Addressing Mental Health Disability in Unsheltered Homelessness: Outpatient Conservatorship in Los Angeles

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Objective: The authors sought to describe a pilot program for gravely disabled individuals experiencing unsheltered homelessness in Los Angeles County that illustrates a promising public health framework to address mental health–related disability in homeless populations.

Methods: Homeless outreach teams implementing the outpatient conservatorship (OPC) pilot program adopted a population health approach, multisystem care coordination, and prioritization of the least restrictive environments. The program allowed initiation of a Lanterman-Petris-Short (LPS) conservatorship outside of a hospital, with the goal of serving highly vulnerable individuals in the least restrictive settings. Between August 2020 and July 2021, the OPC pilot program served 43 clients, corresponding to 2% of those served by the outreach teams during that period. Using observational program evaluation data, the authors examined the impact of the program on this sample of participants.

Results: At 12 months, 81% of OPC clients were no longer experiencing unsheltered homelessness; 65% accessed an LPS conservatorship. Although most OPC clients utilized a psychiatric hospital, 54% left locked settings earlier than would have been possible without the program. One-third of clients referred for LPS conservatorship used unlocked licensed residential facilities in the first year. Negative events, such as remaining in unsheltered homelessness, were more common among clients not referred for LPS conservatorship.

Conclusions: Timely receipt of street-based services and coordination of care before, during, and after referral for LPS conservatorship reduced use of restrictive settings. The OPC program's components constitute a promising triadic framework for addressing mental health disability among unsheltered individuals that warrants further investigation.

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Individuals with severe mental illness (such as psychotic spectrum disorders or severe mood disorders) experience profound disparities in morbidity and mortality rates; bear a disproportionate burden of discrimination, stigma, and social isolation (1–3); face a high risk for crime victimization (4); and are vastly overrepresented among those experiencing homelessness and incarceration (5–7). In Los Angeles County (LAC), rates of homelessness are four times the U.S. average (8), and approximately 10% of clients served by LAC homeless outreach teams had a chart diagnosis of a psychotic spectrum disorder within the previous 5 years (9). Homelessness exacerbates the disparities faced by those with severe mental illness, increasing morbidity and mortality rates, risk for criminalization, substance use, and victimization (10, 11). Symptoms (e.g.,

HIGHLIGHTS

- Los Angeles County's outpatient conservatorship (OPC) pilot program used a population health approach, multisystem care coordination, and prioritization of the least restrictive environments to address mental health disability among individuals experiencing homelessness.
- At 12 months, 81% of clients were no longer experiencing unsheltered homelessness, and 65% accessed a Lanterman-Petris-Short conservatorship.
- Compared with usual care, the findings on the OPC intervention suggest untapped opportunities to minimize time spent in highly restrictive settings for individuals experiencing grave disability.

delusional thought content and executive function difficulties) can directly interfere with efforts to secure housing and basic needs for those experiencing homelessness (12–16).

Policy makers have recently proposed an expanded role for involuntary interventions to address the needs of this population (17). However, current experiences with involuntary approaches justify strong skepticism. In California, a legal strategy created by the Lanterman-Petris-Short Act called an LPS conservatorship can ensure safety for those who are unable to obtain food, clothing, or shelter because of a mental illness (i.e., grave disability) (18–20). LPS conservatorships last for 1 year, unless renewed, and temporarily transfer some decision-making responsibilities to a court-appointed guardian (e.g., a family member, public conservator, or professional fiduciary). Petitions for LPS conservatorship are almost always initiated during an involuntary psychiatric hospitalization. Depending on the length of the court process, individuals may remain in an acute care hospital for 30 days to 6 months on a temporary conservatorship (T-Con) until a hearing, or a court or jury trial, for LPS conservatorship in the county's mental health division of the California superior court. Once in conservatorship, individuals may remain in acute care hospitals for several more months awaiting a bed in a subacute care hospital (i.e., a state hospital or specialized psychiatric step-down hospital, often called an institution for mental disease). That the LPS conservatorship process entails extended periods in locked settings prima facie raises ethical concerns (21–23).

