JustCARE

The Development and Impact of a Multi-Faceted Collective Impact Model

Katherine Beckett, Marco Brydolf-Horwitz, Devin Collins, Allison Goldberg, Emily Knaphus-Soran, and Aliyah Turner

University of Washington

June 3, 2021

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Executive Summary

What is JustCARE?

Developed in the context of a global pandemic and the intensification of the movement for racial justice, JustCARE is a novel collective impact model that simultaneously reduces unsheltered homelessness, barriers to health care, and the harm caused by the criminal legal system – even as it improves public safety and neighborhood quality of life. JustCARE was born in the summer of 2020 as a result of a collaborative effort among community partners and provides supportive interim housing to people contending with income instability, homelessness, substance use disorders, unsupported mental health disabilities, and criminal legal system involvement. Throughout its operations, JustCARE draws on the harm reduction philosophy, focuses on building constructive and trusting relationships, and employs a racial equity lens to ensure that the intervention mainly benefits Black, Indigenous, and other people of color.

JustCARE involves several organizations that provide housing and support. These include The Public Defender Association's LEAD and CoLEAD programs, Evergreen Treatment Services' REACH program, Asian Counseling and Referral Services, and Chief Seattle Club. In addition, JustCARE utilizes de-escalation and safety services from Wheeler Davis Conglomerate, a company formed in 2020 by community leaders to provide safety strategies and services as an alternative to police and private security. JustCARE also works closely with a number of community partners, including business groups such as the Alliance for Pioneer Square and the Chinatown/International District Business Improvement Association, as well as organizations that represent neighbors and other residents. Finally, JustCARE collaborates with a range of social service providers and public entities (such as King County Metro and Seattle Public Utilities) to address quality of life and access issues in impacted neighborhoods.

LEAD

Street based outreach and support

REACH

Street based outreach and support

CoLEAD

Hotel based interim supportive housing provider

Asian Counseling and Referral Services

Hotel based interim supportive housing provider

Chief Seattle Club

Hotel based interim supportive housing provider

Wheeler Davis Conglomerates

Public safety strategies and services

Evaluation Approach

This report is intended to provide policymakers, practitioners, and other interested parties with a detailed overview of what JustCARE is, how it emerged, the work it accomplishes, and lessons it has learned. It also offers policy recommendations aimed at enhancing JustCARE's impact and recommendations for data collection that will facilitate ongoing evaluation.

The analysis draws on several different types of data, all of which were collected from April 2020 through March of 2021. These data include interviews with

- Forty-two JustCARE participants, many of whom were interviewed multiple times over a period of months.
- Twelve outreach responders and other program staff.
- Ten leaders of participating organizations.
- Eleven community members representing organizations of people who live and/or work in impacted areas.
- Seven stakeholders involved with alternative crisis response models across the United States.

The data also include observation of select JustCARE planning and operations meetings, review of administrative documents, and analysis of administrative data provided by REACH, PDA, ACRS, and Chief Seattle Club.

Key Findings

» JustCARE's multifaceted and integrated approach distinguishes it from other related initiatives.

- JustCARE shows why an integrated response that addresses housing needs, mental and physical health, substance use disorders, and criminal legal system involvement is needed, and provides a compelling example of how such integration can be accomplished.
- This integrated approach reduces the policeability of situations and behaviors that might otherwise trigger law enforcement responses.
- JustCARE's focus on both individual- and neighborhood- level quality of life and well-being appears to be unique.

» PDA serves an important role in coordinating across partnering agencies and other stakeholder groups, and illustrates the importance of a strong backbone organization in a collective impact initiative.

- Hiring and supporting a diverse staff with a variety of backgrounds and kinds of knowledge, including lived experience, will enable providers to leverage various kinds of expertise and to build authentic and trusting relationships with participants.

» The success of this housing intervention shows that people who live unsheltered and experience unsupported mental health disabilities and/or substance use disorder are not housing- or service- resistant. Instead, housing must meet basic needs for safety, privacy, and security and be accompanied by appropriate support.

- Unlike many pandemic-induced housing-related initiatives, JustCARE provides housing to people who would otherwise be living unsheltered.
- People who experience unsheltered homelessness are more likely to have significant mental and physical health issues, including substance use disorders, than people who experience sheltered homelessness.
- The JustCARE team found that they could safely house and support the vast majority of people living in encampments. Only 13 percent of those who were enrolled have been exited from the program because they could not be safely housed in the hotels.

» Hotels provide safety, privacy, and security for participants.

- Access to private and secure housing is deeply appreciated by participants, who report significant improvements in psychological and emotional well-being after moving into hotels and establishing positive relationships with outreach responders.
- The use of de-escalation and dedicated safety teams help ensure that hotels remain safe for participants, program staff, and hotel staff.
- At the same time, uncertainty regarding the future of JustCARE funding and the paucity of permanent housing options create anxiety for participants and outreach responders alike.

» Interim supportive housing enables participants to address outstanding legal issues, secure identification, access medical care, obtain benefits, reconnect with family, apply for permanent housing, and more.

- The vast majority of participants identified one or more of these as personal goals and worked toward them with the support of outreach responders.
- As of February 28, 2021, twenty-one JustCARE participants had secured permanent housing and moved out of the hotels. Many others will be able to do so soon.
- Securing access to benefits to which they are entitled makes future independent living possible for many JustCARE participants.
- JustCARE's communication and coordination with legal systems to enable resolution of legal matters appears to be unique and is experienced as extremely helpful by many participants.

» By employing licensed medical providers who provide on-site treatment and coordinate care, JustCARE is able to address participants' complex health needs and create plans for continued care.

- People who live unsheltered contend with a variety of serious mental and physical health issues, often including substance use disorder. This is also true of JustCARE participants.
- Although not an option for all, increased access to medication-assisted treatment for substance use disorders has been helpful for many.

» JustCARE improves public safety and quality of life for participants and communities.

- Unauthorized encampments are often associated with unsafe living conditions that adversely impact residents and their neighbors.
- JustCARE improves individual and neighborhood safety by moving people from encampments to hotels. Both participants and community partners report high levels of satisfaction with this aspect of the intervention.
- JustCARE outreach teams also coordinate care and support for people whose behavior disturbs neighbors but who cannot be placed into hotels in order to reduce harm and improve quality of life for all concerned parties.
- JustCARE appears to reduce participants' reliance on illicit survival strategies such as theft. Interviews with participants and with outreach responders indicate that participants have ceased or decreased their use of such illicit income-generating strategies.
- The employment of harm-reduction oriented, proactive, and creative problem-solving strategies and de-escalation by staff and safety teams have helped to reduce conflict and disruption in the hotels.
- 911 call data show that calls for service in the targeted encampment areas and in the hotels utilized by JustCARE were lower in the aggregate in January-February of 2021 than during the same months of 2020.

» JustCARE helps shift the cultural narrative around public safety and addresses the harm associated with criminal legal responses to behavioral health issues.

- JustCARE works directly with community members to address public safety concerns rather than having dispatchers reroute a small proportion of calls.
  - In this way, JustCARE serves as an important alternative to 911 in the neighborhoods in which it works.
- Community partners report high levels of satisfaction with JustCARE's response, preferring it to law enforcement, sweeps, and dispersal orders.
- JustCARE outreach responders coordinate and communicate with prosecutors and other legal officials in ways that reduce the burden created by past and present criminal legal system involvement.

» JustCARE is an important tool for reducing police interactions with vulnerable people and for reducing the policeability of unsupported mental health disabilities and substance use disorders.

- Many police interactions involve individuals contending with mental health disabilities and/or substance use disorders.

- Recent calls to defund the police rest, in part, in recognition of the harm that too-often accompanies these interactions.
- Decreasing police involvement in the management of behavioral health issues may be the single most effective method for reducing the overall number of daily police interactions with vulnerable populations.

Lessons Learned

Stakeholders and care providers have learned a number of lessons in the course of creating and implementing this novel, collective impact initiative. These lessons include:

» **High level criminal activity involving sexual exploitation, sexual assault, and drug dealing is embedded in many encampment sites.** This makes it difficult for some vulnerable people to engage with service providers and/or leave the encampment. Outreach responders need to anticipate this reality and have a plan for dealing with it.

» **The vast majority of people who have lived unsheltered for extended periods of time and who contend with substance use disorder and/or unsupported mental health disabilities are not housing- or service- resistant. Most can succeed in hotel-like environments with a low-barrier approach, the right supports, and harm reduction orientation.**

- Preparing and training program and hotel staff will help in this effort, as will securing the services of safety experts trained in de-escalation.
- Lodging liaisons are key to the success of any supportive interim housing initiative that relies on hotels or motels.
- People with very severe and persistent mental health impairments such as psychotic spectrum disorder may be better served in a more structured residential group setting that can provide psychiatric rehabilitative services.

» **Lodging agreements provide an important reference point for working with participants and in helping participants build accountability skills and goals.**

» **Hotels provide comfort, privacy, and security, but they do not always provide opportunities for meal preparation.** Anticipating people's needs for food and food preparation is key.

- Stand-alone cooking devices such as microwaves and crock pots, as well as the procuring of nutritious food via food banks and food coops to provide an array of appealing and nutritious options, have been helpful.

» **The presence of a harm reduction-oriented medical provider who provides on-site assessment and care and coordinates care to meet complex health needs is critical.**

» **Contingency management (the use of gift cards and other reward-based incentives) can help support alignment with the lodging agreement and help build independent indoor living skills.**

» **Given that interactions between police and people (especially people of color) with unsupported mental health disabilities are too often unhelpful, de-escalation without reliance on law enforcement is the preferred resolution for all non-emergency situations.**

- Law enforcement engagement with this population should be very limited and, if necessary, carefully managed.

» **Working with prosecutors to address pending and outstanding charges and warrants is extremely helpful.** Prosecutors may be more likely to drop or reduce charges when people are housed and supported.

- Building trusting relationships with prosecutors via LEAD or other mechanisms will facilitate this work.

Policy Recommendations

It is abundantly clear that relying on sweeps, police, and jails to address homelessness and behavioral health issues is a failed strategy.[1] JustCARE providers encounter a number of other important system failures and gaps that further hinder their work. Below, we offer policy recommendations that are intended to address these gaps and improve the efficacy of JustCARE and other efforts to address income instability, homelessness, unsupported mental health disabilities, and substance use disorders without reliance on the criminal legal system. Our recommendations are as follows:

» **Fully fund JustCARE to enable the expansion of its many benefits.**

- The data provided in this report show that JustCARE is a uniquely promising intervention that can meet the needs of both Seattle's most vulnerable residents as well as those of people who live and work near unauthorized encampments.
- Investing in the kind of supportive interim housing that JustCARE provides will enable providers to identify people who do not require permanent supportive housing.
- Like other first responder alternatives to police, Seattle's Health One response unit provides an important service to meet the immediate situation of individuals in crisis. However, alternative crisis response models will only have transformative effects if there are community services available to meet the immediate and long-term needs of people experiencing extreme poverty, substance use disorder, and mental health issues.

» **Significantly expand housing options for people with extremely low incomes.**

- Inadequate affordable housing and permanent supportive housing options sharply limit the long-term impact of interim supportive housing.

- Experts estimate that between 15,000-40,000 new units of affordable permanent housing are needed in the Seattle/King County area to solve the crisis of homelessness.[2]
- Some portion of these should be dedicated to serving people with unsupported mental health disabilities and/or substance use disorder who require supportive housing.

» Invest in street-based outreach in the community aimed at ensuring that people are in HMIS and ECLS and are able to access and maintain their benefits and remain on waiting lists for permanent housing.

- Many people living unsheltered are not in the HMIS (Homeless Management Information System), which functions, in part, as the entry point for certain housing programs.[3] This appears to be because many homeless services do not center or orient around people who live unsheltered and contend with mental health issues and/or substance use disorder.
- Many people who have experienced homelessness for extended periods of time do not appear in the Extended Client Lookup System (ECLS), the county-managed centralized behavioral health database in which publicly-funded care providers upload information about mental health and substance use diagnoses and treatment. As a result of the aforementioned barriers to accessing behavioral health-care, this database is incomplete and of limited utility to providers.

» Invest in mobile healthcare units and community clinics that provide street-based outreach to decrease reliance on emergency rooms for routine medical care, and provide healthcare workers with harm reduction-oriented training regarding substance use disorders.

- Hospital care and urgent care continue to be challenging to coordinate for people who use drugs and who experience a great deal of stigma in the medical system. This stigma makes care coordination challenging and may lead to premature release from medical facilities.
- Although less stigmatizing, the publicly funded behavioral health treatment system continues to present barriers for the JustCARE population because most services are delivered in clinics rather than in the field or on-site. In addition, telecare appointments that occur via telephone and computer create significant barriers to access for some.

» Improve access to mental health and medically assisted treatment (MAT).

- Mental health residential treatment options for people with high acuity mental health issues are highly constrained. Those that do exist are often inaccessible to people with substance use disorders and/or criminal histories.
- The process for securing civil commitments under the Involuntary Treatment Act for people who are a danger to themselves or others is extraordinarily burdensome and inefficient. This system is also characterized by a lack of adequate discharge planning and follow-up care resources in the community, especially interim housing facilities that would be voluntarily accepted by individuals discharged from full confinement.

- The absence of a harm reduction-oriented, medication-assisted treatment protocol for people who use stimulants makes serving people who use stimulants very difficult.

» Where housing remains a barrier and people continue to live outside, invest in making encampments more livable spaces that include health and sanitation services.

- Participants, outreach workers, and other community members interviewed for this study all noted the safety and health concerns related to unauthorized encampments. While interim and long-term housing are preferable to encampments, some of these concerns could be mitigated in the interim through provision of health and sanitation services to encampments.

» Advocate for federal reforms that facilitate the acquisition of benefits and/or provide universal basic income.

- Benefits are extremely difficult to access and maintain for people who experience homelessness. Securing and maintaining means-tested benefits such as food stamps and entitlements such as disability is an extraordinarily complex and burdensome process. These benefits are therefore inaccessible to many people absent interventions such as JustCARE.

Recommendations for Data Collection

This evaluation provides initial insights regarding the evolution and impact of JustCARE in its first six months of operations. A more comprehensive and longer-term assessment of JustCARE's impact at the participant, neighborhood, and system-levels will require improved data collection and integration.

We recommend that the following data be collected in a manner that renders them easily retrievable by analysts. Data needs include:

- Data regarding past and present criminal legal system involvement among enrolled participants.
- Data regarding any use of emergency services, including emergency hospital visits, by enrolled JustCARE participants.
- Data regarding health needs addressed, changes in health status, and changes in self-reported quality of life among JustCARE participants.
- Consistent documentation of service referrals and benefits secured by JustCARE participants.
- Systematic recording of reasons why people are removed/exited from JustCARE and steps taken to ensure their well-being.
- Surveys gauging satisfaction and perceptions of public safety among community partners and JustCARE participants.

If future interventions in encampments occur, we recommend that the following data be collected in order to facilitate robust assessment of the impact of these interventions for neighborhoods:

- Recording and documentation of all services provided, including dumpster provision and other trash mitigation services; coordination with other agencies; services provided in the encampments.
- Before-and-after surveys with people who live and work in impacted areas regarding perceptions of safety and quality of life in the neighborhood.

Initiatives such as JustCARE may well save the city and county money. Each of King County's "familiar faces" – people who contend with homelessness, unsupported mental health disabilities, substance use disorder, and on-going criminal legal system involvement – cost the county an estimated $28,000 as of 2016.[4] In 2021 dollars, this represents a cost of over $31,000 per year. This estimate does not include city or state costs of any kind, or reflect the benefit associated with reduced crime or improved quality of life.

In order to facilitate a cost-benefit analysis of JustCARE, we recommend collection of the following data:

- Survey of local business owners to learn more about whether/how JustCARE's intervention affects hiring and business operations.
- Information regarding prior use of emergency services and jail stays among JustCARE participants that can be compared with use of services and jail stays while enrolled in JustCARE.

Finally, we recommend that JustCARE providers utilize a single data entry system and adopt consistent metrics across care providers to facilitate data collection and analysis.

Introduction

In the fall of 2020, with support from King County officials administering CARES Act funds, a number of community partners launched a new, collaborative initiative that provides supportive interim housing to people contending with homelessness, income instability, substance use disorders, unsupported mental health disabilities, and criminal legal system involvement. Developed in the context of a global pandemic, JustCARE offers a new model for simultaneously reducing unsheltered homelessness, barriers to health care, and the harm caused by the criminal legal system – even as it improves public safety and neighborhood quality of life.

What is JustCARE?

Forged in the context of a global pandemic and heightened calls for racial justice, JustCARE is a novel and multifaceted initiative. It is, at one level, a Housing First intervention that provides interim supportive housing for people who are living unsheltered[5] and are sometimes described as service and housing resistant. It is a health initiative aimed at reducing the transmission of COVID 19 and other communicable diseases and improving access to health care for some of Seattle's most vulnerable residents. JustCARE is also a neighborhood-focused public safety and quality-of-life initiative, one that avoids reliance on the police, the criminal legal system, and sweeps and dispersal orders. At the same time, it is a decarcerative effort, taking proactive steps to minimize police interactions with vulnerable people and ameliorate the harm caused by the criminal legal system. Finally, JustCARE is a collective impact model: a cross-sector collaboration that involves continuous learning and adaptation aimed at creating and implementing a novel response to a complex social problem.

JustCARE's multifaceted nature sets it apart from many other initiatives. For example, unlike many public safety initiatives, JustCARE seeks to reduce reliance on the police and criminal legal system and mitigate the damage caused by outstanding warrants, criminal records and legal debt. Similarly, unlike many other Housing First interventions, JustCARE focuses on both individual needs and the concerns of the neighborhoods in which encampments are located. It does so both by moving people out of unauthorized encampments and into hotels as well as by providing support for individuals whose behavior is experienced by neighbors as disruptive but who cannot be safely housed in hotels.

Throughout its operations, JustCARE draws on the harm reduction philosophy and employs a racial equity lens to ensure that the intervention mainly benefits people of color and marginalized people. Toward this end, it employs a diverse group of outreach responders and other care providers – many of whom bring relevant lived experience and expertise to their work – and pays them a salary that reflects the importance of the work they do and the risks they take to perform it in the context of the pandemic. JustCARE also emphasizes the relational aspect of the work it performs and makes staffing choices that facilitate the development of meaningful, trusting relationships between staff, participants, and community partners.

What is Harm Reduction?

The harm reduction philosophy is central to LEAD and to JustCARE, and rests on the assumption that some people will always engage in behaviors, such as drug use, that are risky and potentially harmful to self and/or others.[6] From a harm reduction point of view, the active intervention of the criminal legal system is counterproductive. Instead, priority should be placed on the provision of health care and social services guided by harm reduction principles to help reduce overall levels of suffering. Harm reduction practitioners emphasize that the path toward abstinence is often long, and sometimes non-existent. Nonetheless, meaningful reductions in human suffering and harmful behavior can be achieved via harm reduction measures, even in the absence of abstinence.

JustCARE involves many different organizations. Central partners include REACH and the Public Defender Association (PDA), both of which support Let Everyone Advance with Dignity (LEAD) and provide street-based outreach and support; PDA's CoLEAD program, Asian Counseling and Referral Services (ACRS), and Chief Seattle Club (with the support of the Seattle Indian Health Board), all of which provide housing and support in hotels; and Wheeler Davis Conglomerate, which provides safety services and strategies in and around the hotels. A variety of other organizations and initiatives, including Alliance for Pioneer Square, HEALTH One, the Chinatown-International District Business Improvement Association, the Downtown Emergency Services Center, King County Public Health, and the Pioneer Square Resident's Council, also play supportive roles. JustCARE also collaborates with a range of social service providers and public entities (such as King County Metro and Seattle Public Utilities) to address quality of life and access issues in impacted neighborhoods.

LEAD	REACH	CoLEAD
Street based outreach and support	Street based outreach and support	Hotel based interim supportive housing provider

Asian Counseling and Referral Services	Chief Seattle Club	Wheeler Davis Conglomerates
Hotel based interim supportive housing provider	Hotel based interim supportive housing provider	Public safety strategies and services

JustCARE is also a collective impact model. Collective impact models involve actors from diverse organizations and sectors that commit to a common agenda in order to develop a new, structured approach to addressing a complex and often evolving social problem.[7] Such models, including JustCARE, have five core features.

1. **Common Agenda:** In collective impact models, stakeholders have a shared understanding of the problem they are addressing and vision for change. Interviews with JustCARE stakeholders reveal a consensus regarding the importance of providing supportive interim housing (as well as permanent housing) for people who are living unsheltered and contending with substance use disorders, unsupported mental health disabilities, and criminal legal system involvement. They also reveal a shared recognition that these issues are inter-connected and must be addressed simultaneously in order to have a transformational impact. Interviews further reveal a shared emphasis on the need to meet the needs of community partners as well as participants, the importance of having a racial equity lens guide this work, the need for services to be trauma-informed and guided by harm reduction principles, and the goal of enhancing public safety and quality of life issues without reliance on the police and criminal legal system wherever possible.
2. **Backbone Function:** In collective impact models, dedicated staff with necessary skills who coordinate the collective impact initiative serve the "backbone" function. In the case of JustCARE, the Public Defender Association (PDA) serves this function by coordinating regular workgroup meetings, providing trainings and protocols, providing funding support and contract development, and troubleshooting new dilemmas that emerge.

3. **Continuous Communication:** Continuous communication enables participants to ensure shared objectives, build trust, and share information. In the case of JustCARE, this communication occurs in regularly scheduled stakeholder meetings as well as through more frequent and informal modes of communication among various partners.
4. **Shared Measurement System:** In a collective impact model, participants collect data and measure results in similar ways in order to ensure alignment and accountability. In the case of JustCARE, administrative data are collected by each participating organization and shared with King County and other funders. These administrative data are incorporated into the description of JustCARE's work in Part I of this report. We also offer some recommendations regarding additional metrics that could be collected to facilitate evaluation of outcomes.
5. **Mutually Reinforcing Activities:** Each of the participating organizations plays a differentiated yet coordinated role in executing the plan of action. In JustCARE, each participating organization plays a unique role that reflects its particular strengths and areas of expertise. This division of labor is described in some detail in Appendix A of this report.

The Organization of the Report

This report provides insights and findings from a year-long evaluation of JustCARE.[8] The analysis focuses on the work JustCARE accomplishes, the lessons it has learned in its first months of operations, and the system failures it encounters and reveals. It also situates JustCARE in relation to other alternative crisis response and housing models that emerged or spread in the context of the pandemic and calls to defund the police. In particular, we compare JustCARE with two increasingly popular interventions: 1) alternative crisis response models based on the CAHOOTS program in Eugene and Springfield, Oregon, and 2) housing initiatives that, like JustCARE, utilize hotels and motels that are largely vacant as a result of the pandemic.

Part I analyzes JustCARE's varied goals and presents data regarding its activities in each of these realms. First, we analyze JustCARE's role as a Housing First provider guided by harm reduction principles. Second, we describe the work JustCARE does in its capacity as a health initiative. Third, we provide an overview of JustCARE's efforts to improve public safety and quality of life in the neighborhoods and hotels in which it works. Finally, we describe the work that JustCARE does to reduce criminal legal system involvement and to resolve outstanding legal issues so that participants are able to address their long-term goals. Throughout this analysis, we highlight JustCARE's positive impacts as well as systemic barriers that limit these impacts. The last section enumerates the lessons it has learned during the first six months of its operations.

Part II situates JustCARE in relation to associated initiatives that proliferated over the past year or so. First, we compare JustCARE to alternative response models based on the Crisis Assistance Helping Out on the Streets (CAHOOTS) model. We also compare JustCARE with other recent housing initiatives that use vacant hotel rooms to shelter people in ways that reduce transmission of the coronavirus. The conclusion summarizes key findings and offers policy recommendations and suggestions regarding data collection to facilitate on-going evaluation.

For interested readers, Appendix A describes how JustCARE emerged and developed, including how each of the centrally involved organizations adapted in the early months of the pandemic, how these partners came together to form this new collective impact initiative, and the areas of expertise that each partner brings to the collaboration. It also presents data collected by REACH regarding the characteristics and needs of people living in encampments in the targeted neighborhoods.

Evaluation Approach

This report is intended to provide policymakers, practitioners, and other interested parties with a detailed overview of what JustCARE is, the work it accomplishes, and the lessons it has learned to date. It also identifies system gaps and offers recommendations regarding policy and future data collection efforts that will facilitate on-going evaluation.

The evolution of JustCARE in the rapidly changing context of the COVID-19 pandemic and increased attention to police violence called for a flexible evaluation approach. As such, our evaluation is informed by the principles of developmental evaluation, which include attention to complex system dynamics and a focus on innovation.[9] Meeting observation, interviews, and frequent interaction between the evaluators and JustCARE stakeholders allowed for informal interim feedback. Similarly, ongoing communication between the evaluators and JustCARE stakeholders made it possible to rapidly adapt our evaluation focus and data collection strategies as JustCARE evolved. Our evaluation assesses some participant-level and community-level impacts; these are presented in Part I of this report. In Appendix A, we also illuminate the process by which this emergent social innovation developed and evolved in a highly volatile context.

Our analysis draws on several different types of data, all of which were collected from April 2020 through March of 2021. These data include interviews with and a survey of forty-two early CoLEAD and JustCARE participants, many of whom were interviewed multiple times over a period of months. We also interviewed twelve outreach responders and other program staff, ten leaders of participating organizations,[10] eleven community members representing organizations of people who live and/or work in impacted areas, and seven leaders of alternative crisis programs across the country.

The survey and interview protocol used with participants was based in part on the protocol developed by Columbia University researchers as part of the Rikers Island Jail Study. Because CoLEAD was the first of the participating programs to provide care in hotel settings, the interview data that were collected in the spring and summer of 2020 pertain to CoLEAD. Interview data that were collected in the fall of 2020 and winter of 2021 also include participants receiving housing and care from Asian Counseling and Referral Services and Chief Seattle Club, and thus refer to JustCARE more broadly. The data also include observations of select JustCARE planning meetings, administrative documents, and administrative data provided by REACH, PDA, ACRS, and Chief Seattle Club. Additional information about data sources is provided throughout the report. Appendix B provides a detailed overview of our analytic approach, interview protocols, and recruitment strategy.

Part I

JustCARE as a Multi-Faceted Intiative

This section of the report describes JustCARE's varied goals and presents administrative and interview data regarding its activities in each of these realms. First, we analyze JustCARE's role as a Housing First provider guided by harm reduction principles. Second, we describe the work JustCARE does in its capacity as a health initiative. Third, we provide an overview of JustCARE's efforts to improve quality of life and public safety in the neighborhoods and hotels in which it works – without reliance on sweeps/dispersal, the police, or the criminal legal system. Fourth, we describe JustCARE's effort to mitigate the harm caused by police interactions with vulnerable populations, criminal records and outstanding warrants. Throughout this analysis, we provide evidence of JustCARE's impacts in each realm. The final section summarizes the lessons JustCARE providers have learned along the way.

