EFFECTIVENESS OF INTEGRATED SERVICES

FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS

A Report to the Legislature as Required by Division 5, Section 5814,

of the California Welfare and Institutions Code

Governor Gray Davis

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EXECUTIVE SUMMARY

This report, required by Assembly Bills (AB) 34, 2034, 334, and 2057, (Steinberg, Chapter 617, 518, 454 and 337, Statutes of 1999, 2000, 2001, and 2002), presents results of the Department of Mental Health's (DMH) implementation of programs at county and city levels serving homeless adults with serious mental illness. There are approximately 300,000 homeless persons in California, including 50,000 with serious mental illness. As of January 31, 2003, 4,881 of these individuals were being served in 35 programs described in this report.

What California has accomplished with AB 2034* programs has never been done before in California's adult community mental health system. Factors that make this effort unique are: (1) the focus on homeless persons with serious mental illness; (2) the mandate to provide immediate housing; (3) the flexibility of the funding; and (4) the collection and reporting of "real-time" client and system outcomes. The legislation cited above provides funding to local mental health programs to act as the single point of responsibility for the comprehensive service needs of individuals who are homeless and have serious mental illness. The comprehensive service needs to be addressed include an immediate and ongoing need for housing. The results of this major programming challenge for local mental health agencies have exceeded everyone's expectations.

Currently 4,071 of the 4,881 persons enrolled in these programs are in some type of housing rather than on the streets. The success of local programs in helping individuals move from homelessness to community housing situations is one way that this demonstration program has broken new ground. As in previous years, evaluation data continue to show dramatic reductions in the number of days of incarceration and inpatient psychiatric hospitalization experienced by individuals in this program. And, for the first time, the data reflect significant increases in the number of persons involved in employment activities. As of January 31, 2003, 13.3%, or more than one out of eight persons enrolled in these programs were involved in some type of employment.

The results document not only the personal success of clients, but the ongoing cost effectiveness of AB 2034 programs. This report estimates that an annual program expenditure of approximately $55 million for 35 local programs has been offset by an estimated savings or cost avoidance of approximately $24.7 million from reduced psychiatric inpatient days and reduced incarcerations. Additionally, we conservatively estimate an additional $2.7 million in savings/cost avoidance as a result of the reduced use of emergency rooms for psychiatric episodes.

***Since statewide expansion of these programs occurred pursuant to Assembly Bill 2034, (Steinberg, Chapter 518, Statutes of 2000) this report will refer to these statewide programs as AB 2034 programs rather than always referencing AB 2034 and AB 334.**

Data Analysis Highlights

The data presented here on 4,881 individuals were collected from all 35 programs beginning with each county's start date (as early as November 1, 1999) through January 31, 2003, and are summarized below.

- Clients are mostly men (59.7%).
- 52.1% are Caucasian, 30.8% are African-American, 11.9% are Hispanic, 1.5% are Asian, and the remaining 3.7% are other ethnic groups.
- Clients are mostly between 25 and 59 years of age (86.3%).
- 3.4% of enrollees are over the age of 59.
- 10.4% of enrollees are between the ages of 18 and 24.

The outcomes presented here for post-enrollment have been annualized, based on the average length of tenure for each consumer in each program, in order to compare them with the consumers' outcomes in the twelve months prior to enrollment. This methodology has been refined since previous years' reporting and as a result has altered some of the outcomes reported. (Further discussion of this calculation can be found in the Appendix 5.)

- The number of days of psychiatric hospitalization since enrollment dropped 55.8%.
- The number of days of incarceration dropped 72.1%.
- The number of days spent homeless dropped 67.3%.
- The number of days of full-time employment increased 65.4%
- The number of days of part-time employment increased 53.1%

The following table summarizes statewide data for five key factors by comparing data reported for the twelve months before services began to the data collected since.

Statewide Data at a Glance (Annualized)

	12 Months Prior to Enrollment	Since Enrollment (Annualized to Represent 12 months)	Percent Increase/Decrease
Number of Days Hospitalized	37,938	16,778	-55.8%
Number of Days Incarcerated	213,106	59,434	-72.1%
Number of Days Homeless	983,709	321,667	-67.3%
Number of Days Employed (Full-Time)	36,971	61,157	+65.4%
Number of Days Employed (Part-Time)	79,758	122,083	+53.1%

This report includes cumulative program information from each county and city program from implementation through January 31, 2003. The report also includes four new types of information and analysis: (1) data on the use of "other" 24-hour care; (2) "current status" information about the number of persons in housing and involved in employment as of January 31, 2003; (3) a comparison between first and second year outcomes for individuals in the program at least two years; and (4) information that documents other identified service-related trends.

DMH, the 35 local programs, and the contract training and evaluation staff, have learned a lot about "what it takes" and what programming elements lead to high performance for programs serving individuals who are homeless and have serious mental illness. Many of these same programming strategies could be successful with other frequent users of public healthcare services who are high-cost, high-risk, have chronic health conditions, psychosocial issues, and whose current use of healthcare services does not result in positive health or social outcomes. We have described the factors we believe most influence success.

While we have learned a lot about what it takes and what it costs to deliver the most effective services to homeless persons with serious mental illness, we do not know everything. For example, other research studies in the country have found that significant public costs occur as a result of homeless persons' frequent use of emergency medical services. Most mental health agencies do not have access to information about emergency room use pre and post enrollment, thus we are likely to underestimate the overall cost savings realized. Local governments may also be saving or avoiding additional costs as a result of reductions in homelessness. For example costs to judicial systems and lost tax revenues from businesses are not accounted for. Conversely, we also know there may be other costs to government associated with supporting formerly homeless individuals who now require some type of 24-hour care "other" than inpatient. We are beginning to collect and analyze this information. With further analysis we will be able to report "current" housing status information on each client enrolled in the program each month, including those in some type of "other" 24-hour care.

We also have questions about what it takes to maintain these programs over time, and how best to maximize their effectiveness and efficiency so that they can sustain individuals in housing and employment activities. Almost every program uses significant program funding to purchase housing and provide housing subsidies for clients living in community housing. This type of housing support is "what it takes" but does limit the program's ability to expand services to others. We want to know how long it takes before individuals are able to completely sustain their own housing without some fiscal subsidy from AB 2034 programs. Are we successful in keeping individuals from returning to prison? Are there ways to assist AB 2034 programs to increase affordable housing by accessing funding made available with the recent passage of Proposition 46, the Housing and Emergency Shelter Trust Fund Act of 2002? With the recent focus on both homelessness and mental health at the national level, would it be worthwhile to explore a federal waiver that might allow for reimbursement of non-traditional services such as housing and employment? While this report provides some limited information in most of these areas, further data collection, analysis and collaboration would enable us to fully explore these and other questions.

What we do know is that these programs have led to significant improvements in the lives of persons they have served. State policymakers, DMH, county mental health directors, administrators, contract training and evaluation staff, and most importantly local line staff and the clients themselves can take pride in what has been accomplished. A few individual client stories can be found throughout this report and others in Appendix 2. Here is one such story.

> Pamela is a 41-year-old African-American female who is dually diagnosed with bipolar disorder and polysubstance abuse, in remission. Prior to enrolling in the AB 2034 program she had been homeless for over ten years and was engaged in prostitution. Additionally, she had been charged with abandonment of her 10-year-old son who was removed from her custody. She had attempted suicide numerous times throughout her homelessness and had been hospitalized twice due to these attempts. Life on the streets was filled with drugs, alcohol and sexual encounters. The drugs would numb her just enough to survive the victimization she incurred as well as the pain brought on by prostitution. The numbness from the drugs masked the fact that she was hungry and unable to care for herself. She experienced this scenario daily on the streets, and the cycle continued for ten years.
>
> Pamela's life has changed dramatically. Upon enrolling in the AB 2034 program, Pamela was placed at a shelter and was supported to initiate communication with her family and to find a job. She was provided with support and encouragement to believe in herself. She was given tools to work with her symptoms, and can now problem solve life's problems. She has been working full time as a secretary at the same job for the last 32 months. She has purchased a used car to get to and from work and has maintained an apartment for 19 months, where she lives with her son. She is now struggling with the trials of parenthood as well as money management. During a tearful exchange she shared what she considers a significant achievement. She happily reported that for the first time in her adult life she was able to have her family over for the holidays.

The 2003-04 Governor's Proposed Budget includes $55 million to continue this program's funding next year via county realignment. The Administration's intent to sustain funding for this program, even in difficult budget times, speaks to the confidence policymakers have in both the individual client outcomes that have been achieved and in the overall cost effectiveness and accountability of the effort.

Recommendations

Based on the findings included in this report, the Department makes the following recommendations.

1. Programs such as these should continue to be included in the spectrum of programs designed to meet the needs of homeless Californians.

2. County and city programs should be held accountable for meeting service model and data reporting requirements as a condition of future funding.

3. The client and system outcome evaluation of this program, including cost effectiveness, should be continued.

4. Training activities should continue for ongoing programs with a specific focus on both housing and employment strategies that help individuals obtain and sustain housing and employment and deal with substance abuse issues.

5. The Advisory Committee should assist the Department in evaluating the performance of these programs, with particular attention to housing and employment outcomes.

Report to the Legislature on

The Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness

Issue Statement

Governor Gray Davis provided approximately $55 million from the General Fund in the state budget for Fiscal Year 2000-01, $65 million in Fiscal Year 2001-02, and $55 million in Fiscal Year 2002-03 for Adult System of Care programs directed particularly at serving homeless persons, parolees, and probationers with serious mental illness. $10 million had been provided in Fiscal Year 1999-00 for three pilot projects with the condition that no future funding would be provided unless the projects could demonstrate positive client and system outcomes including cost effectiveness within that first year. As a result, DMH allocated grant funding to Sacramento, Stanislaus and Los Angeles county mental health agencies who used the funding to enhance services they were already providing to homeless individuals. As documented in the May 2000 report to the Legislature on the effectiveness of these programs, these three pilot projects were very successful in reducing the number of homeless days, jail days and psychiatric hospital days experienced by individuals enrolled in the program. As a result, the Governor and the Legislature have continued to support ongoing funding for these programs.

The Adult and Older Adult Mental Health System of Care Act, specifically those provisions established pursuant to Assembly Bills (AB) 34, 2034, 334, and 2057 (Steinberg, Chapter 617, 518, 454 and 337, Statutes of 1999, 2000, 2001 and 2002, respectively), governs the implementation and administration of the comprehensive service model and provides for establishment at the local level as resources become available. The funding provided in Fiscal Year 2000-01 permitted the Department of Mental Health (DMH) to make permanent the three pilots that began testing this model in 1999 and to expand these services to other county and city programs which currently total 35 statewide. Currently $55 million, which represents the base funding level for this program, is included in the Governor's budget proposal for Fiscal Year 2003- 2004. Existing statutory provisions require an annual report on program results by May 1 of each year. This report is in response to that requirement.

Background

Funding these programs represents the Legislature's and Governor's continued interest in addressing community mental health needs that have largely gone unmet for persons whose illness leads them to being homeless or incarcerated, often repeatedly so. These individuals frequently either avoid contact with mental health services or are without any benefits, including Medi-Cal. Many of these individuals have frequent contact with the criminal justice system, most often for minor crimes, but frequently leading to citations and arrests. This population also experiences high cost psychiatric inpatient hospitalizations because their mental health needs are only addressed when they reach

crisis levels. This leads to lengthier inpatient stays and an increased likelihood of relapse since, when released, these individuals are often again on the street without any resources and choose not to seek ongoing services from local programs. Other significant costs are attributable to this population as a result of their frequent use of emergency room services for both medical and psychiatric healthcare.

The programs that are the subject of this report provide comprehensive services, not limited to mental health, to adults who have serious mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. An addition to the target population, of persons who had an untreated severe mental illness for less than one year and who do not need the full range of services but who are at risk of homelessness unless a comprehensive individual and family support plan is implemented, took effect January 1, 2002, pursuant to AB 334, (Chapter 454, Statutes of 2001).

State funding for these programs enables staff to directly or indirectly provide a comprehensive array of services including outreach, supportive housing and other housing assistance, employment, substance abuse, and mental and physical healthcare including medications. For years the perception has been that, due to economic constraints, traditional mental health programs have been forced to focus on delivering only those services eligible for Medicaid reimbursement. While these medical services are appropriate and necessary, they do not include the vast array of support services necessary to help someone obtain and sustain housing and employment. The flexibility of the funding provided under AB 2034 has made it possible for these programs to provide and subsidize housing and deliver the comprehensive services necessary to support individuals living and working in the community. Although another goal is to help individuals access treatment and begin recovery, this is not a requirement of the program and could deter a person's willingness to accept services if initially emphasized.

What has become apparent to most providers and stakeholders is the therapeutic significance of having a stable place to live, and the foundation this provides for individuals' ability and desire to make progress in other aspects of their lives. Other goals include supporting individuals in employment efforts, and linking them with physical healthcare, substance abuse services, and Veteran's benefits if appropriate.

As these programs reduce recidivism in psychiatric hospitalizations, incarcerations, emergency room use, and homeless days, significant cost avoidance is realized primarily at the local level. (Further data collection and analysis is required to estimate and quantify State cost savings/avoidance which results primarily from keeping persons from returning to state prisons and avoiding physical healthcare costs that may have been funded by State Medi-Cal.) Additionally, as these programs mature, there will be an increase in the number of clients able to gain and keep employment, or complete educational goals. Significant increases in employment activity have already occurred since this report last year and are documented in Appendices 3, 4, 6, and 7.

It should be noted that these AB 2034 programs and the AB 3777 (Chapter 982, Statutes of 1988) programs that preceded them are the only Adult System of Care programs ever

categorically funded by the State of California. The objective of the AB 3777 pilot demonstration was to test both an Integrated Service Agency (ISA) model and a county model, both charged with delivering integrated, comprehensive services to adults and older adults with serious mental illness. The array of services to be provided almost mirrored the existing requirements under AB 2034, and the population served, while not limited to homeless adults, did include them in the target population. An independent outcome evaluation of the AB 3777 demonstration projects identified some program success although outcome data was only collected and reported for 18 months. As a result, when the demonstration period ended, the funding for the three pilot programs was continued with responsibility transferred to the counties where the projects were located.

When realignment was implemented in 1992, the Adult and Older Adult Mental Health System of Care Act was modified to include the comprehensive model for services established under AB 3777 as the goal for ASOC services in California. This language included the caveat that implementation was subject to the appropriation of funding. While some local programs did make modifications to their system and service delivery structures, most programs were unable to provide the comprehensive, non-mental health services such as housing and employment, identified as part of California's ASOC model. During times when the demand for outpatient mental health services always exceeded the funding available, it was not feasible for local mental health agencies to take responsibility for non mental health issues and expand and fund services not eligible for Medi-Cal reimbursement. Until the current Administration approved the implementation of AB 34, no funding had been provided by the State to deliver the comprehensive array of ASOC services defined in legislation since AB 3777.

One goal of the current AB 2034 programs is to provide additional evidence that delivering integrated, comprehensive services to certain populations produces positive client outcomes and is indeed cost effective. Similar to the goal of helping clients integrate into the community in AB 2034 programs, the goal for California's ASOC was to shift the existing service model to a community integration model. Without additional funding, this could only be achieved through the redirection of existing resources to fund those comprehensive services not funded under Medi-Cal. However, without substantive evidence that this would be cost effective with certain populations and could be sustained over the long-term, local policymakers are unlikely to support such a shift. With most of the AB 2034 programs having been operational for about two and one half years, the client and system outcome evaluation of these programs is just beginning to produce information about the long-term effects, including cost effectiveness, of this type of programming. (More detailed background about the initial selection process and the distribution of funding is included in Appendix 10.)

Objectives

Amendments and additions to AB 334 (Chapter 454, Statutes of 2001) provided pursuant to AB 2057 (Chapter 337, Statutes of 2002), further clarify objectives for California's adult system of care serving adults with serious mental illness. Objectives to be obtained as available information permits now include the following:

1. A comparison of Medi-Cal costs, including hospitalizations, two years prior to enrollment in the AB 2034 program to Medi-Cal costs two years after enrollment.
2. The number of persons served who were and were not receiving Medi-Cal benefits in the 12 months prior to enrollment.
3. The number of emergency room visits and other medical costs for those not enrolled in Medi-Cal 12 months prior to program enrollment.

The goal that this program collect and report on all Medi-Cal costs attributable to this population two years pre and post program enrollment, is intended to identify State savings that may result from these programs. Since county mental health programs use local funding to match Medi-Cal dollars for mental health care services, no state costs are saved as a result of reducing Medi-Cal psychiatric hospitalizations or other mental health care costs. While State savings (Medi-Cal match) may occur if costs were reduced for physical healthcare (including hospitalizations and emergency room visits pre and post enrollment), it is more likely that physical healthcare costs would increase post-enrollment as a result of the compromised health status of many homeless persons. Specific Medi-Cal data on physical healthcare costs for persons enrolled in AB 2034 programs is not readily available to DMH. Acquiring this information would necessitate matching individual AB 2034 clients with Medi-Cal service information contained in the Department of Health Service's Medi-Cal files. This process would be costly, time intensive and may or may not identify State savings that can be identified and quantified. Therefore, consistent with the provision in AB 2057 that indicates objectives be met "as available information permits", this objective will not be pursued at this time.

The current data collection and reporting effort for these programs already provides information about the number of individuals receiving Medi-Cal benefits in the 12 months prior to enrollment. (See Appendix 3, Table 10.) And as mentioned in the Executive Summary and later in this report, efforts have begun to document the use of emergency healthcare services both pre and post enrollment.

Evaluation Methodology

The evaluation methodology for these programs employs a "before and after" approach to analyzing both client and system outcomes including cost effectiveness. Baseline information about individuals' experience 12 months prior to program enrollment is obtained through client interviews from every person enrolled in the program. Individual line staff collect and report subsequent data elements that track outcomes after service is initiated. The cumulative data found in Appendix 3, displays both the baseline information and the post-enrollment data.

In addition to gender, age and ethnicity, the baseline data for the twelve months prior to enrollment for each new service enrollee include:

- the number of hospitalizations and days of hospitalization;
- the number of enrollees with co-occurring substance abuse disorders;
- the number of other service contacts with local mental health plan services;
- the client's veteran status and benefits, if any;

- the number of arrests;
- the number of days incarcerated;
- the number of days spent homeless;
- various income sources of the client, if any;
- the number of days employed full time and part time, and
- whether the enrollee was on probation or parole.

Ongoing data include:

- the number of enrolled persons being served;
- the number of enrolled persons who are able to maintain housing;
- the number of enrolled persons who receive extensive community mental health services;
- the number of enrolled persons on probation, parole, and the number of arrests and days incarcerated;
- the number of enrolled persons hospitalized and the number of days hospitalized;
- the number of enrolled persons employed full time and part time, competitively employed, in supported employment, and in vocational rehabilitation;
- the number of persons disenrolled;
- the number of persons referred to and served by local mental health programs; and
- the number of enrollees newly qualified for third party payments or receiving veteran's benefits.

An AB 2034 Data Committee consisting of staff from AB 2034 programs, contract evaluation staff and DMH staff, continue to meet, discuss and refine the reporting methodology necessary to meet both legislative reporting requirements and local program needs. The topic-oriented data tables established at the inception of this program continue as the basis for most data collection and reporting. However, some additional tables have been added that provide: (1) additional cumulative data on the use of "other" 24-hour care; (2) "current" status information on consumers rather than "cumulative" data; (3) a comparison between first and second year outcomes for persons enrolled in the program more than 2 years; and (4) other information that could only be obtained from a limited number of programs but documents other identified service-related trends. Information that falls into the first three categories above can be found in the Findings Section, Pages 13, 16, and 19. Service-related information not reported by every program is found throughout the report. Outcome data is reported monthly by each county and city program for their enrolled clients. These data are presented in Appendix 3.

Development of Program Standards

Although the AB 2034 programs have not been required to adhere to an "absolute" set of program standards, these programs are continually reviewed and monitored against "high performance" criteria developed by DMH. These criteria include:

1. The ability to respond and provide ongoing assistance to clients, landlords and law enforcement, 24 hours a day, 7 days a week
2. Field-based service provision (rather than clinic-based)

3. A staff to client ratio of no higher than 1:15 for Personal Services Coordinators
4. A significant capacity to meet immediate housing needs, including temporary housing at the time clients are enrolled.
5. Demonstrated ability to develop adequate transitional and permanent housing.
6. Dedicated staff specializing in housing and employment
7. Demonstrated ability to maintain clients in housing over time.
8. Demonstrated ability to help people find and maintain employment.

Advisory Committee

The AB 2034 Advisory Committee membership conforms to statutory requirements. This committee initially consulted with the Department in establishing the process for awarding grants to new county and city programs. The committee also examined and critiqued many of the materials and methods used in providing training and consultation to the programs during implementation. Since then the committee has not met nearly as frequently. Instead the Department has focused its efforts on the distribution of funding, the expanded data collection efforts and the training and technical assistance required by programs. Given the current limitations on the frequency of Advisory Committee meetings, the Department is exploring ways in which this body can provide continuous and meaningful input about program development and performance.

FINDINGS

Past Legislative reports on the effectiveness of these programs have documented only "cumulative" results over time. This year "Findings" also includes: (1) a report on the current housing and employment status of individuals enrolled in the program on January 31, 2003; and (2) a comparison of the first and second year outcomes for persons enrolled in the program for at least two years.

Cumulative Data – Results Over Time

The tables in Appendix 4 present program information collected from all county and city AB 2034 programs from implementation through January 31, 2003. All post-enrollment data comparing numbers of consumers, episodes, and days to the year prior to enrollment have been "annualized" to make the comparison with pre-enrollment data meaningful. For the raw "uncorrected" county data refer to Appendix 3.

Demographic Data

Tables 1, 2, and 3 display demographic information about gender, ethnicity, and age, respectively, for each of the county and city programs.

The table below gives a breakdown of the major demographic characteristics of the AB 2034 population.

Demographic Variable	N = 4881	%
Gender		
Male	2,916	59.74
Female	1,957	40.09
Other / Transgender	8	0.16
Ethnicity		
African American	1,504	30.81
Asian American	72	1.48
Caucasian	2,544	52.12
Hispanic	581	11.90
Native American	79	1.62
Pacific Islander	18	0.37
Other	83	1.70
Age		
17 and Under	0	0.0
18 – 24	506	10.37
25 – 45	2,631	53.90
46 – 59	1,579	32.35
60 and Over	165	3.38
Diagnosis		
Psychosis	1,805	36.98
Mood	2,559	52.43
Anxiety	274	5.61
Substance Abuse	76	1.56
Other	131	2.68
No Data	36	0.76
Co-Occurring Substance Abuse		
Yes	3,020	61.87
No	1,861	38.13

Given that a large number of AB 2034 consumers came directly out of jail or prison with their disproportionately high number of males, it is not surprising that approximately 60% of the consumers enrolled in the AB 2034 program are men. Approximately 5 out of 6, AB 2034 consumers are either Caucasian or African American while Hispanics represent about 12% of the AB 2034 population. This lower representation of Hispanics seems to be consistent with the under representation of Hispanics in mental health programs generally and suggests that AB 2034 programs may need to improve their outreach to the Hispanic community.

The diagnostic breakdown of the AB 2034 population reveals some interesting findings. Most notably, mood disorders (e.g., major depression, bi-polar disorder) make up more than half (52.4%) of the entire AB 2034 population while psychotic disorders (e.g., schizophrenia) account for 37% of the diagnoses given. The greater proportion of mood disorders over psychotic disorders among this program's population appears consistent with the population traditionally served by the public mental health system.

A very small number of consumers (1.6%) have only a diagnosis of substance abuse. These are individuals who, in all likelihood, were thought to have serious mental illness when they were enrolled in the program, but once the symptoms produced by their substance abuse cleared, were determined not to have a mental illness. In these instances it can be extremely difficult to disenroll a consumer who does not meet the criterion of having a mental illness. In many smaller counties it is only the AB 2034 program that offers the type of comprehensive services that many extreme substance abusers need to successfully treat their addiction.

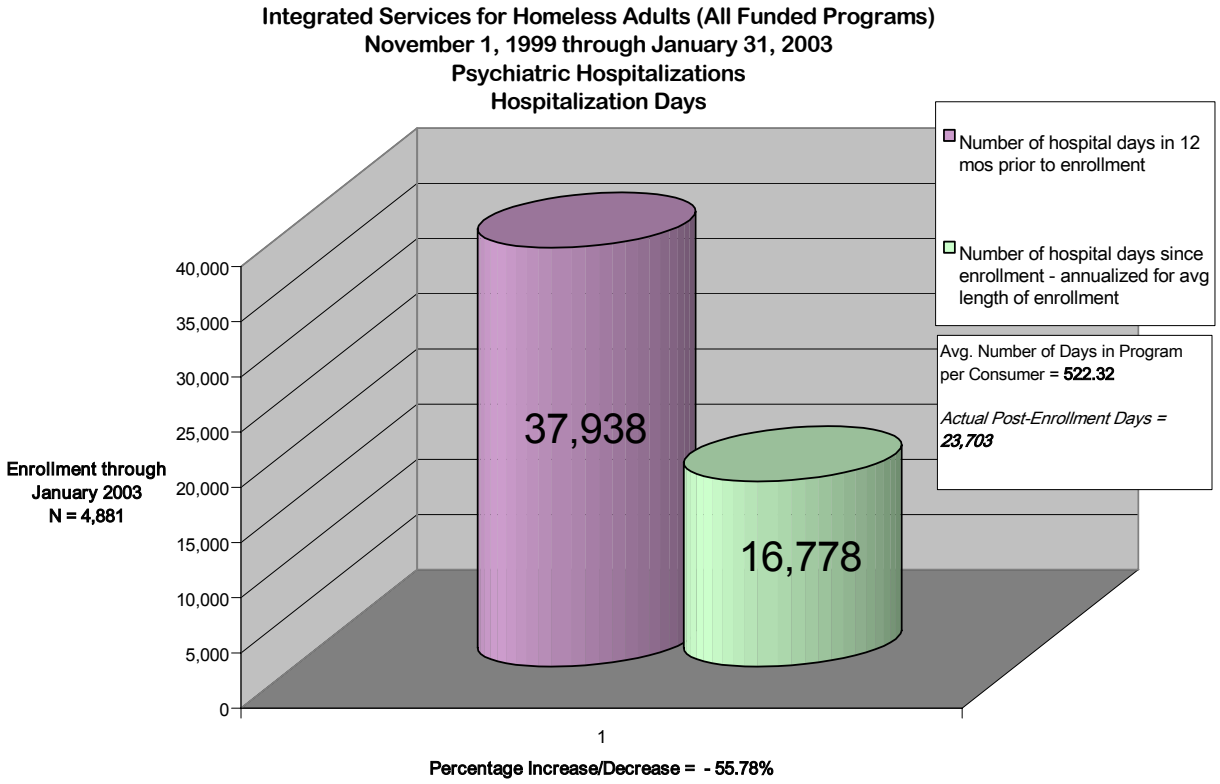
Related to this is the high number of consumers (61.9%) who, in addition to their psychiatric disorder, have a co-occurring substance abuse disorder. It is commonly understood among most mental health staff that it is often the individual's substance abuse issues that pose a greater treatment challenge than the mental illness. For AB 2034 staff the treatment challenge remains, but the program's flexible funding makes it easier to provide all the services necessary to comprehensively address the needs of these individuals. These programs have learned that to be effective it is necessary to treat the mental illness and the substance abuse issues simultaneously rather than separately.

Hospitalizations

Table 5 contains information about hospitalizations prior to and since the consumers' enrollment. As with other tables presenting prior and post service information, the prior data is for a 12-month period. The post-enrollment data are annualized for each county to reflect the consumers' average length of tenure in the program. There were significant reductions in the number of consumers hospitalized, the number of hospitalizations, and the number of hospital days.

- Number of consumers hospitalized decreased 42.3%
- Number of hospital admissions decreased 28.4%
- Number of hospital days decreased 55.8%

It is interesting to note that the number of hospital admissions dropped less than both the number of consumers hospitalized and the number of hospital days consumers experienced. This would suggest that some consumers truly in need of hospitalization are being hospitalized more than they were, but that program staff are able to limit the length of those hospitalizations through appropriate discharge planning.

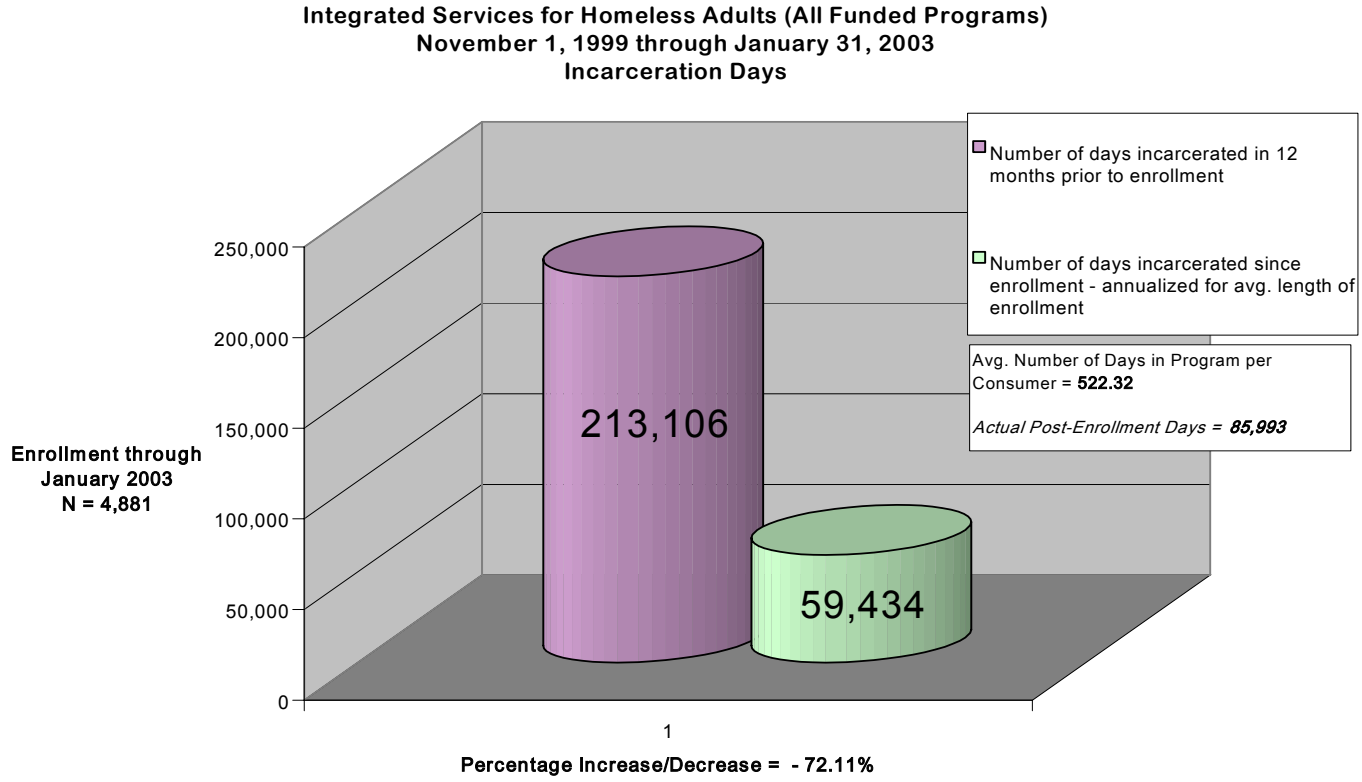


Incarcerations

Table 6 contains information about incarcerations prior to and since the consumers' enrollment. As with other tables presenting prior and post service information, the prior data is for a 12-month period. The post-enrollment data are annualized for each county to reflect the consumers' average length of tenure in the program. There were major reductions in the number of consumers incarcerated, the number of incarcerations, and the number of incarceration days.

- Number of consumers incarcerated decreased 58.3%
- Number of incarcerations decreased 45.9%
- Number of incarceration days decreased 72.1%

Although programs have not been asked to specifically document whether jail days experienced after enrollment are attributable to offenses committed prior to an individual's enrollment, anecdotal information provided by program staff indicates that this has occurred. (See discussion in "Unanswered Questions" Section, found on Page 31.)



Income

Table 7 contains information about the income status of the AB 2034 consumers upon entry into the program and since enrollment. The data indicate that there were large increases in all five of the different types of income. The number of SSI recipients has gone from 1,340 at enrollment to 2,587 post enrollment, a 93.1% increase. Probably most striking, though, is the increase in the number of people receiving wages since enrollment compared to the number receiving wages at enrollment. Only 240 AB 2034 consumers (4.9%) were receiving wages at enrollment. Since that time, 909 consumers (18.6%) have received wages from employment, an increase of 279.8%.

These data speak well of the AB 2034 program's ability to increase the overall income of the consumers they serve. It is particularly important that both benefits and wages have been increased. This suggests that, in addition to helping consumers obtain the benefits to which they are entitled, the AB 2034 programs are beginning to help people move toward economic self-sufficiency through employment.

Housing

Table 8 contains information about homelessness and residential status prior to and since the consumers' enrollment. As with other tables presenting prior and post service information, the prior data is for a 12-month period. The post-enrollment data are annualized for each county to reflect the consumers' average length of tenure in the program. There were reductions in the number of consumers becoming homeless since enrollment when compared to the number of consumers who were homeless in the year prior to enrollment. There were significant reductions in the number of days consumers were homeless. There was also a 73.5% reduction in the number of consumers who were homeless as of January 31, 2003 (809), when compared to the number who were homeless upon program enrollment (3,055).

The number of consumers who became homeless since enrollment (1,197) compared to the number of consumers who were homeless prior to enrollment (4,177) decreased 71.3%.

The overall number of homeless days experienced by consumers decreased from 983,709 to an annualized 321,667, for a 67.3% decrease.

