The Role of Stabilization Programming in Successful Transitions from Homelessness

A Homeless Strategic Initiatives Report

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Executive Summary

The Role of Stabilization Programming in Successful Transitions from Homelessness assesses the urgent need for more cross-system partnerships to enhance efficiency and scale up **stabilization programming** for individuals experiencing **unsheltered homelessness** in the Portland Metro Area, particularly people with **substance use disorders** (SUDs), **serious mental illness** (SMI), and acute medical conditions that interfere with successful housing placement and retention. Commissioned by Homeless Strategic Initiatives (HSI) and prepared by the Technical Assistance Collaborative (TAC), this report examines national and local trends, explores innovative stabilization models across the nation, and provides recommendations for a coordinated system of care that would better integrate housing, health, and social services. Definitions for terms in **bold type** may be found in Appendix A.

Key Findings

Rising Unsheltered Homelessness and its Impact

- In 2024, the number of people experiencing homelessness in the United States reached a record 771,480, an increase of over 100,000 people from 2023.
- In Portland, OR, homelessness increased by 17%, with 7,384 individuals recorded as homeless in a single-night count, compared to 6,297 in 2023.
- In Multnomah County, 456 people experiencing homelessness died in 2023, more than 100 more than the previous year.
- Fentanyl contributed to 89% of overdose deaths among people experiencing homelessness, while 81% involved methamphetamine.
- The U.S. Supreme Court's ruling in *Grants Pass v. Johnson* (2024) permits cities to enforce civil and criminal penalties for "public camping," heightening the urgency for stabilization programs to prevent unnecessary legal consequences and deaths.

Health and Behavioral Health System Gaps

- Rising rates of unsheltered homelessness are closely tied to increasing behavioral health acuity, including more individuals with SMI, SUDs, and chronic health conditions.
- There is a shortage of behavioral health treatment options, including detoxification (**detox**) programs, inpatient mental health services, and medication for opioid use disorder (MOUD).
- The behavioral health workforce is critically understaffed, with providers citing low wages, burnout, and lack of professional development opportunities as key challenges.
- Lack of **affordable housing** remains a primary barrier to stabilization and **recovery**. Portland has too few deeply affordable housing units, and landlords are often unwilling to rent to individuals with high behavioral health needs due to insufficient community-delivered support services.

Challenges with Housing First Implementation

- While Housing First remains the federally recognized best practice for addressing **chronic homelessness**, many programs lack the funding to implement and provide services with the intensity required to stabilize people from the focus population in housing.

- Without adequate stabilization programming, many high-acuity individuals struggle to maintain **permanent housing** due to untreated mental health symptoms, substance use, and chronic health conditions. The lack of adequate community-based support services may result in agencies prioritizing individuals with lower acuity needs who can be served well with existing resources.

Interviews with National Leaders and People with Lived Expertise

In addition to an analysis of local and national trends, TAC conducted interviews with leaders from innovative stabilization programs across the U.S. to identify best practices for engaging high-acuity, unsheltered individuals. TAC explored programs that support individuals experiencing chronic homelessness, SUDs, and SMI. Boston Medical Center's START Clinic and the Roundhouse Program in Massachusetts provide a **harm reduction**-based, low-barrier approach to medical stabilization and housing, particularly for individuals using stimulants and opioids. Prevention Point in Philadelphia combines harm reduction shelter services with mobile medical care and syringe service programs, emphasizing Housing First principles. Denver's RecoveryWorks offers a drop-in center and transitional housing with integrated health care, **case management**, and employment support. Similarly, CASPAR Programs in Cambridge, MA operates a low-barrier shelter model that streamlines access to housing and behavioral health services through a simplified entry system.

To further ground its findings, TAC interviewed 19 individuals with lived experience of homelessness, SUDs, and SMIs. Several key themes emerged:

- Community and Belonging: A strong sense of community was a critical factor in service engagement, with 75% of respondents highlighting its importance.
- Timely Mental Health and Substance Use Treatment: Many individuals reported long wait times for psychiatric care and detox services, hindering recovery efforts.
- Navigation Barriers: Lack of awareness about available services and transportation challenges often prevents individuals from accessing needed support.
- The Role of **Peer Support**: 69% of respondents emphasized the value of peer mentors in helping them navigate systems and sustain engagement.
- Employment as Stability: 38% of individuals expressed that vocational training and **meaningful employment** opportunities were essential to maintaining housing and recovery.

Conclusion

The Portland Metro area has long been recognized for its innovative practices in addressing homelessness, receiving distinguished service awards from federal agencies such as the Substance Abuse and Mental Health Services Administration, the Department of Labor, the Department of Veterans Affairs, and the Department of Housing and Urban Development. The last decade's rise in the availability of illicit drugs, increasing rents, increased cost of living, and the multitude of service disruptions resulting from the COVID-19 pandemic have all impacted Portland's gains. Portland's funders, policymakers, people with lived experience, and health, behavioral health care, and homeless service leaders must come together to advance the high-level recommendations laid out in this report. Portland needs a system of care that can address the multifaceted needs of vulnerable people who are living outside through innovative, coordinated, and collaborative practices focused on population health metrics and supportive communities. This effort will be critical to engage disenfranchised unsheltered people in a continuum of stabilization, housing, health, well-being, and recovery.

Introduction

In August 2024, Homeless Strategic Initiatives (HSI) engaged the Technical Assistance Collaborative, Inc. (TAC) — a nonprofit organization dedicated to supporting our nation's human services, health care, homelessness, and affordable housing systems — to examine the need for better alignment in existing **stabilization programming** for people in the Portland Metro Area who are unsheltered and who are actively using substances or have an untreated serious mental illness (SMI).

Stabilization Programming

As used in this report, "stabilization programming" means a safe place to stay and coordinated care that works to alleviate high-acuity conditions. Such programming can also be used to stabilize people at risk of eviction due to behavioral health symptoms. Stabilization programming is staffed 24/7 and may include a multidisciplinary team of social workers, case managers, substance use disorder (SUD) counselors, psychiatric prescribers, community health workers, peer providers, and housing navigators.

The Oregon Health Authority Behavioral Health Residential + Facility Study references the following facilities which are Medicaid reimbursable, and in which stabilization services can be facilitated:

Residential Mental Health Facilities

- Residential Treatment Facilities
- Secure Residential Treatment Facilities
- Residential Treatment Homes
- Adult Foster Homes

Substance Use Disorder (SUD) Facilities

- Residential SUD Facilities
- Clinically Managed Withdrawal Management Facilities
- Medically Monitored Withdrawal Management Facilities

Crisis Facilities

The authors of this report also identify medical and mental health respite programs and transitional recovery and reentry housing as programs that can offer stabilization support. Some shelters that offer intensive and individualized services can also serve as stabilization programming. While skilled nursing facilities could be an important stabilization setting, few have the staffing capacity and supportive services necessary to care for people experiencing unsheltered homelessness who are active in their substance use or who have psychosis.

In 2024, the number of people documented to be experiencing homelessness in the U.S. on a single night rose to 771,480, a historic record and over 100,000 more than were counted in 2023.[1] For the Portland/Multnomah County Continuum of Care (CoC), the number of people recorded as homeless on a single night in 2024 was 7,384, an increase of over 1,000 from 2023 (6,297).[2] In December 2024, the Multnomah County Health Department reported that 456 people experiencing homelessness died in 2023, an increase of more than 100 deaths from the previous year. Fentanyl contributed to 89% of overdose deaths among this group while methamphetamine was a factor in 81% of them.[3] In June 2024, two months prior to TAC's engagement with OR HSI, the U.S. Supreme Court ruled in *Grants Pass vs. Johnson* that local government ordinances with civil and criminal penalties for camping on public land do not constitute cruel and unusual punishment of homeless people. This is an important moment for communities to understand the types of services and supports that can stabilize people who are difficult to house, to help this population avoid civil and criminal penalties as well as preventable death.

This report is informed directly by conversations with people experiencing chronic homelessness (including those with active substance use, SMI, and chronic health conditions) and with leaders across the country who offer innovative practices to engage these populations in stabilization programming. However, the report starts with a history of the Housing First model of intensive and integrated case management and an explanation of its evolving application since the early 2000s — specifically in the context of significant changes in the illicit drug supply over the same period. Additionally, this report describes findings based on quantitative data provided by Health Share of Oregon. We outline key national trends: rising rates of unsheltered homelessness, ongoing scarcity of culturally responsive and effective treatment models for high-acuity unsheltered individuals, and declining availability of extremely affordable housing in which to stabilize this population. Finally, the report presents high-level recommendations to improve stabilization for people who are unhoused and actively using illicit drugs, to optimize the success of this population in permanent housing placements, **housing tenure**, health, wellbeing, recovery, and **economic self-sufficiency**.

