Institute for Human Services

Housing First Program 1-Year Evaluation

December 31, 2015

Anna R. Smith, MA
John P. Barile. PhD

Department of Psychology
University of Hawai‘i at Mānoa
2530 Dole Street
Sakamaki Hall, C404
Honolulu, HI 96822

UNIVERSITY of HAWAI‘I® MĀNOA

This report presents the status of the Institute for Human Services (IHS) Housing First initiative evaluation for the City and County of Honolulu. This report includes background information on the evaluation approach, intended timeline, and preliminary findings. The procedures and findings in this document will likely change as new information and barriers are identified. As such, this document should only serve as a guide to the evaluation.

Table of Contents

Housing First Program 1-Year Evaluation

Executive Summary

- Individuals and families identified, referred, and admitted to Housing First were high-need.
- Housing First clients were placed quickly and efficiently into housing despite limited low-cost housing stock and barriers to obtaining required documentation.
- Despite challenges, such as large caseloads, staff remained important linkages to community/services.
- Housing First clients report increased engagement with the community, improved physical and mental health, and a rise in their satisfaction with life, even after a relatively brief experience in the Housing First Program.
- Housing First has maintained a 97% housing retention rate, which some case managers and staff attribute to staff cohesiveness and communication.
- Clients interviewed viewed the program positively, holding their case managers in high regard and using their time in the program to rest and look for employment.
- The Housing First Program is sustainable due to its cost-effectiveness, yet many housed clients expressed concern that they may lose their subsidy in the future. We recommend additional resources be dedicated to providing wrap-around services and employment opportunities to program participants after housing.
- Despite challenges, once housed, Housing First clients, even clients housed for only a short period of time, show improved health and quality of life.

Evaluation Overview

Background

Housing First (HF) is a community intervention that offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness (United States Interagency Council on Homelessness, 2013). HF services are unique because they do not require individuals to demonstrate that they are "housing ready" before placement. Instead, HF services are designed to place individuals experiencing homelessness into housing as soon as possible, regardless of current substance use or symptoms of mental illness. Additionally, to support individuals being placed rapidly into housing, support services are provided in the form of intensive case management to all individuals in order to help facilitate the housing process and address physical and mental health needs. HF has received acclaim nationwide as a promising intervention that helps individuals with serious mental illness and/or histories of substance use gain stability (Padgett, Stanhope, Henwood, & Stefancic, 2011; Pearson, Montgomery, & Locke, 2009; Tsemberis, Gulcur, & Nakae, 2004).

In August 2014, the City and County of Honolulu responded to Oahu's homelessness problem by releasing a request for proposals for programs modeled after HF. The Institute for Human Services submitted a proposal and received funding for December 2014 through November 2015 with the possibility of funding renewal for an additional year. The funding contract includes a budget item for program evaluation to examine the program outcomes and fidelity to the HF model. This report is the first installment of this evaluation.

Evaluation Plan

This evaluation report will focus on the implementation of the HF initiative in the City and County of Honolulu between December 1st, 2014 and December 1st, 2015 and will briefly outline the evaluation methods to be used in the coming 11 months. In particular, the evaluation strives to:

- Understand aspects of HF process and implementation;
- Assess adherence to HF fidelity and extent of necessary program modifications;
- Detect outcomes and impacts; and
- Examine achievement of goals and objectives.

This report outlines progress achieved thus far and explains the evaluation plan in more detail.

Process and Implementation

In an effort to document the intended program process, the evaluation team, in collaboration with IHS, developed a logic model that details program activities (e.g., identification of vulnerable people, case management services, etc.) and expected outputs (e.g., number of people identified, number of people housed, number of services received, etc.). Additionally, the logic model lists anticipated short-term goals, long-term goals, and overall program impacts and delineates the process that leads to the attainment of these goals and objectives. The HF theory of change that describes the process in more detail can be found in **Figure 1, Appendix C**. The overall program **Logic Model** can be found in **Appendix A**.

Program Fidelity

Fidelity refers to the degree to which a program is implemented as intended (Dusenbury et al., 2003). Sometimes programs must be adapted to better fit the communities in which they are implemented. However, it is important to measure fidelity by tracking what components are changed and what components are implemented as intended in order to assess which components can be changed and still achieve program effects. The HF model hinges on four essential principles: 1) Homelessness is first and foremost a housing problem; 2) Housing is a right to which all people are entitled; 3) People who are homeless or on the verge of homelessness should be returned to or stabilized in permanent housing as quickly as possible and connected to resources necessary to sustain that housing; and 4) Issues that may have contributed to a household's homelessness are best addressed once the family/individual is housed (The National Alliance to End Homelessness, p. 1, 2009).

These principles guide the **HF Fidelity Criteria Index** (Watson et al., 2013) detailed in **Appendix D.** These criteria are organized into five dimensions:

1. Human resources structure/composition (e.g., having a culturally diverse, appropriately educated staff knowledgeable in harm reduction);
2. Program boundaries (e.g., serves the chronically homeless and drug users);
3. Flexible policies (e.g., drug/alcohol use, relocation if client does not like housing);
4. Nature of social services (e.g., clients are not required to participate in services, small caseloads for case managers, case managers meet with clients 2-3 times a month); and
5. Nature of housing (e.g., scattered-site housing, fast placement upon intake, clients are the leaseholders).

In order to be considered a HF model, programs should contain most of the components outlined in the HF Fidelity Index. This evaluation will document the extent to which the program adheres to the fidelity criteria.

Outcomes and Impacts

The overall outcomes and impacts of this HF model include decreasing the total number of homeless individuals and families on Oahu and decreasing the financial burden on the healthcare system, housing service providers, and the legal system. With the successful implementation of the HF model, outcomes will include increased physical and mental health, social and community connections, and access to services. Outcomes will also include a decrease in stress and substance abuse, an increase in life satisfaction and employment rates, and a decrease in hospital and jail stays.

For more information on how the evaluation team will measure outcomes and impacts, please see the **Measurement Plan** found in **Appendix B.**

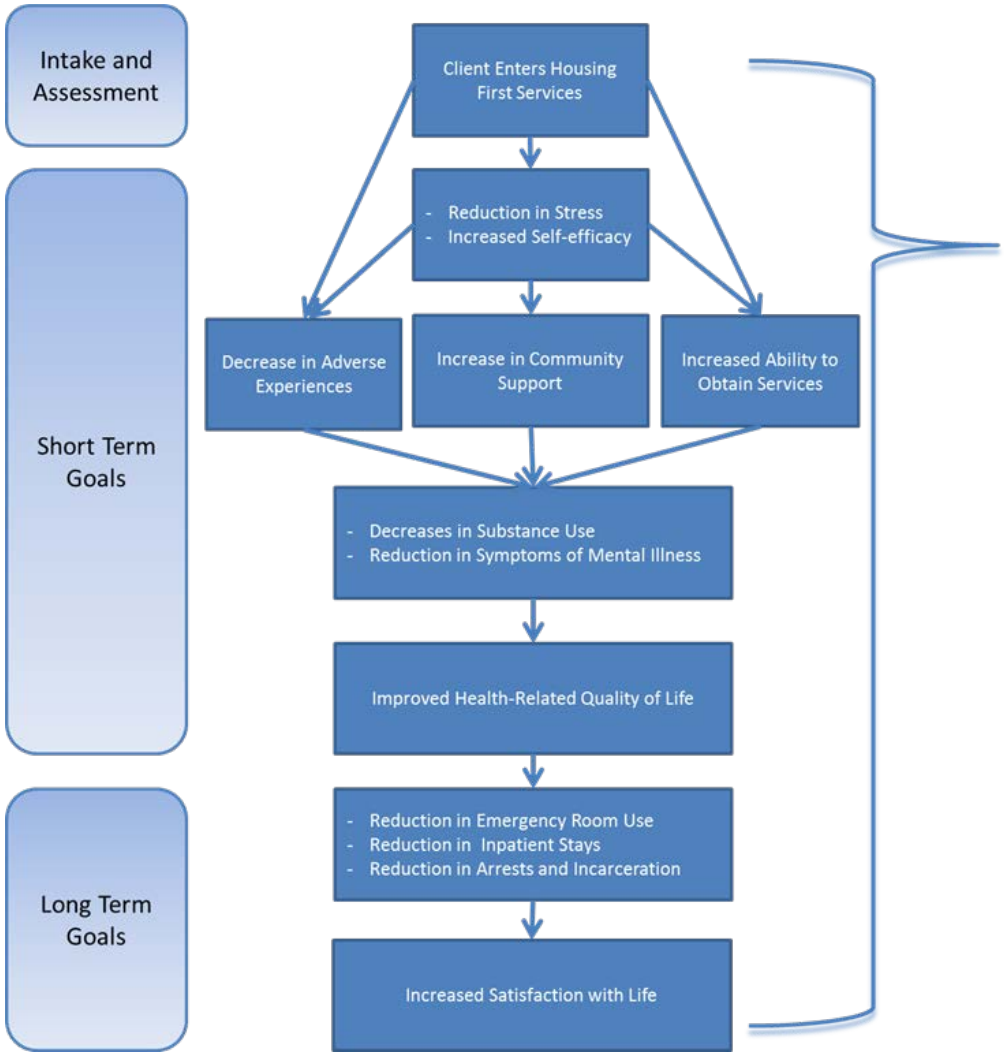
Specific Goals and Objectives

There are several goals and objectives that this Housing First model will attempt to achieve. Short-term goals are focused on physical aspects of participants' daily lives. These include decreasing the occurrence of substance use, decreasing the perception and feelings of stress, increasing mental and physical health, increasing social and community connections, and providing increased access to healthcare and other services. Long-term goals focus on stability and include overall satisfaction and enjoyment in life, decreased time spent in hospitals and jail, and increasing rates of employment

For more information on how the evaluation team will measure achievement of goals and objectives, please see the **Measurement Plan**, found in **Appendix B**

The anticipated progression of these outcomes and potential impact of the program is outlined in Figure 1.

Figure 1. Housing First Theory of Change



Considerations/assumptions:

- Individuals most in need are eligible for housing.
- Individuals receive housing opportunities within one month of being assessed.
- Individuals are able to obtain housing in a desirable location.
- Individuals housing options fit their required level of care.
- Individuals are able and willing to receive services prior to and after placement into housing.
- Staff are available to meet with program participants regularly after placement.
- Property managers do not have unrealistic expectations and policies

Methods

The following research questions – as stated in the Logic Model (Appendix A) – address four main areas of concern: HF attainment of goals (Q1-2), potential factors that may affect the attainment of desired outcomes (Q3), comparison of HF to clients receiving other services (Q4), and fidelity to national HF program model (Q5):

1. Is HF participation associated with attaining short-term (ST) goals (e.g., decreased substance use, increased access to healthcare and services, etc.)?
2. Is HF participation associated with attaining long-term (LT) goals (e.g., decreased hospital and jail stays, increased employment, and increased life satisfaction)?
3. Does place of residence and length of time to placement affect attainment of ST and LT goals?
4. Is participation in HF associated with better attainment of LT and ST goals than participation in other programs?
5. To what extent does IHS-HF adhere to HF model?

Appendix E lists the research methods and measurement tools that will be used to answer the proposed research questions. Additionally, Appendix E explains the analytical plan in more detail.

