**West LA – Sawtelle Neighborhood Council**

**Proposal Plan for Outreach Services**

**FY 2015-2016**

St. Joseph Center (“the Center”) proposes to provide street outreach, assessment, case management, linkage and ongoing supportive services to homeless individuals encountered within the borders of the West LA – Sawtelle Neighborhood Council jurisdiction four days per week. When available, the Center will provide the Neighborhood Council with demographic data and activity reports on all homeless individuals engaged by outreach workers. The Center will use data garnered from assessments to inform treatment planning and linkages to resources. The Center will also track the provision of services to those homeless individuals who enroll in case management and provide information regarding outcomes associated with these interventions.

The recent LA County Homeless Count indicated that 35% of homeless individuals in West LA Service Area 5 suffer from mental illness and 27% struggle with substance use. In addition, an estimated 40% of homeless individuals in West LA Service Area 5 meet the HUD definition of chronic homelessness. Given this information, the Center believes that the most appropriate approach to engage and support program participants is assertive outreach based on the principles of harm reduction. Harm reduction is a best practice approach which attempts to reduce the adverse consequences of drug use among persons who continue to use drugs. The Center will employ intervention-focused case management with a strong application of the Housing First model when housing vouchers are available. Housing First involves providing people experiencing homelessness with housing as quickly as possible and then once housed providing services as needed.

Since 40% of the homeless encountered in the area are expected to be chronically homeless with medical, mental health and substance abuse histories, it is expected that many of these individuals will meet the criteria for being most likely to die on the streets without assertive housing interventions. The proposed services take these and other important factors into consideration.

Proposed Services

• Outreach and Engagement: Staff will begin to provide homeless street outreach in West LA- Sawtelle Neighborhood four days per week, including responses to requests by Councilman Bonin’s office, the Neighborhood Council and the Los Angeles Police Department. At the initial client contact, staff will obtain basic demographic data as well as information on their physical and mental health status through the administration of a standardized assessment (currently the VI-SPDAT). If a homeless individual is unable or unwilling to engage on the first encounter, staff will visit repeatedly and continue to encourage engagement. Once the assessment is completed, individuals will be entered into the SPA 5 Coordinated Entry System (CES), which St. Joseph Center leads. Entering individuals into the CES will help facilitate matching of clients with appropriate housing resources for which they are eligible. In addition to ensuring that clients have access to a wide variety of housing resources and supportive services, the CES will allow St. Joseph Center to keep a by-name list of those individuals who are high utilizers of police and paramedic services. This by-name list will enable staff to begin focusing efforts more intensely on those most likely to die on the streets.

In cases where the outreach team receives a referral regarding an individual posing a serious public health or safety risk, the Center will coordinate with the LAPD, the Department of Public Health or Adult Protective Services to provide the best outcome possible.

• Vehicle Outreach and Freeway Underpasses: St. Joseph Center will provide intensive outreach services in the West LA- Sawtelle area to homeless clients residing in their vehicles and under freeway underpasses on the neighborhood’s borders.

• Intake and Assessment: Once engaged, clients will be assessed further to determine their medical, mental health, psychosocial and substance abuse history. Information obtained will provide the basis for determining appropriate service linkage. Readiness for various housing options, including legal and financial needs will inform the housing plan. The housing plan will include how the client will secure a sustainable source of income, apply for an appropriate housing subsidy, save money for housing costs and conduct a housing search.

• Case Management: The Center, provides intervention-focused case management to chronically homeless clients. Intervention-focused case management is an approach by which the case manager actively works with an individual to move them out of a crisis situation. This client-centered approach maximizes the individual’s physical, social, and economic well-being, and assists with independent living. Within this pro-active model case managers do not wait until the person is ready to accept an intervention. At times, interventions are put into place without the client’s acceptance or knowledge. The case manager recognizes that because of underlying mental health issues, homeless individuals are not always capable of making good decisions regarding their well-being. Therefore, the case manager directs the case management in two ways. First, they identify barriers and work with the individual to eliminate those barriers by engaging other service providers as part of the intervention team. The second component focuses on the case manager-client relationship. Attempts are made to establish a connection with the client quickly by providing him/her with immediate resolutions to treatment goals that are easily obtainable. Subsequent meetings focus on more complicated goals. The intervention-focused case management practice adheres to a harm reduction philosophy. To the greatest extent possible, the Housing First model is also part of this approach as previously mentioned. This approach is intensive, time consuming, and requires that the case manager be in constant contact with the individual to ensure that he/she, whenever possible, is focused on the goal of transitioning to stable, long-term housing.

