Evaluation of the Housing Support and Stability (HSSP) Project

Final Report
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COLLEGE OF SOCIAL WORK
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Evaluation of the Housing Support and Stability (HSSP) Project

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EXECUTIVE SUMMARY

The Housing Support and Stability Project (HSSP) targeted chronically homeless persons in Salt Lake County, Utah, and built on lessons learned during the evaluation of The Road Home's Chronic Homeless Services and Support Project (CHSH) (for more information on this project, see 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 were required 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 diagnosis of a substance use disorder. The HSSP project sought to close this gap by increasing the availability of treatment services, including those for individuals who were screened out of enrollment in the previous project, who have been denied Medicaid, or whose mental health symptoms were a barrier to completing an application to Medicaid.

HSSP's primary goal was to increase clients' housing stability 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 housing placements that would facilitate attainment of treatment goals as well as increase access to resources through enrollment in mainstream benefit programs. Client characteristics and program outcomes are summarized below:

- Over a three-year period, HSSP enrolled 90 clients. The majority were male, White, with an average age of 47 years. More than half were already receiving services through The Road Home's Chronic Homeless Programs at the time of HSSP enrollment. As a group, HSSP clients accounted for more than 33,000 nights spent in emergency shelter prior to HSSP enrollment. The vast majority of clients had co-occurring mental health and substance use disorders and more than half were actively using substances at the time of enrollment.
- Per program intent, all clients were housed and received therapy while enrolled; however, case notes, interviews, and treatment data document some resistance on the part of clients in terms of treatment engagement. This may explain the fact that a substantial portion of clients continued to use substances and experience significant psychiatric symptoms even with treatment.
- HSSP clients' housing stability increased after program enrollment. Clients spent significantly fewer days in shelter, and substantially more time housed, after enrollment into HSSP. While the rate of negative exits from housing did not change, participation in the program appears to have prevented a return to homelessness as the result of eviction or other loss of housing.
- HSSP clients had significantly fewer criminal justice contacts, in terms of arrests and jail days, after program enrollment.
- While HSSP clients were relatively more acute, compared to other clients in The Road Home's Chronic Homeless Programs, they achieved comparable outcomes in

terms of increased housing stability and benefits enrollment and reduced criminal justice contact.

While HSSP clients undoubtedly did better in the program when compared to pre-enrollment, questions remain as to the specific types of services needed to achieve stable housing and reduced criminal justice involvement. Given clients' resistance to therapy, and a perceived drift in therapy from treatment goals toward crisis management, the same outcomes may be achievable by increasing the intensity of case management, rather than providing clinical treatment services. These results suggest the program worked because it resulted in better management, rather than elimination, of clients' behaviors and symptoms, which suggests a need for ongoing services. Given the costs associated with the long-term provision of therapy, it may be more feasible to consider alternative program structures. For example, the same outcomes may be achieved using enhanced case management (such as ICM) models rather than treatment-focused models. Of note, however, medication management, which 80% of HSSP clients received, was perceived by staff to be central to housing stability and may be a necessary component of programs targeting similar clients.

Background and Introduction

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.[1] 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 2016 Utah Homeless Point-In-Time Count identified 168 chronically homeless persons in the state, down from 495 in 2013 (Hartvigsen, Frost, Coulam, Agardy, Tolman, Gray, et al., 2016). 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) targeted chronically homeless persons in Salt Lake County, Utah, and built on lessons learned during the evaluation of The Road Home's Chronic Homeless Services and Support Project (CHSH) (for more information on this project, see 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 were required 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 diagnosis of a substance use disorder. The HSSP project sought to close this gap by increasing the availability of treatment services, including those for individuals who were screened out of enrollment in the previous project, who have been denied Medicaid, or whose mental health symptoms were 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 can threaten their housing placement (Sarver et al., 2014). HSSP was 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, Trauma-Informed Care, and Harm Reduction interventions. HSSP provided 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 harm reduction techniques are associated with better substance use outcomes for persons who are resistant to treatment

[1] The United States Department of Housing and Urban Development (HUD) current definition of chronic homelessness can be viewed here: https://www.gpo.gov/fdsys/pkg/FR-2015-12-04/pdf/2015-30473.pdf. Of note, the definition has been revised since the inception of this project.

(Gaetz, 2012; Miller, Meyers, & Tonigan, 1999). Trauma-informed care 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 receive housing and case management, through The Road Home or other community agencies, in the form of a Housing First 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, harm reduction models incorporated into Housing First 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. This final report also compares HSSP clients to participants in other TRH programs serving chronically homeless persons.

Study Procedures

This HSSP evaluation involved tracking client characteristics, interventions, and outcomes and answers the following research questions:

1. Who does the program serve?
2. What services are HSSP clients receiving?
3. Is HSSP meeting its goals and objectives?

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. This report characterizes data collected on Intake, 6-month and Discharge GPRA.	
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 includes: 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, and release date and type.	

While the emphasis of the evaluation was on HSSP participants, this final report also examined The Road Home's chronic homeless population as a whole (referred to throughout the rest of the report as HIFI). HSSP participants comprise a subset of this population; however, they were identified by TRH staff as having relatively more needs and less access to services. 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 conducted interviews with clients from both the HSSP project and this larger group. Interviews solicited client perspectives on the impact of services, barriers to receiving services, and ongoing or unmet needs. This final report will also answer the following questions:

1. What are client outcomes as the result of program participation? (HIFI and HSSP).
2. What program components and services lead to the best outcomes? (HIFI and HSSP).
3. What barriers are most prevalent when clients do not reach desired outcomes?

Results

The final report describes the entirety of the HSSP project, including its six-month extension (October 1, 2014 through March 31, 2018). During the period covered in this report, the HSSP program enrolled 90[2] clients.

HSSP Client Characteristics[3]

Demographics. Client demographics, collected at Intake, are presented in Table 2. One-half of HSSP clients were male (56%) and the average age at Intake was 46 years (ranging from 20 to 71 years). The majority of clients identified as White (73%); one-fifth identified as American Indian (18%). Only three percent of clients were veterans, although 26% had at least one family member who served in the military (not in table).

Table 2 Demographics at Intake[1]

Total Sample (N)	*90*
Male (%)	56
Age (Mn)	46
Latino/Latina (%)	18
Race (%)	
White	73
Black/African American	10
Asian	0
American Indian/ Alaska Native	18
Native Hawaiian/Pacific Islander	0
Veteran/Served in Military (%)	3
Have children (%)	73
Number of children (Mn)	3

[1]Data taken from GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.

Education and employment. Education and employment data were collected on GPRA forms at Intake, 6-month follow-up, and Discharge. At Intake, slightly more than one-third (35%) of clients had a high school diploma (or the equivalent); slightly fewer clients (29%) had some post-secondary schooling (Table 3). At Intake, the vast majority of clients (92%) were not employed, most commonly due to a disability (48%).

At the 6-month follow-up GPRA, one-third of clients had less than a high school diploma, one-third had a high school diploma, and one-third had attended some college. At the time of the 6-month follow-up, 20% of clients were employed at least part-time. Of those not employed (76%), the majority were disabled (56%). None of the clients who completed a Discharge GPRA were employed; the majority (70%) indicated they were unemployed due to a disability.

[2] Because data were queried from multiple sources, clients may have information recorded on some items but not others; as such, the sample size varies across tables.

Table 3 Education and Employment[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
Education			
Enrolled in School or Job Training Program (%)			
Full-time	1	0	4
Part-time	3	2	4
Education Level (% (n))			
Less than high school	36	33	22
High school/Equivalent	33	32	52
Some college/Degree	29	32	26
Employment			
Employed (% (n))	8	20	0
Unemployed (% (n))	92	76	100
Looking for work	*22*	*7*	*22*
Disabled	*48*	*56*	*70*
Retired	*1*	*2*	*0*
Not looking for work	*27*	*13*	*9*
Volunteer	*1*	*0*	*0*

[1]Data taken from GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.

Current living situation. HSSP clients were recruited from the community's chronic homeless programs (CHP); enrollment into HSSP occurred within 90 days of placement into permanent supported housing. Data collected on GPRA Intake forms show the majority of clients (79%) were living in a housing placement in the month prior to HSSP enrollment (see Table 5, next page). The remaining clients (21%) had lived in a non-permanent situation (i.e., emergency shelter, on the street, or in an institution) for most of the month prior to HSSP enrollment. Even with concurrent HSSP and housing case management services, clients occasionally lost a housing placement, in some cases due to eviction or institutionalization and sometimes voluntarily. This lack of stability was reflected in the fact that 12% of clients were not housed during the 30 days prior to the 6-month GPRA[3], similar to the percentage of clients that were not housed at Intake. At Discharge, the percentage of clients housed in an institutional setting increased to 13% (Table 5), which brought the total percent of clients in non-permanent living situations to 26%.

[3] Intake, 6-month, and Discharge GPRA results cannot be directly compared in order to characterize client change or program impact; due to the discrepancy in sample size, these figures provide a snapshot of three different groups of clients at three points in time.

Table 5 Living Situation[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
Living Situation			
Primary living situation during the past 30 days: (%)			
Shelter	16	2	4
Street/Outdoors	4	4	9
Institution	1	6	13
Housed	79	85	70
If housed, what type of housing: (N)	*71*	*46*	*16*
Own/Rent apartment, room, or house (%)	94[2]	98[2]	83
Someone else's apartment, room, or house (%)	1	0	0
Other[3] (%)	4	2	11

[1]Data taken from GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.
[2]Figures calculated from the 71 clients who reported being housed on the Intake GPRA, 46 housed at the 6-month GPRA, and 16 housed at the Discharge GPRA.
[3]Includes transitional housing and residential treatment facility

Income. At Intake, one-fourth of HSSP clients (28%) reported no income within the past 30 days (GPRA; Table 6, next page). Of those with any income, the average monthly amount was $485. Among clients reporting any income, the majority (72%) identified at least one source of stable 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 $616 (not in table). A minority of clients (28%) with some recent income reported no sources that would be characterized as stable (e.g., non-legal sources, family and friends, and other); those clients had an average monthly income of $143 (not in table). At Intake, men and women were similar in terms of having any income (72% of males and 73% of females); however, females averaged $536 per month compared to $444 per month as reported by males.

At the 6-month follow-up, two-thirds of clients (67%) reported some form of income in the previous month, with an average amount of $557. Three-fourths (75%) of those with any recent income reported at least one stable source; those clients' average monthly income was $700 (not in table). In contrast, clients whose only income came from unstable sources (25%) had an average monthly income of $128 (not in table). When comparing clients' income by gender, females reported a higher monthly average of $624 compared to $514 for males.

At Discharge, nearly two-thirds of clients (65%) reported some form of income in the previous month, with an average of $657. Of those who reported income within the month prior to Discharge, 93% reported at least one stable source. The average income for these individuals was $700 a month. The average amount of monthly income was fairly similar when comparing males ($649) and females ($666; not in table).

Table 6 Income[1]

	Intake	6-Month	Discharge
Total Sample (N)	*90*	*54*	*23*
Monthly Income			
Disability (%)	28	28	57
Mean[2] (Min, Max)	$764 (385, 1400)	$753 (385, 1230)	$725 (189, 1000)
Family/Friends (%)	8	11	4
Mean[2] (Min, Max)	$166 (20, 800)	$79 (20, 120)	$50 (50)
Non-legal (%)	13	13	4
Mean[2] (Min, Max)	$118 (3, 250)	$123 (20, 300)	$50 (50)
Public Assistance (%)	20	13	4
Mean[2] (Min, Max)	$268 (20, 735)	$216 (72, 287)	$287 (287)
Retirement (%)	2	2	0
Mean[2] (Min, Max)	$745 (735, 754)	$787 (787)	--
Other[3] (%)	8	4	4
Mean[2] (Min, Max)	$110 (1, 260)	$55 (40, 70)	$50 (50)
Wages (%)	9	13	0
Mean[2] (Min, Max)	$533 (80, 1400)	$827 (140, 2600)	--
Any Income (%)	**72**	**67**	**65**
Mean[2] (Min, Max)	**$485 (1, 1400)**	**$557 (40, 2600)**	**$657 (50, 1100)**

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.
[2]Average monthly income from this source. Figures based on respondents who reported at least some income from this source.
[3]Other income sources include plasma donation, child support, and "found the money."

Use of medical services. The most common type of medical treatment accessed by HSSP clients during the month prior to Intake was outpatient services (Table 7, next page; 31% had received some treatment in the 30 days prior to Intake). Despite the fact that all clients had mental health or substance abuse diagnoses, relatively few reported recently accessing any type of substance abuse or mental health treatment. Additionally, despite self-reported complex medical needs, detailed in Table 22 (p. 22), only 19% of clients had received recent outpatient treatment for physical health conditions at Intake (9% had been hospitalized and 19% had visited an emergency room for physical health needs). While barriers to accessing treatment were not available in the current data, the figures in Table 14 confirm that HSSP clients, on the whole, were not receiving many medical services at Intake, despite identified needs. At the 6-month follow-up, nearly half of clients had received recent outpatient medical services (43%), most commonly for mental or emotional difficulties (33%) or alcohol or substance abuse (26%). Lower percentages of clients were accessing all forms of medical services at the time of Discharge.

When asked to rate their own health status at Intake, 31% of clients rated it as "poor" and 32% rated it as "fair" (not in table). Those figures were largely unchanged at the 6-month follow-up, wherein 28% rated their health status as "poor" and 30% rated it as "fair." At Discharge, 26% rated their health as "poor" and 44% rated it as "fair." Thus, over half of the clients in each group rated their overall health as sub-par.

Table 7 Recent Use of Medical Services[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
Inpatient Treatment (%)			
For any reason	20	11	9
Physical complaint	9	2	9
Mental or emotional difficulties	4	0	0
Alcohol or substance abuse	8	11	0
Outpatient Treatment (%)			
For any reason	31	43	17
Physical complaint	19	19	9
Mental or emotional difficulties	14	33	9
Alcohol or substance abuse	4	26	4
Emergency Room (ER) Treatment (%)			
For any reason	22	15	9
Physical complaint	19	13	9
Mental or emotional difficulties	2	0	0
Alcohol or substance abuse	3	2	0

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.

Mental health and substance use.

Presenting problem. At Intake, HSSP clients were asked to define their primary presenting concern (recorded in program data; not in table). Recovery from substance abuse and mental health comprised the top two concerns. Other responses included concerns related to housing and physical health. Many clients identified recovery from substance use as their primary need (46%), citing a desire for "sobriety" or to "get clean." Often, housing was mentioned as a motivating factor or aid in the pursuit of recovery. One-third of clients identified mental health concerns such as anxiety, depression, and general emotional well-being as their primary concern.

Mental health symptomology. At Intake, 92% of HSSP clients reported experiencing some level of mental health symptomology during the previous month (GPRA). The most common symptoms were anxiety, depression, and cognitive difficulty with 80%, 76%, and 67% of clients endorsing those symptoms respectively (Table 8). Clients reported experiencing these symptoms for the majority of days within the previous month, with an average response of 21 days for those with anxiety, 16 days for depression, and 20 days for cognitive difficulty. Additionally, HSSP clients were asked to rate the severity of their symptoms based on emotional impact (not in table). Of those who endorsed experiencing mental health symptoms, 58% categorized the impact of symptoms as "extreme" or "considerable" at Intake.

Responses were similar at the 6-month follow-up. Anxiety, depression, and cognitive difficulty remained the most prevalent concerns with 80%, 80%, and 59% of clients endorsing them respectively. At the 6-month follow-up, 60% of clients who endorsed mental health symptoms rated the emotional impact of these symptoms as "considerable" or "extreme" (not in table).

At the Discharge, 48% of clients of those who endorsed having mental health symptoms rated the emotional impact as "considerable" or "extreme" (not in table). The most common mental health symptoms at Discharge remained anxiety (74%), depression (65%), and cognitive difficulty (65%).

Table 8 Mental Health Symptomology[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
During the past 30 days, have you experienced:			
Attempted Suicide (%)	0	6	9
Number of days (Mn)[2]	--	*1*	*16*
Anxiety (%)	80	80	74
Number of days (Mn)[2]	*21*	*18*	*22*
Been Prescribed Psychiatric Medication (%)	32	37	13
Number of days (Mn)[2]	*26*	*28*	*8*
Cognitive Difficulty (%)	67	59	65
Number of days (Mn)[2]	*20*	*20*	*23*
Depression (%)	76	80	65
Number of days (Mn)[2]	*16*	*16*	*23*
Inability to Control Violent Behavior (%)	24	19	39
Number of days (Mn)[2]	*8*	*6*	*9*
Hallucinations (%)	24	22	17
Number of days (Mn)[2]	*17*	*17*	*15*

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.
[2]Of those endorsing experience of the symptom.

