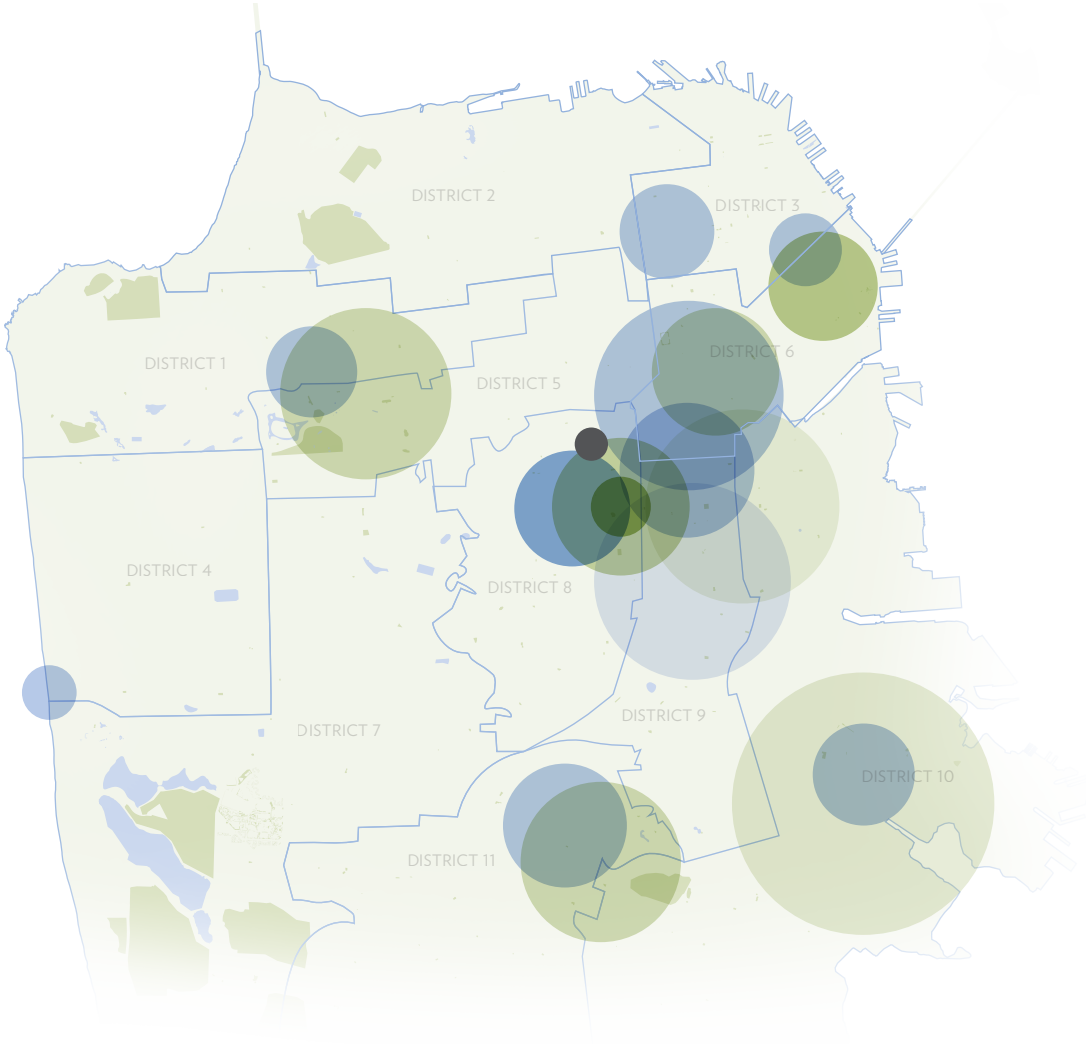



# Behavioral Health and Homelessness in San Francisco: Needs and Opportunities

In July 2017, Tipping Point Community launched an initiative to reduce chronic homelessness in San Francisco. As part of this initiative, Tipping Point Community and the University of California, San Francisco (UCSF) Department of Psychiatry came together to share expertise and strategize about how to raise philanthropic and private-sector funding to work alongside sustainable public investments to improve outcomes for San Francisco residents experiencing long-term homelessness who also have behavioral health care needs (including mental health conditions and/or substance use disorders).

JSI JOHN SNOW, INC.

TIPPING POINT COMMUNITY

UCSF Weill Institute for Neurosciences
Department of Psychiatry

SEPTEMBER 2019

**San Francisco has been a national leader** in innovation and implementation of best practices in the fields of behavioral health and homelessness; yet, there is more work to be done. The population of people experiencing homelessness in San Francisco, and across the Bay Area, is growing, and the Black/African-American community is disproportionately impacted by homelessness. Despite continued investment in combatting homelessness, 2019 Point-in-Time Count data indicate a 17% increase from 2017, with neighboring counties experiencing even larger increases (31% in Santa Clara, and 43% in Alameda). People are becoming newly homeless in San Francisco every day. This underscores the complexity of the problem, rooted in a national disinvestment in public housing and growing income inequality. While solutions must incorporate Federal and State strategies, there is urgent need for collective action across San Francisco to develop solutions, particularly for local residents with a behavioral health need.

Substance use disorders (SUDs) and serious mental illnesses impact an individual's daily life and can have negative consequences for securing and maintaining housing and employment, criminal justice involvement, maintaining social and family relationships, and the ability to carry out self-care activities. There are systemic barriers to accessing mental health and SUD treatment, as well as individual barriers including personal readiness, stigma, and lack of awareness of treatment options. When treatment is available and an individual is ready to receive care for their behavioral health needs, the optimal outcome is often stabilization and recovery, not a permanent cure. Relapses and setbacks are a common part of the recovery process, and many individuals will engage with some form of treatment or services for much of their lives. Effective treatment for SUD and serious mental illness supports progression toward stabilization and recovery, and allows individuals to live self-directed, purposeful lives.

The San Francisco Department of Public Health (DPH) Behavioral Health Services (BHS) provides services to more than 30,000 San Francisco residents each year, many of whom receive the care and treatment they need to achieve stabilization and positive health outcomes. However, the most vulnerable and complex patients in the City—people experiencing homelessness who also have behavioral health (and often physical health) needs—are struggling. To better meet the needs of this population, system improvements need to be made to effectively engage the population in services and provide ongoing treatment throughout the process of stabilization and recovery.

John Snow, Inc. (JSI) was commissioned by Tipping Point Community and UCSF to conduct an assessment of the needs of the target population and develop a set of recommendations on how to improve the existing care delivery system in San Francisco for these individuals. Specifically, the goals of this project were to:

- **Identify key gaps that exist in the current system as related to: services and treatment; coordination across agencies and providers; data availability; and access and outcome disparities based on race, ethnicity, LGBTQ status, and other demographics that correlate with disproportionate homelessness;**
- **Identify existing and planned efforts to address these gaps; and**
- **Make recommendations for where philanthropic, private, and/or public investment could have an impact, including prioritization based on cost, impact, and urgency.**

**IN COLLABORATION WITH TIPPING POINT COMMUNITY AND UCSF, THE JSI TEAM DEVELOPED A VISION STATEMENT TO GUIDE THIS PROJECT:**

> **San Francisco's system of care should know the names and needs of everyone who is homeless with a behavioral health care need (regardless of how they come into the system and whether they are currently using it); provide wrap-around services that promote stabilization and a path to permanent housing; and ensure that systems and services proactively address and reduce disparities impacting Black/African American and LGBTQ individuals experiencing homelessness.**

While the biggest barrier to stabilization is the lack of affordable housing, this report identifies several key areas of investment that would improve the systems serving some of San Francisco's most vulnerable residents: 1) enhanced coordination to more effectively transition people between levels of care; 2) increased treatment and care capacity, with an emphasis on additional residential care facilities and treatment for people suffering from chronic alcoholism and methamphetamine use; and 3) improvements in outreach and engagement to facilitate access to care.

## THIS REPORT INCLUDES:

1. **an executive summary** **(PAGE 4)**
2. **a description of the data collection methodology and analysis that was used to inform the recommendations presented in this paper** **(PAGE 5)**
3. **a brief background on the homelessness and behavioral health care systems in San Francisco** **(PAGE 7)**
4. **a summary of findings, including the current policy landscape influencing these systems** **(PAGE 12)**
5. **a set of recommendations** **(PAGE 19)**

# 1. EXECUTIVE SUMMARY

## VISION

San Francisco's system of care should KNOW the names and needs of everyone who is homeless with a behavioral health care need (regardless of how they come into the system and whether they are currently using it); PROVIDE wrap-around services that promote stabilization and a path to permanent housing; and ENSURE that systems and services proactively address and reduce disparities impacting Black/African American and LGBTQ individuals experiencing homelessness.

### GOAL 1



**IMPROVE SYSTEM COORDINATION**

- Improve data on clients and existing resources through development of shared data platforms
- Establish shared client-centered outcome goals across departments
- Improve system-wide coordination and accountability

### GOAL 2



**ENHANCE ACCESS TO TREATMENT**

- Improve access to short- and long-term housing for all levels of care
- Add additional treatment beds across the continuum of care, including resources for methamphetamine use and chronic alcoholism
- Increase support for care transitions and maintenance

### GOAL 3



**INCREASE ENGAGEMENT**

- Expand field-based behavioral health services
- Build trust through the creation of additional safe spaces and harm reduction services
- Implement client-centered, responsive services including linkage and transportation

Through collective will and urgent action, San Francisco's most vulnerable residents will be supported in achieving HEALTH, HOUSING, and PURPOSE.

