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

Bi-annual Report
April 2012

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

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Background and Introduction

According to Utah's 2010 Comprehensive Report on Homelessness, 3,372 individuals in Utah were homeless during the January 2010 Point in Time count and 24.1% of these individuals were considered chronically homeless (Moore, Day, & Hardy, 2010). Nationally, it is estimated that between 10-20% of all homeless individuals are chronically homeless, but that this small group uses half of all shelter days (McCarty, 2005). 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. 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 not been successful in accessing existing permanent supportive housing (PSH). 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 Road Home identified the Utah Criminal Justice Center (UCJC) as the evaluation partner of the CHSH project on the SAMHSA grant. This evaluation will track client progress (Part I) as well as the development and implementation of the project (Part II).

Study Procedures

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

The first part of the CHSH evaluation involves tracking the CHSH project's collaborative efforts to develop, expand, and implement innovative, evidence-based services for the chronically homeless. In order to conduct this portion of this evaluation, researchers attended weekly 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. In the summer of 2012, an online survey will be conducted with project team members, administrators (e.g., Steering Committee and Community Consortium members) and representatives from partnering agencies. The purpose of

the survey is to gather feedback and to identify any barriers regarding the CHSH project. Results from the first survey will be included in the October 2012 report.

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 Position Descriptions, CHSH Referral Forms, and CHSH Intake Forms
Agency Records
Client Records, including Referral Forms, Intake Assessments, Service Plans, and Case Notes
Team Meeting Observations
Weekly partner, client selection, and staff meetings
Subcommittee Meetings
Monthly Data Subcommittee meetings to address data sharing issues with representatives from CHSH, the Road Home, and partnering agencies

The second part of the CHSH evaluation will involve tracking client characteristics, interventions, and outcomes and will 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 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 answer the first three research questions listed above. Due to the infancy of the program at the time of this report, the last three questions will not be reported on until future reports.

Table 2, on the following page, lists the primary data sources and measures used in the *Client Characteristics* and *Services Received* 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, 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. A majority of the information provided in this report is based on surveys completed by clients. As such, the accuracy of these measures relies heavily upon clients' ability and willingness to recall information. The researchers are currently working with the Project Director and staff from The Road Home to obtaining official records from partner agencies that will reduce the reliance on self-report data. The fourth, fifth, and sixth research questions will be answered in future reports 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**
Road Home/CHSH	
CHSH Client Referral Forms for all clients referred since January, 2012. Data include the referring agency and results from the Vulnerability Assessment. CHSH Intake Forms for clients who are engaged or enrolled in CHSH services. Data is self-report and includes education, employment, benefits enrollment, current homeless status, and mental health, substance abuse, and medical concerns. CHSH ClientTrack Records that document ongoing services provided to clients. Data include length and frequency of contact, services provided, goals set, goals kept, and barriers to reaching goals. Homelessness history at The Road Home from July 1, 2011. Data includes number of shelter nights. Service Plans for enrolled clients. Data includes long-term 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, and social connectedness. A revised GPRA tool, with two new sections (violence/trauma and military service), was released for use beginning March 5, 2012. Because this change occurred in the middle of this reporting period, and therefore was only used with a portion of clients, we will not be reporting on these new sections in this report.	
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 and while receiving services through CHSH. Data includes booking date, offense/booking type (e.g., new charge, warrant of arrest, bench warrant, hold), charge type and severity, release date and type, offender demographics, and court case numbers (when available).	
XChange/CORIS	
Text documents with court case information that is searchable by name, date of birth, court case number, court location, and/or date. Documents include information such as plea date, sentence date, disposition, judge, bail amount, court attendance, compliance with court orders, and sentence imposed. Court records available for a majority of Utah District and Justice Courts.	

Results

The following section of the report details grant activities during the current reporting period, from September 30, 2011 through March 31, 2012. The *Program Implementation* section of this report will describe the CHSH implementation process to date, the referral and enrollment process, the service delivery model and the organizational- and client-level barriers to implementation. Descriptions of clients and the services received are provided in later sections (see *Client Characteristics* on page 7 and *Services Received* on page 18).

Program Implementation

Staff

Hiring. The Road Home hired a full-time Project Director for CHSH, who has hired five full-time staff members: one Housing Coordinator, two Case Managers, and two licensed Substance Abuse/Mental Health Specialists (social workers). The Project Director, both Case Managers, and the Housing Coordinator are all employees of The Road Home and the two social workers are employed by partner agencies, Valley Mental Health and Volunteers of America. While these six individuals form the core of the CHSH team, the program also contracted with Valley Mental Health and purchased one-quarter time services (ten hours each per week) from a clinical psychologist and an Advanced Nurse Practitioner (APRN). The composition of staff is based on the modified Assertive Community Treatment (ACT) model proposed in the grant application. Hiring decisions were made on the basis of education and experience, which was written into the position descriptions. The Program Director, both Substance Abuse/Mental Health Specialists, and one of the Case Managers are licensed, Master's level clinicians. The other Case Manager and the Housing Coordinator have Bachelor's degrees in social work or a related profession. All staff has prior experience working in social services and the majority has experience with the chronically homeless population targeted by this grant. Four of the team members have previously worked for The Road Home and have existing relationships with both potential clients and representatives from partner agencies.

Training. During the reporting period, CHSH staff participated in eight formal training sessions in order to prepare them to work under the Housing First Model and to help clients with benefit enrollment applications. Because all staff are new to the project during this reporting period, all staff were trained on topics directly related to CHSH program goals: Medicaid eligibility and enrollment; SSI/SSDI Outreach, Access, and Recovery; Housing First; administration and interpretation of the SOQ (mental health assessment tool); administration of the GPRA; and accessing clients' benefits history in conjunction with the Department of Workforce Services. Staff also received training on ClientTrack, which is the data management tool used by The Road Home, and specifically on the CHSH template, which was designed to track client goals and progress under the scope of this grant. In addition to grant specific training, the Project Director trained staff on topics related more generally to social service delivery, including diversity and cultural awareness, de-escalation and safety tactics, confidentiality, and establishing boundaries with clients. As specified in the grant application, the Project Director and one of the case managers attended two days of GPRA training and the Project Director attended a conference on the Housing First Model.

In addition to formal training sessions, staff engaged in multiple informal sessions with partner agencies in order to build relationships and clarify program objectives. Over the past three months, the CHSH team has attended seven informal sessions with Volunteers of America, The Road Home,

and Valley Mental Health. While those are partner agencies, who were presumably familiar with CHSH objectives, these sessions served the larger purpose of building specific relationships between CHSH staff and employees from partner agencies who may not have been familiar with CHSH. Because most of these meetings took place at the partner agencies, they served the additional purpose of familiarizing CHSH staff with facilities and services available for clients in the community.

Program Structure and Service Delivery

Team Location. CHSH staff set up an office in close proximity to many agencies that provide services to homeless persons, including partner agencies. This location means that staff had easy access to partner agencies and clients had easy access to staff. Many of the clients served by the project were difficult to locate and the centralized location meant that staff had increased opportunities for spontaneous encounters, either on the street or when a project partner called CHSH staff to meet with a client who was in the partner's office. Additionally, this centralized location facilitated frequent and regular communication between partners regarding client status and allowed for unplanned, joint visits to clients when needed. This flexible, collaborative model of service delivery is central to the modified Assertive Community Treatment model (ACT) under which the project was conceptualized.

Policies and Client Recruitment. The CHSH program drafted written policies and procedures wherein they specified a formal recruitment and referral process, client eligibility requirements, a service delivery model, and data collection procedures (see Appendix B). In keeping with the modified ACT model outlined in the grant application, potential clients are actively identified and targeted through existing services and partner agencies, which include street outreach teams, homeless shelters, detoxification programs, and medical clinics that serve homeless populations. Individuals are identified as potential candidates for CHSH by representatives from partner agencies, based on the following criteria: an unaccompanied homeless person (a single homeless person who is alone and is not part of a homeless family and not accompanied by children) with a Disabling Condition, who has been continuously homeless for a year or more or has had four episodes of homelessness in the last three years. In addition, clients must meet at least one additional criteria: be diagnosed as substance abusing or substance dependent, be diagnosed with a mental illness, have a high number of police, jail, or emergency medical services contacts, have a high number of nights spent at homeless shelters, have been unsuccessful in housing, refused housing in the past, or have a high risk score on the CHSH Vulnerability Assessment tool. See Appendix B for complete eligibility criteria. Over the course of the reporting period, CHSH staff identified problems with the client eligibility criteria, as initially drafted, because they were more inclusive than the population targeted in the grant proposal. This resulted in a large number of referrals that were not appropriate for services, generally when clients' needs were primarily related to substance abuse and the client did not have other mentally or physically disabling conditions that would qualify them for services. The Project Director subsequently refined the eligibility criteria to focus on clients who meet the above criteria and who were also likely to qualify for Medicaid based on disability status.

