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Integrated Coordinated Care Policies in Alameda County for the Unhoused Population

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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2024

Abstract

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Alameda County departments and organizations have continually provided varying services to members in the unhoused community to increase pathways to stabilization for those served, with little success for over 37 years. While there were studies that discussed the issues of high service utilization faced by unhoused behavioral health care recipients, there was little to no literature that discussed these issues in Alameda County, where the numbers of unhoused persons total more than 9,500. There was very little known as to what policy barriers, and conversely, facilitators and key stakeholders in clinical and penal institutions face in implementing integrated coordinated care policies for unhoused behavioral health recipients in Alameda County. Fourteen participants, encompassing practitioners and department heads, were chosen using a purposeful sampling strategy. Data for the study was collected using an IRB-approved interview guide. Benet's polarities of democracy was used as the theoretical framework to analyze the participant responses. Study findings strongly suggested that Alameda County policymakers have opportunities to effect positive social change in the unhoused community as well as for their practitioners through policy changes that include but should not be limited to developing and implementing an overarching integrated coordinated care policy, a single health care record system, and developing diverse leadership over care programs. By implementing an integrated coordinated care policy in Alameda County, policymakers could provide the unhoused community experiencing behavioral health care challenges with pathways to stabilization and create positive social change.

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Dedication

To God, I give all the glory for anything I have accomplished in this dissertation.

I would also like to thank my family and dedicate this study to them: Khalid Jalil Muhammad (born Curley Joseph Guillot Jr.), Dimitri Damascus Perry, Camille Janine Guillot, and Jasmine Aliya Guillot, thank you for being steadfast in your support of my endeavors.

I would also like to thank my father and older sister, Wallace Ray Perry and Waulecia Raychelle (Perry) Gomillion, for instilling in me a love of reading at a young age and my oldest sister, Shandra Renee Perry, for being my sounding board.

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Chapter 1: Introduction to the Study

The focus of this study was to explore and understand the policy barriers and, conversely, facilitators, practitioners, and department heads for service institutions face in implementing effective integrated, coordinated care for unhoused behavioral health recipients in Alameda County. While there were studies that discussed the issues of high service utilization faced by unhoused behavioral health care recipients, there was little to no literature that discussed these issues in Alameda County, where the numbers of unhoused persons total more than 9,500. Accordingly, with this understanding, there is an opportunity to create an integrated, coordinated care policy to address the needs of Alameda County's unhoused behavioral health care recipients. This type of policy could impact these recipients by providing them a pathway to stabilization, which would be a positive social change for Alameda County.

This chapter introduces the study by first discussing the background and context of the issue in Alameda County. The background was and remains that departments and organizations within the county have continually provided varying services to members in the unhoused community in attempts to increase pathways to stabilization for those served, with little success. Additionally, in this chapter, the discussion continued with the study's research problem and the gap in the literature regarding the policy barriers and, conversely, facilitators that clinical and penal institutions face in implementing effective integrated, coordinated care for unhoused behavioral health recipients in Alameda County.

Continuing in the introduction, the research question and the theoretical and conceptual frameworks, which were Benet's (2006, 2012, 2013, 2022, 2023) polarities of democracy and Johnson's (1996) polarity management are explored. These frameworks were used to examine the issues as they pertain to understanding the policy barriers facilitators, practitioners, and department heads for service institutions face in implementing effective integrated, coordinated care for unhoused behavioral health recipients in Alameda County. To complete the chapter, definitions are provided that helped with terms used throughout the study and a discussion of the significance of the research and the subsequent limitations.

Background

The literature researched for this study regarding behavioral health crises and high service utilization demonstrated that the unhoused community in behavioral health crises often used emergency rooms and penal facilities as a form of treatment plan. This type of treatment was favored over having coordinated care plans with a designated physician or medical plan. These recipients also relied heavily on mobile health services, which did not always have tracking to and for extended services. Unhoused clients who also had substance use disorders or a combination of behavioral health crises and substance use disorders demonstrated the same high utilization of emergency rooms and penal services. Most recently, the Alameda County Board of Supervisors has issued a state of emergency regarding homelessness and health care.

Although researchers have investigated this issue, the topic has not been explored in the following ways:

1. No one has explored the key stakeholders' (practitioners and policy makers) perceptions regarding implementation of effective integrated coordinated care and/or cross organizational case management policies in Alameda County.
2. No one has explored this information through the polarity of democracy lens.

The interest of this study was to understand the efficacy of implementing a cross-organizational policy that provides effective integrated, coordinated care for unhoused behavioral health clients in Alameda County with high emergency room and penal service utilization. The study's focus was to explore the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an effective integrated, coordinated care policy to reduce high service utilization and increase behavioral health stabilization for Alameda County's unhoused mental health service recipients. This study may provide information which could lead to the development and implementation of effective integrated coordinated care policies in Alameda County amid this emergency.

Problem Statement

As already stated, services have been provided to the unhoused community in Alameda County for over 37 years; however, there is no concrete evidence of a cross-organizational policy or effective integrated, coordinated care policy. There also appeared to be no consensus as to why this policy creation has not been accomplished. Accordingly, the specific research problem addressed through this study is it is not known what policy barriers, and conversely, facilitators and practitioners in clinical and

penal institutions face in implementing integrated coordinated care for unhoused behavioral health recipients in Alameda County.

There have been some studies that looked at key research for this particular type of policy. For example, Sandhu et al. (2021) discussed the integrated coordinated care system strides made in the previous 10 years, but the authors emphasized the need for continued investment in creating policies and systems throughout the United States. Sandhu et al. (2021) stated specifically regarding this:

> While research on integrating health and social care in the US has focused on small interventions implemented in individual clinics and hospitals and is limited by poor study quality and a focus on process measures, efforts from these broader policy initiatives have reached millions of Americans. Comprehensive evaluation, with a focus on implementation and effectiveness, is still needed. (p. 7).

Additionally, Bhalla et al. (2020), while researching similar programs for the Veteran's Administration in 2012, supported the notion that continued program evaluation was necessary to determine the effectiveness of integrated coordinated care policies and whether implementation in larger regions would be accessible. These two references demonstrate that while research has been ongoing, there were no current studies that demonstrate or identify any implemented integrated care policies, particularly as they pertained to Alameda County.

This study concentrated on the gap in understanding the policy barriers and, conversely, facilitators, and practitioners in clinical and penal institutions face in implementing integrated, coordinated care for unhoused behavioral health recipients in

Alameda County. It may also provide policymakers with data that could assist in developing a cross-organizational policy that could address the foundational needs of the unhoused behavioral health recipients. This proposed policy creation may assist with providing this population with a possible pathway to a stable existence.

Purpose of the Study

The purpose of this generic study was to explore and understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. The phenomenon of interest that prompted me to conduct this study is that for over 35 years, Alameda County's departments and organizations have continually provided mental health services to unhoused behavioral health recipients to increase stabilization. Despite this effort, which was developed due to an awareness of the effectiveness of an implemented integrated, coordinated care policy for the county, institutional recidivism has remained ongoing and unsolved.

Research Question

In this study, my research question was what are the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County?

Theoretical and Conceptual Framework

The theoretical framework is the foundation upon which a researcher builds a study and develops the approach. Grant and Osanloo (2016) described the theoretical framework as the "blueprint" for the dissertation (p. 13). In developing the foundation for this study, it was imperative to provide an appropriate lens to facilitate the research regarding integrated, coordinated care for the unhoused in Alameda County. Benet's (2006, 2012, 2013, 2022, 2023) polarities of democracy are the appropriate framework to provide that research lens. The topics that have utilized Benet's theoretical framework have been rooted in subjects encompassing interdisciplinary aspects as varied as public health, criminal justice, and environmental law and can be used to inform studies where it is necessary to look at aspects of the issue beyond public policy.

Within the framework, Benet discussed his polarity pairs, "ten paired values: a) freedom and authority; b) justice and due process; c) diversity and equality; d) human rights and organizational obligations; and e) participation and representation" (2013a) and discussed how the pairs applied to government-driven approaches or communities, which, for this study, was the unhoused community. Based on Benet's argument, these pairs were interdependent and necessary to establish the arguments regarding workplace democracy; however, this study uses his framework to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Benet stated in 2013 that his findings suggested that democracy is a solution for oppression (p. 31), which an implicit or explicit denial of services for any segment of society might be defined as being. Thus, in exploring the facilitators and/or barriers to integrated coordinated care, Benet's framework was appropriate for this study because it was an examination of services that should be available for all people and what possible reasons there may be that those services are not in place for one segment of people.

To further explore the theoretical framework and its relation to this study, Johnson's polarity management (1996) must be included as the conceptual framework since it is the model for the theoretical framework and is essential to the understanding of polarity thinking. Johnson (1996) developed polarity management by developing the generic mapping process through a series of demonstrations which revealed that current organizational management approaches could be untenable. This untenability is usually due to "either/or" thinking as a resolution to ongoing organizational issues. Johnson asserted that organizations tend to approach issue resolutions by identifying problems and attempting to solve them as if there is only one resolution to be accepted with all others rejected, or in that either/or thinking process. In some cases, this is satisfactory, but there are some problems that require more than this (1996).

Johnson stated that more often, there are problems where either/or thinking is not the correct approach. Those issues are dilemmas where the attempts at resolution go on indefinitely. Johnson defined these as polarities and suggested that one should look at each approach through its positive and negative lenses, or as a both/and supposition,

resulting in polarity thinking in managing issues (1996). There will be a more thorough explanation of both the theoretical and conceptual frameworks in Chapter 2.

Nature of the study

To address the research question in this study, which was to understand the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County, I performed a qualitative study. The specific research design was a generic study, for which I used semi-structured interviews through a researcher-created interview guide. For the interviews, I recruited 10 practitioners and four department heads at Alameda County departments responsible for direct services to the unhoused community. For the coding, I used descriptive coding, as described by Saldana (2016), using first and second-cycle coding. (p. 97). I also used a qualitative data analysis tool (QDA) for coding to assign color-coded labels to words or phrases in the data.

Researchers must have the ability to understand and articulate beliefs about the nature of reality, what can be known about it, and how we go about attaining this knowledge. These are descriptives of a research paradigm. A paradigm is defined as "a basic belief system and theoretical framework with assumptions about 1) ontology, 2) epistemology, 3) methodology, and 4) methods" (Rehman & Alharthi, 2018, p.1). Accordingly, the paradigm is what is used to enable a researcher's understanding of the reality of the world as well as a tool for studying it. (Rehman & Alharthi, 2018).

Researchers develop their data and subsequent research through various paradigms, which use a specific theory for basic understanding (Perera, 2018).

Research Paradigm

The primary research paradigms are (a) positivism, (b) post-positivism, (c) constructivism, and (d) pragmatism. For the purposes of this study, the research paradigm used was pragmatism. Pragmatism is used to focus on the idea of what works rather than what may be considered realistic (Frey, 2018). Cordeiro and Kelly (2019) stated that pragmatism is used to cross-examine and estimate the ideas, beliefs, and actual reality of practical functions.

Pragmatism consistently relates to a strategic examination focused on the resolution of existing problems (Inguaggiato et al., 2019) and is mainly used to explain specific processes that may bring resolution to specific situations (Ormerod, 2020). Specifically, the author stated

> The important point in pragmatic validity is that research is not "just" grounded in practice, but the research must also be useful for practice. Meaning, that the research is leading to new actions for either the person being researched, the person researching or the people reading about the research" (Ormerod, 2020, p. 808)

A pragmatic paradigm is a divided belief structure that impacts various categories of understanding investigations pursuing to gain conclusions based on the proof of the evidence obtained (Brierley, 2017).

Also, pragmatism was the chosen paradigm for this study for its ability and potential for opening organizational activity and developmental procedures (Kelly and Cordeiro, 2020), which was key to understanding the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County.

Study Design

Since this qualitative study was to understand the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County, the research goal was to gather the opinions of Alameda County staff that are involved with providing assistance to the unhoused community experiencing challenges in housing and behavioral health. Because I looked at the perceptions and experiences of Alameda County staff, the generic study design was the most appropriate.

I selected this design because, as Caelli et al. (2003) stated, “a generic study is not guided by an explicit or established set of philosophic assumptions in the form of one of the known [or more established] qualitative methodologies” (p. 4). Kahlke (2014) also suggested that when a study didn’t fall in a specific methodology or may bridge elements from more than one qualitative methodology, a generic study design might be the best approach. Additionally, as described by Kostere & Kostere (2021), “Generic qualitative inquiry investigates people’s reports of their subjective opinions, attitudes, beliefs, or

reflections on their experiences, of things in the outer world" (p. 78). As such, since this study was an inquiry and research study into practitioners' opinions, attitudes, and experiences regarding facilitators and barriers to the implementation of effective integrated coordinated care policies in Alameda County for the unhoused population, the generic study was the appropriate design for the study.

In this study, the semistructured interview or interview guide was the foundation of the generic inquiry and research study with the purpose of ensuring "the same basic lines of inquiry are pursued with each person interviewed" (Patton, 2015, p. 439). Patton stated further

> The guide provides topics or subject areas within which the interviewer is free to explore, probe, and ask questions that will elucidate and illuminate that particular subject. Thus, the interviewer remains free to build a conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style but with the focus on a particular subject that has been predetermined. The guide serves as a checklist during the interview to make sure that all relevant topics are covered. (p. 440).

In short, using this approach allowed me to explore lines of inquiry freely using the guide to ensure data legitimacy. This also allowed for follow-up questions as conversations were established. Patton discussed this follow-up approach, by stating, "Interview skills include asking genuinely open-ended questions; being clear so that the person being interviewed understands what is being asked; asking follow-up questions and probing, as appropriate, for greater depth and detail; and making smooth transitions between sections

of the interview or topics" (p.427). As the researcher, as part of the invitation, I asked to be able to contact anyone if I need to ask for additional information. In those cases, when a follow-up is asked, I included the question in subsequent interviews as well as contacted previous interviewees. According to Rubin and Rubin (2012), this would be considered responsive interviewing.

As previously stated, the research paradigm for the study was pragmatism and aided in the discussion of understanding the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County. I managed information biases through verification from other sources such as policies, particularly if stated there are existing policies. This is also called triangulation. I also reviewed my results with the participants to ensure there was proper representation of what they shared. If I felt even after this that my study demonstrated my own bias, I would document how this may have affected the study (Rubin and Rubin, 2012), which will be discussed later in Chapter 5.

Methodology

Creswell and Poth (2018) asserted that using a qualitative research methodology will help researchers to understand the problem, which for this study was to understand the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in

Alameda County. There are several methods associated with qualitative research, which are narrative, ethnography, grounded theory, case study, phenomenology, or generic study. To understand the selection of the generic study, I will explain the other closely related methods, phenomenology and narrative.

Phenomenology emphasizes what individuals encounter in their life experiences as they relate to a phenomenon (Creswell & Poth, 2018). Neubauer et al. (2019) also asserted that phenomenology supported the understanding and, as such, the foundation or focus of an individual's life encounters. Further, Heotis (2020) stated that phenomenological research discusses people's experiences and what comes from any individual's outcome as it pertains to a phenomenon. Also, the author concluded that phenomenology emphasizes the focus on an individual's concept or idea relating to professional development since it is the evaluation of all the participants or groups that are a part of the phenomenon (Heotis, 2020). Phenomenology could be the appropriate design since this approach relates to the lived experiences of individuals providing an extensive amount of knowledge of a main event or phenomenon related to a group of individuals such as the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County (Qutoshi, 2018). A phenomenological approach could also involve the individuals who have experienced the phenomenon under examination, integrated coordinated care policies in Alameda County, which can be found to be a problematic issue (Creswell & Poth, 2018). Despite all of this, this study

sought to primarily understand the perceptions of the direct service providers or practitioners and policy makers or department heads as opposed to individuals receiving the services or having the lived experience of the barriers or facilitators. Accordingly, phenomenology deals with an explanation of the phenomenon, while seeking to understand the phenomenon from a first-person point of view (Miskir, 2021). As such, phenomenology was not the best methodology for the study.

A narrative approach "is a study that subsumes a group of approaches that in turn rely on the written or spoken words or visual representation of individuals. These approaches typically focus on the lives of individuals as told through their own stories" (Concordia Seminary, LibGuides, 2023, para. 1). Clandinin & Connelly (2000) defined it as "a way of understanding and inquiring into experience through "collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus" (p. 20). Overcash (2003) also stated,

> Narrative research can be defined as collecting and analyzing the accounts people tell to describe experiences and offer interpretation. Narrative research provides an option to explore personal experiences beyond the boundaries of a questionnaire, providing insight into decisions involving treatment, screening, or various health practices, which can help guide how health care services are developed and provided. (p.1).

In short, narrative research is used to focus on the experiences of individuals through their lived experiences in a particular environment. Accordingly, narrative research could be used to study the perceptions of key practitioners and department heads regarding the

barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County. Yet, the interviewees in this type of study would be the individuals receiving the services, not necessarily the providers or those determining policies as it was for this study.

Also closely related, the generic qualitative methodology, as defined by Kahlke (2014) with additional information from Caelli et al. (2003) is "clearest when it is defined in the negative: it is research that "is not guided by an explicit or established set of philosophic assumptions in the form of one of the known [or more established] qualitative methodologies (Caelli et al., 2003, p. 4)" (p.13). As such, this method will allow for open-ended questions in semi-structured interviews, the chosen interview instrument, which, according to Rubin and Rubin (2012), should result in rich data from the practitioners' and department heads' experiences. This resulting rich data would be best for this study to provide an understanding of the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated, coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County. Because of this, the generic method was the selection for the study.

Triangulation

In this qualitative study, triangulation was important in its application to discovering and applying critical interviews to gain insight into the issue of the research, which was to understand the perceptions of key practitioners and department heads

regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County (Noble & Heale, 2019). Dawadi et al. (2021) defined triangulation, stating, "Triangulation, as a qualitative research strategy, is the use of multiple methods or data sources to develop a comprehensive understanding of a research problem or to test validity through the convergence of information from different sources" (p.27). For this study's purposes, triangulation was used to ensure that the study was enriched with the most valid information possible, using other information, such as policies and directives, to compare the information. As the researcher, I also used my own notes regarding policies since I work in the environment and had access to several parts of information (i.e., appropriate data etc.)

Definitions

FSP: Full-service partnership is a cross-organizational and multi-services approach to mental wellness (CA.gov, 2024).

Homeless/homelessness: "someone who lacks a fixed, regular, and adequate night-time residence" (HUD, Ahuja et al. 2020).

Integrated coordinated care: a system of care that would provide assessment and referrals that prioritize health care, housing, and job placement for people experiencing homelessness (Ecker et al.., 2022).

PEH: "persons or people experiencing homelessness" (Biederman et al., 2022, p. 1337), is synonymous with the phrase, unhoused (see below).

PSH: Permanent supportive housing "is defined broadly as subsidized housing matched with ongoing supportive services" (Biederman et al., 2022).

Rough sleepers: a term from England for those sleeping on the street (Clark et al., 2020).

SUD: "substance use disorder" (Biederman et al., 2022, p. 1337).

Recidivism (also institutional recidivism): "repeated inpatient psychiatric stays, detention in jails and prisons, and homelessness" due to behavioral health challenges (Reed et al., 2014, p. 25).

Unhoused community: people who are homeless, or in transitional housing (i.e., shelters) (Ahuja et al., 2020)

Assumptions

For this qualitative study, I selected the generic study design because a generic study is "not guided by an explicit or established set of philosophic assumptions in the form of one of the known [or more established] qualitative methodologies" (Caelli et al., 2003, p. 4). Also, Kahlke (2014) suggested that when a study didn't fall in a specific methodology or may bridge elements from more than one qualitative methodology, a generic study design might be the best approach. Since the study was to understand the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County, I researched the opinions of Alameda County staff that were and are involved with providing assistance to the unhoused community experiencing challenges

in housing and behavioral health. Accordingly, the study was as described by Kostere and Kostere (2021) who stated, “Generic qualitative inquiry investigates people’s reports of their subjective opinions, attitudes, beliefs, or reflections on their experiences, of things in the outer world” (p. 78). As such, since a generic study is used to research such things as people’s personal opinions about a subject, this was the appropriate design for the study.

Because I sought to understand the facilitators of and/or barriers to implementing effective integrated coordinated care policies in Alameda County, my epistemological assumption was that it is important to get the perceptions of these practitioners and department heads that have been providing care to the unhoused community. This information may lead to important information for developing a countywide policy.

Also, by gathering the data on their perceptions, there was an ontological assumption that these stakeholders could have some solutions that might lead to the implementation of an integrated coordinated care policy for Alameda County. Because their perceptions could be a realistic representation of the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County, it was important to capture information regarding their experiences with providing care. It was also important to capture what the stakeholders believed or perceived regarding a countywide policy that could either improve or worsen the care for the unhoused population.

The axiological assumptions were that the 10 values listed as five pairs (freedom–authority, justice–due process, diversity–equality, human rights–communal obligations, and participation–representation) in the polarities of democracy theoretical framework were and are essential for understanding the necessity of an integrated coordinated care policy in Alameda County. This assumption would also be to make sure the policies work for the unhoused population experiencing housing and behavioral health challenges. Accordingly, it was my methodological assumption that gathering perceptions and beliefs from key stakeholders in Alameda County through a qualitative perspective would be useful for generating ideas for the implementation of an integrated, coordinated care policy for the unhoused community experiencing housing and behavioral health challenges, which could lead to positive social change.

Scope and Delimitations

The scope for this study was informed by the research question and encompassed the key practitioners and decision-makers in organizations with policies that impact the unhoused community, specifically those who have received and are receiving behavioral health services in Alameda County. Key practitioners included nurses, physicians, social workers, and staff members in roles that provide services. This also included community health workers, quality managers, and administrative staff. Decision makers were department heads such as the sheriff and/or her management, county organization executives, or city executive management, where the city is within Alameda County.

Exploring perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective

integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County was a preliminary delimitation. Another factor was the semistructured interview utilized for the study, which was primarily completed within an initial interview but, if necessary, follow-up interviews. There were 14 requested interviews, consisting of key practitioners and decision-makers, who will be recruited via targeted emails (access to email addresses) and social networking posts (i.e., LinkedIn).

Limitations

Since I researched integrated coordinated care for unhoused behavioral health recipients in Alameda County, I wanted to get the most accurate information while providing respect for its participants. Yip et al. (2016) stated that the researchers must protect the integrity, privacy, and confidentiality of participants in research. My concern during the study was that those tenets, particularly data integrity, would be breached to make sure that the organization or department appears to be living up to what they stated they were providing for federal or grant funding.

Summary

As stated, the study's focus was to explore and understand the policy barriers and, conversely, facilitators, practitioners, and department heads for service institutions face in implementing integrated, coordinated care for unhoused behavioral health recipients in Alameda County. There have been services provided to the unhoused community in Alameda County for over 35 years; however, there is no concrete evidence of a cross-organizational policy or integrated coordinated care policy or any consensus as to why this has not been accomplished. Accordingly, the specific research problem addressed

through this study was it is not known what policy barriers, and conversely, facilitators and practitioners in clinical and penal institutions face in implementing integrated coordinated care for unhoused behavioral health recipients in Alameda County. The study's research problem was as follows: what are the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County? Assumptions, the scope, delimitations, and limitations were explored in this chapter. The literature relating to the research will be discussed in Chapter 2.

Chapter 2: Literature Review

Introduction

In Alameda County, departments and organizations have continually provided mental health services to unhoused behavioral health recipients to reduce high service utilization and increase behavioral health stabilization, thereby attempting to lower the number of people facing housing challenges or instability. Despite this effort, which may have been developed based on a possible awareness of the proposed effectiveness of an implemented integrated, coordinated care policy for the county, homelessness for specific behavioral health care recipients remains ongoing and unsolved.

As mentioned previously, the interest of this study was to understand the efficacy of providing unhoused behavioral health clients in Alameda County with high emergency room service utilization as a treatment plan with a cross-organizational policy that provides coordinated care. The study's purpose was to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. These stakeholders included health care practitioners, social workers, and organization/department heads. The policy's focus could include using tools such as supportive and robust transition plans as described through data collection. These plans may ensure clients' successful transition into a sustainable stable environment as opposed to relying on hospitals and jails to provide uncoordinated episodic care, which may be supported or argued against in some of the literature.

Literature Search Strategy

The literature review for this study was conducted in four domains, specifically behavioral health, homelessness, recidivism, and their intersection. The libraries and electronic databases searched were ProQuest, OApen, Jstor, Walden Thoreau, Open Athens, Sage PUB, PubMed, eScholarship, and EBSCO, which resulted in peer-reviewed, scholarly journals and articles. The specific search terminology used included: *high service utilization, homelessness, mental health, behavioral health services, integrated care, recidivism, jails, penal systems, hospitals, care facilities, public policy,* and *coordinated care.*

Recidivism, as a search term, was too broad in terminology, which returned an inordinate amount of relevant, but more often irrelevant articles and journals referring to criminal behavior. The review showed the existence of recidivism across many different fields, particularly articles or journals with the central topic of criminal recidivism. Criminal recidivism does play a part in the study as it pertains to high service utilization but does not capture this study's proposal of understanding the efficacy of providing unhoused behavioral health clients in Alameda County who frequently use emergency rooms as a treatment plan with a cross-organizational policy that provides coordinated care. When coupled with behavioral health and hospitals, the result became more focused on the study's problem and purpose. The most referenced were PubMed, SAGE, and Jstor, which had multiple articles involving policies regarding integrated, coordinated care policies. Thus, the goal of the review was to research literature that would support a study that could result in a positive policy application for the unhoused community,

which could then create a significant positive social impact. Accordingly, a total of 109 articles were found relevant to this specific study and were discussed in the following conceptual sections.

Theoretical and Conceptual Framework

For my framework, I used Benet's polarities of democracy. In the polarities of democracy theoretical framework, Benet (2006, 2012, 2013) addressed the "five interrelated polarity pairs" (2013, p.1), which directly informed this study. To further understand the theoretical framework and its relation to this study, Johnson's polarity management (1992) must be included as the conceptual framework since it is the model for the theoretical framework and is essential to the understanding of polarity thinking.

