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Bernalillo County Behavioral Health Initiative: Community Connections Supportive Housing Process Evaluation

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INTRODUCTION

The Bernalillo County Behavioral Health Initiative (BHI) seeks to provide a "strong continuum of care for individuals living with behavioral health conditions, along with their families" (Bernalillo County, 2023). Behavioral health conditions refer to "mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms" (AMA, 2022). The Behavioral Health Initiative began in February 2015 when the Bernalillo County Commission and voters approved a gross-receipts tax expected to generate between $17 and $20 million each year to develop a unified and coordinated behavioral health system in the County and surrounding areas (CPI, 2015). The initial structure of BHI's continuum of care programming took form in April 2015 when the Bernalillo County Commission contracted Community Partners, Inc. (CPI) to develop a business plan for a regional, cohesive system of behavioral health care. CPI proposed behavioral health programs in several categories, which were then vetted and approved for funding by the Albuquerque Bernalillo County Government Commission. One of the programs funded as part of BHI is the Community Connections Supportive Housing (CCSH) program.

The CCSH Program seeks to provide housing and intensive case management services to chronically homeless individuals in Bernalillo County who have mental illnesses, drug use disorders, and are frequent users of criminal justice and emergency medical systems. The goal of the program is to help this target population to remain permanently housed as well as to reduce use of emergency services and recidivism. Providing supportive housing for individuals suffering from behavioral health issues is considered a critical part of the behavioral health care continuum (SAMHSA, 2023).

The CCSH program is a collaborative endeavor by BHI, Bernalillo County Housing Department (HD), and the City of Albuquerque Family and Community Services (FCS). BHI and FCS provide funding for vouchers and HD administers the housing vouchers to qualifying individuals. BHI also contracts with two community-based providers, Crossroads for Women (CFW) and the University of New Mexico Hospital Community Based Services (CBS), who provide intensive case management services to individuals receiving housing vouchers. The City of Albuquerque contracts with Albuquerque Health Care for the Homeless to provide additional services.

To better understand how the CCSH program is being implemented, BHI contracted with the Institute for Social Research (ISR) at the University of New Mexico to conduct a process evaluation. This addresses another core component of BHI's mission, which is to research and evaluate the implementation and impacts of programs it funds. ISR completed a preliminary process evaluation of CCSH in 2017, but since then the providers' programs have changed. The current report provides an evaluation of these modified programs.

Process evaluations are aimed at understanding the internal dynamics of how a program operates. The primary objective of a process evaluation is to assess whether a program has a logical design that utilizes evidence-based practices and whether the program is faithfully implementing that design in practice. This is important because implementing a program according to its design (and best practices) is expected to improve outcomes. Outcomes refer to the improvements a program is designed to produce in its clients and the broader community. A secondary objective of a process evaluation is to assess whether and how program outcomes can be evaluated in the future.

Based on a review of the scientific literature, the evidence-based housing models that are closest to the CCSH program in terms of its goals, target population, and intervention strategy are the Permanent Supportive Housing (PSH) and Housing First (HF) housing models. Based on this literature and an initial review of CCSH program documents, we identified three research questions to guide our process evaluation:

1. **Does the design of the CCSH program adhere to evidence-based practices such as Housing First (HF) and Permanent Supportive Housing (PSH) models?**
2. **Is the CCSH program being implemented in accordance with its design and best practices?**
3. **What outcome data is available and how might a comprehensive assessment of program outcomes proceed in the future?**

To address these questions, we analyzed several types of data, including the scientific literature on supportive housing models, CCSH program documents, surveys of program administrators and staff, and a review of client level data from the different CCSH providers. ISR obtained approval to conduct this research from the Institutional Review Board of the University of New Mexico on 2/23/2022. This report presents the results of this research. The remainder of the report is organized into 4 sections:

1. A Literature Review section, which provides important background on the problem of homelessness in Bernalillo County and elsewhere, and evidence-based interventions to address this problem,
2. A Study Design and Methodology section, which explains how we collected and analyzed our data,
3. A Program Design section, which presents the results of our analysis of the design of the program in terms of its logic and adherence to evidence-based practices,
4. A Program Implementation section, which presents the results of our analysis of the implementation and outcomes of the CCSH program, and
5. A Conclusions section, which summarizes our main findings.

LITERATURE REVIEW

Behavioral Health and Homelessness

According to the 2019 Point-in-Time (PIT) count, the Albuquerque metro area is home to 1,524 homeless individuals (NMCEH, 2019). The PIT count is the number of people who are experiencing homelessness in Albuquerque on one specific night in January. This number gives a baseline estimate of the minimum number of people who were sleeping outside, in shelter, or in transitional housing the night of our PIT count. The 2019 PIT Count for Albuquerque reported that 33% of adults experiencing homelessness stated they have mental health issues and 28% stated they had substance abuse issues (NMCEH, 2019). Of the 567 individuals who were unsheltered, 253 (45%) reported a mental health issue and 249 (43%) reported a substance abuse issue (NMCEH, 2019). Of the 735 individuals who were living in emergency shelters, 185 (25%) reported a mental health issue and 138 (18%) reported a substance abuse issue (NMCEH, 2019). Finally, of the 222 individuals who were living in transitional housing, 66 (30%) reported a mental health issue and 47 (21%) reported a substance abuse issue (NMCEH, 2019). Similarly, the 2017 PIT count for Albuquerque included 379 chronically homeless individuals, 419 severely mentally ill individuals, 381 chronic substance users, and 160 veterans (NMCEH, 2017).

The PIT count does not tell us how many people were staying in motels or doubled up with family or friends. Because we know many people, especially families and unaccompanied youth, are in this situation we know the PIT count is an undercount and the number of people experiencing homelessness in Albuquerque is higher (NMCEH, 2017). A study produced by the Urban Institute estimated that 2,200 households in Albuquerque needed permanent supportive housing as of May 2020 (Leopold et al., 2020). At the same time as more households need permanent supportive housing, median rent prices have significantly increased in Albuquerque. From November 2020 to November 2021, the median rent for a 1-bedroom apartment in Albuquerque rose by 12.8% and the rent for a 2-bedroom apartment rose by 15.5% (Andrews, 2021). These increases compound on each other month by month, and it is known that median rent increases are positively associated with increases in homelessness (Quigley & Raphael, 2010). As a result, there is and will be in the upcoming months and years even more need for permanent supportive housing services in Albuquerque.

Evidence-Based Interventions

Housing for chronically homeless individuals with mental illness and/or substance abuse issues is an essential part of a continuum of behavioral health care (SAMHSA, 2023). Scientific literatures support two housing models for addressing homelessness among this target population: Housing First (HF) and Permanent Supportive Housing (PSH). The HF model involves first providing qualifying individuals with permanent housing and then giving these individuals the freedom to choose other personal goals and improvements to life through case management services, rather than tying requirements to housing (Clarke et al., 2020; Kerman et al., 2021; Latimer et al., 2020; Leclair et al., 2019; Pearson et al., 2007; Pleace, 2018, 2020).

The Pathways Housing First Fidelity Scale is used to rate programs in terms of how closely they follow the HF model and has been shown to correlate with key client outcomes of interest, such as reduced homelessness, enhanced social functioning, and improved quality of life (Goering et al., 2016; Tsemberis et al., 2013). Literatures are also in favor of a second related model, Permanent Supportive Housing (PSH). This model provides housing with no end date along with wraparound services (Aubry et al., 2020; Basu et al., 2012; DeLia et al., 2021; Dickson-Gomez et al., 2021; Hollander et al., 2021; Raven et al., 2020).

According to the HF and PSH models, an effective supportive housing program should not only provide housing but should also provide wraparound services by a dedicated team of trained behavioral health staff who help them navigate the care system and link to other community resources to help them remain housed, to reduce their utilization of emergency medical and criminal justice systems, and to improve their quality of life (Henry et al., 2015). Essential wrap-around services include case management, childcare, education services, peer support, employment assistance and job training (including supported employment opportunities), housing search and counseling, legal services, living skills (e.g., budgeting), substance use treatment, behavioral health services, and assistance with utilities and transportation (CPI, 2015).

STUDY DESIGN & METHODOLOGY

To evaluate the design and implementation of the CCSH program, we collected and analyzed 3 types of data: (1) program documents, (2) client service data, and (3) staff surveys. The methods for collecting and analyzing these data are explained below.

Program documents

We solicited program documents from HD, BHI, CFW, and CBS staff to better understand the design and implementation procedures of the CCSH program. Documents we received included a CCSH Policies and Procedures manual from DBHS and HD and contracts and financial and program audit reports for CBS and CFW. We also utilized publicly available program documents on the Bernalillo County Webpage: Community Connections Supportive Housing Administration Plan (https://www.bernco.gov/community-services/housing-services-programs/community-connections-supportive-housing-admin-plan/).

We reviewed these documents to determine the program's design and implementation plan. A program's design refers broadly to its goals and the strategy for achieving those goals. Typically, the goals deal with bringing about some positive change in a target population, and the strategy is an intervention that prior evidence suggests is effective toward this end. The implementation plan refers to the specific set of procedures a program intends to follow to deliver the intended intervention to the intended target population. This includes procedures for outreach, referral,

screening for eligibility, induction of new clients, assessing clients' needs, delivering appropriate services, and discharging clients when they complete or disengage from the program.

Client Service Data

We solicited service data to better understand how the program in fact operates and whether the plan outlined in program documents is being followed in practice. Client service records include information on client demographics (age, gender, ethnicity); referral and intake dates; assessment results (e.g., clinical diagnoses); date, type, and duration of services received; and discharge dates and reasons.

Staff Surveys

We designed a survey examining administrator and staff perceptions of the CCSH program. The survey was administered to employees of the two community-based providers: CFW and CBS. The survey included questions assessing staff work experience and training, program knowledge, job perspectives, client experiences, services provided, housing quality, impact of COVID-19, and program outcomes. The results of the survey were analyzed to assess whether the CCSH program is being implemented in accordance with the program design and best practices from the perspective of staff.

Limitations

In reporting on program activities and services provided, we are limited by the detail and completeness of the program data we were provided. For CBS, we were unable to collect raw service data due to delays in agreeing on a secure and logistically feasible method of data transfer. Ultimately, we relied instead on the monthly performance reports CBS sends to BHI and a "master list" of discharged clients (which represents less than half of all clients they saw during the study period). While these reports contain important client level data, certain key data points were missing, and the resolution of the data is generally less than that for CFW. We make note of these limitations in our analyses below when applicable.

With regards to program outcomes, we can only currently report on clients housed and program completion rates. This is a short-term outcome that shows who the program has successfully housed and provided supportive services to. However, because we have nothing with which to compare these housing rates, we cannot say whether the program is performing better or worse than expected or whether clients are doing better than they would have if they hadn't received these services. We also currently lack data on medium to long-term outcomes. These issues and limitations are discussed in depth below.

PROGRAM DESIGN

In this section, we report the results of our analysis of program documents. First, we describe the stated goals and strategy of the program and the planned implementation procedures of

the program. Then we discuss whether the design and procedures conform to evidence-based practices.

Program Goals and Strategy

CCSH aims to place chronically homeless individuals with behavioral health issues into scattered site subsidized housing units where they may continue to live indefinitely. To accomplish this, CCSH provides housing vouchers paid to local landlords and wraparound services provided by case management contractors. The target population for the CCSH program is homeless or precariously housed individuals suffering from mental illness and substance use disorder and who are frequent utilizers of criminal justice and emergency medical systems in Bernalillo County.

The program is based on a "harm reduction" model, whereby participants are offered housing without requiring that they first be sober or have successfully completed a treatment program. After providing stable housing, clients are offered treatment and other needed supports to help them minimize the harms associated with drug use, achieve greater independence and improved quality of life, and increase their chances of remaining housed permanently. These intended client improvements, in turn, are expected to contribute to the public good goals of reducing social costs associated with the use of emergency medical and criminal justice services (DBHS & HD, 2021, p. 16). Program documents identify 8 measurable outcomes the CCSH program aims to produce:

1. Increase housing retention and stability for the target population.
2. Increase of linkages to and use of vocational, employment and/or educational services.
3. Reduced use of homelessness and shelter services.
4. Reduced involvement in the criminal justice system.
5. Reduced reliance on emergency medical and mental health services.
6. Decrease in arrests, incarceration, and increased compliance with probation, if involved.
7. Decrease in usage of emergency services, including emergency room use, detoxification services, and emergency shelters.
8. Improved social determinants of health.
   (BHI, 2021a, p. 3)

The CCSH program has a range of resources at its disposal to carry out this strategy. This includes the BHI funding generated from the Gross Receipts Tax to be used for housing vouchers and case management services and the institutional knowledge and contacts of the collaborating institutions (DBHS, HD, FCS, CFW, and CBS). HD plans to leverage contacts in the Metropolitan Detention Center (MDC) and their Psychiatric Services Unit, the District and Metropolitan Courts and their pre-trial supervision agencies, and the Law Offices of the Public Defender to verify client eligibility and to facilitate the release of formerly incarcerated clients into the program (DBHS & HD, 2021). HD also maintains a list of participating landlords in the Bernalillo County area to aid clients in locating scattered site housing. The two community-

based providers contracted for case management services, CFW and CBS, have staff trained to provide behavioral health services. This includes Community Support Workers (CSWs) who are trained "to provide linkages and/or services such as (but not limited to) Medicaid Enrollment/SNAP, job development, transportation, and any other services necessary to address the unmet needs of the clients. Anticipated ancillary training may also include motivational interviewing, cultural competency, First Aid, CPR, and Mental Health First Aid" (BHI, 2021a, p. 3). Additionally, both CFW and CBS have clinicians capable of providing clinical services and rendering clinical judgments about clients' mental health needs.

