
Responding to Chronic Homelessness Project Profile

Focus on: **Outreach and Engagement**

Focus on: **Accessing Mainstream Benefits**

Project Coming Home Contra Costa County

Activity Description

Why: Chronically homeless people were not accessing services and housing available through the Contra Costa County continuum of services and housing system. Contra Costa County Continuum of Care members were pioneer designers of street outreach and engagement teams able to deliver what was needed, when needed.

What: A multi-agency collaborative effort to provide integrated outreach, treatment, housing and support services to chronically homeless individuals. Project Coming Home houses people in scattered site one-bedroom units through Shelter Plus Care grants, providing supportive services on-site.

Partners:

- Contra Costa County Office of Homeless Programs
- County Housing Authority
- Health, Housing and Integrated Service Network
- Contra Costa County Alcohol and Other Drugs Services Division
- Contra Costa County Mental Health Services Division
- Health Care for the Homeless Program
- Mental Health Consumer Concerns
- Phoenix Programs
- Rubicon Programs
- SHELTER, Inc.
- Department of Veterans Affairs
- Neighborhood House of North Richmond
- Bi-Bett

Significant Program Design Features:

Outreach and Supportive Services

- Outreach, assessments, services and linkages occur on the street, in encampments through multi-disciplinary teams using a modified Assertive Community Treatment model
- Outreach staff maintain contact with clients from pre-engagement through treatment
- HHISN staff provide wrap-around case management while consumer are in housing
- Staff provide ongoing services and therapeutic support which is consumer-driven
 - Intensive case management
 - Vocational services
 - Benefits assistance
 - Health Care
 - HIV services
 - Permanent housing placement
- “Any door is the right door to services”: staff are in key service locations to facilitate access to assessment and integrated treatment
- *Dedicated* residential detoxification and treatment beds so that treatment is available on demand

Special focus on outreach to Homeless Veterans with Fast-track services

The Veteran's Outreach Worker, working with the HOPE outreach team, has contacted 280 veterans. Fourteen of these veterans were connected to PCH housing through Shelter Plus Care vouchers. Fifteen veterans have been connected to non-PCH housing. All of the veterans in housing and many of the veterans contacted by the outreach team have been connected to VA medical benefits. Additionally, approximately 50 veterans have begun receiving VA financial benefits. Veterans who were not directly connected to VA benefits by the Veteran's Outreach Worker were given information and encouraged to visit either of 2 local VA offices. Roughly 60% of the veterans contacted by the Veteran's Outreach Worker who are eligible for VA financial benefits had never applied for them prior to her contact with them.

Project Coming Home also created a fast-track for homeless clients to services at the Veteran Administration. At the local VA, there is one way to access non-emergency services. In the past that has often involved waiting a month or two for an appointment. With the advent of the PCH collaboration, the VA partner was able to convince supervisors at the VA to agree to fast-track (arrange for appointments very quickly) homeless veterans in order to help engage them and deal with their medical or mental health issues right away. This has made early mental health screening, assessment and referral to services a standard practice for homeless veterans. Because the Veteran's Care Coordinator is there to arrange the appointments, PCH was able to cut through a lot of red tape and just make these appointments happen, by prearranging this with the VA administrators. In this way, PCH has increased access to care and helped eliminate system disparities in serving veterans who are chronically homeless.

Special Focus on Assisting Clients in Obtaining SSI/SSDI Benefits

Many homeless individuals suffer from mental illness, chemical dependency or co-occurring disorders. The usual thought for case managers is that only individuals with serious and persistent mental illness are eligible for disability benefits. In fact many homeless men and women who are considered to only have substance or alcohol addictions are often not considered for disability evaluation. However, many of these same homeless individuals also show significant cognitive or neuropsychological impairment, some without evidence of serious and persistent mental illness. However, there is extremely limited appropriate evaluation of homeless men and women conducted at clinics and mental health centers. Within the framework of Project HOPE, the HOPE Team through Dr. Virginia Luchetti, Licensed Psychologist of Phoenix Programs, has been conducting psychological and cognitive assessments to help individuals become eligible for Social Security Disability. Because it has been able to conduct fairly in-depth psychological evaluations, it has been able to identify conditions such as Cognitive Impairment, Mild Mental Retardation, Dementia, Attention-Deficit Hyperactivity Disorder, and Posttraumatic Stress Disorder. While conducting these assessments, it was found that cognitive impairment appears to be pervasive in the homeless population. Of the cases submitted for disability evaluation, almost 100% have been approved, many in as short as four weeks.

Selected Funding Sources

Collaborative Initiative to Help End Chronic Homelessness (HHS, HUD, VA) grant
SAMSHA (Substance Abuse Mental Health Services Agency, a division of HHS) grants:

- Community Action Grant
- Targeted Capacity Expansion Grant
- Treatment for Homeless Persons Grant
- HUD Continuum of Care Shelter Plus Care Vouchers
- County Department of Health Services (Homeless Programs, Mental Health, Alcohol and Other Drugs and Healthcare for the Homeless)
- Medi-Cal reimbursements (FQHC)

Outcomes

Since March 2004:

- 48 people into Shelter Plus Care housing
- 112 people into housing not subsidized by paid for by the PCH program
- PCH-funded alcohol and other drug treatment beds have served 46 males in residential treatment, 7 females in residential treatment, and 52 clients (male and female) in detox.
- 50 veterans have begun receiving VA financial benefits (roughly 60% of the veterans contacted by the Veteran's Outreach Worker who are eligible for VA financial benefits had never applied for them prior to her contact with them)
- Closer relationship with the county hospital, the mental health department, and various police departments.
 - the emergency room at the county hospital now contacts the outreach team when a chronically homeless person enters the hospital

- the police departments regularly call the outreach team when they encounter a chronically homeless person in need of services
- members of the county mental health assessment team attend the PCH Project Management meetings and are working with the PCH partners resulting in enhanced quality of mental health care
- Starting November 15, 2004, PCH-partner County Public Health opened 3 new homeless ambulatory care clinics in the 3 areas of the county – West, Central, and East.

Places Where Similar Work is Underway

San Francisco: Direct Access Housing

Santa Clara County: Navigator Project

Los Angeles: Skid Row Collaborative

Most AB 34-funded programs