HAWAIʻI PATHWAYS PROJECT

FINAL REPORT

August 2014–September 2017

CENTER ON THE FAMILY

Acknowledgements

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The photographs featured on the cover page and throughout the report are products from the PhotoVoice Project taken by Hawai‘i Pathways Project clients.

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Contact Information

Center on the Family, University of Hawai‘i at Mānoa
2515 Campus Road, Miller Hall 103, Honolulu, HI 96822
Phone: 808-956-4132
Email: cof@ctahr.hawaii.edu
Website: www.uhfamily.hawaii.edu

Table of Contents

List of Tables

List of Figures

EXECUTIVE SUMMARY

Overview

In the spring of 2013, the homeless rate in Hawai'i was 45.1 per 100,000 people in the general population, second only to the District of Columbia, and 1.3 times higher than the national average (19.3). Hawai'i's chronically homeless population reached 1,031, exceeding 1,000 persons for the first time ever; this increase represented a 13.3% growth, a stark contrast to the 7.3% decline in the national rate of chronic homelessness. O'ahu had the state's largest share of chronically homeless population (67%), with the majority (73%) living unsheltered, such as on the street, in parks, encampments, or other places not meant for human habitation. Among the unsheltered, regardless of their length of homelessness, 429 people reported being diagnosed with serious mental illnesses, 299 were substance users, 22 had HIV/AIDS, and 191 were veterans.

From FFY 14 to FFY 17, the Hawai'i Pathways Project was initiated and administered by Hawai'i State Department of Health, Alcohol and Drug Abuse Division (DOH-ADAD) with funding from the "Cooperative Agreement to Benefit Homeless Individuals for States" (CABHI-States) grant received from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Project was the first in the state of Hawai'i to adopt the evidence-based Pathways to Housing program, which is designed to promptly connect chronically homeless people to permanent housing, without precondition. Addressing any underlying issues then followed around mental health, addiction, medical care, income and education using a client-driven harm reduction approach.

The goal of the Hawai'i Pathways Project was to address the gaps in supportive housing services at program and system levels to achieve sustainable outcomes in housing stability and recovery among chronically homeless persons with substance use, mental health, or co-occurring disorders. The Project aimed to deliver a program that focused on:

- connecting clients to sustainable, permanent housing;
- connecting clients to mainstream benefits and services for low-income people, such as Supplemental Security Income and Medicaid;
- providing community-based evidence-based treatment for substance use and psychiatric disorders that is client driven and recovery oriented; and
- providing a range of recovery resources and support including peer navigation services.

It also aimed to develop short- and long-term strategies to expand or enhance the collaboration of various public and private agencies to address system barriers for accessing housing, treatment and recovery services among the chronically homeless population.

The Hawai'i Pathways Project provided treatment and support services through a hybrid model of Assertive Community Treatment (ACT) and Intensive Case Management (ICM). A multi-disciplinary team of housing specialists, mental health counselors, nurses, peer support specialists, psychiatrists, social workers, substance abuse counselors, and vocational specialists delivered services to clients. Program services were provided on the island of O'ahu by the Helping Hands Hawai'i and Catholic Charities Hawai'i. Program evaluation was conducted by the University of Hawai'i Center on the Family.

This report describes the experience of implementing the Pathways Housing First model in Hawai'i, evaluates the changes this program has made on the lives of people and on the service delivery system, and discusses lessons learned and recommendations for future efforts in serving the most vulnerable people among the homeless. The following are highlights of the report.

Clients' Demographic Characteristics and Experiences

- There were 134 clients who participated in the Hawai'i Pathways Project.
- At program enrollment, 7% were in hospitals or residential treatment facilities, 24% were in emergency shelters or Safe Haven, and 69% were unsheltered.
- 40% of the clients were Hawaiian or Other Pacific Islander (HOPI) or part HOPI, 34% were Caucasian, 8% were Asian, 2% were Black, and 16% were another single race or two or more races.
- Prior to program enrollment, about half of the clients had been homeless for a continuous period of six years or more, with a similar share of clients in the range of 6 to 9 years (23%) versus 10 years or more (26%).
- One-fourth of the Pathways clients were diagnosed with a substance use disorder, 15% had a serious mental illness (SMI), and 60% had a co-occurring substance use and SMI disorders (57%) or co-occurring substance use and mental health disorders (3%).

Treatment and Support Services

- During the 38 months of Project implementation, clients enrolled in the program for an average of 22 months.
- The service team reported a total of 10,549 service contacts, of which 80% were successful contacts and 20% were attempted contacts.
- The average number of service encounters (successful contacts) per client per month was 2.9 times, with more frequent encounters during the post-housing period than the pre-housing period (at 4.2 and 2.8, respectively).
- The Pathways team delivered services to clients via home visits or in places where they were needed, without time limits. Service planning was based on a client-centered approach where the client's choice drove the decision on the type, frequency and intensity of services.
- Clients most frequently used housing support services (32%), followed by treatment services (27%), case management services (18%), and peer support services (16%). Other less frequently used services were medical services (3%), health education (3%), and employment services (2%).

Permanent Housing Placement

- The Hawai'i Pathways Project placed clients in scattered-site private market housing, where rental subsidies were provided through existing Permanent Supportive Housing Programs in the state. Clients were required to sign standard leases with landlords and pay 30% of their income towards the rent.
- 99 clients moved into permanent housing. The housing placement rate of 79% was due to the limited availability of housing vouchers.
- 38% of clients were housed within four months of program enrollment—a benchmark of the Pathways Housing First model for programs without their own supply of housing vouchers.
- Clients waited an average of 8.5 months to move into a permanent housing unit because some vouchers were not available until the second or the third year of the Project.
- The locations of housing units rented by Pathways clients were spread across 15 ZIP code areas on O'ahu. About three-quarters of clients (73%) lived in urban Honolulu.

Program Outcomes

- The housing retention rate was 90%, with 7% returning to homelessness, and 3% leaving the program to unknown destinations.
- The average length of housing at the end of the grant was 13.9 months (range: 0.1 to 34.2).
- 13 housed clients were relocated one to three times due to lease violations (5), illegal or drug related activities (4), client's choice (3), or poor physical housing conditions (1).
- Follow-up interviews reported increases in housed clients' reports of good to excellent health (+42%); and not being physically hurt (+38%), abstinence from alcohol or illegal drugs (+41%), and not having experienced drug-related health, behavioral, or social consequences (+41%).
- Housed clients also reported decreases in psychological or emotional problems not due to substance use (–16% to –26% on various problems); alcohol and drug use (alcohol users –3%, drug users –34%, frequency of alcohol use –32%, frequency of drug use –47%); and health, behavioral and social consequences due to substance use (–50% to –62% on various consequences).

System Outcomes

- From baseline to follow-up, health care costs per client per month decreased by 76%. The average housing costs averaged to $1,100 per month for each client housed by the Hawai'i Pathways Project, and the average cost for providing supportive services by Pathways was $850 per month per client. After considering these costs, the net savings equaled $4,247 per month per client.
- Trainings helped to build the system's capacity by providing housing-focused case management for health plans, enabling health plans to examine service gaps in the system, and assisting Community Care Services (CCS) workers to engage more directly with the homeless service sector.
- Collaboration among state agencies—for example, Departments of Human Services, Health, Public Safety, Transportation, Land and Natural Resources—through HICH strengthened as they worked together on the housing homeless individuals and providing them with resources.
- Medicaid 1115 Waiver Amendment was submitted, which, if approved, would allow for Medicaid to provide supportive housing services for chronically homeless individuals with a behavioral or physical illness, or a substance abuse diagnosis.
- The technical assistance from the Corporation for Support of Housing (CSH) through the Pathways Project's funding provided Hawai'i with housing plans and a financing model. A snapshot of current housing options, as well as proposal on how to finance the development of more affordable housing to meet the needs of the homeless population based on the Point-in-Time Count estimation, were developed.

Discussion and recommendations

The Hawai'i Pathways Project demonstrated a successful model in housing the hardest-to-serve population among the homeless—chronically homeless adults with mental illness, addiction or co-occurring disorders. The Project was implemented with high fidelity, achieved a high housing retention rate, transformed clients' lives, reduced costs in health care utilization, filled the service gap by helping the hard-to-serve homeless population, and accelerated system change. However, the pilot project faced barriers and challenges related to grant administration, workforce availability, housing placement, and clients' treatment and recovery.

The report provides several recommendations that include expanding the Housing First program; prioritizing the needs of chronically homeless individuals and allocating appropriate resources for services; developing a Housing First learning community; and addressing the needs for positive social inclusion.

INTRODUCTION

Background

The Hawai'i Pathways Project was the first in the state of Hawai'i to adopt the evidence-based Pathways to Housing[1] program, which is designed to promptly connect chronically homeless[2] people to permanent housing, without precondition, and then to address any underlying issues around mental health, addiction, medical care, income and education using a client-driven harm reduction approach. From FFY 14 to FFY 17, this Project was administered by Hawai'i State Department of Health, Alcohol and Drug Abuse Division (DOH-ADAD) with funding from the "Cooperative Agreement to Benefit Homeless Individuals for States" (CABHI-States) grant received from the Substance Abuse and Mental Health Services Administration (SAMHSA). On the island of O'ahu, Helping Hands Hawai'i and Catholic Charities Hawai'i provided program services. Program evaluation was conducted by the University of Hawai'i Center on the Family.