Program Procedures:

CCSH program documents describe detailed procedures for referral, screening, and intake; the allocation of housing vouchers; the provisioning of case management services; and the discharge of clients from the program.

Referral, Screening, and Intake

Potential clients can be referred from various points of contact within the behavioral health and criminal justice systems. No self-referrals are permitted. Referral forms request documentation of client eligibility for the CCSH program. Eligibility criteria are that one…

1. "Be homeless or precariously housed,
1. Have a documented behavioral health condition,…
2. [Be] low income as defined by HUD income criteria,
3. Have the ability to complete activities of daily living independently and
4. Agree to participate in case management home visitation and service planning." (DBHS & HD, 2021, p. 5)

HD Intake Coordinators meet with clients and referral sources to verify documents and establish eligibility. Additional eligibility criteria are that the client be 18 years old or older, not have an extensive violent history, not require inpatient treatment for substance abuse, mental health, or medical conditions, not be anticipated to remain incarcerated more than 60 days, and consent to participate in the program including case management programming. If found eligible, the client is placed on the HD waitlist (DBHS & HD, 2021, pp. 5–6).

Individuals remain on the waitlist until funding becomes available, at which point they are drawn from the waitlist to begin the process of receiving a housing voucher and case management services. The first step after being drawn is to contact the client to schedule an application interview. During the application interview, intake coordinators again verify client eligibility (which could have changed while on the waitlist) and help them to fill out the application to CCSH. Clients are withdrawn from the program if they cannot be located to schedule an application interview following two contact attempts. If a client successfully attends their application and screening interview and is found eligible for the program, then the Intake Coordinator assigns the client to a case management service provider (CFW or CBS). The

case management service provider has 10 business days to review the application packet, determine client eligibility for their services, and notify HD of their determination. The eligibility criteria are the same as those mentioned above under the referral process. If eligible, the case manager meets with and interviews the client to assess their needs and assign a dedicated case manager.

At this point, the client is formally accepted into the program.

Voucher and Housing Selection

After being accepted to the program, the client first must attend an HD Voucher Orientation, during which program processes and requirements are explained. The client is then provided a housing voucher. The amount of the voucher is based on Housing and Urban Development (HUD) guidelines and is set such that the client is only expected to allocate 30% of their adjusted gross income to housing costs.

The case manager assists the client in finding appropriate housing, though the responsibility ultimately rests with the client. The client has 60 days plus one possible 30-day extension to find housing. Once a unit is selected, the client, case manager, and HD Intake Technician meet once to perform an initial inspection of the unit and explain expectations for the client. Thereafter, the case manager is expected to conduct home visits at minimum two times per month to visually inspect the unit for damage and compliance with the lease. Only minor children and spouses may reside in the housing unit with the client.

Case Management Service Provisioning

In addition to conducting home inspections, the case manager is also responsible for developing an individualized service plan to help the client maintain stable housing and improve their quality of life. Case managers are expected to provide or facilitate access to the following services: substance use disorder supports; vocational and educational services; behavioral health services (e.g., counseling); medical, dental, and mental health services; public benefits (e.g., SSI, TANF, SNAP, Medicaid); legal services; parenting classes and resources; and transportation services (DBHS & HD, 2021, p. 15).

Performance targets for CFW include seeing 100 female clients and their families per year and maintaining an active roster of 15 clients per case manager at a time, which may be increased to 20 clients subject to approval by the Clinical Director (BHI, 2021b, p. 7). CBS plans to see as many clients as funding permits and to maintain an active roster of 20 clients, which may be increased to 30 clients subject to approval by the Clinical Director (BHI, 2021a, p. 6). In addition to meeting with each client face-to-face a minimum of twice per month for no less than 30 minutes per contact, case management providers will also ensure that clients deemed in need of such services will have access to at least 1 counseling session per week and 1 life skills education or psychosocial rehabilitation session per week (BHI, 2021a, p. 4, 2021b, p. 7).

Discharge

Clients may be discharged from CCSH for a range of reasons. Successful discharge occurs when a client completes all program requirements or else establishes stable housing by another avenue, such as by acquiring employment that makes one ineligible for the income requirement, or by being accepted to receive alternative permanent housing supports, such as Section 8 federal supportive housing. The CFW contract states that clients are expected to remain in the program for around 2 years by which time the client is expected to have "permanent housing and long-term support services in place" (BHI, 2021b, p. 8). However, there does not appear to be any strict time limit to participation in the program.

Unsuccessful discharge can occur from various forms of program non-compliance, including eviction, not paying rent, lease violations, property damage, people living in the unit who are not permitted, non-compliance with housing voucher procedures, non-compliance with case management procedures, not participating in services and treatment agreed upon with the case manager, violent threats or behavior toward county or case management staff, criminal activity, or abandonment of the unit for 7 days or more (though the unit may be held for the client for up to 60 days if incarcerated and up to 90 days for in-patient treatment) (DBHS & HD, 2021, pp. 12–13). On a case-by-case basis, some clients may avoid discharge despite meeting the above criteria. For example, providers may help a client to find a new unit following eviction instead of discharging them, depending on the specifics of the case. Where possible, the case manager is expected to anticipate and help address potential causes for discharge before discharge becomes necessary.

Discussion

CCSH appears to have a logical design and a comprehensive set of planned procedures for implementing it. To assess the degree to which the program is designed in accordance with best practices as established by PSH and HF housing models, we refer to the Pathway Housing First Fidelity Scale. The Pathway Housing First Fidelity Scale is a validated instrument for assessing fidelity to HF best practices, which, in turn has been shown to predict outcomes such as reduced homelessness, enhanced social functioning, and improved quality of life (Goering et al., 2016; Tsemberis et al., 2013). This scale is meant to be used by a team of evaluators who rate a program along 38 items following extensive observations of its operations. Because it is not feasible to do that here, we instead use the scale items as best practice benchmarks to compare the CCSH program to. For convenience and conceptual clarity, I have condensed the 38 items of the fidelity scale to five broad thematic domains: (1) the target population and screening procedures, (2) features of housing units, (3) case management service provisioning, (4) staff training, and (5) contingency of housing benefits.

With regards to the target population, PSH and HF models are tailored to help chronically homeless individuals with mental illnesses and behavioral health issues like substance use disorder. This is the same target population CCSH identifies in program documents.

Additionally, program documents describe detailed referral and screening procedures to select for individuals in this target population.

Best practices regarding the features of supportive housing, according to the fidelity scale, include: offering clients a high degree of housing choice; ensuring housing affordability (ideally defined as 30% of income); providing scattered units within the private housing market as opposed to units within complexes dedicated to supportive housing; not requiring clients to share living spaces; and offering clients guidance with leases, utilities, and landlord relations. The CCSH program as described by program documents conforms with best practices along all these points. The only way CCSH diverges from best practices with regards to housing is on the issue of housing permanence. As the name would imply, the PSH model is intended to provide permanent supportive housing with no end date. However, CCSH program documents imply that clients are only meant to stay in the program for around 2 years, at which point they are expected to have a more permanent housing solution in place. However, clients who abide by program rules are only discharged once they successfully establish an alternative permanent housing solution, which case managers help clients to achieve. In other words, clients can stay longer than two years as needed. Therefore, this does not appear to be a significant departure from the PSH model. Nevertheless, the program could benefit from further clarifying in program documents what the purpose of the two-year time frame is and how it is to be implemented.

Best practices regarding case management services, according to the fidelity scale, include offering off-site, mobile, and 24-hour case management services; providing "person-centered" programming, meaning involving the client in setting goals and selecting preferred services to help achieve those goals; and offering psychiatric, medical, substance use treatment, educational, skill building, employment, legal, financial, and parenting services and supports (Tsemberis et al., 2013). The CCSH program generally follows these best practices in providing services of the above type, in involving clients in case management planning, in offering case management services at people's homes, and providing "…on-call case management services to its clients on evenings and weekends as necessary to maintain adequate client care during off hours" (BHI, 2021b, p. 8, 2021a, p. 5). The CCSH program deviates slightly from best practices in terms of the recommended frequency of case manager contacts and the ratio of clients to case managers. CCSH program documents specify that case managers must meet with clients a minimum of two times, face-to-face per month with a ratio of 20-30 clients per case manager, whereas the fidelity scale recommends meeting with clients once per week (i.e., 4 times per month) with a ratio of 10 clients per case manager.

In terms of staff training, the fidelity scale recommends staff be trained in motivational interviewing, which is an evidence-based technique for cultivating a desire within clients to change problematic aspects of their behavior (Bischof et al., 2021), and "assertive engagement techniques," which are methods for engaging reticent clients. CCSH program documents mention that "anticipated ancillary training may… include motivational interviewing…" (BHI,

2021a, p. 3), which suggests program designers see the value of this technique, but do not require it. Assertive engagement techniques are not mentioned explicitly, though documents do stipulate that CSWs must meet clients in their homes and utilize individualized service planning to better appeal to clients' own goals and preferences.

The most significant departure from the HF model is that CCSH makes clients' ongoing receipt of housing vouchers contingent upon their participation in case management services. While CCSH clients need not be sober when they enter the program, they may be required to participate in substance use treatments once stably housed and must consent to potential drug testing (DBHS & HD, 2021, p. 6). The HF fidelity scale, by contrast, includes multiple items rating the degree to which a program *does not* do this. The only requirement regarding case management participation that should be imposed, according to the HF model, is that clients be present to meet their case managers during the weekly half hour home visits to inspect the apartment. Apart from that, they recommend that clients be free to refuse any services they do not wish to participate in, including psychiatric and substance use treatment services, with no penalty or loss of housing benefits.

CCSH documents state that the program is based on a "harm reduction" approach, rather than the HF model (DBHS & HD, 2021, p. 2). However, it is important to note that harm reduction describes a broader philosophical approach to addressing behavioral health issues, rather than a specific evidence-based practice for addressing housing among this target population. Indeed, HF and PSH are the preeminent harm reduction inspired housing models for this target population, which are supported by the current scientific evidence. It may be that there are good reasons for diverging from these models in the case of CCSH. If so, these reasons should be better articulated so that any benefits or drawbacks to the CCSH program design can be evaluated and necessary modifications made moving forward.

PROGRAM IMPLEMENTATION

In this section we report the results of our analysis of client level data. The goal of these analyses is to assess whether the program is faithfully implementing the plan as described in program documents. First, we report on client level data from the HD waitlist, which tracks clients from referral to intake and the issuance of a housing voucher. Next, we report client level data and staff survey results for the two case management contractors: CFW and CBS. Finally, we discuss what the results say about program implementation and preliminary program outcomes.

Bernalillo County Housing Department (HD)

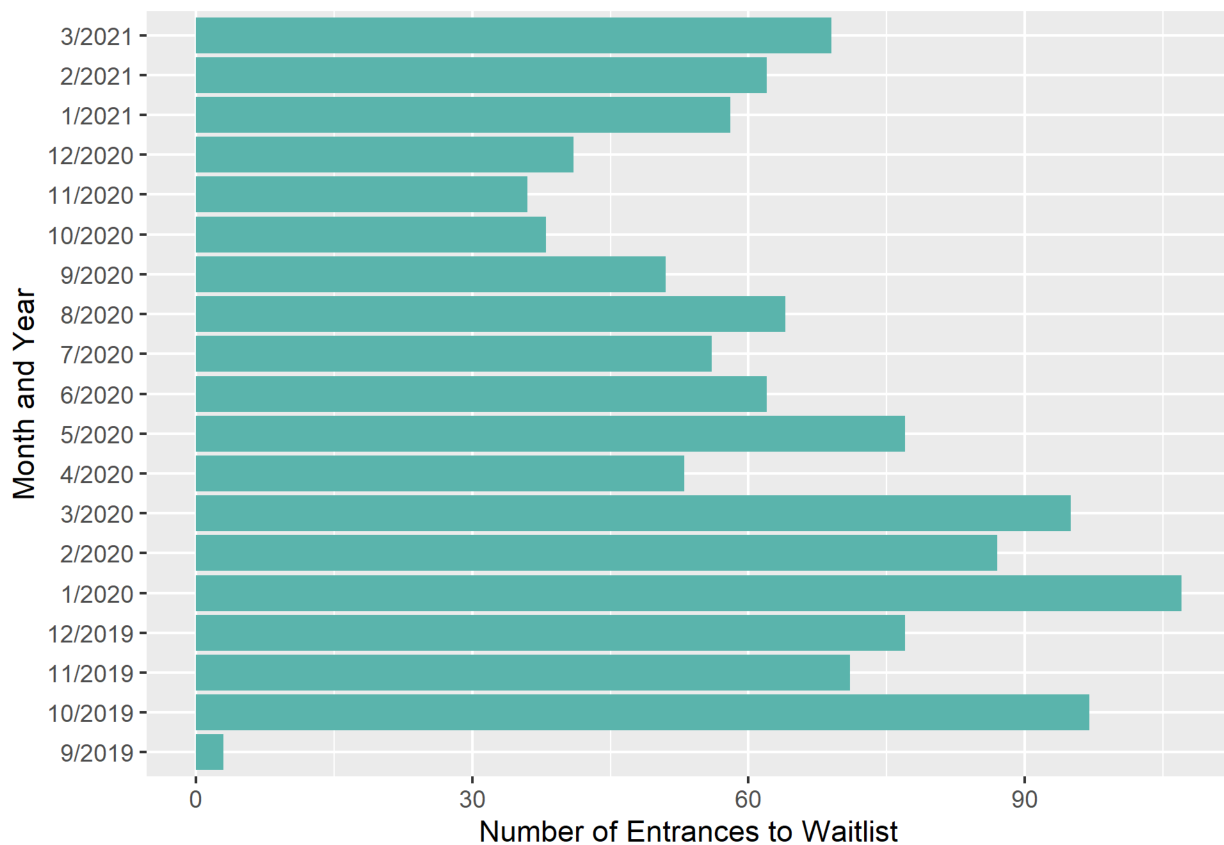
Client level data from HD covers CCSH clients from when they are initially referred to the program and placed on the waitlist, through screening, intake, and the issuance of a housing voucher.

