

Supportive Housing for the Disabled Reentry Population: The District of Columbia Frequent Users Service Enhancement Pilot Program



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**Research Report
December 2011**



URBAN INSTITUTE
Justice Policy Center

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December 2011

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This project was supported by Grant Award #2009-SU-B9-0006, awarded by the Justice Grants Administration, Executive Office of the Mayor, District of Columbia. The funding provided for this grant was awarded to the Justice Grants Administration through the Byrne Justice Assistance Act Grant Program by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice or the District of Columbia Executive Office of the Mayor.

Additional support for this project was provided by a grant from the Foundation to Promote Open Society.

Funding for this project was administered by the Corporation for Supportive Housing.

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The authors extend their gratitude to P. Mitchell Downey of the Urban Institute for his research assistance on the project, as well as William McAllister from Columbia University for his senior technical advice. Akiva Liberman, of the Urban Institute, provided support in reviewing the final document—for which the authors are extremely grateful. Finally, the authors appreciate the support from the program staff, as well as the District of Columbia Department of Corrections and The Community Partnership for the Prevention of Homelessness.

Executive Summary

Introduction

The District of Columbia Frequent Users Service Enhancement (FUSE) Pilot Program, administered by the Corporation for Supportive Housing (CSH) and University Legal Services (ULS), is a permanent supportive housing program specifically targeted to high-risk and high-need individuals with mental illness who have extensive histories of cycling between systems in the District of Columbia (referred to as “frequent users”). Based on a previous assessment by the Urban Institute on the number and characteristics of the frequent user population in the District of Columbia and the housing capacity across the city, as well as CSH’s extensive experience developing programs that provide permanent supportive housing to the frequent user population in cities across the United States, FUSE was designed to fulfill several goals:

1. To create **50 units of permanent supportive housing** for the frequent user population discharged from the District of Columbia Department of Corrections (jail);
2. To improve **coordination across systems** that serve the frequent user population in the District of Columbia, including the jail, the Department of Mental Health, and The Community Partnership for the Prevention of Homelessness (the agency that houses the city’s homeless management information system);
3. To improve **financial integration and policy coordination** among corrections, mental health, and human services agencies;
4. To document **decreased recidivism rates and increased housing stability** for frequent users; and
5. To demonstrate **cost savings** in the District of Columbia’s corrections, human services, and mental health services agencies.

During the planning phase, multiple program partners were recruited into the program. These partners included the D.C. Department of Corrections (DOC), The Community Partnership for the Prevention of Homelessness (TCP), and the D.C. Department of Mental Health. Additionally, University of Legal Services joined CSH to administer the program due to its long-standing presence in the jail as the District’s federally mandated protection and advocacy agency for the human, legal, and service rights of people with disabilities. With funding from the District of Columbia Justice Grants Administration, Executive Office of the Mayor (JGA), the William S. Abell Foundation, the Open Society Institute, the Robert Wood Johnson Foundation, and Fannie Mae, D.C. FUSE began operations in October 2010. Consecutively, JGA funded the Urban Institute (UI) to conduct an independent evaluation of the FUSE program. Using both qualitative and quantitative data from the D.C. Jail, the city’s homeless management information system (HMIS), programmatic data from partners, interviews with stakeholders and program participants, and field observations, the UI evaluation was intended to document (1) the characteristics of the D.C. frequent user population; (2) the initial performance, progress, and success of FUSE (process evaluation); and (3) the short-term outcomes attendant to the program (outcome assessment).

Characteristics of the D.C. FUSE Population

Using administrative data from the D.C. Jail and the city’s homeless management information system, UI analyzed the characteristics of 196 male frequent users identified by the FUSE program during the planning period and over its first six months of operation. The data show that FUSE-eligible individuals were primarily black and middle-aged. Consistent with the definition of being frequent users, the

average lifetime incarcerations in the D.C. Jail for frequent users were nearly 10, which resulted from diverse criminal histories. Offenses ranged from minor public disorder crimes, such as public drunkenness, to more serious violent offenses. Nearly four out of five frequent users had been charged with a violent crime. Only 9 percent of the frequent users had charges in only one category, while 67 percent had charges in three or more separate categories.

System use also varied among the frequent user population. Using hierarchical clustering, frequent users were separated into four distinct clusters/subgroups based on similarities in their use of jail, prison, and shelter, as quantified by optimal matching techniques, over a three-year period (June 1, 2007, to May 31, 2010). The four subgroups varied according to both level and type of system use.

1. *High Incarceration* (22 percent): Individuals in this cluster were characterized by frequent and long periods of jail and prison incarceration over the three-year period. Frequent users in this group, on average, had 4.3 jail stays in the three-year period and were incarcerated—in jail or prison—for 46 percent of the period. Additionally, system use patterns were the most complex, on average, as characterized by the number of changes in status as well as the longitudinal entropy of their system use patterns.
2. *High Shelter Use* (13 percent): Individuals in this cluster were characterized by extended periods of shelter use and low levels of incarceration over the three-year period. On average, frequent users in this group spent 58 percent of the period in shelter and 8 percent in jail.
3. *Moderate System Use* (33 percent): Individuals in this cluster were characterized primarily by the level—rather than type—of system use and possibly by their contemporaneous use patterns. Frequent users in this group spent, on average, 22 percent of the three-year period in shelter and 14 percent of the period in jail. Moreover, this use was heavier in the second half of the three-year period. Frequent users in this group, however, rarely went to prison.
4. *Low System Use* (32 percent): Individuals in this cluster were characterized by relatively low levels of use across all systems. During the three-year period, frequent users in this group spent 86 percent of the period outside of the jail, prison, and shelter systems.

There were very few differences observed among the demographic, criminal, and mental health characteristics of the frequent users within the four clusters. Frequent users in the “High Incarceration” group had a significantly higher number of lifetime incarcerations. Additionally, a significantly higher percentage of the “High Incarceration” cluster committed a public order crime.

Logic and Performance of D.C. FUSE

To understand how and whether the FUSE pilot is meeting its intended goals, the logic and performance of the pilot program were assessed, including documentation of the barriers to and facilitators of successful operations, and understanding whether critical program operations were achieved over the past year. These analyses were based on programmatic data from partners, interviews with stakeholders and program participants, and field observations. The program logic is intended to be an overview of the program’s ideal operational structure and functioning. It describes the program staff and partners, defining their roles and responsibilities, as well as the program activities and their related outcomes. It also suggests potential measures that can be used to assess the level of program outcomes over time and lists the intended impacts of the program at the administrative and participant levels.

Working within the context of the program logic model, the program’s activities were assessed over the first year and multiple facilitators and barriers to successful program implementation were identified. Several key facilitators and barriers are listed below:

Facilitators

- High levels of expertise among the program partners—Identification of strong partners and providers was key to successful program implementation. CSH, ULS, and the permanent supportive housing provider, Pathways to Housing, D.C., have extensive experience working with the frequent user population. Based on their experience, they were able to foster relationships with other providers and partners, foresee and overcome obstacles, and deliver high-quality service to the frequent user population.
- Placement of the transition coordinator in the jail—The transition coordinator is the primary staff member involved in many of the prerelease identification and enrollment activities. The transition coordinator identifies and enrolls program participants in the jail, forms the treatment plan for program participants prior to their release, and organizes case conferencing sessions in the jail where the participant can meet the service providers and have his/her plan explained. The case conference sessions helped to ensure that the FUSE participants received all of the necessary services in a coordinated matter. These activities required multiple in-person meetings with potential FUSE participants *while they were incarcerated*. This position's placement in the jail was critical to facilitating the enrollment and participant planning processes.

Barriers

- Infrequent generation of a static list of potential participants—The list of potential participants is not dynamic and is not generated on a regular, frequent schedule. Thus, there may be many eligible individuals who were in the jail during the program pilot but could not be enrolled simply because they were not included on the list. Further, participants may be enrolled later in their sentences or while they are in jail on pretrial status. This short time line made it difficult to coordinate all of the intake and case conference activities.
- Unique context of jail reentry—Many individuals identified as eligible for FUSE were close to their release date and could not or did not receive all of the prerelease enrollment and reentry planning services from the program. This affected housing and service delivery, as the appropriate services cannot be determined and planned for prior to release. As has been documented in previous studies, the unique context of jails creates a complex landscape for facilitating reentry programs (see Solomon et al. 2008).
- Availability of Housing Vouchers—Because the program did not receive housing vouchers directly from the local housing authority, it relied on community service providers to commit housing vouchers that they already received from the federal and local government to the FUSE program. There was only one supportive housing provider associated with the program over the past year. This affected both the number of individuals the program served and the type of community-based services that were provided.

Preliminary Outcomes

To inform the pilot's evaluation, data were analyzed from ULS, Pathways, the D.C. Jail, and the HMIS to explore the program's preliminary impact on short-term individual-level outcomes. Administrative data were collected from the DOC and TCP to document the outcomes of the first 15 participants in the D.C. FUSE program. Further, programmatic data from partners, interviews with program participants, and field observations were used to describe sociodemographic characteristics and psychiatric, criminal justice, housing, and social service histories, as well as services received through the program directly and through referrals for 11 of the first 15 individuals who consented to participate in the research. Given the short period of the evaluation and the low number program participants, no conclusions can be drawn as to the impacts of the program on participant outcomes.

The initial cohort of FUSE participants demonstrated low educational attainment and limited employment histories. Most were receiving their income prior to incarceration from government programs and/or entitlements. The frequent users had complex mental health histories—the average number of mental health diagnoses, not including substance dependencies, was 2.8. The program participants had extensive self-reported homelessness histories.

Based on the jail, prison, and shelter use patterns of the first 15 FUSE participants, it appears that FUSE primarily serves “High Incarceration” frequent users (7 of 15 clustered in the “High Incarceration” group). As such, services are being provided to the individuals with the most complex system use patterns and those who use the jail the most frequently.

After enrollment, FUSE was successful in delivering a variety of services to the participants. Service delivery outcomes included the following:

- While some participants’ engagement in treatment diminished over time, the assertive community treatment (ACT) teams were successful in maintaining regular contact with the participants, averaging 14 face-to-face contacts a month. Each contact lasted approximately 54 minutes, on average, and they took place across the community, including visits to the participant’s apartment or treatment facility.
- FUSE successfully provided participants with both transitional and permanent supportive housing services; all but one of the participants were housed in a permanent apartment using a program voucher within the first four months after their release.
- Five participants had documented substance use problems. According to the tenants of the “housing first” model, substance use should not disqualify participants from the program. Each participant who had a documented substance use problem is still under an active lease and, in fact, two of those participants received services through a detox or drug rehabilitation program while enrolled in FUSE.
- In the uncontrolled outcome period reviewed by this report, 3 of the 11 participants were successfully employed or participated in employment training. The remaining participants generally received income through Supplemental Security Income (SSI) and other government benefit programs.

Overall, participants were extremely satisfied with the services they received through the FUSE program. The majority of the participants were satisfied with their current living arrangement, although a couple were not satisfied with the housing due to personal safety concerns, issues with the landlord, and the maintenance of the building. Participants were greatly appreciative of the treatment, responsiveness, and respect they received from the members of the ACT teams and felt positive about the services provided by the ACT teams. Many commented that having someone to support them through hard times was very useful.

Administrative outcomes were also tracked but are difficult to assess given the short follow-up period within which to explore outcomes and the lack of a comparison group. In total, 5 of the 15 participants used emergency shelter after their release from jail; however, shelter use occurred prior to placement into permanent housing among 4 of the 5 participants. Further, during the first 10 months of the program, 4 of the 15 participants were reincarcerated. All four were new arrests; three individuals were charged with at least one violent crime and one was charged with a drug crime. Two participants used emergency psychiatric services, once and three times respectively. Those same two participants, along with one other participant, also used emergency medical services multiple times.

The preliminary outcomes are not robust and should not be taken as a prediction of program outcomes. To accurately estimate program impacts as well as any associated cost savings attributable to FUSE, a larger sample of FUSE participants must be evaluated over a longer, standardized outcome period to determine if the participants' use of shelters, hospitals, and jail/prison is lower than it was before program participation and/or lower than a matched comparison group of frequent users who did not enroll in FUSE.

Conclusions

Over the past year of program implementation, the FUSE program has had some successes and challenges in meeting its intended goals: creating 50 units of supportive housing and improving coordination. Indeed, the program has fallen short of its goal of creating 50 units of permanent supportive housing for frequent users leaving the jail; yet it has succeeded in improving coordination across the systems that serve frequent users. Program shortcomings are attributable to a variety of reasons, such as the administrative mechanism used to identify frequent users, the challenge of facilitating the reentry process in the context of the jail, and the lack of available housing vouchers dedicated to the program, which was largely beyond the control of the program, given the political context in the District of Columbia while the program was being implemented.

Over the next few months, the program intends to continue enrolling frequent users into the remaining available supportive housing units. It intends to seek additional partners and/or resources for the remaining housing units and to continue program operations in the city. As FUSE expands, enrolls more participants, and refines its program processes and performance, it will move closer to reaching its latter three goals: improving financial integration and policy coordination among corrections, mental health, and human services agencies; documenting decreased recidivism rates and increased housing stability for frequent users; and demonstrating cost savings in the city's corrections, human services, and mental health services agencies.

I.

Introduction

Individuals with histories of incarceration, homelessness, and mental illnesses or other disabilities often cycle through the criminal justice and homeless system multiple times and also frequently use crisis health and mental health services (Burt and Anderson 2005; Hall, Burt, Roman, and Fontaine 2009a; Metraux and Culhane 2004). Individuals engaged in institutional cycling have not only fiscal but also public safety and public health consequences for the communities in which they live (Clark, Ricketts, and McHugo 1999; Culhane, Metraux, and Hadley 2002; Greenberg and Rosenheck 2008; Kuhn and Culhane 1998). Fortunately, research has shown that individuals who cycle between systems—considered “frequent users”—have been successfully stabilized by permanent supportive housing models using a “housing first” approach (Gulcuret al. 2003; Stefancic and Tsemberis 2007; Tsemberis, Gulcur, and Nakae 2004). Specifically, research has shown that individuals with mental illnesses and chronic histories of housing instability/homelessness have reduced their use of shelters, prisons/jails, and hospitals after receiving permanent supportive housing (Burt and Anderson 2005; Culhane, Metraux, and Hadley 2002; Culhane et al. 2007). The “housing first” approach, targeted to homeless individuals, combines housing placement with assertive engagement, case management, and supportive services. The primary goal is to use housing as a method to stabilize homeless individuals and provide needed services and support. Continued tenancy is not dependent on participation in services or maintaining abstinence; instead, the housing first approach is based on a harm reduction model (see National Alliance to End Homelessness 2006; U.S. Department of Housing and Urban Development 2007).

Given the number of individuals released from prisons and jails, many of whom have histories of housing instability and disabilities, expanding permanent supportive housing programs and the housing first approach to target the reentry population *directly* has the potential to break the costly cycle of incarceration, homelessness, and emergency service utilization. With this in mind, the Corporation for Supportive Housing, an agency whose mission is to prevent and end long-term homelessness through supportive housing, has launched a number of supportive housing reentry models across the country (Fontaine, Roman, and Burt 2010). These housing models are designed to target and focus on individuals at the highest risk of recidivating upon release or recycling through the criminal justice system, particularly local jails. Concurrently, these models are designed to target those who have the greatest need for postrelease services, such as those with extensive histories of mental illness and other disabilities and chronic homelessness. More simply, the models focus on individuals with mental illness or other disabilities, who have extensive histories of cycling between shelters, jails or prisons, and other public crises systems, such as emergency hospitals (Fontaine et al. 2010). In that sense, these are individuals who are the hardest to serve, at the highest risk of failure or relapse, most likely to recidivate, and least likely to successfully manage their mental health symptoms.

The Corporation for Supportive Housing (CSH) launched its first frequent user reentry pilot in New York City. The New York City pilot, called the Frequent Users Service Enhancement Initiative, targeted individuals in New York City who were released from Rikers Island Jail with multiple stays in the shelter and jail system. Preliminary evaluation findings were promising; a quasi-experimental evaluation conducted by the John Jay College of Criminal Justice found that the program significantly reduced shelter use as well as days spent in jail and shelter among the frequent user population (Corporation for Supportive Housing 2009). Following success in New York City, CSH has implemented frequent user programs in several states, including Connecticut, Kansas, and Michigan. While each program is focused

on the disabled reentry population with histories of housing instability, programs in each city are unique, dependent largely on the opportunities for innovation and collaboration present in each jurisdiction (Fontaine et al. 2010).

In the District of Columbia, with funding from the D.C. Justice Grants Administration, the William S. Abell Foundation, the Open Society Institute, the Robert Wood Johnson Foundation, and Fannie Mae, the frequent user program is focused on those released from the District of Columbia Department of Corrections (jail) with a severe and persistent mental illness who have had at least three stays in the D.C. Jail and three stays in the D.C. shelter system or one full year of shelter system use in the past three years. Called the Frequent Users Service Enhancement Pilot (or FUSE), the program has several goals:

1. To create **50 units of permanent supportive housing** for the frequent user population discharged from the District of Columbia Department of Corrections (jail);
2. To improve **coordination across systems** that serve the frequent user population in the District of Columbia, including the jail, the Department of Mental Health, and The Community Partnership for the Prevention of Homelessness (the agency that houses the city's homeless management information system);
3. To improve **financial integration and policy coordination** among corrections, mental health, and human services agencies;
4. To document **decreased recidivism rates and increased housing stability** for frequent users; and
5. To demonstrate **cost savings** in the District of Columbia's corrections, human services, and mental health services agencies.

Since the Pilot's launch, the Urban Institute (UI) has been exploring how the program is meeting its intended goals, with funding from the District of Columbia Justice Grants Administration, Executive Office of the Mayor. CSH has a long history of partnering with evaluators, including UI, to document the performance, progress, and success of its supportive housing reentry programs (Fontaine et al. 2010). The evaluation was funded for one full year, October 2010 through September 2011. Given the limited period within which to evaluate the program, the evaluation has focused specifically on how the program is meeting its first and second goals, since progress on the latter goals take significantly more time to develop. Therefore, UI has conducted a process evaluation of the program focused on whether and how 50 units of permanent supportive housing for the frequent user population leaving the jail have been created; and whether and how systems have coordinated to serve the frequent user population leaving the jail. The evaluation uses qualitative and quantitative data from the jail, the city's homeless management information system, programmatic data from program partners, interviews with program stakeholders and program participants, and field observations of program operations, services, and facilities.

The report develops over five remaining sections. First, the report outlines how the program was developed, how critical program partnerships were formed, and how the UI evaluation examined the extent to which the program met its first and second goals in its first year of implementation. Second, the report describes the targeted frequent user population based on administrative corrections, shelter use, and mental health data. Hierarchical cluster analysis on the system use patterns of the frequent user population were used to contextualize the implementation and potential for the program and to understand the system use patterns of the city's frequent user population and the implications of that system use for potential cost savings and future program planning. Third, the report outlines the logic of the program, based on interviews with stakeholders, interviews with program participants, reviews of program materials, and field observations. Barriers to and facilitators of successful program operations

uncovered during the program's first year of implementation are described, as well as preliminary data on the progress and performance of the program. Fourth, the report describes the characteristics, perceptions, and short-term outcomes of the first 15 participants enrolled in the program through June 2011 based on participant interviews and administrative and program data. The report concludes with general policy implications based on the evaluation findings and an outline of next steps for the evaluation of the program.

2.

History and Development of the D.C. Frequent Users Service Enhancement Pilot Program

Implementation of the FUSE program in the District of Columbia was data-driven, developed following a convergence of interest among various stakeholders in the District: to bring attention to the unique needs of individuals incarcerated in the jail with histories of homelessness and disabilities, and to develop additional permanent supportive housing beds in the city. In particular, in 2005, UI was helping to inform a research and program agenda for the William S. Abell Foundation, which at the time was interested in making strategic investments in the issue of homelessness, given its five-year initiative to make an impact on reducing homelessness in the District (see William S. Abell Foundation 2010 for more information). Meanwhile, beginning in fall 2006, several researchers in UI had been working with CSH through its Returning Home Initiative. The Returning Home Initiative, originally based in Chicago, Ill., Los Angeles, Calif., and New York, N.Y., but later expanded, was exploring the systems that feed or contribute to chronic homelessness, of which incarceration is a part. As such, the Returning Home Initiative was launched to establish permanent supportive housing for formerly incarcerated persons with histories of housing instability and disabilities by developing supportive housing reentry models and to initiate and implement policy changes that strengthened the integration and coordination of the corrections, housing, mental health, and human service systems (see Fontaine et al. 2010 for more information). Finally, in early 2007, then Mayor Adrian M. Fenty of the District of Columbia committed his administration to creating thousands of new units of supportive housing, most of which were intended for single, homeless adults with disabilities. Later in 2007, CSH opened an office in the District of Columbia to advance its mission to end and prevent long-term homelessness in the Washington area through supportive housing.

