Evaluation of the Housing Support and Stability (HSSP) Project

Bi-annual Report
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THE UNIVERSITY OF UTAH

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COLLEGE OF SOCIAL WORK
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Chronically homeless persons are those individuals who have a disabling condition and have been continuously homeless for more than one year or have at least four episodes of homelessness in the last three years. In 2012, United States Department of Housing and Urban Development (HUD) estimated that 16% of the U. S. homeless population could be classified as chronically homeless (HUD, 2013). The 2013 Utah Homeless Point-In-Time Count identified 495 chronically homeless persons, comprising three percent of the total homeless population in the state (Wrathall, Day, Ferguson, Hernandez, Ainscough, Steadman, et al., 2013). When compared to the general homeless population, the chronic population is characterized by a higher prevalence of mental illness, substance abuse, complex medical programs and service resistance (Rickards, McGraw, Araki, Casey, High, Hombs, et al., 2010).

The Housing Support and Stability Project (HSSP) targets chronically homeless persons in Salt Lake County, Utah, and builds on lessons learned during the evaluation of The Road Home's Chronic Homeless Services and Support Project (CHSH), which was a 3-year project started in 2011 (Sarver, Prince, Worwood, & Butters, 2014). In that project, clients received long-term, supported housing, including behavioral health treatment. In order to pay for treatment services, however, clients had to be enrolled in Medicaid. Over the course of the project, more than half of individuals referred to the program were ineligible for Medicaid because their primary diagnosis was a substance use disorder. This left a gap in services for those with an exclusive or primary substance use disorder. The HSSP project aims to close this gap by increasing the availability of treatment services, including those for individuals who may have been screened out of enrollment in the previous project, who have been denied Medicaid, or whose mental health symptoms are a barrier to completing an application to Medicaid.

Chronically homeless clients with untreated substance use disorders are often resistant to services, including housing, and are, therefore, more vulnerable with respect to health and mental health than other clients (Sarver et al., 2014). Even when receiving case management services within the context of a housing placement, many chronically homeless persons do not receive adequate substance abuse treatment, which threatens their housing placement (Sarver et al., 2014). HSSP is designed to address this need by providing behavioral health treatment, regardless of the client's access to Medicaid or other health insurance, using Motivational Interviewing (MI), Trauma-Informed Care (TIC), and Harm Reduction (HR) interventions. HSSP provides services in settings most appropriate for each participant's level of engagement.

The interventions were chosen specifically because of their appropriateness for this group of service-resistant clients. Motivational interviewing and HR techniques are associated with better substance use outcomes for persons who are resistant to treatment (Gaetz, 2012; Miller, Meyers, & Tonigan, 1999). Trauma-informed interventions have demonstrated success with improving behavioral health outcomes for persons experiencing chronic homelessness (Morrissey & Ellis, 2005). In addition to behavioral health services, HSSP clients will receive housing and case management, through The Road

Home or other community agencies, in the form of a Housing First (HF) intervention. Housing First programs have demonstrated success in improving housing outcomes for chronically homeless persons with a history of housing failures (Stefancic & Tsemberis, 2007). In particular, HR strategies incorporated into HF programs show improved housing and health outcomes for service resistant homeless clients (Tsemberis, Gulcur, & Nakae, 2004).

The Road Home (TRH) has requested that the Utah Criminal Justice Center (UCJC) evaluate HSSP, including tracking program activities and characterizing client outcomes. With access to HSSP, clients would be expected to demonstrate increased housing stability, increased participation in mental health and substance abuse treatment, and increased quality of life. In order to evaluate the impact of HSSP, the final report will also include a comparison of outcomes between HSSP clients and participants in other programs serving chronically homeless persons.

Study Procedures

The HSSP evaluation will involve tracking client characteristics, interventions, and outcomes and will answer the following research questions in bi-annual reports:

1. Who does the program serve? (Profile of clients, including demographics, homelessness, criminal history, substance abuse (SA), mental health (MH), and treatment, etc.)
2. What services are HSSP clients receiving? (Profile of services utilized during HSSP participation, including housing, case management, behavioral health treatment, medical, and support services).
3. Is HSSP meeting its goals and objectives? (Measures include the number of clients: enrolled in benefits/health insurance, receiving behavioral health treatment, and housed)
4. What differences exist with respect to accessibility and service-use among vulnerable subpopulations? (Tracking differences in type and amount of services received according to race, ethnicity, gender, and sexual identity).

