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Breaking the Cycle: Evidence-Based Diversion for Homeless Individuals with Mental Illness

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Breaking the Cycle: Evidence-Based Diversion for Homeless Individuals with Mental Illness

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Dedication

To our neighbors experiencing homelessness—may you never go unnoticed.

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Abstract

Breaking the Cycle: Evidence-Based Diversion for Homeless Individuals with Mental Illness

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The resources and infrastructure in place to serve our nation's homeless is spread thin. Issues of capacity, funding, and lack of individualized treatment plans create limited opportunities for individuals to escape their current, often cyclical circumstances. For many, this results in continuous interactions with the justice system and physical-behavioral health systems. This Professional Report seeks to examine the effectiveness of evidence-based diversion strategies used to keep individuals experiencing homelessness from cycling in and out of correctional facilities and unnecessary hospitalization, in both general and psychiatric settings. As a community, we have an ethical and moral responsibility to support homeless individuals suffering with mental illness who may require additional support. This report seeks to determine the most effective way to meet this obligation. Austin is rapidly changing its approach to solving homelessness, which has the potential to increase the number of unsheltered individuals experiencing homelessness, even if only for a brief amount of time. This can in turn lead to negative

social determinants of health and an increased need for diversion from crisis settings. Individuals experiencing homelessness are unique—their needs, conditions, and mitigating circumstances are different. In order for successful diversion to take place, Austin must be robust in its approach. This report surveyed diversion strategies used nationwide in order to examine strategies and resources currently available in Austin and Travis County. Although Austin has a strong capacity for diversion, findings show there is room for improvement. Recommendations to improve Austin's ability to divert homeless individuals with mental illness from unnecessary crisis system interactions include: increased outreach capacity; expansion of the Combined Transportation, Emergency, & Communications Center, Austin's current central dispatch center; creation of a crisis stabilization unit; and 24/7 availability of Integral Care's Expanded Mobile Crisis Outreach Team.

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Population of Interest

On a single night in January 2018, approximately 553,000 individuals (or 22 out of every 10,000) were experiencing homelessness in the United States. Of this total, about two-thirds were staying in sheltered locations – emergency shelters or transitional housing programs – and one-third were unsheltered, living on the streets or in other places not suitable for human habitation (U.S. Department of Housing and Urban Development, 2018). Nearly one-quarter of individuals surveyed in the 2018 point-in-time count were classified as 'chronically homeless,' meaning they had been homeless for one year or more or had experienced at least four episodes of homelessness in the last three years with a combined time of 12 or more months (U.S. Department of Housing and Urban Development, 2018). It is estimated that 20 to 25 percent of homeless individuals struggle with mental illness, a rate roughly four times higher than that found in the general population. In addition, studies have found that over 70 percent of these individuals have a mental health disorder, including schizophrenia, bipolar disorder, severe depression, schizoaffective disorder, and anxiety (Dowd, 2018; Rossi, 1989).

The resources and infrastructure in place to serve our nation's homeless is spread thin. Issues of capacity, funding, and lack of individualized treatment plans create limited opportunities for individuals to escape their current circumstances. For many, this results in continuous interactions with the justice system and physical-behavioral health systems. The U.S. Interagency Council on Homelessness (2017) estimates that chronic homelessness costs the public anywhere between $30,000 and $50,000 per person per year when crisis system interactions are taken into consideration. This Professional Report (PR) aims to examine evidence-based diversion for homeless individuals experiencing mental illness. How do we effectively break the cycle of chronic homelessness in Austin and Travis County?

HIGH UTILIZER

For the purpose of this project, diversion is understood as an act of turning chronically homeless individuals with mental illness away from correctional settings and/or unnecessary hospitalization and emergency room utilization. It is an individualized micro level interaction that leads to macro level change, noted by decreased crisis system interactions. A 'high utilizer' or 'super utilizer' is an individual who often suffers from co-occurring chronic medical, social, behavioral health, and long-term conditions. High utilizers accumulate large numbers of emergency department visits, hospital admissions, and criminal justice interactions that could be avoided by early intervention and diversion strategies. They are the 20 percent of Americans who consume 80 percent of all health care expenditures (Stewart, 2012). Communities have looked for evidence-based, innovative models to combat the revolving door of high utilizers who shuffle in and out of crisis service systems. Ideally, these models would improve outcomes, contain costs, and use bottom-up service planning to meet the unique needs and challenges posed by this population.

Diversion within a community-based approach to mental health care is an intersection of multiple systems, including local and national government institutions and executive agencies, the criminal justice system, law enforcement, mental health or behavioral health authorities, hospitals and emergency departments, and homeless service providers. Constructing a unified model of care across a multidisciplinary network of providers presents unique challenges. Different funding streams that dictate standards and expectations, as well as the use of various databases to track client progress, make it difficult to coordinate local efforts. For these reasons, diversion may look different depending on who is performing it and the context in which it is utilized.

Social Determinants of Health

Individuals who frequently come into contact with crisis systems, including shelters, hospitals, and jails experience negative social determinants of health. The World Health Organization (2019) defines social determinants of health as the conditions in which people are born, live, work and age; circumstances that are shaped by the distribution of power, money, and resources. For individuals experiencing homelessness, the reciprocal relationship between one's health and one's social environment has a disproportionate impact. For example, unsheltered homeless individuals must survive in the midst of changing weather conditions, substandard sanitation, uncertain nutrition, heightened risk of physical and sexual abuse, and limited access to water. Individuals and families utilizing emergency shelters may be considered better off in some regards, but dormitory conditions make transmission of disease easy, and health care availability may be less than optimal (National Health Care for the Homeless Council, 2018; Rossi, 1989). Regardless of where one lays their head at night, homeless individuals are susceptible to experiencing poverty, housing insecurity, unemployment, and social isolation (Corporation for Supportive Housing, 2017). While the average life expectancy in the United States is roughly eighty years of age, chronically homeless individuals are estimated to live only into their sixties (Hayashi, 2016).

This population faces complex health and social issues that are often integrated with past, present, and daily trauma. In response, persons experiencing homelessness often develop coping mechanisms that impact prioritization and decision-making skills. National estimates from 2009 show 38 percent of homeless individuals struggle with alcohol abuse and 26 percent struggle with substance abuse (National Coalition for the Homeless, 2009). These rates are roughly 7 percent and 9 percent higher, respectively, when compared to the general population (National

Institute on Drug Abuse, 2015). The extent of impediments to housing and treatment often depend on where an individual is in his or her recovery, as addiction can cause and prolong homelessness, and homelessness in turn complicates one's ability to engage in treatment. According to the Substance Abuse and Mental Health Services Administration, recovery is a "process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Hogg Foundation for Mental Health, 2015). Once needs are met, rehabilitation is more likely. It is traumatic to have to answer daily such basic questions as "Where will I sleep tonight?" and "When will I be able to eat again?" It is not surprising that people living in homelessness have extreme difficulty achieving stability.

The interconnected nature of homelessness, mental illness, and incarceration has a lot to do with the social determinants of health perspective. For example, it has been stated that the criminality of homelessness resides not in its commission, but in the context in which it is committed. Homeless individuals are frequently arrested for minor crimes directly related to their housing status, acts that some may describe as attempts to acquire shelter, food, or medical assistance (Snow, Baker, & Anderson, 1989). In fact, the majority of justice system interactions for the homeless population are for non-violent offenses that do not warrant incarceration. An ongoing national study conducted since 2010 has found that the three main offenses for which homeless individuals are cited and arrested include sleeping in public, sitting and/or lying down, and loitering (Western Regional Advocacy Project, 2015). Survey data derived from U.S. local jails, as well as adult state and federal prisons, found that incarcerated individuals flagged as homeless were significantly more likely than others to be incarcerated for a property crime, not a drug-related or violent crime (Greenberg & Rosenheck, 2008a; Greenberg & Rosenheck, 2008b). Upon their release, formerly incarcerated individuals experience obstacles to employment,

housing, medical treatment, and financial security, all of which impact their mental and physical well-being. The challenge of achieving stability is profound for this population, as the stigma of incarceration compounds established stigmas associated with mental health and homelessness.

Methodology

This PR seeks to examine the effectiveness of evidence-based diversion strategies used to keep homeless individuals from cycling in and out of correctional settings and unnecessary hospitalizations, in both general and psychiatric settings. This project seeks to answer the following questions: (1) What are the common principles that evidence-based diversion strategies share? (2) How are autonomy and paternalism balanced with regards to intervening with homeless individuals with mental illness? (3) What evidence is there to support one strategy over another in an integrated community response? (4) Where does diversion take place along a continuum of intercept points? And, (5) How do diversion strategies used nationwide compare to what is being utilized in Austin and Travis County? As a community, we have an ethical and moral responsibility to support homeless individuals suffering with mental illness who may require additional support. This project seeks to determine the most effective ways to meet this obligation.

Individuals experiencing homelessness may be diverted from shelter use or relocated altogether and reunited with familiar support systems if the move will end their homelessness. Diversion may also be used as a rapid resolution that takes place after an individual has been incarcerated or hospitalized as a means of shortening the number of days spent in crises settings. For the purpose of this project, only diversion strategies that occurred prior to crises system interactions were considered. Research was aimed toward homeless individuals flagged as 'chronic,' as these individuals often suffer from complex and long-term health conditions and are those least likely to seek assistance autonomously. Information pertaining to individuals flagged as 'veteran,' 'families with children, and/or 'unaccompanied youth' were excluded due to homogeneous programs and initiatives already targeting these populations. Similarly, research

related to homeless individuals who receive Medicare or Medicaid was excluded, as it could potentially silo the focus of the project.

Evidence was collected from online databases, library resources, websites of national organizations and coalitions, and personal interviews with experts in the field. Data and information particular to Austin and Travis County were derived from agencies, government departments, and nonprofit organizations whose aim is to improve service delivery for individuals experiencing homelessness. Key words used throughout the research process included diversion and/or intervention, mental health, homeless, incarceration and/or jail and/or prison, and hospital and/or emergency. Additional search words used early in the process included trauma, doctor, redirection, and treatment. The bulk of research was completed in 2019 from January to April, with additional information incorporated in subsequent months.

Call for Diversion

Former New York City governor Mario Cuomo once stated that efforts to estimate homelessness were equivalent to "counting the uncountable" (Rossi, 1989). National estimates are primarily collected with point-in-time (PIT) counts, unduplicated one-night estimates of both sheltered and unsheltered homeless populations conducted annually nationwide in the last week of January. This data collection tool, although thorough in its geographic implementation, yields insufficient and inaccurate data. Individuals sleeping in public spaces that are not easily observable, clients in hospital settings and mental health or substance use treatment centers, and individuals currently incarcerated are all left out of the count. Individuals residing in Puerto Rico and other U.S. territories are excluded as well (National Law Center on Homelessness & Poverty, 2017). For these reasons, on a national level, the extent of homelessness, and subpopulations therein, is arguably unknowable. As a result, the need for effective intervention and diversion cannot be fully gauged.

According to the Cambridge American Dictionary, 'diversion' is defined as "the act of causing something or someone to turn in a different direction, or to be used for a different purpose" (n.d.). The concept of psychological inertia states that once we are moving in the direction of friction, conflict, and noncompliance, we tend to keep going in that direction (Dowd, 2018). Emotional conflict in these heightened states reduces one's ability for abstract thought which is an essential component of problem solving and empathy (Gorton, 2005). Without diversion, this reduction in functioning can lead to adverse outcomes for homeless individuals with mental illness. Individuals experiencing homelessness pay more attention to nonverbal cues, including body language, vocal inflection, and volume. Furthermore, they tend to value relationships more than their domiciled counterparts as they often view relationships as currency

in the face of lacking financial currency. Considering the increased prevalence of trauma among this population, coupled with an increased risk of present danger, oftentimes homeless individuals are more on alert. This may present itself as being argumentative, hostile, or simply distrusting (Dowd, 2018). Although diversion tactics are important for *all* individuals experiencing homelessness, those with mental illness possess unique service requirements that tend to get overshadowed if they are not separated out as a special consideration (Bhugra, 1996).

Deinstitutionalization that took place in the 1960s and 70s is often blamed as a contributing factor for the increase in homelessness in the United States. Despite a dearth of research data to support this claim, researchers agree that the aggressive discharge and restricted admission of clients placed far more attention to where a mentally ill person would live than to what specific clinical and supportive services they would receive (Bhugra, 1996). It embodies the concept of an institutional shift; individuals were moved out of state and county mental health institutions and into correctional institutions and other settings where they do not receive the treatment they need to stabilize and function. When fixed costs of state hospitals remained high, and funds couldn't be redirected to create adequate community services, state governments declined responsibility for the care of those clients who had been discharged (Stuart, 2016). Richard Troxell, Director of Legal Aid for the Homeless, describes it as a period when the courts flung open the doors of mental health institutions, forcing people with very serious mental health concerns to the streets. He argues that the current social safety net has been shredded and the flow of social service dollars has dwindled to a trickle, where only the most severely afflicted find help (2010). Yet, even this is a rarity. Community based mental health services should give homeless men and women an avenue whereby they can maintain themselves and their condition.

