ABSTRACT

REHABILITATIVE SERVICES FOR CHRONICALLY HOMELESS ADULTS:

A GRANT PROPOSAL

By

Elizabeth Herrera

December 2014

The purpose of this project was to partner with a host agency, locate a potential funding source, and write a grant to obtain funding for a program for the chronically homeless individuals. The program assists chronically homeless individuals with a mental illness, suffering from substance abuse or veterans. A literature review was conducted in order to examine the success of a Housing First model, history of homelessness in America, and challenges faced by the homeless. The program will be located in Homeless Intervention Shelter and House (H.I.S. House) located in Placentia, California. The program consists of housing first, employment skills training, mentoring and financial literacy. Also, supportive services through case management assist in developing attainable short term and long term goals to promote self-sufficiency and improving the individual's quality of life physically, mentally and emotionally. Submission or funding of this grant was not a requirement for the successful completion of the project.

REHABILITATIVE SERVICES FOR CHRONICALLY HOMELESS ADULTS: A GRANT PROPOSAL

A THESIS

Presented to the School of Social Work

California State University, Long Beach

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

Committee Members:

Venetta Campbell, PsyD.(Chair)
Kristina Lopez, Ph.D
Steve Wilson, Ph.D

College Designee:

Nancy Meyer-Adams, Ph. D

By Elizabeth Herrera

B.S., 2012, California State University, Fullerton

December 2014

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

ACKNOWLEDGEMENTS

"He stood by me and gave me strength" 2 Timothy 4:17. Everything I am, everything I have and everything I will be is thanks to the Lord. May these gifts he has given me be to glorify His name always. May my life and my career be my gift to Him. I would like to dedicate this thesis to the one who has given me life and the one who has opened doors for me, this is for you Lord. I would also like to thank those that physically gave me life, my parents. Hector, father, I thank you for all your sacrifices, for teaching me to dream higher and for guiding my steps. I know all that you have done to offer me a better future, I wish to make you proud and offer you my sacrifices as a way to repay you for yours. Leticia, mother, you are my rock and your smile has always been my motivation. You have shown me how to give love and I wish to spread that love to the world. Los amo papa y mama! My siblings and nephews have also filled in the gaps of my heart that have often times needed a cheer. There has been a lot of lost time but know that I appreciate that you shared this sacrifice with me.

Lastly I want to dedicate this thesis to the love of my life, Victor Arteaga. You were there to dry my tears, to turn my frowns into smiles and my frustration into joy. You were my main cheerleader and did all in your power to push me through this process. Words cannot describe how fortunate I feel to have you in my life and to be able to spend the rest of my life with you. I also dedicate this to our future children of whom I wish to make proud. Kids, if your momma can do it, so can you!

"If you want to find yourself, you must lose yourself in the service of others" - Gandhi

TABLE OF CONTENTS

CHAPTER Page

CHAPTER 1

INTRODUCTION

Statement of the Problem

Homelessness is a growing issue in the United States. A homeless person is defined as one who lacks a fixed, regular, and adequate nighttime residence and sleeps in a variety of places not fit for human habitation (OC Partnership, 2013). The reality is that more and more people are suffering in poverty and the issue of homelessness persists across America. The lack of adequate paying jobs, affordable housing, drug addiction, mental illness, and now lack of welfare and social services contribute to the existence of homelessness in America (Donley & Wright, 2012). Once every 2 years, Orange County undertakes an effort to enumerate all of the sheltered and unsheltered homeless people within the county. This effort, known as the homeless point-in-time count is mandated for all communities that receive U. S. Department of Housing and Urban Development (HUD) funding for the homeless programs (U.S. Department of Housing and Urban Development, 2013). HUD requires a count of both sheltered and unsheltered homeless people, as well as certain characteristics among the homeless population. In 2013, a point-in-time survey aimed to count the homeless found that there were nearly 600,000 people experiencing homelessness in the United States, including 395,000 people who were homeless in sheltered locations and 215,344 people who were living in unsheltered locations (HUD, 2013). Though the number of sheltered homeless

individuals remained the same from the previous year, the number of unsheltered homeless people went up 2.8% (Donley & Wright, 2012). With a total of 140,000 homeless, California rated one of the top six states in America with the highest unsheltered homeless. Following California, more than half of the homeless population was living in Florida, Arkansas, Nevada, Mississippi, and Oregon (HUD, 2013). Also found in the point in time survey in 2013, there were a total of 4,251 homeless individuals on any given night in Orange County (HUD, 2013). Furthermore, 40% of homeless people in Orange County are unsheltered, 37% of homeless people live in a household that includes a minor child, although the vast majority of homeless children are sheltered, 19% of the homeless individuals are chronically homeless, and 11% of homeless individuals are living with a severe mental illness (HUD, 2013).

Orange County's homeless sheltered and unsheltered populations are also proporti onally similar to the national population; approximately 60% of homeless people counted were sheltered and 40% of homeless persons were living in a place not meant for human habitation such as streets, cars, parks, abandoned buildings and camps (U.S. Department of Housing and Urban Development, 2013). There were 1,290 respondents who reported their race and findings were compared to the distribution of races among the countywide countywide population; there were 66% of respondents who identified as White/Caucasian, 9% Black/African American, and 9% multiracial. Other races account for almost 16% of the population (OC Partnership, 2013).

Societal Issues Affecting Homelessness

Society has played a role in the increase of homelessness in the last decades. Factors such as the lack of affordable housing, the deinstitutionalization of the mentally

ill and substance abuse are problems seen among the homeless. Homelessness seems to be affecting more men than women across America. From 1960 through 1970, there was an end to low rent housing by urban renewal programs that took away affordable family and single occupancy homes from many poverty level Americans (Hurley, 2008). For many, the new housing that replaced the old was not affordable. During that same time, federal and state financial support for mental health hospitals and outpatient programs severely decreased. The reasoning behind the decreased funds was that medications could make the hospitalized mentally ill self-sufficient. This forced many patients into the streets, abandoned and unsupervised. The deinstitutionalizing of the mentally disabled, who were left without community services, is now seen as major cause of homelessness (Hurley, 2008).

Homelessness is a serious problem among men who represent the majority of groups that commonly experience homelessness, including the unemployed, former prisoners, veterans of the armed forces and members of the foster care system (Faherty, 2009). Men outnumber women in direct access shelter by 4 to 1, compared to 8 to 1 on the street (Hurley, 2008). One clear reason is that the street is a more dangerous place for women than men. Shelter beds are almost all allocated by gender and there are roughly twice as many emergency beds available for women than men because women tend to be with children, and tend to receive more accommodation (Hurley, 2008). Another reason for the gender difference can be women's use of a support system. Women tend to have more intimate relationships that they can reach out to in a time of crisis. Men, on the other hand, have other more destructive ways to cope such as alcohol or drugs and thus may struggle to communicate their needs (Gwadz, Nish, Leonard, & Strauss, 2007).

Obstacles to Ending Homelessness

An issue faced in the homeless population is substance abuse. According to Hurley (2008), studies have documented that one third of the homeless population suffers from chronic alcoholism and one tenth abuse drugs. The needs of this population are greater than those without substance abuse problems because they are more at risk for HIV infection or other health related problems, more likely to be victimized in the streets, be arrested, and ultimately suffer an early death (Gerdes, 2007). Addiction is frequently mentioned as being a major obstacle to ending an individual's homelessness (Rowe & Pelletier, 2012). In an increasingly competitive affordable housing market, drug and alcohol abusers are the last to qualify. Furthermore, new welfare and Social Security Disability income regulations concerning alcohol and drug abusers severely limit the eligibility for assistance with many individuals being denied services if they suffer from an addiction (Hurley, 2008). There is a need for rehabilitative services geared directly towards homeless individuals suffering from an addiction.

Purpose of the Grant Project

The purpose of this project was to write a grant proposal to fund a new rehabilitative program for chronically homeless individuals at a local agency located in Placentia, California. For the first fiscal year this program is expected to meet the needs of at least 25 adults. Services are targeted to assist those with a history of mental illness, substance abuse or who are veterans. All homeless individuals will have the equal opportunity for rehabilitation from the time spent living in the streets to self-sufficiency in society. The principal objective of the program is to provide adult homeless individuals with a case manager and mentor for a support system as well as guidance to

self-sufficiency. The secondary objective of the program is to assist the homeless individuals with the medical, mental health or rehabilitative services they may need. Chronically homeless individuals will also receive short term vocational training and employment skills to enter the workforce. Another objective is to assist the individuals with skill building for sustainment of their permanent living along with continuous access to support services. These services may reduce any future physical or financial hardship encountered.

Program Design

The new program is named Rise Above. The mission is to assist chronically homeless individuals end the cycle of homelessness and help them into self-sufficiency. Due to the diversity of the homeless population, it is important to have a program in which existing and new staff are trained for cultural sensitivity. The proposed program will hire a culturally diverse staff and provide training to ensure appropriate services are given. The program will have the existing executive director and will provide in kind supervision to all staff, will review chart notes from case managers, will oversee care plans for clients and will also assist in grant writing. The executive director has a master's degree in Social Work and has 20 years experience in related fields. Each individual will be assigned a case manager that will be responsible for creating a needs assessment, constructing a care plan, linking clients to resources in the community and assisting clients build attainable short term goals. This program includes two full time case managers dedicating 40 hours a week to the program. The positions require a bachelor's degree in social work or human services field, plus a minimum of 3 years of professional work experience in a related social services field. Each individual will also

work extensively with a housing specialist as soon as he or she enters the program that will assist in searching for affordable housing within the community. The housing specialist will be full time working 40 hours a week. The housing specialist must have a minimum of a bachelor's level education and 2 years of experience as a housing specialist or in a related field.

The program will have a part time volunteer coordinator who will designate 15 hours a week to the program. The volunteer coordinator will assist in recruiting volunteers for the outreach program. This position must have a minimum of a bachelor's level education and 1 year related experience. Volunteers will reach out to local centers where the highest numbers of homeless individuals are known to reside and offer transportation to and from the facility. The program will have a part time grant writer with a minimum of a bachelor's level education and 4 years related experience. The grant writer will raise funds to assist with the cost of the program. A minimum of a bachelor's level education in human services or related field is required and a minimum of 2 years experience. There will be no benefits included for the part time positions. Benefits will only be offered for the two full time case managers.