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 if clients have been exposed to any of 17 traumatic events (either personally, by witnessing, or hearing about the event). Of the 77 clients who had completed the LEC[4], 96% reported that they had personally experienced at least one traumatic event (of those, the average number of events was 7.7, ranging from 1 to 14; not in table). When comparing LEC results by gender, 100% of women had personally experienced at least one traumatic event (Mn=8.3) and 92% of men (Mn=7.2) had experienced at least one traumatic event.

[4] LEC scores were available for 77 of 90 clients (86%).

Clients were also screened for a history of trauma and ongoing psychological impact on GPRA forms. At Intake, 86% of clients indicated that they had a lifetime history of violence or trauma (Table 9). Of those, the vast majority reported experiencing ongoing symptoms from the trauma. At 6-months and Discharge, clients with a history of trauma continued to report ongoing psychological impacts from those events. With respect to recent victimization, 23% of clients reported an experience of physical violence in the 30 days prior to Intake (not in table). At the 6-month follow-up, 31% of clients reported at least one recent episode of physical violence. At Discharge, 26% reported at least one recent episode of physical violence.

Table 9 Impact of Violence and Trauma[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
Experienced violence or trauma in any setting (%)	86	78	70
As a result of that experience have you[2] (%)			
Had nightmares/intrusive thoughts	73	90	75
Tried hard to avoid thinking about it	82	81	81
Felt constantly on guard or watchful	88	83	81
Felt numb/detached from surroundings	70	83	75

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.
[2]Only for those who answered yes to experience of violence or trauma.

ICD-10 diagnoses. Two-thirds of clients (69%) had a mental health assessment recorded in HSSP program data; of those, more than half (65%) were identified with a specific mental health diagnosis, most commonly a mood disorder (50%). In addition, all (100%) clients with an assessment had at least one substance-related diagnosis (Table 10). Of those, 79% were identified as having a drug-related diagnosis and 32% had an alcohol-related diagnosis. The majority of consumers with a substance-related diagnosis (65%) had a co-occurring mental health diagnosis.

Table 10 ICD-10 Diagnoses

Total Sample (N)	*62*[1]
Mental Health Diagnosis (%)[1,2]	65
Anxiety Disorder[3]	35
Mood Disorder	50
Other	33
Any SUD Diagnosis (% (n))[1,2]	100
Alcohol Use Disorder[4]	32
Drug Use Disorder[4]	79
Co-occurring MH	65

[1]62 clients had mental health/substance abuse assessments recorded in program data.
[2]Based on International Classification of Diseases (ICD-10) criteria, as recorded in HSSP program treatment data.
[3]Of those with a mental health diagnosis; clients could have multiple diagnoses
[4]Of those with a substance use diagnosis; clients could have multiple diagnoses

In addition to the ICD-10, HSSP clients were screened using the Drug Abuse Screening Test (DAST-10) and the Alcohol Use Disorders Identification Test (AUDIT-C). The AUDIT-C is a 3-item screening tool that identifies persons who are currently consuming alcohol at hazardous levels. Total scores range from 0-12, with higher scores indicating that the individual's alcohol consumption constitutes a relatively greater risk to his or her safety. For women, a score of three or more is considered positive; for men, a score of four or more is considered positive. At the time of the current report, 88 clients[5] had completed the Audit-C at Intake, with more than half (58%) identified as engaging in hazardous drinking or having active alcohol use disorders. Mean scores, as well as the percent of clients identified as having an alcohol-related substance abuse problem, are presented in Table 11.

The Drug Abuse Screening Tool (DAST-10) is a 10-item tool that screens clients for drug use in the past 12 months. Scores range from 0-10, with higher scores indicating greater treatment needs related to drug abuse. A score that falls between three and five indicates a need for intensive outpatient treatment; a score of 6-10 indicates a need for intensive treatment (ASAM level II, III, or IV). At the time of the current report, 87 clients[6] had completed the DAST-10 at Intake, with 75% identified as having a drug problem, ranging from intermediate to severe. Mean scores, as well as the percent of clients identified as having a drug-related substance abuse problem, are presented in Table 11. At Intake, mean scores on the AUDIT-C were higher for males relative to females; mean scores on the DAST-10 were higher for females relative to males. After six months in HSSP, fewer clients were identified as having active substance use problems; additionally, mean scores were lower for both males and females on both screening tools. Of note, just under half of clients were identified as having active alcohol problems at follow-up. For drug abuse, just over half were identified as having an active disorder.

Table 11 Substance Abuse Screening Tools

	Female		*Male*	
	Mn Score	*% Identified[1]*	*Mn Score*	*% Identified[1]*
Screening Tool				
AUDIT-C[2]				
Intake	3.5	56	4.9	61
Follow-up	3.1	42	4.4	43
DAST-10[3]				
Intake	5.4	85	4.3	67
Follow-up	3.6	53	3.4	52

[1]Percent of clients who were identified as having an alcohol or drug problem according to the screening tool. For AUDIT-C that is a score of 3 or more for women and 4 or more for men. For DAST-10 that is a score of 3 or more for both men and women.
[2]39 females had an AUDIT-C assessment at Intake; 31 had a follow-up assessment. 49 males had an AUDIT-C assessment at Intake; 42 had a follow-up.
[3]39 females had a DAST-10 assessment at Intake; 34 had a follow-up assessment. 48 males had a DAST-10 assessment at Intake; 44 had a follow-up.

[5] AUDIT-C scores were available for 88 of 90 clients (98%) at Intake.
[6] DAST-10 scores were available for 87 of 90 clients (97%) at Intake.

Initial substance abuse treatment needs were further assessed using the American Society of Addiction Medicine (ASAM) criteria. As of the current report, 63% of clients had been assessed using ASAM, which provide a multidimensional overview of risk with respect to an individual's substance use and treatment planning. Table 12 shows that HSSP clients were most at-risk (scored medium or high on the ASAM) in the domains of behavioral health (dimension 3) and relapse potential (dimension 5). Within the third ASAM dimension, Emotional, Behavioral, or Cognitive Conditions and Complications, only 26% of clients were characterized as having mental health conditions that were well managed. Clinician comments suggested that many clients had a history of trauma, endorsed symptoms of depression and anxiety, or presented with delusions or hallucinations indicative of psychosis. These concerns frequently translated into low insight into their mental illness or low compliance with mental health treatment.

Within the fifth ASAM dimension, Relapse, Continued Use, or Continued Problem Potential, no clients reported a current period of sobriety lasting greater than two years. Clinician comments indicated that many clients had multiple prior treatment episodes, with subsequent relapses, and were therefore concerned about managing threats to client sobriety. Threats to recovery included negative peer influences, inadequate coping skills, and a lack of financial resources. Familial issues, stress, lifestyle changes, loneliness, pain, and the loss of familiar routines (due to being housed and/or being sober) were identified as potential triggers to relapse. Comments also indicated that for multiple clients, sobriety was only attained in highly structured settings such as jail or residential treatment facilities. Within the sixth ASAM dimension, Recovery/Living Environment, comments indicated that nearly two-thirds of clients were assessed as being at-risk (63%). This was most commonly related to a lack of social support for recovery (see Table 15) or a housing placement that was not perceived as supportive of sobriety (due to neighbors' use or proximity to areas where drugs were sold). Clinical comments in this dimension often cited clients' struggles with peer pressure, including enjoying the social aspects of substance use and having difficulty maintaining boundaries with peers. Many clients also identified family members and romantic partners as non-supportive of recovery. Comments indicated a struggle between maintaining meaningful relationships while also maintaining sobriety. Some clients cited rules against substance use by their housing placement, but many felt those rules were difficult to enforce.

Table 12 ASAM Levels at Intake

Total Sample (N)	*57*[1]		
Risk Level	*% Low*	*% Med*	*% High*
ASAM Dimension			
Acute Intoxication and/or withdrawal potential	63	26	11
Biomedical conditions and complications	54	37	9
Emotional, behavioral or cognitive conditions and complications	26	56	18
Readiness to change	47	28	25
Relapse potential	18	46	37
Recovery environment	37	44	19

[1]57 clients had an ASAM assessment in program records.

Recent alcohol and drug use. At Intake, the majority of HSSP clients (74%) reported using drugs or alcohol within 30 days prior to program enrollment. Almost half (48%) of clients reported using alcohol at least once in the month prior to Intake (Table 13). A larger percentage of clients reported recent drug use at Intake (60%), most commonly methamphetamine (33% of all clients; 55% of clients with any drug use; not in table) and marijuana (20% of all clients; 34% of clients with any drug use; not in table).

At 6-months, 67% of clients indicated they had recent used substances (drug or alcohol), averaging 17 days of use. The most commonly used drugs were, again, marijuana (19% of all clients; 42% of clients with any drug use; not in table) and methamphetamine (22% of all clients; 50% of clients with any drug use; not in table).

At Discharge, 70% of clients endorsed recent substance use (drug or alcohol) and averaged 16 days of use. The most commonly used drugs were methamphetamine (30% of all clients; 70% of clients with any drug use; not in table) and marijuana (22% of all clients; 50% of clients with any drug use; not in table).

Table 13 Recent Alcohol and Drug Use[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
During the past 30 days, have you used:			
Any alcohol (%)	48	56	39
Number of times (Mn)[2]	*13*	*13*	*10*
Alcohol to intoxication (5+ drinks in one sitting) (%)	33	37	26
Number of times (Mn)[2]	*14*	*16*	*11*
Alcohol to intoxication (4 or fewer drinks in one sitting) (%)	6	17	13
Number of times (Mn)[2]	*5*	*5*	*2*
Both alcohol and drugs (on the same day) (%)	23	28	13
Number of times (Mn)[2]	*8*	*12*	*16*
Any Illegal drugs (%)	60	44	43
Number of times (Mn)[2]	*15*	*12*	*18*
Injected drugs during the past 30 days (%)	15	13	22

[1] As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.
[2] Of those reporting any use of drugs or alcohol

Of those who endorsed using substances within the month prior to Intake, the simple majority were men (70% male and 30% female; not in table). At the 6-month follow-up, two-thirds of those who had used were male (67% male and 23% female; not in table). At Discharge, 56% of those endorsing use were male and 44% were female.

Out of all females at Intake, two-thirds endorsed using either drugs or alcohol at least once in the previous 30 days (66% of all females). This was higher for males at Intake, with 77% of all males endorsing use within the past 30 days. At the 6-month follow-up, 50% of all females and 80% of all males endorsed use. At Discharge, 70% of all females and 69% of all males endorsed using drugs or alcohol at least once within the prior 30 days.

Of clients who had endorsed substance use at Intake, 24% of men and 28% of women had recently used illegal drugs and alcohol on the same day. Those rates were higher at the 6-month follow-up interview (33% of males and 58% of females) and were lower at Discharge (22% of males and 14% of females).

Impact of substance use. At Intake, almost half of clients (39%) reported they had experienced extreme or considerable stress due to alcohol or drugs (Table 14). One-third (30%) reported that recent alcohol or drugs had caused considerable or extreme emotional problems. When looking only at clients who endorsed recent substance use (in past 30 days) at Intake, 50% felt considerable or extreme stress, 22% had given up important activities, and 40% reported emotional problems (not in table). When looking only at clients who endorsed recent substance use (in past 30 days) at the 6-month follow-up, 47% felt considerable or extreme stress, 29% had given up important activities, and 39% reported emotional problems (not in table). Of those who had used substances in the past 30 days prior to completing the Discharge GPRA, 44% felt extreme or considerable stress, 44% reported a change in important activities, and 35% endorsed emotional impact due to substance use (not in table).

Table 14 Emotional Impact of Alcohol and Drug Use[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?				
Intake	15	24	17	22
6-month	15	28	22	15
Discharge	22	17	4	26
Has your use of alcohol or drugs caused you to reduce or give up important activities?				
Intake	37	22	7	10
6- month	24	32	18	4
Discharge	30	9	13	17
Has your use of alcohol or other drugs caused you to have emotional problems?				
Intake	29	17	16	14
6-month	18	28	19	11
Discharge	30	17	9	17

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.

Client self-reported substance use. As part of Intake, HSSP clients were asked to provide a self-report of substances used and their own perception of the severity and frequency of use (recorded in program data). Of the 63 clients for whom there were data, 35% endorsed methamphetamines as their primary substance of choice and 27% endorsed alcohol. The majority of clients (54%) rated the severity of their primary substance of choice as severe and 16% rated the severity as mild. Clients reported a wide range of frequency of use of their primary substance of choice with 25% endorsing no use in the past 30 days, 32% endorsing at least weekly use, and 29% endorsing daily use.

Many clients did not report a secondary substance of choice (49%). Of those who did, alcohol and methamphetamines continued to be most heavily favored. Those with a secondary substance of choice rated the severity most frequently as moderate (37%) and most often used the substance one to two times per week (44%). While 65% of clients did not identify a tertiary substance of choice, marijuana and alcohol were favored most heavily by those who did. Tertiary substance severity was most commonly rated as mild with 32% of responses. Tertiary substances of choice were also used less frequently with people most commonly using it only one to three times per month (18%).

Recovery support. Very few clients had attended any type of recovery support group in the 30 days prior to Intake (Table 15). Approximately half (59%) noted that they had recently interacted with family and/or friends that were supportive of their recovery; this figure was higher for clients who had been in the program for six months (67%) and lower for those at Discharge (57%). More than one-third (42%) of clients relied on family or friends for assistance during a crisis according to Intake responses, although one-third of clients reported having no one to rely on at Intake (31%); that figure was lower (24%) at the 6-month GPRA interview but showed little change at Discharge (30%).

Table 15 Support Systems of HSSP Clients[1]

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
During the past 30 days have you (%)			
Attended any voluntary self-help groups (e.g., AA, NA)	12	19	22
Attended any religious/faith affiliated recovery self-help groups	7	9	9
Attended any other meetings that support recovery	10	9	4
Interacted w family/friends supportive of recovery	59	67	57
To whom do you turn when having trouble (%)			
No one	31	24	30
Family Member	22	32	26
Friends	20	26	17
Social Services Staff	18	11	9
Other	7	0	13

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.

Criminal justice involvement. One measure of criminal justice involvement was provided through data collected from clients during the GPRA interviews. These numbers document clients' self-reported criminal justice involvement with reference to the 30 days prior to their Intake interviews (see Table 16). According to these data, 10% of clients reported at least one arrest in the month prior to Intake. More than half (60%) of clients admitted to committing a crime, including self-reported illegal drug use, during the month prior to Intake; some reported committing multiple crimes (Mn=16). At the 6-month follow-up, a similar percentage (7%) of clients reported being arrested in the previous month while 44% had committed a crime, including self-reported illegal drug use. At Discharge, 13% of clients reported being arrested and 43% reported committing a crime.

Table 16 Self-Reported Criminal Justice Involvement

	Intake	*6-month*	*Discharge*
Total Sample (N)	*90*	*54*	*23*
During the past 30 days have you:			
Been arrested for any reason (%)	11	7	13
# times arrested (Mn)	*2*	*2*	*1*
Spent at least one night in jail or prison (%)	7	7	9
# nights spent in jail or prison (Mn)	*3*	*20*	*9*
Been arrested for drug-related offense(s) (%)	6	2	0
# times arrested for drug-related offenses (Mn)	*1*	*3*	--
Committed a crime (% (n))	60	44	43
# times committed a crime (Mn)	*16*	*12*	*18*
Are you currently (%)			
Awaiting charges, trial, or sentencing	24	22	22
On parole or probation	11	15	13

[1]As reported on GPRA forms. Percentage may not add up to 100% due to missing data, including clients' refusal to answer some questions.

Services Provided by HSSP

Client contacts. HSSP case notes showed that clients (n=82[7]) averaged 21 contacts with staff while enrolled in the program; however, that figure ranged from one to 95 contacts per client (excludes attempted contacts). 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 both attempted and completed contacts, clients averaged 67 contacts during the program (ranging from one to 262). Such numbers demonstrated the importance of assertive outreach when working with this service-resistant group: even though treatment was provided in the client's residence, staff extended specific effort in order to develop and maintain clients' engagement in treatment. When looking only at contacts where staff actually met with clients, interactions lasted 94 minutes on average (duration of service was available for 71% of completed contacts).

Types of services provided. In order to characterize the types of services clients received, the research staff coded case notes according to program activities. Table 17, next page, details the qualitative codes used to analyze the more than 5,400 case notes created since the inception of HSSP.

[7] HSSP enrolled 90 clients; at the time of the data pull, however, 82 clients had at least one service/attempt recorded in case notes.

Table 17 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.
Peer Support
Services provided by Peer Support Specialists, which includes activities related to: setting and maintaining treatment goals; running household errands; developing social connections and participating in leisure activities; providing peer support; and running peer support groups.
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 and crisis.
Transportation
Transportation provided by HSSP staff to clients

HSSP was designed 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 77% of contacts (75% of attempted contacts) and medical staff was involved in 6% of contacts (5% of attempts). Table 18 shows the types of services clients received from HSSP. In keeping with program goals, the majority of clients (90%) received individual therapy and all clients (100%) received some form of therapy (crisis, individual, or group; not in table). 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. One-half of clients (51%) had contact with PSS. HSSP staff worked conjointly with housing case managers in 12% of client contacts (housing case managers were involved in 5% of attempted contacts; not in table).