In the spring of 2013 when the DOH applied for the CABHI-States grant, the homeless rate in Hawai'i was 45.1 per 100,000 people in the general population, second only to the District of Columbia, and 1.3 times higher than the national average (19.3).[3] Hawai'i's chronically homeless population reached 1,031, exceeding 1,000 persons for the first time ever; this increase represented a 13.3% growth, a stark contrast to the 7.3% decline in the national rate of chronic homelessness.[4] O'ahu had the state's largest share of chronically homeless population (67%), with the majority (73%) living unsheltered, such as on the street, in parks, encampments or other places not meant for human habitation.[5] Among the unsheltered, regardless of their length of homelessness, 429 people reported being diagnosed with serious mental illnesses, 299 were substance users, 22 had HIV/AIDS, and 191 were veterans.

These challenges were met with a new synergy that focused on improving the coordination of care in the service delivery system and adopting a Housing First approach in programming.[6] The leading organizations of these efforts were the Hawai'i Interagency Council on Homelessness (HICH), the State's Homeless Programs Office, the City's Housing Office, and two continuum-of-care organizations—Partners In Care on O'ahu and Bridging the Gap on other islands. The public/private partnership worked together to build a coordinated homeless service entry system, starting from the implementation of a standard prescreening tool called Vulnerability Index—Service Prioritization Decision Assistance Tool (VI-SPDAT). In addition, a centralized process was piloted for submitting prescreening data, prioritizing cases with high level of medical and social vulnerability, and connecting

[1] Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services*. 51 (4): 487–493.
[2] According to Housing & Urban Development's definition issued in December 2015, a homeless person is considered "chronically homeless" when he or she has a disability, and has been living unsheltered, in an emergency shelter, or Safe Haven either for a continuous period of at least 12 months, or on at least four separate occasions in the past three years provided that the combined length of time of those occasions is 12 months or more.
[3] National Alliance to End Homelessness. (2014). *The state of homelessness in America 2014*. Retrieved from Alliance to End Homelessness http://endhomelessness.org/wp-content/uploads/2015/04/2014-state-of-homelessness.pdf
[4] Ibid.
[5] C. Peraro Consulting. (2013). *Statewide homeless point-in-time count: 2013 methodology and results.* Retrieved from http://humanservices.hawaii.gov/wp-content/uploads/2014/05/2013-Statewide-PIT-Report-5.15.13pdf.pdf
[6] Yuan, S., Vo. H., & Gleason, K. (2014). *Homeless service utilization report: Hawai'i 2014.* Retrieved from http://uhfamily.hawaii.edu/publications/brochures/60c33_HomelessServiceUtilization2014.pdf

clients with appropriate housing services through case conference. From 2012 to 2014, another significant development of Hawai'i's homeless service system was the establishment of permanent supportive housing programs that used a Housing First approach.[7] The first program was piloted by the state on O'ahu from 2012 to 2013,[8] and the second program was undergoing the process of planning by the City and County of Honolulu in 2013 and 2014. These programs provided rental support for private-market apartments and offered case management services that emphasized pre-housing support, landlord liaison, and housing tenure support.

While the adoption of a Housing First approach to reduce chronic homelessness is a significant milestone for Hawai'i's homeless service system, there are still issues that remain unaddressed. Some of these issues are system barriers and gaps in resources that add to the difficulty in providing adequate mental health and substance abuse services to the chronically homeless population. Building on the Housing First initiative, the piloting of the Hawai'i Pathways Project offered a timely opportunity for stakeholders to work together to address these issues. In this report, we describe the experience of implementing the Pathways Housing First model in Hawai'i, evaluate the changes this program has made on the lives of people and on the service delivery system, and discuss lessons learned and recommendations for future efforts in serving the most vulnerable people among the homeless.

About the Project

The goal of the Hawai'i Pathways Project was to address the gaps in supportive housing services at program and system levels to achieve sustainable outcomes in housing stability and recovery among chronically homeless persons with substance use or co-occurring disorders.

The Project was initially funded for three years from October 2013 to September 2016. Due to delays in executing the service contracts, the Project did not begin its implementation until after 10 months into the first year (August 2014). A one-year no-cost extension was approved by SAMHSA, extending the Project's implementation period to September 2017. The total amount of funding for the Project was $3.1 million, of which 68% was from the CABHI-States grant awarded in 2013 and 32% was from the CABHI-States Supplement grant awarded in 2014. The majority (79%) of the funding was budgeted for the provision of direct treatment and recovery services, outreach, case management, vocational and peer support, and housing placement. The remainder was provided for program administration and system enhancement (13%), Pathways Housing First program training (5%), and Project evaluation (3%). Rental support was not part of CABHI-States and Supplement grants. With the assistance of HICH, this Project obtained commitments from permanent supportive housing programs to provide housing vouchers for Pathways clients. The serving capacity of the program was 155 clients, with the enrollment of new clients targeted at 40 to 60 per year.

Single adults who met all of the following criteria were eligible for this program: (1) scored 10 or higher in VI-SPDAT (version 1); (2) were experiencing chronic homelessness; and (3) were diagnosed with a substance use disorder, serious mental illness, or co-occurring substance use and mental health disorders.

[7] According to the U.S. Department of Housing & Urban Development (HUD), "Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry." *Housing first in permanent supportive housing* [Housing brief]. Retrieved from https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf

[8] Yuan, S., Vo, H., & Garcia, L. (2015). *Permanent supportive housing: Pilot implementation report, Hawai'i 2012–2013.* Retrieved from: http://uhfamily.hawaii.edu/publications/brochures/5d3e2_PSHP_Pilot_FY13.pdf

The Project aimed to deliver a program that focused on the following four aspects:

- Connecting clients to sustainable, permanent housing;
- Connecting clients to mainstream benefits and services for low-income people, such as Supplemental Security Income and Medicaid;
- Providing community-based evidence-based treatment for substance use and psychiatric disorders that is client driven and recovery oriented; and
- Providing a range of recovery resources and support including peer navigation services.

It also aimed to develop short- and long-term strategies to expand or enhance the collaboration of various public and private agencies to address system barriers for accessing housing, treatment and recovery services among the chronically homeless population.

The project team, including DOH-ADAD, Helping Hands Hawai'i, and Catholic Charities Hawai'i, received training and technical assistance from Pathways to Housing to build its capacity to implement the program with fidelity. Developed by Dr. Sam Tsemberis in the early 1990s, Pathways Housing First model has shown strong evidence in improving the health and quality of life of clients with chronically homeless experience and mental health/substance use disorders. Pathways Housing First model reported 85%–90% retention rate across many cities and programs in the U.S.[9] Partnering with HICH through the Governor's Homeless Coordinator, this Project facilitated planning and policy development to address system-level solutions for ending chronic homelessness.

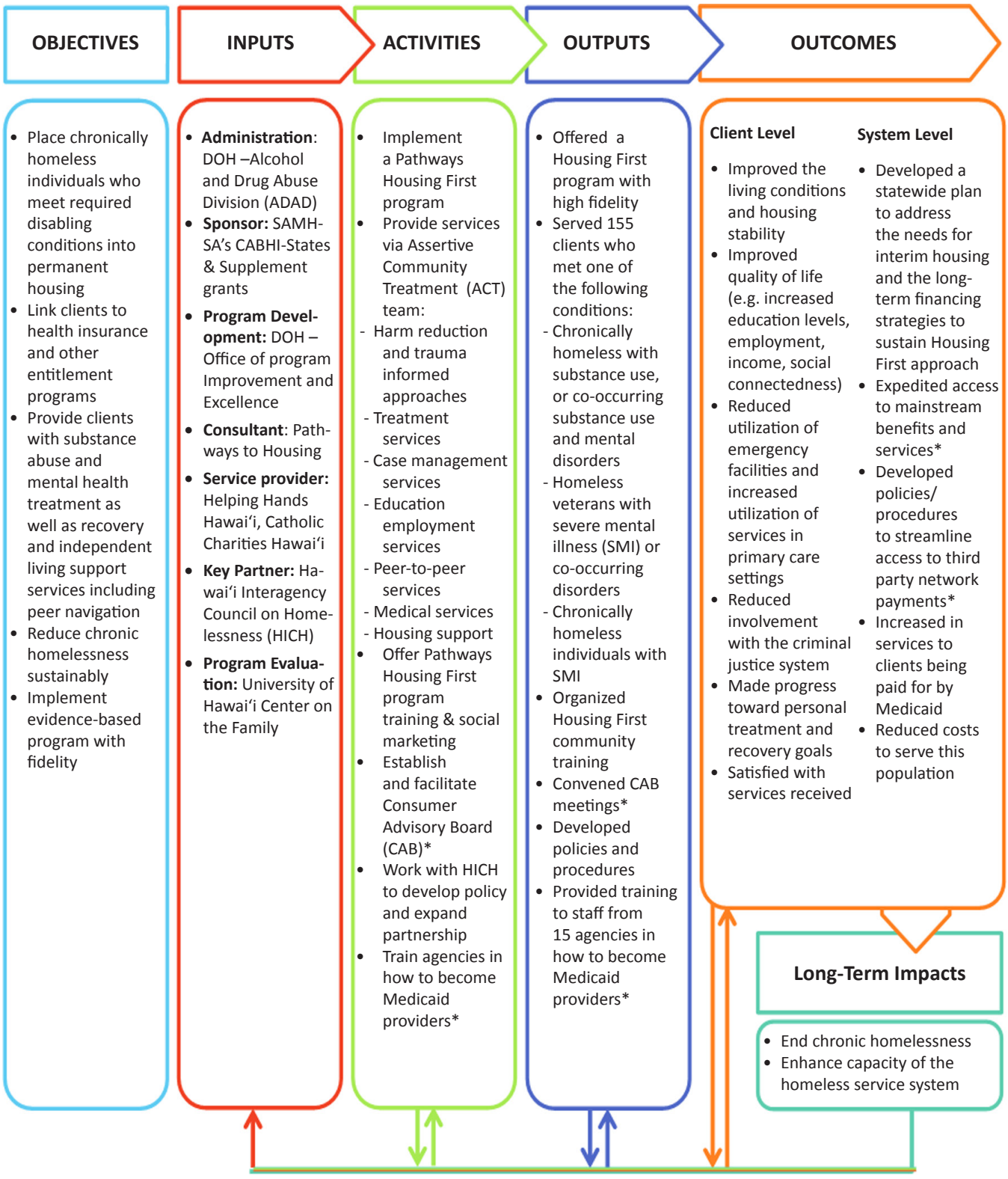
Evaluation

The University of Hawai'i Center on the Family developed a program evaluation plan with input from the program development team at DOH's Office of Program Improvement and Excellence. The plan also incorporated SAMHSA's program reporting requirements and performance measures. The evaluation period covered the entire Project from August 2014 to September 2017. The first year refers to the first 14 months of implementation, ending September 2015; the second year refers to the next 12 months, ending September 2016; and the third year refers to the no-cost extension period of the grant, ending September 2017.

