Appendix B: Detailed Results

Understanding the Landscape of Daytime Services for People Experiencing Homelessness in Los Angeles County

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Table of Contents

Figures

Tables

PART I. Introduction and Overview

1.1. Introduction

In this Appendix we summarize findings according to the five main research questions and the numerous sub-questions that guided the study. Table A.1. in Appendix A lists all the research questions and sub-questions with the respective sections where they are discussed. The methodology employed on this study and limitations are also discussed at length in Appendix A.

As applicable, for each question we identify findings from survey ratings, survey-elicited written narratives, and in-depth interview data. For each survey-related finding we present the sample of respondents, which varies across survey questions due to the branching logic, some missing data, and the fact that not every respondent provided open-ended narratives. In total, we received 320 survey responses from 296 discrete organizations. Among respondents, 72 (23%) came from 24 organizations (12 nonprofits, 8 faith-based organizations, and 4 public agencies), because we allowed multiple responses per organization. In this Appendix, we report counts and percentages based on the number of survey responses rather than unique organizations. That is because more than half of the organizations with multiple responses came from different sites in different parts of the County, sometimes offering very different services (for example, one site may offer domestic violence services only, whereas another in a different part of the County may be a youth drop-in center). We also know from interviews that many local sites have a high degree of autonomy in terms of collaborations in the local community, fundraising, and jurisdiction-specific contracts. Regarding the qualitative data, we report all thematic findings (themes and sub-themes), even those elicited from one respondent, so as to be comprehensive.

The presentation of findings is also responsive to one of UWGLA's key considerations for the investment strategy, i.e., the increase of meaningful collaborations between nonprofits, faith-based organizations (FBOs), community-based organizations (CBOs), and public agencies. Where helpful and where significant organizational differences emerged, findings are delineated by organization type, and statements also indicate where findings apply to all stakeholders. We also include a few overall statistics from the Database compiled with publicly available data.

1.2. Overview

Overall, there is a lot to be positive about. There are hundreds of providing organizations, staffed by highly skilled and motivated individuals, and supported by dedicated volunteers who play an important role. All organizations want to offer high quality services to their clients, and most of them value evidence-based approaches to the services for which such evidence exists. Organizations are proving to be resourceful and creative when it comes to juggling multiple sources of funding and maximizing the strengths of each type of funding. There is considerable inter-organizational collaboration, even if decentralized and often informal.

However, much of this hard work may not always be evident due to the complexity and fragmentation of this service landscape. Los Angeles County is 4,083 square miles.[1] Daytime service provision spans numerous administrative and political jurisdictions at local, county, and state level, which often leads to an inefficient duplicative approach in service delivery. Important

differences in organizational resources and motivations may affect the extent to which organizations can or want to collaborate with each other. Many of these organizational and systemic issues are intractable and difficult to manage in the short term.

In Los Angeles County, organizations that work to provide daytime services to people experiencing homelessness work within a complicated governance structure[2,3] that includes:

- Los Angeles Homeless Services Authority (a joint powers authority of the City and County of Los Angeles);
- Los Angeles Continuum of Care (a service delivery system and jurisdictional planning body that covers the County, but not the Cities of Glendale, Pasadena, and Long Beach, which have their own Continuums of Care);
- City or County Departments of Public Health, Health Services, Public Social Services, Child and Family Services, Sanitation, Public Works, Law Enforcement;
- 88 city governments;
- Hundreds of county and city public libraries;
- Los Angeles County Metropolitan Transportation Authority (a special transportation district established in state law, governed by a local board of directors who represent the county and the cities within the county);
- California Interagency Council on Homelessness (a state agency);
- Veterans' Administration (a federal agency).

Furthermore, cities and unincorporated areas within the County are overlaid by multiple political and administrative boundaries that are consequential for funding and service planning:

- 8 County Public Health Service Planning Areas;
- 5 Los Angeles County Supervisorial Districts;
- 15 Los Angeles City Council Districts;
- City council representation in the other 87 cities.

However, homelessness is a fluid experience, with many individuals traveling – sometimes daily – across cities, SPAs, city council districts and county supervisorial boundaries - in search of services. Encampments may also shift following street sweeps. In this context, this governance structure introduces significant funding, operational, and decisionmaking complexity. As one agency explained, *"[just] within the City of Los Angeles, you're going to find 15 different strategies based on which council district you're in and then you extrapolate that out to the county where you've got 88 different cities." (Gov 3)* This fragmentation also leads to inefficient duplication of efforts among daytime service providers. Our interview findings suggest that these inefficiencies extend to nearly all types of daytime services. For instance, one non-profit provider offered a helpful overview of how fragmentation and misalignment of public agency missions can affect provision of mental health services:

> *"When it comes to mental health issues, the County is responsible for the Department of Mental Health. But the City is responsible for the police and the Homeless Services Authority is responsible for the outreach teams. The city trying to fill the gap by asking the police to become trained mental health responders is not going to be a substitute for sending actual trained mental health responders. But sending in emergency, trained mental health*

responders is not an adequate response to building long-term crisis of mental health which can only be addressed by regular day-to-day, honest visits. And so those three different perspectives on addressing folks who are living on the street with mental health issues mean that simply by the structure of the situation, folks are not pulling in the same direction and frankly it's not even anyone's fault that this isn't happening. It's just not happening" (Non-profit 4, SPA 5)

In the following sections we discuss these findings in greater detail, starting with service capacity, continuing with service documentation, organizational collaborations, client experience with services, and concluding with expansion and investment.

PART II. Daytime Service Provision Capacity

In this section, we summarize findings under the first research question: *What is the capacity for daytime service provision for people experiencing homelessness in Los Angeles County (e.g., location, scale, type, and service access)?* We describe aspects of capacity in daytime services provided to people experiencing homelessness, using an established framework of constructs for understanding organizational capacity for public health services and systems research.[4] Thus, this section summarizes findings about organization types and culture, service system characteristics, fiscal resources, workforce, and physical infrastructure.

2.1. Significant Diversity Across and Within Organization Types and Culture

Research Sub-questions

- What organizations are providing daytime services to people experiencing homelessness in LA County, including faith-based, community-based, non-profits, and public agencies?
- What cultural or trauma-informed practices are utilized at the sites?
- Are there models of successful daytime service provision, system integration, community support, co-location that can be lifted up as case studies?
- If faith-based, what level of faith-based activities occur during service provision? Is any active or passive participation in faith-based activities required to access services?

Key Points

- Within each organizational category (non-profit, FBO, CBO, public agency), there are variations in size, resources, and longevity.
- There is a considerable difference in organizational missions, motivations, values, and service models, which may impact on what and how daytime services are provided throughout LA County, as well as on the extent to which organizations can or want to collaborate.
- Most organizations report valuing and using evidence-based approaches for services where such evidence exists.
- Nearly 40% of FBO providers said their services required no religious component. Of the rest, 88% said the religious component was optional.

By organizational culture we mean organizational mission, preferences, values and service principles.[4] Table 1 summarizes organizational profiles by resources and mission, based on combined survey and interview data.

Table 1. Profiles of Organizational Resources and Motivation Based on Combined Survey and Interview Data.

	Faith-Based Organizations (FBOs)	**Non-profits**	**Community-Based Organizations (CBOs)**	**Public Agencies**
Definitions	Religiously-affiliated charitable, public or private nonprofits or congregations.	Secular public or private registered non-profits.	Informal volunteer organizations at neighborhood level, engaging in political advocacy and providing immediate aid.	City, County or State agencies
Example	House of worship that hosts showers or food programs.	Drop-in centers; mobile clinics; food pantries; soup kitchens; navigation center.	Grassroots organizations crowd funding and supplying tents and other goods at encampment sites.	Departments of Public Health, Mental Health, Health Services, Public Social Services, Child and Family Services Public libraries LA Metro
Mission	Serve parishioners and anybody in need of help, but faith considerations matter in type of service offered.	Serve eligible residents, sometimes defined by age, gender, or other attributes.	Serve anyone experiencing homelessness or poverty within their areas of operation.	Serve all eligible residents.
Funding	**General public donations (62%)** **Other philanthropy (61%)** **Private foundation (51%)** Government funding (39%) Subcontracts with nonprofits (26%) Mutual aid (7%)	**Government funding (85%)** **Private foundation (63%)** **General public donations (63%)** Subcontract with other nonprofits (36%) Other philanthropy (21%) Mutual aid (8%)	**General public donations (67%)** **Government funding (50%)** **Mutual aid (50%)** Private foundation (33%) Other philanthropy (33%) Subcontract with nonprofits (17%)	**Government funding at local, state, and/or federal levels (100%)**
Staffing	Paid staff and volunteers, or volunteers only	Paid staff and volunteers	Mostly volunteers only	Paid civil servants
Geographic Coverage	Varying geographic range	Varying geographic range: some local, some operate at SPA-level, and some across SPAs	Locally oriented, neighborhood-level	City, County, and other boundaries

Table 2 breaks down percentages for each organization type based on two sources of data: our database of organizations within LA County, n=697, and our survey respondents, n=320. The table shows that about two-thirds of organizations in this service space are non-profits. We note that although secular non-profits, as we defined them in the scope of work, represent two thirds of the survey sample, in reality a much larger percentage of service providers are non-profits, since many faith-based organizations are also non-profits.

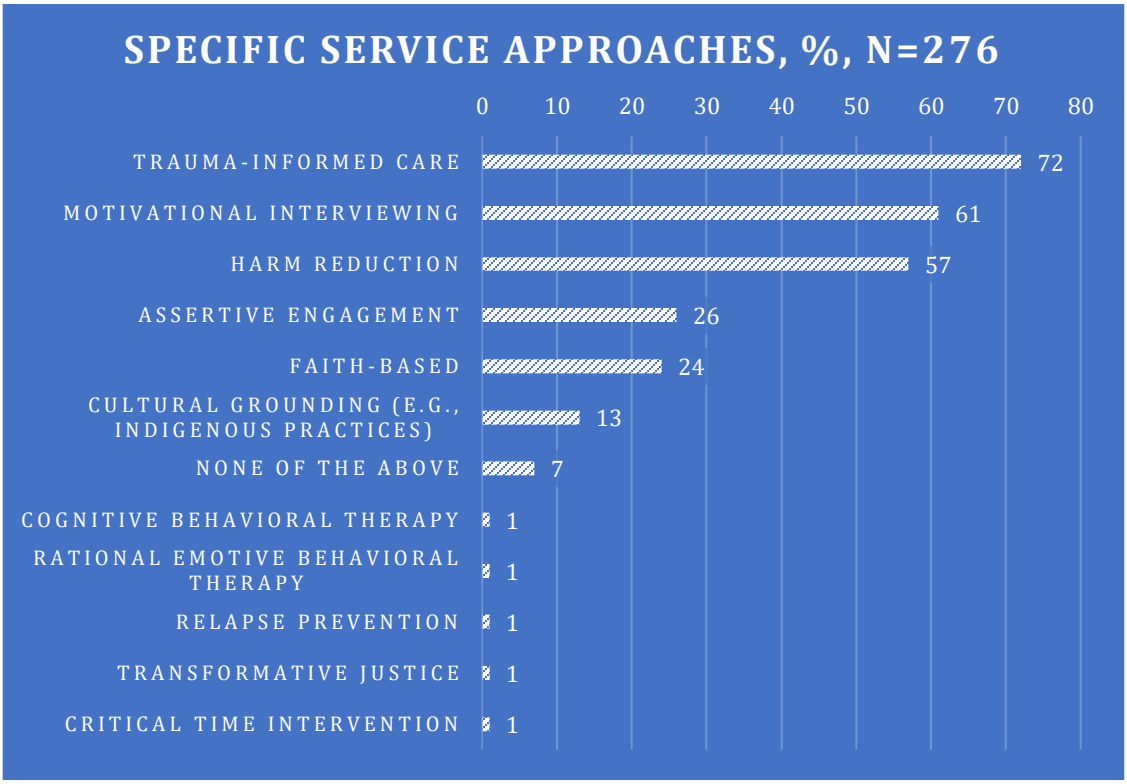
Table 2. Breakdown of daytime services organization types, using two sources of data.

Organization Type	Database count, n=697	% of Database Sample	Survey count, n=320	% of Survey Sample	Survey Representativeness of Database
Non-profit	484	69 %	193	60 %	40%
FBO	137	20 %	101	32 %	74%
CBO	18	3 %	6	2 %	33%
Public Agency	37	5 %	20	6 %	54%
For profit*	21	3%	N/A	N/A	N/A
We only include for-profits in this table, because they are documented in the Database, which includes some health providers that offer low-cost care, including to people experiencing homelessness. We do not call out this category elsewhere in our analysis, and they were not included in our survey sample.					

2.1.1. Shared Service Approaches, But Distinct Service Principles

In the survey we asked participants about specific approaches they use when providing services, by offering them a list of approaches to select all that apply, as well as the option to list other approaches they use. Figure 1 below details the percentages for each approach, showing that the most frequently mentioned ones include trauma-informed care (72%), motivational interviewing (61%), and harm reduction (57%). Harm reduction was mentioned across organization types: non-profits (63%), FBOs (47%), CBOs (33%), and public agencies (58%).

Figure 1. Percentage of organizations using specific service approaches, N=276.



Note: We are missing some responses to this question, because 44 (14%) respondents skipped it.

The top three approaches identified in the survey were also frequently mentioned in interviews, and the quotes below are representative of what we heard across the four organization types:

"We rely on a lot of motivational interviewing that goes hand-in-hand with harm reduction, trauma-informed care. I think that's probably the most significant one just because of the population that we work with. Whether our clients became homeless as a result of trauma or they have experienced a multitude of trauma just from being on the streets, that is something that we trained staff with the minute they come into the door." (Non-profit 3, SPA 4)

"I'm hypersensitive to trauma-informed care. One of the things that I tell people is, when you're getting to know people, don't ask when you first meet them, even the second or third time you meet them, don't say, "I'm really sorry that you're homeless, can you share your story with me?" Even if it's said in a caring tone like that, you just don't do it. You wait, if they want to tell you, that's one thing, but you don't even want to open that. You don't want to have them go through that because, it's just re-traumatizing." (FBO 5, SPA 8)

"Our perspective, and the way we think about outreach, [uses] harm reduction and trauma informed [care]." (CBO 3, SPA 5)

"Strength-based motivational interviewing is a big one, non-violent crisis intervention, de-escalation techniques are trainings that we provide for our field-based staff. But really the

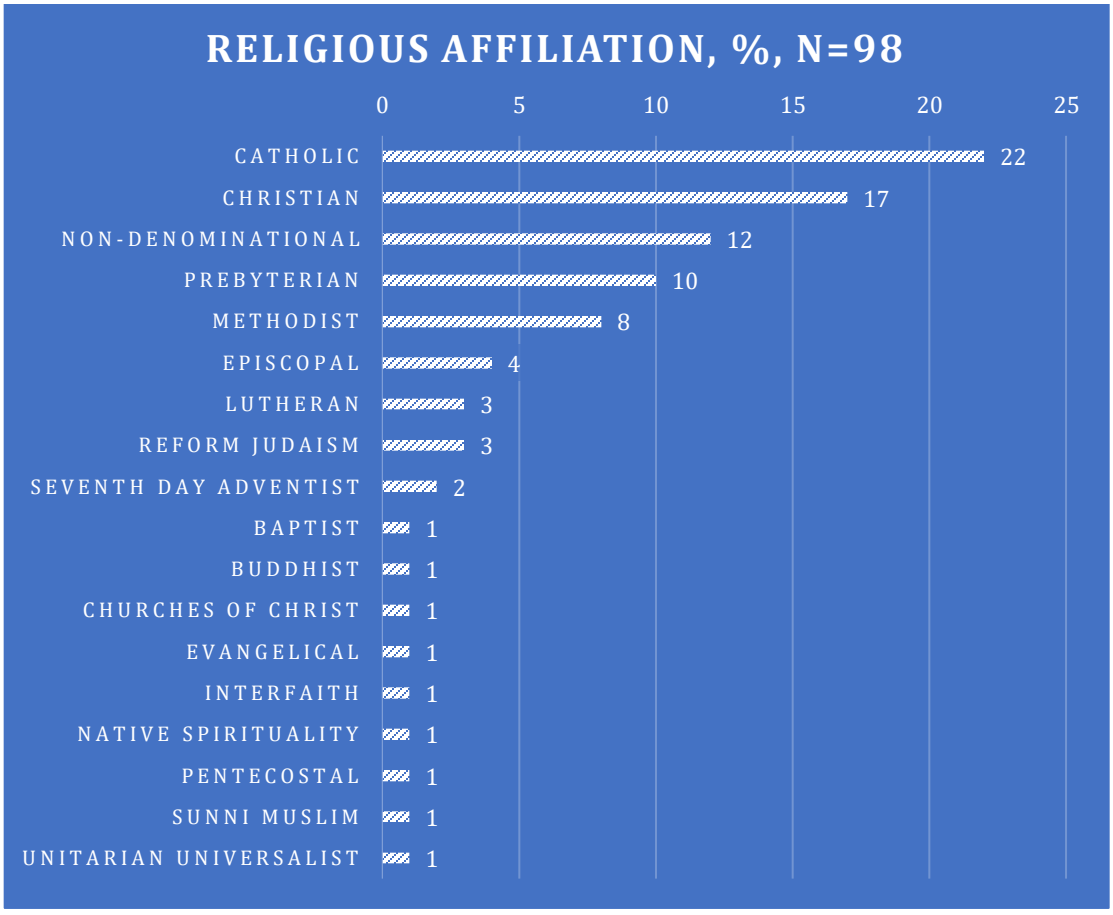
core is trauma-informed care, low barrier, harm reduction, everything has to be provided through a harm reduction lens." (Gov 3)

Despite these commonalities in approaches to how they deliver services, several distinct organizational principles emerged for FBOs and CBOs, which can have implications for service provision. We discuss each of them in separate sections below.

2.1.2. Faith-based provision

Faith-based service provision in LA County occurs among FBOs with a broad range of religious affiliations (see Figure 2 below), but predominantly Christian. We note that with our survey, we may have not reached the full breadth of faith-based organizations, especially since it was conducted only in English.

Figure 2. Religious Affiliation Among FBO providers, N=98.

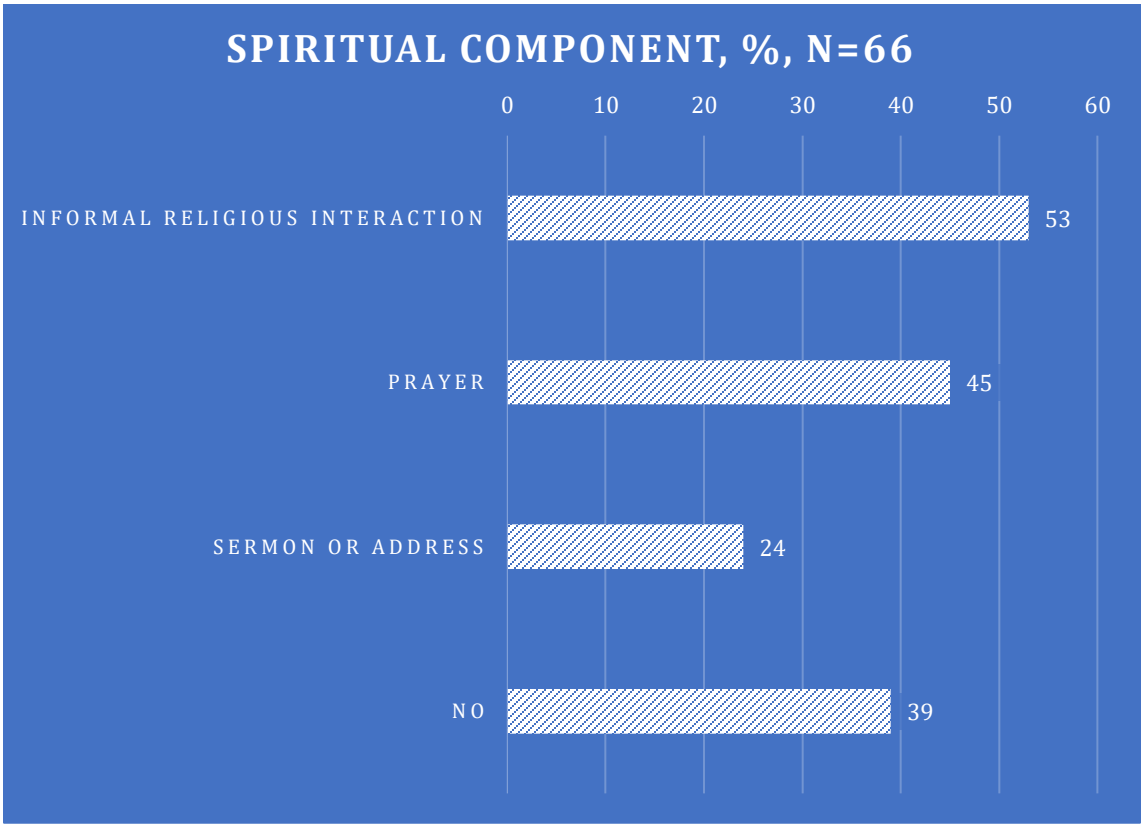


Note: Three FBOs did not provide religious affiliation.

FBO survey respondents were asked if their provision of services involved a religious or evangelical component, with answer options *no, prayer, sermon or address, or informal religious interaction.* Nearly 40% said their service provision had no spiritual component (see Figure 3 below). Those who said their services included a spiritual component were next asked if this was

optional or if clients had to engage before receiving daytime services. For the majority of FBO providers (88%), client involvement with faith was optional.

Figure 3. Provision of service involving spiritual component, n=66.



Note: These percentages are based on the subsample of FBOs that said they offer a spiritual component.

While a majority of surveyed FBOs do not require that the individuals they serve engage in spiritual activities in order to receive service, faith considerations may determine what or how services are provided on site, including when they collaborate with other partners. The following quotes illustrate a few manifestations of these sensitivities:

> *"The delicate thing is because we are pro-life … and we have [other] faith-based groups that are pro-life, sending [their clients] to us realizing that aspect will be respected. So, if a woman is pregnant, we do everything possible to help her in that decision. … But we would talk to the healthcare provider, we'd ask that they do not refer this person, let's say, to have an abortion. Now, if a person chooses to do that, that's up to them." (FBO 2, Multiple SPAs)*

> *"There are a small number of harm reduction interventions that some of our [FBO] partners ask us to hold off on when we're there related to the provision of safe use supplies. Some folks, you can throw as many studies at them as you want, but if they don't feel comfortable with that, we want to be good partners and we don't [offer harm reduction]." (Gov 3)*

2.1.3. Community-based activism

In interviews we learned that many CBOs are firmly rooted in activism with principle commitments to social justice, equity, community well-being, and the public good. In their service provision, such organizations favor what is known as a "horizontal decisionmaking process," whereby member groups or individuals relate to each other as "co-organizers." For many CBOs, core values include autonomy, political and community advocacy, and the flexible provision of immediate relief, for instance, food, shower, blankets, tents, help with procuring personal identification. As one interviewee put it:

> *"The two parts of our mission in a nutshell are to engage and provide relief and advocacy for our unhoused neighbors, and the other side is to engage with our housed neighbors to make sure that they understand the problems and give them a chance to interact with this so they can make better decisions and be better citizens." (CBO 2, Multiple SPAs)*

2.2. Daytime Service System Characteristics: Capacity in terms of what, when, where, and to whom services are provided

Research Sub-questions

- What services do they provide?
- When are the services available/not available?
- Where are these organizations located and where do they provide services?
- What (if any) restrictions are placed on access and eligibility of services?
- What is the language access capacity at the site?

