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

Bi-annual Report
October 2012

THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
COLLEGE OF SOCIAL & BEHAVIORAL SCIENCES
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Background and Introduction

According to the Utah State Community Service Office (2012), 3,527 individuals in Utah were homeless during the January 2012 Point in Time count and 331 of these individuals were considered chronically homeless. Nationally, it is estimated that between 10-20% of all homeless individuals are chronically homeless, but that this small group uses half of all shelter days (McCarty, 2005). Chronically homeless individuals often have a variety of needs, in addition to a lack of housing, which must also be addressed in order to improve their long-term outcomes. Research has consistently found that in order to be successful, recovery must be a collaborative process, involving partners from various fields. Kraybill and Zerger (2003) found that at the service delivery level, the most effective programs for homeless persons emphasized the importance of providing integrated care through interdisciplinary teams typically made up of medical, mental health, substance use, and social service providers.

In September of 2011, The Road Home received funding through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to develop, implement, and evaluate the Chronic Homeless Services and Housing (CHSH) project over the course of a three year period. The CHSH project was designed to fill existing gaps by providing resources and building relationships at the point of client contact, utilizing an interdisciplinary outreach team to deliver services, and staying close to the client at every point during the housing process. The goal of the CHSH project is to use a Housing First approach to stably house chronically homeless individuals who have been the most challenging to engage, have a history of substance abuse and/or mental illness, and who have not been successful in accessing existing permanent supportive housing (PSH). The Housing First model is often defined as an intervention in which housing resources are provided with no requirement or contingencies (e.g., abstinence or employment). There is a growing body of knowledge suggesting that the Housing First model may be more successful at housing homeless populations in comparison to programs that require abstinence (Tsemberis et al., 2004; Stefancic & Tsemberis, 2007).

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

Study Procedures

The data collection, performance measurement, and performance assessment will be 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 polices. Evaluators reviewed program documents, including meeting minutes, policies, protocols, position descriptions, release forms and interagency communications and

recorded the creation and revision of the program structure and service delivery model. In July, 2012, researchers conducted an online survey with project team members, administrators (e.g., Steering Committee and Community Consortium members) and representatives from partnering agencies. The purpose of the survey was to gather feedback and to identify any barriers regarding the CHSH project. Survey results are presented on page 8 of this report.

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

Table 1 Data Sources for Program Implementation

Program Documents
CHSH Procedures and Operations Manual, CHSH Interagency Release of Client Information, CHSH CHSH Referral Forms, CHSH Service Plans, 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
CHSH Surveys
Results from the CHSH Partners Survey and Staff Survey, administered in July, 2012.

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 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. Due to the infancy of the program at the time of this report, the last three questions will not be reported on until future reports.

Table 2 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**
Road Home/CHSH	
CHSH Client Referral Forms for all clients referred since January, 2012. Data include the referring agency and results from the Vulnerability Assessment. CHSH Intake Forms for clients who are engaged or enrolled in CHSH services. Data is self-report and includes education, employment, benefits enrollment, current homeless status, and mental health, substance abuse, and medical concerns. CHSH ClientTrack Records that document ongoing services provided to clients. Data include length and frequency of contact, services provided, goals set, goals kept, and barriers to reaching goals. Homelessness history at The Road Home from December, 1998. Data includes number of shelter nights. Service Plans for Enrolled clients. Data includes long-term goals set with clients and barriers to implementing those goals.	
Government Performance and Results Act (GPRA) Surveys	
Self-reported data collected at Intake, 6 months, and Exit from program covering: demographics, education, employment, income, family, living conditions, drug use, alcohol use, crime and criminal justice, mental health, physical health, treatment/recovery, military service, violence/trauma, and social connectedness. This report provides Intake and 6 month GPRA results.	
Salt Lake County Sheriff's Office (OMS)	
Jail booking history at Salt Lake County Adult Detention Center for 2 years prior to 1st CHSH contact. Data includes booking date, offense/booking type (e.g., new charge, warrant of arrest, bench warrant, hold), charge type and severity, release date and type, offender demographics, and court case numbers (when available). Future reports will include analyses of jail booking occurring while clients are receiving CHSH services.	
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 1st CHSH contact and while receiving services through CHSH. Data includes treatment date and treatment type.	

Data Source	Description
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.	
XChange/CORIS	
Text documents with court case information that is searchable by name, date of birth, court case number, court location, and/or date. Documents used to identify cases filed in Utah District and Justice Courts during the 2 years prior to 1st CHSH contact and while receiving serviced through CHSH.	

Results

The following section of the report details grant activities for the project to date, from October 1, 2011 through September 30, 2012. 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 13 and *Program Activities* on page 24).

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 first year of the CHSH team's implementation of a modified ACT service delivery model within the context of a Housing First program.

Staff

Hiring. There have been no staff changes since the last evaluation report (submitted April, 2012). In keeping with the ACT model, the CHSH team is comprised of six full-time staff members: the Project Director, one Housing Coordinator, two Case Managers, and two licensed Substance Abuse/Mental Health Specialists (social workers). The Project Director, both Case Managers, and

the Housing Coordinator are all employees of The Road Home and the two social workers are employed by partner agencies, Valley Mental Health and Volunteers of America. While these six individuals form the core of the CHSH team, the program also contracts with Valley Mental Health for one-quarter time services (ten hours each per week) from a clinical psychologist and an Advanced Nurse Practitioner (APRN).

Training. During the first year of the grant, CHSH staff participated in eleven formal training sessions in order to prepare them to work under the Housing First Model and to help clients with benefit enrollment applications. Because all staff were new to the project during the first year, all staff were trained on topics directly related to CHSH program goals: Medicaid eligibility and enrollment; SSI/SSDI Outreach, Access, and Recovery (SOAR); Housing First; administration and interpretation of the SOQ (mental health assessment tool); administration of the GPRA; and accessing clients' benefits history in conjunction with the Department of Workforce Services. Staff also received multiple training sessions on ClientTrack, which is the data management tool used by The Road Home, and specifically on the CHSH template, which was designed to track client goals and progress under the scope of this grant. In addition to grant specific training, the Project Director trained staff on topics related more generally to social service delivery, including diversity and cultural awareness, de-escalation and safety tactics, confidentiality, appropriate boundaries with clients, and ethics. During the second reporting period, staff met with representatives from multiple partners agencies to plan an interagency training on motivational interviewing. In addition to these formal training activities, the Project Director meets weekly with staff, one on one, to provide individualized feedback and supervision.

Staff organized and participated in multiple informal sessions with partner agencies in order to build relationships, clarify program objectives, refine referral processes, and create mechanisms for ensuring clients receive comprehensive care without duplicating services. During the first year, members of the CHSH team participated in 24 informal sessions with Volunteers of America, The Road Home, Valley Mental Health, Fourth Street Clinic, Pathways, multiple housing departments, and other social service agencies. During the first reporting period, staff training activities focused primarily on formal training sessions and introducing the CHSH program. During the second reporting period, as the program began to provide ongoing case management to clients, staff training and outreach time was primarily spent on activities related to co-managing clients who were receiving services from multiple agencies.

CHSH staff participated in national training and networking events, including GPRA training, Housing First, SAMHSA Grantee Conference, and statewide meetings regarding health care reform, street medicine, and chronic homelessness.

Program Structure and Service Delivery

Team Location. There were no changes in the physical location of the CHSH team. The office is located in close proximity to many agencies that provide services to homeless persons, including partner agencies. This location allowed staff to have easy access to partner agencies and made staff easily accessible to clients. Many of the clients served by the project were difficult to locate and the centralized location meant that staff had increased opportunities for spontaneous encounters, either on the street or at a project partner's office. Additionally, this centralized location facilitated frequent and regular communication between partners regarding client status and allowed for unplanned, joint visits to clients when needed. This flexible, collaborative model of service delivery is central to the ACT model.

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 keeping with the ACT model, potential clients are actively identified and targeted through existing services and partner agencies, which include street outreach teams, homeless shelters, detoxification programs, and medical clinics that serve homeless populations. Individuals are identified as potential candidates for CHSH by representatives from partner agencies, based on the following criteria: an unaccompanied homeless person (a single homeless person who is alone and is not part of a homeless family and not accompanied by children) with a Disabling Condition, who has been continuously homeless for a year or more or has had four episodes of homelessness in the last three years. In addition, clients must meet at least one additional criteria: be diagnosed as substance abusing or substance dependent, be diagnosed with a mental illness, have a high number of police, jail, or emergency medical services contacts, have a high number of nights spent at homeless shelters, have been unsuccessful in housing, refused housing in the past, or have a high risk score on the CHSH Vulnerability Assessment tool. Since the projects' inception, eligibility criteria have been continuously refined to focus on clients who meet the above criteria and who are also likely to qualify for Medicaid based on disability status. During the current reporting period, restrictions tied to available housing monies required further narrowing of client eligibility criteria. Temporarily, the CHSH program prioritized clients with at least 365 shelter nights (see *Barriers* section of report for further discussion); however, this focus on shelter use did not constitute a formal policy revision.