Polarity Management

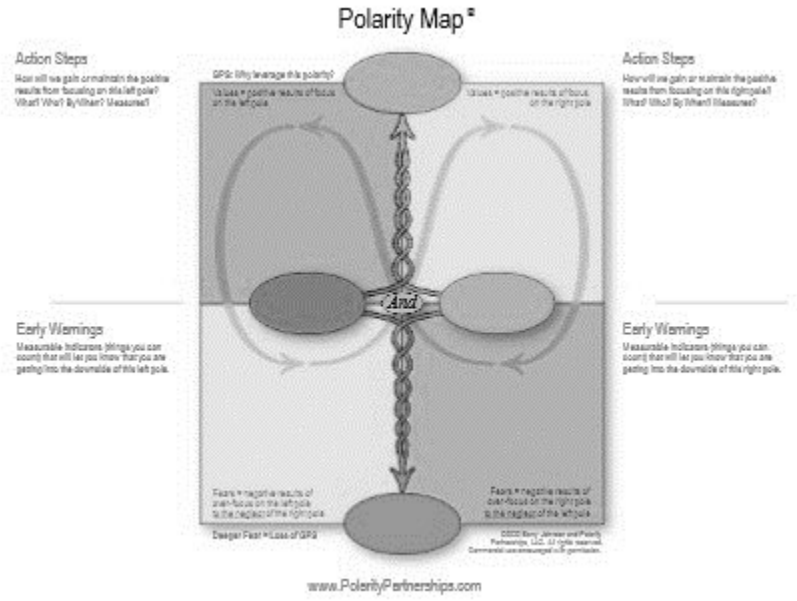
Johnson (1992) developed polarity management by developing the generic mapping process by demonstrating that current organizational management approaches could be untenable. In these approaches, managers and staff identified issues and attempted to solve them through a series of attempts and failures through organizational processes designed to be solved with a single right answer or either/or thinking. Johnson asserted that while there are issues that can be solved using either/or thinking, there are other issues that cannot be solved in this way. He stated that there are some predicaments that have more than one right answer and are interdependent. As such, these dilemmas are considered polarities. Johnson asserted when dealing with a polarity, you cannot accept one thing as a solution and reject or neglect another because polarities and their

solutions cannot act independently. As such, he stated there is a necessity for both/and thinking (1992).

Johnson stated that both/and thinking is necessary to managing polarities because of their interdependence. Accordingly, he asserted that one is looking to get the most from the positive aspects of each solution and avoid the negative aspects of each as well. To accomplish this, Johnson developed a process, the polarity map, as shown in Figure 1, and techniques to demonstrate how to manage them (1992).

Figure 1

Generic Polarity Map



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Johnson's polarity mapping is an approach to using both/and thinking by developing a pole for each side of the argument. Using positive and negative aspects of

each, Johnson developed a four-quadrant framework to identify the benefits and costs of focusing on one favored pole without acknowledging the opposing views, both positive and negative, as shown in Figure 3. By using the process applied to the generic map, participants have a visual representation of each view, which can facilitate discussion to reconcile different points of view (1992). This process has allowed users to see those polarities in opposing pairs or parts of the puzzle, developing a cross-identification that incorporates both strengths and weaknesses into what becomes an infinity loop.

This resulting looping can be higher in the upper quadrants or on positive aspects of the pair, signifying the maximization of the positive quadrants. In other words, this is to accentuate the positive. The lower part of the loop is smaller in the negative quadrants, demonstrating the effort to minimize the negative aspects of the pair. It also shows the interdependence of the pair, which can be further developed into a plan for effective management (1992). This is true with a pair that is effectively managed; however, this is not always the case.

Johnson also demonstrated the effects of poorly managed polarity pairs in the mapping. This is demonstrated when the loop is extending lower in the negative aspects of the pair because the polarity may still be viewed in an either/or aspect. In this case, it is not being managed as polarity, but still as a problem to solve. In this regard, there is an attempt to eliminate negatives, but instead of achieving a win/win supposition, there is a loss for both sides (Johnson, 1992).

Using Johnson's polarity management as a foundation for his research and analysis, Benet developed his theoretical framework, the polarities of democracy, which

will be the theoretical framework for this study regarding integrated coordinated care policies for the unhoused population in Alameda County.

Polarities of Democracy

As previously stated, I chose Benet's theoretical framework, The polarities of democracy as the study's framework. Benet developed this theory while researching his dissertation on workplace democracy at the University of Toronto in 2006. He continued developing the framework during his time at the university as an adjunct professor and as the Executive Director of the Rochester–Toronto Community/University Partnership Project CUPP). In developing a unifying theory of democracy, Benet created his theory following Bohman's description of critical theory (2012). Bohman stated, "a theory is critical to the extent that it seeks human emancipation ... decreasing domination and increasing freedom" (Benet, 2013, p.27, para. 1).

Benet continued to refine his theoretical framework through several iterations, where he continued to apply his theory to other life aspects to promote positive social change, which was critical to this study (Benet, 2012, 2013, 2022, 2023). Benet also used Johnson's polarity management as the conceptual framework for his theory. By using this framework, Benet concluded that leveraging his theory effectively would promote and enhance "democratization in order to overcome oppression in the workplace and in society" (POD, 2023, para. 2). Benet found that for his theory, there were specific paired values that were interdependent because one value could operate well without the other. He developed these as polarity pairs. To explain further, Benet (2006, 2012, 2013, 2022, 2023) detailed how the polarity pairs were developed, and were shown to apply to

government-driven approaches or communities, which, for this study, was Alameda County public policies related to the unhoused community.

As shown in Figure 2 below, Benet developed "ten paired values: a) freedom and authority; b) justice and due process; c) diversity and equality; d) human rights and organizational obligations; and e) participation and representation" (2013) as the polarity pairs for his framework. Based on Benet's assertions, these pairs were interdependent and necessary to establish the arguments regarding workplace democracy, following Johnson as the conceptual framework. He made this identification to signify the pairs that could best "maximize the abilities and achievements of both the individuals within the organization as well as the organizations while eliminating the oppression and inequality that occurs when some individuals wield unchecked power over others" (p. 70).

Figure 2

The Polarities of Democracy Theory as an either/or Solution to Oppression, with the Ten Values Arranged in Their Polarity Relationships

Note: Image reproduced with permission of the Polarities of Democracy Institute

In continuing his research in 2012, Benet continued to draw and demonstrate that the five value sets, including the amended participation and representation, were polarities by exploring their interdependence with one another and function as individual polarity pairs. Examples of the questions Benet analyzed and answered the following, drawing from Johnson (1992):

1. "Is the difficulty ongoing?" (p. 81).
2. "Are there two poles which are interdependent?" (p. 81).

Benet applied these answers to the proposed pair, along with other qualifying aspects of polarities, to determine that participation and representation were a polarity pair. Even still, the pair met the criteria for a polarity pair and became part of the elements of the theory as the final pair. In the following figures, each pair of the framework is shown in a polarity map that identifies the positive and negative aspects for each value. In reference to the maps, Benet (2023) also stated,

> Basic Maps represent just one example of the potential positive and negative aspects of each of the ten values that make up the five Polarities of Democracy pairs. They should not be thought of as the only possible positive or negative aspects of the ten values contained in the theory. Nor should the higher purpose and deeper fear associated with an individual pair be thought of as the only possibility. Students reading my original dissertation research, or conducting their own research, can find dozens if not hundreds of other examples of positive and negative aspects that could be used in the appropriate quadrants of each pair along with an appropriate higher purpose and deeper fear. (p. 21).

Also, Benet et al. (2022) also stated, regarding the maps,

> Please remember that to fully achieve the promise of democracy for all people, you must embrace all ten values and all five pairs. The five pairs are all interrelated and failing to effectively leverage any one pair is certain to negatively impact the ability to effectively leverage the other pairs. While using the full theory, for the purposes of a dissertation, it is permissible to focus only on one or more of the five pairs. (p. 17)

For my study, I have shown all five maps below in Figures 3-7 as I used all five maps in Chapter 5.

Figure 3

A Polarity Map for Identifying Basic Positive and Negative Aspects of the Freedom and Authority Polarity Pair of the Polarities of Democracy's Ten Values

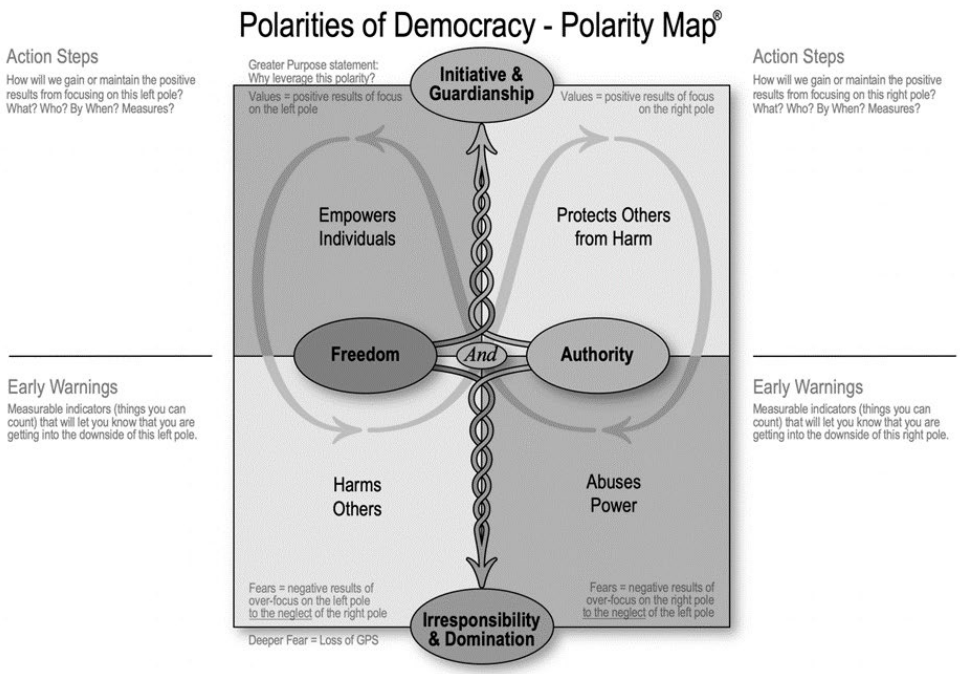

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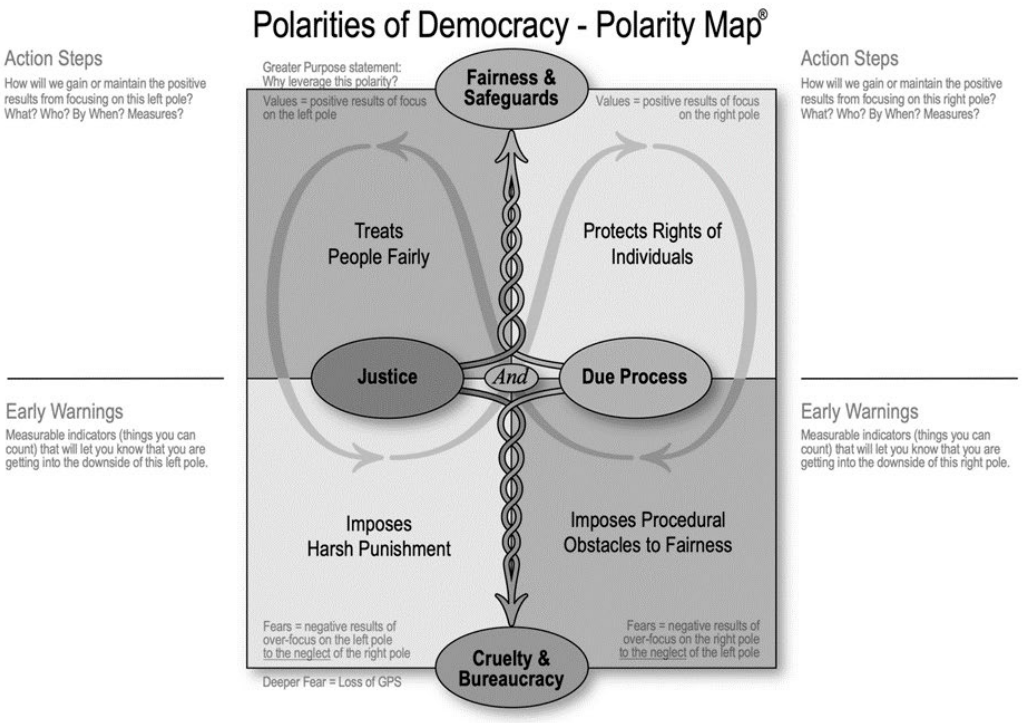
Figure 4

A Polarity Map for Identifying Basic Positive and Negative Aspects of the Justice and Due Process Polarity Pair of the Polarities of Democracy's Ten Values



Note: Image reproduced with permission of Polarity Partnerships LLC and the Polarities of Democracy Institute

Figure 5

A Polarity Map for Identifying Basic Positive and Negative Aspects of the Diversity and Equality Polarity Pair of the Polarities of Democracy's Ten Values

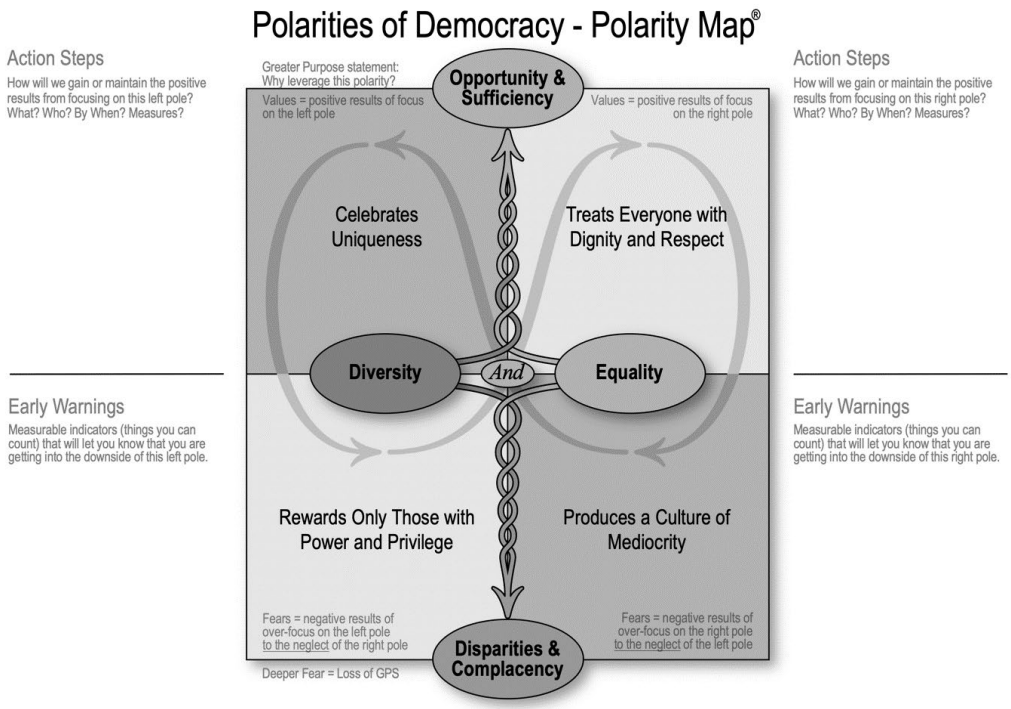


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Figure 6

A Polarity Map for Identifying Basic Positive and Negative Aspects of the Human Rights and Communal Obligations Polarity Pair of the Polarities of Democracy's Ten Values

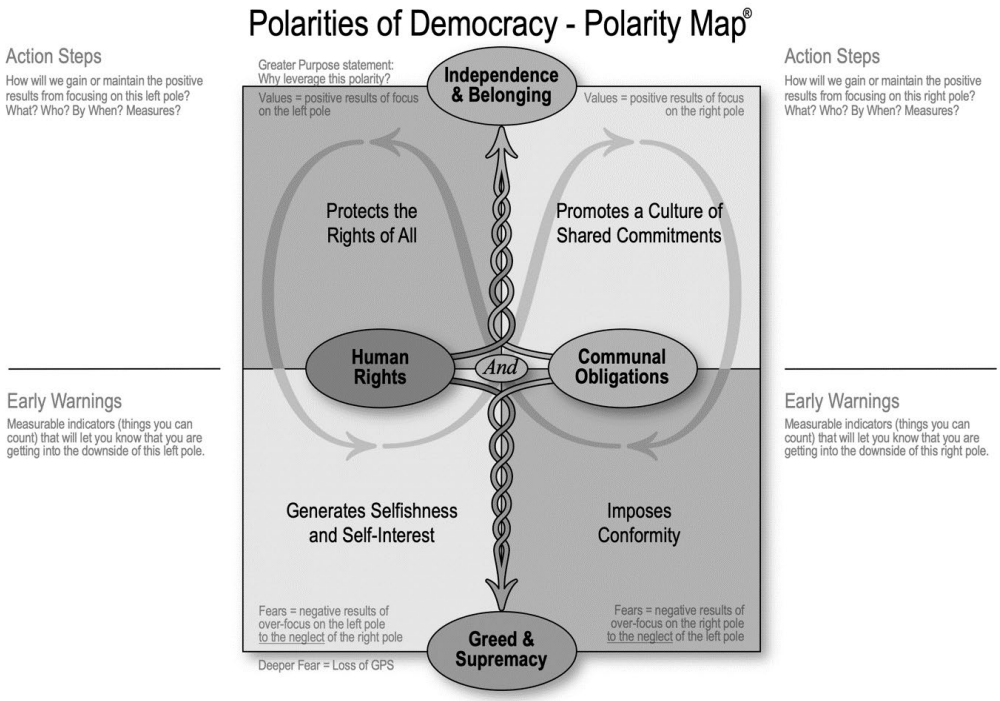

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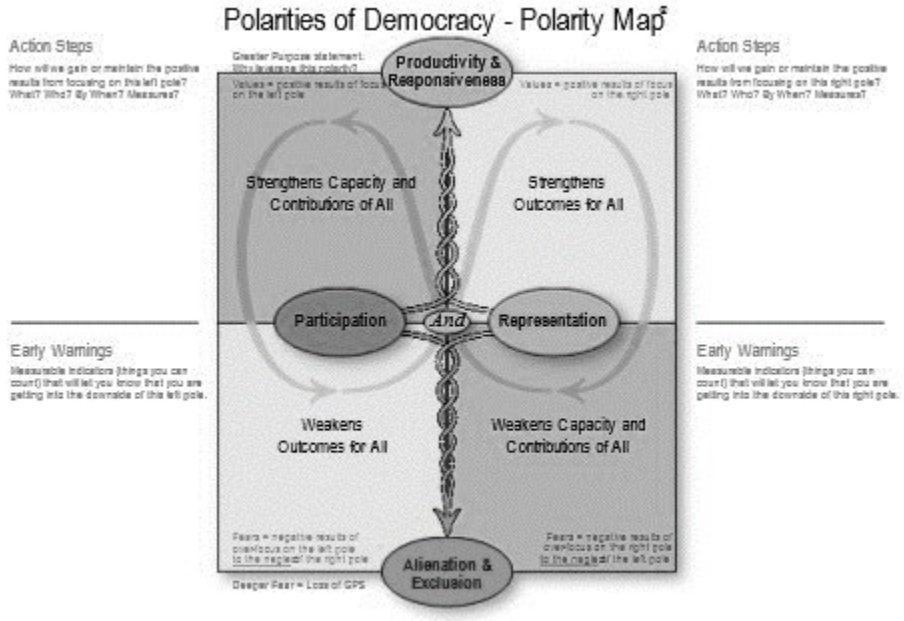
Figure 7

A Polarity Map for Identifying Basic Positive and Negative Aspects of the Participation and Representation Polarity Pair of the Polarities of Democracy's Ten Values



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In further exploration of his theoretical framework, Benet (2013) stated that "additional key findings suggested by the research of the literature include (a the concepts of democracy arose from our emerging consciousness as part of our evolutionary development, b) the fundamental purpose of these emerging concepts of democracy was to overcome oppression, c) the principles of democracy have universal applicability to all cultures and time periods, d) the predominant Western philosophy of utility ignores the role that human altruism plays in our evolutionary (and democratic) development, e) our societal origins provided a more democratic relationship between men and women than the patriarchal societies that have dominated modern history, f) these patriarchal societies have prevented us from attaining a full expression of democracy on a national or global level, and g) if true democracy is to be attained, then these 10 polarity elements must be managed effectively in order to maximize the positive aspects of each element while minimizing the negative aspects of each element (Benet, 2006, 2012b)" (p.32).

Benet (2013) asserted that these findings suggest that this framework can be used in positive social change efforts for healthier and just communities (p. 32). He stated in his findings that, "Further research using the polarities of democracy model as a theoretical framework for social change might serve both to guide the development of strategies and actions designed to create healthy, sustainable, and just communities as well as to generate data that indicate the effectiveness of social change efforts. The model might be particularly useful for participatory research efforts" (2013, p. 35).

Benet (2023) also discussed four tests used to test the polarities of democracy's validity and utility. These four tests were applied to the original research as well as each iteration of ongoing post-doctoral research (Benet 2012,2013, 2021,2022, 2023). He stated, "The first test asks if there is broad support for each of the values of my theory by asking the question: Is there a significant body of literature where advocates argue that an element contained within my theory is an essential element of democracy? The test seeks to ensure that each element of the theory is identified as an essential element of democracy by a significant segment of the theorists writing about democracy in any of the five categories of democratic literature" (2023, p. 3)

Benet explained further that the second test examined the extent to which his theory is consistent with Johnson, using his 1992 Polarity Management edition. Benet stated he drew from Johnson's two criteria for determining whether the issues are either/or propositions or problems that have resolutions or polarities that can be managed. Benet also stated that he also looked at Johnson's twelve traits which he believes are characteristics of polarities (Benet 2006, 2012, 2018). From there, Benet stated he used "these criteria and traits as 14 questions to examine whether a polarity relationship exists" (2023, p.3).

Benet (2023) went on to state that, "The third test applied to the polarities of democracy theory was to determine the extent to which the theory was consistent with the five exemplary models drawn from the five interrelated categories of literature (plus my more than 30 years of organization development experience as an adult education

administrator attempting to implement workplace democracy) that I used for my doctoral and post-doctoral research." He listed the five exemplary models as being:

1. The Managerial Grid Theory (Blake & Mouton, 1985),
2. The Decalogue of Democratic Civic Values (Butts, 1980),
3. The Workplace Democratization Model (Bernstein, 1976),
4. The Democratic Worker Owned Firm (Ellerman, 1990), and
5. The Demand/Control Model (Karasek & Theorell, 1990).

Benet (2023) stated that the "research findings suggest that (a) each of the significant concepts contained in the exemplary models are incorporated within the polarities of democracy theory; (b) there are no significant concepts within their models that are incompatible with the polarities of democracy theory; and (c) the polarities of democracy theory strengthens each of these models" (p.3).

Benet (2023) additionally stated that the fourth test applied to the theory is consistent with the major assumptions defined in the original doctoral research (Benet, 2006). He stated, "In order to assess the face and content validity of my theory, I developed seven questions that grew out of the assumptions that I made regarding democracy based on the findings from that research". In all, the polarities of democracy theoretical framework were consistent with all tests and assumptions that tested its utility and validity (p.3).

Benet's theory has also been used in twenty-six different studies that were focused on positive social change. Examples of these studies include a wide range of subjects, including epidemiology and criminology as it pertains to the contribution to or

the detraction from the reduction of gun homicides by youth in U.S. urban areas (McMillan, 2020) and the poverty-conflict nexus in Northeast Nigeria and the effect that the activities of Boko Haram have had in that area (Agbormbai, 2021). The topics that have utilized Benet's theoretical framework have been rooted in subjects encompassing interdisciplinary aspects as varied as public health, criminal justice, and environmental law and as such can be used to inform studies where it is necessary to look at aspects of the issue within public policy.

One of these studies was on the perceptions of homeless shelter staff workers on chronic homelessness (Griffith, 2017). The study was conducted in two shelters in New Jersey. Griffith's study had some similar themes as this study. One of the similar themes was that the lack of resources and the knowledge of resources has a bearing on an individual struggling with homelessness. There were also discussions about the unhoused community's struggles with behavioral health challenges, including substance use disorder. Griffith found that the polarities of democracy and polarity management were essential to his research, in that there was value in exhibiting the effects of the balancing of the poles for the study. Based on his research, homelessness is and of itself is a polarity and can be managed, not necessarily solved, which this study's results may also support.

Another study was dissimilar to this study. Moran (2022) examined small and midsize business corporate lobbying. His study could not be any more different; however, his work accurately applied Benet's theoretical framework. It was aptly applied to a study that examined when businesses that could have revenues up to $1 billion, which may not

lead most to think of democratic attributes. Yet, Moran's study (2022) demonstrated that there were disparities in treatment for these executives who may need to resort to lobbying to receive fair treatment from the government. There are several others, but I pointed these two out because of the range of topics that have used the polarities of democracy as the theoretical framework.

The logical connections between the theoretical and conceptual frameworks presented and the nature of this study included understanding why Alameda County does not have cross-organizational coordinated care policies and processes that would provide positive outcomes for health, occupational, and environmental stability. As such, I focused on all five interrelated pairs of the polarities of democracy framework, as they were used to demonstrate the possible barriers and facilitators for this study. For the purposes of this study, the pairs were used to explore the polarities regarding mental health services, homelessness, and the proposed management tool of integrated coordinated care. The sections where this will be examined through current literature will be:

1. Homelessness
2. Behavioral Health Disorders
3. Substance Use Disorders
4. Integration of Issues
5. High Service Utilization for Behavioral Health Crises
6. High Service Utilization for Substance Use Disorder
7. Integrated Coordinated Care

8. Government Organizations and Policies
9. Disparities by Race, Gender, and Class

Literature Review Related to Key Variables and/or Concepts

Homelessness

Homelessness was a key factor for this study. The unhoused community, who will be the focus, is defined as "people who are homeless, or in transitional housing (i.e., shelters) (Ahuja et al., 2020)". Homelessness, for the purposes of the study, was defined as "someone who lacks a fixed, regular, and adequate night-time residence" (HUD, Ahuja et al. 2020), which would include those "living in temporary accommodation and hostels as well as rough sleepers and 'sofa-surfers'" (Clark et al., 2020, p. 1). Due to these circumstances, the unhoused community often struggled with additional challenges such as behavioral health crises and substance use disorders. Providing these two definitions demonstrated for this study that the factor of homelessness is not a monolithic subject. Its root causes were often multiple, varied, and often compounded and as such, continue to be so (Lee et al., 2021).

According to Ahuja et al. (2020), they found in their research that homelessness was a cause of poor health among the unhoused community as well because of the same. The authors also asserted that while homelessness was a cause, initial health and behavioral health challenges were contributors to the resulting homelessness as well. As such, these factors proved to be a circular issue, with behavioral health challenges resulting in homelessness, but homelessness also exacerbated the behavioral health challenges. This appeared to be a theme throughout many journals.

To further illustrate that point, Sleet and Francescutti (2021) stated that homelessness has a direct correlation to both physical and mental health challenges. The authors also reiterated the circular aspect with homelessness, in that with declining health, there is an uptick in emergency room visits. With those visits, once a person has been treated, there was no choice but to release the person back into the state of homelessness, which began a cycle of emergency room visits and release. That cycle impacted both the facility, through increased costs and resources for each subsequent visit, and the person receiving care because of the lack of a stabile living environment.

Accordingly, many organizations have determined to look at homelessness as an either/or dichotomy, with the resolution being one of housing first policies. Even so, when researching the literature, several researchers discovered that this approach may be shortsighted. Sandu et al. (2021) stated that housing first policies, without other support such as reestablished relationships and solid alliances with workers, did not always ensure that those served would remain housed. Additionally, Tsai (2020) stated that without other services, housing first initiatives are not always successful in that there have often been other needs (clinical, mental, and substance use) that need to be addressed as well. Both studies pointed out that the additional services are voluntary, and both also stated that in many cases, this may not be the best approach.

In short, housing was an essential component to the unhoused population, but there were other needs that needed to be addressed simultaneously, such as behavioral health challenges and substance abuse.

