Evaluation of the Homeless Assistance Rental Program (HARP)

Final Report

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THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
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Executive Summary

In January of 2006, the Salt Lake County Divisions of Mental Health (MH), Substance Abuse (SA), Criminal Justice Services (CJS), and Youth Services (YS), through an intergovernmental agreement with the Housing Authority of the County of Salt Lake (HACSL) developed the Homeless Assistance Rental Program (HARP). CJS requested that the Utah Criminal Justice Center (UCJC) provide a process and outcome evaluation of HARP. HARP is a relatively new program, yet has already met several of its goals and demonstrated early effectiveness. This early success is especially encouraging considering the vast literature on homelessness that shows the difficulty of making progress with this at-risk population. This report answered the following six research questions.

1. Who does the program serve?

HARP serves a varied clientele. Through November 7, 2007, 102 persons have been placed in HARP housing. Most referrals came from Substance Abuse Services (63%) and the fewest came from Youth Services (7%). Age at intake ranged from 18 to 64 years old. Three-quarters of clients were White. Just over half were female and although most clients live alone, several had children living with them in their HARP unit (29%). Additionally, four female participants gave birth to babies while they were active in HARP.

HARP serves a population that has a documented need for housing assistance. One-third of clients had previously stayed in a shelter, nearly all had experienced some form of homelessness, and one-quarter were verified as "chronically homeless." Over half had a disability, two-thirds had utilized Medicaid, and the majority received food stamps in the two years prior to HARP.

HARP serves clients that have extensive criminal justice system involvement. Nearly two-thirds of clients had been in the Salt Lake County Adult Detention Center (ADC) at some point in the year prior to HARP placement. This indicates that HARP is meeting its goal of using at least half of the housing vouchers for persons who are released from the jail. The sum of jail days accrued by all HARP participants during the year prior to entering HARP was 4,826 days (for 58 persons), representing a substantial strain on the system. Similarly, two-thirds had an arrest recorded in the statewide criminal history file (BCI) for the 18 months preceding HARP placement, and approximately two-thirds have been involved with the Utah Department of Corrections (UDC). Approximately one-quarter were clients of Criminal Justice Services (CJS) specialty programs (e.g., Felony Drug Court, Mental Health Court) either prior to or during HARP participation.

2. What is HARP providing clients?

HARP is providing clients with rental assistance and regular case management. HARP is contributing approximately $454 a month, on average, to each client's rent. Referring agencies (SA, MH, CJS, YS) provide HARP clients with continuous case management. Clients receive approximately three case manager contacts per month. However, most contacts occur in the case managers' offices and less than one-third of clients had any home visits. Furthermore, the high percent of clients missing case management records and the difficulty in compiling information on current case managers for active clients both suggest that the case management aspect of HARP's Supportive Housing model should continue to be monitored. Additional suggestions for best practices for case managers are described under research question five.

Indirectly, HARP is providing enhanced mental health and substance abuse treatment for clients through partnering agencies. For those clients who had MH treatment both prior to and after HARP placement, frequency of treatment attendance decreased steadily following HARP placement, perhaps indicating increased functioning. Conversely, those clients who had SA treatment both prior to and after HARP placement increased their frequency of treatment attendance following HARP intake, perhaps representing increased treatment compliance.

3. Is HARP succeeding?

HARP is seeing some success as demonstrated by several financial measures. Average client rent contribution was over double the required minimum rent and increased over the course of participation. Two-thirds of participants have remained active in the program, while less than half of those who have exited the program had a negative termination status (e.g., eviction, returning to jail or prison, non-compliance with program requirements). DWS benefit usage while in HARP declined among those receiving them prior to HARP, while it increased for those who had not. It is believed that this shift represents a decrease in prior use for those who became more self-sufficient while in HARP and an increase in use for those who were previously unaware of their eligibility for the benefits.

Quality of life measures have also indicated that HARP is having some success. Self-Sufficiency and Housing First Matrices ratings indicate that HARP clients improved their quality of life in several domains, including those who were ultimately unsuccessfully terminated. Client survey results also suggest that client satisfaction with HARP is very high. The following comments made by HARP participants further demonstrate their satisfaction with the program.

> "I have found HARP programs so helpful in getting my life together and the staff at Volunteers of America are awesome."
>
> "It has been my desire to do what ever I can to get off probation. Staying clean and sober has helped. Being off the streets has made it easier to stay away from drugs."
>
> "My life is mine now. I got sick and tired of living the way I was and not having the people in my life I love and House of Hope helped me to do that. I love them."
>
> "Without HARP, I would not be graduating Drug Court. I would not be attending SLCC. This program allowed me to put my life back together. Once I finish school, I will be able to support myself financially. I am very thankful for this program. I don't [know] what if anything could improve it. I pray it continues for others in similar situations."

Some Criminal Justice System measures show promising trends. Both BCI and ADC data showed a decrease in offending among HARP participants from pre- to post-intake. Furthermore, the use of jail beds by HARP clients decreased dramatically in the year following HARP placement from 4,826 jail days in the year prior to HARP (58 people), to 1,000 jail days in the year following HARP start (n = 29). Similarly this represented a drop in jail bookings from 55.7% pre-HARP to 33.0% post-HARP start (and in new charge bookings, specifically, from 21.6% pre-HARP to 12.5% post-HARP start). Additionally, over one-third of HARP clients who were on UDC supervision at intake were successfully terminated from supervision.

However, HARP's success has been limited by continued challenges with the population it serves. Although the total number of HARP clients involved with the criminal justice system decreased, a surprising number of people who did not have recent involvement with the criminal justice system prior to HARP had new arrests following HARP placement. Additionally, the severity of offenses for the few HARP participants that did reoffend was higher, on average, than the severity of offenses occurring prior to HARP intake and four persons returned to prison following HARP placement. These measures all suggest that HARP, like other Supportive Housing models examined in the literature review, can be effective in improving clients' lives, but that these effects may not translate across all problem areas.

4. Who has the best outcomes in HARP?

There were no clear trends regarding which HARP clients were most likely to have a positive outcome status in the program (remain active for over one year or have a positive or neutral exit status) versus a negative outcome status (terminated from the program with a negative exit status). So far, none of the following factors were significantly related to outcome status: age at intake, gender, ethnicity, employment status, amount of rent paid at intake, jail releases in the year prior to HARP, on AP&P supervision at intake, past prison incarceration, or referral source (SA, MH, CJ, YS).

HARP clients that were younger, male, and more criminally involved were more likely to recidivate. The relationship between these three risk factors and criminal recidivism has long been documented in the literature. Several characteristics of HARP participants were not related to recidivism, including minority status, employment status at referral to HARP, whether or not the HARP client had children living with them, and whether or not HARP clients paid below or at the minimum required rent level ($50) at intake compared to above the minimum.

5. What program components and services lead to the best outcomes?

The provision of case management and rental assistance led to better outcomes for clients (see Question 3); however, it is not known at this time what level of services leads to the best outcomes. Variations in the two services that HARP directly provides to clients (rental assistance and case management) were examined in relation to the two outcome categories; however, no statistically significant differences were observed. However, the frequency of case management contacts was greater (more often) for clients who had a positive outcome status and those clients were more likely to have home visits recorded.

Client offending decreased with HARP participation; however, frequency of case manager contacts and changes in client rent contributions were not significantly related to likelihood of recidivism. The lack of relationship between changes in rent contribution and recidivism may indicate that *any* rental assistance leads to positive outcomes (the research in the Brief Literature Review section of this report supports this), and variations are unimportant at this time. It is also interesting to note that frequency of case manager contacts was less for those who recidivated, indicating that more frequent contacts may lead to better criminal justice system outcomes. However, having home visits was not related to likelihood of recidivism. It is recommended that more comprehensive and reliable case manager records be kept for HARP clients. Additional data on the frequency and type of contacts may help illuminate their relationship with client outcomes. Furthermore, the literature has suggested some specific best practices for case managers that may lead to better outcomes for homeless populations. These include: direct service provision (vs. passive referrals), community-based services, small caseload sizes (1:20 ratios, on average), access to 24-

hour crisis services, and home visits. A full description of recommended case manager activities is provided in the Brief Literature Review section of this report. Implementation and documentation of these efforts may help determine which aspects of case management are the most beneficial for HARP clients.

6. What is the cost-benefit of HARP?

Average Monthly Economic Costs reveal economic neutrality. Use and subsequent cost of some benefits increased from prior to after HARP placement, such as treatment, food stamps, and financial assistance. It is thought that these increases suggest enhancement of services received by HARP clients, as well as increased awareness among clients about available benefits. In contrast, some average economic costs decreased, including Medicaid and case management costs. These early declines may represent a trend that will develop across other forms of benefits as HARP participants are followed for a longer period of time.

The criminal justice cost-benefit analysis indicates that HARP has an overall return of $2.61 for every dollar invested. This means that $2.61 is returned to society (victims and taxpayers combined) for every $1 invested in HARP. The greatest economic benefit of HARP comes from reduced victim costs of approximately $7,100 per HARP client. This benefit estimates future reduced costs to victims (loss of property, etc.) based on the average reduction in offending across all HARP participants. The net taxpayer effect is a loss of approximately $250 per client. This means that the reduction in recidivism is not enough to offset the high cost of HARP (approximately $4,200 per person) entirely. However, as time passes the reduction in recidivism may be great enough to offer an economic benefit to both victims and taxpayers. At present the cost-benefit of HARP is already showing a positive return on investment.

Conclusion

The Homeless Assistance Rental Program (HARP) is a relatively new program, yet has already met several of its goals and demonstrated early indications of effectiveness. HARP has targeted the appropriate at-risk population (housing need, co-morbidity with mental health and substance abuse diagnoses) and has exceeded its goal of having half of the referrals come from the jail. Data also reveal that HARP participation, in general, has impacted clients' use of treatment services and public assistance, decreased their involvement with the criminal justice system, and increased their quality of life. A positive criminal justice cost-benefit ratio has also been observed. Due to the relative infancy of this program and the small sample size, additional evaluations should be conducted in the future. Additionally, careful documentation of program efforts, such as case manager and AmeriCorp volunteer contacts with clients, will allow for more detailed analyses. In as little as a year to 18 months from now, the program will have served considerably more clients and the first group of participants' follow-up period will be doubled. Future evaluations will determine whether these preliminary outcomes can be confirmed as the program continues to grow and serve more clients.

Program Overview

In January of 2006, the Salt Lake County Divisions of Mental Health, Substance Abuse, Criminal Justice Services, and Youth Services, through an intergovernmental agreement with the Housing Authority of the County of Salt Lake (HACSL) developed the Homeless Assistance Rental Program (HARP). HARP is a rental assistance program primarily funded through Federal HOME dollars from the Department of Housing and Urban Development (HUD) coupled with general fund tax dollars appropriated by Salt Lake County. HARP takes advantage of existing housing stock to immediately provide housing for special populations. The target population for HARP is homeless persons with mental illness, homeless persons in jail, in substance abuse and criminal justice programs, and youth aging out of the foster care system. The county divisions provide client referral and supportive services, while HACSL provides housing placement and lease support.

As outlined in the HARP Guidelines document dated December 2006 (see Appendix A), potential clients must enter the program through four "doors": Mental Health, Substance Abuse, Criminal Justice Services and Youth Services (or their subcontracting agencies). Eligibility criteria indicate that "At least 50% of the clients in HARP must have been incarcerated in the county jail or in residential treatment facilities." However, the goal, as reported at monthly HARP meetings, is to have 50% of referrals specifically coming from the jail. Two exclusion criteria for HARP participation are: a conviction for manufacturing drugs in public housing or being on the sexual predator list. Furthermore, client's income must be at 80% or below of the Area Medium Income (AMI).

The four "gateway" agencies are also responsible for providing case management for their referred clients throughout their participation in the program. The guidelines indicate that the case manager should assist the client with the housing application process, complete a service plan with the client (outlining necessary programming: mental health treatment, psycho-educational classes, job skills training, or education for example), and provide home visits[1]. It is also suggested that the case manager complete a Self-Sufficiency Matrix with clients that tracks their progress in a number of life areas. The case manager responsibilities document (see Appendix B) further outlines best practices, including assisting with necessities for the apartment, attending regular meetings, and participating in program evaluations of HARP. A separate document (Appendix C) outlines the responsibilities of HACSL. Housing Authority responsibilities include identifying and inspecting potential housing, meeting with case managers, and signing up clients for other housing assistance programs. The HARP guidelines also indicate the availability of AmeriCorp volunteers. Over the course of the program, AmeriCorp volunteers, based out of HACSL, have assisted in client tracking, home visits, and additional services.

[1] The program guidelines stipulate that there "needs to be regular (at least twice a month) contact with the client in order for them to receive subsidized housing." The case manager responsibilities document states, "Visit the client at least once per week initially; prescriptively thereafter" as a best practice. Although neither explicitly requires home visits as the form of regular contact with the clients, discussions at regular HARP meetings have implied that this is an important aspect of the program.

A few client responsibilities are described in the HARP Guidelines document. Clients must pay a minimum rent of $50 per month toward their housing cost or 30% of their monthly income, whichever is greater. Clients are also required to follow the rules and regulations outlined in their lease agreement and complete a service plan with their case manager. Causes for eviction from HARP housing include breaking the lease requirements, returning to residential treatment or detox, or returning to jail. However, the guidelines state that "Efforts will be made to keep their housing available for up to thirty (30) days." Discussions at monthly HARP meetings determined that holding HARP housing for a client who will be out of the unit would be decided on a case-by-case basis.

Assumptions of HARP

HARP was developed and operates on nine assumptions about homelessness and services for persons at risk of homelessness. This section provides a brief description of the academic literature that is in support of or contradicts these assumptions.

Assumption of HARP #1 - There are people in the jail and residential treatment programs who could be better served in a community setting:

It has been well documented that homeless persons comprise a high proportion of inmate and substance abuse and mental health treatment populations. Data obtained from the Bureau of Justice Assistance indicated that 20.7% of all inmates in a state prison that were mentally ill had been homeless in the 12 months preceding arrest. A further 30% of mentally ill inmates in jail and 20% of those in State or Federal prison reported a period of homelessness (U.S. Department of Justice Bureau of Justice Statistics, 1999).

In a survey conducted by the Center for Poverty Solutions (2002), more than half of a homeless population with a history of incarceration cited housing as their most important need (58%). The top four barriers to permanent housing cited by respondents were: paying the security deposit (52.8%); having no stable employment (47.9%); paying utilities (44.2%); and other expenses (43.4%). Many research studies describing possible interventions for homeless populations also note the substance abuse (Tsemberis, Gulcur & Nakae, 2004; Clark & Rich, 2003; Sorensen et al., 2003; Schumacher, Usdan, Milby, Wallace & McNamara, 2000; Saleh et al., 2002) and mental health challenges of those groups (Clark & Rich, 2003; Wasylenki, Goering, Lemire, Lindsey & Lancee, 1993; Cheng, Haiqun, Kasprow & Rosenheck, 2007; Jones et al., 2003; Toro et al., 1997; Morse, 1999; Chinman, Rosenheck & Lam, 2000).

Past interventions have been effective in serving homeless persons with criminal experience, substance abuse issues, and/or mental illness in the community. For example, in a study of case management interventions for injection drug users with and without co-morbid Anti-Social Personality Disorder (ASPD) it was found that participants who had increased interactions with their case manager were more likely to remain in treatment (Havens, 2007). Siegal and Rapp (2002) examined the relationship between case management, treatment engagement, substance abuse, and criminality. It was found that participants who received case management in addition to their substance abuse treatment were more likely to engage in treatment longer than those who

received no case management. Because increased treatment participation is positively correlated with decreased substance abuse, the authors maintain that case management indirectly contributed to decreased legal severity thus minimizing the need to incarcerate. Additional studies have noted the successes of community-based interventions for this population (Cheng et al., 2007; Toro et al., 1997). However, several studies examining services for homeless with criminal histories and substance abuse and mental health problems, note the difficulty of working with this population and that successes can be limited, especially among those with more severe histories (Dixon, Friedman & Lehman, 1993; Dixon, Krauss, Myers & Lehman, 1994; Morse et al., 2006).

Assumption of HARP #2 - It is cheaper to provide people housing with supportive services rather than keep people in jail or residential treatment facilities:

Many studies indicated that supportive housing is more cost-effective than other forms of treatment or detainment. For example, the Minnesota Department of Corrections (2001) found that the per diem cost of housing alternatives for the homeless and people with disabilities was significantly less for those provided with supportive housing as opposed to prison and other types of treatment facilities. This was indicated by a per diem rate of 27 dollars for supportive housing, 86.70 dollars for prison, and 360 dollars for a regional treatment center. These Minnesota findings clearly indicate that average daily rates for supportive housing can be minuscule when compared to prison and other types of treatment facilities. Other studies that show additional evidence for the cost-effectiveness of supportive housing over criminal detainment and other residential treatments include the following: US Department of Health and Human Services, 2004; Clark & Rich, 2003; Morse et al., 2006; Jones, Colson, Valencia & Susser, 1994; and Newman, Reschovsky, Kaneda & Hendrick, 1994.

When comparing the case management component of supportive housing specifically to other similar treatment, Jones et al. (1994) found that a Critical Time Intervention (9 months of homeless prevention case management) costs significantly less than status quo treatments including referrals, rehabilitation, and various treatment programs. It was also found that in tracking the cost of participants, the accrual of criminal justice costs (i.e. time spent in jail) was greater than the cost of long term case management treatment. Thus it appears that the case management component of supportive housing is also more cost-effective than other types of treatment. Other studies (Wasylenki et al., 1993: McGuire & Rosenheck, 2004) have also demonstrated support for the cost effectiveness of case management over other types of treatment.

Assumption of HARP #3 - Family reunification is maximized in a non-correctional setting:

Empirical support for this assumption seems to be split; with two studies contradicting the assumption and three studies finding support. In support, a subcommittee of clinicians from Health Care for the Homeless (HCH) programs and researchers working in the field of homelessness and health care across the United States summarized the key components of six programs deemed most effective in providing substance abuse treatment to homeless populations. The committee found that one model that endorsed a family-centered approach was effective in minimizing homelessness and substance abuse in a non-correctional setting (Kraybill

& Zerger, 2003). Other support was found by the Center for Therapeutic Community Research (Swan, 1997). While no empirical support was provided, the center evaluated a treatment program addressing the needs of mentally ill homeless substance abusers and found that the program was more effective when they added services geared towards family needs. Similar support was found in a policy initiative presented by Visher and colleagues (2004) that aimed at decreasing homelessness. One of the strategies identified was to provide services geared towards improving family ties (Visher, Kachnowski, La Vigne & Travis, 2004). It appears that there is minimal empirical evidence in support of this assumption, but that a family emphasis in homelessness interventions is a common thread in effective programs and the opinions of professionals in the field.

Research to the contrary was found in a survey of inmates in state and federal prisons, which found that large percentages of state/federal inmates had frequent (weekly) contact with their family (Mumola, 2000). Further insight into this conclusion is found in the Mares and Rosenheck (2004) study that found that living status (i.e. homeless, independently housing, or institutional living) was not a factor in satisfaction with family relationships. These findings do not negate the importance of family reunification in decreasing homelessness, as most effective treatments and professionals recognize the importance of family reunification. However, they do indicate that perhaps family reunification is not always maximized in a non-correctional setting.

Assumption of HARP #4 - An individual's potential for positive integration into the community is enhanced if they have housing:

Significant support was found for this assumption. In a study examining the clinical problems and treatment outcomes of homeless people with a history of severe mental illness and incarceration history, 12 months after receiving treatment it was found that long-term incarceration history was more common in individuals who experienced long-term homelessness. The implication being that those individuals who experienced some housing were more successfully integrated into the community; represented by decreased criminal behavior (McGuire & Rosenheck, 2004).

In the aforementioned focus groups held by the Minnesota Department of Corrections, most professionals in the field agreed that the post-release success rates for a significant portion of offenders would improve if more affordable housing with a flexible array of support services were made available. With the knowledge gained from the focus groups, the authors maintain:

> Offenders without suitable housing tend to feel hopeless, isolated, unstable, and 'out of sorts.' It is not uncommon for housing to be taken for granted, especially when one is in possession of his/her own home or a long-term lease. When that sense of security is disrupted by an eviction or other means, one's sense of stability and self-confidence are under siege. Many offenders have a treatment plan, are seeking to be reunited with their family after incarceration, or need to be stabilized on medication. When core needs such as housing or employment are not met, offenders can be thrust into a survival mode resulting in a preoccupation with matters of coping instead of treatment or self-improvement. The breakdown of any of these areas threatens the ability to acquire stability and growth (Minnesota Department of Corrections, 2001, p. 3).

Lastly, in a study following two years of close research with women in metropolitan and regional prisons, families of women in prison, and recently released women inmates, the authors concluded that, "Without some form of secure housing to rely on it is impossible to concentrate efforts on positively changing one's lifestyle (Goulding, 2004, p. 24)." The authors found that many women are released from prison to situations where their priority is simply to find somewhere to sleep that night. The authors concluded that, for female inmates, the availability of adequate and stable housing is a necessary component of any effective rehabilitation process.

The overall findings of inmate tracking and professionals' opinions appear to support the idea that housing is a critical factor for positive integration into the community. This support is considerable. For additional support see: Sosin, Schwingen & Yamaguchi, 1993; Legal Action Center, 2004; Visher et al., 2004; McGuire & Rosenheck, 2004; Hinton, 2004; and Tsemberis et al., 2004.

Assumption of HARP #5 - Safe, decent, affordable housing is a stabilizing factor in an individual's life:

The literature consistently documents the instability of those without residences. Abundant support for this assumption was found. It appears that the existence of housing is not only associated with basic life stability, but also with improvements in mental illness, substance abuse, and criminal activity, which all contribute to life stability. Regarding overall life stability, in the aforementioned analysis of six programs deemed as most effective in treating substance abuse in homeless persons, it was found that the programs uniformly recognize that stable housing is central to attaining treatment goals.

> Homelessness subjects people to multiple health and safety risks and creates a great deal of stress related to meeting basic survival needs from day to day. Having appropriate housing provides individuals with a greater sense of safety and stability, enabling them to meet their basic needs and have increased control over their lives and their environment. These programs consistently report that individuals living in appropriate housing are more likely to be successful in treatment (Kraybill & Zerger, 2003, p 16).

Furthermore, Milby and colleagues (2005) found that participants with housing showed more days of employment, indicating more stability. Sosin, Schwingen and Yamaguchi (1993) noted a similar finding: the provision of housing doubled the rate of accepting services and time spent in care. These findings show support for the overall assumption that housing increased life stability in relation to employment, treatment attendance, and treatment success. For additional sources regarding overall life stability resulting from housing see the following: Morse, 1999; Legal Action Center, 2004; Shern et al., 2000; Tsemberis et al., 2004.

Several studies have also shown improvements in mental illness and substance abuse following the provision of housing. Mares and Rosenheck (2004) found that individuals who secured independent housing showed increased participation in psychiatric treatment. Securing independent housing was also positively correlated with decreased alcohol and drug use when compared with other types of housing (living with someone else, etc). While the treatment here

did not provide housing, these results indicate that the attainment of safe, decent housing, regardless of the means, is associated with stabilized ratings of substance abuse and mental illness. Cheng and colleagues (2007) found that housing and supportive services produced improved clinical outcomes (substance abuse, etc) and measures of overall quality of life. These improvements were significantly greater than those without housing. Improved quality of life and substance abuse were clearly factors that were stabilized by the availability of safe, decent, affordable housing. Dixon and colleagues (1993) also found that those housed had less psychiatric problems than those who were not housed. For additional support see the following: Milby et al., 2005; Mares & Rosenheck, 2004; Minnesota Department of Corrections, 2001; McHugo et al., 2004; Dixon et al., 1994. For improved outcomes regarding criminal justice outcomes see McCarthy & Hagan, 1991 and Center for Poverty Solutions, 2002.

The overall implications of these findings indicate that the existence of housing is directly related to improved overall life stability (employment, quality of life, etc), substance abuse, mental illness, and criminal involvement. As these components are all stabilizing factors in one's life, the research clearly indicates that housing is a prerequisite to achieving life stability.

Assumption of HARP #6 - People booked into the jail tend to use other publicly funded services:

The literature consistently documented the seeking of publicly funded treatment by people released from jails or prisons. However, few studies addressed the extent to which publicly funded services were sought by those individuals. In support of this assumption, Mumola (2002) found that 44% of inmate mothers and 68% of inmate fathers reported receiving social support (SSI, Medicare, etc) upon release from prison. Furthermore, Visher and colleagues (2004) surveyed prisoners released from prisons in Baltimore and found that almost half of the inmates participated in a community program and/or accessed services that were publicly funded. Contradicting this assumption, however, McGuire and Rosenheck (2004) examined the clinical problems and treatment outcomes of homeless people with and without a history of incarceration. They found that the group with no incarceration history and the group with a short-term incarceration history received higher levels of public support payments, used more employment services, and had higher outpatient costs than those who had been in long-term incarceration. The literature then indicates that while it is evident that people released from jail tend to seek services, it is not clear that they seek and receive services more than other at-risk populations.

Assumption of HARP #7 - Time spent in jail does not necessarily change behavior for the better:

The research uniformly documented that time spent in jail does not equate to rehabilitation. The survey conducted by the Center for Poverty Solutions found that 44.4% of Baltimore's inmates received no treatment in prison and 67% were not directed to any services prior to release. The authors of this study stated that "Nationally, many prisoners have substance abuse disorders, low levels of literacy, and limited work experience. Prisons in the United States do little to remedy these deficiencies" (Center for Poverty Solutions, 2002, p. 14).

Furthermore, McGuire and Rosenheck (2004) found that study participants with an incarceration history had more problems (psychiatric symptoms, higher drug and alcohol abuse, and higher levels of dual diagnosis) and scored lower on community adjustment domains than those with no incarceration history. Lastly, a consensus group made up of legal and criminal justice professionals found that:

> Unfortunately, in Philadelphia and across the United States, many men and women who reenter society do so with unresolved substance abuse problems, chronic health issues, a substandard education, and a general lack of resources — or a genuine lack of will — to truly reintegrate (Philadelphia Consensus Group on Reentry & Reintegration of Adjudicated Offenders, 2002, p. 5).

As represented here, the literature soundly supports the belief that incarceration is rarely associated with improved behaviors upon release. For additional documentation of the poor rehabilitation seen by those released from prison see the following: Speiglman & Green, 1999, and Minnesota Department of Corrections, 2001.

Assumption of HARP #8 - Helping individuals recover must be a collaborative process:

The research consistently found that recovery must be a collaborative process. Kraybill and Zerger (2003) found that at the service delivery level, the six effective programs for homeless persons emphasized the importance of providing integrated care through interdisciplinary teams typically made up of medical, mental health, substance use, and social service providers. Not only are providers co-located but they also work collaboratively; each team member has some level of involvement and investment in all aspects of the homeless person's care. These six programs are thought to represent the highest quality of treatment for homeless substance abusers. Their findings regarding treatment collaboration across these studies clearly indicate that this assumption of HARP is key to helping individuals recover (Kraybill & Zerger, 2003).

Morse et al. (1997) provided some support and clarification for this assumption. This study assessed the efficacy of three different types of case management for treating mentally ill homeless persons. The results indicate that diverse access to resources is critical, but simply linking clients to other resources is not sufficient to improve housing, substance abuse, and mental health. The group must also receive more individualized, comprehensive in-house treatment as opposed to simply linking clients with the resources. These findings indicate that a collaborative process is critical to recovery but that the process may be better served when administered comprehensively and in-house.

Furthermore, Arapahoe House, a treatment demonstration site in Denver (Kirby, 1993), prisons across the Philadelphia area (Philadelphia Consensus Group on Reentry & Reintegration of Adjudicated Offenders, 2002), and various authors (Morse, 1999; Speiglman & Green, 1999; Mojtabai, 2005) all endorse the premise that recovery from homelessness requires a diverse, collaborative process.

Lastly, a number of studies found that programs that provided treatment to homeless persons by accessing a collaborative network of services led to decreased homelessness and substance

abuse, as well as increased treatment retention (Dixon et al., 1994; Conrad, Hultman & Pope, 1998; Calsyn, Klinkenberg, Morse & Lemming, 2006). For additional support for the finding that recovery requires a collaborative process see the following: Swan, 1997; Center for Poverty Solutions, 2002; McGuire and Rosenheck, 2002; U.S. Department of Health and Human Services, 2003; Minnesota Department of Corrections, 2001; U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services Disabled and Elderly Health Programs Division, 2004; McHugo et al., 2004, Susser et al., 1997; Shern et al., 2000; and Rosenheck et al. 1998.

Assumption of HARP #9 - Programs like HARP help keep people from returning to jail or residential programs:

The literature supported the belief that programs like HARP help keep people from returning to jail and residential programs. For example, Cheng and colleagues (2007) found that a Supportive Housing intervention, including Section 8 housing vouchers and intensive case management, was significantly more effective than two other interventions that provided case management only or standard Veteran's Administration care (short-term broker case management only). The housing and case management intervention reported a higher number of nights in a housing unit in the past 90 days and fewer nights spent in an institution (such as hospitals, halfway houses, or jails), as well as a number of other life-stabilizing improvements shown to keep people from committing crime.

Furthermore, other, less intensive programs have been shown ineffective in keeping people from returning to jail. Solomon and Draine (1995) studied the effectiveness of intensive case management for individuals released from jail. These interventions were geared towards inmates with severe mental illness who would be homeless upon release. Surprisingly, results indicated that those receiving the intensive case management were more likely than those receiving individual case management and usual care to return to jail one year after release. These findings may indicate that case management without more intensive measures such as housing vouchers is not enough to keep people from returning to jail.

Dixon and colleagues (1994) also found support for this assumption. This study examined what happened to people receiving case management when they did or did not receive Section 8 housing vouchers. Seven percent (7%) of those who did not complete the necessary steps to get a housing voucher returned to jail. While this number is small, it is greater than those provided with Section 8 vouchers, thus legitimizing the belief that programs like HARP help keep people from returning to jail (Dixon et al., 1994).