Client Pre-Screening. In order to coordinate with existing services, which was a primary goal of the grant application, the process for referring clients to CHSH was developed in conjunction with The Road Home's Chronic Homeless Program (CHP). Partner agencies complete a referral packet for targeted individuals, consisting of a signed release of information (ROI) from the client, suggestions for locating the client, and a Vulnerability Assessment. The Vulnerability Assessment, which is filled out by the person making the referral, gauges the client's ability to function in nine domains: homelessness, victimization and vulnerability, substance abuse, basic needs, mental health, organization and orientation, communication, social behaviors, and medical health. The completed referral packet is sent to the Chronic Homeless Coordinator at The Road Home, who gathers additional information about the client, from agency records and conversations with staff, in order to determine the chronically homeless program for which the client is best suited. In this centralized referral process, clients are more likely to be matched with appropriate services and less likely to fall through the gaps created when clients are on multiple housing wait lists that are operated by different agencies. In accord 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.

Client Engagement and Enrollment. Clients are referred to CHSH by the CHP program. In keeping with the program's focus on clients who meet state Medicaid eligibility requirements, the referral includes a formal screening of mental health and medical records when available from partner agencies as well as a consultation with a representative from the Department of Workforce Services (DWS) to determine the client's likely eligibility for mainstream benefits. Program staff conduct the individual pieces of this review and the Project Director makes the final determination on whether to accept an individual to CHSH or to refer the individual back to the Chronic Homeless Program at The Road Home. Service Coordinators continue to work with partner agencies, and particularly the referring agency, to introduce the CHSH program to potential clients. Representatives from partner agencies were present in nearly ten percent of CHSH contacts, for both Engaged and Enrolled clients.

Service Delivery Model. Clients are assigned to staff based in part on the match between client characteristics and staff training and skills; each client is assigned both a Case Manager and a licensed clinician. The Housing Coordinator, Project Director, APRN, and psychologist work with clients as needed, usually at the request of assigned staff, but do not carry caseloads. In addition to providing medical services, both the APRN and the psychologist are used to expedite assessments and documentation required for disability certification. Although clients are assigned to specific clinicians and Case Managers, the entire team participates in the staffing of every case during daily staff meetings. As is expected under the ACT model, the Project Director for the CHSH program provides direct services to clients, both individually and as part of team outreach. The implementation of a team approach to service provision, which is central to the ACT model, is evident in the fact that CHSH client contacts average more than one staff per contact (1.4 staff per contact for Engaged clients and 1.3 staff per contact for Enrolled clients).

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. Because the majority of services provided by the CHSH team are done in the field, the team encountered difficulties with the van's availability as the program's client load increased. In the short-term, staff collaborated with partner agencies to use vehicles; eventually, the team purchased a second vehicle. In response to the large number of clients who were difficult to have regular contact, staff also organized weekly outreach activities, wherein several staff members would specifically search for clients. Staff rotated these outreach duties and made collaborative decisions about which clients to target during daily staff meetings. This pro-active approach to establishing and maintaining relationships with clients is central to the ACT model.

Table 3 Service Delivery Location

	Engaged		Enrolled	
	Discharged	Ongoing	During Engagement	During Enrollment
Location (%):				
CHSH Office	49	30	49	45
Other Agency	28	27	36	27
Client Residence	3	6	2	15
Outside/Street	13	22	6	7
Jail/Institution	6	2	5	1
Other[1]	1	13	1	6

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

CHSH Meetings. As part of implementing the ACT model, the Project Director revised the CHSH meeting structure during this reporting period. In addition to weekly meetings, CHSH staff met daily for one hour to review clients' progress and status. The team's weekly and monthly schedule was tracked on dry erase boards, which were updated during these meetings. Discussion topics focused on scheduling staff time in relation to clients' goals and deadlines, including: appointments, use of the van, paperwork and documentation, and staff schedules. A third dry erase board was used to record and document each client's goals, progress, barriers, and next steps. Weekly staffing meetings, which were two hours long, focused on long-term goals such as client resistance to services, client isolation, and client conflict with partner agencies. During these meetings, the

Project Director also encouraged staff to process their own experiences working with clients, including feelings of burn-out and fatigue. In order to prevent staff exhaustion, client assignments were sometimes adjusted based on the dynamic between staff and clients. During the early phases of project implementation, when staff members were focused on client recruitment, the CHSH team met with partner agencies weekly in order to share information on clients and review the referred client. As the program enrolled more clients, the frequency of these partner meetings—which had focused on referrals—was reduced. Subsequently, partner meetings were moved to a monthly schedule and targeted coordination between agencies and updates regarding agency changes in staff, policies, and protocol.

Staff and Partner Surveys

Surveys were electronically distributed to both CHSH staff and partners in July, 2012. Partners included representatives from agencies as well as members from the Steering Committee and other project subcommittees. The staff survey contained 11 questions and the partner survey comprised 16 questions (see Appendix C for survey forms). The survey was intended to assess respondents' perception of the positive and negative impacts of the project, including the impact on clients and partner agencies, as well as accomplishments, barriers, and problem solving strategies. All seven staff and 24 out of 55 partners (44%) participated in the survey. Table 4 provides details on the survey respondents' familiarity and contact with the CHSH project. The majority of partner respondents were somewhat familiar with the project (70%). Contact with the CHSH project staff regarding CHSH clients, potential clients, or project activities was fairly equally distributed, with 32% of respondents having contact weekly, 27% monthly, and 36% infrequently.

Table 4 CHSH Survey Distribution and Respondent Characteristics

	%
Respondents	
CHSH Project, Steering Committee Member	30
Community Partner Agency, Administrative Staff	35
Community Partner Agency, Direct Services Staff	30
The Road Home, Staff	9
Familiarity of Respondents with CHSH Project (%)	
Completely Unfamiliar	4
Somewhat Unfamiliar	4
Somewhat Familiar	70
Completely Familiar	22
Contact with CHSH project (%)	
Daily	5
Weekly	32
Monthly	27
Infrequently (less than monthly)	36

Staff survey. Seven staff completed the survey; however, no more than four responses were recorded for any one question. Of the staff who did respond, several reported that the engagement process was much longer than they had expected when the project started. While all staff had previous experience working with homeless and/or severely mentally ill persons, respondents reported that clients were even more resistant to housing and services than they had expected. Staff expressed surprise at the degree to which these challenges continued even after housing was attained. Several respondents specifically referenced the prominence of clients' mental health

symptoms as a barrier to setting goals and providing services. While staff expressed strong support for the basic tenets of the ACT model and the larger project goals, some difficulty was evident as they worked to mesh clients' individual needs and goals with larger project objectives. As an example of this tension, staff remarked on the frustration they experienced when negotiating the complex processes involved in preparing and submitting applications for SSI/SSDI and Medicaid. Staff were concerned that these time consuming tasks were taking away from the time they had to spend with clients and providing direct services. When discussing collaboration and problem-solving within the team, all respondents indicated that issues were resolved in a timely and democratic fashion.

Partners survey. Emerging themes from the Partners Survey are detailed below.

Barriers to program implementation. Logistical and resource-related issues were the most commonly cited barriers to program implementation, with the lack of safe, affordable and available housing units listed as the primary obstacle. Respondents also expressed concerns regarding: funding silos that make it difficult to provide comprehensive services; inconsistent eligibility criteria across social service programs; lack of available housing for individuals with criminal histories; and long delays in processing information for benefits and housing applications. One respondent stated: "the maze of requirements and steps it takes to get an ID, for example, inhibits the ability to streamline the long process of getting people off the streets." Others reported barriers related to "the inherent complexity of the homeless population," including resistance to help, lack of trust in agency staff or partner organizations, and the narrow eligibility criteria for Medicaid. One respondent mirrored perceptions from the staff survey, and commented on the difficult and time-consuming nature of engaging clients and maintaining housing.

Accomplishments of the CHSH project. Overwhelmingly, respondents cited the fact that CHSH staff had housed so many chronically homeless individuals as the program's major accomplishment. Additionally, respondents felt that the project had resulted in improved communication between partner agencies, increased understanding among service providers of client's needs, and increased community engagement in the movement to end homelessness. One respondent stated: "It's been a powerful tool in helping to shift the community discussion regarding homelessness. Elected officials are far more receptive to the notion of Housing First. In fact, most have accepted it as the preferred approach (as evidenced by the focus of this year's homeless trust fund allocation)."

Changes in policies or practices as a result of the CHSH project. Nearly half (44%) of respondents indicated that their agency had made some changes to policy or practice as a result of the CHSH collaboration. Changes included collaborative agency referral processes, increased resources allocated to benefits enrollment, and dedication to Housing First as a philosophy for working with homeless populations. The resource and information sharing that is generated within the confines of CHSH work extends to partner agency's other collaborative projects, as one respondent noted: "due to the collaboration, I approach other agencies for advice more often in order to be a better advocate for my clients."

Expectations of the project. Overwhelmingly, the survey results suggest that partners perceive that the CHSH project has been a success to date. One respondent mentioned that: "for the long term, this is one of the most important projects currently in place by which to address homelessness." Some frustration experienced by partners appeared to stem from a misalignment between expectations and program goals: several respondents reported disappointment that the project prioritized clients who qualified for Medicaid and/or SSI/SSDI, despite the fact that this was an explicit grant objective. Two respondents assumed that the project would have set-aside rental

units that would allow participants to bypass housing waitlists; both were frustrated that clients still had to wait for available vouchers and/or units. Another respondent shed insight on this concern, noting that some partners were not living up to obligations—including data sharing, housing, and resources—that they had committed to during the planning phase of the project. In the first six months of the project, The Road Home recognized problems related to housing availability and applied for federal funds to address the shortage; however, those monies had not been distributed at the time the survey was administered.

