

FORUM

POINT-IN-TIME: HOUSING AS HEALTHCARE

Ventura County's approach to homelessness is evolving!

Discussion Topics:

- 2026 Homeless Point-In-Time Count
- Proposition 1/Behavioral Health Services Act (BHSA) and the new Integrated Plan
- Transitional Rent - housing support as a Medi-Cal benefit
- Perspectives from frontline housing and service providers, and discussion of the many ways to house and support those who are homeless and at-risk.

Friday
April 10th, 2026

8:00 AM - 10:30 AM

Gold Coast Transit District
1901 Auto Center Drive, Oxnard

REGISTER →

www.VCHome.org info@vchome.org



David Tovar
Gold Coast Health Plan



Courtney Lubell & Sara Sanchez
Ventura County Behavioral Health



Kimberlee Albers
Director, Ventura County Homelessness Solutions



Rick Schroeder
President
Many Mansions



Jason Meek
Executive Director
Turning Point Foundation

Friday, April 10, 2026

Ventura County's approach to homelessness is evolving. This forum will discuss new ways to house and support those who are homeless, at-risk, or with behavioral health issues.



POINT-IN-TIME: Kimberlee Albers, Ventura County Homelessness Solutions Director: Information about the 2026 Homeless Point-In-Time Count, progress, and needs.

PROP. 1: Courtney Lubell & Sara Sanchez, Ventura County Behavioral Health: Linking housing with behavioral health support systems under Proposition 1/Behavioral Health Services Act (BHSA) and the new Integrated Plan.

TRANSITIONAL RENT: Rick Schroeder, Many Mansions and David Tovar Gold Coast Health Plan: The Transitional Rent program, housing support as a Medi-Cal benefit.

ON-THE-GROUND PERSPECTIVE: Jason Meek, Turning Point Foundation: Insights and perspectives as a frontline housing and service provider.

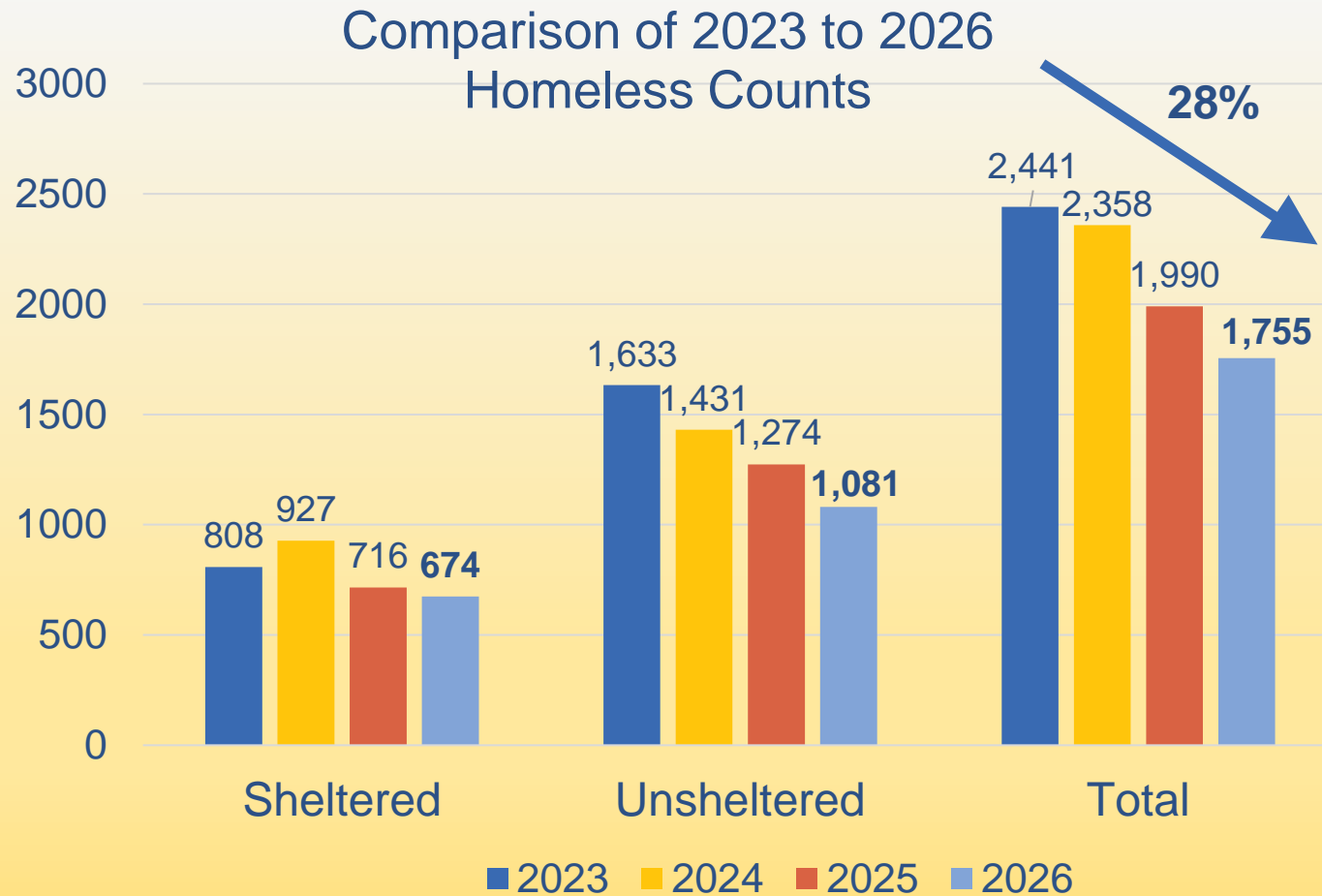


Housing and Homelessness Solutions
County Executive Office
County of Ventura

POINT IN TIME: Housing as Healthcare
April 10, 2026



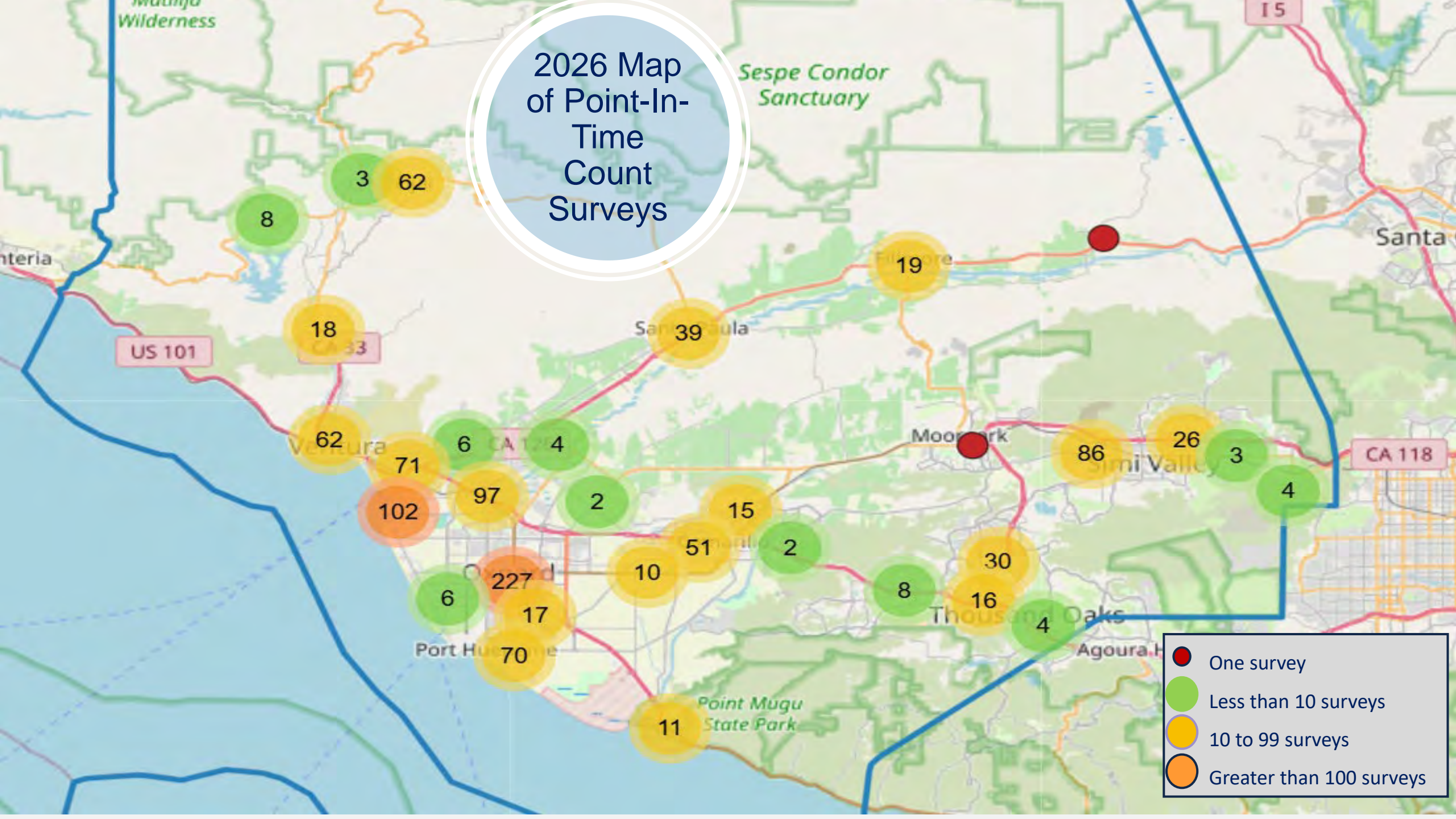
2026 Homeless Point In Time Count Results



