



Integrating Care for People Experiencing Homelessness

A Focus on
Sacramento County



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Executive Summary

A growing number of people are experiencing homelessness in Sacramento County, a common situation across California and the U.S. During 2019, an estimated 10,000 people in Sacramento County experienced homelessness. The 2019 Sacramento Point-In-Time Count found that on any given night, 5,570 people are homeless—a 19% increase since 2017. Of those, about 1,600 are classified as chronically homeless, defined as being without shelter for 12+ months and having a disabling condition such as a physical health condition, mental health condition, and/or substance use disorder (SUD); nearly 4,000 are unsheltered (Figure 1).

Almost 2,000 (53%) of those enrolled in the county’s Homeless Management Information System report two or more health-related conditions. More than half of the enrollees report physical health and chronic mental health conditions. These conditions are commonly exacerbated by the lack of housing where continued exposure to the elements and unsafe environments prevent proper healing. Notably, substance use is common, with 52%

~2,000 enrollees in the Homeless Management Information System (HMIS) self-reported the following conditions:

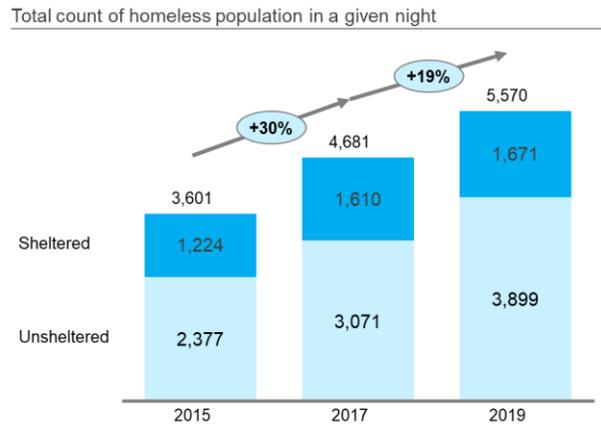
- 52% chronic health condition
- 57% chronic mental health condition
- 53% 2+ co-occurring conditions
- 52% any substance use

of clients reporting any substance use. The rate of methamphetamine (meth) use among the unsheltered is estimated to be 10-25%. Of those who are in county-funded SUD treatment, 43% report meth as their primary drug, followed by heroin (28%), and alcohol (14%). Meth use exacerbates mental and physical health problems and intensifies behaviors that make sustainable housing placement more difficult. Space for residential treatment is limited, especially for those on Medi-Cal; wait times are long.

Sacramento provides a diverse but fragmented array of medical and mental health care, SUD treatment, housing, and social services. These services are under-coordinated and frequently geographically dispersed; however, Pathways to Health and Home and full-service partnership plans that do “whatever it takes” to support high acuity clients are good examples of promising care coordination. Access to safety-net housing, mental health and SUD treatment is limited; most services focus on the low-income population, including the homeless population. Some programs have extensive waiting lists. The approximately 800 emergency shelter beds in Sacramento are insufficient to meet the demand for shelter and transitional and permanent housing are in short supply with waiting lists. Similarly, there are insufficient numbers of inpatient psychiatric and residential drug treatment beds.

These findings were confirmed by Sacramento stakeholders (35 representatives from health systems, social service providers, people with lived experience, community clinics, and local government) who described the primary challenges as: 1) Insufficient capacity in multiple intervention domains; 2) Limited communication or coordination between siloed services.

Figure 1. Sacramento Homeless Population, 2015-2019



of clients reporting any substance use. The rate of methamphetamine (meth) use among the unsheltered is estimated to be 10-25%. Of those who are in county-funded SUD treatment, 43% report meth as their primary drug, followed by heroin (28%), and alcohol (14%). Meth use exacerbates mental and physical health problems and intensifies behaviors that make sustainable housing placement more difficult. Space for residential treatment is limited, especially for those on Medi-Cal; wait times are long.

“There is a capacity issue all around.”
—health system respondent

“There are a number of entities out there doing outreach...then what are the best practices, best standards, and how do we build a more coordinate effort?”
—public agency respondent

CONCLUSIONS

Growing Population of People Experiencing Homelessness

- ❖ The population of people experiencing homelessness is growing rapidly in Sacramento and across California.
- ❖ Approximately 1,600 individuals in Sacramento County meet the definition of chronically homeless, many of whom have complex medical, substance use, and mental health care needs. Some will require permanent supportive housing.
- ❖ Affordable housing is urgently needed in Sacramento and across California.
- ❖ Access to treatment and housing services is limited; many services have extensive waiting lists.

Communication Challenges

- ❖ Stakeholders note that the siloed “system” of services and providers inhibits a sufficient and efficient patient-centered continuum of care. Many services for people experiencing homelessness exist in Sacramento, but most services are dispersed and siloed. Communication between providers of mental health services, substance use disorder treatments, social services, and medical treatments is poorly coordinated.
- ❖ Without consistent methods of communication (phone, address) or ready access to transportation, people experiencing homelessness have difficulty navigating this complex system of care.
- ❖ An integrated, electronic record system for cross-disciplinary service providers to track patient access and utilization is lacking. Alameda and San Diego Counties offer good examples of effective social-health information exchange systems.
- ❖ Housing and health care nomenclatures are different. Effective integration of services will require improved communication through a common language and agreed upon definitions.
- ❖ People experiencing homelessness who have a serious mental illness (SMI) and/or SUD are often released from incarceration without housing or warm hand-offs to short-term care. Criminal justice representatives recognize the need to improve linkage with services at the time of release and to expand diversion programs with clinical and social service partners to improve treatment and follow-up for individuals with mental health and substance use problems.

Effectiveness of Care

- ❖ Co-located comprehensive care models are mostly recent developments, and evidence of their effectiveness is limited. Many interventions used at co-located, comprehensive service centers (e.g., Housing First, medication-assisted treatment for substance use disorder, assertive community treatment) have been found to be effective as stand-alone interventions; it stands to reason that these services would remain effective if co-located in an integrated care campus model.
- ❖ Methamphetamine use is a serious and widespread problem among people experiencing homelessness in Sacramento. No evidence-based medication-assisted treatment for methamphetamine use disorder is currently available, but contingency management is a behavioral technique that offers evidence of effectiveness. Lack of residential SUD

treatment options and underutilization of contingency management are barriers to effective care for people experiencing homelessness in Sacramento.

Exiting Homelessness: Innovative Approaches

- ❖ Across the country, co-located, comprehensive service models are being developed to address the increased need for integrated, supportive care (see Chapter 4 and Appendix B for examples).
- ❖ Co-located models include case management and treatment for medical, substance use, and mental health problems. Most provide temporary housing (shelter, transitional housing, medical respite care) while identifying permanent housing for clients. Other services offered by some programs include dental care, pharmacy, employment training, and pet kennels.
- ❖ Philosophical differences exist among co-located care models; some emphasize “treatment first” while others emphasize “housing first” approaches. Similarly, some models originated from a criminal justice diversion perspective and others were motivated by a model of integrated mental health/SUD treatment.
- ❖ Local innovative programs, such as criminal justice diversion programs, Full-Service Partnerships, and Pathways to Health and Home, warrant expanded capacity.

RECOMMENDATIONS

Coordinated action by stakeholders is needed to make a difference for the growing number of people experiencing homelessness in Sacramento. Current capacity is insufficient. Homeless individuals with complex needs could benefit from an integrated, co-located, patient-centered model of care that includes housing. Relatively small programs in Sacramento based on the concepts of Whole Person Care, supportive housing, and criminal justice diversion are having some success, but greatly expanded capacity is required to help more of those in need of care. The following recommendations stem from empirical evidence and stakeholder feedback:

- ❖ **Expanded capacity for shelters, transitional supportive housing, permanent supportive housing, and Board and Care facilities** is urgently needed to reverse the rising numbers of people experiencing homelessness in Sacramento County.
- ❖ **Capacity for inpatient, residential, and intensive outpatient care of serious mental illness and residential substance use treatment** for people experiencing homelessness must be expanded. Until capacity is expanded, jails and emergency departments in Sacramento County will continue to be a common pathway for people with SMI and SUD in crisis, particularly those experiencing homelessness.
- ❖ Individuals with **SMI and/or SUD being diverted or released from jail require an immediate warm hand-off to coordinated care and housing services**. This will improve quality of life and reduce unnecessary costs to the criminal justice system.
- ❖ **Additional residential treatment programs for people with methamphetamine use disorder** are urgently needed. Programs should offer evidence-based treatment including **contingency management**.
- ❖ A county-wide integrated communication system, such as **an electronic Social-Health Information Exchange**, that supports communication across housing, clinical care, social

services, and the criminal justice system would improve efficiency and access to services for people experiencing homelessness. Systems used in Alameda and San Diego Counties are good resources for Sacramento County.

- ❖ **Co-located, integrated services linked to expanded housing capacity** on site or elsewhere in the Sacramento community could improve care and support transition into long-term housing. This comprehensive approach should incorporate existing successful programs and service providers. It would reduce barriers to care including: limited capacity, lack of transportation, and inadequate communication.
- ❖ Sacramento stakeholders and leaders can **seek guidance from communities with integrated care campuses**. Learning from the experience gained from other sites can inform the local development process in Sacramento. Some model programs offer consulting services.
- ❖ **A cross-disciplinary council of finance experts could collaborate to develop innovative funding options for housing and treatment**. Funding sources for integrated care models vary, and include government sources (city, county, state, federal), health systems, and corporate and philanthropic contributors. An integrated delivery system will require a substantial investment of resources and a team of finance and service delivery experts can leverage creative, integrated funding approaches to expand local capacity through co-located housing and services.
- ❖ **Rigorous evaluations** of integrated care programs are needed to assess their effectiveness. Combined with economic analyses, these would provide estimates of costs and potential benefits of these programs.

Recommended Reading

- 2018 County of Sacramento Homeless Plan
- Homelessness in Sacramento County: Results from the 2019 Point-in-Time Count
- Service Capacity and Gaps for Sacramento's Homeless Population; Environmental Scan, Pathways to Health and Home

Chapter 1: Introduction

Homelessness is a growing challenge across the U.S., particularly in California. A recent poll shows that Californians cited homelessness more frequently than any other issue as the top priority for state government to address in 2020.¹ Insufficient housing and lack of coordinated support services contribute to over-reliance on emergency healthcare and the criminal justice system as substitutes for long-term solutions. In Sacramento County, the 2019 Point-in-Time (PIT) Count [report](#), published by Sacramento Steps Forward, estimated that **5,570 people in Sacramento County** (on a single night in January 2019) **experienced homelessness**.² This includes those who are *sheltered* (e.g., in emergency shelters, transitional housing) and those who are *unsheltered* (e.g., sleeping on the street, in tents, or a vehicle). Overall, the 2019 estimate constitutes a 19% (adjusted) increase in the homeless population since 2017 (in addition to a 30% increase between 2015-2017); this is reflective of the upward national trend in California and across the United States.² The report also estimates that **approximately 10,000 - 11,000 people in Sacramento County will experience homelessness at some point during the year**.²

Two data sets serve as sources for estimating the number of people experiencing homelessness and the health challenges they may face. Each data set possesses certain strengths. The Point-In-Time (PIT) Count, required by the U.S. Department of Housing and Urban Development (HUD), provides the best estimate of the total number of people who are homeless on any given night (as counted in a single night in January). The second important data source is the Homeless Management Information System (HMIS), which contains service utilization data collected by street outreach workers, emergency shelter intake coordinators, and case managers who work with high-need individuals even when they remain on the street. Because HMIS includes only information about individuals involved with these services, this count is different than the PIT count data, and it contains more detail about the health conditions of people with complex needs who are homeless and the social services they use.^a

Key Points

- 5,570 persons experienced homelessness on a given night in Sacramento in 2019.
 - 70% were unsheltered (outdoors, vehicles, abandoned buildings, motel with voucher, bus station) vs. 30% in emergency shelters or transitional housing.
- 30% of those experiencing homelessness met the criteria for chronic homelessness: continually homeless for greater than 12 months and having a disabling condition.
- An estimated 10,000 - 11,000 people will experience homelessness at some time during the year.
- There has been a 19% increase in the number of people experiencing homelessness between 2017-2019.

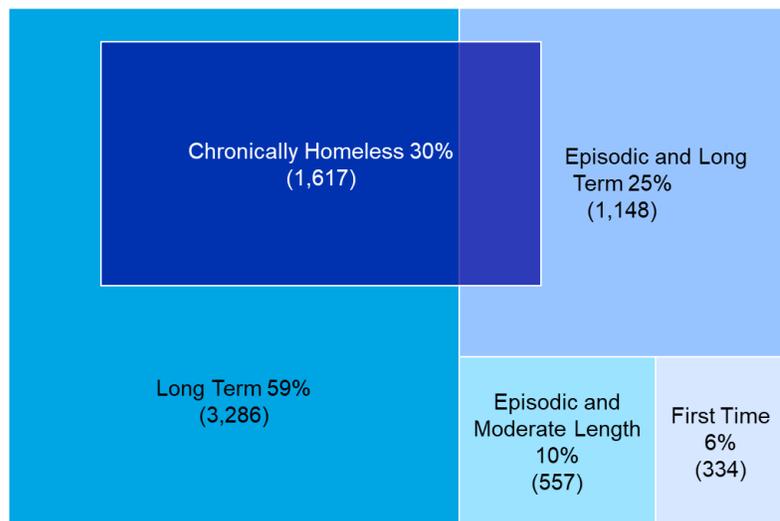
^a The Person-In-Time count is a national biennial event that counts unsheltered persons on a single night (in January); the [Homeless Management Information System](#) (HMIS) is a local data information system sponsored by the federal Department of Housing and Urban Development and financed by participating counties to manage referrals and care of people experiencing homelessness who have contact with the safety net. The HMIS database only records those people who have been enrolled through emergency shelter intake coordinators or case managers or identified through street outreach workers; thus, their acuity may be higher than many other persons who have not had contact with the system. Please see the [Sacramento County Homeless Plan 2018](#) for more details about the data sources.

About 70% of people experiencing homelessness on the night of the 2019 PIT Count were unsheltered as compared with 54% in 2017—meaning that an increasing number of people in Sacramento are sleeping outside or in a location not suitable for human habitation (e.g., on the street, in a vehicle, or in a tent). The distribution of the 30% who were sheltered on the PIT Count night in 2019 included 20% sleeping in emergency housing/shelter and 10% in transitional housing (Table 1).²

Of the 5,570 people who were homeless in 2019, about 1,600 were classified as chronically homeless, defined by HUD as being homeless continuously for at least 12 months or on at least four separate occasions in the last 3 years (totaling 12 months) and having a disabling physical and/or mental health condition that prevents employment (Figure 2).² The chronically homeless in Sacramento County self-reported one or more of the following: chronic mental health issue (57%), substance use (52%), a chronic medical condition (52%). Fifty-three percent reported two or more co-occurring conditions.³

As shown in Table 1 (page 8), the 2019 PIT count found the majority of people experiencing homelessness in Sacramento County were single adults (73%) and male (62%).² Notably, older adults (age 55+ years) comprised about one in five people experiencing homelessness (1,079). Most of these older adults (65%) were sleeping outside. Military veterans represented about 12% of people experiencing homelessness in the County. Additionally, of the estimated 372 homeless families with children, 52% (195) were unsheltered; of those, 44% slept outdoors and 33% slept in vehicles. Ninety-three percent of all people included in the PIT count were born in Sacramento or were long-term residents.²

Figure 2. 2019 PIT Count of Sacramento Homeless Population by Length of Time on Any Given Night (n=5,570)



The 2019 PIT Count report also identified substantial racial/ethnic disparities among people experiencing homelessness. Those identifying as Black/African American were overrepresented, constituting only 11% of the County-wide population but comprising about 34% of the homeless population. Similarly, American Indians and Alaska Natives are disproportionately represented among the homeless population (8%) when compared to the County-wide population (2%) (Table 1).²

Conclusion

The majority of people experiencing homelessness in Sacramento are unsheltered. This population is predominantly composed of middle-aged men; however, all ages are affected including 372 families with children. Despite an infusion of additional resources to address the growing problem, the strain on the healthcare, social services, and criminal justice systems is

evident in Sacramento and across the state. Although this report seeks to provide formative research and recommendations that will inform innovative integrated care solutions for Sacramento County, much of this material is generalizable to other communities that are also considering new approaches to addressing homelessness. This report defines the Sacramento landscape for people experiencing homelessness who have co-existing medical, mental health, or substance use disorders, and includes:

- an overview of existing Sacramento services for the homeless;
- a rapid review of the evidence on integrated/co-located care for homeless populations;
- descriptions of integrated/co-located care models in other U.S. cities;
- Sacramento stakeholder input about needs and challenges; and
- recommended actions for developing integrated solutions for people experiencing homelessness.



Table 1. Demographic description of people experiencing homelessness in Sacramento County from 2019 Point-in-Time Count

	Sheltered* % (n)	Unsheltered % (n)	Total % (n)
Estimated Homeless Population	30% (1,670)	70% (3,900)	100% (5,570)
Gender			
Male	52.8% (882)	65.4% (2549)	61.6% (3431)
Female	46.7% (780)	33.8% (1318)	37.7% (2098)
Transgender	0.4% (6)	0.5% (19)	0.4% (25)
Gender Non-Conforming	0.1% (2)	0.4% (14)	0.3% (16)
Age			
<18 years	22.2% (370)	8.9% (346)	12.9% (716)
18-24 years	10.2% (171)	6.3% (244)	7.5% (415)
24+ years	67.6% (1129)	84.9% (3310)	79.7% (4,439)
Race			
White	50.3% (840)	45.3% (1768)	46.8% (2608)
Black or African American	39.6% (661)	31.1% (1214)	33.7% (1875)
Asian	1.0% (17)	0.8% (32)	0.9% (49)
American Indian or Alaska Native	2.5% (41)	9.7% (380)	7.6% (421)
Native Hawaiian or other Pacific Islander	0.7% (11)	2.9% (112)	2.2% (123)
Multiple Races	6.0% (100)	10.1% (394)	8.9% (494)
Ethnicity			
Hispanic/Latino	19.3% (322)	17.0% (663)	17.7% (985)
Household Composition			
Individuals	947 (17%)	3,119 (56%)	4,066 (73%)
Families with children	572 (10%)	567 (10%)	1,114 (20%)
Unaccompanied Youth	111 (2%)	334 (6%)	445 (8%)
Place of Residence			
Emergency	68.2% (1,139)	-	20.5% (1,139)
Transitional	31.8% (531)	-	9.5% (531)
Outdoors	-	78% (3,042)	55% (3,042)
Vehicle	-	11% (428)	8% (428)
Other	-	11% (430)	8% (430)
Chronically Homeless Adults	25.4% (425)	31.3% (1,222)	29.6% (1,647)
Veteran	10.7% (179)	12.5% (488)	12.0% (667)
Health Status [§]			
Mental illness/substance use disorder	34.6% (577)	25.4% (992)	28.8% (1,569)
<i>Severe mental illness</i>	26.5% (345)	20.5% (728)	22.1% (1,073)
<i>Severe substance use disorder</i>	13.9% (232)	7.3% (286)	9.3% (518)
<p><i>Sources:</i> 2019 Sacramento County Point-In-Time Count; Sacramento County Homeless Management Information System, Aug-Sept 2019.</p> <p><i>Note:</i> Percentages may not add to 100 due to rounding errors.</p> <p>* Those living in emergency shelters and transitional housing</p> <p>[§] Mental illness and substance use asked only of adults: 4,854 (1,300 sheltered and 3,554 unsheltered)</p>			

Chapter 2: Health Impacts of Homelessness in Sacramento County

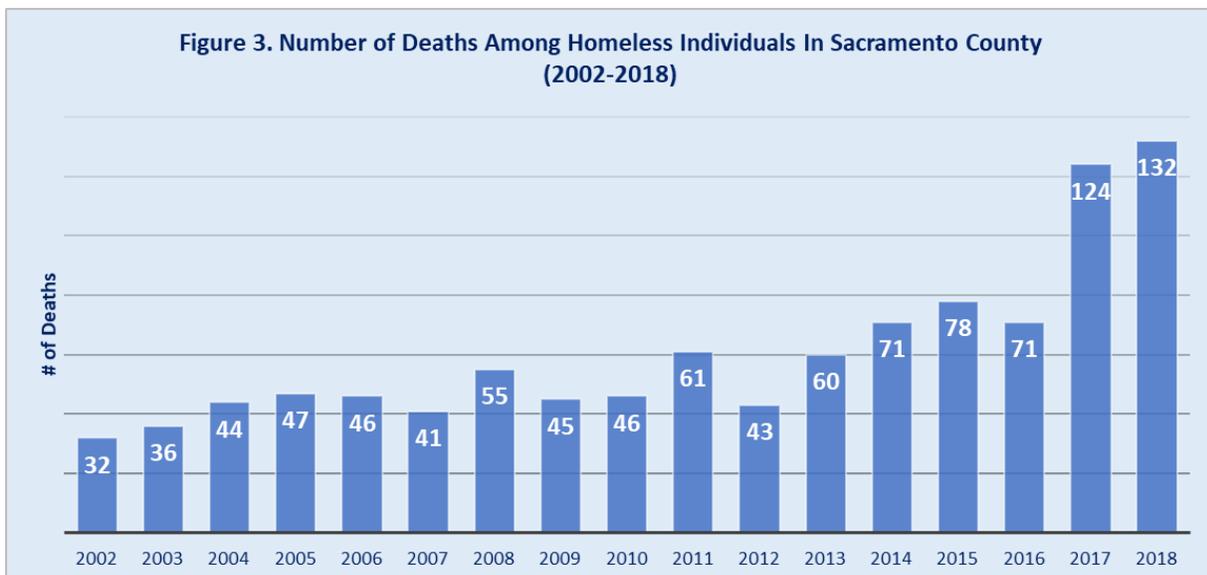
Serious health problems, as a cause or consequence of homelessness, exacerbate the already precarious state of living without shelter. This chapter summarizes what is known about mental and physical health problems, substance use disorders, and chronic homelessness in Sacramento County and provides context for discussion about potential expansion and integration of appropriate services.

Health Status

People who experience homelessness have a high prevalence of chronic medical problems, mental health conditions, and substance use disorders. California Healthline reported that there were 100,000 admissions of homeless patients to California hospitals in 2017, a 28% increase since 2015. Of those patients, 35% were diagnosed with a mental health condition, compared with only 6% for all hospital discharges. The most common hospital discharge diagnoses were mental health disorders, HIV infections, alcohol-drug use, skin disorders, and burns. Sacramento County had the third largest number of hospital discharges of patients who were homeless in the state in 2017, though it was 8th based on population size.⁴

Mortality

From 2002-2018, there were 1,032 deaths among homeless people in Sacramento, a rate of mortality that has been increasing in recent years. Over 45% of deaths over that 16-year period occurred in the last five years (2014-2018) and the most recent count of 132 deaths in 2018 was up from 124 in 2017 (Figure 3). Details for 113 of these deaths in 2019 are provided in a report from the Sacramento Regional Coalition to End Homelessness.⁵ The average age at death in 2019 was 43 years for women and 52 years for men.



Source: Sacramento Regional Coalition to End Homelessness

Forty-nine percent of these deaths were caused by accidents, 22% were attributed to natural causes, 10% were suicides, 7% were homicides, and 12% were undetermined. Underlying causes of death were attributed to injury in 36%, substance abuse in 30%, and cardiovascular causes in 18%. Methamphetamine was an underlying cause of 26% of 108 deaths investigated in 2018.⁵

Chronic Health Conditions

Recent Sacramento HMIS intake data (*which captures a higher-acuity subset of the homeless population*) indicate that about 42% (2,069) of people experiencing homelessness in Sacramento County report having one or more chronic physical health condition.³ Examples include heart disease; severe asthma; diabetes; arthritis; adult onset cognitive impairments (including traumatic brain injury and neurocognitive disorders); severe headaches/migraines; chronic bronchitis; liver conditions; and emphysema.

People enrolled in the Sacramento County Homeless Management Information System (HMIS) self-reported the following conditions:

- Chronic physical health condition: 52%
- Chronic mental health condition: 57%
- 2+ co-occurring conditions: 54%
- Any substance use: 52%

Mental Illness

Fifty-seven percent (2,101) of individuals engaged with homeless services—sheltered and unsheltered—reported having a chronic mental health illness, which can include conditions such as bipolar disorder, depression, schizophrenia, and post-traumatic stress disorder, to the Sacramento HMIS.³ Data are lacking on how many people experiencing homelessness in Sacramento County received treatment for their mental health disorder. The prevalence of *all* Sacramento adults with serious mental illness is similar to the California average (4.4% and 4.2% respectively).⁶ For California adults with any mental illness (2011-2015), only 37% received mental health care services (compared with 43% nationally).⁶

Impact of Unmanaged Mental Illness

Unmanaged mental health conditions contribute to diminished quality of life for patients and their families and friends and lead to avoidable and costly care in emergency departments and hospitals. California hospital emergency departments (EDs) have seen a 30% increase (2010-2015) in the number of ED visits that resulted in inpatient psychiatric admissions.⁶ A study of California ED visits (2009-2014) found that among almost 850,000 visits for mental health care, 28% were visits by frequent users (four or more in 12 months). Those who were identified as homeless or having concomitant mental health and substance use diagnoses were more likely to be frequent users.⁷

“5150 hold” refers to the California code that allows up to a 72-hour involuntary hold in a hospital setting to perform a psychiatric evaluation and stabilize patients who are at risk of harming themselves or others.

Health systems are reporting high numbers of patients undergoing mental health crises in emergency department beds, many of whom are nearly homeless or homeless individuals.⁸

Unpublished data from two Sacramento health systems show that between January 2019 and August 2019, 7,190 patients accounted for 8,596 ED visits that included a psychiatric evaluation for

a 5150 hold (regardless of housing status). On average, the ED length of stay for those visits was 37 hours (minimum 22 minutes; maximum 20 days in the ED). About 3,500 patients were placed on a 5150 hold and had a 55-hour average length of stay. Almost 2,850 patients were transferred to a psychiatric hospital and 51 were discharged to a board and care facility. Most of these patients were covered by Medi-Cal (56%, 64%), followed by Medicare (23%, 22%) and commercial insurance

(11%, 10%); about 3% at both health systems were uninsured. One system estimated that 8% of ED-patients undergoing psych evaluations were homeless while the other system estimated that 30% of their psych evaluations were for patients who were homeless. Although these numbers reflect the general population, they demonstrate a high need for care of people experiencing mental health crises. The lengths of stays in the ED demonstrate a lack of capacity for inpatient psychiatric care and intensive outpatient mental health care accompanied by housing, which delays appropriate care for patients and inhibits flow of care for other ED patients.⁸

Substance Use Disorders

Recent Sacramento County HMIS data show that approximately 59% (2,084) of adults engaged with homeless services self-report some form of substance use (alcohol or drugs excepting prescribed medications) and 9.3% (518) report “severe” substance use (i.e., they indicated that their use of substances prevented them *from being housed or employed*).³ However, these self-reported data likely underestimate the true prevalence of substance use disorders (SUDs) and the need for SUD treatment. It is well understood that self-reported substance use/misuse is heavily underreported due to stigma, fear of not qualifying for services, and lack of patient recognition of problematic substance use.⁹

Due to biases associated with self-reporting, the prevalence of SUD among people who are homeless in Sacramento County may be better estimated using data from the California Outcome Measurement Service (CalOMS) Treatment System. The CalOMS report from the Sacramento County Alcohol and Drug Services System shows 5,000 admissions (for 4,433 unduplicated clients) in Sacramento County in FY 2018-19 (note: this does not include all SUD treatment in the County, but it is inclusive of indigent and Medi-Cal beneficiaries). About 27% of those seeking SUD treatment through the County system reported being homeless at the time of assessment.^{9,10}

In Sacramento County (unlike many regions in the U.S.), the prevalence of methamphetamine use disorder is similar to the prevalence of opioid use disorder (OUD) (inclusive of heroin and prescription opioids). However, within Sacramento’s homeless population, methamphetamine use appears to be about 1.5 times more prevalent than illicit opioid use—at least for those who seek treatment (Table 2). Methamphetamine is also the most common underlying cause of death among homeless people attributed to substance abuse.⁵ Although access to medication-assisted treatment (MAT) has expanded over the past two years, this treatment is only effective for opioid and alcohol use disorders. Treatment options for meth addiction are limited to behavioral therapies and counseling. Contingency management is a specific behavioral approach for which some promising evidence for effectiveness has been published; however, it is not widely used.¹¹⁻¹⁴

Table 2. Sacramento County resident substance use disorder treatment admission data, FY 2017-2018

	Number (%) of all Sacramento clients in treatment by primary drug	Number (%) of clients experiencing homelessness in treatment by primary drug
Methamphetamine	1,552 (27%)	666 (43%)
Heroin	1,633 (29%)	426 (28%)
Alcohol	943 (17%)	220 (14%)
All Other	1,563 (27%)	222 (15%)
Total	5,691 (100%)	1,534 (100%)

Source: Sacramento County Methamphetamine Coalition.¹⁵ Presentation by L Miller, 2019.

Methamphetamine-using clients (including those who were homeless) used county outpatient SUD treatment programs (813) most frequently, followed by residential treatment programs (561), detox centers (141), and intensive outpatient programs (21) in FY 2017-2018. Waiting lists for SUD treatment programs, particularly residential programs, are long. Note that Sacramento County formed a [Methamphetamine Coalition](#) in 2016 to reduce meth use through prevention programs (by public entities, care providers, and law enforcement), treatment expansion, and securing funding to improve data collection.¹⁵

Chronic Homelessness

The federal Department of Housing and Urban Development defines chronic homelessness as:

- being homeless for at least 12 months, or on at least 4 separate occasions in the last 3 years that total 12 months;
- and having a diagnosable substance use disorder, mental illness, developmental disability, PTSD, cognitive impairment from brain injury, or chronic physical illness/disability.¹⁶

According to the 2019 Sacramento County PIT Count study, about 30% (~1,600) of adults experiencing homelessness in Sacramento County met the federal definition of chronic homelessness (on a given night). Additionally, almost 30% of the estimated 372 homeless families reported experiencing long-term continuous homelessness (greater than one year).²



Source: Printed with permission from Sacramento Loaves and Fishes.

Levels of Acuity among the Homeless Population

An analysis of Sacramento HMIS data show that about 2,000 adults would be considered “high acuity” as defined by long-term homelessness and a self-report of having two or more of the following: a chronic physical condition that prevents stable housing, a mental health condition that prevents stable housing, or any substance use. Of those with high acuity, a little over half (1,100) are unsheltered.³

People experiencing homelessness can face varying levels of acuity depending on their duration of homelessness, number and severity of co-occurring conditions, and community network support. Among the 10,000 – 11,000 people experiencing homeless at some point during the year in Sacramento County, it is clear that those with lower acuity will exit homelessness more quickly due to better physical and mental health status and an ability to navigate community services to find permanent housing and other necessary support services. In contrast, those experiencing chronic homelessness are often those at the highest acuity level because of their complex, co-morbid health conditions.

