

A WAY BACK HOME

***A Ten Year Plan to End Chronic
Homelessness***

in

Whatcom County

2003-2013

PREFACE

During the Winter months of 2002-03, a committee convened in a series of meetings to analyze the needs of what is one of the most difficult homeless populations to serve effectively: the chronic homeless. The committee was composed of several members of the City of Bellingham/Whatcom County Coalition for the Homeless—it included staff representatives of homeless service providers, the housing authority and local government. Together they surveyed providers to determine the extent of chronic homelessness in Whatcom County, and they inventoried the resources currently serving the needs of the population.

Representatives of the following organizations provided their time and valuable insights during the development of the Plan:

Bellingham/Whatcom County Housing Authorities
Bellingham School District
The City of Bellingham Office of Neighborhoods & Community Development
Lighthouse Mission
The Opportunity Council
Old Town Christian Ministries
Sea Mar Outreach
St. Joseph's Hospital
Sun Community Services
Whatcom County Health Department
Whatcom Counseling & Psychiatric Clinic

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TABLE OF CONTENTS

Preface.....	2
1. Who are the Chronic Homeless in Whatcom County?.....	4
2. The Face of Homelessness.....	6
3. Vision of the Future.....	7
4. What Resources are Currently Available to Serve the Chronic Homeless?.....	8
5. Current System Serving the Needs of the Chronic Homeless.....	10
6. Barriers to Recovery.....	12
7. What Needs to be in Place to End Homelessness for the Chronic Homeless (The Ideal Continuum)?.....	13
8. What are the Major Gaps in the Continuum of Care System?.....	14
9. Ten Year Strategies for Ending Chronic Homelessness (Housing/Services/Systems).....	15
10. Year 2003-04 Chronic Homeless Action Plan.....	23

Bellingham/Whatcom County Ten Year Plan to End Chronic Homelessness

"To be homeless literally means that you have no home to live in, that you are deprived of your sense of place and privacy, your sense of belonging—all essential elements of identity, of self-worth..."

--Padraig O'Malley, New England Journal of Public Policy

1. Who are the Chronic Homeless in Whatcom County?

"Chronic Homeless" persons are homeless individuals or families who have been on the streets or in and out of shelters for more than a year. "On the streets" means living on the streets, in cars, in tents, in abandoned buildings and other places not meant for human habitation. This group represents the "hard to serve," who either have great difficulty in accessing or remaining in programs of assistance, or who avoid assistance. The Chronic Homeless have major dysfunctions preventing them from leading "normal" lives. They are often disabled by severe mental illness and/or are chronic substance abuse. Few of the Chronic Homeless will ever generate significant income through employment. Therefore, while many will have some financial support through SSI and other public assistance, their lives will only become stabilized through long-term housing and services supports that respond to their unique disabilities.

In April 2003, the U. S. Department of Housing and Urban Development released a new definition of the chronic homeless: "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homeless in the past three years." The U. S. Department of Health and Human Services provides a somewhat different definition in their March 28, 2003 *Comprehensive Plan to End Chronic Homelessness* as follows: "Those (homeless persons) with protracted homeless experience, often a year or longer, or whose spells in the homeless assistance system are both frequent and long."

The Chronic Homeless represent a relatively small proportion of the total homeless population—perhaps 10-20 percent of the total number of homeless in the County. It is estimated that there are approximately 220 chronic homeless persons living in the streets or in temporary shelter in Whatcom County on a given night.*

(*Note: Service data and anecdotal information from service and housing providers serving this population confirm the estimate of 220 chronic homeless persons in Whatcom County. A NSRSN report estimates that on a given day, 560 mentally ill homeless in the five county RSN are on the streets, and 110 are located in Whatcom County. Intake records from key facilities serving the chronic homeless indicate that approximately 50 percent of those they serve are seriously mentally ill.)