Evaluation Timeline

November 2014 – April 2015: Develop assessment tools and protocols
Obtain Secondary Data (HMIS, VI-SPDAT)
Initiate Surveying of Program Participants (HFAT)

May-June 2015: Establish and continue wide-spread surveying of each program participant, each month
Track time between initial assessments for program eligibility, identification of available housing, and placement into housing

July – August 2015: Continue surveying of program participants
Continue to track participant progression to housing
Begin qualitative interviews for potentially three short case studies of program participant

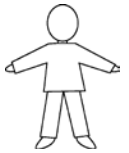
September-October 2015: Continue surveying of program participants
Continue to track participant progression to housing
Conduct fidelity assessment and staff interviews

November-December 2015: Analyze and report Year-1 evaluation findings

Program Evaluation

Program Process & Implementation

Client Information



- Since December 1, 2014, the program has funded housing for a total of 176 clients, resulting in 115 total households. For ten (10) of these clients, Housing First (HF) funded housing, but Pathways provided services. Therefore, 166 clients, comprising105 households, have been housed by and received HF services through IHS.

- An additional 18 people are pending placement for the 2016 cycle. Therefore, a total of 184 people have received IHS Housing First services to date. **This report focuses primarily on the 166 people who have been housed during this funding period and have received IHS Housing First services.*

- Housing First clients' median age is 49 years old (N=166). The majority of clients are male (52%), while 40% of Housing First clients are female.

- The average VI-SPDAT score for the heads of households is 12.5.

- The majority of people housed are adult singles. The 105 households are comprised of 83 adult singles and 22 families.

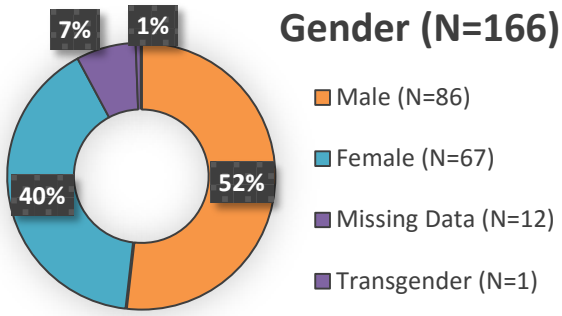


Figure 2. The proportion of each gender's participation in the HF program.

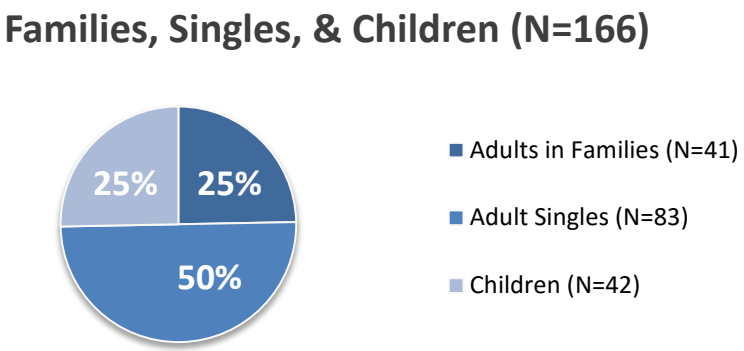


Figure 3. The proportion of adults in families, adult singles and children participating in the HF program.

Intake & Housing

- Intake to placement for the 105 households ranged from 0 to 219 days, with an average of 51 days and a median of 35 days.[1]
- Most Housing First intakes occurred in December 2014, with 23 households entering the program. Since December, the number of intakes each month has generally declined, with spikes in February and July.
- From December 1, 2014 to November 1, 2015, an average of 9 families (15 individuals) were housed per a month, with the highest number of households placed in January and August (N=12). The number of *individuals* housed spiked in October (N=32).

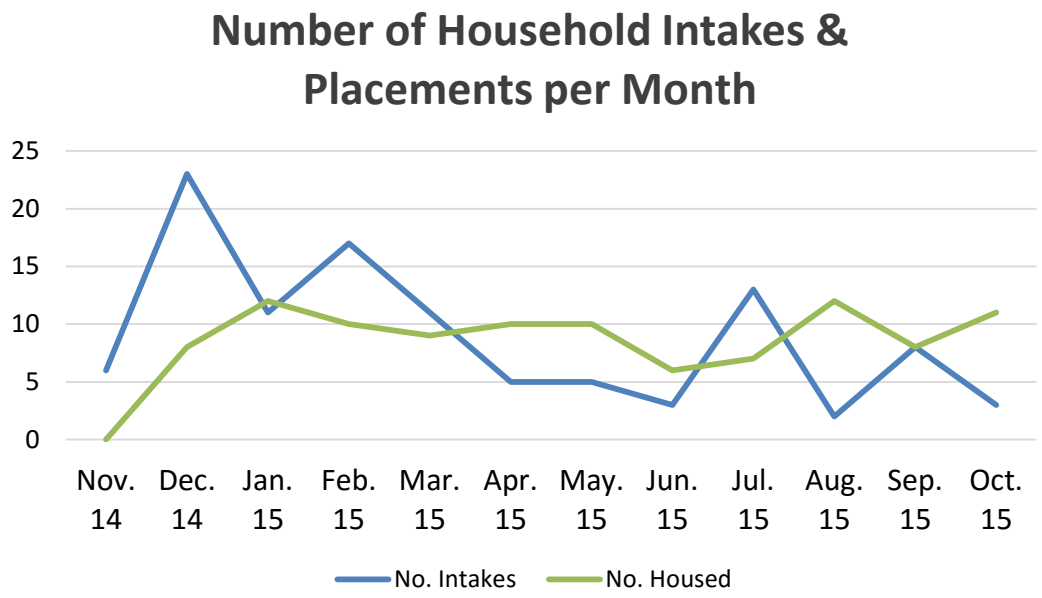


Figure 4. The number of household intakes and placements by month.[2]
**Missing intake data for 1 household and housing data for 2 households.*

[1] For two households, adults in the household were placed at different times, resulting in different lengths of time from intake to placement. In these cases, both lengths of time were included in our calculations.
[2] Missing housing placement date data for 2 households (resulting in households placed N=103). Additionally, 2 households had adults with intake dates in different months. Both dates were included in our analysis (resulting in household intakes N=107).

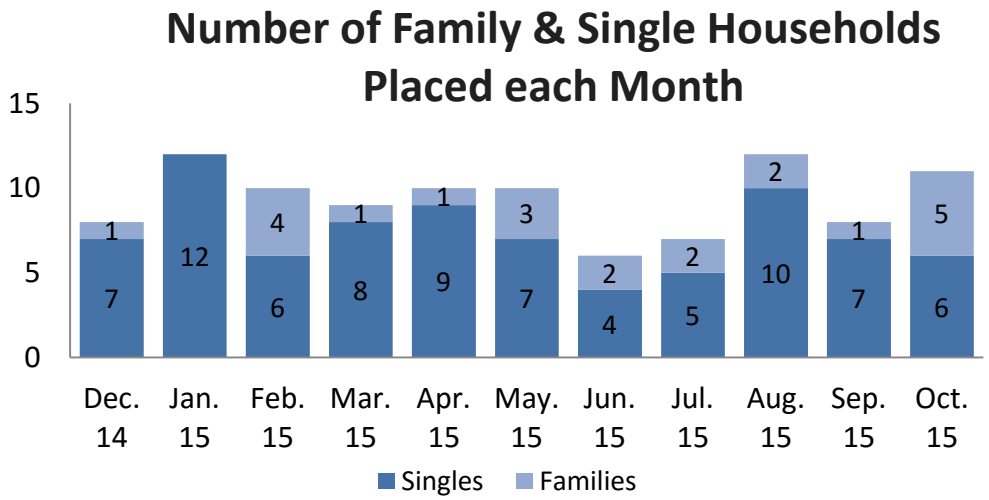


Figure 5. The number and proportion of singles and families placed in the HF Program by month

Barriers to Intake and Housing

Interviews with clients and staff revealed significant barriers to intake and housing placement:

- **Stigma:** Landlord and community stigma greatly hindered housing placement and negatively impacted clients' self-esteem.

> *"It is always easy to house these guys in poor neighborhoods, because that is just how it is. That kind of goes against the scattered site theory because, yeah, it is still scattered site in a sense. [...] It is hard to sell this product to a normal landlord. And even if you try to pitch, guarantee the rent, if anything gets broken, we guarantee to fix it. Just looking at it, may just cause emotional stress that the landlord are not willing to accept." – Case manager on barriers to placement*

> *"And you know, you felt shunned, because people looked down on you. And they, they thought you were less than, and you were looked down upon and that was not a good feeling." – Housing First client*

- **Loss of documentation:** Case managers and clients mentioned that loss of documents, like IDs, was a barrier to outreach, intake, and placement.

> *"And then [my case manager] took me through the process very well. And I did as best I could, I think, to apply myself to, you know, getting the necessary paperworks and documents and things like that because I didn't have my birth certificate and all that stuff. I didn't have my social security card. It had all been stolen- wallet, and all that stuff." – Housing First client*

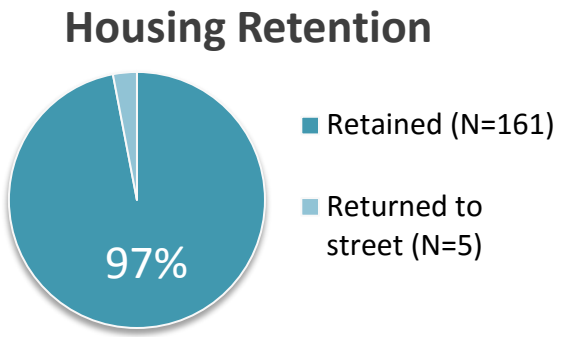
Program and Housing Retention

- The HF program has retained 93% of the 166 clients who have been housed. Therefore, 155 individuals, or 95 households, are currently participating in the program.

- Of the 11 people who have exited the program, only 5 are no longer stably housed. The remaining 6 clients are either deceased or have secured other living situations.
  - Two (2) clients were incarcerated; two (2) were non-compliant with landlords; one (1) left voluntarily.
  - Three (3) clients are deceased; one (1) was unable to live independently and transferred to another program; two (2) clients have found other living situations.

- Therefore, the program has a housing retention rate of 97%.

Figure 6. The proportion of HF clients no longer on the street.



Case Management

Caseload

- The average caseload per case manager for currently housed clients (N=155) is 31 clients or 19 households.
- This HF program stipulates that case managers strive to transfer clients to external case managers once they are stably housed in order to allow for new HF clients to be added to the caseload.
- Of the total number of households that are currently in the program (n=95), 37% (n=35) have external case managers in addition to HF case managers. In other words, for 37% of the cases, case managers are acting as HF case managers only.
- For 62% (n=59) of the cases, the case managers remain both the HF and primary case manager for clients. **Missing data for 1 household.*

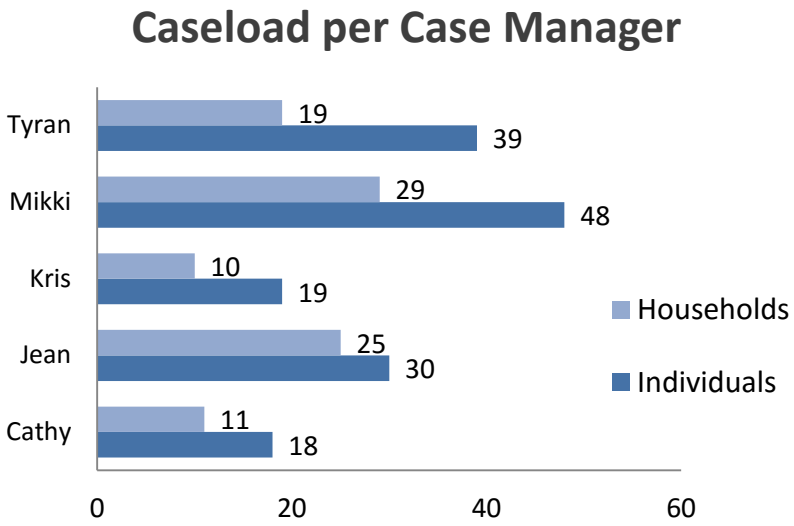


*Figure 7. The breakdown of cases per case manager. *Missing data for 1 client/household.*

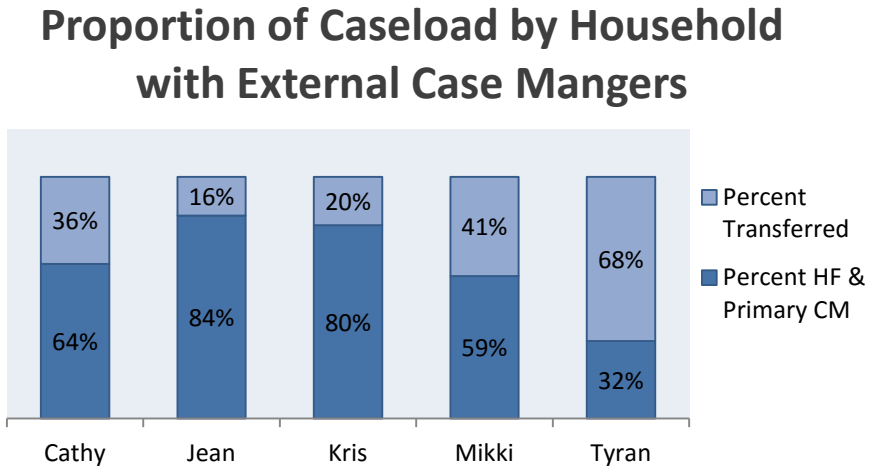


Figure 8. The proportion of each case managers' caseload by household with external case managers.