Client Pre-Screening. In order to coordinate with existing services, which was a primary goal of the grant application, the process for referring clients to CHSH was developed in conjunction with The Road Home's Chronic Homeless Program. Partner agencies complete a referral packet for targeted individuals, consisting of a signed release of information (ROI) from the client, suggestions for locating the client, and a Vulnerability Assessment. The Vulnerability Assessment, which is filled out by the person making the referral, gauges the client's ability to function in nine domains:

homelessness, victimization and vulnerability, substance abuse, basic needs, mental health, organization and orientation, communication, social behaviors, and medical health. The completed referral packet is sent to the Chronic Homeless Coordinator at The Road Home, who gathers additional information about the client, from agency records and conversations with staff, in order to determine the chronically homeless program for which the client is best suited. In this centralized referral process, clients are more likely to be matched with appropriate services and less likely to fall through the gaps created when clients are on multiple housing wait lists that are operated by different agencies.

Client Engagement and Enrollment. Once a case was formally referred to the CHSH program, the client was assigned by the Project Director to a Service Coordinator, who could be a Case Manager or a Substance Abuse/Mental Health Specialist. The Service Coordinator was then responsible for gathering additional information to further assess the client's suitability for the program. This assessment included meeting clients to ascertain their interest in services. At the point when the Service Coordinator began making contact with the client, the client was considered *engaged* in the program. The engagement period was designed to assess congruence between client's needs, client's wishes, and the scope of the CHSH program. If and when the client was receptive to and deemed suitable for the CHSH program, she or he was *enrolled* into the program. During the first part of the reporting period, the decision to enroll clients was made by the Project Director based on information from the referral packet, conversations with partner agencies during weekly partner meetings, and an assessment, which was either conducted in-person or was gathered from other clinicians' records. When the eligibility criteria were revised, as described above, the process for determining eligibility was also revised and included in the Procedures and Operations Manual. The process now includes a formal screening of mental health and medical records from partner agencies as well as a consultation with a representative from the Department of Workforce Services (DWS) to determine the client's likely eligibility for mainstream benefits. While program staff continue to conduct the individual pieces of this review, the Project Director makes the final determination on whether to accept an individual to CHSH or to refer the individual back to the Chronic Homeless Program at The Road Home.

In keeping with the research on this population, some clients have been resistant to engaging with the CHSH team because of mental illness or a previous history with social service agencies. In such cases it was vital that the Service Coordinator worked to build a relationship with the client and gain their trust. In order to engage clients, Service Coordinators often built on the client's existing relationships with other CHSH team members or with staff from partner agencies. As such, the referring individual often accompanied the Service Coordinator to the first contact with the client. While clients were initially enrolled into CHSH at the Program Director's discretion, based on eligibility requirement alone, this process was revised during the reporting period to account for a number of clients who were highly resistant to services. Many of these clients have remained on the engaged list, per their agreement, and have continued to receive some services from CHSH staff. The larger goal of these continued contacts has been to develop relationships and ideally increase the clients' willingness to accept services in the future.

Service Coordinators and Modified ACT. Service Coordinators were responsible for introducing clients to the program, creating and implementing service plans, and coordinating ongoing services. During the first part of the reporting period, Service Coordinators were assigned to clients based on the referring agency, which meant that Service Coordinators were assigned as the lead contact person with designated partner agencies. In order to better match client needs with practitioner skills, the Project Director changed the method for assigning clients to Service Coordinators during the reporting period. As part of this change, the Project Director added an additional weekly Client

Selection Meeting, wherein clients were assigned to Service Coordinators based on the match between client characteristics and Service Coordinator training and skills. Service Coordinators continued to act as a single-point-of-contact with partner agencies. The Housing Coordinator, Project Director, APRN, and psychologist all worked with clients as needed but did not carry caseloads. As is expected under the ACT model, the Project Director for the CHSH program provides direct services to clients, both individually and as part of team outreach.

When clients needed services that the Service Coordinator could not provide directly, he or she coordinated with another team member or partner agency to make other arrangements. A central concern with this population is the client's inability to engage in services. To address this issue, Service Coordinators assumed responsibility for ensuring clients were present to receive services. All the clients engaged or enrolled during this reporting period were new to the program, and so service provision focused primarily on building relationships, addressing crisis and emergency concerns, and getting clients housed and enrolled in benefits. Both the APRN and the psychologist were used to expedite assessments and documentation required for disability certification. While the assignment of clients to specific Service Coordinators is not part of the ACT model, program staff coordinated with each other to ensure seamless and comprehensive delivery of services and to provide services themselves rather than refer clients to other agencies.

Mobile Services. In accordance with the ACT model, client services were provided in the field as well as in the office. To facilitate this model, the CHSH program purchased a van that allowed staff to meet with clients on the street, at their residence, or wherever the client was. The van was also used to transport clients to appointments and services and to assist with tasks that were central to program goals, such as helping clients move into a residence. Assessments were conducted in the field using iPads, which allowed staff to access client records even when they were not in the office. During this reporting period, the Project Director created written guidelines for checking out the van and the iPads. The iPads were stored in a locked cabinet in the Project Director's office, in order to protect client information and to ensure that they would be fully charged when needed.

CHSH Meetings. CHSH staff met weekly to discuss the goals and progress of enrolled clients as well as eligibility, interest, and progress for engaged clients. Staff used these meetings as problem-solving sessions and discussed ways to circumvent obstacles such as client resistance to services, client isolation, and client conflict with partner agencies. In February, when the eligibility and enrollment criteria were revised, the Project Director added an additional weekly meeting, called the Client Selection Meeting, where staff focused specifically on engaged clients' progress towards enrollment or referral back to the Chronic Homeless Program. CHSH staff also held weekly meetings with project partners in order to share information on clients and to review the referred clients list to ensure that all potentially appropriate clients within the community were making it onto the CHSH referral list.

Client Characteristics

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

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

Sample Selection

After a case is referred to the CHSH program, the Project Director begins gathering information to determine whether the client is appropriate for services. As part of this assessment, Service Coordinators may make contact with the client to determine his or her interest in the program. Once the Project Director determines that a client is eligible for services, the Service Coordinator will continue making regular contact with the client, although the client may not have agreed to be a participant. At this point the client is considered *engaged* in the program, which means they are having contacts but have not agreed to receiving services. The engagement period was designed to assess congruence between client's needs, client's wishes, and the scope of the CHSH program. If and when the client is receptive to and deemed suitable for CHSH, she or he is *enrolled* into the program. 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.

When reviewing this section of the report, it is important that the reader keep in mind the small sample sizes being examined in this report. For instance, although a finding that half of all enrolled clients have a certain characteristic is interesting, it is important to remember that this still only represents 11 people.

Table 3 CHSH Samples

	N
Engaged Clients[1]	15
Enrolled Clients	22
Total	***37***

[1] Two of the 15 clients in the engaged sample were closed out from the program during the last week on March 2012 and referred back to the Chronic Homeless Coordinator.

Referrals to CHSH

Referring Agencies. The referral process into CHSH is coordinated through The Road Home's Chronic Homeless Program, which acts as a clearinghouse for referring chronically homeless persons into different housing programs. Partner agencies complete a referral packet for targeted individuals, consisting of a signed release of information (ROI) from the client, suggestions for locating the client, and a Vulnerability Assessment. The completed referral packet is sent to the Chronic Homeless Coordinator at The Road Home, who gathers additional information about the client, from agency records and conversations with staff, in order to determine the chronically homeless program for which the client is best suited. The Chronic Homeless Services Coordinator makes his referral decision based on how well the clients' characteristics match with CHSH service goals and therefore targets persons with a long history of homelessness who also have a disabling condition. Once he determines that a client is a good fit, he sends the entire referral packet to the Project Director.

