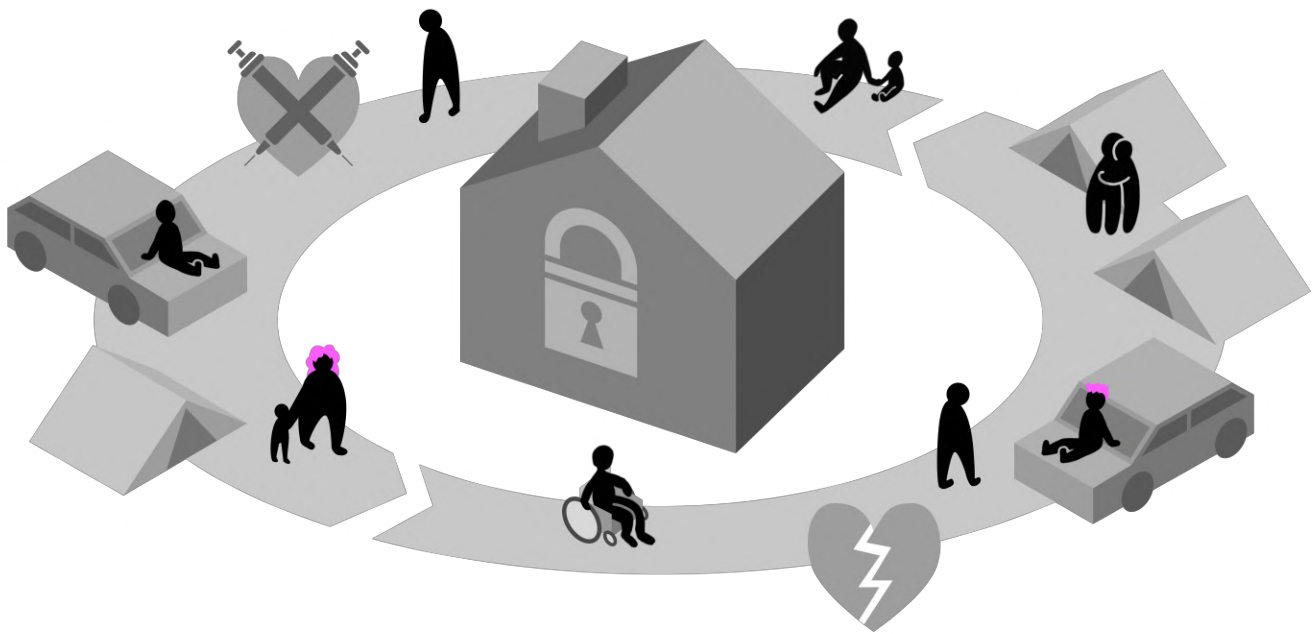


STOP

THE REVOLVING

DOOR



**Coalition On
Homelessness**
September 2020

a street level framework
for a new system

Thank you to our *Peer Researchers*,
who were trained to proctor and
administer the surveys on which this
needs assessment is based.

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INTRODUCTION

We believe in a San Francisco that is thriving, vibrant and where no one is forced to experience sleeping on the hard, cold concrete. Our vision is a San Francisco that prevents homelessness whenever feasible – be that a temporary subsidy for someone who loses their income due to an illness, or a long-term subsidy for an elder who loses the income of their family member to death, or a tenant who is being illegally evicted and simply needs legal representation. A San Francisco where episodes of homelessness that are not preventable, such as those caused by the recent fires or other unforeseeable events, are addressed quickly with immediate placement in shelter while housing is secured within six months, before the damaging effects of homelessness truly take root.

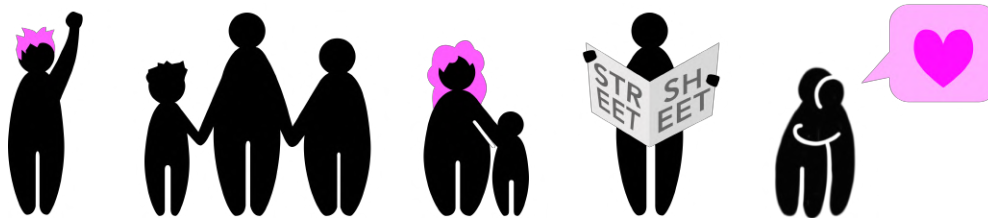
*“Nothing solves homelessness like a home”
—Paul Boden, Executive Director Western Regional Advocacy, Coalition on Homelessness Co-Founder*

To this end, we wrote, gathered signatures, and qualified for the ballot a historic initiative to bring us as close to that vision as we can. In November 2018, Proposition C - Our City Our Home, was passed by San Francisco voters with 61% of the vote. The campaign was led and passed by a strong, diverse coalition of homeless service providers, community organizers, faith communities — and homeless people themselves. The measure will raise \$300 million for permanent, affordable housing, mental health and substance use services, homelessness prevention, and emergency services, including shelter and drop-in centers. While this legislation calls for a needs assessment every three years, we took this opportunity — while Prop. C is contested in a court battle — to delve into what the new system should look like, and what changes need to happen to make the new homeless and treatment delivery system be successful in realizing our vision.

This report presents how we can best address the homelessness crisis in San Francisco by asking the experts on homelessness: homeless people themselves. We turn to them as decision makers and leaders of homelessness policy. As such, homeless people developed and carried out this report — in partnership with researchers and advocates — for the benefit of homeless people.

You will see in this report the voices of those experiencing homelessness. You will hear their suffering, but also their brilliance. There are also many themes that arise and collectively paint a picture of a revolving door that churns people through, and too often, spits people back to the streets where they start over, with more trauma and less hope. The picture is of a treatment system that when it is serving, and accessible to people, is serving them well. The picture is of gaping holes through which people fall from housing into homelessness, but holes that are easily fixed with appropriate investments. While we collected this feedback pre-Covid, the pandemic has made this picture of a failed system crystal clear. This report paints a picture of a new vision of a system that works for everyone. It will not be easy, it will take work, but in these pages you will hear about what changes are needed directly from the true experts — those experiencing the hellscape of homelessness.

“We are all messed up from being homeless. I’m going through the worst time in my life.”



Each chapter of this report focuses on a city system: homelessness prevention, shelter, substance use and mental health treatment. While the focus of this report is on improving homeless services systems and policy for all, we recognize that multiple marginalized groups experience interlocking barriers to safe housing and care. Within each chapter, we highlight the experiences and needs of groups that are particularly marginalized within existing homeless services systems, paying attention to the ways in which race, gender, sexual orientation, age, disability, and being part of a family can cause entire groups of people to fall through the cracks of San Francisco’s homeless services systems. This needs assessment will help policymakers understand the prevalence of and institutional solutions to the homelessness crisis in San Francisco, and make sure that homeless services systems more effectively serve multiply marginalized people.

We have also dedicated a chapter of this report to transgender experiences and needs, centering the voices of transgender women of color and immigrants. Trans women of color are deprived of housing at higher rates than other race and gender groups, yet are under-represented in most research about housing and homelessness. Transgender people experience homelessness at higher rates than cisgender people — one in every two trans people has been homeless — yet trans experiences and needs are routinely marginalized or excluded from discussions of homelessness policy, and trans-led organizations are rarely consulted about issues related to housing.¹ Too often, transgender experiences are subsumed into the category “LGBTQ,” without meaningful representation. Many homeless service and advocacy organizations have no trans women of color in leadership positions or even as staff. In response to this shortcoming in homelessness research and policy, the Coalition on Homelessness reached out to organizations led by transgender women of color to help design and implement a needs assessment that centers trans people’s experiences and needs.

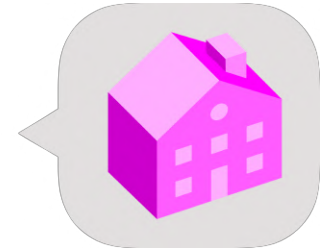
Our decision to include this chapter is a timely one: As federal laws and policies of the Trump Administration and Ben Carson’s Department of Housing and Urban Development endanger transgender and immigrant communities in particular, this report details evidence-based recommendations for local policy to ensure human rights for these marginalized groups.

It may seem like an overwhelming amount of work to do — and it is — but we are not alone in this endeavor. Many efforts have already been deployed through collaboration with city government and community organizations, like Our Trans Home SF, which recently won a \$2.3 million allocation for the City’s first transitional housing for homeless trans and gender non-conforming people.² This is one, small example of how effective community organizing is, but we know there is still work to be done. This report details how doing the necessary work together in partnership with homeless people we can achieve a vision of a San Francisco where **no one is without a home.**

¹ National Alliance to End Homelessness, 2019, “Demographic Data project: Gender Minorities”
<https://endhomelessness.org/wp-content/uploads/2019/06/Gender-Minority-Homelessness-Article-Revised-6-24-19-JJ-002.pdf>

² San Francisco Examiner, January 23, 2020 “First transitional housing project for homeless transgender residents opens in Chinatown”
<https://www.sfoxaminer.com/news/first-transitional-housing-project-for-homeless-transgender-residents-opens-in-chinatown/>

SUMMARY



PREVENTION

- A quarter of respondents became unhoused in the past year.
- Half of respondents did not have a lease the last time they were housed.
- Most participants lost their housing because it was no longer affordable.
- A disproportionate number of those in government-supported housing end up or return to homelessness.
- Rental assistance would have been most helpful in homelessness prevention.

SHELTER

- The majority of survey respondents currently residing outside have either tried and been rejected from shelter or regularly use shelter when it is available.
- San Francisco's shelters present barriers of access to many survey respondents.
- Shelter conditions were considered by most study participants to present challenges to their health, safety, privacy, dignity, or ability to escape poverty and homelessness.
- Nearly one-third of study participants reported being forced to leave shelter against their will.
- There is a demand for both a clean and sober shelter and a shelter that would allow those actively using drugs and alcohol to safely use on site.
- A majority of survey participants would prefer a legal camp with amenities as opposed to existing shelters.
- Participants ranked housing case management and case management as the services that would most improve their shelter experience or make a difference in them accessing a shelter.

SUBSTANCE USE

- Housing is essential for successful outcomes.
- One-third of homeless people in San Francisco report substance use issues, and polysubstance use is common.
- Half of people who report substance use challenges remain untreated.
- There are significant barriers to accessing substance use treatment.
- Treatment works for most to some degree, at least in the short term.
- A diverse system that includes methods of harm reduction and abstinence is needed.

MENTAL HEALTH

- Stable housing after treatment is critical to stabilizing mental health.
- Few homeless San Franciscans receive care, despite demand.
- Overwhelmingly, participants described finding the process for learning about and accessing services to be confusing and difficult.
- Culturally inappropriate or insensitive care proves a barrier to treatment.
- Substance use treatment is necessary for effective mental health care.
- People experience crisis as a first pathway to care.

TRANS HOMELESSNESS

- Binary gender classification and anti-trans discrimination made many transgender people feel unwelcome and unsafe in the city's shelters.
- Transgender people stated a need for gender-affirming mental health and substance use care.
- Criminalization threatened mental health and physical safety.
- Overlapping mental health and substance use care needs resulted from gender-specific trauma.

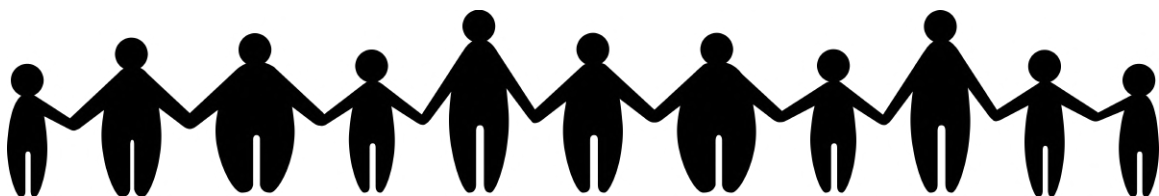
METHODOLOGY

Community-Based Participation Action Research

This needs assessment utilizes a Community-Based Participatory Action Research approach. This is consistent with the COH's mission of centering the voices of people experiencing homelessness in research and policy advocacy. Community-Based Participatory Action Research seeks to involve the community in which the research question takes place at every stage of research. In our own formulation of the survey instrument, the COH invited members of the community from service providers and the unhoused individuals they serve, to City officials from the Department of Homelessness & Supportive Housing, as well as the Department of Public Health, who write and create policy which governs the system in which all parties participate. A diverse team of academic researchers from institutions including the University of California, Berkeley; San Francisco State University; Santa Clara University; and University of North Carolina-Chapel Hill supported research design and data analysis. Each researcher was a subject matter expert on specific sections of this needs assessment such as shelter, substance use, and mental health. Our initial survey went through several drafts with many different community stakeholders and the final survey instrument was revised by our peer research team based on their personal expertise and experience with homelessness.

Peer to Peer Research

This needs assessment also relied on peer to peer research, a way of delivering research which is centered, steered, and conducted by people with lived experience of the issue at hand, in this case, homelessness. Our peer research team was composed of more than a dozen people with lived experience of homelessness, some, who at the time of administering the survey, were precariously housed themselves living in RVs or couch surfing with friends and family. The peer research team was chosen based on interviewing candidates referred to us through ally organizations including GLIDE, the Transgender, Gender-variant, Intersex Justice Project (TGIJP), and Tipping Point Community, from peer leaders in their programs and previous research projects. Once the peer research team was formed, all researchers met together for hours of training on research methods, active and supportive listening, vicarious trauma, and reducing bias in conducting the survey. The survey was proctored by peer researchers on iPads that operated on an offline Qualtrics app which allowed us run a survey anywhere, regardless of connection to the internet.





Survey and Sample

To understand the needs of those experiencing homelessness, the COH conducted surveys with 584 currently homeless participants throughout San Francisco. Surveys were gathered between June 3rd and August 30th. The Project Coordinator was present at all survey sites and was able to identify and prevent duplicates by excluding participants previously surveyed. Surveys were also screened from unique demographic information, like birth date and race, from which likely duplicate surveys were thrown out.

In order to capture a diversity of homeless voices, data collection occurred on the streets and in parks where those who may not be connected to services reside, as well as at drop-ins or shelters. Peer researchers, relying on their lived experience, directed places to go for street and park surveys including Buena Vista Park in the Haight, Dolores Park in the Mission, and Boeddeker Park in the Tenderloin. Specific outreach to people living in their vehicles was conducted in the Bayview. A full breakout of locations where surveys took place can be seen on page 8. It should be noted that the west side of SF was not included.

The teams focused on both areas known to COH staff as public spaces where homeless people spend time and areas around service centers and shelters. This strategy assured a diverse sample that would not bias results toward either those closely tied to service systems or those who were disconnected from service institutions. A team of peer researchers and the project coordinator visited a specific location from a list of public parks, plazas, and service centers. Each survey proctor was instructed to survey people who *appeared* to be poor or homeless and who were spending time in the proctor's assigned location on their assigned day. All surveys were anonymous and participants were instructed that they could skip or refuse to answer any question. Because it is impossible to conduct a truly random sample of a hidden population, we employed a purposive sampling method using population estimates from San Francisco's most recent Point-in-Time (PIT) count as a guide to ensure that we represent various demographic groups of single homeless adults in San Francisco's central city. As one can see at the end of this section on page 12, where we compare our samples demographic to the demographics of those found in the most recent point in time counts, our sample is similar to the PIT count survey.

"I have to give credit to the people I interviewed, because they, just by the sheer numbers, and just by their experience, their lived experience, they are telling the city, "look what we need to do."



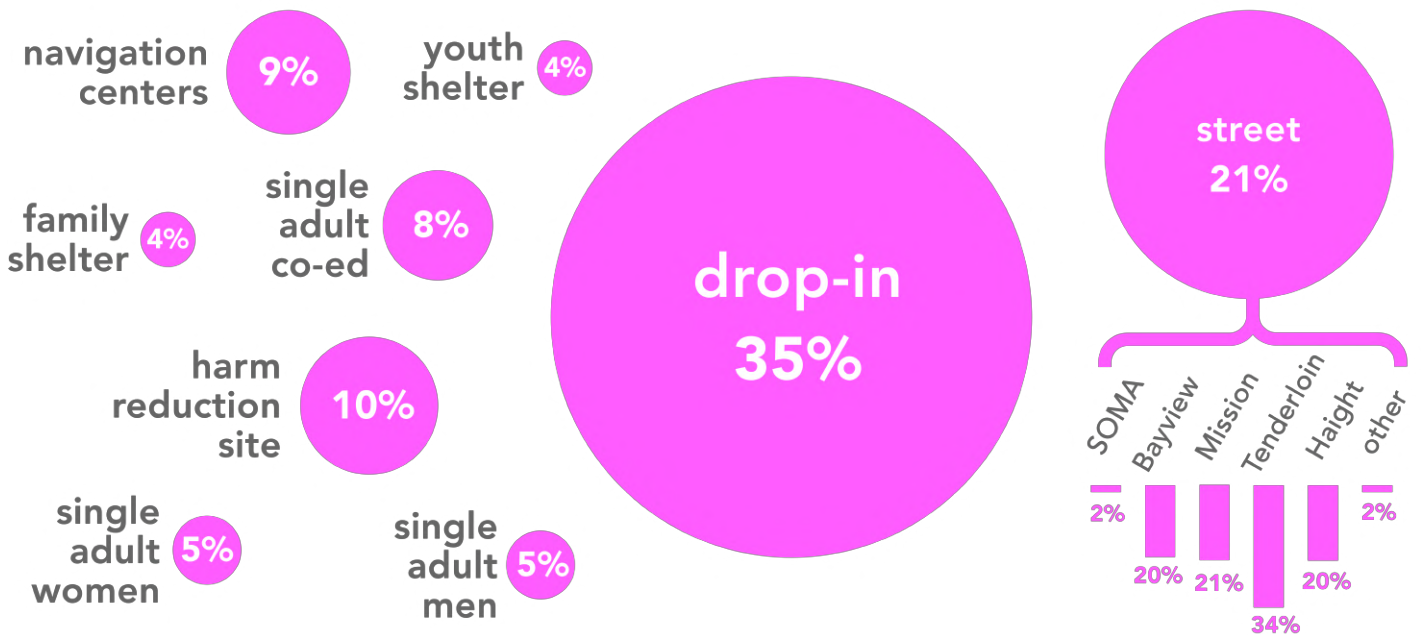
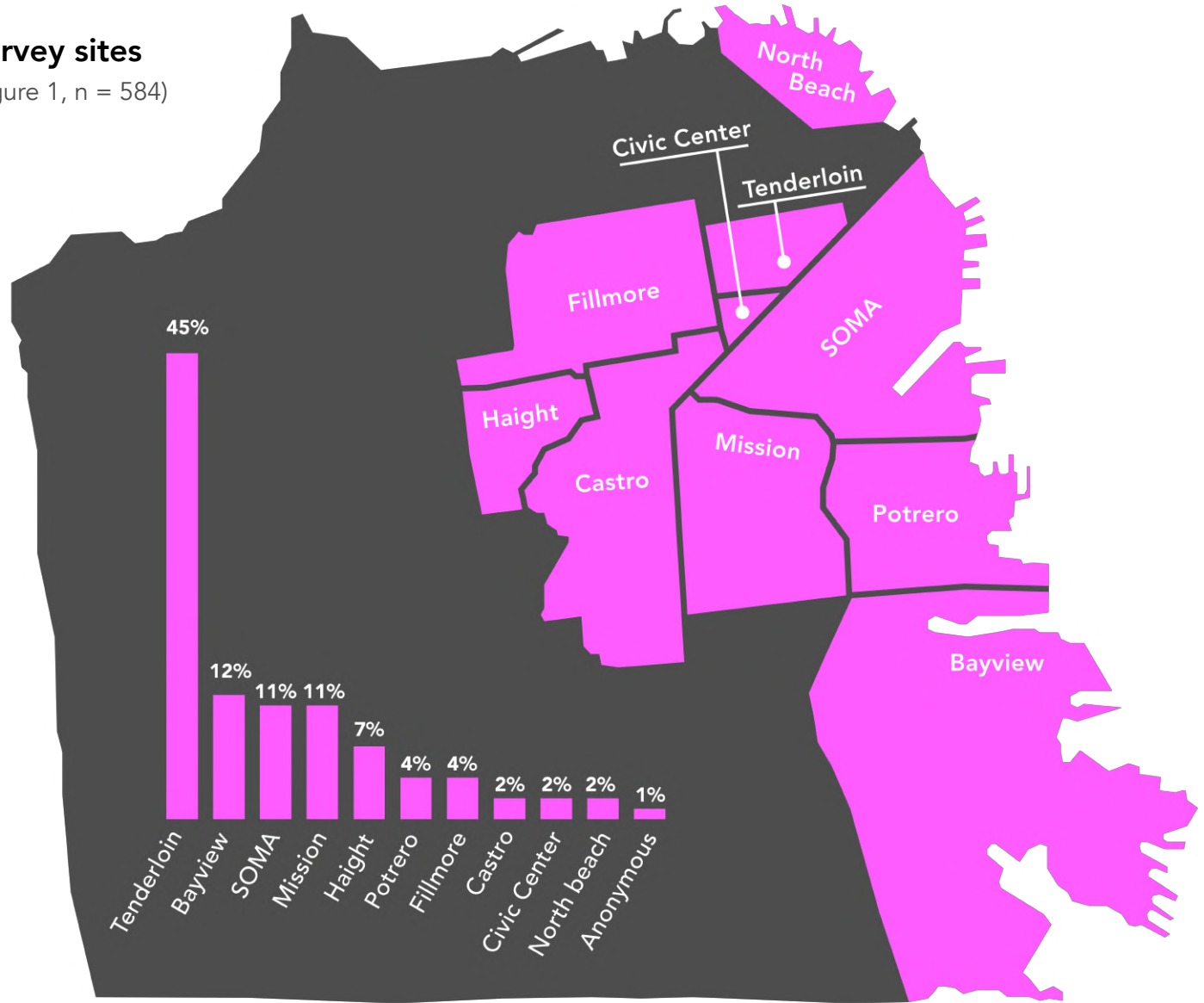
—TJ, Peer Researcher

At shelters, drop-in centers, and other places with a fixed location, flyers were distributed and staff were aware of the survey opportunity for their clients, which often lasted an average of four (4) hours per site. Once present, the Project Coordinator made an announcement in common areas to all clients explaining the survey, eligibility requirements, its purpose, contents, and the \$20 Safeway gift card for their participation. From there, participants signed up on a list and the Project Coordinator assigned participants to peer researchers to conduct the survey. During our first month of data collection, the only eligibility requirement was that one was currently homeless as defined by the CCSF, which includes sleeping outside, camping, residing in vehicles, abandoned buildings, living doubled up, couch surfing temporarily, and living in a Single Room Occupancy (SRO) as a family. As the survey progressed, we created monthly evaluations with demographic sample goals for targeted outreach and data collection moving forward. For example, in the last month of our data collection, we were primarily seeking Latino/a/x individuals as well as people who are under 25 years old. The demographic goals were based on the federally mandated 2019 Point-in-Time (PIT) Count for the CCSF.

While this is the most comprehensive survey of homeless experiences and needs conducted in San Francisco to date, our study has some important limitations. A crucial question about disability was left off of the first 300 surveys collected, which made it impossible to know precisely how many survey participants self-identified as having a disability. We under- and over-sampled some groups. Our study included 10% fewer Transitional Aged Youth proportionally than the City's last PIT count, and 6% more participants older than age 61. The City count found 65% of homeless San Franciscans unsheltered, compared to 56% of our participants. Whereas the City count found 35% sheltered, 53% of our participants had been sheltered for a significant time in the past month. These discrepancies are in large part due to the fact that our survey also included a significant number of participants who are not considered in the City's count and survey, commonly known as the "hidden homeless" including those doubled-up or families in SROs, of which 20% of participants identified having spending a significant time in over the past month. This is also due to the question we asked people, which was not "where are you currently staying?" but rather "where are you primarily staying" and allowed them to choose their main places of residence over the past month. Nonetheless, the lower percentage of those who were primarily unsheltered means they are somewhat under-represented in our sample.

survey sites

(figure 1, n = 584)



Additionally our approach of recruiting transgender participants from service organizations means that the sizable population of trans people who are completely disconnected from services is not represented in this study. While respondents could participate in the general, quantitative survey only if they were currently homeless, focus group and in-person interview participants who were transgender could participate if they had been homeless in the past year. To better understand housing trajectories of transgender immigrants, we included TransLatinx people who had been homeless in the last five years in focus groups and interviews as well. These methodological differences allowed us to understand a broader cross-section of trans experiences of housing deprivation. However, this approach also means that statistics about trans people’s experiences under-represent the most marginalized groups of currently unhoused trans people, and that statistics about experiences and needs are not always comparable across gender categories.

Focus Groups

Twenty-five focus groups were conducted. Focus groups lasted one hour and included five participants. Two researchers facilitated each group while another researcher took notes. Participants were given a \$20 Safeway gift card for their time upon completion of the group, the same incentive as for the survey. Eligibility requirements for the focus group were currently unhoused at time of the focus group, as well as experience with the topic of the focus group. Topics corresponded to each section of the needs assessment: shelter, substance use, and mental health. We included two more sections, one for unhoused transgender individuals as well as one for various groups of people including those in SRO’s, those undocumented, and monolingual Chinese and Spanish speakers, and people who reside in their vehicles. Focus group questions were formulated through the academic research team, COH staff, and the peer research team.

Shelter & Prevention	Substance Use	Mental Health	Trans specific*	Other
Family (First Friendship)	Family & Residential (Women’s Hope)	Family (Hamilton Families)	El/La Para Trans Latinas (individual interviews)	SRO family chinese
Youth (Larkin Street Youth Services)	Youth (Homeless Youth Alliance Needle Exchange)	Youth (Larkin Street Youth Services)	TGIJP (focus group and individual interviews)	SRO family Spanish
Single adult women (Next Door Shelter)	Adult-medication replacement (WARD 93)	Adult, Peer Respite (Hummingbird Navigation Center)	Jazzie’s place Shelter (focus group)	Vehicularly Housed
Street (Buena Vista Park)	Single adult (Waterfront Navigation Center)	Single adult Cooperative Housing (Progress Foundation)	Amber’s Group at SF (completed in town hall style and individual interviews)	Spanish — all gender (MNRC) Monolingual spanish population
Single adult men (Sanctuary Shelter)	Single adult abstinence based (Ferguson Place)	Single adult (Waterfront Navigation Center)	St. James - Mujeres Latinas en Acción (focus group and individual interviews)	Doubled Up Families (one Hispanic focus group at Homeless Prenatal Program, and a bilingual group at COH)

As mentioned, the trans-specific focus groups took on different forms. One was a town hall-style discussion with thirty participants sharing past experiences as well as future improvements and recommendations. The other form of qualitative data collection utilized with transgender participants was one-on-one in person interviews at both El/La Para Trans Latinas and St. James Infirmarý's Mujeres Latinas en Acci3n group. The in-person interviews allowed for more privacy and protected identity, which allowed for participants to be more open with responses. It also gave participants the space to elaborate more and go in depth on housing struggles, shelter experiences, substance use, and mental health treatment through the unique lens of a transgender individual experiencing homelessness.

Data Analysis

QUANTITATIVE ANALYSIS:

- Data was exported from Qualtrics, the survey software, and organized into an excel file with breakdowns of responses. Aside from analyzing individual responses, pivot tables were used to cross tabulate questions to focus on specific subpopulations or to examine the relationships between questions.
- Once data collection ended, there were 632 total completed surveys. The first task in data cleaning was to remove duplicates and unfinished surveys for a total sample of unique, unduplicated participants of 584. Duplicates were discovered through the demographic questions. First, the date of birth was sorted for any duplicates. Next, the same birth dates were compared against each other for race, number of years homeless, sexual orientation, and age. If those responses matched on multiple demographics, one of the duplicate surveys was thrown out. The survey instrument has skip logic embedded in it, so while it may appear as some surveys were unfinished, they were actually complete. Therefore, in determining if a survey was unfinished, a threshold or minimum amount of answers was used to eliminate any surveys which were below the threshold and therefore incomplete and thrown out.

QUALITATIVE ANALYSIS:

- All focus groups were audio recorded and have basic transcriptions from notes taken verbatim during the focus group. Researchers were given notes and audio recordings to pull quotes which give context and depth to the quantitative data. Although qualitative data coding is outside of the capacity of this project, future projects pairing both the quantitative data with coded qualitative data should be considered by universities and other institutions with ample funding and capacity.

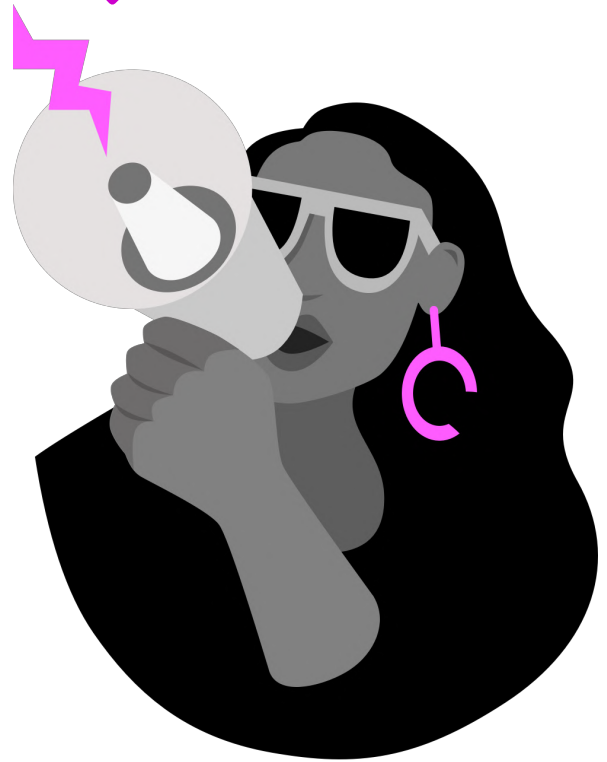
RESPONSE RATES:

- Through this needs assessment, we found most unhoused people were eager to participate, share their opinions, thoughts, and critique of the current homeless systems, which resulted in high response rates throughout the survey. Any questions where the response rate is 90% or below are stated in the report. For full appendix please email oglowacki@cohshf.org.

Community Input and Engagement

As mentioned previously, the Community-Based Participatory Action Research model involves the community in every step of the research project. After data collection ended, community stakeholders were invited to give feedback on the survey results, analysis, and recommendations. These community feedback sessions lasted for one hour and consisted of twenty (20) minutes presenting the data, twenty (20) minutes on feedback and questions, and a twenty (20)- minute discussion on policy recommendations. Since this needs assessment utilizes data compiled from nearly 200 questions, subsections of data were presented on shelter, mental health, substance use, prevention and City supportive housing. Community groups were paired with each of the topics. For example, at the Treatment on Demand Coalition, a combined mental health and substance use presentation was given in one behavioral health presentation. Moreover, at the Mayor's Office of Housing and Community Development, the prevention data was presented as those are under control of that particular office. This community input process is essential in making sure data collected is presented and interpreted alongside the experts themselves to ensure relevance and accuracy.

"My community (Black Transgender folk in SF) specifically needs an opportunity to sustain our lives, I believe Prop C has the availability to sustain lives that otherwise are in uncertain, unstable, scary circumstances."



— L'OREALE "TREASURE" EARLE
Peer Researcher & Focus Group Facilitator)

Survey Demographics

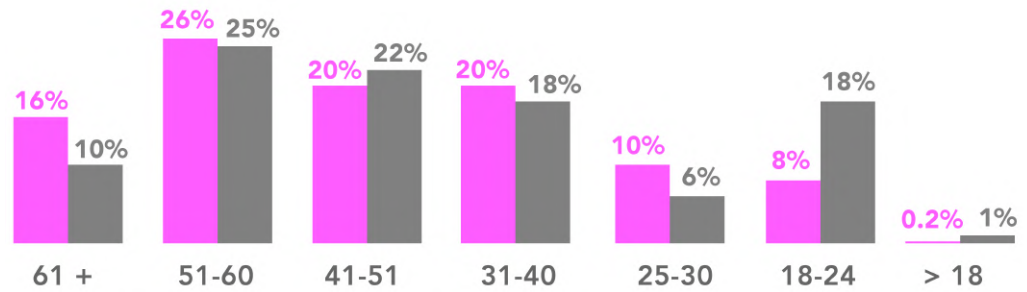
On the right, you can see how the demographics of our 584 survey participants closely matches the most recent point in time count. Our survey included people experiencing homelessness in a variety of living situations. In addition to the settings surveyed by the City in its annual homeless point-in-time count, our survey also included some families with minor children who were living in SROs (which the City defines as homeless), and doubled-up either couch surfing or staying with family. When asked "where have you primarily stayed in the past month" 56% reported being unsheltered (outside, vehicles, abandoned buildings), while 55% reported being sheltered in the City's shelters. As these percentages indicate, a number of participants had been residing a significant amount of time both sheltered and unsheltered in the past month. The City's most recent point-in-time count found 65% unsheltered and 35% sheltered.

