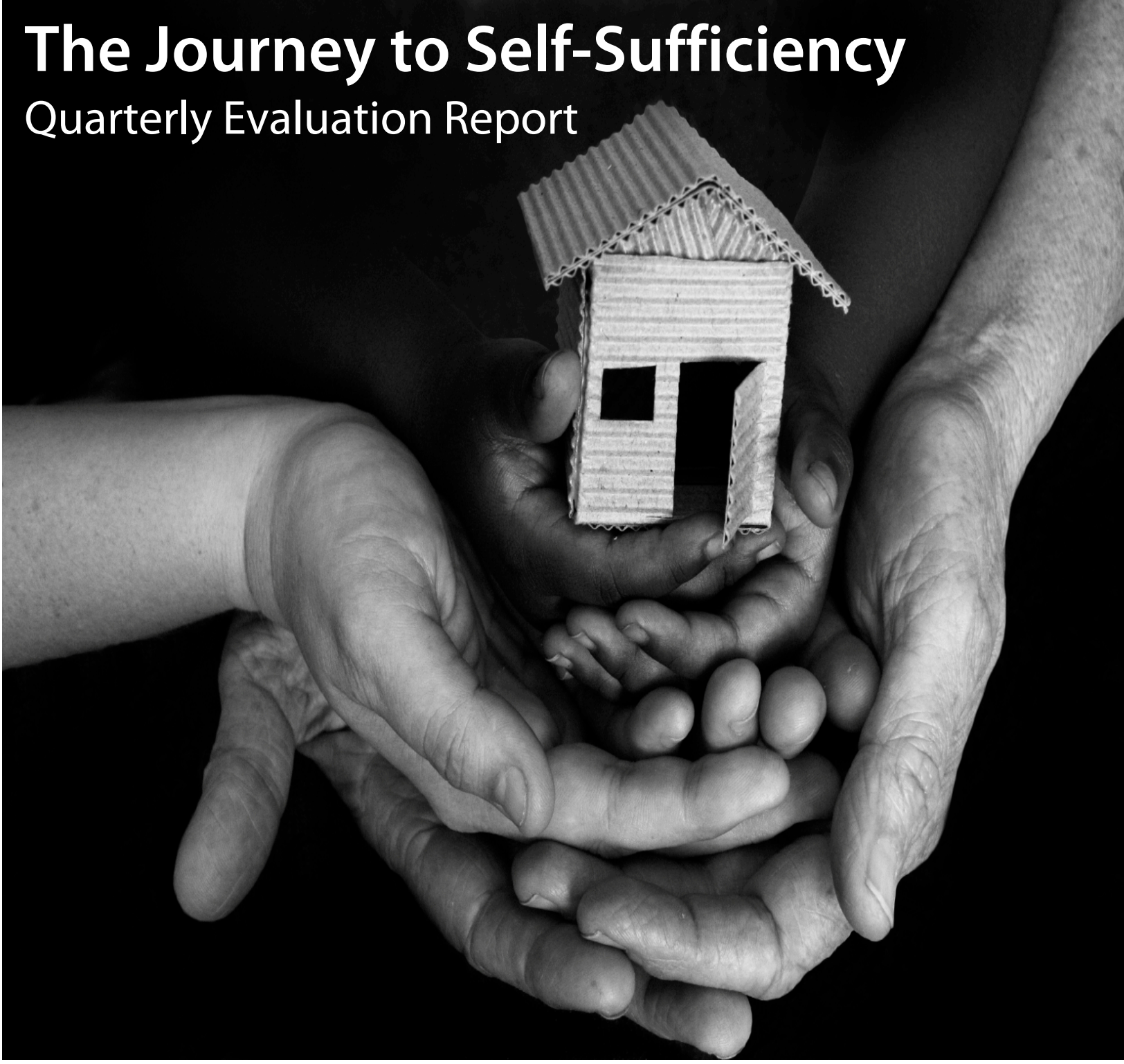
The Journey to Self-Sufficiency

Quarterly Evaluation Report



Downtown Women's Center
Critical Time Intervention Project

December 13, 2013

harder+company
community research

DOWNTOWN WOMEN'S CENTER

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Executive Summary

The Downtown Women's Center was awarded a grant from the Conrad N. Hilton Foundation and Fannie Mae to implement a Critical Time Intervention (CTI) project. CTI is a time-limited case management model designed to prevent homelessness in people with mental illness after institutional discharge or placement in housing. With additional support from the Corporation for Supportive Housing, Los Angeles Department of Mental Health, and Housing Innovations, the CTI project began in 2011 with the goal to provide stable housing and case management to women transitioning out of shelters, hospitals, and other institutions. The purpose of the CTI evaluation is to understand the implementation (successes, challenges, barriers) of CTI and examine the impact that CTI has on participants.