Moreover, because California lacks capacity in these service sectors (24–26), reliance on hospitals to initiate and manage the LPS conservatorship process limits access to the intervention, compromises patient and staff safety, and exacerbates disparities (27–30). A recent report estimated that three-quarters of acute care inpatient psychiatric beds managed by LAC are occupied by individuals awaiting a conservatorship proceeding or transfer to another facility (31). Wait times for subacute care or state hospital beds can last months or years (24). Psychiatric staff at one acute care hospital estimated that 60% of the hospital's patients could be discharged to a lower level of care (31). Los Angeles also lacks community residential settings, having lost an estimated 1,700 beds across 100 licensed residential facilities since 2016 (32). Such an overburdened system is unable to respond flexibly and appropriately to the complex needs of gravely disabled individuals experiencing homelessness.

In this article, we first describe a recovery-oriented, public health framework for addressing mental health disability among individuals experiencing homelessness, a framework that includes a highly circumscribed role for involuntary approaches. Then, we describe a pilot program in LAC that utilized this framework to shift care processes for this population before, during, and after LPS conservatorship. Implemented by a specialized mental health homeless outreach team, the outpatient conservatorship (OPC) pilot was designed to assist gravely disabled individuals to exit unsheltered homelessness. The OPC pilot included clinical, structural, and policy innovations that prioritized the most vulnerable unsheltered individuals, delivered timely services according to need, and made available a novel pathway to LPS conservatorship that prioritized the use of the least restrictive environments. Here, we outline the pilot program's impact on clients who were served during its first year.

A TRIADIC FRAMEWORK TO ADDRESS MENTAL HEALTH DISABILITY AMONG INDIVIDUALS EXPERIENCING HOMELESSNESS

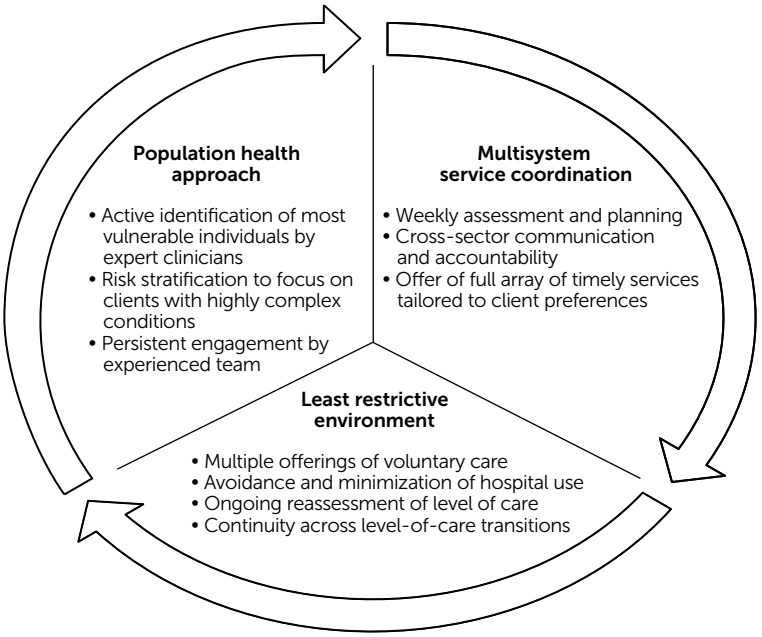
Street-based providers of medical services have outlined public health frameworks for addressing the general medical health needs of homeless populations that prioritize activities, including health risk surveillance in nontraditional settings, innovative partnerships to deliver care where people are living, and continuity of care to coordinate disparate sectors (33–36). We propose a recovery-oriented, public health framework for addressing mental health–related disability among individuals experiencing homelessness that relies on three strategies: a population health approach to proactively identify and engage the most vulnerable unsheltered individuals with severe mental illness, a multisystem care coordination strategy to offer resources in a timely manner, and prioritizing use of the least restrictive settings (Figure 1). We observed how this triadic framework emerged and crystallized in the practices adopted in the LAC OPC pilot, and we believe that the framework may have broader applicability for addressing homelessness among individuals with disabilities related to mental disorders.

Ample evidence supports the effectiveness of each component of the triad, yet rarely are the components implemented robustly in real-world contexts. For instance, a population health perspective represents a view that health among individuals experiencing homelessness exists on a continuum; accordingly, to be effective, the highest-intensity intervention should be targeted only to those showing the highest risks to their general medical health and safety (37–40). Emerging evidence suggests that, without intentional approaches, street outreach teams may not serve those individuals with the most severe general medical and mental health needs (41).