Conclusion

There are high rates of severe and overlapping medical conditions, mental illness, and SUD among long-term or chronically homeless populations. Of the estimated 5,570 people experiencing homelessness on a given night in Sacramento County, about 30% are considered to be chronically homeless, with complex comorbidities that require coordinated care for stabilization and intensive support to achieve housing permanence.²

Chapter 3: Health Care and Housing Support Services in Sacramento County for People Experiencing Homelessness

The previous chapter demonstrated the need for services to support people experiencing homelessness. The complex needs of the chronically homeless population include access to shelters, transitional and permanent housing; medical care; mental health care; and treatment for substance use disorders; as well as social services support. The need for coordination and integration of care and services across sectors is compelling. This chapter presents information about a broad swath of current services in Sacramento (including health care, behavioral health care, and drug treatment). It concludes with a summary of housing and shelter options. People with low incomes or the general population, in addition to people experiencing homelessness, are eligible for many of the services described. Information was obtained from a variety of sources including the 2018 [Pathways to Health and Home Environmental Scan](#), which provides a thorough review of the diverse sets of services in Sacramento County.¹⁷

Services in Sacramento County are exceptionally complex to navigate from both the provider and patient/client perspectives (regardless of housing status), due at least in part to the array of nonprofit organizations delivering services through a variety of funding sources. Contributing factors include:^{16,17}

- An extensive network of County contracts with non-profit agencies providing housing, SUD treatment, and mental health treatment,
- Siloed groups of providers by area of expertise (i.e., housing vs. medical care vs. substance use disorder treatment),
- Multiple funding and payor sources that frequently carry restrictions (eligibility, programmatic, etc.),
- Limited communication between organizations due to
 - incompatible technology platforms, and
 - federal and state privacy regulations prohibiting exchange of data.



Source: Shutterstock.com.

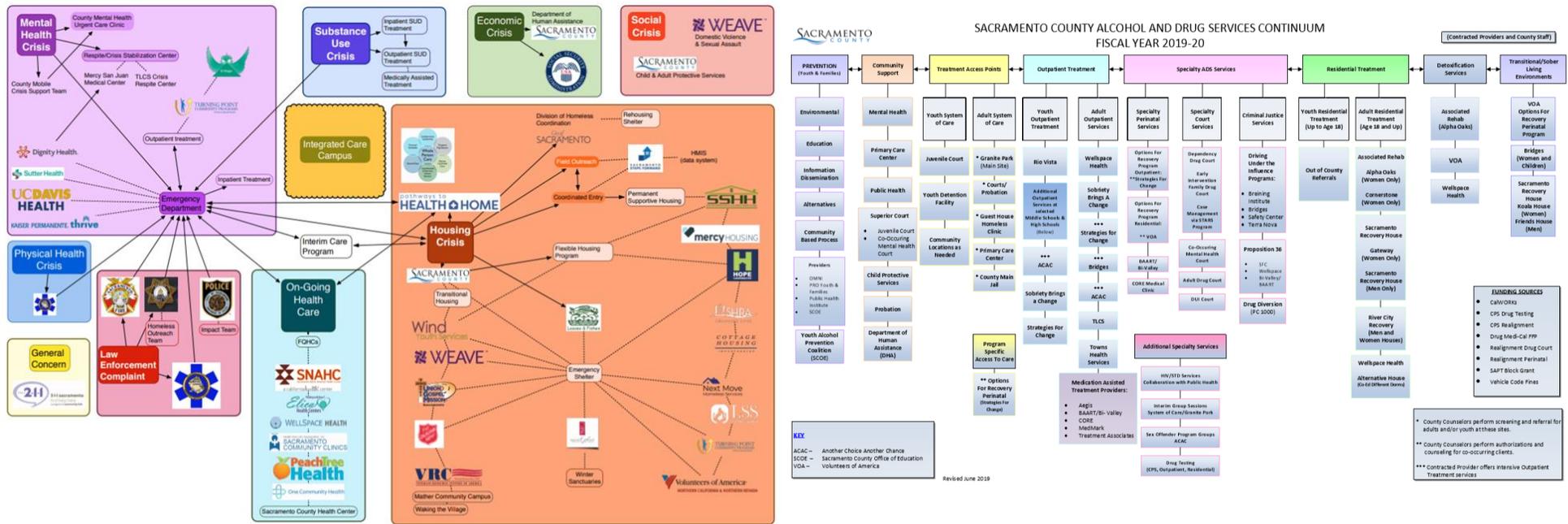
Sacramento County administrators are responsible for the oversight, coordination, and funding of health and human services, especially those concerned with housing, behavioral health care, and the court system. The County released its [Sacramento County Homeless Plan](#) in December 2018, which documents accomplishments to date, and plans to expand programs in conjunction with other primary agencies leading the coordination, subcontracting, and provision of services (i.e., City of Sacramento, Sacramento Steps Forward, Sacramento Housing and Redevelopment Agency, County Justice system).¹⁸ In addition to government-funded programs, advocacy organizations, non-profit providers, health systems, health plans, philanthropic organizations, and religious affiliates also contribute funding and services to support low-income individuals, including people experiencing homelessness.

Stakeholder feedback solicited for this report confirms the complex system as reported by providers and patients. Figure 4 offers competing views of services available in Sacramento. The left side of Figure 4 provides a client-in-crisis perspective and shows multiple service entryways (Client Crisis Map). This map was designed using stakeholder feedback. The right side of Figure 4 provides a County administrative perspective through an organizational service diagram, which shows the breadth and structure of county-sponsored mental health services. Both versions provide a partial, snapshot view of the complex array of services but from different perspectives (Appendix A provides enlarged views), and neither perspective captures all of the providers, programs, and funders. Despite significant effort, we found no comprehensive, consolidated source that inventories numbers of beds, visits, or patients/clients served by all programs.

The web of service providers and payors for the homeless population is composed of public and private entities including the state Medi-Cal program, Sacramento County, County-funded nonprofits, other nonprofits, health systems, clinics, faith-based organizations, and the criminal justice system.

Many of the safety-net systems and programs serve the broader population of low-income residents (inclusive of homeless persons); thus, capacity is more impacted than what might appear to be available when considering only people experiencing homelessness.

Figure 4. Different Perspectives on the Structure of Services Offered by the County: Client Crisis Map vs. County Administrative Services Organizational Chart*



*County organization chart (right) represents only one section of the Client Crisis Map (left). **Enlarged views available in Appendix A.**

Broadly speaking, services for people experiencing homelessness may be grouped into several categories:

- health care (including care for mental health conditions and substance use disorders)
- shelter/housing programs
- criminal justice/first responder programs
- social services (i.e., benefits assistance, job training, legal aid, education, etc.)

Across these categories, both public and private entities provide services including the County, County-funded nonprofits, other nonprofits, health systems and clinics, faith-based organizations and entities connected within the criminal justice system. Each entity relies on different funding streams (with different constraints) including Medi-Cal, state and federal housing dollars, and funding from the state’s Mental Health Services Act. *Note: Not all people experiencing homelessness have equal access to the following programs (and facilities within programs) due to different eligibility criteria associated with funding restrictions, mission, sobriety requirements, ability to ambulate, insurance coverage, etc.*

Health Care Services

The health care services silo is vast and complex. Overlaying the basic health care provider structure is a labyrinthine financing system that controls access to care for certain patient populations based on payor source and program eligibility. The managed care organizations are required to provide mental health services to Medi-Cal beneficiaries (most people experiencing homelessness fall into these categories) who are diagnosed with low-acuity conditions. However, Medi-Cal recipients and the uninsured with more serious mental illnesses and those with substance use disorders receive treatment from County-run or County-funded programs. The complexity of access and lack of continuity of care make it difficult for patients to know where to go and for providers to refer, communicate, and track patient treatment. It also increases the complexity of care coordination (physically and administratively) for patients who must navigate multiple systems.



Source: Printed with permission from [SFCCC](#).

Health Systems

Four health systems offer emergency, acute, and primary care through eight hospitals in Sacramento County.¹⁷ Emergency departments provide care for urgent and emergent medical, mental health, and SUD problems to the greater Sacramento region. Federal law requires them to evaluate every patient who presents to them, regardless of condition or insurance. Thus, emergency departments are the common entry point for people experiencing any form of health crisis, whether it relates to physical health, mental health or substance use disorder. The 2018 Pathways to Health and Home Environmental Scan estimated that the hospital costs of caring for

individuals experiencing homelessness in Sacramento exceed \$53 million per year, of which \$4.8 million are attributable to preventable conditions (e.g., amputations, cold-related injuries, infectious diseases).¹⁷

Effective July 1, 2019, SB 1152 requires that California hospitals collect housing status information from patients and design a discharge planning process and policies for coordinating services and referrals with county behavioral health agencies, and health care and social service agencies for homeless patients. Therefore, the quality of data on homeless patients served by Sacramento hospitals should improve within the next year.¹⁹

In addition to providing patient care, the health systems in Sacramento County also provide in-kind clinical services and financial support (through their community health benefits programs) to 14 programs for individuals experiencing homelessness that target care coordination, respite care, and housing (Pathways). Examples of these programs include Housing with Dignity, the Genesis Project, the Street Nurse Program, and the Willow Clinic.¹⁸

Medical Respite Shelters

Medical respite is an important step in the post-hospital discharge recovery process for homeless individuals. Having a safe, clean place to care for wounds and recover from surgery or chemotherapy is important to healing properly and avoiding unnecessary returns to the health care system. In 2019, there were 59 beds available in three medical respite shelters in Sacramento. WellSpace oversees the *Interim Care Program* that provides medical respite care in a 20-bed unit in partnership with Volunteers of America (VOA). Funded by the four health systems (Dignity Health, Kaiser, Sutter Health, UC Davis Health) and the County, this unit provides beds for ambulatory, sober patients for up to 4-6 weeks (average 19-day stay) who are recovering from surgeries, burns, amputations, etc. Patients receive three meals/day and case management services that support mental health and substance use treatment and permanent housing placement. The unit reportedly has served about 15,000 patients since opening in 2005.²⁰ The *Interim Care Plus* program (also operated by WellSpace) and the Salvation Army Emergency Shelter (funded by Sutter) offer longer stays for intensive respite care to 21 people, and the T3 shelter has 18 beds; both provide wrap-around services similar to the Interim Care Program.¹⁷

Community Clinics

In addition to health systems, people experiencing homelessness (uninsured or Medi-Cal beneficiaries) may obtain primary care and behavioral health services (for mild to moderate mental health conditions) through one of seven federally qualified health centers (FQHCs) or “look-alikes”. With 42 sites across Sacramento County, these FQHCs provide some or all of the following: integrated primary care, outpatient substance use disorder treatment, mental health care for mild-to-moderate mental illness, limited specialty care, diagnostic lab services, radiologic services, dental care, mobile medical outreach programs, and case management/benefits assistance.¹⁷ FQHCs also partner with many of the aforementioned formal homeless programs sponsored by the health systems as well as provide informal services such as veterinary care for patients’ animals, or phone charging stations/free internet to encourage patient adherence to appointments.¹⁷ Apart from the Sacramento County-run primary care clinic, these clinics operate independently and receive reimbursement primarily through Medi-Cal-managed care plans and the state Medi-Cal program (wrap-around payments).²¹

Mental and Behavioral Health Care

Sacramento County provides health services, mental health care and SUD treatment for persons with low incomes, including those experiencing homelessness, through an extensive network of contracts with nonprofit agencies and a few County-run programs. In comparison to some other counties of similar size in California, Sacramento County relies heavily on subcontracting and less on direct provision of services by the County.

The County has multiple subcontractors providing mental and behavioral health care across the spectrum of care from acute crisis to long-term, chronic care for mild to severe mental health diagnoses for Sacramento residents, including those who experience homelessness (see Appendix A for County service organization charts). Our research yielded no comprehensive source that plainly differentiates between the mental health care programs (frequently defined by a funding source) and service providers (who frequently administer or participate in more than one type of program).

Mental and behavioral outpatient health care services can be divided into intensive mental health care services and outpatient mental health care services. Intensive mental health care includes respite/crisis stabilization, inpatient, and residential care. Although the number of beds may look substantial (Table 3), not all patients are eligible for a space due to thematic restrictions on care (e.g., depression only, women only, transitional-aged-youth only, etc.).

- *Mental Health Crisis Service Units* (CSUs) and intake stabilization units (length of stay up to 23 hours) are care options for some people experiencing a psychiatric crisis and a way to avoid unnecessary emergency department visits. Following a psychiatric evaluation, acute crisis management, and drug and alcohol screening, these programs generally refer patients to appropriate follow-up care through inpatient facilities, intensive outpatient programs, or outpatient care. Mercy San Juan Hospital recently opened a crisis stabilization unit that can treat up to 12 patients at a time and the Sacramento County Mental Health Treatment Intake Stabilization Unit can treat 20 patients simultaneously.
- Three short-term *mental health respite centers* are supported through Sacramento County MHSA-funding: TLCS-Mental Health Crisis Respite Center, Turning Point-Abiding Hope Respite House, and St. John’s Mental Health Respite Program.²² Available 24/7, these facilities provide mental health crisis services (screening, referrals, crisis response and care management) for stays ranging between 23 hours to 14 days. Like the crisis residential facilities described below, these centers help avoid unnecessary ED visits or acute psychiatric hospitalizations; however, beds are limited (15 beds between two facilities; bed capacity for third facility is unknown).
- Sacramento County has three mental health *crisis residential facilities* with 42 beds (estimated need is 72 beds) for adults with mental health crises; two more facilities are in development.²³ These facilities offer short-term support with stays ranging between 23 hours to 30 days. These units are available only to those who agree to go voluntarily; units are not available to patients placed on 5150 (involuntary) psychiatric holds (danger to self, danger to others, or gravely disabled).

- *Acute psychiatric hospitals/facilities* provide voluntary and involuntary (locked unit) inpatient care. The number of beds available in California and Sacramento has been declining (as emergency room discharges to psychiatric facilities have been increasing from 18.7/10,000 to 24.5/10,000 [2010-2015]).²⁴ Free-standing, inpatient psychiatric hospitals, and licensed psychiatric health facilities (PHFs) in Sacramento County provide 554 beds (including 50 beds at the Sacramento Mental Health Treatment Center that serve Medi-Cal beneficiaries and the uninsured). A new inpatient psychiatric hospital is slated to open in March 2020 in Sacramento County, adding another 120 beds to the Sacramento area, bringing the total to 604 beds. The [California Hospital Association](#) convened a group of experts to assess the psychiatric patient-to-bed gap across California.⁸ They studied data from 2017 and determined that 50 public psychiatric beds/100,000 population would meet the needs of California (contingent on availability of outpatient services). The Sacramento County psychiatric bed-to-population ratio was estimated at 29/100,000. Using this metric, it appears that despite the additional 120 beds coming online in 2020, Sacramento County remains short almost 600 psychiatric beds. This is similar to the median patient-to-bed gap in other California counties.

Based on a 2019 California Hospital Association report, Sacramento County remains short almost 600 psychiatric beds despite an additional 120 beds coming online in 2020.

FEDERAL “IMD” EXCLUSION
 Access to inpatient psychiatric care is limited for Medi-Cal patients by federal law, which prohibits states from using Medicaid funds to pay for services provided to nonelderly adults in “Institutions for Mental Disease.” IMDs are defined as any psychiatric facility with more than 16 beds. These facilities can receive payment for patients on Medi-Cal only from state or county funds. The federal Institute of Mental Disease (IMD) payment exclusion was intended to leave states with the primary responsibility for financing inpatient behavioral health services. However, the lack of federal funding limits resources and access to needed inpatient services and contributes to high levels of unmet need.

Psychiatric hospitals/facilities provide inpatient mental health care and typically do not accept patients with acute or severe chronic medical conditions, such as wound care or uncontrolled diabetes. There are four medical-psychiatric hospitals in Northern California and none in Sacramento County. Access is limited due to the limited number of beds designated for co-occurring conditions. Therefore, patients experiencing behavioral health crises with co-occurring medical conditions (common among people experiencing homelessness), may wait in the emergency department or an inpatient acute care hospital bed until their mental health crisis resolves or their medical problem resolves sufficiently for them to be discharged home or to a psychiatric-only facility that has an open bed.

- Woodland Memorial is the only hospital in the Sacramento region (Yolo County) with a medical-psychiatric unit that treats patients with co-occurring medical and psychiatric conditions. It has 31 medical-psychiatric beds within its acute care hospital, but Yolo County Medi-Cal beneficiaries commonly fill those beds.
- Intensive mental health services are also provided for inmates at the County’s jails. The Sacramento County Main Jail, which houses 2,400 inmates, contains an 18-bed inpatient psychiatric unit for acute mental health conditions, and the Rio Cosumnes Correctional

Facility provides 16 beds. Mental health services for inmates with lower acuity are also provided. Approximately 20% of inmates have a known prior psychiatric history.²⁵ (See the *Intersection with Criminal Justice System* section for more details.)

Table 3. Facilities Providing Intensive Mental Health Care to Individuals Experiencing Homelessness in Sacramento County

Type	Facility	Beds Available
Crisis Service Units		~32
	Mercy San Juan (serving Sacramento and Placer Counties)	12
	Sacramento County Mental Health Intake Stabilization Unit	20 spaces
Mental Health Respite Care		18
	Turning Point (Abiding Hope)	5
	TLCS Mental Health Crisis Respite Center (Hope Cooperative)	10
	St. John’s Mental Health Respite Program (women only)	3
Crisis Residential Programs[§]		78
	Turning Point Bender Court	6
	Turning Point Oak Park	12
	Turning Point Rapid Turnaround (“south area”)	15
	Turning Point Rio Linda (“north area”)	15
	Stars - The STAY (expected Winter 2019)	15
	Turning Point: Dual diagnosis-themed program	15
Inpatient Acute Psychiatric Hospitals/Facilities*[§]		554
	Heritage Oaks (APH)	125
	Sierra Vista (APH)	171
	Sutter Center for Psychiatry (APH)	73
	Crestwood Engle (PHF)	16
	Crestwood Stockton Blvd (PHF)	16
	Heritage Oaks (Opening soon) (PHF)	16
	Sacramento County Mental Health Treatment Center (PHF)	50
	Crestwood Mental Health Rehabilitation Center	54
	Crestwood American River Adult Residential Facility	28
	Abiding Hope Respite House/Turning Point	5
Criminal Justice		34
	Sacramento County Jail	18
	Rio Cosumnes Correctional Center	16

Note: Woodland Memorial Hospital (Yolo County) has a 31-bed medical-psychiatric unit; it is the only med-psych facility in northern California. Patient referrals from Sacramento County are rarely accepted due to full bed census.

Note: Crisis Service Units permit up to 23-hour stays; Inpatient Acute Psychiatric Hospitals/Facilities permit indefinite involuntary, conservatory, and voluntary inpatient stays; Crisis Residential Programs permit stays up to 30 days; Mental Health Respite programs provide alternative emergency room visit/hospital inpatient care and length of stay varies by organization from <24 hours to 14 days.

PHF=Psychiatric health facility. To receive Medicaid reimbursement, these facilities are limited to ≤16 beds per federal “Institutions for Mental Disease” law.

APH=Acute psychiatric hospital.

*Does not include the additional 120-bed psychiatric hospital anticipated to open March 2020.

[§] Inpatient acute psychiatric hospitals and PHFs may not be available to all patients. For example, Crestwood Mental Health Rehabilitation Center is a locked facility that cares for long-term patients under conservatorship. Crisis Residential Programs are generally thematic and serve certain patient subpopulations such as transitional-aged youth or those who are dually diagnosed (e.g., SUD and mental health); thus, total bed-count may not be available to all patients.

Outpatient Mental Health Services

Sacramento County also provides outpatient mental health services.²² The level of support (psychiatry, intensity of case management services, etc.) depends on disease severity:

Low-intensity services: Wellness and Recovery Centers, County Adult Psychiatric Support Services (APSS) Outpatient Clinic, and El Hogar Guest House, which are supported in part through MHSa General System Development funds.

Moderate-intensity services: County APSS Clinic, TLCS, and Mental Health Services Act-funded Regional Support Teams (El Hogar, TLCS, Northgate Point, Visions).

High-intensity services: Mental Health Services Act-funded Full-Service Partnerships (Transcultural Wellness Center, El Hogar Sierra Elder Wellness, Capital Star, River Oak, Telecare, TLCS New Direction, Turning Point Integrated Services Agency).

In addition to County-sponsored specialty mental health clinics, some primary care clinics provide outpatient behavioral health counseling and medication treatment including the seven federally qualified healthcare centers (FQHCs) in Sacramento. FQHCs receive funding to integrate mental health services into primary care settings for patients with mild to moderate mental health conditions. Low-income patients with serious mental health conditions are referred to County services.

Mismatch in Supply of and Need for Mental Health Care Providers

As noted in Chapter 2, **only 37% of all Sacramento County residents reporting a mental health condition receive care.** Despite the number of services available, the County needs more mental health providers to care for its residents, including homeless individuals who have a higher prevalence of mental health conditions as compared with the overall population. The mismatch between supply and need for services is not uncommon. Researchers at UCSF estimated that California will have 50% fewer psychiatrists and 28% fewer psychologists, licensed marriage and family therapists, professional clinical counselors, and clinical social workers than will be needed in California by 2028 (based on current utilization and unmet need).²⁶ In recognition of the projected dearth of providers, the California Future Health Workforce Commission proposed a series of recommendations to eliminate this projected shortfall and improve the pipeline of students and health workers who seek to provide care in underserved communities.²⁷

Substance Use Disorder Treatment

Treatment for substance use disorder (SUD) varies according to the substance being misused. Counseling services are evidence-based treatments for all SUDs while medication-assisted treatment (MAT) can be a useful modality only for people with alcohol or opioid use disorders. Access to MAT for opioid addiction has expanded over the past two years and there are immediate options for treatment, including MAT induction in the UCDH Emergency Department followed by connection to ongoing outpatient treatment.²⁸

Some primary care clinics provide MAT with integrated behavioral health programs to treat opioid and alcohol use disorders (SUD). There are five providers (seven locations) in Sacramento

County that provide methadone, buprenorphine, disulfiram, naltrexone and/or naloxone. According to a study by the Urban Institute, there were 247 buprenorphine-waivered prescribers with a 30-patient limit, 38 waivered prescribers with a 100-patient limit and 18 waivered prescribers with a 275-patient limit, which together represent 3.4% of the total prescribers in Sacramento County.²⁹

Treatment for SUD is complicated by homelessness. For individuals motivated to stop using who are living outside or in shelters, detoxing and staying clean is substantially more difficult. With continuous exposure to factors that feed the cycle of SUD and no stable support network, the possibility of successful treatment is reduced. In addition, obtaining treatment for methamphetamine addiction (which has no MAT option) and alcohol addiction (with limited MAT available) is particularly challenging for people experiencing homelessness due to limited residential treatment availability (due to insurance status). Referrals may result in long waits with requirements to check back multiple times over months. Limited residential treatment is offered to people with low incomes by religious organizations, but this approach is not appropriate for all individuals.²⁸

Sacramento County has 46 facilities licensed and/or certified by the California Department of Health Care Services to provide SUD treatment:

- 20 outpatient facilities with no detox services;
- 26 facilities with residential programs that provide 517 treatment beds (9 facilities do not offer detox treatment).³⁰

Despite the number of licensed/certified beds in Sacramento County, people experiencing homelessness only have access to a subset of those beds due to insurance status. To enter treatment, they must be assessed first at the County Drop-In Center and may be referred to a SUD treatment provider contracted through the county.¹⁷ The County Alcohol and Drug System of Care (Appendix A) contracts with five residential treatment facilities that offer 224 beds (of which three facilities also offer detox programs). There are 104 beds reserved for women, 72 beds reserved for men, and 48 beds in a co-ed setting. Likewise, access to outpatient SUD treatment services are limited by insurance coverage with seven County-contracted programs accepting Medi-Cal.

Stays in withdrawal management (detox) facilities range between 1-14 days based on need (youth are referred to local EDs); stays at residential treatment facilities range between 1-90 days (youth are referred out of County); and sober living (recovery residences) allow 12-18 month stays for patients.³¹

Health Plans

Five Medi-Cal-managed care plans (Aetna Better Health, Anthem Blue Cross, Health Net, Kaiser Permanente, Molina Healthcare) provide health insurance coverage to more than 425,000 Sacramentans, including people experiencing homelessness. The County reported that the health plan composition of members who were homeless ranged from 1% (Kaiser) to 15% (Molina).¹⁸ Sacramento Medi-Cal enrollees with a mental health diagnosis ranged between 4% - 50% (Molina and Kaiser, respectively); those with substance use disorder ranged between 16% - 44%; and those with three or more chronic conditions ranged between 23% - 59%.

The managed care plans serving Sacramento County Medi-Cal beneficiaries planned to implement a Health Homes Program (HHP) including mental health by January 2020. The HHP

enables plans to identify and assign the highest acuity beneficiaries (including the chronically homeless with co-occurring chronic health conditions or substance use disorders) to community-based care management entities.¹⁸ These entities, contracted with the plan, are required to provide:

1. Comprehensive care management
2. Care coordination (physical health, behavioral health, community-based long-term services and supports)
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

The HHP will overlap with a similar program, Whole Person Care, which is a pilot program that may not sunset in 2020 if the Governor’s FY ‘20-‘21 budget is adopted.³²

Housing Options for People Experiencing Homelessness

Since the mid-1980s the U.S. Dept. of Housing and Urban Development (HUD) has become the primary federal entity funding programs and services for people experiencing homelessness, which are discussed below. During the last two decades, HUD has gradually shifted its funding strategy toward a community-based approach, called the Continuum of Care (CoC) model, which supports local programs and services to address homelessness. Under this model, a community-lead agency submits a single application for all local funding requests for services and programs related to homelessness. The goal is that funded projects align with the specified needs and capacities of the community and its local system of services for the homeless. Essentially, the CoC is a community-driven model to plan and fund services through coordination, collaboration, and strategic use of fiscal resources. CoCs are also responsible for developing a long-term community homelessness strategic plan and year-round planning.



Source: Shutterstock.com.

Most CoCs encompass a variety of programs including street outreach assessment and preventive services; emergency shelter; rapid rehousing; transitional housing; permanent supportive housing. CoCs can also include a range of supportive services including counseling, case management, education and job training, employment supports, access to governmental benefits, and budget assistance. CoCs are required to develop a Coordinated Entry System, a single referral system to improve the efficiency of

service triage and allocation. Upon entry into the system, individuals can access the various services. Sacramento Steps Forward (SSF), the County’s lead CoC agency, administers the Coordinated Entry System. SSF awarded \$20.9 million in housing grants to 23 local housing programs in 2018.³³ *Note that not all people experiencing homelessness have equal access to the*

following programs (and facilities within programs) due to different eligibility criteria associated with funding restrictions, mission (WEAVE, for example), sobriety, ability to ambulate, etc.

Emergency Shelters

Emergency shelters provide temporary stays overnight and are generally unavailable as a day facility. Services at shelters range from a sleeping pad and dinner in a church for a single night to large, government-operated buildings with cots, food service, and wrap-around social services. Shelters may be single-sex, sober-only, or take “all comers.” Usually clients have right of first refusal for consecutive night stays after their first night’s stay, which is reassuring for some during inclement weather months. Shelters frequently face storage challenges for clients with lots of belongings; pets may not be accommodated either.

According to the 2018 HUD Continuum of Care Homeless Assistance Housing Inventory Count, all 32 emergency shelter programs provided a total of 891 year-round beds and 447 winter beds in Sacramento County (note: bed capacity was reduced in 2019 with the closure of the 200-bed Sacramento City Winter Triage Shelter [Railroad Drive] facility).³⁴ The bed inventory for each emergency shelter ranges from 6 beds to 111 beds according to HUD’s listed programs.¹⁷ Additionally, the County reported to HUD 133 overflow (motel) vouchers to people who were turned away from a shelter.³⁴ Some shelters restrict access by gender, age, sobriety, and pet ownership and clients must reapply each night for a shelter bed. In Fall 2019, Sacramento Mayor Steinberg requested that each of the eight city councilmembers identify locations to house 100-bed facilities in their districts. To date, two shelters promising 100 beds each are slated to open in Meadowview (for women and children) and Oak Park (for adults) by 2020. Five other districts have proposed sites, with the largest being a 700-unit site in Del Paso Heights (Councilmember Warren) that combines tent camping (200) with tiny homes, cabins, and single-family residences. This site would offer support services, health clinic, and safe parking lots for additional shelter.³⁵

Sacramento County’s low-barrier *Full Service Re-Housing Shelter* program also offers temporary shelter — 75 beds/night across 15 scattered sites (with plans to boost to 115 beds/night across 25 sites).³⁶ Invitations are by referral only from County programs, including the sheriff’s department, adult protective services, social workers and street outreach teams. Intensive re-housing and supportive services assist an estimated 250-300 people annually.³⁷ Since March 2018, 137 clients have exited this shelter and entered stable housing. The County also notes that there are multiple (but not inventoried) outreach/day centers, such as Loaves and Fishes.

Transitional (supportive) housing

Programs categorized as transitional tend to provide housing for up to 24 months and usually offer wrap-around social services, substance use disorder treatment, and mental health treatment to prepare people for independent living. In 2018, there were about 15 transitional housing programs in Sacramento County offering about 600 beds (a decline from 899 transitional housing beds in 2015).¹⁷ Residents typically transition to permanent housing as their circumstances change and availability allows.

Rapid Re-housing

This program provides housing identification (recruiting landlords, tenant-landlord relations), move-in and short-term rental assistance (e.g., rent and utility deposits), and case management (e.g., legal and credit issues; employment training; lease negotiation, etc.) to prevent low-acuity people from falling into a homeless state or helping them step out of a recent experience with

homelessness. It is intended to be a short-term support service that returns people to stable, independent living quickly. The Sacramento County rapid re-housing bed inventory (short-term rental assistance to clients requiring few support services) doubled from 358 beds to 732 beds between 2015–2018 with an emphasis on families vs. adults (581 and 151 beds respectively).³⁸

SACRAMENTO COUNTY HOMELESS INITIATIVES

- **FSP: Full Service Partnerships** are long established in Sacramento County and provide intensive case management with permanent supportive housing for people who are nearly homeless or homeless.
- **FSRS: Full Service Re-Housing Shelter** is a newer program that uses master leasing of vacant homes to house up to five people with a house monitor. By invitation only, the program has 75 beds/night among 15 sites scattered among neighborhoods. Beds fill quickly and most referrals come from the Sheriff’s Department and Park Rangers. Guests receive intensive re-housing and supportive services.
- **FSRP: Flexible Supportive Re-housing Program** focuses on finding permanent supportive housing for the 250 homeless individuals who use jail and behavioral health care services most frequently. Intensive case management and property-related tenant services.
- **FHP: Flexible Housing Pool** coordinates with County Adult Protective Services, Office of Public Defender, emergency shelters and outreach workers to identify those in need of transitional and permanent housing. Services include court expungement services, case management to address housing, physical and behavioral health issues. Assistance with public or private market housing including deposits, rent, and landlord-tenant relationships.