To date the Downtown Women's Center Critical Time Intervention program has enrolled an ethnically diverse group of 80 participants ranging from 22 to 75 years of age (mean age of 49 years).

- All participants met the HUD definition for chronic homelessness; 53% spent a night on the streets within the three months prior to program entry.
- 71% of CTI participants experienced an overnight hospital stay for medical reasons; 41% did so for emotional reasons.
- 58% of CTI participants have spent an overnight stay in a detention center or jail.

Early-Intermediate Outcomes

As of October 2013, 80 women completed the nine month CTI program. Outcomes at nine months include:

- 100% of participants remain stably housed. Participants did not spend any nights on the street, in a park/public place, in a shelter, or in a jail/prison.
- 100% of participants are currently linked to mental health and/or physical health services. Less than 10% of CTI participants were hospitalized for mental or physical reasons.
- Participants significantly increased contact with family members and reported high levels of satisfaction with the CTI program, staff and the outcomes they have experienced as a result of the program.
- Participants' experienced statistically significant increases in independent functioning and levels of self-sufficiency.

These early findings suggest that women are experiencing real benefits from CTI that have an impact not only on housing stability, but potentially on their use of emergency health care systems, self-sufficiency and quality of life. Preliminary findings from the client focus groups suggest that clients feel a close personal connection to their CTI case manager, which clients feel is key to their success in the program. However, there was also a sense that some women may find the transition out of intense case management challenging than others. For the final evaluation report, we will also explore individual differences in outcomes post-CTI.

Early Evaluation Challenges and Next Steps

The amount of data available for analyses was limited due to challenges from a prior evaluation system (i.e., incomplete evaluation protocols, incorrect measures, missing data). Harder+Company worked in close collaboration with DWC staff to improve data collection. This included the addition of measures that could be completed by case managers (e.g., Self-Sufficiency Matrix) in order to reduce the burden on clients. The evaluation team also worked closely with staff and to clarify and monitor the administration schedule. Such changes were expected to provide richer data for the current reporting period.

Furthermore, the December 2011 planned enrollment of individuals living in DWC's Jill's Place was rescheduled to November 2012 due to construction delays. Additional clients from a third site (the Ford Hotel) who were not included in the original project proposal were included in the evaluation to offset some of the clients lost from the delays in the

opening of Jill's Place. The addition of this third site will allow evaluators to make site comparisons (owned and operated by DWC versus not owned and operated by DWC), which will be included in the final report (March 2014).

The Harder+Company evaluation team is currently conducting interviews with CTI staff and participants to document the implementation of CTI at DWC and Ford; preliminary findings from CTI participants are included in this report. Final analyses and findings for all quantitative and quantitative data will be presented in the final report in March 2014.

Part I: Program Background and Evaluation Purpose

The Downtown Women's Center (DWC) was awarded a grant from the Conrad N. Hilton Foundation and Fannie Mae to implement a time-limited intensive case management model called "critical time intervention" (CTI) with 80 chronically homeless women. With additional support from the Corporation for Supportive Housing, Los Angeles County Department of Mental Health, and Housing Innovations, the CTI project began in 2011 with the goal to provide intensive case management to women transitioning out of shelters, hospitals, and other institutions. The purpose of the CTI evaluation is to understand the implementation (successes, challenges, barriers) of CTI and examine the impact that CTI has on participants.

