Behavioral Health and Homelessness

Findings from the California Statewide Study of People Experiencing Homelessness

Benioff Homelessness and Housing Initiative

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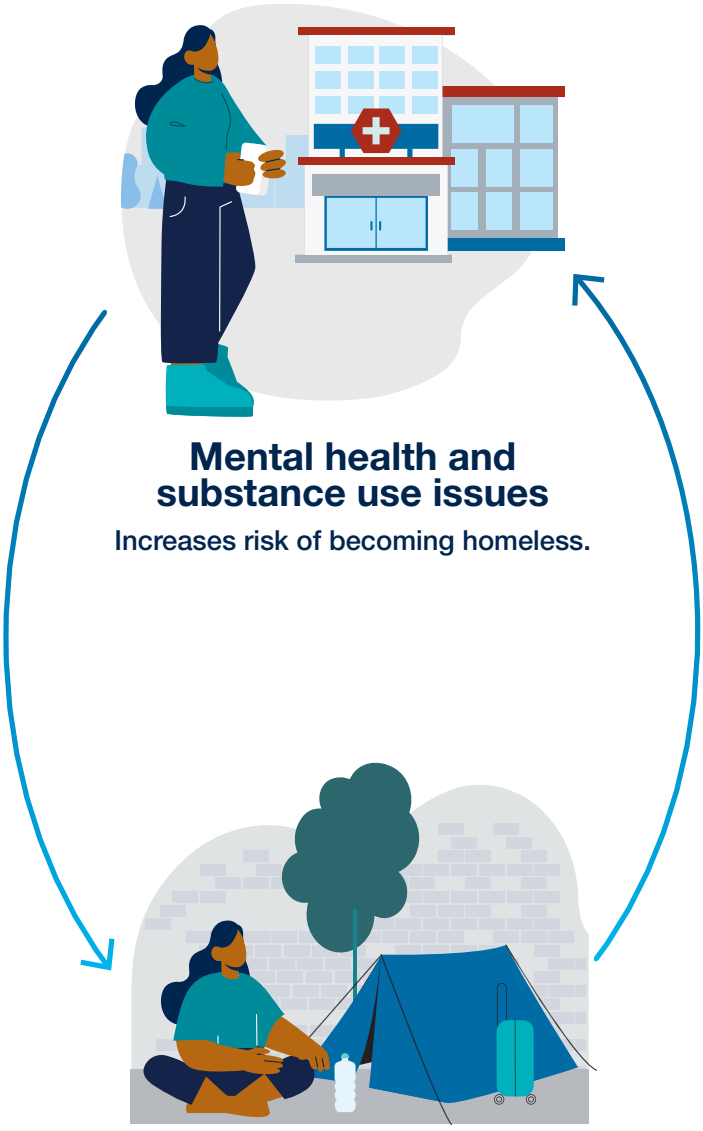
Introduction

Homelessness and behavioral health (mental health and substance use) issues are intertwined. While the availability of housing for the lowest-income households determines the prevalence of homelessness within a community, those with behavioral health challenges are at the highest risk of experiencing homelessness.[1] However, the relationship between homelessness and behavioral health conditions is complicated and bidirectional. While having behavioral health challenges increases the risk that a person becomes homeless, experiencing homelessness can cause or worsen such problems.

Substance use and mental health challenges frequently co-occur. The stresses of homelessness, systemic inequities, and racialized experiences exacerbate them. To appropriately scale interventions, policymakers and practitioners need reliable data on the types and prevalence of symptoms in the population experiencing homelessness.

In this report, we use findings from the California Statewide Study of People Experiencing Homelessness (CASPEH) to contextualize behavioral health challenges within the larger experience of homelessness in California. We do so to provide policymakers and program leaders with the information to make evidence-based decisions. Additionally, we aim to increase public understanding of these issues. Mental health and substance use challenges are common in the general population.



1. Colburn, G., & Aldern, C. P. (2022). Homelessness is a housing problem: How structural factors explain U.S. patterns. University of California Press.

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Both are part of the human experience and addressable. Neither are character flaws, evidence of moral or personal failings, or the result of making 'bad decisions.' We present these data to guide policies and programs to meet the needs of people experiencing homelessness.

Study Overview

The California Statewide Study of People Experiencing Homelessness (CASPEH) is the largest representative study of homelessness in the United States since the mid-1990s. Researchers at the University of California, San Francisco Benioff Homelessness and Housing Initiative (UCSF BHHI) recruited a representative sample of adults experiencing homelessness in California; all participants (3,200) completed an administered questionnaire. A subset (365) participated in one of seven in-depth interviews to provide context.[3] UCSF BHHI has released a series of reports, including a comprehensive report, a report on intimate partner violence and homelessness, a report on racial equity and Black people experiencing homelessness, a report on older adults experiencing homelessness, and topic briefs on pregnancy and homelessness, and unsheltered homelessness as well as tools to support responses to encampments. This report examines experiences of behavioral health needs and homelessness.[4]

Throughout this report, we describe the prevalence of various mental health indicators (e.g., symptoms of depression, anxiety, hallucinations), health care utilization (e.g., substance use treatment, outpatient counseling, psychiatric hospitalizations), and substance use patterns (e.g., regular use of illicit drugs and heavy episodic alcohol use). To assess participants' behavioral health indicators, BHHI's trained interviewers used standard research methods and questions. Because people experiencing homelessness may have limited access to healthcare, we chose questions that asked people to report their mental health symptoms, rather than diagnoses.[5]

Using these data, we created a category called "complex behavioral health needs" to define and describe the segment of the population experiencing homelessness who, due to their level of behavioral health acuity, may require additional supports and services (in addition to housing) to thrive. People with these needs would benefit from being housed in Permanent Supportive Housing with robust staffing models designed to support people with behavioral health complexity (i.e., assertive community treatment or intensive case management) or in community-based settings that serve those who require a higher level of care, such as residential care facilities. Not everyone who has a complex behavioral health need requires these enhanced models, but many will. We define complex behavioral need as one or more of the following:

1. Regular (three times per week or more) illicit drug use (methamphetamines, non-prescribed opioids, or cocaine);
2. Heavy episodic alcohol use (six or more drinks in one sitting, at least once a week);
3. Current hallucinations (defined as a self-report of hallucinations in the past 30 days)
4. Psychiatric hospitalization within the last six months.