The multifaceted nature of JustCARE sets it apart from many related interventions. In fact, the significance of the JustCARE model is that it simultaneously addresses numerous issues – unsheltered homelessness, health, public safety, and criminal legal system involvement – that are often unhelpfully siloed. As Jesse Benet, CoLEAD Program Director, explained,

> *There needs to be a roadmap for those sectors coming together, so no one sector feels the daunting burden of the issue, like this is all the homelessness sector's problem, or this is all behavioral health. Because there's a lot of that that happens. If all the sectors can feel accountable to help, to coming around people and helping meet that complex need, then it feels like more of a teaming up. And I know it's hard to get systems to come together, but if jurisdictions were told, "Get your CJ [criminal justice] champion, get your health care champion, and get your homelessness champion together, those three people can build a table that can bring in investments from multiple systems. Then you could do this JustCARE model that people are invested in, and everybody wants to help make work… We're trying to do that… to pull in those different sectors.*[11]

Before describing how JustCARE addresses a range of issues that are too-often addressed separately, we first provide a demographic snapshot of JustCARE participants as of February 28, 2020. As Table 1 shows, nearly two-thirds (65 percent) of JustCARE participants identify as BIPOC; roughly one third (35 percent) identify as White. This pattern is consistent with the screening data generated by REACH.[12]

Table 1. Demographic Snapshot of JustCARE Participants

RACE/ETHNICITY	
American Indian/Alaska Native	10.8%
Asian	4.5%
Black/African American	35.9%
Latinx/Hispanic	7.6%
Multi-Racial	5.4%
Native Hawaiian/Pacific Islander	.9%
White	35%
GENDER	
Woman	34.1%
Man	65.1%
Non-Binary	.4%
Trans	.4%
AGE	
Age Range	20 - 74
Average Age	39

Source: Brenton Zachry, Data Analyst, Public Defender Association.

Note: Data include people who enrolled in CoLEAD in the spring or summer of 2020 or JustCARE in the fall of 2020 or winter of 2021, and are current as of February 28, 2021. People who identified as Latinx/Hispanic alone or as Latinx/Hispanic and White are included in the Latinx/Hispanic category. All data are self-reported..

JustCARE as a Housing First Intervention

This section describes the work JustCARE does as a Housing First provider. JustCARE provides interim supportive housing and trauma-informed and harm reduction-oriented care in hotels to people with mental health disabilities and/or substance use disorder. The vast majority of people enrolled in JustCARE have been able to remain in hotels, and most are setting and pursuing a range of goals that lead to further stabilization. JustCARE's use of creative and proactive problem-solving techniques appears to help explain why such a large share of enrolled participants have been able to remain safely housed in the hotels.

In what follows, we describe the theory behind, and operationalization of, JustCARE's approach to housing provision. First, we describe the rationale for its provision of interim supportive housing in the hotel context and its commitment to harm reduction, racial and social justice, and trauma-responsivity. Second, we describe how JustCARE tailors this work in the hotel context to meet the needs of hotel staff as well as participants. Third, we discuss JustCARE's case management approach and the impact of its decisions to hire and train a diverse group of outreach responders and to pay them a salary that reflects the challenge and importance of the work they do. Fourth, we describe the experience of JustCARE participants in the hotels. Fifth, we provide data regarding the work JustCARE providers do to support participants as they pursue their goals and to prepare for independent living. Sixth, we describe the creative and proactive techniques JustCARE providers employ in order to de-escalate potential conflicts and keep participants safely housed. Finally, we identify a number of lessons that stakeholders have learned in the course of implementing JustCARE.

Housing First and Harm Reduction

Among other things, JustCARE is a Housing First initiative. All of the organizations that provide care under the JustCARE framework are guided by Housing First principles. Relatedly, their work is also informed by the harm reduction philosophy. This means that JustCARE providers seek to house all of those whom they can safely support to live with others, accept that certain illicit behaviors such as substance use will occur, and work with participants to address and minimize the harm associated with those behaviors by building trusting relationships with outreach responders.

What is Housing First?

Housing First models stress the importance of stable housing, which makes it possible for people to address other issues and challenges. From this perspective, housing is a basic need and right, one that deserves to be met regardless of considerations such as substance use disorder. Housing First has attracted considerable attention in contemporary American policy: it is now embraced by the United States Department of Housing and Urban Development and is a centerpiece of many cities' "10 Year Plans" to end homelessness.[13] To date, however, widespread recognition of the need for Housing First approaches have not translated into the fiscal investments to make this approach widely available.

More specifically, JustCARE draws on Housing First and harm reduction principles to offer supportive interim housing. Doing so offers an important benefit: it enables providers to more accurately assess who will need permanent supportive housing and who simply needs affordable permanent housing. Interestingly, stakeholders report that it is often difficult to predict which of these is the case based on people's behavior and situation while they are living outdoors. Interim supportive housing thus provides an opportunity to facilitate stabilization and needs assessment over several months. As Lisa Daugaard, Director of the Public Defender Association, recounted: "We've been saying for years that most people in LEAD don't need permanent supportive housing, but just leaving them in a limited housing subsidy situation is also a recipe for disaster. There's got to be something in the

middle."[14] This approach can help to ensure that limited permanent supportive housing resources are preserved for those who truly need them, while many others are matched with more flexible resources that generally become available more quickly.

JustCARE partners also believe that supportive interim housing enables people who have been living unsheltered for extended periods of time to (re)acquire the skills that make living indoors viable. Most people entering JustCARE have been living outdoors for well over a year; many had been living unsheltered for more than five years. As PDA Director Lisa Daugaard noted, the skills that are required to remain safe while living outdoors are not the same skills that facilitate success in indoor environments:

> *The goal is that there's skill-building that's happening, like, "Oh, if I bring these six people into my room, it's probably going to get trashed, and somebody's going to burn a hole in the mattress. Maybe, that's not a great idea, when this is all my stuff." So, the hope is that people are learning this delineation from, "Okay, this is what it looks like to live on the street and the skills and tools that I need to do that. And then, here's the shift that needs to happen when I come inside. What are the different skills and tools that I need for that? With support and people kind of reminding me and having ongoing conversations, so I'm set up for a little bit better success, when I'm in my own unit."*[15]

JustCARE providers go out of their way to create a welcoming environment for participants and begin the process of building trust. In the ACRS hotel, for example, "clients are given a welcome kit prior to the enrollment process. The intention is to start with a caring and compassionate approach. The welcome kit consists of toothbrush, toothpaste, non-alcoholic mouthwash, safe sex supplies, $25 gift card and snacks."[16] Virgil Wade, Operations Director at Chief Seattle Club, also described a thoughtful process aimed at helping people to feel welcome in their new surroundings:

> *The model that we set out was to bring them in, bring the guests into the hotel, let them relax for a few days, let them get comfortable with their new surroundings. And then we can start trying to build a rapport with them, and build a relationship, and try to understand what they may be facing. But we didn't want to do that right away. We didn't want to just start piling on, asking questions right away, because then you're going to get some resistance more than likely. We just wanted them to feel the most comfort that they could, and then we would take it from there.*[17]

Once participants have moved into their hotel, JustCARE providers employ motivational interviewing (MI) to enable identification of JustCARE participants' needs and priorities. The use of MI can be contrasted with more traditional approaches that impose program-defined goals and mandates such as sobriety. Instead, MI involves working with clients to identify their own goals, recognize their own agency, and create case management plans to take steps towards clients' self-identified goals. Also known as strengths-based case management, MI "focuses on clients' strengths, self-direction, and the use of informal help networks."[18] Case managers then provide support in navigating and accomplishing these goals, such as securing identification for job applications, completing

requirements for public benefits, applying for long-term housing, addressing legal issues, and meeting conditions of supervision. Evaluations of strengths-based case management have found positive effects on employment and substance use.[19]

JustCARE providers also conduct their work in a trauma-informed manner. "Trauma-informed approaches provide a richer understanding of underlying drivers of behavior, and view trauma as an integral component of risk management, case formulation, relationship-based care, and referral."[20] Consistent with this approach, JustCARE providers focus on not shaming people for potentially harmful or disruptive behavior, or sanctioning that behavior, but rather recognizing it as a symptom of trauma that can be addressed through dialogue, care, services, and support. As discussed below, this does not mean that JustCARE participants are not also required to agree to refrain from causing harm to others and held accountable to that goal.

Finally, outreach responders do a great deal of work to reduce the harm associated with substance use. This includes providing sterile equipment and sharps containers for people who continue to use drugs in the hotels. Even more crucial, perhaps, is the ongoing dialogue that doing harm reduction work entails. Here is how one outreach responder explained this aspect of the work they do:

> *I know a lot of the county, some of the other different agencies do trauma-informed training. But also, this harm prevention piece is really interesting. I think this program is really huge on harm prevention and what that means. It could mean providing folks with harm prevention supplies, whether that's pipes or clean needles. Or it could mean harm prevention in the way that we're helping prevent someone putting, lowering any obstacles for someone. And it's always on a case-by-case basis, where we really want to look at the situation. Where someone may want to go do something extralegal to support their habit, so it's trying to find ways to prevent further interaction with law enforcement. So, that's part of harm prevention… I know that across the nation programs have been utilizing hotels to house individuals. But I think it [JustCARE] is different in the way that it's also doing a lot of other things. It's bringing all of those things, all of the components, the mental health, substance abuse, connecting people to different kinds of things. It's bringing it all together and then helping them stabilize.*

Housing First and Harm Reduction in the Hotel Context

As mentioned previously, participants sign a Lodging Agreement upon arrival at the hotel (see Appendix C). At first glance, it might appear that asking JustCARE participants to sign a Lodging Agreement in which they pledge to follow certain rules is at odds with a harm reduction approach. This is not the case. Rather than serving as a rigid set of rules that justify punishment or expulsion, Lodging Agreements in a harm reduction context create a set of guidelines and opportunities for discussion and learning. As Jesse Benet, CoLEAD Project Director, explained,

> *When you sign a lease or you agree to be in a place and that place has ground rules that are intended to keep the property safe and the people in it safe and the staff safe, I think that that's like regular life. We all have rules that we follow. Even when you own your house, there's still rules, like city ordinances. You take your trash out. So, I don't think having rules flies in the face of harm reduction at all. I actually think harm reduction supports people to reduce harm to themselves and others through relationship and through boundaries. It's not a free for all. And we would be doing people a disservice.... The core tenant of harm reduction is people don't have to stop using to get access to resources.... . That doesn't mean that that use doesn't have some boundaries and rules around it to make it safe for the participants and the hotel staff. It's more about the dignity and the agency that we honor that people have, and trying to come and work alongside and be goal oriented and centered around what they want and need. But it doesn't mean that we allow them to walk all over us in the hotel and trash it.*[21]

Here, CoLEAD Operations Director Tabatha Davis describes how being rooted in a harm reduction approach shapes JustCARE's response to challenging situations such as arguments, disturbances, property damage, and more:

> *So, it's kind of case by case, because you do have to take a look at the reason why a person is responding in that way. Have they always responded that way? Is this new for them? What's changed? And so we do take the time to assess who it is that we're dealing with and why they're doing what they're doing. Because it could mean that something bigger is happening. With hotel staff, one of the first things that we do, or one of my roles is to really listen to the hotel and validate the concern. So, letting them know that we apologize. We really are on the same page. Exposed needles, for example. Certainly, that's off-putting visually to see that, and yes, it is a safety concern. So, while we do take the time, again, to assess what's happening with the individual, there's no tolerance for putting people at risk. So I have a conversation with the hotel, reach out to whatever staff is onsite. And the case managers will go and outreach that person, so knock on the door, find them, call them and have a conversation with them and just kind of reiterate the rules. If they need a new sharps container, we'll make sure that we do that. If they threw it on the floor because their sharps container is full, we'll coordinate getting that picked up and getting them a clean one. But that's kind of the cycle of communication, and then I will follow back up with the hotels just to let them know that the individual has been spoken to, this is what's being communicated, this is our expectation moving forward.*[22]

As this excerpt indicates, doing harm reduction work with people who are contending with substance use disorders and unsupported mental health disabilities in a hotel setting poses particular challenges, particularly with respect to hotel staff. In this context, JustCARE providers and leadership stressed the importance of having a trained hotel liaison and outreach responders who attend to the needs of both participants and hotel staff. In addition to having a dedicated hotel liaison, JustCARE providers offer formal and informal training on topics such as de-escalation and harm reduction, not only to outreach responders but also to hotel staff. These trainings may be formal or informal. As

Victor Loo of ACRS explained,

> *The hotel staff are just not familiar with this population… it was pretty challenging for them. The first instinct for them is they will tell me that I need to call 911 right now. I always explain to them, "No, we do not do that unless it's absolutely life threatening or dangerous, then we do that." I see something, then I will tell them that, "You may want to do it this way, or you want to talk this way." Or when somebody that has schizophrenia says something, you don't want to end up bursting into laughter because it will trigger the person. It will get worse. So that kind of thing. With time, I think it would be good to have an onboard training with the hotel staff. I would say that it's all about how to de-escalate in a way that is that doesn't create more trauma or harm or trigger the clients to react in a more violent way. … And I think that the tone and language that we use really matter. We have clients that take the food and the hotel thinks they're stealing, and I just say, "No, taking. Not stealing. They took the food."*

JustCARE thus relies on Housing First and harm reduction principles to guide its provision of supportive interim housing and its work with participants, but also to inform its interactions with hotel staff.

JustCARE's Approach to Case Management

JustCARE providers employ a continual staffing model such that staff members are reachable around the clock. It also employs assertive case management (ACT). ACT is characterized by very small (15 or fewer) caseloads due to the high intensity and frequency of engagement with clients. This intensity is appropriate for (and facilitated by) the hotel setting, in which case managers have regular access to participants and which requires that case managers assume additional responsibilities such as collaborating with hotel staff. ACT is also characterized by proactive engagement with clients. Table 2 describes these differences between the case management approaches utilized by LEAD, which was the precursor of JustCARE and continues to provide street-based outreach on its behalf, and hotel-based JustCARE providers.

Table 2. Differences Between LEAD and JustCARE Hotel Based Case Management

	LEAD	Hotel Providers
Case Management Model	ICM*	ACT
Client Location	Streets	Hotels
Intensity/Frequency of Engagement	Medium-High	High
Caseloads	<20	<15
Time-Delimited	No	Yes
24-hour staff availability	No	Yes

Note: *ICM stands for Intensive Case Management. ACT stands for Assertive Case Management.*

The research literature indicates ACT is appropriate where services are time-delimited and are concentrated in periods of most acute need (in this case, the pandemic).[23] In fact, the use of ACT and comparatively low caseloads are essential for two main reasons. First, relatively low caseloads enable outreach responders to work intensively with participants while also attending to the needs of hotel staff. Second, as described below, case managers provide a wide array of support services, many of which are extremely time-consuming. These include assisting participants in applying for benefits, accompanying them to court or on medical appointments, and engaging in regular conversations about participants' goals and the steps they can take to meet them.

JustCARE outreach responders come from diverse backgrounds, including having lived experience with the criminal legal, housing, and other social systems, managing one's own and/or loved ones' substance use and behavioral health needs, and working in diverse case management and service settings. These wide-ranging experiences not only enable outreach responders to fruitfully share resources and knowledge, but also to better relate to participants.

The outreach responders we interviewed reflected deeply on how they drew on their previous personal and professional experiences to develop relationships with participants, cultivate a sense of supportive accountability through positive incentives, and activate connections to services and resources. Because the hotels serve as temporary lodging as well as sites of care and case management, outreach responders have frequent interactions with participants, and focus their day-to-day work on checking in with participants and following up on progress towards participants' self-determined goals. Here is how one outreach responder described this relational approach:

> *I think that again, it goes back to that relationship building. I think, and one thing that I know for me, as someone who has lived experience, is first of all identifying, and getting a trusting working relationship with the participant as well as with the people that you work with, your team. … One thing that I know even from my own past experience is that follow-through … Follow-through is so important. It's like, "Let's not have this conversation and you ask me 10,000 questions about what my goals are, what does it*

look like, and we're not following up. We're not checking in on a regular basis to see if those goals have been met." I have seen that in the past, and so I think it's very important that we all have, that we follow through on what we're doing with the participants and even within our leadership and just the team.

In addition to hiring a diverse and dedicated staff and employing an assertive case management approach, JustCARE pays care providers comparatively well. The cost of JustCARE has been politically contentious, though overstated.[24] PDA calculates that the annual cost of providing housing and supportive services for each participant is less than $50,000 per person per year when the program is operating at a scale of nearly 300 rooms and 400 participants. Most of these costs stem from the cost of hotels (51 percent) and care teams (29 percent).[25]

There are only two ways to make JustCARE significantly less expensive: leverage lower hotel costs with long-term contracting or via facility purchase by local government, or reduce staffing and/or pay outreach responders and other care providers significantly less. The latter option would significantly undercut the viability of the model, which requires intensive engagement of staff with participants. Reducing the salary of outreach responders would also likely fuel high rates of turnover and raise questions about equity and fairness. This diverse and committed group of people earn a starting salary of $52,000-$80,000, depending on experience. By contrast, the sworn police salary scale starts at $83,640 and rises quickly thereafter.[26] In fact, the median gross pay among SPD's more than 2,000 employees last year was about $153,000, not including benefits.[27] In this context, the salary structure for JustCARE providers seems both reasonable and important to ensuring that the comparatively high-needs population JustCARE serves receives the care and support they deserve and often require in order to thrive.

Participant Experiences of JustCARE's Hotel-Based Care

Nearly all of the JustCARE participants we interviewed expressed a newfound sense of safety and security – and often euphoria – once they had moved into their own hotel rooms. For participants, the hotel rooms provide basic security – for their bodies and belongings – that they did not have when sleeping outside. For many, the hotels were the first stable place they stayed in years.

Perhaps unsurprisingly, participants started by explaining what a relief it was to have a bed, a bathroom, protection from the elements, and a secure place to keep their belongings. A number of participants even used religious language when describing their experiences, calling the hotel "a blessing" and "thanking the Lord" for the opportunity. One participant said of the transition to the hotel, "it's like going from hell to heaven." Another participant described what having housing meant in simple terms, "the best thing is that I'm up off the streets." Some thought being able to take a hot shower was the best part. For others it was the bed. One participant told us it was "the little things, like going to the bathroom and washing your hands." The ability to do laundry was also important to many participants, as was having a dry and secure place to store their belongings.

Here is a how a few of the participants summed up the experience:

> *It was a feeling that I never felt before, because nobody helped me out like this before or in my life. And it was a good feeling to know that I'm getting off the streets for a little while, and to be in a spot where I'm safe and to be able to lay my head in a warm bed for a little while and to be able to take showers whenever I want and to you know just to be able to be away from all the negative people and all the bad things that are going around outside. Yeah, just a feeling of happiness to be able to be inside.*

Another participant shared that

> *I'm no longer homeless now because as of two weeks ago they were able to find us a resource through CoLEAD and also another organization called REACH, that got me off of the street. I was living in a tent. Being a female in Seattle, Washington is quite dangerous when you're homeless. … What do I like best? Let's see, I have a shower [laughs], just the safety, of course. Because I was in the streets for so long.*

Participants also expressed tremendous relief at being away from environments that were stressful or around people who were bad influences. One respondent remarked on the "quietness" of the hotel, telling us, "there's no arguments, no fights, no gunshots, no police sirens, ambulance sirens." The safety of the hotels was deeply appreciated by participants, the vast majority of whom had been a victim of crime while living on the streets. In fact, 87 percent reported that they had experienced theft, burglary, or robbery in the past year, often repeatedly. Here is how one participant put it

> *During the course of two years I've been homeless down here. I'd say my stuff's been stolen more than 25 times. Because sometimes I would fall asleep and not know it and I won't have my backpack or duffle bag over my shoulder. And when I wake up my duffle bags will be gone.*

Similarly, another told us that

> *I've got basically everything, my phone got stolen when I was on the street. Every time I'm homeless, I end up losing basically everything. Can't trust anybody on the street and the second you let your guard down, they'll steal whatever they can from here. So my mobile phone, my backpack stolen, my wallet stolen twice, my phone stolen three times. Very, very rarely when you get your stuff stolen do you get it back … the entire thing confuses me, because the majority of homeless people are living in this homeless community between the shelters and the tent cities. Most of them don't have any family to speak of that, you know, are on good terms with them. Most of them don't have any friends or places to go like the only people they deal with are the rest of the homeless people. So it's very frustrating and confusing whenever, instead of trying to help each other out, everybody's just trying to steal from one another.*

Even more concerning, 55 percent of those we surveyed reported having been attacked or threatened

in the past year and nearly three-fourths (74 percent) reported that they had witnessed such events in the past year. This violence appears to be a regular feature of life on the streets:

> **Interviewer:** *How often have you witnessed violent incidents?*
>
> **Participant:** *Like, every day for the past six months. It's just the streets. When everyone's piled up there together in the same area and someone steals someone's dope or something like any little thing actually will set off a lot of fights and so that's been constant. The only super significant one was somebody got shot, got shot five times and was hospitalized. I didn't really know him personally. But, yeah, people getting shot and stabbed. Not that abnormal, especially not right now. So I saw a fight basically every day.*
>
> **Interviewer:** *Did you call the police?*
>
> **Participant:** *No, God no, no you don't call the police on the street. That's a good way to get ostracized…. you know, even before COVID started, people, you know, tweaking out on meth or PCP or whatever. One accused me of stealing his blankets and these were my blankets, and I told him I didn't have them. And he told me he would cut my head open and take them.*

Another participant shared that

> *I ended up getting up jumped and robbed in the streets of downtown Seattle, it was very scary for me. It was a nightmare that I never want to repeat. Needless to say I had $1,000 taken from me, I had my cell phone taken, my identity was stolen, my job, my nose was broken and my eye was shattered, all within four months. So yeah, I've just been a miracle waiting to happen [laughs]. CoLEAD saved my life, I swear.*

Without the need to worry about where to sleep or maintain constant vigilance over their things and bodily safety, JustCARE participants repeatedly told us that they experienced a newfound peace of mind since moving into their own hotel room. Many of the hotels also provide residents with a complimentary breakfast, in addition to meals that JustCARE partners provide. Some rooms have a kitchenette and participants who had these rooms told us how much they appreciated being able to cook meals.[28]

Having a clean, quiet, and private room enabled participants to feel safe, focus on other goals, and experience a sense of hope and agency when considering their future. In addition to offering a safe place to sleep, the hotels also serve as central points of care for participants. In the hotels, participants meet with outreach responders, who support them in setting and working towards self-identified goals. JustCARE participants shared that they generally feel supported by outreach responders, and described the many ways in which outreach responders help them to set and work towards their goals:

> **Interviewer:** *What has your relationship with your case manager been like?*
>
> **Participant:** *Um, very helpful. VERY helpful helping me with bureaucratic hoops with the social security and the DSHS. 'Cause I could have had that stuff back on in February, but I get so flustered going through that process, that here I've sat without any nothing because it gets to the point that my stress level gets so high, that whatever the dollar amount or whatever it is that's the benefit, my piece of mind becomes more valuable to me than the benefit of going through this process that's driving me nuts. So he was able to sit with me and that was a big help.*

Similarly, another participant told us that his case managers have been

> *helping me with getting my appointments together. They've been helping me try to find housing. They've been searching and looking for information and stuff for me. They're a bunch of great people. They've been helping me a lot. I think with their help I have gotten more done in the last six months than I have in the last year. … Getting me rides and stuff. They helped me with some food at first. I got my food card filled with food stamps on it, so now I can get food. They've been actually helping me in a lot of ways.*

Some participants did share frustrations they had with outreach responders. These typically involved what participants experienced as changes in processes or rules about which they were unaware or other kinds of miscommunication. Overall, though, participants expressed a great deal of appreciation for the outreach responders with whom they worked.

In addition to the practical guidance that outreach responders provide, some participants indicated that they are able to relate to their outreach responder given the direct experiences many have had with homelessness, substance use, and/or the criminal legal system. For example, one participant told us that

> *It's just kinda nice to have a case worker that knows so little about me but I feel like I've known him forever, if that makes sense. He's got a lot of the same lifestyle, not that I had, but similar. He was homeless at one time. And now he's a worker for CoLEAD. And I'm just like, man, if you can do it, we can. He's an inspiration to me. … I'm like, oh my god, if it ain't meant for me know this man, as my case worker, everything that's happened… I'm filled with blessings and blessings and blessings over and over again.*

Stabilization and Service Provision in the Hotel Context

As life-changing as secure housing is, JustCARE sees the provision of housing not only as an end, but also as an opportunity to help participants stabilize their lives and meet needs that are difficult to address in the absence of stable housing. Toward this end, JustCARE case managers work with participants to address their needs in similar areas, including the following:

- **Permanent housing:** JustCARE providers support participants in their efforts to access permanent housing, including by securing housing vouchers whenever possible, connecting clients with other Housing First programs, and supporting clients in securing drug court housing if doing so is consistent with clients' self-identified goals.
- **Identification:** JustCARE case managers often assist participants in their efforts to secure widely accepted forms of identification. This is often a cumbersome and time-consuming process.
- **Health Care:** JustCARE providers support participants in their efforts to improve their health and obtain health care by connecting clients with health care providers as needed and appropriate. JustCARE also seeks to increase clients' coverage through Apple Health. Like other ACT models, CoLEAD and ACRS offer on-site medical care including COVID-19 testing, medical care, and assistance with securing specialized and follow-up care. This aspect of the work is described in greater detail below.
- **Substance Use Disorder Treatment:** JustCARE providers help to support participants in managing substance use, by encouraging familiarity with and access to safer practices, facilitating access to treatment (including medication-assisted treatment) where desired by clients, and by working toward stabilization.
- **Legal Income:** JustCARE supports participants in accessing and expanding income wherever possible, including by assisting with job applications, pursuing educational opportunities, and accessing public benefits. Each of these processes is difficult to navigate independently, particularly without a stable address or health care, and tend to be exacerbated by criminal justice involvement as well as Covid-19.
- **Criminal Legal Barriers:** JustCARE case managers work with participants to minimize the adverse consequences of prior contact with the criminal legal system, including supporting them in meeting supervision requirements and court dates, sharing information about participant progress, and addressing outstanding arrest warrants.