CTI is an evidence-based approach used for people suffering from severe mental illness who have been hospitalized for psychiatric care and prisoners with mental illness who are transitioning to the community.[1] CTI has been shown to significantly increase the likelihood that chronically homeless individuals remain stably housed,[2] decrease negative psychiatric symptoms, and prevent psychiatric rehospitalization.[3] CTI has also been shown to improve participants' continuity of care-meaning that they are more likely to keep up with their medical and mental health appointments as well as make more connections with their family and the community.[4] While there have been fewer research studies on the impact of CTI on chronically homeless *women*, this evaluation seeks to inform the existing literature and explain how CTI works for this particular population and in the context of Downtown Women's Center.

The CTI program evaluation sought to capture the experiences of women participating in the CTI program as well as identify the key successes and barriers of implementation. The purpose of this report is to highlight the key changes that participants in CTI demonstrated during the initial nine month CTI period. Specifically, this report will discuss how CTI is implemented and describe the immediate-intermediate changes CTI participants experienced as a result of participation in CTI.

Exhibit 1. Evaluation Assessments by Time Period

	Tenant Interviews	CTI Domains	Self-Sufficiency Matrix	Focus Groups	Provider Interviews
Baseline	X	X	X		
Phase 1	X	X	X		
Phase 2	X	X	X		
Phase 3	X	X	X		
Post-CTI				X	X

Evaluation Timeline and Methods

As of September 15th, 2013, 80 women completed the formal CTI program. A variety of methods and measures were employed to capture the experiences of women and staff participating in the CTI program (see Exhibit 1 for a summary of data collection methods) beginning at program enrollment.

[1] Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C., Huckle, S., Parrott, J., Dunn, G., and Shaw, J. (2012) Continuity of care for recently released prisoners with mental illness: a pilot randomized controlled trial testing the feasibility of a Critical Time Intervention. Epidemiology and Psychiatric Sciences, 21:187-193.

Tomita, A., & Herman, D. (2012). The impact of critical time intervention in reducing psychiatric rehospitalization after hospital discharge. Psychiatric Services, 63:935-937, doi: 10.1176/appi.ps.201100468

[2] Herman, D. et al. (2007). Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High Risk Groups. Journal of Primary Prevention 28:295-312.

[3] Tomita, A., & Herman, D. (2012). The impact of critical time intervention in reducing psychiatric rehospitalization after hospital discharge. Psychiatric Services, 63:935-937, doi: 10.1176/appi.ps.201100468

Herman, D., Opler, L., A Felix, Valencia, E., R Wyatt, & Susser, E. (2000). Critical time intervention: Impact on psychiatric symptoms. Journal of Nervous and Mental Disease, 188(3), 135-140.

[4] Dixon, L., Goldberg, R., Iannone, V., Lucksted, A., Brown, C., Kreyenbuhl, J., et al. (2009). Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services, 60, 451-458.

However since some measures were introduced later in the evaluation (for example, The Arizona Self-Sufficiency Matrix), a few findings in this report only capture the change of a portion of the total sample (see Exhibit 2)[5]. According to the CTI tenant survey assessment (N=78); 34 of the participants are from DWC's San Pedro Street location, 24 from Jill's Place, 13 from Ford Hotel, and 7 from scattered sites.

Exhibit 2. Evaluation Assessment Completion Rates

	Tenant Interviews				CTI Domains	Self-Sufficiency Matrix
	Total Possible (N)	% Completed	% Valid	% Declined		
Baseline	80	95%	95%	4%	76	51
Phase 1	80	46%	30%	6%	75	49
Phase 2	80	55%	33%	6%	73	48
Phase 3	78	60%	21%	8%	--	--

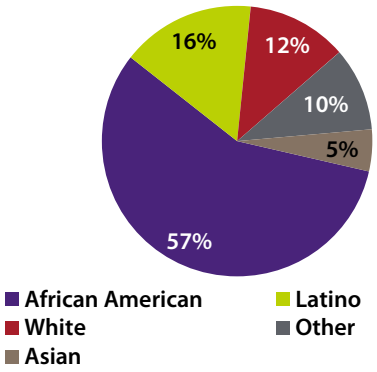
CTI Participant Recruitment and Enrollment

At the onset of the CTI program, 26 new DWC residents were given the opportunity to apply for participation in the program. In order to be eligible for the program, applicants had to meet the following criteria:

- Meet the HUD definition of chronic homelessness
- Mental health diagnosis (includes self-reported diagnoses)
- Case managers believe that applicant would benefit from the program

Five women elected not to participate in CTI.[6] The remaining 21 women applied, met the eligibility criteria, and were enrolled in CTI in March 2011. Additional clients were enrolled at move-in if they met the eligibility criteria and were willing to participate. The additional participants came from two additional program sites: The Ford Hotel (SRO Housing Corporation) and Jill's Place (an additional DWC owned and managed property). As of October 2013, 80 women had enrolled in CTI and completed the formal CTI program.

