



## Director's Update

MHAB September 19, 2019

1. Opening of South County Building
2. MERT and Access Expansion for South County
3. Community Data Roundtable Project
  - a. CANSA
4. HOPES Evaluation- Distribute Copies of Report

### Key Findings:

- Started in March 2018
  - 409 referrals
    - Provided outreach and case management services to 168 individuals
    - 19% of the individuals referred were successfully linked to services
    - A little over 50% either refused services, were unable to be located, or were not appropriate for HOPES.
    - Of the clients who were served by HOPES, 85% remained without housing
      - Housing remains the biggest barrier to supporting success

# Santa Cruz County HOPES

Evaluation of Homeless Outreach and Proactive Engagement Services

2018-2019





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## Key Findings

- Since March 2018, the HOPES team has provided outreach and case management services to 168 out of 409 people experiencing homelessness and mental health/substance use conditions who were referred to the HOPES team (not including some clients who were initially outreached but later refused services).
- Overall, 19% of all persons referred to HOPES (76/409) have been successfully linked to wraparound or treatment services or have been otherwise stabilized.
- Over half of all referrals to HOPES were unable to be stabilized because they either refused services (16%), were unable to be located by HOPES staff (33%) or because their needs or circumstances were not appropriate for the HOPES model (7%).
- 85% of clients (143/169) who were amenable to HOPES outreach and services remained without stable housing and living in Santa Cruz County by the end of June 2019.
- The HOPES evaluation and data collection plans were finalized in March 2019. As a result, certain outcome indicators were not collected until the 4<sup>th</sup> quarter of the 2018-2019 program year.
- Even though twice as many HOPES clients were referred to substance use treatment (n=58) as were referred to mental health treatment (n=29), more clients received mental health treatment (n=24) than substance use treatment (n=16).
- As of June 30, 2019, citations, arrests, jail days and bookings were all considerably lower in the post-HOPES period than the pre-HOPES period, but a final analysis of most of these clients will not be possible until Fall 2019.
- Members of the HOPES team reported that the greatest benefit of HOPES model has been the enhanced efficiency of communication and coordination of services on behalf of homeless clients.
- The greatest challenges faced by the HOPES team are the extreme scarcity of housing options and detox beds available to clients.
- The experience of HOPES team members and findings from national research in this area underscore the challenge of sustaining successful treatment outcomes for clients who lack stable, long-term housing.

## Introduction

According to the 2019 Santa Cruz County homeless point-in-time count, an estimated 32% of the overall homeless population in Santa Cruz County reported that psychiatric or emotional conditions limited their ability to find employment or housing. A similar percentage (30%) reported that their drug and alcohol use affect their ability to find employment or housing. Overall, 39% of homeless individuals surveyed reported one or more disabling health conditions and 28% spent a night in jail in the last year.<sup>1</sup>

Such statistics mirror recent national trends. As of 2017, an estimated 30% of people experiencing chronic homelessness across the U.S. lived with a serious mental illness<sup>2</sup>, and over a third of the homeless population experience alcohol and other substance abuse problems.<sup>3</sup>

To strengthen the county's overall response to the needs of this population, the Santa Cruz County Board of Supervisors allocated funds for a new model of service coordination called the Homeless Outreach, Proactive Engagement and Services (HOPES) Team. HOPES was initiated in March of 2018, following a planning process to incorporate recommendations from an evaluation of the Bob Lee Community Partnership for Accountability, Connection and Treatment (PACT) program conducted led by California State University, Monterey Bay (CSUMB). The planning process incorporated findings from three redesign workgroups—Justice, Clinical and Housing—to form a new model of service.

The resulting HOPES model established a new system for integrating care for homeless individuals with mild to severe mental health, substance use or physical health issues. According to the County's Behavioral Health Division, the focus of the HOPES Team is "to assertively outreach to and engage homeless individuals in a coordinated effort to wrap care around the individual, linking them to services that stabilize the individual's medical and behavioral health needs. Once stabilized, the homeless individual will be linked to a long-term care coordination track that is based on their needs." The new system also supports collaboration between Santa Cruz County Behavioral Health Division and the City of Santa Cruz to fund the program and establish performance outcome measurements.