# 2. METHODOLOGY

In order to make recommendations on how to improve the existing safety-net care delivery system for people in San Francisco who are experiencing homelessness and have behavioral health needs, the JSI team carried out a systematic mixed-methods process to collect data regarding gaps and needs for this population, analyze data to identify the key gaps, and identify and prioritize potential solutions.

## Data Collection

To identify the gaps and make recommendations for systems improvement, the JSI team collected data from six different sources, described in detail below. Data collection was conducted between November 2018 and April 2019.

1. **MONTHLY MEETINGS WITH ADVISORY COMMITTEE:** At the project's inception, JSI formed an Advisory Committee, composed of 10 experts, agency leaders, and key stakeholders connected to the homelessness and behavioral health systems of care in San Francisco. Advisory Committee members included representatives from DPH, HSH, UCSF, Hospital Council, Positive Resource Center, and HealthRight360 (see Appendix III for a list of Advisory Committee members). These members were selected based on their expertise in the field and their ability to lend content knowledge and experience to the findings and ultimate set of recommendations. The JSI team convened the Advisory Committee four times from November 2018 to April 2019. These meetings also served as a data collection method to ascertain emerging needs and to provide updates on existing initiatives for this population.

2. **REVIEW OF EXISTING DATA REPORTS:** JSI conducted a review of existing data and available reports covering relevant populations and systems in San Francisco. Reports and data sources were recommended by Tipping Point Community, UCSF, key informants, members of the Advisory Committee, and DPH leadership. The full list of reviewed documents can be found in Appendix I.

3. **KEY INFORMANT INTERVIEWS:** In collaboration with Tipping Point Community and UCSF, the JSI team developed an initial list of key informants in the City and County of San Francisco. The JSI team expanded the list to include recommendations from DPH leadership, the Advisory Committee, and key stakeholders. These interviewees included clinicians, service providers from non-profit organizations, and leadership from the entire system of care surrounding homelessness and behavioral health, including DPH, the Department of Homelessness and Supportive Housing (HSH), and cross-agency teams. In total, the JSI team interviewed 34 key stakeholders using a semi-structured interview guide (see Appendix II for a list of interviewees). The JSI team took extensive notes during the interviews for subsequent content analysis. Interview topics included existing services and the system of care; challenges and barriers at the patient, provider, and system levels; existing gaps in the system; needs of the target population; and opportunities for enhancing the system of care.

4. **SCAN OF NATIONAL BEST PRACTICES:** JSI conducted a review of national literature and innovative programs to assess best practices around the country for addressing the needs of people who are experiencing homelessness and have behavioral health needs. The national best practices scan allowed for examination of innovative and effective programs and practices in a variety of cities, and identification of the evidence base for reducing homelessness and treating behavioral health conditions with this population.

5. **MONTHLY MEETINGS WITH DPH LEADERSHIP:** The JSI team met with DPH leadership in monthly meetings from December 2018 to April 2019, to provide updates on progress and findings and receive input and guidance for the project.

6. **CLIENT FOCUS GROUP:** JSI held a focus group at Hummingbird Place Psychiatric Respite with 20 individuals with behavioral health needs who are experiencing or have recently experienced homelessness. These individuals were overnight clients at Hummingbird Place at the time of the focus group. Discussion topics included existing services accessed by clients; challenges and barriers faced; existing gaps in the system; and opportunities for enhancing the system of care.

## Data Analysis

JSI team members reviewed all data, interview notes, and meeting notes. Common themes emerging from the stakeholder interviews and meetings were identified on an ongoing, iterative basis, and synthesized with information collected from the review of existing reports. Each month, emerging themes were presented to DPH and the Advisory Committee for review, discussion, and refinement. DPH and the Advisory Committee provided clarification on the emerging findings and offered recommendations for where to seek additional information both through new key informant interviews and through additional literature resources.

# 3. BACKGROUND

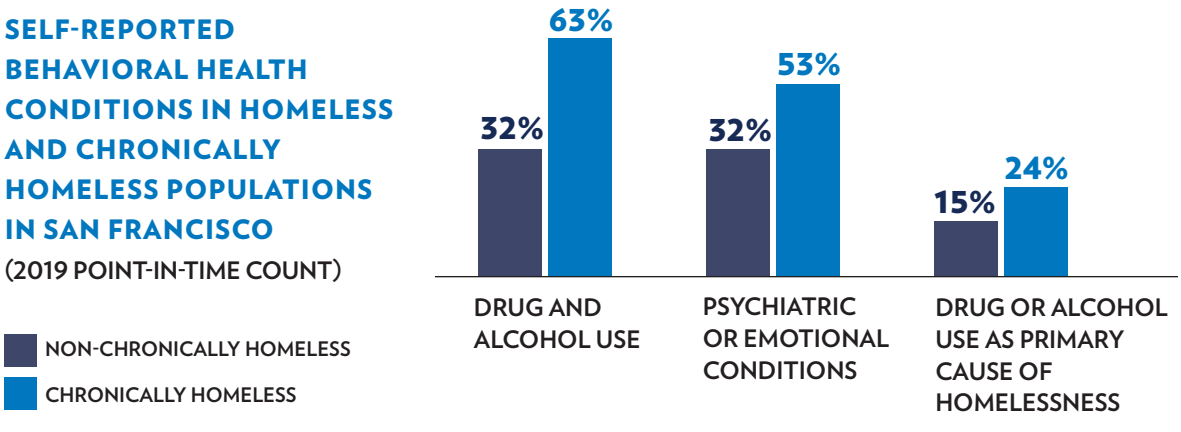
## San Francisco Homelessness

Homelessness is driven by poverty and a shortage of affordable housing. While most people are homeless for a single, short episode, about a quarter of the population nationally remains unstably housed for longer. "Chronically homeless" individuals—defined as people who experience homelessness in repeat episodes—often also suffer from disabling conditions like mental health or substance use disorders, which prevent them from maintaining housing and employment.[i]

According to the 2019 Point-in-Time Count, there were approximately 8,011 individuals experiencing homelessness on any given night in San Francisco, approximately 3,028 (38%) of whom were chronically homeless. This number continues to rise; according to the Department of Homelessness and Supportive Housing, for every person who exits homelessness in San Francisco, three people become newly homeless. A growing number of people experiencing homelessness are over age 60 (10% of the homeless population in 2019, compared to 3% in 2013), and more people are becoming homeless for the first time over age 50. Twenty-seven percent of San Francisco's homeless population, and almost half of the San Francisco homeless population under 25, identify as LGBTQ, and 37% are Black/African-American (see the text boxes that follow for additional information).

Individuals experiencing chronic homelessness are disproportionately unsheltered, suffer from disabling conditions, and are high users of multiple systems (including the medical system, mental health system, and substance use system).[ii] According to the 2019 Point-in-Time Count (in which data is self-reported), the 3,028 chronically homeless individuals in San Francisco have higher rates of drug and alcohol misuse, psychiatric or emotional conditions, and substance use as the primary cause of their homelessness compared to the non-chronically homeless population (see Figure 1 below for detail).

**FIGURE 1:**
**SELF-REPORTED BEHAVIORAL HEALTH CONDITIONS IN HOMELESS AND CHRONICALLY HOMELESS POPULATIONS IN SAN FRANCISCO**
**(2019 POINT-IN-TIME COUNT)**




i Chronic homelessness is defined by the Department of Housing and Urban Development as "someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years, and also has a condition that prevents them from maintaining work or housing" (Point-in-Time, 2017).

ii Individuals who are unsheltered are sleeping outdoors, on the street, in parks, or in vehicles. Sheltered individuals are experiencing homelessness but are residing in temporary shelter, including emergency shelters or treatment facilities.

Data from San Francisco's Coordinated Care Management System (CCMS) database suggests these figures could be higher among the general homeless population; of the 10,856 individuals who experienced homelessness in 2016/2017 and accessed care at DPH, 58% had been treated for serious mental health disorders and 63% had a history of drug or alcohol misuse.

The San Francisco Department of Homelessness and Supportive Housing (HSH) was established in August of 2016 under former Mayor Edwin Lee in an effort to create a single department to align resources and strategy around homelessness and create a service system that connects them to housing. HSH oversees the shelter system, street outreach, and strategies to decrease homelessness, including the coordinated entry system into supportive housing.

