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

Bi-annual Report
October 2013

THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
COLLEGE OF SOCIAL & BEHAVIORAL SCIENCES
UTAH COMMISSION ON CRIMINAL AND JUVENILE JUSTICE
S.J. QUINNEY COLLEGE OF LAW

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

Christian M. Sarver, M.S.W.
Erin B. Worwood, M.C.J.
Jessica Seawright, B.S.
Robert P. Butters, Ph.D.

Bi-annual Report
October 2013

Utah Criminal Justice Center, University of Utah

{THIS PAGE INTENTIONALLY LEFT BLANK}

Table of Contents

Table of Contents i
Background and Introduction 1
Study Procedures 1
Results 4
- **Program Implementation** 4
- **Partner Surveys** 6
- **Staff Surveys** 8
- **Defining the Sample** 10
- **Client Characteristics** 11
- **Program Activities** 22
- **Client Focus Group** 27

Discussion 28
- **Progress on Project Goals** 28

References 30
Appendix A 31
- **CHSH Staff Survey** 32
- **CHSH Partners Survey** 34

Background and Introduction

Nationally, it is estimated that between 10-20% of all homeless individuals are chronically homeless (McCarty, 2005), while the Utah State Community Services Office identifies 285 chronically homeless individuals living in Salt Lake City (State Community Services Office, 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 (State Community Services Office, 2013). Of those, nearly half (42%) were classified as medically vulnerable, including 122 of who had tri-morbid health or mental health conditions. 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 Team (ACT). 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, Service Plans, 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
CHSH Surveys
Results from the CHSH Partners Survey and Staff Survey, administered in August, 2013.

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 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 Referral Forms. Data include vulnerability score as assessed during the Point in Time Survey using Common Ground's Vulnerability Index. 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.	
Salt Lake County Sheriff's Office (OMS)	
Jail booking history at Salt Lake County Adult Detention Center for 2 years prior to 1st CHSH contact. 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). Future reports will include analyses of jail booking occurring while clients are receiving CHSH services.	
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 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.	
CHSH Client Focus Group	
Results from a focus group conducted with CHSH clients	

Results

The following section of the report details grant activities for the project to date, from October 1, 2011 through September 1, 2013. This date, rather than September 30, 2013, 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 11 and *Program Activities* on page 22).

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 Housing Placement Coordinator took a new position as a Chronic Housing Coordinator. In this capacity, he continues to work with the CHSH team, locating apartments and subsidies and assisting with housing applications. The CHSH team hired a new Case Manager to support clients who will be enrolling in the program this year. As the need for new housing units for CHSH clients diminishes, the duties of that position will broaden to other chronically homeless programs and less of the position will be billed to the grant. To enhance program capacity, CHSH added an AmeriCorps volunteer, who will be with the project for one year.

Training. During the current reporting period, CHSH staff participated in six formal training sessions. Staff were trained on topics directly related to CHSH program goals and emerging client needs: mental health and trauma issues for chronically homeless persons; signs and symptoms of substance abuse; vulnerability assessments; the role of navigators in implementation of the Affordable Care Act (ACA); and best practices for case managers using Client Track (the statewide data management system). During this time, staff also conducted three trainings for colleagues and partner agencies.

Staff participated in seven collaborative sessions with partner agencies in order to build relationships, clarify program objectives, and create mechanisms for continuing project activities after the SAMHSA grant expires in September, 2014. During the current reporting period, those sessions included meetings with permanent supportive housing programs, medical providers, and substance abuse providers. Specifically, CHSH staff participated in multiple working sessions with partner agencies to develop relationships, funding streams, and collaborative service delivery systems that will sustain the project in the long-term.

Program Structure and Service Delivery

Team Location. There were no changes in the physical location of the CHSH team during the current reporting period; however, the project rents space from a partner organization that is currently remodeling. As a result, the project experienced short-term (four weeks) changes to their office space, which caused some difficulties for staff and clients to access the CHSH offices.

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 August, 2013, the CHSH program maintained a caseload of 58 Enrolled clients (excluding 16 Enrolled clients who have been discharged) and more than 30 Engaged clients. With current staffing levels, given the intensity of CHSH services, the program is approaching 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 remaining program slots (program capacity is 80 Enrolled clients). As part of this process, staff is reserving spots for a sub-group of nine individuals who are eligible for the program but are currently too resistant to be fully enrolled in the program. For the most part, the program is prioritizing services from existing referrals and not recruiting new clients at the present time.

Service Delivery Model. During the current reporting period, project staff implemented a more formal system for determining the level of services a client receives. 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 (30 clients) are generally seen at least twice a week, Level Two (13 clients) are seen once per week, Level Three (13 clients) are seen every other week, and Level Four (2 clients) are seen as needed. Staff determines and/or revises triage levels at the beginning of each week, based on clients' changing circumstances and 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 (21%) of program contacts involve more than one staff member. In addition to regular meetings with clients, program staff facilitates 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 hosts 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 services were provided in a variety of locations (see Table 3 on the following page). More than half of the work that CHSH does with clients occurs outside the office. Almost one-quarter of contacts occur at other social service agencies, which fits with the organization's goal of increasing access to social services for service-resistant clients. Notably, the majority (43%) of services for current Engaged clients occur in "other" locations, which likely reflects staffs' efforts to seek out and engage a non-housed and

service-resistant group of individuals. In contrast, the majority of services for Enrolled clients take place in the client's residence (32%) or the CHSH office (33%), which likely reflects both regular visits to the client's residence and also Enrolled clients' tendency to seek out program staff, at the office, for support and assistance.

Table 3 Service Delivery Location

	Engaged		Enrolled
	Discharged	Ongoing	
Location (%):			
CHSH Office	42	17	33
Other Agency	24	24	20
Client Residence	3	1	32
Jail/Institution	7	6	2
Other[1]	13	43	11

[1] This includes transportation-related services, shopping locations, and public locations such as parks, streets, or camps

CHSH Meetings. Project staff continues to revise the content and timing of daily and weekly meetings in search of a schedule that adequately addresses planning and scheduling needs. Under the current schedule, staff participates in four regular, weekly meetings, one each on the following topics: setting client triage levels, clinical case staffing, administrative meeting, and a staff peer support meeting. For several weeks during the current reporting period, clinical staffing meetings were conducted weekly in conjunction with the Pathways program; this arrangement was developed in anticipation of the potential merging of the two programs after the SAMHSA grant expires. The arrangement was discontinued because staff determined that the joint format was cumbersome and did not enhance CHSH planning activities.

The CHSH Steering Committee is scheduled to meet quarterly. During the August meeting, the Steering Committee discussed ongoing uncertainties related to Medicaid enrollment (see April, 2013 Bi-Annual report). Additionally, the research team reported the results of the client focus group to the Steering Committee (see *Client Focus Group* section on page 27). The newly-formed Sustainability and Growth Committee, which is tasked with developing and implementing a strategy for continuation of CHSH after grant funding expires, has met twice. Neither the Medicaid Sub-Committee nor the Data Sub-Committee met during the current reporting period.

Partner Surveys

Surveys were electronically distributed to CHSH partners in August, 2013. The survey was comprised of 18 questions, which assessed respondents' perceptions of the impact of the CHSH project on clients and service providers. Partners included agency representatives as well as members of the Steering Committee and project sub-committees. The survey was sent to one representative from each partner agency for targeted distribution; because agency representatives were responsible for distributing the survey within their organization, there is no way to know exactly how many people received the survey and thus no way to calculate a response rate. Nineteen surveys were returned, which included at least one response from every partner agency. The majority of partner respondents were administrators, followed by direct services staff, and Steering Committee members.