The Rise Above program will be delivered in three steps: housing stabilization, training, and service implementation. The first step of the program is the stabilization of immediate needs of obtaining a permanent residence, along with basic needs such as clothing and food. The housing specialist will work in collaboration with local low income apartments and thus assist in the process of obtaining housing. The program will assist in paying the security deposit and first 3 months of rent. For the first 3 months, along with being assigned a case worker; each homeless individual will also be given a

mentor, which will be a volunteer, to give one on one attention to the individual through the process of self-sufficiency. The case worker will develop a care plan which may include health services for physical or mental conditions, application for governmental assistance for which the individual may be eligible (i.e., veterans or the mentally or physically disabled). The care plan may also include connection to local doctors for regular physicals, dental care, social services meetings, or rehabilitative services. The role of the mentor is to be a supporter and advocate for the chronically homeless adults. The mentor will provide transportation to and from the services developed in the care plan and assist with phone appointments, paperwork and so on.

The second step to the program is the training component. During months 1-3, individuals will receive life skills and employment skills through short term vocational training. Assisting the chronically homeless in getting back into the workforce may include helping them build their resume and assisting with interviewing skills. Also, providing them with resources to obtain proper clothing attire to better prepare for interviews.

The third step of the program is the service implementation period. During months 3-6, the individual will have obtained employment and start working towards paying rent and build his or her savings. Individuals must save 80% of all earned income after paying bills, and this will be based on pay stubs, and will put savings in a savings account with the agency. The case worker will assist in providing budgeting and financial literacy. The individual will be given up to 6 months to be able to begin paying his or her entire rent; if the individual fails to do so, the program will extend rental assistance for up to 6 months.

Measurable outcomes for the Rise Above program will include the number of individuals who follow up with their case manager and continue to have financial and housing stability 1 year after entering the program. Success will also be measured via verification of employment and permanent residency.

Definition of Terms

Chronically homeless individual: Refers to an unaccompanied individual with a disability who has either been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years (HUD, 2013).

Continuums of care (CoC): Are local planning bodies responsible for coordinating the full range of homelessness services in a geographic area, which may cover a city, county, metropolitan area, or even an entire state (HUD, 2013).

Deinstitutionalization: Finding and developing appropriate alternatives in the community housing treatment, training, education, and rehabilitation of the mentally disabled who do not need institutional care (Hombs, 2011).

Emergency shelter: Is a facility with the primary purpose of providing temporary shelter for homeless persons (HUD, 2013).

Homeless individual: A person is considered homeless when he or she lacks a fixed, regular, and adequate nighttime residence and sleeps in a variety of places not fit for human habitation or meets certain other requirements. Homeless persons include, but are not limited to, those sleeping in cars, parks, campgrounds, sidewalks, railroad tracks, alleys, storm drains, freeway underpasses, abandoned buildings, emergency shelters, or transitional housing for homeless persons who originally came from the streets or emergency shelters (HUD, 2013).

Housing first: Is characterized by rapid re-housing in permanent, market accommodations without requirements around sobriety or treatment adherence, and facilitating access to specific resources (e.g., health, social, vocational) to support the attainment of client centered goals (Somers, Rezansoff, Moniruzzaman, Palepu, & Patterson, 2013).

Permanent supportive housing: Is designed to provide housing (project and tenant-based) and supportive services on a long-term basis for homeless people with a disability (HUD, 2013).

Point-in-time counts: Are unduplicated 1-night estimates of both sheltered and unsheltered homeless populations. The 1-night counts are conducted by Continuums of Care nationwide and occur during the last week in January of each year (HUD, 2013).

Rehabilitation: To help (a person who has acquired a disability or addiction or who has just been released from prison) to readapt to society or a new job, as by vocational guidance, retraining, or therapy (Singer, 2009).

Transitional housing program: Is housing where homeless people may stay and receive supportive services for up to 24 months and which are designed to enable them to move into permanent housing (HUD, 2013).

Homeless unaccompanied children and youth: Are people who are not part of a family during their episode of homelessness and who are under the age of 25 (HUD, 2013).

Unsheltered homeless people: Include people with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping

accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground (HUD, 2013).

Cross Cultural and Social Work Relevance

Social workers are uniquely qualified to work with chronically homeless individuals because they play a key role in assisting this population in both micro and macro levels as educators, advocates, case managers, counselors and so on (Singer, 2009). In addition to working with individual mental health problems, unemployment, and substance abuse, social workers also address policies that might impact the access to affordable housing, as well as advocate for change in policies. According to the Code of Ethics of the National Association of Social Workers (NASW; 2014), social workers strive for human well being and help people meet their basic needs, including those individuals who are vulnerable, oppressed, and living in poverty. Social workers aim to be advocates and be the voice for those whose services have been closed or unknown, promote social justice and change on behalf of the clients they serve and must be sensitive to cultural and ethnic diversity (NASW, 2014). Social workers display that they are sensitive to culture by cultural competence and cultural knowledge. Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities (NASW, 2014). Cross cultural knowledge is the ability for social workers to understand the history, traditions, values, family systems, and expressions of major client groups that they serve (NASW, 2014). Social workers also strive to end discrimination, oppression, poverty, and other forms of

social injustice and display this by using appropriate methodological approaches, skills, and techniques that reflect the workers' understanding of the role of culture in the helping process (NASW, 2014). Having the understanding of the culture of the population served will lead to better rapport building and thus better services offered. Also, social workers would be able to communicate information about their diverse client groups to other professionals in their collaboration with the community.

Social work professionals are instrumental in providing public policy decision makers (at the local, state, and federal levels) with the information they need to enact the services that would help homeless people. Counselors and human development specialists are most likely to deal with those government agencies responsible for providing such services, as housing, food, and health care to homeless people. Social work professionals needed to realize the important role they play by advocating on behalf of homeless people. Using skills in consensus building, human services providers could bring together organizations with common concerns regarding homeless people.

The Rise Above program will have multicultural diverse staff and will not discriminate services to homeless individuals of any race or gender. The Rise Above program staff will have a mandatory training on cultural sensitivity at the onset of their position. Staff will empower their clients and case managers will gear services depending on the cultural background of the individual and will accommodate services depending on language by either bilingual staff or by the use of a language line. The executive director and director of development will advocate to other agencies and city town hall meetings about the diversity of clients and common needs faced by the

homeless population to bring further awareness to the surrounding areas of Orange County of the need for assistance to the homeless.

CHAPTER 2

LITERATURE REVIEW

The following literature review examines existing literature on topics related to the homelessness. This review will cover characteristics of homelessness, causes of homelessness in America and previous studies conducted of services provided to the homeless. In addition, challenges encountered by homeless individuals and the obstacles faced to reaching self-sufficiency. Effective models of previous services for the homeless were also explored.

Characteristics of Homelessness

Understanding the differences between sheltered and unsheltered homeless is essential if the unsheltered population is going to be adequately helped. The unsheltered homeless are some 38% of the total countable homeless population and perhaps some two-thirds of the chronically homeless (Donley & Wright, 2012). An early study conducted in East Orange County, Florida, examined these differences among homeless people and found that the chronically homeless, unsheltered individuals are the most resistant to services and the most difficult to place into long term housing (Donley & Wright, 2012). Much of this resistance is evidently based on previous negative experiences with shelters and homeless service agencies.

In the study, participants lived in tents or shacks built from scavenged scrap materials in the nearby woods of East Orange County, Florida. Homeless people

gathered in the woods and made a camp site for nearly 800 homeless (Donley & Wright, 2012). The purpose of the study was to study the demography, life circumstances, and needs of the unsheltered homeless. Thirty-nine participants were recruited for the study by the Orlando Health Care Center for the Homeless HOPE Outreach Team and focus groups were composed of 11 women (28%) and 28 men (72%); most were White, 18% were Hispanic, only one was African American (Donley & Wright, 2012). Just fewer than half (45%) reported a previous mental health diagnosis, the most common of which were bipolar disorders, schizophrenia, depression, and posttraumatic stress disorder; 56% said they had a drinking problem; 37% told the researchers about a previous drug problem, and 42% reported being physically disabled (Donley & Wright, 2012). Issues of jobs and money were most frequently mentioned, cited by 41%, followed by medical and disability issues, noted by 18% (Donley & Wright, 2012). This shows that despite the mental illness, alcohol abuse, and drug addiction in this population, very few see these disorders as a primary reason for their homelessness.

Hoffman and Coffey (2008) describe how many homeless people feel that they are treated in the system like a child and have a sense that homeless agency staff know better than homeless people of what services they need, what problems they have, and how services must be delivered (p. 215). In the analysis of 500 interviews, homeless clients discussed instances of being treated as a child, being subject to arbitrary rules, and being treated disrespectfully by staff or being treated as a number or a "thing," instead of as an autonomous living person (Hoffman & Coffey, 2008).

Causes

There are many factors that lead to homelessness in the United States. Four factors will be considered, namely deinstitutionalization of the mentally ill, housing, substance abuse and barriers for veterans.

Deinstitutionalization of the Mentally Ill

Deinstitutionalization is a cause of homelessness in the United States. Deinstitutionalization can be defined by preventing both unnecessary admission to and retention in institutions, finding and developing appropriate alternatives in the community housing treatment, training, education, and rehabilitation of the mentally disabled who do not need institutional care (Hombs, 2011). Dear and Wolch (2010) stated that the transition to community treatment for the individual who has a mental illness was inadequate in providing mental health treatment, financial support, and housing. This led the discharged patients to become homeless. Those who were discharged from mental institutions and unsuccessfully transitioned to community services, developed mistrust in the mental health system and chose to avoid it (Dear & Wolch, 2010).

Hombs (2011) argued that lack of a continuum of community care played a factor towards the cause of homelessness. The deinstitutionalization of mentally ill patients was viewed as the primary cause of homelessness in the 1980s but, deinstitutionalization itself is not to blame. The rationale of releasing mentally ill from long term hospital care, when they did not require it, was appropriate. However, the problem was the careless depopulation of state institutions, without the necessary community support facilities,

housing, and services that would allow former patients to live in the community independently (Hombs, 2011).

Homeless mentally ill people are more likely to return to the streets after psychiatric inpatient treatment if discharged to unstable accommodation and if they disengage from continuum of care. Inpatient treatment alone may not improve housing stability. A study conducted in Minnesota was to assess the effectiveness of programs that helped mentally ill patients obtain housing and continued their engagement with services, sustaining it 12 months after discharge. Fifty clients were admitted during the study period, 29 were designated cases and 21 designated control group (Killaspy, Ritchie, Greer, & Robertson, 2010). Cases were more likely to be street homeless at admission and had moved more frequently than controls in the preceding 12 months (Killaspy et al., 2010). Findings were that designated cases were more likely to sustain stable housing after their release from inpatient psychiatric care (proportion in stable housing for designated cases, $p = .51$; mean days in stable housing for designated control group, $p = .46;$ (Killaspy et. al, 2010). Furthermore, there was greater improvement in engagement of services in which medication non-compliance improved only in cases. At discharge, stable housing can be arranged and sustained successfully for homeless if the collaboration exists between the community and the facilities. Benefits of this continuum of care are the improvement in engagement with services and reduction in factors influencing medication non-compliance.