HOPES is operated by a multidisciplinary team of local homeless and healthcare service providers and is managed by the Behavioral Health Division of the Santa Cruz County Health Services Agency (HSA). Within this team, two staff positions are funded directly through the State of California's Homeless Mentally Ill Outreach and Treatment Program (HMIOT) to support HOPES clients. The HOPES team also partners with the criminal justice system through the PACT and Behavioral Health specialty courts.

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<sup>1</sup> Applied Survey Research. *Santa Cruz Homeless Census & Survey: Comprehensive Report, 2019*.

<sup>2</sup> National Academies of Sciences, Engineering, and Medicine. 2018. *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25133>.

<sup>3</sup> National Coalition for the Homeless "Substance Abuse and Homelessness," (2009). <https://www.nationalhomeless.org/factsheets/addiction.pdf>

The HOPES multidisciplinary team meets 1-3 times per week and is managed by the Behavioral Health Division's Adult Mental Health Services office. Members of the team include the following offices:

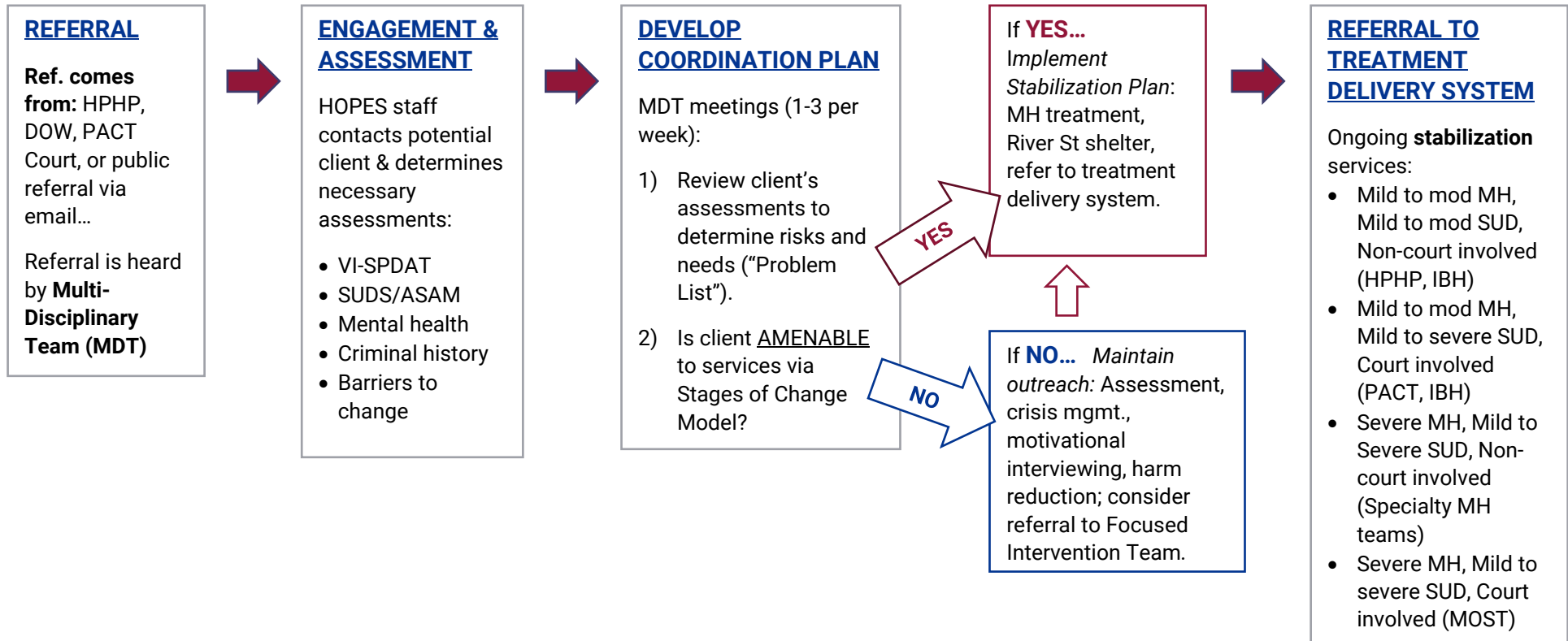
- Adult Mental Health Services, Santa Cruz County Health Services Agency
- Homeless Persons Health Project (HPHP)
- Substance Use Disorder Services (SUDS), Santa Cruz County
- Downtown Outreach Worker (City & County of Santa Cruz)
- Mental Health Liaison (Santa Cruz County)
- Focused Intervention Team (Santa Cruz County)
- Behavioral Health within the Santa Cruz County Jail (Sheriff's Office)
- County Jail Reentry
- Integrated Behavioral Health & Whole Person Care

This evaluation report documents the implementation and outcomes of the HOPES model for clients served from March 2018 through June 2019. It is based on an evaluation plan developed collaboratively by ASR and the County HSA's Behavioral Health Division.