CHSH Mission. Respondents were asked, as an open-ended question, to describe the mission of the CHSH project. The majority of respondents included at least three components to the agency mission, most frequently: targeting chronically homeless persons; obtaining housing for those persons; and providing treatment services for those individuals. While 83% of respondents identified the agency mission as placing chronically homeless individuals in housing, only one-third of respondents described maintaining clients in housing as part of the CHSH mission. Only one-quarter of respondents identified targeted outreach to service-resistant individuals (22%) or long-term support services (28%) as part of the agency mission. Overwhelmingly, respondents indicated that CHSH was achieving its mission (95%) and most (84%) felt that CHSH provided services that were previously unavailable in the community. In particular, respondents identified the program's flexibility as a unique characteristic that was central to its success with clients:

> "CHSH envelopes all services needed…[the project] outreaches, engages, houses and provides stabilization services in whatever way the person being served needs them delivered."

Impact on Clients. Nearly all respondents felt that the project had benefited clients (84%) and partner agencies (82%). In particular, respondents noted that the CHSH program had demonstrated success providing services to a sub-group of individuals who were not previously receiving services, as demonstrated in the following response:

> "I see people getting housed that wouldn't before. I see people getting found in the system that have fallen through the cracks for years."

Most commonly, respondents identified obtaining housing (42%), overcoming client resistance to services (21%), and overcoming systemic barriers to services (26%), as the primary ways that CHSH benefits clients. Several respondents also noted that the provision of stable housing and intensive support was likely to result in additional positive impacts for clients, such as increased opportunities for employment. No respondents identified negative impacts of the CHSH project on clients.

Impact on Partner Agencies. Three-quarters (74%) of respondents reported that their agency has been positively impacted by the CHSH project. Of those respondents who answered this open-ended question, almost half (43%) identified better interagency coordination as a primary benefit. A similar number (43%) felt that the program resulted in more resources to their agency (and thus their agency's clients), as evident in the following response:

> "[CHSH] promotes interagency collaboration and facilitates the availability of more services to the community."

Approximately one-fifth (21%) of respondents felt that there had been some negative impacts to their agency as a result of CHSH, primarily because the project's mission duplicated existing services or was in conflict with a partner agency's mission.

Respondents were asked what priority their agency placed on sustaining the CHSH project after grant funds expire. All respondents indicated that it was somewhat (32%) or very (68%) important to sustain the project beyond September, 2014. When asked what steps their agency had taken to support the continuation of CHSH, one-third of the respondents reported that they did not know if their agency had taken any steps. More than half (58%) of respondents indicated that their agency had done at least one thing to support continued funding of CHSH and 26% of respondents

indicated that their agency was actively engaged in multiple efforts to secure long-term funding. Those efforts include: providing resources such office space or vehicles (32%); providing funding (5%); participating in fundraising efforts (16%); and contacting potential partners to develop support for the project (21%). Several respondents recommended that developing strategies for billing services to Medicaid was the most likely source of secure funding. Because Medicaid is a potential source of ongoing funding, community partners were asked about their ability to advise clients on enrolling in health care coverage as allowed under the Affordable Care Act (ACA). The ACA was identified as an important area for partners and almost half (47%) of respondents indicated that they had already received some training on it.

Staff Surveys

Surveys were electronically distributed to current and former CHSH staff in August, 2013. The staff survey contained seven open-ended questions pertaining to their understanding of clients' benefits from, and barriers to, participating in CHSH. All eight staff members completed the survey.

Program Impact on Clients. Half of respondents indicated that the program's intensive case management—and particularly regular, frequent, and ongoing contact with clients—was an essential mechanism for enhancing clients' increased access to services, development of positive relationships, and increased capacity to set and achieve goals. Respondents also felt that client advocacy with other social service agencies—including setting up appointments, making introductions, and collaborative case staffing—resulted in increased access to resources through the development of coordinated, flexible service delivery systems. Staff articulated the importance of advocating on behalf of clients with other agencies and service providers:

> "[Clients] personally know someone who works within a broad bureaucracy who is on their side and works for them, helping them navigate a complex system of agencies and requirements to get what they want and need."

Staff identified the provision of social support and consistent mental health treatment as program components that enhanced clients' motivation for setting, and the ability to accomplish, goals. In particular, respondents felt that the development of positive relationships—cultivated through empathy, respect, and enforcement of boundaries—was a primary benefit of participation in CHSH:

> "[T]he CHSH program has provided a support network to clients and given them the opportunity to feel cared for and to trust society again."

Program Impact on Partner Agencies. One quarter of respondents described improvements in service quality due to CHSH partnerships with other social service agencies. One-third of respondents noted that the CHSH project has facilitated increased interagency collaboration, which was a benefit to the community network of service providers:

> "[B]ecause of the interaction between team members, agency representatives likely have more knowledge of partner agency's contributions, challenges, boundaries, and more empathy for the other."

One-quarter (25%) of respondents felt that increased collaboration has improved efficiency for all agencies and has allowed them to coordinate their efforts when addressing client needs. As a final benefit to partner agencies, respondents, the majority of whom have a history working with other

social service agencies in the community, indicated that CHSH staff was able to provide relief to overworked partner agencies from some of the time-intensive work with resistant individuals.

Client Barriers to Program Participation. A substantial number of potentially-eligible individuals have long-term, ongoing contact with staff but are not formally enrolled in the program. In order to better understand the needs of this sub-group, respondents were asked to identify the most common reasons that clients choose not to participate in the CHSH. All respondents identified the symptoms of mental illness symptoms as one of the primary barriers to program participation. In particular, the majority of respondents cited clients' paranoia and delusional thoughts as barrier to enrollment, because they resulted in distrust of staff and subsequent avoidance of services or contact:

> "[clients] may fear staff as they fear any other person who is potentially 'in on it.'"

A sub-set of respondents who identified paranoia as a barrier for clients indicated that feelings of distrust may stem from clients' previous experiences with service providers or history of trauma. Half of respondents noted that disorganization, as a symptom of mental illness, prevented individuals from participating in the CHSH program:

> "I think people's mental illness/cognitive ability/ substance abuse issues make it nearly impossible for them to follow through with certain tasks, even if a case manager is beside them the entire time."

When asked to identify strategies for engaging service-resistant individuals, the most common response (50% of respondents) was increased resources and personnel specifically devoted to intensive outreach and recruitment:

> "There needs to be a small team (e.g., 2 people) dedicated solely to the outreach/case management of these individuals. They need highly individualized treatment and attention -- this high level of need too often gets back-burnered or subsumed under the number and needs of other clients who want/are able to work with case managers. A small team could conduct the daily/weekly visits to establish the trust and consistency these outlying clients need to more fully engage with services."

Less frequently, respondents felt that a small group of clients was so persistently mentally ill that they would never agree to services without some "leverage," such as forced medication or hospitalization. None of the respondents endorsed coercive methods as a response to resistant clients, but reinforced the importance of developing and maintaining relationships with those individuals, even if they never consented to full program participation.

Barriers to Providing Services to Enrolled Clients. Even for Enrolled clients, staff identified the symptoms of mental illness as a factor in terms of clients' ability or desire to engage in treatment and services. All respondents indicated that a primary barrier to providing substance abuse and mental health treatment is that clients do not always perceive a benefit to such services:

> "Motivation. Clients can work on substance abuse at any level of the change process but clients who have no interest in abstaining or reducing alcohol or drugs make little measurable progress. Motivation and client factors such as insight and ability to make use of treatment are the main barriers for clients to receive mental health services."

A smaller percentage of respondents also identified limited resources as a factor in the program's inability to engage clients in treatment and recovery services.

> "There's no one provider or agency that I can point any client to and say, go there. So I end up casting around a bit and this slackens the process...and if this coincides with any lack of motivation or readiness on the part of the client to engage with therapy, it can fall apart or be waylaid, indefinitely, very easily. We have providers on our team but this hasn't helped us to function more efficiently with mental health/substance abuse services, I think because these providers get pulled into a case management role more often, and because some others are only part-time on our team. We need full-time providers and strictly defined roles in this regard."