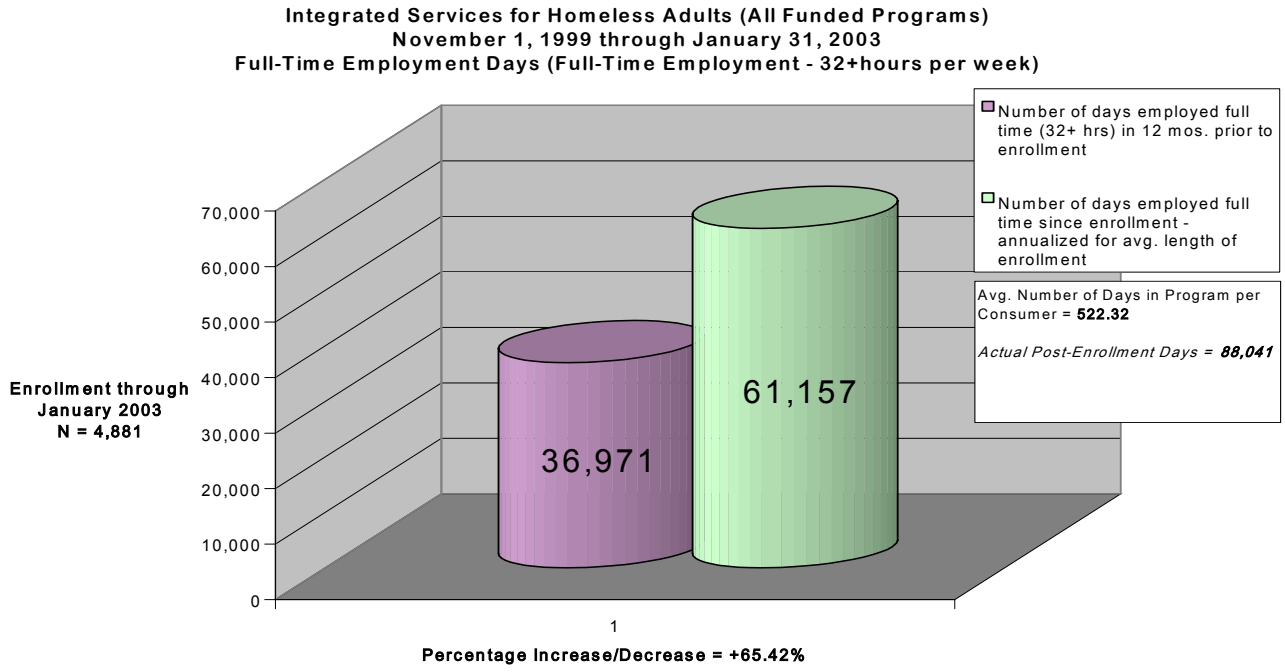
Employment

Table 9 contains information about the employment status of the AB 2034 consumers prior to and since enrollment. There was a modest 19.6% increase in the number of consumers who engaged in full-time employment (defined as 32 hours or more per week). However, there was a much larger 65.4% increase in the number of days of employment, indicating that the programs were quite successful in helping consumers to maintain their jobs for much longer periods of time than previously experienced.

Similarly, there was a 14.4% increase in the number of consumers who engaged in part-time employment (less than 32 hours per week) since enrollment, but there was a significantly larger 53.1% increase in the overall number of employment days since enrollment.

Currently, as of January 31, 2003, 13.3% of all consumers enrolled in the program were involved in some type of employment activity. This equates to more than 1 out of 8 individuals involved with employment. This represents a significant improvement from the outcomes reported last year and was accomplished in only twelve months. Last year's data indicated that 815 consumers were involved in employment prior to enrollment while only 621 were involved in the 12 months after enrollment. (Note: the number of consumers reported as working last year was not "unduplicated".) We know that programs cannot effectively provide employment services when someone does not have a stable place to live. We attribute the improved employment outcomes to the fact that more individuals are now in stable housing and to the focused employment training provided to program staff statewide.

Taken as a whole, these data indicate that helping people with severe and persistent mental illness to find and maintain employment remains one of the greatest challenges for these programs. This is particularly true for AB 2034 consumers because they may also have a significant history of incarceration and therefore face an additional hurdle in convincing employers to give them an opportunity to work. The state will need to consider the best ways to help programs improve their employment outcomes but certainly one way will be to provide specific employment services training as well as encouraging the hiring of more "employment-specific" staff such as job developers and job coaches. (See Training in "Accomplishments" Section found on Page 24.)



Benefits, Disenrollments, and Other

Table 10 contains information regarding a variety of variables. Of special interest are the number of consumers who have obtained health insurance (in most cases Medicaid) since enrollment and the number of consumers that have been disenrolled from the program. This table also includes the category under which persons were disenrolled. To date, 1,225 additional consumers have obtained health insurance since their enrollment, an increase of 42.3% over the 2122 who were insured at enrollment. Information provided by program staff indicates that if individuals have no felonies or previous Social Security Income (SSI) denials, Medi-Cal eligibility can sometimes be obtained in one month. However, to be approved for SSI it usually takes a minimum of four months and up to two years with appeals and administrative hearings. Since many of the individuals in this program have substance abuse issues, this timeframe for SSI approval is not uncommon. This impacts local program costs since it is SSI that provides clients with a modest income so that they may begin paying a portion of their own housing costs. Since the average tenure of persons currently enrolled in the program is less than one and a half years, we expect that those not currently eligible are in process.

Since program inception in November 1999, there have been a total of 8,635 consumers enrolled in the AB 2034 program. There are 4,881 persons currently enrolled and 3,754 consumers that have been disenrolled. Unfortunately, 151 consumers have been disenrolled due to their death while in the program (1.75%). This number is no doubt a reflection of the increased level of co-occurring physical health disorders that exist among the AB 2034 consumer population. The health status of many AB 2034 consumers is compromised by HIV/AIDS, hepatitis C, diabetes, and a variety of other health conditions. It suggests that the AB 2034 programs need to take particular care in addressing the physical health care needs of their consumers.

Another area of possible concern is the number of consumers who simply drop out of the program. 1,958 consumers, 22.7% of all the consumers ever enrolled, have simply disappeared or dropped out in most cases, without explanation. It would take specific resources to try and track these individuals after they have left a program. It might be helpful to review the practices of programs with lower dropout rates and examine if there are common elements that may account for the differences from other programs.

"Other" 24-Hour Care

Table 11 contains information not previously collected or reported in past legislative reports on the effectiveness of these programs. The AB 2034 Data Committee, mentioned previously in this report, agreed that new information should be collected on the specific use of "other" 24-hour care, prior to and since an individual's program enrollment. "Other" (meaning non-hospital) 24-hour care is defined as living in a skilled nursing facility (SNF), an institute for mental disease (IMD), or in a crisis, transitional, or long-term residential care facility and is included as a housing category when data is collected on individuals' housing status. As with other tables presenting prior and post service information, the prior data is for a 12-month period. The post-enrollment data are

annualized for each county to reflect the consumers' average length of tenure in the program. There were increases in the number of unduplicated consumers admitted to "other" 24-hour care, the total number of admissions, and the number of "other" 24-hour care days.

- Number of unduplicated consumers admitted to "other" 24-hour care facilities increased 27.1%
- Number of admissions to "other" 24-hour care facilities increased 27.0%
- Number of days spent in "other" 24-hour care facilities days increased 52.2%

These results are of great interest in terms of both client outcomes and cost effectiveness. We are concerned if clients are languishing in IMDs, when our belief is that these programs should have all the tools necessary, including supported housing options, to avoid the use of these facilities when possible. The county specific data, as of January 31, 2003, found in Appendix 6, indicates that only 18.6% of the consumers in "other 24-hour-care", were in SNFs and IMDs. This equates to 43 individuals in SNFs or IMDs as of January 31, 2003, out of 231 total individuals in "other 24-hour care and 4,881 individuals currently enrolled. While the cost of "other" 24-hour care is significantly lower than hospitalization and incarceration, it is still a major drain on system resources. It is therefore important to account for the possible reasons the use of "other" 24-hour care has increased for consumers in the AB 2034 program.

First of all, it is important to note that AB 2034 consumers have not generally been frequent users of county mental health services in the past. They were more likely to use public emergency healthcare services. It is quite possible that many AB 2034 consumers are finally getting access to appropriate care that has been unavailable until now including the appropriate use of IMDs, SNFs, and residential care.

Secondly, it appears that there are significant differences across counties in terms of their use of "other" 24-hour care. For the entire AB 2034 program, there was an annualized increase of 27,253 days of "other" 24-hour care (from 52,235 days pre-enrollment to 79,488 post enrollment). However, just 5 counties were responsible for an increase of 28,766 days. (This figure is greater than the annualized increase for all programs because some programs experienced decreases in their use of "other" 24-hour care.) If these 5 counties were removed from the analysis, there would have been a small overall decrease of 1,513 days of "other" 24-hour care.

The reasons for the variation among counties in the use of "other" 24-hour care are no doubt numerous. Although possible, it seems unlikely that the consumers in the counties that used higher levels of "other" 24-hour care are in some way more disabled and therefore need a higher level of residential care. We would suggest that the single most important reason may be the lack of adequate alternative residential options for mental health consumers in some counties. Some counties appear to have had a great deal of difficulty developing lower cost supported housing options. And if it comes down to a choice of either having a consumer homeless or using "other" 24-hour care, the program will almost always choose to house the consumer.

What this points out is the critical importance of developing a continuum of supported housing options so that when a consumer no longer needs "other" 24-hour care, there is an appropriate community alternative available. As mentioned earlier in this report, recent funding provided through the implementation of the Housing and Emergency Shelter Trust Fund Act of 2002, if available to AB 2034 programs, possibly through partnering with private developers, could expand affordable housing options and make a tremendous difference in some counties' ability to reduce the use of "other" 24-hour care by consumers in their mental health systems. "Current" housing status information reported in the next section of this report contains information on the number of individuals in "other 24-hour-care, as of January 31, 2003. (See "Admission Vs. Current Residential Status Table, SNF/IMD and Residential Programs, found on Page 17.)

Current Data – Where Are People Today?

The Findings documented to this point represent information made available through the collection of monthly data, which is then added to the cumulative data previously collected. What follows is information on the "current status" of individuals as of January 31, 2003.

Since their inception, the AB 34 programs have used a "cumulative" reporting methodology. In other words, every month we collect and report another month's worth of episodes and days that the AB 2034 consumers have accumulated in the various categories we are tracking: homelessness, incarceration, hospitalization, and employment. Each month's data are aggregated with all the prior months' data, allowing us to compare the consumers' pre-enrollment and post-enrollment outcomes.

This approach makes a great deal of sense because it enables us to evaluate the success of the AB 2034 programs in improving the quality of life for consumers over time. Many of our consumers require months and years of service in order to develop the attitudes, skills and supports that will enable them to overcome and change a lifetime of counter-productive behavior. The cumulative approach toward evaluation employed by the AB 2034 programs allows for the non-linear "up-and-down" nature of recovery from mental illness. In the short run, any single AB 2034 consumer may demonstrate temporary increases in hospitalization or incarceration. But over the long run, the AB 2034 consumer population as a whole will show an overall improvement in their quality of life.

However, as useful as it is, this cumulative approach limits certain types of analysis. Using this reporting methodology, it is very difficult to report the "current status" of quality of life outcomes for consumers in the AB 2034 programs in any systematic way. For example, although we may know that 20% of all AB 2034 consumers may have experienced homelessness at some point since their enrollment, it is more difficult to say how many of them are "currently" homeless. It becomes even more problematic to make finer distinctions about where consumers are currently living. How many consumers are living in shelters, in Board and Care homes, or living independently in their own apartment or house? The cumulative reporting grids generally provide no way to identify this information.

Over time, the AB 2034 Data Committee has addressed this problem by including certain key current status variables as a part of the overall cumulative reporting grids. For example, the Housing grid page has a field that reports the "Number of consumers currently maintaining housing." But this number includes <u>all</u> consumers who are not homeless on the street, in a shelter, in jail, or in a state hospital. It makes no distinction between the members who are living independently and those who are living in, for example, a skilled nursing facility or an Institute for Mental Disease (IMD). Similarly, although we report cumulative hospitalization data pre- and post-enrollment, we had not reported the number of consumers currently hospitalized or the number of episodes and hospital days they have incurred.

The members of the Data Committee have gradually recognized that, while they are incredibly helpful in showing the long-term (years) value of the program, cumulative data have limited value for the purposes of day-to-day and month-to-month quality improvement efforts. For program managers and monitors to be able to improve the quality of the services they provide, they must have access to "current" quality of life data that allow them to benchmark the current performance of their program against other similar programs and track trends within their own program. As a result, the AB 2034 programs have begun to implement a current outcome tracking method in addition to the already well-established cumulative outcome tracking system that has been in place since the inception of the program.

The Table below provides an example of how the new current status report can provide useful information by comparing the current residential statuses of all consumers in the AB 2034 program as of January 31, 2003, with the residential status of these same consumers at enrollment. A county by county breakdown of these data appears in Appendix 6.

ADMISSION VS. CURRENT RESIDENTIAL STATUS OF AB 2034 CONSUMERS

Residential Status	Number of Consumers: Status at Admission	Number of Consumers: Status as of 1/31/03	Percent Change
Homeless / Shelter	2,578	652	-74.7%
Jail / Prison	391	148	-62.1%
State Hospital	86	9	-89.5%
SNF / IMD	52	44	-15.4%
Residential Program	190	188	-1.1%
Board and Care	70	207	+195.7%
Alcohol/ Substance Abuse Facility	219	339	+54.8%
Family of Origin	323	374	+15.8%
Independent Living	831	2,790	+235.7%
Other	140	130	-7.1%
No Data	1	0	
Totals	4,881	4,881	

The "Status at Admission" column shows the number of consumers in each residential status on their day of enrollment. The "Status as of 1/31/03" column shows the number of consumers in each residential category as of January 31, 2003. The "Percent Change" column indicates the percentage increase or decrease in the number of consumers in each of the residential categories.

These data indicate that the AB 34 programs have been extremely successful in moving consumers out of the "Homeless/Incarceration/Institutional" categories at the top of the table to the more independent residential settings at the bottom of the table. Particularly impressive is the fact that fully 62.6% of the consumers were homeless or in jail or in the

State Hospital at the time they entered the program. The number currently homeless or in jail or in the State Hospital has decreased to 16.6% (809) as of January 31, 2003. Similarly, only 17.0% of the consumers were living independently at the time they entered the program compared to 57.2% living independently as of January 31, 2003.

The next table demonstrates the current employment status of the AB 2034 consumers across the state, effective January 31, 2003.

Current Employment Status of AB 2034 Consumers as of January 31, 2003

	Number of Consumers	Percent
Total Consumers Working	650	13.3
Total Consumers Not Working	4231	86.7
Consumers working < 20 Hrs/Week	261	5.3
Consumers working >= 20 Hrs/Week	389	8.0
Consumers working in PAID employment	550	11.3
Consumers working in UNPAID employment	100	2.0

The table reveals that 13.3% of all AB 2034 consumers were working as of January 31, 2003. This equates to more than one out of eight current program enrollees involved in work. A further breakdown indicates that 5.3% were working less than 20 hours per week while 8.0% were working 20 or more hours per week. Furthermore, while most (11.3%) were working in paid employment, a small number were working in volunteer jobs without pay (2.0%).

While these results are a significant improvement over the employment outcomes achieved in prior years, they indicate that the employment of program members is a significant service challenge for the AB 34 programs. Having information about the "current" status of every individual in the program every month will allow program managers to see trends developing by comparing their own program's outcomes from month to month. This will assist them in determining if services are focused in the right area and suggest when changes/improvements need to be considered. All AB 2034 programs will begin reporting current outcome status information (in addition to the submission of their cumulative data) with the submission of their April 2003 data set. Categories for current outcomes to be reported will include: hospitalization status, incarceration status, employment status, housing status, and educational activity.

Comparison of First and Second Year Results – Sustaining Positive Outcomes

The AB 2034 programs have shown a remarkable ability to produce rapid and dramatic outcomes with the population they serve in terms of reductions in hospitalizations, incarcerations, and homelessness. One question that arises is: are the programs able to maintain these gains over time? Having collected data since the inception of the program in November, 1999, we are now able to begin to answer this question.

It is important to remember that, in the 1999-2000 fiscal year, there were only three pilot counties participating in the program: Los Angeles, Sacramento, and Stanislaus. Because of this, there are very few consumers in AB 2034 programs outside these counties who have been in the program for two years. Therefore, it is necessary to restrict our discussion of the comparison of first and second year results to data generated by the three original pilot counties.

The table below compares the 12 months prior to enrollment with the first and second year post-enrollment results for the 893 consumers from Los Angeles, Sacramento, and Stanislaus counties who have been enrolled in AB 2034 for at least 2 years as of January 31, 2003. These numbers are not "annualized" in any way since every one of the 893 consumers has two full years of post-enrollment data.

The table below compares the 12 months prior to enrollment with the first and second year post-enrollment results for the 893 consumers from Los Angeles, Sacramento, and Stanislaus counties who have been enrolled in AB 2034 for at least 2 years as of January 31, 2003. These numbers are not "annualized" in any way since every one of the 893 consumers has two full years of post-enrollment data.

	A	B	C	D	E
	12 Months Prior to Enrollment	1st Year Post Enrollment	Percent Increase / Decrease over prior year	2nd Year Post Enrollment	Percent Increase / Decrease over prior year
Number of Days Hospitalized	5,895	2,667	-54.8%	2,280	-14.5%
Number of Days Incarcerated	55,050	10,170	-81.5%	11,645	+14.5%
Number of Days Homeless	191,794	67,657	-64.7%	31,311	-53.7%
Number of Days Employed	19,163	34,720	+81.2%	43,135	+24.2%

In all four outcome categories, the data demonstrate that the magnitude of change from the year prior to enrollment to the first year post-enrollment (Column A to Column B – Percentage Change in Column C) is much greater than the magnitude of change from the first year post-enrollment to the second year post-enrollment (Column B to Column D –

Percentage Change in Column E). In the case of hospitalization, a decrease of 54.8% in the first year was followed by an additional decrease of 14.5% in the second year. In the case of homelessness, a decrease of 64.7% in the first year was followed by another large additional decrease of 53.1% in the second year. In employment days, an 81.2% increase in the first year was followed by a 24.2% increase in the second year.

There was initial concern because after a strikingly large 81.5% decrease in incarceration days in the first year post-enrollment, incarceration days actually increased 14.5% in the second year post-enrollment. The explanation for this appears to be that there were a number of AB 2034 consumers (20) who were incarcerated in their first year of enrollment and whose incarceration continued into their second year of enrollment. When the second year incarceration days for these 20 consumers are removed, we find the following:

	12 Months Prior to Enrollment	1st Year Post Enrollment	Percent Increase / Decrease over prior year	2nd Year Post Enrollment	Percent Increase / Decrease over prior year
Number of Days Incarcerated	55,050	10,170	-81.5%	9,117	-10.4%

With these days removed, the number of incarceration days shows an additional 10.4% decrease over the number of days incarcerated in the first year.

It should be remembered that, even when the "carry-over" consumers are left in the analysis, the overall decrease for these consumers from their pre-enrollment levels of incarceration is still an impressive 78.8%. Taken together, the data appear to demonstrate that the AB 2034 programs are following up their initial dramatic decreases in homelessness, hospitalization and incarceration days with continued, albeit less dramatic, reductions. Continued evaluation of these programs will indicate whether the programs can maintain these positive results over time.

For a more detailed comparison of the first and second year results, the reader is referred to Appendix 7.

Accomplishments

What we are trying to achieve and have already accomplished with AB 2034 programs has never been done before in the history of California's adult community mental health system. While it goes without saying that the actual client and system outcomes achieved are the primary accomplishment, the fiscal and programmatic design established in statute for these programs has been essential to the programs' success. Numerous programming elements make this demonstration unique, including: (1) the specific "homeless" target population being served; (2) the number of programs implemented statewide; (3) the comprehensive array of services to be provided including a focus on "housing first"; (4) the mandate for specific service model requirements essential to "best practice" programs; (5) the degree of collaboration between local mental health and law enforcement; (6) the comprehensive, real-time, outcome reporting system; and (6) the flexibility of funding provided to local programs including the ability to purchase or subsidize housing. This combination of factors provides the essential structure for establishing accountable, cost effective, "best practice" programs that satisfy the needs of both State and local policymakers. Local programs are able to determine how best to spend their funding to achieve program goals, and accountability is achieved through an outcome reporting system that is meaningful to both state and local policymakers, State DMH, and local program staff and administrators.

Accountability, Outcome Reporting and Evaluation

Both the Legislature and the Governor have demanded "accountability" from these programs from the very beginning. This is evidenced in the data collection and reporting requirements outlined in the initial legislation and in the Governor's decision to only continue funding programs if the first three pilots could demonstrate positive outcomes in the first year. Likewise, once programs were selected for implementation, DMH stressed program performance continuously and sent a clear message to all programs that ongoing funding was contingent on continued high performance. During the program's early implementation phase, DMH closely monitored the number of persons enrolled in each program, the number of persons in some type of housing, and overall program expenditures. While the focus on housing continues, we are just beginning to collect and analyze information about the specific type of housing clients are living in. This is relevant not only in terms of client outcomes but also in analyzing system costs. With most individuals in some type of housing the focus has also expanded to include employment outcomes. Currently DMH is aware that there are one or two programs whose outcomes fall below the average in some critical program areas. The intent is to monitor these programs very closely, determine why their outcomes are not better and provide technical assistance aimed at improved performance. Without the objective data collection and outcome reporting system established for these programs, DMH would not be able to measure program performance or document the program's accountability for State policymakers.

The ongoing monthly collection and reporting of objective client and system outcomes, to document the effectiveness of mental health programs and the overall cost effectiveness

of the effort, has never been accomplished before in California's adult community mental health system. Although a similar effort was conducted during the AB 3777 (Chapter 982, Statutes of 1988) demonstration period, this was limited to three programs and only 18 months of reporting. Currently there are 35, AB 2034 programs reporting client and system outcome information every month. This requires that once baseline information is obtained for each individual enrolled in the programs, line staff be responsible for reporting each and every change in status attributable to these individuals each month, such as where they are living and whether they are involved in employment or education.

The requirements for data collection and reporting, although time intensive, are critical to the success of these programs in that they send a universal message to all. That message, which resounds from line staff to program administrator, from county mental health director to State mental health director, from the Legislature to the Governor, is that what we care about is not limited to what type of mental health service someone is receiving, but rather where people are living, whether they are working, avoiding incarcerations and inappropriate hospitalizations, and generally improving the quality of their lives. This outcome reporting system is one constant that drives the type and intensity of services provided by staff in each of these programs. As the programs have matured, line staff and program administrators have become increasingly interested in comparing their program's outcomes to those reported by other programs. The collection of new "current status" information has made these real-time statistics even more meaningful to local and state staff as a measure of program performance. Currently continuous reporting of an individual's "current" housing and employment status does not occur in any other statewide mental health data system.

In addition to providing information about whether clients are experiencing improvements in their quality of life, this program's outcome reporting system provides information essential to analyzing and evaluating the cost effectiveness of these programs. As stated previously, as these programs reduce recidivism in psychiatric hospitalizations, incarcerations, emergency room use, and homeless days, significant cost savings/avoidance are realized, primarily at the local level. In addition to the local savings/cost avoidance resulting from the reductions in public services identified above, we know that there are many other direct public costs associated with homelessness that are diminished when people no longer live on the street. These include shelters, street outreach, law enforcement and court costs and other uncompensated care provided by private hospitals. Additionally there are other social and economic costs associated with allowing persons to live on the street including a higher incidence of property damage and diminished economic activity. It is expected that the information produced from this program's cost effectiveness evaluation will assist local mental health directors in documenting for local policymakers their agencies' contributions to local cost savings and cost avoidance.

Further data collection and analysis is required to more accurately determine State cost savings/avoidance associated with these programs. For the State, cost savings/avoidance results primarily from keeping persons from returning to state prison and avoiding physical healthcare costs that may have been funded by State Medi-Cal. More discussion of this

issue is contained in the section of the report entitled "Unanswered Questions" found on Page 31.

The program data collected and analyzed to date have provided important information for both state and local policymakers about individual programs' success and their ability to get persons into housing and reduce their days of incarceration, hospitalization and homelessness. This program information is also critical in helping the State identify and evaluate those programs that may have instituted practices that have led to their particular high performance. As mentioned previously, while we have learned a lot about the basics of what it takes and the costs associated with these programs, we do not know everything. Continuation of this evaluation is expected to produce information that could enhance California's long-term efforts to cost-effectively serve high-cost, high-risk persons that are the most frequent users of public healthcare services.

DMH has recently begun to compare hospitalization and Medi-Cal eligibility data reported by AB 2034 programs to data available through various state claiming and reporting systems. The reporting systems include the Client and Service Information (CSI) System, State Hospital and Inpatient Consolidation Data files, and Short-Doyle/Medi-Cal claims files. The intent of this effort is to see if the information reported from AB 2034 programs is consistent with other information sources, thereby enhancing the credibility of the AB 2034 data. A comparison of the systems showed there were fewer hospital admissions and fewer hospital days after enrollment in the AB 2034 program. The comparison also showed more people were eligible for Medi-Cal after enrollment in the AB 2034 program. The comparison was limited to about 70 percent of the clients for whom there were sufficient identifiers to match between the systems. Since the results of the comparisons are in the same direction and general magnitude, it is believed that these outcomes are representative of the entire program.

Collaboration – Beyond Expectations

While interagency collaboration has long been valued by public health and social service agencies, this program has broken new ground in terms of collaboration with law enforcement and with local landlords and employers. During the program's initial outreach and engagement phase, partnerships were formed with law enforcement that resulted in ongoing collaboration even beyond this program. Several of the programs report that, prior to their work with law enforcement on AB 2034, mental health and law enforcement agencies barely spoke to one another. As a result of the collaboration on AB 2034, mental health and law enforcement staff have developed mutual respect for each other and the work each performs. Law enforcement officers report that they now know that they do not have to do it alone. They can make a call and get help from a team and when the team arrives, they can move on to another call. Several of the programs had outreach teams that included both law enforcement and mental health staff. What follows are comments from a police officer who works directly with mental health staff.

> Talking about the mental health worker on his team he said, "Renee taught me to slow down, to listen, not to be thinking about the next call, and to ask

the person to tell me what is bothering them. As soon as you hear their story, then solving the problems and getting the resources falls into place easier. Listening opens the door to cooperation, and the guy in the uniform isn't that bad after all."

Talking about the team approach he said, "There is a huge savings in the team approach when you think about police officer time, arrest and booking costs, jail and court costs, hospitalization costs, etc. We do follow-up with 70 percent of the people we make contact with, but our follow-up is cost-effective because we are breaking the cycle of homelessness and we are treating the mental illness. Most of these individuals have had cycles of arrests and hospitalizations without anyone getting to the root of the problem. That is our job and we are doing it effectively. We would be saving the state more money if we had more access to housing. This is an obvious need in order to break the cycle of homelessness. There have to be places to live that you and I would desire to live in."

Besides the collaboration with law enforcement, these programs have had to develop partnerships with landlords, property managers, and/or hotel/motel desk clerks, to be successful in supporting individuals in housing situations. These programs have learned that to provide effective housing services, it is just as important to have staff available 24 hours a day, 7 days a week, to respond to these individuals, as it is to respond to clients. Likewise, ongoing collaboration with employers is also essential to supporting clients' employment efforts. These types of true community collaboration not only influence immediate program outcomes, but produce long-term effects with regard to the community's understanding of mental illness.

Training

The expectation that upon implementation AB 2034 program staff could immediately deliver community-based, non-traditional services including housing and employment, in a manner that produced successful outcomes, was understandably optimistic. The magnitude of the shift necessary to make these programs successful, in both philosophy and skills held by staff, cannot be underestimated. One of the unique aspects of the AB 2034 experience has been the broad and comprehensive training effort that addressed the critical need to quickly and uniformly bring a large number of individuals across counties and regions "up to speed" on the values and focus of AB 2034 legislation.

First, the expectation that AB 2034 programs would be immediately successful in getting individuals into community housing presented a major challenge for most mental health agencies. The provisions in the legislation required that mental health agencies and their contractors develop expertise in all areas of housing including transitional options, Section 8s, tenant and project-based vouchers, master leasing, and so forth. Since typical staff in mental health agencies have no training and/or education in developing housing options or providing the ongoing services and supports necessary to sustain people in housing, many programs chose to hire staff skilled in these areas. Other programs relied heavily on the

housing training provided by contractors who conducted several regional training events for AB 2034 staff. This training made it very clear that achieving positive outcomes was as much about what you believe is possible as it is about practical solutions to difficult problems. The housing expertise among program staff has increased immensely since these programs began, with that expertise complimented by the power of "belief". To date, more than 400 individuals have attended training on developing and supporting individuals in housing.

What became apparent during all of these training events is that mental health staff had to rethink concepts that were at the core of their professional training and go beyond traditional boundaries to accomplish this community work. As a result one of the more important components of the training was helping AB 2034 program staff to review and improve their own agency culture that may not adequately reflect the principles of recovery and rehabilitation. To date, over 600 staff from these programs around the state have taken part in the Village Integrated Service Agency's "Immersion Training." The Village was established as an Integrated Service Agency demonstration project under AB 3777 (Chapter 982, Statutes of 1988), and has continued to model "best practice" in California since that time. This intensive three-day training allows staff to shadow Village staff and learn strategies essential to successful community integration outcomes. Staff from diverse programs have remarked how this training not only enhanced their skills but provided the "spark" necessary to invigorate them to work with what can be an extremely difficult population.

Another reality for these programs is that both staff and clients have had to raise their expectations for each other. Generally speaking, staff had little expectation that clients could live and work independently, even with supports. For clients, there was little expectation that "the system" had anything meaningful to offer them. To address this issue, specialized training that focused on using various innovative communication tools to engage consumers, was provided to more than half of the AB 2034 programs. These tools enable staff to work with consumers to identify a comprehensive goal that he/she is motivated to attain, that will make it worth re-engaging in community life, including housing and/or employment, and will produce lasting changes. This training, known as "Using Core Gifts", is accompanied by several training sessions in other related areas. These include non-coercive motivation strategies, how to work in community settings to create a welcoming environment for AB 2034 clients, and how to use stories to create community opportunities. Identifying personal gifts and stories has been extremely valuable in serving homeless persons who all too often appear one-dimensional to staff and the community. Although challenging for staff being asked to sometimes ignore traditional boundaries, these training events have been very well received and have involved about 700 participants.

Over the past year regional and web-cast training has also been provided on delivering employment services. This training has focused on strategies for helping individuals move into employment, including but not limited to exploring basic assumptions about "readiness to work" and how individuals can maintain their Social Security benefits while they build work experience. This training also explored the idea that success may be

working for one day, and that even in job failure there are learning opportunities relevant to eventual success. These training events utilized staff and trainers from various agencies and are specifically identified in Appendix 9. To date approximately 189 staff have attended these training events.

> John, a 24-year-old Korean-American male with a dual diagnosis of major depression and cannabis abuse, had been homeless for seven months before being hospitalized in an acute psychiatric hospital for severe suicidal ideations and depressive symptoms. Upon being discharged from the hospital, John was referred to an AB 2034 Program. After they assisted John with finding emergency shelter, he moved in with a friend but was very guarded and would not share his address with staff. The program continued efforts to engage John, including providing financial support to obtain a more secure living environment. John began to trust the staff and accepted assistance in obtaining his Supplemental Security Income (SSI) benefits.
>
> With the receipt of SSI, John was able to secure a studio apartment in Koreatown. As his living situation improved, his depressive symptoms began to subside. He continued to feel better about himself, and made the decision to start looking for work. He stated that he did not want to live on SSI for the rest of his life. Presently, John is employed full time with a law firm as a mail clerk. He no longer receives SSI and continues to live successfully in his apartment. He continues to benefit from the program's support and assistance in maintaining his employment and housing.

As mentioned previously, the challenge to improve employment outcomes is among the most difficult for both staff and clients. As reported by county programs, there is no doubt that the intense level of training that has been provided enhanced their ability to initially engage the individuals enrolled in the programs, produce successful housing outcomes and begin to make strides with employment. The various training events had benefit beyond the specific curriculums addressed. They were generally conducted regionally and brought together both county and contract staff from various programs, who always learned from each other's experience. As mentioned, the education of typical mental health agency staff did not include delivering housing and/or employment services. And, since these types of services are not typically the responsibility of mental health agencies and are not eligible for Medi-Cal reimbursement, most mental health agencies do not provide them and therefore do not train staff in these areas. Many of the county programs have community-based contract providers staffing their AB 2034 programs. Frequently these contract agency staff have more experience with community-based services like housing and employment and therefore are able to share their expanded expertise. For many of the staff working in AB 2034 programs, the only training they have received in outreach/engagement, rehabilitation and recovery, housing and employment, is that funded by AB 2034. Although it is certain that the training thus far has been

meaningful and contributed significantly to the success of these programs, there is still a need to continue working with staff to ensure that their service strategies can sustain people in housing and employment over the long term. And as the programs continue to mature and improve their own abilities, opportunities for programs to come together and share their expertise will continue to be of value.

In addition to the formal training events described, AB 2034 utilized the expertise of the program coordinators from the first three pilot programs in Los Angeles, Sacramento and Stanislaus to facilitate ongoing regional meetings for AB 2034 program coordinators. These events continue to provide excellent opportunities for transferring knowledge from one program to another. Staff have witnessed the change in dialogue over the last two years from "how do we do that?" to "here is how we do this." In addition to facilitating the regional meetings these three coordinators also made site visits and provided individual technical assistance to other local programs.

The ongoing work of the AB 2034 Data Committee, led by contract evaluation staff, has also been essential in ensuring that programs are clear about data collection and reporting requirements. Although for efficiency this committee does not include representation from all 35 programs, each region has at least two programs in attendance and has both program coordinators and data evaluation staff participating. The minutes of each meeting, including changes in data reporting requirements, are distributed to all programs. DMH has been impressed with the high level of interest all programs have in this process.

Throughout this experience, the expertise and ongoing assistance of all training and technical assistance contractors has been invaluable. (See Appendix 9 for a complete list of all training, technical assistance and evaluation contractors.)

Beginning to Change Attitudes

With most projects having been operational for about two years, we are still only beginning to change attitudes about and expectations for individuals with serious mental illness who are homeless or at risk of homelessness. Since the beginning of the program, both local and state staff have been impressed with the projects' ability to get individuals into immediate housing. What has become apparent to most is the therapeutic significance of having a stable place to live and the foundation this provides for individuals' ability and desire to make progress in other aspects of their lives. Each client's success has positively influenced the expectations and attitudes of other clients, staff, local landlords and property managers.

Having been so successful in getting persons into stable housing, the projects have begun to focus on employment goals for individuals. As discussed, for many staff and clients, this is a major shift and requires them to significantly alter their existing expectations. As time goes on and staff and clients are exposed to successful employment outcomes achieved by persons enrolled in these programs, these results will have far-reaching influence on employers and other members of the community.

As discussed previously, one of California's goals is to incorporate what we learn from AB 2034 programs into traditional adult mental health services for those populations who may frequently use public healthcare services in ways that do not result in positive outcomes. If this is to occur then the traditional system needs more evidence that the practices employed in the AB 2034 community-based programs are generating not only positive client outcomes and local cost efficiencies, but evidence that these outcomes can be maintained over time.

What We Have Learned

The legislation that established the AB 2034 programs provided a description of the comprehensive services to be delivered to individuals who are homeless or at risk of homelessness and emphasized other programmatic requirements expected. What follows is a description, based on the programs' experience, of the program elements considered to be critical to this model's success.

Small caseloads for Personal Service Coordinators (PSCs)
The frequency and intensity of contact between PSCs and their clients, essential to supporting and tracking outcomes on individuals who frequently have both mental health and substance abuse issues as well as chronic health issues, demands that staff to client ratios be very low. It is also important to utilize multidisciplinary, culturally competent teams made up of individuals who reflect the color, ethnicity, language, consumer culture and homeless culture familiar to homeless individuals outside the mainstream community.