## Racial Disparities in Homelessness and Behavioral Health

**Nationally, there is a striking racial disparity in the homeless population; the disparity in San Francisco is even greater: Black/African American residents make up less than 6% of the total population, yet make up 37% of the homeless population and nearly half of those who have been homeless for 10 or more years.**

**This disparity is the result of structural racism and historic discrimination that have restricted access to higher-earning jobs, community supports, and homeownership. Mass incarceration of the Black population has meant that public housing and other supportive services have been legally less accessible to this community. Furthermore, lack of family wealth and limited access to credit have increased foreclosure risk for Black families.**

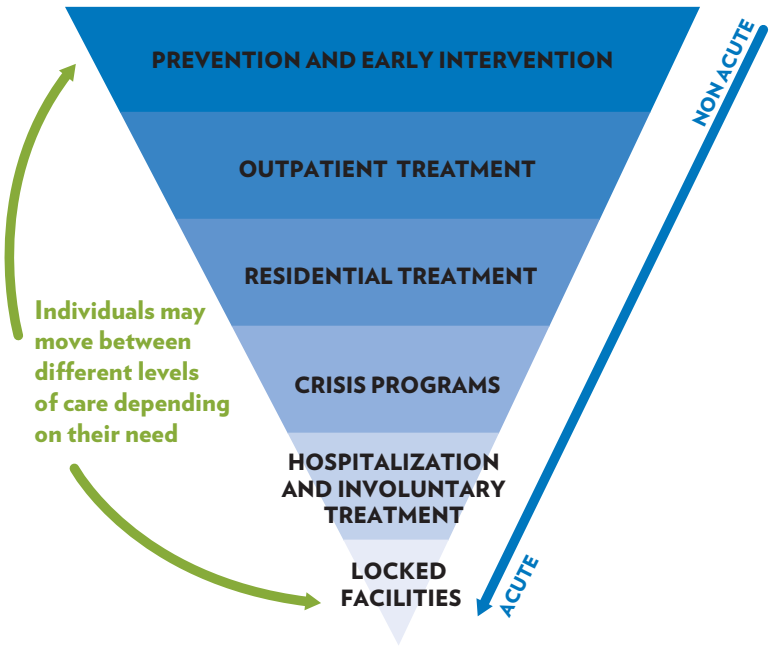
**People of color also experience high rates of mental health conditions, substance use, and traumatic stress, and experience worse behavioral health outcomes than White populations. In San Francisco, the Black overdose death rate is three times higher than the rate for White populations. Black men die at almost twice the rate of White men from liver cirrhosis, though they have lower rates of alcohol use disorder.**

**Among the population of people experiencing homelessness in San Francisco who have a behavioral health condition, Black individuals are the sickest and most vulnerable. The evidence suggests that physical health, behavioral health, and housing systems are not meeting the needs of people of color, and they should be considered an urgent priority for the system of care.**

## Behavioral Health System of Care

The San Francisco Department of Public Health (DPH) Behavioral Health Services (BHS) provides services to more than 30,000 San Francisco residents each year, at a budgeted cost of $370 million. The system of care includes DPH, multiple hospitals, and community-based organizations, and encompasses more than 300 different programs. As shown in Figure 2, these services include mental health crisis services, mental health hospitalization and inpatient services, long-term care in locked and unlocked facilities, residential detox services, residential treatment, outpatient treatment, prevention, as well as linkage and coordination between services and levels of care. Additionally, there are 185 beds in the county jail that are designated as psychiatric beds, including 96 general population beds with behavioral health services, 52 segregated beds, 13 observation beds, and 24 psychiatric overflow beds.

**FIGURE 2:**
**SAN FRANCISCO BEHAVIORAL HEALTH SERVICES**




## Homelessness in the LGBTQ Population

**LGBTQ individuals are disproportionately represented in the population of people experiencing homelessness in San Francisco. Data suggest that these individuals are more likely to be experiencing homelessness for the first time and are less likely to have behavioral health conditions; however, being LGBTQ and experiencing homelessness comes with unique challenges. For example, LBGTQ individuals may feel unsafe in traditional shelters that separate residents by the gender assigned to them at birth, and some may have experienced trauma related to rejection from their families and communities.**

**San Francisco has been a leader in providing services targeting LGBTQ individuals experiencing homelessness. The City has the first shelter focused on serving LGBTQ adults experiencing homelessness (offering 24 beds), and one of the only LGBTQ-specific supportive housing programs for youth in the country (23 beds). Additionally, through the San Francisco LGBT Community Center, DPH has provided $1.5 million for six years of mental health services for youth experiencing homelessness.**

**These programs are in high demand; the LGBTQ shelter and supportive housing always have a waitlist, suggesting that there is a critical need for expanded services designed for the LGBTQ population experiencing homelessness.**

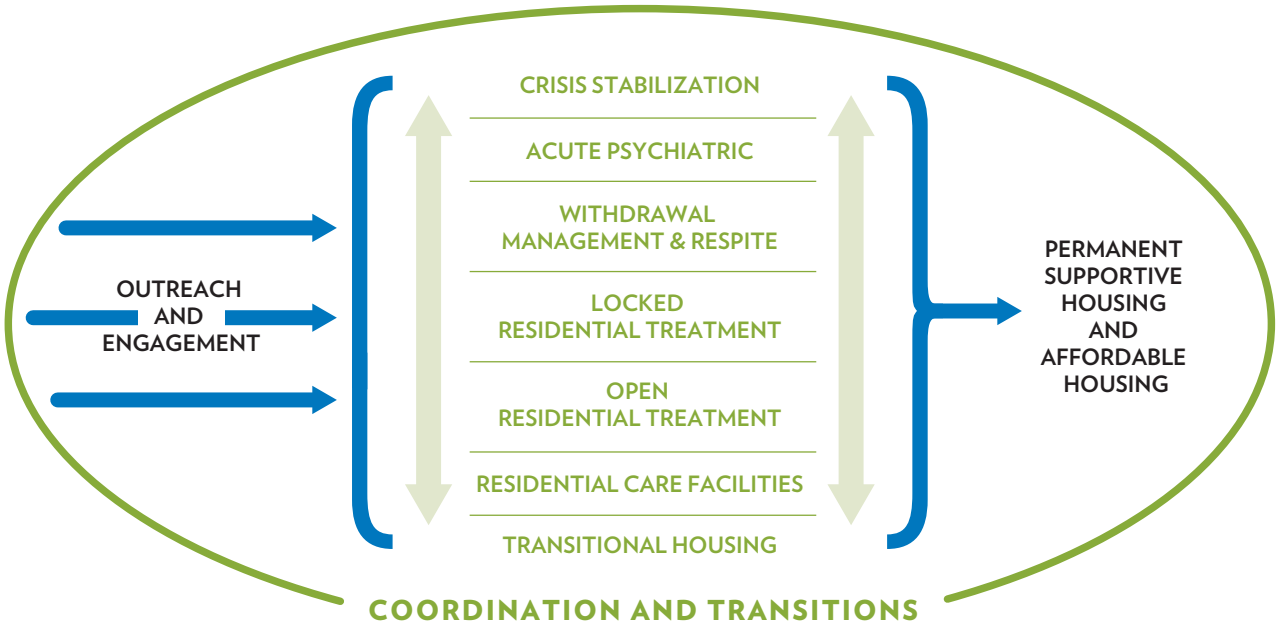
## Homelessness and Behavioral Health in San Francisco

Substance use disorder and mental illness can be both causes and consequences of homelessness, resulting in a high prevalence of behavioral health conditions among chronically homeless populations.[1,2,3] In 2016–17, 13% of BHS mental health clients were homeless and an additional 12% did not have identified housing.[4] From 2016–2018, the leading cause of death among people experiencing homelessness was unintended overdose (35% of deaths), with an additional 5.6% resulting from chronic alcoholism and associated conditions, and 4.9% from acute alcohol toxicity.[5] People who are experiencing both homelessness and behavioral health issues need services and coordination from numerous departments and through multiple levels of care, including a place to sleep. The complex array of services needed and the associated transitions of care require a high level of coordination and cooperation, and services need to be available to clients when they are ready to receive them. These services and engagement strategies will look different for people who have not utilized the system, those who are in crisis, or those who are in recovery.

In addition to DPH and HSH, numerous community programs, departments, and agencies serve people experiencing homelessness who have behavioral health needs in San Francisco, including the Police Department, the Adult Probation Department, collaborative courts, intensive case management services, and cross-agency collaborations. Street-based services are offered through City departments and agencies, including the SF Homeless Outreach Team, DPH street medicine, and EMS-6, a partnership between the San Francisco Fire Department and DPH that dispatches emergency and public health experts to respond to 911 calls for non-emergency medical, social and psychological needs. Despite the efforts of multiple well-meaning groups, agencies working with clients often have different goals and objectives and lack the knowledge or ability to access services provided by other departments.

**FIGURE 3:**

**BEHAVIORAL HEALTH AND HOUSING SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS IN SAN FRANCISCO**



## San Francisco as a Leader in Best Practices

The City and County of San Francisco has long been an innovative leader in the fields of homelessness and behavioral health, and has an ongoing commitment to provide services and continue to innovate. Some of the City's existing model programs, innovations, and approaches include:

**HOUSING FIRST/ PERMANENT SUPPORTIVE HOUSING:** San Francisco was one of the first major cities to implement a Housing First model, which aims to reduce homelessness by focusing on the provision of permanent, affordable housing without preconditions (like sobriety or participation in treatment). San Francisco has been a leader in the development and expansion of permanent supportive housing, and has more than 7,400 permanent supportive housing units.

**HUMMINGBIRD PLACE:** Hummingbird Place Peer Respite provides behavioral health support and engagement to adults in a behavioral health respite program with minimal barriers to entry. The goal of the program is to encourage participation and willingness to engage in ongoing recovery and wellness programs to maximize each individual's functional capacity. The original center has capacity for 25 drop-in clients and 15 overnight beds, and was recently expanded by 14 overnight beds.

**COORDINATED CARE MANAGEMENT SYSTEM (CCMS):** CCMS is a composite database of integrated medical, psychological, and social information about high-risk, complex, and vulnerable individuals served by DPH. This database was initially implemented in San Francisco in 2005, making the City an innovator in cross-department data sharing at the time.

**DPH TRANSITIONS DIVISION:** The Transitions Division provides placement and utilization management for length of stay, care coordination, and case management for severely mentally ill individuals, San Francisco Health Network (SFHN) members with behavioral and complex physical health needs, and high users of SFHN care systems. The goal of the Transitions Division is to ensure clients are stabilized in the most appropriate, least-restrictive setting in the most cost-effective manner.

**HEALTHY STREETS OPERATIONS CENTER (HSOC):** HSOC, developed in January of 2018, brings together representatives from HSH, DPH, SF Police Department, Public Works, SF Controller's Office, SF 3-1-1, SF Department of Emergency Management, and other departments as needed. The role of HSOC is to coordinate agencies involved in addressing homelessness and unhealthy street behavior. In its first year of operation, HSOC contributed to reductions in homeless-related requests for service, average response time to those calls, the number of tents/improvised structures, and the number of encampments with five or more tents/improvised structures.