Key Points

- Gaps were not specifically geographical, with various shortcomings identified to some extent across all 8 SPAs. Gaps were more pronounced in terms of the type of services available, along with the times and days of the week when services were provided.
- Over two-thirds of organizations provide at least one core service, of whom: 86% provide food, 70% help with personal communications, 61% bathrooms and showers, 42% offer a place for daytime rest, and 34% personal storage.
- Over two-thirds (75%) of organizations provide case management.
- Fewer than half of organizations (40%) provide direct professional services or peer-led support groups, a gap consistent across SPAs.
- Across SPAs, services are less available at the weekends (only 58% providers are open Saturdays and 46% Sundays, compared to 90% who are open on week days).
- Across SPAs, services are less available during late afternoon/early evening hours.
- Of organizations that offer services fewer than 8 hours per day, 83% offer core services, and more than half are FBOs.
- Survey respondents perceived service gaps across all SPAs.
- In general, organizations serve a diverse clientele.

2.2.1. What services are provided?

Core Services

Among the providers in our database (n=697), 58% (n=405) provide any core services, such as food, hygiene, day shelter, communications, and storage. However, our Technical Appendix highlights significant methodological challenges with capturing these from public lists and websites. Among the survey respondents, 77% (n=230) said they provide at least one core service, of whom 86% provide food, 61% bathrooms and showers, 42% lounge and daytime rest, 70% help with personal communication, and 34% offer personal storage. See Table 3 below.

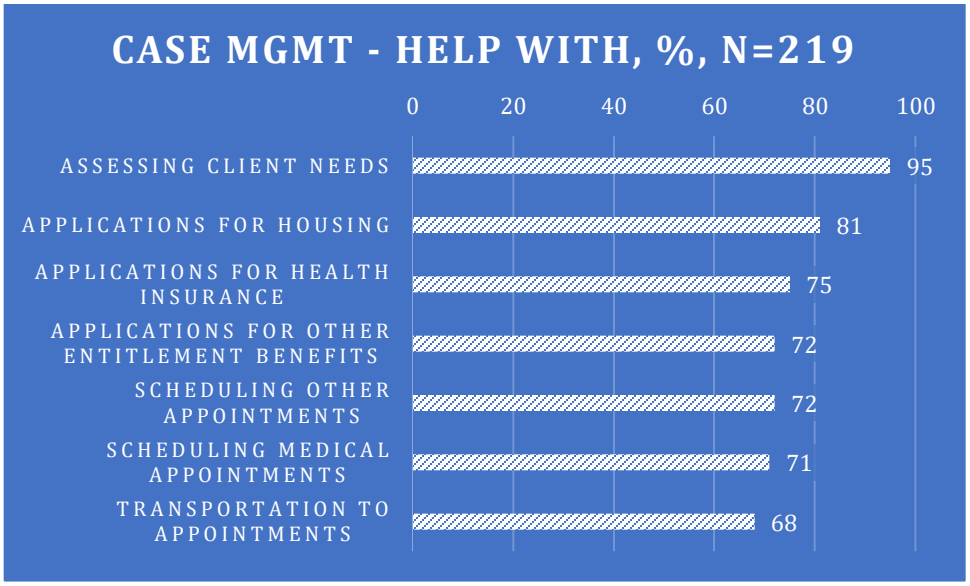
Table 3. Organizations offering core services, using two sources of data (database and survey).

Core Service	Database count, n=405	Database %	Survey count, n=230*	Survey %
FOOD				
Food banks	46	11 %	89	39 %
Emergency food pantry (e.g., bagged food to go)	151	37 %	125	55 %
Hot food distribution	144	36 %	102	45 %
Cooking facilities	48	12 %	48	21 %
Food vouchers	10	2 %	35	15 %
Food distribution to other organizations	14	3 %	56	25 %
PERSONAL HYGIENE AND HEALTH				
Bathrooms	90	22 %	132	58 %
Showers	118	29 %	116	51 %
Haircuts and barbering	6	1 %	45	20 %
Lice treatment/removal	0	0 %	17	8 %
Tents	0	0 %	40	18 %
Laundry	44	11 %	100	44 %
Clothing	75	19 %	160	71 %
Blankets	9	2 %	142	63 %
Toiletries	63	16 %	181	80 %
Menstruation supplies	14	3 %	151	67 %
Harm reduction items	18	4 %	83	37 %
Lounge area	63	16 %	88	39 %
Daytime sleep area	43	11 %	52	23 %
PERSONAL COMMUNICATION				
Phone line	46	11.1 %	88	39 %
Phone charging	2	0.4 %	114	50 %
Mailing address	8	2 %	116	51 %
Computer with internet	65	16 %	105	46 %
PERSONAL STORAGE				
Locker-sized, during services	5	1 %	43	19 %
Cart-sized, during services	2	0.4 %	19	8 %
Locker-sized, on-going, longer than a day	1	0.2 %	36	16 %
Cart-sized, on-going, longer than a day	6	1 %	19	8 %
Safe parking for vehicles	10	2 %	28	12 %
Note: These percentages are based on the sample of organizations that provide at least one core service, which is only 77% of the entire survey sample				

Case Management

Case management is provided by 37.8% (n=263) of organizations in our database (n=697), and 75% (n=221) of survey respondents. More than half of non-profits (86%), FBOs (62%), and public agencies (58%) in the survey sample said they offered case management. None of the CBOs said they did case management. In the survey, we asked respondents to provide additional details about the type of case management support on offer (i.e., how they helped clients, and what referrals they typically provided), and they could select all that applied. Figure 4 shows how organizations said they help clients.

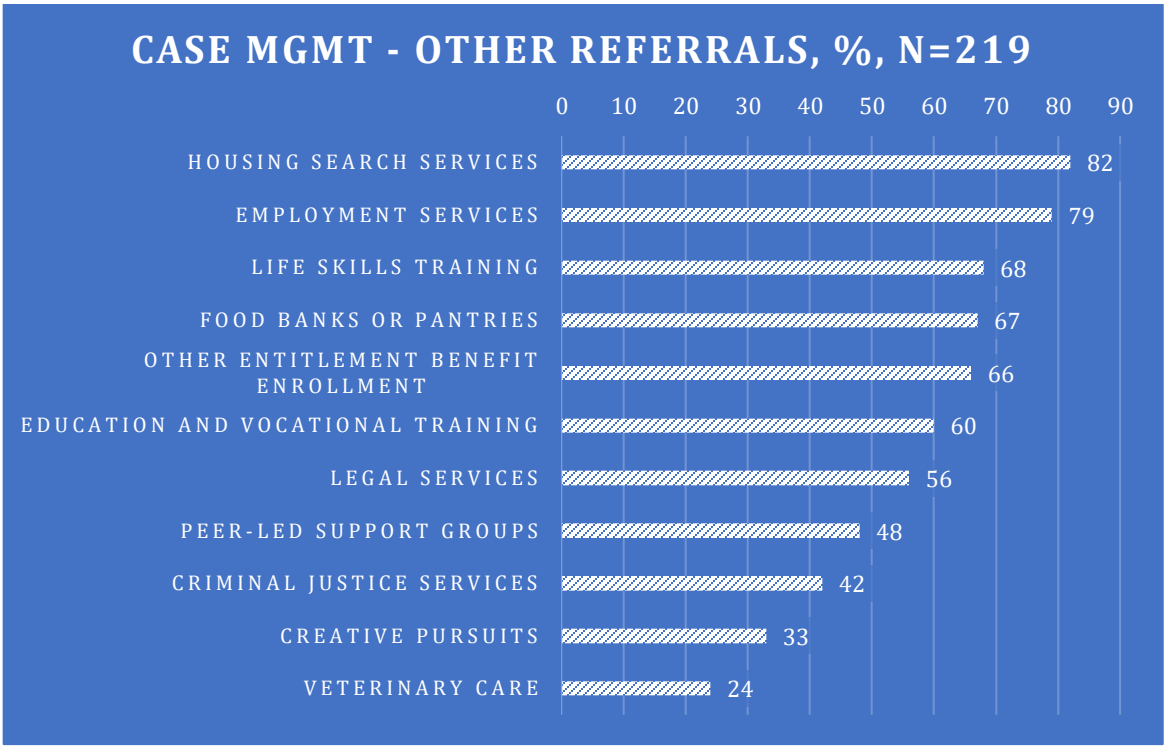
Figure 4. Percentage of organizations by ways in which they help their clients, n=219.



Note: These percentages are based on the sample of organizations that provide case management, which is only 75% of the entire survey sample.

Of survey respondents who provide referrals (n=219) as part of their case management, 79% refer to mental health services, 65% to substance use disorder services, and 60% to physical health services. More than half of non-profits and FBOs, but fewer than half of public agencies (which in our sample included cities, public libraries, County departments, and relevant County offices) said they referred to physical health, mental health, or substance use disorder services. Figure 5 shows referrals to other services, which was asked only of the respondents who said they were offering case management.

Figure 5. Percentage of organizations making referrals other than health, n=219.

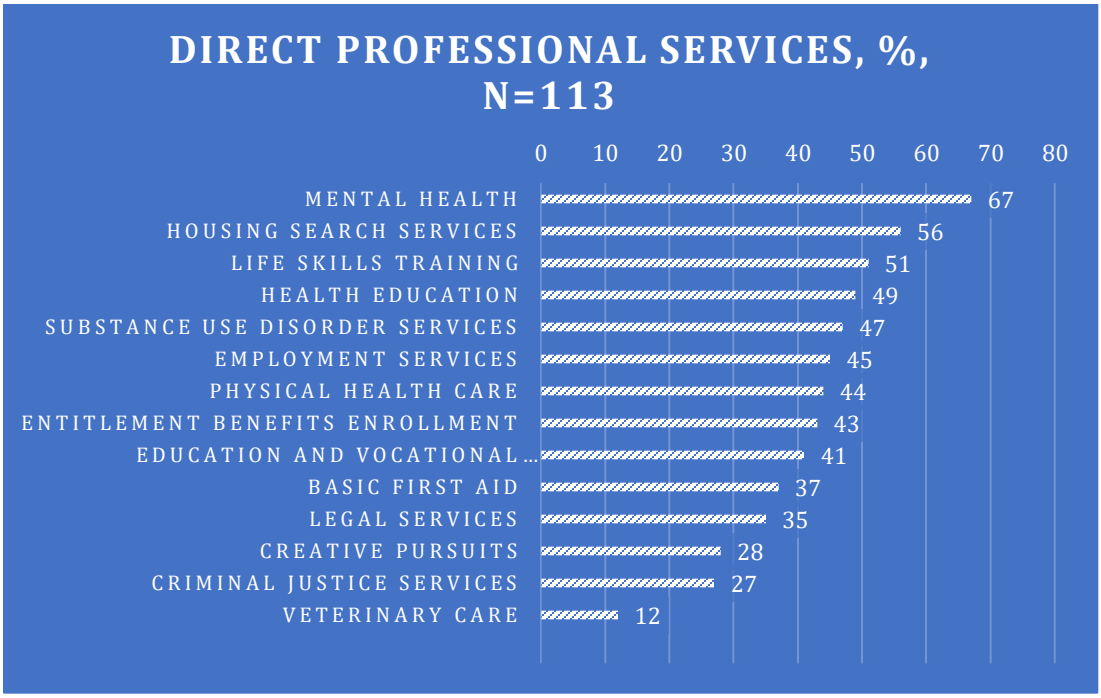


Note: These percentages are based on the sample of organizations that provide case management, which is only 75% of the entire survey sample.

Direct Professional Services

Almost 40% of survey respondents (n=113) said they were providing direct professional services either through their organization or through co-location with other partners. Participants could select all that applied. Fewer than half of non-profits (46%), FBOs (30%), and public agencies (25%) in the survey sample said they offered direct professional services. None of the CBOs offered these services. Figure 6 details the type of reported direct professional service provision.

Figure 6. Percentage of organizations offering direct services, n=113.

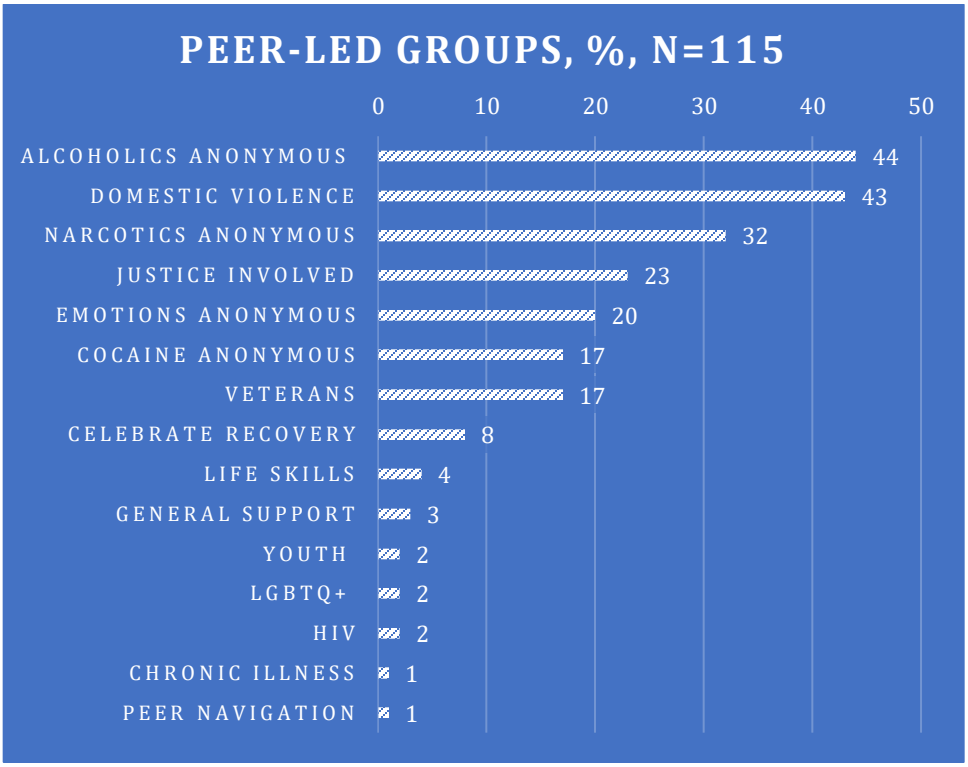


Note: These percentages are based on the sample of organizations that provide direct professional services, which is only 40% of the entire survey sample.

Peer-led Services

Forty percent (n=115) of survey respondents said they were offering peer-led support groups, and participants could select all that applied. Fewer than half of non-profits (43%), FBOs (38%), CBOs (17%) and public agencies (17%) said they offered peer-led groups. Figure 7 details types of support groups offered.

Figure 7. Percentage of organizations offering support groups, n=115.



Note: These percentages are based on the sample of organizations that provide peer-led support, which is only 40% of the entire survey sample.

2.2.2. When are services provided?

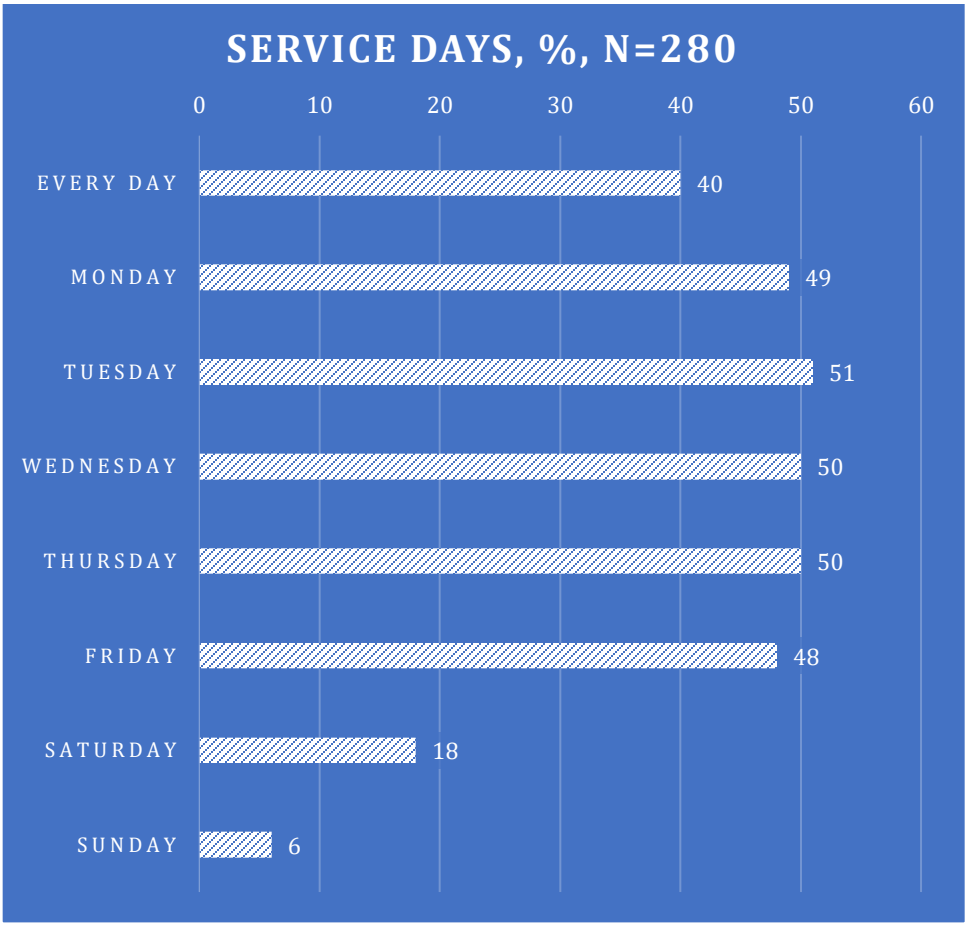
Service days

The survey elicited two data points about when services are provided: days and hours of operation (opening hours and closing hours). When asked about the days when the organization is open, respondents could select "every day" (meaning 7 days) or if not every day, they could select the days of the week when they offer services, which could be any combination of days Monday through Sunday. For instance, someone could have selected Monday only, or Monday through Friday, or Tuesday and Sunday, and so on.

Forty percent of respondents said they were open every day (meaning Monday through Sunday), whereas the other 60% selected one or multiple days when they were open. About half of organizations provided services during at least one week day, with weekends showing a marked gap in service availability (See Figure 8). Of the respondents who are not open every day, a majority are open five days a week (55%), 21% are open six days a week, while 9% are open only one day a week, 5% are open on two days, 5% on three days, and 5% on four days a week. Those open only one or two days a week were mostly non-profits and FBOs. Combining those who are open every day with those open on select days, we note that approximately 90% of survey

respondents are open at some point Monday through Friday, 58% are open Saturdays, and 46% are open Sundays.

Figure 8. Percentage of organizations by service days, n=280.



Note: We are missing some data in response to this question, because 40 (13%) respondents skipped it.

In interviews, we learned that not all organizations provide services weekly or consistently. Some of the faith-based providers, for instance, suggested that their service days occur once or twice a month. Other faith providers with service days every weekend suggested that the services offered may vary with provider availability. For example, a mobile barber or dental hygienist may only come infrequently.

Table 4 details service days by type of organization (n=280), highlighting that non-profits, FBOs, and public agencies are generally less available at the weekends than during week days. The number of CBOs operating during the weekend is higher than during the week.

Table 4. Organizations, by type and service days (n=280).

Service Days	Non-profit (n=170), n (%)	FBO (n=92), n (%)	CBO (n=6), n (%)	Public Agency (n=12), n (%)
Monday (n=249)*	161 (65)	74 (30)	3 (1)	11 (4)
Tuesday (n=255)*	168 (66)	73 (29)	3 (1)	11 (4)
Wednesday (n=250)*	164 (66)	71 (28)	4 (2)	11 (4)
Thursday (n=251)*	165 (66)	71 (28)	4 (2)	11 (4)
Friday (n=246)*	160 (65)	72 (29)	3 (1)	11 (4)
Saturday (n=163)**	94 (58)	58 (36)	5 (3)	6 (4)
Sunday (n=129)**	70 (54)	48 (37)	5 (4)	6 (5)

*Note: We show row percentages. *Includes the respondents who selected the answer option of "Every day, 7 days" plus respondents who selected that specific week day. ** Includes the respondents who selected the answer option of "Every day, 7 days" plus respondents who selected that specific weekend day.*

Table 5 details each core service offered by providers who are open on week days (n=270), and providers open Saturdays (n=163) and/or Sundays (n=129). In total from our survey sample, 173 respondents said they were open on weekends. We do not focus on provision broken down by select weekdays because that is consistent across organizations Monday through Friday. The table highlights that food and storage services are under-provided both during week days and on the weekends. While weekends register a drop in service provision across the board, Sunday is a particularly notable gap.

Table 5. Providers offering core services by day when they are provided, n and %.

Core Service	Providers open week days^ (n=270), n (%)	Providers open Saturdays* (n=163), n (%)	Providers open Sundays** (n=129), n (%)
FOOD			
Food banks	80 (30)	50 (31)	39 (30)
Emergency food pantry (e.g., bagged food to go)	115 (43)	65 (40)	54 (42)
Hot food distribution	89 (33)	57 (35)	43 (33)
Cooking facilities	42 (16)	33 (20)	26 (20)
Food vouchers	33 (12)	21 (13)	15 (12)
Food distribution to other organizations	48 (18)	33 (20)	26 (20)
PERSONAL HYGIENE AND HEALTH			

Bathrooms	124 (46)	81 (50)	62 (48)
Showers	107 (40)	69 (42)	53 (41)
Haircuts and barbering	43 (16)	24 (15)	17 (13)
Lice treatment/removal	16 (6)	13 (8)	10 (8)
Tents	34 (13)	16 (10)	12 (9)
Laundry	94 (35)	61 (37)	47 (36)
Clothing	146 (54)	92 (56)	70 (54)
Blankets	130 (48)	80 (49)	63 (49)
Toiletries	163 (60)	99 (61)	78 (60)
Menstruation supplies	138 (51)	83 (51)	65 (50)
Harm reduction items	74 (27)	43 (26)	32 (25)
Lounge area	82 (30)	50 (31)	43 (33)
Daytime sleep area	47 (17)	29 (18)	23 (18)
PERSONAL COMMUNICATION			
Phone line	78 (29)	47 (29)	37 (29)
Phone charging	107(40)	60 (37)	48 (37)
Mailing address	106 (39)	65 (40)	53 (41)
Computer with internet	98 (36)	58 (36)	43 (33)
PERSONAL STORAGE			
Locker-sized, during services	40 (15)	26 (16)	19 (15)
Cart-sized, during services	18 (7)	8 (5)	7 (5)
Locker-sized, on-going, longer than a day	34 (13)	22 (13)	18 (14)
Cart-sized, on-going, longer than a day	18 (7)	12 (7)	11 (9)
Safe parking for vehicles	25 (9)	20 (12)	15 (12)

*Note: This table combines two points of data: the days when organizations said they were open, and the core services they said they offer in general. Services may not be available consistently on all days when respondents say they are open. ^Includes the respondents who selected the answer option of "Every day, 7 days" and respondents who selected one or multiple week days. * Includes the respondents who selected the answer option of "Every day, 7 days" and respondents who selected Saturday. ** Includes the respondents who selected the answer option of "Every day, 7 days" and respondents who selected Sunday.*

Table 6 details the number and percentages of providers offering other services (any case management, any direct services, a few selected direct services, and any peer-led services) by the days when these are provided. The table highlights that direct health services, such as physical, mental, and substance use disorder services, are under-provided at the weekends.

Table 6. Providers offering other services by day when they are provided, n and %.