Behavioral Health Disorders

Behavioral health disorders can often be a critical challenge to persons experiencing homelessness, changing their status to housed persons, and as such were another key factor for the study. Accordingly, Baker et al. (2018) explored access to behavioral health care for the unhoused community, as well as those facing the risk of homelessness. The authors described that there were contributors to gaps in care for people with behavioral health challenges, with the primary issue for the gap being inadequate coordinated care. They stated that this inadequacy resulted in overuse of emergency rooms and penal facilities for care, as opposed to receiving coordinated care. In another study that focused on palliative care in Rhode Island, Simpson et al. (2023) also stated that people experiencing homelessness often had higher rates of behavioral health issues and often received health care later, resulting in more severe crises and unpredictable outcomes. Moulin et al. (2018) concurred with Simpson and Baker, stating, "Patients with mental illness face barriers to consistent outpatient care. Mental health services tend to be difficult to access and poorly integrated with primary care" (p. 903). While also concurring with Moulin's assessment, Padgett (2020) also offered additional evidence regarding this.

Padgett (2020) offered that there is evidence of a bidirectional relationship between behavioral health challenges and the unhoused community. She asserted that while behavioral health has been a factor for those experiencing homelessness, the effects of being homeless also impacted people's mental states. Echoing that assertion, Lamparter et al. (2021) found in their study that many of the unhoused used the

emergency room for behavioral health challenges, agreeing that the diagnoses often were the result of the state of homelessness. Additionally, in her study, Padgett (2020) referred to Maslow's hierarchy of needs that stated, for those purposes, "fundamental human needs must be met in order to satisfy higher-order needs such as belonging and self-actualisation" (p 199).

Within her work, Padgett (2020) cited several works that looked at the other major factor that affected the unhoused community in tandem with behavioral health challenges, substance use disorders.

Substance Use Disorders

As previously stated, substance use disorders can also be a challenge, but in many cases are in tandem with or co-occurring with behavioral health challenges for the unhoused community. For example, Moulin et al. (2018) stated in their study when people visited the emergency room, substance use disorders often were co-occurring with mental health issues, with homelessness showing as a lesser factor. These co-occurring situations can be that substance abuse is either a contributing factor to becoming homeless or it is the result of being homeless (Nicholas and Urada, 2021). Jurewicz et al. (2022) stated this directly, "Homelessness and substance use have a well-known bidirectional relationship, with substance use noted as both a cause and consequence of homelessness" (p.2).

In contrast, Vohra et al. (2022) stated that substance use alone was one of the primary factors for the unhoused community to seek services, without necessarily commenting or establishing whether the substance use came prior to becoming homeless

or because of the unhoused status. The authors did state that substance misuse is attributed to higher rates of mortality for the unhoused community. Accordingly, substance use disorders can not only affect a person's housing status, but it can also affect the mortality rate within the unhoused community.

Additionally, Jurewicz et al. (2022), in observing the role of social relationships in the unhoused community as it related to substance use, found that substance use often occurred in the unhoused community because of several ongoing themes representing loneliness or solitude: "strain in relationships, limited availability of resources from social relationships, the sometimes negative impact of social relationships on substance use, and the interrelationship between substance use and isolation both early and later in life"(p. 8). Because of these issues, people experiencing homelessness were often in a cyclical phase, using substances that fractured or dissolved relationships, continuing that use due to feeling isolated, and using hospital emergency rooms for social interaction.

Integration of Issues

With the focus of the study being to explore and understand the policy barriers, and conversely, facilitators, practitioners and department heads for service institutions face in implementing integrated coordinated care for unhoused behavioral health recipients in Alameda County, it appeared that when the three key factors of homelessness, behavioral health crises, and substance use disorders combined for the unhoused community, circumstances were extremely difficult and the lack of a coordinated policy became apparent. It also demonstrated that the more these issues are

co-occurring, the people experiencing these integrated issues had a plethora of critical problems that they were facing and for which they would need assistance.

As pointed out by Moulin et al. (2018), when people visited the emergency room, substance use disorders often were co-occurring with mental health issues, with homelessness showing as a lesser factor; however, the authors also pointed out that when looking at frequent users of emergency room services in San Diego, California, the three factors of homelessness, substance use, and mental issues were more likely to be present and occurring together, which created complicated issues that needed to be addressed. Padwa et al. (2022) concurred with this assessment, stating, "People experiencing homelessness had greater frequency of primary substance use prior to entering treatment, greater emergency room and hospital utilization, more criminal justice involvement, and greater prevalence of mental health diagnoses and unemployment" (p. 6). Lamparter et al. (2020) asserted the same, stating that because of a lack of ongoing resources, the unhoused tended to have more psychiatric diagnoses, substance use, and often incapable of getting additional resources due to fear of discrimination regarding their housing status. Lamparter et al. (2020) stated specifically, "Homeless patients also face many barriers to obtaining primary care, including fear of stereotypes and discrimination, difficulty presenting proof of insurance, transportation issues, and scheduling problems" (p. 1317).

Additionally, Padwa et al. (2022) found that people experiencing homelessness, or the unhoused, were more likely to have co-occurring substance and mental health challenges and as such were more susceptible to infectious diseases that could lead to

early mortality. They also pointed out, without intervention, the unhoused dealing with these co-occurring issues, even if they received housing, will more than likely become homeless again with treatment.

To further illustrate the issue, Alameda County, along with other California counties, attempted a pilot program to address the integration of issues. It was called the Whole Person Care initiative, which started in 2016 and ended in 2018 for Alameda County. The Whole Person initiative was a $3 billion Medicaid Section 1115(a) waiver demonstration project focused on improving the integrated delivery of health, behavioral health, and social services for Medicaid beneficiaries who use acute and costly services in multiple service sectors, such as emergency rooms and penal facilities (Tong et al., 2022). Chuang et al. (2020) found in their study of the Whole Person Care initiative that it had multiple issues. There were challenges with partner engagement. The strategies included proactive and consistent communication, clarifying mutual goals for shared clients, formal contracts, and financial incentives for clients. Data sharing, identifying eligible beneficiaries, engaging beneficiaries in care, access to affordable housing, and access to other services were also identified as issues in this study.

The literature discussed in this section supported the study, which was to explore and understand the policy barriers, and conversely, facilitators, practitioners and department heads for service institutions face in implementing integrated coordinated care for unhoused behavioral health recipients in Alameda County.

High Service Utilization for Behavioral Health Crises

For this study, the social problem that prompted the literature research was that for over thirty-five years, Alameda County's departments and organizations have continually provided outpatient services to unhoused behavioral health recipients to attempt to increase mental health stabilization. Even though this service has been performed, high service utilization or emergency room service utilization in hospitals remained ongoing and unsolved. In research literature to support this assertion, a study by Moulin et al. (2018) stated that patients who were homeless, using substances, as well as those insured by Medi-Cal, California's Medicaid program, were more likely to be frequent users of local emergency rooms for behavioral health crises. Moulin et al. (2018) also asserted that this suggests substance use and lack of housing are important factors to consider when dealing with patients with a high frequency of emergency room visits for assistance with mental health needs (p. 905).

Also, in another study regarding emergency room visits and how emergency room education could be effective, Del Buono et al. (2022) stated that in order to provide effective treatment for unhoused patients, their housing designation must be captured during the frequent visits to the emergency room. Del Buono et al. (2022) stated, "Patients experiencing homelessness comprise a common and vulnerable population in emergency medicine (EM). According to the National Hospital Ambulatory Medical Care Survey, in 2017, there were an estimated 990,000 emergency department (ED)visits by individuals experiencing homelessness" (p. 585) The authors went on to state that unhoused patients had more increased mortality, visited the emergency room eight times

more often, yet still received inadequate care, and had higher infectious, mental health, cardiovascular, and respiratory disease prevalence. Del Buono et al. (2022) determined that emergency room personnel should ask patients about housing status as part of their social history, and it should be routinely considered in treatment, dispositions, follow-up plans, as well collaboration with social services (p.589).

Additionally, exploring a little deeper, Clark et al. (2021) stated that addressing the ongoing needs of unhoused behavioral health care recipients required a "high level of coordination", suggesting that integration of services (housing, health care) would be useful (p.1, 4). These studies correlated a patient's housing classification with service utilization, as it is defined in this study, as well as suggested integration of services as a requirement, bolstering the support for a study on integrated coordinated care policies and what role these policies could play in addressing high service utilization.

In looking at more than high utilization for behavioral health crises, Amato et al. (2019) stated that homeless patients were over seven times more likely to return to the hospital emergency room or department within 30 days and over eleven times more likely to return to the hospital emergency room or department in two years (p. 415). The main complaints for these visits are behavioral health crises and substance use or disorder. The authors also recommended policy changes toward establishing integrated care programs. Alameda County is one of these government organizations that have attempted to provide stabilizing programs for unhoused mental health recipients for over thirty-five years and have made it one of its goals and objectives at several different agencies, as well as the

County itself, without evidence or any foundation of integrating and coordinating any services (Alameda County, p. 1).

To further explore the type of situation that Alameda County is in, Reed et al. (2014) also discussed the impact of the underdeveloped or overlapping programs provided by different agencies with unmatched priorities in southeast Georgia, in that it often results in duplicated services or programs that do not address the growing gaps in services for behavioral health crises. Reed et al. (2014) emphasized, "For some individuals with serious mental illnesses, a cycle of repeated hospitalizations and incarcerations may result in them being returned to society less able to lead stable lives and prone to a cycle of hospitalization, incarceration, and even homelessness" (p. 26). This proposed result may also support any study regarding the development of a comprehensive integrated care system in a government entity such as Alameda County.

Testing the integration of services approach, Schick et al. (2019) published a study that discussed the impact of collaborative care on the health-related quality of life for formerly homeless individuals in permanently supported housing in Houston, Texas. In the study, Schick et al. (2019) concluded, "Individuals in PSH (permanently supported housing) receiving services through an innovative integrated care model with a single, coordinated plan of care reported significant and meaningful increases in the health-related quality of life with potential societal cost saving through a reduction in ED (emergency department) use" (p.318). This suggested that a coordinated care plan, or as named in this study, integrated coordinated care, would be helpful in the reduction of emergency room use or high service utilization.

Schick et al. (2019) further stated, “The potential for health and cost-saving benefits supports a financial and humanitarian justification for the continued investment in service delivery models that provide collaborative care to formerly chronically homeless individuals with complex medical, mental, and behavioral health needs” (p. 318). This supported the purpose of this study, which was to understand the key stakeholders’ perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce institutional recidivism and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Institutional recidivism is traditionally defined in reference to penal facilities and in some cases, penal facilities have been a factor in high service utilization. For example, in a study regarding the effectiveness of mental health courts, Loong et al. (2021) observed that while the mental health courts system does help some offenders, there appeared to be a gap in assistance for younger clients and repeat offenders. Specifically, the authors stated that the results of their study demonstrated that the suggestion to strengthen the mental health courts system also demonstrated the need to provide court participants with the necessary care in the first place. Loong et al. (2021) stated, “Thus, it is possible that fewer individuals would rely on mental health courts as a last resort for help if they received the services they needed in the first place – suggesting greater access to community mental health services may be one answer” (p.5). One of their cited journals was one that stated transitional plans upon release are crucial, but also care plans within the facility might help lower the high percentage of service utilization for those

with behavioral health challenges (Reingle Gonzalez & Connell, 2014). These studies could help support and facilitate a study on integrated coordinated care in that care must continually occur and provide integration with other services, but also should extend beyond the facility to provide a greater opportunity to avoid reuse of any institutions for integrated care.

Going a little further into high service utilization within penal institutions, another study by Clark et al. (2021) stated that addressing the ongoing needs of unhoused behavioral health care recipients required a "high level of coordination", suggesting that integration of services (housing, health care) would be useful (pp.1, 4). Additionally, according to Lowder et al. (2018), mental health courts have brought to the forefront certain objectives and goals to reduce recidivism and improve clinical outcomes for people with serious mental illness in the criminal justice system. The authors found the mental health court process had a very modest effect on recidivism compared to traditional criminal proceedings and a more stringent structure might be more effective, providing support for a comprehensive system approach that if it were outside of the penal system should include an integrated plan that includes providing health care and housing.

Ramezani et al. (2022) echoed this result as well, stating that overuse of police services to address behavioral health crisis resulted in high emergency room service utilization to provide care. Their study examined the role that community behavioral health capacity can inform the size of that community's jail population. Ramezani et al. (2022) also stated that policies are often written to separate criminal and behavioral

health care as two systems, instead of examining how they affect each other. Ramezani et al. (2022) stated in their results, “Greater investment and funding of community health and behavioral health services offers the justice system more options for preventing or responding to a range of disruptive and criminal behaviors that may result in jail detention. Programs that divert individuals from jail to treatment are not feasible where treatment services are lacking” (p.9). This journal supported the purpose of this study, which was to understand the key stakeholders’ perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

High Service Utilization for Substance Use Disorder

Demonstrated episodes of high service utilization in published studies were not only evident in the literature for unhoused persons experiencing behavioral health crises, but also for persons experiencing homelessness (PEH) with substance use disorders. The literature also showed that substance use disorders were an indicator, sometimes along with behavioral health crises, for integrated care programs for unhoused persons. Accordingly, Biederman et al. (2022) provided a study on medical respite, which explored patients’ health conditions starting with referral and culminating with programmatic outcomes from a program targeting PEH, both with substance use disorders and without substance use disorders. The authors examined health care utilization patterns of the targeted group before and after participation in an unhoused persons’ medical respite and transitional care program. Biederman et al. (2022) noted that

the program participants, both with and without substance use disorders, demonstrated that with increased access to social services during the program and after the program resulted in an improved and stable housing, income sources, health care insurance, and established support system including reconnection with family and friends (p.1348). This information appeared to align with the study that was to understand the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Furthermore, Amato et al.'s research (2019) delved into both critical utilization circumstances and came to a similar conclusion as Biederman et al. (2022). Amato et al. (2019) stated that unhoused patients were over seven times more likely to return to the hospital emergency room or department within 30 days and over 11 times more likely to return to the hospital emergency room or department in two years (p. 415). The authors stated that the main complaints for these visits were behavioral health crises and substance use disorder. Amato et al. (2019) also recommended institutional and public health policy changes toward establishing integrated care programs that include housing, mental health services, substance use services, and medical provisions (p.419).

Accordingly, Alameda County is one of these government organizations that have attempted to provide stabilizing programs for unhoused mental health recipients for over thirty-five years and have made it one of its goals and objectives at several different agencies, as well as the County itself, without evidence or any foundation of integrating and coordinating any services (Alameda County, p. 1). To look deeper at the type of

situation that Alameda County remains in, Reed et al. (2014) also discussed the impact of the underdeveloped or overlapping programs provided by different agencies with unmatched priorities in southeast Georgia, in that it often results in duplicated services or programs that do not address the growing gaps in services for behavioral health crises. Reed et al. (2014) emphasized, "For some individuals with serious mental illnesses, a cycle of repeated hospitalizations and incarcerations may result in them being returned to society less able to lead stable lives and prone to a cycle of hospitalization, incarceration, and even homelessness" (p. 26). This research appeared to support any study regarding the development of a comprehensive integrated care system in a government entity such as Alameda County.

Integrated Coordinated Care

As this research study was to understand the County's key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County, a similar study in Sonoma County, California, was conducted that looked at the client coordination created for that county and what effects it had on the county's unhoused behavioral health care recipients. The researchers, Rivzi et al. (2021), discussed the program Sonoma developed and used which was called "a Care Management and Coordination System (CMCS)" (p.1). They also stated that the system "comprised the Watson Care Manager (WCM), a front-end system, and Connect 360, which is an integrated data hub that

aggregates information from various systems into a single client record", which will support this study's premise of integrated coordinated care.

The study also revealed that Rivzi et al. (2021) asserted that providing effective care for vulnerable populations, which in this study's case was unhoused populations, would require collaboration and coordination, but helped substantiate the necessary part that technology would need to have in providing coordinated care. They contended that, "… The CMCS data hub, comprising WCM and Connect360, helped to retrieve and consolidate data in one shared place. It provided case workers with the most recent data, such as court dates, benefit eligibility due dates, and doctors' appointments for clients who often need timely actions. According to users, WCM played a valuable role in addressing the challenges unique to social work with homeless populations where information is often transient, including mobile phone numbers, addresses, and contact information" (p.8). As stated previously, Rivzi et al. (2021) supports any research regarding integrated coordinated care in Alameda County.

In a further demonstration that there may be additional programs to integrate into an overall policy, Biederman et al. (2022) completed a study on medical respite that explored patients' health conditions starting with referral and culminating with programmatic outcomes from a program targeting people experiencing homelessness (PEH), both with and without substance use disorders. The authors examined health care utilization patterns of the targeted group before and after participation in an unhoused persons' medical respite and transitional care program. Biederman et al. (2022) also noted that the program participants, both with and without SUD, demonstrated that with

increased access to social services during the program and after the program resulted in an improved and stable housing, income sources, health care insurance, and established support system including reconnection with family and friends (p.1348). This information from Biederman et al. (2022) supported the study that was to understand the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Instead of an established coordinated care policy like Biederman et al. (2022) described, Schiffler et al. (2023) looked at care for people experiencing homelessness through a co-design program. Their study suggested that the co-design approach, or programs designed with input from the participants to mental health care yielded significant benefits for this target population. Schiffler et al. (2023) asserted, "Participants enrolled in the included studies consistently showed reduced symptoms of mental illness and substance use, indicating an improvement in terms of pre-existing psychiatric disorders. Moreover, other important spheres of life were positively affected, such as improved physical health or more stable living situations. In addition, the number of participants seeking acute healthcare services decreased, which was reflected in a lower frequency of hospitalizations or use of emergency care. Participants self-reported an increase in their quality of life, indicating targeted effectiveness" (p.10). This study is consistent with what the study sought to understand regarding integrated care as an approach to social policy.

Continuing with the need for effective integrated care as a policy, Ecker et al. (2022) also illustrated points regarding coordinated care. The authors provided an overview and critique of what they considered to be "the four pillars of coordinated systems—(a) access, (b) assessment, (c) prioritization, and (d) matching and referral "and the practices associated with these pillars. Ecker et al. (2022) did not necessarily agree that this was the best course of action. Conversely, Ecker et al. (2022) asserted that "the components of coordinated systems lack a strong evidence base and that there is little evidence that coordinated systems improve individual-level outcomes such as length of stay in housing. Further, current coordinated system practices, particularly assessments, may be contributing to inequitable access to housing" (pp. 876, 890). In looking at the research articles, Guerrero et al. (2014) provided information from a study completed in Los Angeles County, California that supported this study's premise, which was to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to increase behavioral health stabilization for unhoused mental health service recipients.

In the study, Guerrero et al. (2014) interviewed providers and administrators of various organizations including government officials to discuss their views on policy barriers and facilitators to and for service integration. The authors stated that from the administrators' perspective, there was a consensus of some of the approaches. Guerrero et al. (2014) stated, "Administrators of county mental health and substance abuse treatment services and leaders of social services organizations agreed that provision of integrated health and social services is the best strategy to reduce homelessness and address the

comorbidities present in the homeless population. They highlighted the need for top-level, system-wide regulatory processes and coordination of the current structure of services, representing a common vision to enhance skill levels as well as the formal and informal infrastructure of service delivery. They agreed with the research literature that to accomplish integrated care, several approaches are necessary" (p. 48). The administrators believed that an integrated approach with interagency cooperation was the direction, as agency interdependence is clearly highlighted in that type of program. The authors stated, "Finally, county department leaders should work collaboratively to develop and implement appropriate policy on high standards of integrated care for homeless individuals and also develop strategies to respond to political challenges to accomplish administrative integration. Administrators underscored that only by aligning administrative policy and practice would a coherent framework of integrated care be achievable" (p. 49).

Guerrero et al. (2014), in discussion with providers, stated that they acknowledged the need for service integration, but had felt that instead of a top-down approach that they felt the administrators were preferring, instead there should be a more direct approach that should include peer involvement. The authors discussed that providers felt that trust needed to be established for integrated coordinated care to be accomplished. A point Guerrero et al. (2014) stated specifically, "Symposium participants agreed that housing and integrated care are critical to alleviating homelessness in Los Angeles County. Based on discussions during the event, key ingredients of success include relational and resource factors. Relational issues include

trust, understanding, and effective communication among all collaborating stakeholders; a commitment to address the multifaceted needs of each consumer; and political will and effective leadership." (p. 51). This literature showed that the focus on barriers and facilitators of integrated coordinated care has been a topic for a significant time, yet has not been completely developed, particularly in Alameda County.

There was a further examination relative to the study within the literature developed outside of the United States as well. In England, while Clark et al. (2021) did set out to discuss integration of services for unhoused persons discharged from hospitals, the authors also perform a second analysis of the qualitative data, which were stakeholders' interviews regarding integrated care, to further evaluate the intricacies and inconsistencies in integrated care using a framework called the Rainbow Model of Integrated Care (RMIC). Clark et al. (2021) stated, "The data for this secondary analysis were not specifically focused on integration which meant the themes in the RMIC could not be explored directly nor in as much depth. However, important issues raised in the data directly related to integration of support and the RMIC emerged as a helpful organising framework for understanding integration in this wicked policy context" (p.1). The definition of wicked, in terms of problems as they pertain to social policy, as defined by Rittel and Webber (1973) is an issue with the following characteristics:

1. The solution depends on how the problem is framed and vice versa (i.e., the problem definition depends on the solution)
2. Stakeholders have radically different world views and different frames for understanding the problem.

3. The constraints for the problem and the resources needed to solve it change over time.
4. The problem is never solved definitively. (p.1)

This also aligned with Johnson's assertion that while there are issues that can be solved using either/or thinking, when dealing with an issue that has been determined to be a polarity, instead of identifying ways to solve them as if there is only one resolution, in that either/or process, one should look at both sides of the argument completely, looking at each approach through its positive and negative lenses, or as a both/and supposition, resulting in polarity thinking in managing issues (Johnson, 1996).

Clark et al. (2021) also argued that the idea of integrated care programs for the unhoused is a very careful and delicate balance of formal and informal service integration involving multiple organizations. In their study, Clark et al. (2021) stated, "There were examples in sites of good formal integration work spanning the themes of the RMIC, such as basing commissioning on a person- and population-focused ethos. However, rarely was there a clear system view of integration expressed by interviewees. Perhaps this would have been different in interviews explicitly focused on integration. However, the number of times we found examples of informal arrangements for integration, such as the use of personal relationships between staff and secret caseloads, suggested there was some way to go to develop a system view of better integrated care for discharge from hospital of people experiencing homelessness", (p.20), which specifically informed this study's substantive foundation, which was to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated

coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. This study also helped to inform and shape the next section of the literature review, governmental organizations and policies regarding integrated care.

Government Organizations and Policies Regarding Integrated Care

Since this research study was to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County, selected literature referenced efforts in government organization to attempt or create policies regarding integrated coordinated care for vulnerable populations.

Sandhu et al. (2021) researched the last 10 years of government policy reform and progress to advance the integration of health and social care in the Unites States. The authors focused on certain policy developments and opportunities that resulted in implementation of new policy initiatives that provided for integrated care programs for vulnerable populations. To create these initiatives, the authors stated government health agencies, health care organizations, and community-based organizations needed to develop programs that incorporate their resources in a singular program. Sandu et al. (2021) also stated, "National policies have catalyzed initiatives to test new integrated health and social care models, with the ultimate goal of improving population health and decreasing costs. Preliminary findings demonstrated the need for validated measures of social risk, engagement across levels of organizational leadership and frontline staff, and

greater flexibility from national policymakers in order to align incentives across sectors" (p.1, 6). This reference aligned with the current study regarding an integrated coordinated care policy in Alameda County for the unhoused population.

Conversely, in another study in Illinois, Dickson et al. (2020) did not necessarily see the resulting integrated care when they stated, "The Department of Housing and Urban Development has required major metropolitan areas to develop a coordinated entry system (CES) to prioritize access to permanent supportive housing (PSH) to those who need it the most" (p.1). Dickson et al. (2020) made it clear that the program followed is not the mandated direction of HUD. Rather, the authors found that unhoused clients with behavioral health issues, substance use disorder or dealing with both diagnoses were not serviced by any coordinated care program, even though there was a program described as a coordinated entry system. Moreso, these clients were serviced through higher intensity service programs. Higher intensity service programs are defined as services periods of intensive intervention that may involve multidisciplinary support (Dickson, 2020). This definition did not rise to the level of integrated care and did not describe an integrated coordinated care policy.

In Sonoma County, Rivzi et al. (2021), discussed the program Sonoma developed and used which was called "a Care Management and Coordination System (CMCS)" (p.1). They also stated that the system "comprised the Watson Care Manager (WCM), a front-end system, and Connect 360, which is an integrated data hub that aggregates information from various systems into a single client record", which will support this study's premise of integrated coordinated care.

The study also revealed that the authors additionally asserted that providing effective care for vulnerable populations, which in this study's case was unhoused populations, would require collaboration and coordination, but helped substantiate the necessary part that technology would need to have in providing coordinated care. Rivzi et al. (2021) contended that, "… The CMCS (Care Management and Coordination System) data hub, comprising WCM (Watson Care Manager) and Connect360, helped to retrieve and consolidate data in one shared place. It provided case workers with the most recent data, such as court dates, benefit eligibility due dates, and doctors' appointments for clients who often need timely actions. According to users, WCM played a valuable role in addressing the challenges unique to social work with homeless populations where information is often transient, including mobile phone numbers, addresses, and contact information" (p.8). As stated previously, this study helped substantiate the purpose of the current study in Alameda County, as it was developed as a county policy in Sonoma County.

In Durham, North Carolina, in a further demonstration that there may be additional programs to integrate into an overall policy, Biederman et al. (2022) conducted a study on medical respite, which explored patients' health conditions starting with referral and culminating with programmatic outcomes from a program targeting people experiencing homelessness (PEH), both with and without substance use disorders. The authors examined health care utilization patterns of the targeted group before and after participation in an unhoused persons' medical respite and transitional care program. Biederman et al. (2022) noted that the program participants, both with and without SUD,

demonstrated that with increased access to social services during the program and after the program resulted in an improved and stable housing, income sources, health care insurance, and established support system including reconnection with family and friends, which could be developed into policy for Durham, North Carolina (p.1348). This information from Biederman et al. (2022) supported the research to understand the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Disparities by Race, Age, Gender, and/or Class

Within this study, there were gaps in services for certain individuals who are unhoused and in need of care for behavioral health crises and/or substance use disorders. The literature also revealed that there were disparities in treatment based on one's race, age, gender, or class. In some instances, there were disparities based on a combination of one of more than one demographic (i.e., black women or black poor women) as well as being unhoused.

For example, Cohen et al. (2020) examined the effect the war on drugs had on communities. The authors determined from the research that the results had damaging effects on all systems of life, including education, housing, and healthcare. Because of this, Cohen et al. (2020) stated specifically, "The targeted effects on people of color further entrench health and economic disparities. As the public and policymakers call for a health approach to drug use, it is vital to recognize how systems meant to care and

support are often unable to serve their intended purposes; rather than help people who use drugs or are suspected of using drugs, they frequently punish them" (p.2032).