Following strategic meetings with public administrators and other stakeholders in the Department of Corrections and The Community Partnership for the Prevention of Homelessness, UI was awarded funding from the William S. Abell Foundation in early 2008 to—

- Document the number and characteristics of the frequent user population in the District;
- Assess supportive housing capacity across the city and the interest in and ability to expand the supply;
- Bring together policymakers, practitioners, and researchers to encourage active collaboration in discharge planning for frequent users; and
- Draw attention to the larger policy questions with regard to building supportive community environments for individuals returning from the jail to the community.

2.1. Administrative Data Match and Assessment of Services

The data match to document the number of frequent users and their characteristics in DC used two sources of data, based on data availability:

1. **Shelter Data:** The Community Partnership for the Prevention of Homelessness (TCP) provided data from the city's homeless management information system (HMIS) that identified all

individuals using the public emergency shelter system in the District between October 1, 2005, and September 30, 2007. The data also included demographic characteristics of these individuals as well as the length of their shelter system use.

2. **Jail Data:** The D.C. Department of Corrections (DOC) provided booking and release data that identified every individual with one or more jail episodes between October 1, 2004, and March 31, 2008, but who were not in jail on March 31, 2008. The data also included demographic characteristics of these individuals as well as their number of previous incarcerations in the jail and their mental health diagnosis.¹

Using these data, albeit with slightly different windows, UI matched the jail data with the shelter data and identified a total of 206 individuals who had (1) two or more shelter stays; (2) two or more jail stays; and (3) a mental health diagnosis that would potentially qualify them for services from the D.C. Department of Mental Health (i.e., a serious and persistent mental illness)² (see Hall, Burt, Roman and Fontaine 2009a, 2009b for more information). Stated differently, there were approximately 200 individuals with a serious and persistent mental illness whose names appeared in the jail and shelter system at least twice over a roughly two-year period. The focus on individuals with multiple jail and multiple shelter stays who appeared to have a disabling mental health condition that could make them eligible for services from the Department of Mental Health was purposeful. The goal was to identify frequent users who would be eligible for and benefit the most from permanent supportive housing, in keeping with the mayor's plan to expand supportive housing in the city for single, homeless adults with disabilities.

After identifying the number of frequent users in the District, UI surveyed permanent supportive housing providers in the city to assess the ability and willingness of these agencies to serve the reentry population directly. Through the use of a housing provider survey, face-to-face interviews, and field observations, UI found that providers had both the capacity and willingness to serve the frequent user reentry population. In 2008, 100 percent of the providers said that they would not refuse to rent to an individual with a criminal history per se.³ Yet, across the providers surveyed, only 2 percent of their clients came directly from prison or jail at the time of the survey, illustrating that individuals who found their way to supportive housing agencies did not typically come from a direct referral or link from the jail or prison (Hall, Burt, Roman and Fontaine 2009c). With this information, UI, CSH, and other partners planned a frequent user program that sought to bridge the gap between the high-risk population identified by the data match and the existing service capacity among the city's supportive housing providers.

2.2. Reentry Supportive Housing Forum and Program Planning

In March 2009, UI, CSH, and the District of Columbia Interagency Council on Homelessness cohosted a Reentry Supportive Housing Forum to publicize the results of the data match and service provider

¹ The data match also included data from the Fire and Emergency Medical Services Department (FEMS) on all calls for service during an eight-month period, January 1, 2008, through August 31, 2008, for which an Electronic Patient Care Report was filled out and contained a full name. Given the limitations with the FEMS data (e.g., the data were less reliable than the shelter or jail data, the data were fully outside the window of shelter data and partially outside the window of jail data), these data were not considered in the full analyses assessing the population overlaps (see Hall, Roman, and Fontaine 2009b).

² A jail diagnosis of schizophrenia, bipolar disorders (I and II), borderline personality disorders, or any psychotic disorders was used as a proxy for eligibility for D.C. Department of Mental Health services.

³ Seventeen percent said they would refuse sex offenders and 15 percent said they would refuse individuals with a history of violence against or abuse of children or adults.

assessment. The forum, funded by the William S. Abell Foundation, received broad participation by key public administrators from the Department of Corrections, the Department of Human Services (DHS), the Department of Mental Health (DMH), and the D.C. Housing Authority. Other local stakeholders with an interest in and history of serving individuals with histories of mental illnesses and chronic homelessness were also present at the forum, in addition to national experts focused on these issues outside of the District of Columbia. Public administrators supported the notion of a supportive housing reentry pilot, and following the momentum from the forum, UI worked collaboratively with CSH, DOC, DMH, and The Community Partnership to develop what would later be known as D.C. FUSE.

These pilot planning efforts included gathering requisite memorandums of agreement, informing the data matching process to identify frequent users, and identifying critical program partners. During the planning phase, University Legal Services (ULS) was identified as a key partner due to its long-standing presence in the D.C. Jail as the District's federally mandated protection and advocacy agency for the human, legal, and service rights of people with disabilities. Throughout the planning phase, given the focus on strengthening and informing the discharge planning process and creating a seamless link from incarceration to the community, strong efforts were focused on creating a position within the jail that could identify frequent users and link them to supportive housing in the community. With Abell Foundation funding and support from the jail director, a transition or discharge coordinator was placed in the jail to coordinate the FUSE program. Additional funding for FUSE came from the Open Society Institute, the Robert Wood Johnson Foundation, and Fannie Mae, as well as the continued support from the Abell Foundation.

2.3. Key Program Partners

Given that a key goal of FUSE is to improve coordination among the agencies that serve the frequent user population, five main partners have been integral in the creation of the program. Their roles in the program are further detailed in chapter 4. Through these partnerships, the program hopes to achieve accurate identification of the population in greatest need of supportive housing, at the highest risk of cycling through the jail and shelter system, who are currently detained in the jail.

The **Corporation for Supportive Housing (CSH)** has extensive experience launching and sustaining programs similar to FUSE in other locales. CSH has developed and launched supportive housing reentry programs across the country. The programs are consistent with CSH's mission to strengthen the supportive housing industry and to prevent and end homelessness through supportive housing programs. CSH directs and manages FUSE, bringing lessons learned from other supportive housing reentry programs to inform FUSE in the District.

University Legal Services (ULS) is a nonprofit organization that serves as the federally mandated protection and advocacy agency for people with disabilities in the District of Columbia and is thus authorized to conduct administrative, legal, and other services for people with disabilities. With access to the jail through its D.C. Jail Advocacy Project, ULS is integral to the FUSE program in its ability to recruit and enroll participants into the program and transition them into the community. The transition coordinator position for FUSE, which is responsible for recruitment and enrollment, is a ULS position.

The **District of Columbia Department of Corrections (DOC)** provides data on detainees who might be eligible for FUSE, including their sociodemographic information, criminal and incarceration histories known to the department, as well as their histories of mental illness, as identified by qualified jail staff. DOC has also provided space and office equipment for the transition coordinator position in the jail, as well as access to administrative records contained in the jail. DOC operates two correctional facilities—the Central Detention Facility and the Central Treatment Facility—which provide rehabilitative and reintegration services for detainees.

The Community Partnership for the Prevention of Homelessness (TCP) is a nonprofit organization that coordinates the city's Continuum of Care, which, through providers, includes prevention, street outreach, emergency shelter, transitional housing, and permanent supportive housing services for individuals experiencing homelessness. TCP also manages HMIS, which is the primary database for client-level data on consumers of homeless services in the city. TCP provides data on individuals who might meet the FUSE eligibility criteria.

The **District of Columbia Department of Mental Health (DMH)** is responsible for approving individuals for any mental health services associated with permanent supportive housing and transferring care responsibility. DMH provides emergency care and comprehensive mental health services through a network of core service agencies, specialty providers, and hospitalization facilities. For FUSE, DMH determines which referred individuals are eligible for ACT services.

2.4. Urban Institute Evaluation

To continue its partnership with CSH, UI has been exploring how FUSE is meeting its goals—specifically, creating 50 units of supportive housing for frequent users leaving the jail and improving coordination across systems that serve the frequent user population leaving the jail. Using both qualitative and quantitative data from the jail, the city's HMIS, programmatic data from partners, interviews with stakeholders and program participants, and field observations, the UI evaluation intends to document the initial performance, progress, and success of FUSE (process evaluation) and its short-term outcomes (outcome assessment). Specific questions include the following:

- Whether and how 50 units of permanent supportive housing for the frequent user population leaving the jail have been created.
- Whether and how systems have coordinated to serve the frequent user population leaving the jail.
- Whether and how the program increases access to permanent supportive housing among program participants.
- Whether and how the program increases access to services among program participants.
- What are the short-term, program-specific outcomes for program participants, including service use, mental health functioning, residential stability, and returns to shelter and jail?

3.

Characteristics of the Frequent User Population in D.C.

One of the primary goals of the FUSE pilot is to create 50 units of permanent supportive housing for the frequent user population leaving the D.C. Jail. Theoretically, frequent users are the population most likely to benefit from supportive housing and, therefore, to reduce their institutional cycling and the associated social and fiscal costs to local governments and the larger community. While the logic of focusing on frequent users is relatively straightforward, the term *frequent users* is a generic term for individuals who cycle between systems, including jails, shelters, hospitals, and other emergency crisis systems. Individuals who cycle between systems may or may not have histories of mental illness. Therefore, a critical first step for the FUSE program planners was to outline the definition of frequent users in the District of Columbia.

As mentioned in chapter 2, the 2008 UI data match identified 206 individuals with a serious and persistent mental illness who had been in jail and shelter at least twice over a two-year period. Using that number as a guide, but in the interest of focusing more narrowly on individuals who had the highest need for reentry housing and supportive services, CSH and its partners decided on a more restrictive set of eligibility criteria for the FUSE program. After a few more administrative matches of jail and shelter data to explore whether the data supported more restrictive eligibility criteria, CSH, with its partners, developed the following eligibility criteria for FUSE:

1. Three or more jail episodes in the last three years (jail episodes);
2. Three or more shelter episodes or more than one year of continuous shelter use in the last three years (shelter stays); and
3. A qualifying serious and persistent mental health diagnosis as identified in DOC records (mental illness).

While UI conducted the initial retrospective data match in 2008, for FUSE operations, CSH and UI worked with staff from TCP and DOC to identify frequent users with real-time data to create a list of names that could be fed directly to program planners.⁴ Using this information, the transition coordinator in the jail could recruit and enroll eligible individuals into the pilot. The following process was used to identify frequent users with administrative data sources:

- First, TCP would identify all individuals who met the requisite number of shelter stays in the HMIS.
- Second, DOC would match the shelter data against their jail records to determine which of the individuals identified by TCP had two jail episodes within the last three years, were *currently* in the jail, and had a qualifying serious and persistent mental illness, as identified in the jail mental health records.

⁴ While the data are real-time or current on the day of the frequent user identification, they do become outdated upon release to the transition coordinator. The list of eligible names is static, not dynamic. The list is only entirely accurate on the day it is generated. Further, TCP only identified individuals who met the shelter stay criteria at two points in time. As such, DOC used static lists of individuals who met the shelter criteria (i.e., individuals who met the requisite number of shelter stays from June 1, 2007–May 31, 2010) across time.

- Third, the list of names and associated information are sent to the transition coordinator to recruit and enroll individuals in the pilot (discussed in further detail in chapter 4).

During the program planning phase and initial six months of implementation, 196 men were identified as frequent users on one of the five specific dates on which the frequent user identification occurred with the jail and shelter data.⁵ During this time, women were recruited into the program using an alternative methodology.⁶ To explore how the system use patterns of the several hundred male frequent users identified can potentially inform program operations, the following includes a description of their characteristics. Specifically, using hierarchical clustering based on optimal matching analyses, the HMIS and DOC data are used to identify distinct subpopulations and their system use patterns over time within the larger group of frequent users.

3.1. Data Sources

To understand the characteristics of the frequent user population, UI gathered administrative data from TCP and DOC for those individuals who were identified by the previously described frequent user identification. These data were as follows:

1. HMIS data identifying all individuals using the public emergency shelter system between June 1, 2007, and May 31, 2011, along with the frequency and lengths of their shelter use. A total of 10,468 individuals were identified.
2. DOC data identifying the 196 men identified in the first five data matches as well as their criminal history and mental health diagnoses.

These data sets contained the following identifying information: first and last names (the DOC data also included aliases), dates of birth, race, and gender. The DOC criminal charges were coded into five main categories: (1) violent crimes/crimes against persons; (2) property crimes; (3) drug crimes; (4) public order crimes, including public drunkenness and vagrancy; and (5) any other crime (see appendix C for the group breakdown). Mental health diagnoses were grouped into three main categories to match the FUSE criteria listed in appendix B: (1) schizophrenia/ psychotic disorders; (2) mood disorders; and (3) other qualifying disorders, including posttraumatic distress disorder.

3.2. Methodology

While DOC had identified the 196 men included in the DOC data as frequent users, DOC could not provide their shelter use records to UI under the program's data sharing agreements. As an alternative, UI conducted a supplementary data match, linking the HMIS data provided by TCP with the DOC data. These linked data fully describe the shelter and jail use histories of the identified male frequent users. Hierarchical clustering was used to identify distinct subgroups within the population based on their patterns of system use.

⁵ Only men were identified because TCP did not provide a list of eligible women until the eighth month of program operations.

⁶ Because women were not included in the TCP data match for the first six months of the program, the program used an alternative identification strategy: First, DOC identified all women who had two jail episodes within the last three years and were currently in the jail and had a qualifying serious and persistent mental illness, as identified in the jail mental health records. Second, program staff met with the identified women to determine if they self-reported the requisite number of homelessness episodes and whether they were interested in the program. Third, potentially eligible women were searched manually in the TCP database to confirm that they met the shelter stays criteria.

Data Matching

Neither HMIS nor DOC data are perfect records of identifying information, for several reasons. Individuals may provide incorrect information, such as nicknames or aliases, and facility staff may not enter identifying information into the system fully or accurately. Misspelled or incorrect names challenge the data matching process. Difficulties in collecting and maintaining accurate identification data in HMIS systems have been well documented (see Poulin, Metraux, and Culhane 2008 and U.S. Department of Housing and Urban Development 2005). As such, a flexible set of matching criteria were used to identify individuals in the data. These criteria are based on previous data match standards (Hall, Burt, Roman and Fontaine 2009b) as well as name matching software available in the SAS software package (SOUNDEX 1973). Therefore, to match DOC and HMIS data for the 196 men who were identified as frequent users, the following minimal criteria were used:

- If any two records' last names, dates of birth,⁷ and gender matched, the records were eligible to be a match.
- If any two records had the same gender and met three of the following criteria, the records were eligible to be a match:
 - Same or similar-sounding last name
 - Same or similar-sounding first name
 - Same race
 - Same date of birth

Each of the potential matches identified by the above criteria was then manually inspected by UI researchers to confirm each potential match and, if necessary, to determine the best match among multiple potential matches. Visual inspection was based on the above identifying information as well as overlaps in jail and shelter episodes (i.e., if a jail and shelter record reported simultaneous incarceration and shelter use).

Systems Use Analysis

For each individual whose DOC and HMIS records were linked in the UI data match described above, three-year sequences were generated that described the individuals' system use from June 1, 2007, to May 31, 2010. For each day during that 1,096-day period, each individual was assigned to one of four statuses: (1) in jail; (2) in shelter; (3) in prison; or (4) not in any of these three systems, making a 1,096-day-long daily status sequence.

Jail and shelter status was pulled from the DOC and TCP data, respectively. In a handful of cases (n = 75), the jail and shelter data reported an individual was in both systems simultaneously. Because it has been documented that HMIS data can sometimes capture the end date of shelter use inaccurately (see Poulin et al. 2008 and U.S. Department of Housing and Urban Development 2005), it was assumed that the DOC data were correct in these instances and the HMIS data were incorrect. The individual was therefore placed in a jail status. For the 75 cases where this was uncovered, the average overlap in shelter and jail use was 10 days.

For any individual serving a sentence of more than two years, the D.C. Jail transfers custody to the Federal Bureau of Prisons. As such, the DOC data identify all individuals who were sentenced to the Federal Bureau of Prisons for their crimes, but does not capture their release date from prison. Data

⁷ If dates of birth of two observations with the same name were different but had the same day and month or were within 365 days of each other, the difference in dates was assumed to be due to human error (either by those giving the information or by those recording it) and the observations were considered matched.

from the Federal Bureau of Prisons that detailed the entrance to and exit from prison were not available to UI. To estimate time in prison, UI used the national median prison time served based on offense, sex, and race (Bureau of Justice Statistics 2011). If the estimate of prison sentence overlapped with a subsequent jail or shelter record, it was truncated to avoid any overlap.

Once each individual's daily status sequence was defined, optimal matching (OM) was used to quantify the similarity between each individual in the sample. Optimal matching defines this similarity according to the series of manipulations that would be required to convert one sequence into another. Three operations are used: (1) insertions—inserting a status (e.g., one day in shelter) into a sequence and shifting the remaining sequence pattern one day to the right; (2) deletions—deleting a status from a sequence and shifting the remaining sequence one day to the left; and (3) substitutions—switching the status for a given day. Each of these manipulations was assigned a cost. Insertion and deletions were set constant and substitution costs were specific to the type of substitution, inversely related to the relative frequency of the observed transitions. For example, if the total sample of individuals transitioned between jail and shelter frequently in their daily status sequences but transitioned between jail and prison very rarely, then the substitution cost between jail and shelter would be lower than the substitution cost between jail and prison.⁸

In addition, for each individual's daily status sequence, the number of transitions (i.e., number of times an individual changed status) and longitudinal entropy, which quantifies the distribution of time spent in each in the four possible statuses, were calculated (Studer, Ritschard, Gabadinho, and Müller 2010). The complexity index, developed by Gabadinho and colleagues (as cited in Gabadinho, Ritschard, Müller, and Studer 2011) was also calculated as a composite index of transitions and longitudinal entropy. Finally, using the OM results, the individuals were separated into distinct groups using Ward's method of hierarchical clustering (Gordon 1987; Jain, Murty, and Flynn 1999; Maechler, Rousseeuw, Struyf, and Hubert 2005). The characteristics of each group were determined and variations among the groups were assessed using standard and Kruskal-Wallis analysis of variance (ANOVA) or a Pearson chi-square test of independence, as appropriate, given the nature of the data. For those relationships that showed significance in the multigroup measures, multiple comparisons tests were performed.

3.3. Results

Using the aforementioned matching criteria, UI was able to link records in the DOC and HMIS data sets for 172 men (88 percent of the total). UI's inability to link HMIS records to the full set of 196 frequent users identified by the DOC data is likely due to limited matching information (for example, Social Security numbers were not available) and different identification algorithms used by UI compared to DOC. As reported earlier, homeless and jail data are difficult to match due to inaccurate identifying information. Because female frequent users were not identified in the frequent user identification activities during the first six months of the program, no female frequent users were included in the UI analysis.⁹

Sociodemographic, Criminal, and Mental Health Characteristics of DC Frequent Users

Because the DOC data contained full demographic characteristics, criminal histories, and mental health diagnoses, basic characteristics of the 196 male frequent users identified by the program can be evaluated without using the data match results. Table 1 presents their characteristics. The data show

⁸ The substitution cost matrix was calculated using theTRATE argument of the TraMineR package (Studer, Ritschard, Gabadinho, and Müller 2010). Each cost is calculated by the following: $2 - p(s_i | s_j) - p(s_j | s_i)$, where $p(s_i | s_j)$ is the probability of observing state s_i at day $t + 1$ given that state s_j has been observed at day t .

⁹ Women are included in the program and outcome evaluation sections of this report.

that the D.C. FUSE-eligible individuals were primarily black and middle-aged. Consistent with the notion of being frequent users, the average lifetime incarcerations in the D.C. Jail for frequent users were nearly 10. Of note, this *does not* include incarcerations in other jurisdictions, unless there was a transfer of custody to or from the D.C. Jail. Therefore, the true average lifetime incarcerations for those in the sample could have been much higher, particularly given the geographic context of the District of Columbia and its close proximity to counties in Maryland and Virginia. The frequent users had extensive and diverse criminal histories that ranged from minor public disorder crimes, such as public drunkenness, to more serious, violent offenses. Indeed, almost four out of five frequent users had been charged with a violent crime. Only 9 percent of the individuals identified as frequent users had charges under one category, while 67 percent had charges in three or more separate categories.

Table 1. Demographic, Criminal, and Mental Health Characteristics of FUSE-Eligible Detainees Identified by the D.C. FUSE Program

	D.C. FUSE-Eligible Individuals (n=196)
Demographics	
Average age (years)	43.2
Age range (years)	20–69
Percent black	95.9
Criminal History	
Average lifetime incarcerations	9.6
Average number of charges by booking	1.9
Crime Types (percent of individuals)*	
Violent crime	78.1
Drug crime	80.1
Property crime	70.9
Public order crime	48.0
Other	16.3
Diversity of Crime Types (percent of individuals)	
One crime type	9.2
Two crime types	24.0
Three crime types	34.7
Four crime types	28.6
Five crime types	3.6
Mental Health Diagnoses (percent of individuals)	
Single diagnosis type	77.0
Mood disorder	37.2
Schizophrenia	34.7
Other	5.1
Multiple diagnosis types	18.9
Mood disorder and schizophrenia	12.8
Any other combination	6.1
Unknown diagnosis	4.1

*Crime types of each individual's charges over his/her lifetime; not mutually exclusive.

