

RESEARCH REPORT

Assessment of the Orange County, California, Homeless Mentally Ill Outreach and Treatment Services

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Executive Summary

The California Department of Health Care Services awarded the Orange County Health Care Agency (HCA) a Homeless Mentally Ill Outreach and Treatment (HMIOT) grant in late 2018. The HCA partnered with Telecare to create intensive outreach and mobile mental health treatment components within its existing Full Service Partnership (FSP) contract funded through the Mental Health Services Act. The goal was to increase access to behavioral and mental health services and housing for people with serious mental illness who were also experiencing homelessness and had not been engaged in services. The HCA and Telecare began offering services in April 2019, with outreach efforts continuing through November 2021 and treatment services continuing through December 2021. Starting in March 2020, the Urban Institute conducted a year-long assessment of the implementation and outcomes of the HMIOT services. This report describes those services and outlines the assessment's methodology and findings.

Through the HMIOT services, Orange County aimed to engage people in the target population, assess needs, develop individualized service plans, provide mobile treatment, and address barriers to treatment and housing. The Telecare and HCA HMIOT team used two staffed vans, one for outreach and one for treatment services. The outreach team, which consisted of a Telecare outreach team and an HCA outreach and engagement team, went out to various sites in the community together to reach out to and engage people experiencing homelessness and assess them for the need for HMIOT services. The treatment team, which consisted of a Telecare treatment team, provided mobile short-term behavioral and mental health treatment services and linkage to long-term mental health services to clients engaged by the outreach team.

Urban assessed the implementation and outcomes of the HMIOT services, focusing on the following four questions:

- How many people were served by HMIOT grant-funded mobile services? What was the composition of the people served in regard to demographics, location of residence, and needs?
- What gaps, if any, exist in who was served and what services were provided?
- What were the challenges in engaging clients in these services?
- What share of people served were connected to long-term treatment and/or housing?

To answer these questions, the Urban research team collected primary data through virtual interviews with HMIOT services staff and clients and administrative data maintained by Telecare staff.

Because this study was conducted during the COVID-19 pandemic, Urban further examined the impact of the pandemic on HMIOT services. Findings include the following:

- Many people were strongly and consistently engaged in much-needed HMIOT services. Interviewed clients noted being generally satisfied with the services they received and believed HMIOT personnel were trustworthy and followed through on promises. This was a particularly positive outcome given the complex needs and challenges associated with the HMIOT target population.
- Largely because of the challenges presented by the pandemic, the initiative fell short of some of its target outreach and screening numbers, but almost met enrollment goals.
- Staff and clients reported that HMIOT services helped clients meet a wide range of immediate basic needs, including clothes, hygiene products, physical health services, employment assistance, financial assistance, assistance obtaining personal documents (e.g., ID), assistance applying for government assistance programs (e.g., the Supplemental Nutrition Assistance Program, Electronic Benefits Transfer, MediCal), transportation, and more.
- Clients enrolled in mobile treatment received a range of services, including evaluations and assessments; case management; medical referrals and medication support; and therapy, counseling, and education. Staff also addressed barriers to housing and treatment for many of the enrolled clients and completed Housing Opportunity Applications for over a quarter of enrolled clients. Importantly, nearly all interviewed clients noted that they successfully gained housing while receiving HMIOT services.
- Staff identified several barriers to engagement in meeting the short- and long-term goals of clients. For example, working with a transient population made it difficult to find and maintain contact with clients. Staff and clients both noted a general lack of trust in county-based treatment, which created some challenges for outreach and engagement. In addition, attaining accessible housing and income supports for clients with physical disabilities was a challenge. Further, services were disrupted by the pandemic, which affected staff members' ability to engage in face-to-face interactions and conduct engagement and service delivery activities.
- There were a few limitations with the administrative data Urban used for this report, including incomplete and missing records and limited information about client needs, barriers, and services received.

Based on these findings, Urban identified the following eight recommendations for the Health Care Agency that could help it improve HMIOT services and that could be helpful for similar initiatives and programs being considered by agencies and organizations across the country:

- Clarify the HMIOT services model to all staff through written materials, trainings, and ongoing communications.
- Consider providing comprehensive outreach training to all providers who will be interacting with clients in the field and ensure this training is consistent across all staff.
- Expand and build additional analytic capacity in the program.
- Develop better audits or data-validation checks to ensure information about HMIOT services is accurately and consistently tracked.
- Develop a method to record demographic information about all contacts and reasons people provide for not engaging in services.
- Continue to examine the outputs and outcomes associated with HMIOT services and consistently and clearly track outputs related to HMIOT services goals in the data-tracking system.
- Think about the appropriate scale and scope of the program moving forward by investigating how many people may qualify for HMIOT services and what impact scaling up or down would have on the ability to provide them.
- Continue to provide trustworthy services through HMIOT services and other initiatives targeting people experiencing homelessness in the county.

Assessment of the Orange County, California, Homeless Mentally Ill Outreach and Treatment Services

In late 2018, the California Department of Health Care Services awarded a Homeless Mentally Ill Outreach and Treatment (HMIOT) grant to the Orange County Health Care Agency (HCA), which used the award to create an intensive outreach component within its existing Full Service Partnership (FSP) contract funded through the Mental Health Services Act. The goal of the HCA's HMIOT services is to target and engage adults with serious mental illness experiencing homelessness who are not receiving services through mobile outreach and treatment.¹ These services were implemented in April 2019. Outreach efforts conducted as a part of HMIOT services wrapped up in November 2020 and treatment services continued through December 2020. In March 2020, the Urban Institute commenced a year-long assessment of the implementation and outcomes of the services. This report describes the services and outlines the assessment's methodology and findings.

Homelessness and Mental Illness in Orange County, California

California has gained national attention in recent years for its rapidly growing population of people experiencing homelessness, which topped 150,000 during the state's 2019 Point-in-Time (PIT) count—a count of unsheltered and sheltered people experiencing homelessness on a single night.² The growth in this population is acutely felt in Orange County, whose unhoused population grew by 43.2 percent between 2017 and 2019, the fourth-largest proportional increase across California counties with populations of at least 700,000 during that period.³ Of the 6,860 people experiencing homelessness who were identified in the county by the 2019 PIT count, 3,961 were experiencing unsheltered homelessness and 2,899 were in an emergency or traditional shelter (OCHMIS 2019). The concentration of this population generally mirrors the population density of cities in Orange County; that is, the cities with the largest populations (Anaheim and Santa Ana) also have the most people experiencing homelessness (OCHMIS 2019).

In recent years, the growing population of people experiencing homelessness in Orange County and the county government's response has garnered criticism from some organizations and community

groups. In early 2018, the county enlisted the Orange County Sheriff's Department to clear out a large encampment of unhoused people along the Santa Ana River in Anaheim,⁴ citing as justification high crime rates and complaints from neighborhoods bordering the riverbed. Although county officials planned on offering hotel vouchers and expanding other available emergency shelter options for people displaced through this process,⁵ hundreds ultimately did not receive appropriate housing or services, particularly people with disabilities.⁶

Further, 33 of the 34 cities in Orange County have ordinances that criminalize sleeping or resting in public (ACLU SoCal 2016). Despite these laws criminalizing homelessness, the county's emergency and long-term housing supply only has the capacity to house a fraction of the overall unhoused population, leaving many to contend with the legal repercussions of staying outside. This has led to lawsuits against the county and individual cities, arguing that jurisdictions that fail to provide adequate shelter for the unhoused population cannot also enforce laws that criminalize sleeping outside when no alternative exists.⁷ In response to these lawsuits and the worsening housing crisis, the county has begun to build up its housing infrastructure, but housing advocates contend that the pace of construction has lagged far behind the needs of the unhoused population.⁸