A diagram on the next page outlines the intended process for coordinating treatment and services through HOPES.

## HOPES Model

How an individual client is linked to stabilization services.





## Evaluation Design

This evaluation reports on progress achieved across the five outcome areas defined by the County Behavioral Health Division. Within the evaluation plan, each outcome area is measured by a set of performance indicators aligned to the key outcome questions.

### Outcome Areas

1. System Coordination: How has the HOPES model coordinated services for the intended population?
2. Access to Care: To what extent have HOPES clients acquired greater access to health care, specifically general/medical care, mental health and substance use treatment?
3. Criminal Justice: To what extent have clients complied with the law/courts, and reduced time spent in jail?
4. Quality of Life: How have HOPES clients improved their quality of life: stable housing and sober living environments, improved personal well-being and safety, and access to benefits?
5. Community: How have perceptions of homelessness changed in the county?

The evaluation and data development plan for HOPES was completed in March 2019 and integrated into the HOPES data collection process beginning in April 2019 (the 4<sup>th</sup> quarter of the 2018-2019 fiscal year). The HOPES manager modified the HOPES case management spreadsheets that document all key indicators to fit the indicators described in the evaluation plan. The new indicators developed for the evaluation plan have been tracked primarily for clients who were referred to or served by HOPES between April and June 2019 (Q4).

As a result, the data collected about clients prior to Q4 of 2018-2019 does not include many of the key outcomes defined in the evaluation plan. However, the basic overall status of each client (e.g., resolved, linked to treatment, housed, relocated, refused, actively managed, etc.) was recorded for all clients during the MDT meetings and other periodic reports, and thus may be reported in the findings below. The data used to produce the findings and analysis in this report were provided by the HOPES manager, who compiles the data during MDT meetings and from case notes maintained by case managers working with HOPES clients.

## Results

The results below are organized by the five outcome areas as described in the evaluation plan.

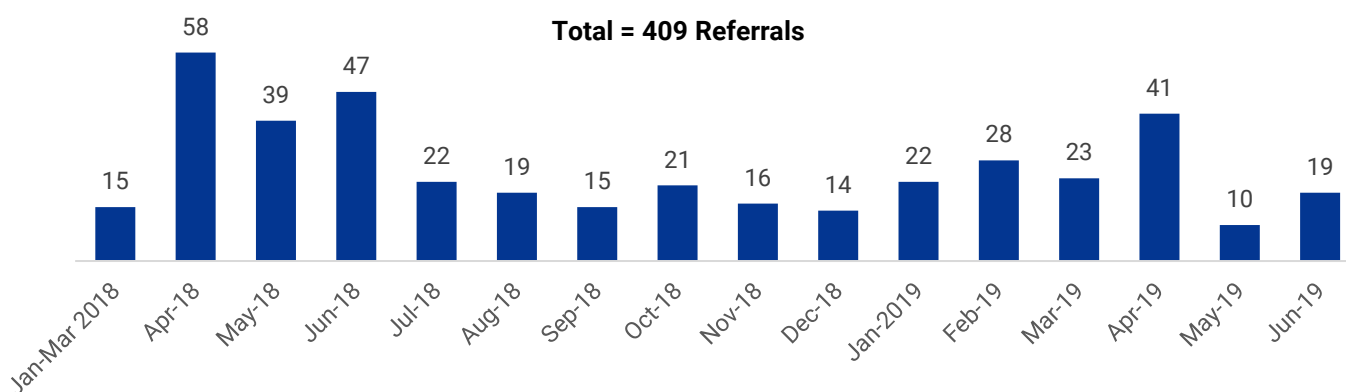
### Outcome Area 1: System Coordination

*Q: How has the HOPES model coordinated services for the intended population?*

#### Total Referrals to HOPES

Overall, 409 people have been referred to HOPES since the program launched in early 2018. As Figure 1 shows, after a period of heavy referrals in the spring of 2018, an average of 21 referrals per month were made between July 2018 and June 2019.