Exhibit 3. Race/Ethnicity (n=78)



CTI Participant Characteristics

CTI participants represent an ethnically diverse cross-section of women (Exhibit 3) whose ages ranged from 22 to 75 years at program entry with a mean age of 49 years. As seen in Exhibit4, about 75% of CTI participants reported that they graduated from high school. Most clients reported their health as less than good at program entry and that they have medical insurance (e.g., Healthy Way LA, ORSA, Medical, Medicaid, private insurance).

All CTI participants shared a history of chronic homelessness. Episodes of homelessness began early for nearly a third of the participants; 30% ran away from home for more than a week once before the age of 17. All participants spent time on the streets, in a shelter or in a public place, and more than half have spent time in a detention center

[5] Not all tenant interview data was completed within the appropriate Phase time period (i.e., some 3 month interviews were completed at 4 or 5 months). The valid percent shows how many of those interviews were actually completed within appropriate time periods.

[6] Program staff did not disqualify any potential participants. Most of the clients who did not enroll in CTI had a social support network, were working, and did not feel like they needed it at time of move-in.

or jail. Additionally, many have faced mental, substance abuse, and physical health issues, as noted in their history of hospitalization (see Exhibit 5 for a description of lifetime housing histories).

Immediate Outcomes- Housing Stability and Hospitalizations

One of the target outcomes of CTI is housing stability. Post CTI outcomes in this area are very promising. Three months prior to CTI, 53% of women were living on the streets and 45% in a shelter (Exhibit 4). Upon completion of CTI, 100% of women enrolled in CTI remained stably housed. Interestingly, for women with matched pre/post data (only about 25% of the total sample) our findings showed that slightly more women were hospitalized for a medical or emotional reason or stayed in an overnight drug/alcohol program. These findings may imply that CTI participants are more connected to needed care, have insurance and/or that CTI participants are experiencing these problems at a high rate once stably housed compared to pre-CTI. While interesting, these findings are only preliminary and do not take into account chronic health or mental health conditions necessary to determine the appropriateness of these hospitalizations for these women.

Exhibit 4. CTI Participant Characteristics at Enrollment (N=78)	
High school graduate (or equivalent) or more	**74%**
In "good" physical health (self-rated)	**45%**
Have medical insurance	**80%**
Not on probation or parole	**91%**

Exhibit 5. CTI Housing Stability (N=23)		
CTI clients with an overnight stay….	**3 Months Prior to Enrollment**	**Post-CTI**
In a detention center or jail	**0%**	**0%**
On the streets	**53%**	**0%**
In a hospital for medical or emotional reasons	**5%**	**9%**
In an overnight program for drug and alcohol	**4%**	**9%**
In a shelter	**45%**	**0%**

Part II:
Change in Independent Functioning, Self-Sufficiency and Quality of Life

The Downtown Women Center's CTI program provides specialized time-limited support in three phases; with more intense case management offered during the first 6 months (e.g., service coordination, money management, benefits counseling, transportation assistance, and crisis-management) and the final three months focused on termination of CTI services with the goal of establishing a support network. The activities that the case managers engage participants in are intended to ensure housing stability by connecting clients to resources and helping them develop the life skills necessary to become independent and self-sufficient.

How do CTI case managers offer support?

CTI case managers offer ***support with respect and dignity,*** *which is crucial during such a transitionary period.*

Once enrolled into the CTI program, clients were assigned to a case manager who worked with them throughout the duration of the program. During the first phase of CTI (months 1 through 3) clients met with their case managers up to five times a week. Case managers and clients worked together to develop a housing stabilization plan, where specific goals are established and tracked throughout the duration of CTI.