Recently, Sacramento County has been undertaking some new activities to address homelessness. For example, there is a shift in the County’s crisis response approach toward increasing the number of low-barrier beds. Sacramento County now offers a *Flexible Supportive Re-Housing program (FSRP)* that focuses on the 250 chronically/long-term homeless people with the highest utilization of costly public services (i.e., jail and behavioral health system interactions). The program supports a case manager (ratio 1:20-25) to assist with housing, intensive case management, tenant services, and rental assistance.³⁹ Case managers from one of four partner agencies (e.g., Consumer Self Help, WellSpace Health, Hope Cooperative-TLCS) provide intensive support for addiction treatment, handling outstanding warrants, obtaining a GED, etc. The program also works with two housing partners (Sacramento Self Help Housing and Volunteers of America) to engage property owners around Sacramento to work to integrate clients back into the community and to provide continuous housing subsidies. The goal is to integrate 250 clients per year; since 2018, 250 top utilizers have been enrolled in the program and 212 have been permanently housed.

Sacramento County also recently instituted a *Flexible Housing Pool (FHP)*, based on the FSRP program that connects existing crisis-response programs with re-housing services. Clients are referred from County Adult Protective Service (APS), the Office of the Public Defender and from designated emergency shelters and street outreach programs. The program provides *property-related and tenant services* and *intensive case management services* using the evidence-based Critical Time Intervention (CTI) approach (see Chapter 5 for discussion of effectiveness of CTI).^{40,41} Services include actions such as improving landlord engagement, incentives, and support; establishing master leases; problem-solving for family/friend reunification; and leveraging Housing

Choice vouchers. The 635 referral slots for this program are parsed out among approved partners (outreach, shelters, Adult Protective Services, Public Defender Jail Diversion Pilot); *shelters will be asked to reserve a portion of their beds for this program*. There is one-time funding for the FHP program from the California State Homeless Emergency Aid Program (HEAP).⁴¹

Permanent Supportive Housing

Permanent Supportive Housing provides low-barrier affordable housing, health care, and wrap-around social services to help chronically homeless individuals with complex needs become successfully housed. There are no limits to lengths of stay and intensive case management services support individuals seeking care for mental health, SUD, and physical co-morbidities. This is a “housing first” model and tenancy is not contingent on (successful) treatment. In 2019, the County reported 27 programs for chronically homeless adults or families (adults and families with serious mental illness also qualify) that housed about 3,000 people.⁴² Two-thirds of the total beds are funded through federal HUD Continuum of Care dollars. Permanent supportive housing programs also receive state MHSA funds, including the Full-Service Partnership (FSP) and General System Development (GSD) funding streams, which provide low-to-moderate intensity outpatient mental health services to individuals with serious mental illness.³²

Permanent supportive housing programs through El Hogar, TLCS, Inc. and Turning Point Community Programs serve 644 people through FSP services and 970 with GSD services.^{18,37} The FSPs are designed for people who have been diagnosed with a severe mental illness and substance use disorder and would benefit from an intensive service program (note that this program is not limited to people experiencing homelessness). They employ a “whatever it takes” approach to help individuals on their path to recovery — housing, employment, addiction treatment, health care, etc. In FY 2016-17, about 25% of Sacramento County FSP clients had experienced homelessness (~500). Unique to FSP programs are a low staff to client ratio (1:10), 24/7 crisis availability, and a team that practices the Assertive Community Treatment (ACT) method and embraces client-driven services with each client choosing services based on individual needs. (See Chapter 5 for evidence of effectiveness of ACT and FSPs.)

Sacramento County, like most other California communities, suffers from a dearth of affordable housing. Ten organizations, including the County’s Housing Support Program, assist with obtaining publicly- and privately-owned permanent supportive housing (also referred to as “housing first”), affordable housing, and rental assistance.

The Housing Choice Voucher program (previously known as “Section 8”) provides financial assistance to families and individuals with very low incomes. An estimated 43,000 families and individuals are wait-listed for 7,000 “tenant-based” rental assistance vouchers, where tenant rent to private landlords is subsidized with public dollars.⁴³ Additionally, there are 625 “project-based” vouchers earmarked for subsets of the homeless population in affordable housing communities. Vouchers are a financing mechanism to reduce barriers to entering the housing market, however, they do not guarantee that the actual housing units are available. See the *Pathways to Health and Home Environmental Scan* for more detail about these programs.¹⁷

Finally, there are a limited number of long-term residential programs in Sacramento County serving persons with serious mental illnesses and/or physical co-morbidities who are unable to live independently. These facilities are generally referred to as Board and Care, group homes, and adult residential care. Federal regulations set monthly rent at about \$35/day/resident to cover food,

EXAMPLES OF COORDINATED CARE EFFORTS IN SACRAMENTO

WHOLE PERSON CARE

Sacramento Covered developed the infrastructure supporting the City's Whole Person Care 4-year pilot program, which promotes "no wrong door," multiple entryway outreach to people experiencing homelessness. It is funded through Medicaid and administered by the **Pathways to Health and Home**. Referrals are only accepted from a partner community health clinic, hospital, managed care plan, or community-based organization or the police department's Impact Team. The program's community health workers, through intensive support, have helped 300 people exit homelessness (including permanent supportive housing for 115 for people with mental illness); enrolled 1,200 people in primary health care programs; and reconnected 100 people with their social security accounts. More than 1,300 people were enrolled by 2019.

MATHER COMMUNITY CAMPUS

Operating on a 33-acre, County-owned property, **Mather Community Campus (MCC)** has been providing transitional housing services for homeless individuals and families who achieved stability through earlier intensive treatment programs. MCC offers transitional housing, employment services, vocational training, life skills, a corrections re-entry program, and recovery support. In 2016, the administrator, Volunteers of America, reported serving more than 885 individuals, families, former foster youth, and veterans through eight residential (267 units) and nonresidential programs.

Recent funding decreases have cut the number of family and single-bed units, the campus food service and several programs. MCC helps about 100 residents complete the 12-month housing program and reports a 96% program success rate in clients exiting homelessness permanently.

The County is overseeing a design review and provider solicitation in 2020.

Sources: Whole Person Care: <https://pathways.sacramentocovered.org/>; <http://www.p2hh.com/>; <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00840>;
MCC: <https://www.voa-ncnn.org/mather-community-campus>;
https://www.saccounty.net/Homelessness/Documents/SacCounty_HomelessInitiative_FINAL.pdf

housing, and 24-7 care. The number of facilities is quickly dissipating across California as business owners sell properties due to escalating property values, aging caretakers, and poor reimbursement. The County reported having about \$3 million set aside for developing more board and care options for Sacramento.⁴⁴

Sacramento Steps Forward intends to issue a new gap analysis and system map of services for helping persons experiencing homelessness connect to housing (including permanent and transitional supportive housing). These documents will inform future actions to improve the Homeless Crisis Response system, including Coordinated Entry into housing, as required by HUD.

Intersection with the Criminal Justice System

Many individuals who interact with the criminal justice system have substance use disorders and mental health problems; some have cynically observed that the jail system has become the default mental health care system. CalMatters reports that 30% of those incarcerated in California receive treatment for a serious mental illness.⁴⁴

The Sacramento Sheriff’s Department reported an average daily population of 3,686 persons incarcerated in Sacramento County jails in March 2019 and an incarceration rate of 238/100,000 persons, higher than the State average of 176/100,000 persons, based on jail profile data reported to the Board of State and Community Corrections and population data from the California Department of Finance. Of the nine California counties with more than 1 million people, Sacramento County has the third highest incarceration rate. Jail records provided by UC Davis Jail Psychiatric Services demonstrate a 97% increase in monthly caseloads for psychiatric services delivered to Sacramento County jail facilities between 2004 and 2018 (783 in 2004 and 1,543 in 2018) despite a 305% decrease in jail bookings during the same time period.⁴⁵

People experiencing homelessness and the subset of people who are chronically homeless have a higher-than-average rate of contact with the criminal justice system as compared with the general population. A study by the Sacramento Public Defender’s office found that 50% of misdemeanor clients are homeless.⁴⁶ Further, the Sacramento Public Defender found in a secondary study that 50% of their mentally ill clients facing misdemeanors were experiencing homelessness--about 2,000 people annually. Public defenders are required by AB 1810 (2018) to identify clients with mental health issues and divert them to services to create a treatment plan.⁴⁶

Police Departments

The Sacramento Police Department arrested more than 4700 homeless people in 2018, a 59% increase from 2012. In addition to arrests, almost 1,200 citations (e.g., for loitering, public intoxication) were issued in 2018. The County Sheriff and City Police Departments have formed outreach teams (Sheriffs’ HOT team and Sacramento PD IMPACT Team)¹⁸ to divert from jail those people experiencing mental health episodes or misdemeanors stemming from homelessness. These teams work to identify (or deescalate) and redirect people to appropriate care.

Sacramento County Jail

The jail does not provide medication-assisted treatment (MAT), so people with opioid use disorder who are incarcerated will experience withdrawal, whether on MAT or still using opioids. When released, they may return to use of opioids and are at greater risk of overdose due to lowered opioid tolerance.

Although mental health triage navigators from TLCS (non-profit agency) work at the jail to connect patients with resources in the community upon release, the jail does not provide medications at release.

Patients who are released without medications often end up in Sacramento’s local emergency departments due to psychiatric decompensation or substance use disorder relapses.

Sacramento Law Enforcement Diversion Strategies	
<p>City: IMPACT Team About 10% of all calls to the Sacramento police department (about 36,000 per year) concern people experiencing homelessness. The Sacramento Police Department’s IMPACT Team responded to 518 of 3,550 homeless-related calls in one month in 2019.</p>	<p>County: Homeless Outreach Team (HOT) Team: 14 deputy sheriffs in 4 teams, working 7 days/week, perform outreach and linkage with social services and jail diversion for people experiencing mental health episodes or misdemeanors stemming from homelessness. This program, <i>Strategies in Policing Innovation</i>, targets high-call service areas with a Sacramento Steps Forward navigator partnered with three part-time deputies to connect homeless individuals with case management and social services through the County Department of Human Assistance. Data on calls responded to were not available.</p>

Courts

Additionally, the offices of the District Attorney, Public Defender, Probation, Parole and Courts have developed a variety of jail diversion options such as a mental health court, substance abuse court, and a coordinated discharge program for parolees to obtain sheltered spaces and social services. The Public Defender's office also created an expungement clinic to help probationers clear their criminal record, which can help to remove barriers to housing resulting from criminal convictions.

As required by AB 1810 (2018), public defenders also identify clients with mental health issues, create treatment plans, and then divert them to services.¹⁸ The Sacramento County Public Defender also collaborated with County partners and created a new program called Project H.E.L.P. (Homeless Engagement Legal Program). This program uses Homeless Emergency Aid Program dollars to provide permanent supportive housing for 80 homeless individuals with pending misdemeanor charges. The court monitors the candidate for up to one year, after which the case is dismissed pending successful program participation. Additionally, once a month, a legal clinic located at Loaves and Fishes provides people with legal counsel in order to address pending citations and bring them to a specialized court. This court, which meets once every four weeks, allows unpaid fines to be converted to community service. In 2018, the court settled 192 cases; 93% of individuals completed their community service hours at Loaves and Fishes.⁴⁶ The specialized court does not require any form of treatment or link people to housing services, however.

The "chronic nuisance offender program," created by the District Attorney's office, links selected people with 10+ arrests within 12 months (or law enforcement referrals) to community-based and County services. Finally, the Sacramento County Probation Department recently ended its contract with Volunteers of America for 25 beds (available for up to 90 days) while probation clients were connected to needed services (e.g., CalFresh, mental health care, drug and alcohol treatment). No program replacement has been proposed to date.

Conclusion

Many clinical, mental health, substance use disorder (SUD), and housing services are potentially available to people experiencing homelessness in Sacramento; however, the majority of safety-net programs are focused on the general low-income population, not just those experiencing homelessness. Thus, treatment and housing services are very impacted and hard to access for people who are homeless, especially for those who have unmanaged serious mental illness, SUD, and/or physical health problems. Services are dispersed throughout the community, and expensive or under-developed public transportation systems present daily challenges for homeless persons seeking care at multiple sites (e.g., coordinating/remembering appointments, traveling to various service locations, filling and storing medications, checking on waiting list status regularly, etc.). The existing supply of supportive housing is inadequate to meet demand for those who require long-term supportive services, including medical, mental health, and SUD care.

Several relatively small programs that coordinate care have successfully assisted some homeless individuals with obtaining permanent housing and navigating clinical and behavioral health treatment. Those who are homeless and interact with the criminal justice system also may benefit from several innovative criminal justice diversion programs, but the court-based programs are not comprehensive enough to provide housing and treatment support upon release that could prevent recidivism.

There remains a serious need to expand and integrate housing, intensive case management, and services capacity for people experiencing homelessness. Most care programs are siloed and under-coordinated, with disparate communication/IT systems and insufficient capacity to significantly reduce the number of people experiencing persistent homelessness in Sacramento County.

Chapter 4: Co-located Integrated Care Models Across the U.S. and California

Some communities across the U.S. and California are experimenting with innovative approaches to improve and expand housing and treatment options for people experiencing homelessness. This report focuses on a newer concept of co-locating integrated housing, social services, and treatment for physical and mental health conditions, including substance use. Several scattered site models that provide integrated, co-located treatment services without associated housing are also profiled. These examples range from small, non-profit organizations serving a neighborhood to multimillion-dollar innovation projects providing integrated services.

The co-located, integrated model is of particular interest to communities seeking to reverse the trend of increasing numbers of people with complex needs who experience homelessness. We see increasing momentum in the adoption of this approach, especially in California due to annual double-digit increases in the cities' homeless populations and the California public identifying homelessness as a top priority.¹ In recognition of this increased need, Governor Newsom's Homeless and Supportive Housing Advisory Taskforce and the proposed FY 20-21 budget are bringing focus and funding to enable innovative solutions.

A rapid environmental scan yielded a small, but diverse group of integrated care models that provide co-located health and social services to people experiencing homelessness who have complex needs. Based on an internet search and discussions with content experts, we selected 13 exemplary organizations that offer at least one site with comprehensive services co-located on a campus or the same city block (with or without providing housing) and 6 innovative, scattered site models. Most organizations with a co-located program have a mature portfolio of dispersed services, and only recently opened (or plan to open) their co-located structures. This chapter briefly describes the organizations with the most established or innovative models and Appendix B provides a summary table of all 19 organizations with links to more information.

Most organizations with an integrated care campus only recently opened (or plan to open) that program as part of an already mature portfolio of dispersed services.

To have met inclusion criteria for this scan, the site must provide at least 3 of the following co-located service categories:

- housing (emergency shelter, transitional and/or permanent [supportive] housing);
- social services;
- physical health care (outpatient and/or inpatient);
- mental/behavioral health care (outpatient and/or residential); and/or
- substance use disorder treatment.

Overview of Selected Models and their Characteristics

The innovative models listed in Appendix B vary in size (e.g., single building, city block, multi-acre) and location (urban, suburban, and semi-rural). Most of the selected organizations began as

scattered site models and expanded to include a building or urban block that co-locates mental health or behavioral health services, substance use treatment services, supportive housing programs, and/or primary care services. Eight are open to clients, and five sites are in the planning or construction stages. None of these models include on-site medical-psychiatric or acute care hospitals, although several organizations report partnering with their local health systems. Eleven organizations include on-site medical care ranging from FQHCs to recuperative care to basic treatment for chronic conditions. All nineteen offer mental/behavioral health services. Of those, at least five emphasized integrated mental health/SUD services with permanent and/or transitional supportive housing. All organizations offer “wrap around” social services such as legal services, employment services, and vocational training.

Co-located, Integrated Care Models

CENTRAL CITY CONCERN (CCC) (PORTLAND, OREGON): CCC is one of many Portland nonprofit organizations providing services to people experiencing homelessness. Established in the late 1970s, it has matured into a coordinated care program offering 26 programs that cover most aspects of the continuum of care with the exceptions of emergency shelter. CCC is a large, complex organization with about 1,000 staff (about 25% of whom have been clients of CCC programs) and operating expenses of about \$75 million in 2018. The revenue covers costs related to housing, staff, and delivery of social services, clinical care, and mental health treatment.⁴⁷

CCC owns, leases, or manages almost 2,000 units of housing in 26 residential buildings, many of which offer supportive social and medical services on-site or within a few blocks of housing options.⁴⁷ CCC describes their housing options as transitional and permanent, market rate and subsidized, which serve people in recovery, living with HIV/AIDS or mental illness and those living on social security/disability incomes. About 60% of the unit inventory is a sober living environment.

CCC is also designated as an FQHC and its Old Town Clinic reports upwards of 5,000 patient visits per year for primary care, mental health, and/or substance abuse. Integrated care teams of 7-8 providers (i.e., physicians, psych nurses, outreach workers) handle low- to medium-acuity patients (about 1,000 patients/team); “ambulatory” teams have smaller caseloads to treat the highest acuity clients. Clients are accepted as walk-ins or through their Law Enforcement-Assisted Diversion (LEAD) program. There is a pharmacy on site and a residency training program in partnership with a local health system. CCC also offers a social enterprise program that provides vocational training to clients. Their business model (selling bed-bug-resistant furniture) provides pay and job-training skills to participants, and income to CCC from the sale of furniture.

Blackburn Center is the newest co-located, integrated “campus” model developed by CCC. Opened in July 2019, it is a six-story building offering medical and behavioral health care with mixed housing:

- 51 units of respite care transitional housing;
- 10 units of palliative care housing;
- 80 units of transitional low-income housing;
- 34 studios of permanent supportive housing;
- mental health treatment;

- SUD treatment;
- primary health care;
- pharmacy services;
- respite care;
- case management;
- commercial space.

Wrap-around social support services include employment services, housing placement, and referrals to other necessary support. The new primary care clinic anticipates serving about 3,000 patients annually. Portland-area health organizations contributed \$21.5 million of the \$52 million project cost.^{48,49} Additional funding was provided by low-income housing tax credits, city, county and state governments, foundations, and local philanthropy. Development of the Blackburn Center was overseen by the CCC’s 16-member board of directors and 7-member executive team.⁴⁹



Blackburn Center, [Central City Concern](#), Portland, OR.
Source: Printed with permission from Central City Concern.



“Wellness Campus”, [Central City Concern](#), Portland, OR.
Source: Printed with permission from Central City Concern.

Located on a city block on Burnside Street, a primary artery in Portland, CCC also operates its “**Wellness Campus**” with multiple, adjacent services. This campus offers *Old Town Clinic*, an FQHC offering treatment for substance use disorder and mental health issues (first two floors of the tall building in photo on left); *Richard L. Harris recovery supportive housing* (180 units in upper floors of tall building); and the *Old Town Recovery Center*, an additional mental health clinic (three-story building in foreground). Additionally, CCC offers a Recuperative Care Program to assist people discharged from the hospital with completing their physical recovery and, if necessary, supporting mental health stabilization and/or substance use disorder recovery.

physical recovery and, if necessary, supporting mental health stabilization and/or substance use disorder recovery.

HOME FORWARD (PORTLAND, OREGON): *Bud Clark Commons* (2011) is another unique model with co-located services that “meet people where they are.” Home Forward owns, operates and manages the building and partners with *Transitions Project, Inc. (TPI)* and *Central City Concern (CCC)* to provide three distinct programs within one 8-story building in downtown Portland. TPI operates Doreen’s Place, the transitional shelter for men, which is located on the first floor. The average stay is 2 months and 45 of the 90 shelter beds are reserved for veterans.⁵⁰ It offers storage for residents’ belongings, exercise facility, common space, and a kitchen (one meal per day, volunteer-prepped), as well as case management services to place clients in permanent housing.⁵¹



Bud Clark Commons, [Home Forward](#), Portland, OR
Source: Printed with permission from Home Forward.

TPI also oversees the Day Center (floors 2-3 of building in photo on left) that provides shower, laundry, mail, and food service, and a learning center with computers and internet connectivity. Twenty service providers support the Day Center as part of the case management program.

CCC operates the Bud Clark Clinic, which offers basic primary care to any person experiencing homelessness. The goal is to help clients achieve a level of comfort with receiving care at their pace

and eventually enabling them to accept more intensive, or comprehensive levels of care (that are provided elsewhere).⁵¹

Home Forward runs the permanent supportive housing (PSH) program on the upper floors of Bud Clark Commons. There are 130 studio apartments, and a common space. There is an exam room adjacent to the PSH common area to provide trauma-sensitive care to PSH residents who find it difficult to seek care in the clinic on the lower floor (apartment visits for residents are also available). Home Forward partners with four health clinics that use the Vulnerability Assessment Tool to help service providers assess need and prioritize PSH placement. The PSH program reports an 80% retention rate.⁵¹

The Bud Clark Commons is a LEED Platinum-certified building that was financed through \$29.5 million in Portland tax increment financing (due to project location in an urban renewal area), \$11.7 million from sales of low-income housing tax credits, and \$3.3 million in American Recovery and Reinvestment Act of 2009 gap financing from HUD. To meet the goals of creating an inviting, durable space that contributes to “the social and physical fabric” of the neighborhood, access to the center’s various programs was carefully considered.⁵¹ Each of the programs has a separate entrance to facilitate operations and promote the safety and well-being of staff, residents, and those seeking services. The Day Center is accessed through a courtyard, which “serves as a transition area between the property’s public and private spaces and limits queuing along the sidewalk by those seeking services” and includes appropriate sight lines in the Day Center to facilitate management of the center services. Design attributes include a heat recovery system to condition air and a high-performance building envelope; rooftop solar panels generate 80 percent of the energy needed for heating hot water and running ENERGY STAR® appliances. Greywater recycling system captures water from showers and washing machines to flush toilets, and the courtyards feature native, drought-tolerant plants.⁵¹

HAVEN FOR HOPE/RESTORATION CENTER (SAN ANTONIO, TX): *Haven for Hope* provides housing, case management and social services to help residents of Bexar County make the transition away from homelessness, while the co-located *Restoration Center* provides clinical care, SUD treatment and psychiatric care. Opened in 2010, Haven for Hope operates in partnership with the City, County,

and local mental health authority (Center for Health Care Services [CHCS]) which operates the health services on the campus. A key characteristic of the Restoration Center is its diversion program; the Center’s Intake Department provides triage and sobering for clients brought in by first responders and provides a 16-bed psych unit (up to a 48-hour stay), a medical triage clinic, and a “sobering room” that first responders use as diversion from ED or jail for people who are homeless and experiencing a psychiatric crisis or are intoxicated.⁵³

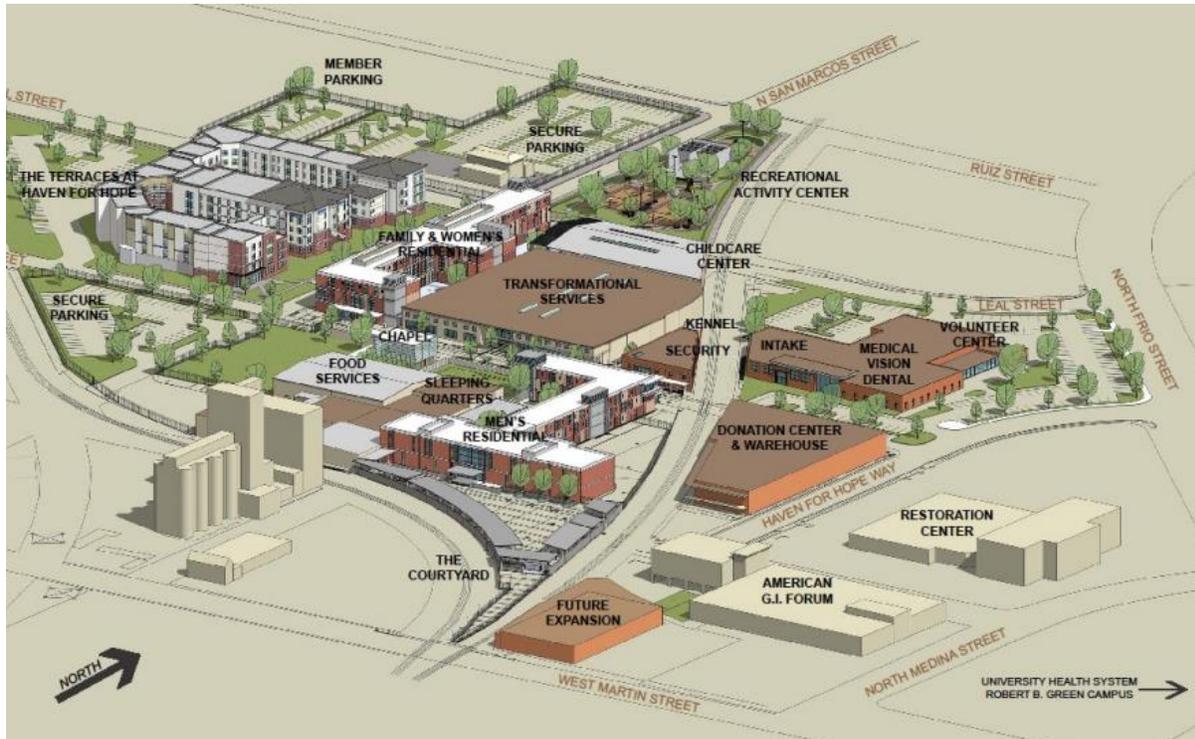
CHCS provides a variety of physical, mental health, and SUD treatment across the campus in facilities with varying levels of care: an accredited detox facility houses 28 beds for stays of 3-7 days; an FQHC provides primary health care to patients; an integrated primary care and psychiatric clinic can stabilize those patients who require more intensive behavioral health treatments and help engage them in routine medical care (funded through a CMS Health Care Innovations award). About 900 patients are served by the CHCS FQHC annually.

Haven for Hope provides on-campus transitional housing that accommodates 80 male and 60 female clients concurrently in a 120-day sober living treatment program. Clients can access recovery treatment, case management, individual and group therapy, and transition planning through this program. The crisis respite program (7-10 days) at the 12-bed Josephine Recovery Center (off-site) provides psychiatric and nursing services, medication management, group and individual therapy and case management services.

Programs providing outpatient mental health care, medical care, and SUD treatment, as well as food, hygiene care, pet kenneling, and dental and vision services, serve thousands of individuals annually. There are 31 service partners located on campus that provide “one-stop shopping” for clients in job training, education, legal services, and ID recovery and another 60 referral partners that serve clients at their own sites across San Antonio. Not without controversy, Haven for Hope initially employed a “treatment first” approach (requiring sobriety before program enrollment) but revised their practices in 2019 to also provide treatment to those contemplating sobriety.

Haven for Hope <i>(Housing focused)</i>	Restoration Center <i>(Treatment focused)</i>
<ul style="list-style-type: none"> • Prospect Courtyard (outdoor area “for those unwilling, unable or waiting to participate in the transformation program) average ~500/night; ~700/day) • Emergency shelter (by working, those in Prospect Courtyard can move here) • Supported housing: 140-bed sober-living, transitional housing, 120-day program (80 men/60 women) 	<ul style="list-style-type: none"> • 40-bed sobering unit (a few hours) • 28-bed detox unit (3-5 days) • 16-bed crisis stabilization unit • 12-bed transitional recovery center (7-10 day stay, hospital step-down/diversion) • Full assessment for SA/MH • Intensive outpatient SUD/MH treatment • Substance Use Community Court • Can transition to Haven for Hope to live in emergency/sheltered housing
<p style="text-align: center;">In May 2019, 975 people were housed on campus (most in the Courtyard or Emergency shelter) with an average length of stay of 147 days for individuals and 110 days for families.⁴³</p>	

The overall program uses a step-care approach to support people exiting homelessness. Prospect Courtyard is the first step and provides a secured outdoor sleeping area with access to facilities for basic hygiene, meals, and medical services for up to 500 people nightly. Clients work at the center and must accept sobriety and mental health services before moving into the shelter, with later moves into transitional or permanent supportive housing when space becomes available and clients have made treatment progress.



Haven for Hope, San Antonio, TX. Source: Printed with permission from [Haven for Hope](https://www.havenforhope.org/).

The Bexar County justice diversion system, which located specialty courts on the campus (Drug Court and a Mental Health Court with Assisted Outpatient Treatment), focuses on individuals who experience homelessness and are involved in the criminal justice system. The Center for Health Care Services (CHCS; a local mental health authority) provides the mental health and SUD services to individuals served in the jail diversion system and Haven for Hope provides transitional housing and supported housing services. It also trains “in-reach peers” to go into the jail prior to release to assist inmates who are homeless with continuity support post-release.⁵⁴

Initial funding for the Haven for Hope/Restoration Center campus was \$101 million, with over \$60 million coming from philanthropic donations and almost no federal funding.⁵⁴ The most recent published operational budget (FY 2016) was \$16 million with private (40%), City-County (25%), State (16%) entities contributing the majority of funds.⁵⁵ Governance is through the County, City, and the local mental health authority (CHCS).⁵⁴

CARE CAMPUS (PENNINGTON COUNTY, SOUTH DAKOTA): To reduce the impact of scattered services for substance use disorder, the County created the Care Campus, a single point of entry for community and law enforcement disposition of people needing care for addiction and mental health crises.⁵⁶ Located on the old National American University campus, the new \$14 million, 70,000 square foot

facility includes a 9-bed crisis stabilization center, 64-bed residential substance use disorder treatment center (just opened in 2019), 46-mat sobering center and 35 detoxification beds.⁵⁷ Care coordination for social services, including transitional housing, medical care, identification and birth certificate assistance, etc., are also available on site. The Care Campus has access to 23 supportive housing efficiency units in which clients may be placed.

