIDS Resources Emergency Act
CCDBG	Child Care and Development Block Grant
CDBG	Community Development Block Grant
CDC	County of Los Angeles Community Development Commission U.S. Centers for Disease Control and Prevention Community Development Corporations
CDHS	California Department of Health Services
CLHF	Congregate Living Health Facility
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
CRB	California Research Bureau
CSAT	Center for Substance Abuse Treatment
CSBG	Community Services Block Grant
CSH	Corporation for Supportive Housing
CSS	County of Los Angeles Department of Community and Senior Services
CYA	California Youth Authority
DCFS	County of Los Angeles Department of Children & Family Services
DHS	County of Los Angeles Department of Health Services
DMH	County of Los Angeles Department of Mental Health
DOL	U.S. Department of Labor
DPSS	County of Los Angeles Department of Public Social Services
DSS	California Department of Social Services
EHAP	Emergency Housing Assistance Program
EMA/EMSA	Eligible Metropolitan Area/Eligible Metropolitan Statistical Area
ESG	Emergency Shelter Grant
FFA	Foster Family Agency
FMR	Fair Market Rent

FPL	Federal Poverty Level
GAO	U.S. General Accounting Office
GR	General Relief
HAART	Highly Active Anti-Retroviral Therapy
HAB	HIV/AIDS Bureau
HACLA	Housing Authority of the City of Los Angeles
HACoLA	Housing Authority of the County of Los Angeles
HAP	Housing Assistance Payment
HCD	State of California Department of Housing and Community Development
HCH	Health Care for the Homeless
HCV	Hepatitis C Virus
HEP	County of Los Angeles HIV Epidemiology Program
HIV	Human Immunodeficiency Virus
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
HOME	HOME Investment Partnerships program
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IDU	Injection Drug Use(r)
ILP	Independent Living Program
LACHAC	Los Angeles Countywide HOPWA Advisory Committee
LACOE	Los Angeles County Office of Education
LAHD	Los Angeles Housing Department
LAHSA	Los Angeles Homeless Services Authority
LIHTC	Low-Income Housing Tax Credit
MHBG	Community Mental Health Services Block Grant
MHP	Multifamily Housing Program
MSM	Men who have Sex with Men
NAMI	National Alliance for the Mentally Ill
NATAP	National AIDS Treatment Advocacy Project
NOFA	Notice of Funding Availability
NIMBY	Not In My Backyard
OA	State of California Office of AIDS
OAPP	County of Los Angeles Department of Health Services, Office of AIDS Programs and Policy
PATH	Projects for Assistance in Transition from Homelessness
PHA	Public Housing Agency
PLWA	Person(s) Living with AIDS
PLWH	Person(s) Living with HIV
PLWH/A	Person(s) Living with HIV/AIDS
POC	Parolee Outpatient Clinics
PRA	Project-based Rental Assistance
RCF – CI	Residential Care Facility for the Chronically Ill
RFI	Request for Information

RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SABG	Substance Abuse Prevention and Treatment Block Grant
SDMH	State of California Department of Mental Health
SHAS	Supplement to HIV/AIDS Surveillance
SHIA	Supportive Housing Initiative Act
SHP	Supportive Housing Program
SMI	Serious Mental Illness
SPA	Service Planning Area
S+C	Shelter Plus Care
SPNS	Special Projects of National Significance
SRA	Sponsor-based Rental Assistance
SRO	Single Room Occupancy
SSBG	Social Services Block Grant
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STAP	HOPWA Short Term Rent, Mortgage, and Utility Assistance Program
STD	Sexually Transmitted Disease
TANF	Temporary Assistance to Needy Families
TAC	Technical Assistance Collaborative
TB	Tuberculosis
THP	Transitional Housing Program
TILP	Transitional Independent Living Plan
TRA	Tenant-based Rental Assistance
VA	U.S. Department of Veterans Affairs
WIA	Workforce Investment Act

APPENDIX C. DEFINITIONS

Administering Agency: Agency that administers a funding program. This agency is generally involved in releasing a funding notice, reviewing applications, awarding grants, executing contracts, and monitoring the grants. This agency may or may not be the agency that receives the funding through the legislative or executive processes.

Advocacy: Includes work designed to increase and maintain awareness of needs of populations served as well as personal advocacy of clients.

Affordable Housing: That housing within the community which is decent and safe, wither newly constructed or rehabilitated, that is occupied by and affordable to households whose income is very low, low, or moderate. Such housing may be ownership or rental, single family or multifamily, short-term or permanent. Achieving affordable housing often requires financial assistance from various public and private sources and agencies.

AIDS: Acquired immune deficiency syndrome. A disorder of the immune system, believed to be caused by the human immunodeficiency virus (HIV), which diminishes the body's response to infectious organisms and certain cancers. AIDS is labeled a syndrome because it can affect people in a multitude of ways, causing various illnesses in different individuals.

Alcohol and Drug Abuse Services: Activities that are primarily designed to prevent, deter, reduce, or eliminate substance abuse or addictive behaviors. Treatment services may include intake and assessment; treatment matching and planning; behavioral therapy and counseling appropriate to the client and the severity of the problem; substance abuse toxicology and screening; clinical and case management; outcome evaluation; and self-help and peer support activities.

Area Median Income: HUD is required by law to set income limits that determine eligibility of applicants for HUD's assisted housing programs, including the Public Housing, Section 8 Housing Choice Voucher, Section 202, and Section 811 programs. Income limits are based on HUD estimates of median family income, with adjustments for family size and for areas with unusually high or low family income or housing-cost-to-income relationships. These levels can be subdivided according to three categories:

> **Extremely Low-Income:** Family whose income is between 0 and 30 percent of the median family income for the area.
>
> **Very Low-Income:** Family whose income does not exceed 50 percent of the median income for the area.
>
> **Low-Income:** Family whose income does not exceed 80 percent of the median income for the area.

Assistance with Daily Living: Assistance with a full spectrum of everyday life needs, including personal and household maintenance.

Attendant Care: Personal one-on-one care to persons with severe medical conditions.

Buddy Services/Support Groups/Non-Professional Counseling: Includes various peer support methods of counseling, including group therapy, spiritual counseling, art therapy, horticultural therapy, buddy services, and other types of counseling.

Case: A person who has a disease of interest.

Case-Fatality Rate: The proportion of persons with a particular disease who die from that disease within a specified period of time.

Case Management: Services or activities for the arrangement, coordination, monitoring, and delivery of services to meet the needs of individuals and families. Component services and activities may include individual service plan development; counseling; monitoring; developing, securing, and coordinating services; monitoring and evaluating client progress; and assuring that clients' rights are protected.

Child Care Services: Services or activities provided in a setting that meets applicable standards of state and local law, in a center or in a home, for a portion of a 24-hour day. Component services or activities may include a comprehensive and coordinated set of appropriate developmental activities for children, recreation, meals and snacks, transportation, health support services, social service counseling for parents, and plan development.

Children's Services: Child-centered services, including child development evaluation and intervention and children's counseling.

Chronically Homeless Person: An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. Disabling condition is defined as " a diagnosable substance use disorder, serious mental illness, developmental disability , or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter during that time.

Combination Therapy: The use of two or more drugs to fight infections. Combinations may be more effective than single drug treatment.

Community Development Corporations (CDCs): Nonprofit organizations usually founded by community residents determined to revitalize their neighborhoods. CDCs may provide social services, develop low-income housing, and/or initiate commercial and retail activity in areas abandoned by commercial developers.

