SAN BERNARDINO COUNTY

HOMELESS
STRATEGIC ACTION PLAN 2022
EXECUTIVE SUMMARY




homeless to Home

Roadmap to Self-Sufficiency

A COLLECTIVE IMPACT APPROACH

San Bernardino County Community Revitalization was established through a merging of Community Development and Housing and the Office of Homeless Services in July 2021 as a concerted effort to focus on strategic and continuous improvement to prevent and reduce homelessness. Community Revitalization aims to increase the supply of affordable housing options to positively impact our neighborhoods, local economy, and livability of communities throughout the county. The effort includes partnerships with several other County departments and offices that have a role in addressing homelessness.

The 2022 Homeless Strategic Action Plan's intention is to increase coordination, expand the impact of the County's housing and homeless programs, and strengthen efforts amongst partners to make a collective impact. Collective Impact[2] describes an intentional way of working together to strategically align and strengthen efforts for the purpose of addressing a complex problem. It will take a coordinated, collective approach, moving from a collection of individual programs to a countywide response that is strategic and data-driven to direct how best to allocate resources, services, and programs that improve the quality of life for those who live, work, and play in San Bernardino County. Community Revitalization, with strategic direction from the Board of Supervisors, will work with the County Administrative Office to pilot new projects and programs for continuous improvement as we invest in affordable housing options for our neighborhoods and communities and address the needs of our most vulnerable residents.

The actions and strategies in the Plan are based on community input from more than 500 stakeholders including, but not limited to: youth, veterans, aged or disabled, formerly homeless individuals, healthcare entities, faith and community-based organizations, cities, and housing developers. The prioritized populations include diverse individuals experiencing chronic homelessness and living with one or more disabling conditions such as mental illness, substance use disorder, developmental disorders, and/or physical ill-health. In addition, individuals known to multiple systems due to the frequency of interaction with crisis services, community safety, justice, and/or healthcare entities are a priority for intervention.

The Plan is Comprised of Three Interrelated Actions:

1. Housing the Most At-Risk
2. Increasing Shelter Capacity
3. System Improvements

[2]Kania, J., & Kramer, M. (2011). Collective Impact. Stanford Social Innovation Review, 9(1), 36–41. https://doi.org/10.48558/5900-KN19

ACTION ONE
HOUSING THE MOST AT-RISK

The United States Department of Housing and Urban Development (HUD) maintains a twofold definition and categories for considering a person homeless. The categories include unsheltered and sheltered individuals as described below:

- An unsheltered homeless person resides in a place not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings (on the street).
- A sheltered homeless person resides in an emergency shelter, transitional housing, or supportive housing for homeless persons who originally came from the streets or emergency shelters.

Additionally, HUD builds on the definitions to describe chronic homelessness as a situation in which an individual living with a disabling condition has either experienced homelessness for longer than a year (during which time the individual may have lived in a shelter, Safe Haven, or a place not meant for human habitation), or has been in and out of homelessness at least four times over a three-year period.

The chronic homeless population potentially qualifies for permanent supportive housing beds. In some cases, these individuals are high utilizers of multiple public safety and safety net services such as healthcare (including inpatient and outpatient emergency care), criminal justice (including law enforcement, courts, and corrections), emergency response, and homeless services. This population is a top concern for community leaders, residents, and first responders. There is a need for accountability for everyone including the individual suffering from untreated mental health and substance use disorders which are leading to homelessness, incarceration, or worse.

Working collectively to offer an array of wraparound services to get individuals the support they need to stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings will help individuals transition from homeless to home. This may also require implementing policies that look at upstream prevention and early intervention. This includes aligning the County's network of housing and homeless services continuum of care to maximize the number of persons to be served. By working together to provide pathways to housing, health, and income stabilization, individuals experiencing homelessness can find their unique roadmap to recovery and self-sufficiency to prevent more restrictive conservatorships, incarceration, and unnecessary hospitalization.