People experiencing homelessness have diverse demographic and health characteristics, experiences, and needs. As of Orange County's 2019 PIT count, most unsheltered people were white (72.63 percent), male (71.75 percent), and between the ages of 25 and 49 (52.24 percent); however, people from all of the racial and ethnic, gender, and age categories included in the PIT count were represented in the county's unhoused population (OCHMIS 2019). A particularly vulnerable and overrepresented population in Orange County comprises people experiencing homelessness and living with substance use disorder and/or mental health needs: 31.2 percent of the population of people experiencing homelessness in Orange County was identified as having a mental illness, compared with 20 percent of the US adult population (OCHMIS 2019; SAMHSA 2019). Similarly, 26.64 percent of Orange County's population of people experiencing homelessness was identified as having a substance use disorder, compared with approximately 8 percent of the US adult population (SAMHSA 2019). Further, some people experiencing homelessness in Orange County may be living with co-occurring mental illness and substance use disorders. Surveys of the population of people experiencing homelessness in Orange County have found that some people report mental health or substance use as a contributing factor to their experience of homelessness, although economic and family factors—such as inability to secure a job with sustainable wages, difficulty finding and retaining affordable housing, domestic violence, and family death—were more frequently cited.⁹

As homelessness grows in Orange County, so do the costs to local government and community organizations. A cost study of homelessness conducted by Orange County United Way estimated that during a 12-month period between 2014 and 2015, approximately \$299 million was spent to manage homelessness in the county (Snow and Goldberg 2017). According to that study, municipalities spent roughly \$120 million and the county government spent roughly \$62 million on services to manage homelessness during this period. Roughly \$121 million was spent providing health care across the housing, criminal justice, and housing service clusters in the cost analysis. The analysis suggested that as homelessness grows in the county, so will the costs associated with managing the lack of affordable housing and the challenges that creates.

In response to these issues, Orange County passed laws intended to provide short- and long-term support to address the lack of housing assistance. The 2009 Homeless Emergency Assistance and Rapid Transition to Housing Act created a governance structure to support the county's Continuum of Care program funded by the Department of Housing and Urban Development. The county's Continuum of Care aims to be the primary source of homelessness assistance by bringing together a system of resources in the public and private spheres to support a spectrum of housing assistance for people in Orange County (Price 2016). However, a 2016 report presented by the county's director of care coordination, Susan Price, highlighted serious shortcomings of the program, stating that "the leadership, accountability and oversight for the homeless services system of care has eroded" (Price 2016, 2). The report highlighted a lack of cooperation among stakeholders; the growing need for mental health facilities and services; and the scarcity of emergency shelter, transitional housing, and permanent supportive housing as key shortcomings in the county's effort to address homelessness.

In recent years, the county has developed a "system of care" that seeks to increase coordination across agencies and provide wraparound services to prevent homelessness (OCHMIS 2019). The system of care comprises a public-private partnership, with county services and community-based groups providing assistance. The system breaks down important services into five components, one of which is behavioral health services. The HMIOT partnership between the Orange County Health Care Agency and Telecare and Orange Adult Mental Health Services (TAO) Central, a contracted FSP, seeks to fill a gap in mental health services by providing direct services to people with serious mental illness experiencing homelessness in the community they reside in.

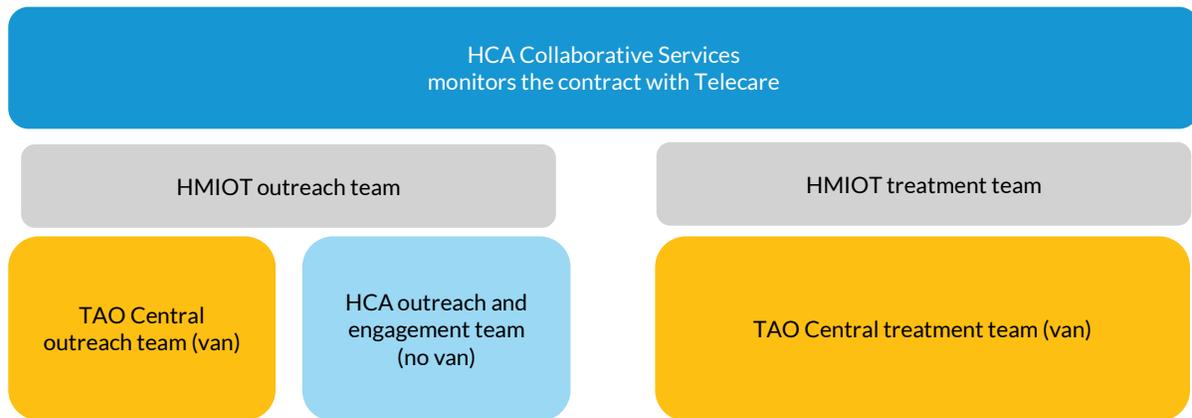
Homeless Mentally Ill Outreach and Treatment Services

Although the system of care was intended to provide services to everyone experiencing homelessness, people with serious mental health needs who experience homelessness are still often underserved in Orange County. Noting this gap in services, county officials applied for and received one-time funding from the California Department of Health Care Services to create an intensive outreach team and a mobile mental health treatment team, which consisted of a partnership between the HCA and TAO Central FSP and launched in April 2019 with outreach services ending in November 2020 and treatment services ending in December 2020.

The goal of the mobile services was to increase access to behavioral and mental health services and housing for people with serious mental illness who were experiencing homelessness and had not been engaged in services. The team aimed to achieve this goal by engaging people in the target population, assessing needs, developing individualized service plans, providing mobile treatment, and addressing barriers to treatment and housing. To provide these services, the team used two staffed vans, one for outreach and one for treatment services. The outreach team, which consisted of a TAO Central outreach team and an HCA outreach and engagement (O&E) team, went out in the field (i.e., various community sites) together to reach out to and engage people experiencing homelessness and to assess whether they needed HMIOT services. The treatment team, which consisted of TAO Central staff, provided mobile short-term behavioral and mental health treatment services and linkage to long-term mental health services to clients engaged by the outreach team. The outreach team comprised two case managers, a peer support specialist, and a driver (who is also a peer recovery specialist). The treatment team comprised a nurse practitioner, two case managers, a peer support specialist, and a peer recovery specialist/driver. Both teams were supervised by a team lead. Figure 1 provides a visual representation of the structure of HMIOT services. The mobile outreach and treatment teams operated throughout the entirety of Orange County.

FIGURE 1

The HMIOT Services Structure



Notes: HCA = Orange County Health Care Agency. HMIOT = Homeless Mentally Ill Outreach and Treatment. TAO = Telecare and Orange Adult Mental Health Services.

Data and Methods

Urban designed its study to assess the implementation and outcomes of the HMIOT services and to inform the HCA on potential avenues for improving implementation and impact. This study was guided by the following four questions:

- How many people were served by HMIOT grant-funded mobile services? What was the composition of the people served in regard to demographics, location of residence, and needs?
- What gaps, if any, exist in who was served and what services were provided?
- What were the challenges in engaging clients in these services?
- What share of people served were connected to long-term treatment and/or housing?

To answer these questions, the Urban research team collected primary data through interviews with HMIOT services staff and clients and administrative data maintained by TAO Central FSP staff. This entire study was conducted during the COVID-19 pandemic. Owing to complications presented by the pandemic, the research team was unable to observe HMIOT activities. In addition, although interviews included questions about the impact of the pandemic on HMIOT services, the study’s findings are complicated by the presence of the pandemic throughout the study period.