Consolidated Plan: A long-term housing and community development plan developed by State and local governments and approved by HUD. The Consolidated Plan incorporates the planning, application, and reporting documents for four programs administered by HUD's Community Planning and Development Division that provide formula grants to states and units of general local government: Community

Development Block Grants (CDBG), Emergency Shelter Grants (ESG), HOME Investment Partnerships, and Housing Opportunities for Persons with AIDS (HOPWA).

Continuum of Care: An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for the HUD's Shelter Plus Care, Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO) Program, and Supportive Housing Program.

Cumulative: Pertaining to the total number of persons reported or diagnosed with AIDS at a specified point in time.

Cumulative Incidence: The risk of developing a particular disease within a specified period of time.

Dually Diagnosed: Term used to describe individuals who are diagnosed with two different disorders, such as mental and addictive illness.

Educational and Instructional Services: Training services provided to improve knowledge, daily living skills, or social skills. Services may include instruction or training in (but not limited to) such issues as consumer education, health education, education to prevent substance abuse, community protection and safety education, literacy activities may include screening, assessment and testing; individual or group instruction; tutoring; provision of books supplies and instructional material; counseling; and referral to community resources.

Emergency housing vouchers: Cash payments to hotels, motels, and shelters for emergency lodging, usually up to 30 days.

Employment Services: Training services provided to assist individuals in securing employment; acquiring or learning skills that promote opportunities for employment, advancement, and increased earning potential; and in retaining a job. Component services or activities may include employment screening, assessment, or testing; tutoring, including literacy training and pre-vocational training; provision of books, supplies and instructional material; counseling or job coaching; transportation; and referral to community resources.

Fair Market Rent (FMR): Determined annually by HUD, this figure calculates the amount that would be needed to pay the gross rent (shelter rent plus utilities) of privately owned, decent, and safe rental housing of a modest (non-luxury) nature with suitable amenities within a given locality. In the Housing Choice Voucher program, for instance, the FMR serves as the basis for determining the "payment standard amount" used to calculate the maximum monthly subsidy for an assisted family. FMRs are also used to determine initial renewal rents for some expiring project-based Section 8 contracts, and to determine initial rents for housing assistance payment contracts in the Moderate Rehabilitation Single Room Occupancy program. The FMR includes calculations for specific bedroom sizes (e.g., 0-bedroom, 1-bedroom, etc.).

Food: Provision of food through housing programs, food banks/pantries, or vouchers.

Hard Costs: "Bricks and mortar," includes general requirements, actual construction, overhead, profit, and construction contingencies.

Harm Reduction: A model of substance use intervention that focuses on helping people who use substances to better manage their use and reduce the harmful consequences to themselves and others.

Health Related and Home Health Services: In-home or out-of-home services or activities that provide direct treatments or are designed to assist individuals and families to attain and maintain a favorable condition of health. Component services and activities may include providing an analysis or assessment of an individual's health problems and the development of a treatment plan; assisting individuals to identify and understand their health needs; providing directly or assisting individuals to locate, provide or secure, and utilize appropriate medical treatment, preventive medical care, and health maintenance services, including in-home health services and emergency medical services; provision of appropriate medication; and providing follow-up services as needed.

Hepatitis B: A form of viral hepatitis, or inflammation of the liver, caused by an infectious agent called the hepatitis B virus (HBV). HBV may be transmitted through contact with body fluids, including blood, saliva, seminal fluid, vaginal secretions, and breast milk.

Highly active antiretroviral therapy (HAART): A combination, or cocktail, of several anti-HIV drugs, at least one of which is often a protease inhibitor.

HIV/AIDS Services: Includes HIV/AIDS primary and secondary prevention services, HIV / AIDS counseling and testing, primary care, provision of HIV/AIDS anti-retroviral and other medications, rehabilitative, and supportive services for persons affected and infected with HIV.

Homeless Family: Family that includes at least one parent or guardian and one child under the age of 18, a homeless pregnant woman, or a homeless person in the process of securing legal custody of a person under the age of 18.

Homeless Person: According to HUD, a person is considered homeless only when he/she resides in one of the places described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings;
- In an emergency shelter;
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelter;
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution;

- Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing; or
- Is being discharged within a week from an institution in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks needed to obtain housing.

Homeless Prevention: Activities or programs designed to prevent the incidence of homelessness, including short-term rent and utility assistance to a person that has received an eviction or utility termination notice; security deposits or first month's rent to permit an individual to move into his/her own apartment; mediation programs for landlord-tenant disputes; legal services programs for representation of tenants in eviction proceedings; and payments to prevent foreclosure on a home.

Household: All the persons who occupy a housing unit (house or apartment), whether they are related to each other or not.

Housing Information and Referral: Assistance in obtaining information on and referrals to appropriate housing along the continuum of care.

Housing Placement Assistance: Assistance in obtaining appropriate housing along the continuum of care. Includes assisting clients in locating appropriate housing, completing applications for rental units and/or housing subsidies, neighborhood familiarization, and resolving landlord and tenant conflicts.

Housing Trust Fund: A dedicated pool, typically administered at the State or local level, that supplies either capital, operating, and/or supportive service financing for affordable housing to certain low-income residents.

Incidence: The number of new cases of a disease that occur during a specified time period.

Incidence Rate: The rapidity with which new cases of a particular disease arise within a given population.

Information and Referral Services: Services or activities designed to provide information about services provided by public and private service providers and a brief assessment of client needs (but not diagnosis and evaluation to facilitate appropriate referral to these community resources.

Issuing Agency: Department in federal, state or local government that issues funding to state or local administering agency or, in some cases, directly to non-profit organizations.

Legal Services: Those services or activities provided by a lawyer or other person(s) under the supervision of a lawyer to assist individuals in seeking or obtaining legal help in civil matters, such as divorce, housing, child support, guardianship, paternity, and

legal separation. Component services or activities may include receiving and preparing cases for trial, provision of legal advice, representation in hearings, and counseling.

Licensed Residential Facility: Program that has received a California license to operate. Includes group homes for children, hospices, board and care facilities, nursing homes, Residential Care Facility for the Chronically Ill, Congregate Living Health Facility, and Adult Residential Facility.

Life Skills (also referred to as Independent Living Skills): These services provide critical life management skills that may never have been learned or have been lost during the course of mental illness, substance use, and homelessness. They are targeted to assist the individual to function independently in the community. Component life skills training includes the budgeting of resources and money management, household management, conflict management, shopping for food and needed items, nutrition, the use of public transportation, and parent training.

Medication Management: Assisting individuals in storing medications and adhering to regular medication routines.

Medications: Provision of prescribed medications needed for medical conditions.

Mental Health Counseling/Treatment: Therapy provided by mental health professionals to individuals experiencing psychological distress. Services include assessment; development of a treatment plan; individual, group, couple and/or family therapy; and crisis intervention. Also includes psychiatric services and prescribing and monitoring of medications.

NIMBY (Not In My Backyard): Neighborhood organizations, other community groups and residents who organize effectively to stop the siting of affordable housing or social service programs. This phenomenon is called "NIMBY" since residents often support the goal of affordable housing so long as it is not located near their homes.

Outreach: Extending services or assistance in order to provide basic materials, such as meals, blankets, or clothes, to homeless persons; or to publicize the availability of shelters and programs to make homeless persons aware of various services and programs.