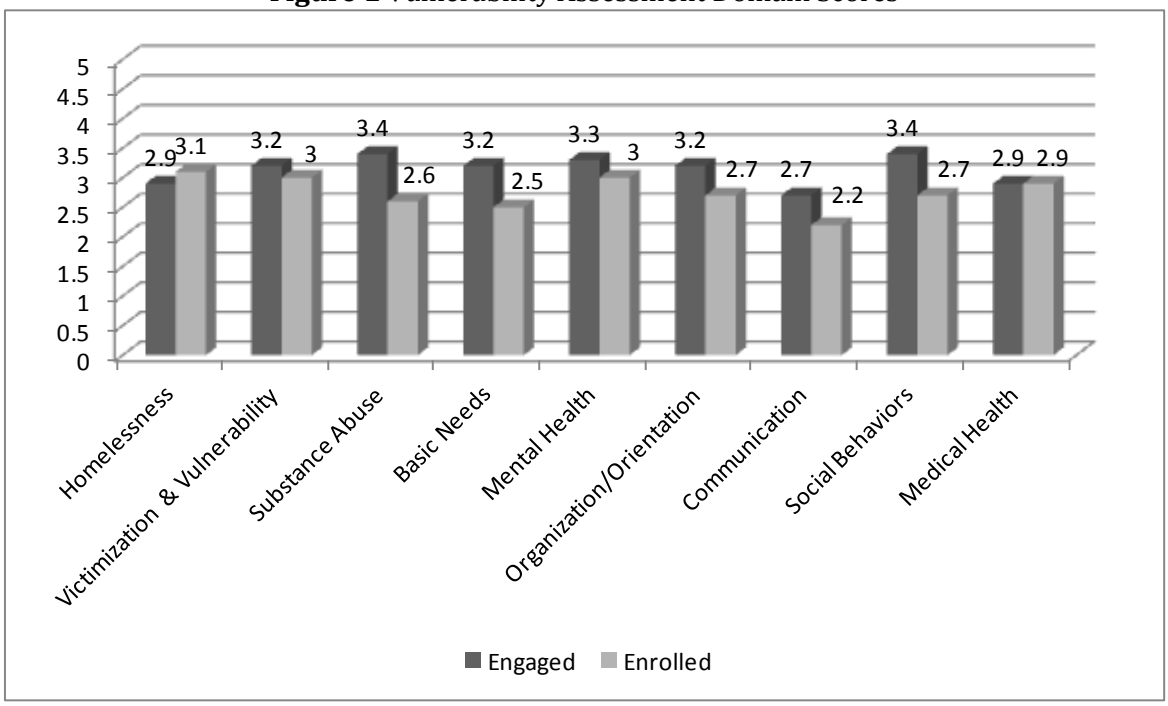
Table 4 Referral Source

Agency/Group Name	Engaged	Enrolled	Combined	
	#	#	#	%
The Road Home	2	3	5	14
Mobile Outreach Street Team (MOST)	2	5	7	19
Pathways	0	3	3	8
Volunteers of America (VOA)	4	1	5	14
4th Street Clinic	1	3	4	11
Unknown	6	7	13	35
Total	15	22	37	--

In order to make a referral to CHSH, referring agencies complete the referral packet, in which they assess clients' vulnerability, obtain a signed release from the client in which he or she agrees to both the referral and information sharing, and information about the best way to make contact with the client. The referral packet, which is a paper document, is then sent to the Chronic Homeless Coordinator who reviews the information, as described above, and forwards it to CHSH when appropriate.

Vulnerability Assessment. The Vulnerability Assessment tool was originally designed for use by The Road Home Chronic Homeless and Pathways programs and was chosen for the CHSH referral process in order to coordinate with those programs. The Vulnerability Assessment identifies clients' areas of greatest need (see Appendix A for a copy of the tool). Individuals are scored on a scale of 1-5 in a variety of areas, including: homelessness, victimization and vulnerability, substance abuse, basic needs, mental health, organization and orientation, communication, social behaviors, and medical health. Higher scores indicate areas of greater need. At referral, engaged clients (28.2) had slightly higher overall scores than enrolled clients (24.7). Figure 1, on the following page, displays the average scores broken out by the individual domains. Although, the two groups score very similarly, a few differences were observed. On average, engaged clients scored higher in the areas of Substance Abuse, Basic Needs, Organization and Orientation, and Social Behaviors. Higher scores in Substance Abuse, Organization and Orientation, and Social Behaviors for engaged clients may reflect the difficulty that those particular vulnerabilities create when Service Coordinators are introducing clients to the program. While some clients are eager for services, Service Coordinator's case notes indicate that many of the clients who are resistant to services are paranoid, distrustful of services, confused, or never sober, and therefore spend more time in the engagement phase as staff work to navigate those barriers.

Figure 1 Vulnerability Assessment Domain Scores



Participant Characteristics at Intake

Demographics. Client demographics at Intake are shown in Table 5 for both engaged and enrolled clients. A majority of clients in both groups were male (73% engaged, 82% enrolled) and had an average age in the low 50s. Just over half (55%) of enrolled clients were White, which was slightly higher than the engaged group (40%). Over two-thirds of enrolled clients (68%) indicated that they had children; however, it is likely that a majority of these children are adults.

Table 5 Demographics at Intake

	Engaged	Enrolled
Total Sample (N)	*15*	*22*
Demographics		
Male (%)	73	82
Age (Mn)	51	53
Hispanic or Latino (%)	0	9
Race (%)		
White	40	55
Black/African American	0	18
Asian	0	5
American Indian/ Alaska Native	53	14
Native Hawaiian/Pacific Islander	6	0
Unknown/Missing Data	0	9
Veteran/ Served in Military (%)	--	14
Percent with Children (%)	--	68
Number of children (Mn)	--	2

Homelessness and Housing. Based on official shelter records, a majority of both engaged and enrolled clients have recently stayed at The Road Home's Emergency Shelter (see Table 6). In fact, between July 1, 2011 and March 31, 2012, both groups spent an average of around 80 nights in the shelter, and as a whole, these 37 individuals accounted for a total of 3,030 nights in the shelter during this nine month period. Due to a database change that occurred in July 2011, we were unable to report on shelter use prior to this date in time for this report. Current efforts are being made to address this issue and we are optimistic that future reports will report on a longer and more detailed history of shelter use for this population. During this reporting period, the Project Director searched clients' historical records with The Road Home by hand in order to determine and confirm their chronic homeless status.

Table 6 Homelessness and Housing at Intake

	Engaged	Enrolled
Total Sample (N)	*15*	*22*
Homeless Shelter Use since July 2011[1]		
Stayed in the Shelter at least one night (%)	80	91
Total # of nights[2]	1210	1820
Average # of nights per client (Mn)	81	83

[1] Shelter use only available from July 2011 forward due to database change. A longer history will be included in future reports.
[2] Total count for entire sample

At Intake, few enrolled clients (18%) reported being primarily "housed" during the previous 30 days (see Table 7). These clients reported staying in someone else's apartment, room, or house (n=2), a motel (n=1) and a garage (n=1). While filling out the Road Home Intake form, engaged clients were asked where they had spent the previous night. Only a quarter (27%) had stayed in a shelter, while another quarter (27%) reported spending the previous night in jail, prison, or a juvenile detention center.

Table 7 Living Situation at Intake

	Engaged	Enrolled
Total Sample (N)	*15*	*22*
Living Situation		
Primary Living Situation during the past 30 days: (%)		
Shelter	--	64
Street/Outdoors	--	14
Institution	--	5
Housed	--	18
Where did you stay last night?		
Emergency Shelter	27	--
Place not meant for habitation (streets, etc.)	7	--
Jail/Prison/Juvenile Detention Center	27	--
Unknown/Missing Data	40	--

Social Connectedness. A small number of enrolled clients were attending self-help groups at the time of their Intake; however, many more (41%) noted that they had recently interacted with family and/or friends that were supportive of their recovery (see Table 8, on the following page).

Just over one-third (36%) of enrolled clients stated at they did not have anyone to turn to, other than themselves, when they were having trouble. It appears that these clients are socially isolated and would benefit from CHSH services, which target improvements in the areas of social connectedness and support systems.