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 fourth question will be addressed in future reports.

Table 1, on the following page, lists the primary data sources and measures used in this report.

Table 1 Data Sources for Client Characteristics and Services Received

Data Source	Description
The Road Home/HSSP	
Intake assessments and history of shelter use for all clients enrolled in HSSP since October, 2014. Data is self-report and includes: demographics; benefits enrollment; current homeless status; and mental health, substance abuse, and medical concerns.	
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. During the timeframe described in this report, only 5 clients had completed follow-up GPRAs; as such, results are only reported for Intake interviews. Subsequent reports will report on follow-up GPRAs.	
Utah Behavioral Health Services, Salt Lake County/UWITS	
HSSP staff record services provided to clients in the Utah Web Infrastructure for Treatment Services (UWITS). Data include: length and frequency of contact, services and interventions, diagnoses, and assessments.	
Salt Lake County Sheriff's Office (OMS)	
Jail booking history at Salt Lake County Adult Detention Center for two years prior to first HSSP contact and while receiving services through HSSP. 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).	

In addition to the questions covered in the bi-annual reports, the final report will also answer the following questions:

1. Who has the best outcomes in HSSP? (Analysis of client characteristics by program outcomes: housing placements and retention, benefits/health insurance enrollment and retention, behavioral health treatment admission and completion).
2. What program components and services lead to the best outcomes? (Appropriate bi-variate analyses will be conducted to determine the relationship between interventions and outcome measures).
3. What barriers are most prevalent when clients do not reach desired outcomes? (Analysis of barrier variables by outcome).

While the emphasis of the evaluation will be on HSSP participants, the final report will also examine The Road Home's (TRH) current or formerly chronic homeless population as a whole (~600-800 individuals). HSSP participants comprise a subset of this population; however, they have been identified by TRH staff as needing behavioral health treatment in a more flexible setting. As such, it is important to examine this larger group to see if HSSP clients differ from the chronic homeless population and to examine differences in services provided by HSSP. In addition to examining data on this larger chronically homeless group, the research team will conduct focus groups with clients from both the HSSP project and this larger group. This focus group will solicit client perspectives on: the impact of programs, barriers to participating in programs, and ongoing or unmet service needs.

Results

The current report describes the first 11 months of HSSP (October 1, 2014, until September 1, 2015). During the period covered in this report the HSSP program enrolled 25 clients.

Client Characteristics

Demographics. Client demographics at Intake are shown in Table 2. Just over half of clients were male (52%) and ranged in age from 24 to 71 years old. The majority of clients were white (84%); one-quarter was Latino/Latina (24%). None of the clients were veterans, although 16% had at least one family member who had served in the military (not in table). While the majority of clients (76%) indicated that they had children, it is likely that a majority of these children were adults at the time of the interview.

Table 2 Demographics at Intake

Total Sample (N)	*25*
Male (%)	52
Age (Mn, range)	47 (24, 71)
Latino/Latina (%)	24
Race (%)	
White	84
Black/African American	8
Asian	0
American Indian/ Alaska Native	8
Native Hawaiian/Pacific Islander	0
Veteran/ Served in Military (%)	0
Percent with children (%)	76
Number of children (Mn)	3.1

Education and employment. Education and employment data was collected on GPRA forms at Intake. Almost half (44%) of clients had a high school diploma (or the equivalent) and more than one-quarter (28%) had attended some college (Table 3). Three clients (12%) were employed part-time at Intake; one-third reported being unemployed due to a disability (36%).

Table 3 Education and Employment at Intake

Total Sample (N)	*25*
Education	
Enrolled in School or Job Training Program (%)	
Full-time	0
Part-time	4
Education Level (%)	
Less than High School	28
High School/Equivalent	44
Some College	28

Total Sample (N)	*25*
Employment	
Employed[1] (%)	12
Unemployed (%)	--
Looking for work	20
Disabled	36
Retired	4
Not looking for work	28

[1] Three clients reported that they had part-time employment.