Many participants we interviewed confirmed that housing enabled them to get out of survival mode and begin developing a plan for transitioning to long-term housing. One person told us they were "always on edge before." Now, with a secure door and place to sleep, the "peace of mind is fantastic." Other people told us that they were "not worried about [their] stuff getting stolen" and that this freed up mental space to work toward goals, such as obtaining identification or applying for subsidized housing. As one participant told us,

> *Above all things, it's a stable environment that's mine. I don't have to worry about dealing with other people. [...] I'm glad that I have a place that I can call my own, that I can sleep in and be safe. And it gives me stability and peace of mind where I can better my future.*

Many respondents told us that stable housing makes many things possible that were previously impossible. For example, many participants described numerous obstacles in accessing public

benefits, including food stamps, social security, and disability, while they were living unsheltered. These obstacles tend to stem from limited access to a phone, internet, and a stable address, all of which are essential components for communication with public agencies. COVID-19 heightened these barriers by reducing the hours of operation or in-person options for government services as well as charitable operations, such as food pantries. Interviewees also described frequent theft of their wallets, social security cards, and IDs while on the streets, disrupting the potential to apply for social services or jobs. The aforementioned cycle between jails and the streets also interrupted benefits. As one participant explained:

> *Because I was in custody, my benefits and stuff that I had got were cut off. I was first in custody from the end of November last year to January 30, then I was out for two months before I went in for the month of April more or less. So, I haven't gotten any money or other benefits since December. And that's one thing that the, especially in the past few days they've spent a lot of time trying to get me connected with social security, and it's a really kind of complicated cumbersome process to go through, and I've never been through it before, and then because of the virus, you can't go in there face to face, and so it's really frustrating.*

Interviewees consistently reported that JustCARE improved their ability to access public services and benefits. In addition to having access to a phone and a stable address, many credited their case managers for helping to navigate the "bureaucratic hoops" of social service agencies and being their "advocate." This included helping residents complete and submit their applications, calling social service agencies and scheduling appointments. For example, one participant told us:

> *I've had food stamps for about two years, something like that, two, three years. Getting them was easy. I did it in-person first, and then I had a mid-certification review come up, and they were closed because of the COVID thing, so that sort of messed things up for me. But my case manager helped me get ahold of somebody on the phone and they had my card mailed within the next two or three days, along with not only the food stamps but the disaster relief money too.*

JustCARE outreach responders also help participants address other basic needs in ways that significantly improve participants' quality of life. They help to arrange transportation to appointments, pick up prescriptions, and provide pre-paid gift cards for food and work clothes. These examples are illustrative of the broader pattern:

> *The relationship that I've had with people who are working for them [CoLEAD], overall it's been positive. They've brought me a food box for like the last two or three weeks from a food bank, every Tuesday, every Tuesday I can go and pick it up. And then they've started doing like two meals during the day that they drop off at the hotel, lunch and dinner, and that's been extremely helpful. Like I said I applied for my social security card, they've helped me to and from doctor's appointments and helped me pick up prescriptions and stuff. They've really helped a lot, that's for sure.*

Another participant described similar kinds of support:

> *I'm disabled from the injury, so I can't work. I do want to go back to school and eventually own my own company, but until then, all that stuff's kind of, everything's kind of hemmed up because of the COVID. So right now, they've been helping me get my ID back together, you know, get all the documents I need so I can go talk to a lawyer about, you know, what do I do about my credit … and uh, how do I get my social security? Yeah, so things have been moving along. It was a little sketchy at first, but things have really smoothed out, and everybody has been just wonderful to me.*

Overall, then, interviews with participants point to a connection between the safety and protection housing offers and participants' mental security and stability. This sense of stability enables participants to work with outreach responders to address other issues and needs. The data shown in Table 3 provide some sense of how commonly these tasks are undertaken by participants with the support of JustCARE providers. As shown here, involvement with JustCARE does not only provide a safe place to stay, but also re-engagement with a host of public services, healthcare systems, and other community-based supports.

Table 3. Hotel-Based Services and Activities

COVID-19 Testing	100%
Primary Care or Other Health Care Connection	64.5 %
ID Assistance	51.8%
DSHS	50.4%
New Housing Assessment	37.6%
Legal Assistance	36.2%
Medication Assisted Treatment	32.6%
Financial Management Assistance	31.9%
Mental Health Treatment	27.7%
Employment Secured	17.0%
Dental Care	12.1%
SSI Enrollment or Activation	9.9%
Education – Enrollment in Community College	6.4%
Optometrist	5.0%
Veterans' Resources	4.3%

Source: *Brenton Zachry, Data Analyst, Public Defender Association.*

Notes: *These data pertain to CoLEAD, which began providing care in the hotel setting approximately six months prior to the involvement of ACRS and Chief Seattle Club. They include 69 CoLEAD participants who were enrolled in CoLEAD before JustCARE was created and 72 JustCARE participants who entered a hotel to work with CoLEAD providers in the fall or winter (141 total participants). These figures refer to categories of service provided per participant. For example, if a participant received legal assistance on multiple occasions, this is counted as one participant having received legal assistance. These data were current as of February 28, 2021.*

In short, JustCARE treats interim housing as an opportunity to address participants' basic needs and support participants' efforts to stabilize their lives and advance their goals. The difference this supportive housing makes in people's lives is substantial and meaningful.

JustCARE's Secret to Success

People who have lived unsheltered for extended periods of time and who contend with unsupported mental health disabilities and/or substance use disorder are sometimes described as housing and service-resistant. The data from JustCARE suggest otherwise. As noted previously, the vast majority of people who were screened in the encampments have experienced long-term homelessness and contend with mental health issues and/or substance use disorder. And yet the vast majority of these people were offered, and accepted, the housing and support offered by JustCARE. Moreover, the administrative data show that only 13 percent of all participants who have enrolled in JustCARE have been exited from it, as shown in Table 4

Table 4. JustCARE Participant Status

Ever enrolled in JustCARE	225
Formerly enrolled, now in permanent housing	21
Removed/exited from JustCARE	30
Deceased	1

Source: Brenton Zachry, Data Analyst, Public Defender Association.

Note: Data are current February 28, 2021 and include people enrolled in CoLEAD before and during JustCARE as well as JustCARE participants who receive care from ACRS and Chief Seattle Club. JustCARE providers make every effort to secure alternative housing or arrangements for people who cannot safely remain in JustCARE hotels.

The fact that the vast majority of JustCARE participants have been able to remain housed in the hotels is impressive. Several factors appear to help explain this. First and foremost, JustCARE providers are extremely reluctant to exit people from the program and from hotels, and employ numerous other options before resorting to this. As Victor Loo, Director of Program Innovation at ACRS, explains,

> *We're pretty gracious. We will not exit a client until we know that we have exhausted all options. I would tell you that the biggest push for exiting a client is mostly coming from the hotel management team. And I understand it. I mean, they're in the hotel business. She has the responsibility for the entire hotel… Some participants will bring in guests, and they are caught on video footage, so we advocate to the hotels that, "No, we can understand it's a violation, but we can't exit the clients." The clients that we have exited mostly involve violent behavior that we cannot contain despite de-escalation. And it has to be repeated. So, if it happened once, we will issue a stern warning. We usually put it in writing. We will give a client a memo. We'll tell them that, "This is your final warning. If this happened again, we will exit you."*

The dedication and creativity that JustCARE outreach responders and other care providers bring to the work also help to explain high levels of housing retention. Effective problem-solving and de-escalation often requires ingenuity and flexibility, qualities that the harm reduction framework tends to foster. Here, CoLEAD Director Jesse Benet explains how he and his staff responded to a situation involving someone who was believed to have been on a several day-long meth binge:

> *One night, we were really struggling with a guy that has meth use but also mental health issues. He was coming and going throughout the day. The hotel was really upset with him. He was stealing things, and we really thought he was on a meth binge, and maybe on day four or five. So, we put together a food box, and I added a cannabis edible to it,[29] and then got it all ready to go. And then, by the time we left, he still hadn't come back. So, the safety team, we asked them to post up there. They were there when he got back. They were able to say, "Hey, man. How's it going? CoLEAD left all this stuff for you. We'd like to just get you settled into room and take a load off, maybe get some sleep. We've got this to help you sleep." And it kept a whole situation, that I know would have gone down with hotel staff, from happening.*

The fact that JustCARE providers take the time to get to know participants also enables them to effectively de-escalate potentially explosive situations. In this example, Victor Loo from ACRS describes a technique he used that reflected his familiarity with the participant in question:

> *We had a client that was just running around naked and yelling at different clients, pounding a door at 3:00, 4:00 AM, and we have to figure out what is the intervention here, and how do we deescalate the situation? … And of all things, you will not believe, it's Gummy Bears. We remembered that the client loves Gummy Bears. So, we use that as a way to calm the person down.*[30]

JustCARE providers also proactively address potential disruptions. Here, Jesse Rawlins (former Housing Liaison for CoLEAD) provides an example of how CoLEAD attempts to prevent property damage by people under the influence of methamphetamine:

> *Someone using heroin is not going to cause property damage in a room, but someone using methamphetamine might very well cause property damage… .. For example, what's been happening a lot is people who use methamphetamine will take their TVs apart. They will take the outlets apart. … [If someone takes their TV apart] we will buy the hotel a new TV… but we don't put a new TV in the room. It could be taken apart again. We've tried to institute what's called tinker boxes, with different items, like keyboards or things that people can just tear apart instead.*[31]

In short, JustCARE has been able to keep people who have lived unsheltered for extended periods of time and contend with complex health issues in hotels by employing creative, proactive, and harm-reduction oriented techniques. These methods enable care providers to prevent and de-escalate potentially disruptive situations while also responding to the concerns of hotel staff. As a result, many people who might otherwise have experienced harmful interactions with the police, been removed from congregate shelters, or ended up in jail have been able to remain safely housed in the hotel setting.

Barriers to Longer Term Success

JustCARE providers have been remarkably successful in terms of keeping people housed and in addressing their most pressing needs. They have also managed to find permanent housing for over twenty participants in a relatively short space of time, even in the absence of a dedicated, permanent housing channel.

Two key barriers limit the long-term impact of this work. These barriers include uncertainty about the future of JustCARE funding and the paucity of affordable and supportive permanent housing options in Seattle/King County. These realities have cast a long shadow over JustCARE providers' work with participants. Here is how one outreach responder explained how uncertainty around the future of funding for JustCARE affected everyone involved:

> *Probably the most challenging thing is the not-knowing, the anxiety around what's going to happen to everyone. So when this runs out, when this funding runs out, when the hotel dries up or kicks people out or whatever it might be, probably just when the funding runs out. That creates a lot of anxiety. There is a lot of anxiety.*

Similarly, another participant shared that "I would say my biggest fear would be that I'd lose the place I have." Another put it this way:

> *I don't want to go back to the laundry room or that type of situation. I mean I do have a plan through my school, I have housing that's supposed to be coming up, you know, but things have kind of been on a delay because of the pandemic has delayed a lot of things, and so, this is like a roller coaster ride sorta. My moods are like, I'm really positive one minute but then when I think about the future, things are still grim. It's stressful.*

For community partners, too, awareness of the time-delimited nature of JustCARE funding has cast a dark shadow. As Maiko Winkler-Chin, Executive Director of the Chinatown/International District Preservation and Development Association, put it, "my biggest fear was okay, you guys are using CARES Act money. What happens on January 1st when the money runs out on December 31st?"[32]

The outreach responders and stakeholders we interviewed also emphasized how the limited availability of permanent housing, particularly for people with criminal records, substance use disorder, and mental health disabilities, sharply impacted the nature of the work JustCARE is able to accomplish. As one CoLEAD outreach responder put it,

> *I think permanent housing is obviously the main goal. Once they're here, this is obviously temporary, so talking about permanent housing is important but I think that that's a huge gap in what we are able to do as a staff and a program. Now I don't feel like we have a lot of access to resources around permanent housing at all … and COVID is happening on top of everything, so wait lists for affordable housing are already years long … In some ways, it feels like this maze that you have to navigate that really goes nowhere.*

Participants, too, are deeply affected by their awareness of the limited nature of affordable long-term housing. With the assistance of outreach responders, many JustCARE participants have applied for subsidized housing. Yet when we asked participants about their future plans, participants generally conveyed a deep sense of uncertainty and worry about the paucity of long-term housing options. As one participant told us, "If I leave the hotel and I have no place to go, it looks bleak." Many others said they feared going back to the street. Here is how one participant put it,

> *I'm exhausted. I just don't have my place. I'm a man, I'm a grown man. I should be in a place. And it hurts. And the more I think about it, the more I talk about it, it's just … I keep telling them I need my own place. It's just touch and go.*

JustCARE as a Health Intervention

Born in the pandemic, CoLEAD and JustCARE were designed, in part, to respond to changes in circumstances wrought by the pandemic, especially reductions in the jail population and the closure of many congregate shelter facilities in order to reduce the transmission of the coronavirus. To make these public health measures sustainable, some attention to the consequences of these decisions for individuals and public spaces was needed. In this section of the report, we describe how JustCARE adapted to operate in the context of the pandemic and the success it has had in limiting the spread of COVID-19. We also describe the creative work it does to increase access to a broad range of health services.

Reducing the Spread of COVID-19

For obvious reasons, there was a clear need to develop training and protocols around infectious disease in order to begin housing and supporting people in hotels. Early on, PDA/CoLEAD worked with an infectious disease expert to develop detailed Health-Safety Risk-Mitigation Protocols for outreach responders and participants. This 20-page document provides detailed guidance about how outreach responders can reduce risk to themselves and to participants while conducting their work in the hotel setting. ACRS and Chief Seattle Club adopted similar guidelines upon commencing their work in the fall.

One of the trickiest aspects of providing housing in the context of the pandemic is ensuring that participants are tested for COVID as soon as possible upon entering the hotel. Here, Victor Loo explains the ACRS approach to this challenge:

> *The idea is when somebody arrives at the hotel, when they finish the enrollment, when we bring them to the room, of course they are in tears… and I will just tell John Doe that I know you're very excited to see this, you haven't had a hot shower and bed, but can do your COVID test please? … You have two choices. Do you do the COVID-19 testing with me now? We just walk less than four blocks, or you have until tomorrow 11:00 AM, to do the testing." And then to incentivize them, we just tell them that we'll give you a $25 Target gift card if we do the test now. … Then we will just tell the client that at 2:30 everybody comes down to the lobby, that's when we will walk together to do the testing together… .*

CoLEAD and Chief Seattle Club also use encouragement and incentives to ensure that people are tested shortly after their arrival at the hotel. Participants are also tested if symptomatic or following exposure to others who may be ill. Overall, JustCARE protocols have been highly successful in terms of minimizing the spread of COVID-19. As of the end of February 2021, just twelve JustCARE participants had tested positive for COVID-19, and all were willing to quarantine in a designated facility. None required hospitalization.

Enhancing Access to Medical Care

For JustCARE providers, the provision of interim housing provided not only a chance to reduce the spread of COVID-19 but also a unique opportunity to address the many health issues with which many participants contend. Research shows that most people who live unsheltered have physical and mental health conditions that require ongoing medical attention. Barriers to routine medical care lead many to rely on the emergency room.[33]

Prior to entering JustCARE, participants dealt with a range of chronic and acute health needs but had inconsistent – and sometimes non-existent – access to health care. For example, one reported losing a limb and enduring a long wait for a prosthetic. Others lived with untreated heart disease. One described experiencing meningitis and seizures while in jail. Some endured protracted pain from injuries that was worsened by lack of housing and treatment. Others described workplace injuries and mounting hospital bills that cost them their jobs, their homes, and their savings. Here is one example:

> *It all comes down to the fact I couldn't work. I was partially paralyzed when the injury happened. So, if you can't go to work, you can't get your insurance paid. If your insurance fails, then you have to pay for it out of pocket if you want to continue on. At the same time, if you don't have any income coming in so you can't pay your bills. That's where I'm at right now. So, I'm waiting for disability. I've been dealing with them for five years now. They denied me two times. They've postponed it numerous times. I finally had my hearing in November, and they labeled me severely disabled but told me to go get a job and that I can't have my money.*

Limited access to housing as well as barriers to care also exacerbated ailments, as this participant explained shortly after his arrival at the hotel:

> *My knee's been an ongoing problem for the past month and a half or so on the streets. The very first time it happened. I literally could not walk. I couldn't leave my tent go to the bathroom. So basically, the people on the block made me call an ambulance and, you know, get checked out because I couldn't walk to Harborview, and I couldn't really walk to a clinic either. So I call them, they're bringing down an ambulance and the x-ray [machine] and, you know, all the unnecessary stuff. So it ends up taking a decent chunk of the savings I had.*

Many participants we interviewed also reported high levels of stress, anxiety, and depression, that were heightened by conditions on the streets:

> *I think I was starting to get manic… I wasn't sleeping at nighttime. I'm still trying to switch over my sleeping schedule. But I got paranoid with people around me and everything so loud, you hear people all the time going by. And you don't have no privacy [as] far as the noise and stuff you hear. So all that was getting to me.*
>
> *I had to stay awake for 20 hours a day, every day to make sure that I would still have*

my cell phone to call my grandmother to let her know I was still alive. So, yeah, it made it made me a little crazy … I had a lot of doctor's appointments and stuff that I would kind of have to bounce around and I would miss a few of them because, the biggest challenge I had was like holding onto a cell phone because people want to steal them because they're worth money. So there would be weeks at a time where I wouldn't have any contact with my like mental health workers or actual doctors, and I would just miss appointments. Then I would pop up and be like "hi guys, sorry I haven't talked to you."

Table 5 provides a sense of the prevalence of various kinds of chronic health issues reported by the JustCARE participants we interviewed.

Table 5. Diagnosed Health Conditions Reported by JustCARE Participants

Other physical health condition	62.8%
Depression	51.2%
High blood pressure	46.5%
Anxiety	44.2%
Chronic back pain	39.5%
Other mental health condition	34.9%
Hepatitis B or C	18.6%
Asthma	14%
Chronic lung disease	14%
Learning disability/cognitive disorder	11.6%
Physical impairment	11.6%
Diabetes	9.3%
Heart disease	9.3%
High cholesterol	9.3%
Sexually transmitted disease	4.7%
No significant diagnoses	2.3%

Source: *Author surveys with 42 JustCARE participants.*

Note: *Other physical conditions identified include: deafness/hearing loss, traumatic brain injury, thyroid disorder, pneumonia, seizures, legal blindness, lupus, migraines, neuropathy, arthritis, atrial fibrillation, ulcers, Crohn's disease, cirrhosis, and less specific issues such as limited mobility and chronic pain. The most common of the other mental health issues identified include bi-polar disorder, PTSD, and schizophrenia.*

Participants' health issues often went unaddressed prior to participation in JustCARE. This was true even for people who had medical insurance. Here, CoLEAD's medical provider, Dr. Kotarski, identified several factors that help explain this pattern:

> *The way that healthcare currently works is we're reducing down primary care into just acute care. And this is really seen for folks who don't necessarily have the ability to access healthcare easily. So what ends up happening is a system of just sick care. And with sick care and an overwhelmed system, we just see these band aid approaches - you have one problem and we're talking about that one problem in this visit and you walk out with your one treatment or your one medication.*[34]

By contrast, in the hotel setting, Dr. Kotarski and other JustCARE health providers have been able to provide continuous care that involves building trust and addressing complex and overlapping health issues. JustCARE health care providers are often able to provide care directly. Where this is not possible, medical providers help to develop and coordinate a treatment plan while outreach responders support participants in scheduling and keeping medical appointments.

Across the board, the participants we interviewed had positive experiences receiving support coordinating doctor's appointments and gaining access to prescriptions necessary for controlling the rapid decline of their health, which was largely neglected while they were unhoused. This increase in access to care had tangible results for participants' physical and mental health. For instance, the participant who had a seizure in jail prior to joining CoLEAD was, at the time of our interview, hopeful about his health and future:

> *Since I've been released from the hospital, I'm not on the streets anymore, I'm looking at getting my social security card, my birth certificate, my ID and all that. It was pretty rough before, but it's starting to look a lot better now, and I've got somewhere to be.*

Another participant explained how access to care helped her stop using illicit drugs: "I'm not using street drugs to manage my ADHD and my dyslexia. I'm working with [a] psychologist and a psychiatrist to explore the naturopathic kind of solution to deal with that. And I think that's wonderful."

Many participants attributed their improved health to the combination of enhanced access to treatment and housing. For example, the participant whose knee injury had prevented his mobility while he was living in an encampment told us that

> *CoLEAD hooked me up with the doctor, and they were able to get me some anti-inflammatories so I can begin the healing process on it again. I'm finally active now and moving again, which is nice … Biggest thing I really needed was just a place where I could recover and they provided that already, and medicine. So yeah, that was pretty huge.*

Many respondents also reported that having a safe and stable place to sleep, secure their belongings, and the ability to bathe regularly greatly enhances their health and sense of security. For example,

the person who described staying up all night to guard his belongings is now able to rest and to make his doctor appointments:

> *Being able to sleep and having the peace of mind knowing that I have a secure door, or there's something that can stop people from, you know, directly affecting my ability to do what I need to, because I still have doctor's visits and stuff, like I'm not healed from my injuries yet, so it's still an ongoing process. But yeah, having that piece of mind has been absolutely fantastic … the peace of mind of not having to worry about every little person that crosses my path. What is their ulterior motive, why are they here, what are they after. I don't have the sense of paranoia that I had, because it's not a necessary component of my everyday survival anymore … and I haven't missed an appointment since being under them. They've helped with transportation there.*

Several JustCARE participants experienced significant ailments or surgeries – including open heart surgery and strokes – during their time in the hotel and described the invaluable support of the hotel and case managers in helping them access medical care, get to appointments, access medications, and recover in a safe, clean environment. Here is one example:

> *I had a couple strokes, so outside of the medical issues, my memory and anything that really has to do with the brain I'm struggling. But outside of that, I'm all right. … My CoLEAD caseworker helps me a lot. Like make sure that I get to my medical appointments because I can't remember nothing.*

Overall, the JustCARE participants we interviewed reported significantly improved access to health care since enrolling in JustCARE and entering the hotel. The data presented in Table 3 above bear this out. This achievement is attributable to the care provided by JustCARE medical staff and their efforts to coordinate care, as well as to the support of JustCARE outreach responders.

Treating and Managing Substance Use Disorders

The vast majority of JustCARE surveyed participants reported having used substance problematically at some point in their lives. Participants identified a range of circumstances that triggered their drug use, including personal trauma and tragedy; medical injury and physical pain; falling in with "the wrong crowd"; eviction; childhood/teenage use; or some combination of these and other factors. Consistent with the screening data provided by REACH, most of those we interviewed reported actively using drugs and/or alcohol when they entered JustCARE.[35]

Some of those with whom we spoke reported not working with JustCARE on their substance use either because they were already in treatment or because they were not seeking to cease or curtail their use. As one put it, "the biggest challenge is the getting clean part. I know I've never been able to do it really, no matter how bad I want it… I don't know why I've never been able to do it. No matter how bad I want it, it seems impossible." Similarly, another participant told us,

> *[I'm] still trying to get sober. It's alright, still kind of a challenge because you know, there's*

days that I wanna just get high. There's days I don't wanna get high.... [CoLEAD work is] going good... we've talked about getting sober... and just check on me and my health... check on me, see if I'm alright... it's helpful. But I'm still using.

Others reported progress with one substance but not with another:

Well, I'm still gonna drink. I can't put that past behind me, I'm 62 years old and I've been drinking since I was 15. But the drugs, that's what I don't do anymore.... So I've put that past behind me, but I still got the alcohol problem. But I've been in treatment, like when my mom passed away. I seen them push a thing over my mom's face, when they zipped her up - can you let her breath? I don't know what to say anymore. I don't know...cause treatment is not gonna fix me. I gotta fix me, I gotta fix my own self.

At the same time, many other participants were interested in reducing their substance use and were engaged, to varying degrees, in that process. Some participants who wanted to quit or cut down on their drug use often saw this as a "first step" toward other goals, especially reunification with children or other family members. As one participant explained, "My main goals are housing and getting my daughter back, really, which involves treatment and a lot of other things like my issues with the law."

For some participants who wanted to stop or reduce their drug use, treatment was not needed; being off the street and away from triggers was sufficient:

[CoLEAD] gets me away from the foolishness and the vices and stuff... what I was surrounded by, you know, on a day-to-day basis, out there on the streets while I was using. That's exactly what this what this hotel and the CoLEAD program has afforded me, ya know? And it's keeping me busy. I don't even have a desire to go out there. Just going out there and using hasn't even crossed my mind.

Best part of my life is being sober. Because I don't have to wake up every day and have to do drugs to make myself normal again. And I was struggling to do that for so long. And I just wake up and I feel like I should without having to do anything. And it feels amazing.

Another participant who has stopped using drugs shared that

Life [before JustCARE] was not very good. I was doing a lot of heroin and meth and stuff. I was going to jail pretty frequently, cause I was doing like burglaries and robbing buildings and all this extra shit. And it was not good. And so CoLEAD has really helped me stay sober and I've been sober for like two months or whatever, and like, it's really good. So I'm really proud of myself."

Other participants, especially people who use heroin, who wanted to quit or reduce their use and needed more than housing to do so were able to obtain medication assisted treatment (MAT, usually Suboxone[36]) with the help of JustCARE providers. As one explained,

> *They called and got us on, got our appointments to get on methadone. Cause usually, by ourselves, we have to call every week and wait until we get on the waiting list, and it's a process. But they just called in, said they're from CoLEAD, and got us in the next day to the program. So that helped a lot. They got us on the next day, which would never happen on our own.*

Another told us,

> *Before I got hooked up with CoLEAD, like I said it was rough. I was living on the streets. And it was, uh, it wasn't very good at all. I wasn't being very healthy, I wasn't making doctor's appointments. I am now. And they've helped me get on Suboxone. They've really been looking out for me… I've cut back on my drug use… I don't like [Suboxone] that much, but it helps. Helps with cravings.*

While most respondents described getting on MAT as helpful, some continued illicit use alongside MAT. As one explained, "They got me on Suboxone. It's going okay … it's helpful but there's times I still wanna use. For the most part it helps my cravings."

