



A RESPONSE TO HOMELESSNESS IN MARIN COUNTY:  
ASSESSING THE NEED & TAKING ACTION



Marin County Continuum of Care

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## I. ACKNOWLEDGMENTS

Thank you to the Marin County Continuum of Care (CoC) partners for your tireless dedication and tenacity in moving toward our goal of ending homelessness. Without you, this work and Marin's continued success would not be possible.

## II. LETTER FROM THE HOMELESS POLICY STEERING COMMITTEE (HPSC) CHAIR

*June 10, 2019*

As recent reports on homelessness statewide will confirm, the issue of homelessness continues to be a crisis for communities across California, and Marin County is no exception. Recent data reveals that 50% of Marin workers earn less than the average income needed to afford a median-priced one-bedroom apartment in San Rafael.<sup>1</sup> In addition to the rising cost of housing, risk factors for homelessness include disproportionately low numbers of affordable housing units, stagnant incomes, and lack of living-wage employment opportunities, as well as uncoordinated access to primary and behavioral health care; these and other factors are increasingly displacing low-income households in Marin County, causing many to fall into homelessness.

Recognizing that reasons for homelessness are multi-faceted and complex, Marin County is committed to understanding the varied pathways into homelessness and the experiences of individuals and families once they fall into homelessness. In an effort to craft a flexible and responsive system of care, the below analysis and planning report seeks to 1) analyze trends regarding the homeless population in Marin County through recent data, 2) uncover gaps in resources provided by the system of care, and 3) offer solutions that will guide the community's next steps in responding to homelessness.

Success in implementing these solutions will depend on the involvement of our full community; for this reason, this report was developed with support from and in collaboration with a diverse array of partners from across the county, including the following:

- County representatives from Health and Human Services, Behavioral Health and Recovery Services, Marin law enforcement/probation;
- Marin Continuum of Care (referred to hereafter as the Homeless Policy Steering Committee, or HPSC);
- The cities of Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, San Anselmo, San Rafael, and Sausalito;
- Housing and homeless service providers and Marin County health plans, community clinics and health centers (described in more detail below under Partnership & Collaboration);
- The Marin Housing Authority; and
- Marin County chapter of the National Alliance on Mental Illness (NAMI), representative of caregivers of persons living with serious mental illness

As these and other partners remain committed to continued collaboration, creativity, and partnership, Marin will continue to make strides in preventing and ending homelessness countywide.

Ann Morrison

Chair, Homeless Policy Steering Committee & Mayor, City of Larkspur

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<sup>1</sup> Marin rental price escalation warning, analysts report, *Marin IJ*, 04/02/18: <http://www.marini.com/business/20180402/marin-rental-price-escalation-waning-analysts-report>; The Department of Housing & Urban Department [defines](#) housing affordability as "housing for which the occupant(s) is/are paying no more than 30 percent of his or her income for gross housing costs." Data USA: Marin County, CA; <https://datausa.io/profile/geo/marin-county-ca/#economy>

### III. THE HOMELESS POPULATION IN MARIN COUNTY

#### Housing Insecurity and Homelessness

To gain a clearer picture of the current status of homelessness in Marin, it is important to understand some of the local economics that contribute to housing instability and homelessness, as well as the effect of cost burden on health.

The 2019 County Health Rankings Report, released by the Robert Wood Johnson Foundation, shows that among 58 California counties, Marin County ranked 54<sup>th</sup> in income inequality, as measured by the ratio between the highest incomes (above 80 percent of the median) and the lowest incomes (below 20 percent of the median).<sup>2</sup> The study reports that median household incomes in Marin County are \$115,400 for white households, \$60,800 for black households, and \$58,600 for hispanic households—showing further disparity across racial groups.

To afford a one-bedroom unit in Marin County, an annual income of \$99,960 is required; to afford a two-bedroom unit, an annual income of \$124,840 is required.<sup>3</sup> When compared to the median incomes listed above, it becomes clear that housing costs outpace median household incomes. Perhaps not surprisingly, the County Health Rankings Report place Marin as 39<sup>th</sup> (of 58 California counties) in the housing cost burden category, indicating that 23% of households in Marin County have at least 1 of out 4 housing problems: overcrowding, high housing costs (exceeding 30% of household income), lack of kitchen facilities, or lack of plumbing facilities. As housing costs outpace local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs. High housing costs can force households to live in unsafe or overcrowded housing, and to move away from neighborhoods where they have family connections and opportunities for good education and jobs; all of this has important implications for physical and mental health. As housing costs rise and income inequality grows increasingly disparate, the chances of becoming homeless also rises.

Families that face insecure housing, forced moves, or homelessness are more likely to experience poor mental and/or physical health and preventable hospitalizations. For children in these families, experiencing homelessness can also be harmful to brain and body function and development, with lifelong and cumulative negative health outcomes for the child, the family, and the community.<sup>4</sup> In order to understand the pathways into homelessness, it is critical to recognize the impact of systemic inequities and economic factors that are part of the intricate interplay of factors that can be a precursor to homelessness.

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<sup>2</sup> 2019 County Health Ranking, California, 2019, <http://www.countyhealthrankings.org/app/california/2019/rankings/marin/county/outcomes/overall/snapshot>

<sup>3</sup> These are the annual incomes a renter household needs in order for a rental home of a particular size at Fair Market Rent to be affordable (ie. not exceed 30% of household income), See Marin County statistics at: <https://reports.nlihc.org/oor/california>

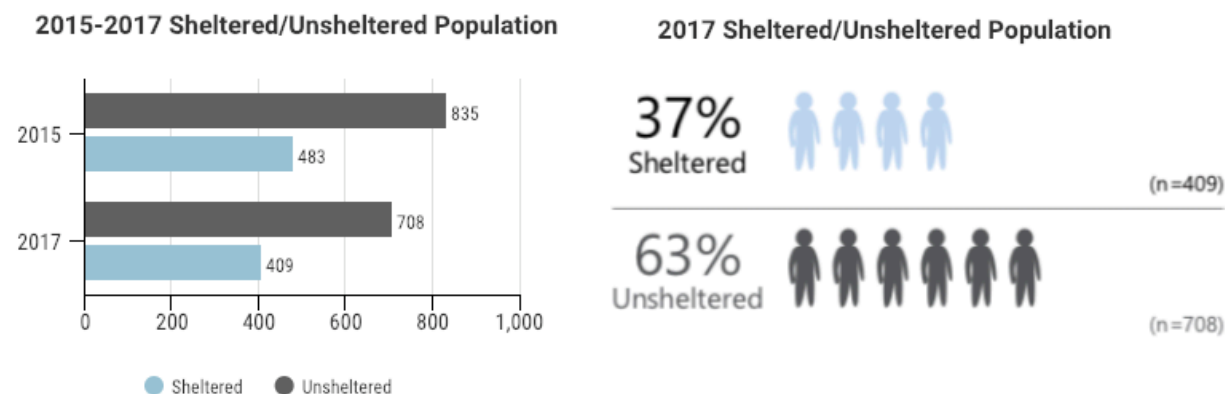
<sup>4</sup> 2019 County Health Ranking, Key Findings Report <http://www.countyhealthrankings.org/reports/2019-county-health-rankings-key-findings-report>

## Point-In-Time Count

The data in this section offers a recent snapshot of the rates and demographics of persons experiencing homelessness in Marin County. Trends in homelessness can be analyzed to help cultivate an informed understanding that homelessness is usually the result of the cumulative impact of multiple factors, rather than a single cause

Data from the Point-In-Time (PIT) Count, (a biannual census of sheltered and unsheltered people experiencing homelessness, a HUD-required activity for Continuums of Care)<sup>5</sup>, reveal that California has the highest rate of unsheltered homelessness in the country; more than two-thirds of people experiencing homelessness are unsheltered across the state.<sup>6</sup> In Marin County's 2017 PIT Count, a total of 1,117 people experienced homelessness on a single night in January — a 14% decrease from the 1,309 people reported in 2015.

Marin County PIT Count data can be further analyzed to understand the prevalence of unsheltered and sheltered populations, generally. A large portion of the homeless population in Marin, 63%, is unsheltered — i.e., living on the streets, in abandoned buildings, encampment areas, vehicles, or boats not moored to a dock and without electricity or sewage pump-out service. While the number of unsheltered individuals decreased by 15% between 2015 and 2017, the overall proportion of unsheltered to sheltered homelessness remains significant: 63% of persons in Marin experiencing homelessness were unsheltered as compared to 37% sheltered. This is inversely proportional to nationwide data from 2017, which reports that 35% of people experiencing homelessness in the United States were unsheltered, while 65% were sheltered.<sup>7</sup>



While the 2017 PIT Count numbers show a decrease in total people experiencing homeless, instances of chronic homelessness are on the rise. Chronic homelessness is defined as homelessness that occurs for at least one year, combined with a disabling condition such as serious mental illness, substance use disorder, or physical disability.<sup>8</sup> The 2017 PIT Count revealed that the number of people experiencing chronic homelessness in Marin grew by 36% to 359 people in 2017, up from 263 people in 2015.

<sup>5</sup> PIT and HIC Guides, Tools, and Webinars; <https://www.hudexchange.info/programs/hdx/guides/pit-hic/#general-pit-guides-and-tools>

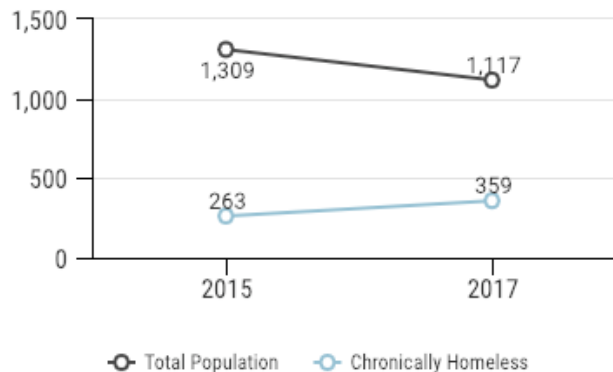
<sup>6</sup> Homelessness in California: California State Auditor; <https://www.auditor.ca.gov/reports/2017-112/summary.html>

<sup>7</sup> The 2017 Annual Homeless Assessment Report (AHAR) to Congress, December 2017; <https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>

<sup>8</sup> HUD's Defining Chronic Homelessness; <https://www.hudexchange.info/resources/documents/DefiningChronicHomeless.pdf>

**Point-in-Time (PIT) Count**

Every two years, during the last ten days of January, communities across the country conduct comprehensive Point-in-Time counts of the local population experiencing homelessness. The PIT count, which is the only source of nationwide data, measures the prevalence of homelessness in each CoC and collects information on both sheltered and unsheltered populations.

**2015-2017 Total Population/Chronic**

This increase in chronic homelessness mirrors national data trends. For the first time since 2008, the number of chronically homeless individuals across the nation increased by 12% between 2016 and 2017.<sup>9</sup> In 2017, California accounted for 42% of all the individuals experiencing chronic homelessness in the United States, which is markedly higher than its share of all individuals experiencing homelessness (31%).<sup>10</sup> In the 2017 PIT survey, 43% of chronically homeless individuals reported economic issues as the primary cause of their homelessness, much like their non-chronically homeless counterparts.<sup>11</sup>

Other data collected during the PIT Count reveals additional information about subpopulations including single adults, families, veterans, and unaccompanied youth, allowing for a deeper understanding of homelessness in Marin. As shown in the following bar graph, from 2015 to 2017, Marin experienced decreases in single adult (19%) and unaccompanied youth homelessness (67%). The CoC statistics also show a decrease between 2015 and 2017 for individuals experiencing homelessness suffering from Serious Mental Illness (SMI) (45%). However, for this same time period, increases were seen among families (31%), chronically homeless adults (25%), and veterans (47%).