- The overall count decreased by 235 persons or 11.8% between 2025 and 2026, 28% since 2023.
- The unsheltered count decreased by 193 persons or 15.1% between 2025 and 2026, 34% since 2023.



2026 Map of Point-In-Time Count Surveys



- One survey
- Less than 10 surveys
- 10 to 99 surveys
- Greater than 100 surveys



Progress insights

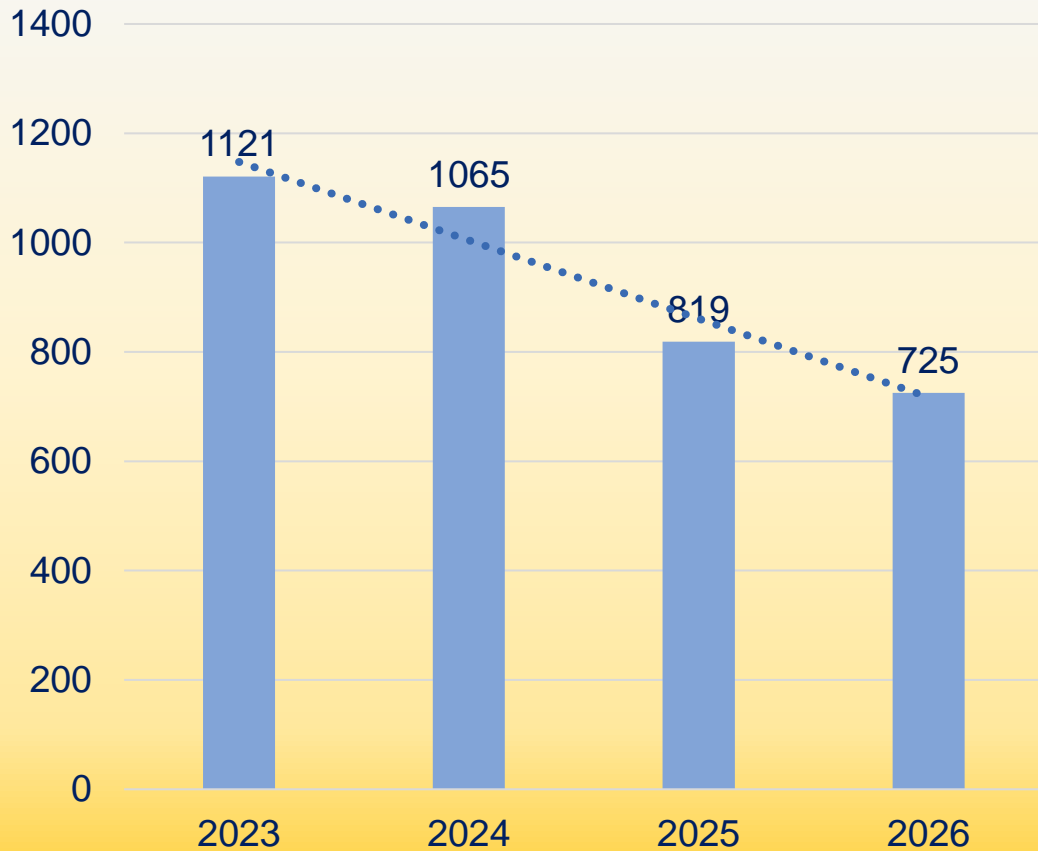
- 297 new **Permanent Supportive Housing** units dedicated to people experiencing homelessness opened in 2024 and 2025.
- **Homelessness Prevention expanded** through rental assistance and landlord incentive programs.
- Additional resources contributed to significant reductions in unsheltered **Veteran and Youth** subpopulations.
- **Encampment resolution** efforts enhanced through multidisciplinary outreach teams and resources from State Encampment Resolution Funding.



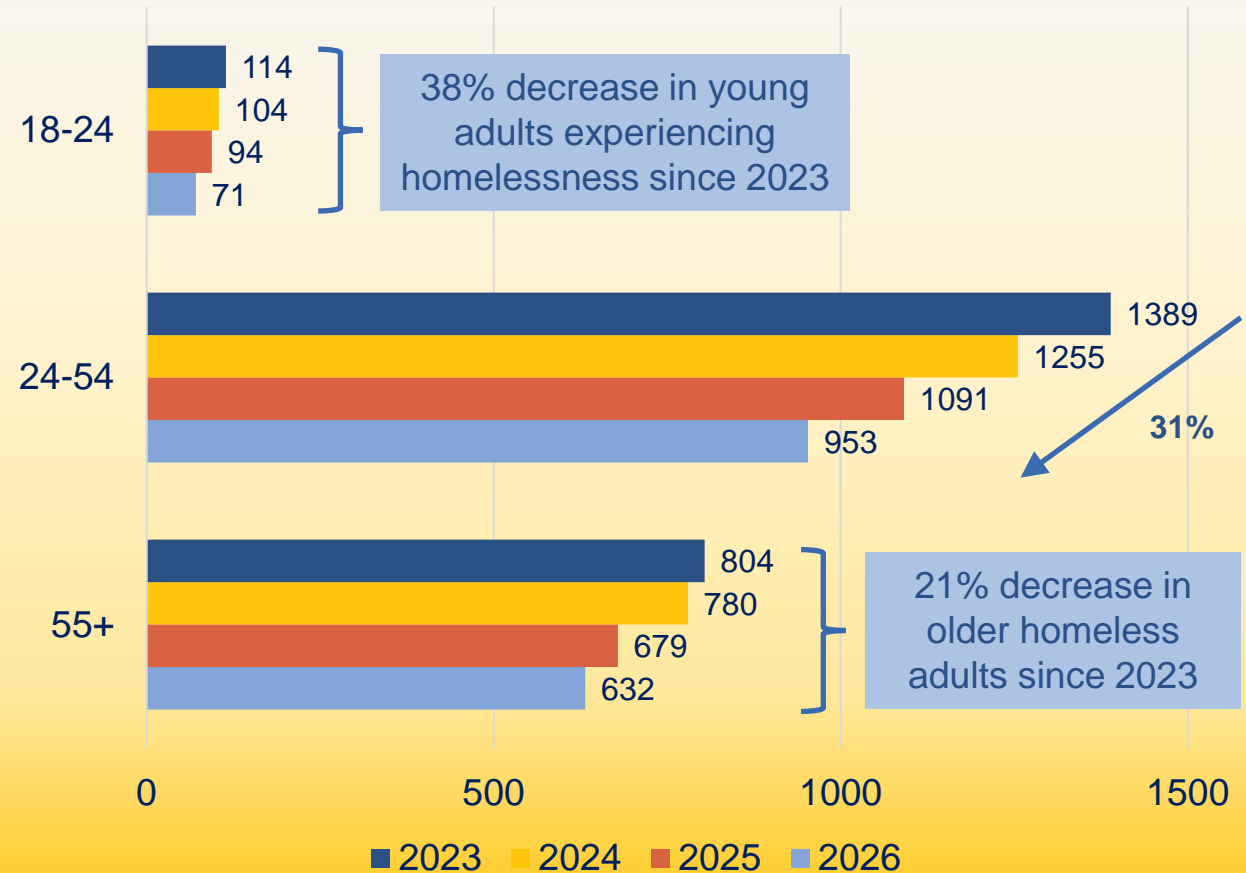


2023 - 2026 Homeless Count Demographics

Chronically Homeless Data for Adults



Age Ranges of Unhoused Adults (Sheltered & Unsheltered)