DATA RELATED TO THIS POPULATION ARE HIGHLIGHTED BELOW:

- In 2022, 1,027 individuals in San Bernardino County were identified as chronically homeless.
- An Office of Homeless Services cost study[1] analysis of data from 2018 to 2019 found the annual average cost of serving homeless high utilizers of services was $31,873 per person per year while living on the streets. The annual average cost of operating a permanent supportive housing program was determined to be $17,652.17 per person per year.
- Symptoms related to untreated behavioral health conditions make it difficult to engage and build trust, often taking an average of 72 encounters before an individual will agree to an evaluation or treatment.

[1]Shinn, G. (2020). An Analysis of Chronic and Veteran Homeless Cohorts in San Bernardino County: Fiscal Impacts and Market Demand for Sustainable Housing Solutions

ACTION ONE (CONTINUED)
HOUSING THE MOST AT-RISK

GOAL:

In one year, 100 unsheltered high utilizers of services will exit homelessness, with 65% entering into stable housing and 35% connected to services to support housing and safety.

THE STRATEGIES FOR IMPLEMENTATION INCLUDE:

- Sharing data between departments to identify persons from each system that present a high usage of accessing necessary care through unsuitable healthcare and criminal justice settings.
- Integration of new and existing resources to support and provide the required care for ongoing stabilization for populations deemed to be the most vulnerable.
- Researching the implementation of alternative court-treatment oriented options such as Assisted Outpatient Treatment (Laura's Law) and the proposed Community Assistance for Recovery and Empowerment (CARE) Court.
- Engaging County departments in the integration of the Lanterman-Petris-Short (LPS) conservatorship process for individuals in need of a restrictive to a least a restrictive setting for stabilization toward independent living.
- Partnering with municipalities to build a network of housing infrastructure capacity to treat and house the most at-risk populations in communities with the highest chronically homeless populations.
- Deploying outreach and field-based mobile healthcare teams (with clinical staff) to engage, support, and/or treat identified individuals experiencing debilitating physical health, mental health, and/or substance use illnesses.
- Facilitating opportunities for healthcare providers to meet with unsheltered persons without existing street outreach and engagement teams when safe and appropriate.
- Transitioning, based on the needs of each person, to the appropriate level of shelter and care.

MEASURES OF SUCCESS INCLUDE:

Outcomes:

- 100 high utilizers of services exit homelessness into a shelter with supports
- 60% increase in the number of individuals engaged in treatment services when compared to the prior six-month period
- Comparison of type of shelter prior to exiting homelessness
- Comparison of how individuals were accessing care and services prior to receiving stable housing and engagement in treatment to how care is accessed and used post stable housing

Outputs:

- Establishing a multi-sectorial committee to conduct biweekly case conferencing meetings that identify and recommend the most appropriate temporary and permanent housing interventions for prioritized populations
- Tracking attendance at case conferencing committee meetings
- Metrics for number and types of encounters with identified individuals
- Metrics including length of time from entry into CES to appropriate service connections and temporary and/or permanent housing options
- Demographics of individuals served

ACTION TWO
INCREASING SHELTER CAPACITY

The Housing Inventory Count (HIC) is a point-in-time inventory of provider programs within the Continuum of Care (CoC) that provide beds and units dedicated to serve individuals experiencing homelessness (per HUD's homeless definition) that includes emergency shelter, transitional housing, hotel/motel vouchers paid by an organization or agency, and seasonal emergency shelter.

A REVIEW OF THE HIC DATA IDENTIFIED THE FOLLOWING TRENDS:

- Year-round shelter beds are administered by providers in only eight municipalities (Barstow, Big Bear Lake, Ontario, Redlands, San Bernardino, Twentynine Palms, Victorville, and Yucca Valley), with only 67% of unsheltered persons living in those cities.
- Four communities identified 50 or more unsheltered persons in their areas and had no beds for unsheltered persons (Colton, Fontana, Rialto, and Highland).
- The number of emergency shelter beds increased by 92% from 257 beds in 2017 to 493 beds in 2022.
- The total number of beds provided by motel vouchers increased 48% from 164 beds in 2017 to 243 in 2022.
- Due to the lack of a centralized tracking system, coupled with the vast geography of the county acting as a barrier to access, on any given night, 18% of shelter beds remain vacant.