Table 8 Support Systems at Intake

	Enrolled
Total Sample (N)	*22*
During the past 30 days:	
Attended any voluntary self-help groups (e.g., AA, NA) (%)	18
# of times attended (Mn)	10
Attended any religious/faith affiliated recovery self-help groups (%)	14
# of times attended (Mn)	2
Attended any other meetings that support recovery (%)	18
# of times attended (Mn)	6
Had interaction(s) with family/friends that are supportive of recovery (%)	41
Person they turn to when having trouble: (%)	
No one	27
Self	9
Family Member	14
Friends	14
Significant Other/Partner	9
Therapist/Clinician	9
Clergy Member	5
God/Higher Power	9
Other	4

Education and Employment. Half (50%) of enrolled clients had a high school diploma (or the equivalent) and a few had college degrees (Associates or higher, see Table 9). None of the enrolled clients were employed at Intake and only a few (18%, 4) indicated that they were looking for work.

Table 9 Education and Employment at Intake

	Enrolled
Total Sample (N)	*22*
Education	
Enrolled in School or Job Training Program (%)	
Full-time	5
Part-time	9
Education Level (%)	
Less than High School	32
High School/Equivalent	50
Associates Degree	14
Bachelor's Degree or higher	5
Employment	
Employed (%)	0
Unemployed (%)	100
Looking for work	18

	Enrolled
Disabled	27
Volunteer work	0
Retired	14
Not looking for work	32
Other	9

Monthly Income. Enrolled clients reported an average monthly income of just over 400 dollars at Intake and 18% reported no income (see Table 10). Two clients reported receiving wages during the previous month; however, the amount was minimal. By far the largest average amounts came from Retirement and Disability payments; however, only a few clients were receiving these types of payments at Intake.

Table 10 Income at Intake

	Enrolled	
Total Sample (N)	*22*	
	%	Amt (Mn)
Monthly Income		
Wages	9	$44
Public assistance	55	$278
Retirement	5	$770
Disability[1]	18	$757
Non-legal income	0	$0
Family and/or friends	5	$20
Other	9	$374
Any Income[1]	**82**	**$402**

[1] One individual received $15000 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.

Physical Health. Over two-thirds (68%) of enrolled clients rated their overall health as fair or poor (see Table 11). This is most likely due to the 64% of clients who self-reported having a chronic health condition and the 23% who reported a physical disability. Nearly a quarter of clients (23%) reported receiving treatment in an Emergency Room (ER) during the month prior to Intake, and on average they were treated twice (see Table 12, on the following page). Clients most commonly received treatment in Outpatient, Inpatient, and ER settings for physical complaints.

Table 11 Physical Health at Intake

	Enrolled
Total Sample (N)	*22*
Overall health rating (%)[1]	
Excellent	14
Very Good	14
Good	5
Fair	45
Poor	23
Chronic Health Condition (%)	64

	Enrolled
Physical Disability (%)	23
Sexual Activity	
Engaged in sexual activity during the past 30 days (%)	23
Number of unprotected sexual contacts (Mn)	7
Ever been tested for HIV (%)	86
Knows the results of HIV test(s) (%)	89

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

Table 12 Medical Treatment – 30 Days Prior to Intake

	Enrolled	
Total Sample (N)	*22*	
	%	# (Mn) [1]
Inpatient Treatment		
For any reason	18	3
Physical complaint	14	3
Mental or emotional difficulties	0	--
Alcohol or substance abuse	5	3
Outpatient Treatment		
For any reason	36	4
Physical complaint	27	4
Mental or emotional difficulties	18	2
Alcohol or substance abuse	5	4
Emergency Room (ER) Treatment		
For any reason	23	2
Physical complaint	18	1
Mental or emotional difficulties	0	--
Alcohol or substance abuse	9	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. Enrolled clients were asked whether they had experienced a variety of psychological/emotional problems during the previous 30 days (see Table 13, on the following page). The most frequently occurring problems were serious depression, serious anxiety or tension, and trouble understanding, concentrating, or remembering. Clients were also asked on The Road Home Intake form if they had any mental health concerns. All enrolled clients indicated that they were experiencing mental health concerns; however, very few (18%) were currently being treated for these issues. Nearly all enrolled clients (91%) were screened for co-occurring substance abuse and mental health disorders, and 40% screened positively for co-occurring disorders. The high incidence of mental health issues and low reported treatment of such ailments suggests that this is an area of need that the CHSH program should focus on addressing with clients.

Table 13 Mental Health at Intake

	Enrolled	
Total Sample (N)	*22*	
	%	# (Mn) [1]
Psychological/Emotional problems experienced in past 30 days:		
Serious depression	59	14
Serious anxiety or tension	59	20
Hallucinations	5	8
Trouble understanding, concentrating, or remembering	55	21
Trouble controlling violent behavior	5	7
Attempted suicide	0	0
Been prescribed medication for psychological/emotional problem	27	30
Mental Illness		
Mental Health concerns	100	
Receiving Mental Health Services	18	
Screened for co-occurring disorders (%)[2]	91	--
Screened positive (%)	40	--

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

[2] Co-occurring mental health and substance abuse disorders

Alcohol and Drug Use. Self-reported data, collected at Intake, suggests that a majority of enrolled and engaged clients have a history of substance abuse (enrolled: 15 out of 17 with data; engaged: all 13 with data); however, Marijuana was the only drug reported by the few enrolled clients (14%, see Table 14) who reported any recent drug use. These discrepancies could represent underreporting of recent drug use or may indicate that although many clients have a history of substance abuse, recent (past 30 day) use is low. Alcohol use among enrolled clients was much higher, with 59% reporting recent alcohol use and 37% reporting alcohol use to the point of intoxication. Nearly half (43%) of clients reporting recent alcohol and/or drug use indicated that things have been "considerably" or "extremely" stressful for them because of their use of alcohol or drugs (see Table 15, on the following page).

Table 14 Alcohol and Drug Use at Intake

	Enrolled	
Total Sample (N)	*22*	
	%	# (Mn)[1]
During the past 30 days, have you used:		
Any alcohol	59	14
Alcohol to intoxication (5+ drinks in one sitting)	32	20
Alcohol to intoxication (4 or fewer drinks in one sitting, felt high)	5	1
Both alcohol and drugs (on the same day)	9	9
Any Illegal drugs	14	7
Marijuana/Hashish	14	7
Injected drugs during the past 30 days	0	--

[1] Of those reporting use, average # of times used during the past 30 days

Table 15 Emotional Impact of Alcohol and Drug Use at Intake for 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?	43	14	14	29
Has your use of alcohol or drugs caused you to reduce or give up important activities?	77	8	0	15
Has your use of alcohol or other drugs caused you to have emotional problems?	57	22	14	7

[1] Only for those clients reporting alcohol and/or drug use during the previous 30 days (n=14)

Criminal Justice Involvement. One measure of criminal justice involvement was provided through self-reported data collected from enrolled clients with reference to the 30 days prior to Intake (see Table 16). According to this data, 18% of enrolled clients were arrested during the previous month and spent at least one night in jail or prison. Over a quarter (27%) of clients admitted to committing a crime in the previous month, and many committed multiple crimes (Mn=9).

Table 16 Self-Reported Criminal Justice Involvement at Intake

	Enrolled
Total Sample (N)	22
During the past 30 days:	
Arrested for any reason (%)	18
# times arrested (Mn)	1
Spent at least one night in jail or prison (%)	18
# nights spent in jail or prison (Mn)	2
Arrested for drug related offense(s) (%)	5
# times arrested for drug-related offenses (Mn)	1
Committed a crime (%)	27
# times committed a crime (Mn)	9
Currently awaiting charges, trial, or sentencing (%)	23
Currently on parole or probation (%)	5

In addition to self-reported data, court (Utah District and Justice Courts) and jail (Salt Lake County Adult Detention Center (ADC)) records were examined for the two years prior to Intake for both engaged and enrolled clients. Nearly two-thirds of engaged clients (60%) and almost half (45%) of enrolled clients were booked into the ADC for a new charge at least once during the previous two years (see Table 17, on the following page). Engaged clients had more bookings for new charges, warrants, and commitments than enrolled clients. When combined (n=37), the two groups account for 134 jail bookings and 2,041 nights spent in jail during this two year period. Nearly all new charges were Misdemeanors and, by far, they were most commonly alcohol-related public order offenses (e.g., open container, public intoxication). A majority of engaged (86%) and enrolled (82%) clients had court cases filed during the previous 2 years. On average, engaged clients had 26 cases filed during this time period and enrolled clients had an average of 16 cases filed with the court. Nearly all cases were filed in Justice Court, and many were handled through the Homeless Court operated out of the Salt Lake City Justice Court (not shown in Table). Combined, the two groups had

621 cases filed in Utah courts during the previous two years. At Intake, a majority of clients in both groups (engaged, 86%; enrolled, 82%) still had at least one open court case, with an average of 4 cases open at Intake into CHSH. These figures are much higher than what was self-reported at Intake (23%, see Table 16, on previous page).