Progress on Housing Veterans



- **69% decrease** in the number unsheltered Veterans from 134 in 2023 to 41 in 2026.
- Approximately **30** unhoused Veterans are awaiting matches to supportive housing and in some cases, referred to a higher level of care.
- **13 new** Veteran Affairs Supportive Housing (VASH) units now occupied at Dolores Huertas Gardens in Oxnard.
- **122 affordable units** now leased at Ventura Springs Veteran Apartments.
- Veterans One Team continues to match unhoused Veterans to housing and services with dedicated outreach.

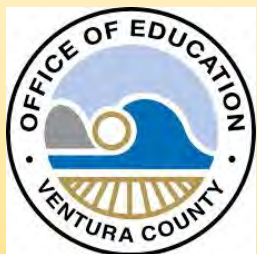
Veterans One Team Collaborative





Progress on Ending Youth Homelessness

Youth Collaborative Partners



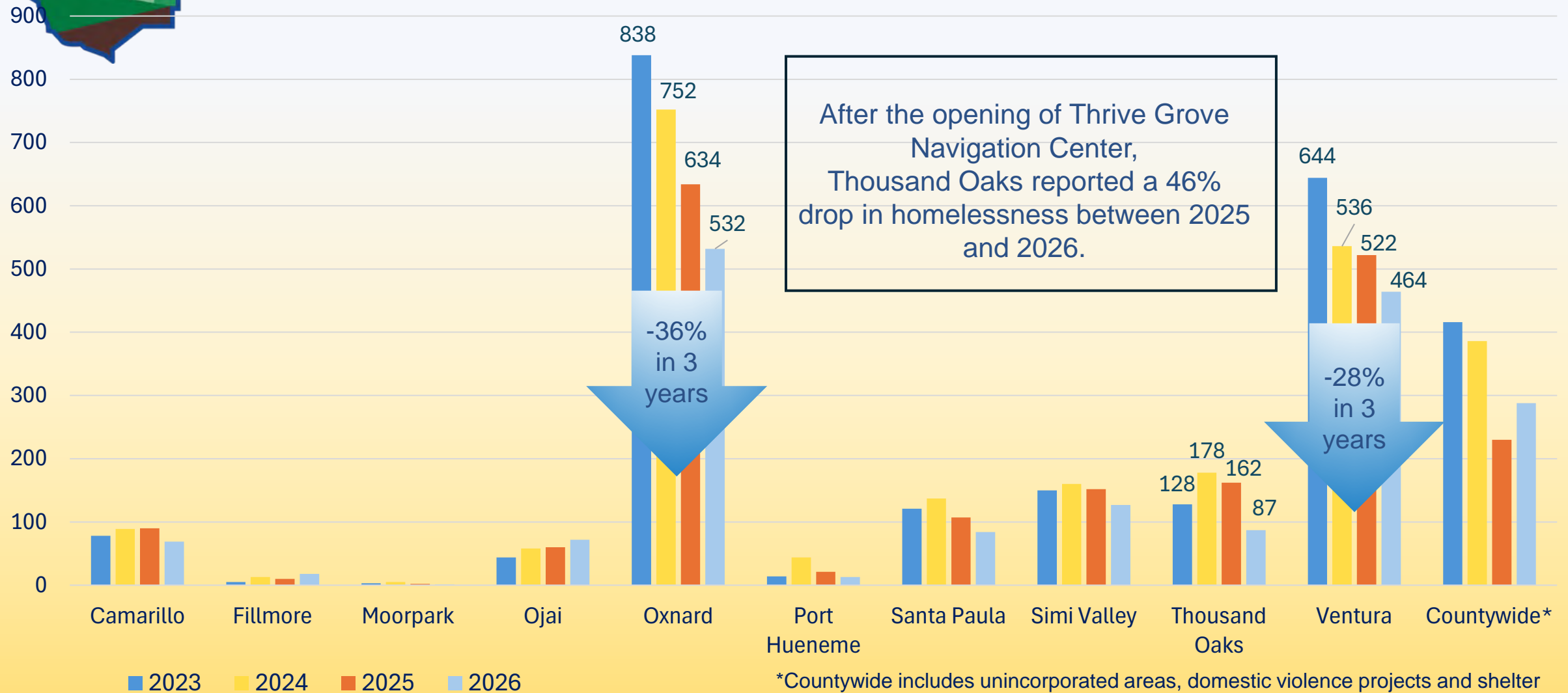
- **65% decrease** in unsheltered Transitional Age Youth (ages 18 to 24) from 52 in 2023 to 18 in 2026.
- **43 Transitional Housing** units at Casa Pacifica's Stepping Stones and Mesa Farm in Ojai.
- **5 Emergency Shelter** beds available at CSU Channel Islands for homeless students.
- **12 Emergency Shelter** beds available through Interface for youth ages 12 to 24.
- Interface Children & Family Services continues to provide street outreach and emergency shelter.

24/7 Youth Outreach Hotline 805-469-5882





2023-26 Comparison by Jurisdiction



After the opening of Thrive Grove Navigation Center, Thousand Oaks reported a 46% drop in homelessness between 2025 and 2026.