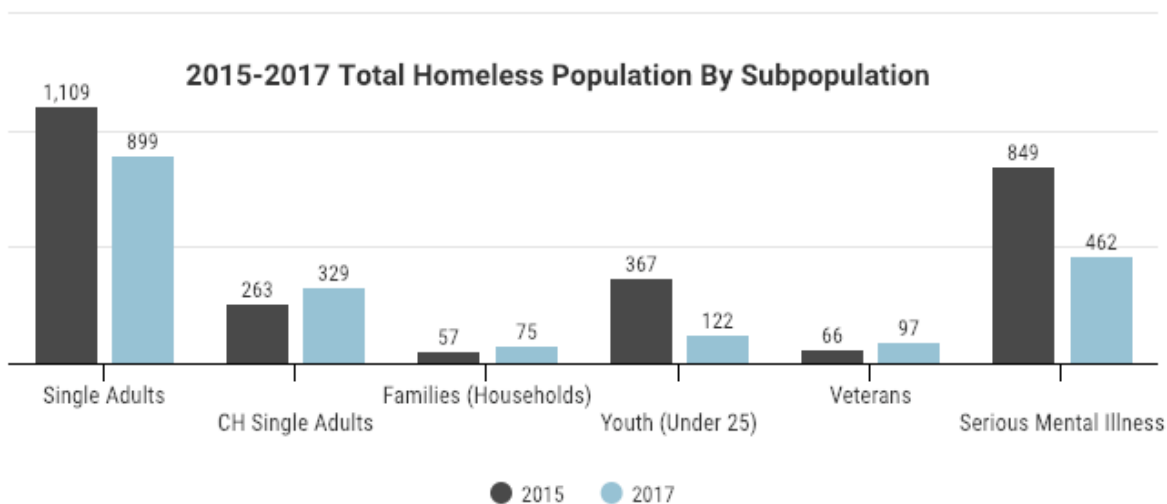
During each PIT count, the CoC utilized the assistance of individuals with lived experiences of homelessness to support volunteers in pin-pointing locations where persons experiencing chronic homelessness frequently congregate, including 25 in the 2017 count.<sup>12</sup>

<sup>9</sup> The 2017 Annual Homeless Assessment Report (AHAR) to Congress, December 2017, Chronically Homeless Individuals: <https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>

<sup>10</sup> Ibid.

<sup>11</sup> 2017 Marin County Homeless Point-In-Time County & Survey; [https://www.marinhhs.org/sites/default/files/files/servicepages/2017\\_07/pit-report-marincounty-final.pdf](https://www.marinhhs.org/sites/default/files/files/servicepages/2017_07/pit-report-marincounty-final.pdf)

<sup>12</sup> 2017 Marin CoC Consolidated Application; [https://www.marinhhs.org/sites/default/files/files/marin\\_2017\\_coc\\_consolidated\\_application.pdf](https://www.marinhhs.org/sites/default/files/files/marin_2017_coc_consolidated_application.pdf)



#### IV. THE HOMELESS SYSTEM OF CARE IN MARIN COUNTY

This section details the recent progress made by the system of care in Marin County as a result of a focus on increased collaboration and prioritization of Permanent Supportive Housing for the most vulnerable in the community. Additionally, this section identifies the areas that may be in need of additional focus, to ensure that improvements to system performance are implemented and successful outcomes are achieved for persons experiencing homelessness increase countywide.

##### System Performance Measures

To understand and improve system performance, Continuums of Care (CoC) must analyze how their system is performing according to the HUD's System Performance Measures (SPMs). While data captured through the Homeless Management Information System (HMIS) has historically focused on project-level performance, SPMs aggregate that data in new ways to show how the system is working as a whole. SPMs can be used for many purposes, including analyzing effectiveness of serving persons experiencing homelessness in the community, identifying gaps in the system of care, and informing systems change. Importantly, the Department of Housing and Urban Development (HUD) uses this data as selection criteria to award funding through the annual CoC Program competition.

While Marin is committed to improving performance under all seven of the HUD developed SPMs,<sup>13</sup> this analysis is focused on the following three measures: the number of persons who become homeless for the first time (Measure 5), the extent to which persons who exit homelessness to Permanent Housing return to homelessness (Measure 2), and the percentage of successful housing placements (Measure 7).

##### First Time Homeless

A strong homeless system of care implements programs and systems to prevent people from falling into homelessness where possible. System Performance Measure 5 captures the number of persons who become homeless for the first time, with the objective of reducing first time instances of homelessness. The measure is calculated by analyzing client entries into Emergency Shelter (ES), Safe Haven (SH), Transitional Housing (TH) and all Permanent Housing (PH) projects using the Homeless Management

<sup>13</sup> For more information on HUD System Performance Measures; <https://www.hudexchange.info/programs/coc/system-performance-measures/#guidance>

## MARIN CONTINUUM OF CARE

Information System (HMIS). If a newly enrolled client does not have HMIS entry or service data in the previous 24 months, they are considered homeless for the first time. Data shows that between FY2015 and FY 2016, Marin experienced a 31% decrease in first time homelessness. Between FY 2016 and FY 2017, however, Marin experienced a 13% increase in first time homelessness. While the increase may be the result of increased effectiveness of outreach efforts – i.e., more people experiencing homelessness for the first time were identified – and increased HMIS coverage, this increase likely also demonstrates a need for increased focus on prevention efforts to reduce first time homelessness.

Number of Persons Who Became Homeless For the First Time	FY2015	FY2016	FY2017
Number of Persons who did not have entries in ES, SH, TH, PH in the previous 24 months	713	491	565

### Returns to Homelessness

An effective homeless response system moves people into Permanent Housing<sup>14</sup> and focuses on effective stabilization and support services to prevent returns to homelessness. System Performance Measure 2 identifies whether or not households are remaining stable in Permanent Housing once they exit homelessness. The measure looks at clients who exited from Emergency Shelter (ES), Transitional Housing (TH), or Permanent Housing (PH), to a Permanent Housing destination in the date range two years prior to the report range. Of those clients, the measure reports on how many of them returned to homelessness as indicated in HMIS for up to two years after the initial exit.

The data reported in the chart below shows what percentage of people who move to Permanent Housing after being homeless experience homelessness again within up to 6 months, between 6 and 12 months, and after 2 years of moving into Permanent Housing. Focusing on the category that captures percentage of returns in two years, between FY2016 and FY 2017, Marin experienced a reduction in returns to homeless when clients exited from Emergency Shelter and Transitional Housing to Permanent Housing. Looking to the same timeframe, Marin experienced an uptick in those who returned to homelessness after exiting from Permanent Housing to another Permanent Housing location. This may signal that more support is needed for those who exit from Permanent Housing in order to maintain stability. It may also signal that households who are placed into PH-RRH are not able to keep up with monthly household expenses once rental assistance concludes (maximum PH-RRH assistance is 24 months). The increase may also be explained by the proficiency of the new Clarity HMIS system, implemented in 2017, which may better identify households returning to homeless, than the previous HMIS system. The Marin CoC is analyzing the possible cause(s) of returns to homelessness in order to inform the development of innovative and responsive solutions.

<sup>14</sup> Permanent housing destinations include: ownership by a client, rental by client (with or without subsidy), or staying permanently with friends or family. For more information, see *Permanent housing destination*; <https://www.hudexchange.info/resources/documents/System-Performance-Measures-Introductory-Guide.pdf>



MARIN CONTINUUM OF CARE

	Returns to Homeless in Less than 6 Months			Returns to Homelessness from 6 to 12 months			Returns in 2 years		
	FY2016	FY2017	Difference	FY2016	FY2017	Difference	FY2016	FY2017	Difference
<b>Exit from ES</b>	17%	11%	-6%	12%	13%	+1%	34%	30%	-4%
<b>Exit from TH</b>	9%	8%	-1%	4%	4%	--	18%	16%	-2%
<b>Exit from PH</b>	1%	14%	+13%	4%	3%	-1%	10%	20%	+10%
<b>Total Returns to Homelessness</b>	10%	12%	+2%	7%	7%	--	21%	23%	+2%

In an effort to prevent returns to homelessness, the Marin Coordinated Entry System enacted policies and protocols for quickly intervening where a client is at risk of falling out of housing after placement. Through collaboration with CoC providers and coordination of resources, a client who faces eviction will be prioritized for the first available housing opportunity ensuring where possible, that returns to homelessness are prevented.

**Successful Placement in or Retention of Permanent Housing**

Increases in the percentage of people who exit to or retain Permanent Housing is evidence of system success. System Performance Measure 7b requires communities to analyze where program participants exit to when they exit homelessness; HUD’s intent under 7b is to count permanent outcomes only. Each measure below shows incremental increases in successful Permanent Housing exits between FY2016 and FY2017.

<b>7b.1: Change in ES, TH and PH-RRH exit to Permanent Housing destinations</b>	FY2016	FY2017	Difference
Percentage of Successful Exits	46%	47%	1%

<b>7b.2: Change in PH exits to Permanent Housing destinations or retention of Permanent Housing<sup>15</sup></b>	FY2016	FY2017	Difference
Percentage of Successful Exits	95%	96%	1%

<sup>15</sup> Universe: Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project

The biggest area for improvement under measure 7b is with respect to measure 7b.1; Marin is committed to increasing the percentage of successful exits from ES, TH, and PH-RRH to Permanent Housing, by identifying more Permanent Housing opportunities to maximize flow from ES, TH, and PH-RRH into permanent locations, and by providing intensive support during the transition period into Permanent Housing.

### Work Underway to End Homelessness in Marin County

Homeless housing and service providers, along with city and county governments, elected officials, behavioral health providers, law enforcement agencies, school districts, hospitals and health clinics, domestic violence advocates, and faith-based organizations are engaged in the work to prevent and end homeless in Marin County. It takes dedication and commitment from entities across various sectors to make meaningful progress that results in system success. Through partnership and collaboration, Marin is developing unique program designs to enhance and increase the availability of PSH, facilitate cross-sector information sharing, and implement better systems for more effective and streamlined resource allocation.

### **Emergency Shelter**

Emergency Shelters provide a safe place to stay for homeless households while efforts are underway to locate appropriate housing. The Marin CoC has taken intentional steps to reduce barriers to entry to Emergency Shelters, with a renewed focus on safe and appropriate diversion, and housing-centric case management. These strategies better support homeless households in focusing their attention on the key work of becoming housed, instead of surviving homelessness. Two shelter providers run eight shelter projects in Marin: Howard Bound of Marin and Center for Domestic Peace. Between these providers, Emergency Shelter beds were available to 194 people across Marin County in 2018, up from 182 in 2017; of the beds available, 55 beds were reserved for families, and 139 beds for individuals.

#### **BEST PRACTICES IN MARIN:**

##### **Emergency Shelters Focused on Accessing Housing**

In alignment with Housing First, the Marin CoC is working with Homeward Bound of Marin, the primary provider of Emergency Shelter in the County, to implement a safe, low-barrier, housing-focused shelter model. Homeward Bound will continue to lower barriers, focus on assessment and triage, provide housing-focused case management, and intentionally link participants to Permanent Housing resources so that people move to housing as quickly as possible. Change is being realized through a combination of programmatic, policy, and operational changes with a focus on housing placement. A critical component of this change is the development of more PSH, as discussed throughout this analysis and planning report.