Lack of Accessibility of Services to the Mentally Ill

The homeless mentally ill population has been reported as hard to reach and in need of specialized, collaborative, street level clinical approaches (D. Page, Petrovich, &

Kan, 2012). Yet, these individuals face significant barriers when trying to access services, particularly public mental health services (J. Page, 2010). To assist this population, three federal programs were designed to meet their needs and provide a referral mechanism for ongoing mental health care (D. Page et al., 2012). The three programs are Safe Havens, Programs for Assistance in Transitioning from Homelessness (PATH), and Health Care for the Homeless projects (HCH). Safe Havens were authorized by Congress in1994 as part of Housing and Urban Development's (HUD) Supportive Housing Program. Safe Havens provide 24-hour, low demand residential and drop in services and their mission is to serve hard to reach homeless people with serious mental illnesses who are on the streets and have been unwilling or unable to participate in supportive services (O'Hara, 2011). PATH program is a federal grant for the homeless mentally ill population and used to support existing community mental health services. HCH programs were established through Title VI of the McKinney Act, which allowed for grants to provide health care for homeless individuals (Page et al., 2012).

A study was conducted to explore a clinical perspective of the characteristics of homeless mentally ill by surveying 255 clinical supervisors of PATH, HCH, and Safe Havens around the United States. (D. Page et al., 2012). There were three significant findings; the first was that 81% or more of the clients served by all of these programs were reported to lack social support. According to the respondents, the isolation faced by homeless mentally ill can affect the effectiveness of treatment (D. Page et al., 2012). The second significant finding was the common diagnosis found within the homeless; schizophrenia, bipolar disorder, or major depression; co-occurring with a substance use disorder (D. Page et al., 2012). The third significant finding was lack of homeless

mentally ill individuals accessing outpatient mental health services. Professionals in the field described that the most common complaints were a history of serious side effects with older psychotropic medication and negative interactions with past providers (D. Page et al., 2012).

Housing

The primary reason why people become homeless is because they cannot afford to pay the rent and/or mortgage (Motley & Perry, 2013). There has been a shortage on the availability of affordable housing. HUD is currently the federal government's major supporter of affordable housing for low income households. According to HUD (2012) affordable housing is defined as housing that costs less than 30% of household income. The HUD program began with the Public Housing Act of 1937; under this act, the federal government finances construction of public housing developments that are then owned and operated by local housing authorities (Jaffee, Dwight, & Quigley, 2010). Residents of public housing developments pay no more than 30% of their income for rent (Jaffee et al., 2010). Housing Choice Vouchers (formerly known as Section 8) is another program in which very low-income families, the elderly, and the disabled are provided vouchers to obtain housing on the private market (Motley & Perry, 2013).

According to the 2013 U.S. Census Bureau, Orange County's population was roughly 3 million making it the third largest county in California and also the fifth largest county in the nation (Orange County Ten-Year Plan to end Homelessness, 2012). Rental units in Orange County are also quite costly. According to the Center for Housing Policy, in the fourth quarter of 2012, the median Orange County two-bedroom fair market rent of $1,546 ranks as the fifth most expensive among 210 U.S. metropolitan

areas; renters must earn at least $29.73 an hour for their housing costs not to exceed 30% of their income (Orange County Ten-Year Plan to end Homelessness, 2012). This means that a minimum wage worker needs to work over 3 times more an hour in order to meet fair market rent. The gap between rental costs and median family income has been one of the largest contributing factors to the number of individuals and families homeless in Orange County. According to the Orange County Fair Housing Council (Fair Housing Council of Orange County, 2010), there were over 14,000 evictions countywide in 2011-2012. In 2011, annual estimate showed roughly 18,000 homeless persons using HUD supported housing (Orange County Ten-Year Plan to end Homelessness, 2012).

Since 1996, Orange County has received approximately $153 million in federal Homeless Assistance Funding, and in 2007, a number of different community meetings were conducted to begin discussions on the development of a countywide Ten-Year Plan to End Homelessness, which is consistent with state and federal initiatives for ending homelessness (Orange County Ten-Year Plan to end Homelessness, 2012). To encourage this goal, communities must report on their progress in developing and implementing a Ten-Year Plan to End Homelessness into the annual application for Continuum of Care Homeless Assistance Funding to HUD (Orange County Ten-Year Plan to end Homelessness, 2012). Cities and counties across the country are being supported by the United States Interagency Council on Homelessness to create results oriented Ten-Year Plans that incorporate a Housing First or rapid re-housing approach, cost/benefit analyses, best practice engagement, service innovations, and prevention.

Over the last decade, there has been a shift in how homeless services are delivered. Many existing homeless service provision systems are based upon a

Continuum of Care model, which is a linear transition of services from emergency to transitional to permanent housing options (Pearson, Locke, Montgomery, & Buron, 2010). Newer research has begun to move the prevailing wisdom away from a Continuum model toward a Housing First or rapid re-housing strategy, which seeks to move homeless individuals into permanent housing as quickly as possible, skipping the shelter system and bringing necessary supportive services to participants within their own homes (Orange County Ten-Year Plan to end Homelessness, 2012).

This strategy is particularly effective for those people who have been chronically homeless and have other factors such as mental illness, substance abuse, or physically disabling medical conditions. In Orange County, the transitional shelter system is effective for the transitionally homeless, that is, those who can actively participate in their own self-sufficiency. A blended model approach provides the optimal chance to address the chronically homeless, and also gears resources to address individuals and families who could achieve success through a rapid re-housing approach (Orange County Ten-Year Plan to end Homelessness, 2012).

Housing First for the Mentally Ill

The Housing First model for individuals experiencing chronic homelessness and mental illness is based on the premise that this population will have housing and recovery outcomes if given immediate access to permanent, independent housing of their choice, and provided with flexible case management services (Connelly, 2014). By design, Housing First stands in contrast to more traditional treatment first transitional housing models, which specify treatment prerequisites, such as adherence to mental health treatment or abstinence from alcohol or drugs, prior to gaining access to permanent

housing (Lincoln, Plachta-Elliott, & Espejo, 2009). One U.S. study, for example, found that 88% of homeless persons with psychiatric disabilities housed in a housing first program were still housed 5 years after entering the program (Tsemberis & Eisenberg, 2010), and a Canadian Housing First program which housed people directly from the street, showed 87% remaining in their homes after 1 year (City of Toronto, 2009).

People who are both homeless and mentally ill are at very high risk of being arrested and involved with the criminal justice system. A study conducted in Vancouver, Canada, showed that Housing First also reduces re-offending among formerly homeless adults. There were 178 participants who had been homeless for over 5 years and the vast majority (92%) experienced a psychotic disorder or manic episode, reflecting the primary eligibility criteria for the housing first programs (Somers et al., 2013). The majority of the sample (67%) was involved with the justice system, with a mean of 8.07 convictions per person in the 10 years prior to recruitment; the most common category of crime was property offences (Somers et al., 2013). Following the Housing First model there was a significant association with lower numbers of sentences (14%) than those who followed the linear sequel of services or treatment as usual (95%; Somers et. al, 2013).

Substance Abuse

Substance abuse is recognized as a major health problem among the homeless. Drug and alcohol abuse often occur with other mental illnesses, physical illnesses, illegal activity, and unemployment (Sullivan, Burnam, & Koegel, 2012). People who cycle in and out of homelessness tend to cycle in and out of alcohol and drug abuse. The relationship between substance abuse and homelessness requires that they are treated together and not independently. Societal factors, such as poverty, unemployment, lack of

housing and individual factors, such as mental illness, criminal behavior, domestic violence and history of child abuse or neglect, are closely associated with both substance abuse and homelessness (Sullivan et al., 2012). From the point-in-time count survey conducted in Orange County in 2013, there were 2,862 homeless counted, in which 986 (34%) suffered from a substance abuse (OC Partnership, 2013). The vast majority of the homeless facing a substance abuse were not receiving shelter at the time of the count, with 753 being unsheltered (OC Partnership, 2013).

Substance abuse has ranked as one of the leading cause to homelessness. Substance abuse often increases the risk of homelessness, and homelessness, in turn, increases the abuse of substances, thus creating a vicious cycle. The rate of alcohol and drug abuse tends to be highest from samples taken from shelters, streets, and clinics (Morrell-Bellai, Goering, & Boydell, 2012). Men are more likely to report alcohol and drug related problems, whereas women had higher rates of mental illness (Morrell-Bellai et al., 2012). Homeless individuals struggling with substance abuse may have needs that may not be met by shelters that encourage self-sufficiency. Society often fails the homeless population by offering inadequate solutions to their problems, which may further undermine their motivation. Shelters with limited resources are often only able to provide food, clothing, and shelter. There is little assistance offered in the way of retraining, employment, counseling or rehabilitative services (Bray & Marsden, 2011).

Homeless individuals often reject treatment for substance abuse. Findings suggest three sets of attributes associated with failure to participate in treatment. These include: disaffiliation, a tendency of certain homeless adults to withdraw from social situations, isolation, a lack of the social support believed to help individuals maintain a

residence and personal loss are claimed to limit client motivation and ability to make use of offered treatment (Sosin & Bruni, 2010). A history of traumatic childhood events and family dysfunction have also been found to influence the initiation of substance abuse, thus leading to homelessness (Taylor-Seehafer, Jacobvitz, & Steiker, 2009).

A study of 75 participants was conducted with the purpose to further understand homeless population's lived experience with substance abuse and to better understand factors that contribute to substance abuse among the homeless (Lowe & Gibson, 2011). The majority of the participants reported multiple involvements in criminal activity which included driving under the influence, drug possession, forgery, grand theft, burglary, drug trafficking, embezzlement, gambling, gun charges, and organized crime (Lowe & Gibson, 2011). Single involvement was reported by 29.3%, whereas 18.7% reported never being involved in crime. Participants' description of their family characteristics, included: parental mental illness (reported by 23 participants), parental addiction, parental emotional, physical, and sexual abuse, parental neglect/poor parenting and lack of family network (Lowe & Gibson, 2011). The majority of the reports came from the different levels of abuse, specifically, emotional abuse (56.0%), physical abuse (56.0%), and sexual abuse; 33.3% (Lowe & Gibson, 2011). Participants also described characteristics of mental and emotional issues. Low self-esteem was the most frequently reported at 69.3%, poor coping skills were reported by 64%, feelings of guilt and shame were reported at 90.7% and 80% of participants described feelings of isolation (Lowe & Gibson, 2011). Societal issues were also characteristics mentioned by the participants. Peer pressure was reported by 53.3% of the participants and lack of support systems was reported by 82.7% (Lowe & Gibson, 2011).