Service coordination matches clients' needs to services, speeds access, and improves satisfaction (42–44) by building bridges across sectors of relevant service providers and ensuring that services and transitions across levels of care are offered appropriately (45, 46). Although the needs of individuals with severe mental illness who are experiencing homelessness are beyond the scope of any single sector, community services are usually disjointed and siloed (47–49), and organizations are rewarded for prioritizing their own interests (50, 51).

Disconnected systems cannot leverage involuntary interventions to promote treatment engagement. In LAC, <10% of

FIGURE 1. Components of the outpatient conservatorship pilot program



individuals with multiple 72-hour psychiatric holds were enrolled in an intensive outpatient treatment program (24), and about 40% of adults who were admitted to fee-for-service acute care psychiatric hospitals were readmitted within 30 days (31). In another California county, 10% of unique individuals with a previous 72-hour hold accounted for one in four emergency medical service encounters (52).

The principle of least restrictive environment is enshrined in California law in the LPS Act (24), but these examples illustrate a failure to deliver on that promise. The principle of least restrictive environment stipulates that people should receive mental health treatment in contexts that curtail autonomy as little as possible (53–55). A least restrictive environment option balances individuals' preferences, their perceptions of an intervention's restrictiveness (56, 57), and risk. Coercive measures are used only in very exceptional circumstances, only after all alternatives are exhausted, and only in circumstances that pose immediate or substantial risk to the individual or others (58). Outpatient commitment, crisis resolution, home treatment policies that result in early hospital release, interventions that support shifts in the level of care as needs change, and housing models that do not require treatment can help optimize the use of least restrictive settings (59–64). Unmet need for services, barriers to access, ineffective services, and fragmentation of services result in the use of overly restrictive practices (45).

THE OPC PILOT PROGRAM

We demonstrate the relevance of the triadic framework by describing how a team specialized in outreach to individuals experiencing homelessness combines a population health approach, multisystem care coordination, and prioritization of least restrictive environments to create alternative care pathways for highly vulnerable unsheltered individuals with disabilities related to severe mental illness. In June 2020, the LAC Board of Supervisors approved a motion that aimed to disrupt the cycle of unsheltered homelessness, incarceration, and hospitalization by permitting psychiatrists affiliated with the LAC Department of Mental Health (LACDMH) Homeless Outreach & Mobile Engagement (HOME) team to petition for LPS conservatorship with the LAC Office of the Public Guardian outside of an acute care hospital. The HOME program is a specialized mental health homeless outreach program modeled on assertive community treatment that includes approximately 100 peer support providers, social workers, and other licensed mental health providers organized into eight teams across geographic regions in LAC. HOME provides basic needs (e.g., food), case management, peer support, housing and service linkages, and mental health services (e.g., assessment and trauma-informed counseling) to approximately 2,000 unique clients with severe mental illness each year. As part of an expansion begun in 2018 to offer street-based treatment, HOME sought to hire at least four full-time psychiatrists, but during the pilot period, HOME included only one full-time and one part-time (20% full-time equivalent) psychiatrist. Throughout the legal process used to evaluate the need for LPS conservatorship, the board motion allowed a HOME client to remain in the least restrictive clinically indicated setting, including the street. Consequently, providers understood that the goals of the pilot program should include decreasing homelessness; increasing access to LPS conservatorship, if indicated; and decreasing reliance on restrictive settings.

A Population Health Approach

Starting on August 3, 2020, the LACDMH and its partners participated in weekly OPC committee meetings. HOME teams used a population health perspective to select client cases to present to the committee, identifying the most refractory cases among the unsheltered population by using active identification, risk stratification, and persistent engagement. Team members drew on their extensive experience in managing chronic mental health conditions in the unsheltered population. They presented to the OPC committee cases of unsheltered clients with severe mental illness who were challenging to engage, exhibited patterns of risky behavior, ignored signs of physical danger, or showed symptoms that interfered with safety (e.g., delusions that prevented acceptance of food). HOME team members also

presented to the OPC committee cases of clients who had been failed by multiple systems and who were vulnerable to victimization, exhibiting signs of general medical health neglect (e.g., open wounds, infestations, limb edema, and weight loss).

Trained HOME social workers completed a validated instrument, the Vulnerability Assessment Tool (VAT), at baseline and 12 months to assess need. The VAT measures vulnerability to increased instability among individuals experiencing homelessness across 10 domains (survival skills, basic needs, indicated mortality risk, medical risks, organization and orientation, mental health, substance use, communication, social behaviors, and homelessness). Higher VAT scores indicate higher vulnerability represented in three strata (a score of ≥29 indicates "highly vulnerable," of 23–28 indicates "moderately vulnerable," and of ≤22 indicates "less vulnerable"). The VAT has adequate internal consistency and interrater reliability (65) and has shown a small but statistically significant relationship with service utilization (66).