In short, Cohen et al. (2020) determined that current policies developed to combat the drug war have a disproportionate effect on the Black community, from separating families, mandatory drug testing that more disproportionately targets Back pregnant women, and other restrictions that result in harsher conditions for Black people. Cohen et al. (2020) stated, "When people are seeking financial and nutritional support to better care for themselves and their families, especially in crisis, drug war logic justifies more barriers to SNAP and TANF and the discontinuation of assistance precisely when people need it the most. To better support financial and economic security of low-income people, advocates can support removing TANF and SNAP bans for people who have felony drug convictions, ending drug testing requirements for public assistance, eliminating mandatory drug treatment requirements for public benefits applicants and recipients, and adequately investing in public benefit programs to ensure they provide enough assistance for families" (p.2029). The authors determined that Blacks, particularly poor Blacks, were targeted more not because of any drug activity, but because of the contact with public services. While the intent may have been to keep recipients on a certain path, the result was often homelessness, food insecurity, lack of utilities, and increased substance use as well as behavioral health crises.

Cohen et al. (2020) also advised that instead of primarily assisting law enforcement through mandatory reporting, programs should perform a shift and develop a multidisciplinary approach to assisting those impacted by these policies. Services would

have included social services programs (reunification, housing, assistance) and health care for substance use disorder and associated psychosis, which supported this study regarding perceptions about the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Another segment that faced disparate treatment was juveniles. Juveniles faced a lot of the same challenges as adults in terms of homelessness and behavioral health challenges. Iwundu et al. (2020) discussed in their study the traumatic effects that various issues (financial instability, violent home environments) had on mental health stability for juveniles, which often resulted in homelessness. Iwundu et al. (2020) stated, ". studies have shown that youths with mental illness are more likely to engage in a greater number of risk behaviors that may increase vulnerability to violent victimization, potentially leading to increased traumatic experiences that may consequently increase the likelihood of homelessness" (p.2). The authors determined the more severe the mental health crises, the more likely that the affected youth would experience homelessness.

Many of these juveniles, who were also homeless, were diagnosed with behavioral health challenges upon entry into the juvenile justice system. Because of this, some researchers have studied how best to address treatment. For example, Underwood and Washington (2016) stated, "The role of the juvenile justice system in meeting the mental health needs of youth offenders must become more focused and limited, yet collaborative with the child protection, education, and child welfare agencies. Instead of

focusing on generating more evidence-based treatments to be used within the juvenile justice system, research seems to suggest that diversion programs and more community-based treatment services would be most beneficial to youth delinquents with mental health difficulties. In order to develop and implement such services; a very clear and standardized screening and assessment process is required" (pp. 9-10) With California's governor, Gavin Newsom, ordering realignment of the juvenile justice system to counties, Alameda County had to determine how to establish public policies that address provisions of care for juveniles that may have been released without any treatment because of this realignment mandate. This study sought to understand the perceptions of key practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County, which included juveniles in a realigning judicial system.

Continuing the look at disparities, Simpson et al. (2023) discussed the differences in palliative healthcare for people experiencing homelessness (PEH), or the unhoused as referenced for the study. Palliative care (PC) was defined by Simpson et al. (2023) as "… specialized medical care for people with serious or life-limiting illness which focuses on the needs of the patient by providing relief of symptoms, stress, and improving quality of life for patients using an interdisciplinary team of providers" (p. 30). The authors stated that the unhoused often seek treatment when their illnesses are more severe, which has a less predictable outcome and presented more complex needs for care. Simpson et al. (2023) stated further, "Barriers to healthcare in populations experiencing homelessness

are similar to barriers to other services including cost, not knowing locations to access care, decreased access to transportation, and lack of legal identification. Illnesses leading to unemployment and higher healthcare costs additionally limit access to care. Even for patients experiencing homelessness that had employment in the previous year, the ability to receive care was limited by access to health insurance" (p.30). However, the authors also determined in the limited access, there were racial disparities as well.

Simpson et al. (2023) noted that whether the recipient was insured or not, people of color did not have access to palliative care (PC) services. Specifically, Simpson et al. (2023) stated, "It is also important to note that racial disparities to quality PC exist independent of insurance status. This is especially concerning as non-Hispanic Black and Hispanic populations are vastly overrepresented in the population experiencing homelessness (lifetime incidence of 16.8% and 8.1%, respectively, compared with 4.8% for White people). These race-based differences are perpetuated by lasting impacts of institutional racism, including historic redlining policies and current discriminatory lending practices, which increases risk for homelessness. While it is beyond the scope of this review to describe the impacts of structural racism on healthcare, it is clear that BIPOC (Black, Indigenous, and People of Color) experiencing homelessness represent a group with an even greater need for targeted advocacy and support. To truly address this healthcare disparity, we must address and eliminate structural racism" (p. 32-33). These authors also determined that the unhoused population with these severe health challenges, including behavioral health and substance use disorder, would benefit from palliative care, which supported this qualitative study of perceptions regarding the barriers to

and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

Another study that supported the research was from Nohria et al. (2022). This study discussed the differences in health care utilization and resulting mortality for Black and White persons experiencing homelessness (PEH) or the unhoused, receiving services from a transitional care program, and the programmatic outcomes for those participants; however, the study also. highlighted that even though Black and White persons experiencing homelessness did not have significant differences in length of stay, observation encounters, outpatient visits, and hospitalizations, Black persons experiencing homelessness revisit the ED less than White persons experiencing homelessness (p.1275).

Nohria et al. (2022) proposed there were several reasons that may have been the determinant for this outcome or as the authors referenced, “informed hypotheses” (p.1275). Explaining further, Nohria et al. (2022) stated, “One potential explanation is that Black PEH may be less inclined to return for health care services due to experiences of racism in health care” (p. 1275). The authors stated that other studies have reported that Blacks have reported experiencing institutionalized racism, including implicit and explicit bias, within the health care system by receiving less care in the emergency rooms or fewer admissions to the hospital as well as less ordered testing for diagnoses (Nohria et al., 2022, Zhang et al., 2020, Ross et al., 2020).

Zhang et al. (2020), as referenced above, discussed significant racial/ethnic differences in the evaluation and management of adult patients in the emergency department. In this study, there appeared to be nothing extraneous to the failure of services than the person's racial identity. Zhang et al. (2020) stated that Black patients and those in the other racial/ethnic group "were less likely than white patients to receive immediate or urgent ESI scores as opposed to semi- or non-urgent care needs. Our study indicates that this racial/ethnic disparity could not be explained by demographic, socioeconomic, or factors related to the patients' clinical presentation or the context of their visit" (p. 4). This study exposed a service bias as it pertained to disparities based on race, gender, and class for the unhoused community and access to coordinated care.

There were several reasons revealed for the bias of service staff (Zhang et al., 2020, Olivet et al., 2021). Olivet et al. (2021) addressed this by stating, "Some individuals described challenges with mental health and substance use as factors contributing to their pathways into homelessness, conditions exacerbated by the stress of experiencing homelessness, or both. Some narratives, like this one from a Black woman, suggested that behavioral health and homeless services are not coordinated:

> [I was at] a program for mental health… they're supposed to help you find housing, like going to a co-op…But then at the last day, they didn't do the co-op because they said that my bipolar symptoms were too high. So, then they discharged me to the street.

In addition to these narratives, some experienced biases about behavioral health. One Native American participant who identified their gender as "2-Spirit" described a

school counselor who "told me that because I was Native American, I was going to become an alcoholic" (p. 92). If the bias was occurring where recipients were to receive services, it appeared that there was a gap for specific individuals to reaching any pathways to stabilization through integrated coordinated care. This proved to be a limitation in this study of understanding the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an effective integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. If the key stakeholders' perceptions regarding the barriers to or the facilitators of an effective integrated coordinated care policy were biased, there may be some gaps in the data for the study. These resulting gaps could result in ongoing issues with establishing effective policy that could lead to pathways of stabilization in Alameda County.

Summary and Conclusion

In Chapter 2, I provided the literature review related to understanding the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an effective integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

This study addressed the gap in the literature regarding the barriers to and/or facilitators of implementing an effective integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County The primary gap was that no one has addressed the

perceptions of the key stakeholders regarding any barriers or facilitators towards implementing an effective integrated coordinated policy in Alameda County and no one has looked at these perceptions through the lens of the polarity of democracy theoretical framework.

In Chapter 3, I will discuss the research design and my role as the researcher for the study. I will also discuss the methodology, which includes how the stakeholders will be selected and how data will be captured. I will then describe and discuss any issues of trustworthiness and ethical procedures.

Chapter 3: Research Method

Introduction

This generic qualitative study was researched because for over 35 years, Alameda County's departments and organizations have continually provided mental health services to unhoused behavioral health recipients to increase housing and health stabilization. Despite this effort, which was developed due to an awareness of the effectiveness of an implemented effective integrated, coordinated care policy for the county, high service utilization or emergency room service utilization remains ongoing and unsolved. The purpose of this qualitative research was to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an effective integrated, coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. The literature showed that professionals understand the need for programmatic intervention, yet it has not been fully developed in Alameda County. This chapter provided the research design, discussed the researcher's role, and described the methodology.

Research Design and Rationale

The study's research question was as follows:

RQ1: What are the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County?

The specific research design was a generic study. Caelli et al. (2003) described generic qualitative research as "…as that which is not guided by an explicit or established set of philosophic assumptions in the form of one of the known qualitative methodologies" (p. 2). Merriam (2002) stated that "researchers who conduct these studies…. Simply seek to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved" (p. 11). Because the study sought to understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an effective integrated, coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County, which, as described by Meriam (2002) is "a perspective of people involved" (p.11), a generic qualitative study was the best research approach.

Role of the Researcher

When conducting a qualitative study interview, the goal is to find out about the experiences of others and to see the world from their perspective (Rubin and Rubin, 2012). To elicit the richest information, researchers should ask participants open-ended questions. Open-ended questions provide more information from participants than closed-ended questions because to answer, participants are required to come up with their own words, phrases, or sentences based on their experiences (Patton, 2015). Patton (2015) also stated

> What is meant by qualitatively studying how things work is getting inside the phenomenon of interest to get detailed, descriptive data and perceptions about the variations in what goes on and the implications of those variations for the people

> and processes involved. A major way to do that is to capture people's stories about how things work (p. 27).

Since I was researching to understand how practitioners experience their work through existing policy and have chosen a generic study, the best approach for the study was semi-structured interviews for data collection (Rashid et al., 2019). This approach was best because as the researcher, I was exploring the experiences that practitioners encountered when providing services based on current Alameda County policy and what they viewed as the barriers and facilitators to providing effective integrated coordinated care.

As the researcher, I developed an interview guide based on my research question. I selected the participants based on the identified group of key stakeholders. Of those selected, I worked with some of the requested interviewees; however, I never supervised, mentored, or trained any of them in their current or any previous positions. In short, no biases or power relationships needed to be addressed, except for the interviews with two department heads. I have worked for both, and when I requested the interviews, I explained that I would be asking questions for this study and that the questions would be similar for all participants, excluding any follow-up questions to answers received. The purpose would be to gather information about barriers and facilitators that had not yet been identified.

I managed information biases through verification with other sources such as policies, particularly if anyone stated there were existing policies. This is also called triangulation. I also had the participants review my results if requested to ensure there

was proper representation of what they shared. If I felt even after this that my study demonstrates my own bias, I will document how this may have affected the study (Rubin and Rubin, 2012).

Methodology

Participant Selection Logic

Because the study was seeking the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated, coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County, the population was, as stated, practitioners and department heads. Practitioners were nurses, social workers, behavioral health care providers, or anyone else in Alameda County who provided services to the unhoused community.

I recruited 10 practitioners and four department heads/directors to provide the data through pre-arranged semi-structured interviews. I chose 10 practitioners from organizations that provide direct services to the unhoused community in Alameda County, which will provide the information necessary for data analysis. I sought participants based on my knowledge of Alameda County's departments and practitioners. The method of contact was through an email invitation with a follow-up call to schedule the interview time upon acceptance to be interviewed. For department heads, I contacted their executive staff first and then provided them with an email invitation. Once selected, the study participants were sent the invitation letter and consent, instructed to review the invitation letter, and sign the Informed Consent, which stated that the participant

understood and agreed with the nature of the study, as well as agreed to participate for the period necessary to gather data.

Ravitch and Carl (2020) used Saumure and Given's (2008) definition from The SAGE Encyclopedia of Qualitative Research Methods, for data saturation. They quoted

> Saturation is the point in data collection when no new or relevant information emerges with respect to the newly constructed theory [that happens as the data are being collected]. Hence, a researcher looks at this as the point at which no more data need to be collected. When the theory appears to be robust, with no gaps or unexplained phenomena, saturation has been achieved and the resulting theory is more easily constructed (p. 795)" (p.288).

As such, 10 practitioners and four department heads were selected. Because Alameda County organizations were closely connected in other policies and procedures, the sample size did not need to be extensive to reach the saturation point for this study.

Instrumentation

I developed an interview guide that consisted of open-ended questions. Open-ended questions provided more information from participants than closed-ended questions because to answer, participants were required to come up with their own words, phrases, or sentences based on their experiences (Patton, 2015). As also stated before, I used triangulation to ensure that I was getting the most valid information possible, using other information, such as policies and directives, to compare the information. I also had my own notes regarding policies since I worked in the environment and had access to the information.

Procedures for Data Collection

When conducting a qualitative study interview, the goal is to find out about the experiences of others and to see the world from their perspective (Rubin and Rubin, 2012). To elicit the richest information, researchers should ask participants open-ended questions. Open-ended questions provide more information from participants than closed-ended questions because to answer, participants are required to come up with their own words, phrases, or sentences based on their experiences (Patton, 2015). Patton (2015) also stated

> What is meant by qualitatively studying how things work is getting inside the phenomenon of interest to get detailed, descriptive data and perceptions about the variations in what goes on and the implications of those variations for the people and processes involved. A major way to do that is to capture people's stories about how things work. (p. 27)

Since I was researching to understand how practitioners experience their work through existing policy and have chosen a generic study, the best approach for the study was semistructured interviews for data collection (Rashid et al., 2019). This approach was best because as the researcher, I was exploring the experiences that practitioners encountered when providing services based on current Alameda County policy and what they viewed as the barriers and facilitators to providing effective integrated coordinated care.

When conducting the virtual interviews, I had previously selected Microsoft Teams; however, I was not able to use this format for recording and/or transcription.

Instead, I used Zoom, providing each participant with his/her individual link to ensure privacy and confidentiality. Each interview was scheduled to last 60 minutes; however, because of different levels of experience, the time used was often different. I ensured that I requested any follow-up interviews, if necessary. Zoom has a built-in transcription feature when saved to my Zoom cloud, which is safely stored on my personal drive. I also took notes, particularly when I asked a follow up question during the interview that may not have been listed. At the end of each interview, I gave a detailed summary of what we discussed to ensure that I captured what was stated.

I ensured confidentiality by referring to each as a participant with a number, i.e., Participant 1 etc. Additionally, prior to the interview, I sent each a Consent form and discussed it with each participant to ensure agreement with the interview. I wanted to make sure of this in case any of the practitioners had lived experience, even though this was not a part of any inquiry.

Data Analysis Plan

Rubin and Rubin (2012) stated these five steps to data analysis:

1. Transcribe and summarize each interview.
2. Define, find, and mark in the text (that is, code) excerpts that have relevant concepts, themes, events, examples, names, places, or dates.
3. From across your interviews, find the excerpts marked with the same code, and sort them into a single data file; then summarize the contents of each file.

4. Sort and resort the material within each file, comparing the excerpts between different subgroups, and then summarize the results of each sorting.
5. After weighing different versions, integrate the descriptions from different interviewees to create a complete picture (p. 190)

As I stated previously, Zoom created the transcript for me. When Zoom failed to transcribe with two of the recordings as it did with the others, I used Descript, a transcription tool associated with Delve, the coding program. Then after reading LaPelle's explanation of using the QDA programs (2014), I researched a program that I originally selected, MaxQDA; however, when that program failed to code in a manner that was explainable, I used Delve instead. In selecting the QDA program, I looked for software that was user-friendly, as well as performed group coding and provided exportation to other software. Delve made the grouping for analysis very easy. I selected the following codes for my transcripts:

1. Care Coordination
2. County Policy
3. Health and Wellness
4. High Risk
5. Mental Health (Mentally Ill as a subset)
6. Substance Use Disorder
7. Homelessness

I coded each subject when I went through the transcript. I exported the coded document to Adobe. I was able to see at what point each coded area came in the interview, what emerging themes and codes developed, and was able to group them in that way.

Issues of Trustworthiness

Lincoln and Guba (1985) stated that trustworthiness in a qualitative research study is important in the evaluation of its worth. Specifically, the authors stated, "How can an inquirer persuade his or her audience (including self) that the findings of an inquiry are worth paying attention to, worth taking account of" (p. 290)? Since I was researching effective integrated coordinated care for the unhoused community with behavioral health challenges in Alameda County, I wanted to get the most accurate information while trying to provide respect for its participants. I looked at the four aspects of trustworthiness: credibility, transferability, dependability, and confirmability to establish trustworthiness for this study.

Credibility

According to Lincoln and Guba (1985), credibility in qualitative research is a measure of the truth value of qualitative research, or whether the study's findings are correct and accurate. To some degree, it relies on the credibility of the researchers themselves, as well as their research methods. Simply stated, credibility can be defined as confidence in the findings of the study, that anyone can relate to the data (Lincoln and Guba, 1985.) If the information is manipulated to achieve something else, it is no longer credible. As discussed by Rubin and Rubin (2012), data must be "accurately and

transparently reported" (p. 63). This is what makes data findings credible. One of the methods used for credibility was triangulation.

Dawadi et al. (2021) defined triangulation, stating, "Triangulation, as a qualitative research strategy, is the use of multiple methods or data sources to develop a comprehensive understanding of a research problem or to test validity through the convergence of information from different sources" (p.27). For the purposes of this study, triangulation was used to ensure that the study was enriched with the most valid information possible, using other information such as policies and directives to compare information.

Transferability

According to Lincoln and Guba (1985), transferability is an assessment of the extent to which findings may be applied outside the bounds of the qualitative study. Colgan and Brydon-Miller (2014) stated, "The transferability of a research finding is the extent to which it can be applied in other contexts and studies. It is thus equivalent to or a replacement for the terms, generalizability and external validity. This entry outlines a brief history of the term and its successors, a discussion of the most important aspects of transferability as it applies to action research and an account of the strategies an action researcher or other researcher can adopt to increase transferability" (para.1). Therefore, transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings (Kochim, 2023) For the purposes of this study, transferability was established by cross-referencing the interviews of practitioners and policymakers with data from Alameda County established policies.

Dependability

Dependability is utilizing a data tool that provides the same result. Dependability is achieved by utilizing the same research techniques and methods to collect and analyze data for the proposed study (Lincoln & Guba, 1985). To ensure dependability for this study, the interview guide was created so that it can provide the documentation, tracking, and replication for each stakeholder interview. I also ensured all information that was not my own was referenced appropriately to provide credit to the original owner. Finally, I ensured all research findings were documented, providing each stakeholder with an opportunity to review and make any changes. This conformed to Moon et al. (2016), which was to ensure the consistency and reliability of the data collected.

Confirmability

Elo et al. (2014) defined confirmability as "objectivity and implies that the data accurately represent the information that the participants provided, and interpretations of those data are not invented by the inquirer" (p. 6). My concern was always those tenets of objectivity were not breached by the participants in an attempt to make sure that the organizations they represented appear to be living up to what they state they have been providing. When conducting this study, for confirmability, I followed where the data led, even if that would have nullified the research objective. Using confirmability and the other aspects of trustworthiness nullified any researcher bias as well.

Ethical Procedures

Each participant was selected based on his/her position as practitioner or decision maker. While some of the participants worked at my former place of business, I had no

leverage over any of their positions. Their positions were either as peers, or I was their subordinate in the job class.

I emailed each to request their participation. Within the body of that email, I asked for their participation and prefaced their continued participation by stating that I would be providing an Informed Consent form in a subsequent email. Information contained in the email can be viewed in Appendix B.

If they agreed to participate in the interview, I provided each participant with an Informed Consent form. The Informed Consent form detailed the interview procedures, the voluntary nature of the interview, and the privacy aspects. It provided them with contact information for the Research Participant Advocate if they have concerns about the interview, as well as Walden University's ethics approval number for this study, which was 02-06-24-1126017. If they consented, they were instructed to answer the email with "I consent to this interview". Lastly, the form suggested the participants copy or print the form for their records.

I then scheduled their interview through email communication and once a date was agreed upon, I sent a Zoom link. Each Zoom link was specific to the participant involved. All subsequent data has remained confidential and stored on an external drive within password protected files only accessible by me. All data will be destroyed by me in five years from the original interview date.

Summary

In Chapter 3, I identified a number for the proposed participants, practitioners, and department heads, that I would interview. The interviews were conducted using

open-ended questions in a semi-structured interview. The supporting literature in this chapter showed that semi-structured interviews will result in rich data, which was paramount to the study.

Coding software was used for the data analysis to ensure appropriate coding of the data. Issues of trustworthiness were addressed, while ethical procedures were detailed as well. As stated in the chapter, when conducting this study, for confirmability, I simply followed where the data led, even if that could have meant nullification of the research objective. If the information is ever manipulated to achieve something else, it is no longer credible. Data credibility is important to reporting results and findings in Chapters 4 and 5.

Chapter 4: Results

Introduction

This chapter contains the results of my generic qualitative study conducted to address the research question and purpose of the study which is:

RQ1: What are the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County to reduce high service utilization and increase behavioral health stabilization?

In this chapter, I will also discuss the setting of the interviews, the demographics of the participants, and how the data were collected. Additionally, I will detail that the analysis was consistent with generic theory methodology and how the analysis tied back to the interview questions. Finally, I will include and explain the process used to analyze transcripts from the 14 semistructured interviews conducted to uncover codes and themes that will be discussed.

Setting

As stated in previous chapters, the purpose of this study was to explore and understand Alameda County key stakeholders' perceptions. As such, key stakeholders were identified as practitioners and department heads/policymakers. Practitioners could be in any position providing services to the unhoused community with behavioral health challenges, such as nurses, community health workers, and clinicians.

Snowballing sampling was used to contact potential interviewees. Snowball sampling is a widely employed method in qualitative research, specifically when studying hard-to-reach populations. Research in the fields of public health (e.g., drug users), public policy (e.g., undocumented immigrants), or niche genres (e.g., buskers) often uses snowball sampling. This sampling method is also used to study sensitive topics or topics that people may prefer not to discuss publicly (Nikolopoulou, 2023, para. 1-3). This is usually due to a perceived risk associated with self-disclosure. Snowball sampling allows you to access these populations while considering ethical issues, such as protecting their privacy and ensuring confidentiality (Patton, 2015)

I contacted 25 prospective participants, 20 practitioners, and five department heads/policymakers via email to gauge interest. Of those initial emails, I received eight immediate responses from practitioners, with immediate denoting specifically on the same day. The final two practitioners were referrals from the eight responding practitioners. I was also able to contact four of the department heads to complete the interview group.

I was able to schedule the interviews beginning on February 26, 2024, and culminating on April 18, 2024. Participants in this study voluntarily agreed to be recorded and interviewed. No present or recent conditions influenced their participation other than their interest in the study. I provided specific criteria for people to participate (i.e., time at the organization, etc.). I did not ask nor was I made aware of any participant that had lived experience, which could have influenced the results.

Demographics

Fourteen participants were interviewed for this study. Of these participants, 10 were practitioners, and four were policy makers/department heads. Tables 1 and 2 indicate the demographics of each participant that met specific requirements as described in each email sent (Appendix A). In each table, using the axis of years of service, the legend is: a) participant number; b) gender; c) racial identity; and d) profession.

Table 1

Demographics (Practitioners)

Practitioner Participants	Gender	Racial Identity	Profession	Years of Service
Practitioner Participant 1	M	W	Community Worker	2
Practitioner Participant 2	F	L	RN	1
Practitioner Participant 3	F	W	RN	4
Practitioner Participant 4	M	W	Management	5
Practitioner Participant 5	F	B	Medical Support Supervisor	5
Practitioner Participant 6	F	W	Clinical Review Specialist	9
Practitioner Participant 7	M	A	Medication Support	5
Practitioner Participant 8	F	L	Data Analyst	3
Practitioner Participant 9	F	B	Medical Support Manager	15
Practitioner Participant 10	M	W	Support Manager	27

Table 2

Demographics (Department Heads)

Department Head Participants	Gender	Racial Identity	Profession	Years of Service
Department Head Participant 1	F	W	Policy Advisor	7
Department Head Participant 2	F	W	Director	5
Department Head Participant 3	F	W	Interim Director	8
Department Head Participant 4	M	W	Director	1

In discussing the demographics shown in Table 1 above, the practitioner participants had varied experience levels, averaging 7.6 years of service. The practitioner participant with the most experience has 27 years with the County, and the one with the least has been with the County for one year. The practitioner participants had varied assignments, all providing direct services to the unhoused population in Alameda County. These assignments cover positions providing medical, behavioral health, housing, and financial support to Alameda County's unhoused population.

In Table 2 above, all four department head participants were from Alameda County agencies as represented, with three (75%) heading departments directly involved in establishing policies for the unhoused population in Alameda County and one (25%) in policy development, management, and oversight for an Alameda County elected official. There was a range of experience, from the required minimum of a year to over 8 years, for an average of 5.25 years.

Of the 14 persons interviewed, all four department head participants identified as White, with gender identification of three females (75%) and one male (25%). Of the 10 practitioners, 50% identified as White, 20% identified as Black, 10% identified as Asian,

and 20% identified as Latin. The practitioner participants' genders were 60% female and 40% male.

Data Collection

When conducting a qualitative study interview, the goal is to find out about the experiences of others and to see the world from their perspective (Rubin & Rubin, 2012). The semistructured interviews from practitioners and department heads/policy makers served as the source for data collection as I explored their perceptions regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated, coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County.

For this study, I created an interview guide, which was approved by the IRB. I used this as a checklist throughout the data collection process. I determined that it would be utilized in this manner in Chapter 3 and found during the process that it was indeed necessary to ensure the interview stayed on the inquiry as well as for data legitimacy. I also took notes that allowed for follow up questions as well as wrote down any questions that emerged for other participants.

I had previously stated that I would use Microsoft Teams to conduct the interviews; however, upon attempting to use the format, I discovered that I could not record or transcribe. Accordingly, I switched my data collection plan to include Zoom instead, providing each participant with his/her link to ensure privacy. For every interview except two, I was in a private office or room that allowed complete privacy.

The two exceptions were conducted in my vehicle, where I was parked in an area with headphones to eliminate anyone overhearing the interviews.

I also assigned each participant a corresponding number to identify the interview. Each interview was scheduled to last 60 minutes; however, because of various levels of experience, the time allocation was often different for each participant. Because Zoom also provided the built-in record and transcription feature that I had expected from Teams, I used it instead. There were two recordings where Zoom failed to create a transcript for one of the interviews conducted in an office and another in my vehicle. I found that Delve had a companion program, which I used to complete the transcripts.