Note* *In this Needs Assessment Report, not all percentages add up to 100%. In the peer research survey, there were many questions for which respondents chose all answers that apply. For example, many respondents report more than one primary residence in the past month.*

■ Survey % ■ SF Point In Time %

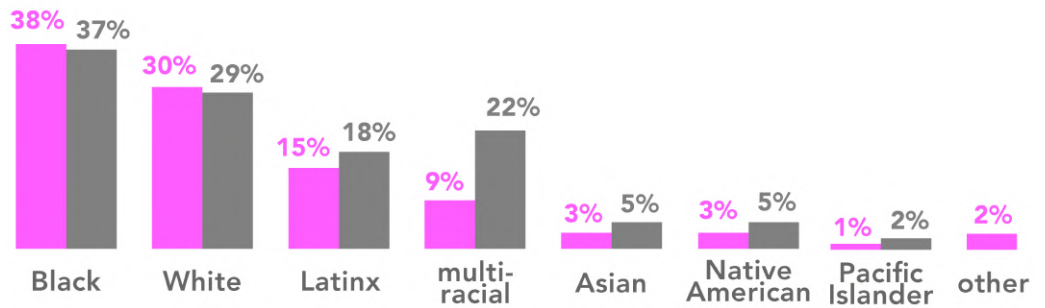
age*

(figure 2, n = 581)



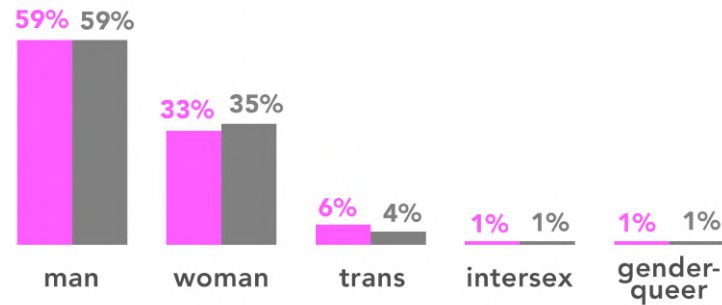
race*

(figure 3, n = 564)



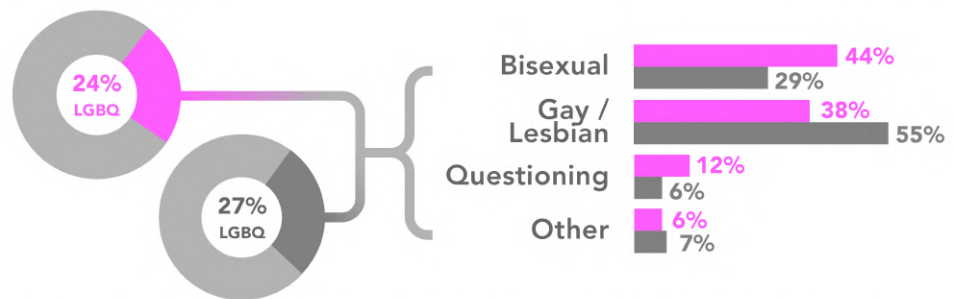
gender

(figure 4, n = 582)



sexual orientation

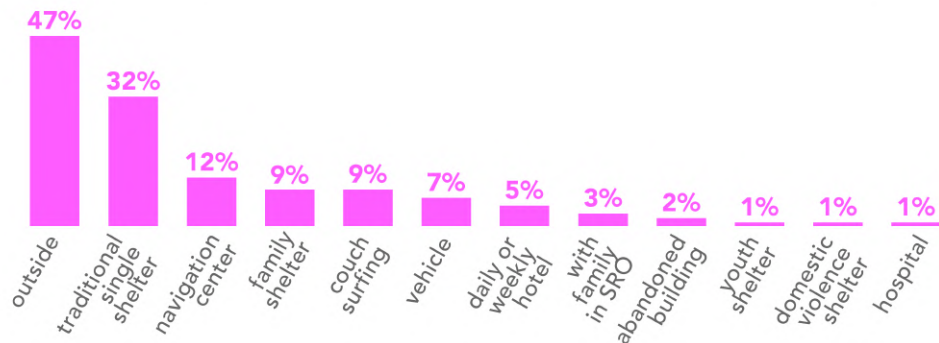
(figure 5, n = 577)



shelter*

(figure 6, n = 578)

* Please note percentages will not add to 100%, due to rounding and because participants could select more than one option for some questions.



PREVENTION

The after-effects of homelessness are devastating – trauma, lost years, shortened life expectancy, compromised health and real human suffering. It is both more cost effective and humane to keep San Franciscans housed, instead of addressing it after the fact. We focused part of this study on prevention for exactly that reason – to ascertain exactly what interventions would work to keep people in their homes. While the homeless population is diverse, there were a lot of common experiences. We started with the very last time respondents had a place of their own and went from there.

It is both more cost effective and humane to keep San Franciscans housed, instead of addressing it after the fact.

EXECUTIVE SUMMARY

A quarter of respondents became unhoused in the past year.

Homelessness is not a static population – many have been homeless for long periods of time, but more are becoming homeless every day.

Half of respondents did not have a lease the last time they were housed.

Poor people in San Francisco often rely on community, informal housing arrangements and family for housing. Although many of them lost that housing for non-payment.

Most participants lost their housing because it was no longer affordable.

This gets back to the root causes of homelessness – the lack of investment in housing for extremely poor people by the federal government – but it also indicates a need for subsidies to keep people in their homes.

A disproportionate number of those in government supported housing end up or return to homelessness.

This is the form of housing we have the most control over. At the very least we should ensure we are doing everything possible to keep people in their housing – from adequate support services, to rental assistance.

Rental assistance would have been most helpful in homelessness prevention.

For a variety of reasons including illness, job and benefit loss, impoverished San Franciscans are losing their homes because they were unable to pay their rent. The good news is that in a city as affluent as San Francisco, this is incredibly solvable through long- and short-term rental assistance programs.

BACKGROUND

While the cost of rent has skyrocketed in San Francisco, wages have remained stagnant. At the root of San Francisco's homelessness crisis is a fundamental lack of deeply affordable and permanent housing, especially when the majority of San Franciscans (65%) are renters. The median cost of a one-bedroom apartment in San Francisco is \$3,450, while those working a minimum wage job in the city make only \$2,702 monthly.¹ Many low-income people in San Francisco are at constant risk of homelessness, just one paycheck away from losing their homes. In order to get ahead of this crisis, we must keep people in their homes.

Catastrophic health issues, temporary job loss, and rents rising above fixed incomes are primary causes that are preventable through rental and other forms of assistance. At the same time, there are increasing numbers of people entering homelessness. Most homeless San Franciscans (70%) were housed in San Francisco at the time they became homeless. Of those, over half (55%) lived in San Francisco for 10 or more years. Among the 31% experiencing homelessness for the first time, almost half had been homeless for less than a year.² In order to effectively address the homelessness crisis, we must end homelessness before it occurs.

INTERSECTIONS OF OPPRESSION

66% of Black homeless San Franciscans have lived in San Francisco for more than a decade.³

"My life would change drastically under Prop C. It would give me and all of these families a great amount of peace to be able to have somewhere stable to go home to... Not having to worry about if the police is going to remove you at three in the morning with all the children because we are parked on the side of the street. Our children will grow up with less traumas because parents will not be overworked to keep a stable home that leads for more family time and more happy memories."



—JAZMIN FRIAS,

Bilingual Peer Researcher and Focus Group Facilitator

¹ San Francisco Housing Needs and Trends Report, San Francisco Housing Needs and Trends Report1–80 (2018).

² San Francisco Homeless Count & Survey Comprehensive Report, San Francisco Homeless Count & Survey Comprehensive Report (2019). Retrieved from <http://hsh.sfgov.org/wp-content/uploads/FINAL-PIT-Report-2019-San-Francisco.pdf>

An Overview of San Francisco's Housing Stock

There are many types of housing in San Francisco that are privately and publicly managed. Here is how we will be referring to these types of housing in this report:

PRIVATE MARKET HOUSING

- This is any housing that is privately owned. San Francisco has the highest cost of housing in the country. With the real estate market at sky high levels, the addition of tens of thousands of high paid jobs in the tech sector, and the failure to protect current renters from displacement, thousands of San Franciscans have been displaced from their homes. Sixty-two percent of low-income residents in the San Francisco Bay Area live in neighborhoods at-risk or already experiencing displacement.³ Due to strong tenant organizing, San Francisco has strong tenant protections compared to other cities and the majority of units are under rent control. However, the inability to control rents in vacant units has incentivized landlords to force tenants out in order to raise the rent.

BELOW MARKET RATE (BMR) HOUSING

- BMR units are managed by the Mayor's Office of Housing and Community Development (MOHCD) and are newly built by for-profit market rate developers that are permanently offered at below the market rate prices. These can be units for rent or bought and owned. These units are typically out of reach to those moving out of homelessness due to higher income requirements, unless coupled with a subsidy.

PUBLICLY SUBSIDIZED HOUSING

- Public housing is built and maintained with oversight from the federal government by the San Francisco Housing Authority. In order to qualify, tenants' incomes must not exceed certain limits as determined by Area Median Income. The last time the wait list opened in January of 2016 over 8,000 homeless households applied, only to be stuck waiting for years.
- City affordable housing is built, maintained and operated by nonprofit agencies with city, state and/or federal subsidies. The majority of these units are developed for low-income or middle-income individuals and families, but there is typically a 20% set-aside for homeless populations.
- City Permanent Supportive Housing (PSH) is housing that is owned by the city or non-profit entity and must be used for the common good, which has rents set at 30% of income and provides on-site supportive housing.
- City master lease housing⁴ is housing where a private landlord maintains ownership and the city leases a block of rooms or the entire building, provides front desk services and manages the building, as well as maintains basic building elements such as paint, carpeting and furniture. The owner collects the rent directly from the city and is responsible for major building maintenance such as elevators, foundation and roof.
- Subsidized private market housing is when the government assists in paying the rent.

³ Zuk, M., & Chapple, K. (2015, July). Case Studies on Gentrification and Displacement in the San Francisco Bay Area. Retrieved from https://www.urbandisplacement.org/sites/default/files/anti-displacement_full_report_11.15.pdf; The San Francisco metro area, which includes tech-heavy suburban San Mateo County, ranks first. The City by the Bay and its environs, a hub for technical service firms like Uber and Salesforce.com, has experienced remarkable 90% growth in tech employment and a 36.5% expansion in STEM jobs from 2006 to 2016. Forbes 2017

⁴ It is important to note that the Department of Homelessness and Supportive Housing places master lease housing under the same category as permanent supportive housing. However, there are important distinctions between the two, which is why we have chosen to place it in a separate category.

According to the Department of Planning’s 2018 San Francisco Housing Needs and Trends Report, BMR and government subsidized housing represents about 9% of San Francisco’s total housing stock and comprise a total of 33,000 units. About 10% of those units (10,267) are permanent supportive and master lease housing that specifically serve homeless people.

In addition to physical units of government subsidized housing, Housing Choice Vouchers (HCVs) allow families to rent in the private market using only 30% of their income each month and covers the difference; there are about 9,500 HCVs in use in the city. There are also local subsidies funded by the state and city. Approximately 1,200 additional households at any one time who are homeless or at risk of homelessness receive short or long term and cover a small portion of the rent in the private market.⁵

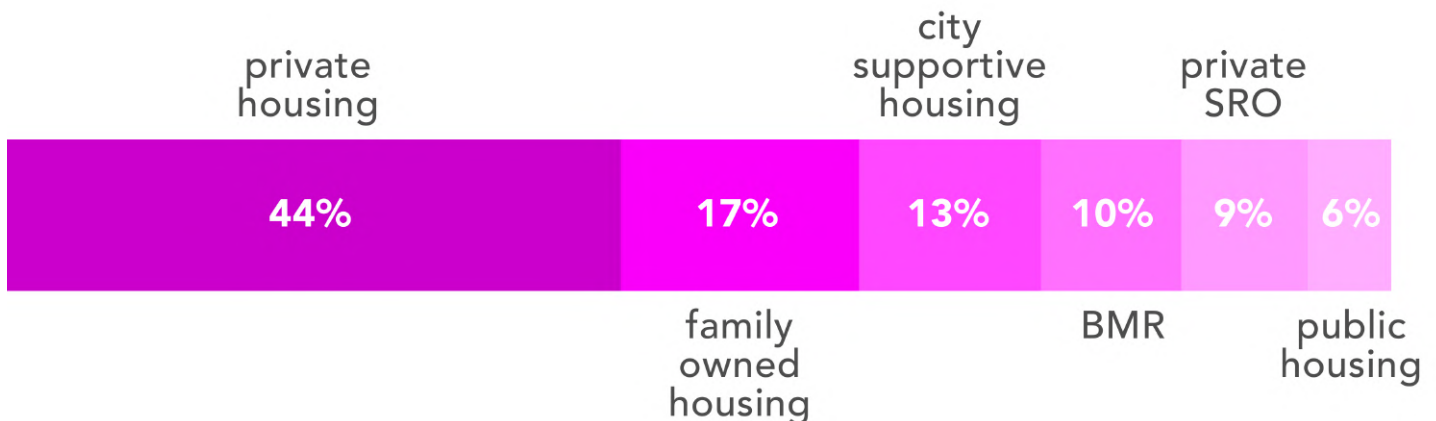
FINDINGS

Housing Status Prior to Homelessness

A series of questions were asked in this study to trace back the set of circumstances that led to homelessness, and more importantly what could be done from a policy perspective to prevent that experience. For almost half (48%) of participants, it was more than three years since they were last housed. However, a significant number of participants were also recently housed: 9% of respondents were housed less than three months ago, and for a quarter of respondents, the last time they had housing was less than a year ago. We followed up with a question about whether they were on the lease, and the answers were about evenly split between yes (49%) and no (51%). As gentrification has hit San Francisco, casual living arrangements without leases through friends and family have disappeared as more poor people are displaced outside of SF, and much of the housing that was traditionally shared among impoverished people is now garnering high rents from one household. Less than one-quarter of respondents were actually evicted from their last housing situation.

what was your last type of housing?*

(figure 7, n = 567)



* Please note that rounding accounts for a total of 99%

⁵ This data comes from a draft from HSH: Data Summary HSH Accomplishments, Draft 3

Most survey participants' most recent housing was in the private market (53%) and 17% lived in housing owned by themselves or by family members. Of those most recently housed by renting in the private market, 17% lived in SRO hotels, housing stock that has long been regarded as the last form of affordable housing, albeit oftentimes in unmaintained and decrepit conditions.

Nineteen percent of participants' were housed in government subsidized housing directly before coming homeless. Of those who lived most recently in government subsidized housing, most (69%) were in city run supportive housing and 31% were in public housing. While 13% had been in Permanent Supportive Housing as their last place of residence before becoming homeless, 18% reported they had been in city permanent supportive housing at any point of their lives. Of the 103 survey participants who had previously been in city supportive housing and were now homeless, 66% had been in that housing in the last 5 years.

Housing Loss and Prevention

Participants were asked why they lost their housing and offered up a variety of reasons. Most commonly (43%), people lost their housing due to an inability to pay rent. The reasons they could not pay rent was due to job loss (37%), low incomes (36%), personal issues (25%), health crisis (21%), a break in benefits (12%), and/or a family member unable to pay rent (12%). Aside from the inability to pay rent, the other most prevalent answers included family dispute (17%), landlord harassment (14%), and change in household makeup (12%). Also notable is that 8% lost housing due to domestic violence. Barriers from the criminal justice system also played a large role, with 7% of participants losing their housing due to being incarcerated, and 3% to the arrest, incarceration, or criminal record of a family member. Over half (51%) of those in private market housing lost their housing due to an inability to pay rent, followed by job loss (21%), and a health crisis (11%).

The eviction rates within government subsidized housing were similarly shocking: more than one in five (24%) participants there had been evicted, with eviction rates highest in city-run SRO units.⁶ When asked why they left, the most common responses were eviction (24%) and the threat of eviction (14%) or being unable to pay rent (24%) most often due to a break in benefits (14%). Although a relatively small sample, African Americans reported leaving due to an eviction or threat of eviction at twice the rate of their white counterparts. In sum, more than 1 in 10 of the currently homeless San Franciscans who participated in the survey became homeless after exiting the city's primary homeless housing program, and 1 in 6 had been housed at one point or another in permanent supportive housing. The fact that nearly one-fifth of respondents had become homeless directly from some form of government supported housing suggests that broader government housing programs deserve more scrutiny about their exits as well.



⁶ It must be noted that 11% of participants asked this question of "why did you leave this (city supportive housing)?" did not answer. Additionally, these percentages use the total of 103 participants for the "City Supportive Housing" section which includes those who did not respond.

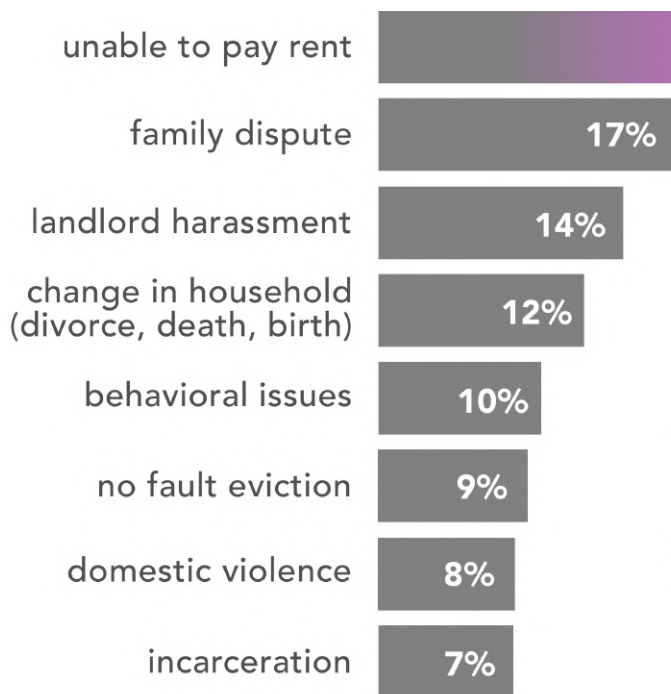
According to the Annual Eviction Report in PSH, half of the evictions of those who became homeless after leaving permanent supportive housing were a result of nonpayment of rent and another 10% were a result of a combination of both nonpayment of rent and lease violations.⁷ Formerly homeless people should not be evicted due to nonpayment of rent in programs that are designed to house homeless people. This year's eviction rates have dropped from the previous year of a 2.25% eviction rate; this is a relatively low eviction rate. However, clientele from the 2016 Eviction Defense Collaborative's (EDC) Annual Report reveals that far more clients in supportive housing (over 500) receive assistance compared to tenants in private market housing (less than 300). Furthermore, between 2006 and 2016, EDC clients facing eviction who have disabilities and rely on supportive housing have increased by 15%, reflecting the lack of adequate support in supportive housing for those who need it most.

INTERSECTIONS OF OPPRESSION

African American participants fell out of government subsidized housing and into homelessness at more frequent rates than their white counterparts. There were clear racial disparities: **17%** of African American respondents reported that they had resided in permanent supportive housing directly prior to their current episode of homelessness compared to only **12%** of whites.

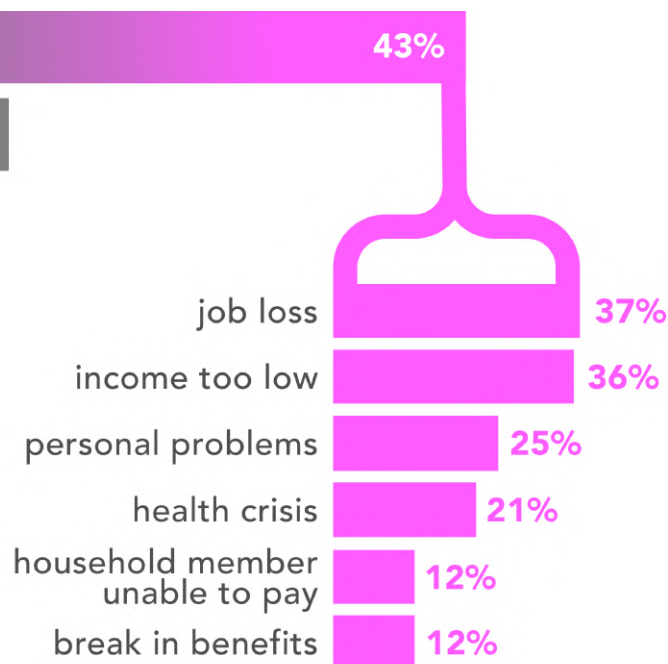
top 9 reasons for losing housing:

(all types of housing included)
(figure 9, n = 548)



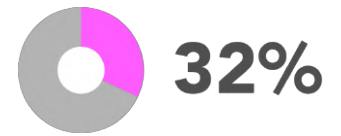
breakout: reason unable to pay rent?

(figure 10, n = 237)

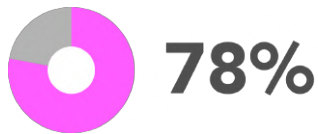


⁷ Department of Homelessness and Supportive Housing, FY 2018-19, Annual Eviction Report in Permanent Supportive Housing.

Participants were also asked what could have helped them stay housed.⁸ In these questions, participants were able to choose multiple answers. By far, rental assistance was the most frequent answer. Nearly one-third (32%) of survey participants who answered this question reported that rental assistance would have prevented them from losing their housing. Interestingly, 78% of those who said they needed rental assistance would have only needed it for one year or less; of those, a little more than one-quarter (26%) reported needed only one to four months of rental assistance to have stayed in their homes. Only a little more than one-tenth (11%) reported that they would have needed permanent rental assistance.



nearly 1 in 3 survey participants who answered this question reported that rental assistance would have prevented them from losing their housing.*

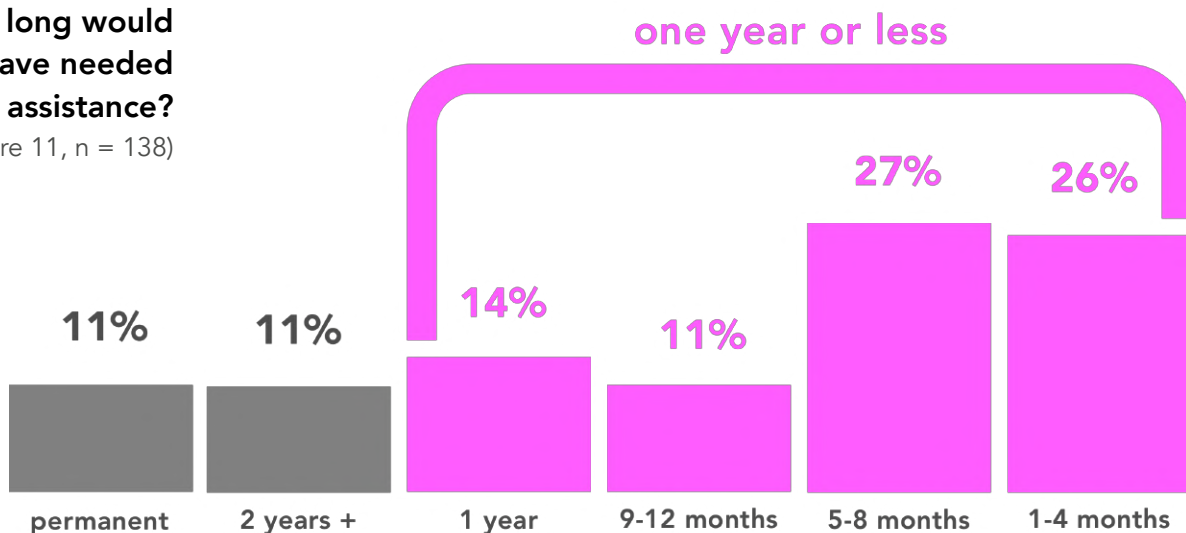


nearly 4 in 5 participants who said they needed rental assistance would have only needed it for one year or less

Those who have spent time in city supportive housing were also asked what policies could have helped them stay housed specifically in that type of housing. A majority of those who responded to this question (52%) said rental assistance, showing even more of a disparity among those who reside in government controlled housing. While City-run permanent supportive housing has a relatively low reported eviction rate (1.87%) in FY 18-19, it is clear that many participants leave that supportive housing under threat of eviction.⁹ Indeed, the findings indicated that 18% of participants had previously been in permanent supportive housing at some point in their lives and were now homeless. The City's own four-year longitudinal 2015 Budget and Legislative Analyst report found even higher rates: 47% of participants had left permanent supportive housing within three years. This varied widely by housing type; most significantly, 66% of people had left city-run SRO master lease housing.

how long would you have needed rental assistance?

(figure 11, n = 138)



* It must be noted that this question had a 75% response rate.

⁸ It must be noted that 25% of participants asked the question "are there any resources the city could have provided to prevent you from losing housing?" did not respond.

⁹ San Francisco Office of Budget & Legislative Analyst, 2016, Impact of Supportive Housing on the Costs of Homelessness. <https://www.sfdph.org/dph/files/jrp/35-SFBudgetAnalystHomelessnessReportMay2016.pdf>

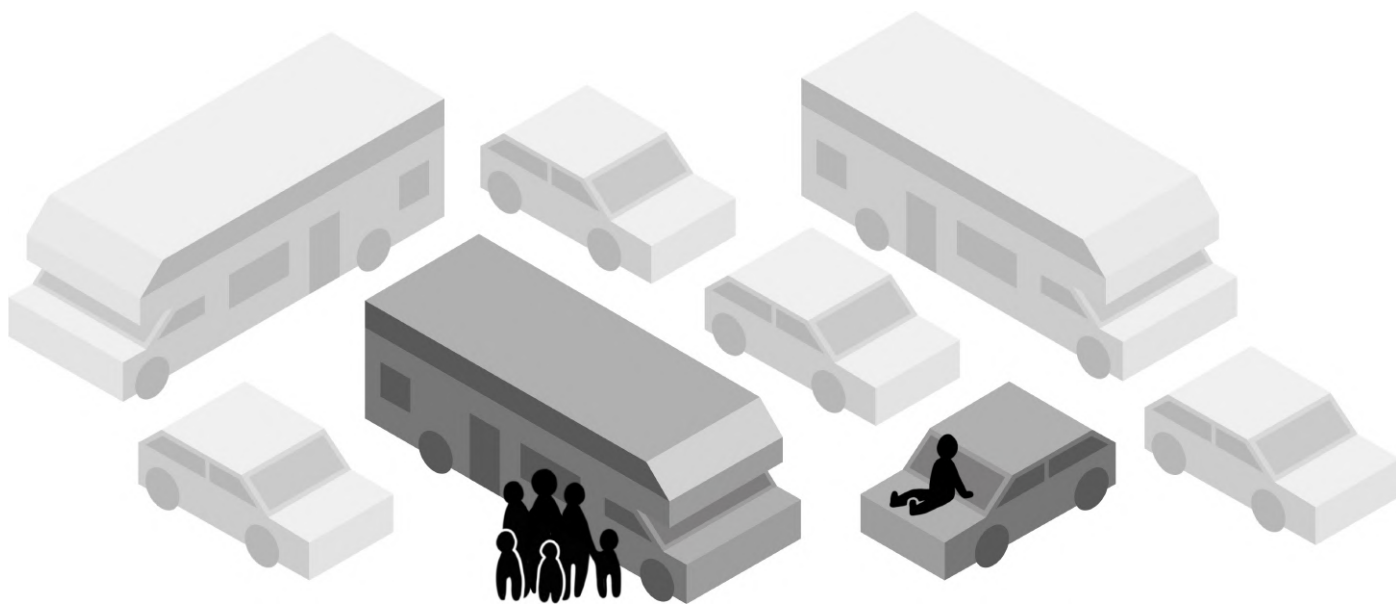
Vehicularly Housed Individuals and Families

According to the SFMTA, over 1,200 people are living in cars, vans, or RVs on the streets of San Francisco. These are families, students, pregnant people, young children, elderly people, people with disabilities, and adults.¹⁰ With an adult shelter waitlist that regularly numbers over 1,000 people and housing waitlists that can span years, vehicles are often the first and only line of defense before people are forced to live directly on city streets. Vehicular living is also often the first step out of street homelessness.

We held a focus group with people who live in their vehicles. During the group, one white man in his fifties mentions his decision to stay in his car:

"I'm a tow truck driver by trade, so I have large lot availability to leave [my vehicle] on the lot. SF being so expensive there aren't many options. The business ended, so I downgraded to my car. I got my tent ready in case I get a flat tire."

People who reside in vehicles are not prioritized for housing, and few resources exist to aid these families and individuals. While vehicular dwelling is far from ideal, it can often be the safest option for an already vulnerable population, yet vehicle dwellers live under constant threats to their only form of shelter. Although San Francisco just opened up the first vehicle living center, few sanctioned locations to park exist, which lead to constant harassment by law enforcement and displacement. Parking citations can end up costing hundreds or thousands of dollars in fines and fees, which can result in tows, and loss of vehicle. The money spent on criminalizing those who live in their cars can better be spent through assisting those living in vehicles with maintenance, tow retrieval and housing when the parking program is full.



¹⁰ SFMTA: Parking Management and Vehicular Habitation. (2018, February 6). Retrieved from https://www.sfmta.com/sites/default/files/reports-and-documents/2018/01/2-6-18_item_12_parking_management_and_vehicular_habitation_-_slide_presentation.pdf

Homeless Families Living in Single Room Occupancies (SROs)

Many of San Francisco's homeless families have not been formally counted by the biennial Point-in-Time Count and are rarely discussed when developing solutions to family homelessness: families living doubled and in families living in single room occupancy hotels. These families typically live in overcrowded situations, sharing spaces with many other household members, and rent from the private market or stay with friends and family, likely without a formal lease. The Point-in-Time Count identified 201 families living unsheltered or in shelter, but there are over 699 families living in Single Room Occupancy hotels and hundreds more living in doubled-up, overcrowded situations.¹¹ In 2015, the San Francisco Unified School District identified 1,419 students who were living doubled up.¹²

*"Living in SROs makes people depressed, causing mental health problems. When it becomes so stressful, people get messed up mentally. There needs to be mental health counseling."
—from family living in SRO*

Families living doubled-up are defined as a family living with one or more other families in a housing units; typically these are overcrowded and unstable housing situations, where families are not on a formal lease and may be asked to leave on short notice. While the Department of Homelessness and Supportive Housing considers these families to be homeless, the Department does not have accurate numbers on these families, who are often incentivized to stay under the social service radar for a number of reasons, including the threat of Child Protective Services taking away their children or violating a friends' lease for staying doubled up in their unit. Due to similar challenges, it was difficult to capture the input of these families in the needs assessment survey. As a result, we conducted two focus groups each for both families living in SROs and families living doubled up.

With only 14% of families living in SROs fluent in English,¹³ one focus group was conducted in Cantonese with five participants and another in Spanish with eight participants. Questions were asked about the current challenges that they faced living in SROs as well as what it would take for them to be able to move out of their current housing situations. Many of the families had been living in SROs for several years, with the longest duration being 18 years. There were clear challenges that SROs presented due to the lack of space and poor living conditions, including bug and rodent infestations, a lack of consistent access to a sanitary and functioning kitchen and bathroom, and chronic air and noise pollution.

"Two of my kids have asthma because of the poor ventilation in the SRO. The doctor told me that if we did not move, our kids taking prolonged medication would be bad for their health. Hearing from the doctor has deepened my worries. I live in fear."

¹¹ Due to inadequacy of tracking these families, we have drawn from existing social service providers for estimates, understanding that they are likely undercounts of actual population numbers. According to the SRO Families United Collaboratives' 2015 SRO Families Report Living in the Margins: An Analysis and Census of San Francisco Families Living in SROs, there are 699 families living in Single Room Occupancies. http://www.chinatowncdc.org/images/stories/NewsEvents/Newsletters/sro_families_report_2015_.pdf

¹² Coalition on Homelessness - San Francisco, "2015, The Roadmap: A Five-Year Plan to End the Crisis of Family Homelessness in San Francisco" <http://www.cohsf.org/wp-content/uploads/2015/06/RoadmapGrey.pdf>

¹³ 2015 SRO Families Report Living in the Margins: An Analysis and Census of San Francisco Families Living in SROs (pg. 31).