Lastly, mixed support for this assumption was also found. For example, Jones and colleagues (1994) found that an intervention that involved housing and intensive case management (focused on assistance in establishing systems of support regarding medication compliance, money management, substance abuse, and housing-related crisis) did not keep people from returning to jail anymore than those that provided individuals with housing and less intensive case management (prep for community placement, assistance in locating community housing, and the development of a treatment plan). Both groups did however have minimal time spent in jail. Additionally, those provided with intensive case management and housing had more time spent in hospitals than those receiving less case management and housing. These results could indicate

that the type of case management delivered is not a factor in reduced jail/institution time, but rather that the provision of housing is the central factor in keeping people from returning to jail.

Brief Literature Review

A number of studies have been conducted to examine the efficacy of Supportive Housing, Housing First, intensive case management, and other interventions aimed at addressing homelessness and issues that often accompany homelessness, including mental illness and substance abuse disorders. A thorough review of the literature pertaining to homelessness and related issues resulted in over 300 articles. From those, nearly 80 were selected for inclusion in our review of housing and homelessness issues for the Homeless Assistance Rental Program (HARP) study. Appendix D summarizes the 28 most representative studies that evaluate the effectiveness of various programs aimed at addressing homelessness and related concerns. A table that lists the 28 studies and shows their "effective," "mixed," or "no effect" status on housing and other outcomes is provided in Appendix E. This introduction provides the briefest overview of the literature.

Supportive Housing

Supportive Housing is typically defined as an intervention in which case management and housing resources are combined. HARP most closely resembles the Supportive Housing model. Twelve studies evaluated Supportive Housing in some form and generally found that Supportive Housing leads to mixed outcomes on both housing and other (treatment, substance abuse, psychiatric ratings, etc.) measures (see table in Appendix E). They did, however, generally show that Supportive Housing is more effective than less intensive interventions, such as case management alone. For example, Cheng and colleagues (2007) found that a Supportive Housing intervention, including Section 8 housing vouchers and intensive case management, was significantly more effective than two other interventions that provided case management only or standard Veteran's Administration care (short-term broker case management only). The Supportive Housing group had better outcomes on some measures (including nights housed, use of institutions, and substance use), but showed no effect on others (e.g., days employed, psychiatric measures & quality of life; Cheng et al., 2007). Similarly, adults with substance abuse problems and homeless experience who were receiving case management and Supportive Housing (individuals given apartments for up to eight months & other types of support) were retained in substance abuse treatment longer than participants who received case management only (Sosin et al., 1993). Lastly, Clark and Rich (2003) also found Supportive Housing to be more effective than case management alone, at least among individuals with high psychiatric and substance abuse severities. In a study of mentally ill homeless persons with a prevalence of substance abuse disorders, it was found that persons with high psychiatric symptom severity and high substance use achieved better housing outcomes with the comprehensive housing program (guaranteed access to housing and housing support services) than with case management alone. However, those with medium to low psychiatric symptom severity and low levels of alcohol and drug use showed no improvement on housing outcomes when compared with the case management only intervention. This study also demonstrated the importance of matching the intensity of the intervention closely with the needs of the client.

Housing First

Housing First is often defined as an intervention in which housing resources are provided with no requirements or contingencies (e.g., abstinence or employment). Three studies specifically examined the efficacy of Housing First interventions. Housing First is generally seen as effective in improving housing outcomes, but has a more limited impact on additional measures of interest (e.g., substance abuse, psychiatric ratings, employment, quality of life, etc.; see table in Appendix E). The Housing First model studied by Tsemberis et al. (2004) significantly decreased homeless rates and increased stable-housing rates when compared to an abstinent-contingent model. However, Housing First and abstinent-contingent housing showed no effect on substance abuse and psychiatric measures. Furthermore, the abstinent-contingent group had higher substance abuse treatment use, indicating that it is more effective than Housing First on improving treatment engagement. Milby and colleagues (2005) also compared a Housing First Model (where no abstinence was required) to abstinence-contingent housing (ACH). In their study of homeless individuals with coexisting cocaine dependence and non-psychotic mental disorders, both groups improved on days housed and employed, as well as increased abstinence. However, there were no differences observed between the two groups, indicating that Housing First can be just as effective as abstinent-contingent housing in improving client outcomes.

Thus, the studies indicate that in treating homelessness that coexists with mental illness and substance abuse, Supportive Housing tends to improve some housing variables as well as a few other variables (e.g., abstinence measures, housing quality, psychiatric rating scales, stressful life events, etc.) when compared with no treatment, case management only, or even abstinent-contingent conditions. However, many of the studies reported mixed results, with the Supportive Housing interventions failing to provide improvements on all measures of interest. The current literature on Supportive Housing and Housing First interventions aimed at addressing homelessness and related concerns portrays the difficulty of working with this population. However, examination of these efforts suggest that Supportive Housing and Housing First models can be effective in making progress with homeless clients experiencing mental illness and substance abuse when they are appropriately matched to the needs of the clientele.

Case Management

Case management has been frequently employed to address homelessness. In addition to the above studies that involve case management within the context of Supportive Housing, a number of studies also examined the efficacy of various types of case management alone for treating homelessness and related problems. In the sixteen studies that examined the efficacy of case management in some form, results were fairly evenly split between studies showing the effectiveness of case management in addressing homelessness and studies showing mixed or no effect on homelessness. Additionally, case management showed generally mixed results on other non-housing outcomes (e.g., treatment retention, substance abuse, psychiatric ratings, etc.; see table in Appendix E). Susser et al. (1997) conducted a study in which the experimental participants were provided with a Critical Time Intervention (CTI). CTI is a time-limited adaptation of intensive case management. CTI provides a community worker who gives transitional assistance, conducts home visits, and coordinates systems of care among various service providers. This study found that those provided with CTI had significantly less homeless

experiences than those provided with usual services (USO, referrals to mental health agencies). At the end of the 18-month follow-up, 8% of the CTI men were homeless while 23% of the USO men were currently homeless. However, in a more recent study of CTI, Jones et al. (2003) found that participants receiving CTI experienced significantly fewer homeless nights over short periods of time, but that this effect did not persist through the 18-month follow-up. The difficulty of evaluating community-based interventions for homelessness is illustrated through the seemingly contradictory results of the Jones and Susser studies of the same intervention (CTI). Solomon and Draine (1995) studied the effectiveness of team-based intensive case management (ACT) for individuals with severe mental illness who would be homeless upon release from jail. Surprisingly, results indicated that those receiving ACT were more likely than those receiving individual case management and usual care to return to jail one year after release. There was no effect between all three groups regarding psychiatric ratings, alcohol use, or quality of life. It appears that many homelessness issues can be addressed by case management, but that issues related to criminal involvement are perhaps better served by a more intensive intervention.

Havens et al. (2007) demonstrated that strengths-based case management was more effective than passive referral to community resources in improving treatment initiation and participation. The improvements noted by Havens et al. (2007) may, however, be marginal, as Sosin et al. (1993) found that case management combined with housing was more effective regarding treatment initiation and retention than case management only. Furthermore, Tsemberis et al. (2004) found that abstinent-contingent housing was more effective than Housing First in improving treatment retention. Thus, in terms of treatment retention, it appears that improvements have an additive effect starting with case management only, moving to Supportive Housing, and ending with abstinent-contingent being the best model for engaging substance abusers in treatment.

The three studies of ACCESS (an intensive case management model for homeless people with mental illness) indicated that intensive case management and additional alliance with case managers, can lead to improved housing and mental health outcomes (Chinman et al., 2000; Mares & Rosenheck, 2004; Rosenheck et al., 1998). It should be noted that improvements in housing outcomes for the ACCESS group were measured against a baseline at intake. Other studies that examined the impact of case management in relation to Supportive Housing conditions (Cheng et al., 2007; Clark & Rich, 2003; Sosin et al., 1993) generally indicated that Supportive Housing (intensive case management plus housing vouchers) provided better outcomes than case management alone.

While the use of case management is frequently supported in the literature, it is evident that particular elements of case management are more effective than others. Two articles evaluating over 20 studies of case management have identified best practice elements of effective case management (Rapp, 1998; Bedell, Cohen & Sullivan, 2000). Below is an overview of these recommendations combined with commonalities seen in programs demonstrating effectiveness found in an additional literature review of over 30 articles. Elements contributing to the effectiveness of case management include: type of model endorsed, delivery type, case manager credentials, location, directedness of services, caseload size, length of service, access to 24-hour services, and type of services rendered.

Model. It is evident that the type of case management (CM) model endorsed directly correlates to the effectiveness of treatment. CM models are typically defined as a set of guidelines and methods thought to guide a case manager's work. The three dominant CM models identified in the literature are the **broker model** (case manager assists in "contracting out" for services), the strengths-based model, and integrative models (Assertive Community Treatment, or ACT being the primary integrative type). **Strengths-based** models are generally based on engagement, assessment, personal case planning, and resource acquisition. It is characterized by medium-sized caseload ratios (1:20), individually-delivered treatment and direct service provided in a community setting. **Assertive Community Treatment** (ACT, the integrative approach) is characterized by team-based, collaborative, on-site care with the provision of 24-hour access and outreach provided in a community setting. ACT is also hallmarked by smaller caseloads (average 10 clients per case manager). Aside from caseload size and team-oriented treatment, ACT differs from strengths-based models by the degree to which they involve the client in the decision making process. ACT employs a 50:50 input, while the strengths-based model allows the client to be almost exclusively responsible for their treatment decisions. Only small input from the case managers is considered.

The majority of studies are aimed at comparing the efficacy of CM models. In a review of over 30 studies evaluating case management, it was almost uniformly demonstrated that ACT (integrative CM model) resulted in the most improved outcomes. In this literature review, ACT showed housing improvements over broker-style case management, outpatient services (Mcbride, 1998), and other standard types of case management (case management characterized by referring out, caseload ratios of 1:50, and office-based; Coldwell, 2007). While ACT presents as the best-practice model for case management, other models show promise as well. Havens, et al., 2007 demonstrated that **strengths-based case management** was more effective than passive referral to community resources in improving treatment initiation and participation.

Delivery team versus individual approach. The advantage of a team-based approach is that it reduces burn-out and increases contiguity in care. Opponents of a team approach argue that it decreases efficiency and case manager responsibility. However, the literature seems to point toward the effectiveness of a team-based approach. For example McGrew and colleagues (1994) found that team-shared caseloads were a significant factor in reduced homelessness.

Case manager credentials. There appears to be great disagreement regarding the qualifications necessary for case managers to be effective. While the best practice standards hold that a case manager have a bachelor's level education, new trends have resurfaced showing positive outcomes when non-degree holders provide case management. For example, Chinman and colleagues (2000) found that a group of case managers who were not required to have degree provided case management as effectively as degree holders (Chinman, Rosenheck, Lam, & Davidson, 2000). Despite this, Morse (1997) found that community workers (volunteers from the community) did not contribute to improved outcomes. While the necessary credentials of a case manager remain unclear, it is clear that a team with various types of professionals (psychiatrists, nurses, medical doctors, and social workers) provides the best treatment (Rapp, 1998).

Location of delivery. The most effective CM models endorse a community-based component (Rapp, 1998). The use of community-based interventions as seen in ACT and outreach work is supported strongly by the literature (Huxley & Warner, 1992). However, Andersen (2002) found that housing outcomes were not influenced by location of services when comparing a primary service setting, a social service agency, and via phone services. This may indicate that community delivery is the preferred method, but that in-office delivery many not be detrimental to client outcomes.

Direct versus referral. Case management models differ in the extent to which services are directly provided by the agency or referred out to other contracting agencies. Both ACT and strengths-based models require that the majority of supportive services be provided directly by the case manager and not referred out. Only services such as medication prescriptions and similar are referred out. The support for direct service provision could easily be found in the ineffectiveness uniformly found in the broker-style case management. This model is hallmarked by outsourcing nearly all services (Kenny, 2004).

Caseload size & number of service contacts. Smaller caseloads and large number of service contracts are often a factor in improved outcomes (Rapp, 1998). ACT is distinguished by its 1:10 to 1:15 ratios. Strengths-based models usually see 1:20 ratios. Both models suggest tailoring caseloads to the extent of the client needs. No positive outcomes were found that had caseloads exceeding 1:20 ratios. Smaller caseloads allow providers to increase frequency of visits. Rife and colleagues (1991) found that the number of service contracts was the only variable predicative of decreased homelessness.

Length of service. Impressive improvements have been seen in short periods of time (less than 6 months). However, some studies show that improvements weaken over time (Jones, 2003). Most best-practice guidelines advocate for indefinite durations of treatment in order to effectively address the complexity of homelessness.

Access to 24-hour services. Many models demonstrating effectiveness provide 24-hour access to crisis and emergency services. The philosophy being that, when in crisis, a client is best serviced by receiving support from a provider they are familiar with.

Case manager responsibilities. It appears that some specific case manager activities increase effectiveness. For example, Mcbride (1998) found that two specific case management service activities: housing contacts (e.g., contacts with private landlords and the public housing authority), and supportive services (e.g., assistance in shopping, budgeting, cooking, and cleaning), were significantly related to less time spent homeless. Additionally, effective ACT models require that case managers work with landlords, social security, housing authorities, welfare agencies, and food pantries to assist their clients. Case managers are also required to assist clients in developing vocational, socialization, and living skills. Specific examples would be finding and visiting employment agencies with clients, practicing living skills, providing transportation, and arranging socialization activities with and on behalf of the client. The models that require such responsibilities have been proven effective over most other models employing less intensive case manager responsibilities (Coldwell & Bender, 2007; Havens, 2007).

The case manager responsibilities for HARP (see Appendix B) include several of these recommended activities, including contact with landlords, home visits, and assistance with day-to-day living issues, such as securing furnishings and keeping the apartment in good order. It is recommended that HARP further examine the effective principles of case management for homeless populations outlined in this section for additional ideas on improving services.

Conclusion

The entire body of literature reviewed on interventions for homeless with substance abuse, mental health, and criminal justice involvement spoke to the complexity of both providing services for this population and evaluating their effectiveness. It was generally the theme that programs and services were more effective if they were: a) more comprehensive, b) of longer duration, and c) appropriately matched to the needs (and severity) of the clientele. Additionally, in-house service provision was generally viewed as more effective than multi-location service provision or passive referrals (Havens et al., 2007; Morse et al., 1997). When looking at the effectiveness of these efforts to improve housing and other outcomes, a consistent theme also develops. Research that utilized less rigorous designs (pre-post measures, for example), had shorter follow-up periods, and examined fewer outcome measures generally found their interventions to be effective. However, studies that utilized comparison groups (especially three or more), had longer follow-up periods, and examined several outcomes of interest generally reported mixed results or no effect. It should also be noted that published research is biased, in that few studies reporting "no effect" are considered for publication. This bias inflates the representation of interventions that have had an effect on homelessness and other outcomes. The total number of programs that have had less effectiveness is not known. These results reaffirm what professionals working in the field already know; current efforts to address homelessness and related problems (substance abuse, mental health, and criminality) are making progress, but no single panacea exists.

Evaluation Overview

The Salt Lake County Division of Criminal Justice Services (CJS) has requested that the Utah Criminal Justice Center (UCJC) provide a process and outcome evaluation of HARP to provide a description and better understanding of the current program, as well as recommendations based on preliminary outcome data.

The evaluation of HARP will answer the following research questions:

1. Who does the program serve?
2. What is HARP providing clients?
3. Is HARP succeeding?
4. Who has the best outcomes in HARP?
5. What program components and services lead to the best outcomes?
6. What is the cost-benefit of HARP?

Methods

Data Sources

HARP partnering agencies and several outside sources provided data for this study. Because providing housing and support services for at-risk population is a collaborative effort, it was important to collect information from as many sources as possible. This section outlines the data that was received from each agency. Table 1, below, provides a brief snapshot of the sample size that was obtained from each agency. The following paragraphs further explain the data requested from each agency and the resulting data matches and samples obtained.

Table 1 Data Sources and Sample Sizes

	Sample Size Obtained	
	N	% of Total
Housing Authority	102	100
Substance Abuse Services	56	54.9
Valley Mental Health	9	8.9
Department of Workforce Services	66	64.7
Criminal Justice Services	102	100
The Road Home Shelter	69	67.6
Utah Department of Corrections	46	45.1
Bureau of Criminal Identification	51	50.0
Salt Lake County Adult Detention Center	88	86.3

The Housing Authority of the County of Salt Lake (HACSL) provided queries from their agency database. These queries included measures of: lease start and end dates; referral and exit status; household members and characteristics (gender, date of birth, ethnicity, disability); and rent review and contract changes (incomes, tenant contribution, HARP contribution). Electronic data was pulled periodically throughout the evaluation, with the final query on November 7, 2007. HACSL electronic records were available for all 102 HARP participants. In addition to electronic data files provided by HACSL, UCJC researchers pulled information from paper HACSL records. This is described in the Surveys and Data Collection section of the report.

Requests for treatment, case management, and billing data were sent to Salt Lake County Substance Abuse Services (SAS) and Valley Mental Health (VMH) in August 2007 for all HARP participants who started HARP housing through May 31, 2007. Both agencies searched their electronic records for these 69 HARP participants by name, date of birth, gender, and additional identifiers. Agency records were queried back to January 1, 2004. These queries resulted in nine (13.0%) HARP clients having VMH treatment and case management data and 56 (81.2%) having SAS data. SAS and VMH agency data presented in the Results section of this report are for those client records that were identified and queried from their datasets.

A list of 67 HARP participants to date was sent to the Department of Workforce Services (DWS) in May 2007. DWS staff hand searched their records by Social Security Number for HARP participants' lifetime use of financial assistance, food stamps, Medicaid, and job referral and training services. The resulting files were provided to UCJC in June 2007. All but one of the 67 clients were found to have used DWS services at some point.

In November 2007, Criminal Justice Services (CJS) provided program participation lists for the Adult Felony Drug Court (FDC), Mental Health Court (MHC), Day Reporting Center (DRC), and FOCUS (a DUI program). UCJC staff linked those program files with HARP participation data and identified those persons who had CJS program participation prior to, during, or after HARP placement. This link was conducted for all 102 HARP participants.

The Road Home Shelter records were searched by staff for shelter stay histories for the 69 HARP participants who started the program through May 31, 2007. Use of The Road Home shelter services was indicated for both pre- and post-HARP periods for those 69 clients.

Adult Probation and Parole (AP&P) in Salt Lake City searched their records in August 2007 to locate O-track numbers (Utah Department of Corrections (UDC) identifiers) for the 71 HARP participants who had started HARP through June 1, 2007. This resulted in 46 (64.8%) HARP clients that had O-track numbers, indicating involvement with UDC. This resulting list was sent to UDC to query their database for information on legal status changes (probation, prison, parole), probation officer contacts, urinalysis testing, programming, and Level of Service Inventory (LSI) scores. Descriptive statistics about HARP participants' UDC involvement are presented as a percentage of the total 71 clients included in the data queries, unless otherwise specified.

Over the course of the evaluation, attempts were made to locate and verify HARP clients' State ID numbers (SIDs, the identifiers used by the Bureau of Criminal Identification (BCI)). SIDs

came from several sources including the: Salt Lake County Adult Detention Center (ADC) database (JEMS), UDC records, and CJS program files. These searches resulted in the identification of SIDs for 51 of the 73 HARP participants (69.9%) who started HARP through June 7, 2007. These identifiers were sent to BCI for a query of the state criminal history record in November 2007. Identifying information from BCI was compared to HARP records to verify the matches. The criminal history data was used to examine pre-HARP criminal histories, as well as recidivism for those who had a sufficient follow-up period following intake into HARP. Unless otherwise stated, descriptive statistics presented for BCI data are out of the 51 HARP clients who had BCI records.

Salt Lake County Adult Detention Center (ADC) bookings were routinely searched for HARP clients throughout the evaluation period. HARP clients were identified in ADC bookings by several combinations of name, date of birth, social security number, and Sheriff's Office number (SO, the identifier used by ADC). Some SOs for HARP clients were found in CJS program records. In addition to the ongoing hand searches, a query of the ADC's database, JEMS, was received in November 2007. It provided jail booking information from July 1, 2000 through November 25, 2007 that included additional information on booking types (warrant, new charge, commitment). These data were used to examine pre- and post-HARP charges and jail involvement, as well as days out of the HARP unit. Although collected throughout the evaluation period and searched through multiple variables, JEMS data was only available on 88 of the 102 HARP participants (86.3%). The remaining 14 HARP clients that were not located in JEMS files were either not booked into the ADC between July 2000 and November 2007, or were booked under an alias that did not match any of the search parameters. JEMS statistics presented in this report are out of those 86.3% of HARP participants who have JEMS data, unless otherwise specified.

Surveys and Data Collection

Surveys

Two client surveys were developed for this evaluation, an active client survey and a former client survey. The purpose of these surveys was to gain a better understanding of participant satisfaction with various aspects of the program, receive suggestions for improvements, and record additional quality of life measures that might help the program to better serve their clients. The current client surveys were given by case managers to HARP clients while in the program. Another survey was mailed out to former clients at least six months following program exit. Follow-up surveys included a cover letter signed by Gary K. Dalton, Division Director of Salt Lake County Criminal Justice Services, and Kerry D. Steadman, Homeless Services Coordinator for the Salt Lake County Community Resources and Development Division, which informed recipients of the nature of the survey and offered them a $20 Smith's gift card as compensation for their time. Copies of the two survey instruments and the cover letter can be found in Appendix F. Completed surveys were mailed directly to UCJC research staff in a postage-paid envelope and individual responses were kept confidential. From April to June of 2007, case managers distributed a total of 37 surveys to current HARP clients. Of these, sixteen completed surveys were received (43.2% response rate). Additionally, 27 former client surveys were mailed

out, of which five completed surveys were received and nine were returned undeliverable (27.8% response rate).

Onsite Data Collection

From April through June 2007, UCJC research staff conducted onsite data collection at HACSL and with case managers from HARP referring agencies. HACSL Housing Assessment and Eligibility Verification forms from paper files were copied into an electronic database maintained by researchers. These documents, completed by HARP applicants and their case managers at referral, included items such as demographics, housing history, income, disability, and criminal history. Copies of these documents can be found in Appendix G. All 69 clients' forms on file at the time were transferred into the research database.

The UCJC research assistant (RA) also met with case managers from the referring agencies who had clients that were active or were formerly in HARP. Through these appointments, the RA obtained records of case manager contacts and completed Self-Sufficiency and Housing First Matrices with the case managers for both active and former HARP participants. The Self-Sufficiency Matrix measures clients on a number of domains, including income, employment, housing, food, education, legal, life skills, mental health, substance abuse, community involvement, and support services. A score was given on each measure for client status at intake into HARP and currently (or at exit, if client was no longer in the program). Ratings ranged from one to five, with one indicating severe problems in that area (e.g., no income, no job, severe substance abuse) and five indicating no problems in that area (e.g., income sufficient – able to save, permanent full-time employment with benefits, no drug or alcohol use in last six months). Domains of the Housing First Matrix included rent, utilities, house keeping, landlord issues, community relationships, and Housing Authority issues. Both matrices were developed by the HARP program and modified slightly by UCJC for the research study. Copies can be found in Appendix H. Records of case manager contacts with HARP clients were obtained from case managers for 42 of 67 (62.7%) clients who had participated in HARP at that time. There was some difficulty in obtaining case manager contact records from all agencies due to the nature of record keeping. However, additional measures of case manager contacts were queried from VMH and SAS billing records. Matrices were completed for 60 of 67 (89.6%) HARP clients, although some, especially the Housing First Matrices, were only partially completed due to missing or unknown information.

Analyses

Descriptive and statistical analyses were conducted using SPSS 15.0®. Analyses were limited by availability of data, both in terms of sample size and follow-up periods. For example, JEMS data from the ADC was examined in various time periods pre- and post-HARP start, including 12 and six months from intake date. However, a lack of variance in the six month data resulted in reporting the 12 month periods prior to and after HARP intake, although that slightly limited sample size. A similar number of HARP clients had either 12 or 18 months of BCI follow-up data available, so the longer period was chosen to measure increased opportunity for recidivism.

Statistical analyses were chosen based on the level and characteristics of the data. The use of the appropriate test based on the characteristics of the data and the assumptions of the test increase the "power," the ability to correctly identify group differences (Pett, 1997). Normally distributed data (e.g., age at intake) were examined using parametric tests (e.g., t-test), while nominal variables (e.g., presence or absence of a jail booking in the year prior to HARP) and non-normally distributed variables (e.g., 18-mo pre-HARP BCI arrests) were examined using nonparametric tests (e.g., Chi-Square, Wilcoxan Signed Ranks Test). All statistically significant results are presented with their test statistic and p value in a footnote or table. The p value is compared to a standardized alpha (ά, significance level). Statistical significance was set at $\acute{\alpha} < .05$, which is standard in the social sciences. This means that the likelihood that the observed difference between groups is due to chance is less than five in 100. Only bivariate (comparisons between two variables) tests are reported, as sample size was not sufficient to conduct multivariate analyses on the outcome data.

The criminal justice system cost-benefit analysis was conducted using (1) the average per-person cost of HARP calculated from Housing Authority rent data, (2) the effect size (the standardized measurement of differences between groups (Cohen, 1988)) from changes in new offenses pre- and post-HARP intake, and (3) the Utah Cost-Benefit Model (Fowles, Byrnes & Hickert, 2005). The Utah model focuses on marginal benefits and costs (at a per-person level). This model used a survey of Utah law enforcement and justice agencies to estimate tax-payer costs and national estimates for victim costs (Fowles, et al.). With the use of this model it is possible to calculate the victim and taxpayer effects (dollars saved/expended) and the cost-benefit ratio (for effective programs this is the dollar return on a dollar invested) from a program's effect size and per-person cost. The per-person HARP cost and recidivism analysis effect size were plugged into the model to find the effects and cost-benefit ratio.

Results

Who does the program serve?

Intake and Demographics

HARP served 102 clients between December 2005 and October 2007. The age of HARP clients at intake ranged from 18 to 64 years old, with 25% of clients 26 years old or younger and 75% of clients 43 years old or younger. Median age was 32.4 years old. Just over half of clients (52.9%) were female and nearly three-quarters (74.0%) were White. The remainder were identified as Hispanic (15.0%), Native American (5.0%), African American (5.0%), or Pacific Islander (1.0%). Intake referral forms indicated that 65.6% of clients had a disability, as verified by the staff who made the referral to HARP. Verified disabilities included physical, mental, or emotional impairment; developmental disability; HIV/AIDS; or chronic problems with alcohol and/or drugs. A much smaller percent of HARP clients (15.7%) had a mental or physical disability recorded in their electronic HACSL file.[2]

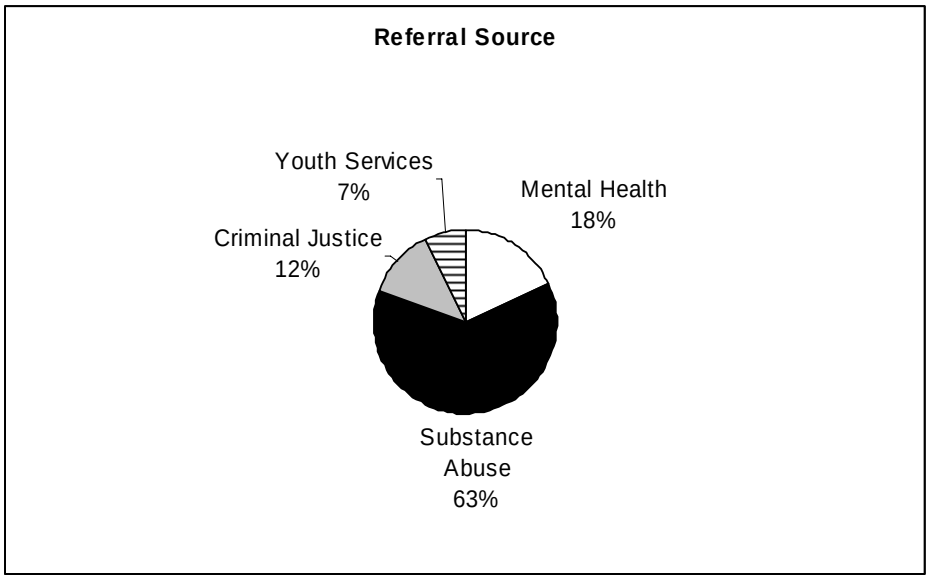
[2] Discussions with HACSL staff indicated that the discrepancy between disability statuses on Eligibility Verification forms and electronic records are most likely due to varying definitions, with the electronic records not including chronic problems with alcohol and/or drugs as a disability.

According to HACSL intake records, two-thirds (67.3%) of clients were jail referrals to the program. Referral sources included many agencies, such as First Step House, House of Hope, Valley Mental Health, Volunteers of America, Youth Services, Criminal Justice Services, Odyssey House, and various representatives of those agencies at the Salt Lake County Adult Detention Center (ADC). As noted in the Program Overview section of this report, potential clients must enter HARP through four "doors": Mental Health, Substance Abuse, Criminal Justice Services, and Youth Services (or their subcontracting agencies). As shown in Figure 1, on the following page, the largest percentage of clients were referred from the Substance Abuse division and their subcontracting agencies. At the time of the final HACSL data query (November 7, 2007), just over one-third (36.3%) of participants had vacated their HARP units.