In total, 55.1 percent of frequent users had a mood disorder diagnosis, 48.5 percent had a schizophrenia diagnosis, and 14.8 percent had a post-traumatic distress disorder (PTSD) diagnosis, which falls in the

“other” category of the FUSE criteria. As shown in table 1, the majority of the frequent users’ (77 percent) individual diagnoses fell into one category; of those 151 individuals, their diagnoses were primarily split between mood disorders and schizophrenia. The remaining 6 percent of individuals with a single diagnosis type had PTSD. There were, however, a substantial number of individuals with diagnoses of multiple types of qualifying disorders (i.e., disorders that met the frequent user criteria), but these individuals primarily had a combination of mood and schizophrenia diagnoses. Of the 37 frequent users with multiple diagnosis types in the DOC records, only 12 had PTSD diagnoses. There were also eight individuals who did not have any official mental health diagnoses in the jail records that were provided to UI, but who were identified as eligible for the program by DOC.

System Use Characteristics of D.C. Frequent Users

To gain a greater perspective on the system use behaviors of the frequent user population, system use patterns of the 172 individuals whose records could be linked in the UI data matching (that is, 172 of the 196 frequent users who have linked HMIS and DOC records) were analyzed over a three-year period, from June 1, 2007, to May 31, 2010. For each day during that 1,096-day period, each individual was assigned to one of four statuses: (1) in jail; (2) in shelter; (3) in prison; or (4) not in any of these three systems. Figure 1 shows the unsorted daily status sequences of all 172 D.C. FUSE eligible men.

The frequent user system use patterns are diverse. Hierarchical clustering was used to separate the 172 frequent users into four distinct clusters/subgroups based on similarities in their system use patterns—quantified by OM.¹⁰ Primarily, these four groups of individuals can be distinguished according to the amount and type of their system use (see figure 2). Two clusters are characterized by their relatively low use of shelter, jail, and prison. Frequent users in the first cluster (32 percent of the total) spent 86 percent of their time outside of these systems on average—significantly more than any of the other clusters ($p < 0.001$). As such, the first cluster is labeled “Low System Use.” When these individuals were present in the HMIS and DOC systems, their time was primarily split between jail (7 percent of the three-year period) and shelter (6 percent). Time spent in prison was very low among this group (less than 1 percent of the three-year period, on average).

Individuals in the second cluster, labeled “Moderate System Use” (33 percent of the total) also spent most of the three-year period outside of the shelter, jail, and prison systems. On average, they were outside of these systems for 684 days (62 percent of the three-year period, on average). Further, they were rarely incarcerated in prison (1 percent of the three-year period, on average). In fact, only five individuals were in prison at all during this period. The group does, however, spend modest amounts of time in shelter and jail. On average, 246 days (22 percent of the three-year period) were spent in shelter and 154 days (14 percent) were spent in the jail.

Conversely, the third and fourth clusters spent the majority of the three-year period in the shelter, jail, and prison systems, on average. The type of system used, however, differed greatly. The third group is labeled “High Shelter Use” because, on average, individuals spent 641 days (58 percent of the three-year period) in shelter. This cluster contains the lowest number of frequent users (13 percent of the total). Time spent in jail was in fact lower than the “Moderate System Use” cluster; individuals spent 8 percent of the three-year period in jail, on average. Time spent in prison (0.5 percent of the three-year period) was low and comparable to both the “Moderate System Use” and “Low System Use” clusters.

¹⁰ See data limitations for a discussion of the cluster choice.

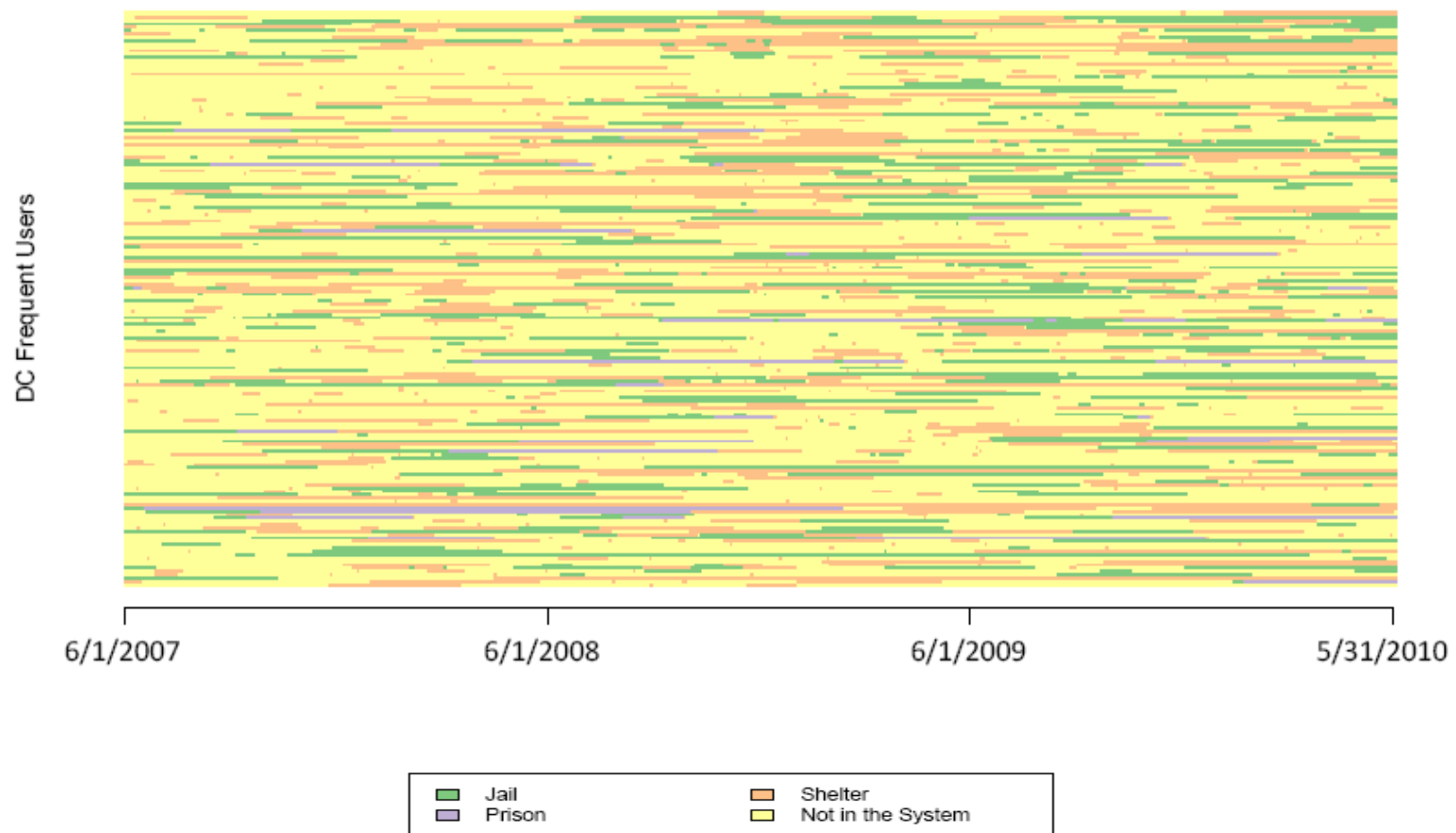


Figure 1. Unsorted jail, shelter, and prison use patterns of the 172 identified frequent user men, from June 1, 2007, to May 31, 2010

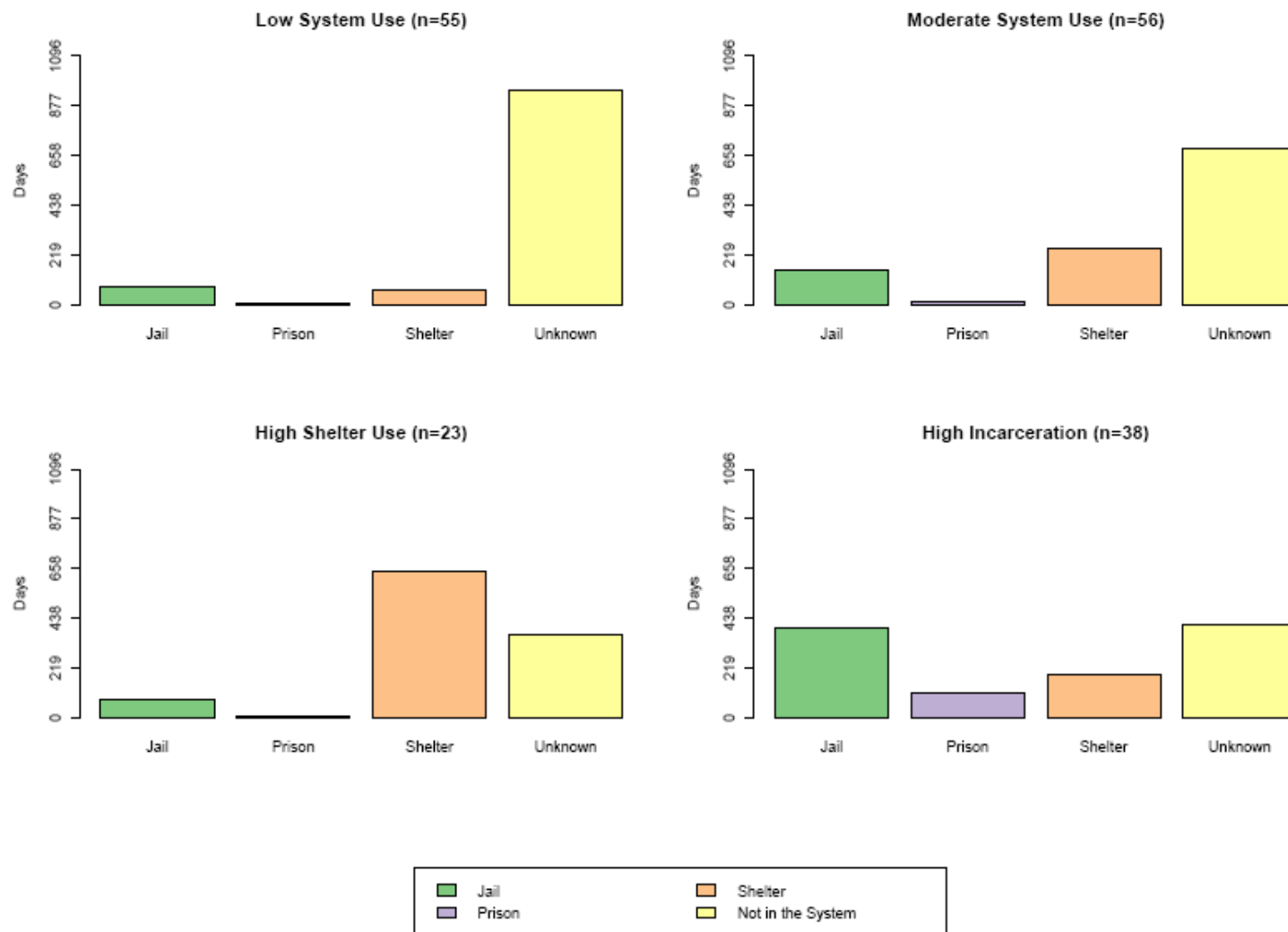


Figure 2. Mean time spent by frequent users in each state, grouped by cluster

The final cluster, which contains 22 percent of the frequent users identified, is characterized by their relatively high level of incarceration. Frequent users in this cluster, on average, spent 394 days in jail and 107 days in prison (36 and 10 percent of the three-year period, respectively). Further, they spent a modest amount of time in shelter—an average of 190 days—more than twice the shelter use of the “Low System Use” cluster.

As described previously, the OM technique evaluates both temporal and subsequence pattern commonalities to determine the similarity of two status sequences. As such, one could reasonably expect to see differing temporal patterns in system use among the clusters along with differential system use levels. Put another way, the clustering may group individuals who are in the same system at the same time together. To explore how much temporal patterns contribute to the clustering of frequent users, the status distribution of each cluster (i.e., the proportion of the group in each status) was visually inspected at each point in the sequence (i.e., June 1, 2007; June 2, 2007; ...; May 31, 2010). This representation is displayed in figure 3. While there is some variation among the clusters, the proportion of individuals within the cluster who were using a particular system remained relatively constant and untrending across the three-year window. This indicates that temporal patterns did not heavily influence the clustering.¹¹ The only exception may be the “Moderate System Use” cluster, which appeared to increase its jail incarceration over the three-year period, while other clusters did not.

Rather than temporal patterns, the subsequence pattern and level of system use appear to primarily influence the clustering. Figure 4 displays the individuals’ status sequences, separated by cluster. The same system use patterns are generally observed for each individual within a cluster. That is, each individual spends time in multiple systems (as is required by the FUSE eligibility criteria), but the *type and length* of system use follow the general cluster patterns—albeit at different points in the three-year period. For example, all of the individuals in the “High Shelter Use” cluster have substantial and often unbroken periods of shelter use spread across the three-year period.

In figure 4, there also appears to be variability among the clusters in the complexity of the system use patterns. This complexity was measured in two ways: (1) the number of transitions in each sequence (i.e., number of times an individual changes statuses); and (2) the longitudinal entropy of each sequence (i.e., the variation in the type of statuses observed and number of days spent in each status). Finally, because transitions and longitudinal entropy are related but separate sequence characteristics, a composite index called the complexity index (Gabadinho et al. 2011) was also used, which combines and reweights the entropy and transition measures to generate a score between 0 and 1, where 1 represents the maximum complexity (i.e., an individual switches systems every day and spends equal time in each possible system). Table 2 presents these measures for each cluster.

¹¹ The independent influence of contemporaneous patterns on the clustering results was not tested for the current study but may be of interest in future, expanded systems use analyses.



Figure 3. Distribution of individuals among the four statuses across time, by cluster

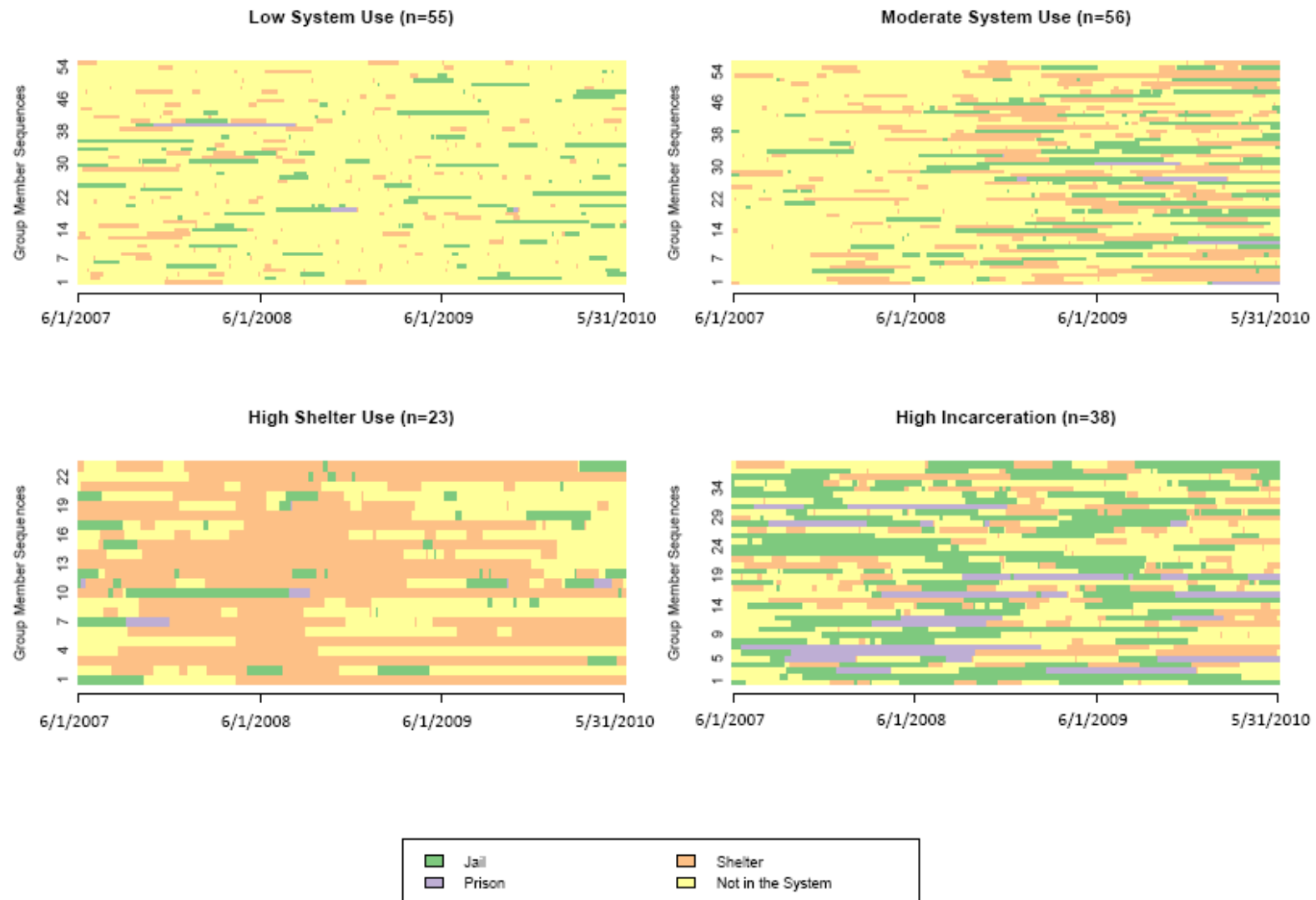


Figure 4. Unsorted jail, shelter, and prison use patterns from June 1, 2007, to May 31, 2010, by cluster

Table 2. Mean Number of Transitions, Longitudinal Entropy, and Complexity Index by Cluster

	Low System Use (n=55)	Moderate System Use (n=56)	High Shelter Use (n=23)	High Incarceration (n=38)	p-value†
Average Number of Transitions	10.5	11.2	8.5*	13.9	<0.0001
Average Longitudinal Entropy	0.3167*	0.5751	0.5267	0.7163*	<0.0001
Average Complexity Index	0.0540	0.0755*	0.0612	0.0929*	<0.0001

†Determined by standard ANOVA.

*Significantly different from all other cluster values; p<0.05.

The “High Incarceration” group has the greatest number of transitions, entropy, and complexity indices among the four frequent user clusters. On average, individuals in this group had 4.3 stays in shelter, 3.2 stays in jail, and 0.6 stays in prison. The number of transitions, however, is not significantly different from the “Moderate System Use” and “Low System Use” cluster. Results of the multiple comparisons tests using Bonferroni corrections show that the “High Shelter Use” cluster had significantly fewer transitions than all of the other clusters and therefore changed statuses less frequently. This cluster, on average, had 3.6 stays in shelter, 1.8 stays in jail, and 0.3 stays in prison. However, they did not use significantly fewer services overall, as indicated by the levels of longitudinal entropy similar to those of the “Moderate System Use” cluster. Conversely, the “Low System Use” cluster had much lower overall use of systems, and thus lower longitudinal entropy while still undergoing a similar number of status transitions, on average. The “High Incarceration” cluster had significantly higher longitudinal entropy and a significantly higher complexity index than all of the other clusters. This can be interpreted to mean that the frequent users in this cluster had the greatest diversity in their system use overall, which is also reflected by a high, but not statistically significant different, average number of transitions.

Finally, table 3 presents the demographic, criminal, and mental health characteristics of the frequent users, separated by cluster. There were no observed differences in the age or race characteristics across the four clusters. Criminal history, however, appears to be associated with cluster assignment. Frequent users in the “High Incarceration” group have, on average, four more incarcerations over their lifetime than frequent users in the other clusters. Moreover, the “High Incarceration” frequent users appear to have more diverse and serious crimes. More than 86 percent of these frequent users have been charged with a violent crime, compared with 82 percent of the “Moderate System Use” cluster, which has the second highest level. While not as serious, the “High Incarceration” cluster also includes a significantly greater number of individuals who have been charged with a public order crime, which may help explain why the frequent users in that cluster, on average, have been charged with 3.2 different crime types—the highest among all of the clusters, albeit not significantly different.

Differences in mental health diagnoses among the clusters were also analyzed. While each individual’s mental health diagnoses were not significantly associated with cluster assignment (p=0.75), there are some suggestive trends observed within the data. Individuals in the “Moderate System Use” cluster appear to have higher levels of PTSD (this was the only diagnosis observed in the “other” category), with 14 percent of individuals having this diagnosis compared to approximately 11 percent of the “High Shelter Use” cluster, which has the second highest percentage of diagnosed frequent users.

