Evaluation of the Chronic Homeless Services and Housing (CHSH) Project

Bi-annual Report
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COLLEGE OF SOCIAL WORK
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S.J. QUINNEY COLLEGE OF LAW

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Background and Introduction

Nationally, it is estimated that between 10-20% of all homeless individuals are chronically homeless (McCarty, 2005). The 2013 Utah Homeless Point-In-Time Count identified 495 chronically homeless persons, which comprises three percent of the total homeless population in the state (Wrathall, Day, Ferguson, Hernandez, Ainscough, Steadman, et al., 2013). Chronically homeless individuals often have a variety of needs, in addition to a lack of housing, which must also be addressed in order to improve their long-term outcomes. As part of the Point-in-Time Count/100,000 Homes Campaign, 678 homeless individuals were surveyed in Salt Lake County in January, 2013; of those, nearly half (42%) were classified as medically vulnerable, including 122 who had tri-morbid health or mental health conditions (Wrathall et al., 2013). Research has consistently found that in order to be successful, recovery must be a collaborative process, involving partners from various fields. Kraybill and Zerger (2003) found that at the service delivery level, the most 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.

In September of 2011, The Road Home received funding through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to develop, implement, and evaluate the Chronic Homeless Services and Housing (CHSH) project over the course of a three year period. The CHSH project was designed to fill existing gaps by providing resources and building relationships at the point of client contact, utilizing an interdisciplinary outreach team to deliver services, and staying close to the client at every point during the housing process. The goal of the CHSH project is to use a Housing First approach to stably house chronically homeless individuals who have been the most challenging to engage, have a history of substance abuse and/or mental illness, and who have never been housed or who have previous, unsuccessful housing placements. The Housing First model is often defined as an intervention in which housing resources are provided with no requirement or contingencies (e.g., abstinence or employment). There is a growing body of knowledge suggesting that the Housing First model may be more successful at housing homeless populations in comparison to programs that require abstinence (Tsemberis et al., 2004; Stefancic & Tsemberis, 2007).

The CHSH project is based on a Housing First philosophy implemented in the form of a modified Assertive Community Treatment (ACT) team. This interdisciplinary service delivery model is intended to provide long-term, comprehensive medical, social, and mental health support to clients with severe mental illness in order to keep them housed and in the community. ACT teams meet daily to monitor client change and provide intensive and frequent outreach to clients (Tsembris, 2010). The Road Home identified the Utah Criminal Justice Center (UCJC) as the evaluation partner of the CHSH project on the SAMHSA grant.

Study Procedures

The data collection, performance measurement, and performance assessment is comprised of two parts: (1) tracking the CHSH project's ongoing efforts to develop, expand, and implement collaborative, evidence-based services for the chronically homeless, and (2) tracking client characteristics, interventions, and outcomes.

In order to conduct the first portion of the CHSH evaluation, researchers periodically attended staff meetings, partner meetings, and committee meetings and recorded changes in services, collaborations, and polices. Evaluators reviewed program documents, including meeting minutes, policies, protocols, position descriptions, release forms, and interagency communications and recorded the creation and revision of the program structure and service delivery model.

Table 1 lists the primary data sources used in the *Program Implementation* section of this report and a brief description of the information obtained from each of these sources.

Table 1 Data Sources for Program Implementation

Program Documents
CHSH Procedures and Operations Manual, CHSH Interagency Release of Client Information, CHSH Referral Forms, and CHSH Intake Forms
Agency Records
Client Records, including Referral Forms, Intake Assessments, and Case Notes
Team Meeting Observations
Regular partner, staffing, and staff meetings
Committee and Community Meeting Observations and Minutes
Steering Committee meetings to address progress and barriers in program implementation, service delivery, and collaboration; Sustainability Subcommittee meetings to develop a long-term funding strategy for the CHSH program; Medicaid Subcommittee meetings to address barriers to Medicaid enrollment for CHSH clients

The second part of the CHSH evaluation involves the tracking of client characteristics, interventions, and outcomes in order to answer the following research questions:

1. Who does the program serve? (Profile of clients, including demographics, homelessness, criminal history, substance abuse (SA), mental health (MH), and treatment history, etc.)
2. What is CHSH providing to clients? (Profile of services utilized during CHSH participation, including housing, case management, SA/MH treatment, benefit enrollment (e.g., food stamps, general assistance) and support services)
3. Is CHSH succeeding? (Measures include: clients placed in Permanent Supportive Housing (PSH), clients remaining in PSH, employment, starting benefits, length of time on benefits, treatment completion, etc.)
4. Who has the best outcomes in CHSH? (Analysis of client characteristics by program outcomes: PSH placements and retention, benefits enrollment and retention, treatment admission and completion, etc.)
5. What program components and services lead to the best outcomes? (Appropriate bi-variate analyses will be conducted to determine relationships between program interventions and outcome measures)
6. What barriers are most prevalent when clients do not reach desired outcome? (Analysis of barrier variables by outcome)

This report will address the first three research questions listed above. In order to have the longest possible follow-up period when assessing the program's impact on clients, the last three questions will be addressed in the final report.

Table 2 lists the primary data sources and measures used in the *Client Characteristics* and *Program Activities* sections of this report. The primary purpose of the design is to yield descriptive data on CHSH participants, services received, and outcomes. Quantitative descriptive statistics include: demographics, homelessness, criminal history, substance abuse, mental health, and treatment history. To answer the third research question (research questions listed on previous page), descriptive statistics on client outcomes (percent placed in housing, clients remaining in housing, employment, benefits enrollment, length of time on benefits, treatment completion) will be provided.

While much of the information provided in this report is based on surveys completed by clients, this report also includes information from staff assessments and criminal justice records. As such, the accuracy of these measures relies somewhat upon clients' ability and willingness to recall information. The researchers also have arrangements in place to gather official records from partner agencies that will reduce the reliance on self-report data. That information will be included in the final report, wherein the fourth, fifth, and sixth research questions will be answered in through descriptive statistics. If data are sufficient, some statistical analyses, such as correlations and bi-variate tests (e.g., chi-square and t-tests) will be conducted.

Table 2 Data Sources for Client Characteristics and Services Received

Data Source	Description
The Road Home/CHSH	
CHSH Client Track case notes and records that document demographics and ongoing services provided to clients. Data include education, employment, chronic health assessment, chronic homelessness assessment, length and frequency of contact, services provided, goals set, goals kept, and barriers to reaching goals. Homelessness history at The Road Home from December, 1998. Data includes number of shelter nights. Data includes goals set with clients and barriers to implementing those goals.	
Government Performance and Results Act (GPRA) Surveys	
Self-reported data collected at Intake, 6 months, and Exit from program covering: demographics, education, employment, income, family, living conditions, drug use, alcohol use, crime and criminal justice, mental health, physical health, treatment/recovery, military service, violence/trauma, and social connectedness. This report provides Intake and 6-month GPRA results.	
Supplemental Client Interviews (SCI)	
Self-reported data collected at Intake and 6-month follow-up as part of the National Evaluation of SAMHSA's Homeless Programs. Data includes questions related to: clients' perception of the care they have received in the program; clients' desired and unmet service needs; clients' satisfaction with their housing situation; and clients' readiness for change with respect to substance abuse treatment.	
Valley Mental Health (OQ-Analyst)	
Results from the Severe Outcome Questionnaire, which is a brief measure of client progress in therapy. Data include measures of: psychological distress, relationships, social role performance, and functional impairment. The S-OQ is administered by clinical staff from Valley Mental Health, a project partner, as well as CHSH program staff.	

Data Source	Description
Salt Lake County Sheriff's Office (OMS)	
Jail bookings into the Salt Lake County Adult Detention Center for the 2 years prior to 1st CHSH contact and while receiving CHSH services are presented in this report. Data includes booking date, offense/booking type (e.g., new charge, warrant of arrest, bench warrant, hold), charge type and severity, release date and type, offender demographics, and court case numbers (when available).	
XChange/CORIS	
Text documents with court case information that is searchable by name, date of birth, court case number, court location, and/or date. Documents were used to identify cases filed in Utah District and Justice Courts during the 2 years prior to 1st CHSH contact and while receiving serviced through CHSH.	

Results

The following section of the report details grant activities for the project to date, from October 1, 2011 through February 28, 2014. This date, rather than March 31, 2014, was chosen because of the amount of time it takes for research staff and partner agencies to collect and analyze data. The *Program Implementation* section of this report will describe ongoing CHSH implementation processes, first documented in the April, 2012 Bi-annual Report. Activities include refinement of referral processes, enrollment criteria, and service delivery model and development of partnerships with collaborating agencies. Descriptions of clients and services provided by CHSH are detailed in later sections (see *Client Characteristics* on page 7 and *Program Activities* on page 20).

Program Implementation

As documented in previous reports, the CHSH project utilizes a modified Assertive Community Treatment (ACT) team approach, which has demonstrated success in improving the quality of care for homeless clients with severe mental illness (Tsembris, 2010). Central to this service delivery model is the use of multi-disciplinary teams to provide long-term, comprehensive, community-based treatment. Clients receive services in their natural environment (e.g., apartment, streets, other service provider's location). ACT teams are comprised of staff with a range of expertise, including: case managers, licensed clinicians, housing specialists, and medical providers. Implemented within the context of Housing First, the ACT team targets its activities toward those necessary to attain and maintain housing. ACT teams provide assertive outreach; assistance accessing mainstream benefits; coordinated case management; psychiatric, substance abuse, and health care services; employment and housing assistance; and other supports critical to helping individuals live successfully in the community. ACT services are intensive, with daily visits for some clients, and long-term, with the expectation that clients will continue to receive intensive services even after they are housed. ACT has been extensively researched and evaluated; leading to its consideration by the U.S. Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMSHA) as an evidence-based practice for persons with serious mental illness. The following sections detail the CHSH team's ongoing implementation of a modified ACT service delivery model within the context of a Housing First program.