In short, as is now widely appreciated, substance use disorder is a chronic health issue. Housing and support have enabled some participants to stop or reduce their drug use. MAT was also helpful for some, particularly for people who used heroin. However, MAT is generally unavailable for people who mainly use alcohol or stimulants. Treatment for these disorders is therefore comparatively challenging. Here, Dr. Kotarski describes how she works with JustCARE participants who are dependent on alcohol in the context of the pandemic:

> *With alcohol, if we can get folks into inpatient treatment and it's a good fit for them, that's what we do. But there can be a lot of resistance and I think COVID added another layer to that because to them it's like well, if I go there and there's COVID there then I'm stuck. I think that added a layer of fear, so what we do instead is again we really work with the harm reduction within the relationship and we start executing tapering and reducing the risk of harm. Stopping alcohol can actually lead to death. So education around that, and then working through tapering schedules. The tapering schedules in and of themselves can be pretty remarkable because they often foster relationships between the caseworkers and the participant.*

Stimulant use is also comparatively difficult to treat, as CoLEAD housing liaison Jesse Rawlins explains:

> *We don't have the same kind of medication treatments [for stimulant use as for opiate use]. I did write a report with a researcher that works at the medical school on an innovative treatment modality using methylphenidate or Ritalin, to literally just substitute one stimulant for a safer stimulant in a regulated way, to not only decrease illicit use but also address the problems that are associated with heightened methamphetamine use. But it's not well researched, it's not well practiced, and so we don't have good strategies for addressing methamphetamine.*[37]

Here, Dr. Kotarski explains how CoLEAD approaches methamphetamine use given this constraint:

> *We focus a lot on harm reduction, as with everyone, but I think because of the lack of options for unique stimulant use there's often a lot more attention to the possibility of underlying mental health issues which are, of course, very blurred, because some of the effects of the use can lead to signs and symptoms that seem very, very similar to mental health issues… so we focus a lot on trying to connect with behavioral health, and looking into health histories and determining what conditions are present and what mental health medication we can use to help support them.*

In sum, JustCARE creates an important opportunity to expand access to holistic approaches to health care for the chronically underserved. JustCARE participants contend with many significant health challenges, including, in many cases, substance use disorder, and have often done so for years. In the context of JustCARE, many participants have been able to access care and address long-standing and complex health needs. While some participants continue to use illicit drugs, they receive equipment and care to minimize the risk associated with their drug use. Because so many health care providers were only seeing patients remotely in 2020, it is likely that many of the conditions for which JustCARE has been able to provide or arrange for treatment would otherwise have involved hospitalization or remained untreated.[38]

JustCARE as Public Safety and Quality of Life Initiative

JustCARE seeks to reduce crime and improve the quality of life in targeted neighborhoods and in the lives of the people it serves. It does so in three main ways. First, by moving large numbers of people living on the streets to hotels, it has effectively eliminated the harms associated with the targeted encampments. Second, JustCARE seeks to reduce participants' reliance on illicit survival strategies by meeting their basic needs, addressing their substance use, and helping them secure the benefits to which they are entitled. Finally, JustCARE uses de-escalation and related techniques to resolve conflicts and prevent violence in the hotels in which it works. Each of these strategies, and evidence of its efficacy, is described below.

From Encampments to Hotels

Many cities, including Seattle, have relied on sweeps and dispersal orders to address the concerns that unauthorized encampments often engender among urban residents. By contrast, JustCARE seeks to improve public safety and quality of life for all Seattle residents – including people living outdoors – by ameliorating the harm associated with unauthorized encampments. This means avoiding punitive and destabilizing sweeps that exacerbate the harm associated with living unsheltered.

Research shows that unauthorized homeless encampments, are often associated with a variety of public safety and quality of life issues that affect both the people who live in them and their housed

neighbors. These issues include:

- **Unhealthy living and environmental conditions.** Conditions in homeless unauthorized encampments can be dangerous to health for camp residents and others who live nearby. Trash attracts rodents and other vermin. Food cannot be safely stored, and dishes cannot be washed; these realities facilitate the spread of food-borne disease. Depending on a camp's location, some residents might have access to portable toilets or public facilities; where this is not the case, people are compelled to use outdoor spaces. These circumstances fuel a variety of health problems, including the spread of communicable disease. The risk of fire is also heightened in many encampments. The on-going threat of sweeps often pushes encampments into spaces characterized by significant environmental hazards.[39]
- **Crime and victimization:** People who experience homelessness – especially those who live unsheltered – report high rates of child and sexual abuse that occurred before they became homeless. This is especially true for women who experience long-term homelessness. Unfortunately, living unsheltered also puts people at high risk of victimization.[40] Some people engage in sexual exploitation, taking advantage of comparatively unregulated encampment spaces.[41] At the same time, some people who live unsheltered employ survival strategies such as panhandling, theft, drug distribution, and exchange of stolen property to generate income.[42] In some encampments, the search for respect may also fuel interpersonal violence.[43] In our interviews, many participants described having experienced both property and violent crime while living unsheltered.
- **Restricted access to public spaces.** In some cases, encampments block access to otherwise public spaces and amenities such as sidewalks, bus stops, and parking lots. This poses a particular challenge for people with mobility issues and those who depend on public transportation.

In short, unauthorized encampments are less than ideal living spaces for residents and neighbors alike.[44] Since its inception in the fall of 2020, JustCARE has sought to reduce the harm associated with encampments in which mainly people of color live. These areas include the Pioneer Square area, especially the three block stretch of 2nd Avenue Extension South that runs between Yesler Way and S. Jackson Street, and the 8th and Jackson area in the Chinatown/International District. As Cathy Jimenez from King County Metro explained,

> *So the encampments [are] definitely something that's increased during COVID. When I've gone down to meet with [people working in the Pioneer Square area], there are a lot more people asking for change, or asking for food, or just a couple of people, literally, I had to do a welfare check and be like, "Dude, are you okay?" Because, they looked like they were dead, maybe just high, or seemingly high. But there's just a lot more of that encounter right now, and so much less of any other normal activity.*[45]

The growth of unauthorized encampments in these areas was causing significant concern and demands for a city-level response. Both residents and businesses expressed concern. As Chris Woodward of the Alliance for Pioneer Square explained,

On the business level, there's a lot of desperation, right? You're one, trying to run your business, two you're trying to navigate all the different resources. And then you're dealing with a presence of houseless people, not necessarily who are acting maliciously or anything, but just the presence. It makes it hard for people to get to your business and feel a sense of safety doing so… .

These conditions engendered significant concern among people who live and work in affected areas. In the spring of 2020, for example, nine CID based organizations sent a letter to Mayor Durkan asking that she ""bring all possible resources to bear to serve the needs of the people living unhoused on South King and South Weller [Streets], preferably sheltering these individuals in permanent or transitional housing, which includes motel/hotel/quarantine sites."[46]

In this context, the community partners with whom we spoke – including people involved with King County Metro, the Downtown Seattle Association, CID Business Improvement Association, the Pioneer Square Resident's Council, the Pioneer Square Alliance, and nonprofits such as Real Change – expressed a great deal of appreciation for the capacity of JustCARE to address their concerns. In many cases, they were also pleased that JustCARE had also addressed the needs of the people who had previously been living unsheltered. Virtually everyone with whom we spoke expressed the desire to see JustCARE expand. Here are a few representative examples:

JustCARE has done a better job than anyone. So, people being helped without sweeping them, without having them lose their items and all the bonuses of wraparound care. Do you need mental health care? Do you need treatment for addiction or help or counseling for addiction or do you need to just get clean? Do you need decent food? Do you need someone to stop preying on you and making money off you? So, I think they're doing fantastic.

~ Tija Petrovich, Chair, Pioneer Square Resident's Council[47]

We have to be sophisticated in what tool we bring to bear. And something that DSA has acknowledged is that some of that work maybe with the justice system and the police department, and some of that work needs alternatives like LEAD. LEAD was really kind of the trailblazer in some of that thinking for us locally, but also nationally. We're not helping folks that need the attention by just putting people in a revolving door of jails and prisons.

~ Jacqueline Gruber, Director of Built environment, Downtown Seattle Association[48]

I mean, if JustCARE could expand its service area, that would be huge for us. We have some significant issues, encampment issues, in the park-and-rides down south and up in the north end, in Shoreline. To be able to expand those services and expand those opportunities would be huge for us.

~ Jose Marenco, Chief of Police, King County Metro[49]

Tiarra [Dearbone] and the team came out within just a couple of days and was able to connect all of the rest of the campers within a week. … I know that REACH had asked everyone specifically what they need. I don't know exactly how CoLEAD went forward with it, but it was within a week or 10 days that everyone was completely gone, and we haven't had any encampment outside since then. And it was because of meeting people where they're at and connecting them directly with services and having the ability to do that without that police presence showing up, which can be a deterrent to folks outside connecting with service providers.

~ Tiffani McCoy, Advocacy Director, Real Change[50]

I did see a visible change in the encampments nearby when the program was first starting, and to be able to hear that over 180 people were outreached to, and over a 100 of them had actually accepted services and to join that program was really nice to hear, and just good to know that people aren't just being shuffled around and are actually … getting services.

~ Monica Ly, Clean and Safe Manager, CID Business Improvement District[51]

Tiarra Dearbone, Project Manager for LEAD in the West Precinct, also conveyed a strong sense that business owners and residents have also been receptive to, and appreciative of, JustCARE's approach:

I have gotten overwhelmingly a positive response, even from people who initially were a little apprehensive about diversion, people who would have advocated for more enforcement. And one of the reasons is because regardless of what we offer people and regardless of how we take care of the individuals, we are actually providing a response that addresses their concerns… . Everyone's complaining, there's an encampment in front of my building. There's an encampment on my sidewalk. There's crime happening outside. I talked to people for months and months about Second Avenue extension and all of their concerns. And they would send me emails and photos of things going on there…. And for them to see what was happening, watching the encampments shrink and then basically be gone, was a huge relief to them. They had been calling the cops every day and they found our response to be more effective and expressed feeling better about that response that people actually got what they needed. And so, I think even if people don't typically support a diversion type approach or alternative to enforcement, they want something that works. And the good thing about that is that it does, and it did.[52]

In short, our interviews with community partners reveal a great deal of appreciation for JustCARE and a sense that its interventions are efficacious. Before and after photos provide additional confirmation that JustCARE had a pronounced impact in the targeted areas. The first two photos show the parking lot at 8th and Jackson before and after the intervention; the subsequent two show the targeted area on 2nd Avenue Extension South before and after people were moved into the hotels and the debris from the encampment was cleared.

Photos: *Northwest corner of CID Interim Parking lot at the intersection of 8th & Jackson, before (left) and after JustCARE (right).*

Photos: *300 block of 2nd Ave. Extension South in Seattle, before (left) and after JustCARE (right).*

JustCARE's intervention thus appears to have dramatically improved the quality of life for JustCARE participants, as well as for people who live or work in the neighborhoods in which the targeted encampments were located. Any concerns community partners expressed about JustCARE centered on the unwillingness of the city and county to provide the funding needed to enable the continuation and expansion of JustCARE.

Reducing Crime by Meeting People's Basic Needs

In addition to moving people from unauthorized encampments into hotels, JustCARE also seeks to improve public safety by meeting participant's basic needs, increasing their access to mental health treatment, connecting them to the benefits to which they are entitled, and addressing substance use disorders. The underlying theory of change is that participants will dramatically reduce or eliminate their use of any illegal survival strategies on which they previously relied when their basic needs are met and their substance use is addressed

Before entering JustCARE, respondents made ends meet through a combination of government

benefits (e.g., food stamps), nonprofit assistance (especially food banks), sporadic employment, assistance from friends and family, and illicit activity. The precise combination of these varied by person and over time. While some of the people we interviewed did not report ever having relied on theft or other illegal activities, all of those who acknowledged doing so prior to entering JustCARE reported having engaged in theft, mainly shoplifting goods from retail stores or food from grocery stores and sometimes reselling items. Some had also sold drugs, and a few respondents said they stole from stores if they needed food or other items. Most, however, told us they stole whenever they needed money. This could be ad hoc (for example, one person told us that when they ran out of money, they would steal and resell the stolen goods) or on-going (another respondent said he made over $200 a day by stealing and selling drugs and other stolen items).

Some (but not all) of the participants we interviewed were quite open about this facet of their pre-JustCARE lives. For example, one participant told us that "Before I got into the CoLEAD program I was just basically doing drugs and doing little small crimes that got me into trouble, like stealing from stores … ." Another said, "I used to snatch money from registers, shoplift on a regular basis. It was pretty much a living." Yet another told us,

> *I started staying on the streets, but I was still on drugs, and then I was on the streets for another year, another year and a half. And I came to downtown, and I just been in downtown the whole time. And started getting in trouble, stealing. They call it boosting, it's another term for stealing from stores. Like I would steal something expensive and sell it for half the price.*

As this excerpt indicates, substance use disorders introduce another source of motivation to engage in theft and other property crimes. Research shows that some people with substance use disorders commit property crimes and engage in other criminal activities such as drug sales in order to generate revenues that can be used to obtain drugs.[53] Consistent with this research, some of the people we interviewed pointed to addiction when explaining their past behavior. For example, one participant shared that

> *I've been struggling with opioid addiction for a number of years, and so it depended if I had that. If I didn't have it, then I'd find ways to get it and even find ways to get money to get it. That was pretty much my number-one. If I didn't have that, then the rest of my day was shot. So, that was my number-one focus. So, from thereafter, if I didn't have that, or if I needed to get that, I'd go out and if it was to go shoplift at stores or if I would run into people that were looking or something, I'd be up for helping them get it. They'd give me their money or a little bit of heroin for helping them get it.*

JustCARE staff have helped participants access government benefits, often starting with obtaining identification and health care, then applying for assistance programs, such as food stamps, SSI, or SSDI. For anyone receiving such assistance, the money has been crucial in making ends meet. In addition, the hotels, food, and gift cards have helped sustain people when need arises. And, as discussed previously, some people have been able to cease or reduce their use of illicit drugs.

Participants made it clear that they felt that their basic needs were now met. One especially enthusiastic participant shared that

> *And CoLEAD is a wonderful program, there's a lot of stuff that they help you with… If you have disabilities, they help with that, they help with counseling, 1-on-1 or they have counseling together if you're a couple… . You know they helped me get a job. Now I get disability but I can only work 10 hours. So, I'm more independent now with CoLEAD. Now I've dealt with other agencies in the past, in other states, but CoLEAD… it's amazing. They even give us $10 in quarters if we needed to wash our laundry. Who does that? You know? That's a blessing.*

In this context, all but one of respondents who acknowledged their prior criminal behavior reported that they had decreased or stopped engaging in theft or selling drugs entirely since entering JustCARE. For example, when asked if his engagement with theft had increased, decreased, or stayed the same, one respondent reported that "It's nonexistent at the moment." Other participants reported sharp decreases in their use of illicit survival strategies:

> **Interviewer:** *Were you committing crimes before?*
>
> **Participant:** *Yeah, not really much, just stupid little things, sometimes stealing stuff, stealing food from stores, things like that. Shoplifting in grocery stores pretty much.*
>
> **Interviewer:** *For how long?*
>
> **Participant:** *Off and on for 3-4, 5 years. Since I been out here.*
>
> **Interviewer:** *Has living in the hotel impacted your involvement in shoplifting?*
>
> **Participant:** *Yeah it's helped a lot, because I don't really have to anymore.*
>
> **Interviewer:** *Why not?*
>
> **Participant:** *Because now we got somewhere to stay, and CoLEAD kinda helps with food and stuff when we need it. Being indoors helps. And they have food here too, at dinner time. We were usually stealing stuff we needed, like food, things like that.*

Similarly, another participant told us that "Yeah, [shoplifting] definitely decreased after CoLEAD because I didn't really need money. I just had to get to the food bank every so often." This theme was nearly universal among people who acknowledged previously engaging in crime as a survival strategy:

> *I was staying at this abandoned house at the time, so as far as food, clothing, entertainment, whatever I needed, I just went out and got it… But once you got steady housing and you don't have to worry about getting kicked out or whatever, you could focus on the good things.*
>
> *I don't [steal] anymore, because I don't want to lose this place. I don't want to lose my eligibility to be in the program. I don't feel like … I don't want to do anything to put losing*

this at risk.

While most participants referenced previously relying on shoplifting, some also admitted to having engaging the more serious crime of burglary before entering JustCARE:

> **Participant:** *I used to burglarize buildings. I used to like, break into buildings, and like, steal all their laptops and iPads and stuff that was in there…*
>
> **Interviewer:** *How long have you been doing that?*
>
> **Participant:** *Four or five years.*
>
> **Interviewer:** *Has CoLEAD changed your engagement in these activities?*
>
> **Participant:** *Of course. I mean I haven't burglarized anything for five months.*

For some, the fact that JustCARE providers met their basic needs explained their diminished use of illicit survival strategies. Other participants attributed their decreased reliance on theft and other crimes to the fact that they no longer needed money for drugs. For example, one told us that

> *There's a correlation between retail theft and addiction. Now I've got money. I'm not going to steal things, to take the dope boy's road just to do drugs. I'm not suffering in that capacity anymore. You know, I'm trending upwards. So when I go in stores, I go in and buy things. I walk out with a clear conscience. And that's all I ask for is peace, peace of mind. And it feels good to walk in the store and buy something and not have, you know, in the back of your mind these people are watching me or they're gonna come after me because they know I stole something or something like that. I just don't like that feeling no more.*

A few participants also mentioned that living on the streets was conducive to assaultive behavior. In these cases, too, respondents reported that receiving housing and care through JustCARE providers helped to reduce this pattern:

> *I don't know how to explain it other than, uh, I would get in trouble a lot, mainly with fighting and getting into arguments with the officers, and occasionally for using drugs while in jail. And it's often pretty stressful for me because, you know, I'm going into jail from homelessness and then I know I'm getting back out to homelessness, and usually there's not really much I can do to help my situation upon getting out. So, I'm often stressed out and feeling like I'm wasting my life being in jail. And that's pretty much it.*

These reports of reduced criminal behavior by JustCARE participants are supported by a few other indicators. For example, the outreach responders we interviewed conveyed the strong impression that participants have dramatically reduced the extent to which they engage in crime in order to generate income and or obtain access to drugs. As one explained,

> *When you're in survival mode, on the streets, you've been in survival mode, and you*

have to do everything while you're in survival mode, whether it's eat, whether it's get some money, no matter what. And then, when you're not in survival mode, seeing those things slowly dissipate. You don't have to go out, all day, downtown. You don't have to sneak guests, up in my room, because I have to maintain that relationship. You're not in survival mode, anymore, and as long as you're on this program, you don't have to worry about normal necessities. So, you can work on yourself.

Other outreach responders responded similarly. As one put it, "Well, if we're speaking about my specific caseload, since being placed in stable housing, none of my participants have been in any more legal trouble. None of them."[54]

Other data are also consistent with these reports of decreased involvement in illegal activities by participants and outreach responders. Nearly all (90.7 percent) of the people we interviewed had been incarcerated in their lifetime; over one third (39.7 percent) reported having been jailed in the past six months alone.[55] Yet the administrative data indicate that only a handful of participants have been re-incarcerated while enrolled in JustCARE. While additional data collection and analysis is required to fully assess the crime-reduction effects of JustCARE, these preliminary data indicate that meeting people's basic needs for shelter, food, and income, and supporting them in ways that enable people to reduce their use of substances, does facilitate a notable decrease in the use of illegal survival strategies.[56]

De-Escalation as Public Safety Strategy

Finally, JustCARE seeks to reduce crime and violence through the use of de-escalation and related problem-solving tactics to diffuse conflicts and other situations that have the potential to generate fights and assaults. This is an intentional strategy, one that is aimed at reducing conflict and decreasing police interactions with JustCARE participants, many of whom are men of color with mental health disabilities.[57] JustCARE providers offer formal trainings on de-escalation to outreach responders and informally educate hotel staff about this issue as well. As Victor Loo of ACRS noted, JustCARE is "all about how to de-escalate in a way that is that doesn't create more trauma or harm or trigger the clients to react in a more violent way."

In addition, JustCARE contracted in November of 2020 with a new firm, Wheeler Davis Conglomerate, that provides a safety-oriented alternative to the police and conventional, armed private security. This firm was co-founded by long-time community organizers and advocates, Dominique Davis and Stephenie Wheeler-Smith, and as calls to defund the police proliferated in 2020:

As the whole social uprising, political uprisings… all the marches and protests and all that, and the defunding the police conversation got more prevalent and started falling into place with the city, the county, everybody's talking about it, we started realizing this is a real thing. It looks like something's going to happen. And in the same instance, we saw Seattle Public Schools and Puget Sound Transit pull contracts with the police departments, with law enforcement. So then, the conversation we started having was, "What is going to happen if they do start defunding the police, and 600, 700 officers

are no longer part of the police department? What communities will not be policed anymore?" It'll be the Black and brown communities that won't get policed anymore. Right? And then what'll happen is, the city or the county will contract with some White security company, and that White security company will have to go on a hiring frenzy to cover boots on the ground. They'll go out and they'll hire either ex-police officers, or people that want to be police officers who couldn't pass the test. So then, we're still faced with the same systemic racism issues that we have been marching and protesting about…. And then some White organization, some White security company gets the contract, gets the money, and gets to put the money back into some other White folks that don't live in the community's pockets…. So, we decided to start not a security company, but a community safety company.

Wheeler Davis Conglomerate staff emphasize that they approach the issue of safety in a very different and more relational way than the police. As Stephenie Wheeler-Smith, co-founder and COO of Wheeler Davis, explained,

We are steering away from security, which gives the connotation of a semblance of policing. And more so toward public safety, which is a communal activity that involves the community's input, that involves the community's responses, that involves the community's help as we think about and reimagine what it looks like to create safe places in our communities. So, we are a part of the community going into our own communities and providing public safety. Versus, going into our communities and policing, continuing to police.

In the context of JustCARE hotels, this approach involves thinking proactively and building trust and relationships:

And so, having the relationships before we even have interaction is our goal. So then we don't have to come in as a security force … we've already built relationships and already built that structure where I can go say to Suzanne or I could say to Isaiah, "Hey, hold on. Calm down. Let me talk to you for a minute. Let's deescalate. Let me get you something to eat. Can I get you something?" And so now, instead of security coming in, "Hey, everybody break it up," kind of thing, it's totally different approaches. Totally different approaches.[58]

Wheeler Davis Conglomerate staff are trained in a variety of areas, including de-escalation, mental health first aid, motivational interviewing, trauma-healing, DBT, and more. They play a particularly important role in maintaining safety at night, when JustCARE staffing is lighter, especially in the hotels served by CoLEAD and Chief Seattle Club. Much of what they do is aimed at preventing disruption and conflict before it occurs.

JustCARE leadership report that the safety teams have been crucial to JustCARE's success in reducing conflict, keeping people safe, and addressing the needs and concerns of the hotel staff:

> *They certainly want people [participants] to see them as a support and a presence, but they're not there to case manage people. They're there to ensure that people are safe, and that all staff are safe, and that CoLEAD staff are safe. I always say that they "keep things at a low roar," especially at night, when people show up, really differently at night than they do in the daytime.... They've also just been available to hotel staff. If something's happening at the hotel that isn't supposed to be happening, whether it's involved in a CoLEAD participant, or not. Sometimes, it's hard to tell if people are affiliated with our folks or not. They can just move people along, "Hey, you can't access the parking garage, right now," or, "Actually, the hotel isn't open. Right now, you have to be a registered guest to be here. There's no visiting." So, there's just this extra presence.*[59]

Among many lessons learned, JustCARE stakeholders have come to believe that the presence of the safety teams is crucial to the operation of the whole enterprise. As Lisa Daugaard put it, "If not for the safety teams, I would have real trepidation... I don't think it would be responsible for an organization, like ours, to have staff deploy into these situations, without a plan for the backup with this skill and capability."[60]

In short, JustCARE seeks to improve public safety by moving people from the streets to hotels and by addressing participants' needs for shelter, food, and income. In addition, JustCARE relies on the services of a new community safety firm that uses de-escalation and other creative tactics to reduce conflict and keep people safe in the hotels. Although the crime-reducing effects of JustCARE are difficult to measure, interviews with participants, outreach responders, and community partners strongly suggest that such reductions have occurred. It thus appears that JustCARE has achieved improvements in public safety and quality of life for participants as well as for people living and working in neighborhoods previously impacted by unauthorized encampments.

JustCARE as Decarcerative Strategy

Although JustCARE seeks to improve public safety, it strives to do so without reliance on the police, the criminal legal system, or harmful and counterproductive encampment sweeps. In fact, it seeks to ameliorate the harm that police encounters, criminal records, and criminal legal system involvement continue to cause JustCARE participants. JustCARE pursues these goals in two main ways, each of which is described below.

Reducing Policeability: 911 Call Mitigation

JustCARE seeks to facilitate a cultural shift in which extreme poverty, mental illness, and substance use disorders are rendered "unpoliceable." "Policeability" refers to the now-dominant cultural frame that designates the police as the most appropriate and effective first response to behaviors such as drug use.[61] Part of what sets JustCARE apart is the active work it does to address people's concerns about such behaviors directly, in effect serving as an alternative to 911.

Reducing reliance on 911 is important for several reasons. First, use of emergency services is

extremely expensive. In addition, 911 calls often generate police interactions that have adverse effects on vulnerable people. People of color, the disabled, and people with mental illness are especially at risk and are often harmed by interactions with the police.[62] For example, research finds a direct relationship between police stops and symptoms associated with Post Traumatic Stress Disorder (PTSD); as frequency of police contact increases, so do symptoms that include anxiety, hyperarousal, and avoidance.[63] Relatedly, unwanted police contact generates "system avoidance"—people's unwillingness to enter into and seek assistance from medical, financial, economic, and educational institutions. [64]

In the summer of 2020, JustCARE staff began conducting outreach with a variety of organizations that represent people who live and work in the areas on which they focus. Here, JustCARE incorporated communication and outreach strategies used by LEAD project managers to address community concerns.[65] Once a working relationship has been established with local businesses, residents, and other affected parties, project managers provide them with a series of alternative complaint mechanisms (to use in place of 911) and other opportunities to express their concerns.

This aspect of JustCARE's work in Pioneer Square was spearheaded by the LEAD Project Manager for the West Precinct, Tiarra Dearbone. Building on relationships that she had formed through LEAD, Tiarra and other JustCARE staff continued to dialogue with people who live and work in the area. This communication was intended to both enable people living and working in the area to express their safety related concerns and for JustCARE to share information about their planned activities with concerned neighbors. Tiarra reports that neighbors have been quite receptive to the idea of addressing the issue in a non-enforcement-oriented way:

> *I've found them [housed residents and businesses] to be welcoming and inclusive and considerate of those living unhoused in the community. And they really do consider them their neighbors and community members and had a lot of interest in trying to support the JustCARE work in any way that they can. Like they even, after we did a presentation for them about a month or so ago, they actually gathered together to do a coat drive for our clients, and provided tons of brand-new coats…. What I find is for most people, if they know that there's an option that actually gives people the services that they need, then they choose that.*[66]

By offering JustCARE as an alternative to reliance on 911, JustCARE provides a mechanism by which community members can express their concerns about non-emergency situations and request assistance for addressing those conditions.

JustCARE's approach to safety and its employment of Wheeler-Davis Conglomerate safety services in the hotels also involves reducing reliance on 911. As Jesse Benet, CoLEAD Program Manager, put it,

> *Instead of calling the cops if participants are doing something, they [the safety teams] are really there to de-escalate any nighttime behaviors … if those things are too out of alignment with what the hotel can allow and our lodging agreement can allow. Then they*

can come alongside and support people in a way that is deescalating, that responds to people's needs, and isn't punitive or, "If you don't get out of here, we're going to arrest you." It's like, "Why are you here? What's going on with you? Oh, you don't have a place to stay. How can we help you figure out something to get you away from the hotel tonight but maybe get a need met?" I know sometimes they've given people food or a ride somewhere.