Interviews

HMIOT SERVICES STAFF

Urban interviewed HMIOT services staff from Telecare and the HCA to gain a detailed understanding of the services; of how clients were identified, engaged, and provided services; and of successes and challenges with HMIOT services. These services involved staff from Telecare and the HCA to varying degrees. In addition to Telecare and HCA leadership, there were 10 Telecare staff positions funded through HMIOT grant funding; 35 HCA outreach staff, most of whom were involved in HMIOT services at some point and to varying degrees; and 2 team supervisors. The HCA provided the Urban researchers a roster of 15 current and former HCA and Telecare staff members involved in HMIOT services, with contact information. The research team then invited staff from the roster to participate in interviews, resulting in a convenience sample of 10 staff members who were interviewed by phone using a semistructured protocol. Interviews included a range of HMIOT staff positions from Telecare and the HCA (positions included leadership and supervisors, case managers, program managers, team leads, and peer support specialists). The research team analyzed interviews using thematic coding.

CLIENTS

Urban also interviewed HMIOT clients involved in treatment to better understand their needs, what services they were provided, and their perspectives on successes and challenges with HMIOT services. Initially, Urban researchers planned to go out with staff to identify and interview clients who agreed to participate. Because of the pandemic, the researchers instead worked closely with staff who identified clients who could consent to interviews, scheduled interviews with clients who agreed to participate, and connected the researchers to clients via phone. The research team conducted phone interviews with clients who agreed to participate using a semistructured interview protocol. Staff who had signed confidentiality pledges were present during these interviews to help facilitate use of the phone and offer assistance to clients as needed throughout the process. All clients were informed that staff members had signed confidentiality pledges.

This process resulted in a convenience sample of seven interviews with HMIOT clients. All participants reported being currently engaged in treatment and services. All but one person receiving services from Telecare were housed at the time of the interviews. There were six male participants and one female participant. The participants ranged from 31 to 57 years old and a majority reported having one or more children. Of the seven participants, five self-identified as white, one as African American/Black, and one as white and American Indian/Alaskan Native. One participant reported being a military veteran. These interviews were also analyzed using thematic coding.

ADMINISTRATIVE HMIOT SERVICES DATA

In addition to staff and client interviews, Urban collected administrative data about HMIOT services. These data provided a more complete picture of client composition and services provided. They included a Microsoft Excel spreadsheet used by TAO Central staff to track outreach and data exported from Caminar, a behavioral health services software for tracking client services. The outreach dataset includes almost every encounter, but because it tracked people before they were engaged in HMIOT services, it includes neither a client identification number nor clients' full names. In addition, data were tracked by hand, and data-quality issues were discovered by HMIOT staff during validation. Therefore, these data were only used to estimate overall numbers for HMIOT activities and identify the locations where outreach occurred using geocoding of zip codes to create a heat map of outreach activities geographically in R statistical and mapping software. We use the word "estimated" throughout this report when referring to these data. Clients who were engaged in HMIOT services had their information tracked in the Caminar system. Data from this system include client demographics, engagement in outreach and mobile treatment, services received, Housing Opportunity Application completion, and barriers to housing and treatment addressed. The research team primarily analyzed these data using descriptive statistics and examined basic bivariate relationships using *t*-tests.

Limitations

There are several limitations to the research presented in this report. First, the short duration of the services provided precludes the use of trend analysis, while the relatively small pool of clients makes it difficult to perform inferential statistics and draw firm conclusions about outcomes for client subgroups. In addition, though the data include rich information about services rendered, they lack information about needs and barriers outside of the context of services provided. This makes it difficult to draw conclusions about whether and how services met the needs of clients and where gaps in services existed based on client need. Moreover, there are observations with missing and out-of-range data that could not be analyzed and issues with data quality and validity that were discovered after analysis was conducted.

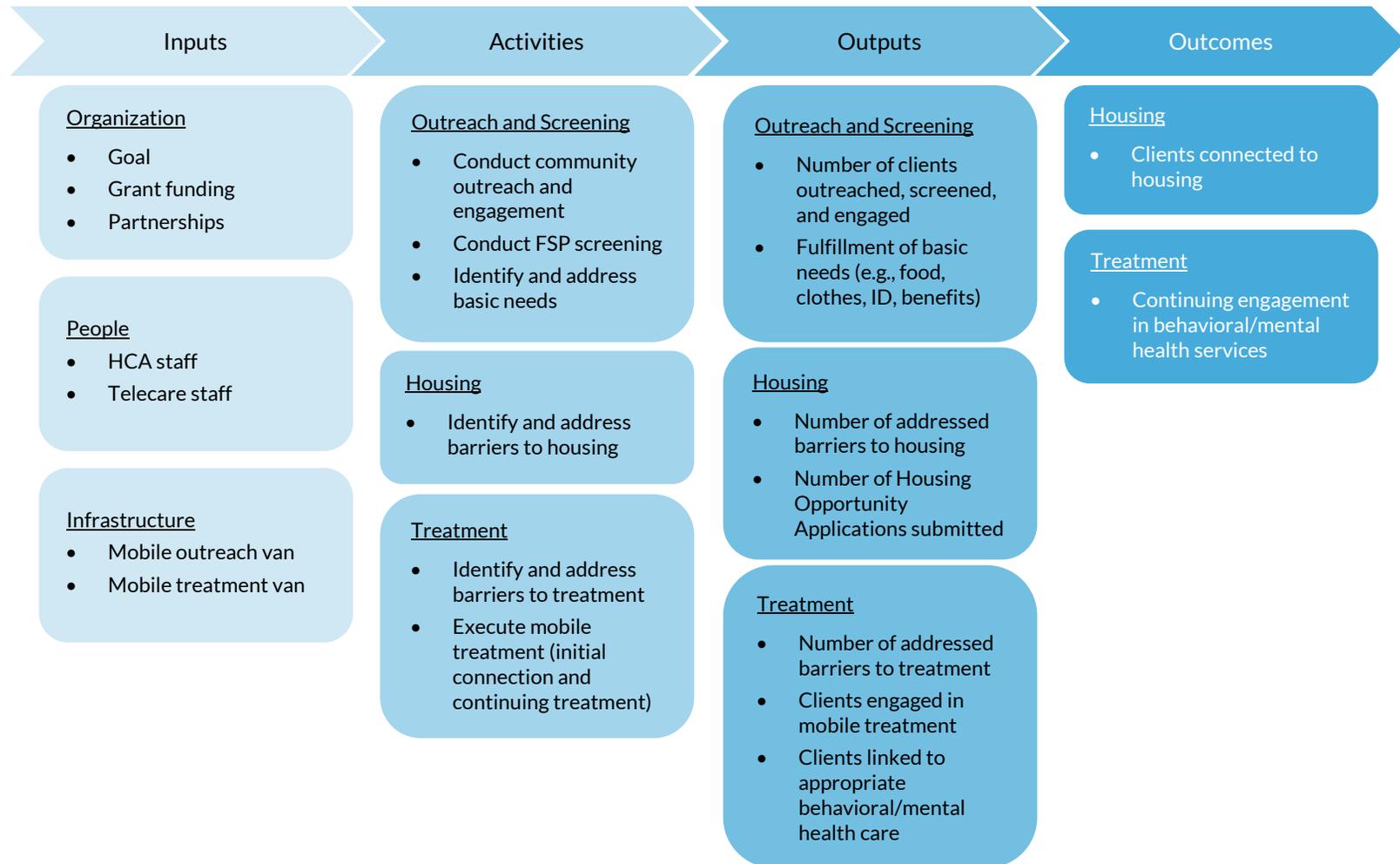
The client and staff interviews helped Urban better understand implementation of HMIOT services, client needs, and services rendered, but these findings also have limitations. The research team interviewed roughly half of the staff involved in HMIOT services, but this was still a small number of people. The interviews were also conducted around the start of the COVID-19 pandemic, when service design and operations were in flux. In addition, the pandemic prevented the research team from observing field operations and affected its ability to conduct client interviews. The team still conducted

interviews with clients over the phone, but because of constraints of the pandemic, this involved only a small group of people who were currently receiving HMIOT services and coming into HCA offices. This represents a bias sample of clients and leaves out the perspectives of people experiencing homelessness who were approached about HMIOT services and declined them or who are still dealing with challenges that make participating in services difficult.