Primary Characteristics

In general, this subpopulation of the homeless has a *disabling condition*—such as a serious health condition, substance abuse and/or psychiatric illness. The group is also a *heavy user of services* in the homeless assistance system and the health and social services system. The USHHS Plan indicates that although the chronic homeless make up 10 percent of the homeless shelter users, they consume 50 percent of the bednights provided by homeless shelters. As a group, the chronic

homeless have great *difficulty in engagement with treatment services*, and a long and poor experience with mainstream programs, which makes re-engagement with services even more difficult. The Chronic homeless have *multiple problems*, which present a challenge to existing service and housing providers when seeking to qualify them for their programs and to provide the level of assistance needed.

The Bellingham/Whatcom County Chronic Homeless Planning Committee identified the following common characteristics of the homeless they encountered:

- ◆ Persons with mental illness
- ◆ Substance abusers
- ◆ Persons with co-occurring disorders
- ◆ Other characteristics
 - ◆ Single men and women, primarily males but an increasing number of females, who are often very difficult to treat because of personality disorders and past abuses.
 - ◆ Persons with developmental disabilities.
 - ◆ Minorities - including Native Americans with high incidence of alcoholism; Hispanics needing help seasonally; and some of the County's Russian immigrant population may fall into chronic homelessness.
 - ◆ Persons returning to the community from penal institutions, including persons who are dangerous mentally ill offenders and level 3 sex offenders.
 - ◆ Others who are unable to access (or incapable of accessing) assistance, or who don't qualify for assistance.
 - ◆ Veterans with Post Traumatic Stress Syndrome.
 - ◆ Unaccompanied Youth.

Personal and Social Characteristics:

- ◆ Have a distrust/fear of the "system"
- ◆ Lack social/communication skills
- ◆ Lack conventional support groups
- ◆ Have significant medical and nutritional problems
- ◆ Often have criminal justice records

2. The Face of Homelessness- Even a Small Amount of Help Makes a Difference

"I was in desperate need of a shower and a bed after living in a van for a couple of weeks and you offered a hotel room for the night. You really make a difference in the lives of people."

- A homeless person served by a local shelter

3. Vision of the Future

We envision a broadened and coordinated system of stabilizing services and facilities for persons in Whatcom County who are chronically in a state of homelessness, so that they may live safely and return to meaningful lives.

The Committee utilized their responses to the following questions as a guide in establishing their vision for ending chronic homelessness:

Who do we want to help?

The chronic homeless, including:

- ◆ Mentally ill
- ◆ Chronic substance abusers
- ◆ Persons with co-occurring disorders
- ◆ Persons with severe behavioral problems

Why do we want to help this population?

- ◆ To return people to meaningful lives
- ◆ To facilitate secure living and reduce self-inflicted harm
- ◆ To reduce pain and suffering
- ◆ To reduce crime on the streets
- ◆ To improve community
- ◆ To reduce disruption of services

How can we best go about helping this population?

- ◆ Humane assistance to encourage a return to productive lives
- ◆ Broaden services to accommodate persons with severe disorders and those coming out of the criminal justice system without housing.
- ◆ Expand programs by building on to existing programs
- ◆ Expand outreach to bring more of the "difficult to serve" into a system of care
- ◆ Expand shelters to serve as a beginning to recovery
- ◆ Provide low performance shelter and housing programs