Without them, the revolving door between homelessness, incarceration, and hospitalization will not cease.

Homelessness is a vortex of varying needs, conditions, and service availability wherein barriers to housing and treatment often depend on where an individual is in their recovery. Successful diversion may employ a recovery-oriented approach, with consumer choice and shared decision making as the foundation on top of which all other work is approached. Principles of recovery that apply to homeless services, including diversion, consist of consumer choice, empowerment rather than control, strengths-based rather than pathology-based orientation, peer support, personal responsibility, and hope for the future (Gillis, Dickerson, & Hanson, 2010). If clients feel that their unique treatment goals dictate decision making, they are more likely to remain engaged, even during moments of crisis that necessitate diversion. For diversion to be successful, those who perform it must be deemed legitimate by the clients they aim to assist. This is accomplished by making clients feel that they are listened to, making the rules predictable and consistent, and being fair as an enforcer (Dowd, 2018). It is person-centered care wherein individuals have the power to make decisions, exert control over their lives, and determine their futures. This is juxtaposed with paternalism; the act of interfering in another's autonomy in order to advance or protect an individual's welfare. Although personal choice should take precedence, rehabilitation models utilize a social control function that could be viewed as paternalistic in nature. This enables those that engage in diversion strategies the ability to vouch for an individual, keep an eye on things, and provide assistance if needed (Rosenheck, 2010). How autonomy and paternalism are balanced is key to successful diversion.

Medical Crisis Systems Utilization

Compared to the general population, individuals experiencing homelessness have higher rates of acute and chronic health conditions due, in part, to barriers to accessing appropriate healthcare. These may include stigma, discrimination, service unavailability, and fragmentation (Stergiopoulos et al., 2018). Restrictions present within a healthcare system on how and to whom care is delivered can lead to hopelessness, distrust, misuse of emergency services, and self-medication (National Health Care for the Homeless Council, 2017). The deinstitutionalization movement and continued funding cuts from public mental health systems have left more individuals struggling with mental illness to fend for themselves. As a result, medical crisis systems such as hospitals and emergency rooms are left to pick up the slack.

For individuals experiencing homelessness, adhering to treatment regimens can be a difficult task. For example, taking medications at certain hours may rely on the presence of available drinking water and/or food with which to take one's medications. That is if the medications were able to be obtained in the first place and kept safe from theft or loss (Hayashi, 2016). Research shows that homeless individuals are nearly four times more likely to be readmitted to a hospital within thirty days of release than their peers who were matched for age, sex, and clinical acuity (Saab, Nisenbaum, Dhalla, & Hwang, 2016). When counting the number of days spent in the hospital, a study conducted in Honolulu found that individuals experiencing homelessness had a hospitalization rate 740 percent greater than their peers who were not homeless (Martell et al., 1992). Another study conducted in New York City found homeless individuals to have a 170 percent greater cost per hospital day and an average stay 4.1 days longer than their domiciled counterparts (Salit, Kuhn, Hartz, Vu, & Mosso, 1998).

Emergency departments (ED) have been referenced as a place where clients end up when preventative care fails (Stewart, 2014). As emergency rooms (ER) are unable to turn clients away, high utilizers present a unique challenge to clinicians, hospital administration, and Emergency Medical Services, by way of significant economic, time, and space burdens. Homelessness has been found to increase both ED and inpatient visits for a number of reasons, including higher comorbidity rates (Saab, Nisenbaum, Dhalla, & Hwang, 2016). Research shows that clients who come to EDs more than three times per year account for roughly seven percent of total ED users, are often in poor physical and mental health, and often come there for treatment of acute medical needs (DiPietro, Kindermann, & Schenkel, 2012). According to federal data, the rate of ER visits involving psychoses, bipolar disorder, depression or anxiety jumped more than 50 percent from 2006 to 2013. During that time, roughly 1 in 8 ED visits stemmed from mental illness or substance use disorder for all clients, not just those experiencing homelessness (Gorman, 2019). A study conducted in Boston found that approximately 6,500 individuals experiencing homelessness cost the state of Massachusetts health care system sixteen million a year in emergency room utilization, roughly $2,500 per person (Bharel et al., 2013).

Despite these studies, data concerning medical crisis system utilization by individuals experiencing homelessness is not thorough. Homeless clients may list an address of a shelter, acquaintance, or even a fabricated address as their primary residence or medical staff may rely on subjective interpretation of homelessness (Feldman et al., 2016). This means that clients experiencing homelessness may not be identified as such and that rates of medical crisis system utilization may be higher than what the research shows. Additional challenges of effective diversion from medical crisis systems include identification of potential candidates and funding.

It is difficult to estimate long term outcomes (i.e., how much cost savings a current investment produce will produce).

DIVERSION STRATEGIES

In the medical arena, evidence-based diversion strategies for homeless individuals with mental illness include psychiatric emergency units, crisis units, outreach, and assertive community treatment (ACT).

Psychiatric emergency units

Psychiatric emergency units were designed to stabilize and treat psychiatric clients, connect them to long-term care and resources, and address the growing number of clients with mental health conditions who end up hospitalized or frequenting the ER. Dr. Scott Zeller, former President of the American Association for Emergency Psychiatry, argues that 80 percent of the time clients' mental health crises should be able to be resolved without a costly inpatient hospital stay. Presenting issues such as drug-induced behavior or medication management can be tackled by psychiatric emergency staff, including nurses, social workers, and psychiatrists on a walk-in basis (Gorman, 2019). After a certain amount of time, generally 24 hours, clients will be discharged to the community, transferred to an inpatient facility, or transferred to a respite facility where they may continue to stabilize. One study found that transferring clients from general hospitals to regional psychiatric emergency units reduced the length of time clients awaited psychiatric care by over 80 percent. Additionally, the assessment and treatment provided by psychiatric emergency units were able to stabilize over 75 percent of crises encountered and three-quarters of clients treated were able to be discharged to the community rather than inpatient care (Zeller, Calma, & Stone, 2014). Although treatment of mental health symptoms is

preferable on an ongoing basis, it is important there remain options for crisis point interactions to serve as a diversion from unnecessary hospitalization.

Crisis units

Crisis Respite Unit

Crisis respite units provide short-term, community-based, crisis support by helping an individual stabilize, resolve problems, connect with ongoing support systems, and recover from a mental health crisis. These units are backed by over 40 years of research that support their effectiveness and value, in part due to their home-like environment (TBD Solutions, 2018). Services may be provided in houses, apartments, or other community living arrangements and typically occur over a relatively brief period of time, generally seven or fewer days. Respite units are the least restrictive crisis unit and clients include individuals who are at low risk of harm to self or others and who may have a functional impairment that requires limited supervision and care. For example, individuals should be able perform their own activities of daily living and administer their own medications (Texas Health and Human Services Commission, 2017a). According to the Texas Health and Human Services Commission, respite facilities generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for persons under their care whom they believe are at risk of a mental health crisis (2017a).

Crisis Residential Unit

Crisis residential units are similar to respite units with the exception of one distinct difference – a client must have a mental health provider's determination for admission to a crisis residential unit (Texas Health and Human Services, 2019a). Services may include physical and psychiatric assessments, daily living skills training, social activities, medication management,

counseling, treatment planning, and referrals to community resources. These units may serve as step-down settings from general hospitalization, as they are smaller facilities for individuals whose needs may not be suitable for emergency settings (National Alliance on Mental Illness, 2015). Typically, facilities do not exceed sixteen beds and the average stay is between three and seven days. Clients include individuals who pose some risk of harm to self or others and who may have fairly severe functional impairment. Despite their presenting condition, a client may come and go at will. An individual crisis treatment plan is developed for each client and psychosocial programming is provided if deemed medically necessary. Program topics may include problem-solving, communication skills, anger management, community re-integration skills, as well as co-occurring psychiatric and substance use diagnosis issues. Staff are on site at all times to provide the most effective, but least restrictive, treatment possible (Texas Health and Human Services Commission, 2017a).

Extended Observation Unit

Extended observation units (EOUs), sometimes referred to as '23-hour beds,' may act as a stand-alone service or one embedded within a crisis stabilization unit (National Alliance on Mental Illness, 2015). Individuals who are at high risk of harm to self or others are treated in EOUs because they are secure and safe. In addition, professional staff are on site 24/7 to provide counseling, medication, and psychiatric care (Texas Health and Human Services, 2019a; Texas Health and Human Services Commission, 2017a). Individuals may be admitted to an EOU under voluntary or involuntary status for up to 48 hours with the following goals: prompt and comprehensive assessment, prompt crisis stabilization, crisis resolution, linkage to appropriate services, and reduced inpatient and law enforcement interactions. If deemed medically necessary, individuals are provided coordinated transfer to a facility with a higher level of care (Texas

Health and Human Services Commission, 2017a). Evaluation research has shown that EOUs are effective in diverting individuals from psychiatric hospitalization, reducing health care costs, and improving treatment outcomes (Saxon, Mukherjee, &Thomas, 2018).

Crisis Stabilization Unit

Crisis stabilization units are for clients who need more acute care as they are designed to treat symptoms of mental illness for those who are at high risk of admission to a psychiatric hospital. These units are small inpatient facilities, similar to EOUs, where counseling and medication are provided in a secure and safe environment for up to 14 days (Texas Health and Human Services, 2019a). According to the National Alliance on Mental Illness, these units hold up to 16 beds, may be designed to admit on a voluntary or involuntary basis, and try to stabilize an individual in crisis and return them to the community as quickly as possible (2019a). Services may include assessment, diagnosis, treatment planning, observation, case management, individual and group counseling, prescribing and monitoring of medication, referral, and linkage to community resources.

Outreach

The Relational and Engagement Model is based on the premise that life has a profoundly relational character. This implies that outreach is not whether one can establish a relationship with another, but rather how any given relationship will develop and take shape from moment to moment over time (Kraybill, 2002). Outreach has been described as client engagement outside the traditional office setting; networking to identify clients and get in contact with them; meeting clients where they are and on their own terms; and simply finding people, assessing their needs, and connecting them with services (National Health Care for the Homeless Council, 2013). Successful diversion, in large part, relies upon outreach, both fixed site and mobile, at both the

community level and the individual client level. Outreach is the relational approach to linking individuals to care, as the more general processes by which people come into care, including referral, appointment, walk-in, screening, intake, etc., have not proven successful in leading to treatment (Kraybill, 2002). Ideally, outreach would help an individual move forward and achieve greater health and personal stability by linking them to services and resources in their community. Effective outreach is conducted patiently, building trust and establishing rapport with individuals in order to engage them on their own timeframe. As such, it is capable of acting as both a preventative measure of diversion and an active measure when diversion is necessary.

An important component of outreach, when working with individuals experiencing homelessness, involves enrolling clients in public benefits, including Medicaid, Medicare, Supplemental Nutrition Assistance Program, Supplemental Security Income, and Social Security Disability. Challenges in the enrollment process may include obtaining necessary forms of identification, maintaining the safety of necessary documents from loss or theft, filling out and submitting an application, providing follow-up contact information, and obtaining verified proof of mental illness. An outreach worker is crucial during this proceeding and is essential in building community partnerships in order to provide clients with a comprehensive offering of services in the community. Agency partners may include faith-based organizations and churches, hospitals, jails, mental health providers, healthcare clinics, law enforcement agencies, courts, food pantries, prepared meal sites, shelters, community centers, libraries, and day centers (National Healthcare for the Homeless Council, 2014). By acting as a bridge, outreach workers are able to link clients to resources and opportunities for ongoing treatment of physical and mental health concerns. Nationwide, medical outreach has taken on different forms in the effort to divert clients from unnecessary hospitalization.

Health Care for the Homeless

Health Care for the Homeless (HCH) was designed in the mid-1980s with the aim to break the psychological and systemic barriers to care faced by individuals experiencing homelessness. This is achieved by providing care in a comprehensive, yet flexible, manner. HCH provides primary health care; substance abuse treatment; case management services; services that enable individuals to utilize amenities of the health center, including outreach, transportation, and translation services; and education of clients regarding the availability and proper use of health services (National Health Care for the Homeless Council, 2011). Outreach through HCH provides a medical alternative for individuals who may be more difficult to reach or those who have a hard time maintaining appointments. In addition to healthcare, HCH programs establish eligibility with public benefit enrollment as well as housing through thorough assessment for substance use, mental illness, housing, criminal justice involvement, social supports, employment interests, work history, and client goals (Kraybill, 2002).