### **Medical Respite**

#### *Transition to Wellness Program*

Transition to Wellness is an innovative collaboration between homeless housing and service providers Homeward Bound of Marin and Ritter Center with local hospitals and other social service providers. The program provides three double-bed rooms at the Next Key Center for adults leaving hospital care who otherwise have no stable housing in which to recuperate. The program also provides nursing supervision,

case management, and other supports from Homeward Bound. Between 2016 and 2017, the program served 52 people, saving 833 days of hospitalization valued at almost \$2.5 million.<sup>16</sup>

### Outreach to Unsheltered Populations

Street outreach focuses on engaging people experiencing homelessness who may be disconnected and alienated, not only from mainstream services and supports but also from the services targeting people experiencing homelessness. Outreach helps establish supportive relationships, and enhance the possibility that people experiencing homelessness will access necessary services and supports that will help them move off the streets.<sup>17</sup>

#### BEST PRACTICES IN MARIN:

##### Targeted Outreach Linking Chronically Homeless People to Permanent Housing:

In 2016, in response to a persistent and growing number of unsheltered people who were also high utilizers of expensive emergency services, Marin began piloting a new, collaborative approach called the Homeless Outreach Team (HOT), a County-funded program run by the St. Vincent de Paul Society. The HOT process in Marin County involves a variety of steps. First, the HOT team creates a list of the most challenging and hard-to-serve chronically homeless individuals through consultation with Coordinated Entry staff. Clients include those who refuse to engage with services, those who have fallen out of Permanent Supportive Housing in the past, and others identified as needing more intensive engagement. HOT case managers attempt to make contact with individuals on the list and proactively engage them in a way that builds trust and confidence in system resources. For those clients who Coordinated Entry and HOT case managers agree face additional systemic barriers to housing, all HOT partners—every provider of services to the chronically homeless in Marin, including behavioral health and law enforcement—come together to craft and implement a customized housing action plan to assist each HOT client to access Permanent Housing and address systemic barriers. HOT partners meet on a biweekly basis to update the group on client progress. Depending on a person’s needs and goals, an action plan may include access to behavioral health treatment, reengagement with family, wraparound case management, advocacy for a higher level of care, or other assistance. The program’s success is measured by not just housing someone, but also by keeping them housed. The intensity of services needed to ensure housing stability requires all public and nonprofit providers to rethink and redesign how services are provided.

### *Downtown Streets Team (DST) of San Rafael and Novato*

Local branches of the Downtown Streets Team, a non-profit outreach and employment program that first began in 2005 in Santa Clara, have been integrated in communities across the Bay Area and beyond.<sup>18</sup> The San Rafael and Novato Downtown Streets Teams (DST) conduct outreach to persons experiencing or at risk of homelessness in Marin County to connect them both to DST’s services and the greater system of care. Since launching in September 2013, the San Rafael DST provides persons with low or no income who are experiencing homelessness or who are at risk with employment opportunities through community beautification projects (e.g. street cleaning and creek restoration). As Team Members, individuals receive

<sup>16</sup> Transition to Wellness, Homeward Bound of Marin; <https://hbomf.org/about-homeward-bound-of-marin/homeless-adults/>

<sup>17</sup> Homeless Hub, Outreach; <http://homelesshub.ca/solutions/emergency-response/outreach>

<sup>18</sup> For more about the history of the Downtown Streets Team, please follow the link: <http://streetsteam.org/about>

non-cash stipends for basic needs in exchange for their participation, as well as the opportunity to engage in wrap-around case management and employment services to find stable housing and employment.<sup>19</sup> Current projects in San Rafael include the “Put Your Change to Work” meter-based donation program to benefit Team Members, as well as the Downtown Cleanup initiative, through which Team Members average 400 hours per week beautifying downtown San Rafael. Downtown Streets Team of San Rafael has successfully averaged between 25 and 30 Team Members since its inception;<sup>20</sup> encouraged by the success of San Rafael DST, the newly-launched DST of Novato looks forward to similar successes as a partner in ending homelessness in Marin County.<sup>21</sup>

### *Marin County Mobile Crisis Response Team (MCRT)*

Comprised of a licensed mental health practitioner and a peer provider, the MCRT team responds to individuals in the community who present with a psychiatric emergency, and offers crisis intervention, stabilization and linkage to appropriate community based services.<sup>22</sup> MCRT collaborates with the citizens of Marin County, community based mental health and substance abuse agencies, hospitals, and local law enforcement, to increase the safety of individuals in a crisis. The team provides rapid crisis intervention in the field to address and de-escalate, as well as stabilize, an immediate crisis in the least restrictive environment possible, through providing services, including: face-to-face crisis counseling and brief supportive interventions; assessment of individual mental health and/or substance abuse needs; transportation to psychiatric emergency services (PES); coordinating appropriate and available community-based services for on-going treatment and follow-up; offering family support services, and; phone consultation to law enforcement, first responders, community providers, families, and other community members.

### *Outreach to Veterans and Connections with Community Partners*

The County Veterans Service Office works with law enforcement throughout the county to help with any veteran-related issue. The Veterans Service Office outreach initiative works to ensure that those who may interact with homeless veterans in the community understand the unique needs of veterans. It is currently part of the training curriculum for law enforcement professionals who are engaged in the Crisis Intervention Team (CIT) program, a model for community policing that brings together law enforcement, mental health providers, hospital emergency departments, and individuals with mental illness and their families to improve responses to people in crisis. Additionally, the Veterans Service Office includes an outreach worker who can help connect homeless veterans with VA and other community services, and also works closely with the courts by connecting veterans within the judicial system with services at the San Francisco VA Medical Center, the San Francisco Veterans Center, and the Oakland Veterans Center.

### *Outreach & HMIS Coordination*

Through innovations to Marin’s Homeless Management Information System (HMIS), outreach teams and other community engagement personnel in Marin County are able to track assessments and referrals to housing placements and other services through HMIS for persons experiencing homelessness. Currently, the Homeless Outreach Team (HOT), the Novato and San Rafael Downtown Streets Teams (DST), and Veteran and mental health outreach workers are able to record outreach data in HMIS, including

<sup>19</sup> For more information on the Downtown Streets Team model, please follow the link: <http://streetsteam.org/model>

<sup>20</sup> San Rafael Downtown Streets Team homepage; <http://streetsteam.org/san-rafael>

<sup>21</sup> For more on Downtown Streets Team of Novato, please see the Op-Ed by Novato Mayor, Denise Athas, at the link: <https://www.marinij.com/2017/02/03/marin-voice-homeless-in-novato-find-hope-through-city-partnership/>

<sup>22</sup> Mobile Crisis Team page; <https://www.marinhhs.org/mobile-crisis-team>; [https://www.marinhhs.org/sites/default/files/files/servicepages/2018\\_02/mcrt\\_brochure\\_final\\_english.pdf](https://www.marinhhs.org/sites/default/files/files/servicepages/2018_02/mcrt_brochure_final_english.pdf)

assessments for Coordinated Entry. In the coming months, the Care Team, another outreach and engagement team focused on homelessness individuals with mental illness, and other outreach providers, will also use HMIS as part of continued Coordinated Entry implementation.

### **BEST PRACTICES IN MARIN: Data Sharing is Improving Outcomes**

Because there are so many pathways into homelessness, there are a variety of different data sources that can and should be used at the community level to drive local planning and action, guide resource investments, strengthen the coordinated responses needed to end people's homelessness, and address broader housing and service needs. As such, Marin is building data sharing infrastructure through its Whole Person Care (WPC) pilot. The WPC pilot will leverage the current data system used among homeless and housing services providers, the Homeless Management Information System (HMIS), in addition to the new health information exchange, the Marin Health Gateway (Gateway), which amalgamates data from nine separate electronic health records systems. Through collaborative leadership and systematic coordination among public and private entities, homeless service providers and health care entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health and housing outcomes. Multi-agency, multi-disciplinary case conferences will facilitate inter-agency communication regarding client status for medical and related social support issues to ensure that there is no duplication of service and to ensure that the member receives the optimal level of case management services addressing the full spectrum of the member's needs.

### **Identification of Homeless Families and Youth**

The Marin County Office of Education (MCOE), as the McKinney-Vento Liaison, supports 18 Marin County school districts in ensuring that unstably housed and homeless youth have access to educational programs. MCOE recognizes the importance of establishing linkages between school systems and community/partner agencies to facilitate access to health care, dental, mental health, and other appropriate services that aim to support stabilization and in turn, success, of unstably housed and homeless students. The MCOE facilitates quarterly meetings of the Homeless/Foster Youth Executive Council which serves as a forum for collaboration and information and resource sharing. Government and nonprofit entities who serve unstably housed, homeless, and/or foster youth are invited to educate attendees from each school district about program resources and ways to access these resources.

### **Preventing Criminalization of Activities Associated with Homelessness**

Leading the charge in the efforts to prevent criminalization of persons experiencing homelessness for activities associated with living unsheltered, the San Rafael Police Department (SRPD) has established a network of relationships with community-based non-profits providing housing and services targeted towards persons experiencing homelessness, such as St. Vincent de Paul Society, Ritter Center, Homeward Bound of Marin, Community Action Marin, Buckelew Programs, Center Point, Adopt A Family, and Marin Humane Society, as well as the County of Marin. SRPD officers collaborate regularly with the Homeless

Outreach Team (HOT) and keep up-to-date on planning and strategies to support individuals experiencing homelessness with whom both teams often engage.

Other local law enforcement, including the Marin County Sheriff, the Novato Police Department (NPD), the Sausalito Police Department, and the Central Marin Police Department, have coordinated with outreach teams and providers to identify people in need of services and to help with outreach events.

### *Outreach with Law Enforcement*

To increase collaboration between departments and providers, and to minimize the potential for the criminalization of activities associated with homelessness, the SRPD hired a Mental Health Outreach Liaison, who provides information to the Special Operations Unit (a unit primarily concerned with quality of life issues in downtown San Rafael) and patrol officers about the individuals being engaged and supported through outreach. The Liaison also helps communicate strategies to reduce harmful or disruptive behavior among people experiencing homelessness. The Special Operations Unit, together with the Mental Health Outreach Liaison, coordinate with community partners to connect individuals experiencing homelessness with housing and services according to their needs. The Mental Health Outreach Liaison is also able to make referrals directly in HMIS for persons engaged, which ultimately leads to placements in Permanent Housing. Emerging strategies utilized through this collaboration include increasing “walk-alongs” between the SRPD and the Mental Health Outreach Liaison, as well as other specialists from county departments, which will enhance the capacity to consistently track all engagements with persons experiencing homelessness or chronic homelessness who may be at risk of involvement/further involvement with the criminal justice system in Marin County.

### *Marin Community Court*

Hosted by St. Vincent de Paul Society of Marin, in partnership with the Marin Superior Court and Legal Aid of Marin, Community Court is a diversion program that assists homeless and low-income defendants in resolving minor offenses, and provides education regarding available support services in the community. The partnership was formed in 2011 with the intention of supporting disadvantaged defendants with low-level offenses, who are often homeless and may be experiencing physical and mental health challenges, in the hopes of minimizing the disproportionate impact these minor offenses may have on housing and health stability for these individuals.

Held once a month in St. Vincent de Paul’s dining facility, the program makes court proceedings more accessible by creating a friendly atmosphere in which participants can resolve minor offenses (often “lifestyle” violations regarding activities associated with homelessness, such as sleeping in parks), which have the potential to cause greater negative impact on the lives of these individuals. In 2016, 370 individuals were assisted to successfully resolve their cases. Community Court personnel work with participants to secure community service hours, connect with social services, medical treatment, rehabilitation programs, and job seeking assistance.<sup>23</sup>

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<sup>23</sup> Community Court; <https://www.vinnies.org/need-help/community-court/>; Community Court is the People’s Court, by Court Executive Officer Kim Turner; [https://www.marincourt.org/PDF/community\\_court.pdf](https://www.marincourt.org/PDF/community_court.pdf)

### *Support and Treatment After Release (STAR) Court*

STAR Court works in collaboration with Marin County's STAR Program, a full-service partnership providing culturally competent, intensive, integrated services to persons with Serious Mental Illness (SMI) who are involved in the criminal justice system. STAR Court is designed to support adults, age 18 and above, who struggle with SMI, with the goal of decreasing the frequency of clients' contacts with the criminal justice system by improving social functioning skills and linking to employment, housing, regular treatment, and supportive services. While not exclusively dedicated to persons experiencing homelessness, the Court serves many who are or who are at increased risk.