4. What Resources are Currently Available to Serve the Chronic Homeless?

Programs Serving the Chronic Homeless in Whatcom County

Organization	Services	Estimated Number of Chronic Homeless Serving at a given point in time (numbers below include duplication)		
		Male	Female	Total
SERVICES				
St. Joseph's Hospital Social Detox	Detox, chemical dependency recovery, case management	16	4	20
St. Joseph's Hospital, Recovery Center-County Jail	Alcohol Protective Custody stays for persons in crisis needing supervision	Unknown		
Whatcom County Health Department (subcontractors)	Outreach to chronic substance abusers			100
Whatcom County Health Department (subcontractors)	Outpatient Treatment			50-100
Whatcom County Health Department	Outreach to chronic substance abusers	unknown		
Salt on the Street	Weekly hot meals, hygiene kits distribution, blanket/coat/glove/clothing distribution	40	5	45
Sea-Mar Clinic	Medical and dental services, prescription drugs, shelter, outreach, advocacy, case management			30
Interfaith	Food for campers	unknown		
Bellingham Food Banks	Food			30
Ferndale Food Bank	Food distribution	3	0	3
Everson Food Bank	Food distribution	8	2	10
Hillcrest Chapel	Food distribution, walk-in mentoring	10	2	12
DSHS	Expedited food assistance, GAU	unknown		
Vietnam Veterans Relief and Benefits Service Office	Veterans Benefits and case management	101	1	102
Bellingham Veterans Center	Counseling, mental health therapy and benefits assistance	14	1	15
Whatcom Counseling and Psychiatric Clinic	Outpatient services Outreach to persons with co-occurring disorders in jails, on the streets			
Rainbow Center	Hot meals, laundry, shower & peer counselors	30	20	50
Northwest Youth Services	Street outreach services (Thursday night only), mediation services	unknown		
Old Town Christian Ministries	Outreach at food banks, bus vouchers, clothing vouchers, sleeping bags/blanket distribution and emergency food (served on Saturday nights only)	150	50	200
EMERGENCY AND TRANSITIONAL HOUSING				
Old Town Christian Ministries	<i>Emergency housing</i>	30	15	45
Lighthouse Mission	<i>Emergency shelter</i>	65	15	80
Project Hope	<i>Emergency shelter</i> * includes 5 families	0	5*	10
Project Hope	<i>Transitional housing</i> for single mothers * also serves 8 families	0	2 3*	5

Sun Community Service - Sun House	<i>Transitional Housing</i> for chronically mentally ill			6
Sun Community Service- Gladstone House	<i>Transitional Housing</i> for persons with co-occurring disorders			5
THE FOLLOWING PERMANENT HOUSING RESOURCES PROVIDE A PERMANENT HOUSING RESOURCE				
BWCHA- Shelter Plus Care	<i>Permanent supportive housing</i>	23	4	27
Lake Whatcom Residential and Treatment Center	<i>Permanent supportive housing</i> for men and women needing supervised care			68
WCPC	<i>I Street House – Homeless with co-occurring disorders</i>			9

5. Current System Serving the Needs of the Chronic Homeless

Outreach and engagement consists of assessment at the County Jail and at St Joseph's Hospital Recovery Center, and through peer support outreach workers on the streets. A full-time position at the County jail has been developed to assist persons with mental illness in jail, and to connect them to appropriate treatment prior to release. A Psychiatrist is also on call at the jail. Whatcom Counseling and Psychiatric Clinic provides a full-time outreach worker for outreach to persons exhibiting dual diagnoses who are on the streets, in the jails or in the Mission. Peer counselors at the Rainbow Center also conduct outreach on the streets and at the jail. Whatcom County Health Department also provides funding for outreach services, while Old Town Christian Ministries and Northwest Youth Services provide outreach services once a week.

Several organizations provide **survival services**, distributing items to protect a personal health and well-being. Several church programs and food banks distribute food. Salt on the Street distributes a variety of basic personal supports such as clothing and hygiene kits, and provides a hot meals program. Old Town Christian Ministries provides sleeping bags, blankets and clothing.

The Rainbow Center provides a **drop in center** with meals, food, showers, laundry, peer counseling and socialization opportunities.

Whatcom Counseling and Psychiatric Clinic provides **assessment**, crisis intervention and stabilization through an Integrated Crisis Response System.

Whatcom County provides five **crisis respite** beds.

There are a number of services available to assist in stabilizing persons with active **substance abuse** problems. St. Joseph's Hospital Recovery Center operates a seven-bed detox program with case management services, and also provides chemical dependency treatment. In-patient services are available for 7-21 days, and then the patient is transferred to the St. Joseph's Hospital Recovery House for up to 60 days. The mental health system coordinates counseling with persons in detox and recovery at St. Joseph's. St. Joseph's operates an Alcohol Protective Custody Program as a "non-booking" jail placement program to detox persons "out of control." This harm reduction effort places persons in the jail with one-on-one observation for the person's protection. There is no **"wet" facility** for persons who are abusing alcohol or drugs, nor is there a "harm reduction" facility.