The results of this study suggest that substance abuse can increase the risk of homelessness, but homelessness can also increase the abuse of alcohol and drugs (Bray & Marsden, 2011). Only three of the 75 participants indicated no history of substance abuse that contributed to their homelessness. Once homeless, the participants were more likely to become multiple substance abusers (Lowe & Gibson, 2011). Alcohol use and tobacco were most popular, followed by cocaine, crack, cannabis, and LSD. An equal number of participants used barbiturates, amphetamines, tranquilizers, and heroin; the less popular substances used included PCP, ecstasy, and painkillers (Morse, Thompson, & Unell, 2013). The participants in this study described a family history of parental addictions and mental illness.

Patterns of substance abuse behavior and coping abilities of the participants may be a reflection of their parents' behaviors. The participants also described the development of poor coping skills in relation to having a poor family environment and also having unresolved emotions and feelings, such as anger and guilt from their childhood which had an impact on their inability to cope as an adult (Morse et. al., 2013). Substance abuse became a coping mechanism with their internal issues. Strategies for intervening in various homeless situations within communities are necessary. Also, assessing the need for mental health services and treatment should be implemented.

Housing Barriers for the Substance Abuse Homeless

Structural factors that may contribute to drug users' greater vulnerability to homelessness include official and unofficial housing policies that determine eligibility for and access to housing and welfare services (Dickson-Gomez, Convey, Hilario, Corbett, & Week, 2009). The effects of housing policies on drug users' access to housing have been

understudied to date. Official policies include the federal "One Strike and You're Out" law passed in 1996 that allows federal housing authorities to consider drug and alcohol abuse and convictions of people when making decisions to evict or deny access to federally subsidized housing (Zlotnick, Tam, & Robertson, 2011). Unofficial policy is that service providers may choose to devote more of their limited resources to homeless individuals without substance abuse problems whom they may see as more deserving or as having a greater chance at success in maintaining their housing (Dickson-Gomez et. al., 2009). Some drug users face multiple barriers to accessing and maintaining stable housing, including long-term substance abuse, mental health issues, and histories of arrest. The housing first model advocates for the provision of housing to drug addicted or mentally ill homeless and is not based on completing treatment programs first or maintaining sobriety. The housing first advocates for housing with supportive services attached, including mental health services, addiction services, and assistance in budgeting, obtaining employment or maintaining an apartment. This is in contrast to Continuum of Care that seeks to enhance clients housing readiness by requiring sobriety and compliance with psychiatric treatment before placement to more permanent housing (Zlotnick et al., 2011).

Barriers for Homeless Veterans

More than 1 million veterans who sought services at Department of Veterans Affairs (VA) facilities in a 1 year period and a quarter of veterans who served in Iraq and Afghanistan had a mental illness diagnosis, including severe mental illness, posttraumatic stress disorder, and substance use disorder (Petrakis, Rosenheck, & Desai, 2011). These mental illnesses are associated with various psychosocial and functional difficulties,

including homelessness, unemployment, and legal problems (Tsai, Stroup, & Rosenheck, 2011). Among homeless veterans, legal assistance for child support issues, outstanding warrants and fines, and restoration of driver's licenses have been identified as three of the top 10 highest unmet needs (Kuhn & Nakashima, 2011).

Legal problems can represent barriers to clinical recovery and community integration (Rowe & Pelletier, 2012). Basic needs such as shelter and a sense of stability may need to be achieved before higher needs are met, such as long-term recovery (Rowe & Pelletier, 2012). Helping clients deal with legal issues also may facilitate greater clinical engagement. One study of 438 clients in a residential drug abuse treatment program found that clients who expressed concerns about legal problems at program admission were less likely to drop out of treatment early, that is, in the first 40 days of treatment (Rowe & Pelletier, 2012). Other legal issues faced are suspended driver's license, potential incarceration for unpaid child support or unpaid taxes, all of which make it difficult to focus on recovery, sobriety, and a healthy lifestyle.

Gender Barriers Faced by Veteran Women

There are 20 times as many male prisoners as females and according to the National Association for the Care and Resettlement of Offenders; half of them have no homes to go to after release (Hurley, 2008). The probation service is not an accommodation agency and does not help released inmates find a place to stay. The transition from incarceration to society is a large gap that without family or friend support can lead to homelessness.

Homeless women veterans face numerous barriers to social services, including lack of information about services, lack of access to services, and lack of coordination

across services. A recent report released by HUD indicates that veteran women are 4 times more likely to be homeless than female nonveterans in the United States and female nonveterans in the U.S. poverty population (HUD, 2011). There are numerous barriers to care and, consequently, homeless women might not receive the services that they need.

There was a study conducted in Los Angeles, California, with an aim to discover the service barriers that veteran women encounter. The study consisted of three focus groups with a total of 29 women veteran participants. Participants described three main barriers to social and psychosocial services: lack of information about services available to them, limited access to services, and lack of coordination across services (Hamilton, Poza, Hines, & Washington, 2012). Women described a sense of isolation and abandonment as their experiences of seeking and receiving services that were either inappropriate or uncomfortable.

Limited Access to Services for Veteran Women

Access to services was limited by a number of factors such as lack of gender appropriate care and lack of long-term housing options. Across all three focus groups, women stated that there were more homeless services for male than female veterans. Lack of gender appropriate care, women described both psychological and physical safety concerns in mixed gender programs that they had utilized. Many women with past history of sexual abuse mentioned that it was hard to enter a program and find that over 80% of the participants in the program were males (Hamilton et al., 2012). Another barrier to services was the lack of housing for single women with no children. Women in the study stated that after they would finish the programs, there was no assistance in

seeking housing or they simply did not qualify for low income housing due to not having children (Hamilton et al., 2012).

Participants experienced little coordination between their screening and receiving the necessary services. Participants noted that they already had the experience during military service of reporting assault and being ignored, or even worse, being stigmatized and further harassed, so reporting alone was not viewed as sufficient for receiving the desired assistance (Hamilton et al, 2012). Furthermore, women had been encouraged not to report experiences of abuse and violence, to suffer in silence and get stronger as a result. This attitude of persevering through women's post military lives contributed to substance abuse and a reluctance to report problems and seek help (Hamilton et al., 2012).

Housing First for Veterans

The Obama Administration and Congress have called for the elimination of veteran homelessness, specifically, the U.S. Department of Veterans Affairs (VA) has established the goal of eliminating veteran homelessness by 2015. To accomplish this mission, the VA has increased resources, transformed its service model to focus on homelessness prevention and permanent housing, increased partnerships at both the federal and local levels, and implemented research informed best practices (Culhane, Metraux, & Hadley, 2012). Findings have indicated that having any stable housing has a dramatic improvement on outcomes, especially those related to residential stability and use of institutional settings, such as hospitals, detox, jails and prisons (Rog, 2013). In addition to its effect on housing stability, permanent supported housing also reduces tenants' use of other institutional services such as shelter, hospitals, and correctional

facilities (Culhane et al., 2012). Retention rates for those that have received the housing first model have been recorded at 85% at 1 year post-housing and up to 80% at 2 or more years post housing (Rog, 2013). Several studies have found decreases in inpatient medical and mental health services, as well as decreases in emergency care for those inpatients that benefited from the model (Montgomery, Hill, Kane, & Culhane, 2013).

A study was conducted to determine whether Veterans participating in a Housing First approach to HUD-Veteran assistance supporting housing (VASH) receive housing more quickly, maintain long term housing stability, and decrease the use of more intensive and expensive health care services such as urgent care and inpatient mental health care, compared with Veterans in housing-readiness programs such as emergency shelters or transitional housing (Montgomery et al., 2013). The study consisted of 107 veterans in the housing first approach and 70 veterans in the transitional shelters and the results illustrated that veterans experiencing homelessness with psychiatric disabilities or substance use problems can live independently in the community when housed first (Montgomery et al., 2013). Data from this study demonstrate that housing first is effective in accessing permanent supported housing and maintaining housing for single adults, especially for those who have experienced chronic homelessness and have a mental health disability. Veterans housed using the housing first approach were eight times more likely than those housed using transitional shelters to maintain housing stability for 12 months (Montgomery et al., 2013).

Social Barriers

There are several social barriers faced by the homeless such as the inability to form family like attachments, lack of assistance in obtaining benefits and lack of

affordability of medication for the mentally ill. One of the social barriers mentioned by the unsheltered homeless was the need to form family like attachments, which is an understandable desire of the participants to be treated as actual human beings with feelings and sensitivities (Donley & Wright, 2012). In a study, a couple described their rejection to services because of the possibility of being separated and described that they were not going to exchange that security and love for a shelter, also, another man described that he was unwilling to let go of his companion dog to receive treatment (Donley & Wright, 2012). Homeless assistance agencies need to make their services more appealing to the treatment resistant.

Homeless individuals also needed assistance applying for social security disability benefits, others were unaware of the benefits they may be entitled to, were unable to deal with the paperwork, or simply had no idea where to seek assistance (Jost, Levitt, & Porcu, 2011). Homeless individuals face the struggles of mental illness or substance abuse that may make it difficult for them to reach out and seek assistance with applying to public assistance.

Another need was for access to appropriate medication management and affordability of such medication, which averages at $800 a month (Donley & Wright, 2012). Likewise, there may be a correlation between lack of medication and alcohol or drug abuse found among the homeless that may reflect efforts to relieve psychiatric symptoms only through self-medication (Donley & Wright, 2012). Furthermore, the traditional substance abuse treatment programs such as the twelve step programs face a struggle when working with those whose addiction is a form of self medication for their

mental illness. Effective treatment will require far more than just opening additional detox beds for this population (Donley & Wright, 2012).

Karger and Stoesz (2011) highlighted ways society could address the problems of the homeless. There is the need for changes in federal housing, income support, social services, health care education, and employment policies. The increase of welfare benefits must be stopped, residency and other requirements that exclude homeless persons must be changed and programs must be made freely available to the homeless and the potentially homeless (Karger & Stoesz, 2011). Federal programs and legislation should be coordinated and expanded to provide decent, affordable housing, coupled with needed services, for all poor families. Karger and Stoesz (2011) concluded that both the states and federal government should intervene directly in the housing market by controlling rents, increasing the overall housing stock, limiting speculation, and providing income supports.