Multisystem Service Coordination

Cases of clients identified by the HOME team were presented to the OPC committee, which then leveraged multisystem case conferencing and service coordination to mobilize all resources available to meet clients' needs. Committee participants included HOME leaders; representatives from DMH divisions with resources to serve HOME clients, including the LAC Office of the Public Guardian, providers of assisted outpatient treatment, and divisions managing subacute care hospital and licensed residential facility resources; the LAC Office of the County Counsel; acute care hospitals; and law enforcement. In all, >40 partners contributed to OPC service coordination. For each client, the OPC committee received a weekly update from the HOME team and ensured comprehensive assessment, treatment planning, linkage, reevaluation of progress, and advocacy until an end point was reached (67, 68). Interorganizational service coordination improved communication, tailored interventions to clients' needs, and generated holistic solutions. The committee fostered learning about complex processes (e.g., testifying and expediting medical clearance from the street). Clients were offered resources according to their preferences and eligibility, including interim housing, permanent supportive housing, licensed residential facilities, street-based psychiatry services, street-based provision of medical services, full-service partnership, assisted outpatient treatment, emergency medical or psychiatric care, and recuperative care. Only after this full array of services had been offered to and declined by the client would a client be considered for LPS conservatorship.

Least Restrictive Environment

The OPC pilot adopted the principle of least restrictive environment before, during, and after LPS conservatorship. LPS conservatorship was not considered until all voluntary services were attempted. Each week, the OPC committee explored whether the array of voluntary services and resources had been offered in a trust-enabling, person-centered manner. It suggested intensifying, diversifying, and improving the quality of street-based service delivery to avoid hospitalization. When hospitalization was indicated, continuity of care by the HOME team allowed for minimizing the time spent in hospitals. Because clients on a T-Con require the involvement of a psychiatrist who can testify at the LPS conservatorship hearing or trial, an inpatient psychiatrist usually assumes this responsibility. In the OPC pilot program, if clinically indicated, the client could step down from an acute care hospital while awaiting a proceeding because the HOME psychiatrist would be available to testify. A proceeding resulting in an LPS conservatorship empowers a court-appointed guardian to compel the client's treatment in an acute or subacute care hospital or placement in structured unlocked housing (typically, a licensed residential facility). The OPC pilot program prioritized the use of licensed residential facilities for individuals in LPS conservatorship by leveraging continuity of care from the HOME team to speed up step-down from hospitals or to place clients directly from the street into licensed residential facilities, avoiding hospital use entirely. (A figure illustrating this process is available in the online supplement to this article.)

METHODS

The DMH+UCLA (LACDMH and University of California Los Angeles) Public Mental Health Partnership (69) used mixed-methods data to track the implementation of the OPC pilot program and its impact on clients. Data included semistructured interviews with committee members (N=30) and a subsample of clients placed in LPS conservatorship through the pilot (N=23); scribed notes from committee meetings; and demographic characteristics, service use, and legal and housing outcomes for all OPC clients enrolled in the first year. Client interview data will be reported elsewhere; only summative findings from committee member interviews are reported here.

RESULTS

Pilot Program Implementation

Findings from committee observations and interviews indicated that a population health approach, multisystem care coordination, and use of least restrictive environments operate interdependently. HOME teams adopted a population health approach to engage their most vulnerable clients because the teams hoped to take advantage of multisystem resources. The teams offered a full range of resources to clients once clients were assured that the least restrictive options would be available. A HOME psychiatrist describes the pilot program as activating the continuum of care: "[We] go on a journey with the patient from one end point to another. . . . I cannot think of a better way that would help you because everything's [on] the table.

