

PREFERRED LIVING SYSTEM: A BLUEPRINT FOR *ACTION*

The Center for Community Partnerships
College of Health & Public Affairs
University of Central Florida



September 2005

**ORLANDO AREA
TRUST FOR THE
HOMELESS**

(O.A.T.H.)
C/O COMMUNITY
FOUNDATION OF
CENTRAL FLORIDA,
INC.
P.O. BOX 2071
ORLANDO, FL 32802

TRUSTEES

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GLEN WIELAND (CHAIR)
JEAN WORRALL
DONNA WYCHE

November 17, 2005

Dr. Larry Martin, Director
UCF Center for Community Partnerships
University of Central Florida
Orlando, Florida 32826

Re: Preferred Living System Report

Dear Dr. Martin:

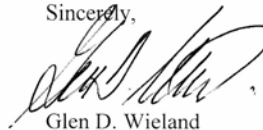
As Chairman of the Orlando Area Trust for the Homeless, I want to express the thanks of the trustees for your recent report and study on a Preferred Living System for the Central Florida community. In March of this year, O.A.T.H. agreed to fund a study through your office and the Center to conduct research and provide administrative assistance in trying to develop an implementation plan for a Preferred Living Center, now being called a Preferred Living System.

We accept your report and wish to express our sincere thanks to you, your staff, the Center and all who participated in the process and development of this report. We know that a lot of hard work went into the development of this report. We also want to thank you, Nancy Ellis and Joan Nelson for attending our meetings and sharing your findings with us.

O.A.T.H. is now planning to issue a Request for Proposal regarding the hiring of an Implementation Manager. This will be the first step in moving forward to better serve the homeless in our community as we attempt to fulfill the intentions of the Trust.

On behalf of the those homeless who may benefit from your efforts, thank you.

Sincerely,



Glen D. Wieland
O.A.T.H.-Chairman

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ACKNOWLEDGEMENTS

The UCF Center for Community Partnerships (CCP) wishes to thank the Board of the Orlando Area Trust for the Homeless (OATH Board) for their leadership and financial support of this community collaborative planning effort. The OATH Board's support enabled the CCP to bring together community providers and funders to focus on the supportive service and housing needs of homeless persons with mental health, substance abuse and dual diagnosis (both mental health *and* substance abuse) issues.

The UCF Center for Community Partnerships (CCP) also wishes to publicly acknowledge those individuals who: attended meetings, made presentations and served on various committees and sub-committees. Some 40 plus individuals representing some 16 government and non-profit organizations either participated and/or were consulted during the process:

Rich Morrison, *Florida Hospital*
Jerry Kasab, *Lakeside Alternatives*
D. Jackson, *Lakeside Alternatives*
Robert Brown, *Coalition for the Homeless*
Broc Rosser, *City of Orlando*
Donna Wyche, *Orange County*
JoAnne Guadalupe, *Salvation Army*
Leo Devlin, *Coalition for the Homeless*
Carole Mason, *Wayne Densch Center*
Keith Theriot, *Health Council of
East Central Florida*
Randy Hawkins, *Lakeside Alternatives*
Maribelle Hernandez, *Wayne Densch
Center*
Emery Ivory, *Heart of Florida United
Way*
JoAnn Gualalupe, *Salvation Army*
Debbie Orr, *Center for Drug Free
Living*
Susan Miller, *Health Care for the
Homeless*
Gene Daniels, *Salvation Army*
Haggeo Gautier, *Pathways to Care*

Dick Jacobs, *Center for Drug Free Living*
Marilyn Gordon, *Homeless Services Network*
Kathleen Green, *Salvation Army*
Jean Worrell, *OATH Board*
John Parke, *Affordable Housing Consultants*
Vicki Garner, *Lakeside Alternatives*
Linda Howad, *Wayne Densch Center*
Antionette Crowl, *Salvation Army*
Jose Irizary, *Coalition for the Homeless*
Linnette Padron, *Lisa Merlin House*
Cheryl James, *Coalition for the Homeless*
Babette Hankey, *Center for Drug Free Living*
Bakari Burns, *Healthcare Center for the
Homeless*
Alana Brenner, *City of Orlando*
Frantz Dutes, *Orange County*
Allison Krall, *Coalition for the Homeless*
Wanda Pearson, *Center for Drug Free Living*
Warren Foster, *Wayne Densch Center*
Todd Dixon, *Center for Drug Free Living*
Annemarie Sheffield, *Lakeside Alternatives*
Lisa Merlin, *Lisa Merlin House*
Helaine Blume, *Grand Avenue Economic
Development Corporation*

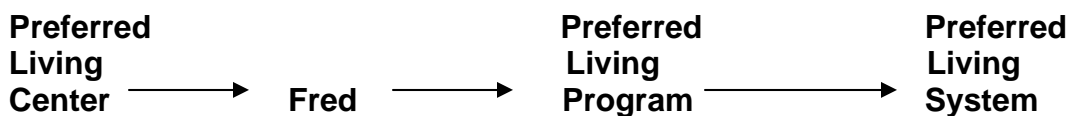
EXECUTIVE SUMMARY

In the Spring of 2005, the Board of the Orlando Area Trust for the Homeless (OATH Board) asked the UCF-Center for Community Partnerships (CCP) to assist with the development of an *action* plan to conceptualize and design a “Preferred Living Center” to address the housing and supportive service needs of homeless persons with mental health, substance abuse and dual diagnosis (both mental health *and* substance abuse) issues.