Summary

It is important that community agencies increase the support provided to the homeless population. There is also a need to apply the housing first model in the service offered to chronically homeless individuals. Housing First stands in contrast to transitional housing models, which specify treatment for mental health or abstinence from alcohol or drugs, prior to gaining access to permanent housing. The chronically homeless individuals suffering from a mental disorder, substance abuse or homeless veterans may have needs that may not be met by shelters that encourage self-sufficiency. Society often fails the homeless population by offering inadequate solutions to their problems, which may further contribute to their chronic situation (Bray & Marsden, 2011). The

effectiveness of the Housing First model in research will inform the Rise Above program to offer services geared specifically towards the needs of those chronically homeless.

CHAPTER 3

METHODS

The following chapter will focus on the program development. This chapter will cover the target population, host agency description, potential funders and needs assessment, and budget narrative of the program. In addition, the description and qualifications for each staff member involved in the program is discussed.

Target Population

The target population for this proposed program consists of 25 homeless individuals, both male and female in Orange County. Priority will be given to the chronic homeless suffering from mental illness and substance abuse, or who are former veterans. In 2013, the demographics for Orange County's homeless was that of the 4,251 unsheltered homeless, 44.7% were White, 35.4% were Latino, 16.2% were Asian/Pacific Islander, and 1.4% was Black (OC Partnership, 2013). Also, 59% were male and 41% were female. The median age range was that 86% of the unsheltered homeless were between the ages of 18-64 (OC Partnership, 2013). The age for the target population in the Rise Above program will be 18 and over. No one will be excluded based on gender or racial ethnicity.

Host Agency

The host agency for this proposed grant will be the Homeless Intervention Shelter (H.I.S. House; 2013). H.I.S House, located in Placentia California, began in 1989 when

the Placentia Presbyterian Church utilized an old farmhouse next door, and decided to make it into a shelter when more and more homeless individuals requested assistance (H.I.S. House, 2013). Volunteers and a resident manager ran the shelter and in 2001, upon receiving a HUD grant, H.I.S. House completed their renovation project and expanded from 25 to 40 beds. H.I.S. House provides a transitional shelter to families and individuals for 4 to 6 months while they develop a source of permanent income and save for housing. H.I.S. House offers a home-like environment in which residents can sleep in a private room, prepare their own meals, do their laundry, and have access to a computer lab on site, access to phone and assistance to search for employment (H.I.S. House, 2013).

H.I.S. House provides weekly case management meetings, counseling, employment guidance and life skills classes. Volunteer mentors meet with residents on a regular basis to support residents in working towards their goals. H.I.S. House offers a second milestone to their program for qualified residents. H.I.S. House purchased two houses next to their facility in which a total of 10 eligible graduates will be able to rent for a low cost up to six months while their continue to increase their savings and move towards self-sufficiency (H.I.S. House, 2013). To qualify for the second milestone of the program, graduates must be recommended for an interview by their case manager. Also, graduates must have obtained employment for 32 hours a week and saved at least one month's income. Staff includes a resident manager, case managers, career developer and administrative assistance. H.I.S. House assists approximately 120 homeless people throughout the year. A letter of agency support can be found in Appendix A (H.I.S. House, 2013).

Potential Funding Source Identification and Selection Strategies

Strategies for grant funding included searching online on websites such as Grants.gov and USA.gov that give grants to non-profit organizations. Western Digital Foundation offers grants to non-profit organizations working with the impoverished population every year. The foundation supports organizations that improve education, support basic human needs, as well as programs protecting the homeless in our communities. Western Digital Foundation offers $100,000 to any non-profit agency working with the homeless (Government Grants, 2014). Another potential funding source was the United Way of Orange County which awards $25,000 - $200,000 annually to non-profit organizations, specifically those applying the new strategic ten year plan to end homelessness (Government Grants, 2014). A third potential funding source was the Weingart Foundation that provides grants for organizations working with the homeless population and they award $35,000 - $2,000,000 (Weingart Foundation, 2014). Based on the need of the proposed program, the Weingart Foundation was selected for this project. The amount offered would be sufficient to begin the proposed rehabilitative program for homeless individuals. Also, H.I.S. House agency and the Rise Above program have values that are aligned with the values of the Weingart Foundation. The foundation provides grants and other support designed to improve the capacity and sustainability of nonprofit organizations to provide effective services in the areas of health, human services, and education of those impoverished. The Foundation gives highest priority to activities that provide greater access to people who are economically disadvantaged and applications are to be specifically address to the needs of low income

children and youth, older adults, and people affected by homelessness (Weingart Foundation, 2014).

Needs Assessment

Once every two years, Orange County undertakes an effort to enumerate all of the sheltered and unsheltered homeless people within the county. This effort, known as the homeless point-in-time count is mandated for all communities that receive HUD funding for the homeless programs (HUD, 2013). HUD requires a count of both sheltered and unsheltered homeless people, as well as certain characteristics among the homeless population. According to Teri Niebuhr (Personal communication, June 29, 2014), the executive director at H.I.S. House, clients lack a safe haven. Most homeless adults she has worked with share that all they need is a supportive environment and people to give them one on one attention. There is a high need for basic life skills such as resume building and mock interviews. Teri Niebuhr stated that having a mental disorder or a history of substance abuse disqualifies adults from receiving services at their shelter because they have not received any funding to assist individuals with such needs. Teri Niebuhr mentioned that she believes there is a high need for services to be given to homeless adults struggling with mental disorders or substance abuse.

Budget Narrative

The approximate budget range for one year is $250,000, not including in kind support. This includes two part time salaries for the case managers, part time director of development, and part time volunteer coordinator and volunteers/mentors. In addition, the projected budget also includes total direct program cost, such as transportation bus vouchers, medication vouchers and supplies that are needed to develop the program.

The executive director will have responsibility for administrative tasks and supervision of program. The supervision administrative tasks will be given in kind, dedicating 8 hours a week in tasks for the program. The existing executive director has a master's level education in Social Work and 20 years experience in related fields.

There will be two full time case managers that will be responsible for creating a needs assessment, constructing a care plan, linking clients to resources in the community and assisting clients build attainable short term goals. In addition, the case manager would maintain communication with all volunteers working individually with clients. The salary of each individual case manager will be $40,000 annually, working 40 hours a week at $16 an hour, including benefits. This position will require a bachelor's degree in social work or human services field, plus a minimum of three years of professional work experience in a related social services field.

There will be a housing specialist to assist individuals and families with finding affordable housing. The housing specialist will also be responsible for conducting an eligibility assessment for each client and then identify any available housing. Assists in familiarizing clients with their rights and responsibilities as tenants, and teach them how to resolve issues with their landlords. Also responsible for increasing the inventory of available housing by reaching out to property owners and local resources and assist clients with limited financial means to secure decent housing. A minimum of a bachelor level education will be required in human services or related field and a minimum of 3 years of experience will be required. This position will be full time with benefits, at $40,000 annually, working 40 hours a week at $16 hourly wage.

The part time volunteer coordinator would be responsible for community outreach, recruitment, training and supervision of volunteers. The salary for the volunteer coordinator is $10,000 annually for an average of 10 hours per week at $14 hourly wage and will require a minimum of an associate's degree in social work or related field and 1 year of outreach experience.

The part time director of development will be responsible for grant writing and fundraising, along with building community relations to get people involved in monetary assistance. The grant writer will make $12,000 annually dedicating 12 hours a week at $16 hourly and will require a minimum of a bachelor's degree in social work or related field and 3 years experience in related field. It is necessary to have a director of development dedicate more time into the program to expand and continue the Rise Above program.

Eligibility criteria for a volunteer/mentor position will require young adults over the age of 18 who have at least 6 months of prior volunteer experience with the homeless population or are currently students at a university. Mentors will be provided extensive training on goal development, and life skills coaching to better work with the homeless population they are serving. The mentor/volunteer positions are unpaid however each volunteer/mentor can credit intern credit hours for their university and a letter of recommendation at the end of their time served. Mentors will be required to see their mentee at least 2 hours a week, for a minimum of 6 months estimating approximately 48 hours. The total staff and volunteer/mentor salaries are $142,000 annually with benefits included. Total direct costs include bus pass transportation ($6,000), food (20,000) and security deposit ($14,000) and rent ($68,000) will be $108,000 annually. Program costs

of office supplies and materials which will include pens, postage stamps, envelopes, paper and printer ink ($800), copying and printing ($400) and mileage reimbursement at .50 per mile up to 100 miles per month/ 3 individuals ($1,800) will be of total cost of $3,000 annually. There is also an administrative overhead cost (10%) of $25,000 to manage the grant which will also come out from the grant. The total direct program costs are $108,000 annually. Please view Line Item Budget in Appendix B.

CHAPTER 4

WEINGART FOUNDATION

The following chapter includes the actual application and detailed information regarding organizational structure, target demographics, an overview of the project, as well as the expected outcomes and objectives used to measure the achievements of the program. This application will also cover information regarding funding, start and end dates of project, and proposed budget. The section for board of director's names, contact information, agency's tax identification number information will not be included due to privacy concerns. The application was completed for education purposes.

Target Geography

Organization Type

The legal organization name is Homeless Intervention and Shelter House. The year H.I.S. House was established was in 1989. Homeless Intervention and Shelter House (H.I.S. House) was founded by Placentia Presbyterian Church. H.I.S. House provides services to families, couples and single adult homeless. Each year H.I.S. House shelters about 130 people. The shelter consists of 13 guest rooms, 2 full kitchens, 4 full bathrooms, 2 family rooms, resident manager quarters, a library room and a computer/employment room. In 2002, H.I.S. House introduced a second step program where six graduates from H.I.S. House are able to enter a three bedroom single family residence near the shelter. For the next 6 months, singles or couples pay $300-345 per month and continue working and saving money for permanent residency. H.I.S. House

has had great collaboration with landlords nearby the Placentia area that collaborate in the transition of housing graduates.

Board of Directors Information

H.I.S. House has an organizational board that consists of a board of directors which include the following positions: President, Vice Presdent, Chief Finance Officer and Secretary. The board members consist of Chairman of the board, Event Chairman, Past chair and Development chair and staff consists of an executive director, 2 case managers, finance director, 2 residential managers and 1 childcare specialist.

Mission

Homeless Intervention Shelter House assists homeless individuals, couples and families to become self-sufficient through housing, training, counseling and personal support.

Programs and Services

H.I.S. House provides a transitional shelter to families and individuals for 4 to 6 months while they develop a source of permanent income and save for housing. H.I.S. House offers a home-like environment in which residents can sleep in a private room, prepare their own meals, do their laundry, and have access to a computer lab on site, access to phone and assistance to search for employment (H.I.S., 2013).