DWC's implementation of CTI is unique in that many services are available to women on-site. This includes a medical clinic, psychiatric services, benefits counseling, mental health services (one-on-one therapy and groups), enrichment activities (i.e. art classes, social outings, etc.), educational and vocational services, health and wellness activities (i.e. physical activity classes, nutrition education and counseling, etc.), and access to 3 meals per day. This is especially the case for CTI participants who are housed within one of DWC's buildings. The CTI participants in the Ford Hotel do not have the same accessibility, but are still connected to services through their CTI case managers.

"I was a person [to my case manager], I was not a case file"

- CTI graduate

Many of the CTI participants had a chronic history of homelessness and have received services from other members in the community. In these cases, CTI case managers were able to collaborate with existing service providers to streamline services received off-site. Aside from the unique contextual setting of DWC, women who received CTI felt that the approach of the case managers was unlike what they had experienced with other case management services. Preliminary findings from 2 focus groups conducted with 11 CTI program graduates included themes suggesting women felt closely connected to their CTI case manager. For example, women mentioned that their case manager treated them like "a friend," "showed they cared," and "were always there" when they needed them. For these women, CTI was more than just being connected to resources, it is about *how* these connections were made. CTI case managers offer support with respect and dignity, which clients felt was crucial during a period of transition.

Are CTI participants becoming more self-sufficient?

Self-Sufficiency and Independent Functioning

CTI case managers offered services that helped clients improve everyday life skills, like paying rent on time, following housing rules, organization and cleanliness as well as linking clients to community resources and building a support network, all with the primary goal of maintaining housing stability. In order to examine if and how CTI clients were becoming more independent and self-sufficient, two widely validated measures (*Arizona Self-Sufficiency Matrix* (SSM) and *Independent Living Skills Checklist*) were incorporated into the present evaluation.

The *SSM* is completed by case managers to assess CTI clients' self-sufficiency at intake/baseline and completion of each CTI phase.[7] The SSM consists of 18 domains including income, employment, housing, food, parenting skills, childcare, children's education, adult education, legal, health care, life skills, mental health, substance abuse, family/social relations, mobility, community involvement, safety and disabilities.[8] Each domain is measured on a five point scale (1-5), with higher scores indicating higher levels of self-sufficiency than lower scores. In order to analyze finding, domain scores were summed into two factors: **Independence** (income, employment, housing, food, adult education, health care, life skills, family relations, mobility and community involvement) and **Dysfunction** (substance abuse, legal, mental health).

The *Independent Living Skills Checklist* is a 14-item checklist of everyday skills completed by CTI case managers at intake and at the completion of each CTI phase. Each item is rated on a scale from 1 to 4 in terms of how much support individuals need to perform everyday living skills. A total score ranging from 14 to 56 can be obtained by summing the individual item scores, with lower scores indicating higher levels of independent functioning and lower scores indicating more support required across the domains.

As can be seen in Exhibit 6, CTI participants made significant improvements both in terms of increasing independence and decreasing dysfunction[9] in a relatively short period of time. The effect size measure (Cohen's *d*) included in Exhibit 6 provides a means of assessing the magnitude of the changes experienced in these domains. Based on standard interpretations of effect sizes within social science research, these are large effects, suggesting CTI has a large impact on DWC clients independent functioning.

Exhibit 6: Change in Self- Sufficiency Over Time (N=55)

Arizona Self-Sufficiency Matrix	Baseline	3 month	6 month	*p* (sig)	*d* (effect size)
Independence Scale	26.6	28.3	29.65	<.01	.64
Dysfunction Scale	12.22	12.5	12.83	<.01	.34
Total Scale Score	38.8	40.78	42.44	<.01	.64

[7] For this reporting period, only SSM data from baseline through 6 month was available for analyses.

[8] For this evaluation, domains related to childcare and parenting were not analyzed due to the fact that none of the CTI clients currently have children in their care.

[9] The significant difference in the Dysfunction domain was driven by the change in Mental Health. Differences for the Substance Abuse and Legal domains were not significant at the item-level (see Appendix A).

Specific changes in self-sufficiency within these domains included:

- *Employment*. As women continued receiving CTI services, their unemployment rate decreased. At baseline, 92% of CTI participants were unemployed. At six months the percentage of employed CTI participants fell to 75% (i.e., 25% of women in CTI had some form of employment).