Responding to the OATH Board’s request, the CCP created a project team consisting of faculty, staff and students to work over the summer months in support of a collaborative community effort on this important social issue. The role adopted by the CCP project team was that of serving as a neutral third party facilitator to bring together the homeless, mental health and substance abuse provider and funder communities to conceptualize and design the Preferred Living Center. Consequently, this document is not so much a CCP report as it is: *a community report*. This report sets forth the best thinking of homeless, mental health and substance abuse service providers and funders as to the conceptualization and design of the Preferred Living Center.

During the community collaboration process, the participating organizations and individuals went through an evolutionary thought process as they collectively sought how best to conceptualize and design a service delivery approach that would meet the needs of homeless persons with mental health, substance abuse and dual diagnosis issues. At first the participants focused on the term *preferred living center*. However, some participants perceived the term “center” to be limiting. Center conjures up notions of a facility and immediately takes the discussion in the direction of a dialogue about “bricks and mortar.” The suggestion was made that the program be called: *Fred*. Since no one had met Fred and since no one knew what Fred looked like, no limitations were placed on the community’s thinking. Use of the term *Fred* eventually gave way to *preferred living program*, which itself was eventually superseded by the term *preferred living system*.

Figure 1 – Evolution of Community Thinking

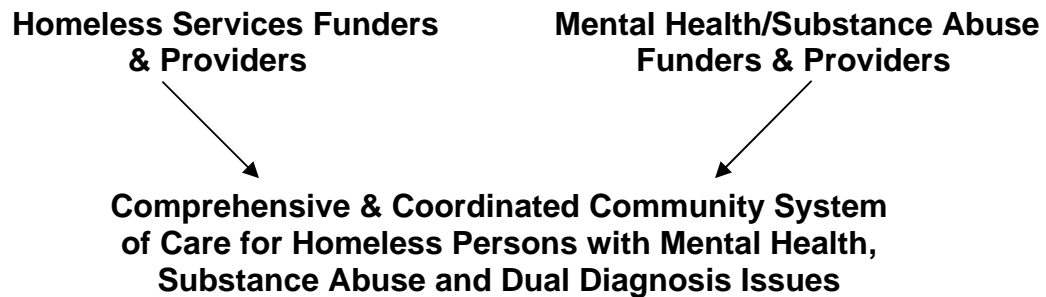


While the above discussion may seem trivial, in point of fact moving from the terms *center* to *Fred* to *preferred living program* to *preferred living system* reflects the evolution in the community’s thinking about the best approach to addressing the needs of homeless persons with mental health, substance abuse and dual diagnosis issues, while making maximum use of the existing capacities of providers and funders.

An explicit assumption of the community collaboration process was that more coordination needs to occur between homeless, mental health and substance abuse providers and funders. Consequently, as part of the community collaboration process, an attempt was

made to encourage providers and funders to think more in terms of an *integrated community system of care*. Figure 2 is a graphic representation of the goal of this community collaboration process.

Figure 2 – The Goal of the Collaborative Community Process



The Preferred Living System (PLS) is conceptualized as a *facility* as well as a *system*.

- By creation of the PLS facility, community capacity will be increased by some 20-35 new beds. These additional 20- 35 beds will be utilized to serve homeless persons with mental health, substance abuse and dual diagnosis issues.
- By creation of the PLS, both services and funding for homeless individuals with mental health, substance abuse and dual diagnosis issues will be better coordinated and integrated. By so doing, it is anticipated that the PLS will result in the more efficient and effective utilization of existing beds in homeless, mental health and substance abuse programs. The expression, *the right client in the right treatment bed* captures the intent of the PLS. Long term, the PLS should result in the realignment and reallocation of beds along the continuum of care to better reflect the changing needs of homeless individuals.

The following recommendations come from the homeless, mental health and substance abuse providers and funders involved in the community collaboration process as interpreted and edited by the UCF project team after review and comment by the OATH Board:

Recommendation 1 - An “Implementation Manager” should be designated to oversee the creation of the Preferred Living System (PLS).

In order to continue and extend the community momentum that currently exists with respect to the Preferred Living System (PLS), an Implementation Manager should be designated to continue working with the various organizations, individuals, committees and sub-committees involved in the development of this *action* plan.

Recommendation 2 - The Implementation Manger should not be a homeless, mental health or substance abuse provider or funder.