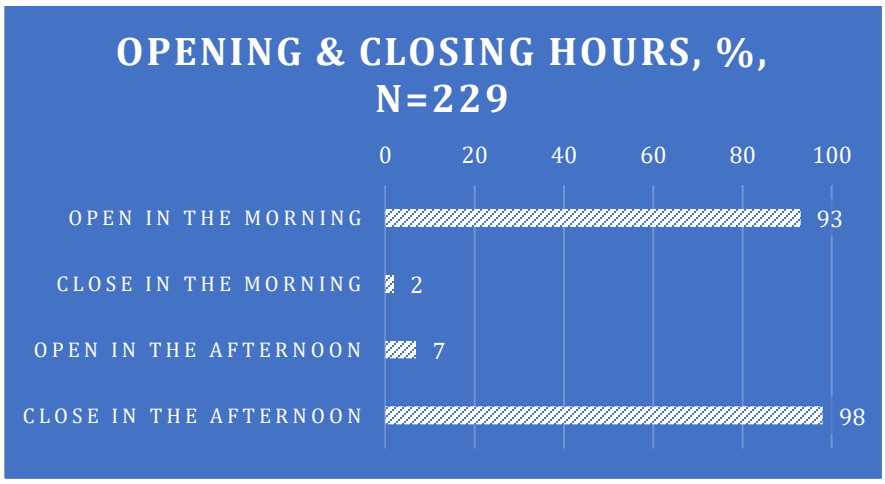
Service	Providers open week days^ (n=270), n (%)	Providers open Saturdays* (n=163), n (%)	Providers open Sundays** (n=129), n (%)
Any Case Management	201 (74)	122 (75)	93 (72)
Any Direct Services	104 (39)	58 (36)	45 (35)
Basic first aid	41 (15)	23 (14)	16 (12)
Physical health care	46 (17)	29 (18)	22 (17)
Mental health care	69 (26)	41 (25)	31 (24)
Substance use disorder services	50 (19)	30 (18)	21 (16)
Any Peer-led Services	108 (40)	67 (41)	51 (40)

Note: *We show column percentages. This table combines two points of data: the days when organizations said they were open, and the case management and direct services they said they offer in general. Services may not be available consistently on all days when respondents say they are open. ^Includes the respondents who selected the answer option of "Every day, 7 days" and respondents who selected one or multiple week days. * Includes the respondents who selected the answer option of "Every day, 7 days" and respondents who selected Saturday. ** Includes the respondents who selected the answer option of "Every day, 7 days" and respondents who selected Sunday.*

Service hours

When asked about their hours of operation, respondents could select 24 hours, or their typical opening and closing times. Fifteen percent of all survey respondents said they are open or available 24 hours a day, with most organizations opening in the morning and closing in the afternoon (See Figure 9, n=229, which excludes those open 24 hours).

Figure 9. Typical opening and closing hours, n=229.



Note: These percentages are based on n=229, which excludes the 15% of respondents who are open 24 hours.

Table 7 below details open hours by organization type, showing that across organization types there is similar service availability by number of hours.

Table 7. Mean, median, and rage of open number of hours by organization type.

	FBO	Non-profit	CBO	Public Agency
Mean Hours Open	10	11	10	11
Median Hours Open	8	9	8	9
Range Hours Open	1-24	1-24	2-24	8-24

However, Table 8 shows the percentage of organizations offering various types of services by the number of hours open, suggesting that the majority of organizations open 24 hours provide mostly core and case management (87%), with a smaller percentage offering any direct services or peer-led services. Among the organizations that offer services fewer than 8 hours per day (n=51), a majority (83%) offer core services, and more than half are FBOs. Most organizations are typically open 8 or 9 hours (typically open between 8am-5pm, 8am-4pm, 9am-5pm or 9am-6pm), and offer mainly core and case management services.

Table 8. Percentage of organizations offering types of services by number of hours open.

Hours Open	% Core Service Providers (n=230)	% Case Management Providers (n=219)	% Direct Service Providers (n=113)	% Peer-led Providers (n=115)
24 hrs (n=47)	87	87	40	53
10-23 hrs (n=49)	63	68	34	37
8-9 hrs (n=129)	73	83	42	41
<8 hrs (n=51)	83	43	36	22
Note: We provide column percentages.				

2.2.3. Where are services provided?

Table 9 below shows a breakdown of organizations by Service Planning Area (SPA), using our survey data. The grey rows show first numbers of providers by SPA from the survey (n and % of survey respondents in each SPA from the sample of 320), followed by 2022 Point in Time counts, and the number of organizations in our survey per 1,000 homeless. SPAs 4 and 6 have the lowest number of survey respondents per 1,000 individuals experiencing homelessness. The light brown rows show daily site capacity using median capacity. This means that about 50% of organizations in each SPA serve fewer than 100 people daily, and 50% serve more than 100 people daily. The median maximum capacity of organizations varies by SPA, from 140 in SPA 5 to 200 in SPAs 1 and 2. These comparisons suggest there may be additional capacity at some

organizations. Next, in the light green rows, we show a breakdown of organizations offering types of services (core, case management, direct services, and peer-led), highlighting that direct and peer-led services are less provided across SPAs, compared to core and case management services. The last set of blue rows show that the weekend services gap is consistent across SPAs. The last row shows that survey respondents perceived services gaps across all SPAs, 16% and 11% identifying SPAs 4 and 3, respectively.

Table 9. Service characteristics by Service Planning Area based on survey responses.

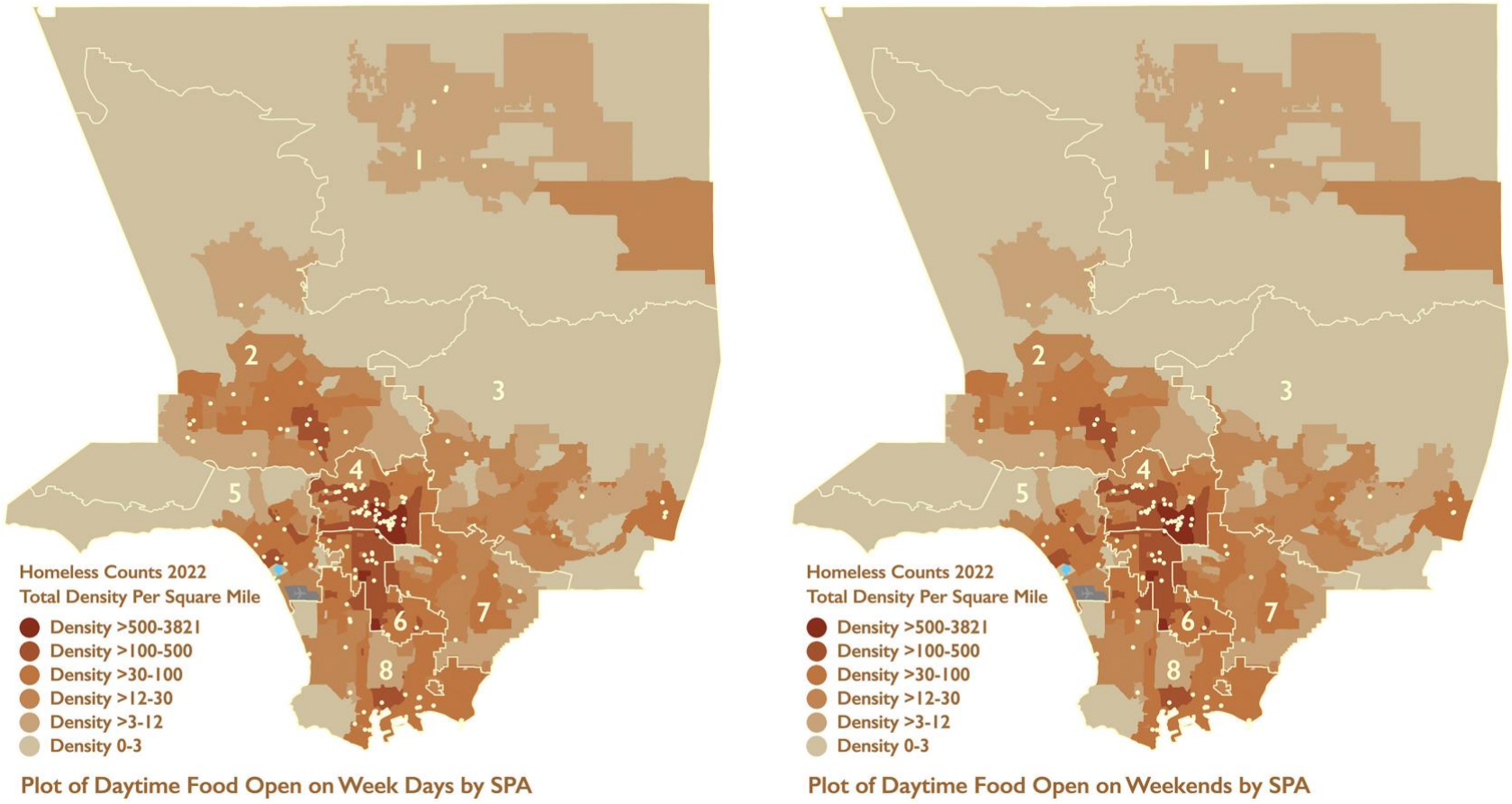
Attribute	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Survey* organizations (n=320), n (%)	70 (23%)	117 (38%)	84 (28%)	148 (49%)	99 (32%)	123 (40%)	87 (29%)	110 (36%)
2022 Homeless Count	4,598	9,604	4,661	17,820	4,604	14,598	4,781	4,445
Organizations per 1,000 homeless**	15.22	12.18	18.02	8.30	21.5	8.42	18.19	24.74
Reported number of people served daily in SPA, mean (median) **	756 (100)	1318 (100)	589 (100)	555 (100)	477 (100)	541 (100)	668 (100)	573 (100)
Reported daily maximum client capacity, mean (median) **	629 (200)	427 (200)	383 (150)	642 (150)	377 (140)	549 (155)	731 (150)	887 (150)
Providers of core services, % **	79%	72%	80%	79%	73%	74%	80%	76%
Providers of case management, % **	85%	78%	75%	78%	74%	76%	80%	74%
Providers of direct services, % **	50%	40%	41%	44%	42%	50%	46%	44%
Providers of peer-led services, % **	47%	42%	44%	39%	39%	45%	48%	41%
Providers open every day, n (%)**	35 (55%)	45 (42)	44 (55)	62 (45)	39 (42)	53 (45)	43 (53)	54 (52)
Providers open Saturdays, n (%)**	10 (16)	15 (14)	8 (10)	23 (17)	19 (21)	15 (13)	12 (15)	18 (17)
Providers open Sundays, n (%)**	1 (2)	5 (5)	5 (6)	8 (6)	5 (5)	5 (4)	4 (5)	4 (3)
Providers open 24 hrs, n (%)** #	13 (20)	17 (16)	15 (19)	25 (18)	14 (16)	19 (16)	16 (20)	21 (20)
Providers open <8hrs, n (%)**	4 (6)	13 (12)	7 (9)	19 (14)	9 (10)	10 (9)	4 (5)	10 (10)

Survey respondents who perceived SPA as having a services gap, n (%)***	16 (8)	13 (7)	20 (11)	29 (16)	9 (5)	12 (7)	9 (5)	10 (5)

**Some organizations provide services across multiple SPAs.*
***Based on the survey sample.*
 # The total number of providers who are open 24 hrs across SPAs does not add up to n=47, because respondents could select all that apply for the SPAs where they operate.
****Based on 121 of n=182 respondents who wrote in their answers to the question "Where in Los Angeles County do you see the biggest gaps in daytime services?"*

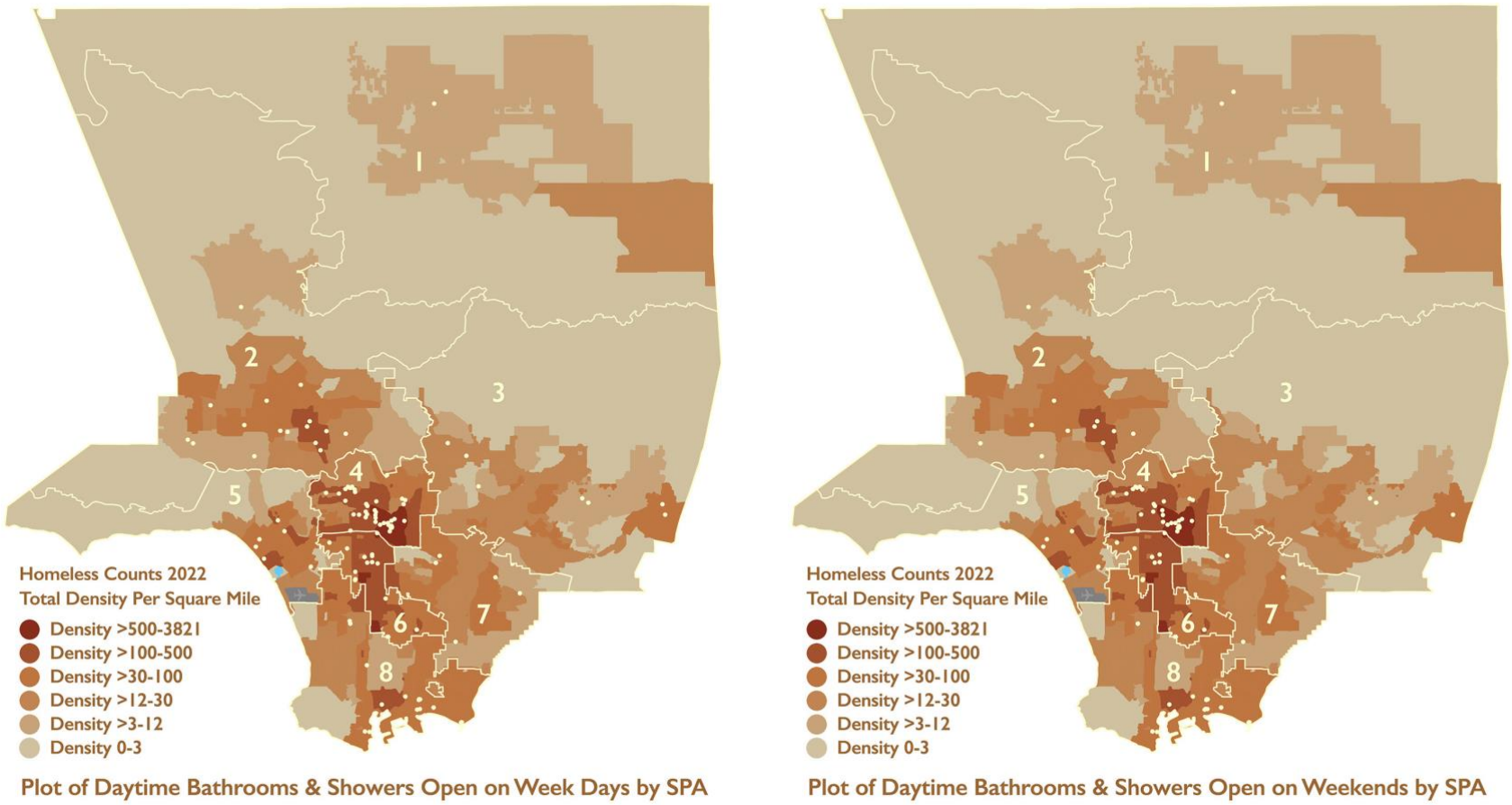
Below we provide a series of visuals mapping some of the services across LA County, based on the database of providers we assembled using publicly available data, n=697, as well as the survey respondents. The visuals show the following groups of services: 1) food (food banks, pantries, hot meal distribution, Figure 10); 2) bathrooms and showers (Figure 11); 3) daytime rest, i.e., lounge and daytime sleep (Figure 12); and 4) health (physical, mental, substance use disorder, including harm reduction, Figure 13). For each set of services, we first show the providers who are open on week days, which includes those who said they are open every day, i.e., 7 days, and those open only on select days Mondays through Fridays), and providers who are only open on the weekends (which includes those open every day, i.e., 7 days, and those open only Saturdays and/or Sundays). We overlay the service providers with the SPA boundaries and the 2022 LAHSA Point-in-Time Homeless Density map[5] (showing a gradient of unsheltered individuals per square mile). It is important to note that these maps combine data about organizations' service days and services offered in general, but our interviews suggest that not all services may be available consistently on the days when organizations say they are open. We do not feature Catalina Island in these graphs, due to lack of service data for that area.

Figure 10. Plot of Food Providers.



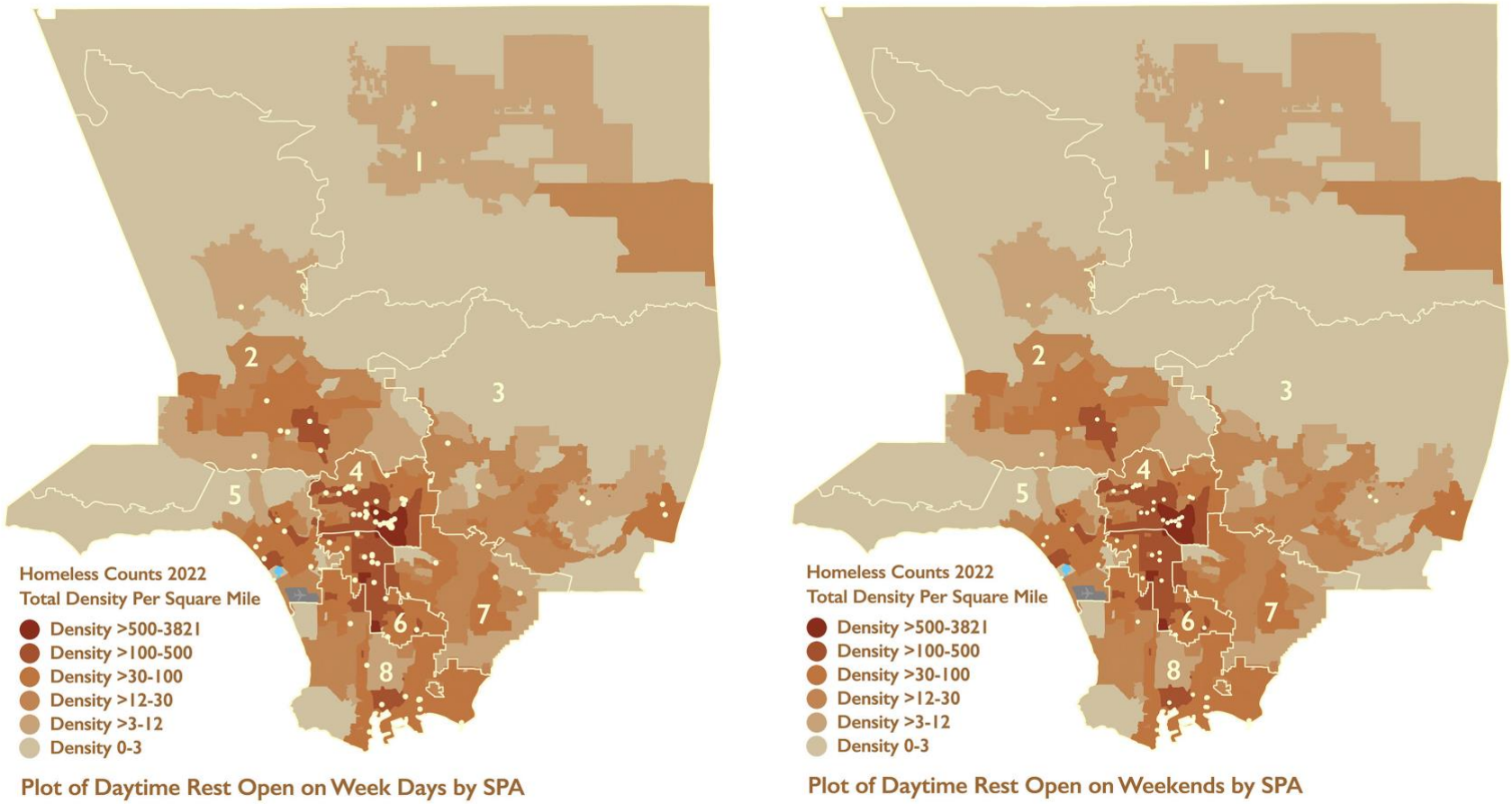
On the left we show where food (food banks, pantries, and hot meal distribution) is offered on week days, including those who said they are open every day, i.e., 7 days, and those open only on select days Mondays through Fridays. On the right we show where food is available on weekends, which includes those open every day. i.e., 7 days, and those open on weekends only. The comparison shows fewer options for food on weekends, especially in SPAs 3, 5, and 7.

Figure 11. Plot of Bathrooms and Showers Providers.



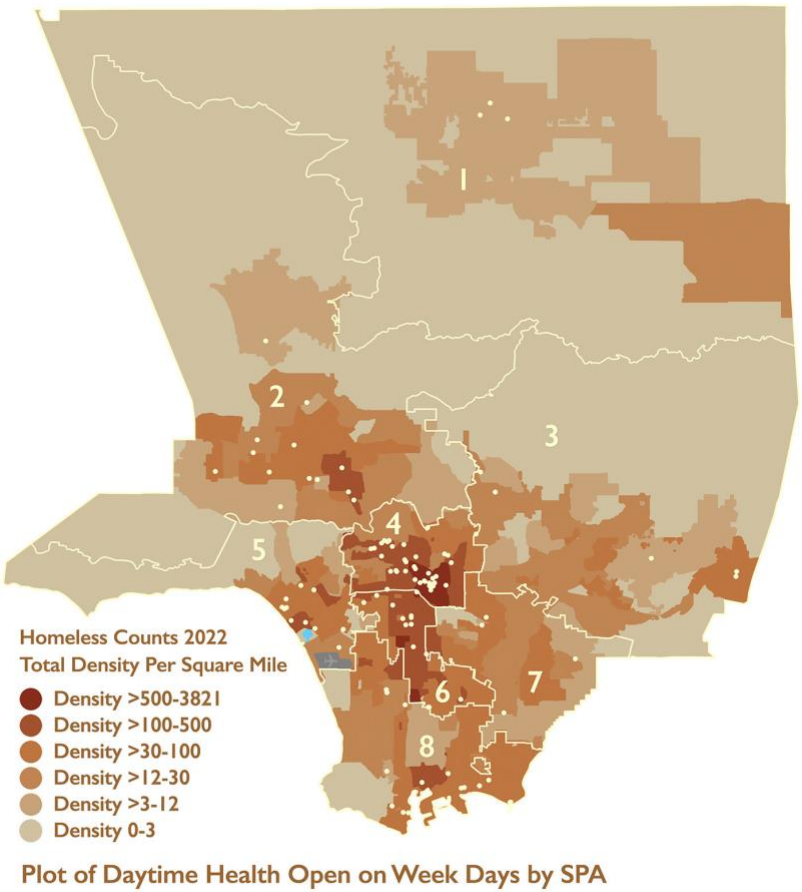
On the left we show where bathrooms and/or showers are offered on week days, including those who said they are open every day, i.e., 7 days, and those open only on select days Mondays through Fridays. On the right we show where bathrooms and showers are available on weekends, which includes those open every day. i.e., 7 days, and those open on weekends only. The comparison shows fewer options for bathrooms and showers on weekends, especially in SPAs 2, 3, 5, and 7.

Figure 12. Plot of Daytime Rest Providers.