In terms of difficulties encountered when placing clients in housing, half of respondents identified system-level and administrative barriers, such as housing restrictions related to clients' criminal history, lengthy application processes, and delays and expenses in acquiring identification documents, as an ongoing source of frustration for clients and staff. Similar difficulties were apparent in respondents' description of barriers when helping clients apply for mainstream benefits: 63% of respondents reported that gathering necessary documentation in terms of disability, homelessness history, and other eligibility requirements, posed a significant barrier to timely completion of applications. Once clients are housed, one-quarter of respondents cited continuing street behaviors—such as drug use, inappropriate visitors, or abandoning the housing placement—as a primary threat to the success of that placement.

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 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 27 people.

Table 4 CHSH Samples

	N
Engaged Clients[1]	54
Enrolled Clients[2]	73
Total	***127***

[1] Thirty-five 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 9/1/2013) and those who were referred and discharged prior to staff contact.
[2] Sixteen of the Enrolled clients have been discharged from the program. The majority of discharged clients were discharged to a less intensive supportive housing program after being housed and stabilized with CHSH.

Referrals to CHSH

Vulnerability Index. During the current reporting period, the Chronic Housing Program (CHP), which centralizes program referrals for chronically homeless persons, continued to use the Vulnerability Index (VI) tool adopted during the 100,000 Homes Campaign. The VI tool is based on empirical research on the mortality risk for homeless adults and produces a composite score of vulnerability that ranges from 1-8 (with 8 indicating the highest level of vulnerability). The VI is comprised of 60 questions and identifies risk specifically on the following points: length of homelessness; age; tri-morbid mental illness, chronic medical condition, and substance abuse history; and high use of emergency medical services. The scale allows the community as a whole (rather than individual agencies) to prioritize the provision of housing and other services to chronic and at-risk homeless persons.

All of the agencies that regularly partner with CHSH have adopted the VI tool, which can be accessed through the statewide Utah Homeless Management Information System (UHMIS). During the annual Point in Time Count, agency representatives and volunteers attempted to administer the survey to all homeless persons in the area. Many of the current CHSH clients have been housed and were therefore not represented in the Point in Time Count. As such, there are currently VI scores for only 30 CHSH clients (18 Engaged clients and 12 Enrolled clients). Of the 18 Engaged clients with VI scores, the mean score was 1.8 (SD=1.2); however, when the clients who received a 0 score (meaning they had none of the eight vulnerability risk indicators) are removed from the analysis, the remaining 14 clients have a mean overall score of 2.3 (SD=1). Of the 12 Enrolled clients who were assessed using the VI, the mean score was 1.3 (SD=1.2). The current VI focuses primarily on medical indicators of client vulnerability; as such, program staff (in conjunction with stakeholders across the state) has been working to develop a new VI that provides a multi-dimensional assessment of clients' risk.

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 (65% Engaged, 67% Enrolled) and had an average age near 50. The majority of clients in both Enrolled

(78%) and Engaged (57%) groups were White. Over half of Enrolled clients (59%) 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
Total Sample (N)	*54*	*73*
Demographics		
Male (%)	65	67
Age (Mn)	49	49
Min, Max	23, 74	26, 71
Hispanic or Latino (%)	7	4
Race (%)		
White	57	78
Black/African American	11	8
Asian	4	3
American Indian/ Alaska Native	22	12
Native Hawaiian/Pacific Islander	2	3
Unknown/Missing Data	--	--
Veteran/ Served in Military (%)	6	11[2]
Percent with Children (%)	--	59
Number of children (Mn)	--	2.6

[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-third (36%) of Enrolled clients reported having at least one family member who had served active duty in the military, reserves, or the National Guard.

Homelessness and Housing. Based on official shelter records, the majority of both Engaged (83%) and Enrolled (85%) clients have previously stayed at The Road Home's Emergency Shelter (see Table 6). Between December 1, 1998 and Intake, both groups spent an average of more than 400 nights in the shelter. As a whole, these 127 individuals accounted for a total of 45,597 nights in the shelter during this period. When comparing shelter use for Enrolled clients, in the period before and after enrollment, a smaller percent of clients stayed at the shelter after they were enrolled, with just over half (60%) 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)	*54*	*73*	*73*
Percent stayed in the Shelter at least one night (%)	83	85	60
Total # of nights[1]	18260	27337	2896
Average # of nights per client (Mn)	405	441	66
Min, Max	5, 2828	4, 3117	2, 389

[1] Total count for entire sample

At Intake, slightly less than half of Enrolled clients (47%) had stayed at an emergency shelter the previous night and nearly one-fourth (23%) 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 (28%), which may reflect the aforementioned trouble those clients

experience in regards to building relationships and connecting with social services. Three-quarters of clients in the Enrolled group (77%) had been continuously homeless for at least one year, while just over half (56%) of Engaged clients had been continuously homeless for at least one year. Engaged clients demonstrated a higher number of discrete episodes of homelessness over the past three years, however, with 33% experiencing at least four episodes of homelessness compared to 25% of the Enrolled group.

Table 7 Living Situation at Intake

	Engaged	Enrolled
Total Sample (N)	*36*[1]	*73*
Living Situation		
Where did you stay last night? (%)		
Emergency Shelter	28	47
Place not meant for habitation (streets, etc.)	33	23
Jail/Prison/Juvenile Detention Center	11	3
Family/Friend Residence	11	9
Other	17[2]	18[3]
Chronic Homelessness: (%)		
Continuously homeless for one year	56[4]	77
Homeless four times in three years	33	25

[1] Information on where the client stayed the previous night was available for 36 of the 54 Engaged clients.
[2] This includes transitional housing for homeless persons, psychiatric hospital, substance abuse facility, and hotel/motel paid for without emergency shelter voucher.
[3] This includes hotel/motel not paid for with emergency shelter voucher, substance abuse/residential treatment facility, psychiatric facility, and transitional housing for homeless persons.
[4] Data on chronic homelessness available for 52 of the 54 Engaged clients

Only 4% of Enrolled clients reported living primarily in a shelter after being in the program for six months, compared to 52% at Intake (see Table 8). While one-fifth (19%) of Enrolled clients indicated that they were living in a house at Intake, 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 living primarily in a house for the preceding 30 days. While this number only reflects the experience of a portion of the Enrolled sample (50 clients), it is important to note that nearly all (97%) of these housed clients were living in their own home at the end of the reporting period.

Table 8 Living Situation at Intake and 6-month Follow-up, Enrolled Clients[1]

	Intake	6-Month Follow-up
Total Sample (N)	*73*	*50*
Living Situation		
Primary living situation during the past 30 days: (%)		
Shelter	52	4
Street/Outdoors	22	14
Institution	7	6
Housed	19	76
If housed, what type of housing: (%)		
Own/Rent apartment, room, or house	29[2]	97[3]
Someone else's apartment, room, or house	43	3

	Intake	6-Month Follow-up
Total Sample (N)	*73*	*50*
Halfway house	7	--
Residential treatment	7	--
Other	14	--

[1] Data taken from GPRA forms. At the end of the reporting period, 50 clients had completed 6-month follow-up GPRAs. In total, 63 clients had been housed by the end of August, 2013; 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.
[3] Percent based on 38 clients who were housed at the time of the 6-month follow-up GPRA.

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 9). At the follow-up interview, a smaller percentage of clients had recently attended a self-help group (30%, not in table). The percentage of clients who reported that they had no one to turn to dropped from 32% to 18% between Intake and six-month follow-up and the percentage who felt that they could rely on family members went up from 15% to 30% between Intake and Follow-up. These numbers suggest that clients' social isolation is less pronounced while participating in the program, which is in accord with the CHSH program's focus on social connectedness and support systems.