Homelessness

The Road Home shelter records indicated that 15.9% of HARP clients had stayed in the shelter at least one night prior to HARP placement. Number of nights spent in the shelter ranged from two to 461. Data obtained from HACSL intake forms indicated that a higher percentage (32.8%) of HARP clients reported having shelter stays prior to HARP placement. These same HARP referral forms indicate that approximately 90% of HARP participants had a homelessness experience; however, there were discrepancies within the forms as to which clients experienced different forms of homelessness (ex: living in places not meant for human habitation, in an emergency shelter, in supportive housing, etc.). One-quarter (26.2%) were "chronically homeless" as indicated on intake forms. This status, defined as an "individual with a disabling condition who has been continuously homeless on the street or in an emergency shelter for a year or more" or an "individual with a disabling condition who has had at least four episodes of homelessness in the past three years," was verified by the staff who made the referral to HARP.

Figure 1 Referral Source

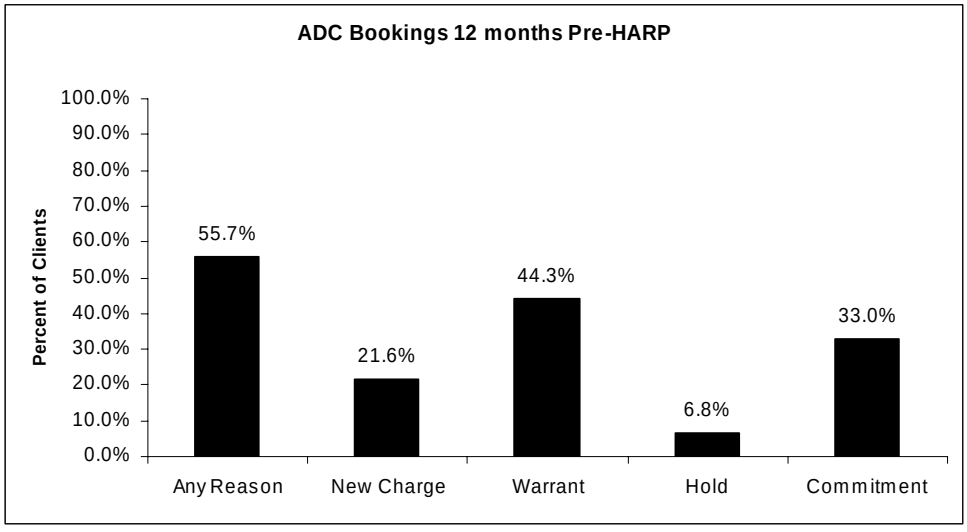


Criminal Justice System Involvement

Adult Detention Center. Just over half (55.7%) of the HARP clients located in JEMS records (86.3%, 88 of 102) had a jail booking in the Salt Lake County Adult Detention Center (ADC) in the 12 months prior to their HARP original lease date. A total of 65.9% had a jail stay during the year prior to HARP intake (release date was within one year prior to HARP, even if booking was prior to that). Days from jail release to HARP start ranged from five days to 332 days. The median number of days from jail release to HARP start was 179 days for this group. This figure (65.9%) is similar to the percent of clients who were indicated as being jail referrals on the HACSL intake forms (67.3%); however, there was a surprising lack of overlap between the two indicators of jail referrals to the program. For example, 31.7% of those who were flagged as jail referred in the HARP intake forms *did not* have a record of a jail booking or release in the ADC in the 12 months prior to HARP start.[3] Conversely, 62.5% of those who were not flagged as a jail referral *did* have a jail booking or release in the 12 months prior to HARP. Although there was a lack of consistency across record sources, both indicate that HARP is meeting its goal of using at least half of the housing vouchers for persons who are released from the jail.

Bookings in the ADC during the 12 months prior to HARP occurred for a number of reasons. Figure 2, below, presents HARP clients' jail bookings in the year prior to HARP start. Counts are duplicated in Figure 2. For example, if a person had a booking on a new charge as well as a warrant, they are included in both columns. Severity of offense for the new charge bookings in the year prior to HARP ranged from Class C Misdemeanors to Second Degree Felonies. Most severe offense was recorded for each person. The median severity among these was a Class B Misdemeanor.

Figure 2 Percent of HARP Clients with Jail Bookings in Year Prior to HARP Intake



[3] A subsequent search of statewide jail booking records indicated that 4 of the 19 did have a jail booking in the year prior to HARP. The remaining 15 individuals identified as being jail referred have no record of bookings in Utah jails in the year prior to HARP start, although all had jail bookings at some point in their history.

Days in jail (per client) in the year prior to HARP ranged from zero (book and release on the same day) to 365. The median for clients with at least one booking was 58 days served, or approximately two months. The sum of jail days accrued by all HARP participants for the year prior to entering HARP was 4,826 days (for 58 persons). This represents a substantial strain on the system. When ADC records were searched from July 1, 2000 forward for all HARP participants, 83.3% had a jail booking prior to HARP start.

Bureau of Criminal Identification. Among those HARP clients with a state criminal history record (69.9%, 51 of 73 queried), two-thirds (66.7%) had a new arrest in the 18-months prior to HARP intake, further indicating the criminal involvement of the population served by this program.

Utah Department of Corrections. A similar group of HARP participants (64.8%; 46 of 71 queried) was also found to have Utah Department of Corrections (UDC) involvement. Of the 71 HARP clients who were included in the data requests sent to AP&P and UDC, 47.9% had a past UDC probation placement, while 12.7% had been in prison and 11.3% had been on parole prior to HARP start. At the time of their HARP placement, 32.4% of clients were actively on UDC probation and an additional 8.5% were on parole. Although these clients may represent a more criminally involved subset, this group also receives additional services through UDC's Adult Probation and Parole (AP&P). The "*What is HARP providing clients?*" section of this report describes the additional services and supervision that this group received while active in HARP housing. A very small group of HARP participants (N = 15) had a Level of Service Inventory (LSI) risk assessment in UDC records that occurred within the two months prior to or after their HARP start date. Among this group, the level of risk (of recidivism) varied widely from a low risk score of seven to a substantial risk score of 36. The median LSI score for this group was 19, which is commonly considered medium risk (Andrews & Bonta, 2001; Austin, Coleman, Peyton & Johnson, 2003; Lowenkamp & Latessa, n.d.). Individual items on the LSI indicate that 40% had a current alcohol or drug problem at the time of the assessment and 60% experienced some level of mental health interference.

Criminal Justice Services. Specialty program records were searched for HARP clients. Prior to their HARP placement, 13.7% of HARP clients had been in Adult Felony Drug Court (FDC), 8.8% had been in Mental Health Court (MHC), 2.0% had been in FOCUS (a DUI program), and one had been in the Day Reporting Center. Exit statuses among CJS participants were nearly evenly split, with 57.1% leaving the programs successfully and 42.9% having a negative exit status (such as unsuccessfully terminated or absconding from the program). While in HARP housing, four clients (3.9%) were still active in MHC and two (2.0%) were active in FDC.

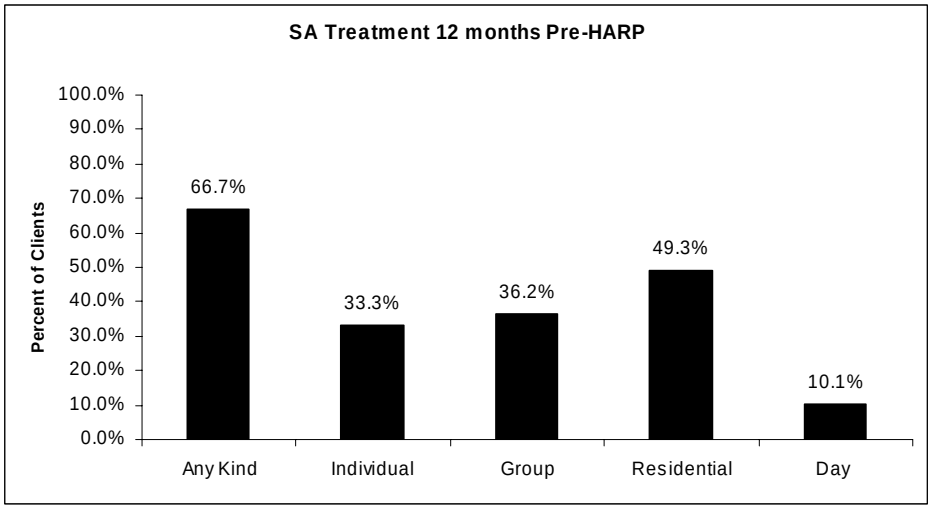
Mental Health and Substance Abuse Treatment Involvement

Nine of the 69 (13.0%) HARP clients queried in Valley Mental Health (VMH) records had treatment or case management from 2004 forward. This figure is just slightly lower than the percent of all clients (18%) that were referred to HARP from the mental health track. Five of nine (55.6%) had mental health (MH) treatment in the year prior to starting HARP. All five received both individual and group treatment, with number of sessions in that year ranging from one to 50 (individual treatment) and two to 109 (group treatment). Two of the five (40%) had residential treatment during the year prior to starting HARP as well. Across all types of MH

treatment received in the year prior to HARP, days between sessions ranged from less than one to just over two days (2.29). This indicates that among those who received MH treatment in the year prior to HARP, participation was frequent.

Substance Abuse Services (SAS) data was found for 56 of 69 HARP participants (81.2%). Of all HARP clients included in the SAS query (N = 69), two-thirds (66.7%) had SA treatment in the year prior to HARP participation. Figure 3 shows that most of the HARP clients who participated in SA treatment in the year prior to HARP had residential treatment. Across all types of SA treatment attended, frequency of sessions ranged from daily to less than once a month. The median number of days between SA treatment for this group was 12.1 days, with 25% attending treatment every 3.5 days, or more often, and 75% attending treatment every 19.7 days, or more often, in the year prior to HARP.

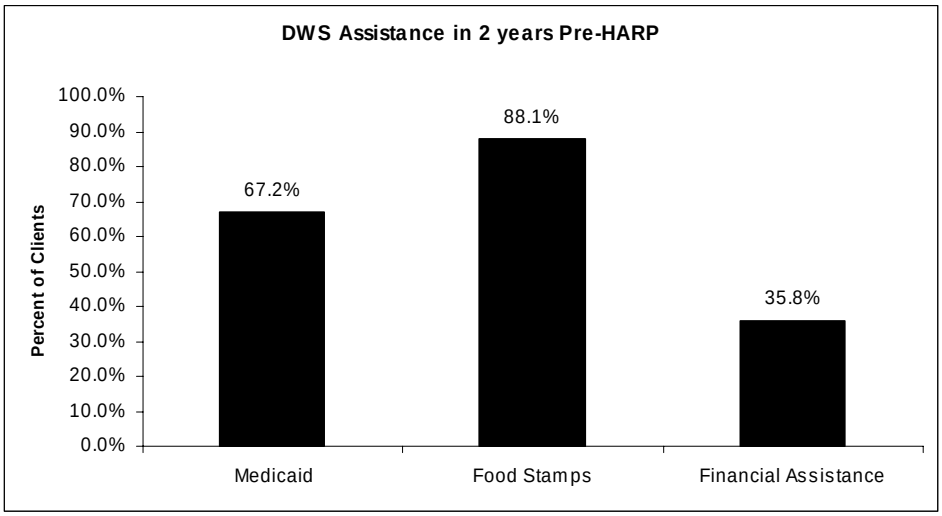
Figure 3 Substance Abuse Treatment in Year Prior to HARP Intake



Department of Workforce Services Assistance

DWS records were hand searched for 67 HARP clients who had participated in the program by May 2007. Of those, 10.4% had job training services prior to HARP. In the two years prior to HARP intake, many of these participants had received Medicaid, food stamps, and financial assistance. As shown in Figure 4, nearly 90% of HARP participants received food stamps, while two-thirds received Medicaid at some point in the two years prior to HARP. For all three types of assistance, number of months receiving benefits ranged from zero to 24 during that two year period. Median number of months receiving assistance during that time period was 14.1 months for Medicaid, 9.3 months for food stamps, and 7.8 months for financial assistance.

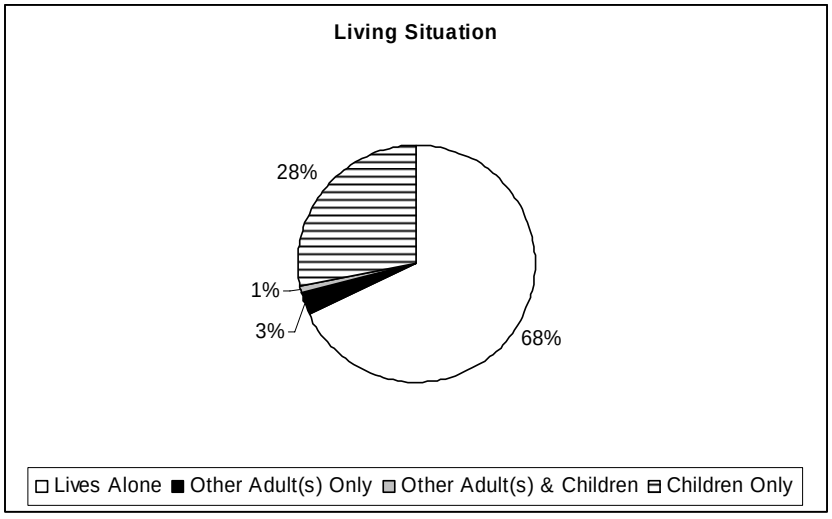
Figure 4 DWS Assistance in Two Years Prior to HARP Intake



Living Situation

HACSL records indicate that the majority of clients receiving HARP housing live alone. As shown in Figure 5, below, the second most common living situation is that of the single HARP client with minor children. Very few HARP clients live with other adults (or provided that information to the Housing Authority). The ages of children living with HARP participants ranged from infants less than 6 months old to teenagers seventeen years old. At intake, the median age was 4.7 years old, and 75% of children living in HARP housing were 10.4 years old or younger. In addition to these youth, four babies were born to female participants while they were active in HARP housing.

Figure 5 Living Situation of HARP Clients



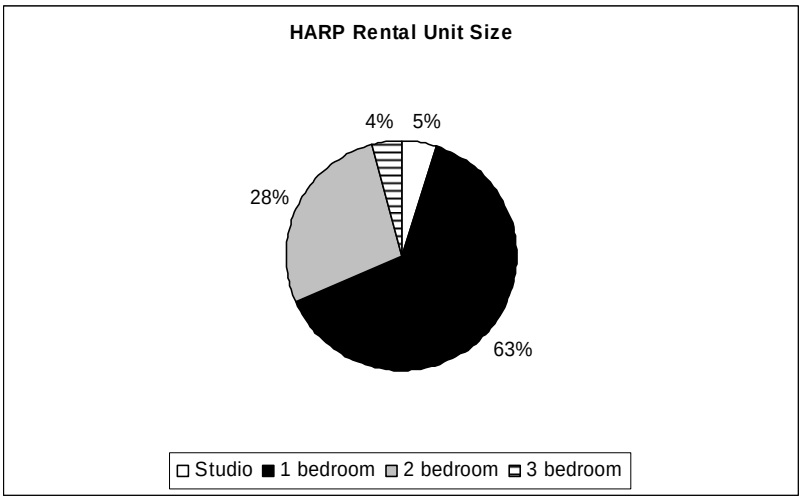
What is HARP providing clients?

Housing Authority Services

Housing Authority records indicate that nearly two-thirds (63.3%) of HARP participants were provided with rental assistance on a one bedroom unit. The following figure (Figure 6, on the following page) shows the size of rental units for HARP clients. As previously mentioned, just over two-thirds of HARP clients live alone. Therefore, unit size mirrors household size closely.

In the approximately 23 months that HARP has been operating, the Housing Authority has contributed $419,073 in HARP rental assistance. When clients first enter HARP, the median monthly rent contribution by HARP is $506, but ranges from $49 to $954. The HARP rent contribution averaged across all months is $454, indicating that client contributions vary from the first contract with the Housing Authority to subsequent ones. In the following "*Is HARP succeeding?*" section of this report, changes in client and HARP rent contributions are further explored.

Figure 6 Rental Unit Size of HARP Clients



Case Management Services

As described in the Program Overview section of this report, case management is a required element of HARP participation. Because case management responsibilities are shared across the multiple referring agencies, no single source of case management records exists. As outlined in the Methods section of this report, case management data came from a number of sources including: VMH billing, SAS billing, and records collected directly from case managers by UCJC research staff. Of the 68 HARP clients who began the program prior to May 2007 (time of data collection by UCJC research staff), case management contact records were obtained for 75% (N = 51). This includes case manager contacts obtained through all methods. For this group, frequency of meetings ranged from more often than once a day to once every two months (60.4 days). The median number of days between case manager contacts with clients was 9.4. Figure 7 shows the frequency of case manager contacts.

The HARP Guidelines document states that visits need to occur at least twice a month. As shown in Figure 7, this frequency is being met by 75% of those clients who had records available. Every effort was made to obtain case manager records for the 68 HARP clients who had participated by May 2007. However, it is not known if those 25% without records did not meet with their case managers regularly or simply did not have sufficient records to document their meetings. One challenge noted during the collection of case manager records was the transferring of HARP clients to different case managers. At the time of data collection over half of the HARP participants had changed case managers at least once, as shown in Figure 8. In some instances it was difficult to locate a current case manager for active HARP clients. Although much of this miscommunication had been worked out by the time of this report, it is recommended that HARP keep a centralized record of active case managers on file at all times.

Figure 7 Frequency of Case Manager Contacts (all data sources)

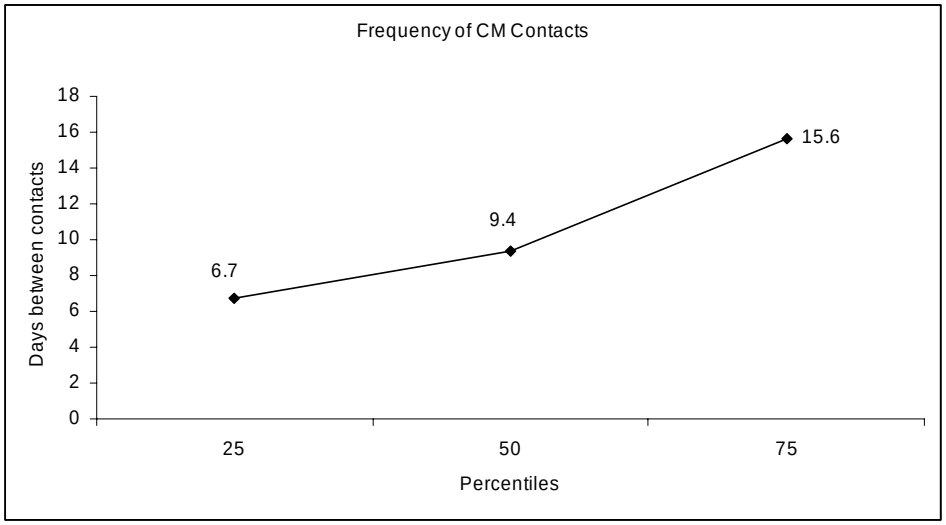
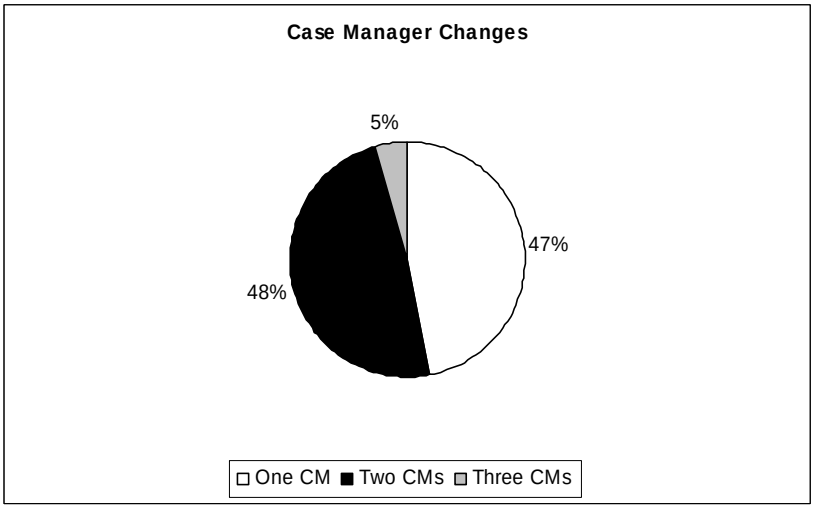


Figure 8 Case Manager Changes



Varying levels of detail were available on case manager contacts that came from each of the three sources. Contact data that was collected directly from case managers showed that over half of the clients (54.8%) had only office visits, while only 28.6% had any home visits. For this subgroup, case manager contacts occurred slightly more often than for the larger group (median of 7.7 days between contacts vs. 9.4 for the larger group). Four HARP clients received case management services through VMH while active in HARP housing. Frequency of case manager contacts for this group was every 3.4 days on average. Just over one-third (35.2%) of HARP clients had case management contacts in SAS billing records. Among that group, case manager contacts occurred every 8.8 days on average. Twelve individuals had case management recorded in SAS billing records for both pre- and post-HARP placement. Frequency of case manager contacts decreased slightly for this group. In the year prior to HARP, there were 5.1 days on average between contacts versus 8.1 days between contacts in the year following HARP placement. The various sources of case management records indicate that HARP is meeting its goal of biweekly contact with clients. However, the high percent of clients missing case management records (25%) and difficulty in compiling information on current case managers for active clients both suggest that the case management aspect of HARP's Supportive Housing model should continue to be monitored. In addition, it is known that AmeriCorp volunteers at the Housing Authority also provide some home visit services. These should also be documented for evaluation purposes.

Mental Health and Substance Abuse Services

Four of the five (80%) HARP clients who received MH services at VMH in the year prior to HARP also received MH services at VMH during HARP. During the first six months after starting HARP, treatment sessions occurred every 3.6 days on average, compared to every 1.7 days on average in the year prior to HARP placement. Furthermore, frequency of treatment sessions decreased to every 7.1 days for the entire year following HARP placement. Although these data represent very few individuals, the gradual decrease in frequency of mental health treatment sessions may indicate improved functioning among these participants. The "*Is HARP Succeeding?*" section of this report further explores changes in mental health functioning as recorded on the Self-Sufficiency Matrix.

As previously noted, two-thirds of HARP participants whose information was sent to SAS for treatment records had treatment in the year prior to HARP start. In the year following HARP intake, 56.3% had SA treatment recorded. The overlap between the two groups was substantial, with 73.9% of the pre-HARP treatment group remaining in SA treatment following HARP placement. Comparisons across time were made for that group that had both pre- and post-HARP placement treatment. As shown in Figure 9, on the following page, the frequency of SA treatment attendance increased dramatically for this group from pre- to post-HARP placement. These figures suggest that, among those who were in treatment across both time periods, intensity and compliance were stepped up initially following housing placement. Information on treatment modality was also available across both time periods.

As shown in Figure 10, on the following page, fewer HARP clients received residential treatment in the year following HARP placement, while more received treatment in the group modality and

an approximately equal percent received individual treatment. Most clients received a mix of treatment modalities and, therefore, are included in all categories in Figure 10 in which they received any treatment.

Figure 9 Frequency of Substance Abuse Treatment among HARP Clients with Treatment Pre- and Post-HARP Placement

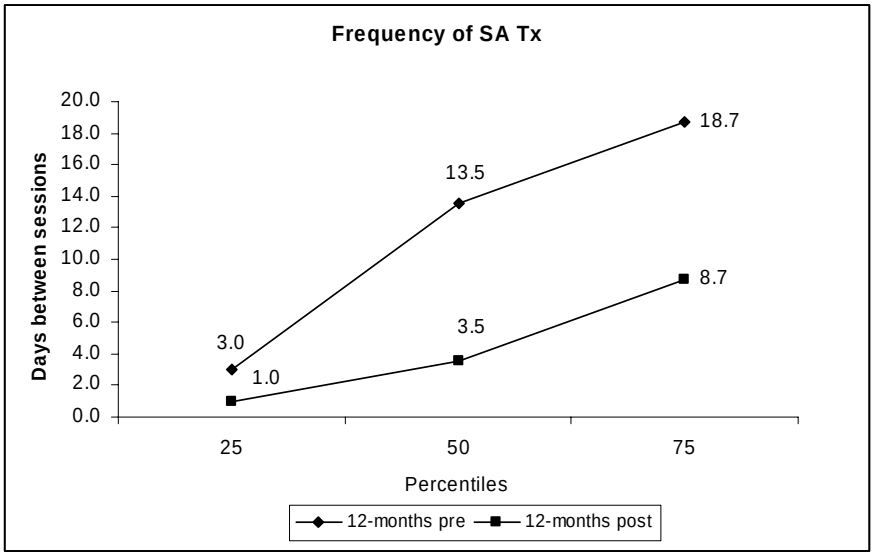
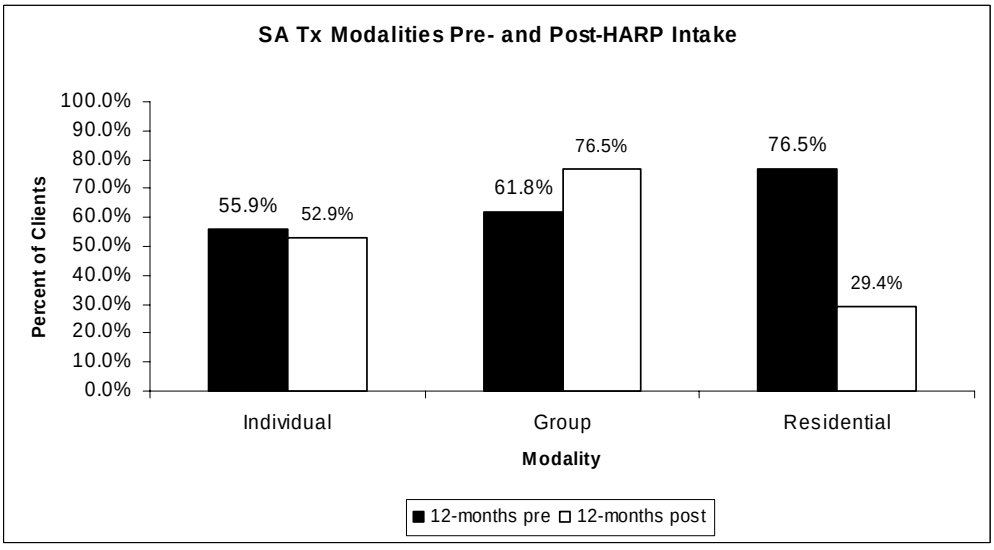


Figure 10 Changes in Substance Abuse Treatment Modality among HARP Clients with Treatment Pre- and Post-HARP Placement



ASAM (American Society of Addiction Medicine) treatment intensity information on SA treatment following HARP intake was available for 91.2% of the group that had both pre- and post-HARP placement treatment. Two-thirds (67.7%) remained at the ASAM level they were first assigned to following HARP placement, while 22.6% decreased ASAM levels and only

9.7% increased treatment intensity. ASAM level changes were only computed for those who had treatment in both time periods and also had at least six months of treatment following HARP intake.

Utah Department of Corrections

Although UDC is not an official partner in HARP, several HARP clients were under UDC jurisdiction while active in HARP; therefore, UDC supervision and programming represent an additional contribution to HARP clients' experience while in the program. As noted in the "*Who does the program serve?*" section of this report, 32.4% of clients were actively on UDC probation and an additional 8.5% were on parole at the time of intake into HARP housing. For HARP clients who were concurrently under UDC supervision, median number of days on supervision leading up to HARP intake was 260 (probation) and 152 (parole), while median number of days remaining on supervision following HARP intake was 310 (probation) and 125 (parole). Lengths of UDC supervision are several months in duration and most HARP clients who were on supervision entered HARP in the middle of their supervision period. While active in HARP housing, clients concurrently under UDC supervision met with their AP&P probation/parole officer every two weeks on average, with 25% meeting every 11.1 days or more often and 75% meeting every 20.5 days or more often. Urinalysis (UA) testing occurred less frequently for this group, with an average of nearly two months lapsing between tests. Among those with more than one UA test, 72.2% had no positive tests recorded. HARP clients who also attended UDC specialty programming (ex: women's programs, mental health, substance abuse) generally had positive outcomes, with two-thirds (66.7%) successfully exiting programs, and 16.7% each having negative or a mix of positive and negative exit statuses.

Is HARP succeeding?

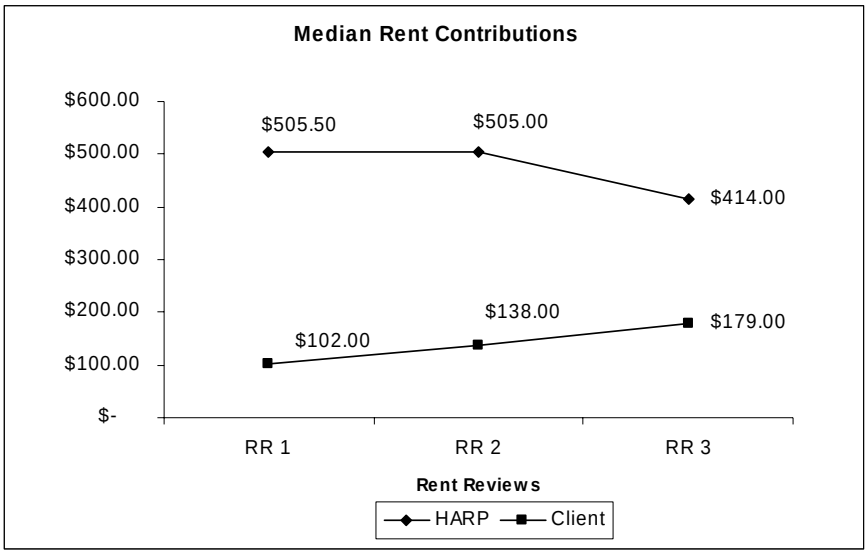
HARP Participation and Exit Status

Participation. HARP participants are required to pay a minimum of $50 or 30% of their income as their monthly contribution to rent. Financial data obtained from the Housing Authority shows that this minimum was generally met. When entering the program, the median rent contribution by clients was $102, but ranged from $0 to $572, with 10.2% of clients paying less than the $50 minimum, 32.7% paying the $50 minimum, and 57.1% paying above the minimum. The median HARP contribution to rent when clients entered the program was $506, and ranged from $49 to $954.