[Because a] person is so impaired, you need to activate every single system of care you have." Several providers described the importance of care continuity before, during, and after LPS conservatorship. One provider said that the pilot program is "working this time . . . because there's the HOME team involved . . . with these clients before they ever come to [the LAC Office of the Public Guardian], and then [there is] ongoing involvement with them" throughout the conservatorship process. Another said, "I think it's wonderful that this pilot is allowing the psychiatrists, the clinicians, the case managers, [and] the teams that have actively been working with the clients and know the clients to initiate the conservatorship. . . . Our team has a lot more information [than inpatient providers have] and that may be more valuable . . . when we're advocating for [less restrictive] levels of care." Another provider emphasized the role of care coordination in decreasing the use of restrictive practices: "[A]s we focused our efforts on these clients who haven't been able to progress for sometimes years at a time, we found that as we brought in [more resources], many of the patients are accepting the resources that we're offering them, and they don't require the conservatorship at all." Another described the committee emphasis on voluntariness: the committee was "good at looking at the holes and the gaps and [saying], 'Well, why haven't you tried this? Are you doing this?' So . . . it may have been like, 'Oh, we didn't try that'" and would return to the client to do so.

A coincidental yet crucial factor in the success of the pilot project was the opportunity to use remote testimony for most court proceedings because of COVID-19 safety protocols that obviated the need for transportation from the street to court. HOME psychiatrist staffing gaps shaped implementation of the program because LAC mental health court processes allow only psychiatrists or psychologists to apply and testify for LPS conservatorship. Shortages of subacute care hospital beds and housing placements prolonged the time spent unsheltered and delayed step-downs to less restrictive environments.

Program Impacts

Clients served. Between August 3, 2020, and June 30, 2021, the OPC pilot program served 43 clients (Table 1). OPC clients constituted 2% of the total number of clients served by HOME over the pilot period (N=43 of 2,143 unique clients) (70). Overall, 67% (N=29) of OPC clients were male, consistent with the percentage in the LAC homeless population (71). Black or African American clients represented 42% of OPC clients. Black individuals are overrepresented among individuals experiencing homelessness in LAC (34% of homeless individuals vs. 9% of the total population) (71). OPC client diagnoses included schizophrenia, schizoaffective disorder, delusional disorder, substance use, and general medical illness (e.g., HIV, extremity infections, atrial fibrillation, wheelchair dependence, traumatic brain injury, and pulmonary embolism).

At baseline, 91% (N=39) of the OPC clients scored in the highly vulnerable range on the VAT (total VAT score ≥29) (Table 1). All but one OPC client had been unsheltered for >12 months, with about one-third (37%) experiencing unsheltered homelessness for 1–5 years; 30% experienced unsheltered homelessness for >5 years and another 30% for an uncertain duration of at least a few years. VAT scores were assessed at 12 months for 36 of 43 clients, with 31% (N=11 of 36) scoring in the highly vulnerable range. The mean±SD change in VAT scores was −7.0±6.4. The VAT domains of communication, medical risk, and social behavior showed the most improvement. Because VATs were administered only to OPC clients, comparisons at baseline and 12 months with all HOME clients or the LAC unsheltered population were not possible.

Exit from unsheltered homelessness. At 12 months, 35 (81%) of 43 clients were no longer unsheltered, and one (2%) was deceased. Thirteen (30%) of 43 clients lived in unlocked independent housing, permanent supportive housing, or licensed residential facilities; two (5%) lived with family; and 20 (47%) were placed in acute or subacute care hospitals (Figure 2). Three (7%) were lost to follow-up, and four (9%) remained unsheltered. At 18 months, 33 (77%) of 43 clients were no longer unsheltered, of whom 13 (39%) were living in independent housing, permanent supportive housing, or licensed residential facilities.

LPS conservatorship. Over 12 months, the committee assessed 32 (74%) of the clients as being gravely disabled and referred these clients for LPS conservatorship. The reasons given by the committee for nonreferral for LPS conservatorship for 11 (26%) of the clients included the following: need for additional offers of voluntary care (N=3); eligibility for enrollment in assisted outpatient treatment, which could continue offers of voluntary care or petition for court-mandated outpatient treatment (N=2); engagement in voluntary care after OPC committee presentation (N=3); and primary diagnoses of substance use disorders with or without comorbid dementia (N=3) and a lack of subacute care hospital services for this population. The mean total VAT score at baseline for the 32 referred clients was 34.5±4.2 versus 32.0±5.2 for the 11 nonreferred clients (Table 1). Among the 11 nonreferred clients, four (36%) had voluntarily gained housing at 12 months. Among the 32 clients who had been referred for LPS conservatorship, the mental health court granted LPS conservatorship for 28 (88%) individuals. At 18 months, 25 (89%) of these 28 clients continued the LPS conservatorship, and three (11%) had been released from conservatorship.