To provide short-term **emergency shelter**, the Lighthouse Mission maintains up to 95 beds for adult singles that are available for the chronic homeless, of which 65-80 beds are typically occupied by chronic homeless persons. Old Town Christian Ministries (OTCM) provides shelter to adults, approximately 1/3 of whom are chronic homeless persons. Project Hope provides up to ten emergency shelter beds for single women and mothers with children.

Only sixteen units of **transitional housing** are available to the chronic homeless through Sun Community Services and Project Hope.

Shelter Plus Care operated by the Bellingham/Whatcom County Housing Authorities is a basic source for meeting the **permanent supportive housing** needs of the disabled chronic homeless. The Housing Authority operates the 109-unit Shelter Plus Care program, in which it is estimated twenty-seven chronic homeless persons are currently served. Some of these are among the fifteen Shelter Plus Care units operated under a subcontract to the Bellingham Veterans Center. Other linkages for placing persons in permanent supportive housing are Lake Whatcom Residential and Treatment Center and WCPC.

6. Barriers to Recovery

- ◆ Insufficient permanent supportive housing resources in the community.
- ◆ No shelter/beds to keep substance abusing people safe and detoxed while they wait for an inpatient bed.
- ◆ Lack of knowledge on how to access assistance.
- ◆ Fear of the system/reluctance to ask for real help.
- ◆ Criminal records.
- ◆ Poor physical health.
- ◆ Multiple drug use.
- ◆ Improper or inadequate use of prescribed medicine.
- ◆ Lack of mobility (lacking driver's licenses).
- ◆ Inability of the care system to respond to persons with major, but undiagnosed, health issues.

7. What Needs to be in Place to End Homelessness for the Chronic Homeless (The Ideal Continuum)?

Housing

- ◆ An Emergency Shelter providing the chronic homeless with secure, safe housing services aimed at engaging them and helping them access Case Management.
- ◆ Pre-treatment beds for people waiting for in-patient chemical dependency beds.
- ◆ A "Harm Reduction" Shelter.
- ◆ Transitional Housing with Intensive Supportive Services.
- ◆ Permanent Housing with Supportive Services.
 - ◆ Including Housing with Low Performance Standards for the "non-conforming."
- ◆ Permanent Affordable Housing with Case Management.

Services

- ◆ Outreach and Engagement Services (in the street, shelters, hospitals, jail and the woods), to build trust.
- ◆ A strong Information and Referral System.
- ◆ Intensive Case Management (long-term and throughout the system).
- ◆ Treatment Services for persons with substance abuse and mental illness.
- ◆ Centralized Crisis Triage Services (including crisis intervention, detox, and assessment and referral).
- ◆ Basic Life Supports for Persons who are Unwilling or Unable to Access Assistance (food, nutrition, clothing/blankets and medical assistance).
- ◆ Transportation.
- ◆ Medical and Dental Services and with Medication Management.
- ◆ Income Management and Support.
- ◆ Legal Services.

Continuum of Care Systems

- ◆ Strong Coordination and Interagency Linkages Modeled on the "A-Team" Concept.
- ◆ A Strong Financial Resources Plan.
- ◆ A Continuum of Beds and Services for Substance Abusers (Pre and Post-Treatment Beds and Treatment Facilities).
- ◆ Culturally Sensitive Services (including translation services and increased coordination with Tribal authorities).
- ◆ Adequate Discharge Planning (particularly from in-patient care).
- ◆ A Workable Solution for assisting in the successful transition of ex-felons from prison to the community, including assistance to Dangerous Mentally-Ill Offenders and Sex Offenders.

8. What are the Major Gaps in the Continuum of Care System?

Housing

- ◆ Pre-Treatment and Post-Treatment Substance Abuse Beds
- ◆ Harm Reduction Housing
- ◆ Emergency Shelter Beds
 - ◆ Beds for Single Men Without Religion-Based Requirements
 - ◆ Two-Parent Families
 - ◆ Families with Male Children over Nine Years Old
 - ◆ Youth
 - ◆ Beds For Single Women
- ◆ Transitional Housing (Including Youth Transitional Facilities)
- ◆ Permanent Supportive Housing
- ◆ Affordable Permanent Housing
- ◆ Substance Abuse Treatment