Staff.

Hiring. During the current reporting period, the CHSH team hired one new Case Manager to fill a vacant position. The CHSH team continues to include an AmeriCorps volunteer, who started in the summer of 2013.

Program structure and service delivery.

Team location. There were no changes in the physical location of the CHSH team during the current reporting period.

Policies and client recruitment. There were no changes in program policies and no formal changes in client eligibility criteria during the current reporting period. At of the end of February, 2014, the CHSH program maintained an active caseload of 62 Enrolled clients (not including and additional 14 clients who completed the program and were discharged to a lower level of care and 4 clients who are deceased) and 11 Engaged clients (excluding 40 Engaged clients who were determined to be ineligible after being screened internally by the program). With current staffing levels and the intensity of CHSH services, the program is currently operating at capacity. As a result, team members are having ongoing conversations among themselves, and with partners, to prioritize those chronically homeless individuals who are best suited for the program slots; in some cases, this includes discharging Enrolled clients who have been stabilized and no longer require the intensive services provided by CHSH. As part of this process, staff continue to reserve spots for a sub-group of individuals who are eligible for the program but are currently too resistant to be fully enrolled.

Service delivery model. During the current reporting period, project staff continued to allocate resources and services based on a triage system. This triage system classifies clients according to immediate need; staffing levels are assigned based on that assessment. There is no explicit criteria, or specific number of services, associated with each triage level; however, Level One clients (29 clients) are generally seen at least twice a week, Level Two (17 clients) are seen once per week, Level Three (12 clients) are seen every other week, and Level Four (5 clients) are seen as needed. Staff determines and/or revises triage levels at the beginning of each week, based on clients' changing circumstances and an informal clinical assessment of need.

CHSH client contacts continue to average more than one staff member per contact (average is 1.3 staff per contact) and one-fifth (22%) of program contacts involve more than one staff member. Eight percent (8%) of contacts involve a representative from another social service agency, most commonly: staff from The Road Home, case managers from the housing facilities where clients live, and medical staff from Fourth Street Clinic. In addition to regular meetings with clients, program staff facilitate two weekly support groups for clients, as a means of fostering the development of positive peer interactions, social support, and problem-solving. In addition, staff host periodic social events for CHSH clients, due to clients' expressed concerns over loneliness and social isolation.

Mobile services. In accordance with the ACT model, client interactions occurred in a variety of locations (see Table 3 on the following page). As documented in case notes, more than half of the work that CHSH does with clients happens outside of the program office. For Enrolled clients during the engagement phase, close to one-third of contacts took place at other social service agencies, which fits with the project's goal of facilitating access to support and resources for service-resistant

clients. The proportion of contacts that took place in other social service agencies dropped to 16% after enrollment in the program, which might reflect clients' increased ability and/or willingness to access those services on their own. After enrollment, client contacts happen most frequently in the clients' residence, which also aligns with the project's stated goal of providing services within clients' homes.

Table 3 Location of Client Contacts

	Engaged		Enrolled	
	Discharged	*Ongoing*	*Engagement*	*Enrollment*
Number of contacts (n)	*312*	*157*	*863*	*6074*
Location (%):				
CHSH office	44	20	40	32
Other agency	25	17	32	16
Client residence	4	--	7	39
Jail/institution	5	6	5	2
Outside/street	12	39	10	5
Other	4	15	6	7

Notably, the two groups of Engaged clients (currently Engaged and Discharged) look different in terms of the location of client contacts. For the Discharged Engaged clients (who are generally discharged due to lack of eligibility), the location of the client contact resembles the Enrolled clients during their engagement period, and happens most commonly in the CHSH office or at another social service agency. This pattern suggests that both groups of clients are willing to make and keep appointments, which may serve as a proxy indicator of a willingness to accept services. In contrast, the majority (52%) of contacts with current Engaged clients (who are generally eligible for the program but unwilling to be fully enrolled) occur outside, on the street, or in other locations where staff "find" them rather than at scheduled appointments. This interpretation is supported by the fact that none of the contacts with long-term Engaged clients were identified as "client initiated," compared to 3% of the contacts for the discharged Engaged clients and 5% of contacts for Enrolled clients after enrollment (not shown in table).

CHSH meetings. Project staff continue to revise the content and timing of daily and weekly meetings in order to adequately address both planning and scheduling needs. Under the current schedule, staff participate in three regular, weekly meetings, one each on the following topics: setting client triage levels, clinical case staffing, and regular staff meeting. Additionally, full staff meetings and meetings with partner agencies continue to occur once per month.

Defining the Sample

The next two sections of this report (*Client Characteristics* and *Program Activities*) will cover the first three research questions:

1. Who does the program serve?
2. What is CHSH providing to clients?
3. Is CHSH succeeding?

In the following section, *Engaged* refers to those clients who have been referred to CHSH and whose eligibility for and/or interest in the program are under consideration. All clients who are referred

to CHSH sign a limited release of information (ROI) that allows program staff to make contact and gather information necessary to determine eligibility. Engaged clients may have ongoing contact with CHSH staff, and receive services related to recruitment and screening, but many have not signed the CHSH ROI that allows for the interdisciplinary services the CHSH program provides, which rely on information sharing and collaborative case management. All clients are considered Engaged at the point of referral; some of those clients become *Enrolled*, if and when they are receptive to, and suitable for, the program. Other Engaged clients may be referred back to the Chronic Homeless Program (CHP), because they are not eligible for CHSH, are not interested in participating, or cannot be located; these clients are considered *Discharged Engaged* clients. Enrolled clients may also be discharged, if it is determined that they do not need the intensive case management provided by CHSH or if clients have stabilized in a permanent supportive housing facility wherein supportive services are provide on-site. The length of the engagement phase varies from client to client; clients who are resistant to services may remain in the engagement phase for months. This prolonged engagement is in keeping with the ACT model, which emphasizes assertive recruitment strategies and flexible service delivery. For the remainder of the report, "Intake" refers to the date of first contact for Engaged clients and the date that the Intake GPRA form was completed for Enrolled clients. Due to revised eligibility requirements during the first part of the project, several clients have GPRA and enrollment dates that are months apart; in those cases, the enrollment date was used as the Intake date. When reviewing this section of the report, it is important that the reader keep in mind the small sample sizes being examined (see Table 4). For instance, although a finding that half of all Engaged clients have a certain characteristic is interesting, it is important to keep in mind that this only represents 25 people.

Table 4 CHSH Samples

	N
Engaged Clients[1]	51
Enrolled Clients[2]	80
Total	***131***

[1] Forty clients have been discharged from the Engaged sample without enrolling in CHSH. The total number of Engaged clients excludes those who have been referred but with whom staff had not had contact (as of 2/28/2014) and those who were referred and discharged prior to staff contact.

[2] Eighteen of the Enrolled clients had been discharged from the program as of February 28, 2014. The majority of these clients were discharged to a less intensive supportive housing program after being housed and stabilized while enrolled in the CHSH program.

Referrals to CHSH. The CHSH program has been at, or near, capacity for almost a year. As such, during the current reporting period, the program has largely focused on existing referrals rather than recruiting new participants. This is in contrast to the first year of the program, when a substantial portion of staff time was devoted to developing and refining recruitment strategies and processes and actively recruiting clients.

Client Characteristics

Demographics. Client demographics collected at Intake are shown in Table 5, on the following page, for both Engaged and Enrolled clients. The majority of clients in both groups were male (67% Engaged, 65% Enrolled) and had an average age near 50. The majority of clients in both Enrolled (75%) and Engaged (59%) groups were White. Nearly one-quarter (24%) of Engaged clients were American Indian/Alaska Natives. Approximately half of Enrolled clients (53%)

indicated that they had children; however, it is likely that a majority of these children were adults. None of the clients had custody of their children at Intake.

Table 5 Demographics at Intake[1]

	Engaged	Enrolled[2]
Total Sample (N)	*51*	*79*
Demographics		
Male (%)	67	65
Age (Mn)	49	49
Min, Max	23, 74	26, 72
Hispanic or Latino (%)	10	4
Race (%)		
White	59	75
Black/African American	10	10
Asian	4	3
American Indian/ Alaska Native	24	13
Native Hawaiian/Pacific Islander	2	3
Unknown/Missing Data	2	1
Veteran/ Served in Military (%)	6	11[3]
Percent with Children (%)	--	53
Number of children (Mn)	--	2.6
Min, Max		1, 9

[1] For Engaged clients, Intake is defined as the date of the first CHSH contact. For Enrolled clients, Intake is defined as the date on which the Intake GPRA was administered.
[2] One Enrolled client refused to answer any questions on the GPRA form and is therefore excluded from these numbers.
[3] Twenty-two Enrolled clients reported having at least one family member who had served active duty in the military, reserves, or the National Guard. Of those, 10 reported having more than one family member serve in active duty.

Homelessness and housing. Based on official shelter records, the majority of both Engaged (94%) and Enrolled (90%) clients had stayed at The Road Home's Emergency Shelter prior to program involvement (see Table 6). Between December 1, 1998 and Intake, both groups spent an average of approximately 400 nights in the shelter. As a whole, these 131 individuals accounted for a total of 50,503 shelter nights during this time period. When comparing shelter use for Enrolled clients, in the period before and after enrollment (these are non-equivalent timeframes), a smaller percentage of clients stayed at the shelter after they were enrolled, with 70% staying at the shelter for at least one night.