To insure that the Preferred Living System is created with the best interests of clients in mind, the Implementation Manager should not be a homeless, mental health or substance abuse provider or funder. This approach follows the formula adopted by the Central Receiving Center (CRC).

Recommendation 3 - An “Implementation Committee” should be constituted to work with the Implementation Manager on the creation of the Preferred Living System (PLS).

Membership on the Implementation Committee should be broadly representative of the homeless, mental health, and substance abuse provider and funder communities and should also include appropriate decision makers from the public and private sectors. Membership on the Steering Committee should be determined by the Implementation Manager.

Recommendation 4 – The Implementation Manager should continue the work of the existing four sub-committees.

During the creation of this *action* plan, four sub-committees of homeless, mental health and substance abuse providers and funders were created: (1) “Assessment, Case Management & Treatment,” (2) “Capacity & Facilities,” (3) “Funding,” and (4) “Evaluation & Monitoring.”

Recommendation 5 - The OATH Board should provide financial support in an amount not to exceed \$100,000 for a period of not more than one year to fund the work of the Implementation Manager.

The work of the Implementation Manager will require considerable staff time and expertise. The OATH Board’s financial support of the Implementation Manager will be crucial to the success of the Preferred Living System (PLS).

Recommendation 6 - The OATH Board should provide financial support to the Preferred Living System (PLS) for *services only*. Additionally, the OATH Board funds should not be released until the Preferred Living System (PLS) *is in actual operation*.

Funding sources to cover capital costs (e. g., facility construction, acquisition, etc.) and basic operating costs (e. g., utilities, maintenance, etc.) are potentially more plentiful and available than are funding sources that can be used to defray service provision costs (e. g. treatment, case management, etc.). Consequently, the OATH Board can have the greatest impact on homeless individuals with mental health, substance abuse and dual diagnosis issues by targeting its funds to be used exclusively for providing services.

Recommendation 7 - The OATH Board should hire a consultant to assist in determining the optimum location of the PLS facility.

While several potential sites were identified during the community collaboration process, the OATH Board should nevertheless retain the services of a consultant to provide expertise and guidance with respect to selecting a location for the PLS facility.

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One of the many community benefits of the PLS will be better data about the needs of homeless individuals and the community resources available to meet these needs. Armed with better data it is anticipated that the community will be better positioned to seek additional federal and state funds.

Recommendation 9 – The PLS should provide or arrange for assessment case management, treatment and housing of limited duration (15 days).

The 15 day figure is a goal and may well vary considerably depending upon the availability of appropriate community beds.

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By placing an emphasis on coordinating and purchasing services from existing homeless, mental health and substance abuse service providers, rather than duplicating these services, the PLS should be able to maximize its financial and other resources and to respond better to the changing numbers and needs of homeless individuals with mental health, substance abuse and dual diagnosis issues.

Recommendation 11 - The PLS should make referrals to other homeless, mental health and substance abuse providers for longer term housing and services.

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Recommendation 12 - The PLS facility should be approximately 17,000 square feet, sufficient in size to provide low-demand services (food, showers, phones, storage, laundry, etc.) to walk-ins.

The relative size of the PLS facility was suggested by the Capacity/Facilities Sub-Committee.

Recommendation 13 - The PLS facility should have between 20 and 35 beds.

This aspect has been called the “Goldie Locks” feature . . . the PLS facility should not be too big, nor too small . . . but just right!

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The operating hours of the PLS facility was again suggested by the “Capacity/Facilities Sub-Committee.”

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The closer the PLS is to other existing services, the greater the opportunities to coordinate services, share staff and programming and generate other synergies.

Recommendation 16 - The PLS facility should have reasonable access to public transportation.

Many clients will necessarily have to rely on public transportation to access other required health and social services and to meet their other transportation needs.

Recommendation 17 – The eventual operator of the PLS facility should be an independent third party (an organization that is not a mental health, substance abuse or homeless services provider or funder).

Retaining the services of an independent third party (an organization or an individual) to operate the PLS facility will help to insure that the process does not favor any one community provider or funder.

1. INTRODUCTION

In the Spring of 2005, the Board of the Orlando Area Trust for the Homeless (OATH Board) asked the UCF-Center for Community Partnerships (CCP) to assist with the development of an *action* plan to conceptualize and design a “Preferred Living Center” to address the housing and supportive service needs of homeless persons with mental health, substance abuse and dual diagnosis (both mental health *and* substance abuse) issues.

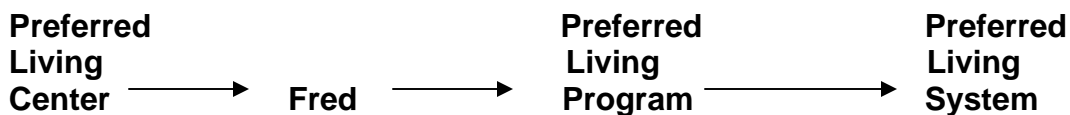
Responding to the OATH Board’s request, the CCP created a project team consisting of faculty, staff and students to work over the summer months in support of a collaborative community effort on this important social issue. The CCP project team consisted of:

- Dr. Lawrence Martin, CCP Director;
- Joan Nelson, MSW, MBA, CCP Associate Director;
- Dr. Peter Colby, Professor of Public Administration;
- Nancy Ellis, MSW, Ph.D. student;
- Michael Campbell, LCSW, Ph.D. student;
- Erin Nabors, Master’s student; and
- Irina Astakhova, Master’s student.