In additional, it appears that the “High Incarceration” cluster has more frequent users who do not have a diagnosis in the DOC mental health records. This may explain the lower level of mood disorder diagnoses among frequent users in this cluster. It also appears that the “Low System Use” cluster had slightly more frequent users with multiple types of diagnoses.

Table 3. Demographic, Criminal, and Mental Health Characteristics of the Frequent Users by Cluster

	Low System Use (n=55)	Moderate System Use (n=56)	High Shelter Use (n=23)	High Incarceration (n=38)	p-value
Demographics					
Age (mean years)	46.1	43.7	42.3	44.0	0.505†
Age range (years)	20-66	21-64	22-68	23-69	
Percent black	98.2	96.4	95.7	92.1	0.441‡
Criminal History					
Lifetime incarcerations (mean)	10.4	10.2	9.6	14.7*	<0.0001†
Number of charges by booking (mean)	1.8	1.7	1.9	1.9	0.323†
Crime Types (percent of individuals)					
Violent Crime	74.6	82.1	73.9	89.5	0.278‡
Drug Crime	76.4	80.4	78.3	76.3	0.955‡
Property Crime	72.7	67.9	78.3	73.7	0.804‡
Public Order Crime	38.2	46.4	43.5	68.4*	0.034‡
Other	16.4	10.7	13.0	15.8	0.832‡
Diversity of Crime Types (percent of individuals)					0.181‡
One crime type	10.9	7.1	17.4	2.6	
Two crime types	30.9	28.6	17.4	18.4	
Three crime types	30.9	37.5	30.4	36.8	
Four crime types	23.6	23.2	30.4	36.8	
Five crime types	3.6	3.6	4.4	5.3	
Mean number of crime types	2.8	2.9	2.9	3.2	
Mental Health Diagnoses (percent of individuals)					0.746‡
Single diagnosis	76.4	80.4	87.0	71.1	
Mood disorder	43.6	37.5	47.8	26.3	
Schizophrenia	30.9	35.7	39.1	36.8	
Other	1.8	7.1	0.0	7.9	
Multiple diagnoses	18.2	16.1	13.0	15.8	
Mood disorder and schizophrenia	12.7	8.9	8.7	13.2	
Any other combination	5.5	7.1	4.3	2.6	
Unknown diagnosis	5.5	3.6	0.0	13.2	

†Determined by standard ANOVA; ‡Determined by Pearson Chi-Square analysis; ‡ Determined by Kruskal–Wallis ANOVA.

*Significantly different from all other cluster values; p<0.05.

3.4. Data Limitations

Before discussing the implications of the findings, several limitations should be acknowledged. These limitations are the result of both the optimal matching technique itself as well as the nature of the data used for the analyses. The primary limitation with the data concerns the estimation of prison sentence length. Detainees of DOC who are sentenced for a period of incarceration longer than two years are sent to the Federal Bureau of Prisons (BOP) to serve their sentence. As such, DOC does not possess accurate release dates from prison for these individuals. Data describing the individuals' entry and exit from the federal prison system are maintained by BOP and were not available to UI researchers. In place of prison release dates—which would be ideal—the average time served among prisoners by race and gender was used. While this estimate has been shown to be biased by unstable prison populations (Lynch and Sabol 1997; Patterson and Preston 2008), the corrected indirect measures were available for the five primary crime categories only (violent crimes/crimes against persons; property crimes; drug crimes; public order crimes, including public drunkenness and vagrancy; and any other crime) in the *Prisoners in 2009* public data set (West, Sabol, and Greenman 2010), whereas the estimates of average time served were available on a charge-specific level. Furthermore, the limitations of this prison estimation are mitigated by the low number of individuals sentenced to prison in the sample (21 individuals, representing 12.2 percent of the sample) as well as their low average prison sentence (average of 250 days among those who went to prison).

Additionally, there are criticisms of the OM technique. These criticisms concern the definition of the insertion and deletion (indel) costs and the substitution costs. The definition of these costs can influence the results of OM substantially (Bison 2009). Indel operations favor similar status patterns, regardless of the timing, while substitution operations favor temporal similarities when determining the similarity of two patterns. If one operation's costs are set lower, then a particular type of grouping can be favored. Due to the nature of the sampling (i.e., individuals had to be incarcerated when the lists were formed to be included in the analyses), the aforementioned analyses favored contemporaneous similarities and assigned substitution costs below the indel costs, proportional to the transition frequencies observed within the data (Studer, Ritschard, Gabadinho, and Müller 2010). While this is an arguably arbitrary determination, it is supported by past applications of OM (Lesnard 2010). Acknowledging these cost designations, however, is critical to an accurate interpretation of the hierarchical clustering results.

Further criticism of the OM technique stems from the fact that the substitution cost matrix must be symmetrical in OM (e.g., the cost of switching from jail to shelter and from shelter to jail must be equal). This can produce logical contradictions when interpreting the substitution costs. For example, in practice, someone can move from prison to shelter, but cannot move from shelter to prison—the individual must go to jail first. Yet the substitution costs of shelter to prison and prison to shelter are equal. However, this critique is not relevant to this report's application of OM. A tremendous number of factors affect individuals' status sequences. For example, a particular criminal history or use of a particular drug could greatly influence an individual's sentence length. The purpose is not to identify or group individuals by the determinants of their status sequence. Instead, the purpose is to group individuals by their pattern of system use over time, and thus the directionality of substitutions is not an important distinction.

Finally, it should be acknowledged that there is limited research regarding how to properly determine the appropriate number of clusters into which a group should be broken (Jain, Murty, and Flynn 1999; Nugent and Stuetzle 2010). While previous literature has performed hierarchical clustering based on the theoretical types of homelessness and shelter use (Kuhn and Culhane 1998), there is no theory predicting the clustering of frequent users' jail and shelter patterns. A cluster sample of four was

selected for this project based on the researchers' visual inspection of the dendrogram and associated merging costs of the hierarchical clustering tree, which is a common analytical approach (Jain et al. 1999).

3.5. Implications

Illustrating the different characteristics and system use patterns of the D.C. frequent user population has the potential to inform future program planning, particularly in terms of recruitment or enrollment strategies and the program's associated service packages or activities. It is also helpful in informing the program's potential for cost savings, particularly to the jail and shelter systems. While all of the frequent users met a set of minimum eligibility criteria, individuals varied considerably in their use of systems. About one-third of the individuals had relatively high use of systems, another one-third had moderate use, and a final one-third had relatively low use. Therefore, jail and shelter system contact is a useful point of leverage for the identification and recruitment of frequent users. In FUSE, individuals are identified and recruited while they are incarcerated in the jail only.

The point of system contact used to recruit in turn influences the types of frequent users who are identified and enrolled into the program. Without considering the multiple logistical factors that influence effective identification and recruitment, jail in-reach efforts favor the recruitment of the "High Incarceration" frequent users along with some of the "Moderate Systems Use" frequent users because these sets of frequent users are incarcerated for the longest periods of time. Conversely, a community-based recruitment mechanism that identifies frequent users during shelter contact would likely yield more "High Shelter Use" and "Moderate System Use" frequent users. This implies that certain types of individuals with certain characteristics are more (or less) likely to be recruited into the program, with potential implications for individuals' success in the program and future system use. Notably, approximately one-third of the frequent users in the "Low System Use" cluster would not likely be enrolled by shelter- or jail-based recruitment strategies. Alternative recruitment methods such as contact with the city's core mental health service agencies or benefit administrators may be more effective at reaching this subgroup.

Once enrolled, the types of frequent users served can inform the treatment strategies employed by the program, which may affect the associated cost savings of the program. Consider, for example, the "High Incarceration" frequent users; these individuals have more diverse and serious criminal histories as well as much higher levels of public disorder crimes—which may indicate higher levels of substance abuse. The behaviors of these frequent users are different, which may influence the appropriateness of the various mental health treatments (i.e., assertive community treatment services vs. community support services) and expected outcomes. Furthermore, the potential cost savings of treatment are also different. For example, the "High Incarceration" frequent users spent the greatest amount of time in the jail and prison systems (which is more costly than emergency shelter use), had the most extensive criminal histories, and transitioned between statuses more often, which further increases costs due to the administrative tasks of system intake and discharge. As a result, programming that reduces frequent use of systems may demonstrate greater cost savings among this subgroup.

More research is necessary to describe more fully the frequent user population and to determine the effectiveness of various recruitment and treatment strategies for the subgroups of that population. Nevertheless, consideration of these diverse frequent user characteristics and behaviors can inform program planning and help demonstrate the need for effective, targeted service delivery for frequent users in D.C. and other jurisdictions.

4.

Logic and Performance of the Frequent User Pilot

To understand how and whether the FUSE pilot is meeting its intended goals, the logic and performance of the pilot program were assessed, including documentation of the barriers to and facilitators of successful operations and understandings of whether critical program operations were achieved over the past year. During the first year, the program has placed particular emphasis on the first two goals of the project: (1) creating 50 units of permanent supportive housing for the frequent user population leaving the District of Columbia Department of Corrections; and (2) improving coordination across the systems that serve the frequent user population in the District, including the jail, the Department of Mental Health, and The Community Partnership. This chapter discusses the program's logic model, detailing the pilot's inputs, activities, and outputs as well as its intended short- and long-term impacts. The chapter concludes with implications of the programs efforts to date and suggestions for development.

4.1. Data Sources and Methodology

To assess program operations, more than one dozen site visits to FUSE partner offices were conducted over the past year. Specifically, data were collected through—

1. **Semi-structured interviews** with the program director, program manager, program partners and clinical staff;
2. **Face-to-face interviews** with program participants who consented to speak to the research team;
3. **Field observations of program operations, services, and facilities**, through the transition coordinator's position in the jail, as well as the transitional and supportive housing staff positions within the community;
4. **Reviews of program materials**, including intake forms, assessment forms, and other reports; and
5. **Frequent teleconferences** with all of the program partners, including clinical staff.

Using these data, a model of the FUSE pilot was developed that describes all aspects of the program and the logic between the program inputs, activities and outputs, and outcomes. The model, shown in figure 5, is split into three main elements: inputs; activities and outputs; and impacts.

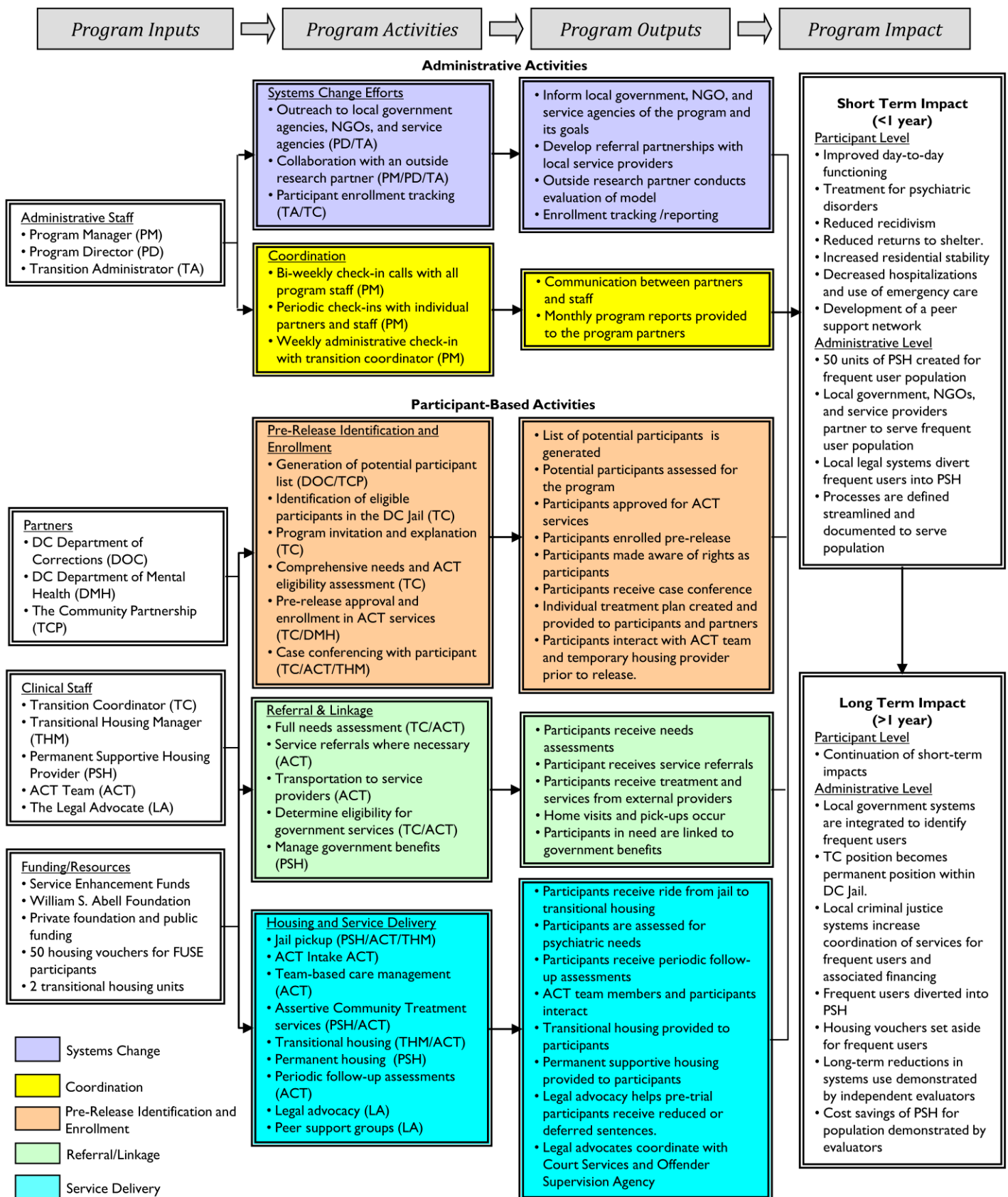


Figure 5. Frequent user service enhancement logic model

4.2. Inputs

As shown in figure 5, program inputs are split into four categories: administrative staff, partners, clinical staff, and funding/resources.

Administrative Staff

Administrative oversight of FUSE is provided by a few key staff members, who are responsible for the continued development and operational oversight of the FUSE pilot. These staff focus their efforts on finding and allocating funding for the program, directing and coordinating program staff, and recruiting and coordinating additional program partners. A long-term goal for the FUSE program is to sustain the program within the existing system operations, which from the perspective of the administrative staff, is accomplished only after the initial five goals of the project have been achieved (see chapter 1).

Program Manager (PM)	The program manager is an employee of the Corporation for Supportive Housing (CSH) and the primary individual tasked with overseeing the day-to-day operations of FUSE by tracking progress of individual FUSE participants, organizing and facilitating frequent program partner meetings, communicating with active partners, and troubleshooting problems as they arise. The project manager is not a full-time staff position, though s/he spends approximately 60 to 75 percent of his/her time on the program. The main goal of the program manager is to address operational issues while preparing for the sustainability of the pilot and to communicate the program's activities and needs to the program director and other partners.
Program Director (PD)	The program director, an employee of CSH, is responsible for the planning, execution, and direction of the overall program. This individual works with local service providers and government agencies to secure funding and resources for the project. Project needs are identified based on consistent feedback and discussions with the program manager and the transition administrator. These responsibilities take approximately 10 to 20 percent of the director's time.
Transition Administrator (TA)	The transition administrator is an employee of University Legal Services (ULS) and full-time legal advocate. He/she is responsible for the supervision of the transition coordinator—who is also a ULS employee (described below)—as well as the coordination of the jail in-reach program partners. As the person in charge of the overall process of enrolling individuals into the program and transitioning them from the jail, the transition administrator also oversees the legal advocacy process (described below), another means of enrolling participants into the program. Given his/her role as a full-time legal advocate who works with disabled populations in the criminal justice system, it is difficult to quantify the percentage of time the TA spends on the D.C. FUSE program specifically. Instead, the position of TA can be seen as an expansion of the TA's ongoing advocacy role.

Partners

FUSE has a variety of partners that assist with the jail in-reach, participant recruitment, release planning, transitional housing services, and permanent supportive housing services components.

Department of Corrections (DOC)	The Department of Corrections manages the jail, the starting point for FUSE participants and a key eligibility criterion. DOC has an existing discharge planning staff and protocol, which has been expanded to include the FUSE program. DOC staff identifies all potential FUSE participants through the administrative data match and provide access to those individuals through the transition coordinator, who works in the jail and supplements the existing reentry and mental health discharge planning infrastructure.
Department of Mental Health (DMH)	DMH's role within the FUSE project is to determine potential program participants' eligibility for assertive community treatment (ACT) services. Information on potential participants, including ACT eligibility forms, level of care utilization system (LOCUS) for psychiatric and addiction services assessment forms, intake assessments, and psychosocial summaries are sent to the ACT coordinator at DMH and are considered for approval. Approval can be expedited or modified to meet a participant's needs. Following ACT approval, participants are enrolled in the FUSE program.
The Community Partnership for the Prevention of Homelessness (TCP)	TCP is a nonprofit organization that provides street outreach efforts, emergency shelter, transitional housing, and permanent supportive housing for homeless individuals in the city. Within the FUSE project, TCP provides data on individuals' emergency shelter stays. The historical shelter use information is used to generate a list of potential FUSE participants in conjunction with DOC data (described below).

Clinical Staff

Among the FUSE program partners are several key staff positions that interact with and serve the FUSE participants directly.

Transition Coordinator (TC)	The transition coordinator, an employee of ULS, is tasked with recruiting FUSE participants through jail in-reach. The transition coordinator is a licensed mental health counselor with experience working with the target population and is certified to conduct eligibility assessments for ACT services in DC. Eighty percent of the transitional coordinator's time is spent in the jail working to enroll and discharge program participants. The remaining 20 percent is spent at the ULS offices on administrative activities (e.g., completing participants' tracking materials and meeting with the transition administrator, a direct supervisor). During the past year, the salary and benefits for the transition coordinator's position were paid through a grant from the William. S. Abell Foundation.
Transitional Housing Manager (THM)	The transitional housing manager, an employee of Community Connections, a community-based service provider, is responsible for the oversight of the two transitional housing units for the FUSE program (described below). Because Community Connections is not the permanent supportive housing provider for FUSE, the THM is not responsible for direct service provision for FUSE participants in the transitional housing units. The THM is responsible for coordinating with the transition coordinator and the permanent supportive housing provider staff to facilitate the discharge planning process, from jail to the transitional housing unit, and from the transitional housing unit to the (continued on the next page)

	permanent supportive housing unit. The THM also maintains the transitional housing unit and identifies and troubleshoots any problems that may arise with the tenants or the housing facility.
Permanent Supportive Housing (PSH) provider	Central to the FUSE program is the provision of permanent supportive housing (PSH) to participants. Over the past year, one organization was the PSH provider, managing both the allocation of housing and the provision of community-based mental health treatment services. The FUSE program does not have its own allocation of housing vouchers; therefore, the PSH provider reserved a set of 25 housing vouchers it already had available for the FUSE program. As a mental health services provider with a history of working in the city, the PSH provider has extensive experience serving the population of homeless individuals with psychiatric disabilities and co-occurring substance abuse disorders, including individuals with criminal histories. Over the past year, Pathways to Housing, D.C. (hereafter referred to as Pathways) has been the PSH provider. Pathways only provides ACT services to FUSE participants.
Assertive Community Treatment (ACT) team	Each FUSE participant is assigned to an ACT team, which comprises social workers, mental health specialists, employment specialists, housing specialists, a registered nurse, and a psychiatrist. The ACT team operates within the PSH provider, closely coordinating housing and treatment services for individual consumers or clients. Each ACT team serves both FUSE participants and other ACT-eligible, non-FUSE clients or consumers. Once an individual is approved for ACT services by DMH and prior to release from jail, the ACT team becomes involved with the discharge planning process. Following release, the ACT team serves the participant by using comprehensive, community-based psychiatric treatment and support while also working to align the participant with housing, health care, substance abuse treatment, and income sources as needed. The ACT team's work is generally funded by Medicaid (for participants who are Medicaid eligible) and DMH. Additional funding for services comes from the grant money awarded to the FUSE project (known as service enhancement money).
Legal Advocate (LA)	Given the role of ULS on the project, a legal advocate is associated with the FUSE project. The primary responsibility of the legal advocate is to ensure that FUSE-eligible individuals are acknowledged by the legal system as being eligible for services tailored to their specific needs. The goal of the legal advocate is to help divert FUSE-eligible individuals from incarceration into the FUSE program, assist in the reduction of their stay in jail, as well as to assist them in the legal process. This position is filled by ULS, which serves as the District of Columbia's federally mandated protection and advocacy system for people with disabilities. Legal advocacy services are provided to FUSE participants through referrals from the transition coordinator or ACT team.

Funding and Resources

The D.C. FUSE program includes a variety of resources to assist staff in providing housing and services to participants. Funding is designated to cover staff and partners' labor hours on the program as well as to pay for participant needs.