24 Hour, 7 Day a Week Availability
It is essential that staff be available 24 hours a day, 7 days a week to respond to clients, landlords and law enforcement. Without this ability to respond situations can escalate resulting in unnecessary hospitalization, incarceration or eviction.

Field or Community Based Services
It is essential that programs provide services in the field and do not expect that clients will come to them for service or support. Also, the non-traditional type of services provided by these programs, such as housing and employment, require a community presence.

Housing and Work First
Some staff may have had doubts initially about a mental health program providing housing for an individual without any commitment that they might accept mental health treatment down the road. The question might be asked "where is the treatment?" with the answer being "it is in the housing and it is in the work." What has become apparent to most is the therapeutic significance of having a stable place to live and the foundation this provides for individuals' ability and desire to make progress in other aspects of their lives. For example, it is very difficult to find ongoing employment when you do not have a place to live. Like housing, employment can provide many therapeutic benefits for individuals including pride in working and getting a paycheck and opportunities for

socialization. The goal in AB 2034 programs is for the housing and employment to support treatment rather than the other way around.

Harm Reduction

Harm reduction is a set of practical strategies utilized to sustain individuals in housing. These principles include accepting for better or worse that licit and illicit drug use is part of our world and choosing to work to minimize its harmful effects rather than simply ignoring or condemning them. Harm reduction recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm. Harm reduction does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use, but does establish the quality of individual and community life as the criteria for successful interventions and policies. Consistent with harm reduction principles, AB 2034 programs have learned that there is no one way to implement harm reduction. Instead individuals enrolled in these programs need varying supports, which may or may not require a sober living environment. Harm reduction strategies meet clients "where they are at", to address the conditions and consequences of drug use along with the use itself.

Flexible Funding

AB 2034 program staff report repeatedly that having the ability to bring something tangible to the homeless consumer at the right moment is often the key to successful engagement. This can be done in large or small ways, but either way requires the ability to access funds immediately and flexibly. Wraparound funds available through petty cash, credit cards or vouchers to purchase something as basic as shampoo, a night's lodging or food and clothing are essential. On a larger scale having the ability to contribute significant funding to complete the rehabilitation of an old apartment complex in exchange for guaranteed access for the target population, or the ability to guarantee a landlord that any damage will be repaired or rent subsidized, is also critical to success.

Consumers as Employees

Consumer employees carry the message of hope and do so with credibility. They challenge the assumptions of both staff and other consumers about what is possible. Several of the AB 2034 programs have hired consumers as staff and considered it to be a significant factor in their success.

True Community Collaboration

With successful outreach and engagement, "deals" may be made by mental health workers on the street corner, outside the jail, on the riverbanks or in homeless shelters. Two things are essential: you exchange something that is meaningful to each party and you keep your promises. What was learned during the focused outreach and engagement phase of these programs has been applied in new collaborations with both old and new partners. To get the job done AB 2034 programs identified who they had to engage (law enforcement, landlords, employers, housing authorities, local businesses, neighborhood associations), identified what would be meaningful to them, and then kept their promises. Due to the flexibility of funding, this could really be successful because the programs had

something tangible to offer – money and the flexibility to do what was needed with that money. This level of collaboration has bred new appreciation, credibility and respect among individuals and agencies that had previously been suspicious or at odds with each other.

Training

As described previously, one cannot underestimate the magnitude of the paradigm shift necessary to the successful implementation of AB 2034 programs. We have learned that the State can have a major impact on local programs by funding training that helps staff make the shift to a service delivery system that embodies the principles of recovery and rehabilitation. As stated previously, since most local mental health agencies are not focused on housing and employment services, the training provided by the State is the only mechanism available to provide staff with the tools and skills they need to do this work. All training and technical assistance opportunities are considered essential in supporting, sustaining and enriching local staff. They also further "best practices" at the statewide level.

Data Feedback Loop

Local AB 2034 programs would no doubt report that collecting and reporting the required outcome information has been very difficult and time consuming. However, none have questioned the value of the data itself for both local program staff and state policymakers. When program staff understand that State policymakers as well as other local programs have access to and are reviewing every program's outcomes, accountability is significantly increased.

The State's Role

What we have learned is the significant impact the State can play in supporting the development of "best practice" programs. By establishing incentives such as flexible funding local programs have the ability to provide comprehensive services without major reliance on Medi-Cal reimbursement. Only the State can make that happen across California's counties. Another factor is the means by which the State determines accountability. In these programs the State has identified how they want to measure performance in the information they track. AB 2034 programs track information about where people are living, whether they are employed, and whether they are being hospitalized or incarcerated. This in turn drives the focus of services at the local level. Uniform, statewide data collection, reporting and evaluation requirements, enable individual programs to establish benchmarks for performance and measure themselves against other similar programs. California benefits from the ability to compare performance and cost effectiveness in the long-term across programs, and learn from both programs' success and failures. Only the State can mandate that this type of information be collected uniformly across programs. Finally, the impact of the State's role in providing ongoing, comprehensive training, that brings programs together regionally and individually to solidify values and best practice strategies cannot be underestimated.

Unanswered Questions

True Savings

We know a lot about what types of cost savings/avoidance are achieved as a result of persons being served in AB 2034 programs, but we do not know everything. For example we know from outcomes reported by these projects that as a result of reduced hospitalizations and incarcerations these programs have produced approximately $24.7 million in cost savings/avoidance.

37,938 Hospital Days Prior to Enrollment minus 16,778 Hospital Days Post Enrollment = 21,160 Hospital Days Reduced x $550.00 (average hospital day) = $11,638,000.

213,106 Jail Days Prior to Enrollment minus 59,434 Jail Days Post Enrollment = 153,672 Jails Days Reduced x $85.00 (average jail day) = $13,062,120

$11,638,000 + $13,062,120 = $24,700,120

On the other hand, another element of service information not currently included in this evaluation also produces significant cost savings. That element is information about the use of medical emergency room services by persons prior to and after their enrollment in these programs.

Information reported on the evaluation of the Corporation for Supported Housing's "Health, Housing Integrated Services Network" indicates that the average number of emergency room visits for persons tracked in this study decreased by 58% in the first year of living in supported housing. The program studied is an initiative of the Corporation's California Program and was implemented in San Francisco. The study, which tracked the participant's use of San Francisco General Hospital's emergency room, estimated that the typical emergency room visit costs $182.00, while the cost of a psychiatric emergency episode is about $550.00. (These are only the hospital costs and do not include the cost of medical procedures and tests, doctors' fees, or any costs for an inpatient admission that may follow the emergency room visit.)

To date this report has only addressed costs associated with acute psychiatric hospitalizations, and has not included any information about either medical or psychiatric emergency room utilization. Most often this type of information is not readily available to local mental health departments unless they actually own or operate hospital emergency facilities. As a result, DMH asked for information on emergency room usage from those programs indicating they could provide it. Stanislaus County Behavioral Health operates the only psychiatric emergency room in the county. They were therefore able to retrieve information about their enrollees' use of psychiatric emergency room episodes from one year prior to enrollment to the present. The information provided indicates that for the 262 clients currently enrolled in the program, psychiatric emergency room visits have decreased from 165 to 53 for a 67.9% reduction. Similarly Sonoma County reports that for the 69 clients currently enrolled, psychiatric emergency room visits have been reduced

from 92 to 41 for a 55.4% reduction. Although we do not have information from every project about psychiatric emergency room episodes, or any information about medical emergency room visits, the information we do have appears generally consistent with the comprehensive study conducted in San Francisco. We therefore have confidence in reporting that we conservatively estimate these programs result in additional local cost savings/avoidance of at least $2.7 million annually, just as a result of reduced psychiatric emergency room episodes. This estimate assumes that each of the 4,881 clients currently enrolled in AB 2034 programs were seen in a psychiatric emergency room setting at least twice during the year prior to enrollment, and only once in the year after enrollment. The cost of the emergency room visit is estimated at $550.00. The calculation is as follows:

4,881 individuals x 2 emergency room visits =9,762 x $550 = $5.4 million
4,881 individuals x 1 emergency room visit = 4,881 x $550 = $2.7 million

Beginning April 1, 2003, persons enrolling in AB 2034 programs will be asked about past emergency room visits, both medical and psychiatric, during the previous 12 months. This will add to the existing baseline information gathered about these individuals. Information will also be collected from this point on about psychiatric and/or medical emergency room use post enrollment.

We know that there are many other direct costs attributable to homelessness including shelters, street outreach, law enforcement and court costs, and other uncompensated care provided by private hospitals. Additionally there are other social and economic costs associated with allowing persons to live on the street including a higher incidence of property damage and diminished economic activity. Although this evaluation did not include identifying and quantifying all public costs associated with homelessness, a recent study performed by the University of Pennsylvania's Center for Mental Health Policy and Services Research has.

This five-year study tracked 4,679 homeless individuals with psychiatric disabilities who were placed into service-enriched housing created by the 1990 New York/New York Agreement to House Homeless Mentally Ill Individuals, a joint initiative between New York City and New York State. This agreement is known as the NY/NY Agreement. This study was the most comprehensive evaluation ever to measure the impact of service enriched housing on homeless persons with mental illness. The study quantifies the tremendous reduction in public costs that occurs when these individuals are placed into permanent and transitional housing enriched with supportive and clinical services.

The researchers examined the use of emergency shelters, psychiatric hospitals, medical services, prisons and jails for individuals living in service-enriched housing in the two years before and after they were placed in housing. They then compared their service use in these two time periods to the service us of control groups of homeless individuals with similar characteristics who had not been placed into NY/NY housing. Collaborating with eight different government agencies, the researchers were able to establish the cost of each type of service use, as well as the cost of constructing, operating and providing services in NY/NY housing.

The quantified reduction in public costs was then compared to the expense of building and operating housing. The study showed that it cost the public only $1,908 more a year to provide service-enriched housing to an individual with mental illness than it does to allow him or her to remain homeless. Overall the study showed that:

- A homeless person with mental illness in New York City used an average of $40,449 of publicly funded services over the course of a year.
- Supportive housing – independent housing linked to comprehensive health support and employment services – provides major reductions in costs incurred by homeless persons with mental illness across seven service systems.
- The reduction in service use pays for 95% of the costs of building, operating and providing services in supportive housing, and 90% of the costs of all types of service-enriched housing in New York City.

Like the evaluation of AB 2034 programs, this study did not measure the positive impact the housing had on the community, by rehabilitating abandoned buildings, revitalizing neighborhoods, increasing jobs and boosting economic activity.

True Costs

Like savings, while we know a lot about what the costs are to serve individuals enrolled in AB 2034 programs, we do not know everything. Currently each program receives grant funding to provide the comprehensive array of services required. This funding, however, was never expected to support all the services that these clients might receive. We know that there is other system funding that supports these clients. For example when an AB 2034 client is hospitalized in an acute psychiatric hospital, it is not AB 2034 program funding that covers the expenditure. Although we do not know the exact dollars spent on these hospitalizations, we have reported the estimated cost avoidance based on the overall reduction in these types of services. During the past year DMH has expanded its data collection requirements to include reporting on individuals receiving other types of 24-hour care, different from acute psychiatric hospitalization. Examples of this would be services in crisis or long-term residential facilities, skilled nursing homes, or Institutions for Mental Disease (IMDs). Although we believe that the costs of these services is still less than would occur if individuals remained homeless, we think it is important to begin to understand all the costs associated with serving this population.

What Does It Take?

What does it take to maintain these programs over time including sustaining individuals in housing and increasing their involvement with employment? How long does it take before individuals are able to pay all of their own housing costs and no longer rely on some subsidy from AB 2034 programs? What percentage of enrollees can we expect to eventually "graduate" from this program and sustain themselves outside of the mental health system? How long will it take for most individuals to take part in at least part-time employment? We know that achieving employment goals can take much longer than

getting someone housed. What level of Medi-Cal reimbursement can we expect these programs to generate and still be accountable for delivering those essential services like housing and employment not fully reimbursed by Medi-Cal? How much training is necessary for staff to become proficient in the delivery of employment services? Some of the AB 2034 programs have begun to analyze questions like this, which cannot be answered in the first few years of programming but instead need to be reviewed over a longer period.

Influence on Criminal Re-offense

How successful are these programs in preventing persons from returning to state prison? How many of the jail days reported for individuals post-enrollment are related to offenses committed prior to their enrollment? We know that one factor contributing to a person's choice to remain homeless has to do with past criminal behavior, including outstanding warrants and probation violations. When persons choose to enroll in this program it frequently means that they will also have to take responsibility for past offenses. Individuals in this situation can expect that staff will utilize mental health or homeless courts and stand beside them to advocate for continued program services rather than incarceration. As a result, many clients are able to bring closure to outstanding criminal justice issues that have contributed to their homeless status. In instances where incarceration does result either due to a past or new offense, program staff are able to offer continuing enrollment and support services for up to one year and re-enrollment in the program if the person is released after one year.

Recently, a few counties reported information about the number of jail days post-enrollment that were attributable to offenses committed prior to program enrollment. Although for this report information was limited, it provided evidence consistent with anecdotal reports. Fresno County reported that 58 consumers were incarcerated in the 12 months prior to enrollment for a total of 6,578 days. Post-enrollment, 34 consumers were incarcerated for a total of 2,982 days. Of those 34 consumers, 22 were incarcerated for 2,031 days for crimes committed prior to enrollment in the program. In other words, of the 2,982 days of incarceration that occurred post-enrollment, 68.1% were for crimes committed prior to enrollment in the program. Further reporting in this area will be explored and evaluated.

Barriers that Still Exist

Limitations on Funding

As mentioned in this report, one advantage of the AB 2034 programs is their ability to pay for services essential to serving homeless individuals that are not reimbursed by Medi-Cal. Most local mental health programs rely on two primary sources of revenue: realignment funds and Medi-Cal funds. Since the realignment dollars are used to match federal dollars for mental health services, this leaves little if any funding available for non-reimbursable services such as outreach, housing and employment.

Staff Resources

Also previously discussed is the general lack of staff statewide who have been trained to deliver the array of community-based services critical to serving homeless individuals. Most clinically licensed staff have never received formal training or education in delivering outreach, housing or employment services. While many of these services can be delivered by non-licensed, community mental health workers, clinical oversight is critical to success. To make this work clinical staff must also be familiar with the values, attitudes and strategies associated with achieving real community integration for clients.

Housing Resources

The lack of affordable housing in California is a statewide issue. The increased housing costs that have occurred just in the last few years have led to more persons being displaced and at risk for homelessness than ever before. For persons with serious mental illness, who frequently rely on Social Security Income (SSI) as their only form of income, the goal to live in their own apartment or house is economically unfeasible. Increasing the income of these individuals through employment while desirable, is almost impossible unless they first have a stable living situation. Therefore unless programs have flexible funding that enables them to purchase and/or subsidize housing, clients are caught in a "Catch-22" situation of not being able to find work until they have a place to live, and not being able to afford a place to live until they are employed. One hopeful development has been the recent passage of Proposition 46, the Housing and Emergency Shelter Trust Fund Act of 2002. This Act currently contains $195 million to provide low-interest loans for supportive housing projects that provide health and social services to homeless individuals with disabilities including persons with mental illness. Since this funding is only available for the housing itself and does not support the services or subsidies necessary to sustain persons in the housing, programs like AB 2034 may be able to provide a source of rental assistance and service funding to match the capital development funding.

Attitudes

As stated previously, all too often homeless persons appear one-dimensional to service providers, business owners and the community in general. The expectation that most of these individuals can live independently, gain employment and generally improve the quality of their lives is not the attitude held by most. Documenting and publicizing the success of AB 2034 programs is one way to change these attitudes and increase quality of life options for California's homeless citizens with mental illness.

Conclusion

We know that thousands of California's citizens have already experienced improved quality of life outcomes as a result of AB 2034 programs. This in turn has produced significant cost savings/avoidance for local government entities including healthcare providers and law enforcement, and led to improved community outcomes in general

across the state. Statutorily State policymakers have fulfilled their leadership role by establishing incentives that enable and inspire "best practice" at the local level and that by definition are outcome based and accountable for their efforts. This has been accomplished by: (1) awarding flexible funding to local programs to provide a comprehensive array of services designed to meet the needs of the individual; and (2) requiring accountability through objective, timely reporting of client and system outcomes that are meaningful to the persons served and California's taxpayers.

The outcomes reported in AB 2034 programs give just the facts. Do people have a place to live, are they staying out of the hospital and out of jail, are they insured and are they getting jobs? The "current status" information now collected and reported by AB 2034 programs answers these questions in real time and documents success in all of these areas. Ideally this documented success, including the local cost savings/avoidance realized, will lead to the expansion of similar programs to serve additional homeless individuals with serious mental illness and others who are the most frequent, high-cost users of public healthcare services.

As stated previously, State policymakers, DMH, county mental health directors and administrators, contract training and evaluation staff, and most importantly local line staff and the clients themselves can take pride in what has been accomplished. DMH would like to particularly acknowledge the line staff and others involved in the data collection, reporting and evaluation effort. This level of continuous "real time" reporting has never been achieved in the adult mental health system. Additionally, continuous, current reporting about an individual's housing and employment status is not available from any other statewide mental health data system. The caliber of this labor-intensive effort speaks to staff's dedication to these programs and the persons being served.

Currently AB 2034 programs serve about 5,000 persons, or 10% of the estimated 50,000 homeless individuals in California with serious mental illness. Continuation of the existing programs looks hopeful and funding is included in the Governor's Proposed Budget for Fiscal Year 2003-04 via county realignment. It is expected that persons currently served in these programs will leave for various reasons, (including having achieved stability and recovery) thus enabling the programs to serve some new individuals. However, given legitimate budget constraints at the state and local level, actual program growth and expansion of these services to other homeless citizens of California who have mental illness is not certain. Many local mental health agencies are seeking alternative funding consistent with delivering integrated, comprehensive services to persons in their communities. As the results outlined in this report have demonstrated, enormous benefits, both clinical and fiscal, are likely to accrue from expanding and increasing these types of services.

We would like to close this report by encouraging readers to review Appendix 2 containing several personal stories about the individuals served in this program. These stories document the diversity of these individuals, their backgrounds, and the personal challenges they faced as a result of circumstance and mental illness. This report

acknowledges these individuals and the courage they have shown in their struggle to recover and demonstrate who they really are.

FISCAL YEAR 2002-2003

AB 2034 PROGRAMS

County Programs	Current Year Funding	Number of Consumers Currently Enrolled	Date of Grant Award
Berkeley City	$ 955,000	108	11/13/2000
Butte	$ 716,250	49	11/13/2000
Contra Costa	$ 261,250	62	6/29/2001
El Dorado	$ 764,000	53	11/1/2000
Fresno	$ 1,910,000	144	11/13/2000
Humboldt	$ 506,666	31	1/17/2001
Kern	$ 1,289,250	143	11/13/2000
Los Angeles	$ 17,448,825	1,694	11/13/1999
Madera	$ 620,750	50	11/13/2000
Marin	$ 1,432,500	103	11/13/2000
Mendocino	$ 506,666	38	1/17/2001
Monterey	$ 308,000	23	7/1/2002
Napa	$ 247,999	25	6/29/2001
Orange	$ 1,146,000	93	11/13/2000
Placer	$ 811,750	82	11/13/2000
Riverside	$ 1,671,250	157	11/13/2000
Sacramento	$ 4,968,475	295	11/13/1999
San Bernardino	$ 1,074,375	156	11/13/2000
San Diego	$ 3,581,250	253	11/13/2000
San Francisco	$ 2,196,500	121	11/13/2000
San Joaquin	$ 955,000	114	11/13/2000
San Luis Obispo	$ 955,000	118	11/13/2000
San Mateo	$ 950,000	71	1/17/2001
Santa Barbara	$ 1,432,500	99	11/13/2000
Santa Clara	$ 456,000	37	3/17/2001
Santa Cruz	$ 401,100	30	11/13/2000
Shasta	$ 811,750	57	11/13/2000
Solano	$ 791,666	105	1/17/2001
Sonoma	$ 1,193,750	66	11/13/2000
Stanislaus	$ 3,344,345	262	11/13/1999
Tehama	$ 764,000	57	11/13/2000
Tri City	$ 955,000	79	11/13/2000
Tuolumne	$ 143,250	11	11/13/2000
Ventura	$ 955,000	67	11/13/2000
Yolo	$ 506,666	28	1/17/2001
Total	$ 57,031,783	4,881	

Consumer Stories

CONSUMER STORIES

What follows are consumer stories generally told by AB 2034 coordinators and some letters written by consumers themselves. As stated previously in this report all too often homeless individuals appear one-dimensional to mental health staff and community members in general. These stories document the diversity of these individuals, their backgrounds, and the personal challenges they faced as a result of circumstance and mental illness. In all cases either names have been changed or releases have been obtained to share this information. Some of the stories have been edited.

Chris' Second Chance

Now in his 50's, Chris (an alias) was a star cross-country runner in High School. After sustaining hip and wrist injuries in the Viet Nam war, he married, started a family and secured an office job in the electronics industry. When he was around 30 years old, his wife left him and he began a 15-year battle with alcohol and crack binging, homelessness and severe mood swings. A year later, he grew severely depressed and was barely stopped from jumping off the Bay Bridge, leading to his first psychiatric hospitalization. Afterwards, he continued drinking and using drugs, with increasing arrests for trespassing, drinking in public, and crack cocaine. He became a familiar face to local law enforcement and court personnel.

Chris tried to get treatment for his war injuries (which got worse due to being homeless), but doctors at the VA withheld needed surgery due to his homelessness and drug use. At age 40, he was diagnosed with congestive heart failure and soon afterwards developed pancreatitis. And, his mobility impairment grew worse. The VA benefits he successfully applied for were just $300/month, and his substance use and depression grew worse. He needed a payee for the V.A., and he arranged for the owner of a liquor store to take this on. Vodka and ice cream were his common breakfast, and he often panhandled and drank all day.

Chris had a passion for writing. He bought a typewriter in the late 1990's and for years he worked on a novel. Despite being homeless, he carried the typewriter with him everywhere he went. He slept in a tent, and frequently wore dresses in public. In court-ordered evaluations, the doctors determined that he had bipolar. By age 42, he had been in seven recovery programs without stabilizing his life. He had tried to get help at the VA clinic, but due to his temper and their limited resources, he was not able to get the kind of help he needed.

In April of 2001, local mental health agency staff out-stationed at the municipal courts referred Chris to the AB 2034 program. He was assigned a service coordinator who got to know Chris by visiting him regularly – usually in jail and at the vacant lot where his tent was. The coordinator reports: "When I saw him drunk as a skunk on the streets, I would sit and talk and listen to what he had to say. We would exchange war stories – I was in the military too." As their relationship evolved, Chris agreed to let his coordinator bring him to the Homeless Veterans Rehab Program. Chris relapsed while he was in the program, and returned to living on the streets. Next, his coordinator got Chris into an independent living, clean and sober renovated hotel program for homeless veterans. He did better this time, but Chris relapsed on crack and got kicked out. Months later, with his coordinator's help Chris was re-admitted to the VA program. This time, Chris stayed with the program 18 months. He successfully proved that his wrist disorder was combat-related, and won an increase in his benefits. Last fall, with his new higher income in place, he was able to rent an unsubsidized apartment, buy a car, and get the hip replacement surgery he needed.

Recently, he finished his novel, got it bound, and is now looking for a publisher. Chris also reunited with his sons after many years without contact. He has had a very good response to mood stabilizer medications, with no serious mood episodes in over a year. He now requires infrequent support from his coordinator, and feels like he is getting a second lease on life.

Frank's Wild Years

The client (alias Frank), an African American male now in his 40's, grew up in the South and played for his college basketball team. Though diagnosed with schizophrenia as early as high school, it wasn't until his second year in college that it dramatically changed his life's path. His delusions became more compelling and his behavior became extremely bizarre. He began a long and dangerous period of homelessness, alcohol use and very severe psychiatric symptoms. He got on SSI before he was 20, after spending almost a year in one psychiatric facility. As his service coordinator put it, "Frank wandered the country east to west, north to south, in just about every state, for about 20 years." He sometimes drank heavily, but other times not at all.

When Frank arrived in the Bar Area in 1996 he was extremely delusional, paranoid, malodorous, disorganized, and very bizarre in appearance including putting unusual substances on his hair and face. His menacing facial expression and odors of urine both limited his access to conventional homeless services. In the late 1990's alone he had 15-20 different psychiatric inpatient admissions. The local psychiatric hospital had referred Frank to the local mental health agency more than once, but Frank did not follow through and in general things did not appear to be changing.

After the local mental health agency was awarded an AB 2034 grant, outreach staff began attending case conference meetings at a local outpatient drug and alcohol recovery program, which primarily served homeless and court-ordered individuals. Frank was using their services at the time, so they referred him. He was assigned a recently hired coordinator who reports: "I started engaging him by helping him get I.D. and offering him payee services, which he accepted. We started budgeting his money and got him hooked up with one of the psychiatrists on the AB 2034 team. He began coming to the clinic daily for money and medications" (which he took voluntarily in front of staff).

As Frank's recovery program began to work more effectively with their dually diagnosed clientele, Frank improved. He moved into one of their transitional housing units, graduated from the program and briefly entered a hotel room subsidized with AB 2034 monies. Simultaneously, the local mental health agency opened a new semi-independent living program in collaboration with a local shelter program, using funds from AB 2034 and a federal grant. Frank moved in, and his strengths began to show. He revealed a strong motivation to work, and he was referred to a county vocational program where he was placed in a 3-month job working with the local Food Bank. He gained a lot of self-confidence and exhibited greater independence and stability. He had a difficult time when that position ended, but with support he averted a serious relapse. He continues seeking employment in the private sector.

Throughout these months, he has struggled with his intense urges to travel again. With his coordinator's help, he successfully visited his family in the South last December. For the first time in his adult life he has a home which he can leave and return to. Thus, he has learned a significant new way to manage his urges to travel. According to his coordinator, "His mother expressed utter amazement and satisfaction that he did this. He still considers going to live back near his family in the South, but he's made the commitment not to become homeless again, meaning to take medications, get a payee, have a place to stay set up before going. We've interrupted his cycle of just wandering around and moving on after a bad experience."

Scott

Scott enrolled in an AB 2034 program in December 1999 after a long history of self-medicating his symptoms of bipolar disorder with alcohol, and several suicide attempts. He acknowledges that his alcohol abuse and failure to maintain treatment for his mental illness contributed to his inability to keep a job. He was also chronically homeless. After enrollment, the program assisted Scott with obtaining housing in a sober living program where he worked on maintaining sobriety. He soon began to value the benefits of psychiatric medications and to take an active role in the management of his symptoms.

Scott became involved with the program's Job Development program, a comprehensive vocational rehabilitation program designed to assist individuals in obtaining employment. Scott secured employment as a member of a street sweeper team that maintained the downtown streets and storefronts. The program continued to provide support and guidance regarding work related problems and successes. Gradually, Scott's work responsibilities increased until he was promoted to be a supervisor with several employees working under his supervision.

Although, Scott continues to struggle with the ups and downs of his psychiatric disorder, with the help and support of the AB 2034 program, he continues to excel. Presently, Scott has maintained his sobriety for two years, full time employment for one year, and his own apartment. His most recent achievement has been to purchase a car.

Mary

Mary enrolled in the AB 2034 program in October 2000 after being released from a correctional facility having served a 180-day sentence for narcotic possession. Mary, diagnosed with bipolar disorder, had a history of numerous hospitalizations due to severe depression, multiple suicide attempts, and a nine year addiction to crack cocaine. Mary entered the AB 2034 program with the desire to get off drugs, get a job and stay out of the hospital. The program assisted her in addressing her substance abuse by linking her to a residential sober living recovery program. Program staff also assisted her in reconnecting with family and positive friends and making concrete plans for permanent housing, school and employment.

After leaving the residential recovery program, Mary worked as an office clerk in the program's Work Experience program, a supportive employment program designed to provide individuals with practical work experience in a competitive environment while receiving necessary support. This met her dream to work in an office, because "women working in an office are well respected by society". Additionally, the program assisted Mary with enrolling in the local community college's computer skills program. Mary excelled in her job as an office clerk, serving as a role model to other consumers who admired her professionalism and excellent work ethic. Because of Mary's achievements, she was referred to the program's Job Development program, a comprehensive vocational rehabilitation program designed to assist individuals in obtaining employment in the community. Through this program she secured employment as a receptionist in a travel company.

Mary still struggles with depression and urges to use drugs. However, her new role in society as a "woman working in an office" has kept her motivated to continue working towards her dreams. Mary has accomplished several noteworthy achievements. She has completed over 12 months of sobriety,

maintained a "B" average in college, maintained her first independent apartment in the community, and been awarded Employee of the Month.

Charles

Charles initially had contact with the AB 2034 Program in October 2001. He stated that he was homeless, had been severely depressed for some time, and that he had frequent panic attacks. These attacks were so severe that he often "hid out from other people." After the program lost contact with Charles in November 2001, he resurfaced five months later and services were re-instated with the hope of developing a strong and trusting relationship with him. As Charles began to regain hope and report that his symptoms were more manageable, he expressed an interest in getting back to work.

Charles indicated he had a background in hotel management. In May 2002 he was presented with an opportunity to interview for an assistant manager position with a property management company. The position offered a monthly salary of $1,200 and a free one-bedroom apartment on the premises. Despite the fact that he was nervous, he was eager to apply. The manager offered Charles the position at the conclusion of the interview. Charles is still employed at the apartment building and has expressed interest in expanding his responsibilities to other sites owned by this property management company. They have been very receptive to his ideas and continue to meet to discuss his options in the company. Today, Charles appears to be a completely new person, who is able to smile and interact with peers in a friendly and caring manner.

Leslie

Leslie enrolled in an AB 2034 program in January 2000 after being incarcerated in a correctional facility since September 1999. Prior to enrolling in the program, Leslie had lived for nine years in her car, parking in various parking lots in Van Nuys or North Hollywood. She would not accept any shelter/housing because her life was committed to her two dogs. Leslie and her dogs would sleep in her car at night and hang out at the local park during the day. Leslie never thought about getting help for her depression or psychosis because she thought only about drugs and the care of her dogs. However, her last incarceration gave her time to rethink what the use of drugs was doing to her life. She decided that she needed a treatment program in order to survive. Diagnosed with major depression with psychotic features, Leslie began seeing a staff psychiatrist and taking prescribed medication. She participated in the AB 2034 program regularly and was active in groups, volunteered, and began to understand the affects of drugs on her life. Once she enrolled in the program, she was able to get off the streets and stop using drugs. Over a period of three years, she moved from shelter living, to independent transitional living, to a Section 8 apartment. Leslie was accepted into the local mental health

agency's Dual Diagnosis Peer Advocate/Counseling Program, and did an internship at a residential drug rehabilitation center. Other peer trainings followed and Leslie became a voice for the homeless mentally ill.

In 2000, Leslie was offered a paid, part-time position at the residential drug rehabilitation center assisting clients in obtaining benefits. In addition, in September 2002 she acquired a paid-time position as a Peer Counselor at a Family Housing Shelter. Presently, she is working at the local community mental health center as an assistant money manager and facilitator of a Life Skills Group, while maintaining her positions at the residential drug rehabilitation center and the Family Housing Shelter.

Although employment initially sparked fear and anxiety for Leslie, she was able to overcome her fears and "beat the odds" with the encouragement of staff members. The numerous successes that Leslie has achieved in her employment have proven to be an inspiration for other clients of the AB 2034 program.

Samuel the Mountain Man

While the success of the AB2034 program is most easily measured by the number of homeless individuals who now have roofs over their heads or by the significant decreases in their psychiatric hospitalizations or arrests, there is another side to the success of this program that is hard to quantify. Persons who used to be isolated, shunned, or ignored are no longer alone. For many of the AB 2034 members, this may well be the most important accomplishment of all. For Samuel, that has certainly been the case.

Looking at Samuel on the street today, most people would not imagine that he is a "success". His 6' 4" frame causes him to stand out on the street, a lanky middle-aged man with long hair and a thick gray beard that brings to mind the image of Grizzly Adams. To the casual eye, he might look a little "odd" as he walks around town or up into the hills in his heavy jacket for his frequent hikes. Yet to those of us who know Samuel, he is a constantly evolving success, a wonderful example of what this program is set up to do. Less than two years ago, Samuel lived in the hills of a Bay Area county, only coming down into town in the evenings to search through trash containers for food and cans. He had been living this way, completely alone and without resources, for many years. Eventually he came to the attention of a local police officer, who spent many hours trying to engage with Samuel and was rebuffed at every turn. Over time the officer's growing concern about Samuel's refusal to accept food or shelter led to Samuel being hospitalized and subsequently enrolled in AB 2034. There we discovered that unkempt, uncommunicative, isolated and angry Samuel had family on the East coast and was a college graduate who used to work in the telecommunications industry and play classical guitar for pleasure. As an adult, he had suffered a severe psychotic break which left him feeling suspicious of and persecuted by others. His life disintegrated. Samuel fled to

California after putting poison in his father's cereal bowl. Here he retreated to the hills where he lived alone, dirty, and poorly fed for over a decade.

In the hospital, Samuel was diagnosed with schizoaffective disorder and placed on medication for the first time. Almost immediately his paranoia and hallucinations decreased and Samuel became willing to work with our staff. From the hospital, Samuel moved into a 3-month housing program. Case managers accompanied him to regular appointments with our psychiatrist and supported Samuel as he learned to follow a schedule and to interact with other residents and staff. Soon Samuel was accepted into long-term supportive housing. Over time, we've worked with Samuel to begin washing his hair regularly; we've helped him understand the benefits of sleeping in a bed and wearing clean clothing.

Last year Samuel was attacked by a group of teenagers while walking down the street. An object was thrown at his face, resulting in a substantial loss of hearing. The audiologist who saw him afterwards told Samuel there was nothing that could be done to restore the hearing. Samuel accepted the news stoically, but our staff refused to accept this, advocating for him to be seen by medical specialists and accompanying him to appointments every week for 6 months. After having had specialized surgery, Samuel has now regained most of his hearing.

Samuel of course is a statistical success--stable in housing with no psychiatric re-hospitalizations and no more police reports. More importantly, despite a long history of broken relationships with his family and the mental health and medical systems, he is re-learning how to connect with other people. He now asks his case manager about how she is doing or fills her in about the goings-on of his family in the East. Together they have set up a checking account and are shopping for a guitar for Samuel to play. They talk about the beauty of the coming spring, as well as Samuel's hopes and concerns about moving into his own apartment. That is truly the best measure of success for Samuel and others. They are no longer alone.