The role adopted by the CCP project team was that of serving as a neutral third party facilitator to bring together the homeless, mental health and substance abuse provider and funder communities to conceptualize and design the Preferred Living Center. Consequently, this document is not so much a CCP report as it is: *a community report*. This report sets forth the best thinking of homeless, mental health and substance abuse service providers and funders as to the conceptualization and design of the Preferred Living Center.

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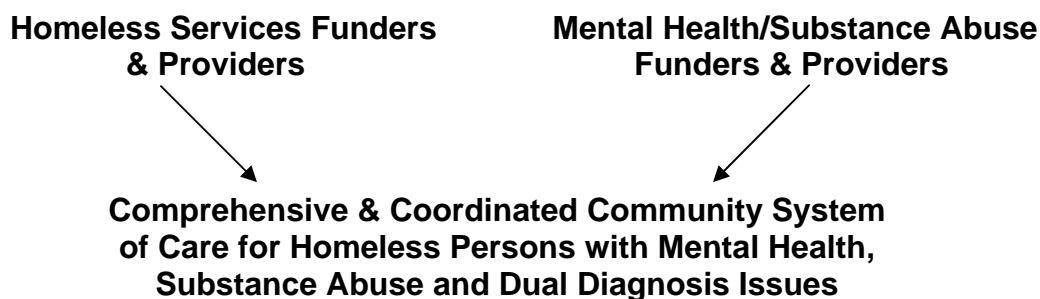


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2. OVERVIEW OF THE COMMUNITY COLLABORATION PROCESS

An explicit assumption of the community collaboration process was that more coordination needs to occur between homeless, mental health and substance abuse providers and funders. Consequently, as part of the community collaboration process, an attempt was made to encourage providers and funders to think more in terms of an *integrated community system of care*. Figure 2 is a graphic representation of the goal of this community collaboration process.

Figure 2 – The Goal of the Collaborative Community Process



The following goal was established for the community collaboration process:

- *To facilitate a discussion between community homeless, mental health and substance abuse service providers and funders regarding the conceptualization and design of a Preferred Living Center (PLC).*

As previously noted the term *preferred living center* underwent several changes to finally emerge as the *preferred living system*.

Action Steps undertaken in the community collaboration process to achieve the goal included:

1. Identification of community homeless service providers.
2. Identification of the pool of current and potential funding sources for services to homeless individuals with mental health, substance abuse and dual diagnosis issues.
3. Coordination of weekly meetings with providers and periodic meeting with funders.
4. Establishment of meeting agendas and plans:
 - A. Establishing meeting goals;
 - B. Clarifying the current systems in place to support the process;

- C. Identifying potential pitfalls to the process;
 - D. Forming inter-agency subcommittees; and
 - E. Finalizing community recommendations.
5. Coordination of ongoing meetings with potential funders.
 6. Finalization of the process for presenting PLS reports including findings and recommendations.

3. RECOMMENDATIONS REGARDING THE CONCEPTUALIZATION & DESIGN OF THE PREFERRED LIVING SYSTEM (PLS)

This section provides a conceptual overview of what the “Preferred Living System” (PLS) operating in the greater Orlando area *should* look like. The PLS concept and design are informed by both research and best practices through the expertise brought to the committee and sub-committee deliberations by the community providers and funders. Additionally, and just as importantly, the PLS conceptualization and design is informed by what the community service providers and funders believe is feasible at this point in time given existing program, fiscal and political constraints.

The PLS is conceptualized and designed as a no-wrong door approach to a community system of care for homeless individuals with mental health, substance abuse and dual diagnosis issues. The target population of the PLS is voluntary clients. The PLS would in many respects mirror the community service system created and operating as the Central Receiving Center (CRC) on Mercy Drive in West Orlando. The major difference between the CRC and the PLS is that the CRC serves involuntary clients (Marchman and Baker Act), while the PLS will serve voluntary clients.