Case Manager Responsibilities

Qualitative data revealed a couple of themes relating to case management:

- **Links to services and community:** Despite challenges, such as large caseloads, staff remain important linkages to community/services:

> *"So, I'm linking to if they want to be linked to other social services and following up. If they've already been linked to make sure they'll still continue being linked to these services. Just getting a weekly update of how they are doing, how they feel the program is working, if it is working, and why it is working"*
> *– Case manager on primary responsibilities*

> *"I got them hooked up with classes. The case managers have been so spread thin trying to get them to remember to tell their client, 'Hey, there's this support group!' [....]. So now it's turning into- I'm partnering with [a UH program] and our housing department to do a series of six classes on budgeting, nutrition- you know, how to buy-you know, make your money last with food stamps, how to be a good tenant, food safety. There'll be cooking demos as well" – Housing First staff member*

> *"I worked with [IHS staff member], and she's wonderful. And I speak to her probably, four times a month. And she's been enormously supportive of me, enormously supportive. And she's extended herself and then some. And she was the one who helped launched me into the volunteer positions, you know. And she, she's been an enormous emotional support. And she's made herself available to me. You know what, I could probably call her up at 5 o'clock in the morning or 2 o'clock in the morning, you know. That's how she is. She's wonderful, and so had been all the IHS staff. All of them."*
> *– Housing First client*

- **High Client-Case Manager Ratio:** Because of the high client-case manager ration, case managers expressed deep concern that they did not have enough time to give the amount of attention necessary to all of their clients given their large caseloads. In particular, they mentioned that "higher-need" clients required the majority of their time, and as a result, the more stably housed clients, like the clients we interviewed, did not receive as much case management time and services The clients we interviewed echoed that sentiment.

> *"It's been really hard for me to keep to that, you know, face-to-face, once-a-week. [...]. And that's where I feel that that's where I have difficulty. But I've just been separating them like – ok, for example, you know this client that I have, you know, he has mobility issues, psychological issues, addiction issues, whatever. So, he needs to be seen more often, whereas the client that is in a program who, they're doing wonderfully, you know I could probably see them every 3 weeks, every month. And you know, I've been using my, my judgment with that. I don't know if I'm supposed to do that or not, but it's almost physically impossible to see everybody plus, you know, stay on top of the notes and files..."*
> *– Housing First case manager*

> *"And I know they're busy. And, I think they kind of see me as one of their more higher-functioning clients. And, maybe I am. But, I think it still…it doesn't make me any less like in need of the same help that other people are receiving. And I don't necessarily know that anybody is getting anything different. I just know that there were these goals that they asked me about, and none of that was really being pursued. You know?" – Housing First client*

Staff Cohesiveness & Communication

The program process required collaborating across multiple agencies with different goals, clientele, strategies, and expectations. Building cohesion and maintaining communication among staff and case managers was key to successful program implementation.

- Although case managers and staff indicated that collaboration across multiple agencies was difficult initially, case managers and staff noted that the resulting cohesiveness was one of the most successful and effective aspects of the program.

> *"I'm really proud of the cohesiveness of our Housing First team. I think it would be a shame if we don't get renewed because I think we appropriately taken the first year to really understand and work out the bugs and problem solve and become more sophisticated and aware as a team and individual providers. So I think we've grown a little great little team that has the potential to continue to have a lot of positive impact." – Housing First staff member*

- However, case managers indicated lapses in communication, noting that they were often confused about who was on their caseload and their clients' status in the program:

> *"But [decisions on housing] never gets communicated down, […].So, whether there's a roster maybe? You know? Or minutes? Or um… you know, just so that [the program coordinator] and the rest of the case managers know where on the spectrum is their client at. Are they in jeopardy? Do they not – 'cause we don't even know if they're paying their rent." – Housing First case manager*

Program Fidelity

The following section compares this Housing First program to Housing First fidelity criteria (Watson et al., 2013) relating to program staff composition, boundaries, policies, and nature of social and housing services. First, we list how this program has met, not met, or exceeded fidelity criteria. Then, we delineate necessary adaptations, including intentional adaptations and adaptations resulting from program barriers. Finally, we present barriers to program implementation and fidelity to the model.

Staff Structure and Composition

Model Criteria		**Program Implementation**		
		Fidelity to Model	**Adaptations**	**Barriers**
Diverse Staff	*Staff highly reflects the diversity within the consumer population*	• The program staff is diverse in age, ethnicity and gender		
Education Requirements	*At least 25% of case managers have a Master's degree or higher.*	• 2 of 5 case managers have a Master's degree or are enrolled in a Master's program		
Harm Reduction/Crisis Intervention Knowledge	*Provides or requires ongoing staff training in harm reduction & crisis intervention.*	• Staff & case managers trained in these approaches • Met once a week to strategize mitigating potential crises		• Staff turnover & collaborating with staff from other agencies made *ongoing* training difficult
Staff Availability	*At least one staff member is available to clients 24 hours a day, 7 days a week.*	• Case managers & clients reported that case managers/staff were available at all hours		
Clinical Staffing	*Has psychiatric staff & mental health professional on staff or contract.*	• One licensed clinical social worker. • One licensed substance abuse counselor • Psychiatrist hired mid-year		

Housing First staff consisted of 5 case managers, 3 housing specialists, a chaplain and community liaison, a program coordinator, a psychiatrist, and a data specialist. The program staff is highly diverse in age, ethnicity and gender. Staff ages range from 29 to 67 years of age and consist of 5 males and 7 females. Staff members' ethnicities include: Japanese (1), Korean (1), Chinese/Caucasian (2), Samoan (1), Portuguese/Caucasian (1), Caucasian (3), and Native Hawaiian (3). All staff was trained in harm reduction and crisis intervention; however, case manager turnover and collaboration with other agencies inhibited formal ongoing training. The program exceeded education and clinical staffing criteria, and clients reported that program staff was always available if needed:

> *"I worked with [IHS staff member], and she's wonderful. And I speak to her probably, four times a month. And she's been enormously supportive of me, enormously supportive. And she's extended herself and then some. And she was the one who helped launched me into the volunteer positions, you know. And she, she's been an enormous emotional support. And she's made herself available to me. You know what, I could probably call her up at 5 o'clock in the morning or 2 o'clock in the morning, you know. That's how she is. She's wonderful, and so had been all the IHS staff. All of them."*
> *– Housing First client on staff availability*

Program Boundaries

Model Criteria		**Program Implementation**		
		Fidelity to Model	**Adaptations**	**Barriers**
Population Served	*Serves only chronically homeless & dually diagnosed individuals & houses current drug users*	• Relied on VI-SPDAT scores to determine vulnerability & risk • All 105 households had at least one person with a VI-SPDAT score of 10 or higher[3] • Housed drug & alcohol users • Data show that clients were highly vulnerable: with multiple physical, mental, & substance abuse issues		
Consumer Outreach	*There is a designated staff member dedicated to outreach or an outreach department*	• Formal outreach was a coordinated effort with Phocused & partner agencies (housing navigators): o Housing navigators administered VI-SPDATs to potential clients o Phocused referred clients with scores of 10 or higher to IHS o IHS outreach workers & case managers find & intake referred clients	• IHS also administered VI-SPDATS internally	• Relying on 3rd parties to outreach and assess client eligibility led to case managers having difficulty finding clients and differing perceptions of risk/vulnerability • Limitations in VI-SPDAT scoring led to the need for additional assessments, slowing intake
Case Management	*Case management responsibilities limited to case management*	• Program's more collaborative approach meant that case managers' responsibilities were not limited to case management	• Initially, case managers served as outreach workers; later transitioned into case management • Case managers worked closely with housing specialists, & sometimes these roles overlapped • Staff noted that coordination with housing specialists was beneficial	• Case managers & staff noted that transitioning from outreach to case management was difficult • Case managers were confused about case management responsibilities

[3] We were unable to obtain scores for 2 households.

Termination Guidelines	*Only terminates clients who demonstrate violence, threats of violence, or excessive nonpayment of rent*	• The program only terminated clients who demonstrated violence or threats of violence or who left voluntarily (n=3)	• Terminated 2 clients who were incarcerated because staff anticipated long-term sentencing for serious offenses	
Termination Policy Enforcement	*Termination policy is consistently enforced*	• Policy was consistently enforced		

The program had a formal policy for identifying high-need clients. "Housing Navigators" from multiple agencies administered VI-SPDATs to potential clients. Phocused scored these VI-SPDATs and referred clients with a score of 10 or higher to IHS. Most of the referred clients did not have a "housing navigator", making it difficult for Housing First case managers to locate clients with whom they did not have a previous relationship. Additionally, when Housing First staff members met with referred clients, they noted that VI-SPDAT scores did not always accurately reflect clients' current states. These difficulties slowed client intake and led to staff having to re-administer VI-SPDATs.