Referral

New referrals to the program are screened for initial eligibility and then placed on the HD waitlist. According to HD service data, 1,115 unique clients were added to the waitlist between 09/11/2019 and 03/31/2021, covering a period of almost 19 months (567 days). Because some of these clients entered the waitlist more than once, there were slightly more total entrances to the waitlist during this period, at 1,204 referrals. This averages to 63.37 referrals per month. There was considerable variability in this rate across months, with a minimum of 3 and a maximum of 107 entrances to the waitlist in a month (Figure 1).

Figure 1.

Number of entrances onto the CCSH Waitlist by date.



Due to logistical difficulties with data collection, CARA opted to collect data on a stratified random sample of CCSH waitlist participants instead of for the entire client waitlist. Using random sampling techniques ensures that this smaller sample is nonetheless representative of the larger client population. To do this, ten waitlist participants were randomly selected from each month from 10/2019 to 04/2021, resulting in a sample of 180 individuals. Those in the sample who joined the waitlist from late 01/2021 through 04/2021 had not yet been drawn off

the waitlist at the time of data collection, and thus, the sample was reduced to 157 participants from 10/2019 to 01/2021. Twelve additional participants were dropped from the sample due to incomplete data, leaving 145 individuals in the final sample.

Data was collected for the sample on all instances of being entered onto the CCSH waitlist between 01/01/2019 to 12/31/2021. There were 33 (22.8%) participants who were entered onto the CCSH waitlist twice during this period, with the remaining participants being entered onto the CCSH waitlist only once.

Client Demographics

Race, ethnicity, and gender of waitlist clients is presented in Table 1 below. The most common reported race was White (71.7%), the second was American Indian/Native Alaskan (7.6%), and the third was Black/African American (4.8%). Asian or Native Hawaiian/Other Pacific Islander comprised 1.4% of the sample. The remaining 14.5% had an unreported race. In terms of ethnicity, 44.1% of the sample were Hispanic or Latino, 42.1% were not Hispanic or Latino, and the remaining 13.8% had an unreported ethnicity. Most individuals in the sample were male (57.9%), with females comprising 39.3% of the sample, and the remaining 2.8% having an unreported gender.

Table 1.

HD sample demographics (N=145).

	# of Participants	% of Participants
Race		
White	104	71.7
American Indian/Native Alaskan	11	7.6
Black/African American	7	4.8
Asian	1	0.7
Native Hawaiian/Other Pacific Islander	1	0.7
Unknown	21	14.5
Ethnicity		
Hispanic or Latino/a	64	44.1
Not Hispanic or Latino/a	61	42.1
Unknown	20	13.8
Gender		
Male	84	57.9
Female	57	39.3
Unknown	4	2.8

Date of birth was available for 141 out of the 145 individuals in the sample. Of the 141 individuals, age at date of placement onto the CCSH waitlist ranged from 19.5 to 67.1 years old, with a mean age of 37.1 and a median age of 35.7.

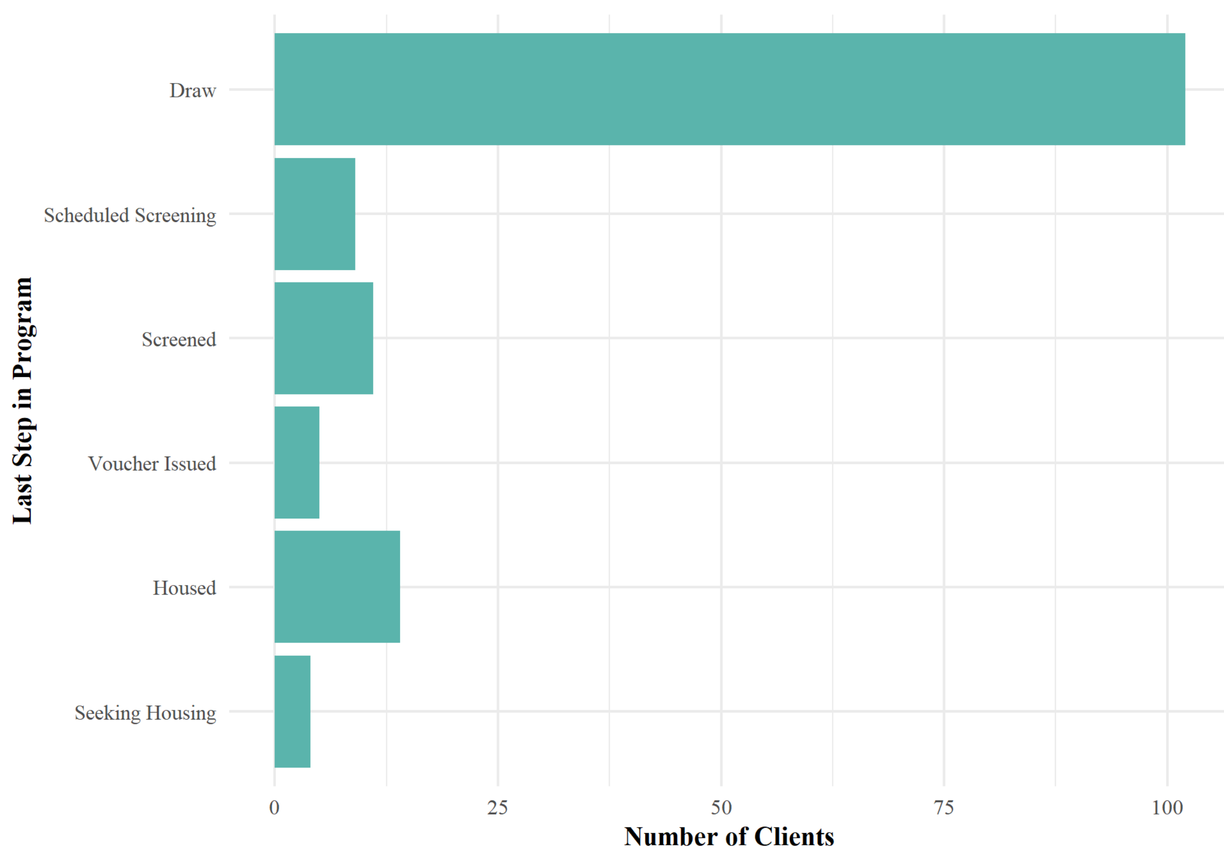
Screening and Intake

Of the 145 individuals in the sample, 102 (70.3%) did not make it further in the CCSH program than being drawn from the waitlist (Figure 2). This is the first step toward receiving a housing voucher. The next step is screening for eligibility. Approximately 6.2% of the sample (9 individuals) were drawn from the waitlist and scheduled their screening with HD but did not complete their screening. Approximately 7.6% of the sample (11 individuals) completed their screening but did not have vouchers issued. Of these 11 individuals, 6 were deemed ineligible for the program, 3 did not complete the necessary paperwork to make an eligibility

determination, 1 was no longer interested in participating in CCSH, and 1 was deemed ineligible by the assigned case manager. Five individuals in the sample (3.4%) were issued a voucher but were never housed. Approximately 9.7% of the sample (14 individuals) were ultimately housed by the CCSH program. Of these, 11 were still active in CCSH at the time of data collection. Lastly, 2.8% of the sample (4 individuals) had been issued vouchers and were in the process of looking for housing at the time of data collection.

Figure 2.

Last step in CCSH (N=145).

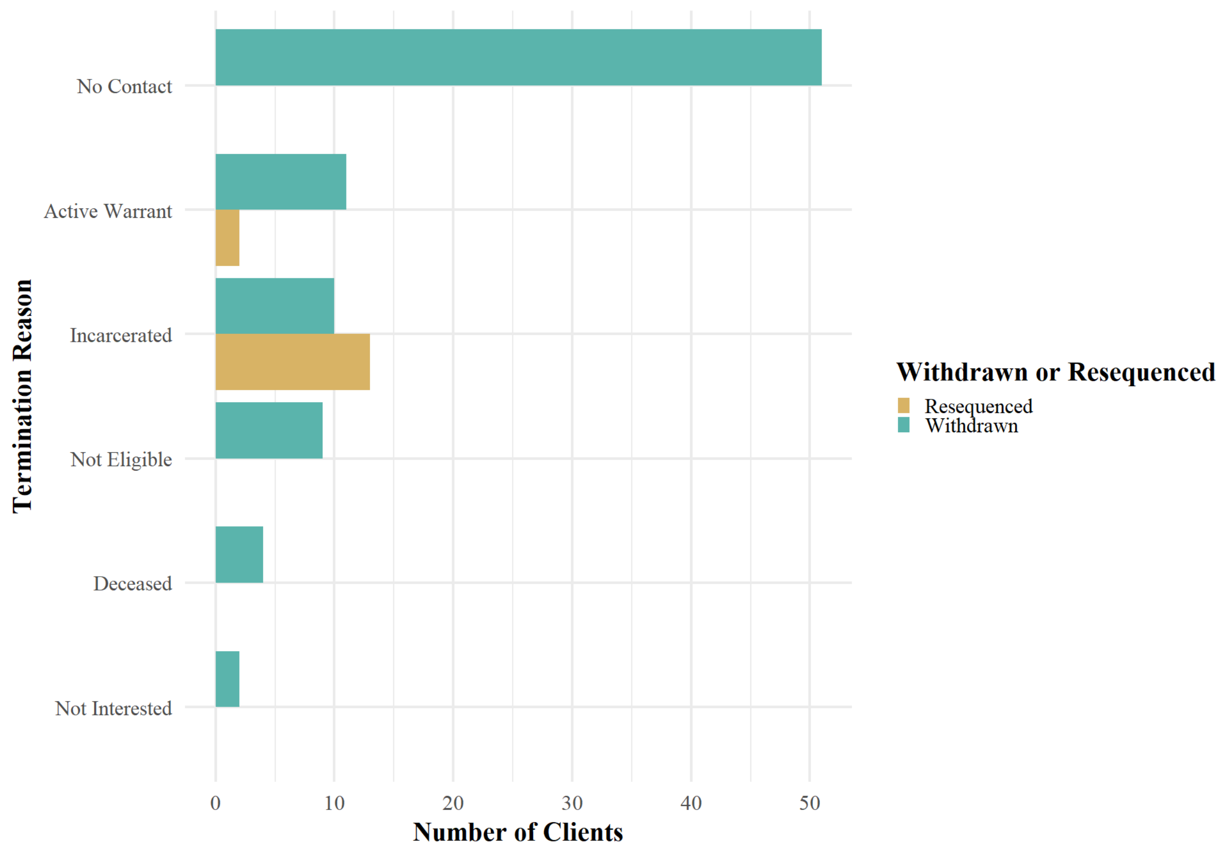


The termination reasons for the 102 individuals in the sample who made it no further than being drawn off the waitlist are presented in Figure 3. The most common reason for termination was not being able to contact the individual (50.0%). The second most common reason for termination was the individual being incarcerated (22.5%). Of the 23 individuals who were incarcerated when they were drawn off the waitlist, 13 were re-sequenced (i.e., placed on the waitlist again) and 10 were withdrawn (i.e., not re-sequenced). The third most common reason for termination was having an active warrant out when they were drawn from the

waitlist, which was the case for 13 clients (12.8% of the sample). Of these 13 clients with an active warrant, 2 were ultimately re-sequenced and 11 were withdrawn. Other reasons for termination, in order of their prevalence were being found ineligible prior to screening (8.8% of the sample), being deceased (3.9% of the sample), and being no longer interested in participating in the CCSH program (2.0%).

Figure 3.

Termination reason for clients whose last step was being drawn off the waitlist (N=102).