Data Analysis

As mentioned previously, Rubin and Rubin (2012) discussed five steps to data analysis:

1. Transcribe and summarize each interview.
2. Define, find, and mark in the text (that is, code) excerpts with relevant concepts, themes, events, examples, names, places, or dates.
3. From across your interviews, find the excerpts marked with the same code, and sort them into a single data file; then summarize the contents of each file.
4. Sort and resort the material within each file, comparing the excerpts between different subgroups, and then summarize the results of each sorting.
5. After weighing different versions, integrate the descriptions from different interviewees to create a complete picture (p. 190).

Accordingly, following the initial step, I listened to the audio while comparing it to the transcripts to ensure accuracy. In some cases, due to overlapping voices, the transcription tool for Zoom would attribute discussions or answers to the researcher when the participant was speaking. That required meticulous editing and listening for accuracy. Additionally, as all these programs learn as the user utilizes them more, certain words initially had to be corrected, such as "Alameda." After looking at a few transcripts, "Alameda" was spelled correctly. I also incorporated my notes taken during each interview as an end page to the interview.

In qualitative data analysis such as for this study, a code is a research-generated construct that symbolizes and, accordingly, attributes interpreted meanings to each piece of data for the resulting purposes of pattern detection, categorization, theory building, and other analytic processes used in this study (Saldana, 2016). As described in previous chapters, I intended to perform the subsequent data analysis following Saldana's descriptive coding process and using first and second-cycle coding. After rereading Saldana (2016) for guidance during this process, I found that the more appropriate process was InVivo coding, which would produce richer coding results. Using first and second-cycle coding means that the data had been reviewed more than once using one or more types of coding. Codes were categorized, which means synthesizing the codes into a consolidated meaning. Categories were moved into themes, phrases, or sentences describing a process derived from the categories. The codes I used included accountability, case management, high risk, and homelessness/unhoused.

Saldana (2016) defined decoding as the process when a researcher looks at segments of data to decipher its core meaning and encoding as the labeling process. During this first cycle, in which I listened to each audio interview and compared it to the transcript as mentioned in the previous section, I looked for interview segments or passages that would denote what key stakeholders perceived as barriers to integrated coordinated care for the unhoused population in Alameda County. In the second cycle, I looked for emerging themes from the larger passages of the data reviewed, providing a single-word code for the label. As the final step in coding, I used Delve as the software coding tool. The resulting tables, Tables 3 and 4, were included on pp. 99 and 120, which show the barriers and facilitator themes mentioned by practitioner and department head participants, as well as some emerging themes that resulted from the interviews.

Evidence of Trustworthiness

As stated in Chapter 3, Lincoln and Guba (1985) stated that trustworthiness in a qualitative research study is important in the evaluation of its worth. Since I was researching effective integrated coordinated care for the unhoused community with behavioral health challenges in Alameda County, I wanted to get the most accurate information while trying to provide respect for its participants. I looked at the four aspects of trustworthiness: credibility, transferability, dependability, and confirmability to provide evidence of trustworthiness for this study.

Credibility

According to Lincoln and Guba (1985), credibility in qualitative research is a measure of the truth value of qualitative research, or whether the study's findings are

correct and accurate. To some degree, it relies on the credibility of the researchers themselves, as well as their research methods. Simply stated, credibility can be defined as confidence in the findings of the study, that anyone can relate to the data (Lincoln and Guba, 1985). For the aspect of credibility, I used triangulation as stated in Chapter 3, Issues of Trustworthiness.

Dawadi et al. (2021) defined triangulation, stating, "Triangulation, as a qualitative research strategy, is the use of multiple methods or data sources to develop a comprehensive understanding of a research problem or to test validity through the convergence of information from different sources" (p.27). I compared programmatic details and directives regarding previous failed initiatives for the unhoused community's care with information derived from the semi-structured interviews. These would include the failed initiative for Whole Person Care discussed in Chapter 2, and SmartCare, which was attempted in 2022, and is now being discontinued for a new program under CalAIM.

Transferability

According to Lincoln and Guba (1985), transferability is an assessment of the extent to which findings may be applied outside the bounds of the qualitative study or the generalizability of inquiry (Tobin & Begley, 2004, Kochim, 2023). As such, the findings of this study, to fulfill the concept of transferability should apply or can be used for other inquiries as reference (Lincoln & Guba, 1985).

Colgan and Brydon-Miller (2014) concurred by stating, "The transferability of a research finding is the extent to which it can be applied in other contexts and studies. It is thus equivalent to or a replacement for the terms, generalizability and external validity.

This entry outlines a brief history of the term and its successors, a discussion of the most important aspects of transferability as it applies to action research and an account of the strategies an action researcher or other researcher can adopt to increase transferability" (para.1). For the purposes of this study, transferability was established by exploring and documenting the key stakeholders' perceptions through semi-structured interviews. While the interview process can be focused more often on how one should listen to participants, interviewing skills can also focus on how to get the interviewee to comfortably answer when the information is challenging to him/her, or in short, the technique.

To explore this, I established confidentiality by first discussing the Informed Consent form at the onset, but also by reassuring each participant throughout the interview, most significantly with department head participants, that the interview was a safe space to share their answers. Glesne (2006) discussed the importance of developing rapport which may also cover building trust. Continuing further, rapport is not to be confused or used interchangeably with building trust as it often is done. In the context of his study, Wieder (2004) also defined, "…rapport as a research tool and trust as a living relationship" (p. 25), further stating that it is trust, not rapport, that facilitates people to tell their stories. Rapport seems to act as a precursor to fostering trust and thus is part of gaining access and "fitting in" (Glesne, 2006, p.140).

For this study, rapport and trust building were necessary, particularly with the department heads, who were expressing opinions that may have been uncomfortable for their counterparts or peers and subordinate practitioners to digest. So, I had to

periodically stop and explain within the interview how the information would be used and maintained, despite explaining the Informed Consent form and asking for any questions at the beginning. This was necessary to build the trust necessary so that participants were comfortable answering questions that they considered to be sensitive to their work.

Dependability

Dependability was achieved by utilizing the same research techniques and methods to collect and analyze data for my study (Lincoln & Guba, 1985). To ensure dependability for this study, the interview guide was created so that it could provide the documentation, tracking, and replication for each stakeholder interview as discussed in Chapter 3. I also ensured all information that was not my own was referenced appropriately to provide credit to the original owner. Finally, I ensured all research findings were documented, providing each stakeholder with an opportunity to review and make any changes. This conformed to Moon et al. (2016), which was to ensure the consistency and reliability of the data collected.

Confirmability

Elo et al. (2014) defined confirmability as "objectivity and implies that the data accurately represent the information that the participants provided, and interpretations of those data are not invented by the inquirer" (p. 6). I worked in the subject environment when I began this study. I followed the appropriate communication steps by contacting all prospective participants with the IRB approved email and after securing interview agreement, the IRB approved interview guide. I also provided each participant with the

IRB Consent form that included the IRB study number and steps to contact the university if they felt they needed to do so. I ensured that all who were interviewed were not in my supervisory span, which also supported a better line of communication in the data collection.

Finally, using confirmability and the other aspects of trustworthiness mitigated any researcher bias. As previously discussed in Chapter 3, my concern has always been that the participants could possibly breach objectivity by embellishing their program results to appear to be fulfilling the funding goals. To eliminate any bias and in using confirmability, I simply followed where the data led.

Study Results

In this section, there will be a thematic summary of the participants' responses to the questions in Appendix B. The data collection and subsequent analysis were to discuss the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County. The second step in the analysis was to explore these perceptions through Benet's (2006, 2012, 2013, 2022, 2023) polarities of democracy as the theoretical framework lens, supported by Johnson's (1992) polarity management as the conceptual framework, both of which will be addressed in Chapter 5.

The themes that emerged were for both barriers and facilitators of integrated coordinated care policies for the unhoused population facing behavioral health challenges in Alameda County. The resulting themes were enriched with the most valid information

possible, including programmatic directives as a cross reference as mentioned in Chapter 3, while also using multiple perspectives throughout data collection to ensure data is appropriate.

Barriers to Integrated Coordinated Care Policies

All participants, practitioners and policymakers, were asked what they felt were barriers to integrated coordinated care policies in Alameda County. The responses are documented in Table 3 below. Based on those answers, there were specific themes that emerged as well as some subsequent important themes that also became apparent.

Table 3

Barriers to Integrated Coordinated Care Policies in Alameda County

Barriers	Code	Participants	Responses
Lack of Coordinated Care Policy	Despite having existing County services, County reliance on contractors with little oversight, so no overarching policy to facilitate care for all County and associated organizations	14	688
Lack of Contractor Policy	County reliance on contractors with little oversight	14	504
Behavioral Health	Must have client acceptance, substance use may interfere	14	243
Lack of Housing	Not enough available or acceptable for stabilization	14	192
Homeless	Locating clients to provide help; must have client acceptance (SUD/behavioral health may influence decision	13	180
Mental Health	Must have client acceptance, substance use may interfere	12	106
Lack of Case Management	In some cases, case management can be present but is often unavailable to assist clients	10	98
Substance Use	Must have client acceptance, substance use	10	57

	may interfere		
Harm Reduction	Use of harm reduction techniques can be both helpful and exacerbate existing conditions	4	25

Barrier Theme 1: Lack of Coordinated Care Policies

Based on the information provided in the interviews, practitioners were aware that Alameda County had policies that provided directives for care of the unhoused, but not aware of any integrated coordinated care policies for the unhoused community facing behavioral health or substance use challenges in Alameda County. There were mentions of previous attempts at such policies such as the Whole Person Care system mentioned in this study, but practitioners appeared to feel there was a disconnect to providing a comprehensive policy that incorporates all available services. Practitioner Participant 4, in speaking of this, stated,

> … For the Whole Person Care or AC3 plan, there were cohorts. Those cohorts of stakeholders came together to create a system, to break down silos, barriers to care and then create individual connections, that in the moment, these actions are good. If you don't have a system that continues on an ongoing basis, especially with the high turnover that we have, it's not going to be successful.

Practitioner Participant 4 continued with,

> Part of what I think the county should do is provide a standard, especially since we contract all these services out, a standard orientation that folks can go through, even though they're not our direct employees. We provide the guidelines. We provide like we have for our staff, those employees. So, the expectations are clear

> on what our contractors are to do, and the employees coming in can get that firsthand from us and really set those standards for everyone.

Practitioner Participant 3 stated,

> I, as a provider, want to be able to access that integration myself. I want to be able to refer my patient to the appropriate behavioral health service. Our own self-worth and safety or sense of safety comes from a young age, and it could carry on through our adult life. But wherever we're at, if we're not safe [as a client], there's a problem with us in Alameda County gaining help if we need it.

Practitioner Participant 3 also stated, when speaking about their knowledge of the County care policies, "... Sometimes, I feel it in my own program, it becomes more of a barrier than a protection of the actual patient's rights. It can feel like the policies prevent somebody from getting where they need to go."

Practitioner Participant 2 stated, "I'm not sure of our integrated care policies."

Practitioner Participant 1, a community worker, flatly stated, "If there are policies, I haven't seen them."

Practitioner Participant 5 shared similar sentiments, stating,

> There are some barriers just based on knowledge of resources and of course, once you are trying to find the policies, there's a re-creation of this 'looking for the resources'. So, it develops into an inequity, because each time they're [the client] starting over again, with the worker looking for policies and resources to address the need.

Practitioner Participant 10's comment was also pointed by stating,

> I think the first one isn't really a policy. Well, it could be a policy, but it's the fact that that we have multiple platforms that don't talk to each other for our care, whether it's within a hospital emergency department, primary care, specialty care, housing services, homeless and support services, benefits, care, job training, or employment resources. They're not all synchronized and working easily together.

These comments demonstrated that at the time of this study, there were no current policies in place to compare, as most existing care policies were either outdated or unknown to the practitioners as well as, in general, there was an expressed lack of knowledge as to what the policies were in the first place.

In comparison to the practitioners' service-oriented statements, the department heads appeared to be more concerned with developing policies not based on providing services necessarily, but as the result of legislative mandate or an effort to align with state legislation.

Department Head Participant 2 stated,

> And so, for example, if there's an opportunity to better use CalAIM or MediCal reimbursement for substance use treatment for people experiencing homelessness, then a policy can be crafted within the county to say, this is how we're going to do it. It needs to be crafted with input from people working on homelessness, people working on behavioral health, and people with lived experience, so it can be implemented. However, implementing a policy absent an available resource has not been very effective unless it's regulatory and court enforceable, because,

> essentially the behavioral health services, specifically substance use and behavioral health services, function as a health plan model in our county."

Department Head Participant 1 also stated in speaking of unhoused behavioral health recipients accessing services,

> But that's a very limited time, and the State has put in place some laws and policies that allow that (services) to be extended a little bit in certain cases here or there. But it's not a panacea, and it's not really the solution that we need. We're now looking forward to the Care Court legislation, which I'm very, very familiar with and something that … [name of an Alameda County supervisor] has been a big champion of…We believe it is not perfect and the implementation is going to be really the key to how well this happens. We believe that legislation that would allow a court to intervene and to mandate mental health services and treatment for an individual's well-being is best.

Department Head Participant 4 replied with a different take, stating,

> What it [policy] should look like is: a low barrier, no wrong door philosophy, and an opportunity where funding streams don't dictate what program models look like. It actually was my motivation to get into government as a provider for a long time, and it feels like our funding streams, and not what the community needs, are driving the way.

There was more of an anticipation of what could be done, as opposed to what Alameda County readily has. This appeared to be at cross purposes with the practitioners

who seemed to be looking for some current directive or policy that encompassed their duties.

Barrier Theme 2: Lack of Contractor Policy

There were also comments that revealed that while Alameda County often contracted out the services provided to the unhoused community, there were no policies to align the contractors' deliverables with County policies. As such, there was not much oversight from the County to avoid redundancies or overlapping service provision without coordination.

Practitioner Participant 8 stated,

> They (Alameda County) provided a lot of funding to external agencies. But those agencies are at different levels of skill and expertise and understanding. And people have different approaches. I think it's been a bit chaotic. It's a terrible thing to do [to clients]. How do you create a system with so many disparate partners in it? How do you create policy and protocol that supports core elements that everybody can agree on so that that you could track to see if you are really having an impact on people's lives?

Practitioner Participant 8 continued by stating,

> I think that if you want to really hold Alameda County accountable, it is the lack of policy driven and program driven consistency to share and to build with their subcontractors, because otherwise you're just saying, 'Yeah, here's some money. Make it better and let's see your outcomes.'

Practitioner Participant 9, who is considered an Alameda County contractor/practitioner, stated,

> I think that the ones who are developing the policies need to really come and talk to us who are out here in the field, doing the work to get real concrete evidence and proof of like how they can improve these systems, because sometimes I think the protocol makers, you know, they have good intentions around it. But we flood the system with so many different programs and in a sense we're kind of toppling over each other and just recreating more work.

Practitioner Participant 1 also stated,

> Part of the problem is a lack of funding, or at least proper use of the funding that's available. So, you have people who are out front [providing services] who aren't trained and haven't the capacity to deal with the population that they are meant to serve.

Practitioner Participant 4 stated,

> A part of what I think the county should do is provide a standard, especially since we contract all these services out, a standard orientation that folks can go through, even though they're not our direct employees. We provide the guidelines. We provide like we have for our staff, those employees. So, the expectations are clear on what our contractors are yet to do and the employees coming in can get that firsthand from us and really set those standards for everyone.

Practitioner Participant 4 went a little further in speaking of standards and inefficiencies, by stating,

> …. By having the county, which we once did many, many years ago, take back being a direct service provider instead of subcontracting it is very important because it's just inefficient to have middle management. It's more expensive and you'll get the argument that it's less expensive, but it's not less expensive. People are utilizing emergency services, and the emergency services are having an impact on the system as a whole. I don't know if any studies have been done, but that would be a good thing to look at, to see if there's data to show that services actually have improved for end users. Sourcing out of the work to contracted agencies also waters down the control that the county has in implementing quality services for end users, because it makes it more challenging to hire and retain good talent, if you will, because the pay isn't good, and it's not sustainable, especially in the Bay Area, for someone to stay in those positions for a long time, so that there's always turnover on a lot of the teams already.

Most department heads were somewhat silent on this lack of policy in that they considered contractors as part of their program. Department Head Participant 3 stated succinctly,

> It is an integrated team approach that serves a portion of the homeless population, and I would say they're able to work closely with mobile crisis to a greater extent and other crisis support services also to a greater extent than most of our community-based organizations hired by the county and working independently, are able to access.

He also stated, while acknowledging his bias as a previous employee of a community-based organization, that the contractor route was a better process with some caveats.

> The county has a burdensome HR process, and just to speak very practically around, you know, staffing and supporting, and so I do not think the current sort of makeup [civil service vs. contractor] is the way. Unfortunately, civil service work is structured and lends itself to direct service. They are doing direct service as well as we might like to do; but I do think the county should really be strategically invested in exactly as you describe accountability. It should be the type of accountability that provides the kind of administrative support and administrative back-office support that enables us to hold providers accountable. I think of it as kind of the same principle as like the macro discussions around accountability at the State right now. The governor is very intent on making sure local governments are performing well and using their homeless dollars to fix these problems. A big auditor's report came out last week with this idea that accountability must mete out in a kind of structure that allows us to do good work.

Barrier Theme 3: Lack of Housing

There was also data that stated that part of the issue with the policy development was the housing status. Housing status, which is often lack of housing, can be a barrier to creating integrated coordinated care policies, according to participants.

For example, Practitioner Participant 10 stated,

> Because there are some critiques of like a too rapid movement from the streets into “permanent housing”, and people being kind of left on their own in an apartment that they're not able to take care of themselves. So, there's often work that needs to be done for housing preparedness.

Practitioner Participant 9 stated,

> There's a standard best practice where these are people who are supposed to make scheduled appointments. Well, when you're dealing with the homeless population, not everyone's going to be able to be on a schedule to just make an appointment or remember to come because their life is ever evolving and changing.

Practitioner Participant 4 also shared in speaking of HIPAA, yet the remark had bearing here as well,

> It's confidential within certain situations and there's bills [laws] all the time, especially around people experiencing homelessness that decrease their rights under the guise of providing care coordination, under the guise of being able to connect with them more and reach out to them more. While I don't like that approach in and of itself, it's also not true, because you're not going to have more access to where someone is, especially if it's someone who doesn't have a fixed address, to be able to do the care coordination that's needed.

Practitioner Participant 7 had a slightly different viewpoint, sharing the following,

> ..., I think that people deserve housing and efficient fast tracking to get people services. Housing is great, and I think housing is healthcare, but the reality is, there's not enough public housing, not enough access points for housing to get

people the wraparound services that would typically come with that type of model.

We, in Health Care for the Homeless, had this philosophy shift in talking to them to see if they do feel like they have a home, even though that [home] is a tent in a street or somewhere, but that is their home. So, we approach that person to get all the services that they need right then and there, even though they may not have the traditional definition of a house, So, I think that housing model or that model for Housing First was again a good intention to really highlight that we need to get these people off the streets and really push them into housing. When people are in housing, yes, there tend to be better outcomes, and that should be an effort and a focus, but it can't be the only focus. It can't be the only priority. And so, I think that a model that elevates other focuses or services to the same level of housing would be a better match.

Department heads concurred with the assessment that homelessness was a barrier to establishing integrated coordinated care policies for the unhoused community.

Department Head Participant 2 stated,

So, another example, or maybe a counter example, is the full-service partnerships (FSP) which are so critical because they are able to provide a pretty high level of service and have strong access within behavioral health systems. However, they're not as well coordinated with our housing and shelter, and homelessness services as they could be. In terms of substance use treatment, which is really important in the moment that someone wants it and is able to access, is often really hard to

> access in that same moment for people who are experiencing homelessness. So, there's an area where I think integration could really be improved.

Department Head Participant 3 stated,

> It's really difficult to go out and find a job when you have nowhere to sleep and shower. It's also really difficult to get meds, hang on to those meds, and take them regularly, or as directed, when you don't actually have a home to store your meds in. It is just like all the trappings of our daily lives that make those things possible, like having your space and being able to set up that space. It's just really difficult to take on anything but survival when you are unhoused like that.

Overall, the data showed that the state of homelessness remained a barrier to providing services, which is a main tenet of establishing an integrated coordinated care policy in Alameda County.

Barrier Theme 4: Lack of Case Management

A lack of sustained case management also interfered with establishing an integrated coordinated care policy in Alameda County. All 10 practitioner participants identified case management as an integral part of providing integrated coordinated care and thus should be identified in Alameda County's policy, with two practitioners describing the expansion of the community health workers' role as an avenue to provide case management for an integrated coordinated care policy.

Practitioner Participant 3 who worked with community health workers on their team, stated,

> You have the benefit of talking to other physicians and nurses and stellar people, and so, case managers must make hard decisions. Having that sort of opportunity of all things working together is kind of dynamic because you can really help a person. I feel whenever a person is a case manager, they're tasked with that active care coordination, but I also think it's okay if it's not at that level.
>
> I wouldn't want anybody to be hired to do their job and then suddenly be expected to work at a higher level. I'm totally appreciative of anybody in their skillset working in their skillset. Some people tend to go above and beyond and that is better for me. But if they're working as a case manager, which honestly is somebody who supports a person, holds them accountable, and tries to set goals with them and maybe must do care coordination when it comes to the act getting them to appointments or getting them situated with some life skills, then those are not easy tasks. That's how I see case management and see case management as having a great place in all of our work.

Practitioner Participant 10 stated,

> To really provide that case management role, especially for working with people right in the middle of homelessness, to me, [case managers] need to use good emerging best practices. One is creating and expanding the roles of community health workers. To give them the power to be able to serve as case managers and care coordinators in with the training and the skills serves two purposes. Number 1, they are uniquely able to be trusted oftentimes and provide more accurate support in the way that people experiencing homelessness need it since they're

> getting it from their peers. And number 2, it is also part of a pathway out of homelessness and towards independence and job skills. This is to have people with lived experience start doing that kind of work and get that kind of training because they're the best equipped to be able to be effective in doing it. And again, it's a pathway out of homelessness and into job security for people with lived experience.

Department heads were mostly silent on this as they unilaterally stated that this applied to direct services; however, this reflected a near dismissiveness and emphasized the practitioners' assertions that they had not been included in policy development that would assist their service delivery.

Barrier Theme 5: Behavioral Health Challenges

Behavioral health challenges, which included substance use challenges, were often discussed as a barrier to establishing protocols for an integrated coordinated care policy for the unhoused community in Alameda County. Based on most of the data, it had to do primarily with the client's ability to accept services and the behavioral health issues that may prevent the acceptance.

Practitioner Participant 3 stated,

> And I think that, and I was just talking to somebody shortly before you about what you touched on, which is that building rapport thing, keep coming back, keep coming back, and offering them incentives to say yes to getting on that path of stabilization. And yet they don't. Are we contributing to this bigger problem by not having a different approach? I do see the value in the building rapport, but I

> also see the faults in it or that maybe it's not always the best approach. There could be other approaches, but I'm not always sure what those are. It just goes back to this lived experience of their own, such as experiences of either failed systems or trauma or mental illness or something, because honestly, I don't always know what that is, as to why they are not in a position to say yes.

Practitioner Participant 1 went a little deeper,

> I think where we lack primarily is in the fact that patients who are incapable of making sane and sober decisions about their medical and psychiatric care due to mental health, severe mental health, and hopelessness, because the system cannot provide the basic needs that individuals have as well as the addiction issue, be it drugs and alcohol behavioral as well. It should be included that until that's addressed, there can really be no long lasting, meaningful dispensation of services that would alleviate the need for emergency room services.

Practitioner Participant 5 also stated,

> Okay, well, this person is sitting on the doorstep of a supervisor's office. They want this person moved and they don't really understand. We might have gone there already and talked to the person. If they don't want services, we can't force them to take services. I think that happens so often that people just don't understand. There has to be more of a movement to educate people in general on how we offer services to people, that this is all at will. If they choose not to take it, there's nothing we can do.

Accordingly, department heads also agreed with this being a barrier to effective policies to help the unhoused community with behavioral health challenges. Department Head Participant 1 stated,

> Our job is always to hear all sides and to understand the issue, and to try and make a plan that can move everyone forward in a way that improves the community for all. There are those philosophical questions, and I think for a long time it's erred in California, at least on the side of personal choice. Somebody lives on the street, and they are suffering from a variety of conditions, co-occurring or not, and they, for whatever reason, say, I don't need help. I'm fine. There's nothing that we can do.

Department Head Participant 2 concurred in a manner, stating,

> I think that in terms of behavioral health and substance use services in particular, we really know that many people will not succeed or will not be able to truly take advantage of those services if they're compelled into them. My approach has always been to try to offer people what they say they need in the moment that they say they need it, and up to now, we have not had enough resources to offer in that way. So, I've always thought that if we could serve everyone who wants to be served in a way that they are able to accept and take advantage of services, we would be in a much better position. Then, you really get to understand who has declined and what else we need to do with those folks, and that's usually better achieved through deep engagement.

Barrier Theme 6: Health Insurance Portability and Accountability Act (HIPAA)

Because of HIPAA laws, the participants that mentioned this asserted that this was and continues to be a barrier to establishing integrated coordinated care policies. Practitioner Participant 5 spoke to this at length, stating,

> And it is really like a lack of education on the public's part, you know, like the average public person doesn't understand HIPAA, and the way we try to break it down to them, is I would not walk into your doctor's appointment and start asking questions. That's very inappropriate. And so, we try to honor our patients in the same way as I get to live [with HIPAA rights].

Practitioner Participant 4 also stated,

> But HIPAA, unfortunately, while it's meant to help create seamless care for all of us, it also has tended and is trending towards eroding our privacy. As much as we talk about it being there when we're informing people about the process, we say it's confidential and it is. It's confidential within certain situations and there's bills [laws] all the time, especially around people experiencing homelessness that decrease their rights under the guise of providing care coordination, under the guise of being able to connect with them more and reach out to them more. While I don't like that approach in and of itself, it's also not true, because you're not going to have more access to where someone is, especially if it's someone who doesn't have a fixed address, to be able to do the care coordination that's needed.

Department heads also agreed that HIPAA laws are a barrier to creating effective policy for the unhoused community. Department Head Participant 3 stated,

> I feel like the State is actively working on the fact that there are some strong privacy laws in place for the different systems of care that have to be upheld. In terms of data sharing, to me, step number one in integrating and coordinating care is knowing who is a part of the care team, who else is out there in these other systems, and what work they are doing. If you don't have that information, then it makes it really hard, because you're reliant on the client to know XY, and Z about every service that they might be receiving or every person that they might be talking to. And so, I do think that there's more work to be done, and the State really needs to help provide a roadmap for the best ways to safely and respectfully share data to facilitate care coordination.