Services

- ◆ Mental Health Services for the Non-Medicaid Eligible Persons
- ◆ A Triage Center
- ◆ Intensive Case Management Services
- ◆ Youth Outreach And Street Services
- ◆ Case Management for Substance Abusers
- ◆ Life Skills Training (Especially Training for Tenant Roles and Responsibilities)

Continuum Of Care Systems

- ◆ Improved Coordination within the Continuum of Care System
- ◆ Community Education/Awareness of Available Services
- ◆ Move Toward a Seamless Housing and Services System and "No Wrong Door" Policies
- ◆ Systems Approach to Working with Persons with Criminal Records and/or Disruptive Behaviors

9. Ten Year Strategies for Ending Chronic Homelessness (Housing/Services/Systems)

STRATEGY 1: Improve outreach and engagement services to encourage the entry of the chronic homeless into the homeless care system and appropriate placement in emergency shelter or permanent supportive housing facilities using "Housing First" placement strategies.

Additional Description or Components

- Expand outreach and engagement services
- Implement "Housing First" strategies to place persons in permanent housing with supportive services when appropriate to their needs
- Provide secure, safe shelter for others not ready for permanent supportive housing
- Link homeless, mental health and Detox services
- Coordinate with institutions releasing persons, such as the County Jail
- Stabilize individuals and secure adequate resources
- Include services for substance abusers and the mentally ill
- Provide access to strong case management and advocacy services
- Develop a Recovery Center
- Develop a co-occurring disorder treatment center

Initial Action Steps

1. Establish a contract between Whatcom County and Whatcom Counseling and Psychiatric Clinic to establish an Outreach Case Manager position that focuses on the mentally ill and substance abusing homeless population.
2. Plan and design a concept for an in-patient co-occurring disorder treatment program that provides beds and services for the mentally ill and substance abusing homeless.
 - Identify potential sites
 - Develop financial resources
3. Develop and operate an in-patient, co-occurring disorder treatment program

Lead Organization

- Whatcom Counseling and Psychiatric Clinic

Other Supportive Partners that will be Involved

- Bellingham/Whatcom County Housing Authorities (housing development skills and potential need for project-based Section 8)
- City of Bellingham (Financial Resources)
- City/County Police
- Whatcom County Health Department
- Old Town Christian Ministries
- Other key non-profit providers

STRATEGY 2: Maximize the integration of services by creating coordinated, case-focused teams of service providers ("A-Teams"), directed at actively resolving the key issues facing the homeless as they move through the continuum. (Creation of linkages and coordination within the continuum of care system modeled after the a-team concept.)

Additional Description or Components

- ❑ A coordinated team-approach to provide resources for the multiple needs of clients
- ❑ "No Wrong Door" so that persons coming into the system are appropriately referred to housing and services regardless of their entry point
- ❑ The A-Teams should be coordinated and facilitated to assure there is follow-through
- ❑ A comprehensive menu of services are accessed to move clients toward maximum self-sufficiency as quickly as possible

Initial Action Steps

1. Convene a meeting of key agencies to explore means of establishing the teams
2. Identify a facilitator for the teams

Lead Organization

- ❑ County Coalition for the Homeless

Other Supportive Partners that will be Involved

- ❑ State Department of Social and Health Services
- ❑ Bellingham/Whatcom County Housing Authorities
- ❑ Sea Mar
- ❑ County Health Department
- ❑ Vocational Rehabilitation
- ❑ City of Bellingham
- ❑ The Opportunity Council
- ❑ The Rainbow Center

STRATEGY 3: Move the chronic homeless as quickly as feasible into an increasing supply of permanent supportive housing.

