

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

**Bi-annual Report
April 2013**



THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
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S.J. QUINNEY COLLEGE OF LAW

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**Christian M. Sarver, M.S.W.
Erin B. Worwood, M.C.J.
Audrey O. Hickert, M.A.
Robert P. Butters, Ph.D.**

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Utah Criminal Justice Center, University of Utah

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Background and Introduction

Preliminary data from the January, 2013, Point in Time count, identified 285 chronically homeless individuals in Salt Lake City (100,000 Homes Salt Lake City Campaign, 2013). Of those, almost one-half had co-morbid (23%) or tri-morbid (18%) health or mental health conditions. 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 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 (Tsemberis, 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 attended daily and weekly staff meetings, partner meetings, and committee meetings and recorded changes in services, collaborations, and policies. 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; Community Emergency Services Group meeting to address problems with tracking client's use of emergency services; Data Subcommittee meetings to address interagency coordination of data collection; Medicaid Subcommittee meetings to address barriers to Medicaid enrollment for CHSH clients

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

1. Who does the program serve? (Profile of clients, including demographics, homelessness, criminal history, substance abuse (SA), mental health (MH), and treatment history, etc.)
2. What is CHSH providing to clients? (Profile of services utilized during CHSH participation, including housing, case management, SA/MH treatment, benefit enrollment (e.g., food stamps, general assistance) and support services)
3. Is CHSH succeeding? (Measures include: clients placed in 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 (see *Objectives* section), 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 a majority of the information provided in this report is based on surveys completed by clients, this report also includes information from criminal justice, housing authority, and health care records. 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 obtain 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
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 1 st 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.
Salt Lake County Division of Behavioral Health Services (DBHS) Records	History of substance abuse and mental illness treatment with Salt Lake County Behavioral Health for 2 years prior to 1 st CHSH contact and while receiving services through CHSH. Data includes treatment date and treatment type.
Salt Lake County Housing Authority Records	History of housing with the Salt Lake County Housing Authority. Data includes prior housing, application status, and eviction/termination.
Valley Mental Health Records	Services provided to Enrolled clients that are paid for through Medicaid funds. Data includes service type, service frequency, and cost information. Data also includes mental health assessments (SOQ) conducted by CHSH staff with Enrolled and Engaged clients.

Data Source	Description
Fourth Street Clinic	History of emergency room visits at five area hospitals. Data includes date of visit.
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 1 st CHSH contact and while receiving serviced through CHSH.

Results

The following section of the report details grant activities for the project to date, from October 1, 2011 through February 28, 2013. This date, rather than March 31, 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 and 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 10 and *Program Activities* on page 23).

Program Implementation

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. There have been no formal staff changes since the last evaluation report (submitted October, 2013). During the current reporting period, however, the Project Director assumed responsibility for coordinating the community-wide implementation of the 100,000 Homes Campaign. In this capacity, the Project Director worked with more than 15 non-profit, private, and government agencies to coordinate and expand the annual Point in Time Count. The 100,000

Homes Campaign is an initiative that seeks to help communities identify and prioritize those chronically homeless persons who are most at risk of premature death. Because the project goals were directly in line with CHSH program goals, CHSH staff and partners decided that it made sense to have the Project Director temporarily assume that role on top of her ongoing CHSH duties. For eight weeks, the Project Director maintained daily contact with the CHSH project and continued to work from her office within the CHSH office but did not participate in direct services with clients. Responsibility for facilitating team and partner meetings was divided among the CHSH staff and clinical supervision was provided by a licensed social worker from The Road Home. The social worker, who attended staff meetings weekly, is the coordinator of the Pathways Project and was therefore familiar with the goals, services, clients, and staff of the CHSH program.

Training. During the current reporting period, CHSH staff participated in six training sessions. Staff were trained on topics directly related to CHSH program goals and emerging client needs: client staffing using a Housing First/ACT model; Social Security Administration (SSA) programs and application process; trauma-informed care; motivational interviewing (MI); the use of home visits as an intervention in a Housing First model; and development and implementation of a statewide system for identifying and prioritizing chronically homeless vulnerable individuals (the aforementioned 100,000 Homes Campaign). The MI training was a four-part series for staff serving a chronically homeless population. As a result of the training, staff changed the process for developing Service Plans, which will now focus on the creation of a shared vision that is based in clients' personal goals and objectives. In addition to these formal training activities, the Project Director meets weekly with staff, one-on-one, to provide individualized feedback and supervision.

Staff participated in five collaborative sessions with partner agencies in order to build relationships, clarify program objectives, refine referral and service delivery processes, and create mechanisms for ensuring clients receive comprehensive care without duplicating services. During the current reporting period, those sessions included meetings with committees and agencies that target homeless persons with high use of emergency services and frequent police contact. As the program enters its second year and provides more long-term services to clients, staff focused on the balance between acute and long-term needs for clients who were receiving services from multiple partner agencies.

Program Structure and Service Delivery

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

Policies and Client Recruitment. There were no changes in program policies and no formal changes in client eligibility criteria during the current reporting period. In the previous reporting period, restrictions tied to available housing monies resulted in a temporary narrowing of client eligibility criteria to prioritize clients with at least 365 shelter nights. Subsequently the program was able to return to a policy of targeting chronically homeless persons whether or not they were also frequent shelter users. At the end of February, 2013, the CHSH program maintained a caseload of more than 50 Enrolled clients and anywhere from 30 to 50 Engaged clients. Due to the intensity of CHSH services, staff has not yet made contact with a number of clients who were referred at the end of last year. Given that the program is approaching capacity, and the current number of "unprocessed" clients, the Project Director and the Chronic Homeless Program made the decision to close the program to new referrals for the time being.

Client Pre-Screening. The screening process for CHSH was revised during the current reporting period, in part as a function of the program operating nearly at capacity but also because of Salt Lake City's participation in the 100,000 Homes Campaign (see previous explanation). This national initiative strives to end chronic homelessness by 2014; one objective to achieve this end is the development of a registry of those chronic homeless persons that are most vulnerable. As part of this process, which was coordinated in conjunction with the annual Point in Time Count, all homeless persons in the community are assessed using Common Ground's Vulnerability Index (VI, see Appendix A). This index is based on empirical data and assesses clients' risk for premature death. The VI assesses vulnerability on a range of domains--including history of homelessness, substance abuse, and mental illness--with an emphasis on medical risk factors.

By using the same metric, across agencies, to evaluate clients' vulnerability, service providers are better able to make decisions regarding allocation of resources. CHSH referrals (when the program is again accepting new referrals) continue to be processed through The Road Home's Chronic Homeless Program (CHP). Partner agencies still obtain a signed release of information (ROI) from the client, suggestions for locating the client, and complete the new Vulnerability Index (VI). The completed referral packet is still 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 VI is now entered into clients' record in the statewide Housing Management Information System (HMIS) used by all providers in The Road Home's continuum of care. 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. In accordance with revised eligibility criteria, this pre-screening process involves determining the likelihood that clients will qualify for Medicaid and SSI/SSDI before they are enrolled in CHSH. Clients who are unlikely to meet those eligibility requirements are referred back to CHP and also to other appropriate housing programs.

Client Engagement and Enrollment. During the current reporting period, CHSH staff participated in an interagency meeting designed to generate a list of referrals for all of the CHP programs. This meeting resulted in 38 new CHSH referrals. Given the number of Enrolled and Engaged clients, staff made contact with new referrals based on client need and staff availability. Eligibility continues to focus on clients' disability status, mental health, and chronic health needs. Once eligibility is determined, program staff works with partner agencies to introduce the CHSH program to potential clients. In the current reporting period, representatives from partner agencies were present at 2% of CHSH contacts. This is a smaller percentage than noted in previous reports (10%), likely due to the fact that the CHSH program is enrolling fewer clients as it reaches staffing capacity. Additionally, the frequency with which agencies partner with CHSH to introduce the program has dropped as staff's familiarity with the ACT model and the client population had increased. The agencies most frequently represented in CHSH contacts are: Fourth Street Clinic (Mobile Outreach Street Team), Volunteers of America (Homeless Outreach Program), and the Department of Workforce Services.

Service Delivery Model. There were no changes to the basic service delivery model used during the current reporting period. The use of a team approach to service provision, which is central to the ACT model, is evident in the fact that CHSH client contacts continue to average more than one staff member per contact (average is 1.3 staff per contact). Additionally, one-fifth (22%) of program contacts involve more than one staff member. The changing nature of the clientele, however, which now consists of a large number of housed clients with different, but ongoing, needs, has resulted in some new service arrangements. Because of an increasing need for staff to respond to client crises,

one staff member now stays primarily in the office each day and is available for unscheduled meetings. A staff-lead support group is also held for clients once a week in order to facilitate positive peer interactions, support, and problem-solving. The Project Director has added a monthly staffing meeting, which is attended by all part- and full-time staff, to monitor clients' progress on long- and short-term goals.