Suggestions. Despite strong support evinced by partners for the CHSH project—both in terms of the necessity for and quality of services—a small portion of respondents expressed concern that the project did not allocate sufficient resources to case management. While there was no unified theme regarding those activities that detracted from case management, respondents referenced disappointment that so many resources were allocated to research, clinical staff, or administration. A few respondents also expressed frustration that the CHSH project duplicated existing services. In contrast, two respondents felt that the program provide unique services that were showing measureable results, but that staff needed to devote more time to outreach and education to counteract the perception that services were being duplicated.

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. 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 CHP, because they are not eligible for CHSH, are not interested in participating, or cannot be located; these clients are considered *Discharged*. 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 Intake.

When reviewing this section of the report, it is important that the reader keep in mind the small sample sizes being examined. 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 21 people.

Table 3 CHSH Samples

	N
Engaged Clients[1]	43
Enrolled Clients[2]	42
Total	***85***

[1] Twenty-one of the 43 clients in the Engaged sample have been discharged without enrolling in CHSH.
[2] Five of the Enrolled clients have been discharged from the program; four of those were housed while in CHSH and then discharged to less intensive supportive housing.

Referrals to CHSH

Referring Agencies. The referral process into CHSH is coordinated through The Road Home's Chronic Homeless Program (CHP), which acts as a clearinghouse for referring chronically homeless persons into different housing programs. Partner agencies complete a referral packet for targeted individuals, consisting of a signed release of information (ROI) from the client, suggestions for locating the client, and a Vulnerability Assessment. The completed referral packet is sent to the Chronic Homeless Coordinator at The Road Home, who gathers additional information about the client, from agency records and conversations with staff, in order to determine the chronically homeless program for which the client is best suited. The Chronic Homeless Services Coordinator makes the referral decision based on how well the clients' characteristics match with CHSH service goals and therefore targets persons with a long history of homelessness who also have a disabling condition. If deemed appropriate, the entire referral packet is then sent to the CHSH Project Director for final approval. As shown in Table 4, below, the Fourth Street Clinic, provides the majority of overall referrals and has the highest percentage of referred clients who become Enrolled (63%, not in table).

Table 4 Referral Source

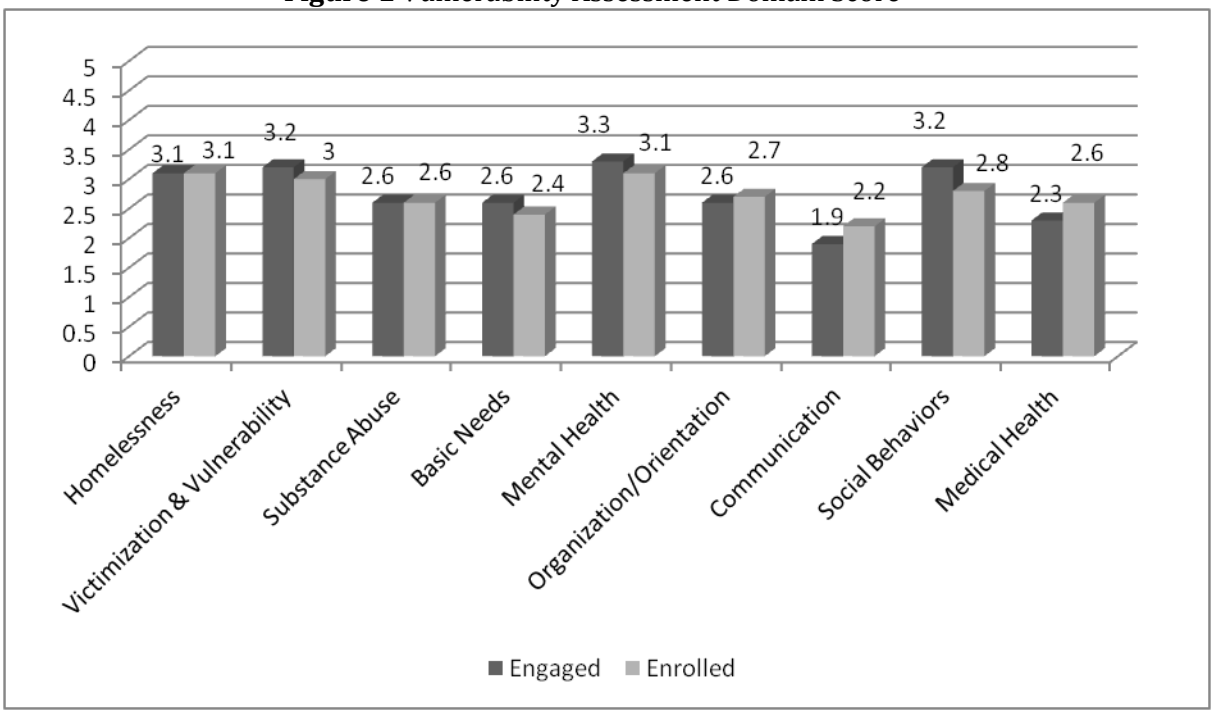
Agency/Group Name	Engaged	Enrolled	Combined	
	#	#	#	%
The Road Home	5	8	13	15
Mobile Outreach Street Team (MOST)	11	8	19	22
Volunteers of America (VOA)	10	5	15	18
4th Street Clinic	8	14	22	26
Other[1]	9	7	16	19
Total	43	42	85	--

[1]Other category includes: 3 referrals from Valley Mental Health; 1 referral from the Utah State Hospital; and 12 unspecified referrals.

Vulnerability Assessment. The Vulnerability Assessment tool was originally designed for use by The Road Home Chronic Homeless and Pathways programs and was chosen for the CHSH referral process in order to coordinate with those programs. The Vulnerability Assessment identifies clients' areas of greatest need (see Appendix A for a copy of the tool). Individuals are scored on a scale of 1-5 in a variety of areas, including: homelessness, victimization and vulnerability, substance abuse, basic needs, mental health, organization and orientation, communication, social behaviors, and medical health. Higher scores indicate areas of greater need. At referral, Engaged clients (26.1)

had slightly higher overall scores than Enrolled clients (24.5). Figure 1 displays the average scores broken out by individual domain. Although the two groups score the same on Homelessness and Substance Abuse, Engaged clients scored higher on Victimization and Vulnerability, Basic Need, Mental Health, and Social Behaviors. Enrolled clients scored higher on Organization and Orientation, Communication, and Medical Health. Higher scores on Social Behaviors for Engaged clients may reflect the difficulty that those particular vulnerabilities create when Case Managers are introducing clients to the program. Case notes indicate that many of the clients who were resistant to the program were distrustful of services, avoidant in terms of relationships, or had a pattern of alienating others; such clients may spend more time in the engagement phase as staff work to overcome those relational barriers. When looking only at Engaged clients who were discharged (n=21), these individuals had slightly lower overall scores (23.9) and lower average scores in the domains of Medical Health (2.0), Mental Health (2.4), and Victimization and Vulnerability (2.7), but had higher average scores in Substance Abuse (2.9) and Basic Needs (2.9), when compared to the Engaged group as a whole. These scores suggest that Discharged clients comprise a distinct population when compared to ongoing Engaged clients, with the former not meeting eligibility requirements in terms of mental and physical health and the latter meeting criteria but have individualized barriers to participation.

Figure 1 Vulnerability Assessment Domain Score



Discharged Clients. Twenty-five percent (25%) of CHSH referrals were considered ineligible for services, although this figure is somewhat inflated by revisions to eligibility criteria that occurred in the first few months of program operation**.** Ineligible clients were discharged from CHSH and referred back to CHP. Table 5, on the following page, details the reasons that clients were considered ineligible for the CHSH program. In some cases (n=16), CHSH had contact with clients prior to discharge; information on those contacts is included in the numbers regarding Engaged clients 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 Tenant Selection	
	#	% of Total Referrals
Disability	13	15
Income	1	1
Chronic Homelessness	2	2
Duplication of Services	1	1
Resistance[1]	3	5
Other	1	1
Total	21	25

[1]This includes both clients whom CHSH staff could not locate and clients who refused to participate in the program.

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 (65% Engaged, 74% Enrolled) and had an average age near 50. The majority (64%) of Enrolled clients were White, which was slightly higher than the Engaged group (56%). Close to two-thirds of Enrolled clients (60%) indicated that they had children; however, it is likely that a majority of these children were adults. In general, Engaged and Enrolled groups appear to be quite similar in terms of demographics.

Table 6 Demographics at Intake[1]

	Engaged[2]	Enrolled
Total Sample (N)	*34*	*42*
Demographics		
Male (%)	65	74
Age (Mn)	48	49
Min, Max	30, 67	31, 71
Hispanic or Latino (%)	3	5
Race (%)		
White	56	64
Black/African American	3	14
Asian	3	5
American Indian/ Alaska Native	21	17
Native Hawaiian/Pacific Islander	3	5
Unknown/Missing Data	--	--
Veteran/ Served in Military (%)	3	14
Percent with Children (%)	--	60
Number of children (Mn)	--	2.4

[1]For Engaged clients, Intake is defined as the date of the first CHSH contact. For Enrolled clients, Intake is defined as the date on which the GPRA form was administered.