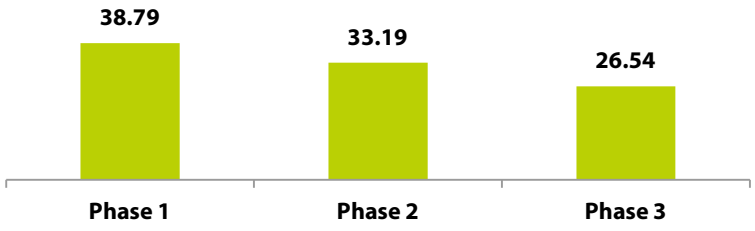
- *Living Skills*. Another marked improvement was in living skills. At baseline, 40% of CTI participants were able to meet all their basic needs of daily living without assistance; by six months, this percentage of CTI participants increased to 60%.

- *Mental Health*. At baseline, 32% of CTI participants were rated as having recurrent mental health symptoms and persistent problems with functioning due to a mental health problem. At six months, the percentage of CTI participants with recurrent mental health symptoms dropped to 6.3%. This suggests that more women were moving toward milder symptomology, most likely due to increased access to mental health treatment.

Focus group data lend support to these findings. For example, some women who completed nine months of CTI noted that while they still would like the support of their case managers from time to time, they feel more comfortable making their own appointments and meeting their basic needs. The improvement in mental health stability was also mentioned in the focus groups. One participant explained that prior to CTI, she was not receiving the appropriate mental health care because she was not connected to the right provider. After her CTI case manager helped connect her to a new provider the difference was remarkable- "night and day."

The focus group findings were also consistent with the findings based on the analyses of the *Independent Living Skills Checklist* data.[10] Overall, clients showed increased independence in handling everyday activities such as preparing meals, taking medication, and budgeting (i.e., decreased scores = less dependency across living skills items) at each phase of CTI. The average change in independent living skills score between Phase 1 and Phase 3 of CTI was 12.25 points, showing a statistically significant increase in progress towards independence for DWC clients (Exhibit 7). For a detailed summary of change made across each living skills on the checklist, see Appendix A.

Exhibit 7: CTI Participants' Independent Functioning Scores* (N=68)



*Scale values ranged from 14-56, with lower scores indicating higher levels of independent functioning and lower scores indicating more support required across the domains.

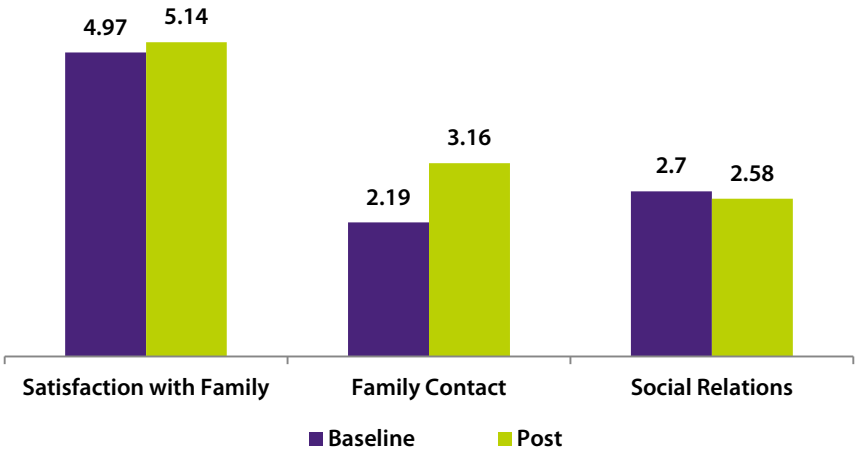
[10] The Independent Living Skills Checklist was a measure collected in the CTI domain survey.

Quality of Life

CTI participants' quality of life was assessed using the *Quality of Life Interview, Full Version*. CTI participants rated their satisfaction via an interview with Case Managers on items that comprised three domains: Satisfaction with Family, Family Contact, and Social Relations. CTI participants were asked to rate each domain at program entry, at nine months (end of CTI), and again at three months post-CTI. For this reporting period, matched baseline/post data from 22 clients was available for analysis[11].