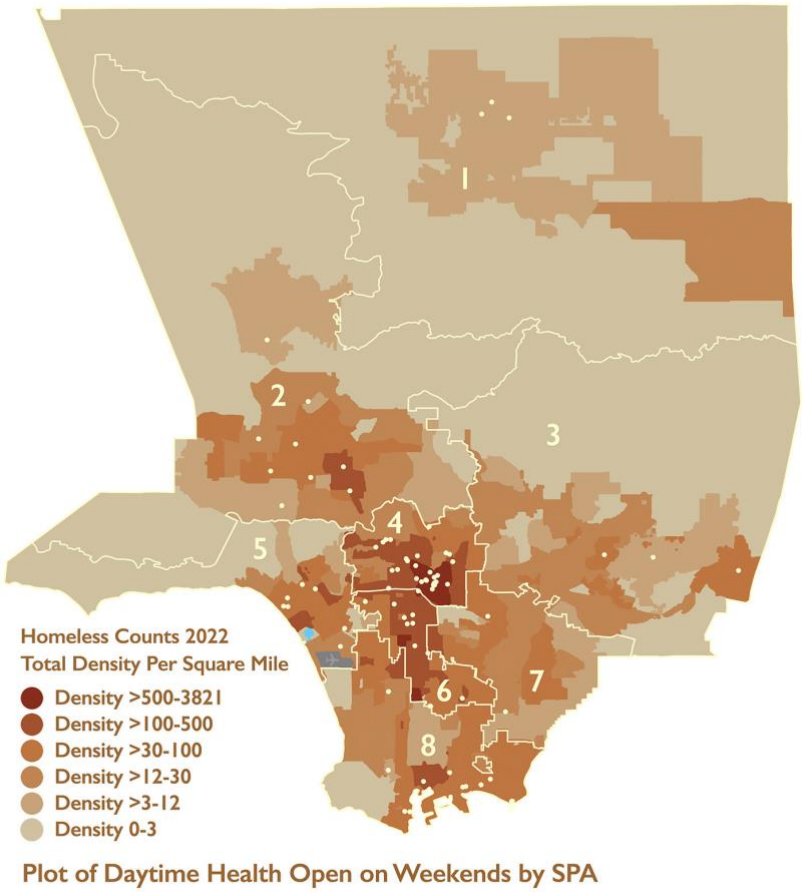


On the left we show where daytime rest (i.e., daytime sleep and/or lounge areas) are offered on week days, including those who said they are open every day, i.e., 7 days, and those open only on select days Mondays through Fridays. On the right we show where daytime rest is available on weekends, which includes those open every day. i.e., 7 days, and those open on weekends only. The comparison shows fewer options for daytime rest on weekends, especially in SPAs 2, 3, 5, and 7.

Figure 13. Plot of Health Providers.



Plot of Daytime Health Open on Week Days by SPA



Plot of Daytime Health Open on Weekends by SPA

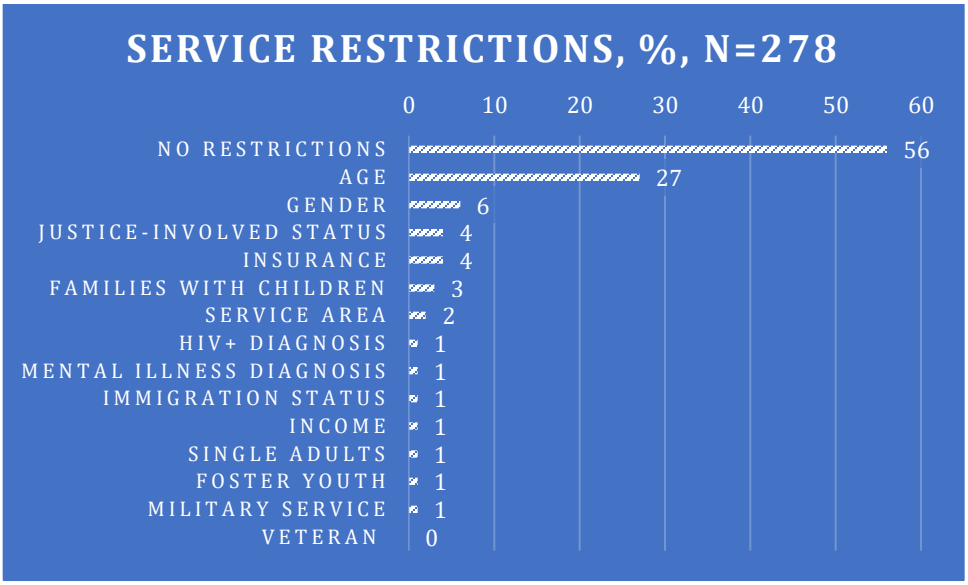
On the left we show where health care (i.e., physical, mental, and substance use disorder services) is offered on week days, including those who said they are open every day, i.e., 7 days, and those open only on select days Mondays through Fridays. On the right we show where health care is available on weekends, which includes those open every day. i.e., 7 days, and those open on weekends only. The comparison shows fewer options for health care on weekends, especially in SPAs 5 and 7.

2.2.4. To whom are services provided?

The survey contained a set of questions aiming to elicit descriptions of the client populations that organizations served, such as service restrictions, age, race or ethnicity, and languages covered. We provided categories for all questions, and participants could select all that apply.

Figure 14 lists reported service restrictions (n=278). More than half of respondents said they had no service restrictions.

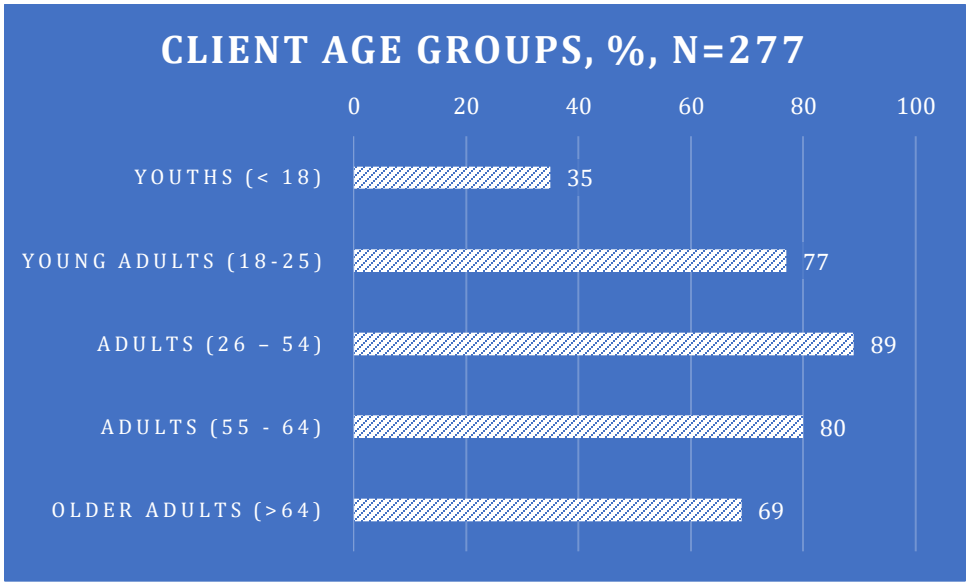
Figure 14. Reported service restrictions, n=278.



Note: We are missing some data in response to this question, because 42 (13%) respondents skipped it.

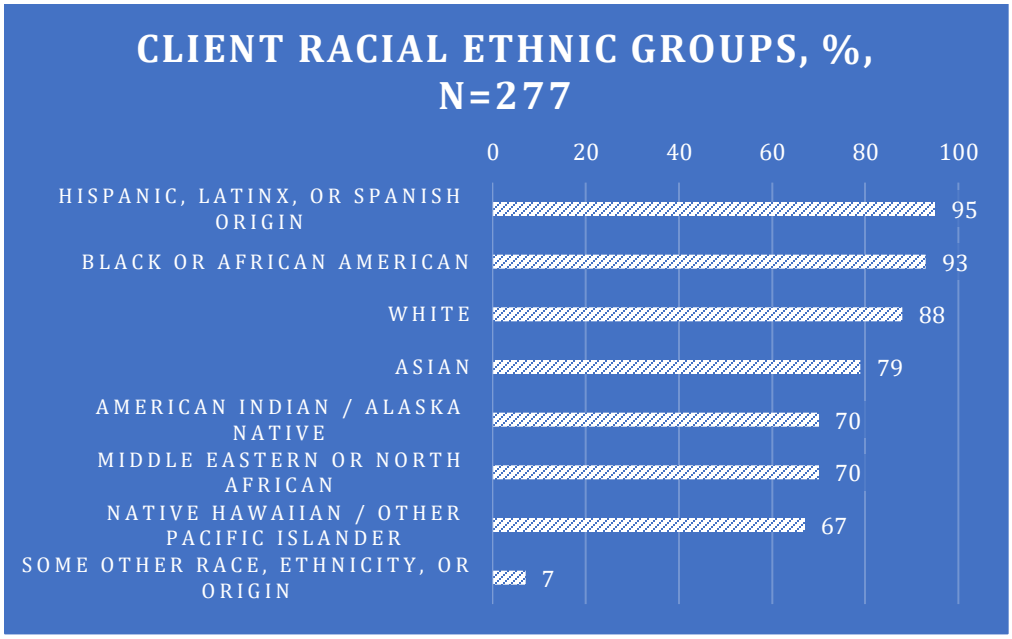
Figures 15, 16, and 17 show reported client characteristics, such as age, race, ethnicity, and other attributes. Fewer than half of organizations report serving minors, but we should note that the youth services system is distinct from the adult services system, and the survey sample may not have captured all youth service providers who offer services only to youths. In general, organizations serve a racially and ethnically diverse clientele.

Figure 15. Client age groups, n=277.



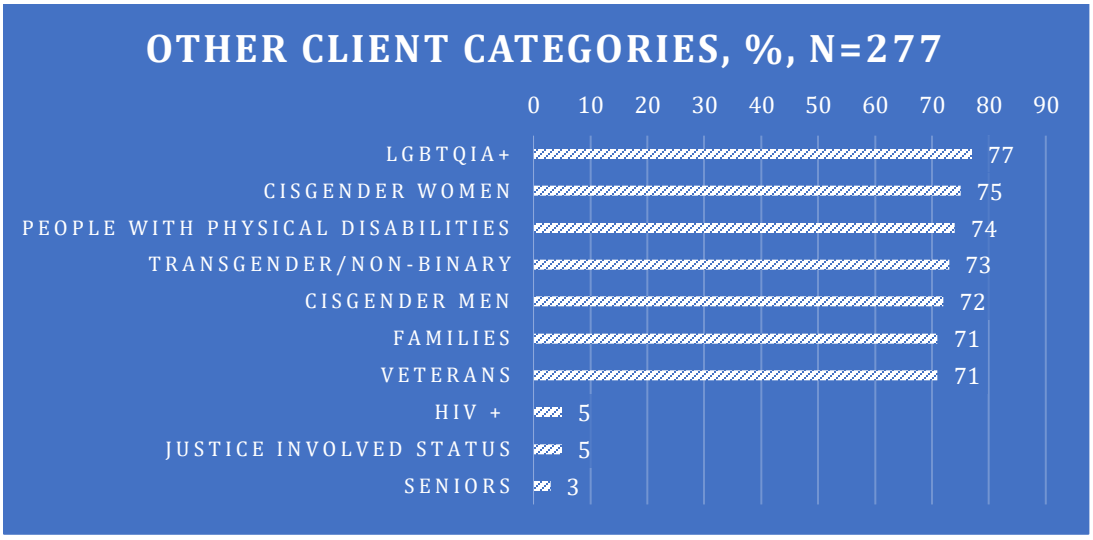
Note: We are missing some data in response to this question, because 43 (13%) respondents skipped it.

Figure 16. Client racial and ethnic groups, n=277.



Note: We are missing some data in response to this question, because 43 (13%) respondents skipped it.

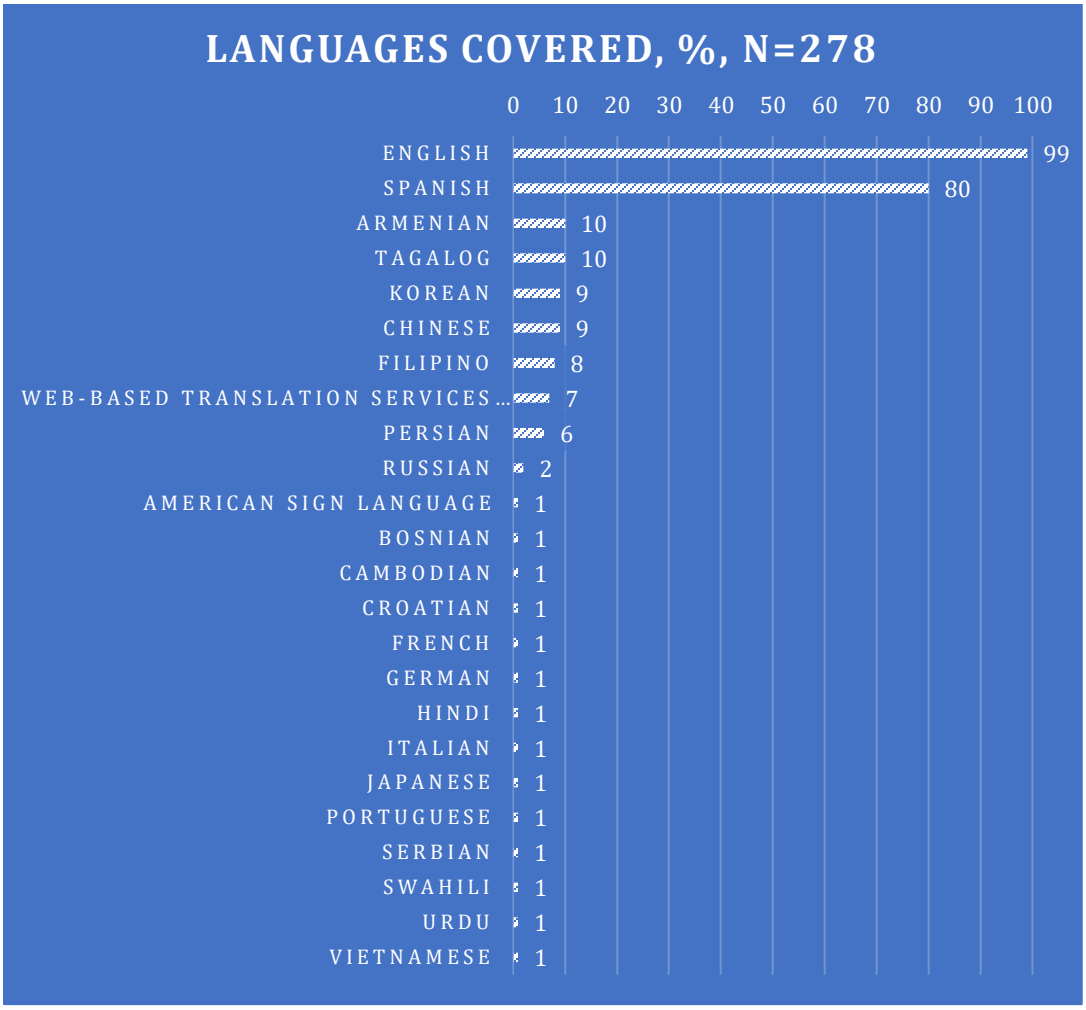
Figure 17. Other client categories served, n=277.



Note: We are missing some data in response to this question, because 43 (13%) respondents skipped it.

Overall, survey responses and interview discussions indicate that language needs are generally covered as needed for each organization's area of operation and clientele. Figure 18 lists the percentage of organizations that provide services in various languages. The response options were: *English, Spanish, Korean, Filipino, Armenian, Chinese, Persian, Tagalog,* and *Other*. In this chart we include responses to the answer options and the open responses that some wrote in.

Figure 18. Percentage of organizations offering services in each language, n=278.



Note: We are missing some data in response to this question, because 42 (13%) respondents skipped it.

2.3. Fiscal Resources

Research Sub-question

- How are organizations funded?

Key Points

- Non-profits, FBOs and CBOs rely on a patchwork of relatively short-term funding from government and private funders.
- Insufficient funding was seen as the most pressing funding challenge (67%), especially for FBOs, followed by funding with too many restrictions (47%), felt especially by non-profits, high operating costs (47%), and short-term funding terms (39%).
- Funding often comes with inherently different conditions and requirements, so organizations expend considerable time and effort to manage the benefits and disadvantages of one type of funding compared to another. Different funding sources with inconsistent reporting requirements were seen to be particularly unhelpful.
- Private funding is perceived as more effective because public funding falls short in several areas.
- Many organizations had insufficient resources to apply for, acquire, and manage more funding.
- Public agencies generally need for more funding from state and federal levels.

Both the survey and interview protocols elicited information about how organizations are funded. First, we asked organizations to select all that apply for their sources of funding, and the results are reported in Table 1 (p. 5) for each type of organization. We also asked participants to tell us what their most pressing challenges were, with the option to select all that apply from the following list: *insufficient funding; funding with too many restrictions; short funding terms; operational costs.*

Of all respondents to this question (n=283), 67% identified insufficient funding as the most pressing challenge, followed by funding with too many restrictions (47%), operational costs (47%), and short-term funding terms (39%). Table 10 below shows how these funding challenges were rated across organization type, highlighting that FBOs felt insufficient funding to be more acute compared both to other responders and to other funding challenges, while non-profits flagged funding restrictions as an issue, more so than other respondents.

Table 10. Percentage of organizations for each funding challenge by organizational type, n=283.

Pressing Challenges	% Non-profit	% FBO	% CBO	% Public Agency

Insufficient funding	65	72	67	62
Funding with too many restrictions	52	40	17	38
Short funding terms	44	29	33	46
Operational costs	47	50	33	38
Note: We are missing some responses to this question, because 37 (12%) respondents skipped this question.				

Next, we focus on findings from the interviews. Overall, we heard non-profit, FBO, and CBO participants describe a patchwork of relatively short-term funding streams from public agencies (local, state, federal), private foundations, other philanthropy, and church member or general public donations. While this diversified funding approach was deliberate, with a view to financial sustainability in the long-term, it was perceived to introduce several distinct challenges. Below we discuss each challenge in greater detail, specifying the types of organizations that mentioned them. The last sub-section explains perceptions from public agency interviewees.

2.3.1. Variation in funding amounts and costs covered

The first challenge is that funding streams vary in amount and what costs or services they support. Non-profits, FBOs and CBOs described constant efforts to manage the strengths of private funding (i.e., private foundation grants, other philanthropic donations or public donations) to address a litany of perceived shortcomings in public funding (mostly referring to reimbursement contracts with city and county agencies). These included insufficient funding, funding with too many strings attached, and continuity of service when reimbursement payments are late or when funding ends. Table 11 below describes how private funding is seen to support daytime service provision when public funding falls short. In general, most interviewees across organization types perceived public funding to constrain their autonomy, flexibility, and creativity of service provision. For some FBOs, this was a deciding factor in whether or not to pursue public funding. Overall, providers were grateful to have private support that allowed them to fund daytime services according to their mission and remit, although a few lamented that shortcomings in their public funding meant they had to use their private funding to plug these gaps instead of using private funds to support innovation in service provision.

Table 11. How private funding supports daytime service provision in LA County.

Ways that private funding supplements gaps in public funding	**Illustrative quotes**
Plug gaps when public sector grants are inadequately funded for: • Qualified service providers (first quote)	"Our current [publicly] funded contracts are not funded to really support those roles, so we've used private dollars to offset that. And it's actually allowed us to bring in a much higher-level caliber staff who, folks that have a Master's degree in social work or marriage and family therapy, who can offer a level of

• Other operating costs (second quote) • Cost of living increases (third quote)	preventative crisis management that we were just absolutely lacking." (Non-profit 2, SPA 2) "Reimbursements will never fully cover our costs, so it will always be a combination of reimbursements, philanthropy, and grants." (Non-profit 7, Multiple SPAs) "Most of our contracts don't build in flexibility to even do cost of living increases, let alone yearly or annual increases. Because we're a large enough agency, we have a bit of wiggle room to be able to flexibly leverage resources. Many of our smaller partners can't keep up." (Non-profit 2, SPA 2)
Fund services when reimbursement payments are late	"One major issue that we have continually dealt with is cash flow on our contracts… trying to figure out a better way to get paid quicker on reimbursement-based contracts. We have almost collapsed multiple times because of being behind on payments, 90 days, 120 days, I mean, even longer. There really hasn't been an institutional shift to deal with this issue other than workarounds facilitated by private philanthropy." (Non-profit 8, SPA 4)
Fund service continuity when public support ends	"They [local council district office] paid for the porta potties and the showers. But it's a new day and a new year with [changed leadership], we do not have that relationship and also the shower people are super stretched. So, we don't have that anymore and now we're paying for porta potty out of pocket." (CBO 3, SPA 5)
Fund services that are not usually within scope of public grants	"We do raise a significant portion of money specifically from philanthropy and foundations, individual donors to do the daytime services because there still are no public dollars that fund those efforts: daytime services and the wellness program. … I could imagine if there was more private dollars or more flexible dollars in the system, we could do a lot more, we could expand our library program. We could have multiple day center service sites. We could do a lot." (Non-profit 8, SPA 4)
Fund services that otherwise require excessive administration under public contracts	"In particular with the public funding sector, there are so many limits on how we can spend the funding and any sort of deviation requires a lot of red tape to cut through and it makes it very challenging. For example, a lot of our case management services involve linking folks to medical care and in the absence of one of our staff being able to physically drive someone to their medical appointments, we rely on Uber and Lyft. But for our Department of Mental Health programs specifically, we're challenged by having to get permission from our funder prior to each and every ride, which when you have 1000 clients, 2000 clients, is not feasible, so those are just costs that we have to eat and it's an integral part of services." (Non-profit 3, SPA 4)

Provide in-house services to address county-level service gaps, such as untimely referrals	"We actually have been using private dollars to build up a mental health program that's internal. The reality is that most programs are completely underfunded. I would say that the Department of Mental Health wants to be very responsive, but the reality is often they have wait lists and often it takes six to eight weeks to get an intake, which is where our internal mental health program can provide a bit of a gap fill." (Non-profit 2, SPA 2)

2.3.2. Unhelpful administrative requirements

The second challenge mentioned by non-profits, FBOs and CBOs is that managing reporting requirements for multiple ongoing public and private grants and seeking new funding can be especially unhelpful for smaller and larger organizations. The quote below illustrates this issue for a smaller non-profit:

> *"I think for organizations that are our size and slightly smaller, I think that there is a real uphill battle to write the grants, follow the grants, do all the stuff in terms of reporting on stuff for any kind of government money." (Non-profit 1, SPA 4)*

Some larger FBOs with public and private funding also described the effort they undertake to comply with funding expectations:

> *"There's requirements for reporting so we have a quality assurance in our organization to make sure that we are fulfilling the requirements of the [public and private] contracts. … We also have an independent audit on all of us, that I think is critical for the agency and my message to program people is not only do we need to be responsible for funding that we get from individual donors and foundations, but we also need to be efficient and effective in the government funding that we get from the federal, from the state, from the local [agencies]." (FBO 2, SPA 4)*

2.3.3. Funding is too short-term

Third, funding is often short term, between one and three years, which non-profits and FBOs perceived to inhibit long-term planning and other organizational growth. This quote illustrates this issue in a way that emerged often across providers:

> *"Three years is a challenge because to look only three years out doesn't match our or any agency's strategic plan which is usually 10 years out. So, there are a lot of question marks when it comes to further down the pipeline. It is a challenge to have to know that there's a sense of security and so that's really where we rely on our private foundations and private donations to sustain." (Non-profit 3, SPA 4)*

2.3.4. Funding paradox

Overall, this complicated funding landscape creates a paradox in which many organizations had insufficient capacity (e.g., staffing, expertise to compete, acquire and manage additional funding) to apply for sufficient resources At the time of the interviews, several organizations (including non-profits, FBOs, and CBOs) expressed interest in increasing their capacity to secure and administer diverse funding. This was motivated by a desire to support or expand their provision of daytime services. However, this desired funding expansion was perceived to require a level of organizational capacity that many admitted they lacked. For example, one non-profit wanted to pursue state opportunities, such as CalAIM, which funds enhanced case management and community supports. They noted the stringent requirements to become such a contractor:

> *"We just don't have the infrastructure essentially for that. You have to have a clinical care consultant. So, we'd have to have a partnership with a provider, you have to have a social worker overseeing it. So, there's requirements that we can't fulfill." (Non-profit 1, SPA 4)*

Another non-profit described their ongoing effort to expand licensing among their providers, *"so that in the future we can be sustained partially through reimbursements for our services." (Non-profit 7, SPA 5)* Finally, one agency had attempted to organize several smaller organizations as part of a collaborative funding effort, and explained the numerous barriers encountered:

> *"Walking them through that process and going through it, we realized how challenging it can be and it feels virtually impossible for some of them. They had to get their SAM number, their ID number and they have to go through that whole process. It's not that it's necessarily difficult, but it can be overwhelming for people. You have to go through that whole thing, and then getting a response back from them in a timely manner with a lot of our funding opportunities coming up with incredibly tight deadlines. And then on top of it needing that match of like in kind donations or up front cash donation. It made it so difficult for the smaller organizations to even qualify to be funded. … I can't even imagine what it's like for the ones that have never done it." (Non-profit 5, SPA 1)*

Among CBOs that operated informally and wanted to transition to a more formally organized effort, the need for technical and financial assistance was even more pronounced. One explained how they felt stuck in a catch-22 situation, unable to pursue larger financial support (e.g., more than $20,000) because they had no full-time staff, but unable to hire someone full-time without sustained financing. One registered non-profit that had started as a CBO suggested that their transition had been facilitated by a process called *fiscal sponsorship*, whereby a larger 501c3 non-profit organization extends its tax-exempt status to smaller organizations, including taking on administrative tasks such as contracting, accounting, and human resources in exchange for a percentage of the contracts awarded to the smaller organization. This in theory frees up time and resources for the smaller organization to focus on service provision. The aim for such arrangements is to build up infrastructure and expertise among smaller organizations, with the ultimate goal to reach a point when they can become independent and file for 501c3 status. However, not all CBOs were willing to formalize in order to attract more funding, as this interviewee pointed out:

"I would say not so much getting into non-profit or other sorts of arrangements. I am fully hoping for the opposite where the people with the purse strings just see what it is we do and just fund it." (CBO 3, SPA 5)

2.3.5. Funding challenges among public agencies

Finally, public agencies reported funding from general funds at municipality level, county funds (such as Measure H), state and federal funds (HUD, American Rescue Plan). Given the hierarchy of funding, a couple of participants explained that local public agencies sometimes deal with the same issues that other stakeholders experience, such as delayed payment or inability to fund certain programs when certain state or federal program funding ends, as this comment suggests:

"One of the biggest challenges in this line of work is that so much of it is reimbursement-based. So what the providers are experiencing oftentimes are the same things that we are experiencing. We are primarily a fiscal pass-through organization. We have our funders that we pull dollars from that then we dispense out to providers so the issue that the providers are having with us is oftentimes a similar issue that we are having with our respective funders." (Gov 1)

Several interviewees underscored the need for more funding from state and federal level, noting that lack of serious investment in affordable housing will undermine efforts to provide daytime services, especially when it comes to intensive case management and health care. Several respondents noted:

"One of the things we have been pushing for a long time is for the state to match the federal funding. If they were to match it, it would be more money than we have now." (Gov 4)

"If the federal government doesn't dramatically increase their levels of funding for affordable housing, then we'll keep spinning our wheels with [daytime services]." (Gov 3)

2.4. Workforce

Research Sub-questions

- What is the staff capacity? Volunteer capacity?