Homelessness and housing. Based on official shelter records, all but one HSSP client had stayed at The Road Home's Emergency Shelter for at least one night (Table 4). In total, clients averaged 351 nights in the shelter since 1998, although that figure ranged from one to more than 1,000 nights. When looking at shelter use in the past year (since September 1, 2014), 64% of clients (n=16) had stayed in the shelter for at least one night (not in table). Within the past year, those clients averaged 83 shelter nights (ranging from 1 to 328 nights).

Variation in clients' experience of homelessness is evident in the fact that nearly half reported being homeless four or more times during the past three years; those clients were homeless for an average of 20 months (ranging from 2 to 96 months) in the current episode. For eight clients, the current episode was their only episode of homelessness in the past three years; those individuals averaged 46 months (ranging from 12 to 96 months) homeless in the current episode.

Table 4 History of Homelessness and Shelter Use

Total Sample (N)	*25*
Homeless Shelter Use Since 1998	
Stayed in the shelter at least one night (%)	96
Total # of nights	8433
Min, Max	1, 1084
Average # of nights per client (Mn)	351
# Times Homeless in the Past 3 Years (%)	
4+ times	46
2-3 times	21
Current episode is the only one	33
Months continuously homeless (Mn)	27
Min, Max	2, 96

HSSP was intended to provide additional support services to persons who were simultaneously enrolled in housing and case management programs. Because clients were recruited from programs that house chronically homeless persons, the majority (80%) reported being housed on the Intake GPRA forms (Table 5). When looking at program enrollments in The Road Home database, clients were enrolled in HSSP, on average, within 43 days of being housed (ranging from 7 to 94 days).

Table 5 Living Situation at Intake[1]

	Intake
Total Sample (N)	*25*
Living Situation	
Primary living situation during the past 30 days: (%)	
Shelter	16
Street/Outdoors	4
Housed	80
If housed, what type of housing: (%)	
Own/Rent apartment, room, or house	95[2]
Someone else's apartment, room, or house	5[2]

[1] Data taken from GPRA forms.
[2] Percent based on sample of 20 clients who indicated that they were housed at Intake.

Income. At Intake, one-fourth of HSSP clients (24%) reported no income within the past 30 days (Table 6; data reported on GPRA forms). Of those with an income, the total monthly amount from all sources ranged from $20 to $820 (average amount among clients with any income was $444). Of clients reporting any income, more than half (57%) reported at least one source of regular income (in the form of wages, public assistance, retirement, or disability benefits). Clients with at least one source of stable income reported an average monthly income of $612. In contrast, a substantial portion of HSSP clients had no regular source of income. Nearly half of clients with some recent income (42%) reported no sources that would be characterized as stable (e.g., all reported sources were non-legal, family and friends, and other); those clients had an average monthly income of $201.

Table 6 Income at Intake

Total Sample (N)		*25*
	%	Amt (Min, Max[1])
Monthly Income:		
Disability	24	$687, $733
Family/Friends	20	$20, $800
Non-legal	4	$200
Public Assistance	8	$287, $441
Retirement	4	$754
Other	16	$27, $260
Wages	12	$80, $646
Any Income	**76**	**$20, $820**

[1] The lowest and highest monthly amount, of those who had income from this source.

Mental health and substance abuse. The majority of clients were diagnosed with mental health (80%) and substance use (100%) disorders (Table 7). Among clients with a mental health diagnosis, the most common diagnoses were mood and anxiety disorders; more than one-third (35%, not in table) had at least two mental health diagnoses. Thirty-nine percent of clients had multiple substance abuse diagnoses. Almost half of all clients (40%) were diagnosed with alcohol use disorder and three-quarters (76%) were

diagnosed with other substance use disorders. Three-quarters of HSSP clients (76%,) were diagnosed with co-occurring mental health and substance use disorders.

Table 7 Mental Health at Intake

Total Sample (N)	*25*
Mental Health Diagnosis (%)	80
Anxiety Disorder	32
Mood Disorder	64
Schizophrenia	16
Other	8
Any SUD Diagnosis (%)	100
Alcohol Use Disorder	40
Substance Use Disorder	82
Co-occurring MHD/SUD (%)	76

[1] Data reported in HSSP records (using ICD-9) and other medical records and include diagnoses identified before client was enrolled in HSSP.