Defining Complex Behavioral Health Needs

In this report, we defined complex behavioral health needs as one or more of the following:

1. **Regular (three times per week or more) illicit drug use (methamphetamine, non-prescribed opioids, or cocaine).**
2. **Heavy episodic alcohol use (six or more drinks in one sitting at least weekly).**
3. **Current hallucinations (defined as a self-report of hallucinations in the past 30 days).**
4. **Psychiatric hospitalization within the last six months.**

3. The seven interview topics were: behavioral health, the experience of homelessness for Black Californians, experience of homelessness for Latino/a/x Californians, incarceration, interpersonal violence, precipitants of homelessness, and barriers to regaining housing.

4. We draw data from the structured interview and in-depth interviews. While one of the seven in-depth interviews included only people with complex behavioral needs and focused questions about behavioral health challenges, many participants in the other interviews discussed their experiences with these issues. For our in-depth interview data, we include interviews in which participants discussed behavioral health, whether it was part of the focused behavioral health interview or not.

5. As is common in research settings, we did not diagnose people with substance use disorders or mental health conditions, as these require clinical evaluation. We present these indicators of "complex behavioral health needs" as a way of approximating those who would likely benefit from treatment or enhanced services to thrive.

Behavioral Health and Homelessness: Key Findings and Recommendations

Key Substance Use Findings

We asked people about their use of alcohol and certain illicit drugs. **Overall, 35% reported current regular illicit drug use, defined as use three times or more a week of either methamphetamines, non-prescribed opioids, or cocaine.**

Methamphetamine was the most common; 32% of adults experiencing homelessness reported regular methamphetamine use, 11% regular opioid use, and 3% regular cocaine use. Among those who reported regular illicit drug use, 91% reported regular methamphetamine use. Of current regular opioid users, 80% reported concurrent regular use of methamphetamine. White people younger than 50 were the most likely to report regular illicit drug use (52%) and Black people under 50 were the least likely (20%).

Among the overall population of adults experiencing homelessness in California, 9% reported regular heavy episodic drinking, defined as six or more drinks on one occasion at least once a week.

Among people who used drugs regularly, 42% reported that they began to use regularly after the first time they experienced homelessness. Of those with regular drug use or current heavy alcohol use, 28% reported that during this episode of homelessness, they wanted substance use treatment but were unable to access it.

Key Mental Health Findings

Thirteen percent of adults experiencing homelessness reported that they experienced hallucinations currently. Black people (18%) reported the highest prevalence of hallucinations.

Five percent of adults experiencing homelessness reported having a recent inpatient psychiatric hospitalization.

Over half of participants (51%) reported current symptoms of anxiety severe enough to interfere with some degree of functioning, and nearly half (48%) reported severe symptoms of depression. Thirty-seven percent reported trouble remembering things.

Three fourths of regular users of cocaine (75%) and over two thirds of regular opioid users (68%) reported severe anxiety. Over two thirds of regular opioid users (71%) reported severe depressive symptoms.

Key Complex Behavioral Health Needs Findings

Approximately half (48%) of adults experiencing homelessness reported having at least one complex behavioral health need, defined as either regular drug use, heavy episodic alcohol use, current hallucinations, or recent psychiatric hospitalization. People with complex behavioral health needs were over twice as likely (27% versus 12%) as those without to have entered their current experience of homelessness directly from an institutional setting (jail, prison, or inpatient behavioral health treatment setting).

People with complex behavioral health needs were more likely to report unsheltered homelessness (89%) than those without complex behavioral health needs (68%). Those with complex behavioral health needs reported higher rates of jail stays during their episode of homelessness (37%) than those without (22%). **They were more likely to report having been "roughed up" by the police (57% versus 38%) or having experienced a forced displacement in which they lost their belongings (49% versus 23%).**

People with complex behavioral needs reported higher rates of having experienced violence during their episode of homelessness. These varied by gender. Cisgender men with complex behavioral health needs reported higher rates of physical (50%) and sexual (13%) violence compared to cisgender men without (22% and 1% respectively). Cisgender women with complex behavioral health needs reported higher rates of physical (58%) and sexual (24%) violence compared to cisgender women without (21% and 9% respectively).

People with complex behavioral health needs, like those without, most frequently reported cost as a major barrier to housing (89% of those with complex needs and 90% of those without). Those with complex needs reported other barriers to housing more commonly than those without, including lacking help from a case manager or housing navigator, (70%), missing documents (64%), giving up/having no energy (56%), credit issues or past evictions (54%), criminal justice records (46%), or struggling with mental health and/or substance use (44%).

Recommendations

Homelessness Prevention Recommendations

Because of the high proportion of people with complex behavioral needs entering homelessness from institutional settings, we recommend that:

- Policymakers and program leaders should ensure that residential treatment programs, youth correctional facilities, and jails have strong relationships with Continuums of Care and coordinated entry processes to ensure that people can access appropriate services and housing upon release.
- Policymakers should ensure that housing support is a fully integrated and required component of prison re-entry support services.
- IN CALIFORNIA: Policymakers and program leaders should ensure access to services funded through Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (commonly called BH-CONNECT) to stabilize those exiting institutional settings such as prison, jail, and psychiatric hospitals through a range of supports, including transitional rental assistance. To do so, they should build strong connections between Continuums of Care and Housing Supports.
- IN CALIFORNIA: Administrators of justice programs should maximize use of CalAIM's Justice-Involved Reentry Initiative for those exiting prisons and jails. The initiative provides an array of Medicaid funded services up to 90 days prior to release, including clinical behavioral health services, medications (including Medication Assisted Therapy for opioid use disorder), and reentry care management services.

