



ERAF II Funding Recommendations  
Smart Bridging for Our City Our Home Prop C Funding  
*Our City Our Home Coalition, April 2019*

**Summary**

The Our City Our Home Coalition is recommending homeless solution uses for ERAF II funding. There are several critical homeless housing projects that need funding immediately and we cannot afford to wait for the lawsuit while there is a humanitarian and public health crisis on our streets. The Mayor and the Board of Supervisors have done excellent work allocating life-changing funding in the first round, but there are still critical funding needs in this second round, in particular for housing homeless children and youth and community behavioral health services.

**Introduction**

Proposition C: Our City Our Home was passed by voters in November 2018 with over 60 percent of the voters' approval. The proposal itself is very simple – a small increase in gross receipts tax on business incomes over \$50 million. The revenue Proposition C is expected to generate will effectively double the current budget for homelessness relief in San Francisco, bringing in between \$250 and \$300 million annually. The revenue is being held in a fund, awaiting the result of a legal challenge.

Recently, the Controller announced a second windfall of \$140 million in discretionary funding from the state via ERAF. The timing of the two sets of funding could not have been more critical: We have many projects in the pipeline that would alleviate the homeless crisis if only there was funding. Meanwhile, a new ordinance has been introduced at the Board of Supervisors calling for half of the funding to go to affordable housing.

**Background of the ERAF Funding**

Excess ERAF funding has come in due to increased property taxes, and earlier funding represents funds from FY 17-18 and FY 18-19, a little over \$200 million in each year with a sum

total of \$414.7 million. Of these funds, \$88.5 million was allocated for homelessness housing and services. The money will be spent on 300 shelter beds, 550 housing units and 86 beds for those with acute behavioral health needs. The current discretionary funding of \$140 million represents funds from FY 19-20 which is expected to total \$180 million, and the Mayor is set to make recommendations as part of the FY 19-20 budget on how to allocate those funds, to be announced by June 1st, with the Board weighing in during the month of June in it's own budget negotiations.

## Recommendations

These proposals represent the recommendations of people with lived experience with homelessness and frontline service providers working daily to address a crisis that is overwhelming them. Excellent investments were made in the first set of ERAF allocations, as they were focused on single adults experiencing chronic homelessness; however, key populations were left out, such as families and children. What we know is that half of our homeless population became homeless before the age of 25<sup>1</sup>, and our current system leans heavily towards waiting until that homeless person has been homeless for decade and has had their health and daily living experiences destroyed before they receive any assistance.

Homeless housing for families with children make up only 7 percent of the units in San Francisco, while the homeless family population, often hidden and ceaselessly undercounted, is 33 percent of the homeless population. <sup>2</sup> For homeless children, without intervention, the likelihood of experiencing chronic homelessness as an adult is very high, with dramatic high school dropout rates, high rates of trauma, and negative impact on educational outcomes. <sup>3</sup> Homeless youth face the same issue – proportionally fewer resources and constantly undercounted and hidden. In addition, the behavioral health investment in ERAF I focused on locked sub acute psychiatric beds, instead of less expensive and for most more effective community based strategies. Our behavioral health system is far too dependent on high-end care, where too many individuals' first experience with the system is when they are in the worst possible shape and entering a locked facility or emergency department. Again, we must get homeless people the help they need *before* they are in crisis, as early investments pay off and will prevent severe human suffering, future high costs and the continuous perpetuation of

---

<sup>1</sup> San Francisco 2017 Point in Time Count

<sup>2</sup> National Alliance to End Homelessness

<https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/children-and-families/> In addition, SFUSD homeless count extrapolated for children aged 0-5, is equivalent to over 3,000 children, plus their parents equates to over 4,500 humans residing in intact families with no safe and decent housing of their own.