The amount of rent paid by clients varied over the course of participation and would change with "rent reviews." Life events that precipitated rent reviews (RR) included changes in household size, employment status, and income. There were no set intervals for rent reviews. Figure 11, on the following page, shows changes in rent contributions by rent reviews. Just over half (60, 58.8%) of the HARP clients had a second RR, and 33 (32.4%) had a third RR. Figure 11 shows the median value at each of these reviews. The overall trend was for clients to increase the amount of rent they were contributing to their housing at each rent review. However, individual calculations showed that 43.3% of clients actually decreased the amount of rent they were paying from the first to the second RR, while 23.3% continued to pay at the same level and one-third

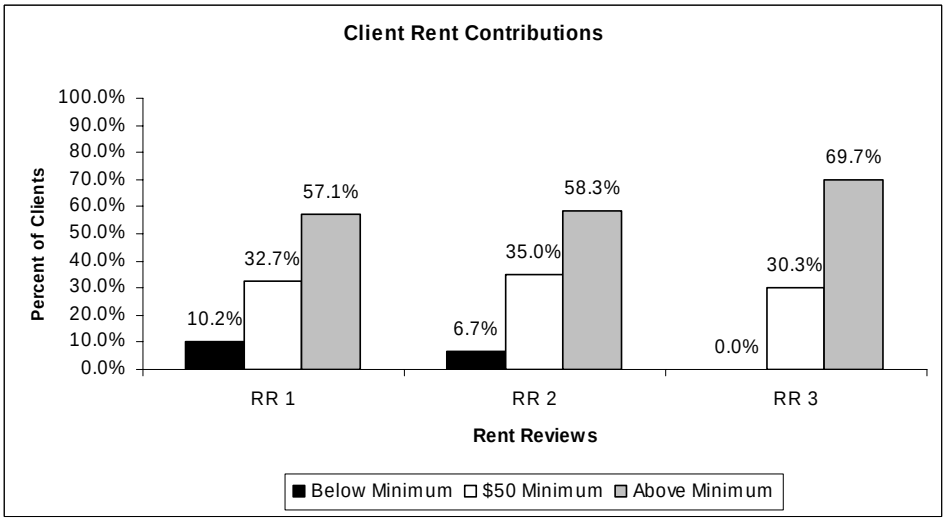
(33.4%) increased the amount of rent they were paying. Although client contributions to monthly rent showed an increase across rent reviews, annual gross incomes reported at those reviews remained relatively stable. Median annual gross income at the first rent review was $7,045 compared to $6,936 at the second RR and $7,946 at the third RR. However, the percent of clients reporting no income did decrease steadily across the three RR from 31.6% to 25.0% to 21.2%.

Figure 11 Median Rent Contributions at Rent Reviews



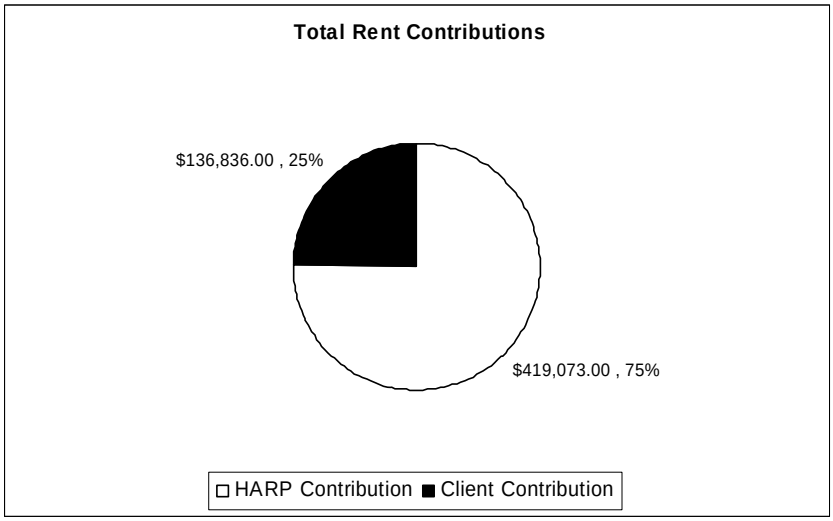
The percent of clients who were paying less than the minimum required rent decreased as median client contributions increased across rent reviews. Figure 12 presents the same theme of increasing client contributions across time.

Figure 12 Percent of Clients Paying Minimum Rent across Rent Reviews



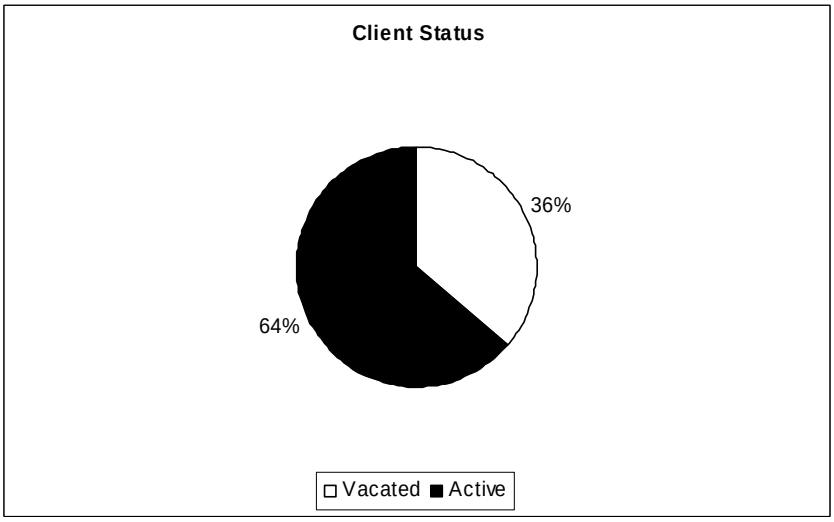
Time in HARP housing ranged from less than one month (0.97) to nearly two years (22.1 months). The median time in HARP was eight (8) months. Average client rent contribution across that time (taking into account changes in rent contributions) was $137, while the average HARP contribution across the same time was $454 per month. From program inception to November 7, 2007, HARP has contributed a total of $419,073 to client rents. Additionally, clients have contributed a total of $136,836, for a grand total of $555,909 having been spent on HARP rents. Figure 13 shows that this is a three-quarter to one-quarter distribution.

Figure 13 Total Rent Contributions for HARP



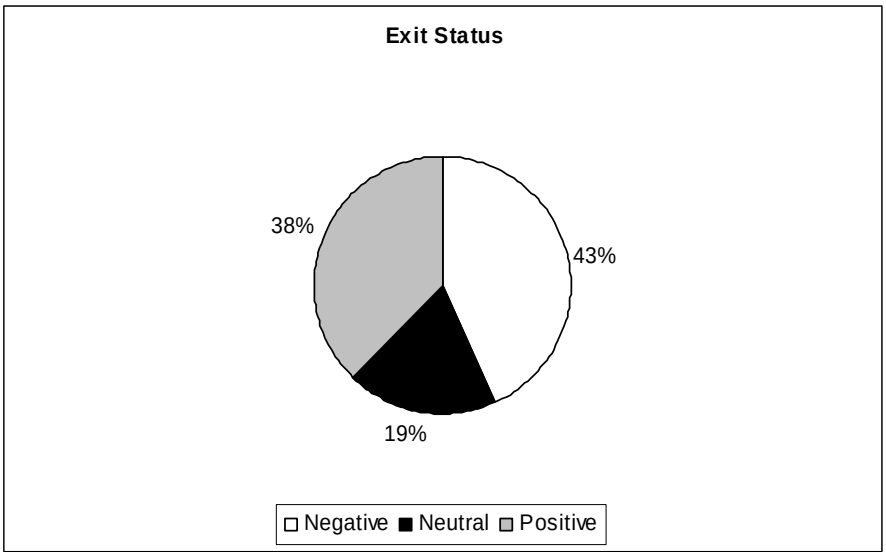
Exit Status. As of November 7, 2007, just over one-third (36.3%) of HARP clients had left HARP housing, while 63.7% remained active (shown in Figure 14). Median time in the program for former clients was 9.2 months, but ranged from 1.6 to 19.6. Median time in the program for active participants was 6.3 months, with a range of 0.97 to 22.1.

Figure 14 Client Status as of November 11, 2007



Of those who had left the program, just over half (56.7%) had either a positive or neutral exit status, while 43.2% had a negative exit status. Figure 15 displays the exit status of former clients. Clients considered to have a positive exit status were those that became self-sufficient or were able to pay market rate, moved to other funding streams, or moved in with family. Some exit circumstances viewed positively by HARP personnel may not be viewed the same way by clients (see the Client Surveys section of this report). Neutral exit statuses included: applicant requested to leave program, returned to a treatment program, or client was deceased. The following were identified as negative exit statuses: eviction, returning to jail or prison, non-compliance with program requirements, or absconding from the program.

Figure 15 Exit Status for Former HARP Clients



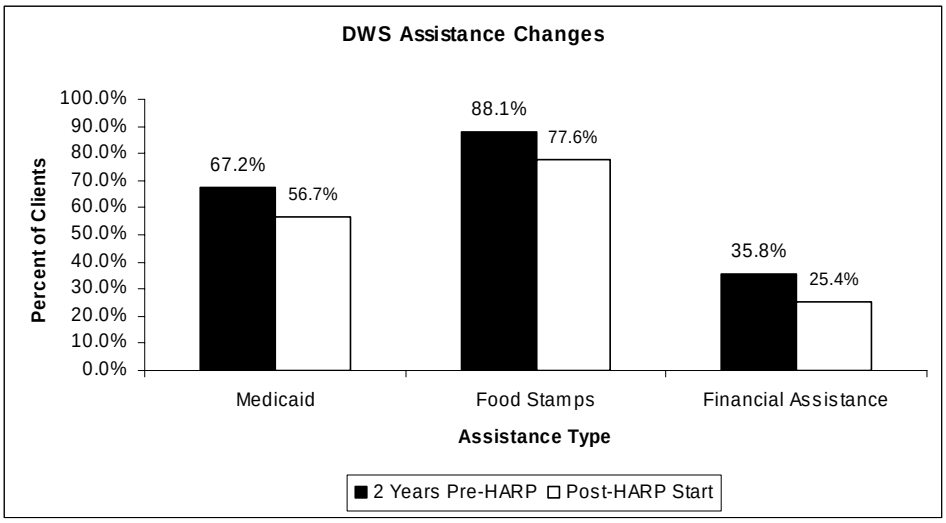
Department of Workforce Services Assistance

The percent of HARP clients utilizing DWS services and assistance varied by time period. Across all three assistance types (financial assistance, food stamps, Medicaid), fewer HARP clients utilized DWS assistance after beginning their HARP placement than in the two years prior. Figure 16, on the following page, shows these changes. None of the changes in DWS assistance use status (yes or no) were statistically significant.[4] This, however, could have been due to changes in opposite directions masking the effect of the other. For example, half (50%) of those on the financial assistance benefit prior to HARP did not receive the benefit after starting HARP; however, 11.6% of HARP clients who did not receive financial assistance prior to HARP did start receiving it after they began the program. Similarly, food stamp use saw a 16.9% decrease from pre- to post-HARP intake for those who were on it prior to HARP and a 37.5% increase for those who did not get that benefit prior to HARP. One-fifth (22.2%) of those on Medicaid prior to HARP did not remain on that benefit after staring HARP, while 13.6% of those not on Medicaid prior to HARP started the benefit after entering housing. Two of the seven

[4] McNemar's Test $p > .05$

(28.6%) clients that received job training prior to HARP intake also used this service after entering HARP. An additional four persons also received job training after entering HARP for a total of 9.0% receiving job training after starting HARP. These types of shifts may indicate that clients who formerly received the benefits may be able to reduce or quit use after stabilizing in HARP housing, while those who needed, but were not receiving, the benefit prior to HARP had support after entering HARP that allowed them to access these additional services.

Figure 16 Department of Workforce Services Changes



Self-Sufficiency and Housing First Matrices

As noted in the Surveys and Data Collection section of this report, matrices were completed by case managers and rated clients on a number of life areas, with lower scores (one) indicating greater problems and higher scores (five) indicating greater self-sufficiency. Areas measured included income, employment, housing, food, child custody, childcare, children's education, adult education, legal, health care, life skills, mental health, substance abuse, family relations, mobility, case management plan, community involvement, and support services. Copies of the Self-Sufficiency and Housing First Matrices can be found in Appendix H. Ratings were recorded for client statuses at intake (Time One) and currently (in spring 2007 if still active) or exit (if terminated), hereafter referred to as the Time Two matrix.

The greatest problem areas at intake (as indicated by an average score of less than three) were: income, employment, housing, food, adult education, and health care. While initial problem areas were relatively consistent across both active and unsuccessfully terminated clients, a few differences were observed. Active clients, on average, scored lower in the areas of family and community involvement, while terminated clients had lower scores in the legal domain. Although many of these domains continued to be problem areas for clients while in or upon exit from HARP, both groups did experience significant improvements in a number of domains (see Figure 17, on page 35).

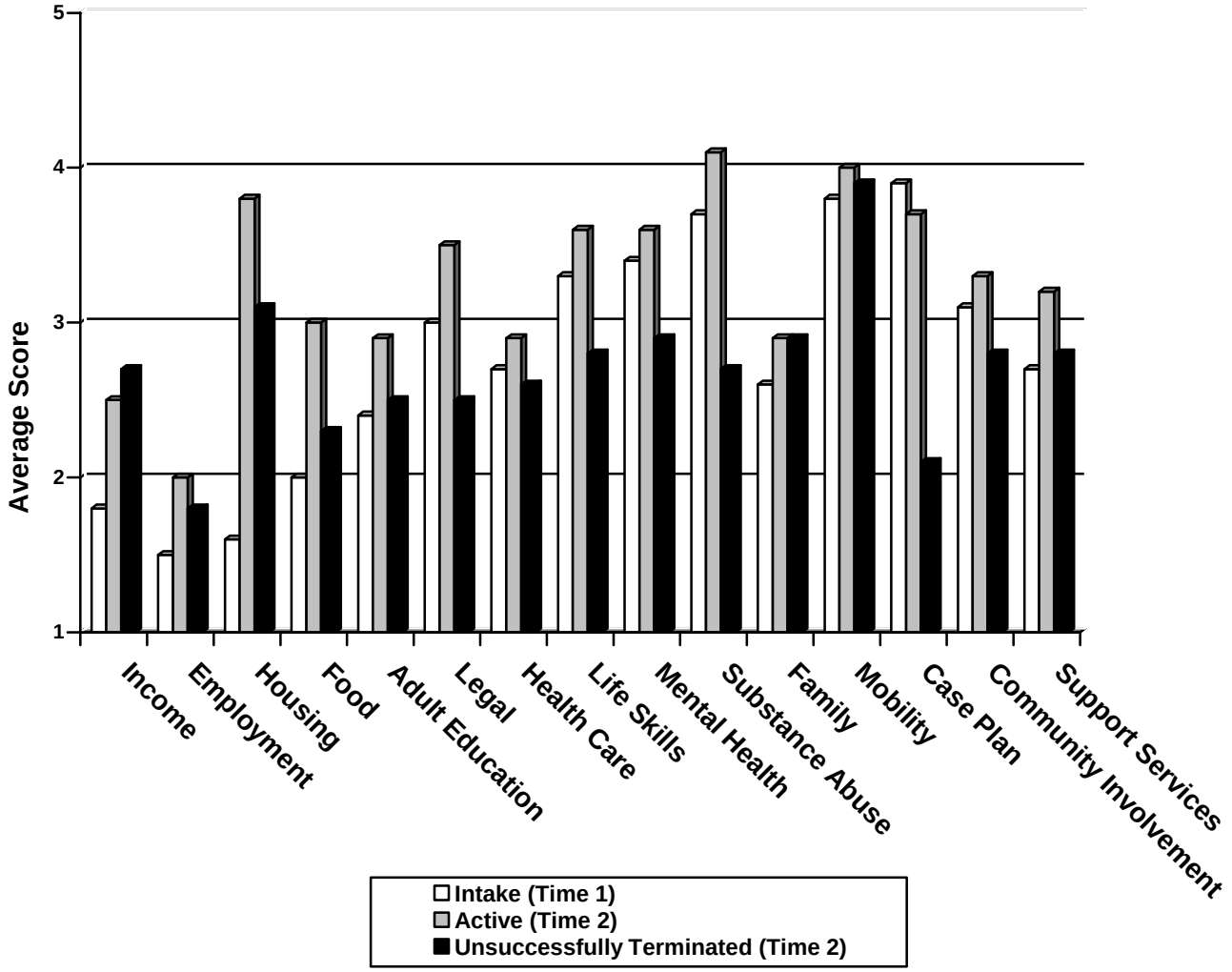
Those who were active at the time of their Time Two matrix had improved scores in all 18 domains, except meeting all requirements of their case management plan, which fell for all clients (active, -0.2 and unsuccessfully terminated, -1.5). Clients who were active when their Time Two matrix was completed continued to experience problems in the areas of income, employment, adult education, and health care. On the other hand, unsuccessfully terminated clients continued to score low in their initial problem areas as well as a number of additional areas. These new problem areas included mental health, substance abuse, life skills, and case management plant. It is likely that these new problem areas contributed to, if not caused, these clients to be terminated from the program. It is interesting to note, however, that the unsuccessfully terminated clients experienced some improvement in income, employment, housing, and food.

Housing First Matrices were collected in the same manner as Self-Sufficiency Matrices. Domains of the Housing First Matrix included rent current (having rent paid in full), income changes, utilities on and current, house keeping, case management, landlord issues, community relationships and legal system, and Housing Authority issues. Ratings on Housing First matrix domains for clients at intake were all above the median score of three; however, this is most likely due to that fact that most case managers did not begin home visits until after the clients were settled into their new apartments. Likewise, average domain scores for clients who were active when their second matrix was completed were above the median score of three in all areas. Unsuccessfully terminated clients also scored high in all but one domain (landlord complaints) at intake; however, the score in this domain had improved drastically by the time these clients exited the program. Upon exit, the only problem area, below the median score of three, for this group of unsuccessfully terminated clients was case management.

Although scores were high in all domains for most clients at intake, clients who were active at Time Two had slightly higher scores at intake when compared to those clients who were unsuccessfully terminated by the time of their second matrix. Due to this slight difference in initial scores, unsuccessfully terminated clients experienced more dramatic increases and decreases at Time Two, when compared to their active counterparts. Unsuccessfully terminated clients drastically increased their scores in the community relationships domain by Time Two, while active clients, with an already high score, saw no change in this domain. Both groups experienced minor decreases in domain scores at Time Two in the areas of income, case management, and Housing Authority issues. However, both groups also experienced improvements in the areas of rent current, utilities, house keeping, and landlord complaints at Time Two.

Overall, results from the case manager completed matrices indicate that HARP clients have a number of problem areas when entering the program, most notably, employment, housing, income, and food. The ratings also indicate that all clients show some improvement from intake to Time Two regardless of whether they remained active during the spring of 2007 or had been terminated (unsuccessfully) from the program. These ratings suggest that even those who ultimately leave the program unsuccessfully still benefit from participation in the program. Although general trends have been observed, no dramatic contrasts were present between groups. It is suggested that matrix data be collected routinely (every other month) by case managers during their meetings with HARP clients if more nuanced changes are to be observed.

Figure 17 Self-Sufficiency Matrix Domain Changes over Time



Client Surveys

Current Client Survey. Current client survey respondents were primarily White (75.0%), female (81.3%), and ranged in age from 20 to 47, with an average age of 35. Compared to the entire sample of HARP participants, current client survey respondents were more likely to be female. HARP referral and case management source varied, with the greatest number coming from House of Hope (9), followed by Salt Lake County Criminal Justice Services (3), Volunteers of America (3), and Valley Mental Health (1). This distribution is roughly equivalent to the referral source for all HARP clients, with the majority being referred from Substance Abuse Services and their subcontracting agencies.

A majority of HARP clients who completed the current client survey noted that they were "very satisfied" with the services they had received from the Salt Lake County Housing Authority (81.3%), Department of Workforce Services (60.0%), and Criminal Justice Services (55.6%). Although the Housing Authority received a high level of overall satisfaction, one client identified a need for staff to be more responsive. Clients receiving mental health (N=10) or substance abuse (N=11) services were "very satisfied" with these services (72.7% and 90.9%, respectively).

According to respondents, the frequency of telephone and in person contacts with their case managers had declined slightly since starting HARP; however, nearly half (42.8%) of all respondents noted that at the time of survey completion they were meeting with their case manager in person at least once a week. Nonetheless, one client identified a desire for more contact with their case manager.

Overall, however, clients were satisfied with their case manager and "strongly agreed" or "somewhat agreed" that their case manager clearly explained the building rules to them (62.6%), worked with them to develop and make sure they understood their case plan (81.3%), and made site visits to their apartment (69.2%). Likewise, the majority of clients felt that their case manager was responsive to their requests (66.7%), sensitive to their cultural/ethnic background (87.5%), and treated them with respect (87.5%).

Nearly half (46.7%) of respondents noted that they were living in a residential treatment facility during the six months prior to HARP participation. The remainder of respondents lived in their own house, apartment, or room (6.7%), with someone else (13.3%), in jail or prison (13.3%), or were homeless (20.0%). Although three respondents identified themselves as homeless during the six months prior to HARP, only two reported spending any nights in a shelter during that time period. This is consistent with data obtained from The Road Home Shelter, showing about 16% of HARP clients having a record of shelter stays at their facilities.

Most respondents had at least their high school diploma or GED (71.4%) and 36.4% were enrolled in school at least part-time while in HARP. These responses are comparable with case manager ratings of clients' education level on the Self-Sufficiency Matrix, with most having marked "Has High School Diploma/ GED" or "Enrolled in literacy and/or GED classes." Almost half of all respondents (41.7%) were employed full-time during the six months prior to participation in HARP, with an additional 25.0% employed part-time. Surprisingly, no respondents reported full-time employment while in HARP, but the percent employed part-time

increased to 75.0%. Compared to the larger group of HARP participants that had Self-Sufficiency Matrices, survey respondents were more likely to be employed. Only four respondents (26.7%) reported owning a vehicle while in HARP and almost half (46.7%) relied on public transportation, with 38.5% stating that bus tokens were made available to them. Ratings on the Mobility domain of the Self-Sufficiency Matrix also indicate that transportation is not a major problem for HARP clients.

Respondents were asked to self-report on their drug use during the six months prior to HARP as well as during HARP (see Table 2, below). Although very few respondents reported drug use during the time period prior to HARP, this number did decrease during HARP. The largest decrease in use was seen for methamphetamines. Four survey respondents used methamphetamines in the six months prior to HARP intake, but none reported using it while active in HARP.

Table 2 Self-Reported Drug Use Before and During HARP

	6 months prior		**During**	
Drug Type	N	%	N	%
Amphetamines	2	12.5	1	6.3
Barbiturates	2	12.5	1	6.3
Marijuana	3	18.8	0	0.0
Cocaine	2	12.5	1	6.3
Psychedelics	1	6.3	0	0.0
Heroin	2	12.5	0	0.0
Inhalants	1	6.3	0	0.0
Methadone	2	12.2	0	0.0
Methamphetamines	4	25.0	0	0.0
Other Opiates	3	18.8	1	6.3
Sedatives	1	6.3	0	0.0
Other Drugs	1	6.3	0	0.0

Respondents experiencing serious depression, anxiety, or tension during the six months prior to HARP reported improvements in their mental/emotional health while in HARP (see Table 3, on the following page). However, very little, if any, change was noted for the few suffering from: trouble understanding, concentrating, or remembering; trouble controlling violent behavior; or serious thoughts of suicide.

Clients were asked to rate their overall health during the six months prior to HARP participation, as well as their current overall health. About 85% of clients said they were in good health during both time periods. About one-third (31.3%) of respondents reported suffering from at least one chronic medical problem that interfered with their daily life while in HARP. Such medical problems included: dental, vision, arthritis, depression, chronic pain, and Hepatitis C. Slightly more than half of all respondents (56.3%) reported having health insurance and less than half of respondents (40%) reporting a chronic medical condition were insured. Survey respondents may not represent all HARP participants in these areas. On the Self-Sufficiency Matrix (completed by

case managers for a larger group of participants), it was indicated that clients had limited health care coverage and difficulty accessing care.

Table 3 Mental/Emotional Problems Reported by Clients

	6 months prior		During	
Mental/Emotional Problems	N	%	N	%
Serious depression	10	71.4	6	42.9
Serious anxiety or tension	7	50.0	4	28.6
Hallucinations	0	0.0	0	0.0
Trouble understanding, concentrating, or remembering	4	28.6	4	28.6
Trouble controlling violent behavior	2	14.3	1	7.1
Serious thoughts of suicide	3	21.4	2	14.3

The majority of respondents (73.3%) had children, and only two respondents' parental rights had been terminated for at least one of their children. Of the eleven clients with children, only a third (33.4%) stated that their children were currently living with them. Three of these clients noted that their children were no longer living with them because they were adults. These figures are similar to Housing Authority records which indicate that less than one-third of HARP participants live with dependent children. The remainder of the children were living with another parent (2), non-parental relative (2), or incarcerated (1). More than half (63.6%) of all respondents with children noted that their children have health insurance.

Respondents were asked how helpful they had found HARP housing. All but two respondents (87.5%) said that the program was "very helpful," and half stated that they were "very happy" with the services they had received through HARP.

> "I have found HARP programs so helpful in getting my life together and the staff at Volunteers of America are awesome."
>
> "It has been my desire to do what ever I can to get off probation. Staying clean and sober has helped. Being off the streets has made it easier to stay away from drugs."
>
> "My life is mine now. I got sick and tired of living the way I was and not having the people in my life I love and House of Hope helped me to do that. I love them."
>
> "Without HARP, I would not be graduating Drug Court. I would not be attending SLCC. This program allowed me to put my life back together. Once I finish school, I will be able to support myself financially. I am very thankful for this program. I don't [know] what if anything could improve it. I pray it continues for others in similar situations."

Former Client Survey. Only five former client surveys were completed and returned. All respondents were White (100.0%) and most were males (80.0%), with an age range from 27 to

59 and an average age of 35. Compared to the entire HARP sample, this group had fewer women and minorities. Four of the five respondents originally entered HARP through the substance abuse services track, with one entering through the mental health services. Three of the five vacated HARP housing on positive or neutral grounds (transfer to other subsidized housing program, moved with family, & self-sufficient). The two remaining respondents were terminated from HARP because they were serving jail time; however, only one was in jail on a new charge.

According to survey results, none of the respondents reported having used services through the Salt Lake County Housing Authority or Department of Workforce Services since leaving HARP. However, some of the respondents had participated in 12-Step programs (3), substance abuse treatment (1), and other Criminal Justice Services programs (2).

Only one of the five respondents reported experiencing homelessness and moving more than once (four times) since leaving HARP housing. According to Housing Authority records, this individual left HARP housing because they moved with their family; however, this view was not shared by the client:

> "I was asked to leave the apartment HARP helped me get into because a new owner bought the apartments 3 months after I signed a year contract with the former owner. It messed up a lot and I still need an apartment for me and my family. Try to make sure things like this don't happen to others and do more follow ups on those you assist. I think that would make a huge difference on the successes of your program."

None of the respondents were enrolled in school or job training at the time of survey completion and all were employed (4 full-time; 1 part-time). A few respondents reported experiencing serious depression (1), anxiety or tension (3), or trouble understanding, concentrating, or remembering (1) since leaving HARP. No respondents reported drug use since leaving HARP and all rated their overall health as good (3) or very good (2). Only one respondent reported suffering from a chronic illness that interferes with their life and two had health insurance.

Only two respondents had a child and neither one had ever had their parental rights terminated. Only one of the respondents had an underage child who was living with them. The other respondent's child was an adult and was serving time in prison. Former clients were asked for suggestions on how HARP could better serve clients. Suggestions included: more individualized case plans, better inspections of HARP housing, working with the landlords to make sure they follow through with the rules, reducing the number of stipulations, and conducting more follow-ups.

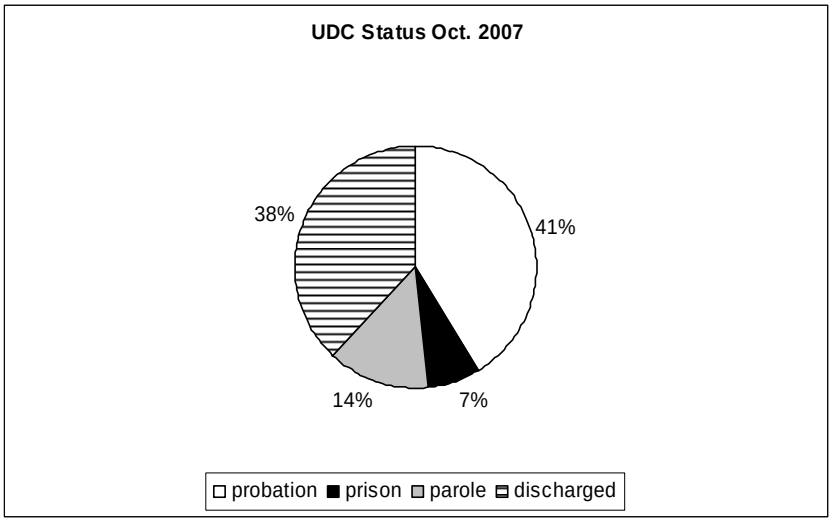
Respondents were asked how helpful they had found HARP housing. Three respondents found HARP "very helpful," and one each found it "somewhat helpful" and "very unhelpful." Likewise, three respondents noted that they were "very happy" with the services they had received through HARP, with one respondent each answering "somewhat happy" and "somewhat unhappy." Surprisingly, both respondents who were unsuccessfully terminated from HARP because they were sentenced to jail terms found HARP "very helpful" and were "very happy" with the services they had received.