Unlike other Housing First models, this model included intense coordination between housing specialists and case managers, which sometimes led to overlap in roles. However, both staff and case managers reported that this coordination was helpful and necessary:

> *"I think most of the models are very specific of the housing roles versus the case manager roles. Over here, it kind of overlaps a little bit more. […]. We are all willing to play different roles. Sometimes we do play the housing specialist role. Sometimes the housing specialist plays the case manager role. We also know who is appropriate for the lead at the time, because sometimes the housing person will have to make a decision and we, as the case manager will let the client know, "okay, this is the housing specialist's decision, they're going to make it." And you know, our role is to facilitate and help them, and vice versa. Sometimes we have to make a decision, and housing specialist just back us."*
> *– Housing First case manager*

Case managers also functioned in the role of outreach workers initially before transitioning into case management:

> *"What I think we really did was we co-opted into a case management program. And outreach work is very different from case management work. There are many similarities, your sense of mission is equal, the population is the same population, but the duties and roles of the case manager with linking and brokering, kind of temporary of in the moment vibe into the work they do with the clients with exceptions*

probably, but – so [we] really had to take outreach workers and turn them into case managers."
– Housing First staff member

Some case managers noted that this transition was difficult:

"I think it [difference between outreach and case management] needs to be really clear. I believe even with outreach workers, but to assume that the outreach worker can become a case manager – it's two separate levels of care."
– Housing First case manager

"As the case manager for City Housing First… we have, we have a list of stuff. […] And I'm really bad at… the data part. I mean I wasn't really trained so […]. I been trying to, like I'll use the first hour of the day at the office, and then from 9 to like 3 with clients and then maybe till 4 do the notes. And I'm trying to make that a routine. I've not been ever trained to do this."
– Housing First case manager

Flexible Policies

Model Criteria		**Program Implementation**		
		Fidelity to Model	**Adaptations**	**Barriers**
Flexible Admissions Policy	*Has a formal protocol for admitting most vulnerable clients.*	• Phocused referred the most vulnerable clients to HF • HF outreach workers & case managers attempted to locate and then intake these referred clients. • Once completing intake, clients placed on housing list	• Most vulnerable clients were moved up on the housing list even if they did not have all necessary documents	• Invalid VI-SPDAT scores and difficulty finding referred clients significantly slowed the intake & housing placement process
Flexible Benefit/Income Policy	*Possession of or eligibility for income benefits is not a housing prerequisite.*	• Clients were not required to be "housing ready" • Clients were not required to possess or be eligible for income/benefits		
Consumer Choice in Housing Location	*The program works with clients to find desirable housing.*	• Considered clients' wishes regarding housing location & type	• Not always able to accommodate all of clients' wishes because of significant barriers • Gave clients 3 opportunities to decline housing option before moving client to bottom of housing list	• Barriers, such as landlord stigma, pets, handicap accessibility, landlord clauses barring alcohol/drugs, & limited affordable housing availability, made it difficult to accommodate all client requests & house clients quickly
Flexible Housing Relocation	*Always attempts to relocate clients when they are dissatisfied with their current housing placement.*	• Quickly rehoused evicted clients/clients who were having difficulty with landlords • Worked to rehouse clients with "reasonable concerns".		
Unit Holding & Case Management Continuation	*Holds housing for hospitalization & incarceration for more than 30 days & program continues to offer case management services while unit is unoccupied.*	• Continued to offer case management services while units were unoccupied due to clients' short-term hospitalizations, evictions, etc.		• Difficult to coordinate with criminal justice and medical systems - case managers do not always know when clients are hospitalized or incarcerated.

Flexible with Missed Rent	*Is flexible with missed rent payments but holds the client accountable.*	• Housing specialists handled rent payments & work with clients to anticipate payment issues • Did not exit any clients due to nonpayment of rent		
Flexible Alcohol/Drug Use	*Allows illicit drug/alcohol use & housing allows illicit drug/alcohol use in units.*	• Allowed drug & alcohol use	• Some landlords did not allow drug & alcohol use	• Landlord restrictions led to conflict between tenants & landlords and inhibited program fidelity
Eviction Prevention	*Has a formal policy & protocol to work with clients to prevent eviction & has a staff member dedicated to eviction prevention.*	• The program had a formal policy and protocol to work with clients to prevent eviction • Recently partnered with the University of Hawaii at Mānoa to offer classes on being good tenants & money management	• While no particular staff member was dedicated to eviction prevention, case managers, staff, & housing specialists worked together to prevent eviction by anticipating problems, strategizing solutions, & working as liaisons between clients & landlords	
Consumer Input	*Has formal & informal mechanisms for receiving & implementing client input.*	• The program had *informal* mechanisms for receiving client input, particularly through case manager meetings and support groups	• No *formal* mechanisms for client feedback. • For the next funding period, will conduct a photo project designed to receive and implement client feedback	

Despite significant barriers, the program housed highly vulnerable clients with no income or income benefits, offering eviction prevention and reasonable client choice of housing. Because of limited affordable housing stock and landlord stipulations regarding pets and alcohol/drugs, providing client choice and housing clients quickly became difficult. Therefore, the program offered clients a maximum of three units before placing them at them at the bottom of the housing list until more units came available.

> *During the process of looking for housing, there's a lot of contact between the housing specialist and the client because they need to go see the place. We let them see the place. We let them say yes or no to the*

> *place if they like it. There's a few of them that we'd deny them the place, but majority of them will take whatever comes." – Housing First housing specialist*

The program maintained flexible policies regarding alcohol and drug use, missed rent payments, and housing relocation. Again, landlord clauses restricting alcohol/drugs contradicted HF's flexible policies and led to conflict between landlords and tenants.

> *Yea, but drugs, all the landlords don't allow it. They don't allow any illegal activities at all in their unit or even on their property. Yea, but with this program, because we allow it, we had to express to the whole team that because we allow it, doesn't mean the landlord allows it. So we had to understand that. And we have to for them to stay in housing. We have to keep telling our clients that – "handle your business outside. Don't do it on the property, don't do it on the unit." But at the same time, as a housing specialist and a case manager, we try to work on those issues with them – we need to try to minimize their use.*
> *– Housing First housing specialist*

Housing First housing specialists were essential in mitigating these conflicts and avoiding eviction.

> *"For me, because we converse for a long time, they open up so much units for us. So then we have that relationship with them because we deal with them all the time. They realize the kind of clients that are coming in. We even have landlords that will come and have lunch with us downstairs. So, yeah, we build that relationship with them. But there's just a few landlords that we just, we kinda know what client to put into certain landlords. Yea. We have landlords that is willing to be patient. Willing to work with this client. Then we know we can put our hard client into that unit only because we know that it's going to take some time to transition." – Housing First housing specialist*

The program has met or exceeded criteria regarding rent payment and relocation. No clients have been exited due to rent nonpayment, and clients with reasonable concerns (e.g., conflicts with landlords) have been rehoused. In order to elicit more client input on these processes, the program is working with the evaluation team to develop a client input policy that will include a photo response project and a survey with clients.

Nature of Social Services

Model Criteria		**Program Implementation**		
		Fidelity to Model	**Adaptations**	**Barriers**
Low-demand Service Approach	*Clients not required to engage in any services except for case management in order to receive/continue receiving housing*	• Did not require clients to engage in any service besides case management		
Harm Reduction Approach	*Uses a harm reduction approach & staff has a strong conceptual understanding*	• Staff & case managers engaged in and had a strong understanding of the harm reduction approach		
Small Caseloads	*Case managers have 10 or fewer clients on their caseloads*	• Case managers had well above the 10 cases maximum	• Case managers have on average 19 households (31 individuals) on their caseloads	• Not enough case managers for the number of clients • Stably housed clients not transferred to external case managers, resulting in high caseloads • Care coordination difficult to determine which clients may have external case managers • Large caseloads led to severe anxiety and burnout among case managers
Regular In-Person Case Management Meetings	*Clients meet with case managers 2-3 times a month on average, but program has policy that more frequent meetings occur in the first 1-6 months*	• Case managers & clients indicate that they did not meet 2-3 times a month	• Case managers prioritized clients they perceived to be more "high need" • "Higher functioning" clients not seen as often • Used a multiple case management team approach so that a member of the team tries to see clients weekly	• Large caseloads contributed to difficulty in seeing all clients regularly • "High need" clients took up the majority of time

Ongoing Consumer Education	*Clients receive ongoing education in Housing First and harm reduction policies & practices.*	• Education occurred informally and individually. • Program considering including an educational component during intake for the next funding year.	• The program offered support groups that encouraged clients to take steps in skill-building and community connection.	• Some evidence suggests that clients were not aware of the service aspect of the program. • Difficult to provide formal education to clients when the program cannot require clients to attend education classes.

As the model stipulates, the program did not require clients to participate in any services besides case management and allowed clients to set their own goals for the program:

> *"Housing First is client-based, client-driven goals. So, whatever they think is most important."*
> *- Housing First case manager*

> *"We don't require, too, much. We don't require anything actually. As long as you follow the case manager and follow your lease, those are kind of the only rules." - Housing First case manager*

Case managers were trained and had conceptual knowledge of harm reduction approaches. Part of their approach was utilizing a multiple case management team to help reduce harm and prevent impending crises. Therefore, some member of the team was supposed to meet with clients regularly, particularly in the beginning.

> *"And when they get housed, we try to see them one or two times a day – a week. After that if they're still not needy – they're not a client that needs so much attention – then we do just once a month and the case manager goes there once a week." – Housing First housing specialist*

However, case managers were unable to meet with clients weekly, mostly because of high caseloads.

> *"I feel like I'm failing miserably in seeing everybody once a week plus keeping up with all of the other stuff that you gotta keep up with. […] I just don't think it's realistic to have the caseload we have and then have to do the amount of home visits we have to do. That's just not gonna happen. […] I feel like that – it's a lovely idea, and you know what? If I had 12 clients, I might be able to do that. You know? But we're talking like 27…30…whatever. I don't even know how many." - Housing First case manager*

Though clients receive an informal introduction on the program, its policies, and its approach, *ongoing* education can be difficult because of high caseloads and the fact that the program cannot require clients to participate in education. However, the program does offer support groups and classes that clients can opt to attend. Evidence suggests that higher functioning clients are well informed of the program, even working with the case manager as a team, while other higher need clients may need additional education:

> *"However, a lot of these people don't understand that this is a program. Most local people here are used to Section 8. Section 8 is you get a subsidy, and that's your place. You get reevaluated a year from now. As long as you pay your rent, there's no problems; there's no issues. This one is much more invasive. However, these patients – clients – haven't gotten that message. And even though it's read to them when they're signing their papers, they're totally at a loss." – Housing First case manager*

Nature of Housing and Housing Services

Model Criteria		**Program Implementation**		
		Fidelity to Model	**Adaptations**	**Barriers**
Scattered-site Housing	*Housing is scattered-site in buildings operated by private landlords.*	• Program strove to meet scattered-site criteria. • Housing is operated by private landlords		• Obstacles related to other program criteria (e.g., landlord clauses barring illicit drug/alcohol use; finding desirable housing for clients) and limited affordable housing made scattered-site a challenge
Fast Placement into Permanent Housing	*The program places clients into housing in one week or less.*	• Time from intake to placement ranged from 0 to 219 days • Median time from intake to placement was 35 days	• The program identified units ahead of time so that they were ready when clients were identified	• Difficulty finding dislocated clients • Clients' loss of identification documents • Competition from other programs • Landlord stigma or opposition to the program • Finding units for disabled clients • Finding units appropriate for larger families • Balancing clients' desires with these obstacles
Temporary Housing Placement	*Temporary housing placement does not last more than one month.*	• Temporary housing was not used frequently in this program		.
Consumer is Leaseholder	*100% of consumers are the leaseholders of their units.*	• All clients are leaseholders of their units		

The program faced significant barriers to housing clients quickly in scattered-site housing, including landlord stigma and/or restrictions, limited affordable housing stock, and balancing clients' needs and desires with these obstacles. For example, some clients needed handicap assessable units, pet-friendly units, and/or units large enough for their families. Additionally, competition from other housing programs limited the available housing stock.

> *And as great as some landlords are, that are willing to help these individuals, I don't think they are willing to take that kind of liability [allowing drug and alcohol use]. That is always the issue. It is always easy to house these guys in poor neighborhoods, because that is just how it is. That kind of goes against the scattered site theory because, yea, it is still scattered site in a sense.*
> *– Housing First case manager*

> *"Our biggest challenge was finding housing for these clients because a lot of the landlords, they don't want to deal with this population, yea? And it's understandable because they don't want to have to deal with the complaints, and any illegal things that happens in their unit. But part of our job is vouching for them, letting the landlords know that trying to convince them to coming on our side. That was one of the biggest challenges." – Housing First housing specialist*

Despite these barriers, the program was able to house most clients in about a month, with 100% of clients being the leaseholders of their units.