<sup>3</sup> Cutuli, J.J., Desjardins, C.D., Herbers, J.E., Long, J.D., Hesistaad, D., Chan, C.K., Hinz, E., and Masten, A. "Academic Achievement Trajectories of Homelessness and Highly Mobile Students; Resilience in the context of Chronic and Acute Risk," *Child Development*, 2012:1-17.

chronic homelessness. Here are some investments that could be ramped up quickly and would address some of those key deficits.

## **I. HOUSING**

### **A. Housing for Transitional Aged Youth**

Parcel U has been sitting vacant for years, as it is a small site, and does not fit into many of the funding streams. ERAF funding would be the perfect fix to fill the monetary gap. The size however, makes it perfect for Transitional Aged Youth, as the population is served well with more intimate settings.

- SITE: Parcel U
- NUMBER SERVED: 30 units
- COST: \$11,000,000
- DESCRIPTION: 100% homeless TAY building in D5 that has a funding gap and if filled could begin construction. The site has been sitting vacant for years due to lack of funding because of unique size and characteristics don't fit into many funding streams.

### **B. Section 8 for Families**

There are no 100% homeless family buildings on the horizon, or even in the MOHCD pipeline at this point. Homeless families are circulating from the street, to shelter, to sofa beds and back to the streets and shelters again, with very little way out. There are no public housing exits, which in years past served as the primary exit from shelter, as vacant units are held for public housing rebuilds. There are rapid re-housing subsidies, but they are operating at capacity and are short term subsidies that work for some who can take over rent on their own, but for many more families a long term subsidy is needed. For the hundreds of families living in residential hotels, there is absolutely no way out for them, they are quietly suffering while their children's development is negatively impacted by inhumane and inadequate shelter. At the same time, there are families in Supportive Housing who could move out, making room for more families coming out of shelters and off the streets for whom rapid re-housing does not serve and who are stuck in homelessness. This effort was started under Mayor Ed Lee, and then fell apart with financial problems with the SFHA. This key intervention can be replaced with ERAF funds.

- SITE: Private Housing through Housing Choice Vouchers for Homeless Families
- NUMBER SERVED: 75 families over 4 years
- COST: Total \$5,500,000 for 4 years
- DESCRIPTION: Fund 75 Section 8 Vouchers, 50 for families in SRO's and 25 for Moving On families. These are permanent rental assistance usually funded by federal government, and were awarded but never utilized due to cash flow problems with SFHA.
- With the city taking over the SFHA, SF could fund this for four years and have the SFHA take over.

### **C. Treasure Island Supportive Housing for Veterans**

This is a site that was in our original request. It is an excellent opportunity that can begin construction quickly once the funding gap is completed. The development is called the "Maceo May" named after Swords to Plowshares long time program director and advocate for homeless veterans. Veterans have been disproportionately hit by homelessness, as an estimated 15% of our homeless population are veterans. Former President Obama made this population a priority, and invested in housing subsidies that will be used for the operating costs of this project. However, the project still has a capital funding shortfall of almost \$11 million.

- SITE: Treasure Island Vet Housing
- UNITS/NUMBER SERVED: 200
- COST: \$10,900,000 one time (could change depending on state grant in May which could cover costs in full or in part)
- DESCRIPTION: Permanent Supportive Housing for Vets on Treasure Island

## II. COMMUNITY BEHAVIORAL HEALTH

### **A. Supervised Injection Site**

We are proposing a model in which SFDPH would authorize a program through an annual or multi-year contract with a community-based organization (CBO) that would operate the OPS in a city-owned facility. The program would operate 24 hours a day, 7 days a week.

- SITE: TBD, run by new non profit
- NUMBER SERVED: 50,000 visits by over 500 clients
- COST: \$2 million annually, \$2.5 million start up costs
- DESCRIPTION: Improve health outcomes, reduce Overdoses and HIV transmissions through safe injection facility
- Creation of 24 hour safe injection or overdose prevention site. Overdose Prevention Sites (OPS) are controlled health care settings where people can more safely inject drugs under clinical supervision and receive health care, counseling, and referrals to health and social services, including drug treatment.