Table 6 Homeless Shelter Use since December 1998

	Engaged	Enrolled	
		Pre-CHSH	*CHSH*
Total Sample (N)	*51*	*80*	*80*
Percent stayed in the Shelter at least one night (%)	94	90	70
Total # of nights[1]	18525	31978	3732
Average # of nights per client (Mn)	386	444	67
Min, Max	3, 2871	1, 3117	1, 441

[1] Total count for entire sample

At Intake, almost half of Enrolled clients (48%) reported staying at an emergency shelter the previous night and one-fifth (21%) had stayed on the streets or somewhere not meant for human habitation (see Table 7 on the following page). Fewer Engaged clients reported staying at the shelter the previous night (27%), which may reflect the aforementioned resistance those clients experience with respect to building relationships and connecting with social services. More than three-quarters of clients in the Enrolled group (78%) had been continuously homeless for at least one year, compared to just over half (55%) of Engaged clients. Baseline data from the Supplemental Client Interviews (SCI), which is available for 24 Enrolled clients, confirmed the unstable nature of clients' housing situations: on average, clients had lived in three different places during the previous six months, most commonly in a homeless shelter, on the street, in a motel/hotel, or in jail (not shown in table).

Table 7 Living Situation at Intake

	Engaged	Enrolled
Total Sample (N)	*34*[1]	*77*[2]
Living Situation		
Where did you stay last night? (%)		
Emergency Shelter	27	48
Place not meant for habitation (streets, etc.)	35	21
Jail/Prison/Juvenile Detention Center	12	3
Family/Friend Residence	12	10
Other	15[3]	18[4]
Chronic Homelessness: (%)		
Continuously homeless for one year	55[5]	78
Homeless four times in three years	33	25

[1]Information on where client stayed the previous night was available for 34 of the 51 Engaged clients.
[2]Information on where client stayed the previous night was available for 77 of the 80 Enrolled clients.
[3]This includes psychiatric hospital, residential substance abuse facility, and transitional housing for homeless persons.
[4]This includes hotel/motel not paid for with emergency shelter voucher, substance abuse/residential treatment facility, psychiatric facility, and transitional housing for homeless persons.
[5]Data on chronic homelessness available for 49 of the 51 Engaged clients.

Only 3% of Enrolled clients reported living primarily in a shelter after being in the program for six months, compared to 51% at Intake (see Table 8). Almost one-fifth (18%) of Enrolled clients indicated that they were housed at Intake; however those arrangements consisted of residential treatment centers, halfway houses, and friends' and family members' homes. In contrast, in the six-month follow-up GPRA interviews, more than three-quarters (76%) of Enrolled clients reported being housed for the preceding 30 days. While this number only reflects the experience of a portion of the Enrolled sample (64 clients), it is important to note that nearly all (98%) of these housed clients were living in their own home six months after enrolling in the program.

Table 8 Living Situation at Intake and Follow-up, Enrolled Clients[1]

	Intake	6-Month Follow-up
Total Sample (N)	*79*	*64*
Living Situation		
Primary living situation during the past 30 days: (%)		
Shelter	51	3

	Intake	6-Month Follow-up
Total Sample (N)	*79*	*64*
Street/Outdoors	23	11
Institution	8	10
Housed	18	76
If housed, what type of housing: (%)		
Own/Rent apartment, room, or house	29[2]	98
Someone else's apartment, room, or house	43	2
Halfway house	7	--
Residential treatment	7	--
Other	14	--

[1] Data taken from GPRA forms. At the end of the reporting period, 64 clients had completed 6-month follow-up GPRAs. In total, 74 clients had been housed by February, 28, 2014; however, not all of those clients had completed a 6-month follow-up GPRA.
[2] Percent based on sample of 14 clients who indicated that they were housed at the time of the Intake GPRA.

Baseline and six-month follow-up data from the SCI also demonstrated post-program changes in Enrolled clients' housing circumstances. Table 9 shows that, in the six months prior to program enrollment, the majority (92%) of clients who had completed an SCI (n=24) had experienced difficulties locating suitable housing, most commonly due to problems with: the cost of housing; bad credit history; criminal history; and saving money for a rent deposit. At the six-month follow-up interview, far fewer clients (16%) reported experiencing problems finding an appropriate place to live.

Table 9 Problems Finding Housing at Intake and Follow-up

	Intake	6-Month Follow-up
Total Sample (N)	*24*	*25*
I have had problems finding a place to live (n (%))	22 (92)	4 (16)
Of those, problems were with: (n (%))[1]		
Affordability	17 (71)	4 (16)
Safe neighborhood	7 (29)	--
Rent deposit	14 (58)	4 (16)
Bad credit	12 (50)	1 (4)
Criminal record	9 (38)	1 (4)
Big enough for family	1 (4)	--
Can live with partner	5 (21)	--
Can live with children	1 (4)	--
Near transportation	4 (17)	1 (4)
Complete treatment	2 (8)	--
Clean and sober	3 (13)	--
Discrimination	1 (4)	--
Other	3 (13)	--

[1] Based on participants' ratings of problems they had finding housing at the time of the survey

Social connectedness. Less than half (44%) of Enrolled clients attended a self-help recovery group at least once in the 30 days prior to Intake (not shown in table), and approximately

half (52%) noted that they had recently interacted with family and/or friends that were supportive of their recovery (see Table 10 on the following page). At the follow-up interview, a smaller percentage of clients had recently attended a self-help group (30%, not shown in table). The percentage of clients who reported that they had no one to turn to dropped from 33% at Intake to 18% at the six-month follow-up. Likewise, the percentage who felt that they could rely on family members increased from 14% at Intake to 30% six months after starting the program. These numbers suggest that clients' social isolation is less pronounced while enrolled in the program, which is in accordance with the CHSH program's focus on enhancing clients' social support systems.

Table 10 Support Systems of Enrolled Clients at Intake and Follow-up

	Intake	6-Month Follow-Up
Total Sample (N)	*79*	*64*
During the past 30 days:		
Attended any voluntary self-help groups (e.g., AA, NA) (%)	29	18
# of times attended (Mn)	11	4
Min, Max	1, 40	1, 12
Attended any religious/faith affiliated recovery self-help groups (%)	17	10
# of times attended (Mn)	8	2
Min, Max	1, 30	1, 4
Attended any other meetings that support recovery (%)	20	11
# of times attended (Mn)	7	6
Min, Max	1, 15	1, 15
Had interaction(s) with family/friends that are supportive of recovery (%)	52	54
Person they turn to when having trouble: (%)		
No one	33	18
Family Member	14	30
Friends	13	16
Professional	21	14
Religious Entity	15[1]	14[2]

[1] Includes 3 respondents who indicated "clergy" and 9 who indicated "God" or other "higher power."
[2] Includes 2 respondents who indicated "clergy" and 7 who indicated "God" or other "higher power."

Education and employment. One-third (39%) of Enrolled clients had a high school diploma (or the equivalent) and almost one-quarter (23%) had attended some college (see Table 11). Similarly, one-third (36%) of Engaged clients had a high school diploma (or the equivalent), although fewer Engaged clients had some college (17%). Approximately one-third of clients in both groups had an education level less than a high school diploma. None of the Enrolled clients were employed at Intake and only a few (8%) indicated that they were looking for work.

Table 11 Education and Employment at Intake

	Engaged[1]	Enrolled
Total Sample (N)	*47*	*79*
Education		
Enrolled in School or Job Training Program (%)		
Full-time	0	3
Part-time	0	5
Education Level (%)		

	Engaged[1]	Enrolled
Total Sample (N)	*47*	*79*
Less than High School	38	34
High School/Equivalent	36	39
Some College	17	23
Unknown	6	5
Employment[2]		
Employed (%)	2	0
Unemployed (%)	--	100
Looking for work	26	8
Disabled	--	54
Retired	--	8
Not looking for work	--	27
Other	--	4

[1] Data on education was available for 47 of the 54 Engaged clients.
[2] Employment status and whether looking for work were the only employment measures available for Engaged clients

Monthly income. On the GPRA forms, Enrolled clients reported an average monthly income of $522 at Intake and $611 at the six-month follow-up (see Table 12). By far the largest source of monthly income, at both time periods, came in the form of disability and retirement payments. Although not necessarily representing the largest amounts, public assistance and disability payments were the most common sources of income for clients at Intake and at the six-month follow-up.

Table 12 Income at Intake and Follow-up, Enrolled Clients

	Intake		6-Month Follow-up	
Total Sample (N)	*78*[1]		*64*	
	%	Mn[2]	%	Mn[2]
Monthly Income				
Wages	3	$44	5	$241
Public assistance	50	$247	56	$312
Retirement	3	$685	6	$625
Disability[3]	37	$716	36	$729
Non-legal income	3	$53	2	$40
Family and/or friends	1	$20	2	$20
Other	9	$52	9	$185
Any Income	**79**	**$522**	**83**	**$611**

[1] Income data for two clients was missing.
[1] Of those clients who reported an income, the average amount.
[2] One individual received $15,000 in Disability back payments during the 30 days prior to completing the Intake GPRA. To avoid inflating the average, this figure was replaced with the mode Disability payment ($698) in these calculations.

Intake forms completed at The Road Home provided a similar profile of Enrolled clients, the majority of whom (84%) reported at least one source of income, most frequently in the form of food stamps or disability payments (Table 13 on the following page). When compared to Enrolled clients, fewer Engaged clients reported any income at Intake (56%). These numbers do not account

for one-third of the Engaged sample (15 Engaged clients did not have income information in agency records) and may not be an accurate reflection of the economic status of the sample as a whole.

Table 13 Income at Intake

	Engaged[1]		Enrolled[2]	
Total Sample (N)	*36*		*77*	
	%	Mn[3]	%	Mn[3]
Monthly Income				
SSA Retirement	0	--	3	$785
SSI/SSDI[4]	17	$761	39	$734
General Assistance	11	$284	18	$272
SNAP[5]	50	$134	62	$151
Other[6]	8	$1018	3	$128
Any Income	**56**	**$558**	**84**	**$537**

[1] Income data was available for 36 of the 51 engaged clients.
[2] Income data was available for 77 of the 80 Enrolled clients.
[3] Of those clients who report an income, the average amount.
[4] One individual received $15,000 in Disability back payments prior to Intake. To avoid inflating the average, this figure was replaced with the mode Disability payment ($698) in these calculations.
[5] One individual received $1,700 in SNAP back payments prior to Intake. To avoid inflating the average, this figure was replaced with the mode SNAP payment ($200) in these calculations.
[6] Three Engaged clients reported "Other" Income; of those, one received $1764/month in tribal funds, one received $650/month from family, and one received $640/month from earned income. Two Enrolled clients reported "Other" Income; of those, one received $200/month from "panhandling" and one received $28/month from earned income.