Goals & Objectives

Housing First Assessment Tool

Program participants' progress is tracked throughout their participation in the HF program. The primary means to monitor participants' progress is through the administration of the Housing First Assessment Tool (HFAT). Between the start of the program and November 1st, 2015, 92 HFATs were administered. These 92 assessments were administered to a total of 48 unique individuals. Twenty-two of these individuals have completed the assessment twice, three have completed the assessment three times, one person completed the assessment four times and two have completed it five times. 52% identified as male, 44% identified as female, and one identified as transgender (2%). 42% were born in Hawaii and the average age was 53. In the coming months, these 48 participants, along with newly assessed clients, will complete the HFAT every 30 days. Currently, the average time between individuals first and second assessment is 52 days. For the purposes of this evaluation, we will focus on the 23 HF clients who have completed at least 2 assessments[4].

The HFAT data was paired with Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) data that was collected during their initial screening for the HF program. The VI-SPDAT data was used to assess whether individuals with higher scores are provided housing opportunities quicker than those with lower scores and whether these findings can be corroborated by health-related quality of life inventories included on the HFAT. VI-SPDAT data may also be used to identify appropriate matched-comparisons (individuals not in the Housing First program) and/or identify groups of individuals that report greater success in the program during the coming year. On average, the first assessment was given 86 days after being housed and the second assessment was given 139 days since being housed.

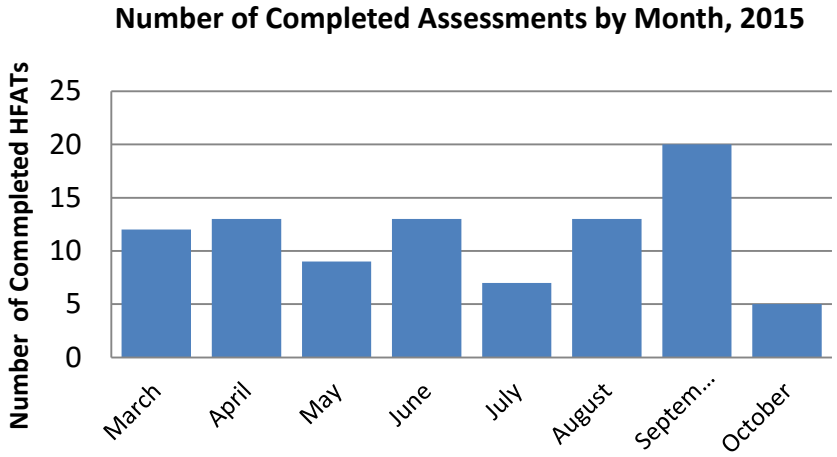


Figure 9. The number of completed HFATs dipped in July and again in October. Next steps will include an increased focus on additional follow-up assessments for all clients

[4]We currently do not have enough data to present findings from a comparison group (only 7 individuals have completed at least to assessments). Comparison group assessments will continue and we expect to be able to report on a substantial comparison group in the next report.

Primary Outcomes

Short-Term Goals: Is HF participation associated with attaining short-term goals?

- Of the Housing First participants who have completed two assessments (n = 23), the majority denied drinking alcohol (52% reported never drinking alcohol at both assessments) or street drugs (74% reported never using illegal drugs at the first assessment and 65% reported never using illegal drugs at the second assessment). It is possible that these reports are not entirely accurate if participants feared that they could lose their housing voucher if they report this behavior (staying free of drugs and alcohol is not a requirement to be in the HF program but is a requirement in many traditional housing programs).

- Housing First clients report a decrease in the frequency that they experienced violence or trauma, from 30% reporting these experiences in the prior 30 days at the first assessment, down to 9% at the second assessment.

- Housing First clients report increased engagement with the community, improved physical and mental health, even after a relatively brief experience in the Housing First Program. These findings are presented in Figure 11, Table 2, and Table 3.

- There is currently limited empirical evidence to support that program participants have an increased access to healthcare services. While it is possible that individuals have decreased access if their new housing is distant from the services that they traditionally receive, it is also likely that housing stability enables individuals easier access to services.

> *"What I'm saying is that a life event like being housed makes things a lot better for me. [...] I can be proactive in taking steps to make things better besides the medications and the counseling that I get and the support, like [mentions IHS Staff member]. The groups that I go to, and exercise, sleeping, and diet. Sleeping better, having a place to live, all these kinds of things all work together, so it's a holistic type." – Housing First client*

Table 1. Review of Program Goals

Short-Term Goals	Preliminary Evidence
1. Decreased substance use	Inconclusive
2. Decreased Adverse Experiences	Supported
3. Increased mental health	Supported
4. Increased physical health	Supported
5. Increased social support	Supported
6. Increased community connections	Supported
7. Increased access to healthcare	Inconclusive
8. Increased use of needed services	Inconclusive
9. Decreased stress	Supported
Long-Term Goals	
10. Increased life satisfaction	Partial Support
11. Decreased hospital stays	Inconclusive
12. Decreased jail stays	Partial Support
13. Increased Employment	Inconclusive

Long-Term Goals: Is HF participation associated with attaining long-term goals?

- It is currently too early to assess the potential long-term impacts of the Housing First program, as many of the impacts would likely take more than 6-months to a year to occur. Despite this, there is an indication that HF clients are being arrested less frequently than they did before being housing. Specifically, based on background checks of program participants, 25 HF clients were arrested in the year prior to being housed and only 5 have been arrested since being housed, many of which were for minor infractions. Additionally, no individual has been arrested since being housed that had not been recently arrested prior to being housed.

- Despite the HF clients' limited experience in the program, individuals that completed at least two assessments report positive improvements in their satisfaction with life (Table 2).

- We currently have limited data on hospital stays and employment data but plan to include this data in future reports. Preliminary data suggests that some clients are interested in pursuing employment.

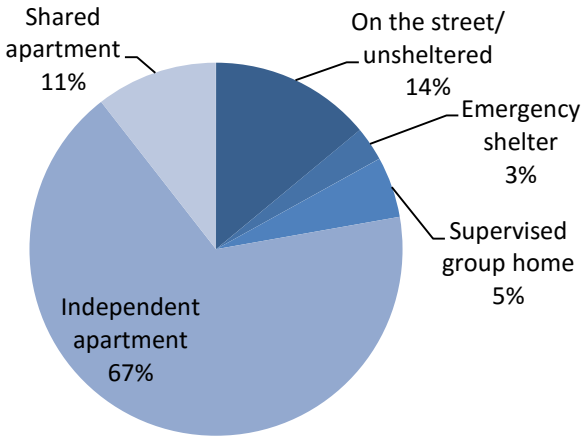
> *"I'm going to look into some other part-time employment and, you know something with structure. Hopefully, something in the field of art. Or something art-related. I don't know how choosy I can really be, but, you know, [something that] brings in money, and also, I want to get a circle of friends, you know, that support. Not just a support group. I want to get a healthy bunch of friends."*
> *– Housing First client*

Assessment Findings

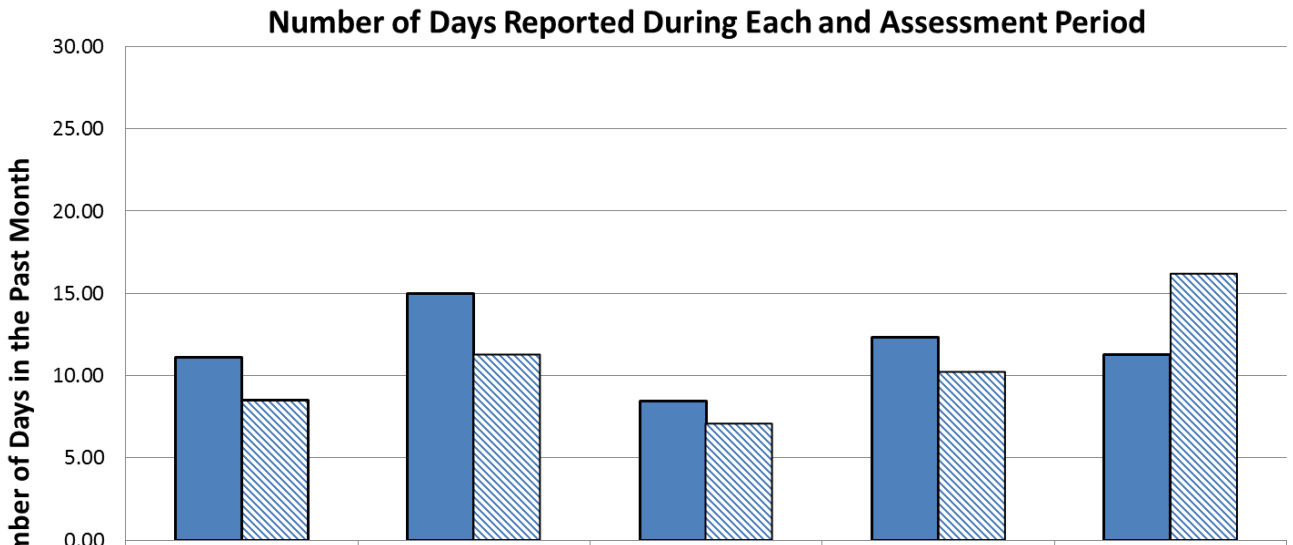
The following figures are based upon Housing First clients that completed at least two HFATs (n=23). They were created to determine whether individuals who have recently obtained housing services report differences in their housing history, support, stress, and quality of life over a short time period (52 days on average).

We first inventoried where Housing First participants spent the night in the month prior to their assessments. We found that while not all program participants had been placed into an independent apartment prior to their first assessment, all **Housing First clients reported staying in their new housing every day in the month prior to their second assessment.**

Figure 10. The percentage of days in the previous month HF clients reported in each location during their first assessment



- **HF clients reported spending every night in their new apartment during their second assessment. This suggests that changes in Housing First clients' health and well-being from their first to second assessment were likely due to the housing and support services provided by the Housing First Program.**



	# of Physically Unhealthy Days	# of Mentally Unhealthy Days	# of Days Activities were Limited	Days without Enough Rest or Sleep	Days Full of Energy
Housing First - 1st Assessment	11.09	14.96	8.43	12.35	11.27
Housing First - 2nd Assessment	8.52	11.27	7.09	10.22	16.23

Figure 11. The number of unhealthy days reported by program participants during their first and second assessment

- Housing First participants report, on average, fewer physically unhealthy, mentally unhealthy, and activity limitation days at follow-up compared to baseline.

- Despite this notable progress, the number of physically unhealthy days across all programs and assessment periods is well above the mean for adults living in Hawaii (physically unhealthy days = 3.46 days; mentally unhealthy days = 2.83; activity limitation days = 4.78*; Source: Hawaii 2013 Behavioral Risk Factor Surveillance System Questionnaire, CDC, 2014*).

Progress in the Areas of Stress, Satisfaction with Life, Social Support and Community Connections

We are also interested in determining whether participants in the Housing First program are about to utilize social support and community connections to reduce stress and increase their satisfaction with life. If these changes are established, there is a stronger indication that individuals will be able to sustain their housing and on-going well-being. The following results are based on 23 Housing First clients who have completed at least two assessments, which are on average, given 52 days apart.

Table 2. Changes from 1st to 2nd Assessment for Housing First Participants

HFAT Variables	1st Assessment	2nd Assessment	% Change
	Mean	Mean	%
Average Perceived Stress (1=Low stress, 5 = High Stress)	2.71	2.46	-10
Available Social Support (1=Low support, 5=High Support)	2.91	3.11	7
Number of days had hope for the future	19.00	21.87	15
Number of days visited a community of faith or spirituality	2.91	3.30	13
Number of days participated in a community group activity (e.g. sports, art, music, writing)	3.30	3.70	12
Average Satisfaction with Life (1 = low satisfaction, 5=high satisfaction)	2.99	3.10	4

- Participants in the Housing First program report a 10% decrease in stress between their first and second assessment.
- Participants report increases in available social support, hope for the future, and connections to community groups.
- While small, participants are reporting increases in their satisfaction with life despite only a short period of time passing between their first and second assessment.