DOWNTOWN EMERGENCY SERVICES CENTER (DESC) (SEATTLE, WASHINGTON): DESC requires identification, residency in King County, and Medicaid enrollment for people experiencing homelessness to obtain care (Medicaid enrollment assistance is provided). It offers both the scattered-site model and the co-located model of care. Through its scattered site model, DESC offers five emergency shelters (~500 total beds; range=25-258/shelter) and 13 supportive housing sites (with 1,400 units) with case management and meals, and some with nursing care on the premises. It also provides case management support to clients housed across 300 scattered-site apartments. Other services include health care (through 40 providers and partnerships with an FQHC and a major health system); crisis response (diversion and crisis respite programs); employment support; and a hygiene (shower/laundry) facility.⁵⁸ Outpatient substance use treatment services are integrated with their assertive community treatment program as well as mental health services for those with co-occurring illnesses.⁵⁹ In 2017, with an operating budget of \$42.7 million, DESC reported having served 9,500 clients (75% of whom used more than one DESC service) and helping 500 people exit homelessness each year.⁶⁰

The Estelle, opened by DESC in 2018, offers 91 studio units of supportive housing for people with serious mental health conditions (most of whom are formerly homeless); 15 of the units provide medical respite care following hospital discharge.⁶⁰ All Estelle residents have access to the on-site primary care clinic operated in partnership with Harborview Medical Center. The first floor includes amenities such as a courtyard, common space containing a dining room, community TV and activity space, computer lounge, and staff/case manager offices. DESC case managers use CHASER, a data system to track client service utilization, to access any client records as needed to improve care effectiveness and efficiency.⁶¹



The Estelle, Downtown Emergency Services Center, Seattle, WA. Source: Printed with permission from the [Downtown Emergency Services Center](#).

DESC is adding to its portfolio Seattle's first building with co-located housing and health care. The \$79 million **Hobson Place**⁶² will include 177 permanent supportive housing units, a clinic (mental and physical health conditions), lab services, and a pharmacy. The clinic is designed to provide 10,000 visits annually (for walk-ins, building residents, and referrals). Phase 1, which commenced August 2019, will provide 85 studio apartments, support services, and communal spaces for those who are disabled and formerly homeless. Phase 2, commencing early 2020 and scheduled to open in 2021, will add the integrated health care facility and 92 units of affordable housing for people with disabilities who have experienced homelessness. Under the guidance of its 15-member board and 34-member executive team, DESC will own and operate both buildings and provide support services to tenants. Start-up funding comes from the State (general fund, housing trust fund, and building communities fund), Seattle's housing levy, federal low-income housing tax credits, and private investors.



Hobson Place Downtown Emergency Services Center, Seattle, WA.
Source: Printed with permission from the [Downtown Emergency Services Center](#).

SHATTUCK CAMPUS (BOSTON, MASSACHUSETTS): The Shattuck Campus,⁶³ slated to open in 2022, seeks to improve access to housing, health care, and social services, with few barriers for people experiencing chronic homelessness. This project was stimulated by the recognition that scattered and uncoordinated care creates barriers for those with complex needs who want to exit homelessness.⁶⁴ This project arose from the planned re-location of the 260-bed Lemuel Shattuck hospital, which provides inpatient and outpatient services to primarily low-income community members. These clinical services will be moved to a new structure in Boston's South End in 2022. Existing structures on the campus, including emergency shelter and a detox center, will be retrofitted and new structures added to provide at least 75-100 supportive housing units, an emergency shelter, outpatient medical services, behavioral health services, urgent psychiatric care, and substance use treatment services across the 13-acre campus. This [Continuum of Care](#) model (including residential and outpatient treatment options) will support person-centered care.⁶⁴

Campus planning and site design are in development. The Commonwealth of Massachusetts embarked on an organized, [transparent planning process](#) to gather community and stakeholder input into the initial design of Shattuck Campus and the selection of services. The Commonwealth received eight responses to its Request for Information in 2019 to gauge the interest of potential partners and the types of services they would offer to support the vision/mission of the campus. Responses will help to inform potential partnerships and service delivery models.⁶⁴ The five non-profit organizations currently providing SUD treatment, mental health treatment, and shelter services (Victory Programs; Pine Street Inn [shelter and stabilization], Bay Cove Human Services; Health Care Resource Centers [MAT]; High Point Detox) responded to the RFI and will likely remain on the campus.



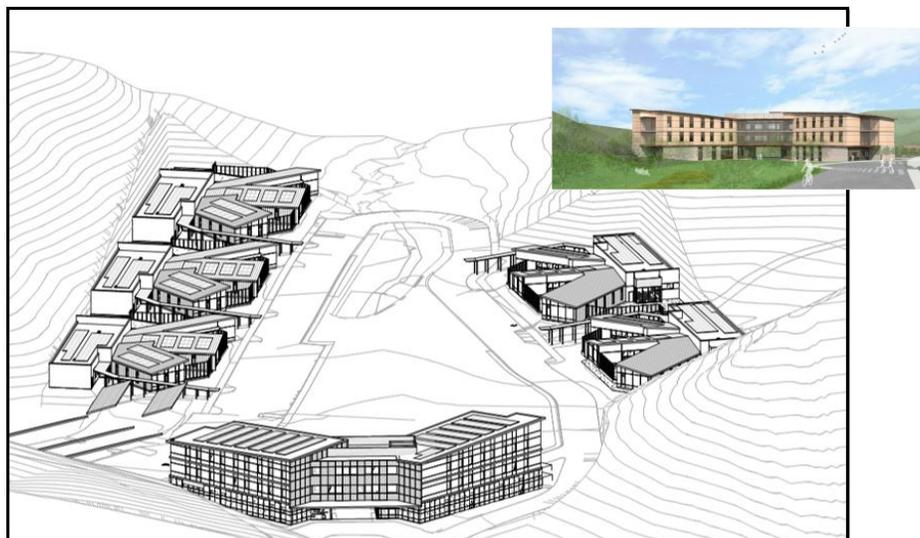
Shattuck Campus (vision), Boston Massachusetts (opening 2022).

Source: Printed with permission from [Shattuck Campus Planning Commission](#).

Anticipated funding sources for Shattuck’s 2-acre supportive housing project will include the “811” federal rental subsidy program for individuals with disabilities, “Section 8” project vouchers (acceptable for permanent supportive housing projects), a State voucher program, and HUD Continuum of Care rental subsidies. In addition, there are a number of State and City housing funding sources.⁶⁵

CORDILLERAS MENTAL HEALTH FACILITY (CMHF) (SAN MATEO, CALIFORNIA): CMHF is a mental health rehabilitation center that will co-locate supportive care options including transitional housing. The current facility provides psychiatric care (inpatient locked, and step-down beds for treating people with serious mental illnesses) for up to 117 people; however, capacity is inadequate in quality and size. The County notes that it is more costly to send patients outside of the County for care and expanding CMHF capacity will improve care and client transition back into the community.⁶⁶

The new campus will be anchored by the CMHF Campus Center, a three-story building that will house a primary care health center, administrative offices, social gathering spaces (art, exercise, etc.), and commercial kitchen (for client training and food service). The upper floors will provide transitional



Cordilleras Mental Health Facility, San Mateo, California (planned opening 2021).

Source: Printed with permission from [San Mateo County](#).

supportive housing for 57 residents (up from 49 currently). Treatment for substance use disorder and basic medical care will also be available. To abide by facility constraints imposed by the IMD rule (see page 19), San Mateo also will build five separate single-story, 16-bed mental health rehabilitation centers each focusing on a different population.⁶⁶ There will be a total of 80 mental health rehabilitation center beds – an increase of 12 beds total for the campus. The County will use a contract management approach governing the campus; a request for proposals will be issued for each of the centers. No vendor may run more than one center per IMD rule (but could also run the Campus Center which is not subject to IMD rule). Some economies of scale may be achievable if the vendors are successful in negotiating ancillary contracts (e.g., shared food service, janitorial, or IT support).⁶⁷ The campus is projected to open in summer 2022 at a cost of approximately \$85 million.

DOUGLAS COUNTY, KANSAS: On a smaller scale, Douglas County is floating a bond to the electorate to fund an integrated behavioral health campus adjacent to the Lawrence Memorial Hospital and Bert Nash Mental Health Center.⁶⁸ The campus would provide three tiers of supportive care: a 20,000 square foot behavioral crisis center that includes an 8-room residential ward (up to two beds per room); a two-story transitional co-ed group home (8-12 beds) as a step down from the crisis center or for those in need of transitional supportive housing (for a few weeks to 9 months); and 8-10 long-term supportive housing units. The behavioral health crisis center would provide outpatient individual and group counseling, and the next-door proximity to clinical and outpatient mental health services would supplement the inpatient and residential behavioral care campus.

RESTORATIVE CARE VILLAGES (RCV) (LOS ANGELES, CALIFORNIA): Construction of four villages⁶⁹ on Los Angeles County-owned property was proposed in June 2019. Each site will provide a mental health urgent care center, a wellness center, and recuperative/respice care and short-term residential treatment programs that integrate physical and mental health care and social service wrap-around support. The intent with locating these villages adjacent to hospitals is to improve appropriate care for eligible patients by diverting them from unnecessary emergency department care. The RCV design is similar to the Cordilleras campus design; each village will host five separate buildings housing 16 residential-treatment beds per building to accommodate IMD rules, with an additional 48 beds in the recuperative care center.⁷⁰



Restorative Care Village: Olive View, Los Angeles, California (opening TBD). Source: [Olive View-UCLA EIR](#)

This design allows for an expansion of inpatient psychiatric care that remains eligible for Medical reimbursement since no inpatient facility would exceed the IMD 16-bed threshold. Villages are proposed for the following Los Angeles County health care campuses: Olive View-UCLA (Sylmar, pictured), LAC-USC (Boyle Heights), MLK (Willowbrook) and Rancho Los Amigos (Downey).⁷¹

Phase I of the Restorative Care Village at the Boyle Heights LAC+USC Medical Center location will be completed in Fall 2021 at cost of \$68.4 million. The campus will offer a 96-bed recuperative care center, mental health residential treatment centers totaling 64 beds, and a 160-bed transitional housing unit. Motivation for this effort stems from the average daily census at the LAC-USC Medical Center of ~100 patients who cannot be discharged due to the lack of step-down care. Discharged patients will have access to case management, primary health care, mental health care, and substance use disorder services. Future Phases will include transitional supportive housing, a skilled nursing facility, mental health urgent care center and outpatient treatment. A Recovery and Respite Center will offer sobering and detoxification services and, possibly, permanent supportive housing.⁷²

So Others May Eat (SOME) (WASHINGTON, D.C.): SOME recently opened its \$90 million, 320,000 square foot Conway Center which provides a robust continuum of services. Built to serve 10,000 homeless and low-income patients annually, Conway showcases a health clinic (including dental services), a pharmacy, integrated behavioral health services, and inpatient and outpatient SUD treatment. It is across the street from a Metro station to ease transportation barriers. Social services include job training and employment services. This city-block facility also includes 202

units of housing divided between family and adult-only residences. A playground is on site as well as street-facing retail space.⁷³

Innovative Wrap-around Services

(see Appendix B for details)

In addition to providing core services (housing, medical and behavioral health care services), some programs provide less common services (co-located with housing or service centers) such as:

- acupuncture
- palliative care (Central City Concern)
- spiritual services
- pet kennel services (Haven for Hope)
- social enterprise business training (CMHF in San Mateo County—a retail store showcasing food and art products created by clients enrolled in an on-site job-training program; Central City Concern – clients employed in bedbug-resistant furniture manufacturing)
- dental and vision care
- transportation services to other community providers
- occupational therapy (Project Renewal, NYC)
- podiatric services for people with diabetes (Care for the Homeless, NYC)
- “housing first” consulting services for agencies (DESC)
- day centers providing food, hygiene facilities, and other wrap-around services during business hours (Home Forward)

Scattered Site Models (excludes on-site housing)

HOMELESS SERVICES CENTER: ARLINGTON STREET PEOPLE’S ASSISTANCE NETWORK (ARLINGTON, VA): A-SPAN finds that their Homeless Services Center, which provides co-located services, improves the effectiveness of care and efficiency in exiting clients from homelessness. Services include “housing first” placement, mental health care, showers, laundry, computer and mail access, cafeteria, job training, and employment assistance, in addition to an ~80-bed (25 seasonal) shelter. Moreover, five medical respite rooms are available for recently discharged patients to support full recovery following a hospitalization. A nurse practitioner manages follow-up care such as specialty care referrals and medication management. They also offer street outreach services to build trust and relationships with clients to help them access additional services at the Homeless Services Center when they are ready.⁷⁴

HOMELESS PERSONS’ HEALTH PROJECT (SANTA CRUZ, CA): HPHP is a primary care clinic adjacent to the Homeless Service Center and the River Street Shelter. Each entity operates independently but also collaborates to improve client health and help them exit homelessness. The clinic offers integrated health and mental health care with behavioral health counselors on site. Support staff assist clients with obtaining benefits, permanent (supportive) housing, and specialist referrals. The clinic also offers medication assisted treatment (MAT) for opioid and alcohol disorders.⁷⁵

PROJECT RENEWAL (NEW YORK, NY): This non-profit organization provides a continuum of housing options for people experiencing homelessness in New York City. The organization’s services are generally scattered; however, they have a transitional housing option (Fletcher Residence 55 residents), and a permanent housing option (Geffner House 307 residents), that provide on-site

case management, health care, and occupational therapy for residents. Additionally, life skills training, such as cooking and money management classes, are provided at Fletcher Residence.⁷⁶

Funding and Governance

The programs described above rely on some combination of funding from federal, state, local governments; health care organizations; philanthropies/foundations; businesses; and private donors. Depending on the real estate market and size of the co-located program, capital expenses ranged between \$11 million and \$75 million. Central City Concern's \$75 million infrastructure budget was funded by local health systems, foundations, and state funds.⁷⁷ SOME raised \$70 million through public funding, low interest loans, and tax credit financing to build the Conway Center.⁷³

Examples of operational funding strategies include leveraging low-income housing tax credits and Medicaid funds; procuring contributions from local health systems and health plans and negotiating rent-free building space. For example, the Downtown Emergency Services Center receives city, county, state, and federal funding (including funding from the Department of Housing and Urban Development).⁷⁸ Haven for Hope's multimillion-dollar budget has been funded primarily by a single local donor for many years, although more recently they are expanding to other sources.

Depending on the locale and system design, the governance of these organizations varies. The Shattuck Campus will be operated by the Commonwealth of Massachusetts. The Pennington County (South Dakota) Sheriff's office and Health and Human Services Department partner to operate the Care Campus. DESC and CCC are 501c3 organizations with boards of directors to guide their substantial executive leadership teams. DESC has a 12-member executive team and 20 senior managers, who are overseen by a board of directors. According to its Articles of Incorporation,⁷⁹ CCC relies on a board of 16 directors to select the President and CEO of CCC. Their executive team, comprised of seven leaders, runs day-to-day operations.

Conclusion

A variety of programs located around the United States are implementing the co-located, integrated services model, many of which include on-site supportive housing. These examples represent a broad range in capacity, focus, funding and governance structures. This variation provides an opportunity for stakeholders to consider the most relevant model components and create a locally adapted model that expands service capacity and improves coordination of care for people with complex conditions who are experiencing homelessness.

Chapter 5:

Rapid Evidence Review of Effectiveness of Coordinated Care

This rapid evidence review identifies peer-reviewed studies and grey literature about the effectiveness of coordinated inpatient and outpatient care for homeless and near-homeless people with medical, mental health, and substance use problems. Our initial search focused on peer-reviewed studies of health outcomes for homeless persons receiving services through a co-located, integrated care system. Initial inclusion criteria for this review limited selected publications to systematic reviews, meta-analyses, and randomized control trials (RCTs), recognized as the top tiers in the hierarchy of evidence. However, rigorous peer-reviewed studies of this topic were very sparse. This is likely due to the nascent stage of this co-located model; of the 13 co-located, integrated care models identified in this report, about half were in the planning stages or opened since 2018.

Due to a very low yield of results from the initial search, we expanded inclusion criteria to include evaluations of integrated care programs for people experiencing homelessness and studies of individual services that are potential components of co-located integrated care models. These broader search criteria provided context and better insight into the unique nature of a co-located, integrated care system for people experiencing homelessness.

Using key search terms from the research team, a UC Davis medical librarian conducted the baseline search of MedLine, PsychLit, and Google Scholar to identify relevant peer-reviewed and grey literature. We selected 792 relevant titles for abstract review and reviewed 101 full papers; 34 are summarized here, including 7 program evaluations of varying rigor.

Housing Approaches

Treatment First (Peer-reviewed Literature)

Treatment First (TF) practice asserts that, without first stabilizing patients through behavioral health treatment, people experiencing homelessness will maintain unhealthy patterns of behavior and be quickly evicted from housing.⁸⁰ Treatment First programs provide a period of respite and recovery for people who are both homeless and have underlying behavioral health or SUD issues that can be addressed. Accordingly, such programs often have strict requirements for treatment compliance and sobriety that must be met in order to qualify for and sustain a housing option.⁸⁰ A recent systematic review and meta-analysis of 6 randomized controlled trials (RCTs) of TF programs characterized the studies as low to very low quality yet concluded that TF with day treatment compared to treatment-as-usual may reduce the number of days individuals spend homeless.⁸¹

Like the impact of TF on housing outcomes, the effects of TF on behavioral health measures are unclear. One rapid literature review by Fitzpatrick-Lewis et al. found that TF was more effective than “Housing First” or treatment-as-usual at decreasing substance use and improving psychiatric outcomes.⁸² However, as noted subsequently by other researchers, effect sizes are typically small and literature reviews have contradictory conclusions on this subject. Further, TF programs typically suffer from significantly higher rates of attrition relative to the Housing First model.⁸³ Due to these inconsistent results and substantial methodological limitations, statements on the

effectiveness of TF cannot be made with confidence until more research on TF outcomes is available. The Treatment First method has been abandoned in California and across much of the U.S. in favor of the method known as Housing First.

The evidence of effectiveness for Treatment First is ambiguous with some evidence pointing to improvements in sustained sobriety; however, study quality is weak across the studies identified in this literature scan.

Housing First (Peer-reviewed Literature)

Unlike TF programs, Housing First (HF) programs are based on the concept that stable housing is a prerequisite for effective substance use and mental health treatment.⁸⁴ Proponents of the HF model contend that the stressors and risk factors of living without a home not only interfere with treatment compliance, but exacerbate or even cause behavioral health and SUD issues.^{85,86} As such, HF provides clients first with housing, then encourages voluntary treatment. As evidence of effectiveness has mounted for the HF strategy, the TF strategy has fallen out of favor.

Multiple systematic reviews of HF strategies have been conducted and the studies included in those reviews frequently overlap.^{81,87–89} The most recent review, conducted by the U.S. Community Preventive Services Task Force, included 26 studies of clients with disabilities who were homeless (8 RCTs and 18 pre/post studies with concurrent comparison groups). The authors concluded that HF has better outcomes than TF including reductions in ED visits, hospitalizations, and days homeless as well as improved quality of life and rates of housing stability.⁸⁷

Two systematic reviews overlapped significantly in their study inclusion and their authors reached similar conclusions: HF is effective when compared with usual treatment, but is tempered by concerns of bias introduced by methodological weaknesses.⁸⁸ Munthe-Kaas et al. included 8 RCTs (of moderate quality and published between 1990-2016) in their systematic review of homelessness interventions. They concluded that HF likely increases the amount of time spent in paid housing and lowers the amount of time spent homeless as compared with usual treatment (e.g., shelters, basic case management, drop-in centers, wait lists, etc.).⁸¹ A systematic review by Baxter et al. included a meta-analysis of four RCTs (published between 1992-2017). They found that those in HF programs made fewer emergency department visits (incident risk ratio [IRR]=0.63%; CI 0.48-0.82) and were less likely to be hospitalized (IRR=0.76; 95% CI 0.70-0.83). They also spent more days housed (standardized mean difference=1.24; 95% CI 0.86-1.62) and were more likely to remain housed up to two years post-intervention (risk ratio=2.46; 95% CI 1.58-3.84).⁸⁸ However, no consistent differences were seen between the intervention and control groups for substance use, mental health, or quality of life.⁸⁸ Baxter et al. noted a high risk of bias among the four studies, due to problematic randomization protocols, blinding procedures, statistical methodology, and data reporting.⁸⁸ An older review by Benston concurred with the conclusions from the aforementioned reviews; it was based on 14 studies, half of which were cited in the other reviews.⁸⁹

Finally, Weitzman et al. conducted a randomized controlled trial across three communities (two in California) to evaluate a HF supportive housing demonstration program for the communities' costliest individuals who were homeless. Funded by the Corporation for Supportive Housing (CSH), this 5-year study used a data-driven client identification method to identify and randomize homeless individuals with the highest medical costs into an integrated permanent supportive housing cohort or a control group. The program provided permanent housing; ongoing supportive

case management; an appropriate mix of mental health and substance abuse treatment services; and primary health care. The authors sought to ascertain whether the data-centered identification process and full supportive housing: 1) increased housing stability, 2) reduced homelessness, 3) decreased use of crisis health care services, and 4) improved physical and mental health.⁹⁰

The Weitzman et al. RCT included San Francisco, CA (102 participants); Connecticut state (430 participants); and Washtenaw County, MI (242 participants). (Los Angeles County, CA, with 107 participants, was unable to randomize its client base and was excluded from this analysis.) Clients were identified as high utilizers of medical care through cross-matching administrative data sources, such as shelter data, hospital and/or Medicaid records, and randomized into control and intervention groups. Those who were randomized into the intervention arm received one or more of the following intervention services: co-located housing and services on site; combinations of co-located and scattered site interventions; housing vouchers; access to patient navigators, case managers and/or integrated housing-health care teams. The authors used intent-to-treat (ITT) and Treatment-on-the-Treated (TOT) analyses. (The ITT control group was identified during randomization; whereas the TOT analysis used a 1:1 pairing by matching each housed individual with a control counterpart who was most similar in total cost, number of hospitalizations, and ED visits in the 12 months prior to randomization). The ITT findings were weak for all sites but San Francisco where reductions in hospitalizations (-0.62, $p=0.006$) and total number of hospital days (-5.22, $p=0.013$) at the 12-month follow-up were observed. The authors note that San Francisco had more affordable housing available than the other sites, which likely contributed to the stronger outcomes. The TOT approach (changes in utilization as a result of participation in the program) revealed a reduction in ED visits (-2.47 visits) and in hospitalizations (-0.56 admissions) in the San Francisco cohort; some reductions in health care costs/utilization and improvements in self-reported quality of life metrics also were reported though, not unexpectedly, many participants across all sites still experienced complicated and serious health problems 12-18 months post-randomization.⁹⁰

Substantial limitations to this study included significant heterogeneity between locations in terms of costs, organization, management, nature and intensity of programs. For example, providers in Michigan had no previous experience with the Housing First model employed by this intervention and had to train and build the program from scratch. Additionally, federal budget sequestration delayed access to housing vouchers and housing placement differentially among sites. Access to cost and utilization data was challenging and inconsistent among sites. San Francisco may have produced better outcomes due not only to its experience with the Housing First care approach, but also to its already established centralized congregant housing facility that had a co-located FQHC, and social workers (5), a nurse, a health worker, property management staff, and the intervention program manager all on site. All San Francisco enrollees were housed in this location. Other sites used a scattered site approach that required case managers to find scarce, affordable housing scattered across the community, get clients stabilized in housing, then start to link them to medical, mental health and substance use services months after the study started. Case managers asserted that these operational and administrative delays likely impacted the disappointing study results from 12- and 18-months post randomization. Furthermore, the authors noted that local context and federal and state policies heavily influenced the outcomes: locales with more providers (substance use/mental health/housing) and better communication networks at baseline saw better outcomes. Weitzman et al. concluded that supportive housing is effective for some homeless individuals who are high medical utilizers; however, identifying those populations who benefit most is difficult.⁹⁰

Housing First/Permanent Supportive Housing (Program Evaluations)

Permanent supportive housing (PSH) is defined as low-barrier, long-term affordable housing that provides case management, health care, and supportive social services to those who experience chronic homelessness, and those who have serious mental and/or physical illness.^{91–93} While early PSH programs followed the TF model, current programs utilize a Housing First (HF) approach; as such, PSH and HF programs have been grouped together for the purposes of this report. Kizer et al. published a rigorous review of the literature in 2018 for the National Academies of Sciences, Engineering, and Medicine (NASEM) and concluded that there is insufficient evidence to determine whether PSH is effective for improving health outcomes. The authors cited serious flaws in study methods throughout the literature, including the consistent lack of definitions of “usual care” and inconsistent reporting on type, intensity, and frequency of intervention services. Furthermore, inconsistent definitions of PSH and services made it difficult for the authors to generalize findings across subpopulations among the homeless. The NASEM committee that reviewed the findings levied a series of recommendations to improve the quality of future research and evaluation efforts. Recommendations included convening subject matter experts to assess how research and policy could be used to facilitate access to PSH to ensure availability of needed support and health care services.^{92, 94}

Hunter et al. conducted an evaluation of a Los Angeles County initiative, Housing For Health (HFH), which provides permanent supportive housing (PSH) for people experiencing homelessness who have co-morbid physical and behavioral health conditions.⁹⁵ Like other PSH programs, HFH combines long-term housing with case management to improve health and reduce use of services by homeless individuals. Utilizing a pre-post design, the researchers investigated services use by 890 individuals (83% of whom experienced chronic homelessness) one year prior to and one year after receiving housing. On average, clients’ use of medical and mental health inpatient and outpatient services dropped significantly once housed. For example, provision of PSH was associated with an 80% reduction in ER visits (1.64 fewer visits), a 61% reduction in medical inpatient days (four fewer days), and a 44% reduction in outpatient visits (four fewer visits). Furthermore, 19 fewer participants were incarcerated during the post-housing period; however, there was a twofold increase in the number of days incarcerated (to 2.76 days) among those who were incarcerated. (Authors did not speculate about this increase.) In contrast, use of emergency shelters, substance use treatment and probation services were unchanged after housing. Limitations of this evaluation include significant County policy changes that occurred during the study period, potential errors in the dataset due to disparate, uncoordinated County data systems, and lack of longitudinal data.

The Los Angeles 10th Decile Project, a 5-year pilot project sponsored by the Corporation for Supportive Housing, used intensive case management to place 147 individuals with complex health care needs into PSH, 30 of whom exited within a year of their housing placement. Although integrated care was a key component of this pilot project, the housing was not co-located with the services. Author Susan Lee reported that both ED visits and inpatient days decreased (by 79% and 64%, respectively) within the first year. As a result of program feedback following the first year, 10th Decile patient navigators were embedded at two hospitals to improve “warm handoffs” between the discharging hospital and community service programs.⁹⁶

Evidence suggests that Housing First approaches (sometimes combined with Permanent Supportive Housing) improve housing stability and reduces inpatient health care use. There is a lack of clear evidence of effectiveness of the impact of Housing First on most behavioral health and SUD outcomes.

Transitional Housing (Peer-reviewed Literature)

Transitional Housing (TH) provides temporary (typically < 24 months) housing to individuals, combined with case management, to prepare individuals or families for a successful shift to permanent residence. One well-designed, randomized controlled trial of TH was conducted by Gubits et al. on behalf of HUD to study the effects of three programs helping 2,282 families across 12 communities exit homelessness. They found that, compared to treatment as usual, those enrolled in TH program experienced fewer days homeless than those offered usual care during the time when TH was available.⁹⁷ However, this difference was smaller than the difference between those who were offered permanent housing subsidies versus usual care.⁹⁷ Further, those in the TH group did not experience improved mental health or substance use outcomes at 20- or 37-months follow-up. The authors concluded that permanent housing subsidies produced the best outcomes.⁹⁷

Conducted on behalf of HUD to examine the effects of transitional housing for families, Burt et al. conducted an observational study of 179 families in 36 TF programs across 5 communities. The authors found that longer stays in TH were associated with a decreased likelihood of being homeless one year after exiting a program. Longer stays in a program were associated with greater educational attainment, and greater likelihood of continuous employment. However, 12 months post-program, those experiencing longer or more frequent episodes of homelessness had higher odds of being unemployed or earning lower wages than their counterparts with fewer days of homelessness. Similarly, those with addiction or domestic violence history had poorer employment and wage outcomes compared to those without those experiences. At program exit, 21% of mothers had been treated for alcohol use disorder, 65% for SUD, and 42% of children who were not with their mother at TH program entry had been reunited during the program stay. The authors concluded that among all outcomes measured, TH helped families attain goals of stable housing and substance use treatment.⁹⁸

There is limited evidence that transitional housing reduces days homeless and supports sobriety. There is insufficient evidence to determine the effectiveness of providing transitional housing to promote the outcome of stable housing;

Case Management and Care Coordination

Providing support services to people experiencing homelessness can cross definitional lines. There is no consistent definition of these services and provision of them may involve a single individual or a multidisciplinary team. Case management and care coordination are considered distinct services. Case management provides linkages to a comprehensive set of medical and social services unique to each client's needs. Case managers generally meet several times per week with clients to offer social and life-skills support as well as appointment coordination. Care coordination typically focuses on coordinating the medical needs of a patient among various providers, setting appointments, and facilitating patient-provider communication.⁹⁹

Assertive Community Treatment (Peer-reviewed Literature)

Assertive Community Treatment (ACT) is a form of case management developed to serve people with SMI in community settings; this method is frequently used in the Full Service Partnership programs discussed earlier.¹⁰⁰ Practitioners of ACT embed themselves within communities to assess, train, and support their clients in a holistic way.¹⁰¹ This integrated approach was first conceptualized as requiring a multidisciplinary team of mental health professionals (e.g., nurse, case manager, social worker, drug and alcohol counselor) providing the most needed services themselves, rather than contracting with disparate service providers.¹⁰¹

Effectiveness research on ACT varies by the client subpopulation evaluated and the research methods used. The authors of a systematic review (40 RCTs) found that ACT is consistently most impactful and cost-effective for high utilizers of psychiatric hospital services. Effect sizes are smaller, but still significant, for those who use hospitals less frequently; however, such interventions do not achieve cost savings for these clients (which they do for high-utilizers).¹⁰² Although ACT likely decreases service utilization, evidence is less clear for whether it improves housing stability or directly improves mental health outcomes, such as quality of life or psychiatric symptoms. Bond and Drake report that more recent studies have shown ACT to be as effective as services provided in communities with well-developed mental health care systems.¹⁰³ A systematic review and meta-analysis by Burns et al. concluded that although ACT/intensive case management for people with SMI was effective at reducing hospital days for those with high rates of hospital use, it was less successful for those with already low utilization.¹⁰⁴

The evidence for the benefits of ACT for people with SUD who are homeless is ambiguous. Fries and Rosen found four RCTs that met their literature review criteria when assessing the effectiveness of ACT in treating substance use.¹⁰⁵ The studies showed that integrated ACT contributed marginal improvement in reducing substance use when compared with usual case management treatment. A 2019 systematic review by Penzenstadler et al. identified 11 RCTs that addressed ACT and substance use.¹⁰⁶ Similar to Fries and Rosen, these authors also concluded that ACT offered no overall benefit to reducing substance use as compared with control groups. Four of the 11 studies focused on homeless populations, with two finding greater client program satisfaction and housing stability for ACT clients than the control group, but no difference in reductions in substance use (and the other two found no difference in any outcomes measured). The authors noted that poor study quality and inconsistent methodology between studies prevented their arriving at conclusive results.¹⁰⁶

Assertive Community Treatment (Program Evaluation)

The Homeless Multidisciplinary Street Team (HMST) in Santa Monica seeks to improve health outcomes and reduce service utilization among people experiencing homelessness who frequently use public services.¹⁰⁷ The HMST uses the Assertive Community Treatment model of care, which employs a multidisciplinary team to help people experiencing homelessness address their basic needs. A recent RAND evaluation used qualitative stakeholder interviews and a quantitative analysis of outcomes of those enrolled to investigate program effects on client health and service use. The authors found that local providers valued the ability of the HMST-integrated service model to fill gaps between local service providers. Within a year of engaging with the HMST, police encounters declined 35% for HMST clients relative to the comparison group. It should be noted, however, that HMST clients had much higher baseline police involvement than the comparison group. Although clients used fewer services after being engaged by the HMST, the program has had difficulty graduating its clients to step-down care. Limitations of this evaluation include the lack of

an appropriate comparison population, the lack of access to cost and utilization data, and a focus on a limited scope of outcomes.¹⁰⁷ Although these services were not co-located, the degree of integration in this program is informative for models seeking integrated, co-located care.