While the figures presented in Table 18 document 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 services related to basic needs, case management, medical care, and transportation; these services were in addition to case management provided through their housing placement (see Table 25 for more detail).

Table 18 Type of Service--HSSP

Total Sample (N)	*82*	
	% of clients	# of services[1]
		Mn (Min, Max)
Service Type		
Assessment	82	3 (1, 9)
Basic needs	69	6 (1,20)
Case management	91	16 (1, 57)
Criminal justice	40	8 (1, 85)
Medical	79	11 (1, 34)
Peer support	51	18 (1, 77)
Group support	24	4 (1, 11)
Therapy-Individual	90	24 (1, 101)
Therapy-Crisis	44	6 (1, 29)
Transportation	58	7 (1, 39)

[1]Figures do not include attempted contacts

Benefits enrollment. Table 19, next page, presents a snapshot view of changes in clients' benefits status during program enrollment. More than half of clients (65%) were actively enrolled in a medical insurance program (including Medicaid, Medicare, and the state-run Primary Care Network), which represents an increase from Intake (46% enrolled). As noted earlier, one goal of HSSP was the provision of behavioral health services to individuals with chronic substance abuse disorders who do not qualify for Medicaid; as such, the fact that one-third of clients were not enrolled in a health insurance program was expected.

Case notes document that clients' enrollment in benefits programs was an ongoing process; even clients who were eligible had difficulty completing applications, maintaining eligibility, and filing appeals if their application was denied. In some cases, clients with benefits had their enrollment closed due to missing a mandatory review. 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 jeopardized enrollment in the others. While HSSP was not primarily tasked with completing benefits applications, staff worked closely with housing case managers to complete and submit applications, file appeals, and ensure clients were current with program reviews.

Table 19 Mainstream Benefits for Enrolled Clients

Total Sample (N)			89	
	Intake[1]	*Active*[2]	*Applied*[3]	*Denied*[4]
Mainstream Benefit Type %				
Medical[5]	46	65	5	9
SSI/SSDI	36	43	7	8
Food Stamps	82	76	1	2
General Assistance	14	13	0	1
Other[6]	10	7	0	0

[1]Enrolled in benefits within 30 days of HSSP Intake (before or after enrollment), as recorded in TRH records; percentage is calculated from the 72 clients who had a financial assessment recorded during this time.
[2]Enrolled in benefits as of March 12, 2018, as recorded in HSSP records; includes one client who was enrolled at time of death.
[3]Client has applied for benefit recently; includes open applications, an appeal subsequent to a denial, or a recent denial (90 days).
[4]Client was denied eligibility during application process and has not appealed the decision.
[5]Client has medical insurance, including Medicaid, Medicare, or other public program
[6]Includes TANF, child support, Social Security Retirement and unemployment insurance and employment benefits; the figure does not include employment income.

Project Goals

HSSP's primary goal was to increase clients' housing stability 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 housing placements that would facilitate attainment of treatment goals as well as increase access to resources through enrollment in mainstream benefit programs. Final status on each of these goals is described below.

Housing placement. The HSSP program met its three-year goal of housing 90 clients.[8] TRH records demonstrated that HSSP clients had a history of lengthy and repeated episodes of homelessness; in addition, clients had behavioral health and resource barriers that threatened the stability of any housing placement. Client's instability was evident in the fact that nearly one-fourth of those with a Discharge GPRA reported being homeless or living in an institution in the preceding month. The project's success was evident in the fact that most of the individuals who lost a housing placement were rehoused, with few or no days homeless in between (see following section for more details).

Behavioral health treatment. As intended, the HSSP program enrolled clients with chronic substance abuse; on the ASAM, nearly all clients were assessed as needing an intensive outpatient or residential inpatient level of care. The majority had mental health diagnoses that complicated recovery, as well as limited resources in terms of positive social support. HSSP staff provided therapeutic interventions to all enrolled clients. As intended, these services were provided in flexible settings: in client's homes, in jail, and during

[8] HMIS records show at least one housing enrollment for 97% of HSSP clients; per program report, the remainder were housed but the placement was not recorded at the time of the pull.

transport to other service providers. Staff was both mindful of clients' treatment goals and assertive in engaging clients in treatment, as demonstrated by the range of treatment settings and topics and the amount of time spent locating clients and rescheduling appointments. In addition, the majority of clients received peer support services, which included facilitating participation in recovery support groups.

Benefits enrollment. The majority of clients were enrolled in food stamps and at least one public health insurance program during HSSP enrollment. In keeping with the three-year goal, all clients received assistance in exploring possible benefit options. Case notes documented staff's collaboration with housing case managers to complete applications, obtain and prepare necessary documentation, and maintain enrollment status. Of note, in many cases where a client's SSI/SSDI application was denied, the cause was listed as a failure to complete the application within the required 90-day window. Many of those clients had started the application prior to HSSP enrollment, which further demonstrates the importance of ongoing case management and treatment services for these chronically homeless individuals.

Comparing HSSP to the Larger Chronic Homeless Population

The following section compares HSSP clients, across a range of characteristics and outcomes, to individuals receiving services through The Road Home's other programs for chronically homeless persons. Clients in those programs are identified throughout the remainder of this report as the HIFI sample[9]. As noted earlier, HSSP participants comprise a subset of this population; however, they were identified by TRH staff as having especially acute needs and greater barriers to service access when compared with other chronically homeless individuals. Of note, GPRA and program data were not available for clients with a primary HIFI enrollment; the following analyses rely on TRH data.

Sample Characteristics

Demographics. As indicated by Table 20, nearly all clients served by either HSSP or HIFI have a self-reported disabling condition. Most clients in both programs were White. On average, HIFI clients were older (51 years) than HSSP clients (47 years). Nearly three-fourths of HIFI clients were male; however, HSSP clients were evenly split between genders, with 56% identifying as male. More than one-half of HSSP clients were concurrently enrolled in HIFI (67%; not in table).

Table 20 Demographics[1]

	HSSP	*HIFI*
Total Sample (N)	*89*	*226*
Male (%)	56	74
Age (Mn)	47	51
Latino/Latina (%)	17	13
Race (%)		
White	82	86
Black/African American	10	9
Asian	0	0
American Indian/ Alaska Native	11	6
Native Hawaiian/Pacific Islander	0	0
Veteran/Served in Military (%)	2	17
Disabling Condition (%)	98	98

[1]Data taken from Client Track. Percentage may not add up to 100% due to missing data.
[2]89 HSSP clients had a service record in TRH data.

History of shelter use. Prior to enrollment, the majority of clients in both programs had stayed at TRH's emergency shelter for at least one night[10] (80%; Table 21). In total, HSSP clients averaged 444 nights in the shelter, although that figure ranged from one to 2,001 nights. A similar percentage of clients with concurrent enrollment (both HSSP and

[9] HIFI clients were only included in the comparison if they met the following characteristics: individuals (not families) enrolled during the HSSP project (2014 through 2017). Clients who received services from both HIFI and HSSP were classified as HSSP.
[10] Shelter records were available for 260 clients.

HIFI) spent at least one night in shelter prior to program enrollment (87%). Those clients also averaged more than 400 nights (Mn=434). A similar percentage of HIFI clients stayed in emergency shelter (78%) and the average number of nights was the lowest at 390.

Table 21 History of Shelter Use

	HSSP	*HIFI*	*Both*[3]
Total Sample (N)	*89*	*226*	*60*
Homeless Shelter Use Since 2011			
Stayed in the shelter at least one night (%)[1]	85	78	87
Total # of nights	33,748	68,942	22,561
Min, Max	1, 2001	1, 1281	1, 1618
Average # of nights per client (Mn)[2]	444	390	434

[1] Data were only available for nights spent in TRH shelter. Nights spent in other shelters or living on the street were not available.
[2] Mean number of shelter nights for the 76 HSSP and 177 HIFI clients who had stayed at least one night.
[3] Concurrently enrolled in both HSSP and HIFI programs.

Physical and mental health. Self-report data, available in TRH records, provide insight into clients' assessment of their own health status. Clients were asked to identify a variety of diagnoses, which are presented in Table 22 according to the program in which clients are enrolled: HSSP, HIFI, or both. Table 22 shows that the majority of clients, in all three groups, indicated that they had a chronic health condition (78-83%; most commonly diabetes, cancer, or Hepatitis C). One-third described themselves as having a developmental disability. When comparing HIFI and HSSP, more HSSP clients endorsed health concerns related to substance abuse, and particularly drug abuse, and mental health. Clients concurrently enrolled in both HSSP and HIFI had the highest rates of substance abuse and mental health diagnoses; nearly all of those with a mental health diagnosis (99%) reported a co-occurring substance use disorder.

Table 22 Self-Reported Physical and Mental Health

	HSSP	*HIFI*	*Both*[1]
Total Sample (N)	*89*	*226*	*60*
Health Concerns (%)			
Alcohol abuse	61	50	72
Both drug and alcohol abuse	48	32	60
Chronic health condition	78	78	83
Developmental disability	33	32	30
Drug abuse	79	52	87
HIV	1	3	2
Mental health	91	76	97
Co-occurring Mental Health and Substance Use[2]	*93*	*74*	*99*
Physical disability	57	62	60

[1] Concurrently enrolled in both HSSP and HIFI.
[2] Of those with self-reported mental health diagnoses

Benefits and income. Table 23, next page, presents benefits and financial information based on program as well as by pre-enrollment and during enrollment. These data were gathered from financial assessments administered by TRH staff. The percentages calculated pre-enrollment characterize the year prior to program enrollment (e.g., a client that had SNAP benefits during one pre-enrollment assessment but not on another pre-enrollment assessment would still be included in the percentage of those who had received that benefit during the year prior to enrollment[11]). During includes the two year period following a clients' enrollment into the program. Financial assessments were not available for all clients and percentages in Table 23 are based on the number of clients with an assessment, not total program participants.

When considering benefit access across groups, very few clients in either group had ever received employment-related benefits, including Social Security Retirement (SSR), either before or during enrollment. Nearly all clients had received food stamps, both before and during enrollment and many had publicly funded health insurance (e.g., Medicaid or Medicare). Prior to program enrollment, the groups look different, in terms of benefits, with fewer HSSP clients enrolled in most programs. In contrast, in the two years after program enrollment, the groups look similar in terms of benefits enrollment (e.g., 58% of both groups were receiving Disability payments). This is particularly notable given that the majority of HSSP clients were already HIFI clients at the time of enrollment and had therefore been receiving support related to benefits. Eligibility was not the barrier to enrollment for at least a subset of clients and the additional support services may have been successful in increasing access to benefits, particularly health insurance and disability payments.

[11] For this reason, figures for HSSP clients may differ from those presented in earlier tables, which characterize enrollment and income at within 30 days of Intake.

Table 23 Benefits and Income

	HSSP		*HIFI*		*Both*[1]	
	Pre	*During*	*Pre*	*During*	*Pre*	*During*
Total Sample (N)	*89*		*226*		*60*	
Sample with Financial Assess. (n)	*78*	*76*	*190*	*206*	*56*	*54*
Any Employment Benefit[2] (%)	1	3	5	6	2	2
Disability Insurance[3] (%)	40	58	51	58	36	52
Employed (%)	13	12	15	13	14	9
Family Assistance[4] (%)	8	3	1	2	5	4
General Assistance (GA) (%)	21	21	17	17	23	24
Health Insurance[5] (%)	55	74	62	71	57	76
Housing Assistance (%)	13	20	10	25	14	22
Medicaid[7]	51	68	55	60	52	69
Medicare[7]	13	16	12	18	13	19
Other Income[6] (%)	6	4	3	6	7	4
SNAP Benefits (%)	91	88	86	85	89	87
Social Security Retirement[8]	1	1	4	3	2	2
Veteran's Benefit[8]	--	--	2	1	--	--

[1] Concurrently enrolled in both HSSP and HIFI.
[2]Includes public and private pensions, insurance, retirement, unemployment, SSR, workman's compensation, veteran benefits; does not include SSDI.
[3]Includes SSI, SSDI, veteran's insurance, private.
[4]Includes TANF, CHIP, WIC.
[5]Health insurance includes Medicaid, Medicare, PCN, private insurance, and veteran's insurance.
[6]Other sources include pan handling, working under the table, money received from family and friends, and illegal sources.
[7]Included within Health Insurance
[8]Included within Any Employment Benefit

Income. Table 24, next page, details average monthly income from any source, organized according to program and enrollment status. Like Table 23, these data come from TRH financial assessments administered to clients before and during program enrollment[12]. In the year prior to enrollment, HIFI clients had the highest average monthly income ($551), which was higher than HSSP ($502) and concurrently enrolled clients ($488). When looking at the two years post-enrollment, HIFI clients' average income was higher by $34 a month. In contrast, both HSSP and concurrently enrolled clients' income decreased slightly. Because these figures include income from all sources (including family and friends, pan-handling, and other unstable sources), the decrease likely reflects changes in unstable income, especially given increases in benefits enrollment documented in Table 23.

[12] Which is why they differ, slightly, from income amounts collected on GPRA forms and presented in Table 6.

Table 24 Monthly Income

	HSSP		*HIFI*		*Both*[1]	
	Pre	*During*	*Pre*	*During*	*Pre*	*During*
Total Sample (N)	89		226		60	
Any income (n)	75	75	185	202	53	54
Average Income[2]	502	489	551	585	488	462
Income Min, Max	(111, 1500)	(1, 1551)	(1, 2044)	(1, 1786)	(32, 1551)	(111, 1230)

[1]Concurrently enrolled in both HSSP and HIFI.
[2]Among those who reported any income at least once in timeframe.

Services

HIFI clients averaged 799 days enrolled in HIFI (ranging from one to 1,350); among those with a shelter stay prior to HIFI enrollment (n=177), clients averaged 1,007 days between first shelter stay and program enrollment. HSSP clients averaged 589 days enrolled in HSSP (ranging from 1 to 1,203); among those with a shelter stay prior to enrollment (n=77), clients averaged 1,398 days between the first shelter stay and program enrollment (ranging from 24 to 2,401 days). Concurrently enrolled clients averaged 682 days (calculated from HSSP enrollment) with 1,322 days, on average, between first shelter stay and program enrollment (n=53).

Table 25 provides an overview of services provided to HSSP and HIFI clients, by The Road Home (TRH), after enrollment. Across most service types, all three groups look similar, with approximately two-thirds of clients receiving assistance related to basic needs (62-78%), case management (85-96%), and transportation (57-70%). Very few clients received services related to behavioral health needs (4-6%), employment (3-4%), or street outreach (1-3%). When compared to HSSP clients, substantially more HIFI clients received relatively more assistance in meeting their basic needs (average services received is 9 vs 14). While service provision to both groups looks relatively similar in Table 25, it is important to remember that HSSP clients were receiving additional services, beyond what is described in Table 25 (see Table 18, p. 18). As such, HSSP clients were receiving case management and support services from at least two programs (HSSP and TRH). While enrolled in HSSP, nearly all clients (88%) received supplemental services through TRH (recall that HSSP is a TRH program as well).

Table 25 also compares clients who were living in congregate settings (project-based, with other chronically homeless persons and onsite case management) and scattered site (in the community, with case management provided in the clients' home[13]). When compared to scattered site placements, substantially more congregate-based clients received assistance with basic needs, crisis management, housing, and transportation from TRH.

[13] Approximately 10% of clients in both HIFI and HSSP lived in congregate housing.

Table 25 Other Services Provided by TRH[1]

Total Sample (N)	89	226	60	29	268
	HSSP	*HIFI*	*Both*	*Congregate*[2]	*Scattered*[2]
Service Type % of clients (Mn # of services)					
Basic Needs	62 (9)	78 (14)	68 (7)	97 (16)	76 (12)
Behavioral Health	4 (1)	6 (5)	5 (1)	10 (5)	6 (4)
Mental Health	*100 (1)*	*86 (5)*	*100 (1)*	*67 (5)*	*93 (4)*
Substance Use	--	*14 (4)*	--	*33 (6)*	*7 (1)*
Case Management	85 (78)	96 (82)	93 (79)	100 (87)	99 (80)
Crisis Management	36 (2)	32 (5)	42 (3)	69 (6)	31 (4)
Emergency Shelter	1 (1)	--	2 (1)	--	1 (1)
Employment Services	3 (1)	4 (2)	3 (1)	3 (1)	4 (2)
Health Services	12 (2)	7 (2)	10 (2)	17 (1)	8 (2)
Housing	36 (9)	42 (8)	40 (9)	55 (4)	41 (9)
Street Outreach	2 (6)	1 (3)	3 (6)	--	2 (4)
Transportation	57 (16)	70 (15)	62 (15)	82 (11)	69 (15)

[1]These services were provided by TRH and were not provided as part of HSSP programming.

[2]These categories include HSSP, HIFI, and Both clients and are classified according to whether clients were living in scattered or congregate housing placements. Approximately 10% of clients in both programs lived in congregate housing.