Anonymous - In His Own Words

Since my teenage years, I have suffered from bipolar disorder. Despite my condition, I was able to earn a BA in Economics from UC Berkeley and an MBA from Harvard. My illness was never triggered while attending school, but I had major psychotic episodes that were triggered by stress from the workplace. Between 1986 and 2000 I was hospitalized several times because of my illness. In most cases I had to quit my job and find a new living situation. The disease was basically controlling my life.

In the summer of 1999 I had a major breakdown and completely lost touch with reality. My delusional thinking had me believing that I could communicate via

ESP with family and friends. The ESP conversations were telling me that I should quit my job and move out of the room I was renting. I did just that and starting renting motel rooms and spending the days having imaginary conversations, mostly with my father. In these conversations my father was telling me that I was a very "special" person and that my ESP conversations were made possible by the same technology that enables wireless communication such as radio or cellular phones. The theory was that as I had internal thoughts in my head, I produced brain waves that were being picked up by antenna stations—just like a cell phone. And the return conversation from the imaginary person I was talking to was being transmitted from these same antenna stations and received directly by my brain. So all day long, I would have these imaginary conversations that were telling me I was going to get a special job with the government and that I was to marry a woman who I had gone out with ten years earlier. The fantasy and the conversations kept me occupied all day and night.

Eventually, I was picked up by the police and hospitalized. After being released from the hospital I was sent to a homeless shelter. During this time, I was still suffering from the same delusion. I lasted three days in the homeless shelter and then began renting motel rooms again. Eventually, I was picked up by the police again and hospitalized. After being released from the hospital I was sent to a board and care home with severely ill people. For one year, I clung to my fantasy until eventually I lost patience from waiting for the job and marriage to materialize. At that point I looked up the woman I was supposed to marry and called her expecting that she too had been having a similar ESP experience and was expecting my call. We spoke briefly and I quickly found out that she was happily married. Immediately, my fantasy was shattered and a few days later I realized that I had basically been making up all of my ESP conversations in my head. I then went into a severe depression, moved out of the board and care home, rented a motel room and tried to commit suicide with alcohol and medication. It didn't work. I attempted suicide again, this time slashing my wrists. I attempted suicide once more by taking six weeks of medication at one time.

After being hospitalized following my third suicide attempt, I was sent to live at a mental health residential facility. At this point, I was 'sane' again but severely depressed and having constant suicidal thoughts. During my stay I twice rented a hotel room on the tenth floor and sat on the fire escape railing trying to work up the courage to fall to my death. Eventually, I realized I didn't have the courage to do it. With no way of killing myself, I resigned myself to trying to start some kind of new life and cope with my illness. My depression was still very severe, and although I had given up on the idea of killing myself, I often wished that I were dead instead of having to face the thought of trying to rebuild my life. At this point, I had been out of work for two and half years and had given up on the idea of ever holding another serious

job. So I faced the fact that I would probably spend the rest of my life at or near the poverty level and remained totally depressed.

While living in the residential facility, I eventually found some part time work as a softball umpire. The work was low stress and I was very competent at my job. This lifted my depression somewhat and proved to me that I could still 'function' in the real world. Shortly thereafter, the mental health program managed to set me up in an apartment of my own through a county sponsored rent subsidy program. After moving into the apartment I began working with the California Department of Rehabilitation, and received funding to attend a trade school for electronic technicians, a six month program leading to an entry level technician job. While attending the school, an old Harvard Business School friend managed to track me down after hearing about my situation through the 'grapevine.' He told me that he would do everything in his power to help me reestablish my life.

My friend immediately set me up with some part time work doing investment research out of my home at night. Attending school in the day and working at night kept me occupied and moving in a positive direction. My depression began lifting considerably and I had the feeling that things might work out after all. After three months of doing the investment research, my friend approached me about becoming a partner in a business he was planning to start. To make a long story short, we opened the business together and have been extremely successful with it. I am now part owner of a thriving business, and because my friend is aware of my illness, I am able to take on just the right amount of work and responsibility to ensure that I remain mentally healthy. My depression is almost completely gone and my future prospects are once again very bright.

Had it not been for the mental health AB 2034 program and the support I received from the program director and my personal counselor, I might not have been healthy enough to take advantage of this good fortune in my life. This program allowed me the time to recuperate from my severe psychotic break and begin taking small steps to restore my life. Obtaining affordable housing, and receiving weekly counseling has given me a foundation to work from, and I have managed to regain myself confidence and optimism through my umpiring, investment research, and the new business I co-own and manage. I am still receiving weekly counseling from the program that is helping to prevent any possible relapse. At this point, I am hopeful that I can manage my illness and enjoy a full and productive life.

Transition Age Youth Consumer No. 1

This young woman entered the program in October 2001, after being asked to leave another transitional housing program. Prior to entering that THP, she was homeless after exiting long-term out of home placement which she had

resided in since infancy. She was pregnant, admittedly substance abusing while pregnant, and had fought with her juvenile court judge as she was being evicted from her prior program resulting in a very real threat of the removal of her child at birth.

This young woman immediately entered a transitional housing unit, and began to apply for financial assistance, medical insurance for herself (prenatal care) and Section 8 housing that she would need. She began to discuss custody issues for her child, and addressed her substance abuse by trying to participate in group mental health services, although this wasn't easy for her. She was distrustful of staff, and really had to work hard to get along with her peers, or accept directions or assistance of any kind.

In January of 2002 this young woman gave birth to a healthy baby boy, with no positive drug screen. She began to work with a public health nurse immediately. In March of 2002 she began to take classes for her diploma, which was very challenging for her. She attended tutoring twice weekly, and began working a paid work experience site in May.

In July, she relapsed into substance abuse. This lapse lasted approximately five weeks. AB 2034 program staff increased monitoring of her safety and her child, and moved her to a new transitional housing unit in September. Gradually, she returned to her previous level of functioning, and she maintained her education, although she did not return to employment for some time.

In October this young woman requested assistance in obtaining independent housing, indicating that the transitional housing units with multiple residents were causing her undue stress. Finally, in December 02 a permanent low-income housing unit was obtained, and the Section 8 process scheduled to be completed in sixty days. While the program staff were open to retaining this young woman until she completed her diploma, and regained full time employment, this young woman determined that she could meet her needs financially and she wanted an opportunity to try to be truly independent. She calls program staff periodically, and knows that she is welcome to return to avert any mental health crisis she may experience, but she is enjoying her first experience living in her own home during her lifetime.

Transition Age Youth Consumer No. 2

This young man entered the AB 2034 program initially in 1999. He had been discharged from foster care/group home residence the prior spring, and had returned to the county after failing at Job Corp. He was very afraid of his life on the streets, and his anxiety disorder had developed into fantasy stories of where he was going, and what he was going to do. He told Visions staff that he was being recruited as a running back for the NFL, but needed a place to stay

temporarily. He entered the program one week before his nineteenth birthday. This young man wanted to go to college. He was not able to maintain a class schedule or employment sufficient to support himself in the first year. He became interested in an art college out of state, enrolled himself and made arrangements to attend. Program staff took him, and his belongings, to school in the fall of 2000, and he attended two different schools until 2001. He returned to the area, again disappointed with his inability to maintain in the educational/employment environments due to his diagnosis, but still interested in attending college somehow.

This young man has since maintained periods of employment, and finished college courses. He has learned his limitations, and areas of skill. He has learned what to expect from his mental health disability when under stress, and can plan for that. In the fall of 2002 he began receiving SSI benefits, and again began the process of college application, this time with the supportive services he needs. He left in January of 2003 to reside in a dormitory, and attend school full time. He made excellent plans, and back up plans, to complete the semester financially. He is knowledgeable of services available to him in the community, and calls every other week on the phone to check in. He feels very positive about his situation, and feels that he has accomplished his goal of being a college student.

L. M.

L.M. was homeless off and on for several years. When admitted to the AB 2034 program, she had severe paranoia related to the FBI following her, trying to get her hospitalized. She has now been in transitional housing for almost 2 years, and while she is still symptomatic at times, she has successfully returned to and completed a year of junior college and has applied to attend CSU next year. She is giving a speech in her class this week on "Homelessness and Mental Health."

S. S.

S.S. has a long history of schizophrenia, and has several family members who are also diagnosed with mental illness. He has an interested and involved family who have frequently taken him in and tried to help out, but over the past year his symptoms became too difficult for the family to deal with and he was lost on the streets many times. He has fully engaged with AB 2034 staff after close work by the Outreach team, and is now living in transitional housing. He has also been accepted by the Department of Rehabilitation and will be attending welding school. His delusions persist, but he works out daily at a local gym, has friends, and is looking forward to competitive work after his training.

R. M.

R.M. has a diagnosis of bi-polar disorder and poly-substance abuse. He has had several incarcerations in the past due to his drug use. He lived in a clean and sober environment for 8 months, and then moved into transitional housing. He began having weekly visitation with his two teen-age sons since he had his own apartment, and has reconciled with his family. He continues to receive individual therapy with a program clinician to assist in his recovery and relationship issues. R.M. has been accepted by the Department of Rehabilitation to assist with completing his CAADAC at U.O.P. He is half-way through the program and plans to become a drug and alcohol counselor upon completion. RM currently leads AA groups at various community locations. He is awaiting final approval for his Shelter Plus Care Housing Certificate and will be moving into permanent housing in the near future.

T. D.

T.D. has spent almost half his life in prison. He started drinking at age 10, his father died when client was a teenager, and mother was an alcoholic. He married and had 4 children, but during an incarceration his wife took his kids away and he has not seen them since. T.D. was recently released from Folsom Prison after completing sentence for parole violation. He completed the 28 day program at Nirvana Drug and Rehabilitation Services and has moved into transitional housing. He is now working with the employment specialist to get his G.E.D. He will be taking his GED test in March, and plans to continue with his education at a local junior college. He is currently in Oklahoma visiting his mother whom he has not seen in many years. TD is proud of his accomplishments and plans to continue in his recovery and educational goals.

E. G.

E.G., who has a diagnosis of bipolar disorder, was living in his pick-up truck when he first came to the AB 2034 program. He was scared and very depressed over his situation. He became a member of the program and was given the opportunity to stay in a motel until transitional housing became available. Once he was in transitional housing he began to work part time as a cook at Denny's. After several months he obtained a Shelter Plus Care certificate through the Housing Authority and was able to move into his own apartment. E.G. then began to work for a social services agency as a bilingual educator. He is now married and is receiving couples therapy through the program. He recently was diagnosed with Hodgkin’s Lymphoma after the program psychiatrist noted his deteriorated physical condition and referred him to ER. He is following up with oncology appointments and receiving support from the program.

R. A.

R.A came to the AB 2034 program upon release from prison in December of 2001. He used drugs and suggested to the outreach team during the engagement process that he was not sure if his "Voices" were spiritual, drug related, or an illness. R. A. spent the next few months in a motel, as he became familiar with his team and the doctor at the mental health program. In April 2002, R.A. moved into transitional housing and began working on his stated goals with his team. He also received help from the Occupational Therapist in living skills and budgeting necessary to maintain his housing. R.A.'s next goal was employment, which he obtained the following month.

On May 16, 2002, R. A. was hired as a Technician for a Pest Control Company. Later that month R.A. was put to the test when he was asked to share his transitional apartment with a member from the Transitional Age Youth Program.

As of January 2003, R.A. has successfully maintained his transitional housing, with a roommate, and is working with the team and the Housing Specialist in locating permanent housing. In three short months, R.A. will celebrate his one-year anniversary at his place of employment. His position is Monday through Friday, 8 a.m.-5 p.m. and he earns $10.00 an hour.

R.A. has worked closely with his team, the doctor, the employment specialist, and the occupational therapist, in maintaining employment while managing his illness. He has had no incarceration days since his December 2001 release. R.A. indicates that he is grateful that he had this program to turn to at a very low time in his life.

Michelle

Michelle is a single mother of 2 children ages 4 and 12. She has known homelessness since the age of 12, doing here first line of cocaine with her mother at the age of 13. Through the years she has battled depression, anxiety, and drug addiction. Michelle was introduced to the AB2034 in March of 2001 by social services and the homeless shelter. She was enrolled in the program in April of 2002. Michelle's stay at the shelter was coming to an end when the position of assistant caretaker became open. With the support of the program and her desire to stay clean she was given the position. She was soon promoted to Lead Caretaker. She continued to succeed and after 6 months Michelle felt it was time to look for a place of her own wanting to improve the lifestyle for her young son and also provide a place for her 12 year old daughter to visit as she lives with her biological father. After much persistence Michelle found a small home and moved in. At this point the agency managing the shelter considered her for a job with Americore. She accepted the position and was given training at the local community college earning a certificate in parenting. She now provides resources and assistance for those families in the shelter and screens applicants for housing assistance and the homeless

prevention program. Michelle continues to meet with her personal service coordinator weekly to for help with money management and personal growth issues. With her current income she is almost self-supporting. Michelle has been clean for 19 months, maintained housing for 7 months and a job for almost 1 year - all a first in her life. A big turning point in her life was when she was invited to sit on The Perinatal Multi-Agency Team as an Advisor, not as the client being discussed as she had been numerous times in the past. Michelle values her life experiences and uses them in assisting others down a better path in life.

Robert - To Whom It May Concern:

When I joined the service in 1966, I had Attention Deficit Disorder. They should never have accepted me. But the Army had a need for bodies. 1967 and 1968 found me in Southeast Asia. I was in the infantry with the 101st Airborne. When I got back to the states my problem became more pronounced. I couldn't adjust to stateside duty. Exit Army.

I couldn't keep a job, my family life was going down the tube. These were the first signs of my PTSD. When I first heard of PTSD I scoffed at idea. I thought it was just guys trying to get over on the government. I was wrong. Alcohol and drug abuse kicked into high gear. Lost two families because of it. Everything I did was anticlimactic compared to combat. Time stood still, yet flew by thirty-two years later, I was still in the jungle and rice paddies. Every waking moment the war filled my head, at night it invaded my dreams. At this time I had been living in my dome tent. Always changing camps, staying one step ahead of the cops. I had no job, no income, and no future. I went and talked to a counselor at mental health, she sent me to this shrink. I was then referred to the AB 20334 program. By this time I had 10 years in a tent and I wasn't too sure about an apartment. The program didn't let any grass grow under their feet. I was busy for the 1st time in years, with constructive things to do. I saw shrinks, eye doctors and even a dentist. I was prescribed Wellbutrin and Zyprexa. After taking these drugs (medications) for a while, I noticed that the war was gone. I went from living in a tent stuck in Southeast Asia with no income, except for what I could get by any means, except violence - to living in an apartment with a legal income and paying my monthly bills on time.

Appendix 3

Integrated Services for Homeless Adults Programs
(All Funded Programs)

Cumulative "Raw" Data

November 1, 1999 through January 31, 2003

Table 1
Cumulative "Raw" Data
November 1, 1999 through January 31, 2003

County Programs	Enrollments and Demographics-Gender							
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
	Number of contracted consumers	Number of consumers currently enrolled	Number Male	% Male	Number Female	% Female	Number Other / Trans gender	% Other Transgender
Berkeley	100	108	80	74.07%	28	25.93%	0	0.00%
Butte	50	49	41	83.67%	8	16.33%	0	0.00%
Contra Costa	40	62	44	70.97%	18	29.03%	0	0.00%
El Dorado	50	53	36	67.92%	17	32.08%	0	0.00%
Fresno	150	144	84	58.33%	60	41.67%	0	0.00%
Humboldt	30	31	18	58.06%	13	41.94%	0	0.00%
Kern	150	143	73	51.05%	70	48.95%	0	0.00%
Los Angeles	1,440	1,694	1,090	64.34%	603	35.60%	1	0.06%
Madera	50	50	27	54.00%	23	46.00%	0	0.00%
Marin	100	103	55	53.40%	48	46.60%	0	0.00%
Mendocino	30	38	24	63.16%	14	36.84%	0	0.00%
Monterey	22	23	14	60.87%	9	39.13%	0	0.00%
Napa	20	25	13	52.00%	12	48.00%	0	0.00%
Orange	100	93	62	66.67%	31	33.33%	0	0.00%
Placer	75	82	42	51.22%	40	48.78%	0	0.00%
Riverside	200	157	90	57.32%	67	42.68%	0	0.00%
Sacramento	300	295	150	50.85%	145	49.15%	0	0.00%
San Bernardino	150	156	91	58.33%	63	40.38%	2	1.28%
San Diego	250	253	146	57.71%	105	41.50%	2	0.79%
San Francisco	120	121	78	64.46%	42	34.71%	1	0.83%
San Joaquin	120	114	45	39.47%	69	60.53%	0	0.00%
San Luis Obispo	120	118	79	66.95%	39	33.05%	0	0.00%
San Mateo	75	71	41	57.75%	29	40.85%	1	1.41%
Santa Barbara	100	99	51	51.52%	48	48.48%	0	0.00%
Santa Clara	40	37	22	59.46%	15	40.54%	0	0.00%
Santa Cruz	30	30	20	66.67%	9	30.00%	1	3.33%
Shasta	60	57	27	47.37%	30	52.63%	0	0.00%
Solano	100	105	68	64.76%	37	35.24%	0	0.00%
Sonoma	75	66	32	48.48%	34	51.52%	0	0.00%
Stanislaus	250	262	133	50.76%	129	49.24%	0	0.00%
Tehama	75	57	31	54.39%	26	45.61%	0	0.00%
Tri-City	83	79	49	62.03%	30	37.97%	0	0.00%
Tuolumne	12	11	9	81.82%	2	18.18%	0	0.00%
Ventura	65	67	37	55.22%	30	44.78%	0	0.00%
Yolo	30	28	14	50.00%	14	50.00%	0	0.00%
Total	**4,662**	**4,881**	**2,916**	**59.74%**	**1,957**	**40.09%**	**8**	**0.16%**

Table 2

Cumulative "Raw" Data

November 1, 1999 through January 31, 2003

County Programs	Enrollments and Demographics-Ethnicity															
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	2.11	2.12	2.13	2.14	2.15	2.16
	Number of contracted consumers	Number of consumers currently enrolled	Number African American	% African American	Number Asian American	% Asian American	Number Caucasian	% Caucasian	Number Hispanic	% Hispanic	Number Native American	% Native American	Number Pacific Islander	% Pacific Islander	Number Other	% Other
Berkeley	100	108	49	45.37%	3	2.78%	50	46.30%	3	2.78%	1	0.93%	0	0.00%	2	1.85%
Butte	50	49	1	2.04%	0	0.00%	47	95.92%	1	2.04%	0	0.00%	0	0.00%	0	0.00%
Contra Costa	40	62	15	24.19%	0	0.00%	38	61.29%	8	12.90%	0	0.00%	0	0.00%	1	1.61%
El Dorado	50	53	1	1.89%	0	0.00%	48	90.57%	1	1.89%	1	1.89%	0	0.00%	2	3.77%
Fresno	150	144	31	21.53%	1	0.69%	73	50.69%	35	24.31%	2	1.39%	0	0.00%	2	1.39%
Humboldt	30	31	1	3.23%	0	0.00%	26	83.87%	1	3.23%	3	9.68%	0	0.00%	0	0.00%
Kern	150	143	16	11.19%	2	1.40%	97	67.83%	20	13.99%	4	2.80%	1	0.70%	3	2.10%
Los Angeles	1,440	1,694	910	53.72%	13	0.77%	504	29.75%	212	12.51%	12	0.71%	6	0.35%	37	2.18%
Madera	50	50	5	10.00%	0	0.00%	28	56.00%	17	34.00%	0	0.00%	0	0.00%	0	0.00%
Marin	100	103	18	17.48%	5	4.85%	72	69.90%	8	7.77%	0	0.00%	0	0.00%	0	0.00%
Mendocino	30	38	0	0.00%	0	0.00%	33	86.84%	2	5.26%	2	5.26%	0	0.00%	1	2.63%
Monterey	22	23	2	8.70%	0	0.00%	18	78.26%	2	8.70%	0	0.00%	0	0.00%	1	4.35%
Napa	20	25	0	0.00%	1	4.00%	22	88.00%	2	8.00%	0	0.00%	0	0.00%	0	0.00%
Orange	100	93	15	16.13%	9	9.68%	56	60.22%	11	11.83%	1	1.08%	1	1.08%	0	0.00%
Placer	75	82	1	1.22%	2	2.44%	71	86.59%	5	6.10%	3	3.66%	0	0.00%	0	0.00%
Riverside	200	157	40	25.48%	0	0.00%	75	47.77%	34	21.66%	5	3.18%	0	0.00%	3	1.91%
Sacramento	300	295	86	29.15%	5	1.69%	171	57.97%	19	6.44%	5	1.69%	2	0.68%	7	2.37%
San Bernardino	150	156	47	30.13%	1	0.64%	78	50.00%	26	16.67%	3	1.92%	0	0.00%	1	0.64%
San Diego	250	253	67	26.48%	5	1.98%	153	60.47%	18	7.11%	3	1.19%	5	1.98%	2	0.79%
San Francisco	120	121	47	38.84%	4	3.31%	53	43.80%	10	8.26%	1	0.83%	2	1.65%	4	3.31%
San Joaquin	120	114	28	24.56%	3	2.63%	60	52.63%	15	13.16%	1	0.88%	0	0.00%	7	6.14%
San Luis Obispo	120	118	9	7.63%	1	0.85%	100	84.75%	7	5.93%	1	0.85%	0	0.00%	0	0.00%
San Mateo	75	71	10	14.08%	6	8.45%	46	64.79%	5	7.04%	1	1.41%	0	0.00%	3	4.23%
Santa Barbara	100	99	10	10.10%	0	0.00%	72	72.73%	14	14.14%	3	3.03%	0	0.00%	0	0.00%
Santa Clara	40	37	5	13.51%	2	5.41%	20	54.05%	9	24.32%	1	2.70%	0	0.00%	0	0.00%
Santa Cruz	30	30	3	10.00%	0	0.00%	23	76.67%	3	10.00%	1	3.33%	0	0.00%	0	0.00%
Shasta	60	57	1	1.75%	0	0.00%	51	89.47%	0	0.00%	5	8.77%	0	0.00%	0	0.00%
Solano	100	105	32	30.48%	0	0.00%	62	59.05%	4	3.81%	4	3.81%	0	0.00%	3	2.86%
Sonoma	75	66	2	3.03%	3	4.55%	54	81.82%	3	4.55%	3	4.55%	0	0.00%	1	1.52%
Stanislaus	250	262	25	9.54%	4	1.53%	183	69.85%	45	17.18%	4	1.53%	0	0.00%	1	0.38%
Tehama	75	57	0	0.00%	0	0.00%	48	84.21%	3	5.26%	4	7.02%	1	1.75%	1	1.75%
Tri-City	83	79	21	26.58%	2	2.53%	35	44.30%	20	25.32%	1	1.27%	0	0.00%	0	0.00%
Tuolumne	12	11	0	0.00%	0	0.00%	11	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Ventura	65	67	3	4.48%	0	0.00%	42	62.69%	17	25.37%	4	5.97%	0	0.00%	1	1.49%
Yolo	30	28	3	11.00%	0	0.00%	24	85.50%	1	3.50%	0	0.00%	0	0.00%	0	0.00%
Total	**4,662**	**4,881**	**1,504**	**30.81%**	**72**	**1.48%**	**2,544**	**52.12%**	**581**	**11.90%**	**79**	**1.62%**	**18**	**0.37%**	**83**	**1.70%**

Table 3

Cumulative "Raw" Data

November 1, 1999 through January 31,2003

County Programs	Enrollments and Demographics-Age											
	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	3.10	3.11	3.12
	Number of contracted consumers	Number of consumers currently enrolled	Age 0 to 17	% Age 0 to 17	Age 18 to 24	% Age 18 to 24	Age 25 to 45	% Age 25 to 45	Age 46 to 59	% Age 46 to 59	Age 60+	% Age 60+
Berkeley	100	108	0	0.00%	8	7.41%	56	51.85%	37	34.26%	7	6.48%
Butte	50	49	0	0.00%	4	8.16%	18	36.73%	25	51.02%	2	4.08%
Contra Costa	40	62	0	0.00%	3	4.84%	35	56.45%	24	38.71%	0	0.00%
El Dorado	50	53	0	0.00%	2	3.77%	34	64.15%	17	32.08%	0	0.00%
Fresno	150	144	0	0.00%	12	8.33%	83	57.64%	45	31.25%	4	2.78%
Humboldt	30	31	0	0.00%	4	12.90%	14	45.16%	11	35.48%	2	6.45%
Kern	150	143	0	0.00%	23	16.08%	84	58.74%	33	23.08%	3	2.10%
Los Angeles	1,440	1,694	0	0.00%	168	9.92%	959	56.61%	522	30.81%	45	2.66%
Madera	50	50	0	0.00%	4	8.00%	31	62.00%	15	30.00%	0	0.00%
Marin	100	103	0	0.00%	5	4.85%	44	42.72%	47	45.63%	7	6.80%
Mendocino	30	38	0	0.00%	4	10.53%	13	34.21%	20	52.63%	1	2.63%
Monterey	22	23	0	0.00%	3	13.04%	6	26.09%	11	47.83%	3	13.04%
Napa	20	25	0	0.00%	2	8.00%	13	52.00%	8	32.00%	2	8.00%
Orange	100	93	0	0.00%	6	6.45%	53	56.99%	29	31.18%	5	5.38%
Placer	75	82	0	0.00%	11	13.41%	42	51.22%	28	34.15%	1	1.22%
Riverside	200	157	0	0.00%	22	14.01%	92	58.60%	38	24.20%	5	3.18%
Sacramento	300	295	0	0.00%	20	6.78%	189	64.07%	79	26.78%	7	2.37%
San Bernardino	150	156	0	0.00%	16	10.26%	86	55.13%	49	31.41%	5	3.21%
San Diego	250	253	0	0.00%	21	8.30%	104	41.11%	100	39.53%	28	11.07%
San Francisco	120	121	0	0.00%	19	16.00%	68	56.00%	34	28.00%	0	0.00%
San Joaquin	120	114	0	0.00%	0	0.00%	66	57.89%	42	36.84%	6	5.26%
San Luis Obispo	120	118	0	0.00%	7	5.93%	63	53.39%	41	34.75%	7	5.93%
San Mateo	75	71	0	0.00%	10	14.08%	33	46.48%	20	28.17%	8	11.27%
Santa Barbara	100	99	0	0.00%	6	6.06%	43	43.43%	47	47.47%	3	3.03%
Santa Clara	40	37	0	0.00%	3	8.11%	27	72.97%	6	16.22%	1	2.70%
Santa Cruz	30	30	0	0.00%	1	3.33%	15	50.00%	14	46.67%	0	0.00%
Shasta	60	57	0	0.00%	7	12.28%	34	59.65%	14	24.56%	2	3.51%
Solano	100	105	0	0.00%	12	11.43%	59	56.19%	32	30.48%	2	1.90%
Sonoma	75	66	0	0.00%	7	10.61%	29	43.94%	28	42.42%	2	3.03%
Stanislaus	250	262	0	0.00%	67	25.57%	128	48.85%	64	24.43%	3	1.15%
Tehama	75	57	0	0.00%	15	26.32%	25	43.86%	17	29.82%	0	0.00%
Tri-City	83	79	0	0.00%	6	7.59%	41	51.90%	30	37.97%	2	2.53%
Tuolumne	12	11	0	0.00%	2	18.18%	5	45.45%	4	36.36%	0	0.00%
Ventura	65	67	0	0.00%	4	5.97%	32	47.76%	30	44.78%	1	1.49%
Yolo	30	28	0	0.00%	2	7.00%	7	25.00%	18	64.00%	1	4.00%
Total	**4,662**	**4,881**	**0**	**0.00%**	**506**	**10.37%**	**2,631**	**53.90%**	**1,579**	**32.35%**	**165**	**3.38%**

Table 4

Cumulative "Raw" Data

November 1,1999 through January 31,2003

County Programs	Outreach Efforts					
	4.1	4.2	4.3	4.4	4.5	4.6
	Number of contracted consumers	Number of consumers currently enrolled	Unduplicated number of outreach consumers during this reporting period	Number of outreach contacts during this reporting period	Number of consumers enrolled to date (Including Dropouts)	Number of new consumers enrolled during this reporting period
Berkeley	100	108	1	1	146	1
Butte	50	49	1	1	75	0
Contra Costa	40	62	9	23	114	6
El Dorado	50	53	2	2	156	2
Fresno	150	144	21	22	271	2
Humboldt	30	31	57	82	37	1
Kern	150	143	10	10	278	2
Los Angeles	1,440	1,694	144	226	2,806	33
Madera	50	50	1	1	98	1
Marin	100	103	7	9	117	2
Mendocino	30	38	29	67	100	0
Monterey	22	23	8	15	23	3
Napa	20	25	6	14	29	0
Orange	100	93	32	37	159	0
Placer	75	82	0	0	181	0
Riverside	200	157	8	15	463	5
Sacramento	300	295	97	146	570	13
San Bernardino	150	156	17	18	291	0
San Diego	250	253	28	73	407	8
San Francisco	120	121	28	30	192	5
San Joaquin	120	114	49	117	184	2
San Luis Obispo	120	118	5	8	214	0
San Mateo	75	71	1	1	104	0
Santa Barbara	100	99	13	20	167	2
Santa Clara	40	37	2	2	44	1
Santa Cruz	30	30	39	44	43	1
Shasta	60	57	14	33	177	5
Solano	100	105	4	5	181	0
Sonoma	75	66	7	9	96	0
Stanislaus	250	262	182	498	509	11
Tehama	75	57	7	17	97	0
Tri-City	83	79	1	1	118	1
Tuolumne	12	11	7	24	25	0
Ventura	65	67	9	13	113	2
Yolo	30	28	4	21	50	2
Total	**4,662**	**4,881**	**850**	**1,605**	**8,635**	**111**

Table 5

Cumulative "Raw" Data

November 1, 1999 through January 31, 2003

County Programs	Psychiatric Hospitalizations						
	5.1	5.2	5.3	5.4	5.5	5.6	5.7
	Number of consumers currently enrolled	Number of unduplicated consumers hospitalized in 12 mos prior to enrollment	Number of hospitalizations in 12 mos prior to enrollment	Number of hospital days in 12 mos prior to enrollment	Number of unduplicated consumers hospitalized since enrollment	Number of hospitalizations since enrollment	Number of hospital days since enrollment
Berkeley	108	43	110	2,775	33	61	1,005
Butte	49	18	31	226	13	31	206
Contra Costa	62	6	6	458	7	10	246
El Dorado	53	13	15	641	5	5	18
Fresno	144	27	35	601	13	19	84
Humboldt	31	5	6	125	6	9	181
Kern	143	34	42	1,495	11	17	139
Los Angeles	1,694	302	459	12,580	319	733	8,209
Madera	50	3	5	39	3	4	17
Marin	103	35	96	620	36	63	589
Mendocino	38	6	7	288	6	12	71
Monterey	23	8	15	192	3	4	35
Napa	25	3	3	87	2	2	231
Orange	93	37	55	1,058	34	68	1,984
Placer	82	23	29	1,416	9	20	589
Riverside	157	15	25	414	14	27	219
Sacramento	295	66	125	1,450	36	82	1,316
San Bernardino	156	43	61	700	30	81	641
San Diego	253	82	144	2,634	75	157	2,386
San Francisco	121	54	102	1,691	42	88	1,121
San Joaquin	114	15	16	524	14	20	149
San Luis Obispo	118	26	38	510	11	15	129
San Mateo	71	50	90	2,583	16	29	312
Santa Barbara	99	17	19	315	12	31	341
Santa Clara	37	14	19	747	8	15	268
Santa Cruz	30	7	8	133	9	13	120
Shasta	57	14	15	232	2	2	18
Solano	105	5	5	57	5	6	84
Sonoma	66	30	46	897	16	31	583
Stanislaus	262	85	154	1,026	72	138	1,205
Tehama	57	10	10	804	17	24	684
Tri-City	79	14	16	381	11	16	113
Tuolumne	11	5	6	63	1	1	1
Ventura	67	9	15	111	14	32	384
Yolo	28	6	9	65	3	3	25
Total	**4,881**	**1,130**	**1,837**	**37,938**	**908**	**1,869**	**23,703**

Table 6

Cumulative "Raw" Data

November 1,1999 through January 31, 2003

County Programs	Incarcerations, Probation and Parole								
	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9
	Number of consumers currently enrolled	Number of consumers on probation at any time in 12 mos prior to enrollment	Number of consumers on parole at any time in 12 mos prior to enrollment	Number of unduplicated consumers incarcerated in 12 months prior to enrollment	Number of incarcerations in 12 months prior to enrollment	Number of days incarcerated in 12 months prior to enrollment	Number of unduplicated consumers incarcerated since enrollment	Number of incarcerations since enrollment	Number of days incarcerated since enrollment
Berkeley	108	11	2	49	79	3,574	29	52	1,773
Butte	49	7	1	10	17	497	9	16	739
Contra Costa	62	0	1	10	13	1,576	5	6	592
El Dorado	53	15	2	15	21	1,472	5	5	78
Fresno	144	32	20	58	70	6,578	34	43	2,982
Humboldt	31	3	0	12	14	738	7	8	139
Kern	143	12	2	42	49	1,735	14	20	1,085
Los Angeles	1,694	258	178	808	986	129,376	427	670	44,380
Madera	50	8	13	27	32	4,835	17	32	2,821
Marin	103	14	11	17	36	1,474	18	43	1,942
Mendocino	38	7	0	13	20	981	12	15	411
Monterey	23	0	0	2	2	49	0	0	0
Napa	25	6	1	7	7	1,435	4	4	572
Orange	93	0	0	29	35	2,921	19	32	1,233
Placer	82	13	3	23	28	3,149	12	16	556
Riverside	157	5	2	29	29	3,681	15	17	1,415
Sacramento	295	74	5	116	216	4,016	96	231	2,571
San Bernardino	156	29	3	36	43	4,440	18	41	1,592
San Diego	253	30	10	50	56	3,897	41	52	2,455
San Francisco	121	31	4	54	76	6,020	25	55	2,033
San Joaquin	114	16	3	14	16	1,344	3	3	20
San Luis Obispo	118	25	5	39	51	4,555	13	20	785
San Mateo	71	3	1	17	19	1,619	10	18	441
Santa Barbara	99	12	4	24	28	2,600	24	45	2,077
Santa Clara	37	4	0	10	11	449	12	17	826
Santa Cruz	30	1	0	7	12	122	3	3	3
Shasta	57	7	2	16	17	763	5	6	426
Solano	105	11	3	37	40	4,531	21	29	1,680
Sonoma	66	4	1	15	17	2,292	11	15	710
Stanislaus	262	59	13	63	100	5,277	69	177	4,173
Tehama	57	22	4	27	27	2,163	23	38	2,795
Tri-City	79	11	7	14	16	2,060	15	24	2,103
Tuolumne	11	3	1	2	2	197	1	1	1
Ventura	67	1	0	16	19	1,994	12	22	435
Yolo	28	4	1	8	16	696	3	6	149
Total	**4,881**	**738**	**303**	**1,716**	**2,220**	**213,106**	**1,032**	**1,782**	**85,993**