Barrier Theme 7: Harm Reduction

Harm reduction programs have been listed as both a barrier and a facilitator because participants saw them as both. Practitioners felt that harm reduction could be helpful but could also exacerbate existing substance use issues by helping to facilitate the continued use by providing the drug paraphernalia. Practitioner Participant 3 stated,

> It is helping somebody actually learn the skills and what it feels like to abstain from using, eventually getting off drugs, that is their goal. It's just really hard. So, they may have to do less in order to be safe along the way, and somebody may choose to just do less along the way. They've met their goal because it makes them feel better along those lines.

Practitioner Participant 8 saw it more as a double-edged sword, stating,

> You keep a person alive because it gives you another opportunity to try to help that person, support that person considering going into recovery. And to me that's what harm reduction is about. So, it has its place. But it's not a panacea, and it doesn't take the place of supporting people to health and wellness outcomes that that create a better quality of life for them wherever they're at. You can't give somebody needles until they die. I mean, I guess you could. But that that's not really the point, in my opinion.

Barrier Theme 8: Diversity

Practitioners felt that the lack of diversity in leadership, which was also demonstrated in the Department Head participant demographics on p. 89, was a barrier to service equity for the unhoused community in Alameda County. Practitioner Participant 8 mentioned in several parts of the semi-structured interview. For example, she stated,

> I think one of the things that the County of Alameda has to do better is to create more diversity in leadership, because we have people who come from a certain class and look a certain way and see the world in a certain way. That doesn't mean that they're not good people, and they don't want to do right by Alameda County's population; but it does limit the amount of creativity and the perception and the lenses that are used to create the policy and even implement it. I think that's a real stumbling block.

The quote continued with,

> It's about not having the right color plate. If I want to be so crude as to say it, but it really is about finding people from diverse backgrounds and with different kinds of skills or perspectives, and not being afraid of that.

Practitioner Participant 5 also spoke to diversity, stating,

> You know, it's important for us to make sure that we have people that represent everybody in the fold. The same old agencies are getting all the money, and they may have a good infrastructure, so they often know how to apply for grants. Yet, it is those mom-and-pop programs that are doing the work and how do we put them in the fold some kind of way, because they are tapping into a population of people that traditionally don't have access to those resources. So, understanding that all those programs are needed and then I will say that I feel like there is coordinated entry.

According to Alameda County's Point in Time count of the unhoused community in 2022, which is done every three years, "individuals identifying as Black/African American were overrepresented in the population experiencing homelessness. An estimated 43% of persons experiencing homelessness identified as Black/African American compared to 10% of the county's overall population" (Burr et al., 2022, p.23). While the demographic in my study is 100% White for those in leadership/policymaking positions, there could be some White Savior Complex (WSC) at play, which is something that would not be answered in my study (Finnegan, 2022). Accordingly, the current policies have continued to directly affect the unhoused community and as Practitioner

Participant 8 stated, and the demographics for department heads show in this chapter, there remains a lack of diversity in the leadership roles.

Facilitators to Integrated Coordinated Care Policies

Table 4

Facilitators to Integrated Coordinated Care Policies in Alameda County

Facilitators	Code	Participants	Responses
Accountability	County has held their own organizations accountable for expenditures of funds without providing results.	13	157
Case Management	In some cases, case management can be present but is often unavailable to assist clients	10	98
Harm Reduction	Use of harm reduction techniques can be both helpful and exacerbate existing conditions	4	25

Facilitator Theme 1: Accountability

Accountability is seen as a facilitator because Alameda County has held their own agencies accountable for reporting the results for expenditures of County funds, but as previously discussed, this does not appear to be true for Alameda County subcontracted entities. Agencies emphasized efforts to find inventive processes to provide County services to the unhoused community that contractors were not expected to incorporate in their deliverables. Developing accountability standards that incorporate contractors as well as County agencies was viewed as a congruent approach towards developing integrated coordinated care policies for the unhoused community. Practitioner Participant 4 spoke to this by stating,

> …All of it matters and we're only able to think about what the budgeting allows because that's all we have at our fingertips because it comes up from the Feds as well. We need more understanding and advocacy at a local level first to be able to

> shift things to demonstrate how it works to take it forward up the chain to be a model for the rest of the country. There are other places in the world that already model how to do some of these things successfully. We don't learn from that and try to implement that ourselves because it's too expensive.
>
> Part of what I think the county should do is provide a standard, especially since we contract all these services out, a standard orientation that folks can go through, even though they're not our direct employees. We provide the guidelines. We provide training like what we have for our staff for those employees. You learn tutorials either in person or online and we set the orientation. So, the expectations are clear on what our contractors are yet to do and the employees coming in can get that firsthand from us and really set those standards for everyone.

Department heads also thought of accountability as a facilitator yet viewed funding as the motivator for accountability. Department Head 3 related,

> They definitely saw that theme there if counties are given flexible dollars to support individuals with complex needs. What are the things they're going to launch? Most counties used those dollars in one form or another heavily towards homelessness and heavily towards behavioral health. That says a lot right there. Counties also use that money to say we need better data systems. Alameda County set up the SHIE, the Social Health Information Exchange, which lives on, of course, and is sort of seen a new life under CalAIM. It really touched on some key areas there that are now kind of wrapped up and repackaged under CalAIM and looks different.

> At least, it sort of got the State to recognize that across California, if we could do anything with this money, this is the priority for us. I do think that that helped launch CalAIM, because we knew Whole Person Care would end because the State is never comfortable with flexible dollars for too long, letting counties propose how they want to spend funds on their own. So, we knew that that would come to an end, and then the State would be more prescriptive with how money was spent with learning from how Whole Person Care got released to now funding something like the CalAIM waiver.

Department Head Participant 4 also stated,

> We think of it when we think about services as a high-cost model, right? The per client cost of a full-service partnership (FSP). When you think about the actual cost of that person not receiving that support and how we all talked about this many times, right? It's like the $1 million dollar Murrays [Murray Barr, an unhoused person with substance use disorder in Nevada whose medical bills totaled $1M over the course of ten years (Gladney, 2006).] of a long time ago. The kind of first report that pointed to this shows that the cost of someone to not have that full-service partnership (FSP) is a lot more costly in terms of the amount of systems they bounce through. So, it's simple. If we had robust care where people had dedicated teams that could meet their needs and preempt accessing those services, and even if they do help them navigate out of there to where they don't just fall back in, then, that's what it would take, short of changing our systems radically to force integration and force homeless services to be embedded

> at every emergency department and force behavioral health services to be connected at every shelter. Teams that can essentially mobilely support people and be their navigators is the only other option. And right now, we have that in a limited way. So, if we scale that, that would probably be the quickest way to shore up a major system change to reduce right or increase the integration.

Facilitator Theme 2: Case Management

Under Barrier Theme 4, participants had already established case management as an integral part of an effective integrated coordinated care policy for the unhoused population. When present, participants agreed that it would assist clients with wraparound services that could be offered under an integrated coordinated care policy. Using additional quotes, Practitioner Participant 9 stated,

> Case management and coordinated care are very similar. They kind of go hand in hand in programs like mine. You often are dealing with a population of folks that have multiple different challenges. And so, having one, different teams all working together, and then also, we all each are kind of doing some type of like case management for that patient: even with us, having, like the structure of being like a care team setting, each one of the care team members are doing some portion of case management for that patient that they're all surrounded.

Facilitator Theme 3: Harm Reduction

Harm reduction programs are listed as both a facilitator and barrier because participants saw these programs as both an assistance and hindrance to the unhoused population. Using a different quote for this section, Practitioner Participant 3 stated,

> On the street, harm reduction is a little bit easier, because there's no program there. It makes a lot of sense for people. For example, one woman, she's taking the Suboxone in the injection form. I don't believe she's using any heroin, but she's still using crystal meth. Maybe heroin is more of a trigger for her and the crystal is something she can take or leave. I'm not speaking for her, but that's kind of what I get from people's different drugs of choice. It does seem like there's heavier substances out there for other people. They might just need that one thing to get them back on track, but they're still using a drug. I do think the ultimate goal for people, in my opinion, is to stop, but they just may not be in a position to either verbalize it because they don't even know where to begin or they wouldn't know what life was like without drugs. They've been using meth or heroin for 20 plus years and they're only 40. So where does one even begin? There's so much held on to [trauma] that for that person, harm reduction does work.

From this participant's perspective, harm reduction is a facilitator, not a barrier to effective integrated coordinated care policies in that it can be an additional resource to assist clients to a path of stabilization.

Summary

This chapter provided the data and data analysis from the interviews of the selected 14 participants, 10 practitioners and four department heads/policymakers. The questions in the interview guide were coded to reflect the themes for barriers and facilitators of integrated coordinated care policies for Alameda County's unhoused population. In some cases, a theme operated as both a facilitator and barrier, such as harm

reduction and case management. In Chapter 5, the results will be discussed through the lens of the theoretical framework and recommendations will be made based on that discussion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This chapter will discuss the conclusions and recommendations of my generic qualitative study conducted to answer the research question:

RQ1: What are the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County?

I performed a qualitative study to address the research question in this study. The specific research design was a generic study, for which I used semi-structured interviews through a researcher-created interview guide. For the interviews, I recruited 10 practitioners and four department heads at Alameda County departments responsible for direct services to the unhoused community. For the coding, I used descriptive coding, as described by Saldana (2016), using first and second-cycle coding. (p. 97). I also used a qualitative data analysis tool (QDA) for coding to assign color-coded labels to words or phrases in the data. This chapter also includes recommendations and conclusions from the analysis conducted in Chapter 4. The key findings were:

1) There was no established integrated coordinated care policy for Alameda County despite previous initiative attempts.
2) While holding their own agencies accountable and providing some useful programs such as harm reduction and attempts at case management on an inconsistent basis, there was no consistent care policy due to a lack of

oversight for contractors and an overall lack of consistent programs such as harm reduction and case management for the unhoused community.

3) A lack of housing can circumvent service provision for the unhoused community.
4) There was a preference for department heads to develop a policy that is an either/or process for the unhoused community with behavioral health challenges. Either they receive care that is legally mandated or face imprisonment.
5) Additionally, practitioners and department heads found HIPAA restrictions compounded by behavioral health challenges for the unhoused community limited the service process as well as any progress toward creating integrated coordinated care policies for both Alameda County agencies and contractors, resulting in gaps of service for that community.
6) There is a lack of diversity in Alameda County's leadership, which may inhibit creative thinking regarding integrated coordinated care policies as well as funding more diverse contractors.

Interpretation of the Findings

As already stated, the problem statement was that there had been services provided to the unhoused community in Alameda County for over 37 years; however, there is no concrete evidence of a cross-organizational policy or effective integrated, coordinated care policy. There also appeared to be no consensus as to why this policy creation has not been accomplished. Accordingly, the specific research problem that was

addressed through this study is that it is not known what policy barriers, and conversely, facilitators and practitioners in clinical and penal institutions face in implementing integrated coordinated care for unhoused behavioral health recipients in Alameda County.

The results showed what the practitioners and department heads determined were some of the policy barriers, and conversely, facilitators, they faced in implementing integrated coordinated care policies for unhoused behavioral health recipients in Alameda County. To interpret the subsequent findings, I confirmed my findings with the literature found in Chapter 2.

My first key finding was that Alameda County did not have an established integrated, coordinated care policy despite previous attempts at initiative. One of those initiative attempts mentioned in Chapters 2 and 4 was the Whole Person Care initiative attempt and failure. Chuang et al. (2020) performed a study on Alameda County's attempt at Whole Person Care (WPC) during 2016-2018. As explained by practitioner participants, the WPC initiative failed in Alameda County because of the challenges also mentioned in my study as ongoing problems.

As mentioned by Chuang et al., there were challenges with partner engagement. The strategies included proactive and consistent communication, clarifying mutual goals for shared clients, formal contracts, and financial incentives for clients. Data sharing, identifying eligible beneficiaries, engaging beneficiaries in care, accessing affordable housing, and accessing other services were identified as issues in this study (Chuang et al., 2020). These are all issues my current study's participants identified as ongoing

problems. Accordingly, Chuang et al. (2020) were consistent with my finding that the lack of an integrated, coordinated policy had been previously identified, but the issues due to this lack of policy remain unresolved, and having such a policy was and is extremely important for vulnerable populations such as the unhoused in Alameda County.

Another key finding was there was no consistent care policy due to a lack of oversight for contractors and an overall lack of case management for the unhoused community. As demonstrated in my findings, each County agency has its own policies to follow that hold their own agencies accountable while also providing some inconsistent programs such as harm reduction and case management. I also discovered that each individual contracting agency has its own policies that govern its service provision to the unhoused community. Yet, there has been and continues to be a demonstrated inconsistency regarding how to provide and document services given to the unhoused community. This has led to service gaps or a failure to provide any services because there is nothing available as an overall tool for service governance. Additionally, there is no consistent programmatic management for the unhoused community. Having inconsistent programmatic management, such as case management and harm reduction, was identified as one of the contributing barriers to establishing an integrated, coordinated care policy in Alameda County. Participants identified case management as an integral part of providing integrated, coordinated care as well as harm reduction as a useful tool for integrated, coordinated care when these programs are fully operationalized and thus should be fully defined for inclusion in any established integrated, coordinated care policy for Alameda County.

Accordingly, my finding was consistent with Sandhu et al. (2021), who discussed the necessity of having a consistent care policy for all service providers. Sandhu et al. (2021) researched the last 10 years of government policy reform and progress to advance the integration of health and social care in the United States. The authors focused on certain policy developments and opportunities that resulted in the implementation of new policy initiatives that provided for integrated care programs for vulnerable populations. To create these initiatives, Sandhu et al. (2021) stated that government health agencies, healthcare organizations, and community-based organizations needed to develop programs that incorporate their resources in a singular program. Additionally, my finding was consistent with Sandu et al. (2021), who stated

> National policies have catalyzed initiatives to test new integrated health and social care models, with the ultimate goal of improving population health and decreasing costs. Preliminary findings demonstrated the need for validated measures of social risk, engagement across levels of organizational leadership and frontline staff, and greater flexibility from national policymakers in order to align incentives across sectors. (p.1, 6)

My finding was also consistent with Taylor et al. (2022), who confirmed the need for consistent case management in assisting the unhoused community with achieving stabilization and necessitated its inclusion as an integral part of any integrated coordinated care policy. Taylor et al. (2022) specifically stated, “Case management was associated with all service use outcomes with all relationships demonstrating more case management visits was associated with greater odds of routine service utilisation” (p. 1).

Another of my findings was that the lack of housing can circumvent service provision for the unhoused community. It appeared that service provision could also depend upon the ability to locate a person who needs assistance, as the unhoused community is very mobile and without a stationary address. Service providers may know the general proximity of an unhoused person but cannot necessarily depend on this for accuracy. This has led to service gaps, which revealed a possible health service inequity.

My study finding was consistent with Lamparter et al. (2020), who discussed services for the unhoused. The authors stated that because of a lack of ongoing resources, the unhoused tended to have more psychiatric diagnoses and substance use, and were often incapable of getting additional resources due to fear of discrimination regarding their housing status; however, Lamparter et al. (2020) also stated specifically, "Homeless patients also face many barriers to obtaining primary care, including fear of stereotypes and discrimination, difficulty presenting proof of insurance, transportation issues, and scheduling problems" (p. 1317). Again, this was consistent with the finding regarding the barriers that the unhoused community faced simply due to a lack of an address.

Another key finding was that there was a preference for department heads to develop a policy that is an either/or process for the unhoused community with behavioral health challenges. Either the unhoused community with behavioral health struggles receives the care that is legally mandated by the courts or faces imprisonment for failure to follow through with any court mandates. This did not mean that there would be any policy that would designate integrated, coordinated care. Instead, the department heads would treat the court process as Johnson (1996) described in this study's conceptual

framework. Johnson (1996) asserted that organizations tend to approach issue resolutions by identifying problems and attempting to solve them as if there is only one resolution to be accepted with all others rejected, or in that either/or thinking process. This approach limited any participation by practitioners who wanted to provide services for the unhoused community and could result in health inequities. At the same time, clients would go through a court process to receive care.

My finding regarding department heads' policy preferences was consistent with Loong et al. (2021). Their study was regarding the effectiveness of mental health courts. The authors stated that the results of their study demonstrated that the suggestion to strengthen the mental health court system also demonstrated the need to provide court participants with the necessary care in the first place. Loong et al. (2021) specifically stated

> Thus, it is possible that fewer individuals would rely on mental health courts as a last resort for help if they received the services they needed in the first place – suggesting greater access to community mental health services may be one answer (p.5).

Accordingly, the need for an integrated coordinated care policy should be considered as a part of the solution for care for the unhoused community in Alameda County.

Another key finding was that practitioner and department head participants found HIPAA restrictions compounded by behavioral health challenges for the unhoused community limited the service process as well as any progress toward creating integrated coordinated care policies for both Alameda County agencies and contractors, resulting in

gaps of service for that community. Succinctly, HIPAA restrictions established in Alameda County did not allow for a comprehensive medical record inclusive of all services provided for anyone in the unhoused community. This is due to County agencies and contractors each using separate medical record systems and based on HIPAA laws, appropriately limiting access to anyone outside of their respective agencies. Accordingly, the ability to communicate with other agencies and contractors regarding care for the unhoused community has been limited and problematic as practitioners must then rely on the behavioral health clients to consent to providing information. Because each agency, contractor, and medical facility in Alameda County has their own system, there was no one place where service care information could be accessed to ensure a continuum of care in Alameda County.

Rivzi et al. (2021) was consistent with this finding. In their study, the authors discussed a program Sonoma County developed and used which was called "a Care Management and Coordination System (CMCS)" (p.1). Rivzi et al. (2021) also stated that the system "comprised the Watson Care Manager (WCM), a front-end system, and Connect 360, which is an integrated data hub that aggregates information from various systems into a single client record", which demonstrated that the finding regarding HIPAA restrictions and the ability for cross agency communication regarding care for the unhoused community is feasible. This has also made policy development, such as what Rivzi et al. (2021) described in their study, difficult.

Rivzi et. al was also consistent with the finding that providing effective care for vulnerable populations would require collaboration and coordination. Rivzi et al. (2021)

contended that, "… The CMCS (Care Management and Coordination System) data hub, comprising WCM (Watson Care Manager) and Connect360, helped to retrieve and consolidate data in one shared place. It provided case workers with the most recent data, such as court dates, benefit eligibility due dates, and doctors' appointments for clients who often need timely actions. According to users, WCM played a valuable role in addressing the challenges unique to social work with homeless populations where information is often transient, including mobile phone numbers, addresses, and contact information" (p.8), not only demonstrating the need for a single comprehensive medical record for service providers but also for the individual clients' ability to accept services.

Finally, the key finding regarding diversity was that there was a lack of diversity in Alameda County's leadership, which may have inhibited creative thinking regarding integrated coordinated care policies as well as inhibited funding to more diverse and qualified contractors. This was interesting given the demographic for Alameda County's unhoused community, which is primarily people of color. My study found that it was essential to have diverse service providers and policymakers that may be able to have more creative ideas regarding service provision that could create more outreach to the unhoused community in Alameda County. When diversity in staffing and leadership has not occurred, there have been apparent service inequities for that population.

Nohria et al. (2022) was consistent with my finding that a lack of diversity created a possible deterrent, stating, "One potential explanation is that Black PEH (people experiencing homelessness) may be less inclined to return for health care services due to experiences of racism in health care" (p. 1275). The authors also stated that other studies

have reported that Blacks have reported experiencing institutionalized racism, including implicit and explicit bias, within the health care system by receiving less care in the emergency rooms or fewer admissions to the hospital as well as less ordered testing for diagnoses (Nohria et al., 2022, Zhang et al., 2020, Ross et al., 2020), again using these references to be consistent with my finding that the unhoused community has experienced service or health care inequities.

Theoretical Framework

In looking at the findings through the lens of the theoretical framework, I looked at all the established polarity pairs using the polarity map for each pair as described and shown in Chapter 2. The theoretical framework was Benet's polarities of democracy with Johnson's polarity management as the conceptual framework. Benet developed this framework using Johnson as the model for understanding polarity thinking. In his framework, Benet developed "ten paired values: a) freedom and authority; b) justice and due process; c) diversity and equality; d) human rights and organizational obligations; and e) participation and representation" (2006, 2012, 2013, 2022, 2023) as the polarity pairs as shown in Figure 2. These pairs were interdependent and necessary to establish the arguments through each iteration of Benet's framework. He did this identification to signify the pairs that could best "maximize the abilities and achievements of both the individuals within the organization as well as the organizations, while eliminating the oppression and inequality that occurs when some individuals wield unchecked power over others" (p. 70).

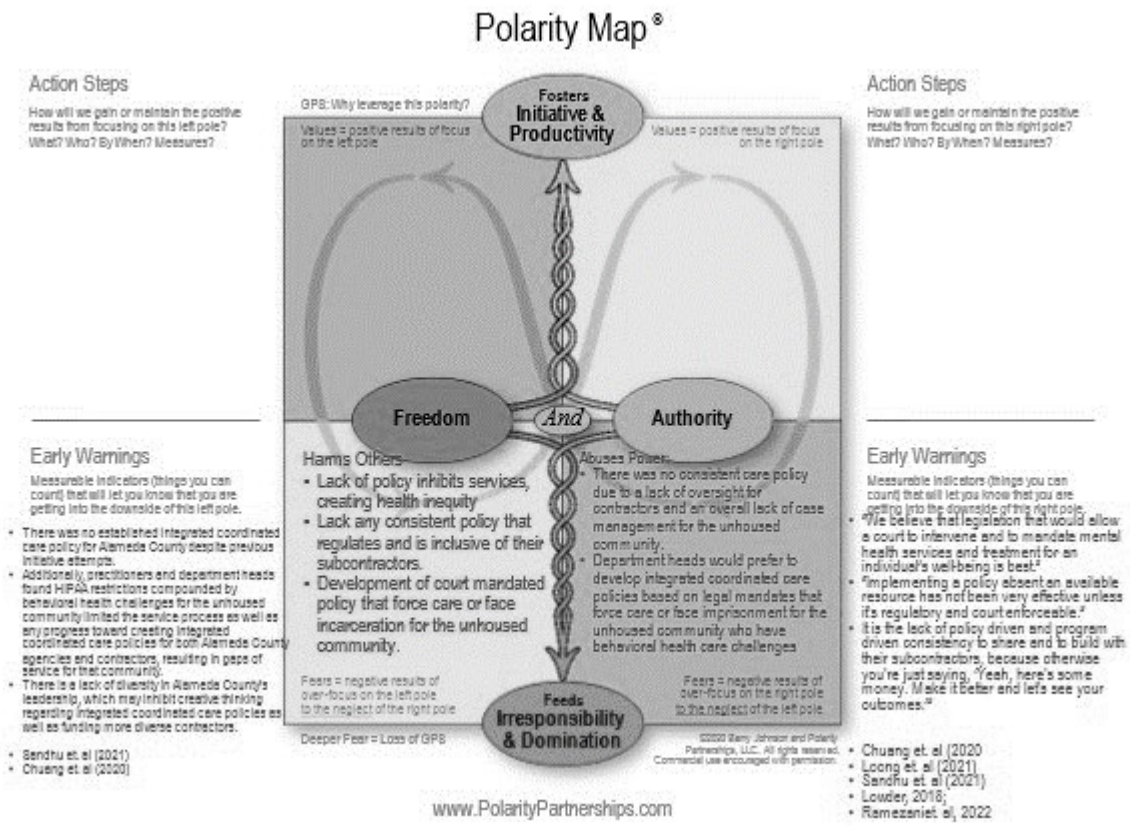
Freedom and Authority

As shown in Figure 8 below, the polarity map for freedom and authority shows actions that promote or foster initiative and productivity. Accordingly, the unhoused community should feel empowered and protected from harm for this pair to have a positive effect. Yet, there were several aspects of the findings, that fall in the negative poles, which pointed to an overall authority over the unhoused community as opposed to freedom for that community.

My study found that the unhoused community has the right of acceptance or refusal of services; however, the logic as echoed for most of the department head participants in Alameda County was to modify that right in favor of court mandated or legislatively driven treatment, as in Care Court mandates. As previously mentioned, department head participants thought this would be a more effective treatment process that could be developed into policy, but it did not necessarily allow for the client to participate freely, inhibiting initiative and productivity. Also, while protected by HIPAA, the lack of policy inhibited service delivery for the unhoused community facing behavioral health challenges. This included a lack of an overall policy for the County that provided detailed subcontractor governance. Accordingly, the resulting loop on the polarity map, as shown in Figure 8, would fall in the negative poles for freedom and authority, which demonstrated that the actions fostered irresponsibility due to client refusal of services and governmental domination due to a voiced intent to legally mandate treatment if any policy was created.

Figure 8

Study Findings as a Polarity Map for Freedom and Authority



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Justice and Due Process

As demonstrated in Figure 9 below, the polarity pair, justice and due process, fosters fairness and protection, which in this study would be for the unhoused community. As such, that community should have a sense of productivity as well as be able to take initiative within their service needs. Yet, the findings demonstrated negative aspects of the polarity pair of justice and due process, thereby signaling an ineffective leveraging, which elicited more insensitivity and levels of retribution, amid a level of

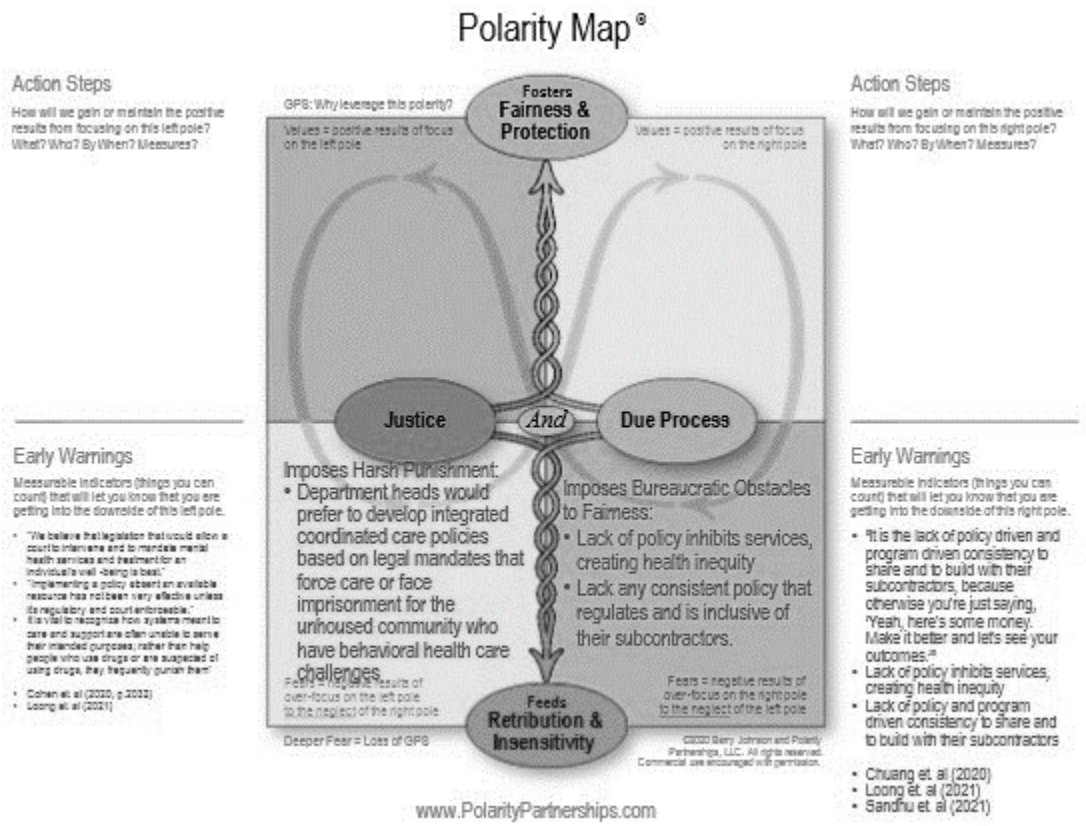
mandate in the process surrounding the creation of an integrated coordinated care policy in Alameda County.