Permanent Housing: Housing where there is no pre-established expectation that the resident vacate after the passage of a certain amount of time.

Permanent Supportive Housing: Housing that has no limit on length of stay and that is linked to on-site or off-site services. Services must help the tenant retain the housing, improve his or her health status, and/or maximize his or her ability to live and (when possible) work in the community.

Physical Health Services: In-patient or out-patient care from a physician, dentist, nurse or other health care professional for medical purposes.

Poverty Guidelines: Simplified versions of the federal government's statistical poverty thresholds used by the U.S. Census Bureau to prepare its statistical estimates of the number of persons and families in poverty. The poverty guidelines issued annually by the U.S. Department of Health and Human Services are used for administrative purposes—for instance, for determining whether a person or family is financially eligible for assistance or services under a particular federal program.

Predevelopment Financing: Also known as risk capital. Loans used for expenses such as earnest money for site control, preliminary engineering or architectural studies, hazardous materials surveys, and other activities necessary to determine if a project is feasible and to prepare applications for project funding. Predevelopment financing for affordable housing development is most readily available from below-market lenders.

Prevalence: The proportion of persons in a given population who have a particular disease at a point or interval of time.

Prevalence Rate: The number of persons living with AIDS at a specified time divided by the total population at the same time.

Project Sponsor: The primary organization responsible for carrying out the proposed project activities.

Proposition 46: Refers to a bond measure passed on California's 2002 ballot, entitled the Emergency Shelter Trust Fund Act of 2002. This measure created trust funds to do the following: provide shelters for battered women; clean and safe housing for low-income seniors; emergency shelters for homeless families with children; housing with social services for homeless persons with mental illness; repairs/accessibility improvements to apartments for families and handicapped citizens; military veteran homeownership assistance; and security improvements/repairs to existing emergency shelters. This measure is funded by a one-time $2.1 billion bond issue.

Protease Inhibitor: A drug that binds to and blocks HIV protease from working, thus preventing the production of new infectious viral particles.

Rate: A measure of the probability of the development of a disease in a specified population during a specified period of time (see below).

> **Incidence Rate**: The number of new cases diagnosed in one year divided by the total population at risk in that same year.
>
> **Prevalence Rate**: The number of persons living with AIDS at a specified time divided by the total population at that same time.
>
> **Cumulative Rate**: The cumulative number of persons reported with AIDS during a specified period divided by the total population at the midpoint of that same time period.

Referral: Provision of information to clients regarding off-site services.

Rehabilitation: Cost of labor, tools and supplies for improving building from deteriorated or substandard to good condition or with the purpose of converting building to the intended use or to repair or replace a major building system in danger of failure. Does not include minor improvements.

Rent: Financial assistance paid directly to landlords on behalf of for short periods of time to allow tenants and homeowners to remain in their current housing.

Rental Assistance: Rental subsidies, usually to low- and very low-income households, to bridge the gap between the rent such households can afford and the amount needed by property owners and landlords to ensure that their properties are economically feasible. These forms of payment can be provided as either project-based, sponsor-based, or tenant-based rental assistance (see below).

> **Project-based Rental Assistance (PRA):** Rental assistance payments made to a sponsoring agency for units owned by the agency. Assistance for each unit covers the difference between the Fair Market Rent and 30% of the tenant's monthly-adjusted income. In some circumstances, tenants may pay up to 40% of their income in rent. Tenant loses assistance if s/he vacates assisted unit.
>
> **Sponsor-based Rental Assistance (SRA):** Rental assistance payments made to a sponsoring agency for units owned or master leased by the agency. Assistance for each unit covers the difference between the Fair Market Rent and 30% of a tenant's monthly-adjusted income. In some circumstances, tenants may pay up to 40% of their income in rent. Tenant loses assistance if s/he vacates assisted unit.
>
> **Tenant-based Rental Assistance (TRA):** Rental assistance payments made to a landlord on behalf of a tenant. Tenant pays 30% of monthly-adjusted income and Housing Authority pays for difference between the tenant's share and the Fair Market Rent, as prescribed for each given area. In some circumstances, tenants may pay up to 40% of their income in rent. Tenants may change rental units and keep their rental assistance.

Safe Haven: Program with no limit on length of stay for homeless persons with severe and chronic mental illness.

Service Planning Area (SPA): Geographic subdivisions of Los Angeles County established to decentralize public health services into 8 regional areas in order to be more responsive to local needs.

Sexually Transmitted Diseases: Diseases that spread from one sexual partner to another as a result of sexual intercourse.

Shared Housing: Residents individually lease locked bedrooms in a single family home and share bathrooms, kitchens, and living areas. Residents share responsibility for housekeeping, cooking, and other common activities. The housing may or may not be linked to on-site or off-site services.

Single Room Occupancy: Also known as an SRO. A studio apartment that provides very limited cooking facilities and a shared bathroom. Often in rehabilitated hotels, an SRO can be used for emergency, transitional, or permanent housing.

Soft Costs: Non-construction costs of professional services, financing costs, carrying costs, start-up costs necessary to build the project.

Special Needs Housing: Any type of affordable housing that is targeted to persons with special needs, which for this plan includes youth emancipated from the dependency and delinquency systems, homeless persons with mental illness, and persons living with HIV/AIDS. Typically, special needs housing programs have a strong supportive service component to address the unique needs of clients.

Substance Abuse Counseling/Treatment: Includes regular individual and group counseling, crises counseling, day treatment, and more intensive programs such as residential rehabilitation and methadone detoxification and maintenance.

Supportive Housing: Affordable housing combined with a range of support services that help people with disabilities or special needs—including mental illness, substance abuse, physical handicaps, and AIDS—stabilize their lives and live as independently as possible.

Supportive Services: Services designed to address the needs of specific populations, such as the homeless or persons with HIV/AIDS, often provided in tandem with housing services. Examples of supportive services include child care services, employment counseling, outpatient health services, and case management.

Surveillance: Ongoing observation of a population for rapid and accurate detection of changes in the occurrence of particular diseases.

Technical Assistance: Assistance provided to agencies to increase organizational and program capacity.

Transitional Living Services: Those services and activities designed to help make the transition from homelessness to stable housing. Component services or activities may include supervised practice living, budgeting, one-time payments associated with establishing tenancy, food planning and preparation, and post-foster care services for homeless persons.

Transportation: Includes cost of gas, drivers, vans, and/or bus tokens and passes to assist individuals to get to supportive services and self-sufficiency activities.

Tuberculosis: An infectious disease that is caused by *Mycobacterium tuberculosis*, which is spread by coughing. The organism may replicate in the lungs and in other tissues such as liver, bone, or brain.