Outcomes

The original intent of this section of the report was to compare the HIFI and HSSP case management programs as well as the congregate and scattered site housing approaches. However, an initial examination of the data indicated that the HIFI and HSSP groups, in particular, were not comparable prior to program participation. As noted in the report to date, and characterized more fully in the following section, the HSSP group was somewhat more at-risk prior to program participation on indicators of homelessness, substance use, mental health, and criminal justice contact. Despite attempts to select individuals enrolled in the programs at similar times, the HIFI program had a median start date in October 2014 and the HSSP program had a median start date in January 2016. Because of both community and jail-related policy changes during that time, it is not appropriate to compare the two groups as if their contextual influences were similar. As such, the following section relies on pre- and post-enrollment comparisons to describe program impact on intended outcomes.

Emergency shelter use. Table 26, next page, compares time spent in shelter before and after enrollment into primary case management. For all three types of case management, the average number of days spent in shelter was substantially lower after enrollment. In order to compare clients with differential observation periods (e.g., number of days before and after enrollment), the percent of time clients spent in shelter was also calculated[14]. Prior to case management enrollment, clients were in shelter between one-

[14] For pre-enrollment, this was the number of days spent in shelter divided by the number of days between first shelter enrollment and case management enrollment. For post-enrollment, this was the number of days spent in shelter divided by the number of days between case management enrollment and March 12, 2018 (date of data pull) or date of death for deceased clients. Analyses were conducted using the Wilcoxon signed-rank test.

quarter and one-third of the time; after enrollment, those figures dropped to less than 10% of the time. For HIFI clients, the percent of time spent in emergency shelter was significantly lower after HIFI enrollment (*Mdn=0%*) compared to the percent of time spent in shelter prior to HIFI enrollment (*Mdn=26.0%*), T*=9.00*, *p=.000*, *r= -.53*. For HSSP clients, the percent of time spent in emergency shelter was significantly lower after HSSP enrollment (*Mdn=0%*) when compared to the percent time spent in shelter prior to HSSP enrollment (*Mdn=19.7%*), T*=10.00*, *p=.000*, *r= -.48*. For HIFI/HSSP clients, the percent of time spent in emergency shelter was significantly lower after HIFI/HSSP enrollment (*Mdn=0%*) when compared to the percent time spent in shelter prior to HIFI/HSSP enrollment (*Mdn=22.4%*), T*=113.00*, *p=.000*, *r= -.49*.

Table 26 Shelter Use Before and After Enrollment

	HSSP[1]	*HIFI*[2]	*Both*[3]
Pre-Enrollment			
Days shelter use (Mn)	379[4]	305[5]	379[6]
Percent of time in shelter (Mn)	26	30	27
Post-Enrollment			
Days shelter use (Mn)	26[4]	25[5]	26[6]
Percent of time in shelter (Mn)	7	3	7

[1]Average days in pre-enrollment period, Mn=1,398; average days in post-enrollment period, Mn=604. Includes shelter enrollments after discharge from case management, which is why figures differ from those on p. 25.
[2]Average days in pre-enrollment period, Mn=1,007; average days post-enrollment period, Mn=1,029. Includes shelter enrollments after discharge from case management, which is why figures differ from those on p. 25.
[3] Concurrently enrolled in both HSSP and HIFI. Average days in pre-enrollment period, Mn=1,322; average days in post-enrollment period, Mn=691. Includes shelter enrollments after discharge from case management, which is why figures differ from those on p. 25.
[4]Among the entire sample, which is why figures differ from Table 21.
[5]Among the entire sample, which is why figures differ from Table 21.
[6]Among the entire sample, which is why figures differ from Table 21.

Housing stability. Enrollment into housing placements (e.g., long- and short-term housing subsidies, in both congregate and scattered placements), are documented in TRH records. Among HIFI clients, 60% had at least one recorded housing enrollment that occurred during program enrollment; among HSSP clients, 94% had at least one recorded housing enrollment that occurred during program enrollment[15]. When looking at those housing enrollments, HIFI clients were housed for an average of 745 days and HSSP clients were housed for an average of 417 days. Because HSSP clients were recruited from chronic housing programs, nearly all had a housing placement that started before program enrollment. If the number of days housed prior to program enrollment are included in the preceding calculation, HSSP clients were housed for an average of 568 days.

One measure of housing stability was the number of times a client lost a housing placement and returned to homelessness. While clients often had multiple housing enrollments, some portion of those were best characterized as transfers from one program or funding source to another (with no loss of housing). In other cases, an enrollment ended because of a

[15] Per conversations with staff, all HSSP clients (n=90) were enrolled in housing prior to program enrollment; the current report reflects enrollments that had been recorded at the time of the data pull.

problem (e.g., the client did not comply with housing rules, engaged in criminal activity, did not pay rent) and the client became homeless again. In some instances, institutionalization (e.g., incarceration or hospitalization) resulted in homelessness.

Tables 27 and 28 compare client outcomes when looking only at housing exits that resulted from non-compliance or would be classified as negative[16] (e.g., into homelessness, jail/prison, hospitalization, residential substance abuse, and unknown). Table 27 shows the percent of clients in each program with at least one negative exit from a housing enrollment.[17] Prior to program enrollment, one-third of HSSP clients (33%) had at least one negative exit. Among HIFI clients, 19% had at least one negative housing exit prior to program enrollment. After program enrollment, nine percent of HIFI clients, and 21% of HSSP clients, had a negative housing exit. In both timeframes, three times as many HSSP clients had an exit due to non-compliance; those figures were highest among clients with a concurrent enrollment.

TABLE 27 Negative Housing Exits

	HIFI		*HSSP*		*HIFI+HSSP*	
Timeframe[1]	*PRE*	*DRG*	*PRE*	*DRG*	*PRE*	*DRG*
Any negative exit[2] (%)	19	9	33	21	34	29
Homelessness[3] (%)	17	7	27	19	25	26
Institution[4] (%)	2	1	9	2	12	3
Non-compliance[5] (%)	7	6	22	17	24	22

[1]Housing exit occurred prior to primary case management enrollment (Pre) or while enrolled (Drg).
[2]Client exited enrollment to homelessness, institutionalization, or unknown destination.
[3]Client exited enrollment and became homeless
[4]Client exited enrollment due to incarceration or hospitalization
[5]Client exited enrollment due to non-compliance; did not necessarily become homeless as a result.

Some clients had multiple negative exits; as such, Table 28 shows the average number of negative housing exits, among clients with any negative exit. When comparing groups, HSSP clients averaged more negative exits both before (1.2 vs 1.3) and after (1.0 vs 1.3) program enrollment. Of note, the average number of negative exits dropped, when comparing pre- and during-enrollment periods, for HIFI clients but not for HSSP clients. The combined results of Tables 27 and 28 show that fewer clients in both groups had any negative exits after enrollment; however, more HSSP clients had more negative exits in both time periods. The relatively higher rate of negative exits among HSSP clients (with and without HIFI), even with the additional treatment services provided by HSSP, reflects the fact that clients were selected for HSSP based on a history of failed housing placements and/or resistance to services.

[16] The loss of a housing placement due to non-compliance does not inevitably result in homelessness. As such, "negative exit" refers to an exit that results in homelessness while "non-compliance" refers to an exit that stems from not following rules (civil or criminal), whether or not the client became homeless as a result. This includes failure to pay rent.

[17] The percentages in Table 27 are calculated among clients with at least one housing enrollment in the specified timeframe.

TABLE 28 Number of Negative Housing Exits

	HIFI		*HSSP*		*HIFI+HSSP*	
Timeframe[1]	*PRE*	*DRG*	*PRE*	*DRG*	*PRE*	*DRG*
Negative exits[2] (Mn)	1.2	1.0	1.3	1.3	1.3	1.3
Homelessness[3] (Mn)	1.1	1.0	1.2	1.2	1.2	1.2
Institution[4] (Mn)	1.0	1.0	1.3	1.5	1.1	1.5
Non-compliance[5] (Mn)	1.1	1.0	1.4	1.3	1.4	1.3

[1]Housing exit occurred prior to primary case management enrollment (Pre) or while enrolled (Drg).
[2]Client exited enrollment to homelessness, institutionalization, or unknown destination.
[3]Client exited enrollment and became homeless
[4]Client exited enrollment due to incarceration or hospitalization
[5]Client exited enrollment due to non-compliance; did not necessarily become homeless as a result.

Another measure of housing stability, commonly used to assess the impact of HF interventions, is the percent of time that clients were housed after enrollment[18]. When looking only at clients with a housing enrollment that occurred during or after program enrollment, HIFI clients were housed 72% of the time. In comparison, HSSP clients were housed 64% of the time[19]. These figures are similar to Stergiopoulos's (2018) findings, which showed clients in HF programs were stably housed 63-74% of the time during a 24-month post-enrollment follow-up period. Given relatively higher rates of negative exits among HSSP clients, as presented in Tables 27 and 28, the comparable rates of housing stability, according to this metric, suggest that HSSP was successful in achieving intended housing outcomes.

Criminal justice contacts. As noted in the report to date, and further characterized in the section that follows, the HSSP group was somewhat more at-risk prior to program participation as indicated by jail related outcomes. The two programs also took place during slightly different periods, with the HIFI program having a median start date in October 2014 and the HSSP program having a median start date in January 2016. Because of both community and jail-related policy changes, it is not appropriate to compare the two groups as if their contextual influences were similar.

What follows is a series of summary tables and within-group pre-post analyses for each of the two case management programs (HIFI and HSSP) and for the two housing approaches (congregate and scattered site) performed separately. The tables provide descriptive jail outcomes for the period two years prior to enrollment as well as outcomes post program start. The post-enrollment period is not equivalent to the fixed, two-year pre-enrollment and should not be directly compared for that reason.

Because the pre and post periods in the tables below are not equivalent, it would be impossible to determine whether, for example, incidents of criminal behavior declined after enrollment, or, alternatively, whether criminal activity only appeared to decrease due

[18] This was calculated by dividing the total number of days with an open housing enrollment by the total number of follow-up days (date of data pull or death for deceased clients).
[19] When looking at all clients, including those with no housing enrollments in the timeframe, HIFI clients were housed 42% of the time and HSSP clients were housed 61% of the time.

to shorter follow up periods post-enrollment. To address this issue, another set of analyses were conducted to examine whether, over equivalent periods pre and post, new charge bookings, crime severity, and days in jail changed from pre- to post-intake.

To examine these outcomes, the amount of follow up time post-intake was calculated for each client. An equivalent period was then established in the pre-intake period such that each pre-post period was both equivalent and person-specific. For example, if client 'A' had 250 days of follow up time post-intake, an equivalent period of time was set for pre-intake comparison. For person 'A', adult detention center records were then queried and compared across these equivalent timespans (i.e., 250 days pre compared to 250 days post).

HSSP jail bookings. Salt Lake County Adult Detention Center (ADC) records were examined for the two years prior to enrollment and post-HSSP start. For this outcome, clients were only considered if they had a program intake date preceding the most recent available date for which ADC data were available (i.e., 12/31/2017). Two HSSP cases were removed from the analysis because they had enrollment dates after this date. Eighty one HSSP cases remained for analysis.

Forty-seven of 81[20] HSSP clients (58.0%) were booked into the ADC at least once during the two years prior to Intake, most commonly for new charges or warrants/summons (see Table 28). These 47 HSSP clients accounted for 138 new charge jail bookings and 3,870 nights spent in jail during this two-year period prior to intake. The majority of new charges were misdemeanors (90% of all charges) and the most common pre-intake charge type was public order offenses (50% of all charges shown). These numbers suggest that, prior to starting the HSSP program, a majority of clients were repeatedly involved in the criminal justice system, most commonly for non-violent, less severe offenses.

Jail bookings occurring post-program start were also examined for all HSSP clients. Because post-start periods are based on each client's intake date, the length of follow-up varies widely by client (Mn = 605, SD = 340) and is not equivalent to the two-year pre-intake period (which was fixed per client). During the post-start period, clients accounted for a total of 82 new charge jail bookings and 1,950 nights spent in jail. Similar to the pre-intake period, the majority of new charges in the post enrollment period were misdemeanors (77% of all charges) and the most common charge type was public order offenses (45% of all charges shown). However, unlike the pre-enrollment period, post-enrollment felony charges were fairly common (20% of all post-enrollment charges).

[20] Sample size is smaller because of the date the jail data were queried.

Table 28 HSSP Criminal Involvement—Jail Bookings 2 Years Prior to and After HSSP Start [1]

Total Sample (N)	*81*	
Jail Bookings Prior to and After Program Start	2 Years Prior	Post-Start[2]
At least one jail booking for (% (n)):		
Any reason[3]	58 (47)[4]	42 (34)
New charge(s)	47 (38)	36 (29)
Warrant(s)	56 (45)	37 (30)
Commitment(s)	28 (23)	14 (11)
Of those with Any[3] booking(s):		
Nights spent in jail *per booking* (Mn (SD))	17 (39)	14 (31)
Nights spent in jail *per client* (Mn (SD))	82 (102)	57 (99)
Nights spent in jail for *entire sample* (sum)	3,870	1,950
Of those with New Charge (NC) booking(s):		
Min, Max number of NC bookings *per client*	1, 23	1, 14
Number of NC bookings *per client* (Mn (SD))	6 (6)	4 (4)
Number of NC bookings for *entire sample* (sum)	138	82
Number of charges for entire sample (sum)	237	121
Charge Severity/Degree (%[5](n)):		
Infraction	1 (2)	3 (4)
Misdemeanor	90 (213)	77 (93)
Felony	9 (22)	20 (24)
Charge Type (%[6](n)):		
Person	7 (17)	9 (10)
Property	21 (49)	17 (20)
Drug	17 (39)	24 (27)
Public Order	46 (105)	39 (45)
Obstruction	8 (19)	11 (13)

[1] Jail data were available through 12/31/17.

[2] Follow-up timeframes for post-start jail bookings vary by client, ranging from 66 to 1,187 days (Mn = 605, SD = 340); because of this variation, the two columns are not comparable.

[3] Does not include holds.

[4] 47 of 81 clients (58.0%) had jail events during the two-year pre-intake time period relevant to this table; 71 of 81 clients (88%) had jail events since 2009 (data not shown in table).

[5] Percentages here represent percentages within the crime severity category and, therefore, sum to 100% (within rounding) across infractions, misdemeanors, and felonies.

[6] Percentages here represent percentages within the charges types and, therefore, sum to 100% (within rounding) across the five charge types provided; though they occurred, other charges (8 total pre, 6 total post) were rare and are not represented in the table.

As mentioned, because the pre and post periods in the table above are not equivalent, it is impossible to determine whether incidents of criminal behavior declined after intake, or, alternatively, whether criminal activity only appeared to decrease due to shorter follow up periods post-intake. Accordingly, another set of analyses were conducted to examine whether, over equivalent periods within persons both pre and post, new charge bookings, crime severity, and days in jail changed from pre- to post-intake.

The three figures that follow provide visual summaries of significance tests that were conducted for each outcome using distributions appropriate for count data (e.g., Poisson,

negative binomial type I or II, Poisson inverse Gaussian). The appropriate distribution for each outcome was selected using model fit criteria. For simplicity, details of the model building process and parameter estimates are omitted. Instead, figures provide a visual density plot showing the count (i.e., number of occurrences) of each outcome by period (i.e., pre- and post-intake). The density plots have the following properties:

- The x-axis (horizontal axis) provides the range and values of the outcome.
- The y-axis (vertical axis) provides the count of clients with the specific value of the outcome shown on the x-axis; because a property of densities dictates that the counts can exceed the number of cases at a specific density, the actual counts have been removed to avoid confusion. The reader should simply interpret higher peaks as indicating more cases fall under a given value on the x-axis.
- Densities represent the number of people with a particular outcome value; as such, each plot shows the density of clients, by pre and post, who scored within a particular value of the outcome.
- Vertical lines in the figures denote the means for the two time periods.
- An annotation within the figures provides the p-value, or significance of the difference between periods; all significant differences were in the anticipated direction, but not all differences were significant.
- A significant difference is indicated by an annotation p-value less than .05; numbers greater than .05 are not statistically significant at traditional levels.

Consider Figure 1 as an illustration of the above features. Figure 1 provides results for the analysis of number of new charge bookings per client. The number (and range) of new charges is provided on the horizontal, x-axis, while the number of clients with each value of a new charge is provided on the vertical, y-axis. For ease of visual interpretation, the figure's x-axis has been rescaled using a square root transformation, which compresses the x-axis and reduces skew. Looking at both pretest and posttest values, we see that the vast majority of clients had zero new charge bookings. At posttest, however, fewer clients had a high number of charges relative to pretest; accordingly, we see greater densities of higher counts of new charges under the pre-test distribution.