My finding was while the unhoused community continued to have personal health information protection via HIPAA, which would a positive aspect for justice and due process, department heads expressed that court mandates should help drive the efficiency of any integrated coordinated care policy, which would limit the unhoused community to have the ability to accept or refuse services, thereby demonstrating retribution and insensitivity which is the negative poles of justice and due process. Also, my finding was that the unhoused community would still have the right of refusal or acceptance of services; however, there was no established policy that provided oversight for contractors who were paid by Alameda County to perform essential services for the unhoused community. As practitioner participants stated, contractors were paid to provide services with Alameda County without establishing the guidelines of how those services will be rendered or how service completion will be reported, again signaling the negative poles of retribution and insensitivity for the unhoused community's rights to healthcare.

The resulting loop in Figure 9 fell in the negative poles for justice and due process, which demonstrated that the actions fostered retribution due to governmental insistence on developing policies with legally mandated treatment as a course of action or fail penalties such as incarceration. There was also the element of insensitivity to developing a policy that gives the targeted community, the unhoused, a choice or an ability to develop any choices based on a given policy.

Figure 9

Study Findings as a Polarity Map for Justice and Due Process



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Diversity and Equality

As shown in Figure 10 below, the polarity pair, diversity and equality should foster opportunity and sufficiency for the targeted population, which in this study would be for the unhoused community. As such, that community should have an ability to take advantage of opportunities as well as be able to provide for themselves within those opportunities, which in this case would be a path to stabilization through an integrated coordinated care policy. The findings demonstrated negative aspects of the polarity pair

of justice and due process, thereby signaling an ineffective leveraging of the polarity pair, diversity and equality, and showing more disparities in opportunities for the unhoused community and an overall complacency from Alameda County's service organizations.

My findings revealed that Alameda County does not provide services that are easy for the unhoused community to access, which might be mitigated with an integrated coordinated policy. There are often issues with transportation to sites that provide the necessary resources for those in behavioral health or substance use crisis or for those merely attempting to gain access to programs that would put them on the pathway to stabilization.

My findings also revealed that department head participants asserted that without legal mandates, an integrated coordinated care policy might not be enforceable. The sentiment appeared to be that the intention would be to force people to receive care or face legal repercussion, including imprisonment. This is not an incentive to receive care for the unhoused community.

Of the existing policies, there were no policies that govern contractors' practices and service provision as it pertains to the unhoused population. Contractors were funded by Alameda County but developed their own policies that may not have met the standards set by Alameda County's organizations that provide services to the unhoused population.

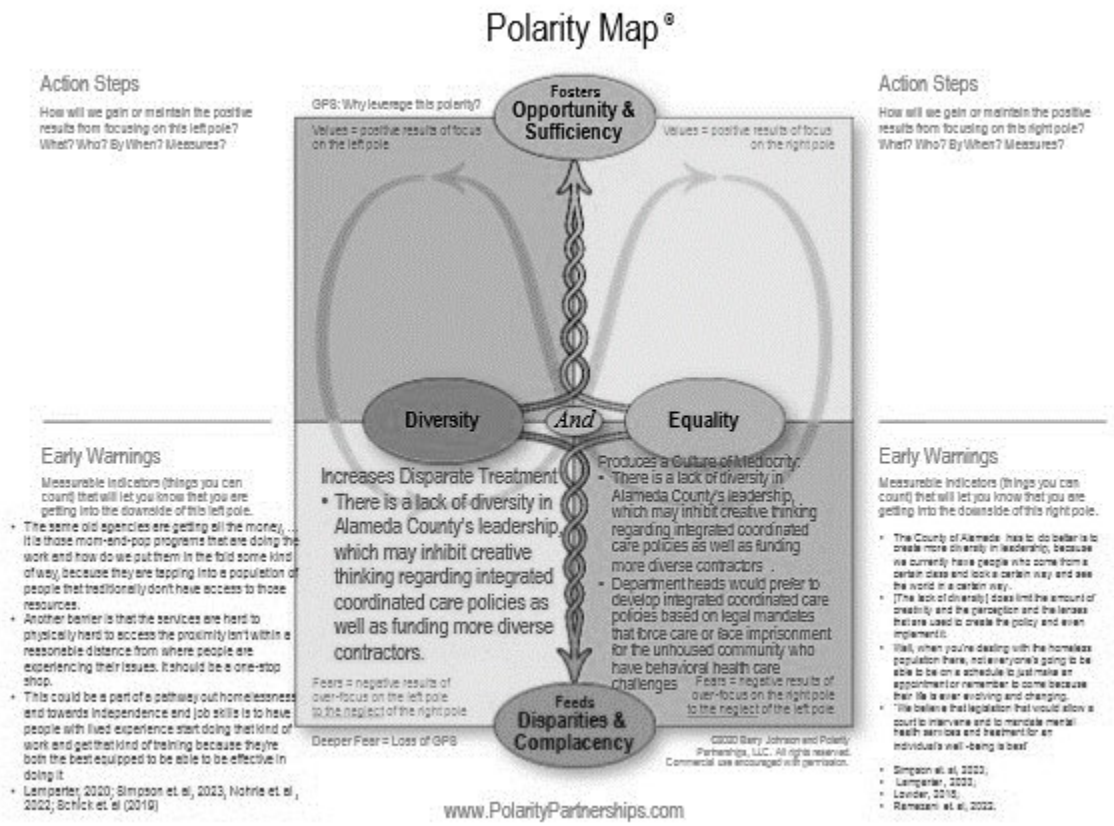
Additionally, my study documented that practitioner participants specifically wanted to see Alameda County create a pathway to independence for the unhoused community by training those with lived experience (i.e. one who had been unhoused and received services) to assist with client engagement. The sentiment was that having those

with lived experience would be extremely helpful in assisting with both finding and reaching those in need, particularly those who may have fallen out of the County's radar.

My study revealed there was also a lack of diversity in leadership in Alameda County's organizations. Practitioner participants lamented the lack of diversity as part of the lack of creativity around outreach, as there was a sense that the leadership lens was limited. Accordingly, the early warnings for diversity and equality appeared to demonstrate more complacency and disparities without an integrated coordinated care policy in Alameda County for the unhoused community, thereby producing rewards for the privileged and a culture of mediocrity, as shown in Figure 10. The resulting loop in Figure 10 fell in the negative poles when leveraged for diversity and equality, which demonstrated that the actions fostered more complacency and disparities in opportunities for treatment for the unhoused community without an integrated coordinated care policy in Alameda County.

Figure 10

Study Findings as a Polarity Map for Diversity and Equality



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Human Rights and Communal Obligations

As shown in Figure 11 below, the polarity pair, human rights and communal obligations, should foster belonging and independence for the targeted population, which in this study would be for the unhoused community. As such, that community should have felt a sense of belonging in society as well as be able to establish their independence, which in this case would be a path to stabilization through an integrated coordinated care policy. The findings demonstrated negative aspects of the polarity pair

of human rights and communal obligations, thereby signaling an ineffective leveraging of the polarity pair, and showing more of a sense of greed and supremacy in Alameda County's organizations.

My findings revealed that Alameda County did not provide services that are easy to access for the unhoused community, which could be mitigated with an integrated coordinated policy. There were often issues with transportation to sites that provide the necessary resources for those in behavioral health or substance use crisis or for those merely attempting to gain access to programs that would put them on the pathway to stabilization. Department head participants also voiced that without legal mandates, an integrated coordinated care policy might not be enforceable. The sentiment appeared to be that the intention would be to force people to receive care or face legal repercussion, including imprisonment. This is not an incentive to receive any services for the unhoused population.

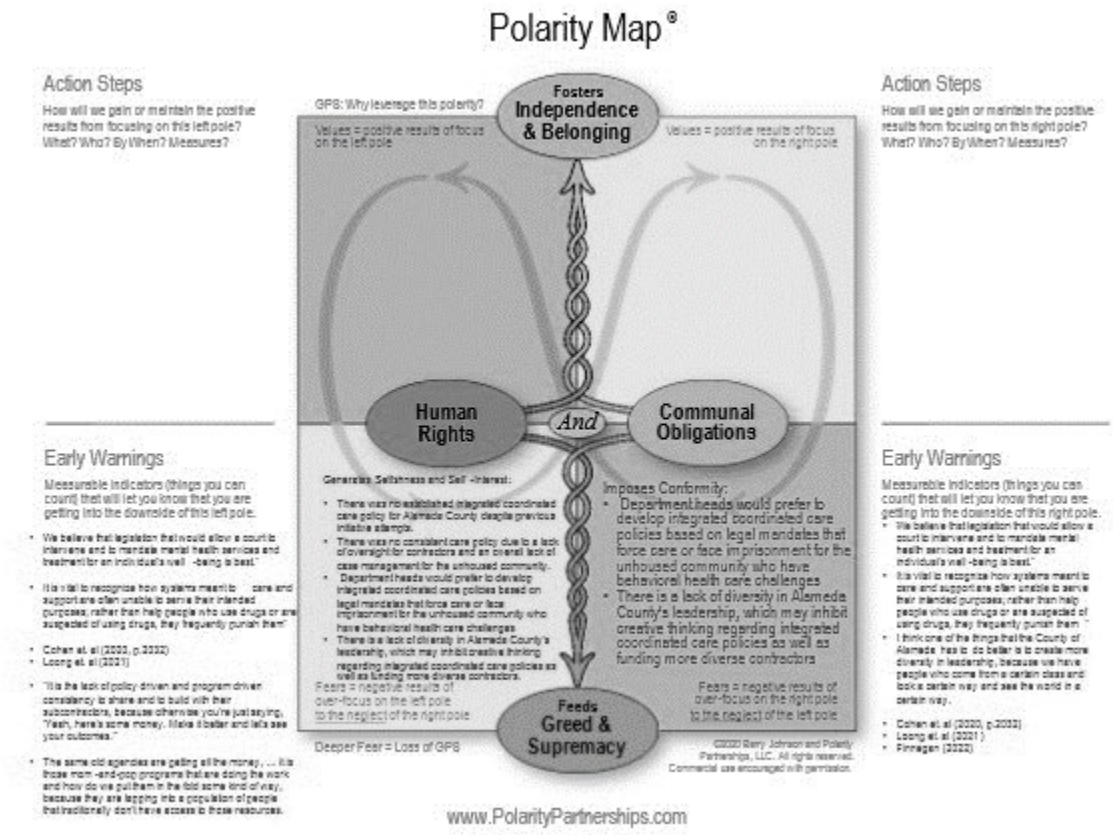
Additionally, my findings revealed that there were no policies that govern contractors' practices and service provision as it pertains to the unhoused population. Contractors were funded by Alameda County but developed their own policies that may not have met the standards set by Alameda County's organizations that provided services to the unhoused population. My study also documented that practitioner participants specifically wanted to see Alameda County create a pathway to independence for the unhoused community by training those with lived experience (i.e. one who had been unhoused and received services) to assist with client engagement. The sentiment was that having those with lived experience would be extremely helpful in assisting with both

finding and reaching those in need, particularly those who may have fallen out of the County's radar.

There was also a lack of diversity in leadership in Alameda County's organizations. Practitioner participants lamented the lack of diversity as part of the lack of creativity around outreach, as there was a sense that the leadership lens was limited. The resulting loop in Figure 11 fell in the negative poles when leveraged for human rights and communal obligations, which demonstrated that the actions fed more selfishness among Alameda County's service providers and imposed conformity in treatment for the unhoused community. Without an integrated coordinated care policy in Alameda County, these actions appeared to establish that there were inequities to establishing independence and a sense of belonging. as shown in Figure 11 below.

Figure 11

Study Findings as a Polarity Map for Human Rights and Communal Obligations



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Participation and Representation

As shown in Figure 12 below, the polarity pair, human rights and communal obligations, should foster productive and responsive policies for the targeted population, which in this study would be for the unhoused community. As such, Alameda County's policies should be inclusive and provide positive pathways for the unhoused community. That community should have felt there was an established program for their stabilization, while practitioners should have productive policies that enable them to provide effective

services. The results demonstrated that since there is no integrated coordinated care policy, Alameda County's department heads and practitioners appeared to provide unproductive services that instead appeared to leave the unhoused community feeling excluded and alienated.

My findings revealed that Alameda County did not provide services that are easy to access for the unhoused community, which could be mitigated with an integrated coordinated policy. There were often issues with transportation to sites that provide the necessary resources for those in behavioral health or substance use crisis or for those merely attempting to gain access to programs that would put them on the pathway to stabilization. Department head participants also voiced that without legal mandates, an integrated coordinated care policy might not be enforceable. The sentiment appeared to be that the intention would be to force people to receive care or face legal repercussion, including imprisonment. This is not an incentive to receive any services for the unhoused population.

Additionally, my findings revealed that there were no policies that govern contractors' practices and service provision as it pertains to the unhoused population. Contractors were funded by Alameda County but developed their own policies that may not have met the standards set by Alameda County's organizations that provided services to the unhoused population. In many cases, because of the lack of an overall integrated care policy, practitioners and unhoused clients did not have clarity as to which program provided which services, leading to a service gap for clients and knowledge gap for practitioners.

Lamparter et al. (2020) was consistent with this finding. The authors stated that because of a lack of ongoing resources, the unhoused tended to have more psychiatric diagnoses, substance use, and often incapable of getting additional resources due to fear of discrimination regarding their housing status. Lamparter et al. (2020) stated specifically, "Homeless patients also face many barriers to obtaining primary care, including fear of stereotypes and discrimination, difficulty presenting proof of insurance, transportation issues, and scheduling problems" (p. 1317). Again, this was consistent with what practitioner participants voiced as their concerns regarding the lack of policy resulting in an ongoing search for resources and how clients' care can suffer from this.

My study also documented that practitioner participants specifically wanted to see Alameda County create a pathway to independence for the unhoused community by training those with lived experience (i.e. one who had been unhoused and received services) to assist with client engagement. The sentiment was that having those with lived experience would be extremely helpful in assisting with both finding and reaching those in need, particularly those who may have fallen out of the County's radar. Opie et al. (2023) confirmed this as well, by stating that even though there are some training limitations, there were positive outcomes achieved for the unhoused community when people with lived experience have been a part of the services they received. Accordingly, the policy should incorporate all internal and external (contractor)service models to create a single coordinated plan of care, as confirmed by Schick et al. (2019)

There was also a lack of diversity in leadership in Alameda County's organizations. Practitioner participants lamented the lack of diversity as part of the lack

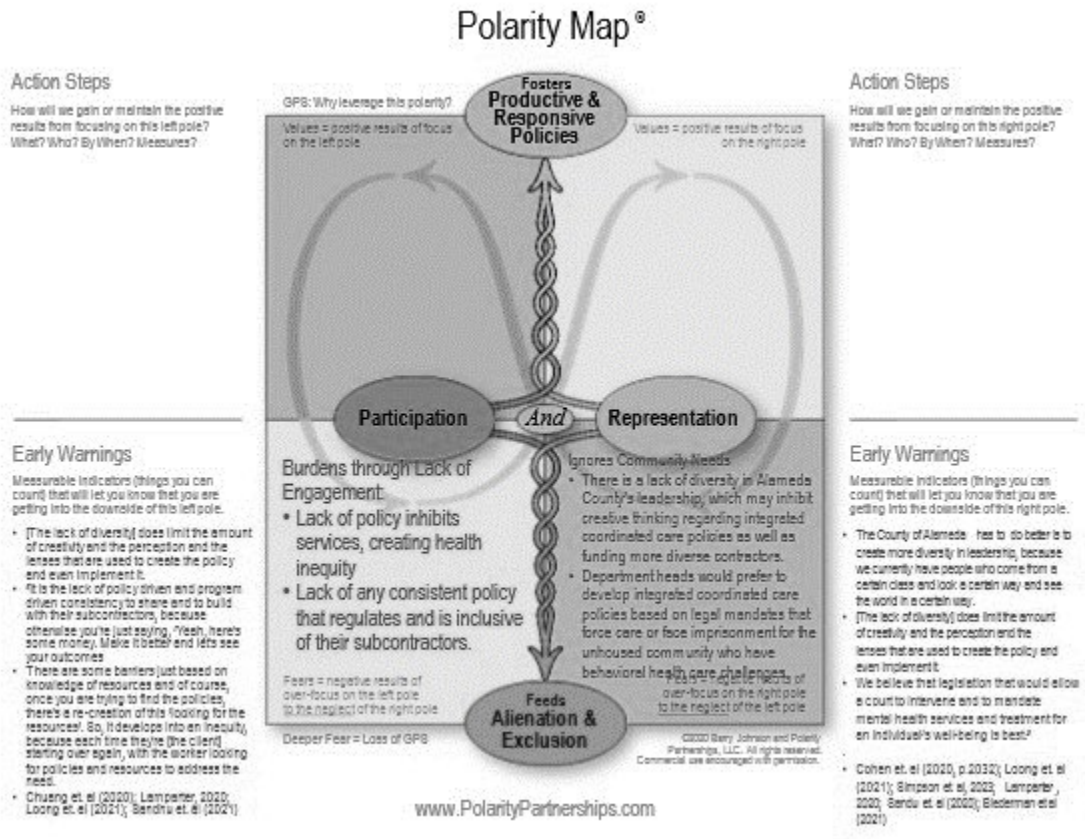
of creativity around outreach, as there was a sense that the leadership lens was limited. With this limited lens, my study revealed Alameda County's established programs did not incentivize clients, sometimes due to staff's lack of knowledge of these programs and a level of inflexibility because of the lack of congruent programs from County organizations and contractors, pointing to the need for an integrated coordinated policy.

Sandu et al. (2021) was consistent with these findings when stating, "National policies have catalyzed initiatives to test new integrated health and social care models, with the ultimate goal of improving population health and decreasing costs. Preliminary findings demonstrated the need for validated measures of social risk, engagement across levels of organizational leadership and frontline staff, and greater flexibility from national policymakers in order to align incentives across sectors" (p.1, 6).

The resulting loop in Figure 12 fell in the negative poles when leveraged for participation and representation, which demonstrated that the actions fed more counterproductivity or a lack of productivity among Alameda County's service organizations based on established policies that did not encompass an integrated coordinated care policy. This also appeared to leave the unhoused community feeling excluded and alienated from service providers attempting care without an integrated coordinated care policy in Alameda County, leading to service inequities for the unhoused community.

Figure 12

Study Findings as a Polarity Map for Participation and Representation



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Limitations of the Study

In Chapter 1, I stated, in terms of limitations, that since I researched integrated coordinated care for unhoused behavioral health recipients in Alameda County, I wanted to get the most accurate information while providing respect for its participants. Yip et al. (2016) stated that the researchers must protect the integrity, privacy, and confidentiality of participants in research. My concern during the study was that those tenets, particularly data integrity, would be breached to make sure that the organization or

department appears to be living up to what they stated they were providing for federal or grant funding. I found that the limitation did occur, supported by some other aspects of the study.

To start, even though qualitative research is open-ended, and perspective based, which results in rich data, participants have more control over the content of the data collected because the responses given are not measured (Price & Murnan, 2004). In some of the results, it may have been helpful to quantify how many within the unhoused community was assisted or refused services through Alameda County's programs.

Another limitation could have been participant bias regarding previous programs that were mentioned, such as the Whole Person Care pilot program. I was able to use literature to check for any possible bias within the study regarding this program, as well as the issue that only one participant critiqued the program.

The purpose of this qualitative generic study was to explore and understand the key stakeholders' perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. Based on this, future research studies can be conducted, which will be discussed below.

Recommendations

For this study, there were 10 practitioners and four department heads who participated. As stated in Chapter 4, the practitioner and department head participants were selected using snowball sampling, as described in that chapter by Nikolopoulou

(2023) and Patton (2015). The participants were asked about their perceptions regarding the barriers to and/or facilitators of implementing an integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County.

During the interview process each of the 14 participants talked about how they would define integrated coordinated care and any subsequent policy of which they were aware. They were also asked about institutional recidivism (emergency room s and penal institutions) and its causes. Some of the responses were beyond the scope of this study but could benefit from future research. For example, several responded that unhoused clients with substance use disorders often without reason will decline direct mobile services, which was not necessarily a part of this study. Moulin et al. (2018) confirmed this when they pointed out that when looking at frequent users of emergency room services in San Diego, California, the three factors of homelessness, substance use, and mental issues were more likely to be present and occurring together, which created complicated issues that needed to be addressed. This suggests that a further study may be necessary to determine what clients feel directly impacts their declination of the services that could lead to a pathway of stabilization.

Another study could be conducted to examine the impact that the lack of an integrated coordinated care policy would have on unhoused families who all need different levels of service or intact families that are attempting to provide support to an unhoused individual struggling with behavioral health care challenges. Either of these

studies could be helpful to understand how impactful effective integrated coordinated care policies could be in Alameda County.

Implications

The empirical implications resulting from this study are intended to map out outcomes that could result from the completed research to support positive organizational, policy, and individual social change for the unhoused community and service provider organizations in Alameda County. Using the lens of Benet's (2006, 2012, 2013) theoretical framework, the intent is to share this study with Alameda County decision makers, so it could result in the development and implementation of an integrated coordinated care policy for the unhoused community in Alameda County with behavioral health care struggles, which could lead to a pathway to stabilization for that community, a positive social change. Accordingly, one of the implications is that Alameda County could accomplish several things by implementing an integrated coordinated care policy. First, the County could provide a homogenous organizational approach to an integrated coordinated care policy by incorporating all services and service providers under one policy. This could also include further development of prototype programs such as harm reduction and a training program for people with lived experience to assist with providing services that exist within current programs as my findings have revealed.

The second item that this policy implementation could address is the finding regarding HIPAA protection limiting the ability to provide services. If Alameda County developed the overarching policy for internal and external providers, there should also be

a coordinated health record. Rivzi et al. (2021) confirmed this in their journal study in discussing the program Sonoma County developed and used which was called "a Care Management and Coordination System (CMCS)" (p.1). They also stated that the system "comprised the Watson Care Manager (WCM), a front-end system, and Connect 360, which is an integrated data hub that aggregates information from various systems into a single client record", which demonstrated that the finding regarding HIPAA restrictions and the ability for cross agency communication regarding care for the unhoused community is feasible and necessary.

Finally, there is an implication regarding diversity in leadership. This is a very impactful implication given the demographic for Alameda County's unhoused community, which is primarily African American at 43% (Burr et al., 2022), and the demographic for department heads for organizations developing the policies is 100% Caucasian based on Table 2 on p.88 of this study. Nohria et al. (2022) proposed there were several reasons that may have been the determinant for this outcome or as the authors referenced, "informed hypotheses" (p.1275). Nohria et al. (2022) stated, "One potential explanation is that Black people experiencing homelessness may be less inclined to return for health care services due to experiences of racism in health care" (p. 1275). The authors also stated that other studies have reported that Black people have reported experiencing institutionalized racism, including implicit and explicit bias, within the health care system by receiving less care in the emergency rooms or fewer admissions to the hospital as well as less ordered testing for diagnoses (Nohria et al., 2022, Zhang et al., 2020, Ross et al., 2020). There could be a necessity to expand the lens of the policy

maker as Alameda County practitioner participants have suggested, which could result in positive social change for the unhoused community. Several voiced this concern during the data collection in that they stated that it may be helpful for the unhoused community to see people who look like them providing services as well as the lack of diverse leadership leading to a narrower view of service possibilities. Otherwise, it appeared to be a health inequity for the unhoused community in Alameda County.

Zhang et al. (2020), as referenced above, was also consistent with my finding when they discussed significant racial/ethnic differences in the evaluation and management of adult patients in the emergency department. The authors stated there appeared to be nothing extraneous to the failure of services than the person's racial identity. Zhang et al. (2020) went further, stating that Black patients and those in the other racial/ethnic group "were less likely than white patients to receive immediate or urgent ESI scores as opposed to semi- or non-urgent care needs. Our study indicates that this racial/ethnic disparity could not be explained by demographic, socioeconomic, or factors related to the patients' clinical presentation or the context of their visit" (p. 4). This study exposed a service bias as it pertained to disparities based on race for the unhoused community and access to coordinated care, a sentiment echoed in this study. This study was consistent with my finding regarding the need to have a wider lens in leadership and policymaking to develop an effective integrated coordinated care policy for Alameda County, which could result in positive social change for the unhoused community, as well as service providers.

As shown in Figure 13 below, in applying the information to the polarity map for freedom and authority, which would foster initiative and productivity, action steps and results could empower the unhoused community and protect individuals from harm. The action step for freedom would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflect the community and would be funded by Alameda County. (Tsai 2020; Sandu et al., 2021).

The first positive result for freedom that could empower the unhoused community is that it could allow members a roadmap to participate in care services and a pathway to stabilization. The second result could be for service providers in that it could provide internal and external practitioners with a clear understanding of available resources. Finally, it could be a way to develop diverse leadership with decision making regarding integrated coordinated care, where Alameda County would hopefully consider that since a significant portion of the unhoused community is Black or African American (43%), there might be more success by employing people in leadership roles with a more rounded view of the challenges that black and brown people face (Opie et al., 2023; Burr et al., 2022).