Table 7

Cumlative" Raw" Data

November 1,1999 through January 31, 2003

County Programs	Income										
	7.1	7.2	7.3	7.4	7.5	7.6	7.7	7.8	7.9	7.10	7.11
	Number of consumers currently enrolled	Number of unduplicated consumers receiving GA/GR at enrollment	Number of unduplicated consumers receiving SSI / SSDI at enrollment	Number of unduplicated consumers receiving TANF at enrollment	Number of unduplicated consumers receiving VA benefits at enrollment	Number of unduplicated consumers receiving wages at enrollment	Number of unduplicated consumers receiving GA/GR since enrollment	Number of unduplicated consumers receiving SSI / SSDI since enrollment	Number of unduplicated consumers receiving TANF since enrollment	Number of unduplicated consumers receiving VA benefits since enrollment	Number of unduplicated consumers receiving wages since enrollment
Berkeley	108	4	26	0	2	1	11	90	0	3	4
Butte	49	4	16	4	1	1	14	35	4	4	23
Contra Costa	62	3	23	0	1	3	3	29	0	1	14
El Dorado	53	2	13	2	0	9	7	18	2	0	18
Fresno	144	60	11	4	2	5	109	33	7	2	39
Humboldt	31	5	11	0	0	1	11	18	0	1	2
Kern	143	5	15	2	0	0	22	93	4	1	4
Los Angeles	1,694	407	329	19	4	69	779	825	34	20	328
Madera	50	5	7	7	0	1	7	21	8	0	12
Marin	103	18	47	1	0	8	54	85	4	0	31
Mendocino	38	0	25	0	3	5	2	28	0	3	11
Monterey	23	4	8	0	0	1	7	14	0	0	4
Napa	25	2	18	1	0	1	2	21	2	0	5
Orange	93	2	43	0	2	0	7	67	0	3	20
Placer	82	6	29	5	0	11	13	42	6	0	17
Riverside	157	2	31	8	0	19	6	47	11	0	45
Sacramento	295	105	81	5	0	7	47	175	7	0	12
San Bernardino	156	3	35	1	1	8	5	67	5	3	23
San Diego	253	17	86	3	5	7	31	161	4	13	23
San Francisco	121	19	51	0	0	1	21	67	0	0	3
San Joaquin	114	7	59	5	0	8	15	81	7	2	35
San Luis Obispo	118	11	58	0	3	5	17	69	0	4	10
San Mateo	71	3	25	0	1	2	4	47	0	2	21
Santa Barbara	99	17	42	7	0	5	31	73	9	1	21
Santa Clara	37	3	22	0	1	1	3	27	1	6	5
Santa Cruz	30	3	11	1	0	3	9	24	1	0	14
Shasta	57	2	26	4	2	1	12	30	5	2	4
Solano	105	2	20	2	1	12	31	33	2	2	31
Sonoma	66	1	38	0	1	4	2	54	0	2	17
Stanislaus	262	13	65	12	6	24	23	102	22	8	69
Tehama	57	7	13	4	0	3	8	13	2	1	5
Tri-City	79	21	15	6	0	4	39	37	8	1	18
Tuolumne	11	0	4	0	0	4	0	1	0	0	2
Ventura	67	0	22	3	0	0	0	43	4	0	9
Yolo	28	0	15	0	0	6	10	17	0	0	10
Total	**4,881**	**763**	**1,340**	**106**	**36**	**240**	**1,362**	**2,587**	**159**	**85**	**909**

Table 8

Cumulative "Raw" Data

November 1,1999 through January 31, 2003

County Programs	Housing												
	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	8.10	8.11	8.12	8.13
				Summary	Sub1	Sub2	Sub3	Sub4					
	Number of consumers currently enrolled	Number unduplicated consumers homeless during 12 mos prior to enrollment	Number of homeless days during 12 mos prior to enrollment	Number of consumers homeless at enrollment	Number of consumers on the street at enrollment	Number of consumers in jail at enrollment	Number of consumers in a shelter at enrollment	Number of consumers in a treatment facility at enrollment	Number of homeless days since enrollment (INCLUDING SHELTER DAYS)	Number of unduplicated consumers becoming homeless since enrollment (INCLUDING CONSUMERS IN SHELTERS)	Number of consumers currently maintaining housing (EXCLUDING CONSUMERS IN SHELTERS)	Number of homeless days since enrollment (EXCLUDING SHELTER DAYS)	Number of consumers currently maintaining housing (INCLUDING CONSUMERS IN SHELTERS)
Berkeley	108	106	34,108	101	84	3	13	1	18,979	58	75	16,284	77
Butte	49	47	9,102	35	23	1	10	1	1,751	13	43	1,492	43
Contra Costa	62	62	16,615	48	8	0	40	0	3,552	30	54	2,041	58
El Dorado	53	40	6,556	33	30	3	0	0	1,434	5	48	1,434	48
Fresno	144	110	25,410	39	29	5	5	0	6,586	51	123	6,205	125
Humboldt	31	30	9,182	24	19	1	3	1	3,420	13	25	2,905	25
Kern	143	109	21,846	48	37	1	8	2	3,641	18	136	2,765	137
Los Angeles	1,694	1,423	348,908	993	537	308	123	25	166,929	565	1,432	119,603	1,471
Madera	50	38	8,522	15	4	3	8	0	3,639	22	43	3,078	43
Marin	103	103	28,966	103	66	0	34	3	24,429	72	77	23,482	79
Mendocino	38	33	7,836	31	22	1	8	0	8,440	19	26	7,556	30
Monterey	23	23	5,498	20	18	0	0	2	989	6	17	858	18
Napa	25	23	4,984	21	21	0	0	0	3,231	5	18	3,231	18
Orange	93	82	20,872	67	48	4	5	10	10,202	50	78	8,243	82
Placer	82	66	13,796	44	35	4	2	3	6,453	27	66	5,156	68
Riverside	157	136	28,715	83	54	2	26	1	10,636	36	131	7,575	140
Sacramento	295	295	65,791	234	172	3	47	12	18,594	181	272	17,989	277
San Bernardino	156	120	18,956	102	87	2	12	1	13,657	55	125	10,036	128
San Diego	253	229	55,262	187	110	7	58	12	20,651	53	217	14,096	220
San Francisco	121	121	34,688	86	51	18	15	2	8,664	25	112	6,118	114
San Joaquin	114	69	8,435	45	22	2	20	1	1,153	4	114	342	114
San Luis Obispo	118	111	31,245	99	71	5	22	1	20,692	25	57	16,026	61
San Mateo	71	53	9,827	29	18	0	9	2	2,228	16	65	2,228	65
Santa Barbara	99	81	17,315	63	46	1	16	0	9,051	42	85	5,924	92
Santa Clara	37	28	4,185	17	5	2	8	2	3,875	15	27	2,087	31
Santa Cruz	30	30	9,426	24	15	2	7	0	3,015	11	27	1,718	29
Shasta	57	45	7,329	33	19	0	14	0	4,585	11	36	2,897	42
Solano	105	103	28,504	85	73	2	10	0	8,286	41	71	7,189	73
Sonoma	66	57	14,308	43	29	2	10	2	6,297	36	51	5,494	51
Stanislaus	262	212	43,833	166	129	3	34	0	24,250	82	219	21,555	225
Tehama	57	37	6,642	27	27	0	0	0	8,817	25	36	8,306	36
Tri-City	79	59	13,496	36	25	4	7	0	7,373	23	69	6,208	70
Tuolumne	11	11	3,013	11	9	0	2	0	223	1	11	94	11
Ventura	67	59	14,562	49	44	0	5	0	3,483	21	59	3,258	60
Yolo	28	26	5,976	14	12	0	0	2	1,021	7	27	980	27
Total	**4,881**	**4,177**	**983,709**	**3,055**	**1,999**	**389**	**581**	**86**	**440,226**	**1,664**	**4,072**	**344,453**	**4,188**

Table 9
Cumulative "Raw" Data
November 1, 1999 through January 31, 2003

County Programs	Employment													
	9.1	9.2	9.3	9.4	9.5	9.6	9.7	9.8	9.9	9.10	9.11	9.12	9.13	9.14
	Number of consumers currently enrolled	Number of consumers with no employment in 12 mos. prior to enrollment	Number of consumers employed full time (32+ hours) in 12 mos. prior to enrollment	Number of days employed full time (32+ hrs) in 12 mos. prior to enrollment	Number of consumers employed part time (< 32 hours) in 12 mos. prior to enrollment	Number of days employed part time (< 32 hrs) in 12 mos. prior to enrollment	Number of consumers employed full time since enrollment	Number of days employed full time since enrollment	Number of consumers employed part time since enrollment	Number of days employed part time since enrollment	Number of consumers in competitive employment since enrollment	Number of consumers in supported employment since enrollment	Number of consumers referred to Dept. of Rehab	Number of consumers employed at end of period
Berkeley	108	102	0	0	6	701	0	0	4	1,075	2	2	0	2
Butte	49	38	4	158	7	1,003	3	635	22	6,538	2	23	2	13
Contra Costa	62	57	1	11	4	118	6	732	10	777	1	14	11	6
El Dorado	53	34	0	0	19	3,928	9	1,110	13	2,057	13	6	1	10
Fresno	144	119	15	2,280	7	872	13	1,435	24	2,868	35	1	22	12
Humboldt	31	29	1	88	1	31	0	0	2	663	0	2	0	2
Kern	143	119	8	1,109	16	2,428	1	121	3	481	0	5	0	2
Los Angeles	1,694	1,502	52	8,311	141	23,479	144	38,083	310	91,499	230	256	49	199
Madera	50	45	0	0	5	1,084	4	784	8	2,013	4	9	0	5
Marin	103	72	16	1,502	22	987	18	1,829	32	2,407	25	24	31	9
Mendocino	38	31	1	61	6	1,881	4	1,122	9	3,077	6	5	2	8
Monterey	23	19	0	0	4	887	1	88	3	218	2	2	4	2
Napa	25	24	1	365	0	0	1	242	5	279	3	2	0	3
Orange	93	88	0	0	5	764	6	1,702	15	2,657	17	5	0	10
Placer	82	53	4	484	27	5,104	7	2,154	10	3,513	15	2	1	15
Riverside	157	127	11	2,000	20	4,476	23	3,508	32	4,811	28	26	0	29
Sacramento	295	212	49	5,678	40	3,585	58	9,464	90	5,275	67	62	1	22
San Bernardino	156	146	1	364	9	1,800	11	2,030	13	1,898	21	4	10	15
San Diego	253	230	5	567	20	3,092	8	2,098	17	4,047	13	12	23	17
San Francisco	121	109	4	370	7	818	2	363	8	1,673	2	7	1	3
San Joaquin	114	102	5	920	7	1,206	15	2,242	26	4,124	32	8	0	22
San Luis Obispo	118	108	1	365	9	1,978	2	777	9	3,631	6	4	0	10
San Mateo	71	50	10	1,543	13	1,675	5	349	20	2,129	14	13	0	13
Santa Barbara	99	82	5	773	14	1,176	8	902	18	3,302	11	15	0	11
Santa Clara	37	33	0	0	4	910	0	0	5	893	0	5	1	5
Santa Cruz	30	20	3	182	9	1,458	0	0	14	2,810	3	16	0	10
Shasta	57	40	4	865	13	1,347	1	252	4	490	3	1	0	3
Solano	105	79	9	1,518	18	3,465	17	4,802	20	4,246	18	21	9	17
Sonoma	66	59	0	0	7	1,626	3	134	16	1,286	7	14	8	9
Stanislaus	262	208	34	5,858	24	2,687	44	7,607	40	8,058	58	14	5	35
Tehama	57	38	4	277	14	1,093	4	847	6	1,097	4	1	21	5
Tri-City	79	62	5	704	12	1,117	8	1,680	16	3,135	11	13	7	12
Tuolumne	11	7	0	0	4	78	1	87	3	213	3	0	0	5
Ventura	67	58	4	618	7	622	4	625	7	684	7	2	0	3
Yolo	28	21	0	0	7	2,282	1	237	9	2,676	9	1	1	6
Total	**4,881**	**4,123**	**257**	**36,971**	**528**	**79,758**	**432**	**88,041**	**843**	**176,600**	**672**	**597**	**210**	**550**

Table 10

Cumulative "Raw" Data

November 1,1999 through January 31, 2003

County Programs	Benefits, Disenrollments, and Other													
	10.1	10.2	10.3	10.4	10.5	10.6	10.7	10.8	10.9	10.10	10.11	10.12	10.13	10.14
							Summary	Sub1	Sub2	Sub3	Sub4	Sub5	Sub6	Sub7
	Number of consumers currently enrolled	Number of consumers with co-occurring alcohol or substance abuse at enrollment	Number of consumers with at least 1 mental health contact in 12 mos prior to enrollment	Number of consumers without health insurance (e.g. Medicaid, Medicare, HMO, Vet Health) at enrollment	Number of consumers obtaining health insurance (e.g. Medicaid, Medicare, HMO, Vet Health) since enrollment	Number of consumers having served at any time in the U.S. armed forces	Number of consumers disenrolled to date	Number of disenrolled consumers who died since admission to the program	Number of disenrolled consumers found not to meet minimum program qualifications	Number of disenrolled consumers who dropped out of program	Number of disenrolled consumers who moved out of area	Number of disenrolled consumers leaving program for OTHER reasons	Number of consumers disenrolled due to Incarceration (Post-anniversary)	Number of consumers who graduated (no longer using public mental health services)
Berkeley	108	56	81	52	32	1	38	4	2	21	8	2	1	0
Butte	49	23	39	8	6	13	26	3	1	13	6	0	0	3
Contra Costa	62	42	41	25	0	6	52	1	0	48	1	2	0	0
El Dorado	53	27	40	19	3	5	103	1	12	41	21	9	0	19
Fresno	144	124	77	113	29	13	127	4	17	72	14	0	20	0
Humboldt	31	14	21	10	3	4	6	1	0	1	3	0	0	1
Kern	143	108	128	113	71	2	135	1	27	65	33	0	0	9
Los Angeles	1,694	1,226	1,028	1,163	530	74	1,112	55	42	612	189	11	184	19
Madera	50	29	39	15	8	1	48	1	1	24	15	0	1	6
Marin	103	68	73	35	32	13	14	1	5	2	1	4	0	1
Mendocino	38	13	35	12	11	6	62	5	10	27	12	5	2	1
Monterey	23	7	14	10	4	8	0	0	0	0	0	0	0	0
Napa	25	8	24	6	4	1	4	0	0	1	3	0	0	0
Orange	93	26	46	47	20	10	66	3	4	36	13	3	4	3
Placer	82	54	68	40	12	4	99	0	17	32	30	3	3	14
Riverside	157	87	154	96	9	5	306	0	5	223	61	7	0	10
Sacramento	295	175	218	212	192	52	275	13	33	127	42	48	10	2
San Bernardino	156	79	83	100	28	15	135	6	5	79	36	8	1	0
San Diego	253	146	167	130	61	22	154	6	26	91	27	0	3	1
San Francisco	121	84	70	56	16	11	71	4	6	33	20	3	4	1
San Joaquin	114	43	90	33	14	6	70	4	7	25	23	3	1	7
San Luis Obispo	118	64	81	34	3	18	96	4	4	64	19	1	1	3
San Mateo	71	27	53	32	16	8	33	6	0	16	11	0	0	0
Santa Barbara	99	51	60	54	32	7	68	6	4	31	26	0	1	0
Santa Clara	37	15	33	12	0	5	7	0	1	3	2	1	0	0
Santa Cruz	30	12	16	16	10	1	13	1	0	6	2	3	1	0
Shasta	57	21	43	7	3	10	120	1	47	37	15	0	1	19
Solano	105	72	35	33	13	18	76	2	0	63	7	3	1	0
Sonoma	66	42	46	9	5	5	30	2	6	15	3	3	0	1
Stanislaus	262	157	175	140	11	12	247	9	20	86	53	4	12	63
Tehama	57	33	45	30	26	4	40	2	12	8	12	1	3	2
Tri-City	79	34	54	49	4	7	39	2	0	23	10	3	0	1
Tuolumne	11	8	11	4	1	2	14	0	0	2	2	4	3	3
Ventura	67	28	56	32	15	11	46	3	4	25	6	2	3	3
Yolo	28	17	16	12	1	2	22	0	7	6	2	2	1	4
Total	**4,881**	**3,020**	**3,260**	**2,759**	**1,225**	**382**	**3,754**	**151**	**325**	**1,958**	**728**	**135**	**261**	**196**

Table 11

Cumulative 'Raw" Data

November 1,1999 through January 31, 2003

County Prorams	Other 24-Hour Care Facilities (Not Including Acute Inpatient)						
	11.1	11.2	11.3	11.4	11.5	11.6	11.7
	Number of consumers currently enrolled	Number of unduplicated consumers in 24-hour care facilities in the 12 mos prior to enrollment	Number of 24-hour care episodes in the 12 mos prior to enrollment	Number of 24-hour care facility days in 12 mos prior to enrollment	Number of unduplicated consumers in 24-hour care facilities since enrollment	Number of 24-hour care episodes since enrollment	Number of 24-hour care facility days since enrollment
Berkeley	108	9	9	252	29	32	4,025
Butte	49	2	2	96	0	0	0
Contra Costa	62	21	25	2,407	51	64	5,692
El Dorado	53	1	1	22	2	2	178
Fresno	144	24	27	2,923	4	4	399
Humboldt	31	4	5	53	5	8	1,088
Kern	143	11	13	1,320	12	9	2,098
Los Angeles	1,694	174	188	22,884	132	153	20,001
Madera	50	0	0	0	5	6	399
Marin	103	3	4	142	6	12	561
Mendocino	38	1	2	87	8	11	392
Monterey	23	1	1	150	8	9	630
Napa	25	6	7	503	5	4	228
Orange	93	3	3	99	14	17	2,005
Placer	82	23	27	2,698	38	34	8,462
Riverside	157	16	16	1,184	37	35	5,606
Sacramento	295	11	13	459	16	34	548
San Bernardino	156	4	4	87	6	6	578
San Diego	253	30	36	2,140	38	35	4,673
San Francisco	121	30	39	1,889	34	48	5,727
San Joaquin	114	19	22	1,710	24	17	1,777
San Luis Obispo	118	7	7	1,553	32	37	8,449
San Mateo	71	22	22	1,399	18	13	1,743
Santa Barbara	99	7	7	1,177	7	4	470
Santa Clara	37	19	27	1,691	16	13	999
Santa Cruz	30	4	4	510	10	13	1,880
Shasta	57	4	4	706	5	4	223
Solano	105	10	12	904	73	96	6,983
Sonoma	66	6	6	367	23	25	3,644
Stanislaus	262	12	12	1,802	29	39	748
Tehama	57	0	0	0	0	0	0
Tri-City	79	6	7	534	9	9	943
Tuolumne	11	0	0	0	0	0	0
Ventura	67	1	1	363	1	1	23
Yolo	28	3	6	124	17	23	716
Total	**4,881**	**494**	**559**	**52,235**	**714**	**817**	**91,888**

Appendix 4

Integrated Services for Homeless Adults Programs
(All Funded Programs)

Annualized Data and Corresponding Graphs

November 1, 1999 through January 31, 2003

Table 5

Annualized Data

November 1, 1999 through January 31, 2003

County Programs	Annualized Psychiatric Hospitalizations						
	5.1	5.2	5.3	5.4	5.5	5.6	5.7
	Number of consumers currently enrolled	Number of unduplicated consumers hospitalized in 12 mos prior to enrollment	Number of hospitalizations in 12 mos prior to enrollment	Number of hospital days in 12 mos prior to enrollment	Number of unduplicated consumers hospitalized since enrollment - annualized for avg. length of enrollment	Number of hospitalizations since enrollment - annualized for avg length of enrollment	Number of hospital days since enrollment - annualized for avg length of enrollment
Berkeley	108	43	110	2,775	26	47	778
Butte	49	18	31	226	8	20	134
Contra Costa	62	6	6	458	11	16	382
El Dorado	53	13	15	641	7	7	26
Fresno	144	27	35	601	9	14	60
Humboldt	31	5	6	125	4	6	129
Kern	143	34	42	1,495	11	16	135
Los Angeles	1,694	302	459	12,580	197	451	5,022
Madera	50	3	5	39	2	3	12
Marin	103	35	96	620	23	40	373
Mendocino	38	6	7	288	3	7	40
Monterey	23	8	15	192	7	9	83
Napa	25	3	3	87	3	3	352
Orange	93	37	55	1,058	23	47	1,365
Placer	82	23	29	1,416	7	15	435
Riverside	157	15	25	414	15	29	234
Sacramento	295	66	125	1,450	19	42	682
San Bernardino	156	43	61	700	31	82	652
San Diego	253	82	144	2,634	54	113	1,721
San Francisco	121	54	102	1,691	35	72	922
San Joaquin	114	15	16	524	13	19	138
San Luis Obispo	118	26	38	510	12	16	137
San Mateo	71	50	90	2,583	14	26	277
Santa Barbara	99	17	19	315	9	23	255
Santa Clara	37	14	19	747	8	14	252
Santa Cruz	30	7	8	133	7	10	97
Shasta	57	14	15	232	3	3	27
Solano	105	5	5	57	5	6	89
Sonoma	66	30	46	897	10	20	370
Stanislaus	262	85	154	1,026	41	79	686
Tehama	57	10	10	804	12	16	463
Tri-City	79	14	16	381	7	10	68
Tuolumne	11	5	6	63	1	1	1
Ventura	67	9	15	111	13	30	356
Yolo	28	6	9	65	3	3	26
Total	**4,881**	**1,130**	**1,837**	**37,938**	**652**	**1,316**	**16,778**

Table 6

Annualized Data

November 1, 1999 through January 31, 2003

County Programs	Annualized Incarcerations, Probation and Parole								
	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9
	Number of consumers currently enrolled	Number of consumers on probation at any time in 12 mos prior to enrollment	Number of consumers on parole at any time in 12 mos prior to enrollment	Number of unduplicated consumers incarcerated in 12 months prior to enrollment	Number of incarcerations in 12 months prior to enrollment	Number of days incarcerated in 12 months prior to enrollment	Number of unduplicated consumers incarcerated since enrollment - annualized for avg. length of enrollment	Number of incarcerations since enrollment - annualized for avg. length of enrollment	Number of days incarcerated since enrollment - annualized for avg. length of enrollment
Berkeley	108	11	2	49	79	3,574	22	40	1,373
Butte	49	7	1	10	17	497	6	10	482
Contra Costa	62	0	1	10	13	1,576	8	9	920
El Dorado	53	15	2	15	21	1,472	7	7	113
Fresno	144	32	20	58	70	6,578	24	31	2,146
Humboldt	31	3	0	12	14	738	5	6	99
Kern	143	12	2	42	49	1,735	14	19	1,051
Los Angeles	1,694	258	178	808	986	129,376	264	407	27,249
Madera	50	8	13	27	32	4,835	12	22	1,976
Marin	103	14	11	17	36	1,474	11	27	1,231
Mendocino	38	7	0	13	20	981	7	8	231
Monterey	23	0	0	2	2	49	0	0	0
Napa	25	6	1	7	7	1,435	6	6	872
Orange	93	0	0	29	35	2,921	13	22	848
Placer	82	13	3	23	28	3,149	9	12	410
Riverside	157	5	2	29	29	3,681	16	18	1,514
Sacramento	295	74	5	116	216	4,016	50	120	1,332
San Bernardino	156	29	3	36	43	4,440	18	42	1,619
San Diego	253	30	10	50	56	3,897	30	38	1,771
San Francisco	121	31	4	54	76	6,020	21	45	1,671
San Joaquin	114	16	3	14	16	1,344	3	3	19
San Luis Obispo	118	25	5	39	51	4,555	14	21	836
San Mateo	71	3	1	17	19	1,619	9	16	391
Santa Barbara	99	12	4	24	28	2,600	18	34	1,552
Santa Clara	37	4	0	10	11	449	11	16	776
Santa Cruz	30	1	0	7	12	122	2	2	2
Shasta	57	7	2	16	17	763	7	9	628
Solano	105	11	3	37	40	4,531	22	31	1,785
Sonoma	66	4	1	15	17	2,292	7	10	450
Stanislaus	262	59	13	63	100	5,277	39	101	2,376
Tehama	57	22	4	27	27	2,163	16	26	1,893
Tri-City	79	11	7	14	16	2,060	9	14	1,260
Tuolumne	11	3	1	2	2	197	1	1	1
Ventura	67	1	0	16	19	1,994	11	20	404
Yolo	28	4	1	8	16	696	3	6	154
Total	**4,881**	**738**	**303**	**1,716**	**2,220**	**213,106**	**715**	**1,200**	**59,434**

Table 8
Annualized Data
November 1, 1999 through January 31, 2003

Annualized Housing

County Programs	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	8.10	8.11	8.12	8.13
				Summary	Sub1	Sub2	Sub3	Sub4					
	Number of consumers currently enrolled	Number unduplicated consumers homeless during 12 mos prior to enrollment	Number of homeless days during 12 mos prior to enrollment	Number of consumers homeless at enrollment	Number of consumers on the street at enrollment	Number of consumers in jail at enrollment	Number of consumers in a shelter at enrollment	Number of consumers in a treatment facility at enrollment	Number of homeless days since enrollment (INCLUDING SHELTER DAYS) - annualized for avg. length of enrollment	Number of unduplicated consumers becoming homeless since enrollment (INCLUDING CONSUMERS IN SHELTERS) - annualized for avg. length of	Number of consumers currently maintaining housing (EXCLUDING CONSUMERS IN SHELTERS)	Number of homeless days since enrollment (EXCLUDING SHELTER DAYS) - annualized for avg. length of enrollment	Number of consumers currently maintaining housing (INCLUDING CONSUMERS IN SHELTERS)
Berkeley	108	106	34,108	101	84	3	13	1	14,698	45	75	12,611	77
Butte	49	47	9,102	35	23	1	10	1	1,142	8	43	973	43
Contra Costa	62	62	16,615	48	8	0	40	0	5,523	47	54	3,173	58
El Dorado	53	40	6,556	33	30	3	0	0	2,081	7	48	2,081	48
Fresno	144	110	25,410	39	29	5	5	0	4,740	37	123	4,466	125
Humboldt	31	30	9,182	24	19	1	3	1	2,433	9	25	2,067	25
Kern	143	109	21,846	48	37	1	8	2	3,528	17	136	2,679	137
Los Angeles	1,694	1,423	348,908	993	537	308	123	25	102,603	345	1,432	72,434	1,471
Madera	50	38	8,522	15	4	3	8	0	2,549	15	43	2,156	43
Marin	103	103	28,966	103	66	0	34	3	15,480	46	77	14,880	79
Mendocino	38	33	7,836	31	22	1	8	0	4,747	11	26	4,250	30
Monterey	23	23	5,498	20	18	0	0	2	2,336	14	17	2,027	18
Napa	25	23	4,984	21	21	0	0	0	4,926	8	18	4,926	18
Orange	93	82	20,872	67	48	4	5	10	7,018	34	78	5,670	82
Placer	82	66	13,796	44	35	4	2	3	4,763	20	66	3,806	68
Riverside	157	136	28,715	83	54	2	26	1	11,378	39	131	8,103	140
Sacramento	295	295	65,791	234	172	3	47	12	9,632	94	272	9,318	277
San Bernardino	156	120	18,956	102	87	2	12	1	13,890	56	125	10,207	128
San Diego	253	229	55,262	187	110	7	58	12	14,896	38	217	10,168	220
San Francisco	121	121	34,688	86	51	18	15	2	7,122	21	112	5,029	114
San Joaquin	114	69	8,435	45	22	2	20	1	1,067	4	114	317	114
San Luis Obispo	118	111	31,245	99	71	5	22	1	22,045	27	57	17,074	61
San Mateo	71	53	9,827	29	18	0	9	2	1,977	14	65	1,977	65
Santa Barbara	99	81	17,315	63	46	1	16	0	6,762	31	85	4,426	92
Santa Clara	37	28	4,185	17	5	2	8	2	3,640	14	27	1,960	31
Santa Cruz	30	30	9,426	24	15	2	7	0	2,427	9	27	1,383	29
Shasta	57	45	7,329	33	19	0	14	0	6,756	16	36	4,269	42
Solano	105	103	28,504	85	73	2	10	0	8,802	44	71	7,637	73
Sonoma	66	57	14,308	43	29	2	10	2	3,992	23	51	3,483	51
Stanislaus	262	212	43,833	166	129	3	34	0	13,806	47	219	12,271	225
Tehama	57	37	6,642	27	27	0	0	0	5,971	17	36	5,625	36
Tri-City	79	59	13,496	36	25	4	7	0	4,417	14	69	3,719	70
Tuolumne	11	11	3,013	11	9	0	2	0	232	1	11	98	11
Ventura	67	59	14,562	49	44	0	5	0	3,232	19	59	3,024	60
Yolo	28	26	5,976	14	12	0	0	2	1,056	7	27	1,013	27
Total	**4,881**	**4,177**	**983,709**	**3,055**	**1,999**	**389**	**581**	**86**	**321,667**	**1,197**	**4,072**	**249,298**	**4,188**

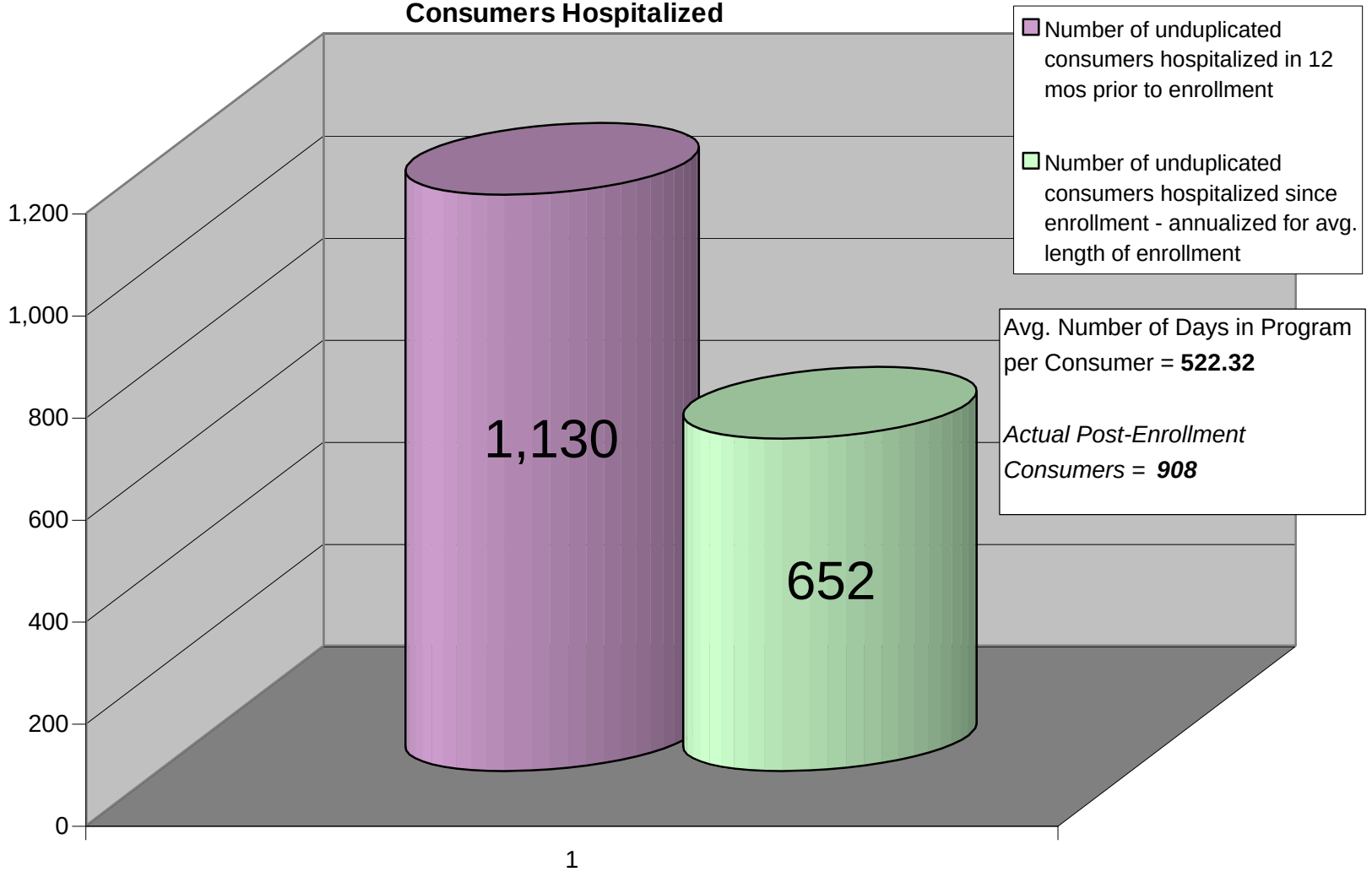
Table 9
Annualized Data
November 1,1999 through January 31, 2003