The figure, with corresponding vertical lines, also shows that the mean post-intake is significantly less than pre-intake (p=.011), indicating clients had fewer new charge bookings post-intake relative to pre-intake. Although alternative explanations for the difference (e.g., regression to the mean) cannot be ruled out in this observational design, the analysis of equivalent time periods does indicate fewer new charge bookings post-intake, which *may* be attributable to program effects (among other possible explanations).

Figure 1

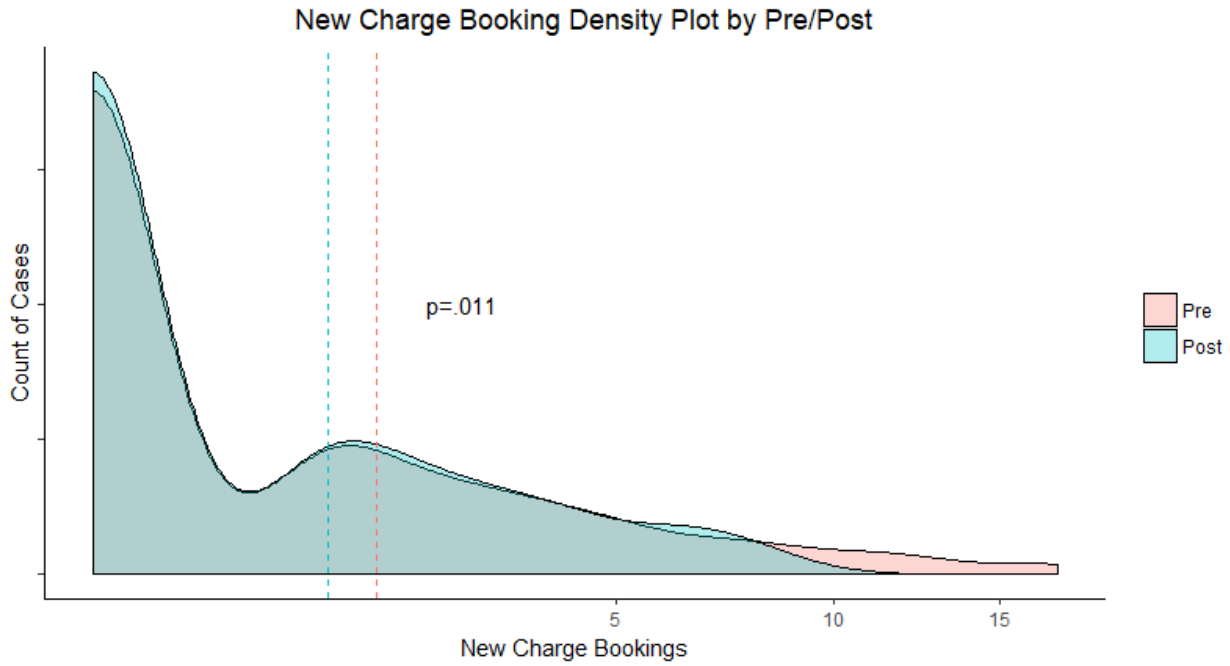
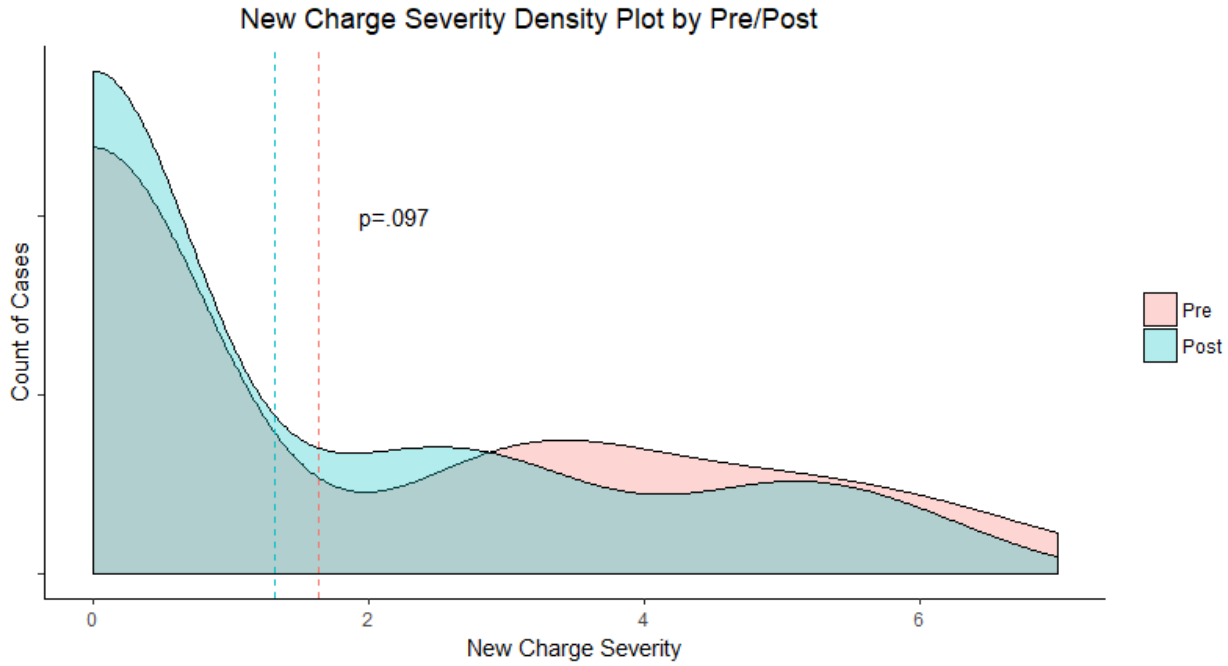


Figure 2 below provides results for the analysis of the maximum severity of offenses by time-period. Note that, though not technically a count variable, crime severity is distributed as a count variable and can be reasonably modeled as such given its distributional form (though the outcome is admittedly not represented by interval data). For this analysis, crime severity ranged across the following values: 0 (no crime), 1 (infraction), 2 (class C misdemeanor), 3 (class B misdemeanor), 4 (class A misdemeanor), 5 (third degree felony), 6 (second degree felony), and 7 (first degree felony). Therefore, higher means/values are less desirable on the outcome and indicate a crime of greater severity.

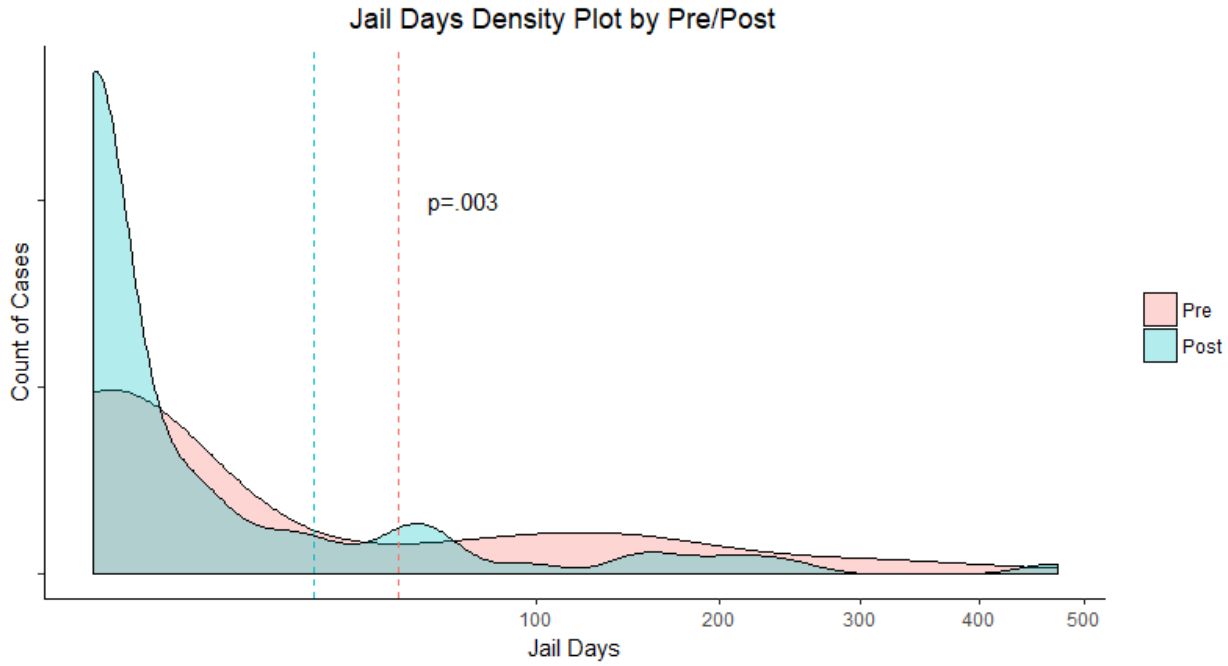
The figure, with corresponding vertical lines, shows that the mean post-intake is statistically equivalent to pre-intake (p=.097). From visual inspection of the density plot, one can see that more clients committed no new offenses (coded 0) during the post period, but that difference was not significant.

Figure 2



Finally, Figure 3 below provides results for the analysis of the number of jail days by time-period. For ease of visual interpretation, the figure's x-axis has again been rescaled using a square root transformation, which compresses the x-axis and reduces skew. The figure shows that the mean number of jail days post-intake is significantly less than pre-intake (p=.003), which *may*, again, be attributable to program effects (among other possible explanations). It is also notable that many more clients had 0 jail days in the post period than in the pre-period.

Figure 3



HIFI jail bookings. Salt Lake County Adult Detention Center (ADC) records were also examined for the two years prior to enrollment and post-HIFI program start. As with HSSP, clients were only considered if they had a program intake date preceding the most recent available date for which ADC data were available (i.e., 12/31/2017). Seven HIFI cases were removed from the analysis because they had enrollment dates after this date. Two hundred twenty five HIFI cases remained for analysis.

Ninety of 225 HIFI clients (40.0%) were booked into the ADC at least once during the two years prior to intake, most commonly for new charges or warrants/summons (see Table 29). These 90 HIFI clients accounted for 199 new charge jail bookings and 5,423 nights spent in jail during this two-year period prior to intake. The majority of new charges were misdemeanors (80% of all charges) and the most common pre-intake charge types were public order offenses (34% of all charges shown) and property offenses (33% of all charges shown). These numbers suggest that, prior to starting the HIFI program, less than half of HIFI clients were involved in the criminal justice system, most commonly for non-violent, less severe offenses.

Jail bookings occurring post-program start were also examined for all HIFI clients. Because post-start periods are based on each client's intake date, the length of follow-up varies widely by client (Mn = 987, SD = 417) and is not equivalent to the two-year pre-intake period (which was fixed per client). During the post-start period, clients accounted for a total of 154 new charge jail bookings and 3,595 nights spent in jail. Similar to the pre-intake period, the majority of new charges in the post enrollment period were misdemeanors (81% of all charges). However, three offense types were nearly equally likely: property, public order, and drug.

Table 29 HIFI Criminal Involvement—Jail Bookings 2 Years Prior to and After HIFI Start [1]

Total Sample (N)	*225*	
Jail Bookings Prior to and After Program Start	2 Years Prior	Post-Start[2]
At least one jail booking for (% (n)):		
Any reason[3]	40 (90)[4]	27 (60)
New charge(s)	32 (71)	20 (45)
Warrant(s)	37 (83)	24 (55)
Commitment(s)	18 (40)	11 (24)
Of those with Any[3] booking(s):		
Nights spent in jail *per booking* (Mn (SD))	18 (42)	13 (30)
Nights spent in jail *per client* (Mn (SD))	60 (98)	60 (108)
Nights spent in jail for *entire sample* (sum)	5,423	3,595
Of those with New Charge (NC) booking(s):		
Min, Max number of NC bookings *per client*	1, 43	1, 25
Number of NC bookings *per client* (Mn (SD))	5 (6)	6 (6)
Number of NC bookings for *entire sample* (sum)	199	154
Number of charges for entire sample (sum)	327	275
Charge Severity/Degree (%[5](n)):		
Infraction	1 (2)	3 (9)
Misdemeanor	80 (261)	81 (223)
Felony	20 (64)	16 (43)
Charge Type (%[6](n)):		
Person	10 (29)	6 (16)
Property	33 (94)	31 (81)
Drug	23 (67)	27 (70)
Public Order	34 (97)	28 (72)
Obstruction	8 (19)	8 (21)

[1] Jail data were available through 12/31/17.

[2] Follow-up timeframes for post-start jail bookings vary by client, ranging from 8 to 1,327 days (Mn = 987, SD = 417); because of this variation, the two columns are not comparable.

[3] Does not include holds.

[4] 90 of 225 clients (40.0%) had jail events during the two-year pre-intake time period relevant to this table; 142 of 225 clients (63.1%) had jail events since 2009 (data not shown in table).

[5] Percentages here represent percentages within the crime severity category and, therefore, sum to 100% (within rounding) across infractions, misdemeanors, and felonies.

[6] Percentages here represent percentages within the charges types and, therefore, sum to 100% (within rounding) across the five charge types provided; though they occurred, other charges (12 total pre, 15 total post) were rare and are not represented in the table.

As with the HSSP group above, because the pre and post periods in the table above are not equivalent for the HIFI program, it is impossible to determine whether incidents of criminal behavior declined after intake, or, alternatively, whether criminal activity only appeared to decrease due varying follow up periods post-intake. Accordingly, the same analyses as with the HSSP group were conducted to examine whether, over equivalent periods within persons both pre and post, new charge bookings, crime severity, and days in jail changed from pre- to post-intake for the HIFI program.

As before, the three figures that follow provide visual summaries of significance tests that were conducted for each outcome. Figures provide a visual density plot showing the count (i.e., number of occurrences) of each outcome by period (i.e., pre- and post-intake). The density plots in this section have the same properties as described above.

Figure 4 provides results for the analysis of number of new charge bookings per client. The number (and range) of new charges is provided on the horizontal, x-axis, while the number of clients with each value of a new charge is provided on the vertical, y-axis. The figure's x-axis has been rescaled using a square root transformation, which compresses the x-axis and reduces skew. Looking at posttest values, we see relatively more zeros (or no new charges) relative to pretest. While the time periods are similar on the high number of new charges, clients were notably more likely to have a small number of new charges (e.g., 1 or 2) at pretest relative to posttest.

The figure, with corresponding vertical lines, also shows that the mean post-intake is significantly less than pre-intake (p=.000), indicating clients had fewer new charge bookings post-intake relative to pre-intake. Although alternative explanations for the difference (e.g., regression to the mean) cannot be ruled out in this observational design, the analysis of equivalent time periods does indicate fewer new charge bookings post-intake, which *may* be attributable to program effects (among other possible explanations).