Mobile Services. In accordance with the ACT model, client services were provided in the field as well as in the office (see Table 3). More than half of the work that CHSH does with clients occurs outside the office. Many of the office-based services involve administrative duties such as writing case notes and phone contact with clients to arrange meetings, appointments, transportation, and other services. During the last reporting period, the CHSH program acquired a second vehicle to facilitate the large percentage of client services that happen in the field. Nonetheless, staff continues to collaborate with other agencies, usually from The Road Home, to meet the service delivery requirements of the ACT model. Staff continues to provide weekly outreach, wherein teams of Service Coordinators schedule time to go to clients' residence and other locations (for clients who are not yet housed) to deliver services.

Table 3 Service Delivery Location

	Engaged		Enrolled	
	Discharged	Ongoing	During Engagement	During Enrollment
Location (%):				
CHSH Office	47	16	39	40
Other Agency	26	28	36	22
Client Residence	4	3	9	28
Outside/Street	13	30	10	6
Jail/Institution	5	10	4	--
Other ¹	4	13	2	4

¹This includes transportation-related services that occur in one of the CHSH vans

CHSH Meetings. Due to the Project Directors' temporary work assignment to the 100,000 Homes campaign, staff assumed primary responsibility for facilitating meetings during the current reporting period. The regular meeting schedule includes: daily staff meetings; weekly staffing meetings; monthly client review meetings that include all full- and part-time staff; and monthly partner meetings. The team's part-time psychologist and nurse practitioner attend the morning staff meeting one day a week in order to schedule specific services (usually formal assessments and/or diagnoses, medication management, or informal insight into clients' barriers and behavior). During these meetings, staff often process through their experiences working with clients, including feelings of burn-out and fatigue. This processing was particularly important during the current reporting period, wherein several of the CHSH clients died. The vulnerability of the CHSH clients is evident in the fact that all three died of causes related to chronic homelessness, despite that they were housed and receiving treatment from CHSH and partner agencies at the time of their deaths. The application of the Housing First model—which gives primacy to client decision-making and autonomy—to the targeted population requires a balancing act for staff, who employ an empowerment-based model in the context of clients who are at risk of serious injury or death.

The CHSH Steering Committee is scheduled to meet quarterly; because of scheduling difficulties due to the holidays and community involvement in the 100,000 Homes Campaign, the December meeting was cancelled. During the March meeting, the Steering Committee discussed difficulties

related to Medicaid enrollment (see Barriers section). Additionally, the Committee discussed the need to plan for project sustainability after grant funding ends. The other CHSH committees meet as needed: the Medicaid Committee met once during the current reporting period and the Data Sub-Committee met several times to facilitate gathering data regarding clients' use of emergency services.

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 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. The length of the engagement phase varies from client to client; clients who are resistant to services for various reasons—including paranoia and delusions related to mental illness—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 Enrolled 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	70
Enrolled Clients ²	54
Total	124

¹ Twenty-three of the 70 clients in the Engaged sample have been discharged without enrolling in CHSH. This number excludes clients who have been referred but with whom staff has not had contact.

² Eight of the Enrolled clients have been discharged from the program. Four of those were housed while in CHSH and subsequently discharged to less intensive supportive housing programs; one was discharged due to the client's resistance to services; and three are deceased.

Referrals to CHSH

Vulnerability Index. During the current reporting period, the CHSH team implemented a new Vulnerability Index (VI) tool. This decision stemmed largely from the agency's (and larger Salt Lake City community's) decision to participate in the 100,000 Homes Campaign. The new VI 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 (see Appendix A for a copy of the instrument). 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 new VI, which can be accessed through the statewide Utah Homeless Management Information System (UH. 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 14 CHSH clients (10 Engaged clients and 4 Enrolled clients). Of the ten (10) Engaged clients with VI scores on the new instrument, the mean score was 1.4 (SD=1.3); 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 seven clients have a mean overall score of 2 (SD=1). Of the four Enrolled clients who were assessed using the new VI, two had a score of 0 and the remaining two both received a score of one.

Discharged Clients. Twenty-three percent (23%) of CHSH referrals were discharged from the program without being enrolled, either because they were resistant to enrollment or because staff determined that they were ineligible for services. This figure is lower than previous reports, which likely reflects a stabilizing of eligibility criteria (the criteria were revised early in the project) that are now resulting in a greater number of appropriate referrals. Ineligible clients were discharged from CHSH and referred back to CHP. Table 5 details the reasons that clients were considered ineligible for the CHSH program. Although never officially enrolled in the program, the CHSH team had multiple contacts with these Engaged clients prior to discharge. Because the ACT model is based on aggressive outreach that includes the goal of developing relationships with resistant clients, information on those contacts is included throughout this report. The majority of Discharged clients were ineligible because they did not have a disability that would qualify them for Medicaid under state guidelines.

Table 5 Reasons for Ineligibility

Not Eligible Due To:	Clients Referred Back to CHP	
	#	% of Total Referrals ¹
Disability	16	16
Income	1	--
Other Housing Obtained	4	4
Other ²	2	2
Total	23	23

¹Percent of total referrals is calculated using only those clients with whom the project has had contact (47 Engaged, 54 Enrolled).

²Other includes one client who could not be located and one client who did not meet the criteria for chronically homeless.

Client Characteristics

Demographics. Client demographics collected at Intake are shown in Table 6 for both Engaged and Enrolled clients. The majority of clients in both groups were male (69% Engaged, 70% Enrolled) and had an average age near 50. The majority of clients in both Enrolled (70%) and Engaged (66%) groups were White). Over half of Enrolled clients (56%) 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 program Intake. In general, Engaged and Enrolled groups appear to be quite similar to each other in terms of demographics.

Table 6 Demographics at Intake¹

	Engaged	Enrolled
<i>Total Sample (N)</i>	<i>47</i>	<i>54</i>
Demographics		
Male (%)	69	70
Age (Mn)	48	50
Min, Max	22, 73	26, 72
Hispanic or Latino (%)	8	4
Race (%)		
White	66	70
Black/African American	3	11
Asian	3	4
American Indian/ Alaska Native	22	13
Native Hawaiian/Pacific Islander	3	4
Unknown/Missing Data	--	--
Veteran/ Served in Military (%)	2	13
Percent with Children (%)	--	56
Number of children (Mn)	--	2.5

¹For 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 GPRA form was administered.

Homelessness and Housing. Based on official shelter records, the majority of both Engaged (75%) and Enrolled (82%) clients have previously stayed at The Road Home's Emergency Shelter (see Table 7). Between December 1, 1998 and program Intake, both groups spent an average of more than 450 nights in the shelter. The overall percentage of clients with a history of shelter use dropped somewhat during the current reporting period (in the last report 97% of Engaged clients and 95% of Enrolled clients had stayed in the shelter). This likely stems from the program's acquisition of housing funds, in August, 2012, that required the program to specifically target individuals with high shelter use. During the current reporting period, the program actively recruited individuals who were chronically homeless but had not stayed in the shelter. As a whole, these 101 individuals accounted for a total of 41,557 nights in the shelter during this period (since December 1998). When comparing shelter use before and after enrollment, fewer clients stayed at the shelter after they were enrolled, with slightly more than half (54%) staying at the shelter for at least one night.

Table 7 Homeless Shelter Use since December 1998

	Engaged	Enrolled	
		<i>Pre-CHSH</i>	<i>CHSH</i>
<i>Total Sample (N)</i>	47	54	54
Percent stayed in the Shelter at least one night (%)	75	82	54
Total # of nights ¹	17627	23930	857
Average # of nights per client (Mn)	490	543	30
Min, Max	5, 2643	23, 3140	1, 144

¹ Total count for entire sample

At Intake, slightly less than half of Enrolled clients (48%) had stayed at an emergency shelter the previous night and nearly one-fifth (17%) had stayed on the streets or somewhere not meant for human habitation (see Table 8). Fewer Engaged clients reported staying at the shelter the previous night (29%), 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 (76%) had been continuously homeless for at least one year, while just over half (52%) 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 37% experiencing at least three episodes of homelessness compared to 25% of the Enrolled group.

Table 8 Living Situation at Intake

	Engaged	Enrolled
<i>Total Sample (N)</i>	44 ¹	54
Living Situation		
Where did you stay last night? (%)		
Emergency Shelter	29	48
Place not meant for habitation (streets, etc.)	29	17
Jail/Prison/Juvenile Detention Center	10	4
Family/Friend Residence	10	11
Other	23 ²	19 ³
Chronic Homelessness: (%)		
Continuously homeless for one year	52	76
Homeless four times in three years	37	25

¹Information on where the client stayed the previous night was available for 44 of the 47 Engaged clients.

²This includes transitional housing for homeless persons (n=2), psychiatric hospital (n=2), psychiatric facility (n=2), and client's own residence (n=3). Represents 31 clients with records in Client Track.

³This includes hotel/motel not paid for with voucher (n=2), substance abuse/residential treatment facility (n=4), psychiatric facility (n=1), and transitional housing for homeless persons (n=3).

Only 6% of Enrolled clients reported living primarily in an emergency shelter after being in the program for six months, compared to 59% at Intake (see Table 9). While one-fifth (20%) 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, almost three-quarters (71%) 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 (35 clients), it is important to note that all of these housed clients were living in their own home at the end of the reporting period.