APPENDIX D. INVENTORY OF HOUSING AVAILABLE TO SPECIAL NEEDS POPULATIONS

A. Youth Emancipated from the Dependency and Delinquency Systems

1. Emergency Shelter

Table D-1. Emergency Shelter Beds for Youth Emancipated from the Dependency and Delinquency Systems

Organization	Program Name	Ages Served	SPA	Beds
Covenant House California	Crisis Shelter	18-21	4	48
Jovenes, Inc.	La Posada Emergency Shelter	17-24	4	6
Tarzana Treatment Center	Emergency Shelter Program	18-21	1	12
			Total:	**66**

2. Transitional Housing

Table D-2. Transitional Housing Beds for Youth Emancipated from the Dependency and Delinquency Systems

Organization	Program Name	Ages Served	SPA	Beds
A Community of Friends	STEP-OUT Apartments	18-21	6	20
Atlantic Recovery Services	Emancipated Youth Program	17-21	8	16
B.R.I.D.G.E.S., Inc.	Primer Paso	18-23	2	6
B.R.I.D.G.E.S., Inc.	Terreno Miero	18-23	2	6
B.R.I.D.G.E.S., Inc.	Refugio Tranquilo	18-23	2	6
Bridges of Faith	Home Opportunities Meets Emancipation	17 and older	7	8
Catholic Charities of Los Angeles	Rancho San Antonio Independent Living Program for Emancipated Foster Youth	18-23	2	20
Center for Human Rights and Constitutional Law	Freedom House	18-23	4	14
Concerned Citizens of South Central Los Angeles	Gwen Bolden Manor	18-25	6	15
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	1	12
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	2	35
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	3	41
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	4	6
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	5	12
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	6	41
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	7	30

Table D-2. (cont.) Transitional Housing Beds for Youth Emancipated from the Dependency and Delinquency Systems

Organization	Program Name	Ages Served	SPA	Beds
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	8	55
County of Los Angeles DCFS Transitional Housing Program	DCFS Transitional Housing Program for Homeless Young People	18-21	Un-Identi-fied	12
Covenant House California	Rights of Passage Transitional Living Program	18-23	4	24
Covenant House California	Supportive Apartment Program	18-23	4	16
Gay and Lesbian Adolescent Social Services	Scheuer House High Desert Youth Project	18-21	1	27
Gay and Lesbian Adolescent Social Services	Scheuer House North Hollywood	18-21	2	22
Gramercy Housing Group	Gramercy Court	18-24	4	30
Hillview Mental Health Center	Jump Start 1	18-21	2	5
Hillview Mental Health Center	Jump Start 2	18-21	2	10
Hillview Mental Health Center	Jump Start 3	18-21	2	10
Hillview Mental Health Center	Room and Board	17 and older	2	10
Hollywood Wilshire YMCA	A Brighter Future	18-28	4	22
Homes for Life Foundation	Athena	18-21	3	18
Jovenes, Inc.	Casa Olivares	18-24	4	4
L.A. Gay and Lesbian Center	Kruks/Tilsner Transitional Living Program	18-24	4	24
Mental Health Association	Long Beach	18-25	8	9
New Economics for Women	La Posada	16-25	4	60
Penny Lane	Penny Lane HUD Transitional Housing Program	18-24	2	36
Penny Lane	Penny Lane HUD Transitional Housing Program	18-24	1	18
Portals	Selby House Emancipated Foster Youth Program	18-21	4	6

Table D-2. (cont.) Transitional Housing Beds for Youth Emancipated from the Dependency and Delinquency Systems

Organization	Program Name	Ages Served	SPA	Beds
Portals	Transitional Age Youth	18-21	4	12
Richstone Family Center		18-22	8	9
San Fernando Community Mental Health Center, Inc.	Transitional Youth	18-21	2	21
The Salvation Army	The Way In Transitional Housing	18-22	4	6
The Sycamores	Transitional Independent Living Program	18-21	3	24
Tarzana Treatment Center	Youth Transitional Living Program	18-21	1	12
Tarzana Treatment Center	Transitional Living Program	18-21	8	12
United Friends of the Children	Pathways	18-23	6,7	57
Vista Del Mar		18-22	2	4
YMCA of Santa Monica	Transitional Housing and Education Program	18-22	5	8
			Total:	**871**

3. Housing in Development

Table D-3. Housing in Development for Youth Emancipated from the Dependency and Delinquency Systems

Organization	Program	Ages Served	SPA	Beds
Transitional Housing				
County of Los Angeles DCFS Transitional Housing Program	Bridges	18-21	All	8
Covenant House California	Crisis Shelter/Transitional Housing	18-21	4	16
St. Anne's	St. Anne's Transitional Housing Project	18-21	4	39
Wilene's Regrowth Center	Village Resource Center	18-24	3	6
			Subtotal	**69**
Permanent Housing				
A Community of Friends	Rayan St. Apartments	18-24	2	25
Penny Lane	Penny Lane Permanent Housing Program	No age specified	2	14
			Subtotal	**39**
			Total:	**108**

B. Homeless Persons with Mental Illness

1. Emergency Shelter

Table D-4. Emergency Shelter Beds for Homeless Persons with Mental Illness

Organization	Program	SPA	Beds
AKILA Concepts	DMH Funded Shelter Bed Program	8	8
Casa de Rosas	DMH Funded Shelter Bed Program	6	9
Catholic Charities of Los Angeles, Inc.	DMH Funded Shelter Bed Program	1	10
Gospel Army (Now Midnight Mission)	Midnight Mission	4	5
Help is on the Way	DMH Funded Shelter Bed Program	6	9
L.A. Family Housing	DMH Funded Shelter Bed Program2	2	2
L.A.M.P., Inc.	LAMP Day Center/ Crisis Shelter	4	18
Miracle Star	DMH Funded Shelter Bed Program	1	5
Ocean Park Community Center	DMH Funded Shelter Bed Program	5	15
Parents of Watts	Parents of Watts	6	56
People Assisting The Homeless (P.A.T.H.)	DMH Funded Shelter Bed Program	4	9
The Salvation Army – Bell Shelter	DMH Funded Shelter Bed Program	7	8
SRO Housing Corporation	DMH Funded Shelter Bed Program, Russ Hotel	4	9
Transition House DBA	DMH Funded Shelter Bed Program	4	5
Union Station	DMH Funded Shelter Bed Program	4	2
Weingart Center Association	Specialized Shelter	4	10
		Total:	**180**

2. Transitional Housing

Table D-5. Transitional Housing Beds for Homeless Persons with Mental Illness

Organization	Program	SPA	MI Reserved Beds
B.R.I.D.G.E.S., Inc.	Casitas Pacificas	3	14
B.R.I.D.G.E.S., Inc.	Esperanza	3	14
B.R.I.D.G.E.S., Inc.	Casitas Tranquilas	3	15
Didi Hirsch Community Mental Health Center	Via Avanta	2	40
ENKI	Wiltern Place	4	2
Exodus	Vermont House	6	18
Exodus	3374 Overland	5	10
Exodus	3372 Overland	5	6
Exodus	3370 Overland	5	2
Exodus	10617 Woodbine	5	10
Exodus	10641 Woodbine	5	4
Help is on the Way	Help is on the Way	6	69
Hillview	9500 Natick	2	6
Hillview	9512 Natick	2	5
Hillview	Granada Cottage	2	8
Hillview	Granada West	2	4
Hillview	Granada House	2	6
Hillview	Brussells House	2	6
Hillview	Granada Condo	2	4
Hillview		2	6
LAMP, Inc.	LAMP Village	4	48
P.A.T.H. (People Assisting the Homeless)	Foundation House-Transitional Living Program	4	20
Portals	Twin Peaks Dual Diagnosis Residence	4	14
Portals	Westside Neighbors	4	14
Portals	Rampart Transitional Residence	4	20
Portals		6	4
Portals	Master Leased Property	6	3
Portals	Master Leased Property	4	34
San Fernando Valley Community Mental Health, Inc.	The Harbor	2	12
San Fernando Valley Community Mental Health, Inc.	Independent living Program	2	20
San Fernando Valley Community Mental Health, Inc.		2	8

Table D-5 (cont.) Transitional Housing Beds for Homeless Persons with Mental Illness