Least restrictive environment. Among the 32 clients who had been referred for LPS conservatorship, 28 (88%) had an acute care psychiatric hospital stay at some point during a 12-month period (Figure 3). The mean number of days in the hospital during these 12 months was 96.9±76.1 for all 32 referred clients and 98.0±81.1 for the 28-client subset.

TABLE 1. Characteristics of clients whose cases were presented to the outpatient conservatorship committee from August 3, 2020, to June 30, 2021[a]

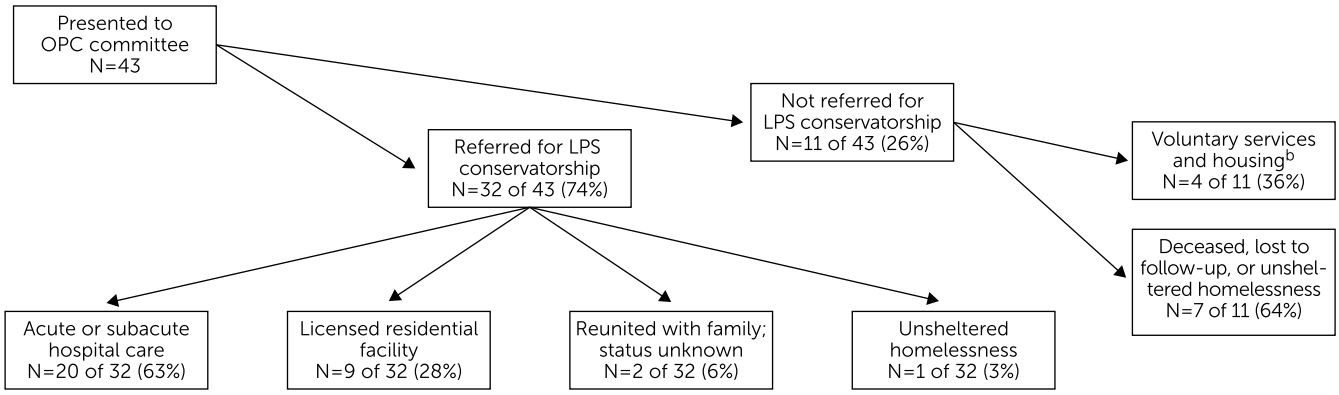
	Total (N=43)		Referred for LPS conservatorship (N=32)		Not referred for LPS conservatorship (N=11)	
Characteristic	N	%	N	%	N	%
Gender						
Female	14	33	12	38	2	18
Male	29	67	20	63	9	82
Age in years (M±SD)	48±14		49±13		48±16	
Race-ethnicity						
Black or African American	18	42	16	50	2	18
White or Caucasian	14	33	11	34	3	27
Latinx	6	14	2	6	4	36
Asian American	3	7	2	6	1	9
Native Hawaiian or Pacific Islander	1	2	0	—	1	9
Multiracial	1	2	1	3	0	—
Homelessness duration of current episode (years)						
<1	1	2	1	3	0	—
1–5	16	37	11	34	5	45
6–10	6	14	3	9	3	27
11–15	4	9	4	13	0	—
≥16	3	7	2	6	1	9
Uncertain length, at least a few years	13	30	11	34	2	18
Vulnerability Assessment Tool score at baseline						
Total (M±SD)	34.0±4.5		34.5±4.2		32.0±5.2	
≥29 (highly vulnerable)	39	91	31	97	8	73
23–28 (moderately vulnerable)	3	7	1	3	2	18
≤22 (less vulnerable)	1	2	0	—	1	9
Housing status at 12-month follow-up						
Sheltered	35	81	31	97	4	36
Unsheltered	4	9	1	3	3	27
Lost to follow-up	3	7	0	—	3	27
Deceased	1	2	0	—	1	9
Acute care psychiatric hospital days over 12 months						
0	11	26	4[b]	13	7	64
1–50	5	12	3	9	2	18
51–100	14	33	12	38	2	18
101–150	8	19	8	25	0	—
>150	5	12	5	16	0	—
LPS conservatorship at 12 months						
Yes	28	65	28	88	0	—
No	15	35	4	13	11	100

[a] LPS, Lanterman-Petris-Short.
[b] One of the four individuals with 0 days in an acute care psychiatric hospital used an acute care general medical hospital.

Nineteen (59%) of the 32 clients used subacute care placements. Fifteen (54%) of the 28 clients stepped down from acute psychiatric care earlier than would have been the case without the support of the pilot program (i.e., on T-Con): nine (60%) of these 15 clients stepped down early to licensed residential facilities, and six (40%) stepped down to subacute care hospitals. Unlike for a typical LPS conservatorship process, 14 (44%) of the 32 clients used unlocked licensed residential facilities at some point over the 12-month period.