Table 9 Living Situation at Intake and 6-month Follow-up, Enrolled Clients¹

	Intake	6-Month Follow-up
<i>Total Sample (N)</i>	54	35
Living Situation		
Primary Living Situation during the past 30 days: (%)		
Shelter	59	6
Street/Outdoors	13	14
Institution	7	9
Housed	20	71
If housed, what type of housing: (%)		
Own/Rent apartment, room, or house	18	100
Someone else's apartment, room, or house	46	--
Halfway house	9	--
Residential treatment	9	--
Other	18	--

¹Data taken from GPRA forms. At the end of the reporting period, 35 clients had completed 6-month follow-up GPRA's. In total, 50 clients had been housed by the end of the reporting period; however, not all of those clients had completed a 6-month follow-up GPRA.

Social Connectedness. Less than half (46%) of Enrolled clients attended a self-help recovery group at least once in the 30 days prior to Intake (not in table), while exactly half (50%) noted that they had recently interacted with family and/or friends that were supportive of their recovery (see Table 10). At the follow-up interview, a smaller percentage of clients had recently attended a self-help group (34%, not in Table), but an even larger percentage (63%) reported supportive contact with family and/or friends. The percentage of clients who reported that they had no one to turn to dropped from 35% to 11% between Intake and 6-month follow-up and the percentage who felt that they could rely on family members went up from 13% to 31% 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 10 Support Systems of Enrolled Clients

	Intake	6-Month Follow-Up
<i>Total Sample (N)</i>	54	35
During the past 30 days:		
Attended any voluntary self-help groups (e.g., AA, NA) (%)	30	17
# of times attended (Mn)	12	4
Min, Max	1, 40	1, 12
Attended any religious/faith affiliated recovery self-help groups (%)	15	9
# of times attended (Mn)	3	2
Min, Max	1, 6	1, 4
Attended any other meetings that support recovery (%)	24	14
# of times attended (Mn)	6	7
Min, Max	1, 15	1, 15
Had interaction(s) with family/friends that are supportive of recovery (%)	50	63
Person they turn to when having trouble: (%)		
No one	35	11

	Intake	6-Month Follow-Up
<i>Total Sample (N)</i>	54	35
Family Member	13	31
Friends	15	20
Professional	19	17
Religious Entity	17	20

Education and Employment. Almost half (42%) of Enrolled clients had a high school diploma (or the equivalent) and nearly one-quarter (23%) had reported completing some college degree (see Table 11). In comparison, only one-fifth (20%) of Engaged clients had a high school diploma (or the equivalent). Engaged and Enrolled clients were similar in terms of the number who had an education level that was less than a high school diploma (35% for both groups). None of the Engaged or Enrolled clients were employed at Intake and only a few of the Enrolled clients (11%) indicated that they were looking for work.

Table 11 Education and Employment at Intake

	Engaged ¹	Enrolled
<i>Total Sample (N)</i>	31	54
Education		
Enrolled in School or Job Training Program (%)		
Full-time	0	4
Part-time	0	4
Education Level (%)		
Less than High School	35	35
High School/Equivalent	20	42
Some College	16	23
Unknown/Missing	29	0
Employment²		
Employed (%)	0	0
Unemployed (%)	--	100
Looking for work	--	11
Disabled	--	54
Retired	--	6
Not looking for work	--	26
Other	--	4

¹Information on education was only available for 31 of 47 Engaged clients.

²For Engaged clients, the only information available on Employment was status.

Monthly Income. Enrolled clients reported an average monthly income of just under \$500 at Intake and almost \$600 at Follow-up (see Table 12). A slightly larger percentage of Enrolled clients reported having an income at Follow-up (86% compared to 81%). By far the largest average amounts came from Retirement and Disability payments. In keeping with CHSH program goals, a higher percentage of clients were receiving public assistance at Follow-up compared to Intake (57% and 51%, respectively) and the average monthly income was higher (a \$76 increase).

Table 12 Income at Intake and 6-month Follow-up, Enrolled Clients

	Intake		6-Month Follow-up	
<i>Total Sample (N)</i>	54		35	
	%	Amt ¹ (Mn)	%	Amt ¹ (Mn)
Monthly Income				
Wages	4	\$44	6	\$320
Public assistance	51	\$232	57	\$372
Retirement	4	\$685	9	\$803
Disability ²	38	\$700	23	\$823
Non-legal income	2	\$75	--	--
Family and/or friends	2	\$20	3	\$20
Other	9	\$195	14	\$24
Any Income¹	81	\$498	86	\$574

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, a similar number of Engaged clients reported any income at Intake (86%). The average amount was substantially less, however (\$346) (see Table 13). These numbers do not account for almost half of the Engaged sample (26 did not have income information in agency records) and are likely not an accurate reflection of the economic status of the sample.

Table 13 Income at Intake, Engaged Clients

	Engaged ¹	
<i>Total Sample (N)</i>	21	
	%	Amt (Mn) ²
Monthly Income		
SSA Retirement	0	--
SSI/SSDI	29	\$738
General Assistance	19	\$282
SNAP	86	\$134
Other	19	\$679
Any Income	86	\$346

¹ Income data was available for 21 of the 47 engaged clients.

² Of those clients who report an income, the average amount.

Physical Health. Nearly three-quarters (73%) of Enrolled clients rated their overall health as fair or poor at Intake (see Table 14), 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, where 83% of Enrolled clients indicated having a disabling health condition (which included a mental health diagnosis), 18% indicated that they had a physical disability, and one-third (30%) indicated that they had a chronic health condition (not shown in table). Twenty percent (20%) of Enrolled clients reported that they were not receiving services to treat their physical health condition. In comparison, 74% of Engaged clients reported having a disabling health condition, three percent (3%) indicated that they had a physical disability and one-fourth (24%) indicated that they had a chronic health condition (not in the table). More than 40% of Engaged clients reported that they were not receiving services for a chronic health condition.

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

	Intake	6-Month Follow-Up
<i>Total Sample (N)</i>	54	35
Overall health rating (%)¹		
Excellent	11	17
Very Good	7	9
Good	9	23
Fair	43	26
Poor	30	26

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

Almost one-third of Enrolled clients reported receiving treatment in an Emergency Room (ER) during the month prior to Intake (29%) and Follow-up (26%). On average, clients reported being treated in the ER two (2) times in the month preceding Intake and Follow-up (see Table 15). Clients who received ER-based substance abuse treatment, however, were treated an average of two (2) times at Intake and one (1) time at Follow-up. Nearly one-quarter (22%) of clients received inpatient treatment during the month prior to Intake, compared to 26% of clients in the thirty days prior to the Follow-up interview.

Table 15 Medical Treatment at Intake and Follow-up

	Intake		6-month Follow-up	
<i>Total Sample (N)</i>	54		35	
	% (n)	Mn ¹	% (n)	Mn ¹
Inpatient Treatment				
For any reason	22 (13)	8	26 (9)	14
Physical complaint	11 (6)	3	14 (5)	19
Mental or emotional difficulties	4 (2)	--	6 (2)	4
Alcohol or substance abuse	9 (5)	13	11 (4)	6
Outpatient Treatment				
For any reason	57 (23)	6	40 (14)	4
Physical complaint	28 (15)	3	26 (9)	2
Mental or emotional difficulties	24 (13)	3	29 (10)	3
Alcohol or substance abuse	6 (3)	19	6 (2)	3
Emergency Room (ER) Treatment				
For any reason	29 (15)	2	26 (9)	2
Physical complaint	20 (11)	1	17 (6)	1
Mental or emotional difficulties	6 (3)	1	6 (2)	3
Alcohol or substance abuse	9 (2)	2	6 (2)	1

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

Emergency Room Contacts. In addition to the self-report data on use of emergency medical services, CHSH project staff and partners obtained emergency room (ER) records for Enrolled clients. The following data (see Table 16) documents ER visits to five area hospitals for 33 Enrolled clients. These preliminary numbers show a reduction in the number of Enrolled clients who are being treated at local ERs. While the average number of visits increases (4 before CHSH and 5 during enrollment), both the number of clients with ER visits drops (from 45% to 10%) and the

sum total of visits made by the group drops (from 60 to 15). Based on the information reported in this section, it appears that clients in both the Engaged and Enrolled groups are frequent users of the ER services, in some cases as a source of non-emergency care for medical or mental health concerns. Although preliminary, the data in this report suggest that intensive case management is a promising means for helping clients obtain the appropriate type of care.

Table 16 Emergency Room Use, Enrolled Clients

<i>Total Sample (N=33)</i>				
Emergency Room (ER) Treatment	% (n)	Mn ²	Sum ³	Min, Max ⁴
Before CHSH Contact	45(15)	4	60	2, 10
During Engagement	24 (8)	4	32	2, 7
During Enrollment	10 (3)	5	15	2, 10
After Discharge	--	--	--	

¹ ER records, going back to 2010, were obtained for 33 of the 54 Enrolled clients.
² Of those with ER records, the average number of ER visits.
³ The total number of ER visits for all clients for whom records were obtained (N=33).
⁴ Of those clients with ER records, the minimum and maximum number of visits.

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 17). The most frequently occurring problems were serious depression, serious anxiety or tension, and trouble understanding, concentrating, or remembering. At 6-month follow-up interviews, a smaller percentage of clients reported experiencing depression or anxiety than at Intake. Of those who did experience problems, they averaged a shorter number of days of distress.