Key Points

- Public agencies and non-profits rely primarily and extensively on paid staff, with staff medians of 30 and 25 respectively, compared to 5 for FBOs and 0 for CBOs.
- FBOs and CBOs rely far more heavily on volunteers, with volunteer medians of 10 and 5 respectively, compared to 4 for non-profits, and 0 for public agencies.
- Professional staffing shortages were flagged by 69% of public agencies, 60% of non-profits, 53% of FBOs and 50% of CBOs.
- Volunteer shortages were problematic for 45% of FBOs, and 50% of CBOs, compared to 17% of non-profits, and 15% of public agencies.
- Professional staffing shortages are particularly acute for mental health and substance use disorder services.

Both the surveys and interviews elicited data regarding organizational workforce resources. The former sought to capture a quantitative metric of workforce size, while the latter delved into workforce strengths and weaknesses.

Table 12 below summarizes what survey participants said when asked to estimate the number of paid staff and volunteers who support provision of daytime services to people experiencing homelessness. This was an open-ended response option, so respondents typed in their estimates. This table highlights the important role that volunteers play for non-profits and FBOs in supplementing the work of full-time paid staff, whereas volunteers are vital for CBOs.

Table 12. Reported numbers of paid staff* (n=279 responses) and volunteers** (n=252 responses), by organization type.

Paid staff and volunteers, homeless services	**Non-profit**	**FBO**	**CBO**	**Public Agency**
Paid Staff, range (median)	0-18,000 (25)	0-10,000 (5)	0 (0)	0-800 (30)
Volunteers, range (median)	0-1,800 (4)	0-1,000 (10)	1-20 (5)	0-200 (0)

** We report range and median (rather than average) because several large organizations appeared to have submitted outlier estimates, perhaps also including their sites outside of Los Angeles County.*
*** The in-depth interviews with providers brought up an important point about volunteer estimates: when talking about volunteers, some report an overall number of volunteers which includes both regular and one-off volunteers, and can often represent thousands of individuals, whereas others mention only the regular daily or weekly volunteers, which are typically significantly fewer than 1,000, sometimes only a few dozens.*

We also asked participants to tell us what their most pressing challenges were, with the option to select all that apply from the following list: *professional staffing shortages; volunteer shortages;* and *security and risk of violence.*

Of all respondents to this question (n=283), 58% identified professional staffing shortages as an important challenge, followed by security and risk of violence (29%), and volunteer shortages (27%). Table 13 below shows how these workforce challenges were rated across organization type, highlighting that more non-profits and public agencies flagged professional staffing shortages as an issue, compared to FBOs and CBOs, but volunteer shortages were more problematic for FBOs and CBOs than for non-profits and public agencies.

Table 13. Percentage of organizations for each workforce challenge by organizational type, n=283.

Pressing Challenges	% Nonprofit	% FBO	% CBO	% Public Agency
Professional staffing shortages	60	53	50	69
Volunteer shortages	17	45	50	15
Security and risk of violence	24	37	33	31
Note: We are missing some responses to this question, because 37 (12%) respondents skipped this question.				

Another open-ended survey question that garnered responses about staffing was *Where in Los Angeles County do you see the biggest gaps?* While most respondents to this question wrote in locations of perceived gaps (n=121 of 182 respondents, presented in Table 9), one-fifth perceived staffing gaps in general and staffing for mental health and substance use disorder services in particular. This finding aligned with our interview results, where almost all stakeholders described workforce challenges, with some variations. Non-profits and public agencies experienced challenges with paid staff turnover and shortages, which was perceived to be acute for certain types of services, such as therapists to address mental health and substance use disorders. The shortages in trained and certified staff pre-dated the COVID-19 pandemic but were exacerbated by the resulting lifestyle changes and workforce preferences for remote work. Similar challenges were identified in the environmental scan as well. [6,7]

To address this problem, some providers seek partnerships that facilitate pipelines to staffing, such as trainee students who need certification. This quote is representative of how this issue was framed:

> *"Staffing right now is the biggest challenge. I think we've seen collectively just a major shift in our workforce and our partnerships with local university and graduate programs has been really helpful. We could use a lot more of that just as a pipeline into the workforce. I think we've seen staff shortages across the board but specifically, with our mental health positions. I think because the need for mental health services across the board has grown so tremendously, the workforce that we've relied on in the past, when faced with doing field-based services where you are 100% out in the field, having to mask up and do outreach versus sit on your couch and provide therapy from your laptop. We've not been able to compete with that and I think we've made a lot of adjustments in terms of salary, thanks to our private foundations and donations. I don't know that it's a problem that money can answer, unfortunately." (Non-profit 3, SPA 4)*

Unlike non-profits and public agencies, CBOs and FBOs noted a significant dependence on volunteers to reach their organizational goals, which is seen to bring both strengths (due to highly

motivated, hardworking, and reliable volunteers) and challenges. Some FBO stakeholders said that over the years their volunteer base had been diminishing, through both aging and decreasing church attendance. One interviewee described their problem as follows:

> *"I think that there's enough money in the system that if we could find within the church family, a couple of more volunteers that were willing to do it, that we have enough funds that we could do a couple of locations. And I have made appeals if somebody's interested in participating in the ministry to let me know, and so far nobody has come forward." (FBO 1, SPA 2)*

CBO interviewees spoke about reliance on dedicated volunteers who typically work full time or have family commitments, which presents difficulties for coordination, as this comment suggests:

> *"We have about 80 volunteers participating in different activities over six days a week, sometimes seven. We are doing both our grocery program now and our homeless outreach work. So we're at the point where myself personally, I'm putting in so many hours that it is not sustainable if we can't figure out a way to make me staff or hire staff." (CBO 1, SPA 5)*

Both interviews and past evidence suggest that this workforce model might create a host of planning problems,[8-10] because relying significantly on volunteers can create complications in efficiently finding and managing available volunteers, especially for evening and weekend hours, or for help with urgent time-sensitive issues.

Finally, staffing shortages were also an issue for public agencies, for some of whom staffing levels were perceived as not commensurate with the needs for homeless services. One agency noted that *"COVID brought a lot of budget cuts, so their staff is short, my staff is short, our grants program got cut. So those things all went away. (Gov 5, SPA 5)"* Another public agency described a similar issue:

> *"[Without that specific grant] generally it is me and actually it's part-time me because … I tag team for other responsibilities in my division and then it's a part-time secretary who also tag teams together. So, my team is me, technically, it's me. So [with a new grant] I have been able to hire some staffing, mostly support staff to do some work for me. That again will go away as of September 30th of 2024." (Gov 4, Multiple SPAs)*

Similar to some of the non-profits, to overcome staffing challenges, some government agencies look to establish partnerships that facilitate pooling of staffing resources, as this interviewee explained: *"It's a very big system and so right now they're stretched pretty thin. The idea of bringing on our additional partners is to be able to concentrate those outreach efforts and be more strategic in our deployment with the other outreach providers." (Gov 6, Multiple SPAs)*

2.5. Physical Infrastructure

Research Sub-questions

- What is the organizational scale?
- How many people can each site serve in a day at maximum capacity? How many do they serve per day on average?

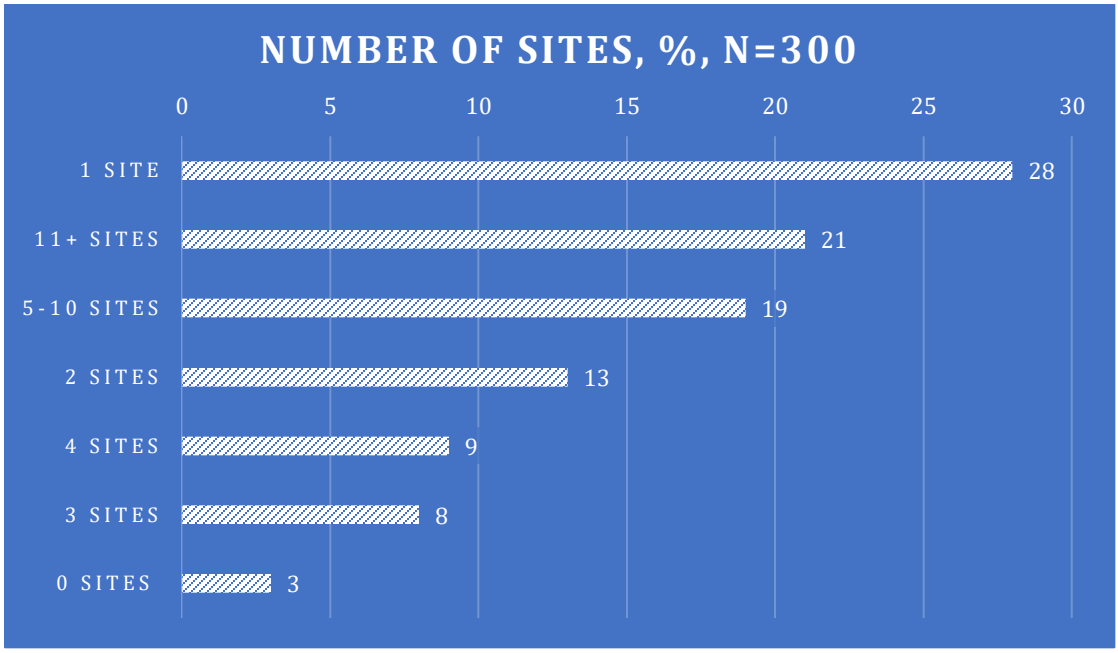
Key Points

- Providers vary in scale and physical capacity: 40% listed more than five sites, 30% had two to four sites, 28% operated at single sites, and 2% had no client facing office, offering mobile services instead.
- What constitutes physical infrastructure varies with type of daytime service offered, ranging from mobile health vans, shower trucks, storage for donations, to interior design.
- Challenges included building, space, and access issues (53%) and equipment shortcomings (27%).
- Many expressed a need for expanding or enhancing their physical infrastructure, such as adding facilities for showers, storage, loading bays for donations, or additional vans/trucks for mobile service provision.
- Survey data suggest there may be additional client capacity across SPAs.

Both the surveys and interviews elicited data regarding organizations' physical infrastructure. The former sought to capture a quantitative metric of infrastructure. That is, we asked participants to write in the service capacity in terms of clients served and the number of sites they had, whereas the latter aimed to contextualize these metrics by delving into unique infrastructure challenges associated with the types of services they provide.

As reported in Table 9, across SPAs there may be extra capacity among organizations, when comparing the median number of people served daily (100 in each SPA) versus the median maximum capacity (between 140 and 200). See Figure 19 below, showing that nearly one-third of survey respondents operated at single sites, one-third had two to four sites, and 40% listed more than five sites. Three percent of respondents had no client facing office, but instead offered mobile services at pop-up sites or encampments. On average, non-profits reported 8 sites, FBOs 9 sites, CBOs 1 site, and public agencies 38 sites.

Figure 19. Percentage of organizations by number of sites, n=300.



Note: We are missing some data in response to this question, because 20 (6%) respondents skipped it.

We also asked participants to tell us what their most pressing challenges were, with the option to select all that apply from the following list: *buildings, space, and access issues; equipment shortcomings*. Of all respondents to this question (n=283), 53% identified buildings, space, and access issues, followed by equipment shortcomings (27%). Table 14 below shows how these infrastructure challenges were rated across organization type, highlighting that while more than half of each organization type reported buildings, space, and access issues as a challenge, more CBOs and public agencies rated this as a challenge.

Table 14. Percentage of organizations by each challenges type, n=283.

Pressing Challenges	**% Non-profit**	**% FBO**	**% CBO**	**% Public Agency**
Buildings, space, and access issues	51	54	67	62
Equipment shortcomings	15	17	17	23
Note: We are missing some responses to this question, because 37 (12%) respondents did not answer this question.				

Considering the range of daytime services offered in LA County, physical infrastructure is a very broad concept. In provider interviews, not all entities expressed infrastructure needs in the same way. Depending on what service or combination of services they offered, perceived gaps varied across providers. Organizations that focused on core services noted the need for expanded facilities for showers, bathrooms, and laundry; storage space for food or clients' personal items; space for daytime rest and relaxation; parking space to accommodate deliveries or mobile service provision. For example, *"Right now in the current space that we're in, we're very limited because*

we don't have a loading dock, we don't have the space that we need in order to receive produce and goods from larger organizations." (Non-profit 1, SPA 4).

A few organizations that provide services such as case management, support groups, or health care (both mobile and fixed location) noted various needs, from adequate interior space design and outside green space for group activities, to expanded fleets of vans. For instance, one non-profit provider described the importance of purposeful design when serving unhoused clients:

> *"It's not a huge space, and I think it definitely affects our ability to facilitate more. And to be honest, the building is not designed for what it is we do. … It's a lot of little rooms. But if I were to start over and have my own ability to design a building structure, it would be a lot more open and horizontal rather than having two stories with little, tiny rooms." (Non-profit 8, SPA 4)*

Other interviewees echoed the importance of thinking about *"how to make [day spaces] user friendly" (FBO 2, Multiple SPAs)* or *"useful and robust and welcoming, and use them as a place for service connectivity as well as socialization and stabilization… just a safe environment for people." (Gov 5, SPA 5).*

PART III. Service Documentation and Information Sharing

In this section, we summarize findings under the second research question: *How do service providers document their provision of daytime services?* We first describe the type of data organizations collect, specific software platforms they use to manage data, and perceptions on information sharing. Then we focus on their perceptions around LA County's Homeless Management Information System (HMIS). Throughout we point out perceived gaps in service documentation.

Research Sub-questions

- (How) are organizations documenting their service provision?
- Are organizations using specific tools to document their service provision outside of HMIS (e.g., Excel, Apricot, other case management tools, other public/private records system like Electronic Healthcare Records systems)?
- What is the current gap in documentation of daytime service provisions in LA County?
- Do organizations know about the Homeless Management Information System (HMIS)?
- Have they tried to access or utilize it in the past?
- Are they interested in learning more about and starting to use HMIS to document services?

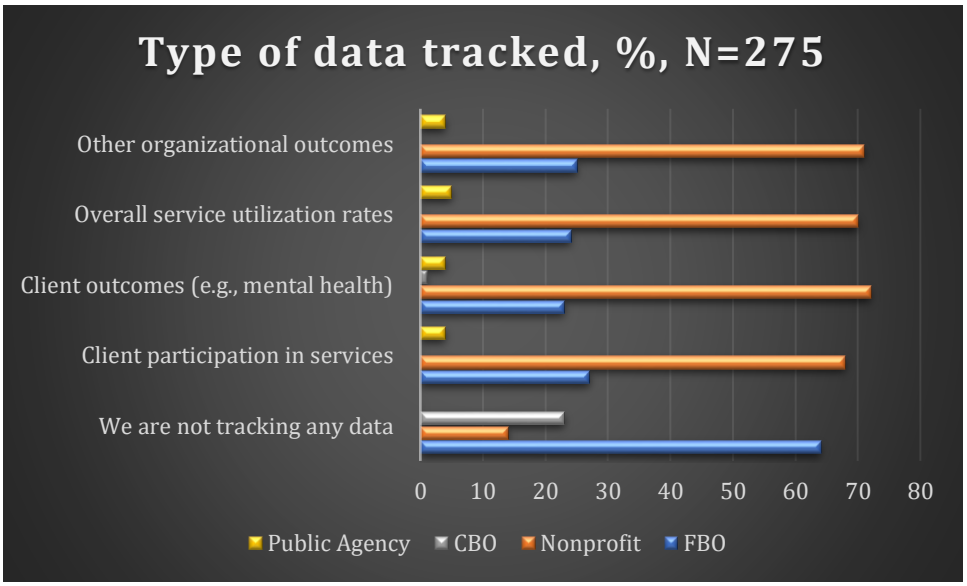
Key Points

- Most respondents collected client data (90% name or contact information, 80% demographic data); 60% gathered housing history, case manager and/or provider connections, mental health history, disability status, substance use history, and physical health history; fewer collect past service utilization (56%), history of interpersonal or other violence (53%), and criminal records (42%).
- A quarter of those interviewed perceived that data collection was not adequately funded.
- Service documentation and data sharing are somewhat fragmented and inconsistent, and thus less actionable. Many perceived "data silos" at agency level.
- FBOs and CBOs said they collected less data compared to non-profits and public agencies, primarily out of concern this may impede client trust. Among those organizations that collected no data (n=22), two thirds were FBOs and a quarter were CBOs.
- Only about half of providers said they used HMIS.
- Discussions revealed important perceived strengths but also problems with HMIS, which are seen to affect data quality and reporting accuracy.

3.1. Type of Data Collected

The survey asked several questions about documentation of daytime service provision. First, we asked what type of data respondents tracked, with the following answer options: *we are not tracking any data; client participation in services; client outcomes (e.g., mental health); overall service utilization rates; other organizational outcomes (e.g., efficiency).* Findings suggest that service documentation is inconsistent across types of organizations, both in terms of what and how data are collected and shared. For example, among those tracking no data, more than half are FBOs and just over 20% are CBOs, whereas non-profits collect a broad range of data (see Figure 20).

Figure 20. Percentage of participants for each type of data tracked, by organization type, n=275.



Note: We are missing some responses to this question, because 45 (14%) respondents skipped it.

We also asked about what type of client data organizations were collecting, with a set of closed ended answer options. When it comes to reported collection of client data (n=274), most providers said they collected name or contact information (90%) and demographic information (80%). About two-thirds said they were gathering mental health history (61%), physical health history (58%), disability status (61%), substance use history (60%), housing history (62%), and case manager or provider connections (62%). Around half said they were collecting past service utilization (56%), and history of interpersonal or other violence (53%), and somewhat fewer than half were gathering data about criminal records (42%) and other relevant personally identifiable or legally protected information (44%).

In interviews, we heard several providers note that data collection is often not adequately funded, which means not enough staff resources are available to ensure quality of data collection and reporting, as this comment suggest:

"Fund us. We need the staff to have the time to do that. And if you're concerned that we're not out there every second interfacing with the next homeless person that showed up, but you also

don't build in admin time into your contracts, no, they don't have time to go down and log every single service that they provide." (Non-profit 6, SPA 2)

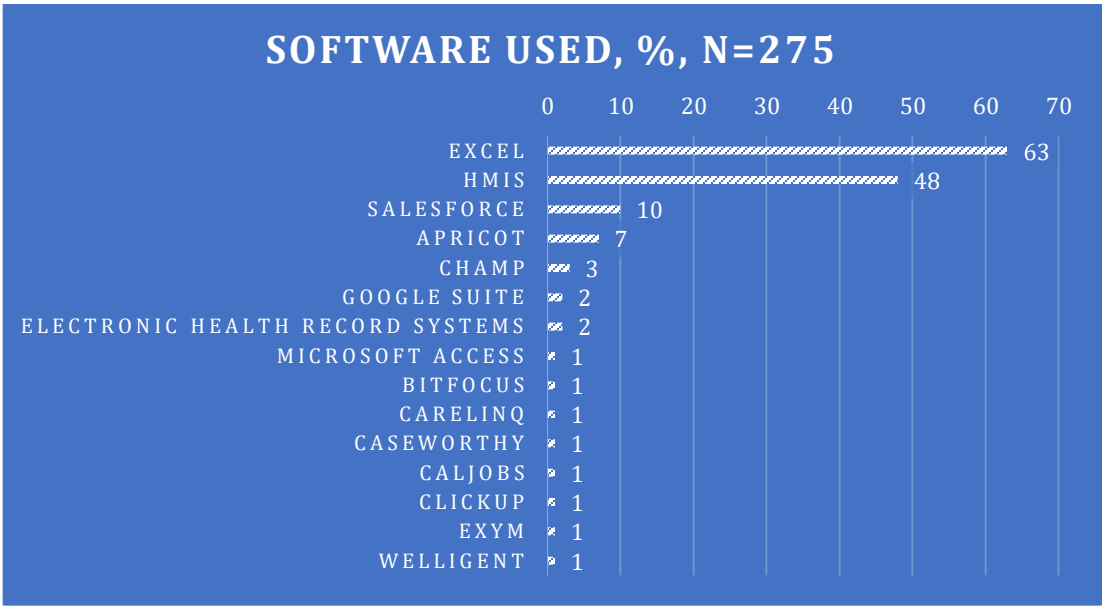
A few interviewees from non-profits, FBOs and CBOs also brought up the issue that frequent and intrusive data collection can impede rapport and trust building with their clients. Our discussions suggested that this applied to data required by both government contracts and partnerships among non-profits, FBOs, and CBOs. The comment below is illustrative of the issue:

"We absolutely do not do intakes when people come in. I'd say that in terms of an evaluation or an assessment of someone, sometimes that takes place over several conversations rather than just me asking you a list of 15 questions. Our staff are really strategic to try to get stories from people and understand where they are so that we can identify strategies to help them move forward when or if they want to take those things on." (Non-profit 8, SPA 4)

3.2. Software Platforms for Data Management

Next, we asked what platforms respondents used to manage their services, with answer options: *HMIS; Excel; Apricot; Salesforce; Other.* Respondents could select all that apply. Only about half of survey respondents (48% of n=275) said they used LA County's Homeless Management Information System platform (Clarity®), with 63% reporting use of Excel (see Figure 21 which shows software use for all respondents). Of those organizations using Excel (n=172), 68% were non-profits, 27% were FBOs, and 5% were public agencies. Among HMIS users (n=133), 64% are non-profits, 30% are FBOs, 5% are public agencies, and 1% community-based organizations. Next, we wanted to understand how some organizations may have access to HMIS, given the stricter criteria for HMIS licenses (discussed in detail in section 3.4 below). A closer examination of HMIS users by their reported co-location with other agencies (discussed in more detail in Part IV) shows that among those with access to HMIS, 54% said they have other organizations co-locating at their sites, and 37% said they co-locate at other agencies. Among HMIS users that are FBOs, 28% have other agencies co-locate at their sites, and 24% said they themselves co-locate at other agencies. This suggests that perhaps some HMIS use may occur through partnerships with other organizations that have an HMIS license.