**STREET-BASED BUPRENORPHINE:** San Francisco's Street Medicine Team has successfully piloted a program which provides low-barrier buprenorphine —a medication which blocks the craving for opioids and the painful symptoms of withdrawal—to people with opioid addiction who are experiencing homelessness. This program is now permanent, and receives ongoing funding from the City to help reduce injection drug use and connect people to care. Current funding will allow more than 250 individuals to access the program over the next two years.

**NAVIGATION CENTERS:** Navigation Centers provide long-term homeless residents with room, board, and case managers to connect them with available services. Unlike traditional shelters, Navigation Centers have very few barriers to entry (partners, pets, and possessions are all welcome). The first Navigation Center opened in San Francisco in 2015; HSH now operates six Navigation Centers across the City, and the model is being replicated across the country. Since 2015, 46% of Navigation Center guests in San Francisco have ended their experience of homelessness after a stay in a Navigation Center.

# 4. FINDINGS

## Current Policy Landscape

In addition to the existing programs and services in the City, there are numerous policies under discussion or recently passed which may impact the funding and system of care for people experiencing homelessness who have behavioral health needs in San Francisco.

**PROPOSITION C:** Proposition C is a local gross receipts tax initiative in San Francisco that would fund housing and homelessness services.[6] The initiative would tax corporations with over $50 million in gross annual receipts, and tax payroll expenses for certain businesses with over $1 billion in gross annual receipts.[7] These taxes would go to the "Our City Our Home Fund" to fund supportive housing, expansion of shelter beds, legal assistance and rent subsidies, and mental health and substance use services.[8] Funds from the tax are expected to reach approximately $300 million per year.[9] Prop C passed in the November 2018 election, with 61% approval; however, it has faced legal challenges and the tax will not be implemented unless the legal issues can be resolved.

**SENATE BILL 1045 (CONSERVATORSHIP: SERIOUS MENTAL ILLNESS AND SUBSTANCE USE DISORDERS):** Mental health conservatorship is used for people with severe psychiatric disorders who cannot provide for their most basic personal needs, allowing professional treatment staff to provide treatment and care to individuals, often in a locked psychiatric facility, without the individual's voluntary consent.[10] State Senator Scott Wiener authored California State Senate Bill 1045, a pilot program granting authorities conservatorship rights to provide supportive housing and intensive wraparound services for Californians who are high utilizers of emergency departments and the justice system, and are chronically homeless, seriously mentally ill, or suffer from substance use disorder.[11] SB 1045 was approved by Governor Brown in September 2018 and allows for the expansion of conservatorship law in the Counties of San Francisco, Los Angeles, and San Diego through a five-year pilot program.[12] Conservatorship is a strategy that may allow for a more assertive response to the needs of this population, but does not provide additional resources to the system of care. In June 2019, the San Francisco Board of Supervisors passed a bill to adopt SB 1045. As written, very few people (fewer than five) could be impacted by the new legislation; another bill pending approval in the state legislature (SB 40) would make changes which could increase that number to 50.

**SENATE BILL 1152 (HOSPITAL PATIENT DISCHARGE PROCESS: HOMELESS PATIENTS):** California State Senate Bill 1152 requires hospitals to establish a written process for post-hospital care arrangements for homeless patients and coordinate services and referrals to post-hospital care.[13] SB 1152 was a response to homeless patients being discharged to the street, and requires hospitals to discharge patients experiencing homelessness to a health care provider, behavioral health agency, social service agency, nonprofit social services provider, or governmental service provider, as well as provide patients with adequate care and basic needs before discharging.[14]

**ERAF FUNDING:** The City of San Francisco plans to use $157 million of two-year Educational Revenue Augmentation Fund (ERAF) windfall funding from the state on affordable housing (including small-site acquisitions, housing development, and public housing upgrades) and homelessness and behavioral health (including leasing buildings or large blocks of rooms, an emergency homeless shelter, expansion of navigation centers, 14 additional healing center beds, and 72 additional substance use recovery beds).

**SAFE INJECTION SERVICE:** Safe injection services are a harm reduction strategy that provide a safe space for individuals to inject illegal substances, with trained staff present and able to respond in case of overdose. Evidence from safe injection services worldwide shows reductions in overdose, negative health consequences of unclean injections, and public injecting, and increased entry into substance use treatment.[15,16] Many legal barriers stand in the way of safe injection services in the United States. Mayor Breed has been working to bring a facility to San Francisco, and Governor Gavin Newsom has expressed openness to safe injection services. In February 2019, California legislators Scott Wiener and Susan Eggman reintroduced the AB362 bill that would launch a safe injection pilot program in San Francisco.[17]

**1115 WAIVER /WHOLE PERSON CARE (WPC):** In 2016, San Francisco was awarded up to $37 million per year for five years for a Whole Person Care pilot, part of California's 1115 Medi-Cal waiver. San Francisco's WPC pilot targets homeless adults, particularly those who are high utilizers of urgent/emergent care in multiple systems and/or who have experienced long-term homelessness (more than 10 years). This work includes system and service delivery transformation, and support for data sharing through technology solutions.

**DRUG MEDI-CAL:** California's Drug Medi-Cal Organized Delivery System waiver program expands Medi-Cal coverage for substance use services, thereby increasing the availability of services and patients' ability to access them. Newly covered services include case management, multiple levels of residential substance use disorder treatment, withdrawal management, recovery services, physician consultation, medication-assisted treatment such as methadone and buprenorphine, and intensive outpatient psychiatric services.

**CHANGES TO IMD EXCLUSION:** Institutes for Mental Disease (IMDs) are hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental illness, including medical attention, nursing care, and related services. Since the inception of Medicaid, the U.S. Congress has prohibited states from using Medicaid funds for IMDs for non-elderly adults. However, there are recent efforts to undo the exclusion; Congress approved an exception for delivery of substance use disorder services, and there are efforts to find ways to add mental health services to the exception.[18]

**HEAL OUR CITY:** In September 2019, Mayor Breed announced the first steps in a long-term plan to provide care for people who have behavioral health needs and who are also experiencing homelessness in San Francisco. The initial steps of the new Heal Our City initiative will provide enhanced care coordination, create a multi-agency effort to streamline housing and health care for the City's most vulnerable, and increase access to behavioral health services by expanding hours of the City's Behavioral Health Access Center. The initial effort will focus on 230 of the most vulnerable behavioral health clients experiencing homelessness, and will serve as a model to address the needs of the larger population.

**MENTAL HEALTH SF:** Mental Health SF is a measure proposed by Supervisors Hillary Ronen and Matt Haney that will be on the March 2020 ballot. As described by the Supervisors, this measure would create a 24/7 mental health drop-in center that would allow any San Franciscan, regardless of their insurance status, to meet with psychiatrists and access medication and substance use treatment on demand. It would also launch a new Office of Coordinated Care within DPH to provide oversight, collect data, and manage the care of patients throughout the system.

## Summary of Key Findings

This section provides a summary of findings related to the system of care in San Francisco for people experiencing homelessness who also have behavioral health needs. Key findings include three general categories:

1. **Enhancements to data tracking, data sharing, and development of shared outcome goals could promote increased coordination and accountability.**
2. **Although there are many resources available, there are gaps in treatment and bed shortages in some levels of care.**
3. **Outreach, engagement, and effective care transitions are critical to stabilization.**

Detailed descriptions of the key findings and considerations for implementation are provided below.



### Enhancements to data tracking, data sharing, and development of shared outcome goals could promote increased coordination and accountability.

**Data on the system of care and available resources are inconsistent.** Despite the existence of numerous reports, assessments, and data sources, there is no single, reliable "source of truth" for information on the number of beds available or demand for those beds at each level of care within the behavioral health care system. BHS does not track or aggregate wait times across the system; any waitlists that exist are created and kept by individual service providers. Information about the number of beds and wait times for those beds vary widely in different reports and anecdotally. DPH is currently working on an assessment of existing beds across the system, but this does not yet include information on how many beds are available at a given time or what the level of demand for each type of bed is. This lack of real-time inventory data for the behavioral health care system creates barriers for client referrals and placements. Without this data, it is difficult to determine what the actual bed shortages are at each level of care.

**Despite widespread interest in data sharing, barriers continue to exist.** Concerns around the legality and security of data sharing are preventing cross-provider and cross-agency data sharing. In particular, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations 2, also known as 42 CFR Part 2, limits substance use programs' ability to share information without patient consent. This is viewed as a major barrier to data sharing for this population. Data sharing at a client level across providers improves care coordination and reduces duplication of efforts, ultimately providing better care for clients.

**Patient-level outcome goals are not shared across agencies or providers and are not consistently evaluated at a population level.** Though providers are responsible for the patients that are in their facilities, there is no system-level accountability to clients or to equity across the population. No single agency is accountable for the movement of patients through different services or the cycling of patients in and out of the system, and providers are not sufficiently aligned around high-level patient outcomes. In some instances, patients ultimately return to the street due to a lack of housing after extensive resources are invested into their care. Increased collaboration around these patients across agencies

could help maintain recovery, improve their outcomes, and maximize resources. Relatedly, numerous client prioritization lists exist for different agencies and service providers, but these lists are currently not coordinated or aligned. Multiple entities are often providing the same individuals with overlapping and complementary treatment and stabilization services, and aim to coordinate their efforts. However, coordination is challenging, resulting in fragmented care for clients.[19]

Improved tracking of outcome data is needed to support data-driven decision making and the use of evidence-based practices. Without outcome data on programs and services, it is not possible to know whether programs are effectively serving their purpose or meeting the needs of the population, or to know which programs and services should be expanded or scaled back.