Three (9%) of the 32 clients who had been referred for LPS conservatorship used neither acute nor subacute care hospitals; by means of the power granted to the court-appointed guardian at the placement of the LPS conservatorship, these clients moved from the street to licensed residential facilities and remained at this level of care. For example, a 55-year-old man who was living in a park believed that he was required to do so while awaiting orders from an espionage agency. This client declined all offers of voluntary housing over a 5-month period, but the HOME team cultivated trust by advocating for his safety with peers in the park, bringing supplies to increase his comfort, and connecting him to a street-based medicine team to address his general medical health concerns. With the client's consent, the HOME psychiatrist initiated a low-dose

FIGURE 2. Twelve-month outcomes among unsheltered clients served by the outpatient conservatorship (OPC) pilot program[a]

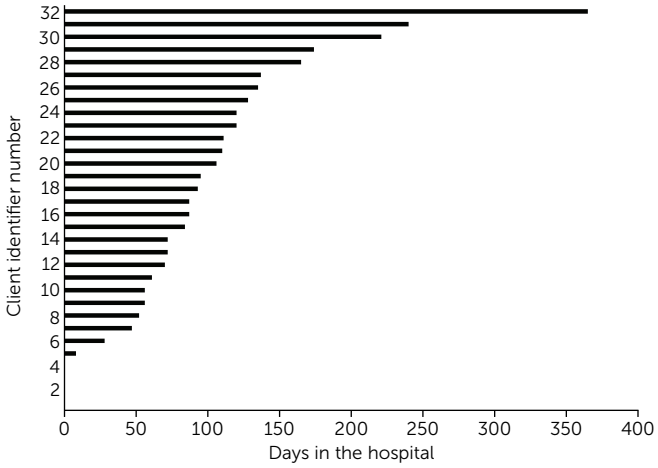


[a] LPS, Lanterman-Petris-Short.
[b] Clients remained voluntarily engaged with the Homeless Outreach & Mobile Engagement (HOME) team to obtain or sustain voluntary housing. At 12 months, two of four clients used brief acute hospital care to this end.

antipsychotic medication. After court determination of grave disability, he moved into a licensed residential facility for the follow-up duration. Similar trajectories were accessed by a 54-year-old man experiencing chronic homelessness who was found to be catatonic and to have a skin infestation and by a 66-year-old man who lived surrounded by plastic bags, trash, and rotten food; heard surrounding buildings tell him that he could not leave; and often refused food and cover from the rain.

Other clients accessed a licensed residential facility early. One 37-year-old woman had been living for several years on a bus bench, having grandiose delusions and illogical speech, sometimes lighting fires under the bench to keep warm, and storing her feces in bags under the bench. She refused all services over 9 months. Her items were frequently stolen, and providers suspected that others victimized her. Subsequently, the client built a tarp tent over the bench and refused to come out or let providers look in. She developed medical complications that were thought to result from burning materials for warmth inside the tent. After an acute care hospitalization during which an LPS conservatorship petition was filed, the client moved to an unlocked residential setting within the first year. Similar positive trajectories were observed for a 55-year-old man who previously dressed in trash bags and walked in circles and a 55-year-old man who was cachectic and mute, lacked shoes, and dressed in plastic bags.

FIGURE 3. Acute psychiatric hospital use over 12 months among clients referred for Lanterman-Petris-Short conservatorship (N=32)



DISCUSSION

The LAC OPC pilot program combined a population health strategy, multisystem care coordination, and the use of least restrictive environments to serve highly vulnerable unsheltered individuals with mental health–related disabilities. We call this a triadic framework to address mental health disability among individuals experiencing homelessness because the three components were interrelated and interdependent. The results of the OPC pilot program reported here reflect an observational program evaluation only. Several limitations of this study—most notably, the lack of a comparator group—should be considered when interpreting the results. Nonetheless, the HOME team apparently was successful in assessing and stratifying risk among its clients to identify a group of high-risk individuals; 65% of OPC clients were placed on an LPS conservatorship. Multisystem care coordination appeared to improve engagement and continuity of care, with only three clients lost to follow-up at 12 months. The OPC pilot used innovative practices that lessened the use of restrictive settings, including filing a petition for LPS conservatorship from the street, involving street-based teams (rather than inpatient psychiatrists) to testify in court proceedings, and facilitating early step-downs from hospitals.