Homelessness Response System Recommendations

Because of the high burden of mental health and substance use disorders among people experiencing homelessness, we recommend:

- Continuum of Care leaders, in collaboration with health experts, policymakers, people with lived experience, and other community leaders, should redesign coordinated entry systems to match clients to the appropriate services or service setting rather than simple prioritization. This redesign may require

introducing clinical evaluation at certain junctures to ensure the appropriate treatment is identified for the client.

- Policymakers and program leaders should integrate methamphetamine treatment into programs that support people who experience homelessness, including contingency management and other promising strategies.

- Policymakers should invest in targeted responses for people experiencing homelessness who have an alcohol use disorder, including sobering centers and managed alcohol programs. They should expand access and reduce barriers to evidence-based medication treatment including naltrexone.

- Policymakers and program leaders should design and fund programs to respond to the high prevalence of anxiety and depression. Such programs would include trauma-informed design, connection to outpatient behavioral health supports, and training staff on how to effectively respond to clients who are experiencing severe anxiety or depression.

- Continuum of Care leadership should prioritize health and homelessness systems integration, with a focus on behavioral health integration.

- Policymakers should invest in emergency response services for people experiencing behavioral health crises that do not require law enforcement.

- Jurisdictions should limit and clearly define the role of law enforcement in any engagement with people experiencing homelessness, particularly those who live in unsheltered circumstances.

- To enhance health and safety and increase opportunities for engagement between case managers, mental health providers, and people experiencing unsheltered homelessness, policymakers should choose strategies of progressive intensive engagement[6]—rather than forced displacement, which separates people with complex behavioral needs from the services they need.

- IN CALIFORNIA: Continuum of Care leadership should look at using state-level flexibility created through 1115 waivers and other mechanisms to integrate Medicaid models of behavioral health support, particularly peer navigation and other peer support services, which can provide more support than traditionally funded outreach.

- IN CALIFORNIA: Community leaders and policymakers should work together to fully implement Full Service Partnership models that offer a range of supports, including Assertive Community Treatment (ACT) and other recovery supports. A Full Service Partnership (FSP) is a comprehensive mental health program that aims to provide a wide range of services to individuals with severe mental illness, often using a "whatever it takes" approach. ACT is a specific, evidence-based model within an FSP program.

6. As outlined in BHHI's model guidance on encampment resolution strategies.

Substance Use Recommendations

Because of the high rates of methamphetamine use and variation in use patterns across racial and ethnic groups of people experiencing homelessness, we recommend:

- Policymakers should invest in low-barrier, evidence-based substance use treatment programs, with a focus on treatment for methamphetamine use and polysubstance use of methamphetamine and opioids. These programs should be available on demand at any point in a person's housing journey (i.e., while housed, experiencing unsheltered homelessness, or in shelter).
- Program leaders should incorporate culturally specific models for treatment, involving community leaders who can assist people in achieving their recovery goals.
- IN CALIFORNIA: MediCal is available to cover traditional health care practices for substance use disorders. This coverage is particularly important for Black and Native American/Indigenous populations and should be used whenever available. Continuum of Care leaders should partner with these communities to ensure that culturally responsive supports for behavioral health are available whenever possible.[7]

7. More information on MediCal behavioral health benefits is available here.

8. CASPEH data on transgender and gender-expansive individuals is limited. There is a need for further research that focuses on these populations.

Behavioral Health and Homelessness: A Deeper Look

Regular Drug Use

Our study asked people about their use of certain illicit drugs (methamphetamines, non-prescription opioids, and cocaine) and alcohol. Thirty-five percent of homeless Californians reported current regular illicit drug use, most commonly methamphetamine (32% of all Californians experiencing homelessness; 91% of those who reported current regular use of any drug). Eleven percent reported regular opioid use and 3% regular cocaine use. The majority (80%) of those who used opioids regularly also used methamphetamine regularly. Nearly half of Californians experiencing homelessness (42%) reporting current regular substance use reported that they began using drugs after their first episode of homelessness.

> *"Not having a place to stay, you fall into the wrong groups. They're just surviving… being homeless kind of puts you in a disadvantage… there's no real support. The support are the people around you. And normally, the people around you are offering drugs and alcohol to cope with the pain. They're showing you different ways to survive… it's a circle… Everybody's just constantly running in a hamster wheel.*
>
> **– 26-YEAR-OLD BLACK WOMAN**

White people experiencing homelessness were significantly more likely to report current regular drug use (42%) than members of other racial/ethnic groups. Cisgender men (38%) and transgender/gender expansive individuals[8] (37%) had a higher prevalence of current regular drug use than cisgender women (28%).

White adults ages 25-49 were most likely to report regular use (52%). They were also most likely to report methamphetamine use (47%). Black adults younger than 50 were the least likely to report any regular drug use. Black adults 50 and older were the most likely to report cocaine use (7%) (Table 1).

TABLE 1. Current Regular Drug Use

	Any Illicit Drug	Metham-phetamines	Opioids	Cocaine
White				
25-49 years	52%	47%	18%	4%
50+ years	32%	28%	9%	1%
Black				
25-49 years	20%	18%	4%	1%
50+ years	33%	27%	6%	7%
Latinx				
25-49 years	39%	39%	10%	1%
50+ years	25%	24%	6%	0%
Multiracial				
25-49 years	38%	37%	16%	2%
50+ years	29%	26%	21%	2%
Overall				
25-49 years	38%	36%	12%	3%
50+ years	30%	26%	9%	3%

Overall, 11% of Californians experiencing homelessness and 23% of those with regular drug use reported experiencing an overdose during their current episode of homelessness. Fifty-two percent of current regular drug users reported having naloxone.