Figure 21. Percentage of Software Used, n=275.



Note: We are missing some responses to this question, because 45 (14%) respondents skipped it.

3.3. Information Sharing

In interviews, providers often lamented data silos at agency level, whereby many important service providers maintain their own systems without communication and connectivity to other organizations. Examples of such data silos included LAHSA, Department of Children and Family Services (DCFS), Department of Mental Health (DMH), Department of Public Social Services (DPSS), the Domestic Violence (DV) system, and the street medicine providers. This comment is representative:

> *"It's not only that it's not bidirectional, the County departments each have their own systems. So it's a challenge in terms of who has access to what with respect for confidentiality and HIPAA practices. But as a result you only know the amount of information in your system and you can access some small data points like copies of IDs. But generally speaking I wouldn't be able to go into one system and identify how many times a person has been incarcerated or hospitalized or engaged with the EMS in the last, you know, three months. Which from a homeless services standpoint, that's really good data to have to really understand. We're operating from limited resources." (Non-profit 2, SPA 2)*

Many organizations that manage a combination of government and private funding are required to use various systems to report their activities. It is not uncommon for a non-profit to use HMIS (for their LAHSA contracts), CHAMP (for their DHS contracts) and other records databases. However, these software platforms are not integrated and do not communicate with each other. This creates a significant organizational burden to manage data across these platforms. In practice this can also mean that an organization with clients who may have entered the service

system differently (e.g., some through DHS, some through DMH, some through street outreach), may not have the same type of data across all their clients. We often heard comments such as this:

> *"We're using HMIS, and about four other systems. ServicePoint, our DHS housing for health programs use CHAMP, our mental health programs use our own internal electronic health record. It's called XTEM, and I think if our Chief Compliance and Evaluation Officer were here, she would impart the struggle of using multiple systems that don't communicate with one another. In terms of data collection, we do have to rely on a lot of our own internal practices to get to unique numbers because a client who's seen in outreach is going to be tracked in one system. If they're also receiving mental health, those contacts are going to be tracked in another system, and then their medical. It gets to be very challenging to see how many services it does take to actually lead someone through the system." (Non-profit 3, SPA 4)*

In addition, some organizations may be collecting data that are different from what is collected at County level, which further impairs alignment of data measurement and sharing:

> *One of the things that we were very adamant about collecting early on in [our City], that was last known zip code, because we wanted to know where people were becoming homeless. Because we really needed to see 'is there's something we need to do different in [our City] to make sure our folks don't become homeless' and be able to prioritize and help define our fair share of the problems. … Historically, people just wander into our community and so HUD changed their data standards back in 2010 or 2011 to say you no longer need to collect that information, which was then hard for us because we still ask our agencies to do it but people that use the County system don't do it. So they're not used to doing it and so we lose a lot of that data. (Gov 5)*

3.4. Homeless Management Information System

We asked respondents how familiar they were with the Homeless Management Information System, with the following answer options: *haven't heard of it; have heard of it, but never used it; or have used it in the past but not currently.* They could only select one option. Forty percent of survey respondents to this question (110 of 275) said they had not heard of HMIS, whereas 38% had heard but never used it. Among those who reported using HMIS either now or in the past (n=132), 49% felt it was *highly beneficial*, 46% said it was *somewhat beneficial*, and only 5% said it was *not at all beneficial*. Among all respondents, 44% were interested in learning more about HMIS, with one-quarter *not interested* and one-third *unsure*.

Interviews with public agency stakeholders clarified that use of HMIS requires payment of user licensing fees, which become more costly as user privileges increase (e.g., read-only access versus full access). In issuing these licenses, LAHSA considers, among other things, if providers are funded by LAHSA or not, and how user access is purposeful and aligned with what an organization does, especially given the amount of client-level personal identifying information that exists in the system. At the time of the interview, it was estimated that there were "probably tens of thousands" of licenses in LA County.

Some providers appreciated the intent of HMIS and saw it as helpful to document client encounters and identify case managers for clients seen through street outreach efforts. However, many also brought up several perceived weaknesses related to how the County's HMIS platform is currently set up. Table 15 below summarizes these weaknesses with supporting quotes.

Table 15. Perceived weaknesses of Los Angeles County's Homeless Management System Information Platform.

Theme	Illustrating quotes
HMIS does not track client experience data (first quote) or client milestones (second quote) that could inform future referrals	"We try to track how people have done when they've gone somewhere before previously, which is not tracked in HMIS. 'What are your experiences?' It makes a big difference if somebody's always had bad experiences moving into a congregate shelter, you probably don't want to offer them that again, because maybe there's a different way that they can go." (CBO 2, Multiple SPAs) "We document through the lens of milestones rather than just hard outcomes that maybe you would document in HMIS, for instance. 'I had a significant conversation with so and so today who hasn't been talking for like six months, this person got their ID.' Our information gathering is very nontraditional." (Nonprofit 8, SPA 4)
HMIS does not always facilitate data accuracy, with input quality varying depending on user thoroughness (first quote) and how staff interpret data fields (second quote)	"It's not an easy thing to do the level of detailed data entry that makes HMIS useful. So with the level of turnover of staff at non-profits, it's very difficult to maintain high data quality." (Gov 5) "Within HMIS, you record when a referral is made and then later you go in and you can update to confirm that that referral was obtained or not obtained. … But if you just don't see your participant again who you've been working with for weeks, is it because they attained that referral? Is it because they've left the state and they live somewhere else now? So that's going to be participant closed out of the system, no exit interview, destination unknown, but you made those referrals for that person. So that can be a challenge as well. 'Referral made' and 'referral attained' is not intrinsically tied together in the system, you have to manually go in and update it based on your best knowledge of what happened, sometimes days, weeks, months or years after that referral was made." (Gov 3)
HMIS does not standardize reporting quality, as frequent changes to data fields are seen to affect accuracy of reporting and long-term data continuity	"There's been a lot of changes in HMIS, like constantly. … When we're trying to pull data back out, [these changes] make it extremely complicated to get accurate data. They'll change where fields are at, which seems like nothing. But now, my data person has two or three different historical fields that they have to go in, create a formula for it to pull out all of that data that used to just be one field. Things like that have been a challenge. … We're constantly trying to figure it out on our own, and I'm assuming every SPA is doing that. So it does make me question how accurate is this across the board, because we struggle, and everybody has their own way of doing it, everybody pulls it differently." (Non-profit 5, SPA 1)
HMIS takes a long time to update data in the system, which precludes flexibility in	"When you update data, it takes 24 hours for that to be reflected in the system and in reports so there's really not an ability to be nimble and quick with what we're trying to evaluate and process." (Non-profit 3, SPA 4)

service provision	
HMIS does not focus on end user experience, as its user interface is not perceived to be friendly or intuitive	"There are ways that the system could be simplified and that it could be a little bit easier to use. I wish there was a little bit more collaboration with providers in how HMIS is built because the reality of trying to track some of this data on a day-to-day program like the Access Center, it can get a little hectic and so to then go through this interface and collect tons of information, it's just not realistic." (Non-profit 2, SPA 2)
HMIS does not allow universal level of access, as users have varying access privileges, and the resulting hierarchy is perceived to frustrate coordination	"It makes data sharing from the non-profit to the government oversight world very difficult. It also encourages some organizations to silo their data. And it also makes collaboration between service providers that are HMIS certified and those providers which are not very difficult. … We have faith-based organizations in regularly to do things like serve food at our lunch counter. But we don't really connect to faith-based organizations for things like helping our outreach team. I'm sure if there are organizations that wanted to do that kind of work, we would be happy to connect with them. But it would be difficult because of the differences in access and the confidentiality issues around HMIS and figuring that out I think would be very important to being able to build a broader base of community organizations that could work together." (Non-profit 4, SPA 5)

PART IV. Inter-Organizational Collaborations

In this section, we summarize findings under the third research question: *How do daytime service providers connect to the Los Angeles County homeless service system and overall public sector?* We first provide an overview of how organizations collaborate with each other, then we examine how collaborations vary by type of organization. We then focus on how organizations identify referral options and describe their perceptions around referral success. In the last section we describe collaborations with public libraries.

Research Sub-questions

- How are the organizations connected to one another and to the larger homeless service sector?
- Who does the site receive referrals from?
- Who does the site provide referrals to?
- Who does the site hold contracts with? (e.g., public agencies, non-profits)
- What existing co-locations/partnerships exist at the site?
- Are organizations connected with searchable resources databases (e.g., 211, LAHSA's Get Help page, WIN, Aunt Bertha, 1Degree)? Which ones and in what way?
- What partnerships currently exist with public libraries and public transit?

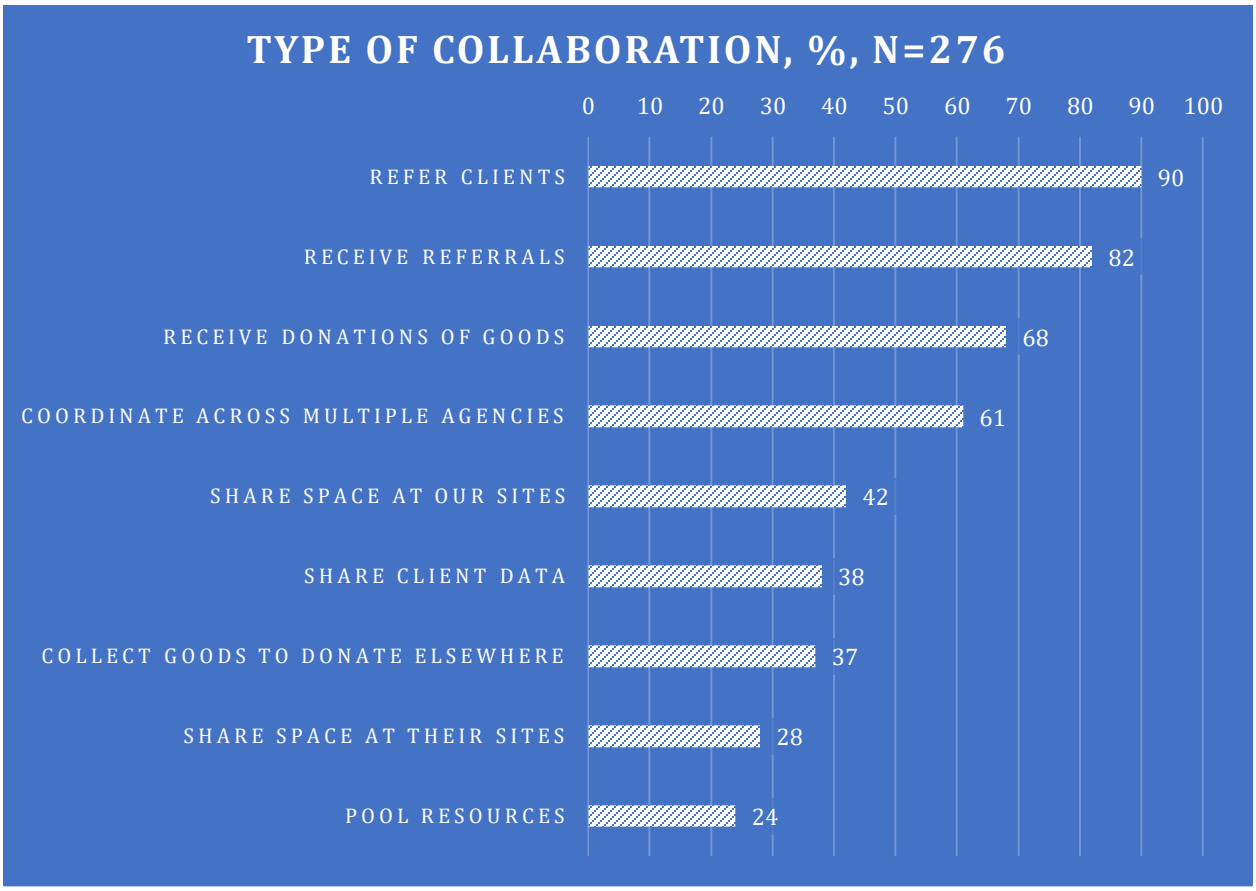
Key Points

- There is considerable inter-organizational collaboration; however, it is typically local, informal, and lacking a centralized strategy.
- There are mixed approaches to collaboration depending on organization size rather than type. Larger providers tend to collaborate laterally (across the spectrum of providers) and vertically (from local to federal levels). Smaller scale providers tend to collaborate more at local community level.
- Frequency of interactions with partners depends on the service provided.
- For the majority, making (90%) and receiving (82%) client referrals is the dominant form of collaboration. Predominant referral mechanisms were LA's 211 Directory (67%) and their organization's own directory (59%).
- A majority felt their referrals were mostly (69%) or almost always (18%) successful. Referral success was seen to vary according to client motivation and/or available resources at other organizations. These issues were often overcome when organizations had good rapport with partners, effective and motivated case management, and reliable in-house provision of services like mental health.
- General public services, such as transportation and libraries can be of considerable value, although collaborations are somewhat limited, and have been affected by funding cuts during the pandemic.

4.1. Overview of collaboration

In survey and interview data, stakeholders described extensive efforts to share information and resources, but these efforts are typically local, informal (reliant on individual initiative and connections), and lacking a centralized strategy. In the survey, we asked participants if they worked with other organizations, and nearly all said they were working with other organizations (95%). The others said they were either not working with others but interested (4%) or not collaborating and not interested (1%). Next, we asked those who were working with other organizations to select all that apply from a list of types of collaboration. Figure 22 details how providers collaborate with each other, highlighting that referring clients was the dominant form of collaboration across stakeholders. More than half of respondents also said they coordinated across multiple agencies and received donations of various goods. For organizations that do case management (n=219), we asked with whom they were coordinating care: 72% coordinated with social services providers, 71% with housing providers, while 63% coordinate with health providers. Fewer than half of respondents said they shared space through co-location (42% "share space at our sites" and 28% "share space at their sites"), and 38% shared client data. Pooling of resources was only reported by one-quarter of participants.

Figure 22. Percentage of organizations engaging in each type of collaboration, n=276.



Note: We are missing some responses to this question, because 44 (14%) respondents skipped it.

Table 16 shows type of collaboration by organization type, highlighting similarities of collaboration approach between non-profits and FBOs.

Table 16. Percent of organizations by type of collaboration, n = 276.

Type of collaboration	%Non-profit	%FBO	%CBO	%Public Agency
Refer clients	94	84	80	92
Receive referrals	91	67	40	75
Receive donations of goods	65	79	60	33
Coordinate across multiple agencies	61	59	60	75
Share space at our sites	45	43	0	17
Share client data	40	34	0	42
Collect goods to donate elsewhere	33	46	80	25
Share space at their sites	30	23	40	17
Pool resources	22	27	40	25
*Note: We are missing some responses to this question**, because 44 (14%) respondents skipped it**.*				

4.2. Collaborations vary by organization type

In-depth interviews revealed commonalities and differences in how stakeholders collaborate. Across organizations, the frequency of interactions with partners varies depending on the reason for their collaboration. Typically, provision of services such as medical care often involved daily coordination with partners (e.g., daily client referrals, daily coordination among mobile clinic providers regarding where in LA County they will provide services on a given day). Other services, such as legal clinics or employment training, could require weekly, monthly, or more infrequent coordination with partners, depending on the nature of their arrangement. Below we discuss some of the difference across organization types.

4.2.1. Non-profits

Among non-profit interviewees, establishing synergistic collaborative relationships was integral to meeting their service delivery goals. In general, they expressed openness to any collaboration that would help better identify and serve target clients, including with other non-profits, FBOs, CBOs, public agencies, and large and small businesses. These included partnerships to facilitate formal client referrals (e.g., to food pantries, art programs, health providers, employment preparedness), partnerships to facilitate delivery of donated goods at a non-profit's site (such as food and clothing), partnerships to facilitate co-location of services at a non-profit's site (e.g., mobile health clinics, mobile showers, legal advice, government agency), partnerships to supplement workforce shortcomings (e.g., organize church volunteers, host students for practicum hours), and other informal, ad hoc partnerships (e.g., one-off donations, information sharing to help locate clients). One non-profit interviewee explained the varying types of collaboration they manage, which is representative of what we heard across interviews:

"We're doing a lot of partnering with other service providers to do mental health services and substance use services on site, things like overdose prevention workshops, we have volunteers doing art groups, financial literacy classes, we have employment programming coming on site, we'll have community partners come on site and just table a flyer for resources that we're not offering on site, but just to be able to say, hey, if you come here you can get this." (Non-profit 2, SPA 2)

4.2.2. Faith-based organizations

We heard a similarly mixed approach to collaboration in discussions with FBO participants. Some larger FBOs collaborate formally with agencies, businesses, and non-profit organizations at federal, state, and local level, to refer clients, receive regular in-kind donations (e.g., food), and share indoors or outdoors space with mobile providers. Smaller FBOs work primarily informally with community groups and other FBOs in their neighborhoods, sharing space, donations, and other resources, or informing their patrons of each other's services. One FBO in our qualitative sample did not provide any direct services, but they support other organizations with money, *"either other faith organizations or social service agencies,"* as the interviewee explained.

4.2.3. Community-based organizations

CBOs reported frequent synergistic collaboration with other CBOs, non-profits, and FBOs, for example by sharing resources with other CBOs to organize events at various churches throughout the week or augmenting existing community events. While some CBOs structured their collaborations around a shared political philosophy, others were more pragmatic, working with corporate or political offices (e.g., local council districts) to receive financial or in-kind support (e.g., tents, Narcan). The first quote below summarizes the tensions around collaboration, whereas the second offers an example of a more pragmatic approach:

"Not all mutual aid groups share the same willingness that I do to collaborate with traditional service providers. Some mutual aid groups have taken more of an advocacy role that I think to traditional service providers feels adversarial. Because of the political background and that horizontal decisionmaking tradition, a lot of mutual aid groups that I'm aware of have even had to have a debate within themselves about, do we become a formalized non-profit? Do we not become a formalized non-profit? What are the strengths and weaknesses of going the way of the establishment? We don't want to lose our ability to make certain decisions to serve our community in the way that we exist to serve." (CBO 1, SPA 5)

"We play ball with anybody who wants to help. There's plenty of work to be done without getting dragged into political fights." (CBO 2, Multiple SPAs)

4.2.4. Public agencies

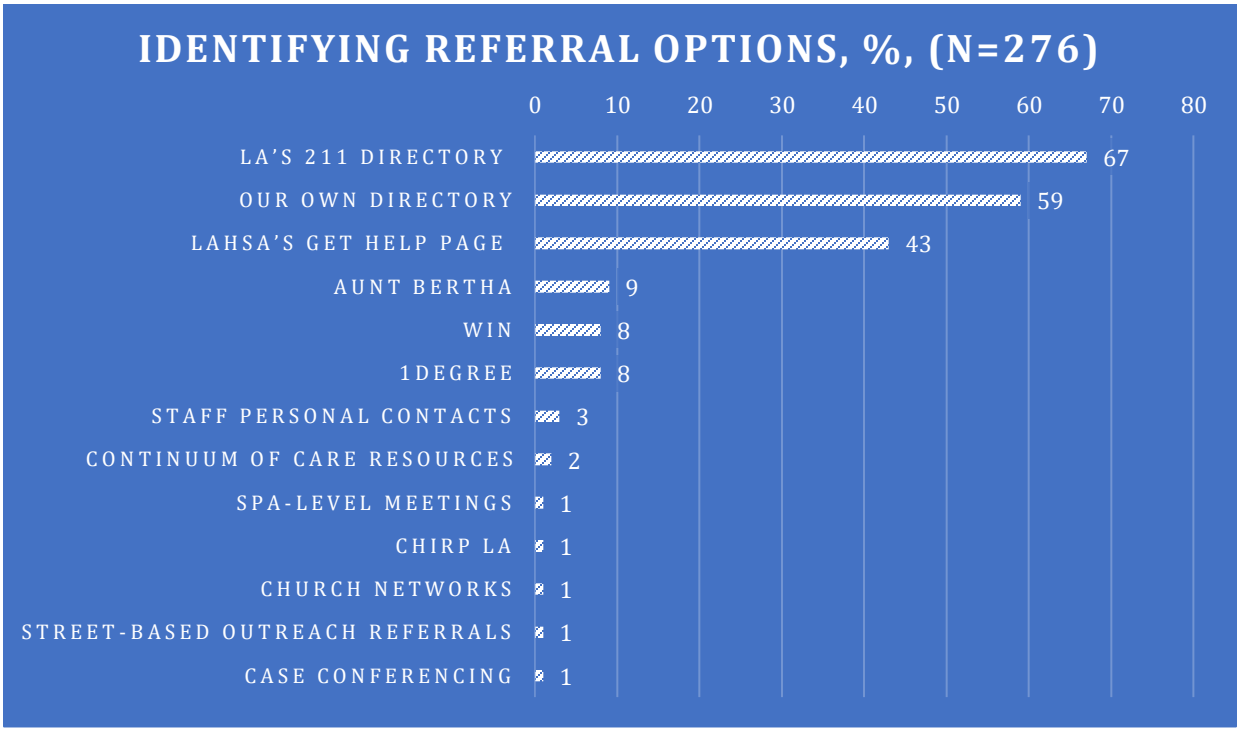
Among public agencies, narratives suggest that collaboration occurs more often within, rather than across, administrative jurisdictions, such as at city level, county level, SPA level, and special

jurisdictions such as schools or business improvement districts. However, Councils of Governments (COGs) that operate under joint powers authorities or memoranda of understanding have emerged as an important facilitator of regional collaboration among cities: *"the COG is a great way for us to collaborate with other jurisdictions, Culver City, Beverly Hills, West Hollywood." (Gov 5).*

4.3. Identifying referral options

In the survey, we asked respondents to tell us how they identify potential options where they can refer clients. They could select all that apply among *LA's 211 Directory; LAHSA'S Get Help page; WIN; Aunt Bertha; 1Degree; Our own directory;* or *Other.* In Figure 23 below we list the answer to these categories, but also the ones listed under "other." A majority of respondents (67%) said they used LA's 211 Directory and nearly two-thirds also said they have their own directory.

Figure 23. Percentage of organizations using each type of referral identification option, n=276.



Note: We are missing some responses to this question, because 44 (14%) respondents skipped it.

In in-depth interviews, we heard some providers explain the advantages of building in-house service referral directories, which included the ability to update contact information based on personal networking, ensuring that the organizations where they refer provide care based on shared values (e.g., trauma-informed), and accounting for client experience feedback:

"There are many groups out there that either don't provide trauma-informed care or aren't the friendliest or the most welcoming place for unhoused people. So we try to identify the

groups that are very welcoming and are low barrier and easy access and refer there. And part of that is through our personal connections, and a lot of it is from feedback from the individuals that we've referred to in the past. 'We've referred you to this clinic or to this harm reduction group, how did that go? Did you like them? Did you not?' We often don't have to solicit that feedback. They'll tell us the next time we see them, but that's valuable information for us. And then there are some resources that are harder to come by or – and so then we just have to kind of refer to whatever is available. But we do always try to make a personal connection. If we're going to be referring someone to somewhere, we try to have had a conversation or a phone call with that organization at least once in the past, so we know who we are referring them to." (Non-profit 7, Multiple SPAs)

We have also heard some providers complain about the low success rate with the county's 211 directory and the homeless outreach portal (LA-HOP), as illustrated by this comment.