Organization	Program	SPA	MI Reserved Beds
San Fernando Valley Community Mental Health, Inc.	Cedros	2	6
San Fernando Valley Community Mental Health, Inc.	Tobias	2	5
San Fernando Valley Community Mental Health, Inc.	Little Tobias	2	2
San Fernando Valley Community Mental Health, Inc.	Tyrone	2	10
San Fernando Valley Community Mental Health, Inc.	Tyrone 2	2	2
San Fernando Valley Community Mental Health, Inc.	Tyrone 3	2	4
San Fernando Valley Community Mental Health, Inc.	Tyrone 4	2	5
San Fernando Valley Community Mental Health, Inc.	Sattellite Housing Doris Foster Apts.	2	6
San Fernando Valley Community Mental Health, Inc.		2	24
Southern California Alcohol and Drug Programs, Inc.	Positive Steps- Men's Transitional Housing	7	7
Southern California Alcohol and Drug Programs, Inc.	Long Beach Residential Facility	8	12
Southern California Alcohol and Drug Programs, Inc.	Positive Steps- Women and Children Transitional Housing	7	30
SRO Housing Corporation	Golden West Hotel	4	71
The Salvation Army	Bell Shelter Transitional Housing (Phase III)	7	59
The Salvation Army	Bell Shelter (Phase I&II)	7	232
		Total:	**921**

3. Permanent Housing

Table D-6. Permanent Housing Beds for Homeless Persons with Mental Illness

Organization	Program	SPA	Beds
A Community of Friends	Amistad	4	49
A Community of Friends	Big Berendo	4	16
A Community of Friends	Little Berendo	4	18
A Community of Friends	California Apartments	8	39
A Community of Friends	City Terrace	7	63
A Community of Friends	Figueroa Court	6	6
A Community of Friends	Fox Normandie Apartments	4	36
A Community of Friends	Gower	4	55
A Community of Friends	La Primavera	4	36
A Community of Friends	Las Palomas	4	50
A Community of Friends	Maryland	4	29
A Community of Friends	Orbison	4	6
A Community of Friends	Selby	4	29
ENKI	Volunteers of America	4	6
Homes for Life Foundation	Ashtabula Homes	3	21
Homes for Life Foundation	Buchanan House	4	6
Homes for Life Foundation	Denker House	5	9
Homes for Life Foundation	Harbor Gateway Homes	5	18
Homes for Life Foundation	Harvest House	7	8
Homes for Life Foundation	HFL Garden Villa Homes	5	24
Homes for Life Foundation	Madison House	3	9
Homes for Life Foundation	Palms Court	5	21
Homes for Life Foundation	Wilson House	3	8
Kedren	Reality House	6	12
LAMP, Inc.	Lodge	4	48
LAMP, Inc.	Scattered Site Master Lease	4	75
Mental Health Association – Antelope Valley	MHA Property	1	1
Mental Health Association – Village	Atlantic Apartments	8	3
Mental Health Association – Village	Merit Hall Apartments	8	20
Mental Health Association – Village	My Front Door	8	24
Mental Health Association – Village	Sara's Apartments	8	12
Mental Health Association - Village	Tay House	8	5
SCHARP	SCHARP	6	5
		Total:	**767**

Table D-7. Permanent Housing Beds for Homeless Persons with Dual or Multiple Diagnoses

Organization	Program	SPA	Beds
A Community of Friends	Cornerstone Apartments	2	36
A Community of Friends	Fedora	4	22
Project Headway	Geyser House	2	6
Skid Row Housing Trust	Boyd Hotel	4	12
Skid Row Housing Trust	Dewey Hotel	4	42
Skid Row Housing Trust	Genesis Hotel	4	1
Skid Row Housing Trust	Olympia Hotel	4	17
Skid Row Housing Trust	Sanborn Hotel	4	17
Skid Row Housing Trust	Simone Hotel	4	69
Skid Row Housing Trust	St. George	4	28
		Total	**250**

4. Targeted Long-Term Rental Assistance

Table D-8. County of Los Angeles Section 8 Homeless Vouchers

Name of Agency	Beds
Asian Pacific Counseling and Treatment Centers	20
Los Angeles County Department of Mental Health	342
Pacific Clinics	47
Southern California Health and Rehabilitation Programs	15
Total:	**424**

Table D-9. City of Los Angeles Section 8 Homeless Vouchers

Name of Agency	Beds
Pre- 1997	465[1]
Good Shepherd Center for Homeless Women	75
Los Angeles County Department of Mental Health	235
Ocean Park Community Center	40
Skid Row Housing Trust	95
St. Joseph Center	125
San Fernando Valley Community Mental Health	165
Special Service for Groups	25
SRO Housing Corporation	50
Venice Community Housing	7
Total:	**1282**

Table D-10. County of Los Angeles Shelter Plus Care Certificates

Project Sponsor	Beds
Los Angeles County Department of Mental Health	155
Mental Health Association in Los Angeles County	47
New Directions, Inc.	54
Total:	**256**

[1] This figure is based on the assumption that 30% of the 1550 Section 8 Homeless program certificates available between 1990 and 1997 were accessed by nonprofit organizations targeting the homeless mentally ill.

Table D-11. City of Los Angeles Shelter Plus Care Certificates

Project Sponsor	Program Name	Beds
A Community of Friends	39 West	33
A Community of Friends	Brandon Apartments	30
A Community of Friends	Figueroa Apartments	34
A Community of Friends	Fox Normadie	11
A Community of Friends	Parker Hotel	32
A Community of Friends	Vista Nueva	30
Beacon House	124 West 11th Street	8
Los Angeles County Department of Mental Health		135
Hillview Mental Health Center	Hillview Village	50
Hillview Mental Health Center	Tenant-based	20
L.A. Family Housing Corporation	Independence	30
Los Angeles County Department of Mental Health	LA's HOPE Collaborative	76
LAMP, Inc.	LAMP Lodge	14
Mental Health Association in Los Angeles County	Crossroads Village	20
Para Los Ninos		25
Portals		25
Skid Row Housing Trust	Skid Row Collaborative	24
Skid Row Housing Trust	Boyd Hotel	47
Skid Row Housing Trust	Genesis Hotel	28
Skid Row Housing Trust	Las Americas	41
Skid Row Housing Trust	Olympia Hotel	30
Skid Row Housing Trust	Sanborn	28
Skid Row Housing Trust	Simone	52
Special Service for Groups		72
SRO Housing Corporation	Brownstone Hotel	47
SRO Housing Corporation	Various Hotels	218
St. Joseph Center		40
Step Up On Second		9
Venice Community Housing Corporation		31
Watts Labor Community Action Committee	McCoy Plaza	11
	Total:	**1251**

Table D-12: City of Long Beach Shelter Plus Care

Project Sponsor	Program Name	Beds
Mental Health Association in Los Angeles County		37
	Total:	**37**

Table D-13. City of Pasadena Shelter Plus Care

Project Sponsor	Program Name	Beds
Pacific Clinics		40
	Total:	**40**

Table D-14. City of Santa Monica Shelter Plus Care

Project Sponsor	Program Name	Beds
Ocean Park Community Center		70
Step Up on Second		34*
	Total:	**104**