H.I.S. House provides weekly case management meetings, counseling, employment guidance and life skills classes. Volunteer mentors meet with residents on a regular basis to support residents in working towards their goals. H.I.S. House offers a second milestone to their program for qualified residents. H.I.S. House purchased two houses next to their facility in which a total of 10 eligible graduates will be able to rent for a low cost up to six months while their continue to increase their savings and move

towards self-sufficiency (H.I.S., 2013). To qualify for the second milestone of the program, graduates must be recommended for an interview by their case manager. Also, graduates must have obtained employment for 32 hours a week and saved at least one month's income.

Program Impact: outcomes

H.I.S. House has helped over 2,000 individuals and families since 1989. In 2013, H.I.S. House was able to assist 132 people. Program effectiveness is shown by pre and post test for financial workshops and budgeting. When participants enter the program they are given a pre-test and asked questions regarding how they handle their money and their skill level of managing, budgeting and saving income. At exit, participants are given a post test and effectiveness of such programs is determined. Of the 132 residents served at H.I.S. House in 2013, 125 participated in the pre and post testing. Through the pre and post testing, 85% of participants demonstrated an increased awareness of basic concepts of budgeting. Verbal and written client feedback indicates that 90% of participants report increased knowledge of available community resources for homeless such as housing, food, clothing, utility assistance and vocational resources. Success in the program is determined by those that are able to obtain employment and move into a permanent residency. Last year, 83% of participants successfully graduated, obtained financial stability and moved into their own permanent residency.

What is the Name of Your Project?

The name of the project is called Rise Above and the motto is "*Rise above and beyond your circumstance."*

Provide an Overview of Your Project

The mission for the new program Rise Above, is to assist chronically homeless individual's end the cycle of homelessness and help them into self-sufficiency through a housing first model. Due to the diversity of the homeless population, it is important to have a program in which existing and new staff are trained for cultural sensitivity. The proposed program will hire a culturally diverse staff and provide training to ensure appropriate services are given by having documentation in various languages, by the use of bilingual staff or trained/certified interpreters during assessments, treatment sessions, meetings, and for or other events for families who would require this level of assistance. The program will have the existing executive director and will provide in kind supervision. The executive director has a master's level education and 20 years experience in a related field. Each individual will be assigned a case manager that will be responsible for creating a needs assessment, constructing a care plan, linking clients to resources in the community and assisting clients build attainable short term goals. This program will have two full time case managers dedicating 40 hours a week to the program. This position will require a bachelor's degree in social work or human services field, plus a minimum of 3 years of professional work experience in a related social services field. Each individual will also work extensively with a housing specialist as soon as he or she enters the program that will assist in searching for affordable housing within the community. The housing specialist will be full time working 40 hours a week. The housing specialist must have a minimum of a bachelor's level education and 2 years of experience as a housing specialist or in a related field.

The program will have a part time volunteer coordinator who will designate 15 hours a week to the program. The volunteer coordinator will assist in recruiting volunteers for the outreach program. This position must have a minimum of a bachelor's level education and 1 year related experience. Volunteers will reach out to local centers where the highest numbers of homeless individuals are known to reside and offer transportation to and from the facility. The program will have a part time grant writer with a minimum of a bachelor's level education and 4 years related experience. There will be a part time director of development that will be responsible for grant writing and fundraising, along with building community relations to get people involved in monetary assistance. This position will have a minimum of a bachelor's level education in human services or related field is required and a minimum of 2 years experience. There will be no benefits included in any of the in kind or part time positions. Benefits will only be offered for the two full time case managers (See attached Appendix B).

The Rise Above program will be delivered in three steps: housing stabilization, training, and service implementation. The first step of the program is the stabilization of immediate needs of obtaining a permanent residence, along with basic needs such as clothing and food. The housing specialist will work in collaboration with local low income apartments and thus assist in the process of obtaining housing. The program will assist in paying the security deposit and first 3 months of rent. For the first 3 months, along with being assigned a case worker; each homeless individual will also be given a mentor, which will be a volunteer, to give one on one attention to the individual through the process of self-sufficiency. The case worker will develop a care plan which may include health services for physical or mental conditions, application for governmental

assistance for which the individual may be eligible (i.e., veterans or the mentally or physically disabled). The care plan may also include connection to local doctors for regular physicals, dental care, social services meetings, or rehabilitative services. The role of the mentor is to be a supporter and advocate for the chronically homeless adults. The mentor will provide transportation to and from the services developed in the care plan and assist with phone appointments, paperwork and so on.

The second step to the program is the training component. Also, during months 1-3, individuals will receive life skills and employment skills through short term vocational training. Assisting the chronically homeless in getting back into the workforce may include helping them build their resume and assisting with interviewing skills.

The third step of the program is the service implementation period. During months 3-6, the individual will have obtained employment and start working towards paying rent and build his or her savings. Individuals must save 80% of all earned income after paying bills, and this will be based on pay stubs, and will put savings in a savings account with the agency. The case worker will assist in providing budgeting and financial literacy. The individual will be given up to 6 months to be able to begin paying his or her entire rent; if individual fails to do so, the program will extend rental assistance for up to 6 months.

Requests Title

The general operating request is to begin a new program that will assist families avoid the shelter process and quickly enter housing. Expenses will be used to hire new staff and pay current staff that will also participate in this new program, along with program office expenses and direct expenses in rental assistance.

Projected Goals and Outcomes

The goal for the Rise Above program is to be a rehabilitative program for the chronically homeless individuals and to provide a supportive environment to assist individuals with skill building for sustainment of permanent housing and self-sufficiency. Primarily, Rise Above will use a housing first model and imminently house 25 homeless individuals. After the basic necessities are met such as housing, food, and clothing are met, the program will assist individuals become self-sufficient through extensive one on one work to obtain employment and meet all other areas of need such as mental and physical health. Rise Above will assist homeless individuals obtain housing stabilization through coordination with affordable housing list. Housing specialist will work one on one to offer guidance in searching for housing. Outcomes will be that 95% of participants will stably house and remained house for 12 months.

Another goal is that Rise Above will assist will job training, employment skills and vocational training. BSW will assist in workshops and assist in job search. Outcomes will be that 85% of the 25 participants will be able to obtain employment and begin self-sufficiency by 3-6 months of the program. Also, Rise Above will facilitate financial literacy and implementation of budgeting skills. BSW will assist with skills in working on building financial goals and beginning a savings. Outcomes will be that 90% of participants will learn to manage income and implement a savings plan. Each individual is to participate in a 12 month program process and success will be determined if they remain housed for a minimum of another 12 months after graduating from the program.

Percentage Low-Income Served

In order to be eligible for the Rise Above program, participants need to be literally homeless. In Orange County, HUD defines homelessness as a person who lacks a fixed, regular, and adequate nighttime residence and sleeps in a variety of places not fit for human habitation or meets certain other requirements. Homeless persons include, but are not limited to, those sleeping in cars, parks, campgrounds, sidewalks, railroad tracks, alleys, storm drains, freeway underpasses, abandoned buildings, emergency shelters, or transitional housing for homeless persons who originally came from the streets or emergency shelters (HUD, 2013). Also, participants must not exceed the 30% poverty level. For 1 individual to be under the 30% guideline they must not exceed more than $19,000 annual income (HUD, 2014). What will be considered as income is any governmental assistance such as cash aid, social security income, unemployment benefits, earned income or child support. Proof of all documentation will be requested at the initial interview. One hundred percent of the participants in the Rise Above program will be low income.

Geographic Region Served

H.I.S. House is located in northern Orange County, in the city of Placentia California. Services for the Rise above program will be for homeless individuals residing throughout the county of Orange.

Total Projected Budget

The approximate budget range for one year is $275,000, not including in kind support. This includes two part time salaries for the case managers, part time director of development, and part time volunteer coordinator and volunteers/mentors. In addition,

the projected budget also includes total direct program cost, such as transportation bus vouchers, medication vouchers and supplies that are needed to develop the program.

The executive director will have responsibility for administrative tasks and supervision of program. The supervision administrative tasks will be given in kind, dedicating 8 hours a week in tasks for the program. The existing executive director has a master's degree in Social Work and 20 years experience in related fields.

There will be two full time case managers that will be responsible for creating a needs assessment, constructing a care plan, linking clients to resources in the community and assisting clients build attainable short term goals. In addition, the case manager would maintain communication with all volunteers working individually with clients. The salary of each individual case manager will be $40,000 annually, working 40 hours a week at $16 an hour, including benefits. This position will require a bachelor's degree in social work or human services field, plus a minimum of three years of professional work experience in a related social services field.

There will be a housing specialist to assist individuals and families with finding affordable housing. The housing specialist will also be responsible for conducting an eligibility assessment for each client and then identify any available housing. Assists in familiarizing clients with their rights and responsibilities as tenants, and teach them how to resolve issues with their landlords. Also responsible for increasing the inventory of available housing by reaching out to property owners and local resources and assist clients with limited financial means to secure decent housing. A minimum of a bachelor level education will be required in human services or related field and a minimum of 3

years of experience will be required. This position will be full time with benefits, at $40,000 annually, working 40 hours a week at $16 hourly wage.

The part time volunteer coordinator would be responsible for community outreach, recruitment, training and supervision of volunteers. The salary for the volunteer coordinator would be $10,000 annually for an average of 10 hours per week at $14 hourly wage and will require a minimum of an associate's degree in social work or related field and 1 year of outreach experience.

The part time director of development will be responsible for grant writing and fundraising, along with building community relations to get people involved in monetary assistance. The grant writer will make $12,000 annually dedicating 12 hours a week at $16 hourly and will require a minimum of a bachelor's degree in social work or related field and 3 years experience in related field. It is necessary to have a director of development dedicate more time into the program to expand and continue the Rise Above program.

Eligibility criteria for a volunteer/mentor position will require young adults over the age of 18 who have at least 6 months of prior volunteer experience or are currently students at a university. Mentors will be provided extensive training on goal development, and life skills coaching to better work with the homeless population they are serving.

The mentor/volunteer positions are unpaid however each volunteer/mentor can credit intern credit hours for their university and a letter of recommendation at the end of their time served. Mentors will be required to see their mentee at least 2 hours a week, for a minimum of 6 months estimating approximately 48 hours. The total staff and

volunteer/mentor salaries are approximately $142,000 annually with benefits included. Total direct costs transportation, food and living expenses will be $80,000. Office supplies and materials will be $3,000. Please view table 1 for a breakdown of the categories. A line item budget can be found in Appendix B.

What Amount are you Requesting from the Weingart Foundation?