Housing First History

While many communities state that they utilize Housing First principles and operate Housing First programming, it is important to draw attention to the original model that the federal government began endorsing in the early 2000s. The Housing First model was founded by Dr. Sam Tsemberis at Pathways to Housing in New York City in 1992, based on the belief that people experiencing homelessness who had serious mental illness (SMI) (e.g., schizophrenia) shouldn't have to prove they were "housing ready" before being placed into **permanent supportive housing** (PSH). The idea of housing readiness had previously consisted of criteria that a person needed to meet before a program would agree to enroll

[1] U.S. Department of Housing & Urban Development, Office of Community Planning & Development (2024). *The 2024 annual homeless assessment report to Congress*. Washington, D.C.: U.S. Department of Housing & Urban Development.

[2] U.S. Department of Housing & Urban Development, Office of Community Planning & Development (December 2024). 2024 AHAR: Part 1 - PIT estimates of homelessness in the U.S. (From this page, download "2007 - 2024 Point-in-Time Estimates by CoC."

[3] Multnomah County (OR) (2024, December 19). Multnomah County releases 2023 domicile unknown report of homeless deaths.

them in supportive housing. Examples of these restrictive criteria included showing up for scheduled appointments at a behavioral health clinic, adhering to psychiatric medications regimens, and abstaining from illicit drug and alcohol consumption. Compliance with such criteria was required for a person to be deemed ready and eligible for a housing placement, and as a result, these programs often screened out people with the highest-acuity conditions who often exhibited the symptoms of their illnesses — the very symptoms that could more effectively be treated in safe and supported housing. People could lose their housing because of behaviors caused by untreated mental illness or substance use disorders that caused lease violations.

The original Housing First program incorporated an established **evidence-based practice** called Assertive Community Treatment (ACT), first used in Madison, Wisconsin in the early 1970s, to move people diagnosed with SMI out of state psychiatric hospitals after years of institutionalization and stabilize them the community. This model was frequently characterized as a "hospital without walls" due to its use of intensive community-based case management offered by a multidisciplinary team which included 24/7 crisis response services. Numerous studies over several decades have found that when ACT is offered as prescribed by its **fidelity scale**, it is the most effective model for supporting community living for people with SMI, with some studies finding that ACT participants experienced a 37% greater reduction in homelessness and a 26% greater improvement in psychiatric symptom severity compared with those receiving standard case management.[4] Furthermore, ACT has effectively been adapted to serve people released from **forensic and correctional settings**, and researchers have documented decreases in jail days when compared to those not served by a **jail diversion** ACT team.[5] A 2023 report from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) offers more information on fidelity to the ACT model, which is associated with outcomes documented in the research.

When Pathways to Housing launched Housing First, it did so with fidelity to the ACT model and served people with primary SMI who were experiencing unsheltered homelessness, and who in some cases had co-occurring substance use disorders (SUDs). In 2002, the U.S. Interagency Coalition on Homelessness (USICH) launched the Collaborative Initiative to Help End Chronic Homelessness in which 11 sites across the country were granted funding from the U.S. Department of Housing and Urban Development (HUD), SAMHSA, the Health Resources and Services Administration (HRSA), and the Department of Veterans Affairs (VA) to replicate to-fidelity Housing First/ACT programming for people who met the definition of chronic homelessness. Only two of the eleven sites enrolled people experiencing chronic homelessness with a primary SUD: Portland's Central City Concern and Colorado Coalition for the Homeless in Denver. The remaining sites applied the Pathways to Housing eligibility criteria in which a participant had to have a primary SMI. Pertaining to the issue of stabilization, HUD allowed for up to 90 days of temporary housing placement for people who needed immediate stabilization while a permanent housing placement was attained.[6] Interestingly, this initiative was launched prior to the Affordable Care Act and **Medicaid** expansion, so people who had primary SUDs were not typically eligible for Medicaid (which

[4] Goulet, M., Dellazizzo, L., Lessard-Deschênes, C., Lesage, A., Crocker, A. G., & Dumais, A. (2021). Effectiveness of Forensic Assertive Community Treatment on forensic and health outcomes: A systematic review and meta-analysis. *Criminal Justice and Behavior, 49*(6): 838–852.

[5] Goulet, M., Dellazizzo, L., Lessard-Deschênes, C., Lesage, A., Crocker, A. G., & Dumais, A. (2021). Effectiveness of Forensic Assertive Community Treatment on forensic and health outcomes: A systematic review and meta-analysis. *Criminal Justice and Behavior, 49*(6): 838–852.

[6] Interview with Ed Blackburn, former Executive Director of Central City Concern

covers the cost of health and behavioral health care and was associated with a person securing **Supplemental Security Income** due to a **documented disabling condition**). This exclusion was based on a 1996 Social Security Administration policy decision.

Over the past two decades, the Housing First model has been elevated as the gold standard by the federal government and national organizations working to end homelessness. Communities across the country were advised through HUD Continuums of Care to adopt Housing First, though there were no federally designated funds to cover the cost of its intensive community-based service model (ACT) other than Medicaid, which varies from state to state and did not cover these services for those with primary SUD. Over time, communities across the country endorsed Housing First and listed themselves as Housing First operators, often without understanding, or being able to fund, full fidelity to the model. More recently, new illicit drugs like fentanyl have made their way into the drug supply, complicating opioid use disorder management when compared to non-synthetic opioids (heroin), the most available form of illicit opiates in the early 2000s when the Housing First model was endorsed as a best practice for serving people experiencing chronic homelessness.[7] It is important to recognize that there is a dearth of research on best practices for supporting people experiencing chronic homelessness who are using synthetic opioids and/or methamphetamines within Housing First programs.

Today, Housing First is widely accepted as a best practice — but providers unable to fund to-fidelity programs frequently select people with lower-acuity behavioral health needs for their available supportive housing slots; this happens because the services required to meet higher-acuity challenges are unfunded, and the providers have likely experienced the phenomenon of property owners and managers excluding high-need individuals as a result of lease violations when those more intensive services are unavailable. This problem is compounded by the affordable housing crisis seen across the country, in which not enough very low-income units are available, and landlords choose tenants without extensive eviction histories or criminal convictions. Oregon is not alone, as highlighted in the national trends section below.

Note: In 2008, the **rapid rehousing** intervention model, intended to reduce the duration of homelessness for a family or individual was advanced by HUD. Rapid rehousing utilizes short-term rental assistance with light case management services and alignment with Housing First principles of having no conditions required for eligibility, other than being homeless. In incorporating rapid rehousing into the continuum of homelessness interventions, the field recognized that not everyone experiencing homelessness requires a permanent housing subsidy or intensive, multidisciplinary services. Initially, the intended population for rapid rehousing was people who were episodically homeless, generally only for short periods.[8] However, today, communities across the country confuse rapid rehousing for Housing First, though the most consistently cited evidence for Housing First is based on ACT levels of care.

[7] Weber, A. N., Trebach, J., Brenner, M. A., Thomas, M. M., & Bormann, N. L. (2024). Managing opioid withdrawal symptoms during the fentanyl crisis: A review. *Substance Abuse & Rehabilitation, 15*: 59–71.

[8] U.S. Department of Housing & Urban Development (n.d.). Housing search assistance toolkit.

Portland in the Context of National Trends

Unsheltered Homelessness and Racial Disparities

First and foremost, unsheltered homelessness is increasing almost everywhere. Due to historical and structural racism, many groups — especially African Americans and American Indians / Alaska Natives (AI/AN) — experience homelessness at elevated rates. Strikingly, African Americans represent only 13% of the general population but 37% of people experiencing homelessness and more than 50% of homeless families with children.[9]

Additional Health Challenges

Rising rates of unsheltered homelessness are closely tied to increased acuity and co-morbidity, with data indicating more substance use, higher acuity of SMI, and more chronic health conditions in this population. For unsheltered people, such challenges are both induced and exacerbated by heightened exposure to environmental stressors, trauma, and violence.[10]

Affordable Housing Shortage

In Portland and across the nation, the shortage of affordable housing is a critical driver of unsheltered homelessness. According to the National Low Income Housing Coalition there is a shortage of 7.3 million low-income units nationwide, and not even one of the 50 largest metro areas has enough **low-income housing** to meet the needs of its community members.[11] For individuals with disabilities, the landscape is even more bleak. According to TAC's most recent Priced Out data, there is not a single U.S. housing market where a person whose sole source of income is Supplemental Security Income (SSI) can afford safe and adequate housing without rental assistance. Lack of access to safe, stable housing means individuals are less likely to be able to address their health, substance use, and mental illness concerns.

Ongoing Changes in the Illicit Drug Supply

This is all further complicated by the fact that we are now in the Fourth Wave of the opioid epidemic, which is characterized by a dramatic rise in overdose deaths that involve stimulants such as cocaine and

[9] National Alliance to End Homelessness (2025). Homelessness and racial disparities.