The table below provides a preliminary glimpse of how the variables found in the Housing First Theory of Change model (p. 8) are associated with one another – or are statistically correlated. Correlations range from 1 to -1. If two variables are positively correlated (1) they move in the same direction – e.g., higher satisfaction with life is associated with greater hope for the future (r = .48); if they are negatively correlated (-1), they move in opposite directions, e.g., as stress goes up, satisfaction with life goes down (r = -47). These correlations do not suggest that one variable causes the other, but they do support our theory of change model.

Table 3. Correlations between Primary Variables of Interest

	VI-SPDAT	Support	Stress	Sat. with Life	Hope	General Health	Living on the Street	Ind. Apt.	Alcohol Use
Support	.07								
Stress	.21	-.27							
Satisfaction with Life	-.25	.08	-.47**						
Hope	-.36	.35	-.69**	.48*					
General Health	.02	-.01	-.46*	.28	.44*				
Living on the Street	.23	-.01	.27	-.47*	-.31	.32			
Independent Apartment	-.15	-.32	-.07	.44*	.20	-.33	-.47*		
Alcohol Use	.27	-.16	.28	-.44*	-.43*	.19	.53**	-.28	
Drug Use	.08	-.49**	.16	-.23	-.20	.00	.26	-.13	.41*

Note. *p<.05, **p<.01, statistically significant associations

Among Housing First Clients:

- Higher levels of social support were found to be associated with less drug use (r = .49, p<.01).
- Higher levels of stress were found to be associated with less satisfaction with life (r = -.47, p<.01), less hope for the future (r = -.69, p<.01), and worse health (r = -.46, p<.05).
- Higher levels of satisfaction with life were found to be associated with more hope for the future (r = .44, p<.05) and lower likelihood of using alcohol (r = -.43, p<.05).
- Living on the street was found to be associated with a greater likelihood of using alcohol (r = -.47, p<.01).
- Alcohol use was found to be associated with a greater likelihood of using street drugs (r = -.47, p<.01)

Considerations for Outcomes & Impacts

Additional themes and outcomes emerged from the data that have implications for the program's long-term impact. Overall, the clients interviewed viewed the program positively, holding their case managers in high regard and were using their time in the program to rest and look for employment.

Client Initiative

The clients interviewed took great initiative in assisting their case managers in the housing process and in obtaining services and employment after placement. Two of the interviewees were employed, and one was actively seeking employment.

> *"Well, I didn't have an address, I couldn't get a job. And so now, I have a part time job. And I also do a volunteer job that I do [... It's a] class for disabled people, and that's very, it's just very rewarding for me to do that. And it's in a field that I enjoy, [...and] it's something that I feel like I'm making a contribution and I'm not just laying around, feeling sorry for myself, you know? I'm doing a positive thing. And it is a very positive thing. It's an uplifting thing for me, and it's a fun thing for all of us."*
> *– Housing First client*

Time for Rest

All of the clients interviewed expressed feeling great relief in the initial period following housing. This reprieve was both difficult and necessary in making the transition to being housed and recovery from the trauma of homelessness.

> *"Now I'm in housing – I came in a little bit too late, sort of. My whole body's falling apart in my house, yeah? I mean, I wish I had it before. I mean, this program is good. Yeah? To take up somebody before they get health issues." – Housing First client*

> *You know, I remember when I first got into Housing First, I can't lie, I was still in my head space. Where I was just like… lost. You know? And, even though I worked really hard, and showed up, and did the things, and all that stuff that I had to do to get in it […], once I got in, I was kind of like [sighs]. You know? It's like "now I can stop." And now, today – I feel like just this past month – I feel like there's been a new me starting to come out. – Housing First client*

Case Managers as Role Models

Clients held their case managers in high regard and seemed to view them as role models. A couple of interviewees desired to give back to the community by becoming case managers themselves.

> *"I really like [my case manager]. I think she's a special person. I even asked her, 'How could I maybe do what it is that you do? I'd like to maybe help people like you help people.' [...]. So, I mean, I'd like to be of service to other people that have been in my situation and, you know, people who had drug problems. I find a lot of the people that I know in the program are better off with being housed."*
> *– Housing First client*

Sustainability

Both case managers and clients expressed concern about what happens next with the program. Clients showed emotional distress at not knowing how long they could remain in the program, which necessarily affects the type of career/education path they take. Case managers were concerned that "lower functioning" clients would take longer to transition to independent living than the program could allow.

> *"Now I'm starting to kind of worry. Like I'm feeling happy, and I'm like things are starting to look better for me. But what's gonna happen? What's gonna happen like when the year is up, when the lease is up? Am I going to get kicked out? I'm worried. Are they gonna like let me stay? Is everything going to change? Am I suddenly gonna have to like pay more? And I don't know any of these questions. And I'm- I'm scared. You know? Because, I don't know if I'll be ready, and I would like to know if I NEED to be ready to do those things. Because if I need to be ready, I need to prepare. And I need some warning. Can't just like find out 30 days before the end of the lease. [...]. I'm worried that this is going to get taken away. Before I've had a chance to really just do what I need to do." – Housing First client*

> *"I just think the program, it needs to be extended. It can't just be one year or two years because that's pie-in- the-sky thinking. That just, it doesn't happen. You know, you might get the few and far between person that... you know. But a lot of the people that we're working with...it's just not going to happen."*
> *– Housing First case manager*

Next Steps

- The HFAT will be administered to all new HF clients and re-administered to existing clients on a monthly basis.
- Summary data from the HFAT, including the identification of specific services needed by program clients, will be reported back to program staff on a bimonthly basis
- VI-SPDAT data will be interpreted to determine whether the most vulnerable individuals are receiving and maintaining housing, whether their vulnerability can be corroborated by supporting HFAT data, and whether the health status of individuals entering the program is a determining factor in their ultimate success in the program.
- Qualitative HF interviews will be conducted with a small subset of program participants to determine which elements of the program are most critical to their success or failure in the program.
- Qualitative interviews will be conducted with HF program staff to identify barriers to implanting the program as intended and assess the implementation of the HF model in Honolulu compared to established HF fidelity criteria.
- The evaluation team will utilize an additional qualitative data collection technique in the upcoming evaluation period. We will use a photo feedback method – a creative way to conduct research with vulnerable populations in a way that is empowering and participatory. The data will help the evaluation team track nuanced behavior and attitude change with clients as well as will provide insight into the program process.
- Gain access to additional cost-effectiveness data. We currently have only limited cost-effectiveness data available but it is worth noting that Larimer et al. (2009)[5] found that potential Housing First participants on average, utilized $4,066 worth of services per month due to their dependency on medical and criminal justice systems prior to receiving services. This cost equates to $48,792 annually. They found that after only 1 year of receiving Housing First services, monthly costs to the system were reduced to $958 per month or $11,496 annually. Therefore, as long as the Housing First program is implemented appropriated, it will likely remain cost-effective even if the average services costs rose to $37,296 per client, per year.

[5] Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., ... & Marlatt, G. A. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA, 13*, 1349-1357.

Recommendations

Based on challenges indicated in the interviews and the barriers to program implementation and fidelity, we make the following recommendations for the next funding year. We recommend that the funders:

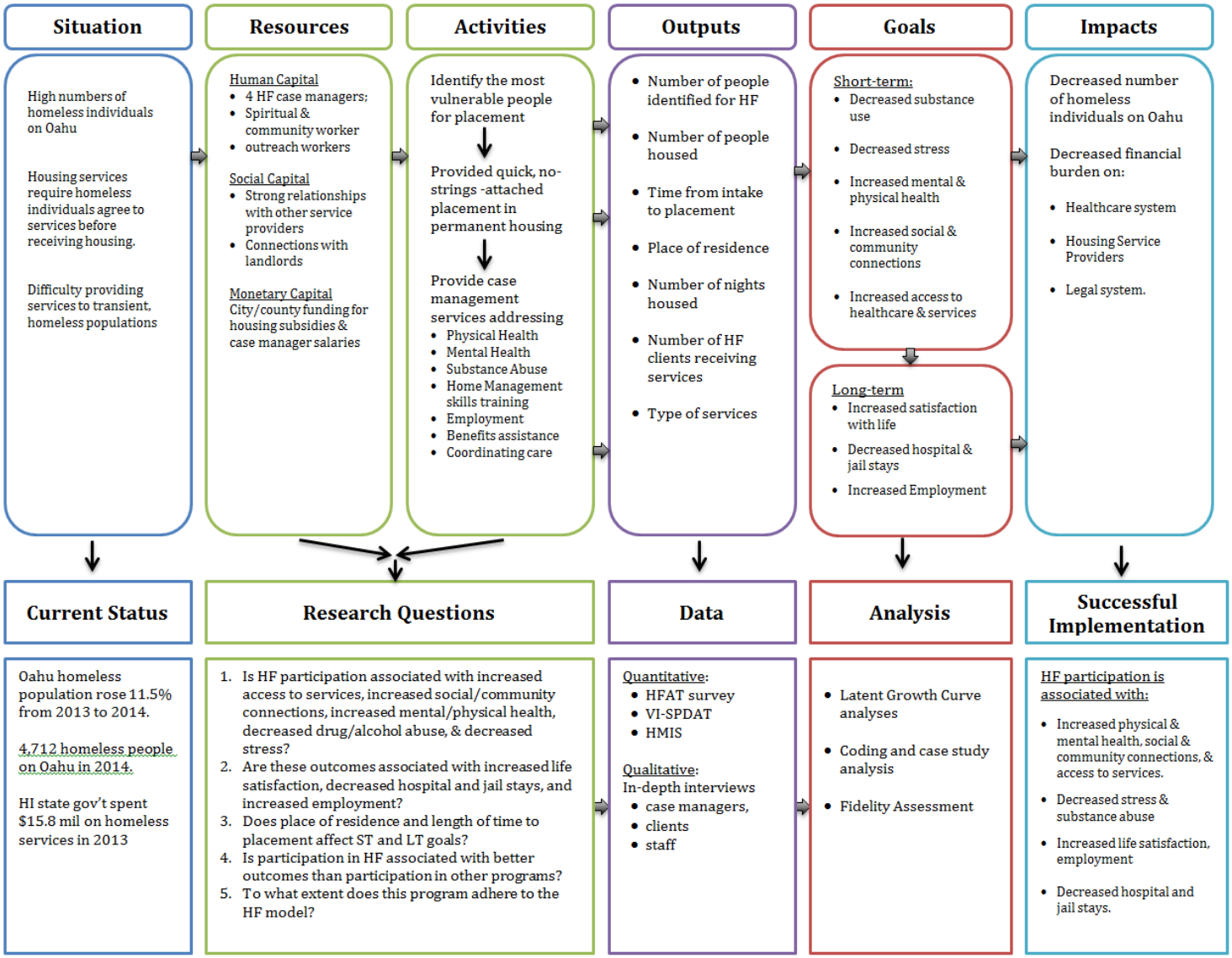
- Dedicate additional funding for more resources to provide wrap-around services and employment opportunities to clients.
- Fund more case management positions in order to reduce the number of cases per case manager to the desired 10 caseloads.
- Reinforce outreach procedures so that potential clients are assigned a housing navigator who can connect potential clients with housing first case managers quickly and efficiently OR consider restructuring this procedure in a way that eliminates the unnecessary barrier of requiring the program to go through a third party to determine client eligibility and location.