STAR Court consists of 3 phases (typically 6-months per phase), each with a set of legal, housing, vocational, and treatment components. The program takes an average of 18 months to complete successfully. When participants successfully graduate from the STAR Court, they may have their misdemeanor-related case dismissed, jail sentences stayed, and/or probation terminated.<sup>24</sup> By providing this and other specialized court programs and services to highly vulnerable individuals, many damaging effects of further involvement in the criminal justice system may be avoided, positively impacting not only the lives of these individuals but the community overall as well.

## **Efforts to Prevent Homelessness and Divert Persons Away from the Marin System of Care**

### *Prevention*

“Prevention” services are those that assist housed persons experiencing instances of instability, and prevent them from falling into homelessness. The St. Vincent de Paul Society of Marin is able to support the community’s efforts to prevent instances of homelessness where possible through the Return Home Program. For those households who are imminently at risk of becoming homeless, Return Home may be used as a tool to locate alternative housing or provide transportation to existing housing if out of the area in the form of fuel cards, airline fare, or bus tickets to persons who have a verifiable residence outside of Marin.

Marin County Health & Human Services provides local Rapid Rehousing funding to St. Vincent de Paul and fellow CoC Board members and Coordinated Entry participants, Ritter Center and Adopt A Family of Marin, that can be used for prevention services. Providers also use private donations and regional funds like Season of Sharing to provide prevention services.

### *Diversion*

In addition to providing services to aid with prevention of homelessness, the Return Home Program also assists with “diversion,” a strategy employed to assist persons who have recently entered homelessness with returning to sustainable housing, thereby diverting the individual from entering the homeless system of care in the first place. Local phone assistance lines, including those operated by Adopt A Family of Marin and Marin County Health & Human Services Aging and Adult Services, are trained to provide diversion counseling to help persons who have recently become homeless to identify resources to which they may have access.

The importance of diversion as a strategy to prevent those newly homeless from entering the system of care has become increasingly apparent. As an initial effort to understand what a diversion program with access to additional resources might look like in Marin, St. Vincent de Paul Society of Marin conducted a

<sup>24</sup> STAR Court; [http://www.marincourt.org/STAR\\_court.htm](http://www.marincourt.org/STAR_court.htm)



small diversion pilot through their Rotating Emergency Shelter (REST) in November 2017. This pilot will continue in 2019-20 using Homeless Emergency Aid Program (HEAP) funding.

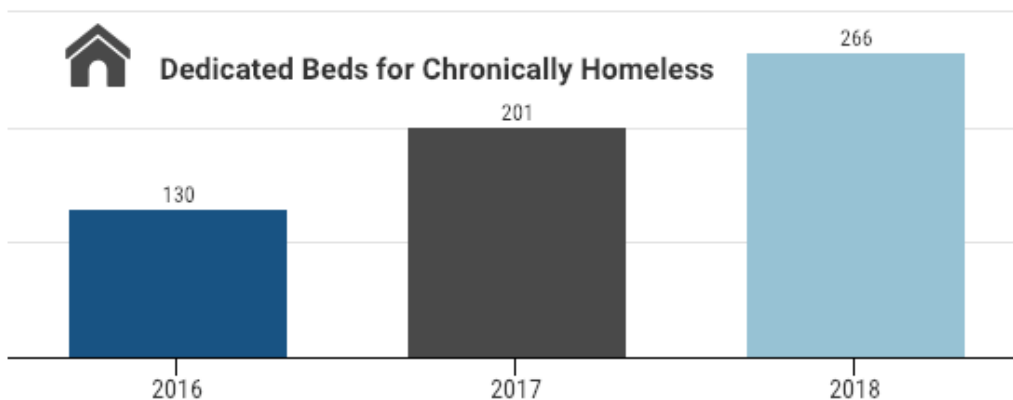
### Housing-Focused Resources in Marin County

Marin is focused on increasing access to housing by collaborating with community partners to increase housing inventory through the following methods: new construction and acquisition of a diverse range of housing options (including additional units of Permanent Supportive Housing); rehabilitation of rental units; enhancing landlord engagement; efficient allocation of housing resources, and; streamlining referrals and processing of participants' eligibility for housing placements. In 2018, Marin added more than 70 new Permanent Supportive Housing units, including new vouchers and new construction.

#### *Permanent Supportive Housing for Chronically Homeless Households*

Permanent Supportive Housing (PSH) is an intervention that combines non-time limited affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect participants with community-based health care, treatment, and employment services.<sup>25</sup> Research shows that PSH is the most appropriate housing resource for people experiencing chronic homelessness, and is a model that results in cost savings to various public service systems, including health care.<sup>26</sup>

Since 2005, HUD has encouraged CoC's to create new PSH beds dedicated for use by persons experiencing chronic homelessness.<sup>27</sup> To ensure that all PSH beds funded through the CoC Program are used as strategically and effectively as possible, Marin is committed to dedicating more beds to chronically homeless persons in each annual competition cycle. In an effort to serve the most vulnerable, and ultimately reduce chronic homelessness, Marin increased CoC-funded dedicated beds by 105% from 2016-2018.



Demonstrating a further commitment to serving chronically homeless persons in Marin, the County and CoC have made a local decision to dedicate non-HUD funded PSH to those who are experiencing chronic homelessness. The community uses a local definition of chronic homelessness which is slightly less rigid

<sup>25</sup> National Alliance to End Homelessness, Permanent Supportive Housing

<sup>26</sup> National Health Care for the Homeless Council, Permanent Supportive Housing; <https://www.nhchc.org/policy-advocacy/issue/permanent-supportive-housing/>

<sup>27</sup> Notice CPD-16-11; <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>



than the HUD definition, providing needed flexibility to serve those who are high needs and narrowly miss the HUD eligibility requirements.

### *Whole Person Care (WPC) Pilot Program*

In 2017, Marin launched a Whole Person Care (WPC) pilot after receiving approval from the state to utilize a Section 1115 Waiver. The Whole Person Care (WPC) pilot is a five-year program aimed at providing more efficient, high quality, integrated care by better coordinating physical health, behavioral health and social services for Medi-Cal patients who are high users of multiple health care systems, yet continue to have poor health outcomes. Marin's WPC pilot provides housing-focused case management using the Assertive Community Treatment (ACT) model, provided by Ritter Center. In partnership with the lead agency on the WPC grant (Marin HHS), the Marin Housing Authority provides 50 housing vouchers to be paired with the supportive services, effectively creating 50 new PSH units.

#### BEST PRACTICES IN MARIN:

##### Housing First Policies in Marin's System of Care and Programs:

Housing First is a homeless assistance approach that prioritizes providing Permanent Housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the understanding that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or addressing substance use issues. Additionally, Housing First is based on the philosophy that client choice is valuable in housing selection and supportive service participation, and evidence that exercising that choice is likely to make a client more successful in remaining housed and improving their life.<sup>1</sup> Though many local providers had already started adopting Housing First principles, Marin accelerated its shift towards a Housing First Model in 2016, with a series of trainings, meetings, and interviews with homeless housing and service providers about program models, admission policies, and rules governing program participation. In 2017, Marin continued to make progress through targeted technical assistance for homeless housing programs, including on-site meetings, focused on reducing barriers and eliminating pre-conditions to program entry. In 2017, Marin also launched its Coordinated Entry (CE) system, and the Policies and Procedures governing the CE system enshrine system-wide Housing First principles and commit participating housing/service providers to a Housing First approach.

### *Rapid Re-Housing (RRH)*

Rapid Re-housing is an intervention aimed at helping persons experiencing homelessness to obtain housing quickly, increase self-sufficiency, and stay housed through the provision of short term financial support (e.g., rent/utility arrears, rental assistance, moving costs, etc.) and case management. This time-limited assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the needs of the person.<sup>28</sup> Rapid Re-Housing providers in Marin County include St. Vincent de Paul Society, Adopt A Family of Marin, and Ritter Center. The programs they provide are funded through County general funds, HUD

<sup>28</sup> National Alliance to End Homelessness, Rapid Re-Housing

Emergency Solutions Grants (ESG), and CalWORKS Housing Support Program funds. In addition, in 2017, County Health & Human Services and Homeward Bound of Marin were able to coordinate with Swords to Plowshares to bring Supportive Services for Veteran Families (SSVF) Rapid Re-Housing to Marin County.

### *Transitional Housing (TH)*

Like Rapid Re-housing, Transitional Housing is time limited in nature. It is designed to provide individuals and families with interim stability and support to successfully move to and maintain Permanent Housing. Transitional Housing has long been part of the housing continuum for persons experiencing homelessness, and in particular for sub-populations such as survivors of domestic violence and youth. However, in recent years, HUD and other federal partners have dis-incentivized the use of Transitional Housing for most subpopulations as research has shown it to be less cost-effective and less successful as compared to other housing models, such as Rapid Re-housing.<sup>29</sup>

The Housing Inventory Count (HIC) is a point-in-time inventory of provider programs within a CoC that provide beds and units dedicated to serve persons who are homeless, categorized by four Program Types: Emergency Shelter (ES); Transitional Housing (TH); Rapid Re-housing (RRH); and Permanent Supportive Housing (PSH). The following chart shows the Marin CoC's housing inventory from 2015 to 2018.

**2015-2018 Housing Inventory Count**

Project Type	2015	2016	2017	2018
Emergency Shelter (ES) Beds	184	178	182	194
Transitional Housing (TH) Beds	228	211	167	208
Rapid Re-Housing (RRH) Beds	70	70	155	112
Permanent Supportive Housing (PSH) Bed	378	383	371	549
Total Beds	860	842	945	1,063

### *Mainstream (Section 811) Voucher Program*

In 2018, the Marin CoC was awarded funding through the Mainstream (Section 811) Voucher Program to assist persons with disabilities experiencing or at risk of homelessness. Through this opportunity, Marin added 28 vouchers for permanent scattered-site housing placements with supportive services – 22 dedicated for persons experiencing homelessness and 6 for persons who are transitioning out of institutional settings.

### *Housing Choice Voucher (HCV) Program (formally known as Section 8)*

The Housing Choice Voucher program is the federal government's major program for assisting very low-income individuals and families through the provision of housing subsidies, called vouchers. A family or individual that receives a housing voucher is responsible for finding a suitable housing unit of the household's choice in the private market. The housing subsidy is paid directly to the landlord, with the remainder of the rent paid by the household.

<sup>29</sup> Costs Associated With First-Time Homelessness for Families and Individuals, HUD; [https://www.huduser.gov/portal//publications/pdf/Costs\\_Homeless.pdf](https://www.huduser.gov/portal//publications/pdf/Costs_Homeless.pdf)

The Marin Housing Authority (MHA) administers the HCV program in Marin County. As permitted by HUD, MHA has established two homeless preferences, which prioritize vouchers for individuals and/or families experiencing homelessness, and individuals or families experiencing chronic homelessness. Starting in 2017, MHA began to set aside up to 50 vouchers each year to serve chronically homeless individuals and families referred to the HCV list through the Marin Coordinated Entry System. Through a partnership with Marin’s Whole Person Care pilot, these 50 vouchers are paired with supportive services, including housing search assistance and on-going intensive case management.