"It has helped me straighten out my life compared to not wanting to live. It has given me hope to survive."

Criminal Justice System Involvement

Utah Department of Corrections. As reported in the "*Who does the program serve?*" section of the report, nearly half (40.8%) the HARP clients were active on AP&P supervision (probation or parole) at their intake into HARP housing. As of October 18, 2007, just over half (55.2%) remained on supervision, while 37.9% were discharged, and two (6.9%) were in prison. Figure 18, below, shows this distribution. Of the clients who were discharged from AP&P supervision after beginning HARP, 63.6% had a successful discharge, with 57.1% occurring during HARP and 42.9% occurring after vacating HARP housing. Two persons who were not on supervision at HARP intake subsequently began probation with AP&P. One remained on probation while the other was successfully discharged after vacating HARP.

Figure 18 UDC Legal Status as of Oct. 18, 2007
for HARP Clients on AP&P Supervision at Intake

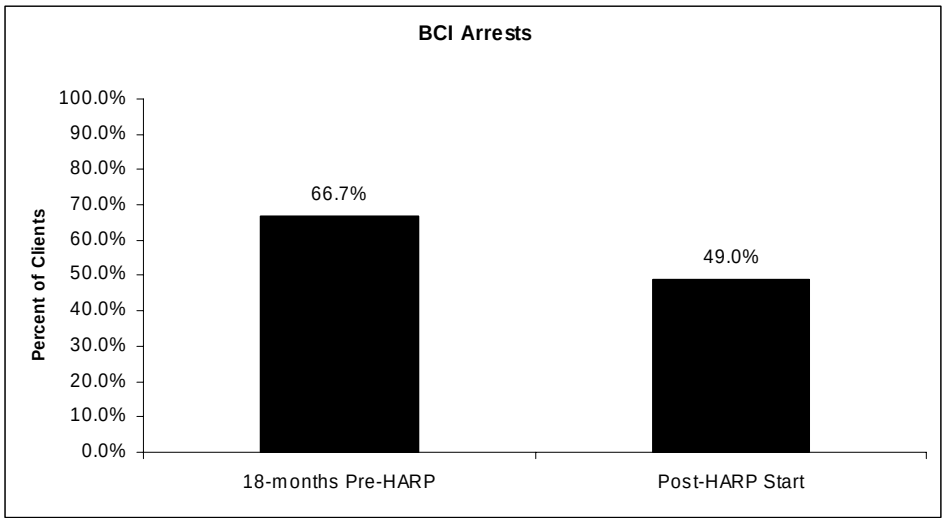


While active in HARP housing, four persons (13.8%) who were on AP&P supervision at intake had a new violation that resulted in a return to prison. As reported above, two persons remained in prison at the time of data collection. Time from HARP intake to the violations and return to prison ranged from 74 to 168 days. Days in prison, while also active in HARP housing, ranged from five (5) to 68. Three of the four clients (75.0%) were ultimately terminated from HARP and one remained active in HARP housing. The client who remained active in HARP was in prison for 68 days.

Bureau of Criminal Identification. As reported in the "*Who does the program serve?*" section of the report, two-thirds of HARP clients located in BCI records (34 of 51) had an arrest in the 18-months directly preceding HARP intake. In the 18 months following HARP start, nearly half (49.0%) of those with BCI information had a new arrest. The most common types of charges were property (60.0% of recidivists had a property charge), drug (40.0%), and person (24.0%).

When limiting recidivism to only those HARP participants that had 18 months of BCI follow-up after starting HARP, nearly two-thirds (64.9%) had a new arrest. Figure 19, below, shows changes in arrests for all persons in the BCI record. Although the percent of clients with arrests decreased from prior to HARP to after starting, it was not statistically significant[5]. Furthermore, the decrease in mean number of arrests from 18 months pre-HARP to 18 months following HARP start (2.5 to 1.8) was not statistically significant either[6].

Figure 19 Changes in BCI Arrests



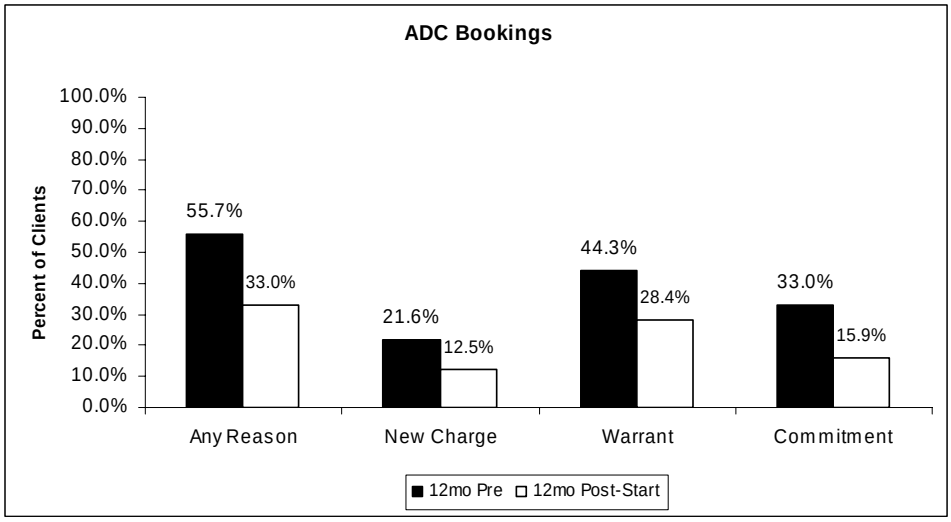
Adult Detention Center. Use of the Salt Lake County Adult Detention Center (ADC) varied widely from 12 months prior to HARP start to the 12 months after entering HARP. As shown in Figure 20, on the following page, jail bookings in general decreased for the HARP participants who had jail data (88 of 102, 86.3%). Among the few HARP clients that had bookings for new charges in the year following HARP intake, over half (63.6%) had new property charges. The subgroups presented in Figure 20 are not mutually exclusive, so an individual could be included in several columns if they had bookings for both new charges and warrants during either time period. Statistical analyses of jail booking changes were limited to those HARP clients who had at least 12 months of follow-up after HARP intake. This allowed for an equal opportunity to accrue bookings in the pre and post-start periods. Among this group, the decrease in jail bookings for any reason was statistically significant.[7] However, decreases in bookings for specific reasons (new charge, warrant, or commitment) were not statistically significant[8]. This is most likely due to the small sample sizes of these subgroups.

Severity of offenses for those that had a new charge in the year following HARP intake ranged from Class C Misdemeanors to First Degree Felonies. Most severe degree of offense was recorded for each person. Median degree of severity was Third Degree Felonies. Compared to new charges in the 12 months prior to HARP intake, new charges in the year following HARP

[5] McNemar's Test $p > .05$
[6] $z = -1.271$, $p > .05$
[7] Sign Test one-tailed $p < .05$
[8] Sign Test one-tailed $p > .05$ for all three

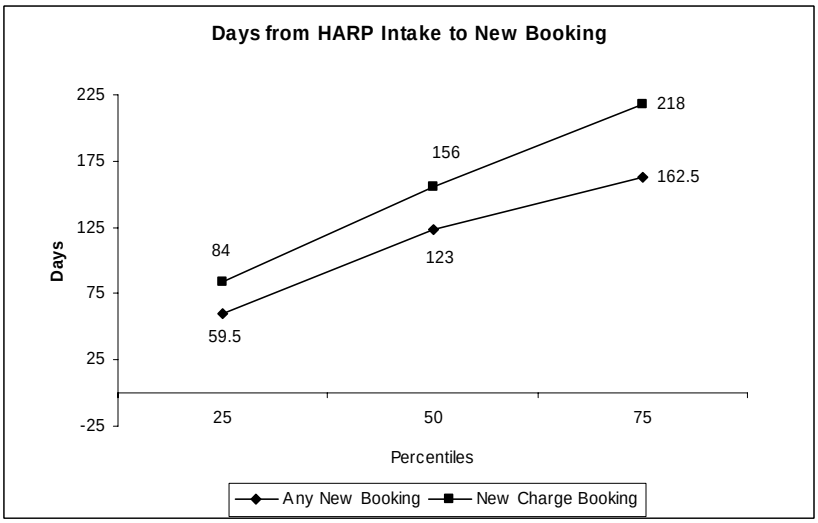
intake were more severe (3rd Degree Felony on average, compared to Class B Misdemeanor). However, fewer offenses were committed in the year following HARP intake and fewer persons committed those offenses.

Figure 20 Changes in ADC Bookings



Time from HARP intake to the first jail booking ranged from three (3) days to 280 days, with the median being 123 days. The amount of time from HARP start to the first booking on a new charge was slightly longer, ranging from 56 to 489 days, with a median of 156 days. Figure 21, below, shows the distribution of time to any new booking and new bookings for new charges.

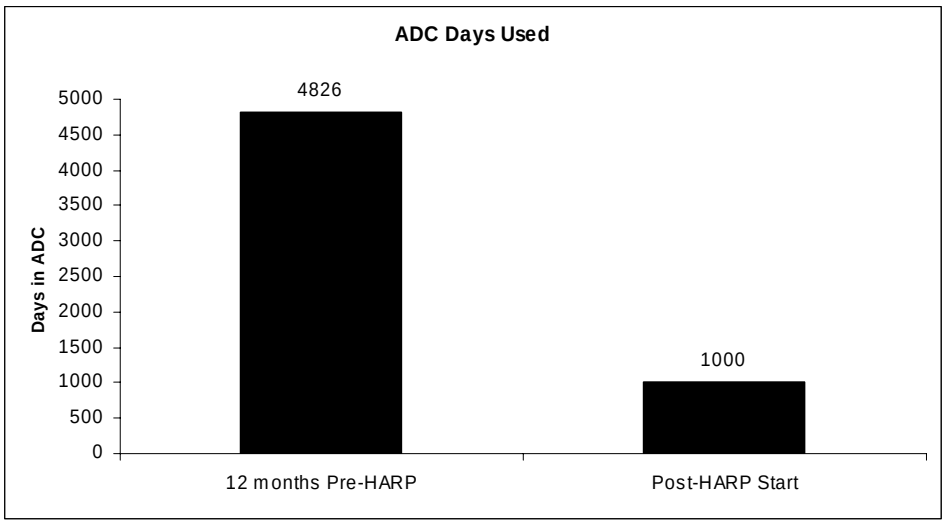
Figure 21 Days from HARP Intake to New Jail Bookings



For the HARP clients who had a new booking in the year following HARP intake, days in jail on those bookings ranged from zero (book and release on same day) to 153. The median number of days in jail, while active in HARP housing, was 16. The total number of jail days utilized by

active HARP clients was 1,000 (29 clients). Although considerable, this represents a sharp decline in jail days used compared to the 12 months prior to HARP start (see Figure 22, below). The percent of time that HARP clients spent in jail while active in the program was minimal, with 50% of clients spending 4.2% or less of their "active" time in jail.

Figure 22 Change in Jail Day Usage



Who has the best outcomes in HARP?

Outcome Measures

To answer the final two research questions, two new outcome measures were created. Success in HARP could be defined in two ways: remaining in stable housing and not recidivating (no new charges). To create the first outcome variable, HARP active status and exit status measures from the Housing Authority were combined. HARP clients who had left the program on a positive or neutral exit status OR clients who have remained in the program for greater than one year were all considered to have "positive" outcomes. This group was contrasted against clients who left the program on negative exit statuses. Clients who had been in HARP for less than one year were excluded from this analysis. Figure 23, on the following page, shows the distribution of clients who met the positive and negative criteria for the new "outcome status" variable.

The second outcome variable measured recidivism and combined any new charge recorded in either BCI or JEMS datasets. Figure 24, on the following page, shows the distribution of HARP clients who had at least one arrest for a new charge.

Recidivism

Several factors that have been shown to be related to future criminal involvement were also related to risk of rearrest within the HARP sample. For example, younger persons are more likely to recidivate (Kazemian, LeBlanc, Farrington & Pease, 2007; Steffensmeier, Allan, Harer & Streifel, 1989; Hirschi & Gottfredson, 1983); as are males (Spohn, Piper, Martin, & Frenzel,

2001; Wolfe, Guydish, & Termondt, 2002); and those with greater past criminal involvement (Spohn et al.;Goldkamp, 1994; Wolfe, et al.). Similar results were present in the HARP sample. Those who had a new arrest after starting HARP were about five years younger (M = 30.9) than those who did not recidivate (M = 35.4). This difference was statistically significant[9]. A larger percentage of male participants than females had a new arrest (41.5% vs. 23.4%); however, this difference failed to reach statistical significance.

Figure 23 HARP Clients in Outcome Status Analyses

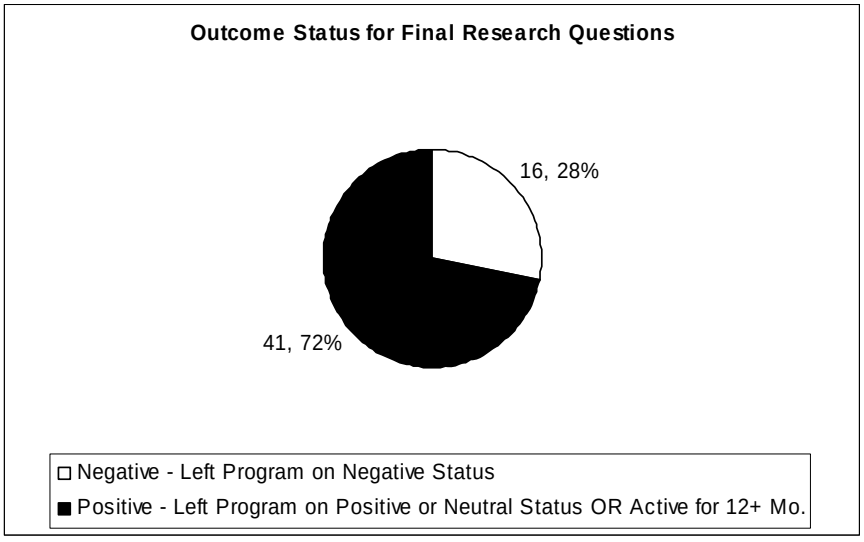
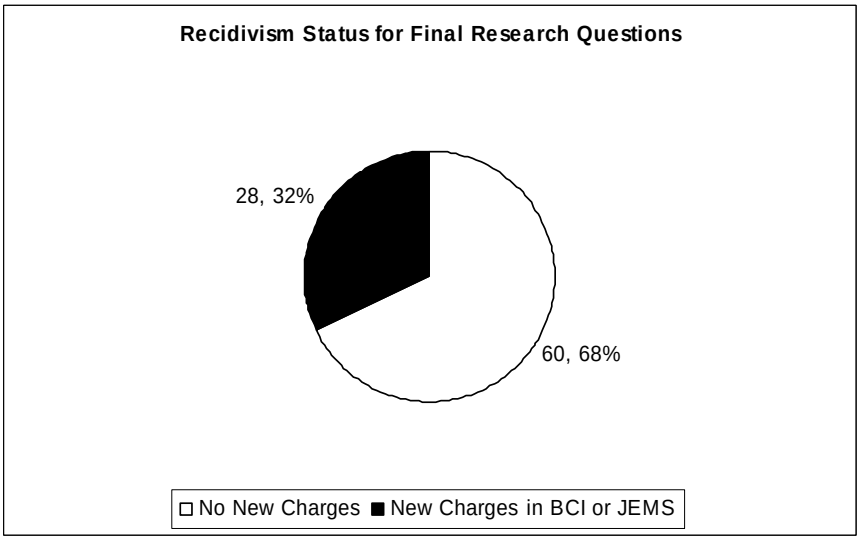


Figure 24 HARP Client Recidivism



Lastly, several measures of past involvement with the criminal justice system were all shown to be significantly related to the likelihood of having a new arrest after starting HARP. Table 4

[9] One-tailed t-test $t = 1.929$, $p < .05$

displays these comparisons. Those who had been in jail in the year prior to HARP, were on AP&P supervision at the time of starting HARP, or were in prison at any time prior to HARP were all more likely to have a new charge after starting HARP than clients who did not have these characteristics. However, the strength of relationship between these variables and the likelihood of rearrest was weak[10], indicating that other factors beyond past criminal justice system involvement may be influencing recidivism.

Youth Services referrals had an increased risk of recidivism compared to other referral sources. Over three-quarters (83.3%) of those referred from Youth Services had a new charge following HARP placement, compared to rearrest rates of 25.0% to 29.4% for the other three referral sources. Sample sizes were too small to report on the statistical significance of this relationship. Additionally, the observed relationship between Youth Services referrals and likelihood of new charges is most likely an artifact of the age of HARP participants referred from that program. Previous analyses already demonstrated that younger participants are more likely to reoffend than older ones.

Table 4 Recidivism by Pre-HARP Criminal Justice System Involvement

	Percent with New Charge Post-HARP Intake	χ^2	p
Jail Release within 12-mo Pre-HARP	41.4%	7.17	< .01
No Jail Release within 12-mo Pre-HARP	13.3%		
AP&P Supervision at HARP Intake	51.9%	7.21	< .01
No AP&P Supervision at HARP Intake	23.0%		
Prison Incarceration Prior to HARP	71.4%	5.50	.03
No Prison Incarceration Prior to HARP	28.4%		

Some factors examined in relationship to having a new charge that did not show any difference among groups were: minority status, employment status at referral to HARP, whether or not the HARP client had children living with them, and whether or not HARP clients paid below or at the minimum required rent level ($50) at intake compared to above the minimum. Employment status and amount of rent paid by client at intake were both included in the outcome comparisons since they were thought to represent clients' level of financial hardship. Presence or absence of children living in the HARP unit was included, as it may influence client motivation to succeed in the program. However, no differences were observed in new charge rates among these groups. Past failure in Criminal Justice Services (CJS) programs was also examined in relation to likelihood of rearrest; however, sample sizes were too small to report on this analysis. Additionally, multivariate analyses that examined the interaction of the significant predictors of rearrest could not be performed due to small sample size.

[10] $\varphi = .285$ (jail release), $\varphi = .286$ (AP&P supervision), $\varphi = .250$ (prison)

Outcome Status

As shown in Figure 23, on page 44, nearly three-quarters of HARP participants had a positive outcome status, as defined by remaining active in the program for at least one year or having a neutral or positive exit status (applicant requested to leave program, able to pay own rent, moved in with family, moved to other subsidized program, etc.). The same client characteristics that were examined in relation to recidivism were also compared to outcome status. None of the variables that had sufficient sample size to examine statistical significance had a relationship to HARP outcome status. Those who were successful in HARP compared to those who had a negative exit status did not differ on: age at intake, gender, ethnicity, employment status, or amount of rent paid at intake. Nor were there any differences in HARP success among those who did or did not have jail releases in the year prior to HARP, were or were not on AP&P supervision at intake, or did or did not have past prison incarceration. Additionally, there were no differences in outcome status by referral source (SA, MH, CJ, or YS).

Although differences in outcome status by whether or not HARP clients had children living with them was not statistically significant, the observed differences are substantial enough to warrant attention. Approximately half (53.3%) of HARP clients with children living with them had a positive outcome status, compared to over three-quarters (78.6%) of those without children. This early trend suggests that additional efforts should be made to retain HARP clients with children in housing and ensure that they leave the program under positive circumstances. Sample size was too small to report statistical significance on the relationships between past CJS program failure or pre-HARP BCI arrests and outcome status. However, trends in the data suggest that past CJS program failure and arrests in the 18 months prior to HARP both are related to greater likelihood of negative outcome status in HARP.

What program components and services lead to the best outcomes?

HARP essentially provides two services to its clients: rental assistance and case management. Although additional wrap-around services are utilized by several clients (e.g., SA and MH treatment, DWS assistance, AP&P services), these two components are the basic units of HARP. Measures of these two services were compared to HARP outcome status and presence or absence of new charges following HARP placement.

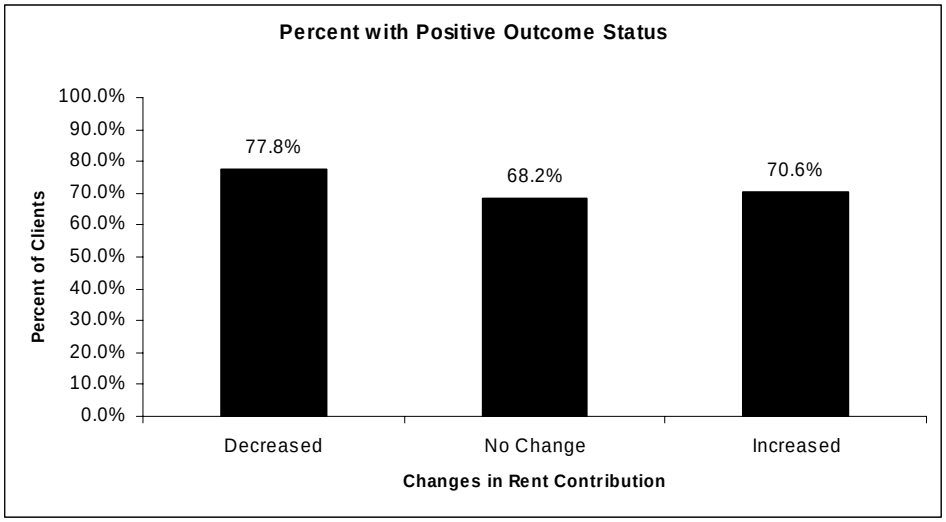
Outcome Status

At this time, there is no statistically significant relationship between frequency of case manager contacts or number of case managers a client has had and outcome status. The average number of days between case manager contacts for clients who had a negative outcome status was 13.98 days, which is just slightly less often than the mean for clients who had a positive outcome status (every 12.31 days). Similarly, clients who had the same case manager throughout participation in HARP had a 72.4% success rate (as indicated by positive outcome status), compared to 70.4% for those with two or more case managers. Similarly, a slightly higher percentage of clients who had at least one home visit recorded in their case management records had a positive outcome status compared to clients with no home visits recorded (81.8% vs. 65.2%); however, this difference was not statistically significant. It is believed that the small sample sizes (of persons

with case management data available) and lack of variation in case management services received (most clients received similar frequency and type of visits) have contributed to the lack of statistically significant findings in the data.

To measure HARP rental assistance a new variable was created that examined changes in client rent contribution. If clients decreased the amount of rent they were paying from intake to subsequent rent reviews they were assigned a value of -1. If clients continued to pay at the same rate (either had no new rent reviews or stayed at the same rate on subsequent rent reviews) they were assigned a value of 0. If clients increased the amount of rent they were paying across HARP participation they were assigned a value of 1. As shown in Figure 25, the percent of clients who had a positive outcome status was approximately equal across those who paid less, more, or the same amount while active in HARP.

Figure 25 Outcome Status by Changes in HARP Client Rent Contribution



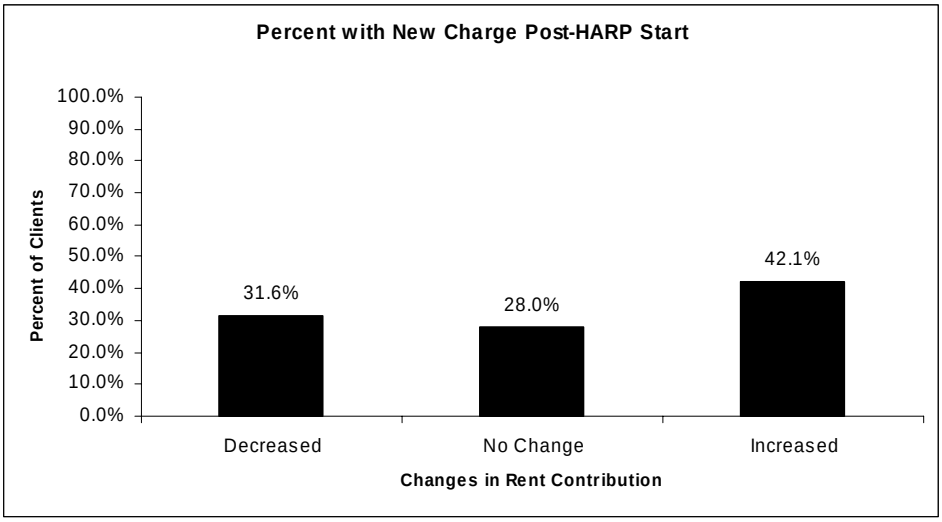
A final during HARP participation measure that was examined in relation to outcome status was having a new jail booking in the 12 months following HARP intake. This measure was examined, as it is thought to be a proxy for program compliance (remaining in the housing unit, avoiding legal problems, etc.). There was not a statistically significant difference in outcome status between those who had a new booking in the year following HARP intake (57.1% had a positive outcome status) and those who did not have a new booking (76.9% had a positive outcome status). This lack of finding reflects what is known about HARP policies. Every effort is made to enable clients to remain in housing (or find new subsidized housing), even if they have brief periods of incarceration. That there is no statistically significant difference in outcome status between clients who have new jail bookings and those who do not can be viewed as a success of HARP, since one of the program's goals is to provide a source of stability in clients' lives, regardless of continued involvement in the legal system.

Recidivism

HARP clients that had a new charge following HARP placement had slightly less frequent contact with their case managers (every 13.0 days on average) than those who were not rearrested (M = 10.8 days); however, this difference was not statistically significant. Clients who had only one case manager were more likely than those with two or more to have a new charge (66.7% vs. 31.3%). This difference was statistically significant; however, the relationship was low[11]. This finding was initially counterintuitive, as it was expected that clients with more case managers (representing additional instability) would have worse outcomes. However, because the sample size was small and the follow-up periods short, it may be that clients with only one case manager were those who were rearrested shortly after entering the program and those who did not have a new charge had a longer time to receive services from additional case managers. There was not a statistically significant difference in recidivism rates for clients who did or did not have home visits recorded.

Lastly, changes in client rent contributions were examined in relation to new charges. Although there was some variation in likelihood of having a new arrest (see Figure 26) by changes in rent contribution across HARP participation, none of these differences were statistically significant. At this time, the variation in amount of rent contribution that HARP provides is not significantly related to recidivism. However, the provision of rental assistance has impacted offending, as indicated in Figure 20, on page 42, which shows the decrease in jail bookings for HARP clients from pre- to post-HARP intake.

Figure 26 Recidivism by Changes in HARP Client Rent Contribution



What is the cost-benefit of HARP?

A general guide to assessing the economic value of a public program is to compare its economic costs against its economic benefits. This procedure mimics what is prescriptive for a private

[11] $\chi^2 = 6.916$, $p < .05$, $\varphi = .351$

investment project. If the benefits exceed the costs (suitably discounted for anticipated revenue streams) the project is considered profitable and decision makers should adopt the project. While straightforward in theory, cost benefit analysis is frequently difficult to apply, primarily for two reasons. The first is that fiscal data are not readily available and the second is that there needs to be a monetized translation of costs and benefits in order for comparison. Microeconomic theory goes a long way to help solve both of these problems and is used in this section.

Marginal analysis examines incremental costs and benefits. As a program expands all that is required is to be able to compare, at the margin, the cost of provision against the benefit of provision. This marginal or incremental comparison is the optimization principle to guide decision as to whether provision is profitable or not. It assumes that fixed costs (or sunk costs) do not come into play (or have already been accounted for).

Because the HARP program's fixed or overhead costs are largely in place, a considerable amount of analysis of costs and benefits can be compared by examining incremental costs and benefits – those attributable to accommodating one more client. With the additional assumption that the program is not so large that it pushes capacity, average costs can be compared with average benefits. In what follows, data are discussed in these sorts of dimensions – average dollars per client. This analysis is likely to be very reflective of the true marginal costs because the size of the program was not large during the time the data were collected and harmonized.

A primary design of the analysis was to look at pre and post HARP start data for sets of comparable clients to see the extent to which HARP altered behavior. Dimensions of analysis included food, health, and shelter and are summarized in Table 5, on the following page, for the roughly sixty HARP families for which data could be effectively harmonized. HARP not only provides rental subsidy, but provides information to clients in regards to available social programs such as the Department of Workforce Services benefits, including Medicaid and food stamps. A desirable goal of the program would be to see whether or not HARP clients would more fully take advantage of these services. If, for example, individuals would seek medical assistance under the Medicaid system instead of relying on emergency room services there would be significant economic benefits accruing to the community. Or if families somehow could actually become healthier under HARP, the program would be considered tremendously successful in economic terms. These features are indicative of the extraordinarily high costs of health care in the United States (Hwang, 2001; Kushel, Vittinghoff & Haas, 2001). Overall, the data reveal economic neutrality for the families studied for the economic variables assembled. By this we mean average per client costs did not seem to be much affected by the HARP program. But there are several key findings which highlight an important presence attributable to HARP involvement.

First, prior to and after beginning HARP, Salt Lake County direct client costs are significantly different. The mean charges are a bit over double (from $48 to $101) after exposure to HARP which is clear evidence that HARP does in fact lead clients to seek social service resources. As would be expected, there was not a significant change in the per client case management costs (since during this period inflation was so low). The drop in Medicare costs (from $32 to $22) is also significant. Although not as dramatic, this change might be related to an improvement in

clients' overall health. This would not be a surprising result and would be a large benefit of having a secure place to live.