Participants reported statistically significant ($p<.01$) increases in the frequency of family contact over the course of their participation in CTI; however participants did not report meaningful increases in their satisfaction with their family relationships or in the frequency of social contact with non-family members (Exhibit 8).

Exhibit 8: Quality of Life Ratings for CTI Participants (N=22)



Client Outcomes

CTI participants were asked to report changes in their physical health, mental health, and ability to function daily as a result of the program. (Most of the data utilized in this evaluation was reported by clinical staff, so self-report data serves as an important point of comparison against staff reported outcome). CTI participants completed ten items on a five-point Likert scale ranging from strongly agree to strongly disagree. Exhibit 9 illustrates the percent of clients at the nine month assessment point who indicated they strongly agree or agree with each statement. Unfortunately matched client data for the three and nine-month assessment periods was not available for enough CTI participants to assess change.

[11] *Satisfaction with Family* Scale values ranged from 1=Terrible 2= Unhappy, 3= Mostly Dissatisfied, 4= equally dissatisfied/satisfied, 5= Mostly Satisfied, 6 =Pleased, 7 =Delighted; *Family Contact* Scale values range from 1= not at all, 2 = less than once a month, 3 = at least once a month, 4 = at least once a week, 5= At least once a day; *Social Relations* Scale values range from 1= not at all, 2 = less than once a month, 3 = at least once a month, 4 = at least once a week,
5= At least once a day

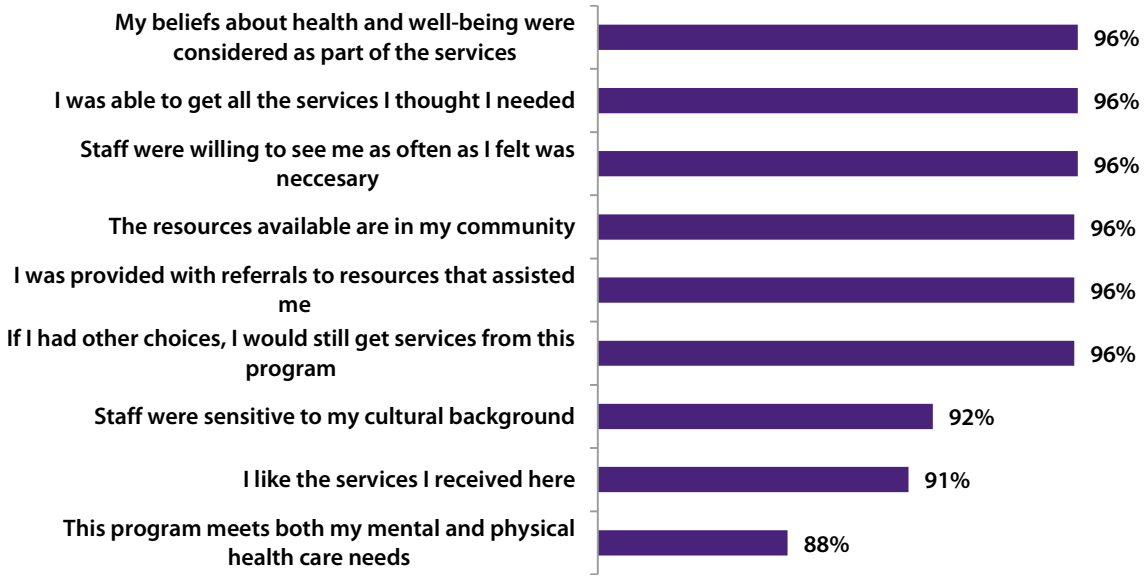
Exhibit 9: Percent of CTI Participants Who Agreed/Strongly Agreed with Each Statement at Nine Months (N=22)

There are several interesting trends in the data. Nearly all clients reported that they know how to get help when needed and are better able to take care of their needs. Most women reported increased ability to do things they want to do and to deal effectively with daily problems. Relatively fewer women felt their mental health symptoms were not bothering them as much or that their physical health was improved.