County Programs	Annualized Employment													
	9.1	9.2	9.3	9.4	9.5	9.6	9.7	9.8	9.9	9.10	9.11	9.12	9.13	9.14
	Number of consumers currently enrolled	Number of consumers with no employment in 12 mos. prior to enrollment	Number of consumers employed full time (32+ hours) in 12 mos. prior to enrollment	Number of days employed full time (32+ hrs) in 12 mos. prior to enrollment	Number of consumers employed part time (< 32 hours) in 12 mos. prior to enrollment	Number of days employed part time (< 32 hrs) in 12 mos. prior to enrollment	Number of consumers employed full time since enrollment - annualized for avg. length of enrollment	Number of days employed full time since enrollment - annualized for avg. length of enrollment	Number of consumers employed part time since enrollment - annualized for avg. length of enrollment	Number of days employed part time since enrollment - annualized for avg. length of enrollment	Number of consumers in competitive employment since enrollment - annualized for avg. length of enrollment	Number of consumers in supported employment since enrollment - annualized for avg. length of enrollment	Number of consumers referred to Dept. of Rehab	Number of consumers employed at end of period
Berkeley	108	102	0	0	6	701	0	0	3	833	2	2	0	2
Butte	49	38	4	158	7	1,003	2	414	14	4,263	1	15	2	13
Contra Costa	62	57	1	11	4	118	9	1,138	16	1,208	2	22	11	6
El Dorado	53	34	0	0	19	3,928	13	1,611	19	2,986	19	9	1	10
Fresno	144	119	15	2,280	7	872	9	1,033	17	2,064	25	1	22	12
Humboldt	31	29	1	88	1	31	0	0	1	472	0	1	0	2
Kern	143	119	8	1,109	16	2,428	1	117	3	466	0	5	0	2
Los Angeles	1,694	1,502	52	8,311	141	23,479	83	22,366	181	53,639	136	145	49	199
Madera	50	45	0	0	5	1,084	3	549	6	1,410	3	6	0	5
Marin	103	72	16	1,502	22	987	11	1,159	20	1,525	16	15	31	9
Mendocino	38	31	1	61	6	1,881	2	631	5	1,731	3	3	2	8
Monterey	23	19	0	0	4	887	2	208	7	515	5	5	4	2
Napa	25	24	1	365	0	0	2	369	8	425	5	3	0	3
Orange	93	88	0	0	5	764	4	1,171	10	1,828	12	3	0	10
Placer	82	53	4	484	27	5,104	5	1,590	7	2,593	11	1	1	15
Riverside	157	127	11	2,000	20	4,476	25	3,753	34	5,147	30	28	0	29
Sacramento	295	212	49	5,678	40	3,585	30	4,902	47	2,732	35	32	1	22
San Bernardino	156	146	1	364	9	1,800	11	2,065	13	1,930	21	4	10	15
San Diego	253	230	5	567	20	3,092	6	1,513	12	2,919	9	9	23	17
San Francisco	121	109	4	370	7	818	2	298	7	1,375	2	6	1	3
San Joaquin	114	102	5	920	7	1,206	14	2,075	24	3,818	30	7	0	22
San Luis Obispo	118	108	1	365	9	1,978	2	828	10	3,868	6	4	0	10
San Mateo	71	50	10	1,543	13	1,675	4	310	18	1,889	12	12	0	13
Santa Barbara	99	82	5	773	14	1,176	6	674	13	2,467	8	11	0	11
Santa Clara	37	33	0	0	4	910	0	0	5	839	0	5	1	5
Santa Cruz	30	20	3	182	9	1,458	0	0	11	2,262	2	13	0	10
Shasta	57	40	4	865	13	1,347	1	371	6	722	4	1	0	3
Solano	105	79	9	1,518	18	3,465	18	5,101	21	4,510	19	22	9	17
Sonoma	66	59	0	0	7	1,626	2	85	10	815	4	9	8	9
Stanislaus	262	208	34	5,858	24	2,687	25	4,331	23	4,587	33	8	5	35
Tehama	57	38	4	277	14	1,093	3	574	4	743	3	1	21	5
Tri-City	79	62	5	704	12	1,117	5	1,006	10	1,878	7	8	7	12
Tuolumne	11	7	0	0	4	78	1	91	3	222	3	0	0	5
Ventura	67	58	4	618	7	622	4	580	6	635	6	2	0	3
Yolo	28	21	0	0	7	2,282	1	245	9	2,767	9	1	1	6
Total	**4,881**	**4,123**	**257**	**36,971**	**528**	**79,758**	**307**	**61,157**	**604**	**122,083**	**483**	**418**	**210**	**550**

Table 11
Annualized Data
November 1,1999 through January 31, 2003

County Prorams	Annualized Other 24-Hour Care Facilities (Not Including Acute Inpatient)						
	11.1	11.2	11.3	11.4	11.5	11.6	11.7
	Number of consumers currently enrolled	Number of unduplicated consumers in 24-hour care facilities in the 12 mos prior to enrollment	Number of 24-hour care episodes in the 12 mos prior to enrollment	Number of 24-hour care facility days in 12 mos prior to enrollment	Number of unduplicated consumers in 24-hour care facilities since enrollment - annualized for avg. length of enrollment	Number of 24-hour care episodes since enrollment - annualized for avg. length of enrollment	Number of 24-hour care facility days since enrollment - annualized for avg. length of enrollment
Berkeley	108	9	9	252	22	25	3,117
Butte	49	2	2	96	0	0	0
Contra Costa	62	21	25	2,407	79	100	8,850
El Dorado	53	1	1	22	3	3	258
Fresno	144	24	27	2,923	3	3	287
Humboldt	31	4	5	53	4	6	774
Kern	143	11	13	1,320	12	9	2,033
Los Angeles	1,694	174	188	22,884	79	89	12,100
Madera	50	0	0	0	4	4	279
Marin	103	3	4	142	4	8	355
Mendocino	38	1	2	87	4	6	220
Monterey	23	1	1	150	19	21	1,488
Napa	25	6	7	503	8	6	348
Orange	93	3	3	99	10	12	1,379
Placer	82	23	27	2,698	28	25	6,246
Riverside	157	16	16	1,184	40	37	5,997
Sacramento	295	11	13	459	8	18	284
San Bernardino	156	4	4	87	6	6	588
San Diego	253	30	36	2,140	27	25	3,371
San Francisco	121	30	39	1,889	28	39	4,708
San Joaquin	114	19	22	1,710	22	16	1,645
San Luis Obispo	118	7	7	1,553	34	39	9,001
San Mateo	71	22	22	1,399	16	12	1,546
Santa Barbara	99	7	7	1,177	5	3	351
Santa Clara	37	19	27	1,691	15	12	938
Santa Cruz	30	4	4	510	8	10	1,513
Shasta	57	4	4	706	7	6	329
Solano	105	10	12	904	78	102	7,418
Sonoma	66	6	6	367	15	16	2,310
Stanislaus	262	12	12	1,802	17	22	426
Tehama	57	0	0	0	0	0	0
Tri-City	79	6	7	534	5	5	565
Tuolumne	11	0	0	0	0	0	0
Ventura	67	1	1	363	1	1	21
Yolo	28	3	6	124	18	24	740
Total	**4,881**	**494**	**559**	**52,235**	**628**	**710**	**79,488**

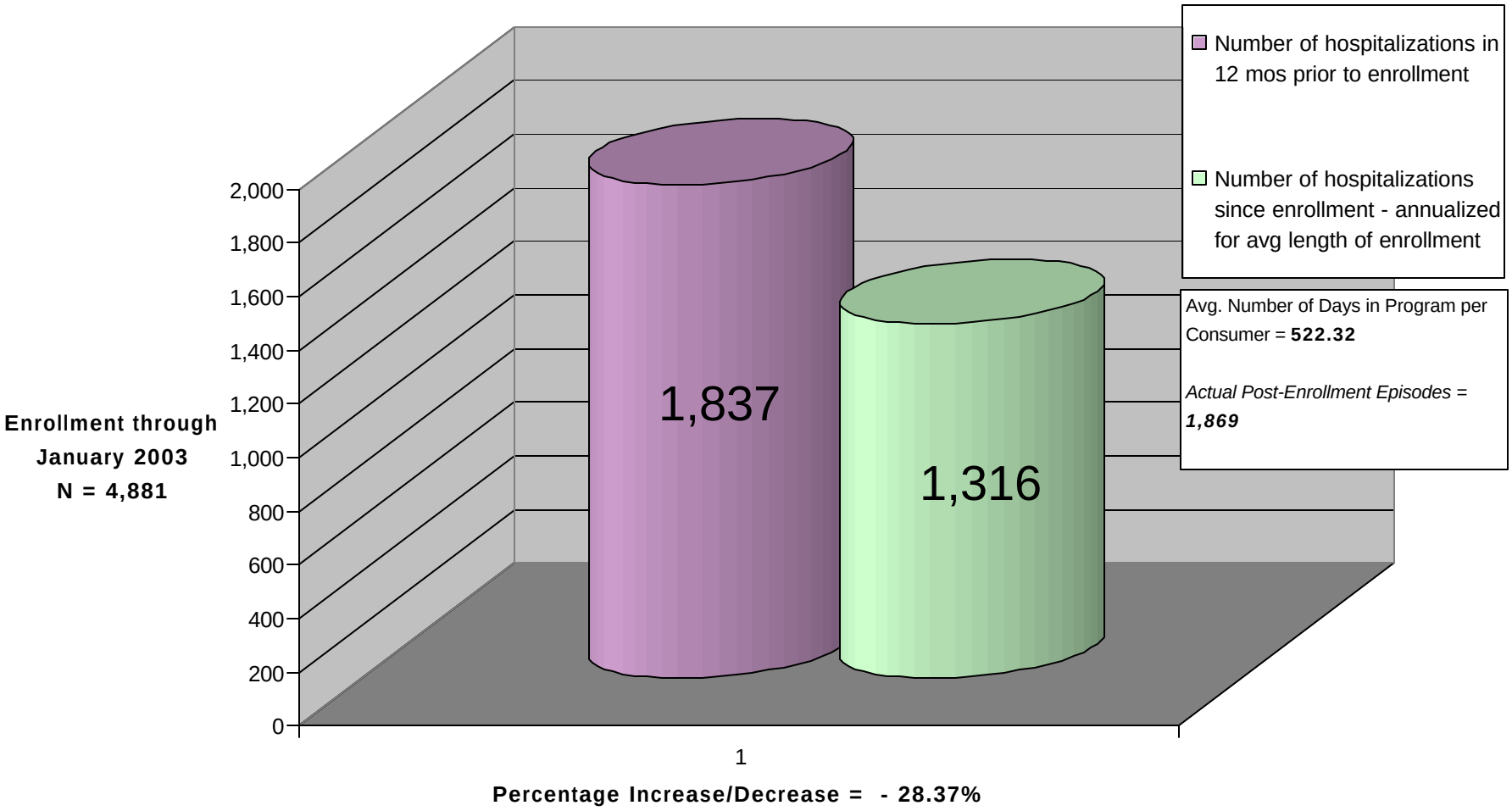
Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Psychiatric Hospitalizations
Consumers Hospitalized



Enrollment through January 2003
N = 4,881

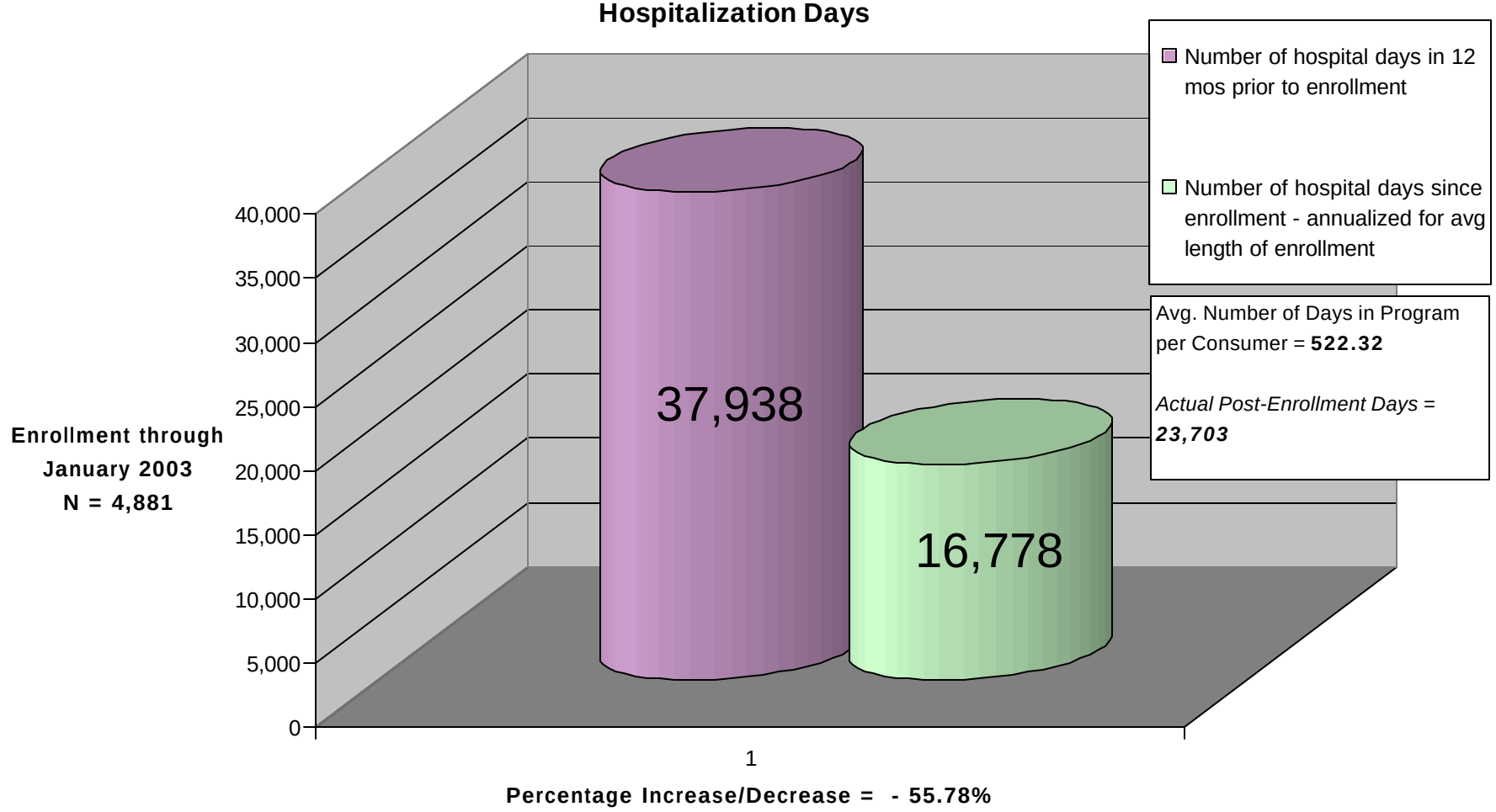
Percentage Increase/Decrease = - 42.30%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Psychiatric Hospitalizations
Hospitalization Episodes



Percentage Increase/Decrease = - 28.37%

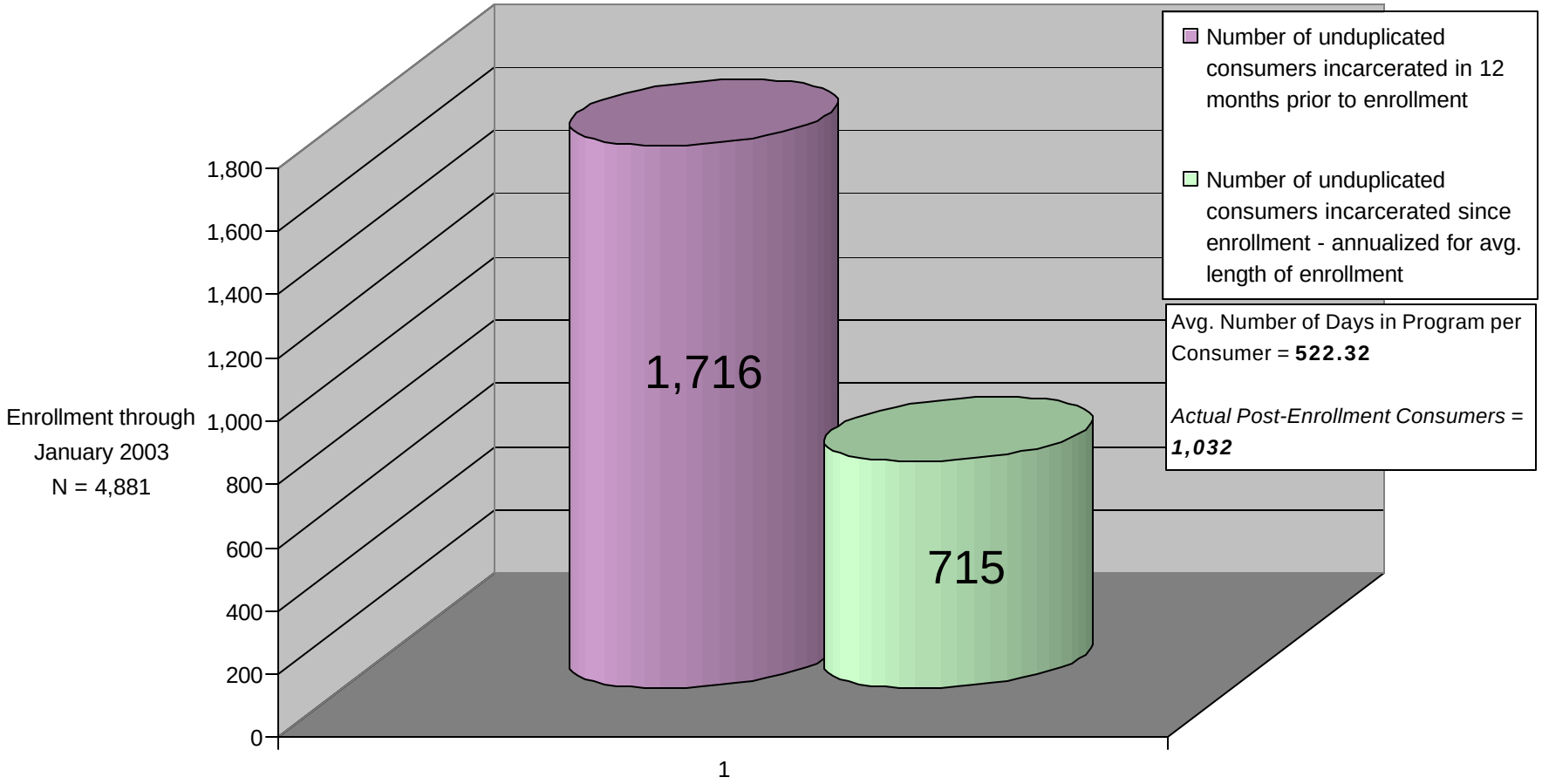
Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Psychiatric Hospitalizations
Hospitalization Days



Enrollment through January 2003
N = 4,881

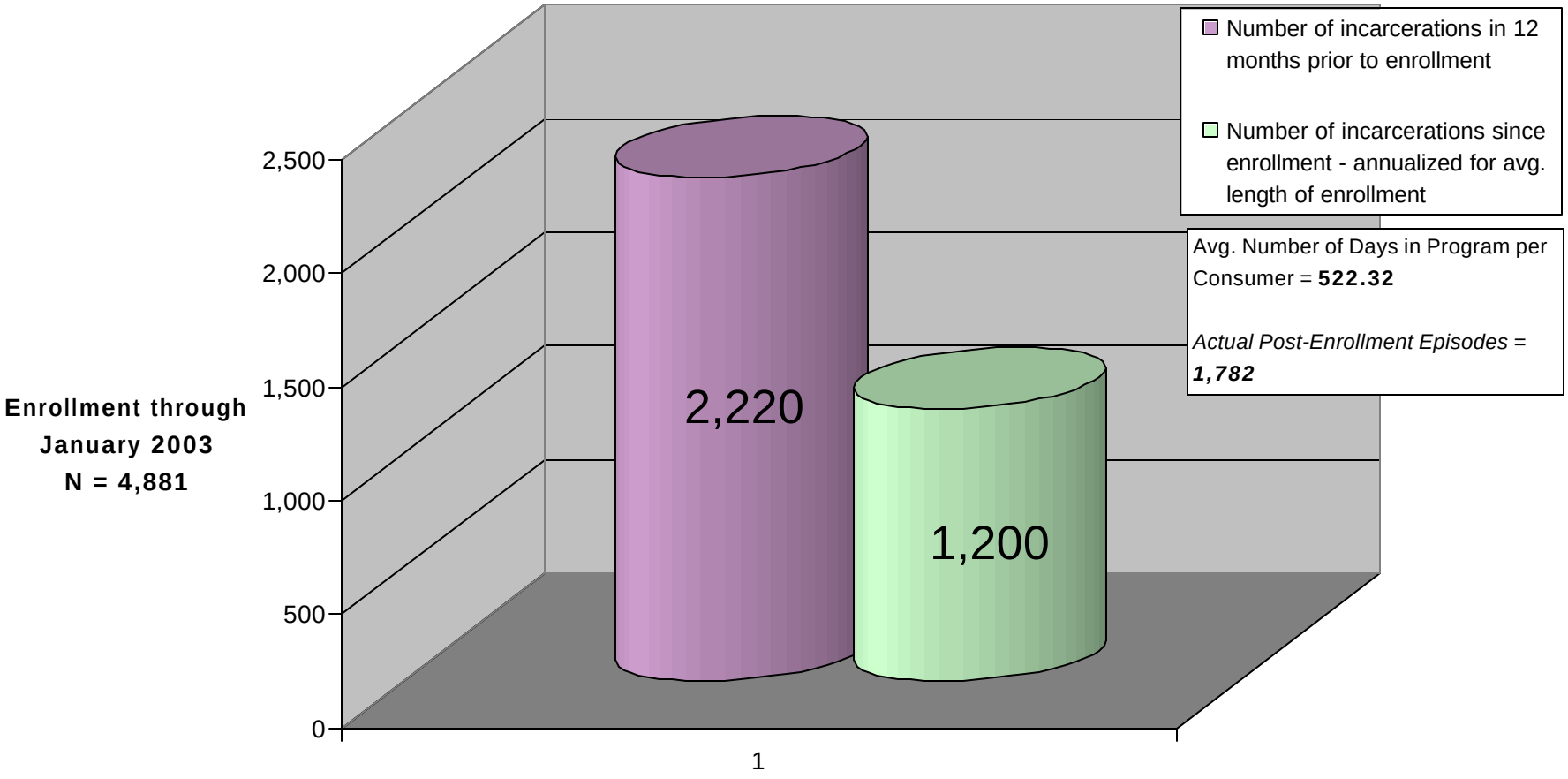
Percentage Increase/Decrease = - 55.78%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Consumers Incarcerated



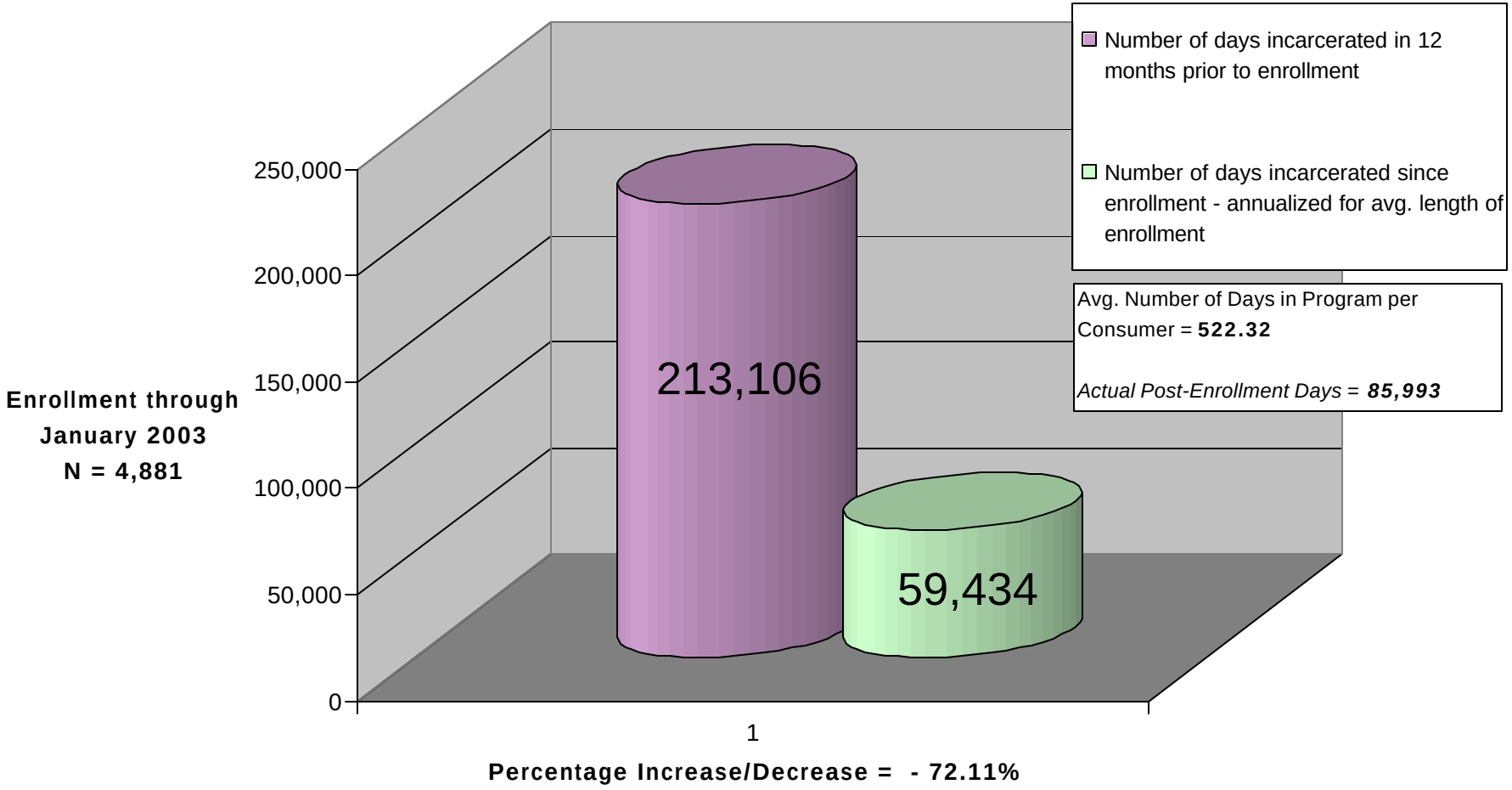
Percentage Increase/Decrease = - 58.33%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Incarceration Episodes



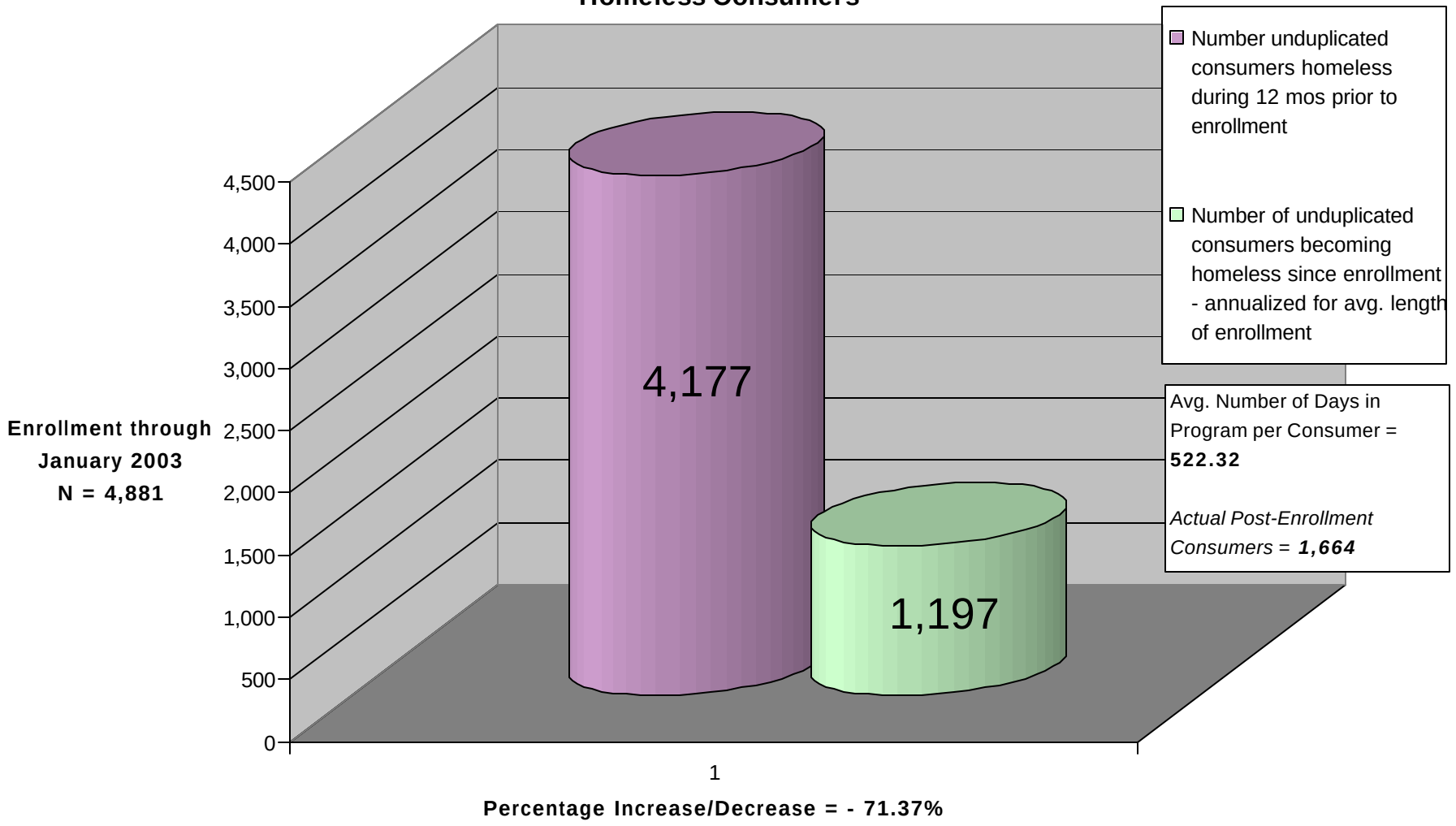
Percentage Increase/Decrease = - 45.93%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Incarceration Days

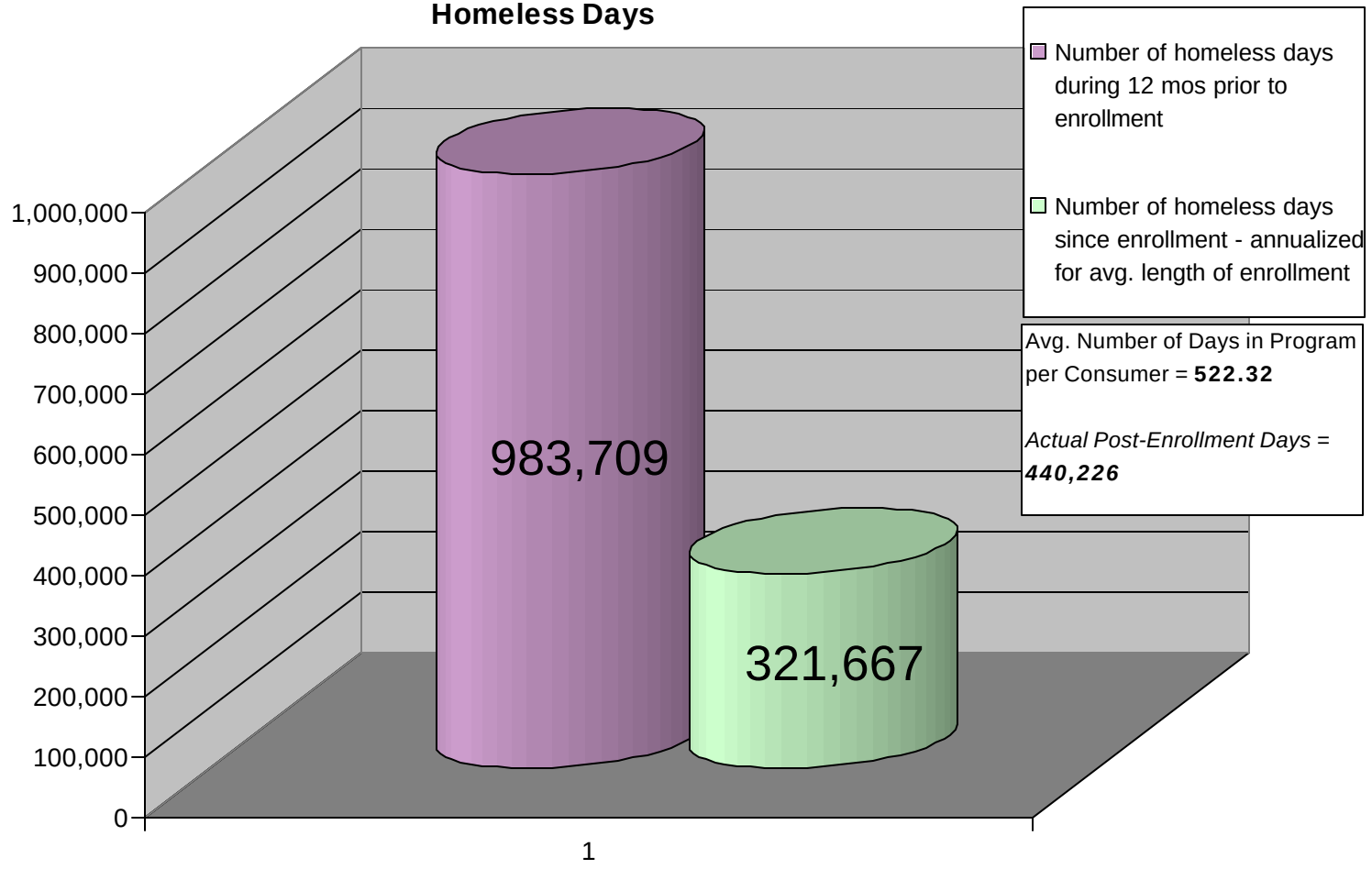


Percentage Increase/Decrease = - 72.11%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Homeless Consumers



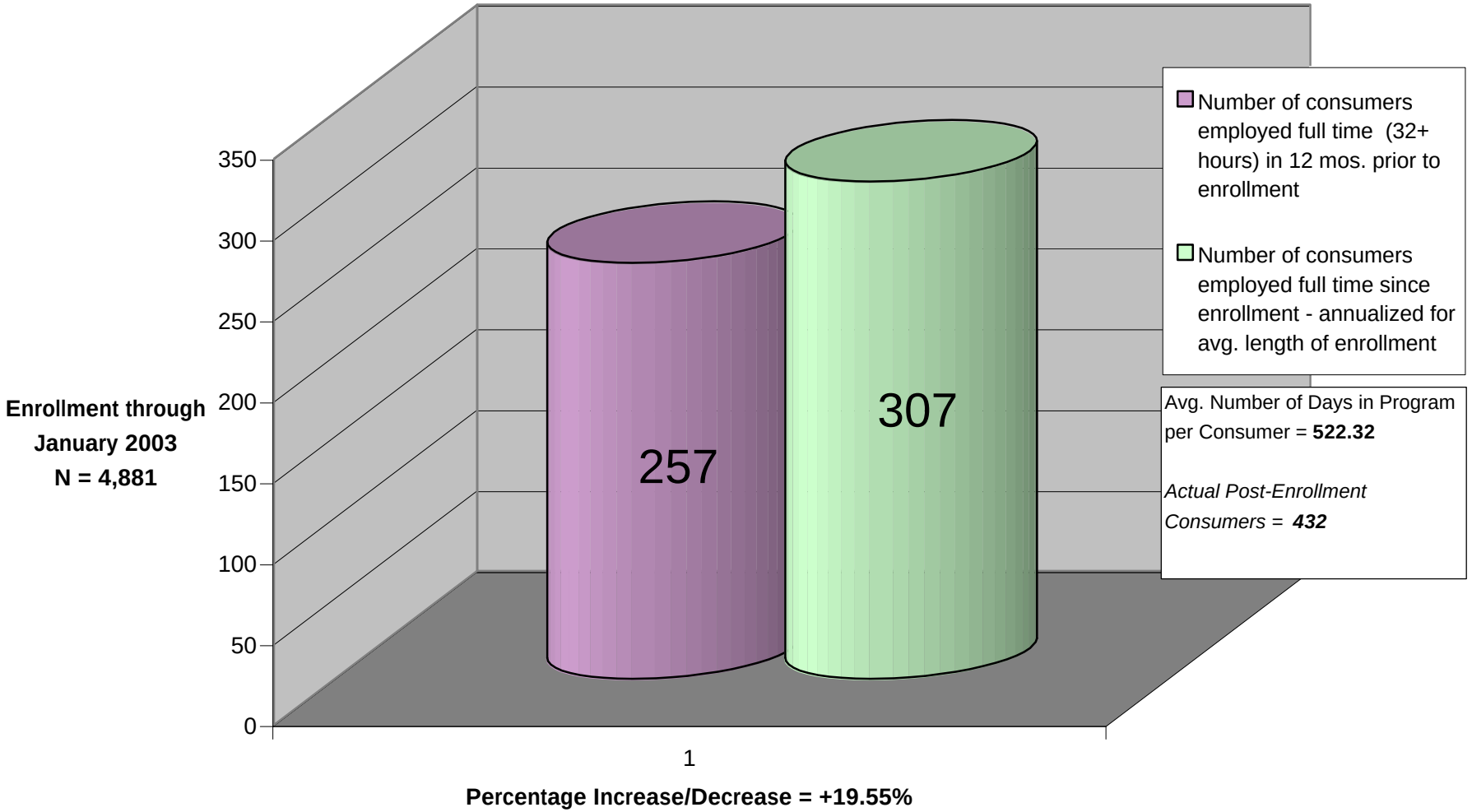
Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Homeless Days