Table 9 Support Systems of Enrolled Clients

	Intake	6-Month Follow-Up
Total Sample (N)	*73*	*50*
During the past 30 days:		
Attended any voluntary self-help groups (e.g., AA, NA) (%)	28	16
# of times attended (Mn)	11	4
Min, Max	1, 40	1, 12
Attended any religious/faith affiliated recovery self-help groups (%)	17	8
# of times attended (Mn)	8	2
Min, Max	1, 30	1, 4
Attended any other meetings that support recovery (%)	21	12
# of times attended (Mn)	7	6
Min, Max	1, 15	1, 15
Had interaction(s) with family/friends that are supportive of recovery (%)	52	58
Person they turn to when having trouble: (%)		
No one	32	18
Family Member	15	30
Friends	14	16
Professional	18	14
Religious Entity	15[1]	18[2]

[1] Includes 3 respondents who indicated "clergy" and 8 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. Forty percent (40%) of Enrolled clients had a high school diploma (or the equivalent) and one-fifth (19%) had attended some college (see Table 10). One-third (31%) of

Engaged clients had a high school diploma (or the equivalent) and one-quarter (26%) had some college. 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 10 Education and Employment at Intake

	Engaged[1]	Enrolled
Total Sample (N)	*39*	*73*
Education		
Enrolled in School or Job Training Program (%)		
Full-time	0	3
Part-time	0	5
Education Level (%)		
Less than High School	36	37
High School/Equivalent	31	40
Some College	26	19
Unknown	8	4
Employment[2]		
Employed (%)	2	0
Unemployed (%)	--	100
Looking for work	23	8
Disabled	--	53
Retired	--	6
Not looking for work	--	27
Other	--	4

[1] Data on education was available for 39 of the 54 Engaged clients.
[2] Employment status and whether looking for work were only measures available for Engaged clients

Monthly Income. Enrolled clients reported an average monthly income of $500 at Intake and approximately $600 at the six-month follow-up (see Table 11). By far the largest average monthly income came from Disability and Retirement payments at both time periods.

Table 11 Income at Intake and 6-month Follow-up, Enrolled Clients

	Intake		6-Month Follow-up	
Total Sample (N)	*71*[1]		*50*	
	%	Mn[2]	%	Mn[2]
Monthly Income				
Wages	3	$44	6	$241
Public assistance	54	$252	56	$293
Retirement	3	$685	8	$625
Disability[3]	32	$706	36	$739
Non-legal income	2	$53	2	$40
Family and/or friends	1	$20	2	$20
Other	11	$133	14	$161
Any Income	**86**	**$500**	**86**	**$602**

[1] Two clients had missing data for income on the GPRA forms.
[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 excluded from average amount calculations.

When compared to Enrolled clients, fewer Engaged clients reported any income at Intake (64%) and the average monthly amount was slightly less ($477) (see Table 12). These numbers do not account for one-quarter of the Engaged sample (15 did not have income information in agency records) and may not be an accurate reflection of the economic status of the sample.

Table 12 Income at Intake, Engaged Clients

	Engaged[1]	
Total Sample (N)	*39*	
	%	Mn[2]
Monthly Income		
SSA Retirement	0	--
SSI/SSDI	28	$745
General Assistance	10	$283
SNAP	51	$133
Other[3]	8	---
Any Income	**64**	**$477**

[1] Income data was available for 39 of the 54 engaged clients.
[2] Of those clients who report an income, the average amount.
[3] Three Engaged clients reported having "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. Because they represent such a small percentage of Engaged clients, these figures were excluded from the average income figure.

Physical Health. Nearly three-quarters (72%) of Enrolled clients rated their overall health as fair or poor at Intake (see Table 13), compared to 52% at six-month follow-up. The high percent reporting poor health on the GPRA forms mirrors information reported in the CHSH Intake forms; of those Enrolled clients with health assessments at intake (n=31), 90% indicated having a chronic health condition (which could include a mental health diagnosis) and 29% reported a physical disability (not shown in table). Nearly half (42%) of those Enrolled clients reported that they were not receiving services to treat their chronic health condition. Of the 18 Engaged clients with a health assessment at intake, 83% reported having a chronic health condition (which could include a mental health diagnosis) and 40% were not receiving services for that condition.

Table 13 Physical Health at Intake and Follow-up, Enrolled Clients

	Intake	6-Month Follow-Up
Total Sample (N)	*72*	*50*
Overall health rating (%)[1]		
Excellent	8	14
Very Good	7	10
Good	13	24
Fair	40	26
Poor	32	26

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

One-fifth of Enrolled clients reported receiving treatment in an Emergency Room (ER) during the month prior to Intake (22%) and Follow-up (20%). On average, clients reported being treated in the ER two (2) times in the month preceding Intake and Follow-up (see Table 14 on the following page).

Table 14 Medical Treatment at Intake and Follow-up, Enrolled Clients

	Intake		6-month Follow-up	
Total Sample (N)	*73*		*50*	
	% (n)	Mn[1]	% (n)	Mn[1]
Inpatient Treatment				
For any reason	18 (13)	8	20 (10)	13
Physical complaint	6 (8)	3	12 (6)	16
Mental or emotional difficulties	2 (3)	11	4 (2)	--
Alcohol or substance abuse	5 (7)	13	8 (4)	6
Outpatient Treatment				
For any reason	44(32)	5	36 (18)	5
Physical complaint	30 (22)	3	18 (9)	2
Mental or emotional difficulties	25 (18)	4	26 (13)	3
Alcohol or substance abuse	6 (4)	14	8 (4)	9
Emergency Room (ER) Treatment				
For any reason	22 (16)	2	20 (10)	2
Physical complaint	16 (12)	2	14 (7)	1
Mental or emotional difficulties	6 (4)	1	4 (2)	--
Alcohol or substance abuse	3 (2)	--	4 (2)	--

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

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 most frequently occurring 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. At Intake, the majority of clients indicated that they had experienced some psychological or emotional problems in the previous 30 days (82%); of those, almost one-half (44%) described themselves as extremely or considerably bothered by those problems (not shown in table). At the 6-month follow-up, the majority (82%) again indicated that they had experienced psychological or emotional problems in the previous 30 days; of those, 36% described themselves as extremely or considerably bothered by those problems (not shown in table).

Table 15 Mental Health at Intake, Enrolled Clients

	Intake		6-Month Follow-up	
Psychological/Emotional problems experienced in past 30 days:				
Total Sample (N)	*73*		*50*	
	% (n)	Mn[1]	% (n)	Mn[1]
Serious depression	62 (45)	15	66 (33)	17
Serious anxiety or tension	67 (49)	18	66 (33)	16
Hallucinations	15 (11)	19	16 (8)	15
Trouble understanding, concentrating, or remembering	59 (43)	22	62 (31)	17
Trouble controlling violent behavior	11 (8)	8	8 (4)	13
Attempted suicide	1 (1)	--	6 (3)	14
Been prescribed medication for psychological/emotional problem	40 (29)	26	40 (20)	25

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

Clients were also asked on The Road Home Intake form if they had any history of mental illness. Forty-seven (47) Enrolled clients had an Intake Assessment for mental health, of which 89% indicated that they had a mental illness. Of those, 86% indicated it was a chronic condition and 57% were currently receiving services. Nearly half (43%) of Enrolled clients indicated that they had a developmental disability; of those, 77% were receiving some sort of services for the condition. Of Engaged clients with an Intake Assessment (86%, 28) indicated that they had a mental illness; of those, 79% indicated that the condition was chronic and 39% were currently 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. For the 30 Enrolled clients with assessment data, 65% indicated that they had a history of drug abuse and 73% indicated a history of alcohol abuse; of those, almost three-quarters (82% drug abuse, 72% alcohol abuse) indicated that the condition was chronic (not shown in table). In the Intake Assessment, only 7% of Enrolled clients with a substance abuse problem were receiving treatment for alcohol abuse and one-third (33%) were receiving treatment for drug addiction. For the 32 Engaged clients with assessment data, 50% indicated a history of alcohol abuse and 57% indicated a history of drug abuse. More than three-fourths of clients indicated that their substance abuse history was chronic (78% alcohol abuse and 85% drug abuse) and far fewer were currently receiving treatment for these issues (33% for drug abuse and 23% for alcohol abuse).