Additional information on clients' substance use is gathered using the Drug Use Questionnaire (DAST-10); and the AUDIT-C. Initial identification of treatment needs, and ongoing evaluation, is assessed using the American Society of Addiction Medicine (ASAM criteria). At the time of the current report, 17 clients had completed the Audit-C, with slightly more than half (53%) identified as engaging in hazardous drinking or having active alcohol use disorders. Seventeen clients had also completed the DAST-10; of those, 82% were identified as having at least a moderate drug problem. Forty-one percent of clients who had completed the DAST-10 were identified as having a substantial or severe problem. All but two clients had completed the ASAM criteria, which provide an assessment of risk on each of the following six dimensions: withdrawal potential, biomedical complications, emotional or behavioral complications, readiness to change, relapse potential, and recovery environment. HSSP clients were most at-risk in the dimensions relating to readiness to change and relapse potential.

Trauma. The Life Events Checklist (LEC) was used to screen for clients' history of exposure to traumatic events (in particular those associated with subsequent development of psychological symptoms, including post-traumatic stress disorder). Of note, the LEC is a screening tool and not a diagnostic assessment. The LEC asks clients if they have been exposed to any of 17 different traumatic events (either personally, by witnessing, or hearing about the event). The 15 clients who completed the LEC reported that they had personally experienced an average of 9 (ranging from 4 to 13) traumatic events.

Clients were also screened for a history of trauma and ongoing psychological impacts on the GPRA forms. At Intake, 83% of clients indicated that they had a lifetime history of violence or trauma (Table 8). Of those, the majority reported ongoing symptoms from the trauma, with nearly all (85%) indicating that the felt like they were constantly on guard. With respect to recent victimization, 24% of clients reported being the victim of a violent attack in the 30 days prior to Intake.

Table 8 Impact of Violence and Trauma

Total Sample (N)	*25*
Experienced violence or trauma in any setting (%)	83
As a result of that experience have you[1] (%)	
Had nightmares/intrusive thoughts	60
Tried hard to avoid thinking about it	75
Felt constantly on guard or watchful	85
Felt numb/detached from surroundings	80

[1] Only for those who answered yes to experience violence or trauma, n=20

Recent alcohol and drug use. The majority of clients (76%) had used drugs or alcohol within 30 days of program enrollment, which was expected given the program's target population. Information collected on GPRA forms showed that 52% of clients reported using alcohol at least once in the month prior to Intake (Table 9). A larger percentage of clients reported recent drug use at Intake (68%), most commonly methamphetamine (48% of all clients) and marijuana (28% of all clients). Clients reported using alcohol and illegal drugs with similar frequency: for both substances, the average number of days of use in the past month was 13.

Table 9 Recent Alcohol and Drug Use at Intake

Total Sample (N)	*25*
During the past 30 days, have you used:	
Any alcohol (%)	52
Number of times (Mn)[1]	13
Alcohol to intoxication (5+ drinks in one sitting) (%)	16
Number of times (Mn)[1]	14
Alcohol to intoxication (4 or fewer drinks in one sitting, felt high) (%)	28
Number of times (Mn)[1]	5
Both alcohol and drugs (on the same day) (%)	32
Number of times (Mn)[1]	7
Any Illegal drugs (%)	68
Number of times (Mn)[1]	13
Injected drugs during the past 30 days (%)	12

[1] Of those reporting any use

At Intake, nearly half of clients (48%) reported extreme or considerable stress due to alcohol or drug use (29%; Table 10). One-third of clients (32%) reported that alcohol and drug use had caused considerable or extreme emotional problems in the past month.

Table 10 Emotional Impact of Alcohol and Drug Use at Intake[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	28	20	24	24
Has your use of alcohol or drugs caused you to reduce or give up important activities?				
At Intake	64	12	12	8
Has your use of alcohol or other drugs caused you to have emotional problems?				
At Intake	44	20	20	12

[1] Percentages calculated from the 24 clients who responded to these questions.

Social connectedness. Very few clients had recently attended any type of recovery support group in the 30 days prior to Intake (Table 11). Close to half (44%) noted that they had recently interacted with family and/or friends that were supportive of their recovery. Approximately three-fourths of clients relied on family, friends, or social services staff for assistance, although 28% of clients reported having no one to rely on for assistance during crises.