The grant seeker is requesting a total amount of $275,000 for one year of service.

Estimate the Amount of People that will Benefit from this program

The Rise Above program is expected to assist a total of 25 individuals in a span of one year.

Expected Start Date

Rise Above program is expected to begin June 1st, 2015.

Expected End Date

Rise Above program is expected to begin June 1st, 2015.

Objectives

Objective 1: Assist homeless individuals obtain housing stabilization through coordination with affordable housing list. Housing specialist will work one on one to offer guidance in searching for housing.

Outcome 1: Stably house 95% of chronically homeless individuals.

Objective 2: Assist will job training, employment skills and vocational training. BSW will assist in workshops and assist in job search.

Outcome 2: Individual will increase employability skills and find full time job for 85% of participants.

Objective 3: Facilitate financial literacy and implementation of budgeting skills. BSW will assist with skills in working on building financial goals and beginning a savings plan.

Outcome 3: 90% of participants will learn to manage income and begin savings.

12 Month Line Item

The implementation process for the program is divided into 12 months. Please view Appendix C.

CHAPTER 5

LESSONS LEARNED

As a first time grant writer, there were many fears and uncertainties at the beginning of this process. The writer quickly came to understand that time management and organizational skills would become a key component to the successful completion of this assignment. Many times the writer as faced with the lack of patience or motivation but knowing that the skills obtained through this assignment would carry on with me for the rest of my professional life kept me going. This writer learned the importance of policy, networking, grant writing and funding. This writer was stretched intellectually and learned that her confidence was also growing along with the process.

Professional Development

This writer has worked with the homeless population for 4 years by internship and employment. This writer works with homeless families but was particularly interested in assistance to the single homeless individuals that often times struggled to obtain services for the lack of agencies or lack of agencies willing to help homeless without children. This writer saw the need in the community and reached out to a host agency, H.I.S. House that works with single homeless adults. Through phone conferences and meetings with H.I.S. House's executive director, this writer was able to develop a grant relevant to the needs of the host agency.

With limited knowledge in grant writing, but with firsthand experience in challenges with working with homeless, this writer began to research information related

programs that have been successful in the past with homeless individuals and along with the executive director's view of a successful program a decision was made on the proposed program. This writer learned how grant proposals are a fundamental part to the attempt of improving the quality of life for the chronically homeless individuals. In addition, this writer learned how to research and obtain data that focus on challenges faced with chronically homeless and also the success of programs. This writer was also able to develop a realistic program by identifying who needs to be involved on an organization level, what supplies would be needed, and how much the program designed would realistically cost on an annual basis.

Funding Source

This writer had no knowledge in finding a funding source, which was another challenge this writer experienced during the grant writing process. Due to the fact that this writer works at a homeless family shelter alongside a grant writer, this writer decided to conduct an interview with the grant writer and obtain more information in searching for grants. This writer continued to do more research and found the best match, Weingart Foundation, which is specifically interested in funding programs that will work with homeless or people with extremely low income. After finding the best match for grantor, this writer completed their application form based on the Weingart Foundation website that had detailed information, eligibility requirements and the grant application, which were all very easy to find and understand. This writer was pleased with the foundation of choice because it meets the program's needs.

Implications for Social Work Policy and Practice

Through this process, this writer obtained more knowledge regarding services for the chronically homeless individuals. This writer researched and explored different studies conducted and services implemented with this population. This writer mainly focused on programs that have been successful in not only getting homeless off the streets but those successful in helping homeless individuals remain housed. Through the literature review this writer learned that in order for homeless to obtain employment and focus on caring their health concerns such as a mental illness or substance abuse, housing must be implemented. Other research has provided that a housing first model has been effective. Instead of having homeless go through a transitional living program in which individuals are prepared for living in an apartment independently, housing first and then offering supportive services can assist homeless stabilization. This write also learned that the primary reason why people become homeless is because they cannot afford to pay the rent and/or mortgage. As social workers, we must advocate for the need of lower rental rates in Orange County. Also learned, was the importance of treating each client with integrity regardless of their current situation. Based on surveys conducted, some homeless individuals felt that they were being treated as less of an individual for being homeless. It is important for social workers to show respect, empathy and work in a non-judgmental manner.

Micro and Macro Levels of Social Work

In researching the history of homelessness in America this writer learned how policies such as the deinstitutionalization of the mentally ill has contributed significantly to the high numbers of mentally ill homeless after. This writer learned how the policy

plays a role in the necessity seen in the homeless population. This writer learned that in Orange County, grant assistance is given mostly to homeless families with children as oppose to homeless individuals and learned that assistance in geared more towards assisting children. This gave this grant writer an insight into what targeted homeless population Orange County funding is used for and understood why there are more homeless individuals in the street. There is a high need for assistance to the chronically homeless individuals in Orange County, but if that specific targeted population is not a priority, there are not a lot of funded programs willing to assist chronically homeless, none the less, a single homeless struggling with a mental disorder or substance abuse. This writer also found that it is important for policymakers to become aware of the needs of chronically homeless ill in Orange County and the need for advocates from the shelter to be constantly informing the policymakers of the necessity if services.

Personal Lessons

The entire master's in social work program has been a challenge; thesis was the cherry on top. Looking back at this process, this writer sees herself as a different person. The growth in this writer has been from the depths of her to the extremities of her persona. It was been a process of self-motivation, perseverance, patience and ultimately self-growth. This writer was not aware of how determined she was and how hard this writer was willing to work on something. During this process, this writer's tears became her strength that lead this writer to the goal of accomplishment. It was extremely difficult to balance a life between work, school, internship, church, fiancée, family and friends. Procrastination became this writer's worst enemy, which lead to bigger stressors. This writer tried her best to set time apart for thesis on a weekly basis, keeping an agenda of

my responsibilities and making efforts to prioritizing duties. Often times, last minute things would come up and thesis would be pushed extra days. Not being successful in that method has allowed this writer to realize the importance of getting things done ahead of time and not waiting for last minute in order to decrease stress and exhaustion.

Another significant lesson learned was the balance between self-care and social life. Often times this writer felt the need to do activities that would decrease this writer's stress and provide self-care, but other times this writer would prefer the social life rather than working on thesis. This writer found many excuses to keep pushing off thesis and dedicate more time to social outings. This writer believes that self-care is very important but in order to complete thesis, social life has to be sacrificed at times. This writer became engaged during the program and planning a wedding while working on thesis was not a good combination.

Lastly, another lesson learned was the importance of having a positive support system in life in general. Working in the social work field can easily lead to burn out. Learning and working with the vulnerable population, can become overwhelming if there is not a good support system outside of work. The exceptional guidance and patience from this writer's thesis advisor assisted in the understanding for the requirements of the grant proposal. This writer's thesis advisor was always quick to respond and never hesitated in explaining information at a slower pace. Also, as this writer wrote this grant proposal, family, friends and fiancée provided emotional support and encouragement. Overall, this writer will utilize these challenges and growth to continue to offer the best in the social work field. This writer no longer fears for the future, for this writer now knows that there is no dream too far from reality.

APPENDICES

APPENDIX A

LINE ITEM BUDGET

Line Item Budget

Item #	Description of item	Costs	Total Costs
Salaries:			
1	2 FTE Case manager	$16 per hour @40 hrs/wk + benefits	$80,000
2	1 FTE Housing Specialist	$16 per hour @ 40 hrs/wk + benefits	$40,000
3	1 PTE Volunteer Coordinator	$14 per hour @ 10 hrs/wk	$10,000
4	1 PTE Director of Development	$16 per hour @ 12 hrs/wk	$12,000
5	1 Executive Director	8 hrs/wk	In Kind
6	Mentors/Volunteers	2hrs/wk	In Kind
Total Salary Costs:			**$142,000.00**
Direct Program Costs:			
7	Bus Pass Transportation	$6,000	$6,000
	Supplemental Food	$20,000	$20,000
	Security Deposit	$14,000	$14,000
	Rent Payments	$68,000	$68,000
8	Supplies (Pens, postage stamps, envelopes, paper, printer ink, etc).	$800	$800
9	Copying and Printing	$400	$400
10	Mileage Reimbursement	.50 per mile up to 100 miles per month/ 3 individuals	$1,800
Total Direct Program Cost:			**$108,000.00**
Indirect Costs:			**$25,000.00**
Total Funding Needed:			**$250,000.00**
Total Program Costs:			**$275,000.00**

APPENDIX B

HOST AGENCY LETTER

APPENDIX C

12 MONTH TIME LINE

12 Month Timeline

Month 1:

• Discuss project plans to new and existing staff.

• Recruit and train mentors/volunteers in multiple areas such as career exploration, providing support, developing goals, coaching basic skills to help participants obtain self-sufficiency, making community linkages, etcetera.

- Develop documentation letters.
- Create list of supplies needed for activities and projects.

Month 2

- Announce of funding to 2-1-1 general homeless hotline.
- Outreach to emergency shelters and local areas where homeless individuals are known to reside will be established.
- Case managers will begin phone screenings and in person interviews will begin for potential candidates.

Month 3

- Step 1 of the program established: participants will be chosen and assigned to housing specialist to be housed.
- Guidelines for participation in the program will be given.
- Paperwork will be collected and all related documentation necessary.
- Pre-test on financial literacy will be given to candidates.

Month 4

- Participants will be paired up with a mentor/volunteer.
- Case manager will be assigned and begin working one on one with clients.

- Short term goals will be established with case manager.
- Resources will be given to participants.

Month 5

- Step 2 of the program established: Coach Life skills will begin.

  -Job/vocational and employment training will be established.
- Case managers continue to meet one on one on a weekly basis for a minimum of 1 hour.
- Ongoing rapport building

Month 6

- Participants will continue to work on short term goals.
- Participants will continue to seek and/or obtain employment.
- Ongoing rapport building
- Case managers continue to meet one on one on a weekly basis for a minimum of 1 hour.
- Mentors/ Volunteer meet a minimum of 2x a month with participants.

Month 7

- Step 3 of the program established: participants begin budgeting their income.
- Ongoing financial literacy workshops.
- Participants will continue to work on techniques and skills learned related to their goals and will be provided opportunities to practice out skills learned.
- Participants establish long term goals.
- Case managers continue to meet one on one on a weekly basis for a minimum of 1 hour.