**Figure 1. New HOPES Referrals by Month, 2018-2019**



Source: HOPES client management system.

#### Status of All Referrals through June 2019

Through June 2019, 54% (n=219) of clients referred to HOPES signed a consent to receive treatment and other services and to allow their personal information to be provided to HOPES-connected organizations. A portion of this group engaged very briefly or not at all with HOPES because they later refused to participate, were referred to FIT, or were determined to be an inappropriate referral.

Overall, 23% (n=93) of referrals have been actively case managed or otherwise linked to stabilization services. Of this group, 19% (n=76) of all referrals, have been successfully linked to stabilization services or otherwise resolved. This may include relocation, placement in permanent housing or a sober living environment, or placement in a residential treatment program with wraparound services that require no further support from HOPES staff.

An additional 18% (n=75) have been in contact with HOPES staff (i.e. actively outreached) to develop a case plan but have not been actively case managed or linked to services.

The remaining 59% (n=241) of referrals have either refused services (16%), have been unable to locate (33%) are inappropriate for HOPES (7%), or are deceased (3%). Figure 2 provides the most recent status of all clients referred to HOPES since March 2018.

**Figure 2. Status of all HOPES Referrals as of June 30, 2019**

	<b>N</b>	<b>PCT OF REFERRALS</b>
<b>Signed Consent/ROI</b>	219*	54%
<b>Clients Actively Served by HOPES</b>	93	23%
<ul style="list-style-type: none"> <li>• Successfully Resolved/Linked</li> </ul>	76	19%
<ul style="list-style-type: none"> <li>• Received case management, but not yet successfully linked</li> </ul>	17	4%
<b>Actively Outreached</b> (In communication but not actively case managed, not resolved, not refused)	75	18%
<b>Refused Services</b> (may have briefly received services/outreach at some point)	67	16%
<b>Unable to Locate/No Contact</b>	135	33%
<b>Inappropriate Referrals or Referred to FIT</b>	27	7%
<b>Deceased</b>	12	3%
<b>TOTAL REFERRALS</b>	<b>409</b>	<b>--</b>

Source: HOPES client management system.

\*This number is drawn from the HOPES summary report compiled by HOPES manager.

Note: 12 clients are documented as having completed the SmartPath Coordinated Entry Assessment (VI-SPDAT) among 22 clients whose status was updated beginning in March 2019.

## Referral Origins

The most common locations from which potential HOPES clients were referred were the County Jail and downtown Santa Cruz.

**Figure 3. Most Common Locations at Time of Referral**

	N
County Jail	63
Downtown Santa Cruz	43
Ross Camp	12
Janus of Santa Cruz	7
Santa Cruz Residential Recovery	6
Homeless Persons Health Project (HHPH)	6
Homeless Services Center	5
Dominican Hospital	5
River Street Shelter	5
<b>TOTAL LOCATIONS REPORTED</b>	<b>177</b>

Source: HOPES client management system.

Note: This table shows locations from which at least five clients were referred. The following locations were reported for 1-4 referrals each: Sober living environment, City of Watsonville, Staff of Life, Library, East Santa Cruz, The Stagg, Windsor Skyline, Beach Flats, Telos, Salvation Army, Boulder Creek, Front St Residential Care, VA program, Harvey West Park, West Cliff, Shelter, Skilled Nursing Facility, beach, Residential Treatment.

## Multidisciplinary Team (MDT) Meetings & Additional HOPES Staff

During MDT meetings, HOPES staff and service providers gather to review the current status and needs of HOPES clients and to coordinate services and treatment options on their behalf. In the first 12 months of HOPES, meetings were held every Monday, Wednesday and Friday. During Q4 of 2018-2019, however, HOPES staff reduced the frequency to twice per week because it became increasingly difficult for many team members to attend all three days. Currently, MDT meetings are held 1-2 times per week, and typically include 8-12 staff.

Since March 2018, the HOPES team has held 150 MDT meetings, an average of 2.2 meetings per week. Although individual meeting attendance was not tracked until April 2019 it is possible to estimate the overall staff hours dedicated to these meetings.