Table 17 Criminal Justice Involvement from Official Records

	Engaged	Enrolled
Total Sample (N)	*15*	*22*
Jail Bookings – 2 years prior to Intake		
Percent with prior booking(s) for *any reason* (%)	73	59
Percent with prior booking(s) for *new charge(s)* (%)	60	45
Percent with prior booking(s) for *warrant(s)* (%)	73	55
Percent with prior booking(s) for *commitment(s)* (%)	53	36
Of those with booking(s):		
Total number of bookings[1]	71	63
Average number of bookings (Mn)	7	5
Total nights spent in jail[1]	1057	984
Average total nights spent in jail (Mn)	96	76
Of those with new charge(s):		
Total number of new charges[1]	73	68
Average number of charges (Mn)	8	7
Charge Type (%):		
Person	0	9
Property	19	12
Drug	7	1
Public Order	71	78
Alcohol-related	90	79
Other	3	0
Charge Severity (%):		
Misdemeanor	93	97
Felony	7	3
Criminal Court		
Percent with court case(s) filed (%) - 2 years prior to Intake	86	82
Of those with case(s) filed:		
Total number of cases filed [1]	342	279
Average number of cases filed (Mn)	26	16
Jurisdiction: (%)		
Justice Court	98	99
District Court	2	1
Percent with open court case(s) at Intake[2] (%)	80	82
Total number of open cases [1]	51	76
Average number of open cases (Mn)	4	4

[1] Total count for entire sample

[2] Court cases that have been filed with the court but have not been adjudicated/sentenced

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 extremely high jail bookings and court case filings associated with this small group of individuals represents an immense and expensive burden on the criminal justice system.

Services Received

Case Management

On average, enrolled clients were in the engagement period for 19 days; however, this varied greatly, ranging from 0 to 60 days. Engaged clients have been in the engagement period for substantially longer (Mn=49 days, see Table 18). Clients received case management through the CHSH team members while they were in both the engagement and enrollment periods. On average, case managers met with engaged clients every 7 days and enrolled clients every 3 days. After enrolling in the program, clients met with their case manager every four days, on average. Case management contacts occurred in a variety of locations and lasted around 45 minutes during the engagement period and 50 minutes for enrolled clients (Mn, not shown in table).

Table 18 Case Management (CM) Contacts

	Engaged	Enrolled
Number of days (Mn):		
in Engagement period	49	19
in Enrollment period	--	36
Number of CM contacts (Mn):		
during Engagement period	5	4
during Enrollment period	--	10
Total minutes of CM (Mn):		
during Engagement period	222	177
during Enrollment period	--	498
Days between CM contacts (Mn):		
during Engagement period	7	3
during Enrollment period	--	4

Goals and Services

In keeping with the project objectives, the larger goals set for all clients were the attainment of stable housing, enrollment in benefits, and employment where appropriate. Clients encountered multiple barriers to achieving those goals, most of which are inherent to the target population. Clients had difficulties making and keeping appointments, maintaining eligibility in benefit programs and on housing lists, establishing connections with social service agencies, completing applications, and keeping track of documents such as birth certificates and social security cards. In response to such barriers, staff set short term goals with clients, which included the following types of assistance: obtaining replacement identification cards, filling out applications, setting appointments, transporting clients to appointments, advocating for clients with partner agencies, and helping clients stay in compliance with requirements such as lease agreements or probation conditions. Given the mental health and substance abuse issues within this population, Service Coordinators frequently had to start work with clients by setting goals related to relationship-

building, with the larger intent of engaging the client in services in the future. Service Coordinators also set goals targeting social isolation, and worked to facilitate ongoing relationships between clients and other service providers.

Benefits Enrollment

Table 19 presents a snapshot view of clients' mainstream benefits status as of March 31, 2012. Enrolling clients in benefits is an ongoing process for Service Coordinators, as even clients who are eligible for those benefits have difficulty completing applications, maintaining eligibility, and filing appeals if their application is denied. Service Coordinators are continuously working to help clients obtain replacement documentation, file appeals, complete all necessary forms, and get disability certification.

Table 19 Mainstream Benefits for Enrolled Clients

Mainstream Benefit Type (n)	Approved[1]	Application Filed	Appeal Filed	Denied
Medicaid	12	2	0	4
SSI/SSDI	11	1	1	4
Food Stamps	19	0	0	1
General Assistance	1	1	0	3
Veteran's Benefits/Pension	3	0	0	0
Temporary Assistance for Needy Families (TANF)	0	0	0	0
Primary Care Network (PCN)	3	4	0	0
Medicare	6	0	0	0

[1] This number includes both clients enrolled in benefits during CHSH participation and prior to CHSH participation

Housing Placement

Table 20 Housing Placement for Enrolled Clients

Funding Source	Housing Type	Total # Units	# Clients Served
HPRP	Scattered	2	2
Salt Lake County General Funds	Congregate	1	1
Project Based Shelter + Care	Congregate	1	1

Four of the 22 enrolled clients have been placed in housing (see Table 20). The Housing Coordinator works with Service Coordinators to make sure that clients are given choices in terms of where they live. Service Coordinators also collaborate with the Housing Coordinator to facilitate housing activities for clients, including touring available housing units, lease signing, security and rent deposits, moving, and setting up the household with furnishings and food. One of the biggest barriers to housing has been the lack of housing vouchers available in the community. Staff is in constant communication with area housing coordinators, to maintain their clients' position on housing lists, but have still had a difficult time finding units. The Road Home has also applied for additional funds to provide subsidies for CHSH clients (see *Resources* paragraph of *Organizational Barriers* on page 22).

Discussion

Organizational Barriers

Staff Training

Many of the CHSH staff was hired at approximately the same time the office was opened and they began working with clients at the same time they were being trained on the service delivery model and program policies and procedures. This arrangement created some inconsistencies in the initial collection of data. For example, Service Coordinators had not been trained to administer the GPRA form when the program started and were unsure how to answer some of the questions and of the necessity to enter GPRA information into SAIS within three days of administering the form. As the project was starting, the Director designed several templates for recording case notes and service plans, but staff sometimes used existing forms, rather than the new ones, resulting in data being recorded in a range of formats during the first month of the program. Those problems were resolved during the current reporting period as staff received ongoing training.

While staff came to the project with experience working with chronically homeless persons, the modified ACT model is different from the service model that many staff had worked with previously. This discrepancy, along with delayed training, resulted in some confusion among staff as to their roles and responsibilities. Because client recruitment, referral, and eligibility requirements were revised several times during the reporting period, staff's uncertainty about the service delivery model was exacerbated by the changing nature of program policies and protocols. The Project Director addressed those issues during weekly staff meetings and addressed the following primary concerns: affirming the high dosage of services required in an intensive case management model; discussing management of the blurring of boundaries that can occur when licensed clinicians also function as Service Coordinators; and clarifying the process for referring clients who did not meet CHSH eligibility guidelines.

Collaboration

The weekly partner meetings were intended to be used to share information and facilitate active recruitment of potential clients, in keeping with the ACT model. Several problems in the referral process emerged during these meetings, including: the changing nature of the eligibility requirements; the importance of ongoing targeting of potential clients; and the importance of making all staff at partner agencies aware of CHSH goals and services and not just the agency representatives who attend the weekly meetings. To address these problems, agency representatives were asked to familiarize their staff with the CHSH program or to arrange a meeting between their staff and CHSH. Additionally, the Chronic Homeless Coordinator began sharing his list of referrals at partner meetings, so partners could identify new clients who should be added to the list.