A program logic model was created based on the original proposals submitted with the CABHI-States and Supplement grant applications (Figure 1). It served as a blueprint for the Hawai'i Pathways Project and guided the evaluation. Some program activities were not implemented and some system-level issues were not addressed due to low priority and other external readiness factors; therefore, those areas were not evaluated (as indicated by an asterisk in the logic model).

[9] Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services.* 51 (4): 487–493.; Pathways to Housing. (2012). Pathways to Housing 2012 Annual Report.

Figure 1: Logic Model of Hawai'i Pathways Project



Note: The original logic model is presented above. An asterisk (*) denotes a program area that was not implemented due to changes in project's priorities and other external readiness factors.

The evaluation of the Hawai'i Pathways Project focused on 13 key areas, including six programmatic areas (1–6), five program outcomes (7–11), and two system outcomes (12–13), which are listed in Table 1.

Table 1: Evaluation Areas

Programmatic Areas	Program Outcomes	System Outcomes
1. Program fidelity and training	7. Housing stability	12. Cost reduction
2. Referral, admission, and discharge processes	8. Quality of life	13. Impacts on Programs and Policies
3. Clients' characteristics	9. Health and health care service utilization	
4. Housing First service team	10. Involvement in the criminal justice system	
5. Treatment and supportive services	11. Progress in personal recovery goals	
6. Permanent housing placement		

Evaluation data was collected via various different methods, including SAMHSA's Government Performance and Results Act (GPRA) and other tools. A summary of the data collection methods that were used is presented in Table 2.

Table 2: Data Collection Methods

Tool	Sources	Schedule
1. Government Performance and Results Act (GPRA) questionnaire	Face-to-face structured interviews with clients, by service team	Complete interview at program intake, 6-month, 12-month, and discharge.
2. PhotoVoice	Housed clients told stories of photographs they took, in a one-on-one or small group setting with the evaluation team	Conduct in the 1st and 2nd years
3. Key informant interview: Service team, ADAD project coordinator, HICH chair	Semi-structured interviews by the evaluation team	Conduct at the end of the 2nd & 3rd years
4. Program's referral, admission, and discharge information	Online forms completed by service team	Enter data on a continuous basis, due by the 5th day of the following month
5. Service log: Services provided to clients	Spreadsheet completed by service team	Enter data on a continuous basis, due by the 5th day of the following month
6. Housing status of clients	Spreadsheet completed by service team	Enter data on a continuous basis, due by the end of program implementation

GPRA interviews were completed by all 134 clients at program intake. Follow-up interviews were conducted with 116 clients, representing a follow-up rate of 87%. When multiple follow-up interviews were completed, only one was used in the baseline follow-up analysis: For the housed clients, it was the first follow-up interview after housing placement; for the un-housed clients, it was the last follow-up interview. Twenty clients participated in the PhotoVoice project and were interviewed individually (15) or in small groups of 2–3 persons (5). Semi-structured interviews were conducted with 11 Project staff members and other key stakeholders. Participation in the GPRA interviews and PhotoVoice were both voluntary and not a condition for services. Tokens of appreciation in the form of supermarket gift cards were provided to clients who participated in the GPRA follow-up interview ($10), GPRA discharge interview ($30), and PhotoVoice interview ($30). Institutional Review Board (IRB) approvals for various study protocols were obtained from the University of Hawai'i.

Other data used in this report were gathered from the program's referral, admission and discharge information; reports of service delivery; and changes in housing status of the clients. An additional reference was the Program Fidelity Assessment report completed for the Hawai'i Pathways Project by Dr. Sam Tsemberis and Juliana Walker of the Pathways to Housing Institute on February 28, 2017.

To maintain client confidentiality, pseudonyms are used throughout the report. Due to rounding, percentages may not always add up to 100 in this report. This evaluation study focused on describing the Project's implementation and short-term impacts on the lives of the participants and the homeless service system. Significance tests were performed on changes from baseline to follow-up. In this study, the minimum significance level for a given test is a p-value of less than 0.1 (*), which means the probability for the observed change to occur by chance is less than 1%. Stronger evidence is indicated by a p-value of less than 0.05 (**) and less than 0.01 (***). It should be noted that the strength of evidence increases with the increase in sample size, the size of change, and the data variance. Due to the small number of Project participants, it is expected that strong evidence on program impacts would not be found on behaviors or events of few occurrence.

These are my slippers. They symbolize for me for other people to live in my shoes. To just be more open and not so closed-minded or looking down at us [who] are homeless. Not everybody chooses to be homeless, you know? I didn't; it just happened. I'm taking it one day at a time [now]….I try to say, don't judge a book by its cover but so many people [do]. It's sad that society puts a title on your head that you're homeless so you must be bad, on drugs or an alcoholic. Instead of just asking.
—Kapena, client

PROGRAMMATIC AREAS

1. Program Fidelity and Training

The Hawai'i Pathways Project was modeled after the evidence-based Pathways Housing First program developed by Dr. Sam Tsemberis in New York City during the 1990s. This program was adopted by many cities across the United States, Canada, and other countries to eradicate chronic homelessness with great success. The Project received training and technical assistance from Dr. Tsemberis and Julian Walker of the Pathways Housing First Institute to guide the implementation. In January 2017, the Institute conducted a fidelity assessment of the Hawai'i Pathways Project. The fidelity assessment measures cover five domains: (1) housing choice and structure, (2) separation of housing and services, (3) service philosophy, (4) service array, and (5) program structure. Each domain has 6 to 10 items, with each item rated on a scale from 1 (low fidelity) to 4 (high fidelity), for a total of 38 items and 152 maximum score possible.[10] The Hawai'i Pathways Project received a score of 134, which was 88% of the total possible score. The Program Fidelity Report[11] results showed that the Hawai'i Pathways Project implemented the Housing First model with high fidelity.

> - Team philosophy, practice and operations are consistent with the Pathways Housing First model.
> - The team has several well-trained and experienced staff members who have a clear understanding of the Housing First model and operate the program in a manner that is consistent with the program's core principles and values.
> - The team has…consistently [offered] clients housing of their choice, on their own terms, without prerequisites for treatment or sobriety that has created the success for many who had remained homeless for years.
> - The team understands and practices the principle of keeping housing separate but coordinated with support and treatment.
> - The housing provided by the team generally meets the fidelity standards for Housing First.
> - The apartments are rented from community landlords and are integrated into the building and community so that participants are living in "their home" not "in a program." …This is helpful in facilitating a normative lifestyle and social interaction with other members of the community.
>
> —Program Fidelity Report, p.3–4

The Hawai'i Pathways Project also engaged in training and social marketing of Pathways Housing First program in the state. In February 2014, Dr. Tsemberis and Ms. Walker were invited to provide training and to educate stakeholders about the Pathways Housing First model. The community training was well attended by stakeholders including state agencies, policymakers and service providers in the homeless, health and human service fields. Moreover, the project team participated in several "boot camps" organized by the Interagency Council to discuss strategies and challenges in implementing Housing First. The team members also presented at the annual Statewide Homeless Awareness Conference (2015–2017) and the Harm Reduction Conference (2017) to share their experience about implementing Housing First and harm reduction approaches. Furthermore, the project team reached out to health plans and case management programs to get them on board with incorporating the Housing First approach and applying Motivational Interviewing techniques in serving clients with chronically homeless experiences.