-36%
in 3
years

-28%
in 3
years

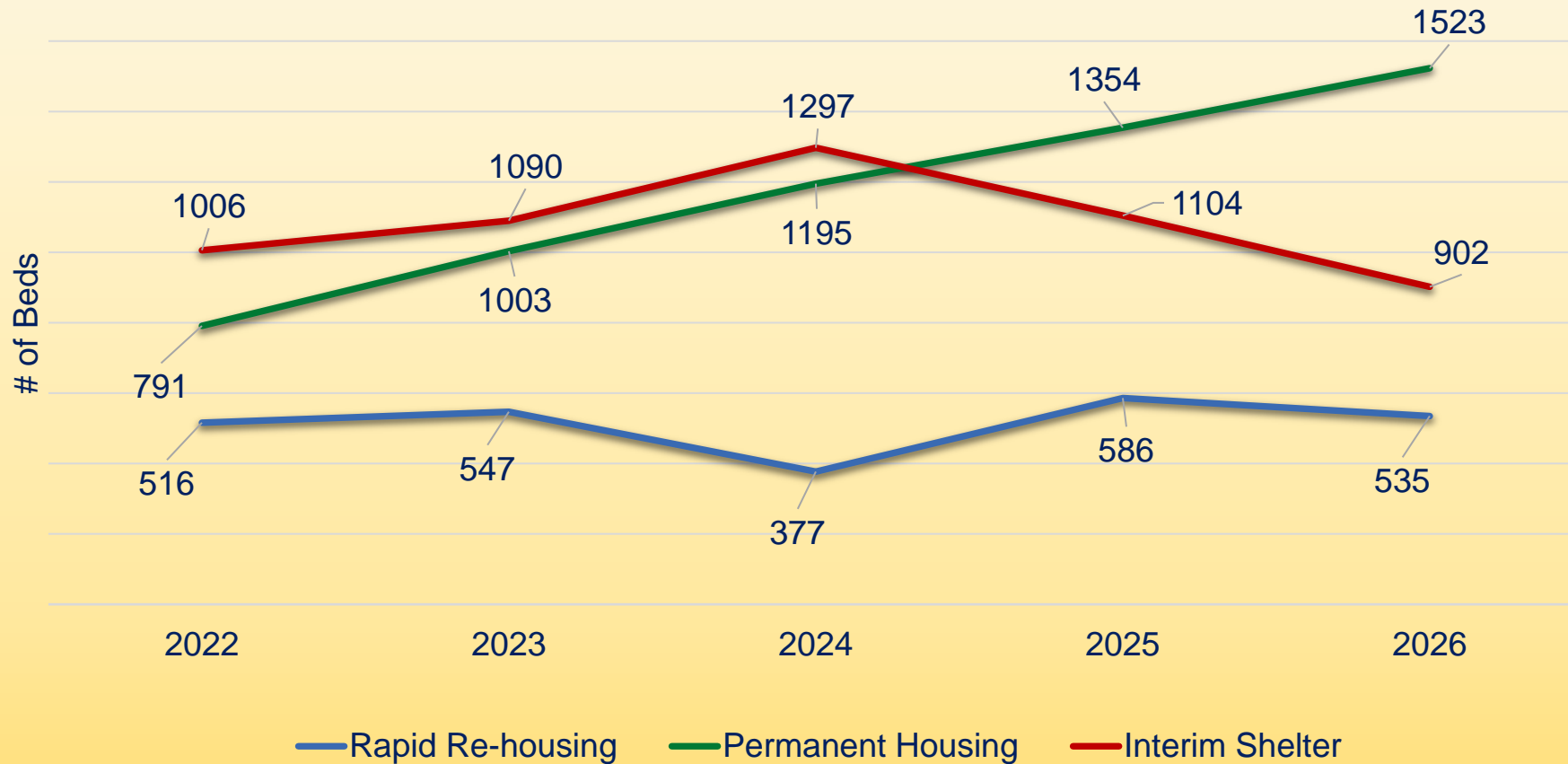
*Countywide includes unincorporated areas, domestic violence projects and shelter programs serving residents from across the County..



Dedicated Housing Inventory Chart



Beds Dedicated to Persons Experiencing Homelessness



HUD requires a full inventory of all beds dedicated to persons experiencing homelessness.

The **green line** shows the increase in permanent housing from steady investments.

The **red line** shows a decrease in interim shelter following temporary motel voucher programs closing.



Unsheltered Adult Subpopulations

Subpopulations:	2025		2026		Difference	
	#	%	#	%	#	%
Chronically Homeless Adults	453	36.0	403	37.6	-50	-11.0
Families including Chronically Homeless Families	10*	--	9**	--	-1	-10
Persons w/Chronic Health Conditions	393	31.3	335	31.3	-58	-14.8
Persons w/a Developmental Disability	103	8.2	82	7.7	-21	-20.4
Persons w/HIV/AIDS	9	0.7	9	0.8	0	0.0
Persons w/Mental Health Problems	341	27.1	292	27.2	-49	-14.4
Persons w/a Physical Disability	331	26.3	270	25.2	-61	-18.4
Substance Users	422	33.6	333	31.1	-89	-21.9
Veterans	64	5.1	41	3.8	-23	-35.9
Experiencing Homelessness Because of Domestic Violence, Dating Violence, Sexual Assault, or Stalking	245	19.5	167	15.6	-78	-31.8

Table 9. Unsheltered Adults by Subpopulations

*In 2025, 10 families consisted of 36 persons of which 19 were adults and 17 were children. Of the 10 families, 3 were chronically homeless and included 6 adults and 5 children.

** In 2026, 7 families consisted of 19 persons of which 10 were adults and 9 were children. Of the 7 families, none (0) were chronically homeless



Homelessness Prevention Progress

Top 10 Causes of Those At-Risk of Homelessness

(provided by United Way)

- 1 Job Loss / Reduced Hours
- 2 Disabling Conditions
- 3 Unexpected Expenses
(car/medical)
- 4 Domestic Violence / Safety Concern
- 5 Divorce or Change in Household
- 6 Eviction
- 7 Unaffordable Rent Increase
- 8 Unit No longer Habitable
(flood/fire)
- 9 Discharged from Institution
- 10 Housing Voucher Subsidy Reduced

\$2.6M State Homeless Housing Assistance and Prevention (HHAP) for two years of prevention (July 2025 – June 2027)

- **197 households** or 444 persons served since July 2025
- **98% housing retention** with supportive services
- Providing landlord incentives, rental assistance, housing navigators and case management.

\$1.12M additional HHAP funding awarded to United Way for countywide homeless prevention funds over the next 3 years.

\$250K Eviction Prevention Program (May 2026 – October 2027)

- County Executive Office has partnered with **Ventura County Legal Aid** to provide support for tenants facing eviction.
- Services include legal counsel, mediation services, referrals to resources, representation, and forms assistance.

The **Housing Rights Center** provides fair housing services and offers landlord and tenant workshops.





Ventura County Homelessness Plan

Action Area 1: Housing Prioritization & Funding

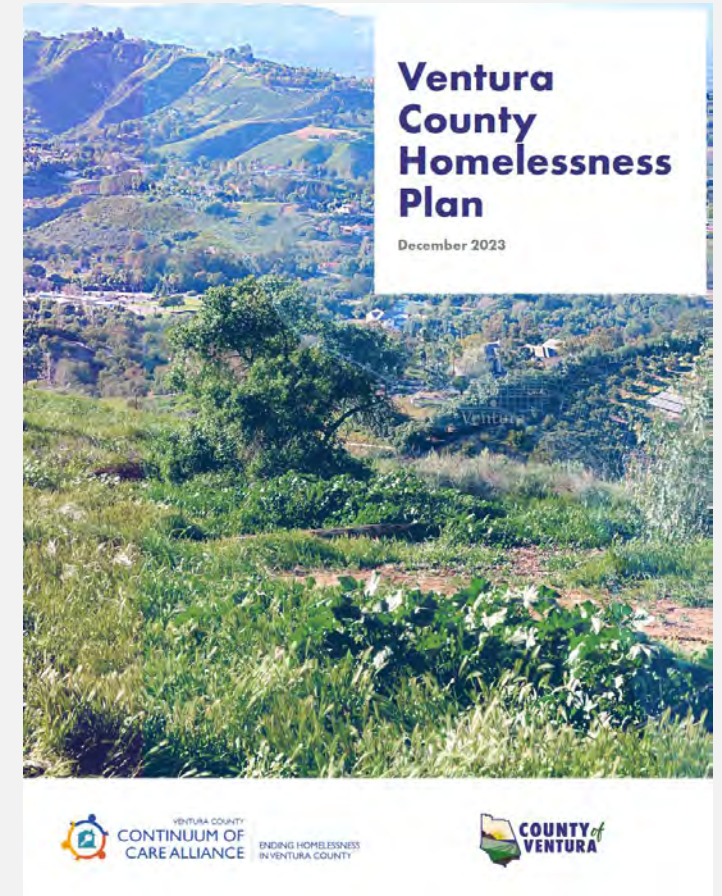
Action Area 2: Regional Coordination & Leadership

Action Area 3: Outreach & Service Delivery

Action Area 4: Data-Driven Decision Making

Action Area 5: Representation & Inclusivity

Adopted by the Board of Supervisors on February 27, 2024





Action Area 1: Housing Prioritization & Funding

Key Progress:

- 688 new units completed since the Ventura County Homelessness Plan was adopted.