Additional Description or Components

- ❑ Create housing resources for persons who are seriously mentally ill and/or are chronic substance abusers
- ❑ Implement a "Housing First" model moving the homeless from the streets into permanent supportive housing—which will reduce the drain on other public services
- ❑ Include use of project-based Section 8 rental assistance where appropriate
- ❑ Permanent housing for persons being released from jail and prisons

Initial Action Steps

1. Assess the Shelter Plus Care Program to determine if it could be modified to better serve the chronic homeless
2. Determine if there are needs for respite housing for persons relapsing or with temporary behavioral problems
3. Support the development of the Recovery Center to provide Permanent Supportive Housing
4. Establish a housing program under the Partnership for Community Safety, for homeless persons with felony convictions who have co-occurring disorders
5. Establish post-chemical dependency half-way and transitional housing

Lead Organization

- ❑ Whatcom Counseling and Psychiatric Clinic

Other Supportive Partners to be Involved

- ❑ Bellingham/Whatcom County Housing Authorities
- ❑ City of Bellingham
- ❑ Whatcom County Mental Health
- ❑ Evergreen AIDS
- ❑ The Opportunity Council
- ❑ Bellingham Police Department, Whatcom County Sheriff and the Whatcom County Jail
- ❑ United Way
- ❑ Other key non-profit providers

STRATEGY 4: Expand transitional housing resources for the disabled homeless.

Additional Description or Components

- ❑ Intensive substance abuse and mental health services with housing
- ❑ Coordinated links with pre-treatment and post-treatment housing
- ❑ Consider Oxford House models independent living for recovering abusers

Initial Action Steps

1. Convene providers to assess the specific needs, best practices and options for the creation of transitional housing and post-treatment housing
2. Consider the linkages with existing housing and services resources in the community to fill specific gaps
3. Develop specific proposals and seek funding for transitional housing

Lead Organization

- ❑ Whatcom Counseling and Psychiatric Clinic

Other Supportive Partners to be Involved

- ❑ City of Bellingham
- ❑ Whatcom County Mental Health
- ❑ Evergreen AIDS
- ❑ Other chemical dependency service providers

STRATEGY 5: Develop the "community will" and commitment to create a healthy community; Involve the government and the businesses community in expanding political and financial resources.

Additional Description or Components

- ❑ Planning should focus on involving government, business, foundations and educational institutions such as the University as "partners" in the solutions to end homelessness
- ❑ Enlist the involvement of those affected by the chronic homeless, such as downtown businesses
- ❑ Tie in with economic development planning and downtown planning
- ❑ Use the "Partnership for Community Health" approach as a model

Initial Action Steps

1. Carefully plan and orchestrate a long-term plan to involve the community in solutions
2. Convene a small group of dedicated persons to develop initial strategies, including community education/community involvement approaches
3. Study best practices of other communities nationally
4. Develop a theme to stimulate involvement and commitment
5. Convene a larger group of major segments of the community to develop the final, long-term plan, including a financing plan and coordination

Lead Organization

- ❑ Initial Conveners: The Homeless Coalition/City of Bellingham

Other Supportive Partners to be Involved

- ❑ United Way
- ❑ The Opportunity Council
- ❑ Western Washington University
- ❑ Downtown Renaissance Network
- ❑ The Bellingham/Whatcom County Housing Authorities
- ❑ Foundations
- ❑ County Government
- ❑ All non-profit providers

STRATEGY 6: Include an intensive case management/medical/dental component in all new beds developed in the continuum.

Additional Description or Components

- ❑ Establish project planning standards to assure coordination with existing providers and conformance with the Continuum of Care and Chronic Homeless Plans
- ❑ Coordinate with medical/dental service providers, developers and project funders
- ❑ Tie in with the development of community-wide standards for case management

Initial Action Steps

- ❑ Plan for key services in the first project (the Recovery Center) to establish a model

Lead Organization

- ❑ Whatcom Counseling and Psychiatric Clinic

Other Supportive Partners to be Involved

- ❑ The Homeless Coalition (provider of education)
- ❑ City of Bellingham (include standards in projects developed with City-controlled funding)
- ❑ The Opportunity Council
- ❑ All non-profit providers
- ❑ Housing developers

STRATEGY 7: Develop a continuum of beds and services for persons suffering from substance abuse (including a "damp" facility, pre-treatment beds, post-treatment beds, along with critical substance abuse treatment services).