[10] Richards, J., & Kuhn, R. (2022). Unsheltered homelessness and health: A literature review. *AJPM Focus*, 2(1)

[11] National Low Income Housing Coalition (2024). *The gap: A shortage of affordable homes*. Washington, DC: National Low Income Housing Coalition

methamphetamine in addition to synthetic opioids like fentanyl.[12] The fourth wave also features other **adulterants** in the drug supply — most notably the sedative xylazine, whose strong effects leave users vulnerable to the elements as well as to assault[13]; its continued use also causes large wounds and infections that are difficult to treat. Preliminary data from 2024 shows that overdose deaths are finally decreasing for some, but Black, Brown, and Indigenous communities are still experiencing the dramatic increase brought on by the Fourth Wave.[14]

Gaps in Access to Treatment and Housing

The combination of these issues creates a complex clinical picture that is challenging to treatment for service providers both nationally and in Portland. Homelessness itself is a significant barrier to accessing treatment and recovery services, leading to a cycle that is difficult to break without cross-system, collaborative, and integrated intervention. The nation must now provide integrated treatment and other forms of support to homeless individuals who are managing opioid dependence, stimulant addiction, and mental illness. However, treatment options for this population remain limited, and widespread stigma complicates efforts to offer comprehensive, integrated care. Existing treatment providers are underfunded, understaffed, and ill-equipped to meet the diverse needs of hard-to-serve individuals, especially those with co-occurring challenges. In Portland as in other parts of the country, there is a shortage of both substance use and psychiatric treatment beds.[15, 16] According to the Oregon Health Authority, the state would need to add a significant number of treatment beds to meet the needs of Oregonians with SUDs.[17] In Multnomah County, the lack of stabilization programming means that many individuals with complex challenges are not able to receive care that meets their needs.

The lack of **evidence-based, trauma-informed care** for individuals experiencing chronic homelessness or with complex needs contributes both to poor treatment outcomes and to challenges maintaining stability.[18] For example, while most states have invested heavily in improving access to MOUD, the gold standard for opioid use disorder treatment, they have not taken similar steps to ensure access to **contingency management** (CM) which is the most researched and evidence-based practice for people

[12] Jenkins, R. A. (2021). The fourth wave of the US opioid epidemic and its implications for the rural US: A federal perspective. *Preventive medicine, 152*(Part 2)

[13] Jenkins, R. A. (2021). The fourth wave of the US opioid epidemic and its implications for the rural US: A federal perspective. *Preventive medicine, 152*(Part 2)

[14] Garnett, M. F., & Arialdi, M. M. (2024). Drug overdose deaths in the United States 2023–2024. *NCHS Data Brief, No. 522*

[15] McBain, R. K., Cantor, J. H., & Eberhart, N. K. (2022). Estimating psychiatric bed shortages in the US. *JAMA Psychiatry, 79*(4): 279–280

[16] Post, R., Boss, R., & Horton, A. (2022). Resolving homelessness: The critical need for a substance use disorder system of care. Portland, OR: Homeless Strategic Initiatives

[17] Public Consulting Group (2024). Oregon Heath Authority behavioral health residential+ facility study: June 2024 final report

[18] Diana, A., Saunders, H., & Hinton, E. (2025, January 9). Section 1115 waiver watch: A look at the use of contingency management to address stimulant use disorder. *KFF Policy Watch*

using methamphetamines. At this time, only five state waivers (California, Delaware, Hawaii, Montana, and Washington) have had CM approved as a covered benefit through an 1115 waiver.

Programs that do attempt to use evidence-based practices are rarely funded well enough to implement them to fidelity.[19] As previously noted, Housing First programs operated to fidelity are effective in reducing homelessness and improving overall health outcomes. However, the nationwide underfunding of Housing First initiatives limits their ability to maintain fidelity to the model. Without proper funding, these programs struggle to provide the necessary wraparound services, including community-based and intensive case management, health care, addiction treatment, mental health treatment, and **employment supports** that individuals need to succeed. Similarly, the broader **system of care for SUDs** lacks sufficient financial resources to translate research and evidence to practice, meet treatment demand, and adequately train staff — leading to inadequate services and poor outcomes.[20] This national funding disparity is evident in Oregon, where an investment of $835,484,858 is needed to adequately address substance use treatment demand alone.[21] Lastly, there is a national shortage of programs that are culturally responsive and can effectively serve racial, ethnic, and gender minorities, as well as LGBTQ+ populations.[22] Many individuals from marginalized communities face additional barriers to care, and the absence of culturally tailored services often leads to both disengagement from treatment and reduced efficacy of interventions — perpetuating cycles of substance use and homelessness — whereas culturally tailored services promote improvement in health behaviors and outcomes.[23]

Behavioral Health Workforce Shortage

Another national issue is the **shortage of qualified professionals** across the substance use and mental health treatment fields.[24] The Oregon Substance Use Disorder Services Inventory and Gap Analysis issued in 2022 documents this problem in the Portland Metro Area and the entirety of Oregon. As of December 2023, more than half of the U.S. population lived in **Mental Health Professional Shortage Areas**.[25] Furthermore, the behavioral health workforce is predominantly female and non-Hispanic White, meaning that even if providers are available they may not meet the needs and preferences of all

[19] Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Systemic barriers in substance use disorder treatment: A prospective qualitative study of professionals in the field. *Drug and Alcohol Dependence, 189*:62-69

[20] Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Systemic barriers in substance use disorder treatment: A prospective qualitative study of professionals in the field. *Drug and Alcohol Dependence, 189*:62-69

[21] Public Consulting Group (2024). Oregon Heath Authority behavioral health residential+ facility study: June 2024 final report

[22] Jones, C. T., & Branco, S. F. (2021). Cultural considerations in addiction treatment: The application of cultural humility. *Advances in Addiction & Recovery, 9*(1).

[23] Jones, C. T., & Branco, S. F. (2021). Cultural considerations in addiction treatment: The application of cultural humility. *Advances in Addiction & Recovery, 9*(1).

[24] Post, R., Boss, R., & Horton, A. (2022). Resolving homelessness: The critical need for a substance use disorder system of care. Portland, OR: Homeless Strategic Initiatives

[25] Post, R., Boss, R., & Horton, A. (2022). Resolving homelessness: The critical need for a substance use disorder system of care. Portland, OR: Homeless Strategic Initiatives

communities.[26] In addition to traditional clinicians and medical providers, peer support workers — i.e., specially trained professionals with lived experiences in recovery — are an invaluable resource in supporting long-term recovery. However, the lack of permanent and reliable sources of funding for peer programs and the insufficient number of trained peer providers means that many individuals in need of support do not have access to this vital resource. Throughout the SUD treatment and recovery workforce, burnout and high turnover are pervasive. Low compensation is one contributing issue, with hourly wages for these professionals significantly less than in fields requiring similar years of education and qualifications.[27] In Oregon, according to an 2022 OHSU report, there are not enough providers across disciplines who treat people with SUDs, including peers, certified alcohol and drug counselors, qualified mental health professionals, and physicians waivered to prescribe suboxone.[28]

Missed Opportunities for Community Integration

Long-term stability and recovery are strongest in the community. Therefore, involvement in support systems and access to meaningful employment are both key factors in successful recovery from SUDs and SMI. However, there is a shortage of recovery community support services that can provide ongoing encouragement and resources to individuals in recovery. Additionally, the lack of employment services that can help individuals with histories of substance use and homelessness reintegrate into the workforce could hamper stability, a wasted opportunity given that employment is a motivator for individuals to initiate and continue participating in treatment.[29] Without the financial independence and social support that employment offers, many individuals struggle to maintain long-term stability.

National Scan

Between August and October of 2024, TAC interviewed five programmatic leaders identified by TAC and HSI as employing innovative practices to serve people who are experiencing unsheltered homelessness and who have active SUD, mental illness, and acute medical conditions. Using a structured interview guide, these leaders were asked about subpopulations served, programmatic components, models employed, challenges in serving the population, policies that impede adequate service delivery, financing mechanisms, and their perspectives on the most important components required to effectively engage and serve this population through stabilization programming. The program leaders interviewed were:

[26] Post, R., Boss, R., & Horton, A. (2022). Resolving homelessness: The critical need for a substance use disorder system of care. Portland, OR: Homeless Strategic Initiatives

[27] Vine, M., Staatz, C., Blyler, C., & Berk, J. (2020). *The role of the workforce system in addressing the opioid crisis: A review of the literature*. Washington, DC: Mathematica

[28] Lenahan, K., Rainer, S., Baker, R., & Waddell, E. N. (2022). *Oregon substance use disorder services inventory and gap analysis: Estimating the need and capacity for services in Oregon across the continuum of care*. Portland, OR: OHSU-PSU School of Public Health.