Recently Completed:

- Rancho Sierra (Many Mansions): 24 Permanent Supportive Housing units and 25 affordable units.
- Casa de Carmen (Community Development Partners and Mercy House): 55 units Permanent Supportive Housing and 110 interim shelter beds to replace temporary armory shelter in Oxnard.
- Valentine Road, Phase II (Ventura Housing): 134 Permanent Supportive Housing units



Casa de Carmen



Rancho Sierra Senior Apartments



Action Area 1: Housing Development Pipeline

Stage of Development:

Units in Pre-development: 875

Units in Construction: 192

Unit Type:

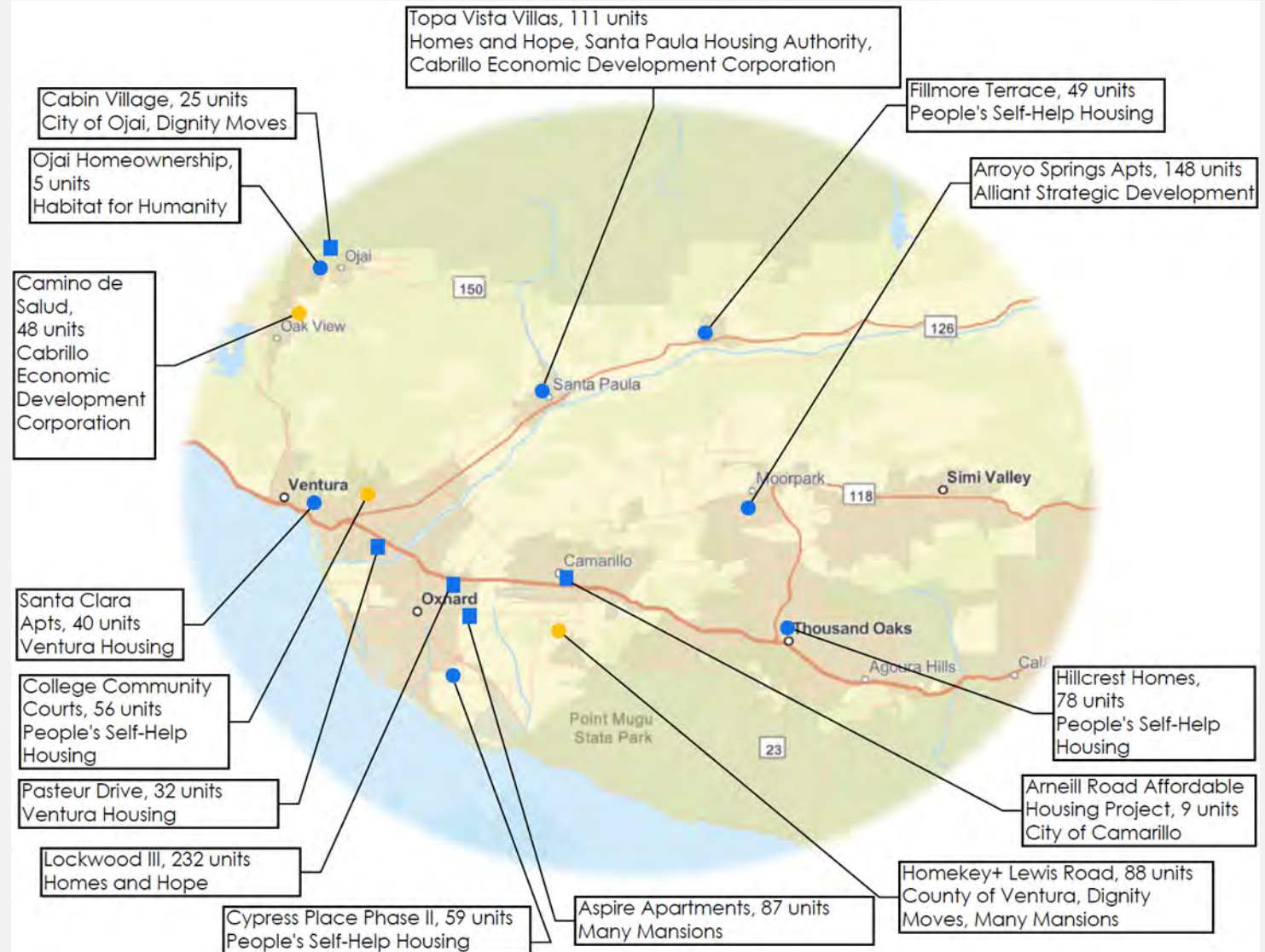
Affordable Rental Units: 758

Permanent Supportive Housing: 226

Affordable Homeownership: 83

Total Housing Units: 1,067

- Predevelopment, County-funded
- In Construction, County-funded
- Predevelopment, not County-funded





Kimberlee Albers;
Homelessness Solutions Director
County of Ventura
805-654-2455
Kimberlee.albers@venturacounty.gov

Thank You



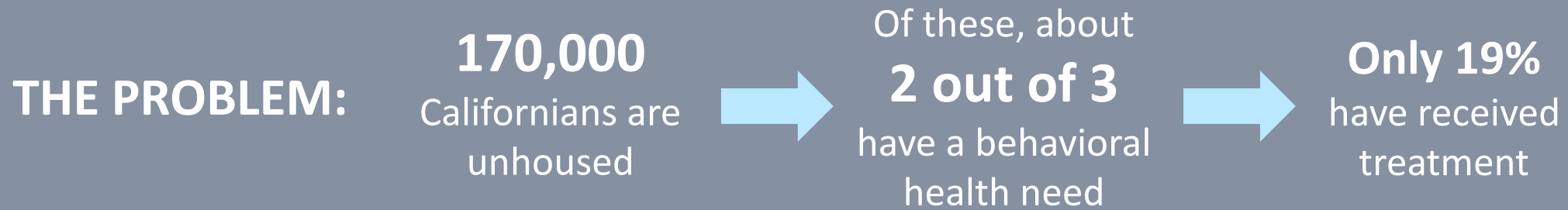
VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

April 2026

BEHAVIORAL HEALTH SERVICES ACTION (BHSA) HOUSING ALLOCATION

**Sara Sanchez, Critical Care and Navigation Services, Division Chief
Courtney Lubell, Special Projects MHSA/BHSA Manager**

Proposition 1: Overview



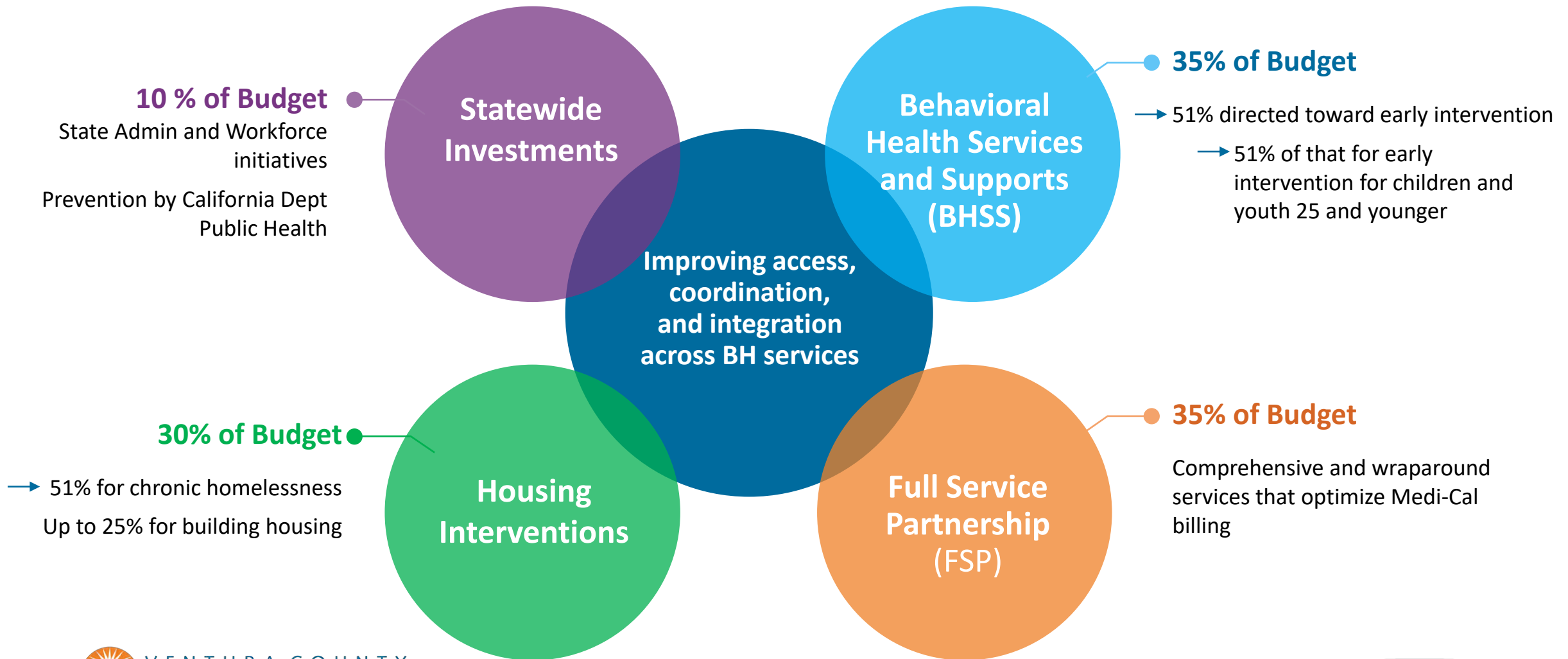
Approved by California voters in March 2024, it focused on:

\$6.4B 
Use bonds to build supportive housing


Reallocate funding to support people with greatest behavioral health needs


10,000
Increase treatment beds across the state

BHSA Requirements: Funding Allocations Effective July 1, 2026





VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

KEY LEARNINGS FROM THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

Overview Community Health Needs Assessment(CHNA)



Secondary Data Analysis



Community Wide Survey (9,022 responses – 75% complete, 25% partial)



Community Focus Groups (6)



Community Partner Listening Sessions (6)

Top Level Insights from the CHNA: Access Barriers

Key Takeaways: Top Barriers to Accessing Behavioral Health Services in Ventura County



Mental Health Care

- Could not find a provider
- Services were too expensive
- Did not know where to go for help



Substance Use Treatment

- Did not know where to go for help
- No health insurance
- Fear of judgment or stigma



Housing Services

- Rent or housing costs were unaffordable
- Long waitlists
- Could not find available housing
- Did not meet eligibility requirements
- Did not know where to find resources



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KEY LEARNINGS FROM THE COMMUNITY PLANNING PROCESS (CPP)

FOCUS: BEHAVIORAL HEALTH

Who we Engaged in the Community Planning Process (CPP)

29 stakeholder groups engaged with input across the three BHSA funding categories

27 Key Informant Interviews (KII)

50+ In Reach Presentations

3 Virtual Town Halls

6 In-person Town Halls

200 Surveys

Overview Health Management Associates (HMA) CPP Recommendations

System Coordination

- Create or enhance a cross-agency referral and navigation system.

Access and Quality of Care

- Advance culturally and linguistically responsive care, alongside tailored intensive services to specialized populations.
- Guarantee seamless transitions between levels of care.

Workforce Development

- Integrate peer specialists across all levels of care.
- Invest in workforce recruitment and retention.

Supportive Services and Interventions

- Provide family education to provide resources and support to families.
- Expand non-congregate and gender-responsive housing and include wraparound supports.
- Seek ways to maintain dedicated funding for suicide prevention.
- Preserve VCBH's presence in underrepresented communities, partnering with trusted local CBOs for outreach and education.

Examples from the Integrated Plan re: Housing Interventions

System Coordination

- **Increase collaboration with Managed Care Plans** (Gold Coast and Kaiser) on Medi-Cal Eligible individuals and housing needs (e.g., Transitional Rent).

Access and Quality of Care

- **Grow an FSP for TAY**, an early intervention program for **Veterans**, and **housing supports for seniors**.

Supportive Services and Interventions

- **Expand rental subsidies** and investing in **new housing initiatives**.

Addressing Housing Needs: Current Efforts

- Behavioral Health Bridge Housing (BHBH) Grant
 - Vagabond
 - Khepera House
 - Spirit of Santa Paula
 - Safe Haven Turning Point
 - Valentine Permanent Supportive Housing – Rental Assistance
 - Various Housing sites throughout Ventura County – Rental Assistance
- BHBH Population serves:
 - Individuals who are unhoused **with**
 - Serious Behavioral Health condition and significant impairment



Delivery of Care & Collaboration

- **Delivery of Service**

- **Rapid Integrated Service Engagement (RISE)** team – ensuring linkage to the unhoused population needing support with appropriate linkage to care
- **Wellness on Wheels** – Providing behavioral health care to rural and underserved communities
- **Bridge to Wellness** – Multi-disciplinary team providing treatment for individuals that are unhoused with a behavioral health condition

- **Collaboration**

- **Backpack Medicine** – serving individuals living in the local river bottoms, homeless encampments, parks
- **Local Law Enforcement** – Partnered with RISE to engage individuals with behavioral health needs
- **Managed Care Plan** (Gold Coast Health Plan & Kaiser Permanente) – linking Medi-Cal Beneficiaries to Cal-Aim Housing Community supports



BHSA Eligibility Criteria & Accessing Care

- **Eligibility Criteria - BHSA**
 - Meet Specialty Mental health Services (SMHS) Access Criteria, **OR**
 - Have at least one diagnosis of a moderate or severe Substance Use Disorder
 - Priority population:
 - chronically homeless, experiencing homelessness, or at risk of homelessness
 - at risk or involved in the just system
 - in child welfare system
- **Access Points**
 - 24/7 Ventura County Behavioral Health Access Line (1-866-998-2243)
 - Behavioral Health Outreach Teams
 - Walk-in to a VCBH Clinic



Upcoming BHSA Integrated Plan Public Comment Window

The **community and stakeholders** are invited and encouraged to provide formal input on the Integrated Plan during the public comment period. Community feedback gathered through the public comment process will help inform final refinements to the BHSA Integrated Plan.

➤ **30-Day Public Comment and Public Hearing Period**

➤ **Opens: April 20, 2026**, at the Behavioral Health Advisory Board (BHAB)

➤ **Closes: May 18, 2026**, at the Behavioral Health Advisory Board (BHAB)

➤ **Who can participate:**

➤ Community members and stakeholders.

➤ **How to Submit Public Comment**

➤ Online submission via the County Prop 1 webpage will be **available on April 20th, 2026**.

Integrated Plan (IP) Timeline

Development Period

- April-May 2025**
 - Begin analysis of Integrated Plan draft from DHCS
- June – July 2025**
 - Continue Integrated Plan (IP) analysis and collaboration with IP stakeholders
- August-November 2025**
 - Community Planning Process (CPP) to inform the Integrated Plan (IP)

- December 2025 – February 2026**
 - Integration of CPP into Integrated Plan

Approvals

- March 2026**
 - CEO approval of draft Integrated Plan
- March 31, 2026**
 - Approved Integrated Plan draft submitted to DHCS
- April and May 30, 2026**
 - 30-day comment period of Integrated Plan (April 20)
 - BHAB Public Hearing of Integrated Plan (May 18)
 - Incorporate Public Comment into IP.
- June 30, 2026**
 - VCBH Integrated Plan (IP) approved by Board of Supervisors
 - Integrated Plan submitted to DHCS no later than June 30th



VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

THANK YOU!



**Gold Coast
Health Plan**SM
A Public Entity

Managed Care, CalAIM, & Supporting Health in Ventura County

David Tovar
Business Strategy Manager

Integrity

Accountability

Collaboration

Trust

Respect

Gold Coast Health Plan

Who We Serve



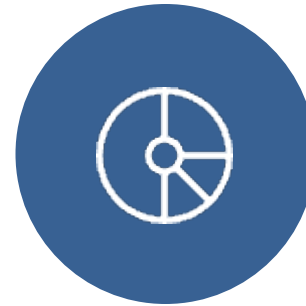
A Snapshot of Our Community Impact

GCHP provides coverage to 227,367 members, representing a significant portion of the Ventura County community.



Community Footprint

1 in 3 Ventura County residents, 1 in 2 Ventura County children (ages 0-5), 1 in 6 Ventura County seniors



Membership Demographics - By Age

Children & Youth (0-17): 34%,
Adults (18-64): 55%,
Seniors (65+): 11%



Membership Demographics - By Language

English (61%),
Spanish (37%),
Other (2%)



The Role of Gold Coast Health Plan

GCHP as the Local Integrator

Payer and Administrator

As the Medi-Cal Managed Care Plan (MCP) for Ventura County, GCHP receives funding from DHCS to authorize, administer, and pay for Health Care and CalAIM services.