As drafted, the CHSH grant included information sharing between partner agencies for service delivery and program evaluation purposes. The mechanism for sharing information was predicated on pre-existing memoranda of understandings (MOU), which allowed for this type of collaboration in current service programs. As the project was implemented, however, that sharing became difficult when legal staff from various agencies objected to formal information sharing. The CHSH project has drafted release of information (ROI) forms, allowing partners to share information, but those forms have been continuously revised pending the approval of the various agency

representatives. This process has been complicated by the fact that staff felt it was burdensome to have clients sign multiple releases, a concern that is particularly relevant for this population, who often suffer from mental illness that includes paranoia and delusion. Efforts to create a single MOU have been further hampered by the lack of consistency among agency representatives who attend the monthly Data Sub-Committee meetings. While agency representation has been strong, agencies have not always sent the same staff person, which has resulted in partial information and lack of follow-through regarding agency requirements for the ROI. At the end of this reporting period, the CHSH program was using a draft ROI that had been approved by the majority of partners, and was using individual release forms from the Department of Workforce Services. The project has not been accessing information formally from The Fourth Street Clinic, which changed Executive Directors in the time between grant writing and project implementation. The new Director was concerned that Health Insurance Portability and Accountability (HIPAA) regulations would impact information sharing with respect to clients' medical records. To resolve this problem, project staff has continued to meet with the Clinic Director and the research team to develop information sharing strategies that are in accordance with HIPAA regulations. These problems may have been averted, in part, if specific CHSH project MOUs were drafted when the grant was being written.

Throughout this period, staff was able to access information informally. CHSH staff members are employed by several different agencies, and have therefore been able to access information from multiple systems within several agencies. This unique situation allowed them to gather information about clients who had signed a CHSH ROI in order to determine client eligibility for CHSH and also develop service plans. Much of the focus of services during this period was on getting clients enrolled in mainstream benefits, which required information from the Department of Workforce Services regarding clients' current enrollments. In order to facilitate service delivery while the ROI was under review with the DWS legal team, a DWS worker was seated on the CHSH team, attended staff meetings, and informally shared information. In general, staff has had minimal difficulty accessing clients' individual agency records for purposes of providing services. Information sharing problems have surfaced primarily in relation to gathering historical and ongoing client data for evaluation purposes.

CHSH team members are employed by different social service agencies in order to facilitate seamless service delivery and collaboration between agencies. This dual role has been beneficial, for the most part, but complicates the process of tracking grant activities. One of the CHSH staff members splits time between three agencies, all of which work with the CHSH clients. The distinction between which work should be recorded in which agency's files is not always clear. This problem has been addressed during staff meetings and part-time staff has been encouraged to document those services that are being provided under the CHSH rubric in a format that is accessible to the entire CHSH team.

Service Model

As the grant was written, clients were assessed for substance abuse and mental illness using tools that were congruent with those used by partner agencies. Since the project was implemented, however, those assessments were determined to be clinically irrelevant and practically unfeasible. CHSH staff has worked with Valley Mental Health, which is a partner agency, to select other assessments that are sensitive to short-term client change, are relatively quick to administer, are easy to interpret, and are used by other service providers in the county. Valley Mental Health provided staff training on administering and interpreting the mental health assessment (SOQ) and is willing to provide training on the substance abuse assessment tool. As a result of these changes, relatively few clients have received formal mental health assessments from the CHSH team and

none have been formally assessed for substance abuse by CHSH staff. In order to address this problem, staff has been collecting substance abuse assessments conducted by partner agencies and using them to develop clients' service plans. The Project Director has worked with partner agencies to select a more suitable assessment tool (ASAM) and staff training is scheduled for April, 2012.

A primary focus of the grant was the enrollment of clients into mainstream benefits. That process was initially complicated by the large number of referred clients who were not eligible for those benefits. Most of those clients were ineligible because they had substance abuse issues but no other physical or mental disability that were reported or readily identifiable, which must be present to qualify for Medicaid and SSI/SSDI. CHSH staff worked to enroll clients in the Primary Care Network (PCN), a state health insurance program, if they were not eligible for Medicaid. While revisions to the eligibility criteria have addressed the problem of enrolling ineligible clients into the CHSH program, to some degree, staff still encounters difficulty documenting clients' disabilities. For instance, some difficulty has been experienced when making a distinction between cognitive impairment due to substance abuse and impairment due to other factors such as mental illness or brain injury. Furthermore, clients who abuse substances may not be sober enough while meeting with a provider for the assessment to be accurate.

Resources

During this reporting period, CHSH staff obtained housing for four clients. The placement of additional clients was hampered by a lack of available housing vouchers. Housing units and vouchers that were committed to the CHSH project at the time the grant was written were in service by the time the project started. In March, The Road Home was awarded Continuum of Care leasing dollars from the Department of Housing and Urban Development (HUD). The Road Home applied for the funds specifically to address gaps in housing for the clients served by this grant and the monies, which will be available in July, 2012, will provide new rental subsidies for 32 CHSH clients. While the new HUD leasing dollars will address these shortages for the immediate future, additional funding will be needed in coming years because the existing housing and voucher stock does not create enough openings through natural attrition to accommodate all new CHSH clients. This issue has been presented to the CHSH Steering Committee, which includes representatives from city and county Housing Authoritites, and efforts are being made to develop ongoing solutions.

Client Barriers

Housing First and ACT models both target clients with significant barriers to stable housing and benefits enrollment, and those difficulties were evident, as expected, in the clients served by the CHSH program. Staff was often unable to locate clients and spent a significant amount of time searching for clients, both on the street and through agency and informal contacts. Clients were also often resistant to services, because of mental illness and/or previous history with social service agencies. In these situations, staff spent significant time building rapport with clients, by building on existing relationships, providing clients with services they were willing to accept, and spending time with clients without requiring that the client set specific goals or formally engage in CHSH services. Those methods are in line with the ACT model, which is based on the assertive engagement of clients, community-based services, and a no dropout policy. Clients who were resistant to services remained on the engagement list and continued to receive ongoing visits from program staff in an effort to increase enrollment in services.

Several clients expressed interest in the program but were unable to engage in services and treatment due to ongoing substance abuse, often because the client was intoxicated during

meetings with the Service Coordinators. Staff attempted to address this problem by strategizing with partner agencies to be notified when these clients were found to be sober. In keeping with the ACT model, clients were not required to engage in treatment or stay sober to be eligible for services; however, assessments and goal setting was more likely to be successful when the client was able to fully participate in the process.

Progress on Project Goals

The CHSH Program's primary goals are to increase chronically homeless persons' access to housing and mainstream benefits, with a specific focus on those individuals who have a history of substance abuse, mental illness and resistance to engaging in social services. During this reporting period, program staff completed many key activities identified in the grant application. As discussed above, the Project Director has hired and trained staff, created policies and protocols, set up an office, and implemented an interagency process for targeting and referring appropriate clients. Within the first three months, the program has already enrolled 22 clients and engaged an additional 15 individuals. Program success with all of these clients was evident in the fact that clients continued to set and keep appointments throughout the reporting period. In some cases, clients who had previously been highly resistant to services began actively seeking contact with their Service Coordinator.

During this reporting period, the CHSH program has demonstrated a commitment to timely completion of project goals. Staff has received extensive training on issues important to working in the modified ACT model, including Housing First, benefits enrollment, community resources, and mental health assessments. The Project Director worked with staff and partners to create and modify recruitment procedures in order to ensure the program was reaching its intended population. This report demonstrates that the program is now targeting an appropriate clientele: both engaged and enrolled clients are high risk, in terms of their vulnerability, and are high resources users, as demonstrated by their history of extensive shelter nights, frequent use of emergency medical services, and high number of contacts with the criminal justice system.

Interagency information sharing, which is a central component of the CHSH service model, reduces duplication of services, facilitates program evaluation simultaneous to service delivery, and increases the quality of client care because staff is able to make informed decisions about clients. Working with partners to target and serve clients increases the chances that clients will receive appropriate services and reduces the strain placed on partner agencies, many of which have been working with these clients for years without sufficient resources to provide intensive case management. The interdisciplinary outreach team model allows staff to provide a variety of services at one time, rather than setting multiple appointments, and to track client's progress toward goals over time.