[2]From this point forward, the number of clients in the Engaged category excludes five clients who were discharged to CHP prior to contact with staff (received no services) and four clients who were referred to the program but with whom CHSH staff had not yet had contact at the end of the reporting period.

Homelessness and Housing. Based on official shelter records, the majority of both Engaged (97%) and Enrolled (93%) clients have stayed at The Road Home's Emergency Shelter (see Table 7). Between December 1, 1998 and September 30, 2012, both groups spent an average of more than 400 nights in the shelter. As a whole, these 76 individuals accounted for a total of 35,070 nights in the shelter during this period.

Table 7 Homeless Shelter Use since December 1998

	Engaged	Enrolled	Combined
Total Sample (N)	*34*	*42*	*76*
Percent stayed in the Shelter at least one night (%)	97	93	95
Total # of nights[1]	13,993	21,077	35,070
Average # of nights per client (Mn)	424	540	487
Min, Max	3, 2849	3, 3140	3, 3140

[1] Total count for entire sample

At Intake, more than half of Enrolled clients (51%) had stayed at an emergency shelter the previous night and nearly one-quarter (20%) had stayed on the streets or somewhere not meant for human habitation (see Table 8). Very few Engaged clients reported staying at the shelter the previous night (6%), which may reflect the aforementioned trouble those clients experience in regards to building relationships and connecting with social services. Close to three-quarters of clients in both groups (70% Engaged, 76% Enrolled) had been continuously homeless for at least one year; however, a higher percent of Enrolled clients demonstrated a higher number of discrete episodes of homelessness over the past three years.

Table 8 Living Situation at Intake

	Engaged	Enrolled
Total Sample (N)	*12*[1]	*42*
Living Situation		
Where did you stay last night? (%)		
Emergency Shelter	6	51
Place not meant for habitation (streets, etc.)	27	20
Jail/Prison/Juvenile Detention Center	9	5
Family/Friend Residence	17	7
Other	42[2]	24[3]
Chronic Homelessness: (%)		
Continuously homeless for one year	70	76
Homeless four times in three years	12	24

[1]Information on where the client stayed the previous night was only available for 12 of the Engaged clients, which most likely indicates that fewer Engaged clients stayed in the shelter.
[2]This includes transitional housing for homeless persons (n=1), psychiatric hospital (n=3), and client's own residence (n=1).
[3]This includes hotel/motel not paid for with voucher (n=1), substance abuse/residential treatment facility (n=3), and transitional housing for homeless persons (n=3).

No Enrolled clients reported living primarily in an emergency shelter after being in the program for six months, compared to 60% at Intake (see Table 9). While almost one-quarter (17%) of Enrolled clients indicated that they were living in a house at Intake, none of those arrangements were the client's own home. In contrast, in the six-month follow-up GPRA interviews, more than half (68%) of Enrolled clients reported living primarily in a house for the preceding 30 days. While this number only reflects the experience of half of the Enrolled sample (22 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. In addition, another 15 Enrolled clients who had not been in the program long enough to complete follow-up GPRA interviews were also housed at the end of this reporting period.

Table 9 Living Situation at Intake and 6-month Follow-up (Enrolled Clients[1])

	Intake	6-Month Follow-up
Total Sample (N)	*42*	*22*
Living Situation		
Primary Living Situation during the past 30 days: (%)		
Shelter	60	0
Street/Outdoors	6	23
Institution	10	9
Housed	17	68
If housed, what type of housing: (%)		
Own/Rent apartment, room, or house	--	100
Someone else's apartment, room, or house	43	--
Halfway house	14	--
Residential treatment	14	--
Other	14	--

[1]Data pulled from GPRA forms. At the end of the reporting period, 22 clients had completed 6-month follow-up GPRAs. In total, 30 clients were housed by the end of the first year (see Table 9); however, not all of those clients have completed a 6-month follow-up GPRA.

Social Connectedness. Almost half (48%, not shown in table) of Enrolled clients attended a self-help group at least once in the 30 days prior to Intake, while 45% 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 (38%) had recently attended self-help groups, but a larger percentage (59%) had had supportive contact with family and/or friends. The percentage of clients who reported that they had no one to turn to dropped from 42% to 18% between Intake and 6-month 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
Total Sample (N)	*42*	*22*
During the past 30 days:		
Attended any voluntary self-help groups (e.g., AA, NA) (%)	33	18
# of times attended (Mn)	14	3
Min, Max	2, 40	2, 4
Attended any religious/faith affiliated recovery self-help groups (%)	17	9
# of times attended (Mn)	3	3
Min, Max	1, 6	1, 4
Attended any other meetings that support recovery (%)	24	19
# of times attended (Mn)	6	5
Min, Max	1, 15	1, 15
Had interaction(s) with family/friends that are supportive of recovery (%)	45	59

	Intake	6-Month Follow-Up
Total Sample (N)	*42*	*22*
Person they turn to when having trouble: (%)		
No one	42	18
Family Member	12	41
Friends	14	18
Professional	27	18
Clergy Member	2	5

Education and Employment. Almost half (44%) of Enrolled clients had a high school diploma (or the equivalent) and several had college degrees (Associates or higher, see Table 11). In comparison, only one-third of Engaged clients had a high school diploma (or the equivalent). A smaller percentage of Engaged clients (22%) than Enrolled clients (39%) reported having less than a high school diploma. None of the Enrolled clients were employed at Intake and only a few (14%) indicated that they were looking for work. The high percentage of clients reporting that they have a disability (43%), and therefore cannot work, may explain the small portion of clients who are seeking employment.

Table 11 Education and Employment at Intake

	Engaged[1]	Enrolled
Total Sample (N)	*24*	*42*
Education		
Enrolled in School or Job Training Program (%)		
Full-time	0	5
Part-time	0	5
Education Level (%)		
Less than High School	22	39
High School/Equivalent	34	44
Associates Degree	19	15
Bachelor's Degree or higher	0	2
Unknown/Missing	25	0
Employment[1]		
Employed (%)	0	0
Unemployed (%)	--	100
Looking for work		14
Disabled	--	43
Retired	--	7
Not looking for work	--	31
Other	--	5

[1]Information on unemployment was not available for Engaged clients.

Monthly Income. Enrolled clients reported an average monthly income of just over $500 at both Intake and Follow-up (see Table 12). A slightly larger percentage of Enrolled clients reported having an income at Follow-up (81% compared to 86%). 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 (64% and 45%, respectively) and the average monthly income was slightly higher ($15 increase).

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

	Intake		6-Month Follow-up	
Total Sample (N)	*42*		*22*	
	%	Amt[1](Mn)	%	Amt[1](Mn)
Monthly Income				
Wages	5	$44	5	$40
Public assistance	45	$237	64	$331
Retirement	5	$685	14	$803
Disability[2]	41	$703	18	$694
Non-legal income	--	--	--	--
Family and/or friends	2	$20	5	$20
Other	5	$40	18	$17
Any Income[1]	**81**	**$509**	**86**	**$524**

[1] Of those clients who reported an income, the average amount.

[2] One individual received $15000 in Disability back payments during the 30 days prior to completing the Intake GPRA. To avoid inflating the average, this figure was excluded from average amount calculations.

In contrast to Enrolled clients, only 50% of Engaged clients reported any income at Intake and the average amount was only $260 (see Table 13). Of the clients who did report any income, the majority of that income came from General Assistance (a state-funded program) and food stamps (SNAP).

Table 13 Income at Intake, Engaged Clients

	Engaged[1]	
Total Sample (N)	*24*	
	%	Amt (Mn)[2]
Monthly Income		
SSA Retirement	0	--
SSI/SSDI	4	$630
General Assistance	13	$268
SNAP	21	$181
Other	5	$40
Any Income	**50**	**$260**

[1] Income data was available for 24 of the 34 engaged clients.

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

Physical Health. More than two-thirds (71%) of Enrolled clients rated their overall health as fair or poor at Intake (see Table 14), compared to 46% at six-month follow-up. The high percent reporting poor health on the GPRA forms mirrors information reported in the CHSH Intake forms, where 37% of Enrolled clients indicated having a chronic health condition and 22% reported a physical disability (not shown in table). Only 20% of those clients reported that they were receiving treatment for their chronic health condition. In comparison, nine percent (9%) of Engaged clients reported having a chronic illness and six percent (6%) reported having a physical disability. Differences in the two groups regarding physical health most likely stem from the program's eligibility criteria, which focus on recruiting clients who will qualify for Medicaid under state guidelines.

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

	Intake	6-Month Follow-Up
Total Sample (N)	*42*	*22*
Overall health rating (%)[1]		
Excellent	12	27
Very Good	10	5
Good	7	23
Fair	38	32
Poor	33	14

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

Around one-quarter of Enrolled clients reported receiving treatment in an Emergency Room (ER) during the month prior to Intake (29%) and Follow-up (27%). On average clients reported being treated in the ER 1.3 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 times. One-fourth (26%) of clients received inpatient treatment during the month prior to Intake, compared to 18% of clients at Follow-up. This information is based on clients' self-report; however, future evaluation reports will include clients' use of emergency services collected from area hospitals.