Assessment Findings

As part of the assessment, Urban developed a logic model for HMIOT services (figure 2) that includes the inputs, activities, outputs, and outcomes of the services. As designed, the HMIOT **inputs** included a goal, grant funding, HMIOT services staff, partnerships, and two vehicles. **Activities** involved outreach and engagement with potential clients, screening for service eligibility and needs, identification of basic needs and services to address them, mobile treatment, and identification of housing and treatment barriers and services to address them. **Outputs** of HMIOT services included fulfillment of basic needs, clients engaged in mobile treatment (defined as successful completion of intake and two follow-up sessions), clients linked to appropriate mental health treatment, removal of barriers to housing and treatment, and number of submitted Housing Opportunity Applications (these are applications used in Orange County to refer clients to permanent supportive housing such as Continuum of Care voucher applications and applications for Mental Health Services Act housing project apartments). These services were expected to result in two key **outcomes**: clients continuing their engagement in behavioral/mental health services and being connected to housing.

FIGURE 2
The HMIOT Services Logic Model



Source: Logic model of HMIOT services developed by Urban.

Notes: FSP = Full Service Partnership. HCA = Orange County Health Care Agency. HMIOT = Homeless Mentally Ill Outreach and Treatment.

HMIOT Services: Inputs

The HMIOT services were guided by the goal to “increase access to behavioral health services and housing by engaging individuals, developing individualized needs assessment and service plans and addressing barriers to treatment.” Inputs included \$2,221,000 of grant funding from the California Department of Health Care Services, 10 Telecare staff funded by the grant, additional HCA and Telecare staff who supported services funded through existing sources, partnerships with shelters and other treatment and service providers, and one mobile outreach vehicle and one treatment vehicle. The staff who went out in the field as part of a multidisciplinary team typically included a team lead, a nurse practitioner, two peer specialists, four case managers, and two people who are drivers and recovery specialists. Health Care Agency outreach and engagement staff also went out in the field.

Through interviews, Urban found that HMIOT staff were generally well informed of the goal of HMIOT services. Staff identified the core goal of the services as being to provide resources and reduce barriers to care for people experiencing homelessness and mental health needs in Orange County. Staff noted that the services are supposed to reach people who are typically difficult to engage, who are generally distrustful of county-based mental health services, and who often have trouble accessing traditional services. As one staff member described, “This program is providing services to people who wouldn’t otherwise get these kinds of services. We’re trying to connect bridges between services with people who didn’t know our kind of services were available.”¹⁰ Staff explained that HMIOT services are designed to meet clients where they are and to help them eventually become self-sufficient.

This program is providing services to people who wouldn’t otherwise get these kinds of services. We’re trying to connect bridges between services with people who didn’t know our kind of services were available. –HMIOT staff member

Although staff could identify the goal of HMIOT services, they were less clear on the services’ design and specific components. They noted that the design had changed since implementation to improve operations and because of the pandemic, which likely contributed to the reported confusion. When asked about operations, staff reported that before the pandemic, the HCA O&E team worked alongside the team operating an HMIOT van to engage and enroll potential clients across the county.

Staff interviewed by Urban reported that, in response to the pandemic, the two teams had begun performing outreach separately. This was later changed as operations shifted toward prepandemic design.

Most staff did report that the pandemic initially limited active outreach activities, resulting in fewer face-to-face services, but services resumed to expected levels after a few months. According to interviews, after the pandemic began, the O&E team began calling the Telecare HMIOT outreach team if it identified a potentially eligible person while interacting with people in the shelters and hotels that house people through the state's Project Roomkey program. One Telecare staff member described this new system as if they were "on call," waiting at the office for an O&E team member to reach out about someone before going out in the field. Generally, when asked about outreach and follow-up procedures, staff noted that procedures had changed multiple times and that it was difficult to keep up with these changes.

Staff agreed that the partnership between Telecare and HCA is integral to HMIOT services. However, staff also offered mixed responses when asked about partnerships. Some stated the relationships between Telecare and HCA staff were positive, whereas others indicated the relationships were sometimes strained and that communication could be improved. Overall, though, staff agreed that the partnership had improved and that communication was better than at the outset of the initiative. Most were encouraged by the improvements that had been made to the services and all had successes to report.

HMIOT Services: Activities

As part of HMIOT services in Orange County, staff engaged in several activities. Mainly, staff provided field-based services, using the vans as private mobile spaces for conducting intake and providing treatment. One vehicle was intended for outreach and identifying potential clients, and the other was intended for providing mental health treatment services to clients in the field and for coordinating with other FSPs for housing services and coordinated entry-system services. In addition to outreach, screening, and general case management, services related to outreach and treatment included evaluations and assessments, individual and group therapy and counseling, education, medical referrals and medication assistance, and crisis intervention. In addition, HMIOT funds were made available to assist with housing and basic needs of clients. As a part of housing-related services, HMIOT staff filled out Housing Opportunity Applications with some clients.

When asked about HMIOT service activities, staff described the services they provided and resources they linked clients to. All staff discussed community outreach and engagement activities. In addition to outreach, staff most commonly cited mental health and substance use resources such as access to medication, group and individual therapy services, and peer support and case management. Staff consistently praised the increased accessibility of mental health services that the initiative provided. One staff member noted, “I think this program has had opportunity and segued into changing the belief of the acceptability of behavioral health services for the homeless. By bringing them the service, they feel more welcomed.”¹¹ Staff also reported meeting the basic needs of clients, such as by providing clothing and food. Generally, staff with the outreach van worked to meet a person’s immediate needs and then, after a client was enrolled, a case manager worked with the client to make a care plan to address longer-term needs such as employment, benefits, and housing. In interviews, staff emphasized the strength of the range of HMIOT services provided to a particularly vulnerable population. They also praised the increased accessibility and adaptability of services as a key success.

The clients Urban interviewed praised HMIOT staff’s proactive approach to identifying them for services and reported having had positive experiences being approached by staff. They emphasized the importance of the friendly demeanor and trustworthiness of staff and their ability to provide various shelter and housing resources. One client stated, “They weren’t pushy and didn’t make false promises. They were friendly and just talked to me about mental health and ... offered to help me.”¹² One participant shared how they were approached while living on the street and were grateful for the offer for housing, as that had never happened to them before. Another participant shared that they had been given offers for housing in the past that never came to fruition, and the ability of the Telecare staff to follow through on their offer was extremely important to them. Another emphasized the importance of staff being genuine and trustworthy, stating, “I’ve been through a lot in my life, but this one is not just in it for the money. They have been very proactive and involved.”¹³ One participant shared that their experience included being approached by a staff member, making an appointment, and being assigned a case manager who worked with them throughout their involvement in the HMIOT services. That client noted that it only took two to three days after their initial contact with staff to be connected to a case manager.

They weren’t pushy and didn’t make false promises. They were friendly and just talked to me about mental health and ... offered to help me. –HMIOT client

HMIOT Services: Outputs and Outcomes

The short-term outputs of the services included people outreached, screened, and enrolled in services; the number and type of immediate basic needs fulfilled; the number of clients engaged in mobile treatment; the number of clients linked to appropriate behavioral/mental health care; removal of barriers to housing and treatment; and the number of Housing Opportunity Applications submitted. As designed, the longer-term outcomes focused on clients' continuing engagement in behavioral/mental health services and their being connected to housing.