Table 5 Descriptive Statistics for Average Monthly Economic Costs (Dollars per Client) Pre and Post HARP Intake

Variable	Mean	Std. Dev.	Min	Max
Pre Treatment	48.82	66.72	0	343.49
Post Treatment	101.15	193.35	0	899.75
Pre Medicare	32.21	88.87	0	409.53
Post Medicare	22.78	63.66	0	352.17
Pre Case Management	36.77	110.07	0	591.20
Post Case Management	31.26	67.31	0	371.68
Pre Food Stamps	232.19	183.04	0	518.00
Post Food Stamps	252.28	218.79	0	722.79
Pre Financial Assistance	78.64	147.66	0	555.00
Post Financial Assistance	96.30	223.09	0	1110.00

Data Sources: Department of Workforce Services, Salt Lake County Division of Substance Abuse Services, Valley Mental Health

It appears from these data that HARP spillover benefits, in terms of providing guidance to clients in terms of social and health services, are significant. The direction of change is in accord with expectations, with treatment compliance (and thus attendance and costs) increasing, while clients are active in HARP housing, and most benefit usage increasing as clients become aware of their eligibility to receive various forms of assistance (financial and food stamps). Because the analyses were based on data that was collected over a short period of time (in the 2 years prior to and following HARP intake), some initial increases in costs (such as for treatment and case management) are expected to decrease over longer periods of time. The decrease in Medicaid costs may be an early indicator of a trend that could develop across other forms of assistance. As HARP clients' lives become more stable with the addition of housing, employment and other forms of self-sufficiency (e.g., health insurance) may increase.

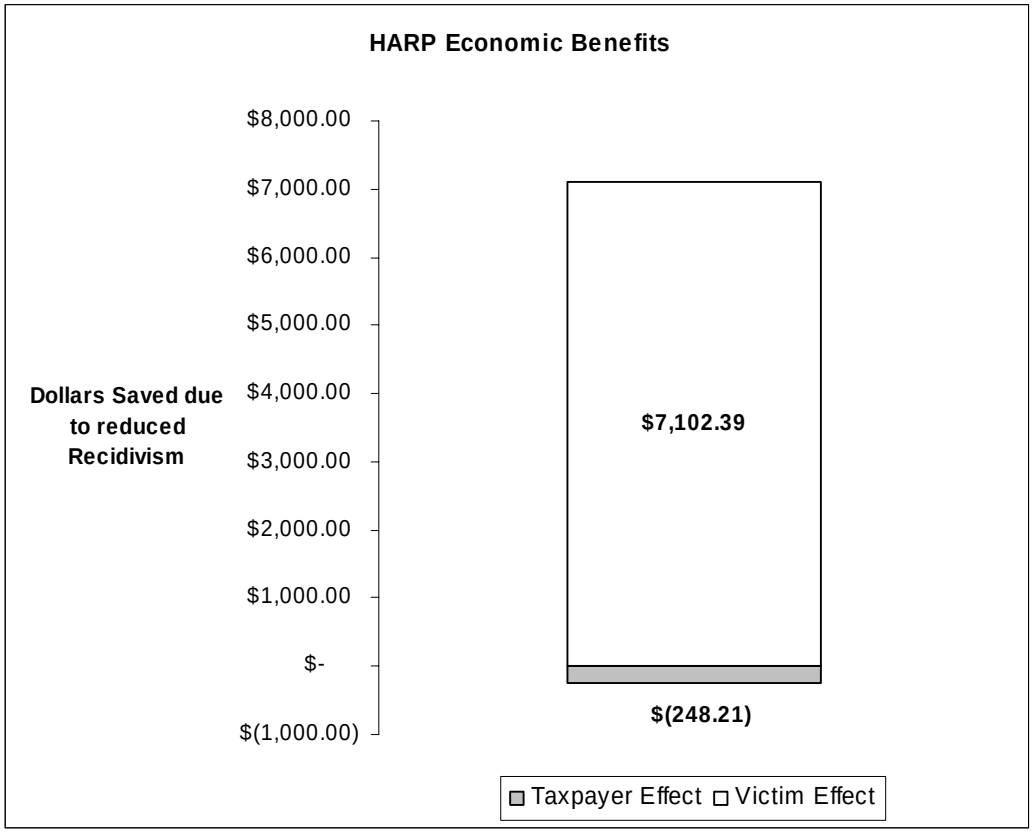
Criminal Justice Cost-Benefit of HARP

The criminal justice financial impact of HARP was calculated using the Utah Cost-Benefit model (Fowles, et al., 2005). The average per-person cost of HARP was calculated by examining HACSL rent contribution data. Average per-person cost was estimated at $4,177 (HARP average monthly rent contribution of $454 multiplied by 9.2 months as the average length of HARP participation for former clients). The effect size of HARP was calculated by examining the change in bookings for new charges (as recorded in ADC data) from pre- to post-HARP start. The change from 21.6% with a new charge booking in the year prior to HARP compared to 12.5% with a new charge booking in the year after starting HARP represented an effect size of -0.18.

When entered into the cost-benefit model, the resulting cost-benefit ratio for HARP is $2.64, indicating that for every dollar spent there is an approximately $2.64 return on investment. However, the return is not evenly distributed across taxpayer and victim effects. As shown in

Figure 27, victims are saved approximately $7,100 from the reduction in future expenses that would have occurred had HARP had no effect on recidivism. The net taxpayer effect is $-248.21, meaning that there is a slight loss to the taxpayers due to the high cost of the program and the size of the program's effect on recidivism. However, the effect of HARP on recidivism should be revisited when the program has been in operation for a longer period of time and has served more clients. Additionally, HARP's impact on rearrest rates is likely to change over time.

Figure 27 Taxpayer and Victim Cost-Benefit of HARP



Discussion and Conclusion

In its nearly two years of operation, the Homeless Assistance Rental Program (HARP) has served a unique population of at-risk individuals in Salt Lake County by referring potential clients through four gatekeepers: Mental Health, Substance Abuse, Criminal Justice Services and Youth Services (or their subcontracting agencies). Results from this process and outcome evaluation indicate that HARP is already having a measurable impact. Main findings from the Results section are briefly described here as they relate to the six research questions.

1. Who does the program serve?

HARP serves a varied clientele. Through November 7, 2007, 102 persons have been placed in HARP housing. Just over half were female and three-quarters were White. Age at intake ranged

from 18 to 64 years old, median age was 32.4. Over half had a disability when chronic problems with alcohol and/or drugs were included in the definition. Most referrals came from Substance Abuse Services and the fewest came from Youth Services. Although most clients live alone, several had children living with them in their HARP unit.

HARP serves a population that has a documented need for housing assistance. One-third of clients had stayed in a shelter prior to HARP placement, while nearly all indicated experiencing some form of homelessness. One-quarter were verified as "chronically homeless" on their eligibility forms by their case managers. Two-thirds had utilized Medicaid in the two years prior to HARP, while the vast majority received food stamps during that time.

HARP serves clients that have extensive criminal justice system involvement. Nearly two-thirds of clients had been in the Salt Lake County Adult Detention Center (ADC) at some point in the year prior to HARP placement. This indicates that HARP is meeting its goal of using at least half of the housing vouchers for persons who are released from the jail. The sum of jail days accrued by all HARP participants for the year prior to entering HARP was 4,826 days (for 58 persons), representing a substantial strain on the system. Similarly, two-thirds had an arrest recorded in the statewide criminal history file for the 18 months preceding HARP placement, and approximately two-thirds have been involved with the Utah Department of Corrections (UDC). Approximately one-quarter were clients of Criminal Justice Services (CJS) specialty programs (e.g., Felony Drug Court, Mental Health Court) either prior to or during HARP participation.

2. What is HARP providing clients?

HARP is providing clients with rental assistance. The units that are provided through HACSL are appropriate to clients' family size (percent of multi-bedroom units match the percent of HARP clients with more than one family member). HARP is contributing approximately $454 a month, on average, to each client's rent.

HARP is providing regular case management. Referring agencies (SA, MH, CJS, YS) provide HARP clients with continuous case management. Clients receive approximately three case manager contacts per month, with most contacts occurring in the case managers' offices. Less than one-third of clients had any home visits by their HARP case manager. Additionally, over half of the HARP clients had two or more case managers, indicating that this could be a form of instability in their lives. Furthermore, the high percent of clients missing case management records and the difficulty in compiling information on current case managers for active clients both suggest that the case management aspect of HARP's Supportive Housing model should continue to be monitored.

Indirectly, HARP is providing enhanced mental health (MH) and substance abuse (SA) treatment for clients through partnering agencies. For those clients who had MH treatment both prior to and after HARP placement, frequency of treatment attendance decreased steadily following HARP placement. This may indicate increased functioning for these individuals. Conversely, those clients who had SA treatment both prior to and after HARP placement increased their frequency of treatment attendance following HARP intake. This is thought to be representative of increased treatment compliance for this group.

3. Is HARP succeeding?

HARP is seeing some success as demonstrated by several financial measures. Average client rent contribution was over double the required minimum rent and increased over the course of participation. Two-thirds of participants have remained active in the program, while less than half of those who have exited the program had a negative termination status (e.g., eviction, returning to jail or prison, non-compliance with program requirements). Overall, usage of DWS benefits decreased from pre- to post-HARP start; however, a couple of interesting trends were noted in the analysis. DWS benefit usage while in HARP declined among those receiving them prior to HARP, while it increased for those who had not. It is believed that this shift represents a decrease in prior use for those who became more self-sufficient while in HARP and an increase in use for those who were previously unaware of their eligibility for the benefits.

Quality of life measures have also indicated that HARP is having some success. Self-Sufficiency and Housing First Matrices ratings indicate that HARP clients improved their quality of life in several domains. This was even true for those who were ultimately unsuccessfully terminated from the program. Although only a few former client surveys were completed, these results also suggest that client satisfaction with HARP is very high and that problem areas, such as substance use, have declined following participation.

Some Criminal Justice System measures show promising trends. Both BCI and ADC data showed a decrease in offending among HARP participants from pre- to post-intake. Furthermore, the use of jail beds by HARP clients decreased dramatically in the year following HARP placement. Additionally, over one-third of HARP clients who were on UDC supervision at intake were successfully terminated from supervision.

However, HARP's success has been limited by continued challenges with the population it serves. Although the total number of HARP clients involved with the criminal justice system decreased from pre- to post-HARP start, a surprising number of people who did not have recent involvement with the criminal justice system prior to HARP had new arrests following HARP placement. Additionally, the severity of offenses for the few HARP participants that did reoffend was higher, on average, than the severity of offenses occurring prior to HARP intake and four persons returned to prison following HARP placement. These measures all suggest that HARP, like other Supportive Housing models examined in the literature review, can be effective in improving clients' lives, but that these effects may not translate across all problem areas.

4. Who has the best outcomes in HARP?

There were no clear trends regarding which HARP clients were most likely to have a positive outcome status in the program (remain active for over one year or have a positive or neutral exit status) versus a negative outcome status (terminated from the program with a negative exit status). Those who were successful in HARP did not differ in age at intake, gender, ethnicity, employment status, or amount of rent paid at intake when compared to those who had a negative exit status. Nor were there any differences in HARP success among those who did or did not have jail releases in the year prior to HARP, were or were not on AP&P supervision at

intake, or did or did not have past prison incarceration. Additionally, there were no differences in outcome status by referral source (SA, MH, CJ, YS).

HARP clients that were younger, male, and more criminally involved were more likely to recidivate. The relationship between these three risk factors and criminal recidivism has long been documented in the academic literature. Although prior jail bookings, past prison incarceration, and being on AP&P supervision at intake were all related to increased risk of reoffending, the strength of the relationship between these variables and recidivism was low. This indicates that other factors also influence the likelihood of rearrest. Several characteristics of HARP participants were not related to recidivism, including minority status, employment status at referral to HARP, whether or not the HARP client had children living with them, and whether or not HARP clients paid below or at the minimum required rent level ($50) at intake compared to above the minimum.

5. What program components and services lead to the best outcomes?

The provision of case management and rental assistance led to better outcomes for clients (see Question 3); however, it is not known at this time what level of services leads to the best outcomes. Variations in the two services that HARP directly provides to clients (rental assistance and case management) were examined in relation to the two outcome categories; however, no statistically significant differences were observed. Although it is important to note that frequency of case management contacts was greater (more often) for clients who had a positive outcome status and those clients were more likely to have home visits recorded. Additionally, having a new jail booking in the 12 months following HARP intake was not significantly related to outcome status. Because every effort is made by HARP staff to enable clients to remain in housing regardless of involvement with the criminal justice system, this can be viewed as a success of HARP.

Client offending decreased with HARP participation; however, frequency of case manager contacts and changes in client rent contributions were not significantly related to likelihood of recidivism. The lack of relationship between changes in rent contribution and recidivism may indicate that any rental assistance leads to positive outcomes (the research in the Brief Literature Review section of this report supports this), and variations are unimportant at this time. It is also interesting to note that frequency of case manager contacts was less for those who recidivated, indicating that more frequent contacts may lead to better criminal justice system outcomes. However, having home visits was not related to likelihood of recidivism. It is recommended that more comprehensive and reliable case manager records be kept for HARP clients. Additional data on the frequency and type of contacts may help illuminate their relationship with client outcomes.

Literature has suggested that the provision of case management can be effective, with particular elements of case management being more effective than others. Some recommendations for improved case management with homeless populations were identified in the academic literature. For instance, more intensive case management was found to lead to better outcomes than passive referrals. Additionally, although the education level of the case manager has been found to be unimportant, several factors of delivery are linked to better outcomes, including: community-

based, direct services from the primary case manager; small caseload sizes (1:20 ratios, on average); access to 24-hour crisis services; and home visits. A more complete review of the effective elements of case management is presented in the Brief Literature Review section of this report. Implementation and documentation of these efforts may help determine which aspects of case management are the most beneficial for HARP clients.

6. What is the cost-benefit of HARP?

Average Monthly Economic Costs reveal economic neutrality. Use and subsequent cost of some benefits increased from prior to after HARP placement, such as treatment, food stamps, and financial assistance. It is thought that these increases suggest enhancement of services received by HARP clients, as well as increased awareness among clients about available benefits. In contrast, some average economic costs decreased, including Medicaid and case management costs. These early declines may represent a trend that will develop across other forms of benefits as HARP participants are followed for a longer period of time.

The criminal justice cost-benefit analysis indicates that HARP has an overall return of $2.61 for every dollar invested. The greatest economic benefit of HARP comes from reduced victim costs of approximately $7,100 per HARP client. This benefit is estimated based on the average reduction in offending across all HARP participants. The net taxpayer effect is a loss of approximately $250 per client. This slight loss on taxpayer investment is due to the high cost of HARP per client (approximately $4,200) and the thus far limited effect on recidivism rates. The cost-benefit of HARP should be re-examined in the future.

Recommendations and Conclusion

Data Collection. HARP clients come from a variety of referral sources, and therefore have case managers who work for a variety of agencies. As such, HARP client records varied and were found to be inconsistent and often lacking in areas important to the evaluation of this program. It is recommended that the Housing Authority keep an ongoing database of past and current clients with information on active and former case managers and their contact information. Additionally, a minimum requirement for case management record keeping should be adopted across all agencies. This does not need to be an undue burden on the case managers. However, it should be a simple agreement, such as keeping a spreadsheet with dates and locations of all client contacts. AmeriCorp volunteers at the Housing Authority should also track their contacts with clients in a similar manner. Such documentation would allow for client interventions and support to be monitored and linked to outcomes.

Similarly, although completion of the Self-Sufficiency and Housing First Matrices are not currently required, it is suggested that case managers begin completing these matrices with clients at least every other month. In addition to providing case managers with valuable information, the collection of these additional measures would greatly enhance future evaluations and provide better insight into what factors lead to the best outcomes.

It may also be helpful to regularly allow clients the opportunity to provide feedback to the program. Selected client satisfaction items from the UCJC-developed surveys in Appendix F

could be used. An anonymous one-page survey could be given to clients quarterly at case manager office visits and completed surveys mailed to a central location, such as the Housing Authority or the Salt Lake County Government Center, by the client.

Lastly, some information is already being collected on the homeless verification forms case managers complete with clients when referring them to the program; however, this type of data could be expanded to better document the type and severity of clients' homeless experiences prior to HARP. For example, the literature suggests that those who came from an institution or someone else's home fair better than those who were living on the streets prior to treatment. It would be best to have a section that documents number of nights living in each setting type (on the streets, in a treatment facility, in jail, in a hospital, in someone else's home, etc.) in the year prior to HARP.

Program Operation. The data examined in this report indicate that HARP is having a positive impact on the clients served. The five partnering agencies and their sub-contracting agencies have done a commendable job of coordinating services for a population that has multiple needs. In its first two years of operation HARP has continued to streamline the processes for referral, screening, intake, and supervision of clients. The HARP partners have solved challenges, such as how to retain clients when they leave their treatment providers (through successful and unsuccessful termination), and continue to brain storm new ideas through annual stakeholder surveys. It is recommended that these processes continue. In addition, there are several components of effective case management strategies and homeless assistance programs that have been outlined in the literature review sections of this report. It is recommended that these ideas be reviewed by the HARP partners and implemented where possible.

Conclusion. The Homeless Assistance Rental Program (HARP) is a relatively new program, yet has already met several of its goals and demonstrated early indications of effectiveness. HARP has targeted the appropriate at-risk population (housing need, co-morbidity with MH and SA diagnoses) and has exceeded its goal of having half of the referrals coming from the jail. Process and outcome data also reveal that HARP participation, in general, has impacted clients' use of treatment services and public assistance, decreased their involvement with the criminal justice system, and increased their quality of life. A positive criminal justice cost-benefit ratio has also been observed. Due to the relative infancy of this program and the small sample size, additional evaluations should be conducted in the future. In as little as a year to 18 months from now, the program will have served considerably more clients and the first group of participants' follow-up period will be doubled. Future evaluations will determine whether these preliminary outcomes can be confirmed as the program continues to grow and serve more clients.

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HOMELESS ASSISTANCE RENTAL PROGRAM

(HARP)

GUIDELINES

December, 2006

Need:

Approximately 70% of the people in the Salt Lake County Jail have a substance abuse problem. There is a 3 month waiting list for placement in a residential substance abuse treatment bed.

The Salt Lake County jail books and releases over 30,000 individuals per year. Ten percent (10%) of inmates in the county jail population are homeless (approximately 200 people) at any one time. Approximately 2,000 people are homeless each night in Salt Lake County.

Assumptions:

- Some people in jail or in residential treatment could be better served if they were in safe and affordable housing in the community.
- It is cheaper to provide people housing with supportive services rather than jail or residential treatment.
- Safe, decent affordable housing is a stabilizing factor in an individual's life. Recovery is a collaborative process.

Background:

HARP is a rental assistance program primarily funded through Federal HOME dollars from the Department of Housing and Urban Development (HUD) coupled with general fund tax dollars appropriated by Salt Lake County. HARP provides housing assistance to homeless individuals referred to the program by the County Divisions of Substance Abuse, Mental Health, Youth and Criminal Justice Services and other community based non-profit programs.

Clients are provided housing opportunities throughout Salt Lake County and case management services which are an essential component for placement. Partners in HARP include the four divisions noted above along with the Department of Workforce Services (DWS), Fourth Street Clinic and LDS Humanitarian Services. DWS provides employment and public assistance resources, Fourth Street Clinic, medical services and LDS Humanitarian Services, bed frames and mattresses and vouchers for goods offered through Deseret Industries.

Eligibility: In order to be eligible for HARP clients must be homeless and Salt Lake County residents. HARP is targeted toward individuals who are or have been incarcerated in the county jail, or in a mental health or substance abuse residential treatment facility or are youth aging out of the foster care system. At least 50% of the clients in HARP must have been incarcerated in the county jail or in residential treatment facilities. Clients enrolling in HARP cannot have a conviction for manufacturing drugs in public housing or be on the sexual predator list.

Clients requesting housing through HARP must be referred by one of the four divisions of county government; Mental Health, Substance Abuse, Criminal justice Services and Youth Services or their subcontracting agencies.

County divisions or their subcontractors that place clients into HARP must have the ability to provide case management services. A list of suggested case management activities is included as

Attachment A. Clients are required to pay a minimum rent of $50 a month toward their housing cost or 30% of their monthly income, whichever is greater. Rental assistance is targeted to individuals and families whose income is at 80% or below of the Area Medium Income (AMI). Those income guidelines are included as Attachment B.

State Adult Probation and Parole Clients:

Funding for HARP comes from Federal HOME and Salt Lake County funds. Individuals under the responsibility of State Adult Probation and Parole are not eligible for HARP unless they are coming out of the county jail or a mental health or substance abuse residential treatment facility in Salt Lake County. If an individual has been released on parole from the state prison and is homeless, they are the responsibility of the Utah State Department of Corrections for housing, not the HARP program.

Rights/Privileges of Clients in Housing:

Clients in HARP subsidized housing enjoy all the rights and privileges as other tenants of private housing in the community. The lease agreement signed by the client and the landlord will generally spell out the rules and regulations associated with the housing. The lease normally covers issues such as rental payments, utilities, complaints, etc. Case managers are encouraged to make sure clients understand those rules and regulations particularly when it comes to issues such as drugs and alcohol, weapons, guests, parties and other activities that may impact other tenants' quiet enjoyment of their housing. In addition, case managers will report client information on their housing status as needed.

Application Process:

Agencies interested in enrolling clients into HARP must assist the client in completing a housing application. A copy of the application is included as Attachment C. Applications are available at the Housing Authority of Salt Lake County which is located at 3595 South Main Street, Salt Lake City Utah. Phone number contact is 284-4439. The housing application is not just for HARP but for other housing programs offered by the County Housing Authority. Once an application is fully complete, a client(s) will be placed on a waiting list. As part of the application process, the client must complete a release of information form to allow an evaluation of HARP. That release of information form is included in the application packet.

Upon receiving a completed application and based on funding availability, the Housing Authority will identify housing options for the client(s) appropriate for their needs. Once selected, the client will sign the lease for housing between themselves and the landlord. Case managers are encouraged to be a part of this process. As a partner in HARP, the County Housing Authority has agreed to provide a variety of services to help the client and case managers. Those services are included in Attachment D.

Waiting List Guidelines:

Clients for whom there are completed applications are placed on a waiting list on a first come first served basis. An incomplete application although filed with the County Housing Authority will not be placed ahead of a completed application even though it may have been received earlier. All information must be complete in order for the client(s) to be considered for housing.

Case managers should check with their clients on the waiting list at least monthly to see if they still have a need for housing. If their status has changed, that should be communicated in writing to the County Housing Authority so an accurate record can be maintained. Based on funding, preference may be given to woman or men with children under the age of 12.

Termination/Quit Guidelines:

Prior to terminating a client's housing or case management services, a review shall take place with the client, the agency that placed the client in HARP and the County Housing Authority. During this review, all options for continuing the client in HARP should be explored including moving the client to other housing and/or transferring case management responsibilities to another agency. If a client is removed from HARP, the case files shall document the reasons for such removal. A client removed from the program will no longer have their monthly rent subsidized by HARP funds. A client can remain in their existing housing if they pay the full amount of rent and abide by the terms and conditions of the lease signed between the client and the landlord.

Clients may be terminated from HARP if they break the lease requirements, return to substance abuse and mental health residential treatment, return to detox or are rearrested and return to jail. Efforts will be made to keep their housing available for up to thirty (30) days. If a client is removed from housing for a short period of time (14 days or less), that information needs to be communicated to the County Housing Authority.

Clients may move from HARP to other publicly subsidized housing programs such as Section 8 or Shelter Plus Care. Clients moving to those programs will be subject to the appropriate rules and regulations governing those funding sources.

Service Plan Completion:

Many clients placed in HARP have been asked to complete a variety of activities as part of a service plan. This may include substance abuse or mental health treatment, psycho-educational classes, job skills training or education for example.

The service plan is developed by the case manager in conjunction with the client. If the client completes their service plan or time in the agencies' program, they will continue to receive case management services. The nature and frequency of case management may change but there still needs to be regular (at least twice a month) contact with the client in order for them to receive subsidized housing.

Evaluation Guidelines:

Assessing effectiveness and demonstrating outcomes is a major objective of HARP. To meet that goal, case managers are required to document client progress in their case files. It is suggested that the "Self Sufficiency Matrix, developed in Arizona be used for that purpose. A copy of that matrix is included as Attachment E. At the time a client enters HARP, a narrative of the client's situation and self sufficiency should be completed and placed in their file. At least quarterly and at termination, the client's status should be updated in their client file using the Self Sufficiency Matrix as a guide regarding the type of information that should be recorded.

Quarterly, information on HARP is provided to the Salt Lake County Mayor's Office and the County Council. Information for this report is taken from data maintained by the County Housing Authority which in turn is provided by case managers. Each agency should report self-sufficiency data to the County Housing Authority for each client they have in the program by the 15th of the month following each quarter.

The county has entered into a contract with the University of Utah to evaluate approximately 50 clients in who were in HARP as of June 30, 2006 and track their progress for the next year.

HARP Governance:

On a monthly basis, meetings are held with the case managers, County Housing Authority, and representatives of the divisions that place clients in HARP. The purpose of the meeting is to exchange information, identify problems and work on solutions. Those involved are encouraged to attend this monthly meeting. The meeting is normally held at either Criminal Justice Services or Substance Abuse Services on the fourth Tuesday of each month beginning at 3:00 p.m.

AmeriCorp Guidelines:

Salt Lake County recently received approval for an AmeriCorp program to place up to 20 AmeriCorp volunteers with agencies that provide services to the homeless. Some agencies participating in HARP are also agencies that have the opportunity to have an AmeriCorp volunteer. These volunteers need to work approximately 1700 hours a year (30-33 hours per week) for which they are eligible for an educational stipend. They receive a monthly allowance for their work. The agencies using AmeriCorps volunteers participated in the recruitment and selection process. Volunteers are not clinicians or social workers but are to provide direct services to homeless clients. A job description outlining their responsibilities has been developed by the respective agencies where they work. Day to day supervision is provided by the agency housing the volunteer with program oversight the responsibility of the County Division of Community Resources and Development. If the program is successful, the funding for the AmeriCorp program could be renewed for another two years. A list of agencies participating in the AmeriCorp program is included in Attachment F.

Appendix B Case Manager Responsibilities

Responsibilities of Divisions/Case Managers In Homeless Assistance Rental Program (HARP)

Revised January, 2006

These responsibilities are based upon "best practices" for case management of the homeless:

- Identify clients to participate in the program
- Assist clients in completing the Housing Assistance Rental Program Assessment form
- Obtain a signed "Release of Information or Consent to Participate" form for each client
- Secure the client's signature on the housing lease forms
- In so far as possible, assist the client in arranging for furnishings and necessities for apartments
- Act as a resource to the client(s) who need help moving in/out of apartments, becoming familiar with building rules, location of services, etc.
- Verify client income
- Counsel with the client to assure payment of rent to landlord
- Develop a case management plan for each client
- Assist the client in accessing appropriate support services
- Attend regular staff meetings with other case managers involved with HARP
- Visit the client at least once per week initially; prescriptively thereafter
- Provide the Salt lake County Housing Authority with 2-3 contact names in the event of emergencies
- Deal with client behavioral issues as they occur in the housing units or refer to the Crisis Line
- Report client status issues monthly
- Participate in program evaluations of HARP

Responsibilities of the Salt Lake County Housing Authority In The Homeless Assistance Rental (HARP) Program

1. Dedicate an employee to the program
2. Identify and recruit landlords for scattered site housing.
3. Inspect sites for safety and health concerns
4. Develop lease agreements and home assistance contracts with landlords.
5. Serve as contact with landlords on building and tenant housing concerns.
6. Coordinate monthly meetings with case managers on housing issues
7. When appropriate attend regular client staffing meetings
8. Provide semi annual housing training for agencies
9. Sign up clients in the program for other housing assistance programs
10. Use available funding resources to provide housing
11. Provide monthly report on expenses for the program
12. Verify Income
13. Participate in program evaluation and compile data for quarterly report for the County Council.

Appendix D Homelessness Literature Review

Introduction

A number of studies have been conducted to examine the efficacy of Supportive Housing, Housing First, intensive case management, and other interventions aimed at addressing homelessness and issues that often accompany homelessness, including mental illness and substance abuse disorders. A thorough review of the literature pertaining to homelessness and related issues resulted in over 300 articles. From those, nearly 80 were selected for inclusion in our review of housing and homelessness issues for the Homeless Assistance Rental Program (HARP) study. This section summarizes the most representative studies that evaluate the effectiveness of various programs aimed at addressing homelessness and related concerns.

In order to interpret the study findings accurately, a basic understanding of the terminology used is necessary. Supportive Housing is typically defined as an intervention in which case management and housing resources are combined. Housing First is often defined as an intervention in which housing resources are provided with no requirements or contingencies (e.g., abstinence or employment). While definitions of housing status vary considerably, the term independently housed generally constitutes sleeping in an apartment, room or house of one's own or of a family member or friend. A dependently housed status typically means being institutionally housed in hospitals, halfway houses, or jails. Homeless status generally means sleeping in an emergency shelter, substandard single room occupancy hotel, or outdoors (Cheng, Haiqun, Kasprow & Rosenheck, 2007).

A few specific programs were most prevalent in the literature pertaining to homelessness, substance abuse, mental health, and criminality. We will give a brief overview of those program models, and then move on to the discussion of study results. We will discuss the merits of all of the studied interventions, describing the studies' methodology, results, and bottom line on how effective the intervention was at addressing homelessness and other related outcomes (e.g., psychiatric functioning, substance abuse, criminality, social stability, employment).

Access to Community Care and Effective Services and Support (ACCESS) is a 5-yr community demonstration program that provides funding to 18 substance abuse and mental health agencies to provide intensive case management to homeless people with mental illness.

Assertive Community Case Management (ACCM) provides in-house comprehensive case management services for homeless mentally ill.

Assertive Community Treatment (ACT) provides team-based intensive services in a community setting for homeless people with mental illness. The ACT team consists of outreach providing psychiatric and nursing services, case management, peer counseling, and family support.

Critical Time Intervention (CTI) is a time-limited adaptation of intensive case management. CTI was designed for homeless persons with mental illness who were transitioning from various institutions to the community. CTI provides a community

worker who gives transitional assistance, conducts home visits, and coordinates systems of care among various service providers.

Demonstration Employment Project – Training and Housing (DEPTH) follows a Supportive Housing and intensive case management model. DEPTH services include job training and placement, case management, linking clients to services, and locating permanent housing.