[29] Lenahan, K., Rainer, S., Baker, R., & Waddell, E. N. (2022). *Oregon substance use disorder services inventory and gap analysis: Estimating the need and capacity for services in Oregon across the continuum of care*. Portland, OR: OHSU-PSU School of Public Health.

- Boston Medical Center's START Clinic in Boston, MA: Justin Alves, Co-Medical Director
- Prevention Point in Philadelphia, PA: Katie Perch, Lead Program Officer for Harm Reduction and Housing and Dale Tippett, Director of Homeless Services
- RecoveryWorks in Lakewood, CO: James Ginsburg, Executive Director:
- The Boston Medical Center Grayken Center for Addiction's Roundhouse Program in Boston, MA: Miriam Komoromy, Medical Director
- Cambridge and Somerville Programs for Addiction Recovery (CASPAR) in Cambridge, MA: Maureen Cunningham, Senior Program Director

Several cross-cutting themes emerged, in which all the interviewees shared the same perspectives. Following the list of these themes is information about each organization and its leaders' unique suggestions and proposed considerations for the design of stabilization programming.

Cross-Cutting Themes

- Efforts should begin immediately to connect unsheltered people who are using substances and those with untreated mental illness to permanent housing opportunities. All programmatic leaders noted the critical importance of long-term housing solutions, the lack of affordable housing, and the need to start the housing navigation process as soon as possible after entering stabilization programming.
- Services and housing solutions should be individually tailored. All programmatic leaders recognized that the system does not now have the capacity to treat people as individuals, an approach which is fundamental to the provision of recovery-oriented care. Leaders not only advocated for a range of services but also a variety of housing settings including congregate, scattered-site, abstinence-based, and harm reduction.
- Programs should utilize a multidisciplinary, integrated treatment team approach that includes medical and behavioral health care, peer support, and case management or social work. This team should work both as a collective and in partnership with each person served.
- Basic needs for safety, sleep, hygiene, and food must be met before addressing anything else. Programmatic leaders affirmed that without these needs met, people's judgement and decision-making is impaired.
- Programs need to have low thresholds for entry and high thresholds for discharge. Programmatic leaders supported the removal of unnecessary and punitive barriers to entry and services so that the most vulnerable people can access them. Once people are in the program, staff should work with them in a person-centered way to avoid administrative discharge whenever possible.
- Staff working in the program must have an advanced understanding of the focus population. Staff need ongoing training and opportunities to develop expertise in substance use, mental health, and the unsheltered lifestyle; complex trauma; traumatic brain injuries; and desire to be in community.

- Staff retention efforts should be implemented so that expertise is developed. Approaches should include paying a living wage with benefits; adopting policies that prioritize staff well-being; providing adequate supervision; and being responsive to staff's evolving needs.
- As many services as possible should be co-located or integrated to ease the burden of navigating complex systems. Build partnerships with other systems to coordinate services.
- Trauma-informed care must be foundational to all programming.
- Interventions should address the unique needs of the population rather than being drawn from any one framework, philosophy, or blanket approach. Programmatic leaders agreed that the care needs of this population exceed the services that are currently available.

Perspectives from Programmatic Leaders

Boston Medical Center's START Clinic, Boston MA

Justin Alves, M.S.N., F.N.P.-B.C., A.C.R.N., C.A.R.N., C.N.E. — Co-Medical Director, START Clinic

The START clinic is part of Boston Medical Center's Office Based Addiction Treatment (OBAT) clinic and specializes in the treatment of stimulant use disorders. Boston Medical Center's OBAT program has successfully used nurse care managers to deliver state-of-the-art addiction treatment in an integrated primary care setting for over 14 years. The START clinic offers contingency management as well as medications and is a national leader in its approach to the care of people who use stimulants and other substances. START uses outreach and harm reduction to engage individuals who are mostly unsheltered and living in a large encampment in Boston. In addition to its office-based services, START operates a drop-in space where people who need to rest or have overused (over-amped) stimulants can get support.

Suggestions and Considerations from START

1. Integrate medication for addiction treatment, withdrawal, and psychosis onsite — including innovative approaches to relieving symptoms of stimulant use disorder (sleeplessness, paranoia, agitation, psychosis).
2. Focus on engagement, trust-building, and repairing trust after incidents that occur in the program.
3. Design program spaces to meet the needs of the population, e.g., a cool-down space for stimulant users who are overamping. The cool-down space reduces stimuli by offering a dark, quiet room with a bed after the participant is offered something to eat and medications to relieve symptoms.
4. Establish policies and procedures that accommodate those who use stimulants and their unique needs.
5. Promote and respect autonomy.
6. Integrate contingency management.

Boston Medical Center's Grayken Center for Addiction Roundhouse Program, Boston, MA

Miriam Komaromy, M.D., Medical Director

The Grayken Center is a national leader in innovative addiction treatment, research, policy, and advocacy. During the COVID-19 pandemic the Grayken Center stood up a low-threshold urgent care clinic and transitional housing program in a former hotel called the Roundhouse. The Roundhouse aimed to help people with SUDs and mental health challenges to exit one of city's largest encampments. Though the funding for this program ended due to neighborhood resistance to the program, initial studies gleaned some promising results for this model. In addition to low-threshold transitional living and case management services for individuals with high barriers to housing, the Roundhouse provided medical services for people who were active in their substance use, such as sedation monitoring, withdrawal management, linkage to MOUD, wound care, and drug testing. Anyone experiencing homelessness was able to access the low-threshold medical clinic, while transitional housing was available for those referred. Furthermore, BMC/Roundhouse partnered with the Mayor's Office of Housing to extend rental subsidies and vouchers to its residents. This program was granted a waiver to operate as a satellite urgent care clinic due to flexible regulatory practices established during the COVID-19 pandemic.

Suggestions and Considerations from Roundhouse

1. The need for comprehensive 24/7 access to behavioral health services cannot be overstated when serving this population, including those experiencing methamphetamine-related psychosis.
2. There should be a line in states' Medicaid plans that covers sedation monitoring for people who use drugs. Sedation monitoring in this setting includes medically monitoring vital signs for someone who is over sedated due to substance use. Sedation monitoring is used to divert people from the emergency room when that level of intervention is not needed.
3. There is a need for robust services all in one place. Don't leave people to figure it out on their own. For services that cannot be provided in the program, ensure someone is there to hold a person's hand while they navigate complicated systems.
4. Start neighborhood engagement processes early and provide ongoing community education about new programming.
5. Be selective about partners and staff. Ensure you are partnering with agencies whose missions align with your program's. Create ways to hold partners accountable to remaining mission-driven. Working with for-profit partners may require special care to clarify all expectations.
6. Staff need to be consistent and well trained (especially in assertive engagement) and must understand the mission.
7. Try to reduce staff turnover to ensure continuity of care by paying a living wage, providing adequate training and supervision, promoting staff wellbeing, and being responsive to their evolving needs.

8. Ensure flexibility in caseload size based on the acuity of people served.
9. Residents value a sense of community in transitional housing, and some fear moving to permanent housing and being isolated — Consider placement in permanent housing that has a similar model to the transitional housing they are leaving, or offer incentives to move on to permanent housing.
10. Use technology and innovation to provide medication management services onsite.
11. Provide spaces for people to use drugs that are not visible to the public, provide amnesty lockers, and set up separate spaces for people who are over-amped vs. those who are sedated from other substances.

Prevention Point, Philadelphia, PA

Katie Perch, M.S.W., Lead Program Officer for Harm Reduction and Housing
Dale Tippett, Director of Homeless Services Beacon House

Prevention Point is a nationally recognized public health program that offers harm reduction services to the residents of Philadelphia, PA. The program is deeply respected in the harm reduction community for providing responsive, creative, and compassionate services. Prevention Point operates a syringe service program, transitional housing, mobile medical care, MOUD, medical respite, and intensive case management. Its population of focus is unsheltered people who use drugs. Prevention Point's 60-bed transitional housing program, Beacon House, is the only shelter space in the city designed to serve people who are active in their substance use. Beacon House often serves individuals with co-occurring behavioral health diagnoses and people whom other shelter spaces are unable to accommodate.

Suggestions and Considerations from Prevention Point

1. Funding must be increased to support the hiring of medical professionals and experienced staff. Additionally, funding should be more flexible to meet evolving needs. Funding for the treatment of the focus population is insufficient as it is only available through certain sources, most of which have constraints on how the money can be used. Comprehensive addiction treatment is expensive, and many organizations struggle to cover the cost of providing it.
2. Do not use HUD chronic homelessness definition as an eligibility criterion — it is too stringent and excludes many people from housing opportunities.
3. Include capacity for landlord engagement as it is critical to helping people find housing.
4. Work with local government to garner support for humane interventions.
5. Integrate naloxone access, drug testing, syringe services, and strategies for safer consumption into any harm reduction programming.
6. Integrate MOUD and withdrawal management.
7. Establish memorandums of understanding with key partners to coordinate care.
8. Establish close partnerships with pharmacies to support the use of MOUD.