Health. The following sections report on clients' physical and mental health, including their substance use, history of victimization, and use of medical services.

Physical health. Nearly three-quarters (71%) of Enrolled clients rated their overall health as "fair" or "poor" at Intake (see Table 14), compared to 53% at six-month follow-up. The high percent reporting poor health on the GPRA forms mirrors information reported in the CHSH Intake forms, where 75% of Enrolled clients were identified as having at least one chronic health condition (excluding mental health diagnoses) and 14% had a physical disability (not shown in table). When looking at Engaged clients, more than half (59%) were also identified as having at least one chronic health condition at Intake (excluding mental health diagnoses) and 8% had a physical disability. Thirty-five Engaged clients were asked to rate their own health during Intake; of those, 57% rated their health as "fair" or "poor" (not in table).

Table 14 Physical Health at Intake and Follow-up, Enrolled Clients

	Intake	6-Month Follow-Up
Total Sample (N)	*78*	*62*
Overall health rating (%)[1]		
Excellent	10	11
Very Good	6	11
Good	13	24
Fair	39	26

Poor	32	27

[1] Based on participants' ratings of how they would rate their overall health at the time of the survey

Mental health. At Intake, Enrolled clients were asked whether they had experienced a variety of psychological/emotional problems during the previous 30 days (see Table 15). The majority (81%) of clients indicated that they had experienced some psychological or emotional problems in the past month; of those, almost one-half (48%) described themselves as extremely or considerably bothered by those problems (not shown in table). The most frequently reported problems were: serious depression; serious anxiety or tension; and trouble understanding, concentrating, or remembering. For clients who reported psychological or emotional problems, symptoms were prevalent for more than half of the previous 30 days, on average. Six months after enrolling in the program, the majority (81%) of clients reported experiencing psychological or emotional problems during the previous 30 days; of those, 35% described themselves as extremely or considerably bothered by those problems (not shown in table).

Table 15 Mental Health at Intake and Follow-up, Enrolled Clients

	Intake		6-Month Follow-up	
Psychological/Emotional problems experienced in past 30 days:				
Total Sample (N)	*78*		*63*	
	n (%)	Mn[1]	n (%)	Mn[1]
Serious depression	48 (62)	15	38 (60)	18
Serious anxiety or tension	53 (68)	18	40 (63)	16
Hallucinations	13 (15)	18	10 (16)	16
Trouble understanding, concentrating, or remembering	45 (59)	22	38 (60)	17
Trouble controlling violent behavior	9 (12)	8	5 (8)	11
Attempted suicide	1 (1)	--	3 (5)	14
Been prescribed medication for psychological/emotional problem	32 (41)	25	24 (38)	24

[1] Of those reporting problem, average number of days they experienced it during the past 30 days

Clients were also assessed for mental health history on The Road Home Intake form and 75% of Enrolled clients were identified as having a mental illness (not shown in table). Of those, almost half (47%) were receiving services for the condition at the time of the assessment. Only 8% of Enrolled clients were identified as having a developmental disability and only one client was receiving services for the condition. The seriousness of clients' mental health concerns was evident in the Supplemental Client Interview (SCI; n=24), where almost three-fourths (71%) of clients reported being diagnosed with, or treated for, schizophrenia, major depression, or bipolar disorder at some point in their lives. Half of clients who completed the SCI had been diagnosed with, or treated for, anxiety, phobia, or obsessive compulsive disorder. More than one-third (38%) had been diagnosed, or treated for, post-traumatic stress disorder (PTSD) and one-quarter (25%) for attention deficit hyperactivity disorder (ADHD), conduct disorder, or a personality disorder.

Of the 49 Engaged clients for whom Intake data was available, more than half (53%) were identified as having a mental illness; of those, 46% were receiving services at the time of the assessment. Ten percent (10%) of Engaged clients were identified as having a developmental disability and none were receiving services for the condition.

Alcohol and drug use. Self-reported data collected at Intake suggests that a substantial portion of Enrolled and Engaged clients with substance abuse concerns have chronic problems for which they are not receiving treatment. On The Road Home Intake form, more than half (53%) of Enrolled clients were identified as having a history of substance abuse (30% with alcohol abuse, 25% with drug abuse, and 13% with both drug and alcohol abuse). In terms of ongoing alcohol use, the GPRA results demonstrated that 44% of Enrolled clients reported any alcohol use in the month prior to Intake and a similar proportion (46%) reported use in the month prior to Follow-up (see Table 16). Compared to alcohol use, a smaller percentage of Enrolled clients reported recent drug use at Intake (20%) and Follow-up (17%). At Intake, seven Enrolled clients were receiving treatment for drug abuse and only one was receiving treatment for alcohol abuse (not shown in table).

Table 16 Alcohol and Drug Use at Intake and Follow-up, Enrolled Clients

	Intake	6-month Follow-up
Total Sample (N)	*79*	*63*
During the past 30 days, have you used:		
Any alcohol (%)	44	46
Number of times (Mn)	8	11
Alcohol to intoxication (5+ drinks in one sitting) (%)	25	25
Number of times (Mn)	8	11
Alcohol to intoxication (4 or fewer drinks in one sitting, felt high) (%)	13	10
Number of times (Mn)	5	13
Both alcohol and drugs (on the same day) (%)	11	6
Number of times (Mn)	5	13
Any Illegal drugs (%)	20	17
Number of times (Mn)	14	11
Injected drugs during the past 30 days (%)	4	3

Based on self-reported data from The Road Home Intake form, over half (57%) of Engaged clients reported a history of substance abuse (22% with alcohol abuse, 25% with drug abuse, and 14% with both drug and alcohol abuse). At intake, three Engaged clients were receiving services for drug abuse and three were receiving services for alcohol abuse.

Table 17 indicates that more clients reported extreme or considerable stress due to alcohol or drug use at Intake (29%) than at their six-month follow-up (18%). A similar percent of clients reported that their alcohol or drug use had caused them to give up important activities or have emotional problems at both Intake and Follow-up.

Table 17 Emotional Impact of Alcohol and Drug Use at Intake and Follow-Up, Enrolled Clients[1]

	Not at All	Somewhat	Considerably	Extremely
During the past 30 days: (%)				
How stressful have things been for you because of your use of alcohol or other drugs?				
At Intake	50	21	10	19
At 6-Month Follow-Up	67	15	--	18
Has your use of alcohol or drugs caused you to reduce or give up important activities?				
At Intake	72	15	5	8
At 6-Month Follow-up	76	9	6	9

	Not at All	Somewhat	Considerably	Extremely
Has your use of alcohol or other drugs caused you to have emotional problems?				
At Intake	59	22	10	10
At 6-Month Follow-up	72	9	9	9

[1] Only for those clients reporting alcohol and/or drug use during the previous 30 days (n=42 at Intake, n=33 at Follow-up)

On the SCI, Enrolled clients who reported a 6-month history of alcohol or drug use were asked a series of questions designed to assess their readiness for change in terms of substance use. For each statement, respondents were asked to rate their agreement on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). A mean score of 3, for example, would indicate that on average, clients neither agreed nor disagreed with the statement. Table 18 details clients' self-assessments for all of the readiness for change statements (for alcohol use only, n=11).

Table 18 Readiness for Change, for Clients with 6-month History of Alcohol Use

	Intake
Total Sample (N)	*24*
Have you drank any alcohol in the past 6 months? (%)	46
Of those, agreement with the following statement: (Mn)[1]	
I don't think I drink too much.	4.2
I am trying to drink less than I used to.	3.5
I enjoy drinking but sometimes I drink too much.	3.0
Sometimes I think I should cut down on drinking.	2.9
It's a waste of time thinking about my drinking.	3.7
I have recently changed my drinking habits.	3.6
Anyone can talk about wanting to do something about drinking,	4.0
I am at the stage where I should think about drinking less alcohol.	3.4
My drinking is a problem sometimes.	2.5
There is no need for me to think about changing my drinking.	2.8
I am actually changing my drinking habits right now.	3.5
Drinking less alcohol would be pointless for me.	2.5

[1]Only for respondents who indicated they had used alcohol within the past 6 months

The results suggest some ambivalence in terms of clients' readiness for change with respect to alcohol use. For example, the only statement that received a mean score of more than four (representing strong agreement) was "I don't think I drink too much." Similarly, the mean score for the statement "My drinking is a problem sometimes" was 2.5, indicating some level of disagreement. In combination, these ratings suggest that clients do not perceive a need to change their behavior with respect to alcohol use. In contrast, the statement "Anyone can talk about wanting to do something about drinking, but I am actually doing something" received a mean score of 4, which would suggest that clients are engaging in a conscious process to change their behavior with respect to alcohol use. Respondents were asked the same questions regarding drug use; however, for those questions (and for the 6-month follow-up questions for both alcohol and drug use) the sample size was less than ten so the results are not reported here.

***History and impact of violent victimization*.** At Intake, 66 Enrolled clients were assessed for a history of violence or trauma.[1] Of those, 68% reported experiencing violence or trauma at

[1] This question was added to the GPRA form after the CHSH program started.

some point in their life. Of those, the majority reported experiencing ongoing symptoms from the trauma: 77% experienced nightmares, 81% reported intrusive thoughts, 82% expressed being constantly on guard, and 68% reported feeling numb and detached. On the six-month follow-up GPRA, more than half of clients 60% (n=37) reported a history of violence, of which 65% had nightmares, 72% experienced intrusive thoughts, 73% were on constant guard, and 68% felt numb and detached. With respect to recent victimization, 23% of clients (n=15) reported being the victim of at least one violent attack in the 30 days prior to Intake, and 10% (n=6) reported experiencing such violence at least once in the month prior to their follow-up GPRA.