Enrollment through January 2003
N = 4,881

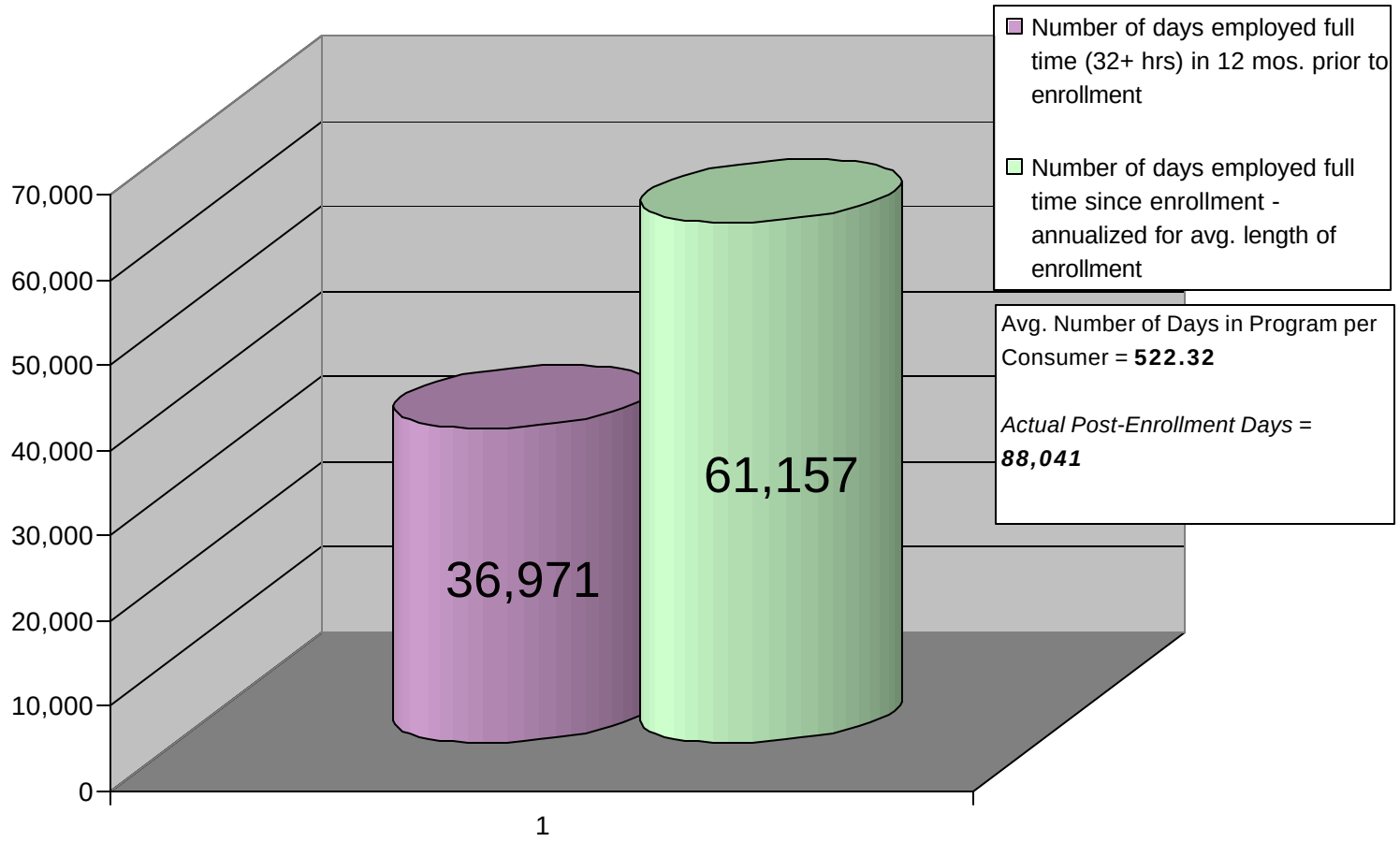
Percentage Increase/Decrease = - 67.32%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Full-Time Employed Consumers (Full-Time Employment - 32+ hours per week)



Percentage Increase/Decrease = +19.55%

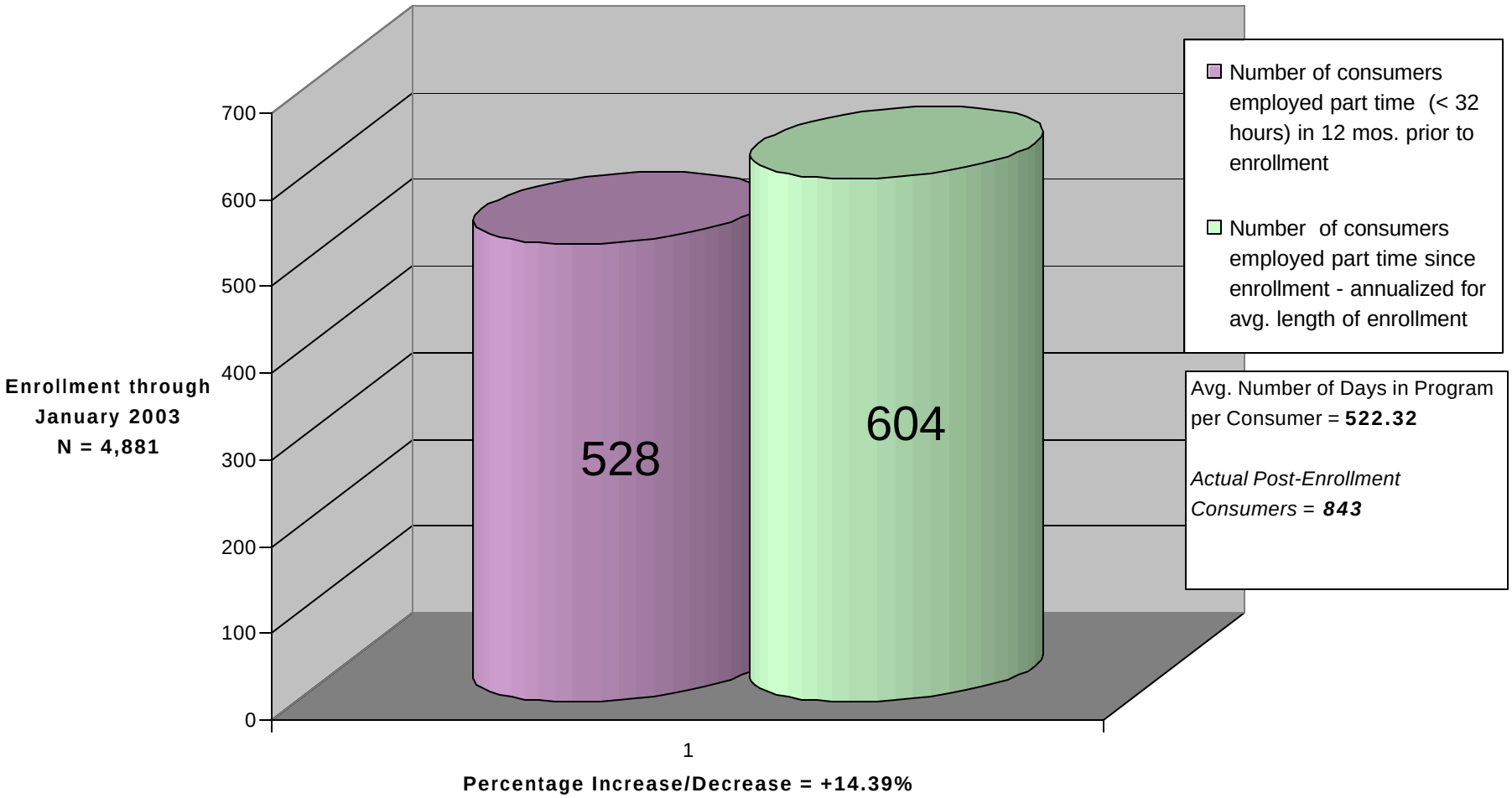
Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Full-Time Employment Days (Full-Time Employment - 32+hours per week)



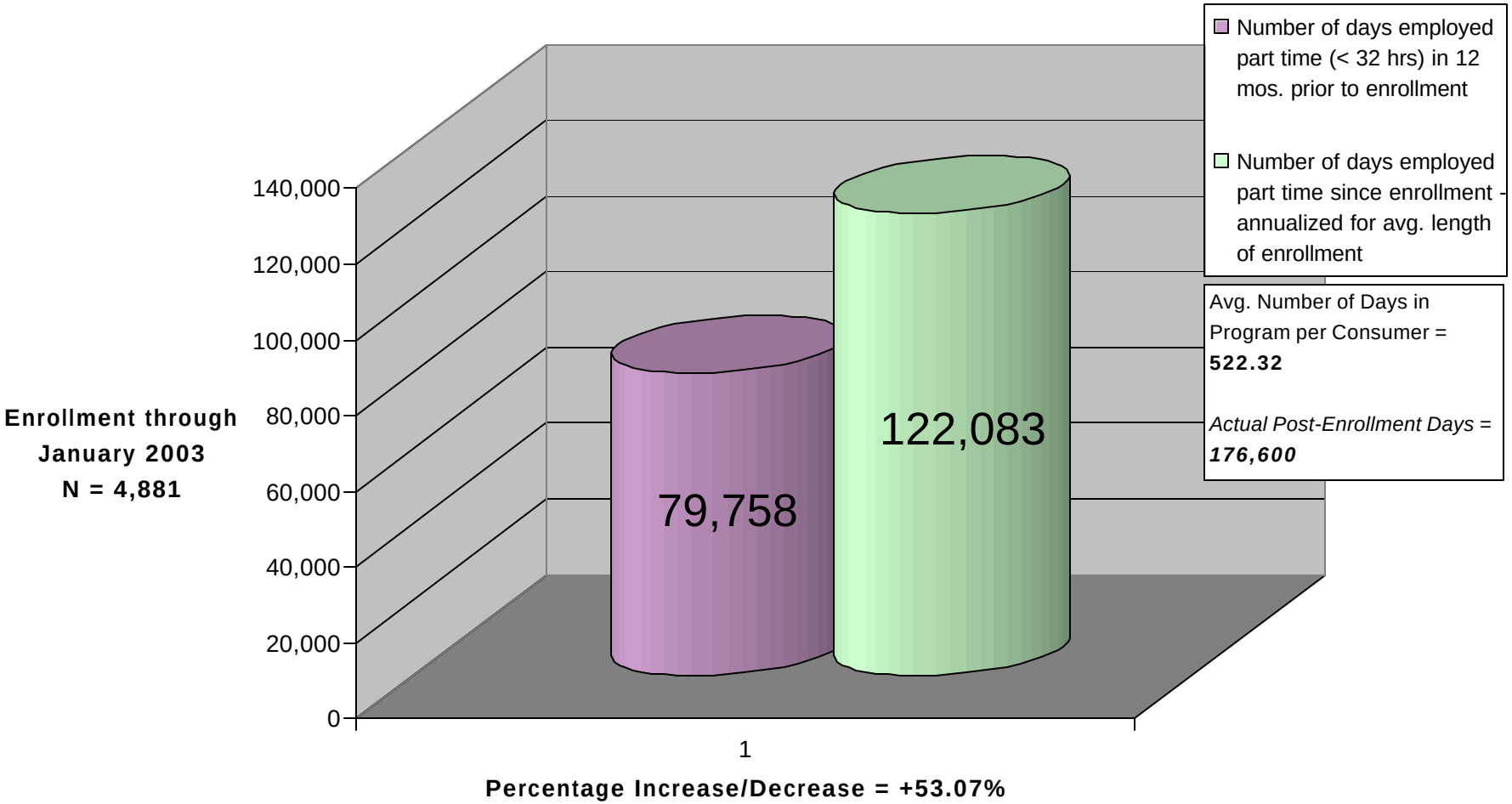
Enrollment through January 2003
N = 4,881

Percentage Increase/Decrease = +65.42%

Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Part-Time Employed Consumers (Part-Time Employment - <32 hours per week)



Integrated Services for Homeless Adults (All Funded Programs)
November 1, 1999 through January 31, 2003
Part-Time Employment Days (Part-Time Employment - <32 hours per week)



Revised Factor for Annualizing AB 2034 Post-Enrollment Cumulative Data

The AB 2034 programs collect twelve months of pre-enrollment historical data on every consumer enrolled in the program. This information is then compared to their post-enrollment statistics. However, most members have not been in the program for exactly one year – They may have been in the program anywhere from 1 day to (currently) 3 years and 3 months. To complicate things even more, on a program level this is changing with every new enrollment and disenrollment and with every passing day.

Past Legislative Reports have used the length of time the AB 2034 programs had been in operation to calculate an annualization factor that allows the accurate comparison of pre-enrollment and post-enrollment data. For example, if a particular county's AB 2034 program had been in operation for 15 months, then total hospital days post-enrollment would be divided by 15 to equal one month, and then multiplied by 12 to equate to 12 months. This same calculation was then used for all post-enrollment data for that county.

However, using the length of time a program has been in operation has a significant problem. Namely, it tends to "over-correct" because it assumes that all consumers have been in the program since the day the program began. This results in the program's post-enrollment reductions in such areas as hospitalization and incarceration appearing slightly better than they actually are.

To be more accurate we now annualize the post-enrollment data based on the average length of enrollment for all consumers in that program. As a result the data grids more accurately compare one year pre-enrollment to one year post-enrollment. Altering this calculation does impact the results reported in terms of reductions in hospitalization, incarceration and homelessness. Compared to the information included in last year's legislative report, the percent of reduction in these areas is lower by from 10% to about 12%.

As a result, the 65.6% reduction reported last year for hospital days, is now being reported as a 55.8% reduction in hospital days. The good news is that this level of reduction appears consistent with results reported in other studies of supported housing efforts for homeless individuals. For example, the study conducted in San Francisco by the Corporation for Supportive Housing, and cited previously in this report, indicates that for persons in housing at least one year, hospital days decreased by 57%.

A reduction of 81.5% was reported last year for days of incarceration. This report reflects a 72.1% reduction. Clearly this is still a significant reduction in jail days and although we do not have data from every program, information reported from a few programs indicates that a significant number of the post-enrollment jail days were attributable to offenses committed prior to enrollment.
A reduction of 79.1% was reported last year for homeless days. This report reflects a 67.0% reduction in homeless days.

What follows is hypothetical information used to demonstrate the new calculation for annualizing post-enrollment data.

1. To make this calculation, you need the average tenure of the currently enrolled clients in the program. Consider the following (hypothetical) program of 10 members:

Member	Length of Stay in Program
1	398
2	243
3	25
4	579
5	2
6	634
7	132
8	234
9	89
10	254
Total	2,590

The total number of days that the 10 currently enrolled members have spent in the program is 2,590. Since there are 10 members in the program, divide 2,590 by 10 to arrive at an average tenure of 259 days per member. This is the average tenure for the currently enrolled AB 2034 members.

2. Next, you divide one year (365 days) by the average tenure to get the annualization factor:

365 days in a year / 259 average tenure days = 1.41 annualization factor

3. Finally, you apply the annualization factor to the post-enrollment cumulative data by multiplying the non-annualized post-enrollment hospital days by the annualization factor.

Non-annualized Number of Hospital Days Post-Enrollment = 923

923 x 1.41 =

Annualized Number of Hospital Days Post-Enrollment = 1,301

Thus, if a program has been in existence LESS than a year (as in this example), their post enrollment numbers will be GREATER than their raw numbers. If a program has been in existence MORE than a year, then their post-enrollment numbers will be SMALLER than their raw numbers. (And, of course, if the average tenure was EXACTLY 1 year, then the annualized numbers and the raw numbers would be equal).

All the data in the "Annualized" tables have been calculated using this method.

Appendix 6

Integrated Services for Homeless Adults Programs
(All Funded Programs)

Current Data and Corresponding Graph

As of January 31, 2003

Table 8-1 : Housing – Page 1

Table 8-2 : Housing (Continued) – Page 2

Table 9 : Employment

Table 8-3 : Consumers Homeless at Enrollment vs. Consumers Currently Homeless -- Page 1

Table 8-4 : Consumers Homeless at Enrollment vs. Consumers Currently Homeless (Continued) -- Page 2

Graph 13 : Homelessness

-Consumers Homeless at Enrollment vs.

Consumers Currently Homeless

Current Data

As of January 31,2003

Housing -- Page 1

County Programs	8.1 Number of consumers currently enrolled	8.2 Number of consumers homeless or in shelters at end of period	8.3 Percentage of consumers homeless or in shelters at end of period	8.4 Number of consumers in jail or prison at end of period	8.5 Percentage of consumers in jail or prison at end of period	8.6 Number of consumers in state hospital (or long term acute hospital) at end of period	8.7 Percentage of consumers in state hospital (or long term acute hospital) at end of period	8.8 Number of consumers in SNF or IMD at end of period	8.9 Percentage of consumers in SNF or IMD at end of period	8.10 Number of consumers in Crisis, Transitional, or Long-Term Residential Treatment at end of period	8.11 Percentage of consumers in Crisis, Transitional, or Long-Term Residential Treatment at end of period
Berkeley	108	30	27.8%	3	2.8%	0	0.0%	2	1.9%	4	3.7%
Butte	49	2	4.1%	4	8.2%	0	0.0%	0	0.0%	0	0.0%
Contra Costa	62	7	11.3%	1	1.6%	0	0.0%	0	0.0%	21	33.9%
El Dorado	53	5	9.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Fresno	144	14	9.7%	7	4.9%	0	0.0%	0	0.0%	0	0.0%
Humboldt	31	6	19.4%	0	0.0%	0	0.0%	0	0.0%	1	3.2%
Kern	143	6	4.2%	1	0.7%	0	0.0%	0	0.0%	1	0.7%
Los Angeles	1,694	193	11.3%	69	4.1%	0	0.0%	12	0.7%	28	1.7%
Madera	50	0	0.0%	7	14.0%	0	0.0%	0	0.0%	2	4.0%
Marin	103	21	20.4%	4	3.9%	1	1.0%	0	0.0%	2	1.9%
Mendocino	38	12	31.6%	0	0.0%	0	0.0%	1	2.6%	0	0.0%
Monterey	23	6	26.1%	0	0.0%	0	0.0%	0	0.0%	4	17.4%
Napa	25	6	24.0%	1	4.0%	0	0.0%	1	4.0%	1	4.0%
Orange	93	10	10.8%	2	2.2%	3	3.2%	3	3.2%	2	2.2%
Placer	82	12	14.6%	2	2.4%	2	2.4%	0	0.0%	17	20.7%
Riverside	157	19	12.1%	7	4.5%	0	0.0%	0	0.0%	8	5.1%
Sacramento	295	17	5.8%	6	2.0%	0	0.0%	2	0.7%	3	1.0%
San Bernardino	156	28	17.9%	3	1.9%	0	0.0%	1	0.6%	1	0.6%
San Diego	253	34	13.4%	2	0.8%	0	0.0%	4	1.6%	10	4.0%
San Francisco	121	8	6.6%	1	0.8%	0	0.0%	11	9.1%	5	4.1%
San Joaquin	114	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	1.8%
San Luis Obispo	118	59	50.0%	1	0.8%	1	0.8%	3	2.5%	24	20.3%
San Mateo	71	6	8.5%	0	0.0%	0	0.0%	2	2.8%	1	1.4%
Santa Barbara	99	13	13.1%	1	1.0%	0	0.0%	0	0.0%	0	0.0%
Santa Clara	37	6	16.2%	4	10.8%	0	0.0%	1	2.7%	1	2.7%
Santa Cruz	30	3	10.0%	0	0.0%	0	0.0%	0	0.0%	3	10.0%
Shasta	57	19	33.3%	2	3.5%	0	0.0%	0	0.0%	0	0.0%
Solano	105	31	29.5%	3	2.9%	0	0.0%	0	0.0%	5	4.8%
Sonoma	66	12	18.2%	1	1.5%	2	3.0%	0	0.0%	2	3.0%
Stanislaus	262	37	14.1%	6	2.3%	0	0.0%	0	0.0%	37	14.1%
Tehama	57	15	26.3%	6	10.5%	0	0.0%	1	1.8%	0	0.0%
Tri-City	79	6	7.6%	4	5.1%	0	0.0%	0	0.0%	2	2.5%
Tuolumne	11	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Ventura	67	8	11.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Yolo	28	1	3.6%	0	0.0%	0	0.0%	0	0.0%	1	3.6%
Total	**4,881**	**652**	**13.4%**	**148**	**3.0%**	**9**	**0.2%**	**44**	**0.9%**	**188**	**3.9%**

Table 8 (Page 2)

Current Data

As of January 31, 2003

Housing -- Page 2

County Programs	8.12 Number of consumers currently enrolled	8.13 Number of consumers in drug or alcohol facility at end of period	8.14 Percentage of consumers in drug or alcohol facility at end of period	8.15 Number of consumers in Community Care (Board and Care) facility at end of period	8.16 Percentage of consumers in Community Care (Board and Care) facility at end of period	8.17 Number of consumers living with family at end of period	8.18 Percentage of consumers living with family at end of period	8.19 Number of consumers living independently at end of period	8.20 Percentage of consumers living independently at end of period	8.21 Number of consumers living in OTHER setting at end of period	8.22 Percentage of consumers living in OTHER setting at end of period
Berkeley	108	7	6.48%	9	8.33%	4	3.70%	47	43.52%	2	1.85%
Butte	49	1	2.04%	1	2.04%	0	0.00%	41	83.67%	0	0.00%
Contra Costa	62	4	6.45%	0	0.00%	4	6.45%	25	40.32%	0	0.00%
El Dorado	53	5	9.43%	0	0.00%	5	9.43%	38	71.70%	0	0.00%
Fresno	144	7	4.86%	3	2.08%	10	6.94%	103	71.53%	0	0.00%
Humboldt	31	1	3.23%	1	3.23%	3	9.68%	17	54.84%	2	6.45%
Kern	143	26	18.18%	11	7.69%	19	13.29%	74	51.75%	5	3.50%
Los Angeles	1,694	207	12.22%	107	6.32%	182	10.74%	855	50.53%	41	2.48%
Madera	50	0	0.00%	0	0.00%	4	8.00%	35	70.00%	2	4.00%
Marin	103	2	1.94%	5	4.85%	3	2.91%	64	62.14%	1	0.97%
Mendocino	38	0	0.00%	0	0.00%	1	2.63%	21	55.26%	3	7.89%
Monterey	23	1	4.35%	0	0.00%	0	0.00%	12	52.17%	0	0.00%
Napa	25	2	8.00%	1	4.00%	0	0.00%	12	48.00%	1	4.00%
Orange	93	1	1.08%	4	4.30%	4	4.30%	63	67.74%	1	1.08%
Placer	82	6	7.32%	0	0.00%	2	2.44%	37	45.12%	4	4.88%
Riverside	157	15	9.55%	5	3.18%	7	4.46%	94	59.87%	2	1.27%
Sacramento	295	3	1.02%	9	3.05%	12	4.07%	220	74.58%	23	7.80%
San Bernardino	156	10	6.41%	4	2.56%	18	11.54%	75	48.08%	16	10.26%
San Diego	253	6	2.37%	16	6.32%	4	1.58%	173	68.38%	4	1.58%
San Francisco	121	1	0.83%	1	0.83%	2	1.65%	91	75.21%	1	0.83%
San Joaquin	114	1	0.88%	1	0.88%	7	6.14%	102	89.47%	1	0.88%
San Luis Obispo	118	2	1.69%	3	2.54%	2	1.69%	22	18.64%	1	0.85%
San Mateo	71	1	1.41%	3	4.23%	8	11.27%	50	70.42%	0	0.00%
Santa Barbara	99	5	5.05%	4	4.04%	5	5.05%	71	71.72%	0	0.00%
Santa Clara	37	1	2.70%	5	13.51%	5	13.51%	14	37.84%	0	0.00%
Santa Cruz	30	0	0.00%	0	0.00%	0	0.00%	23	76.67%	1	3.33%
Shasta	57	2	3.51%	0	0.00%	2	3.51%	32	56.14%	0	0.00%
Solano	105	3	2.86%	0	0.00%	4	3.81%	58	55.24%	1	0.95%
Sonoma	66	1	1.52%	0	0.00%	1	1.52%	41	62.12%	6	9.09%
Stanislaus	262	6	2.29%	6	2.29%	35	13.36%	128	48.85%	7	2.67%
Tehama	57	0	0.00%	2	3.51%	2	3.51%	31	54.39%	0	0.00%
Tri-City	79	7	8.86%	5	6.33%	8	10.13%	46	58.23%	1	1.27%
Tuolumne	11	1	9.09%	0	0.00%	0	0.00%	8	72.73%	2	18.18%
Ventura	67	4	5.97%	1	1.49%	8	11.94%	44	65.67%	2	2.99%
Yolo	28	0	0.00%	0	0.00%	3	10.71%	23	82.14%	0	0.00%
Total	**4,881**	**339**	**6.95%**	**207**	**4.24%**	**374**	**7.66%**	**2,790**	**57.16%**	**130**	**2.66%**

Table 9

Current Data

As of January 31, 2003

County Programs	Employment										
	9.1	9.2	9.3	9.4	9.5	9.6	9.7	9.8	9.9	9.10	9.11
	Number of consumers currently enrolled	Number of unduplicated consumers working (PAID AND UNPAID) at end of period	Percentage of unduplicated consumers working (total) at end of period	Number of unduplicated consumers working less than 20 hours per week at end of period	Percentage of unduplicated consumers working less than 20 hours per week at end of period	Number of unduplicated consumers working => 20 hours per week at end of period	Percentage of unduplicated consumers working => 20 hours per week at end of period	Number of unduplicated consumers working in PAID employment at end of period	Percentage of unduplicated consumers working in PAID employment at end of period	Number of unduplicated consumers working in UNPAID employment at end of period	Percentage of unduplicated consumers working in UNPAID employment at end of period
Berkeley	108	4	3.70%	1	0.93%	3	2.78%	2	1.85%	2	1.85%
Butte	49	14	28.57%	9	18.37%	5	10.20%	13	26.53%	1	2.04%
Contra Costa	62	6	9.68%	0	0.00%	6	9.68%	6	9.68%	0	0.00%
El Dorado	53	10	18.87%	2	3.77%	8	15.09%	10	18.87%	0	0.00%
Fresno	144	18	12.50%	12	8.33%	6	4.17%	12	8.33%	6	4.17%
Humboldt	31	8	25.81%	8	25.81%	0	0.00%	2	6.45%	6	19.35%
Kern	143	5	3.50%	3	2.10%	2	1.40%	2	1.40%	3	2.10%
Los Angeles	1,694	219	12.94%	79	4.67%	140	8.27%	199	11.76%	20	1.18%
Madera	50	5	10.00%	3	6.00%	2	4.00%	5	10.00%	0	0.00%
Marin	103	10	9.71%	8	7.77%	2	1.94%	9	8.74%	1	0.97%
Mendocino	38	8	21.05%	3	7.89%	5	13.16%	8	21.05%	0	0.00%
Monterey	23	2	8.70%	2	8.70%	0	0.00%	2	8.70%	0	0.00%
Napa	25	3	12.00%	1	4.00%	2	8.00%	3	12.00%	0	0.00%
Orange	93	19	20.43%	7	7.53%	12	12.90%	10	10.75%	9	9.68%
Placer	82	17	20.73%	5	6.10%	12	14.63%	15	18.29%	2	2.44%
Riverside	157	32	20.38%	7	4.46%	25	15.92%	29	18.47%	3	1.91%
Sacramento	295	22	7.46%	6	2.03%	16	5.42%	22	7.46%	0	0.00%
San Bernardino	156	16	10.26%	4	2.56%	12	7.69%	15	9.62%	1	0.64%
San Diego	253	19	7.51%	6	2.37%	13	5.14%	17	6.72%	2	0.79%
San Francisco	121	3	2.48%	2	1.65%	1	0.83%	3	2.48%	0	0.00%
San Joaquin	114	32	28.07%	14	12.28%	18	15.79%	22	19.30%	10	8.77%
San Luis Obispo	118	10	8.47%	7	5.93%	3	2.54%	10	8.47%	0	0.00%
San Mateo	71	15	21.13%	10	14.08%	5	7.04%	13	18.31%	2	2.82%
Santa Barbara	99	15	15.15%	5	5.05%	10	10.10%	11	11.11%	4	4.04%
Santa Clara	37	6	16.22%	4	10.81%	2	5.41%	5	13.51%	1	2.70%
Santa Cruz	30	10	33.33%	8	26.67%	2	6.67%	10	33.33%	0	0.00%
Shasta	57	4	7.02%	0	0.00%	4	7.02%	3	5.26%	1	1.75%
Solano	105	18	17.14%	5	4.76%	13	12.38%	17	16.19%	1	0.95%
Sonoma	66	15	22.73%	9	13.64%	6	9.09%	9	13.64%	6	9.09%
Stanislaus	262	52	19.85%	17	6.49%	35	13.36%	35	13.36%	17	6.49%
Tehama	57	5	8.77%	3	5.26%	2	3.51%	5	8.77%	0	0.00%
Tri-City	79	12	15.19%	4	5.06%	8	10.13%	12	15.19%	0	0.00%
Tuolumne	11	5	45.45%	1	9.09%	4	36.36%	5	45.45%	0	0.00%
Ventura	67	4	5.97%	0	0.00%	4	5.97%	3	4.48%	1	1.49%
Yolo	28	7	25.00%	6	21.43%	1	3.57%	6	21.43%	1	3.57%
Total	**4,881**	**650**	**13.32%**	**261**	**5.35%**	**389**	**7.97%**	**550**	**11.27%**	**100**	**2.05%**

Table 8-3
Current Data
Status at Enrollment vs. Status January 31, 2003

County Programs		Housing -- Page 1										
		8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	8.10	8.11
		Number of consumers currently enrolled	Number of consumers homeless or in shelters	Percentage of consumers homeless or in shelters	Number of consumers in jail or prison	Percentage of consumers in jail or prison	Number of consumers in state hospital (or long term acute hospital)	Percentage of consumers in state hospital (or long term acute hospital)	Number of consumers in SNF or IMD	Percentage of consumers in SNF or IMD	Number of consumers in Crisis, Transitional, or Long-Term Residential Treatment	Percentage of consumers in Crisis, Transitional, or Long-Term Residential Treatment
Berkeley	at enrollment	108	97	89.81%	3	2.78%	1	0.93%	1	0.93%	1	0.93%
	at EOP	108	30	27.78%	3	2.78%	0	0.00%	2	1.85%	4	3.70%
Butte	at enrollment	49	33	67.35%	1	2.04%	1	2.04%	1	2.04%	0	0.00%
	at EOP	49	2	4.08%	4	8.16%	0	0.00%	0	0.00%	0	0.00%
Contra Costa	at enrollment	62	48	77.42%	0	0.00%	0	0.00%	0	0.00%	12	19.35%
	at EOP	62	7	11.29%	1	1.61%	0	0.00%	0	0.00%	21	33.87%
El Dorado	at enrollment	53	30	56.60%	3	5.66%	0	0.00%	0	0.00%	0	0.00%
	at EOP	53	5	9.43%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Fresno	at enrollment	144	34	23.61%	5	3.47%	0	0.00%	0	0.00%	3	2.08%
	at EOP	144	14	9.72%	7	4.86%	0	0.00%	0	0.00%	0	0.00%
Humboldt	at enrollment	31	22	70.97%	1	3.23%	1	3.23%	2	6.45%	0	0.00%
	at EOP	31	6	19.35%	0	0.00%	0	0.00%	0	0.00%	1	3.23%
Kern	at enrollment	143	45	31.47%	1	0.70%	2	1.40%	0	0.00%	5	3.50%
	at EOP	143	6	4.20%	1	0.70%	0	0.00%	0	0.00%	1	0.70%
Los Angeles	at enrollment	1,694	660	38.96%	308	18.18%	25	1.48%	28	1.65%	69	4.07%
	at EOP	1,694	193	11.39%	69	4.07%	0	0.00%	12	0.71%	28	1.65%
Madera	at enrollment	50	12	24.00%	3	6.00%	0	0.00%	0	0.00%	0	0.00%
	at EOP	50	0	0.00%	7	14.00%	0	0.00%	0	0.00%	2	4.00%
Marin	at enrollment	103	100	93.20%	0	0.97%	3	0.97%	0	0.00%	0	1.94%
	at EOP	103	21	20.39%	4	3.88%	1	0.97%	0	0.00%	2	1.94%
Mendocino	at enrollment	38	30	78.95%	1	2.63%	0	0.00%	0	0.00%	0	0.00%
	at EOP	38	12	31.58%	0	0.00%	0	0.00%	1	2.63%	0	0.00%
Monterey	at enrollment	23	18	78.26%	0	0.00%	2	8.70%	0	0.00%	0	0.00%
	at EOP	23	6	26.09%	0	0.00%	0	0.00%	0	0.00%	4	17.39%
Napa	at enrollment	25	21	84.00%	0	0.00%	0	0.00%	0	0.00%	1	4.00%
	at EOP	25	6	24.00%	1	4.00%	0	0.00%	1	4.00%	1	4.00%
Orange	at enrollment	93	53	56.99%	4	4.30%	10	10.75%	0	0.00%	0	0.00%
	at EOP	93	10	10.75%	2	2.15%	3	3.23%	3	3.23%	2	2.15%
Placer	at enrollment	82	37	45.12%	4	4.88%	3	3.66%	0	0.00%	11	13.41%
	at EOP	82	12	14.63%	2	2.44%	2	2.44%	0	0.00%	17	20.73%
Riverside	at enrollment	157	80	50.96%	2	1.27%	1	0.64%	1	0.64%	6	3.82%
	at EOP	157	19	12.10%	7	4.46%	0	0.00%	0	0.00%	8	5.10%
Sacramento	at enrollment	295	219	74.24%	3	1.02%	12	4.07%	0	0.00%	0	0.00%
	at EOP	295	17	5.76%	6	2.03%	0	0.00%	2	0.68%	3	1.02%
San Bernardino	at enrollment	156	99	63.46%	2	1.28%	1	0.64%	1	0.64%	0	0.00%
	at EOP	156	28	17.95%	3	1.92%	0	0.00%	1	0.64%	1	0.64%
Total	**at enrollment**	**3,306**	**1,638**	**49.55%**	**341**	**10.31%**	**62**	**1.88%**	**34**	**1.03%**	**108**	**3.27%**
	at EOP	**3,306**	**394**	**13.28%**	**117**	**3.03%**	**6**	**0.20%**	**22**	**0.88%**	**95**	**3.85%**