Assuming an average of 10 staff attended each meeting, with meetings lasting an average of one hour, HOPES staff are estimated to have committed 1,500 hours to MDT meetings collectively between March 2018 and June 2019, or 1,125 hours per year. Individually, this would equate to 112 hours per staff member spent in MDT meetings per year.

After the evaluation plan was finalized in April 2019 the HOPES manager began tracking individual MDT meeting attendance and representation. During this period, MDT meetings were regularly attended by the HOPES Manager, Supervisor, and intern, along with a Downtown Outreach Worker, Mental Health Liaison and Focused Intervention Team Manager, and representatives from the Homeless Persons Health Project (HPHP), the County SUDS office, Jail Behavioral Health, Jail Reentry Staff, and the Integrated Behavioral Health/Whole Person Care supervisor.

#### ADDITIONAL STAFFING FOR HOPES TEAM

In addition to the hours dedicated to MDT meetings, the County funded two additional Behavioral Health staff positions dedicated to HOPES services. These positions were funded by the State of California's Homeless Mentally Ill Outreach and Treatment Program (HMIOT).

## Outcome Area 2: Access to Care

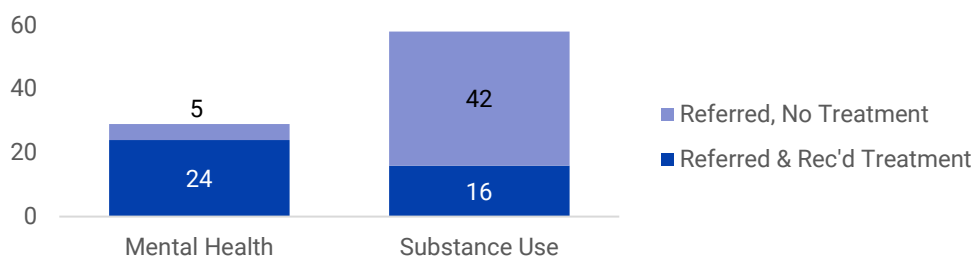
*Q: To what extent have HOPES clients acquired greater access to health care, specifically general/medical care, mental health and substance use treatment?*

Most of the indicators of access to care were not tracked for active clients until the evaluation plan was finalized in March 2019. The following section therefore reports on the most complete data available from both summary reports generated by HOPES staff and from Q4 client level data. The following outcomes assume a baseline status of no access to medical care, mental health and substance use treatment upon joining HOPES.

### Mental Health & Substance Use Referrals & Treatment

Through June 2019, data indicate that twice as many HOPES clients have been referred for substance use treatment (n=58) as mental health treatment (n=29) after joining HOPES. However, only 28% of clients referred for substance use (n=16) have been treated whereas 83% of mental health referrals have been treated (n=24). Furthermore, six clients who entered substance use treatment withdrew before completing the treatment program.

**Figure 4. New Mental Health & Substance Use Referrals (Mar. 2018-June 2019)**



Source: HOPES client management system.

Note: One client withdrew from MH treatment in Q4, and six clients withdrew from SUD treatment in Q4.

The following two outcomes include clients outreached or managed since March 2019, the last four months of the reporting period.

### **Access to a Primary Care Physician**

PCP Visits: 16 recent clients have seen a primary care physician in the last year.

*Time Period:* March – June 2019

### **Emergency Department Visits**

Total Visits: 23 visits to the ED by HOPES clients active in Q4.

Number of Clients: 9 clients visited the ED in Q4.

*Time Period:* Clients active in Q4, 2018-2019

## Outcome Area 3: Criminal Justice

*Q: To what extent have clients complied with the law and courts, and reduced time spent in jail?*

### Specialty Court Referrals

Through June 2019, 20 HOPES clients have been referred to the PACT court (resumed March 2019) and 9 have been referred to the Behavioral Health Court.