Clients were also asked on The Road Home Intake form if they had any mental health concerns. Seventy percent (70%) of Enrolled clients indicated that they had a mental illness at Intake; of those, 86% indicated it was a chronic condition and 61% were currently receiving services (not shown in the table). Forty-three percent (43%) of Enrolled clients indicated that they had a developmental disability; of those, 77% were receiving some sort of services for the condition. Seventy-six percent (76%) of Engaged clients indicated that they had a mental illness at Intake; of those, 82% indicated that the condition was chronic and half were currently receiving services. Sixty-six percent (66%) of Engaged clients indicated that they had a developmental disability at Intake and approximately one-third (37%) reported that they were currently receiving services for the condition (not shown in table).

Case notes indicate that many clients had previously refused treatment, although the reasons for client refusal were not consistently documented.

Table 17 Mental Health at Intake, Enrolled Clients

	Intake		6-Month Follow-up	
Psychological/Emotional problems experienced in past 30 days:				
<i>Total Sample (N)</i>	54		35	
	% (n)	Mn ¹	% (n)	Mn ¹
Serious depression	67 (36)	15	69 (24)	19
Serious anxiety or tension	69 (37)	18	63 (22)	19
Hallucinations	15 (8)	19	14 (5)	13
Trouble understanding, concentrating, or remembering	54 (29)	30	63 (22)	19

	Intake		6-Month Follow-up	
Psychological/Emotional problems experienced in past 30 days:				
<i>Total Sample (N)</i>	54		35	
	% (n)	Mn ¹	% (n)	Mn ¹
Trouble controlling violent behavior	13 (6)	10	6 (2)	18
Attempted suicide	2 (1)	3	6 (2)	20 ²
Been prescribed medication for psychological/emotional problem	43 (23)	30	43 (15)	24

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

² This includes data from one client who reported attempting suicide every day in the 30 days prior to the interview.

Mental Health Treatment. A small percentage of Engaged (9%) and Enrolled (15%) clients had a history of mental health treatment¹ in the two years prior to CHSH Intake (see Table 18). These numbers appear to contradict clients' self-report figures, as detailed above, which suggest that more than half of clients in both groups are receiving services. The disparity between clients' comparatively high numbers of self-reported treatment for mental illness, and the low numbers regarding receipt of treatment, suggest that clients' lack of insight into their receipt of services may be a barrier to services.

A relatively small percent of clients received mental health treatment after CHSH intake; however, because clients have different program intake dates, the pre- and post-time periods are not equivalent. Because the data only reflects services provided with Salt Lake County funding, the relatively small numbers of clients receiving services after Intake does not include the services that clients are receiving from the CHSH program.

Table 18 Mental Health Treatment

	Engaged		Enrolled	
<i>Total Sample (N)</i>	47		54	
Mental Health (MH) Treatment (Tx)	2 Yr Pre	Dur	2 Yr Pre	Dur
Percent with any MH Tx Services ¹ (% (n))	9 (4)	2 (1)	15 (8)	4 (2)
Of those with any:				
Total number of MH Tx Service Units ² (sum)	4	1	10	2
Service Type (sum):				
Assessment	3	1	7	1
Therapy	3	0	4	1
Medication Management	4	0	4	2
Psychosocial Rehab	2	0	1	0
Case Management	2	0	4	2
Inpatient	0	0	3	0
Residential	1	0	2	2

¹ Services includes assessments as well as MH Tx admissions

² Multiple MH service types (e.g., assessment, therapy, & med mgmt.) could be provided during one service unit

Alcohol and Drug Use. Self-reported data, collected at Intake, suggests that a significant percent of Enrolled and Engaged clients have a history of substance abuse. For Enrolled clients (N=40 clients with information in Client Track), 38% indicated that they had a history of drug abuse and 40%

¹ Source: Salt Lake County Division of Behavioral Health Services (DBHS)

indicated a history of alcohol abuse; of those, more than three-quarters (82% drug abuse, 81% alcohol abuse) indicated that the condition was chronic (not shown in table). Less than ten percent (6%) of Enrolled clients indicated that they were receiving substance abuse treatment for alcohol and one-third (33%) were receiving treatment for drug addiction. For Engaged clients (N=28 clients with information in Client Track), 38% indicated a history of alcohol abuse and 21% indicated a history of drug abuse. More than 80% of clients indicated that their substance abuse history was chronic and less than half were currently receiving treatment (36% for drug abuse and 33% for alcohol abuse).

In terms of recent alcohol use, more than half of Enrolled clients (70%) reported alcohol use in the month prior to Intake and nearly as many (63%) reported use in the month prior to their 6-month follow-up interview (see Table 19). Further scrutiny of the data, however, reveals that a smaller percentage of clients were drinking to intoxication at their six-month follow-up than at Intake.

Table 19 Alcohol and Drug Use at Intake and 6-month Follow-up, Enrolled Clients

	Intake	6-month Follow-up
<i>Total Sample (N)</i>	54	35
During the past 30 days, have you used:		
Any alcohol (%)	70	63
Number of times (Mn)	9	10
Alcohol to intoxication (5+ drinks in one sitting) (%)	46	40
Number of times (Mn)	9	12
Alcohol to intoxication (4 or fewer drinks in one sitting, felt high) (%)	14	6
Number of times (Mn)	2	9
Both alcohol and drugs (on the same day) (%)	17	3 ¹
Number of times (Mn)	6	--
Any Illegal drugs (%)	34	20
Number of times (Mn)	14	7
Injected drugs during the past 30 days (%)	4	3

¹One client used both alcohol and drugs for 30 days.

Both illegal drug use and combined alcohol and drug use were less common at follow-up than at Intake. Notes from staff meetings suggested 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. This data, however, suggests that clients' substance use may be less intense, even if it is more frequent, than use during the period prior to program enrollment. Table 20 indicates that a similar number of clients reported extreme or considerable stress due to alcohol or drug use at both Intake and 6-month follow-up, but a larger percentage of clients reported no stress at all due to substance use after participating in CHSH.

Table 20 Emotional Impact of Alcohol and Drug Use at Intake and Follow-Up, Enrolled Clients¹

	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	48	23	7	23
At Follow-Up	60	20	--	20

	Not at All	Somewhat	Considerably	Extremely
Has your use of alcohol or drugs caused you to reduce or give up important activities?				
At Intake	71	14	4	11
At Follow-up	72	12	8	8
Has your use of alcohol or other drugs caused you to have emotional problems?				
At Intake	63	20	10	7
At Follow-up	71	13	8	8

¹ Only for those clients reporting alcohol and/or drug use during the previous 30 days (n=31 at Intake, n=25 at Follow-up)

Substance Abuse Treatment. Approximately half of clients, in both the Engaged (40%) and Enrolled (50%) groups, have a history of substance abuse (SA) treatment² in the two years prior to CHSH (see Table 21); with the Enrolled group averaging more treatment services. Of the 27 Enrolled clients who utilized SA treatment services in the two years prior to CHSH, 301 SA treatment service units were used, with the bulk being Detox admissions (257 total). During participation in CHSH, 13 Enrolled clients have utilized SA treatment services, with detox admissions (65 total) being the most common type of service. It should be noted that the “during” CHSH time period varies by length of time each client has been in the program and is non-equivalent with the two year pre-CHSH period.

Table 21 Substance Abuse Treatment

	Engaged		Enrolled	
<i>Total Sample (N)</i>	47		54	
Substance Abuse (SA) Treatment (Tx)	2 Yr Pre	Dur	2 Yr Pre	Dur
Percent with any SA Tx Services ¹ (% (n))	40 (19)	13 (6)	50 (27)	24 (13)
Of those with any:				
Average number of Tx Admissions ² (Mn (SD))	5 (4)	--	11 (13)	--
Total number of SA Tx Service Units ¹ (sum)	106	15	301	71
Treatment Type (sum):				
Assessment	8	0	12	1
Detox	85	14	257	65
Residential Rehab – Short term	2	0	4	2
Residential Rehab – Long term	1	0	8	1
Intensive Outpatient	4	0	15	0
Outpatient	6	1	5	2

¹Services include assessments as well as SA Tx admissions

²Excludes assessments

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 22). According to this data, 15% 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 (30%) of clients admitted to committing a crime during the month prior to Intake (compared to 20% at Follow-up), and many committed multiple crimes (Intake, Mn=12; 6-month follow-up, Mn = 8).

² Source: Salt Lake County Division of Behavioral Health Services (DBHS)

Table 22 Self-Reported Criminal Justice Involvement, Enrolled Clients

	Intake	6-month Follow-up
<i>Total Sample (N)</i>	54	35
During the past 30 days:		
Arrested for any reason (%)	15	14
# times arrested (Mn)	2	1
Spent at least one night in jail or prison (%)	15	14
# nights spent in jail or prison (Mn)	8	4
Arrested for drug related offense(s) (%)	2	--
# times arrested for drug-related offenses (Mn)	--	--
Committed a crime (%)	30	20
# times committed a crime (Mn)	12	8
Currently awaiting charges, trial, or sentencing (%)	21	18
Currently on parole or probation (%)	8	6

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 (43%) and Enrolled (41%) clients were booked on a new charge at least once during the previous two years (see Table 23). Approximately half of the clients in both groups (Engaged clients, 51%, Enrolled clients, 50%) had been booked into the jail for a warrant during the prior two years. When combined (n=101), the two groups accounted for 228 jail bookings and 4,573 nights spent in jail during this two year period.