Of the 102 individuals whose last step in CCSH was being drawn off the waitlist, dates of termination from CCSH were collected for 101 individuals (99.0%). The length of time from entrance onto the waitlist until termination ranged from 248 days to 783 days, with an average of 514.7 days and a median of 583 days.

Issuance of Housing Voucher

A total of 23 individuals in the sample had a voucher issued. Of these, five were unable to find housing in the allotted time frame and so were terminated from the program. Ultimately, 14

individuals in the sample were housed using the voucher, 11 of whom remained active in the program at the time of data collection. Of the three individuals who had been housed but were no longer active in CCSH at the time of data collection, one withdrew due to no longer being interested, one lost their housing and was unable to find other housing, and one was deceased. Lastly, five individuals had housing vouchers issued at the time of data collection and were actively looking for housing. Of the 23 individuals who were issued housing vouchers, the length of time between entrance onto the waitlist and having a voucher issued ranged from 285 days to 759 days, with an average of 522.8 days and a median of 579 days. For those 14 individuals who ultimately found housing, the time from being issued a voucher to being housed ranged from 16 days to 122 days, with an average of 61.5 days.

Crossroads for Women (CFW)

Client data was collected for all CCSH clientele served by CFW from 01/01/2019 to 12/31/2021, comprising 198 entrances into CFW and 196 unique clients. Because one entrance into CFW was excluded for missing data, the data analyzed comprised 197 unique entrances into CFW and 196 unique clients. The data collected consisted of client demographics and services provided to each client by CFW.

Client Demographics

CFW clients ranged in age from 20 to 68 years old, with an average age of 41.5 and a median age of 39.0. Nearly half (45.9%) of all clients were from 31-40 years old (Table 2).

Table 2.

CFW client ages (N=196).

Ages	# of Clients	% of Clients
20-30	20	10.2%
31-40	90	45.9%
41-50	53	27.0%
51-60	23	11.7%
61-70	10	5.1%
Total	196	100.0%

The ethnicity and race of CFW clients are presented in Table 3. In terms of ethnicity, the majority of clients (69.5%) were Hispanic/Latino. In terms of race, the majority of clients were

White (75.6%), followed by American Indian, Alaska Native or Indigenous (9.6%), and Black or African American (6.6%).

Table 3.

Race and Ethnicity of CFW Clients (N=197).

	# of Clients	% of Clients
Ethnicity		
Hispanic/Latino	137	69.5%
Non-Hispanic/Latino	60	30.5%
Race		
White	149	75.6%
American Indian, Alaska Native, or Indigenous	19	9.6%
Black or African American	13	6.6%
Asian or Asian American	3	1.5%
Native Hawaiian or Pacific Islander	3	1.5%
Multiracial	1	0.5%
Refused/Unknown	9	4.6%

Note: Clients with more than one entry into CFW were counted for each entry into CFW.

Screening and Assessment

One requirement for participation in the program is having a diagnosed mental health condition. These diagnoses are also used for service planning. We were provided data on CFW client diagnoses based on the International Classification of Diseases (ICD-10) diagnostic categories. We simplified these diagnoses by only looking at the disease category and ignoring sub-category distinctions (e.g., F11.21 and F11.23 would both be categorized as F11 in this report). There were 45 categories of diagnoses observed in CFW clients. Only 13 of these categories had 10 or more clients with a diagnosis in each category. Counts of the number of clients with a diagnosis in each of these 13 diagnostic categories are presented in Table 4.

Table 4.

CFW Clients Diagnoses (N=196).

Diagnostic Category	# of Clients	% of Clients
Reaction to severe stress, and adjustment disorders	160	81.2%
Other stimulant related disorders	112	56.9%
Other anxiety disorders	109	55.3%
Opioid related disorders	105	53.3%
Alcohol related disorders	58	29.4%
Bipolar disorder	56	28.4%
Major depressive disorder, recurrent	51	25.9%
Depressive episode	39	19.8%
Cannabis related disorders	19	9.6%
Cocaine related disorders	18	9.1%
Adult and child abuse, neglect and other maltreatment, confirmed	17	8.6%
Attention-deficit hyperactivity disorders	15	7.6%
Specific personality disorders	10	5.1%

Note: a single client can receive multiple diagnoses, meaning individuals can be counted more than once (i.e., the above percentages will not total to 100%).

Most clients were diagnosed with an alcohol or substance abuse disorder, with 56.9% suffering from "other stimulant related disorders," 53.3% from opioid related disorders, and 29.4% from alcohol related disorders. Only 34.5% of clients had no diagnosed alcohol or drug abuse disorder. Additionally, most clients had a diagnosis of one or more mental health conditions. The most common diagnosis was "reaction to severe stress, and adjustment disorders," with 81.2% of clients suffering from this mental health condition. Only 33 clients (16.8%) had no diagnosed mental health condition.

Service Delivery

Progress notes were collected from CFW. Progress notes describe what services clients received and the dates and duration of services. The number of progress notes by service type for the period from 1/1/2019 to 12/31/2021 is presented in Table 5. The majority (51.6%) of progress notes were for independent living services. The second most common category of services was financial/educational/vocational (11.4%), followed by family/social services (11.4%). The least common category of services provided was recreational (0.0%).

Table 5.

Total count and duration (in hours) of services provided by CFW each year and for the entire study period.

Service Category	Total Count	Total Duration	2019 Count	2019 Duration	2020 Count	2020 Duration	2021 Count	2021 Duration
IL	11103	5622.5	1412	882.25	5096	2383	4595	2357.25
F/E/V	2453	1083.75	337	242.5	1152	461	964	380.25
F/S	2446	1366.5	527	420.5	901	429	1018	517
OTH	1842	1017.75	760	638.5	912	306.5	170	72.75
SA/R	1322	764	125	85.5	300	167.5	897	511
MH	870	517.25	256	198.75	333	165	281	153.5
MED	773	428	165	120.75	284	123.25	324	184
LGL	323	191	84	65	101	51.25	138	74.75
VOC	128	56.25	0	0	0	0	128	56.25
REC	11	7.75	0	0	0	0	11	7.75
N/A	238	0	106	0	40	0	92	0
Total	21509	11054.75	3772	2653.75	9119	4086.5	8618	4314.5

Note: F/S = Family/Social; F/E/V = Financial/Educational/Vocational; IL = Independent Living; LGL = Legal; MED = Medical; MH = Mental Health; OTH = Other; SA/R = Substance Abuse & Recovery; VOC = Vocational.

The duration of services in each category received by individual clients is presented in Table 6. There is considerable variability in terms of the quantity of service hours each client received, with a minimum of 0 hours received by at least one client in every category and a maximum of 110.8 hours received by one client for a single service category.

Table 6.

Duration of CFW services received by individual clients for each service category.

Service Category	Min	Mean	Max
IL	0.0	28.6	103.8
F/E/V	0.0	5.5	110.8
F/S	0.0	6.9	54.5
OTH	0.0	5.2	37.3
SA/R	0.0	3.9	46.3
MH	0.0	2.6	25.0
MED	0.0	2.2	29.0
LGL	0.0	1.0	13.5
VOC	0.0	0.3	4.3
REC	0.0	0.0	1.5

Note: F/S = Family/Social; F/E/V = Financial/Educational/Vocational; IL = Independent Living; LGL = Legal; MED = Medical; MH = Mental Health; OTH = Other; SA/R = Substance Abuse & Recovery; VOC = Vocational.

The number of progress notes each client received was divided by the number of days they were clients of CFW to calculate the average number of progress notes per day per client. This provides a measure of the frequency of service contacts per client. On average, clients had 0.3 progress notes per day (i.e., approximately one progress note every four days). Once again, there was considerable variation across clients, with one client receiving only 0.02 progress notes per day on average and another client receiving an average of 1.3 notes per day.

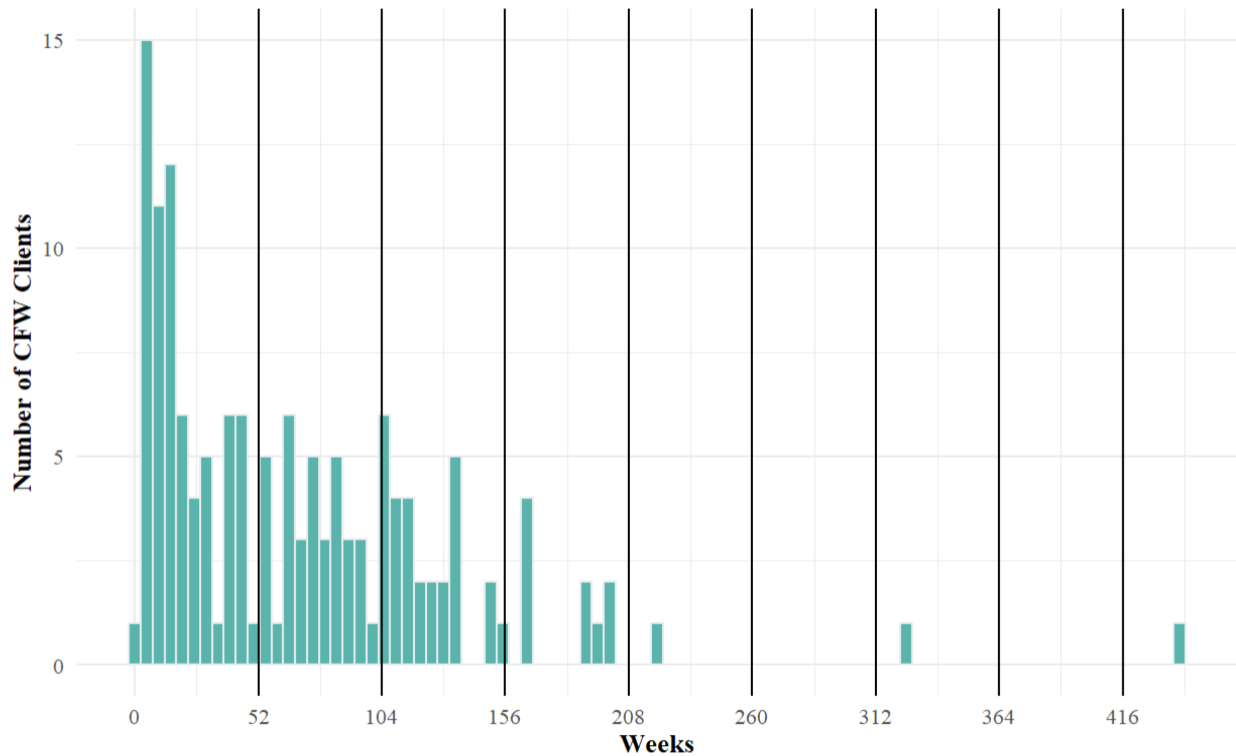
Discharges

Of the 197 unique entrances into CFW, 57 clients were active in the program as of 12/31/2021. Of the 143 discharged clients, 68 (47.6%) spent less than one year as a client of CFW, 37 (25.9%)

spent between one to two years, 25 (17.5%) spent from two to three years, and 10 (7.0%) spent from three to four years (Figure 4). The remaining three clients (2.1%) spent 4.2, 6.3, and 8.5 years as clients of CFW.

Figure 4

Length of time CFW clients spent in the program in weeks.

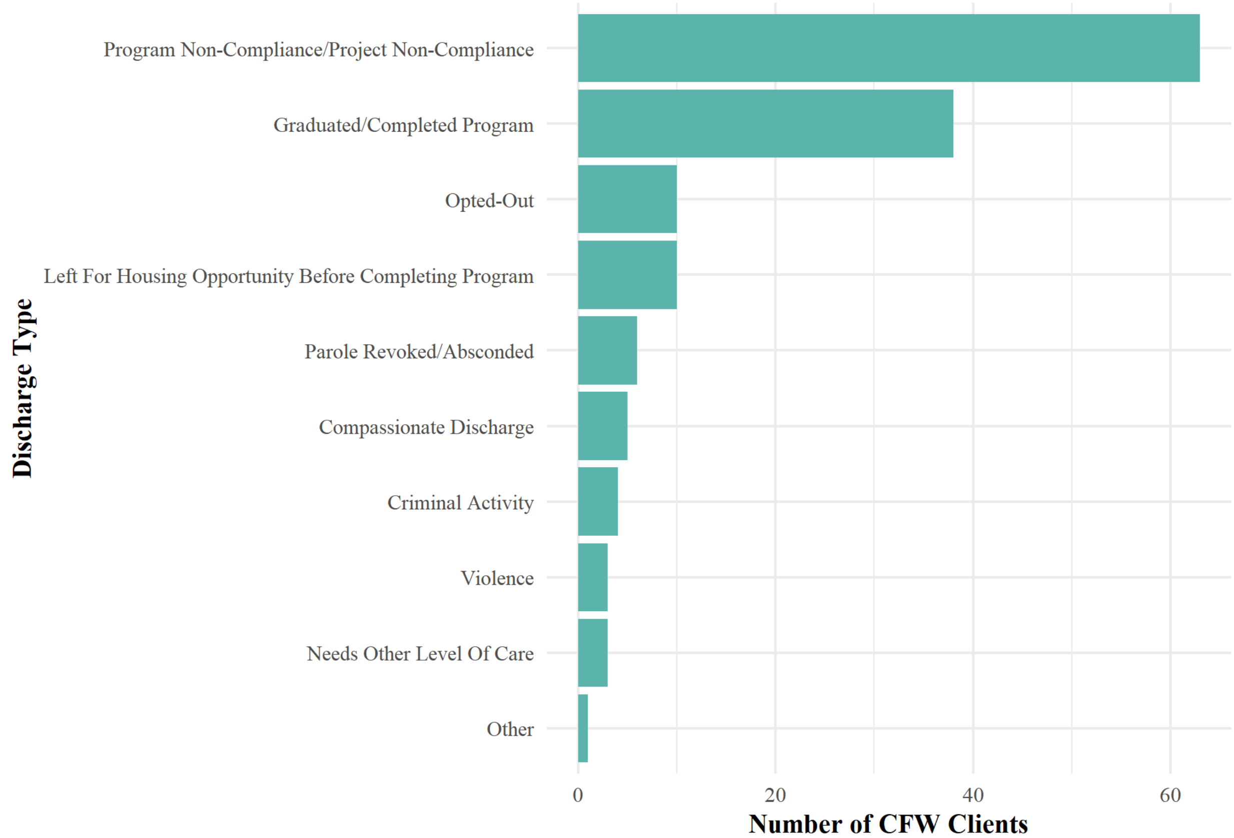


Note: Each black line marks a year.