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4. SUB-COMMITTEE REPORTS

The following sections summarize the conceptualization and design conclusions and recommendations of the four Preferred Living System (PLS) sub-committees:

- 4A - Assessment, Case Management & Treatment Sub-Committee
- 4B - Capacity/Facilities Sub-Committee
- 4C - Funding Sub-Committee
- 4D - Monitoring & Evaluation Sub-Committee

It should be noted that in some instances the recommendations (e. g., number of beds at the PLS facility) contained in the previous section differ from the sub-committee reports. *An attempt was made to report sub-committee comments and recommendations as they were stated, even when disagreement existed between sub-committees and the conclusions of the CCP project team.*

4A - ASSESSMENT, CASE MANAGEMENT & TREATMENT SUB-COMMITTEE REPORT

The Preferred Living System (PLS) should provide assessment, case management and treatment services for homeless individuals with mental health, substance abuse and dual diagnosis issues and should be conceptualized and designed in accordance with the following principles:

1. Assessment/Outreach

Assessment/outreach for the PLS should be based on the following principles:

A. No Wrong Door

Clients entering the PLS can come for any number of initial sources: hospitals, law enforcement, homeless shelters, jail, treatment facilities, Public Defender's Office, pre-trial release, the Central Receiving Center (CRC) and homeless, mental health and substance abuse service providers.

B. Common Integrated Intake Screening Instrument

A common integrated intake screening instrument should be utilized by the PLS facility and all homeless, mental health and substance abuse providers operating in the PLS. The common integrated intake screening instrument should be similar to the one employed by the Central Receiving Center (CRC). With appropriate training, the instrument can be administered by case managers/staff from any service providers in the PLS. The instrument should be made accessible to all members of the PLS through the management information system of the Homeless Services Network (HSN).

C. Screening Out Inappropriate Clients

As part of the common integrated intake process, inappropriate clients should be screened out of the PLS. Inappropriate clients are those: who have violent histories, who pose a risk of suicide, who have acute/serious medical conditions, and who are sex offenders.

D. Admissions for Service

The focus of the PLS should be on serving voluntary clients to the exclusion of non-voluntary clients. When bed space availability is an issue, admissions should also be based on clients' readiness for treatment. The Center for Drug Free Living has a "readiness for treatment" screening instrument that it is willing to share with the PLS.

E. Walk-Ins

Walk-in clients should be screened on-site at the PLS facility.

2. PLS Facility

The PLS facility should be conceptualized and designed according to the following principles:

A. Provision of Low Demand Services

The PLS facility should provide low-demand services to encourage walk-ins. The following services should be available: food, showers, phones, storage, laundry facilities, mail services and others.

B. PLP Facility Staff

PLS facility staff should be trained in engagement and motivational interviewing to encourage clients who visit the PLP facility to access other needed services.

C. Bed Availability/Length of Stay

A number of transitional housing beds (20 - 40) should be a major component of the PLS facility. These beds should be used to accommodate clients who are awaiting bed space for housing or treatment from other community providers. The average length of stay should be some 15 days.

D. Staff Services During Client Stays

During client stays at the PLS facility, staff should insure that: an assessment is completed, information about the client is obtained from other services providers, an initial medical screening is performed, a determination should be made if an application for SSI/SSDI should be initiated, the client's identification should be established, outpatient detox and medication administration should be initiated and the client should be stabilized prior to referral to another PLS service provider.

E. Development of Preliminary Treatment Plans & Identification of Appropriate PLS Service Provider Placements

Based upon the client assessment, staff observations and records obtained from other PLS service providers, a preliminary treatment should be developed and a multi-disciplinary staff team should identify the appropriate PLS provider/program/bed/service/level of treatment required. A referral should then be made. PLS service providers should agree to accept referrals from the PLS facility, if funded by PLS or HUD/SHP.

3. Case Management/Service Coordination

A. Case Manager/Care Coordinator

A highly trained and skilled case manager/care coordinator should follow clients throughout the PLS.

B. Preliminary Treatment Plan

The case manager/care coordinator should develop the initial treatment plan.

C. Access Additional Services

The case manager/care coordinator should attempt to access any and all other services needed by clients or benefits to which clients are entitled.

D. Initiation of Case Management Services

Case management services should begin immediately after a client becomes a resident at the PLS facility.

4. Treatment Components

A. Detox

B. Outpatient Detox

C. Residential Treatment (short term and long term)

D. Medication Management

E. Purchased Medical Services

F. Purchased Psychiatric services.

5. Sub-Committee Members

- Marilyn Gordon (Chair), *Homeless Services Network*
- Annemarie Sheffield, *Lakeside Alternatives*
- Randy Hawkins, *Lakeside Alternatives*
- JoAnn Guadalupe, *Salvation Army*
- Maribelle Hernandez, *Wayne Densch Center*
- Antoinette Crowl, *Salvation Army*
- Leo Devlin, *Coalition for the Homeless*
- Debbie Orr, *The Center for Drug Free Living*
- Wanda Pearson, *The Center for Drug Free Living*
- Dick Jacobs, *The Center for Drug Free Living*
- Kathleen Green, *Salvation Army*
- Susan Mille, *Healthcare Center for the Homeless*
- Warren Foster, *Wayne Densch Center*
- Michael Campbell, *UCF-Center for Community Partnerships*

4B – CAPACITY & FACILITIES SUB-COMMITTEE REPORT

The PLS *facility* should be conceptualized and designed in accordance with the following principles:

1. PLS Facility

- A. The PLS facility should be the central point of access.
- B. The PLS facility should have some 30-35 emergency shelter beds.
- C. The PLS facility should operate 24/7.
- D. The PLS should provide low-level services (e. g., food, showers, phones, storage, laundry facilities, lockers, mail services, other).
- E. The PLS facility size should be approximately 17,000 square feet.
- F. Two potential sites exist for locating the PLS facility:
 - Michigan Avenue and 26th Street in unincorporated Orange County. The property is owned by the Center for Drug Free Living. The property would have to be rezoned.
 - Lakeside/Princeton property on Mercy Drive in West Orange County. The property is owned by Lakeside Alternatives. The property would not have to be rezoned. The property is also near the existing Central Receiving Center (CRC).

2. Sub-Committee Members

- Donna Wyche (Chair), *Orange County*
- John Parke, *Affordable Housing Consultants*
- Keith Theriot, *Health Council of East Central Florida*
- Joze Irizarry, *Coalition for the Homeless*
- Warren Foster, *Wayne Densch Center*
- Marilyn Gordon, *Homeless Services Network*
- Todd Dixon, *Center for Drug Free Living*

4C – FUNDING SUB-COMMITTEE REPORT

The Preferred Living System (PLS) will require financial support in three areas (capital, operating and service):

1. Capital

The sub-committee identified several potential funding sources for capital costs. The estimate of potential funds for capital is some \$2,750,000. Specifics are contained in the *OATH Board: Homeless Services Mapping Project*.

2. Operating

The Homeless Services Network (HSN) has applied for a Department of Housing & Urban Development (HUD) grant (3 years @ \$367,000 per year) that can be used to cover operating expenses. For specifics, see Attachment A.

3. Services

Funding for services is the most problematic. The sub-committee formulated several recommendations including:

- A. Request the OATH Board to provide \$2.2 million in funding for services over a three year period.
- B. Pursue various federal grants to fund overlay services.
- C. Pursue local and national foundation funding to cover overlay services.
- D. Pursue direct state funding, in the successful manner of the Central Receiving Center (CRC).

4. Other Recommendations

- A. Reformulate the existing community working group as the Preferred Living Center Steering Committee.
- B. Request that the OATH Board invest a maximum of \$100,000 for a period of up to one year to cover the costs of implementing the Preferred Living System (PLS) action plan.

5. Sub-Committee Members

- Dick Jacobs, *Center for Drug Free Living*
- Marilyn Gordon, *Homeless Services Network*
- Kathleen Green, *Salvation Army*

- Carol Mason, *Wayne Densch Center*
- Lind Howard, *Wayne Densch Center*
- Keith Theriot, *Health Council of East Central Florida*

4D - EVALUATION & MONITORING SUB-COMMITTEE REPORT

The Evaluation & Monitoring Sub-Committee” submitted never formally met. However, the “Assessment, Case Management & Treatment Sub-Committee” did include some evaluation and monitoring recommendations in its reports. The recommendations are:

- Evaluate the increase in access to treatment/services/beds for the target population;
- Evaluate (monitor) retention in treatment;
- Evaluate housing retention (length of stay in permanent housing);
- Evaluate the numbers/percentages of individuals who increase their income (either through employment or benefits); and
- Evaluation measures can be used in a monitoring approach to “tweak” the PLS.

5. REVENUE MAXIMIZATION (RevMax) & LONG TERM FINANCIAL SUSTAINABILITY PLAN

The centerpiece of the discussion in this section is the PLS facility. A financial summary of the estimated costs and projected revenues for the project are included in Table 1 (see next page). As Table 1 illustrates (see next page), the recommendation here is that the OATH Board provide funding for *treatment services* only for up to three years, with the caveat that OATH Board funds not be released until the *PLS facility is in actual operation*. The community mental health, substance abuse and homeless services providers believe that sufficient one-time capital funding can be secured from one or more sources. Additionally, the Homeless Services Network (HSN) anticipates receipt of Department of Housing & Urban Development (HUD) funding adequate to cover basic facility operations (lights, heating/cooling, etc.) for three years.

Providing funding for *treatment services* is where the OATH Board can have the greatest community impact on the needs of homeless individuals with mental health, substance abuse and dual diagnosis issues. In the long run, some of the service components can likely be funded for at least some clients through mainstream programs for: mental health, substance abuse, medical care, education, vocational rehabilitation and job training. However, it can be difficult for the homeless to access mainstream services. Moreover, Orange County Government has experienced particular difficulty locating funding for the critical area of case management. As a result Orange County Government is funding case management at the Central Receiving Center (CRC). All of the above suggests that the best use of OATH Board funding is for *treatment services* in order to establish an effective process for seeking mainstream funding and developing a track record of efficiency and success to persuade other funders to cover the revenue shortfalls after the initial three year start-up period.