Between April 1, 2019, and November 31, 2020, HMIOT staff estimate that roughly 2,000 contacts were made. These contacts were made with 952 unique people, of whom HMIOT staff estimate that roughly 500 were assessed for whether they met eligibility criteria (i.e., whether they had a serious mental illness and were experiencing homelessness) for services. Of those assessed, 172 were determined to meet the eligibility criteria and 122 completed intake and were enrolled in HMIOT mobile treatment.

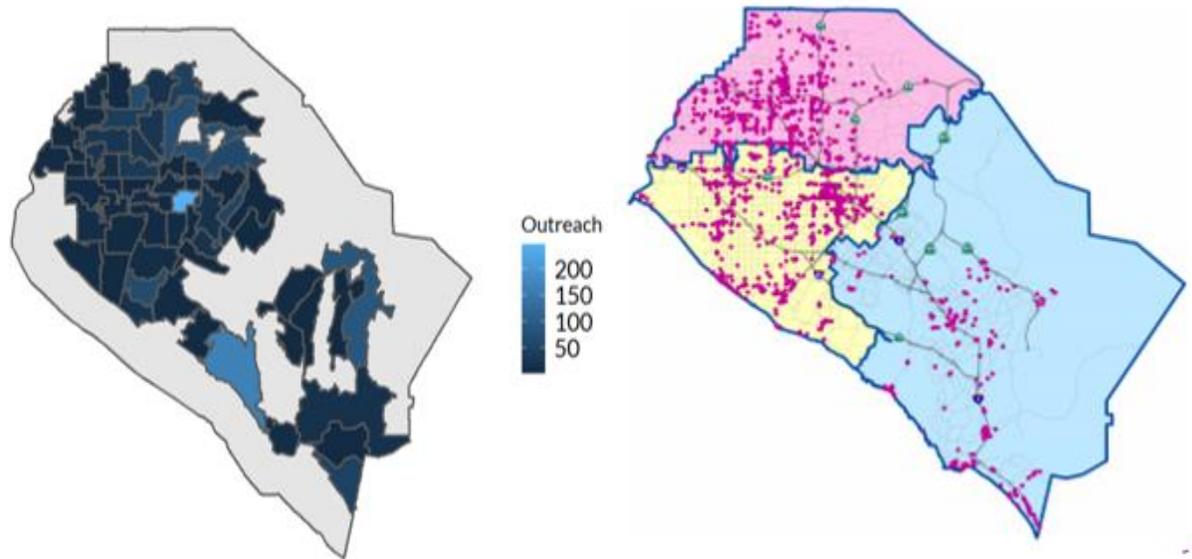
As part of the services provided through the HMIOT initiative, staff have a list of specific barriers to housing and treatment that they track. Of the 122 clients who were enrolled, all were engaged in treatment (i.e., they completed intake and at least two follow-up sessions), 94 had specific barriers to treatment addressed, 86 had specific barriers to housing addressed, and 32 completed Housing Opportunity Applications. In its interviews with seven HMIOT clients, the research team found that nearly all of them were satisfied with the services overall. In the rest of this section, we discuss outputs and outcomes that had occurred as of our assessment.

OUTREACH

As discussed above, HMIOT staff outreached 952 people over roughly 2,000 contacts to offer services during the 17-month study period. Figure 3 shows a map of outreach efforts, by density within each zip code, compared with the locations of people experiencing homelessness based on the 2019 Point-in-Time survey (OCHMIS 2019). From this comparison, it is evident that the density of outreach efforts was similar to that of people experiencing homelessness. Some of the higher outreach densities are representative of the outreach efforts in shelters that are not reflected in the Point-in-Time count map.

FIGURE 3

HMIOT Outreach by Zip Code Compared with 2019 Point-in-Time Count



Sources: Left: Homeless Mentally Ill Outreach and Treatment outreach data. Right: “Everyone Counts: 2019 Point in Time Summary” (Orange County Homeless Management Information System, 2019).

Notes: HMIOT = Homeless Mentally Ill Outreach and Treatment. The left side and bottom of this map includes parts of Orange County that are in the Atlantic Ocean and would not be included in outreach efforts. In the left-hand map, outreach numbers are the numbers of people outreached in each zip code in Orange County during the period of HMIOT service provision. In the right-hand map, purple dots represent the location where a person was known to be experiencing homelessness in Orange County, using the night of January 22, 2019, as the Point-in-Time date.

Of those contacted, an estimated 500 people were assessed for whether they met the eligibility criteria for services, and 172 were determined to be eligible. Of the latter, 41 percent were between 51 and 60 years old, 60 percent were male, 66 percent were white, and 19 percent were Hispanic/Latine. Of those who reported their marital status, 66 percent reported being single. Family military status was not recorded for most (76 percent) of the people outreached. Most people (96 percent) reported that their primary language was English; other reported languages included Armenian, Spanish, Tagalog, and Vietnamese. Primary disability was not reported for roughly 30 percent of people, but of those who self-reported a primary disability, just over half reported mental illness and just under half reported both mental illness and substance use disorder. Very few people reported only substance use disorder as a primary disability. Per the eligibility criteria, all HMIOT clients were determined to have a serious mental illness by staff, who reported that many people also had substance use disorder. Detailed information on the demographics of people reached and assessed and determined to meet eligibility criteria is available in the appendix. There are no data available on the people who were outreached but

not determined to meet eligibility criteria or those outreached and not assessed, as they were unlikely to provide a name and other demographic information for HMIOT staff to enter into their data system.

IMMEDIATE BASIC NEEDS

While engaging with clients, HMIOT staff identified many immediate basic needs, including mental health stabilization services and help applying for benefits and income support. Although these needs were not tracked in the Caminar data system, the Urban research team included questions about needs and services in its staff and client interviews. Staff highlighted that although clients and cases differed, the services were well designed to adapt to each person's need. By providing each client individualized support, case managers worked alongside clients to identify needs and create plans to address them.

They help you out with whatever you need. –HMIOT client

Similarly, clients reported during interviews that HMIOT services helped with a wide range of immediate basic needs, including clothes, hygiene products, physical health services, employment assistance, financial assistance, assistance obtaining personal documents (e.g., ID), assistance applying for government assistance programs (e.g., the Supplemental Nutrition Assistance Program, Electronic Benefits Transfer, MediCal), transportation, and more. The majority of interviewed clients said that HMIOT services addressed their needs. One participant stated, "They'll help you out with whatever you need," sharing that they received assistance applying for Supplemental Nutrition Assistance Program benefits and health care, getting their stimulus check, applying to jobs, and addressing medical needs around medication, doctors, and therapy. Another participant talked about how helpful it was to receive reliable parking for their car. One participant shared, "I've had quite a few needs ... Telecare has been there the whole time." Still another stated, "Everybody at Telecare is so positive. Always game to help you. They go the extra mile."¹⁴

*Everybody at Telecare is so positive. Always game to help you. They go the extra mile.
–HMIOT client*

MOBILE TREATMENT AND LINKAGE TO LONG-TERM TREATMENT

The staff Urban interviewed highlighted behavioral health services and particularly medication and counseling support as integral components of HMIOT services. Because the target population for these services included people with severe behavioral health needs, staff often cited the need to stabilize clients as a priority before addressing other, longer-term needs. However, the stigma around receiving services, particularly from the county, served as a persistent barrier to providing support to clients. Although staff often expressed discouragement at low engagement with mental health services, they also emphasized that most of the people they served would not have received support without HMIOT services. Staff underscored that the target population is one that typically “falls through the cracks” of county services, so being able to engage and provide any sort of support was a success. Although the clients Urban interviewed were all engaged in treatment, the research team declined to ask specific questions about their treatment to respect their privacy and protect confidential health information.

As noted above, 172 people were assessed to be eligible for services by HMIOT staff, although only 122 completed the intake process and were enrolled in mobile treatment. The demographics of the people enrolled in mobile treatment are similar to those of the full group assessed as eligible. More detailed demographics for both groups are available in the appendix.