Figure 4

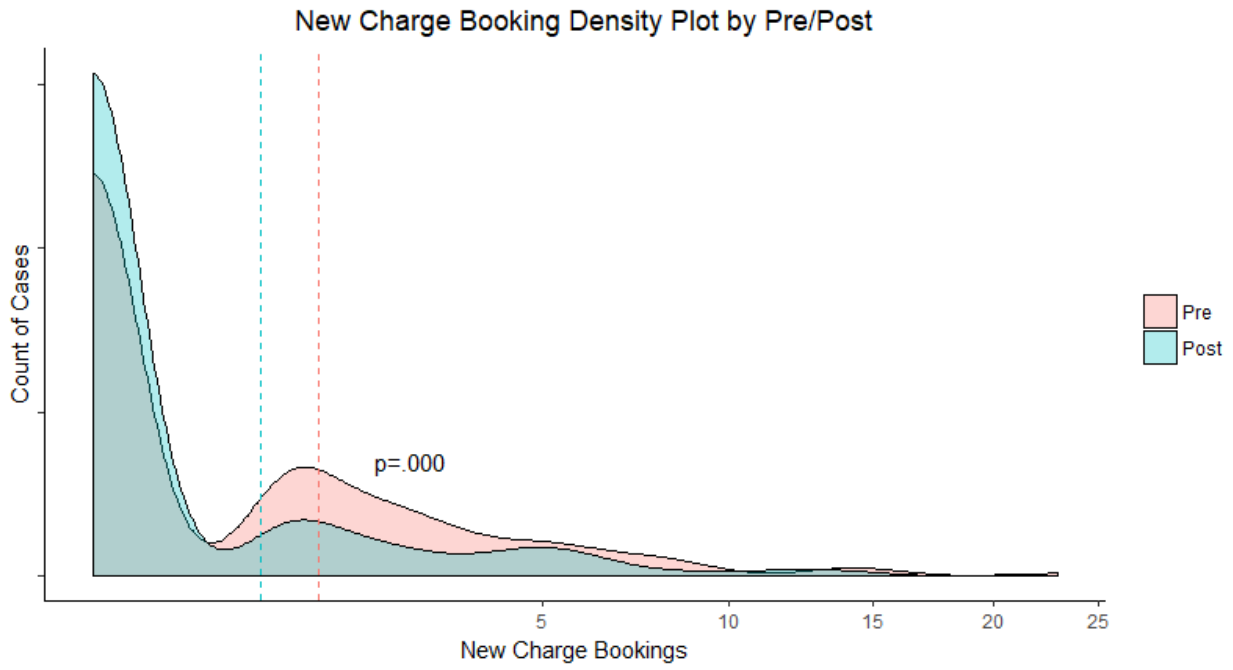
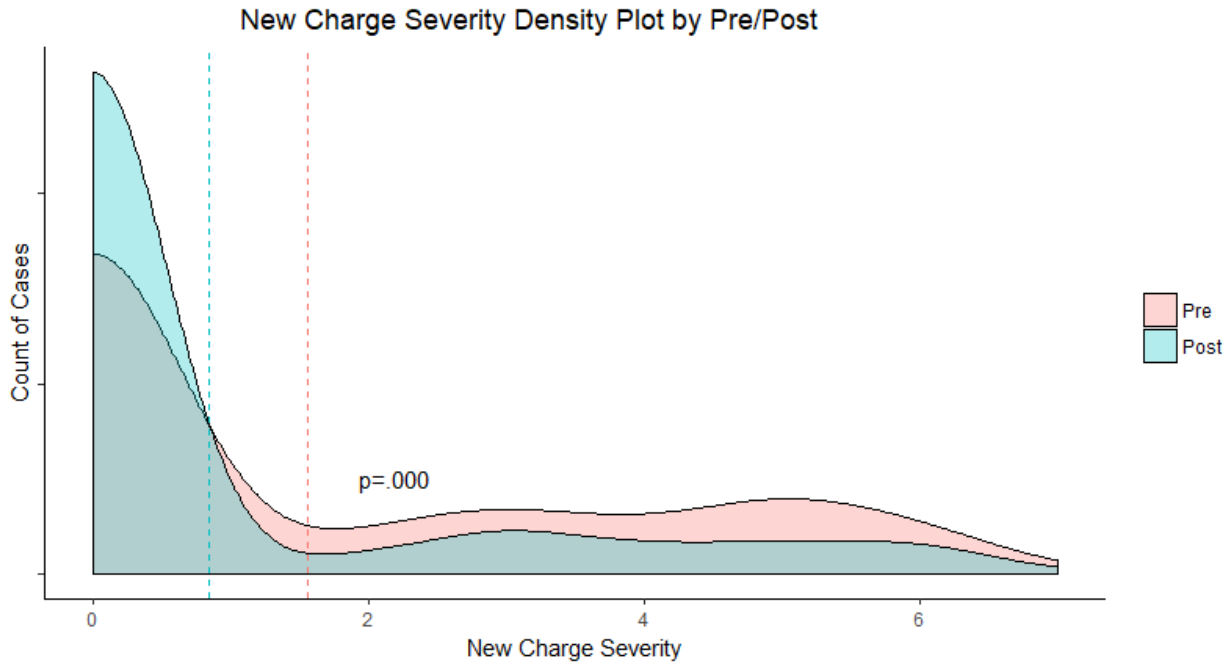


Figure 5 below provides results for the analysis of the maximum severity of offenses by time-period. As before, crime severity ranged across the following values: 0 (no crime), 1 (infraction), 2 (class C misdemeanor), 3 (class B misdemeanor), 4 (class A misdemeanor), 5 (third degree felony), 6 (second degree felony, and 7 (first degree felony). Therefore, higher

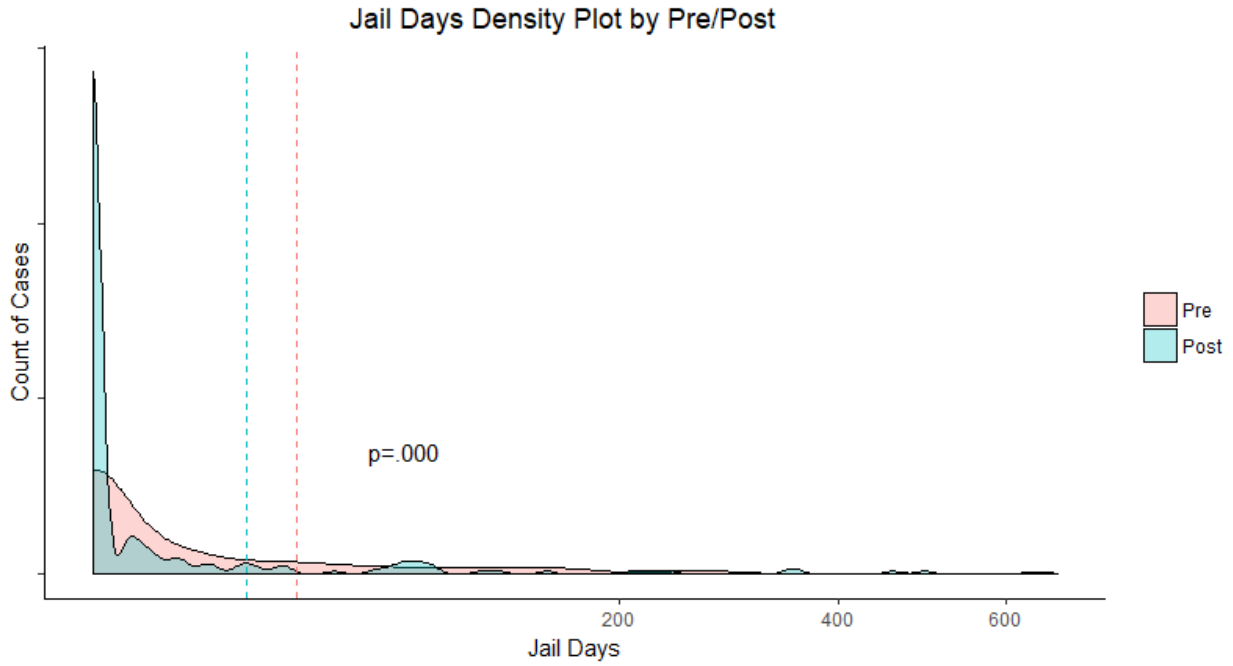
means/values are less desirable on the outcome and indicate a crime of greater severity. The figure, with corresponding vertical lines, shows that the mean post-intake is significantly less than pre-intake (p=.000). At post, zeros were considerably more common. The effect may be attributable to program effects (among other possible explanations).

Figure 5



Finally, Figure 6 below provides results for the analysis of the number of jail days by time-period. For ease of visual interpretation, the figure's x-axis has again been rescaled using a square root transformation, which compresses the x-axis and reduces skew. The figure shows that the mean number of jail days post-intake is significantly less than pre-intake (p=.000), which *may*, again, be attributable to program effects (among other possible explanations). It is also notable that many more clients had 0 jail days in the post period than in the pre-period.

Figure 6



Scattered-site jail bookings. Salt Lake County Adult Detention Center (ADC) records were next examined for individuals with a scattered site housing placement. These placements consist of both HSSP and HIFI clients, and, accordingly, are not mutually exclusive from analyses involving those groups. Clients were only considered for this analysis if they had an enrollment date preceding the most recent available date for which ADC data were available (i.e., 12/31/2017). Nine scattered site cases were removed from the analysis because they had enrollment dates after this date. Two hundred seventy seven scattered site clients remained for analysis.

One hundred twenty five of 277 scattered site clients (45%) were booked into the ADC at least once during the two years prior to enrollment, most commonly for new charges or warrants/summons (see Table 30). These 125 scattered site clients accounted for 314 new charge jail bookings and 8,787 nights spent in jail during this two-year period prior to enrollment. The majority of new charges were misdemeanors (84% of all charges) and the most common pre-intake charge type was public order offenses (36% of all charges shown). These numbers suggest that, prior to their scattered site placement, just less than half of HIFI clients were involved in the criminal justice system, most commonly for non-violent, less severe offenses.

Jail bookings occurring post-program start were also examined for all scattered site clients. Because post-start periods are based on each client's enrollment date, the length of follow-up varies widely by client (Mn = 875, SD = 439) and is not equivalent to the two-year pre-intake period (which was fixed per client). During the post-start period, clients accounted for a total of 205 new charge jail bookings and 5,032 nights spent in jail. Similar to the pre-

intake period, the majority of new charges in the post enrollment period were misdemeanors (79% of all charges), but, unlike the pre-period, the most common charges post were similar across public order, property, and drug charges (from 27-30% of charges shown).

Table 30 Scattered Site Client Criminal Involvement—Jail Bookings 2 Years Prior to and After Scattered Site Enrollment [1]

Total Sample (N)	*277*	
Jail Bookings Prior to and After Program Start	2 Years Prior	Post-Start[2]
At least one jail booking for (% (n)):		
Any reason[3]	45 (125)[4]	31 (85)
New charge(s)	36 (101)	23 (65)
Warrant(s)	42 (116)	27 (76)
Commitment(s)	22 (60)	12 (32)
Of those with Any[3] booking(s):		
Nights spent in jail *per booking* (Mn (SD))	18 (40)	14 (32)
Nights spent in jail *per client* (Mn (SD))	70 (100)	59 (107)
Nights spent in jail for *entire sample* (sum)	8,787	5,032
Of those with New Charge (NC) booking(s):		
Min, Max number of NC bookings *per client*	1, 43	1, 23
Number of NC bookings *per client* (Mn (SD))	5 (6)	5 (5)
Number of NC bookings for *entire sample* (sum)	314	205
Number of charges for entire sample (sum)	525	338
Charge Severity/Degree (%[5](n)):		
Infraction	1 (4)	2 (8)
Misdemeanor	84 (439)	79 (266)
Felony	16 (82)	19 (64)
Charge Type (%[6](n)):		
Person	9 (44)	7 (21)
Property	26 (132)	28 (89)
Drug	20 (100)	27 (86)
Public Order	36 (183)	30 (98)
Obstruction	9 (46)	9 (28)

[1] Jail data were available through 12/31/17.

[2] Follow-up timeframes for post-start jail bookings vary by client, ranging from 8 to 1,279 days (Mn = 875, SD = 439); because of this variation, the two columns are not comparable.

[3] Does not include holds.

[4] 125 of 277 clients (45.1%) had jail events during the two-year pre-intake time period relevant to this table; 195 of 277 clients (70.4%) had jail events since 2009 (data not shown in table).

[5] Percentages here represent percentages within the crime severity category and, therefore, sum to 100% (within rounding) across infractions, misdemeanors, and felonies.

[6] Percentages here represent percentages within the charges types and, therefore, sum to 100% (within rounding) across the five charge types provided; though they occurred, other charges (20 total pre, 16 total post) were rare and are not represented in the table.

Because the pre and post periods in the table above are not equivalent for the scattered site clients, it is impossible to determine whether incidents of criminal behavior differed after enrollment. Accordingly, analyses were again conducted to examine whether, over

equivalent periods within persons both pre and post, new charge bookings, crime severity, and days in jail changed from pre- to post-enrollment.

As before, the three figures that follow provide visual summaries of significance tests that were conducted for each outcome. Figures provide a visual density plot showing the count (i.e., number of occurrences) of each outcome by period (i.e., pre- and post-intake). The density plots in this section have the same properties as those above.

Figure 7 provides results for the analysis of number of new charge bookings per client. The number (and range) of new charges is provided on the horizontal, x-axis, while the number of clients with each value of a new charge is provided on the vertical, y-axis. The figure's x-axis has been rescaled using a square root transformation, which compresses the x-axis and reduces skew. Looking at posttest values, we see slightly more zeros (or no new charges) relative to pretest. While the two time periods are similar on the high number of new charges, clients were notably more likely to have a small number of new charges (e.g., 1 or 2) at pretest relative to posttest.

The figure, with corresponding vertical lines, also shows that the mean post-intake is significantly less than pre-intake (p=.000), indicating clients had fewer new charge bookings on average post-intake relative to pre-intake. Although alternative explanations for the difference (e.g., regression to the mean) cannot be ruled out in this observational design, the analysis of equivalent time periods does indicate fewer new charge bookings post-intake, which *may* be attributable to program effects (among other possible explanations).

Figure 7

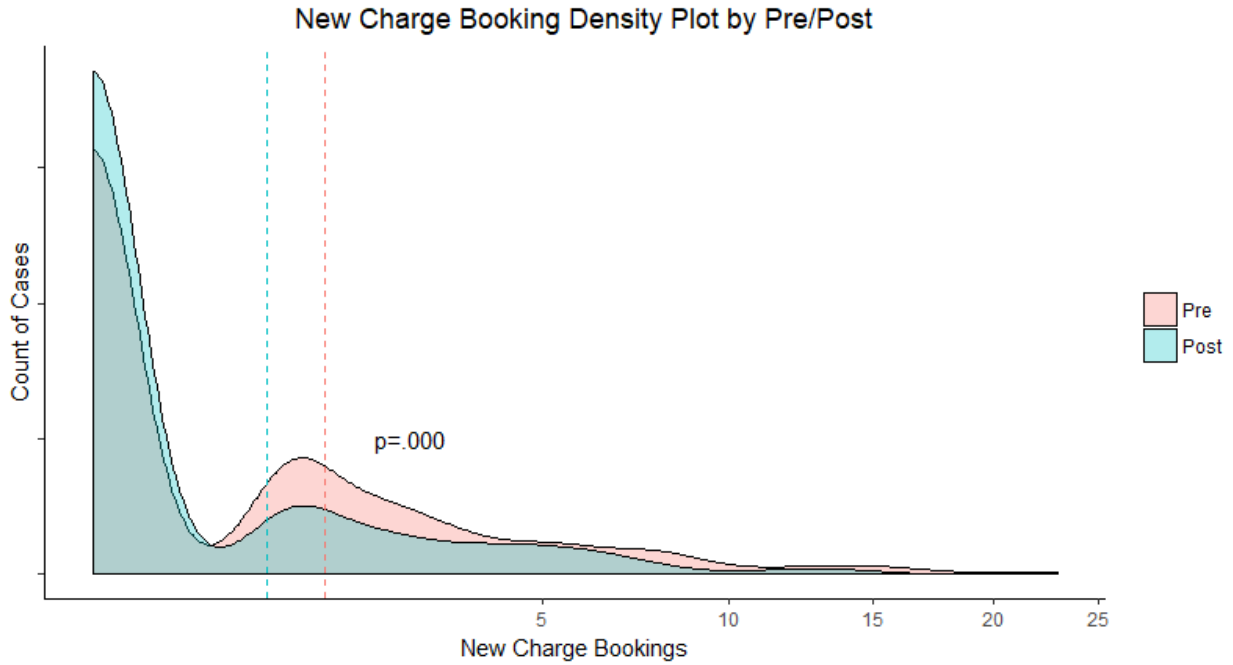
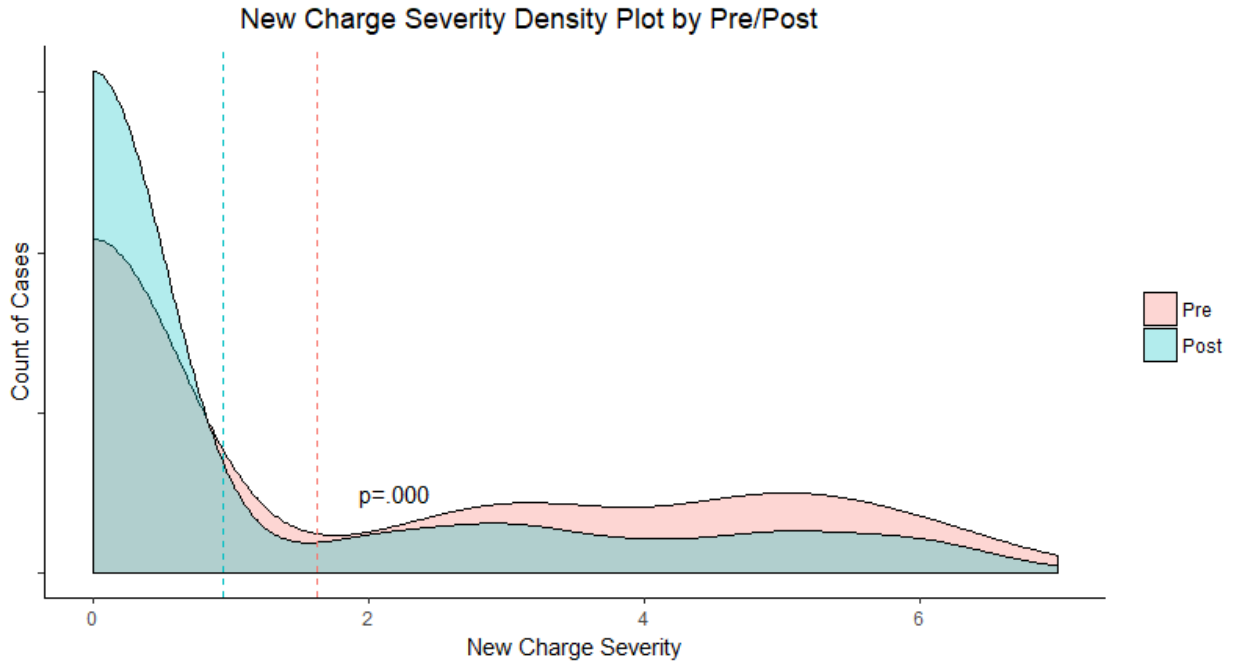
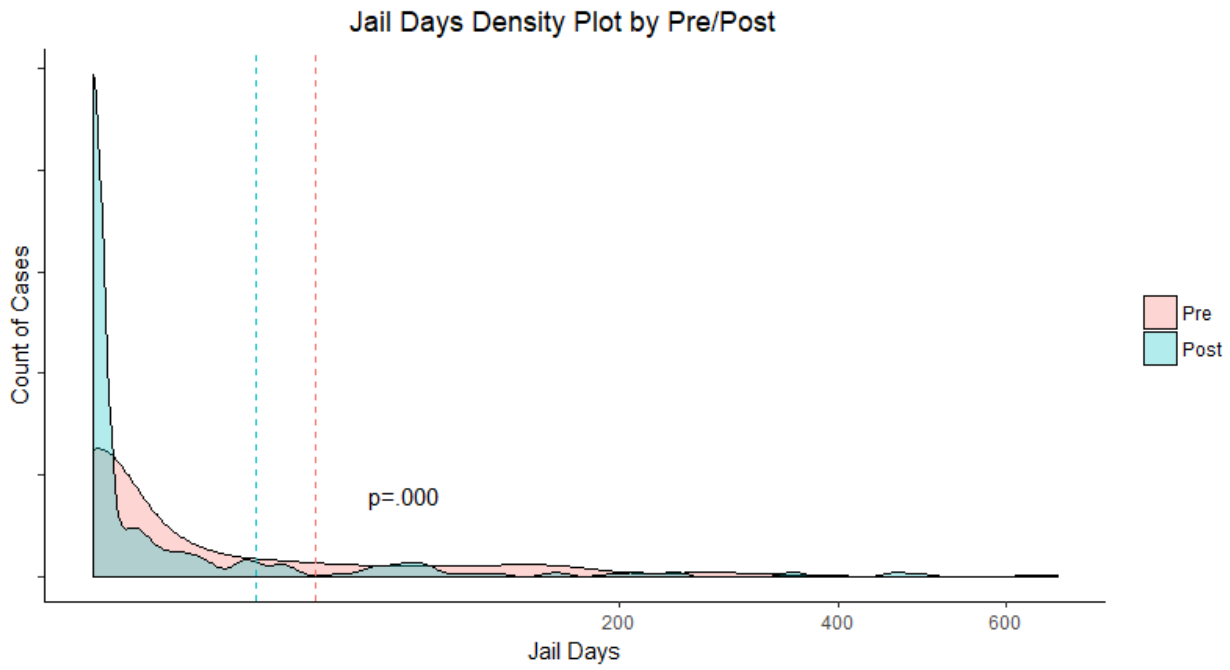