Use of medical services. In general, a larger proportion of clients received inpatient, outpatient, and emergency room treatment during the month prior to Intake than during the month prior to the Follow-up interview (see Table 19). While a smaller percentage of clients used emergency medical services in the days prior to the Follow-up interview, the average number of emergency room visits remained the same at both points in time (Mn=2).

Table 19 Medical Treatment at Intake and Follow-up, Enrolled Clients

	Intake		6-month Follow-up	
Total Sample (N)	*78*		*63*	
	n (%)	Mn[1]	n (%)	Mn[1]
Inpatient Treatment				
For any reason	17 (22)	8	11 (17)	14
Physical complaint	9 (11)	3	7 (11)	18
Mental or emotional difficulties	4 (5)	13	2 (3)	4
Alcohol or substance abuse	5 (6)	13	4 (6)	6
Outpatient Treatment				
For any reason	36 (46)	6	22 (35)	5
Physical complaint	25 (32)	3	10 (16)	2
Mental or emotional difficulties	21 (27)	4	17 (27)	3
Alcohol or substance abuse	5 (6)	12	4 (6)	9
Emergency Room (ER) Treatment				
For any reason	18 (23)	2	12 (19)	2
Physical complaint	13 (17)	2	9 (14)	1
Mental or emotional difficulties	5 (6)	1	2 (3)	3
Alcohol or substance abuse	2 (3)	2	2 (3)	1

[1] Of those reporting treatment, average number of nights spent in inpatient treatment and number of times received outpatient or ER treatment.

Criminal Justice Involvement. One measure of criminal justice involvement was provided through self-reported data collected from Enrolled clients during the GPRA interviews. These numbers document clients' criminal justice involvement with reference to the 30 days prior to their Intake and six-month follow-up interviews (see Table 20 on the following page). According to this data, 12% of Enrolled clients reported being arrested during the month prior to Intake and 11% reported being arrested in the month prior to Follow-up. One-third (27%) of clients admitted that they committed a crime during the month prior to Intake (compared to 19% at Follow-up), and many reported committing multiple crimes (Intake, Mn=11; 6-month follow-up, Mn=13).

Table 20 Self-Reported Criminal Justice Involvement at Intake and Follow-up, Enrolled Clients

	Intake	6-month Follow-up
Total Sample (N)	78	63
During the past 30 days:		
Arrested for any reason (%)	12	11
# times arrested (Mn)	1	1
Spent at least one night in jail or prison (%)	13	14
# nights spent in jail or prison (Mn)	10	10
Arrested for drug-related offense(s) (%)	1	--
# times arrested for drug-related offenses (Mn)	--	--
Committed a crime (%)	27	19
# times committed a crime (Mn)	11	13
Currently awaiting charges, trial, or sentencing (%)	17	18
Currently on parole or probation (%)	7	5

Jail Bookings. In addition to self-reported criminal involvement data, jail (Salt Lake County Adult Detention Center) and court (Utah District and Justice Courts) records were examined for the two years prior to Intake and post-referral[2] for both Engaged and Enrolled clients (see Table 21). Slightly less than half of Engaged (49%) and Enrolled (46%) clients were booked into the jail on a new charge at least once during the two years prior to their referral and over half were booked into the jail on a warrant (59% Engaged, 51% Enrolled). Thirty-nine percent (39%) of Engaged clients and 28% of Enrolled clients were booked into the jail on a commitment during the two years prior. When combined, the two groups accounted for 325 jail bookings and 6,654 nights spent in jail during this two-year period (not shown in table).

The most common charge types among both Engaged and Enrolled clients were for public order, property, and drug offenses. On average, the most severe charge that clients incurred were class "A" misdemeanors, regardless of the group (i.e., Engaged, Enrolled) or time period (2 years prior to or post-referral). Since their referral to the program, nearly half (43%) of Engaged clients and 20% of Enrolled clients have been booked into the jail on a new charge at least once. When comparing pre- and post- jail booking data it is important to keep in mind that the two time periods are nonequivalent and post follow-up periods vary greatly, from only 26 days to 708 days.

Table 21 Criminal Involvement—Jail Bookings Prior to and After Referral[1]

	Engaged		Enrolled	
Total Sample (N)	*51*		*80*	
	2 Yr Pre[2]	Post[3]	2 Yr Pre[2]	Post[3]
Jail Booking(s) for (%):				
Any reason	61	47	58	23
New charge(s)	49	43	46	20
Warrant(s)	59	41	51	19
Commitment(s)	39	33	28	13

[2] Referral - the first contact date for Engaged clients and the GPRA Intake date for Enrolled clients

	Engaged		Enrolled	
Total Sample (N)	*51*		*80*	
	2 Yr Pre[2]	Post[3]	2 Yr Pre[2]	Post[3]
Of those with any booking(s):				
Total number of bookings[4] (sum)	135	87	190	63
Average number of bookings (Mn (SD))	4 (4)	4 (3)	4 (4)	4 (3)
Total nights spent in jail[4] (sum)	3277	1336	3377	1186
Average total nights spent in jail (Mn (SD))	106 (117)	56 (55)	73 (95)	66 (85)
Of those with new charge(s):				
Most Severe Charge (Mn)[5]	MA	MA	MA	MA
Charge Type (n (%)):				
Person	7 (28)	6 (27)	10 (27)	4 (25)
Property	14 (56)	9 (41)	22 (59)	6 (38)
Drug	9 (36)	9 (41)	8 (22)	6 (38)
Public Order	16 (64)	8 (36)	19 (51)	11 (69)
Obstruct Law Enforcement	5 (20)	3 (12)	9 (24)	3 (19)
Number of days in follow-up period				
Mn (SD))	--	496 (186)	--	493 (187)
Min, Max	--	95, 708	--	26, 708

[1] Bookings into the Salt Lake County Jail through 12/31/13
[2] Referral - the first contact date for Engaged clients and the GPRA Intake date for Enrolled clients
[3] Follow-up period varies depending on program referral date
[4] Total count for entire sample
[5] Mn (SD): Engaged-Pre 3.2 (1.7); Engaged Post 3.4 (1.8); Enrolled Pre 2.8 (1.2); Enrolled Post 3.3 (1.4)

Court Cases. A majority of Engaged (82%) and two-thirds (68%) of Enrolled clients had at least one court cases filed in the State of Utah during the two years prior to their referral to the CHSH program (see Table 22). Enrolled clients had an average of 12 court cases filed during this time period (Engaged, Mn=15) and nearly all of these cases were filed in Justice Court (Engaged, 94% of cases; Enrolled, 92%). Combined, the two groups had 1,438 cases filed during the previous two years (not shown in table). Far fewer Enrolled clients had any cases filed since their referral to the CHSH program (48%, compared to 73% of Engaged clients). Not surprisingly, most cases filed during the two time periods were for low-level offenses (i.e., misdemeanors and infractions). As previously mentioned, it is important to keep in mind that the pre- and post- time periods are nonequivalent when making comparisons and that follow-up periods range from 59 days to 791 days. Although measuring court involvement slightly differently, these official figures are much higher than the percent of clients self-reporting that they were awaiting charges, trial, or sentencing at Intake (17%) or six-month follow-up (18%), see Table 20 on page 18).

Table 22 Criminal Involvement – Court Cases Prior to and After Referral[1]

	Engaged		Enrolled	
Total Sample (N)	*51*		*80*	
Court Cases filed in District or Justice Court	2 Yr Pre	Post[2]	2 Yr Pre	Post[2]
Percent with court case(s) filed (%)	82	73	68	48
Of those with case(s) filed:				
Total # of cases – for entire sample (sum)	633	510	805	260
Min, Max	1, 60	1, 79	1, 67	1, 35

	Engaged		Enrolled	
Total Sample (N)	*51*		*80*	
Average number of cases (Mn (SD))	15 (17)	13 (20)	12 (14)	7 (8)
Jurisdiction (%)				
Justice Court	94	92	92	90
District Court	6	8	8	10
Case Level (n (%))				
Felony	17 (3)	26 (5)	20 (3)	17 (7)
Misdemeanor	425 (67)	315 (62)	501 (62)	166 (64)
Financial[3]	11 (2)	11 (2)	21 (3)	7 (3)
Infraction	151 (24)	154 (30)	222 (28)	63 (24)
Other[4]	29 (5)	4 (1)	41 (5)	7 (3)
Number of days in follow-up period				
Mn (SD))	--	643 (171)	--	576 (224)
Min, Max	--	81, 791	--	59, 780

[1] Court cases filed through 2/28/2014
[2] Follow-up period varies depending on program referral date
[3] Financial includes: Child Support Lien, Debt Collection, Hospital Liens, Abstract of Judgment - Financial, Tax Liens, and Small Claims/Park TP cases
[4] Other includes Traffic Court, Protective Order, Eviction, and Traffic Citation cases

Based on the information reported in this section, it appears that a significant number of clients in both the Engaged and Enrolled groups are heavily involved in the criminal justice system, although most commonly for non-violent low-level offenses. Even though these individuals appear to be of low risk to public safety, the high incidence of jail bookings and court case filings associated with this small group of individuals represents a substantial cost to the criminal justice system.

Program Activities

All work with clients was documented in The Road Home's data management system (Client Track). The following analysis of program activities and services is based on data extracted from that system.