Possible Sources of Revenue: Federal Programs Which May Help

The recommendations described in this report are very much in-step with current “Housing First” thinking and proposed new programs at the national level. The federal government through HUD is promoting a new initiative to “End Homelessness” in ten years, and has taken a particular interest in permanent supportive housing for the chronically homeless as the key to achieving this goal (U. S. Interagency Council on Homelessness, 2004). Chronically homeless are typically unaccompanied, homeless for long periods of times or multiple times, disabled by substance abuse or mental illness and perhaps physical and developmental problems, frequently hospitalized and incarcerated, and often panhandle and sleep in public places.

Essentially this new initiative came from The National Alliance to End Homelessness which caught the attention of then-HUD Secretary Mel Martinez and generally fit Bush Administration social policy themes. An Interagency Council on Homelessness has been established to maintain momentum on this initiative.

Table 1
 Estimated Costs and Funding Options¹
 For the Preferred Living System Facility

Funding Type	Amount (approximate)	How Often?	Purpose	Potential Funding Sources
Capital Funding	\$1,700,000	one-time dollars	17000 sq ft building by construction or purchase and retrofitting an existing building for assessment/intake, the drop-in services, and 24/7 housing for 30-35 transitional beds;	Options include: HUD Facilities Grant, HUD/SHP, Orange County HOME program, CDBG, DCF Homeless Housing Assistance Grant, local support ²
Basic Operations Funding	\$367,000	annual costs	including maintenance, security, utilities, laundry, supplies etc. for the facility and basic programs described above	HSN HUD CoC Grant (3 years beginning late 2005 - early 2006), while pursuing long-term funding
Treatment Services Funding	\$733,000	annual costs	for overlay services such as intake/assessment, health care, mental health counseling, case management, and substance abuse training to stabilize the transitional bed clients	OATH (requested for 3 years at \$733,000 per year), while pursuing long-term funding

¹ A complete list of federal funding to assist the homeless may be found in the “Economic Impact of Homelessness is Significant; Improvements Needed at State and Local Levels” from the State of Florida Office of Program Policy Analysis & Government Accountability, Report No. 05-01. (See Appendix A.) A complete list of state activities may be found in Appendix C of the same report. The report is online at <http://www.oppaga.state.fl.us/reports/pdf/0501rpt.pdf> . In addition, the web sites of the Interagency Council on Homelessness (www.ich.gov/) and of the National Alliance to End Homelessness (www.endhomelessness.org/) together provide a comprehensive and up-to-date look at the federal funds that are/could be available for the homeless including the particular interests of our project.

² The most recent HSN CoC application lists over \$8 million in combined city/county, foundation, and private support (Homeless Services Network, 2004).

Currently, the President's 2006 budget proposal for HUD includes the Samaritan Initiative to provide new funding for permanent supportive housing and case management services. A coalition of social service organizations is pushing a complementary proposal, the Services for Ending Long Term Homelessness Act (SELHA), which would authorize funding for HHS to provide mental health, substance abuse, and related services to individuals in supportive housing. However, in order to make a solid case for receiving whatever funds may become available under either program, 'every jurisdiction needs solid information on who is homeless, why they became homeless, what homeless and mainstream assistance they receive and what is effective in ending their homelessness' (U. S. Interagency Council on Homelessness, 2004).

It is obvious that the Preferred Living System (PLS) facility proposed here not only has the same emphasis as these new federal initiatives, it also will make a major contribution to obtaining the data to secure funding and spend it wisely.

Possible Sources of Revenue: Spend to Save

An important potential source of revenue for both the Preferred Living System (PLS) facility and later permanent supportive housing would be those organizations that currently incur the high costs of dealing with the chronically homeless.

Though constituting only 10% of the homeless population, the *chronic* homeless are estimated to consume 50% of all resources expended on the homeless such as emergency medical services including ambulance, EMT and emergency room services, psychiatric treatment, detox facilities, shelters, and law enforcement and corrections services (Burt, Aron and Lee, 2001). For example, in Jacksonville, a seven month tracking study of one 35 year-old homeless man with bipolar disorder and alcoholism revealed that he was admitted four times to a crisis stabilization unit, made three visits to hospital emergency rooms and two visits to intensive care, spent two days in a shelter, and was incarcerated in the county jail for 120 days at a total cost of \$43,545 (State of Florida Office of Program Policy Analysis & Government Accountability, 2005, p. 3).

A recent local study found that in 12 months during 2002-2003, the Orlando Police Department reported that costs of making arrests on persons identified as homeless were approximately \$235,737; costs to City Prosecutors to follow-up on these cases were \$31,030. The Orlando Fire Department reported that emergency calls to the Coalition for the Homeless, Orlando Rescue Mission, and Salvation Army costs the City \$67,410 (FY2002/2003). Orlando Regional Health Systems reported that medical charges for in-patient care for homeless/transient defined persons were \$4.56 million (305 patients); out-patient fees were \$1.19 million (1460 patients) (Oct/02 Sep/03). Total uncollected charges exceeded \$4.6 million. Average charge for out-patient care through Orlando Regional Health Systems was over \$815 per patient. Florida Hospital and their Central Florida facilities reported that medical charges for in-patient care for homeless/transient defined persons were 9.45 million (571 patients); out-patient fees were \$1.86 million (1,373 patients) Total uncollected charges exceeded \$9.54 million (City of Orlando, 2004).