The reason for discharge as categorized by CFW staff is presented in Figure 5. Of the 143 clients, 38 (26.6%) of clients completed or graduated from the program, 44.1% were terminated for non-compliance, 9.1% left the program due to incarceration, absconding justice, having parole/probation rescinded, or having engaged in violence. A total of 14.0% chose to leave the program due to either opting out for unspecified reasons or for other housing opportunities. Around 2.1% of all CFW clients were discharged due to needing a different level of care and 3.5% were discharged due to death (referred to as a “compassionate discharge”).

Figure 5.

Discharge reasons for CFW clients (N=143).



Discharge destination for the 143 discharged clients is presented in Table 7, describing the client's planned living arrangements after leaving CFW. Discharge destination data was missing for 55.9% of discharged clients. For those clients with discharge destination data (N=63), the most common housing arrangement was a rental with a Section 8 Housing Choice Voucher (HCV) or other housing subsidy. Staying with family/friends or jail/prison were the second most common living arraignments post-CCSH. Only one client reported living in a place not meant for habitation.

Table 7.

Discharge destination of CFW clients (N=143).

Destination	# of Clients	% of Clients
Data not collected	80	55.9%
Rental by client, with HCV voucher or other ongoing housing subsidy	26	18.2%
Staying or living with family/friends	11	7.7%
Jail, prison or juvenile detention facility	11	7.7%
Rented/Owned by client, no ongoing housing subsidy	10	7.0%
Deceased	4	2.8%
Place not meant for habitation	1	0.7%

CFW Staff Surveys

Out of ten staff and administrators from CFW who were eligible to take our staff survey, seven began the survey and four completed it. Employee backgrounds of the seven CFW staff who answered this portion of the survey are presented in Table 8. The majority of CFW respondents were community support workers (57.14%), with three other respondents (42.86%) comprising three other roles. The minimum level of educational achievement was “some college credit” (57.14%) and the highest education level observed was a bachelor’s degree (28.57%). Out of the seven respondents, only one reported not receiving any trainings specific to the CCSH program. The most common training that staff received were CPSW training (28.57% of respondents), CCSS training (28.57% of respondents), ethics (28.57% of respondents), and trauma-informed care (28.57% of respondents). All respondents felt that they were provided sufficient training for the CCSH program.

Table 8.

CFW staff roles, education, and training.

	Count	%
Role		
Program Administrator	1	16.7
Program Staff	5	83.3
Highest Education		
Some College Credit	4	57.1
Associate's Degree	1	14.3
Bachelor's Degree	2	28.6
Master's Degree	0	0.0
Received Training Specific to CCSH		
Yes	6	85.7
No	1	14.3

In terms of work experience, CFW staff had worked an average of 2.5 years for CFW and an average of 2.7 years in the field of behavioral health (Table 9).

Table 9.

Staff work experience.

	N	Mean	Min	Max
Years Worked for CFW	7	2.5	0.3	5.7
Years Worked in Field	3	2.7	0.0	6.0

CFW Staff Knowledge of the CCSH Program

Staff were asked eight questions assessing their knowledge of the program, half of which were open-ended questions. One such question asked staff if there is a CCSH policies and procedures manual, which there is. All but one respondent from CFW correctly answered that the manual does exist (Table 10). Another question asked staff if there is a time limit for which clients may participate in the program, which there isn't. Three out of four respondents correctly answered that the program had no time limit, while one respondent did not know how long the program was designed to last. Another question asked staff if there are eligibility criteria for the program, which there are. Five out of seven (71.4%) of CFW staff correctly answered that there are eligibility criteria, while two responded that they did not know. Potential clients can be excluded from the CCSH program for numerous reasons, including but not limited to, needing a higher level of care, sexual offenses, or not fully meeting the eligibility criteria. Four out of seven respondents incorrectly stated that there were not reasons for excluding individuals from participating in CCSH. However, six out of seven respondents correctly answered that there were circumstances in which a participant would be removed from the program.

Table 10.

Staff knowledge of the CCSH program.

Knowledge Area	N	# of Correct Responses	% of Correct Responses
Has a Manual	7	6	85.7
Length of Program	4	3	75.0
Eligibility	7	5	71.4
Exclusion of Clients	7	3	42.9
Client Removal	7	6	85.7

CFW Staff Perceptions of Clients

Staff were asked seven questions regarding perceptions of housed clients on a five-point Likert scale ranging from one ("strongly disagree") to five ("strongly agree"). The responses to these questions are presented in Table 11. Staff, on average, neither agreed nor disagreed with the statements that housed clients often had extensive criminal justice histories, were frequent users of ER services, and almost always had substance use or co-occurring disorders. However, there was considerable variability in staff responses with many indicating either agreement or disagreement with these statements. Most staff strongly agreed with the statement that housed clients could benefit from wraparound services, although some disagreed. Staff, on

average, were in slight agreement with the statement that housed clients are suited to scattered site housing, while staff neither agreed nor disagreed that housed clients may be better suited for single site housing.

Table 11.

Staff perceptions of housed clients (N=7).

	Mean	Min	Max
Housed Clients Often have Extensive Criminal Justice Histories	3.3	2.0	5.0
Housed Clients Often are Frequent Users of ER Services	3.0	1.0	5.0
Housed Clients Almost Always Have Substance Use or Co-occurring Disorders	3.1	2.0	5.0
Housed Clients are Good Candidates for CCSH	3.6	1.0	5.0
Housed Clients Could Benefit from Wraparound Services	4.6	2.0	5.0
Housed Clients are Suited to Scattered Site Housing	3.4	2.0	5.0
Housed Clients May be Better Suited for Single Site Housing	3.1	2.0	5.0

Staff were asked to describe the types of clients who typically succeed in the program and those who typically fail. The three respondents who responded to this question all described clients who do well as those who are motivated to change their life, and two cited engaging in vocational services. Two staff members described the characteristics of clients who do not do well in the program, which included (1) being unmotivated to change, and (2) having untreated severe mental health issues.

CFW Staff Perceptions of Services Provided

All four staff members who responded to the open-ended question "what are the primary goals of the program," responded that it was to teach skills and/or provide services for independent living and self-sufficiency.

CFW staff were asked to assess whether the CCSH program systematically delivers specific interventions to address dimensions of wraparound service provision (i.e., physical health,

employment, education, housing satisfaction, social support, spirituality, and recreation and leisure). With an inter item correlation of 0.45 for these seven questions, it is appropriate to combine these items into a mean score describing the perceived completeness of wraparound service provision. This score is presented in Table 12 below. Scores could range from one to five, with one indicating strong disagreement and five indicating strong agreement with the proposition that CFW systematically delivers comprehensive wraparound services. On average, staff scores were somewhere between agree and strongly agree (4.1).

Table 12.

Staff agreement/disagreement with the proposition that CFW offers comprehensive wraparound services (1 = "strongly disagree"; 5 = "strongly agree") (N=6).

	Mean	Min	Max
Comprehensive wraparound services are offered.	4.1	3.0	5.0

The dimension of wraparound services that CFW staff believed the program addressed the least was spirituality, with a mean of 3.0 ("neither agree nor disagree") and a range from 1.0 to 5.0. The next least addressed domain was physical health, with a mean question score of 3.7 and a range from 3.0 to 5.0. The dimensions that CFW staff believed the program addressed the most were education and employment, both of which had a mean of 4.7, and a range of 3.0 to 5.0.

CFW Staff Perceptions of COVID-19 Impact

Three questions assessed the perceived impact of the COVID-19 pandemic on the program. All six respondents strongly agreed the program was disrupted by COVID-19 and most respondents (66.7%) strongly agreed that clients participated in less programming due to COVID-19. However, respondents had a median response of neither agree nor disagree to the statement that individuals were unable to participate in the program due to COVID-19, with responses that ranged from strongly agree to strongly disagree.

CFW Staff Perceptions of CCSH Housing

Staff members were asked six questions regarding their perceptions of housing for clients. Staff strongly agreed that well-maintained rental units were essential for the wellbeing of clients and ranged from neutral to agreement with rental units being structurally safe and well-maintained (Table 13). Staff, on average, tended to slightly disagree with the statement that rental units were accessible for those with disabilities. Staff strongly agreed that rental costs were often burdensome for clients.

Table 13.

Staff perceptions of CCSH housing (N=6).

	Mean	Min	Max
Rental Units are Structurally Safe and Well-Maintained	3.5	3.0	4.0
Rental Units are Accessible for Those with Disabilities	2.8	1.0	4.0
Well-Kept and Maintained Rental Units are Essential for the Health, Safety, and Wellbeing of Clients	4.7	4.0	5.0
Rental Costs for Participants are Often Burdensome	4.5	3.0	5.0
Many Property Owners Reduced Operating Expenses and Deferred Maintenance During the Pandemic.	3.5	3.0	5.0
Rental Housing Stock is in Danger of Falling Further into Disrepair.	3.3	3.0	4.0

Note: Scores range from one to five where scores close to one indicate strong disagreement while scores close to five indicate strong agreement.

CFW Staff Perceptions of Housing First

Staff members were asked six questions regarding their perceptions of how well the program adheres to the housing first model. Most staff strongly disagreed with the statement that participants are able to quickly find housing of their choosing. Staff also tended to disagree with the statement that participants can move into housing quickly and that continued tenancy is not linked to engagement in clinical treatment or service provision (Table 14). Respondents, on average, were neutral about whether the program offers participants who have lost their housing access to new housing. These responses indicate lack of adherence to the housing first model. However, respondents ranged from neutral to strong agreement with participants having some choice in the services they receive and strong agreement with the program taking a harm reduction approach to substance abuse.

Table 14.

Adherence to the Housing First model (N=6).

	Mean	Min	Max
Participants are able to Quickly Find Housing of Their Choosing	1.5	1.0	3.0
Participants are able to Move into Housing Quickly	2.5	1.0	4.0
Continued Tenancy is not Linked in any way to Adherence to Clinical Treatment or Service Provision	2.7	1.0	3.0
The Program Offers Participants who Have Lost their Housing Access to a New Housing Unit	3.3	3.0	5.0
Participants Have Some Choice in the Services They Receive	4.3	3.0	5.0
The Program Uses a Harm Reduction Approach to Substance Use	5.0	5.0	5.0

Note: Scores range from one to five where scores close to one indicate strong disagreement while scores close to five indicate strong agreement.

CFW Staff Job Perceptions

Four scales were used to assess staff perceptions of their job. We utilized the organizational climate subsection of the CJ Survey of Organizational Functioning (TCU CJ SOF) to assess staff perceptions of their work and their employer (Institute of Behavioral Research, 2004). This assessment measures staff perceptions along six dimensions of organizational climate: mission, cohesion, autonomy, communication, stress, and change. Clients are scored along a five-point scale for each dimension, where a score close to zero indicates low levels of the variable of interest, and scores near five indicate high levels. Responses indicated high levels of adherence to the mission of CFW, cohesion among staff, and organizational communication. Respondents reported moderate levels of autonomy in the performance of their job and willingness of employees and management to change and adapt to new contingencies (Table 15).

Table 15.

CFW staff perceptions of organizational climate (N=5).

	Mean	Min	Max
TJ COF SOF OC			
Mission	4.32	3.60	4.80
Cohesion	4.37	4.17	4.83
Autonomy	3.80	3.40	4.00
Communication	4.04	3.60	4.60
Stress	2.80	2.50	3.50
Change	3.60	3.40	3.80
Total Score	3.82	3.54	4.02

Note: Scores range from one to five where scores close to one indicate low levels of the variable of interest, and scores near five indicate high levels.