Network Building

GCHP contracts with traditional medical providers alongside non-traditional Community-Based Organizations (CBOs), shelters, and housing navigators.

Oversight & Quality

GCHP monitors provider performance, ensures regulatory compliance, and tracks the total cost of care.

Collaboration

GCHP serves as an integrator, aligning Medi-Cal funding with local government agencies, the Continuum of Care (CoC), and Behavioral Health departments.



Moving Beyond the Clinic Walls

A Paradigm Shift with CalAIM

1

Paradigm Shift to Whole-Person Care

CalAIM transforms Medi-Cal from traditional medical insurance to a "whole-person care" system.

2

Addressing Root Causes

Focuses on social determinants of health (SDOH) like mental illness, substance use, and homelessness, which impact health outcomes and costs.

3

Core Pillars

Includes Enhanced Care Management (ECM) for clinical and social coordination and Community Supports (CS) for essential life needs.

CalAIM signifies a major change, enabling Medi-Cal to fund non-medical services addressing essential needs, improving health outcomes and reducing healthcare costs by tackling the social determinants of health directly.



**Gold Coast
Health Plan**
A Public Entity

Enhancing Member Engagement

Targeted Care Management for High-Needs Medi-Cal Members



Targeted Intervention: Enhanced Care Management (ECM)

A comprehensive care coordination benefit for Medi-Cal members with the highest needs.



Populations of Focus

Individuals experiencing homelessness, adults with serious mental illness or substance use disorders, and those transitioning from carceral settings.



The Lead Care Manager

Each member is assigned a dedicated Lead Care Manager who provides support in their current environment (street, shelter, hospital).



Program Goals

Assess clinical, behavioral, and social needs; develop a care plan; and connect members with appropriate Community Supports.



Community Supports: Expanding Healthcare Beyond Clinical Care

Definition: Non-clinical services addressing social drivers of health, classified as "In Lieu of Services" (ILOS) under federal Medicaid rules.

Core Principle: Medically appropriate and cost-effective alternatives to traditional high-cost medical care (e.g., ER visits, hospitalizations).

Examples: A broad menu of 15 approved supports, including:

- **Transitions:** Assisted Living Facility, Nursing Facility
- **Food:** Medically Tailored Meals / Medically Supportive Food
- **Environmental:** Asthma Remediation, Home Modifications
- **Short-Term Safety:** Respite Services

While optional for Managed Care Plan to offer and Members to accept, Community Supports are vital tools that GCHP offers to proactively keep members safe and healthy in the community.

Bridging the Gap: The Broader Homeless Response System

Braiding Medi-Cal with Local Housing Resources

A Collaborative Approach to Homelessness



GCHP's Role

Provides time-limited support to stabilize individuals and facilitate navigation to longer-term housing.



Strategic Partnerships

GCHP collaborates with Many Mansions and Ventura County Behavioral Health for seamless housing transitions.



Braided Funding

Medi-Cal can be used for immediate support, while county resources provide long-term housing solutions.



The Ultimate Goal

A closed-loop system where healthcare stabilizes and local housing sustains recovery.

Integrating healthcare and housing resources to ensure long-term stability for individuals experiencing homelessness.



**Gold Coast
Health Plan**
A Public Entity

CalAIM is an initiative to improve the quality of life and health outcomes of the Medi-Cal population by meeting people where they are in life, addressing social drivers of health and breaking down barriers in accessing care.

18,770 GCHP Members Have Received ECM and CS Services



Since January 2022

5,119

**Members Received
Enhanced Care Management (ECM)**

16,468

**Members Received Community Supports
(CS) Services**



**Housing Transition/Navigation
Services**

5,871 Days Provided
to 1,515 Unique Members



**Short Term Post-Hospitalization
Housing**

3,546 Days Provided
to 43 Unique Members



**Recuperative Care
(Medical Respite)**

39,308 Days Provided
to 616 Unique Members



Respite Services*

45,527 Hours Provided
to 299 Unique Members

*excluding 60 manual claims



**Personal Care/Homemaker
Services**

442,651 Hours Provided
to 681 Unique Members



Medically Tailored Meals

7,285,537 Meals Delivered
to 14,820 Unique Members



‘Housing Trio & Transitional Rent’



OUR MISSION

Our mission is to develop and maintain quality affordable housing and to provide services that enrich the lives of our residents, uplifting the community.

OUR VISION

We envision a vibrant, inclusive community where everyone has access to affordable housing and the support needed to thrive.



CaAIM: Addressing Social Determinant of Health



California Advancing and Innovating Medi-Cal (CaAIM)

- Address social determinants of health
- **Objectives:**
 - Improving health outcomes
 - Reducing healthcare system costs
- **Implementation**
 - Enhanced Care Management (ECM)
 - Community Supports – in collaboration with community-based organizations

Housing is a Social Determinant of Health



1. **Stable housing improves health outcomes and reduces public healthcare spending.**
2. **Housing focused ‘Community Supports’**
3. **‘Housing Trio’**
 - Housing Transition Navigation Services
 - Housing Deposits
 - Housing Tenancy & Sustaining Services
4. **Transitional Rent**
5. **Must be ‘Eligible’**



The 'Housing Trio'

Housing Transition Navigation Services:

- Eligible members can receive assistance to find, apply for, and secure housing.

Housing Deposits:

- Eligible members receive assistance with security deposits, utilities set-up fees, first and last month's rent, etc.
- Eligible members can also receive funding for medically necessary items like air conditioners, heaters, and hospital beds.



The 'Housing Trio'

Housing Tenancy and Sustaining Services

- Eligible members receive support to maintain safe and stable tenancy once housing is secured
- Includes coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction

The Transitional Rent Program

1. New 'community support' launching in the State.
2. For members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria.
3. Covers up to six months of rent (up to 110% of SAFMR).
4. Many Mansions' role:
 - Support in determining eligibility
 - Administer rent payments
 - Provide integrated services for a focused approach to housing stability ('Housing Trio')
 - Expand housing supply in the private market
 - Offer dedicated landlord support





Eligibility Requirements

- 1. Medi-Cal members**
- 2. Clinical risk factor**
 - Current population of focus: SMI or SUD
 - Potential future expansion may include other disabilities/chronic health conditions
- 3. Social risk factor**
 - Experiencing or at risk of homelessness
- 4. In 'transition'**
 - Shelters
 - Carceral system
 - Hospitalization
 - Etc.
- 5. Must have a 'month 7' plan**
 - Many Mansions staff support member in creating a 'Housing Support Plan'

How Will This Work?

- Submit a referral to Many Mansions (or MCP)
- Eligibility details and forms will be live on our website next week
- Contact our CalAIM team to consult, if in doubt

This is where it gets complicated:

1. No instant approval for Transitional Rent.
2. If Many Mansions deems the member “*likely* eligible for TR” → seeks approval for Housing Trio → starts Navigation Services to create a Housing Support Plan.
3. Once a month 7 plan is secured → Many Mansions seeks approval for Transitional Rent.
4. Once approved, Many Mansions identifies a housing placement and supports member in moving in.
5. Many Mansions proceeds to administer rent payments, provide Tenancy Sustaining Services, coordinate with ECMs and VCBH, support issues resolution with landlords, supports a month 7 successful transition.



What Does it Mean to Our Combined Efforts



1. Housing Units Availability

- Enables adding private units to the mix, in support of complex-needs households

2. Funds infusion into Existing Systems

- (e.g., full rent for x months when a member enters PSH)

3. Better Outcomes with an Integrated Approach

- Subsidy + stabilization services + systems-wide coordination

4. Early Intervention with at-risk households

5. Member Financial Stabilization

- Covers rent gaps, utilities arrears, deposits. For easier stabilization.

Turning Point Foundation

37+ years of specialized local services

Serving community members facing the highest barriers to stability in Ventura County.



Housing + services = stability

Why this work remains urgent

Housing instability, trauma, and behavioral health needs often reinforce one another.