Frequency and intensity of client services. On average, Enrolled clients were in the engagement period for 64 days (see Table 23 on the following page); however, this varied greatly, ranging from 0 to 375 days (6 clients were enrolled immediately and had no days in the Engagement period). Engaged clients were in the engagement period for substantially longer (Mn=199 days, ranging from 0 to 757 days). When looking at clients by discharge status, the currently Enrolled clients (n=62) averaged 71 days (SD=83) in the engagement period and 446 days (SD=222) in the enrollment period. In comparison, the currently Engaged clients averaged 427 days (SD=240) in the engagement phase, which is nearly as many days in engagement as the Enrolled clients were in the enrollment phase. These numbers suggest that the engagement period functions as a *de facto* form of program enrollment for a subset of eligible, but service-resistant, clients.

Clients received services in both the engagement and enrollment periods. On average, Engaged clients received CHSH services every 22 days and Enrolled clients every four days. CHSH services are designed to be in-depth, both in terms of frequency and intensity, as indicated by the fact that, on average, Enrolled clients received services almost two times per week. When looking only at

case management and counseling services, client interactions averaged almost one hour (Mn=49 minutes, not shown in table). At the time of this report, staff had recorded over 7,584 hours of case management and counseling contacts with Enrolled clients and an additional 793 hours with those clients during their engagement period. Analysis of CHSH records demonstrate how intensive services are, even for clients who are not officially enrolled in the program. Since the inception of the CHSH program, staff have spent the equivalent of 456 hours (or 27,340 minutes) providing case management or counseling to Engaged clients who have never been officially enrolled in the program. On average, individual case management and counseling contacts with Engaged clients lasted for more than 40 minutes.

Table 23 Client Contact with CHSH Program Staff

	Engaged	Enrolled
	Mn (SD)	Mn (SD)
Number of days		
in Engagement period	199 (194)	64 (78)
in Enrollment period	--	424 (213)
Number of Services		
during Engagement period	16 (17)	15 (19)
during Enrollment period	--	145 (116)
Average Minutes of Contact per Client[1]		
during Engagement period	558 (649)	642 (831)
during Enrollment period	--	5688 (4077)
Days between Services		
during Engagement period	22[2] (28)	7 (9)
during Enrollment period	--	4 (3)

[1]Minutes reflects time spent providing case management and treatment services. Time spent on other activities was not consistently recorded in the data.
[2]This excludes one client who was in engagement for 399 days with only one service contact.

In total, CHSH clients (including Engaged and Enrolled) received 13,463 discrete services during their involvement with the program. This represents 793 services for Engaged clients; 1,101 services during engagement for Enrolled clients; and 11,569 services during enrollment. When looking at clients by discharge status, the currently Engaged clients (n=10) averaged 31 services during the engagement period, compared to an average of 16 services per client for the Engaged group as a whole and an average of 15 services per client for the Enrolled group during the engagement period. This numbers provide further support the finding that the engagement period is functioning as a form of enrollment for a sub-set of service-resistant clients.

Type of service. Clients' receipt of services, by type, is presented in Table 24. The term "Concrete services" refers to instrumental forms of support, such as: transportation, bus tokens, clothing vouchers, food boxes, and fees associated with obtaining identification documents. Housing services refer to both support services—such as searching for a housing unit or intervening with a landlord on behalf of a client—and tangible services, such as rental deposits and utility payments. Case management includes eligibility assessments, street outreach, and any other activity recorded by staff as case management.

In terms of the type of service received, the engagement phase appears similar for both Engaged and Enrolled clients, with the following exceptions: street outreach comprised a bigger proportion

of the services provided to currently Engaged clients (9% vs 1% Enrolled clients, not shown in table). This likely reflects the fact that these clients are unwilling to seek out services and contacts are being initiated by staff. Enrolled clients received more services devoted to mental health counseling, housing, and concrete services after enrollment, than they did during their engagement period. The comparatively larger amount of concrete services provided after engagement reflects the goals and objectives of the CHSH program, which seek to provide clients with long-term support that will facilitate and maintain clients in housing.

Table 24 Service Type by Client Enrollment

	Engaged		Enrolled	
Total Sample (N)	*40*	*10*	*74*	*80*
	Discharged	Ongoing	Engage	Enroll
Type of Service Provided: (n (%))				
Case management	400 (83)	252 (81)	859 (78)	7894 (68)
Concrete services	48 (10)	28 (9)	110 (10)	1882 (16)
Counseling	32 (7)	26 (8)	104 (9)	1457 (13)
Housing	1 (0)	1 (0)	19 (1)	266 (2)
Substance abuse	1 (0)	4 (1)	9 (1)	70 (1)
TOTAL	**482**	**311**	**1101**	**11569**

Case notes. In addition to services provided, a detailed description of staff interactions with clients, including clients' needs, state of mind, progress, and barriers, is available within Client Track in the form of case notes. In order to analyze this information, the research staff coded notes into the following primary program activities, which correspond to the grant objectives: administrative activities, advocacy, basic needs, benefits, case management, criminal justice, engagement, housing, medical, mental health, outreach, and substance abuse. Table 25 details the qualitative codes used to analyze more than 7,400 case notes created since the inception of the CHSH program.

Table 25 Case Note Codes

Program Activity and Description
Administrative Activities
Activities related to managing and documenting program activities, including: administering assessment forms, documenting discharges, and terminations
Advocacy
Setting up appointments or arranging services for client with other agencies, attending and/or transporting clients to appointments, and any efforts with another agency on behalf of the client
Basic Needs
Activities required to meet basic needs, such as the provision of food or clothing
Benefits
Any activities related to obtaining mainstream benefits, including establishing eligibility, arranging for assessments, obtaining documents, setting up appointments, filing appeals, and providing training in managing benefits
Case Management

Program Activity and Description
General program activities including phone contacts, residence visits, weekly check-ins, and appointment scheduling and reminders. Finally, includes activities that do not fit into the other categories.
Criminal Justice
Activities related to clients' encounters with the criminal justice system, including: visiting clients in jail, facilitating community service hours, and advocating for clients with Adult Probation and Parole (AP&P).
Engagement
Assertive outreach, introducing clients to the program, building relationships, assessing clients' eligibility, administering GPRA forms, or other activities related to enrollment
Housing
Activities related to housing, including discussion of options, engagement in the application process, lease signing, moving-in assistance, obtaining furnishings, advocacy with landlords and housing case managers, and ongoing housing maintenance needs
Mental Health
Activities related to mental health needs, including assessment, therapy, prescriptions for medications, crisis support, and referrals
Outreach
Formal and informal attempts to locate clients, including unsuccessful efforts to locate clients
Substance Abuse
Activities related to substance abuse needs, including assessment, therapy, and referral to Detox

Table 26 provides an overview of the content of staff interactions with clients, as documented in case notes. Contacts are broken out according to type, including those services that occupy staff time, but during which the client is not present or receiving a direct benefit (e.g., writing case notes, trying to get a hold of a client). Because multiple topics are often addressed in a single contact, these percentages do not sum to 100.

Table 26 Total Client Contacts

Total Case Notes = 7,411	
Topic Addressed	% of Case Notes
Advocacy	22
Basic Needs	18
Benefits	14
Case Management[1]	49
Criminal Justice	5
Engagement	6
Medical	14
Mental Health	18
Housing	15
Substance Abuse	6

Total Case Notes = 7,411	
Topic Addressed	% of Case Notes

[1]Case management includes activities related to administrative duties (12% of case management activities) and outreach (17% of case management activities)

When compared to services provided, the case notes give additional detail on the nature of client interactions with staff. For instance, mental health issues are addressed during both formal therapy sessions and also in the course of routine interactions between clients and staff. Of the 18% of case notes that were coded as having a mental health component, program activities included: medication management; crisis intervention; working to develop trust and build a therapeutic alliance; motivational interviewing; and unplanned, brief interventions to help clients cope with stressors, some of which originated with program activities such as moving or applying for benefits. Substance abuse treatment comprised less than 1% of services received by clients; however, substance abuse was addressed in 6% of client interactions. Often, these interactions consisted of helping clients who were resistance to substance use treatment manage the symptoms of substance use (and even arranging admission into detoxification programs).

Similarly, formal housing services comprised one percent (1%) of the total services provided to clients, but housing-related issues were evident in 15% of client contacts. Activities coded as housing included: helping clients acquire necessary household items such as cleaning supplies or furniture; helping clients prepare for an inspection; and facilitating general maintenance needs, including communicating repair needs to the appropriate entity and preparing the client to have an unfamiliar person in their homes to make repairs. CHSH staff assisted client with making rent payments, resolving overdue bills, and completing paperwork required to maintain housing. Additionally, staff provided ongoing support in the form of helping clients find new apartments—if their unit became unsuitable or they were evicted—find permanent housing options—if the unit was temporary—and applying for new vouchers that allowed for more flexibility in the terms of the lease (such as adding another person to their lease). Staff also assisted in any subsequent moves the client required and in vacating an apartment if the client left unexpectedly.

Table 27 (on the following page) shows the content of case notes by enrollment status. After enrollment, the majority of staff time was spent on issues related to advocacy, basic needs, case management, and mental health services; for each of these categories, Enrolled clients averaged more than 15 contacts each. Of note, staff continued to conduct outreach activities with clients even after they were enrolled in the program. In fact, clients had an average of seven outreach contacts after enrollment. This figure suggests that assertive outreach, initiated by staff, remains a central component of maintaining client stability even after engagement.

For long-term Engaged clients, staff averaged ten outreach and seven engagement contacts per client, which is in line with the perception that this is a resistant group that is not seeking services of their own accord. Further support of this interpretation is evident in the fact that none of the contacts with the long-term Engaged clients were initiated by the client, compared to 5% of enrollment contacts and 3% of engagement contacts for Enrolled clients (not shown in table).