Literature Review Summary

Several studies have shown that Supportive Housing, providing additional services along with housing assistance, can be more effective than less intensive alternatives. A project sponsored by the National Institute of Mental Health tested the effectiveness of various types of housing support and rehabilitation services across several metropolitan areas (Shern et al., 1997). The different types of housing support implemented varied from consumer-run housing (independent living) to Section 8 housing certificates. The different types of case management provided included rehabilitation, intensive case management, and assertive case management. All teams used some type of case management. Overall findings were that the housing status of participants varied depending on the setting at which the participant resided before treatment (street versus shelter, etc) and the nature of the intervention. For example, in the New York site, 90% of participants were living on the street pre-intervention, whereas 38.9% of those provided with case management lived in community housing post-intervention. This is compared to 52% of those in the no-treatment condition that were still homeless and 20% who were living in an institution at follow-up. Conversely, in Baltimore, only 14% of participants were living on the street pre-intervention. Here 80% of those receiving assertive community treatment were housed in a community setting post intervention. Thus, it appears that stability pre-intervention was a factor in housing status post-intervention. However, participants in all 12 experimental conditions across all four sites were significantly more likely than controls to be living in community housing post intervention. This was even true for controls that were provided with some level of treatment. Finally, participants were regarded as stably housed if they did not move from their residence before the final follow-up (time varied); 78% of those living in community housing met this condition. Thus, it appears that case management and various housing supports are more effective than controls in improving housing statuses and stability.
Bottom Line: Supportive Housing showed *mixed* impact on improving housing outcomes.

A study conducted by Newman, Reschovsky, Kaneda, and Hendrick (1994) assessed the efficacy of Section 8 housing vouchers. Data was collected in a series of interviews. Pre-post interviews were attempted but some individuals had been using their certificates for up to 6 months before baseline data was gathered. Results indicated that housing certificate use was associated with increased residential moves from the street and group setting residences (1/3 of participants) to living in permanent residences. Summing all types of moves; 90% changed housing status after receiving certificates. This is a positive finding in that previous data has indicated that many individuals choose to stay in the same residences even after receiving vouchers. Results also indicated that the number of individuals living alone increased significantly. The most common change was from living with unrelated persons to living alone. This is generally perceived as a positive change as group housing tends to be less stable and permanent. Pre-post comparisons indicated that housing conditions and affordability improved in

ratings of the post-certificate residences. However, these improvements were not stable over time. At midpoint (approx. 12 months), improvements of quality and affordability were decreased while there were increased problems for the neighborhood (crime, etc). However, after 18 months of participation, certificate use was associated with improvements in all four program variables: affordability, housing problems, neighborhood problems, and service gaps. Thus, it appears that Section 8 housing is effective in changing housing status from less stable to more stable residences and that while the change is not fully stable, it tends to pursue even until 18 months. Additionally, it appears that Section 8 housing certificates are a factor in minimizing housing costs, neighborhood problems, service gaps, and housing problems. Again, while these changes are not always stable, the changes seem to persist for at least 18 months. **Bottom Line: Housing First was *effective* on housing outcomes and *mixed* on other outcomes (ratings of housing & neighborhood).**

Cheng and colleagues (2007) found that a Supportive Housing intervention, including Section 8 housing vouchers and intensive case management, was significantly more effective than two other interventions that provided case management only or standard Veteran's Administration care (short-term broker case management only). The intervention group experienced a higher number of nights housed in the past 90 and fewer nights spent in an institution (such as hospitals, halfway houses, and jails), as well as fewer days consuming any alcohol, intoxicated, and using drugs in the community. The intervention group also had lower alcohol and drug index scores. However, there were several measures that showed no difference across groups, including: days employed, psychiatric index score, medical index score, expenditures on substance abuse, positive housing characteristics, negative housing characteristics, social help, social network size, social contacts, and overall quality of life. These findings indicate that access to housing subsidiaries and case management services provides improvements in housing and substance abuse measures. However, psychiatric measures, housing ratings, and social measures were not improved by this type of intervention (Cheng, et al., 2007). **Bottom Line: Supportive Housing was *effective* on housing outcomes, but *mixed* on other outcomes (substance use, psychiatric ratings, housing ratings, & social measures).**

In an additional study of Supportive Housing, Section 8 rental assistance with intensive case management for homeless veterans, it was found that one year after receiving Section 8 certificates, 83.9% of participants were housed. Two case management activities influenced housing outcomes. The act of the case manager securing Supplemental Security Income (SSI) was positively correlated with increased housing. However, the case manager accompanying the client to the first meeting with the housing authority was negatively correlated with housing. Findings also indicated that ratings of the quality of the apartment and/or neighborhood at which one was housed were not predictive of housing retention (Kasprow, Rosenheck, Frisman & DiLella, 2000). This study suggests that one year housing retention can be a result of Supportive Housing models. **Bottom Line: Supportive Housing had a *mixed* impact on housing outcomes.**

Milby and colleagues (2005) examined the effectiveness of both Supportive Housing and Housing First models in their study of homeless participants with coexisting cocaine dependence and non-psychotic mental disorders. They tested the efficacy of Supportive Housing when abstinence was required compared to a Housing First model, where abstinence was not required. The conditions included abstinence-contingent housing (ACH), non-abstinence-contingent housing (NACH), or no housing. All groups received the same substance abuse day treatment for the duration of the study. Baseline to six and 12-month comparisons for housing changes (days

housed) and employment outcomes (days employed) indicated that all groups showed strong improvement, but there was no difference between the groups. Regarding substance abuse measures, it was found that those receiving the housed conditions regardless of the abstinence requirements showed consistently higher abstinence prevalence than those receiving no housing. Those in the ACH showed some rates of higher abstinence than those in the NACH, but the difference was not significant. Thus, the results lend support to the efficacy of Housing First models which, as demonstrated here, can lead to improved outcomes similar to models that have abstinent contingencies (Milby, et al., 2005). **Bottom Line: Housing First and Supportive Housing both had *mixed* impact on housing and other outcomes (employment & substance use).**

Another study that assessed the impact of abstinence-contingencies on improved outcomes was conducted by Tsemberis, Gulcur, and Nakae (2004). In this study of homeless mentally ill, participants were provided with either Housing First and optional treatment that follows the Assertive Community Treatment (ACT) model or a control condition in which treatment follows a Continuum of Care model, where housing is based on abstinence and treatment contingencies. Results indicated that the Housing First model was significantly more effective in improving homelessness outcomes as these participants had significantly faster decreases in homelessness rates and increases in stably-housed rates when compared with those receiving abstinent-contingent housing. This was the case even up to a 24-month follow-up. Housing First participants also had significantly more perceived choices as indicated by a Consumer Choice Scale which measures whether the perception of personal choice is a factor in recovery. However, Housing First and abstinent-contingent comparisons showed no effect on substance abuse and psychiatric measures. In addition, the abstinence- contingent group was found to have significantly higher utilization of substance abuse treatment programs than the Housing First group. Furthermore, abstinent-contingent participants had an increase in service use over time while Housing First participants decreased in service use over time. Thus, it appears that unconditional housing is more effective than conditional housing in decreasing homelessness and increasing perception of personal choice. However, it is less effective than conditional housing in engaging participants in seeking and attending treatment. Results also indicate that neither model is effective in improving substance abuse and psychiatric measures (Tsemberis et al.). **Bottom Line: Housing First was *effective* on housing outcome, but *mixed* on other outcomes (Consumer Choice, substance use, & treatment attendance). Supportive Housing had *mixed* impact on housing and other outcomes.**

Dixon, Friedman, and Lehman (1993) also conducted a study in which individuals were provided with Assertive Community Treatment (ACT). While there was no comparison group, this study evaluated the 10-month outcomes of individuals receiving ACT and Section 8 housing vouchers. This study found ACT to be effective in moving participants from non-permanent statuses into permanent housing (44.4 average days spent in permanent housing). However, this change was rarely stable as each participant had an average of 5 moves from permanent to other types of housing (transition, street, or institutional). It was also found that those experiencing psychiatric relapse and active substance abuse showed less improvement on the number of days spent housed. Type of financial assistance received was a factor in housing status, as those receiving SSI or (Social Security Disability Insurance) SSDI had more days housed than those receiving general public assistance. Thus, ACT may be effective in changing short-term homeless patterns, but psychiatric, substance abuse, and type of financial assistance factors also

contribute to the effectiveness of ACT in terms of long-term housing stability. **Bottom Line: Supportive Housing had *mixed* impact on housing outcome.**

Dixon and colleagues conducted another study on the relationship between ACT and homelessness, this time examining Section 8 housing vouchers as a dependent variable (Dixon, Krauss, Myers & Lehman, 1994). Clients were referred to an ACT team. Once referred to the ACT team, the application process for Section 8 certificates began. Findings indicated that there were no demographic differences between receivers and non-receivers of Section 8 (age, gender, & race). However, those with increased psychopathology as indicated by the BPRS (psychiatric symptom severity measure) were significantly less likely to receive a certificate. Those with affective disorders were more likely to get certificates than those with schizophrenia. The authors ascertained that this was likely due to the fact that staff often perceived these individuals as incapable of independent living and were thus denied a certificate. Receivers were more likely than non-receivers to still be in treatment after one year. One year after referral, 33% of non-receivers were living independently and 7% were in jail. Regarding length of time to apply, those with schizophrenia took significantly longer to apply than those with affective disorders (7.5 versus 2.8 months). Authors believed that this was likely a result of the basic dysfunctional nature of schizophrenia. These findings indicate that while age, gender, and race are not a factor in securing Section 8 housing after receiving the ACT intervention, the severity of psychiatric illness is a significant factor in the acquisition of housing. Further implications are that severe mental illness precludes the necessary skills for even applying for and securing stable housing. **Bottom Line: Case Management had *mixed* impact on housing outcome.**

In an additional study assessing ACT, participants were provided with one of three treatments including, Integrated Assertive Community Treatment (IACT; same clinical team provides mental health and substance abuse treatment), Assertive Community Treatment Only (ACTO; referred to other agencies for treatment), or standard care (given information about services only) (Morse et al., 2006). Participants were required to have a comorbid substance and severe psychiatric disorder. Findings were that professionals implementing ACTO had significantly more contact with clients than any other condition. IACT and ACTO were equally effective and significantly more effective than the control group on ratings of client satisfaction and number of days stably housed. This significant increase in number of days stably housed for IACT and ACTO over the standard care lasted until 18 and 24 months. At this point all groups improved but there was no significant difference across all groups. There was no effect on psychiatric (BPRS scale) and substance abuse measures. All conditions improved over time. In another study on the same population, Calsyn, Klinkenberg, Morse, and Lemming (2006) focused on treatment alliance and its subsequent influence on treatment outcomes. It was found that the intervention received was not a factor in the level of alliance perceived by the client and the therapist. In combining the findings from these two studies, it appears that an integrated approach to treatment (IACT) costs less while producing equally improved outcomes over a more brokerage style of treatment (ACTO) on measures of treatment alliance, housing status, and client satisfaction. However, the brokerage style of treatment (ACTO) provided more service contacts than any other group, which could account for the increased cost. Finally, it appears that an Assertive Community Treatment of any kind is not more effective than standard care on psychiatric, substance abuse, or long-term housing measures (Morse et al., 2006). **Bottom Line: Case Management was *mixed* on housing and other outcomes (psychiatric ratings, substance use, & treatment alliance).**

Solomon and Draine (1995) studied the effectiveness of ACT for individuals released from jail. Participants were provided with: 1) ACT (team-based intensive services in a community setting, providing personal case management to assist in mental health access with constant consultation with a psychiatrist), 2) individual case management provided by a forensic specialist (more conversational than ACT, not team-based, minimal interaction with psychiatrist, brokerage style case managment), or 3) usual care upon jail release (referral to a community mental health center). These interventions were geared towards inmates with severe mental illness who would be homeless upon release. Surprisingly, results indicated that those receiving ACT were more likely than those receiving individual case management and usual care to return to jail one year after release. There was no effect between all three groups regarding the BPRS scale (psychiatric measure), the alcohol scale of the ASI, or the subjective quality of life measures. These findings indicate that case management is equally effective as usual jail-release services. However, the results also found that 46% of the sample returned to jail at least once in the following year perhaps indicating that a more intensive approach is needed. These findings are contrary to those found by Morse and colleagues (2006) that documented the overall effectiveness of ACT over other treatment in improving housing status, overall satisfaction, and psychiatric measures. Thus, it appears that many homelessness issues can be addressed by ACT, but that issues related to criminal involvement are perhaps better served by a more intensive intervention. **Bottom Line: Case Management had *no effect* on other outcomes (jail, psychiatric rating, alcohol use, & quality of life).**

Calsyn, Klinkenberg, Morse, and Lemming (1998) examined the impact ACT had on social relationships among severely mentally ill homeless. ACT was compared to other types of treatment, including outpatient therapy, drop-in-centers, and brokered case management. ACT was examined based on who was providing the treatment including professionals, paraprofessional, and community workers. General findings suggest that ACT tends to be more effective in increasing the professional social network of the client, but that ACT does not fare better than other treatments in improving the relationships within the client's natural social network. Perhaps a more intensive intervention is needed in improving the social relationships of the homeless, which is thought to be critical in recovery. **Bottom Line: Case Management had *mixed* impact on other outcomes (professional and natural social networks).**

Although the ACT model of case management demonstrated some success, a study of adults with substance abuse problems who also have homeless experience found that participants who were receiving case management and Supportive Housing (individuals given apartments for up to eight months & other types of support) were retained in substance abuse treatment longer than participants who received case management only. This held true for up to three months after treatment initiation. It was also found that regardless of condition, participants who had previous homeless experience were more likely to have lower retention rates (Sosin, Schwingen & Yamaguchi, 1993). **Bottom Line: Supportive Housing model was more *effective* than case management alone on other outcomes (treatment retention).**

Clark and Rich (2003) also found Supportive Housing to be more effective than case management alone, at least among individuals with high psychiatric and substance abuse severities. In a study of mentally ill homeless persons with a prevalence of substance abuse disorders, it was found that persons with high psychiatric symptom severity and high substance use achieved better housing outcomes with the comprehensive housing program (guaranteed access to housing and housing support services) than with case management alone. However, those with medium to low psychiatric symptom severity and low levels of alcohol and drug use

showed no improvement on housing outcomes when compared with the case management only intervention. **Bottom Line: Supportive Housing and Case Management were *mixed* on housing outcomes.**

A study conducted by Wasylenki, Goering, Lemire, Lindsey, and Lancee (1993), investigated the effectiveness of Assertive Case Management, which is similar to other studies' definition of Intensive Assertive Community Treatment (IACT). Participants in this study of homeless mentally ill were assessed nine months before and after they entered the outreach treatment program. This style of Assertive Case Management provided usual case management with the addition of aggressive outreach and the provision of direct services. The intervention was also linked with hostels which perform three functions; to provide emergency shelter, transitional accommodation, and semi- permanent residence. Nine months after program entry results indicated that participants spent significantly less time in hostels and more weeks in permanent housing than at baseline (9 months before program entry). The BPRS rating scale (a psychiatric severity scale) indicated that scores decreased significantly from baseline to follow-up. Additionally, social functioning showed improvement in most areas. The area of self-maintenance was the area that showed least improvement and did not reach significance. Measures of social networks (number of supportive relationships, contacts, reciprocal relationships, & confidants) improved significantly from baseline to follow-up. These findings suggest that the assertive style of case management is effective in moving individuals from less permanent places of residence to more permanent residences. The intervention also appears effective in minimizing psychiatric measures and in increasing social stabilization. However, these results were not always significant. **Bottom Line: Supportive Housing was *effective* in improving housing outcomes, but *mixed* in its impact on other outcomes (psychiatric ratings, social functioning, & social networks).**

In another study of homeless adults with mental illness and substance abuse problems, those receiving DEPTH, a Supportive Housing and intensive case management intervention, showed significant improvement over time (from baseline to 18-month follow-up) on three variables. The improved variables included: number of days homeless, physical health, and rating of stressful life events. In addition to the change-over-time comparisons, 13 outcome variables were also compared between the intervention and control group. Participants in the no treatment control were not provided with any of DEPTH's services but were allowed to seek whatever kind of treatment they wished during the follow-up periods. There was no effect on 10 out of 13 variables (days homeless, job income, other income, physical health, SCL- 90-R psychiatric symptoms, family index, support index, ISEL support, self efficacy, & drinking index) The three variables that showed better outcomes for the DEPTH group were housing quality, BPRS scale (psychiatric rating scale), and stressful life events (Toro et al., 1997). **Bottom Line: Supportive Housing was *mixed* in its impact on both housing and other outcomes (income, health, psychiatric ratings, family, self efficacy, alcohol use, housing quality, & stressful events).**

While the above studies indicate that interventions like Supportive Housing may be more effective than less intensive interventions, this study also addresses the *level* of intensity between two types of Supportive Housing. Participants were provided with an Integrated Housing Program (case management and housing services provided by one coordinated agency) or Parallel Housing (case management provided by three different mobile teams, following an ACT model). Both groups received housing that differed. The Integrated Housing group followed a traditional continuum model, which provided a more intensive control over housing, decreased

level of integration with the community at large, and the presence of live-in staff. For instance, in the Integrated Housing Program, clients lived in buildings that were primarily occupied by other mental health clients. The parallel housing group followed a more traditional Supportive Housing model, where clients were not segregated from the rest of the tenants, continued tenancy was not contingent upon treatment attendance, and no staff were present to supervise tenants. The more intensive integrated housing program showed the most improvement on housing measures (at 18 months 68.1% of parallel housing and 85.5% of integrated housing participants were living in stable housing). It is useful to note, however, that both Supportive Housing interventions improved housing measures from baseline (88.3% and 82.0% of participants were homeless at baseline compared to 18- month statuses above). The more intensive integrated housing group also showed greater improvement on quality of life measures and psychiatric ratings. Level of Supportive Housing intensity was not a factor in the amount of services used or number of days spent institutionalized (McHugo et al., 2004). **Bottom Line: Supportive Housing was *effective* in improving housing outcomes, but *mixed* in its impact on other outcomes (psychiatric ratings, quality of life, services used, & days institutionalized).**

Thus, the studies indicate that in treating homelessness that coexists with mental illness and substance abuse, Supportive Housing tends to improve some housing variables as well as a few other variables (abstinence measures, housing quality, psychiatric rating scales, stressful life events, etc.) when compared with no treatment, case management only, or even abstinent-contingent conditions. However, many of the studies reported mixed results, with the Supportive Housing interventions failing to provide improvements on all measures of interest. As previously discussed, the Tsemberis et al. (2004) study found that Housing First was more effective than conditional housing in decreasing homelessness and increasing perception of personal choice. However, it was less effective than conditional housing in engaging participants in seeking and attending treatment. Sosin and colleagues (1993) found that Supportive Housing was more effective than case management alone in treatment retention. Thus, it appears that the efficacy of Housing First in treatment retention is better than case management only, but perhaps not as effective as abstinent-contingent models regarding treatment retention. The current literature on Supportive Housing and Housing First interventions aimed at addressing homelessness and related concerns portrays the difficulty of working with this population. However, these efforts have shown that Supportive Housing and Housing First models can be effective in making progress with homeless clients experiencing mental illness and substance abuse when they are appropriately matched to the needs of the clientele.

Case management has been frequently employed to address homelessness. In addition to the above studies that involve case management within the context of Supportive Housing (or as part of a treatment program that also frequently involve housing provision (e.g., ACT)), a number of studies also examined the efficacy of various types of case management alone for treating homelessness and related problems.

In a study of homeless mentally ill, participants were given one of three interventions: 1) Assertive Community Case Management (ACCM) with Community Workers (in-house comprehensive services for unlimited time along with daily living skills assistance provided by community workers), 2) Assertive Community Case Management Only (same treatment as group 1 except no access to community workers), and 3) Broker Case Management (case-manager assists in "contracting out" for services) (Morse et al., 1997). Those receiving Assertive Community Case Management without community workers were found to have the most number of days with stable housing at 18 months post intervention when compared to participants

receiving either Broker Case Management or Assertive Community Case Management with community workers. While case management paired with comprehensive services resulted in the best housing outcomes, all three types of case management resulted in increased number of days stably housed. Both groups receiving Assertive Community Case Management received significantly more service contacts than those receiving Broker Case Management. These groups also had significantly higher client satisfaction ratings and lower psychiatric severity ratings (related to thought disorders and unusual activity) than the broker condition. There was no effect found across all three treatment groups regarding substance abuse ratings and measures of anxiety-depression, hostility, and self esteem. Broker Case Management was found to be the least effective in minimizing psychiatric ratings. Thus, it appears that the Assertive Community model of case management is most effective in improving housing, overall satisfaction, and some psychiatric outcomes when compared to Broker Case Management. The results also indicate that the presence of community workers is not a factor in improving outcomes. **Bottom Line: Case management was *effective* in improving housing outcomes, but *mixed* in its impact on other outcomes (client satisfaction, psychiatric ratings, substance use, & self esteem).**

A study assessing the efficacy of a Critical Time Intervention (CTI) model was conducted by Jones, Colson, Valencia, and Susser (1994). This version of the CTI model focused on assistance in establishing systems of support regarding medication compliance, money management, substance abuse, and housing-related crisis. Participants were homeless and mentally ill men who either received CTI or treatment as usual (prep for community placement, assistance in locating community housing, and the development of a treatment plan). All participants were provided with housing placements (based on need, preference, etc). Possible placements included structured programs with housing, single-room hotels, community residences, and transitional living. The follow-up period for the study lasted 18 months, with CTI lasting up to nine of those 18 months. Results indicated that participants receiving CTI experienced significantly less homeless nights than those receiving usual care (1760 versus 732). However, CTI men were more likely to have hospital stays than men receiving usual care (17 versus 14) and to have more total nights of hospitalization (1171 versus 912). The number of nights spent in a jail was assessed but showed no effect because only 11 men in both groups experienced any jail time during the follow-up period. Regarding mental health treatment utilization, the CTI participants used more outpatient clinics than usual care participants (30 average visits versus 17). No effect was observed on utilization of psychiatric emergency rooms or day programs. These results indicate that the Critical Time Intervention model is effective in minimizing overall homelessness and increased utilization of outpatient treatment services. However, the intervention does not appear advantageous over typical treatment in minimizing institutional visits. **Bottom Line: Supportive Housing was *effective* in improving housing outcomes, but *mixed* in its impact on other outcomes (hospital stays, jail, treatment attendance, & psychiatric ERs).**

A more recent study conducted by Jones and colleagues (2003) found that participants receiving a Critical Time Intervention (9 months of homeless prevention case management) experienced significantly fewer homeless nights than participants receiving usual care over short periods of time. However, the case management intervention was not found to be more effective than usual care in decreasing number of homeless nights over extended periods of time (18-month follow-up). This may indicate the weaker effects of case management alone on impacting

housing outcomes compared to more intensive interventions, such as Supportive Housing. **Bottom Line: Case Management was *mixed* in its impact on housing outcomes.**

Susser et al. (1997) also conducted a study in which the experimental participants were provided with a Critical Time Intervention (CTI). This study of homeless men with severe mental illness who were being discharged from a psychiatric institution to community living found that those provided with a CTI (community worker provided transitional assistance and continuity of care through home visits, etc) had significantly less homeless experience than those provided with usual services (USO; referrals to mental health agencies). This was indicated by a number of variables. First, CTI participants had significantly less average homeless nights than those provided with usual services at 18-month follow-up (30 average nights versus 91). Furthermore, at the end of the 18-month follow-up, 8% of the CTI men were homeless compared to 23% of the USO men. When the number of homeless episodes was compared, results indicated that the CTI group had a significantly lower risk of homelessness than the USO. Lastly, it was found that extended homelessness (54+ nights) and intermediate homelessness (30-54 nights) measures were both smaller in the CTI group than the USO group. Thus, these findings indicate that a case management model that provides transitional services and continuity of care is critical in decreasing homelessness when an individual is transitioning from an institutional to a community setting. **Bottom Line: Case Management was *effective* in improving housing outcomes.**

When comparing the two Jones and colleagues studies (1994, 2003) the original research showed that CTI improved housing, but not institution use; however, later findings found that housing status was actually only improved in the short-term (before 18-month follow-up). This combination indicates that perhaps CTI is only effective in improving short-term housing statuses. The results of the Susser and colleagues (1997) study are interesting because they show improvements in housing persisting through an 18-month follow-up period. The difficulty of evaluating community-based interventions for homelessness is illustrated through the seemingly contradictory results of the Jones and Susser studies on the same intervention (CTI).

Several studies have tested the impact of case management on homelessness by examining a program called ACCESS. The first study presents findings from a survey of living arrangements gathered from ACCESS participants at 12 months after receiving intensive case management. The survey found the intervention to be effective in increasing the number of individuals independently housed at 12 months post enrollment (37% compared to an entry requirement that participants be homeless 7 of the last 14 days). The treatment was not found to affect ratings of perceived housing quality or family relationship satisfaction as indicated by pre-post treatment comparisons. All participants showed improvements in clinical status, use of psychiatric services, and increased access to housing services12 months after entering services. Those who were independently housed showed greatest improvements on measures of quality of life and reduction in perceived unmet housing needs (Mares & Rosenheck, 2004). **Bottom Line: Case Management was *effective* in improving housing outcomes, but *mixed* in its impact on other outcomes (housing quality, family relationships, clinical status, psychiatric services, & quality of life).**

An earlier evaluation of ACCESS focused on the systems integration model (part of case management aimed at increased access to a broad array of services key in homeless mentally ill treatment). Pre-Post comparisons were made. Results indicate that service system integration was a factor in improved housing outcomes at 12-month follow-up as those stably housed

increased from 5% at baseline to 25% at 3 months and 44% at 12 months (Rosenheck et al., 1998). **Bottom Line: Case Management was *effective* in improving housing outcomes.**

An additional analysis of the ACCESS program was conducted on the first of two cohorts entering the ACCESS program. As previously noted, participants were homeless with severe mental illness. This sample also had a prevalence of alcohol disorders. This study aimed at assessing the impact of therapeutic alliance on treatment. It was found that the client's level of alliance with their case manager was significantly associated with decreased homelessness and increased life satisfaction (Chinman, Rosenheck & Lam, 2000). **Bottom Line: Case Management was *effective* in improving both housing and other outcomes (life satisfaction).**

The three studies of ACCESS indicate that intensive case management and alliance with case managers can lead to improved housing and mental health outcomes. It should be noted that improvements in housing outcomes for the ACCESS group were measured against a baseline at intake. Other studies that examined the impact of case management in relation to Supportive Housing conditions (see Cheng et al., 2007; Clark & Rich, 2003; Sosin et al., 1993) generally indicated that Supportive Housing (intensive case management PLUS housing vouchers) provided better outcomes than case management alone.

In a study on substance abusers who had HIV/AIDS and a prevalence of criminal and homeless experience, Sorensen et al. (2003) found no effect when individuals given a case management intervention (one year of limitless brokerage/full services model of case management) were compared with a brief contact intervention (education, referrals to substance abuse and HIV services) on all primary outcome measures including ASI composite scores (psychiatric, medical, legal, family, etc), HIV risk, service use, and quality of living situation (homelessness, support, and employment). The only exception noted was that those receiving brief contact scored higher on measures of sex risk than those receiving case management. These findings provide little support for the efficacy of case management over a brief intervention in impacting HIV risk, quality of living, and ASI scores. **Bottom Line: Case Management had *no effect* on housing outcomes, and was *mixed* in its impact on other outcomes (psychiatric, medical, legal, and family domains of ASI, HIV risk, & service use).**

In addition to the above studies regarding homelessness and case management, another body of literature testing the effectiveness of case management specifically examines variables that are commonly faced by homeless individuals including substance abuse, mental health, employment, and criminality. Siegal and Rapp (2002) examined veterans receiving substance abuse treatment for opiate and cocaine use. It was found that participants who received case management in addition to their substance abuse treatment were more likely to engage in treatment longer than those who received no case management. However, results also indicated that increased length of case management participation was positively correlated with increased legal severity scores. These results indicate that case management was effective in increasing treatment engagement, but that the case management and treatment provided was not effective in decreasing legal severity scores. While this was a puzzling finding, the authors ascertain that if both models are combined, the results indicate that case management is effective in decreasing legal severity. This conclusion is made because case management was found effective in engaging clients in treatment and because increased treatment participation is positively correlated with decreased substance abuse, the authors maintain that case management indirectly contributes to decreased legal severity. **Bottom Line: Case Management was *mixed* in its impact on other outcomes (treatment engagement & legal severity).**

A study on participants receiving substance abuse treatment in a residential setting tested whether or not varying the location at which the case management was provided produced significant outcomes. Results indicated that those receiving case management delivered in person at a social service agency had significantly higher improvements on drug abuse and psychiatric scales when compared to the control group that received no case management. It was also found that those receiving case management delivered in-person at the primary treatment facility had significantly higher improvements on the legal and employment domain when compared to the control group. Comparisons between those receiving case management delivered in-person at the primary treatment facility, those receiving case management in person at a social service agency, and those receiving case management delivered via phone yielded no effect across all outcomes. Additionally, no effect was found across all treatment groups including the control condition on measures of substance-abuse free days (Saleh et al., 2002). Thus, the findings indicate that while the presence of case management was found to produce improved outcomes over a no-treatment control, the location at which the treatment is provided was not a factor in improving outcomes. **Bottom Line: Case Management was *mixed* in its impact on other outcomes (substance use, psychiatric ratings, legal severity & employment).**

A study on injection drug users who had a prevalence of Anti-Social Personality Disorder (ASPD) found a strengths-based case management intervention to be more effective than passive referral to community resources in improving treatment initiation and participation. A strengths-based intervention is generally based on engagement, assessment, personal case planning, and resource acquisition. Case managers typically provide transitional assistance, employment, and transportation to health and social service agencies (Havens et al., 2007). **Bottom Line: Case Management was *effective* in its impact on other outcomes (treatment retention).**

The improvements noted by Havens et al. (2007) may, however, be marginal, as Sosin et al. (1993) found that case management combined with housing was more effective regarding treatment initiation and retention than case management only. Furthermore, Tsemberis et al. (2004) found that abstinent-contingent housing was more effective than Housing First in improving treatment retention. Thus, in terms of treatment retention, it appears that improvements have an additive effective starting with case management only, moving to Supportive Housing, and ending with abstinent-contingent being the best model for engaging substance abusers in treatment.