### **B. Residential treatment for high-need substance users, including methamphetamine users**

There is a compelling need for specialized residential treatment for those who have severe addiction needs, especially for methamphetamine users. We currently only have one small outpatient treatment facility focused on this gay male housed meth users. The proposal here is to add two small intensive facilities (15 beds each) for people with substance use disorder + co-occurring mental health needs whose symptoms cannot safely be managed in larger facilities.

- SITE: TBD
- UNITS/NUMBER SERVED: 120 annually
- COST: One-time start-up: \$400,000 + the cost of site acquisition (est \$3MM/site)
- Annually: \$1.3MM local + \$2.1MM federal match
- DESCRIPTION: Two small residential treatment programs for meth/other hard drug users who have co-occurring mental health challenges

### **C. Transitions Navigators**

Currently our system lends itself to something many of us refer to as the “trauma of churning” whereby homeless people cycle in and out of programs and back to the streets due to lack of system capacity at alarming rates. This not only causes further decompensation but erodes valuable trust and hope that anything can change for them. This proposal is for 10 Case managers/system navigators to help people transition between services such as step-down from psychiatric emergency services, emergency department, jails, and so forth to ensure people are able to come back into treatment or are connected to needed services.

- SITE: TBD
- UNITS/NUMBER SERVED: 1500 annually
- COST: Cost for five master’s level staff + five peer staff = \$900,000/annually
- DESCRIPTION: 10 Case managers/system navigators to help people transition between services

### **D. Replacement Post-treatment beds for substance use disorder treatment and residential step-down**

Post-treatment and step down beds are critical to ensure successful recovery after leaving treatment. There are currently not enough of these, and to make it worse, we are about to lose existing capacity that is set for demolition on Treasure Island. When homeless people go through treatment, and then return to streets, it is exceptionally difficult to continue in a positive direction with recovery.

- SITE: TBD
- UNITS/NUMBER SERVED: 400 people annually
- COST: One time cost: \$22.8M
- DESCRIPTION: Replace existing capacity set for demolition on Treasure Island. No on-going costs as services paid for through existing mechanisms using federal, state, and local resources.

### **E. Double Shot: TAY Residential Treatment with step down to Co-Op housing**

Currently there are no residential treatment programs specifically for to serve the unique needs of transitional aged youth. There is tremendous need for both residential treatment and co-op housing for transitional aged homeless individuals suffering from severe behavioral health needs. The two are linked, as one is not successful without the other. Again, as individuals churn through the system, to the hospital and back to the streets, because there are no beds available, and this is a key intervention to halt that cycle. These would provide Community Mental Health Services that lead to long term stability and wellness.

- SITE: TBD
- NUMBER SERVED: 85 annually
- COST: Total \$9 million one time and \$600K annually
- DESCRIPTION: This would add both a 90 day licensed residential treatment facility that would serve individuals coming out of the hospital, and an additional two co-ops for the individuals to move into once stabilized in residential treatment.
  - FUND 1: New 90 day Transitional Licensed Residential Treatment Facility for 12 beds serving 75 unique individuals per year. \$5 million start up to purchase property and license, and \$600K per year operating with 40% additional need covered through MediCal
  - FUND 2: New Coop housing approximately 10 people. \$4 million start up 1 time costs, no on-going costs because current Co-Op staffing can cover.