"For my family, we dream of moving out of the SROs."



Non-functioning elevators are an issue that more than half of all SRO tenants face in the city and are serious challenges for families.¹⁴ One woman, who lives on the third floor, explained why this is challenging, "The doctor would order nutritional milk for my daughter. Each month, I need to lug cases of nutritional milk up the stairs, over 100 bottles." Another participant who had a physical disability said, "I have difficulty walking and others need to help me use the kitchen, the toilet." He said that it takes him about 15 minutes to go up the four flights of stairs and that he seldom leaves the SRO for this reason. Families also stated difficulty doing everyday tasks due to the lack of space and shared kitchen and bathroom spaces, particularly for children:

"We have five kids, the oldest is 18. There are a lot of inconveniences. The kids do their homework on the bed, while the little ones are playing around them. They cannot focus on their homework. Their father is a driver, going to work at 4 a.m. When he gets up, the whole room is lit up. You can't get a good rest. And our one-year-old is crying all the time."

"My [17 year old] daughter is growing up. She has to share the bed with me and there is no space for herself, no space to do homework; three of us share a bunk bed ... we can't even turn in bed."

"I got a spittoon for them to pee [in the room]. I find it difficult taking care of small kids. I have to pour out their pee and poo."

¹⁴ San Francisco Department of Public Health, 2016, Single Room Occupancy Hotels in San Francisco: A Health Impact Assessment. <https://www.pewtrusts.org/-/media/assets/external-sites/health-impact-project/sfdph-2016-sroh-exec-summm.pdf>

"It's the lack of work. And since I don't have documentation, it gets difficult for me."

"I do not have English skills or job skills. I hope to get manual work or lower skill level jobs. If I get a job, I would have an income. I would have less stress. I could pay rent and have a job."

"My sister tells me to get out [of hotel], that she will help me. I tell her 'and the deposit, and everything, what then?' Why get out? When I know that I won't be able to pay [elsewhere]."

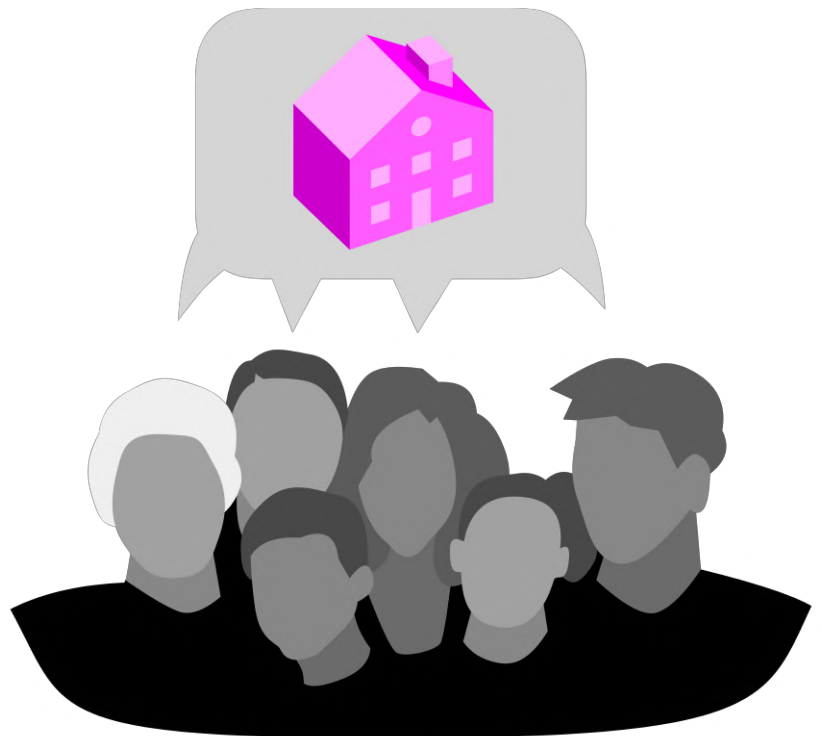
"Rents are too high for us. If the rent is lower, owners do not rent to us. Since I have many kids, they don't want to rent to us."

"I used to sell tamales, but now I sell fruit. And from there, I save to help my husband with the little bit of what I make, we scrounge and pay rent."

Families were forced to stay in SROs due to the lack of other affordable housing options. Furthermore, while many participants have previously applied to affordable housing units, none have obtained any, or have been unable to qualify due to minimum income requirements.

When asked what would assist with moving out of an SRO, the answer was obvious: affordable housing — but also, job opportunities that paid well enough to move out of SROs.

When it comes to families in SRO's and living doubled up, the City has mostly focused on keeping these households where they are. This has had clearly disastrous impacts on the families involved, who would be better served by moving into permanent housing.



POLICY RECOMMENDATIONS

Pass Policies to Keep Housing Affordable

- Fully repeal the Costa Hawkins Rental Housing Act, a California measure that was passed in 1994 that limits municipalities' ability to implement vacancy control in rental units. This will reduce landlord incentives to displace existing tenants and prevent rents from spiking when a tenant moves or is forced out.¹⁵
- Support local and statewide measures that expand tenant protections and expand rent control.
- Support a California constitutional amendment recognizing the Fundamental Human Right to Housing in California.
- Fully repeal the Ellis Act, a statewide measure that allows landlords to evict entire buildings.

Reinvest in Public Housing

- Direct city lobbyists to prioritize their time pushing for elimination of the Faircloth Amendment and restoration of public housing funding back to pre-1978 levels adjusted for inflation.
- Eliminate entry barriers to public housing including debt and past criminal records.

Expand Access to a Variety of Affordable Permanent Housing Options

- Expand investments in permanent supportive housing, flexible housing subsidies, need based subsidies and other forms of permanent housing assistance through ensuring Our City Our Home fund is kept whole and released through defense of lawsuit or returning to ballot. In a recent study by Tipping Point community, 89% of homeless people agree that the best way to help someone experiencing homelessness is to support their efforts to find a long-term place to live. They also felt that autonomy matters. Respondents ranked basic essentials including access to one's own bathroom and kitchen above even their own safety when asked about important factors they were looking for in housing. Lastly, "family," "job," and "it's home" were among the top reasons why people felt it was important to stay in San Francisco. A variety of housing options that include an ability to stay in San Francisco, or live outside of impoverished areas, as well as ensuring units with basic amenities is key to success.¹⁶

Prevent Homelessness for Housed San Franciscans in the Private Market

- Expand rental assistance programs for those who are facing eviction for nonpayment of rent or habitual nonpayment of rent. These programs should be flexible on a case-by-case basis and allow for both short- and long-term rental assistance, and should be available as needed, as many times as needed.
- Ensure right to counsel along with comprehensive legal assistance is available from early in the process, before unlawful detainers are issued all the way through the court hearings. Fully fund right to counsel.
- Expand enforcement of anti-discrimination policies for families with Section 8 vouchers.
- Create data inventory of housing stock with eviction frequencies and rent prices and record of vacancies.
- Increase mental health services for tenants who receive eviction notices.

¹⁵ The Cost of Costa Hawkins, 2016, San Francisco Anti-Displacement Coalition
<http://sfadc.org/wp-content/uploads/2018/07/The-Cost-of-Costa-Hawkins-On-Screen-Version.pdf>

¹⁶ Tipping, "The View From the Outside" April 2, 2019

- Amend California Code of Civil Procedure 1161(2) to allow payment up to the day of Unlawful Detainer trial.
- Expand outreach to buildings at risk from speculators or possible evictions by tenant rights advocates.
- Require “just cause” to evict tenants statewide.

Prevent Homelessness for San Franciscans Housed in Government Subsidized Housing

- Ensure that permanent supportive housing is truly that: permanent and with the appropriate amount of support to ensure that individuals are able to maintain their housing.
- Remove nonpayment of rent as a reason to evict, by developing an early warning system to guarantee that nonpayment does not lead to an eviction. Reach out to tenants immediately when rent is late, create a mutually agreed upon plan for payment.
- Expand voluntary support services such as payee programs, direct rent payment, case management and policies that help at risk tenants stabilize their homes where they have the opportunity for long term tenancy.
- Insert standardized language in city subsidized housing contracts, including Rental Assistance Demonstration (RAD), HOPE SF, Permanent Supportive Housing, and Master Lease contracts that ensure eviction prevention steps are taken, including conflict resolution, payment plans, money management assistance, hoarding abatement, in home support services, as well as bans against harassment of tenants and unfair evictions.
- Halt the widespread use of unrealistic stipulated settlements (contracts that tenants sign that if they break them they are automatically evicted) that consistently lead to eviction, and ensure when stipulated agreements occur, providers never insert nuisance issues or other terms that could never support a lawful eviction into stipulated agreements or other items that were never an issue in the original eviction. Stipulated settlement agreements must also include the right to a hearing or trial and not lead to immediate eviction with no due process.
- Track data and outcomes to better serve current and future tenants in supportive housing. Currently, the Department of Homelessness and Supportive Housing does not track outcomes when homeless people exit supportive housing nor do they track outcomes past 12 months in supportive housing. This data must be regularly collected and analyzed to guarantee a housing system for homeless people that best serves them. This includes tracking reasons individuals left housing.
- Ensure housing system is fluid to allow for easy transferring between buildings when family size changes, when unresolvable conflict occurs, or when tenant’s safety is threatened. The rules for emergency transfers would need to be more flexible to allow for more success.
- Expand Right to Counsel to HUD Hearings.
- Establish uniform training for building/property managers contracted by CCSF including de-escalation and restorative justice practices with strict monetary fines for non-compliance.

Address the High Turnovers in Permanent Supportive Housing

- Assess reasons for individuals exiting permanent supportive housing.
- Change the current 30-day window for reinstating benefits to 90 days for County Adult Assistance Program beneficiaries in master lease housing, and actively give assistance to tenants to get reinstated including on-site enrollment.
- Establish a well-publicized hotline posted in every building for master lease residents to alert Department of Homelessness & Supportive Housing (DHS) when they feel they are being harassed or bullied out of housing by property management, or when their safety is being compromised inside buildings.

Problem Solving for People Who Are Vehicularly Housed

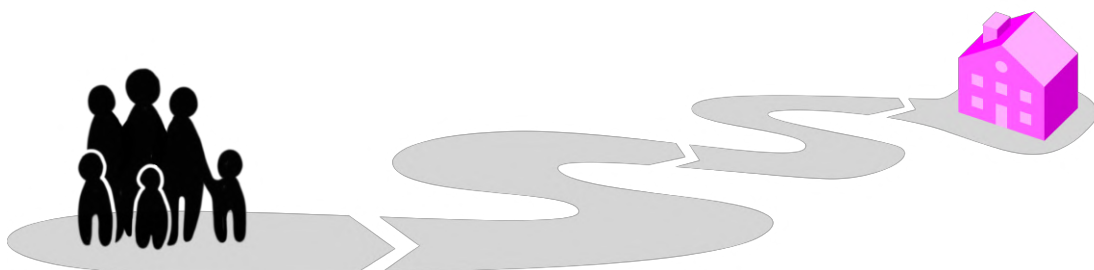
- Rather than criminalizing and taking curb space from people who live in their vehicles, ensure accessible problem solving funds through DSHS to assist with tows, parking tickets, repairs, smog tests, and other resources to aid those who live in their vehicles.
- Halt the towing of vehicles that people live in unless a safety risk is present.
- Ensure safe parking is available city wide.

Facilitate Work and Employment for the Currently or Recently Unhoused

- Train and incentivize local employers to hire people actively experiencing homelessness and provide additional support services to those employees to help them stabilize in both a job and housing.
- Create specific, medium- term housing for those enrolled in the program so they can't time out, become homeless, and have to leave their job.
- Create policy that will allow vulnerable housed and unhoused people to work without risk of losing their government benefits until they are solidly, demonstrably no longer in need of them.

Municipal Practices to Increase Income in Order to Preserve Housing

- In programs where benefits are tied to housing such as Care not Cash, continue benefits for 3 months as a bridge to allow opportunities for benefits to be reinstated.
- Automatically enroll all eligible SSI consumers in CalFresh, increasing ability to pay rent.
- Cease the suspension of driver's licenses for failure to appear in traffic court and clear the backlog of related holds on licenses that have already been filed with the California Department of Motor Vehicles. Loss of Driver's License leads to loss of employment, and housing.
- Include specific *ongoing* funding to address homelessness among youth in future funding administered by the Homeless Coordinating and Financing Council.
- Make immigrant taxpayers, who file taxes each year using an Individual Taxpayer Identification Number, eligible for the California Earned Income Tax Credit, as well as those on work status through Deferred Action for Childhood Arrivals (DACA) or Temporary Protected Status (TPS).
- Prohibit criminal history inquiries during the housing application process—scale the Oakland measure, Fair Housing Ordinance, up to the state level.
- Push for federal HUD funding awarded to California to be proportionate to the actual state need/size of the homeless population.
- Revisit previous attempts to amend state laws that have granted Business Improvement Districts (BIDs) excessive authority to collect and spend property assessment revenue on private security, which further contributes to the criminalization of the homeless.
- Halt the practices of illegal property confiscation, sweeps, ticketing homeless people for housing status offenses, towing of vehicles individuals reside in, in order to halt the further perpetuation of homelessness and instability which leads to unduly extending periods of homelessness and suffering.



SHELTER

Shelters have been shown to play a stabilizing role for those experiencing homelessness: serving as a safe haven from domestic abuse, inclement weather or police harassment faced when living outdoors, a platform to maintaining employment, a pathway to accessing social services and benefits, and a means of improving health compared to residing outdoors in public space. However, research has consistently found barriers to accessing shelter, poor shelter conditions that fossilize poverty and traumatize clients, and unstable exits that often lead back into homelessness.¹ This section assesses the benefits and challenges of shelter and navigation centers in San Francisco among our study participants and considers what improvements and changes they see as most urgent and necessary.

EXECUTIVE SUMMARY

The majority of survey respondents currently residing outside have either tried and been rejected from shelter or regularly use shelter when it is available.

Of those unsheltered, 81% have either used or tried to access shelter in the past, while only 15% of those who were unsheltered at the time of the survey had utilized shelter in the past month. Nearly 40% of currently unsheltered homeless survey participants have utilized shelter in the past year. This contradicts the dominant narrative that most unsheltered homeless are resisting or refusing services outright.

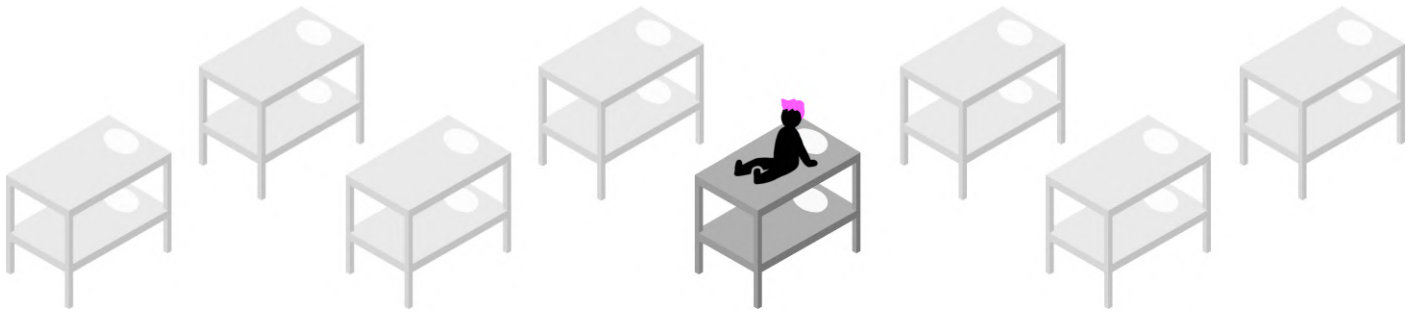
San Francisco's shelters present barriers of access to many survey respondents.

The majority of respondents currently staying in shelters reported that they had tried and failed to access a bed in the past: 64% reported having tried and failed to access shelter in the past due to a lack of available beds, 37% due to excessive waits, 29% due to finding it too complicated, and 29% from missed check-in for the strict curfew.

Shelter conditions were considered by most study participants to present challenges to their health, safety, privacy, dignity, or ability to escape poverty and homelessness.

Focus group participants described strict curfews and limits on nights-out interfering with getting hired or maintaining jobs and maintaining and caring for family. Those suffering from mental health conditions described the congregate settings as exacerbating their conditions. Those residing outside reported avoiding shelter as a means to evading institutionalization and the dependency and stigma they felt it entailed. The limits on pets and partners in most of the city's shelters were seen as more destabilizing than remaining outdoors. Others described the congregate settings of shelter as incubators of disease, a setting that provokes regular violence and social conflict between clients, and an environment that deprives them of privacy.

¹ Hopper, Kim, 2003, *Reckoning with Homelessness*. Cornell University Press. Lyon-Callo, Vincent, 2008, *Inequality, Poverty, and Neoliberal Governance: Activist ethnography in the homeless sheltering industry*. University of Toronto Press. Gowan, Teresa, 2010, *Hobos, Hustlers, and Backsliders: Homeless in San Francisco*. University Of Minnesota Press.



A majority of survey participants would prefer a legal camp with amenities as opposed to existing shelters.

When study participants were asked “If the city had a legal free campsite, where you could camp outside in your private tent and have access to toilets, showers, and have some basic security would you prefer to stay there as opposed to the existing shelters?” 58% reported that they would, 10% maybe, and only 32% said they would not. Of those who endorsed a legal campsite, 44% were currently in shelter at the time of the survey.

Nearly one-third of study participants reported being forced to leave shelter against their will.

Thirty-two percent of survey participants who had stayed in shelter had been forced out due to time limits at some point in the past. Another 30% left due to mistreatment, 15% because the rules didn’t accommodate them, and 14% were kicked out of shelter. Of study participants who had stayed in shelter, 31% had been asked to leave shelter by a staff member or were formally denied service before their time was up.

There is a demand for both a clean and sober shelter and a shelter that would allow those actively using drugs and alcohol to safely use on site.

Seventy-one percent of respondents said they would prefer to stay in a dedicated clean and sober shelter as opposed to existing shelters. Twenty-six percent of respondents reported that they would prefer to stay in a shelter to safely use drugs on site. When asked about a shelter with a safe injection site in a separate room with a trained nurse supervising, responses are split: 48% support this, 41% oppose, 8% are unsure, and 3% didn’t care.

Participants ranked housing case management and case management as the services that would most improve their shelter experience or make a difference in them accessing a shelter.

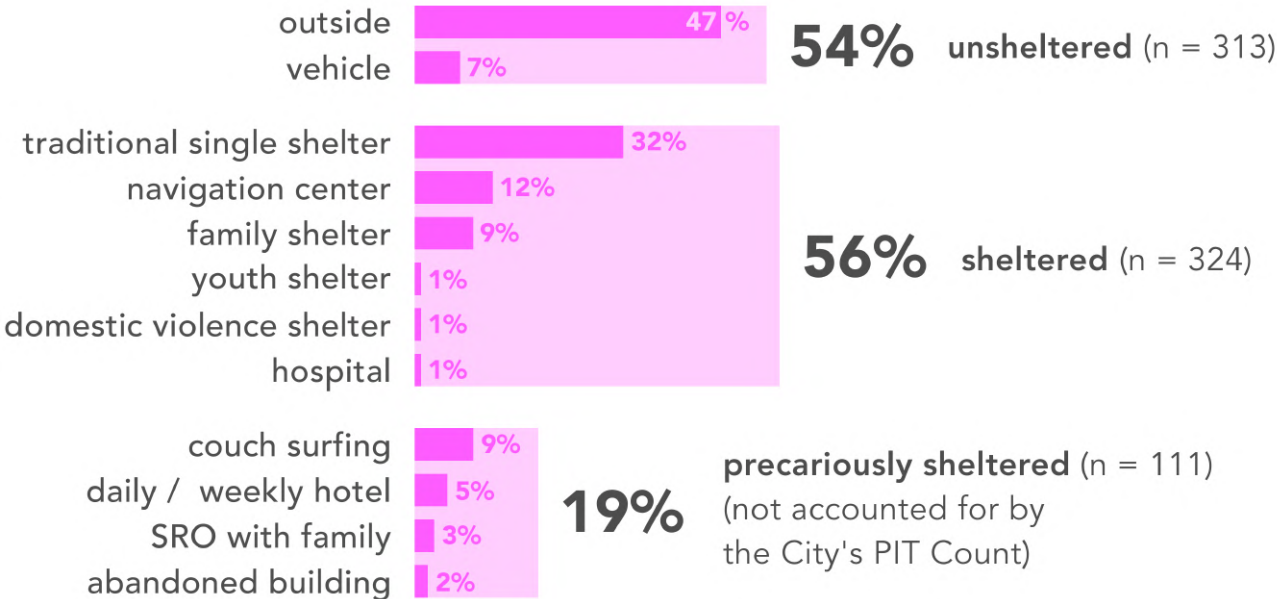
A high proportion of participants reported they would use housing case management (76%) or case management (74%) if these services were made available. The need for case management was also a significant theme in the focus groups. Participants reported lack of access to case management staff and to information on appropriate services as significant barriers. Many participants complained of low-quality case management.

BACKGROUND & FINDINGS

Dynamics of Shelter Use in the Midst of a Shelter Crisis

The United States has a shortage of 7.2 million affordable homes.² Those unable to remain stably housed due to this affordability crisis face a scarcity of available shelter, where unhoused people outnumber shelter beds. This holds true in San Francisco. On a single night in 2019, the city counted 9,784 people experiencing homelessness, but placed its shelter capacity at 3,400 beds, including conventional shelters, navigation centers, stabilization beds, and transitional housing units.³

where have you primarily stayed in the last month?* (figure 12, n = 578)



Among the 578 survey respondents, 324 identified being sheltered as a primary living condition over the past month and 315 identified being primarily unsheltered. 52 participants (9%) had spent equal time between being sheltered and unsheltered in the past month alone. Fifteen percent of those currently on the street reported having been sheltered at some point in the last month. Nearly 40% of currently unsheltered homeless survey participants have utilized shelter in the past year and 81% of those unsheltered have either used or tried to access shelter in the past. In contrast to the city’s biennial Point-in-Time count that portrays a static perception of sheltered and unsheltered homelessness, the reality is that there is a high rate of churning between street and shelter. When survey participants who had been homeless for one year or more and had stayed in shelter at some point in the past year were asked, “In the past year how much time have you spent in shelter?” only 27% reported that they resided in shelter for the full year.

* 52 participants (9% of the sample) had spent equal time between being sheltered and being unsheltered in the past month alone which accounts for the total to be greater than 100%.

² National Low Income Housing Coalition, 2018, The Gap. Washington DC. <https://reports.nlihc.org/gap>

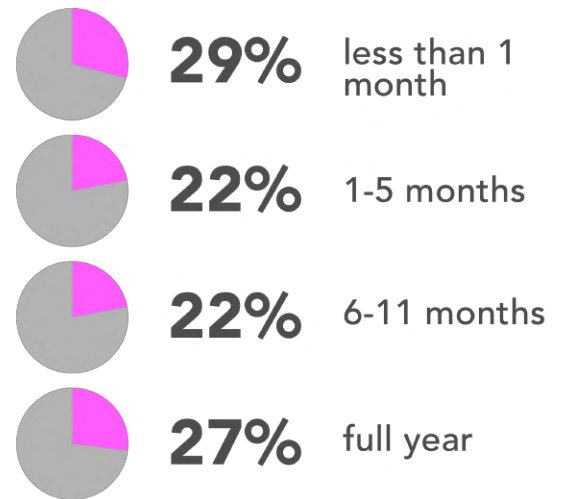
³ city and County of San Francisco Office of the Mayor, Oct. 31, 2019, "Mayor London Breed Adds 20 New Beds to Civic Center Navigation Center" <https://sfmayor.org/article/mayor-london-breed-adds-20-new-beds-civic-center-navigation-center>

Instead, 21% reported spending 6 to 11 months in shelter, 22% said 1 to 5 months in shelter, and 29% less than a month in shelter over the past year.

Most unsheltered respondents used shelter. Forty percent of study participants who had stayed in shelter reported having stayed at more than one, and 50% had accessed shelter through more than one entry point such as the 90-day wait list, waiting for one-day beds, or referrals from the hospital, jail, or Homeless Outreach Team. The city’s navigation centers do not pull names from wait list or take walk-ins, but rely on referrals from very select sources even when they have vacant beds. However, even the city’s navigation center shelters, which were designed to offer higher quality services with a more relaxed rules matrix to help navigate people from the street into housing was found to have a high rate of turnover among study participants.

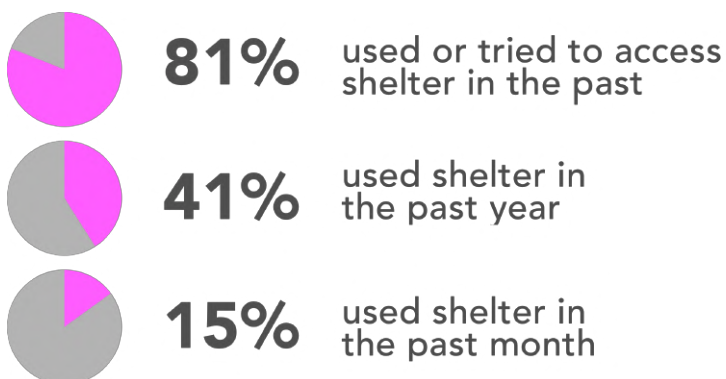
The study found that 26% (n=154) of survey respondents had stayed in navigation centers in the past, although only 12% (n=70) were currently staying in navigation centers. As one African American man, aged 53, who was currently residing in another city shelter explained:

time in shelter in the past year among folks who’ve been homeless for at least a year:
(figure 13, n = 413)



“I was at a navigation, that didn’t make any sense at all. I was at 3 navigations. When you leave it’s done. You shouldn’t have to leave until you get your housing. They give you a date for 30 days - when that 30 days is up, you don’t have housing and you’re back to square one, and almost in a worse way because you don’t have your clothes, jacket - and then they put you out. Say you do 30 days here, 60-90 there, 120 there. But in the navigation, if the time’s up you got to go.”

among those unsheltered at the time of the survey: (figure 14, n = 321)



These findings suggest that most of those residing in public space are not in fact “service resistant” or “shelter resistant,” since most have utilized services and shelters in the past, and most often, multiple times through multiple points of entry. Instead, our study found that many barriers to shelter were not of homeless people’s own choosing, but rather structural barriers to access, a fragmented system, inadequate shelter conditions, and high rates of unstable and unwanted exits.

Accessing Shelter

The majority of respondents currently staying in shelters reported that they had tried and failed to access a bed in the past: 64% reported having tried and failed to access shelter in the past due to a lack of available beds, 37% due to excessive waits, 29% due to finding it too complicated, and 29% due to missed check-in times. Among study participants who had never stayed in shelter, 22% reported that the confusing process was their primary deterrent. Administrative data and responses from the focus groups reveal how the process of waiting for shelter prohibits access to those seeking it and also proves to be a major deterrent for many to even attempt to access shelter in the first place. On a typical day in 2019, there were over 1,200 people waiting on San Francisco's single adult shelter waitlist for a shelter bed.⁴

Reaching the top of the list typically takes between one to two months. Once getting a bed, the person will have to exit after 90-120 days, get back on the list, and wait for another one to two months. If one doesn't own a phone or have any kind of computer access, they have to call in to 311 and visit drop in centers to check, or they risk getting kicked off the list if they don't respond when their number comes up. As one 36-year old man currently staying in shelter recounted in a focus group: "A month and a half I spent every other day calling 311." This system is greatly improved over the strict line based systems of the past, but draws attention to capacity issues, and these improvements have not been extended to the single night system.

Without a guaranteed bed, one can always wait for a single-night bed, but these involve long waits and do not always result in getting a spot to sleep. Such waits typically last over four hours. It is not unusual to wait over eight hours. This wait requires those who have jobs and are working to decide between keeping their job and not having shelter or accessing shelter and losing their job.

A 30-year old Native American man who had been in a shelter, but was now currently living around Buena Vista Park described trying to make shelter fit with his work schedule:

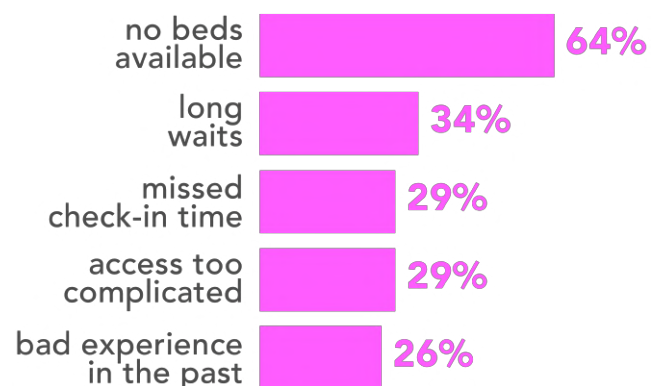
"Sometimes you have to bend your entire schedule and they say you have to be there at 4. (exclaims) Come on man - I'm right in the middle of working!"

At MSC South, a main entry point for accessing shelter, elderly men and women, people with disabilities, and violently sick are all equally forced to wait for hours outside without chairs or a place to sit before making it inside the entrance. Even in the cold freezing rain, requests for blankets or chairs are denied by staff who claim that such charity is against protocol. While waiting, people regularly endure interpersonal conflicts that arise between frustrated clients, insults hurled by those biking or driving by, and solicitations for sex.

Yet even with these arduous waits, not only are the city's shelters full nearly every night, on many evenings over 100 people end up sleeping in chairs having waited hours to access a bed due to the fact that they are all utilized.

primary barriers to shelter:

answers from those who *have* used shelter in the past 5 years
(figure 15, n = 302)



⁴ city and County of San Francisco. Shelter Reservation Wait-list https://sf311.org/information/waitlist#How_to

As a 65-year old African American man currently staying at Sanctuary Shelter explained in a focus group:

“Sometimes I have to spend weeks sitting at a chair in MSC South, maybe you get a bed, maybe you stay in a chair. You continue doing that for weeks until your number comes up.”

Among those who hadn't stayed in shelter in the past five years, the most common barriers to access were the shelter system's bad reputation (40%), bad experience (30%), confusing process to access (22%), and the shelter's congregate setting (22%). More than 1 in 10 of those who have not used shelter reported that they avoid it due to no beds being available, theft, waiting, curfew, and staff treatment. When respondents were asked to prioritize their top four barriers their answers aligned with the most common barriers reported above. Although partners and pets were discussed as barriers in the focus groups and are key policy priorities for the city in its new navigation centers, only 12% reported this as being a barrier in the survey. Finally, a number of participants in focus groups discussed the challenges of maintaining their access to shelter in relation to government benefits.

primary barriers to shelter:

answers from those who have *not* used shelter in the past 5 years (figure 16, n = 125)



One way that a person in San Francisco can maintain a shelter bed longer than the 90-day time limit is through enrollment in the city's general assistance program. To access the benefit of a renewable guaranteed bed primarily requires a person to be actively seeking work, participating in a job training program, or working a few hours a week in a government-partnered program. However, one is not able to participate in this program if they are receiving Social Security Income even though that monthly benefit is not enough to secure housing in San Francisco. If one begins working and earning a larger salary, they are moved off general assistance and lose access to their shelter bed. However, most people still require a number of months of pay to save up for the necessary first month's and last month's rent for a deposit, before making the transition into housing. In short, the general assistance option for a guaranteed bed is off-limits to many due to physical and mental health challenges and creates a trap for those who are able to move back to work and in so doing, lose their access to shelter.

These findings point to the multiple challenges faced by both those currently using shelter trying to maintain and regain their beds as well as the barriers preventing many residing outside the shelter system from accessing it in the first place. The general scarcity of shelter in San Francisco discussed in the previous section is regularly used as justification by city officials for the existing time limits, the idea being that equitable distribution of a scarce resource necessarily requires time-sharing. The consequences, as one may expect, are long waits and a disincentive to agencies and providers to improve accessibility. Another justification used by city officials to support the policing and street cleaning of homelessness in public space is that certain individuals resist and turn down offers of shelter. However, the findings of this study rather show that a majority of San Francisco's homeless are in fact using and trying to access shelter on a regular basis but are limited by the structural limitations of the city's own policies restricting access and their enforced turnover.