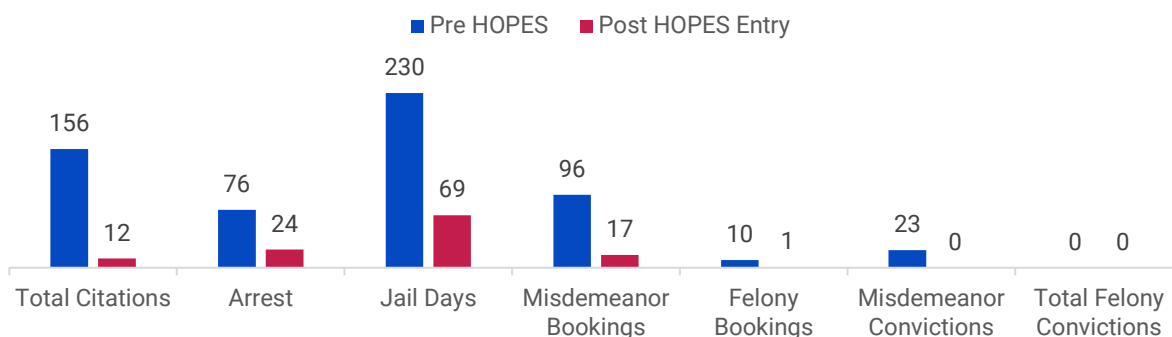
### Citations, Arrests, jail time, bookings, and convictions

The HOPES evaluation plan calls for criminal justice outcomes to be assessed over a 12-month period: 6 months preceding HOPES (Pre) and 6 months following HOPES entry (Post).

The HOPES team began tracking these outcomes for clients enrolled in March 2019. Twelve out of 18 clients with detailed criminal justice data joined HOPES between March and May 2019, which means their 6-month post-HOPES entry period will end after the 2018-2019 program year and thus cannot be fully assessed for this report.

Figure 5 (below) should therefore be considered as a preliminary pre/post comparison of citations, arrests, jail time, bookings and convictions for recent clients. Within this sample, citations, arrests, jail days and bookings all declined precipitously for HOPES clients after agreeing to receive services.

**Figure 5. Preliminary Arrest, Citation and Bookings Results**



Source: HOPES client management system, Santa Cruz County Sheriff's Office.

N=18 March-June 2019 Clients

\*Most of the clients with post-HOPES enrollment crime-related data have been active for less than six months.

## Outcome Area 4: Quality of Life

*Q: How have HOPES clients improved their quality of life: stable housing and sober living environments, improved personal well-being and safety, employment, and access to benefits?*

### Access to Benefits

Medi-Cal coverage at pre and post-HOPES was recorded for 39 clients and Supplemental Securing Income (SSI) status was recorded for 23 clients. The following tables are disaggregated by the quarter in which services began to account for different pre and post-HOPES time periods.

The Medi-Cal coverage rate rose from 90% to 95% after joining HOPES.

**Figure 6. HOPES Clients with Medi-Cal Coverage**

SERVICES BEGAN	MEDI-CAL – PRE	MEDI-CAL – POST
Q4 (n=8)	63%	95%
Q3 (n=8)	93%	100%
Q2 (n=8)	100%	100%
Q1 (n=2)	--	--
Mar-June 2018 (n=6)	100%	100%
<b>TOTAL (N=39)</b>	<b>90%</b>	<b>95%</b>

Source: HOPES client management system.

Note: Results for sample sizes less than 5 are not shown.

Q4: Apr-Jun 2019; Q3: Jan-Mar 2019; Q2: Oct-Dec 2018; Q1: Jul-Sep 2019.

The percent of clients receiving SSI rose from 26% to 30% after joining HOPES.

**Figure 7. HOPES Clients Receiving Supplemental Security Income (SSI)**

SERVICES BEGAN	SSI – PRE	SSI - POST
Q4 (n=8)	25%	25%
Q3 (n=10)	0%	0%
Q2 (n=3)	--	--
Q1 (n=0)	--	--
Mar-June 2018 (n=2)	--	--
<b>TOTAL (N=23)</b>	<b>26%</b>	<b>30%</b>

Source: HOPES client management system.

Note: Results for sample sizes less than 5 are not shown.

Q4: Apr-Jun 2019; Q3: Jan-Mar 2019; Q2: Oct-Dec 2018; Q1: Jul-Sep 2019.



## Housing Placements & Exits in Q4

Due to the finalization of the evaluation plan in March 2019, placement data regarding housing, residential treatment, sober living environments and other key placements and resolutions are available for the Q4 period only (April-June 2019).

Sober living environments (n=13) and residential treatment facilities (n=13) were the most common type of placements as clients exited HOPES, although five of the 13 who entered residential treatment left immediately and did not continue.