Intensive Case Management (Peer-reviewed Literature)

Like ACT, Intensive Case Management (ICM) involves a comprehensive scope of services, low client-to-practitioner ratios, high-frequency contact, and community outreach. However, there are key differences between ICM and ACT: rather than being handled by multidisciplinary teams, ICM clients interact with a single case manager who coordinates and facilitates clinical and housing services by outside providers.^{108,109} Case managers' background and training varies.

According to a 2018 systematic review and meta-analysis of six ICM studies, ICM likely leads to fewer people reporting homeless events at 12-18 months follow-up, and may increase the number of people in stable housing at 12-18 months follow-up compared to treatment as usual.⁸¹ Further, ICM may reduce the number of days spent homeless, and may result in a minor difference in the number of people experiencing homelessness over a two-year period.⁸¹

There is a preponderance of evidence that ACT effectively reduces preventable health and public service use, but limited, ambiguous evidence that it reduces SUD among those who are homeless, due in part to weak study designs. The effect of ACT on housing outcomes is not well studied. Similarly, only weak evidence of effectiveness of ICM in reducing days or episodes of homelessness is available.

Full Service Partnerships (Peer-reviewed Literature)

Supported through California's Mental Health Services Act, Full Service Partnerships (FSPs) closely align with Assertive Community Treatment and use an Intensive Case Management approach to improve housing and health outcomes for people who are affected by serious mental illness and at risk of or experiencing homelessness.¹¹⁰ Specifically, these "whatever it takes" FSP programs provide permanent supportive housing and case management assistance to coordinate physical and mental health care and SUD treatment services, and to help secure employment and education.¹¹¹⁻¹¹⁵

Evidence for the effectiveness of FSPs is somewhat limited. For example, Gilmer et al. studied 209 FSP clients compared to 154 propensity score-matched homeless persons receiving public mental health services in San Diego County 2005-2008. As expected, the number of outpatient visits increased substantially for FSP clients as compared with the control group; however, the probability of their using inpatient and emergency services declined by 11% and 20%, respectively (whereas those probabilities increased for the control group by 12%). A difference-in-difference analysis showed that FSP reduced justice system use by 17%, inpatient services by 14%, and emergency services by 32%.¹¹¹ FSP clients reported statistically significantly better quality of life measures than their counterparts, and employment rates did not change. The authors concluded that that FSPs reduce homelessness (68% fewer days homeless than control group), improve quality of life and offset their program costs by more than 80% due to savings from mental health care avoided in jail, inpatient, and emergency care settings.¹¹¹

Using a similar methodology in a much larger study, Gilmer et al. later compared 10,231 FSP clients with 10,231 propensity score-matched homeless clients receiving public mental health services in three California counties from 2004 to 2010. They reported equivalent reductions in

inpatient psychiatric days across the FSP and control groups, but increased days (and costs) in mental health outpatient visits for FSP clients, perhaps indicating a previously unmet need. FSP clients also saw an average decrease of three days in state hospitals following enrollment. Those in FSP programs experienced a lower mean number of days and 12 fewer days overall in the criminal justice system than the control group. A sub-analysis showed that inpatient costs decreased in two of three counties — perhaps due to different delivery systems or different populations. The authors acknowledged that housing status was not controlled for in the analysis; therefore, different service uptake behaviors, perhaps inherent to housing status, may have affected study outcomes. The authors also noted that the results from this statewide study contrast with more positive cost-savings findings from studies of pilot programs. They postulate that potential program selection bias may confound the findings; populations enrolled in the larger programs may include enrollees who need less intensive services or may benefit less from FSP than those who are recruited into pilot programs. Furthermore, there may be a difference in staff experience and commitment in pilot programs versus those who are working in fully implemented programs. The authors did not include analysis of criminal justice mental health costs, unlike earlier studies that found cost-savings.¹¹²

Full Service Partnerships (Program Evaluation)

The MHSA Fiscal Year 2018-19 Annual Update, published by the Sacramento Department of Health Services, reported that seven FSPs serving Sacramento County served 1,889 (unduplicated) clients of whom 488 (26%) experienced homelessness.²² FSPs demonstrated substantial reductions in negative outcomes and improved client self-management of behavioral health conditions. For example, homeless occurrences and days were reduced by 72% and 91% respectively, after one year of providing services. Additionally, unique client *and* total mental health ED visits decreased in FY 2017-18 by 62% and 68%, respectively (n=702 clients with 1970 visits at baseline). Similar decreases were seen for:

- Psychiatric hospitalizations (decreased by 59.6%)
- Psychiatric hospital days (decreased by 72.5%)
- Arrests (decreased by 60.1%)
- Incarcerations (decreased by 44.9%)
- Incarceration days (decreased by 53%)

The FSPs discharged 321 clients whose average time in the programs was about 3 years (ranging from 1 day to 5+ years). The primary reason for client discharge was “met goals” (27%) followed by “not located,” “moved,” “discontinued,” and “deceased” (17%, 14%, 14%, and 11% respectively). *Note that these numbers reflect the total FSP population, of which 488 (26%) experienced homelessness. Those enrolled for at least a year saw a 91% decrease in homeless days (56,500 fewer days).*

In Los Angeles County, Mental Health Services Act (MHSA) funds are used to fund the expansion of Full-Service Partnerships (FSP), which provide those (of all ages and shelter status) diagnosed with a severe mental illness with an intensive, client-centered, service program.¹¹⁶ In an evaluation of the Los Angeles FSP program 2012-2016, Ashwood et al. found that the percent of FSP clients who experienced homelessness decreased from 46.1% to 19.8%. Among all FSP clients (housed and unsheltered), incarceration decreased from 17% to 8.5% in the year following program enrollment. Similarly, inpatient hospitalization for mental health reasons decreased from 22% to 16.2% for all FSP clients at 12 months post-enrollment. Importantly, program participation was respectable for this hard-to-treat population; 19.2% completed the program and 41% were still active at the time of

the evaluation. Building on a previous evaluation, researchers at RAND used a pre-post research design to analyze 24,282 FSP clients served by the Los Angeles FSP program in the same time period (2012-2016).¹¹⁷ They reported a net cost savings of \$82.9 million over 5 years. Specifically, cost savings were seen in four of five outcomes, with only primary care seeing an increase in expenditures (16%).¹¹⁸ The largest savings were realized in the criminal justice system (68%) due to reductions in total number of detentions and their duration, followed by reduction in inpatient mental health (18%) and homeless services (4%).¹¹⁹

Evidence indicates that Full Service Partnerships are effective in reducing days of homelessness, inpatient admissions, and involvement with the criminal justice system. The evidence of cost-effectiveness is unclear due to conflicting findings.

Critical Time Intervention (Peer-reviewed Literature)

Unlike ICM and ACT, which are ongoing treatments, Critical Time Intervention (CTI) features an intentionally limited duration of care.⁸¹ Case managers engaged in CTI typically have a bigger caseload than those using ICM and ACT.⁸¹ CTI focuses on improving continuity of care by facilitating contact between clients and service providers.¹²⁰ Compared to case management strategies of higher intensity, the evidence that CTI improves housing outcomes is less robust. A systematic review of three CTI RCTs highlighted conflicting results of studies evaluating different outcome variables: the intervention resulted in little to no difference in the number of persons experiencing homelessness; led to fewer days spent homeless; or reduced amount of time prior to moving to independent housing.⁸¹

Although the effectiveness of CTI in increasing housing stability is questionable, evidence for other outcomes is more promising. Authors of a 2013 systematic review noted promising results in reducing length of hospital stays, increasing outpatient service utilization, and improving mental health and SUD outcomes; however, these results were based on weak study designs.¹²² Further, in a population of women exiting domestic violence shelters, the CTI group had fewer symptoms of PTSD and fewer unmet care needs than those who received treatment as usual.¹²³ However, no differences were found in substance use, quality of life, re-abuse, symptoms of depression, psychological distress, self-esteem, or family and social support.¹²³ Finally, another RCT found that while CTI appeared to increase family support, no impact was seen on self-esteem, quality of life, excessive alcohol use, or cannabis use.⁸⁵

Overall, the evidence for the effectiveness of care coordination or case management methods is limited, especially for people experiencing homelessness, and study findings are inconsistent. The strongest evidence exists for ACT and FSP, which show some reduction in preventable health and public service use and in days homeless. CTI shows reductions in inpatient care in some studies, and ICM and ACT may reduce days of homelessness. However, limited evidence suggests that CTI impact is no different than standard care for substance use or quality of life outcomes.

Mental Health Treatment

A variety of mental health services have been evaluated for their effectiveness. Because these services are part of integrated care for many people experiencing homelessness, especially those who experience chronic homelessness, we briefly review this evidence here.

Mental Health Crisis Stabilization (Peer-reviewed Literature)

A review of systematic reviews evaluated the effectiveness (and cost-effectiveness) of mental health crisis care pathway interventions for pre-crisis support, urgent/emergency care, inpatient and outpatient stabilization, and secondary crisis prevention.¹²⁴ Evidence from this review (6 systematic reviews, 9 guidelines and 15 primary studies) showed: limited evidence of effectiveness for pre-crisis support (e.g., telephone support, triage, quick referral) for a range of mental health disorders; clear evidence of liaison psychiatry models (psychiatry teams embedded in urgent care/ED) reducing risk of readmissions, reducing wait times and improving client satisfaction. These studies suffered from low quality evidence due primarily to the dominance of descriptive studies rather than RCTs. Mental health training for law enforcement improved likelihood of transporting people to urgent and emergency crisis care for jail diversion, but it did not appear to decrease police force used in mental health-related calls. Crisis resolution teams showed clinical- and cost-effectiveness. Crisis houses and acute day hospital care are also currently recommended by the National Institute for Health and Care Excellence. Reviewers noted serious gaps in effectiveness research regarding access to pre-crisis support; urgent and emergency access to crisis care; inpatient care; post-discharge transitional care; and Community Mental Health Teams/intensive case management teams. The evidence base is of low quality likely reflecting the challenge of studying complex interventions.

A report submitted to the California Mental Health Services Oversight and Accountability Commission summarized findings from a literature review of a variety of crisis intervention programs for adults.¹²⁵ It included 7 systematic reviews, 4 RCTs, and 7 observational studies with comparison groups. Briefly, a few studies suggested that adding (pre-crisis) case management or individual crisis plans for persons with high crisis-service utilization was not effective in reducing ED utilization or hospitalizations. Most studies of interventions to reduce duration of untreated psychoses had negative findings. There was very limited evidence that co-responder programs between mental health workers and police reduce arrest rates of people in crisis, but mixed results as to whether these interventions reduce psychiatric hospitalizations or improve first responder or patient safety. Follow-up with primary care and outpatient psychiatric care in the post-crisis period was improved by patient navigators and mobile crisis follow-up teams. Evidence suggests that mental health triage offered in the ED decreased hospitalizations; and crisis residential treatment (discussed below) was supported by robust evidence. Review authors also concluded that use of peer-specialist services provided to individuals previously on involuntary holds was associated with reduced hospitalization (possibly attributable to greater use of crisis stabilization supports). Similar to conclusions from other reviews, these authors noted that with the exception of evidence for effectiveness of crisis residential treatment, studies were generally small and had weak study designs.

Methodological weaknesses prevent drawing conclusions about the effectiveness of crisis interventions and stabilization. Co-responder programs may reduce arrest rates for those in acute crisis; there is limited evidence that interventions like case management and peer counseling reduce psychiatric hospitalizations or improve linkage to follow-up care.

Residential Treatment (Acute and Subacute Care for Mental Health) ***(Peer-reviewed Literature)***

Residential mental health treatment explicitly serves those with diagnosed behavioral health disorders and aligns with the tenet of providing mental health care within the least restrictive environment.¹²⁶ These residential programs only accept voluntary patients, and often have a

capacity of 12 or fewer beds. Lengths of stays at residential facilities range from days to weeks (acute crisis residential) or up to six months (subacute care). Such facilities typically provide medication supervision, counseling, peer support and navigation.¹²⁶ Thomas and Rickwood examined 26 studies in a systematic review of the clinical and cost effectiveness of acute/subacute residential programs for mental health treatment. They reported that residential acute care resulted in clinical treatment outcomes equivalent to inpatient care and at less cost due to either fewer days of care or lower readmission rates. Users reported high levels of satisfaction. The number of subacute care studies was insufficient for drawing conclusions for the review; however, each of the three studies did show significant improvements in clinical outcomes. Another systematic review concluded that residential treatment combined with case management may increase the number of participants in stable housing after one year and increase the proportion of time spent in stable housing compared to treatment as usual.⁸¹

There is clear evidence that psychiatric residential treatment produces health outcomes equivalent to hospitalization, and at lower costs and with high levels of patient satisfaction.

Substance Use Disorder Treatments

As discussed in Chapter 2, the prevalence of substance use disorder (SUD) is estimated to be between 10% and 60%, and likely at least 30% among people experiencing homelessness in Sacramento. (Substance use disorder includes misuse of alcohol, prescription drugs, and illegal drugs.) SUD treatments vary depending on the substance being misused, but can include medication-assisted treatment (MAT), medical management of withdrawal, contingency management, cognitive behavioral therapy, 12-step programs, and other counseling methods. SUD programs may be outpatient or residential. Being without housing makes SUD treatment more difficult. For MAT, medication may be lost or stolen. For methamphetamine use, where some combination of contingency management, counseling, and abstinence are the only available options, residential treatment is likely to be more effective than outpatient treatment. In this section we review evidence on MAT, contingency management, and residential treatment programs.

Medication-Assisted Treatment (Peer-reviewed Literature)

Medication-assisted treatment (MAT) has the strongest evidence of positive outcomes in treating opioid use disorder (OUD) and alcohol use disorder (AUD). Methadone, buprenorphine, and naltrexone are the three FDA-approved drugs found to be effective in arresting opioid use and improving physical health when used in concert with counseling and psychosocial support.¹²⁷ Thomas et al. concluded that, based on their analyses of 16 RCTs and 7 systematic reviews/meta-analyses, strong evidence supports use of MAT to increase treatment retention and reduce illicit opioid use.¹²⁸ Another systematic review and meta-analysis analyzed the impact of MAT for opioid use on overall health and concluded that MAT participants had substantially lower risk of all-cause mortality and overdose mortality as compared with those who were untreated with MAT.¹²⁹ A 2018 systematic review by Maglione et al. found inconclusive evidence of effectiveness of MAT on functional outcomes (i.e., cognitive, physical, occupational, social/behavioral, and neurological outcomes) based on reviews of 30 RCTs and 10 comparative studies.¹³⁰ Substantial flaws in study methodologies contributed to the weak findings.¹³⁰ Overall, there is strong evidence that MAT improves outcomes for those with OUD.

MAT can also be used to treat alcohol use disorder. Disulfiram, acamprosate, and naltrexone are the most common FDA-approved drugs used to treat alcohol use disorder. A 2014 systematic review of 122 RCTs found evidence that acamprosate and naltrexone were effective in reducing those with AUD from returning to drinking.¹³¹

Contingency Management (Peer-reviewed Literature)

As noted earlier, about 45% of homeless people seeking treatment for SUD are addicted to meth. Meth addiction contributes to costly drug-induced psychotic events that frequently result in ED visits and sometimes in psychiatric hospitalization. It is a difficult addiction to manage, with no evidence-based medication treatments available. Contingency Management (CM) is a behavioral management technique that provides “reinforcement in exchange for objective evidence of a desired behavior.”¹³² Generally, modest payments (cash or vouchers) are combined with counseling to incentivize patient abstinence; payment is provided for negative amphetamine drug test results. Davis et al. identified 69 studies meeting their criteria for a literature review of the effectiveness of CM across multiple SUDs. They concluded that voucher-based CM shows “high treatment efficacy, moderate to large effect sizes during treatment that weaken but remain evident following treatment termination, and applicability across a diverse set of substance use disorders, populations, and settings consistent with and extending results from prior reviews.”¹³³ Davis et al. concluded that this method can be effective in community-based clinic settings.

Lee and Rawson conducted a review of 12 studies that investigated the effectiveness of CM on decreasing methamphetamine use. They found strong evidence of effectiveness whether CM occurred alone or in parallel with cognitive behavioral therapy. The authors noted some waning effects of CM post-intervention and that sustained abstinence rates over the long term are unknown.¹³⁴ Roll et al. (2013) performed an RCT examining CM use with or without psychosocial treatment for methamphetamine users. Notably, they found that as CM duration increased (from 4 weeks to 12 weeks) attendance and rates of abstinence also increased.¹³⁵

Substance Use Disorder Residential Treatment (Peer-reviewed Literature)

Although research on residential treatment for SUD is limited, the studies that have been conducted indicate residential treatment may lead to favorable outcomes for patients with substance use disorders; however, the methodological rigor of this research is limited. Furthermore, preliminary evidence suggests residential treatment may not be suitable for those with SUD and persistent SMI or those who are unwilling to remain abstinent.¹²⁶ For those experiencing homelessness, residential treatment for SUD provides essential support; it stands to reason that treatment of SUD in the absence of stable housing is unlikely to be successful.

Substance use disorder is exceptionally challenging to treat. MAT, especially in combination with behavioral therapy, has the greatest body of evidence supporting its effectiveness for maintaining treatment of opioid and alcohol disorders. There is a preponderance of evidence indicating that contingency management, when used in conjunction with behavioral therapy, helps patients abstain from methamphetamine use during treatment, but effects wane somewhat post-treatment. Although study quality is weaker, residential treatment for SUD can also produce positive outcomes for some, through improved housing stability and sobriety.

Medical Respite (Peer-reviewed Literature)

Medical Respite programs serve people experiencing homelessness who need some medical care but are not sick enough for an inpatient hospital setting. They often have co-occurring mental health or substance use disorders. Respite programs are typically used as a step-down resource for people without housing who are being discharged from the hospital. To our knowledge, there is only one extant published systematic review of medical respite programs;¹³⁶ researchers reviewed thirteen articles that met inclusion criteria, and noted a heterogeneity of methodological rigor and reported outcomes. They found that medical respite programs reduced future hospital admissions, inpatient days, and hospital readmissions. The evidence on emergency department use and cost was mixed. The authors concluded that results were promising, but that more research is needed.¹³⁶

Conclusion

We were unable to locate substantive evidence on the effectiveness of integrated, co-located models of care for people experiencing homelessness; most of these programs have only recently been established or are still in the process of development. However, we were able to identify limited evidence about components of integrated programs, including Housing First, assertive community treatment, Full Service Partnerships, crisis residential treatment of serious mental illness, and treatment for SUD with MAT and contingency management. It stands to reason that individual component interventions with evidence of effectiveness would remain effective in integrated programs.

Chapter 6: Stakeholder Feedback Regarding a Comprehensive Care Campus Concept

This chapter summarizes input from stakeholders regarding the need for an integrated care approach to ameliorating homelessness in Sacramento County. The findings are organized into *Discoveries* and *Reactions*. *Discoveries* emerged from stakeholder reflections about service needs and challenges of serving people experiencing homelessness. They are organized into three topics:

- Current challenges that need to be *overcome*,
- Existing approaches, programs, and infrastructure that need to be *retained and optimized*,
- Special subjects that warrant *highlight*

Reactions summarize stakeholders' responses to a hypothetical, integrated care campus concept informed through interviews and from an online confidential survey sent to interviewees.



Source: Shutterstock.com

Methods: We conducted one-on-one interviews with 35 individuals from 24 organizations and conducted two focus groups (5 advocates/peer support providers and 18 Sacramento County Criminal Justice Cabinet members, respectively) between July 2019 and October 2019 to inform consideration of a hypothetical Sacramento comprehensive care campus for mental health, medical care, substance use, and housing support for people experiencing homelessness. We asked for opinions about current program operations in Sacramento County, user experiences, the concept of an integrated care campus, potential barriers to the campus concept, and alternatives. Stakeholders included individuals from local health systems, community clinics, social service providers, people with lived experience, and local agencies (see *Appendix C* for participating stakeholder organizations). Interview notes, memos, and recordings/transcripts were analyzed to identify thematic patterns. See *Appendix C* for additional details about the research approach and methods. The UC Davis and California State University Sacramento Institutional Review Boards considered the study exempt from human subjects research.

Discoveries

The conceptual crisis map in Figure 5 is a rendering of how most stakeholders described the constellation of programs and service interventions in Sacramento County for individuals experiencing a crisis associated with homelessness. Each large domain represents a general crisis type that a person may experience. They include experiences related to mental health; substance use; economic problems; social, physical, law enforcement complaints; health care; housing; and general concerns. The arrows represent pathways toward potential landing spots, i.e. agencies or organizations that offer services, where a person may go to obtain needed assessment and assistance. For instance, a person experiencing a mental health crisis may land at an urgent care clinic, a respite center, or one of the local emergency rooms. Outputs from the landing points are not illustrated.

Four main points are illustrated with Figure 5:

1. There are many intervention points—i.e., agencies, organizations, businesses, and private and public programs addressing acute and chronic service needs across siloes including mental and physical health; substance use; housing; and law enforcement.
2. The organizations involved represent a tremendous allocation of resources.
3. The intervention field is varied and complex.
4. Although individuals frequently experience crises that affect them in more than one domain, landing points are often isolated within crisis domains and curtailed by closed programmatic or organizational boundaries.

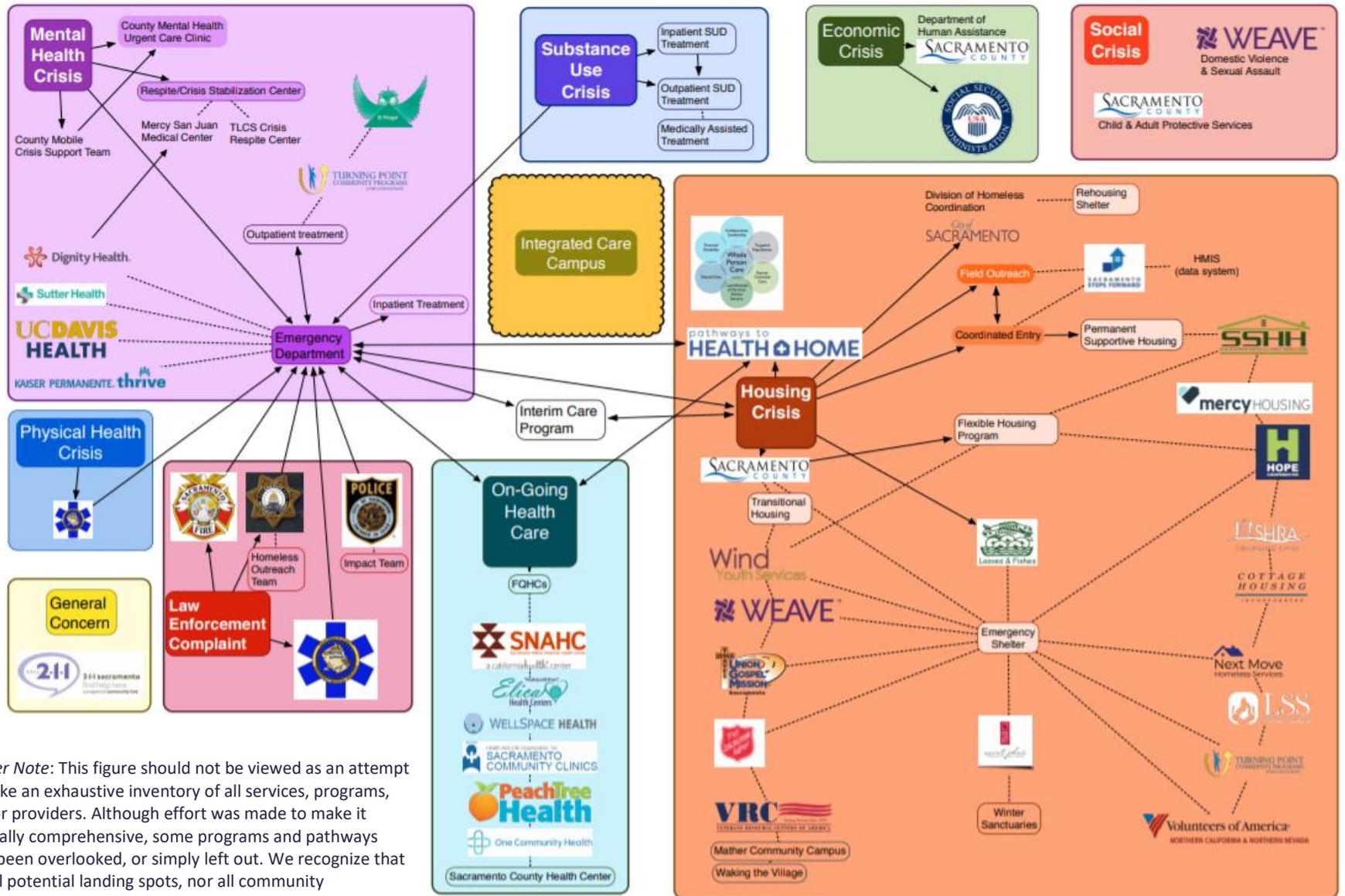
The gold concept cloud located in the center represents the question: *“What role would an integrated care campus play and where might it fit within this complex mix of programs and services aimed at addressing a variety of human crises?”*

Interviewees were asked to *“Tell me a bit about your experience with the coordination of healthcare and social services for people who experience homelessness and who indicate need for mental health and substance abuse treatment, as well as social/life skill support. What seems to be lacking?”*

Respondents consistently identified two challenges: **insufficient capacity** in multiple intervention domains; and **limited coordination, communication, and organization among service providers** for this population. Respondents identified these challenges arising from limited coordination:

- gaps in data sharing and communication;
- broken or non-existent service pathways;
- redundant/inconsistent practice standards; and
- regulatory and funding misalignments.

Figure 5. Client Crisis Map



Reader Note: This figure should not be viewed as an attempt to make an exhaustive inventory of all services, programs, and/or providers. Although effort was made to make it generally comprehensive, some programs and pathways have been overlooked, or simply left out. We recognize that not all potential landing spots, nor all community organizations or programs are depicted in this figure; however, we are confident that it illustrates a comprehensive enough picture to inform conversation and a starting point for total intervention system mapping.

The gold concept cloud located in the center represents the questions: "What role would an integrated care campus play and where might it fit within a complex mix of current programs and services aimed at addressing a variety of human crises?"

Insufficient Capacity and Limited Coordination

Most respondents across sectors agreed that there is insufficient service capacity. Multiple interviewees identified a **lack of inpatient psychiatric beds**, and nearly all respondents mentioned a need for “service exits;” in particular, the **lack of affordable, accessible housing** was presented as a major barrier that impacts all areas of intervention.

“There is a capacity issue all around.”

– health system respondent

“I don't know how many beds there are, but let's say there's 500 beds [for substance abuse treatment], and there's a need for 2,500...You'd (A patient would) be lucky to be called in [to access treatment at] three months.”

– social service agency respondent

Most respondents also relayed concern over limited coordination, communication, and organization among the multitude of intervention services for this population. Even if authority for such planning exists, respondents indicate leadership and implementation is lacking.

“The lack of coordination between the county and the city has been a big barrier.”

– health system respondent

[the various elements] “have too many philosophical pieces and no thought leader.”

– social service agency respondent

In addition to identifying general concerns about the lack of coordination, respondents identified specific challenges that arise from it. Each of them is presented in more detail below.

Data Sharing and Communication Gaps

Lack of data sharing and gaps in communication were mentioned as impeding the ability to serve people in crisis effectively.

“I feel the way they are implementing [data systems] is holding us back...We're mandated to put data into a system that won't talk to anything else [the hospitals, or other service providers].”

– social worker

Furthermore, having multiple information systems creates communication barriers.

“Data sharing at the system level is very hard.”

– public agency respondent

“It's really a communication link that's necessary somehow. Sometimes the call [to 911] was initiated by your staff, so you know exactly where [the client] is, or maybe you get a call from the ER.” [Although, absent a communication channel, in other instances] “they just disappear for 5 days.”

– social service agency respondent

Alameda and San Diego Counties have developed social-health information exchanges (SHIE) to improve their data exchange efficiency by permitting cross-disciplinary access among health care, housing, criminal justice, and social worker providers to monitor services obtained by clients from different siloes.¹³⁷ Benefits include: 1) efficient system navigation for patient/clients and case managers; 2) support for holistic needs assessments to accurately identify specific services or programs that need bolstering; 3) ability to identify efficient use of dollars by adjusting only those services that really require expansion/contraction; and 4) ability to be utilized no matter the homeless service model used, whether scattered or at one co-located site.

Broken or Non-existent Service Pathways

Limited coordination produces disconnected service options, particularly for persons having more than one type of service need.

"I don't even mention County AoD [Alcohol and Drug Services] to someone on the streets if they decide they want to get clean. Even if they got to the assessment center on Power Inn, they'd have to call once a week to remain eligible to receive services. For a homeless person, that simply isn't gonna happen."

– social service agency respondent

Redundancy and Inconsistent Practice Standards

In Sacramento, approval and allocation of intervention resources are managed and tracked by multiple entities. For example, at least three separate systems exist to track service access and outcomes. County staff and the general public uses the Sacramento Homeless Information Network Ecosystem (SHINE), an online self-service portal that homeless families can use to register for emergency shelter space. Sacramento Steps Forward manages the Homeless Management Information System (HMIS), a local information technology system used by homeless service providers to collect confidential client-level data including demographics, history of homelessness and services accessed, and service need. Additionally, the Whole Person Care/Pathways to Health and Home program uses a proprietary data management system managed by Sacramento Covered for its subset of enrollees who are chronically homeless. Finally, additional clinical tracking systems are introduced through Medi-Cal-managed care plans and FQHCs. If homeless patients using no consistent source of care present to a provider not previously assigned to provide their care, services provided to them could not be reimbursed until the patient is properly reassigned.