We utilized two sub-scales created by Castle (2008) to measure job stress and job satisfaction. Additionally, we utilized a scale measuring personal efficacy, which refers to staff perceptions they can positively affect clients and help them accomplish their goals (Saylor & Wright, 1992). Each sub-scale is scored on a five-point scale in which one indicates strong disagreement and five indicates strong agreement that one's job experience is characterized by the attribute in question. Staff reported low to moderate levels of job stress, with an average score of 3, which is defined as neutral, or "neither agree nor disagree" with the statement that one's job is stressful (Table 16). Staff indicated somewhat higher levels of job satisfaction, with an average score of 4.1, which indicates general agreement with the statement that their job is satisfying to them. Respondents indicated even higher levels of perceived personal efficacy in their work with CFW clients, with an average score of 4.3.

Table 16.

CFW staff perceptions of job stress, job satisfaction, and personal efficacy.

	N	Mean	Min	Max
Job Stress	6	3.0	2.5	3.8
Job Satisfaction	6	4.1	3.8	4.2
Personal Efficacy	5	4.3	3.3	5.0

Note: Scores range from one to five where scores close to one indicate low levels of the variable of interest, and scores near five indicate high levels.

CFW Staff Final Perspectives

Lastly, staff were asked several open-ended questions about program outcomes and key program challenges. Four CFW staff indicated that the most accurate measure of program effectiveness is the number of participants who graduate. Several also mentioned that research reports evaluating the program were useful for measuring program effectiveness. In terms of the perceived biggest challenges to the program, all four respondents to this question cited the problem of client substance abuse. Additionally, half of respondents cited lack of transportation and other client resources, client non-compliance with program rules, and difficulty finding housing. One or more clients also mentioned the problem of untreated mental health conditions, domestic violence, staff salary, and lack of participating landlords.

UNMH Community Based Services (CBS)

Due to logistical difficulties in agreeing upon a secure and feasible method of data extraction and transfer, we ultimately used the monthly performance reports CBS sends to county as our primary source of client level data. We were provided 29 separate monthly reports covering the period from 08/01/2019 to 12/31/2021. Because these reports contained individual client names and dates of birth, we were able to match data on individual clients across months. According to the reports, CBS saw 269 unique clients during this period. Data collected included client demographics, client needs, services received that month, and discharge dates and reasons. We were also provided a "master list" spreadsheet, which contained data on 120 CBS clients who discharged from the program during the study period.

Demographics

CBS clients ranged in age from 20 to 65 years old, with an average age of 38.8. A plurality of clients (39.4%) were in the 31-40 year old age range (Table 17).

Table 17.

CBS client ages (N=269).

Ages	# of Clients	% of Clients
20-30	51	19.0%
31-40	106	39.4%
41-50	74	27.5%
51-60	29	10.8%
61-70	4	1.5%
missing	5	1.9%
Total	269	100.0%

The CBS client population was 78.1% male (Table 18). This heavy male skew is not surprising given that males account for a disproportionate share of the total homeless population (Korhonen, 2023), and because most eligible female clients are referred to CFW.

Table 18.

Gender of CBS clients (N=269).

Gender	# of Clients	% of Clients
Male	210	78.1%
Female	56	20.8%
Transgender	2	0.7%
Unknown	1	0.4%
Total	269	100.0%

The ethnicity and race of CBS clients is presented in Table 19 below. In terms of ethnicity, the client population was roughly evenly split between Hispanic/Latino (45.4%) and non-Hispanic/Latino (43.9%), with the remaining 10.8% having an unreported ethnicity. In terms of race, most clients were White (74.7%), followed by Black or African American 11.9%, and American Indian, Alaska Native, or Indigenous (8.9%).

Table 19.

Ethnicity and racial identity of CBS clients (N=269).

	# of Clients	% of Clients
Ethnicity		
Hispanic/Latino	122	45.4%
Non-Hispanic/Latino	118	43.9%
Unknown	29	10.8%
Race		
American Indian or Alaska Native	24	8.9%
Asian	1	0.4%
Black or African American	32	11.9%
Native Hawaiian or Pacific Islander	1	0.4%
White	201	74.7%
Other	3	1.1%
Refused/Unknown	7	2.6%

Screening and Assessment

One requirement for participation in the CCSH program is having a diagnosed mental health condition. These diagnoses are also used for service planning. Data on these diagnoses were limited. Monthly reports only contained data on client diagnoses from 06/2020 onward. Based on these data, 97.3% of CBS clients had at least one diagnosis for mental health or substance use disorders. However, monthlies only reported the primary diagnosis for each client each month, whereas many clients have multiple, co-occurring disorders. The “master list” dataset, by contrast, contains all diagnoses a client received throughout their involvement with CBS. Therefore, we relied on the “master list” data when analyzing client diagnoses. However, it is important to remember that the “master list” data only describes the 44.6% of clients who discharged from CBS during the study period.

Client diagnoses are based on the International Classification of Diseases (ICD-10) diagnostic categories. We simplified these diagnoses by only looking at the disease category and ignoring sub-category distinctions (e.g., we would categorize both F11.21 and F11.23 as F11).

There were 20 unique categories of diagnoses observed in CBS clients. Table 20 below presents the 9 most common diagnoses, all of which apply to greater than 5% of the observed client

population. The most common diagnosis, which applied to 41.7% of clients was “reaction to severe stress, and adjustment disorders.” The next most common diagnoses were “opioid related disorders” (35.8%), “other stimulant related disorders” (i.e., stimulants other than cocaine) (35.8%), and “depressive episode” (19.2%). Diagnoses data were missing for 46 clients (38.3%), which were recorded as either “awaiting assessment” or were left blank.

Table 20.

Number of CBS clients receiving different diagnoses (N=120).

Diagnostic Category	# of Clients	% of Clients
Reaction to severe stress, and adjustment disorders	50	41.7%
Opioid related disorders	43	35.8%
Other stimulant related disorders	43	35.8%
Depressive episode	23	19.2%
Anxiety disorders	21	17.5%
Alcohol related disorders	16	13.3%
Bipolar disorder	12	10.0%
Schizophrenia	8	6.7%
Major depressive disorder	7	5.8%
Awaiting assessment	43	35.8%
Missing	3	2.5%

Note: a single client can receive multiple diagnoses, meaning individuals can be counted more than once (i.e., the above percentages will not total to 100%).

Service Delivery

Monthly reports contained the total number of hours of “face to face” and “other” case management services a client received each month. “Face to face” case management refers to home visits and other case management services delivered in person. “Other” case management refers to phone contacts with clients as well as research done on behalf of clients (e.g., communicating with a public defender).

By summing across months, we were able to calculate the total number of case management service hours each client received. In total, CBS delivered 9,238.3 hours of “face to face” and 584.3 hours of “other” case management services during the 29-month period for which we

have data (08/01/2019 – 12/31/2021). This averages to 2.0 hours of "face to face" and 0.12 hours of "other" case management services delivered per client per month. However, there was considerable variability across clients in the quantity of case management received, with a minimum of 0 hours and a maximum of 13.0 hours of "face to face" case management received by a single client in a month.

Monthly reports also contained data on the categories of case management services delivered each month to each client (e.g., community activities, education, legal, etc.), though they do not breakdown how many hours were allotted to each service type. To analyze these data, we calculated what percentage of clients receive each category of service each month and averaged this percentage over the 29 months of service coverage. Life skills services were the most delivered category of case management service, with 85.6% of clients on average receiving this service each month (Table 21). The next most common category was mental health services (53.9%), followed by education (48.1%), and substance abuse outpatient treatment (30.3%). The least widely delivered case management services were for "other health" (4.2%) and vocational rehabilitation (9.6%).

Table 21.

The percentage of CBS clients receiving each category of case management services each month, on average.

Case Management Category	% of Clients Receiving Service Each Month
Community Activities	22.4%
Education	48.1%
Legal	21.2%
Life Skills	85.6%
Mental Health	53.9%
Other Health	4.2%
Parenting/Family Support	15.8%
Psychiatry	12.7%
Substance Abuse Outpatient	30.3%
Transportation	30.0%
Vocational Rehabilitation	9.6%

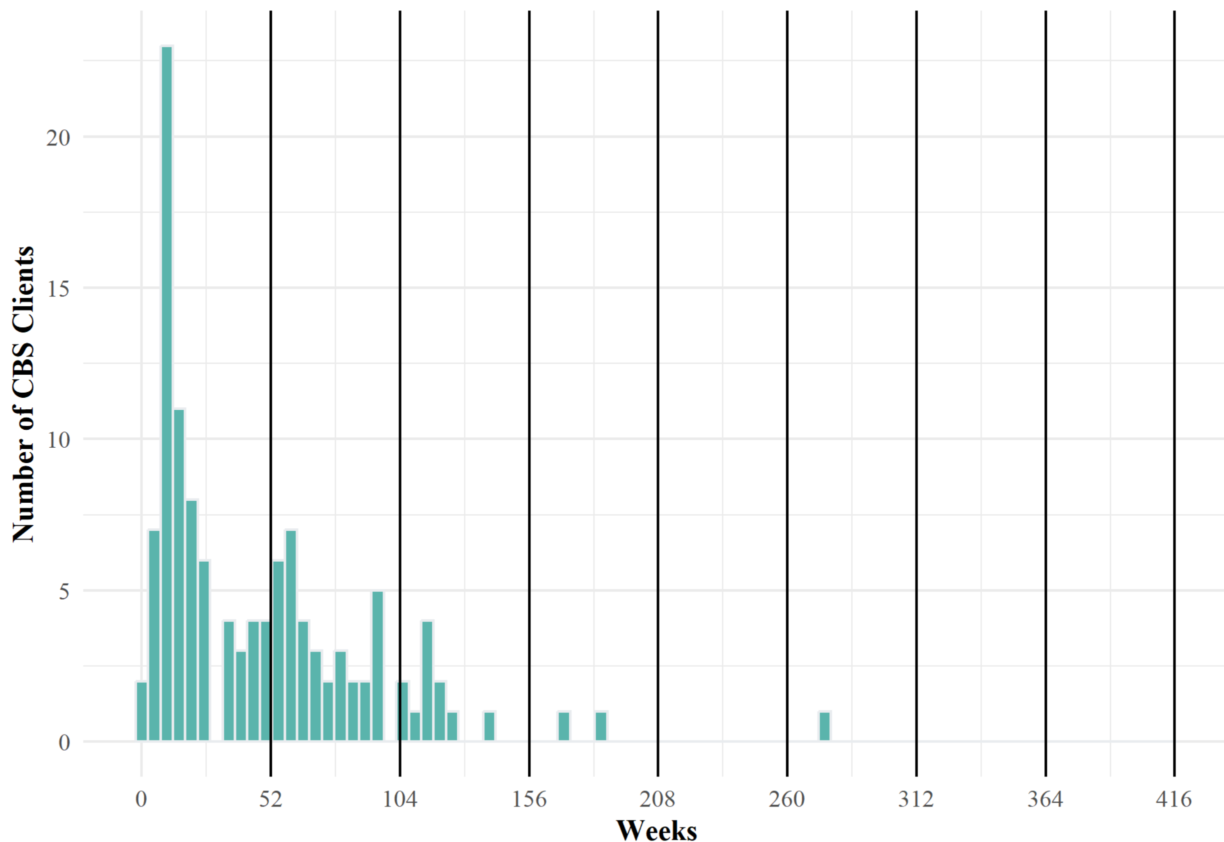
Note: most clients receive multiple categories of case management each month.

Discharges

Of the 269 clients enrolled during the coverage period, 126 (46.8%) had discharge dates. Presumably, the remaining 53.2% of clients were still active in the program as of 12/31/2021. Of the 126 clients with discharge dates, five were discarded from our analysis because they had discharge dates that were prior to their enrollment dates. One additional client was excluded from our analysis due to an enrollment date from 1980, which must be in error. This left 120 clients with enrollment and discharge dates, which we used to calculate the total time clients spent in the CBS program. Shorter client stays were the most common, with 59.2% of clients spending less than a year in the program, 30% spending 1-2 years in the program, 8.3% spending 2-3 years in the program, 1.7% spending 3-4 years in the program, and 0.8% spending 5-6 years in the program (Figure 6).

Figure 6.

Length of time CBS clients spent in the program in weeks (N=120).