In in-depth interviews, participants described different patterns of use. Some described using substances throughout the life course, from early teens into adulthood. Others described episodic substance use that shifted based on their life circumstances. Many participants reported periods of sobriety. Some reported initiating and managing abstinence without treatment, while others reported positive treatment experiences that led to abstinence. Those whose substance use waxed and waned reported that negative events—including job loss, death of family members, experiences of interpersonal violence, reentry into homelessness post-incarceration, and untreated mental health symptoms—caused relapse or increased use.

Homelessness can significantly worsen substance use and mental health. Homelessness makes it more difficult for people to reduce or quit substance use and complicates their efforts to access behavioral health treatment. Participants described ongoing contact with police and anxiety about being questioned, harassed, or arrested due to their use. Some participants reported that this stress led them to increase their use. People who used methamphetamines described that it gave them energy and allowed them to stay awake. By staying awake, participants could protect themselves from experiencing violence, harassment, and theft—including allowing them to be prepared if police or other authorities came through to arrest or displace them.

Participants noted how substance use made their situation more bearable. For some, it helped build community, giving them social and emotional benefits that made them feel more secure. They noted other benefits, including helping them manage physical and mental health symptoms. Using substances provided participants with a brief reprieve from their difficult circumstances, helping them manage symptoms of depression and anxiety, or helping them cope with grief from death of friends and family—even when those deaths were from overdose.

> *I used to use heroin when I was younger. I use meth, but I use fentanyl, too. It's an opiate, so I get sick without it. It's the only thing that's been there for me is my drugs. Through all this s***, the only thing that's ever been there is drugs. I've got nothing else, nobody else. When I needed help most – I was a kid. I was like 12 when I started getting high on meth. I started using fentanyl like a year or two ago.*
>
> **– 25-YEAR-OLD, LATINA WOMAN**

Many, including those who reported on the benefits of using drugs, noted the negative impacts of their use. They described harmful physical and mental health impacts they experienced, including overdoses, infections, liver damage, paranoia, and hallucinations. Participants described how substance use had affected their ability to access resources like shelter and their motivation to make changes they needed to regain employment and housing.

Participants described how their homelessness impacted their substance use. They described how being around others using substances—whether in encampments or shelters—made it difficult to reduce their use or abstain. Many noted that regaining housing would help them access treatment and reduce their substance use, by allowing them to control their environment and by relieving many of the stressors of homelessness.

> *My goals are to stop using [drugs], period. So, that way, I can get treatment. That's my main goal – my main objective. It's just hard. When you're out here, it's hard. Because, everywhere you go, somebody's breaking out a pipe, somebody's doing this. You know? It's hard. It's hard.*
>
> **– 42-YEAR-OLD NATIVE WOMAN**

Marcus' Story[9]

Marcus has been using fentanyl and methamphetamines off and on for over two years. He recently started living in his car because the friend he was staying with was evicted. He parks the car next to an encampment where he knows there are people who will watch out for him in case he overdoses. Since he left his friend's house, his drug use has increased. He attributes this to the stress of homelessness worsening his mental health. He shares drugs to be social and because doing so helps him determine if his supply is safe. Outreach workers come around with naloxone, which is helpful because Marcus sees lots of people overdosing. He feels like his health and mental health are worsening but believes that he cannot stop using it in his current situation.

Heavy Episodic Drinking

Among the overall population of adults experiencing homelessness in California, 9% reported regular heavy episodic drinking, defined as six or more drinks on one occasion at least once a week. Heavy drinking was lowest for white people (5%) and highest for Latino/a/x (12%), Native American/Indigenous (11%), Black (10%), and multiracial people (9%). There were no differences in prevalence by gender for heavy episodic drinking.

9. Throughout this report, we use vignettes from our in-depth interviews to illustrate participants' experiences. These composites, a common qualitative research method, protect privacy while capturing shared themes and the range of experiences across participants.

Charles' Story

Charles was diagnosed with bipolar disorder when he was in his early twenties. He had had several prior hospitalizations but hadn't received a diagnosis and had been put on medicines that hadn't helped. His worsening health caused him to leave college and move back with his parents. After someone outed him as gay to his parents, he was kicked out, which left him without housing, mental health care, or stability. He stayed temporarily with friends, but his friends used methamphetamines. When he used it, his symptoms worsened. Fearing for his health, he left and went to a shelter. There, he began to drink heavily. He has been drinking until he "blacks out" several times per week to "take a break from it all," but would like some help to reduce his drinking. In the homeless shelter, he has been unable to access treatment or medication.

Among those with a lifetime experience of psychiatric hospitalization, nearly half (44%) were first hospitalized after their first episode of homelessness.

Hallucinations

Hallucinations are defined as sensory experiences (vision, hearing, etc.) of things that are not there that occur while the person is awake. Many things can cause hallucinations, including psychiatric conditions (e.g., schizophrenia, severe depression, bipolar disease), use of substances (e.g., methamphetamines), withdrawal from substances (e.g., alcohol), and medical conditions or side effects of treatment. Overall, 13% of adults experiencing homelessness reported that they had hallucinations. Black people (18%) and Native American/Indigenous people (13%) reported the highest prevalence of current hallucinations; white people (8%) and Latino/a/x (9%) reported the lowest. Cisgender men and cisgender women had similar prevalence of current hallucinations (13% and 11%); transgender/gender expansive people reported higher prevalence (19%).

Among those who reported currently experiencing hallucinations, over one third (36%) reported regular methamphetamine use and 14% reported weekly heavy alcohol use. Among people who reported current regular methamphetamine use, 14% reported current hallucinations. Among those who reported weekly heavy alcohol use, 20% reported current hallucinations.