"The biggest challenge I think that we had and continue to have is if a client is a patient at [health provider 1] and [health provider 2] is providing a service, [provider 2] cannot get reimbursed for the process to switch over to their care."

– social service agency respondent

Respondents also indicated that multiple providers are performing similar services, such as navigation, without uniform expectations, service oversight and coordination.

“There are a number of entities out there doing outreach...then what are the best practices, best standards, and how do we build a more coordinated effort?”
– public agency respondent

“Right now, who knows what is going on with all the organizations [who are doing navigation]?”
– social service agency respondent

Regulatory and Funding Misalignments

Poor coordination is compounded by a parallel problem—misalignment of various local, state, and federal regulatory and funding regimes. For example, most medical care for people experiencing homelessness is funded through Medi-Cal. Sacramento County is using the Geographic Managed Care Model, which includes multiple plans each with their own designated provider networks.

Medi-Cal eligibility processes and funding restrictions inadvertently complicate emergency department services and discharge for people experiencing homelessness. A health system discharge planner explained that when an indigent person who is not enrolled in Medi-Cal presents at the ED, payment cannot be conferred to the hospital for services (even if the hospital preemptively assumes eligibility). Furthermore, follow-up care that could be paid by Medi-Cal is not available to the provider if the patient does not follow through with enrollment through the County.

Respondents also indicated that HUD’s funding priority toward “housing first” approaches for people with the highest acuity has led to reduced funding for housing integrated with services, making it hard for service providers to meet complex service needs.

“At times, Housing First can mean, housing only.”
– social service agency respondent

“There is a little bit of a disconnect, the funders are targeting the most vulnerable people on the streets...I have to find those who are most likely to die on the streets, bring them into my shelter, and somehow keep them alive. However, the money they are paying isn't such that I can hire a nurse. You know what I need? A staff of medical professionals - I'm accepting patients that are living on the streets.”
– social service agency respondent

Retaining and Optimizing Current Elements in Sacramento County

In this section, we present current programs and service elements or infrastructure that multiple respondents mentioned as exemplar.

Programs

Responses from a Sacramento County program, a City of Sacramento program, and two health system collaborations are described in this section. For each, a brief description is given, and a representative response is quoted (see Chapter 3 for more program details).

Flexible Supportive Re-Housing Program: Sacramento County's FSRP provides highly flexible re-housing and stabilization services to chronically/long-term homeless people who utilize costly public services the most.

"This is a fantastic project, because they are flexible. They do whatever they have to do to get people, who are the population we're talking about, stably housed. [There is a property management team] ... And there's a whole other team called ICMS, which is Intensive Case and Management Services."

– social service agency respondent

Low Barrier Triage Shelter: According to the City of Sacramento's website, the low barrier triage shelter in the City of Sacramento is generally characterized by the following: open and staffed 24/7; allows (and encourages) guests who typically cannot access traditional shelters, including those with pets, partners and/or possessions; accepts guests presenting with mental health or addiction issues; or guests who have been banned from traditional shelters.¹³⁸ Shelters providing on-site wrap-around services by professional staff do not exit people to the streets, but rather allow them to stay until a permanent housing opportunity has been identified.

"These are rough numbers, we saw 600 plus people, and we housed about 200. So, about 30%. If you look at the number of people who have years of accumulated homelessness among the people that were housed, even though 30% doesn't seem like a lot...it's a big impact. I think it would more than have paid for itself based on the costs that those 200 people had on systems such as emergency rooms and jails."

– social service agency respondent

Pathways to Health and Home: This effort, including health systems, community organizations, and public agencies, fosters deeper collaboration and coordination between service providers to assess the range of health and housing needs, share data across systems, coordinate care in real-time, and evaluate health and housing outcomes.

"It's Dignity, Sutter, UCD. And then the four health plans: Health Net, Anthem, Aetna, and Molina...with all the community partners, they're making it work."

– social service agency respondent

Interim Care Program (ICP): This collaboration among area health systems provides temporary respite and recovery for homeless patients who are healthy enough to be discharged from a hospital, but have no housing alternative, family or other means of support.¹³⁹

"This is a partnership for adults in need of respite. We house people and make sure they get wrap-around services."

– health system respondent

Infrastructure Elements

The following three elements were mentioned by multiple stakeholders as facilitating coordination, communication, and organization among current service interventions.

Coordinated Entry: According to HUD, coordinated entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. (See HUD link for details about the coordinated entry process.)

“Right now, we just have coordinated entry into housing [continuum of care funded], not into shelters. But, that’s part of what we’re looking at with the system [system improvements underway]-- is how do we coordinate entry into shelters?”

– public agency respondent

Data-Sharing Agreements: Partners in the Pathways to Health and Home (P2H) program described implementing data sharing in accordance with applicable state and federal laws and regulations. Data sharing between health care and social services (and potentially more broadly) can improve care coordination and enable clients to be located more quickly.

“Through Pathways, if someone comes into contact with the emergency room, it makes it into the [Pathways] shared system. We can see that...It is very helpful, it gets you to the level of the plan...When a housing option comes available and I need to find a client, I can look in the system and see, oh, [a specific clinic] had her. She’s been in the hospital. Now she is in ICP. I can see all that all in real time.”

– social service agency respondent

Collective Impact Model: Generally, collective impact refers to the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem at scale.¹⁴⁰ In particular, Pathways to Health and Home used this model to effectively form partnerships, based on a shared vision and a shared communication style, to better serve their enrollees collaboratively.

“We [P2H partners] formed under what’s called the collective impact model. So, our agencies all came together with a shared vision, shared communication styles, weekly meetings around our shared enrollees. It really was a community effort to serve this population.”

– social service agency respondent

Special Subjects That Warrant A Highlight

This section highlights several key issues, mentioned by multiple stakeholders as important for understanding the current situation in Sacramento and serving people in crisis, that warrant particular attention.

Methamphetamine

As noted in Chapter 2, methamphetamine use exacerbates other health conditions and presents serious challenges to effectively serving clients. Its use complicates making an appropriate diagnosis, especially for emergency department personnel trying to distinguish between methamphetamine-induced psychosis and organic psychosis.

~ What is the most challenging substance in relation to client needs?

"Meth, hands down, meth."

~ What is the challenge with meth?

"When you have a mental health disorder it [meth] is steroids for your [disorder]; it makes your psychosis that much more intense...If you give [it to someone with] a schizoaffective disorder, meth is like pouring gas on the fire...Someone who is schizoaffective and appropriately treated - they can be housing stable. Give them meth, and they're being kicked out in two days."

– social service agency respondent

"It's really expensive" [when a person ends up in an in-patient psychiatric facility, but substance use detoxification and treatment would have been more appropriate].

– health system respondent

Additionally, treatment options are limited, and further reduced when residential treatment is needed to reduce relapse. In addition, patients may not be accepted by inpatient facilities if they have co-occurring mental health and physical health needs.

"If you want to access pretty much any type of modality, detox, residential or outpatient, you have to go through the county"

– health system respondent

"We have a really good relationship with the people at AoD [Alcohol and Drug] services on Power Inn Road. They'll place my people in beds, but it was a big struggle. But obviously your people [the clients] have to be willing. We're looking at about a month waiting list to do an inpatient rehab...but, it's a good resource, but you're not acknowledging anything else [meaning co-occurring conditions or situational consideration] - so, it's hard for a person to go into rehab who has a severe mental illness. Or, I've had a number of my clients that have a chronic illness that have been released after like 2 days, because their medical need is too much for them [the rehab facility]"

– social service agency respondent

Experience, Ideology and Service Philosophy

Several respondents were concerned about disparate levels of understanding of the complex medical and social service needs of the chronically homeless among partners working across programs (or within collaborative projects). This can lead to variation in service quality, but it also can mean clients are treated differently in different programs. Several respondents mentioned potential misalignments in ideology and service philosophy between law enforcement, social welfare, and the medical model.

“I think the other piece of it—if you aren't working with chronically homeless people—it's really important to understand chronically homeless people...

“So, the way that everybody treated a customer was not the same. And there were a lot of customers who felt that that was a result of this inability for us to all be on...Or at least respect each other's differences, but be on the same page. Inasmuch as you don't understand the needs of the chronically homeless, you consider them as resistant.”

– social service agency respondent

Trauma and Moral Injury

Crisis intervention services are often designed to treat specific conditions and acute circumstances such as mental illness and substance use or an occurrence of homelessness. However, several service providers discussed the need for a trauma-informed approach to crisis intervention and on-going service provision for this population.

In particular, one social service respondent introduced moral injury as a central component of the client experience. The respondent explained that the term moral injury originally comes from work with veterans who return from war and cannot re-integrate into society. Moral injury refers to the internal consequences of the “the deeds they have done or the deeds that have been done to them—deeds that are so opposed to their moral fabric, that they see themselves as not worthy.”

“What we've also come to know is that most people are struggling with this huge amount of trauma and moral injury, and we can't address that through only their lack of resources.... A strength-training model [for clients is also needed]. It's hard to make progress.”

– social service agency respondent

“We're still noting that people who are chronically homeless have a lot of those same characteristics [as veterans who have suffered moral injury]...And the more I talk to people who have been chronically homeless, the more I understand why there is a moral injury. Because their need to survive on the streets or on the river have done to them things that put them in the [similar type of] space as the veterans.”

– social service agency respondent

Focus Group: Lived Experience and Peer Support

The Mental Health Services Act (MHSA) encourages the inclusion of advocates with lived experience to contribute to County human services planning and implementation. Five system advocates with peer-support roles in non-profits participated in our focus group. They highlighted the need for using a consistent, trauma-informed approach, as noted above. Specifically, they noted that uninformed service philosophy and stigma associated with mental illness can build barriers between people experiencing health crises and professional service providers and systems, including law enforcement. Respondents acknowledged that some government entities are working to train officers, and that the introduction of mobile mental health response teams have helped reduce the escalation of events. These response teams have the added benefit of helping to reduce the advocate's (family/friend) fear of calling for help and managing potential embarrassment around an event that becomes public. Further, advocates mentioned that lack of community awareness about access to available services and where to turn in a crisis remains a concern.

"What do you do when you call 911 [in crisis]? It's law enforcement, and uniforms...sirens and cars come out to your house. That can affect your station in the community and family relationships. There has been work done [in training officers] in relation to that spectacle that comes."

These comments are consistent with observations from others with lived experience as reported in the 2018 Sacramento County Homeless Plan. For example, 20 respondents with lived experience (or family members) noted that the system is difficult and confusing to navigate due to conflicting advice, nonexistent coordination among different providers at scattered locations.¹⁸

Finally, focus group participants discussed service disruptions that occur when people receiving mental health treatment through Sacramento County transition from youth to adult service divisions. Members in this group expressed appreciation for the mobile crisis units that have been created to provide a more service-oriented team response that, in times of crisis, can attempt de-escalation strategies. However, apparently dispatch of such a unit can depend on the caller asking for it rather than the typical emergency response call.

"Now there's the mobile crisis team that goes out - and it's not law enforcement - it's a crisis team that knows mental health."

- system advocate respondent

In addition to crisis teams, the focus group participants reported that integrated peer counselors are a valuable component, for current service provision and future expansion. The MHSA has placed a value on peer support; however, Governor Newsom vetoed a bill that outlined certification procedures for providers with lived experience (peer counselors), giving them an opportunity to work within county departments and with contracted service providers, and thus expanding professionalization of such workers.¹⁴¹

Reactions to an Integrated Care Campus Concept

In this section, we summarize comments made in direct reference to the hypothetical concept of an integrated care campus. In addition to in-person interviews and focus groups, we gathered responses from these participants via an online, confidential survey. This provided an additional means for systematic data collection. Interviewees were invited via email to participate. The request included a summary document, *Sacramento Mental and Medical Health Campus – Project Prospectus*, for participant review (See Appendix C). Of the 35 interviewees, 15 answered the follow-up survey. Below we provide each question and a summary of the responses.

1. Having read the *Sacramento Mental and Medical Health Campus – Project Prospectus*, what are your thoughts?

In general, respondents voiced positive interest in the integrated care campus concept, especially in relation to the need for integrated and collaborative planning.

“I am always excited to see innovative approaches to Sacramento County's challenges with mental illness and homelessness, and I think there could be many benefits to having many services co-located in this way.”

“It is badly needed. Integration of those with severe mental health concerns, physical health needs, and substance use would be a welcomed resource for this community.”

However, concerns were also raised by survey respondents and stakeholders. For example, several respondents questioned how an integrated care campus might fit with existing services. A respondent questioned the merit of focusing attention toward a new project given that this could direct resources away from work currently underway. Another expressed concern about allocating what would be a large capital investment into facilities given uncertain and limited on-going funding, especially funding for services. Lastly, while some respondents shared appreciation that new energy was being exerted around a potential campus and toward addressing service needs, they expressed apprehension about whether anything would happen, questioning the feasibility of such a project moving forward.

“Upon reading the Project Prospectus: how would this new project support the large network of existing services provided by Sacramento County, its contracted providers, and other agencies supporting individuals with mental health conditions and/or who experience homelessness?”

“There is a lack of vision of how it [a comprehensive campus] dovetails with existing services and agencies, a lack of cohesive vision - is it [a campus] addressing homelessness, mental illness, substance use, the need for inpatient med / psych beds, etc.?”

2. Can you identify at least two challenges that could prevent development of such a campus?

Land use siting and adequate funding were the two most mentioned potential barriers to developing a campus.

“Siting such a facility [a large, multi-service campus] would be immensely difficult in Sacramento.”

“NIMBYism...other projects have faced resistance from nearby residents who didn't want a mental health facility in their neighborhood.”

Funding was the second barrier mentioned often by respondents—a potential lack of dollars and a potential mismatch of funding sources. Also, several respondents, having connected the campus concept being considered in Sacramento to the one developed in San Antonio, wondered whether flexible funds such as those provided by a wealthy donor there could be obtained here.

“Having enough flexible resources to fund this campus will be difficult. Public dollars have strict requirements [on] how they can be spent and are already deployed into many programs and initiatives throughout the county.”

Also, a couple of respondents wondered about governance and oversight if a campus were developed.

“Who has what responsibility and how is financial support tied to the level of responsibility/oversight? Who will govern the campus? Who will set rules and standards for operations and have authority over accountability? What happens when something goes wrong?”

3. Can you identify at least two opportunities or resources that could facilitate development of such a campus?

Multiple respondents pointed out the potential for leveraging existing organizations, programs and service elements. For example, local community-based organizations were identified as a resource, and the Continuum of Care was considered helpful for future coordination of services. Also, existing efforts were discussed that could align with planning and implementation of a campus. For instance, a respondent offered, “if justice-involved persons are targeted, there are California Health Facilities Financing Authority Community Services Infrastructure grant funds that could provide start-up funds for getting the physical building needs met.” Another person suggested that potential funding could come from MHSA, No Place Like Home, the City and County, and SAMHSA.

4. In your experience, what is the most effective approach or existing program/effort being taken to care for people who experience homelessness that indicate need for mental health and substance abuse treatment, as well as social/life skill support?

Responses to this survey question were vague; more informative, in-depth answers were provided during interviews (as described above). Several people responded, “I don't know,” or “none that I know of” and others answered with a critique, such as “there are lots of little pop-up programs that are making a difference (and lots that aren't), but little coordination between them,” or “I am unaware of any program that effectively provides such treatment and support at the current time.”

Survey respondents noted that the following approaches and programs by local providers were effective (responses are listed here in their entirety):

- *“Housing First is the most effective approach, in my experience.”*
- *“I think that coordinated entry and homeless navigation systems can be effective in helping homeless individuals [to] access services.”*
- *“The Flexible Supportive Re-Housing Program seems to be the most successful initiative, as it appears to be doing best at meeting its goals.”*
- *“Sutter Pace (except AOD [Alcohol and Drug services]), and TLCS’s intensive services.”*
- *“Low barrier shelters with on-site supportive services have proven highly successful in getting people off the street and into housing in CA’s largest cities, including Sacramento.”*
- *“Perhaps the University’s [UC Davis] effort to train psychiatrists that are dual boarded (medicine and psychiatry) in community defined best practices.”*
- *“Maybe Mobile Crisis Teams - social worker out there on the streets, knowing the patients in their area, checking in on people, doing what it takes to help.”*
- *“Wellness & Recovery Centers/Consumer Self-Help, Inc, Guest House, T-Core, Hope Cooperative.”*
- *“Programs that offer peer support specialists are praised by consumers. Mental Health America of Northern California offers various programs employing peers, as well as training programs for peer staff and leadership on utilizing peers in the mental health workforce. Consumers experiencing homelessness have expressed their appreciation for centers with drop-in models, such as the Wellness and Recovery Centers.”*

Conclusion

Hundreds of people are working diligently, and considerable public and private resources are being deployed, to assist people in Sacramento experiencing chronic homelessness, yet the number of people on the streets on any given night continues to grow. A key take-away from these stakeholder interviews and surveys is that what is often spoken of and characterized as a “system” of care is in fact, not a system.

Stakeholders identified many challenges that impede care in the fragmented configuration of services for individuals experiencing housing, mental health, physical health, substance use and other crises (Figure 3 Client Crisis Map). They noted:

- insufficient service capacity,
- limited coordination, communication and organization,
- broken or non-existent service pathways, whereby multiple providers are performing similar services, and
- misalignments of various local, state, and federal regulatory and funding regimes.

Stakeholders also discussed existing program models and infrastructure that should be retained and optimized whether a new campus model project is pursued or not. These programs or approaches included: The Flexible Supportive Re-Housing Program, the low barrier triage shelter

approach, Pathways to Health and Home and the Interim Care Program. Infrastructure elements included coordinated entry, data-sharing agreements, and a collective impact model of shared governance.

Several key contextual factors within California warrant particular consideration when developing or expanding new models that serve people in crisis. First is the prevalence of and challenges associated with methamphetamine use in Sacramento County and throughout the State. Second, some respondents highlighted that service partners across systems often have varying levels of understanding of chronic homelessness and complex medical and social service needs. Third, moral injury was discussed by several interviewees as a central component of client experience and a barrier to successful integration into society, suggesting service providers must be attuned to the trauma that clients have experienced both before and while homeless.

Finally, in their reactions to the concept of an Integrated Care Campus, stakeholders indicated appreciation for new energy being invested into this issue. Multiple respondents noted the potential for leveraging existing organizations, programs and service elements. Several were apprehensive about the feasibility of a large-scale, consolidated service campus due to the funding and land-use citing constraints.

Chapter 7: Conclusions & Recommendations

Sacramento and other California communities must act now to implement solutions for effective, comprehensive help to the persistently homeless. The policy window is wide open for a bold, integrated program to disrupt the cycle of homelessness and poor mental and physical health.

- Community awareness and interest in addressing homelessness is at an all-time high. In recent polls, 85% of Californians were concerned or very concerned about homelessness. Californians cited homelessness more frequently than any other issue as the top priority for State government to address in 2020.
- Sacramento political leaders, including the Mayor, other local elected officials, State representatives, and the Governor, are prioritizing care and support for this population with complex needs. The Governor's 2019-2020 May Budget Revision increased state support by \$1 billion to mitigate the "homeless epidemic."
- The California Department of Health Care Services is applying for a CMS Medicaid waiver that includes *Enhanced Care Management* and *In Lieu of Services* as part of its emphasis on population health and social determinants of health. Based on Whole Person Care pilot programs, these strategies would reimburse managed care plans for clinical and non-clinical services to support "high need" populations, including people experiencing homelessness.¹⁴² This could include the development of a "clinically-linked housing continuum."

This report illustrates the extensive set of services and programs for people experiencing homelessness in Sacramento County. However, the fragmented, siloed care system has limited capacity and cannot overcome the significant barriers to people exiting homelessness as evidenced by the continued growth in the County's homeless population (a 30% increase between 2015–2017 and 19% increase between 2017–2019).

Developing a common language among housing, health, mental health and SUD providers is a critical element to successfully designing an integrated, person-centered approach to providing care in Sacramento. Indeed, this appears to be a common challenge among many communities as described in the National Housing Conference report sponsored by the Kresge Foundation where participants sought to create and share strategies to build housing-health partnerships. They noted that, although there are some overlapping goals between health care and housing providers, their perspectives are very different.¹⁰⁰ Each group has important expertise, which needs to be woven together to create a true continuum-of-care safety net that seamlessly cares for clients and assists them with exiting from homelessness.

Evidence regarding the effectiveness of integrated, co-located services is limited — primarily attributable to this model's nascent stage of development. Stronger evidence of effectiveness exists for the component services of an integrated care model, including mental health, medical care, substance use disorder, and Housing First efforts. Integrating these services with fidelity should retain their effectiveness or multiply it.

Communities across the U.S. are experimenting with new co-located care systems that employ the characteristics of Whole Person Care and Supportive Housing. Sacramento has made some

efforts to weave services together (e.g., Mather Community Campus; Pathways to Health and Home [see Chapter 3]), but capacity is limited for the 4,000 unsheltered and 1,600 chronically homeless people in the community. An expansion of comprehensive, integrated services and supportive housing capacity will provide more people with the opportunity to permanently exit from homelessness. Incorporating a rigorous evaluation of outcomes will be a critical element to improve our understanding of what works best.

Conclusions

Growing Population of People Experiencing Homelessness

- ❖ The population of people experiencing homelessness is growing rapidly in Sacramento and across California.
- ❖ Approximately 1,600 individuals in Sacramento County meet the definition of chronically homeless, many of whom have complex medical, substance use, and mental health care needs. Some will require permanent supportive housing.
- ❖ Affordable housing is urgently needed in Sacramento and across California.
- ❖ Access to treatment and housing services is limited; many services have extensive waiting lists.

Communication Challenges

- ❖ Stakeholders note that the siloed “system” of services and providers inhibits a sufficient and efficient patient-centered continuum of care. Many services for people experiencing homelessness exist in Sacramento, but most services are dispersed and siloed. Communication between providers of mental health services, substance use disorder treatments, social services, and medical treatments is poorly coordinated.
- ❖ Without consistent methods of communication (phone, address) or ready access to transportation, people experiencing homelessness have difficulty navigating this complex system of care.
- ❖ An integrated, electronic record system for cross-disciplinary service providers to track patient access and utilization is lacking. Alameda and San Diego Counties offer good examples of effective social-health information exchange systems.
- ❖ Housing and health care nomenclatures are different. Effective integration of services will require improved communication through a common language and agreed upon definitions.
- ❖ People experiencing homelessness who have a serious mental illness (SMI) and/or SUD are often released from incarceration without housing or warm hand-offs to short-term care. Criminal justice representatives recognize the need to improve linkage with services at the time of release and to expand diversion programs with clinical and social service partners to improve treatment and follow-up for individuals with mental health and substance use problems.

Effectiveness of Care

- ❖ Co-located comprehensive care models are mostly recent developments, and evidence of their effectiveness is limited. Many interventions used at co-located, comprehensive service centers (e.g., Housing First, medication-assisted treatment for substance use disorder, assertive community treatment) have been found to be effective as stand-

alone interventions; it stands to reason that these services would remain effective if co-located in an integrated care campus model.

- ❖ Methamphetamine use is a serious and widespread problem among people experiencing homelessness in Sacramento. No evidence-based medication-assisted treatment for methamphetamine use disorder is currently available, but contingency management is a behavioral technique that offers evidence of effectiveness. Lack of residential SUD treatment options and underutilization of contingency management are barriers to effective care for people experiencing homelessness in Sacramento.

Exiting Homelessness: Innovative Approaches

- ❖ Across the country, co-located, comprehensive service models are being developed to address the increased need for integrated, supportive care (see Chapter 4 and Appendix B for examples).
- ❖ Co-located models include case management and treatment for medical, substance use, and mental health problems. Most provide temporary housing (shelter, transitional housing, medical respite care) while identifying permanent housing for clients. Other services offered by some programs include dental care, pharmacy, employment training, and pet kennels.
- ❖ Philosophical differences exist among co-located care models; some emphasize “treatment first” while others emphasize “housing first” approaches. Similarly, some models originated from a criminal justice diversion perspective and others were motivated by a model of integrated mental health/SUD treatment.
- ❖ Local innovative programs, such as criminal justice diversion programs, Full-Service Partnerships, and Pathways to Health and Home, warrant expanded capacity.

Recommendations

Coordinated action by stakeholders is needed to make a difference for the growing number of people experiencing homelessness in Sacramento. Current capacity is insufficient. Homeless individuals with complex needs could benefit from an integrated, co-located, patient-centered model of care that includes housing. Relatively small programs in Sacramento based on the concepts of Whole Person Care, supportive housing, and criminal justice diversion are having some success, but greatly expanded capacity is required to help more of those in need of care. The following recommendations stem from empirical evidence and stakeholder feedback:

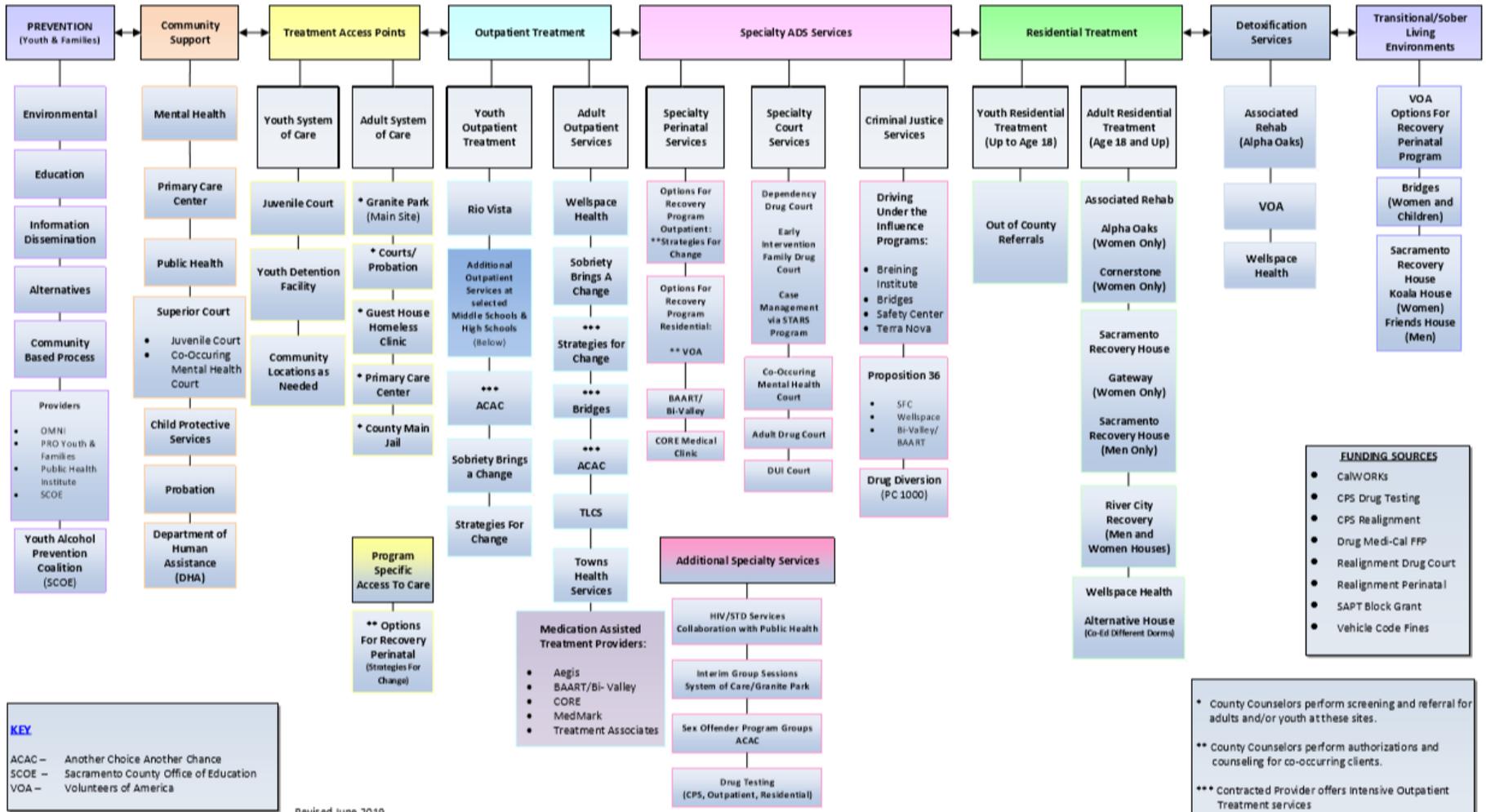
- ❖ **Expanded capacity for shelters, transitional supportive housing, permanent supportive housing, and Board and Care facilities** is urgently needed to reverse the rising numbers of people experiencing homelessness in Sacramento County.
- ❖ **Capacity for inpatient, residential, and intensive outpatient care of serious mental illness and residential substance use treatment** for people experiencing homelessness must be expanded. Until capacity is expanded, jails and emergency departments in Sacramento County will continue to be a common pathway for people with SMI and SUD in crisis, particularly those experiencing homelessness.
- ❖ Individuals with **SMI and/or SUD being diverted or released from jail require an immediate warm hand-off to coordinated care and housing services**. This will improve quality of life and reduce unnecessary costs to the criminal justice system.

- ❖ **Additional residential treatment programs for people with methamphetamine use disorder** are urgently needed. Programs should offer evidence-based treatment including **contingency management**.
- ❖ A county-wide integrated communication system, such as **an electronic Social-Health Information Exchange**, that supports communication across housing, clinical care, social services, and the criminal justice system would improve efficiency and access to services for people experiencing homelessness. Systems used in Alameda and San Diego Counties are good resources for Sacramento County.
- ❖ **Co-located, integrated services linked to expanded housing capacity** on site or elsewhere in the Sacramento community could improve care and support transition into long-term housing. This comprehensive approach should incorporate existing successful programs and service providers. It would reduce barriers to care including: limited capacity, lack of transportation and inadequate communication.
- ❖ Sacramento stakeholders and leaders can **seek guidance from communities with integrated care campuses**. Learning from the experience gained from other sites can inform the local development process in Sacramento. Some model programs offer consulting services.
- ❖ **A cross-disciplinary council of finance experts could collaborate to develop innovative funding options for housing and treatment**. Funding sources for integrated care models vary, and include government sources (city, county, state, federal), health systems, and corporate and philanthropic contributors. An integrated delivery system will require a substantial investment of resources and a team of finance and service delivery experts can leverage creative, integrated funding approaches to expand capacity through co-located housing and services.
- ❖ **Rigorous evaluations** of integrated care programs are needed to assess their effectiveness. Combined with economic analyses, these would provide estimates of costs and potential benefits of these programs.