*Moving On Program*

The Moving On Program was established by the Marin Housing Authority in collaboration with the County of Marin to facilitate the flow of eligible households from PSH to a Housing Choice Voucher subsidy. This program is dedicated to clients who participate in PSH but have been stabilized enough for independent living. Once a household is identified as no longer needing intense support services, the Moving On Program facilitates the transfer of the household from PSH program to the HCV program, through a preference established by the MHA. Where possible, Moving On takes every effort to facilitate a transition in place, avoiding any disruption of the household. When the household cannot stay in the same housing unit, the Moving On Program provides case management and assistance locating and securing a new unit, ensuring the household remains stably housed as they transition to lower levels of care. The program is aimed at promoting efficient use of resources, ultimately increasing the availability of PSH units for the most service intensive clients. Moving On is a national best practice and one of the only methods that increases PSH capacity without new construction. The Moving On Program was established in 2016, and since then it has transitioned 105 households from PSH to independent living.

*Landlord Partnership Program & Landlord Liaison Project*

The intent behind the Marin Housing Authority’s Landlord Partnership Program and Landlord Liaison Project is to increase the availability of rental housing for families holding vouchers provided by the Housing Choice Voucher program. Working in tandem, these initiatives incentivize landlord participation in the HCV program by offering funds to be used as additional Security Deposits to mitigate losses for damages and vacancies, as well as by offering access to a dedicated landlord liaison 24-hour hotline, establishing a Landlord Advisory Committee, and landlord workshops and trainings.<sup>30</sup> This innovative program launched in 2016 through a partnership with the County of Marin. From July 2016 to December 2018, the Landlord Partnership Program exceeded expectations, including:

Goal	Outcomes
Partner with 50 new landlords	Partnered with 106 new landlords
Assist 50 families with security deposit	Assisted 105 families with security deposit
Increase successful search rate for voucher holders from 37% to 55%	Increased successful search rate to 61.42%

*Rental Rehabilitation Loan Program*

A current strategy to increase the stock of affordable rental housing in Marin County is the Rental Rehabilitation Loan Program. Through this program, owners of existing rental properties apply for interest-free loans to support the rehabilitation or creation of rental units for Housing Choice Voucher tenants. An annual allocation of federal funds enables the program to provide technical assistance, as well

<sup>30</sup> Marin Housing Authority, Landlord Partnership Program; <https://www.marinhousing.org/landlord-partnership-program.html>

as \$25,000 to correct any maintenance or ADA accessibility issues in existing units, and \$35,000 for the creation of compliant rental units, where 51% of total units will be rented to low-income tenants who are Housing Choice Voucher holders. To incentivize property owners to keep the units affordable and available for the target population, the loans will remain interest-free so long as the rental units are occupied by an HCV tenant; the loans become due and payable at 3% interest when no longer occupied by an HCV tenant, and 5% interest for units that were never occupied by an HCV tenant.<sup>31</sup> In 2016, MHA provided rental rehabilitation loan funds to four landlords for seven units, for a total of \$175,000. In 2017, MHA provided loan funds to eight landlords for fourteen units for a total of \$390,000.<sup>32</sup>

## Coordination Entry System

### *Planning, Coordination, and Implementation in Marin County*

The Coordinated Entry System (CES) is a centralized or coordinated process designed to streamline participant intake, assessment, and provision of referrals throughout the entire Marin homeless system of care. HUD policy mandates that the CES covers the entire geography of Marin County, is easily accessible by individuals and families seeking housing or services, is well advertised, and utilizes a comprehensive and standardized assessment tool. The purpose of CE is to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, and connected to housing and homeless services based on their strengths and needs.<sup>33</sup>

In February 2017, the Marin County Coordinated Entry Committee, comprised of CoC- and non-CoC-funded homeless housing and service providers, began meeting to discuss systems mapping and drafting of Policies and Procedures to guide the operations of Coordinated Entry in Marin County. On August 9, 2017, the Marin Coordinated Entry Policies & Procedures were finalized and approved by the Marin CoC board (the HPSC); in October 2017, Coordinated Entry launched in Marin County. In the first year of operation, the Marin County Coordinated Entry System housed 70 chronically homeless people.

The Coordinated Entry system utilizes a “No Wrong Door” approach, enabling clients to access low-barrier points of entry at various physical provider locations and remotely over the phone. The Coordinated Entry infrastructure is built upon the collaboration and commitment of provider organizations who are committed to serving the most vulnerable in alignment with the principles of Housing First.

### *Organizing & Prioritizing Participants Using HMIS*

The Marin Coordinated Entry system uses the Homeless Management Information System (HMIS) to capture data from coordinated entry assessments of persons experiencing homelessness (using the Vulnerability Index - Service Prioritization Decision Assistance Tool, or “VI-SPDAT”), to make referrals and in this way track placements in Permanent Housing. All programs that participate in HMIS have the ability to input coordinated entry assessments and place referrals onto an aggregated, prioritized listing, otherwise known as the “Community Queue”. The Community Queue dynamically changes as new client referrals are added through HMIS. From the Community Queue, the highest-needs individuals experiencing homelessness are drawn onto an “Active List” where the work begins to identify appropriate housing opportunities for eligible households. In order to identify appropriate housing opportunities for households on the Active List, a case conference is held among all provider agencies participating in HMIS who have touched that client and those that may have available housing units. Taking into account any

<sup>31</sup> Marin Housing Authority, Rental Rehabilitation Program; <https://www.marinhousing.org/rental-rehab-loan-program.html>

<sup>32</sup> Landlord Partnership Program Report; <https://www.marincounty.org/~media/files/departments/cd/planning/housing/affordable-housing/landlord-incentives/lpp-semiannual-report-jan-2018.pdf?la=en>

<sup>33</sup> Marin Coordinated Entry System Policies & Procedures, Approved by the Homeless Policy Steering Committee August 9, 2017.

known client preferences, once a client is matched with a housing opportunity and the agency accepts the referral, the placement is recorded and tracked in HMIS.

### *Integration of Other Permanent Supportive Housing – Planning for Referrals to No Place Like Home-Assisted Units*

Marin County will be able to assess NPLH-eligible participants, including people At Risk of Chronic Homelessness (per the NPLH definition) through the Marin Coordinated Entry System. Screening questions to identify and prioritize participants who meet the definitions for populations within the Target Population will be integrated into the standardized intake and referral processes used by providers participating in the Coordinated Entry System.

The primary method by which participants will be identified for referral to NPLH-Assisted units will be through the Coordinated Entry System. Coordinated Entry staff will ensure that participants identified as appropriate to receive referrals to behavioral health services who are also experiencing homelessness or are “at risk” of chronic homelessness will be assessed for referral to housing options through the Coordinated Entry System, by ensuring they complete a VI-SPDAT assessment.<sup>34</sup> To capture vulnerability criteria specific to those “at risk” of chronic homelessness, additional pre-screening questions may be added to the VI-SPDAT assessment to better coordinate referral processes for NPLH-Assisted Units.

After receiving an assessment, households will continue to be prioritized and referred to housing through the Coordinated Entry System using the Marin County HMIS, before being matched with and placed in an appropriate and available housing unit. Per the Marin County Coordinated Entry Policies and Procedures, the Coordinated Entry provider will run an updated report in HMIS every two weeks to determine which individuals and families assessed have risen to the top of the prioritized list<sup>35</sup>; the CE provider will then convene the Housing Placement Case Conference of the providers and staff working closest with the participant to discuss the available housing options, including NPLH-Assisted units, to determine the most appropriate placement option. Where a participant on the high-priority list meets the eligibility criteria for placement in NPLH-Assisted Units, the Coordinated Entry Provider will work with the housing providers who have familiarity with the participant to streamline placement in a NPLH-Assisted Unit.

Additionally, children and adolescents experiencing serious emotional disturbance concurrently with homelessness, and their families, will be prioritized for NPLH-Assisted units after further coordination and integration of data systems with the Marin County Office of Education and the Marin County HHS Behavioral Health and Recovery Services department, which will allow for identification and streamlining of referral processes for this population.

For detailed information on NPLH data collection and reporting requirements, please see Appendix B.

## **Partnership & Collaboration**

With the help of many valuable partners, outlined below, Marin County continues to make progress on a variety of initiatives aimed at preventing and ending homelessness in Marin. These partners and key stakeholders work together to establish a coordinated and community-wide response to the complex issue of homelessness. As you will see in the chart below, partners collaborate in a variety of ways:

<sup>34</sup> Marin HHS Whole Person Care webpage; <https://www.marinhhs.org/whole-person-care>

<sup>35</sup> Marin Coordinated Entry System Policies & Procedures; [https://www.marinhhs.org/sites/default/files/boards/general/approved\\_2018\\_coordinated\\_entry\\_policies\\_and\\_procedures\\_2018.02.14.pdf](https://www.marinhhs.org/sites/default/files/boards/general/approved_2018_coordinated_entry_policies_and_procedures_2018.02.14.pdf)

## MARIN CONTINUUM OF CARE

**Provider Agency:** The providers listed below operate Emergency Shelters, Permanent Housing, and provide a variety of wrap-around services to assist and stabilize homeless families, youth, and individuals in Marin County. Because clients often touch many service providers, provider agencies are in regular communication. Providers have been members of the Homeless Policy Steering Committee (HPSC) since its inception, and remain an integral part of the CE system implementation and monitoring.

**CoC Board Member:** The Homeless Policy Steering Committee (HPSC) is the governing body of the Marin CoC. The HPSC develops long-term strategic plans and facilitates year-round efforts to identify the needs of homeless individuals and families in Marin. Regular meetings of the HPSC provide a forum for coordination for Marin’s county-wide response to homelessness. The HPSC is open to all interested parties, including the public, and homeless or formerly homeless individuals. The HPSC is comprised of 18 areas of representation as shown below.

- |                                     |                                |
|-------------------------------------|--------------------------------|
| 1. Elected Officials                | 10. Law Enforcement            |
| 2. County Health and Human Services | 11. Probation                  |
| 3. Community Development            | 12. Homeless Service Providers |
| 4. Public Housing Agency            | 13. Homeless Housing Providers |
| 5. Community Funder                 | 14. School Districts           |
| 6. Consumer Representative          | 15. Business Community         |
| 7. Domestic Violence                | 16. Hospitals                  |
| 8. Faith-Based Organization         | 17. Veterans’ Services         |
| 9. Affordable Housing Developer     | 18. Employment Services        |

**Coordinated Entry (CE) Partner:** The Coordinated Entry Committee is responsible for successfully implementing and monitoring the CE system. Provider agencies, other community partners, and Marin County Health and Human Services have been meeting monthly, since 2017, to discuss, provide feedback, and make decisions about system implementation.

**Whole Person Care (WPC):** The WPC pilot allows system-wide care coordination, data sharing, referrals, assessments, program administration, case conferencing, and care navigation for homeless and precariously housed high system utilizers.

**Outreach Partner:** A variety of outreach workers and teams operate in Marin, with other partners working alongside them to facilitate engagement and referrals. Outreach partners collaborate regularly to ensure duplication is prevented and clients are served in a coordinated fashion.