Street Medicine

Street medicine is the provision of health care directly to unsheltered individuals experiencing homelessness on the streets by way of outreach workers and ad hoc outdoor clinics (Street Medicine Institute, 2018). Created in the mid-1980s, the field of street medicine now resides in over 85 cities and 15 countries. Currently it is present in over 20 states and no less than 45 cities in the United States, including New York, Chicago, Los Angeles, Detroit, and Washington, D.C. Pittsburgh held the first street medicine symposium in 2005 and the Street Medicine Institute was created in 2009 with the mission to inspire and equip communities worldwide to provide Street Medicine services to 'rough-sleeping' homeless persons (Montgomery, 2018; Street Medicine Institute, 2018). Taking into account the social

determinants of health perspective, unsheltered homeless individuals may be at a greater risk for negative health outcomes, including higher prevalence of disease, physical abuse, and poor hygiene. Unlike stationed health care clinics, street medicine practitioners seek out their clients in campsites, under bridges, in watersheds, and other places not meant for human inhabitation. Upon their encounter, street medicine clinicians connect individuals with follow-up appointments and shelter opportunities, but the connection doesn't stop with a warm hand-off. It is a humanizing way of providing medical treatment that provides hope and dignity, things that individuals experiencing homelessness may not be accustomed to seeing in medical settings (Montgomery, 2018). Advice from the Colorado Coalition for the Homeless for other programs wishing to implement street medicine is for staff to be flexible, take time building relationships, and have the patience to learn the unique needs of each individual encountered (Health Outreach Partners, 2015).

Mobile Crisis Outreach Teams

Mobile crisis outreach teams, referred to as MCOTs, provide face-to-face assistance to individuals who are at risk of harm to self or others through counseling services in a site of the client's choosing. This service is available to all ages 24/7, 365 days a year (Shafer & Ashford, 2015). MCOTs provide a combination of crisis services including emergency care, urgent care, and crisis follow up and relapse prevention to ensure the safety of the individual and others who may be placed at risk by the individual's behavior. Interventions include, but are not limited to, psychiatric evaluation, administration of medications, hospitalization, stabilization, and resolution of the crisis. At a minimum, standards recommend an MCOT team in an urban environment should include a physician, preferably a psychiatrist, an advance practice nurse, a registered nurse, and a physician assistant or a licensed practitioner of the healing arts (Texas

Health and Human Services Commission, 2017a). Through prompt assessment and evaluation, MCOTs serve as an alternative to unnecessary psychiatric hospitalization by ensuring that the client remains in the community and is connected with physical and/or mental health services.

Assertive Community Treatment

Assertive Community Treatment (ACT), often referred to as Intensive Case Management (ICM), was developed at Mendota State hospital in Madison, Wisconsin in the early 1970s in response to the deinstitutionalization movement (Solomon, 2015). ACT teams serve individuals with severe mental illness who tend not to utilize local community health centers, are prone to frequent relapses and hospitalizations, and have psychosocial impairment (Essock et al., 2006). ACT teams may also be beneficial for individuals experiencing substance use disorder or those with criminal justice involvement. ACT clients are individuals who have been more costly to the system because they have entered the mental health system at crisis points rather than engaging with services on an ongoing basis.

ACT teams provide individualized comprehensive mental health services including assessment, treatment, support services, and rehabilitation (Morrissey, Meyer, & Cuddeback, 2007). Teams are minimally comprised of a psychiatrist, registered nurse, clinician, and a case manager, with additional professionals with greater specialization added if necessary. Evidence-based practices are able to be merged into ACT services, including cognitive behavioral treatment, individual placement and support, supported employment programs, and illness management and recovery. When compared to standard clinical case management, ACT has a lower staff-to-client ratio, delivers the majority of services in the community rather than a clinic, incorporates shared caseloads, adopts 24-hour responsibility for clients, and provides services directly to clients in a setting of their choosing (Solomon, 2015). Services are provided without a

time limit, which has been argued as unsustainable because when teams reach their capacity, they are unable to take on new clients in need. If necessary, research has shown that transferring clients in a highly planned manner poses limited to no negative consequences, as long as clients understand they may return to ACT if deemed clinically necessary (Solomon, 2015).

It is estimated that ACT is the service of choice for 20 percent of individuals with a severe mental illness (Schmidt, Pinninti, Garfinkle, & Solomon, 2013). When compared to other case management models, studies have found that ACT produces a reduction in hospitalization and length of stay when clients are hospitalized, a decreased use of homelessness and crisis services, high degrees of client satisfaction, and an increased client engagement with services (Solomon, 2015). ACT interventions, while successful at reducing psychiatric hospitalization rates and improving housing stability, were not shown to be effective at reducing arrest or incarceration rates (Abracen, Gallo, Looman, & Goodwill, 2016). Furthermore, the cost effectiveness of the ACT model has not been determined within communities with established mental health systems of care and hospital use (Dieterich, Irving, Park, & Marshall, 2011).

Criminal Justice System Involvement

Individuals with mental illness, who might have previously been treated in psychiatric facilities, are now being housed and treated in jails and prisons. Many individuals, who receive inadequate mental health care and face additional victimization while incarcerated, end up leaving jail or prison in a worse state than when they went in (Torrey et al., 2014). Individuals experiencing homelessness are eleven times more likely to face incarceration when compared to the general population (National Law Center on Homelessness & Poverty, 2018). Furthermore, formerly incarcerated individuals are almost ten times more likely to be homeless than the general public with an estimated 50,000 formerly incarcerated individuals entering shelters upon their release each year (Couloute, 2018; United States Interagency Council on Homelessness, 2016). Individuals experiencing homelessness are more prone to arrests and incarceration for misdemeanors and other crimes, in part due to their marginalization, socioeconomic status, and the public nature of their day to day lives spent on the streets (Metraux & Culhane, 2006).

Homelessness often serves as a link between mental illness and criminal behavior; once an individual enters homelessness, the chances of being overlooked by the mental health system or becoming ensnared in the criminal justice system are greatly increased (Bhugra, 1996). In 2005, more than half of men and three-quarters of women held in jails and prisons had been officially diagnosed with a mental health disorder or met the criteria for a mental health disorder under standardized psychiatric measures. Of these men and women, nearly three-quarters also met criteria for a substance use disorder (James & Glaze, 2006). Even short stints in correctional facilities can be detrimental to an individual with mental illness by way of loss of contact with medical providers; limited access to medications, if the correctional facility is able to acquire the correct medication in the first place; and loss of housing and financial stability.

Psychologists label most homeless individuals with previous criminal justice involvement as 'habituated to punishment,' meaning they have experienced so much punishment that the threat of more, or actual incarceration, no longer serves as a deterrent to criminal behavior (Dowd, 2018). Diversion of homeless individuals with mental illness from correctional settings is necessary and has the potential to change an individual's behavior, reduce re-arrests, decrease the number of days spent in jail, lessen substance use and psychiatric symptoms, and minimize criminal justice expenditures (HCH Clinicians' Network, 2004). Diversion enhances public safety by increasing the focus on more serious offenders, keeping court dockets from becoming too large, saving the courts time, and reducing prison overcrowding (Mental Health America, 2018).

DIVERSION STRATEGIES

Diversion of mentally ill individuals experiencing homelessness from the criminal justice system occurs along a continuum (i.e., before formal charges are filed, and after). Diversion tactics that occur before charges are filed primarily involve efforts from local law enforcement. Those that take place after charges have been filed occur in the court system and are championed by forensic assertive community treatment (FACT) teams.

Law enforcement

The rate of mental illness present in correctional settings is directly impacted by the rate at which individuals with mental illness are arrested by law enforcement agencies. Law enforcement discretion is contingent on how officers read situations, interpret citizen actions, and formulate their response in light of what is expected and 'normal' in a given situation (Stuart, 2016). Without proper training in how to effectively respond to mental health crises, officers may perceive calls involving a mental health crisis as unpredictable and dangerous. Without

training in de-escalation and mental health symptom recognition, officers may inadvertently approach a crisis in a manner that only makes it worse (Ruiz & Miller, 2004). When engaging with homeless individuals with mental illness, law enforcement should act as a negotiating tool to aid individuals in avoiding incarceration at all cost.

There is a distinction between officers who act as enforcers versus those who act as empowering collaborators. 'Therapeutic policing,' a form of enforcement wherein officers use coercive ultimatums – enter a treatment center or go to jail – does more harm than good. This is because the options of self-improvement and new behavior are incongruent with the unique biography of an individual and the social organization from which they come (Stuart, 2016). Punishment-driven enforcement has been shown to be less effective with people with mental illness; individuals under the influence of substances or alcohol; and those who are habituated to punishment, highly traumatized, and emotionally overwhelmed. Empathy-driven enforcement, on the other hand, relies upon principles of empathy rather than consequences that stem from noncompliance (Dowd, 2018). Although there may be hindrances of the position to establishing relationships, law enforcement officers can strengthen their knowledge of local resource availability, diversion programs, and substance use treatment options in order to effectively divert an individual from unnecessary incarceration. Training elements, implementation, and follow up are essential components of effective diversion and should include discussions of mental health, de-escalation, redirection, and empathy.

One diversion tactic that law enforcement may use if necessary, in place of incarceration or psychiatric hospitalization, is placing an individual on an emergency detention. With respect to an individual's autonomy, this tactic may be seen as a way of restricting someone's freedom for their own safety, but it is intended to be used as a last resort. The main criteria for the

detention of a mentally ill individual, homeless or not, with or without a warrant, are that the individual must present as an imminent and substantial risk to themselves or others. If a law enforcement officer believes this to be true, they will transport the individual to a psychiatric facility for further evaluation rather than arrest them (Travis County, 2019). According to Texas' Health and Safety Code, an appropriate facility is either the nearest inpatient mental health facility, a mental health facility deemed suitable by the local mental health authority, or an emergency medical services provider (1999). Upon arrival, the facility will conduct a thorough evaluation of the individual within 48 hours and will either issue a physician's certificate for mental illness, indicating a need for further detention, or they will discharge the client unless another arrangement is made (Texas Department of Family and Protective Services, 2019; Travis County, 2019).

Crisis Intervention Team

The Crisis Intervention Team (CIT), often referred to as the "Memphis Model," is a first responder model of police-based crisis intervention where specialty trained law enforcement officers respond to emergencies involving individuals with mental illness, many of whom are homeless. Implemented nearly thirty years ago, CIT has proven to be an effective diversionary practice that has spread to over 2,700 communities nationwide (National Alliance on Mental Illness, 2019b). CIT officers voluntarily receive forty hours of specialized training provided by mental health clinicians, consumer and family advocates, and police trainers. Curriculum content includes signs and symptoms of mental illness, mental health treatment, co-occurring disorders, legal issues, and de-escalation techniques. Curriculum may also include information pertaining to developmental disabilities, trauma, and excited delirium (Watson & Fulambarker, 2012). Critical elements necessary for an effective CIT include knowledgeable call dispatchers and a

designated psychiatric emergency drop-off where an officer may transport an individual. A no refusal policy in place at this drop-off site allows an officer to get back out on the road as quickly as possible and ensures that the individual previously in custody receives treatment. Challenges with CIT include the need for ongoing collaboration and buy-in from local psychiatric emergency services; as well as training dispatch personnel to identify and appropriately assign mental health related calls to CIT, especially if emergency communications are a separate agency from the police department that CIT is operating out of (Watson & Fulambarker, 2012).

According to the National Alliance on Mental Illness, CIT programs give police officers more tools to do their job safely and effectively; keep law enforcement's focus on crime; produce cost savings; and create connections between law enforcement, mental health providers, hospital emergency services, and individuals with mental illness and their families (2019b). When compared to other police-based diversion models, CIT was found to have high utilization rates, rapid response time, frequent referrals to treatment, and the lowest arrest rate (Center for Prison Reform, 2015). In Memphis where the program was piloted, CIT resulted in an 80% reduction of officer injuries during a mental health crisis due to the increased knowledge and training they received regarding effective engagement (National Alliance on Mental Illness, 2019b). CIT is a successful diversion strategy that avoids unnecessary incarceration by reducing arrests and increasing the use of appropriate treatment in the community.

Courts

In the court system, diversion strategies that take place after charges have been filed occur in limited jurisdiction courts such as municipal court and problem-solving courts. Problem-solving courts are comprised of homeless courts, community courts, and mental health courts. In these settings, judges and other court personnel have an opportunity to divert homeless

individuals with mental illness away from correctional settings into mental health and/or substance use treatment. The Constitution requires cities provide alternatives to incarceration for fine-only offenses for indigent defendants and prohibits a court from committing an indigent defendant to jail for inability to pay (Office of the City Auditor, 2016).