Figure 8 below provides results for the analysis of the maximum severity of offenses by time-period. As before, crime severity ranged across the following values: 0 (no crime), 1 (infraction), 2 (class C misdemeanor), 3 (class B misdemeanor), 4 (class A misdemeanor), 5 (third degree felony), 6 (second degree felony, and 7 (first degree felony). Therefore, higher means/values are less desirable on the outcome and indicate a crime of greater severity. The figure, with corresponding vertical lines, shows that the mean crime severity post-intake is significantly less than pre-intake (p=.000), which *may*, again, be attributable to program effects (among other possible explanations). Notably, there are a greater number of zeros (no new charge) during the post-period relative to the pre-period.

Figure 8



Finally, Figure 9 below provides results for the analysis of the number of jail days by time-period. For ease of visual interpretation, the figure's x-axis has again been rescaled using a square root transformation, which compresses the x-axis and reduces skew. The figure shows that the mean number of jail days post-intake is significantly less than pre-intake (p=.000). It is also notable that many more clients had 0 jail days in the post period than in the pre-period.



Congregate-site jail bookings. Salt Lake County Adult Detention Center (ADC) records were next examined for individuals with a congregate site housing placement. These placements consist of both HSSP and HIFI clients, and so are not mutually exclusive from analyses involving those groups. Clients were only considered for this analysis if they had a program intake date preceding the most recent available date for which ADC data were available (i.e., 12/31/2017); however, in the case of congregate site placements, no cases were removed from the analysis because they had enrollment dates after this date. There were 29 congregate site cases available for analysis.

Twelve of 29 congregate site clients (41%) were booked into the ADC at least once during the two years prior to enrollment, most commonly for new charges or warrants/summons (see Table 31). These 29 congregate site clients accounted for 23 new charge jail bookings and 506 nights spent in jail during this two-year period prior to enrollment. The majority of new charges were misdemeanors (90% of all charges) and the most common pre-intake charge type was public order offenses (49% of all charges shown). These numbers suggest that, prior to their congregate site placement, just less than half of HIFI clients were involved in the criminal justice system, most commonly for non-violent, less severe offenses.

Jail bookings occurring post-program start were also examined for all scattered site clients. Because post-start periods are based on each client's enrollment date, the length of follow-up varies widely by client (Mn = 988, SD = 346) and is not equivalent to the two-year pre-intake period (which was fixed per client). During the post-start period, clients accounted for a total of 31 new charge jail bookings and 513 nights spent in jail. Similar to the pre-intake period, the majority of new charges in the post enrollment period were misdemeanors (86% of all charges) and were public order offenses (36% of all charges shown).

Table 31 Congregate Site Client Criminal Involvement—Jail Bookings 2 Years Prior to and After Congregate Site Enrollment [1]

Total Sample (N)	*29*	
Jail Bookings Prior to and After Program Start	2 Years Prior	Post-Start[2]
At least one jail booking for (% (n)):		
Any reason[3]	41 (12)[4]	31 (9)
New charge(s)	28 (8)	31 (9)
Warrant(s)	41 (12)	31 (9)
Commitment(s)	10 (3)	10 (3)
Of those with Any[3] booking(s):		
Nights spent in jail *per booking* (Mn (SD))	14 (49)	12 (22)
Nights spent in jail *per client* (Mn (SD))	42 (83)	57 (76)
Nights spent in jail for *entire sample* (sum)	506	513
Of those with New Charge (NC) booking(s):		
Min, Max number of NC bookings *per client*	1, 8	1, 25
Number of NC bookings *per client* (Mn (SD))	5 (3)	6 (8)
Number of NC bookings for *entire sample* (sum)	23	31
Number of charges for entire sample (sum)	39	58
Charge Severity/Degree (%[5](n)):		
Infraction	0 (0)	9 (5)
Misdemeanor	90 (35)	86 (50)
Felony	10 (4)	5 (3)
Charge Type (%[6](n)):		
Person	5 (2)	9 (5)
Property	28 (11)	23 (12)
Drug	15 (6)	21 (11)
Public Order	49 (19)	36 (19)
Obstruction	3 (1)	11 (6)

[1] Jail data were available through 12/31/17.

[2] Follow-up timeframes for post-start jail bookings vary by client, ranging from 201 to 1,327 days (Mn = 988, SD = 346); because of this variation, the two columns are not comparable.

[3] Does not include holds.

[4] 12 of 29 clients (41.4%) had jail events during the two-year pre-intake time period relevant to this table; 18 of 29 clients (62.0%) had jail events since 2009 (data not shown in table).

[5] Percentages here represent percentages within the crime severity category and, therefore, sum to 100% (within rounding) across infractions, misdemeanors, and felonies.

[6] Percentages here represent percentages within the charges types and, therefore, sum to 100% (within rounding) across the five charge types provided; though they occurred, other charges (0 total pre, 5 total post) were rare and are not represented in the table.

Because the pre and post periods in the table above are not equivalent for the scattered site clients, it is impossible to determine whether incidents of criminal behavior differed after enrollment. Accordingly, analyses were again conducted to examine whether, over equivalent periods within persons both pre and post, new charge bookings, crime severity, and days in jail changed from pre- to post-enrollment.

As before, the three figures that follow provide visual summaries of significance tests that were conducted for each outcome. Figures provide a visual density plot showing the count (i.e., number of occurrences) of each outcome by period (i.e., pre- and post-intake). The density plots in this section have the same properties as those above.

Figure 10 provides results for the analysis of number of new charge bookings per client. The number (and range) of new charges is provided on the horizontal, x-axis, while the number of clients with each value of a new charge is provided on the vertical, y-axis. The figure's x-axis has been rescaled using a square root transformation, which compresses the x-axis and reduces skew. The analysis indicated that there was no statistical difference between the number of new charges at pre relative to post enrollment for congregate site clients.

Figure 10

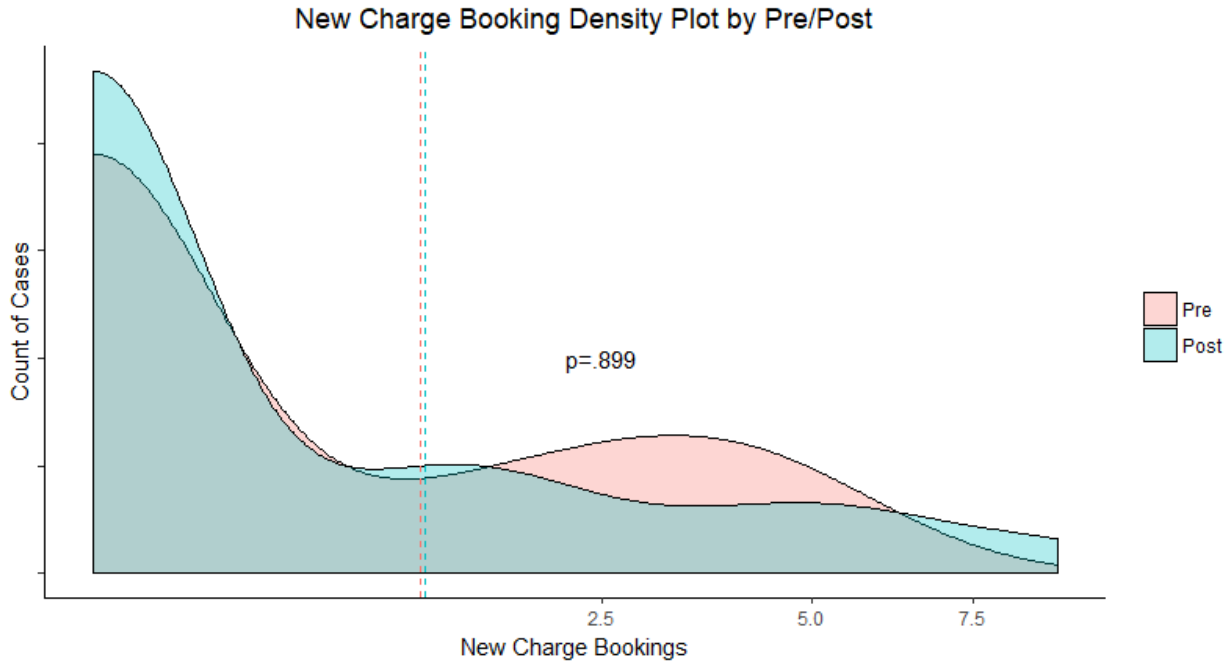
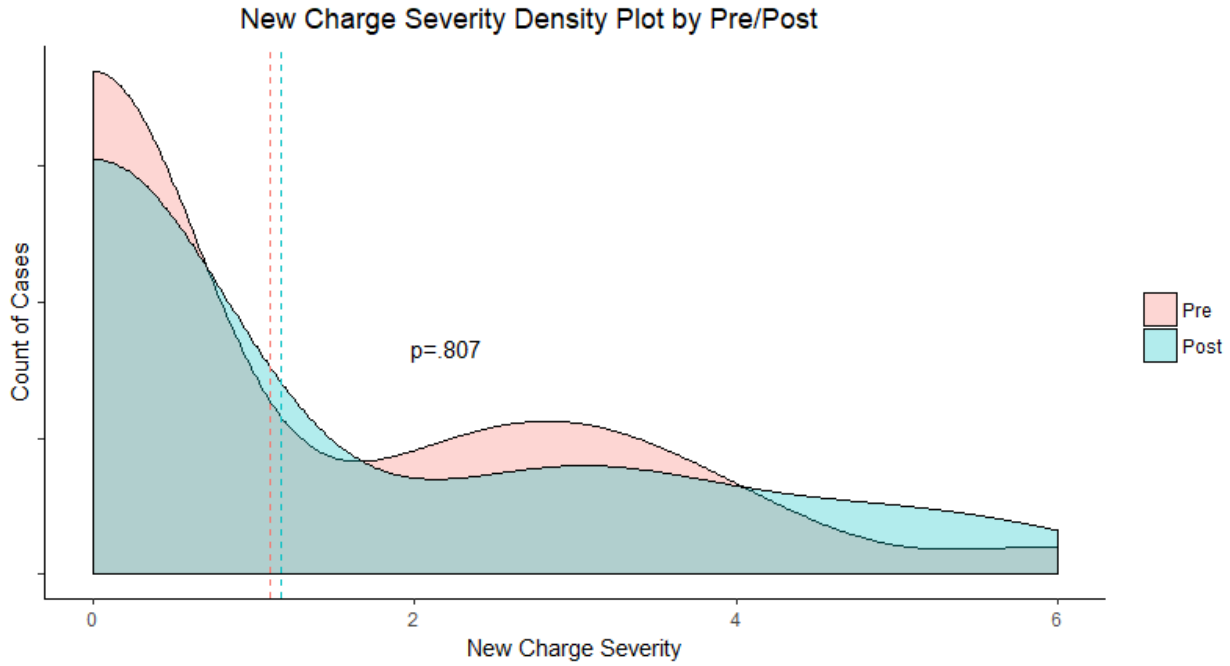


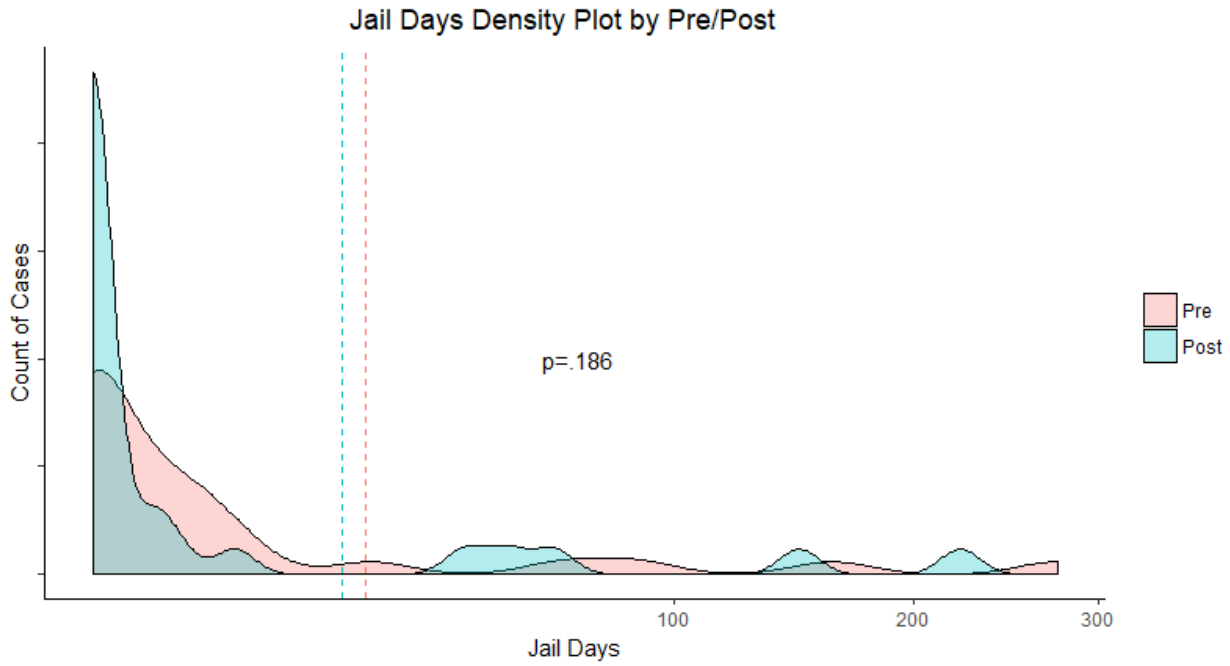
Figure 11 below provides results for the analysis of the maximum severity of offenses by time-period. As before, crime severity ranged across the following values: 0 (no crime), 1 (infraction), 2 (class C misdemeanor), 3 (class B misdemeanor), 4 (class A misdemeanor), 5 (third degree felony), 6 (second degree felony, and 7 (first degree felony). Therefore, higher means/values are less desirable on the outcome and indicate a crime of greater severity. The figure, with corresponding vertical lines, shows there was no statistical difference in the average severity of new charges during the pre and post periods.