Conclusion

The entire body of literature reviewed on interventions for homeless with substance abuse, mental health, and criminal justice involvement spoke to the complexity of both providing services for this population and evaluating their effectiveness. It was generally the theme that programs and services were more effective if they were: a) more comprehensive, b) of longer duration, and c) appropriately matched to the needs (and severity) of the clientele. When looking at the effectiveness of these efforts to improve housing and other outcomes, a consistent theme also develops. Research that utilized less rigorous designs (pre-post measures, for example), had shorter follow-up periods, and examined fewer outcome measures generally found their interventions to be effective. However, studies that utilized comparison groups (especially three or more), had longer follow-up periods, and examined several outcomes of interest generally reported mixed results or no effect. It should also be noted that published research is biased, in that few studies reporting “no effect” are considered for publication. This bias inflates the

representation of interventions that have had an effect on homelessness and other outcomes. The total number of programs that have had less effectiveness is not known. These results reaffirm what professionals working in the field already know: Current efforts to address homelessness and related problems (substance abuse, mental health, & criminality) are making progress, but no single panacea exists.

Appendix E Homelessness Literature Review Table

Study			*Impact on Homelessness*			*Impact On Other Outcomes*		
Author	**Year**	**Program Name**	**Supportive Housing**	**Housing First**	**Case Management**	**Supportive Housing**	**Housing First**	**Case Management**
Calsyn, Klinkenberg, Morse, & Lemming	2006	ACT						Mixed
Calsyn, Morse, Klinkenberg, Trusty, & Allen	1998	ACT						Mixed
Cheng, Haiqun, Kasprow, & Rosenheck	2007		Effective			Mixed		
Chinman, Rosenheck, & Lam	2000	ACCESS			Effective			Effective
Clark & Rich	2003		Mixed		Mixed			
Dixon, Friedman, & Lehman	1993	ACT	Mixed					
Dixon, Krauss, Myers, & Lehman	1994	ACT			Mixed			
Havens, et al.	2007							Effective
Jones, Colson, Valencia, & Susser	1994	CTI	Effective			Mixed		
Jones, et al.	2003	CTI			Mixed			
Kasprow, Rosenheck, Frisman, & DiLella	2000		Mixed					
Mares & Rosenheck	2004	ACCESS			Effective			Mixed
McHugo, et al.	2004		Effective			Mixed		
Milby, et al.	2005		Mixed	Mixed		Mixed	Mixed	
Morse, et al.	1997	ACCM			Effective			Mixed
Morse, et al.	2006	ACT			Mixed			Mixed
Newman, Reschovsky, Kaneda, & Hendrick	1994			Effective			Mixed	
Rosenheck, et al.	1998	ACCESS			Effective			
Saleh, et al.	2002							Mixed
Shern, et al.	1997		Mixed					
Siegal & Rapp	2002							Mixed
Solomon & Draine	1995	ACT						No Effect
Sorensen, et al.	2003				No Effect			Mixed
Sosin, Schwingen, & Yamaguchi	1993					Effective		
Susser, et al.	1997	CTI			Effective			
Toro, et al.	1997	DEPTH	Mixed			Mixed		
Tsemberis, Gulcur, & Nakae	2004	ACT	Mixed	Effective		Mixed	Mixed	
Wasylenki, Goering, Lemire, & Lindsey	1993		Effective			Mixed		

Appendix F HARP Cover Letter and UCJC Surveys

SALT LAKE COUNTY

PETER M. CORROON
Salt Lake County Mayor

Jean Nielsen
Human Services Department
Director

Gary K. Dalton
Criminal Justice Services
Director

Ronald L. Oldroyd
Criminal Justice Services
Associate Director

ADMINISTRATIVE SERVICES
801 / 799-8400
801 / 799-8455 fax

PRE-TRIAL

DAY REPORTING CENTER
801 / 595-4000
801 / 595-4005 fax

PRETRIAL SERVICES
801 / 799-8400
801 / 799-8430 fax

POST-TRIAL

COURT SERVICES
801 / 799-8466
801 / 799-8493 fax

PROBATION SERVICES
801 / 799-8460
801 / 799-8494 fax

TREATMENT SERVICES
801 / 799-8466
801 / 799-8493 fax

145 East 1300 South, Suite 305
Salt Lake City, UT 84115
www.slcocjs.org

September 17, 2007

Dear [redacted]:

You can receive a **$20 Smith's gift card** for completing and returning the enclosed survey regarding your experiences with HARP (Homeless Assistance Rental Program). As a former HARP housing resident, you are invited to share your experiences since exiting HARP housing and your satisfaction with the program. Your participation in this survey is greatly appreciated and will assist HARP in better serving clients through understanding the challenges that clients face after exiting the program.

If you choose to participate, please return your completed survey in the provided business reply envelope (no postage necessary). As indicated on the envelope, completed surveys will be sent directly to researchers at the Utah Criminal Justice Center (UCJC) at the University of Utah. Your information will remain confidential and no individual responses will be shared with Criminal Justice Services or any other authorities.

A unique number has been assigned to each survey to allow UCJC researchers to track the completion and return of surveys. This number is located in the upper left-hand corner of the enclosed survey and will not be attached to any of your responses. Any results from the surveys given to HARP will be presented in a way that examines the entire group of responses and will not include any identifying information. After UCJC receives your completed survey, a $20 Smith's gift card will be mailed to you as compensation for your time. If you would like the gift card mailed to a different address than the one where you received this survey, please indicate the new address on the back of your survey.

If you have any questions about this research or your participation, you can call Audrey Hickert at UCJC at 581-4459. Your honesty in completing the survey and willingness to help HARP improve their services is greatly appreciated.

Sincerely,

Gary K. Dalton
Division Director
Criminal Justice Services

Kerry D. Steadman
Homeless Services Coordinator
Community Resources & Development Division

Salt Lake County Homeless Assistance Rental Program (HARP)
Survey for Current Clients

Today's Date: _____

How satisfied have you been with the following since entering HARP?

Services/Programs	Very Dissatisfied	Somewhat Dissatisfied	Unsure	Somewhat Satisfied	Very Satisfied	Did not participate
Housing Authority	☐	☐	☐	☐	☐	☐
Employment Assistance (DWS)	☐	☐	☐	☐	☐	☐
12-Step programs (AA/NA/CA)	☐	☐	☐	☐	☐	☐
Substance Abuse Treatment	☐	☐	☐	☐	☐	☐
Mental Health Treatment	☐	☐	☐	☐	☐	☐
Criminal Justice Services programs	☐	☐	☐	☐	☐	☐

Comments: _____

_____

Approximately how frequently do you have contact with your HARP case manager?

	Less than once a month	Once a month	2-3 times a month	Once a week	More than once a week
When I first started HARP					
In Person	☐	☐	☐	☐	☐
By Phone	☐	☐	☐	☐	☐
Currently					
In Person	☐	☐	☐	☐	☐
By Phone	☐	☐	☐	☐	☐

How strongly do you agree or disagree with the following statements?

	Strongly Disagree	Somewhat Disagree	Unsure	Somewhat Agree	Strongly Agree	N/A
My HARP case manager …						
Clearly explained the building rules at my HARP housing unit.	☐	☐	☐	☐	☐	☐
Worked with me to develop and make sure I understood my case management plan.	☐	☐	☐	☐	☐	☐
Makes site visits to my apartment.	☐	☐	☐	☐	☐	☐
Is responsive to my requests (in person, phone, e-mail, etc.)	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Somewhat Disagree	Unsure	Somewhat Agree	Strongly Agree	N/A
Treats me with respect.	☐	☐	☐	☐	☐	☐
Is sensitive to my cultural/ethnic background.	☐	☐	☐	☐	☐	☐

Comments: _____

_____

How many times have you moved over the last 5 years? _____

Where did you live most of the time during the 6 months prior to entering HARP housing? (*Check only one*)

Location:	6 months prior to HARP
Your apartment, room, or house	☐
Someone else's apartment, room, or house	☐
Halfway House	☐
Residential Treatment	☐
Shelter or Safe Haven	☐
Jail or Prison	☐
Homeless	☐
Other (please specify) : _____	

Approximately how many nights did you spend in a homeless shelter during the 6 month prior to entering HARP housing? _____

Please indicate your status on the following items for *both* the 6 months prior to HARP and during HARP. We are interested in which areas of your life may have changed since entering HARP housing.

	6 months prior to HARP	During HARP
SCHOOL AND JOB TRAINING		
Not enrolled	☐	☐
Enrolled, full-time	☐	☐
Enrolled, part-time	☐	☐
EDUCATION		
What is the highest level of education you have completed?		
Less than high school	☐	☐
GED	☐	☐
High school graduate	☐	☐
Some college	☐	☐
College graduate (Bachelor's level)	☐	☐
Advanced degree (Masters, Ph.D., J.D., or M.D.)	☐	☐
Other (please specify) : _____	☐	☐
EMPLOYMENT		
Unemployed	☐	☐
Employed, full-time (35+ hours per week)	☐	☐
Employed, part-time	☐	☐

If currently employed during both time periods, skip next question	6 months prior to HARP	During HARP
If unemployed, were you:		
Unemployed, looking for work	☐	☐
Unemployed, not looking for work	☐	☐
Disabled	☐	☐
Retired	☐	☐
Student	☐	☐
Homemaker	☐	☐
Other (please specify) : _____	☐	☐
TRANSPORTATION		
Which forms of transportation do you have access to? *(check all that apply)*		
Own vehicle	☐	☐
Someone else's vehicle	☐	☐
Public Transportation	☐	☐
Do you have a valid driver's license? ☐ **Yes** ☐ **No**		
Have bus tokens been made available to you? ☐ **Yes** ☐ **No**		
DRUG USE		
Have you used any of the following controlled substances?		
Amphetamines	☐	☐
Barbiturates	☐	☐
Cannabis/Marijuana	☐	☐
Cocaine	☐	☐
Hallucinogens/Psychedelics	☐	☐
Heroin	☐	☐
Inhalant	☐	☐
Methadone	☐	☐
Methamphetamine	☐	☐
Other Opiates	☐	☐
Sedatives/Hypnotics/Tranquilizers	☐	☐
Other (please specify) : _____		
MENTAL HEALTH		
Have you experienced any of the following?		
Serious depression	☐	☐
Serious anxiety or tension	☐	☐
Hallucinations	☐	☐
Trouble understanding, concentrating, or remembering	☐	☐
Trouble controlling violent behavior	☐	☐
Serious thoughts of suicide	☐	☐
OVERALL HEALTH		
How would you rate your overall health?		
Excellent	☐	☐
Very Good	☐	☐
Good	☐	☐
Fair	☐	☐
Poor	☐	☐

Please answer "yes" or "no" to the following questions based on your current situation.

	Yes	No
Do you have any chronic medical problems that continue to interfere with your life?	☐	☐
If YES, please specify: (*optional*) _____		
Do you have health insurance?	☐	☐
Do your children have health insurance? *(Skip if not applicable.)*	☐	☐
Have you received assistance obtaining health care?	☐	☐
CHILDREN		
Do you have children?	☐	☐
If NO: (*skip to next section)*		
If YES:		
Have you ever had your parental rights terminated for any of your children? Comments: _____	☐	☐
Are your children currently living with you?	☐	☐
If NO: Why not? _____		
If YES:		
Do you have adequate child care?	☐	☐
Are your children enrolled in and attending school?	☐	☐

Overall, how helpful have you found HARP housing?

☐ 1 - Very Unhelpful ☐ 3 - Unsure ☐ 5 - Very Helpful

☐ 2 - Somewhat Unhelpful ☐ 4 - Somewhat Helpful

Overall, how happy have you been with the services that you have received through HARP?

☐ 1 - Very unhappy ☐ 3 - Somewhat happy ☐ 5 - Not Sure

☐ 2 - Somewhat unhappy ☐ 4 - Very happy

Is there anything else you would like to share about life since entering HARP housing?

Do you have any suggestions on how HARP can better serve clients?

Thank you for your participation.

Salt Lake County Homeless Assistance Rental Program (HARP)
Survey for Former Clients

Today's Date: _____

Have you used any of the following services since leaving HARP housing?

Services/Programs:	Yes	No
Housing Authority	☐	☐
Employment Assistance (DWS)	☐	☐
Case Management Please specify agency: _____	☐	☐
12-Step programs (AA/NA/CA)	☐	☐
Substance Abuse Treatment	☐	☐
Mental Health Treatment	☐	☐
Criminal Justice Services programs	☐	☐
Other (please specify): _____		

How many times have you moved since leaving HARP housing? _____

Where have you been living most of the time since leaving HARP housing? (Check only one)

Location:	
Your apartment, room, or house	☐
Someone else's apartment, room, or house	☐
Halfway House	☐
Residential Treatment	☐
Shelter or Safe Haven	☐
Jail or Prison	☐
Homeless	☐
Other (please specify) : _____	

Approximately how many nights have you spent in a homeless shelter since leaving HARP housing?

_____

Are you currently on probation? **Yes** ☐ **No** ☐

Are you currently on parole? **Yes** ☐ **No** ☐

Please indicate your current status on the following items.

EDUCATION
☐ Not enrolled
☐ Enrolled, full-time
☐ Enrolled, part-time
EMPLOYMENT
☐ Unemployed
☐ Employed, full-time (35+ hours per week)
☐ Employed, part-time

If currently employed: *(If currently unemployed, skip to next question)*

How long have you been at your current job? _____

If currently unemployed, are you: *(If currently employed, skip to next question)*

- ☐ Unemployed, looking for work
- ☐ Unemployed, not looking for work
- ☐ Disabled
- ☐ Retired
- ☐ Student
- ☐ Homemaker
- ☐ Other (please specify) : _____

TRANSPORTATION

Which forms of transportation do you have access to? *(check all that apply)*

- ☐ Own vehicle
- ☐ Someone else's vehicle
- ☐ Public Transportation

Do you have a valid driver's license? ☐ **Yes** ☐ **No**

Have bus tokens been made available to you? ☐ **Yes** ☐ **No**

DRUG USE

Have you used any of the following controlled substances since leaving HARP?

- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Cannabis/Marijuana
- ☐ Cocaine
- ☐ Hallucinogens/Psychedelics
- ☐ Heroin
- ☐ Inhalant
- ☐ Methadone
- ☐ Methamphetamine
- ☐ Other Opiates
- ☐ Sedatives/Hypnotics/Tranquilizers
- ☐ Other (please specify) : _____

MENTAL HEALTH

Have you experienced any of the following? *(check all that apply)*

- ☐ Serious depression
- ☐ Serious anxiety or tension
- ☐ Hallucinations
- ☐ Trouble understanding, concentrating, or remembering
- ☐ Trouble controlling violent behavior
- ☐ Serious thoughts of suicide

OVERALL HEALTH

How would you rate your overall health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Please answer "yes" or "no" to the following questions based on your current situation.

	Yes	No
Do you have any chronic medical problems that continue to interfere with your life?	☐	☐
If YES, please specify: (*optional*) _____		
Do you have health insurance?	☐	☐
Do your children have health insurance? *(skip if not applicable)*	☐	☐
CHILDREN		
Do you have children?	☐	☐
If NO: (*skip to next section)*		
If YES:		
Have you ever had your parental rights terminated for any of your children? Comments: _____	☐	☐
Are your children currently living with you?	☐	☐
If NO: Why not? _____		
If YES:		
Are they enrolled in and attending school?	☐	☐
Do you have adequate child care?	☐	☐

Overall, how helpful have you found HARP housing?

☐ 1 - Very Unhelpful ☐ 3 - Somewhat Helpful

☐ 2 - Somewhat Unhelpful ☐ 4 – Very Helpful

Overall, how happy have you been with the services that you have received through HARP?

☐ 1 - Very Unhappy ☐ 3 - Somewhat Happy

☐ 2 - Somewhat Unhappy ☐ 4 - Very Happy

Is there anything else you would like to share about life since leaving HARP housing?

Do you have any suggestions on how HARP can better serve clients?

Thank you for your participation.

Appendix G Housing Assessment and Eligibility Verification Forms

Homeless Assistance Rental Program
Housing Assessment

Referral Information

Referring Agency: _____

Contact Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

Facsimile Number: _____

Jail Diversion: Previous Incarceration Y / N

If yes: When_____

Where_____

Current Status_____

Participant Information (must attach copies of identification listed below)

Head of Household Name: _____

Previous/current address: _____

_____

Telephone: _____

Date of Birth: _____ Sex: _____

Social Security Number: _____

Marital Status: _____

Veteran: ____ Yes ____ No

Verification: __ Picture ID/DL, __ Birth Certificates,
(All verification is mandatory) __ Social Security Card, __ Income Verification

Housing History

List past residence or contact information:

_____

_____

Number of prior evictions from housing when listed on the lease: _____

Reasons for prior evictions:

___ Nonpayment of rent_____

___ Person in household not on lease_____

___ Illegal activity drug related_____

___ Illegal activity non-drug related_____

___ Domestic violence

___ Property damage

___ Other (explain) _____

Has participant ever received housing assistance before?

___ Yes, when and from what agency? _____

____ No

If yes, please answer the following

Did the participant leave in good standing? ___ Yes __ No

Does participant owe money to a housing authority? ___ Yes __ No

Has participant ever been homeless? ___ Yes ___No

If yes, please complete the following:

Most recent episode:

When? _____

How long? _____

Other episodes:

When? _____

How long? _____

When? _____

How long? _____

Has participant stayed in the following?

___ shelter (name): _____

___ hotel/ motel (name): _____

___ with family

___ with friends

___ living in car

___ living on the streets

Verification of homelessness _____

Attach written certification from providers or client declaration

Income

List all sources of income

____ Employment

Employer address and contact name and number _____

_____

____ Employment $_____per month

____TANF $_____per month

____ SSI $_____per month

____ Social Security $_____per month

____ Food Stamps $_____per month

____General Assistance $_____per month

____ Disability $_____per month

____ Worker's Compensation $_____per month

____ Retirement/Pension $_____per month

____ Child Support $_____per month

____ Other (explain) _____ $_____per month

____ Other (explain) _____ $_____per month

Determination of Disability

Does the participant have a disability? ____ Yes ____ No
If yes, who has the disability? _____
What is the disability?

___ permanent
___ physical (please note type of limitation and if any accommodation is needed)
_____
___ mental
___ chemical dependency
___ other (explain):_____

Has this disability been diagnosed?

___ Yes, by whom? _____
Attach 3rd party written certification, SSDI verification or other evidence
___No, why? _____

Will participant require ongoing assistance? ___ Yes (explain nature) ___ No

_____

_____

What other services is the participant receiving? _____

_____

_____

Criminal History

Has participant been convicted of manufacturing methamphetamines? ___

Has participant been convicted of a violent crime? ___ If yes, please explain

_____

Does participant have any outstanding criminal justice issues?

___ outstanding warrants (explain) _____
___ bail violations (explain) _____
___ current convictions, awaiting sentencing
___ sentencing obligations

Are there any legal and/or personal matters which could interfere with participant taking possession and maintaining occupancy in housing? Explain any issues

_____

_____

Date received by HACSL: _____

HOUSING AUTHORITY OF THE COUNTY OF SALT LAKE

HOMELESS ASSISTANCE RENTAL PROGRAM PARTICIPANT ELIGIBILITY VERIFICATION FORM

Instructions: ***This program must serve persons who meet program regulation eligibility. The program must maintain documentation on file to prove a person's eligibility.***

All applicants must complete Sections A, B, and C.

Section A: Homeless Verification

All participants must meet one of the following homeless situations prior to entering the program. Check one and attach appropriate documentation:

☐ In places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings. *Please attach a signed and dated letter verifying collateral contacts with other agencies, a signed statement by the client, or other verifying documentation.*

☐ In an emergency shelter. *Please attach a signed and dated letter from a shelter staff person or other social service agency that can verify the shelter stay.*

☐ In transitional or supportive housing (for homeless persons who originally came from the streets or emergency shelter). *Please attach a signed and dated letter from the transitional provider verifying the current stay and the client's homeless status prior to transitional housing.*

☐ In any of the above places, but is spending a short time (up to 30 consecutive days) in a hospital or other institution. *Please attach a signed and dated letter from that institution verifying that the person has been there for less than 30 days and a letter verifying the person's homeless* status before entering that institution (e.g. an Emergency Shelter or Transitional Housing Program).

☐ Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified, and the person lacks the resources and support networks needed to obtain housing. *Please attach a signed and dated letter verifying the eviction proceedings and unsuccessful attempts to secure other housing options. Include information regarding income and lack of resources.*

☐ Is being discharged within a week from an institution in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and he/she lacks the resources and the support networks needed to obtain housing. *Please attach a signed and dated letter verifying unsuccessful attempts to secure other housing options. Include information regarding income and lack of resources, and inability to detain further.*

☐ Is fleeing a domestic violence housing situation and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. *Please attach a signed and dated letter/statement from the individual or from a staff person at an agency assisting the individual/family.*

Not Homeless. Not eligible for participation in this program.

Section B: Disability Verification

Check one and attach appropriate documentation such as a letter from a medical doctor, licensed social worker, psychiatrist/psychologist, State service agency confirming disabling condition or SSDI/SSI documentation:

- ☐ A physical, mental or emotional impairment which (i) is expected to be of long-continued and indefinite duration, (ii) substantially impedes an individual's ability to live independently, and (iii) is of such a nature that such ability could be improved by more suitable housing conditions.
- ☐ A developmental disability as defined in section 6001 of this title.
- ☐ HIV/AIDS.
- ☐ Chronic problem with alcohol and/or drugs.
- ☐ Not Disabled. Non-disabled persons are not eligible for participation in SHP Permanent Housing Programs or Shelter Plus Care Programs.

Section C: Chronic Homelessness

Please indicate if participant meets definition of chronically homeless:

- ☐ Individual with a disabling condition who has been continuously homeless on the street or in an emergency shelter for a year or more. *Please attach letters identifying the individuals stay in shelters or on the street with dates that demonstrate 12 consecutive months or more and a letter from a medical doctor, licensed social worker, psychiatrist/psychologist, State service agency confirming disabling condition or SSDI/SSI documentation.*

- ☐ Individual with a disabling condition who has had at least four episodes of homelessness in the past three years. *Please attach a written statement from participant or program staff certifying dates and locations of prior homeless stays and a letter from a medical doctor, licensed social worker, psychiatrist/psychologist, State service agency confirming disabling condition or SSDI/SSI documentation.*

- ☐ Not chronically homeless.

This form and the appropriate verification must be filed in each case record and be available for review. Please also include client income verification in each case record.

_____
Name of staff verifying homelessness

_____
Agency

_____
Date

Note: This form is to be used as a checklist and guide for program staff. It does not serve as a substitute for the required documentation that should be collected and maintained in each participant's file.

Appendix H Self-Sufficiency and Housing First Matrices

Clients' Name					Case Manager's Name (Person Interviewed)		
Domain	**1**	**2**	**3**	**4**	**5**	**Score**	**Comment**
Income	No income	Inadequate income; inappropriate spending	Adequate with subsidy, can meet basic needs	Adequate without subsidy	Sufficient - Able to save		
Employment	No job	Temp., part-time, seasonal, inadequate pay, no benefits	Full-time, inadequate pay, few or no benefits	Full-time, adequate pay with benefits	Permanent full-time, good income and benefits		
Housing	Homeless; threat of eviction	Transitional, temp or substandard housing; current rent unaffordable (over 30% of income)	In stable housing that is safe, only marginally adequate	Household is safe, adequate subsidized housing	Household is safe, adequate unsubsidized housing		Dependent vs. Independent:
Food	No food or means to prepare it; relies on other sources for free or low cost food	Household is on food stamps	Can meet basic food needs, but requires occasional assistance	Can meet basic food needs without assistance	Can choose to purchase any food the household desires		
Child Custody	Parental rights have been terminated	Child(ren) have a current out-of-home placement with DCFS	Has current DCFS referral for abuse or neglect	Has partial/full custody of children, can not provide adequate care	Has partial/full custody of children, demonstrates good parenting		
Childcare	Needs childcare, but none is available or accessible and child is not eligible	Childcare is unreliable or unaffordable, inadequate supervision	Affordable subsidized childcare available, but limited	Reliable, affordable childcare is available	Able to select quality childcare of choice		
Children's Education	One or more eligible children not enrolled in school	One or more eligible children in school, but not attending	Enrolled in school, but one or more children only occasionally attending school	Enrolled in school and attending class most of the time	All eligible children enrolled and attending school on a regular basis		
Adult Education	Literacy problems, no high school diploma/GED; serious barriers to employment	Enrolled in literacy and/or GED classes or has sufficient commands of English to where language is not a barrier to employment	Has High School Diploma/ GED	Needs additional education/training to improve employment situation and/or resolve literacy problems	Has completed education/training needed to become employable. No literacy problems		

Legal	Outstanding warrants and/or tickets	Current charges pending, non-compliance with probation/parole	Fully compliant with probation/parole terms	Successful completion of prob/parole, no new charges in past 12 mos.	No legal involvement for 12 mos. or more		
Health Care	No medical coverage with immediate need	No medical coverage and great difficulty accessing medical care. Some household members may be in poor health	Some members on CHIP/Subsidized Health Care	All members can get medical care when needed, but may strain budget	All members are covered by affordable, adequate health insurance		
Life Skills	Unable to meet basic needs such as hygiene, food and activities for daily living	Can meet a few but not all needs of daily living without assistance	Can meet most but not all daily living needs without assistance	Able to meet all basic needs of daily living without assistance	Able to provide beyond basic needs of daily living for self and family		
Mental Health	Danger to self or others, severe difficulty with day-to-day life	Recurrent M.H. symptoms, not a danger, persistent problem functioning	Mild symptoms present, but transient, moderate difficulty functioning	Minimal symptoms, slight impairment in functioning	Symptoms absent or rare, good functioning, nothing more than every day concerns		
Substance Abuse	Severe abuse, dependence at risk of institutional or hospitalization	Preoccupation with use of drugs, alcohol, withdrawal, avoidance, neglect of daily activities	Use within last 6 mos. That caused recurrent social problems	Has used in past 6 mos. But no evidence of social problems or dangerous use	No drug or alcohol use in last 6 mos.		
Family Relations	Lack of necessary support from family or friends, abuse is present, or child neglect present	Family/friends may be supportive, but lack ability or resources to help, members do not relate well to others, potential for abuse or neglect	Some support from family/friends; family acknowledge and seek to change negative behaviors; are learning communication and support	Strong support from family or friends; household members support each others efforts	Expanding support network; household is stable and communication is open and consistent		

Mobility	No access to transportation; public or private; may have car but inoperable	Transportation available but unreliable, unpredictable, unaffordable. May have car but no insurance	Transportation is available and reliable, but limited or inconvenient, driver licensed, but minimally insured	Transportation is generally accessible to meet basic travel needs	Transportation is readily avaliable and affordable; car is adequately insured		
Case Management Plan	Failing to meet requirements of plan, unaware of case manager	Meeting some requirements, failing other significant areas	Meeting more requirements, failing some less important ones	Meeting most important requirements of plan	Meeting all requirements of plan, ready to graduate		
Community Involvement	Not applicable due to crisis situation, in survival mode	Socially isolated and/or no social skills and/or lacks motivation to become involved	Lacks knowledge of ways to become involved	Some community involvement; but barriers exist such as transportation/childcare	Actively involved in the community		
Support Services & Agencies	Not able to access social services/agencies for support services	Has some, but inadequate level of supportive services with assistance	Can obtain some support services independently, in other areas needs assistance	Can obtain most services independently	Can function well with social service agencies, does not need assistance		

Client Name:_____ **Case Manager:**_____

Client No.:_____ **Program:**_____ **Date:**_____ **Agency:**_____ **Phone No.:**_____

Domain	1	2	3	4	5	Score	Comment
Rent Current	Rent never current	Behind in rent most of the time	Current in rent about half the time	Mostly current with rent	Never behind in rent		
Income Changes - Verified and Reported	Income has changed, but not reported	Comments:			Income remains as reported to Housing Authority		
Utilities on and Current	Utilities off and not current	Utilities have been shut off in past. Not current	Utilities on. Past due amounts owing	Utilities on. Minor problem with staying current	Utilities on. Never had past due balance		
House Keeping	Apt. not clean, unsanitary, unsafe	Apt. not clean, but sanitary and safe	Apt. not clean, but acceptable	Apt. clean, neat, pleasant	Apt. very clean, spotless (over-clean?)		
Case Management	Not aware of case manager or plan	Aware of case manager and plan, but no progress yet	Meets with case managers and progressing on parts of plan	Meets regularly with case manager and progressing with most of plan	Meets regularly with case manager and progressing with all of plan		
Landlord Issues	Multiple repairs needed, house unsafe	Important repairs needed, house safe	Some repairs needed	Only minor repairs needed	No repairs needed		
	Major complaints, lease violations	Many complaints, possible eviction	Some complaints, marginal	Minor complaints, no lease violations	No complaints, meeting all requirements		
Community Relationships, Legal System	Multiple complains from neighbors and visits from police. Danger of eviction or arrest	Some neighbor complaints and unresolved tenant issues	Minor or normal amount of neighbor/tenant issues	Most community relationships resolved or normal	All community relationships resolved and normal		
Housing Authority Issues	Difficulty working with HACSL paperwork, unresolved issues	Some unresolved issues reporting income, paperwork	Most issues with Housing Authority resolved	Only minor issues with Housing Authority remain	All issues with Housing Authority resolved		