Judges

Judges have options when it comes to diversion from incarceration. For individuals experiencing homelessness, who may or may not have a mental illness, judges may prescribe a deferred sentence if an individual completes mandatory programs and stays away from further justice system involvement. Rehabilitative programming, meant to remove individuals from the typical channels of the criminal justice system, may include work release programs, sober living environments, day reporting centers, restorative justice, or probation supervision (Young & De Jong). A consideration must be made regarding the unique approach a judge takes with those who enter their courtroom. This includes how that approach has been shaped by the judges' background and any extra training they may or may not have received relevant to those they encounter. A judge who works with individuals experiencing homelessness, as well as individuals with mental illness, should understand the barriers in place for these populations. Furthermore, a judge should recognize the unique circumstances that may have brought an individual before them and tailor their decision accordingly.

Municipal Court

Municipal courts are courts of limited jurisdiction, which means their authority resides over specific subject matter, cases, or individuals brought before them. This is in contrast with courts of general or 'original' jurisdiction who may hear any type of case (Substance Abuse and Mental Health Services Administration, 2015). Less serious charges are often handled in

municipal courts which make them an attractive venue for diversion. Essential elements of effective diversion at the court level include identification and screening, including pre-trial services to assess for bail risk. Bail risk factors include a lack of employment, lack of personal relationships, and lack of an address. These factors serve as red flags, prompting the identification of individuals best suited for diversion (Substance Abuse and Mental Health Services Administration, 2015). With this in mind, diversion may be more tenable for certain populations, like homeless individuals with mental illness, as these individuals will only return to the streets upon their release from jail or prison. Municipal courts that implement identification and screening, recovery-based engagement, a court-based clinician, and proportional response are in the best position to minimize criminal justice involvement, reduce unnecessary incarceration, and facilitate engagement in mental health and substance use services (Substance Abuse and Mental Health Services Administration, 2015).

Municipal courts are "fine only" courts, which means they cannot require that a defendant pay out a fine with jailtime if there is a demonstrated inability to pay. In response, the court must consider payment plans and alternative courses of action (Lovett, 1996). Challenges present in diversion efforts at the court level include the volume of cases, lack of leverage over an individual, and the brief time available to address complex individual needs (Substance Abuse and Mental Health Services Administration, 2015). Actors involved at the court level include a prosecutor, a defense counsel, court-based clinicians, the judge and court staff, and often a court liaison. Prosecutors often have an option of not filing charges so that diversion may take place. This may look like an agreement with court-based clinicians where an intake and assessment take place and a stable contact provided for follow-up (Substance Abuse and Mental Health Services Administration, 2015). Court-based clinicians act as an added screening capacity that

follows the initial screening conducted by the defense counsel. These clinicians are tasked with determining clinical eligibility and treatment needs. Despite their lack of clinical training, judges and court staff can identify potential diversion candidates by becoming familiar with repeat offenders, their circumstances, and their behavioral health needs (Substance Abuse and Mental Health Services Administration, 2015). Court liaisons serve as "boundary spanners," connecting the court system with the local mental health authority. These individuals facilitate referral of clients to treatment providers, obtain court required status reports and documentation, and enhance collaboration and coordination between systems (Shafer, & Ashford, 2015).

Problem-Solving Courts

Even if a homeless individual has a municipal court charge, many municipal courts will decide to redirect that individual to a problem-solving court. These are smaller auxiliary courts that may be better suited to the unique needs of an individual and include Homeless Courts, Community Courts, and Mental Health Courts. Individuals are referred to one of these courts either through arraignment or on a walk-in basis, dependent on what the judge decides.

Thirteen states currently operate homeless courts within their jurisdiction to provide court sessions for homeless defendants to resolve outstanding offenses and warrants (National Center for State Courts, 2019b). The goal is to help participants navigate their legal matters while promoting self-sufficiency. According to the American Bar Association, the Court recognizes a participant who stands before the Homeless Court as a human being who has struggled through hard times and is making an effort to overcome hardship (2006). Since their inception in 1989, homeless courts have worked closely with community shelters and other housing agencies to coordinate efforts with local attorneys and the court. Each jurisdiction in which a homeless court

operates has their own eligibility criteria and alternative courses of action at their disposal, including, but not limited to, community service and residential treatment centers (Lopez, 2017).

A community court is a problem-solving court that addresses quality of life cases with an intent to improve public safety (National Center for State Courts, 2019a). The first community court, Midtown Community Court, was established in 1993 in New York City to work with community members to tailor creative responses to local concerns, reinvigorate public trust in justice, reduce the use of incarceration, and forge new responses to minor offending (Center for Court Innovation, 2019). Research on the implementation and early effects of Midtown over its first 18 months found the project impacted the types of sentences handed out at arraignment, more than doubling the frequency of community service and social service sentences (Sviridoff, Rottman, Ostrom, & Curtis, 1997). Community courts are holistic and therapeutic, and as such, they are designed to rehabilitate individuals rather than incarcerate them.

The cornerstones of mental health courts are the treatment of illness, public health, and harm reduction. Although the eligible types of charges and diagnoses may vary by jurisdiction, all mental health courts utilize a problem-solving model with an emphasis on linking defendants to effective treatment and supports (Almquist & Dodd, 2009). Mental health courts often limit their caseloads to individuals with misdemeanors or felonies not involving physical harm to others, and participants are identified through mental health screening and assessments (Substance Abuse and Mental Health Services Administration, 2015). Participants voluntarily engage in a judicially supervised treatment plan developed by court staff and mental health professionals, and the court team often uses individualized incentives and sanctions tailored to an individual's specific circumstances (Almquist & Dodd, 2009). There are more than 150 mental

health courts operating in the U.S. today that have effectively diverted persons charged with non-violent crimes away from correctional settings (Bureau of Justice Assistance, 2019).

Forensic Assertive Community Treatment

Forensic Assertive Community Treatment (FACT) was designed to serve justice-involved adults with serious mental illness. An adaptation of the assertive community treatment model, FACT was developed in response to the inefficiency of ACT teams in reducing arrest or incarceration rates. Like ACT, FACT has key guiding principles, including but not limited to, a multidisciplinary staff, determination of an individual's unique needs, time unlimited services, 24/7 accessibility, low consumer to staff ratios, and aid in the improvement of community living skills as a means of reducing unnecessary incarceration (Abracen, Gallo, Looman, & Goodwill, 2015). Although FACT is an extension of ACT, it often does not include the psychiatric element in service provision. Furthermore, providers assist participants in obtaining appropriate services rather than directly providing services (Aos & Drake, 2013; Abracen, Gallo, Looman, & Goodwill, 2015). The FACT model, when compared with treatment as usual, has been found to decrease the number of convictions, reduce the number of days spent in correctional and/or emergency medical settings, and increase the number of days spent in outpatient mental health treatment (Lamberti et al., 2017).

FACT eligible participants include individuals who have been found incompetent to stand trial or have been on an active 'not guilty by reason of insanity' commitment within the past year, as well as individuals who are high utilizers of the criminal justice system for behaviors directly related to their mental illness. FACT engages in diversion prior to arrest as well as after an arrest by providing support and resources to support an individual's recovery and ability to follow through with court proceedings (Integral Care, 2019b). A role specific to FACT

is a forensic specialist or liaison who acts as the key player in partnerships with criminal justice agency representatives, including judges, police officers, and probation and parole officers. This individual is tasked with collaborating with criminal justice officials in identifying treatment options that are recovery oriented and facilitating referrals to other services as needed. This communication does provide the FACT team with some legal leverage over an individual, but FACT services are voluntary and agreed upon in writing in order to maintain client-centered care (Morse & Thumann, 2015).

Diversion Strategies Used for Medical and Criminal

Some diversion strategies work in both the medical and criminal justice arenas. These include supportive housing models, namely Pay for Success and the Frequent Users System Engagement (FUSE) initiative, as well as efforts funded by the Substance Abuse and Mental Health Services Administration (SAMSHA).

SUPPORTIVE HOUSING

Supportive housing, an evidence-based intervention that provides intensive case management to connect individuals with services in their community, is effective for chronically homeless adults who are frequent and costly users of emergency crisis services. This is noted in improved mental and physical health, which in turn decreases the number of arrests, use of emergency service utilization, and need for substance use detox and/or treatment (Cunningham, Pergamit, Gillespie, & Hanson, 2016). By combining affordable housing with comprehensive and client-driven supportive services, supportive housing helps tenants engage in preventative and ongoing health care, hopefully eliminating the need for crisis medical services as a means of addressing health care needs (Corporation for Supportive Housing, 2017). Supportive housing can be used with individuals, youth, and/or families experiencing homelessness, individuals and families at risk of being homeless or institutionalized, and individuals experiencing multiple barriers to independent living (Corporation for Supportive Housing, 2017).

Supportive housing embraces a housing first (HF) approach where individuals and families are connected to housing without preconditions. Created by Pathways to Housing founder, Dr. Tsemberis, HF has high rates of housing retention (85-90%) among subpopulations of the homeless community, including high utilizers. HF does not require that tenants are sober, complete substance use or mental health treatment, or complete service participation

requirements. Rather, it serves as an alternative approach communities have implemented using a harm-reduction model (Corporation for Supportive Housing, 2017). Evidence has shown that the cost associated with the implementation of HF is able to be offset by its benefits, including decreased involvement with correctional and/or medical settings (Perlman & Parvensky, 2006). One program in Seattle that targeted and provided housing for 95 severe alcoholics within the homeless population saw a savings of $4 million by decreased health care costs and jail-related expenses. This program cost less than $14,000 per person per year but total cost offsets for participants averaged $2,449 per person per month after accounting for housing program costs (Larimar et al., 2009). Despite this example of a strong return on investment, finding a funding source for the building of new HF housing structures or the repurposing of older ones remains a challenge for local communities. Research has shown that successful HF models include the following elements: consistent and clear communication between health care and housing providers, comprehensive services that are client-driven, prioritization of the most vulnerable for housing, a streamlined process, a sufficient supply of accessible and affordable housing, systems coordination to support interim housing solutions, and adequate financing (Corporation for Supportive Housing, 2017).

HF relies on the belief that individuals can and will address their challenges once their basic needs are met. This promotes the autonomy of an individual through client-centered care. One element that HF programs often utilize, which walks a fine line between autonomy and paternalism, are representative payees. These are third-party agencies, organizations or institutions who handle client's income and manage their benefits, including the disbursement of funds to pay bills, rent, and meet basic needs (Social Security, 2019). Representative payees are necessary when an individual is unable to take on the responsibilities themselves, often due to

severe mental illness or housing instability. The representative payee program can be used as a way to encourage individuals to develop independent living and money management skills. Additional benefits include an increased ability to meet basic needs; declines in homelessness, victimization, and arrest; and increased adherence to outpatient substance use treatment. Although this intervention has been proven effective, caution should be taken throughout its implementation as it creates risk for improper use, mismanagement of funds, and financial abuse (Appelbaum, Spicer, & Valliere, 2016).

Pay for Success

Pay for Success is a nationwide program that captures the highest utilizers of crisis system interactions, including the court system, correctional institutions, and emergency medical settings. The program is diversionary in that it houses and/or connects participants to services at a quicker rate when compared to individuals not in the program. According to the Nonprofit Finance Fund, Pay for Success is an approach that ties payment for service delivery directly to measurable outcomes to ensure that high-quality and efficient social services are in place for individuals and communities (2018). The program has been utilized in the criminal justice realm as well as early childhood and health related fields. When applied to homelessness, Pay for Success allows for an integrated approach for high utilizers that includes access to housing and supportive services such as mental health and substance use treatment, educational and vocational support, health services, and financial consulting.

Pay for Success involves investors, project managers, transaction coordinators, social service providers, the target population, an independent evaluator, and the back-end payor. Steps involved include: (1) a payor agrees in a contract to provide funding if and when the services achieve a pre-agreed-upon result, determined by an independent evaluator; (2) contracts are

accompanied by financing agreements that provide upfront capital to support delivery of services throughout the project period, usually from private investors; and (3) a back-end or outcomes payor, often the government, repays the private investor when desirable outcomes are achieved (Nonprofit Finance Fund, 2018). The program can be used to report accountability and efficiency through the allocation of resources and funding only when desired outcomes are achieved. According to the Nonprofit Finance Fund, over a dozen Pay for Success projects had been launched and fifty were in development as of 2017 (2018).