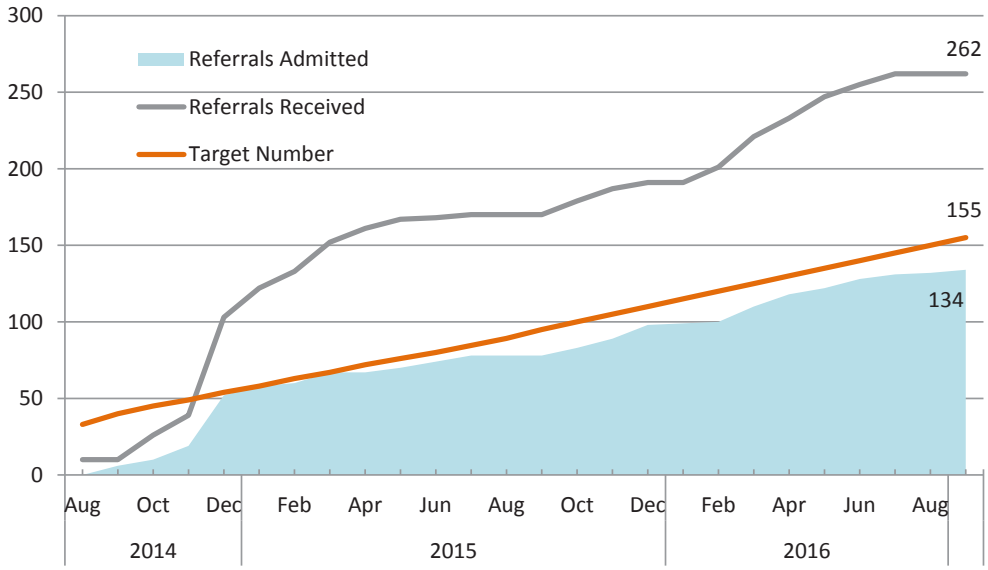
[10] Tsemberis, S. & Stefancic, A. (2011). Pathways Housing First fidelity scale (ACT version) [unpublished].
[11] Tsemberis, S., & Walker, J. (2017). Program fidelity report. Prepared for Helping Hands Hawaii Pathways Housing First Program [unpublished].

2. Referral, Admission and Discharge

Referral and Admission

The Hawai'i Pathways Project received 262 referred cases and admitted 134 (51%) clients, meeting 86% of the enrollment target. Due to a 10-month delay in executing service contracts, the Project was under great pressure to catch up with the target number, which was reached at the sixth month of program implementation in January 2015. However, the enrollment of new clients fell short again after April 2015. The last client was admitted to the program in September 2016.

Figure 2: Numbers of Referrals, Admissions, and Target Enrollment



Nearly three-quarters of referrals came from the coordinated entry system (CES) for homeless services where people with a VI-SPDAT score of 10 or higher were identified as needing permanent supportive housing. Through the Project's outreach efforts, the referral network was expanded to other service providers who didn't have access to the CES. Other referral sources included substance abuse treatment service providers (11%), hospitals (9%), community mental health service providers (5%), and others (2%). Referrals from CES had the highest admission rate, at 57%, and referrals from substance abuse treatment service providers and "other" sources had the lowest rates, at 27% and 33%, respectively.

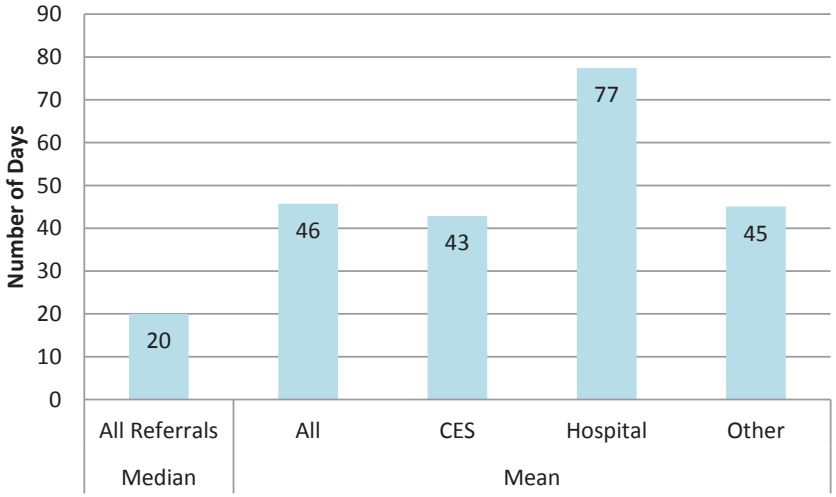
Table 3: Referral Sources

	CES	Hospital	SAT	CMH	Other	Total
Number of referrals	191	23	30	12	6	262
% of total referrals	73%	9%	11%	5%	2%	100%
% of referrals admitted	57%	43%	27%	50%	33%	51%

Note: CES—coordinated entry system for homeless services; SAT—substance abuse treatment providers; CMH—community-based mental health service providers; other—state and other community agencies.

Half of the clients were admitted within 20 days upon being referred to the Project, while the mean was 46 days (range: 0–380). People referred from hospitals took an average of 77 days, probably due to health conditions requiring extended periods of care.

Figure 3: Length of Admission Process

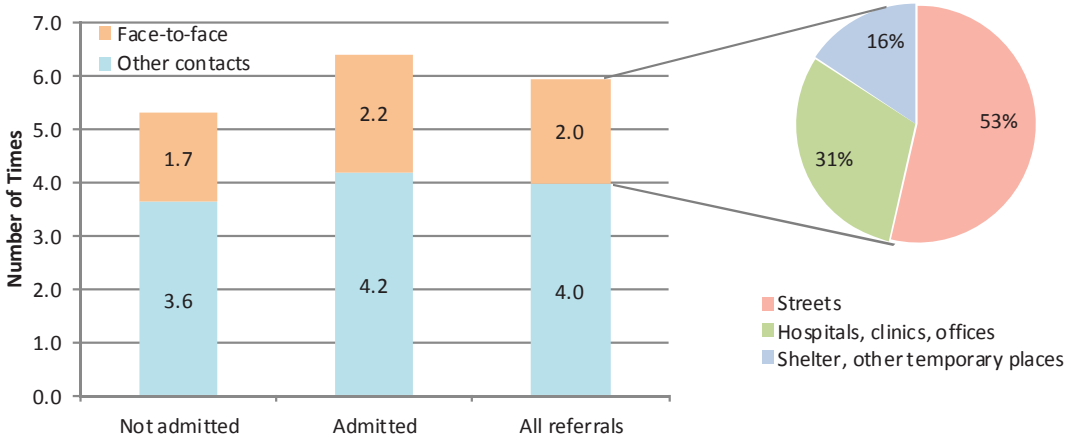


John was living in a tent on the Kapālama Canal and had no interest in being housed, but we kept showing up…. Then, we started to uncover some of his grief and trauma. [Now] he's been housed for two and a half years.
—Service team member

Note: CES stands for Coordinated Entry System for homeless services; other referral sources included community-based mental health and substance abuse treatment providers and others.

The admission process involved establishing contacts with the referrals, engaging the referrals for eligibility screening, and obtaining consent from those eligible for participating in the program. On average, the service team contacted each referral six times before an admission decision could be made. About 10% of referrals were contacted 15 times or more. Overall, one-third of the contacts during the admission process were face-to-face meetings with referrals at places in which they were located, such as: streets (53%); hospitals, clinics, or other organizations (31%); or shelters or other temporary locations (16%). About two-thirds of the contacts were made to clients by telephone or through various types of collateral contacts.

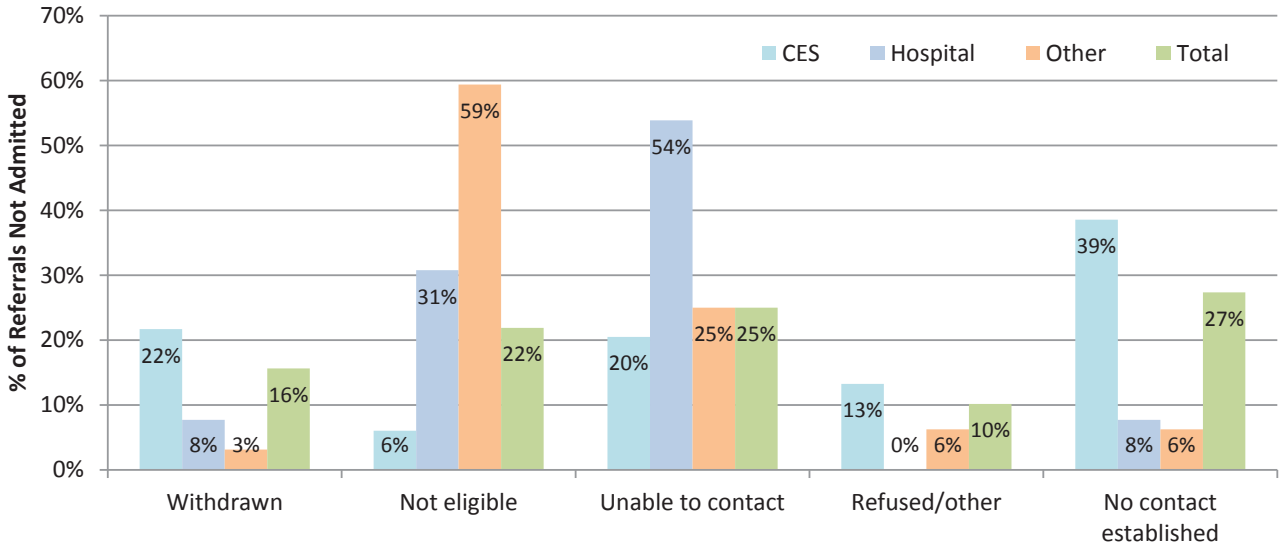
Figure 4: Type and Location of Contacts



Note: Other contacts include those made to clients by telephone or through various types of collateral contacts.

Of the 128 referred cases that were closed or denied, the main reasons were: no contacts were established with referrals before the close of Project enrollment period by September 2016 (27%); inability to contact or locate the referrals (25%); referrals did not meet program entry criteria such as low VI-SPDAT score, not homeless, or no disabilities (22%); referrals were withdrawn due to other housing opportunities, hospitalization or death (16%); and referrals refused services or other reasons (10%). People referred by hospitals were more likely to have problems in re-establishing contacts by the team after they left the hospital, whereas those referred by other community organizations were more likely to be not meeting the chronically homeless and behavioral health criteria for utilizing this program.