Residing in Shelter

Our survey and focus groups also examined people's experiences in shelter. A series of questions asked respondents to indicate if they felt their well-being was improved, reduced, or remained the same in shelter compared to residing on the street. The results of those questions are reported on the following page. As one can see, on several questions, reports of people's condition being improved was greater than those reporting that the shelter made no difference in their well-being or hindered their well-being in comparison to the street. Compared to residing on the street, 62% of participants reported being more stable in shelter. 63% reported improved physical health, 59% reported getting better rest, 49% reported having easier access to food, 58% said it was easier to make appointments, and 55% reported feeling safer.

However, across most of these measures 25 to 35% of study participants reported no differences in their condition or ability to access services and 5 to 15% reported the shelter hindering their well-being as compared to the street. For instance, only 50% of study participants felt that shelter improved their mental health. Whereas, 29% felt that it made no difference and 22% reported that the shelter hindered their mental health.

INTERSECTIONS OF OPPRESSION

Those reporting a drug or alcohol challenge disproportionately reported that shelter had a negative impact on their mental health (28%) compared to those who did not report a drug or alcohol problem (19%).



50%

only half of study participants felt that shelter improved their mental health.

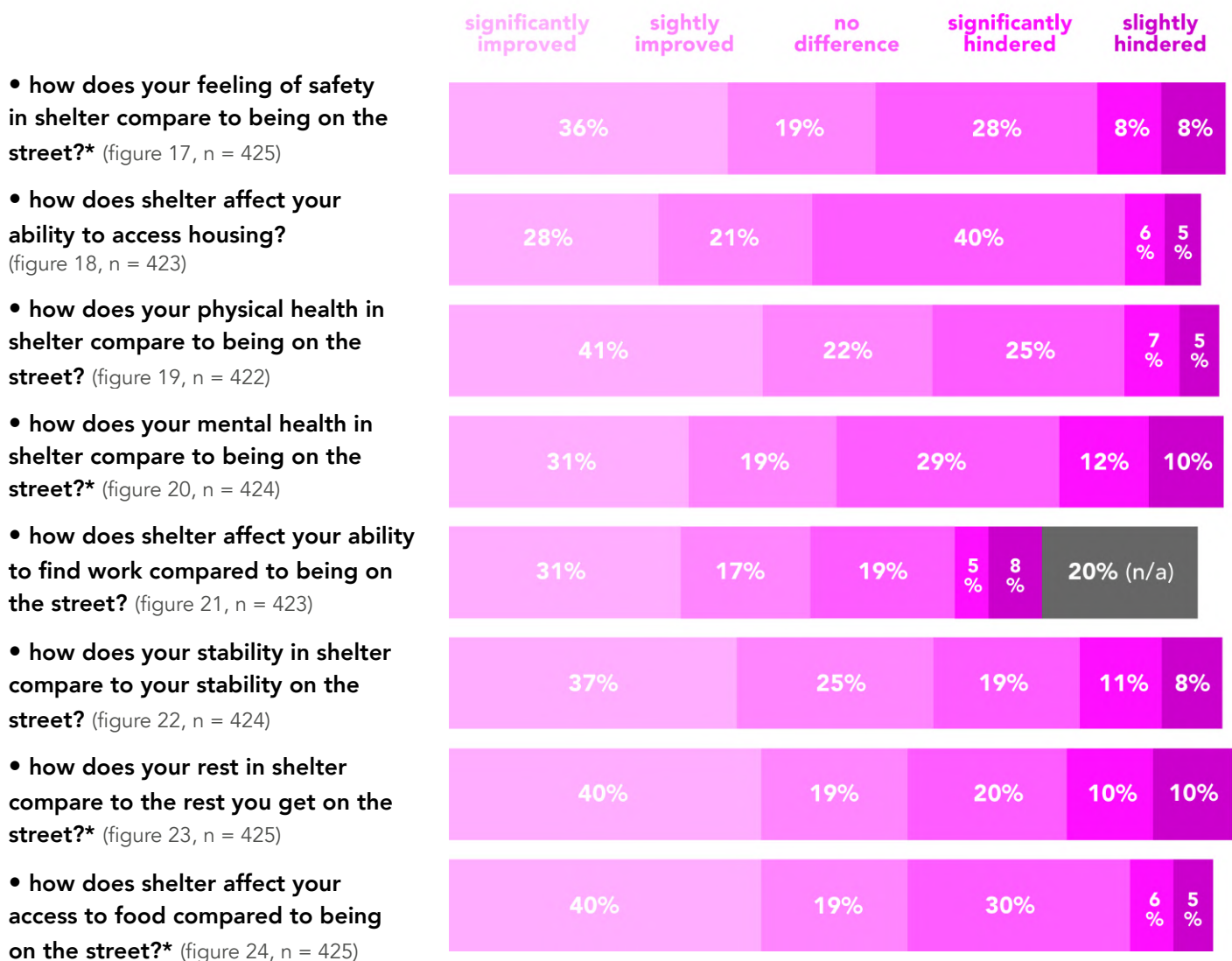
INTERSECTIONS OF OPPRESSION

Although most participants felt that shelter had either a positive or no effect on their mental health and sense of safety, Cis females and Trans participants also were more likely to report that shelter had a negative impact on their mental health (25% and 24% respectively) as compared with their cis male counterparts (19%). Trans participants were also more likely to report feeling less safe in shelter (24%) vs. the streets in comparison to their cis-male (16%) and cis-female (17%) counterparts.

In areas where respondents did feel that the shelter improved their well-being compared to the streets, focus groups revealed a number of ways that their condition was nonetheless aggravated by shelter policies and practices as compared to living in a normal housing environment. 20% of those staying in shelter had left at some point in the past because they found the rules unworkable. Most of San Francisco's shelters have curfews requiring clients to check-in between 6 to 8 p.m. each evening. Having more than three late check-ins or nights out within 30 days results in losing your 90-day bed and having to wait months to get back inside.

This policy is a primary cause of unwanted exits as discussed in the next section, and conflicts with some people’s working schedules or ability to be hired for evening work. The policy is also isolating, preventing people from participating in social and family life beyond the shelter. In many of San Francisco’s shelters people are forced to leave the shelter between 7 and 8 a.m. With a lack of drop-in centers and truly free indoor public spaces, for the many who lack work or family to visit this means spending a significant amount of time outside in public space during the day. Although 55% of respondents felt safer in the shelter than on the streets, many qualified this response in the focus groups explaining that they nonetheless did not actually feel safe. Fights between clients are common and police are called regularly into the shelter. As one 34-year-old white man explained, “There’s also a lot of theft, a lot of dog-eat-dog scenarios, rather than we should all help each other try to get out of that situation.”

Study participants also complained of having their belongings and property being limited by shelter policy and staff. Thirty-three percent of respondents reported having belongings confiscated upon entering shelter at some point in the past five years. The most common being personal belongings (55%), weapons or tools of self-defense for survival on the streets like Mace (34%), drug use supplies (22%), medicines (21%), and outdoor survival gear (10%). It may be understandable that shelters would limit people bringing in entire campsites from the street if shelter was a final stop on the way into housing. However, as this section has already discussed, San Francisco’s shelters function more as rest-stops and waystations for many who will soon return back to the streets and once again require these belongings, largely due to the shelters own time strictures.



* Please note rounding accounts for these responses not to add up to 100%

As discussed in the next section, altercations and conflicts with staff were more often the reason that clients were asked to leave shelter against their will than conflicts with other residents. Thirty percent of all respondents who had stayed in shelter reported either leaving by choice after experiencing mistreatment by staff or being asked to leave shelter by staff, where they felt mistreated. Thirty-eight percent of respondents who had been asked to leave shelter (n=98) were due to a direct conflict with staff as opposed to 29% of those who had a conflict with another resident. Collectively, these challenges of residing in shelter created various barriers for people to ultimately exit homelessness. As one 35-year-old shelter resident explained:

"I feel, my personal opinion and experience in observing - they aren't professional for this to be their job. They are not compassionate people. You have to have compassion to deal with this type of thing because once the compassion is gone and you're just in your, your place of work, then everybody is just a job. Nobody is anything anymore. Nobody, you don't have, you don't have a mission to help people anymore. You just have a mission to get a paycheck, you know?"

Although San Francisco's shelters are seen by most respondents as providing important services that improve their daily lives in comparison to the street, there are still many who find that it does not significantly improve their well-being, and in certain dimensions make it worse. This points to the gap between shelter provision and client needs in various dimensions of care and support.

Unwanted Shelter Exits

One limit of this study, which focuses exclusively on currently homeless people in San Francisco, is that it does not examine the experiences of the thousands of San Franciscans who resolve their homelessness and move into housing from the streets and shelter each year either through their own efforts and/or the aid of the city's many charities, social service providers, and government programs. The city's homeless department, controller's office, and budget legislative analyst's office have all completed studies on successful practices and initiatives, which are further referenced in the recommendations of this section.⁵ What has been much less examined by the city's research are the causes and consequences of unwanted exits from shelter.

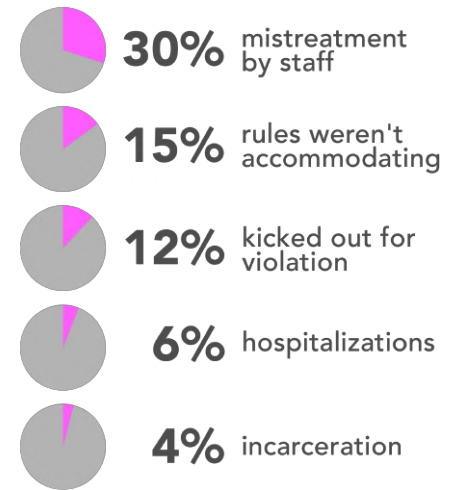
"I feel like it's hard to get any sort of momentum going when you're trying to figure out what the hell to do because you're constantly bombarded by some other scenario that's going on."

Our survey asked respondents who had resided in shelter if they had ever left shelter against their will. Thirty-two percent of respondents reported that they had been forced out due to time limits. As previously discussed, the city's 90-day limit on guaranteed shelter beds and seven-day and 30-day limits on some navigation center stays all limit the amount of time one can stay before having to re-enroll on the waitlist, incur daily waits for a single-night bed, or find other options. Thirty percent of study participants have left shelter at some point due to mistreatment by staff. Among these 95 survey respondents who had been asked to leave by staff, 38% reported that it was due to a direct conflict with a staff member and nearly 20% left in reaction to an experience of perceived discrimination by staff.

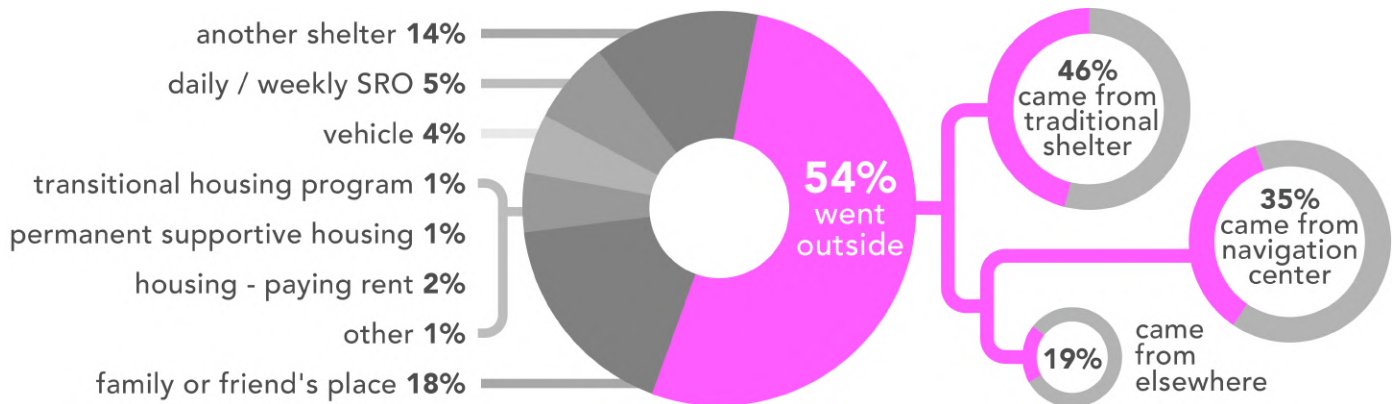
⁵ Herring, Chris, March 7, 2019, "Interrogating San Francisco's Approach to Street Homelessness," *Medium*. <https://medium.com/@streetsheet/interrogating-san-franciscos-approach-to-street-homelessness-fb6b393df41b>

Fifteen percent of respondents who had resided in shelter in the past five years had left at some point because the rules didn't accommodate them. As already discussed, San Francisco's shelters have curfews requiring clients to check in between 6 and 8 p.m. each evening. Having more than three late check-ins or nights out within a 30-day period results in losing your 90-day bed and having to wait months to get back inside. Twelve percent of respondents reported being kicked out of shelter for such violations, including 6% due to hospitalizations and 4% due to incarcerations, even if as brief as a few days. Focus group participants also mentioned family emergencies and overtime work shifts resulting in missed check-ins and loss of shelter beds. Although many shelters have processes to accommodate these situations, they are at the discretion of the staff and typically require pre-approval which prove difficult under various circumstances. Our survey also asked respondents where they went after last leaving shelter. The largest portion (54%) moved outside into public space, while others moved into family or a friend's place temporarily (18%), another shelter (14%), vehicles (4%), or a daily/weekly SRO (5%). Again, our survey would not have captured those who moved successfully into housing and are no longer homeless. However, the fact that more than half of the respondents who are currently on the streets (n=310) reported having been in shelter previously, and exited shelter into another condition of homelessness indicates the high degree of churning between shelters and other situations of precarious housing.

top answers of forced exits from shelter:
 from respondents who had been kicked out of shelter in the past 5 years (figure 25, n = 95)



after the last time you left shelter, where did you go? (figure 26, n = 310)



The study's finding that nearly one-third of shelter residents had been pushed out of shelter due to time-limits highlights the structural limitations of scarcity that exist in the current system that result in many people residing outdoors or in temporary housing arrangements against their will. The finding that 30% of study participants who had resided in shelter have left shelter at some point due to mistreatment points to systemic problems in client-staff relations. Finally, the restrictive timetables, curfews, and rules discussed in the previous section proved to result in unwanted exits for a consequential portion of those using shelter as well (15%). All of these findings point to further limits and shortcomings of San Francisco's shelter system, as well as the key areas survey participants felt reform and alternatives were most necessary.

Reforming Shelter and Finding Alternatives

The study's survey and focus groups asked a series of questions about the change homeless San Franciscans wished to see in the current shelter system. Survey respondents were asked how likely they would be to use a number of additional services and how they would prioritize these services. The generally high response rate across the board on these services and amenities indicates the broad-based demand among shelter users to access more meaningful material resources, but also engage with more services, if they are of high quality, easily accessible, and lead to meaningful outcomes. The most frequently chosen responses, when asked "what additional services would you utilize" were food, case management, housing case management, and hygiene products. When asked to rank the most important services you'd like to see added for shelter clients in general they were (in order) housing case management, food, case management, 24-hour access/no curfews, and stays beyond 90-days

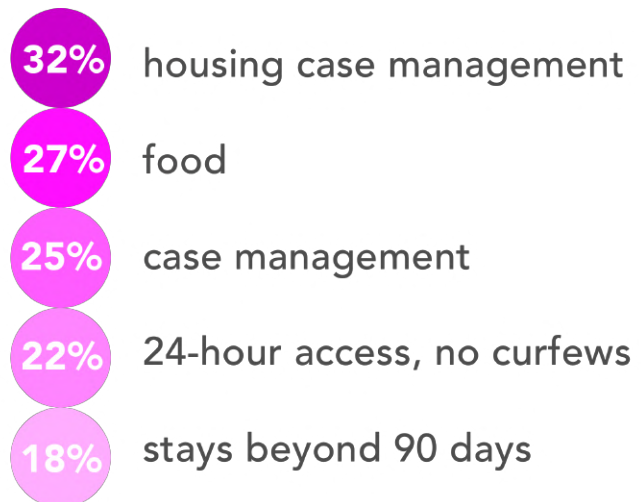
As discussed in the previous sections, the 90-day limits, strict curfews, and requirements to leave the shelter during the days proved a significant barrier to access and maintaining shelter. In focus groups, participants also discussed how these rules made everyday life difficult and created an added stress to their already stressful lives. In the focus groups we discovered that many had issues with the strictly scheduled eating times at shelter, the inability to bring in one's own food into shelter, and the nutritional quality and diversity of choice in food selections. However, it's also important to note that when asked "how does shelter affect your access to food compared to being on the street," 49% of respondents reported that it was significantly improved by being in shelter.

which of the following services in shelters would you use if they were made available? (figure 27, n = 566)

most popular by how many times chosen



most often in people's top 4



Finally, participants ranked housing case management and case management as the services that would most improve their shelter experience or make a difference in them accessing shelter. A high proportion of participants, both currently sheltered and unsheltered reported they would use housing case management (76%) or case management (74%) if were made available. The need for case management was also a significant theme in the focus groups, as well as other sections of this report like substance use and mental health treatment.

Participants reported lack of access to information and case management staff as a significant barrier to accessing needed resources. For instance, a young woman currently residing at a youth shelter explained:

“At the shelter, it is so disorganized. You have a case manager who doesn’t know what’s going on because you hear something from a different person about housing available over here but she’s telling me something else. One thing that went with the shelter was a lack of help that the case management provides is very disorganized. I’ve heard so many people over the four months that I’ve been in the shelter: Can I get a different case manager? She’s not helping me.”

“(You need) someone to guide you so you know what the services are. There are a lot of people who don’t know where to go, don’t know who to talk to, and what they can or can’t do for you. You don’t want to talk to someone who can’t do anything for you. You can talk to them about personal stuff, but as far as getting the housing done, you gotta know who those people are.”

This sentiment was similarly expressed by a 53-year old African American man currently residing in shelter who felt a need for a person to provide guidance through a complex bureaucracy.

The survey also asked respondents if they were content with how the current shelter system handles drug use among clients. Although current policy restricts drug and alcohol use within the shelter walls, several residents reported drug and alcohol use being tolerated or going under the radar of staff at various shelters. More research is needed to determine whether shelter users who do not use drugs or who are trying to stop or reduce the use of drugs are dissatisfied with being sheltered alongside people who do not share these goals, or whether the primary cause of dissatisfaction is drug use on site and harmful behaviors that might become more likely following drug use.

The survey asked respondents if there were a dedicated clean and sober shelter would they prefer to stay there over existing shelters. Seventy-one percent of respondents said they would. There was not a large difference between those who reported having a problem with drug or alcohol challenges versus those who did not in how they responded to this question. Seventy three percent of those who said they did not have a substance use problem said they’d prefer a clean and sober shelter while seventy percent who identify as having a substance use problem also preferred a clean and sober shelter. There were however, differences in these preferences by race.



It is clear that existing shelters are unsatisfactory to people who do not use drugs as well as to drug users and people trying to reduce their use. These results show that for people who want to reduce or terminate their substance use, being away from drugs and drug use is important. However, people who slip (studies show that most people who eventually stop using drugs slip or relapse multiple times on the road to recovery) also need a safe place to stay. Results indicate a need for diverse options, and to balance the diverse needs of people using drugs, people trying to stop or reduce drug use, and people who do not use drugs.

The survey also asked people if there were a shelter that allowed people who were actively using drugs or alcohol if they'd prefer to stay there over existing shelters and 26% said yes. Again, there were differences in this response according to race. Thirty seven percent of White participants preferred a shelter that allowed people to actively use versus only 22% of Blacks and 19% of Latinx respondents. This finding points to clients' desire for a diversity of shelters to meet a diversity of needs. In one of our focus groups held with a group of men currently residing outside, three mentioned the drug use among those in shelters as a major deterrent for them, who were each in recovery. Two men explained why they weren't interested in being in shelter:

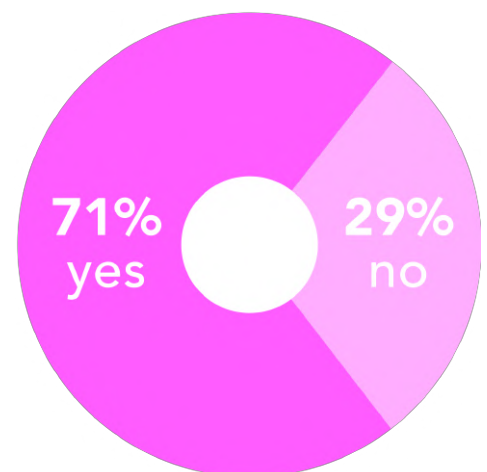
"I don't like the drug use there. Triggering for my next assault charge that will put me in prison. I'll give them an ass whooping. I can't be around that."

"It's the same for me, I'm a recovering addict. I don't get as angry at addicts anymore, but I know that being around that can cause me to act in some ways."

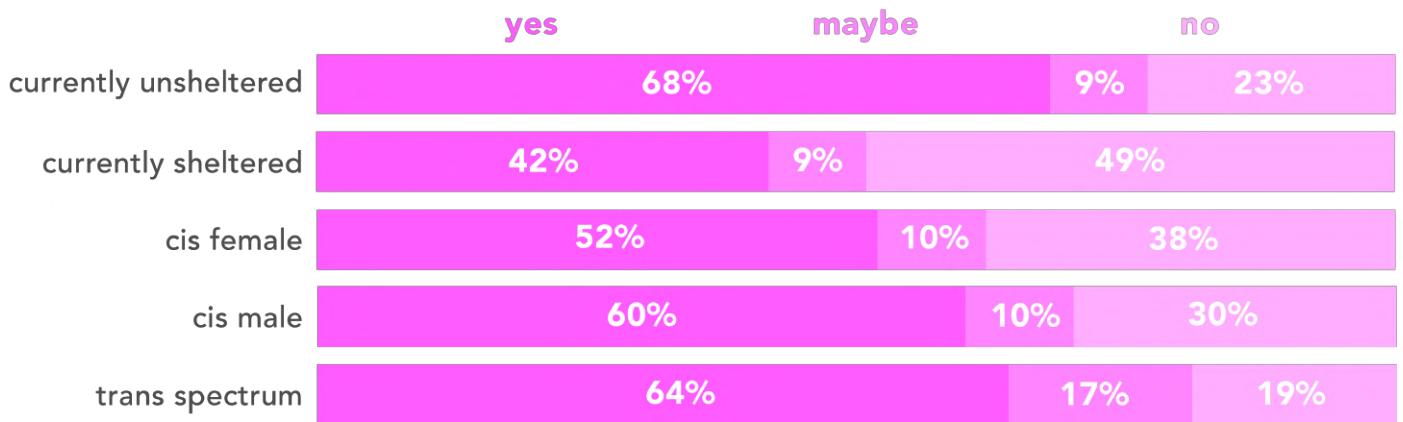
Finally, our survey asked participants if they would prefer "a legal free campsite, where you could camp outside in your private tent and have access to toilets, showers, and have some basic security." Most survey participants (58%) said they would prefer such an option compared to the existing shelters. Among participants who report drug or alcohol use as a challenge, 66% preferred a free legal campsite while 54% of those reporting no drug or alcohol challenges preferred this option. As one might expect this was a more prevalent perspective among those currently residing outdoors (67%), however more surprising is that nearly 50% of those sheltered preferred such an option and 10% saying that they might prefer this. Even 48% of those in family shelters reported preferring this option as compared to the current shelter. We only discussed the camping option in one focus group, which was limited to a group of single men aged in their 20s to 40s around the Haight-Ashbury neighborhood, which gives us a limited scope to the reasons behind this preference but they referenced several of the complaints voiced in the previous sections about shelter: the curfews and waits, the lack of privacy and congregate setting, and the lack of self-governance and reliance on staff, and how an organized camp would alleviate these concerns, through the provision of private tents, self-managed security, and accessible amenities.

**if there were a
dedicated clean and
sober shelter, would
you prefer to stay there
over existing shelters?**

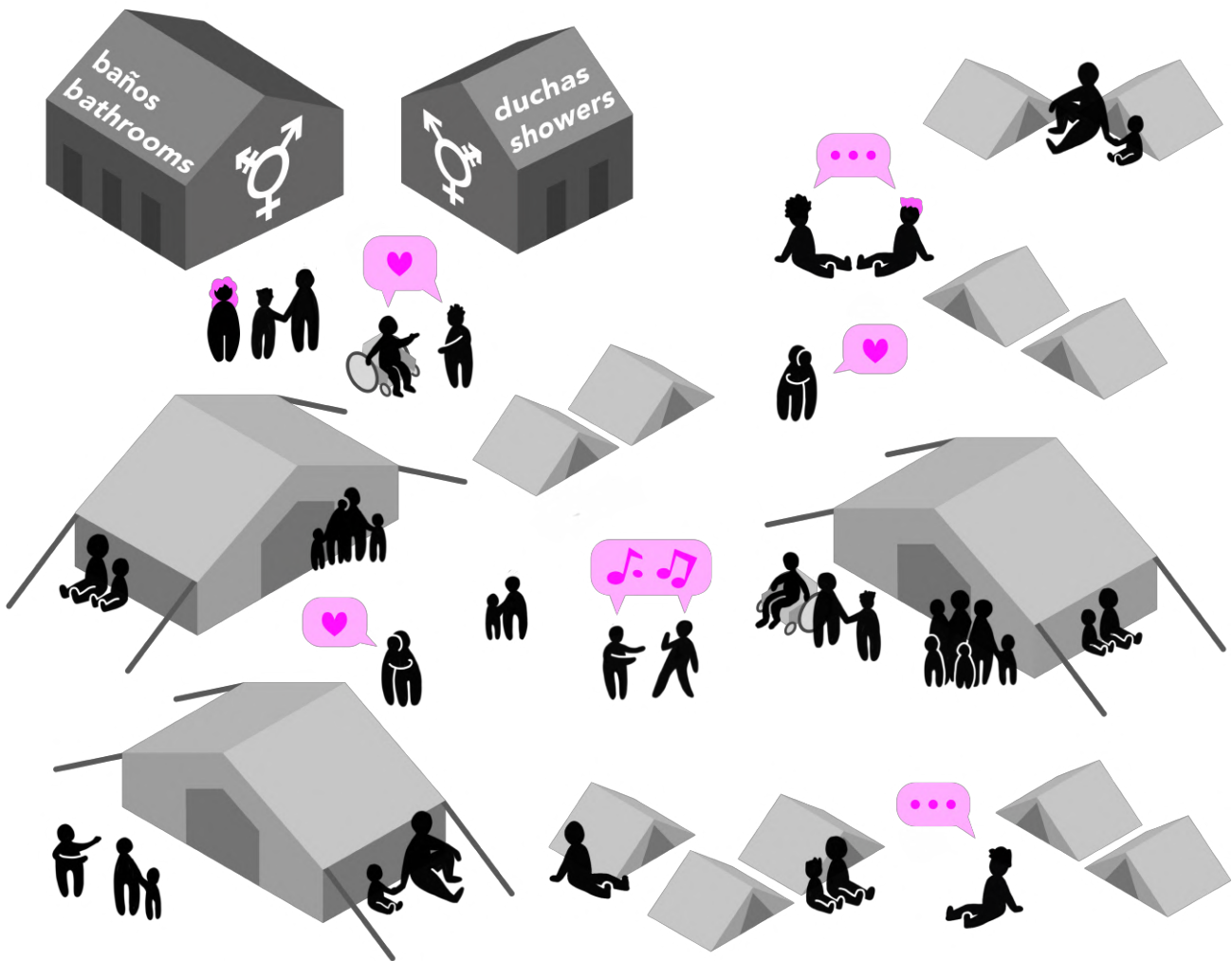
(figure 28, n = 574)



preference for legal camp with amenities vs. current shelter: (figure 29, n = 575)



in favor: $\frac{1}{2}$ cis-women $\frac{3}{5}$ cis-men $\frac{2}{3}$ trans people



POLICY RECOMMENDATIONS

Varieties of Deeply Affordable Housing

- Currently, only those who are rated Tier 1, or most acute, are offered any housing resources. What this means in practical terms is that homeless people must be severely acute before getting housing, typically after being homeless for long periods of time. For those who are not Tier 1, they are sent to problem solving that offers a variety of resources short of housing. Problem solving should include housing offers as well, such as private market subsidies, or assistance with other forms of housing applications.

Transparent Pathways to Housing

- Most homeless housing is under Coordinated Entry in San Francisco, however there are other housing resources outside of it. The city should ensure updated housing access information sheets are distributed monthly, with instructions on how to apply, including below market rate units, private subsidies, opening of HCV lists in other Bay Area Counties, public housing application spots and so forth. Clear and transparent housing opportunities and the application process should be posted online.

Case Management Aimed at Housing Support

- Most of the single adult system has centralized case management through START (Shelter Treatment and Access to Resources Team) but it is limited to a small portion of shelter clients. If there are transparent housing opportunities, there is not a need for comprehensive case management in the shelter system, however START should be expanded by 30% to serve all those in shelter who would need additional assistance navigating the system. With additional staff the START team could move from a passive to more active, yet still voluntarily, engagement with clients. For instance, currently people have to go to the team's office hours or make an appointment. They find out about the team through flyers. A more active model might include one where people are approached and told about options one-on-one during meals. For the family shelter system, case management already exists, however there continues to be challenges with quality. Additional regular training and supervision with formal reviews from clients would help address these issues.

Adopt Rules Matrix of Navigation to All Shelters Systemwide

- The original Navigation Center proved to be a popular model that better met the needs of its clients than the traditional shelter system. All shelters should adopt its rules matrices that made the center so successful. Rules should be re-evaluated for necessity, and remove those that are overly petty, while using creative problem solving to address concerns. There should be very simple rules and they should be easy to understand and remember. Beyond necessary rules such as banning violence, these include:
 - 24-hour access with no curfews or forced morning leave times.
 - Ability for clients to store property on or off site.
 - Ability to access healthy food throughout the day rather than limited times.

More Shelter with Low Threshold Drop-In Access

- San Francisco has eliminated most of this form of shelter access, preferring instead either referral based or wait list. These work for different types of homeless people – those who are able to navigate the wait

list, or those lucky enough to be offered a navigation bed. Currently, only winter shelters have drop-in access, and they tend to serve many individuals who are elderly or have other barriers to services. It is important to have all three forms of shelter beds all year round. We recommend that at least 20% of the beds be drop-in based, including navigation center beds into the total.

Varieties of Shelter

New shelters might consider focusing on specific needs and preferences as described by many in the focus groups. Some of these ideas included:

- A wet shelter where alcohol was permitted.
- A shelter that included a safe consumption spaces.
- A shelter or spaces in shelter for those in recovery who prefer to reside with others who also want to live in “clean and sober” environments.
- A shelter that focused on employment training, opportunities, and those working.
- A shelter that included private or semi-private sleeping quarters, such as in the family shelter system.

Improved Conditions to Support Healthy Living

Ensure shelters have adequate maintenance budgets to guarantee clean bathrooms, floor and other components of the facility.

Improved Staffing

With low unemployment rates and low salaries of frontline shelter workers, it is difficult to attract and maintain quality staff. There needs to be concerted efforts to increase staff wages above the 2% cost of doing business nonprofits receive. At the same time, there is a strong source of potential staff among the homeless population. Well defined job training programs, with structured work practice and formal training combined with trauma centered supervision should be implemented.

Daytime Drop-In Centers

For a variety of reasons, San Francisco lost about 50% of its drop-in capacity as compared to 15 years ago. At the same time many of the shelters are unable to open during the day, because of mixed use of the space. For those shelters which can open during the day, the city should allow for proper funding to do so, as well as expand drop in capacity to serve a currently underserved area. This resource should include assistance with a variety of needs from securing identification, to holding support groups as well as access to showers, bathrooms and storage.

Storage Facilities

A major barrier for those entering shelter is the requirement to abandon much of their property including survival gear for when they have to reside outside when they can't access shelter as well as basic personal belongings and valuables needed for day to day existence. While the new navigation centers have recognized and met this need, other shelters remain without storage for anything beyond one backpack and one piece of luggage. Secure storage areas within shelters, and/or convenient storage areas off site or in drop-in centers would aid both those who find property as a barrier to shelter and those having to reside in public space who do not have a safe place for their valuables.

SUBSTANCE USE

Substance use can be a coping mechanism for homeless people on the streets, a way to “self-medicate” mental health challenges, a means to dull pain, or to drown out recurring traumatic events. For about a third of unhoused San Franciscans, substance use has become an issue that can have health and socio-economic consequences. Participants’ experiences with substance use treatment in SF is a focus of this report. When participants are able to access and stay in treatment, most participants report that treatment is effective at helping them manage, reduce, or abstain from substance use. Long-term success is often contingent on participants’ ability to access stable, affordable housing upon exit from treatment, which is relatively rare. Some people are able to address their substance use issues while homeless, but for most homeless people, their housing status acts as a barrier to addressing substance use issues. There are mixed reports with regard to the effectiveness or preferability of harm reduction versus abstinence-only treatment programs.