The Denver Housing to Health Initiative is one Pay for Success project that provides supportive housing for individuals flagged as frequent users of both criminal justice and emergency medical services in Denver, Colorado. The target population includes individuals experiencing homelessness, substance use disorder, mental health concerns; and individuals who commit low-level offenses such as nuisance violations, panhandling, alcohol and drug use, and trespassing (Cunningham, Pergamit, Gillespie, & Hanson, 2016). Eligible participants were identified by cross referencing arrest data from 2012-2014 with data from the Homeless Management Information System (HMIS) and criminal justice data. Project leaders hoped to find individuals with at least eight arrests over the last three years; who identified as homeless at the time of arrest, verified by data showing they utilized an emergency homeless shelter; and had a certain number of jail days. The aim of the project is to provide 250 supportive housing units, achieved through a mixture of single-site homes in buildings built with low-income housing tax credits and scatter-site units converted to supportive housing (Cunningham, Pergamit, Gillespie, & Hanson, 2016). According to the Urban Institute, these 250 individuals cost the city $7.3 million a year when crisis system interactions were taken into account. Individuals spent, on average, 77 days in jail in the year after they met eligibility requirements, but after they were

housed, 64 percent of participants had no criminal justice interaction. Even though this initiative is in the early stages of evaluation, the housing stability outcomes as of 2017 offer promising evidence that goals will be reached (Cunningham, Pergamit, Gillespie, & Hanson, 2016).

FUSE initiative

The Frequent Users Systems Engagement (FUSE) initiative by the Corporation for Supportive Housing helps communities break the cycle of homelessness and crisis among individuals with complex medical and behavioral health concerns who are high utilizers of crisis services. This is achieved by data-driven problem solving, policy and systems reform, and targeted housing and services to stabilize individuals through supportive housing (Corporation for Supportive Housing, 2019; Aidala, McAllister, Yomogida, & Shubert, 2014). FUSE is used in over thirty communities with the belief that housing instability and homelessness increases the risk for incarceration and unnecessary hospitalization and, conversely, incarceration and hospitalization increase the risk for homelessness. When formally evaluated, FUSE shows reductions in crisis service utilization and improved housing retention (Corporation for Supportive Housing, 2019).

An evaluation of a second-generation FUSE initiative in New York City found that supportive housing significantly improved the lives of 200 individuals who were high utilizers of jails and homeless shelters. This was noted by reduced days spent in jail and/or shelter and a reduction in the use of crisis health services, which ultimately led to significantly lower governmental costs (Aidala, McAllister, Yomogida, & Shubert, 2014). Project participants received permanent supportive housing in a variety of units that were subsidized so that a tenant paid no more than 30 percent of their income or housing allowance on rent. At the 12-month mark, an evaluation showed over 90 percent of participants were housed in permanent housing.

In addition, there was a 40 percent reduction in days incarcerated, lower measures of psychological distress, higher measures of family and social support, increased use of residential treatment facilities, and a decreased use of emergency medical services. Overall, the intervention reduced annual average costs for inpatient and crisis medical and behavioral health systems by $7,300 per individual over a 24-month follow up period. In addition, average total costs for shelter and jail days was reduced by roughly $8,370 per person per 12-month period (Aidala, McAllister, Yomogida, & Shubert, 2014).

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMSHA), a branch of the U.S. Department of Health and Human Services, leads public health efforts to advance the behavioral health of all by reducing the impact of substance abuse and mental illness on communities in the United States (Substance Abuse and Mental Health Services Administration, 2019). SAMSHA has multiple programs that may serve in a diversionary manner, including Cooperative Agreements to Benefit Homeless Individuals (CABHI); Projects for Assistance in Transition from Homelessness (PATH); Grants for the Benefits of Homeless Individuals (GBHI); SSI/SSDI Outreach, Access, and Recovery (SOAR); and Treatment for Individuals Experiencing Homelessness (TIEH). Although funding allocation and how programs play out will vary according to state and local efforts, they have the potential to prevent unnecessary incarceration and/or hospitalization for homeless individuals with mental illness.

CABHI

According to SAMSHA, CABHI programming is intended to aid *chronically homeless individuals with behavioral health issues* locate housing and supportive services through the provision of grant funding. Grants are awarded for up to three years to bolster local efforts in the

delivery of comprehensive behavioral health treatment and recovery-oriented services. These services target individuals with a substance use disorder, serious mental illness, history of emotional disturbance, and/or co-occurring mental and substance use disorder by way of targeted outreach, direct treatment, peer support, and case management (2019b). These services strengthen diversionary practices by equipping individuals with the necessary skills and support to be self-sufficient and healthy.

PATH

PATH grants are distributed annually, in a noncompetitive fashion, to all fifty states in the U.S. as well as the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands. Funds are awarded to local and nonprofit agencies, who serve as PATH providers, under an agreement to adhere to specific requirements (2019d). There are approximately 600 local PATH organizations that engage local mental health authorities and housing programs by connecting with individuals who are largely disconnected from either system. This is accomplished through partnerships with Housing First and Permanent Supportive Housing programs; provision of flexible client-centered recovery-oriented services; improved access to public benefits such as SSI/SSDI; and collaboration with medical providers to develop an integrated approach to mental health and physical health services while improving access to employment opportunities (Substance Abuse and Mental Health Services Administration, 2013). PATH provides services to individuals experiencing homelessness with a serious mental illness including outreach, screening and diagnostic treatment, substance use treatment, referrals for primary care, employment training, educational services, and housing services. In 2017 alone, PATH funding enabled contact with 139,515 individuals and provided services for 73,246 eligible clients (Substance Abuse and Mental Health Services

Administration, 2019d). These services may have played a key role in the avoidance of unnecessary incarceration or hospitalization, whether contacts were PATH eligible or not.

GBHI

GBHI programming supports the development and expansion of community infrastructure, primarily domestic public and private nonprofit entities in the integration of treatment and services for individuals with substance use disorder, co-occurring mental and substance use disorders, as well as those already in supportive housing environments. Similar to CABHI, GBHI utilizes outreach, screening and assessment, direct treatment, case management and recovery-oriented services to place program participants in permanent housing. GBHI grants are awarded for up to five years in two categories: GBHI and GBHI-Services in Supportive Housing. Funds should be utilized to target individuals and families experiencing homelessness, but GBHI-SS funding in particular is predicated on placement in permanent supportive housing for program participants (2019c). The GBHI program serves as a diversionary tactic by enhancing the long-term sustainability of community systems that provide housing and supportive services for chronically homeless individuals with mental illness.

SOAR

According to the SAMSHA, SOAR increases access to social security disability benefits for individuals with behavioral health issues who are at risk of experiencing or are who are currently experiencing homelessness. These individuals may have a serious mental illness, a co-occurring mental and substance use disorder, or a severe medical impairment (2019e). A successful SOAR application is one that is thorough and includes all forms of necessary identification and medical documentation of a disability that inhibits employment and necessitates monetary support. This poses unique challenges for individuals experiencing

homelessness as they are less likely to have a safe place to store documents and may be at an increased risk of theft. Anyone can become a SOAR case manager by completing a free online course that teaches someone how to complete SSI/SSDI applications for adults, SSI applications for children, and the ways in which a case manager may act as a bridge between an applicant, the Social Security Administration, field offices, and state agencies (Substance Abuse and Mental Health Services Administration, 2019e). SOAR case managers are key in assisting individuals obtain benefits that aid in their recovery and prevent further incarceration and/or hospitalization.

TIEH

TIEH expands access to mental and substance use disorder treatment for homeless individuals with a serious mental illness, emotional disturbance, or a co-occurring mental and substance use disorder. This is accomplished by increasing access to evidence-based treatment services, peer support, services that support recovery, and connections to permanent housing (Substance Abuse and Mental Health Services Administration, 2019f). This grant, awarded for up to five years, requires linkage to the Department of Housing and Urban Development's Coordinated Entry (CE) system, an assessment and referral tool used to connect individuals experiencing homelessness with appropriate agencies. CE processes help communities prioritize assistance based on the vulnerability and severity of need of each individual assessed, enabling the identification of service gaps and the tailoring of treatment and housing approaches accordingly (Texas Homeless Network, 2019). TIEH serves as a diversion tactic by placing an individual on the housing and service spectrum while increasing the availability of treatment options in the community.

Austin/Travis County[1] Spotlight

LANDSCAPE

The Austin metropolitan area is projected to grow 42 percent between 2010 and 2030 (Austin Area Sustainability Indicators, 2019a). City of Austin demographer Ryan Robinson projects that Austin will take on over 60,000 new residents in 2019, a pattern only exasperated by an overall job creation rate in the region of nearly 3.5 percent (Egan, 2019). According to the Ending Community Homelessness Coalition (ECHO), the lead agency that plans and implements community-wide strategies to end homelessness in Austin, 233 more individuals experiencing homelessness were housed in 2018 than in 2017. Yet, during the same time, Austin experienced a five percent increase in its overall homeless population (2019). The U.S. Department of Housing and Urban Development recommends that households pay no more than 30 percent of total income on housing, a threshold not met by more than one-third of Travis County households (Community Advancement Network, 2019). The convergence of population growth, employment vacancy rates, housing vacancy rates, and housing affordability mean more individuals and families may be at risk of experiencing homelessness. For those already experiencing homelessness, these factors make it harder to escape their current circumstances.

According to the Meadows Mental Health Policy Institute, one in four Texans live in a county with workforce shortages of mental health professionals including clinical psychologists, psychiatric nurses, clinical social workers, licensed professional counselors, and marriage and family therapists (2016). As of 2017, Texas was second to last in access to care with a ratio of individuals per behavioral health care provider at just under 1,000 to one (Mental Health America, 2019). One in five adult Texans have mental health needs and approximately one

[1] The Austin/Travis County region will be referred to as "Austin" throughout the remainder of the paper.

million live with a serious mental illness including schizophrenia, bipolar disorder, major depression, and post-traumatic stress disorder (Meadows Mental Health Policy Institute, 2016; Texas Health and Human Services, 2016). In addition, an estimated 1.6 million adult Texans have a substance use disorder and one in three Texans live with a co-occurring mental health and substance use disorder (Meadows Mental Health Policy Institute, 2016; Texas Health and Human Services Commission, 2016). When the need for mental health treatment is great, but the availability of treatment options is not, many are unable to seek care or are reluctant to do so.

Homeless population

On January 26, 2019, 2,255 individuals were experiencing homelessness in Austin. Of this total, 1,086 were sleeping unsheltered and exposed to the elements, a seven percent increase since 2018 (ECHO, 2019). CE assessment data through February 2019, combined with data collected at the end of January 2018, reveals the following characteristics of Austin's homeless population: 57 percent have no earned income, a three percent reduction since 2018; 70 percent report their homelessness is connected to previous trauma or abuse, an eight percent increase since 2018; 70 percent report having no planned activities that bring them joy, a one percent increase since 2018; 36 percent currently experience a mental health issue that would make it difficult to live independently; 39 percent report being a survivor of domestic abuse; 47 percent report having legal issues going on that may result in incarceration; 36 percent report having spent at least one night in jail; 51 percent are unable to take care of basic needs like bathing, using a restroom, or accessing clean food and water; and 13 percent report that drug and/or alcohol use will make it difficult to maintain housing (ECHO, 2018; 2019).

According to Cynthia Nagendra, Director for the Center for Capacity Building at the National Alliance to End Homelessness (NAEH), Austin experienced a 21 percent increase in its

chronically homeless population from 2018-2019 (2019). Nagendra and her team have been assessing Austin's homeless population for the last year and are assisting the City in restructuring service provision at Austin's Resource Center for the Homeless (ARCH). In addition, NAEH is helping plan the building of a new temporary homeless shelter to accommodate the changes taking place at the ARCH. Currently the ARCH is capable of sleeping 190 individuals overnight, but that capacity will drop to 130 under the new design. Individuals who are not able to sleep at the ARCH any longer can either decide to stay at the new temporary shelter being planned, seek alternative shelter, or turn to the streets. This change in Austin's homeless service provision landscape has the potential to increase the number of unsheltered individuals experiencing homelessness, even if only for a brief amount of time, which may lead to negative social determinants of health and an increase in the need for diversion from crisis settings.

High Utilizers

According to the Meadows Mental Health Policy Institute, Texas spends $1.4 billion in emergency room costs and $650 million in local justice system costs annually to address mental illness and substance use disorders that are not properly addressed in the community (State Bar of Texas, 2018). There are approximately 65,000 super utilizers in Texas who are at the highest risk of repeat use of jails, emergency departments, hospitals, and homeless services and 37,000 of them live in poverty. Furthermore, it is estimated that only 15 percent of these super utilizers living in poverty receive mental health care (Meadows Mental Health Policy Institute, 2016). According to the Ending Community Homeless Coalition, in 2017 an individual experiencing homelessness in Austin averaged 37 inpatient hospital stays, 21 emergency room visits, and 19

transports from Austin-Travis County Emergency Medical Services (EMS), totaling $220,000 in medical costs (Buchanan, 2017).

Medical Crisis System Diversion

PSYCHIATRIC EMERGENCY UNIT

Psychiatric Emergency Services (PES) is a walk-in urgent-care psychiatric emergency clinic that provides psychiatric crisis assessments, immediate intervention, referrals to appropriate treatment settings based on level of care ascertained, connection to community resources, and medication evaluation (NAMI Austin, 2019). Integral Care is the Local Mental Health and Intellectual and Developmental Disability Authority in Austin and Travis County, that has an immense amount of programming and services utilized by individuals and families experiencing homelessness.