In terms of recent alcohol use, 41% of Enrolled clients reported any alcohol use in the month prior to Intake and half (50%) reported use in the month prior to their six-month follow-up interview (see Table 16). Notes from staff meetings suggest that some clients increased substance use immediately after being housed. Staff speculated that changes in living circumstances could have created anxiety or fear for clients, resulting in an increase in substance use. The percent of clients reporting illegal drug use, however, was smaller at follow-up (10%) when compared to intake (21%); similarly, the frequency of use was smaller.

Table 16 Alcohol and Drug Use at Intake and 6-month Follow-up, Enrolled Clients

	Intake	6-month Follow-up
Total Sample (N)	*73*	*50*
During the past 30 days, have you used:		
Any alcohol (%)	41	50
Number of times (Mn)	9	10
Alcohol to intoxication (5+ drinks in one sitting) (%)	23	32
Number of times (Mn)	9	11
Alcohol to intoxication (4 or fewer drinks in one sitting, felt high) (%)	11	20
Number of times (Mn)	5	11
Both alcohol and drugs (on the same day) (%)	11	10
Number of times (Mn)	5	14
Any Illegal drugs (%)	21	10
Number of times (Mn)	14	11
Injected drugs during the past 30 days (%)	4	2

Table 17 indicates that more clients reported extreme or considerable stress due to alcohol or drug use at Intake (30%) than at 6-month follow-up (17%). 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 (see Table 17).

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	49	22	11	19
At Follow-Up	66	17	--	17
Has your use of alcohol or drugs caused you to reduce or give up important activities?				
At Intake	71	15	6	9
At Follow-up	76	10	7	7
Has your use of alcohol or other drugs caused you to have emotional problems?				
At Intake	61	22	11	6
At Follow-up	71	11	11	7

[1] Only for those clients reporting alcohol and/or drug use during the previous 30 days (n=37 at Intake, n=29 at Follow-up)

History of Violence. At Intake, 68% of Enrolled clients indicated that they had a history of violence or trauma in the previous 30 days (not shown in table). Of those, the majority reported experiencing ongoing symptoms from the trauma: 77% reported nightmares, 84% reported intrusive thoughts, 82% expressed being constantly on guard, and 69% reported feeling numb and detached. Of the clients with a six-month follow-up GPRA at the time of this report, 59% (29) reported a history of violence, of which 66% had nightmares, 71% experienced intrusive thoughts, 79% were on constant guard, and 69% felt numb and detached. With respect to recent victimization, 22% of clients (13) reported being the victim of a violent attack in the 30 days prior to Intake, and 10% (5) reported such violence in the month prior to their six-month follow-up GPRA.

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 Intake and the six-month follow-up interview (see Table 18). According to this data, 11% of Enrolled clients were arrested during the month prior to Intake and 14% reported being arrested in the month prior to Follow-up. One-third (27%) of clients admitted to committing a crime during the month prior to Intake (compared to 22% at Follow-up), and many committed multiple crimes (Intake, Mn=12; 6-month follow-up, Mn = 13).

Table 18 Self-Reported Criminal Justice Involvement, Enrolled Clients

	Intake	6-month Follow-up
Total Sample (N)	73	50
During the past 30 days:		
Arrested for any reason (%)	11	14
# times arrested (Mn)	1	1
Spent at least one night in jail or prison (%)	12	14
# nights spent in jail or prison (Mn)	10	5
Arrested for drug related offense(s) (%)	1	--
# times arrested for drug-related offenses (Mn)	--	--

	Intake	6-month Follow-up
Total Sample (N)	73	50
Committed a crime (%)	27	22
# times committed a crime (Mn)	12	13
Currently awaiting charges, trial, or sentencing (%)	16	16
Currently on parole or probation (%)	7	6

Jail Bookings. In addition to self-reported data, jail (Salt Lake County Adult Detention Center (ADC)) and court (Utah District and Justice Courts) records were examined for the two years prior to Intake for both Engaged and Enrolled clients. Slightly less than half of Engaged (48%) and Enrolled (44%) clients were booked on a new charge at least once during the previous two years (see Table 19). Just over half of clients in both groups (Engaged clients, 56%, Enrolled clients, 52%) were booked into the jail for a warrant during the prior two years. When combined (n=127), the two groups accounted for 323 jail bookings and 6,904 nights spent in jail during this two year period (not shown in table). 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 intake or post-intake). The most common charge types among Engaged and Enrolled clients in both time periods were for public order and property offenses. When comparing pre- and post- jail booking data it is important to keep in mind that the two time periods are nonequivalent.

Table 19 Criminal Involvement—Jail Bookings[1]

	Engaged		Enrolled	
Total Sample (N)	*54*		*73*	
Jail Bookings Prior to and After Referral	2 Yr Pre	Post[2]	2 Yr Pre	Post[2]
Percent with booking(s) for any reason (%)	59	33	56	22
Percent with booking(s) for new charges	48	32	44	21
Percent with booking(s) for warrants	56	30	52	18
Percent with booking(s) for commitments	37	20	30	11
Of those with any booking(s):				
Total # of bookings - for entire sample (sum)	141	67	182	46
Average number of bookings (Mn (SD))	4 (4)	4 (3)	4 (4)	3 (2)
Total nights spent in jail[4] (sum)	3634	776	3270	521
Average total nights spent in jail (Mn (SD))	114 (124)	43 (44)	80 (98)	33 (47)
Of those with new charge(s):				
Most Severe Charge (Mn)	MA	MA	MA	MA
Charge Type (%):				
Person	27	24	25	20
Property	50	47	63	67
Drug	35	35	22	33
Public Order	65	41	53	73
Obstruct Law Enforcement	19	18	22	13
Number of days in follow-up period				
Mn (SD))	--	299 (172)	--	317 (168)
Min, Max	--	23, 524	--	11, 517

[1] Bookings into the Salt Lake County Jail through 6/30/13

[2] Follow-up period varies depending on program start date

Court Cases. Approximately three-quarters of Engaged (78%) and Enrolled (77%) clients had court cases filed in the State of Utah during the two years prior to Intake (see Table 20). Enrolled clients had an average of 10 court cases filed during this time period (Engaged, Mn=12) and nearly all of these cases were filed in Justice Court (Engaged, 94% of cases; Enrolled, 93%). Combined, the two groups had 1,088 cases filed during the previous two years (not shown in table). Far fewer Engaged (43%) or Enrolled (38%) clients had any cases filed since Intake into the CHSH program. Not surprisingly, most cases filed during the two time periods were for low-level offenses (Misdemeanors and Infractions). As previously mentioned, it is important to keep in mind that the pre- and post- time periods are nonequivalent when making comparison. 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 (16%) or Follow-up (16)%, see Table 18 on page 19).

Table 20 Criminal Involvement – Court Cases

	Engaged		Enrolled	
Total Sample (N)	*54*		*73*	
Court Cases filed in District or Justice Court	2 Yr Pre	Post[1]	2 Yr Pre	Post[1]
Percent with court case(s) filed (%)	78	43	77	38
Of those with case(s) filed:				
Total # of cases – for entire sample (sum)	642	727	446	219
Min, Max	1, 62	1, 76	1, 67	1, 35
Average number of cases (Mn (SD))	12 (16)	8 (16)	10 (14)	3 (6)
Jurisdiction (%)				
Justice Court	94	94	93	92
District Court	6	6	7	8
Case Level (%)				
Felony	3	5	3	7
Misdemeanor	67	61	65	64
Financial[2]	2	1	2	1
Infraction	24	33	25	25
Other[3]	5	1	5	3
Number of days in follow-up period				
Mn (SD))	--	357 (184)	--	370 (185)
Min, Max	--	18, 601	--	24, 594

[1] Follow-up period varies depending on program start date
[2] Financial includes Child Support Lien, Debt Collection, Hospital Liens, Abstract of Judgments, Tax Liens, and Small Claims cases
[3] Other includes Traffic, Protective Order, and Eviction 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 minor 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 an expensive burden on the criminal justice system that cannot be ignored.