For most homeless people, their housing status acts as a barrier to addressing substance use issues.

EXECUTIVE SUMMARY

One-third of homeless people in San Francisco report substance use issues, and polysubstance use is common.

Thirty-four percent (34%) of survey participants reported current challenges with substance use. The most common substances that participants received treatment for were methamphetamines, heroin, alcohol, and cocaine. Polysubstance use was common - almost half (49%) of participants who reported using substances experienced challenges with more than one substance at a time.

Half of people who report substance use challenges remain untreated.

One in five (20%) participants who reported challenges with substance use were receiving substance use treatment at the time of the survey*. A little more than half (51%) of the same respondents reported receiving substance use treatment services in the past five years, and about half were not receiving treatment.

There are significant barriers to accessing substance use treatment.

For those who had issues accessing treatment, the specific barriers were lack of availability of beds, long waitlists, confusing systems to navigate, cost, and treatment program rules.

* It must be noted that the question “have you received any services for your substance of alcohol use in the last 5 years” had a response rate of 85%.

Treatment works for most to some degree, at least in the short term.

By and large, treatment was effective to some degree for many who were able to access it. Among participants who were able to receive substance use treatment, 80% reported they were totally or partially successful at meeting their goals. However, almost a quarter (2%) of respondents indicated that the substance use treatment program they attended was too short, which suggests that the duration of the program may be a factor that affects outcomes.

A diverse system that includes methods of harm reduction and abstinence is needed.

Participants reported a range of perspectives with regard to treatment philosophies on abstinence. A little over one-third (34%) said abstaining from drug use completely is the best approach. When asked what approach helps people stay in treatment, 53% of participants found harm reduction programs that support progress toward recovery goals while not requiring abstinence helpful, while 47% said that abstinence-only programs work best for them.

Housing is essential for successful outcomes.

Following treatment, more than two-thirds (67%) of participants exited back onto the streets or to a shelter (it must be noted that the response rate for this question is 89%). The vast majority (88%) said that stable housing is crucial in maintaining treatment goals and treatment would “prove pointless” if they didn’t have stable housing. That is, many unhoused people have nowhere to go during and after treatment, limiting the success of treatment and leaving people vulnerable to relapse or other dangerous outcomes.



“One big impact of Prop C would be lowering the use of substances because TransLatina women would have opportunities to be in things that actually benefit us. How are you supposed to be OK if the night before you needed to exchange sex for a place to live or being up all night waiting for a client to pay for a motel so you can rest? What we need is opportunity.”

—LISSETH SANCHEZ,
Spanish-language Peer Researcher &
facilitator of Mujeres Latinas en Acción

BACKGROUND

By a range of measures, the substance use treatment system in SF is far from meeting the challenge of the sheer magnitude and complexity of need among people who are homeless. According to the SF Medical Examiner's office, fatal opioid overdoses more than doubled from 134 in 2018 to 290 in 2019.¹ Because the treatment system is maxed to capacity, many neighborhoods have visible signs of the struggle with substance use, such as littered syringes, open air drug use and sales, and people in the community who are intoxicated or unconscious. Evidence like this shows that the City has not prevented harm related to substance use nor provided the promised *Treatment on Demand*, which was passed by voters in 2008.² Vastly improved substance use treatment services is among the principle changes needed to address the homelessness crisis and suffering in our community.

The SF Department of Public Health (SFDPH) serves about 7,000 unique individuals over the course of a year for substance use disorders, while at least 24,000 meet the criteria for substance use treatment under MediCal.³ The types of services provided by the City range from prevention, early intervention, outpatient treatment, residential, to medical treatment. In general, harm reduction services tend to be outpatient and peer-based with a street focus, while residential treatment programs follow a strict abstinence-based model.

Since the Affordable Care Act, substance use disorder services such as residential treatment and methadone maintenance are reimbursable. This has been a major shift in the system, especially for methadone, which in the past had long waitlists for

free services. However, this shift has come with unintended consequences and has not resulted in full reimbursement for city costs of providing care. In 2016-17, 46% of substance use disorder clients were insured by MediCal and 54% were not, thereby limiting reimbursement for treatment uninsured people receive. In addition, MediCal comes with restrictions, such as limiting residential stays to 90 days, when according to SFDPH, a third of the clients need longer stays.⁴ There has also been a struggle with billing in many organizations, resulting in MediCal refusing to reimburse when they audit programs in SF, so additional staff is needed to cover this new billing duty.

Treatment on Demand, whereby an individual seeking treatment receives it right away, is considered a best practice to ensure a treatment seeker is not lost back to the streets, but is rarely a reality in San Francisco.

In order to access substance use treatment in SF, there is a centralized access center that also serves as a central hub for all behavioral health services. Individuals can go and see if they can get on a waitlist for services there and utilize the pharmacy, but it serves as primarily information and referral without case management or transportation assistance. Those with more acute needs, who need elevated assistance entering or navigating the system of care, are reliant on outreach workers and case managers who they may or may not have. *Treatment on Demand*, whereby an individual seeking treatment receives it right away, is considered a best practice to ensure a treatment seeker is not lost back to the streets, but is rarely a reality in San Francisco.

¹ San Francisco Chronicle, (2020, January 21), "Fentanyl, heroin overdoses in San Francisco more than doubled in 2019." Retrieved from <https://www.google.com/amp/s/www.sfchronicle.com/bayarea/amp/Fentanyl-heroin-overdoses-in-San-Francisco-more-14993628.php>

² Proposition T Free and Low-Cost Substance Abuse Treatment Programs City of San Francisco. (2008, November 4). Retrieved from <http://www.smartvoter.org/2008/11/04/ca/sf/prop/T/>

³ SF Budget and Legislative Analyst's Office, 2018, Behavioral Health Audit https://sfbos.org/sites/default/files/041918_SF_MA_Behavioral_Health_Services.pdf

⁴ *ibid.*

FINDINGS

Prevalence of Substance Use Challenges

Substance use rates among people who are homeless are much higher than for those who are housed because substance use is both a cause and an outcome of homelessness. However, it is a widespread and harmful misconception that all people who are homeless use drugs and alcohol. Almost all participants of the survey (576 of 584) responded to the question, “Is drug or alcohol use a challenge for you?” One-third (34%) responded that alcohol and drug use is a problem they face, a rate almost three times higher than the rate of alcohol and drug use in the general population in SF, which is estimated to be 10.8%.⁵ Therefore, although most people who are homeless do not have problematic drug or alcohol use, a significant portion do struggle with these challenges.

Of those who have substance use challenges, about half (51.5%) of participants reported using only a single substance. The substances that have caused the most challenge over the last five years were *methamphetamines* (n=25), *heroin* (n=25), *alcohol* (n=17), and *cocaine* (n=16). These top substances presenting challenges for people who are homeless are different than the most commonly reported substance use disorders in the general population, which are alcohol, cannabis, prescription pain medication, methamphetamines, cocaine, prescription stimulants, and heroin.⁶ That is, people who are homeless struggle with different types of drug use than the general population, which is one key reason they may require special treatment approaches.

The most commonly reported substance use issues involved:

- *Methamphetamines*
- *Alcohol*
- *Cocaine*
- *Heroin*

Almost half of participants who reported substance use challenges (n=63, 48.5%) reported polysubstance use, or experiencing challenges with more than one substance at a time. The most commonly reported combinations of polysubstance use were *alcohol and cocaine* (n=8), *heroin and methamphetamines* (n=7), and *alcohol and methamphetamines* (n=6). When all types of substance use were considered (one substance reported combined with polysubstance use), the substances that were most challenging to participants were *methamphetamines* (n=54), *alcohol* (n=50), *cocaine* (n=50), *heroin* (n=38), and *cannabis* (n=18). Opioids and painkillers were also high on the list when the various types are combined (n=20), such as prescription pain medications, fentanyl, non-prescription methadone, and morphine.

INTERSECTIONS OF OPPRESSION

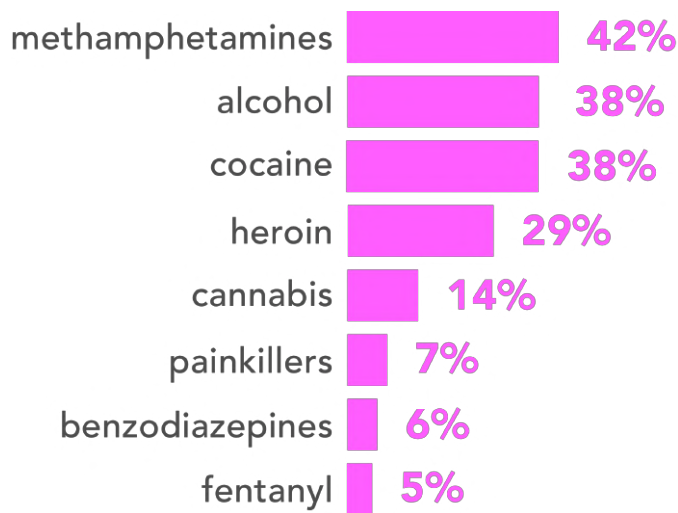
One-third (34%) of homeless people responded that alcohol and drug use is a problem they face, a rate almost three times higher than the rate of alcohol and drug use in the general population in SF. **40%** of those people are multiracial. Of those who are Native American, **40%** said drug or alcohol use is a current challenge for them, compared to 34% of all homeless people. **39%** of trans/gender non conforming participants also have a current challenge.

⁵ SAMHSA, (n.d.), Substance Use and Mental Disorders in the San Francisco-Fremont MSA, <https://www.samhsa.gov/data/sites/default/files/NSDUHMetroBriefReports/NSDUHMetroBriefReports/NSDUH-Metro-San-Francisco.pdf>

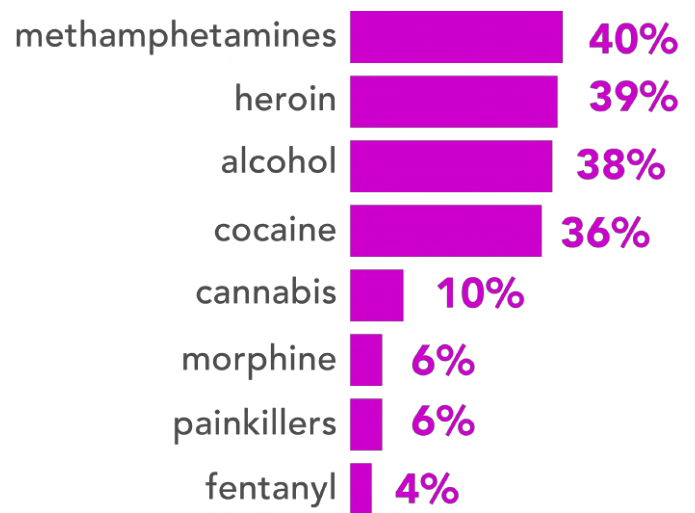
⁶ SAMHSA, 2019, National Survey on Drug Use and Health (2018) <http://www.samhsa.gov/data/report/2018-nsduh-annual-national-report>

When asked the substances participants have received substance use treatment for, the most common responses were *methamphetamines* (n=57), *heroin* (n=56), *alcohol* (n=55), and *cocaine* (n=52). This reporting reflects the most commonly reported problematic substances, with the exception of heroin, which is reported in higher numbers for treatment experiences. This is likely due to the increased access to medically assisted treatment such as methadone.

substances that have been a challenge for those with issue (figure 30, n = 130)



primary substance addressed in substance use treatment (figure 31, n = 143)

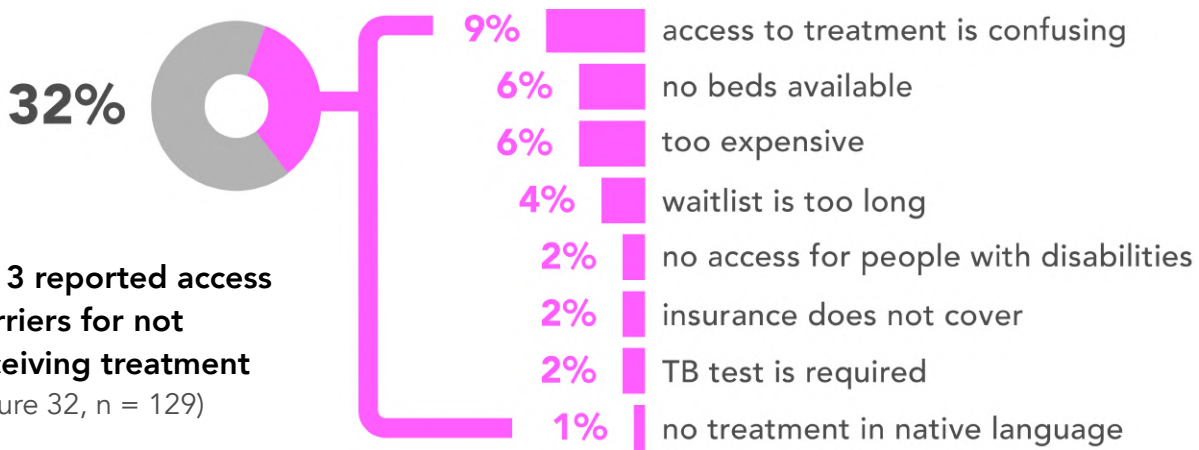


Treatment Access and Experiences

Of participants who have had a substance use challenge in the last five years (n=294), slightly more than half (n=144) of respondents reported receiving some type of substance use services in the past five years. Approximately one-third of participants were court-ordered to attend treatment, while most attended treatment voluntarily. The most frequent forms of treatment were residential treatment programs, followed by Alcoholics Anonymous or Narcotics Anonymous, detoxification programs, peer-support groups offered by non-profit or health organizations, harm reduction oriented peer-support groups, medication assisted treatment (e.g. methadone maintenance), and finally faith-based peer-support groups. Based on these responses, most participants are enrolled in programs that are abstinence-based.

Half of respondents with substance use challenges did *not* receive treatment in the past five years. When participants were asked the reasons they did not receive treatment, they provided a range of open-ended responses across four categories: 1) general, 2) treatment access, 3) treatment rules, 4) treatment staff and treatment clients*. Most commonly, 41% of participants reported not being ready for treatment, 34% reported not having a need, and 15% reported quitting substance use without treatment. This data indicates that a considerable subset of homeless people often have other unmet needs that take priority over seeking treatment, such as survival, getting nutritional needs met, finding a place to sleep, despite having self-reported challenges with substances. Issues with access to treatment was the second most commonly reported barrier. Participants indicated that access to treatment was confusing (9%), there were no beds available (6%), that the cost of treatment was too high (6%), and that the waitlist was too long (4%).

* It must be noted that the question had a response rate of 90%.



These responses indicate that substance use treatment programs can be confusing to navigate, particularly in the absence of resources that consolidate the wide array of different types of services. In the focus groups, participants described experiences that support the survey responses. For example, one focus group participant, a 20-year-old multi-racial man, informed us that he wasn't able to find treatment programs independently on the internet. Instead he found treatment through the hospital:

"When I was homeless, I was really looking online for like, 'where can I go for help?' And there wasn't anything online, there wasn't anything like that. You can't really ask Google, 'what can I do?' The only way I found [treatment] was by going to a hospital..."

Participants like the one above point to the lack of a clear pathway for how to access treatment. He also illustrates that people experiencing homelessness often reach the point of emergency or crisis before receiving care. When asked what gets in the way of getting treatment, another participant, a white man in his sixties indicated that complications with insurance and finances are a barrier:

"[Treatment programs] want to know if you have insurance. If you have health insurance or the ability to pay. Not everyone can qualify for disability and there's not enough free [treatment programs] out there."

The third most commonly reported barrier for not attending treatment was problems related to treatment program rules. Participants reported that the treatment curfews were too strict (4%), that the rules in general were too strict (4%), and that treatment programs required abstinence/sobriety (3%).

treatment rules that participants struggled with
(figure 33, n = 129)

Treatment curfews are too strict	4%
Rules in general are too strict	4%
Requires abstinence	3%
Partner/spouse not allowed	2%
Pet not allowed	2%
No medication assisted treatment	2%
Treatment stay is too short	1%
Treatment hours conflict with work schedule	1%
No place to store belongings while in treatment	1%

From the focus group interviews, some participants noted that it was particularly discouraging that many treatment programs prohibit cannabis use. Participants who used cannabis therapeutically found rules prohibiting cannabis to be a deterrent to treatment given the legal status of medical and recreational cannabis in California. For example, one participant, a 67-year-old African American, said:

"I don't wanna go [to detoxification program]. You have to stop smoking weed before you can just start detoxing off of [other] shit."

Another focus group participant, a 26-year-old Jewish woman, said:

"I think [treatment programs] should get more on page with California marijuana and the recognized health benefits. CBD is a lot better for me than methadone and I know what's best for my body. I can't do that in this program."

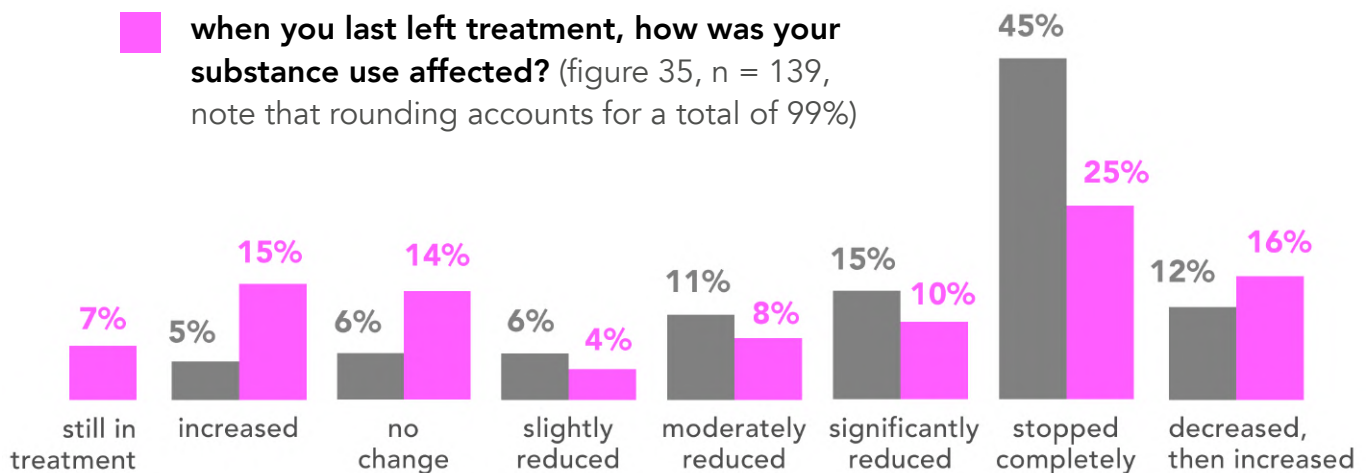


Effectiveness of Treatment

The majority of respondents indicated that substance use treatment was effective, particularly while they were enrolled in treatment. Eighty percent of participants reported that treatment helped to improve their substance use issues, either supporting them to totally (35%) or partially (45%) meet their recovery goals. While undergoing treatment, 45% of participants stopped using drugs and/or alcohol completely, and 26% significantly or moderately reduced their use. Treatment helped two-thirds of respondents address the underlying issues that led to substance use. Seventy-four percent of participants said the program helped them become more stable. Following treatment, 25% of respondents stated they stopped using completely, and in total, nearly half (47%) of respondents reported some reduction in use.

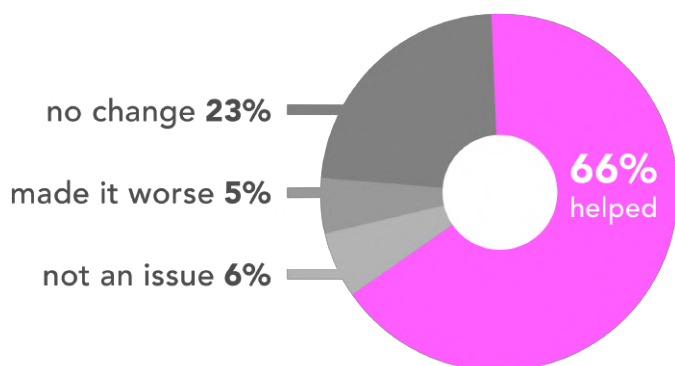
■ while in treatment, how was your substance use affected? (figure 34, n = 144)

■ when you last left treatment, how was your substance use affected? (figure 35, n = 139, note that rounding accounts for a total of 99%)

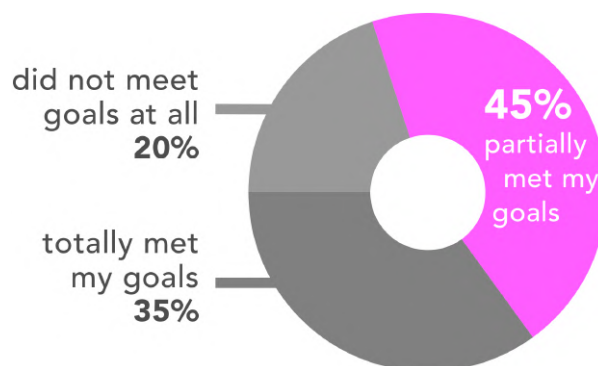


There were limitations to the effectiveness of treatment. Over half (51%) of respondents said the length of the program was appropriate, but 25% said the program was too short. Also, a majority of respondents (62%) indicated they left treatment programs early in the past. It is noteworthy that MediCal restricts clients to two 90-day stays in treatment per year. If clients leave treatment early, they have only one more opportunity to access treatment. The length of stay in a program is an important consideration because shorter retention in treatment programs has been linked to higher rates of post-treatment substance use and other negative outcomes.⁷

did the program help you address underlying issues that led to your substance use? (figure 36, n = 142)



how much did treatment help you meet your goals around drug use? (figure 37, n = 142)



Experiences in Substance Use Treatment

By and large, participants report positive experiences with treatment staff and the appropriateness of services. Participants reported that treatment programs offered age-appropriate services (89% strongly agree or agree), were accommodating of disabilities (85% strongly agree, agree, or not an issue), and respected gender and sexual identities (94% strongly agree, agree, or not an issue). The majority of participants felt that staff treated them positively (84% strongly agree or agree). Many participants in the focus groups told us about positive experiences with treatment counselors, staff, and other clients. For example, one participant, a 35-year-old Latina woman, told us that her treatment program was like “family”:

“When I came here I was like, ‘damn, I gotta do this program.’ But when I got here, I met the girls and the counselors and it’s like a family. They’re teaching me coping skills. You know it’s not gonna be perfect, I have my downfalls and stuff, and they tell me never to give up. We have a therapist here and it’s helpful cause she listens to us and gives us pointers. We share rooms, lots of us have roommates. It’s kinda become a family and I never thought it was gonna be like this. That’s why I’ve stayed here. There’s been times where I just wanna say ‘screw this, I’m leaving,’ but then I think of everything I can lose and it’s not worth it.”

⁷ Hubbard, R. L., Craddock, S. G., & Anderson, J. (2003). Overview of 5-year followup outcomes in the drug abuse treatment outcome studies (DATOS). *Journal of substance abuse treatment*, 25(3), 125-134.

Another participant, a 49-year-old white woman, was so impressed with her treatment program that following discharge that she stayed on as a volunteer:

"The people who run [the treatment program] are amazing in that they don't have bad attitudes. It doesn't matter if you've been there twice or 15 times, they don't say 'here again?' They try to help everybody... I was so impressed with my stay there - and I've been there more than once - that I took my time out and I went out there to volunteer and spent my spare time there."

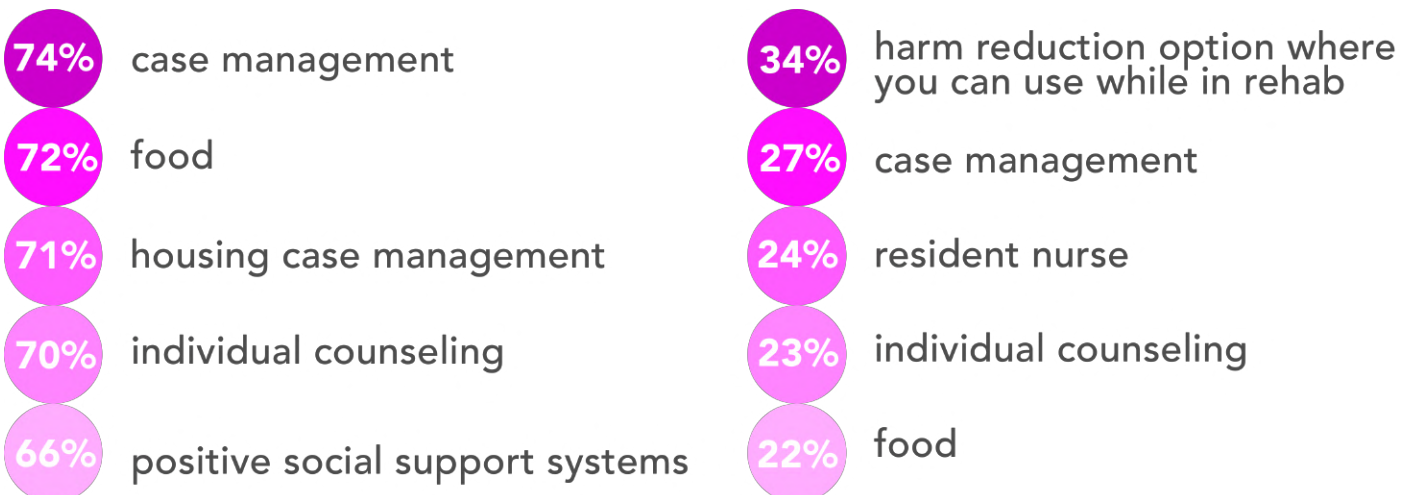
However, despite these positive experiences with staff, the majority of participants (62%) indicated they left treatment early at some point. The top reasons for leaving early were problems with treatment rules, finding better opportunities, conflicts with other clients, or because the program did not seem to work. A sizable portion (34%) of respondents indicated that the rules of treatment programs were too strict.

Participants strongly supported the need for individualized treatment services with managed care while in substance use treatment. When asked what services they would utilize if available in substance use treatment, case management was the number one selection out of dozens of potential options, an indicator of the need and demand for individualized, one-on-one support. The most popular services respondents felt needed to be improved were case management (74%), food (72%), housing case management (71%), and individual counseling (70%).

which of the following services would you utilize if they were made available within a substance use treatment program? (figure 38, n = 279)

most popular by how many times chosen

most often in people's top 4



Abstinence or Harm Reduction?

Many substance use treatment programs are based on either harm reduction or abstinence-only philosophies. Harm reduction in substance use treatment involves a *non*-abstinence-only approach that focuses on a range of personal goals and allows participants who are active users to obtain treatment. Harm reduction can include abstinence, but also includes approaches like methadone, resources like syringe-exchange or free condoms, as well as therapeutic approaches to group or individualized treatment where abstinence is not the only goal. The debate surrounding abstinence versus harm reduction approaches in treatment is ongoing in the broader substance use treatment community, as it is among the clients we surveyed. This is a challenging topic because clients in a given treatment program are in different stages in recovery, and have different needs and expectations. Some people may need to remain abstinent as a condition of parole, probation, or CPS, or may simply have abstinence as their personal goal. Others are unable to be abstinent or quit “cold turkey,” and in some cases it may be unsafe to do so. When asked which approach helps to retain in treatment, the outcome was nearly split with half (53%) of respondents indicating they would be more likely to remain in treatment if active use is permitted, and half (46%) indicating that abstinence-only is what works for them. About half (55%) of respondents said an abstinence requirement in treatment helped them compared to 27% who said it did not.



54%

About half of respondents indicated they would be more likely to remain in treatment if active use is permitted.



46%

The other half indicated that abstinence-only is what works for them

Although harm reduction involves a range of approaches, when participants were asked about their opinion about harm reduction, most talked about group therapeutic settings in which abstinence is not required to attend and participate. The focus group interviews helped us examine this issue further. One participant, a 59-year-old Native American man, when asked what barriers keep him from staying in treatment said that it was challenging to be in a treatment setting with people who were actively using substances:

“For me when I was in treatment, it was other people using. To see people using while you're doing well is a problem. I was doing my [recovery] work, but people near me were using and getting caught and then coming back [to treatment].”

“When I went to a 12-step program I read the big book of AA and realized I'm a drunk and there's no minimizing. I didn't hear about harm reduction until I came to SF. Everything [before] was always based in abstinence. For myself there is no little bit, or reduction - it has to be abstinence. Although I failed a couple times I'm gonna keep trying till [abstinence] happens cause my mental health is at stake, my health is at stake. Using substances really puts me into psychosis and drug-induced paranoia. It's not a fun way to live, or for those around me, so the aim of my game is complete abstinence.”

Another participant, a 34-year-old white man, informed us that he had not heard of harm reduction until he came to SF, but he is convinced that abstinence is the only approach that works for him.

Another participant, a multi-racial man in his early fifties, explained that a little bit of substance use leads to further substance use, a destructive cycle that leads him to become non-adherent to life-saving medications. He needs abstinence-only programming to help him avoid that cycle:

"I've been trying to use [substances] successfully for years and I've been unsuccessful. The consequences are getting worse and it's starting to affect my health. If I started using alcohol ... alcohol always leads me back to methamphetamine use. And if I use methamphetamine, it's definitely affected my health. I was on dialysis twice. I got second-degree burns from an unexpected accident. I stopped taking my HIV meds because I was too busy using and I was out of it. It's self destructive so for me the only answer is abstinence. It took getting burned for me to figure that out."

"Mine [treatment] recently has been AA meetings and focus groups because I've begun to take notes and I write down things which resonate with me, especially what I need to work on as an individual to stay abstinent from using. I like meetings and peer support- holding each other accountable. But abstinence alone doesn't seem to help. I say no and then 30 minutes later I'm using."

On the other hand, many participants indicated that harm reduction was an important component in their recovery process. One focus group participant, a 33-year-old Native American man, indicated that although he learns skills from abstinence-based treatment, abstinence-only hinders his recovery goals.

Treatment and Housing

While some participants were enrolled in treatment that involved housing such as residential treatment (32%), the majority were unhoused while undergoing treatment, either living outside (34%), in the shelters (16%), or other temporary arrangements (13%)*. The vast majority (88%) of respondents said having stable housing after treatment is important, and that they consider treatment to be pointless without housing. Coupled with data on participants' housing situation following discharge from treatment, with almost half (46%) being exclusively outside and only 11% in stable housing, this data shows that many unhoused people have nowhere to go during and after treatment. Most people return back to the streets.

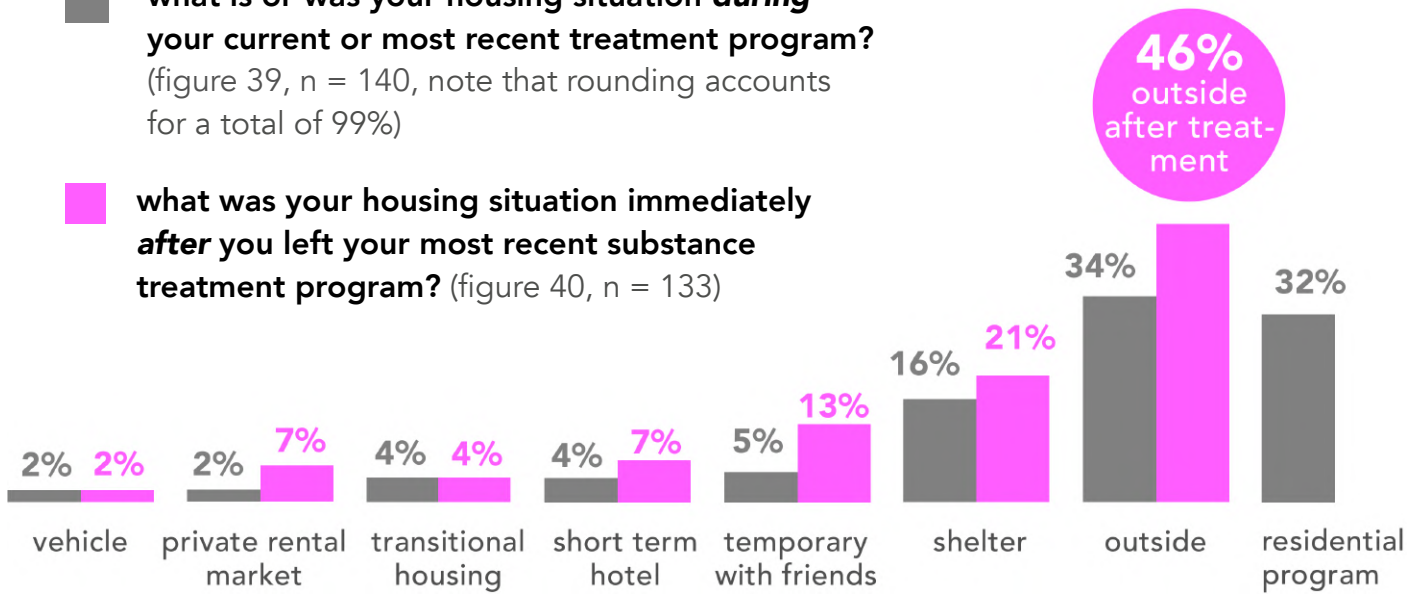
One man, who has been homeless for six years, described the relief he experienced coming off the streets and into residential substance use treatment during one of the focus groups:

"I was happy to be inside a place with food to eat, a shower, clean clothing and sheets. I was tired of running around and being asked to leave. If I was sitting in a certain spot for too long, you know, 'you gotta go.' I was worn out from using. It's more than a full-time job being homeless. Trying to find where you're going to sleep and in my case using to cope with all of that. The nightmare was over. At least temporarily."