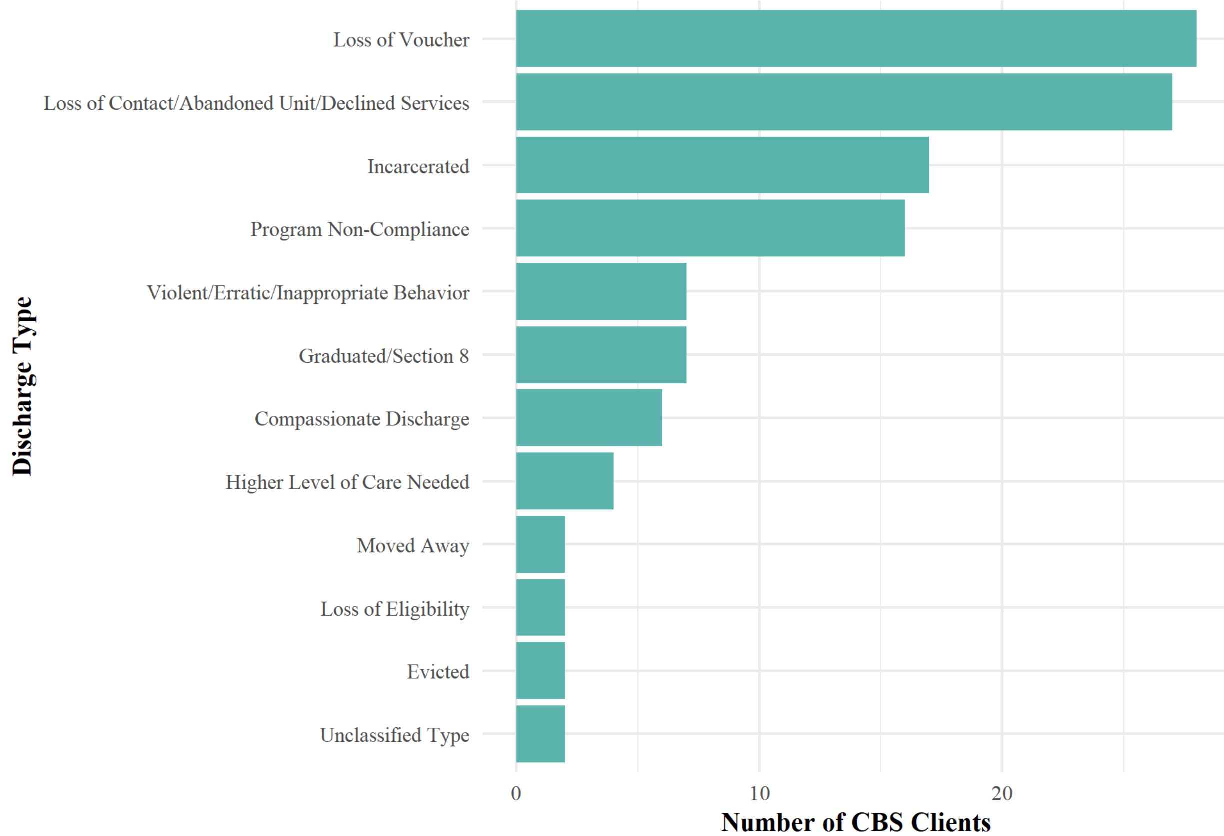
Note: Each black line marks a year.

Although monthlies report discharge dates, they do not report discharge reason. Therefore, we relied instead on the "master list" spreadsheet, which contains the discharge reason for all 120 clients who discharged during the study period.

There were 56 different categories of discharge reason reported in the "master list" spreadsheet. However, many of these categories overlapped (e.g., "CSW unable to locate client" and "Loss of contact"). By combining similar categories, we were able to group all clients into one of twelve overarching discharge categories. These categories, in order of their prevalence, were loss of the housing voucher (23.3%), loss of contact/abandonment of housing unit/declined services (22.5%), being incarcerated for an extended period of time (14.2%), program non-compliance, which includes violations of a behavior contract, program and lease violations, and lack of participation in case management programming (13.3%), violent/erratic/inappropriate behavior toward program staff (5.8%), graduation from the program or acquiring Section 8 supportive housing (5.8%), compassionate discharge (i.e., client death) (5.0%), needing a higher level of care (3.3%), moving outside the service area (1.7%), loss of eligibility (e.g., being unable to live independently) (1.7%), and eviction (1.7%). There were also two clients (1.7%) who could not be confidently classified according to any of the above categories because they were either vague (e.g., "Dismissed from UNMH) or involved multiple categories (e.g., "lost housing, missed many appointments") (Figure 7).

Figure 7.

Discharge reasons for CBS clients (N=120).



We opted to aggregate a range of discharge reasons dealing with program violations into a single "program non-compliance" category in Figure 7 above to facilitate comparison with CFW, which reports discharges according to this category. It is worth noting, however, that CBS reports more detailed categories of non-compliance, including whether the client was discharged for failing to participate in agreed to case management services, which was the case for 3 clients (2.5%). It would be useful for both providers to record "lack of participation in case management" as a separate discharge category moving forward because discharging clients for this reason represents a deviation from the HF model. Tracking the number of these discharges provides a measure of the degree to which CCSH diverges from HF in practice.

CBS Staff Surveys

Out of the eleven staff and administrators at CBS involved in CCSH, four completed the survey. Employee backgrounds of the CBS staff who answered this portion of the survey are presented in Table 22 below. One participant was a community support worker, while the other non-administrative participant worked in a supervisory role. The other two participants were

administrators occupying different positions. The minimum education level among respondents was a bachelor's degree (50.0%) and the highest education level was a master's degree (50.0%). Out of the four respondents, all four reported receiving trainings specific to the CCSH program. The most common training that staff received were comprehensive community support services (CCSS) training (75.0%), motivational interviewing training (50.0%), and monthly clinical trainings (50.0%). One respondent felt that they were not provided sufficient training for the CCSH program.

Table 22.

CBS staff roles, education, and training (N=4).

	Count	%
Role		
Program Administrator	2	50.0
Program Staff	2	50.0
Highest Education		
Some College Credit	0	0.0
Associate's Degree	0	0.0
Bachelor's Degree	2	50.0
Master's Degree	2	50.0
Received Training Specific to CCSH		
Yes	4	100.0
No	0	0.0

In terms of work experience, CBS staff had worked for an average of 3.3 years for CBS and an average of 4.0 years in the field of behavioral health (Table 23).

Table 23.

CBS staff work experience (N=4).

	N	Mean	Min	Max
Years Worked for CBS	4	3.3	0.8	9.2
Years Worked in Field	2	4.0	4.0	4.0

CBS Staff Knowledge of the CCSH Program

Staff were asked eight questions assessing their knowledge of the program, half of which were open-ended questions. One such question asked staff if there is a CCSH policies and procedures manual, which there is. All four respondents correctly answered that the manual does exist (Table 24). Another question asked staff if there is a time limit for which clients may participate in the program, which there isn't. Three respondents (75.0%) stated that clients were expected to be in the program for around two years; however, half of respondents (50.0%) stated that the program should be longer. Another question asked staff if there are eligibility criteria for the program, which there are. All four respondents correctly answered that there are eligibility criteria and identified what the criteria were. Additionally, all respondents correctly stated that there are reasons for excluding potential clients from the program and the circumstances under which participants would be removed from the program. In general, these results indicate that CBS staff are knowledgeable about the CCSH program.

Table 24.

CBS staff knowledge of the CCSH program (N=4).

Knowledge Area	% Correct Responses
Has a Manual	100.0
Eligibility	100.0
Exclusion of Clients	100.0
Client Removal	100.0

CBS Staff Perceptions of Clients

Staff were asked seven questions regarding perceptions of housed clients on a five-point Likert scale ranging from one ("strongly disagree") to five ("strongly agree"). The responses to these questions are presented in Table 25. Staff tended to agree with the statement that housed clients often have extensive criminal justice histories. All respondents strongly agreed that housed clients could benefit from wraparound services. Respondents, on average, neither agreed nor disagreed with the remaining statements about housed clients, like that they are frequent users of ER services, always have substance use or co-occurring disorders, are good candidates for CCSH, are suited to scattered site housing, or that they may be better suited to single site housing.

Table 25.

Perceptions of housed clients (N=4).

	Mean	Min	Max
Housed Clients Often have Extensive Criminal Justice Histories	4.3	2.0	5.0
Housed Clients Often are Frequent Users of ER Services	2.7	2.0	3.0
Housed Clients Almost Always Have Substance Use or Co-occurring Disorders	3.5	2.0	5.0
Housed Clients are Good Candidates for CCSH	1.8	1.0	3.0
Housed Clients Could Benefit from Wraparound Services	5.0	5.0	5.0
Housed Clients are Suited to Scattered Site Housing	2.8	2.0	3.0
Housed Clients May be Better Suited for Single Site Housing	2.5	2.0	3.0

Note: Scores range from one to five where scores close to one indicate strong disagreement and scores close to five indicate strong agreement.

Staff were asked to describe the types of clients who typically succeed in the program and those who typically fail. Three out of four respondents (75.0%) stated that being motivated to change and/or engaging in services were characteristics of clients who do best in the program. Reasons for not doing well in the program cited by staff included needing a higher level of care (75%), being unwilling to engage in treatment (75%), or being unmotivated to change (75%).

CBS Staff Perceptions of Services Provided

All four staff members who responded to the open-ended question “what are the primary goals of the program,” responded that it was to assist clients in gaining the skills necessary for independent living. Additionally, three staff indicated that providing case management services for all life domains was a primary goal of the program.

CBS staff were asked to assess whether the CCSH program systematically delivers specific interventions to address seven different dimensions of wraparound service provision: physical health, employment, education, housing satisfaction, social support, spirituality, and recreation and leisure. Responses to these seven questions were combined into a mean score for each staff member indicating their general perceptions of the comprehensiveness of wraparound services offered by CBS. This score is presented in Table 26. Scores range from one to five, with one indicating strong disagreement and five indicating strong agreement with the proposition

that CBS systematically delivers comprehensive wraparound services. On average, staff agreed with this proposition (4.0).

Table 26.

Staff agreement/disagreement with the proposition that CBS offers comprehensive wraparound services (1 = "strongly disagree"; 5 = "strongly agree") (N=6).

	N	Mean	Min	Max
Service Provision	4	4.0	2.4	4.7

The dimension of wraparound services that CBS staff believed the program addressed the least was spirituality, with a mean of 3.3 and a range from 1.0 to 4.0. The next least provided service domain was recreation and leisure, with a mean score of 3.8 and a range from 2.0 to 5.0. The domain that CBS staff believed the program addressed the most was social support, which had a mean score of 4.8, and a range of 4.0 to 5.0.

CBS Staff Perceptions of COVID-19 Impact

Three questions assessed the perceived impact of the COVID-19 pandemic on the program. Respondents ranged from neutral to agreeing with the statement that the program was disrupted by COVID-19. Respondents, on average, neither agreed nor disagreed with the statement that participants engaged in less programming due to COVID-19 and generally disagreed with the statement that individuals were unable to participate in CCSH due to COVID-19.

CBS Staff Perceptions of CCSH Housing

Staff members were asked six questions regarding their perceptions of housing for clients. Respondents tended to disagree that rental units were structurally safe and well-maintained (Table 27), while agreeing with the statement that well-kept and maintained rental units are essential for the health, safety, and wellbeing of clients. Respondents tended to disagree with the statement that rental units were accessible for those with disabilities. Staff strongly agreed that rental costs were often burdensome for clients.

Table 27.

Staff perceptions of CCSH housing (N=4).

	Mean	Min	Max
Rental Units are Structurally Safe and Well-Maintained	1.5	1.0	2.0
Rental Units are Accessible for Those with Disabilities	2.0	1.0	4.0
Well-Kept and Maintained Rental Units are Essential for the Health, Safety, and Wellbeing of Clients	4.0	1.0	5.0
Rental Costs for Participants are Often Burdensome	5.0	5.0	5.0
Many Property Owners Reduced Operating Expenses and Deferred Maintenance During the Pandemic.	3.5	3.0	3.0
Rental Housing Stock is in Danger of Falling Further into Disrepair.	4.3	3.0	5.0

Note: Scores range from one to five where scores close to one indicate strong disagreement while scores close to five indicate strong agreement.

CBS Staff Perceptions of Housing First

Staff members were asked six questions regarding their perceptions of how well the program adheres to the housing first model. All respondents strongly disagreed with the statement that participants are able to quickly find housing of their choosing, and that participants can move into housing quickly (Table 28). There was moderate disagreement with the statement that continued tenancy is not linked to engagement in clinical treatment or service provision. Respondents, on average, were neutral about whether the program offers participants who have lost their housing access to new housing. These responses indicate lack of adherence to the housing first model. However, respondents strongly agreed with the statements that participants have some choice in the services they receive and that the program takes a harm reduction approach to substance abuse.

Table 28.

Adherence to the Housing First model (N=4).

	Mean	Min	Max
Participants are able to Quickly Find Housing of Their Choosing	1.0	1.0	1.0
Participants are able to Move into Housing Quickly	1.0	1.0	1.0
Continued Tenancy is not Linked in any way to Adherence to Clinical Treatment or Service Provision	1.5	1.0	2.0
The Program Offers Participants Who Have Lost their Housing Access to a New Housing Unit	3.0	2.0	4.0
Participants Have Some Choice in the Services They Receive	4.8	4.0	5.0
The Program Uses a Harm Reduction Approach to Substance Use	5.0	5.0	5.0

Note: Scores range from one to five where scores close to one indicate strong disagreement while scores close to five indicate strong agreement.

CBS Staff Job Perceptions

Four scales were used to assess staff perceptions of their job. We utilized the organizational climate subsection of the CJ Survey of Organizational Functioning (TCU CJ SOF) to assess staff perceptions of their work and their employer (Institute of Behavioral Research, 2004). This assessment measures staff perceptions along six dimensions of organizational climate: mission, cohesion, autonomy, communication, stress, and change. Clients are scored along a five-point scale for each dimension, where a score close to zero indicates low levels of the variable of interest, and scores near five indicate high levels. CBS staff reported moderate adherence to the mission of CBS, cohesion among staff, organizational communication, autonomy, and willingness to change within the organization (Table 29).