**Figure 8. Number of Clients Placed in Treatment, SLE, Housing, or Relocated in Q4**

SERVICES BEGAN	IN RESID. TRMT (NO DROP OUT)	ENTERED TRMT & DROPPED OUT	SOBER LIVING ENV.	LINKED TO BEHAV. HEALTH SERV.	SKILLED. NURSING FAC.	RELOC. (H. BOUND)	HOUSED	ANY PLACEMENT*
Q4 (n=65)	3	3	3	5	0	3	0	15
Q3 (n=60)	3	2	5	0	1	1	2	12
Q2 (n=42)	2	0	5	0	0	1	0	6
<b>TOTAL (N=167)</b>	<b>8</b>	<b>5</b>	<b>13</b>	<b>5</b>	<b>1</b>	<b>6</b>	<b>3</b>	<b>33</b>

Source: HOPES client management system.

\*Unduplicated total count.

Note: Individual clients may be represented in more than one category.

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*Between March 2018 and June 2019, **85%** of HOPES clients (143 of 169) who needed housing and were amenable to outreach lacked stable housing as of July 2019.\**

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\*Stable housing includes permanent housing, skilled nursing facilities, sober living environments, and relocations to areas outside of the county where support networks exist. Clients who could not be reached, who refused services, or were referred out of HOPES to other programs are not included in the denominator.

The following quality of life outcomes are not reportable here but should be available in subsequent reports as more data are collected:

- WHOQOL-BREF survey results: This is a quality of life survey offered to clients to understand how they perceive their own physical health, psychological health, social relationships, and living environment.
- Shelter Bed Days: This measure was reported for two clients in Q4.

## Outcome Area 5: Community

*Q: How have perceptions of homelessness changed in the county?*

The community level indicators detailed for this outcome area are provided as a baseline and will continue to be monitored as new data becomes available.

### Residents That Feel Safe

2017: 63% of county residents feel “very safe” in their neighborhood, 31% are “very concerned” about crime.<sup>4</sup> The next update of this outcome will be available in 2020.

### Residents Who Perceive Homelessness as the Greatest Challenge to Quality of Life

2017: 13% of county residents reported that homelessness as the primary issue that reduces the quality of life in the county; an additional 24% reported the cost of living/housing as the primary issue.<sup>5</sup> The next update of this outcome will be available in 2020.

### Number of People Experiencing Homelessness

2019: According to the Homeless Point-In-Time Count conducted in January 2019, 2,167 people were experiencing homelessness across the county, a marginal reduction from the 2,249 people counted in January 2017.<sup>6</sup>

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<sup>4</sup> Santa Cruz Community Assessment Project, 2017. Applied Survey Research.  
<https://www.appliedsurveyresearch.org/scccap>

<sup>5</sup> Ibid.

<sup>6</sup> Applied Survey Research. *Santa Cruz Homeless Census & Survey: Comprehensive Report, 2019.*

## Conclusion

### HOPES Outcomes Summary

This evaluation report provides an initial review of implementation and outcome results over the first 16 months of HOPES outreach and case management services. During this time the HOPES team coordinated a range of services and provided additional staff for homeless individuals in Santa Cruz County who needed integrated physical and mental health care and substance use treatment.

Specifically, the HOPES team has provided outreach and case management services to 168 out of 409 people referred to the HOPES team (not including some clients who were initially outreached but later refused services) since March 2018. Of this group, 76 clients (45%) have been successfully linked to wraparound or treatment services or have been otherwise stabilized. Nonetheless, the challenge of finding stable housing remained for most clients: 143 clients (85%) who were amenable to HOPES outreach and services remained *without* stable housing and living in Santa Cruz County by the end of June 2019.

The data for clients served since March 2019, when the evaluation plan was finalized, is more detailed than for the prior period. In the fourth quarter of the 2018-2019 fiscal year (April-June), 33 HOPES clients exited HOPES and were stabilized in one or more of the following conditions:

- 13 clients placed in residential treatment facilities,
- 13 clients placed in sober living environments,
- 6 clients relocated to another city via Homeward Bound,
- 5 clients linked to Behavioral Health Services,
- 3 clients permanently housed.

Over half of all referrals to HOPES were unable to be stabilized because they either refused services (16%), were unable to be located by HOPES staff (33%) or because their needs or circumstances were not appropriate for the HOPES model (7%).