During the post-Intake period (which is based on clients' intake date and therefore not equivalent to the two year, pre-enrollment period), Engaged and Enrolled clients accounted for 57 jail bookings and 542 nights in jail. Engaged clients committed more severe offenses than Enrolled clients during the two years prior to intake, but committed offenses of similar severity in the time after intake. The most common charge types among Enrolled clients in both time periods were for public order and property offenses. The most common charge types for Engaged clients were property, drug, and public order offenses.

Table 23 Criminal Involvement—Jail Bookings¹

	Engaged		Enrolled	
<i>Total Sample (N)</i>	47		54	
Jail Bookings Prior to and After Referral	2 Yr Pre	Post	2 Yr Pre	Post
Percent with booking(s) for any reason (%)	57	30	56	22
Percent with booking(s) for new charges (%)	43	29	41	19
Percent with booking(s) for warrants (%)	51	21	50	15
Percent with booking(s) for commitments (%)	34	19	27	6
Of those with any booking(s):				
Total number of bookings ² (sum)	90	32	138	25
Average number of bookings (Mn(SD))	3(3)	1(1)	4(5)	1(2)
Total nights spent in jail ² (sum)	2745	347	1828	195
Average total nights spent in jail (Mn(SD))	102(116)	25(26)	61(82)	16(21)
Of those with new charge(s):				
Most Severe Offense:				

	Engaged		Enrolled	
<i>Total Sample (N)</i>	47		54	
Severity of Charges (Mn)	F3	MA	MB	MA
Charge Type (%):				
Person	13	6	20	3
Property	29	23	37	20
Drug	32	19	6	3
Public Order	29	13	43	17

¹Due to staffing changes in Salt Lake County, this only reflects data pulled through December 31, 2012.

²Total count for entire sample

A majority of Engaged (82%) and Enrolled (79%) clients had court cases filed in the State of Utah during the previous two years (see Table 24). Enrolled clients had an average of 14 cases filed in Justice or District court during this time period (Engaged, Mn=13). 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 1,086 cases filed during the previous two years. More than half of Engaged clients (53%) and just under half (47%) of Enrolled clients had at least once case filed since Intake. Not surprisingly, most cases filed after Intake were for low-level offenses (Misdemeanors and Infractions) and were filed in Justice Court (95% for both groups). 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 (21%) or Follow-up (18%, see Table 21 on page 21).

Table 24 Criminal Involvement – Court Cases

	Engaged	Enrolled
<i>Total Sample (N)</i>	47	54
Percent with court case(s) filed - 2 years prior to Intake ¹ (%)	82	79
Of those with case(s) filed:		
Total number of cases ²	505	581
Min, Max	1, 62	1, 66
Average number of cases (Mn (SD))	13 (15)	14 (17)
Jurisdiction (%)		
Justice Court	93	95
District Court	7	5
Case Level (%)		
Felony	3	1
Misdemeanor	64	71
Financial ³	2	1
Infraction	25	23
Other ⁴	6	4
Percent with court case(s) filed since Intake ¹ (%)	53	47
Of those with case(s) filed:	302	158
Total number of cases ²		
Min, Max	1, 60	1, 33
Average number of cases (Mn (SD))	12 (16)	6 (8)
Jurisdiction (%)		
Justice Court	95	95
District Court	5	5

	Engaged	Enrolled
Total Sample (N)	47	54
Case Level (%)		
Felony	3	3
Misdemeanor	61	67
Financial ³	1	2
Infraction	33	27
Other ⁴	2	1

¹ Intake is defined as the first contact date for Engaged Clients and the GPRA Intake date for Enrolled Clients

² Total count for entire sample

³ Financial includes Debt Collection, Small Claims, and Child Support Lien cases

⁴ Other includes Cohabitant Abuse, Traffic, 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 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.

Program Activities

Staff Activities

All work with, or on behalf of, clients was documented by staff in case notes that provided detailed descriptions of staff activities, as well as clients' needs, state of mind, progress, and barriers. Primary program activities included: engagement, advocacy, benefits, basic needs, medical, substance abuse, mental health, criminal justice, housing, outreach attempt, and case management. Table 25 details the qualitative codes used to analyze almost 4,000 case notes created since the inception of the CHSH program.

Table 25 Program Activity Codes

Program Activity	Description
Administration	Activities related to managing and documenting program activities, including: administering follow-up GPRA forms; documenting no shows; and documenting discharges, transfers, and terminations.
Advocacy	Setting up appointments or arranging services for client with other agencies, attending and/or transporting clients to appointments, and any efforts with another agency on behalf of the client
Basic Needs	Activities required to meet basic needs, such as the provision of food or clothing
Benefits	Any activities related to obtaining mainstream benefits, including establishing eligibility, arranging for assessments, obtaining documents, setting up appointments, filing appeals, and providing training in managing benefits
Case Management	General program activities including phone contacts, residence visits, weekly check-ins, and

Program Activity	Description
	appointment scheduling and reminders.
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
Outreach	
	Formal and informal attempts to locate clients, including unsuccessful efforts to locate clients
Other	
	Activities that do not fit into the above categories.

Program Activities. Table 26 provides an overview of how program staff's 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 staff records multiple types of service in each case note, these percentages do not total 100. These figures highlight the substantial amount of time spent advocating on behalf of clients, which includes coordinating activities related to benefits enrollment. Furthermore, a significant portion of staff time is spent trying to locate clients (see Outreach category), which offers some insight into the nature of this population, many of whom are disinclined or unable to seek out services on their own.

Table 26 Program Activity

<i>Total Case Notes = 3,631</i>	
Program Activity	% of Case Notes
Administration	5
Advocacy ¹	34
Basic Needs	22
Benefits	20
Case Management	10
Criminal Justice	4
Engagement	6
Medical	16
Mental Health	17
Housing	12

<i>Total Case Notes = 3,631</i>	
Program Activity	% of Case Notes
Outreach	7
Substance Abuse	6
Other ²	2
² Other includes Group (N=24)	

Client Contacts and Services

On average, Enrolled clients were in the engagement period for 48 days; however, this varied greatly, ranging from 3 to 234 days (see Table 27). On average, Engaged clients have been in the engagement period for substantially longer (Mn=100 days, ranging from 11 to 335 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 14 days and Enrolled clients every four (4) 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 40 minutes each (not in table). At the time of this report, staff had recorded over 3,000 hours of contact with Enrolled clients and an additional 400 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 300 hours (or 18,000 minutes) working just with Engaged clients.

Table 27 Client Contact with CHSH Program Staff

	Engaged	Enrolled
	Mn (SD)	Mn (SD)
Number of days		
in Engagement period	100 (72)	48 (52)
in Enrollment period	--	217 (74)
Number of Services		
during Engagement period	12 (13)	12 (13)
during Enrollment period	--	92 (65)
Average Minutes of Contact per Client		
during Engagement period	369 (483)	473 (627)
during Enrollment period	--	3408(2239)
Days between Services		
during Engagement period	14 (12)	4 (3)
during Enrollment period	--	4 (3)

The nature of services provided is different for Engaged compared to Enrolled clients. Twice as many Enrolled clients receive services related to mental health and they receive nearly twice as many services (see Table 28). Many more Enrolled clients also receive services related to interagency advocacy and accessing mainstream benefits. As one would expect, more Enrolled clients receive services related to Housing. Of interest, however, is the comparatively high number of contacts per Enrolled client related to Advocacy and Basic Needs as compared to Housing. These numbers confirm findings throughout this report, pointing to the wide range of services required to obtain and maintain housing for this population.

Staff members averaged more than ten (10) contacts per client (for 54 Enrolled clients) on issues related to benefits enrollment, basic needs, and mental health services (see Table 28). For Advocacy services, which include acting on behalf of clients with other agencies, staff averaged more than 20 contacts per client. Across all client groups, a substantial portion of staff time was spent on outreach attempts, which include time spent looking for a client whether or not staff were actually successful locating the client. The average number of outreach efforts is highest for Engaged clients, which is likely a function of these individuals' resistance to services and staffs' ongoing attempts to establish a relationship. The tenuous nature of clients' ability to engage in services, however, is evident in the fact that more than half of Enrolled clients cannot be located at some point during program participation.

When working with Engaged clients, staff spent a significant amount of time on outreach activities (average 7 contacts per client). In contrast, staff time with Enrolled clients during the engagement phase was spent on activities related to advocacy and medical. These differences appear to reflect differences noted in the previous paragraph. For the Engaged population, resistance to services is a primary barrier and staff therefore devoted time to seeking out and engaging clients. Enrolled clients, in contrast, are more open to receiving services but need assistance negotiating complex public benefits systems. For clients in all stages of program engagement, assisting clients to meet basic needs is a primary task for staff.

During the current reporting period, case notes document increasing stress for housed clients related to interactions with neighbors, social support, lack of recreational and leisure activities, and anxiety. Once the stress of living and surviving on the streets was resolved, staff noted that some of the clients developed new stressors in response to their changed circumstances. As a result, CHSH staff implemented a weekly support group for clients to address some of these concerns. Groups were facilitated by at least two CHSH staff; staff also provided transportation as necessary. As recorded in case notes, clients provided peer support to each other on topics including: stress resulting from being housed, communication skills, coping skills, and treatment and recovery concerns. Approximately ten percent (10%) of CHSH clients participated in this group.