SPD 911 call data indicate that these strategies have been effective. In particular, these data show that calls for service associated with the two targeted encampment areas were notably lower in January-February of 2021 (following JustCARE's intervention) than they were in the same months of 2020. Moreover, total calls for service and 911 calls concerning events in and immediately surrounding the hotels utilized by JustCARE also declined in the aggregate (see Table 6 below). While these data do not establish a causal relationship between JustCARE interventions and reduced 911 calls, they are consistent with, and generally supportive of, the idea that JustCARE can help reduce reliance on expensive (and sometimes dangerous) emergency response services.

Table 6. Calls for Emergency Service Before and After JustCARE

Encampment areas	Jan-Feb 2020	Jan-Feb 2021	Percent Change
All Calls	478	296	-38%
911 Calls	341	209	-39%
JustCARE Hotels			
All Calls	416	345	-17%
911 Calls	242	213	-12%

Source: *Loren Atherley, Director of Performance Analytics and Research, Seattle Police Department.*

Note: *Data include civilian-initiated calls for service describing situations occurring within 500 feet of the two encampment locations (the intersection of 8th and S. Jackson in the CID and the 300 block of 2nd Ave Extension South) and within 500 feet of five JustCARE hotels: The Wallingford Inn, the Kimpton Palladian, the Holiday Inn on North Aurora, Staybridge Suites, and La Hacienda. Calls were higher during the latter period in some hotels, but lower in the aggregate.*

Mitigating the Harm Caused by Criminal Legal System Involvement

Past and present criminal legal system involvement often have profoundly destabilizing effects for people seeking to stabilize their lives. Research shows, for example, that the experience of incarceration reduces earnings and employment, increases housing instability and indebtedness, and impairs physical health and mental well-being.[67] Non-confinement based forms of criminal legal supervision – including, increasingly, electronic home monitoring – also cause significant harm by imposing a vast array of burdensome rules and restrictions, enhancing debt, and generally failing to assist people as they seek to stabilize their lives.[68] Low-level felony convictions (even absent evidence of incarceration or criminal legal supervision) reduce job applicants' prospects, especially for applicants of color. Even misdemeanor convictions and short jail stays have destabilizing effects and are associated with increased risk of subsequent criminal legal system involvement.[69] Legal debt stemming from unpaid fees and fines is also extraordinarily burdensome and a barrier to stabilization for many.[70]

In light of these realities – and in recognition of JustCARE participants' often extensive legal histories – JustCARE outreach responders provide information, support and options that can change the outcome in the courtroom and help participants address outstanding criminal legal system issues, especially outstanding charges and warrants. To do this, outreach responders coordinate and communicate regularly with defense attorneys, prosecutors, and probation officers. JustCARE outreach responders are able to serve this coordination and communication role in part because of the positive working relations LEAD helped to forge over the past decade.

In many instances, prosecutors in the Seattle City Attorney's Office and in other prosecutorial offices will dismiss outstanding charges when JustCARE participants are working productively with their outreach responders to turn their lives around. In one recent case, for example, the outreach responder sent an email to the relevant city attorney describing his client's progress:

> *Since moving in on 3/25/2021 [participant name] has been engaging with me at our scheduled meeting times and with other staff as things come up. He has been proactive around meeting his goals and as of today has reached 4 of the 7 he has set so far. If you have any further questions please feel free to contact me.*

To which the prosecutor in question responded:

> *Turns out your client actually has 2 open SMC cases from 2015. Given the age of the cases and that he is engaged in CoLEAD, the City filed Motions to Dismiss both cases with the court. He has no other open SMC cases or reports pending review in the SCAO filing queue.*

In another recent example, a municipal court judge struck probation and dismissed an outstanding case from 2015 after learning of the participant's work with JustCARE. In an even more recent case, city attorneys released a participant from a no-contact order preventing him from communicating

with his mother (and which his mother did not want) and dropped three outstanding cases.

While not all of the participants we interviewed described having engaged in this process, those who did found it to be enormously helpful. One participant put it succinctly: "I have a couple cases that I had warrants on prior to being in the program and my caseworker helped me get them out of warrant status and back into the courts." Similarly, another participant told us,

> *CoLEAD is the biggest and best support I could have right now. Because not only can they help me in my personal life, but they can advocate for me with the court systems. And their advocacy and their speaking up for me can help prevent what happened last time.*

Some of the people we interviewed also highlighted the importance of the support that outreach responders provided when cases were not dismissed. In such cases, outreach responders often helped participants arrange for transportation and even accompanied them on the court appearances. As one participant explained,

> *[My outreach responder] was there to remind me and keep my eye on the prize, keep focused and get it done, you know. Whereas in the past, the court date would come up and maybe I'd remember it and I'd be like, depending on how I felt that day, am I going to go again, or whatever. You know, it took that out of the equation. Even if I didn't feel so great I was going because I had someone standing with me that was steady, you know, ready to help me out. I wouldn't want to let him down. Accountability, that's the word, accountability.*

Lessons Learned

Outreach responders and JustCARE leadership offered many thoughts about things that have worked well as well as things they wish they had been better prepared for when undertaking this (highly improvisational) work. Here is a brief summary of the "lessons learned" by stakeholders and care providers to date:

- **High level criminal activity involving sexual exploitation, sexual assault and drug dealing is embedded in many encampment sites.** This makes it difficult for some vulnerable people to engage with service providers and/or leave encampments. Outreach responders need to anticipate this reality and have a plan for dealing with it.
- **The vast majority of people who have lived unsheltered for extended periods of time and who contend with substance use disorder and/or unsupported mental health disabilities are not housing or service resistant, and most can succeed in hotel-like environments with a low barrier approach, the right supports and harm reduction orientation.**
  - Preparing and training program and hotel staff will help in this effort, as will securing the services of safety experts trained in de-escalation.

- Lodging liaisons are key to the success of any supportive interim housing initiative that relies on hotels or motels.
- People with very severe and persistent mental health impairments such as psychotic spectrum disorder may be better served in a more structured residential group setting that can provide psychiatric rehabilitative services.

» **Hiring and supporting a diverse staff with a variety of backgrounds and kinds of knowledge, including lived experience, will enable providers to leverage various kinds of expertise and to build authentic and trusting relationships with participants.**

» **Lodging agreements provide an important reference point for working with participants and in helping participants build accountability skills and goals.**

» **Hotels provide comfort, privacy, and security, but do not always provide opportunities for meal preparation.** Anticipating people's needs for food and food preparation is key.

- Stand-alone cooking devices such as microwaves and crock pots, as well as the procuring of nutritious food via food banks and food coops to provide an array of appealing and nutritious options, have been helpful.

» **The presence of a harm reduction-oriented medical provider who provides on-site assessment and care, and coordinates care to meet complex health needs, is critical.**

» **Contingency management (the use of gift cards and reward-based incentives) can help support alignment with lodging agreements and help build independent indoor living skills.**

» **De-escalation without reliance on law enforcement is the preferred resolution for all non-emergency situations.**

- Given that interactions between police and people (especially people of color) with unsupported mental health disabilities are too often unhelpful, law enforcement engagement with this population should be very limited and, if necessary, carefully managed.

» **Working with prosecutors to address pending and outstanding charges and warrants is extremely helpful.** Prosecutors may be more likely to drop or reduce charges when people are housed and supported.

- Building trusting relationships with prosecutors via LEAD or other mechanisms will facilitate this work.

These lessons learned may be helpful for others interested in implementing something akin to JustCARE. The following section of the report compares JustCARE to adjacent interventions that became more widespread in the context of the pandemic.

Part II

JustCARE in Context

In this section of the report, we compare JustCARE with related initiatives that have proliferated in the context of the pandemic. First, we compare JustCARE to alternative response models based on the CAHOOTS model. Next, we compare JustCARE with other recent housing initiatives that use vacant hotel and motel rooms to shelter people in ways that reduce the transmission of the coronavirus. These analyses are intended to help readers appreciate the different ways jurisdictions across the country are attempting to reduce police interactions with vulnerable people and to address the housing crisis in the context of the pandemic.

Reducing Policeability: CAHOOTS vs. JustCARE

Calls to defund the police have echoed across the country since the murder of George Floyd by Minneapolis police officer Derek Chauvin. While the idea of completely abolishing the police remains controversial, many support the idea of shifting resources away from the police and authorizing others to address the many non-emergency situations to which police are summoned via 911 calls. At the same time, it is increasingly clear that people experiencing homelessness, mental health disabilities, and substance use disorders are the subject of many 911 calls, and a growing number of studies document the myriad harms caused by police to vulnerable populations. For example, a third to a half of all people killed by police are disabled;[71] one in four people killed by police suffer from a mental illness. [72]

While this research makes the potential negative impacts of policing plain, it leaves considerable ambiguity regarding concrete policy alternatives with the potential to reduce, or potentially even eliminate, these negative outcomes. In this context, the CAHOOTS model, pioneered in Eugene, Oregon, has received significant attention and is being explored or implemented in jurisdictions nationwide. As of the summer of 2020, CAHOOTS had 310 outstanding requests for information from communities across the country.[73] A seemingly endless list of cities, including Oakland, Portland, San Francisco, Denver, New York, and others have recently announced the development of a new initiative based on the CAHOOTS model. And the recent expansion of federal funding for such initiatives means that this model is likely to continue to spread.[74]

Like JustCARE, CAHOOTS was originally developed to reduce police interactions with vulnerable people.[75] CAHOOTS began in 1968 as a volunteer-run mobile crisis unit that operated alongside the police, but evolved in the 1980s to become a mobile crisis unit that is dispatched through the 911 call system in Eugene and Springfield, Oregon. Although CAHOOTS is housed in, and funded by, the

police department, it is commonly described as an alternative to police.[76]

In one sense, this description is accurate. Although typically dispatched through the 911 system, CAHOOTS sends unarmed civilian first responders to respond to situations that involve neither emergencies nor crimes. Moreover, many CAHOOTS-inspired initiatives describe their objective as reducing police involvement in non-emergency and non-criminal situations involving behavioral health issues. The Rapid Integrated Group Health Care Team (RIGHT CARE) in Dallas, for example, seeks to "shift the focus of mental health crisis response to paramedics and health systems in order to create a health-based response to mental health crises."[77] Similarly, San Francisco's Street Crisis Response Teams (SCRT) are intended to "provide rapid, trauma-informed response to calls for service to people experiencing crisis in public spaces in order to reduce law enforcement encounters."[78]

At the same time, CAHOOTS models are often housed in, and funded by, police departments. For example, CAHOOTS itself and Olympia's Crisis Response Units are housed within city police departments. Other initiatives (including San Francisco's Street Crisis Response Teams (SCRT) and RIGHT Care in Dallas) are jointly housed in city police and fire departments. While a few CAHOOTS type initiatives are administratively housed in non-profit organizations, this appears to be less common. To the extent that these initiatives are housed in, and funded by, police departments, it is unclear whether they can be said to shift resources away from the police. Moreover, in some instances (such as RIGHT Care in Dallas), police officers are included in the crisis response team.

JustCARE and alternative response models based on CAHOOTS are similarly aimed at reducing police interactions with, and the jailing of, people contending with substance use disorders and unsupported mental health disabilities (and other vulnerable people). Yet there are four key differences between JustCARE and CAHOOTS-based alternative response models.

The first key difference concerns the nature of the situations that may be handled by first responders other than the police. In CAHOOTS and many initiatives that are based upon it, strict rules govern the calls to which it can and cannot respond. For example, CAHOOTS "teams are not permitted to respond when there's 'any indication of violence or weapons,' or to handle calls involving 'a crime, a potentially hostile person, a potentially dangerous situation … or an emergency medical problem.'[79] Whenever situations involving any crime are off-limits, the capacity of these initiatives to facilitate either decriminalization or decarceration, and to address racial inequities in the criminal legal system, is reduced.

Second, initiatives based on CAHOOTS typically involve re-routing a relatively small proportion of 911 calls. JustCARE's approach to reducing police contact with people with unsupported mental health disabilities and substance use disorder is quite different. Specifically, JustCARE works with community members to address their concerns and identify areas of need. In the process, JustCARE staff are engaging in deep cultural and relational work in the neighborhoods in which they work, inviting community members to reevaluate their tendency to rely on 911 to address non-emergency situations and the underlying assumption that the police and criminal legal system offer the most appropriate and effective way of responding to these situations. In this sense, JustCARE is doing the

cultural work that reducing the "policeability" of behavioral health issues will require.

Third, unlike alternative crisis response models based on the CAHOOTS prototype, JustCARE provides interim housing and intensive case management to people whose behavior has historically attracted the attention of police and neighbors. That is, JustCARE is an alternative second – and sometimes first – responder. While all of these initiatives operate in the shadow of the national failure to invest sufficiently in permanent affordable housing, JustCARE provides interim supportive housing and assertive case management over a period of time. While comparatively expensive to operate, its intervention is far longer-lasting and potentially more transformative than the short-term interactions facilitated by CAHOOTS frameworks.

Finally, JustCARE's unique capacity to focus on heavily impacted neighborhoods means that it provides tangible improvements in targeted neighborhoods that are deeply felt and appreciated by people who live and work in those neighborhoods. By contrast, CAHOOTS initiatives are oriented at the individual and not the neighborhood level. These initiatives are simply not designed to have neighborhood-level impacts.

Although quite different, these two types of interventions are, in theory, highly compatible. For example, in Seattle, HEALTH One, an alternative emergency response initiative housed in the Seattle Fire Department,[80] could serve as a source of referrals for JustCARE. However, funding limitations have meant that JustCARE has not been able to enroll people beyond those moved from encampments in Pioneer Square and the CID into hotels. Expanding JustCARE would create a unique opportunity to connect a short-term crisis responder such as Health One to the longer term and more comprehensive response that JustCARE provides.

Reducing the Spread of COVID-19 by Housing People Experiencing Homelessness

As COVID-19 spread in the spring of 2020, communities across the country scrambled to find ways to reduce the risk of transmission among people experiencing homelessness. In fact, Urban Institute researchers estimate that 70 percent of all communities relied, to some extent, on hotels and motels to keep vulnerable people safe during the pandemic.[81] Unlike JustCARE, however, it appears that most of these initiatives focused on people experiencing sheltered homelessness rather than unsheltered homelessness.

The U.S. Department of Housing and Urban Development (HUD) classifies people who lack stable housing in two broad categories: sheltered and unsheltered. People experiencing sheltered homelessness live in an emergency shelter or transitional housing, which may also include domestic violence shelters and residential programs for homeless or runaway youth. People experiencing

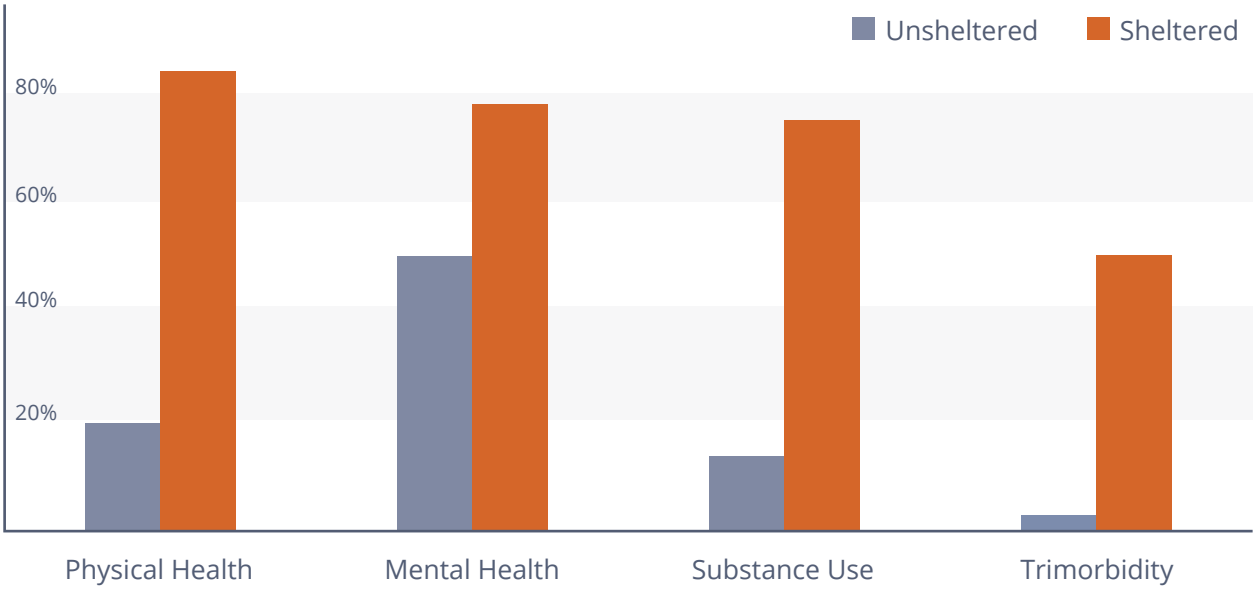
unsheltered homelessness live in places "not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street."[82]

Because crowded, indoor conditions were known to spread COVID-19, most initiatives focused on people living in densely populated, congregate shelters. The Urban Institute's review of these efforts revealed that "Communities most often used hotels to isolate symptomatic or test-positive people and to deconcentrate shelters, which initially showed high rates of spread." Unfortunately, given space and fiscal limitations, this meant that communities

> *were least likely to prioritize people who were unsheltered, even though people forced to live outside endure conditions that often result in poor health outcomes and are at risk of spreading communicable diseases. Based on our scan, none of the major-city CoCs [Communities of Care] with homeless populations of more than 4,000 people prioritized those experiencing unsheltered homelessness unless they met other criteria for hotel placement, such as contracting the coronavirus.*[83]

Research shows that people who live unsheltered experience significantly greater physical and mental health challenges than people who live in shelters and other congregate settings. The results of a recent national survey, for example, reveal that the prevalence of physical and mental health issues is far greater among people living unsheltered. Rates of substance use are also substantially higher among people who live outdoors, as Figure 1 shows.

Figure 1: Prevalence of Physical Health Conditions, Mental Health Conditions, and Substance Use Among People Living Sheltered and Unsheltered



Source: *Janey Rountree, Nathan Hess, and Austin Lyke, Health Conditions Among Unsheltered Adults in the U.S., California Policy Lab, October 2019 (Figure 4)*

The authors of this study summarize their findings as follows:

> *The analysis finds stark differences between people who are unsheltered and people who are sheltered. Unsheltered people — especially unsheltered women — report profoundly greater health challenges, higher rates of experiences of violence and trauma, and longer lengths of homelessness than people who are staying in shelters. The higher rates of health conditions and vulnerability for people experiencing unsheltered homelessness begin even before people lose their housing and are also seen early in their experiences of homelessness. These findings raise questions about whether emergency shelters are serving people with high health needs when they initially become homeless. Finally, unsheltered adults are engaged by police and emergency services much more regularly than sheltered individuals.*

Thus, while JUSTCARE similarly seeks to reduce the spread of COVID-19 among people without permanent housing, it differs from many other hotel-based programs by housing people who would otherwise be living unsheltered. As the research described above indicates, this population contends with even greater health challenges, including substance use disorders, and relies more heavily on emergency services. By focusing on this population, JustCARE provides interim supportive housing to the most vulnerable and targets the population that would otherwise rely most extensively on expensive emergency services and facilities.

JustCARE differs from other recent housing initiatives in two other ways as well. First, JustCARE provides intensive case management in the hotel setting with the goal of meeting participants' basic needs, and helping them to access benefits, secure long-term housing, and reduce their criminal legal system involvement. For JustCARE, hotel-based housing is not only shelter; it is also an opportunity for participants to stabilize, address long-standing financial, legal, and health-related challenges, and to prepare for long-term housing and independent living where appropriate. Although systematic data about case management services provided by other housing initiatives are unavailable, it appears that most of those housing initiatives provide far lower levels of support. Moreover, LEAD's long-established relationship with prosecutors and other legal officials enables JustCARE providers to address participants' criminal legal issues. This feature of JustCARE appears to be unique.

Second, JustCARE providers are trained extensively in the use of de-escalation and other problem-solving techniques. As was discussed previously, it also relies on the services of Wheeler Davis Conglomerate to help to ensure safety in and around JustCARE hotels without reliance on 911 or the police. In these ways, and due to the comparatively great presence of staff, JustCARE actively reduces reliance on 911 calls for emergency services. And as was shown previously, JustCARE's intervention is associated with comparatively low numbers of 911 calls in targeted areas. [84]

In short, JustCARE focuses on the most vulnerable people and provides a comparatively robust form of support for people who are living in hotels and motels. Although more expensive than programs that lack these features, JustCARE's approach likely saves taxpayer monies by reducing reliance on emergency services. Additional research is needed to systematically assess the potential cost savings associated with JustCARE.

Part III

Conclusion

Developed in the context of a global pandemic, JustCARE offers a new model for simultaneously reducing unsheltered homelessness, barriers to health care, and the harm caused by the criminal legal system – even as it improves public safety and neighborhood quality of life. The fact that JustCARE stakeholders take overt and intentional measures to pursue all of these goals sets it apart from many other interventions. JustCARE's multifaceted nature stems from its comprehensive recognition of the people it serves, who have contended with unsheltered homelessness, mental health disabilities, substance use disorders, and more, often for many years. Addressing just one of these aspects of people's lives will simply not lead to transformative change. A coordinated and multi-dimensional response is needed, and JustCARE offers an important model of how this can be done while simultaneously addressing the public safety concerns of other residents and reducing reliance on 911.

Key Findings

This report is intended to provide policymakers and others a deeper understanding of what JustCARE is, how it emerged during the pandemic, the theory of change on which it is based, the work it accomplishes, and some early indicators of its promise. Key findings include:

» **JustCARE's multi-faceted and integrated approach distinguishes it from other related initiatives.**

- JustCARE is simultaneously a Housing First/harm reduction intervention; a health-related initiative; a public safety intervention; and a decarcerative project. It is also a collective impact model that involves cross-sector collaboration, regular communication, and on-going program revision and improvement.
- JustCARE shows why an integrated response that addresses income instability, housing, behavioral health, and criminal legal system involvement is needed, and provides a compelling example of how it can be done.
- Throughout its operations, JustCARE's work is guided by the harm reduction philosophy and a commitment to racial equity. The care it provides is oriented toward the development of trusting relationships and is trauma informed.
- JustCARE's focus on both individual and neighborhood level quality of life and well-being distinguishes it from other interventions.

» **PDA serves an important role in coordinating across partnering agencies and other stakeholder groups, and illustrates the importance of a strong backbone organization in a**

collective impact initiative.

- The development of the JustCARE coalition was built out of a need for greater cross-sector and cross-agency coordination to address the interrelated issues of homelessness, healthcare, and criminal-legal system involvement. LEAD project managers and other PDA staff played a key role in facilitating conversations and building relationships across partnering organizations and community stakeholder groups (including public utilities, first responders, public transit, service providers, community members, legal system actors, etc.). Their efforts to ensure that everyone felt their concerns were met and needs were addressed have been vital to the success of the effort.
- Hiring and supporting a diverse staff with a variety of backgrounds and kinds of knowledge, including lived experience, will enable providers to leverage various kinds of expertise and to build authentic and trusting relationships with participants.

» **The success of this housing intervention shows that people who live unsheltered and contend with unsupported mental health disabilities and/or substance use disorders are not housing or service resistant, but rather that housing must meet basic needs for safety, privacy, and security and be accompanied by appropriate support.**

- Unlike many pandemic-induced housing-related initiatives, JustCARE provides housing to people who would otherwise be living unsheltered. The JustCARE team found that they could safely house and support the vast majority of people living in encampments, and only 13 percent of those who have been enrolled have been exited from the program.
- People who experience unsheltered homelessness are more likely to have significant mental and physical health issues, including substance use disorders, than people who experience sheltered homelessness.
- The JustCARE team found that they could safely house and support the vast majority of people living in encampments, and only 13 percent of those who were enrolled have been exited from the program because they could not be safely housed in the hotels.
- The use of lodging agreements, de-escalation, and creative, proactive and harm-reduction oriented problem-solving techniques by staff and dedicated safety teams have helped to ensure that the vast majority of people enrolled in JustCARE are able to remain safely housed.

» **Hotels provide safety, privacy, and security for participants.**

- Access to private and secure housing is deeply appreciated by participants, who report significant improvements in psychological and emotional well-being after moving into hotels.
- The use of de-escalation and safety teams help ensure that hotels remain safe for participants, program staff, and hotel staff.
- At the same time, uncertainty regarding the future of JustCARE funding and the paucity of permanent housing options create anxiety for participants and outreach responders alike.

» **Interim supportive housing enables participants to address outstanding legal issues,**

secure identification, access medical care, obtain benefits, reconnect with family, apply for permanent housing, and more.

- The vast majority of participants identified one or more of these as personal goals and work toward them with the support of outreach responders.
- By the end of February 2021, 21 JustCARE participants had secured permanent housing and moved out of the hotels. Many others will be able to do so soon.
- Securing access to benefits to which they are entitled makes future independent living viable for many JustCARE participants.
- JustCARE's communication and coordination with legal systems to enable resolution of legal matters appears to be unique, and is experienced as extremely helpful by many participants.

» **By employing licensed medical providers who provide on-site treatment and coordinate care, JustCARE is able to address participants' complex health needs and create plans for continued care.**

- People who live unsheltered contend with a variety of serious mental and physical health issues, often including substance use disorder. This is also true of JustCARE participants.
- Although not an option for all, increased access to medication-assisted treatment for substance use disorders have been helpful for many.

» **JustCARE improves public safety and quality of life for participants and communities.**

- Unauthorized encampments are often associated with unsafe living conditions that adversely impact residents and their neighbors.
- JustCARE improves individual and neighborhood safety by moving people from encampments to hotels. Both participants and community partners report high levels of satisfaction with this aspect of the intervention.
- JustCARE outreach teams also coordinate care and support for people whose behavior disturbs neighbors but who cannot be placed in hotels in order to reduce harm and improve quality of life for all concerned parties.
- By meeting participants' basic needs in hotels, JustCARE seeks to reduce participants' reliance on illicit survival strategies such as theft. Interviews with participants and with outreach responders indicate that participants have ceased or decreased their use of such illicit income-generating strategies.
- The employment of harm-reduction oriented, proactive, and creative problem-solving strategies and de-escalation have helped to reduce conflict and disruption in the hotels.
- Dedicated safety teams help to de-escalate conflicts and ensure safety in the hotels, especially at night.
- 911 call data show that calls for service in the targeted encampment areas and in the hotels utilized by JustCARE were lower in the aggregate in January-February of 2021 than during the same months of 2020.