**Hiring and retaining staff is challenging.** Working with this population can be very difficult, and many providers experience violence and trauma in the course of doing their jobs. Key informants reported lower salaries in this field in San Francisco than in the private sector and some neighboring counties; this, combined with the extremely high cost of living in San Francisco and the slow pace of the hiring process, makes it difficult to recruit and retain staff. Challenges with recruitment and retention, which exist to some degree in this field statewide, were also named as the driving cause of shortages in intensive case management services in San Francisco.



## Although there are many resources available, there are gaps in treatment and bed shortages in some levels of care.

**San Francisco's shortage of affordable housing impacts the entire care continuum.** There is a well-documented lack of sufficient affordable housing in San Francisco. In addition to being a problem in its own right, this creates a backlog throughout the entire system of care for people experiencing homelessness. People cannot leave one level of care (residential treatment or an inpatient unit, for example) until there is a bed available for them at the next level of care. Key informants reported individuals with low levels of need occupying beds designated for medical or therapeutic purposes; this results in the use of high-cost interventions for people who could be better served by a less costly level of care if it were available. For example, a bed in an acute diversion unit, which provides an alternative to or stepdown from inpatient services, costs $154–$350 per day on average, compared to $2,400 per day for an acute care hospital bed.[20, 21]

In addition, the number of Residential Care Facilities (RCFs)[iii], also known as assisted living facilities or board and cares, in San Francisco has been declining over the last decade (including a 40% reduction between 2009 and 2014), as a result of aging and retiring ownership, a competitive real estate market, and a stagnant Social Security Income rate. San Francisco's Long Term Care Commission estimated that the "break even" rate for RCFs in San Francisco was $2,000 per month, approximately twice what they currently earn through SSI payments. Though San Francisco provides a "patch" to supplement current payments, raising payments to approximately $1700/month, the model is still financially unsustainable.

iii RCFs provide subsidized housing with support services, including prepared meals, laundry and medication services. RCFs have been the standard of care for people living in the community with severe mental health disabilities and functional impairment.

The existing business model is not working, and these closures leave a significant number of low-income people with medical and/or behavioral health needs with no place to go.

**There is an insufficient supply of appropriate beds in some levels of care.** In addition to the backup created by the lack of affordable housing, there are shortages of particular bed types in the City. Having a place to live is critical to stabilization and on-going treatment. When a treatment bed is not available when someone is ready for care, the opportunity for engagement and care is often lost. In addition, if a stabilization bed is not available post-treatment, the benefits of treatment can diminish. The number of beds needed at each level is unclear because supply and demand are not currently being tracked in real-time, and because backlogs in one level of care can result in patients remaining in beds they no longer need. However, key informants identified a particular need for more:

- Locked sub-acute beds
- Mental health and co-occurring (mental health and substance use) residential treatment beds
- Medical detox beds, including more flexible options for length of stay
- Shorter-stay substance abuse treatment beds (offering 3, 5, or 7-day options)
- Extended observation beds for people leaving psychiatric emergency services (PES)

**Methamphetamine use is a growing and difficult problem.** Methamphetamine use, and associated morbidity and mortality, has been on the rise in San Francisco. Clients using methamphetamine often present as psychotic, which can strain emergency and psychiatric services and law enforcement resources. From 2011 to 2016, emergency room visits related to methamphetamine use increased by 600%, and hospital admissions rose by 400%. Of Zuckerberg San Francisco General Hospital and Trauma Center's (ZSFG) 7,000 psychiatric emergency visits in 2018, nearly half were individuals who were high on methamphetamine. Substance use disorder treatment admissions for methamphetamine have been increasing, with methamphetamine accounting for 19% of total admissions (third behind heroin and alcohol). Deaths involving methamphetamine have also been increasing, with 87 overdose deaths involving methamphetamine in 2017.[22] Methamphetamine use is highly prevalent among people experiencing homelessness, with more than 50% of new clients for homeless services reporting methamphetamine use in 2015.[23] Though there are behavioral therapies that are effective for methamphetamine use, there is no medication to treat methamphetamine use, complicating the possible approaches to addressing the growing problem.

**Additional resources for chronic or severe alcohol use disorder are needed.** Alcohol use disorder is the most prevalent disorder among people experiencing homelessness and is life-threatening if not managed. Alcohol use is the number one predictor of cognitive impairment, and directly impacts a person's ability to engage in supportive housing. Though there are proven approaches to alcohol use disorder, San Francisco does not currently have any residential treatment programs specific to severe alcohol use disorder. The treatment beds that are available are within larger facilities which can be difficult for alcohol use disorder patients to tolerate, or which are physically inaccessible to older or disabled individuals.

**The homeless population is aging, complicating access to appropriate care.** The homeless population in San Francisco is increasingly experiencing dementia, which complicates potential treatment options. Though dementia is not considered an official mental health diagnosis in San Francisco (but rather falls under the jurisdiction of the Department of Aging and Adult Services), people with dementia have unique

needs and are not ultimately expected to recover, resulting in the need for long-term care and extended occupancy of beds. There are few custodial care dementia facilities in San Francisco. Incontinence, which is more common in older adults, also presents additional challenges for the homeless population in San Francisco, as many organizations and providers are not equipped to accept people with incontinence.

**Additional inclusive services could benefit moderate utilizers of City services.** Though there is significant focus on high-cost, high utilizers, additional services and outreach are needed for people who are moderate utilizers at risk of becoming a high user without an intervention. For example, transitional age youth don't always meet service criteria if they have not been homeless for a long time; however, intervening early can prevent long-term homelessness.

**There is a significant waitlist for intensive case management services.** A recent report found a significant waitlist for intensive case management services (ICMS). This is in part because many clients receive ICMS for years, resulting in rare openings for new clients. The City and County of San Francisco has planned an expansion of ICMS, including a full review of the 1,400 current ICMS cases to identify areas for improvement and reform: the launch of a new Transitional Age Youth (TAY) System of Care Full Services Partnership/ICMS for up to 40 clients; the opening up of 200 existing ICMS slots through shifts of clients to lower levels of care; and new funding to support the transition from ICMS to outpatient services with peer linkage teams and peer engagement on the streets. There may be a need for additional expansion of ICMS after these efforts have been implemented, but the scope of additional need will not be known until these changes have been made.



## Outreach, engagement, and effective care transitions are critical to stabilization.

**Additional field-based services may be needed to meet people where they are.** Though there are numerous agencies and organizations providing field-based services in San Francisco, key informants identified shortages of specific services on the street including: 1) outreach services like the homeless outreach team (HOT), 2) mental health services for lower acuity needs that would not require emergency services (such as counseling, peer support, or medication management), and 3) additional mobile methadone vans to provide treatment to homeless individuals where they are. Relatedly, there is a need for improved coordination between existing providers of field-based services. These services are essential for reaching people who are not ready to enter residential treatment or engage with the system in traditional ways. Field-based services are an opportunity to provide care for these individuals in a way that meets their needs and preferences, and may open a door to connecting them with additional services.

**More low-threshold services offered in accessible locations can help meet the non-medical needs of clients and connect them to care.** Many people in need aren't engaging in the system at all; CCMS data reveals that 10% of deaths among people experiencing homelessness are individuals who had never used City health or social services.[24] Engaging with this population takes time and trust-building, and is more effective if there is something to offer people. People who are experiencing homelessness may use the medical emergency room or psychiatric emergency services (PES) when they don't have a medical need because these places have other items they need—safety, shelter, a warm meal, and caring people, with

little or no barriers to entry. Nearly 20% of adults accessing urgent and emergency services experienced homelessness in the last year, and seven out of 10 episodes of care in PES are for people experiencing homelessness. Additionally, San Francisco has no managed alcohol programs, a low-barrier approach to engaging clients with chronic alcoholism (see Appendix IV for detail on the evidence base for MAPs). This highlights the need for more accessible, non-clinical, drop-in services with connections to care, alongside increased outreach, to engage this population. The challenge in the provision of such services lies in the need to balance access to services with client and provider safety and pathways for exiting the service. Hummingbird Place, a new psychiatric respite center, provides behavioral health navigation services through a daytime drop-in center, in addition to overnight respite services. Hummingbird could serve as a model for this type of accessible service.

**Improved linkages and coordination are needed for successful care transitions.** Though official referral processes exist for getting patients from one point of care to another, these processes are not always well understood by staff or clients; even if a client receives a referral, it may be challenging to physically get there. In some cases, there is a lack of consistency in the process of getting a client admitted to a facility, and access to open beds is based on individual connections or a given provider's knowledge of the system.

There are also logistical challenges in connecting patients to care, including limitations on:

- hours for referrals (shelters and medical detox stop accepting referrals in the mid-afternoon);
- transportation to bring patients to services; and
- program hours.

These limitations mean that in many cases, an individual seeking a referral or services on a Friday afternoon will not be able to access care until Monday morning.

The DPH Transitions Division team is effective at managing the behavioral health network of resources; however, the work of the Division does not address how clients who do not qualify for the available resources get care. Effective care transitions require clear referral protocols, information sharing between providers, and linkage support for clients. The timing for a successful transition in care is critical; once a client has engaged and received some treatment, it is essential to support their uninterrupted care through stabilization.

# 5. RECOMMENDATIONS

These findings were organized into a framework representing three main goals for enhancing the system of care to improve service delivery. These goals and the strategies for achieving them are outlined below.