Given the inherent difficulties of working with this population while collaborating with so many partner agencies, it is not surprising that the program has encountered some hiccups in its first few months of operation. That being said, the Project Director has done an exemplary job identifying and addressing barriers as they arise. Although the Project Director functions as the project leader, the CHSH program is a truly collaborative model, and as such, team members frequently consult with partners to address client and program barriers. This shared service delivery model can itself pose challenges, but the progress that the CHSH program has made to date demonstrates the model's positive benefits for clients, partners, and funders.

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Appendix A - Vulnerability Assessment Index

Homelessness

Time in shelter and on the streets

0	1	2	3	4
N/A	Homeless 1 year or 4 episodes of homelessness in the last 3 years.	Homeless 1-3 years and/or 1000+ shelter nights.	Homeless 3-10 yrs.	Homeless 10+ yrs.

Victimization & Vulnerability

Behavior, environment, & social relations

0 (No Vulnerability)	1 (Mild Vulnerability)	2 (Moderate Vulnerability)	3 (High Vulnerability)	4 (Severe Vulnerability)
Never victimized; Maintains adequate protection against environmental hazards/conditions; Behavior is safe/low risk.	Seldom victimized; uses appropriate recovery resources when needed Engages in some risky behavior (i.e. prostitution, drug use).	Occasionally victimized & reports being taken advantage of; Involved in detrimental social situations; Sometimes in hazardous environmental conditions.	Often victimized; Frequently engages in high risk behavior; Frequently exposed to unsafe environmental conditions.	Consistently victimized; Almost always surrounded by dangerous social influences; Almost always exposed to hazardous environmental conditions.

Substance Abuse

Use and its impact on functioning

0 (No Impact)	1 (Mild Impact)	2 (Moderate Impact)	3 (High Impact)	4 (Severe Impact)
No use for 5 or more years.	Either no use or occasional use, but no significant effects on functioning for the past 2+ years.	Occasional to regular use w/ moderate impact for past year.	Frequent use w/ substantial impairment; May binge but not daily.	Chronic, dangerous use; Risk for withdrawal or OD high; Life severely impaired or threatened.

Basic Needs

Food, shelter, hygiene, & critical health care

0 (Not Problematic)	1 (Mildly Problematic)	2 (Moderately Problematic)	3 (Highly Problematic)	4 (Severely Problematic)
Self-Reliant; Strong knowledge of resources; Regularly accesses resources; Maintains a basic standard of living.	Maintains a knowledge of local resources; Some trouble accessing resources; Occasionally doesn't meet basic needs.	Some knowledge but irregular access of local resources; Needs assistance in maintaining basic needs; Inconsistent self care.	Will access services/resources only in extreme situations; Very rarely meets basic needs; Poor self care.	Completely dependent; Incapable of accessing surrounding resources; Does not meet daily basic needs.

Mental health

Disorders, treatment, and symptomatic behavior

0 (No MH Issues)	1 (Mild MH Issues)	2 (Moderate MH Issues)	3 (High MH Issues)	4 (Severe MH Issues)
Appears to have no or minimal mental health issues.	Mild mental health issues (i.e. depression, anxiety) that are easily treated; Generally consistent w/ treatment.	May be involved in treatment and may be taking meds but struggles with treatment follow-through; Insight slightly impaired.	Poor follow through with treatment and/or treatment avoidant. May take meds inconsistently; ER used for main mental health care; May talk to self or inanimate objects.	Socially isolates or is inappropriately emotional in public places (crying, anger, yelling, obscene or profane language used); Significantly impaired ability to deal with daily stressors.

Organization/Orientation

Managing appointments and daily life

0 (No Impairment)	1 (Mild Impairment)	2 (Moderate Impairment)	3 (High Impairment)	4 (Severe Impairment)
Able to keep track of appts.	Occasional difficulties staying organized but is able to keep needed appts w/ minimal assistance.	Regular difficulties w/ organization; Needs assistance to keep appts; May be easily distracted but can be redirected.	Memory impaired or may be unable to track conversation; Poor awareness of surroundings.	Highly confused or disorientated in reference to time, place, or person.

Communication

Language, expressing needs, and understanding

0 (No Communication Barrier)	1 (Mild Communication Barrier)	2 (Moderate Communication Barrier)	3 (High Communication Barrier)	4 (Severe Communication Barrier)
Able to communicate needs in a productive way.	May slightly struggle with understanding written or spoken instructions but generally communicates needs.	Has some trouble communicating needs; Language barrier may be an issue.	Significant difficulty communicating w/ others, unless assisted; Language barrier may be an issue w/ limited interpretation resources available.	Unwilling or unable to communicate needs; May have insurmountable language barrier.

Social Behaviors

Sociability, interactions, and response to stress

0 (No Impairment)	1 (Mild Impairment)	2 (Moderate Impairment)	3 (High Impairment)	4 (Severe Impairment)
Generally cooperative & calm; Handles stress and problems in healthy/appropriate ways	Normally sociable but stress has a noticeable effect on functioning; May have a few socially inappropriate reactions to situations.	May get along w/ others but struggles in social situations, sometimes to the point of acting out; May not read social situations well.	Frequently avoidant and/or doesn't get along well w/ others; Tendency to fight, even w/ friends.	Pattern of alienating others (i.e. manipulative, poor boundaries, socially inappropriate or unpleasant, anger issues, reclusive, lacks empathy, authority issues)

Medical Health

Disease/conditions, health care, and risk for mortality

0 (No Risk)	1 (Low Risk)	2 (Moderate Risk)	3 (High Risk)	4 (Dire Risk)
No chronic, or severe, or major health problems; Accessing regular health care provider.	Minor health problems; Inconsistently accesses health care.	≥3 hospital admits for the past year, *and/or* ≥3 ER visits for the last 3 mos., *and/or* 1 chronic medical condition that is being treated.	48+ yrs old *and/or* ≥1 chronic medical condition w/ inconsistent treatment (i.e. cirrhosis of liver, end stage renal disease, HIV/AIDS, frostbite, immersion foot, hypothermia).	60+ yrs old *and/or* ≥1 untreated chronic or terminal disease (treated or not).

Appendix B – CHSH Procedures and Operations Manual

Chronically Homeless Services and Housing (CHSH) Project

SAMHSA - Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant

PROCEDURES AND OPERATIONS MANUAL

CLIENT SELECTION

A. Clients will be referred to the program through The Road Home's Housing Placement Team who maintains a list of chronically homeless individuals in Salt Lake County who have been identified by one of our partner agencies as chronically homeless.
   I. Once a referral has been made into the program by the Housing Placement Team, a CHSH team member will contact the initial referring agency to obtain detailed information regarding client characteristics, needs, barriers, etc.
   II. An attempt will be made to arrange a meeting with the client and referring partner to facilitate in building rapport with the identified client.
   III. During the initial meeting CHSH staff will be assessing for appropriateness for the project. Eligibility factors are identified below.

B. Clients will be assessed to determine eligibility for services. All clients must qualify as **chronically homeless** as defined by:
   I. an unaccompanied homeless person (a single homeless person who is alone and is not part of a homeless family and not accompanied by children) with a Disabling Condition, who has been continuously homeless for a year or more or has had four (4) episodes of homelessness in the last three (3) years.

C. Clients will be screened through DWS to determine eligibility for Medicaid and other mainstream benefits. Client ineligible for Medicaid will likely not be good candidates for enrollment in CHSH and will be referred to another program. This will be assessed on a case-by-case basis with final approval given by the Project Director.
   I. Clients can qualify for Medicaid based on old age, blindness, or disability status. CHSH therapists, Project Director, APRN, and Psychologist can assess for disability status with final approval granted by Project Director.
   II. Medical and mental health records will be reviewed for help in the determination of disability status.
   III. Team members will consult with the appropriate DWS Eligibility Worker to assist in determining whether the respective disability will be sufficient to qualify for Medicaid.

D. In addition to chronic homelessness and disabling condition clients must meet the criteria of at least one of the dimensions listed below:
   1. Diagnosed as substance abusing or substance dependent
      - To be confirmed by Project Director
   2. Diagnosed mental illness
      - To be confirmed by Project Director
   3. High police, jail, and ER contacts
   4. High shelter nights
   5. Were previously unsuccessful at making it through the process of housing or have turned it down
   6. High risk score on CHSH Assessment tool

- To be completed by CHSH team member if not previously completed by referring agency

E. Clients must be willing to engage in regular (at least weekly) visits with team members.

F. Clients deemed ineligible for enrollment in CHSH will be referred back to the Housing Placement team for referral to a more appropriate program. CHSH team will work in collaboration with partner agencies to ensure clients are being served.