RecoveryWorks, Denver Metro Area, CO

James Ginsburg, M.A., C.A.D.C. III, Executive Director

RecoveryWorks is a nonprofit organization that operates a drop-in center, transitional housing, and medical respite for unsheltered people who use drugs and have other behavioral health conditions. At the drop-in Navigation Center, RecoveryWorks guests can access services that meet their basic needs like showers and meals and connect with onsite medical and behavioral health care. They can also receive referrals to the 34-unit transitional housing program where they work with case management staff to secure permanent housing. The transitional housing program, like the drop-in Navigation Center, offers onsite medical and behavioral health care. The state of Colorado has invested in the success of RecoveryWorks programming and has funded rental subsidies for people who participate in some of its programming. Lastly, RecoveryWorks operates medical respite for people experiencing homelessness where they can recover from medical procedures, injuries, and illnesses in a safe environment.

Suggestions and Considerations from RecoveryWorks

1. Involve the focus population and community partners in design, implementation, and evaluation of services.
2. Services should incorporate the following five pillars: Peer-driven, recovery-focused, strengths-based, trauma-informed, and person-centered.
3. Enhance capacity to address SUDs and SMI across the entire system or continuum of care in addition to developing exceptional program staff.
4. Nurture partnerships with community-based organizations and relevant government agencies.
5. Leadership must be clear on mission and lead with these values to get staff and community members on board with programming.

Cambridge and Somerville Programs for Addiction Recovery (CASPAR), Cambridge, MA

Maureen Cunningham, Director of Cambridge Shelter Programs

CASPAR partners with the City of Cambridge to offer robust supportive services in its shelter system. It operates medical street outreach, two low threshold shelters, one harm reduction shelter, permanent supportive housing, a housing navigation and stabilization program, and Medicaid-reimbursable housing supports. CASPAR also has Health Care for the Homeless/Cambridge Health Alliance clinics and a behavioral health clinician integrated into its program sites and outreach vans. It has partnerships with the Cambridge Housing Authority, ACCESS Syringe Service Program, Cambridge Health Alliance, and various City of Cambridge departments. In 2022, the City of Cambridge CoC changed how it administered its HUD-funded coordinated entry (CE) program to allow greater access to Emergency Housing Vouchers for people with the longest lengths of stay in shelter or on the streets. In conjunction, it funded housing navigation and stabilization staff at several shelters, including CASPAR's, so CE assessment, housing search, and follow-up supportive services could all occur in-house with persons served in the system. Post-housing-placement supportive services are provided by people with whom

people served already had established relationships including housing navigators, shelter staff and outreach workers. Additional partnerships and close collaboration with the Cambridge Housing Authority allow shelter housing teams to secure vouchers for people with significant barriers. Guests receiving services through the housing team continue accessing medical and behavioral health services through Health Care for the Homeless clinics.

Suggestions and Considerations from CASPAR

1. Co-locate critical housing, health care and behavioral health services in all shelter sites — also offer them to anyone served by outreach.
2. Leverage existing relationships between trusted staff and people served to maximize participation in services.
3. Continuity of services and providers is critical.
4. Simplify coordinated entry to maximize participation and allow shelter staff and outreach workers to perform coordinated entry assessments.
5. Partner with housing authorities to lower barriers to housing.
6. Work collaboratively with local government, other agency partners, and funders to identify solutions.

Perspectives from People with Lived and Living Experience

In September 2024, TAC conducted key informant interviews with 19 single adults who identified as having substance use and/or serious mental health disorders, including those with comorbid chronic health conditions and who likely met the definition of chronic homelessness. TAC worked with Central City Concern staff to identify key informants who had participated in five different programs that serve people experiencing chronic homelessness (see Table 1 below). Using a structured interview guide, interviewees were invited to answer any or all the available questions over a period of 15-minute increments, for up to 60 minutes. TAC compensated interviewees but did not inform them that TAC would be dispensing cash compensation until after the interview had been completed, to avoid unduly influencing participation.

Table 1: Programs through which Key Informants with Lived Experience were Identified

Program	Number of Key Informants
The Richard Harris Transitional Recovery Housing Program, operated by Central City Concern, serves individuals exiting Hooper Subacute Detox or residential treatment who express a desire for outpatient treatment and a supported sober living environment where they can work towards long-term recovery, to become employed and to secure permanent housing.	4
Housing Rapid Response (HRR), operated by Central City Concern, is a stabilization program designed to serve highly vulnerable homeless individuals with co-occurring disorders who are also high utilizers of the criminal justice system due to frequent drug-related charges. HRR offers six months of sober housing and supports treatment planning that assists clients in their efforts to work towards permanent housing and self-sufficiency. *Note: HRR is not to be confused with the "Rapid Rehousing" model*	3
The Recuperative Care Program (RCP), operated by Central City Concern, delivers crucial medical respite services to low-income and homeless individuals following hospitalization. Through comprehensive health care access, transitional housing, and intensive case management, RCP strives to improve health outcomes, reduce homelessness, and streamline hospital operations.	2*
HEART Homeless Street Outreach	5**
Safe Rest Villages include alternative outdoor shelters and Portland's first RV Safe Park, as well as a congregate shelter. All City Shelters include case management with wraparound behavioral and mental health services.	2***

** Three individuals were interviewed at RCP, but only two were analyzed as the third one's responses were incoherent to the interviewer.*

*** Six individuals were interviewed associated with HEART, but only five were analyzed as the sixth one's responses were incoherent to the interviewer.*

**** Three individuals were interviewed at SRV, but only two were analyzed as the third one's responses were incoherent to the interviewer.*

Of the individuals interviewed, 75% reported they were male and 25% reported they were female. Fifty percent of interviewees identified as White, 19% as Black, 6% as multiracial, 13% as AAPI, and 13% did not disclose their race or ethnicity. All interviewees said English was their first language.

The questions asked in the key informant interviews are provided below, along with a summary of responses:

If there was an opportunity to go to treatment or stabilize before entering housing, would you find that helpful? 69% of respondents answered "Yes," while 31% answered "No."

Have you ever lost housing? If so, how many times have you lost your housing in the last five years? 69% of respondents stated that they had lost housing in the last five years while 12% stated they had not been housed at any time during the last five years. Only 19% reported that they hadn't lost housing in the five years preceding their most recent episode of homelessness, for which they were now being served in one of the above identified programs (RHP, HRR, RCP, SRV).

A series of questions sought people's perspectives about the most important features that need to be available for them to want to engage in services and stabilize (i.e., **What are some challenges you are currently experiencing and what would help you overcome them? What kinds of supports have been most helpful to you in improving your life? What do you think is missing from the current service system that is especially important for people who use drugs and for people with mental illness? What would you change about the current services to make them better?)** When the responses were analyzed, seven different themes emerged**.**

- Creating a sense of *belonging and community* was the most frequently endorsed response (75% of respondents). One respondent reported that feeling isolated in housing may result in people ending up back on the streets where they may feel a stronger sense of community with those in an encampment. Another respondent stated, *"Sometimes it's lonelier inside than out here."*
- The importance of scaling up ***peer providers*** was endorsed by 69% of respondents. One respondent stated, "How can you help me if you have no idea what it's like to be out here?" to signify how important Peer Providers are in engaging people out of unsheltered homelessness. Additionally, several respondents identified peer mentorship and fellowship groups (i.e., 12-step programs) as a necessary support service for them to stabilize.
- *Care coordination* was also endorsed by 69% of respondents. Respondents shared a variety of ways in which it is nearly impossible to navigate into many services. One individual stated that they wanted to access an SRV placement but could not figure out how to do this and that the Joint Office's website offers no information about how to get a referral. This person stated they don't know what services various homeless service providers offer and suggested a central website where people could identify the type of programming available and the referral mechanism. Another individual stated that 211 should offer more navigation support. One respondent stated "*Don't wait for people who are living outside to come to the programs or to state what they need! We are so used to being moved, it's dehumanizing. People need dedicated case management who check in with them daily*."
- *Accessibility of services* was endorsed by 63% of respondents. Several respondents spoke about the challenges in accessing services due to the distance between the many systems they need to access, lack of transportation, and limited hours of operations. The solutions suggested included more co-location in the form of a One-Stop where all health care, behavioral health care, benefits and entitlements, employment, housing and food could be offered in accessible locations. One respondent stated that relying upon public transportation is nearly impossible and can sometimes be dangerous. This person, who uses a wheelchair, shared that due to unreliable transportation they were unable to make it to an eviction court hearing and were therefore evicted. Respondents noted the need for homeless service staff and peer providers to transport them to the services they need and want, and to help them navigate into those programs via a warm handoff.
- The need for *on-demand mental health* services was identified by 50% of respondents. One respondent shared that there is so much untreated mental illness on the streets, and he doesn't

know why nothing is being done about this. “People are suffering and it’s inhumane and dangerous!” He believes that more involuntary commitments need to be conducted. Another respondent described wanting to be prescribed medications for his mental health symptoms but was unable to get an appointment with a prescriber. Another stated that there needs to be a variety of therapists that a person can choose to work with, because not every therapist can work with every client, while another respondent stated that there needs to be therapy available 24/7 and not just during business hours. While the crisis line can be helpful, it’s difficult to open up to a person he doesn’t know on a phone line or to build trust with a faceless person. Finally, one respondent stated that his previous experience seeking mental health treatment was unsatisfying because he didn’t feel that he was receiving individualized services or the level of intensive mental health care he needed.