Psychiatric Hospitalizations & Other Mental Health Symptoms

Overall, 5% of adults experiencing homelessness reported having a psychiatric hospitalization in the prior six months. There were no reportable differences by race, ethnicity, or gender. Among all homeless Californians, 27% reported spending time in a psychiatric hospital at some point in their lifetime. Among those with a lifetime experience of psychiatric hospitalization, nearly half (44%) were first hospitalized after their first episode of homelessness. In the six months prior to the current episode of homelessness, 7% reported having had a psychiatric hospitalization.

People who used drugs regularly or had heavy episodic alcohol use had higher prevalence of mental health symptoms than those who did not, highlighting the role of co-occurring mental health and substance use problems.

The most common mental health symptoms were those related to mood disorders, anxiety, and cognitive challenges.[12] Over half of participants (51%) reported current symptoms of anxiety severe enough to interfere with functioning, and nearly half (48%) reported severe depressive symptoms; 39% reported trouble remembering things. Only 21% of those with any mental health symptoms reported receiving treatment (either medication or counseling). Many people experienced more than one mental health symptom. Thirty-nine percent of people reported experiencing both anxiety and depression; 24% reported anxiety, depression, and trouble remembering; and 7% reported experiencing anxiety, depression, trouble remembering, and hallucinations.

People who used drugs regularly or had heavy episodic alcohol use had higher prevalence of mental health symptoms than those who did not, highlighting the role of co-occurring mental health and substance use disorders.

Three fourths of regular cocaine users (75%) and over two thirds of regular opioid users (68%) reported severe anxiety. Over two thirds of regular opioid users (71%) reported severe depressive symptoms (Table 2).

TABLE 2. Mental Health Symptoms in Last 30 Days

	Overall	Of Current, Regular Users Of:			
		Alcohol	Cocaine	Metham-phetamine	Opioids
Anxiety	51%	62%	75%	60%	68%
Depression	48%	60%	60%	59%	71%
Hallucinations	13%	20%	31%	14%	21%
Trouble Remembering	37%	50%	46%	38%	33%

Treatment

Despite high rates of use and overdose, homeless Californians had limited access to substance use treatment (including residential, outpatient, opioid replacement, twelve step, or other forms of substance use treatment).

Among those with current regular drug use, weekly heavy alcohol use, or any lifetime experience of regular opioid use, only 10% reported receiving any treatment currently. Twenty-eight percent of people with regular drug or heavy episodic alcohol use reported that during this episode of homelessness, they wanted but were unable to access treatment. In in-depth interviews, participants reported experiencing long wait lists or lack of treatment availability. Those who wanted treatment reported spending a lot of time and energy trying to access it.

> *"So, the last time I talked to my therapist and was on medication was, I thought, like around the time I got evicted… I haven't seen a doctor in so long, I've got to start all over again… I'm like, 'That does not make any sense.' So, the only appointment they have is months from now. And like I'm going to lose my mind. I need something now. Like there's no emergency appointments… [I] feel like I'm going in circles. I've called the crisis line. I've called so many numbers."*
>
> **– 40-YEAR-OLD WHITE WOMAN**

"I want to see a psychiatrist… it seems like I'm not getting nowhere again. You know? I want to get back on my meds. I want to – and I'm not getting nowhere. I need the help to get a referral or something… because I have a psychiatrist… [but] I don't know how to get ahold – get in contact with them… I'm trying to access my records so I could have that paperwork. And, because, with my mental, it's like I accumulate papers everywhere. I have some here. I have some at my mom's. I have some, you know, just everywhere."

– 35-YEAR-OLD LATINA WOMAN

Treatment Access

Among those with current regular drug use, weekly heavy alcohol use, or any lifetime experience of regular opioid use, only 10% received any treatment currently.

Participants often reflected on prior experiences of drug treatment. There was no consensus on the best treatment model—rather, people expressed a desire for flexibility because what worked for some people did not for others. Some spoke about the benefits of prolonged (90 days or longer) residential treatment. Some participants valued strict and structured programs, with many rules and limitations on behavior and activities. Others noted that the rigidity of programs and staff served as a barrier to recovery goals and led to their leaving prior to program completion.

Some participants wanted to exit homelessness to sober living environments. They reported that they had been able to maintain sobriety after leaving these programs. However, others who had been in sober living programs noted that these programs had not met their needs or that they had returned to substance use after they left.

Treatment Needs

Twenty-eight percent of people with regular or heavy episodic alcohol use wanted treatment but could not access it during this episode of homelessness.

Participants reported struggling with regaining stability after receiving residential substance use treatment, particularly if they left treatment without stable housing. For example, one participant told us about completing a residential treatment program that they found helpful, but that they lost their housing during the treatment. When they exited the program into homelessness, they relapsed. Others noted that they became sober during incarceration, but when they exited with neither housing nor employment they relapsed.

Participants who had received medications for opioid use disorders (i.e., methadone and buprenorphine) described how medication had helped them reduce their opioid use and overdose risk. Some enrolled in methadone programs expressed an interest in taking home doses of methadone, rather than needing to go daily, which they found difficult. Participants who used methamphetamines expressed a desire for a medication, akin to methadone, that could reduce their use.[10]

Some participants reported that when they sought mental health care, health care providers instead sent them to substance use treatment. Participants reported subsequently receiving mental health

10. There is no replacement therapy available for stimulants, including cocaine and methamphetamine. There is evidence for contingency management as an effective treatment. Other treatment is psychosocial.

diagnoses from substance use treatment providers. Several reported significant delays in receiving diagnoses and treatment for co-occurring mental health disorders.