Organization/Agency	Provider Agency	CoC-Board Member	CE Partner	Whole Person Care	Outreach Partner
1. Adopt A Family of Marin	√	√	√	√	
2. Bright Heart Health	√			√	
3. Buckelew	√	√	√	√	
4. Center for Domestic Peace	√	√	√		
5. Coastal Health Alliance	√			√	

MARIN CONTINUUM OF CARE

Organization/Agency	Provider Agency	CoC-Board Member	CE Partner	Whole Person Care	Outreach Partner
6. Community Action Marin	√	√	√	√	√
7. Downtown Streets Team	√	√	√	√	√
8. Healthy Marin Partnership	√			√	
9. Homeward Bound of Marin	√	√	√	√	
10. LifeLong Medical Care	√			√	
11. Marin Center for Independent Living	√		√	√	
12. Marin City Health and Wellness	√		√	√	
13. Marin Community Clinics	√		√	√	
14. Marin Community Foundation			√		
15. Marin County Board of Supervisors		√			
16. Marin County Community Development Agency		√			
17. Marin County Council of Mayors & Councilmembers		√			
18. Marin County Health and Human Services	√	√	√	√	√
19. Marin County Office of Education	√	√			
20. Marin County Public Defender	√			√	
21. Marin County Probation Department		√		√	
22. Marin General Hospital	√			√	
23. Marin Housing Authority	√	√	√	√	
24. Marin Organizing Committee	√	√			
25. Opportunity Village	√			√	
26. Partnership Health Plan of California				√	
27. Ritter Center	√	√	√	√	√
28. Saint Vincent de Paul Society	√	√	√	√	√
29. San Rafael Police Department		√	√	√	√



## MARIN CONTINUUM OF CARE

Organization/Agency	Provider Agency	CoC-Board Member	CE Partner	Whole Person Care	Outreach Partner
30. Side By Side TAY (Formerly Sunny Hills)	√		√	√	
31. The Spahr Center	√		√	√	
32. Whistlestop	√			√	

As evidenced above, Marin’s partners are collaborating across a variety of programs and activities on a regular basis. This collaboration and partnership facilitates continued program expansion, streamlined coordinated care, increased transparency, and best of all, improved health and housing outcomes for homeless and chronically homeless individuals and families being moved into and supported in housing. Significant work is also happening regionally with neighboring counties in an effort to share and implement successful solutions and best practices. Specifically, the Marin CoC has collaborated with regional Built for Zero teams, participated in Bay Area HMIS, CE system, and Veteran services forums and conferences, and attended various speaking engagements across counties sharing best practices.

## V. SOLUTIONS TO HOMELESSNESS IN MARIN COUNTY

Through many community discussions of priorities and strategies to prevent and end homelessness in Marin County, stakeholders have advocated for and set the following goals:

- **End Chronic and Veteran Homelessness in Marin County by 2022;**
- **Create Additional Permanent Housing Opportunities to Address Needs of the Most Vulnerable;**
- **Maintain and Enhance Fidelity to the Principles of Housing First;**
- **Improve and Expand Data Sharing Capacity to Provide Comprehensive, Coordinated Care to Persons Experiencing Homelessness;**

To achieve these goals, the following solutions have been identified for further community focus and development.

### Solution 1: Identifying and Funding Additional Needed Resources

#### **A. Fulfilling the Need for More Site-Based Permanent Supportive Housing**

While it is long held that Permanent Supportive Housing is a best practice model in serving high needs clients, the significance of the permanence itself should be highlighted. Unlike Emergency Shelter, which is often a temporary and inadequate stand-alone solution, Permanent Supportive Housing provides critical, non-time limited assistance. Without Permanent Supportive Housing resources to move clients into, system flow becomes stagnated and the Emergency Shelter system becomes overwhelmed. In order to decrease homelessness, a community must consider how each person will exit homelessness to housing.



An analysis by Opening Doors Marin, a public-private partnership that seeks to strategically align broad stakeholder groups in the creation of more affordable housing units across Marin, has determined that the Marin Continuum of Care requires additional Permanent Supportive Housing (PSH) beds to meet the current and future needs of chronically homeless individuals and families in Marin County. While efforts to identify scattered site PSH opportunities have been successful, there is a significant need for the creation of more site-based PSH. To meet the unmet needs of those experiencing homelessness in Marin County, community partners recommend the creation of additional site-based housing with sufficient services to allow for 24-hour on-site support, incorporating peer support/peer-led groups to help newly housed tenants achieve housing stability while following a low-barrier, harm reduction approach.

The Marin CoC Board (HPSC), in collaboration with providers participating in Coordinated Entry, have made clear that there is consensus among community leadership in the understanding that housing (especially PSH) is at the center of the homeless crisis, and that need far outweighs the supply of PSH units in Marin. Further, the Coordinated Entry Committee set a goal to end Chronic Homelessness in Marin by 2022. Progressing toward these goals from 2017 to 2018, Marin increased PSH units by 108 units, 32.4%, for a total of 549 PSH units in 2018. This growth is only the beginning, as Marin remains focused and committed to increasing PSH through new development, rehabilitation, and acquisition of provider-owned PSH through the No Place Like Home program, CoC Program competition, and other funding sources and initiatives.

To fund additional site-based Permanent Supportive Housing for persons experiencing chronic homelessness, the Marin CoC will explore all federal, state, and local funding opportunities as well as partnerships with private donors and business interests. One funding opportunity of great priority to the Marin CoC is the No Place Like Home (NPLH) Program, a state initiative dedicating \$2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness.<sup>36</sup>

Some possibilities for new site-based Permanent Supportive Housing project locations include a remodel of Homeward Bound's Mill Street shelter in San Rafael, and the decommissioned Hamilton Air Force Base in Novato.

## **B. Continuing Commitment to Creation of Scattered-Site Permanent Housing Opportunities**

The Marin CoC will continue to expand the availability of scattered-site Permanent Housing opportunities for persons experiencing homelessness through Permanent Housing bonus funding made available during the annual Continuum of Care (CoC) Program Competition, administered by the Department of Housing and Urban Development (HUD).

## **C. Implementing Additional Best Practice Service Models**

Through the 5-year Whole Person Care (WPC) Pilot Program, starting in 2018, Ritter Center has been able to implement housing-based case management based on the Assertive Community Treatment (ACT) Model, a service delivery model that provides comprehensive, locally-based treatment to persons with Serious Mental Illness. The WPC ACT team meets for comprehensive daily case conferencing, and while it does not contain the embedded psychiatric and nursing staff of a high-fidelity ACT team, it is able to connect clients directly to the medical staff at Ritter Center, an FQHC.

<sup>36</sup> No Place Like Home Draft Guidelines, April 28, 2017, <http://www.hcd.ca.gov/grants-funding/active-funding/docs/Draft-NPLH-Guidelines-FINAL-05-01-17-All-Edits.pdf>

Additionally, the Marin CoC seeks to deepen partnerships through collaboration with local healthcare organizations to support a “Housing as Healthcare” approach; this will assist with strengthening connections between provisions of mental health services and housing. As with the Transition to Wellness respite program in Marin, (mentioned above), Marin seeks to gain additional support and funding from healthcare organizations to further implement this revolutionary approach.

The Marin CoC is also committed to increasing housing-focused Emergency Shelter capacity; additional funding was provided in 2018 to support Homeward Bound’s efforts to hire and train additional case management staff, in an effort to further reduce barriers and align the entire system of care towards a focus on Housing First.

## **Solution 2: Continuing Focus/Targeted Approach on Highest Needs Clients**

### **A. Prioritizing Highest Needs Clients Through Coordinated Entry**

By continuing to discuss the issues that impact the most vulnerable persons experiencing homelessness in Marin and bring ideas and potential solutions to the Coordinated Entry Committee, the CoC is able to further refine Marin’s policies for prioritizing those with the highest needs through the Coordinated Entry System. One important new policy concerns prioritizing program participants who exit from institutional settings.

Preventing returns to homelessness is a primary goal of the Marin County Coordinated Entry program. In the event that a client leaves a PSH program for an institutional setting (including, but not limited to, jail, prison, hospital, skilled nursing facility, mental health facility, and substance use treatment), the exiting program is responsible for maintaining contact with the client during their institutionalization; by ensuring that staff remain in contact with Housing program participants who experience a stay in an institutional setting longer than 90 days, and would not be considered by the HUD definition for “chronic homelessness” to be eligible any longer for rental assistance through PSH, staff can inform the Coordinated Entry program prior to the participant’s release from the institutional setting, and ensure that he or she will receive the next PSH bed for which they are eligible.<sup>37</sup> In this way, the CoC can continue to prioritize vulnerable individuals who otherwise would likely return to homelessness.

Furthermore, the CoC is committed to capturing a more accurate representation of participant information to better prioritize persons experiencing homelessness. In order to enhance the efficacy of case conference conversations to assist with housing match and placement, case managers are invited to provide additional, contextualized observations supported by objective, verifiable information that may affect a participant’s score on the VI-SPDAT where this information corrects or fills in gaps in self-reported information.

### **B. Continuing Movement Towards a Housing First System**

In an effort to align the Marin CoC system of care towards a focus on Housing First, efforts have shifted away from investing in Emergency Shelter (e.g., 2018 saw the closure of the Rotating Emergency Shelter Team, aka REST program), and instead have been concentrated on investing in the creation of additional Permanent Housing for persons experiencing chronic homelessness, and interim housing for those who have been prioritized and are awaiting placement in Permanent Housing.

<sup>37</sup> Marin Coordinated Entry System Policies & Procedures, updated and approved by the Homeless Policy Steering Committee August 8, 2018.

Additionally, in an effort to reduce returns to homelessness, CoC-funded providers are also placing emphasis on a local concept termed “Housing Second”; under this approach, when participants housed in CoC-funded Permanent Housing fall out of their placement, the Coordinated Entry provider and CoC-funded providers act quickly to address the issues that led to the instability and then rapidly rehouse the participant.

### C. Developing Services for Under Served Populations

The Marin CoC recognizes that there are some populations that are not adequately served by the existing system of care. The CoC will collaborate with other stakeholders in the community to increase or create resources to serve these populations, including encouraging government to develop solutions where none currently exist.

#### *Aging Population*

The population in Marin is aging rapidly. According to a 2017-2018 Marin County Civil Grand Jury Report, it is estimated that 27% of Marin residents are over 60 years old and the number is expected to increase to 34% by 2030.<sup>38</sup> The report cites concern that the County may not be prepared for this rapid demographic shift, especially with respect to adequate resources.

Lack of affordable in-home services, paired with rising costs of residential facility care, puts many older adults at risk of housing instability. The Marin CoC alongside other community partners are committed to advocating for and developing affordable services to support aging in place, so that older adults are ensured quality of life, safety, and housing stability. In advocating for affordable in-home services, the Marin CoC hopes to fill the gap for those who lack the financial resources to meet their basic living and health care needs, but have incomes above the federal poverty line, which makes them ineligible for government assistance programs.

#### *Dementia Population*

Hand-in-hand with the aging population comes the population of people living with Alzheimer’s and dementia. Advanced cognitive impairments can cause delusions, difficulty communicating, depression, lack of self-care, and confusion, making it difficult or impossible for people to live independently. Yet memory care facilities are financially out of range for most people living in poverty, and facilities that accept Medi-Cal are few and far between. Because of the shortage of facilities, memory care providers are able to pick and choose who they accept; chronically homeless individuals with co-occurring behavioral health issues are rarely able to find placements. However, these clients also have service needs higher than any Permanent Supportive Housing can provide. Even when pairing clients with live-in aides, caretaker burnout and limited hours for in-home supportive services have hampered PSH providers’ ability to stabilize those with severe cognitive impairments. The Marin CoC continues to struggle to find appropriate placements for those with dementia, and seeks structural changes to address this growing gap in the system of care.