These expenses suggest the possibility that building permanent supportive housing may actually be cheaper than not. A study in San Francisco estimates that the care of one chronically homeless person without permanent housing costs an average of \$61,000 per year, while treatment and care in permanent supportive housing costs only about \$16,000 per year (City of San Francisco, 2004, p. 8). Similarly, Hennepin County reported a savings of \$6200 per family when comparing services to families in supportive housing to homeless families (Hennepin County, 2003).

The leading large-scale study of this subject followed nearly 5000 homeless with severe mental illness in New York City. Researchers discovered that placement of such individuals in permanent supportive housing at an average cost of \$17,280 per year produced measurable savings of \$16,282 in other public services formerly utilized by these individuals (Culhane, Metraux and Hadley, 2002). In addition, it is well-known that there are difficult to quantify but very real negative impacts on economic activity and property values in communities where the homeless currently congregate which would end with better housing. And finally, the formerly homeless have better mental health, less substance abuse, fewer arrests, higher rates of employment etc. once in permanent supportive housing. This is a “win-win” proposition for all concerned.

Local recognition of the potential of “spending to save” has led Orange County and local hospitals to support the Central Receiving Center to reduce costs at the county jail and in emergency rooms. In addition, the recent City of Orlando Mayor’s Committee Report on the Homeless suggested that funding might be available via an additional assessment to the existing Downtown Development Board or by establishing a new special district in the light of business’ concerns with panhandling and aggressive behavior by the chronically homeless in the downtown area. This project should generate similar support for similar reasons. The following stakeholders, at a minimum, should be approached for funding or assistance in obtaining funding:

- Mayor, City of Orlando
- Mayor, Orange County
- Agency/Department Heads
- Business & Civic Leaders
- Law Enforcement Officials
- United Way/Chambers of Commerce
- Housing Developers & Service Providers
- Hospital Administrators
- Individuals experiencing Chronic Homelessness
- Non-profits/Foundations
- Faith-based Organizations
- General Public

Possible Revenue Maximization (RevMax) Strategies

As a term, “revenue maximization” means exactly what its name implies: an attempt to insure that revenues to support a particular service, activity or target group are maximized to the greatest extent possible. Frequently, revenue maximization refers to attempts to leverage additional federal funding, and particularly federal Medicaid funding. This is particularly true of persons with co-occurring mental health and substance abuse issues, widespread among the chronically homeless (see Martin et al., August 2004 for a full discussion of revenue maximization).

Maximizing federal funding for health and social services is currently a much-discussed topic in Florida. One study estimated that in 2002, the state of Florida failed to draw down as much as \$900 million available federal dollars due to the lack of state matching funds (Carasso and Bess, June 2003). The Florida’s Children’s Services Councils and United Ways then persuaded the Florida Legislature to approve the Local Funding Revenue Maximization Act Florida Statutes Chapter 409 Section 017 which provides incentives for Florida state agencies to partner with local governments and non-profits to utilize non-state appropriated funds as a match for federal programs. Moreover, the state of Florida already requires its county governments to pay part of the state cost of Medicaid financing for hospitalization. Thus, it appears that the state of Florida already has an administrative infrastructure in place that could perhaps be utilized and expanded in developing revenue maximization strategies. Nonetheless, actual use of the statute has been minimal to date. However, the United Ways of Florida continue to actively seek ways to use this strategy to bring more money to the state.

There are two apparent limitations on using revenue maximization to serve the homeless:

- *First*, Florida is doing well on a statewide basis in obtaining dedicated homeless funding. It has received more than its pro-rata amount of funds in each of the last three years according to a State of Florida study released this year (State of Florida, January 2005, p. 3).
- *Second*, when we look to Medicaid or other mainstream programs, we confront the well-known fact that the chronically homeless often have difficulty gaining access to federal mainstream assistance because they lack the documentation to prove eligibility for such programs (and for Veterans Administration programs; a significant percentage of this sub-group of the homeless are veterans). Local confirmation may be found in the UCF-Center for Community Partnerships analysis of the first six months of CRC operations which revealed that a full 60% of the patients were classified as indigent (UCF-Center for Community Partnerships, December 2003).

Perhaps RevMax in this context must first mean providing the assistance and environment in which the homeless are able to obtain and retain their documentation and thus qualify for basic mainstream benefits. This assistance and environment is a key component of the current proposal.

It should be noted that the Heart of Florida United Way is in the process of commissioning a revenue maximization (RevMax) study to determine how additional federal and state funds might be secured to serve the needs of homeless individuals with mental health, substance abuse and dual diagnosis issues.

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