Table 15 Medical Treatment at Intake and Follow-up

	Intake		6-month Follow-up	
Total Sample (N)	*42*		*22*	
	% (n)	Mn[1]	%	Mn[1]
Inpatient Treatment				
For any reason	26 (11)	9	18 (4)	3
Physical complaint	12 (5)	3	14 (3)	3
Mental or emotional difficulties	2 (1)	--	--	--
Alcohol or substance abuse	12 (5)	13	5 (1)	--
Outpatient Treatment				
For any reason	57 (24)	5	50 (11)	3
Physical complaint	26 (11)	3	27 (6)	4
Mental or emotional difficulties	24 (10)	3	18 (4)	2
Alcohol or substance abuse	7 (3)	19	5 (1)	--
Emergency Room (ER) Treatment				
For any reason	29 (12)	1	27 (6)	1
Physical complaint	17 (7)	1	18 (4)	1
Mental or emotional difficulties	5 (2)	1	--	--
Alcohol or substance abuse	9 (4)	2	9 (2)	2

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

Mental Health. At Intake, Enrolled clients were asked whether they had experienced a variety of psychological/emotional problems during the previous 30 days (see Table 16 on the following page). 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-eight percent (78%) of Enrolled clients indicated that they had mental health concerns at Intake; while 52% of Engaged clients indicated that they had mental health concerns (not shown in table). For both Engaged and Enrolled clients, the number receiving treatment for mental health problems was low at Intake: only 25% of Enrolled and 17% of Engaged clients reported receiving treatment. Case notes indicate that many clients had refused treatment, although the reasons for client refusal were not documented.

Table 16 Mental Health at Intake

	Intake		6-Month Follow-up	
Psychological/Emotional problems experienced in past 30 days:				
Total Sample (N)	*42*		*22*	
	% (n)	Mn[1]	% (n)	Mn[1]
Serious depression	71 (30)	16	59 (13)	14
Serious anxiety or tension	67 (28)	22	59 (13)	20
Hallucinations	17 (7)	17	5 (1)	8
Trouble understanding, concentrating, or remembering	59 (25)	23	55 (12)	21
Trouble controlling violent behavior	12 (5)	11	9 (2)	7
Attempted suicide	2 (1)	3	--	--
Been prescribed medication for psychological/emotional problem	43 (18)	30	27 (6)	30

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

Mental Health Treatment. Less than one-fifth of either Engaged or Enrolled clients had a history of mental health treatment[1] in the two years prior to CHSH Intake (see Table 17). These numbers appear to confirm clients' self-report figures, as detailed above. The disparity between clients' relatively high numbers of self-reported mental illness, and the low numbers regarding receipt of treatment, suggest that clients' lack of insight into their symptoms is not a primary barrier to services.

Table 17 Mental Health Treatment

	Engaged	Enrolled
Total Sample (N)	*23*	*42*
MH Treatment (Tx) – 2 years *prior* to Intake		
Percent with any MH Tx Admissions (% (n))	17 (4)	10 (4)
Average number of Admissions (Mn (SD))	4 (4)	2 (1)
Total number of Tx Admissions	14	7
Treatment Type (n)		
Assessment	3	3
Therapy	1	1
Medication Management	1	2
Inpatient	9	0
Residential	0	1

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

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 (Enrolled: 49% with a history of alcohol abuse and 32% with a history of drug abuse; Engaged: 21% with a history of alcohol abuse and 27% with a history of drug abuse; not in table). On the CHSH Intake forms, three Enrolled clients reported that they were receiving treatment for both substance abuse and mental illness; no other Enrolled or Engaged clients reported receiving substance abuse treatment at Intake.

In terms of recent alcohol drug use, half of Enrolled clients (50%) reported alcohol use in the month prior to Intake, while 64% reported use in the past month during their 6-month follow-up interview (see Table 18). 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 18 Alcohol and Drug Use at Intake and 6-month Follow-up for Enrolled Clients

	Intake	6-month Follow-up
Total Sample (N)	*42*	*22*
During the past 30 days, have you used:		
Any alcohol (%)	50	64
Number of times (Mn)	10	11
Alcohol to intoxication (5+ drinks in one sitting) (%)	68	45
Number of times (Mn)	10	14
Alcohol to intoxication (4 or fewer drinks in one sitting, felt high) (%)	14	--
Number of times (Mn)	3	--
Both alcohol and drugs (on the same day) (%)	23	5[1]
Number of times (Mn)	6	--
Any Illegal drugs (%)	21	14
Number of times (Mn)	15	11
Injected drugs during the past 30 days (%)	0	0

[1]One 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 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 19 indicates that a similar number of clients reported extreme or considerable stress due to alcohol or drug use at both Intake and six-month follow-up, but a larger percentage of clients reported no stress at all due to substance use while enrolled in CHSH.

Table 19 Emotional Impact of Alcohol and Drug Use at Intake for Enrolled Clients[1]

	Not at All	Somewhat	Considerably	Extremely
During the past 30 days: (%)				
How stressful have things been for you because of your use of alcohol or other drugs?				
At Intake	42	23	8	27
At Follow-Up	60	13	--	27
Has your use of alcohol or drugs caused you to reduce or give up important activities?				
At Intake	70	13	4	13
At Follow-up	60	13	13	13

	Not at All	Somewhat	Considerably	Extremely
Has your use of alcohol or other drugs caused you to have emotional problems?				
At Intake	56	24	12	8
At Follow-up	64	14	7	14

[1] Only for those clients reporting alcohol and/or drug use during the previous 30 days (n=26 at Intake, n=15 at Follow-up)

Substance Abuse Treatment. More than half of clients, in both the Engaged and Enrolled groups, have a history of substance abuse treatment[2] in the previous two years (see Table 20), with the Enrolled group averaging more treatment admissions. For both groups, the most common type of treatment was Detox, with very few clients receiving residential treatment services.

Table 20 Substance Abuse Treatment

	Engaged	Enrolled
Total Sample (N)	*23*	*42*
Substance Abuse (SA) Treatment (Tx) – 2 years *prior* to Intake		
Percent with any SA Tx Admissions (%)	57	57
Of those with any:		
Average number of Tx Admissions (Mn (SD))	7 (4)	12 (14)
Total number of Tx Admissions	86	290
Treatment Type (n):		
Assessment	6	10
Detox	74	252
Residential Rehab – Short term	1	4
Residential Rehab – Long term	0	8
Ambulance - Outpatient	5	16

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 21). According to this data, 19% of Enrolled clients were arrested during the month prior to Intake and 14% reported being arrested at follow-up. Over one-third (31%) of clients admitted to committing a crime during the month prior to Intake (compared to 14% at six-month follow-up), and many committed multiple crimes (Intake, Mn=17; 6-month follow-up, Mn = 11).

Table 21 Self-Reported Criminal Justice Involvement: Enrolled Clients

	Intake	6-month Follow-up
Total Sample (N)	42	22
During the past 30 days:		
Arrested for any reason (%)	19	14
# times arrested (Mn)	4	1
Spent at least one night in jail or prison (%)	19	14
# nights spent in jail or prison (Mn)	11	5

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

	Intake	6-month Follow-up
Total Sample (N)	42	22
Arrested for drug related offense(s) (%)	19	--
# times arrested for drug-related offenses (Mn)	1	--
Committed a crime (%)	31	14
# times committed a crime (Mn)	17	11
Currently awaiting charges, trial, or sentencing (%)	21	9
Currently on parole or probation (%)	10	5

In addition to self-reported data, court (Utah District and Justice Courts) and jail (Salt Lake County Adult Detention Center (ADC)) records were examined for the two years prior to Intake for both Engaged and Enrolled clients. Slightly more than half (53%) of Engaged clients and nearly three-quarters (73%) of Enrolled clients were booked on a new charge at least once during the previous two years (see Table 22). Nearly all Enrolled clients (92%) had been booked into the jail for a warrant during the prior two years, compared to 56% of Engaged clients. When combined (n=74), the two groups accounted for 197 jail bookings and 3,596 nights spent in jail during this two year period. Engaged clients committed more severe offenses than Enrolled clients and one-third (33%) had a drug offense (compared to 8% of Enrolled clients). The most common charge types among Enrolled clients were for public order and property offenses.

Table 22 Criminal Involvement – Jail Bookings

	Engaged	Enrolled
Total Sample (N)	*32*	*42*
Jail Bookings – *2 years prior* to Intake[1]		
Percent with prior booking(s) for *any reason* (%)	66	62
Percent with prior booking(s) for *new charge(s)* (%)	53	73
Percent with prior booking(s) for *warrant(s)* (%)	56	92
Percent with prior booking(s) for *commitment(s)* (%)	34	54
Of those with booking(s):		
Total number of bookings[2]	69	128
Average number of bookings (Mn (SD))	3 (2)	5 (5)
Total nights spent in jail[2]	1903	1693
Average total nights spent in jail (Mn (SD))	91 (113)	65 (86)
Of those with new charge(s):		
Most Severe Offense:		
Severity of Charges (Mn)	MA	MB
Percent Misdemeanor (%)	53	79
Percent Felony (%)	47	21
Charge Type (% (n)):		
Person	14 (3)	23 (6)
Property	29 (6)	42 (11)
Drug	33 (7)	8 (2)
Public Order	38 (8)	54 (14)

[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

A majority of Engaged (88%) and Enrolled (81%) clients had court cases filed in the State of Utah during the previous two years (see Table 23). On average, both Engaged and Enrolled clients had 17 cases filed in Justice or District court during this time period. 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 945 cases filed during the previous two years. Half of Engaged clients and just over half (57%) 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. 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 (9%, see Table 21 on page 21).