We recommend that the program:

- Devote more resources to helping successful ("higher functioning") clients find employment and access services to help "graduate" clients from the program, ensuring long-term program sustainability.
- Develop a program model that explicitly delineates the process of transferring clients to external case managers and provide on-going training to case managers on this model.
- Formally and clearly delineate case manager, outreach worker, and housing specialist responsibilities.
- Ensure that a running master list that includes each client, his or her status and progress in the program, and assigned case manager is accessible to all program staff (including case managers and housing specialists) and the evaluation team.
- Relay information regularly to clients regarding the program's future, their progress in the program, and expectations for their future in the program.
- Continue to develop a formal mechanism for receiving and responding to client input and feedback.

Appendix A

IHS Housing First Logic Model



Appendix B

Measurement Plan

The following section outlines the ways in which the evaluation team will measure Housing First (HF) outcomes, short-term goals, and long-term goals as indicated in the logic model. The measurement framework below lists the indicators we will use to measure these outcomes as well as shows the data source for each indicator and explains how that data will be collected. The evaluation will rely on three primary data sources: the **Hawaii State Homeless Management Information System** (HMIS), the **Vulnerability Index and Service Prioritization Decision Assistance Tool** (VI-SPDAT) scores, and the **Housing First Assessment Tool** (HFAT). A summary of indicators measured using the HFAT can be found in the Housing First Assessment Tool – Measurement Summary (p.20). HMIS individual client data is maintained by case managers and service providers throughout the state, including IHS HF staff. After gaining access to the system, the evaluation team will be able to search for HF clients in the system. VI-SPDATs are administered by outreach workers and case managers from various housing service providers throughout the state. Because VI-SDAT scores are used to vet HF clients into the program, each client should have at least one VI-SPDAT score.

The main data source will be the Housing First Assessment Tool, designed specifically for this HF program. Ideally, HF case managers or IHS outreach workers should administer the HFAT upon initial identification of the client for HF. It is important that we obtain data before housing placement in order to show differences in outcomes before and after the program. The study design requires that individual clients' data are available across multiple points in time. Therefore, Housing First case managers, with the assistance of the evaluation team, should strive to administer the HFAT to clients monthly after the initial assessment at intake. The HFAT not only will be useful in detecting Housing First impact, but also, will be useful to case managers in documenting client progress, identifying emerging client issues, and matching clients with services. The table below provides a summary of HFAT measures and indicates the purposes these measures are meant to serve.

Additionally, the evaluation team plans to conduct **semi-structured interviews** with representatives from different stakeholder groups, including case managers, IHS staff, HF clients, and landlords to supplement the survey data and to provide a context for understanding that data. Interview questions will explore experiences with Housing First – examining what worked, what didn't, and what could work better. Interviews will be transcribed and coded for common themes within groups and across groups. Survey data supplemented by personal experiences will provide a comprehensive view of HF impact.

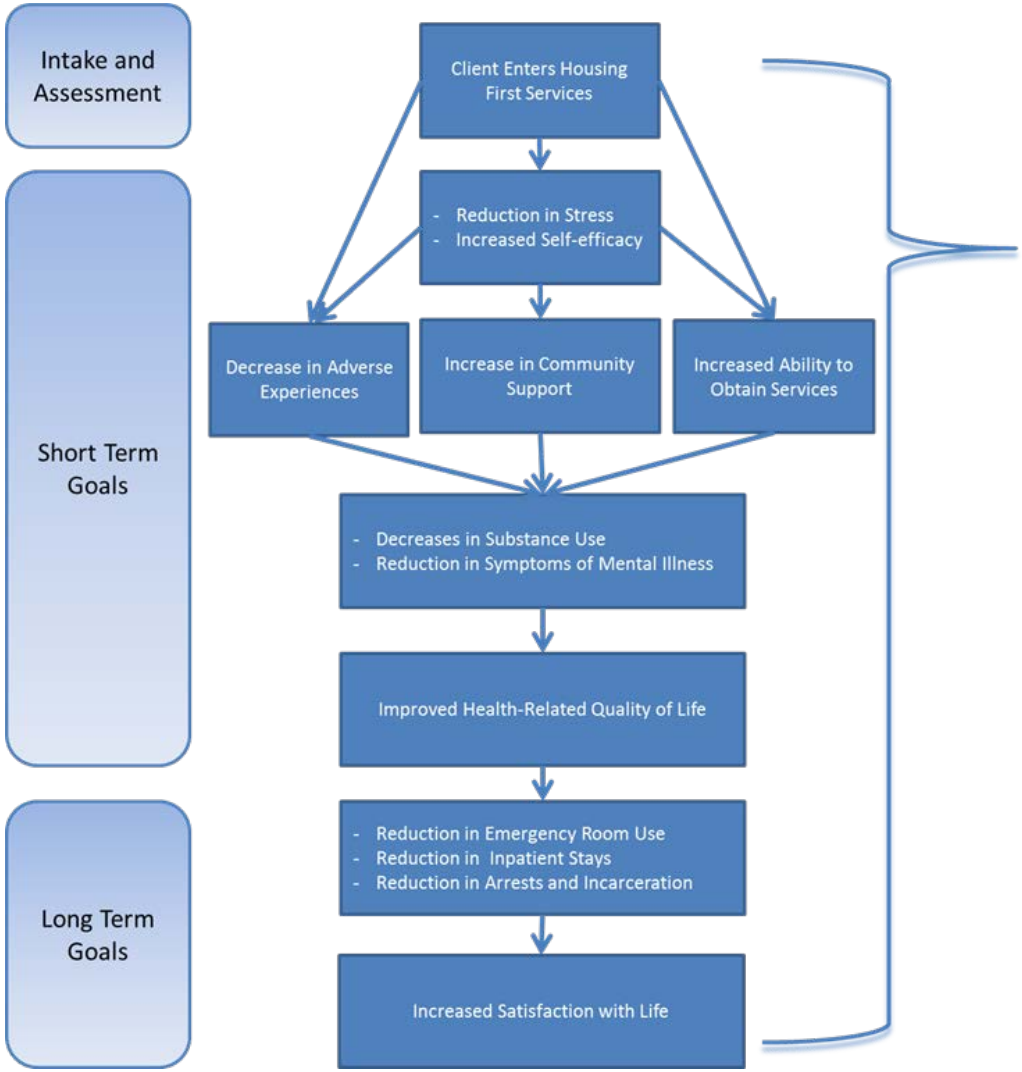
Housing First Assessment Tool – Measurement Summary		
Purpose	**Measure**	**Explanation**
Documenting Client Progress	Social support	Do clients have emotional and physical support available?
	Life satisfaction	Extent to which clients are satisfied with their life
	Self-efficacy/Stress	Clients' confidence in their abilities to control what happens to them.
	Access to healthcare	Do clients have access to routine and specialized healthcare as needed?
	Physical/mental health	Assesses the number of unhealthy days client has experienced in past month
	Frequency of adverse experiences	How often clients have experienced trauma/ anxiety/abuse in past month
	Community support	Frequency of participation in community groups, such as faith-based or sports groups
	Housing Situation	Current housing status (homeless, shelter, transitional, etc.)
Identifying Emerging Issues	Alcohol/drug use	Frequency of alcohol and drug use and clients' feelings toward their use.
	Hospital/Jail time	Frequency of time spent in hospital/jail and type of crime/illness
	Housing preferences	If given a choice, what type of housing would clients prefer and what location?
Matching Clients with Services	Services needed	Clients identify what services they feel like they still need
	Helpful services	Clients identify which services have been most helpful
	Benefits received	Clients identify what government benefits they receive

Housing First Measurement Framework

Outcomes	Indicators	Data Source	Data Collection Method
1. Most vulnerable people identified for HF	• Number of people identified for HF • Identified people's VI-SPDAT scores	• HMIS database • VI-SPDAT	• Extracted from HMIS • Extracted from VI-SPDAT
2. Identified clients are housed	Number of people housed	HMIS database	Extracted from HMIS
3. Identified clients are housed quickly	Number of days from intake to placement	HMIS database	Extracted from HMIS
4. Identified clients placed in permanent housing	Place of residence	HMIS database/ HFAT	Extracted from HMIS or HFAT
5. Placed HF clients fewer # nights on street	Number of nights housed	HMIS database/ HFAT	Extracted from HMIS and/or HFAT
6. Placed HF clients continue to receive services	Number of HF clients receiving services	HFAT	Extracted from HFAT, administered at baseline & monthly thereafter
Short-Term Goals	**Indicators**	**Data Source**	**Data Collection Method**
14. Decreased substance use	• Monthly frequency of drug use • Monthly frequency of alcohol use	HFAT	Administered at baseline & monthly thereafter
15. Decreased Adverse Experiences	Monthly frequency of • Trauma • Anxiety • Abuse	HFAT	Administered at baseline & monthly thereafter
16. Increased mental health	Number of unhealthy days per month	HFAT	Administered at baseline & monthly thereafter
17. Increased physical health	Number of unhealthy days per month	HFAT	Administered at baseline & monthly thereafter
18. Increased social support	• Availability of emotional support • Availability of physical support	HFAT	Administered at baseline & monthly thereafter
19. Increased community connections	Frequency of participation in community groups/activities	HFAT	Administered at baseline & monthly thereafter
20. Increased access to healthcare Routine Specialized	• Does client have health care coverage? • Does client have a PCP? • Does client have access to a nearby specialist? • Is cost an inhibitor? • Length of time b/t routine checkups • Travel distance to PCP	HFAT	Administered at baseline & monthly thereafter

21. Increased use of needed services	• Services used • Services needed • Frequency of meetings with case workers	HFAT	Administered at baseline & monthly thereafter
22. Decreased stress	4 questions assessing impact of personal stress	HFAT	Administered at baseline & monthly thereafter
Long-term Goals	**Indicators**	**Data Source**	**Data Collection Method**
1. Increased life satisfaction	5 questions assessing attitudes toward life	HFAT	Administered at baseline & monthly thereafter
2. Decreased hospital stays	Frequency of days spent in ERs and hospital	HFAT	Extracted from HFAT
3. Decreased jail stays	Frequency of days spent in jail	HFAT	Extracted from HFAT
4. Increased Employment	Employment income indicated	HFAT	Extracted from HFAT

Appendix C
Figure 1. Housing First Theory of Change



Considerations/assumptions:

- Individuals most in need are eligible for housing.
- Individuals receive housing opportunities within one month of being assessed.
- Individuals are able to obtain housing in a desirable location.
- Individuals housing options fit their required level of care.
- Individuals are able and willing to receive services prior to and after placement into housing.
- Staff are available to meet with program participants regularly after placement.
- Property managers do not have unrealistic expectations and policies