- The need for *on-demand treatment for substance use disorders* was endorsed by 50% of respondents. One individual noted that while services shouldn’t be forced, there does need to be more intensive outreach to people who are using substances outside to build rapport and support engagement into treatment. Another respondent reported he had tried to detox from heroin over 100 times on his own and at an area subacute detoxification center over 70 times, stating that he believed if detox centers offered smoking porches that there would likely be fewer people leaving against medical advice. He shared that he would value a 30-day residential treatment program with **intramuscular medications** for opioid use disorder, 3–4 hours of group each day including **dialectical behavioral therapy**, **education on disease management**, followed by **outpatient treatment**, case management, employment supports and supportive housing. Another individual identified that MOUD and recovery supports that are aligned with compassionate and loving care is what has been most helpful as well as staff that won’t *“give up”* on you. Another respondent reflected that inpatient treatment programs are often operated like *“dictatorships”* and wished that while in treatment patients could be allowed to smoke, make phone calls, and go outside. This respondent stated that people need to go someplace to stabilize for a month before moving into permanent housing. Another respondent who was living in the SRV shared that **methadone** has worked well for him and helped him to focus on goals other than getting and using fentanyl, while another respondent stated, *“methadone was life changing because nothing else has helped with withdrawal, not even detox.”* Finally, another respondent spoke about the importance of harm reduction services.
- *Employment services* were listed by 38% of respondents. Of those who responded about their desire to secure employment, all spoke both about the need for income and the desire to do something meaningful with their time. Several respondents who were being served in stabilization programming reported that they were not permitted to seek employment until they had been enrolled for 60 days. Two respondents shared that having a job would help them stay sober, with one of these respondents suggesting that “There needs to be job training programs to give people a sense of purpose.” Another respondent noted that becoming employed would help them to feel a part of normal society. Two respondents identified wanting to work in the field of addressing homelessness. (For more information on the role of employment in ending homelessness, including evidence-based practice supported employment, see *The Role of Employment in Ending Homelessness: A Report to the Homeless Strategic Initiative on Supported Employment*.)

The Role of Belonging and Community in Engagement

As noted by the perspectives of both programmatic leaders and people with living and lived expertise, programming that creates a culture of belonging and sense of community is critically important to effectively engage people who have the highest acuity conditions and who represent marginalized populations. In *Our Epidemic of Loneliness and Isolation*, a 2023 report by the U.S. Surgeon General, belonging is described as "a fundamental human need — the feeling of deep connection with social groups, physical places, and individual and collective experiences." Humans have an innate desire to belong, to be "wanted, needed and expected," the credo of the Fountain House program which first began when ten psychiatric patients at a New York state hospital in the 1940s formed a self-help group. Today, Fountain House's "clubhouse" model has been replicated more than 300 times in nearly 40 U.S. states and in 30 countries. The intent of these programs is to address the social isolation, stigma, and hopelessness experienced by people with SMI, including those who are homeless. People who are estranged from family, unable to make friends, and besieged by multiple losses and traumas (e.g., housing, health, significant others, family, employment, educational attainment, financial stability, dignity, safety) can most optimally recover when utilizing supports that respect their inherent dignity and need for belonging. These tenets can be found in many street outreach programs, shelters, health and behavioral health clinics, other treatment settings, recovery community organizations, and in supportive housing and employment services; however, investment in the staff who work in these settings — both in wages and in training and supervision — must be strengthened, in addition to ensuring that people with lived and living expertise are substantively engaged at every level through partnerships in the co-design, operations, governance, and evaluation of programming intended to serve them.

Summary of Portland Area Data Relevant to the Need for Stabilization Programming

As described in the 2022 report, *Resolving Homelessness: The Critical Need for a Substance Use Disorder System of Care* and reinforced in the 2024 Multnomah County Homelessness Response Action Plan, the Portland Metro Area requires a cross-systems alignment and coordination effort that is data-informed, braids together available funding streams, and utilizes policy levers to drive unified efforts to bring people with the greatest needs off of the streets and into stabilization programming. In recent data shared by the coordinated care organization Health Share of Oregon (HSO), increasing acuity of individuals experiencing homelessness is apparent, as is the strain on existing systems and the urgent need for innovative solutions. As noted above, the emergence of new illicit drugs is driving increased acuity in this population. The impact of these factors is evident in the rising number of individuals with unmet needs, leading to increased risks, costs, and a "**service recycling**" phenomenon within both health care and housing systems. Essentially, the current health care system is paying to treat the complications that arise from untreated behavioral health conditions, creating a cycle of crisis and intervention that fails to address the root causes of instability.

HSO's data reveals that one in twelve of its adult members fall within a cohort characterized by opioid use disorder, stimulant use disorder, psychosis, or substance-associated overdoses. As may already be

evident, these individuals experience significantly higher rates of inpatient admissions compared to the rest of the HSO member population, illustrating a "**level of care mismatch**" for high-acuity, **dual diagnosis** patients whose needs cannot be met by the current service system in the Portland Metro Area.

The absence of such comprehensive services in the Portland Metro Area poses a significant barrier to successful housing placement for individuals with high acuity conditions. Landlords may be hesitant to accept tenants with complex needs, fearing potential disruptions or challenges, and without adequate ongoing support, individuals may struggle to maintain housing stability and independence. The HSO presentation suggests that a coordinated system of shelter and supportive services, supportive housing, affordable and deeply affordable housing, behavioral health care, and integration with law enforcement and corrections is necessary to effectively address this problem.

Robust stabilization services that prioritize intensive, individualized support for both medical and behavioral health needs are crucial to ensuring successful PSH placement and long-term housing stability for individuals with high acuity conditions. To develop and implement these services will require a systemic shift that prioritizes coordinated care; breaks down silos between health care, housing, and social services; and addresses underlying factors that contribute to homelessness and instability. Critical components of a comprehensive solution include strategies such as mobile health partnerships that bring services directly to clients; the expansion of evidence-based SUD treatment; increased access to all levels of behavioral health supports; and expansion of ACT-like models. Ultimately, investing in robust stabilization services is not only a moral imperative but also a fiscally responsible strategy that can reduce the strain on emergency services, hospitals, and the criminal justice system.

The need for stabilization services prior to PSH placement for individuals with **high-acuity conditions** is also documented by Central City Concern's Recuperative Care Program (RCP) in a 2023 analysis shared with TAC. RCP supports individuals experiencing homelessness as they recover from acute medical conditions and addresses social determinants of health by providing medical and social services along with respite bed programming. The analysis identified a considerable unmet demand for these services, emphasizing the need for program expansion. Notably, there are demographic disparities in RCP enrollment, with Black and female patients underrepresented compared to their representation among populations of people experiencing homelessness, raising concerns about equitable access to these crucial services.

RCP's vulnerability tier system effectively identifies people with high-acuity needs, with Tier 3 representing individuals at high risk of death or significant harm if not enrolled in the program. These Tier 3 clients often require longer stays and more intensive resources, highlighting the importance of providing appropriate support to this population. Significantly, Tier 3 clients were discharged to permanent housing at more than twice the rate of clients in Tiers 1 and 2, indicating the program's success in connecting people with high-acuity needs to stable housing. However, Tier 3 clients also demonstrated lower medical goal achievement rates, suggesting the need for potential adjustments to service design and goal-setting processes to better address the complex needs of this group.

The analysis also highlighted the program's effectiveness in reducing reliance on expensive acute care services, thereby achieving significant cost savings. Clients enrolled in RCP experienced average savings of $6,758.88 over a 90-day period compared to those who did not enroll, with most savings realized

within the first 30 days. This finding emphasizes the economic benefits of providing stabilization services before PSH placement, as it reduces reliance on costly emergency and inpatient services.

These findings and those represented in the HSO data strongly support the need to scale up robust stabilization programs that can effectively address the needs of individuals with high-acuity conditions and improve their chances of successful PSH placement and housing tenure. By providing a structured environment, medical care, behavioral health treatment, and social support, stabilization programs can address the acute challenges faced by these individuals, making them more likely to be accepted by landlords and better equipped to sustain housing in the long term. Also, it is a critical necessity that rental subsidies and the appropriate level of supportive housing services be available to stabilization clients upon discharge.