Table 23 Criminal Involvement – Court Cases

	Engaged	Enrolled
Total Sample (N)	*32*	*42*
Court Cases		
Percent with court case(s) filed (%) - *2 years prior* to Intake[1]	88	81
Of those with case(s) filed:		
Total number of cases [2]	409	536
Min, Max	1, 60	1, 66
Average number of cases (Mn (SD))	13 (17)	13 (17)
Jurisdiction (%)		
Justice Court	94	95
District Court	6	5
Case Level (%)		
Felony	3	1
Misdemeanor	67	72
Financial[3]	2	1
Infraction	23	22
Other[4]	6	4
Percent with court case(s) filed *since Intake*[1](%)	50	57
Total number of cases	150	92
Min, Max	1, 40	1, 19
Average number of cases (Mn (SD))	5 (10)	2 (4)
Jurisdiction (%)		
Justice Court	97	99
District Court	3	1
Case Level (%)		
Felony	2	1
Misdemeanor	61	69
Financial[3]	1	0
Infraction	35	28
Other[4]	1	2

[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 24 details the qualitative codes used to analyze more than 2,300 case notes created during the first year of the CHSH program.

Table 24 Program Activity Codes

Program Activity	Description
Engagement	
Assertive outreach, introducing clients to the program, building relationships, assessing clients' eligibility, administering GPRA forms, Intake forms or other activities related to enrollment	
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	
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	
Basic Needs	
Activities required to meet basic needs, such as the provision of food or clothing	
Medical	
Program activities related to medical needs, including transportation to appointments, picking up prescriptions, and arranging for treatment	
Substance Abuse	
Activities related to substance abuse needs, including assessment, therapy, and referral to Detox	
Mental Health	
Activities related to mental health needs, including assessment, therapy, prescriptions for medications, crisis support, and referrals	
Outreach Attempt	
Unsuccessful efforts to locate clients	
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	

Program Activity	Description
Case Management	
General program activities including phone contacts, residence visits, and appointment scheduling and reminders.	
Other	
Activities that do not fit into the above categories, including general administrative activities, documenting client no shows, and discharge activities.	

Program Activities. Table 25 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. For instance, 39% of case notes documented Advocacy activities and 26% dealt with helping clients meet their basic needs. These figures highlight the large amount of staff time spent in Advocacy, which includes coordinating activities related to benefits enrollment. Furthermore, a significant portion of staff time is spent trying to locate clients (see Other 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 25 Program Activity

Total Case Notes = 2338	
Program Activity	% of Case Notes
Engagement	10
Advocacy[1]	39
Basic Needs	26
Medical	15
Substance Abuse	6
Mental Health	12
Criminal Justice	5
Housing	7
Other[2]	20

[1]Advocacy includes assistance with obtaining benefits (23.5%)
[2]Other includes outreach attempts and general administrative activities, including scheduling appointments, documenting client no shows, and discharge activities.

Client Contacts and Services

On average, Enrolled clients were in the engagement period for 25 days; however, this varied greatly, ranging from 0 to 155 days. Engaged clients have been in the engagement period for substantially longer (Mn=107 days, ranging from 6 to 241 days, see Table 26). 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 16 days and Enrolled clients every ten days. During enrollment, clients met with a member of the team every four days, on average. 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 more than 45 minutes (not in table). At the time of this report, staff had recorded over 1,000 hours of contact with Enrolled clients and an additional 137 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. For instance, during the first year of the project, CHSH staff spent the equivalent of 164 hours working just with Engaged clients.

Table 26 Client Contact with CHSH Program Staff

	Engaged	Enrolled
	Mn (SD)	Mn (SD)
Number of days		
in Engagement period	107 (68)	25 (30)
in Enrollment period	--	168 (73)
Number of Services		
during Engagement period	16 (18)	7 (8)
during Enrollment period	--	59 (50)
Average Minutes of Contact per Client		
during Engagement period	340 (460)	274 (211)
during Enrollment period	--	1,634 (1100)
Days between Services		
during Engagement period	16 (16)	10 (13)
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 27 on the following page). Many more Enrolled clients also receive services related to interagency advocacy and accessing mainstream benefits. As one would expect, many more Enrolled clients receive services related to Housing. Of interest, however, is the comparatively small number of contacts per client related to Housing: Enrolled clients receive two and three times as many services related to Advocacy and Basic Needs. These numbers confirm findings throughout this report, pointing to the wide range of services required to get this population into housing and maintain that housing.

Staff members averaged five contacts per client (for 17 Enrolled clients) on issues related to criminal justice involvement, such as attending hearings, contacting probation officers, and arranging for opportunities to complete community service hours. For all client groups, a significant portion of staff time was spent on outreach attempts, which meant that staff went looking for, but was unable to locate the client. The case notes document the impact of client absences at scheduled appointments on housing applications, benefits enrollment, and medical and mental health services. Interestingly, Enrolled clients represent both the most and the least amount of contacts related to outreach; staff spend very little time "looking" for Enrolled clients during engagement but a lot of time looking for those clients during enrollment. In part, these numbers reflect more frequently scheduled appointments for Enrolled clients, who are working on housing and benefits applications. These numbers also suggest the ongoing impact of clients' medical, mental health, and substance abuse diagnoses, even with the stabilization provided through housing and intensive case management. For many Enrolled clients progress is cyclical rather than linear.

When working with clients who were ultimately discharged from engagement, staff time was distributed equally between engagement, advocacy, and activities related to meeting basic needs (20% each). When working with Engaged clients (both currently Engaged and the engagement portion of Enrolled clients' experience), staff spent the bulk of their time in activities related to

engagement efforts and one-third of their time on advocacy. Once clients were enrolled, staff spent the bulk of their time on Advocacy, Benefits, Basic Needs, and Medical. These distributions indicate that CHSH clients have ongoing needs related to health care, basic survival, and social services, which is in keeping with the ACT model.

Table 27 Program Activity by Client

	Engaged		Enrolled	
	Discharged	Ongoing	Engagement	Enrolled
Total Sample (N)	*14*	*21*	*33*	*42*
Program Activity by Client:				
Engagement (%)	79	95	100	43
Number of Services (Mn)	3	5	3	2
Advocacy	57	71	52	98
Number of Services (Mn)	3	4	4	19
Benefits	71	48	70	95
Number of Services (Mn)	2	3	3	11
Basic Needs	64	48	61	86
Number of Services (Mn)	3	4	3	14
Medical	36	48	42	81
Number of Services (Mn)	4	4	2	8
Substance Abuse	36	10	15	57
Number of Services (Mn)	2	2	2	5
Mental Health	43	38	42	81
Number of Services (Mn)	4	4	3	6
Criminal Justice	14	19	9	41
Number of Services (Mn)	2	2	3	6
Housing	7	24	12	79
Number of Services (Mn)	--	2	3	4
Outreach Attempt	36	48	9	55
Number of Services (Mn)	3	3	2	3
Case Management	0	0	0	95
Number of Services (Mn)	--	--	--	6
Other	71	33	27	62
Number of Services (Mn)	2	--	2	3

Barriers. Sixty percent (60%) of Enrolled clients experienced barriers related to substance abuse, mental health, or physical ability (see Table 28). This corroborates findings from the staff survey, wherein staff reported clients' mental health—and subsequent inability to keep appointments, establish relationships, and keep track of documentation—as a primary barrier to program participation and success. Interestingly, half of Enrolled clients could not be located at some point after engagement, which is almost as high as the rate for Engaged clients. Closer examination of case notes, however, pointed to differences between the two groups. Enrolled clients, who were often eager for services in the beginning and therefore sought out CHSH team members, often rotated through cycles with respect to their mental health and substance abuse. As those symptoms increased, some clients went "missing" for a short period of time; however, client's relationship to staff continued. While these cycles may impact housing and benefits applications, clients were generally "found" in a short period of time and clients were therefore able to continue to progress

toward program goals. The instability in clients' lives, even when receiving case management, however, points to the importance of the ongoing role that staff play in keeping clients connected with services.

In contrast, Engaged clients were often "missing" for longer periods of time and in ways that interrupted their relationship with staff and other social service agencies. Like Enrolled clients, Engaged clients encountered problems related to physical and mental health; however, they appeared to be less open to using or allowing the CHSH team to help manage those problems. Discharged clients, in contrast, were often open to services but did not meet eligibility requirements, often because their primary disability was related to substance abuse rather than mental illness or a medical issue. Both staff and partner surveys indicate some frustration over the CHSH program's inability to work with clients who are seriously impaired and for whom no other program exists.