ENROLLMENT IN CHSH

A. Enrollment in the Chronic Homeless Services and Housing program is contingent on approval of the Project Director.
B. Once it has been demonstrated that a client is eligible to receive services and they have been approved by the Project Director, they will officially be enrolled in the Chronic Homeless Services and Housing program.
C. The client will be assigned to a primary Service Coordinator who will track them throughout their enrollment in the program.
D. Client's Service Coordinator will complete the Intake interview to be documented in ClientTrack. The Service Coordinator will also complete necessary GPRA data sheets to be reported to the U of U Research team.
E. CHSH team will work collaboratively to develop a comprehensive service plan for each client based on their unique needs. The service plan is to include but is not limited to:
    a. Enrollment in Medicaid, and other mainstream benefits for which they are eligible.
    b. Referral to a mental health clinician for mental health and/or substance abuse treatment.
    c. Screening by CHSH's team APRN for medication evaluation.
    d. Screening by CHSH team's Psychologist for appropriate testing.
    e. Completion of housing applications.
    f. Assistance with accessing employment resources.

CLIENT SERVICE PLAN IMPLEMENTATION

A. Each client will meet with a DWS Eligibility Worker to determine eligibility for and begin enrollment in mainstream benefits which include Medicaid, General Assistance, SSI/SSDI, and any other relevant programs.
B. Each client will be assisted in completing housing applications and will meet with a licensed clinician for purposes of a disability certification.
C. Clients for whom substance abuse or mental illness in indicated will be referred to a CHSH team Therapist for provision of recovery services.
    - If substance abuse is indicated and substance abuse services are indicated, CHSH clinician will complete the American Society of Addiction Medicine (ASAM) patient placement criteria.
    - If mental illness is indicated, the Severe Outcome Questionaire-2.0 (SOQ-2.0) will be completed prior to mental health treatment and quarterly thereafter.
D. As needed, clients will be referred to CHSH Psychologist for relevant assessments and testing.
E. As needed, clients will be referred to CHSH medication provider for medication evaluation.

F. As needed, clients will be referred to community treatment providers such as Valley Mental Health and Volunteers of America, Utah.

CLIENT ASSESSMENTS

1. Clients for whom substance abuse is indicated will be assessed using the ASAM. Baseline will be established at the initiation of treatment and periodically thereafter.
2. Clients requiring mental health treatment will be assessed using the SOQ. This assessment can be administered online or on paper and results are generated upon entry into the SOQ database. The website for this is and each clinician on the team has been provided a log-in and received training on administering the assessment.
3. Each client requiring treatment will be given a DSM-IV diagnosis.
4. National Outcome Measures will be collected at intake and exit.
5. A structured assessment must be completed for each client. This could be done by any of the clinicians on the team (Bree, Sandra, Aly, Sam, or Mitch). It must include:
    a. Client's chief complaints, desires, and goals
    b. Past and current living arrangements
    c. Family history, including where born and raised, family substance abuse or mental health issues, domestic violence, religious affiliation, etc.
    d. Past and current primary relationships, including marriages, relationships, children
    e. Medical status, including medication history
    f. Education/employment history/income/debt
    g. Current substance abuse use as well as substance abuse history, drugs used, ages, times in treatment, etc.
    h. Current/past mental health treatment and medications
    i. Legal History
    j. Clinical Impressions (grooming, dress, appearance, consciousness, orientation, general information provided, abstraction/theoretical, intellect, memory, delusions, hallucinations, thought process, thought content, mood, affect, depressive features, motor behavior, behavioral stability, attitude/relating, insight, assaultiveness and suicidality
    k. Axis I-V Diagnoses
    l. County mental health, substance abuse and medical clinic records will be obtained to gather any past documented history. This will be done in accordance with all necessary confidentiality and releases of information.

	GPRA	Chronic Homeless Assessment	CHSH Intake	Addiction Severity Index (ASI)	DSM-IV diagnosis	S-Outcome Questionnaire (SOQ)	National Outcome Measures (NOMs)
pre-baseline		X			X		
baseline	X			X	X	X	
enrollment			X		X		X
quarterly				X		X	X
discharge	X			X		X	X

- **Pre-baseline-anything done before our team would be involved (Jonathan Chi's vulnerability index, diagnoses done by other clinics, etc**
- **Baseline-any paperwork or assessments completed before enrolment to the CHSH**
- **Enrollment- any paperwork completed upon enrolling into the CHSH**
- **Quarterly-any paperwork or assessments that need completion during any period of time during enrollment in the CHSH**
- **Discharge-any paperwork or assessments completed upon leaving the CHSH program (voluntary or non-voluntary)**

DISCHARGE POLICY
Clients will be discharge from the program on a case-by-case basis.

CLIENT FILES
Client files will include the following documentation:

- Release of information
- CHSH Assessment Tool
- ClientTrack Intake assessment
- GPRA intake form
- Copy of housing application paperwork
- Disability Certification
- Copy of ID
- Birth certificate
- Copy of Social Security card
- Copy of Medicaid card
- Individualized Services Plan
- Recovery Services including assessments and diagnoses

STAFF MEETINGS

A. A daily team meeting is held at 9am, Monday through Friday. During this meeting each client is discussed and the team daily schedule is developed. The weekly and monthly schedule is also developed during these meetings.
B. A weekly two hour case staffing is held for the purposes of clinical staffing and service planning. During this meeting, the agency mission is reviewed, scheduling discussed, clients are staffed for appropriateness of the project, difficult caseload issues raised and general supervisory guidance is given.
C. A partner agency meeting is held once weekly to discuss the clients CHSH is serving, problem-solve roadblocks, share information, and generally to ensure duplication of services is prevented. CHSH staff will attend this weekly meeting.
D. A monthly all agency staff meeting is held regularly to discuss overall agency goals and activities.

RESOURCES

Case managers utilize 211 online at informationandreferral.com. We also have information and referral resource lists on file. Case managers utilize the 211 Red Book as needed.

The Housing Placement Coordinator and CHSH Staff also rely upon several different resources for finding available rental units. The most critical resource is our established relationships with PSH property managers and Housing Authority representatives. Additional resources include gosection8.com, a compilation of landlord/units, and relationships with participating landlords and word of mouth.

ENROLLMENT IN MAINSTREAM BENEFITS

A major component of this project is to enroll clients in Medicaid and other mainstream benefits. To determine eligibility:

- Clients must sign a release of information.
- Team members can track clients using MyCase once the release is in place.
- A referral must be made to DWS. The Eligibility Worker assigned to our project is:
    - Robert Birkinshaw

DATA ENTRY, DOCUMENTATION and SHARING OF DATA WITH EVALUATORS

A. Intake and discharge information is entered in ClientTrack (HMIS) database within 2 business days of the occurrence.

Instructions on entering clients into ClientTrack:

The programs for each level of interaction are as follows:

1. SAMHSA Engagement: For those clients you are just starting to engage and will do minimal work with (outreach only, some transportation, basic relationship building, etc….)

2. SAMHSA Case Management: For those clients you intend to work with long term and assist with Medicaid and/or Housing options

Note: All clients who are enrolled in the Engagement program but are graduating to the Case Management program should first be exited from the Engagement program.

Intake Process: All clients being enrolled into the Case Management intensive program will need to go through the full intake flow and have a complete assessment done in ClientTrack. The standard workgroup you select at login (TRH: Case Managed Programs) will take you through this workflow and collect all necessary data elements.

Those clients being enrolled into only the Engagement program may only need a very minimal intake with the required fields collected at intake. To go through this simple intake process, you will need to change your workgroup selected at login to UHMIS: Emergency Assistance to access the basic intake flow. If you do an intake into the Engagement program through your normal login workgroup (TRH: Case Managed Programs), you will be required to go through the long intake process that asks more questions than you would likely have answers for at a basic interaction level.

B. GPRA forms will be completed, scanned in and saved to the client's file and emailed to the U of U Research Team upon completion.

C. Case notes and case plan will be scanned into Client Track and will be delivered monthly along with other data from ClientTrack, forwarded by the IT department.

D. Copies of the CHSH Assessment, ASI, and SOQ results will be picked up monthly by a member of the U or U Research Team. These forms will be included in the client's file.