"We have relatively low success I would say. I mean, the 211 calls, the LA-Hop referrals are, I don't know if we've ever made a connection that way. We've tried certainly, but it's very rare. I think the first one I ever made it took like three months for me to get an email response back saying 'thank you for your referral, we weren't able to find this person or something like that'. And I know many other people find those systems to be not very helpful for actually getting outreach to individuals." (Non-profit 7, Multiple SPAs)

4.4. Perceived referral success

To ascertain perceptions about their referral programs, we asked survey respondents who said they made referrals as part of their case management (n=219) to rate the success of their referrals, choosing one of: *almost always successful; mostly successful; mostly unsuccessful; almost always unsuccessful;* or *I am not sure.* Among all respondents (n=219), 18% said their referrals were almost always successful, and 69% said they were mostly successful. Four percent rated their referrals as mostly unsuccessful, whereas 12% were not sure. Table 17 below details survey ratings of perceived general success of referrals by organization type, showing similarities between non-profits and FBOs, as well as that public agencies felt unanimously that their referrals were successful.

Table 17. Percentage of organizations by each type of rating of referral success, %, N=219.

Perceived success	% Non-profit	% FBO	% CBO	% Public Agency
Almost always successful	12	21	0	0
Mostly successful	69	65	0	100
Mostly unsuccessful	5	4	0	0
Almost always unsuccessful	0	0	0	0
I am not sure	15	11	0	0

Note: These percentages are only based on the sample of organizations that provide case management, which is only 75% of the entire survey sample.

To better understand what motivated these ratings, we next asked respondents to explain their rating in a comment. Of the subsample of respondents (n=219) who rated the perceived success of their referrals, 146 provided narratives explaining their choices. The prevailing themes of these narratives were: variations in client motivation and barriers (n=42), variations in resources and eligibility criteria at other agencies or in the community (n=39), positive rapport with other organizations (n=22), intensity of case management (n=22), care model approach (n=18), and limited follow-up both at referral source and destination (n=18). Other themes mentioned less often included organizational longevity (n=3) and staff training on referrals (n=3). Table 18 details the thematic range by rating, showing how these dimensions manifested themselves across successful and unsuccessful referral programs. The key point is those who rated their referrals as either *almost always successful* or *mostly successful* cited positive rapport with partner organizations, effective and motivated case management and reliable in-house service provision as ways to manage challenges that are outside of their control, such as the variations according to client motivation and/or available resources at other organizations.

Many of the themes from the open-ended narratives on referrals' success rate also emerged in our interviews across non-profits, FBOs, and public agencies. For example, one public agency provider explained that workforce turnover and the related frequent need for staff training on referrals was a reason why they often experienced delays in receiving referrals from access centers:

> *"I have two particular sites that have been a little bit more difficult to work with. A lot of it is really, honestly, contingent on staffing. We find that the housing staffing at most of the access points has a very, very high turnover rate. And so we're either constantly training somebody how to access our services or we're constantly training somebody to understand what services we provide. And then we're constantly reconnecting with people to help explain things usually many times, sometimes several times a month. So, that's been a bit of an issue. So, sometimes there may be a delay in referrals because we have access centers that have changed staff yet again and may not understand who we are and what we do and then having to re-explain to them the service model that we have and what services we can provide." (Gov 4)*

Table 18. Thematic range by rating of referral success.

Themes	Almost always successful (n=17 unique comments out of total ratings, n=30)	Mostly successful (n=108 unique comments out of total ratings, n=151)*	Mostly unsuccessful (n=8 unique comments out of total ratings, n=9)*	I am not sure (n=12 unique comments out of total ratings, n=29)*
Variations according to client motivation and barriers (n=42)	N=1 Some clients are seen to be more motivated than others	N=35 Client may not always be ready for or willing to pursue certain services, or may lack transportation, cell phones, or identity documentation needed to attend scheduled appointments. Some clients leave the service area, and others may resolve issues on their own prior to completing referral.	N=3 Client engagement affected by COVID-19, and lack of follow-through once referred.	N=3 Limited client reach after first engagement.
Variations according to resources and client eligibility criteria at other agencies (n=39)	N=0	N=32 Lack of housing was perceived to be the dominant issue, although others noted limited capacity for mental health and substance use disorder services. Referral system is perceived to be "overloaded," with long wait lists. Eligibility for certain client categories is also seen as problematic, especially single individuals and seniors.	N=6 Referral system is perceived to be "overburdened" and "overwhelmed," with resources that "do not adequately provide the services we are seeking." One respondent noted referral difficulties during evenings and weekends.	N=1 Limited access to specialty care appointments.

Themes	Almost always successful (n=17 unique comments out of total ratings, n=30)	Mostly successful (n=108 unique comments out of total ratings, n=151)*	Mostly unsuccessful (n=8 unique comments out of total ratings, n=9)*	I am not sure (n=12 unique comments out of total ratings, n=29)*
Positive rapport with other organizations (n=22)	N=5 Relationship and trust building with other organizations, sometimes developed over many years.	N=16 Formal partnerships, relationships and rapport with reliable partner agencies that may facilitate expedited referrals and even "back door" placements.	N=0	N=1 Partner organization is co-located at their site.
Effective and motivated case management (n=22)	N=3 Case manager perseverance through "continued monitoring" of referral status.	N=17 Consistent and persistent advocacy for client, establishment of trust with client, depth of understanding client needs, persistent follow up after referral	N=1 Case managers many not always follow through after referral was made.	N=1 Currently developing a navigation program to monitor referral status on behalf of clients.
Care model that includes reliable in-house service provision and/or client-centered approach (n=18)	N=4 Services, such as behavioral health are provided in-house; organization uses a whole-person, client-centered approach.	N=13 In-house service provision for housing navigation and behavioral health, Relational Homeless Outreach Model, care coordination, and taking a client-centered approach, i.e., only referring clients to services for which they are eligible or in which they are interested.	N=0	N=1 Provision of services in-house.
Limited follow up at referral source and destination agency (n=18)	N=0	N=11 Workforce turnover at other agencies and uncoordinated data tracking limit follow-up.	N=1 No returned calls from destination agency.	N=6 Uncoordinated data, limited tracking ability for follow-up, lack of response from destination agency.
Organizational longevity (n=3)	N=2 Experience providing these services for over 20 years.	N=1 More than 7 years of experience.	N=0	N=0

Staff training (n=3)	N=2 Staff training about resources, especially when on-boarding new staff.	N=0	N=1 Sometimes staff lack the training and experience for how to make referrals.	N=0
***Note: the column totals do not always add up to the number of total unique respondents, because some comments were more elaborate and touched on multiple themes. For example, in the second column we have 108 unique respondents, but the count by theme adds up to 125.*				

4.5. Collaborations with public agencies, such as libraries and public transit

General public services, such as transportation and libraries can be of considerable value to people experiencing homelessness, but collaborations with other surveyed providers are currently somewhat limited. This may present a missed opportunity to deliver extended benefits to clients, providing case management at library locations, for example. Several interviewees mentioned long-standing collaborations with public libraries, but some of the programs were cut when the COVID-19 pandemic began. Public libraries are seen as an important public space to facilitate programs, such as adult literacy, arts, and poetry readings that bring together housed and unhoused residents. Some stakeholders were aware that libraries had been ramping up their services to meet the needs of all their patrons, including coordination with social service and mental health providers, and hosting co-located services on site:

> *"We have a relationship with the Durant Library in Hollywood. We also have one with the West Hollywood Library and we're just beginning discussions with the Westwood Public Library as well. … Some of the libraries have been happy to welcome us in. They give us a space to set up and they can be really busy days. … We have got some referrals from the libraries that there's somebody they're particularly concerned about or somebody who they know is always there. They'll ask us to come check on them, and then along with the co-location, they will always post a flyer to let people know about our services and when we'll be there next." (Non-profit 7, multiple SPAs)*

However, even the library system was perceived to be fragmented and challenging to coordinate with across the County, especially as many library branches have leeway with local programming, as this provider explained:

> *"You've got LA city-related pieces. But then you've got all the other little public libraries that may fall under their own respective cities. Los Angeles County Public Library System or if there's a city-based, like Diamond Bar has their own city-based library." (Gov 4)*

With regards to collaborations with public transit agencies, few survey respondents and interviewed providers mentioned existing or planned collaborations with public transit agencies at county or city-level. However, one public transit agency described a potential model that could expand such collaborations:

> *"The hub, it is something that we are trying to incorporate. As we bring on our new partners, we are in communication with different cities to see where that hub could be implemented and where it would be most impactful. That is something that we hope to establish this year, this fiscal year where it is in the works. … What they do in Philadelphia, what they've done is basically bring up like a pop-up for lack of a better word, a pop-up resource center where all the services and linkages to housing and different services come to one location and they provide showers, hot meals, access to applications for identification, a host of resources that are all at one location. It allows for a more seamless interaction." (Gov 6)*

PART V. Client Experience with Services

In this section, we summarize findings under the fourth research question: *How do people experiencing homelessness in Los Angeles County feel about daytime service provision?* In this section we only include results from the in-depth interviews with unhoused individuals. We first provide an overview of the interviewee sample, followed by a summary of perceived barriers and facilitators to accessing daytime services, as well as perceived service gaps.

Research Sub-questions

- What are the most important services that daytime service centers can/do provide to people experiencing homelessness?
- What are the barriers to accessing daytime services or other reasons why people choose not to go to certain sites?
- What are examples of daytime service centers that feel inaccessible, unsupportive, or unhelpful?
- What are examples of daytime service centers that feel welcoming, culturally inclusive, supportive, and helpful?
- How does the design or atmosphere of a location impact the experience of accessing services at a site?
- Do people experiencing homelessness notice differences in engaging faith- or community-based service providers versus public sector or nonprofit service providers? If so, what are those differences?
- Where do people experiencing homelessness see gaps in the daytime service landscape? Where/how would people with lived experience prioritize expansion of services?

Key Points

- We interviewed 21 unhoused residents in North Hollywood (n=2), Hollywood (n=7), Skid Row (n=6) and Venice (n=6). Their age ranged from 21-66, 12 were male, 7 female, 1 transgender, and one did not specify.
- The most important services that people experiencing homelessness used every day were food (100%), clothing (90%), personal hygiene (62%), health care (57%), and phone charging (52%).
- Participants expressed both negative and positive experiences with all types of providers, including mixed views about engaging with faith-based organizations: some were grateful for help, but a few also recounted negative experiences.
- Unhoused individuals experienced difficulties accessing services when sites are overcrowded, a long distance away, and open at restricted times.
- They often felt discouraged from using services due to rude or condescending staff, or due to perceived discrimination.
- Service access was perceived to be easy when sites are close by, and open consistently and conveniently.
- Favored organizations had friendly, nonjudgmental, and professional staff, in a welcoming atmosphere, which they often described as “calm.”
- Perceived service gaps include help with finding housing (81%), food (50%), health services (32%), places where they can just “relax”, “hang out” (32%), showers and laundry (27%), longer service hours (23%), services at the weekend (18%), phone charging (18%), and help with ID procurement (18%).

5.1. Sample overview

Table 19 summarizes the demographic characteristics of people experiencing homelessness who participated in our in-depth interviews.

Table 19. Demographic Characteristics of Interviewed Clients (N=21*).

Characteristics	Mean (SD) / N (%)
Age	
Range	21-66
Median	40
Mean	42.5 (13.74)
Gender	
Male	12 (57%)
Female	7 (33%)
Transgender	1 (5%)
Sexual Orientation	
Heterosexual	12 (57%)
LGBTQIA+	3 (14%)
Did not disclose	3 (14%)
Religious Affiliation	
Baptist	1 (5%)
Buddhist Calvinist	1 (5%)
Catholic	1 (5%)
Christian	4 (19%)
Jewish	2 (10%)
Muslim	2 (10%)
No Religious Affiliation	7 (33%)
Location of Interview	
Hollywood	7 (33%)
North Hollywood	2 (10%)
Skid Row	6 (29%)
Venice	6 (29%)
**We are missing some information for three participants*	

5.2. Perceived client experience with daytime services

5.2.1. Most important services people used

The most important services that people experiencing homelessness received every day were food provision, health care, phone charging, clothing, and personal hygiene. But all respondents returned repeatedly during the discussions to the most pressing service they needed, which was help with finding permanent subsidized housing. In general, individuals found out about most

services through word of mouth, either from other people in the same situation or from outreach workers, and by identifying services on their own (e.g., while walking around a neighborhood, searching the internet). About one-quarter cited specific drop-in centers and shelters where they were given flyers with information about services.

5.2.2. Perceived barriers to services

Table 20 details perceived barriers to accessing daytime services with supporting quotes showing that issues emerged across interview locations. Respondents spoke about access difficulties, such as having to wait a long time for services at crowded sites, distance to service sites, sites open at restricted times, and expectation to provide personal information and ID in order to receive services. The dominant reason why organizations were perceived to be unsupportive was rude and condescending staff, particularly security guards overseeing some of the sites. Some clients were uncomfortable having to exchange expressions of gratitude for service provision, and being looked down upon. Perceived discrimination due to race or gender was also a factor for a few.

5.2.3. Perceived facilitators to services

Table 21 details perceived facilitators for accessing daytime services, supported by interviewee quotes from multiple locations. Respondents described what made it easy for them to access services, which ranged from proximity to service site, consistency and convenience of service hours, to having ID. Reasons why organizations were perceived to be supportive included friendly, nonjudgmental staff, followed by a welcoming atmosphere (often described as "calm"), professional staff, and giving out clear information.

5.2.4. Perceived differences across organizations

Regarding differences in perceived experience by organization type, comments were mixed. Negative and positive experiences listed in Tables 20 and 21 occurred across a range of non-profits, FBOs, and public agencies. Attitudes to receiving help from FBOs were generally positive, and clients were grateful for services that met their needs in a dignified manner, regardless of who provided the service (see Table 22). However, several persons recounted negative experiences with an FBO (see Table 22).

5.2.5. Perceived gaps

Table 23 summarizes perceived service gaps. More than half of interviewees mentioned housing navigation as a significant gap. Half of interviewees mentioned gaps with several aspects of food provision (such as food quality, daytime availability, and warm food). A third spoke about the need for drop-in places where they can just "relax," "hang out" and take care of immediate needs. A third also perceived gaps in health provision, including mental health and transgender care. Almost a third mentioned gaps in places where they can shower and do laundry, and about a fifth flagged the need for longer daytime service hours for all services. Fewer than a fifth identified weekend services, ID procurement, and phone charging as gaps.

Table 20. Perceived barriers to accessing daytime services, including other reasons why people choose not to go to certain sites.

Themes and subthemes	Representative Quotes
Access Difficulties	
Crowded sites (n=7)	"Sometimes when you get there, there's a line. Some people do wait out there in line for about an hour before they start. Sometimes you might have to stand in line." (North Hollywood) "[The organization] only gives you a small portion and you stand in a long line about almost an hour, close to, depending. I try to get there early like before four just to stand in line because of how accumulated the crowd could be and I've ended up all the way around the corner and I've still got a little bit of portion of some food." (Skid Row) "The line is too long." (Hollywood)
Distance (n=5)	"Of course, finding a food bank. Sometimes those aren't real close. You have to go the distance so that makes it difficult because I don't have a car anymore." (Venice) "We all have to pick up all our things and drag them in the bus. It's a lot of work." (Hollywood)
Open at restricted times (n=4)	"It's hard to get anything down to a schedule when you're homeless." (Hollywood) "The only thing that made it difficult is that hours sucked." (Venice)
Required ID and personal information (n=4)	"They're nosy. They want your name just to take a shower." (Hollywood) "If I had ID, I wouldn't mind going." (North Hollywood)
Unsupportive organizations	
Rude and condescending staff, especially security guards (n=8)	"To be honest with you, they rude. Especially the security guard, like, they're disrespectful. They just don't care what they say. Like they just treat people like we're not humans… I told myself that I'd starve and go hungry before I go back to [organization name]" (Skid Row) "I was very upset about the way they ran their security and the way that they could talk to you." (Venice) "I used to go over there all the time. Now I realize that they send your mail back after like 10 days. Usually it's 30 days, but I didn't read the rules. And so the lady that runs the place goes, "Do you need a list of the rules?" And so I felt like somebody just stuck an ice pick in my forehead and I walked away trying to have a smoke." (Venice)
Perceived discrimination (n=3)	"Very discriminatory. No counselor spoke to me. They didn't tell me about no paperwork, anything." (Hollywood) "There's a bit of racial overtones and undertones all through this place." (Hollywood) "I'm sick of it already and I'm tired. They won't give me a chance or shot to work somewhere that's at least LGBT and trans welcoming and a working environment for the trans people in the community." (Hollywood)

Table 21. Perceived facilitators to accessing daytime services, including reasons why individuals find organizations to be welcoming.

Themes and subthemes	Representative Quotes
Easy Access	
Proximity (n=4)	"Location. That's everything. Location makes it easy." (Venice) "I feel like all of the day services that are available are in good locations where you can get to them by walking or bus." (Venice)
Consistent or convenient hours (n=2)	"The hours are convenient. They are open every day. They are open from 5am to 12:30 in the afternoon." (Venice) "Scheduled times, they're consistent." (Venice)
Having ID (n=1)	"Well we have most of our documents together already, instead of having to go about and look for ways to get it. And sign up to get more documents, we already have our stuff." (Hollywood)
Supportive organizations	
Friendly, non-judgmental staff (n=13)	"A lot of them are open and friendly. Some are curious and ask questions." (Hollywood) "They do all they can, they understand when you can't make it." (Hollywood) "They don't judge. They're just there to help you, but they're not going to break you down." (Venice)
Welcoming atmosphere (n=5)	"The courtyard, the atmosphere, the calmness of it. The greens. Everything." (Hollywood) "They're calm, collected. Now they're letting everybody come inside." (Skid Row) "You can charge your phone. Ain't really nobody out there yelling and screaming. No drama. Then they got the flowers and everything decorated. Nice. And they keep their bathroom and stuff clean. … They got a bookcase." (Skid Row) "The energy, the staff, the architecture says that you are part of me. When the architecture and the energy says you are not part of me, a mentally ill person can feel it even more so sometimes than normal people." (Venice)
Professional staff (n=4)	"This place is so professional." (Skid Row) "Yeah, they're very nice. Very professional." (Venice)
Giving out clear information (n=2)	"They give you information on other services and everything too. They have like pamphlets on different places you can go for or food banks or whatever like that. So they've been very helpful too." (Venice) "Just giving you clear instructions on like how they can help. I guess that's the main thing. … Instead of like having you go on this goose chase. So yeah, those places they tell you, you will be here and we'll help and then they are. So that's very nice of them I think." (Venice)

Table 22. Positive and negative attitudes to receiving help from FBOs.

Positive	Negative
"I don't have a problem getting free food. [laughs] If I have to listen to somebody a little bit, that doesn't bother me either. As long as they don't shove it down my throat. As long as somebody doesn't just like push it on you, like you have to do this, you have to do that. Well, I'll go somewhere else. I don't have to do anything." (Venice) "I don't mind going to a church. They give free clothes or free food. I used to go to a church that had free food on Sunday. Either Sunday or Saturday, they will have a morning breakfast and I would go to the church. I think it was on Sunday. Every Sunday they would have breakfast. It used to be really nice breakfast." (North Hollywood)	"I just don't like how some of them come out here and they rebuked me, and I don't like that. All that rebuking shit gotta stop, because you're rebuking me, judging me on my sexuality preference of a person, but not knowing I might be a good person. I have a good heart, intention in life, and good intention to people out here, because I don't cross my lines with the allies or the straight community." (Hollywood) "I wouldn't want to go. … You can stay there during the day for 24 hours, but they expect a lot out of you. … They want you to get up three or four times a day or get up to read the Bible, or pray, or sing, or whatever." (North Hollywood) "Churches have always been horrible. I can't even remember the horrible things they did. … It's a shame to go there. That's not a good thing." (Venice)

Table 23. Perceived Daytime Service Gaps by People Experiencing Homelessness (N=21).

Perceived Service Gaps	%	Representative Quotes
Housing navigation	81	"Sometimes they're a big joke because they tell you one more week, or one more month, or it's coming real soon. So, it's been going on pretty much for the last two years that I submitted my paperwork in to get housing." (Venice) "LAHSA's job was to take me to the building, and I found out where it was at Whittier. They didn't take me to Whittier to go pick up my voucher and see where there's any housing or listing Section 8 apartments. And they were rooting for me to lose my Section 8 and my voucher, so I lost all of that." (Hollywood)
Food (including better food quality, more food available during the day, and preference for warm food)	50	"They have breakfast, they have lunch, and then at two o'clock they have a snack. They don't serve dinner there." (North Hollywood) "A hot meal, you know what I'm saying? Even if it's just chicken. That's a hot meal. That's something to eat." (Skid Row) "Better food, not something that tastes bad and it's a lot of it." (Skid Row)
Place to get respite from the streets and get services	32	"More decompression centers. More centers where we can decompress and shower, have a change of clothes and maybe have a change of heart." (Hollywood) "Other places where people could go into, chill, hang out." (Hollywood) "Somewhere to relax. They can come in and watch some TV and play some games or something. And just have it in a day room. Have a movie day." (Venice)
Health care (including mental health, and transgender care)	32	"Somewhere to help with personalized mental health areas." (Hollywood)
Shower and laundry	27	"There's not a whole lot of places to shower around here." (Venice) "That's one place that they need, is a place for people to wash their clothes and shower." (Hollywood) "Showers are kind of scarce." (North Hollywood)
Longer daytime hours for all services	23	"I would think they would at least be able to go to at least 6:30 to the afternoon, just to give you time to do whatever you need to do." (North Hollywood) "If they will serve dinner about five or six... But they don't serve dinner, and then they close at three." (North Hollywood)

		"Longer periods of time will be helpful. You can break it; you can do a couple of hours in the morning and then a couple hours in the afternoon because that way everybody gets it." (Skid Row) "Things should be open later. There should be more things to do. It seems like there's some medieval curfew or something." (Venice)
Services on the weekend	18	"They should have it every day instead of stopping on the weekends because people need something. They should be open seven days a week." (Hollywood) "Most people stock Monday through Friday because they know Saturday Sunday people go out." (Skid Row) "It would be nice if everything was every day for food." (Venice)
ID procurement	18	"A lot of homeless people don't have an ID. And to get an ID it takes up to three months to get your ID, maybe even longer." (North Hollywood)
Phone charging	18	"It's very hard to find chargers. There's no way to charge your phone." (Venice) "You already know, it's a game. It's Starbucks. It's an outlet I see somewhere in Santa Monica where I could sit down and feign like I'm having their coffee until they say, hey, excuse me, sir, stuff like that." (Venice)
Other services mentioned less often, include case management, employment support, disability and aging, transgender care, barbering and haircuts, transportation to appointments, storage and document safe keeping, safe long-term parking.		

PART VI. Expansion Plans and Investment Priorities

In this section, we summarize findings under the fifth research question: *Are there providers that have existing plans to expand services or are otherwise primed to make large expansions of services in the near future?* We first provide an overview of what plans organizations have for future expansion, then we examine their investment priorities.

Research Sub-questions

- How do providers plan to expand?
- What investment priorities do they identify?