Table 11 Support Systems of Enrolled Clients at Intake and Follow-up

Total Sample (N)	*25*
During the past 30 days:	
Attended any voluntary self-help groups (e.g., AA, NA) (%)	8
Attended any religious/faith affiliated recovery self-help groups (%)	4
Attended any other meetings that support recovery (%)	0
Had interaction(s) with family/friends that are supportive of recovery (%)	44
Person they turn to when having trouble: (%)	
No one	28
Family Member	24
Friends	24
Social Services Staff	24

Use of medical services. The most common type of recent medical treatment accessed by HSSP clients was outpatient services (Table 12; 36% had received some treatment in the 30 days prior to Intake). Despite the fact that all clients had mental health and substance abuse diagnoses, relatively few were accessing any type of treatment related to those needs. In additional to behavioral health needs, more than half of HSSP clients (64%) were identified as having additional chronic health conditions, such as diabetes, epilepsy, and Hepatitis C; however, only one-quarter of clients had received recent treatment for physical health conditions. While barriers to accessing treatment were not available in the current data, the figures in Table 12 confirm that HSSP clients, on the whole, were not receiving medical services at Intake, despite identified needs.

Table 12 Recent Use of Medical Services at Intake[1]

Total Sample (N)	25
Inpatient Treatment (%)	
For any reason	4
Physical complaint	0
Mental or emotional difficulties	0
Alcohol or substance abuse	4
Outpatient Treatment	
For any reason	36
Physical complaint	24
Mental or emotional difficulties	16
Alcohol or substance abuse	4
Emergency Room (ER) Treatment	
For any reason	24
Physical complaint	12
Mental or emotional difficulties	0
Alcohol or substance abuse	4

[1] As reported on GPRA forms.

Criminal justice involvement. One measure of criminal justice involvement was provided through self-reported data collected from clients during the GPRA interviews. These numbers document clients' criminal justice involvement with reference to the 30 days prior toIntake interviews (Table 13). According to this data, 12% of clients reported being arrested during the month prior to Intake. Forty-four percent (44%) of clients admitted that they committed a crime during the month prior to Intake, and many reported committing multiple crimes (Mn=8 crimes committed in the past month).

Table 13 Self-Reported Criminal Justice Involvement at Intake

Total Sample (N)	25
During the past 30 days:	
Arrested for any reason (%)	12
# times arrested (Mn)	1
Spent at least one night in jail or prison (%)	4
# nights spent in jail or prison (Mn)	--
Arrested for drug-related offense(s) (%)	4
# times arrested for drug-related offenses (Mn)	--
Committed a crime (%)	44
# times committed a crime (Mn)	8
Currently awaiting charges, trial, or sentencing (%)	28
Currently on parole or probation (%)	4

Jail bookings. In addition to self-reported criminal involvement, jail (Salt Lake County Adult Detention Center (ADC)) records were examined for the two years prior to Intake for all clients. More than half (64%) were booked into the ADC at least once during the previous two years, most commonly for new charges or outstanding warrants (Table 14). When looking only at those clients with at least one booking (n=16), HSSP clients

accounted for 118 jail bookings and 1,509 nights in jail during this two-year period. The majority of new charges were misdemeanors (85% of all charges) and the most common charge types were public order offenses (40% of all charges).

These numbers suggest that a small majority of clients were repeatedly involved in the criminal justice system, most commonly for non-violent minor offenses. Even though these individuals appear to be of low risk to public safety, the high jail bookings associated with this small group suggests that incarceration may function, at least in part, as a *de facto* response to untreated symptoms of mental illness and substance abuse.