Table 28 Program Activity by Client

	Engaged		Enrolled	
	Discharged	Ongoing	Engagement	Enrolled
<i>Total Sample (N)</i>	23	24	28	54
Program Activity by Client:				
Engagement (%)	50	28	100	--
Number of Services (Mn)	3	5	4	--
Administration (%)	9	0	14	52
Number of Services (Mn)	--	--	3	3
Advocacy (%)	45	28	93	91
Number of Services (Mn)	4	3	6	21
Benefits (%)	27	8	57	95
Number of Services (Mn)	4	3	5	12
Basic Needs (%)	41	12	71	87
Number of Services (Mn)	3	6	4	14
Medical (%)	27	16	46	83
Number of Services (Mn)	5	3	5	10
Substance Abuse (%)	14	4	14	37
Number of Services (Mn)	2	--	3	8

	Engaged		Enrolled	
	Discharged	Ongoing	Engagement	Enrolled
<i>Total Sample (N)</i>	23	24	28	54
Mental Health (%)	32	20	64	74
Number of Services (Mn)	4	6	4	12
Criminal Justice (%)	9	4	21	30
Number of Services (Mn)	2	--	3	7
Housing (%)	14	8	21	80
Number of Services (Mn)	2	2	3	9
Outreach Attempt (%)	27	16	40	54
Number of Services (Mn)	4	7	3	5
Case Management (%)	14	8	18	76
Number of Services (Mn)	3	2	3	8
Other ¹	--	--	--	28
Number of Services (Mn)	--	--	--	3
¹ Consists primarily of psycho-educational support group implemented for clients during this time period.				

The case notes indicate that three-fourths (74%) of Enrolled clients are receiving recovery services related to mental illness and 37% are receiving recovery services related to substance abuse. While the entire CHSH team provides these services, specialized interventions (such as 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 63% of Enrolled clients and averaged eight contacts per client (ranging from 2 to 24 services per client, not in table). The clinical psychologist worked with 17% of Enrolled clients and averaged five contacts per client (ranging from 2 to 13 contacts per client, not in table). These team members also worked with Engaged clients, providing services, assessments, and diagnoses. Approximately ten percent (10%) of Engaged clients received recovery services from the clinical psychologist (9%) and the nurse practitioner (8%).

Services Provided Through Valley Mental Health. The CHSH program maintains an Enrolled client caseload of 50, as well as providing ongoing services to more than 50 potential clients. As a result, staff is not always able to provide long-term recovery services for clients with mental health and chemical dependency issues. While staff provides one-on-one counseling for some clients, treatment services provided by CHSH staff focus primarily on crisis management and medication stabilization. In order to facilitate clients' access to long-term recovery treatment, the Project Director expanded upon the existing collaboration with Valley Mental Health, which is a local mental health treatment provider and project partner. Subsequently, formal therapy has been initiated with 13 CHSH clients. Three of the current CHSH staff are employed through Valley Mental Health (one full-time and two part-time). As of October 1, 2012, billable services delivered by those staff are paid for through Medicaid. Since the beginning of the project, six (6) CHSH clients have received clinical services through Valley Mental Health, totaling more than 500 discrete services and 4,000 minutes of service, at a cost of \$40,829. The most frequent type of service provided is targeted case management, followed by pharmacological management, and residential living services. When looking just at services provided by CHSH staff to CHSH clients through Valley Mental Health (which are dated from October 1, 2012), a subset of three clients have received a total of 28 services (Mn per client=9, (SD=6)) that total 940 minutes (Mn per client=313, (SD=209)) and cost \$1095 (Mn per client=\$365, (SD=116)). The services most frequently provided by CHSH staff are pharmacological management and individual counseling.

Barriers. Barriers to service delivery were identified by CHSH staff in 12% of the total case notes (n=432). Inability to locate a client and inability of a client to engage in service provision were the most frequently noted barriers. In more than one-third of notes where a barrier was indicated, the client could not be located (34%) or was not able to participate in service delivery, most frequently due to symptoms related to mental illness or substance use (33%). CHSH staff also documented the following impediments to program participation: administrative barriers, such as problems with documentation, application, or establishing program eligibility (15%); client resistance, including open refusal to engage in services as well as chronically missing appointments (10%); and criminal justice involvement, including being arrested or detained and difficulty finding housing due to criminal record (5%).

Staff noted barriers to service provision for three-quarters (74%) of Enrolled clients once they were fully enrolled in the program (see Table 29). More than half (54%) could not be located on at least two occasions (see Table 29), accounting for the most frequent barrier to service provision (73% of Enrolled clients with barriers). Client's ability to participate in housing, benefits enrollment, and recovery processes were present for 44% of Enrolled clients (60% of Enrolled clients with barriers); administrative barriers were present for one-third of clients (33%) and one-quarter (24%) continued to resist services even after enrollment. Three-quarters of Enrolled clients (74%) were unable to participate in service provision at some point, primarily because the staff was unable to locate them or because of the impact of symptoms of mental illness, chronic illness, and chemical dependency. Case notes indicate that some clients abused substances more frequently after they were housed than beforehand. Staff attributed these behaviors to a combination of: greater access to resources as well as boredom and loneliness resulting from living alone after living in shelters and on the streets for so long. Staff documented barriers to service provision in the case notes of 33% of Engaged clients. As noted previously, the most frequently cited barriers were locating the client and clients' inability to participate in service provision (63% of Engaged clients for whom a barrier was noted, not in the table). Client resistance was the primary barrier to enrollment for 50% of Engaged clients for whom a barrier was present.

Table 29 Barriers to Service Delivery by Client

	Engaged		Enrolled	
	Discharged	Ongoing	Engagement	Enrollment
<i>Total Sample (N)</i>	23	24	50 ¹	54
Barrier: (%)				
Resistance ²	9	17	10	24
Ability ³	30	21	24	44
Criminal History ⁴	9	--	4	13
Administrative ⁵	22	4	24	33
Unable to Locate ⁵	30	21	35	54
Any ⁶	58	33	52	74

¹ For four of the Enrolled clients, the first case note occurred on the same date as the client's Enrollment date.

² Resistance ranged from blatant opposition to services/benefits to not showing up at scheduled appointments

³ Ability included barriers related to mental health, substance abuse, or medical issues

⁴ Criminal History included barriers resulting from time in jail, to difficulties obtaining housing because of criminal background checks

⁵ Administrative barriers included needing follow up to obtain birth certificates, disability certification, identification, etc.

⁶ Percent of clients for whom any barriers was documented

Benefits Enrollment

A primary goal of the CHSH program is to enroll clients in mainstream benefits. Table 30 presents a view of clients' mainstream benefits status at Intake and at the end of the current reporting period (February 28, 2013). 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 30 Mainstream Benefits for Enrolled Clients¹

Mainstream Benefit Type (n)	Intake	Open ²	Applications ³	Denied
Medicaid	12	38 ⁴	1	4
SSI/SSDI	19	31	8	5
Food Stamps	31	40	1	--
General Assistance	8	4	1	--
Veteran's Benefits	--	1	--	--
Medicare	4	5	--	--

¹ This number reflects the benefits enrollments of Enrolled clients as recorded on Intake forms (n=54)

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

⁴ Number includes two clients who died but whom were enrolled in Medicaid at the time of the death

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 one-fourth (n=21) of Engaged clients in some capacity in order to increase clients' access to resources. Table 31 provides a view of Engaged clients' mainstream benefits status as of February 28, 2013. 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 eligibility. 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 31 Mainstream Benefits for Engaged Clients¹

Mainstream Benefit Type (n)	Intake ²	Open	Applications ³	Denied
Medicaid	10	6	4	--
SSI/SSDI	6	2	2	1
Food Stamps	18	6	1	--
General Assistance	4	1	--	--
Medicare	3	--	--	--

¹ This number reflects the benefits enrollments for engaged clients as recorded on intake forms (n=21)

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

Fifty (50) clients have been placed in housing since the programs' inception (see Table 32). 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. Staff expressed concern in meetings that some of the clients require a greater level of supervision than is available from current housing programs.

While the CHSH program seeks to have weekly contact with clients once they are housed and stabilized, in some cases staff were checking on clients 3-4 times per week, as well as communicating with on-site case managers, out of concern for the client's safety. Two clients vacated their units during the current reporting period and chose to return to the streets; the CHSH program continues to work with these clients and provide services with the hopes of finding more suitable housing in the future.

Data from Salt Lake County Housing Authority (HACSL) shows that the majority of both Engaged (86%) and Enrolled (83%) clients had not been housed in a county program in the two years prior to CHSH involvement. One Engaged client and five Enrolled clients had been housed with the county in the two years prior to CHSH involvement, but were terminated for reasons including: failure to pay rent, program expiration, and non-compliance. Currently, nine (9) CHSH clients are housed in HACSL units. Two Engaged clients and one Enrolled client moved into county housing after being discharged from the CHSH program. At this time, data regarding clients' housing history is not available from the Housing Authority of Salt Lake City.