> *"I went into residential rehab for six months. Here in [City]. And then I moved into their sober living environment when I graduated from the program. And then I relapsed after a couple months, and they kicked me out. And I've been homeless ever since."*
>
> **– 42-YEAR-OLD WHITE WOMAN**

Complex Behavioral Health Needs

To better understand the experiences and needs of homeless Californians for enhanced supportive services, we created a category of those with complex behavioral health needs who might benefit from a higher level of behavioral health support. We defined this category as having at least one of the following: regular illicit drug use; heavy episodic alcohol use at least weekly; current hallucinations; or a recent psychiatric hospitalization. By this definition, almost half (48%) of adults experiencing homelessness in California met criteria for having a complex behavioral health need. The 52% of homeless Californians who did not have any of these needs require support accessing affordable housing, finding job opportunities, and connecting to mainstream services (such as health services) but likely do not need specialized services and supports directed at those with complex behavioral health conditions. Those with complex behavioral needs more likely need robust services and supports to ensure their success in housing, such as intensive case management (ICM) or Assertive Community Treatment (ACT).

11. Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatric Services, 51(4), 487–493. https://doi.org/10.1176/appi.ps.51.4.487.

12. Mental Health Commission of Canada. (2014). National final report: At Home/Chez Soi project. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/mhcc_at_home_report_national_final_eng_2.pdf

13. Raven, M. C., Niedzwiecki, M. J., & Kushel, M. (2020). A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services. Health Services Research, 55(S2), 797–806. https://doi.org/10.1111/1475-6773.13553

80%-90% of people experiencing chronic homelessness with complex behavioral health problems can thrive in permanent supportive housing.

Evidence demonstrates that most people with complex behavioral health needs can thrive in community settings, so long as they receive appropriate services. Research including Pathways to Housing[11], the Chez Soi study[12] in Canada, and Project Welcome Home[13] in Santa Clara County demonstrated that 80%-90% of people experiencing chronic homelessness with complex behavioral health problems can thrive in permanent supportive housing. A smaller group benefit from more intensive services, such as those offered in residential care facilities. Not everyone with a complex behavioral need will require these more intensive supports. Like many others in the community who are housed, some with behavioral health needs may manage with support through their primary care provider and/or community outpatient behavioral health supports, but others will require more intensive services. Those with complex behavioral needs who remain homeless will benefit from low-barrier access to services, such as those offered by street medicine and shelter health services.

Assertive Community Treatment (ACT)

ACT is a community-based approach to mental health care that provides intensive, individualized support to people with severe mental illness. In the ACT model, a multidisciplinary team delivers services in community settings (including in client's homes) to help them maintain stability and live independently in the community. Services, available 24/7, include things like psychiatric treatment, medication management, housing assistance, and vocational training. Typically, teams provide services at least 4 times a week and actively engage clients. The team typically includes psychiatrists, psychologist, nurses, social workers, case managers, vocational support, and others with a low client-staff ratio.

We found similar prevalence of complex behavioral health needs among white (50%), Black (44%), Latino/a/x (49%) multiracial (50%) Native American/ Indigenous (50%), and Asian American and Pacific Islander (AAPI) (48%) (Table 3).

TABLE 3. Prevalence of Complex Behavioral Health Needs by Race

RACE	People with complex behavioral health needs
White	50%
Black	44%
Latinx	49%
Multiracial	50%
Native American / Indigenous	50%
AAPI	48%
Other	53%
Overall	48%

Pathways to Housing

Pathways to Housing is a program model for people who experience chronic homelessness who have severe mental illness with or without co-occurring substance use disorders. Adapted from the ACT model, Pathways provided subsidized housing with assertive wrap around services, similar to that offered by ACT teams for this population. While teams provided active outreach and assertive engagement, clients did not have to remain sober or take mental health medications to qualify. The success of this model led to the development of Permanent Supportive Housing on a Housing First basis.

There is a robust evidence base in support of programs that offer PSH with fidelity to the original model or with adaptations. The Chez Soi study is a randomized control trial that enrolled over 2100 people experiencing chronic homelessness with severe mental illness in 5 Canadian cities. Over three quarters had co-occurring substance use disorders. Clinicians evaluated clients and assigned them to either an ACT model or ICM model based on severity of need and then randomly assigned clients to ACT or ICM vs. usual care. They found that over 85% of those assigned to ACT or ICM remained housed at the study conclusion, far better than those inusual care.

The Welcome Home study in Santa Clara County randomly assigned people with chronic homelessness and high use of multiple systems to PSH with ICM model vs. usual care. Like in Chez Soi, those assigned to PSH had over 85% housing retention, far beyond those assigned to usual care. Not only did they have dramatically improved housing outcomes, but also had reductions in emergency services, compared to those in usual care.

Transgender and gender-expansive individuals (57%) and cisgender men (51%) exhibited a higher prevalence of complex behavioral health challenges compared to cisgender women (42%) (Table 4).

TABLE 4. Prevalence of Complex Behavioral Health Needs by Gender

GENDER	Proportion with complex behavioral health needs
Cisgender male	51%
Cisgender female	42%
Transgender and gender expansive	57%
Overall	48%

Complex Needs & Substance Use

Using our definition, reporting regular illicit drug use qualified one for having a complex behavioral health need. Not everyone who had a complex behavioral health need reported regular illicit substance use, but three quarters (74%) did. Of those with complex behavioral health needs, 67% reported regular methamphetamine use, 24% reported regular opioid use, and 7% reported regular cocaine use.

People with complex behavioral health needs had significantly higher rates of overdose during their current episode of homelessness (20%) than those who did not have complex needs (3%). People with complex health needs were four times more likely to report access to naloxone (41% versus 12% respectively).

Complex Needs & Heavy Drinking

By definition, all who reported heavy episodic drinking had a complex behavioral health need. While not everyone with a complex behavioral health need reported heavy episodic alcohol use, 19% did.

Complex Needs & Hallucinations

By definition, all who reported current hallucinations had a complex behavioral health need; roughly one quarter (27%) of those with complex behavioral needs reported hallucinations.

Complex Needs & Psychiatric Hospitalizations

Reporting a recent psychiatric hospitalization qualified as a complex behavioral health need. Of those with complex needs, 11% reported a recent psychiatric hospitalization.