Table 14 Criminal Involvement—Jail Bookings 2 Years Prior

Total Sample (N)	*25*
Two Years Pre-HSSP Intake	
At least one jail booking for (%, n):	
Any reason[a]	64 (16) [b]
New charge(s)	52 (13)
Warrant(s)	60 (15)
Commitment(s)	40 (10)
Of those with Any[a] booking(s):	
Min, Max number of bookings *per client*	1, 21
Number of bookings *per client* (Mn (SD))	7 (7)
Number of bookings for *entire sample* (sum)	118
Nights spent in jail *per booking* (Mn (SD))	15 (21)
Nights spent in jail *per client* (Mn (SD))	94 (112)
Nights spent in jail for *entire sample* (sum)	1,509
Of those with New Charge (NC) booking(s):	
Min, Max number of NC bookings *per client*	1, 10
Number of NC bookings *per client* (Mn (SD))	3 (3)
Number of NC bookings for *entire sample* (sum)	41
Number of charges for entire sample (sum)	80
Charge Severity/Degree (n):	
1st Degree Felony	1
2nd Degree Felony	2
3rd Degree Felony	9
Class A Misdemeanor	9
Class B Misdemeanor	25
Class C Misdemeanor	34
Charge Type (n):	
Person	8
Property	14
Drug	14
Public Order	32
Open Container[c]	*2*
Public Intoxication[c]	*15*

Total Sample (N)	*25*
Two Years Pre-HSSP Intake	
Commercial Sex	1
Traffic	3
Obstruction	7
Other	1

[a] Does not include holds

[b] 16 of 25 clients had jail events during the two year time period relevant to this table; 22 of 25 had jail events since 2009 (data not shown)

[c] indicates charge is a subset of Public Order offenses; these offenses partially duplicate those under public order

Services Provided by HSSP

Client contacts. On average, staff had contact with clients every six days; however, almost one-third of case notes (30%) documented that staff was unable to locate the client and therefore unable to provide services (this figure included both scheduled appointments at which the client was not present and unscheduled attempts by staff to locate clients at home). When looking at the number of days between any attempt to meet with client (successful or not), staff was reaching out, on average, every five days. Between November 2014 (when the first client was enrolled) and September 1, 2015, staff spent 81 hours, collectively, in unsuccessful attempts to provide services to clients. Such numbers demonstrate the importance of assertive outreach when serving this service-resistant group: even when services are provided in flexible settings, staff must extend specific effort in order to develop and maintain clients' engagement in treatment. Client services were intensive in terms of frequency, as described above, and length: when looking only at contacts where staff was able to meet with clients, interactions lasted 51 minutes on average (Table 15).

Table 15 HSSP Contacts

Total Sample (N)	*25*
	Mn (Min, Max)
Days enrolled in HSSP as of 8/31/2015	168 (1, 280)
Average number of contacts per client:[1]	32 (1, 72)
Average minutes per contact:[2]	51 (15, 360)
Days between contacts:	
Actual contact	7 (3, 26)
Contact or attempt	5 (2, 26)

[1] Excludes times when staff attempted to make contact but could not locate client (called "no shows"). On average, 22 HSSP clients had 15 "no shows" each (ranging from 1 to 49 per client).

[2] Excludes time spent attempt to find client or provide services when client could not be located.

Type of service provided. All staff interaction with clients was documented in case notes, which provide a summary of client need, service provided, and future plans. In order to characterize the types of services clients received, the research staff coded case notes

according to program activities. Table 16 details the qualitative codes used to analyze the more than 1,100 case notes created since the inception of HSSP[1].

Table 16 Service Codes

Program Activity and Description
Assessment
Conducting assessments related to mental health, substance abuse, and medical diagnoses. The primary mental health assessments used by the program are: AUDIT-C, DAST-10, ASAM, LEC, and the ICD-9. Included in this category are assessments conducted or arranged by staff in support of client applications to Medicaid, SSI/SSDI, or other public benefit programs.
Basic Needs
Activities required to meet clients' basic needs, such as the provision of food or clothing.
Case Management
General program activities including: phone contacts, residence visits, weekly check-ins, appointment scheduling and reminders, making arrangements with other providers, and other activities related to helping clients achieve goals and maintain stability.
Criminal Justice
Activities related to clients' encounters with the criminal justice system, including: visiting clients in jail, facilitating community service hours, and advocating for clients in court or with probation supervision agencies (e.g., County Probation, Adult Probation and Parole (AP&P)).
Medical
Activities related to diagnosing, managing, and treating clients' mental health medical needs. This includes assessment, providing prescriptions, psycho-education, and helping clients fulfill prescriptions and organize medications. This also includes facilitating and assisting clients' ability to access treatment for other medical needs, such as: scheduling appointments, providing transportation, and sitting in on appointments to help clients interpret information.
Therapy
Therapeutic interventions provided by licensed mental health clinicians. To the degree possible, this excludes non-therapeutic activities provided by licensed mental health staff. Therapy contacts were further divided into the following categories: individual, group, and crisis.
Transportation
Transportation provided by HSSP staff to clients