* It must be noted that the question had a response rate of 89%.

■ **what is or was your housing situation *during* your current or most recent treatment program?**
 (figure 39, n = 140, note that rounding accounts for a total of 99%)

■ **what was your housing situation immediately *after* you left your most recent substance treatment program?** (figure 40, n = 133)



This participant, like many others experiencing homelessness who enter treatment, was released back onto the streets or to other insecure and temporary living arrangements. Nearing the end of his treatment, he stated:

"I'm leaving here next Saturday and I don't know where I'm going. That's kind of a big stressor. I have a place I could go but it's not a healthy environment and that's an easy relapse for me. That's my biggest thing I worry about leaving here. Having that stress of trying to complete everything you have going. That weight on your shoulders."

Lack of housing seriously affects readiness for treatment. When participants respond with not being ready for treatment or not needing treatment, a major barrier is not having stable, secure, safe housing.



POLICY RECOMMENDATIONS

Permanent Supportive Housing, Rental Subsidies, Step Down Housing after Treatment

- Respondents reported how important stability in housing post treatment was to their recovery. The city has recently invested in step down housing, which has been successful in improving outcomes. There should be fluid access to housing directly from treatment programs (i.e. the treatment coordinates transition into housing) to promote long term success. Housing should be offered at a range of levels of care, as the needs of homeless people with substance use issues can vary from needing more intensive support in housing for more acute participants, to independent living that only requires economic assistance to afford rent.

Individualized Support Through Intensive Case Management

- People who are homeless have expressed demand for individualized support to meet recovery goals. Due to the complex nature of substance use disorders and its links to trauma, mental health, racism, homophobia, lack of housing, and isolation, one-on-one support through models like Intensive Case Management is needed. As part of the ICM expansion recommended in the mental health section, this expansion should include competitive wages for case managers and meeting national caseload standards, which is a client load of no more than 15 cases.

System That Accommodates Across Client Range of Readiness

- People who are homeless represent a wide range of variability in intervention needs. Many people who are homeless indicate they are not ready for substance use treatment, but these individuals may still benefit from increased stability, outreach and resources. Expanding and intensifying street-based outreach utilizing harm reduction strategies may be a way to promote safety while people are actively using. Providing clean syringes, naloxone, safety/hygiene kits, street-based counseling, and disseminating safer use education can equip people who are not ready for treatment with the tools and knowledge to use more safely. These efforts should be carried out in tandem with offers of shelter, residential treatment, and housing options and other means to stabilize an unhoused person.
- In a treatment setting, substance use programs need to accommodate across the range of readiness among clients. Rather than a dyad of abstinence-only or harm reduction, therapeutic group settings can investigate how to integrate aspects of both models into treatment, targeting the specific goals and needs of individual clients. Treatment programs also need additional support from the city to address licensing and MediCal regulations that currently require abstinence.

Evidence-Based Treatment Protocols Related to Cannabis

- Cannabis use is legal in California and the therapeutic uses of cannabis for a wide range of health issues is well documented. However most treatment programs, especially abstinence-based programs, do not permit the use of cannabis (while nicotine use is typically permitted). This is a deterrent for people accessing and remaining in treatment, particularly if clients are using cannabis medically to manage health issues. Evidence-based protocols for the use of cannabis in different types of treatment settings is needed.

Expand Naloxone Kits and Refills

- Homelessness is a major risk factor for opioid overdose. Yet, most homeless people do not carry naloxone. The number is low even among people who report having issues with opioids. Expanded naloxone training and distribution, along with a simple process for obtaining refills, is needed for people who are homeless.
- Moreover, naloxone training and availability needs to be expanded among staff at specific sites and organizations that serve homeless people. This is important because naloxone cannot be administered to oneself - naloxone must be available to a person witnessing an overdose to administer it. Homeless encampments, navigation centers, shelters, permanent supportive housing, homeless service organizations, and jail (inside and at discharge) systems are potential sites where naloxone can be made available to homeless people and staff. For sites where homeless people have privacy, such as in supportive housing, additional efforts must be taken to avoid fatal overdoses of those alone in their rooms. This can be developing a buddy system, a request for call back from the front desk within a short period of time, and ability to request safety checks.

Comprehensive and Accessible Real Time Inventory Database

- Many homeless people are unable to know what treatments are available, and how a particular treatment program might fit into their individual recovery needs. In fact, no one knows — the city does not have a single source for information on available beds. The City needs to develop a comprehensive and accessible real time inventory database of existing substance use treatment program slots, eligibility criteria, and availability, in order to reduce the confusion and frustration of navigating a complex treatment system. This database should be available online, accessible to service providers, and the general population.

Flexible Duration of Treatment

- Many substance use treatment programs operate on a set timeframes (e.g. four weeks, 12 weeks) based on a variety of factors such as capacity, insurance reimbursements, and the needs of the client. However, substance use issues are often chronic and ongoing. There is a need for treatment options that are flexible in duration to meet the ongoing needs of homeless people who use substances — for many programs that means offering longer stays. Longer stays are often not reimbursable by MediCal, so there needs to be general funds available for this, as well as changes in MediCal regulations.

Expand Dual-diagnosis Services

- Of those who currently have or have had a substance use challenge in the last five years, one-quarter (25.7%) report mental health issues as well. It is widely recognized that for many, substance use is a condition of mental health issues. People suffering from a mental health issue (e.g. bipolar disorder) may self-medicate with stimulants or tranquilizers, and thus develop a substance use disorder. This can be particularly problematic for people who are homeless, who may not have access to medical care to manage their mental health issues. However, despite many efforts, few programs are truly dual diagnosis — leaning instead in one direction or the other. Our recommendation is for treatment programs to investigate and apply best practices for addressing mental health, along with substance use, for people undergoing treatment in residential and community settings.

Expanded, Improved Approaches Targeting Stimulant Issues are Needed

- Methamphetamine can be a problematic substance for homeless people in San Francisco and is often used as a survival strategy. However, many treatment programs do not offer specific programming for stimulant use disorders. In general, there are limited effective treatment options available for methamphetamine use. There is a need for improved approaches for managing methamphetamine use specifically, such as the methamphetamine drop in center that is currently being developed. Any approach must recognize that much of the issues associated with use are the result of a system that has failed to care for disenfranchised community members with dignity.

Fluidity Between Permanent Supportive Housing and Residential Treatment

- People living in permanent supportive housing may face periods when they need more intensive substance use services. Permanent supportive housing systems should allow residents to enter intensive residential treatment without a risk of losing their housing. This would require subsidies to cover rent while they are away in some situations, and flexibility in the Department of Housing and Urban Development (HUD) and local regulations.

Trauma-informed Care as Standard Practice in Substance Use Services

- Trauma and mental health are deeply linked to substance use. These include childhood sexual and physical traumas to traumas endured while homeless as well as a variety of diagnosed and undiagnosed mental health challenges. Trauma-informed care must be an integral, standard practice in substance use programs. We recommend that the city adopt trauma-informed care as a standard practice throughout the treatment system, and augment resources to existing programs to ensure these challenges are addressed.

Expand Substance Use Services in Current Drop In Centers

- Many homeless people find that they only get care when they are in crisis, such as at Psychiatric Emergency Services. Even then, it is for a short period of time and they find themselves back out on the streets. It is important that there are peer-based and professional substance use services that meet people where they are at and that are easily accessible, prior to crisis scenarios. Utilizing some current drop in spaces for this purpose is a way to connect with people consistently while maintaining easy access. We recommend the city ensure current drop-in services have robust substance use services as part of their regular operations.
- Additionally, Drug Adulterant Testing Services should be expanded at current substance use treatment programs, which allow people to accurately identify the drugs they intend on using. This could prove life-saving information to those who currently have substance use challenges.

Expand Medical Detox and Medically Supported Detox Beds

- Both medical detox and medically-supported detox beds have been in high demand since most of them were lost during the Great Recession. There have been expansions of the number of these beds, but they are still nowhere near meeting the need, in particular for women. This is a key component of having treatment available on demand.

Expand Peer Based Support Services

- Training and paying peers (people who are homeless who are working to manage substance use or are in recovery) to provide street based support and assistance navigating the substance use system is a way to both create jobs, engender trust, and inspire hope among the unhoused community who identify as having substance use challenges. We recommend expanding existing peer programs and creating new programs to serve underserved communities.

Fully Implement Treatment on Demand

- Voters passed Proposition T for Treatment on Demand in San Francisco in 2008, but this ideal has never been met. Record keeping has been problematic (e.g. no tracking waitlists) thus there is no way to know what the pent up demand actually is. It is vital to have real time inventory, track turn-aways, and expand capacity based on that unmet need. Given the nature of substance use disorders, it is crucial that we not only reach out to drug users with something to offer, but that when drug users reach out for help that they receive it immediately.

Enact the Getting Home Safe Act

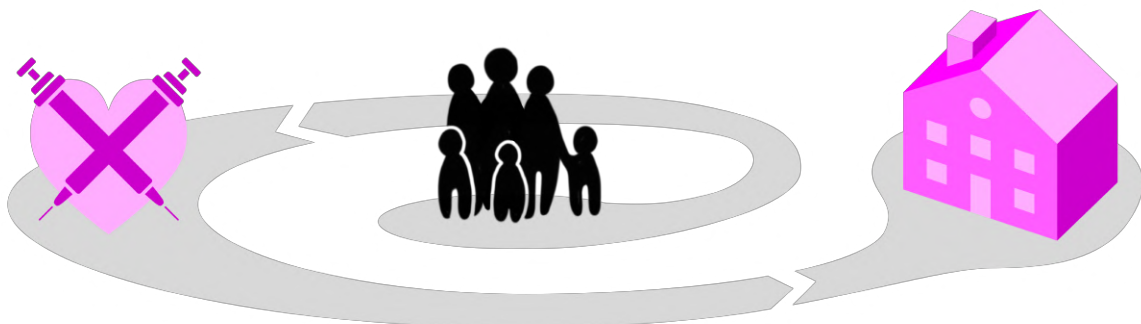
- Allowing Sheriffs to discharge inmates during the daytime would ensure releases during safer hours, and times of the day when transportation and support services are available. Additionally, when people with substance use challenges become incarcerated, many times their tolerance lessens, which increases the risk of overdose when using again. Flexibility on release would positively influence the health of those who use substances.

Open Safe Consumption Spaces

- Safe consumption sites prevent overdoses and transmission of disease, while allowing for connection with health care. These sites improve health and treatment outcomes and demonstrate effective engagement of drug users in services. These should both be stand alone programs and set up in existing shelters and housing programs.

Decriminalize Paraphernalia

- Expand the Health and Safety Code to allow for all additional forms of paraphernalia available through the California Syringe Exchange Supply Clearinghouse to be decriminalized.



MENTAL HEALTH

Mental health issues are forefront on the minds of many San Franciscans - whether it is through reading about the crisis in the media, witnessing the effects of untreated mental health issues on unhoused neighbors, or having experienced it yourself - no one can deny the existence of the problem. Study participants' experience with the mental health system is a focus of this report. We found that few who need services are getting the care they deserve, facing capacity, bureaucratic or cultural barriers. We also found that the lack of dual diagnosis care, alongside lack of placement in stable housing post treatment presented barriers to individuals ability to successfully care for their mental health. Too often, individuals first experience with care is through emergency care, such as Psychiatric Emergency Services, rather than in a community setting.

EXECUTIVE SUMMARY

○ Few homeless San Franciscans receive care, despite demand.

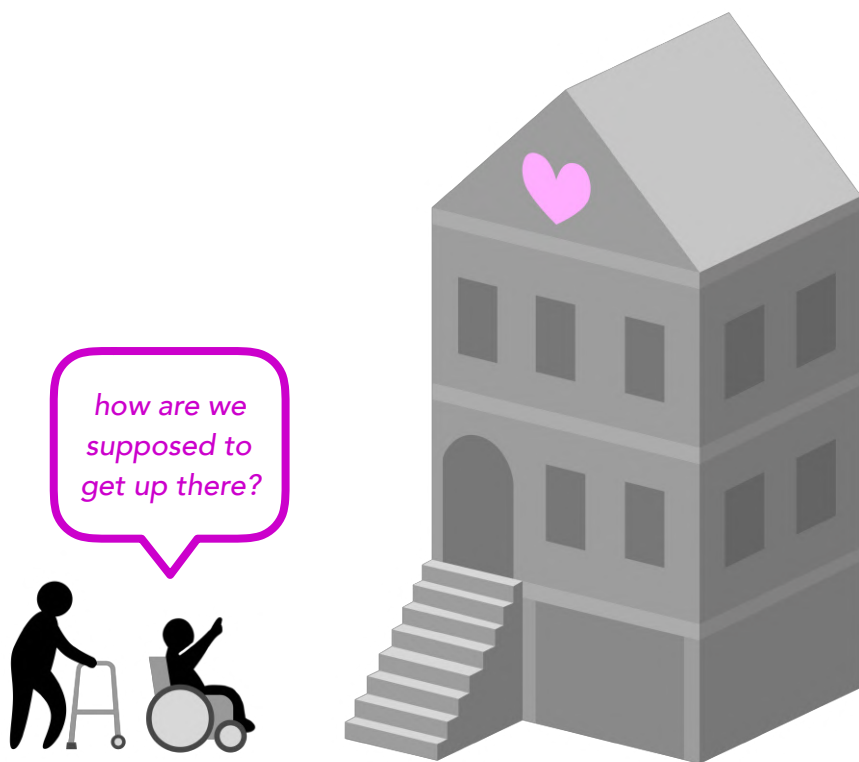
Of the participants who responded to the mental health section, 40% have not received treatment in the last five years. While this means a majority of respondents in this section have received treatment, there are still gaps in effective management of mental illness. Notably, of those who have received treatment, 60% reported experiencing a mental health crisis in the past five years in San Francisco. When asked how frequently they were linked to care following crisis, 21% were only sometimes able to get the care they needed, while 14% rarely got care, and 10% never got the care they needed. When respondents did report engaging in care- be that outpatient, peer support or residential- they noted that they significantly benefited from treatment and were generally satisfied with the services they received.

○ There are significant barriers to accessing mental health services.

Overwhelmingly, participants described finding the process for learning about and accessing services to be confusing and difficult. Barriers related to access include lack of or problems with transportation, not knowing where to go, issues with insurance, and cost of treatment. More than half (52%) of all respondents when asked why they haven't had mental health treatment yet reported issues with access.

○ Substance use treatment is necessary for effective mental health care.

Sixty percent of participants who reported having mental health challenges asserted that substance use treatment would be necessary for mental health care to be effective for them while an additional 11% were unsure. Despite the need for and potential utility of incorporating substance use treatment into mental health services, participants who reported actively using drugs described feeling unwelcome when attempting to obtain mental health services. One frequently cited example, of being searched and threatened with expulsion from residential treatment if caught using substances, were commonly mentioned barriers to accessing mental health and other services for people who were actively using substances



1 / 3 of those who reported having a physical disability thought the program was not accommodating. This is a real challenge here in SF as many residential treatment sites are in older Victorian buildings that are not accessible for people with ambulatory challenges. Modification to include elevators is expensive and unfunded.

Culturally inappropriate or insensitive care proves a barrier to treatment.

Another barrier identified during the focus groups was receiving culturally insensitive or inappropriate care. It is critical for all staff to be trained and become competent in matters relating to class differences as a part of ongoing diversity training to ensure sensitive care. This issue was particularly salient for non-English speakers and individuals who identified as LGBTQ. Additionally, those who were older than 40 years of age were less likely to view their mental health program as age appropriate, suggesting necessary reform in programming for older adults.

Stable housing after treatment is critical to stabilizing mental health.

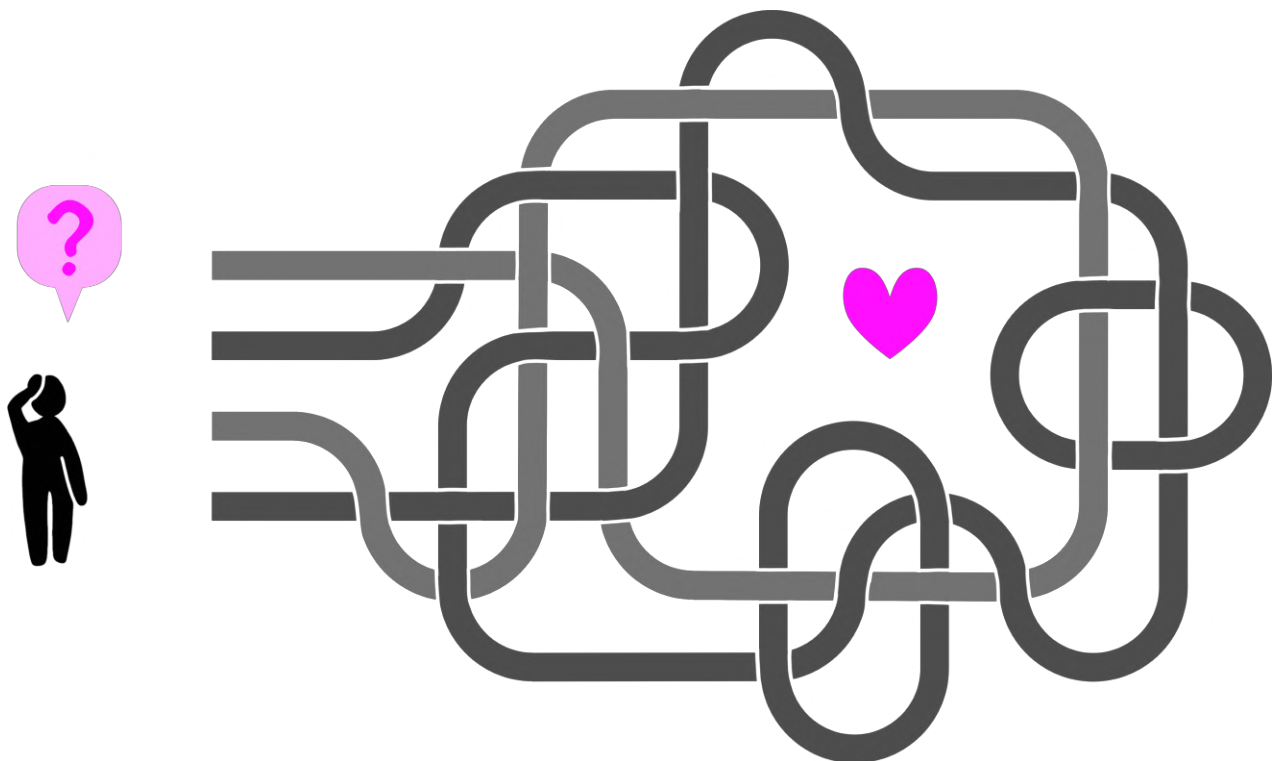
Our findings indicate the effectiveness of mental health care treatment depends on reducing the significant distress related to housing instability. Respondents who either received mental health services in the past five years or who were in need of them were asked about the relative importance of stable housing after treatment. Of the 284 respondents, the vast majority (92%) indicated stable housing after treatment would be “very important” for treatment to be successful, and without housing, treatment would be rendered pointless. Unfortunately, over half (63%) of these same respondents reported that they were homeless outside or in a shelter the last time they left a treatment program and only 9% were in some kind of stable housing (transitional, permanent supportive, or private housing). A lack of stable housing also meant that many respondents had to continuously prioritize finding safe places to sleep, eat and care for themselves, thus impeding their ability to seek out and engage in treatment.

BACKGROUND

The San Francisco Mental Health system is operated by the Department of Public Health (DPH). Outpatient care is provided through the Community Behavioral Health Services Division, or CBHS. In-patient and emergency care is provided through the Ambulatory Care Division, which includes the Psychiatric Emergency Service and in-patient hospitalization units. CBHS operations are divided into two main branches, ones operated, staffed and accountable to the Department by contractors and San Francisco's own Civil Service staffed and operated clinics, known generally as the ISC's, or Independent Service Centers.

Routes to Care

There are several routes to care for people who are homeless and experiencing mental health challenges. In general, these fall into a) the emergency system of care, for people who present in crisis and b) intake through the CBHS system, which includes a 24 hour behavioral health hotline. Individuals who present with urgent or emergent mental health needs may receive referrals and placement to treatment as part of their crisis resolution process. For individuals with lower acuity, the Behavioral Health Access Center forms the backbone of the triage and referral structure in San Francisco. Individuals seeking assistance can go to the B.H.A.C. and receive evaluation and in some cases transitional case management and supportive counseling while seeking care. Intake at the contractor level of care is typically an authorized and utilization reviewed process from central intake, although some contractors maintain their own intake, evaluation, and triage systems, such as HealthRight 360, and the Tenderloin Outpatient Clinic. This can lead to confusion on the part of the consumer, who may have a difficult time identifying and understanding the pathway to care they should follow.



Behavioral Health Care

Independent Service Centers provide a range of support in the behavioral health realm for people experiencing mental illness. Generally this includes case management, supportive psychotherapy, and psychiatric evaluation and medication management. Different ISC's may have specific population or service focus. Mission Mental Health is the culturally appropriate service site for Latinx populations, but also offers specific services for African-Americans with mental illness and incarceration history, for example. There are also specialty clinics serving sub-populations, such as the Adult Behavioral Health service clinic at 755 South Van Ness, which provides culturally relevant support for LGBTQ+ populations. In order to obtain care at the clinic or ISC level, a person must have the appropriate insurance (or none), and have a treatable and discoverable diagnosis. In general, a multi-visit, multi-assessment protocol is used to ensure medical necessity criteria are met for homeless people experiencing mental health challenges. Wait lists are common. Only a few of the professionals at each ISC are able to meet with clients in the community, escort them to appointments or provide outreach case management support, a much needed service. Individuals receiving intensive case management services at the ISC level have to qualify and be referred to specialty programs as high users and typically have experienced multiple emergency psychiatric hospitalizations. Individuals seeking case management, psychiatric support and supportive counseling may present themselves during intake hours and receive assessment and evaluation for ongoing care at an ISC. At times individuals are discharged from psychiatric hospitalization with referral and appointment to an ISC.

Contractor Provided Support

The second source of care and support for homeless people experiencing mental illness originates from non-profit agencies contracted to DPH. Some of them provide the same range of services as an ISC, psychiatry, case management, and supportive counseling. Access to these services is almost exclusively by referral from a central evaluation and referral unit of the Department. As noted below, there are substantial wait lists for these services. Given that a homeless person may have difficulty remaining in contact with the central allocation unit, many people who are referred may not be advised of an open case management slot and be bypassed, usually classed as lost to follow up. Other contracted non-profit entities may provide population specific care, such as the START (Shelter Treatment and Access to Resources Team) operating in the shelters, Progress Foundation, which supports residential care in Acute Diversion Units, as well as the Dore Urgent Care Clinic and Westside Community Services, which provides acute and urgent care psychiatric support. Except for START, operating in the shelters, no specific agency or treatment team in the non-profit arena provides contracted services exclusively for homeless people with dedicated cultural competency in the community of poverty, although many of the clients of these agencies and programs are without housing.

Urgent Care

Urgent care is defined as critically needed care, either medical or social without present risk to life safety. San Francisco has several urgent-to-emergent care management teams and sites. Westside Crisis, Dore Urgent Care, and support from the B.H.A.C, as well as Comprehensive Community Crisis Services, a part of C.B.H.S., comprise the major components of the urgent care system. They are not intended to provide long term case management support for homeless people, but rather care that assists people in crisis to manage through the crisis and obtain the care they need once the crisis is resolved. All of them have the capacity to place a person in crisis on an involuntary 72-hour hold, sometimes referred to as a 5150. Individuals who present with urgent needs for psychiatric support, evaluation and medical treatment, may go to Westside Crisis and receive same-day service, intended as bridge care with a maximum of three refills of medication and are then typically referred to an ISC.

Summary

San Francisco's mental health support system is frequently referred to as a 'rich' system, rich with resources and capacities, and this is true in comparison to many municipalities. However, it does not come anywhere close to meeting the need for homeless people with mental illness and substance use challenges. The scarcest, yet most needed care is intensive case management and A.C.T. or Assertive Case Management. The behavioral health system of care has not been able to manage the placement and residential care needs of homeless people with presenting mental health and substance use challenges. As a result, it has focused on providing medical-model treatment versus access to stabilizing housing resources due to the lack of dedicated housing units for individuals experiencing homelessness and mental illness.

The San Francisco Behavioral Health system is overwhelmed with people seeking care and over long periods of time, essential services such as day treatment, clubhouse model care,¹ and residential care provision has ended, leading to large gaps in services needed to serve the population most at risk. The access to mental health treatment in San Francisco is through multiple, independent routes. As with a managed care organization, it is generally thought that multiple routes to care, while confusing, may provide greater access than a single, tightly administered point of access system.

FINDINGS

Participants were asked two questions to determine if they would answer the mental health section: if they received mental health treatment in the last five years in San Francisco or if they considered themselves to have a mental health issue that could benefit from treatment. Of the 573 who responded, 31% had gone through treatment for mental health in the last five years. If they had not received treatment, they were asked if they considered themselves to have a mental health issue. Nearly a quarter (22%) of respondents who had not received services in the past five years in San Francisco responded that they had a mental health issue that could benefit from treatment, as well as 7% who were 'unsure'. Those who responded yes to either question (and who responded unsure to the latter) completed the mental health section, totaling to 295 individuals of the 584 participants, or 50% of the sample.

Prevalence of Mental Illness

People experiencing homelessness are more likely to experience mental illness and some estimates state 45% of homeless people have a mental illness, rates we found to be similar in our own study.² The lack of affordable housing, especially in large metropolitan areas with already high costs of living, as well as reduced community services available in the community are contributing to increased homelessness among the mentally ill.³ In addition, funding allocations for public health needs have continued to diminish since state and local governments implemented budget cuts during the recession.⁴ Lastly, the very trauma of experiencing homelessness has a negative effect on one's mental health.

¹ Clubhouse care refers to a community mental health service model of day time care, typically for individuals with serious and persistent mental illness presented as a club for members. People come to a treatment site, or clubhouse, to typically have lunch, treatment as needed, groups and the opportunity to meet with providers.

² Mental Illness Policy, & Fuller Torrey, E. (n.d.). 175,000 Homeless Mentally Ill.

³ Fazel, Seena, et al., 2008, "The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis." *PLoS Medicine*, vol. 5, no. 12, doi:10.1371/journal.pmed.0050225.

⁴ Johnson, N., Oliff, P., & Williams, E. (2017, October 11). An Update on State Budget Cuts. Retrieved from <https://www.cbpp.org/research/an-update-on-state-budget-cuts>

It comes as no surprise to San Franciscans that we have a mental health crisis among housed and unhoused residents. The Department of Public Health recently identified 4,000 homeless people who have co-occurring serious mental health and substance use issues who are in need of care.⁵ They have prioritized 300 individuals who have the most severe symptoms and challenges for care, although they have not identified funding sources or bed capacity to serve them. In practice, this means they go on top of an already full list of people who need complex care. In San Francisco, the city spends over \$340 million for behavioral health services for over 30,000 clients served by 300 programs. It comes nowhere near meeting the need. Co-Occurring substance use and mental health residential treatment, beds for those released from PES, (and jail) intensive case management, and accessible peer based support have all been identified as shortfalls in the system in varying reports and audits.

For a system of care to promote mental health and well being it must recognize and understand the causes of human distress in the real world. These social obstacles include childhood trauma, poverty and social inequity. These societal realities need to be accepted alongside the experiences of people in human distress.

INTERSECTIONS OF OPPRESSION

Running away as a child or teen:
 42% of all survey participants experienced this. **61%** of all trans participants experienced this.

INTERSECTIONS OF OPPRESSION

Sudden death of a family member that affected your housing:
 Nearly 1 in 3 (30%) participants said yes to this experience. 38% of African Americans said yes to this experience, as well as 45% of Trans folks. 58% of trans African Americans, 55% of African Immigrant men, 40% of Latinx trans folks, and **67%** of Multiracial trans folks had this experience as well.

INTERSECTIONS OF OPPRESSION

Abuse that made your home unsafe as a child:
 Nearly 1 in 3 (32%) participants said yes to this experience. 40% of cis women and 58% of trans participants said yes. 80% of trans Latinx participants had this experience. **80%** of Multiracial Trans people had this experience.

INTERSECTIONS OF OPPRESSION

Nearly **1 / 3** (30%) of those ages 41-50 disagreed that their mental health program was age appropriate compared to 8% of those aged 25-30.

INTERSECTIONS OF OPPRESSION

1 / 5 trans participants did not think their mental health program affirmed their gender identity.

⁵ Fracassa, D., & Thadani, T. (2019, September 4). "SF counts 4,000 homeless, addicted and mentally ill, but timeline for help still unclear." Retrieved from <https://www.sfchronicle.com/bayarea/article/SF-counts-4-000-homeless-addicted-and-mentally-14412061.php#photo-18203101>

Homeless respondents that had mental health challenges reported many common mental health conditions, including anxiety (61%) and depression (72%). More than half of respondents with mental health challenges described having worked on issues related to trauma (49%). Despite a 3% prevalence of psychotic disorders in the general population, nearly 8% of homeless survey respondents endorsed psychotic symptoms (e.g., hearing voices).⁶ A comparable number (27%) described working on relationship issues or suicidal thoughts/behaviors (21%) with a mental health care provider in the past.

Accessing Treatment

For participants who saw themselves as benefiting from treatment but not currently receiving treatment, they were asked to rank their top reasons for not entering treatment. Participants reported that the primary reasons for not accessing care involved issues with access. Specifically, being unsure about where to go or who to see, confusion around making an appointment, no appointments available, issues with insurance, care being too costly, or not being able to access care due to problems with transportation, childcare, or scheduling were identified by 60% of respondents. A quarter of respondents indicated they were “not ready”, which appeared to be an issue of higher priorities such as seeking a place to sleep. Among those who have attempted to seek out mental health support, long waitlists and a lack of transparency about the resources available were a source of frustration for many focus group participants. One young mother stated that she has been desperately seeking therapy to help her cope with the stress of raising her children without a stable home:

"[the mental health system is]... really backed up right now. I'm on the waitlist for mental health services in [community provider] and they have a long waitlist. I also went somewhere else to get help and they all have waitlists. I'm just trying to get in somewhere."

Another participant said:

"Word of mouth is sometimes how we find out about things. Nothing is ever posted or advertised."

"When I first tried to get help I went to SF General, and at this time- I stayed on the 6th floor- in the mental ward- a total of 2 weeks and then they released me back into the public. So that was my first entry of help."

Unfortunately, the inability to access services until their mental health had reached crisis level was a common theme amongst our mental health focus group respondents, resulting in unnecessarily traumatizing, costly, and preventable hospitalization. Many stated that they had found it very difficult to know where to begin to seek out help in the first place. According to an African-American woman in her fifties, she didn't get access to help until she was admitted to the hospital.

⁶ Perälä J, Suvisaari J, Saarni SI, et al. Lifetime Prevalence of Psychotic and Bipolar I Disorders in a General Population. *Arch Gen Psychiatry*. 2007;64(1):19–28. doi:10.1001/archpsyc.64.1.19.

Experience with the Mental Health System

"My own experience taught me a lesson, if you're by yourself on the streets you trust nobody. Not supposed to trust nobody, not even family. Ever since I moved to SF and I found [the] drop-in, it changed me. "I need help", I said to myself. I'm done going through all this struggle. Nobody should be going through this. My counselors have been very respectful, I never expected to be called by my first name. I feel like I'm actually a part of something."