An individual's level of care, which dictates what they are eligible for in terms of treatment, is subjective because it relies on self-reporting dictated during an intake assessment. An LOC1 is eligible for basic services such as case management at the clinic and community referrals. An LOC2 is given to individuals who have been diagnosed with Major Depressive Disorder and would benefit from the availability of counseling. An LOC3 includes rehabilitation and ongoing support in the field by case managers who assist with medication management and transportation. An LOC4 encompasses high wrap around needs eligible for an assertive community team's involvement. And lastly, an LOC5, which isn't used often, involves transitional services to aid an individual after leaving the unit with relapse prevention services and follow-up (Texas Health and Human Services Commission, 2017b). Super utilizers are often LOC4 due to their frequent use of and interaction with emergency departments, hospitals, and correctional settings.

PES is distinct from Yellow Pod, a psychiatric emergency room where clients in Austin are held for treatment. Clients may stay in Yellow Pod as long as staff believe is necessary, and

will be given medication during that time, but they are referred to PES for prescription medication (G. Rodriguez, personal communication, March 27, 2019). Although individuals may be able to stay as clients for a longer amount of time in Yellow Pod, PES provides mental health support for up to 90 days and connects individuals to other Integral Care programs that may be better suited for ongoing treatment (Integral Care, 2019c). An individual is taken to PES in lieu of psychiatric hospitalization and general and/or psychiatric emergency room utilization.

CRISIS UNITS

Crisis respite unit

According to the Hogg Foundation for Mental Health, services provided by Texas crisis respite units are for a short amount of time and can last anywhere from eight hours to 30 days of short-term crisis care for individuals at a low-risk of harm to self or others (Hogg Foundation for Mental Health, 2018). There is currently one active crisis respite unit in Austin and Travis County and one in development.

Next Step Crisis Respite is a program that helps adults recover from a mental health crisis through case management, social and life-skills training, and linkage to local resources for ongoing support (Integral Care, 2019c). It is the largest Integral Care facility housing 41 beds, nine of which are used for competency restoration byway of referrals from Austin State Hospital and Travis County Correctional Complex. Staff include administration, case management, nursing, and a prescriber that is on site once a week. Clients are initially authorized a nine day stay, but an extension may be granted. According to Program Manager Michelle Whetstone, individuals stay on average for two to three weeks and the entire time is voluntary. Individuals experience no out-of-pocket costs during their stay, may come and go as they please, but must be able to self-administer their medications when a nurse is not present. An estimated 90 percent of

those who utilize Next Step have a co-occurring substance use and mental health disorder. Ms. Whetstone describes it as providing structure to individuals in need, but not overwhelming them with structure (M. Whetstone, personal communication, March 4, 2019). Upon an individual's release, Next Step staff have the ability to reserve a mat at the Austin Resource Center for the Homeless (ARCH) or the Salvation Army, and often refer client's to boarding homes with whom Next Step has already established relationships.

Allen Graham, Founder & Chief Executive Officer of Mobile Loaves & Fishes recently announced that Phase II of Community First! Village (CFV) will include a 16-bed respite facility connected to a 20,000 square foot medical clinic. A program of the Mobile Loaves & Fishes organization, CFV operates under the belief that homelessness is caused by a profound and catastrophic loss of family (Thibaudeau-Graczyk, Graham, & O'Conner, 2019). It is a 51-acre master planned development that provides affordable, permanent housing under the Housing First model and a supportive community for former chronically homeless men and women. Once Phase II of its construction is complete, CFV will be able to house nearly 500 formerly homeless individuals, equating for roughly 40 percent of Austin's chronically homeless population (Mobile Loaves & Fishes, 2019).

Crisis residential unit

According to the Hogg Foundation for Mental Health, crisis residential services in Texas provide between one day and two weeks of crisis-level services in a safe, clinical, residential setting for individuals who present some immediate risk of harm to self or others (2018). In 2018, 24,832 individuals received crisis residential services across the state, a number that is expected to grow to 25,000 in 2019. Furthermore, the average amount spent per person for services is expected to grow from $2,345 to $2,800 (Hogg Foundation for Mental Health, 2018).

Currently, there are three active crisis residential units in Austin and Travis County, including 15th Street, The Inn, and the Guy Herman Center for Mental Health Crisis Care. Some critical distinctions between these units and Next Step is that clients must see a provider within 24 hours of being admitted and there is 24/7 availability of nursing staff. At Next Step, clients must see a provider within a window of four days and nursing staff present during normal business hours (M. Whetstone, personal communication, May 10, 2019).

15th Street, housed in the former Ronald McDonald House in downtown Austin, is a crisis residential unit that helps individuals experiencing a mental health crises on a voluntary basis for an average of ten days. During that time, clients work with staff on goals of their choosing, including but not limited to, managing mental health symptoms and stabilizing with the use of medications; maintaining sobriety; locating employment opportunities; accessing public benefits such as food stamps and social security; linkage to ongoing outpatient services or medical treatment; surveying and assessing viable housing options; and taking care of legal impediments such as parole, probation, court dates, etc. Referrals primarily come through PES or the Mobile Crisis Outreach Team (MCOT) and the Expanded Mobile Crisis Outreach Team (EMCOT). Additionally, referrals may come from outpatient Integral Care teams and from hospitals and emergency departments during overnight hours when clients cannot be taken to PES. According to LPHA Team Lead Sarah Kincheloe, the majority of clients admitted to 15th Street are homeless, and a vast majority have dual mental health and substance use disorders. To ensure that clients feel supported in their recovery upon leaving 15th Street, staff make a concerted effort to link individuals with as much support systems as possible, including other Integral Care departments and community agencies. The diversionary capacity of 15th Street is immense and

can occur prior to crisis system interaction and after, primarily following incarceration (S. Kincheloe, personal communication, May 10, 2019).

The Inn is a 16-bed overnight facility where an individual experiencing a mental health crisis may stay for up to seven days. Services include assistance in stabilization, access to medication, alcohol and drug use recovery support, mental health support groups, and linkage to local programs and resources for ongoing treatment and recovery support (Integral Care, 2019c). In addition to nursing staff, there are administrative staff and two case managers who assist an individual in preparing a treatment plan to be enacted upon their release. The Inn is in the same infrastructure that houses PES, so naturally providers prefer the majority of referrals come from PES directly. The Inn was designed to accommodate dual-occurring mental health and intellectual and developmental disabilities although adherence to this design does not always take place. Out of all crisis units in Austin and Travis County, The Inn tends to be at capacity more often than others. This could be due to its geographic proximity to PES or because the need for The Inn's unique approach is greater (M. Whetstone, personal communication, May 10, 2019).

The Judge Guy Herman Center for Mental Health Crisis Care offers wrap-around crisis assessment and stabilization with the use of medication, individual and group therapy, peer support and case management (T. Abzug, personal communication, July 9, 2018). Modeled after the Burke Center in Lufkin, Texas, the Herman Center serves as an intermediate level of care between mobile crisis outreach teams, law enforcement, and restrictive inpatient stays. There are 12 crisis residential beds at the facility; communal restrooms; a community area with a TV, books, and arts and craft supplies; a private phone booth that guests may use; and an outdoor patio that guests may visit with staff supervision. A registered nurse and a licensed vocational

nurse are on staff at all times and counselors are on-site 8am to 10pm. Nurse practitioners and case managers are also on-site seven days a week. Referrals are accepted from mobile crisis outreach teams, PES, and voluntary and involuntary emergency room transfers (Marloff, 2017). According to Practice Manager Tracy Abzug, 50 to 70 percent of individuals served at any given time have housing insecurity and/or immediate housing need (personal communication, July 9, 2018). The only individuals who cannot be served by the Herman Center are those with significant medical or wound care needs and those who are actively engaging in violent behavior, as the Center cannot administer restraints to individuals who may require a higher level of care (Marloff, 2017).

Extended observation unit

According to the Hogg Foundation for Mental Health, extended observation units (EOUs) in Texas provide 23 to 48 hours of psychiatric observation in a controlled environment with the goal to provide short-term stabilization and diversion from costlier alternatives (2018). The Judge Guy Herman for Mental Health Crisis Care is a 16-bed facility, four of which are reserved for individuals brought to the facility under an emergency detention. The Herman Center is the country's first and only non-hospital setting that accepts individuals brought to the facility by law enforcement on an emergency detention. It is the Center's hope to relieve law enforcement of their legal responsibility over an individual within fifteen minutes so they may return to their patrol route. Once a guest is assessed at arrival, they are taken to an exam room for a skin check, urine analysis, drug screen and a breathalyzer. These tools help staff understand any mitigating factors that may be influencing a presenting mental health crisis, and tailor their treatment approach accordingly. The guest is then offered a shower and a clean set of clothes before they are taken to one of the four EOU beds that has a private restroom. Staff hope that clients detained

on an emergency detention will be able to transfer to the residential floor of the Center after recuperating for 48 to 72 hours (Marloff, 2017).

HEALTH CARE FOR THE HOMELESS

Health Care for the Homeless (HCH) operates in Austin in three fixed locations strategically positioned in geographic regions with a high prevalence of individuals experiencing homelessness. HCH clinics include the CommUnityCare clinic located inside the ARCH, the C.D. Doyle Clinic, and the Topfer Family Health Resource Center stationed at CFV.

The ARCH clinic opened on October 4, 2004 and is open forty hours a week to provide primary medical care to clients on a walk-in or appointment basis (CommUnityCare Health Centers, 2019). In addition to primary care, the ARCH clinic provides integrated behavioral health services by mental health professionals who provide intensive case management and linkage to housing, legal, substance use treatment, and other resources (TexVet, 2019). Medical care may range from minor cuts and bruises to chronic disease management and treatment. Testing is available for Hepatitis, HIV, and Tuberculosis, and the clinic works in conjunction with a mobile CommUnityCare Dental Clinic and the Right to Sight clinic that provides eye exams and glasses prescriptions on a weekly basis. Two case managers located at the Salvation Army, adjacent to the ARCH, are on hand to organize client care and connect clients to services to meet their unique needs (CommUnityCare Health Centers, 2019).

The C.D. Doyle Clinic is a student-run free clinic supported by the Dell Medical School at The University of Texas at Austin. It operates on Sunday afternoons from 2:00 – 4:00pm in the gym of St. David's Episcopal Church. Services are available to any individual regardless of whether they have health insurance, forms of identification, or a place to call home that is deemed appropriate for human inhabitation. The clinic is staffed by volunteer physicians,

medical students, nurse practitioners, and pre-health undergraduate volunteers. Services include wound care, minor acute care, prescriptions (not including narcotics), blood pressure checks, blood sugar checks, medical advice, vaccinations every three months, HIV testing, and pregnancy testing. In addition, referrals can be made to clinic and social service options in the community and education provided on local resources, including how to apply for the Medical Access Program (C.D. Doyle Clinic, 2019). The Medical Access Program (MAP) is a local program provided by Central Health that covers primary and specialty care, urgent care, prescriptions, and dental care. MAP services that require pre-approval from an individual's primary care provider include hospital inpatient services, outpatient services, home health and supplies, as well as specialty dental services. Primary health care providers that work with MAP include CommUnityCare, El Buen Samaritano, Lone Star Circle of Care, and People's Community Clinic (Central Health, 2019).

The Topfer Family Health Resource Center provides primary and behavioral health care services to formerly homeless residents who live at CFV. The Center was funded through a donation from the Topfer Family Foundation and is operated by Integral Care and CommUnityCare (Barragan, 2016). Phase II of CFV will include the construction of a 20,000 square foot medical clinic that will increase the capacity to serve and the number and specialty of services provided (Thibaudeau-Graczyk, Graham, & O'Conner, 2019).

OUTREACH

Individuals experiencing homelessness can be diverted from emergency medical settings through outreach capacity currently in place in Austin. This occurs when someone receives medical care outside of the emergency room by Street Medicine or the Community Health Paramedic (CHP) program. Diversion may also take place if an individual is redirected to their

primary care physician, Street Medicine, or CHP instead of calling 911 for an EMS transport to the emergency room.