There are not enough shelter beds available in each region of the county to meet the need.

GOAL:

Work with cities and other partners to increase the supply of year-round permanent shelter by 200 beds throughout the county to accommodate diverse populations.

ACTION TWO (CONTINUED)
INCREASING SHELTER CAPACITY

A MULTITUDE OF TRAUMA-INFORMED APPROACHES AND STRATEGIES WILL BE DEPLOYED:

- Building new partnerships with municipalities and the county's unincorporated areas to host emergency/transitional shelters, safe places to park with access to hygiene, and supportive services.
- Developing innovative pilot programs that improve community safety, test innovative low-barrier shelter solutions, and increase partnerships.
- Reducing barriers to shelter such as allowing pets, storage of personal items, greater privacy, allowing access to service delivery partners, and longer and more flexible stays to create more low-barrier shelters.
- Funding a variety of bed options to increase single-room and single-family occupancies.
- Developing hotel/motel voucher programs that include jurisdictions that counted 50 unsheltered persons or more in 2022 and had no shelter beds for unsheltered persons.
- Creating pop-up/mobile shelters.
- Implementing a centralized monitoring system to support maximizing the use of available shelters.
- Training shelter staff and outreach teams in evidence-based processes such as Listen, Empathize, Agree, Partner (LEAP), Motivational Interviewing, and Trauma-informed approaches.

MEASURES OF SUCCESS INCLUDE:

Outcomes:

- Increase shelter bed capacity across the county by 40%, as measured by year-round permanent shelter and emergency shelter
- Increase beds occupied by 200
- Increase low-barrier shelters

Outputs:

- Increase utilization rate from 87% to 95%
- 100% of shelters will be trained in trauma-informed approaches
- 10% of shelters will create low-barrier policies
- 100% of staff are trained in LEAP, Motivational Interviewing, and Trauma-informed approaches

ACTION THREE
SYSTEM IMPROVEMENTS

In a review of feedback from each stakeholder engagement session, a primary need was consistently identified: the need to improve coordination across the entire continuum of the homelessness service system.

GOAL:

Improve the overall functioning of the Coordinated Entry System (CES).

A VARIETY OF STRATEGIES WILL BE IMPLEMENTED, INCLUDING:

- Implementing an integrated approach to solving local unsheltered and sheltered homelessness by weaving together all outreach and engagement activities and data through Esri's ArcGIS (Geographic Information Systems) software for mapping and data visualization, and location services.
- Establishing a Coordinated Outreach Resources and Engagement (CORE) Program consisting of street outreach and engagement teams that will meet frequently to ensure street outreach and engagement is nimble enough to regularly engage homeless individuals in a timely manner by appropriate street outreach teams.
- Expanding Housing Search services and activities by increasing the number of staff whose sole responsibility is assisting individuals in locating and obtaining suitable housing.
- Advancing the development of a by-name list of all individuals experiencing homelessness by subpopulation that includes a set of data points that integrate into the CES and the Homeless Management Information System (HMIS).
- Conducting weekly case conferencing meetings to identify and recommend the most appropriate temporary and permanent housing interventions for individuals entered into the CES.
- Using the data obtained from CoC's annual comprehensive review of CES performance to create a responsive system that ensures individuals experiencing or at risk of homelessness are matched in a timely manner with the intervention that will most efficiently and effectively end their homelessness.
- Designing and piloting innovative services within alternative centers as a focus on stabilization, recovery or diversion, to support community safety and increased access to services and supports across the continuum.