* Nine (9) of these beds are project-based vouchers

5. Housing in Development

Table D-15. Housing in Development for Homeless Persons with Mental Illness

Organization	Program	SPA	Beds
Transitional Housing			
Ocean Park Community Center	OPCC Safe Haven	5	25
San Fernando Valley Mental Health Center	New Start	2	30
		Subtotal	**55**
Permanent Housing			
A Community of Friends	Central Court	6	7
A Community of Friends	Gateways Housing	4	29
A Community of Friends	New Directions	2	62
A Community of Friends	Santos Plaza Apartments	6	36
A Community of Friends/Step Up on 2nd	Step Up on 5th		46
A Community of Friends	Willow Apartments	6	23
A Community of Friends	Woodland Terrace	2	30
East Los Angeles Community Corporation	Las Flores	4	12
Exodus	Woodbine House	5	32
Homes for Life Foundation	Cedar Street Homes	7	38
Homes for Life Foundation	HFL Van Nuys Apartments	2	14
Homes for Life Foundation	HFL Birch Grove	7	20
Homes for Life Foundation	HFL Elm Street	7	14
Homes for Life Foundation	Van Owen		24
Little Tokyo Service Center Development Corporation	Pacific Housing	3	8
Pacific Clinics	Permanent Supportive Housing II	3	8
Project ACHIEVE	Supportive Housing Program	3	6
PROTOTYPES	Pomona Apartments	3	31
SCHARP	Hoover	6	6
Skid Row Housing Trust	Abbey Hotel	4	90
Skid Row Housing Trust	Rainbow Hotel	4	80
SRO Housing Corp.	Lyndon Hotel	4	48
		Subtotal	**664**
		Total	**719**

C. Persons Living with HIV/AIDS

1. Emergency Shelter

Table D-16. Emergency Shelter Beds for Persons Living with HIV/AIDS

Organization	Program	SPA	Beds
Covenant House	Emergency Shelter	4	6
Friends Research Institute	Safe House	2	4
Joint Efforts, Inc.	Women's Educational Community AIDS Network	8	6
JWCH Institute, Inc.	HIV Emergency Housing Program (HELP)	4	3
JWCH Institute, Inc.	HOPWA	4	5
LAMP, Inc.	Day Center/Shelter	4	4
New Image Emergency Shelter for the Homeless	Emergency Hotel/Motel and Meal Voucher Program	varies	40
Parents of Watts	Emergency Shelter	6	2
People Assisting the Homeless	Regional Homeless Center	4	3
SRO Housing Corporation	Russ Hotel	4	10
Tarzana Treatment Center	Emergency Voucher Program	2	4
		Total	**87**

2. Transitional Housing

Table D-17. Transitional Housing Beds for Persons Living with HIV/AIDS

Organization	Program	SPA	Beds
A Place for Miracles	A Place for Miracles	3	15
Being Alive Housing, Inc.	St. Francis House Apts.	8	6
Being Alive Housing, Inc.	Founders Hall	8	10
Covenant House	Transitional Living Program	4	6
Friends Research Institute	Safe House	2	6
Jenesse Center, Inc.		6	4
Joint Efforts, Inc.	Women's Educational Community AIDS Network	8	4
JWCH Institute, Inc.	HIV and AIDS Transitional Shelter (HAT)	4	7
L.A. Family Housing Corp.	HOPWA Pilot	2	6
L.A. Family Housing Corp.	Valley Shelter	2	6
LAMP, Inc.	Village Transitional Residence	4	12
LAMP, Inc.	Lodge Apartments	4	8
Live Again Recovery Home, Inc.	HIV Positive House	2	6
Los Angeles Gay and Lesbian Center	Kruks/Tilsner Transitional Living Program	4	4
Ocean Park Community Center	Turning Point	5	2
Palms Residential Care Facility	Palms Residential Care	6	26
People Assisting the Homeless	Regional Homeless Center	4	18
Portals	Community Connections	4	20
SRO Housing Corporation	Russ Hotel	4	5
		Total	**171**

3. Permanent Housing

Table D-18. Permanent Housing Units for Persons Living with HIV/AIDS

Organization	Program	SPA	Units
First AME Church	Eugene Thomas Manor	4	43
Friends Research Institute	Safe House	2	12
Hollywood Community Housing Corporation	Casa Verde	4	11
Hollywood Community Housing Corporation	Dunning	4	1
Hollywood Community Housing Corporation	Harold Way Apartments	4	16
Hollywood Community Housing Corporation	Innes Heights Apartments	4	19
Hollywood Community Housing Corporation	Kenmore	4	7
Hollywood Community Housing Corporation	Mirada Terrace	4	20
Hollywood Community Housing Corporation	St. Andrews	4	17
Hollywood Community Housing Corporation	Wilcox	4	1
Hollywood Community Housing Corporation	Waterloo Heights	4	18
Project New Hope	Callahan/DeFields Apts.	8	16
Project New Hope	Casa Del Sol	4	10
Project New Hope	Doug Anglin New Hope Apartments	4	9
Project New Hope	Hoover Apartments	4	25
Project New Hope	Jack H. Plimpton Apts.	2	21
Project New Hope	Martha Bryant Apartments (S+C Master Leasing)	6	12
Project New Hope	Norlin Apartments (S+C Master Leasing)	2	15
Project New Hope	Nyumba Apartments	6	9
Project New Hope	Rick Weiss New Hope Apts.	5	37
Project New Hope	Scattered Site	4	9
Project New Hope	Scattered Site	4	26
Project New Hope	Scattered Site	4	30
Project New Hope/ Homestead Hospice and Shelter	Scattered Site Master Leasing	4	32
Project New Hope	Tripp House	8	4
Skid Row Housing Trust	Dewey House	4	30

Table D-18 (Cont.). Permanent Housing Units for Persons Living with HIV/AIDS

Organization	Program	SPA	Units
Skid Row Housing Trust	San Pedro House	4	19
Skid Row Housing Trust	Lincoln Hotel	4	40
SRO Housing Corporation	Eugene Hotel	4	43
SRO Housing Corporation	Rivers Hotel	4	35
Salvation Army	Alegria-Bethesda House	4	28
The Serra Project	CHOISS (Scattered Site Master Leasing)	2	20
The Serra Project	CHOISS (Scattered Site Master Leasing)	3	8
The Serra Project	CHOISS (Scattered Site Master Leasing)	5	4
The Serra Project	CHOISS (Scattered Site Master Leasing)	7	14
The Serra Project	CHOISS (Scattered Site Master Leasing)	8	29
Venice Community Housing	Navy Blue and Ballona Villas II	4	15
West Hollywood Community Housing Corporation	Palm View Apartments	4	40
		Total Existing Units	**745**

4. Targeted Long Term Rental Assistance for People with HIV/AIDS

Table D-19. HOPWA Tenant-based Rental Assistance

Housing Authority	Beds
City of Los Angeles	858
County of Los Angeles	194
City of Long Beach	9
City of Pasadena	8
Total:	**1,069**

Table D-20. HOPWA Project-based Rental Assistance

Organization	Program Name	SPA	Beds
Hollywood Community Housing Corporation	Argyle Court	4	24
West Hollywood Community Housing Corporation	Harper Community Apartments	4	22
		Total:	**46**

Table D-21. City of Los Angeles Section 8 Homeless Vouchers

Organization	Beds
AIDS Service Center	50
Palms Residential Care Facility	25
Total:	**75**

5. Housing in Development

Table D-22. Permanent Housing Units in Development for Persons Living with HIV/AIDS