Program Activities

All work with, or on behalf of, clients was documented by staff in Client Track (a data management system). The following section is based on analysis of information extracted from that system.

Frequency and Intensity of Client Contacts. On average, Enrolled clients were in the engagement period for 65 days (see Table 21); however, this varied greatly, ranging from 3 to 408 days (not shown in table). On average, Engaged clients have been in the engagement period for substantially longer (Mn=165 days, ranging from 2 to 594 days). Clients had contact with team members, and often received services, in both the engagement and enrollment periods. On average, team members met with Engaged clients every 18 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 Enrolled clients saw their service provider almost two times per week and those interactions averaged almost one hour (Mn=55 minutes, not in table). At the time of this report, staff had recorded over 5,640 hours of contact with Enrolled clients and an additional 631 hours with these clients while they were still in the engagement period. Analysis of CHSH records indicate how intensive services are, even for clients who are not officially enrolled in the program. Since the inception of the CHSH program, staff spent the equivalent of 450 hours (or 26,934 minutes) working just with Engaged clients. Contacts with Engaged clients averaged more than 40 minutes each.

Table 21 Client Contact with CHSH Program Staff

	Engaged	Enrolled
	Mn (SD)	Mn (SD)
Number of days		
in Engagement period	165 (147)	65 (82)
in Enrollment period	--	332 (178)
Number of Services		
during Engagement period	17 (16)	14 (17)
during Enrollment period	--	120 (94)
Average Minutes of Contact per Client[1]		
during Engagement period	528 (591)	548 (677)
during Enrollment period	--	4635 (3335)
Days between Services		
during Engagement period	18 (19)	7 (7)
during Enrollment period	--	4 (3)

[1]Minutes reflects time spent providing case management or treatment services. Staff do not record the length of time spent on other activities.

Program Activities. A detailed description of staff activities, as well as clients' needs, state of mind, progress, and barriers, is available within Client Track in the form of case notes. Primary program activities included: engagement, advocacy, benefits, basic needs, medical, substance abuse, mental health, criminal justice, housing, outreach attempt, and case management. Table 22, on the following page, details the qualitative codes used to analyze more than 5,000 case notes created since the inception of the CHSH program.

Table 22 Program Activity Codes

Program Activity	Description
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	
General program activities including phone contacts, residence visits, weekly check-ins, and appointment scheduling and reminders. Activities related to managing and documenting program activities, including: administering follow-up GPRA forms; documenting no shows; and documenting discharges, transfers, and terminations. Also includes formal and informal attempts to locate clients, including unsuccessful efforts to locate clients. Finally, includes activities that do not fit into the above 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.	
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 furnishing, 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	
Substance Abuse	
Activities related to substance abuse needs, including assessment, therapy, and referral to Detox	

Table 23, on the following page, provides an overview of how staff time is allocated, as documented in case notes. Services 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 types of service are often recorded in a single case note, these percentages do not sum to 100. These figures highlight the substantial amount of time spent advocating on behalf of clients and providing general case management. Comparatively, these notes indicate that staff spent considerably less time providing services related to criminal justice, substance abuse, and engagement. The substance abuse clinician on staff was involved in 70% of the substance abuse contacts, while the mental health clinician was involved in 33% of the mental health contacts (not in table).

Table 23 Total Program Activity

Total Case Notes = 5,599	
Program Activity	% of Case Notes
Advocacy	28
Basic Needs	20
Benefits	17
Case Management[1]	40
Criminal Justice	4
Engagement	5
Medical	14
Mental Health	16
Housing	17
Substance Abuse	6

[1]Case management includes activities related to Administrative duties (16% of case management activities) and Outreach (19% of case management activities)

The nature of services provided is different for Engaged compared to Enrolled clients and for Enrolled clients in the engagement and enrollment phases. Twice as many Enrolled clients received services related to mental health and they received nearly twice as many services (see Table 24). Many more Enrolled clients also receive services related to interagency advocacy and accessing mainstream benefits. As one would expect, more Enrolled clients received services related to Housing.

Staff members averaged more than 10 contacts per Enrolled client on issues related to advocacy, basic needs, case management, housing, medical, and mental health services (see Table 24). For those same clients, staff time during the engagement phase was primarily spent on activities related to advocacy, benefits, and general case management. For Engaged clients, who have not been fully enrolled in the program, staff time is almost equally distributed among the range of activities; relatively fewer clients, however, are receiving services related to advocacy, benefits, housing, or substance abuse. For all clients, the Engagement phase looks similar, in terms of services received, with the exception that relatively fewer Engaged clients are receiving services related to basic needs and benefits assistance while comparatively more Enrolled clients receive services related to general case management.

Table 24 CHSH Services by Client Enrollment

	Engaged	Enrolled	
Total Sample (N)	*54*	*73*	
Type of Service Provided		Engaged	Enrolled
Percent of clients who have received service (%)		--	--
Advocacy	52	59	92
Basic needs	39	53	93
Benefits assistance	46	68	95
Case management	78	58	100
Criminal justice	13	15	47
Engagement	83	79	27
Housing	28	29	93
Medical	37	37	81
Mental health	43	42	81
Substance abuse	17	15	55

	Engaged	Enrolled	
Total Sample (N)	*54*	*73*	
Average number of services provided (Mn (SD))			
Advocacy	2 (2)	4 (5)	20 (21)
Basic Needs	3 (3)	3 (2)	14 (14)
Benefits	2 (2)	4 (3)	10 (10)
Case management	4 (4)	11 (11)	23 (19)
Criminal justice	3 (3)	3 (2)	6 (6)
Engagement	3 (3)	3 (2)	1
Housing	2 (1)	3 (4)	13 (9)
Medical	3 (2)	3 (4)	11 (10)
Mental Health	3 (3)	3 (3)	12 (14)
Substance Abuse	2 (2)	2 (2)	7 (9)

The case notes indicate that more than three-fourths (81%) of Enrolled clients are receiving services related to mental illness and approximately half (55%) are receiving services related to substance abuse. While the entire CHSH team provides these services, 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 worked with 64% of Enrolled clients and averaged nine contacts per client (ranging from 2 to 28 services per client, not in table). The clinical psychologist worked with 22% of Enrolled clients and averaged nine contacts per client (ranging from 2 to 25 contacts per client, not in table). A few Engaged clients also received recovery services from the clinical psychologist (7%) and the nurse practitioner (17%). Formal community mental health treatment, as a complement to CHSH services, has been initiated with 25 Enrolled clients.

Benefits Enrollment

A primary goal of the CHSH program is to enroll clients in mainstream benefits. Table 25 presents a view of clients' mainstream benefits status at Intake and at the end of the current reporting period. Enrolling clients in benefits is an ongoing process for staff, as even clients who are eligible for those benefits have difficulty completing applications, maintaining eligibility, and filing appeals if their application is denied. CHSH team members are continuously working to help clients obtain replacement documentation, file appeals, complete necessary forms, and get disability certification. The apparent drop in the number of clients receiving state General Assistance funds is primarily a function of the time-limited nature of the funds.