Item	List of Homeless Interventions	One Time Cost	Annual Cost	Total Cost: 4 years operating + one time costs	Number of people served annually
1A	Supportive Housing for Youth	\$11,000,000	0	\$11,000,000	30
1B	Section 8 for Families	0	\$1,375,000	\$5,500,000	75
1C	Treasure Island Supportive Housing for Vets	\$10,900,000	0	\$10,900,000	200
2A	Supervised Injection Site	\$2,500,000	\$2,000,000	\$10,500,000	500/50,000 visits
2B	Residential Treatment for Methamphetamine Users	\$3,400,000	\$1,300,000	\$8,600,000	120
2C	Transitions Navigators	0	\$900,000	\$3,600,000	1500
2D	Replacement Post-treatment beds for substance use disorder treatment and residential step-down	\$22,800,000	0	\$22,800,000	400
2E	Double Shot; Transitional Licensed Residential Treatment Facility	\$5,000,000	\$600,000	\$7,400,000	75
2E	Double Shot: Step Down Co-Op Housing	\$4,000,000	0	\$4,000,000	10
	Total	\$59,600,000	\$4,876,300	\$84,300,000	2410



## Attachment 1

### Narrative safe injection

#### Overview

According to the City Department of Public Health, there are an estimated 22,500 people who inject drugs (PWID) in San Francisco. Many PWID, especially individuals experiencing homelessness do not have access to safe/private environments in which to inject. This leads many to use in public spaces. Individuals injecting in public spaces are more likely to use rushed injection practices, thereby making them more vulnerable to overdose and other injection-related complications – and in San Francisco there are approximately 100 deaths each year from opioid overdose. Additionally, injecting in public location increases the presence of needle detritus in those locales, which is considered a public nuisance and creates the potential for needle stick injuries in the general public. Overdose Prevention Sites (OPS) are controlled health care settings where people can more safely inject drugs under clinical supervision and receive health care, counseling, and referrals to health and social services, including drug treatment.

#### Overdose Prevention

Data consistently demonstrate that OPS are effective at preventing overdose-related deaths. In a large multi-site assessment of all OPS in existence published in 2004, and among the estimated millions of injections performed at OPS up to that time, no overdose deaths had occurred. In Vancouver, in 2017, the OPS conducted 2,151 overdose interventions and had no deaths. Since the the opening of the site in 2003, there have been 6,440 overdose interventions and no deaths. In Sydney, there were 329 overdoses at the OPS over the eighteen-month trial period with naloxone administration in 81 cases and no fatalities. At German OPS sites during 2000-2013, staff assisted in the reversal of 3,180 overdoses with no deaths.

#### Cost Effectiveness

According to an analysis released by Altarum, a nonprofit health research institute, the annual cost of the country's opioid crisis has increased from \$29.1 billion in 2001 to an estimated \$115 billion in 2017. Given this, an analysis of 2008 data at the site estimated the number of HIV infections and deaths averted by the program and determined that the OPS created \$6 million/year in savings after taking into account program costs. Multiple statistical models have used existing data to examine the potential impact of OPS in other cities. An analysis for San Francisco indicated that a single OPS would generate \$3.5 million in savings annually, prevent 3.3 HIV and 19 HCV infections, and help 110 PWID enter drug treatment. In Baltimore, researches estimated that a single OPS would lead to \$7.8 million in savings with an annual cost of \$1.8 million; it would prevent approximately four HIV infections, 21 HCV infections, and 6 overdose deaths.

#### Program

We are proposing a model in which SFDPH would authorize a program through an annual or multi-year contract with a community-based organization (CBO) that would operate the OPS in a city-owned facility. The program would operate 24 hours a day, 7 days a week.

#### Staffing

This model will necessitate the creation of a new 501(c)(3) organization to operate the OPS. This model includes a range of staffing roles: directors and shift managers, health educators, linkage to care workers, medical providers, substance use counselors, and overdose prevention educators.

#### Location

With this model, we envision a physical brick-and-mortar site in an existing city-owned facility. The City and County of San Francisco might also purchase a modular space in a fixed location, or a series of mobile sites. Potential options for this would be the proposed Tom Waddell Urban Health Clinic modular space in Stevenson Alley, or any other health clinics, housing sites, or homeless service locations the city currently operates; these options would allow for natural integration of services, a strength of this model.