Service enhancement funds	Six thousand dollars in service enhancement money is allocated for each FUSE participant to used to cover a variety of non-Medicaid-billable services, such as temporary housing in a hotel or staff hours for jail pickups. Service enhancement money is funding assembled by CSH through public and private support.
William S. Abell Foundation	Start-up funding was provided to CSH and ULS by the William S. Abell Foundation. Beginning in mid-2000s, the William S. Abell Foundation had a strategic initiative to make investments in the city that would reduce homelessness. The foundation supported CSH staff and the salary and benefits for the transition coordinator located in the DC Jail. The foundation also provided funding for the 2008 data match conducted by the Urban Institute and the subsequent forum (described in chapter 2).
Private foundation and public funding	CSH has benefited from a variety of private and public funding for FUSE. Private funding comes from the Robert Wood Johnston Foundation, the William S. Abell Foundation, the Fannie Mae Foundation, and the Open Society Institute. CSH was awarded a grant from the Justice Grants Administration of the Office of the District of Columbia Mayor in 2010. All of these funds have been used in the planning and launch of the FUSE pilot and to fund part of the program manager and program director positions. Funds are also used as service enhancement dollars.
50 housing vouchers for FUSE participants	Provided by the D.C. Housing Authority (DCHA), Housing Choice Vouchers and Local Rent Supplement (LRS) dollars are used by Pathways to provide FUSE participants with PSH. Following budget considerations, the DCHA allocates a number of these vouchers for PSH in the city each year. These vouchers are assigned to a PSH provider, which manages their distribution to eligible persons.
Two transitional housing units	The two transitional housing units provided to FUSE participants by Community Connections are funded through the U.S. Department of Housing and Urban Development (HUD). The transitional housing, based on the requirements of the HUD funding, is designated for individuals who have been homeless prior to move-in and have mental health issues.

4.3. Program Activities and Outputs

For the FUSE pilot, staff completes a variety of activities, from working directly with participants to facilitate their reentry into the community to building and maintaining partnerships with local service providers and government agencies to assist in the reentry process. In the logic model (figure 5), these activities are sorted into five categories based on their function within the FUSE program; the staff or partners associated with each activity are shown in parentheses. In addition, each category of activities has an associated set of intended outputs that the activities aim to generate.

System Change Efforts

One of the goals of the FUSE pilot is to coordinate the services and resources of community partners and local government agencies, as well as to institutionalize the program into existing operations. Therefore, some portion of the program director's and program manager's time is spent facilitating system change in the District agencies that serve frequent users.

Outreach to local government agencies, nongovernmental organizations, and service agencies (PD/TA)	To sustain and institutionalize the services provided to the frequent user population in the city, the program director and transition administrator interact with local government, nongovernmental, and community-based agencies to advocate for the FUSE program, secure additional funding for its operations, and establish the program as a cross-system collaboration that utilizes the capabilities of the criminal justice, mental health, housing, and human service agencies to serve the frequent user population.
Collaboration with an outside research partner (PM/PD/TA)	The program manager, program director, and transition administrator maintain contact with external research partners to collect and analyze data on the program's implementation, performance, and outcomes. This information is intended to be useful in identifying and publicizing program successes and to inform future program modifications. As well, relationships with research partners are seen as critical to securing additional funding and partnerships for FUSE.
Participant enrollment tracking (TA/TC)	The transition administrator and transition coordinator follow each participant's enrollment process into the program and report it to DOC monthly. This report also details how many potentially FUSE-eligible individuals were enrolled into the program, what services they received from the transition coordinator, and why any potential participants were not enrolled. The reports also highlight success stories. These reports are intended to document the enrollment activities of the transition coordinator and to help DOC determine how to incorporate the transition coordinator position into its discharge planning process.

Potential measurable outputs of the program's system change effort activities are as follows:

- How and to what extent have local government, nongovernmental, and community-based agencies been informed about the program and its goals?
- How and to what extent have partnerships with local service providers been developed to increase referrals for frequent users?
- How and to what extent has a research partner been used to assess, evaluate, and refine the model and evaluate the outcomes of program participants?
- How and to what extent has participant enrollment tracking occurred and been reported to DOC?

Coordination

In addition to the activities designed to implement and sustain the program, administrative staff are responsible for coordinating all partners on the operational activities of the program. The program involves several steps for individual participants, with each step being managed largely by a different agency (e.g., from jail to community, from transitional housing to permanent supportive housing). Therefore, coordination is critical since it serves to keep all partners aware of program activities and allows for troubleshooting whenever problems occur. It also allows for continuity in services provided to participants during the aforementioned transitions.

Biweekly calls with all program staff (PM)	Program partners participate in biweekly calls organized by the program manager. The calls keep all partners apprised of program activities and allow for communication among all of the service providers with whom the participants interact. Through these calls, program-related problems can be identified and discussed and troubleshooting can occur.
Periodic meetings or check-ins with individual partners and staff (PM)	Similar in function to the biweekly calls, these periodic meetings serve to focus on particular issues and questions or coordination involving specific partners or staff. The program manager facilitates these meetings or check-ins, as necessary, depending on needs of the program.
Weekly administrative check-in with transition coordinator (PM)	Since the transition coordinator serves as the program's initial contact with potential FUSE participants, frequent communication between the program manager and the transition coordinator allows for early identification of any individual participant issues.

Potential measureable outputs of the program's coordination activities include the following:

- Whether and how often communication between partners is occurring.
- Whether and how often monthly program reports have been provided to the program partners.

Prerelease Identification and Enrollment

The FUSE pilot was designed for a specific population, based on detailed eligibility requirements. Therefore, various activities between program partners are necessary to identify eligible participants. Once potential participants are identified, staff seeks to contact and enroll them into the program before they are released into the community.

Generation of potential participant list (DOC/TCP)	A list of potential participants is created through a data-sharing agreement between TCP and DOC. The list, which originates from TCP, identifies all people who appeared in the emergency shelter system three or more times over the past three years. Then, a data specialist at DOC determines whether any of the individuals listed in TCP data are currently in the jail with at least two previous stays in the DC Jail within three years <i>and</i> meet the FUSE program's mental health criteria. The mental health criteria—a serious and persistent mental illness—are based on DOC mental health records. The DOC conducts a mental health assessment on every individual booked into the jail and may provide mental health treatment to individuals exhibiting symptoms during incarceration. The lists of potential participants have not been generated on a regular schedule. Rather, each list is generated at the request of the program manager. Once generated, each list is sent directly to the transition coordinator.
Identification of eligible participants in the DC Jail (TC)	From the combined list of potential participants, the transition coordinator reviews the legal status of each individual and prioritizes contact with individuals based on their release dates. For individuals who do not have a release date (i.e., have a pretrial status), their case is referred to the legal advocate for review (described below). These individuals are contacted (continued on the next page)

	after all sentenced individuals have been approached or if the legal advocate determines that their case might be diverted through their participation in FUSE.
Program invitation and explanation (TC)	Once a list of potential participants has been created and prioritized by jail release dates and legal status, the transition coordinator arranges to speak with each individual to explain the program and its services. Because people are detained in various locations within the jail, potential participants are brought to a central meeting room in the jail. The transition coordinator does not go into the wards. The first contact with the individual includes an initial intake assessment to confirm program eligibility. At this point, potential participants can either refuse participation in the program or agree to proceed with the enrollment process. If the individual agrees to proceed, the transition coordinator will secure authorization to collect the individual's full medical history, which helps to confirm program eligibility and will be used in the application for ACT services.
Comprehensive needs and ACT eligibility assessment (TC)	In the next meeting, the transition coordinator conducts a comprehensive history and needs assessment and administers the LOCUS (level of care utilization system from psychiatric and addiction services, a formal assessment of treatment needs offering a level of care recommendation) and ACT eligibility assessments. The needs assessment is used to inform the individual treatment plan, and the LOCUS and ACT eligibility assessments are necessary for the application for ACT services.
Prerelease approval and enrollment in ACT services (TC/DMH)	Once the transition coordinator determines that the individual may be ACT eligible, an ACT application is created, which includes a psychosocial summary based on medical history records and copies of the LOCUS and ACT eligibility assessments. The applications are sent to the ACT coordinator at the Department of Mental Health for approval of ACT services. Upon approval, the person is considered "enrolled in FUSE" and is assigned to the PSH provider. The approval process generally occurs just prior to an individual's release date; a response from DMH is typically received within two to three days of the application's submission.
Case conferencing with participant (TC/ACT/THM)	Prior to the person's release, the transition coordinator organizes a case conference session to be held at the jail. The primary purpose of the case conference is to generate a release plan and to explain it to the participant. A variety of individuals may be invited to the case conference, depending on the participant's needs, including an ACT team member, the transitional housing manager, a DOC case manager, a DOC discharge planner, DOC clinical staff, a DMH liaison, a government benefits specialist, the individual's attorney, a Court Services and Offender Supervision Agency (community corrections) liaison, and the participant's family or friends. During the case conference, a transition plan summary form is used to discuss every step of the release process. The form includes mental health care, medications, housing, benefits/income, substance abuse treatment, basic living needs, transportation from jail, conditions of release, and health insurance/Medicaid. The form is populated before the meeting by the transition coordinator based on the needs assessment. During the conference, the various partners discuss the plan and make any necessary changes. Additionally, each person present at the conference discusses his/her role in the participant's transition from the jail, ensuring that the partners and the participant know who is responsible for what. Using the information gathered during the case conference, the transition (continued on the next page)

	coordinator finalizes the transition plan for the participant and sends it to all of the necessary partners and staff members. The participant also receives a copy of the plan.
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Potential measurable outputs of prerelease identification and enrollment activities include the following:

- How many lists of frequent users have been generated?
- How many individuals have been assessed for the program?
- How many individuals have been assessed and approved for ACT services?
- How many eligible participants are enrolled prerelease?
- How many eligible participants are made aware of their rights as a participant?
- How many case conference sessions have been scheduled?
- Whether and how many individual treatment plans have been created and provided to the participant and all partners.
- Whether and how many participants interacted with their ACT team and temporary housing provider prior to release.
- Who participates in the case conferencing sessions and how often do they participate?

Referral and Linkage Activities

Once FUSE participants have been identified and enrolled into the program, they are assessed for needs and linked with appropriate services to meet those needs.

Full needs assessment (TC/ACT)	Participants' needs, including mental health diagnoses, are assessed at two points in the FUSE program. Needs (along with eligibility) are assessed by the transition coordinator initially and are considered when preparing the participant's transition plan. They are assessed again during the ACT intake process (described in table 9). The ACT team conducts its own intake assessment to determine specific housing needs, basic living needs, and benefits/income needs. As the individual's participation with the program continues, needs are continually reassessed by ACT team members through regular interaction and engagement.
Service referrals where necessary (ACT)	When a individual's needs exist outside the scope of the ACT team's capabilities (e.g., ACT teams do not provide substance abuse treatment), referrals to other community-based services are made.
Transportation to service providers (ACT)	When participants are linked to services outside the scope of the ACT team, the ACT team helps to provide transportation to and from such services (e.g., hospital visits). Additionally, the ACT team will conduct home visits and/or pick up FUSE participants for meetings with the ACT team.
Determine eligibility for government services (TC/ACT)	During the needs assessments conducted by the transition coordinator and the ACT teams, participants are screened for eligibility for government benefits such as Social Security benefits, Supplemental Nutrition Assistance Plan (SNAP) benefits, and Medicaid.

Manage government benefits (PSH)	The PSH provider plays a critical role in managing participants' government benefits. In cases where benefits are managed by the PSH provider, the provider claims the benefits and disburses them to the individual. For example, in the case of housing subsidies, the PSH provider claims the subsidy and disburses it directly to the participant's landlord, so that rent is paid consistently and on time.
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Potential measurable outputs of referral and linkage activities include the following:

- How many needs assessments have been completed?
- How many service referrals have been conducted?
- How many participants have received treatment from external service providers?
- How many home visits or pickups have occurred?
- Of the participants who have a need, how many have received their government benefits?

Housing and Service Delivery Activities

The program provides a large number of direct services to participants, specifically housing and supportive services.

Jail pickup (PSH/ACT/THM)	The program seeks to begin community-based services for participants immediately upon release from jail, to facilitate a seamless transition from jail to the community. To do this, the ACT team assumes oversight of the individual at release by picking the individual up from the jail and providing transportation to his or her transitional housing.
ACT intake	Once the individual is released into the care of the ACT team, a comprehensive intake process is performed. This includes an assessment by a psychiatrist on the ACT team to determine the individual's mental health treatment course. The transition plan is also used to initially assign ACT services.
Team-based care management (ACT)	The ACT team, with its multidisciplinary staff and diverse capabilities, offers a suite of psychiatric and social services for the individual. Because these capabilities are housed within a single team that communicates and interacts frequently with the individual participant, care is highly coordinated. The team meets to discuss each participant daily, and a team member is on call 24 hours a day.
Assertive Community Treatment services (PSH/ACT)	ACT services center around the participants' needs. ACT teams are available and on call at all times and usually provide services in the participant's natural environs (at home or in the community). The ACT model also involves intense collaboration with the participants in achieving their goals of recovery and independent living. The D.C. Department of Mental Health regularly audits ACT teams to ensure that they are providing services in accordance with the ACT model.
Transitional housing (THM/ACT)	While a participant is selecting his/her permanent apartment, s/he may be placed into one of the two transitional housing units available to the FUSE program, if available. Prior to release, the transitional housing manager inspects the housing unit to ensure that it is in an acceptable condition (continued on the next page)

	and coordinates with the ACT team to arrange for move-in on the date of release. While participants are in the transitional housing units, the transitional housing manager will perform periodic check-ins and address any issues that arise. If a transitional housing unit is not available when a new FUSE participant is released, individuals are temporarily housed in a hotel until permanent housing is secured. The ACT team arranges the hotel stay, which is funded by the service enhancement dollars. Not every FUSE participant needs or receives transitional housing units through FUSE. Some participants are required to live in a halfway house following their release, are sent to in-patient substance abuse treatment directly following release, or choose to live in a shelter upon release. ACT services are not contingent on any housing placement and begin upon release.
Permanent supportive housing (PSH)	The PSH maintains a housing staff, which is responsible for administering its housing vouchers. The PSH housing staff identifies landlords who are willing and able to accept the program's housing vouchers and provides the FUSE participants with multiple housing options across the city. The ACT team then helps the participant select which apartment he/she wants, providing transportation to view the units. To ensure housing stability, the PSH provider works with the landlord directly, administering the housing voucher and paying rent using the participant's income and benefits, as available.
Periodic follow-up assessments (ACT)	As the FUSE participant continues with the program, periodic follow-up assessments are used to gauge progress and needs, as well as eligibility for ACT services.
Legal advocacy (LA)	The legal advocate can provide services to FUSE participants both before and after their release from jail. Potential participants who are not sentenced when they are identified by the transition coordinator are immediately referred to the legal advocate. The legal advocate then reviews the potential participant's case and contacts the individual's attorney to estimate when the individual will be released and whether the potential participant may be eligible for a diverted sentence. If appropriate, the legal advocate will present the FUSE program as an alternative to sentencing on behalf of the potential FUSE participant. Legal advocacy services are also provided after release, such as by representing the FUSE participant during formal interactions with the Court Services and Offender Supervision Agency (community corrections) or in the event of a rearrest.
Peer support group (LA)	The legal advocate also organizes a semimonthly peer support service group. This group is similar to a mentoring session where FUSE participants can seek advice from peers with similar histories of residential instability, mental illness, and criminal justice system involvement.

Potential measurable outputs of the housing and service delivery activities include the following:

- How many participants have received a ride from the jail?
- How many participants have been assessed for psychiatric needs?
- How many participants have received periodic follow-up assessments?
- How often and in what ways do participants interact with a member of their ACT team?
- How many participants have been placed in transitional housing?
- How many participants have been placed in permanent supportive housing?

- How many participants have received a reduced or deferred sentence?
- How and to what extent are legal advocates coordinating with Court Services and Offender Supervision Agency?

4.4. Impacts

As discussed in the Introduction, the FUSE pilot has five goals: (1) to create 50 units of permanent supportive housing for frequent users; (2) to improve coordination across systems for frequent users; (3) to improve financial integration and policy coordination; (4) to document decreased recidivism rates and increased housing stability; and (5) to demonstrate cost savings. The underlying logic of these goals is that permanent supportive housing is worth the investment and continued attention by policymakers and practitioners because it is an effective way to reduce recidivism, increase residential stability, and improve the day-to-day functioning of the disabled reentry population with extensive histories of incarceration and housing instability. The expected impact of the FUSE pilot is on two levels: administrative and participant/client/consumer.

Short-Term Impact (<1 year)

During the one-year pilot period, the FUSE program intended to develop and operationalize its activities. As described previously, those activities are diverse and range from the individual level to the system or administrative level. Direct participant services include prerelease identification and enrollment, referral and linkage, and housing and service delivery, which are collectively intended to produce the following short-term participant-level impacts:

- Improvements in day-to-day functioning
- Treatment for psychiatric and other health disorders
- Reductions in returns to jail
- Reductions in returns to shelter
- Increases in residential stability
- Decreases in hospitalizations and use of emergency care
- Development of a peer support network

The FUSE pilot also expects short-term impacts related to the administrative functions of the program. These impacts focus on increasing the capacity, efficiency, and visibility of the program, ultimately resulting in increased partnerships and greater resources for the frequent user population. Administrative-level impacts during the one-year pilot period include the following, particularly with respect to the first two goals of the pilot (creation of supportive housing beds and coordination across systems):

- Fifty units of permanent supportive housing are created for the frequent user population.
- Local government agencies, nongovernmental agencies, and community-based service providers partner to serve the frequent user population.
- Local legal systems divert frequent users into permanent supportive housing prior to or at sentencing.
- Processes are defined, streamlined, and documented to serve the frequent user population.

Long-Term Impact (>1 year)

As existing participants remain active and involved in supportive housing beyond the initial pilot year and new participants are provided housing, program goals focus on maintaining and continuing to

improve participant functioning and well-being. As such, the participant -level outcomes remain the same. On the administrative level, the services, capacity, and resources for frequent users should increase, and policy and practice focused on the frequent user population should be institutionalized or sustained into existing government and service agencies' practices. By institutionalizing the program, supportive housing for the frequent user population would become a routine practice for the mental health, criminal justice, human services, and housing services systems. It would thus become more efficient and effective in offering services and generating its intended impacts. Specific long-term administrative level impacts include the following:

- Local government systems are integrated to identify frequent users effectively and efficiently.
- Transition coordinator becomes a permanent position within the D.C. Jail.
- Local criminal justice, mental health, and human services systems increase coordination of services for frequent users and associated financing.
- Frequent users are diverted into permanent supportive housing at arrest or sentencing.
- Housing vouchers are set aside for frequent users.
- Long-term reductions in criminal justice system outcomes and shelter system outcomes resulting from the provision of permanent supportive housing for frequent users are demonstrated by independent evaluators.
- Cost savings of permanent supportive housing for the frequent user population are demonstrated by independent evaluators.

4.5. Findings

The process evaluation, through the development of the logic model, was designed to assess the progress and performance of the program with particular respect to its first two goals: creation of supportive housing beds for frequent users; and facilitating coordination among agencies that serve frequent users. Through semistructured interviews with program staff and participants, field observations of program processes and facilities, reviews of program materials, and frequent teleconferences with staff, the extent to which the FUSE program has achieved some of the program outputs shown in figure 4 have been assessed. Many of the outputs for the FUSE program cannot be achieved in isolation, but have been influenced heavily by the contextual circumstances that the program faced within the District of Columbia during the pilot period. In the following section, findings from the process evaluation with respect to its performance and progress are discussed, as well as the barriers to and facilitators of successful operations. The program's progress and performance are presented below, grouped by the set of program activities shown in figure 2.

System Change Efforts

Through frequent meetings, the Corporation for Supportive Housing and University Legal Services have been working diligently to inform local government agencies about the program and its potential to break the costly cycle of systems use for the disabled reentry population. In particular, several meetings with high-level public administrators at the Department of Corrections, the Department of Mental Health, and the local housing authority have occurred throughout the past year. Meanwhile, ULS has sent monthly reports to DOC staff to update them on the progress of the transition coordinator in enrolling individuals into FUSE. While CSH and ULS have been successful in completing the activities designed to foster change within the correctional, mental health, and housing system, the program has faced several barriers to its system change efforts.

Facilitators

- University Legal Services' position and standing with the Department of Corrections—ULS was identified as a critical program partner due to its history of working with individuals in the jail with mental illnesses. ULS had an existing relationship with DOC and was able to use that relationship to facilitate the placement of the transition coordinator in the jail.
- The Corporation for Supportive Housing's national supportive housing initiative—CSH's 10-year history of creating and implementing supportive housing programs across the country has been helpful to the efforts of D.C. FUSE. When planning D.C. FUSE, CSH built on the lessons learned through other supportive housing reentry initiatives, including programs in New York City and Chicago and its national Returning Home Initiative (RHI). Furthermore, through these programs and RHI, CSH had fostered a partnership with the Urban Institute to assist in the evaluation efforts that would be useful to facilitating system change and sustainability in D.C.