Enrollment in mobile treatment is defined as completing the intake and at least two follow-up sessions. The 122 enrolled clients received a range of service including evaluations and assessments, case management, medical referrals and medication support, and therapy, counseling, and education (individual and group). From April 1, 2019, to December 31, 2020, 4,376 hours of services outside of outreach activities were recorded in HMIOT administrative data. This included more than 3,000 hours for case management, 542 hours for evaluations and assessments, 366 hours for medical referrals and medication support, and 116 hours for therapy, counseling, and education. Clients received between 5 and 349 services; on average, they received 51 services and roughly 7 hours of services. Most services were provided in the community (including in shelters, stores, and other community locations), in a clinic, or through telephone or a telehealth network. Clients received services between 0 and 467 days after initially being reached, at an average of 59 days.

The number, duration, and location of services does not noticeably vary by age, gender, race, or primary disability. Table 1 provides details about the number and duration of services provided.

TABLE 1

HMIOT Services Provided to Engaged Clients

Service	# of times provided	# of clients receiving service	Avg. # of sessions per client	Avg. minutes of service per client
Evaluations and assessments	433	111	3.90	75.15
Case management	5,343	122	43.79	37.27
Medical referrals/medication support	371	97	3.83	59.14
Therapy, counseling, and education (individual)	54	30	1.80	144.30
Therapy, counseling, and education (group)	30	7	4.29	65.17
Other	30	18	1.67	68.00

Source: Urban analysis of HMIOT data tracked through the Caminar data system.

Note: HMIOT = Homeless Mentally Ill Outreach and Treatment. Other services include collateral services, crisis intervention, and crisis psychiatric services.

The HMIOT staff compiled a list of predetermined barriers to treatment, including substance use, legal concerns, lack of insight into mental health, medical concerns, partner/spouse, transportation, follow through, lack of social supports, interpersonal skills, pets, lack of income, memory loss, storage, children or child care, codependency, lack of coping skills, and ownership of tools.¹⁵ Staff addressed one or more of these barriers for 94 clients, with substance use and legal concerns being the most common. Table 2 specifies the number of times barriers were addressed. Note that 105 instances of barriers were addressed, as some clients experienced multiple barriers. Any barrier that was addressed for fewer than four clients is listed as “other”; these include interpersonal skills, pets, lack of income, memory loss, storage, children or child care, codependency, lack of coping skills, and ownership of tools.

TABLE 2

Treatment Barriers Addressed in Provision of HMIOT Services

Barrier	# of clients with barriers addressed
Substance use	21
Legal concerns	18
Lack of insight into mental health	11
Medical concerns	10
Partner/spouse	9
Transportation	9
Follow through	7
Lack of social supports	4
Other	16

Source: Urban analysis of HMIOT data tracked through the Caminar data system.

Notes: HMIOT = Homeless Mentally Ill Outreach and Treatment. Any barrier addressed for fewer than four clients is listed as “other”; these include interpersonal skills, pets, lack of income, memory loss, storage, children or child care, codependency, lack of coping skills, and ownership of tools.

Clients' barriers to treatment were addressed between 0 and 505 days after being outreached, the average being 146 days. The demographics of the clients who did not get barriers addressed are similar to those of the group of clients that did have barriers addressed, though Hispanic/Latine clients were more likely to have barriers to treatment addressed. Using *t*-tests of significance, Urban found that this difference was statistically significant ($p = 0.005$). Further, people who had barriers to treatment addressed received slightly more services on average than clients who did not have barriers to treatment addressed. This difference was also statistically significant ($p = 0.012$). Moreover, HMIOT staff tracked connections to permanent treatment services, but because of issues with data validity and quality, we cannot report on those numbers.

HOUSING

Housing and stable income were the most common long-term needs cited by staff for clients, and some staff reported working with people to find stable housing and help them apply for benefits and employment support. However, interviews also revealed a lack of clarity among some staff about what housing-related services could be provided through HMIOT services. The HMIOT services were designed to provide a range of shelter and housing support to all contacted people. Staff also had access to flex funds that could be used to support clients with housing costs and other needs, but these funds were only available to clients enrolled in services. It is unclear why there was confusion among some staff about housing services; it could have owed to changes in operations and limitations, confusion over eligibility criteria, and restrictions on flex funds. In addition, housing needs appeared to be further confounded by the county's response to the pandemic and attempts to limit congregate housing, such as shelters. The HCA O&E team reported engaging with clients and potential clients through the state's Project Roomkey program, which placed unhoused people in hotels at the beginning of the pandemic, but it is unclear how many clients found longer-term housing solutions. Staff noted that the pandemic affected the job market and therefore impacted efforts around income stability.

When they offer board and care, that really put the wind beneath my wings. Telecare is a one-stop shop. —HMIOT client

Significantly, most of the seven clients Urban interviewed reported having gained housing while receiving HMIOT services. One client noted that this is what differentiated the HMIOT services from

others. They stated, “When they offer board and care, that really put the wind beneath my wings. Telecare is a one-stop shop.” Participants acknowledged the benefits of receiving housing through HMIOT services. Another client stated, “I’m just so thankful for the room and board and thankful that a corporation like this is here to help me reach my goals so I’m not just here alone in the streets.”¹⁶

Several clients stated that obtaining housing through other organizations was a challenge. One emphasized the mistrust they felt when a different organization made a promise to provide housing and did not follow through. Some clients reported that their circumstances improved after they started receiving HMIOT services. One stated, “I got out of the street because of Telecare. I was doubting [the case manager] because of all the problems I had. I was trying to get into Section 8 housing in various parts of Orange County, but I was so far down the list that I didn’t think I would get out. Several other agencies have made promises, but those didn’t materialize. Telecare lived up to their word, which was very surprising. I love the apartment I live in now and I give credit to Telecare.”¹⁷

Telecare lived up to their word. –HMIOT client

There were some clients Urban interviewed who experienced difficulties in having their needs met. In particular, physical disabilities presented challenges in obtaining stable income and housing, with one client reporting that their Supplemental Security Income was not enough to make rent, saying, “Right now, I need help paying rent. Nobody is helping me pay rent. And if I don’t get help, I’ll be back on the streets.”¹⁸ Accessibility was also an issue among people with disabilities receiving HMIOT services; for instance, some of the housing options were not wheelchair accessible. These experiences highlight the unique hurdles people with disabilities face in obtaining stable and accessible housing.

Right now, I need help paying rent. Nobody is helping me pay rent. And if I don’t get help, I’ll be back on the streets. –HMIOT client

Like treatment barriers, HMIOT staff compiled a list of predetermined barriers to housing acquisition and recorded how many and which types of housing barriers they addressed for clients.

Urban’s analysis of these data indicate that housing barriers were addressed for 86 clients, with substance use and legal concerns being the most common. Other addressed housing barriers included follow through, lack of insight into mental health, partner/spousal barriers, lack of social supports, pets, transportation, medical concerns, and interpersonal skills. Any barrier addressed for fewer than four clients was included in the “other” category; these include age, children or child care, lack of coping skills, memory loss, storage, and tools.

TABLE 3
Housing Barriers Addressed in Provision of HMIOT Services

Barrier	# of clients with barriers addressed
Substance use	20
Legal concerns	14
Follow through	8
Lack of insight into mental health	8
Partner/spouse	8
Lack of social supports	5
Pets	5
Transportation	5
Medical concerns	4
Interpersonal skills	4
Other	9

Source: Urban analysis of HMIOT data tracked through the Caminar data system.

Notes: HMIOT = Homeless Mentally Ill Outreach and Treatment. Any barrier addressed for fewer than four clients is listed as “other”; these include age, children or child care, lack of coping skills, memory loss, storage, and tools.