Appendix D

Housing First Fidelity Criteria

Watson et al. 2013 Housing First Fidelity Index	
Dimension I: **Human resources-structure & composition**	**Refers to the composition & structure of the staffing.**
1. Diverse Staff	Program staff highly reflects the diversity within the consumer population.
2. Minimum Education Requirements	At least 25% of case managers have a Master's degree or higher.
3. Harm Reduction & Crisis Intervention Knowledge	Program provides or requires ongoing training in harm reduction & crisis intervention for staff
4. Staff Availability	At least one staff member is available to consumers twenty-four hours a day, seven days a week
5. Clinical Staffing	Program has psychiatric staff and mental health professional on staff or contract
Dimension II: **Program boundaries**	Limits placed on who the program will serve & the responsibilities of key staff members.
6. Population Served	**Program serves only chronically homeless & dually-diagnosed individuals, & it houses current drug users.**
7. Consumer Outreach	There is a designated staff member dedicated to outreach or an outreach department.
8. Case Management Responsibilities	Case management responsibilities are limited to case management.
9. Termination Guidelines	The program only terminates consumers who demonstrate violence, threats of violence, or excessive non-payment of rent.
10. Termination Policy Enforcement	The service termination policy is consistently enforced.
Dimension III: **Flexible policies**	**Policies & rules are written to appropriately serve consumers with greatest need/vulnerability & to allow them maximum choice in terms of substance use & housing.**
11. Flexible Admissions Policy	The program has formal protocol for admitting consumers with the greatest need/vulnerability
12. Flexible Benefit/Income Policy	The possession of or eligibility for income benefits is not a prerequisite for housing.
13. Consumer Choice in Housing Location	The program works with consumers to find desirable housing.
14. Flexible Housing Relocation	The program always attempts to relocate consumers when they are dissatisfied with their current housing placement.
15. Unit Holding & Continuation of Case Management	The program holds housing for hospitalization & incarceration for more than 30 days & program continues to offer case management services while unit is unoccupied.
16. Flexible with Missed Rent Payments	The program is flexible with missed rent payments, but holds the consumer accountable.
17. Flexible Alcohol Use Policy	The program allows alcohol use & housing allows alcohol in units.
18. Flexible Drug Use Policy	The program allows illicit drug use & housing allows illicit drug use in units.
19. Eviction Prevention	The program has a formal policy & protocol to work with consumers to prevent eviction & has a staff

	member dedicated to eviction prevention.
20. Consumer Input into Program	The program has formal & informal mechanisms for receiving & implementing consumer input.
Dimension IV: **Nature of social services**	**The structure, policies, & practices related to social services offered by the program. (There is some overlap with Dimension IV; however, this dimension refers specifically to social services).**
21. Low-demand Service Approach	Consumers are not required to engage in any services except for case management in order to receive/continue receiving housing.
22. Harm reduction approach to service provision	Program uses a harm reduction approach & staff has a strong conceptual understanding.
23. Regular in-person Case Management Meetings	Consumers meet with their case managers 2-3 times a month on average, but program has a policy that more frequent meetings occur in the first 1-6 months after admissions.
24. Small Case Loads	Case managers have 10 or fewer consumers on their caseload.
25. Ongoing Consumer Education	Consumers receive ongoing education in Housing First and harm reduction policies & practices.
Dimension V: **Nature of housing & housing services**	**The structure of housing & housing services offered by the program and/or private landlords.**
26. Structure of Housing	Housing is scattered-site in buildings operated by private landlords.
27. Fast Placement into Permanent Housing	The program places consumers into housing in one week or less.
28. Temporary Housing Placement	Temporary housing placement does not last more than one month.
29. Consumer is Lease Holder for Housing Unit	100% of consumers are the leaseholders of their unit.

Appendix E

Housing First Analytical Plan

Research Questions

The following research questions – as stated in the Logic Model – address four main areas of concern: Housing First attainment of goals (RQ 1-2), potential factors that may affect the attainment of desired outcomes (RQ 3), comparison of HF to clients receiving other services (RQ 4), and fidelity to national HF program model (RQ 5):

RQ 1. Is HF participation associated with attaining short-term (ST) goals?

- Decreased substance use
- Decreased stress
- Increased mental & physical health
- Increased social & community connections
- Increased access to healthcare & services

RQ 2. Is HF participation associated with attaining long-term (LT) goals?

- Increased life satisfaction
- Decreased hospital & jail stays
- Increased Employment

RQ 3. Does place of residence and length of time to placement affect attainment of ST and LT goals?

RQ 4. Is participation in HF associated with better attainment of LT and ST goals than participation in other programs?

RQ 5. To what extent does IHS-HF adhere to HF model?

Participants

Research participants include IHS clients who are participating in Housing First (treatment group) and IHS clients who are participating in other housing services (comparison group). Additionally, IHS staff and HF case managers will be involved in the fidelity checklist and qualitative interviews.

Measures
The evaluation team proposes the following measures to answer the above research questions:

- Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT). The VI-SPDAT consists of two tools:
  - Vulnerability Index: Measures medical vulnerability of homeless
  - Service Prioritization Decision Assistance Tool: Used to assist case managers and outreach workers with client intake and resource allocation by measuring homeless clients' acuity.

- Housing First Assessment Tool (HFAT): Developed by Jack Barile to assess IHS's HF effectiveness at achieving ST and LT goals.

- Watson et al., 2013 Housing First Fidelity Index (HFFI): Gives checklist of nationally agreed-upon criteria for HF models.

- HF Qualitative Interview Instrument (HFQII): Semi-structured interview guide to assess adherence to program model and to supplement quantitative data by providing context.

These measures are described in more detail in the measurement section of this proposal.

Procedures
Each HF client will be administered the HFAT once a month, beginning at baseline (intake). HF case managers, IHS outreach workers, and members of the evaluation team will work together to administer the instrument. Additionally, IHS outreach workers and case managers will administer the HFAT once a month (beginning at intake) to a comparison group of IHS clients who are participating in alternative housing services.

VI-SPDAT scores should be available for each HF client and comparison group client since all Oahu housing service providers use the instrument to assess vulnerability before providing services. Members of the research team will obtain VI-SPDAT scores from PHOCUSED, the organization who scores the instruments. Additionally, IHS should provide any relevant VI-SPDAT scores to the research team.

Evaluation team research will enter VI-SPDAT and HFAT data into Qualtrics, a university-supported data management and collection program. Each HF client will be given an ID number comprised of initials from the following: Agency, Gender, Interviewer Initials, Month Day of FIRST interview, Client First/Last Initials. Additionally, HFATs will be matched with VI-SPDATs so that each

participant should have a VI-SPDAT and at least 4 HFAT scores. The evaluation team will pick up iHS-collected HFATs once a week and will provide IHS with the coversheets of any evaluation team-collected HFATs from that week.

The evaluation team will administer the Fidelity Index to case managers, IHS staff, and HF clients at 6-month intervals. This data will also be entered into Qualtrics for analysis.

Data obtained from IHS and HF clients will be kept under double-lock – in a locked file cabinet in a locked lab. Besides the original paper HFAT and VI-SPDATs, all data will use ID numbers with no names in order to protect clients' confidentiality.

Analysis Strategy

The evaluation team will test the above research questions primarily by conducting a *latent growth analysis*.[6] This method will allow us to determine how Housing First clients change over time after intake. Four or more time points of HFAT measurement can show changes in ST and LT goals, such as days housed, ER use, number of healthy days, life satisfaction, stress, etc. Obtaining multiple HFAT scores over time can give a more complete picture of the ways in which being housed affects these variables over time. Latent growth analysis will be particularly useful in answering Research Questions 1, 2, and 4.

Research Question 4 involves the use of a comparison groups' HFAT scores. Having a comparison groups' scores will allow us to tell if changes in ST and LT goals are different for HF clients than for clients receiving other types of housing services. For example, we anticipate that HF clients will experience a reduction in ER visits after being housed and that ER visits will continue to decline the longer clients are housed. Comparison group data will allow us to see if ER visits have reduced more for HF clients than for other housing clients. See Graph 1 below for a hypothetical example.

Path analysis can be used to test the effect that certain variables, like place housed and time to placement, may have on ST and LT goals. For instance, we may find that HF participation is associated with decreased stress; however, HF participation may be associated with increased stress if there is a large amount of time between intake and placement.

To further understand the context of HF and to uncover topics not covered in HFAT and HFFI, members of the evaluation team will conduct interviews with primary stakeholders. The interviews will then be transcribed and coded for common themes within and across groups (HF case managers, HF clients, IHS staff).

[6] For more information on latent growth analysis, see Duncan and Duncan (2009), available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888524/

To analyze the adherence of the program to national HF, the evaluation team will examine the HFFI to check agreement across groups on items and frequencies. This will be completed by determining the level of adherence to each of the 5-10 program HF characteristics defined by Watson et al., 2013.

Analysis Methods by Research Question

Research Q	Method	Measure	Participants
1. Is HF participation associated with attaining ST goals?	• Latent Growth Analysis	• HFAT	• HF clients
2. Is HF participation associated with attaining LT goals?	• Latent Growth Analysis	• HFAT	• HF clients
3. Does place of residence & length of time to placement affect attainment of ST & LT goals?	• Path Analysis testing for moderation (Regression)	• HFAT • HMIS	• HF clients
4. Is participation in HF associated with better attainment of LT & ST goals than participation in other programs?	• Latent Growth Analysis using a comparison group	• HFAT	• HF clients • Non-HF clients
5. To what extent does IHS-HF adhere to HF model?	• Frequencies (Checklist) • Qualitative data coding (Interviews)	• HFFI • HFQII	• IHS staff • HF case managers • HF clients

Appendix F
Interview Instrument
Institute for Human Services Housing First Service Providers

Participant Code #: _____ **Interviewer: _____**
Place: _____ **Time: _____**

I. Role in Housing First
Thank you for agreeing to participate in this study. I want to start by talking about your role in the Housing First project.

1. Please describe how you became involved with Housing First?

2. What are your primary responsibilities with regard to Housing First?

II. Challenges
We are also interested in some of the barriers to HF implementation and suggestions you may have to improve the program.

1. Please describe some of the challenges you faced as a HF service provider.
   PROBE: With regard to finding housing for the client? With regard to …

2. What was the **biggest** challenge you encountered?

3. How did you overcome or respond to these challenges?

III. Successes
We want to document the major successes of the Housing First program…

1. Please describe some of the successes you've had with your clients?

2. Please describe your greatest success story so far. (Prompts: How long did the client wait for housing? What goals has the client accomplished? What aspects of your role have been the most beneficial?)

IV. Program Fidelity

One of the goals of this study is to understand the ways in which the program was implemented. The following questions address Housing First implementation here on Oahu.

1. What is the typical amount of time from intake to housing placement?

2. Please describe any changes to the program that had to be made once the program began?

3. What makes the housing first program unique or different from how you have done case management with clients in the past?

4. What aspects of the housing first program are similar to how you have done case management with clients in the past?

V. Demographics

Age: _____
Gender: _____
Race/ethnicity: _____
Years working with homeless population: _____
Years in Hawaii: _____

Appendix G
Interview Instrument
Institute for Human Services Housing First Service Clients

Participant Code #: _____ **Interviewer: _____**
Place: _____ **Time: _____**

I. Background

Thank you for agreeing to participate in this study. I want to start by talking about your experience with homelessness and how you came to be involved with Housing First.

1. Please describe a typical day in your life since you became homeless. (Prompts: Where do you sleep? Where do you go during the daytime? What activities do you do?)

2. What events led to your becoming homeless?

II. Housing First Experience

One of the goals of this study is to understand the ways in which the program works here on Oahu and the quality of your experience with the program.

5. How long have you participated in the Housing First program? Have you been placed into housing? How long did it take for you to be placed into housing once you were identified for the program?

6. Please describe your experiences with your case manager. (Prompts: How often do you meet? How long are your meetings? Does the case manager address questions or concerns you have?)

7. Please describe your overall satisfaction with the case management you have received.

8. What do you like most about the Housing First program?

9. What do you like least about the Housing First program?

III. Challenges

4. Please describe any challenges you have faced since participating in the housing first program. (Prompts: Issues with case management? Issues with your landlord? Transportation? Housing? Other concerns?)

5. What was the **biggest** challenge you encountered?

6. How did you respond to these challenges?

IV. Successes

1. Please describe any successes you have had since participating in the Housing First program. (Prompts: Goals met with case management? Transportation? Housing? Other successes?)
2. What was is the greatest success you have had so far?

3. How did you respond to this success?

V. Experiences

1. We are interested in finding out how things have changed for you since being enrolled in the Housing First Program. Since starting in the program:
    a. Has the number of people that you can count on when you need them changed?
    b. Are you able to do things that you were not able to do before?
    c. Are you involved in any social groups?
    d. Has your health or well-being changed?

V. Demographics

Age: _____
Gender: _____
Race/Ethnicity: _____
Number of years homeless: _____
Number of times homeless:_____
Years in Hawaii: _____