» **JustCARE helps shift the cultural narrative around public safety and addresses harm associated with criminal legal responses to behavioral health needs.**

- Unlike models based on the CAHOOTS framework, JustCARE works directly with community members to address public safety concerns rather than having dispatchers reroute a small proportion of 911 calls.
  - JustCARE serves as an important alternative to 911 in the neighborhoods in which it works.
  - JustCARE also helps to facilitate a cultural shift away from conceiving of behavioral health and homelessness as issues to which police are an appropriate response.
  - Community partners report high levels of satisfaction with JustCARE's response and preferring it to law enforcement, sweeps, or dispersal orders.
- JustCARE outreach responders coordinate and communicate with prosecutors and other legal officials in ways that reduce the burden created by past and present criminal legal system involvement.

» **JustCARE is an important tool for reducing police interactions with vulnerable people and for reducing the policeability of behavioral health.**

- Many police interactions involve individuals contending with mental health disabilities and/or substance use disorders. [85]
- Recent calls to defund the police rest, in part, in recognition of the harm that too-often accompanies interactions between the police and people of color, as well as people with behavioral health issues.
- Decreasing police involvement in the management of behavioral health issues may be the single most effective method for reducing the overall number of daily police interactions, particularly those involving vulnerable populations[86]

Policy Recommendations

JustCARE providers encounter a number of important system failures and gaps that hinder their work. Moreover, it is abundantly clear that relying on sweeps, police, and jails to address homelessness and behavioral health is a failed strategy. Below, we offer policy recommendations that are intended to address these gaps and improve the efficacy of JustCARE and other efforts to address homelessness, behavioral health, and substance use disorders without reliance on the criminal legal system. Our recommendations are as follows:

» **Fully fund JustCARE to enable the expansion of its many benefits.**

- The data provided in this report show that JustCARE is a uniquely promising intervention that can meet the needs of both Seattle's most vulnerable residents as well as those of people who live and work near unauthorized encampments.
- Investing in the kind of supportive interim housing JustCARE provides will enable providers to

identify people who do not require permanent supportive housing. Doing so will help ensure that permanent supportive housing opportunities are preserved for those who truly need them.

- Seattle's Health One response unit provides an important service to meet the immediate situations of individuals in crisis – but it will only have transformative effects if there are community services available to meet the intermediate and long-term needs of people experiencing extreme poverty, unsupported mental health disabilities, and/or substance use disorder.
- Initiatives such as JustCARE may well save the city and county money. Each of King County's "familiar faces" – people who contend with homelessness, unsupported mental health disabilities, substance use disorders, and on-going criminal legal system involvement – cost the county an estimated $28,000 per year in 2016. In 2021 dollars, this represents a cost of over $31,000 per year. This estimate does not include city or state costs of any kind, or reflect the benefits associated with reduced crime and improved quality of life.[87]

» Significantly expand housing options for people with extremely low incomes.

- Inadequate affordable housing and permanent supportive housing sharply limit the long-term impact of interim supportive housing.
- Experts estimate that between 15,000-40,000 new units of affordable permanent housing are needed in the Seattle/King County area to solve the crisis of homelessness. [88]
- Some portion of these should be dedicated to serving people with unsupported mental health disabilities and/or substance use disorder who require supportive housing.

» Invest in street-based outreach in the community aimed at ensuring that people are in HMIS and ECLS and are able to access and maintain their benefits and retain eligibility for housing.

- Many people living unsheltered are not in the HMIS (Homeless Management Information System), which functions, in part, as the entry point for certain housing programs.[89] This appears to be because many homeless services do not center or orient around people who live unsheltered and contend with unsupported mental health disabilities and/or substance use disorder.
- Many people who have experienced homelessness for extended periods of time do not appear in the Extended Client Lookup System (ECLS), the county-managed system behavioral health database in which care providers upload information about mental health and substance use diagnoses and treatment. The aforementioned barriers to accessing behavioral health care means that this database is incomplete and of limited utility to providers.

» Invest in mobile healthcare units and community clinics that provide street-based outreach to decrease reliance on emergency rooms for routine medical care, and provide healthcare workers with harm reduction-oriented training regarding substance use disorders.

- Hospital care and urgent care continue to be challenging to coordinate for people who use

substances and continue to experience a great deal of stigma in the medical system. This stigma makes care coordination challenging and leads to premature release from medical facilities.

- Although less stigmatizing, the publicly funded behavioral health treatment system continues to present barriers for the JustCARE population because most services are delivered in clinics rather than in the field or on-site. In addition, telecare appointments that occur via telephone and computer create significant barriers to access for some.

» Improve access to mental health and medically assisted treatment (MAT).

- Mental health residential treatment options for people with high acuity mental health issues are highly constrained. Those that do exist are often inaccessible to people who use drugs and/or have criminal histories.
- The process for securing civil commitments under the Involuntary Treatment Act for people who are a danger to themselves or others is extraordinarily burdensome and inefficient. This system is also characterized by a lack of adequate discharge planning and follow-up care resources in the community, especially interim housing facilities that would be voluntarily accepted by individuals discharged from full confinement.[90]
- The absence of a harm reduction-oriented, medication assisted treatment protocol for people who use stimulants makes serving people who use stimulants very difficult.

» Where housing remains a barrier and people continue to live outside, invest in making encampments livable spaces that include health and sanitation services.

- Participants, outreach workers, and other community members interviewed for this study all noted the safety and health concerns related to unauthorized encampments.
- While interim and long-term housing are preferable to encampments, some of these concerns could be mitigated in the interim through provision of health and sanitation services to encampments.

» Advocate for federal reforms that facilitate the acquisition of benefits and/or provide universal basic income.

- Benefits are extremely difficult to access and maintain for people who experience homelessness. Securing and maintaining means-tested benefits such as Food Stamps and entitlements such as Disability is an extraordinarily complex and burdensome process. These benefits are therefore inaccessible to many people absent interventions such as JustCARE.

Recommendations for Future Evaluation of JustCARE

Our evaluation provides initial insights regarding the evolution and impact of JustCARE in its first year of operations. A more robust and ongoing assessment of JustCARE's impact at the participant, neighborhood, and system-levels will require improved data collection and integration. We recommend that the following data be collected in a manner that renders them easily retrievable by analysts. Data needs include:

» **Data regarding illicit activities and criminal legal system involvement among enrolled participants, including**

- Self-reported illicit activities
- Public order citations
- Jail bookings and jail stays
- Criminal convictions and sentences imposed
- Cases dismissed

» **Data regarding any use of emergency services, including emergency hospital visits, by enrolled JustCARE participants.**

» **Data regarding health needs addressed, changes in health status, and changes in self-reported quality of life among JustCARE participants.**

» **Consistent documentation of service referrals and benefits secured by JustCARE participants, including**

- Public benefits (SNAP, TANF, SSI/SSDI)
- Legal navigation
- Employment assistance
- Housing
- Transportation
- Treatment

» **Systematic recording of reasons why people are exited from JustCARE and steps taken to ensure their well-being.**

» **Surveys gauging satisfaction and perceptions of public safety among community partners and JustCARE participants.**

If future interventions in encampments occur, we recommend that the following data be collected in order to facilitate robust assessment of the impact of these interventions for neighborhoods:

- Recording and documentation of all services provided, including dumpster provision and other trash mitigation services; coordination with other agencies; services provided in the encampments.
- Before-and-after surveys with people who live and work in the adjacent areas regarding perceptions of safety and quality of life in the neighborhood.

In order to facilitate a cost-benefit analysis of JustCARE, we recommend collection of the following data:

- Survey of local business owners to learn more about whether/how JustCARE's intervention affects hiring and business operations.
- Information regarding prior use of emergency services and jail stays among JustCARE participants that can be compared with use of services and jail stays while enrolled in JustCARE.

Finally, we also recommend that JustCARE providers utilize a single data entry system and adopt consistent metrics across care providers to facilitate data collection and analysis.

Appendix A

The Development Of A Collective Impact Model

JustCARE's Emergence and Organizational Partners

LEAD

In many ways, the emergence of JustCARE in Seattle/King County was made possible by the prior existence of LEAD. Until recently, LEAD stood for Law Enforcement Assisted Diversion. Administratively housed in PDA, LEAD seeks to reduce the neighborhood and individual-level harm associated with drug and sex markets – as well as the criminal legal costs and human suffering associated with conventional enforcement practices – by channeling people who are at high risk of arrest into intensive, a community-based, case management approach that is guided by harm reduction principles.

The Public Defender Association

The Public Defender Association (PDA) is a non-profit organization that advocates for criminal legal system reform and develops alternatives that shift from a punishment paradigm to a system that supports individual and community health, according to its website. In addition to serving as the backbone organization for JustCARE, PDA also houses a number of organizations dedicated to advancing criminal justice reform in King County and Washington State. These include LEAD, CoLEAD, VOCAL and Civil Survival. The latter two of these organize people directly impacted by the criminal legal system, homelessness, and/or substance use to advocate for reform.[91] Several outreach responders shared that they learned about jobs with CoLEAD through their work with VOCAL and Civil Survival (as well as Community Passageways) and harness their lived experiences to relate with participants and advance JustCARE's mission.

LEAD was originally designed as a pre-booking diversion framework. In this context, referral to LEAD occurred when LEAD-trained Seattle Police Department officers and sergeants diverted people suspected of various low-level offenses upon arrest. Early on, however, stakeholders also elected to enable police officers and others to make "social contact" referrals in the absence of probable cause or in lieu of arrest. Until recently, both arrest and social contact referrals were subject to review by

LEAD-trained law enforcement officers who were tasked with confirming that the referred person was thought to engage in law violations and that the behavior of concern stems from unsupported mental health disabilities, substance use disorder, trauma, and/or extreme poverty.

Once referred to LEAD, participants receive intensive case management services guided by harm reduction principles on a voluntary basis. Participation is not time-delimited, meaning that participants can remain involved in LEAD for as long as it is useful. Case managers use motivational interviewing (MI) and a variety of other techniques to build relationships and trust, to help participants identify their own priorities and goals, and to work collaboratively to address those goals. Researchers have found LEAD to be highly effective in terms of reducing criminal legal system involvement and costs, improving participant well-being, and more.[92]

LEAD has evolved considerably over the past year. In 2020, the SPD's failure to approve many people who had been referred to LEAD, or to proactively refer participants, created a bottleneck that blocked access to enrollment and services. At the same time, it became clear that arrest referral was unlikely to occur in the context of the pandemic. The intensification of protests against police violence and systemic racism in the summer of 2020 also had a pronounced impact on LEAD.

In this context, LEAD project managers explored with city and county councils a way to expand referral options such that police no longer serve as gatekeepers.[93] Today, potential participants may be referred to LEAD by neighbors, treatment and social service providers, the Department of Corrections, the Mobile Crisis Team, the Crisis Diversion Center, public defenders, family members, other concerned parties, and others through a new community-referral process, or through self-referral. These referrals may be verified by either law enforcement or the LEAD Project Management Team as people at risk of exposure to the criminal legal system. To reflect this change, the LEAD acronym now stands for Let Everyone Advance with Dignity.

The pandemic also had a pronounced effect on LEAD operations. While the paucity of housing options and other needed services have long posed challenges for LEAD case managers and participants, [94]this problem became more acute in the context of the pandemic. As Chloe Gale, REACH Co-Director, explained:

> *As the pandemic rolled in, we saw shutdowns that affected the service response for people living unsheltered very dramatically. Most agencies in the homeless service community were trying to figure out how to support people, to isolate inside, and stay safe. Because of workforce limitations, many of them had to stop a lot of their congregate care spaces or move them into safer spaces like motels. A lot of the drop-in service access closed down. Food programs, day centers, hygiene facilities were closing. Also, just general public businesses closed, so there was a lack of toilets, facilities, and restaurants that people could go use a restroom or wash their hands. Very dramatic lack of amenities for people who are living outside. The other thing that stopped was the pipeline to shelter. People that had shelter spaces, that were safe and secure for them, were staying there. We saw a lot less turnover, the ability to move inside almost*

> *completely dried up. People who were living outside were really stuck there, without access to care.*[95]

Tara Moss, Seattle-King County LEAD Project Director, also emphasized the challenges the spread of COVID-19 posed for LEAD operations:

> *Shelters were closed, telehealth replaced in person care and support systems. Drop-in centers were closed. The ability to get cash was harder. Low level jobs were harder to procure. Legal and illegal drug markets were all impacted due to the pandemic… a lot of our engagement was impacted and just abruptly halted.*[96]

JustCARE participants we spoke with confirmed that their already extraordinarily challenging circumstances became even more difficult as a result of the pandemic. As one explained,

> *[COVID] made it hard for me to access community resources such as food stamps, anything to do with DSHS. Even like, I got a court case going on right now. It's made it longer than I think it should have been or needed to be. From them getting continuances and extending the amount of time that people need to wait to have their legal situations dealt with or taken care of. [Interviewer: Has it impacted how you secure food?] Yeah, definitely. Not all the places that were open are open anymore, like food banks. I didn't have my food stamp card for two months or more.*

In the context of the pandemic, then, LEAD struggled to connect participants to housing, health care, and other needed services even as conditions deteriorated for people who were living unsheltered. Still, LEAD case managers without personal or familial medical vulnerability continued to engage in street-based outreach, checking in on and supporting LEAD participants in encampments and other locales wherever and however possible.

Also in 2020, regional jails implemented booking guidelines that excluded people arrested on many misdemeanor and non-violent felony charges, and courts effectively closed for an extended period of time. The King County Executive, recognizing that correctional facilities are at particular risk for the spread of COVID-19, declared an intent to reduce the jail population during the emergency period. Yet many people who were candidates for jail release lacked housing. In this context, and with input from local stakeholders, PDA developed a new version of LEAD – CoLEAD – that was adapted to meet the needs of the people it serves under these radically altered conditions.

CoLEAD

CoLEAD (for Community and Co-Responder) was developed in the spring of 2020 and is housed in the Public Defender Association. Like LEAD, CoLEAD is a harm reduction intervention aimed at improving public safety and the well-being of people contending with extreme poverty, substance use disorders, unsupported mental health disabilities, and criminal legal system exposure.

Yet CoLEAD differs from LEAD in several important ways. First, CoLEAD draws on newly available

funds to use hotels and motels to provide supportive interim housing for participants. Second, some CoLEAD clients came directly from jail, which authorities sought to de-populate in order to reduce the spread of Covid-19.[97] Third, CoLEAD uses continual staffing and the assertive case management model to ensure that support staff are nearly always available to CoLEAD participants. Finally, CoLEAD staff include a dedicated medical provider. Over time, some especially vulnerable LEAD participants were co-enrolled in CoLEAD.

Shortly after the lockdown went into effect in March of 2020, PDA began to search for hotels with which it might contract to provide housing to people who would otherwise live outdoors. As Jesse Benet, CoLEAD Program Director, recalled,

> *There had already started to be a little scuttlebutt nationally around the use of hotels. And that started us reaching out to contacts we had through the LEAD work, the neighborhood engagement work, there are hotel organizers or people that are part of the hoteling culture and world. And we got in touch with some of those folks and they started connecting us with hotels that were struggling that might be open to this. And we just kind of wheeled and dealed.*[98]

of 2020 (and added a fourth hotel later). Throughout these conversations with potential hotel partners, PDA was clear about the fact that the rooms would be used to house (formerly) unhoused people with unsupported mental health disabilities and/or substance use disorders. In order to address the concerns of hotel managers and staff, PDA/CoLEAD committed to developing an on-site staffing model and developed a lodging agreement that participants sign when they move into the hotel (see Appendix B).[99] Unless very serious or continuous, violations of this housing agreement do not lead to program removal. Rather, they serve as guidelines that create opportunities for CoLEAD staff to address participant behaviors that are disruptive or harmful, and to engage in additional harm reduction work with both participants and hotel staff.[100]

Early on, PDA and CoLEAD leadership decided on a unique approach to hiring case managers (now called outreach responders). Rather than focusing exclusively or primarily on hiring people with particular educational credentials, PDA/CoLEAD placed equal value on lived experience and intentionally tapped into networks that include many people of color and people with relevant experiential knowledge. Two LEAD Project Managers with lived experience conducted the interviews. Here, CoLEAD Operations Manager Tabatha Davis explains the result:

> *So, the number of [formerly incarcerated people] and ex-users that put on their CoLEAD shirt every day and come to work is like, you talk about a diverse work group. It is beautiful. It is beautiful. And the folks that they encounter every day, they're not dumb. They've been out here surviving. They can spot phony and fake anywhere. And with that, they respond to our team because it's all about the relationship. So their ability to form a relationship with the participants so quickly I think is also paramount to the success. But you're only able to do that because real recognizes real.*[101]

CoLEAD then set about providing training to the diverse team of outreach responders it hired. First and foremost, CoLEAD provided extensive training in COVID-19 related safety protocols. They also created and offered training regarding harm reduction, drugs and drug user health, motivational interviewing, mental health first aid, CPR, and other relevant topics. Many of these trainings are updated and offered repeatedly. At the time of our interviews, additional training on street-based outreach, working with prosecutors and other criminal legal officials (regarding outstanding cases), and trauma-responsivity was being planned.[102] The outreach responders we interviewed generally reported feeling well-prepared for their work as a result of these trainings. As one put it, "we have trainings all the time here. They offer all kinds of trainings."

Early on, CoLEAD decided to contract with a dedicated naturopathic doctor (Dr. Cyn Kotarski) who would serve as a licensed medical provider in the hotels. The rationale for this decision is twofold. First, by hiring a dedicated medical provider who works on-site, CoLEAD sought to ensure compliance with infectious disease protocols, enable regular testing, and reduce barriers to medical care. Second, by hiring a naturopathic doctor, CoLEAD sought to expand the range of potential treatment options for participants to consider.[103] Stakeholders believed this was important because many marginalized people have had negative experiences with conventional medical providers and are relatively open to naturopathic alternatives.[104]

Very recently, CoLEAD acquired space in the Civic Hotel where they will implement a number of new features made possible by vaccination. At the Civic Hotel, CoLEAD will be the sole operator and have full site control. In this context, staff will be present in the hotels around the clock. Many outreach responders have participated in PDA's Civil Survival project, and staff from VOCAL-WA will offer support for participants aimed at fostering civic engagement and community building. Leaders also hope to work with community partners to address trauma and interpersonal violence, and to build a community accountability model that promotes healing and transformation.

Although CoLEAD was originally conceived as a temporary response to the pandemic, it underscored the importance of housing to any successful effort to reduce the harm associated with substance use disorder and mental health disabilities among people living unsheltered. It has also demonstrated the viability of a revised version of the model that does not depend on police as gatekeepers as well as the benefits of a 24-7 staffing model and employing licensed medical providers to ensure greater access to health care and medication-assisted treatment.

A few months into CoLEAD's operations, PDA leadership recognized that it would be difficult to document its impact because its operations spanned King County. In order to show impact at scale, a more geographically focused approach was required.[105] At the same time, the number of people living outside in the downtown area appeared to be growing, sweeps of homeless encampments continued (despite the purported suspension of such sweeps),[106] and neighbors in impacted areas continued to express a high level of concern about encampments and related issues. Fortuitously, newly available CARES Act monies had become available to reduce the economic and health impact of COVID-19. The availability of these monies made the possibility of conducting an intensive operation in a particular locale viable.

In this context, the idea of JustCARE was born. Previously, CoLEAD had considered focusing on 2nd Avenue Extension South in Pioneer Square as part of a demonstration project. Home to a number of social service agencies (including Chief Seattle Club, the Union Gospel Mission, and PDA itself), a growing number of people living outdoors set up tents and other structures along this several block-long stretch and in nearby Courthouse Park during the pandemic. Concern was also growing about expanding encampments in the Chinatown International District (CID). In this context, nine CID based organizations, concerned about the health safety, and recovery of their vulnerable and culturally distinct neighborhood, sent a letter to Mayor Durkan asking that she "bring all possible resources to bear to serve the needs of the people living unhoused on South King and South Weller [Streets], preferably sheltering these individuals in permanent or transitional housing, which includes motel/hotel/quarantine sites."[107]

With hopes of expanding operations in the CID and Pioneer Square areas, CoLEAD contacted a number of potential partners with extensive experience in street-based outreach, harm reduction, and homeless services, especially in communities of color. These organizations included Asian Counseling and Referral Services and Chief Seattle Club. They also included REACH, with which PDA was already collaborating to operate LEAD. Below, we briefly describe each of these partners and its role in the collaboration now known as JustCARE.

Asian Counseling and Referral Services

Founded in 1973, "ACRS promotes social justice and the well-being and empowerment of Asian Americans and Pacific Islanders and other underserved communities – including immigrants, refugees, and American-born – by developing, providing and advocating for innovative, effective and efficient community-based multilingual and multicultural services."[108] ACRS has a large and growing staff of about 240 people. Like LEAD and CoLEAD, ACRS emphasizes the social determinants of health and is guided by the harm reduction philosophy. ACRS seeks to provide culturally competent care, in which mainly BIPOC staff "support people to focus on and balance their mind, body, and spirit."[109]

ACRS works in a variety of different areas, including child and youth development, aging services, recovery services, citizenship and immigration, and more. ACRS also has particular experience and expertise with the provision of behavioral health services, including for people with criminal legal system involvement and high acuity mental health issues.[110] This latter expertise was of great utility to the JustCARE coalition, as CoLEAD had previously been unable to provide housing and support to people with comparatively serious mental illness.

When approached by CoLEAD/PDA about the possibility of collaborating, ACRS responded affirmatively, seeing the focus on CID and Pioneer Square as an opportunity to serve communities of color. As Victor Loo, Director of Practice Innovation for ACRS, explained,

> *Even though ACRS has done the work with the population served by JustCARE, we had*

never had a 24/7 behavioral health care program. So, it took me a while to figure out whether this is something that we are ready to do and we can do during the pandemic, but it's that trusting relationship that we have. And then I was also able to visit the encampments. And I just was very driven and motivated that this is something that I think we need to do to address the issues, especially during the pandemic. A majority of the clients that we serve right now, they are from the BIPOC community. And to me personally, that is so critical.[111]

In addition to employing staff who are fluent in many languages and have the capacity to house and support people with higher acuity mental health issues, ACRS is connected to a range of health care providers that facilitate their work with hotel-based participants. As Victor Loo explained,

We can provide primary care, dental care, vision care, medication assisted treatment. We have our own pharmacy at our main office. If somebody needs a prescription, we can actually do that as well. And then the unique thing again, we're a licensed behavioral health provider. We don't have to refer the clients out to an external provider. If they need mental health or substance use disorder service, then we can provide it.

Like CoLEAD, ACRS has been able to ensure that one or more licensed health providers are available to people staying in the hotel at all times. ACRS also ensures that a licensed clinical supervisor is on site around the clock.

Chief Seattle Club

Chief Seattle Club is a Native-led human service agency and day center, the mission of which is to provide a sacred space to nurture, affirm and renew the spirit of urban Native people.[112] *In its day center, Chief Seattle Club typically offers food, primary health care, housing assistance, a legal clinic, and a Native arts training program. Chief Seattle Club has long directed its services toward Native people who are experiencing homelessness and sees Native cultures, languages, and traditions as the primary tools for achieving healing and transformation.*[113] *Chief Seattle Club was compelled to close its day center and hygiene facilities during the pandemic. However, it ramped up its meal distribution efforts in the spring and summer, producing more than 10,000 meals per month.*[114]

Over the summer, PDA/CoLEAD leadership approached Chief Seattle Club about joining the JustCARE coalition, recognizing that Chief Seattle Club's long history of outreach with Native people experiencing homelessness would enable JustCARE to better serve this population. Chief Seattle Club leaders were concerned about worsening neighborhood conditions and, having experienced occasional instances of violence toward staff, felt the situation was quite dire. Chief Seattle Club was enthusiastic about the initiative and eager to contribute. As Virgil Wade, Operations Director for Chief Seattle Club, explains,

> *JustCARE is not just putting a roof over somebody's head. It's about reaching out to people, finding out what their needs are. And all kinds of people, those that have mental health challenges, those that have physical disabilities, those are the most vulnerable. I mean, those are the chronic homeless. And so I think that that's what JustCARE has done, is reached out to those that really need it, need someone there that can support them. Not just put a roof over their head and say, "Okay, well, enjoy it for the next 30 days", but truly make a connection with them and see what kind of support services that you can provide, hopefully leading to some kind of permanent housing, but understanding the individuals and listening to what their challenges are. So that's what I understand it to be and that's the way we have approached it with JustCARE.*[115]

Chief Seattle Club leadership also agreed that it was important that they were involved in the provision of care in order to build trust with Native participants:

> *Native people are sometimes very, I guess you would say, they don't trust a lot of people, and rightfully so. Because they don't understand what your objective may be. And so it's really when you have a Native person, like Chief Seattle Club provides, that can do that outreach, it makes it a little easier, makes it more, I guess you'd say, more warming for that individual to know that it's a person that they may be able to build a relationship with.*[116]

Chief Seattle Club ensures that the care it provides is culturally appropriate for the Native participants they serve. For example, after one participant died as a result of an overdose shortly after moving into the hotel, Chief Seattle Club engaged in a thoughtful process aimed at honoring the deceased while also addressing the trauma that other participants and staff experienced as a result of the death:

> *So, there's certain protocols that are done sometimes depending on that individual and their tribal affiliation, if they're Native, in terms of what happens from that point on. And so contacting family members, and it goes even further than that, but making sure that everything is properly done, even their clothing, all of that stuff. So that was a process. It didn't just happen like, okay, well, the next day they're out of the room and we move on to the next one. Now that took a few days to sort out, make sure that we did everything we could, and customarily, respectfully for their traditional beliefs and ways of life. So, again, the cultural appropriateness when you're dealing with something like that.*

In short, Chief Seattle Club brings a wide range of skills, experience, and understanding that enables it to ensure that Native JustCARE participants receive culturally appropriate care and support. Chief Seattle Club is able to make arrangements for behavioral health care for its participants through Seattle Indian Health Board and Cowlitz Behavioral Health.

REACH

Housed in Evergreen Treatment Services, which provides medication assisted treatment for people contending with opiate use disorder, REACH provides street-based case management and outreach services to adults living outdoors in King County, particularly in the Pioneer Square and CID areas.[117] In the course of this work, REACH focuses on building relationships with people experiencing homelessness and seeks to connect them with whatever services they may need.[118] Since 2011, PDA has contracted with REACH to provide street-based outreach services as part of LEAD.

Given its experience and expertise in street-based outreach, REACH was well-positioned to conduct the street-based outreach and screenings that made it possible for JustCARE to move people from encampments into hotels.[119] While this process appears straightforward, it is an extremely complex undertaking even absent a pandemic, one that can only be safely and effectively done by people with significant experience in street-based outreach. Among other things, this work involves building trust and rapport over a period of time while addressing people's immediate needs for supplies, food, and clothing.

This work is also time-consuming and labor intensive. At the site at 8th and Jackson, for example, at least six outreach workers conducted outreach at the encampment, which contained over 50 tents and extended inside of the parking lot. Outreach workers provided food, water, socks, and garbage bags, and installed and secured very large sharps containers to be used for disposal of syringes. PDA purchased and arranged for the installation of a waste management container and for a mobile team from the Health Department to provide vaccinations. In the end, REACH/JustCARE coordinated with 27 different agencies to bring needed services and supplies to the encampment.