Street medicine

HCH currently has a street medicine team that goes out into the community three times a week to provide primary care to unsheltered homeless individuals who are not able to come to a clinic or are the least likely to seek help autonomously. This Mobile Med team also provides on-site care at locations in the community beyond the clinics already in place to aid individuals who cannot access these fixed locations. Settings that invite Mobile Med to set up temporary clinics may include local schools, faith-based organizations, churches, and other community-based organizations (CommUnityCare Health Centers, 2019). Austin was recently awarded a five-year, $2.3 million SAMSHA grant to develop a mobile care team to serve homeless men and women with behavioral health disorders and chronic medical conditions. The creation and implementation of the team is a collaboration between The University of Texas at Austin's Dell Medical School, CommUnityCare, and Integral Care. A principal of the grant is the creation of an integrated multidisciplinary team, so the team will be comprised of a physician or nurse practitioner, a psychiatrist or nurse practitioner, a licensed drug counselor, nursing and mental health case managers, and a peer navigator. The team will rely on partner organizations and other outreach teams already in the field for referrals and identification of new clients (Clark-Madison, 2019).

Community health paramedic

CHP was developed in 2009 to work with repeat, low-priority callers with little to no economic safety net, to improve their quality of life and link them with ongoing care in order to reduce or eliminate their dependency on emergency services (Marloff, 2017; Buchanan, 2017).

Currently, there are 10 CHPs in the field, either stationed at fixed sites or mobile, who engage and collaborate with agencies that interact with CHPs target population. On average, CHPs have 15 years of experience. Services provision includes MAP enrollment, scheduling and transportation to and from doctor's appointments, administration of street medicine in the field, picking up prescription medications and delivering them to the client, managing said prescriptions, and identification of potential SOAR applicants (A. Price, personal communication, May 6, 2019). Since its inception, CHP has contributed to a 60 percent reduction in emergency calls from its target population, equating to roughly 1,000 clients a year. Each emergency call that is prevented equates to one less $500 bill from EMS and one less ER visit (Buchanan, 2017).

An initiative of EMS, Pop Up Resource Clinics (PURCs) are put on by CHPs monthly to bring multiple interventions together in one place for clients to utilize. The location changes each month in order to extend services to individuals experiencing homelessness in regions across Austin. PURCs have the potential to serve up to 300 clients and provide 800 interventions in the span of just a few hours (Thibaudeau-Graczyk, Graham, & O'Conner, 2019). On average, PURCs offer 12 different interventions from agencies including, but not limited to, Front Steps, MAP, Integral Care, Austin Animal Services, EMS mobile medical clinic, Mobile Loaves & Fishes, Salvation Army, the Ending Community Homelessness Coalition (ECHO), and Communities for Recovery.

ASSERTIVE COMMUNITY TREATMENT

There are three operational ACT teams in Austin: ACT, City ACT, and FACT. According to Program Manager Elizabeth Baker, these teams assertively engage the chronically homeless population by providing community-based services and innovative engagement

strategies to build rapport, establish a trusting relationship, and identify and work toward goals related to housing, employment, harm reduction, and wellness (Housing First ATX, 2016). ACT teams support clients with complex mental and physical health needs through 24-hour mental health crisis support, one-on-one emotional support, case management, housing and employment assistance, access to medicine, nursing services, drug and alcohol treatment, and assistance with daily living skills. The ACT and City ACT teams include social workers, counselors, a housing specialist, a substance use counselor, a peer support specialist, a registered nurse and an advanced practice nurse (E. Baker, personal communication, May 8, 2019). This interdisciplinary team serves chronically homeless individuals, individuals with frequent psychiatric emergencies, as well as individuals with frequent criminal justice system involvement. Services are brought to the clients; 80 percent of ACT services are provided in the community or within the client's home. There is no limit on the time that an individual may remain an ACT client if their needs dictate ongoing support (Housing First ATX, 2016).

Criminal Justice System Diversion

LAW ENFORCEMENT

According to Sergeant Michael King, all Austin Police Department (APD) officers receive mental health training because it's not a question of *if* they are going to engage with someone with a mental illness, but a question of *when* (Marloff, 2017). All incoming cadets receive a 40-hour mental health training that includes identification of crisis, de-escalation, mental health disorders and symptom recognition, suicidal ideation, psychopharmacology. In addition, officers are made aware of local resources that may serve as alternative options than taking someone to jail that may require treatment. These include EMCOT, PES, the Sobering Center, HOST, etc. Training asks cadets to confront their own biases towards those they will inevitably encounter and instead place themselves in their shoes; what barriers is this individual experiencing? And what are the mitigating circumstances? A role-play component was recently included where cadets are able to receive feedback from EMCOT staff, as well as established officers. The training is facilitated by Integral Care, NAMI Austin, and the CIT Unit and all officers receive an additional 40-hour training after serving two years in the field (M. Aguilar, personal communication, March 27, 2019).

Crisis Intervention Team

The APD's CIT Program, formerly known as the Mental Health Unit, was created in 1999 following a series of officer-involved shootings that killed several people with mental illness. CIT was developed to address the need for education, training, and tactics for law enforcement and to provide officers with more guidance on how to de-escalate tense situations and how to recognize when someone may be experiencing a mental health crisis (Austin Police

Department; Marloff, 2017). The Team is separated into two divisions: APD CIT Certified Patrol Officers and the APD CIT Unit.

Certified Patrol Officers are available 24/7 and respond to the majority of incidences involving mental health crises in the field. There are more than 160 of these officers city-wide who voluntarily received an extra 40-hours of extensive crisis intervention training that stresses the least restrictive outcomes. An officer is only eligible for this position after two years of law enforcement service. These officers have the power to perform an emergency detention if deemed necessary and collaborate with mental health providers to locate an environment to transport an individual that is better suited to their needs (Austin Police Department). These officers are also able to dispatch EMCOT to the scene so that they return to their patrol. The APD CIT Unit, on the other hand, is responsible for training officers, reviewing incidents in the field, performing follow-up as necessary, setting policy, and managing the CIT Program. Unit officer's function as secondary responders by reviewing all calls classified as involving or relating to a mental health crisis who an APD officer comes into contact with. Based on this analysis, the Unit determines whether a follow-up is necessary, either by phone or in person (Austin Police Department; Marloff, 2017). In 2016 alone, CIT received nearly 12,000 reports, 5,500 of which were emergency detentions (Marloff, 2017).

COURTS

Judges

Texas law provides three alternatives to incarceration for indigent defendants: payment plans provided by the administrative branch of the court or a judge, community service for those who are physically able to complete it, and a partial or complete waiver of fines or fees. The Texas Code of Criminal Procedures gives judges complete discretion to determine if a defendant

is indigent under the following considerations: the monetary amount of the fine, and the source of income, expenses, and disabilities of the defendant (Office of the City Auditor, 2016). Data from the Bureau of Justice Statistics shows, in 2013, that Texas had 1,531 municipal judges and 456 general jurisdiction district judges (Substance Abuse and Mental Health Services Administration, 2015). Despite the presence of diversion procedures for indigent individuals, their use may inevitably be applied inconsistently due to the sheer number of judges across the state and the judicial discretion they are allotted.

Municipal court

Austin Municipal Court provides adjudication of Class C misdemeanor offenses including traffic violations, city ordinances, parking violations, and select state and school offenses that are commonly punishable by a fine. The Court does not offer case management services, and the right to legal representation is not extended to defendants with Class C misdemeanors because they are fine-only. Individuals are referred to the Downtown Austin Community Court (DACC) if the offense committed is once labeled a 'quality of life' offense and if case management services are deemed necessary (Office of the City Auditor, 2016). While the Municipal Court operates under a more traditional perspective, DACC operates under a more clinical perspective (P. Valdez, personal communication, June 6, 2018).

Community court

DACC was established in 1999. It was the eighth community court established in the United States, and the first of its kind in Texas (City of Austin, 2018). Although DACC is a community problem-solving court, its mission statement is "to end homelessness by providing comprehensive, long-term services to individuals experiencing homelessness" (City of Austin, 2019). In this light, DACC serves arguably as a homeless court as well. DACC is a jurisdictional

court responsible for offenses committed within Downtown Austin, East Austin, and the West Campus area of The University of Texas at Austin. If an offense is committed outside of this jurisdiction, then it is handled by the Municipal Court who has the option to refer it to DACC. The majority of offenses adjudicated through DACC are 'quality of life' offenses committed by individuals experiencing homelessness. A disproportionate amount of these offenses are committed by a small number of defendants who are super utilizers of the criminal justice system (City of Austin, 2018).

An audit carried out by the City of Austin in 2017 found that 18,000 citations were written from 2013 to 2016 for panhandling, camping, and sitting or lying down in unauthorized areas. According to DACC, 90 percent of these cases failed to appear in court and/or pay the associated fines, resulting in arrest warrants for over 70 percent (Office of the City Auditor, 2017a). These warrants have the ability to impede employment and housing opportunities, displace individuals from primary and behavioral health providers, and disqualify an individual from receiving public benefits. DACC recognizes this risk for the chronically homeless population living with mental illness and substance use disorder in its jurisdiction and tailors its approach accordingly.

A key component of DACC is the prosecutor who has the authority to offer a reduced fine or a deferred disposition that requires an individual take rehabilitative steps to settle their case. Alternative sanctions may include community service restitution, connecting with housing and social service providers in the community, engaging in case management, attending appointments, applying for benefits, or completion of the CE, which puts an individual on the housing spectrum in Austin and Travis County (City of Austin, 2018). Community service restitution is designed to hold individuals accountable through restoration of the community.

Activities that provide this vehicle for change include picking up trash, painting over graffiti, working at the DACC garden, and festival set-up and clean-up efforts (City of Austin, 2018). Jail time may also be used as credit towards an associated fine, at a rate of at least $50 a day. Between 2014 and 2016 DACC credited defendants nearly $600,000 for jail time served (Office of the City Auditor, 2017a). If an individual is unable to pay a fine or fee associated with their offense, they must appear in court to resolve the citation and have alternative options considered. If an individual fails to appear, diversion is unable to be fully considered and an arrest warrant will inevitably be issued (Office of the City Auditor, 2016). Outreach teams, especially HOST, play an important role in encouraging individuals to engage with DACC in avoidance of unnecessary jail time.

The target population for DACC case management services are frequent offenders with 25 or more cases with the court and at least one active case in the last two years. Case management is client-centered and comprehensive, with no one case manager taking on more than 15 clients at a time. Clients become engaged in case management either through the arraignment docket, walk-in docket, on-call case management referrals, field contacts, and referrals from other agencies. Services and referrals include detox, 90-day residential treatment programs, legal system navigation, emergency hygiene and clothing, ID documents, emergency shelter, transitional housing, public benefit enrollment, employment and housing assistance, mailing address, crisis intervention, transportation, counseling services, and physical and behavioral health treatment (City of Austin, 2018). Despite an annual projected caseload of 12,000, DACC is unable to provide case management services to all who request it (City of Austin, 2018). There is a currently a waitlist of approximately 120 and individuals are prioritized off that waitlist based on the number of citations received and/or the referral source (P. Valdez,

personal communication, June 6, 2018). For example, DACC currently has three case managers who accept referrals solely from HOST.

FORENSIC ASSERTIVE COMMUNITY TREATMENT

Integral Care's FACT team was created over a year ago to accompany the two ACT teams already in position. The key distinction between the three is that FACT provides services to individuals with extensive criminal justice interaction to help reduce recidivism, arrest, and incarceration rates of individuals with mental illness. FACT is a partnership between Integral Care, Travis County Sheriff's Office, Downtown Austin Community Court, Austin Police Department, and Central Health. FACT serves in a diversionary capacity by engaging with individuals prior to arrest, as well as collaborating with law enforcement and the court system if an arrest does take place. Services include mental and primary health care, counseling, medications, family education and support, peer support, permanent supportive housing, and document storage (Integral Care, 2019b). The team is comprised of a housing specialist, a licensed chemical dependency counselor, a CommUnityCare health professional, an LPC trauma recovery counselor, case managers, and a forensic specialist (M. Liguori, personal communication, March 5, 2019).

Diversion Strategies Used for Both

Crisis Hotline

Integral Care is distinct from other local mental health authorities in Texas because their crisis hotline is not contracted out. Having the call center in-office provides for greater accountability. The crisis hotline is available 24 hours a day, seven days a week, and is staffed by mental health professionals who provide crisis support, immediate assessments, access and referrals to Integral Care programming, assistance with appointments and billing, as well as connection to other community resources. The hotline is accredited by the American Association of Suicidology (Integral Care, 2019c).

Sobering Center

The Sobering Center Austin was created by the City of Austin and Travis County to provide a safe environment for individuals detained by law enforcement or emergency medical services for public intoxication. Its mission statement is to enhance public health and public safety by providing an alternative, non-punitive approach, to the emergency room and jail for publicly intoxicated individuals. According to the Sobering Center, public intoxication costs $1,400 per visit on average to the emergency room, $876 per EMS transport, $152 per transport for jail booking, and $55 to 97 per booking in officer time (2019). The Sobering Center serves individuals with chronic substance use problems, many of whom are experiencing homelessness and living with co-occurring substance use and mental health issues. There are multiple benefits for all parties involved. APD and EMS are able to drop an individual off at the Center, relinquish their legal responsibility over that individual, and return to their patrol route. Benefits to the individual include prevention of a criminal record for first-time offenders, peer counseling, and community referrals for treatment and ongoing support. For city and county services, the Center

reduces jail crowding and saves booking and admission costs to both jail and emergency departments. Upon arrest or EMS pick-up an individual is able to request transport to the Sobering Center if they are not in commission of another crime. Furthermore, an individual is free to leave the Center at any time, but if there is a safety concern an APD officer will evaluate their level of intoxication and their chance of being rearrested (Sobering Center Austin, 2019).