Table 28 Barriers to Service Delivery by Client

	Engaged		Enrolled	
	Discharged	Ongoing	Engagement	Enrollment
Total Sample (N)	14	16	31	38
Barrier: (%)				
Resistance[1]	21	44	10	45
Ability[2]	36	50	19	61
Criminal History[3]	7	6	7	18
Administrative[4]	43	13	16	53
Unable to Locate[5]	29	56	19	50
Other[6]	21	6	13	37

[1] Resistance ranged from blatant opposition to services/benefits, to not showing up at scheduled appointments
[2] Ability included barriers related to mental health, substance abuse, or medical issues
[3] Criminal History included barriers resulting from time in jail, to difficulties obtaining housing because of criminal background checks
[4] Administrative barriers included needing follow up to obtain birth certificates, disability certification, procurement of identification, etc.
[5] Trying/unable to locate or unsuccessful outreach attempt
[6] Other included a range of unique barriers, including out of cell phone minutes, conflict with an acquaintance resulting in isolating behavior, difficulties transitioning from homelessness to housing

Benefits Enrollment

A primary goal of the CHSH program is to enroll clients in mainstream benefits. Table 29 presents a view of clients' mainstream benefits status at Intake and at the end of the first grant year (September 2012). 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.

Table 29 Mainstream Benefits for Enrolled Clients[1]

Mainstream Benefit Type (n)	Intake[2]	Open	Applications[3]	Denied
Medicaid	4	26	2	4
SSI/SSDI	16	19	4	5
Food Stamps	23	30	--	--

Mainstream Benefit Type (n)	Intake[2]	Open	Applications[3]	Denied
General Assistance	5	11	1	2
Veteran's Benefits	2	2	0	0
Medicare	6	6	0	0

[1] This number reflects the benefits enrollments of Enrolled clients as recorded on Intake forms (n=40).
[2]This number reflects the number of clients enrolled in the benefit prior to program enrollment.
[3]This number includes applications that have been submitted but no decision has been made yet

While CHSH staff do not work on mainstream benefits with Engaged clients to the same degree that they work with Enrolled clients, they do average three contacts per client (for half of the Engaged clients) working on access to resources. Table 30 provides a view of Engaged clients' mainstream benefits status as of September 30, 2012.

Table 30 Mainstream Benefits for Engaged Clients[1]

Mainstream Benefit Type (n)	Intake[2]	Open	Applications[3]	Denied
Medicaid	4	10	1	0
SSI/SSDI	3	5	0	1
Food Stamps	12	10	--	--
General Assistance	4	4	0	0
Medicare	1	--	--	--

[1] This number reflects the benefits enrollments for engaged clients as recorded on intake forms (n=32).
[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

Thirty out of 42 Enrolled clients (71%) were placed in housing during the first year of the grant (see Table 31 on the following page). CHSH team members collaborated with the Housing Coordinator to facilitate housing-related activities for clients, including touring available units, lease signing, security and rent deposits, moving, and setting up the household with furnishings and food. In response to the lack of available housing vouchers, The Road Home obtained additional federal funds, a portion of which were dedicated to CHSH clients. Those funds were anticipated to be available in July, 2012; however, staff encountered difficulties coordinating between clients' housing eligibility status, unit eligibility, funding restrictions, and client preferences (see Barriers). Despite these difficulties, the CHSH program met the grant requirements and housed 30 clients in the first year of the grant.

Data from Salt Lake County Housing Authority (HACSL) sheds light on the importance of intensive case management in terms of housing CHSH clients. Despite a lengthy history of homelessness, 18% of Engaged clients and ten percent (10%) of Enrolled clients had never applied for housing through HACSL. Twenty-four percent (24%) of Enrolled clients had filled out applications prior to CHSH contact but were subsequently removed from housing lists (for missing appointments, failing to complete review, or not updating contact information). Seven Enrolled clients and one Engaged client had previously been housed through HACLS; all were eventually terminated for noncompliance, criminal behavior, or vacating the unit.

Table 31 Housing Placements for Enrolled Clients

Project/Owner Housing Type	#
Valley Mental Health	
Facility	2
Scattered	1
Salt Lake County Housing Authority	
Facility	2
Scattered	4
Salt Lake City Housing Authority	
Facility	3
The Road Home	
Scattered	5
Facility	7
The Road Home/State of Utah	
Scattered	6
TOTAL Units	**30**

Discussion

Housing

At the time the CHSH program was envisioned, several community partners committed resources in the form of housing units. Some partners understood this promise to mean that the CHSH team would have units specifically set aside for program clients and that they would be available as soon as the client was enrolled. In practice, those units were difficult to access because of low turnover in units tied to public housing vouchers. This lack of available units and vouchers reduced the number of clients that the program was able to house during the first half of the year. Delays in housing were frustrating for both clients—who often expected to be housed immediately—and community partners—some of whom expected that a referral to CHSH would result in immediate housing. In particular, results from the Partners Survey indicate that some agency staff felt that without dedicated housing units, the CHSH team was duplicating case management services already available for the chronically homeless population.

CHSH staff took action to resolve both the housing shortage and the "public relations" problem that resulted from it. Staff applied for, and received, federal funding from the US Department of Housing and Urban Development (Continuity of Care or COC). Thirty-six vouchers were dedicated to CHSH clients. While the COC monies were available on July 1, 2012, CHSH staff encountered further barriers placing clients, due to restrictions on the use of those monies. COC funds cannot be used to pay for units for which the landlord receives tax credits, which eliminated the majority of housing units with which the program had existing relationships. Furthermore, COC monies must be used within the context of a Master Lease, and most landlords were resistant to entering a contractual relationship with The Road Home (the agency holding the grant) rather than the person occupying the unit. As a result, agency staff (from both CHSH and The Road Home) redirected their efforts into finding new units that met the requirements and on developing a process so that potential landlords would enter a Master Lease. One prominent feature of the Master Lease arrangement is the protection of the landlord's ability to screen potential residents and make the final decision

about who will occupy a unit. While this problem-solving was ultimately successful, it meant that CHSH staff could not actually use COC funds until September, 2012.

Because COC funds also require that a portion of recipients have at least 365 days of shelter use, CHSH staff had to specifically recruit clients who had stayed in the shelter. For some partners, this felt like additional restrictions on the program's eligibility criteria (because so many of the referrals were for clients who refused to stay in the shelter or access other social services, and were therefore perceived as even more vulnerable than those staying in shelters). In order to clarify program goals and services, staff provided ongoing updates at partner meetings regarding program services (which are focused on intensive case management, rather than dedicated housing units) and client eligibility. During the second half of the year, staff met with representatives from many different social service and supportive housing programs, to ensure that clients were placed in the most appropriate program and that services were not duplicated.

Collaboration

The weekly partner meetings were initially intended as a means for regularly sharing information and to facilitate the active recruitment of potential clients. At the beginning of the project, these meetings functioned as a forum for refining the referral processes, which was revised several times. The meetings also served as a way to recruit and find new referrals and review the breadth of referrals. As the CHSH program began providing intensive services to ongoing clients, weekly partners meetings became somewhat redundant, and attendance dropped sharply. As a result, the Project Director moved the meetings to a monthly format and also contacted partner agencies and reminded them of their obligation to the program. Meeting attendance has been high ever since, in part because the purpose of the meeting has been revised. Discussion in the partner meetings now focus primarily on policy, program, or staff changes at partner agencies; status of ongoing clients; and brainstorming long-term goals. With regard to agency changes, the meetings provide an important forum for networking and maintaining close relationships with partners. Because staff turnover has such a big impact on interagency collaboration, the meetings also provide an opportunity to introduce CHSH program goals, eligibility criteria, referral processes, and information sharing procedures to new staff at partner agencies.

The interagency release of information (ROI), completed at the end of the last reporting period, was fully operational during the current reporting period. For the majority of agencies, this signed ROI has been sufficient to allow sharing for both service delivery and the program evaluation. Medical information, however, is also subject to regulations of the Health Insurance Portability and Accountability Act (HIPAA). Project staff, the research team, and Fourth Street Clinic staff met during this reporting period to develop a system for gathering information on clients' use of medical services, and particularly emergency services use. This process requires a separate ROI, drafted in accordance with HIPAA regulations, that allows area hospitals to release information to Fourth Street Clinic, which will then share summary data with the research team. CHSH staff has begun gathering those ROIs during the GPRA interviews. While this process should provide data on emergency services use for most CHSH clients, Fourth Street Clinic can only request records for its own clients. Although a majority of CHSH clients are also Fourth Street Clinic clients, this data gathering technique will exclude records for those clients who are not clients of the Clinic or who do not sign this additional ROI.

While much of the focus of CHSH services is focused on getting clients enrolled in mainstream benefits, the SSI/SSDI application process is so time consuming and intricate that staff often do not have sufficient time to complete clients' applications. In order to address this problem, CHSH

developed a plan in conjunction with Fourth Street Clinic and Valley Mental Health, both of which employ SSI/SSDI Outreach, Access and Recovery (SOAR) officers who work for Department of Workforce Services. These officers 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 have started assisting SOAR workers with the application by gathering information, providing observational reports, and contacting the clients, as necessary. Representatives from the Department of Workforce Services, Fourth Street Clinic, and Valley Mental Health attend the projects' Steering Committee and Medicaid Subcommittee meetings, and continue to monitor the success of this arrangement and its impact on staff workload and clients' benefits status.