Complex Needs & Other Mental Health Symptoms

People with complex behavioral health needs reported a significantly higher prevalence of current anxiety (64%), current depression (63%), or current trouble remembering (46%) than those without complex needs (38%, 34%, and 28% respectively). Despite this finding, rates of outpatient and/or prescription medication treatment were similar for those with and without complex behavioral health needs (21% and 15% respectively).

Experiences Prior to Homelessness for Those with Complex Behavioral Health Needs

Prior to becoming homeless, 44% of those with complex behavioral health needs and 52% of those without lived in housing for which they didn't have tenancy rights. A smaller proportion of both groups were housed in places for which they held a lease or mortgage (29% of those with complex behavioral health needs and 36% of those without). People with complex behavioral health needs were over twice as likely to have entered their current episode of homelessness from an institutional setting (e.g., jail, prison, residential drug treatment setting) as those who did not meet the criteria (27% versus 12%).

Overall, 14% of all people experiencing homelessness said their personal drug or alcohol use was a reason for leaving their last housing situation; 4% said it was the most important reason. For people with complex behavioral health needs, 26% reported that their own drug or alcohol use was a reason for leaving their last housing and 8% said it was the most important reason, compared with 1% of those without a complex behavioral health need.

Experiences During Homelessness for those with Complex Behavioral Health Needs

Length

Individuals with complex behavioral health needs reported significantly longer episodes of homelessness compared to those without (median of 24 versus 17 months). To meet the federal government definition of chronic homelessness, a person must both have been homeless for an extended time and have a disabling condition.[14] Many without disabling conditions meet the time criteria; similar proportions of homeless Californians with (76%) and without (70%) complex behavioral health needs met the temporal definition of chronic homelessness. This finding reflects how the lack of affordable housing drives and sustains the homelessness crisis.

Shelter Accessibility

We found significant differences in shelter use between people with complex behavioral health needs versus those without. A higher proportion of those with complex behavioral health needs reported that they spent most of their nights in an unsheltered location during the prior six months (89% versus 68%). In both those with and without complex behavioral health needs, a high proportion wanted but were unable to access shelter (45% of those with complex health needs and 39% of those without), suggesting a significant unmet need for shelter for people regardless of behavioral health profile.

Health

People with complex behavioral health needs reported a high prevalence of functional and physical health needs. Forty percent of individuals with a complex behavioral health need reported difficulty with at least one activity of daily living (ADL); 22% reported having difficulty with three or more. Two thirds (66%) of those with complex behavioral health conditions reported having one or more chronic health problems, compared to 54% without. A higher proportion of those with complex behavioral health needs (29%) than those without (17%) reported having mobility impairment. Having co-occurring behavioral health needs and functional impairment (or chronic health conditions) may complicate efforts to receive care for either, as many behavioral health treatment programs lack the capacity to care for people with functional or mobility impairments, and programs designed to provide care for people with functional impairment may lack the capacity to assist those with complex behavioral health needs.

Healthcare Access & Utilization

People with and without behavioral health needs had similar rates of health insurance; 84% and 83% respectively (Table 5); most had MediCal (California's Medicaid program).

14. The federal definition of chronic homelessness requires that a person has either a current episode that has lasted 12 months or more or 4 or more episodes in the prior 3 years totaling more than one year and that they have a disabling condition.

People with and without complex behavioral health needs report similar rates of needing but being unable to receive health care (25% and 19%) and being unable to access prescribed medication (26% and 18%).

TABLE 5. Health Insurance Status Among People Experiencing Homelessness in California

	Uninsured	MediCal Only	MediCal and Medicare
PEH with complex behavioral health needs	16%	73%	3%
PEH with no complex behavioral health need	17%	70%	4%

Almost half (43%) of those with a complex behavioral health condition reported having at least one emergency department visit in the last six months, compared to 31% without a complex behavioral health need.

Interactions with the Police and Authorities

Homeless Californians had frequent contact with police and authorities. Nearly one-third (29%) of all homeless Californians had a jail stay during their current episode of homelessness. However, those with complex behavioral health needs reported higher rates of jail stays (37%) than those without (22%). Similarly, people with complex behavioral health needs were more likely to report having been "roughed up" by the police (57% versus 38%) or having experienced a forced displacement in which they lost their belongings (49% versus 23%).[15]

John's story

John is living in an encampment with about 20 other people on a riverbank, a spot well known to the local police. He uses methamphetamines to help him stay up at night. Police conduct raids occasionally early in the morning, during which he must either gather his belongings and leave or risk being arrested for having drug paraphernalia; he notes that this makes it harder to think about stopping using methamphetamines, because they help him prepare to leave quickly. He used to drink alcohol but stopped because when he passed out from drinking, people would steal his things, or he would be unprepared for when the police

15. These kinds of actions are often colloquially referred to as sweeps.

came. He acknowledges that methamphetamine use leaves him feeling wired. Sometimes he is not able to sleep for several days in a row, which makes him feel worse. He notes that given where he is living, he does not see a way for him to avoid using methamphetamines.

Economic Challenges

Individuals with complex behavioral health needs reported significantly lower incomes (median $300/month) compared to those without complex needs (median $500/month). Those with complex needs were more likely than those without to report informal sources of income, including recycling/selling used goods (51% versus 34%), panhandling, or asking for money (21% versus 10%), or selling drugs (17% versus 1%). They were more likely to report having received money from others in their household (11% versus 4%).

Violence & Behavioral Health

People with complex behavioral health needs reported significantly higher experiences with both physical and sexual violence than other people experiencing homelessness. These experiences had stark gender dynamics; thus, we present these findings by gender (Table 6).

Cisgender men with complex behavioral health needs reported higher rates of physical (50%) and sexual (13%) violence compared to cisgender men without (22% and 1% respectively). Cisgender women with complex behavioral health needs reported higher rates of physical (58%) and sexual (24%) violence compared to cisgender women without (21% and 9% respectively).