Barriers

- Changes in the mayoral administration—In January 2011, nearly three months following the pilot's implementation, a new mayor for the District of Columbia was elected. This represented a significant barrier to the program's system change efforts; there were changes not only in the mayoral position, but additional staff changes in other public administrators in the District, including the director of the Department of Corrections. While the new administration continued to support the project, including the transition coordinator position in the jail, much of the planning and outreach that occurred prior to the change in administration dissolved.
- Renegotiation of contracts within the Department of Corrections—During the pilot's first year, DOC renegotiated its contract with its health provider in the jail. In addition, during the pilot's first few months, the director of health in the jail, an early supporter of FUSE, left the position. This represented another barrier to the program's system change efforts, given that an individual who was familiar with FUSE operations and integral to its implementation was no longer in the position. This change required the program staff to re-form lines of communication with a new director and staff.

Coordination

The pilot was designed to coordinate multiple partners and their services into a single program, given the target population (i.e., frequent users of multiple systems). Because the program is designed to coordinate multiple, previously unassociated or loosely associated partners into one program, its operation presents challenges in terms of communication and coordination across program partners. Therefore, clear decisionmaking protocols and processes become necessary to ensure that the program runs smoothly across agencies and partners operate in a unified manner instead of as isolated units. This is precisely the impetus behind CSH's development of supportive housing models for frequent users. Frequent users' issues cross multiple systems that have been only loosely or wholly unassociated with one another, necessitating system change and coordination efforts that encourage and facilitate increased service and attention to this population (Fontaine et al. 2010).

Despite the potential for challenges, the program is designed to avoid such issues through frequent communication among partners and administrative oversight provided by the program director, program manager, and transition coordinator and transition administrator. The process of finding potential participants, enrolling them, and providing them with services is designed to work in a largely linear fashion, with each participant being attended to by program partners in succession (e.g., transitional coordinator in the jail, then the transitional housing manager and the permanent supportive housing providers from the jail to the community, and then the ACT team in the community). Over the

past year, frequent check-in calls and meetings were occurring with program partners, including the research team. Monthly reports to program partners have been consistently provided.

Facilitators

- Case conferencing sessions—Over the past year, the case conference sessions typically included at least the transition coordinator and a representative from Pathways (PSH provider). Other sessions included the transitional housing manager and legal advocate. During these meetings, the program partners discussed the reentry plan with the FUSE participant, ensuring that each program partner was aware of its own and all other partners' responsibilities. The case conference sessions helped to ensure that the FUSE participants received all of the necessary services in a coordinated matter.

Barriers

- Split management structure—The split management or oversight structure that rests between ULS and CSH has posed some barriers to coordination. The transition coordinator is an employee of ULS and subsequently reports to the transition administrator. The transition administrator is also focused on being responsive to the local government stakeholders, most notably public administrators within DOC. However, the program director and program manager from CSH are responsible for overseeing the entire program and managing the program's overall performance and progress, from enrollment into the program to the linkage to permanent supportive housing. As the creator of FUSE, CSH is also focused on developing and sustaining the program and demonstrating program success to funders. As previously mentioned, the decision to house the transition coordinator position within ULS was chiefly due to the agency's history of working with and within DOC (and with the mentally ill population within DOC), which facilitated its ability to have physical space in the jail from which to conduct the prerelease enrollment process. Due to the split structure; however, the transition coordinator must report to and respond to feedback from multiple individuals with slightly different perspectives.
- Depth of the partnership—Frequent check-in calls and meetings occurred with all of the program partners, including the program director, program manager, transition administrator, transitional housing manager, and permanent supportive housing manager. Other individuals are often invited to participate in the check-in calls, including staff from CSH, ULS, and DMH. The depth of the partnership creates a challenge for coordination. Inherent in the issue that is being tackled, the partnership for FUSE includes various individuals focused on different aspects of the program. Stated differently, some partners are focused on the administrative aspects of the program while others are focused on the participant-based aspects. The check-in calls have been used primarily as an opportunity to discuss individual cases and troubleshoot problems at the participant level rather than report on overall program operations with respect to administrative-level impacts and activities. This is understandable given that the program is in its start-up phase. However, this might account for the challenges in making significant progress on the administrative-level outputs or brainstorming on ways to make more progress.

Prerelease Identification and Enrollment

Prerelease identification and enrollment activities were designed to identify frequent users with disabling mental health conditions while they were incarcerated in the jail and to enroll them into the program before their release to the community. In turn, the delivery of services associated with FUSE, including the case conference sessions and transition plans, would also begin prerelease. Prerelease enrollment is based on the idea that coordinated reentry planning, particularly for the population that is at the highest risk of recidivating, should ideally begin before a person is released into the community.

In practice, however, a handful of individuals were recruited into the program from the community, and therefore did not receive a *prerelease* transition plan or case conference session. The presence of multiple entrypoints into the program creates pathways into the program that are less clearly defined and could present problems for program partners. In particular, the coordination of services becomes more difficult when the pathways into the program are not streamlined. For example, if an individual is recruited into the program while in the community, it is not clear whether or who would create a transition plan for that individual, particularly since the transition coordinator typically conducts this work from within the jail. In another example, it is not clear how individuals' eligibility for the program should be assessed if they are recruited from a community referral source.

Figure 6 was created to show the pathways into the program based on a participant enrollment tracking sheet created by the evaluation team for the transition coordinator. Recall, the following steps occur for the transition coordinator to enroll an individual in the program: First, TCP identifies how many individuals meet the requisite number of three shelter stays in the HMIS over the past three years; second, DOC checks the shelter data against its jail records to determine which of the individuals identified by TCP had two jail episodes within the last three years, were *currently* in the jail, and had a qualifying serious and persistent mental illness, as identified in the jail mental health records; and third, the list of names is sent to the transition coordinator to recruit and enroll individuals in the pilot.

After receiving the names, the transition coordinator works to enroll detainees in FUSE. Among the lists of potentially eligible individuals produced for the program, 62 percent did not have a release date (i.e., they were in pretrial status). These individuals were subsequently moved to the bottom of the transition coordinator's priority list while the legal advocate at ULS reviewed their cases to determine which individuals were likely to be released during the pilot enrollment period or whose cases might benefit from enrollment in FUSE (i.e., the case might be diverted if housing was in place). After the transition coordinator has the initial meeting with each potentially eligible individual, the pool of potential participants is reduced for a few reasons:

1. When prioritizing the list, the transition coordinator makes some determinations of eligibility (e.g., pretrial and likely to be sentenced to prison);
2. Despite attempts by DOC to get the list of names to the transition coordinator quickly, the list tends to include individuals who are no longer in the jail at the time the transition coordinator is ready to speak to them; and
3. Due to limited time within which individuals are actually in the jail, the transition coordinator is unable to meet with all potential participants prior to their release date.

Of the individuals the transition coordinator is able to speak to, further determinations are made regarding eligibility that reduce the pool of potential participants. During or following the meeting, potential participants can be excluded from the program due to personal choice (e.g., desire to work with or continue working with another service provider, having no need for housing, or refusal) or circumstance (e.g., having too long a jail sentence, being sent to federal prison, or not being eligible for ACT services).

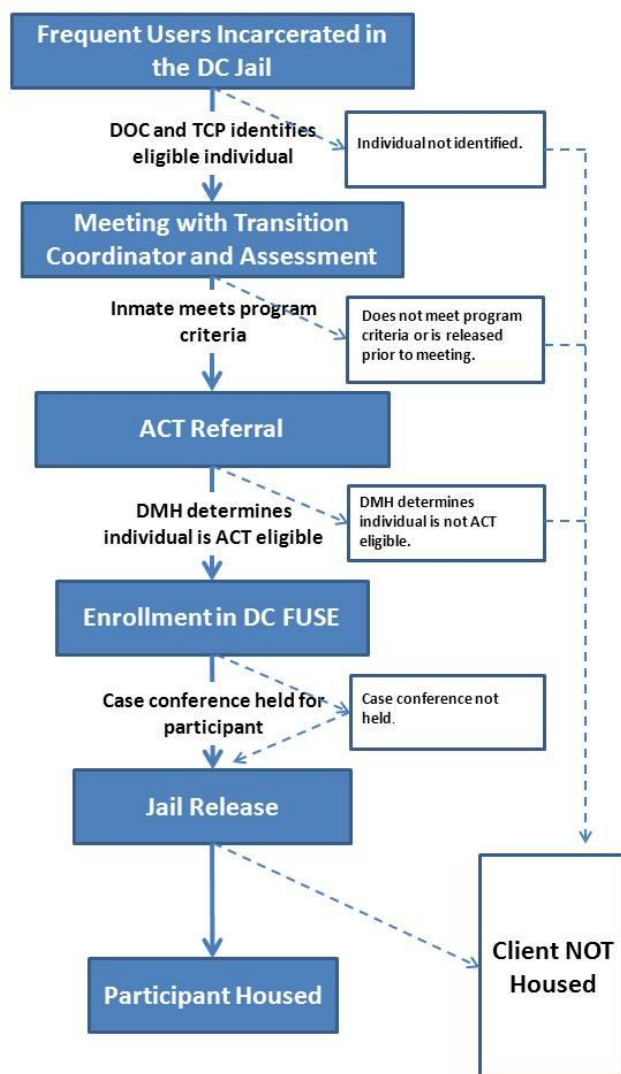


Figure 6. Participants' pathway into program through DC Jail

After meeting with the transition coordinator, individuals are given a LOCUS assessment, which, along with a psychosocial history assessment and other background information, is sent to DMH for approval for ACT services. Though this can reduce the number of potential participants, most individuals are approved by DMH, due in part to the FUSE screening process by the transitional coordinator. Pending approval for ACT services, the individual is enrolled in the program. Following enrollment and prior to release, the transition coordinator usually sets up a case conference for participants where their transition and treatment plan will be discussed by program partner staff. As shown below, not everyone enrolled in FUSE received a case conference session while in the jail, and some did not receive a case conference session attended by program partner staff due to short notice about their release dates. In some cases, case conferences were held outside of the jail. Table 4 describes how the enrollment

process reduces the pool of 110 potential FUSE participants¹² from the TCP/DOC lists to the group of 14 individuals enrolled and served by the program (as of July 15, 2011).

Table 4. FUSE Participant Tracking and Enrollment

Stage in Enrollment Process	Excluded from pool of potential participants	Remaining pool of potential participants
TCP/DOC Frequent User Identification	-	110
Not in jail when list was received	26	
Deemed ineligible prior to meeting with TC	14	
Released prior to meeting with TC	19	
Meeting with transition coordinator	-	51
Chose to stay with current provider	9	
Sent to federal prison or sentence too long	17	
Did not need housing	2	
Refused program	4	
Not ACT eligible	5	
ACT Referral	-	14
Denied ACT services by DMH	0	
Enrollment in D.C. FUSE*	-	14
Case Conference not held **	-	
Release from Jail	-	14
Not released from jail	0	
Participant Housed	13	14
Participant not housed	1	

* This figure does not include an additional two individuals who were identified as enrolled through jail in-reach but for whom tracking records are unknown to the research team. The number of total enrollments through jail in-reach was 16 participants. The table only describes participants who were enrolled through jail in-reach. As of July 31, 2011, 19 participants had been enrolled, three through community referrals. One community referral was made from a test exchange prior to the release of the first DOC list. The second community referral was drawn from the second list but had been released from jail at time of the referral. The third community referral was identified through CSH communication with the city's pretrial services agency but was not on a TCP/DOC list.

**Twelve participants received case conferences in jail. Those who did not receive a case conference in the jail remained in the program.

In addition, the first four lists produced by TCP did not include any women, though program administrators did not want to exclude women. Therefore, an alternative means of finding female participants was used through May 2011, when TCP began including women on the lists sent to DOC. To create the alternative women's list, DOC data were used to find women who met the jail and mental health eligibility criteria for the program. This list was created three times and produced a total of 66 women. The transition coordinator then met with many of these women to introduce the program and to determine their interest in the program and to their self-reported history of homelessness. Twenty-seven women reported being homeless three times in the past three years. This information was checked against TCP records. Of those 27 women, 5 met the shelter stay criteria according to TCP records. From this group of five women, only one was approved by DMH as ACT eligible and was subsequently enrolled into the program.

¹² This set of 110 individuals are those frequent users identified by DOC and provided to the program during its first eight months of operation. This group of frequent users was constructed separately from the 196 male frequent users discussed in chapter 3, though some individuals are contained in both samples (n unknown).

Facilitators

- Placement of the transition coordinator in the jail—The transition coordinator is the primary staff member involved in many of the prerelease identification and enrollment activities. The coordinator identifies eligible participants in the jail, introduces the program, administers a comprehensive needs assessment and ACT eligibility assessment, submits the applications for ACT services to DMH, and organizes the case conference sessions. These activities require multiple in-person meetings with potential FUSE participants *while they are incarcerated*. This position's placement in the jail is critical to facilitating the enrollment process. If the position were not in the jail, it would be difficult to arrange multiple meetings with individuals with histories of housing instability to complete the enrollment process and identify a transition plan. The placement of the transition coordinator position in the jail was facilitated by DOC, which provides the transition coordinator with an office and access to facility meeting rooms, computers, and office supplies without charge. Additionally, DOC has provided the transition coordinator with unrestricted access to all detainees as well as access to the DOC medical and criminal databases.
- Generation of the potential participant list—All of the above-mentioned activities of the transition coordinator are conducted using the list of potential participants generated by DOC, using DOC and TCP data. Without the list of potential participants, the transition coordinator would need to recruit individuals using alternative methods, such as discharge planner referrals and self-reported histories of incarceration and homelessness, which would likely yield fewer potential participants (as demonstrated by the alternate mechanism used to identify women through May 2011).

Barriers

- Infrequent generation of a *static* list of potential participants—The list of potential participants is not dynamic. It is not generated on a regular, frequent schedule. Instead, each time the program director or program manager makes a request, TCP and DOC staff form a list of individuals who meet the FUSE eligibility *and* are currently incarcerated in the jail. To date, the program has generated six lists over a period of nine months. There may be many eligible individuals who were in the jail during the program pilot period but could not be enrolled simply because they were not incarcerated on the six days the program lists were created.
- Unique context of jail reentry—Many detainees who were identified as eligible for FUSE were close to their release date and could not or did not receive all of the prerelease enrollment and reentry planning services from the program due to the short timetable. This affects housing and service delivery, as the appropriate services cannot be determined and planned for prior to release. As has been documented in previous studies, the unique context of jails creates a complex landscape for facilitating reentry programs (see Solomon et al. 2008).
- Use of FUSE as a diversion tool—As previously mentioned, one component of the FUSE program is legal advocacy. Legal advocacy in the FUSE program has been used as a diversion tool to reduce an individual's time spent in jail. While the program has had some success in these endeavors, it has been limited. Although more than half of the potential participants identified on the frequent user lists did not have a sentence, only a handful were eventually enrolled into the program. While the use of FUSE as a diversion tool is innovative, with the potential to reduce the sentenced jail population or perhaps prison population, it also has the potential to reduce the time and attention the transition coordinator has to spend on enrolling and linking sentenced frequent users into supportive housing. While the legal advocate performs all of the

advocacy work with the transition administrator, the transition coordinator's time and attention are required to first identify and then refer individuals to the legal advocate.

Referral and Linkage

The referral and linkage activities are intended to meet the needs of each individual participant. While the program provides a range of services, it cannot meet all of the needs of the individuals it serves. As such, individuals are referred to external service providers and benefit administrators. Individual participant needs are identified prerelease through the comprehensive intake assessment administered by the transition coordinator. The participant's needs are discussed during the case conferencing session, where the program partners form a comprehensive, individual treatment plan. Any needs that cannot be addressed through direct program services are met through service referrals and linkage.

The program has been successful in evaluating participant needs and generating individual treatment plans, which include referrals to external services. All of the participants who were enrolled into the program through the jail completed an intake assessment and transition plan. Moreover, this occurred despite the fact that a couple of individuals did not have enough time between enrollment and release to complete a case conference session. In these instances, the transition coordinator created the transition plan, explained it to the participant, and sent it to the program partners. Once the participant was released, the permanent supportive housing provider was responsible for overseeing participant services. During the pilot period, the program successfully provided participants with external service referrals for medical services, substance abuse treatment, Interim Disability Program (IDA) benefits, SSI benefits, SNAP benefits, and job training.

Facilitators

- Inclusion of Economic Security Administration benefit administrators in the case conferencing sessions—The Economic Security Administration (ESA) (formerly known as Income Maintenance Administration: IMA) representative in the jail was involved in the FUSE case conferencing sessions and reentry planning efforts, enrolling eligible individuals in IDA and SNAP benefits prior to their release from jail. This helped to ensure that some FUSE participants received necessary food and income support immediately upon release while they waited for their other benefits to start.

Barriers

- Short timeline from identification to release—Due to the nature of the frequent user identification, participants may be identified as eligible and subsequently enrolled later in their sentences or while they are in jail on pretrial status. This short timeline makes it difficult to coordinate all of the intake and case conference activities. As a result, some participants did not receive a case conference, and their service referrals occurred later than they would have given earlier identification and enrollment.
- Individuals cannot apply for or restore Social Security or SSI benefits until after release—Procedures for applying to or restoring benefits vary based on the individual's benefits history and term of incarceration. While some of these procedures could begin prerelease, due to the extensive application requirements and limited resources available in the D.C. Jail, applications are not submitted until after release. This delays the receipt of these services as applications are processed. The Interim Disability Assistance (IDA) program helps to fill this gap, providing benefits while individuals are waiting for approval of their applications, but IDA requires additional coordination and is sometimes unavailable.

Housing and Service Delivery

As detailed in the logic model, the program is designed to provide a large number of direct services to the participants. These services, which begin prerelease, are generally targeted at the common, qualifying needs of the FUSE population: mental health services, legal advocacy services, and housing. The first service a potential participant may receive is legal advocacy. During the past year, all frequent users who were identified by DOC and had a pretrial status (which was *more than half* of all of the identified frequent users) were referred to the legal advocate for review. Many received legal advocacy assistance. However, among those individuals who were eventually enrolled into the program, only a handful had received legal advocacy services. This is likely because the overwhelming majority of pretrial frequent users (and legal advocacy service recipients) were ineligible for the program. There are also cases in which the legal advocacy is unable to divert individuals from the criminal justice system, due to circumstances well beyond their control (e.g., judicial discretion).

The remaining suite of services, described in detail in the logic model, were conditional on enrollment into the program. Service delivery was generally informed by the transition plan, generated during the case conference session or by the transition coordinator directly. Prior to release, the transition coordinator and transition manager oversee all service delivery. Starting at jail pickup, the permanent supportive housing provider takes over primary responsibility for service delivery though other program partners providing housing and services, including the transitional housing manager.

Overall, housing and service delivery was successful for those individuals who were enrolled into FUSE. Participants received temporary and permanent housing as well as a variety of services, which included both traditional, Medicaid-billable ACT services as well as supplemental services such as transportation to buy clothes and groceries. For example, nearly all of the participants enrolled through the jail were picked up by permanent supportive housing staff at the jail at the time of their release (participants' receipt of services is described in more detail in Chapter 5: Preliminary Outcomes of the Pilot). The jail pickups—funded by FUSE's service enhancement dollars—are a critical first step in facilitating the reentry process, given that the first hours and days following release from jail and prison have been found to be the moments when individuals are at the greatest risk of failure, relapse, or recidivating.

The program struggled, however, to meet its goal of generating 50 units of permanent supportive housing for the frequent user population. Through the first 10 months of the program, the program secured 20 units of dedicated permanent supportive housing slots or units, filling 17 of those units. A variety of facilitators and barriers contributed to these successes and shortcomings.

Facilitators

- Pathways' experience serving criminally involved populations—During stakeholder discussions, multiple members of the PSH provider's staff indicated that the FUSE participants did not differ greatly from their typical ACT service population. Many of Pathways' existing clients/consumers have extensive criminal and homeless histories. As such, Pathways staff have much experience working with high-risk populations, albeit more limited experience with direct pickups from the jail and in-reach into the jail.

Barriers

- Availability of housing vouchers—Because the program did not receive housing vouchers directly from the local housing authority, it relied upon community service providers to commit housing vouchers that they already received from the federal and local government to the FUSE program. Interviews with program partners and staff revealed that there were multiple community providers that were interested in providing PSH services to the FUSE participants early in the program planning process; however, all but one provider could not or would not

commit the necessary housing vouchers (or did not have them available) at the time of program implementation. Thus, only one supportive housing provider was associated with FUSE over the past year. This affected both the number of individuals the program served as well as the type of community-based services that were provided. Pathways pledged 20 housing units (using a scatter-site model) for FUSE participants, which did not meet the program's original goal of 50 units of PSH. Furthermore, Pathways provides ACT services only. In consequence, FUSE participants must be ACT eligible to participate in the program. As shown in the trajectories into the program described above, five individuals were not enrolled into the program because they were not ACT eligible. If another service provider that provided different forms of PSH (e.g., community support services) were included in the program, more of the frequent users identified in the TCP and DOC list, who met with the transition coordinator, might have been enrolled into the program and housed in the community.