Figure 11



Finally, Figure 12 below provides results for the analysis of the number of jail days by time-period. For ease of visual interpretation, the figure's x-axis has again been rescaled using a square root transformation, which compresses the x-axis and reduces skew. The figure, with corresponding vertical lines, shows there was no statistical difference in the average number of jail days during the pre and post periods.

Figure 12



In summary, most time-matched outcomes revealed less criminal justice involvement (with respect to the Adult Detention Center) in the period post enrollment in TRH programs or enrollment in a scattered site placement. The notable exception to this trend occurred for congregate site clients for whom criminal justice involvement and severity was not reduced post-enrollment. While this might be partly due to the smaller sample size in this group (N=29, which reduces the power to find an effect), it is also possible there is an inherent difference in either the congregate placement or the clients who receive it that makes them less amenable to change in this regard.

Housing and Overall Well-Being

Consistent with previous research, participation in HIFI and HSSP was associated with increased housing stability (Goering et al., 2014). The impact of Housing First (HF) on other indicators of well-being is less clear, with studies showing mixed results in terms of clients' mental health symptoms, substance use, overall quality of life, and social integration (Golembiewski et al., 2017; Padgett et al., 2006; Stergiopolous et al., 2015). In order to understand clients' qualitative experience in HF, one-on-one interviews were conducted with HIFI and HSSP participants. UCJC researchers interviewed 22 clients during February, 2018. Questions solicited information on clients' perceptions of the impact of housing and services on their health, finances, relationships, and overall well-being.

The interview sample was comprised of 12 HSSP participants and 10 HIFI participants. The interviews lasted one-half hour, on average, and were conducted at the HIFI offices or the client's home. Each interview was conducted by one interviewer who made written notes in addition to an audio recording of the interview. Responses were then entered into an interview document, analyzed, and summarized for this report.

Demographics. Approximately 64% of those interviewed were male (n=14). Close to one-fifth (18%) of individuals were currently homeless at the time of the interview (Table 32). Of those, all were male and most (75%) were in the HIFI program.

Table 32 Demographics

	HSSP	*HIFI*	*Total*
Sample (N)	*12*	*10*	*22*
Male (%)	50	80	64
Female (%)	50	20	36
Housed (%)	92	70	82
Homeless (%)	8	30	18

Satisfaction with living situation. On a scale of 0-7, individuals' average satisfaction with their current living situation was 4.9 (includes those who were currently housed and homeless). When comparing groups, HIFI respondents tended to report longer tenure in their housing placement, which is consistent with the data presented earlier. Among clients who were housed at the time of the interview, clients valued their housing placement because it afforded warmth, privacy, security, and appropriate facilities to sleep, cook, and bathe. Many participants appreciated that housing provided them with an opportunity to host visits from family and friends. A smaller percentage felt that housing gave them an opportunity to socialize with neighbors, which increased their sense of community belonging. With regard to the specific characteristics of their placement, the majority of clients prioritized access to public transportation, grocery stores, and other services.

Housed clients also identified several concerns regarding their housing situation. Security concerns, with respect to other residents of the apartment complex, and noise levels were the most frequently cited complaints. Drug use and activity in apartment complexes were difficult to manage, especially for clients who were trying to maintain sobriety; for others, drug activity made them feel unsafe. The fact that residents living in congregate housing demonstrated no difference in jail bookings post-enrollment may somewhat confirm clients' perception about drug use, and safety, in congregate settings. Some respondents expressed concern about the physical condition of their apartment (e.g., cleanliness, appliances not working) and also fear that the landlord might not renew their lease if they requested maintenance to address those issues.

Among clients who were currently homeless, respondents expressed frustration with finding a suitable housing placement, due to rental costs or eligibility restrictions (such as eviction history or criminal background). Several said that they had chosen to leave a previous housing placement due to frustration with noise levels, drug use, and management's rules.

Table 33 Satisfaction with Living Situation

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
I have no housing; no response (%)	0	20	9
Dissatisfied (%)	25	20	23
Neutral (%)	0	10	5
Satisfied (%)	75	50	64

Ability to pay bills. Overall, clients rated their ability to pay bills (6.6) and pay rent on time (6.8; not in table) strongly. The majority of participants felt able to pay their bills (77%, Table 36), which was largely attributed to the receipt of public benefits such as rental assistance or Social Security income; nearly all clients expressed concern they would not be able to pay bills, including rent, if they lost such assistance. Among the clients who did not have any income, several said they managed their finances by trying to avoid "having bills to pay."

Table 36 Ability to Pay Bills

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	17	20	18
Unable (%)	0	0	0
Somewhat able (%)	8	0	5
Able (%)	75	80	77

Ability to afford groceries. When compared to paying rent, participants indicated less ability to buy groceries with an average of 5.4 on the 0-7 scale (not in table). Of those who were consistently or periodically unable to afford groceries (23%; Table 37), several cited reliance on food banks as a means to supplement their income or food stamps.

Several participants described themselves as unable to afford healthy food, such as fresh fruit and vegetables. Paying rent often took priority over buying groceries; however, many clients knew how to access sources of food in case of emergency. These responses align with data previously detailed in Table 25 about TRH services, showing that over 70% of clients accessed services related to meeting basic needs, which included food.

Table 37 Ability to Afford Groceries

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	5	30	18
Unable (%)	33	0	18
Somewhat able (%)	8	0	5
Able (%)	50	70	59

Financial assistance. Participants were asked to identify those persons or agencies they turned to for assistance paying bills. Just over one-third of individuals responded that they either did not need help paying bills or would refuse to ask others for help (Table 35). The remaining participants were evenly split between identifying professionals within social services and private individuals such as family or ecclesial leaders.

Table 35 Assistance Paying Bills

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Family or Ecclesiastical Leader (%)	33	30	32
Case Management/Public Assistance (%)	33	30	32
Nobody (%)	33	40	36

Ability to save money. With respect to financial stability, clients gave the lowest rating to their ability to save money each month, with an average response of 4.2 on a 0-7 scale (not in table). Many HSSP participants felt that they could not save any money (58%; Table 38); in comparison, slightly more HIFI participants were able to save (50%). Of those who could save, many received some form of Social Security or disability payment. This aligns with financial data from TRH presented in Table 23, which showed that more HIFI participants had access to disability benefits or were employed.

Table 38 Ability to Save Money

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	17	40	27
Unable (%)	58	0	32
Sometimes able (%)	8	10	9
Able (%)	17	50	32

Transportation. When asked to identify persons whom participants asked for help with transportation, case management staff (HSSP) and nobody (HIFI) were the most frequent responses (Table 39). Case management staff identified by participants came from multiple agencies including HSSP, HIFI, and housing-specific staff. In particular, HSSP clients (many of whom had multiple case managers and treatment staff) relied on professional staff for transportation assistance. Several respondents linked this response to the question on housing satisfaction, indicating the latter partially depended on the accessibility of public transportation, which served as a primary mode of transportation for 23% of participants.

Table 39 Assistance with Transportation

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Family or friend (%)	8	10	9
Case management staff (%)	50	30	41
Public transportation (%)	25	20	23
Nobody (%)	17	40	27

Treatment services. Compared to HIFI clients, more HSSP clients had received substance abuse treatment in the past (83% vs 50%). At the time of the interview, one-half (50%) of HSSP clients were participating in regular therapy (sessions at least once a week), compared to just 30% of HIFI clients. When considering the impact of treatment, the majority of HSSP clients (67%) felt strongly that therapy helped them cope with stress, reduced social isolation, and facilitated increased access to medications and health care. HSSP clients, in particular, indicated that program enrollment increased their access to psychiatric medication.

Clients expressed some ambivalence about therapy as well. Most commonly, those concerns centered around confidentiality (particularly those participating in group interventions), having been previously "forced" to be in therapy, and feeling like the therapist did not always allow them to focus on their specific concerns (for example, treatment may be focused on substance use when the client wanted to address relationship skills). In addition, clients expressed some concern about staff turnover, which meant they had multiple clinicians or periods of time when they were between service providers.

Table 40 Impact of Treatment

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	9	70	41
Disagree (%)	5	0	5
Neutral (%)	0	0	0
Agree (%)	67	30	55

Treatment engagement. When asked whether they wanted to receive therapy (new or continuing), more HSSP clients (83%) expressed interest than HIFI (30%). Relatively more HSSP clients indicated they enjoyed therapy and felt engaged with treatment (50% vs 20%). This difference was partially explained by the integrated nature of HSSP services, wherein multiple treatment providers work together on the same team. HSSP clients, in particular, felt that their therapists and case managers worked together to coordinate services (50%; not in table). In contrast, some HIFI interviewees had case managers and therapists at entirely different agencies. In these cases, communication between the two ranged from inconsistent to non-existent.

Table 41 Treatment Engagement

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	42	80	59
Disagree (%)	0	0	0
Neutral (%)	8	0	5
Agree (%)	50	20	36

Housing and substance use. Fifteen interviewees had received some form of substance use treatment in the past. Those with a history of substance use disorders rated housing highly in terms of its positive impact on substance use (Mn= 6.4 on the 0-7 scale; not in table). Table 42 shows that 50% of HSSP clients felt that being housed led to decreased substance use. Participants cited getting away from other users, stress reduction, and fostering the development of other life goals as primary ways in which housing contributed to a reduction or cessation of substance use. Of note, some clients also noted concerns with their housing placement with respect to substance use, particularly drug use by other apartment complex residents and the lack of daily structure relative to the emergency shelter.

Table 42 Housing and Substance Use

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	50	70	59
Disagree (%)	0	0	0
Neutral (%)	0	0	0
Agree (%)	50	30	41

Housing and relationships. Of those respondents who had housing, most endorsed a positive impact of housing on relationships with family and friends, with averages of 6.5 and 6.3 respectively (not in table). Many respondents identified stable housing as helpful because it provided them with a place to visit with family; as a result, they saw family more regularly. Other benefits of housing included an increased sense of independence and reduced worry on the part of family members. A portion of respondents indicated that housing had no impact on relationships with family, largely due to entrenched and long-term isolation from family members. Of note, the clients interviewed were individual

adults; the family relationships impacted were those of people who did not live with the client.

Table 43 Housing Improved Family Relationships

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
I have no housing; no response (%)	8	80	41
Disagree (%)	8	0	5
Neutral (%)	0	0	0
Agree (%)	83	20	55

Similarly, most participants who responded to the question felt that housing also improved their relationships with friends (not in table), because it allowed them to choose who to spend time with (in contrast to living in the shelter or public spaces). Other participants characterized housing as having a mixed impact on relationships, because of the need to establish boundaries with friends based on housing rules (e.g., no overnight visitors, no substance use). Some clients expressed a sense of social isolation when living alone and missed both friendships and social opportunities available at the shelter. This isolation was exacerbated by lack of resources, which prevented them from travelling to visit family and friends or having regular telephone access.

Community resources. Many respondents felt knowledgeable about community resources before enrolling in their current program. Commonly accessed resources include services related to disability benefits, health insurance, food banks, and housing support. Despite this familiarity, respondents felt that program staff increased the strength of their connection to service agencies. Respondents indicated they had become newly-aware of agencies that assisted with utility bills, legal concerns, and outstanding issues related to criminal justice contacts. Several participants worried that there were many more people living in homelessness than could be accommodated by existing service providers; those fears were heightened due to the new shelter system and enforcement activities tied to Operation Rio Grande.

Case manager resources. Respondents ranked their case manager, and other program staff, highly in terms of helpfulness in accessing resources, with an average of 6.8 on the 0-7 scale. Many clients provided glowing responses about the care and services provided by case managers. The most often cited ways in which case managers provided assistance were: increased access to health care; coordinating care between providers; and pro-actively working to identify and solve problems. While some respondents felt that therapists and case managers provided distinct services, others appreciated that they could turn to either provider for a range of support (both emotional and tangible). The primary critique, with respect to case managers, was a concern that they were overworked and therefore difficult to access.

Satisfaction with services. Overwhelmingly, clients in both programs were satisfied with the services they received. When comparing HIFI and HSSP, participants in

the latter program typically had more providers and received a wider range of services (particularly with respect to therapy and medication management). Even respondents who described themselves as minimally accessing services felt comforted knowing there was someone to turn to when problems arose. Clients also felt regular case management allowed them to identify and address problems—such as conflicts with other tenants—before they escalated to a level that would threaten the housing placement. HSSP clients, in particular, said that service providers worked to coordinate a range of needs, including scheduling medical appointments, providing therapy, and making sure basic needs were met. A small number of HSSP clients were resistant to therapy, but nonetheless felt they relied on the HSSP team for emotional support.

When respondents did express concerns about services, those were mostly related to limited resources, due to heavy caseloads on the part of program staff. In addition, some respondents wished they had more access to financial assistance for transportation and housing costs. Several respondents wanted case managers to devote more resources toward facilitating a sense of community among residents.

Table 44 Satisfaction with Services Received

Total Sample (N)	*12*	*10*	*22*
	HSSP	*HIFI*	*Total*
Not applicable; no response (%)	8	20	14
Dissatisfied (%)	0	0	0
Neutral (%)	17	0	9
Satisfied (%)	75	80	77

Discussion

By design, the HSSP program targeted chronically homeless persons with relatively acute needs and barriers to accessing resources. When compared to HIFI clients prior to program enrollment, HSSP clients had higher rates of self-reported substance use, higher rates of criminal justice contact, and higher rates of failed housing placements (exiting to homeless or an institution and/or exiting due to criminal activity or non-compliance with the rules of housing). When looking at program data (available only for HSSP clients), the majority of individuals were assessed as having serious substance abuse needs; had limited access to treatment, in part, due to complications of mental illness and subsequent lack of insight into the impact of substance use. Analysis of program records and case notes showed that HSSP services were provided as intended: all clients were housed, received therapy and case management assistance applying for benefits. In addition to HSSP, the vast majority of clients were receiving concurrent services through TRH. Those services included both increased dosage—in terms of case management, basic needs, and transportation—as well as a wider array of services (individual and group therapy and medication management).

In terms of outcomes, both HIFI and HSSP clients saw reduced rates of criminal justice contact and emergency shelter use when comparing pre- and post-enrollment. In both groups, fewer individuals experienced negative exits from housing (e.g., homelessness or

institutionalization) after enrollment. Nonetheless, the rate of negative exits from housing was higher for HSSP clients pre-enrollment (more clients with negative exits) and those figures remained higher post-enrollment. In part, this may be due to the fact that a substantial portion of HSSP clients continued to use substances (per self-reported GPRA data) even while in treatment. Case notes showed many HSSP clients were resistant to services, and often cancelled or skipped therapy appointments. The drop in criminal justice contacts, in conjunction with stable and relatively high rates of negative housing exits, suggests being housed allowed clients to avoid arrests related to homelessness. Nonetheless, ongoing substance use may have resulted in behavior that threatened clients' housing placement (e.g., non-compliance with the rules or destruction of property). The results confirm research showing that HF interventions can increase housing stability and reduce criminal justice contacts even among clients who continue to use substances.

Conclusion and Recommendations

The primary goal of HSSP was to increase clients' housing stability; reductions in substance use and experience of mental health symptoms were expected to facilitate this increase, but were not goals in and of themselves. The results presented here suggest the program was largely successful: after enrollment, clients spent almost no nights in the emergency shelter and were housed, on average, 60% of the time. In addition, clients had significantly less criminal justice contact, in the form of jail bookings, after program enrollment. The fact that outcomes were so similar across HIFI and HSSP is an indicator of the program's success, because HSSP targeted clients who encountered increased barriers to housing stability, even in HF programs.

HSSP was theorized to improve housing stability via the reduction of symptoms and behaviors related to untreated substance use and mental health disorders. Despite receipt of enhanced treatment services, self-reported substance use and experience of psychiatric symptoms remained relatively high. This finding replicates HF research, showing increased housing stability accompanied by ongoing substance use and experience of psychiatric symptoms. Case notes and qualitative interviews provided some insight into the impact of treatment services: 1) many clients were ambivalent about treatment, as evidenced in both clinical notes and the high number of missed or canceled appointments; 2) client crises, both in terms of basic needs and emotional well-being, often dominated therapeutic sessions, which may have interrupted progress on treatment goals while still addressing threats to housing stability; and 3) many clients were assessed, at Intake, as needing a higher level of care that the treatment services available through HSSP.

While HSSP clients undoubtedly did better in the program when compared to pre-enrollment, questions remain as to the specific types of services needed to achieve stable housing and reduced criminal justice involvement. Given clients' resistance to therapy, and a perceived drift in therapy from treatment goals toward crisis management, the same outcomes may be achievable by increasing the intensity of case management, rather than providing clinical treatment services. These results suggest the program worked because it resulted in better management, rather than elimination, of clients' behaviors and

symptoms, which suggests a need for ongoing services. Given the costs associated with the long-term provision of therapy, it may be more feasible to consider alternative program structures. For example, the same outcomes may be achieved using enhanced case management (such as ICM) models rather than treatment-focused models. Of note, however, medication management, which 80% of HSSP clients received, was perceived by staff to be central to housing stability and may be a necessary component of programs targeting similar clients.

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