HSSP was intended to provide enhanced clinical treatment that complemented case management services provided by housing case managers. To that end, at least one licensed mental health clinician was involved in 70% of contacts (including attempted contacts) and a nurse practitioner was involved in 14% of contacts (including attempts). Table 17 shows the types of services clients received from HSSP. In keeping with program goals, nearly all clients were receiving therapeutic interventions, most commonly in the form of individual therapy (96% of clients who received any therapy) and brief interventions to respond to crises (78% of clients who received any therapy). A smaller percentage of clients were participating in group therapy (26% of clients receiving any

[1] Other categories will be added, in upcoming reports, as necessary. Currently, some coded categories are not presented in Table x because they occurred with relative infrequency. This will likely change as more clients are enrolled in the program.

therapy). The majority of clients (76%) also received some medical treatment through HSSP, primarily related to assessment, diagnosis, and, when indicated, prescription of psychiatric medications. The nurse practitioner also provided ongoing psychoeducation and support to clients who were taking medication. In addition to increasing access to clinical interventions, HSSP relied on Certified Peer Support Specialists (PSS) to assist clients with setting and maintaining recovery goals. The majority of clients (88%) had regular contact with the peer support specialists.

While these figures are evidence of the clinical focus of the HSSP program, the actual services provided demonstrate the complex and ongoing needs of the target population. In addition to therapy and peer support, the majority of clients received regular case management contacts; these services were provided in addition to case management provided through their housing placement (see Table 18 for more detail).
The figures in Table 17 include both actual and attempted contacts. The fact that one-third of intended contacts resulted in missed or cancelled appointment are evidence of the fact that clients' ongoing mental health and substance use concerns can be a barrier to receiving HSSP services.

Table 17 Type of Service--HSSP

Topic Addressed	% of clients	# of services
	n	Mn (Min, Max)
Assessment	72	3 (1, 8)
Case management	96	12 (1, 31)
Criminal justice	36	5 (1, 24)
Basic needs	48	4 (1, 11)
Medical	68	6 (1, 16)
Peer Support	68	6 (1, 17)
Therapy	92	14 (2, 30)
Individual[1]	*96*	*10 (1, 20)*
Group	*26*	*3 (1, 4)*
Crisis	*78*	*5 (1, 11)*
Transportation	60	5 (1, 15)

[1] Among those who received any therapy

Other services. As noted earlier, all HSSP clients were concurrently enrolled in other programs for chronically homeless persons and were, therefore, receiving services from at least two programs. The vast majority of HSSP clients (92%; n=23) were receiving those services as part of a housing placement and 84% were receiving some of those supplemental services through The Road Home (recall that HSSP is a TRH program as well). Table 18 provides an overview of non-HSSP services provided to clients, through TRH, while they were enrolled in HSSP. Of note, the majority of clients were receiving assistance in the form of case management, transportation, and basic needs from both TRH and HSSP.

Table 18 Other Services Provided by TRH[1]

Topic Addressed	% of clients[2]	# of services
	n	Mn (Min, Max)
Assessment	10	5 (3, 6)
Case management	100	36 (2, 77)
Crisis	10	3 (1, 5)
Basic needs	57	8 (1, 27)
Transportation	60	8 (2, 33)

[1] Clients may also have received services from other social service providers, but data on the number and type of service was not available. These figures exclude emergency shelter nights, which was reported on p. 5.
[2] Of those receiving any services from TRH

Benefits Enrollment

Table 19 presents a snapshot view of clients' mainstream benefits status as of September 1, 2015. Fewer than half of clients (44%) were actively enrolled in medical insurance or SSI/SSDI benefits. As noted earlier, one of HSSP's goals is the provision of behavioral health services to individuals with chronic substance abuse disorders who do not qualify for Medicaid; as such the fact that less than half of clients were enrolled in a health insurance program was expected. Maintaining clients' enrollment in benefits programs was an ongoing process, as even clients who were eligible had difficulty completing applications, maintaining eligibility, and filing appeals if their application was denied. In some cases, clients who previously had benefits had their enrollment closed due to missing mandatory reviews. In the case of SSI/SSDI, Medicaid, and General Assistance (a short-term, state-funded program), clients' eligibility was intertwined: loss of enrollment in one can jeopardize enrollment in the others. While HSSP is not primarily tasked with completing benefits applications, staff does work closely with housing case managers to complete and submit applications and appeals and to ensure that clients were current with program reviews.