—20 year old Latino man who first found himself without a home at age 17.

Of those who've received treatment, 53% of respondents reported that they had received medication management services whereas 81% had received individual therapy and 33% had received group therapy. Twenty-eight percent (28%) of the same group reported that they had worked with a peer who identified as being in recovery from substance use or other mental health issue, which was the same proportion of respondents (28%) who indicated they had received residential treatment for a mental health issue. When individuals received treatment they mostly had positive outcomes. Regarding their perceptions of psychiatric stability following treatment, 62% of respondents reported feeling more stable after treatment, whereas 28% described no change and 10% indicated diminished psychiatric stability post-treatment.

When survey respondents were able to access treatment, it appeared that they were able to work on underlying issues related to mental health issues (e.g., traumatic experiences in childhood, depressive symptoms that exacerbate substance use). One participant stated:

"I depend on those programs for my life. For real. My case manager helps, I always talk to them. The day treatment centers, you have to be involved in the groups. I want to help myself, so I participate."

Findings from the needs assessment survey indicated mental health programs helped 53% of respondents address underlying issues. Another focus group participant, a 20 year old Latino man, explained:

"Substance use is something I talk about with my counselors. I feel like I'm not by myself anymore, I have my girlfriend and counselor and psychiatrist, and this whole room. Mental health provided me with a lot of resources, and they're about to give me my own house. I am seeking medication for aggression, but it's not for substances."

Efficacy of Mental Health Services

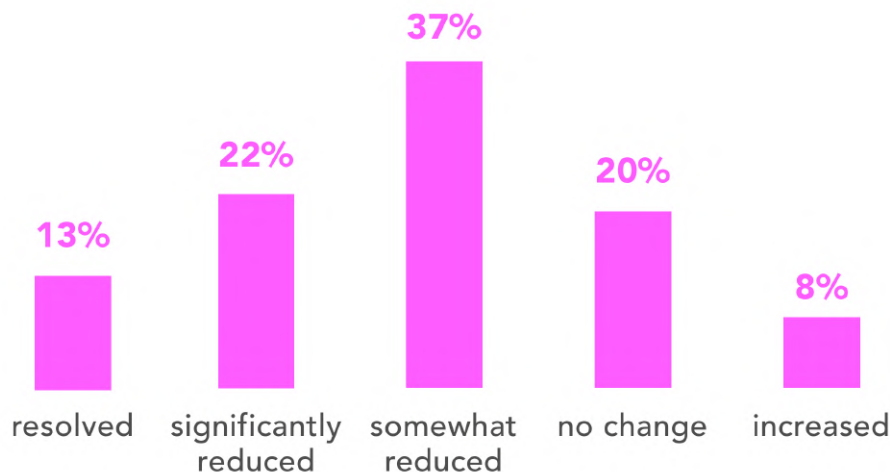
When persons experiencing homelessness were able to receive mental health care, the majority reported improvement in symptoms, ranging from total remission (13%) or significant (22%), moderate (17%) or slight improvement (20%) in symptoms. However, when asked about symptoms when treatment was complete, 11% indicated their symptoms increased and 10% said their symptoms reduced for some time, but then returned.

When conducting the focus groups, the most positive feedback by far stemmed from participants who had successfully managed to enter care, go through the process of the Acute Diversion Unit (ADU) to a Residential Treatment Facility (RTF) and into long-term housing or other permanently affordable living situation with treatment available as needed.

The respondents who were able to successfully engage in San Francisco's mental healthcare system expressed relief, gratitude, and a strong commitment to maintaining their mental well-being as well as helping others do the same. One focus group participant, a 52 year old African-American man said:

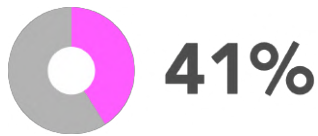
"In the ADU I felt really comfortable... the way that people treated me, they made me forget about my distress, and they encouraged me, and helped me find a house.. So they helped me. I didn't have a bad time there. Things got much better for me once I got established in the co-op. I started going to the Day Treatment Center and using the support groups; it helps me clear my mind. I still find that after 5 years that I function better, using support groups to do something for my mental attitude."

if currently in treatment, how has your mental health been affected?
(figure 41, n = 166)



Treatment and Housing

Unfortunately, most participants are not connected to housing through mental health treatment. When asked where participants went after residential treatment, more than a third (34%) were staying outside and nearly another third (29%) were in shelter. Only 9% of participants found themselves in housing (transitional, permanent supportive, or through the private market) after residential mental health treatment.



Of those who responded that their mental health symptoms returned or increased after treatment, 41% were homeless outside or in a shelter, indicating lack of stable housing as a barrier in maintaining treatment goals.

One focus group participant, a 65 year old white man shares his anxiety about exiting care back onto the streets:

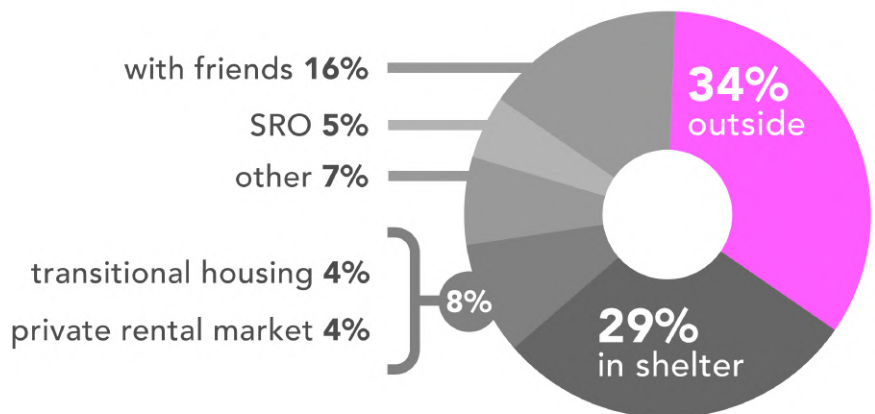
"When I was in the hospital, I didn't know what was going to happen. I had no idea. People were coming and going but I was still staying there. I didn't know if I was gonna go back out on the street or where I would end up- it's just scary cause you don't know what's going to happen to you."

Parallel findings in the Budget and Legislative Office Audit of San Francisco Behavioral Health services that found that of 4,666 homeless visitors to Psychiatric Emergency Services, 1,786 or almost 40% were released back to the streets without even a referral in FY 17-18⁷.

Finally, all persons who completed this section of the survey were asked about the relative importance of stable housing after treatment. Of the 284 persons who provided a response to this question, 92% indicated stable housing after treatment would be "very important" for treatment to be successful. Unfortunately, 84% of respondents reported that they were homeless outside or otherwise precariously housed the last time they left a treatment program. Even people who were formerly homeless but are in co-op housing shared similar anxieties about ending up back on the streets.

When you last left a treatment program, what was your housing situation immediately after?*

(figure 42, n = 167)



only **8%** of participants had housing after treatment.

* Note that rounding accounts for a total of 99%.

⁷ Budget and Legislative Office, Performance Audit of Behavioral Health Services, April, 2018 https://sfbos.org/sites/default/files/041918_SF_MA_Behavioral_Health_Services.pdf

"I was in a co-op on 43rd Ave and it was sold, and for about 3 months we were in limbo, not knowing if there was going to be another place for us. Fortunately there was another place that my roommate and I got into, but the situation was really unsure for awhile. I had put myself into the mindset of ending up having to go back in a shelter..." —62 year old white woman

Many participants also described having access to a stable social and living environment as vital to their ability to recover and improve psychological functioning, including this participant, a 65 year old white man:

"When you have a roof over your head, it takes away a lot of stress. You don't have to worry about where you're going to get something to eat, where you're gonna be able to shower or having a place to sleep at night, because the shelters in this City are snake pits. That's no way to live. [A residential program] gives you a lot of peace of mind, so that whatever's going on with you, you can work on that. And not have to deal with being out on the street all the time."

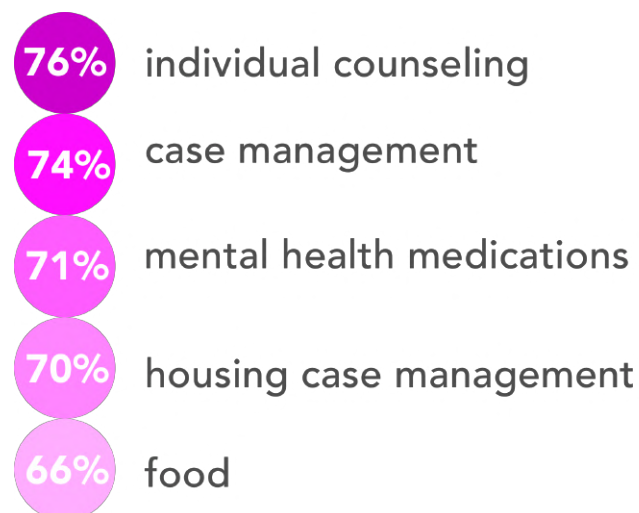
Our findings indicate the effectiveness of mental health care treatment depends on reducing the significant distress related to housing instability.

Ideal Treatment Programs

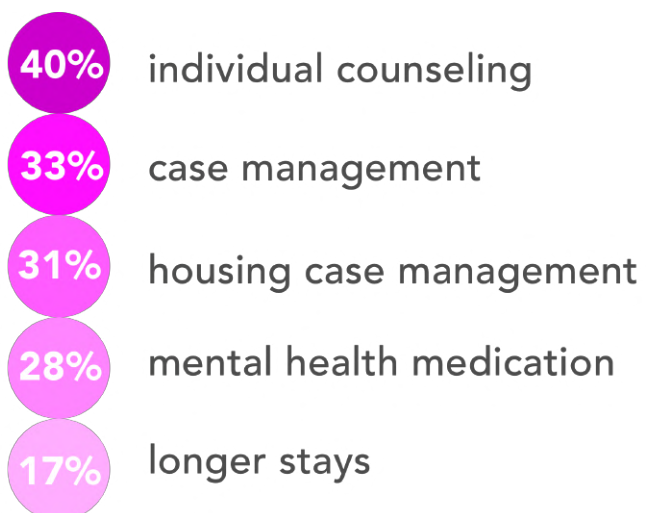
Respondents were asked about which services they would utilize if made available through a mental health treatment program. The most frequently selected services were individual counseling/therapy and case management, followed by mental health medications and housing case management. After selecting programs they would use, participants were asked to select a top 4, most important services. The services most often in people's top 4 were individual counseling, case management, housing case management, mental health medications, and longer stays.

which of the following services would you utilize if they were made available within a mental health program? (figure 43, n = 266)

most popular by how many times chosen



most often in people's top 4



POLICY RECOMMENDATIONS

Purchase Residential Care Facilities, Co-ops, and a Pipeline to Permanent Affordable Housing

- Co-ops are flats that are rented or purchased and share case management. Individuals leaving residential care, once stabilized move into them. This ensures continuity of care and has been tremendously successful at halting the system churn that many in the mental health system experience. The city could purchase flats, and ensure stability for acute clients who don't need the higher level of care that includes preparation of meals as a board and care facility provides, but who can live independently in a group setting with case management support. Also in high demand, are supportive housing units. For many, who can live in private spaces independently and need occasional support services, this model can be successful for homeless people struggling with mental health issues. According to the plan laid out by the Our City Our Home Coalition for use of Prop C, November 2018 fund, at least another 500 newly constructed supportive housing units can be added to the current affordable housing pipeline and 1,500 units in the current pipeline can be subsidized to ensure 1,500 additional homeless units are set aside. These 2,000 units can be supplemented with 1,000 master lease units in existing SRO's to greatly expand housing access for homeless people.

24 Hour On-Call Crisis Support

- Ensure mental health programs have **24 hour on-call crisis support** to ensure success.

Expand Availability of Voluntary Mental Health Services

- San Francisco has an over reliance on "high end care," with thousands of people each year, never getting the help they need until they are in crisis, ending up in a revolving door of emergency hospital based care and back to the streets, or others who are held in expensive beds because lower levels of care are not available. Beds are badly needed in the community, including expanding Acute Diversion Units, co-occurring substance use and mental health residential treatment beds, as well as continued respite, observation beds for those leaving Psychiatric Emergency Services (PES), peer based trauma recovery services, quality board and care facilities, and other living arrangements.

On-site Mental Health and Case Management Services at Drop-ins, Shelters & Nav Centers

- Bringing mental health services to places where homeless people with mental health issues already congregate would expand access. At times the survival mode that homeless people are in compounded by mental health disabilities prevents people from keeping appointments or navigating complicated processes. These services could be available as drop-in services, ensuring care continuity. For example a therapist could keep hours at a drop-in center and a navigation center, so once the client leaves the navigation center there would not be an interruption of care.

More Culturally Sensitive Services, Particularly for Women, LGBTQ Folks, and Immigrants

- Successful mental health treatment is often linked in tangible ways to culture, identity, and language, as without common ground, essential trust is difficult to craft. It is critical that our system is diverse enough to meet the complexity of humanity. A 53 year-old transwoman recalls her struggle with finding a therapist who fits her needs: "Accessing care is impossible; I cannot see a male therapist... [my] biggest barrier is feeling safe and finding an appropriate provider. "

Expand Quality Peer Support Services in Existing and New Programs

This should include improving professional training and compensation for staff. Peer support services are often more effective than clinical services⁸. Peers can develop trust, inspire hope, build community and provide counseling. In order to meet the overwhelming need for mental health services, it is critical that San Francisco invest in training peer experts and ensuring they are compensated in a way that provides stability as well as having on-going support and supervision. Peer professionals can allow for staff expansions in new and existing programs such as outreach, intensive street based care, residential programs, crisis intervention, drop-in facilities, shelter services and more. A 20 year-old Latino man speaks to the importance of peer-based services: "We should all have that one counselor who's actually been through the struggle who can totally understand. I pick people to open up to who have actually been homeless."

Develop Alternative Response to Psychiatric Crisis from Police

Given the lack of preventive and community based mental health care, there are thousands of people who experience psychiatric crisis each year in San Francisco. Overwhelmingly, the response to the crisis is a police officer dispatched to the scene. Police should not function as first responders to psychiatric crisis, absent a threat to public safety. This is both ineffective and costly, and while training and change in protocol has reduced this outcome, at times it still can lead to unnecessary force, harm upon people with disabilities, and injury on the part of officers. The San Francisco Police Commission passed a resolution in January of 2020 calling on the city to develop an alternative to a police response to homelessness. It cited models such as CAHOOTS (Crisis Assistance Helping Out on the Streets) in Eugene, Oregon that send an integrated social services and medical team dispatched from the emergency (911) call center. They are able to replace lost medication, conduct crisis intervention, make appropriate placements in facilities, and make referrals to further care as well as provide a supportive and listening ear.

Create Neighborhood Based Services

Over time, much of the geographic diversity has been lost, and programs have centralized in the central city area. Geographic diversity is critical to ensure cultural competency and accessible services. Many respondents were frustrated that most services were downtown, while their own neighborhoods went underserved.

Dual-Diagnosis Residential Services

Of the total 3,229 unduplicated clients recorded in Avatar as receiving psychiatric emergency services in FY 2016-17, two-thirds (65.5%) had co-occurring mental health and substance use disorder diagnoses. However, despite many efforts, few programs are truly and equally dual diagnosis competent- leaning instead in one direction or the other, or fulfilling neither treatment goal effectively. Our recommendation is to expand these high demand residential programs, and to have dual-diagnosis residential services that treat substance use disorders alongside co-occurring mental health issues.

⁸ Journal of Affective Disorders; December 2012, (Psychiatric Rehabilitation Journal; Winter 2007)
<http://peersforprogress.org/learn-about-peer-support/science-behind-peer-support/#MH>

Availability of Day Treatment

Many respondents asked for restoration of day treatment programs. These are structured programs (sometimes termed, “The Clubhouse Model”) with groups and community building that also serve as a vibrant place to be during the day, when done well. Some of these have been lost, such as the Hyde Street Mental Health Services Tenderloin Day Treatment Program that was shuttered during the recession. Other successful models, such as the Village in Long Beach could be replicated, which is a residential mental health recovery program for homeless people.⁹

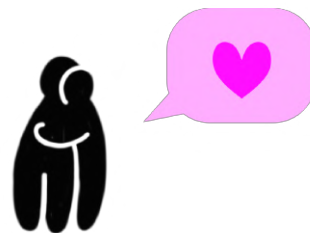
Expand Intensive Case Management to Meet Need

For high acuity clients, navigating complicated bureaucracies, attending appointments, securing housing and meeting every day needs can be impossible without special assistance. Like almost every problem in the mental health system, the issue is a lack of capacity. Intensive case management programs are low-caseload high-frequency models for those with the most acute mental health needs. According to the Budget Legislative Analyst Audit of 2018, from FY 2012-13 to FY 2016-17, for every adult discharged from intensive case management, more than two adults were referred for services. Only 10.9% of the high user group had been assigned to an intensive case manager during FY 2016-17. We found this need echoed in many of the study participants' experiences.

Drop-in Services for Young People

There has been a dearth of homeless services in general for young people, and in particular mental health services. The loss of youth behavioral treatment beds, the closure of the Homeless Youth Alliance drop-in, have all added to the challenges in providing culturally appropriate services for homeless and street identified youth facing mental health challenges in an already struggling system. At the same time, there is tremendous need for mental health services among this population who frequently are homeless after escaping abuse, or exiting foster care. Having drop-in services, with showers, and a place to rest and receive basic care is a starting place to develop trust and engage youth in mental health services. Residential Care Facilities, also known as Board and Cares or Assisted Living Facilities are in short supply and we are losing them rapidly. But since 2012, San Francisco has lost more than a third of licensed residential facilities that serve people younger than 60, and more than a quarter of those serving older clients.¹⁰ These are critical parts of our systems, often family run and extremely underfunded, that the city must assertively ensure continuity by purchasing them as soon as there is word of one going out of business and before the buildings go on the market whenever possible. Funding from ERAF, and eventually Mental Health SF, and Our City Our Home Fund could be used.

"Things got much better for me once I got established in the co-op. I started going to the Day Treatment Center and using the support groups; it helps me clear my mind. I still find that after five years that I function better, using support groups to do something for my mental attitude."



⁹ https://211la.org/211search/more?site_id=1066210004

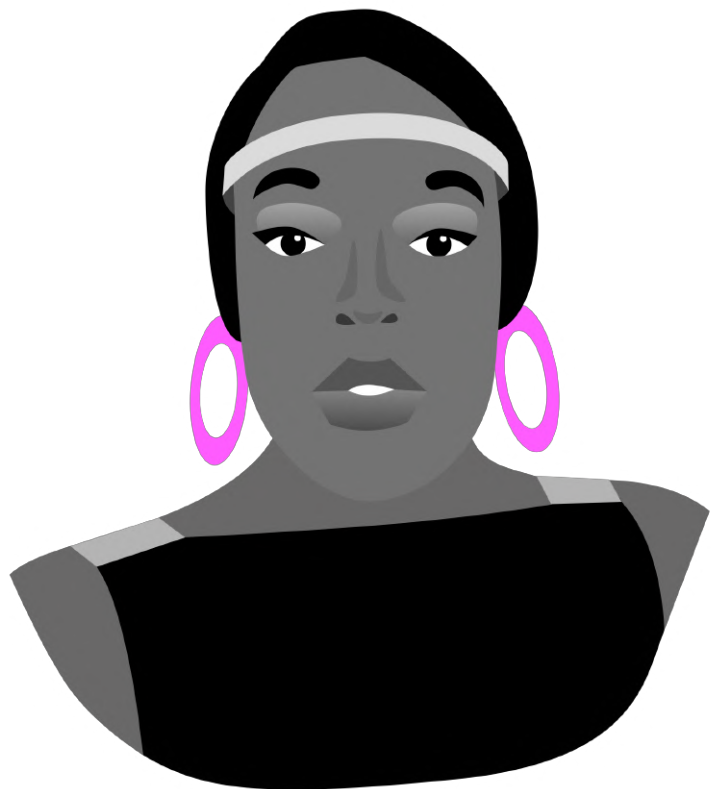
¹⁰ <https://www.sfchronicle.com/bayarea/article/SF-board-and-care-homes-for-seriously-mentally-13766754.php>

TRANS HOMELESSNESS

Trans people experience rates of unemployment and homelessness that are disproportionately high compared with those of cisgender people. Yet when trans people seek support services, they often encounter the same dynamics of exclusion that contributed to job loss or housing deprivation in the first place. In San Francisco and nationwide, trans people need comprehensive support and safe housing. In response to years of advocacy by transgender communities, San Francisco has taken promising first steps toward ending the crisis of transgender homelessness. Our Trans Home SF has successfully advocated for rental subsidies, housing navigators, and other crucial changes, but gaps in the city's homeless service system still disproportionately harm trans people, and dire unmet need remains.¹

This chapter of the report centers the voices of transgender women of color and immigrants. Trans women of color are deprived of housing at higher rates than cisgender people—one in every two trans people has been homeless—yet trans experiences and needs are routinely marginalized or excluded from discussions of homelessness policy, and trans-led organizations are rarely consulted about issues related to housing. Too often, transgender experiences are subsumed into the category “LGBTQ” without meaningful representation. Many homeless service and advocacy organizations have no trans women of color in leadership positions or even as staff. In response to this shortcoming in homelessness research and policy, the Coalition on Homelessness partnered with organizations led by transgender women of color to help design and implement a Needs Assessment that centers trans people’s experiences and needs. Our decision to include this chapter is a timely one: As federal laws and policies of the Trump administration and Ben Carson’s Department of Housing and Urban Development endanger trans and immigrant communities in particular, this report details evidence-based recommendations for local policy to ensure human rights for multiply-marginalized groups.

“Access and education are a big deal to my community. There are lots of people who just don’t have access to services, housing, or jobs because of their skin color, gender identity, criminal history, or housing status. Prop C is a way to rectify the systematic exclusion of people who daily face these oppressions.”



—Ms EARL

Peer Researcher & Focus Group Facilitator)

¹ See <http://www.ourtranshomesf.org> to learn more.

EXECUTIVE SUMMARY

Binary gender classification and anti-trans discrimination made many transgender people feel unwelcome and unsafe in the city's shelters.

Most transgender participants reported experiencing transphobic harassment in shelters.

The primary reason for transgender study participants' departure from shelters was to escape mistreatment (39%). In addition, 36% left because they timed out, and 16% were kicked out.

Transgender people stated a need for gender-affirming mental health and substance use care.

The criminalization of sex work along with "Quality of Life" law enforcement created unsafe working and living conditions for many transgender women, making them vulnerable to violence and trauma. As in shelters, binary gender classification and anti-trans discrimination made some study participants feel unsafe and unwelcome in treatment facilities or made access more challenging.

Criminalization threatened mental health and physical safety.

Due to racialized gender profiling and disproportionate criminalization of survival and earning strategies, transgender participants' daily lives were often shaped by law enforcement. Forty-five percent of respondents in the survey of currently homeless transgender participants reported having experienced violence perpetrated by police officers and 33% (13/40) of TransLatinx participants experienced police violence, including in their countries of origin. For many, mental health challenges stemmed from past and ongoing exposure to violence. Eighty-five percent of TransLatinx participants had applied for asylum in the U.S., and had overlapping and unmet legal and mental healthcare needs, including gender-affirming and linguistically competent therapists who could help with asylum cases.

Overlapping mental health and substance use care needs resulted from gender-specific trauma.

For transgender participants, mental health issues were often rooted in ongoing exposure to gendered and sexual violence resulting from housing deprivation and labor market exclusion.

BACKGROUND

Nationwide and in San Francisco, transgender people are more likely than cisgender people to experience homelessness, yet there are few services tailored to meet trans people's housing and service needs.² Nationally, a majority of transgender women of color are deprived of safe, stable housing at some point in their lives and 70% of transgender people using shelters report discrimination or violence by shelter staff.³ Recent studies demonstrate that transgender people are particularly vulnerable to harassment and violence in San Francisco's homeless shelters.⁴ Although they are the most affected by housing deprivation, the needs of transgender people, and especially trans women of color, are frequently marginalized in housing and homelessness policy.

Trans Research Methods

In order to develop evidence-based recommendations to help end the crisis of transgender homelessness, we conducted a mixed-methods study with 132 currently and recently homeless transgender people in San Francisco. To understand housing and service needs, we gathered in-depth survey, focus group, and interview data from currently and recently unhoused transgender people. We surveyed 72 currently and recently homeless transgender people as a subpopulation within the Coalition on Homelessness's broader survey-based study, and conducted focus groups with 15 currently and recently unhoused transgender people (seven of whom also completed surveys). Given the lack of empirical data on these issues specific to trans people, our team conducted one-on-one interviews with an additional 12 English-speaking participants at organizations serving low-income trans people, including many formerly incarcerated participants, and 40 Spanish-speaking participants at organizations that work specifically with the TransLatinx community. Because all trans participants were recruited from organizations, the sizable population of trans people who are completely disconnected from services is not represented in this study. All data collection instruments were designed in collaboration with service providers and transgender community leaders. Community input guided us to use stratified sampling for interviews and focus groups among two groups that are disproportionately affected by housing deprivation: TransLatinx immigrants and formerly incarcerated trans people. All interviews and focus groups were conducted by transgender and nonbinary staff and peer researchers, COH staff, or trained cisgender peer researchers who had personally experienced homelessness. All interviewers and focus group facilitators received training and support from the authors.

Community-Informed Action Steps

To identify community concerns and priority areas for advocacy, peer researchers conducted two town hall meetings, one with 30 English-speaking transgender participants and one with nine Spanish-speaking transgender participants. Based on the responses of this diverse group of participants, as well as our review of national data, academic researchers worked with partners at participating organizations (El/La Para Trans Latinas, Mujeres Latinas en Acción, the St. James Infirmary, the Transgender Gender-variant and Intersex Justice Project and the San Francisco Coalition on Homelessness) to develop evidence-based policy recommendations. We discuss these following the findings below.

² Beltran, T, Allen A, Lin J, Turner C, Ozer E, & Wilson E. (2019). Intersectional Discrimination is Associated With Housing Instability among Trans Women Living in the San Francisco Bay Area. *International Journal of Environmental Research and Public Health*. 16: 4521. P. 1-11.

³ James, SE, Herman, JL, Rankin, S, Keisling, M, Mottet, L, & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality, p. 176.

⁴ Yarbrough, D. (2016). "Outlaw Poverty Not Prostitutes:" *Sex Workers' Responses to Poverty Management in San Francisco*. Proquest Dissertation Publishing: University of California, San Diego; Greene, J. (2018) "Categorical Exclusions: How Racialized Gender Regulation Reproduces Reentry Hardship." *Social Problems*, 66(4), 548-563.

FINDINGS

Causes of Homelessness Among Transgender People

Like respondents to the general survey, most trans survey respondents (46%) lost their housing due to an inability to afford rent. Trans people also experienced high rates of housing loss related to gender-based violence. For example, 26% of currently homeless transgender survey participants lost housing due to domestic violence compared with 8% in the general sample, and 22% lost housing related to a family dispute compared with 17% in the general sample. An additional 10% of currently homeless transgender survey participants lost their housing due to family members not accepting their gender identity, and 8% lost housing because they were incarcerated.

Why do we see these higher rates of housing loss among trans respondents? Among trans people, it is particularly common to be kicked out of a family member's house at a young age. One in 10 currently homeless trans respondents initially lost their housing due to family members not accepting their gender identity. More than 45% of currently homeless transgender survey respondents were homeless at or before the age of 18. This reflects a disproportionately high percentage compared with the frequency of homelessness at or before age 18 in the broader homeless population our team surveyed. This finding is consistent with findings of other studies showing that transgender youth are more likely than cisgender youth to experience homelessness.⁵

Economic Barriers & Discrimination

Trans participants described anti-trans discrimination as having an effect on both their ability to find work and their ability to secure housing. Sometimes, anti-trans discrimination was direct and explicit, while other times it was indirect — but in both cases, participants were clear that it is a major barrier to securing housing. For example, one TransLatina interview participant said:

"I thought San Francisco was more open to transgender people, but my experience shows that it is not. When I apply for a room, it depends on how the landlord thinks I look. I applied for a room and my application was approved. When he saw me, the landlord revoked my approval because he said I looked like a man." (translated from Spanish)

Among TransLatinas, additional factors also led to housing deprivation, including language and legal barriers that increased the difficulty of obtaining housing as an immigrant. Nine TransLatinas who participated in this study also experienced particular housing challenges following incarceration, including immigration detention. These overlapped with language and legal barriers to make this group particularly vulnerable to housing deprivation.

⁵ Applied Survey Research (2019). San Francisco Youth Homeless Count and Survey Comprehensive Report. <http://hsh.sfgov.org/wp-content/uploads/FINAL-Youth-Report-2019-San-Francisco-1.pdf>

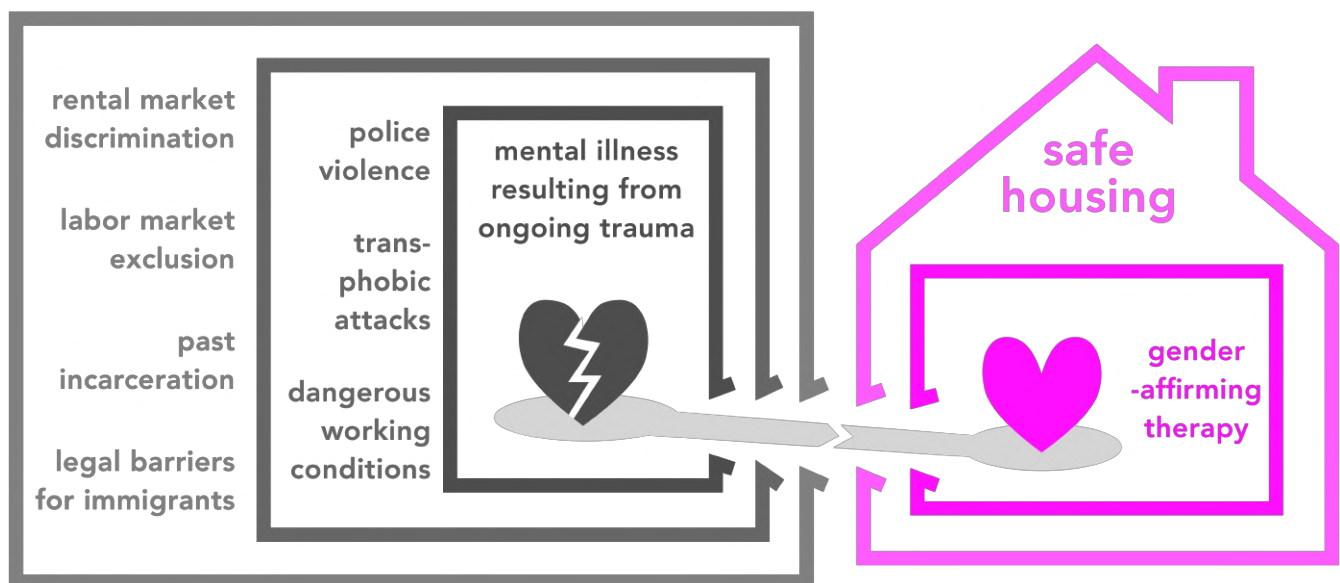
Legal Barriers to Housing Stability

Even when trans people are able to obtain housing, they frequently find themselves in unstable situations. Sometimes their lack of legal immigration status compromises their ability to contest illegal actions on the part of landlords. Several participants mentioned this insecurity:

"If someone doesn't have documents, they can tell you in any moment, leave ... Not having documents means not having a voice. When you have documents, you can follow up on your legal rights." —TransLatina (translated from Spanish)

Like legal barriers that leave many non-citizens in precarious informal housing situations, criminal records can block access to many housing options. Of currently homeless trans survey respondents who reported having been incarcerated in San Francisco, half (16/39) were living outside or in vehicles compared with 40% (16/40) of those who had not been incarcerated in San Francisco. Of those reporting criminal records affecting access to housing, 75% (12/16) who said their criminal records affected their housing were living outside or in vehicles compared to 47% (15/32) who didn't think their records affected their housing access.

Costly and highly competitive rental markets, multiple forms of discrimination, and administrative barriers can make housing nearly impossible to obtain. The instability produced by this lack of access to stable housing is compounded by lack of access to safe employment and government benefits.