**TABLE 1: FINDINGS FRAMEWORK AND SUMMARY OF PRIORITY SOLUTIONS**

## VISION

**San Francisco's sytem of care should know the names and needs of everyone who is homeless with a behavioral health care need (regardless of how they come into the system and whether they are currently using it); provide wrap-around services that promote stabilization and a path to permanent housing; and ensure that systems and services proactively address and reduce disparities impacting Black/African American and LGBTQ individuals experiencing homelessness.**

### GOAL 1: IMPROVE COORDINATION, ACCOUNTABILITY, AND OUTCOME ALIGNMENT

**STRATEGY 1:** Improve data on clients and existing resources

SOLUTIONS

- Development of real-time behavioral health bed database
- Support for behavioral health Epic implementation

**STRATEGY 2:** Establish shared client-centered outcome goals

SOLUTIONS

- Cross-agency alignment around prioritization of clients
- Establishment of shared outcome goals across departments

**STRATEGY 3:** Improve system-wide coordination and accountability

SOLUTIONS

- Legal support for data sharing
- Support for WPC platform implementation
- Improved staff retention

### GOAL 2: IMPROVE STABILIZATION AND TREATMENT

**STRATEGY 1:** Improve access to short- and long-term housing for all levels of care

SOLUTIONS

- Additional supportive housing
- Increased number of Residential Care Facilities
- Increased availability of care for clients with dementia or incontinence

**STRATEGY 2:** Increase availability of appropriate, accessible treatment

SOLUTIONS

- Interventions for the treatment of methamphetamine use and chronic alcoholism
- Additional treatment beds across the continuum of care

**STRATEGY 3:** Increase support for care transitions and maintenance

SOLUTIONS

- Increased availability of intensive case management services

### GOAL 3: INCREASE SYSTEM ENGAGEMENT

**STRATEGY 1:** Expand field-based services

SOLUTIONS

- Additional field-based behavioral health services

**STRATEGY 2:** Create additional safe places to build trust

SOLUTIONS

- Managed alcohol programs
- Additional behavioral health respite/day programs

**STRATEGY 3:** Implement client-centered, responsive services

SOLUTIONS

- Non-emergency transportation
- Linkage coordinators to improve care transitions
- Expanded service and referral hours

The recommendations in this section do not address the root causes of homeless; instead, they focus on improving the system of care serving people who have become homeless who need support from the behavioral health system. Likewise, these recommendations do not address discrimination and the root causes of racial inequities, which have resulted in alarmingly disproportionate homelessness among Black/African-American populations; however, because these inequities exist, it is critical to implement programs with geography and target population in mind and to include demographic breakdowns in outcomes data in order to assess whether populations are being served equitably.

The following are recommendations for priority solutions for enhancing the system of care in San Francisco for people experiencing homelessness who also have behavioral health needs, refined based on their potential impact on the target population, their alignment with City goals, and their potential impact on disparities, equity, and inclusion (summarized in Table 2). In some cases, the City and County of San Francisco has already dedicated resources to address the identified gaps. Mayor London Breed and the new Director of the Department of Public Health, Dr. Grant Colfax, have identified homelessness and behavioral health as two of their top priorities, and recently established a new position to assess the behavioral health system of care for people experiencing homelessness and identify opportunities for expansion and change. The recommended additional services come with additional costs; philanthropy may be able to play a role in supporting these recommendations, and some ongoing costs can be defrayed through strategic implementation and oversight of a Medicaid revenue-maximization strategy.



## GOAL 1: IMPROVE COORDINATION, ACCOUNTABILITY, AND OUTCOME ALIGNMENT

In order to effectively serve the population of individuals experiencing homelessness who have a behavioral health need, the system needs to know who they are (at an individual and population level), have shared system-wide goals, and be able to do continuous program planning and improvement by understanding the resources available, how effective they are, and where changes are needed to improve outcomes. Specific recommendations to move the system in that direction are:

### STRATEGY 1: Improve data on clients and existing resources.

1. **BUILD A REAL-TIME BEHAVIORAL HEALTH RESOURCE INVENTORY.** This inventory would track the number of behavioral health care beds, utilization, and wait times and interface with the online bed inventories for shelter and permanent supportive housing within the Online Navigation and Entry (ONE) System. Improvements to data collection and tracking can also facilitate a better

understanding of what behavioral health resources are available and what the real-time need for those services is. While there is a belief that there are shortages in some treatment bed types, this is a necessary first step to establish how many of each type are needed.

The Department of Public Health recently did a one-time inventory of all behavioral health beds that exist across the continuum of care in San Francisco. Building on that inventory, a centralized real-time system for tracking the supply and demand for behavioral health resources could be created that allows for regular, on-going reporting of client referrals and placements. This would create a better understanding of the need to expand or reduce the volume of behavioral health beds at each level of the continuum of care based on actual need and availability. This would also facilitate better understanding of who is accessing beds (and who is not) and support identification of and approaches to racial disparities in treatment. This system could ultimately interact with the system tracking shelter beds to facilitate transitions into and out of shelters.

2. **ENSURE THE EPIC IMPLEMENTATION INCLUDES A PLATFORM FOR BEHAVIORAL HEALTH DATA SHARING.** DPH is in the process of implementing Epic, an electronic health record system that allows for tracking of patient information within and across health systems including street medicine, jail health, hospitals, primary care, and maternal and child health. A shared electronic health record can improve communication between providers around individual clients, facilitate seamless care transitions, track system-wide patient outcomes, and guide decisionmaking to reduce disparities. The first wave of implementation (physical health data) is set to take place August of 2019, with additional data and providers to follow through 2023.

   The plan to integrate behavioral health data into Epic is currently facing technical challenges, including the lack of integration between the current behavioral health billing system (Avatar) and Epic, and legal barriers related to data sharing. Overcoming these hurdles and ensuring behavioral health data can be shared within Epic is critical to support the care coordination of behavioral health clients.

## STRATEGY 2: Establish shared client-centered outcome goals.

1. **LEAD CROSS-AGENCY EFFORT TO PLACE HIGHEST-NEED CLIENTS.** The existence of numerous, varied priority client lists across departments and agencies results in fragmented and incomplete care for clients. By identifying a shared set of high-priority clients, agencies can work together to provide wrap-around services to a small number of very high-need individuals. This would help ensure that extensive investments of resources actually lead to stabilization for these clients, and could provide lessons learned for how to best care for complex individuals with many needs.

2. **ESTABLISH SHARED OUTCOME GOALS ACROSS DEPARTMENTS AND AGENCIES.** There is currently no system-level accountability to clients or to equity across the population. The establishment of shared, client-centered outcome goals across providers and departments would support more complete care for clients and help ensure all of their needs are being met. Aligning providers and agencies around the ultimate goals that they help clients achieve—like stabilization—could support collaboration and prevent patient recidivism.

## STRATEGY 3: Improve system-wide coordination and accountability for continuous quality improvement.

1. **PROVIDE LEGAL SUPPORT FOR DATA SHARING.** Sharing patient health and treatment data across providers and agencies is an ongoing challenge. While there are laws that govern data sharing requirements, interpretation of those laws vary by vary by county, and neighboring counties have found ways to share data effectively. Sharing information allows for better coordinated services, and investments in data sharing systems will be made in vain if the legal obstacles to sharing cannot be overcome. Additional work with legal counsel and the City Attorney is needed urgently to facilitate data sharing in San Francisco.

2. **SUPPORT THE WHOLE PERSON CARE PLATFORM IMPLEMENTATION.** San Francisco's WPC pilot focuses on data coordination across agencies. A cross-department team has been working collaboratively to improve coordination and outcomes, and to align or coordinate the various client/patient priority lists that exist across agencies. The pilot also includes the development of a Whole Person Care (WPC) Platform, which will integrate data across systems and departments including the ONE system, San Francisco Human Services Agency, Department of Aging and Adult Services, health plans, and the death registry. The WPC Platform will support care coordination, and could allow for assessment of outcomes across multiple systems. This work will continue past the end of the pilot (2020) and will need ongoing support.

3. **INCREASE EFFORTS AROUND STAFF RETENTION.** Improved efforts to support and retain staff could lead to a more effective workforce and more consistent patient care. Providers and staff who care for this population often face violence and trauma in their daily work. Offering increased security, training, and counseling to providers could help alleviate the toll of their work. Higher wages for providers could also improve recruitment and retention efforts, allowing leading providers to live and work in San Francisco and provide quality and consistent care to complex patients.



# GOAL 2: IMPROVE STABILIZATION AND TREATMENT

## STRATEGY 1: Improve access to short- and long-term housing for all levels of care.

1. **INCREASE AVAILABILITY OF AFFORDABLE AND SUPPORTIVE HOUSING.** Though San Francisco leads the nation in the provision of permanent supportive housing, there is a need for more supportive and affordable housing. There are more than 3,000 chronically homeless individuals on a given night, and only 80–100 units of supportive housing become available each month. One strategy for increasing permanent supportive housing is to add permanent "Moving On" subsidies which would allow individuals who have stabilized in permanent supportive housing and no longer need intensive services to transition to independent housing, thereby opening up beds throughout the system.

2. **INCREASE THE NUMBER OF RESIDENTIAL CARE FACILITIES (RCFs).** RCFs are a critical level of care for patients who need ongoing support but no longer need medically-intensive services. A new model of operation is needed to address the shortage of available beds in an effective and efficient way, one that likely includes having RCFs run by a non-profit, and potentially having more beds per unit.