Organization	Program	SPA	Units
Encore Hall Senior Housing	Encore Hall Senior Apartments	4	35
Hollywood Community Housing Corporation	Alessandro Court	4	18
Hollywood Community Housing Corporation	Palomar Apartments	4	27
Palms Residential Care Facility	Walnut Tree Village	6	23
Palms Residential Care Facility	Palms Village II	6	25
Project New Hope	Flowers House Replacement	5	12
Project New Hope	Laguna Senior Apartments	4	14
Project New Hope	Main Street New Hope Apts.	6	35
Project New Hope	St. George Hotel	4	15
		Total Units in Development	**204**

Appendix E. Summary of Public Funding Programs

	Eligible Activities				Housing Type				Target Populations					Grant Type	
	D	SS	O	RA	ES	TH	PH	SH	HMI	EFY	HIV	H	D	F	C
TARGETED															
AB 2034	✓	✓	✓	✓	✓	✓	✓		✓					✓	
Ryan White CARE Act		✓	✓								✓			✓	
City of Industry Special Needs	✓					✓	✓		✓	✓	✓				✓
HOPWA	✓	✓	✓	✓	✓	✓	✓				✓			✓	✓
Independent Living Program		✓	✓	✓	✓	✓				✓				✓	
PATH		✓	✓	✓					✓					✓	
NON-TARGETED FUNDING SOURCES															
FEDERAL															
Affordable Housing Program	✓					✓	✓								✓
CalWORKs		✓	✓	✓	✓	✓	✓					✓		✓	
Community Development Block Grant	✓	✓	✓	✓	✓	✓	✓							✓	
Emergency Food and Shelter Program		✓	✓	✓	✓							✓		✓	
Emergency Shelter Grants	✓	✓	✓		✓							✓		✓	
Health Care for the Homeless		✓										✓		✓	✓
HHS Block Grants															
MHBG		✓							✓					✓	
SABG		✓												✓	
CSBG		✓	✓											✓	
SSBG	✓	✓												✓	
CCDBG		✓												✓	
HHS Discretionary Grants															
Treatment Systems for Homeless Persons		✓							✓			✓			✓
Substance Abuse Treatment Capacity Expansion		✓													✓
TCE (Prevention of Substance Abuse and HIV)		✓									✓				✓
HOME	✓			✓		✓	✓							✓	
Homeless Veterans Reintegration program		✓										✓			✓
HUD-VA Supported Housing Program		✓		✓			✓		✓			✓			
Low-Income Housing Tax Credits	✓		✓			✓	✓								✓
Mainstream Housing Opportunities				✓			✓						✓		✓
Medi-Cal		✓											✓	✓	
Section 202	✓		✓	✓			✓						✓		✓
Section 8 (Housing Choice Voucher)				✓			✓							✓	
Section 8 SRO Moderate Rehabilitation				✓			✓					✓			✓
Section 811	✓		✓	✓			✓						✓		✓
Shelter Plus Care				✓			✓		✓		✓	✓	✓		✓
Supportive Housing Program	✓	✓	✓			✓	✓	✓				✓	✓		✓
Transitional Living Program For Older Homeless Youth		✓	✓	✓	✓	✓				✓					✓
VA Homeless Providers and Per Diem	✓														
VA Loan Guarantee	✓					✓						✓			✓
VA Supported Housing Program		✓					✓					✓			
Workforce Investment Act		✓												✓	
STATE															
California Special Needs Financing Program (CalHFA)	✓	✓					✓		✓	✓	✓		✓		✓
EHAP-Capital Grants	✓				✓	✓		✓				✓			✓
EHAP-Operating Grants			✓	✓	✓	✓		✓				✓		✓	
Multifamily Housing Program	✓					✓	✓		✓		✓	✓	✓		✓
Proposition 10	✓	✓	✓												✓
Proposition 36		✓	✓												✓
LOCAL															
Affordable Housing Trust Fund	✓						✓								✓
General Relief		✓	✓												✓
Redevelopment Set-aside	✓						✓								✓

D = Development
SS = Supportive Services
O = Operating
RA = Rental Assistance

ES = Emergency Shelter
TH = Transitional Housing
PH = Permanent Housing
SH = Safe Haven

HMI = Homeless Mentally Ill
EFY = Emancipated Foster Youth
HIV = Persons with HIV/AIDS
H = Homeless
D = Disabled

F = Formula
C = Competitive

APPENDIX F. RESOURCES

Federal Agencies

Administration on Children and Families	www.acf.hhs.gov
Health and Human Services	www.hhs.gov
Health Resources and Services Administration	www.hrsa.gov
Housing and Urban Development	www.hud.gov
Substance Abuse and Mental Health Services	www.samhsa.gov
Veterans Affairs	www.va.gov

Other Federal Resources

Federal Home Loan Bank	www.fhlb.gov
Health Care for the Homeless Information Center	www.hchirc.bphc.hrsa.gov
National Clearinghouse for Alcohol and Drug Information	www.SAMHSA.gov
National Mental Health Information Center	www.mentalhealth.samhsa.gov
National Resource Center or Homelessness and Mental Illness	www.nrchmi.samhsa.gov
Interagency Council on Homelessness	www.ich.gov

State Agencies

Department of Health Services	www.dhs.ca.gov
Department of Housing and Community Development	www.hcd.ca.gov
Department of Mental Health	www.dmh.cahwnet.gov
Department of Social Services	www.dss.cahwnet.gov/cdssweb
California Housing Finance Agency	www.calhfa.ca.gov

Local Agencies (City and County of Los Angeles)

Chief Administrative Office	www.cao.co.la.ca.us
City of Los Angeles Housing Department	www.lahd.lacity.org
Community Development Commission	www.lacdc.org
Department of Children and Family Service	www.dcfs.co.la.ca.us
Department of Community and Senior Services	www.css.co.la.ca.us
Department of Health Services	www.ladhs.org
Department of Mental Health	www.dmh.co.la.us
Department of Public Social Services	www.ladpss.org
Housing Authority of the City of Los Angeles	www.hacla.org
Housing Authority of the County of Los Angeles	www.lacdc.org/housing/index
Los Angeles County Commission on HIV	www.hivcommission-la.info
Los Angeles County Office of Education	www.lacoe.org
Los Angeles Homeless Services Authority	www.lahsa.org
Office of AIDS Programs and Policy	www.lapublichealth.org
Probation Department	www.probation.co.la.ca.us

Technical Assistance

The following organizations offer either technical assistance and/or financial intermediary services, with a focus on affordable housing and/or supportive services for special needs populations.

AIDS Housing of Washington	www.aidshousing.org
California Housing Partnership Corporation	www.chpc.net
Center for Urban Community Services	www.cucs.org
Child Welfare League of America	www.cwla.org
Corporation for Supportive Housing	www.csh.org
Local Initiatives Support Corporation	www.liscnet.org
National Alliance to End Homelessness	www.naeh.org
National Law Center on Homelessness and Poverty	www.nlchp.org
Shelter Partnership, Inc.	www.shelterpartnership.org
Technical Assistance Collaborative, Inc.	www.tacinc.org

DESCRIPTION OF CRITICAL EIGHT PRIORITY RECOMMENDATIONS

Request the Board to adopt a formal policy establishing the Alliance as the body for addressing housing policy/program, funding, and project opportunities for vulnerable health and human services populations in Los Angeles County. (Plan Objective: A.6)

By acting as the County's housing umbrella, the Alliance would be in a position to serve as a conduit for communicating strategies, coordinating various County interdepartmental housing efforts and activities, and recommending the allocation of dedicated resources. The Alliance would review these initiatives, where appropriate, and support them through technical assistance and guidance related to strategy, resource utilization, and production opportunities. Moreover, the Alliance would function as a "one-stop-shop" facilitator for developers and other stakeholders seeking to collaborate with the County on interdepartmental housing with services. Additionally, your Board would benefit through the Alliance's ability to serve as the hub for the County's coordinated housing system (including various Board initiatives), tracking interdepartmental housing efforts and resources, and noting and promoting the implementation of any necessary course corrections/adjustments within the system.