This collaboration with DWS and the SOAR workers also produces another benefit, in that it 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 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.

CHSH team members are employed by different social service agencies in order to facilitate seamless service delivery and collaboration between agencies. In the previous report, the dual role of some CHSH staff—working for several agencies—had complicated the data collection process, because staff activities were not always recorded in a format that was available to the research team. This problem has been addressed, as a result of trainings on each agency's data systems, and all services are being recorded under the CHSH rubric in a format that is accessible to the entire CHSH team. In anticipation of the project's second year, wherein some program services will be billed to Medicaid, project staff, the research team, and relevant partner agencies are meeting to discuss mechanisms for tracking CHSH staff time and activities.

Resources

As discussed above, the CHSH program sought additional funding in response to limitations in housing vouchers. Nonetheless, program staff experienced ongoing difficulties with accessing sufficient resources to engage clients and set them up in functioning households. While staff often relied on gift cards for both of these activities, the availability of these cards is not consistent. The project has worked in collaboration with partner agencies to access different sources of funding—such as Access to Recovery funds, which provide small amounts of money to clients in order to help them access substance abuse treatment—these funds often come with restrictions. Both staff and partner surveys referenced the difficulty of finding money to pay for things such as medical records requests (which are part of applying for Medicaid and SSI/SSDI) and incidentals related to daily living.

The need for access to some source of unrestricted funds was made more acute by programmatic changes at some partner agencies. Volunteers of America relocated and lost access to a large warehouse which had been kept stocked with food, clothing, and other essentials. Without access to those supplies, CHSH staff had far less flexibility providing basic necessities to clients. Additionally, the Department of Workforce Services established more restrictive lifetime limits for food stamps

and General Assistance, both of which were a primary source of funds for clients. While clients can extend time on both of these programs by participating in job search and employment activities, many of the CHSH clients are not able to work.

Client Barriers

Housing First and ACT models both target clients with significant barriers to stable housing and benefits enrollment, and those difficulties were evident, as expected, in the clients served by the CHSH program. Staff was often unable to locate clients and spent a significant amount of time searching for clients, both on the street and through agency and informal contacts. Clients were also resistant to services, because of mental illness and/or previous history with social service agencies. In these situations, staff spent significant time building rapport with clients, by building on existing relationships, providing clients with services they were willing to accept, and spending time with clients without requiring that the client set specific goals or formally engage in CHSH services. Those methods are in line with the ACT model, which is based on 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 enrollment in services.

The staff surveys provide confirmation of the ongoing and intensive needs that CHSH clients experience even after they are housed. 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. 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. Some clients did not stay in their units consistently, which also required advocacy by staff so that clients did not get evicted for vacating their unit.

Progress on Project Goals

One of the starkest indicators of the CHSH program's impact is the difference in clients' rates of enrollment in mainstream benefits while they are in the engagement phase compared to the enrollment phase of the program. At Intake, only ten percent (10%) of Enrolled clients were on Medicaid, compared to two-thirds (66%) with an open enrollment or an application filed at the end of the first year. In comparison, 13% of Engaged clients had an open Medicaid enrollment at Intake compared to 33% at the end of September (excluding clients who were discharged from the program due to ineligibility). The difference in enrollment rates between the two groups—both of whom are, presumably, eligible for Medicaid—highlights the necessity for ongoing, coordinated case management to maintain clients' access to services. By the end of the first grant year, more than half (55%) of Enrolled clients were receiving SSI/SSDI, 30% were receiving state-funded General Assistance and three-fourths (71%) were enrolled in the SNAP program. In comparison, less than 20% of Engaged clients were enrolled in SSI/SSDI and one-third were receiving food stamps at the end of the first year.

During the first year, the CHSH program has demonstrated a commitment to timely completion of project goals. Staff received extensive training on issues important to working in the ACT model, including Housing First, benefits enrollment, community resources, and mental health assessments.

The Project Director worked with staff and partners to create and modify recruitment procedures in order to ensure the program was reaching its intended population. The service delivery model has been revised significantly since the beginning of the project; services are provided from a team-based approach, and client progress and barriers are tracked and reviewed on a daily basis.

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

The CHSH Program's primary goals are to increase chronically homeless persons' access to housing and mainstream benefits, with a specific focus on those individuals who have a history of substance abuse, mental illness and resistance to engaging in social services. During the first year, program staff completed all key activities identified in the grant application. The Project Director hired and trained staff, created policies and protocols, set up an office, and implemented an interagency process for targeting and referring appropriate clients. Within the first year, the program enrolled 42 clients from 85 referrals. Program success was evident in the fact that 30 clients were housed during the first year of the program, despite the aforementioned barriers surrounding vouchers, available units, and client resistance.

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Appendix A - Vulnerability Assessment Index

Homelessness

Time in shelter and on the streets

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

Victimization & Vulnerability

Behavior, environment, & social relations

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

Substance Abuse

Use and its impact on functioning

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

Basic Needs

Food, shelter, hygiene, & critical health care

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

Mental health

Disorders, treatment, and symptomatic behavior

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

Organization/Orientation

Managing appointments and daily life

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

Communication

Language, expressing needs, and understanding

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

Social Behaviors

Sociability, interactions, and response to stress

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

Medical Health

Disease/conditions, health care, and risk for mortality

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

Appendix B – CHSH Procedures and Operations Manual

Chronically Homeless Services and Housing (CHSH) Project

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

PROCEDURES AND OPERATIONS MANUAL

CLIENT SELECTION

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

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

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

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

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

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

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

ENROLLMENT IN CHSH

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

CLIENT SERVICE PLAN IMPLEMENTATION

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

D. As needed, clients will be referred to CHSH Psychologist for relevant assessments and testing.
E. As needed, clients will be referred to CHSH medication provider for medication evaluation.
F. As needed, clients will be referred to community treatment providers such as Valley Mental Health and Volunteers of America, Utah.

CLIENT ASSESSMENTS

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

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

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

DISCHARGE POLICY

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

CLIENT FILES

Client files will include the following documentation:

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

- Recovery Services including assessments and diagnoses

STAFF MEETINGS

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

RESOURCES

Case managers utilize 211 online at informationandreferral.com. We also have information and referral resource lists on file. Case managers utilize the 211 Red Book as needed.
The Housing Placement Coordinator and CHSH Staff also rely upon several different resources for finding available rental units. The most critical resource is our established relationships with PSH property managers and Housing Authority representatives. Additional resources include gosection8.com, a compilation of landlord/units, and relationships with participating landlords and word of mouth.

ENROLLMENT IN MAINSTREAM BENEFITS

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

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

DATA ENTRY, DOCUMENTATION and SHARING OF DATA WITH EVALUATORS

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

Instructions on entering clients into ClientTrack:

The programs for each level of interaction are as follows:

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

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

Note: All clients who are enrolled in the Engagement program but are graduating to the Case Management program should first be exited from the Engagement program.
Intake Process: All clients being enrolled into the Case Management intensive program will need to go through the full intake flow and have a complete assessment done in ClientTrack. The standard workgroup you select at login (TRH: Case Managed Programs) will take you through this workflow and collect all necessary data elements.
Those clients being enrolled into only the Engagement program may only need a very minimal intake with the required fields collected at intake. To go through this simple intake process, you will need to change your workgroup selected at login to UHMIS: Emergency Assistance to access the basic intake flow. If you do an intake into the Engagement program through your normal login workgroup (TRH: Case Managed Programs), you will be required to go through the long intake process that asks more questions than you would likely have answers for at a basic interaction level.

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

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

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

Appendix C – Staff and Partner Survey Questions

CHSH PARTNERS SURVEY

In what capacity do you work with the CHSH project?
How familiar are you with the CHSH project?
How often do you have contact with CHSH project staff regarding CHSH clients, potential clients, or project activities?
How has your collaboration with the CHSH project improved the quality of care that clients receive?
Have there been any detrimental impacts on the quality of services that clients receive as a result of the CHSH collaboration?
How has your workload changed as a result of collaboration with the CHSH project?
From your perspective, what is the primary mission/goal of the CHSH project?
What were your initial expectations of this collaboration?
Have your expectations of the collaboration changed since the project was implemented? If so, how?
Have you or your agency made any formal or informal changes to policies or practices based on collaboration with the CHSH project?
Please provide examples of changes you/your agency has made as a result of collaboration with the CHSH project.
From your perspective, what are the primary accomplishments of the project to date?
From your perspective, what barriers have the CHSH project encountered to date?
When problems arise relative to this project, how are they typically resolved?
Please include any additional comments or suggestions you have regarding the CHSH project

CHSH STAFF SURVEY

From your perspective, how has the CHSH project improved the quality of care that clients receive?
From your perspective, has the CHSH project had any negative impacts on client services? Please describe
From your perspective, how has the CHSH program affected the work of partner agencies (VOA, Fourth Street Clinic, etc)?
From your perspective, what is the primary mission/goal of the CHSH project?
What were your initial expectations of this project?
Have your expectations of the project changed since implementation? If so, how?
From your perspective, what are the primary accomplishments of the project to date?
From your perspective, what barriers has the CHSH project encountered to date?
When problems arise relative to this project, how are they typically resolved?
Please include any additional comments or suggestions you have regarding the CHSH project