Shelter Experiences of Transgender Participants

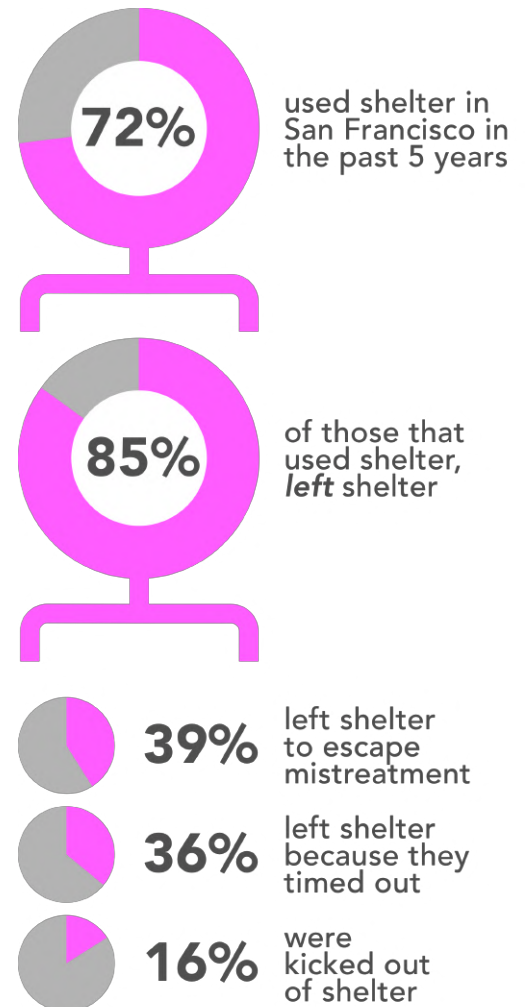
Enforcement of binary gender norms in San Francisco shelters makes transgender women particularly vulnerable to experiencing gender-based violence in and eviction from homeless services.⁶ Qualitative studies have shown how gender policing by shelter and transitional housing program staff puts transgender women at risk of carceral system involvement, as staff call the police to respond to transgressions of gender norms.⁷ Most (52 out of 72) people surveyed had used shelters in San Francisco within the last five years. Forty-four of these shelter users left shelters for a variety of reasons. The primary reason for departure from shelters was to escape mistreatment (39%), compared with 30% of the overall population; 36% left because they timed out, and 16% were kicked out, sometimes following conflicts related to gender identity or sexuality. Fifty-two percent (52%) of transgender shelter users had been asked to leave or forced to leave shelter. This indicates a need for improved policies for conflict resolution and institutionalization of support for diverse gender identity and expression.⁸

Transgender people are uniquely vulnerable both on the street and in shelter. 56% (30/54) of trans people felt safer staying in shelter than on the street, 19% (10/54) felt less safe in shelter than on the street, and 26% said there was no difference in how safe they felt staying in shelters vs. on the streets. On the street, transgender people face physical and sexual violence, the risk of which is heightened by policing. In shelters, transgender participants face frequent harassment by other shelter residents and sometimes also staff. Regarding mistreatment from other residents, an interview participant said:

"In my experience in shelters, many people want to victimize me, for example harassing me in the bathroom. They tell me I have to go to the men's bathroom and not the women's. This is hate-based violence." —TransLatina (translated from Spanish)

trans shelter exits

(figure 44, n = 72)



⁶ Yarbrough, D. (2016). "Outlaw Poverty Not Prostitutes:" Sex Workers' Responses to Poverty Management in San Francisco. Proquest Dissertation Publishing: University of California, San Diego; Greene, J. (2018) "Categorical Exclusions: How Racialized Gender Regulation Reproduces Reentry Hardship." *Social Problems*,66(4), 548-563.

⁷ Yarbrough, D. (2016). "Outlaw Poverty Not Prostitutes:" Sex Workers' Responses to Poverty Management in San Francisco. Proquest Dissertation Publishing: University of California, San Diego; Yarbrough, D. (forthcoming). "The Carceral Production of Transgender Poverty: Theorizing Intersectional Vulnerability."

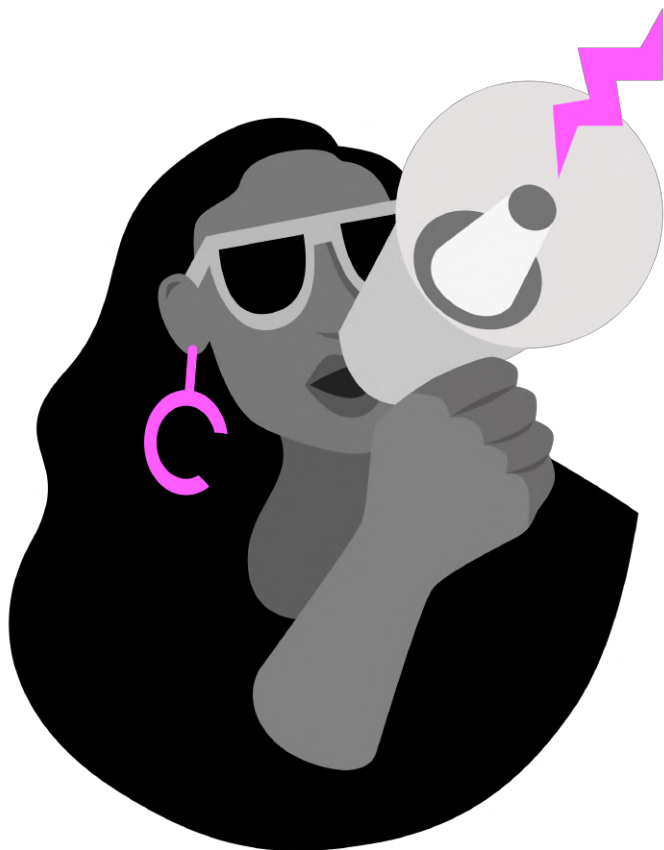
⁸ Because trans survey participants were not recruited from streets or camps, this study may under-represent the extent to which transgender people experience gender-related mistreatment in shelters. A survey of transgender people who have moved from shelters to camps or streets would reveal a fuller spectrum of experiences with the shelter system.

Many trans participants reported avoiding shelters all together, either because of bad experiences in the past or the reputation of San Francisco's shelters as hostile to transgender people. One of the participants in a TGIJP-facilitated focus group at a homeless shelter spoke to the poor treatment of trans residents by staff members:

"Without staff that's dedicated, it's a dangerous place inside. I know people who sleep outside because they can't take abuse from staff members."

Many interview and focus group participants spoke to the importance of "dedicated shelters," or shelters that are available specifically and uniquely to trans residents. Trans study participants frequently experienced discrimination and gender-based violence from cisgender providers, and emphasized that organizations led by and for transgender people were key to their survival and well-being. Jazzie's Place has been one such dedicated shelter space. Although very limited in its capacity, it has been an important resource that was originally intended to serve queer and trans people whose safety is threatened in the general shelter system. However, according to staff at TGIJP, Jazzie's Place has recently experienced an influx of cisgender and heterosexual residents, and as a result is considered less of a safe shelter space than in prior years. This underscores the need for more shelter for all, and dedicated safe spaces for vulnerable queer and trans shelter users.

Peer Researcher **Treasure L'Oreal Earle** had this to say about dedicated space:



"My experience of being a Peer Researcher tells me that there is a population that is unserved. There is a population that has been relegated to substandard living conditions. There are individuals who have to live in dire circumstances, who don't have a place to go. There are a whole lot of individuals that do not have a specific place that is built for them. For example, there was Jazzie's Place, it was transformational but the mission of the place has been watered down and the target audience it was meant to serve has been left out of its current place. Well Jazzie's was for Black trans folks and now it's for anyone — the mission has broadened so there is no specific space for transgender women. There is no specific space. There's men's shelters, women's, youth, and trans can go to these places, but now there's no specific place for trans folk, who were promised a place specifically for them."

Safe Shelter and Housing for Transgender People

Interview and focus group participants also emphasized the need to address safety in deep rather than superficial ways. One transgender focus group participant said of her shelter experience:

"I felt I had to change the way I dress and present, including in places that are supposed to be safe, [where there were] things up on the walls about inclusion. You can have as many signs up as you want to, you're still gonna treat me different. Places aren't safe for everybody."

"Staff should be trans, or people who are capable of understanding what we want and need. Many people who work in these housing offices have no idea, and no ability to even imagine, what trans people go through; no understanding of our struggles and what we need. "

—TransLatina participant (translated from Spanish)

Participants discussed how dedicated shelter spaces could build capacity to support trans people by ensuring trans leadership, competency, and safety across the board. One of the primary suggestions was to hire trans staff in shelters and housing offices, and to prioritize permanent housing support.

TransLatinx participants also emphasize the need for linguistic competency across homeless services, including in shelters. Staff inability to communicate with monolingual Spanish-speakers is a serious barrier for TransLatinx people who are seeking housing and services.

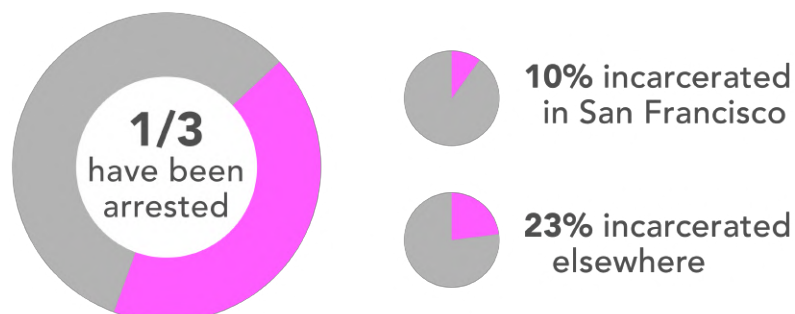
"Because we are migrants, our first language is different. In order to adapt to this country, we need more support focused on our specific needs." (translated from Spanish)

Need for Transgender and Undocumented Housing

Indeed, more than just shelter, trans people need safe, stable housing. This is particularly true for people who are leaving incarceration or ICE detention, yet these experiences can create additional legal obstacles to people's ability to obtain stable housing.

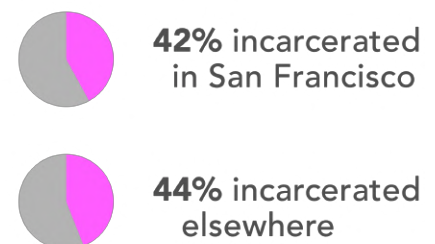
incarceration of TransLatinx participants

(figure 45, n = 40)



incarceration of currently homeless Trans participants in survey

(figure 46, n = 72)



Housing deprivation related to past incarceration particularly affects trans people of color. Of trans survey respondents formerly incarcerated in San Francisco, 85% identified as people of color. Of trans respondents formerly incarcerated elsewhere, 52% identified as people of color. The groups most affected by incarceration were Black and Latinx. Most respondents left incarceration with unaddressed legal and housing needs. For some participants who were able to find housing after incarceration, transphobia made it hard to maintain. One formerly incarcerated participant said:

The groups most affected by incarceration were Black and Latinx.

"They sent me to a re-entry facility and I'm the first transgender they've ever had. [I wish] that we would be put in a safe environment upon release until we can get physically able to be on our feet and not have to worry about homelessness or being raped or beat up."

Organized camps with basic amenities have been proposed as short-term solutions to housing scarcity, and could be particularly helpful to transgender people who are vulnerable in shelters as well as on the streets. Like many cisgender respondents to the general survey, 58% of trans survey respondents said they would prefer a camp with basic amenities over shelter. However, there was also a higher rate of trans respondents who said that they would not prefer camps (28%, of trans survey participants, compared with 10% of the general survey participants).



"We need immediate safe structures for trans people coming out of jails, prisons, and locked facilities."

—JANETTA JOHNSON,
Executive Director of the Transgender
Gender-variant and Intersex Justice Project

Physical Well-Being, Mental Health and Substance Use

Many respondents in our study described how lack of housing affects physical and mental health. This is a particular concern among trans people, since health outcomes among trans people in general are already significantly compromised by experience or fear of discrimination leading to delay or avoidance in seeking care.⁹ Respondents described the many connections between physical health and safety, violence, and mental health as they negotiated living without housing.

⁹ Seelman, KL, Colón-Díaz MJ, LeCroix RH, Zavier-Brier M, & Kattari L (2017). "Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults." *Transgender Health*. 2(1): 17–28.

For many trans participants, chronic conditions combine with housing deprivation to create serious health risks. Transgender people more often reported that they were living with HIV than cisgender people: 25% of respondents in a general survey of currently and recently homeless trans people in San Francisco and 30% of respondents in a targeted sample of TransLatinas reported that they were living with HIV. This is consistent with data from San Francisco’s Department of Public Health showing that transgender women have been diagnosed with HIV at higher rates than other groups.¹⁰ Of trans participants living with HIV, 12/18 were currently staying in shelters and 5/18 were currently staying on the street.

Conditions of discrimination and instability can also lead trans people who are unhoused or in unstable housing situations to encounter violence. For some, this means enduring violence or mistreatment at the hands of intimate partners or sex work clients to secure temporary housing. One TransLatina participant described the danger of doing sex work while precariously housed or unhoused:

“Because of my need for a place to sleep at night, I have had to put up with violence. To submit to things I don’t want to do for a place to stay. This is what it means not to have a stable place to live.” (translated from Spanish)

Repeated exposure to gender-based and sexual violence on the streets and in shelters can result in continual retraumatization that undermines the effectiveness of traditional mental healthcare for many transgender women. A housing-centered approach to mental healthcare can interrupt the cycle of violence and trauma.

“San Francisco needs to prioritize safe housing for trans women because we are the most vulnerable to physical and sexual assault on the street. The best mental healthcare for the trans community is preventing violence and trauma by providing safe housing.”

—JANETTA JOHNSON,
Executive Director of the Transgender
Gender-variant and Intersex Justice Project



¹⁰ San Francisco Department of Public Health Population Health Division. (2018). HIV Epidemiology Annual Report. San Francisco Department of Public Health.

Overlapping Mental Health and Legal Needs for Transgender Immigrants

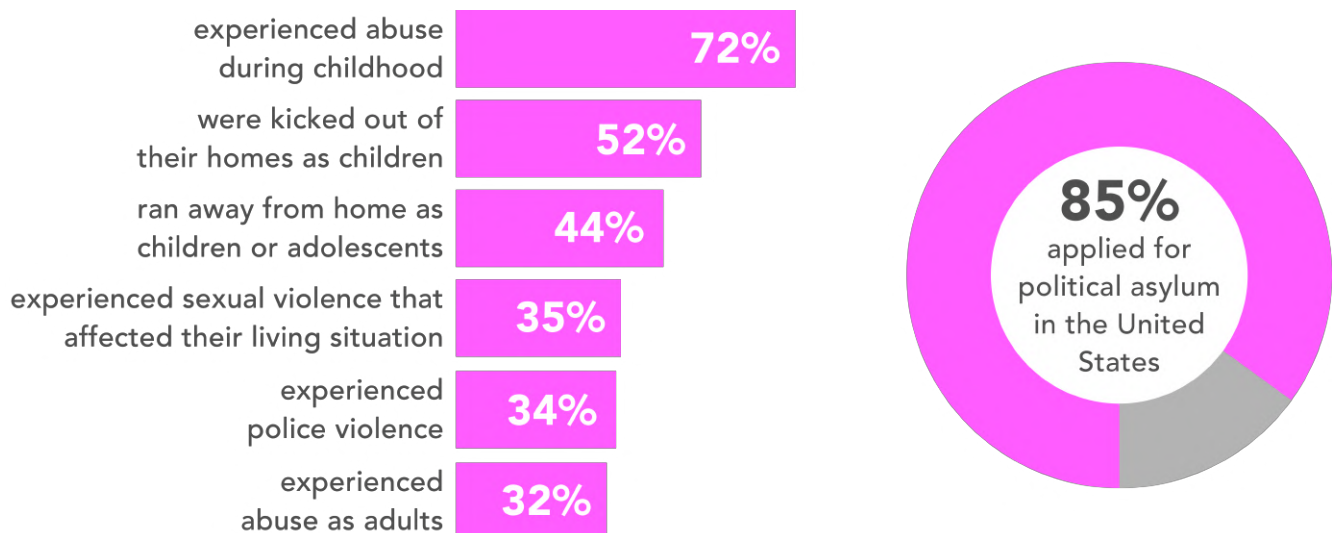
Transgender immigrants have complex legal needs. A majority— 34 out of 40 — of TransLatinx interview participants had applied for political asylum in the United States. Of these participants, 14 reported that they received a visa, and 11 were still waiting or in process. Immigration status affects the ability to access survival resources like housing, cash aid, medical care, and food benefits. Barriers to HUD-funded housing may be particularly onerous for trans people who are not citizens or permanent residents, or who have a criminal record. San Francisco needs to prioritize local resources for these particularly vulnerable populations. Participants reported difficulty finding affordable mental health providers who could speak Spanish and had the expertise to support asylum applications and provide gender-affirming care.

“Many girls need mental health support. I include myself in this list. Sometimes we can’t get mental healthcare because we can’t pay. Sometimes therapists charge a lot and we can’t pay this. Right now, I’m looking for a therapist who won’t charge too much to help me get my asylum.” — TransLatina participant (translated from Spanish)

Applicants for political asylum were often fleeing severe violence in their home countries. In addition to hate-based violence by strangers, asylum applicants reported high rates of family and intimate partner violence. Of transgender asylum applicants, 35% experienced sexual violence that affected their living situation, 72% experienced abuse during childhood, 52% had been kicked out of their homes as children, and 32% experienced abuse as adults. 44% percent said they ran away from home as children or adolescents, and 34% had experienced police violence, often in their countries of origin and sometimes also in the United States.

experiences of TransLatinx participants

(figure 47, n = 40)



Mental Health & Substance Use Care that Addresses Ongoing Trauma

Mental healthcare providers often focus on helping clients cope with past trauma, but have a limited ability to help clients avoid traumatic situations that come with being unhoused or precariously housed. This report makes clear that past experiences are not the main issue: violence and trauma are ongoing in the lives of most trans study participants. From physical attacks on transgender women in public space to depression and anxiety caused by housing and labor market exclusion, study participants confront daily threats to their mental health. Outpatient mental healthcare visits can help individuals survive, but are not equipped to address the structural and institutional sources of ongoing threats to mental health. Many trans people will leave a mental health provider's office and return to conditions of poverty, discrimination, and violence that continuously threaten their well-being. Traditional mental healthcare alone cannot prevent traumatic events from happening—in many cases, repeatedly. One interview participant described how continual exposure to violence in her underground economy work precipitated a mental health crisis:

“Unfortunately I have not had many opportunities for dignified paid work. The resources from programs that the city provides have never come to me. And this makes me feel unstable. I am often on the brink of harming myself. Four years ago I [attempted suicide] because I felt unsafe, because I had to put up with any type of violence that was done to me.”
— TransLatina participant (translated from Spanish)

Exclusion from housing and employment pushed many transgender participants into underground economies, exposing them to criminalization and violence. In addition to high rates of interpersonal violence, trans respondents also reported more frequent experiences of police violence than cisgender study participants: 49% of currently homeless trans survey respondents had been harassed by police, 45% experienced violence perpetrated by police officers, 67% had been incarcerated.

TransLatina study participants emphasized the need for specific policy responses to overlapping forms of marginalization for immigrants, transgender people and sex workers:

The most effective mental healthcare is accompanied by wraparound services, including safe housing and employment options. Many transgender study participants said that their depression and hopelessness resulted from labor market exclusion and concomitant exposure to violence in more dangerous informal economy jobs like street-based sex work. Participants reported that violence made them lose interest in work and other projects like school, and that depressive symptoms made it difficult to earn enough money to maintain housing.

“As TransLatinas, our human right to have a dignified life, to have basic services to be able to live and feel physically safe and psychologically stable, is constantly violated. Many programs have disqualified me for being trans, for being an immigrant, or because of the language barrier. There are many obstacles that create vulnerability for the TransLatina community. We have to trade sex for a place to sleep, to do things we don't want to do with landlords because of necessity, because otherwise they'll throw us out on the streets. This is not social justice. There are many forms of violence that target our community, and we often have to stay quiet about this because there are no other options for us.” (translated from Spanish)

While gender-affirming therapy and peer counseling are crucial resources in helping people to survive adverse conditions, it is San Francisco's responsibility to address the root causes of violence and material deprivation experienced by transgender residents, not only the attendant feelings of depression, hopelessness, or suicidality. Post-traumatic stress is a normal (and sometimes even adaptive) response to violence and the most effective intervention is removal of the sources of danger from the environment.¹¹ Transgender people interviewed about their needs after surviving violence overwhelmingly stated that they needed housing and a safe place to go, in addition to counseling and psychological support.

Effective Housing & Care for Transgender Drug Users & People Living with Mental Illness

People who do not have access to affordable and gender-affirming mental health and psychiatric care sometimes use illicit drugs to cope with acute post-traumatic stress and mental illness symptoms. Many transgender drug users in this study relied on harm reduction supplies and services as well as peer-based counseling to help them reduce drug use. Trans people who accessed residential substance use treatment programs identified interlocking barriers to maintaining sobriety upon exit. One TransLatina respondent described successfully completing a four-month-long residential drug treatment program and applying unsuccessfully for transitional housing.

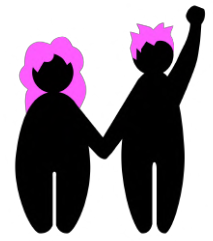
*"No transitional living programs wanted to give me a space. They always decide based on their personal prejudices and they didn't see me as a person or acknowledge the progress I'd already made. There was no one who gave me an opening to take the next step."
(translated from Spanish)*

Suddenly without housing and support, she tried to maintain her sobriety, but was unable to do so. Lack of coordination between programs hits transgender people particularly hard, since discrimination can block access to many housing options. San Francisco's shortage of residential treatment and lack of housing for drug users means that the many drug users and people living with mental illness cycle between the city's single adult shelters and the streets. Being deprived of shelter can precipitate or exacerbate mental illness, especially for trans people who become more vulnerable to physical and sexual violence while unhoused. At the same time, people under the influence of drugs or alcohol or who are in mental health crisis might exhibit behavior that is frightening or harmful to other shelter users. Shelters are often ill-equipped to deal with mental health crises, particularly among trans shelter users. The city must expand housing-centered voluntary mental health and substance use care resources for transgender people.

¹¹ Brown, LS. (2017). Contributions of feminist and critical psychologies to trauma psychology. In S. N. Gold (Ed.), *APA handbook of trauma psychology: Foundations in knowledge* (p. 501–526). American Psychological Association. <https://doi.org/10.1037/0000019-025>; Schwarz, R. (2013). *Tools for Transforming Trauma*. Routledge; Street, A., & Dardis, C. (2018). Using a social construction of gender lens to understand gender differences in posttraumatic stress disorder. *Clinical Psychology Review*, 66, 97-105.

POLICY RECOMMENDATIONS

Recommendations to Prevent Homelessness and Provide Gender-Affirming Shelter and Care for Transgender People



Experiences of homelessness are different for different people. Some might wonder why we would include recommendations about one specific group. This section does not intend to say that only trans people need policy attention. Instead, it highlights experiences of interlocking marginalization, as guided by intersectional feminism. Focusing on and addressing interlocking barriers can make more visible the ways that these converge to make navigating systems difficult for everyone, even though some people are more severely affected by these than others. From this vantage point, recommendations that improve living conditions for trans people will improve conditions for everyone — and will also prevent policy changes that benefit some people but leave trans people, particularly trans women of color, behind. Many times, homeless services policy relies on race and gender neutral recommendations that can leave the most marginalized groups behind. Instead, we need to take concrete steps to make sure that homeless services — which are often organized using binary gender segregation and run by cisgender people — are safe and welcoming for trans people.

Like everyone, trans people will benefit most from truly permanent housing, investment in public housing, prevention of housing loss, and effective and well-resourced shelter and treatment programs. At the same time, certain provisions are necessary to ensure that these work for trans people — which means they will work better for everyone.

RECRUIT AND HIRE TRANS PEOPLE WHO HAVE EXPERIENCED HOMELESSNESS

● Ensure Gender-Affirming Care in Staffing and Hiring.

Binary gender segregation in housing and treatment facilities can exclude trans, nonbinary, and queer people and expose them to harassment. Dedicated programming can help, but all programs should employ staff capable of providing gender-affirming care and addressing transphobia. Homeless service programs must recruit and prioritize hiring of transgender applicants who have experienced homelessness. Homeless service programs should hire trans people with lived experience of homelessness to train existing staff. Incidents involving transgender shelter and transitional living programs (TLP) residents should be reported to the Transgender Gender-Variant & Intersex Justice Project (TGIJP) and the Coalition on Homelessness (COH) for review of related shelter and TLP policies and practices.

● Invest in Housing and Shelter Provided Exclusively by and for Transgender People.

Many interview participants reported feeling safest and most welcome in service organizations with dedicated programs run by and for transgender people. We recommend hiring and paid professional development of transgender staff who have demonstrated skill in creating safety for transgender residents to staff trans-specific city-funded shelters. Candidates for homeless services jobs should be interviewed by transgender and nonbinary staff and residents.

Reinstate community referral placement for Jazzie’s Place to ensure the population there is trans, as intended.

Jazzie’s Place was originally designed to be a trans friendly shelter, with thoughtfulness about physical design and allowance for fluidity of gender inside the space. The access process was carefully designed to ensure that the space would serve the intended population, with referral and placement outside of typical shelter sign up time at Mission Neighborhood Resource Center. That process was changed so that the way into Jazzie’s Place is no different from any other shelter — when beds open up there they are offered to the entire homeless population on the waitlist. This has resulted in moving from its original mission. A similar process as to what was originally designed should be put in place with placement authority from providers who serve this community.

ENSURE TRANS ACCESS TO EXISTING PROGRAMS

Create Physical Structures to Promote Safety and Gender-Affirming Care in Congregate Living Environments.

Bathroom and shower facilities in many congregate living environments are sites of harassment. The city should create gender-neutral and more private bathroom and shower options, dedicated safe spaces for transgender residents, and other changes to physical structure. In the meantime, trans residents should be able to shower at different times as requested, and staff should be trained to address privacy and safety needs.

Long Term Housing and Support for Transgender People in Residential Substance Use Treatment Programs.

A lack of available housing forces residential substance use treatment programs to release most people who complete the program back into homelessness, which does not support sustained sobriety or health. The City and County of San Francisco must increase the availability of long-term and permanent housing to improve outcomes for drug users, making sure trans people are fully included. Existing transitional housing programs for drug users can be unsafe and unwelcoming to transgender people. The City should collaborate with transgender run organizations to create housing transition plans for trans people’s direct placement in safe housing.

Flexible Rental Subsidies for Transgender People.

Income documentation for subsidies can present a barrier to members of the transgender community, particularly formerly incarcerated people and undocumented immigrants, who disproportionately work in the informal economy. Some housing programs inadvertently discriminate against transgender people and block educational attainment through income requirements. It is counterproductive to force transgender subsidy recipients to seek work in a low-wage labor market where discrimination renders most jobs unavailable and unwelcoming. Flexible rental subsidies for transgender people can help them to pursue diverse self-identified goals. Rental subsidies should be available for whatever locations individual transgender applicants identify as safe for them, including locations inside and outside of San Francisco, if requested by the subsidy-seeker: The city should not force trans people out of San Francisco simply because it is unaffordable.

Improve Data Collection and Evaluation of Outcomes for Trans People in Shelters, Subsidized Housing and Transitional Living Programs.

Track all evictions and voluntary departures from supportive and subsidized housing by gender identity. Programs that disproportionately evict trans people must work with trans-led organizations to make a plan for reform.

ENSURE SERVICES ARE PROVIDED BY AND FOR TRANS PEOPLE

Develop Dedicated Programs for Transgender People.

While all programs should be safe and welcoming for transgender people, many feel safest and most welcome in dedicated programs run by and for transgender people. The City should ensure that these resources are available as programs simultaneously strengthen their ability to provide gender-affirming care and services.

Harm Reduction-Based Residential Programs for Transgender Drug Users.

While many participants ultimately wanted to stop using drugs, they expressed a wish for transgender-run housing resources that would provide health and safety resources to active drug users. Harm reduction services worked well for many participants, and they wanted safe housing that they would not lose if they used drugs or relapsed. Creation of harm reduction-based residential programs, in addition to changes to existing abstinence-based programs to make them safer for trans people, will allow transgender drug users to choose the model that works best for them.

Gender-Affirming and Linguistically Competent Therapy and Peer Counseling.

There are few therapists who are affordable, have experience with transgender clients, and speak Spanish. One way to expand resources would be to train Spanish-speaking transgender people as paid peer counselors. Paid peer counselor training programs as an employment pathway could enhance mental health resources as well as job security for Trans people, particularly Latinx immigrants.

Trans-Only Floors of Single Room Occupancy Hotels for Dorm-Style Communal Living.

Many transgender women rely on Single Room Occupancy hotel rooms as a safer alternative to the city's shelter system. However, binary gender segregation of single-sex bathrooms and showers still present a challenge for many trans residents. Designating safe floors reserved for trans residents and managed by a trans-serving organization would streamline service provision and increase levels of comfort and safety. Crucially, trans residents should have equal opportunity to stay in any SRO (not just trans-only SROs or floors); the reserved floor should not allow managers to deny access to other floors or spaces.

*"Staff should be trans, or people who are capable of understanding what we want and need. Many people who work in these housing offices have no idea, and no ability to even imagine, what trans people go through; no understanding of our struggles and what we need."
—TransLatina participant (translated from Spanish)*

END RELIANCE ON POLICE IN EMERGENCY HOUSING AND SERVICES

Decrease Police Involvement and Invest in Mental Health Crisis Intervention and Restorative Practices in Shelters and other homeless Programs.

Staff in San Francisco shelters and behavioral health programs sometimes rely on police to enforce rules and gender-related conflict. It would prevent trauma and arrest to have more non-law enforcement mental health and crisis intervention resources available. San Francisco can take several specific steps to end service providers' reliance on police, including: ensuring adequate numbers of

staff trained in mental health crisis and de-escalation; hiring non-transphobic staff who are equipped to address transphobic behavior among cisgender shelter users; and training shelter staff and users in Restorative Practices in smaller shelters. Investing in smaller shelters with higher staff to client ratios will support these changes, and will benefit all shelter users. In the short term, the city should prioritize emergency housing provided by and for transgender people who are particularly underserved by San Francisco's existing resources. Until shelters can eradicate anti-trans harassment and violence, the City should prioritize LGBTQ and trans-specific emergency housing that can keep trans and nonbinary people safe.

Transformation of Shelter and Transitional Living Program Training and Policy to Respond More Effectively to Mental Health Crisis.

Effective responses require the intervention of trained mental health professionals, not arrest or incarceration. While participants and service providers want support for crisis resolution, they worried that emergency services could be traumatic and/or result in arrest. Gender-affirming mental healthcare, including crisis response resources, is crucial for trans people living with mental illness.

PREVENT TRANS EXCLUSION AND BUILD ON COMMUNITY STRENGTH

Preventing Transgender Homelessness.

Prevention of trans homelessness requires addressing labor market exclusion, criminalization, anti-trans discrimination, and legal barriers to housing, including immigration status for many trans asylum seekers and a criminal record for many formerly incarcerated transgender people. Transgender homelessness results in large part from a cycle of criminalization and labor market exclusion. To prevent transgender homelessness, San Francisco City and County must combine decriminalization of trans people's earning and survival activities with investment in creation of safe living-wage jobs for transgender people.

Develop Local Programs to Circumvent Federal Exclusion of Formerly Incarcerated Trans People and Immigrants From Housing Access.

As federal policies make housing support increasingly difficult to access for transgender people, especially immigrants and formerly incarcerated people, San Francisco should expand local housing subsidy programs to immediately house trans people coming out of jails, prisons and immigration detention. This could serve as an alternative to federal funding sources to ensure survival for transgender people who are ineligible for federal aid.

San Francisco's Housing Policy Must Center Concerns Related to Immigration Status and Language Among Trans People.

Among people without legal immigration status, the combined effects of discrimination, language barriers, and legal documentation contributed strongly to housing deprivation. TransLatinas struggled to secure work and housing, even despite San Francisco's status as a sanctuary city. The threat or reality of immigration detention or deportation also affected job and housing security, limiting the degree to which people were able to access assistance with basic survival needs. As one interview respondent said, "TransLatinas are invisible to policymakers."

A Community-Based Approach to Mental Health.

Supportive spaces for recreation and community-building are a crucial source of strength and stability for unhoused transgender people, even when other needs might seem more pressing. Trans participants said that spending time doing recreational activities, attending cultural events, and engaging in artistic practice with other trans people strengthened collective ability to confront transphobia, discrimination and violence.



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