Table 19 Mainstream Benefits for Enrolled Clients

Mainstream Benefit Type (%)	Intake[1]	Active[2]	Applied	Denied[3]	Appealed
Medical[4]	44	44	16	25	0
SSI/SSDI	28	24	4	32	8
Food Stamps	44	72	4	4	0
General Assistance	0	8	0	40	8

[1] Enrolled in benefits at HSSP Intake
[2] Enrolled in benefits on September, 2015
[3] Client submitted an application and was found ineligible
[4] Client has medical insurance, whether Medicaid, Medicare, or other

Discussion

Progress on Project Goals

HSSP's primary goal was to increase clients' housing stability, in particular by providing clinical interventions to stabilize clients' substance abuse and mental health needs. The program also intended, through collaboration with chronic housing programs, to find suitable housing placements and increase access to resources through enrollment in mainstream benefit programs. Progress on each of these goals is described below.

Housing placement. As of September 1, 2015, 23 of 25 HSSP clients had been housed, which was close to the first year goal of 30 clients. The majority of those placements were in permanent supportive housing. Of clients who were housed, days in housing averaged 191, which was in keeping with project goals of achieving six months of housing stability for 28 clients during the first year. Two clients' housing placements were terminated due to issues related to non-compliance; however, both of those individuals were still receiving services from HSSP in the hopes of achieving stability in a future housing placement.

Behavioral health treatment. HSSP staff provided therapeutic interventions to 23 of 25 clients to date; the program goal for the first year was to provide behavioral health interventions to 30 clients. Of note, some clients had been enrolled in the program for less than one week at the time data for the current report was pulled; those clients have likely received such services by now. As intended, those services were both clinical and comprehensive: the majority of clients were receiving both therapeutic and medical interventions related to behavioral health needs. In addition, the vast majority of clients received peer support services to assist in developing and maintaining treatment goals; those services included transporting clients to recovery support groups.

Benefits enrollment. One goal of HSSP was to increase access to behavioral health services for clients who were not eligible for mainstream benefits programs such as Medicaid. As such, the majority of clients were not enrolled in health insurance at Intake, although case notes document staffs' work exploring other health insurance options, such as the state-funded Primary Care Network. Clearly, the behavioral health services described earlier would not be available to most HSSP clients through mainstream benefits programs. Staff was involved in monitoring clients' ongoing enrollment in benefits programs, completing and submitting new applications, and submitting appeals. As evidence of these efforts, the number of clients receiving food stamps nearly doubled after HSSP enrollment.

References

Gaetz, S. (2012). *Substance use and addiction: Harm reduction*. Washington, DC: Substance Abuse and Mental Health Services Administration (SAMHSA).

Alvaro, C., Henry, M., de la Cruz, R. J., & Brown, S. (2012). *Volume 1 of the 2012 annual homeless assessment report to Congress*. Washington, DC: Abt Associates and the U. S. Department of Housing and Urban Development.

Miller, W. R., Meyers, R. J., & Tonigan, J. S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting Clinical Psychology, 67,* 688-697.

Morrissey, J. P., & Ellis, A. R. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *Journal of Substance Abuse Treatment, 28*(2), 121-133.

Rickards, L. D., McGraw, S. A., Araki, L., Casey, R. J., High, C. W., Hombs, M., et al. (2010). Collaborative initiative to help end chronic homelessness: Introduction. *Journal of Behavioral Health Services & Research, 37*(2), 149-166.

Sarver, C. M., Prince, K. P., Worwood, E. B., & Butters, R. P. (2014). *Evaluation of the Chronic Homeless Services and Housing Project: Final report*. Salt Lake City, UT: Utah Criminal Justice Center, University of Utah.

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

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

Wrathall, J., Day, J., Ferguson, M., Hernandez, A., Ainscough, A., Steadman, K., et al. (2013). *Comprehensive report on homelessness*. Salt Lake City, UT: Utah Housing and Community Development Division, State Community Services Office.