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<sup>38</sup> Marin is Aging: Are We Ready? Marin Civil Grand Jury Report, 2018-2018, <https://www.marincounty.org/~media/files/departments/gj/reports-responses/2017-18/marin-is-aging.pdf?la=en>

### *LGBTQ Population*

Members of the LGBTQ community are more likely to become homeless, and once homeless, more likely to endure discrimination and harassment that extends their homelessness. LGBTQ populations experiencing homelessness are historically under-identified, and as a result are served in a way that does not meet their unique needs or take into account their unique experiences and challenges. The Marin CoC recognizes the importance of building capacity to serve the distinct needs of LGBTQ persons, and is committed to developing system improvements to better serve LGBTQ individuals across the homeless system of care. This includes building LGBTQ capacity within agencies that serve general populations of persons experiencing homelessness, as well as encouraging the development of LGBTQ-specific services. The CoC is also committed to developing enhanced approaches for identification and improved outreach efforts targeted at those who are least likely to access to the system, including LGBTQ populations.

### *Highest Needs Population*

An effective crisis response system requires the right mix of interventions that match the needs of the people experiencing homelessness in the community. In analyzing the current system of care, The Marin CoC has identified a gap for households that do not qualify for placement in a skilled nursing facility but who need more intensive supports than Permanent Supportive Housing can offer. This unique population is often in need of intensive medical supports, along with case management and assistance with activities of daily living. The Marin CoC will continue to advocate for funding, especially at the state level, to develop housing and services solutions that foster safety, dignity, and housing stability for households who need care that extends beyond that available through PSH.

## **Solution 3: Bolstering Common Resources & Improving Linkages to Services**

### **A. Improving Outreach Coordination to Ensure Maximum Engagement to All Persons Experiencing Homelessness**

To better coordinate outreach teams, the Marin CoC intends to organize bi-weekly or bi-monthly case conferencing meetings comprised of outreach providers; this way, outreach teams will ensure that persons experiencing homelessness who are not connecting with light-touch outreach are being identified for more active engagement through Marin's specialized outreach teams, including the Homeless Outreach Team and new Homeless Mentally Ill Outreach and Treatment (HMIOT) team. Acting as the lead entity in charge of outreach in Marin, the HMIOT team will coordinate with other outreach teams to enhance accountability and full coverage of outreach to all of Marin County.

### **B. Enhancing Data Sharing for More Effective Services and Treatment**

Through the Whole Person Care program, Marin will be able to more effectively share and evaluate participant data; by importing HMIS data into the Whole Person Care data system, providers will be able to better understand the scope of community need. Marin County continues to fully fund HMIS at no cost to providers, and continues to add new users through outreach to and collaboration with homeless service providers who have not before participated in HMIS.

### **C. Working Regionally to Coordinate Efforts with Neighboring Counties**

Marin County actively engages with neighboring counties to share best practices, demonstrate strategies to assist with partnership building/forming collaborations, and to solicit and offer services to fill gaps that may exist in either system of care; for instance, through previous engagement with San Francisco County partners, Marin County was able to form an agreement with Swords to Plowshares to provide Supportive

Services for Veteran Families in Marin. Additionally, the Marin CoC participates in a regional collaborative along with other Bay Area communities to discuss factors that have a shared impact on the prevalence of homelessness in the region, as well as strategies that can be implemented as a coordinated effort.

### **D. Implementing Youth Systems Integration**

Marin has had tremendous success with integrating the adult system of care, and in 2018, is attempting to replicate this success in the system of care for homeless youth through comprehensive systems mapping to understand how youth currently flow through the system and to identify where gaps may exist. 2019 will also see the implementation of a Youth By-Name List, (modeled on the Built for Zero approach to ending Veteran homelessness). Marin will continue these efforts by creating a working group to help address persisting systemic issues pertaining to youth homelessness in Marin.

## VI. APPENDIX A - CONSIDERATIONS FOR PERSONS EXPERIENCING HOMELESSNESS WITH MENTAL HEALTH & CO-OCCURRING DISORDERS

### Overview of Homelessness for Persons with Mental Health & Co-Occurring Disorders in Marin County

In Marin County, numerous programs and strategies are currently being utilized to ensure that the needs of adults and Transition Age Youth affected by Serious Mental Illness (SMI), children affected by Serious Emotional Disorder (SED), and persons experiencing Co-Occurring Disorders (e.g., physical disability and SMI/SED, or Substance Use Disorder and SMI/SED), are met to the extent possible; additionally, these initiatives help to gather valuable information about the level of need of these populations in Marin County for the purpose of enhancing resource capacity and service provision.

According to HMIS data, between the years 2015 and 2017, approximately 174 persons experiencing homelessness in Emergency Shelter, Transitional Housing, or places not meant for human habitation concurrently experienced physical health and mental health conditions on average each year; for this same time period, approximately 247 persons experiencing homelessness concurrently experienced substance use disorder and mental health conditions on average each year in Marin County.

Total Persons in Homeless Situations <sup>39</sup>	2015	2016	2017
Co-Occurring Physical Health and Mental Health Conditions	143	131	249
Co-Occurring Substance Use and Mental Health Conditions	211	207	322

Due to recent efforts to enhance the capacity of Marin's HMIS through Clarity to collect data on the number of participants in Permanent Supportive Housing and Rapid Re-housing experiencing co-occurring physical/mental health conditions and substance use disorders, data from 2017 reveals that 35 participants experienced co-occurring physical/mental health conditions while 32 participants experienced co-occurring substance use/mental health conditions.<sup>40</sup>

Total Persons in Permanent Housing <sup>41</sup>	2015	2016	2017
Co-Occurring Physical Health and Mental Health Conditions	11	10	35
Co-Occurring Substance Use and Mental Health Conditions	12	13	32

<sup>39</sup> i.e., Emergency Shelter, Transitional Housing, Place not Meant for Habitation, or Safe Haven; data pulled from the Marin Homeless Management Information System through a custom query provided by Bitfocus.

<sup>40</sup> [Infographic to be inserted for this information].

<sup>41</sup> i.e., Permanent Supportive Housing or Rapid Rehousing; data pulled from the Marin Homeless Management Information System through a custom query provided by Bitfocus.

To further support data collection efforts, the Marin CoC and participating partners plan to leverage the enhanced capacity and coordination provided by the Marin Coordinated Entry System to use HMIS to collect and analyze the total number of individuals, families, and unaccompanied youth experiencing homelessness and chronic homelessness with SMI, SED, and co-occurring disorders. For more information concerning data collection and planning efforts to better serve these populations, please see below for the summaries of emerging strategies and programs currently receiving Mental Health Services Act<sup>42</sup> (MHSA) and other funding.

### Serving Adults At Risk of/Experiencing Homelessness with Serious Mental Illness

#### *Odyssey Program (Homeless) Full Service Partnership<sup>43</sup>*

Employing the Assertive Community Treatment (ACT) approach, the Odyssey Program provides intensive, integrated services to adults aged 18 and older, with serious mental illness and who may have co-occurring substance use disorder and/or serious health condition(s), who are either homeless or at risk of becoming homeless. From 2015 to 2016, the program engaged 87 individuals; of the 71 individuals who participated for at least 2 years, homeless days were decreased 68%.

Through partnerships with the Marin Housing Authority's Shelter Plus Care Program and other community partners, participants are connected to housing through the Marin Coordinated Entry System; both participants and their support systems, including family and friends, receive services to address the specific needs of participants with SMI, which are available 7 days a week, 24 hours a day. Outreach and engagement services are provided by the CARE Team, currently the primary source of referrals to the Odyssey Program, and supported by a peer-operated drop-in center, the Enterprise Resource Center. Similar to the "Move On" program administered by the Marin Housing Authority, the Odyssey Program also has implemented a "Step-Down component" for participants no longer in need of intensive levels of supportive services.

#### *Barriers to Serving Adults with SMI in Marin County*

Due to the limited stock of affordable housing in Marin County, and despite a robust partnership with the Marin Housing Authority, it has become increasingly challenging to find housing for participants exiting homelessness with a serious mental illness. Service provision for the target population is also further affected by the limited funding to hire additional case managers and specialists with the needed skills to provide the level of care necessary to meet the participants' needs.

### Serving Youth and TAY At Risk of/Experiencing Homelessness with Serious Emotional Disorders

#### *Youth Empowerment Services (YES) Full Service Partnership<sup>44</sup>*

Marin County's Youth Empowerment Services (YES) program, in partnership with nonprofit mental health agency, Seneca, serves approximately 40 youth through age 21 experiencing significant mental health challenges, as well as significant risk factors often leading to homelessness. The YES model is an intensive, strengths-based model through which assessment, case management, and individual/family therapy and

<sup>42</sup> MHSA FY2017-2018 Annual Update – Marin Health and Human Services;  
[https://www.marinhhs.org/sites/default/files/files/mhhsa/mhhsa\\_au\\_-\\_complete\\_-\\_6.8.17.pdf](https://www.marinhhs.org/sites/default/files/files/mhhsa/mhhsa_au_-_complete_-_6.8.17.pdf)

<sup>43</sup> MHSA FY2017-2018 Annual Update – Marin Health and Human Services;  
[https://www.marinhhs.org/sites/default/files/files/mhhsa/mhhsa\\_au\\_-\\_complete\\_-\\_6.8.17.pdf](https://www.marinhhs.org/sites/default/files/files/mhhsa/mhhsa_au_-_complete_-_6.8.17.pdf); page 141.

<sup>44</sup> MHSA FY2017-2018 Annual Update – Marin Health and Human Services;  
[https://www.marinhhs.org/sites/default/files/files/mhhsa/mhhsa\\_au\\_-\\_complete\\_-\\_6.8.17.pdf](https://www.marinhhs.org/sites/default/files/files/mhhsa/mhhsa_au_-_complete_-_6.8.17.pdf); page 112.



family partner support and medication services are provided by bilingual and culturally competent clinicians who are able to meet with youth and their families in their homes and in the community. The YES program also involves outreach efforts to reach unserved and underserved communities; in many cases, YES clients are bilingual, but family-based services to parents often require a bilingual clinician in order to engage parents successfully.

### *Transition Age Youth (TAY) Full Service Partnership (FSP)<sup>45</sup>*

Administered by community partner Side By Side (Formerly Sunny Hills Services), Marin County's Transition Age Youth (TAY) Program provides approximately 28 participants between the ages of 16-25 years experiencing serious emotional disturbances/ mental illness with supportive services and linkages to housing supports, preventing those at risk from falling into homelessness. These services are strengths based, evidence based and client centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services, as well as coordinated individual and group therapy and psychiatric services for TAY participants. Initial outreach and engagement is essential for these age cohorts who are naturally striving toward independence and face more obstacles due to their mental illness than the average youth. A bi-monthly Family Support Group (FSP) for families of TAY with mental health illness and substance use, whether or not their child is enrolled in the TAY program, is provided by a TAY staff.

There is also a two-bedroom apartment available to FSP clients in the TAY Program, recognizing that stable housing is important in maintaining mental health. Due to the TAY Program's very limited housing capacity, other housing programs available for those 18 years and over are also utilized by TAY participants as appropriate, and many still live with their family which will continue to be their main source of support.

### *Barriers to Serving Youth and TAY with SED in Marin County*

Efforts to consistently collect information concerning youth experiencing Serious Emotional Disturbance have met with various barriers. There are 18 school districts in the county and while each collects data, data systems are specific to each district, and data is not shared across districts (with the exception of special education). This creates an especially large burden in collecting data, and requires considerable outreach to every individual school district to collect.

A unified data system for special education, called SPACE, is a repository for all 18 school districts, where information is stored about children with any level of disability. In pulling data from SPACE, the Marin County Office of Education was able to identify students who are identified as homeless with a learning disability (which includes Serious Emotional Disturbance). However, recent numbers have been low, which suggests that there is inconsistency in how school districts are entering information about homelessness into the system. As an added complexity, self-reporting of homelessness among students/families may be artificially low.