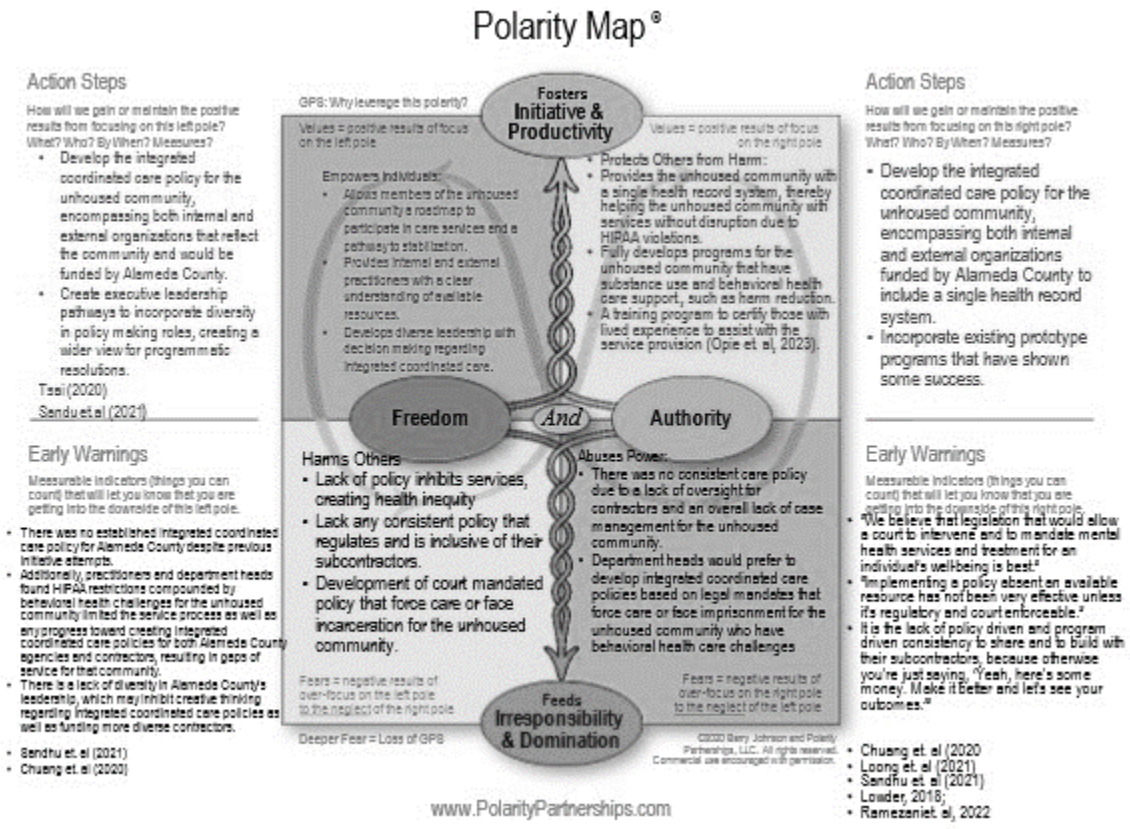
The first action step for authority that could protect individuals from harm could be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations funded by Alameda County to include a single health record system. Having a single health record system would have all providers using a system funded by Alameda County should capture all services

rendered by internal and external organizations under their purview for an individual, which could be useful in helping the unhoused community with service provision without disruption due to HIPAA violations as a result.

The second step for authority could be to incorporate existing prototype programs that have shown some success with providing services for the unhoused community. The result would provide a level of protection for both the unhoused community and service providers. Expanding programs that can help ease issues for the unhoused community struggling with substance use, such as harm reduction, which would assist them by helping them to safely use while addressing their addiction while still unhoused and not in a program. Also, developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have been found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023).

Figure 13

Action Steps as shown on a Polarity Map for Freedom and Authority



Note: Image reproduced with permission of Polarity Partnerships LLC and the Polarities of Democracy Institute

As shown in Figure 14 below, in applying the information to the polarity map for justice and due process, which would foster fairness and protection, action steps and results could treat the unhoused community fairly and protect the rights of individuals. The action step for justice would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflect the community and would be funded by Alameda County (Tsai 2020; Sandu et al., 2021).

One result for justice that could treat the unhoused community fairly would be to provide services where the unhoused community live, with no residence required. This would enable the community to receive services where they are, with no expectation of having an address.

Another result could be to train people with lived experience to assist with providing services. Developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023).

Lastly, a result could be to provide members of the unhoused community with a clear understanding of available resources. This would allow them to know what is accessible for treatment or any other possible services that would be a part of the integrated coordinated care policy, allowing them to participate in their care.

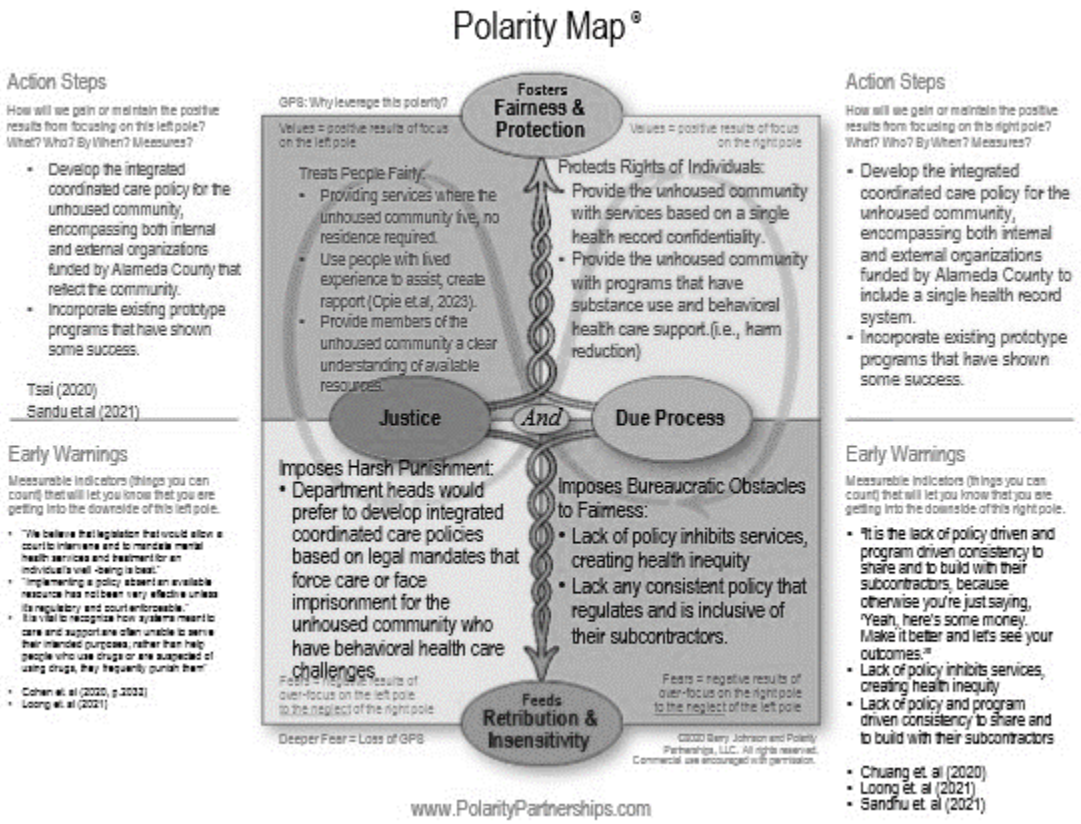
The action step for due process could be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations funded by Alameda County to include a single health record system. The result of having a single health record system would have all providers using a system funded by Alameda County should capture all services rendered by internal and external organizations under their purview for an individual, which could be useful in helping the unhoused community with service provision without disruption due to HIPAA violations.

The second action step would be to incorporate existing successful prototype programs into the integrated coordinated care policy. One of the results could be to train people with lived experience to assist with providing services. Developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have been found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023).

Another program expansion, harm reduction, can help ease issues for the unhoused community struggling with substance use, such as harm reduction, which would assist them by helping them to safely use while addressing their addiction while still unhoused and not in a substance use program.

Figure 14

Action Steps as shown on a Polarity Map for Justice and Due Process



Note: Image reproduced with permission of Polarity Partnerships LLC and the Polarities of Democracy Institute

As shown in Figure 15 below, in applying the information to the polarity map for diversity and equality, which would foster opportunity and sufficiency, action steps and results could celebrate the unhoused community's uniqueness and treat them with dignity and respect. The first action step for diversity would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflect the community and would be funded by Alameda County, as shown in Figure 15 (Tsai 2020; Sandu et al., 2021). The result would be to

provide services where the unhoused community live, with no residence required. This would enable the community to receive services where they are, with no expectation of having an address.

The second action step would be to incorporate existing successful prototype programs into the integrated coordinated care policy. The result could be to train people with lived experience to assist with providing services, while also reflecting the main demographic of the community. Developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have been found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023).

The first action step for equality would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflected the community funded by Alameda County to include a single health record system., as shown in Figure 15 (Tsai 2020; Sandu et al., 2021). As stated earlier, having a single health record system would have all providers using a system funded by Alameda County should capture all services rendered by internal and external organizations under their purview for an individual, which could be useful in helping the unhoused community with service provision without disruption due to HIPAA violations. The result could support interdisciplinary teams with going into the community provide services, as well as incentives to get services (Simpson et al., 2023).

The other result could be to provide services where the unhoused community lives, with no residence required. This would enable the community to receive services where they are, with no expectation of having an address, thereby treating the unhoused community despite their circumstances.

The second action step would be to incorporate existing successful prototype programs into the integrated coordinated care policy, while the third action step would be to develop leadership pathways to incorporate diversity in policy making roles, creating a wider view for programmatic resolutions. The results for these steps would be programs that reflect the majority demographic of the community, which according to Burr et al. (2022) is Black or African American at 43% in 2022. Accordingly, a program to train people with lived experience to assist with providing services, while also reflecting the majority demographic of the community. Developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have been found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023).

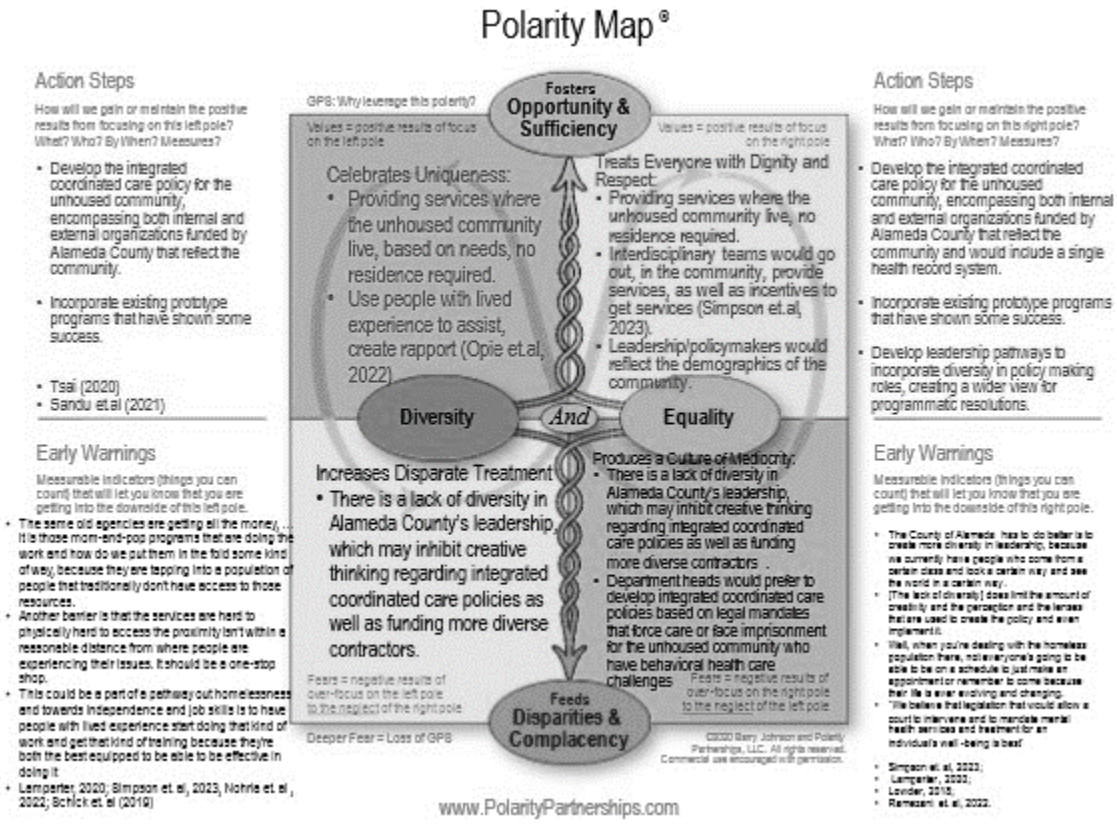
Another program expansion, harm reduction, can help ease issues for the unhoused community struggling with substance use, such as harm reduction, which would assist them by helping them to safely use while addressing their addiction while

Lastly, a result could be to develop leadership pathways to incorporate diversity in policy making roles, creating a wider view for programmatic resolutions. To do this

would allow for promotional opportunities to executive leadership positions for qualified people of color, but also could expand the creativity in creating programs for the unhoused community. Information beyond the scope of this study would need to be developed to determine how best to accomplish these promotional opportunities.

Figure 15

Action Steps as shown on a Polarity Map for Diversity and Equality



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As shown in Figure 16, in applying the information to the polarity map for human rights and communal obligations, which would foster independence and belonging, action steps and results could protect the rights of the unhoused community and promote a

culture of shared commitments. The first action step for human rights would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflect the community and would be funded by Alameda County, which would include a single health record system (Tsai 2020; Sandu et al., 2021). As stated earlier, having a single health record system would have all providers using a system funded by Alameda County that would protect medical information while capturing all services rendered by internal and external organizations under their purview for an individual, which could be useful in helping the unhoused community with service provision without disruption due to HIPAA violations from multiple systems. The other result could be to provide services where the unhoused community lives, with no residence required. This would enable the community to receive services where they are, with no expectation of having an address, thereby treating the unhoused community despite their circumstances.

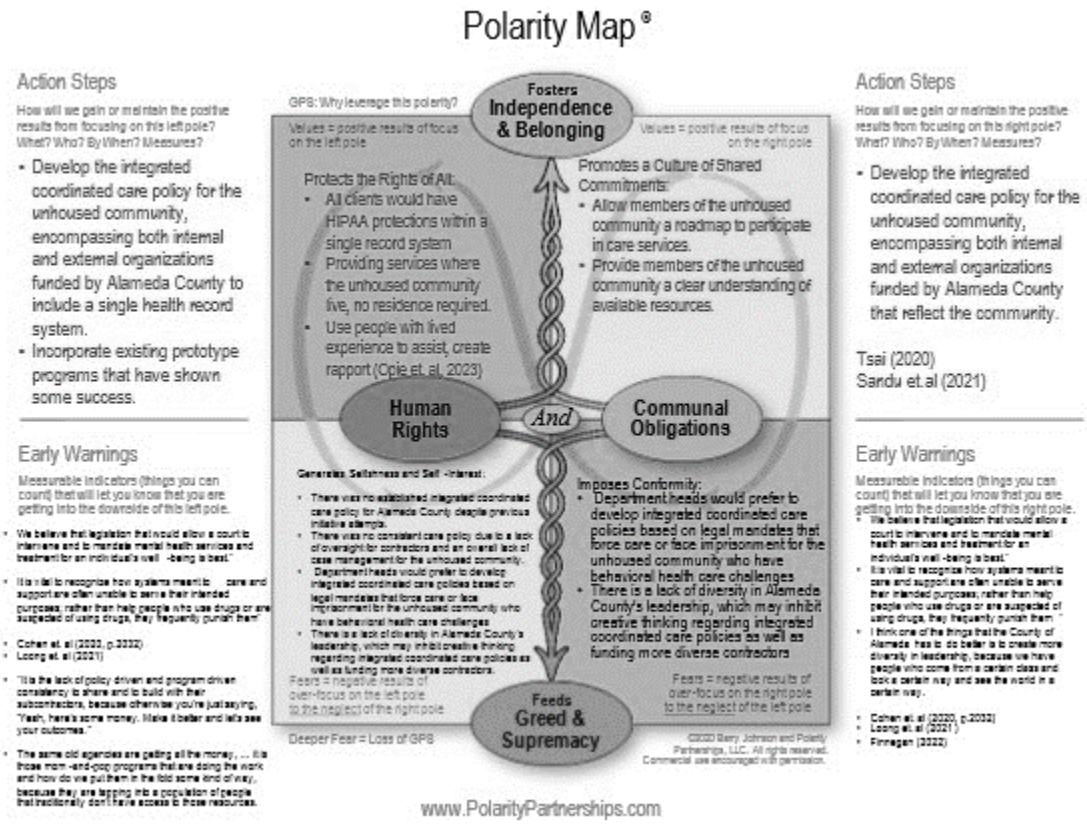
The second action step would be to incorporate existing successful prototype programs into the integrated coordinated care policy, The result could be a program to train people with lived experience to assist with providing services, while also reflecting the majority demographic of the community, which 43% Black or African American (Burr et al., 2022). Developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have been found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service

providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023).

The first action step for communal obligations would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflect the community and would be funded by Alameda County, as shown in Figure 16 (Tsai 2020; Sandu et al., 2021). One result could be to provide members of the unhoused community with a clear understanding of available resources. This would allow them to know what is accessible for treatment or any other possible services that would be a part of the integrated coordinated care policy, allowing them to participate in their care. The second result could be for service providers in that it could provide internal and external practitioners with a clear understanding of available resources.

Figure 16

Action Steps as shown on a Polarity Map for Human Rights and Communal Obligations



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As shown in Figure 17 below, in applying the information to the polarity map for participation and representation, which would foster productive and responsive policies, action steps and results could generate meaningful engagement and consider the needs of the unhoused community. The first action step for participation would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and external organizations that reflect the community and would be funded by Alameda County, which would include a single health record system (Tsai 2020; Sandu

et al., 2021). As stated earlier, having a single health record system would have all providers using a system funded by Alameda County that would protect medical information while capturing all services rendered by internal and external organizations under their purview for an individual, which could be useful in helping the unhoused community with service provision without disruption due to HIPAA violations from multiple systems. The other result could be to provide services where the unhoused community lives, with no residence required. This would enable the community to receive services where they are, with no expectation of having an address, thereby treating the unhoused community despite their circumstances.

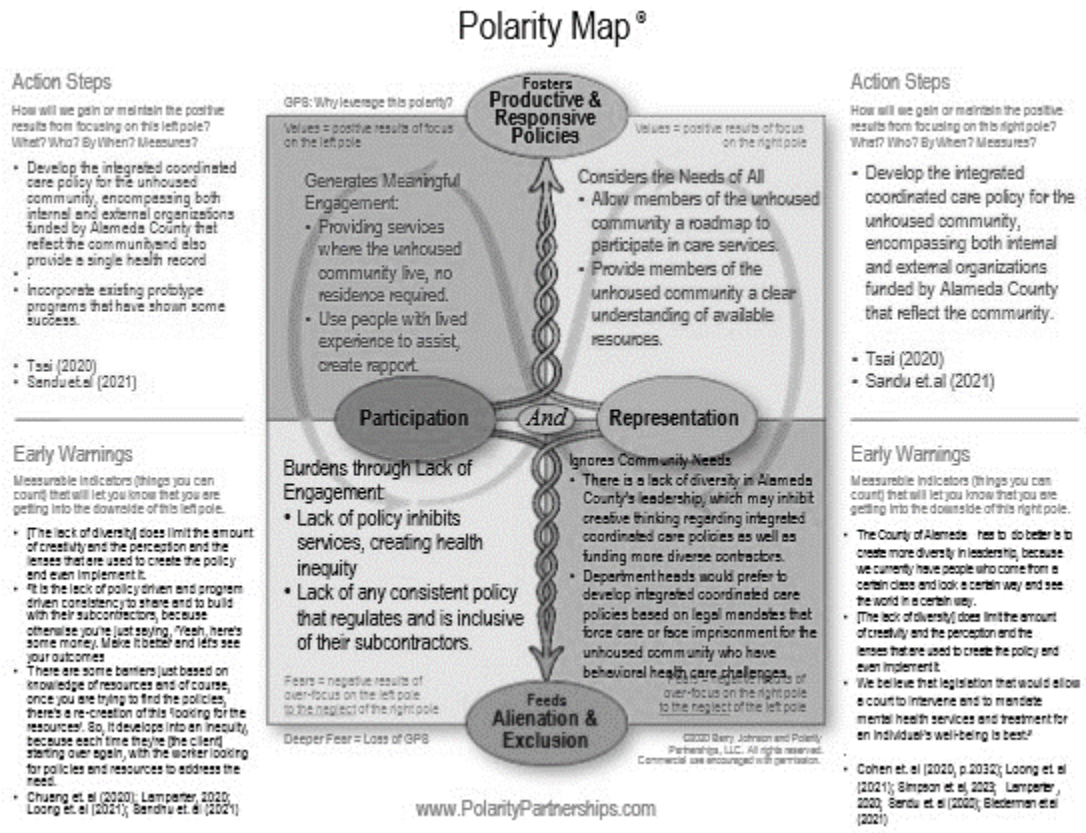
The second action step would be to incorporate existing successful prototype programs into the integrated coordinated care policy, The result could be a program to train people with lived experience to assist with providing services, while also reflecting the majority demographic of the community, which 43% Black or African American (Burr et al., 2022). Developing training programs for people with lived experience to assist with service provision within organizations would provide a possible career ladder for those that have been found stabilization through Alameda County's possible integrated coordinated care programs. Those with lived experience can provide service providers with insight into how to better assist the unhoused community, while also developing rapport with both providers and clients (Opie et al., 2023). With both in place, this would allow the unhoused community to participate meaningfully in their care.

The first action step for representation would be to develop the integrated coordinated care policy for the unhoused community, encompassing both internal and

external organizations that reflect the community and would be funded by Alameda County, as shown in Figure 17 (Tsai 2020; Sandu et al., 2021). One result could be to provide members of the unhoused community with a clear understanding of available resources. This would allow them to know what is accessible for treatment or any other possible services that would be a part of the integrated coordinated care policy, allowing them to participate in their care. The second result could be for service providers in that it could provide internal and external practitioners with a clear understanding of available resources, which would allow the practitioners to feel that they are aware of services and can provide a full-service menu of care for the unhoused community.

Figure 17

Action Steps as shown on a Polarity Map for Participation and Representation



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Conclusion

My generic qualitative study was conducted to provide the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County.

Alameda County should provide the unhoused community with ongoing services that address any inequities in provisions. By developing the integrated coordinated care policy, Alameda County could provide positive social change for the unhoused community on an individual and family level by allowing their participation in their care, providing them with a roadmap of services that can lead to a pathway of stabilization, and a possible career path for those that stabilized and want to assist with services to their previous community.

Alameda County can also provide the practitioners with an integrated coordinated care policy that includes funding for a single health record source and addresses all available resources that will enable service providers to assist the community without any disruption to the available resources. In addition to providing the policy, Alameda County policymakers should also provide those providing direct services with a set of codified and clearly defined standards that would be a directive and reference for their duties. Finally, diversity in leadership can allow for promotional opportunities for those currently providing direct services to leadership roles, allowing for additional perspectives in policy creation and implementation. All of this could be a positive social change for organizations, the unhoused community, and on an individual level, practitioners.

Additionally, with the County Administrator at the helm as the final decisionmaker with the Board of Supervisors, direct service agencies such as Social Services, Alameda County Health (formerly Health Care Services Agency), and Alameda

County Behavioral Health should convene as a policy development consortium to develop and implement an integrated coordinated care policy for the unhoused community. This consortium should include those currently providing direct services to provide input and feedback. This policy development group could address specialized service provisions for which the appropriate participating agency could provide their expertise in developing the policy. It also could ensure a process for the unhoused community that would avoid service redundancies yet could establish a pathway to stabilization for that community.

Alameda County policymakers could use Benet's (2006, 2012, 2013, 2018, 2022) polarities of democracy as they address the state of emergency as it pertains to homelessness going forward. Developing a policy that addresses the polarity pairs of Benet's framework could help Alameda County policymakers to establish an overarching policy that can provide the unhoused community with a pathway to stabilization and an avenue to continued productivity.

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Appendix A: Interview Process

All interviews will be completed via Zoom. Within the invitation, I will explain my study to each requested participant and ask for their participation. Upon receiving the responding email that states they will participate, I will send the Informed Consent document. I will also email dates that we can have the interview.

The interview questions were developed and approved using an IRB approved interview guide. The interview guide provides the researcher with the ability to capture rich data. It follows a definitive blueprint: preparation, theory, selection of participants, development of research interview questions, interview implementation, and transcription (Patton, 2015). When conducting a qualitative study interview, the goal is to find out about the experiences of others regarding the research question and to see it from their perspective (Rubin and Rubin, 2012). Additionally, by using open-ended questions, the researcher garners more information from participants than closed-ended questions because to answer participants are required to come up with their own words, phrases, or sentences based on their experiences (Patton, 2015).

The whole process should take no more than 60 minutes. I will inform each participant that the interview is voluntary, and they can retract their agreement to participate at any time during the interview.

Appendix B: Interview Introduction and Questions

Introduction

First, thank you for taking the time to participate in this research.

Next, let's introduce ourselves to each other. (*Provide participant with more background, if necessary)*

As you may know, I am a Walden PhD candidate in Public Policy and Administration. As part of my qualitative study, I am conducting interviews to capture data regarding key stakeholders' perceptions of the barriers to and/or facilitators of implementing an effective integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County. I am seeking those who have experience with providing direct services and developing policies for the unhoused community in Alameda County.

My research question is:

RQ: What are the perceptions of practitioners and department heads regarding the barriers to and/or facilitators of implementing public policies that lead to effective integrated coordinated care for individuals experiencing housing and other behavioral health challenges in Alameda County?

Accordingly, I would like to ask you some questions about your experience with integrated coordinated care policies at your organization for the unhoused community receiving mental health services.

I hope to use this information to provide information to the County regarding the barriers to and/or facilitators of implementing an effective integrated coordinated care policy to reduce high service utilization and increase behavioral health stabilization for unhoused mental health service recipients in Alameda County, in terms of the impact each could have on institutional recidivism for unhoused mental health clients.

I am required by my university to protect the identities of interviewees and their organizations. I am not permitted to share interviewee names, identifying details, contact info, or recordings with anyone outside of my Walden University supervisors (who are also required to protect your privacy). Any reports, presentations, or publications related to this study will share general patterns from the data, without sharing the identities of individual interviewees or their organizations. Data will be kept secure by password protection. The interview transcripts will be kept for at least 5 years, as required by my university. The collected information will not be used for any purpose outside of this study.

The interview should take about 60 minutes. Do you agree to being recorded? Are you available to respond for that amount of time?

If so, let's begin by asking you some questions about your role in the organization.

1. As it pertains to your role, how would you define integrated coordinated care?
2. Based on your definition, what are your perceptions regarding Alameda County's current integrated coordinated care policies?
3. Have the current policies contributed to institutional recidivism for the unhoused behavioral health recipients in Alameda County?
4. How have these policies been a barrier to institutional recidivism for this group?
5. In your role, how would you define successful case management results from Alameda County's integrated coordinated care policies?
6. Do you see these two (integrated coordinated care and case management) as similar to each other for the unhoused population?
7. If similar, why?
8. If dissimilar, what are the differences?
9. Based on your experiences, what are the possible policy barriers that interfere with cross-agency communication and coordination for unhoused behavioral health recipients in Alameda County?

10. Are there any County facilitators that lead to effective integrated coordinated care? If so, what are they?
11. In your experience, who would be considered a high utilizer of Alameda County's institutions?
12. At your organization, what constitutes stabilization for discharge in Alameda County?
13. How is this discharge status determined?
14. In your experience, after the discharge status, what are the circumstances that result in the continual utilization of Alameda County facilities by those receiving behavioral health services in the unhoused community?
15. As part of your duties, tell me your discharge process.
16. Tell me your referral process if you have one.
17. What factors signify a successful transition to care management?
18. What factors signify an unsuccessful transition to care management?

I appreciate you taking the time for this interview. First, let me briefly summarize the information that I recorded during our interview.

Again, I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know so that I can successfully introduce this to policymakers?

If not, I should have all the information I need. If I find I need to, would it be all right to contact you if I have any more questions?

Thanks again.