Housing barriers were addressed between 0 and 505 days after initial outreach, and the average was 170 days. Demographics for enrolled clients who had at least one barrier addressed were similar to those for clients who did not have or need a barrier addressed. Those with barriers addressed received slightly more services on average compared with the group that did not have barriers to housing addressed. This difference was marginally statistically significant ($p = 0.06$).

Housing Opportunity Applications were completed for 32 clients; this took between 13 and 541 days after outreach, with an average of 214 days. Clients with housing applications completed were more likely to receive a slightly longer duration of services on average than the clients without applications completed. This difference was marginally statistically significant ($p = 0.05$).

Barriers to Engagement

Although HMIOT services offered a broad array of services to clients, staff identified several barriers to engagement in meeting clients' short- and long-term goals. Many of these barriers were specific to the population that HMIOT targeted. Staff highlighted that working with a transient population made it difficult to find and maintain contact with clients. Staff also noted logistical issues working with this population, such as lack of access to transportation, a cell phone, or a watch to help clients make it to appointments for services the mobile treatment van could not provide. Staff repeatedly brought up transportation as a barrier to clients' receiving services, especially in the southern part of Orange County, which was described as large and spread out. Further, staff described that clients with mental health needs often expressed distrust of county-based treatment. Staff suggested that this likely stemmed from negative prior experiences with mental health service providers, denial of mental health needs, or the stigma around receiving mental health services.

Staff also noted that it typically takes multiple outreach attempts for clients to feel comfortable engaging with the HMIOT services. Some of the clients Urban interviewed echoed this distrust based on previous experiences, but generally expressed trust and satisfaction toward staff providing HMIOT services. In sharing their own experiences receiving the services, the clients did not note many barriers, other than those with disabilities struggling to find affordable and accessible housing that met their needs.

In addition to barriers stemming from the diversity of the population served, some staff members identified programmatic barriers to providing services, such as eligibility requirements. Staff described unclear guidance on eligibility for services, which may have contributed to delays in enrolling and providing services. Staff emphasized the need to clarify eligibility requirements to receive HMIOT services to ensure all eligible and interested people had access to the services.

Because the administrative data do not include information on client needs absent services received, Urban could not compare the degree to which clients' needs overall aligned with services rendered. As such, this report does not identify gaps in services provided based on client need. That said, interviews with staff and clients did not uncover any unmet needs, with the exception of some staff expressing confusion and frustration about the availability of housing options and housing-related services for clients.

In addition to examining the specific barriers to engagement identified by the assessment activities, Urban compared the people who received HMIOT services with the population of people experiencing homelessness in Orange County, as recorded in the 2019 PIT count (OCHMIS 2019). Based on the

availability of the HMIOT data, Urban focused on the population of clients assessed and found eligible, rather than everyone who received outreach through HMIOT. Urban compared the demographics of this group with those of the county's population of people experiencing homelessness. The research team found that the population assessed for and engaged in HMIOT services included smaller shares of people identifying as white and non-Hispanic/Latine (53 percent, compared with 73 percent) and male (58 percent compared with 72 percent) than the overall population of people experiencing homelessness in the county. The HMIOT population was also older on average: 41 percent of clients were between the ages of 51 and 60, whereas a majority of people in the overall population of people experiencing homelessness in the county are between 25 and 49.

Several things could explain these differences between HMIOT clients and the overall population of people experiencing homelessness in the county. For example, the HMIOT services targeted the population of people with serious mental illness, which may be generally different from the overall population. Further, the demographics of people experiencing homelessness in the areas where HMIOT staff concentrated outreach efforts are likely to differ from those of the overall population. Lastly, the willingness of demographic groups to receive HMIOT services likely varied.

Conclusion

Overall, through the leadership and direction of the Orange County Health Care Agency, the implementation of the Homeless Mentally Ill Outreach and Treatment Program was a success. The initiative aimed to fill a service need among people experiencing homelessness in the county by identifying, outreaching, and connecting people with serious mental health needs to mobile treatment and addressing their immediate and longer-term needs. Moreover, the HCA and Telecare built and strengthened a successful partnership that served as the foundation for the services. This resulted in the removal of the critical barriers many clients faced in receiving and participating in services.

It is clear that as of Urban's assessment of administrative data and staff and client interviews, many people were strongly and consistently engaged in the HMIOT initiative and were receiving much-needed services. The few clients we interviewed reported being generally satisfied with the services they received through the initiative and were comfortable with the outreach teams and the providers at Telecare. Clients also noted that HMIOT personnel were trustworthy and followed through on promises. This was a particularly positive outcome given the complex needs and challenges associated with the target population (i.e., people experiencing homelessness who have a serious mental illness, whom the staff we interviewed said are often distrustful of county personnel and behavioral health

service providers). Interviewed clients mentioned that this was a clear departure from some of the other programs and service providers in the county. The initiative's success had an immediate benefit for HMIOT clients, and it also created the opportunity to rebrand and change the perception of county services among this high-needs population, something that may help outreach and service delivery over the long term.

In addition to identifying these successes, Urban uncovered a few challenges and barriers to HMIOT implementation. Of note, HMIOT services were disrupted by the outbreak of the COVID-19 pandemic, which occurred approximately one year after the launch of the initiative. Associated safety protocols significantly affected staff members' ability to engage in face-to-face interactions, limiting or altering outreach, engagement, and service delivery. Similarly, although the state's Project Roomkey was instrumental in providing noncongregate shelter options for people experiencing homelessness, it also created challenges for HMIOT staff in finding and engaging potential clients. Despite these extremely difficult circumstances, the HCA and Telecare were able to adapt to the situation and continued to provide services to the target population. For example, after the pandemic, the O&E team began notifying Telecare personnel when it was separately interacting with a client who may have been eligible for HMIOT services (such as when the O&E team was visiting shelters, hotels, or other housing used for Project Roomkey).

Largely because of the challenges presented by the pandemic, the Orange County HMIOT initiative fell short of some of its target outreach, screening, and enrollment numbers. For example, the HCA planned on making 3,750 client contacts (including duplicate contacts) throughout the initiative, whereas staff made closer to 2,000. Nonetheless, the number of clients enrolled (122) was very close to the target number (125). Moreover, the percentage of clients who were screened and eligible and were enrolled (70 percent) far exceeded the 30 percent target.

Other challenges that arose during implementation were typical for this kind of initiative. For example, Telecare experienced turnover among its HMIOT staff, something the pandemic exacerbated. Moreover, as is the case with the launch of any new initiative, there were some communication issues between the HCA and Telecare, particularly in the beginning. Though communication generally improved throughout the initiative, some staff lacked a clear understanding of HMIOT policies and practices (e.g., confusion or disagreement about eligibility requirements and housing-related services). Lastly, some staff noted differences in training and competencies between the HCA O&E team and the Telecare HMIOT staff. Although members of the O&E team already had extensive training and field experience related to outreach, Telecare staff received more limited training through the initiative

before going into the community to interact and engage with potential clients. In addition, there were issues with consistent and accurate data collection.