• Referrals and Program Coordination: When the Center is unable to directly meet the needs of clients, SJC staff provide assertive wrap-around support in collaboration with other community-based providers which offer mental health, substance abuse and health care services. If the Center’s clinical staff suspects that an individual is gravely disabled or at risk of harm to self or others, SJC staff will request follow up by the County Department of Mental Health’s (DMH) Psychiatric Emergency Team or the Los Angeles Police Department. When individuals are hospitalized (voluntarily or involuntarily) the Center’s staff will work closely with DMH and hospital staff to ensure that they are released from the hospital only after effective treatment and discharge planning. Without this, individuals will likely reappear and return to homelessness in the community. When indicated, staff will be involved in systems coordination that may result in conservatorship. In other cases, staff will identify an appropriate residential treatment or living situation such as a Board and Care or Sober Living program.

If the individual’s status does not indicate a need for psychiatric hospitalization, the outreach team may ask for the individual to be transported to Edelman Mental Health Center for further evaluation. Minimally, the team will continue to be in contact with the individual with a goal of getting the person to accept services. Our experience has shown that, in many instances, acceptance of an appropriate medication regimen often comes before an individual expresses a willingness to move indoors. In these cases, education, the building of trust, and the introduction of the individual to mental health services (by assisting with scheduling and transporting) are essential.

• Emergency Shelter, Bridge and Permanent Housing Placement: The SJC Outreach Worker/Case Manager will always urge clients to transition off the streets. When vouchers are available clients are often moved directly into permanent housing. This is an approach known as Housing First. When vouchers are not available, which unfortunately is often the case, clients are strongly encouraged to go into a shelter or to access bridge (transitional) housing. Large group shelters are sometimes inappropriate for individuals who suffer from severe mental illness. They often find the shelter environment overwhelming. Zero tolerance environments may not work for some individuals who are continuing to self-medicate with alcohol or drugs. Research suggests that low barrier environments which do not require sobriety, acceptance of mental health treatment or medication for housing eligibility are most effective with this population. Placement in high-tolerance shelters such as Safe Havens, the use of short and longer term motel vouchers or the identification of independent housing units supported by intensive case management (Supportive Housing) have been found to be more suitable housing options for many.

Once an individual does obtain a housing voucher, the case manager helps the individual identify a unit and complete the lease up process. The Center’s staff has been successful in helping hundreds of clients secure housing by developing positive relationships with landlords and property managers, and by educating clients on how to best present themselves to landlords.

• Post Placement/Retention Services: Once a client is placed in permanent housing, the Center’s staff maintains contact with the client to ensure continued housing stability. At least one initial home visit will be conducted with additional visits as needed. Regular contact with the client provides the Case Manager with the opportunity to check-in with clients, as well as identify and address any problems that could threaten their housing stability.

Program Objectives (2015-16)

• Develop cooperative relationships with LAPD in West LA – Sawtelle Neighborhood, business owners and residents. Attend West LA – Sawtelle Neighborhood Council Homeless Committee meetings on quarterly basis to update community on progress of project.

• Through a field outreach team, provide ongoing outreach to homeless persons, including veterans within the West LA – Sawtelle Neighborhood Council boundaries. Outreach efforts will include persons living in their vehicles (the specific number will be added once the funding level and local census information is obtained).

• Collect base line data on at least 75% of homeless individuals encountered. Data (coded for confidentiality) will include general information such as gender and racial/ethnic identity. It may also include age, family status, length of homelessness, veteran status, amount and source of income if any and disability(s). The team will also collect information about physical health, mental health and substance abuse history as well as prior emergency room stays and hospitalizations.

• Provide intervention focused case management to homeless West LA – Sawtelle Neighborhood residents who are considered the most vulnerable and/or highest utilizers of services (the specific number will be added once the funding level and local census information is obtained).

• Provide treatment referrals and ongoing support to chronically homeless clients found in the area (the specific number will be added once the funding level and local census information is obtained).

• Provide quarterly program reports that include program statistics, complaint descriptions and summary of outreach activities.

• Provide quarterly reports to the Homeless Committee, Council and/or other organizations as requested by City staff.