- Types of housing vouchers used—Multiple types of housing vouchers were used to house participants in the FUSE program. Specifically, the Housing Choice Vouchers required inspection and approval from the local housing authority to be used, which caused some delays in the time it took for the participant to be housed in a permanent apartment. If temporary housing was not available from Community Connections during this time, some individuals ended up back in shelter or other temporary housing while they waited for their permanent housing.

4.6. Implications

As the program continues to enroll more frequent users, the operational structure and program partners will likely remain dynamic. As demonstrated in the program logic, FUSE coordinates the activities of multiple program partners with various roles and responsibilities. At its core, the objective of FUSE is multifaceted, treating individual needs while trying to reform and integrate system-level policies for the frequent user population in the District of Columbia. This, in turn, provides both opportunities and challenges.

To date, the program has taken advantage of multiple opportunities to serve the frequent user population. Program partners have championed the initiative within DOC and DMH, as well as the Executive Office of the Mayor, and individual community providers have contributed resources to the program directly. Moving forward, the program will need to continue to solicit support from local government agencies and social service providers to sustain and expand the FUSE program. Most notably, the program needs to secure additional housing vouchers. To date, the program has received 20 dedicated housing vouchers from Pathways, which have been used to house 17 people. Once those vouchers have been used, if no other resources or housing providers are identified, it is unclear what the next step for the program will be. Had the program received dedicated housing vouchers from the start, which are undoubtedly difficult to secure in the current economic climate, rather than receiving them from local service providers, then the program would have a clear path moving forward and could potentially expand enrollment. Without these vouchers, the program will need to fundamentally change its service delivery structure. As such, securing additional housing vouchers represents the most critical need of the program.

In addition to housing vouchers, the remaining aforementioned barriers can be overcome by adjusting the program's outreach and coordination to increase the strength of the existing partnerships and to generate new ones. As these adjustments to the program are made, performance measures—recommendations for which are suggested in the program logic model—should be finalized and tracked to ensure that the program is operating as intended. In turn, these measures can be paired with

program outcome and impact measures to determine whether, and to what extent, the program achieves its short- and long-term impact and cost savings goals.

5.

Preliminary Outcomes of the Pilot

To inform the process evaluation, data were analyzed from ULS, Pathways, DOC, and TCP to explore the program's preliminary impact on short-term individual-level outcomes. Given the short period of the evaluation, the assessment of outcomes focuses primarily on the experiences of the first 15 individuals in the FUSE program. Specifically, this chapter describes the characteristics of the initial FUSE cohort, including their sociodemographic characteristics and psychiatric, criminal justice, housing, and social service histories, as well as services received through the program directly and through referrals. Finally, descriptions of individuals' perceptions and satisfaction with the program are discussed, as well as their preliminary shelter and recidivism outcomes. Based on these data, several points of success have been identified, as well as potential opportunities for improvement.

5.1. Data Sources

To document the initial outcomes of the pilot, individual-level data were collected from a variety of sources: (1) administrative data on shelter use and incarceration; (2) program data and reports on intake assessments and service delivery logs; and (3) semistructured face-to-face interviews with participants.

- **Administrative Data:** DOC and TCP provided updated data for the first 15 individuals who were enrolled into the program, through June 30, 2011. These data detailed returns to shelter and reincarceration following release from jail.
- **Program Data:** Individual-level program data were collected from Pathways and ULS for those who signed a research consent and protected health authorization form, giving UI permission to request their information. Of the first 15 individuals enrolled, 11 signed a research consent to allow researchers to collect their information from ULS and Pathways. For these 11 individuals, information collected by ULS and Pathways and provided to UI included the following:
 - **FUSE intake form** from the initial meeting between the participant and the transition coordinator in the jail. The form gathers basic background information on the participant.
 - **FUSE assessment form** that details the participants' psychiatric, criminal, housing, and social histories and summarizes this information in the form of a psychosocial summary.
 - **ACT referral form** that includes information pertinent to appropriateness for ACT services and is provided to DMH for ACT approval.
 - **LOCUS (Level of Care Utilization System from Psychiatric and Addiction Services) worksheet**, a formal assessment of participants' treatment needs that offers a level of care recommendation.
 - **Booking information** from the participants' most recent jail booking.
 - **Jail health and mental health history** that provides a comprehensive history of all general health and mental health issues documented at the jail, which includes diagnoses and prescriptions as well as comments and assessments from doctors.
 - **DC FUSE transition plan summary** that describes the plan created by program partners to transition the participants from jail to the community and outlines services and needs.

- **ACT intake** that is administered immediately after release and documents the individual's treatment needs and preferences; fields include cultural and spiritual beliefs, health, military history, legal status, substance use, financial resources, and vocational and educational history.
- **Skills Assessment** that is used to gauge the participant's self-sufficiency.
- **Monthly notes** that are submitted by the ACT team detailing participant progress.
- **Episode log** that records significant adverse events such as arrest or hospitalization.
- **Participant Interviews:** Through Pathways, UI researchers conducted face-to-face interviews with seven of the eleven consenting participants. Of the four individuals who did not participate in the interviews, one was enrolled in the Comprehensive Psychiatric Emergency Program, one was reincarcerated, and two were not engaged with the program staff at the time of the interviews. No one flatly refused to speak to the research team. Interviews were conducted at the Pathways office—though Pathways staff was not present during the interviews—and lasted approximately 30 minutes. UI staff asked a series of questions about the participants' opinions of the housing unit, program processes, and program services, as well as their opinions on their interactions with the transition coordinator and ACT team, and their overall satisfaction with the program.

5.2. Participant Characteristics

Using administrative and program data, the following tables describe the initial cohort of individuals enrolled in the program, including sociodemographic characteristics, mental and physical health and substance abuse histories, and criminal justice and shelter use profiles. Administrative data are available for all 15 individuals who entered¹³ the program from November 2010 through June 2011, but only 11 participants consented to the release of personal program information. Furthermore, one of the consenting participants was not enrolled in the jail and therefore does not have the same program documents. As such, this section summarizes the FUSE intake forms, assessments, and other program forms, as well as jail medical and mental health histories, for the first 10 participants.

Demographic Characteristics

Table 5 shows the demographic characteristics of the initial FUSE cohort, based on data from program intakes and assessments. Given the low number of individuals described, it is difficult to make assessments of the typical or average FUSE participant. In general, consistent with the population with chronic shelter use and criminal and substance abuse histories, the initial cohort of FUSE participants demonstrated low educational attainment and limited employment histories (Nino, Loya, and Cuevas 2010). Most were receiving their income prior to incarceration from government programs and/or entitlements. By comparing this group to the larger group of frequent users identified by the TCP/DOC list described in table 3, a few comparisons are possible. First, the individuals served by FUSE are slightly older, on average, than the larger frequent user population and include the higher end of the age range. No one served by the program since June 2011 is younger than 42 years old. In all other respects, the initial FUSE cohort appears representative of the broader group of frequent users.

¹³ Program entry defined at initial entry into ACT services.

Table 5. Demographic Information on the First Cohort of FUSE Participants

	DC FUSE Participants (n=10)
Age (mean)	53.2
Sex	
Male	9
Female	1
Race	
Black	7
White	2
Marital Status	
Married	1
Not married	9
Have children	6
If yes, number (mean)	2.16
Education	
Less than high school	5
High school graduation/GED	2
Some college	2
College – associate or bachelor’s degree	1
Source of income before incarceration	
Employment	1
Food Stamps	2
IDA	1
SSI	1
None	4
Will have job once released?	
Yes	0
No	9

Mental Health Histories and Current Diagnoses

Table 6 shows the mental health, substance abuse, and general health histories of the sample of the initial FUSE cohort. Of note about the mental health histories and diagnoses of the sample of FUSE participants is the frequency of multiple diagnoses and the presence, for each individual, of at least one diagnosed drug dependency. The average number of mental health diagnoses, not including substance dependencies, was 2.8. Among the 11 individuals enrolled in FUSE, mood disorders were the most frequent diagnosis, and a mood disorder with another FUSE-eligible mental health diagnosis (see appendix B for a list of FUSE diagnostic criteria) was the most common combination of diagnoses. One participant did not have a FUSE-eligible mental health diagnosis but was instead diagnosed with two non-FUSE, nonsubstance dependence disorders—personality disorder (not otherwise specified) and mood disorder (not otherwise specified). Given the diagnosis criteria for FUSE, it is unclear why this individual was enrolled into the program. For a more detailed breakdown of the frequencies of all diagnoses among the sample of FUSE participants, see appendix A.

Table 6. Mental Health and Health Histories of First Cohort of FUSE Participants

	DC FUSE Participants (n=10)
Have mental health diagnosis?	10
Number of mental health diagnoses, including drug dependencies (mean)	4.7
Number of current mental health diagnoses, NOT including drug dependencies (mean)	2.6
Single diagnosis (NOT including drug dependencies)	2
Mood disorder	1
Schizophrenia	1
Other	0
Multiple diagnoses (NOT including drug dependencies)	8
Mood disorder and schizophrenia	1
Mood disorder and other	5
Schizophrenia, multiple types	1
Non-FUSE combination (1)	2
Number of mental health medications(mean)	2.8
Receive mental health services in the community(Yes/No)	8 / 1
Used emergency psychiatric services during 3 years before incarceration? (yes / no)	7 / 3
2 times	2
3 to 4 times	1
4 to 6 times	2
More than 6 times	1
Unknown	1
Used emergency room for general medical concerns during 3 years prior to incarceration? (yes / no)	6 / 4
Admitted to hospital for any reason during 3 years prior to incarceration? (yes / no)	7 / 1
Number of current general health diagnoses (mean)	5.2
LOCUS score (mean)	20.5
Have ever used drugs or alcohol	10
Alcohol	5
Marijuana	8
Cocaine or crack cocaine	5
Age of first use of drugs or alcohol (mean)	20.5

(1) One individual enrolled in FUSE carried no FUSE-eligible mental health diagnoses.

Despite the presence of multiple mental health diagnoses, it is necessary to be minimally self-sufficient and independent to be eligible for ACT services. The criteria for self-sufficiency are seen through a LOCUS assessment score between 20 and 23 (the score ranges between 7 and 35; higher scores indicate greater treatment needs or lower levels of self-sufficiency).¹⁴ Stated differently, the individual's disability must not be so severe as to inhibit him or her from being treated successfully by ACT services. The assessment of treatment needs and potential for self-sufficiency are supplemented by the participant's self-reported abilities (reported in detail in appendix A). In general, participants were able to shop for and prepare their own food, clean and do laundry, as well as other basic daily living tasks.

All participants in the research sample had been diagnosed with one or more forms of substance dependence, including alcohol dependence, cocaine dependence, cannabis dependence, and even cases of phencyclidine (PCP) induced psychotic episodes with hallucinations. Though drug abuse is not an eligibility criterion for FUSE participation, it is clear that those enrolled in FUSE have histories of drug use.

Self-Reported Housing, Homelessness, and Shelter Use Histories

Another key criterion in the recruitment and enrollment of participants for FUSE is a history of homelessness. Table 7 shows participants' histories of residential instability. Consistent with the program's eligibility criteria, all FUSE participants in the research sample reported a history of living on the street or in shelters, including frequent, persistent episodes of homelessness in the three years prior to incarceration. Though data on homelessness are also available through HMIS, self-reported data are included here for two main reasons. First, because HMIS data are available for only three years prior to the incident of incarceration (the offense that led participants to being enrolled in the program), and second, because HMIS data require the individual to have been in contact with an HMIS-linked service. Therefore, HMIS data cannot determine an individual's complete history of homelessness; self-reported housing histories offer richer information that is difficult to uncover through HMIS.

Because the data were reported by the frequency and length of homelessness on individuals' FUSE intake forms, they are reported here in a similar fashion. Seven individuals' forms contained information regarding the length of periods of homelessness and eight individuals' forms contained information regarding frequency of homelessness in the three years prior to incarceration. Of those who had information on length of periods unhoused, three had episodes of homelessness that lasted less than five years, while four had episodes of homelessness that lasted 10 years or more. For the eight participants with data on the frequency of homelessness in the three years prior to incarceration, three had fewer than five episodes of homelessness, two had between five and ten episodes of homelessness, and one had more than ten episodes of homelessness. Additionally, two individuals were homeless throughout the entire three years prior to incarceration. Though all participants had histories of frequent and persistent homelessness, it is notable that eight participants had previously leased or owned their own housing but lost it for some reason. Some common reasons for losing housing included an inability to maintain employment and therefore pay rent and associated housing costs, family conflict or abuse leading to housing instability, or problems with addiction leading to housing instability.

Most of the FUSE participants included in the research sample had been able to house themselves previously, but due in part to mental illness, drug problems, and difficulty finding employment, had

¹⁴ A LOCUS assessment score is based on questions regarding risk of harm, functional status, comorbidities, recovery environment (level of support and level of stress), treatment and recovery history, and engagement with treatment. This test is administered by a trained social worker—for FUSE, the transition coordinator.

frequent periods of homelessness and often spent time cycling between the street, shelters, jails, and friends' and family's homes. Much of this housing instability and frequent systems use is attributed to the effects of mental health issues, and therefore, an assessment of the individual's ability to function, take care of himself/herself, and act independently is a large factor in deciding treatment needs and planning for care after release.

Table 7. Self-Reported Housing, Homelessness, and Shelter Use Histories

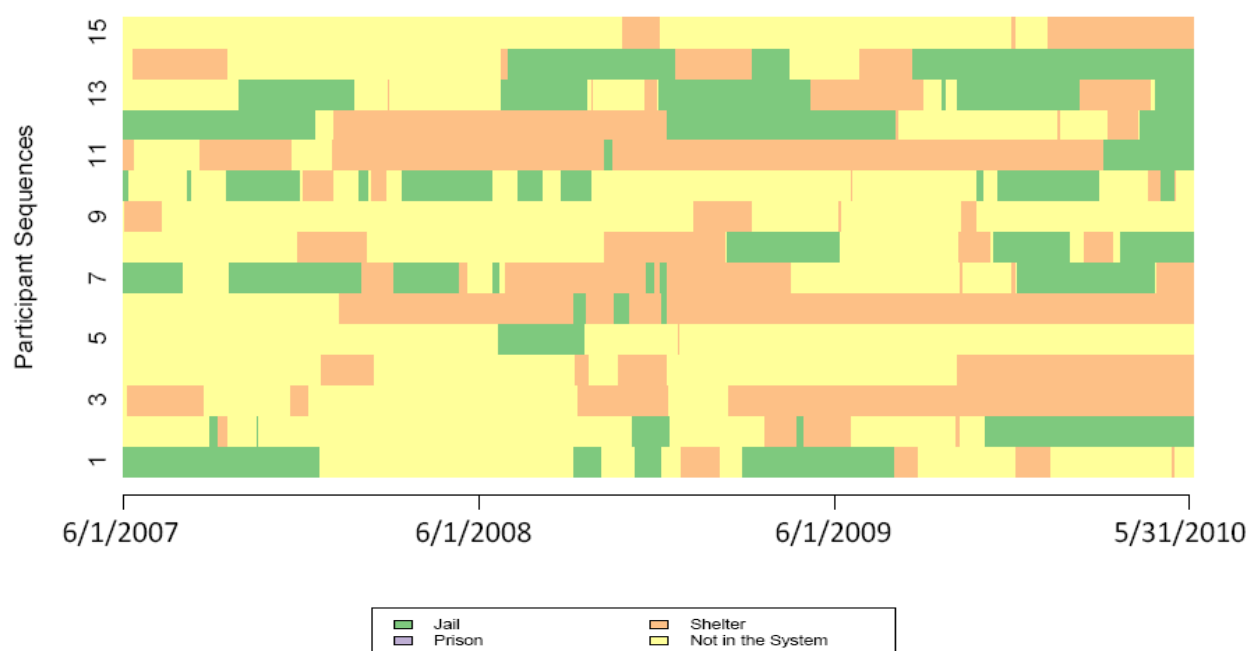
	DC FUSE Participants (n=10)
Have ever lived on the street or in a shelter	10
Longest period of homelessness (n=7)	
Less than 5 years	3
Between 5 and 10 years	0
Between 10 and 15 years	2
More than 15 years	2
Frequency of homelessness over 3 years prior to incarceration (n=8)	
Less than 5 times	3
Between 5 and 10 times	2
More than 10 times	1
Homeless throughout 3 years	2
Have ever leased or owned own housing	8
How/why lost housing (if ever leased or owned)	
Family issues (conflict/abuse)	2
Problems with employment/rent/bills	3
Problems with addiction	1
Other	2

Administrative Incarceration and Shelter Use Histories

The first 15 individuals enrolled into the FUSE program were fairly representative of the overall frequent user population. As previously noted, the first cohort of FUSE participants was slightly older. They similarly exhibit diverse criminal histories, with charges across multiple crime categories. The diversity in crime types was also seen in the most serious incident offense. Of the 15 individuals enrolled into the program, three committed a property crime, five committed a drug crime, and six committed a violent crime (see table 8). One individual was admitted through pretrial diversion and therefore has no incident offense data.

Table 8. Demographic and Criminal Characteristics of the First 15 DC FUSE Participants, Taken from the D.C. DOC Administrative Data

	DC FUSE Participants (n=15)
Demographics	
Age(mean years)	46.0
Age range (years)	28-69
Black	13
Female	1
Criminal History	
Lifetime incarcerations (mean)	8.3
Number of charges by booking (mean)	1.9
Crime Types (percent of individuals)	
Violent crime	14
Drug crime	9
Property crime	12
Public order crime	9
Other	14
Diversity of Crime Types	
One crime type	0
Two crime types	2
Three crime types	3
Four crime types	5
Five crime types	5

**Figure 7. Unsorted jail, shelter, and prison use patterns from June 1, 2007, to May 31, 2010, of the first 15 individual enrolled into the DC FUSE program.**

Using the data provided by TCP and DOC, figure 7 shows the system use characteristics of these 15 individuals. They cycled in and out of incarceration and shelter frequently, but had no prison use during the three-year window. As shown in table 9, seven of the individuals fall into the “moderate incarceration” category identified in chapter 3, while the remaining eight are equally distributed among the other three categories.

Table 9. System Use Clustering Assignments of the First 15 DC FUSE Participants*

	DC FUSE Participants (n=15)
Low System Use	3
Moderate Shelter Use	3
High Shelter Use	2
High Incarceration	7

* See chapter 3 for a complete description of the cluster methodology and outcomes.

5.3. Participant Perceptions of FUSE

Through interviews with seven FUSE participants, UI was able to conduct analyses of participant perceptions of and satisfaction with the FUSE program. Generally, participants were satisfied with their housing in terms of the housing itself, locale and neighborhood, and access to basic needs (e.g., groceries), but a handful were slightly unsatisfied with their housing location. Participants were generally unsure about what to expect when transitioning from jail to the community, particularly with respect to what was *supposed* to happen as part of the program. Most, however, said the program exceeded their expectations. Interactions with the transition coordinator were positive, and participants highly lauded their ACT team members and the services and care they provided. Below, greater detail is provided on the perceptions of the seven FUSE participants who spoke to the research team.

- **Housing**—Most of the participants were satisfied with their current living arrangement, although, a couple were not satisfied with the housing due to personal safety concerns, issues with the landlord, and the maintenance of the building. For individuals who were placed in transitional housing, most were content to share the living space with another tenant and felt the transitional housing manager was helpful when any problems with the unit arose. Participants seemed to appreciate having a choice in their housing location, though not all reported to have this option. When given a choice, participants were able to choose among two or three places to live. Participants’ views on the accessibility of their neighborhoods were also generally favorable, with many enjoying the easy access to groceries, stores, and transportation. Views on neighborhood safety, however, varied slightly from participants feeling a connection to the community and appreciating key-card controlled apartment access to noting the need to be vigilant about one’s surroundings and feeling uncomfortable about local drug and gambling crimes. For the most part, however, participants noted that, despite potential safety issues, personal safety was a matter of watching out for oneself.
- **Transition into the Program**—Of those who received it, interviewees said they benefited from the case conference session in the jail. By design, the program participants each have a serious and persistent mental illness, which may influence their understanding and expectations of the program. This makes effective transition planning and coordination of services critical. Generally, participants had positive reactions about their interaction with the transition coordinator, recalling that they appreciated the transition coordinator’s efforts to explain the program to them and what was available to them. Yet some participants did report that they were confused about the discharge process, unsure of what to expect upon release, and in fact, surprised that the services were available in the community in the way the transition

coordinator had explained them. Many participants claimed that their personal expectations were far exceeded by the services they received through the program.