Table 32 Housing Placements for Enrolled Clients

Project/Owner	
Housing Type	#
Valley Mental Health	
Facility	3
Scattered	1
Salt Lake County Housing Authority	
Facility	2
Scattered	7
Salt Lake City Housing Authority	
Facility	5
Scattered	2
The Road Home	
Scattered	19
Facility	5
The Road Home/State of Utah	
Scattered	7
TOTAL Units	50

Discussion

Housing

To date, the CHSH program is on track to meet the housing goals specified in the grant by the end of the fiscal year. As of February 28, 2013, 50 CHSH clients have been housed; the combined goal for the first two years is 60 clients.

Collaboration

As detailed in the previous report, medical information is subject to regulations of the Health Insurance Portability and Accountability Act (HIPAA) and therefore not covered by the current release of information (ROI). Because the CHSH program is intended, in part, to ensure that clients

are receiving appropriate medical care, and thereby reduce unnecessary use of emergency services, project staff felt that it was important to document clients' emergency room visits. A sub-committee of the CHSH Data Sub-Committee continued to work on implementing a system for gathering information on clients' use of emergency medical services. The team created a separate ROI, drafted in accordance with HIPAA regulations, so that area hospitals could release information to Fourth Street Clinic. The CHSH staff collected ROIs at the same time they were conducting GPRA interviews. Fourth Street Clinic staff members then processed the releases and requested information from five area hospitals. Currently, data on emergency room use in the past two years has been gathered for 35 Enrolled clients. This sub-committee continues to meet in the hopes of being able to gather cost data from hospitals on services received by clients.

CHSH staff continues to work with Fourth Street Clinic and Valley Mental Health to complete Medicaid and SSI/SSDI applications. Both of these agencies employ SSI/SSDI Outreach, Access and Recovery (SOAR) officers who work for Department of Workforce Services (DWS) and provide case management for clients throughout the Medicaid and SSI/SSDI application process. In order to come to the attention of SOAR workers, clients are referred by a doctor to the state's General Assistance program (for persons with long-term disabilities), which triggers a SOAR worker's involvement on the application. CHSH staff provides assistance to SOAR workers with the application by gathering information, providing observational reports, and contacting the clients, as necessary. As a result of this process, staff are now specifically tracking clients' status for GA benefits (individuals can only receive these benefits for up to 12 months) and targeting the GA application as a means for getting clients enrolled in SSI/SSDI. This collaboration with DWS and the SOAR workers centralizes the SSI/SSDI and Medicaid application process. In the state of Utah, clients who apply for Medicaid are required to also apply for SSI/SSDI. If they apply for both programs simultaneously, however, and they are denied SSI/SSDI and the Medicaid application will automatically be denied. This denial means that clients are ineligible to apply for Medicaid for one full year. If the Medicaid application is submitted first, and subsequently approved, the client can retain Medicaid during the appeals process if their SSI/SSDI application is denied. Coordinating with SOAR workers reduces the chances that clients will go off Medicaid, which can jeopardize access to medication and treatment for chronic condition.

As noted previously, the sheer number of current CHSH clients means that staff is primarily focused on short-term recovery services and crisis intervention. In order to facilitate comprehensive recovery services to clients, the Project Director and Valley Mental Health (VMH) expanded the existing collaboration between the two organizations. Currently, VMH provides long-term services—including groups, supportive housing, pharmacological management, chemical dependency services, and a drop-in center—for homeless individuals with severe and persistent mental illness. In the expanded partnership between CHSH and VMH, CHSH clients who qualify are simultaneously opened up as clients at the appropriate VMH program and are therefore eligible for clinical services through one of the agency's treatment programs.

Resources

During the current reporting period, the Project Director and the Steering Committee began planning for the CHSH project's long-term sustainability. In part, the monies needed to fund the project in the future are expected to come from Medicaid. This funding process was started at the beginning of the second year (October 1, 2012), at which point eligible services provided to clients by the three clinicians who work for Valley Mental Health (licensed social worker, nurse practitioner, and psychologist) are being billed to Medicaid. Due to uncertainties regarding Utah's participation in the Medicaid expansion (under the Affordable Care Act), the total amount of monies

that will be available through this mechanism is not known at this time. If the State of Utah does participate in Medicaid expansion, the eligibility standards for CHSH clients will likely expand to accommodate newly Medicaid-eligible individuals. The Steering Committee recently met with a policy expert from DWS, which administers the Medicaid program, and anticipates that the Utah's Governor will make a decision by the end of the summer. In the meantime, the Steering Committee has created a sub-committee that will begin meeting in the spring to strategize additional long-term funding options.

Client Barriers

Housing First and ACT models both target clients with significant barriers to stable housing and benefits enrollment. Not surprisingly, those difficulties were evident 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 resistant to services, because of mental illness and/or previous interactions 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 enroll in the CHSH program. Those methods are in line with the ACT model, which is based on assertive engagement of clients, services provided in the community, 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 utilization of services.

As noted in previous reports, CHSH clients demonstrate ongoing and intensive needs even after they are housed. Data gathered from case notes and observation of staff meetings revealed that clients struggled with the lack of daily living skills, social isolation, limited resources, boredom, and negative peer interactions once they were housed. Staff employed multiple approaches to addressing these issues, including arranging "recreational" events that were intended to teach clients how to find meaningful activities to occupy themselves. In response to emerging client needs, staff implemented a weekly support group to assist clients in the development of coping and social skills. Additionally, staff takes turns covering a shift at the office in order to respond to crises and unplanned visits from clients. For clients who were involved in interpersonal conflicts within their housing units, staff often contacted landlords or housing project case managers to find ways to keep those infractions from resulting in terminations.

As noted in the previous report, staff continues to experience some frustration when working with clients for whom they do not feel they have adequate resources. In some cases, this stems from behaviors related to severe mental illness, which pose a risk to client safety once those persons are housed in scattered site units. The pressure to monitor some clients more closely—and the relative dearth of housing options that would provide closer supervision—can be a burden for staff. In several instances, clients vacated their housing units in order to return to street living. In attempting to help those clients maintain occupancy in a rental unit, some staff has voiced the concern that they feel like they are trying to house clients against their will. This concern highlights the possible disconnect between the program's Housing First philosophy, which gives primacy to clients' needs, and the goals of the grant, which are to get clients into housing. For the time being, staff will continue to work with clients who have vacated their units and provide services related to public benefits, treatment, and basic needs.

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 February, 2013, the program had made contact with 101 individuals and has a list of more than 20 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 February, 2013, 44 clients were open in Medicaid; however, some of those clients already had open files or applications submitted at program Intake (see Table 30, page 28). The difficulty in reaching this goal stems from a combination of issues. In part, program staff overestimated the number of homeless individuals in the community who were eligible for Medicaid but not already enrolled. Since the program's inception, CHSH staff has found that a significant portion of the chronically homeless individuals were already enrolled or had applications in progress. Case notes indicate that there is still a lot of work to do in terms of helping clients maintain those benefits, but such activities do not comprise new enrollments.

The CHSH program has also encountered problems enrolling clients in Medicaid stemming from the targeted client population: chronically homeless individuals with mental illness and chemical dependency issues. Often, the effects of substance use mask the symptoms of mental illness. Because the presence of substance abuse, in the absence of mental or physical disability, does not qualify an individual for Medicaid, clients cannot be enrolled in the program if a clinician is unable to make a specific mental health diagnosis that is not purely the result of substance use. As a result, staff spends significant time attempting to identify and document mental illness, where one exists. This problem is exacerbated by the fact that the State of Utah has not yet decided whether or not to participate in the Medicaid expansion. If the state does participate, the majority of CHSH clients would be eligible under income rules and the disability ruling will become less important as a barrier to enrollment and access to services.

Housing. As noted previously, the CHSH program is well on its way to meeting grant goals related to housing clients. This success is particularly remarkable given funding difficulties related to housing (documented in the previous report) and is a tribute to the program's persistence and innovative problem-solving. 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. In order to address this issue, the program continues to discuss possible solutions with both partner agencies and the Steering Committee.

Provision of Recovery Services. The grant application stated that the CHSH project would provide recovery services to 90 clients over three years. Currently, 40 Enrolled clients have received those services for mental health issues and 18 for chemical dependency. In addition, 12 Engaged clients have received recovery services. The CHSH team provided screening and assessments, one-on-one counseling, medication management and treatment services for clients. The Project Director

indicated that the actual number of clients receiving services is likely higher, but that the information is not always recorded in case notes. To address this concern, the research team will meet with staff in the next month and create a revised template for recording client contacts.

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 13 CHSH clients; these interventions complement ongoing services provided by CHSH.

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Appendix A - Vulnerability Assessment Index

Vulnerability Index Survey Consent Form

Consent for Interview

We are here today to talk to you about your housing and service needs. If you give us permission, we will ask you some questions for about 10 minutes and take a picture of you so we can identify you at a later date. These questions are about your health and housing and we will also ask for your social security number. By participating in the interview you give permission to Community Solutions and Utah Homeless Management Information Systems to provide your information to homeless service providers for the purpose of furthering services and housing in this community.

The information that you tell us during the interview will be stored in the Utah Homeless Management Information System (UHMIS), which is a secure database that collects information about homelessness. Identifying information will be kept confidential and will only be shared with outreach workers and case managers who will follow up with you for services.