MEASURES OF SUCCESS INCLUDE:

Outcomes:

- Improvements in the length of time from entry into by-name list to CES
- Improvements in the length of time from entry into CES to appropriate service connections, and appropriate temporary and/or permanent housing options

Outputs:

- Demographics of individuals and families being assisted, including where they are being helped
- Process reviews conducted to continuously improve the system

SAN BERNARDINO COUNTY

HOMELESS TO HOME: A ROADMAP FOR SELF-SUFFICIENCY

The Plan for 2022, Homeless to Home: A Roadmap to Self-Sufficiency, illustrates an array of wraparound services, programs, and housing options aimed at increasing self-sufficiency for individuals experiencing or at risk of homelessness. It provides an overview of the continuum of services, supports, shelter options, and the average duration for each of the ten categories along the continuum. As the individual level of risk and utilization of services increases, so does the intensity of services and supports from less support to most support. Each component across the Roadmap is delivered via a combination of contracted provider agencies, County departments, faith- and community-based organizations, municipalities, and/or community partners working together.

KEY

ARMC: Arrowhead Regional Medical Center
CDH: Community Development and Housing
CBO: Community-Based organizations
CoC: Continuum of Care
DAAS-PG: Department of Aging and Adult Services – Public Guardian
DBH: Department of Behavioral Health
DPH: Department of Public Health
FBO: Faith-Based organizations
HA: Housing Authority
MCO: Managed Care Organization
TAD: Transitional Assistance Department
WDD: Workforce Development Department

homeless to Home

Roadmap to Self-Sufficiency

We envision a San Bernardino County where, through partnership, we prevent and reduce homelessness.

MORE SUPPORT → LESS SUPPORT

PERMANENT SUPPORTIVE HOUSING
Permanent housing that includes housing assistance and supportive services

Chronically homeless adults living with a disability

CBO, CoC, DAAS-PG, DBH, FBO, HA, MCO

ONGOING

TRANSITIONAL HOUSING
Leased housing provided until individual/family can move into permanent housing

Homeless individuals and families

CBO, CFS, CoC, DBH, DPH, FBO

1-24 MONTHS

INTERIM HOUSING
Long-term emergency housing for homeless waiting for permanent placement

Unsheltered individuals and families

CBO, CoC, DAAS-PG, DBH, Veterans

1-24 MONTHS

RAPID RE-HOUSING
Housing relocation or stabilization services that help to quickly transition to permanent stable housing to be able to take over lease

Homeless individuals and families in need of stabilization

ARMC, CBO, CoC, DBH, FBO, MCO, TAD, Veterans

9-12 MONTHS

EMERGENCY SHELTER
A place for individuals to live when they can not live in their previous residence

Domestic Violence Survivors, Disaster Victims, individuals in need of shelter (i.e., extreme weather)

CBO, CoC, DAAS-PG, DBH, FBO, HA

1-90 DAYS

DIVERSION
Interventions to immediately address the need of an individual that just lost their housing and has become homeless

Recently unsheltered or precariously housed individuals and families

CBO, CDH, CoC, DAAS-PG, DBH, DPH, FBO, HA, MCO

1-90 DAYS

PREVENTION
Services available that help an individual or family avoid losing current housing or from moving to emergency shelter

Individuals and families at high risk of homelessness

ARMC, CBO, CDH, CoC, DAAS-PG, DBH, FBO, HA, MCO, Sheriff, TAD, WDD

VARIES

OUTREACH ACTIVITIES
Reaching out to unsheltered individuals and families and connecting them to essential services, resources, and housing. Linkages and referrals.

Unsheltered individuals and families

CBO, CDH, CoC, DAAS-PG, DBH, DPH, FBO, Sheriff, TAD

ONGOING

RENTAL ASSISTANCE
Providing subsidies for rent

Homeless individuals and families at risk of homelessness

CBO, Cities, DAAS-PG, HA

VARIES

SHARED HOUSING
People living in one rental housing unit sharing costs

Homeless individuals and families

CBO, CoC, DAAS-PG

ONGOING

CONCLUSION

The need for bold action has never been greater. Implementation of the Plan requires expanded coordination between systems, emphasizes the use of data, and includes training opportunities for all partners, as well as innovative approaches to housing development and connecting individuals to needed supports. Implementation will require tremendous effort, new partnerships, and innovative strategies that require the entire community to be a part of the solution. Through this alignment, the system will reduce both the number of individuals and families who experience homelessness and the length of time spent homeless.

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