A series of other long term outcomes were also monitored by the HOPES manager in accordance with the HOPES evaluation plan beginning in March 2019. Between March 2018 and June 2019, 24 HOPES clients entered mental health treatment and 16 clients entered substance use treatment, even though twice as many clients were referred for substance use treatment (58) than mental health treatment (n=29).

Other key outcome indicators were mostly documented between March and June 2019, once the evaluation and data development plans had been solidified. Results over this period are preliminary as they are intended to be assessed over the six month period following the start of HOPES services. As of June 30, 2019, citations, arrests, jail days and bookings were all considerably lower in the post-HOPES period than the pre-HOPES period, but a final analysis of most of these clients will not be possible until Fall 2019. Quality of life indicators showed little overall change for clients whose insurance and benefits data were available at pre and post. Post-HOPES Medi-Cal coverage rose from 90% to 95% and the percentage of clients with SSI rose from 26% to 30%.

## HOPES Team Perspective

During the 16 months that the HOPES team met to support homeless residents, members of the team reported that the greatest benefit has been the enhanced efficiency of communication between providers. Regular MDT meetings where members can quickly and directly build rapport with each other and gain a deeper understanding of the services and options available to clients across sectors have helped reduce the amount of time they would otherwise spend on the phone or using email to locate resources and link clients. During MDT meetings, HOPES team members reported, staff can conduct a substantial amount of case management and treatment planning on behalf of clients in a very compressed time period because many of the key people are already in the room.

The greatest challenges team members and staff said they face are the extremely scarce housing options and detox beds available for clients. HOPES team members expressed concern that clients who are successfully stabilized are vulnerable to relapse or other risks because they often remain unable to secure any kind of safe and permanent housing. The limited availability of detox beds also creates pressure on staff to find secondary options and reduces their ability to support clients who are ready to address their addictions.

## Recent Research on Housing and Recovery Programs

The findings from the HOPES evaluation summarized above underscore the idea that supporting clients' long-term recovery is considerably more challenging when those clients lack stable housing.

This challenge is also reflected within a substantial body of research conducted over the last 20 years which highlights the role of supportive housing programs in successful recovery efforts. A 2016 paper on supportive housing programs by the Center on Budget and Policy Priorities shows why treatment programs for homeless persons that lack housing support are less likely to succeed.

It noted multiple studies demonstrating the benefits of stable housing for homeless persons with chronic mental and physical health symptoms as well as those with long arrest histories.<sup>7</sup> For example, one of the largest studies in this area found that homeless people with severe mental illness placed in a New York City supportive housing program spent 115 fewer days in shelters, 75 fewer days in psychiatric hospitals, and eight fewer days in jail in the two years after entering the program, compared to a similar group without supportive housing.

The CBPP policy paper also reported that “a majority of evidence on behavioral health in supportive housing...studies show consistently that those in supportive housing reduce their use of substances over time.”

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<sup>7</sup> Dohler, et al. “Supportive Housing Helps Vulnerable People Live and Thrive in the Community.” Center on Budget and Policy Priorities. May 31, 2016. <https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community>

## Recommendations from Santa Cruz County HSA, Behavioral Health Division

Based on the findings in this report and their direct experiences with the HOPES team since March 2018, the HOPES management team recommends the following steps to improve services and outcomes for clients across the county.

- Additional community resources for Residential Substance Use Disorder programming are needed to meet the treatment of homeless individuals served by HOPES. Currently, long waits and a lack of bed capacity present serious barriers to recovery.
- Additional Sober Living Environments (SLEs) are needed to allow individuals to maintain sobriety off the streets.
- Additional development of affordable or low-income housing would present a more permanent solution to resolving the housing challenges faced by individuals with substance use disorders and mental health conditions living on the streets.

## About the Researcher

Applied Survey Research (ASR) is a social research firm based in Santa Cruz County. ASR is dedicated to helping people build better communities by creating meaningful evaluation and assessment data, facilitating information-based planning, and developing custom strategies. ASR has more than 30 years of experience working with public and private agencies, health and human service organizations, city and county offices, school districts, institutions of higher learning, and charitable foundations. Through community assessments, program evaluations, and related studies, ASR provides the information that communities need for effective strategic planning and community interventions.

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