Table 8-3
Current Data
Status at Enrollment vs.Status January 31, 2003

County Programs		Housing -- Page 1										
		8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	8.10	8.11
		Number of consumers currently enrolled	Number of consumers homeless or in shelters	Percentage of consumers homeless or in shelters	Number of consumers in jail or prison	Percentage of consumers in jail or prison	Number of consumers in state hospital (or long term acute hospital)	Percentage of consumers in state hospital (or long term acute hospital)	Number of consumers in SNF or IMD	Percentage of consumers in SNF or IMD	Number of consumers in Crisis, Transitional, or Long-Term Residential Treatment	Percentage of consumers in Crisis, Transitional, or Long-Term Residential Treatment
San Diego	at enrollment	253	168	66.40%	7	2.77%	12	4.74%	0	0.00%	13	5.14%
	at EOP	253	34	13.44%	2	0.79%	0	0.00%	4	1.58%	10	3.95%
San Francisco	at enrollment	121	66	54.55%	18	14.88%	2	1.65%	11	9.09%	12	9.92%
	at EOP	121	8	6.61%	1	0.83%	0	0.00%	11	9.09%	5	4.13%
San Joaquin	at enrollment	114	42	36.84%	2	1.75%	1	0.88%	0	0.00%	8	7.02%
	at EOP	114	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	1.75%
San Luis Obispo	at enrollment	118	93	78.81%	5	4.24%	1	0.85%	0	0.00%	2	1.69%
	at EOP	118	59	50.00%	1	0.85%	1	0.85%	3	2.54%	24	20.34%
San Mateo	at enrollment	71	27	38.03%	0	0.00%	2	2.82%	6	8.45%	12	16.90%
	at EOP	71	6	8.45%	0	0.00%	0	0.00%	2	2.82%	1	1.41%
Santa Barbara	at enrollment	99	62	62.63%	1	1.01%	0	0.00%	1	1.01%	4	4.04%
	at EOP	99	13	13.13%	1	1.01%	0	0.00%	0	0.00%	0	0.00%
Santa Clara	at enrollment	37	13	35.14%	2	5.41%	2	5.41%	0	0.00%	7	18.92%
	at EOP	37	6	16.22%	4	10.81%	0	0.00%	1	2.70%	1	2.70%
Santa Cruz	at enrollment	30	22	73.33%	2	6.67%	0	0.00%	0	0.00%	3	10.00%
	at EOP	30	3	10.00%	0	0.00%	0	0.00%	0	0.00%	3	10.00%
Shasta	at enrollment	57	33	57.89%	0	0.00%	0	0.00%	0	0.00%	2	3.51%
	at EOP	57	19	33.33%	2	3.51%	0	0.00%	0	0.00%	0	0.00%
Solano	at enrollment	105	83	79.05%	2	1.90%	0	0.00%	0	0.00%	5	4.76%
	at EOP	105	31	29.52%	3	2.86%	0	0.00%	0	0.00%	5	4.76%
Sonoma	at enrollment	66	39	59.09%	2	3.03%	2	3.03%	0	0.00%	2	3.03%
	at EOP	66	12	18.18%	1	1.52%	2	3.03%	0	0.00%	2	3.03%
Stanislaus	at enrollment	262	163	62.21%	3	1.15%	0	0.00%	0	0.00%	9	3.44%
	at EOP	262	37	14.12%	6	2.29%	0	0.00%	0	0.00%	37	14.12%
Tehama	at enrollment	57	27	47.37%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	at EOP	57	15	26.32%	6	10.53%	0	0.00%	1	1.75%	0	0.00%
Tri-City	at enrollment	79	32	40.51%	4	5.06%	0	0.00%	0	0.00%	3	3.80%
	at EOP	79	6	7.59%	4	5.06%	0	0.00%	0	0.00%	2	2.53%
Tuolumne	at enrollment	11	9	81.82%	2	18.18%	0	0.00%	0	0.00%	0	0.00%
	at EOP	11	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Ventura	at enrollment	67	49	73.13%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	at EOP	67	8	11.94%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Yolo	at enrollment	28	12	42.86%	0	0.00%	2	7.14%	0	0.00%	0	0.00%
	at EOP	28	1	3.57%	0	0.00%	0	0.00%	0	0.00%	1	3.57%
Total	**at enrollment**	**4,881**	**2,578**	**52.82%**	**391**	**8.01%**	**86**	**1.76%**	**52**	**1.07%**	**190**	**3.89%**
	at EOP	**4,881**	**652**	**13.28%**	**148**	**3.03%**	**9**	**0.20%**	**44**	**0.88%**	**188**	**3.85%**

Table 8-4
Current Data
Status at Enrollment vs.Status January 31,2003

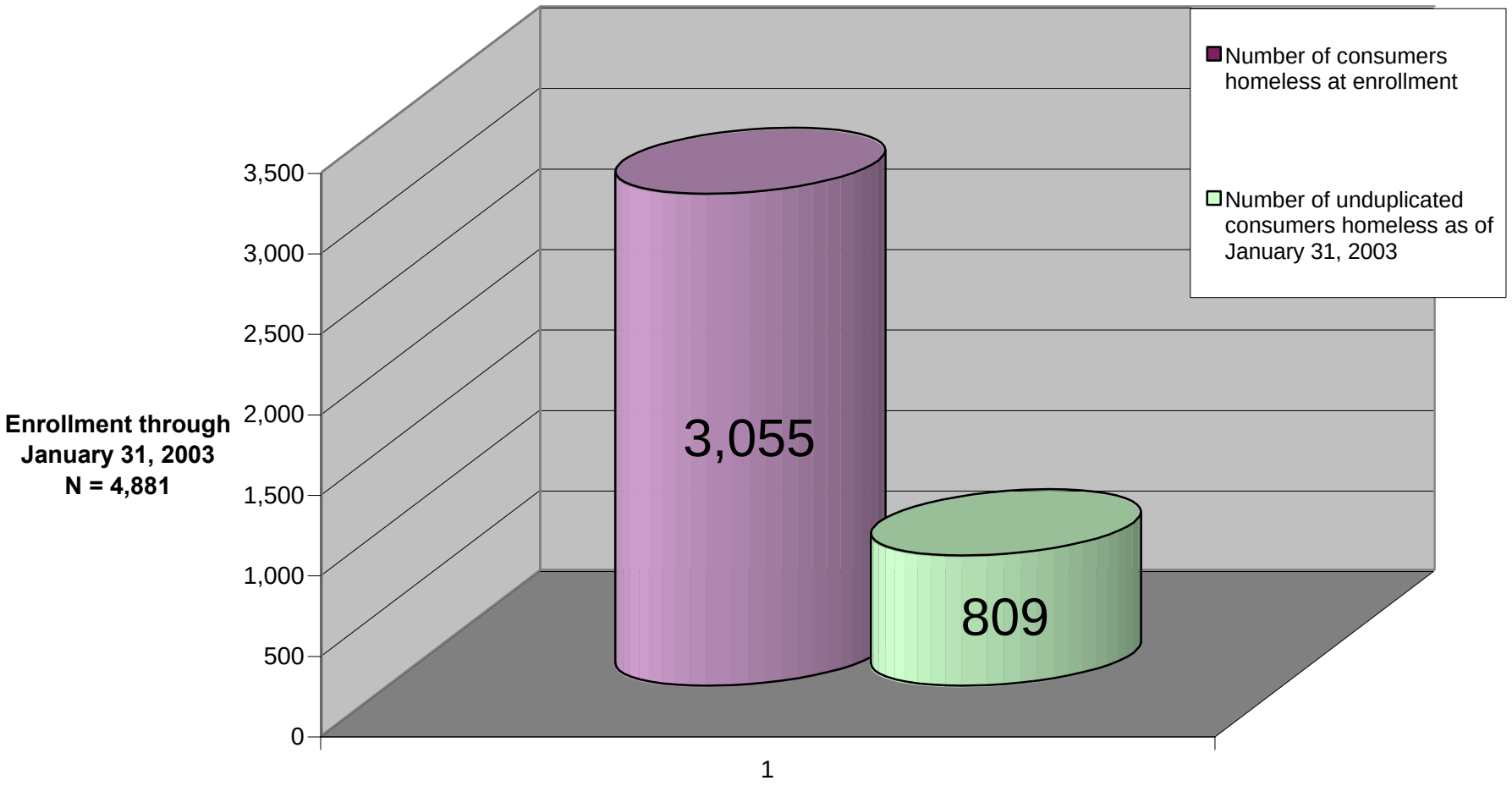
County Programs	Housing -- Page 2													
		8.12	8.13	8.14	8.15	816%	8.17	818%	8.19	820%	8.21	8.22	8.23	8.24
		Number of consumers currently enrolled	Number of consumers in drug or alcohol facility	Percentage of consumers in drug or alcohol facility	Number of consumers in Community Care (Board and Care) facility	Percentage of consumers in Community Care (Board and Care) facility	Number of consumers living with famiy	Percentage of consumers living with family	Number of consumers living independently	Percentage of consumers living independently	Number of consumers living in OTHER setting	Percentage of consumers living in OTHER setting	Members without data	Percentage of Members without data
Berkeley	at enrollment	108	1	0.93%	0	0.00%	1	0.93%	2	1.85%	1	0.93%		0.00%
	at EOP	108	7	6.48%	9	8.33%	4	3.70%	47	43.52%	2	1.85%		0.00%
Butte	at enrollment	49	0	0.00%	0	0.00%	1	2.04%	11	22.45%	1	2.04%		0.00%
	at EOP	49	1	2.04%	1	2.04%	0	0.00%	41	83.67%	0	0.00%		0.00%
Contra Costa	at enrollment	62	0	0.00%	1	1.61%	0	0.00%	1	1.61%	0	0.00%		0.00%
	at EOP	62	4	6.45%	0	0.00%	4	6.45%	25	40.32%	0	0.00%		0.00%
El Dorado	at enrollment	53	3	5.66%	0	0.00%	3	5.66%	14	26.42%	0	0.00%		0.00%
	at EOP	53	5	9.43%	0	0.00%	5	9.43%	38	71.70%	0	0.00%		0.00%
Fresno	at enrollment	144	1	0.69%	7	4.86%	21	14.58%	73	50.69%	0	0.00%		0.00%
	at EOP	144	7	4.86%	3	2.08%	10	6.94%	103	71.53%	0	0.00%		0.00%
Humboldt	at enrollment	31	1	3.23%	0	0.00%	1	3.23%	3	9.68%	0	0.00%		0.00%
	at EOP	31	1	3.23%	1	3.23%	3	9.68%	17	54.84%	2	6.45%		0.00%
Kern	at enrollment	143	24	16.78%	5	3.50%	17	11.89%	40	27.97%	4	2.80%		0.00%
	at EOP	143	26	18.18%	11	7.69%	19	13.29%	74	51.75%	5	3.50%		0.00%
Los Angeles	at enrollment	1,694	128	7.56%	28	1.65%	138	8.15%	272	16.06%	37	2.18%	1	0.06%
	at EOP	1,694	207	12.22%	107	6.32%	182	10.74%	855	50.47%	41	2.42%	0	0.00%
Madera	at enrollment	50	0	0.00%	0	0.00%	5	10.00%	28	56.00%	2	4.00%		0.00%
	at EOP	50	0	0.00%	0	0.00%	4	8.00%	35	70.00%	2	4.00%		0.00%
Marin	at enrollment	103	0	2.91%	0	0.00%	0	0.00%	0	0.00%	0	0.00%		0.00%
	at EOP	103	2	1.94%	5	4.85%	3	2.91%	64	62.14%	1	0.97%		0.00%
Mendocino	at enrollment	38	1	2.63%	0	0.00%	2	5.26%	3	7.89%	1	2.63%		0.00%
	at EOP	38	0	0.00%	0	0.00%	1	2.63%	21	55.26%	3	7.89%		0.00%
Monterey	at enrollment	23	0	0.00%	0	0.00%	0	0.00%	3	13.04%	0	0.00%		0.00%
	at EOP	23	1	4.35%	0	0.00%	0	0.00%	12	52.17%	0	0.00%		0.00%
Napa	at enrollment	25	1	4.00%	0	0.00%	0	0.00%	2	8.00%	0	0.00%		0.00%
	at EOP	25	2	8.00%	1	4.00%	0	0.00%	12	48.00%	1	4.00%		0.00%
Orange	at enrollment	93	0	0.00%	1	1.08%	1	1.08%	23	24.73%	1	1.08%		0.00%
	at EOP	93	1	1.08%	4	4.30%	4	4.30%	63	67.74%	1	1.08%		0.00%
Placer	at enrollment	82	3	3.66%	1	1.22%	3	3.66%	14	17.07%	6	7.32%		0.00%
	at EOP	82	6	7.32%	0	0.00%	2	2.44%	37	45.12%	4	4.88%		0.00%
Riverside	at enrollment	157	5	3.18%	2	1.27%	10	6.37%	46	29.30%	4	2.55%		0.00%
	at EOP	157	15	9.55%	5	3.18%	7	4.46%	94	59.87%	2	1.27%		0.00%
Sacramento	at enrollment	295	8	2.71%	0	0.00%	7	2.37%	10	3.39%	36	12.20%		2.71%
	at EOP	295	3	1.02%	9	3.05%	12	4.07%	220	74.58%	23	7.80%		0.00%
San Bernardino	at enrollment	156	8	5.13%	0	0.00%	11	7.05%	25	16.03%	9	5.77%		0.00%
	at EOP	156	10	6.41%	4	2.56%	18	11.54%	75	48.08%	16	10.26%		0.00%
Total	**at enrollment**	**3,306**	**184**	**5.57%**	**45**	**1.36%**	**221**	**6.68%**	**570**	**17.24%**	**102**	**3.09%**	**1**	**0.03%**
	at EOP	**3,306**	**298**	**9.01%**	**160**	**4.24%**	**278**	**7.66%**	**1,833**	**57.18%**	**103**	**2.72%**	**0**	**0.0%**

Table 8-4
Current Data
Status at Enrollment vs. Status January 31,2003

Housing -- Page 2

County Programs		8.12	8.13	8.14	8.15	816%	8.17	818%	8.19	820%	8.21	8.22	8.23	8.24
		Number of consumers currently enrolled	Number of consumers in drug or alcohol facility	Percentage of consumers in drug or alcohol facility	Number of consumers in Community Care (Board and Care) facility	Percentage of consumers in Community Care (Board and Care) facility	Number of consumers living with famiy	Percentage of consumers living with family	Number of consumers living independently	Percentage of consumers living independently	Number of consumers living in OTHER setting	Percentage of consumers living in OTHER setting	Members without data	Percentage of Members without data
San Diego	at enrollment	253	4	1.58%	7	2.77%	5	1.98%	34	13.44%	3	1.19%		0.00%
	at EOP	253	6	2.37%	16	6.32%	4	1.58%	173	68.38%	4	1.58%		0.00%
San Francisco	at enrollment	121	0	0.00%	0	0.00%	0	0.00%	12	9.92%	0	0.00%		0.00%
	at EOP	121	1	0.83%	1	0.83%	2	1.65%	91	75.21%	1	0.83%		0.00%
San Joaquin	at enrollment	114	0	0.00%	6	5.26%	7	6.14%	45	39.47%	3	2.63%		0.00%
	at EOP	114	1	0.88%	1	0.88%	7	6.14%	102	89.47%	1	0.88%		0.00%
San Luis Obispo	at enrollment	118	1	0.85%	1	0.85%	2	1.69%	9	7.63%	4	3.39%		0.00%
	at EOP	118	2	1.69%	3	2.54%	2	1.69%	22	18.64%	1	0.85%		0.00%
San Mateo	at enrollment	71	4	5.63%	1	1.41%	8	11.27%	11	15.49%	0	0.00%		0.00%
	at EOP	71	1	1.41%	3	4.23%	8	11.27%	50	70.42%	0	0.00%		0.00%
Santa Barbara	at enrollment	99	5	5.05%	2	2.02%	9	9.09%	15	15.15%	0	0.00%		0.00%
	at EOP	99	5	5.05%	4	4.04%	5	5.05%	71	71.72%	0	0.00%		0.00%
Santa Clara	at enrollment	37	2	5.41%	2	5.41%	4	10.81%	4	10.81%	1	2.70%		0.00%
	at EOP	37	1	2.70%	5	13.51%	5	13.51%	14	37.84%	0	0.00%		0.00%
Santa Cruz	at enrollment	30	0	0.00%	0	0.00%	0	0.00%	2	6.67%	1	3.33%		0.00%
	at EOP	30	0	0.00%	0	0.00%	0	0.00%	23	76.67%	1	3.33%		0.00%
Shasta	at enrollment	57	1	1.75%	0	0.00%	5	8.77%	15	26.32%	1	1.75%		0.00%
	at EOP	57	2	3.51%	0	0.00%	2	3.51%	32	56.14%	0	0.00%		0.00%
Solano	at enrollment	105	0	0.00%	0	0.00%	5	4.76%	10	9.52%	0	0.00%		0.00%
	at EOP	105	3	2.86%	0	0.00%	4	3.81%	58	55.24%	1	0.95%		0.00%
Sonoma	at enrollment	66	1	1.52%	0	0.00%	3	4.55%	11	16.67%	6	9.09%		0.00%
	at EOP	66	1	1.52%	0	0.00%	1	1.52%	41	62.12%	6	9.09%		0.00%
Stanislaus	at enrollment	262	7	2.67%	2	0.76%	30	11.45%	48	18.32%	0	0.00%		0.00%
	at EOP	262	6	2.29%	6	2.29%	35	13.36%	128	48.85%	7	2.67%		0.00%
Tehama	at enrollment	57	2	3.51%	1	1.75%	8	14.04%	9	15.79%	10	17.54%		0.00%
	at EOP	57	0	0.00%	2	3.51%	2	3.51%	31	54.39%	0	0.00%		
Tri-City	at enrollment	79	3	3.80%	3	3.80%	12	15.19%	15	18.99%	7	8.86%		0.00%
	at EOP	79	7	8.86%	5	6.33%	8	10.13%	46	58.23%	1	1.27%		0.00%
Tuolumne	at enrollment	11	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%		0.00%
	at EOP	11	1	9.09%	0	0.00%	0	0.00%	8	72.73%	2	18.18%		0.00%
Ventura	at enrollment	67	2	2.99%	0	0.00%	3	4.48%	11	16.42%	2	2.99%		0.00%
	at EOP	67	4	5.97%	1	1.49%	8	11.94%	44	65.67%	2	2.99%		0.00%
Yolo	at enrollment	28	3	10.71%	0	0.00%	1	3.57%	10	35.71%	0	0.00%		0.00%
	at EOP	28	0	0.00%	0	0.00%	3	10.71%	23	82.14%	0	0.00%		0.00%
Total	**at enrollment**	**4,881**	**219**	**4.49%**	**70**	**1.43%**	**323**	**6.62%**	**831**	**17.03%**	**140**	**2.87%**	**1**	**0.02%**
	at EOP	**4,881**	**339**	**6.95%**	**207**	**4.24%**	**374**	**7.66%**	**2,790**	**57.18%**	**130**	**2.72%**	**0**	**0.0%**

Integrated Services for Homeless Adults (All Funded Programs)
Consumers Homeless at Enrollment vs. Consumers Homeless as of January 31, 2003



Appendix 7

Comparison of First and Second Year Results

- Los Angeles, Stanislaus and Sacramento

Table 1 : Persons Enrolled for 2 Years, First Year Data

Table 2 : Persons Enrolled for 2 Years, Second Year Data

Table 1

COMPARISON OF FIRST AND SECOND YEAR RESULTS
LOS ANGELES, STANISLAUS & SACRAMENTO

Persons Enrolled for 2 Years, **First Year Data** – 893 Clients

HOSPITALIZATIONS

Number of consumers hospitalized in 12 months prior to enrollment	Number of consumers hospitalized since enrollment	Percent Change	Number of hospitali-zations in the 12 months prior to enrollment	Number of hospitalizations since enrollment	Percent Change	Number of hospital days in the 12 months prior to enrollment	Number of hospital days since enrollment	Percent Change
196	138	-29.6%	354	238	-32.8%	5,895	2,667	-54.8%

INCARCERATIONS

Number of consumers incarcerated in 12 months prior to enrollment	Number of consumers incarcerated since enrollment	Percent Change	Number of incarcerations in the 12 months prior to enrollment	Number of incarcerations since enrollment	Percent Change	Number of incarceration days in the 12 months prior to enrollment	Number of incarceration days since enrollment	Percent Change
426	177	-58.5%	574	242	-57.8%	55,050	10,170	-81.5%

HOMELESSNESS

Number of consumers homeless at enrollment	Number of consumers currently not maintaining housing at the end of 1st year	Percent Change	Number of homeless days in the 12 months prior to enrollment	Number of homeless days since enrollment	Percent Change
530	104	- 80.4%	191,794	67,657	- 64.7%

EMPLOYMENT

Number of consumers employed in 12 months prior to enrollment	Number of consumers employed since enrollment	Percent Change	Number of days employed in the 12 months prior to enrollment	Number of days employed since enrollment	Percent Change
120	225	+ 80%	19,163	34,720	+81.2 %

Table 2
COMPARISON OF FIRST AND SECOND YEAR RESULTS
LOS ANGELES, STANISLAUS & SACRAMENTO

Persons Enrolled for 2 Years, **Second Year Data** – 893 Clients

HOSPITALIZATIONS

Number of consumers hospitalized in 12 months prior to enrollment	Number of consumers hospitalized since enrollment	Percent Change	Number of hospitali-zations in the 12 months prior to enrollment	Number of hospitalizations since enrollment	Percent Change	Number of hospital days in the 12 months prior to enrollment	Number of hospital days since enrollment	Percent Change
195	128	- 34.4%	354	198	-55.9%	5,895	2,280	- 61.3%

INCARCERATIONS

Number of consumers incarcerated in 12 months prior to enrollment	Number of consumers incarcerated since enrollment	Percent Change	Number of incarcerations in the 12 months prior to enrollment	Number of incarcerations since enrollment	Percent Change	Number of incarceration days in the 12 months prior to enrollment	Number of incarceration days since enrollment	Percent Change
426	190	-55.4%	574	234	-59.2%	55,050	11,645	- 78.8%

HOMELESSNESS

Number of consumers homeless at enrollment	Number of consumers currently not maintaining housing at end of 2nd year	Percent Change	Number of homeless days in the 12 months prior to enrollment	Number of homeless days since enrollment	Percent Change
530	90	- 83%	191,794	31,311	- 83.7%

EMPLOYMENT

Number of consumers employed in 12 months prior to enrollment	Number of consumers employed since enrollment	Percent Change	Number of days employed in the 12 months prior to enrollment	Number of days employed since enrollment	Percent Change
120	296	+146.7	19,163	43,135	+125.1%

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1700 K Street
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AB 2034 Advisory Committee Roster

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(Revised April 2003)

CONTRACT RESOURCES FOR TRAINING, TECHNICAL ASSISTANCE AND EVALUATION

Advocates for Human Potential, Inc.
262 Delaware Avenue
Delmar, New York 12054
(518) 475-9146

Employing People with Psychiatric Disabilities who are Homeless
Trainers:
Gary Shaheen and Tom Lorello, Advocates for Human Potential, Inc.
Danny Marquez, Crossroads Employment Services
Joy Tsuhako, Social Security Administration
Terry Truitt, California Department of Mental Health
Cheryl Grimm, California Department of Rehabilitation
Karen Kane, San Bernardino County

Social Enterprise Development-Principles, Practices and Possibilities
Trainers:
Gary Shaheen, Advocates for Human Potential, Inc.
Beth Anderson, Center for the Advancement of Social Entrepreneurship at Duke University's Fuqua School of Business
Kristen Ace, The Roberts Enterprise Development Fund
Michele Tatos, CVE, Inc.
David Feehan, International Downtown Association

California Institute for Mental Health (CIMH)
2030 J Street
Sacramento, California 95814
(916) 556-3480, Extension 123

Working with Transition Age Youth who are Homeless
Trainers:
Chris Coppola, San Mateo County Mental Health
Debra Rades & Bridget Kenevan, Caminar/CLC, San Mateo County
Kelly Mraz, Families First, Stanislaus County
Ernie Rodriguez, Stepping Stones, Canada College, San Mateo
Jennifer Martin, Stepping Stones, Canada College, San Mateo
Karen Escovitz, Matrix, Philadelphia, PA, YES I & II, a school to work transition project
Michael Shockett, CAMINAR/CLC, San Mateo, YES program
Pamela Thayer, NVCSS, Redding, Java City
Dr. Hewitt "Rusty" B. Clark-University of South Florida
Anne B. Stanton, MSW-Larkin Street Youth Center, San Francisco
Verna Kelly and Gian Graham, Prototypes Women's Center, Los Angeles
Dr. David Mee-Lee, consultant, trainer, educator, Davis
Dr. Lisa Steele, Greater Long Beach Child Guidance Center, Long Beach

CIMH Continued

Creating Alliances: Engagement of People with Psychiatric Disabilities who are Homeless
Trainers:
Guyton Coluntuono, Mental Health Association – Los Angeles – The Village
Gilbert Sildate, Tri-City Mental Health
Bruce Anderson, Community Activators

Technical Assistance and Training Steering Committee
The CIMH Executive Director, Sandra Naylor Goodwin and the CIMH Training Coordinators, Vicki V. Smith and Alice J. Washington, coordinated technical assistance to AB 2034 counties and conducted regional roundtables facilitated by:
Dawn Cunningham, Stanislaus County,
Maria Funk, Los Angeles County,
Frances Freitas, Sacramento County, and
Jet Kruse, Humbolt County.

Other training included monthly telephone discussion by providers of AB 2034 activities directed at the transition age youth population and presentations at statewide conferences attended by AB 2034 staff, including the California Association of Social Rehabilitation Agencies, the Adult System of Care Partnership Conference, and Regional Transition Age Youth trainings.

Community Activators
P.O. Box 328
Vashon, Washington 98070
(206) 463-3666

Core Gift Training
Trainers:
Gina Anderson and Bruce Anderson, Managing Partners

Corporation for Supportive Housing
1330 Broadway, Suite 601
Oakland, California 94612
(510) 251-1910

Supporting People with Psychiatric Disabilities and Substance Abuse Issues in Housing
Trainers:
Joy Rucker, Jonathan Hunter, Lauren Hall, and Christine Garcia, Corporation for Supportive Housing

Housing 101
Trainers:
Maryann Leshin and Anne Wilson, Corporation for Supportive Housing
Ruth Schwartz, Shelter Partnership
Monique Lawshe, A Community of Friends

Corporation for Supportive Housing, Continued

Housing 102
Trainers:
Maryann Leshin and Anne Wilson, Corporation for Supportive Housing
Frank Motta, Santa Clara County
Andrew Wicker, Contra Costa County
Paul Powell, Transitional Living Community Services

Mental Health Association – Los Angeles (MHALA): Village Integrated Service Agency (ISA)
320 North Pine Avenue, suite 601
Long Beach, California 90802
(562) 285-1330, Extension 249

Immersion Trainings (Training provided on site in Long Beach, CA)
MHALA Trainers:
Wayne Munchel, LCSW, Director of Training and Consultation
Martha Long, CPRP, Director of the Village
Shannon Pettit, MSW, Homeless Assistance Program Director
Jacqueline Williams, Personal Service Coordinator
Richard Hart, Personal Service Coordinator
Joe Verrone, CPRP, Assistant Director of Transition Age Youth
John Fouts, Personal Service Coordinator
Paul Barry, M.Ed., CPRP, Associate Director
Mark Ragins, M.D.
Valarie Jones, CPRP, Neighborhood Director
Isabelle Alvarez, Community Integration Coordinator
Alison Steward, Community Integration Coordinator
John Travers, CPRP, Community Integration Coordinator
Diane Figgins, Housing Coordinator

Immersion Training Breakout Sessions
MHALA Trainers:
Jeff Milette, Personal Service Coordinator
Erin Von Fempe, LCSW, Neighborhood Director
Vivian Martin, Financial Planner
Mike McKenna, Financial Planner
Debbie Robinson, MSW, Director of Transition Age Youth
Patti Huff, RN, Personal Service Coordinator
Charlene Scott, RN, Personal Service Coordinator
Anne Thompson, RN, Personal Service Coordinator
Sara Ford, CPRP, Training Coordinator
Antara Banerjee, Training Coordinator

Employment Immersion (two-day) Training
MHALA Trainers:
Bob Ramos, Employment Coordinator
Vicky Gonzalez, CPRP, Employment Services Coordinator
Jose Rubio, Employment Coordinator
Susan Hagar, Worksite Supervisor

MHALA: Village ISA, Continued

AB 2034 Data Collection and Performance Outcomes Evaluation

MHALA Staff:

Dave Pilon, Ph.D., CPRP, Director, Outcomes and Research Division

Yiling Hu, Technical Support Specialist

Monica Davis, Technical Support Specialist

Additional Background

What follows is additional background information related to the initial establishment of the first three AB 34 programs in 1999 and the additional programs established pursuant to AB 2034 in the following year.

Selection Process

As required by earlier statute, the selection of the first three counties for the initial grants beginning in October of 1999, was based on the availability of existing programs able to provide integrated services with extensive experience in serving similar target populations. Typically, these programs employ psychosocial rehabilitation and recovery principles and consist of: outreach for identification, assessment, and diagnosis of target clients; mental health treatment including provision of medications and medication education and monitoring; and service coordination to ensure development of a plan with access to services that meet the client's expressed needs. Factors included in these considerations were the counties' working agreements with other providers such as law enforcement, alcohol and drug services, medical and dental health practitioners, rehabilitation services, and housing providers. As statutorily required, funding for programs in these three counties was maintained for Fiscal Year 2000-2001, based on the significant success of results demonstrated and reported in the previous year.

Expansion of the programs in these three counties and the funding of new county and city programs was based on several factors, including those specified in statute and the amount of funds remaining for Fiscal Year 2000-2001 after earlier, successful programs were maintained. Primary among these factors was the ability to develop integrated adult service programs that met the statutory criteria for an adult system of care, even if such programs did not exist at that time within the county system. The following readiness criteria were developed, with advisory committee consultation, to judge such capacity within each applicant county or city.

1. Ability to assess service capacity and approximate the number of homeless persons with serious mental illness in the county who could receive services.
2. Established community partnerships with law enforcement, veteran's services, probation, housing coalitions, city officials, businesses, etc. These relationships should be past the "sign-on" stage.
3. Joint outreach with law enforcement, veterans service agencies, former homeless clients, etc. to identify clients for enrollment.
4. Providers that can deliver culturally competent, recovery-based services for this population, including psychosocial and psychiatric rehabilitation services.

5. Capacity to meet immediate housing needs, including temporary housing, at time of enrollment.
6. Ability to develop and provide permanent housing resources, relationships with landlords, and supported housing services.
7. Ability to develop jobs and related job resources, work with the Department of Rehabilitation, and enable clients to find and keep employment.
8. Ability to meet medical, dual diagnosis, and unanticipated expenses for basic needs of enrollees.
9. Direct support staff (e.g. personal service coordinators) that approximates a 12 to 1 staffing ratio or less.
10. Ability to submit requested data in a timely manner.

Based on the criteria identified, each applicant county or city submitted a proposal for the Department to evaluate from which an operational work plan could be formulated later if funded. If the written proposal adequately met these criteria, the applicant was invited to present details of their proposed program to department staff for further analysis. Approved grant awards were based upon these results.

Conditions of the awards required that local programs ensure that all funds provided be used to provide new service in integrated adult service programs and ensure that none of the grant funds are used to supplant existing services to adults with severe mental illness. As previously stated, each local program was required to submit a work plan for approval by the state. In addition to a complete description of the program, the work plans identify the amount of contract funds to be expended and for what period, the total number of unduplicated clients to be enrolled, the maximum number of clients to be served at any one time, the outreach methods to be used, and the portion of funds used for that purpose. Also required were assurances that state and federal requirements regarding tracking of funds would be met and that patient records would be maintained in such a manner as to protect privacy and confidentiality as required under state and federal law.

Allocation of Funds and Conditions for Allocation

In Fiscal Year 2000-01, State General Funds were provided to expand the number of AB 34/2034 programs from the three initial pilot programs to a total of 26 programs statewide. Since funding was not allocated until November 2000, only partial-year funding (8 months) was allocated to these programs to carry them through FY 2000-01. Because there was a balance of base funding unallocated, a decision was made to offer one-time funding to other counties to establish AB 34/2034 programs with the understanding that additional funding would be contingent on program performance and the availability of additional funding in the next year's budget. This process resulted in eight additional counties receiving one-time grant awards, with FY 2000-01 funding available for expenditure through June 2002.

When an additional $10 million in base funding was provided for AB 34/2034 programs in FY 2001-02, the Department reviewed program proposals from both the 26 “ongoing” programs requesting additional funding to expand their existing programs, the eight “one-time” programs requesting continued and/or expanded funding, and any counties requesting funding to establish new AB 34/2034 programs. Upon completion of that application review process the Department planned to provide expansion funding to about half of the ongoing programs, to convert six of the one-time programs to ongoing status, to provide additional one-time funding to two programs and to fund one new county program. Before this occurred it became clear that these expansion funds were in jeopardy of being reduced from the AB 34/2034 funding base. In May 2002, as part of the Governor’s May Revise, the $10 million was officially identified for reduction from the program’s ongoing base budget.

Since funding for the eight one-time programs was only available through June 2002, without additional funding these programs were facing immediate shut-down. Given this situation the DMH and the California Mental Health Director’s Association considered a proposal that would result in ongoing county programs accepting less money so that continued funding could be provided for seven of the eight one-time counties and one new program. The overall goal agreed to was to do the least amount of harm to all programs that were performing well, but continue to watch performance. As a result all programs accepted a 4.5% reduction in program funding in Fiscal Year 2002-03. Although the official target enrollment numbers were reduced accordingly for all programs, no individuals were disenrolled as a result of these funding reductions. Instead, programs are either serving fewer persons as a result of normal attrition, or are attempting to serve similar numbers of persons with reduced funding.