High-Level Recommendations

Recommendation 1: Identify existing resources and opportunities for cross-system partnerships to scale up stabilization programming.

Both leaders whose programs serve this population in other regions and people with living experience of chronic homelessness (69%) identified the need to use stabilization programs to engage people with active substance use disorders (SUDs, untreated serious mental illness (SMI), and/or acute medical conditions into programming that offers comprehensive and coordinated care that is matched to their level of need, delivered by a multidisciplinary team. Level of need should be established by mental health, SUD, and health care assessments. Also, as documented in both the HSO data and the RCP data analysis, many people experiencing unsheltered homelessness need this level of care prior to being accepted into permanent housing. Given a) the shortage of extremely affordable housing, b) landlord reluctance to house this population, and c) the lack of robust supportive services that align with fidelity to Housing First, many people living outside may benefit from stabilization before they can sustain placement in permanent housing. Existing partners and payors (e.g., City of Portland, Metro, Multnomah County, CareOregon, Oregon Health Authority, Oregon Housing and Community Services) should strengthen cross-system alignment and utilize existing resources to scale up stabilization programming and pair those who benefit from such programming to housing subsidies post-stabilization. Funding stabilization programming may support priority outcomes outlined in the Multnomah County 2024 Homelessness Response Action Plan related to sheltering or housing 50% of those on the by-name list; reducing unsheltered homelessness for priority populations at rates equal to or greater than their representation in the overall population; and decreasing exits from shelters, hospitals, and carceral settings to street homelessness.

Recommendation 2: Design a system of care that promotes integration and coordination of care. As previously recommended in HSI's 2022 report, *Resolving Homelessness: The Critical Need for a Substance Use Disorder System of Care*, the Portland Metro Area must create an executive body that can bring health and behavioral health care providers together with the homeless service system in a coordinated manner to address the multifaceted population health needs of people with high-acuity conditions who are experiencing unsheltered homelessness. Care Oregon, in partnership with the Joint Office on Homelessness, should convene this body of behavioral health, supportive housing, and homeless service payors, providers, and people with lived expertise to estimate the

number and types of stabilization program beds and to-fidelity Housing First teams necessary to serve this population of people *and* to determine strategies that pair housing subsidies with those who need them upon transition, similar to the Roundhouse program, RecoveryWorks, and the CASPAR shelter program cited above. Portland itself has a history of systemwide coordination through its Homeless Alcohol and Drug Intervention Network (HADIN). This network was used for case consultation, triaging of clients across programs, and the evaluation of new models of care for subpopulations of special concern in the 1990s and early 2000s.

Recommendation 3: Evaluate and improve existing service systems' efforts to build supportive communities of care. Many individuals interviewed reported that fostering a sense of belonging, community, and connection would significantly increase the likelihood of their engaging in any type of programming that would address their needs. Service providers should conduct a thorough evaluation of their current offerings and the degree to which they foster a culture of belonging. This effort should involve collecting feedback from participants about their experience of community within these spaces. Before investing in new resources or developing additional programs, it is essential that Portland's service providers ensure that existing services are optimized to meet the community-building needs of individuals who are unsheltered. Working to address the need for a culture of belonging across the system of care may improve engagement of people who are unsheltered, stabilization, eventual attainment of permanent housing, housing tenure, and health and wellness.

Recommendation 4: Design, implement and continuously evaluate workforce recruitment and retention practices.

HSI and its partners should design a strategic plan in which wages can be increased, staffing patterns right-sized, and staff skilled up through ongoing training, clinical supervision, and continuous quality improvement to ensure that they adhere to best practices. Additionally, HSI and its partners could build partnerships with philanthropy, area colleges, workforce investment boards, universities, and state or federally funded health care workforce initiatives to attract new social workers and behavioral health care providers into the community. Finally, TAC recommends that this workforce recruitment and retention effort include cross-system implementation of best practices in supporting staff through vicarious trauma and traumatic events, to include timely clinical debriefs, paid leave, and rotation of staff working with high acuity to lower acuity populations.

Recommendation 5: Scale the provision and accessibility of MOUD.

Medications for opioid and alcohol use disorders are considered best practice internationally. There is also increasing evidence for the use of certain prescribed medications for stimulant use disorder, which includes off-label prescribing. The following recommendations provide ways to make these medications more accessible to people in encampments.

Establish or scale mobile MOUD. Create or scale mobile methadone units by partnering with existing opioid treatment programs (OTPs). Ideally, mobile units should offer all three types of MOUD: methadone, buprenorphine, and naltrexone. Mobile MOUD units can provide additional services like behavioral health services and the distribution of naloxone and harm reduction supplies. Another option to expand medication for addiction would be to enhance the capacity of existing street medicine. Medical street outreach physicians can provide buprenorphine for opioid use, naltrexone for opioid and alcohol use, and a variety of medications for stimulant use. They can also provide warm handoffs to brick-and-mortar treatment when appropriate.

Maximize the use of the 72-hour rule. Relaxed federal guidelines allow certain medical settings (inpatient admissions, emergency departments) to administer methadone for up to 72 hours and then connect people to a brick and mortar or mobile OTP. This practice may be ideal for individuals who present repeatedly to emergency rooms for complications related to OUD, as it gives them an immediate connection to an agonist medication. Methadone is the most effective intervention for people with severe OUD, especially in the age of fentanyl.[30] The Roundhouse Clinic, referenced in the above national scan section of this report, had success in utilizing this rule to connect unsheltered people with MOUD through its low-threshold ambulatory care clinic. California's Bridge Program has had similar successes. In Portland, OHSU is currently utilizing this model to bridge people to longer-term addiction treatment. These existing models should be scaled and widely adopted.

Establish medication units by partnering with Federally Qualified Health Centers (FQHCs). Medication units operate similarly to mobile opioid treatment programs in that they act as satellite clinics or extensions to brick-and-mortar OTP sites. Most FQHCs already offer other medications for addiction treatment, but methadone has historically been inaccessible due to federal regulations. To serve the population of focus for this report, citing a medication unit at an FQHC/Health Care for the Homeless program would be ideal given that they are already serving people who are unsheltered. However, medication units are not limited to FQHCs. For example, a ruling in Ohio allows for medication units in a variety of settings.

Recommendation 6: Formally establish additional stimulant clinics.

A successful stimulant clinic must be able to triage cases and direct people to the appropriate resource. For example, some people who experience stimulant-induced psychosis may need immediate intervention in a hospital emergency department, while others may simply need to sleep for several hours. Stimulant clinics can offer spaces for people to de-escalate safely which could include the use of short- or long-term medications for stimulant use disorder. Stimulant clinics often also provide contingency management, group and individual counseling, and in best practice examples are integrated with primary care. The START clinic at Boston Medical Center, which is referenced in the national scan section above, is a best practice example of a stimulant clinic embedded in an office-based addiction treatment setting. In Portland, OHSU offers a contingency management program that could be scaled or expanded. Additional stimulant clinics could be established to maximize impact.

Conclusion

The Portland Metro Area has long been recognized for its innovative practices in addressing homelessness, receiving distinguished service awards from federal agencies such as the Substance Abuse and Mental Health Services Administration, the Department of Labor, the Department of Veterans Affairs, and the Department of Housing and Urban Development. The last decade's rise in the availability of illicit drugs, increasing rents and cost of living, and the multitude of service disruptions resulting from the COVID-19 pandemic have impacted Portland's gains. The city's funders, policymakers, people with lived experience, and health, behavioral health care, and homeless service leaders must

[30] Buresh, M., Nahvi, S., Steiger, S., & Weinstein, Z. M. (2022). Adapting methadone inductions to the fentanyl era. *Journal of Substance Abuse Treatment, 141*

come together to advance the high-level recommendations laid out in this report. Portland needs a system of care that can address the multifaceted needs of vulnerable people who are living outside through innovative, coordinated, and collaborative practices focusing on population health metrics and creating a system that centers supportive communities of care. This approach will be critical to improving the engagement of disenfranchised people living unsheltered into a continuum of stabilization, housing, health, well-being, and recovery.

Appendix A: Glossary of Terms

Adulterants: Substances added to drugs or alcohol to dilute or enhance effects, often leading to risks of overdose or other harmful health consequences**.**

Affordable Housing: Housing that is affordable to individuals or families whose income is below the median income of a community, typically costing no more than 30% of the person's income. Affordable housing includes low- to moderate-income households and may or may not involve government programs or subsidies.

Case Management: A collaborative process where a professional works with individuals to assess their needs, set individualized goals, coordinate services, and ensure that they receive appropriate care.

Chronic Homelessness: According to HUD, individuals meet the definition for chronic homelessness if they have a documented disabling condition; are living in a place not meant for human habitation, a safe haven, or shelter; and have been homeless for at least a year *or* four or more times in a period of three years.