This outreach, assessment, and preparation process took approximately six weeks. During this time, REACH was also working to accomplish two other goals. First, REACH sought to understand the needs of potentially interested JustCARE participants and lay the foundation for their eventual move into hotels. Toward this end, REACH conducted screenings to determine participants' most pressing needs, identify behavioral health history and issues, and assess existing connections to service providers (and the lack thereof). Ultimately, REACH/JustCARE also worked with potential participants to dispose, pack, and move their belongings and dismantle structures left behind. Finally, REACH and PDA staff facilitated the transport of participants and their belongings to the hotels, laid the groundwork for any physical or mental health care participants might need upon their arrival at the hotel, and prepared hotel-based staff by providing background regarding substance use, mental health issues, and other relevant dynamics.

In the process of conducting this work, REACH collected information about the people they screened in encampments, mainly in the CID and Pioneer Square areas. Some key findings from this data collection process include:

- 209 people agreed to be interviewed as part of the screening process.
- Nearly three fourths (73 percent) of those interviewed were people of color.
- Nearly two-thirds (63 percent) of those interviewed identified as men; 36 percent identified as women. None identified as trans or non-binary.
- Interviewees ranged in age from 20-74, with the majority in their 30s and 40s. Just over one in five (21.4%) were over 50 years old.
- Eighty percent indicated that they needed support to address substance use. A large majority of those interviewed reported needing housing, mental health care, and/or legal services. Many also sought assistance with accessing benefits, medical care, and securing identification.
- Most of those interviewed reported using drugs and/or alcohol; only 16 percent did not. Methamphetamine and heroin were the most commonly used substances. Nearly half used more than one substance.
- 90 percent of those interviewed had been living unsheltered for at least one year, and one-third had been homeless for at least five years.

Generally speaking, the results of this screening process are consistent with other research, which indicates that people who live unsheltered are more likely to be male and of color than people who experience sheltered homelessness.[120] In addition, comparatively large proportions of people living unsheltered contend with mental health disabilities and substance use disorders.[121]

Despite the severity of the need among the people screened by REACH, this work was highly successful. Data provided by REACH indicate that 69 percent of the people interviewed/screened by REACH moved into JustCARE hotels after completing the screening process; another 13 percent moved in within weeks, for a total interim housing placement of 82 percent. Nearly all (96.5 percent) of those offered housing placements accepted. Of those screened in the relevant neighborhoods, fewer than 5 percent were not offered hotel rooms because their physical or mental health needs could not be met or because it was not clear that housing them in a hotel would be safe for other participants and/or hotel staff.[122] Nearly three-fourths (73.5 percent) of those who were interviewed and obtained housing in a JustCARE hotel were people of color. As Table A1 shows, just five of those who were deemed offered a hotel room declined housing.[123]

Table A1. Initial Post-Screening Housing Related Outcomes

OFFERED JUSTCARE HOUSING	
ACRS Hotel	64
CoLEAD Hotel	53
Chief Seattle Club Hotel	19
Waitlist (and Housed Later)	28
Refused Housing	5
Bus Ticket Home	1
NOT OFFERED JUSTCARE HOUSING	
Already housed	6
Indication of predatory behavior	7
Already enrolled in LEAD	2
Under 18 years old	1
OTHER	
MIA - Could not be located post-screening	7
Deceased	1

Source: *Whitney Walker, REACH*

Notes: *Data refer to people living in encampments mainly in the Pioneer Square and CID areas who underwent initial screening by REACH in the fall of 2020.*

Ultimately, those placed on the waitlist were also able to move into hotels and motels as rooms became available. As Chloe Gale, REACH Co-Director, remarked, "it went remarkably well. I think it's fairly shocking that we moved 80 to 90 percent of the people with high needs in this space inside."[124] These outcomes cast doubt on the idea that many people living unsheltered are housing-resistant. The fact that so many people with mental health issues and apparent substance use disorders were willing and able to be moved into hotels suggests that the vast majority of people who have lived unsheltered for extended periods of time are not service or housing-resistant, but rather have had negative experiences in congregate shelters and/or have complex needs that many housing providers are not prepared to meet.

While screening people living in encampments, REACH and JustCARE staff also took time to hear and address the concerns of people who live and/or work in the targeted areas about the impact of the unauthorized encampments in their communities. One of the main concerns REACH heard about was trash. As Chloe Gale, REACH Co-Director, recounted: "It was clear, the very first site that we did, that one of the biggest issues was in a private parking lot, and that there was a ton of trash. One of the biggest issues was that the trash was not getting dealt with." To address this concern, REACH and PDA worked with public health, public utilities, and others to address the health and sanitary needs

of the community. This involved negotiating the relocation of some newly erected structures and securing dumpsters and sharps containers, as well as arranging for appropriate disposal of debris and hazardous materials.

People living and working in the CID also expressed concern about the fact that the metro bus stop adjacent to the parking lot at 8th and Jackson was no longer accessible. This was not only an issue at this particular site, but rather was a growing problem across the downtown area. As Cathy Jimenez, Fare Violation Program Manager with King County Metro, explained:

> *And so, when that [the Navigation team] went away, we started to see a really big decrease in riders on the buses, but a bigger increase in encampments around our transit areas, around light rail stops, around bus stops, around right of ways in transit facilities…. And it was about that time that JustCARE had gotten the green light, and gotten their funding from CARES Act funding, to start doing outreach in the Pioneer Square, in the CID area. And it was perfect because that's where we were experiencing a lot of these encampment impacts, that was where the concentration of them were happening, for transit. So, the executive office put me in touch with Lisa [Daugaard, Director of PDA], and by end of September, beginning of October, we were sharing Metro sites with them. And they were giving us a communication loop about where they were doing outreach… and I could see the immediate impact of what they were doing. Our supervisors, that were out in the fields could see, "Hey, this encampment is totally gone." Or, "This encampment is reduced in size considerably." So, it was visible, tangible outcomes very quickly.*[125]

More generally, community partners expressed appreciation that their concerns were being addressed by some entity. Here is how Chris Woodward, Business Development Director for the Alliance for Pioneer Square, characterized the business communities' response to JustCARE's intervention:

> *Thankfulness and relief, because I think people get discouraged with the city. There's the defund conversation, the dissolving of what was then known as the Navigation Team, I think that left people feeling like there weren't any tools or that the city didn't care about them. So, for them to reach out to the Alliance, for the Alliance to reach out to the JustCARE program, and for them to see something happen, had to feel good. So, to some degree, thankfulness.*[126]

Although sometimes expressing concern about "the defund conversation" and the termination of the city's Navigation Team,[127] there was a clear willingness on the part of many to accept that JustCARE was responsive to their challenges. Many community partners were also grateful that JustCARE participants would be receiving the housing and services they need. As Monica Ly, Clean & Safe Manager for the Chinatown/International District Business Improvement Association explained,

> *I did see a visible change in the encampments nearby when the program was first starting, and to be able to hear that over 180 people were outreached to, and over a 100*

of them had actually accepted services and to join that program was really nice to hear, and just good to know that people aren't just being shuffled around and are actually getting services.[128]

Together, JustCARE partners created a new way of meeting the needs of people with unsupported mental health disabilities and substance use disorders who were living outdoors when the pandemic hit – and at the same time, addressing the needs and concerns of their housed neighbors. The timeline below summarizes the process though which this occurred.

JustCARE Timeline

Spring 2020 (March - May)

» *Local and National Context*

- King County issues shelter-in-place order in response to Covid-19.
- Local shelters close and jails release people due to the pandemic.
- Protests against police violence spread across the country following the murder of George Floyd in Minneapolis.

» *Birth of CoLEAD*

- LEAD and CoLEAD conduct outreach to people living in encampments in Burien and coordinate with jail administrators to facilitate referrals
- PDA/CoLEAD hires an initial, highly diverse group of outreach responders
- PDA contracts with hotels and launches CoLEAD. Participants have access to private, clean hotel rooms, testing for Covid-19, and support from outreach responders.
- Research team begins first round of interviews with CoLEAD participants and observes relevant planning meetings

Summer 2020 (June - August)

» *Local and National Context*

- Conversations about defunding the police and investing in racial justice, and community-led responses to public safety spread.

» *Evolution of JustCARE*

- CoLEAD expands operations.
- Stakeholders begin to conceive of JustCARE as a coalition of community-based organizations that advance public safety and address the needs of unhoused people with unmet behavioral health needs without reliance on police and in geographically targeted areas.

- LEAD expands its outreach to community partners, encouraging local businesses, property owners, and other organizations to reach out about any concerns around the encampments or needs of unhoused neighbors.
- Research team continues interviews and meeting observations.

Fall 2020 (September - December)

» *Local and National Context*

- Concerns about encampments intensify.

» *Evolution of JustCARE*

- REACH and LEAD commence outreach with potential participants and community members in the targeted areas.
- Participants move from encampments into hotels staffed by ACRS, CoLEAD and Chief Seattle Club.
- JustCARE contracts with Wheeler Davis Conglomerate for safety coordination in the hotels.
- Research team conducts second round of interviews for CoLEAD participants, and first round for ACRS and Chief Seattle Club participants; conducts interviews with outreach responders, and continues interviews with stakeholders.

Winter 2020-2021 (January- March)

» *Context*

- King County sees a second wave in Covid-19 infections
- Nation and local area prepare for vaccine roll-out.

» *JustCARE*

- JustCARE providers continue to supports participants and arrange for vaccine appointments.
- Research team begins final round of interviews of participants and completes interviews with stakeholders and community partners.
- Research team collects and analyzes administrative data.

Appendix B

Data and Methods

We began to study CoLEAD in the spring of 2020. When JustCARE emerged in the fall we broadened the scope of our research to include all of its partner organizations. Below, we describe the development of the interview protocol, our recruitment strategy, the chronology of interviews and follow-ups, and demographic characteristics of participant-respondents, and information about interviews with community partners and stakeholders.

Participant Interviews

Participant Interview Protocol Development

The protocol for participant interviews was developed in coordination with a research team in New York City. The Rikers Island Longitudinal Study (RILS), led by Professor Bruce Western at Columbia University, began in 2018 to examine how race, poverty, and related vulnerabilities shape pretrial outcomes. When the pandemic broke, RILS began to capture in real time how the spread of COVID-19 and subsequent steps to reduce the incarcerated population impacted the lives of study participants. In King County, CoLEAD coordinated with jail administrators and defense counsel to support individuals released from jail due to the pandemic. Given the shared challenges and parallel strategies in these jurisdictions, and the similarities between the two groups of participants, we coordinated with RILS to develop our interview protocol.

Both studies explore how people with long histories of poverty, jail-involvement, unsupported mental health disabilities and/or substance use disorder fared during Covid-19, with a particular focus on how individuals' experiences and access to social services prior to and during the pandemic shaped their well-being and opportunities for stability. Our interview protocols include detailed questions about:

- Demographic characteristics
- Biographical life circumstances
- Health related issues
- Contact with the police and criminal legal system.

Because our participants only included people who were receiving housing and support, we also asked questions about how people experienced that housing, how they hoped to move forward in their lives, how they interacted with their case managers, what they liked and didn't like about hotels, how their relationships were affected by their new status, whether they continued to use substances

and interact with the legal system, and more. We also asked detailed questions about their exposure to and testing for COVID-19.

Connecting with CoLEAD and JustCARE Participants

In order to connect with participants for interviews, we coordinated with outreach responders who work directly with participants in the hotels. Outreach responders distributed fliers to participants describing our research and request for interviewees. The fliers provided our Google Voice number, which was staffed by our research team twice a day, Monday through Friday, to conduct an interview. Interviews took place by phone and lasted between 45 and 120 minutes. Following each interview, the researcher contacted the outreach responder to provide the participant with a $50 pre-loaded VISA card as compensation for their time.

The first round of interviews began on May 25, 2020 and continued through August 18, 2020. We conducted interviews with 37 participants in this initial phase. In early fall 2020, CoLEAD joined with the Asian Counseling and Referral Service (ACRS) and Chief Seattle Club to create JustCARE. In order to understand the experiences of participants arriving at the hotels during this period, our research team conducted an additional first round of interviews with five new participants, the majority of which took place during November and December 2020. Thus, 42 JustCARE participants participated in at least one interview with our research team.

While these initial interviews captured the experiences of participants prior to and upon arrival at hotels, we also sought to understand whether and how JustCARE served their needs over time. Therefore, we conducted up to two follow-up interviews with participants. The second interview took place one to two months following the first interview, with some discrepancy due to difficulty in reaching some participants. Outreach responders were invaluable in helping the research team reconnect with participants for follow-up interviews, providing our team with updated contact information and reminding participants of their interviews. Of the five participants who arrived at the hotels and were interviewed in fall 2020, four participated in two interviews and one participated in one interview. This condensed interview schedule was designed to align with the general time frame of final interviews conducted for the majority of participants.

For participants who arrived at the hotels in spring and summer 2020 during the early months of the pandemic, we aimed to conduct third interviews either at the time of their exit from the hotels or within nine months of their first interviews. As is well-documented in social science research, longitudinal studies that aim to assess a cohort's progress over time face notorious difficulties with retention. Of the 37 participants who conducted first interviews from May through August 2020, 20 conducted second and third interviews. Outreach responders, again, helped the research team reconnect with participants for these interviews and provided insight about some participants who were difficult to reach. For instance, one participant entered in-patient treatment between the second and third interview; other participants obtained permanent housing and had a different phone number that was no longer provided by JustCARE.

Participant Interviewee Demographics

Table B1 shows the demographic characteristics of JustCARE participants we interviewed; Table B2 shows the proportion of respondents who participated in each round of interviews.

Table B1. Demographic Characteristics of CoLEAD/JustCARE Interviewees

RACE/ETHNICITY	
American Indian/Alaska Native	4.7%
Asian	2.4%
Black/African American	23.8%
Latinx	7.1%
Multi-Racial	9.5%
Native Hawaiian/Pacific Islander	4.8%
White	47.6%
GENDER	
Woman	28.6%
Man	69%
Other/Unknown	2.3%
AGE	
Age Range	21 - 65
Average Age	40

Note: *Data based on interviewee self-reports. A total of 42 distinct individuals were interviewed.*

Table B2. Proportion of Respondents who Participated in One, Two, and Three Interviews

	Percent	Number
Interview 1	100%	42
Interview 2	83.3%	35
Interview 3	47.6%	20

Interviews with Community Partners

We interviewed eleven community partners in February and March of 2021 for this study. Table B3 lists the community partners who were interviewed for this study.

Table B3. Community Partners Interviewed

NAME	TITLE	ORGANIZATION
Brian Cannon	Sr. Manager, Safety Services	Downtown Seattle Association
Jacqueline Gruber	Director of Built Environment	Downtown Seattle Association
Cathy Jimenez	Fare Violation Program Manager	King County Metro
Derek Lum	Policy Analyst	Interim Community Development
Monica Ly	Clean & Safe Manager	CID Business Improvement Association
Jose Marenco	Chief of Police	Metro Transit Police
Tiffani McCoy	Advocacy Director	Real Change
Lisa Nitze	VP Marketing, Investment & Community Partnerships	Nitze-Stagen
Tija Petrovich	Chair	Pioneer Square Resident's Council
Maiko Winkler-Chin	Executive Director	CID Preservation and Development Authority
Chris Woodward	Business Development Director	Alliance for Pioneer Square

The interview protocol for community partners included the following questions:

1. **Do you live or work in Pioneer Square/CID? If so, for how long?**
   a. Can you tell me a little about the neighborhood?
   b. What do you like about living (or working) there?
   c. Are there things you're concerned about in the neighborhood?
   d. How has the area changed since the pandemic started?

Or, for Metro:

2. **What kinds of issues were you encountering in the CID/Pioneer Square area? How was the pandemic affecting those issues?**

a. How did you learn about JustCARE?
b. How do you understand JustCARE's aims?
c. How do you think they're advancing these goals?

3. **Can you tell us about how and why you reached out to/connected with JustCARE?**
   a. What concerns do you have about [the relevant area]?
   b. Before JustCARE was here, how did you respond to similar situations? What happened?
   c. Are there any other groups you would have considered calling?

4. **What has happened since you reached out to JustCARE?**
   a. What was their response?
   b. Do you feel your concerns have been addressed?
   c. If yes, how so?
   d. If no, can you explain why not? What more do you hope would be done?

5. **Would you say you feel more safe, less safe, or neither since you began engaging with JustCARE?**

6. **Would you say that your quality of life has improved, worsened, or stayed the same since you began engaging with JustCARE?**

7. **How would you like to see JustCARE evolve moving forward?**

8. **Is there anything else you think is important for us to understand about this part of Seattle or your experience with JustCARE?**

Interviews with Outreach Responders

We interviewed twelve CoLEAD outreach responders in the course of this research. This interview protocol included the following questions.

1. **How long have you been working with CoLEAD?**
   a. Can you tell me a bit about how/why you choose to apply to work for CoLEAD? What drew you to this type of work?
   b. Did you know anything about PDA when you applied?
   c. To what extent did the pandemic factor into this decision?

2. **A few months in, how do you feel CoLEAD is doing?**
    a. What is working well?
    b. What is not working well?
    c. Is there anything you would change about CoLEAD if you could?

3. **What do you think are CoLEAD's goals?**
    a. How do you think CoLEAD is different from other programs that provide services for the homeless/people involved in the criminal legal system?
    b. What would you define as success for a CoLEAD participant?

4. **How do you see your role in advancing CoLEAD's goals?**
    a. If you were talking to someone who wasn't familiar with your work, how would you describe what a CoLEAD outreach responder does?

5. **What was the training process like for you?**
    a. Did you feel you got enough training?
    b. Are their particular topics you wish you had more training around?

6. **What has it been like for you to do this type of work?**
    a. What has been challenging about it?
    b. What has been rewarding about it?
    c. What kinds of things have you found helpful beyond the formal training you received?
    d. What helps you feel supported as you do this work? Are their particular things that are not happening in CoLEAD that you would find helpful?
    e. Are there ways supervisors could better support outreach responders?
    f. Do you have any particular lived experience you have found to be helpful? If so, how is it helpful?

7. **How do you feel about the program's emphasis on harm reduction?**
    a. What does harm reduction mean to you? Was harm reduction new for you? How do you feel about that aspect of CoLEAD?
    b. How do you implement harm reduction in working with participants?
    c. How do you balance CoLEAD's harm reduction orientation with the need to ensure safety for your clients, other hotel guests, and hotel staff? How do you navigate situations in which clients are putting themselves or others at risk?

8. **What is your relationship like with hotel staff?**
    a. Have you learned any lessons about how to make sure hotel staff are working cooperatively with CoLEAD staff?
    b. In your experience, what are the benefits and challenges of the hotel setting?

9. **Who's the participant you've worked with that has benefited most from CoLEAD?**
    a. From your perspective, what has made this a productive experience for them?

10. **How about your participant who has struggled most to make progress?**
    a. What has their experience while in CoLEAD been like?
    b. We've heard from some participants that they used to engage in criminal activity, such as theft, burglary, or selling drugs, before starting with CoLEAD.
    c. Do you know if some participants are still engaging in such behavior?
    d. Why do you think that is?

11. **How would you characterize the similarities and differences across the participants with whom you work?**
    a. Do you feel CoLEAD participants are facing different types of challenges?
    b. Do you use different strategies for different participants?

12. **Are there particular resources to help meet participants' goals that you don't have access to now?**

13. **Is there anything else you would like for us to understand about CoLEAD or your work as an outreach responder?**

Interviews with JustCARE Leadership

We interviewed ten JustCARE leaders, as shown in Table B4.

Table B4. JustCARE Leaders Interviewed

NAME	TITLE	ORGANIZATION
Jesse Benet	CoLEAD Director and Deputy Director of PDA	Public Defender Assoication
Lisa Daugaard	Director	Public Defender Assoication
Tabatha Davis	CoLEAD Operations Director	Public Defender Assoication
Chloe Gale	REACH	REACH/Evergreen
Tiarra Dearbone	LEAD Project Manager, West Precinct	Public Defender Assoication
Cyn Kartarski	Medical Director	Public Defender Assoication
Victor Loo	Director of Practice Innovation	Asian Counseling and Referral Services
Tara Moss	Seattle-King County LEAD Project Coordinator	Public Defender Assoication
Jesse Rawlins	Lodging Liaison	Public Defender Assoication
Virgil Wade	Operations Director	Chief Seattle Club

The interview protocol for leadership included the following questions:

1. **Can you tell me about your organization?**
   a. What are its main goals?
   b. How is your organization funded?
   c. What's unique about your organization, and how does it fit into the Seattle non-profit world?

2. **What is your role in the organization?**
   a. How long have you been in this position?
   b. In what ways were conditions on the ground changing this spring and summer? How did this affect the work that you do?

3. **How did you become involved in JustCARE?**
   a. When did you first become aware of the coalition that was to become JustCARE?
   b. What particular role does your organization play in this coalition/initiative?
      - How was this decided?
   c. What role do you in particular play in JustCARE?
   d. How does your organization complement other organizations involved in JustCARE?

4. **How would you define JustCARE's main goals?**
   a. What and whose needs is JustCARE designed to respond to?
   b. Is JustCARE hoping to impact any systems? If so, how does it hope to have this impact?
      - How will you assess whether JustCARE has this impact?

5. **How is JustCARE's approach to _____ [situation described above] different from other programs or initiatives you have observed?**
   a. How do you think it serves the needs of participants relative to other initiatives?
   b. Is JustCARE's effort to _____ [referring to system impact] new?

6. **How does the collaboration work in practice?**
   a. How have the organizations within the coalition managed resources and information?
   b. What do you think are the benefits of collaboration?
   c. What are some of the challenges associated with collaboration?
   d. How have JustCARE stakeholders and project managers responded to these challenges?
   e. Has JustCARE created mechanisms whereby it can learn from, and respond to, challenges it faces?

7. **How do you feel about the program's emphasis on harm reduction?**
   a. What does harm reduction mean to you? Was harm reduction new for you? How do you feel about that aspect of CoLEAD?
   b. How do you implement harm reduction in working with participants?
   c. How do you balance CoLEAD's harm reduction orientation with the need to ensure safety for your clients, other hotel guests, and hotel staff? How do you navigate situations in which clients are putting themselves or others at risk?

8. **What does the on-the-ground work look like for you and outreach workers in your organization?**
   a. Can you describe what a typical day looks like for you in this work?

b. In your experience, what are the benefits and challenges of the hotel setting?

9. **What have been the most significant challenges for your organization in carrying out its role in JustCARE?**
   a. How have you dealt with those challenges?
   b. What have you and your organization learned so far that would have been helpful to know at the outset?

10. **For hotel providers: What do you do in a crisis situation? What kind of process occurs to make sense of what happened, process any issues, and derive lessons learned?**

11. **For hotel providers: Have you been able to rely on the security services of Dom et. al? How has this worked out for you?**

12. **For hotel providers: How often have you had to move folks? Remove folks? How are these decisions made? What if any follow up occurs after an incident like this occurs?**

13. **For hotel providers: Have there been any positive COVID tests? If so, how are these handled? Has this had any implications for your efforts to build trust with participants?**

14. **What would you need to make your work as effective as possible?**
   a. If you could change one thing about the way JustCARE operates, what would it be?

15. **Where do you see JustCARE 6 months from now? What about 12 months from now?**
   a. Do you hope to see it transform into something more permanent?
   b. What will be needed to make this possible?

16. **What has been the most surprising thing to you about your work with JustCARE?**
   a. Is there anything else you think is important for us to understand about JustCARE?

Appendix C

CoLEAD/JustCARE Lodging Agreement

PDA CO-LEAD TEMPORARY LODGING AGREEMENT, effective July 6, 2020

This contract is by and between the Public Defender Association (PDA) and you, _____. By signing this contract, you agree to be the sole lodger of PDA'S temporary Co-LEAD lodging arrangements at _____, Seattle, King County, State of Washington, or to share that lodging with these other members of your household also specifically invited by PDA:

_____.

You also agree to the following:

2. PDA has lawfully arranged for your use of this temporary lodging in a hotel. PDA/Co-LEAD hereby allows you to use this temporary lodging on conditions specified here. This agreement begins on _____, 2020 and ends on _____, 2020, but no longer than 29 days.

3. This temporary lodging in a hotel is provided in a time of public health emergency, when most in Washington State have been ordered by Governor Inslee to limit normal interactions by observing social distancing and sanitation precautions. We have all been directed not to approach anyone except those we live with at a distance of less than six feet, and the hotel staff are working to honor public health guidelines and need guests to do the same. It is a condition of your stay in this temporary lodging that you will observe the public health emergency and not have anyone other than those listed on this form in your room.

4. No guests whatsoever are allowed in your unit other than those listed here, no matter how long they stay—even for a few minutes. Your cooperation is important to your own health and the health of hotel workers and other guests of the hotel, who are expected to follow the same guidelines. If you do violate this rule and it is discovered you have had guests or have guests in your room, you will be given two warnings and then will be asked to leave the hotel, and possible exited from the Co-LEAD program overall. If your household composition changes such that you need to add a person to this agreement, we will explore with you whether we can accommodate that—please bring it to the attention of Co-LEAD staff for discussion.

5. You agree to abide by all rules of the hotel, and to comply with all requests from hotel staff. This is

important to ensure you can continue to use the lodging, and to ensure that others we are helping are also able to stay in a safe and secure place.

6. Co-LEAD is providing a scarce resource in a time of public health emergency. If you decide to cease using the temporary lodging, there are others who could benefit, so we ask you to let your Co-LEAD Outreach Responder know that you are leaving. If you leave and do not occupy the room for 24 hours or longer without making arrangements with the Outreach Responder team, we will consider you to have completed your stay. At that time we will remove any belongings and store them, if safe, lawful and feasible, for up to 90 days, when possible, in a separate storage area. You may claim them by contacting Bernadette Stanek at bernadette.stanek@defender.org, 206-392-0050 extension 739. Any belongings you leave for more than 24 hours which cannot be safely, lawfully and feasibly collected and stored will be discarded.

7. You agree to be enrolled in PDA's Co-LEAD program, which is providing emergency support for people sheltering in place during the public health emergency. You agree to sign a Release of Information allowing Co-LEAD Outreach Responder(s) to communicate necessary information with partners who have funded this program about the impact and success of the program, though we will make every effort not to share sensitive information about your situation unless we are legally required to do so.

   If your enrollment in the Co-LEAD Outreach Responder program ends, you agree to move out immediately.

8. You agree to follow all Washington State and King County mandates related to the use of masks during this public health epidemic. Masks are required as of the WA State Governor's order[1] effective on June 26, 2020, for entrance into any public space, which includes public spaces in all hotels in the Co-LEAD program. You agree to wear a mask during all interactions with any Co- LEAD staff.