Table 29.

CBS staff perceptions of organizational climate.

	N	Mean	Min	Max
TJ COF SOF OC				
Mission	4	4.1	3.2	4.8
Cohesion	4	4.0	3.0	4.3
Autonomy	4	3.7	3.4	4.0
Communication	3	4.1	3.6	4.4
Stress	4	3.1	2.3	4.4
Change	3	3.8	3.4	4.6
Total Score	3	3.8	3.2	4.2

Note: Scores range from one to five where scores close to one indicate low levels of the variable of interest, and scores near five indicate high levels.

We utilized two sub-scales created by Castle (2008) to measure job stress and job satisfaction. Additionally, we utilized a scale measuring "personal efficacy", which refers to staff perceptions that they can positively affect clients and help them accomplish their goals (Saylor & Wright, 1992). Each sub-scale is scored on a five-point scale in which one indicates strong disagreement and five indicates strong agreement that one's job experience is characterized by the attribute in question. Staff reported low to moderate levels of job stress, with an average score of 3, which is defined as neutral, or "neither agree nor disagree" that one's job is stressful (Table 30). Staff reported high levels of job satisfaction, with an average score of 4.8 and perceived personal efficacy in their work, with an average score of 4.4.

Table 30.

CBS staff perceptions of job stress, job satisfaction, and personal efficacy.

	N	Mean	Min	Max
Job Stress	4	2.9	2.0	4.0
Job Satisfaction	4	4.8	4.6	5.0
Personal Efficacy	4	4.4	4.4	5.0

Note: Scores range from one to five where scores close to one indicate low levels of the variable of interest, and scores near five indicate high levels.

CBS Staff Final Perspectives

Lastly, staff were asked several open-ended questions about program outcomes and key program challenges. Staff responded to the question, "What do you feel is the most accurate measure of effectiveness for the program" by citing measurable outcomes such as quality of life improvements, reduced incarceration, reduced utilization of higher levels of care, progress in treatment plan goals, and reductions in substance abuse. In terms of the perceived biggest challenges to the program, staff cited (1) a shortage of viable housing due to fewer properties accepting vouchers and landlords imposing restrictions on the types of CCSH clients they accept, (2) difficulties working with HD due to a lack of understanding about the challenges that accompany trying to house individuals with severe mental illness who often lack clear communication channels, (3) difficulties dealing with clients in need of higher levels of care, and (4) issues around low client engagement.

Discussion

The data from HD, CFW, and CBS reported above reveal that the CCSH program is, for the most part, being implemented according to plan and to best practices.

HD generally follows planned procedures with regards to referral, screening, and intake of new clients to CCSH. The HD waitlist data shows numerous individuals being referred to the program and added to the waitlist each month. When funds become available, clients are being drawn from the waitlist and screened for eligibility to receive a housing voucher. That these procedures are working in terms of locating individuals from the intended target population is evidenced by staff perceptions of CCSH clients as well as case management service data on client diagnoses, which show high rates of behavioral and mental health issues among the client population. Over 65% of CFW clients had a diagnosed alcohol or drug abuse disorder and 83.2% of clients suffer from a mental health condition. Similarly, 97.3% of CBS clients had at least one clinical diagnosis for mental health or substance use issues, and many had multiple such diagnoses. Of those in our sample who received a voucher, 78% were either housed or

actively looking for housing at the time of data collection. This is close to the target of housing 85% of individuals receiving a voucher, which is a performance benchmark set forth in the HF fidelity scale of best practices (Tsemberis et al., 2013, p. 1).

The two case management contractors, CFW and CBS, appear to generally provide services of the intensity and types outlined in planning documents. CFW served 197 unique clients during the 3-year study period from 01/01/2019 to 12/31/2021. This averages to 65.7 clients per year, which is somewhat less than their target of seeing 100 clients per year. CBS saw 269 clients in the 2.4-year study period from 08/01/2019 to 12/31/2021, which averages to 112 clients per year. In terms of the amount of case management services offered per client, CBS provided an average of 2.12 hours of services per month per client. This is more than double the minimum number of services specified in program documents (two half hour face to face visits per month per client). Similarly, CFW clients received, on average, one service contact every four days, indicating a high rate of case management provisioning. The two providers are similar in terms of what types of services they provide the most. The service CFW offered the most, in terms of service hours was, independent living, followed by financial/educational/vocational, family/social, other, and substance abuse and recovery services. The most common service for CBS was life skills, followed by mental health, education, substance abuse, and transportation. Service data also reveals considerable variation across individuals in terms of the quantity and types of services received. This is consistent with providers following the stated plan of offering individualized services tailored to the unique strengths, needs, and preferences of each client. The breadth and individualization of services offered is further corroborated by staff survey responses.

Discharge data shows that clients are being discharged from the program for the reasons outlined in planning documents, such as non-compliance, incarceration for over 60 days, and successful program completion (i.e., graduation). The fact that clients are graduating from the program further reveals that CCSH is successfully moving some clients through all phases of the program up to the point that they have achieved a sufficient level of housing stability, either through financial independence or alternative supports (e.g., Section 8).

There are, however, some aspects of program implementation that merit further scrutiny because they diverge from best practices and/or are not functioning as well as may be expected. With regards to referral, screening, and intake, it is striking that most individuals who are added to the HD waitlist are not ultimately housed. Indeed, over 70% don’t make it further than having their name drawn from the waitlist. This is at least partly attributable to the long wait times, which may be caused by the limited availability of funding or other bottlenecks in the processing of HD clients. The average wait time from being added to the waitlist to being drawn is over 500 days, during which time many individuals’ circumstances and needs will have changed. This issue is compounded by the fact that homeless individuals with behavioral and mental health issues have inherently unstable living situations. Half of clients who were discharged after being drawn from the waitlist could not be located by HD staff. An additional

35.3% were incarcerated or had an active warrant for their arrest. Ultimately, only 9.7% of the individuals in our waitlist sample ended up housed by the CCSH program. Future research might look at how screening procedures and the effectiveness of attempts to contact drawn individuals could be improved. However, it may be that a low rate of housed clients is unavoidable when dealing with this target population and long wait times.

Out of the 145 individuals in our waitlist sample from HD, 23 (15.9%) were successfully contacted, screened, and issued a voucher. Of these, five individuals never found housing. This could be due, in some instances, to a lack of initiative on the part of clients to locate appropriate housing. However, another key reason could be that qualifying housing is in short supply. Survey responses show that staff from both CFW and CBS believe housing stock is declining and a key barrier to program effectiveness is the general lack of safe, accessible, and cheap housing and/or the limited availability of housing units that accept program vouchers. This could also explain the delays between receiving a voucher and finding housing. According to HD data, the average time from being issued a voucher to being housed by CCSH was 61.5 days. This exceeds both the 42 day timeline set forth as a best practices benchmark in the HF fidelity scale (Tsemberis et al., 2013, p. 1) and the 60 day initial cutoff to find housing specified in program planning documents. Increasing the supply of qualifying housing and/or assisting clients in their search for housing could be a fruitful area for future program improvement.

Another possible area for improvement is with data collection and reporting. Our analysis of the case management providers was limited by the resolution of the data. The monthly performance reports sent to county, which we relied on for our analysis of CBS, lack crucial detail with regards to service hours by type. CBS collects these data in their Cerner database in the form of individual service notes, but extracting these data would be time consuming as it requires reading the individual notes in narrative form. Presumably, this is how the monthly performance reports are generated. Incorporating more structured data entry fields in the Cerner database and/or adding fields to the performance reports for service hours by type would facilitate future program evaluation and quality improvement efforts. Another data collection issue is that the two case management providers utilize different categories for recording discharge reasons, which makes comparison across programs difficult. Standardizing the reporting of discharge reasons using a smaller set of discharge categories relevant to program goals and processes could facilitate ongoing quality improvement efforts.

Standardizing reporting on discharge reasons is also critical for assessing the degree to which the CCSH program diverges in practice from the HF model by discharging clients for failing to participate in case management services. While CBS reports “lack of participation” as a discharge reason, CFW reports only the broader category of “program non-compliance,” which encompasses a variety of other discharge reasons. That both programs do in fact discharge clients for lack of participation in case management is corroborated by staff survey responses, which show that staff believe clients’ continued housing benefits are contingent on their ongoing participation in case management services. However, it would also be useful to know

(1) how many clients are, in fact, being discharged for that reason by each provider, and (2) how salient is the threat of discharge due to non-participation in the minds of CCSH clients? Ultimately, it may be that the decision by CCSH to diverge from the HF model in this way is reasonable. However, to assess this with confidence, we will need to know to what extent the program deviates from the HF model in practice and what the results of that divergence are in terms of client outcomes.

Outcomes

A secondary objective of this process evaluation is to identify what outcome measures could be used to assess program effectiveness. Program documents list the following as intended outcomes:

1. Increase housing retention and stability for the target population.
2. Increase of linkages to and use of vocational, employment and/or educational services.
3. Reduced use of homelessness and shelter services.
4. Reduced involvement in the criminal justice system.
5. Reduced reliance on emergency medical and mental health services.
6. Decrease in arrests, incarceration, and increased compliance with probation, if involved.
7. Decrease in usage of emergency services, including emergency room use, detoxification services, and emergency shelters.
8. Improved social determinants of health.
   (BHI, 2021a, p. 3)

In this section, we discuss briefly what measures could be used to assess these outcomes, either based on current data or by incorporating additional data in a future study.

According to the program data presented in this report, CCSH is succeeding in providing supportive housing and case management to qualifying individuals. Moreover, some of these individuals successfully achieve housing stability by gaining employment and improving their financial situation or by securing alternative supports to maintain long-term housing (e.g., Section 8). These results pertain to the short-term outcomes one through three above, as they demonstrate that some clients became stably housed, engaged in case management services (vocational, employment, educational, etc.), and were not using homelessness and shelter services. However, because we have nothing to compare these outcomes to, we are unable to assess whether CCSH clients are improving more than they would have if they had not participated in CCSH. The most feasible way to assess this moving forward would be to compare CCSH clients after participating in the program to themselves from before they entered the program. For example, if we had data on clients' rates of criminal justice involvement for a two-year period prior to their receiving CCSH services as well as for a two-year period after receiving those services, we could assess whether clients improved along outcomes four and six above. Outcomes five and seven could be assessed in a similar way with Hospital Information Exchange (HIE) data on clients' medical system involvement before and after participation in CCSH.

CONCLUSIONS

The primary objective of this study was to evaluate whether the CCSH program is designed and being implemented in accordance with its design and evidence-based practices as defined by the HF and PSH housing models. To assess this, we analyzed CCSH program documents, client service data, and staff surveys.

The results of our analysis of program documents indicate that the CCSH program is generally designed in accordance with evidence-based practices. Namely, the specification of the target population and the types and intensity of services offered are broadly consistent with the best practices set forth in the HF and PSH housing models. Moreover, the planned procedures for intake, service provisioning, and discharge are both comprehensive and consistent with the broader program goals and strategy. The primary area of deviation from best practices is around the issue of making housing support contingent on participation in case management programming. A secondary deviation is that program documents mention a 2-year service period, after which clients are expected to establish housing independence by alternative means. While this would seem to violate the PSH model, which advocates making housing permanent, it does not appear that CCSH discharges anyone who is compliance with the program until such time as alternative supports are in place.

With regards to program implementation, service data from HD, CFW, and CBS reveal that CCSH is generally following its implementation plan in practice, from referral and intake through service delivery and eventual discharge. Areas for potential improvement include (1) shortening the time to being housed by increasing the availability of safe, accessible, and cheap housing that accepts program vouchers, and (2) improving and further standardizing data collection and reporting practices, particularly in reporting discharge reasons and service delivery hours by service type. According to CBS administrators, data on service hours by service type are tracked internally by their organization and were included in a previous version of the performance report sent to BHI. Therefore, it should be easy to reincorporate these data into future reports.

A secondary objective of this study was to evaluate preliminary outcome data and identify outcome measures and analyses that could be utilized to assess program effectiveness in a future study. While there is some outcome data in terms of the number of clients receiving housing and case management services and the number of successful discharges, there is currently nothing to compare these data to. By collecting data on clients' pre- and post- their involvement in the CCSH program, it should be possible to assess whether clients are improving in terms of the medium to long-term outcomes of improved housing stability, independence and quality of life and reduced burden on public services.

Recommendations

1. **Clarify in program documents what the purpose of the proposed 2-year service period is and how this timeline is to be implemented.**
2. **Clarify why the CCSH program diverges from the HF model in making receipt of housing benefits contingent on service participation and what the effects of this are expected to be in terms of client outcomes.**
3. **Explore ways to improve the success rate for contacting clients drawn from the waitlist.**
4. **Explore ways to reduce the time from issuing vouchers to housing clients, perhaps by increasing the availability of safe, accessible, and cheap housing that accepts program vouchers.**
5. **Improve and standardize data collection and reporting, especially around the topics of discharge reason and service hours by service type.**
6. **Conduct a future evaluation of outcomes, ideally by utilizing data on clients' criminal justice and emergency medical systems involvement pre- and post- their participation in the CCSH program.**

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