- Interactions with PSH Provider and ACT Teams—In general, participants were greatly appreciative of the treatment, responsiveness, and respect they received from the members of the ACT teams. The frequency with which participants met with their ACT team members varied from multiple weekly interactions to monthly interactions, but several claimed to drop by their ACT teams' offices whenever they could or when they felt they needed help. Most participants felt positive about the services provided by the ACT teams, commenting that having someone to support them through hard times was very useful. Many participants also noted their appreciation for ACT teams helping them with shopping for clothes and food, as well as helping them to settle in their apartments. Regarding what participants desired more from ACT teams, some participants voiced an interest in receiving more money, especially for travel and reuniting with family and friends, but were otherwise appreciative of the care they were receiving.
- Community Reintegration and Self-Sufficiency—Many participants were very happy to receive the housing and services they had been provided through the FUSE program and felt that it had helped keep them from relapsing into drug use or going back to jail. Some participants voiced optimistic views of their future, considering enrollment into general education classes and seeking some form of employment. Yet the majority of participants voiced a lack of faith in being able to find work again, either because of their mental health issues or criminal history.

5.4. Short-term Outcomes

The goals of the FUSE program are to provide permanent housing and enhanced treatment services for the frequent user population specifically, which in turn may eliminate the expensive institutional cycling behavior of the District's frequent user population. Specifically, the program hopes to—

- Improve day-to-day functioning of participants
- Provide treatment for participants' psychiatric and other health disorders
- Reduce participants' returns to jail
- Reduce participants' returns to shelter
- Increase participants' residential stability
- Decrease hospitalizations and use of emergency care among participants

At this time, the FUSE program has not attained a sufficient enrollment size for analysis of treatment effects. However, the initial outcomes can be presented within the context of the existing research on permanent supportive housing and assertive community treatment. Both of these interventions have been shown to be independently linked with positive impacts among homeless individuals with severe mental illness. Specifically, PSH has been shown to reduce shelter use as well as emergency hospital use and incarceration (Culhane, Metraux, and Hadley 2002). The New York City FUSE program, which treated a similar, but not an identically defined frequent user population, was shown to reduce frequent users' returns to shelter and reduce their length of shelter use and length of jail use in the first year following program enrollment (Corporation for Supportive Housing 2009). Furthermore, a meta-analysis of 10 studies on the effects of ACT for homeless individuals with severe mental illness shows that, compared to standard case management, ACT is associated with significant decreases in the rates of homelessness and significant decreases in the severity of psychiatric symptoms experienced by the homeless mentally ill (Coldwell and Bender 2007). If the FUSE program can deliver these services successfully, then it is likely to achieve its primary impacts—though the full extent of the program impacts will nevertheless need to be determined.

In recognition of this promising research base, the short-term outcomes of the FUSE participants are split into two types of measures:

- 1) **Service Delivery Outcomes:** The key services that participants received while enrolled in the FUSE program, as well as their individual functioning.
- 2) **System Use Outcomes:** The initial system use levels among participants after enrollment.

Service delivery outcome data were only available for 11 of the first 15 participants enrolled into FUSE who consented to participate in the UI research project and share their data collected by the FUSE program with the research team. Systems use outcome data from DOC and TCP were drawn from both the program and administrative data, which were available for all of the first 15 participants. The outcome and program data are reported across an uncontrolled reporting period ranging from two to eight months.

Service Delivery Outcomes

- **Mental Health Treatment**—All of the participants enrolled in the FUSE program were placed into an ACT team within the permanent supportive housing provider, where they received an array of services (see chapter 4). At the time of the UI analysis, the participants had been receiving ACT services for an average of 5.7 months. While some participants' ACT engagement reduced over time, the ACT team was successful in maintaining regular contact with the participants, averaging 14 face-to-face contacts a month. Each contact lasted approximately 54 minutes, on average, and took place across the community, including visits to the participant's apartment or treatment facility. As the program continues to enroll participants, engagement can be tracked across a standardized time period. This will better quantify the full dose of treatment received by participants and determine whether treatment dosing is related to outcomes.
- **Housing**—FUSE successfully provided participants with both transitional and permanent supportive housing services; all but one of the participants were housed in a permanent apartment using a program voucher within the first four months after their release. The small number of participants, however, prevents a richer analysis of participants' pathways into housing. During the pilot period, participants used a variety of temporary housing supports, including mandatory halfway house placement, community connections transitional housing, substance abuse inpatient treatment, and hotels. Housing is a critical need upon release from jail, and these pathways are important to understand and contextualize the role of the program as a reentry service provider.
- **Substance Use**—As documented in the participant characteristics section, all of the FUSE participants have a diagnosed substance abuse history, and while receiving ACT services, 5 of 11 had documented substance use. However, according to the tenants of the housing first model, substance use should not disqualify participants from enrollment in FUSE. Each participant who had a documented substance use problem is still under an active lease and, in fact, two of those participants participated in a detox or drug rehabilitation program while enrolled in FUSE. As the program continues to provide services, participant outcomes can be tracked to estimate whether housing and program participation reduces substance use over time.
- **Employment**—Using prior research as an indicator, many of the participants will likely not obtain employment, and the services may not positively impact employment status (Bond 2004; Burns and Santos 1995; Martinez and Burt 2006; McFarlane et al. 2000). Nevertheless, employment outcomes should be tracked as part of any ongoing program evaluation. In the uncontrolled outcome period reviewed by this report, 3 of the 11 participants were successfully

employed or participated in employment training. The remaining participants generally received income through SSI and other government benefit programs.

Systems Use Outcomes

- **Shelter Use**—Given the extensive homeless histories of the FUSE participants, research suggests that some of them will return to shelters despite having transitional and permanent housing available. The goal of the program, however, is to reduce the overall level of system use. As such, both the number and length of shelter stays should be evaluated. In the uncontrolled outcome period reviewed for this evaluation, HMIS records indicated that 5 of the 15 participants used emergency shelter after their release from jail. Each had one episode of shelter use, ranging from 1 to 92 days. However, shelter use only occurred prior to placement into permanent housing among four of the five participants. At this time, given the very short follow-up window, it is unclear if these observed reductions in shelter use after placement into permanent housing were sustained. To accurately estimate the reductions in shelter use as well as any associated cost savings attributable to FUSE, a larger sample of FUSE participants must be evaluated over a longer, standardized outcome period to determine if the participants' use of shelter is lower than it was before program participation and/or lower than a matched comparison sample of frequent users who did not enroll in FUSE.
- **Recidivism**—Similar to shelter use, frequent incarceration is an intransigent characteristic of this population that is difficult to change, but whose reduction can increase participant and public well-being and generate significant cost savings. During the first 10 months of the program, 4 of the 15 FUSE participants were reincarcerated. All four were new arrests; three individuals were charged with at least one violent crime and one individual was charged with a drug crime. As indicated above, to assess the program's success fully and accurately, recidivism should be tracked over a longer, standardized outcome period and compared to preprogram criminal histories and/or a matched comparison group. A longer outcome period is preferable given the housing first approach employed by the FUSE program, which does not take away housing upon reincarceration. As such, individuals who recidivate may still demonstrate long-term reductions in jail use attributable to FUSE participation.
- **Emergency Psychiatric and Medical Service Use**—Of the 11 participants who consented to have their records collected, 2 used emergency psychiatric services, once and three times respectively. Those same two participants also used emergency medical services multiple times, as did one other participant. These three participants all entered the program with high levels of need, and their emergency service use was associated with substance use and public disorder episodes. Considering the extensive self-reported histories of emergency psychiatric and medical services and associated costs, these outcomes should be tracked as the program continues and expands operations, to determine the full impact of the program on individual and system well-being.

Finally, it must be emphasized that these preliminary outcomes are not robust and should not be taken as a prediction of program outcomes. Rather, these data generally inform the overall program assessment, indicating the range of services delivered to FUSE participants and providing a framework upon which the program can be assessed after continued, expanded operations.

5.5. Implications

FUSE remains in its pilot phase and is still fully implementing its enrollment and service delivery structures. Consequently, an accurate determination cannot be made as to the outcomes or impacts of the program. Instead, the outcome evaluation serves to provide context to the process evaluation

(chapter 4), informing the type and extent of service delivery observed during the pilot phase of the program. Several strengths as well as opportunities for improvement have been identified based on the outcome assessment. This report is intended to inform continued program development and service delivery. Meanwhile, outcome data can continue to be collected, and can be used to inform a robust evaluation of the program's impacts after a longer period of operation.

Based on the characteristics of the first 15 FUSE participants, it appears that the program is successfully recruiting frequent users who have high needs. Individuals displayed extensive histories of serious psychiatric disorders, comorbid with substance abuse and chronic physical health conditions. Furthermore, the participants had extensive histories of housing instability and criminal justice involvement, beyond the three-year window of frequent use required as part of the FUSE eligibility criteria.

Analyzing system use patterns of the participants, most were part of the "High Incarceration" and "Moderate System Use" subgroups of frequent users. As discussed in chapter 3, the recruitment of this type of frequent user is likely due to the nature of program enrollment. By enrolling in the jail, the program interacts with frequent users who are incarcerated more frequently and for longer periods of time. These individuals have the highest levels of jail and prison system use and transition between statuses most often, indicating that they are the most costly frequent users and treating them may produce the most cost savings. However, to fully evaluate the potential cost savings of the program, outcomes must be tracked across more participants and for a longer period of time.

Initial outcomes also indicated that there were multiple opportunities for improvement in the FUSE program. In particular, many of the participants reported that they did not know what to expect from the program before they were enrolled and released from jail. This indicates that the program would benefit from more communication between the participant and both the transition coordinator and permanent supportive housing provider. More communication would not only help to ensure that the participant understands the services s/he will receive, but may also improve service delivery by more fully engaging the participant in the development of the treatment plan. In addition, shelter use prior to placement in housing indicates a need for more transitional housing. Only two transitional units were at the disposal of the program, limiting the number of participants who were able to use this resource. Finally, additional transitional housing would help to improve the jail discharge planning process, ensuring that participants transition from the jail to the program both immediately and seamlessly.

Based on UI's assessment of FUSE's preliminary, ongoing successes as well as multiple opportunities to improve, the FUSE program shows potential for strong impacts on overall system use levels among frequent users in D.C. However, to accurately document and assess these impacts, program outputs and outcomes must be collected for more participants over a longer outcome period. Further, if possible, comparisons to a matched group of frequent users who did not enroll in FUSE would be ideal and preferable to an uncontrolled pre-post analyses comparing system use before and after program enrollment.

6.

Conclusions and Next Steps

Over the past year of program implementation, the FUSE program has had some successes and challenges in meeting its intended goals: creating 50 units of supportive housing and improving coordination. Indeed, the program has fallen short of its goal of creating 50 units of permanent supportive housing for frequent users leaving the jail; yet it has succeeded in improving coordination across the systems that serve frequent users. Specifically, the program faced challenges in creating 50 units of supportive housing for frequent users for two reasons. First, the program faced difficulties in identifying and enrolling individuals into the 20 housing slots that it had available through Pathways. As mentioned, this was due to various reasons, such as the administrative mechanism used to identify frequent users, the challenge of facilitating the reentry process in the context of the jail, and the use of FUSE as a diversion tool for the pretrial population. Second, the program faced difficulties identifying another housing service provider with available vouchers willing to partner with the program and receiving a set of dedicated vouchers from the local housing authority. Many of the challenges identifying additional housing resources were beyond the control of the program, given the political context in the District of Columbia while the program was being implemented.

Despite the challenge with enrolling participants into the housing program and creating the desired number of housing units, the program certainly facilitated and improved coordination across some of the systems that serve frequent users. The FUSE program created new linkages among District agencies and strengthened partnerships between agencies that had previously been only loosely associated. For example, while the mechanism for identifying frequent users hampered enrollment due to the frequency of the data pulls, it nevertheless represented a significant victory for the program, from which other jurisdictions might learn how to identify a target population using a purely data-driven approach. In another example, the program is a successful demonstration of how multiple agencies whose missions are to serve frequent users from slightly different vantage points (i.e., Corporation for Supportive Housing, Community Connections, University Legal Services, and Pathways to Housing-D.C.), can coordinate under one program and work within existing local government structures and processes. These partnerships were all in place from the program's inception and continued over its first year of operations. A next step would be to expand the partnership to other agencies operating in the jail and the community, and thereby identify and serve more frequent users in the District.

With respect to individual-level outcomes, it is not clear whether the FUSE program has met all of its goals. For the most part, this is due to the limited period within which the evaluation could observe outcomes and to the limited number of individuals served by the program. Certainly, the 15 individuals enrolled into the program from November 2010 through June 2011 all received housing with supportive services, and most of these individuals had a seamless transition from the jail to the community, since their enrollment into the program began before their release from jail. From that perspective, the program was successful, especially given that some of the individuals in the program had never been exposed to housing and services before their incarceration or received case management services as comprehensive as assertive community treatment services.

Yet, there were a handful of individuals who were rearrested during the evaluation period. Whether this is a success or failure of the program is dependent on the perspective. For the program stakeholders, specifically those delivering the community-based service, it is clear that FUSE *should be* intended for

those who are the highest need—individuals who need and would most benefit from the housing first model. From that perspective, a return to jail is not necessarily a failure of the program per se, and in fact, may be part of the process toward more positive outcomes for individuals. Recall that all of these individuals have extensive histories of incarceration; therefore, moderating their return to jail following program entry is likely to include at least one return to jail. Also consider the success of the New York City frequent users program, which showed significant decreases in individuals' *length* of stay in jail but not their *rate* of reincarceration (or jail stays) (Corporation for Supportive Housing 2009). That is, frequent users with supportive housing were rearrested at rates statistically no different from those who did not get housing, but those with supportive housing who were rearrested had lengths of stay in jail shorter than those who were rearrested and did not receive supportive housing. While any rearrest or reincarceration is ideally avoided, shorter lengths of jail stay are nonetheless a positive (and less costly) outcome. That could be the reality in D.C. as well, though the evaluation did not have enough time in the period of performance to observe this empirically.

From the criminal justice system perspective, however, any return to jail is costly, should be avoided, and is the primary metric when considering program success or failure. For that reason, FUSE *should be* intended for those who are the highest risk of recidivating. In reality, however, individuals with the highest risk of recidivating may not be those with the highest need for housing and supportive services in the community. Criminogenic risk factors do not neatly align with mental health or substance abuse need factors (Reentry Policy Council 2004); for obvious reasons, they are focused on altering different behaviors and conditions. Further, individuals' behavioral health issues may or may not be associated with their criminal justice system contact (Du, Zhao, and Hser 2011; MacArthur Research Network 2005; Singh, Grann, and Fazel 2010). Stated differently, people may come into contact with the criminal justice system for reasons that are unrelated to their behavioral health conditions. Therefore, for these individuals, a program may help them manage their behavioral health conditions or maintain residential stability, while making no change in their likelihood of coming into contact with the criminal justice system.

Over the next few months, the program intends to continue enrolling frequent users into the remaining supportive housing units that are available. It intends to seek additional partners or resources for the remaining 30 housing units and continuing program operations in the city. As FUSE expands, enrolls more participants, and refines its program processes and performance, it will move closer to reaching its latter three goals: improving financial integration and policy coordination among corrections, mental health, and human services agencies; documenting decreased recidivism rates and increased housing stability for frequent users; and demonstrating cost savings in the city's corrections, human services, and mental health services agencies.

Appendix A: Comprehensive DC FUSE Participant Information

Mental Health and Health Histories

	DC FUSE Participants (n=10)
Have mental health diagnosis?	10
Number of current mental health diagnoses (mean)	4.7
Alcohol dependence	7
Schizophrenia (paranoid type)	7
Cocaine dependence	5
Cannabis dependence	3
Depressive disorder	3
Dolysubstance dependence	3
Pipolar disorder	2
Major depressive d/o (recurrent moderate resistant)	2
Major depressive d/o (recurrent w/ severe psychotic)	2
PCP-induced psychotic disorder	2
Adjustment disorder w/ depressed mood	1
Anxiety disorder	1
Major depressive (recurrent in partial remission)	1
Mood disorder	1
Opioid dependence	1
Personality disorder	1
Post-traumatic stress disorder	1
Psychotic disorder	1
Schizoaffective disorder	1
Schizophrenia (disorganized)	1
Schizophrenia (residual)	1
Number of mental health medications (mean)	2.8
Receive mental health services in the community(Yes/No)	8 / 1
VOA	3
Green Door	1
Community Connections	1
PSI	1
Washington Hospital Center	1
Unknown	1
Health Care Provided by	
Medicaid	7
Alliance	1
Medicaid and Alliance	1

LOCUS Scores, Functionality, Self-Sufficiency

	DC FUSE Participants (n=10)
LOCUS score (mean)	20.5
Recommended LOCUS level of care	
(I) Recovery Maintenance and Health Maintenance	-
(II) Low Intensity Community Based Service	-
(III) High Intensity Community Based Service	8
(IV) Medically Monitored Non-Residential Services	2
(V) Medically Monitored Residential Services	-
(VI) Medically Managed Residential Services	-
<i>Risk of harm</i>	
Minimal risk of harm	4
Low risk of Harm	4
Moderate risk of harm	2
Serious risk of harm	-
Extreme risk of harm	-
<i>Functional Status</i>	
Minimal impairment	-
Mild impairment	5
Moderate impairment	4
Serious impairment	1
Severe impairment	-
<i>Comorbidity</i>	
No comorbidity	1
Minor comorbidity	3
Significant comorbidity	3
Major comorbidity	3
Severe comorbidity	-
<i>Recovery environment (level of stress)</i>	
Low-stress environment	-
Mildly stressful environment	-
Moderately stressful environment	1
Highly stressful environment	9
Extremely stressful environment	-
<i>Recovery environment (level of support)</i>	
Highly supportive environment	-
Supportive environment	2
Limited support in environment	7
Minimal support in environment	1
No support in environment	-
<i>Treatment and recovery history</i>	
Full response to treatment and recovery mgmt.	-
Significant response to treatment and recovery mgmt.	-
Moderate/equivocal response to treatment and recovery mgmt.	8
Poor response to treatment and recovery mgmt.	2

	DC FUSE Participants (n=10)
Negligible response to treatment	-
<i>Engagement</i>	
Optimal engagement	-
Positive engagement	-
Limited engagement	7
Minimal engagement	3
Unengaged	-
Can shop for self (yes / no)	8 / 1
Can prepare own food/cook (yes / no)	9 / 0
Can clean and do laundry on own (yes / no)	8 / 1
Have ever had a bank account (yes / no)	6 / 3
Have a representative payee (yes / no)	2 / 7
Need reminders to take medication(s) (yes / no)	4 / 5
Use equipment for mobility assistance (yes / no)	3 / 6

Appendix B: DC FUSE Diagnostic Criteria

All Schizophrenia/Psychotic Disorders (under 295 in DSM)	All Mood Disorders (under 296 in DSM)	Other Disorders (specific for FUSE)
<ul style="list-style-type: none">• Paranoid type• Disorganized type• Catatonic type• Undifferentiated type• Residual type• Schizophreniform• Schizoaffective disorder	<ul style="list-style-type: none">• Manic disorder, single episode• Manic disorder, recurrent episode• Major depression, single episode• Major depression, recurrent episode• Bipolar affective disorder, manic• Bipolar affective disorder, depressed• Bipolar affective disorder, mixed• Bipolar disorder, unspecified• Manic-depressive psychosis, other and unspecified	<ul style="list-style-type: none">• Post-traumatic stress disorder• Depressive disorders (NOS)• Psychotic disorders (NOS)

Appendix C: Charge Classification Categories

The following charge classification categories are intended to translate the D.C. DOC charge category coding into one of five categories: (1) violent crime; (2) public order crime; (3) property crime; (4) drug crime; and (5) other.

Violent Crime	Public Order Crime	Other Crime
<ul style="list-style-type: none"> • Aggravated Assault • Assault • Crimes against Family Members • Crimes against Persons • Homicide • Kidnapping • Rape • Rape/Sex Abuse • Robbery • Sex Abuse • Sex Offenses • Stalking • Threats 	<ul style="list-style-type: none"> • ABC • DC Code Violation • Disorderly • DUI • Prostitution • Public Order • Weapons 	<ul style="list-style-type: none"> • Traffic • Abscond • Bail Reform Act Violation • Conspiracy • Contempt • Crimes against the US • Domestic Violence • Escape • Failure to Appear • Failure to Appear • Fugitive • Juvenile Court • Misdemeanor Arrest Warrant • Obstruction of Justice • Offense committed while on Release • Other • Other Felony • Other Misdemeanor • POCA • Possess Implements of Crime • Probation • Parole Violation • Parole Violation other • Release Violation • Supervised Release • Wanted in another jurisdiction • Writ
Drug Crime	Property Crime	
<ul style="list-style-type: none"> • Drug Offenses 	<ul style="list-style-type: none"> • Arson • Auto Theft • Burglary • Burglary/Robbery • Extortion • Forgery • Fraud • Larceny • Property Crime • Stolen Property • Theft • Unlawful Entry • Vandalism 	

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December 2011



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