MCOT/EMCOT

The Mobile Crisis Outreach Team (MCOT) was originally developed in Austin in 2006 to better serve individuals in crisis without engagement from APD or EMS. It grew in 2012 with additional state approved funding and in 2013 MCOT began working closely with APD by responding to officers on patrol when prompted (Marloff, 2017). The Expanded Mobile Crisis Outreach Team (EMCOT) was then developed to provide a more immediate response rate. MCOT provides 8-hour and 24-hour follow ups for calls received through the Crisis Hotline, which assesses the risk level and dictates the amount of time in which follow up is necessary. EMCOT, on the other hand, is able to be dispatched to the scene immediately by the Crisis Hotline or first responders. This service is available across Travis County which means EMCOT may be requested by EMS, the Travis County Sheriff's Office, Lakeway Police, the Department of Public Safety, and Travis County Sheriff's Office administrators at the Travis County Correctional Complex and Central Booking (Marloff, 2017). Mental health professionals are often called out into the field but may also be called to jail or hospital settings if staff believe an individual may be unable to overcome barriers upon their release without support. EMCOTs goal is to arrive to the scene within 30 minutes and relieve first responders within 15 minutes, a goal that is met 80 to 95 percent of the time (M. Aguilar, personal communication, March 27, 2019;

Marloff, 2017). The ultimate goal for both teams is to provide supportive follow up as soon as possible following a mental health crisis.

MCOT and EMCOT assist with diversion from incarceration or hospitalization through the provision of psychiatric assessments, screening and triage, case management, crisis intervention services, medication management, rehabilitative skills training, and service linkage to community resources for continued support and stabilization (G. Rodriguez, personal communication, March 27, 2019). Master's level clinicians bring treatment into the community to aid those who are unable or unwilling to seek treatment on their own. This assistance is open for ninety days, completely voluntary, with a goal of connecting an individual to long-term treatment (Marloff, 2017). In FY 2017, MCOT served 4,563 unduplicated individuals and EMCOT was dispatched 3,244 times with an average of nine times per day (Marloff, 2017; Integral Care, 2019a). When referred through law enforcement, EMCOT has a 98.7 percent diversion rate from arrest and 93.3 percent diversion rate from involuntary placement. When referred by EMS, EMCOT has a 75.1 percent diversion rate from emergency department transfer and admission (Integral Care, 2019a).

HOST

Austin's Homeless Outreach Street Team (HOST) was created in 2016 to reduce the number of arrest warrants for Austin's homeless population and address the needs of individuals experiencing homelessness before they reach a state of crisis by focusing on public safety issues (Office of the City Auditor, 2017b). This collaborative, proactive approach hinges on connections, as HOST links individuals with resources in the community to meet their unique needs and mitigating circumstances. Whether an individual asks for assistance is subjective to their mental health, where they are in their recovery, and/or how their experiences in the past

have shaped their ability to trust. HOST hits the pavement Monday through Friday, in both Downtown Austin and the western edge of The University of Texas at Austin, to connect with individuals and families experiencing homelessness. HOST is comprised of two APD officers, one CHP, one case manager from DACC, four behavioral health specialists, and one peer support specialist.

HOST has a robust diversionary capacity from jail, psychiatric hospitalization, and emergency room utilization. A diversion occurs at the time of the encounter, even if an individual eventually ends up utilizing crisis systems. Diversion can take place by referring someone to mental health and/or substance use treatment; transporting an individual to PES; placement at The Inn, Next Step, Guy Herman, or 15th Street; calling EMCOT; redirecting someone to their primary care physician, CHP, or Street Medicine; and by relocating an individual or family somewhere that will effectively end their homelessness (K. Dorrier, personal communication, February 6, 2019).

SUPPORTIVE HOUSING

Pay for Success

ECHO launched a Pay for Success Supportive Housing pilot program in May of 2018 to reduce Austin's criminal justice and emergency health system costs by housing 250 vulnerable individuals who frequently utilize crisis services. This five-year project is anticipated to result in cost reductions of millions across the health care, criminal justice, and social services systems (City of Austin, 2016). ECHO will house 25 super utilizers and wrap-around intensive case management will be provided by two outreach teams that will use a modified ACT model. One team will be funded through Caritas of Austin and another through Integral Care (E. Baker, personal communication, May 8, 2019). As of March 2019, the City of Austin had $6 million in

reserves for the program, $4 million of which was from St. David's Foundation. City leaders are hoping to raise a total of $16 million for the program and would repay investors up to $6 million and a federal grant, Travis County, Central Health, CommUnityCare Collaborative, and Episcopal Health Foundation would collectively contribute up to $9.5 million (Clark, 2019; Findell, 2019).

FUSE initiative

The FUSE initiative is utilized in Travis County through a Justice Reinvestment Initiative (JRI) that began in May of 2013 to provide permanent supportive housing and ancillary support services for chronically homeless individuals with mental illness who were frequent users of the Travis County Correctional Complex. Funding was acquired through an application process submitted by a Community Consortium of key justice stakeholders, other county and city agencies, and community stakeholders. This group guides Travis County through its justice reinvestment activities and is responsible for collecting and analyzing criminal justice data, identifying local drivers of incarceration, and identifying strategies to reduce the impact of these drivers (Parks et al., 2016). At the end of March 2016, 50 percent of the 30 people initially housed had been rearrested, compared to 81 percent of the 80-person control group (Meredith, 2016). Grant funding was provided for the initial two-year period, ending in the fall of 2015, but the Consortium was successful in securing county funding for the program through FY 2018 (Center for Effective Public Policy, 2016). JRI requires ongoing assessment of the strategies implemented to assess whether they are indeed yielding intended results (Parks et al., 2016).

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

PATH/ACCESS Homeless Services

PATH is a federally-funded program designed to provide outreach to homeless individuals by developing helpful relationships and collaborating to create person-centered care. In Travis County, PATH services and length of engagement varies according to individual need. PATH's target population includes adults experiencing homelessness, mental illness and/or substance use disorder. The team is comprised of outreach specialists, psychiatrists, mental health professionals, an advanced practice nurse, a certified medical assistant and a licensed clinical supervisor (Milardo, 2018). This multidisciplinary team engages with individuals living unsheltered under bridges, in wooded areas, and abandoned buildings. They are also strategically stationed in the community to provide services at places including the ARCH, Salvation Army, public libraries, food pantries, and soup kitchens. As Austin continues to grow, the geographic area that PATH is responsible for covering continues to grow as well.

According to data derived from FY 2017, 15,115 individuals experiencing homelessness were contracted by PATH across the state. Of this amount, nearly 7,000 were enrolled in PATH services (Ita, 2018). Formula funding for PATH in the state of Texas in FY 2018 totaled $4,995,434, an increase from the $4,500,000 received in FY 2017 (Substance Abuse and Mental Health Services Administration, 2018; Ita, 2018). Funding is awarded to PATH contractors across the state who are selected based on poverty, density indices, historical allocations, and geographic areas that exhibit the greatest need. Funding is re-procured every five years and contractors participate in a conference call quarterly to address successes, challenges, and technical difficulties in implementing the program. The next procurement for PATH funding will be in FY 2024 and will not be tied to Integral Care's performance contracts (Texas Health and Human Services, 2019b).

Recommendations

There are several recommendations that can be made as a means of improving Austin's ability to divert homeless individuals with mental illness from unnecessary hospitalization, emergency room utilization, and incarceration. Broader considerations, that would benefit diversion efforts in an indirect manner, include the following: (1) the development of sanctioned campsites for the homeless population to enable better management of mental and physical health needs, easier tracking of clients by clinicians and outreach workers, and safe storage options for individuals' belongings; (2) the creation of individualized shelters for special populations would enable specialized treatment of unique circumstances, such as substance use disorder, severe mental illness, or those with an intellectual and developmental disability to mitigate crisis system interactions by encouraging on-going treatment of health care needs; and (3) creating a unified database to enhance collaboration between service providers, coordinate local efforts, and limit the number of databases utilized across homeless service provision.

Individuals experiencing homelessness are distinctive—their needs, conditions, and mitigating circumstances are different. Successful diversion relies on client choice, strengths-based orientation, and acknowledgement of the systems at play in an individual's life. Not all diversion strategies are transferable as politics and funding streams vary across counties, cities, and states across the United States. The systems that feed into homelessness are not slowing down. Austin must improve its ability to divert homeless individuals with mental illness from unnecessary crisis system interactions. This can be accomplished in the following ways:

Increased Outreach Capacity

Ideally, all individuals and families experiencing homelessness would be able to be identified, engaged, and connected to resources to address their needs. Street outreach programs

no longer have the capacity to engage everyone experiencing homelessness across Travis County. In addition, there is currently a lack of systematic coordination among active outreach teams which leads to duplication of geographic coverage, leaving other regions, and the individuals living in those regions, largely untouched. Increasing Austin's current outreach capacity would demonstrate the need for increased, targeted resource allocation by allowing local policymakers to see just how pervasive homelessness truly is. Homelessness is not solely a downtown issue. In order to identify and engage with all individuals and families experiencing homelessness across the region, additional jurisdictional teams should be enacted to find those that may not be identified by the primary methods currently used to collect data about the homeless population. Improved identification would bolster the data collection process and would serve as a catch-all for individuals who have fallen through the cracks.

CENTRAL DISPATCH CENTER EXPANSION

In Austin on any given day, APD receives 3,000 to 4,000 calls. It is unclear how many of these are crisis related as this distinction isn't easily made over the phone (Marloff, 2017). The Combined Transportation, Emergency, & Communications Center (CTECC), Austin's current dispatch center, only dispatches APD, EMS, and/or the Austin Fire Department to the scene (2019). These teams then alert EMCOT if mental health services are needed. Expanding CTECC to provide a more streamlined process, that includes mental health dispatch, would create better and more efficient outcomes for individuals in crisis, free up emergency teams to address other needs in the community, and lessen the extent to which law enforcement officers act as first responders to mental health crisis when mental health professionals are better suited. An important element of this expansion is the training component, as dispatch personnel must be

able to identify and appropriately assign mental health related calls. This would ensure that the right service is provided (i.e., matched) to the right person at the right time.

Creation of a Crisis Stabilization Unit

Crisis stabilization units are a core element of crisis care that provide immediate access to emergency psychiatric care and short-term residential treatment for the resolution of acute symptoms that necessitate a higher level of care (Austin Area Sustainability Indicators, 2019b; Hogg Foundation for Mental Health, 2018). Austin currently does not have a crisis stabilization unit, which justifies a deep dive into the data to determine if the benefits of such a unit warrant its construction and funding. Furthermore, an investigation must be conducted to determine what would be needed to rule out altered mentation in order to provide the best treatment possible – what does the emergency room do that our current crisis infrastructure does not? Blood work? Constraint-Induced Therapy? The Guy Herman EOU, the next level of care down, completes a skin check, a urine analysis, a drug screen, and a breathalyzer. An additional consideration is the necessary security level when working with those with the greatest need (i.e. would staff be allowed to do hand restraints or sedate clients for their own safety). Moreover, the insurance component would need to be teased out as well as the determination of who would be allowed to transport individuals directly to the unit and under what circumstances.

24/7 EMCOT Availability

EMCOT currently has staff in office Monday through Friday from 6am to 10pm, and Saturday and Sunday from 10am to 8pm. MCOT, on the other hand, has staff in office Monday through Friday from 8am to 10pm, and Saturday and Sunday from 10am to 8pm. MCOT is able to be dispatched by the Crisis Hotline between the hours of 10pm and 6am on weekdays and between 8pm and 10am on weekends. Although both teams are in office 365 days a year, the

critical role that EMCOT plays in a diversionary capacity warrants an investigation into its expansion. According to Program Manager Marisa Aguilar, law enforcement frequently asks when EMCOT will have staff available, in office, overnight that officers may utilize (M. Aguilar, personal communication, March 27, 2019). This clearly speaks to the beneficial nature of the program, not just for those in crisis, but for everybody. By changing the response rate, we are able to ensure the safety of all involved. EMCOT is funded jointly by the City of Austin and Travis County through the end of FY 2019 and Integral Care is currently considering options for expansion in FY 2020 (L. Wilson-Slocum, personal communication, May 8, 2019).

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