Figure 5: Reasons for Denial



Note: CES stands for Coordinated Entry System for homeless services; other referral sources included community-based mental health and substance abuse treatment providers and others.

Discharge

Of the 134 clients enrolled, 19% were discharged due to the client's death (9); client becoming ineligible for services (9); or client requiring long-term nursing care or hospitalization, or incarceration (8).

The remaining 108 clients (81%) were all discharged by September 2017 when the CABHI-States and Supplement grants ended. Of these clients, 85 (79%) were successfully discharged to a program with an appropriate level of continuing support. Of these clients, the majority (51) was connected to the Comprehensive Community Services (CCS) program or the case management services by Helping Hands Hawai'i. Some (29) were transferred back to their permanent supportive housing programs for case management, and a few un-housed clients (5) were admitted to another housing placement program.

Twenty-three clients (21%) were discharged without a transition plan due to lack of contact or inability to locate the client (14), client refusing services (7), or staff's safety concerns (2).

One of our graduates just came back over here to say hello. He wanted to say, "Hey, I'm still here and just want you guys to know I'm doing okay."
—Service team member

3. Clients' Characteristics

Demographics

The average age of the 134 clients was 50 years (median: 52; range: 24–76). Nearly three-quarters (72%) of the clients were men. Most clients self-identified as Hawaiian or other Pacific Islander (HOPI) or Part HOPI (40%), or white (34%). Regarding their educational attainment, most clients reported having obtained a high school diploma (38%) or higher level of education (44%). More than half (57%) had children. At the start of Project enrollment, the majority of clients (69%) was living in places not meant for human habitation while one-fourth (24%) were in an emergency shelter or Safe Haven, and the remaining clients were in an institution (hospital 3%, or residential treatment facility 4%).

Table 4: Demographic Characteristics

	Number	Percent
Gender		
Male	96	72%
Female	35	26%
Transgender	3	2%
Race		
Hawaiian or Other Pacific Islander (HOPI)/ Part HOPI	51	40%
Caucasian/White	44	34%
Asian	10	8%
Black	2	2%
Other single race/2 or more races[a]	21	16%
Educational Attainment		
Less than high school diploma	25	19%
High school diploma	50	38%
Some college	43	33%
Bachelor's degree or higher	14	11%
Have children		
Yes	75	57%
No	56	43%
Living Situation at Program Enrollment		
Unsheltered	92	69%
Emergency shelter or Safe Haven	32	24%
Hospital or residential treatment facility	10	7%
Total	**134**	**100%**

Note: Some totals are less than 134 due to missing: race (6), education attainment (2), have children (3).
[a] The "2 or more races" category does not include Part HOPI.

VI-SPDAT Score

All clients were screened by the VI-SPDAT (single person, version 1) where a score between 10 and 20 signified the need for permanent supportive housing placement. Among the Pathways clients, 57% had a higher score, between 13 and 16. Those who had participated in any programs in the homeless service system prior to enrolling in Pathways tended to have a higher vulnerability score (13 and above), compared to the new homeless service users (62% vs. 41%).

Table 5: VI-SPDAT Score and Homeless Service Utilization History

VI-SPDAT Score	New Homeless Service Users	Existing Homeless Service Users	Number of Clients	Percent of Clients
10	15	18	33	25%
11–12	5	20	25	19%
13–14	12	37	49	37%
15–16	2	25	27	20%
Total	**34**	**100**	**134**	**100%**

Homeless Experience

All Pathways clients are chronically homeless by HUD's definition. About half of them enrolled in the Project had been homeless for a continuous period of six years or more, with a similar share of clients in the range of 6 to 9 years (23%) vs. 10 years or more (26%). Three-quarters of clients (100 out of 134) have accessed homeless services before being referred to Pathways.

Table 6: Length of Homelessness

Length of Continuous Homelessness	Percent of Clients
1–2 years	23%
3–5 years	28%
6–9 years	23%
10 years or more	26%

Behavioral Health Status

The CABHI-States and Supplement grants focus on the chronically homeless population with substance use, co-occurring disorders, or serious mental illness. One-fourth of the Pathways clients were diagnosed with a substance use disorder, 15% had a serious mental illness (SMI), and 60% had a co-occurring substance use and SMI (57%) or co-occurring substance use and mental illness (3%). The majority of clients (72%) had two or more diagnoses. The top six diagnoses that affected 12% or more clients were: affective psychoses (43%), drug dependence (43%), adjustment reaction (39%), alcohol dependence syndrome (37%), nondependent abuse of drugs (20%), and schizophrenic psychoses (12%).

Table 7: Substance Use and Mental Health Disorders

Diagnosis	Number	Percent
Category		
Substance abuse only	34	25%
Serious mental Illness (SMI) only	20	15%
Co-occurring substance use and mental health disorders/SMI	80	60%
Co-occurring Substance use and...		
Mental	*4*	*3%*
SMI	*76*	*57%*
Most Common Diagnosis		
296. Affective psychoses	57	43%
304. Drug dependence	57	43%
309. Adjustment reaction	52	39%
303. Alcohol dependence syndrome	49	37%
305. Nondependent abuse of drugs	27	20%
294. Schizophrenic psychoses	16	12%

Note: Diagnosis was reported in ICD-9 codes.

Veteran Status

Twenty-five clients reported that they had previously served in the armed forces, the National Guard, or the reserves, representing 19% of all clients. Two-thirds of military veterans (68%) who participated in Pathways were diagnosed with SMI.

Table 8: Substance Use and Mental Health Disorders among Veterans

Diagnosis Category	Number of Veterans	Percent
Substance abuse only	8	32%
Serious mental illness (SMI) only	5	20%
Co-occurring substance use and SMI	12	48%
Total	25	100%

Here's the bus stop on my next station where every time I get up, this is where I go. Tripler, bus stop, and the VA….I used to go [to Tripler] every day. Now they got me going only on my appointment time.
—Mike, client

4. Service Team

The Hawai'i Pathways Project provided treatment and support services through an Assertive Community Treatment (ACT) model. Pathways' ACT team was a multi-disciplinary team that consisted of housing specialists, mental health counselors, nurses, peer support specialists, psychiatrists, social workers, substance abuse counselors, and vocational specialists. The service team held meetings 2–3 times a week to discuss cases, and to deliver services based on clients' changing needs. For example, the Certified Substance Abuse Counselor (CSAC) would visit a client who expressed interest in entering a rehabilitation program; a nurse would visit a client to treat his wound; and a peer support specialist—someone who had lived the recovery experience—would visit a client to provide support. While team members had their own specific roles, they worked together to provide the needed supports for clients to be successful in housing and recovery. For instance, an Intensive Case Manager (ICM) would take a client to a medical appointment if the team nurse was not available or to a housing appointment when the housing specialist could not.

The service team grew from three to eight members in the first year and from eight to fourteen members in the second year. However, only eight members remained on the team in the third (extension) year because some staff members decided to leave due to the uncertainty of whether the Project would be extended. The ICM-to-clients ratio was about 1 to 20, and the overall staff-to-clients ratio was maintained at around 1 to 10 until the third year when it became as high as 1 to 18. To address the staff shortage, the Project contracted Mental Health Kokua to provide peer coaching and the CHOW Project to provide housing navigation and outreach services in the last year of the Project. In addition, there were administrators at the Helping Hands Hawai'i and Catholic Charities Hawai'i who oversaw the team's effort and a Project assistant who provided clerical support.

> *There was one day where I was out doing outreach, and all I did was to help her clean her tent--that was what she needed. Her tent had roaches all over it, and old food.*
> *–Service team member*

Table 9: Service Team Composition

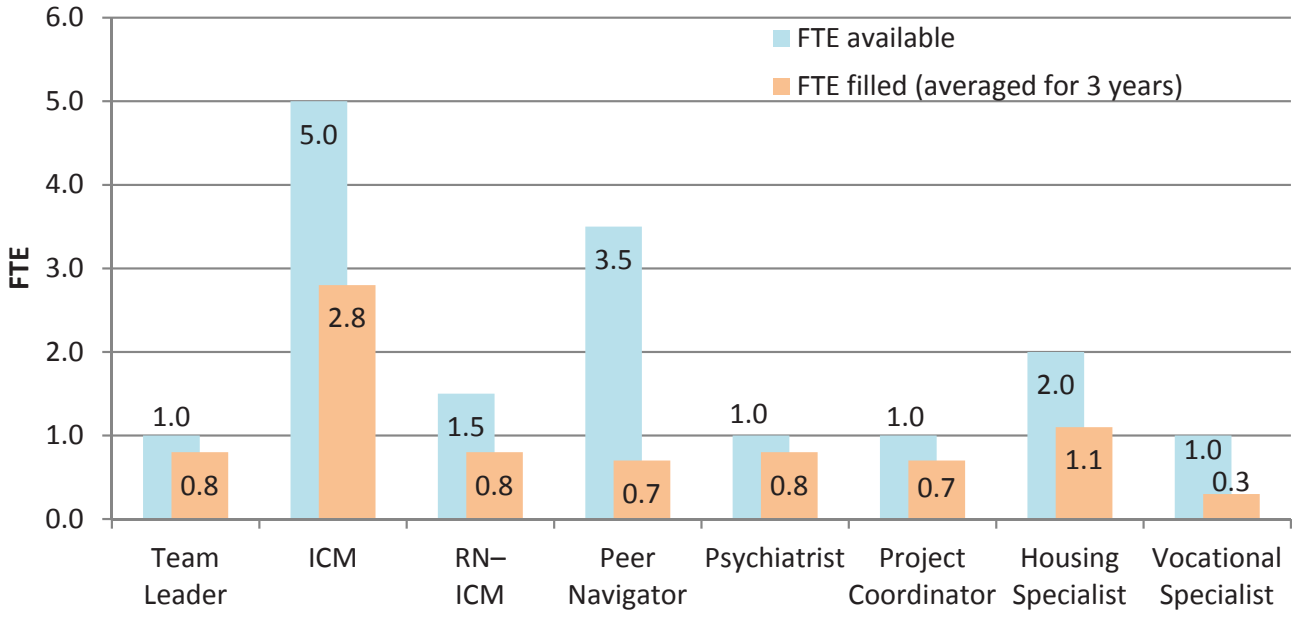
Role	Start of Program	Year 1	Year 2	Year 3
Psychiatrist/APRN-RX	1	1	1	1
Project Coordinator	1	1	1	0
Team Leader	0	1	1	1
RN-ICM	1	1	2	1
ICM – Veteran	0	1	1	1
ICM – CSAC, other	0	1	3	2
Housing Specialist	0	1	2	1
Peer Navigator	0	1	2	1
Vocational Specialist	0	0	1	0
Total	**3**	**8**	**14**	**8**