Contingency Management (CM): A psychosocial intervention that involves reinforcing engagement in treatment for substance use disorders, as well as reinforcing other recovery-related behaviors; CM is widely considered the most effective treatment for stimulant use disorder, and also has evidence as an effective treatment for alcohol, cannabis, and tobacco use disorders and as an effective adjunctive intervention to medications for opioid use disorder (MOUD).

Continuums of Care **(CoCs):** A coordinated system of services funded by the U.S. Department of Housing and Urban Development (HUD) designed to assist individuals experiencing homelessness. Continuums of Care are regional and facilitate the coordination of services between different entities supporting individuals experiencing homelessness, such as: nonprofit homeless providers, faith-based organizations, governments, public housing agencies, school districts, social service providers, and mental health agencies. CoCs are responsible for planning and implementing programming to support the homeless individuals and families in their region.

Detox: A medical process that helps individuals safely withdraw from substances, particularly alcohol or opioids, while managing withdrawal symptoms that can be dangerous or life-threatening**.**

Dialectical Behavior Therapy (DBT): A form of cognitive behavioral therapy that emphasizes acceptance and change, often used to treat individuals with intense emotions, self-harm behaviors, or borderline personality disorder.

Documented Disabling Condition: A medical or mental health condition that is formally recognized and diagnosed, often used for determining eligibility for various benefits or services.

Dual Diagnosis: The co-occurrence of both a mental health disorder and a substance use disorder, which often requires integrated treatment approaches.

Economic Self-Sufficiency: The ability of individuals or families to support themselves financially, which may or may not include relying on government-funded programming for which they qualify.

Education on Disease Management: Instruction provided to individuals on how to manage chronic conditions, including strategies for coping, treatment, and prevention**.**

Employment Supports: Services and resources designed to help individuals with barriers to employment (e.g., mental health or substance use challenges) find and maintain jobs.

Evidence-Based Practice: Clinical practices or interventions based on research and empirical evidence demonstrating their effectiveness. It should be noted that the existing evidence base has historically been developed by people who benefitted from institutional racism and at times excludes perspectives from Black, Brown, and Indigenous communities. Culturally specific and emerging and promising practices should always be considered.

Fidelity Scale: A tool used to assess how closely a program or intervention adheres to its intended model or best practices, such as this Housing First fidelity scale.

Forensic and Correctional Settings: Environments related to legal and criminal justice systems, such as prisons, jails, and courts.

Harm Reduction: A public health approach aimed at minimizing the negative consequences of substance use, focusing on reducing related illness or injury, and maximizing other health-promoting behaviors. Harm reduction is a pillar of the U.S. Department of Health and Human Services' (HHS) overdose prevention strategy because it is critical to keeping people who use drugs not only alive, but as healthy as possible.[31]

High-acuity conditions: Physical and behavioral health conditions that seriously affect a person's ability to function, so that the highest level of resources and staffing are necessary to help them successfully access housing, stabilize in housing, and remain housed. Indicators used to determine acuity include:

- Illness and physical, mental, and behavioral health (diagnoses, chronicity of illness, severity);
- Cognitive functioning (memory, thinking, reasoning, decision-making, and communication skills);
- Independence in activities of daily living (e.g., showering/tending to personal hygiene, cleaning/maintaining living space, taking out the trash, shopping for groceries, cooking/preparing food, taking medications);
- History of trauma and adverse childhood experiences;
- Levels of natural supports and connectedness to family, friends, community, resources; and
- Housing history (chronicity of experience of homelessness) and past tenant experiences.[32]

Housing Tenure: The length of time people remain housed.

[31] Post, R., Boss, R., & Green, L. (2022). *Boosting the power of harm reduction: Creating a comprehensive and culturally responsive system of care serving people experiencing homelessness with substance use disorders*. Boston, MA: Technical Assistance Collaborative.

[32] U.S. Department of Housing and Urban Development (October 2020). *COVID-19 homeless system response: Primer on serving people with high-acuity needs*.

Intramuscular Medication: A form of treatment for opioid use disorder that involves administering medications like buprenorphine or naltrexone via injection.

Jail Diversion: Programs designed to redirect individuals with mental health or substance use disorders away from jail and into appropriate treatment and rehabilitation services, *or* programs designed to prevent involvement with the criminal legal system.

Level of Care Mismatch: Occurs when the frequency, intensity, duration or type of care provided to an individual does not align with their needs, potentially leading to poor treatment or outcomes.

Low-Income Housing: Housing for individuals or families whose income is significantly lower than area median income (AMI) typically less than 50% to 80% of AMI. Low-income housing often involves government programs or subsidies to help reduce rent costs, making it affordable for individuals who cannot afford standard market-rate rents.

Meaningful Employment: Jobs or work that provide individuals with a sense of purpose, stability, and fulfillment, often aligning with their values and long-term goals and allow for financial stability. In the context of working with individuals with SUD or SMI this also means employment that is integrated into the community where individuals are not given separate or lesser roles due to the challenges they face. An exemplary model, when implemented to fidelity is Individual Placement Support /Supported Employment (IPS/SE). Learn more in *The Role of Employment in Ending Homelessness: A Report to the Homeless Strategic Initiative on Supported Employment*.

Medicaid: A joint federal and state program that helps cover medical costs for some people with limited income and resources. The federal government has general rules which all state Medicaid programs must follow, but each state runs its own program. This means eligibility requirements and benefits vary from state to state.

Medication for Opioid Use Disorder (MOUD): Medications such as methadone, buprenorphine, or naltrexone, used as part of a treatment plan for individuals with opioid use disorder.

Mental Health Professional Shortage Area (MHPSA): Geographic areas or populations where there is a shortage of qualified mental health professionals, making it difficult to access necessary care.

Methadone: A synthetic opioid used to help individuals with opioid use disorder manage cravings and withdrawal symptoms.

Outpatient Treatment: Treatment for behavioral health or substance use disorders that does not require an overnight stay in a hospital or treatment facility. There are a range of outpatient treatment options.

Peer Support: Support provided by specially trained professionals with lived experience of mental health or substance use challenges, whose role is to use their lived experience to help others navigate recovery.

Permanent Housing: Housing without restrictions on length of stay and where the individual is the tenant or leaseholder, affording them all rights of tenancy.

Permanent Supportive Housing: A housing model that combines long-term housing assistance with supportive services intended to help people maintain tenancy. PSH programs serve formerly homeless individuals and families in which at least one person has a documented disability.

Rapid Rehousing: A model that provides short-term rental assistance and services to help people obtain housing quickly, increase self- sufficiency, and stay housed.

Recovery: An ongoing process of improving health, well-being, and quality of life for individuals with behavioral health or substance use disorders. Recovery is an individualized process that is dependent upon the person's unique goals and what they feel contributes to a meaningful life.

Serious Mental Illness (SMI): A group of mental health diagnoses that significantly impair an individual's ability to function, including schizophrenia, bipolar disorder, and other psychotic disorders.

Service Recycling: The practice of repeatedly providing the same services to individuals, often due to lack of long-term solutions for the problems that contribute to the recurrence of illness or crises.

Stabilization Programming/Services: Programming that offers people who are experiencing unsheltered homelessness with active and untreated behavioral health and/or chronic health conditions a safe place to sleep and coordinated care that works to alleviate high-acuity conditions. Such services can also be used to stabilize people who are facing risk of eviction due to behavioral health symptoms that pose a safety risk to the community in which they are housed. Stabilization programming is staffed 24/7 and includes a multidisciplinary team including social workers/case managers, SUD counselors, psychiatric prescribers, community health workers, peer providers, and housing navigators to assist with transitions to permanent supportive housing when indicated. Examples of existing stabilization programs include residential treatment for SUDs, subacute detoxification, medical respite programs (e.g. the Recuperative Care Program), Multnomah Crisis and Treatment Center (CATC), Unity Center for Behavioral Health, mental health respite beds, and transitional recovery and reentry housing. Some shelters in which intensive and individualized services are offered can also serve as stabilization programming.

Substance Use Disorder (SUD): A treatable condition characterized using alcohol, drugs, or medications in a way that significantly impacts a person's life and well-being. SUDs can range from moderate to severe including physical dependence.

Supplemental Security Income (SSI): A federal income program designed to help individuals who are elderly, blind, or disabled and have little or no income.

System of Care for Substance Use Disorders: A comprehensive approach that integrates services across multiple systems (health care, social services, etc.) to treat individuals with substance use disorders holistically.

Trauma-Informed Care: An approach to treatment that recognizes and responds to the effects of trauma, emphasizing safety, trustworthiness, and empowerment for individuals receiving care.

Unsheltered Homelessness: A form of homelessness where individuals do not have access to any form of shelter or housing, and may be living on the streets or in other places not meant for human habitation**.**