- Mental illness and homelessness frequently overlap, making recovery harder without a stable place to live.
- Affordable housing shortages and high living costs can outpace wages, fixed incomes, and subsidies.
- Trauma, domestic violence, veteran mental health needs, and limited employment options can deepen housing risk.
- People typically require treatment, income support, and housing assistance simultaneously—not one after the other.



Recovery is more challenging when housing, income, health, and safety **all** have to be stabilized at once.

Turning Point Foundation: Who We Are

Data-informed, evidence-based support for people affected by mental illness and homelessness.



Founded in 1988

Responds to community needs linked to mental illness and homelessness.

We use current data and evidence-based practices to match people to the level of care and support they need.

Goal: move people from crisis toward stability, recovery, and community living.



Housing continuum...

Different settings meet different levels of need—from immediate safety to longer-term supportive housing.

Transitional Housing:

For veterans who need a bridge from instability to permanent housing.

Permanent Supportive Housing:

Wooley House, Steven's Place, and Villa Calleguas pair housing with ongoing support.

Emergency Shelter:

Our Place Safe Haven offers immediate stabilization and safety.

Adult Residential and Elder Care:

Thompson Place, Rincon, and Oak Place support residents with higher care needs.

Housing works best when the unit, rent support, and tenancy services arrive together.



Community-based sites help translate housing into real stability.



Mental Wellness and Recovery Supports

Housing stability is reinforced by peer support, treatment engagement, and daily living skills.

Wellness Center — peer support specialists and self-help-oriented recovery assistance.

Growing Works — supportive employment and horticultural therapy.

R.I.S.E. — support for clients who cannot access further treatment.

Mobile Wellness — peer support across housing sites in Ventura County.

Recovery Centers — living skills, work readiness, recreation, and community integration.

These programs build function, connection, and independence—not only symptom relief.



Proposition 47

The TPF framing emphasizes coordinated reentry support rather than a single service response.



Goal: a path to sustained freedom

Mental health

Substance use care

Housing

Employment

Mentorship

Support groups + education

When these supports are bundled, people are more likely to sustain housing, treatment engagement, and community connection.



Housing + Behavioral Health Benefits:

- Better Mental Health Outcomes
- Reduced Financial Stress
- Greater Housing Stability and Safety
- Fewer Crisis and Lower Use of Emergency System
- Improve Long-term Functioning and Quality of Life

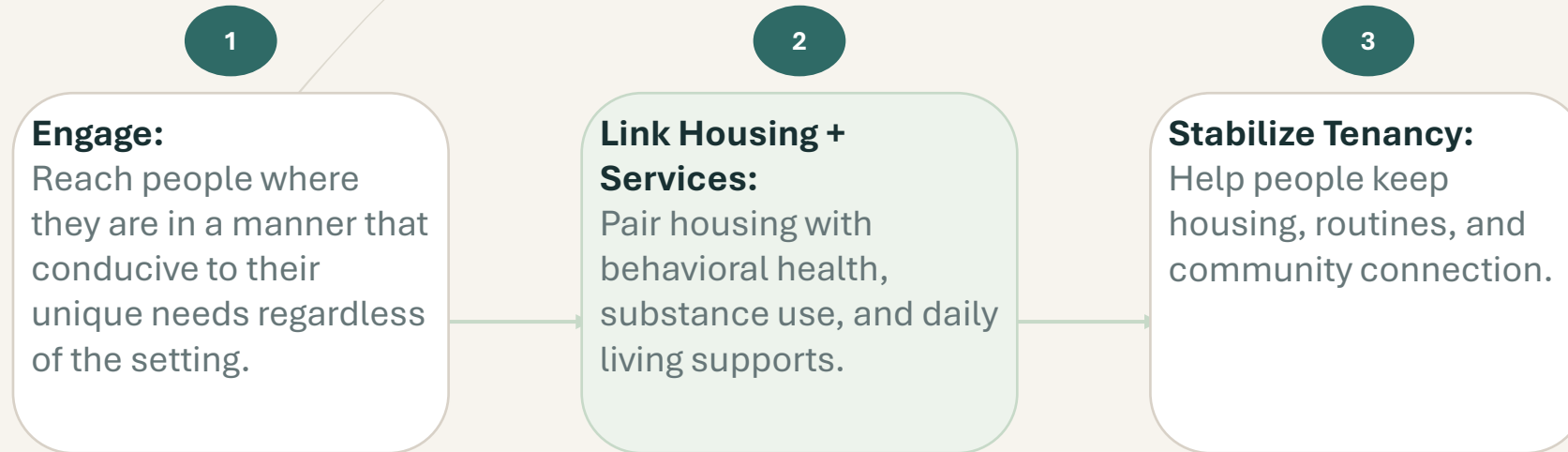
People do better when housing and services arrive together.

**HOUSING
+ SERVICES
= STABILITY**



What we hope to continually accomplish in greater numbers:

Move people from crisis and homelessness to stable tenancy with ongoing support.



The goal is not only placement—it is successful tenancy and recovery.



Key challenges as a housing service provider

Funding limits, process friction, and a tight rental market stack on top of one another.

1

Funding Gap:

Short-term or restricted dollars may not cover tenancy support, peer services, transportation, and landlord engagement.

2

Procedural Friction:

Multiple referrals, eligibility rules, documentation, and billing requirements can slow placement and create duplication.

3

Tight Housing Market:

Limited affordable units, landlord hesitation, and move-in costs make placements harder; retention still requires ongoing support.

These barriers stack on top of one another: even when housing is available, placement can still stall if services or approvals lag.



THE STRONGEST FIXES MAKE HOUSING AND SERVICE SYSTEMS WORK AS ONE CONTINUUM.

1. Stabilize Funding:
Multi-year, flexible dollars for tenancy support and wraparound services.

2. Simplify access
Common referrals, shared documentation, and faster approvals.

3. Expand unit supply
Landlord incentives, risk-mitigation funds, and move-in resources.

4. Coordinate accountability
Clear handoffs across county, hospitals, health plans, and housing partners.

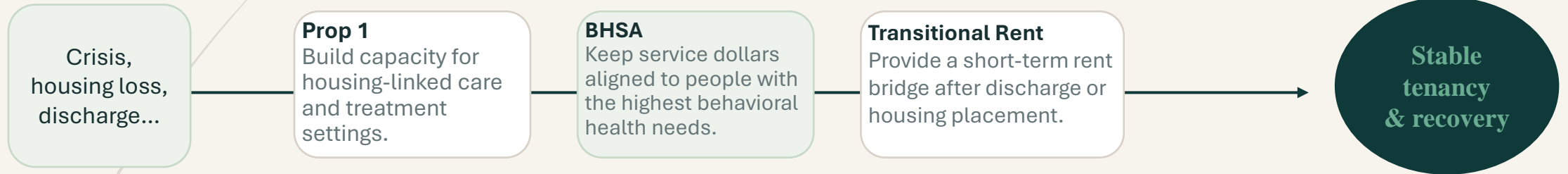
**Faster placement
+ stronger retention**

WHEN THESE STEPS ALIGN, PROVIDERS CAN SPEND LESS TIME NAVIGATING SYSTEMS AND MORE TIME HELPING PEOPLE STAY HOUSED.



Putting the tools together

Prop 1, BHSA, and Transitional Rent are strongest when they function as one bridge to stable tenancy.



Health
Safer living conditions, better rest, medication adherence, and more routine medical care.

Behavioral health
Better treatment engagement, fewer crises, and stronger recovery stability.

Financial
Lower reliance on emergency, inpatient, shelter, and justice-system responses.

Better outcomes for people + better value for the community

Priority: simple eligibility • rapid approvals • warm handoffs • service funding beyond the first rent bridge



Thank you for engaging in these important housing conversations.

Bookmark www.vcHOME.org/forums for upcoming events and resource materials from prior gatherings.

HOME hosts these Forums to address key challenges and solutions in Ventura County's housing landscape. These sessions provide a platform for professionals, community members, and officials to discuss issues like affordability, housing policy, and innovative housing solutions.

If you're interested in collaborating on a future forum, please reach out to Karen Fraser, Executive Director, at Karen@vchome.org.