Note: Service team composition data included all positions that were filled at any length or full-time equivalent (FTE) units in the respective reporting year. APRN-RX—advanced practice registered nurse with prescriptive authority; RN—registered nurse; ICM—intensive case manager; CSAC—Certified Substance Abuse Counselor. Year 1: August 2014–September 2015; Year 2: October 2015–September 2016; Year 3: October 2016–September 2017.

One of the main barriers in reaching the Project's enrollment target was the inability to fully staff the service team. The service team had a total of 18 positions or 16 full-time equivalent (FTE) units available, but only 50% of all available FTEs were filled over the three-year period. The state's low unemployment rates (e.g., 4.1% in October 2014 and 3.3% in October 2015) could have made hiring more difficult, and certain job positions were particularly hard to fill due to required work experience or unique qualifications. The most difficult to fill was the peer navigator positions that required a Hawai'i Certified Peer Specialist credential (20% of available FTEs filled), followed by the vocational specialist (30%), housing specialists (55%), and positions with specializations in intensive case management (including ICM-Nurse, ICM-Veteran, ICM-CSAC, and other ICM) that required two years of experience serving the homeless or substance use populations (55%).

Other positions had better recruitment results at 70%–80% of the available FTEs having been filled. The Project coordinator position (filled 70% FTE) was responsible for coordinating Project's activities, connecting with partner agencies, and engaging community stakeholders. The team leader position (filled 80% FTE) required a Certified Substance Abuse Counselor or equivalent credential and was mainly responsible for running daily meetings, coordinating services, supervising staff, and providing direct services to clients. The psychiatrist or advanced practice registered nurse with prescriptive authority (APRN-RX) position (filled 80% FTE) provided assessment and medical care in the community where the clients were located.

Figure 6: Service Team Positions Available and Filled



Note: Data for the available full-time equivalent (FTE) units for each position is presented. Filled positions were calculated based on a three-year average to represent the extent to which each position was filled for the implementation period.

Due to staffing issues, the Hawai'i Pathways Project team adopted an individual caseload approach, with each client assigned to a case manager while other team members served as a backup and provided specialized services as needed. This deviated from the Pathways Housing First recommended approach to shared caseloads.

> *The morning meeting is very much like an ACT team morning meeting…. Also, individual caseloads are managed flexibly to make geographic coverage for home visits more efficient.*
> *—Program Fidelity Report, p. 7*

5. Treatment and Support Services

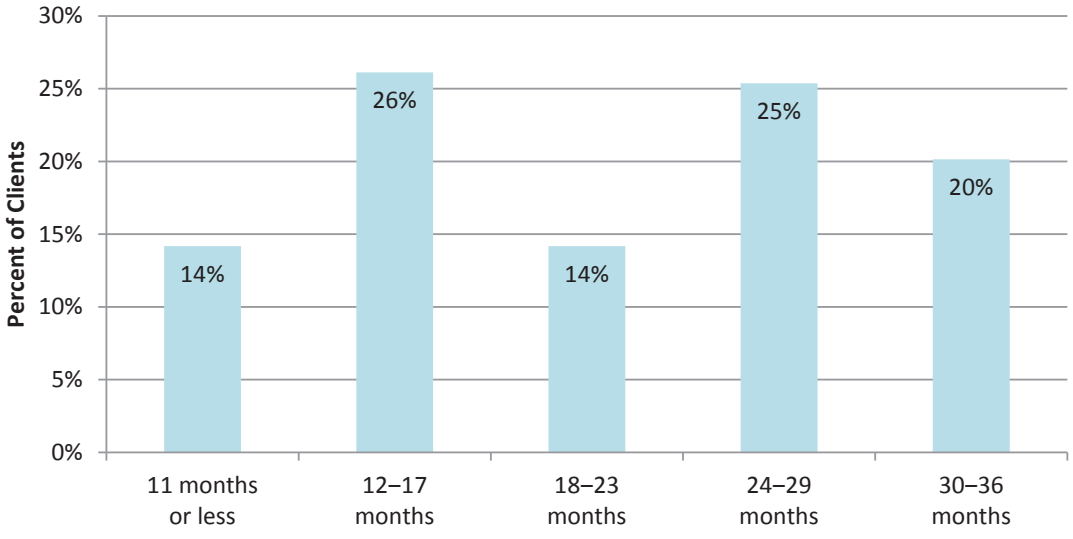
The Hawai'i Pathways Project focused on providing harm reduction and trauma-informed care for people experiencing chronic homelessness and behavioral health issues. It also offered a broad scope of treatment services directly and coordinated treatment with community providers if the clients were already connected to their own providers. Intensive case management was available for everyone, which included the coordination of medical care with providers such as hospitals, primary care providers, Waikiki Health Center, and Kalihi-Palama Health Center. Other main categories of services were housing support, peer support, employment support, and health education. Crisis response was available 24/7.

The Pathways team delivered services to clients via home visits or in places where they were needed, without time limits. Service planning was based on a client-centered approach where the client's choice drove the decision on the type, frequency and intensity of services to be provided. The service team recognized that clients have their own set of needs, experiences, characteristics and strengths, and that support should be flexible, accepting and adaptive to specific needs of individual clients. The team utilized Motivational Interviewing techniques to help clients set their own goals and worked with clients in deciding on strategies and support needed to reach those goals. As a Housing First program, Pathways clients were not required to participate in psychiatric treatment or obtain sobriety as a condition to housing; however, they had to agree to weekly home visits by the service team.

> *[This project is about] harm reduction, housing first…. If you are going to tell them [to stop], they're going to be turned off by you. We're already working with people that nobody else wants to work with, that nobody else wants to house…. So if you want to get results, you got to meet them where they're at and provide them with education and build rapport. And you're not going to see anything happen overnight, but this is the steps that it's going to take.*
> *—Service team member*

During this 38-month Project, clients were enrolled for an average of 22 months (or 648 days, ranging from 51 to 1,110 days). One in five clients enrolled for 30–36 months, 25% enrolled for 24–29 months, 14% enrolled for 18–23 months, 26% enrolled for 12–17 months, and 14% for 11 months or less.

Figure 7: Length of Enrollment



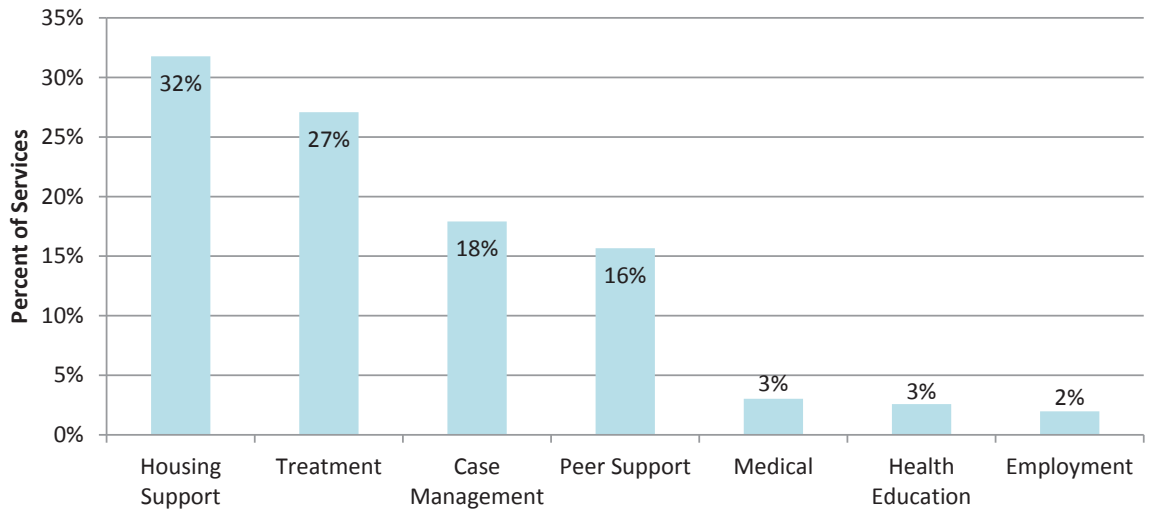
The service team reported a total of 10,549 service contacts, of which 80% were successful contacts and 20% were attempted contacts. The majority of the unsuccessful contacts were outreach attempts to clients at unsheltered locations before they were housed. The average number of service encounters (successful contacts) per client per month was 2.9 times, ranging from 0.1 to 7.7 times. The intensity was higher after, rather than before, the clients were housed, at 4.2 versus 2.8 times per month per client.