Establish a Countywide Special Needs Housing Operating and Supportive Service Trust Fund. (Plan Objective: B.1, merged with Objective D.2)

Identify departmental and General Fund resources that could be used for establishing and implementing a Trust Fund that would provide operating and service resources in support of the development of housing with support services for special needs populations. Through the Community Development Commission and other existing resources, the County possesses the ability to construct housing structures needed to shelter a portion of the targeted populations; however, funding for operational (i.e., rent subsidies), and supportive services (i.e., mental health, substance abuse, family support, etc.) to sustain and enable clients to live as independently as possible is not in place. Without permanent, affordable, housing with support services, the most vulnerable client populations will not be able to achieve stability or sustain self-sufficiency. Moreover, without addressing the long-term housing and comprehensive service needs of these populations, we cannot affect the long-term costs to the County's health and human service infrastructure associated with recidivism.

This recommendation is structured to maximize access and use of potential funding opportunities, such as Proposition 46, Proposition 63, Hilton Foundation funds, and City of Industry resources, to name a few. Actual use of resources set-aside through this proposed Fund will be based on priorities established by your Board and the Alliance recommendations.

Departmental Staffing

Another essential component required to sustain the proposed interdepartmental housing infrastructure is staff. Although the details of the implementation plan are still forthcoming, Alliance members will need to commit to identifying and assigning staff along one or more levels of the County's housing infrastructure: 1) at the Alliance (policymaking) level; 2) the department (coordination) level; and 3) Countywide by Service Planning Area (SPA). A description of the staff needed along with some of their basic responsibilities and the corresponding Plan recommendations are as follows:

Each Alliance member shall identify a housing and homeless prevention coordinator within their respective department. (Plan Objective: A.2)

- *Alliance (policymaking) level*
  - Staff at this level will need to have access to decision-makers within their organizations, and also have some level of authority to make commitments on their behalf.
  - To the extent possible, this person would consistently represent their department at the Alliance and would be responsible for, but not be limited to, coordinating departmental resources in support of Alliance activities and priorities as outlined in the Alliance's Collaborative Agreement of November 4, 2003.

- *At the department (coordination) level*
  - Staff at this level will probably have to be dedicated staff serving as their department's homeless prevention coordinator(s) and lead housing locator(s).
  - Tentatively, staff responsibilities would include, but are not be limited to: understanding, accessing, and applying departmental resources quickly and flexibly in response to Alliance policies and priorities. Staff would also be responsible for coordinating interdepartmental activities and resources (including any funding or project challenges/opportunities) with their counterparts, and ensuring that coordination with local SPA teams and departmental representative(s) to the Alliance occurs on a timely and consistent basis.

- *Establish dedicated housing specialist teams in each SPA. (Plan Objective: D.9)*
  - Each department, or group of departments, should establish at least one SPA-based team of housing specialists in each SPA responsible for helping clients overcome barriers to obtaining permanent housing.
  - Housing specialists, under the direction of the lead departmental housing locator, who may be a contractor, would recruit property owners/managers willing to rent to clients, and also interface with case managers to ensure that clients obtain intensive support services that promote their ability to live as independently as possible for the long-term, as well as, services for overcoming barriers to obtain and maintain permanent housing, that include,

but are not limited to:

- Landlord/Tenant education;
- Advocacy for/access to housing subsidies and/or project-based Section 8 units;
- Transportation;
- Coaching to meet potential property owners;
- Advocacy/referrals to specific property owners willing to rent to homeless families;
- Assistance in overcoming bad credit, no credit, or eviction histories; and
- Assistance in obtaining move-in funds.

- By addressing both sides of the housing equation the likelihood that these SPA-based Countywide teams will achieve a greater rate of success for clients will increase exponentially.

Create and cultivate the political will to address special needs housing concerns and development. (Plan Objective: B.2)

- *Invest in the creation of a Countywide Anti-Nimby (Not In My Backyard) task force to coordinate community education and outreach efforts, and education efforts for elected officials and other decision-makers to help address concerns and overcome resistance to housing being sited for these special populations*

Create more permanent housing resources for emancipated foster youth through the development of new housing. (Plan Objective C.2)

- In recognition that the lives of foster youth are often turbulent and fraught with significant challenges as they transition to adulthood and independence, it is vital to provide them access to permanent supportive housing to improve their outcomes as they relate to education, employment, health care, etc. Permanent housing developments are designed to provide youth emancipated from the foster care and/or probation systems with a living environment that promotes residential stability and assists them to achieve self-sufficiency, while facilitating their transition, when necessary, to other appropriate and affordable housing opportunities.
- County and city housing agencies should be encouraged to design funding opportunities to incorporate the unique experiences and needs of this target population and to design permanent housing programs that target different segments of the emancipated foster youth population who demonstrate different levels of functioning.

Ensure a broader array of housing options to respond to the disparate and evolving needs and circumstances of homeless persons with mental illness. (Plan Objective: D.1)

- Permanent housing developments must assist persons with mental illnesses in maintaining long-term, permanent housing.

- County and city housing agencies should be encouraged to design funding opportunities to increase the stock of permanent, affordable, supported housing across Los Angeles County. Supportive housing has proven to be a best practice in addressing the housing needs of mentally ill individuals and specifically those who are homeless.

Increase the number of permanent supportive housing units targeted to people living with HIV/AIDS. (Plan Objective: E.3)

- Commit to creating at least 100 units (or two affordable housing developments) over the next two years, targeted to people living with HIV/AIDS (PLWH/A), through the collaborative efforts of the Los Angeles Housing Department, and the Community Development Commission (CDC), the Los Angeles Homeless Services Authority, the County Office of AIDS Programs and Policy (OAPP), and the Special Needs Housing Alliance.
- Continue to utilize the Federal Housing Opportunities for People with AIDS (HOPWA) and City of Industry Fund programs as operating/service and capital financing mechanisms for the development of permanent supportive housing targeted to the population. However, prioritize the use of City of Industry Funds for permanent housing for PLWH/A.
- Initiate an HIV Housing Task Force (HHTF) to include representatives from the City of Los Angeles' HOPWA, Housing Authority of the County of Los Angeles (HACOLA), OAPP, the Los Angeles County HIV Commission, and CDC to plan/implement strategies for developing more permanent housing opportunities for PLWH/A. In addition, the HHTF would act as an oversight committee to ensure follow-through on implementing plans to develop more permanent housing opportunities and for HIV Housing related issues/concerns.
- Through the HHTF, develop collaborative methodologies to maximize the development of permanent housing units for PLWH/As by leveraging funding for capital, rental subsidies, operational costs, and supportive service opportunities.
- Conduct a focus group for housing developers to determine challenges that exist in developing such housing and identify incentives that may encourage the development of PLWH/As.
- Develop standards of care to be recognized by HOPWA, OAPP and the HIV Commission that delineate what level/type of services must be offered by any permanent housing unit developed for PLWH/As.