Additional Description or Components

- ❑ Develop a "seamless" system of to serve the entire set of needs for recovery
- ❑ Consider the potential for "harm reduction" models for chronic substance abusers, including "Damp" facilities for long-term abusers who may relapse
- ❑ Build in a means of persons preventing persons relapsing or acting out from losing their housing and recycling out of the system

Initial Action Steps

1. Convene a meeting of substance abuse program providers and developers to develop a plan of action to fill gaps in the system serving substance abusers' needs
2. Inventory available services and beds
3. Visit other model facilities and programs in the state
4. Develop specific proposals and seek funding for transitional housing

Lead Organization

- ❑ Whatcom County Health Department

Other Supportive Partners to be Involved

- ❑ St. Joseph's Hospital
- ❑ Whatcom County Health Department subcontractors
- ❑ Whatcom Counseling and Psychiatric Clinic
- ❑ Lake Whatcom Center

STRATEGY 8: Establish a Crisis Triage Center for emergency intervention and stabilization of persons in crisis through client-based outreach, engagement, assessment, referral and program enrollment.

Additional Description or Components

- ❑ Provide stabilization services including residential care
- ❑ Goal of retaining current housing
- ❑ Enhance Integrated Crisis Response Programs and "no wrong door" approach

Initial Action Steps

1. Enter into agreements to develop a Triage Center
2. Design and finance the Center, integrating social detox and mental health crisis respite
3. Open the Triage Center and seek financing for a nursing component

Lead Organization

- ❑ Whatcom County Health Department

Other Supportive Partners to be Involved

- ❑ St. Joseph's Hospital
- ❑ Whatcom County Health Department
- ❑ Whatcom Counseling and Psychiatric Clinic
- ❑ Bellingham Police Department, Whatcom County Sheriff and the Whatcom County Jail

10. Year 2003-04 Chronic Homeless Action Plan

Goals : What are we trying to accomplish?	Action Steps: How are we going to accomplish the goal?	Responsible Person/Organization: Who is taking the lead?	Target Dates: (mo/yr of accomplished)
1. Maximize the integration of services by creating coordinated, case-focused teams of service providers ("A-Teams") Initial Goal: Expand outreach and case management services for homeless persons with co-occurring disorders	1. Create an Outreach Case Manager position	Jane Relin (of Whatcom Counseling and Psychiatric Clinic (WCPC)) and Whatcom County	7/03
	2. Outreach Case Manager identifies specific cases in the targeted population	Outreach Case Manager (of WCPC) & the Rainbow Center	8/03
	3. Begin engaging the targeted population and refer to appropriate agencies	Outreach Case Manager (of WCPC) & the Rainbow Center	8/03
2. Establish a Triage Center for emergency intervention and stabilization of persons in crisis	1. Develop written agreements (between key providers) for a coordinated system of care for substance abuse and mental disorders	Gary Williams (Whatcom County Human Services Div), St Joseph's Hospital & WCPC	7/03
	2. Design Triage Center and develop financing plan	" "	7/03
	3. Plan the co-location of social detox, mental health crisis respite and integrated crisis response programs	" "	9/03
	4. Identify a revenue source for adding a nursing component to the Triage Center	" "	12/03
3. Expand emergency shelter and permanent supportive housing beds for the chronic homeless	1. Assemble a development team to plan the a new multi-use building to house the Rainbow Center, shelter and permanent supportive housing	Jane Relin (of WCPC), Michelle Morlan (of Common Ground)	7/03
	2. Identify site, develop design and budget.	Michelle Morlan (of Common Ground)	7/03
	3. Prepare funding proposals	Michelle Morlan (of Common Ground)	12/03
	4. Construct and open facility	Jane Relin (of WCPC)	10/04
4. Increase the availability of housing for persons with mental health and substance abuse who are being released from penal institutions	1. Enter into an agreement to transfer building to WCPC for conversion to permanent supportive housing for homeless, including ex-felons	Marty Snyder (The Opportunity Council) & WCPC	7/03
	2. Enter into a MOU with Housing Authority, State of Washington, WCPC, the Opportunity Council and the City of Bellingham to provide support to housing	Jane Relin (of WCPC)	8/03
	3. Work with the neighborhood association in which the project is to be located to develop acceptance and a participation program	Jane Relin (of WCPC) & the Partnership for Community Safety	8/03