Client satisfaction

Client satisfaction was also assessed using nine items adapted from the MHSIP. CTI participants rated items on a one to five Likert scale which ranged from strongly agree to strongly disagree. Exhibit 10 below shows the percent of women who agreed or strongly agreed with each statement. Data from 24 clients at the nine month assessment were available for analysis on this measure. Unfortunately there were too few women with complete data at more than one time point to examine change in satisfaction over time

Exhibit 10: Percent of CTI Participants Who Agreed/Strongly Agreed with Each Statement at Nine Months (N=24)



Overall participants were highly satisfied with the services they received as part of the CTI program. Women liked the services, felt involved in decision making about their care, felt staff were sensitive to their cultural background, and felt the program did a good job meeting both their mental and physical health needs.

What do the Findings Tell Us about the Impact of CTI?

The preliminary analyses presented here suggest that whether reported by CTI clients themselves or from the vantage point of case managers, women appear to be making important strides in self-sufficiency via their participation in CTI. Women are stably housed, have increased access to regular physical and mental health care, some have secured employment and all report increased quality of life. The final evaluation report for CTI will carefully examine individual differences in the impact of CTI participation on self-sufficiency, satisfaction and quality of life outcomes for participants.

Next Steps in Evaluation

The final evaluation report (available in March 2014) will provide a complete assessment of the progress of CTI clients over the course of the 9 month CTI period, including a 12 month follow-up. The final evaluation report will include:

- *Focus on Individual Differences*. Preliminary focus group findings suggest that some women may find the transition out of intensive case management more challenging than others. In subsequent analyses, we will explore individual differences in functioning post-CTI with the goal of providing recommendations for identifying clients most likely to benefit from CTI.

- *Qualitative Findings.* Analyses of qualitative data including interviews with CTI staff and property managers and focus groups with CTI participants. This data will be able to provide a richer understanding about the process by which CTI can help support formerly homeless individuals transition into the community as well as explain any challenges with implementation.

- *Complete Quantitative Assessment Findings*. Final analyses of CTI tenant survey data, CTI domain data, and Self-Sufficiency data will be presented to show the overall progress of tenants from baseline to 12 month follow-up.

- *CTI site comparisons.* Quantitative and qualitative analyses will explain any key differences in the implementation and outcomes of CTI by site/context.

- *Implications for practice and policy*. Recommendations for the continued implementation of CTI at DWC will be presented as well as how CTI can make broader contributions to housing policy.

Appendix A. Self Sufficiency Matrix Individual Domain- Specific Change

Domain	Baseline	3 months	6months
Housing**	4.04	4.00	4.15
Employment*	1.14	1.24	1.33
Income*	2.56	2.80	3.09
Food**	2.62	2.84	2.96
Adult education	2.68	2.73	2.79
Health care coverage	4.18	4.20	4.31
Life skills*	3.04	3.35	3.65
Family social relations*	2.17	2.44	2.50
Mobility*	3.50	3.82	4.00
Community involvement*	3.24	3.69	3.85
Legal	4.82	4.78	4.79
Mental health*	2.90	3.22	3.48
Substance abuse	4.54	4.49	4.56
Safety	4.64	4.71	4.67
Disabilities	3.27	3.58	3.53

*Significant difference in mean scores, where $p<.01$
** Significant difference in mean scores, where $p<.05$

Appendix B. Independent Life Skills Checklist Individual Item Change

Item	Baseline	Three Month/ Phase 2	Six Months/ Phase 3
Paying bills*	2.96	2.43	1.9
Budgeting*	3.42	2.8	2.28
Maintaining entitlements and other paper work*	2.89	2.6	1.96
Maintaining a home*	2.83	2.44	1.82
Preparing/obtaining meals	2.78	2.23	1.73
Travelling*	2.87	2.41	1.96
Personal care/hygiene*	2.29	1.88	1.59
English proficiency**	1.41	1.33	1.21
Awareness of needs and knowing when to seek help*	3.04	2.69	2.06
Able to access help when needed*	2.68	2.28	1.8
Managing health/behavioral health needs and services*	2.91	2.64	2.15
Taking medications*	2.63	2.39	1.92
Keeping Appointments*	3.16	2.65	2.2
Discriminating danger/asserting and protecting self**	2.66	2.47	2.03

*Significant difference in mean scores, where $p<.01$
** Significant difference in mean scores, where $p<.05$

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