3. **PROVIDE ADDITIONAL RESOURCES FOR CLIENTS WITH DEMENTIA OR INCONTINENCE.** San Francisco's homeless population is aging, and additional resources need to be added to existing levels of care in order to accommodate clients who have dementia and/or are incontinent. For example, some of San Francisco's permanent supportive housing services could build on their strengths of serving adults with severe behavioral disabilities by building in services to address age-related conditions.

## STRATEGY 2: Increase availability of appropriate, accessible treatment.

1. **ADD ADDITIONAL RESOURCES FOR TREATMENT OF METHAMPHETAMINE USE AND CHRONIC ALCOHOLISM.** Methamphetamine is the most frequently identified unaddressed issue in the behavioral health system. San Francisco recently announced the creation of a methamphetamine task force, co-chaired by Mayor Breed and Supervisor Rafael Mandelman, and coordinated by the Health Department. The Task Force includes representatives from public health, addiction research, and community members with lived experience. The Task Force is set to release recommendations in the Fall of 2019 for addressing the rising use and impacts of methamphetamine in San Francisco. Investing in these recommendations will be critical for filling a gap in services for this population (see Appendix V for detail on possible interventions).

   Chronic alcoholism is another significant challenge faced by the system of care for people experiencing homelessness in San Francisco. Unlike methamphetamine use, however, there are numerous known approaches for addressing chronic alcoholism. Increased availability of

evidence-based approaches, including dedicated accessible residential treatment facilities, clean and sober housing, and new models of medical detox could reduce premature mortality among people experiencing homelessness. The development and implementation of a managed alcohol program (also known as a "wet house") should be considered to meet the needs of this population.

2. **ADD ADDITIONAL TREATMENT BEDS ACROSS THE CONTINUUM OF CARE.** There is a need for additional behavioral health beds at numerous levels of care to meet the needs of the population, beyond the new beds supported by ERAF funding. This likely includes locked sub-acute beds, medical detox facilities (with increased flexibility in length of stay), sobering sites, residential treatment beds, and recovery step-down beds; however, the extent of the need at any given level is not currently clear due to lack of real-time tracking data on bed availability.

## STRATEGY 3: Increase support for care transitions and maintenance.

1. **EXPAND AVAILABILITY OF INTENSIVE CASE MANAGEMENT SERVICES (ICMS).** ICMS provide support for clients, connecting them to care and supporting their transitions. San Francisco is currently working to expand ICMS, including a full review of current ICMS cases and new funding to support the transition from ICMS to outpatient services. These efforts will likely help close the gap in ICMS and facilitate improved transitions for clients. Intensive case management has also been shown to be successful in attaining stable housing for LGBTQ individuals experiencing homelessness; expanding outreach and ICMS for the LGBTQ population can help address disparities in homelessness. This investment of City resources highlights the importance of increasing access to these services. There may be a need for additional expansion of ICMS after these efforts have been implemented, but the scope of additional need will not be known until these changes have been made.



# GOAL 3: INCREASE SYSTEM ENGAGEMENT

While some people who are experiencing homelessness are high-utilizers of the health system, others urgently need care, or are engaging but not maintaining services. The design and implementation of services is as important as their availability; having services that are responsive to client needs facilitates engagement with the system, ultimately improving patient outcomes. Convenient service locations, culturally competent services, and assistance with care transitions help people engage in and maintain services.

## STRATEGY 1: Expand field-based services.

Additional field-based behavioral health services are needed to meet people where they are. Building off the successful street-based buprenorphine program, street-based mental health and substance use services could offer a low-barrier, adaptive form of treatment that not only provides a much-needed service but acts as a doorway to the system for people who are disconnected.

## STRATEGY 2: Create additional safe spaces to build trust.

1. **DEVELOP AND IMPLEMENT A MANAGED ALCOHOL PROGRAM.** Managed alcohol programs (MAPs) are part of a comprehensive harm reduction approach to alcohol use disorder (AUD). MAPs administer a set amount of alcohol to individuals with alcohol use disorder to help stabilize their drinking patterns, avoid some of the harms of excessive alcohol intake, and increase their ability to participate in daily-life activities. MAPs can also help connect participants to additional services. MAPs offer an alternative to abstinence-based treatment and can help stabilize individuals with AUD who are experiencing homelessness.

2. **ADD ADDITIONAL DAY PROGRAMS.** Trust is essential for connecting with patients with complex needs and keeping them engaged in the system of care. Drop-in respite, day programs, or other low-barrier programs offer the opportunity to build trust with clients and offer them a safe place to be. Hummingbird Place and Hospitality House run model programs in San Francisco, and Dreamcatchers Empowerment Network and Turning Point Community Programs offer model programing throughout the state. Considering new locations or neighborhoods for these facilities could help address racial disparities in service access and outcomes. The City and County recently expanded Hummingbird Place by 14 beds; however more sites throughout the city would be beneficial.

## STRATEGY 3: Implement client-centered, responsive services.

1. **INCREASE AVAILABILITY OF NON-EMERGENCY TRANSPORTATION.** The provision of transportation helps clients make it to appointments, and is particularly important for populations who do not have their own form of transportation or have difficulties accessing public transit.

2. **EXPAND THE NUMBER OF LINKAGE COORDINATORS.** In addition to having the right treatment and services available, clients need to be able to transition between sites and levels of care. Expanding the number of linkage coordinators, in particular from high-intensity service centers like PES and the ED, would help clients engage in lower levels of care.

3. **EXPAND SERVICE AND REFERRAL HOURS.** Clients benefit when services and referrals are available during the brief window when an individual is ready and able to receive care. When not cost-prohibitive, service and referral hours should be expanded to accommodate the needs of clients and other service providers.

## Lessons from National Best Practice Review

The following best practices and recommendations should be considered when designing and implementing services and programming for this population.

**ADDRESS RACIAL DISPARITIES:** As described above, historical structures and policies have led to unequitable access to services and unequal health outcomes for communities of color. When examining the impact of a service or system for people of color, it's important to consider the cause of poor outcomes and adjust programming to meet the needs of these populations. For example, most behavioral health interventions are designed for White, middle class populations. This may impact how people of color experience behavioral health care, and may result in less favorable outcomes. Offering more flexible or culturally-appropriate solutions, including interventions that address multigenerational violence and trauma, may facilitate uptake of services and lead to improved outcomes for people of color. Black and African American individuals often experience the worst health outcomes within the population of people experiencing homelessness with behavioral health needs, and addressing racial disparities within this population should be considered a priority.

**PROVIDE TRAUMA-INFORMED CARE:** Many people experiencing homelessness and those who have behavioral health needs have lived through trauma; additionally, the experience of being homeless can itself be traumatizing. These individuals can be further traumatized by the cycling in and out of care and services that often occurs with this population. Providing trauma-informed care can help minimize the negative impacts of the system on these individuals. For example, smaller shelters and care facilities are more conducive to recovery than large, crowded sites, which can be overwhelming for people with behavioral health needs.

**UTILIZE PEER SUPPORT MODELS:** Peer support models allow for individuals who were once homeless and experiencing mental health and/or substance use disorders but have achieved significant recovery to help other individuals reach recovery and obtain housing supports. Peer support specialists can teach skills, provide support, and assist in obtaining treatment resources and additional support services. Research has demonstrated positive outcomes for peer support services in a range of settings for homeless persons, including improvements in alcohol-related problems, and increases in treatment retention, client satisfaction, and rates of abstinence.[25]

**FACILITATE CHANGE THROUGH MOTIVATIONAL INTERVIEWING (MI):** MI is a person-centered and collaborative therapeutic approach designed to enhance an individual's motivation for change. Techniques include: using empathy and not power or authority; exploring and resolving ambivalence to change; focusing on a person's strengths rather than weaknesses; respecting a person's autonomy and decisions; recognizing that a person experiencing homelessness with a behavioral health condition is facing complex problems and may be in different stages of readiness to change for each area. MI can be used to help an individual who is homeless make behavioral health changes but can also help achieve goals related to accessing and maintaining transitional and permanent housing.

# CONCLUSION

The findings and recommendations in this report are intended to provide a roadmap for areas of intervention that could improve care for some of San Francisco's most vulnerable residents. While there is no single solution and improvements will take time and funding, there is a strong commitment in San Francisco to continue to improve service and care for this population. The City has already taken responsibility for some of the recommendations in this report, including funding in the Mayor's proposed budget for the coming fiscal year, and continues to strategize around these topics. As part of this effort, Tipping Point Community and UCSF have identified specific areas that could be impacted through private funding; this could include advocacy around policies at the local and state level. Supporting San Francisco's most vulnerable residents in achieving health, housing, and recovery is a complex challenge that will not be solved by a single agency or policy, but through collective will and urgent action.

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1.7 million people in the Bay Area don't have the resources to meet their basic needs. Tipping Point identifies and invests in the most promising interventions by funding a portfolio of poverty-fighting organizations and implementing a series of focused initiatives. Working with government and non-profit service providers, Tipping Point launched the Chronic Homelessness Initiative, which will cut chronic homelessness in half by 2022.

The UCSF Department of Psychiatry and the Langley Porter Psychiatric Institute are among the nation's foremost resources in the fields of child, adolescent, adult and geriatric mental health. Together they constitute one of the largest departments in the UCSF School of Medicine and the UCSF Weill Institute for Neurosciences, with a mission focused on research, teaching, patient care and public service.