Appendix A: Description of Sacramento County Services

SACRAMENTO COUNTY ALCOHOL AND DRUG SERVICES CONTINUUM FISCAL YEAR 2019-20

(Contracted Providers and County Staff)

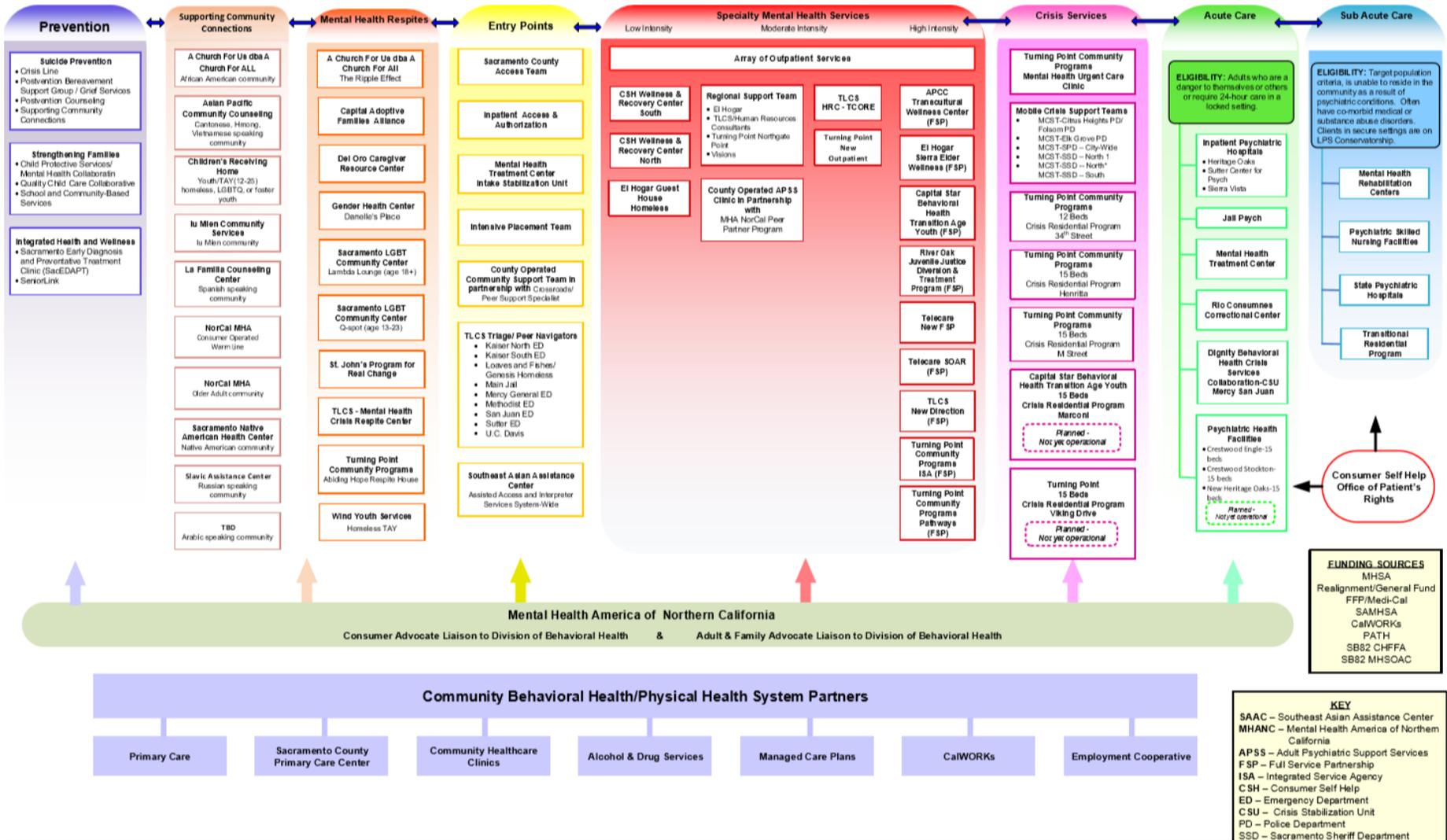


Sacramento County Services: Adult Mental Health Service Continuum Fiscal Year 2019-20

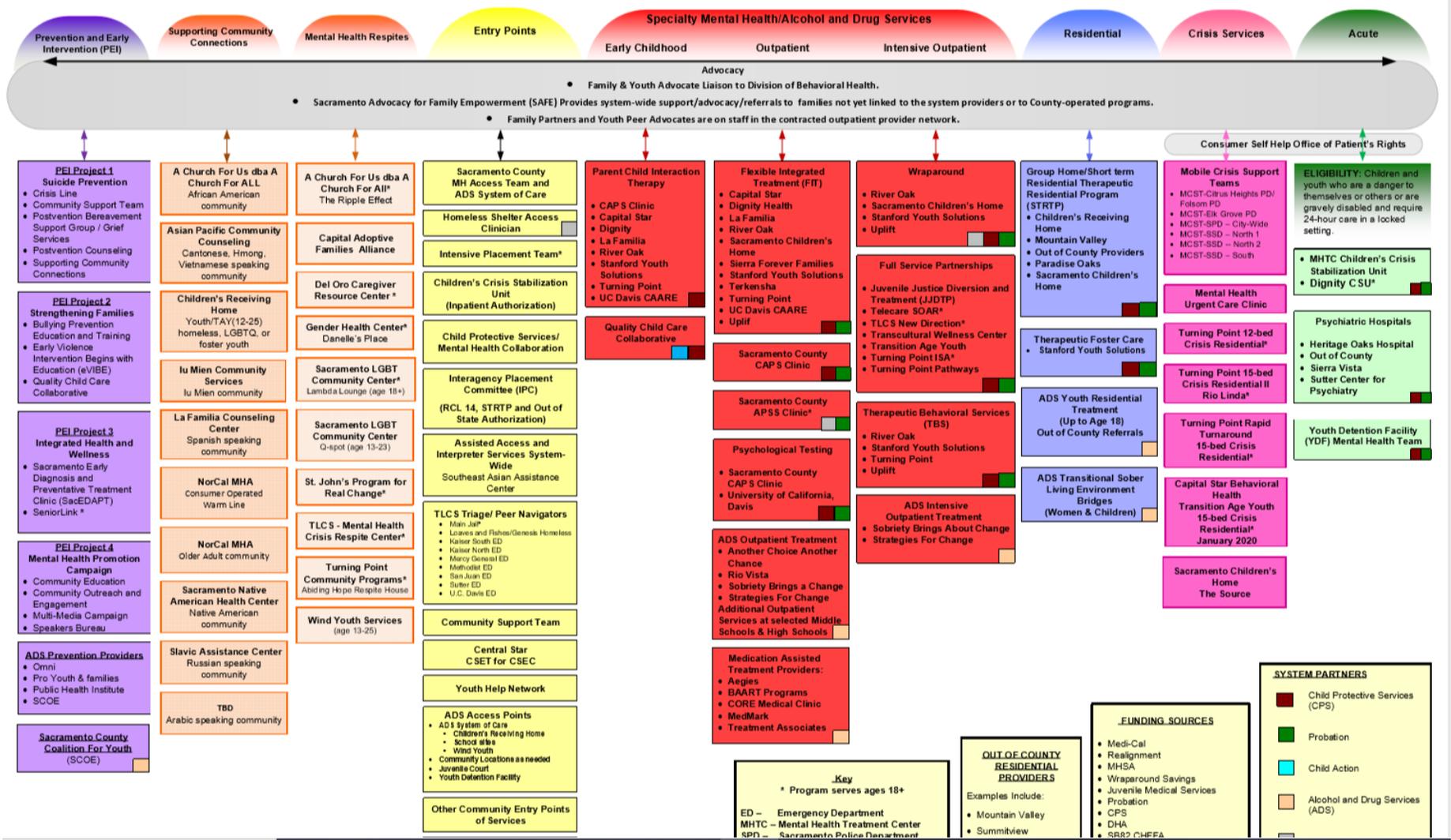


Fiscal Year 2019-20

July 2019



Sacramento County Services: Child and Family Behavioral Health Service Continuum Fiscal Year 2019-20



Appendix B: Integrated Care Models

Table B.1. Integrated Care Co-located Models (most models have one co-located site within a larger program portfolio; italics describe services outside of the co-located site)

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
<p>Care Campus (Pennington County, SD) 70,000 sf building ~\$14M construction cost</p>		<ul style="list-style-type: none"> Mental Health Treatment Adult Residential Treatment 	<ul style="list-style-type: none"> Detox Services (35 Beds) Inpatient and Outpatient SUD Treatment (64 Beds) Crisis Care (9 Beds) 	<ul style="list-style-type: none"> ID/ Birth Certificate Assistance 	<ul style="list-style-type: none"> Transitional Housing Supportive Housing (23 Units) 	<ul style="list-style-type: none"> Law Enforcement Diversion
<p>Central City Concern (Portland, OR)</p> <ul style="list-style-type: none"> <i>Old Town Clinic-Old Town Recovery Center / Harris Building</i> 	<ul style="list-style-type: none"> Primary care Pharmacy Basic lab Acupuncture After hours care Hep C treatment 	<ul style="list-style-type: none"> Old Town Clinic outpatient mental health care Old Town Recovery Ctr outpatient addiction & mental health care 	<ul style="list-style-type: none"> Outpatient addiction treatment 	<ul style="list-style-type: none"> Case management 	<ul style="list-style-type: none"> Harris building – recovery supported housing (180 units) Eviction prevention Housing placement services 	<p>3 adjacent buildings provide medical, housing, and social services. Harris Building ~\$14.5M</p>
<ul style="list-style-type: none"> <i>Blackburn Center</i> (opened 2019) \$52M construction cost 	<ul style="list-style-type: none"> FQHC (~3,000 pts/yr) Pharmacy Recuperative care (51 units) Palliative care (10 units) Basic lab 	<ul style="list-style-type: none"> Mental Health Care 	<ul style="list-style-type: none"> Addiction Treatment CCC Sobering Program 	<ul style="list-style-type: none"> Case Management Employment Assistance 	<ul style="list-style-type: none"> Transitional housing (80 units) Permanent Supportive Housing (34 studios) Housing placement services 	

Table B.1. Integrated Care Co-located Models (most models have one co-located site within a larger program portfolio; italics describe services outside of the co-located site)

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
Colorado Coalition for the Homeless (Denver, CO) <ul style="list-style-type: none"> Stout Street Health Center/Renaissance Stout Street Lofts 53,192 sf \$35.3M construction cost 	<ul style="list-style-type: none"> FQHC (~18,000 patients/yr) Dental Care Vision Care Pediatrics 	<ul style="list-style-type: none"> Integrated Behavioral Health 	<ul style="list-style-type: none"> Substance Abuse Treatment Services 	<ul style="list-style-type: none"> Social Services Life Skills Training Financial Literacy Employment Assistance 	<ul style="list-style-type: none"> Supportive Housing and Services (78 units in Renaissance Lofts upper floors) 	<ul style="list-style-type: none"> Health Outreach Program (mobile clinic with pharmacy, lab, dental, vision care, etc.) Respite care off-site Affordable Housing for Low Income off-site
Cordilleras Mental Health Facility (San Mateo, CA) OPENING 2022	<ul style="list-style-type: none"> Primary Care 	<ul style="list-style-type: none"> Mental Health Rehabilitation Center (80 Beds) Crisis Stabilization 	<ul style="list-style-type: none"> Substance Use Treatment 	<ul style="list-style-type: none"> Case Management Job Training 	<ul style="list-style-type: none"> Transitional Supportive Housing (57 Beds) Medically-oriented Secure Residential 	<ul style="list-style-type: none"> Art center Chapel Retail store Bed-bug elimination room
Douglas County Mental Health Campus (Douglas County, KS) OPENING 2021		<ul style="list-style-type: none"> Respite beds up to 14 days Crisis Center (14 beds) w/ 	<ul style="list-style-type: none"> Medication assisted detox (23 hrs) and crisis stabilization (<73 hrs) 		<ul style="list-style-type: none"> Transitional Supportive Housing (8-12 Beds; 6-12 mos.) The Cottages Permanent Supportive Housing (8-10 Units) 	<ul style="list-style-type: none"> Hospital and county health center are adjacent

Table B.1. Integrated Care Co-located Models (most models have one co-located site within a larger program portfolio; italics describe services outside of the co-located site)

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
<p>Downtown Emergency Service Center (Seattle, WA)</p> <ul style="list-style-type: none"> The Estelle 91 units Hobson Place (117 units) OPENING 2020-2021 	<ul style="list-style-type: none"> Primary Care providers at 8 supportive housing buildings On-site clinic at Hobson w/ integrated care 	<ul style="list-style-type: none"> Mental Health Services Crisis Respite (20 beds) off-site Mobile Crisis Team 	<ul style="list-style-type: none"> Outpatient Substance Use Disorder (MAT available) Alcoholism Treatment 	<ul style="list-style-type: none"> Comprehensive Case Management Services Vocational Training Veterans Outreach Employment Services 	<ul style="list-style-type: none"> Supportive Housing (medication monitoring) Emergency Shelter Hygiene Facilities 	<ul style="list-style-type: none"> First Responder Crisis Diversion Facility Community resident activities Garden Computer lab/tv lounge
<p>Haven for Hope /Restoration Center (San Antonio, TX)</p> <p>Multiple campus buildings \$101M construction cost</p>	<ul style="list-style-type: none"> Medical Care Dental Care Vision Care Initiated Trauma Informed Care 	<ul style="list-style-type: none"> Mental Health Services (16 Bed Psych Unit) 	<ul style="list-style-type: none"> Detox and Sobering (40 Bed Sobering Unit, 28 Bed Detox Unit) 12 bed transitional recovery center 	<ul style="list-style-type: none"> Legal Services Vocational and Certificate Training Programs + 70 onsite partners; +80 referral partners 	<ul style="list-style-type: none"> Supported housing (140 beds) Emergency shelter (200 beds) Outdoor courtyard (~500/night) Dormitory (575 beds) 	<p>~975 housed on campus with 147-day average length of stay</p> <ul style="list-style-type: none"> Law Enforcement Diversion Spiritual Services Pet Kennel Specialty courts
<p>Home Forward (Portland, OR)</p> <ul style="list-style-type: none"> Bud Clark Commons 	<ul style="list-style-type: none"> Acute Care Clinic 	<ul style="list-style-type: none"> Mental Health Services 	<ul style="list-style-type: none"> Substance Use Treatment 	<ul style="list-style-type: none"> Case Management Vocational and employment training 	<ul style="list-style-type: none"> Permanent Supportive Housing (130 Units) Transitional Shelter (90 Beds) 	<ul style="list-style-type: none"> Storage Exercise Facility Kitchen Courtyard

Table B.1. Integrated Care Co-Located Models (most models have one co-located site within a larger program portfolio; italics describe services outside of the co-located site)

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
				<ul style="list-style-type: none"> • Money Management Services • Life Skills Training • Advocacy 	<ul style="list-style-type: none"> • Day Center (with Shower, Laundry, Mail, Food, and Learning Center with Internet) 	
New Genesis (Los Angeles, CA)	<ul style="list-style-type: none"> • Physical Health Assessments • Preventative Health Screenings • Ongoing Treatment for Chronic Illness • Referral to Specialty Care 	<ul style="list-style-type: none"> • Mental Health Services • Crisis Intervention 	<ul style="list-style-type: none"> • Co-Occurring Substance Abuse Services 	<ul style="list-style-type: none"> • Targeted Case Management • Health Education • Life Skills Training 	<ul style="list-style-type: none"> • Transitional Housing (50 beds) 	<ul style="list-style-type: none"> • Community Outreach Services • Collateral Contacts
One Stop Homeless Services Center (Baton Rouge, LA) <ul style="list-style-type: none"> • 34,000 sf building • \$8.4 million construction cost 	<ul style="list-style-type: none"> • Baton Rouge Primary Care Collaborative (one wing) • Dental Care (3 provider groups) • HIV/AIDs quick testing 	<ul style="list-style-type: none"> • Catholic Charities--Diocese of Baton Rouge behavioral health wing 	<ul style="list-style-type: none"> • Substance Use Treatment 	<ul style="list-style-type: none"> • Legal Services (LSU students + attorney) • Vocational Rehabilitation and Employment 	<ul style="list-style-type: none"> • Permanent Supportive Housing (36 Units) • Transitional Housing • Emergency Shelter 	46 partners including UpLIFTD, Louisiana Rehabilitation Services, Women's Community Rehabilitation Center, O'Brien House, Healing Place Serve, U.S. Veterans Affairs and the LSU Dept. of Psychology

Table B.1. Integrated Care Co-located Models (most models have one co-located site within a larger program portfolio; italics describe services outside of the co-located site)

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
<ul style="list-style-type: none"> • ~\$2 million operating budget • 800-1,000 people/year 	<ul style="list-style-type: none"> • Pharmacy Services 			<ul style="list-style-type: none"> • Life Skills Training 	<ul style="list-style-type: none"> • Day Center w/ showers, laundry, telephone/Internet 	
<p><u>Restorative Care Village: LAC+USC Medical Center</u> (Los Angeles, CA) OPENING 2021: (Phase I)</p>	<ul style="list-style-type: none"> • Recuperative Care Center (96 Beds) • Acute Care Hub (adjacent to LAC-USC Hospital) 	<ul style="list-style-type: none"> • Mental Health Outpatient Center (SMI-focus) • Mental Health Urgent Care Center • Mental Health Residential Treatment (64 Beds) 	<ul style="list-style-type: none"> • Substance Use Disorder Treatment • Recovery & Respite Center (sobering and detox) 		<ul style="list-style-type: none"> • Transitional Housing • Skilled Nursing Facility • Permanent Supportive Housing under consideration 	<ul style="list-style-type: none"> • Continuum of clinical services urgent, emergency, inpatient to residential detox/rehab and IMD • First Responder Diversion Program
<p><u>Shattuck Campus</u> (Boston, MA) OPENING 2022</p>	<ul style="list-style-type: none"> • Outpatient Medical Services (260 Beds) • Limited Health Services Clinics • Pharmacy Services 	<ul style="list-style-type: none"> • Urgent Psychiatric Care Services • Ambulatory Behavioral Health Services 	<ul style="list-style-type: none"> • Substance Use and Co-Occurring Treatment 	<ul style="list-style-type: none"> • Case Management • Job Training • Education Services 	<ul style="list-style-type: none"> • Supportive Housing (75-100 Units) • Emergency Shelter 	
<p><u>So Others Might Eat (SOME)</u> (Washington, D.C.)</p>	<ul style="list-style-type: none"> • Health Center 	<ul style="list-style-type: none"> • Mental Health Services 	<ul style="list-style-type: none"> • Inpatient Treatment 	<ul style="list-style-type: none"> • Job Training 	<ul style="list-style-type: none"> • Permanent Supportive 	<ul style="list-style-type: none"> • Pharmacy • Playground • Green (garden) Roof

Table B.1. Integrated Care Co-located Models (most models have one co-located site within a larger program portfolio; italics describe services outside of the co-located site)

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
<ul style="list-style-type: none"> The Conway Center 320,000 sf building 			<ul style="list-style-type: none"> Intensive Outpatient Treatment Outpatient Treatment 		<ul style="list-style-type: none"> Housing (202 Units) Transitional Housing 	<ul style="list-style-type: none"> 3 levels underground parking

Table B.2. Integrated Care Scattered-Site Models

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
Alameda County Healthcare for the Homeless Program (Oakland, CA)	<ul style="list-style-type: none"> Primary Care Specialty Care Dental Care Optometry 	<ul style="list-style-type: none"> Mental Health Services Behavioral Health 	<ul style="list-style-type: none"> Substance Use 			<ul style="list-style-type: none"> Social Health Information Exchange (innovative IT platform to enhance cross silo communication)
Friendship Place (Washington, D.C.)	<ul style="list-style-type: none"> Primary Care 	<ul style="list-style-type: none"> Mental Health Services 	<ul style="list-style-type: none"> Addiction Treatment Services 	<ul style="list-style-type: none"> Comprehensive Case Management Supportive Services 	<ul style="list-style-type: none"> Housing Assistance Shelter 	<ul style="list-style-type: none"> Welcome Center house day center, clinic, and pharmacy Offer Veteran Focused Supportive Services
Healthcare for the Homeless (Baltimore, MD)	<ul style="list-style-type: none"> Medical Care Dental Care Convalescent Care 	<ul style="list-style-type: none"> Psychiatric Care Behavioral Health 	<ul style="list-style-type: none"> Addiction Services 	<ul style="list-style-type: none"> Care Management Public Benefit Assistance 	<ul style="list-style-type: none"> Temporary and Permanent Housing Referrals 	<ul style="list-style-type: none"> Securing ID Referrals Transportation

Table B.2. Integrated Care Scattered-Site Models

Name (Location)	Medical Services	Mental Health Services	Substance Use Treatment Services	Social Services	Housing and Basic Needs	Notes
Homeless Services Center at the Arlington Street People’s Assistance Network (Arlington, VA)	<ul style="list-style-type: none"> Medical Care (~1,000 visits annually) 5 Medical Respite beds 	<ul style="list-style-type: none"> Counseling 		<ul style="list-style-type: none"> Case Management Job Training Rapid Re-housing placement Financial literacy training 	<ul style="list-style-type: none"> Permanent Supportive Housing Shelter (~80 beds) Cafeteria 	<ul style="list-style-type: none"> Day Program (laundry/showers) Classroom space
Homeless Persons Health Project (Santa Cruz, CA)	<ul style="list-style-type: none"> Primary Care (~6,500 visits/yr) 	<ul style="list-style-type: none"> Integrated Behavioral Health Treatment Mental Health Client Specialist 	<ul style="list-style-type: none"> Medication Assisted Treatment 	<ul style="list-style-type: none"> Benefits Advocacy 	<ul style="list-style-type: none"> Permanent Supportive Housing 	<ul style="list-style-type: none"> Information and Referrals
Project Renewal (New York, NY) <ul style="list-style-type: none"> <i>Fletcher Residence</i> (55 transitional beds) <i>Geffner Residence</i> (307 permanent supportive beds) 	<ul style="list-style-type: none"> Primary Care Medical Vans Optometry Shelter-Based Primary and Dental Clinics 	<ul style="list-style-type: none"> Psychiatry Occupational Therapy 	<ul style="list-style-type: none"> Substance Abuse Treatment 	<ul style="list-style-type: none"> Case Management Vocational Training Job Placement 	<ul style="list-style-type: none"> Transitional, Permanent Supportive, & Affordable Housing Mental Health & Specialized Shelters 	<ul style="list-style-type: none"> Cooking classes Money management classes <i>Social enterprises</i> <i>Law Enforcement Diversion</i> <p><i>(Italics represent non-site specific services)</i></p>

Links to Information about Integrated, Co-located Models

Care Campus (Pennington County, SD)

- <https://www.pennco.org/ccadp/>
- <https://www.usnews.com/news/best-states/south-dakota/articles/2018-09-08/pennington-county-to-open-social-services-complex>

Central City Concern (Portland, OR)

- <https://www.centralcityconcern.org/>

Blackburn Center

- <https://www.centralcityconcern.org/housingishealth/blackburn>

Old Town Clinic-Old Town Recovery Center

- <https://www.centralcityconcern.org/services/health-recovery/old-town-recovery-center/>
- <https://www.centralcityconcern.org/oldtownclinic/services>

Richard L. Harris Building

- <https://www.centralcityconcern.org/properties/richard-l-harris-building>

Colorado Coalition for the Homeless (Denver, CO)

- <https://www.coloradocoalition.org/>
- https://www.commonwealthfund.org/publications/newsletter-article/2014/oct/colorado-coalition-homeless-model-supportive-housing?redirect_source=/publications/newsletter/2014/oct/colorado-coalition-homeless-model-supportive-housing
- <https://www.enterprisecommunity.org/invest/impact-note/social-return-on-investment/stout-street>
- <https://nmtccoalition.org/project/stout-street-health-center-2/>
- <https://www.youtube.com/watch?v=aCPZvdXUSbo>

Cordilleras Mental Health Facility (San Mateo, CA)

- <https://www.smchealth.org/article/cordilleras-campus-redesign>

Douglas County Mental Health Campus (Douglas County, KS)

- <https://www.douglascountyks.org/bh/recovery-campus>

Downtown Emergency Service Center (Seattle, WA)

<https://www.desc.org/>

The Estelle

- <https://www.desc.org/what-we-do/housing/estelle/>

Hobson Place

- <https://www.desc.org/what-we-do/housing/hobson-place/>

Haven for Hope (San Antonio, TX)

- <https://www.havenforhope.org/>
- <https://www.havenforhope.org/wp-content/uploads/2019/10/H4H-Fact-Sheet.pdf>

Home Forward (Portland, OR)

- <http://www.homeforward.org/>

Bud Clark Commons

- https://www.huduser.gov/portal/casestudies/study_12202012_1.html
- <http://www.homeforward.org/development/property-developments/bud-clark-commons>
- <https://www.centralcityconcern.org/services/health-recovery/bud-clark-clinic/>

(clinic run by Central City Concern, but located in HF Bud Clark Commons)

New Genesis (Los Angeles, CA)

- <http://skidrow.org/buildings/new-genesis-apartments/>
- [http://file.lacounty.gov/SDSInter/dmh/197236_31_Innovations -
An Integrated Mobile Team Approach.pdf](http://file.lacounty.gov/SDSInter/dmh/197236_31_Innovations_-_An_Integrated_Mobile_Team_Approach.pdf)

One Stop Homeless Services Center Capital Area Alliance for the Homeless (Baton Rouge, LA)

- <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/one-stop-homeless-services-center>
- [http://gchp.net/projects/detail/One Stop Homeless Services Center](http://gchp.net/projects/detail/One_Stop_Homeless_Services_Center)
- <https://www.homelessinbr.org/more-on-homelessness>

Project Renewal (New York, NY)

- <https://www.projectrenewal.org/>

Fletcher Residence/Geffner House

- <https://www.nyconnects.ny.gov/services/fletcher-residence-omh-pr-504706179014>

Restorative Care Villages (Los Angeles, CA)

Boyle Heights Restorative Care Village (LAC+USC Medical Center Redevelopment)

- <https://hildalsolis.org/la-county-approves-68-4-million-for-construction-of-the-restorative-care-village-at-lacusc-medical-center/>

- <https://urbanize.la/post/la-county-plans-second-phase-restorative-care-village>
- <https://urbanize.la/post/restorative-care-village-getting-underway-la-county-usc-medical-center>
- <https://urbanize.la/post/la-county-plans-second-phase-restorative-care-village>

Shattuck Campus (Boston, MA)

- <https://www.mass.gov/service-details/shattuck-campus-proposed-supportive-housing>
- <https://www.mass.gov/service-details/shattuck-campus-redevelopment-request-for-information>

So Others May Eat (SOME): Conway Center (Washington, D.C.)

- <https://stories.wf.com/conway-center-revolutionizes-affordable-housing-washington-d-c/>
- <https://www.some.org/services/social-services/addiction-treatment>
- <https://www.some.org/news-events/newsblog/conway-center-bring-new-hope-dcs-homeless-and-low-income-residents>
- <https://www.some.org/news-events/newsblog/our-way-1000-units-affordable-housing>
- <https://www.some.org/news-events/newsblog/recent-happenings-some-june>

Links to Information about Integrated, Scattered-site Models

Alameda County Healthcare for the Homeless Program (Oakland, CA)

- <https://www.achch.org/>
- https://www.achch.org/uploads/7/2/5/4/72547769/strategic-plan_2019-21_finalopt.pdf
- <https://nhchc.org/alameda-county-health-care-for-the-homeless-program/>

Friendship Place (Washington, D.C.)

- <https://friendshipplace.org/>

Healthcare for the Homeless (Baltimore, MD)

- <https://www.hchmd.org/>

Homeless Persons Health Project (Santa Cruz, CA)

- <http://www.santacruzhealth.org/HSAHome/HSADivisions/ClinicServices/HomelessPersonsHealthProject.aspx>

Homeless Services Center at the Arlington Street People's Assistance Network (Arlington, VA)

- <https://www.a-span.org/>

Mental Health Center of Denver (Denver, CO)

- <https://mhcd.org/the-recovery-center/>

Appendix C: Stakeholder Feedback

C.1 Stakeholder Research Approach and Methods

Stakeholder selection: Research teams from CHPR and CSUS collaboratively identified potential stakeholders to be interviewed from a variety of direct client-serving and administrative leadership positions. Potential interviewees were recruited via email. Once scheduled, interview participants were informed about the research purpose, their right to participate or revoke participation, and the protocol in place to protect their confidentiality. All interviewees provided verbal consent. In this report, we identify respondents only in terms of the sector they represented, such as social service provider, health system, or public agency, not by name or affiliation. In total we interviewed 35 people from 26 organizations or public agencies and conducted two focus groups between July 2019 and October 2019. The list of the sectors from which data were collected and the organizational affiliations of respondents within those sectors are given below in section C.2 of this appendix.

Interviews: Open-ended question sets were developed for each targeted stakeholder sector. Most interviews lasted one hour and were conducted at the respondent's private office. (See interview guides in C.3).

Focus groups: Two focus groups were hosted in order to capture input from larger constituencies – system advocacy, and criminal justice. Our systems advocate focus group included members of the local Mental Health Services Act Oversight and Accountability Council (MHSAOC) and staff of Mental Health NorCal embedded within the County service and planning departments. The second focus group was hosted as part of a regular meeting of the Sacramento County Criminal Justice Cabinet. The Cabinet serves as the planning body for Sacramento County's adult and juvenile criminal justice systems.

Data collection and analysis: Careful notes were taken during each interview. Most were recorded, unless the interviewee preferred no recording. To enhance analytic rigor, we engaged in memo writing, peer debriefing, and kept an audit trail. We analyzed notes, memos and interview recordings/transcripts to identify patterns across interviews, eventually emerging at higher-order themes. The process of analysis involved "careful reading and re-reading of the data" (Rice and Ezzy 1999, p. 258).^a

Additional data were collected through an online confidential survey. For most interviewees, this survey was sent via email after the interview with a copy of the document *Sacramento Mental and Medical Health Campus – Project Prospectus* (See Appendix D).^b

^a Rice, P., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne: Oxford University Press.

^b The prospectus written for this project, *Sacramento Mental and Medical Health Campus - Project Prospectus*, describes a hypothetical comprehensive multiple service campus, providing inpatient, crisis, substance use treatments, and outpatient care, wrap-around social services and supportive housing targeting the needs of the homeless population with mental health and substance use problems in Sacramento County.