As a strategy going forward, the Marin County Office of Education will pull a list of students with SED, conduct outreach to district representatives whose students are on this list, and ask them to update homelessness status as applicable. The Office of Education will also add a general reminder to school districts to complete the homelessness "check-box field" when they are entering data into SPACE.

Additionally, barriers to serving youth with mental health challenges and Serious Emotional Disorders often involve the need for youth to receive treatment at outpatient office-like settings. As case management and clinician engagement with family and support networks is vital to the success of this

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<sup>45</sup> MHSA FY2017-2018 Annual Update – Marin Health and Human Services; [https://www.marinhhs.org/sites/default/files/files/mhsa/mhsa\\_au\\_-\\_complete\\_-\\_6.8.17.pdf](https://www.marinhhs.org/sites/default/files/files/mhsa/mhsa_au_-_complete_-_6.8.17.pdf); page 119.



population, excessive case load ratios affected by even temporary decreases in capacity have a significant effect on service provision to youth. Additionally, lack of housing capacity for youth and their families continues to be a significant barrier to serving this population.

### Serving Older Adults with SMI At Risk of/Experiencing Homelessness

#### *Helping Older People Excel (HOPE) Program<sup>46</sup>*

Operational since 2007, the HOPE Program serves roughly 58 adults who are 60 years of age and older with serious mental illness, who are at risk of homelessness, hospitalization, or institutionalization; participants may also experience co-occurring substance abuse disorder and/or other serious health condition. Additionally, transition age older adults, ages 55-59, may be eligible for admission to the program as well, to be determined on a case by case basis.

Linkages to needed services and supports are provided by a multi-disciplinary/multi-agency team, supported by Marin’s Senior Peer Counseling Program, which is staffed by older adult volunteers and County mental health staff, and which provides outreach, engagement, and support services. For those 31 individuals who remained in the program for at least 2 years, the number of homeless days decreased by 83%, while mental health emergencies requiring crisis stabilization decreased by 31%.

#### *Barriers to Serving Older Adults with SMI in Marin County*

Often, older adults with SMI who are either at risk of or are experiencing homelessness have complex housing and service needs, above what typical Permanent Supportive Housing programs in Marin County have the capacity to provide.

### Serving Veterans with SMI At Risk of or Experiencing Homelessness

#### *Veteran’s Community Connection<sup>47</sup>*

Administered by the Marin County Veteran’s Service Office through the Department of Health and Human Services, the Veteran’s Community Connection program provides supportive services and links to housing and benefits for veterans with serious mental illness involved in the criminal justice system, many of whom are also experiencing homelessness. The program works in close collaboration with the Department of Veteran’s Affairs, which develops participants’ mental health treatment plans, for which it also covers many of the associated clinical treatment costs. Participants are identified through outreach and engagement by a part-time case manager, and through referrals from the VA.

#### *Barriers to Serving Veterans in Marin County*

Many Veterans still experience barriers affecting their ability to remain stably housed; one such barrier concerns interruption to the successful completion of the participants’ treatment plan, which puts Veterans at higher risk of escalating mental health needs and returns to homelessness. Although the Veterans’ Community Connection program has helped many Veterans to connect to housing, supportive services, and benefits since 2015, this population is still in need of additional housing and case management support to bolster success.

<sup>46</sup> MHS FY2017-2018 Annual Update – Marin Health and Human Services; [https://www.marinhhs.org/sites/default/files/files/mhsa/mhsa\\_au\\_-\\_complete\\_-\\_6.8.17.pdf](https://www.marinhhs.org/sites/default/files/files/mhsa/mhsa_au_-_complete_-_6.8.17.pdf); page 135.

<sup>47</sup> MHS FY2017-2018 Annual Update – Marin Health and Human Services; [https://www.marinhhs.org/sites/default/files/files/mhsa/mhsa\\_au\\_-\\_complete\\_-\\_6.8.17.pdf](https://www.marinhhs.org/sites/default/files/files/mhsa/mhsa_au_-_complete_-_6.8.17.pdf); page 101.

## VII. APPENDIX B – PLANNING FOR NPLH COMPLIANCE &amp; CROSSWALK OF CRITERIA

In anticipation of integrating additional units of Permanent Supportive Housing into the Marin County homelessness system of care through the No Place Like Home (NPLH) Program, the following information concerns specific planning for data collection and reporting requirements as detailed in the NPLH Program Guidelines; additionally, a number of barriers and challenges to serving and capturing data for the NPLH Target Population are identified below. Content demonstrating satisfaction of the criteria for NPLH County Homeless Plans may be found on the following pages of this analysis:

NPLH Criteria	Section and Page Number
1) Overview of the planning efforts to address homelessness in the County, including specific goals, strategies and activities and the specific period in which these goals, strategies, and activities will be implemented. Include current efforts and initiatives, particularly efforts to end homelessness and make it non-recurring. Please include efforts of local partner jurisdictions, including cities and unincorporated areas;	1) The Homeless System of Care in Marin County, pages 5-19;
2) Description of overall number of persons experiencing homelessness; single adults; families, unaccompanied youth; persons experiencing chronic homelessness;	2) The Homeless Population in Marin County, pages 3-8;
3) Description of the number of persons experiencing homelessness who also have Serious Mental Illness, who are children or adolescents with Serious Emotional Disturbance, or have co-occurring disabilities;	3) Overview of Homelessness for Persons with Mental Health & Co-Occurring Disorders in Marin County, pages 26-29;
4) Description of the County's partners, including cities within the County who are working to end homelessness. This description could include local homeless Continuums of Care, housing and homeless services providers, health plans, community clinics and health centers, and other health care providers, public housing authorities, and people with lived experience of homelessness. If there are barriers, such as lack of key stakeholder entities, please explain;	4) Partnership & Collaboration, pages 19-22;
5) Description of the range of current community-based services available to people experiencing homelessness;	5) Work Underway to End Homelessness in Marin County, pages 8-18;

<p>6) Outline of efforts to prevent criminalization of homelessness, including but not limited to the following:</p> <ul style="list-style-type: none"> <li>• A homeless court or other alternative court programs;</li> <li>• Homeless outreach teams that divert persons experiencing homelessness to community resources;</li> <li>• Psychiatric emergency response teams;</li> <li>• Efforts to link persons experiencing homelessness with supports and services rather than jail, etc.;</li> </ul> <p>7) Description of the Coordinated Entry System the homeless Continuum(s) of Care are operating in the County, with a brief description of how it is being implemented;</p> <p>8) Description of procedures the County or the Continuum(s) of Care developed to make all persons experiencing homelessness aware of the assessment and referral process to access available housing, including outreach to persons who may experience barriers to accessing the assessment and referral system related to race, color, religion, sex, age, national origin, familial status, disability, sexual orientation, or gender identity;</p> <p>9) Description of plans to refer eligible people to NPLH-funded units, including plans to refer people meeting the definition of “At-Risk of Chronic Homelessness” through the existing or separate Coordinated Entry System;</p> <p>10) Describe systems in place to collect the data required under NPLH, including systems to ensure the following:</p> <ul style="list-style-type: none"> <li>• The NPLH project sponsors submit an independent audit for projects funded, prepared by a certified public accountant,</li> <li>• The NPLH project sponsors submit annual compliance reports,</li> </ul>	<p>6) Preventing Criminalization of Activities Associated with Homelessness, pages 11-13;</p> <p>7) Coordinated Entry System, pages 18-19;</p> <p>8) Planning, Coordination, and Implementation in Marin County, pages 18-19;</p> <p>9) Integration of Other Permanent Supportive Housing – Planning for Referrals to No Place Like Home-Assisted Units, pages 18-19;</p> <p>10) Data Collection Planning for NPLH-Assisted Units, page 31;</p>
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<ul style="list-style-type: none"> <li>• The NPLH project sponsors submit NPLH project-specific data outlined in Section 214 of the NPLH Guidelines;</li> </ul> <p>11) Description of planning efforts to provide aggregated data on the following:</p> <ul style="list-style-type: none"> <li>• Emergency room visits for NPLH tenants before and after move-in</li> <li>• Average number of hospital and psychiatric facility admissions and in-patient days before and after move-in</li> <li>• Number of arrests and returns to jail or prison before and after move-in.</li> </ul> <p>12) Include a description of barriers to collecting these data, and how the County intends to work through the challenges.</p> <p>13) Description of overall challenges and barriers the County experiences in providing housing, services, and conducting outreach to persons experiencing homelessness;</p> <p>14) Description of challenges or barriers the County anticipates in providing service to No Place Like Home eligible individuals/families. This could include barriers such as transportation barriers, lack of partner agencies, inadequate housing and services resources, need for increased coordination among services providers, need for increased data collection and analysis capacity, emerging implementation of a Coordinated Entry System, implementing a referral process and services plan for people At-Risk of Chronic Homelessness, etc.; and</p> <p>15) Describe the solutions and models the County intends to pursue during the period identified in the plan. Describe partnerships with jurisdictions within the County;</p>	<p>11) Data Collection Planning for NPLH-Assisted Units, page 33;</p> <p>12) Barriers and Challenges to Serving NPLH Target Population, page 33;</p> <p>13) Solutions to Homelessness in Marin County, pages 22-25;</p> <p>14) Barriers and Challenges to Serving NPLH Target Population, page 33;</p> <p>15) Solutions to Homelessness in Marin County, pages 22-25;</p>
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### Data Collection Planning for NPLH-Assisted Units

To comply with the data collection and reporting requirements as detailed in the No Place Like Home (NPLH) Program Guidelines, the Marin County Department of Health and Human Services will collaborate with each NPLH project property manager and lead service provider to gather all data and information listed in Section 214 of the Program Guidelines. Information on project occupancy restrictions will be collected and maintained by the Marin Housing Authority operating as the Coordinated Entry Provider.

Additionally, the following practices will be adopted by NPLH-funded supportive housing projects in Marin County: 1) An independent audit will be submitted from a certified public accountant for each NPLH-funded supportive housing project 90 days after the end of each program year; 2) compliance reports will be submitted by program managers to Marin County HHS for all NPLH-Assisted units; 3) by the last day of the Fiscal Year, data will be submitted to the California Department of Housing and Community Development including all items listed in Section 214 (e) of the NPLH Program Guidelines.

Through continued inter-departmental collaboration and creative leveraging of data-collection processes through the Whole Person Care pilot and other initiatives, Marin County and the CoC expect the continued and enhanced strategies above to have a profoundly positive impact on efforts to end homelessness in Marin County in the months and years to come.

### Barriers and Challenges to Serving NPLH Target Population

#### *Need for Increased Collaboration - Data Collection and Analysis Capacity*

One challenge in understanding the current scope of the need of children and adolescents experiencing homelessness concurrent with serious Emotional Disturbance is the lack of integration of the data systems that currently collect this level of information. School Districts may have barriers to capturing this type of data because data on these services largely seem to be collected outside of the school-setting and kept confidential.

Additionally, while school districts and the Office of Education are able to capture data regarding the number of children and adolescents experiencing homelessness who receive special education services for “emotional disturbance,” this definition is inconsistent with the definition as housed in the Mental Health Services Act (WIC Section 5600.3). Where it can benefit the provision of housing and services to children and adolescents who may be eligible for NPLH-Assisted housing, methods for capturing and streamlining sharing of the various data sets for comparison purposes must be developed for all eligible children, adolescents, and their families to be identified for assistance through the NPLH program.

#### *Expanding Pathways for Referral Processes to NPLH-Assisted Units*

As explained above, additional referral processes must still be explored and finalized in order to accommodate identification, assessment, and prioritization for eligible members of the NPLH-Target Population, in order to facilitate referrals to NPLH-Assisted Units. This also includes enhancements to discharge planning protocols and practices with institutional settings, including jails, probation, hospitals, and residential treatment facilities, etc.