At the end of 1 year, 81% of OPC clients were no longer experiencing unsheltered homelessness (Table 1); 26% at 12 months and 30% at 18 months were living in unlocked structured or independent housing. These observations

indicate notable impacts among individuals in a highly vulnerable group; about two-thirds of the OPC clients had endured unsheltered homelessness for several years. Although housing outcomes for a matched cohort were not available, housing placement rates for individuals experiencing homelessness in LAC are lower than those observed in this study. For example, 16% (N=209 of 1,324) of HOME clients served over 10 months in 2022 had a housing placement (70). Among all individuals served by LAC homeless outreach in the year before the pilot, 20% obtained housing placement within 12 months (9).

The OPC pilot included a narrow but critical role for involuntary care when every other approach failed to ensure safety. Only 2% of HOME clients were deemed eligible for the OPC program, and LPS conservatorship was not considered until OPC clients repeatedly declined services despite experiencing compromised safety. However, among those who were deemed appropriate for LPS conservatorship, 97% were no longer unsheltered at 12 months. Among OPC clients who were not referred for LPS conservatorship, 64% remained homeless, were lost to follow-up, or died despite intensive supports from HOME and the OPC committee. Although our evaluation did not allow for examination of systematic differences between referred and nonreferred clients, these results support further study of when involuntary care may be appropriate for those experiencing homelessness with a mental health–related disability.

The high proportion of OPC clients requiring acute and subacute hospital care at 12 and 18 months attests to the severity of the clients' mental health disability. Nonetheless, pilot findings suggest untapped opportunities to minimize time spent in locked settings for gravely disabled individuals. A recent study of clients experiencing homelessness who were placed on involuntary psychiatric holds at an LAC public hospital reported that referral for LPS conservatorship was associated with a mean length of inpatient stay of 155 days (23). In contrast, among OPC clients who were referred for LPS conservatorship, the average number of inpatient days over 12 months was 97, a difference of 2 months. Individuals who were placed on a T-Con or LPS conservatorship in LAC typically spend at least a year in locked acute and subacute care settings; a 2019 report found that the average length of stay at specialized subacute care hospitals serving clients in LPS conservatorship in LAC was about 343 days (31). In contrast, almost half of the OPC clients who were referred for LPS conservatorship stepped down from acute or subacute care hospitals into licensed residential facilities over 12 months; nine (28%) of the 32 OPC clients lived in such facilities at 12 months.

The importance of the care coordination component of the OPC pilot study suggests that disconnected and inaccessible systems of care impose a drag on timely care for vulnerable clients. OPC providers reported that gathering all resources for clients was novel and impactful. The timely availability of street-based treatment options and robust offering of all voluntary services by a skilled team obviated the need for LPS conservatorship in some cases. Continuity of care by the HOME team facilitated movement of clients along the continuum of care (72). Even in contexts where evidence-based approaches are widely available, improving care coordination could enhance outcomes for clients who decline service engagement (73, 74).

Our findings also reflect the profound effect of persistent structural racism in compounding disadvantages experienced by individuals with severe mental illness. Black individuals are overrepresented in the OPC client sample and among those referred for LPS conservatorship (27). Other clients were underserved because of resource gaps. As noted, three OPC clients with co-occurring substance use disorders with or without dementia were not referred for LPS conservatorship, despite their vulnerability, because subacute care hospitals serving this population were unavailable. The scarcity of resources increased reliance on acute care hospitals because of the wait periods for subacute care or licensed residential beds or because these step-down facilities might decline to manage a general medical health problem. Only one of eight HOME teams was staffed with a full-time psychiatrist, increasing the use of restrictive settings, because only clients served by a HOME psychiatrist could step down from a hospital while awaiting a hearing or trial.

CONCLUSIONS

The triadic framework used in the OPC pilot project—comprising a population health strategy, multisystem care coordination, and use of least restrictive environments—constitutes a promising approach for serving gravely disabled individuals experiencing homelessness and for lessening the profound disparities experienced by individuals with severe mental illness. Further research is needed to explore refinements such as how to optimize the use of innovative pathways to housing and which resource gaps must be filled to make them accessible. This study's findings suggest that licensed residential settings, acute and subacute care psychiatric hospitals, and intensive street-based treatment teams play vital roles in addressing homelessness.

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