- Mentors/ Volunteer meet a minimum of 2x a month with participants.
- Ongoing rapport building

Month 8

- Step 3 of the program established: Participants will begin to pay their own rent.
- Participants continue to work on budgeting and savings.
- Participants will continue to work on techniques and skills learned related to their goals and will be provided opportunities to practice out skills learned.
- On Case managers continue to meet one on one on a weekly basis for a minimum of 1 hour.
- Mentors/ Volunteer meet a minimum of 2x a month with participants.
- Ongoing rapport building

Month 9

- Participants continue to work on their long term goals.
- Participants will continue to work on techniques and skills learned related to their goals and will be provided opportunities to practice out skills learned.
- On going Coach Life skills & financial literacy workshops.
- Participants continue to work on budgeting and savings.
- Ongoing case management meetings on a weekly basis for a minimum of 1 hour.
- Ongoing mentors/ volunteer meetings a minimum of 2x a month with participants.
- Ongoing rapport building

Month 10

- Participants continue to work on their long term goals.
- Participants will continue to work on techniques and skills learned related to their goals and will be provided opportunities to practice out skills learned.
- On going Coach Life skills & financial literacy workshops.
- Participants continue to work on budgeting and savings.
- Ongoing case management meetings on a weekly basis for a minimum of 1 hour.
- Ongoing mentors/ volunteer meetings a minimum of 2x a month with participants.
- Ongoing rapport building

Month 11

- Participants continue to work on their long term goals.
- Participants will continue to work on techniques and skills learned related to their goals and will be provided opportunities to practice out skills learned.
- On going Coach Life skills & financial literacy workshops.
- Participants continue to work on budgeting and savings.
- Ongoing case management meetings on a weekly basis for a minimum of 1 hour.
- Ongoing mentors/ volunteer meetings a minimum of 2x a month with participants.
- Ongoing rapport building.

Month 12

- Begin exit paperwork.
- Finalizing of case management and mentors/volunteer work.
- Participants will continue to work on techniques and skills learned related to their goals and will be provided opportunities to practice out skills learned.
- Certificated provided for completion of life skills and financial literacy workshops.
- Program evaluation

  -Post test on financial literacy distributed.

REFERENCES

REFERENCES

Bray, R., & Marsden, M. (2011). *Drug use in metropolitan America*. London: Sage.

City of Toronto. (2009). *What housing first means for people: Results of Streets to Homes post-occupancy research*. Toronto, Canada: City of Toronto Shelter, Support & Housing Administration.

Connelly, J. (2014). The role and meaning of interim housing in housing first programs for people experiencing homelessness and mental illness. *American Journal of Orthopsychiatry*, *84*(4), 431–437.

Culhane,D.P.,Metraux,S., & Hadley,T. (2012). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, *13*(1), 107–163.

Dear, M., & Wolch, J. (2010). *Landscape of despair: From deinstitutionalization to homelessness*. Princeton, NJ: Princeton University Press.

Dickson-Gomez, J., Convey, M., Hilario, H., Corbett A.M., & Week, M. (2009). Unofficial policy: Access to housing, housing information and social services among homeless drug users in Hartford, Connecticut. *Substance Abuse Treatment, Prevention, and Policy*. *2*,8-17.

Donley, A., & Wright, D. (2012). Safer outside: A qualitative exploration of homeless people's resistance to homeless shelters. *Journal of Forensic Psychology Practice*, *12*, 288-306.

Faherty, A. (2009). *Welfare reform.* Washington, D.C.: Chelsea House Productions.

The Fair Housing Council of Orange County (2010) Retrieved on August 25, 2014 from http://www.fairhousingoc.org

Gerdes, L.I. (2007). *The homeless: Opposing viewpoints.* Detroit, MI: Greenhaven Press.

Government Grants. (2014). Listing of government grants. Retrieved on July 17, 2014 from http://www.grants.gov/web/grants/applicants.html.

Gwadz, M.V, Nish, D., Leonard N.R, & Strauss S.M. (2007). Gender differences in traumatic events and rates of post-traumatic stress disorder among homeless youth. *Journal of Adolescence*, *30,* (1) 117-129.

Hamilton, A., Poza, I., Hines, V., & Washington, D. (2012). Barriers to psychological services among homeless women veterans. *Journal of Social Work Practice in the Addictions*, *12*,2–68.

Haugen, D.M., & Box, M.J. (2006). *Poverty.* Detroit, MI: Greenhaven Press.

Hoffman, L., & Coffey, B. (2008). Dignity and indignation: How people experiencing homelessness view services and providers. *The Social Science Journal*, *45*, 207–222.

Hombs, M. E. (2011). *Contemporary world issues: American homelessness*. Santa Barbara, CA: ABC-CLIO.

Homeless Intervention Shelter. (2013). Homeless intervention shelter. Retrieved on June 20, 2014 from http://www.hishouseplacentia.org/Main/Home.html.

Hurley, J.A. (2008). *The homeless: Opposing viewpoints.* San Diego, CA: Greenhaven Press.

Jaffee, T., Dwight M. & Quigley, J. (2010). What role for government sponsored enterprises. *Journal on Urban Affairs*, *30*, 103–130.

Jost, J. J., Levitt, A. J., & Porcu, L. (2011). Street to home: The experiences of long- term unsheltered homeless individuals in an outreach and housing placement program. *Qualitative Social Work, 10*, 244–263.

Killaspy, L., Ritchie, M., Greer R., & Robertson, K. (2010). Homelessness: A case study. *Political Science Quarterly*, *3,* 174-203.

Karger, P., & Stoesz, M. (2011). *Personal and situational perspectives on rejection of a homelessness and substance abuse program: An exploratory study*. Social Work Research, *24*, 16–2.

Kuhn, J. H., & Nakashima, J. (2011). *The seventeenth annual progress report: Community homelessness assessment local education and networking group for veterans.* Washington, DC: U.S. Department of Veterans Affairs.

Lincoln, A. K., Plachta-Elliott, S., & Espejo, D. (2009).Coming in: An examination of people with co-occurring substance use and serious mental illness exiting chronic homelessness. *American Journal of Orthopsychiatry, 79*, 236–24.

Lowe, J., & Gibson, S., (2011) Reflections of a homeless population's lived experience with substance abuse. *Journal of Community Health Nursing, 28*, 92–104.

Montgomery, A., Hill, L., Kane, V., & Culhane, D. (2013). *Housing chronically homeless veterans: Evaluating the efficacy of housing first approach to HUD-VASH*. Humbolt, CA: U.S. Department of Veterans Affairs, National Center on Homelessness Among Veterans.

Morrell-Bellai, T., Goering, P. N., & Boydell, K. M. (2012). Becoming and remaining homeless: A qualitative investigation. *Issues in Mental Health Nursing, 21*, 581–604.

Morse, M., Thompson, C., & Unell, I. (2013). Down but not out: A survey of homelessness. *Substance Use and Service Provision, 4*, 36–40.

Motley, C.,& Perry, V.G. (2013). Living on the other side of the tracks: An investigation of public housing stereotypes. *Journal of Public Policy & Marketing, 32*, 48–58.

National Alliance of Social Workers (NASW). (2014). *Code of ethics*. Retrieved on July 8, 2014 from http://www.socialworkers.org/

OC Partnership. (2013). *The 2013 homeless point-in-time count and survey*. Retrieved from http://www.ocpartnership.net

Orange County Ten Year Plan to End Homelessness (2012) Retrieved on July 23, 2015 from http://occommunityservices.org/hcd/homeless/commission

O'Hara, A. (2011). *In from the cold: A tool kit for creating safe havens for homeless people on the street.* Northvale, N.J.: Jason Aronson. pp. 7–13.

Page, J. (2010). Barriers to transferring care of homeless people with serious mental illnesses to community mental health organizations: Perspectives of street-based programs. *Best Practices in Mental Health: An International Journal, 3(*1), 26–40.

Page, D., Petrovich, T., & Kan, R. (2012). Mental disorders among homeless people admitted to a psychiatric emergency service. *Psychiatric Services, 61*, 264–271.

Pearson, C. L., Locke, G., Montgomery, A. E., & Buron, L. (2010). *The applicability of Housing First models to homeless persons with serious mental illness: Final report*. Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Petrakis, I. L., Rosenheck, R. A., & Desai, R. A. (2011). Substance use comorbidity among veterans with posttraumatic stress disorder and other psychiatric illness. *The American Journal on Addictions, 20*, 185–189.

Rog, D. (2013). The evidence on supported housing. *Psychiatric Rehabilitation Journal, 27*(4), 334–344.

Rowe, I., & Pelletier, M. (2012). Subtypes of nonmedical prescription drug misuse. *Drug Alcohol Depend,* 102 (1–3), 63–70.

Singer, P. (2009). *The life you can save: Acting now to end world poverty*. New York, NY: Random House.

Somers J.M., Rezansoff, S.N., Moniruzzaman, N., Palepu A. & Patterson M., (2013). *Housing first reduces re-offending among formerly homeless adults with mental disorders: Results of a randomized controlled trial.* Philadelphia, PA: Lippincott Williams & Wilkins.

Sosin, M., & Bruni, M. (2010). Personal and situational perspectives on rejection of a homelessness and substance abuse program: An exploratory study. *Social Work Research, 24*, 16–27.

Sullivan, G., Burnam, A., & Koegel, P. (2012). Pathways to homelessness among the mentally ill. *Social Psychiatry, 35*, 444–450.

Taylor-Seehafer, M., Jacobvitz, D., & Steiker, L. (2009). Patterns of attachment organization, social connectedness, and substance use in a sample of older homeless adolescents. *Journal of Family and Community Health, 31*, 581–588.

Tsai, J., Stroup, T. C., & Rosenheck, R. A. (2011). Housing arrangements among a national sample of adults with chronic schizophrenia living in the United States: A descriptive study. *Journal of Community Psychology, 39*, 76–88.

Tsemberis, S., & Eisenberg, R. F. (2010). Pathways to housing: Supported housing for street-dwelling homeless individuals. *Psychiatric Services, 51*(4), 487–193.

U.S. Census Bureau. (2013). State and county quickfacts. Retrieved on August 15, 2014 from http://www.census.gov

U.S. Department of Housing and Urban Development. (2011). *Veteran homelessness: A supplemental report to the 2009 annual homeless assessment report to congress.* Retrieved from http://www.hudhre.info/documents/2009AHARveterans Report.pdf

U.S. Department of Housing and Urban Development. (2013). *The 2013 point- in-time estimates of homelessness: Supplement to the annual homeless assessment report*. Retrieved from http://www.hudhre.info/documents/PITHIC_Supplemental AHARReport.pdf

Weingart Foundation (2014) *Weingart Digital Foundation Grant Guidelines*. Retrieved on August 10, 2014 from http://www.weingartfnd.org/grant-guidelines

Zlotnick C., Tam T., & Robertson M.J. (2011). Disaffiliation, substance use, and exiting homelessness. *Substance Use & Misuse, 38*,577-599.