The questions solicited general thoughts related to the integrated care campus concept approach, as well as asked respondents to identify specific challenges and potential opportunities. Finally, respondents were asked to rank the importance of including each of 25 service elements in an integrated service campus aimed at serving people who experience homelessness and have multiple health care and social service needs.

C.2 Stakeholder Interviewee Organizations by Sector

Sector	Organization
Health System	Central Valley Health Network
	Dignity Health
	Hospital Council
	Kaiser Permanente
	Sutter Health
	UC Davis Medical Center. Case Management
	UC Davis Medical Center. Emergency Department
Public Agency	City of Sacramento. City Manager’s Office
	Sacramento County. Division of Behavioral Health
	Sacramento County. Executive Office
	Sacramento County. Health Services
	Sacramento Police Department. IMPACT Team
	U.S. Department of Veterans Affairs
Social Service	First Steps Communities
	Hope Cooperative
	Legal Services of Northern California
	Loaves & Fishes
	Mental Health NorCal
	Mercy Housing
	Sacramento Covered
	Sacramento Self Help Housing
	Sacramento Steps Forward
	Transform Health
	Turning Point
	Volunteers of America
Winter Sanctuary	

C.3 Stakeholder Interview Guide

General Question Guide

- Tell me a bit about your experience with the coordination of health care and social services for people with....what seems to be the most effective? What seems to be lacking?

- Are you aware of active health care/social service collaborations among service providers in Sacramento County?
 - Strengths? Weaknesses?

Domain-Specific Questions

Health System Providers representing homeless and mental health services and health system leadership.

- Explain the demands this population places on your clinic, hospital, office.
 - Can you please describe the service load for their organization? About how many people/month (or week or year) in this category do you serve?
 - What are your frustrations?
 - What do you think are the patients' frustrations?
 - What would be helpful to address both?
- Are there regulatory (or organizational) challenges that impede your placement possibilities for these patients?
- What are your main collaborations? (With which organizations do you collaborate?)
 - What are barriers to collaboration-coordination of care to improving health care and reducing utilization?

Collaborative Programs: (organizations that integrate with hospital systems)

- *...include questions about gaps in services, care coordination, and currently scalable intervention strategies*
- Please, tell me about the collaboration you have going? How did it come about?
 - What is most helpful about it?
 - What are your frustrations?
 - What do you think are the patients' frustrations?
 - What frustrations do you think your collaborators experience?
 - What would be helpful to address these?
 - Can you please describe the service load for this collaboration? About how many people/month (or week or year) in this category do you serve?
 - Should this be replicated or expanded? How? By you or others? Where are the gaps?

Integrated Care Campus (ICC) visioning

- Are you aware of any models of comprehensive community service campuses?
- What elements, services, facilities and/or supports must be a part of any future community support campus to support the needs of severely and chronically ill people with mental illness, and/or substance use disorder, and chronic medical problems who may also be homeless?
- If such an ICC were to be pursued, which organizations do you think must be partners? In what ways do you think your organization would best be engaged?
- If you had unlimited funds to develop an ideal system or structure to address needs of people who are homeless and also experiencing severe mental health...etc., what would that system or structure look like?

Appendix D: Stakeholder Background for Evaluating Campus Concept

The following information was presented to interviewees to solicit feedback on an integrated care campus concept.

Coordinating Community Care: Sacramento's Integrated Care Campus

How co-locating and integrating existing clinical, behavioral, and supportive services will more effectively assist people experiencing homelessness or mental illness

A new collaboration among Sacramento leaders supports developing an innovative approach to address the complex needs of people experiencing homelessness or near-homelessness who have co-existing conditions (i.e., serious mental illness, substance use disorder, acute/chronic medical problems). Some communities have successfully implemented a campus-based model that integrates and co-locates crucial behavioral health, medical, and supportive housing services into a single campus site. With a grant from the California Health Care Foundation, the Center for Healthcare Policy and Research at UC Davis is now conducting formative research on an approach to address the needs in Sacramento County.

Problem: An increasing number of Californians are experiencing homelessness, including in Sacramento County.

In 2019, Sacramento County estimated there are 5,570 people homeless on any given night, a 19% increase since 2017.

- 30% are chronically homeless and struggle with co-existing conditions such as mental illness, substance use disorders, and/or physical disabilities. This subset remains challenging and costly to treat.
- Mental health calls for service are increasingly taking resources from law enforcement officers, paramedic responders, and ambulance transports. Law enforcement has few options for dealing with disruptive people with mental health issues beyond arrest, 5150 holds,^a or leaving them in the community untreated.
- Patients with a mental health crisis frequently wait in overcrowded emergency departments, where their conditions often worsen. All four health systems in Sacramento are quite affected.^b
- Sacramento County has only 6 facilities with 451 licensed psychiatric beds, which are essentially full year-round (based on the reported 137,914 psychiatric census days).

- Only four inpatient psychiatric facilities in Northern California accept individuals with co-existing medical conditions; bed availability for the many patients with both conditions is increasingly rare.

^a “5150 holds” refers to the California code that allows up to a 72-hour involuntary hold in a hospital setting to perform a psychiatric evaluation and stabilize patients at risk of harming themselves or others.

^b In 2018, UC Davis Medical Center had 2,245 visits with 72-hour mental health 5150 holds (an average of 187/month). In June 2019, more than 13,000 hours of Emergency Department (ED) time (25% of total ED bay capacity) was dedicated just to 5150 holds, with many more hours going to those being treated voluntarily for mental health and substance use disorder.

- Once patients in mental health crises gain admission to a psychiatric hospital, coordinated social services and housing support may not be available during the stay or at discharge, or may not be easily accessed after discharge, increasing the chance of a recurrent crisis and return to the ED.
- Supportive services available across the community are often fragmented and travel needed to obtain services at multiple locations is often a barrier to homeless or mentally ill patients. For people facing mental health issues, this cycling through can create additional anxiety because they are not getting the treatment they need. It results in additional use of services and resources.

Concept: There are different issues and solutions required to help various sub-groups of people experiencing homelessness and near homelessness. This campus would focus first on finding solutions and building facilities for those who are the most challenging to treat—those with the highest acuity due to co-morbid medical and mental health conditions who experience chronic homelessness. The scope of campus services and patient eligibility beyond this population would depend on the path endorsed by a broad array of stakeholders, as well as available financing and sites of operation.

The integrated campus model offers the advantage of providing an innovative continuum of care and comprehensive treatment services, including acute care for individuals with medical problems, mental illness and/or substance use, with a focus on transition from acute crisis care to long-term housing and coordinated outpatient treatment. Co-location of these services increases the effectiveness of interventions and is more cost-efficient for agencies providing help. The campus would feature a well-designed, residential environment (green/garden) with an enhanced perimeter and internal security.

The integrated model would be patient-centered and infused with a low threshold approach to treatment, reducing barriers and providing high levels of care coordination. The approach would effectively redefine the current fragmented and dispersed care system of treat-and-release-treat-and-release for the homeless population with mental health and/or substance use disorders.

ELEMENTS OF PROPOSED MENTAL HEALTH CAMPUS	
Medical-psychiatric care facilities	Wrap-around support services
<ul style="list-style-type: none"> • Inpatient care for patients with mental health issues requiring hospitalization, as well as coexisting acute psychiatric and medical conditions • Crisis stabilization services • Outpatient behavioral health treatment integrated with a primary care FQHC operated on site by Sacramento County and/or in partnership with established FQHCs in the area • Substance use treatment, including medication-assisted treatment 	<ul style="list-style-type: none"> • Subsidized supportive housing • Board and care facilities for those with homelessness and serious chronic medical conditions • Housing placement services • Legal services • Social services (vocational training, education, employment, food hall, etc.) • Integration with jail diversion programs and jail release programs on same/adjacent site

Projects with some or many elements of this campus concept exist in various cities in the United States, including Haven for Hope in San Antonio. The Center for Healthcare Policy and Research at UC Davis is now undertaking an analysis of the feasibility of the campus model, including review of existing services in Sacramento County (well documented in the [2018 County of Sacramento Homeless Plan](#)), and the successes and challenges of model projects in communities across the U.S. This analysis will also include input from key stakeholders including community organizations, health systems, government agencies, service providers, and other groups devoting resources to supporting Sacramento residents who experience homelessness, mental health illnesses, and/or substance use disorders. Meantime, a working group will engage key stakeholders with relevant expertise to develop a workable funding plan and a timetable and sequence for potential launch.

EXAMPLES OF INTEGRATED CARE CAMPUSES

Appendix E: Rapid Evidence Review Summary Tables

Table E.1. Housing Literature

Author	Year	Methodology	Results	Limitations
Treatment First (TF)				
Fitzpatrick-Lewis et al. ⁸²	2011	Rapid Systematic Review	<ul style="list-style-type: none"> Eighty-four studies from 2004-2009 identified. TF was associated with lower chance of relapse compared to treatment as usual. According to one study, TF may be more effective than HF at improving abstinence and housing stability outcomes. 	<ul style="list-style-type: none"> The rapid nature of the review prohibited a truly comprehensive search. Study quality was evaluated as moderate or weak in all studies examined.
Munthe-Kaas et al. ⁸¹	2016	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> Six RCTs (results not pooled) TF may be better than treatment as usual at improving housing stability. Unclear whether TF is superior to other programs, such as ACT or HF, at increasing housing stability. 	<ul style="list-style-type: none"> As program fidelity is often unreported, the degree to which programs under the same label adhered to the principles of their model is unknown. Authors did not systematically review or meta-analyze secondary outcomes.
Housing First (HF)				
Baxter et al. ⁸⁸	2019	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> Four RCTs No consistent impact of HF on short-term health or substance use outcomes. Relative to control interventions, HF led to reduced emergency department use (IRR = 0.63; 95% CI 0.48 to 0.82), fewer hospitalizations (IRR = 0.76; 95% CI 0.70 to 0.83) and fewer days spent hospitalized (SMD = -0.14; 95% CI -0.41 to 0.14) Those in HF programs had more days housed (SMD = 1.24; 95% CI 0.86 to 1.62). 	<ul style="list-style-type: none"> Limited to quantitative data on RCTs One large study had an outsized impact on effect sizes calculated for hospitalization and housing stability outcomes. All studies were determined to have a high risk of bias.

Table E.1. Housing Literature

Author	Year	Methodology	Results	Limitations
Fitzpatrick-Lewis et al. ⁸²	2011	Rapid Systematic Review	<ul style="list-style-type: none"> • Eighty-four studies from 2004-2009 identified (only 10 of moderate quality, none of strong) • For people with SMI experiencing homelessness, housing provided at hospital discharge increased housing stability. • For people with SUD experiencing homelessness, HF was correlated with decreased substance use and service utilization, as well as increased housing stability. • According to one study, TF was more effective than HF at improving abstinence and housing stability (p = .0031). 	<ul style="list-style-type: none"> • The rapid nature of the review prohibited a truly comprehensive search. • Study quality was evaluated as moderate or weak in all studies examined.
Munthe-Kaas et al. ⁸¹	2016	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> • Eight RCTs (results not pooled) • HF likely superior to treatment as usual at reducing homelessness, improving housing stability and increasing the amount of time in housing. • Unclear whether HF is superior to other programs, such as ACT or TF, at increasing housing stability. 	<ul style="list-style-type: none"> • As program fidelity is often unreported, the degree of model adherence by programs under the same model is unknown. • Authors did not systematically review or meta-analyze secondary outcomes.
Hunter et al. ⁹⁵	2017	Program Evaluation	<ul style="list-style-type: none"> • Four RCTs • Relative to controls, intervention groups had 23 to 29% reduction in hospital days, and 24 to 33% reduction in emergency department visits. 	<ul style="list-style-type: none"> • Dataset was designed for administration, not research, which introduces potential for error. • Different programs had different admission criteria and model fidelity, making comparison difficult.
Lee ⁹⁶	2017	Program Evaluation	<ul style="list-style-type: none"> • In the first year, emergency department visits decreased by 79%. • Hospital admissions decreased by 64%. • 35% of those with SUD were engaged in treatment, as were 62% of those with mental illness. 	<ul style="list-style-type: none"> • Targeted only the 10% highest cost and need, so impacts on less acute populations may not be the same. • No direct measures of health – e.g. wellbeing

Table E.1. Housing Literature

Author	Year	Methodology	Results	Limitations
Kizer et al. ⁹²	2018	Literature Review	<ul style="list-style-type: none"> • The weight of the evidence to date does not support PSH in improving health outcomes among people experiencing homelessness. • PSH effectively maintains housing stability over 1-2 years for people experiencing chronic homelessness. • More research is needed; subject matter experts should be convened to assess how research and policy could be used to facilitate access to PSH and ensure availability of needed support and health care services. 	<ul style="list-style-type: none"> • Most studies did not actively seek persons with SMI experiencing homelessness. • Lacks RCTs and other rigorous research studies.
Weitzman et al. ⁹⁰	2017	Program Evaluation	<ul style="list-style-type: none"> • Multisite RCT • Pooled values showed no significant difference between HF and controls in medical hospitalizations, psychiatric hospitalizations, days hospitalized, ED visits, outpatient visits, or costs. 	<ul style="list-style-type: none"> • HF programs are heterogeneous, making comparison difficult. • Data parameters were often unavailable at certain sites. • Authors argue 18-month follow-up may be too short to see measurable impacts.

Table E.1. Housing Literature

Author	Year	Methodology	Results	Limitations
Transitional Housing (TH)				
Burt ⁹⁸	2015	Literature Review	<ul style="list-style-type: none"> • Transitional housing (TH) helped families attain goals of stable housing and adherence to substance use treatment one year after exiting the program. • Longer stays in a program were associated with greater educational attainment, and greater likelihood of continuous employment although those with longer/more frequent episodes of homelessness had higher odds of unemployment or lower wages than their counterparts. • Those with addiction or domestic violence history had poorer employment and wage outcomes compared to those without those experiences. • At program exit, 21% of mothers had been treated for alcohol use disorder, 65% for SUD, and 42% of children who were not with their mother at TH program entry had been reunited during the program stay. 	

Table E.1. Housing Literature

Author	Year	Methodology	Results	Limitations
Gubits et al. ⁹⁷	2016	RCT	<ul style="list-style-type: none"> • Of three program interventions, permanent housing subsidies had better 3-year outcomes (housing stability, well-being and food security) for families than transitional housing or rapid-rehousing programs (or usual care). • TH did improve housing stability as compared with usual care. • No impact on well-being (e.g., SUD, violence, school attendance, etc.) or self-sufficiency (e.g., income, work) or family preservation. 	<ul style="list-style-type: none"> • Study did not include discussion of limitations. • Not all programs were available in all 12 communities. • Sample was too small to permit subgroup analysis.
Full-Service Partnerships (FSP)				
Gilmer et al. ¹¹¹	2010	Quasi-experimental	<p>Compared to controls, & following intervention:</p> <ul style="list-style-type: none"> • FSP group experienced fewer days homeless • Reduced emergency department visits, justice-system use • Increased outpatient mental health utilization • Quality of life increased 	<ul style="list-style-type: none"> • Participants were not randomized to conditions. • FSP group may have been more susceptible to regression to the mean.
Gilmer et al. ¹¹⁰	2013	Explanatory and Exploratory Sequential Design (Qual->Quant->Qual)	<ul style="list-style-type: none"> • Fidelity to principles of HF vary. • Most programs provide rich array of services. • Programs adhere less to principles of low barriers of entry and choice in residence. • Interventions to increase fidelity are identified. 	<ul style="list-style-type: none"> • Not all FSPs were included, participated. • May have missed important conceptual components of FSP implementation. • Only have qualitative data on program directors, not representative of staff.

Table E.1. Housing Literature

Author	Year	Methodology	Results	Limitations
Gilmer et al. ¹¹²	2014	Quasi-experimental	<ul style="list-style-type: none"> The number of outpatient visits attended by the FSP group increased relative to matched controls. 	<ul style="list-style-type: none"> Participants were not randomly assigned to conditions. Databases used may not have captured all mental health services rendered. Data on other services, like SUD use and justice-system involvement, were not collected. Outcomes such as measures of depression and anxiety were not measured.
Sacramento County ²²	2019	Program Evaluation	<ul style="list-style-type: none"> Decrease number of homeless (72.4%); days homeless (90.8%); psychiatric hospitalizations (59.6%); hospital days (72.5%); arrests (60.1%), incarcerations (44.9%); and incarceration days (53%) 	<ul style="list-style-type: none"> Difficulty of obtaining identifying information made tracking difficult. Data could not be linked to HER. Demographic data were limited. No control group
McBain et al. ¹¹⁹	2018	Program Evaluation	<p>Reductions in:</p> <ul style="list-style-type: none"> Criminal justice detention (% detained and duration), Behavioral health inpatient admissions, and Homelessness. Increase in primary care use/costs. 	<ul style="list-style-type: none"> Long-term impact was not measured. No data on outcomes such as suicide rates or occupational improvements collected. Most of the data were self-reported.

FSP: Full-Service Partnership; **HF:** Housing first; **SUD:** Substance use disorder; **RCT:** Randomized controlled trial; **IRR:** Incidence rate ratio; **SMD:** Standardized mean difference; **PEH:** People experiencing homelessness; **SMI:** Severe mental illness; **TF:** Treatment first; **ACT:** Assertive community treatment

Table E.2. Case Management Literature

Author	Year	Methodology	Results	Limitations
Assertive Community Treatment (ACT)				
Bond et al. ¹⁰³	2001	Literature Review	<ul style="list-style-type: none"> • Twenty-five RCTs • Reduced hospital utilization; increased housing stability; and improved symptoms and subjective quality of life • Higher program fidelity was associated with better outcomes. 	<ul style="list-style-type: none"> • ACT treatment did not include vocational support/training, social skills development, or family engagement. • Research is needed to compare non-consumer and consumer case managers and step-down models of care.
Fries & Rosen ¹⁰⁵	2011	Literature Review	<ul style="list-style-type: none"> • Four RCTs • No impact on substance use outcomes compared to controls, perhaps stemming from methodological issues in extant research. 	<ul style="list-style-type: none"> • ACT SUD treatment did not include evidence-based SUD treatment. • Future research should examine which models to pair with ACT.
Penzenstadler et al. ¹⁰⁶	2019	Systematic Review	<ul style="list-style-type: none"> • Eleven RCTs (five datasets) • When strict RCT eligibility criteria are used, there are few methodologically robust studies on ACT for SUD. • Four data sources indicated increased treatment engagement among ACT clients. • Two data sources revealed evidence for reduced hospitalization. • Higher the program fidelity to ACT, the better the client outcomes. • Results on SUD outcomes were inconsistent. 	<ul style="list-style-type: none"> • Despite strict eligibility criteria, many included studies had substantial risk of bias.
Ashwood et al. ¹⁰⁷	2019	Program Evaluation	<ul style="list-style-type: none"> • 52.9% reduction in police department encounters, compared to 18.4% reduction in control group in first 6 months. • In following 6-18 months, 70.5% decrease in police encounters, compared to 3.5% decrease in controls. • 56% reduction in ED visits • Only “graduated” one client from program 	<ul style="list-style-type: none"> • Only have data on small number of outcomes • No random assignment, no control group at all for some measures • Comparison population had fewer police encounters at baseline

Table E.2. Case Management Literature

Author	Year	Methodology	Results	Limitations
Intensive Case Management (ICM)				
Burns et al. ¹⁰⁴	2007	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> • Twenty-nine trials • ICM likely reduced hospital utilization, compared to controls (-0.23, 95% CI = -0.36 to -0.09 for hospital use at baseline; -0.44, -0.57 to -0.31, for hospital use in control groups). • ACT is more effective than standard ICM at reducing hospital use (coefficient -0.31, CI = -0.59 to -0.03), apart from reduced patient to staff ratios. 	<ul style="list-style-type: none"> • Incomplete fidelity data leads to the possibility of an imprecise effect size of the intervention on hospital use. • Used imputed SDs for some data centers; if these imputed SDs were inaccurate, the observed effect size would be inaccurate.
Dieterich et al. ¹⁰²	2010	Systematic Review	<ul style="list-style-type: none"> • Forty RCTs • Compared to treatment as usual, ICM group more likely to have improved general functioning, attain employment, avoid homelessness, and reduce hospital utilizations. 	<ul style="list-style-type: none"> • Authors reported most studies included in meta-analysis had a high risk of selective reporting. No studies provided data for relapse or important improvement in mental state.
Munthe-Kaas et al. ⁸¹	2016	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> • Eighteen RCTs • ICM is probably better than treatment as usual at reducing homelessness at 12-18 months (RR = 0.59, 95% CI = 0.41 to 0.87). • ICM may be better than treatment as usual at increasing housing stability at 12-18 months (SMD = 0.90; 95% CI = 0.00 to 1.79 in four pooled RCTs), or reducing the number of days spent homeless (SMD = -0.27; 95% CI = -.046 to -0.09 in six pooled RCTs). 	<ul style="list-style-type: none"> • As program fidelity is often unreported, the degree of model adherence by programs under the same model is unknown. • Authors did not systematically review or meta-analyze secondary outcomes.
Critical Time Intervention (CTI)				
de Vet et al. ¹²²	2013	Systematic Review	<ul style="list-style-type: none"> • 33 RCTs • CTI may reduce hospital stays and increase outpatient service use. • May enhance behavioral health outcomes 	<ul style="list-style-type: none"> • Heavy reliance on self-reported data • Large degree of heterogeneity between studies, with insufficient data on program fidelity • Qualitative data and analyses of non-randomized trials were excluded.

Table E.2. Case Management Literature

Author	Year	Methodology	Results	Limitations
Lako et al. ¹²³	2018	RCT	<ul style="list-style-type: none"> • Women in the CTI group had fewer symptoms of PTSD and fewer unmet care needs than those who received treatment as usual. • Among those with low levels of social support, CTI improved psychological distress and family support. • No differences were found in quality of life, symptoms of depression, psychological distress, self-esteem, or family and social support. 	<ul style="list-style-type: none"> • Small study sample size (n=136) • Experimental blinding failed on occasion. • Study conducted in the Netherlands, may not generalize to the US population. • Follow-up was limited to 9 months post shelter exit, which precludes conclusions about long-term impacts
Munthe-Kaas et al. ⁸¹	2016	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> • Three RCTS • Compared to treatment as usual, CTI may lead to little or no difference in number of people who were homeless; lead to fewer days spent homeless and may reduce the amount of time spent in a shelter. 	<ul style="list-style-type: none"> • Unknown fidelity of programs under the same label • Study quality was low due to performance and reporting bias (inadequate reporting of randomization and blinding methods).
Shaw et al. ¹²⁰	2017	RCT	<ul style="list-style-type: none"> • For prisoners with SMI, CTI increased engagement with community mental health teams at 6, but not 12 months. 	<ul style="list-style-type: none"> • Research delays necessitated significant deviation from intended study protocols. • Further research is needed into the effectiveness of modified versions of CTI to suit specific subpopulations.

RCT: Randomized controlled trial; **ACT:** Assertive community treatment; **SUD:** Substance use disorder; **CTI:** Critical time intervention; **PTSD:** Post-traumatic stress disorder; **SMI:** Severe mental illness; **ICM:** Intensive case management; **SD:** Standard deviation; **RR:** Risk reduction

Table E.3. SUD, Mental Health, and Medical Respite Literature

Author	Year	Methodology	Results	Limitations
Crisis Stabilization (CS)				
Paton et al. ¹²⁴	2016	Literature Review	<ul style="list-style-type: none"> • One review of reviews, six systematic reviews, nine guidelines, and 15 primary studies • Evidence of effectiveness of liaison psychiatry models in reducing risk of readmissions, reductions in wait times, and improved client satisfaction. • Crisis-related law enforcement training models • Evidence that crisis resolution and home treatment teams reduced risk of hospital admission. • Enough evidence to recommend acute day hospitals and crisis houses as alternatives to inpatient treatment. 	<ul style="list-style-type: none"> • Evidence base lacks study of repeated use of care/relapse rates and intervention impact on self-harm. • Most literature was of low quality likely reflecting the challenge of studying complex interventions. • Serious gaps in effectiveness research were noted in pre-crisis support, urgent and emergency access to crisis care, inpatient care, post-discharge transitional care, and Community Mental Health Teams/intensive case management teams.

Table E.3. SUD, Mental Health, and Medical Respite Literature

Author	Year	Methodology	Results	Limitations
Melnikow et al. ¹²⁵	2019	Report	<ul style="list-style-type: none"> • Seven systematic reviews, four RCTs, and seven observational studies with comparison groups. Limited or mixed evidence on all findings. • Co-responder programs reduced arrest rates; mixed evidence on hospitalizations, responder or patient safety. • Pre-crisis case management or individual crisis plans for high crisis utilizers were not effective in reducing ED utilization or hospitalizations. • MH triage offered in EDs decreased hospitalizations. • Patient navigators and mobile crisis follow-up teams improved primary care and outpatient psychiatric care follow-up. • Peer support services were associated with reduced hospitalizations. 	<ul style="list-style-type: none"> • Authors note that most studies were small with weak study designs, with the exception of those on the effectiveness of crisis residential treatment.
Residential Treatment (RT)				
Munthe-Kaas et al. ⁸¹	2016	Systematic Review and Meta-analysis	<ul style="list-style-type: none"> • Two RCTs (results not pooled) • Residential treatment may be more effective than treatment as usual at improving housing stability and/or reducing homelessness. • Unclear whether residential treatment is superior to ACT or TF at increasing housing stability. 	<ul style="list-style-type: none"> • As program fidelity is often unreported, the degree of model adherence by programs under the same model is unknown. • Authors did not systematically review or meta-analyze secondary outcomes.

Table E.3. SUD, Mental Health, and Medical Respite Literature

Author	Year	Methodology	Results	Limitations
Thomas & Rickwood ¹²⁶	2013	Systematic Review	<ul style="list-style-type: none"> • Twenty-six studies • The clinical treatment outcomes for acute residential programs were equivalent to inpatient care at a reduced cost and with higher patient satisfaction. 	<ul style="list-style-type: none"> • Due to few studies on subacute programs - unable to draw conclusions. • Studies rarely reported detailed demographic characteristics or details on patient diagnoses. • Many studies had small sample sizes, and details on maintenance of improved outcomes was limited.
Medication-Assisted Treatment (MAT)				
Jonas et al. ¹³¹	2014	Systematic Review	<ul style="list-style-type: none"> • 112 clinical trials and one cohort study with 12 weeks or more of MAT for AUD • Both acamprosate and naltrexone were associated with a reduction in returning to heavy drinking. • No significant differences documented between naltrexone and acamprosate. 	<ul style="list-style-type: none"> • Medication and psychosocial interventions were not compared.
Ma et al. ¹²⁹	2018	Systematic Review	<ul style="list-style-type: none"> • Thirty studies • Individuals with OUD in MAT group had lower rates of all-cause mortality and overdose mortality. • Discharged participants had higher risk of all-cause death and overdose death. • Longer retention in MAT was associated with lower all-cause mortality. 	<ul style="list-style-type: none"> • Possibility of selection bias, as studies were predominantly registry-based. • Few studies investigated naltrexone MAT. • Studies were conducted in high-income countries, and may not be generalizable. • Most participants were drug-free when entering the program.

Table E.3. SUD, Mental Health, and Medical Respite Literature

Author	Year	Methodology	Results	Limitations
Maglione et al. ¹³⁰	2018	Systematic Review	<ul style="list-style-type: none"> • Thirty RCTs, 10 observational studies • Methodological flaws limit the conclusions on the effectiveness of MAT on functional outcomes for people with OUD. • Study outcomes on criminal activity and other social/behavioral outcomes were inconsistent. • Few differences noted among MAT drug types; There was some evidence of lower prevalence of fatigue with buprenorphine compared to methadone. • No evidence of MAT-type differences in insomnia or cognitive measures were found. 	<ul style="list-style-type: none"> • Most controlled trials were of low methodological quality. • Heterogeneity between study procedures made comparing results difficult.
Thomas et al. ¹²⁸	2014	Literature Review	<ul style="list-style-type: none"> • Sixteen RCTs and seven reviews/meta-analyses • Solid evidence of effectiveness of buprenorphine maintenance to reduce illicit drug use • Buprenorphine and methadone maintenance showed similar reduction in illicit opioid use, but buprenorphine was associated with a lower risk of side effects but a higher risk of attrition. • Buprenorphine was associated with better fetal and maternal outcomes compared to treatment as usual. • Neonatal abstinence syndrome was less severe on average with buprenorphine than methadone maintenance 	<ul style="list-style-type: none"> • Future research should focus on increasing early treatment retention and subpopulation moderators in BMT. • Scant detail was provided on assessment of methodological rigor.

Contingency Management (CM)

Table E.3. SUD, Mental Health, and Medical Respite Literature

Author	Year	Methodology	Results	Limitations
Davis et al. ¹³³	2016	Systematic Review	<ul style="list-style-type: none"> 69 studies Voucher-based CM had moderate to large effect size during treatment, then tapered off when treatment ended. Results were consistent across different SUDs, populations, and settings. 	<ul style="list-style-type: none"> Research on cost effectiveness is lacking. Studies attempting to find an ideal balance between the size of incentive and effectiveness were lacking.
Lee & Rawson ¹³⁴	2008	Literature Review	<ul style="list-style-type: none"> 12 studies on the effectiveness of CM on reducing methamphetamine use There was strong evidence for effectiveness for CM alone or combined with cognitive-behavioral therapy. 	<ul style="list-style-type: none"> Meth use tends to rebound once CM ends. The number of studies of use of CM on methamphetamine users was small.
Roll et al. ¹³⁵	2013	RCT	<ul style="list-style-type: none"> Tested psychosocial treatment vs CM + psychosocial treatment, for varying durations, for reducing methamphetamine use. CM plus psychosocial treatment was more effective than psychosocial treatment alone. Clients receiving longer treatment duration reported more days abstinent than those in shorter duration groups. 	<ul style="list-style-type: none"> Sample size (116 participants across four groups) was modest. Impact of CM on users of multiple illicit substances is unknown. Unclear if these findings extend to participants with more severe stimulant use (as measured by ASI composite scores).
Medical Respite (MR)				
Doran et al. ¹³⁶	2013	Systematic Review	<ul style="list-style-type: none"> Thirteen studies MR programs reduced hospital utilization among persons experiencing homelessness. There is inconclusive but promising evidence that MR programs may reduce emergency department use. MR programs may improve housing outcomes. 	<ul style="list-style-type: none"> Included few studies of strong methodological quality on MR programs; only one RCT. As MR programs are often combined with housing or case management, it is difficult to conclude MR is the causal element in reduced hospital utilization.

MAT: Medication assisted treatment; **RCT:** Randomized controlled trial; **MR:** Medical respite; **ODU:** Opioid Use disorder; **RT:** Residential treatment; **TF:** Treatment first; **CM:** Contingency Management

Appendix F:

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