Table 27 CHSH Contacts, Engaged and Enrolled Clients

	Engaged		Enrolled	
Total Sample (N)	*49*		*80*	
	39	*10*		
Type of Service Provided	Discharged	Ongoing	Engage	Enroll
Percent of clients who have received service: (%)				
Administrative	64	70	50	85
Advocacy	51	70	66	88
Basic needs	41	40	59	93
Benefits assistance	51	40	80	90
Case management	26	60	44	100
Criminal justice	13	40	15	50
Engagement	90	100	81	25
Housing	22	20	40	95
Medical	41	40	40	80
Mental health	38	70	49	84
Outreach	41	50	33	81
Substance abuse	23	10	19	58
Average number of services provided: (Mn (SD))				
Administrative	2 (1)	2 (2)	2 (2)	4 (4)
Advocacy	3 (2)	3 (2)	4 (5)	19 (21)
Basic Needs	3 (2)	6 (4)	3 (2)	16 (15)
Benefits	2 (2)	2 (1)	4 (3)	10 (10)
Case management	4 (4)	5 (3)	5 (7)	29 (25)
Criminal justice	2 (1)	2 (1)	4 (3)	6 (7)
Engagement	3 (3)	7 (6)	4 (5)	--
Housing	2 (1)	2 (1)	3 (3)	13 (9)
Medical	3 (2)	3 (1)	3 (4)	11 (10)
Mental Health	3 (2)	5 (5)	4 (3)	17 (19)
Outreach	2 (2)	10 (8)	3 (3)	7 (7)
Substance Abuse	2 (1)	--	2 (2)	8 (10)

The case notes indicated that a majority (84%) of Enrolled clients received mental health services and approximately half (58%) received substance abuse services from the CHSH program (not shown in table). The substance abuse clinician on staff was involved in 42% of the contacts wherein substance abuse was addressed, while the mental health clinician was involved in 33% of the contacts wherein mental health issues were addressed. In addition to the full-time clinicians on staff, specialized interventions (e.g., medication management and psychological testing) are provided by two part-time team members, a clinical psychologist and a nurse practitioner. The nurse practitioner was involved in 9% of all contacts, 20% of substance abuse contacts, and 30% of mental health contacts. The nurse practitioner worked with 76% of Enrolled clients, averaging nine contacts per client (ranging from 1 to 39 services per client, not shown in table). The clinical

psychologist worked with 50% of Enrolled clients and averaged five contacts per client (ranging from 1 to 30 contacts per client, not shown in table).[3]
Engaged clients also received services from the clinical psychologist (21%, with an average of two contacts per client) and the nurse practitioner (29%, with an average of four contacts per client).

Standard Outcome Questionnaire (S-OQ). Because of its widespread use among local treatment providers working with clients who are experiencing both homelessness and mental illness, the CHSH team chose the S-OQ 2.0 as an outcome measure to assess clients' symptomatic distress and progress on mental health goals. The S-OQ is one variation of the Outcome Questionniarre-45 (OQ-45), which is a clinical decision tool that provides clinicians with feedback if a patient is not having the expected reaction to therapy and is therefore at risk of treatment failure (e.g., dropping out of treatment) (Lutz, Lambert, Harmon, Tschitsaz, & Stulz, 2006). The S-OQ 2.0 is designed specifically for use among clients with serious mental illness and, like the OQ-45, is administered regularly, prior to clinical sessions, in order to provide the clinician with immediate feedback on the client's response to an intervention (Carey, 2000).

The self-report measure consists of 45 items with two subscales: the OQ-30, which is a 30-item short form of the OQ-45, and the 15-item Serious Mental Illness scale. For all 45 statements on the S-OQ, clients are asked to rate the frequency with which they experience the concern that the statement describes (on a scale of 0-4, with 1 indicating "Never" and 4 indicating "Almost Always"). For the S-OQ, the community normative score range is 0-59 and the clinical score range is 60-180 (OQ Analyst, 2014). The Reliable Change Index (RCI), which alerts clinicians to meaningful clinical change, is 11; clients whose score changes by 11 points (from the first, or pre-treatment, administration of the S-OQ) are classified as significantly changed (e.g., Reliably Worse or Reliably Improved). For the subscale, OQ-30, which provides a global assessment of patient functioning, the community normative score range is 0-43, the clinical score range is 44-120, and the RCI is ten (OQ Analyst, 2014).

Client scores for each administration of the S-OQ 2.0 were extracted from the Valley Mental Health (VMH) database, OQ-Analyst. This software package calculates scores, generates reports, and provides alerts to indicate when a client is at risk for treatment failure. Scores were pulled for all Enrolled clients starting two years prior to the intervention (January 1, 2010) to the current date (February 28, 2014). Scores were included in the analysis if the S-OQ was complete (e.g., the client had answered all 45 questions) and was administered during the relevant dates. The results described below include S-OQ scores administered by program staff as well as clinicians from all of the VMH clinics.

Use of the S-OQ by CHSH. As shown in Table 29, 35 Enrolled clients had at least one S-OQ score recorded since January 1, 2010 (for two of those clients, the first administration of the S-OQ occurred prior to 2010; records entered prior to 2010 were not included in the current analysis). Of those, 14 clients (40%) had completed at least one S-OQ prior to program enrollment and 27 (77%) had completed at least one S-OQ after enrollment. Overall, clients averaged more than two (Mn=2.6, SD=2.3) S-OQ scores since January 1, 2010. When looking only at S-OQ administrations completed after program enrollment, clients averaged slightly less than two per client (Mn=1.9, SD=1.7). Fourteen CHSH clients (40% of those with any S-OQ score) had an S-OQ score that had been

[3] Due to an administrative issue, the clinical psychologist's notes were unavailable for the time period between October and December, 2013. As such, the figures throughout the report underestimate the number of mental health contacts because they do not include contacts with the clinical psychologist for those dates. The issue has been corrected and the notes will be available for the final report.

administered by a member of the project staff. When limited to S-OQs administered by CHSH program staff, the average number of S-OQ scores per client was slightly more than one (Mn=1.4, SD=0.75). The low number of administrations by program staff suggests that the S-OQ is not being used as a regular means for monitoring clients' psychological symptomology or response to mental health treatment.

CHSH client S-OQ scores. When looking at clients' first S-OQ score, the average score per client was higher than 70 (Mn=73.3), which is within the clinical score range of 60-180 for this instrument (see Table 28). For that same S-OQ administration, the average score on the OQ-30 was 51, which is also within the clinical range. On the SMI subscale, however, OQ Analyst identifies a score of 25.9 as the norm for a sample of individuals participating in outpatient mental health treatment; the average score for the CHSH sample is lower than the outpatient norm (Mn=23.7). This may reflect previously documented limitations with the use of the S-OQ, and other self-report measures, with seriously mentally ill individuals, who are likely to underreport their distress with respect to psychological symptoms (Carey, 2000).

Table 28 Client S-OQ Scores

	Time 1	Time 2	Time 3	Final[1]
Total Sample (n)	*35*	*17*	*12*	*17*
S-OQ Score (Mn (SD))	73.4 (39.7)	82.5 (36.3)	79.1 (39.2)	85.1 (35.8)
OQ-30 (Mn (SD))	51.0 (25.6)	56.7 (24.0)	57.1 (26.0)	59.1 (25.7)
SMI (Mn (SD))	23.7 (14.6)	25.9 (13.1)	22.0 (13.8)	24.1 (14.5)
MRCIS[2]	1.2 (1.5)	1.4 (1.8)	1.0 (1.5)	1.5 (1.8)

[1] Shows the average score when looking at clients' last S-OQ (this number could reflect any score between the second or the ninth score on record; this figure excludes clients with only one score on record.

[2] The mean number of Most Critical Item Status (MRCIS) indicators for which a client responded with a 3 (Frequently) or 4 (Almost Always).

Table 28 shows the average S-OQ scores at Time 1, Time 2, and Time 3 (including the two subscales). In addition, the last column (Final) shows the average score when looking at clients' last S-OQ (this number could reflect any score between the second or the ninth score on record; this figure excludes clients with only one score on record). Overall, the mean scores show that clients enter treatment with scores in the normative range for a clinical population and that subsequent S-OQ administrations continue to show mean scores in the clinical range.

The S-OQ is intended to provide feedback on clients' response to treatment; as such, the relative difference between scores is an important component of interpreting the results. When looking at the average change in client scores between Time 1 and Time 2 (n=17, for clients with at least two scores on record), the difference was 1.2 (SD=25.3), indicating a small negative change. Between Time 1 and Time 3 (n=12, for clients with at least 3 scores on record), the average difference was -5.9 (SD=16.9), indicating a small improvement that was below the Relative Change Index (RCI) of 11. Between Time 1 and the Final Score (n=17), the average change was 3.8 (SD=24.6), indicating a small negative change. These numbers indicate that CHSH clients are experiencing substantial symptoms in the areas of psychological distress, relationships, social role performance, and functional impairment and that clients who completed multiple SO-Qs did not demonstrate clinically meaningful change during the course of treatment. Given the small number of administrations per client and the limited sample with more than one SO-Q, caution should be used when interpreting this information.

As part of the feedback process for clinicians, the S-OQ Clinician Report provides summary scores for client's responses to questionnaire items that screen for risk of suicide, substance abuse, violence at work, and hallucinations and/or mania. According to S-OQ interpretation guidelines, "It is recommended that clinicians consider any response other than Never as an alert to possible risk in these areas." As an indicator of client risk, Table 28 shows the average number of Most Recent Critical Item Status (MRCIS) items for which clients responded with a three (Frequently) or four (Almost Always) when completing the S-OQ. At all three times analyzed, CHSH clients responded with a three or four on at least one MRCIS item on average.

Barriers to service delivery. Given the target population for this grant, one would expect staff to encounter substantial barriers when working to obtain housing, income, benefits, and treatment services for clients. While factors such as substance abuse, mental health, resistance to services, and criminal history make it harder to achieve grant objectives, those barriers are also an omnipresent concern with the current population. In order to better understand the role that these barriers play during the course of service delivery, however, the research team requested that staff track those circumstances and events that specifically prevented them from being able to provide an intended service on a given day. Staff began tracking this information on September, 1, 2013. Of the 1,694 notes recorded since that date, 9% indicated that some barrier was encountered that prevented staff from providing an intended service or completing a specific task on that day. Most commonly, the barrier identified was clients' inability to engage in the service, due to symptoms or impacts of substance abuse, mental health diagnoses, or cognitive impairment (66% of notes where a barrier was indicated). Client resistance was the second most common barrier, and was identified in 38% of notes where some barrier was indicated (in 24% of notes where a barrier was indicated, the client could not be located). When looking only at long-term Engaged clients, staff identified barriers to service provision in 21% of case notes, and noted client resistance in three-fourths (75%) of notes where a barrier was identified.