Table 25 Mainstream Benefits for Enrolled Clients

Mainstream Benefit Type (n)	Intake[1]	Open[2]	Applications[3]	Denied
Medicaid	22	56	5	2
SSI/SSDI	24	44	10	2
Food Stamps	45	60	--	--
General Assistance	14	4	--	--
Veteran's Benefits	--	1	2	--
Medicare	5	5	--	--

[1] This number reflects the benefits enrollments of Enrolled clients as recorded on Intake forms (n=73)
[2] This number reflects the current status of clients in the program
[3] This number includes new applications and appeals that are being handled by CHSH

While CHSH staff does not work on mainstream benefits with Engaged clients to the same degree that they work with Enrolled clients, they do work with almost half (46%) of Engaged clients in some capacity in order to increase clients' access to resources. Table 26 provides a view of Engaged clients' mainstream benefits status at the end of the current reporting period. In some cases, more clients are receiving benefits at Intake than at later data collection points; this reflects the ongoing struggle of CHSH clients to maintain program enrollment even after benefits are approved. In comparison, the benefits enrollment numbers for Enrolled clients is increasing, for the most part, demonstrating the program's efficacy in helping clients maintain eligibility status.

Table 26 Mainstream Benefits for Engaged Clients[1]

Mainstream Benefit Type (n)	Intake[2]	Open	Applications[3]	Denied
Medicaid	9	10	1	1
SSI/SSDI	11	5	-	1
Food Stamps	20	4	-	--
General Assistance	4	1	1	--
Medicare	4	2	--	--

[1] This number reflects the benefits enrollments for engaged clients as recorded on intake forms
[2] This number reflects clients who were enrolled in benefits prior to CHSH participation
[3] This number includes both new applications and appeals that are being handled by CHSH

Housing Placement

Sixty-three (63) clients have been placed in housing since the programs' inception (see Table 27). The housing units comprise a mix of facility-based and scattered-site units and are funded through a range of state and federal housing programs.

Table 27 Housing Placements for Enrolled Clients[1]

Project/Owner Housing Type	#
Valley Mental Health	
Facility	3
Scattered	1
Salt Lake County Housing Authority	
Facility	3
Scattered	8
Salt Lake City Housing Authority	
Facility	4
Scattered	2
The Road Home	
Scattered	30
Facility	5
The Road Home/State of Utah	
Scattered	7
TOTAL Units	**63**

[1] Subsequent to being housed, three clients died and five abandoned their housing placement.

Client Focus Group

The research team conducted a focus group with CHSH clients in order to better understand clients' experience in the program. Eleven (11) clients attended the focus group, which lasted approximately one hour. Clients received a $20 grocery store card as compensation for attending. All of the participants were Enrolled clients who were currently housed. Three research assistants took notes during the discussion and documented participants' responses to a set of open-ended questions pertaining to grant goals. For the purposes of this report, feedback has been arranged according to common themes reported by group participants, which fall into six broad categories: housing, income and resources, social integration, treatment and recovery, and service delivery.

Housing. Participants believe that being housed has provided a sense of safety and stability and has facilitated clients' ability to monitor and control behaviors that were difficult to manage while living on the streets or in shelters. A substantial number of respondents identified past issues of theft at shelters and expressed a sense of relief about no longer having to worry about their personal belongings (e.g., identification, medicine). Several respondents made positive remarks regarding the ease with which they now receive mail and other important documents. Most respondents expressed appreciation for the comforts that housing provides, such as a respite from extreme weather and communicable disease or a place to prepare meals. Participants expressed some concerns around housing, primarily related to the limited availability of housing options in desirable neighborhoods and the length of time it takes to obtain housing.

Income and resources. Most respondents reported experiencing an increase in their income as a result of CHSH participation and all of those described a subsequent sense of self-respect and independence. The majority of respondents specifically attributed the increase in resources to the efforts of CHSH staff. Respondents noted that program staff had helped them apply, secure, and maintain public assistance. Even clients who were receiving benefits prior to program enrollment felt that their overall access to resources had improved because the CHSH team facilitated access to medical, psychological, and substance-abuse treatment services. Several respondents expressed gratitude that having more income allowed them greater comfort as well, in terms of quality food, an air conditioner, and laundry services.

Social integration. The majority of respondents identified social integration as a primary benefit of the CHSH program. In some cases, CHSH staff had specifically helped participants connect with family and friends. For other respondents, feelings of connection were a by-product of other changes that the CHSH program had helped them make. Many respondents cited housing as a source of self-respect, pride, and stability, which allowed them to address health and behavior issues and subsequently renew relationships with family and old friends. Frequently, respondents noted that becoming housed had increased their interest in community involvement. More than half of respondents said that being homeless had made them feel like outcasts, or people unworthy of a place in the community; in contrast, having a place to live generated a renewed sense of self-respect and belonging.

Treatment and recovery. According to some participants, their motivation for, and access to, treatment services has been enhanced by CHSH participation. In particular, respondents identified the following program characteristics as central to their desire and ability to receive treatment services: frequent home visits from staff, who knew them and were familiar with their symptoms and coping skills; regular access to a psychologist and medical provider; and non-judgmental, client-oriented relationship with program staff. Several participants indicated that they had decreased their substance use following enrollment in the CHSH Program because they had

housing stability and ongoing social support. In contrast, several respondents reported that substance abuse remains a regular aspect of their lives. Those clients expressed a belief that staff would prefer they quit using substances; however, clients also believed that staff would support them regardless of choices around substance use.

Service delivery. Participants praised the individualized services they received from CHSH. In particular, clients expressed the belief that CHSH was unique in comparison to other programs because: staff are non-judgmental in their work with clients; clients are able to contact staff directly and frequently; staff are actively involved in helping clients solve problems; and clients feel like staff treat them like "family." Many respondents expressed surprise and gratitude at the assertive recruiting efforts made on their behalf and at staff's willingness to help with enrollment paperwork. Only one participant identified feeling that staff could be too involved at times. Most appreciated the high level of involvement and concern for on them throughout their enrollment in CHSH.

In general, focus group participants praised the CHSH Project for the intensity of service delivery, the lack of requirements placed on clients in order to receive services, and the quality of staffs' relationship with clients. Clients believe that being housed has given them a platform of security and self-respect, from which they can address health issues, protect belongings, and rebuild strained relationships.

Discussion

Progress on Project Goals

Targeted Outreach. The CHSH program has already exceeded its three-year goal of providing targeted outreach services to 90 chronically homeless persons. At the end of August, 2013, the program had made contact with 127 individuals and has a list of more than 30 additional clients who have been referred to the program. In order to provide adequate services to current clients, the CHSH program has decided to stop accepting new referrals, for the time being.

Enrollment in Mainstream Benefits. Getting clients enrolled in Medicaid continues to be the most difficult objective for the CHSH program. The combined enrollment goals for the first two years of the grant were to get 75 clients enrolled in Medicaid. At the end of August, 2013, 56 clients were open in Medicaid and another 7 applications were being processed; however, some of those clients already had open files or applications submitted at program Intake (see Table 25 on page 25). As documented in the previous report, difficulties reaching this goal stem from a combination of issues. During the current report period, 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 Fourth Street Clinic. Additionally, the percentage of CHSH clients who lack insight into mental illness and substance abuse 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. 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 difficult 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 targeted by this program) are not being housed. As mentioned previously, the program is addressing this concern by capping program enrollment while holding open several slots 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, 57 Enrolled clients have received those services for mental health issues and 31 for chemical dependency. In addition, 16 Engaged clients have received recovery services. The CHSH team provided screening and assessments, one-on-one counseling, medication management, and treatment services for clients.

In some cases, clients need more intensive recovery services to make progress on their treatment goals. To address that need, the Project Director expanded upon the existing collaboration with Valley Mental Health, a local mental health treatment provider and project partner. Subsequently, formal therapy has been initiated with 25 (this has increased from 13 clients in the last report) CHSH clients; these interventions complement ongoing services provided by CHSH.