Transgender and gender-expansive people with complex behavioral health needs reported higher rates of physical (76%) and sexual (50%) violence compared to people without (20% and 24% respectively).

TABLE 6. Experiences of Violence Among Californians Experiencing Homelessness

POPULATION	People with complex behavioral health needs	People without complex behavioral health needs
Cisgender male		
Physical Violence	50%	22%
Sexual Violence	13%	1%
Cisgender female		
Physical Violence	58%	21%
Sexual Violence	24%	9%
Transgender, non-binary, gender expansive		
Physical Violence	76%	20%
Sexual Violence	50%	24%

Attempts to Exit Homelessness

Those with and without complex behavioral health needs were equally likely to receive any help from case managers or housing navigators to find housing. Less than half of those with (47%) and without (45%) reported having received any help during the current episode. In the last six months, only a quarter of those with (26%) and without (25%) complex needs reported receiving help at least once a month.

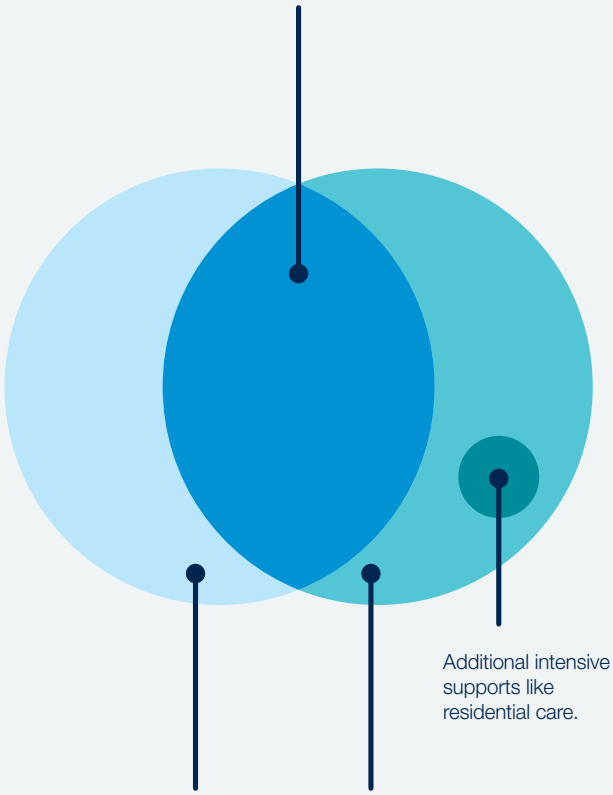
Regardless of behavioral health needs, the most common barrier to housing was affordability; 89% of those with complex needs and 90% without reported that their inability to afford housing was a key barrier to their regaining housing. Despite having similar levels of any contact with case managers, those with complex needs were more likely than those without to report other barriers to regaining housing, including lacking (adequate) help from a case manager or housing navigator (70%), missing documents (64%), giving up/having no energy (56%), credit issues or past evictions (54%), criminal justice records (46%), or struggling with mental health and/or substance use (44%).

People with complex behavioral health needs face numerous barriers to housing, even more so than those without. In addition to overcoming housing affordability, there is a need to focus on providing support to overcome these additional barriers to ending a person's experience of homelessness (Table 7).

TABLE 7: Barriers to Housing Among Californians Experiencing Homelessness

	People with complex behavioral health needs	People without complex behavioral health needs
Lack of help from a case manager	70%	57%
Missing documents	64%	44%
Giving up/lack of energy	56%	38%
Credit issues/ past evictions	54%	43%
Criminal justice records	46%	27%
Struggling with behavioral health	44%	16%

Support Needs Among People Experiencing Homelessness



Conclusion

Although people experiencing homelessness have a high prevalence of substance use and mental health conditions, the relationship between homelessness and behavioral health challenges is bidirectional. Having these conditions increases the risk of becoming homeless, and homelessness exacerbates these challenges. The hopelessness, lack of sleep, and lack of safety surrounding homelessness worsen mental health symptoms and increase the use of substances as a coping mechanism. Further, homelessness interrupts access to care and the ability to receive treatment. People experiencing homelessness were frank about how the conditions of homelessness worsened their mental health and their motivation to reduce or end their substance use. Even so, many wanted—and often sought—treatment but were unable to access it.

We found that half of adults experiencing homelessness had no indication of complex behavioral health needs. To end their homelessness, these individuals will require dedicated efforts to increase their economic opportunities, housing navigation, and access to housing that they can afford. They should be connected to mainstream safety-net health and social services. Leaving them without these resources could lead to health deterioration and to require more extensive services to support their exit from homelessness.

Half of adults had indications of complex behavioral health needs, which suggests the need for additional support and services in addition to affordable housing. For most people, these services can be provided through evidence-based services partnered with subsidized housing.

Robust data demonstrates that 85% or more of people with a diagnosis of severe mental illness (with or without co-occurring substance use disorders) can thrive in supportive housing when they receive appropriate support services, through program models such as ACT and ICM.

These models work best when people are matched to the appropriate service model, which typically requires a clinical evaluation. A smaller number of these individuals will need a higher level of care, such as that provided through residential care facilities.

When people have the safety and security of home, they are more likely to accept treatment, and it is easier to provide that treatment. Until people can receive the housing and support that they need, we must mitigate the harm that people experience, including the elevated risk of overdose and involvement in the criminal legal system. There is an urgent need for affirmative outreach to meet people where they are and to provide them with behavioral health services led by people trained to provide such services. Policymakers and practitioners should focus on expanding access to substance use treatment so that when people are ready for change, they are able to pursue it. In short, meeting the needs of those who are suffering will require scaling our housing development responses to address the fundamental need for housing, while providing evidence-based services to address issues that accompany homelessness.