Client perception of services. The Supplemental Client Interview (SCI) provides additional insight into clients' experiences in the CHSH program. At both Intake and six-month follow-up, clients were asked to identify whether or not they had experienced a range of needs during the previous six months and whether they had received services to address that need. Table 29 shows that the most commonly identified needs at Intake were in the areas of: housing, transportation, and case management. For all the clients who expressed a need for services, the majority indicated that they had also received the appropriate service. At Follow-up, the most commonly identified needs were similar, with the majority, again, indicating that they had received the appropriate service. Because less than half of Enrolled clients had completed the SCI at the time of this report, this data should not be interpreted as being representative of the entire sample.

Table 29 Need for and Receipt of Services at Intake and Follow-Up

	Intake		6-Month Follow-Up	
Total Sample (N)	*24*		*13*	
Need for (and receipt of) services (n)	Need	Received	Need	Received
Outpatient substance abuse treatment	3	2	2	1
Treatment in detox program	2	5	1	1
Residential substance abuse treatment	--	--	--	--
Methadone services	1	1	2	1
Outpatient mental health treatment	11	8	4	4

	Intake		6-Month Follow-Up	
Total Sample (N)	*24*		*13*	
Need for (and receipt of) services (n)	Need	Received	Need	Received
Inpatient mental health treatment	1	1	2	2
Trauma-specific treatment	3	2	2	2
Consult for psychiatric medications	10	9	6	4
Case management	14	15	7	8
Vocational/Rehabilitation services	8	3	2	2
Housing services	20	19	8	8
Transportation services	13	11	8	7
Self-help or peer support services	7	3	5	2
Other services[1]	5	3	--	--

[1] Other services were: bus pass, food, legal issues, medical services

On the SCI, clients were also asked to assess the quality of care they received from the CHSH program. For each statement, respondents were asked to rate their agreement on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). A mean score of 3, for example, would indicate that on average, clients neither agreed nor disagreed with the statement. Table 30 details clients' ratings on all of the perception of care statements.

Table 30 Perception of Care at Intake and Follow-up

	Intake	6-Month Follow-Up
Total Sample (N)	*22*	*11*
Need for (and receipt of) services (Mn (SD))		
I feel free to complain.	3.6 (1.4)	3.7 (1.0)
I was given information about my rights.	4.1 (1.0)	3.7 (1.0)
Staff told me what side effects to watch out for.	3.7 (1.2)	3.7 (1.0)
Staff were sensitive to my cultural background.	3.6 (1.4)	3.7 (1.0)
I felt comfortable asking questions about treatment and	3.7 (1.1)	--
I decided my treatment goals.	3.1 (1.2)	--
If I had other choices, I would get services from this agency.	3.8 (1.3)	--

The results show that, at Intake, clients felt that they were given appropriate information regarding treatment from the CHSH program (Mn=4.1). The lowest mean score (Mn=3.1), for the statement "I decided my treatment goals," suggests that respondents felt neutral in terms of whether or not they had set their own treatment goals. As mentioned earlier, these numbers represent less than half of the Enrolled clients and should be interpreted with caution.

At the Follow-up, clients were asked several additional questions regarding their perception of care. Of those with available data (n=11), the mean score was 3.7 for the following three statements: 1) Staff here believe that I can grow, change, and recover; 2) Staff encouraged me to take responsibility for how I live my life; and 3) Staff respected my wishes about who is and who is not to be given information about my treatment.

Benefits Enrollment

A primary goal of the CHSH program is to enroll clients in mainstream benefits. Table 31 presents a view of clients' mainstream benefits status at Intake and at the end of the current reporting period. These figures show that a majority of clients are currently enrolled in Medicaid (60%) and close to half are receiving food stamps (48%) and SSI/SSDI (43%).

Table 31 Mainstream Benefits for Enrolled Clients

Mainstream Benefit Type (n)	Intake[1]	Open[2]	Applications[3]	Denied
Medicaid	27	48	7	3
SSI/SSDI	30	34	8	5
Food Stamps	48	38	1	--
General Assistance	14	3	--	--
Veteran's Benefits	--	2	--	--
Medicare	6	11	--	--

[1] This number reflects the number of Enrolled clients who indicated on their Intake forms that they were enrolled in benefits (n=77)
[2] This number reflects the current status of clients in the program and excludes clients whose coverage has lapsed or who have died.
[3] This number includes new applications and appeals that are being handled by CHSH

General Assistance is a time-limited program, which likely explains the fact that fewer clients are receiving funds after program enrollment. The fact that fewer clients are receiving food stamps after enrollment, when compared to Intake, likely reflects the increase in clients' overall income, making them ineligible for the program. In terms of other types of benefits, one client is currently enrolled in Utah's Primary Care Network, which is a state-based health insurance program and 17 clients had an ongoing rental subsidy. At Intake, no clients were identified in Client Track as having any type of housing assistance (e.g., Section 8, public housing, or other ongoing rental assistance).

Housing Placement

As of February 28, 2014, 74 clients had been placed in housing (see Table 32). The housing units consist of a mix of facility-based and scattered-site units and are funded through a range of state and federal housing programs.

Table 32 Housing Placements for Enrolled Clients[1]

Project/Owner Housing Type	#
Valley Mental Health	
Facility	4
Scattered	1
Salt Lake County Housing Authority	
Facility	5
Scattered	4
Salt Lake City Housing Authority	
Facility	5
Scattered	11
The Road Home	
Facility	6
Scattered	33

The Road Home/State of Utah	
Scattered	5
TOTAL Units	**74**

The SCI provides some insight into clients' experience with housing while in the CHSH program. On the SCI, clients are asked to rate their satisfaction with their current living situation, at both Intake and Follow-up. For each statement, respondents were asked to rate their agreement on a scale of 1 (Very Dissatisfied) to 5 (Very Satisfied). A mean score of 3, for example, would indicate that on average, clients were neither satisfied nor dissatisfied with their housing situation with respect to the statement. Table 33 shows that, for all indicators, clients' satisfaction with housing improved while enrolled in CHSH. In particular, their average overall satisfaction changed from an average score of 2 (dissatisfied) to 4 (satisfied). Because these numbers represent a small portion of Enrolled clients, caution should be used when interpreting these results.

Table 33 Satisfaction with Current Living Situation at Intake and Follow-up

	Intake	Follow-up
Total Sample (N)	*15*	*13*
How do you feel about: (Mn (SD))		
Amount of choice you have over where you live	2.5 (1.4)	3.5(1.1)
The safety of your neighborhood	2.3 (1.3)	3.7 (1.3)
The amount of privacy you have	2.2 (1.3)	4.0 (1.2)
How affordable your place is	3.4 (1.2)	4.2 (0.7)
The condition of your place	2.9 (1.5)	3.3 (1.0)
The safety and security of where you live	2.3 (1.3)	3.6 (1.3)
The opportunities you have to socialize in the place where you live	3.0 (1.3)	3.3 (1.2)
Overall satisfaction	2.4 (1.4)	3.8 (1.3)

Discussion

Progress on Project Goals

Targeted outreach. The CHSH program exceeded its three-year goal of providing targeted outreach services to 90 chronically homeless persons. At the end of February, 2014, the program had made contact with 131 individuals and has a list of more than 15 additional clients who have been referred to the program. In order to provide adequate services to current clients, the CHSH program is no longer accepting new referrals.

Enrollment in mainstream benefits. Getting clients enrolled in Medicaid continues to be the most difficult objective for the CHSH program. The three-year enrollment goal for the grant was to have 100 clients enrolled in Medicaid. At the end of February, 2014, 48 clients were open in Medicaid and another seven applications were being processed (see Table 31 on page 30). The number of clients with open enrollments, however, does not serve as an accurate proxy for the number of clients with whom staff has successfully completed Medicaid applications. To date staff has assisted 62 clients with Medicaid applications that were approved; however, due to lapses in coverage and client death, only 48 clients are currently on Medicaid. As documented in the previous

reports, difficulties reaching this goal stem from a combination of issues. Staff identified client resistance as a primary barrier to Medicaid enrollment: often because of costs incurred by clients—for medications, deductibles, or spend-down—who are currently receiving medical services at no cost through the Fourth Street Clinic. Additionally, the percentage of CHSH clients who lack insight into their own illnesses may not perceive a benefit to enrollment because they do not feel that they need mental health, substance abuse, or medical care.

Housing. As noted previously, the CHSH program is well on its way to meeting grant goals related to housing clients (grant goal was to house 80 clients in 3 years). Staff continues to express ongoing concern about the difficulty of housing resistant clients due to the fast-paced process through which housing units are vacated and filled. While the program attempts to prioritize those clients who are the hardest to house, it is difficult, if not impossible, to hold units open while staff build relationships with clients. As such, staff have expressed a concern that clients who want to be housed (and are therefore easier to house) are being placed, while those who are the most difficult to place (and are specifically targeted by this program) are not being housed. As mentioned previously, the program is addressing this concern by capping program enrollment while holding several slots open for long-term Engaged clients.

Provision of recovery services. The grant application stated that the CHSH project would provide recovery services to 90 clients over three years. Currently, 67 Enrolled clients have received those services for mental health issues and 46 for chemical dependency. In addition, 22 Engaged clients have received mental health services and 10 have received substance abuse services. The CHSH team provided screening and assessments, one-on-one counseling, group counseling, medication management, and treatment services for clients.

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