Table 10: Average Number of Service Encounters per Client per Month

Number of Service Encounters	Pre-housing Period	Post-housing Period	Overall
Mean	2.8	4.2	2.9
Median	2.5	3.7	2.9
Range	0.1–15.2	0.5–22.8	0.1–7.7

Most service encounters involved multiple types of services, with the average being 1.7 service units per encounter. While the amount of time spent for each service unit was not reported, a typical service encounter was 30 minutes (median; mean: 33.78 minutes; 90% range: 5–120 minutes). The category of services that were most frequently used was housing support services (32%), followed by treatment services (27%), case management services (18%), and peer support services (16%). Other less frequently used services were medical services (3%), health education (3%), and employment services (2%).

Figure 8: Service Utilization



Note: A total of 14,676 service units were reported from 8,432 service encounters.

During the project period, housing support services were received by 130 clients (97%) and each of these clients received an average of 35.9 service units. Housing support services were mainly provided by case managers and housing specialists, and included pre-housing services, services to support housing tenure, and re-housing services.

Table 11: Number of Clients Served and Service Utilization by Type of Service

Service Type	Number of Service Units	Number of Clients	Average Units Per Client
TOTAL	**14,676**	**134**	**109.5**
Housing Support Services	**4,663**	**130**	**35.9**
Pre-housing Services	1,705	130	13.1
Services to Support Housing Tenure	2,672	99	27.0
Re-housing Services	286	22	13.0
Treatment Services	**3,974**	**121**	**32.8**
Assessment	1,458	109	13.4
Individual Counseling	748	95	7.9
Brief Intervention	584	91	6.4
Treatment or Recovery Planning	363	84	4.3
Mental Health Services	232	62	3.7
Pharmacological Interventions	142	53	2.7
Screening	129	50	2.6
Community Integration & Recovery Suppl. Service	142	46	3.1
Co-occurring Treatment/Recovery Services	106	36	2.9
Referral to Treatment	52	24	2.2
Brief Treatment	11	10	1.1
Other Counseling	7	7	1.0
Case Management Services	**2,628**	**116**	**22.7**
Care Coordination	1,768	111	15.9
Transportation	310	87	3.6
Individual Services Coordination	535	75	7.1
Other Case Management Services	15	10	1.5
Peer-to-Peer Services	**2,299**	**92**	**25.0**
Peer Coaching or Mentoring	920	79	11.6
Peer Housing Support	851	76	11.2
Peer Navigation Services	492	56	8.8
Information and Referral	30	17	1.8
Other Peer Services	6	6	1.0
Medical Services	**444**	**69**	**6.4**
Health Education: Substance Abuse & Other	**378**	**67**	**5.6**
Employment	**290**	**28**	**10.4**

Note: Data is based on unduplicated types of services reported for each encounter. A total of 14,676 service units were reported from 8,432 service encounters, averaged at 1.7 service units per encounter. The length of each service unit was not reported. A typical service encounter was 30 minutes (median; mean = 33.78 minutes; 90% range = 5–120 minutes).

Treatment services were received by 121 clients (90%) at an average of 32.8 service units per client. Major treatment services included assessment, received by 109 clients, followed by individual counseling (95), brief intervention (91), treatment or recovery planning (84), and mental health services (62).

Case management services were received by 116 clients (87%) at an average of 22.7 service units per client. Major case management services were care coordination (111 clients), transportation (87), and individual services coordination (75). These services focused on supporting housing stability of clients.

Peer support services were received by 92 clients (69%) at an average of 25.0 service units per clients. More than half of clients used peer coaching or monitoring services (79), housing support services (76), and four in ten used peer navigation services (56). These services focused on supporting clients after they were housed. The majority of the services was provided by the peer specialists but some were offered by other service team members.

Medical services were received by 69 clients (51%) at an average of 6.4 service units per client. Pathways' psychiatrists and nurses provided community-based treatment for illness or injury, and other medical services for clients who did not have an established relationship with any medical service providers.

General health education and substance abuse education were received by 67 clients (50%) at an average of 5.6 service units per client. Pre-employment and employment coaching services were received by 28 clients (21%) at an average of 10.4 service units per client.

We would show up every single day, post-housing, for a week or two, and give the clients the consistency of care.... [We would] say, "Does your shower work? Do you have food in your fridge? Did you finish your application for your benefits? Did you collect your allowance check…?" Things like that.
—Service team member

I'm looking [at] where I came from to get here ….[It wasn't] too long [ago] or too bad. I could have probably sped [things] up if I got my head out of my rear—excuse me—and kept doing what I wanted or needed to do. [It] just took time, nothing else, to get me, to get my head, [and to] get one with myself. I didn't feel I was together as a whole. And if I didn't get with myself, I can't help myself, [and] how could I help anybody else?...The worker Camille had a lot of influence [in] getting me to wake up… She would be here [and] come to wherever I was. I could be doing whatever, and she would come to me and [say], "Hey, we got to do this. We got to do that." Basically, [she was] getting me out of my shell and into society.
—Bailey, client

6. Permanent Housing Placement

The Hawai'i Pathways Project placed clients in scattered-site private market housing, where rental subsidies were provided through existing Permanent Supportive Housing Programs in the state. Clients were required to sign standard leases with landlords and pay 30% of their income towards the rent. They had to follow the conditions of their lease in the same ways as any other renters. Housing was not contingent on abstinence or treatment, but intensive support services helped clients maintain stable housing. One of the core principles of Housing First is that housing and support services are separated. As a couple of examples, clients who have to move out of their housing by choice or due to involuntary lease termination will receive re-housing assistance rather than being discharged from the Project; clients who no longer require intensive support services will not be asked to leave their home or give up their housing vouchers.

Another core principle of Housing First is client choice. The housing specialist searched for housing based on clients' preferences, and set up unit showings to let the clients decide if they wanted to apply. Once the application was submitted and approved, the clients would sign the lease with the landlord and set up electricity or other utilities as needed. The Hawai'i Pathways Project would also furnish the apartment, provide move-in kits, and assist clients with moving their personal items.

The Project secured a total of 80 permanent supportive housing vouchers—52% of the enrollment target— through the assistance of the Hawai'i Interagency Council on Homelessness (HICH). The scarcity of rental assistance was the Project's main barrier in offering Housing First to all clients. Sources of the vouchers were the newly-funded Housing First programs by the state (20) and the City and County of Honolulu (10 from Increment I and 20 from Increment II), as well as other continuing programs funded by HUD such as Shelter Plus Care program (20), Veterans Affairs Supportive Housing (VASH, 6), and permanent supportive housing program for persons with AIDS (4).

Table 12: Source of Housing Voucher

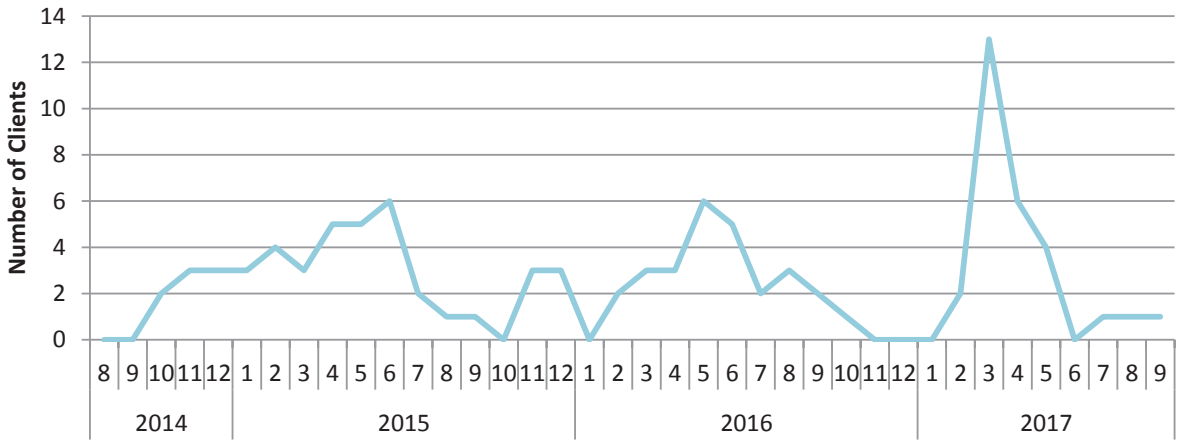
Funding Source	Organization	Number of Vouchers	Percent
City Housing First Increment I	I.H.S.	10	13%
City Housing First Increment II	U.S. Vets	20	25%
HUD Shelter Plus Care	Kalihi-Palama Health Center (10) Steadfast Housing Devel. Cor. (10)	20	25%
HUD VASH	U.S. Vets	6	8%
HUD HOPWA	Gregory House	4	5%
State Housing First	U.S. Vets	20	25%
Total		**80**	**100%**

Note: I.H.S.—Institute of Human Services; U.S. Vets—United States Veteran Initiatives; HUD—U.S. Department of Housing and Urban Development; VASH—Veterans Affairs Supportive Housing; HOPWA—Housing Opportunities for Persons with AIDS.