9. You agree to allow inspections of the unit by Co-LEAD Outreach Responder(s) whenever we request entry, and you agree to be present for the inspection. Co-LEAD Outreach Responder staff will contact you via phone by calling or texting to provide you notice of entering your unit for repairs or other facility concerns unless an emergency exists. You agree to work with Co-LEAD to provide wellness checks on you in your room, whenever necessary and will be present to receive supplies, as needed, from Co-LEAD staff.

10. Hotel staff will also need to enter the unit to clean and maintain it. This will be done according to the policies of the hotel, and you may need to allow them to enter while you are in the room.

11. You agree to work with your Co-LEAD Outreach Responder in assessing any potential health issues,

1 https://www.governor.wa.gov/news-media/inslee-announces-statewide-mask-mandate

including but not limited to coronavirus. So that we can determine whether isolation and quarantine are necessary, you must agree to a Covid-19 test prior to, or as soon as you are provided a hotel room, and whenever requested by Co-LEAD staff based on specific known risk of COVID transmission. If you do not complete a Covid-19 test provided by the Co-LEAD Healthcare provider within three business days of hotel placement or after being requested based on known risk of COVID exposure, your Co-LEAD stay and program participation will be terminated immediately.

12. After your hotel placement and initial Covid-19 test, if you present with symptoms specifically of coronavirus or have a known heightened risk of transmission (based on contact with someone known to be COVID positive), you agree to be tested for the virus (again). If tested positive, you agree to self-quarantine in your temporary lodging residence for at least 14-days and work with your Co-LEAD Outreach Responder or other relevant health care staff and health care authorities to determine next steps.

13. You agree to make every effort to keep the unit clean and in good condition during your tenancy and to leave premises in a clean and orderly condition before you depart.

14. You agree to use utilities, plumbing, other fixtures and appliances properly and for their intended use only. You agree to not damage, deface or remove any part of the premises, including equipment, appliances, fixtures or furnishings. You agree not to put holes in the wall or damage wallpaper, and to leave everything that you found when you began your stay in the room when you depart. If you take apart anything in your room or damage hotel property, you can be asked to leave the hotel and Co-LEAD program participation immediately.

15. You agree not to smoke in the unit and to smoke only in areas designated by the hotel.

16. You must report any damage or problems in your unit right away to your Co-LEAD Outreach Responder.

17. You agree that PDA/Co-LEAD will not be responsible for a financial loss you suffer in regard to your personal property.

18. Any difficulties with other hotel guests or with the temporary lodging residence staff should be discussed with your Co-LEAD Outreach Responder right away. You agree not to disturb other guests or engage in violent, abusive or threatening behavior. If hotel staff bring a complaint or concern to the Co-LEAD Outreach Responder team, you are expected to promptly discuss the issues with your Co-LEAD Outreach Responder or Outreach Responder Supervisor.

19. You agree not to sell legal or illegal drugs in the hotel. Illegal activity of any kind is prohibited throughout the hotel. Unlawful activity of any sort on the premises is grounds for immediate termination of your permission to stay in these temporary accommodations.

20. Any personal alcohol and other intoxicating substances shall be confined to the individual's temporary lodging residence. Under no circumstances will the lodger consume any intoxicating substances outside of the hotel/motel room.
21. Firearms of any kind are not allowed in the building. Other potential items that could be used as weapons, such as kitchen knives, shall be confined to the temporary lodging unit

22. Any contact with law enforcement must be reported to your Co-LEAD Outreach Responder immediately.

23. If the hotel chooses to relocate you to a different unit, you will cooperate with the move.

24. The current arrangement for lodging will not exceed 29 days. If for any reason, PDA/Co-LEAD chooses to, or concludes it should, stop paying for your stay at the hotel, you will either vacate the room immediately or make your own independent arrangements with the hotel to continue on, separate and apart from any arrangements PDA/Co-LEAD has made and with no further obligation for PDA/Co-LEAD to pay.

25. You understand that there is no guarantee or right to continue in these lodging arrangements for any period of time.

26. If any part of this contract is violated, and PDA/Co-LEAD chooses not to enforce that specific provision, this shall not be considered consent to violate the contract on any other occasion.

27. Should any provision in this agreement be found to be contrary to any local, state or federal law, it shall be considered null and void, just as if it had never appeared in the agreement, and it shall not affect the validity of any other provision in the agreement.
28. This agreement, together with any written and signed addenda hereto, constitutes the entire agreement between the parties. Any changes or modifications must be in writing and signed by the parties.

I have read the "PDA Co-LEAD Temporary Lodging Agreement" and agree to its provisions. I understand that failure to comply can result in the termination of my lodging. I have had an opportunity to ask questions and have them answered.

_____ _____

Lodger Signature Date

Lodger Name (please print) _____

Co-LEAD Case Outreach Responder Date

Co-LEAD Outreach Responder Name (please print)

Endnotes

1 Amanda Y. Agan, Jennifer L. Doleac, and Anna Harvey, "Misdemeanor Prosecution," available online at https://www.nber.org/papers/w28600; Katherine Beckett and Steve Herbert, *Banished: The New Social Control in Urban America* (Oxford University Press 2010); Teresa Gowan, *Hobos, Hustlers, and Backsliders: Homeless in San Francisco* (University of Minnesota Press, 2010); Issa Kohler-Hausmann, *Misdemeanorland* (Princeton University Press, 2018); Forrest Stuart, *Down, Out and Under Arrest: Policing and Everyday Life in Skid Row* (University of Chicago Press, 2018).

2 Benjamin Maritz and Dillip Wagle, *Why Does Prosperous King County Have a Homelessness Crisis?* McKinsey & Company, January 22, 2020.

3 Being in HMIS does not guarantee access to these housing programs, but one cannot access some of them without being registered in HMIS.

4 King County, *Familiar Faces Cost Analysis Summary of Findings: Phase 1* (April 7, 2016).

5 The U.S. Department of Housing and Urban Development (HUD) classifies people who lack stable housing in two broad categories: sheltered and unsheltered. People experiencing sheltered homelessness live in an emergency shelter or transitional housing, which may also include domestic violence shelters and residential programs for homeless or runaway youth. People experiencing unsheltered homelessness live in places "not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street." See U.S. Department of Housing and Urban Development, *A Guide to Counting Unsheltered Homeless People* (Washington, D.C., 2008).

6 For a useful overview of harm reduction, see Alan Marlatt and Katie Witkiewitz, "Update on Harm-Reduction Policy and Intervention Research," A*nnual Review of Clinical Psychology 6* (2010).

7 Hallie Preskill, Marcie Parkhurst, and Jennifer Splansky Juster, *Guide to Evaluating Collective Impact: Learning and Evaluation in the Collective Impact Context* (Collective Impact Forum, no date).

8 Our research began in the spring of 2020 with a focus on CoLEAD, then evolved to encompass JustCARE. See Appendix B for more methodological details.

9 M. Q. Patton, M. Q., K. McKegg, and N. Wehipeihana (eds.), *Developmental Evaluation Exemplars: Principles in Practice* (The Guilford Press., 2016); M. Q. Patton, M. Q., *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use* (Guilford Press, 2010).

10 These include Jesse Benet, CoLEAD Director and Deputy Director of PDA; Lisa Daugaard, Executive Director of PDA; Tabatha Davis, Manager of CoLEAD Operations; Tiarra Dearbone, LEAD Project Manager for the West Precinct; Chloe Gale, REACH Co-Director; Dr. Cyn Kotarski, ND, Medical Director for PDA; Victor Loo, Director of Practice Innovation at ACRS; Tara Moss, Seattle-King County LEAD Project Director, Jesse Rawlins, Housing Liaison for CoLEAD; and Virgil Wade, Operations Director, Chief Seattle Club.

11 Interview with Jesse Benet, CoLEAD Program Manager, February 23, 2021.

12 REACH screening data are presented in Appendix A (see Table A1). The figures presented in Table 1 above include early CoLEAD referrals from Burien parks and King County jails, both of which involved a slightly larger share of White participants than the areas subsequently targeted by JustCARE.

13 National Alliance to End Homelessness, *A Plan, Not a Dream: How to End Homelessness in Ten Years* (Washington, D.C., 2000).

14 Interview on February 23, 2021.

15 Interview with Lisa Daugaard, Director of PDA, February 23, 2021.

16 Personal communication with Victor Loo, ACRS Director for Program Innovation, April 3, 2021.

17 Interview with Virgil Wade, Operations Director, Chief Seattle Club, March 2, 2021.

18 Wouter Vanderplasschen et al., "Effectiveness of Different Models of Case Management for Substance-Abusing Populations." *Journal of Psychoactive Drugs* 39, 1 (2007)

19 Ibid.

20 Helga Thordarson and Tiffany Rector, "From Trauma-Blind to Trauma-Informed: Re-thinking Criminalization and the Role of Trauma in Persons with Serious Mental Illness," *CNS Spectrums* 25,5 (2020).

21 Interview with Jesse Benet, CoLEAD Program Director, November 11, 2020.

22 Interview with Tabatha Davis, CoLEAD Operations Manager, November 11, 2020.

23 Stephane Morandi et al., "Intensive Case Management for Addiction to Promote Engagement with Care of People with Severe Mental and Substance Use Disorders: An Observational Study," *Substance Abuse Treatment & Prevention Policy* 12, 26 (2017); David Ponka, "The Effectiveness of Case Management Interventions for the Homeless, Vulnerably Housed and Persons with Lived Experience: A Systematic Review," *PLoS ONE* 15, 4 (2020); Sue Lukersmith, Michael Millington, and Luis Salvador-Carulla, "What Is Case Management? A Scoping and Mapping Review," *International Journal of Integrated Care* (2016).

24 Erica C. Barnett, "JustCARE Disputes JustCARE's Cost Claims," *Publicola,* April 28, 2021.

25 Ibid. Another 10 percent is spent on participants' basic needs, 5 percent on the safety teams, 4 percent on project operations, and 1 percent on screening and outreach.

26 Salary details available at https://www.seattle.gov/police/police-jobs/salary-and-benefits#income

27 Daniel Beekman, "374 Seattle Police Department Employees Made at Least $200,000 Last Year; here's How," *Seattle Times,* August 10, 2020.

28 In fact, one of the biggest complaints about the hotels came from people who did not have kitchenettes who found cooking for themselves difficult with only a microwave. After receiving feedback from our team about this frustration, PDA attempted to respond to this in a number of ways. Initial efforts to contract with meal providers were of limited success. Ultimately, the provision of crock pots and food for people without full kitchenettes appears to have been most successful.

29 Cannabis products are legally available in Washington State; this purchase was not funded by federal or local government monies.

30 Interview with Victor Loo, Director of Practice Innovation at ACRS, February 19, 2021.

31 Interview with Jesse Rawlins, CoLEAD Housing Liaison, November 10, 2020.

32 Interview on March 10, 2021.

33 Bernard Harcourt, "Policing L.A.'s Skid Row: Crime and Real Estate Redevelopment in Downtown Los Angeles (An Experiment in Real Time)," *University of Chicago Legal Forum* 2005:325-403 (2005).

34 Interview with Dr. Cyn K0tarski, Medical Director, PDA, August 28, 2020.

35 The screening data compiled by REACH indicate that 84 percent of the people screened in encampments were currently using drugs (mainly methamphetamine and heroin). See Table A1 in Appendix A for more information.

36 Some also found methadone to be helpful. A handful of pregnant participants were prescribed Subutex.

37 Interview with Jesse Rawlins, CoLEAD Housing Liaison, November 10, 2020.

38 Interview with Dr. Cyn K0tarski, Medical Director, PDA, August 28, 2020.

39 On these environmental and health issues, see Erin Goodling, "Intersecting Hazards, Intersectional Identities: A Baseline Critical Environmental Justice Analysis of US Homelessness," *EPE: Nature and Space* 2019: 1-24 (2019); Philippe Bourgeois, "The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments," *Substance Use & Misuse,* 33:11, 2323-2351 (1998).

40 S. Ballintyne, *Unsafe Streets: Street Homeless and Crime* (London: Institute for Public Policy Research, 1999); Jana L. Jasinski et al., *The Experience of Violence in the Lives of Homeless Women: A Research Report* (Washington D.C.: National Institute of Justice, 2005); Angela J. Stewart et al., "Victimization and Posttraumatic Stress Disorder Among Homeless Adolescents," *Journal of the American Academy of Child & Adolescent Psychiatry* 43:3: 325–331 (2004).

41 See, for example, Vianna Davila and Vernal Coleman, "Man Convicted in Rape, Prostitution Case Traced to Seattle Homeless Encampment," *Seattle Times*, March 8, 2019.

42 Scott Ballintyne, *Unsafe Streets: Street Homeless and Crime* (London: Institute for Public Policy Research, 1999); Philippe Bourgeois, "The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments," *Substance Use & Misuse,* 33:11, 2323-2351 (1998); Teresa Gowan, *Hobos, Hustlers, and Backsliders: Homeless in San Francisco* (University of Minnesota Press, 2010); Forrest Stuart, *Down, Out and Under Arrest: Policing and Everyday Life in Skid Row* (University of Chicago Press, 2018).

43 Philippe Bourgeois, "The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments," *Substance Use & Misuse,* 33:11, 2323-2351 (1998); Forrest Stuart, *Down, Out and Under Arrest: Policing and Everyday Life in Skid Row* (University of Chicago Press, 2018).

44 See also Lauren Dunton et al., *Exploring Homelessness Among People Living in Encampments and Associated Costs* (U.S. Department of Housing and Urban Development, 2020).

45 Interview on February 18, 2021.

46 Letter quoted in Erica C. Barnett, "Co-LEAD Allowed to Start Moving People from Seattle Streets into Hotels, Too Late to Help Those Removed in Last Three Sweeps," *Seattle South Emerald,* May 27, 2020.

47 Interview on February 17, 2021.

48 Interview on February 18, 2021.

49 Interview on February 26, 2021.

50 This intervention involved REACH, LEAD, and CoLEAD, and occurred before JustCARE was created. Interview on September 18, 2020.

51 Interview on February 25, 2021.

52 Interview with Tiarra Dearbone, LEAD Project Manager for the West Precinct, January 26, 2021.

53 Trevor Bennett and Katy Holloway, "The Causal Connection Between Drug Misuse and Crime," *The British Journal of Criminology* 49, 4: 513-31 (2009); Philippe Bourgeois, "The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments," *Substance Use & Misuse,* 33:11, 2323-2351 (1998); Teresa Gowan, *Hobos, Hustlers, and Backsliders: Homeless in San Francisco* (University of Minnesota Press, 2010); Forrest Stuart, *Down, Out and Under Arrest: Policing and Everyday Life in Skid Row* (University of Chicago Press, 2018).

54 Nearly half of the JustCARE respondents we interviewed did not report ever having employed illegal survival strategies. Of those who admitted doing so, 91 percent reported that the extent to which they engaged in these behaviors had declined or ceased since their enrollment in JustCARE.

55 This high level of prior criminal legal system involvement among JustCARE participants is consistent with evidence from King County's Familiar Faces initiative, which found that nearly six in ten (58.6 percent) of the "familiar faces" who were booked into jail four or more times in the previous year were living unsheltered; 94 percent had been diagnosed with either a chemical dependency issue or a mental health issue (often both). See https://www.kingcounty.gov/~/media/elected/executive/constantine/initiatives/hhs-transformation/documents/familiar-faces/Population_analysis_combined_6_26_16.ashx?la=en

56 The issue of substance abuse complicates this, as the benefits participants receive are typically not enough to cover the cost of drugs if they are used regularly. We recommend that future research explore this issue in greater depth.

57 One in four people killed by police suffers from mental illness. See Doris A. Fuller et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (Washington D.C.: Treatment Advocacy Center, 2015).

58 Interview with Dominique Davis, co-founder of Wheeler Davis Conglomerate, January 29, 2021.

59 Interview with Jesse Benet, CoLEAD Program Manager, January 29, 2021.

60 Interview with Lisa Daugaard, Director of PDA, February 18, 2021.

61 Luis Daniel Gascón and Aaron Roussell, *The Limits of Community Policing: Civilian Power and Police Accountability on Black and Brown Los Angeles* (New York: New York University Press, 2019).

62 Doris A. Fuller et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (Washington D.C.: Treatment Advocacy Center, 2015).

63 Amanda Geller et al., "Aggressive Policing and the Mental Health of Young Urban Men," *American Journal of Public Health,* 104: 12: 2321-2327 (2014).

64 Sarah Brayne, "Surveillance and System Avoidance: Criminal Justice Contact and Institutional Attachment," *American Sociological Review,* 79, 3: 367-391 (2014).

65 Due to LEAD's involvement in JustCARE, there was significant overlap in the people conducting this outreach work.

66 Interview with Tiarra Dearbone, LEAD Project Manager for the West Precinct, January 26, 2021.

67 Alexes Harris, Heather Evans, and Katherine Beckett, "Drawing Blood from Stones: Monetary Sanctions, Punishment, and Inequality in the Contemporary United States," A*merican Journal of Sociology* 115: 1753-99 (2010); Jeremy Travis, Bruce Western, and Steven Redburn, editors, *The Growth of Incarceration in the United States: Exploring Causes and Consequences. Committee on Causes and Consequences of High Rates of Incarceration* (Washington, D.C.: The National

Academies Press, 2014).

68 John M. Halushka, "The Runaround: Punishment, Welfare, and Poverty Survival After Prison," Social Problems 67, 2: 233-50 (2019); Issa Kohler-Hausmann, *Misdemeanorland* (Princeton University Press, 2018); Reuben Jonathan Miller, "Devolving the Carceral State: Race, Prison-Reentry, and the Micro-Politics of Urban Poverty Management," *Punishment & Society* 16, 3: 305-35 (2014).

69 Amanda Y. Agan, Jennifer L. Doleac, and Anna Harvey, "Misdemeanor Prosecution." Available online at https://www.nber.org/papers/w28600

70 Alexes Harris, Heather Evans, and Katherine Beckett, "Drawing Blood from Stones: Monetary Sanctions, Punishment, and Inequality in the Contemporary United States," *American Journal of Sociology* 115: 1753-99 (2010).

71 David M. Perry and Lawrence Carter-Long, *The Ruderman White Paper on Media Coverage of Use of Force and Disability* (Ruderman Family Foundation, 2016).

72 Doris A. Fuller et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (Washington D.C.: Treatment Advocacy Center, 2015).

73 Rowan Moore Gerety, "An Alternative to Police that Police Can Get Behind," *The Atlantic,* December 28, 2020.

74 Richard Alonso-Zaldivar, "Feds Fund Mental Health Crisis Team to Stand in for Police, *Associated Press,* April 23, 2021.

75 For CAHOOTS in 1968, these were mainly young people who used drugs and often had negative experiences with the police.

76 See, for example, Aaron Stagoff-Belfort, "Biden Should Use Federal Dollars to Fund Alternatives to Police," *The Atlantic,* October 1, 2020.

77 See http://www.dallascitynews.net/dallas-public-safety-agencies-launch-innovative-mental-health-program

78 See https://sfmayor.org/article/san-franciscos-new-street-crisis-response-team-launches-today

79 Rowan Moore Gerety, "An Alternative to Police that Police Can Get Behind," *The Atlantic,* December 28, 2020.

80 Health One is the Seattle Fire Department's Mobile Integrated Health response unit and is designed to reduce the impact of non-emergent calls on Seattle Fire's Operations Division, and to better connect individuals in need with appropriate care and services. See https://www.seattle.gov/fire/safety-and-community/mobile-integrated-health/health-one

81 Nicole DuBois, Abigail Williams, and Samantha Batko, *Temporary Housing Placements Kept People Safe During the Pandemic but Will Not Curb the Growing Homelessness Crisis* (Urban Institute, August 2020).

82 See U.S. Department of Housing and Urban Development, *A Guide to Counting Unsheltered Homeless People* (Washington, D.C.: Office of Community Planning and Development, U.S. Department of Housing and Urban Development, 2008).

83 Nicole DuBois, Abigail Williams, and Samantha Batko, *Temporary Housing Placements Kept People Safe During the Pandemic but Will Not Curb the Growing Homelessness Crisis* (Urban Institute, August 2020).

84 Housing First providers that house former shelter residents in hotels during the pandemic also report decreases in 911 calls. Seattle's Downtown Emergency Services Center (DESC), for example, reports that "in 2019, the shelter averaged 5.2 calls to 911 every day. The same group of people, now at the Red Lion, are averaging 1.3 calls per day – a 75% drop" (see https://www.desc.org/building-better-crisis-response-systems/). DESC attributes this decline in 911 calls to the stability hotel rooms afford their residents. It stands to reason that JustCARE's focus on quality of life in targeted neighborhoods, comparatively robust support system in hotels, and overt 911 call mitigation strategies extend this benefit.

85 Doris A. Fuller et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (Washington D.C.: Treatment Advocacy Center, 2015); Chris Herring, Dilara Yarbrough, and Lisa Marie Alatorre, "Pervasive Penality: How the Criminalization of Poverty Perpetuates Homelessness," Social Problems 19: 67:137-49 (2019); Melissa Reuland, Matthew Schwarzfeld, and Laura Draper, *Law Enforcement Responses to People with Mental Illness* (New York: Council of State Governments, 2009).

86 Data from King County's Familiar Faces initiative provides further evidence of the ubiquity of police interactions with people with behavioral health issues. These data indicate that nearly six in ten (58.6 percent) of the "familiar faces" who were booked into jail four or more times in the previous year were living unsheltered; 94 percent had been diagnosed with either a chemical dependency issue or a mental health issue (often both).

87 King County, *Familiar Faces Cost Analysis Summary of Findings: Phase 1* (April 7, 2016).

88 Benjamin Maritz and Dillip Wagle, *Why Does Prosperous King County Have a Homelessness Crisis?* McKinsey & Company, January 22, 2020.

89 People on this list are not guaranteed housing, but cannot access certain housing programs without being in HMIS.

90 Two JustCARE participants were hospitalized via the ITA and subsequently released back to the street. One of these was a man in his sixties who has post-Covid dementia and other cognitive impairments, and who was supposed to be released to a skilled nursing facility. Instead, he was booked into jail within 24 hours of hospital release.

91 http://www.defender.org/about

92 Seema L. Clifasefi, Heather S. Lonczak, and Susan Collins, "Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment and Income/Benefits Outcomes and Associations with Recidivism," Crime & Delinquency, 63, 429–45 (2017); Susan Collins, Heather S. Lonczak, and Semma L. Clifasefi, "Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes." Evaluation and Program Planning 64: 49-56 (2019).

93 David Kroman, "Seattle's Arrest Alternative, LEAD, Moves Beyond Police," *Crosscut*, July 17, 2020. Under the new LEAD protocol (signed 3/31/21), law enforcement officers may still refer people arrested for possessing fewer than seven grams of a controlled substance, drug traffic loitering, trespass, misdemeanor theft, unlawful bus conduct, obstructing an officer, misdemeanor property destruction or prostitution offenses to LEAD. In addition, law enforcement and others in the community may refer people who are engaged in law violations due to extreme poverty, drug activity, or behavioral health issues through the social contact or community referral process. In the latter instance, either law enforcement or the LEAD Project Management Team can verify that these conditions exist. In cases of social contact or community referral, no per se criminal history exclusions apply.

94 Katherine Beckett, "The Uses and Abuses of Police Discretion: Toward Harm Reduction Policing," Harvard Law & Policy Review 10: 77- 100 (2016).

95 Interview with Chloe Gale, REACH Co-Director, January 31, 2021.

96 Interview with Tara Moss, Seattle-King County LEAD Project Director, January 27, 2021.

97 CoLEAD focused in particular on people who were released from jail with conditions that they were unlikely to be able to meet absent support as well as individuals who were detained in the jail whom the county/city agreed to release on the condition that CoLEAD provide intensive case management and housing support.

98 Interview with Jesse Benet, CoLEAD Program Director and PDA Deputy Director, November 11, 2020.

99 Interview with Jesse Rawlins, CoLEAD Housing Liaison, November 20, 2020.

100 Interview with Jesse Benet, CoLEAD Program Director and PDA Deputy Director, November 11, 2020.

101 Interview with Tabatha Davis, CoLEAD Operations Manager, November 11, 2020.

102 Interview with Jesse Benet, CoLEAD Program Director and PDA Deputy Director, November 11, 2020.

103 Interview with Jesse Benet, CoLEAD Program Director, November 11, 2020.

104 Interview with Jesse Benet, CoLEAD Program Director, November 11, 2020.

105 Interview with Lisa Daugaard, Director of PDA, February 18, 2021.

106 See Erica C. Barnett, "Despite 'Suspension,' Encampment Sweeps Continue in the Chinatown-International District," *South Seattle Emerald*, May 21, 2020.

107 Letter quoted in Erica C. Barnett, "CoLEAD Allowed to Start Moving People from Seattle Streets into Hotels, Too Late to Help Those Removed in Last Three Sweeps," *Seattle South Emerald*, May 27, 2020.

108 https://acrs.org/

109 Interview with Victor Loo, Director of Practice Innovation at ACRS, February 19, 2021.

110 Ibid. Much of this experience pertains to ACRS's Mental Illness Chemical Abuse (MICA) program, which focuses on people living unsheltered.

111 Interview with Victor Loo, Director of Practice Innovation at ACRS, February 19, 2021.

112 https://chiefseattleclub.org/history-and-mission

113 Ibid.

114 Interview with Virgil Wade, Operations Director, Chief Seattle Club, March 2, 2021.

115 Ibid.

116 Ibid.

117 Interview with Chloe Gale, REACH Co-Director, January 31, 2021.

118 https://www.etsreach.org/programs/

119 Kelsey Brennan, CoLEAD Entry and Services Manager, also played a crucial role in the outreach and screening process.

120 B. Erlenbusch, M. Marr, and P. White, *Life on Industrial Avenue: A Profile of an Urban Encampment In Downtown Los Angeles With Ten Policy Recommendations* (Los Angeles: Los Angeles Coalition to End Hunger & Homelessness, 2001); see also Lauren Dunton et al., *Exploring Homelessness Among People Living in Encampments and Associated Costs* (U.S. Department of Housing and Urban Development, 2020).

121 Ibid; see also U.S. Department of Housing and Urban Development, *A Guide to Counting Unsheltered Homeless People* (Washington, D.C., 2008).

122 People with significant criminal histories involving repeated violence AND whose interactions with outreach staff raised significant security concerns were not perceived as safe to house in the hotels.

123 Outreach workers expressed concern that others may have been pressuring or coercing those who declined housing to do so.

124 Interview with Chloe Gale, REACH Co-Director, January 31, 2021.

125 Interview on February 18, 2021.

126 Interview on February 23, 2021.

127 See Erica C. Barnett, "Durkan Suspends Navigation Team," *South Seattle Emerald*, October 1, 2020, available at https://southseattleemerald.com/2020/10/01/durkan-suspends-navigation-team/

128 Interview on February 25, 2021.