References

Kraybill, K., & Zerger, S. (2003). *Providing treatment for homeless people with substance use disorders.* Nashville, TN: National Health Care for the Homeless Council.

McCarty, M. (2005). *Homelessness: Recent Statistics, Targeted Federal Programs, and Recent Legislation*. Congressional Research Service. The Library of Congress. Washington, DC.

Salt Lake City, 100.000 Homes Campaign. (2013). *Registry week fact sheet.* Salt Lake City, UT: Author.

Stefancic, A., & Tsemberis, S. (2007). Housing first for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. *Journal of Primary Prevention, 28,* 265-279.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 4,* 651-656.

Tsembris, S. (2010). Housing First: The Pathways model to end homelessness for people with mental illness and addiction. City Center, MN: Hazeldon.

Utah State Community Service Office (2012). *2012 Point-In-Time Count (PIT), Housing Inventory Chart (HIC), and a Tool for Determining Unmet Need* [PowerPoint Slides]. Retrieved from http://www.docstoc.com/docs/123321802/2012-Point-In-Time-Count-%28PIT%29-Housing-Inventory-Chart-%28HIC%29-and-

APPENDIX A
CHSH Staff and Partner Surveys

CHSH Staff Survey, Second Year

The University of Utah has developed this survey to gather feedback on the second year implementation of the Chronic Homeless Services and Housing (CHSH) project.

Information obtained by the researchers is recorded in such a manner that participants CANNOT be identified, directly or through identifiers linked to the participants. Your anonymity will be maintained and data will be reported in aggregate. The University of Utah team will analyze the survey data and create a full report of the findings. Results will be shared with all survey recipients and a focus group will be held to discuss the findings.

If you have questions, complaints, or concerns, or if you feel you have been harmed by this research, please feel free to contact, Rob Butters, Director of the Utah Criminal Justice Center at the University of Utah at (801) 585-3246.

Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints, or concerns which you do not feel you can discuss with the principal investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by e-mail at irb@hsc.utah.edu.

It should take you 10-15 minutes to complete the survey. Participation in this survey is voluntary. You can choose not to take part and you can also choose not to finish the survey or omit any questions you prefer not to answer without penalty or loss of benefits. By clicking on the link below to enter the survey, you are giving consent to participate in the survey. Thank you for your participation.

* 1. I consent to participate in this survey

Impact of CHSH Project

2. From your perspective, what have been the positive impacts of the CHSH program on clients?

3. What have been the positive impacts of the CHSH program on partner agencies and other service providers?

Client Barriers

4. A substantial number of potentially-eligible individuals have long-term, ongoing contact with staff but do not formally enroll in the program. From your perspective, what are the most common reasons that clients choose not to participate in the CHSH program?

5. What, if anything, could be done to increase the accessibility of the CHSH program for resistant individuals?

Barriers to Service Provision

6. What barriers do you encounter most commonly in terms of obtaining and maintaining housing for clients?

7. What barriers do you encounter most commonly in terms of obtaining and maintaining clients' access to benefits, such as Medicaid or food stamps?

8. What barriers do you encounter most frequently in terms of providing substance abuse and mental health services for clients?

Community and System Barriers

9. What the most significant organizational, community, and systemic barriers to obtaining and maintaining housing for chronically homeless persons (check all that apply)?

- Duplication of Services (e.g., multiple agencies in community providing similar services to group of overlapping clients)
- Eligibility Requirements (e.g., individuals are in need of services but they do not qualify through existing programs)
- Gaps in Services (e.g., services that individuals need are not available in the community)
- Program Capacity (e.g. need more staff, more space, more vehicles)

Other (please specify)

Thank you for participating in the CHSH Staff Survey

CHSH Project, Community Partners Survey

The University of Utah developed this survey to gather feedback on the second year implementation of the Chronic Homeless Services and Housing (CHSH) project of The Road Home (also referred to as the SAMHSA grant).

Information obtained through this survey is recorded in such a manner that participants CANNOT be identified, directly or through identifiers linked to the participants. Your anonymity will be maintained and data will only be reported in aggregate. The University of Utah team will analyze the survey data and create a full report of the findings. Results will be shared with all survey recipients and a focus group will be held to discuss the findings.

If you have questions, complaints, or concerns, or if you feel you have been harmed by this research, please feel free to contact, Rob Butters, Director of the Utah Criminal Justice Center at the University of Utah at (801) 585-3246.

Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints, or concerns which you do not feel you can discuss with the principal investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by e-mail at irb@hsc.utah.edu.

It should take you 10-15 minutes to complete the survey. Participation in this survey is voluntary. You can choose not to take part, not to finish, or to omit any questions you prefer not to answer without penalty or loss of benefits. By clicking on the link below to enter the survey, you are giving consent to participate in the survey. Thank you for your participation.

*1. I consent to participate in this survey

Relationship to the CHSH Project

2. What organization do you work for?

- Department of Workforce Services
- Fourth Street Clinic
- Housing Authority of Salt Lake City
- Housing Authority of Salt Lake County
- The Road Home
- Salt Lake County, Division of Behavioral Health Services
- State Community Services Office
- State of Utah, Department of Health
- State of Utah, HMIS
- VMH
- VOA

Other (please specify)

3. In what capacity do you work with the CHSH project?

CHSH Project, Steering Committee Member

Partner Agency, Administrative

Staff Partner Agency, Direct Services

Staff Other (please specify)

Mission of CHSH Project

4. In your opinion, what is the mission of the CHSH project?

5. Overall, do you feel that the CHSH project is achieving its mission?

Yes, for the most part

Yes, but the mission is different than what I initially thought it was

No

Other (please specify)

6. What, if anything, do you think the project could do differently to better achieve its mission?

Impact on Clients

7. In your opinion, does the CHSH project provide a unique service to clients?

Yes, the project provides necessary services that were previously unavailable in the community

Sort of, the project provides necessary services that duplicate existing services in the community

No

Other (please specify)

8. Please provide examples of the benefits you have observed for clients as a result of the CHSH project.

9. Have you observed any detrimental impacts on clients as a result of the CHSH project?

- Yes
- No

10. Please provide examples of the negative impacts you have observed for clients as a result of the CHSH project, if any.

Impact on Community Partners

11. Has the CHSH project had a positive impact on you or your agency's work with chronically homeless persons (e.g. workload is lighter, more services available, better coordination between agencies)?

- Yes
- No

12. Please provide examples of the positive impacts of the CHSH project on you and/or your agency.

13. Has the CHSH project had any negative impacts on you or your agency's work with chronically homeless persons?

- Yes
- No

14. Please provide examples of the negative impacts of the CHSH project on you or your agency's work with chronically homeless persons, if any.

THE CHSH project is currently funded through September, 2014. The following questions relate to your thoughts on the

importance of sustaining the project, with local funding, beyond that time.

15. What priority do you place on sustaining the CHSH project beyond September, 2014?

Very important | Somewhat important | Not very important | Not at all important

Comments

16. What steps has your agency taken to sustain the CHSH project beyond its current funding (check all that apply)?

- Agency has committed funding to sustain CHSH
- Agency has committed personnel to sustain CHSH
- Agency has committed other resources to sustain CHSH (office space, administrative services, vehicles)
- Agency has been seeking additional funding to sustain CHSH (through grant writing, fund raising, etc.)
- Agency has contacted additional partners (non-profit, private, or government agencies) to develop support for CHSH project
- Don't know

Other (please specify)

17. One potential source of ongoing funding for the CHSH project is to enhance client resources via increased access to Medicaid. Given upcoming changes to Medicaid under the Affordable Care Act (ACA), do you feel like your agency is prepared to advise clients on enrolling in health care coverage as allowed under the ACA (Obamacare)?

18. Do you have any suggestions for sustaining the CHSH project beyond the current funding cycle?

Thank you for completing the CHSH Community Partners Survey!