Some of the questions we ask during the interview might make you feel uncomfortable or be upsetting. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break or to skip any of the questions. You can skip any questions you do not want to answer, end the interview at any point, or choose to not have your picture taken. Additional information about UHMIS, and a list of participating agencies, is available from your case manager or online at <http://hmis.utah.gov>.

We will give you a \$5 food card at the end of the interview to thank you for your time. No one will be upset or angry if you decide not to be interviewed today.

SIGN BELOW IF AGREEING TO BE INTERVIEWED

Your signature (or mark) below indicates that you have read (or been read) the information provided above, have gotten answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

Date

Signature (or Mark) of Participant

Printed Name of Participant

Please sign below if you also agree to have your picture taken

Signature (or Mark) of Participant

Pre-Question: Have you recently completed a homeless count survey? <input type="checkbox"/> Yes (STOP, do not complete survey) <input type="checkbox"/> No		
1. INTERVIEWER'S NAME		2. TEAM # <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER
3. DATE	4. TIME	5. LOCATION

Okay, first I would like to collect some basic demographic information:

6. FIRSTNAME	7. LASTNAME	8. MIDDLE NAME
9. NICKNAME/STREET NAME		10. Has Consented to Participate: <input type="checkbox"/> YES <input type="checkbox"/> NO
11. Social Security Number <input type="checkbox"/> Don't Know or Don't Have <input type="checkbox"/> Refused		
12. DOB/Age <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or Partial DOB Reported <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused		
13. What is your gender? (select one) <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Don't know <input type="checkbox"/> Refused		
14. What is your marital status? (select one) <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married & Living with Spouse <input type="checkbox"/> Married & Not Living with Spouse <input type="checkbox"/> Common Law <input type="checkbox"/> Living Together <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Legally Separated <input type="checkbox"/> Other		
15. Ethnicity (select one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused		
16. Race (select as many as apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused		
17. Primary Language		Limited English? <input type="checkbox"/> YES <input type="checkbox"/> NO

I'm going to ask you a few questions about your housing history...

18. What is the total length of time you have lived on the streets or in shelters?	# of Years:
	# of Months:
19. Have you been living in an emergency shelter and/or on the streets for the past year or more? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
20. How many times have you had to stay in shelters or on the streets in the past three (3) years?	# of Times:
21. Where do you sleep most frequently? (select one) <input type="checkbox"/> Shelters <input type="checkbox"/> Streets <input type="checkbox"/> Car/Van/RV <input type="checkbox"/> Subway/Bus <input type="checkbox"/> Beach/Riverbed <input type="checkbox"/> Other (specify)	
22. What city/Zip did you live in prior to becoming homeless?	
23. Where did you sleep on the night of Wednesday, January 30 th ? (select one) <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Other	

Okay, now I'd like to ask you a few questions about your health...

24. Where do you usually go for healthcare or when you're not feeling well? <input type="checkbox"/> Fourth Street Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> VA <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Does not go for care		
25. How many times have you been to the emergency room in the past three months? _____		
26. How many times have you been hospitalized as an inpatient in the past year? _____		
27. Do you have an alcohol or drug problem, a serious mental health problem, a developmental disability, or a chronic physical illness or other disability? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Refused		
28. Do you have now, have you ever had, or has a healthcare provider ever told you that you have a severe mental illness? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Refused		
29. Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?		
a. Kidney disease/ End Stage Renal Disease or Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
b. History of frostbite, Hypothermia, or Immersion Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
c. History of Heat Stroke/Heat Exhaustion	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
d. Liver disease, Cirrhosis, or End-Stage Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
e. Heart disease, Arrhythmia, or Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
f. HIV+/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
g. Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
h. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
i. Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
j. Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
k. Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
l. Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
m. DO NOT ASK: Surveyor, do you observe signs or symptoms of serious physical health conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Drug/Alcohol Use...

n. Have you ever abused drug/alcohol, or been told you do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
o. Have you ever abused drugs, or been told you do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
p. Have you consumed alcohol everyday for the past month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
q. Have you ever used injection drugs or shots?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
r. Have you ever been treated for drug or alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused
s. DO NOT ASK: Surveyor, do you observe signs or symptoms of alcohol or drug abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mental Health...

- t. Are you currently or have you ever received treatment for mental health issues? ☐ Yes ☐ No ☐ Refused
- u. Have you ever been taken to the hospital against your will for mental health reasons?
..... ☐ Yes ☐ No ☐ Refused
- v. DO NOT ASK: Surveyor, do you detect signs or symptoms
of severe, persistent mental illness?..... ☐ Yes ☐ No

Other...

- w. Have you been the victim of a violent attack since you've become homeless? ☐ Yes ☐ No ☐ Refused
- x. Are you or have you ever been a victim of domestic violence? ☐ Yes ☐ No ☐ Refused
- y. Do you have a permanent physical disability that limits your mobility? [i.e., wheelchair, amputation, unable to climb stairs]?
..... ☐ Yes ☐ No ☐ Refused
- z. Have you had a serious brain injury or head trauma that required hospitalization or surgery?
..... ☐ Yes ☐ No ☐ Refused

30. What kind of health insurance do you have, if any? (check all that apply)

- ☐ Medicaid ☐ Medicare ☐ VA ☐ Private Insurance ☐ None ☐ Other (specify):

Alright, now I've just got a few more questions...

31. Have you ever served in the US Armed Forces (Full-time: Army, Navy, Air Force, Marine Corps, or Coast Guard) or were you ever called into active duty as a member of the National Guard or as a Reservist?
..... ☐ Yes ☐ No ☐ Don't Know ☐ Refused
32. If yes, which war/war era did you serve in?..... ☐ Korean War (June 1950-January 1955)
☐ Vietnam Era (August 1964-April 1975)
☐ Post Vietnam (May 1975-July 1991)
☐ Persian Gulf Era (August 1991-Present)
☐ Afghanistan (2001-Present)
☐ Iraq (2003-Present)
☐ Other (Specify) ☐ Refused
33. If yes, what was the character of your discharge?..... ☐ Honorable ☐ Other than Honorable
☐ Bad Conduct ☐ Dishonorable ☐ Refused
34. Have you ever been in jail? ☐ Yes ☐ No ☐ Refused
35. Have you ever been in prison? ☐ Yes ☐ No ☐ Refused
36. Have you ever been in foster care? ☐ Yes ☐ No ☐ Refused

37. How do you make money? (choose as many as apply)

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Work, on-the-books | <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Pension/Retirement |
| <input type="checkbox"/> Work, off-the-books | <input type="checkbox"/> Sex Trade | <input type="checkbox"/> None of the Above |
| <input type="checkbox"/> SSI | <input type="checkbox"/> Drug Trade | |
| <input type="checkbox"/> SSDI/SSA | <input type="checkbox"/> Recycling | |
| <input type="checkbox"/> VA | <input type="checkbox"/> Panhandling | |
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> No Income | |

38. What is your citizenship status? ☐ Citizen ☐ Legal Resident ☐ Undocumented ☐ Refused

39. What is the highest grade in school you completed?

- | | | | | |
|---|---|---|--------------------------------|---------------------------------------|
| <input type="checkbox"/> K-8 | <input type="checkbox"/> Some high school | <input type="checkbox"/> High School Graduate | <input type="checkbox"/> GED | <input type="checkbox"/> Some College |
| <input type="checkbox"/> College Graduate | <input type="checkbox"/> Post Graduate | <input type="checkbox"/> Decline to State | <input type="checkbox"/> Other | |

OK, now I'm going to ask you some questions about your community40. Is there a person/outreach worker that you trust more than others? ☐ Yes ☐ No ☐ Refused

41. If yes, Person: _____ Which agency do they belong to? _____

42. Can we contact you at a later date to provide information on services?: ☐ Yes ☐ No ☐ Refused

43. If yes, What is the best way to contact you? _____

Lastly, I want to ask about any other people who were residing with you on the night of Wednesday, January 30th (If no one else, skip to final page and ask to take picture).

44. Did any other household members stay with you the night of Wed., January 30, 2013?

☐ Yes ☐ No ☐ Refused

IF YES:

How many children under the age of 18 stayed with you? _____

How many adults between the ages of 18-24 stayed with you? _____

How many persons over the age of 24 stayed with you? _____

Can I ask you a little more detail about these household members?

45. Can you give me the names, age and gender of each household member, what their relationship to you is whether or not they are a veteran and whether or not they have any of the following disabling conditions?

First Name, Last Name and relationship to primary respondent (Spouse/Partner/Child/Etc.)		Age	Gender	Veteran?	Victim of Domestic Violence	Chronic Substance Abuse	Physical Disability	Developmental Disability (permanent)	Mental Health (substantial and long-term)	Chronic Health Condition (permanently disabling)	HIV/AIDS	None apply
1.	First Name: Last Name: Relationship:											
2.	First Name: Last Name: Relationship:											
3.	First Name: Last Name: Relationship:											
4.	First Name: Last Name: Relationship:											
5.	First Name: Last Name: Relationship:											
6.	First Name: Last Name: Relationship:											
7.	First Name: Last Name: Relationship:											
8.	First Name: Last Name: Relationship:											