Recommendations

Based on its findings, the research team identified the following recommendations that could help the Health Care Agency improve the HMIOT initiative, and that could be helpful for similar initiatives across the country:

- Clarify the HMIOT services model to all staff through written materials, trainings, and ongoing communications. There was confusion among some staff about the initiative's eligibility requirements, services available to clients, and acceptable outreach methods. Clear and consistent communication on these components up front can make implementation smoother and improve uptake among staff.
- Consider providing comprehensive outreach training to all providers who will be interacting with clients in the field and ensure this training is consistent for all staff. This can help ensure staff are on the same page about conducting outreach and engaging clients. If providing the same level of training to all staff is not feasible, consider having Telecare service providers work more closely with members of the HCA O&E team to better understand the team's approach to outreach and gain more on-the-job experience.
- Expand and build additional analytic capacity. As of our analysis, HMIOT staff recorded most of the outreach, assessment, enrollment, and service provision data in the Caminar system, whereas other information (e.g., the number of contacts) was only tracked by hand. In addition, changes in data collection and recording procedures and variation in how staff recorded data resulted in inconsistencies in these data. Improving these systems and processes will better position the HCA and Telecare to understand the impacts of the initiative and demonstrate its successes to funders and other partners.
- A related recommendation is to develop better audits or data-validation checks to ensure information about HMIOT services is accurately and consistently tracked. Staff have already compared hand-coded records with the information in Caminar and found some discrepancies between the two sources. Going forward, this should be done on a regular basis so staff can identify these inconsistencies early and make immediate course corrections when needed. In addition, validation could be built into data-recording systems to improve consistency in how data are recorded across staff.
- Develop a method to record demographic information about all contacts and reasons people provide for not engaging in services. This additional data collection could be useful in improving HMIOT services through a better understanding of barriers to engagement for potential clients.

- Continue to examine the outputs and outcomes associated with HMIOT services and consistently and clearly track outputs related to the goals for the services in Caminar (e.g., referrals to shelters, use of flex funds, attainment of permanent housing, connection to long-term treatment, continued engagement in long-term treatment). This will help the HCA and Telecare better understand how services fit clients' diverse needs, identify service gaps that can be addressed, and better understand the extent to which HMIOT services are meeting stated long-term goals.
- Think about the appropriate scale and scope of the program moving forward by investigating how many people may qualify for HMIOT services and what impact scaling up or down would have on the ability to provide them.
- Continue to provide trustworthy services through the HMIOT initiative and other initiatives targeting people experiencing homelessness in Orange County. As noted above, one of the notable successes of the HMIOT initiative was the level of trust staff built with clients. Continuing these efforts over the long term will help maintain and strengthen these relationships, which may make clients more receptive to much-needed services in the future.

Appendix. Client Demographics

TABLE A.1
HMIOT Client Demographics

	Clients assessed to meet criteria (n = 172)		Clients enrolled (n = 122)	
	Frequency	Percentage	Frequency	Percentage
Age group	(n = 172)		(n = 122)	
30 to 40	29	16.86	23	18.85
41 to 50	39	22.67	29	23.77
51 to 60	70	40.70	51	41.80
Over 60	11	6.40	6	4.92
Under 30	23	13.37	13	10.66
Gender	(n = 168)		(n = 121)	
Female	67	39.88	45	37.19
Male	100	59.52	75	61.98
Transgender	1	0.60	1	0.83
Race	(n = 139)		(n = 107)	
American Indian/Alaskan Native	1	0.72	1	0.93
Asia/Pacific Islander	7	5.04	6	5.61
Black/African American	13	9.35	9	8.41
Hispanic/Latine	26	18.71	19	17.76
White	92	66.19	72	67.29
Primary language	(n = 144)		(n = 112)	
Armenian	1	0.69	1	0.89
English	138	95.83	106	94.64
Spanish	3	2.08	3	2.68
Tagalog	1	0.69	1	0.89
Vietnamese	1	0.69	1	0.89
Marital status	(n = 98)		(n = 87)	
Divorced	15	15.31	15	17.24
Domestic partner	2	2.04	0	0.00
Married	6	6.12	6	6.90
Separated	5	5.10	5	5.75
Single	65	66.33	58	66.67
Widowed	5	5.10	3	3.45

Source: Urban analysis of HMIOT data tracked through the Caminar data system.

Note: HMIOT = Homeless Mentally Ill Outreach and Treatment.

Notes

- ¹ We acknowledge that some people prefer terminology such as “people who are unhoused” or “houselessness” to distinguish between the existence of a sheltered space and the term “home,” which can mean more than a physical space. We have chosen to use the terms “homelessness” and “people experiencing homelessness” throughout this report to be consistent with the name of the grant funding connected to the services assessed. This is also the terminology predominantly used by staff and clients we spoke with as a part of our research.
- ² “California Homelessness Statistics,” United States Interagency Council on Homelessness, accessed March 31, 2021, <https://www.usich.gov/homelessness-statistics/ca>.
- ³ Luke Money, Faith E. Pinho, Hillary Davis, and Priscilla Vega, “Unsheltered, Part 1: Why does Orange County have a homeless problem and how can it be solved?” *Los Angeles Times*, December 30, 2019, <https://www.latimes.com/socal/daily-pilot/news/story/2019-12-30/part-1-why-does-orange-county-have-a-homeless-problem-and-how-can-it-be-solved#:~:text=The%20latest%20comprehensive%20census%20of,according%20to%20results%20released%20Wednesday>.
- ⁴ Anh Do and Benjamin Oreskes, “Hundreds of homeless face eviction or arrest as O.C. clears encampment amid shelter bed shortage,” *Los Angeles Times*, January 22, 2018, <https://www.latimes.com/local/lanow/la-me-ln-orange-county-homeless-sweep-20180122-story.html>.
- ⁵ Jordan Graham and Theresa Walker, “Orange County to clear out riverbed homeless encampment, provide 400 motel vouchers for displaced people, under proposed agreement,” *Orange County Register*, February 13, 2018, <https://www.ocregister.com/2018/02/13/orange-county-to-clear-out-riverbed-homeless-encampment-provide-400-motel-vouchers-for-displaced-people-under-proposed-agreement/>.
- ⁶ Disability Rights California, “Settlement reached in Orange County regarding homeless encampment at the Santa Ana Riverbed,” Disability Rights California, July 23, 2019, <https://www.disabilityrightsca.org/press-release/settlement-reached-in-orange-county-regarding-homeless-encampment-at-the-santa-ana>.
- ⁷ Thy Vo and Cassidy Dillon, “Judge demands progress on homeless shelters by September 7,” Voice of OC, December 8, 2020, <https://voiceofoc.org/2018/08/judge-demands-progress-on-homeless-shelters-by-september-7/>.
- ⁸ Nick Gerda, “Homelessness in Orange County: 2019 year in review,” Voice of OC, January 2, 2020, <https://voiceofoc.org/2020/01/homelessness-in-orange-county-2019-year-in-review/>.
- ⁹ Money, Pinho, Davis, and Vega, “Unsheltered, Part 1.”
- ¹⁰ Homeless Mentally Ill Outreach and Treatment Program staff member, interview by Urban research team, May to June 2020.
- ¹¹ Homeless Mentally Ill Outreach and Treatment Program staff member, interview by Urban research team, May to June 2020.
- ¹² Homeless Mentally Ill Outreach and Treatment Program client, interview by Urban research team, October 2020.
- ¹³ Homeless Mentally Ill Outreach and Treatment Program client, interview by Urban research team, October 2020.
- ¹⁴ Homeless Mentally Ill Outreach and Treatment Program clients, interview by Urban research team, October 2020.

- ¹⁵ By partner/spouse, we mean experiences a client may have that are connected to their partner/spouse, such as a lack of support for engagement in treatment, being in a restrictive relationship (i.e., domestic abuse), or limited housing resources for couples that want to live together. By follow through, we mean a client's struggles to follow through with services for various reasons, such as mental health symptoms, memory, motivation, and lack of insight into their mental health. By tools, we mean tools a client may have that require special storage solutions (e.g., a large space or temperature regulation).
- ¹⁶ Homeless Mentally Ill Outreach and Treatment Program clients, interview by Urban research team, October 2020.
- ¹⁷ Homeless Mentally Ill Outreach and Treatment Program client, interview by Urban research team, October 2020.
- ¹⁸ Homeless Mentally Ill Outreach and Treatment Program client, interview by Urban research team, October 2020.

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