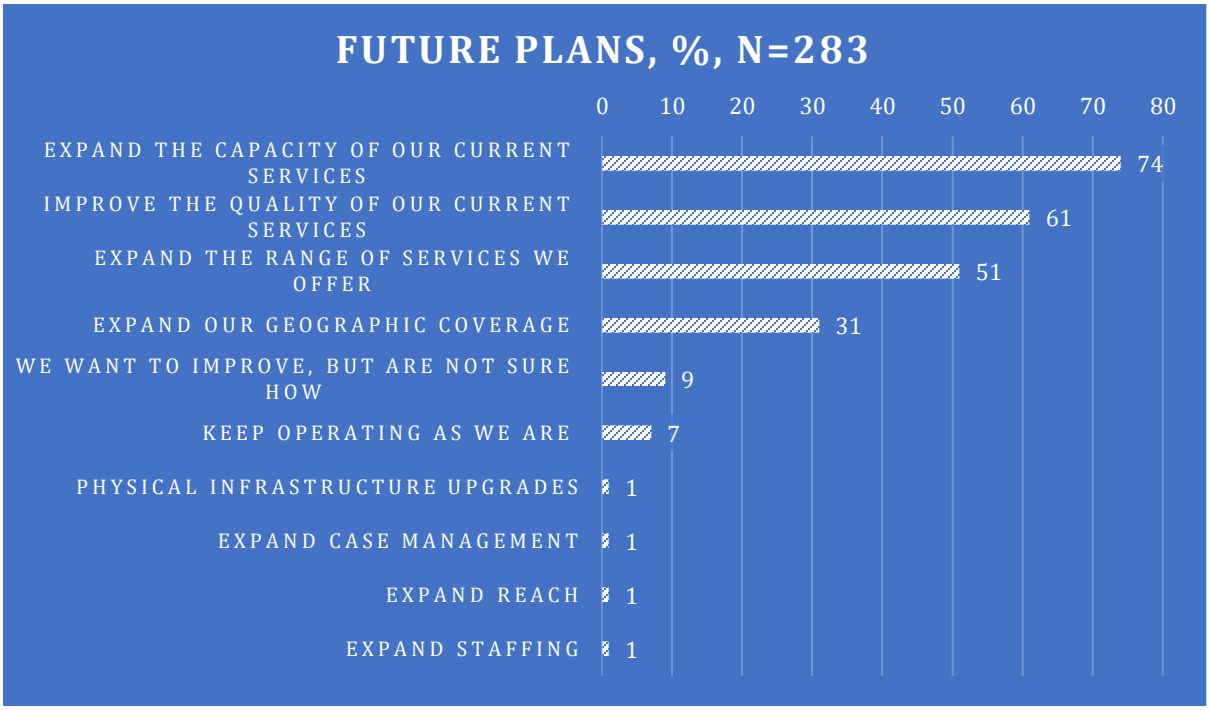
Key Points

- Most organizations were interested in expanding the capacity of current services (74%) or improving the quality of their current services (61%).
- Half of survey respondents said they wanted to expand the range of services they offer, most notably mental health services and other services, such as employment support and vocational training.
- The top three investment priorities were:
    - funding long-term (longer than one-time, one year) (n=144); ranked as a first priority by a third, and as a second priority by 42% of those who chose it.
    - funding for capital assets, such as building space (n=129), ranked as a first priority by 63% of those who chose it, with a fifth ranking it as second priority;
    - funding for administrative work/overhead (n=121), ranked as first priority by 41% of the subsample, and as second priority by 35%.
- Community resistance was seen as a threat to service expansion. It constrains when and how services are delivered, and it drains resources as organizations deal with local resistance by engaging in appeasement, education, and outreach.

6.1. Plans for future expansion

We asked participants about their future plans, whereby they could select all that apply from this list of options: *keep operating as we are; expand the capacity of our current services; expand the range of services we offer; expand our geographic coverage; improve the quality of our current services; we want to improve but are not sure how; other.* See Figure 24, where we list answers to these options and break down what was written in under "other." A majority of respondents said they were either interested in expanding the capacity of their current services (74%) or improving the quality of their current services (61%). Half were looking to expand the range of services offered (51%) and a third were interested in expanding the geographic coverage of their services.

Figure 24. Percentage of organizations with each type of future plan, n=283.



Note: we are missing some data in response to this question, because 37 (12%) respondents skipped it.

Table 24 shows how these plans varied by organizational type, suggesting that the focus on capacity for and quality of current services is strong for non-profits, FBOs and public agencies, but less so CBOs.

Table 24. Percentage of organizations, by type, that selected each type of future expansion plans (n=283).

Future Plans	% Non-profit	% FBO	% CBO	% Public Agency
Expand the capacity of our current services	77	70	50	62
Improve the quality of our current services	61	62	33	69
Expand the range of services we offer	49	51	50	69
Expand our geographic coverage	36	23	17	23
We want to improve, but are not sure how	5	14	33	15
Keep operating as we are	9	4	17	0
Note: we are missing some data in response to this question, because 37 (12%) respondents skipped it.				

Among the subsample of respondents (n=144) who selected *Expand the range of services we offer*, 117 provided narratives in response to a prompt asking them to describe the services that they intended to add in future. Table 25 shows intent to expand services by organizational type.

Table 25. Percentage of organizations by their intent to expand, n=117.

Services (themes)	% Non-profit (N=70)	% FBO (N=37)	% CBO (N=3)	% Public Agency (N=7)
Health Services (n=42) *Mostly mental health, but also medical care, substance use disorder services, and mobile health*	36	35	33	43
Housing (n=40) *Mostly interim and permanent housing, but a few mentioned shelter capacity*	30	40	0	57
Other Services (n=32) *Including employment support, education and vocational training, peer-led groups, outreach, legal, childcare while parents receive services*	29	32	0	0
Case Management (n=20)	17	16	67	0
Services for Specific Populations (n=11)	10	8	33	0
Core Services (n=10) *Including food, hygiene, storage, and survival items*	9	8	33	0
Organizational Management (n=9) *Including capacity to plan efficiently and for contingencies*	10	3	0	14
Drop-in Center (n=3)	3	3	0	0
Note: These percentages are calculated from the 117 respondents from the subsample of respondents (n=144) who selected Expand the range of services we offer. The column percentages are based on the Ns at the top of the column.				

In interviews we heard expressed interest in expansion that mirrored the survey respondents' focus on capacity for daytime services. However, "capacity" meant different things to different organizations. For example, those providing services at drop-in centers spoke about the need for more space where unhoused folks can rest, eat, and engage in meaningful activities. Some suggested larger venues than those where they currently operate, while others spoke about higher numbers of drop-in centers, situated at shorter intervals and closer to public transit. Those organizations offering mobile services spoke about more vans or trucks to be able to cover larger areas, or the same areas but more often. For organizations with diverse client profiles, including but not limited to people experiencing homelessness, such as libraries and transit agencies, "capacity" referred to professional staff (like social workers) who can provide linkage to mental health and social services.

Several interviewees cautioned against organizational expansion that departs from an organization's original core values and mission. For example, some questioned expansion to new services outside their purview or becoming homeless daytime service providers in the first place, instead of working to find synergies with existing providers and reduce duplication of service. Table 26 below shows subthemes with supporting quotes.

Table 26. Subthemes about the need to steer clear of mission creep.

Subtheme	Illustrative quote
Limit scope expansion among nontraditional service providers	"I'm all very excited about Narcan training that's happening at the library. I think it's fantastic how they're expanding. But it would almost be mission creep for them to become an entire other service provider

	when we could be partners and letting them do what they do best and letting us do what we do best, instead of reinventing the wheel. … [Also] the city just cannot become the answer to everything. And the way that cities are creeping in and becoming almost service providers and getting so ingrained in homeless services is a really dangerous path, because that's just not politicians' jobs." (Non-profit 6, SPA 2)
Identify and encourage synergistic collaboration	"And then I will say specifically BIDs [Business Improvement Districts] are paying for staff to monitor and to walk the area and maintain safety, which has largely been an enforcement-based approach. But I've seen a couple of BIDs, where they understand that having water and knowing the service providers in the area that they can refer to is a net positive for everybody and making that more of a partnership in a helpful way. That is, you're not going to become a service provider, you're not going to become a case manager, but there's something you could do with the front line to provide the compassionate and useful warm hand off and to help in the system." (Non-profit 6, SPA 2)
Core values guide service expansion	"We really don't try to bend our values or our mission for funding. I think that we've tried to stick with that with public funding and even private funding. What are our values, and are we trying to bend to get funding and do something?" (Non-profit 4, SPA 5) "As far as trying to fill everybody's needs we're just kind of compartmentalizing. We give food and clothes and showers and here's a list, you need to try and find something. Because we just can't do more than what we're doing especially with volunteer help." (FBO 4, SPA 8)
Mission creep in order to secure funding	"We get the grant. We've been doing it now for four months. And we have to jump through this hoop and that hoop or whatever hoop. … It was the epitome of chasing money and competing for dollars so that we can pay staff to do stupid stuff when they could be using the money so much better." (FBO 3, SPA 4)

6.2. Investment priorities

We gave survey respondents a list of possible opportunities for investment in daytime services and asked them to rank the priorities they felt should be considered. Table 27 shows the investment options we included, as well as respondents' rankings. The column titled N shows the number of respondents who offered any ranking for each of the investment options. The remaining columns show the percentage from each N that ranked it as number 1, 2, or 3.

Around one half of respondents selected one of the following three priorities:

- funding long-term (longer than one-time, one year) (n=144); this option was ranked as second priority by 42% of this subsample. About a third chose this as their top priority.
- funding for capital assets, such as building space (n=129), ranked as a first priority by 63% of the subsample, with a fifth ranking it as second priority;
- funding for administrative work/overhead (n=121), ranked as first priority by 41% of the subsample, and as second priority by 35%.

Table 27. Rankings of investment priorities.

Top three investment priorities	**N**	**% Ranked as #1**	**% Ranked as #2**	**% Ranked as #3**
Funding long-term (longer than one-time, one year)	**144**	29	42	26
Funding for capital assets, such as building space	**129**	63	19	17
Funding for administrative work/overhead	**121**	41	35	21
Retention of qualified staff	107	22	35	41
Recruitment of qualified staff	102	21	43	32
Specialist training relating to this population	86	14	31	50
Specialist training relating to the homeless service system	76	20	17	55
Technical assistance with procuring funding	45	44	20	22
Recruitment of volunteers	30	17	37	30
Retention of volunteers	19	5	26	32
Other (e.g., system realignment to use sober living, Shared Recovery Housing, Peer Services; mental health services, address NIMBYism, fund access centers in every city, expand shelter beds)	16	50	25	19
Note: We are missing some responses to this question because 37 (12%) respondents skipped it.				

Although only a few survey respondents wrote in narratives about the need to invest in addressing community resistance, in interviews we heard almost half of the providers talk about the need to address community resistance to provision of services to people experiencing homelessness. This was perceived to be fueled by what they described as NIMBY-ism, i.e., 'not in my back yard' attitudes. In practical terms, fear and resistance among residents and businesses are perceived to constrain when and how service providers deliver their services. For example, not allowing unhoused clients to congregate outside a hot food distribution center, or limiting the amount of time a client can spend in one place. In addition to constraining service provision, community resistance was also seen as a drain on resources, as organizations need to invest already tight money and labor in community appeasement, education, and outreach:

"In general, I think there's a lot of misconceptions that are starting to unfortunately gain more traction around the benefits of harm reduction, and if done correctly, harm reduction can be the most effective tool supporting folks with substance use disorders. You get a lot of folks who just don't understand. … Whatever it is that we're trying to put in the community, we're going to get that pushback and we're going to get a lot of angry community members saying this will increase homelessness in this area, this will increase substance use in this area, this will increase crime in this area, this will lower property value in this area. And we can show study after study after study after study that shows the exact opposite, but that knee jerk reaction is always like, 'I don't want it here. Even if I believe in it, even if I think it's a good thing to have philosophically, I don't want it here in my community.'" (Gov 3)

Over a quarter of interviewees suggested investing in neighborhood-level daytime drop-in centers, open seven days a week to meet a range of needs, including food provision, bathroom and shower, phone charging, laundry, daytime rest, storage, and service navigation without limiting how long people can be there and without dictating what people should do while they are there. They felt that such centers would address multiple issues simultaneously, such as service gaps and community resistance:

"Creating safe spaces for people to exist during the day is a service that actually makes the case that we're all trying to make about how we all need to coexist, and I think would do huge things to diffuse a lot of the tension that's growing in the city. … Just keeping people fed and giving them a safe place to connect with others is actively bringing down the cortisol levels of the entire neighborhood, which is a net positive for everybody." (Non-profit 6, SPA 2)

PART VII. Conclusion and Recommendations

This review of the landscape of daytime service provision to people experiencing homelessness in Los Angeles County offers a snapshot in time of the challenges and opportunities for investment to expand or improve services.

Despite survey fatigue across the study of homelessness in LA County, our questionnaire achieved a high completion rate, garnering extensive responses to open-ended questions. We exceeded the number of targeted responses, as well as the depth of the written-in responses. This justified the time spent carefully shaping the thread that the questionnaire. This rich mix of survey data was further enhanced by in-depth interviews with both providers and people experiencing homelessness.

In summary, there is a lot to be positive about. There are hundreds of providing organizations, staffed by highly skilled and motivated individuals, and supported by dedicated volunteers who play an important role in helping reach service goals. All organizations want to offer high quality services to their clients, and most of them value evidence-based approaches to the services for which such evidence exists. Organizations are proving to be resourceful and creative when it comes to juggling multiple sources of funding and maximizing the strengths of each type of funding. There is considerable inter-organizational collaboration, even if decentralized and often informal.

However, much of this hard work may not always come across due to the complexity and fragmentation of this service landscape. Daytime service provision spans numerous administrative and political jurisdictions at local, county, and state level, which often leads to an inefficient duplicative approach in service delivery. Important differences in organizational resources and motivations may affect the extent to which organizations can or want to collaborate with each other. Many of these organizational and systemic issues are intractable and difficult to manage in the short term.

Within the complex landscape of provision exist opportunities for better and more effective collaborations, as the diverse range of providers seek to provide more consistent help. Despite the intractability of issues such as geopolitical structures, providers expressed motivation in identifying opportunities to provide day services for people experiencing homelessness. Using actionable findings of the current strengths and weaknesses in this area of provision, we can suggest strategies (i.e., overarching set of goals), tactics (i.e., specific actions to accomplish the strategies), and, where applicable, further research (i.e., added explorations that could enhance strategic planning in the long term). Table 28 below lists recommendations by groups of findings.

Our recommendations fall into five areas: 1) services offered and physical capacity (such as buildings, capital equipment); 2) human resources (paid and volunteer staff); 3) data gathering and sharing of information; 4) inter-organizational collaboration; and all with the ultimate collective aim of improving 5) the client experience, wellbeing, and outcomes.

Table 28. Recommendations.

Key findings relevant for each area of recommendations	Recommended strategies, tactics, and future research
Services Offered and Physical Capacity	
Service gaps were identified fairly evenly across all SPAs. *Over two-thirds of organizations provide at least one core service, such as food (86%), help with personal communications (70%), bathrooms and showers (61%), daytime rest (42%), and personal storage (34%).* *Over two-thirds (75%) of organizations provide case management.* *Fewer than half of organizations (40%) provide direct professional services (such as health care, legal help) or peer-led support groups, a gap consistent across SPAs.* *Across SPAs, services are less available at the weekends (only 58% providers are open Saturdays and 46% Sundays, compared to 90% who are open on week days).* *Across SPAs, services are less available during late afternoon and early evening hours.* ***Of organizations** that offer services fewer than 8 hours per day, 83% offer core services, and more than half are FBOs.* *Many organizations had insufficient resources to acquire additional support to assist PEH, and many would prefer funding with fewer strings attached.* *What constitutes physical infrastructure varies with type of daytime service offered, ranging from mobile health vans, shower trucks, storage for donations, to interior design.*	**Strategy: Increase availability of drop-in centers.** Typically, such a center has indoor space that offers multiple services in one location, ideally every day, and with a focus on those services that are under-provided, but that are most sought by people experiencing homelessness. Essentially, a one-stop shop for all their basic day-to-day needs. **Tactic 1**: **Help fund existing providers who are already offering multiple services**, since they have already developed know-how for collaboration, coordination, and partnership building. Fund these providers to build physical and service capacity as they see fit, for instance: • **add new services** to their current offering by working with organizations that provide just one service, such as mobile showers, mobile clothing, mobile health, food drop-off, etc.; • **offer more of the same current services**, but for longer hours or on more days; • **improve quality of services**, through more staff training and/or supervision and accountability mechanisms **Tactic 2: Help fund education and training on how to set up drop-in centers with multiple services through inter-organizational collaboration**. For example, develop a how-to manual, possibly including video education and case studies, that is a comprehensive one-stop reference for anyone seeking to help set up a drop-in center, lifting away much of the burden of conducting research and covering common areas such as legal requirements, fiscal requirements (how much it costs to build and operate a drop-in center) insurance, law enforcement and neighborhood representative concerns, food handling and hygiene, security, with logistical recommendations and an encouraging motivational component. In short, everything that an organization needs to work with other partners to set up a drop-in centers, in a comprehensive checklist format, that also includes links to potential sources of funding.

Challenges included building, space, and access issues (53%) and equipment shortcomings (27%). *Most organizations are interested in expanding the capacity of current services (74%) or improving the quality of current services (61%).* *Half of survey respondents are interested in expanding the range of services they offer, most notably mental health services, and services such as employment and vocational training.* *The top ranked investment priorities were funding long-term (longer than one-time, one year); funding for capital assets, such as building space; and funding for administrative work/overhead.*	**Further Research 1**: Acquire and analyze objective metrics (i.e., based on official documents rather than self-reported data) of organizational capacity (e.g., building size, staffing records, capital assets, funding, operational costs), service provision (e.g., service frequency, case ratio, number of referrals made) and utilization (e.g., number of clients served by service type, frequency of client meetings, number of referrals completed) at organization and SPA-level. These would provide a more accurate picture of capacity, where self-reported data and estimates may fall short. **Further Research 2:** Incorporate funders' in-depth perspectives in future studies to understand their values and what motivates their funding priorities, what outcomes matter to them, and what they see as the best way to deploy investments in this service area.
Human resources	
Public agencies and non-profits rely primarily on and are extensively operated by paid staff, with staff medians of 30 and 25 respectively, compared to 5 for FBOs and 0 for CBOs. *FBOs and CBOs rely far more heavily on volunteers, with volunteer medians of 10 and 5 respectively, compared to 4 for non-profits, and 0 for public agencies.* *Professional staffing shortages were flagged by 69% of public agencies, 60% of non-profits, 53% of FBOs and 50% of CBOs.* *Volunteer shortages were problematic for 45% of FBOs, and 50% of CBOs, compared to 17% of non-profits, and 15% of public agencies.* *Professional staffing shortages are particularly acute for mental health and substance use disorder services.*	**Strategy 1**: **Make better and more rewarding use of specialist expertise in different areas, across different areas of provision.** **Tactic 1**: **Place the encouragement to collaborate more effectively at the heart of strategic funding**, such as prioritizing joint applications from organizations with complementary capabilities that intend to work together to minimize workforce shortages. **Tactic 2**: **Train organizations to better identify and coordinate sources of specialized help**, such as partnering with universities where students need practicum hours**.** **Tactic 3: Help fund volunteer drives and campaigns to encourage more people to fill expertise gaps,** such as IT or legal, or to plug service gaps in the weekly cycle, such as evenings and weekends.
Data gathering and sharing of information	
A quarter of those interviewed perceived that data collection was not adequately funded.	**Strategy 1**: **Build a culture that values data** with a broader understanding of the benefits of collecting and using appropriate data to

Service documentation and data sharing are somewhat fragmented and inconsistent, and thus less actionable. Many perceived "data silos" at agency level. *Only about half of providers said they used HMIS.* *Discussions revealed important perceived strengths but also problems with HMIS, which are seen to affect data quality and reporting accuracy*	inform decision making, as well as the responsibilities for security and confidentiality. **Tactic 1: Sufficiently fund data collection and analyses tasks separately from other service-related activities**, to ensure sufficient time, training, and resources are available to collaborate and innovate on data collection, analyses and sharing. This is perhaps one of the thorniest areas to deal with. Not only are there a range of legal and personal data security considerations, but also this is a more specialist evolving area of expertise that is likely more outside the day-to-day understanding of many of the organizations providing practical services on the ground. However, when personal information and other data are appropriately captured and utilized for such purposes as service coordination and referral, it can bring significant benefits to both providers and clients, not just in areas such as medication and treatment management, but also in following the progress of housing, work, and other sequential activities with required follow-ups. It can also reduce the burden on providers and clients from having to collect duplicate information at every point of service entry.
Inter-organizational collaboration	
There are mixed approaches to collaboration depending on organization size rather than type. *Frequency of interactions with partners depends on the service provided.* *For the majority, making (90%) and receiving (82%) client referrals is the dominant form of collaboration. Predominant referral mechanisms were LA's 211 Directory (67%) and their organization's own directory (59%).* *A majority felt their referrals were mostly (69%) or almost always (18%) successful. Referral success was seen to vary according to client motivation and/or available resources at other organizations. These issues were often overcome when organizations had good*	**Strategy 1: Capitalize on the collaborations that already exist.** **Tactic 1: Place encouragement to collaborate at the heart of strategic funding,** such as prioritizing joint applications from organizations with complementary capabilities that intend to share capital assets, space, that intend to co-locate, etc. **Further Research 1:** Explore best practice and models of collaboration and monitor collaborations over time to help refine the targeting of funding.

rapport with partners, effective and motivated case management, and reliable in-house provision of services like mental health. *General public services, such as transportation and libraries can be of considerable value, although collaborations are somewhat limited, and have been affected by funding cuts during the pandemic.*	
Client experience, wellbeing and outcomes	
The most important services that people experiencing homelessness used every day were food (100%), clothing (90%), personal hygiene (62%), health care (57%), and phone charging (52%). *Unhoused individuals experienced difficulties accessing services when sites are overcrowded, a long distance away, and open at restricted times.* *They often felt discouraged from using services due to rude or condescending staff, or due to perceived discrimination.* *Service access was perceived to be easy when sites are close by, and open consistently and conveniently.* *Favored organizations had friendly, nonjudgmental, and professional staff, in a welcoming atmosphere, which they often described as "calm."* *Perceived service gaps include help with finding housing (81%), food (50%), health services (32%), places where they can just "relax", "hang out" (32%), showers and laundry (27%), longer service hours (23%), services at the weekend (18%), phone charging (18%), and help with ID procurement (18%).*	**Strategy 1: Strengthen and expand the culture of holistic, client-centered service provision**, that delivers targeted help with dignity. **Tactic 1: Direct funding to organizations that can demonstrate they have a client-centered focus**. Organizations can demonstrate client-centeredness in many ways, including policies, training, or by actively involving clients in designing services or spaces; this should be built into funding requirements and monitored for quality improvement and performance. **Tactic 2: Fund success through monitoring client-reported outcomes**, garnered, for example, through satisfaction surveys. Ideally, such surveys would be standardized to help meet our recommendation for data consolidation. **Future Research 1:** Explore the use of evidence-based approaches, such as Experience-Based Co-Design,[11] in client-centered services to understand how they can be implemented to help steer practical and cultural changes in the provision of services for people experiencing homelessness. Future research into the way that such evidence is currently, and can be best, deployed is likely to be a powerful ongoing component in tackling the problem, which is an ever-changing challenge that we all face. **Further Research 2:** Increase understanding of how this problem is being tackled elsewhere, both nationally and internationally, with a view to adopting, adapting, and implementing best practices wherever it may be found is practical and feasible.

Abbreviations

BID	Business Improvement District
CES	Coordinated Entry System
CHIRP LA	Comprehensive Housing Information & Referrals for People living with HIV/AIDS
COG	Council of Governments
COVID-19	coronavirus disease 2019
DCFS	Department of Children and Family Services
DHS	Department of Health Services
DMH	Department of Mental Health
DPH	Department of Public Health
DPSS	Department of Public Social Services
DV	Domestic Violence
HIPAA	The Health Insurance Portability and Accountability Act
HMIS	Homeless Management Information System
HUD	U.S. Department of Housing and Urban Development
LA-HOP	Los Angeles Homeless Outreach Portal
LAHSA	Los Angeles Homeless Services Authority
Measure H	Sales tax funding the revenue stream to address and prevent homelessness
SPA	Service Planning Area

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