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Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults, Tia Martinez and Martha Burt, July 2006

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Tri-Morbidity Infographic, SFDPH, 2018

Whole Person Care California Medi-Cal 2020 Waiver Presentation, Health Commission SFDPH, April 2017

WPC Top 100 HUMS Project Summary, WPC Team, Dec. 6, 2018

WPC Discovery Summary, WPC Team, Dec. 11, 2018

# APPENDIX II: KEY INFORMANT INTERVIEW LIST

Jason Albertson, HSH

Angelica Almeida, DPH

Scott Arai and John Fostel, PRC Baker Places

Ayanna Bennett, DPH

Anton Bland and Mark Leary, PES ZSFG

Elizabeth Bromley, LA ACT program

Jack Chase, ZFSG Care Coordination

Kelly Eagen and Alice Moughamian, Medical Respite and Sobering Center

Susan Ehrlich, ZSFG

Steve Field, Progress Foundation

Jennifer Friedenbach, Coalition on Homelessness

Lisa Golden, DPH

Hemal Kanzaria, Maria Martinez, Dara Papo, Maria Raven, and Amber Reed, Whole Person Care

Jeff Kositsky, HSH

Captain David Lazar, HSOC/SFPD

Eileen Loughran and Tracey Packer, DPH

Judy Martin, BHS

Tanya Mera, Jail Health

Fumi Mitsuishi, Citywide

Captain Simon Pang, EMS6

Sneha Patil, DPH

David Serrano Sewell, Hospital Council of Northern and Central California

Melida Solorzano, Hummingbird Psychiatric Respite

Barry Zevin, Homeless Outreach Team (HOT)

# APPENDIX III: ADVISORY COMMITTEE MEMBERS

Brett Andrews, PRC/Baker Places, CEO

Alice Hm Chen, Department of Public Health, Chief Medical Officer and Deputy Director for the SFHN

Kavoos Ghane Bassiri, Department of Public Health, Director of Behavioral Health Services

Kelly Hiramoto, Department of Public Health, Director of SFHN Transitions

Hemal Kanzaria, Associate Professor of Emergency Medicine at UCSF

Margot Kushel, Director of the UCSF Center for Vulnerable Populations (CVP) at ZSFG

Mark Leary, UCSF Department of Psychiatry, Director of Division of Acute Emergency Services

Dara Papo, Department of Homelessness and Supportive Housing, Care Coordination Services Manager

David Serrano Sewell, Hospital Council of Northern and Central California, Regional Vice President

Ana Valdes, HealthRIGHT 360, Chief Healthcare Officer

# APPENDIX IV: MANAGED ALCOHOL PROGRAMS

## Managed Alcohol Programs (MAP)

### WHAT IS IT?

Research demonstrates that abstinence-based treatment approaches are frequently ineffective with unstable housing or homelessness. An MAP offers an alternative to abstinence-based treatment. It is part of a comprehensive harm reduction approach based on the understanding that regular administration of a set amount of alcohol will allow participants to stabilize their drinking patterns and avoid some of the harms of excessive alcohol intake. Goals of MAP also include helping with cravings, withdrawal and inappropriate behavior (due to the tailored dose of alcohol, unique for each individual), decrease in substance seeking behaviors, and an increased ability to participate in daily life activities

MAPs are similar to "wet houses" or "wet shelters", but are structured to ensure a range of services are provided along with managing and dispensing alcohol. All wet shelters/houses do not dispense alcohol but may allow it in the shelter.

### WHAT ARE THE COMMON BEST PRACTICES?

MAPs are offered as both residential and day programs with differences in six key dimensions including:

- program goals and eligibility
- food and accommodation
- alcohol dispensing and administration
- funding and money management
- primary care services and clinical monitoring
- social and cultural connections.

MAPs administer regular doses of beverage alcohol to people with alcohol use disorders (AUDs) alongside related health and social supports (such as referrals or access to housing, income support, health care, psychotherapy, and other health and social programs).

### IS IT EFFECTIVE?

Overall results seem to show that MAPs have positive impacts including:

- fewer hospital admissions, detox episodes, and police contacts leading to custody, reduced non-beverage alcohol consumption, and decreases in some alcohol-related harms;
- stabilize drinking patterns;
- reduced alcohol-related harms ;
- increased access to non-judgmental health and social care.

The MAP was, as described by participants, a safer environment and a home with feelings of family and a sense of community that countered stigma, loss, and dislocation with potential for healing and recovery. The MAP environment characterized by caring, respect, trust, a sense of home, "feeling like family", and the opportunities for family and cultural reconnections is consistent with First Nations principles for healing and recovery and principles of harm reduction.

### WHAT ARE THE CHALLENGES?

**FUNDING.** The majority of MAPs are funded through multiple sources and often face challenges securing permanent funding to cover costs.

**LINKING HOUSING WITH MAP PARTICIPATION.** Housing is a central program component but in some cases maintenance of housing is dependent on continuing receipt of the alcohol intervention. It is important to consider what level of linking MAP and housing is appropriate to ensure individuals do not return to homelessness if they leave or no longer need the program.

**LONG TERM HEALTH CONSEQUENCES.** It is important to make sure MAPs are not contributing to overall increase in alcohol consumption by setting up ongoing assessments and monitoring. Need to set up ongoing assessment and monitoring of health and impact of chronic alcohol use.

**DRINKING OUTSIDE THE PROGRAM.** Program managers and implementers need to determine how to address the issue of individuals drinking outside of the program to make sure there is not increased harm by dispensing alcohol.

| WHO'S DOING IT? | DOES IT WORK? |
|---|---|
| Brooks, H.L., et al. Implementing managed alcohol programs in hospital settings: A review of academic and grey literature. Drug and Alcohol Review 2018; 37 (Suppl. 1), S145–S155. | Of the 40 studies reviewed, 28 studied the administration of alcohol to hospital inpatients, with most reporting positive outcomes related to prevention or treatment of alcohol withdrawal.<br><br>14 studies looked at MAPs in the community and reported that they help stabilize drinking patterns, reduce alcohol-related harms and facilitate non-judgmental health and social care. |
| Pauly B, Gray E, Perkin K, Chow C, Vallance K, Krysowaty B, Stockwell T. Finding safety: a pilot study of managed alcohol program participants' perceptions of housing and quality of life. Harm Reduct J 2016;13:1–11. | When compared to controls, MAP participants were more likely to retain their housing and experienced increased safety and improved quality of life compared to life on the streets, in jails, shelters, or hospitals.<br><br>They described the MAP as a safe place characterized by caring, respect, trust and a nonjudgmental approach with a sense of family and home as well as opportunities to reconnect with family members. |
| Vallance K, Stockwell T, Pauly B et al. Do managed alcohol programs change patterns of alcohol consumption and reduce related harm? A pilot study. Harm Reduct J 2016;13:1–11. | Compared with periods off the MAP, MAP participants had 41 % fewer police contacts, 33 % fewer police contacts leading to custody time, 87 % fewer detox admissions, and 32 %fewer hospital admissions.<br><br>Compared with controls, MAP participants had 43 % fewer police contacts, significantly fewer police contacts (38 % less) that resulted in custody time, 70 % fewer detox admissions, and 47 % fewer emergency room presentations.<br><br>Marked but non-significant reductions were observed in the number of participants self-reporting alcohol-related harms in the domains of home life, legal issues, and withdrawal seizures.<br><br>Qualitative interviews with staff and MAP participants provided additional insight into reductions of non-beverage alcohol use and reductions of police and health-care contacts. |
| Susan E. Collins et al. Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories. American Journal of Public Health 2012; 102, 3:511–519.. | Seattle "Wet House" (1811 Eastlake)<br><br>Individuals experiencing homelessness with with alcohol problems decreased their consumption over two years at the facility, a project-based Housing First program that did not require abstinence or treatment attendance<br><br>The average amount of alcohol consumed on a typical drinking day by the 95 study participants had decreased by about 25 percent at the end of the two-year study.<br><br>Intervention exposure, represented by months spent in housing, consistently predicted additional decreases in alcohol use outcomes. |

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# APPENDIX V: POSSIBLE APPROACHES TO METHAMPHETAMINE USE

**CONTINGENCY MANAGEMENT (CM):** CM interventions most commonly use concrete incentives such as vouchers exchanged for goods or services (e.g., gift certificates, toiletries, electronics) as reinforcers for maintaining abstinence from substance use. Studies have shown this model to be effective in abstaining from substance use, increasing treatment attendance and completing treatment goals. Several studies have shown promising results for using CM for homeless individuals with substance use disorder. [i, ii, iii]

**MATRIX MODEL:** The Matrix Model is an evidence-based treatment approach that focuses on engaging and sustaining abstinence with individuals with substance use disorder who use stimulants such as methamphetamine and cocaine. The model integrates evidence-based approaches such as cognitive behavioral therapy, contingency management, motivational interviewing, 12-step facilitation, and family involvement. Individuals are monitored for substance use through urine testing. The therapist serves as a coach and a positive non-judgmental support for the individual with a focus on promoting the patient's self-esteem and continued engagement in treatment.

**SOBERING CENTER:** Sobering Centers provide a safe place for people to become sober from alcohol and/or other drugs. These centers are seen as an alternative to hospitals and jails and often provide supportive services focused on substance use, as well as mental illness and medical conditions. Beyond providing supportive care for individuals who are experiencing homelessness, the goal is to also reduce unnecessary emergency department admissions and reduce criminal justice involvement for individuals publically intoxicated on alcohol or other drugs. Unfortunately, there is little research to support the outcomes of these centers but several exist across the country. Most sobering centers operate seven days a week and are often open 24 hours each day. [iv, v]

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v. Warren O, Smith-Bernardin S, Jamieson K, Zaller N, Liferidge A. Identification and Practice Patterns of Sobering Centers in the United States. *J Health Care Poor Underserved*. 2016; 27:1843–1857.