Before the Project started, 40 vouchers were promised; however, about half of them were not available until the second half of the first year. An additional 20 vouchers were secured in the second year and another 20 were obtained in the third year. The Project was able to place a total of 99 clients with 80 vouchers due to re-allocation of vouchers following program discharge of housed clients. Reasons for discharge are discussed in the

Housing Stability Section of this report. Overall, the housing placement rate was 74%. About 2.6 clients were placed into housing per month (range: 0–13), and the months with few or no housing placements reflected the lack of availability of housing vouchers in those periods.

Figure 9: Housing Placement by Month



The Hawai‘i Pathways Project helped 38 clients move quickly into a permanent housing unit of their choosing, defined as moving-in within four months upon entering the Project by the Pathways Housing First model. However, due to the limited availability of housing vouchers and given that about only one-fourth of the vouchers became available in the third year, half of the housed clients waited 6.1 months or longer to move into a permanent housing unit (mean: 8.5 months; range: 0.0–33.1).

Table 13: Housing Availability

Number of Months from Enrollment to Housing Placement	Number of Housed Clients	Percent
0–4	38	38%
5–8	26	26%
9–12	18	18%
13 or more	17	17%
Total	99	100%

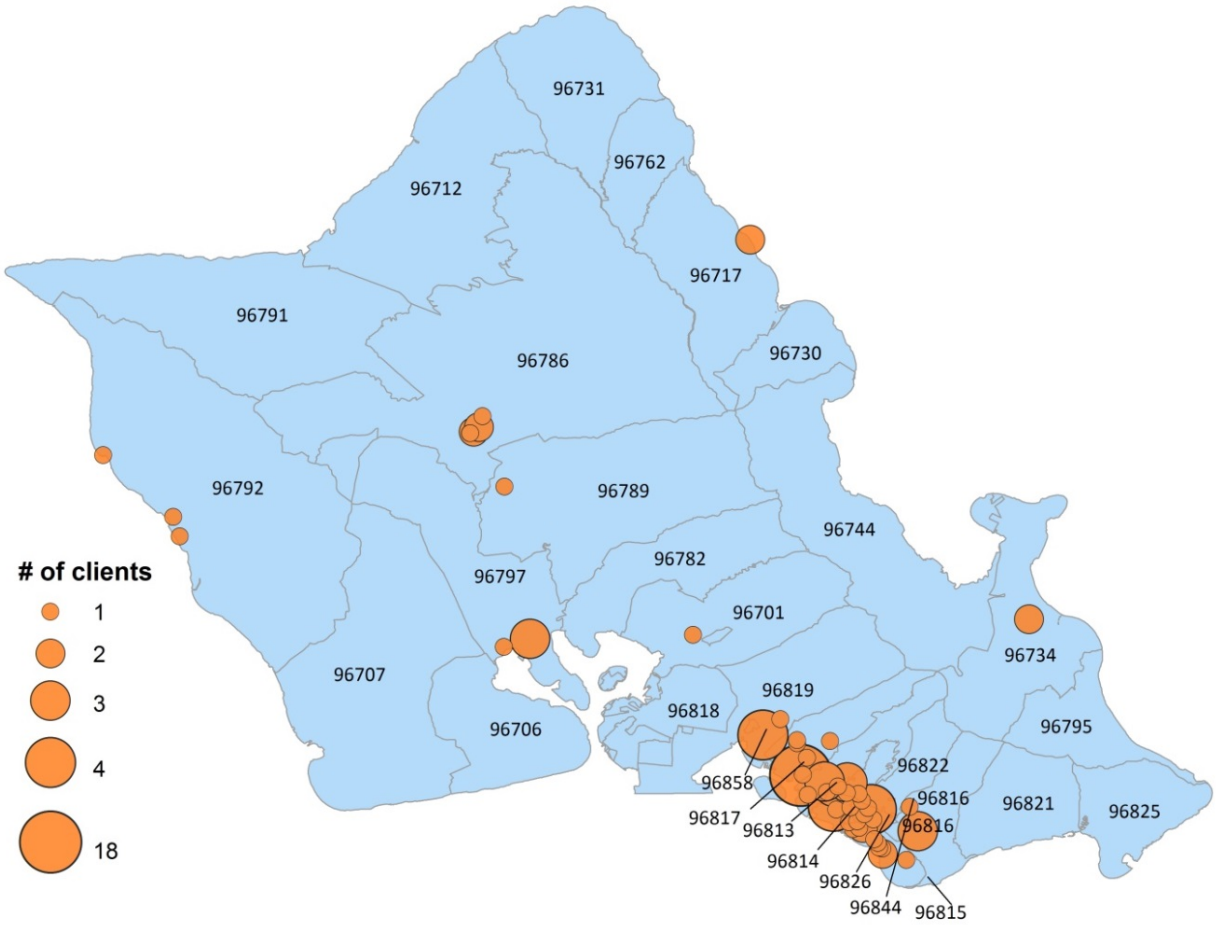
Note: Mean = 8.5 months; median = 6.1 months; range = 0.1–33.1 months.

Another major barrier to housing placement was finding landlords who accepted housing vouchers and were willing to rent to Pathways clients. More landlords became willing to rent after hearing about some initial successes of housing placements. In addition, the availability of the city’s housing complex—Winston Hale—made it possible for the Project to house 18 remaining clients in the final year.

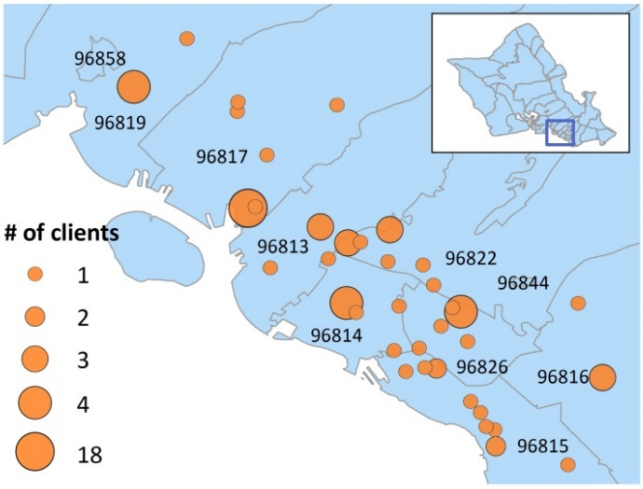
The locations of housing units rented by Pathways clients were spread across 15 ZIP code areas on O‘ahu (see Figure 10). About three-quarters of clients (73%) lived in urban Honolulu with the top three highly concentrated ZIP codes being 96817 (23 clients), 96815 (11 clients) and 96822 (10 clients).

Figure 10: Housing Location

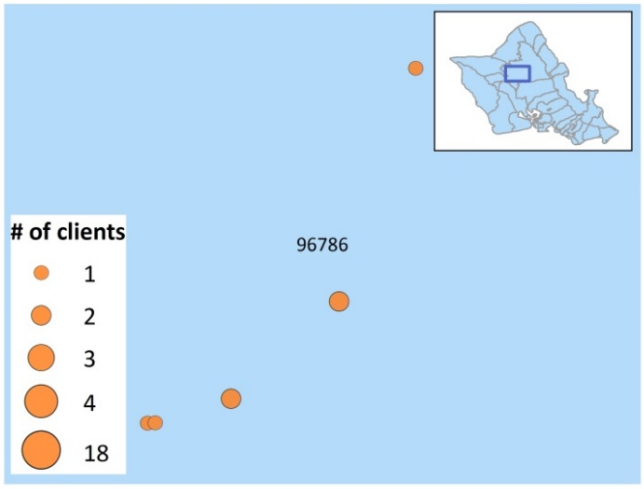
a. Island of O'ahu



b. Part of urban Honolulu



c. Zip Code 96786



PROGRAM OUTCOMES

7. Housing Stability

The top intervention priority of the Hawai'i Pathways Project was to assist chronically homeless persons with addictions and mental health challenges to obtain and retain housing. Of the 99 clients who moved into permanent housing, 11 withdrew from the Project due to death (7) or requiring nursing care or long-term hospitalization for non-psychiatric reasons (4). Of the remaining 88 clients, nine clients left for an unknown destination (3) or returned to homelessness (6), but the rest—a total of 79—were still in permanent housing at the end of the grant period, representing a housing retention rate of 90%. Hawai'i's outcome was consistent with nationwide results: Pathways Housing First model reported 85%–90% retention rate across many cities and programs in the U.S.[12] Housing vouchers of the clients were not affected by the ending of the CABHI grant. At discharge, the permanent supportive housing programs that provided the vouchers took over the case management of the clients. Some clients were also enrolled in the Medicaid's Community Care Services or received the extended case management services from the Helping Hands Hawai'i.

> *[Pathways clients] are the guys with the highest VI-SPDAT scores. [The kind of guys that some outreach] workers would say, "honestly, I don't know how this person ever going to get into housing." Now, to see Pathways figure out a way where they can provide the right levels of support that are tailored to each person to get them in housing—I think that's huge.*
> *— Governor's Coordinator of Homelessness*

Table 14: Housing Status at the End of the Grant Period

Housing Status	Number of Clients
Permanent Housing	**79**
Subsidized housing with supportive services	77
Non-subsidized permanent housing	1
Moved in with family/friend—permanent	1
Homeless	**6**
Unsheltered settings	5
Emergency/transitional shelter (including hostel)	1
Unknown	**3**
Other	**11**
Deceased	7
Long-term care facility or care home	3
Hospitalization (non-psychiatric)	1
All Housed Clients	**99**

[12] Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services.* 51 (4): 487–493.; Pathways to Housing. (2012). Pathways to Housing 2012 Annual Report.

For the clients who were housed and remained housed (79) at the end of the grant, the mean length of housing was 13.9 months and the median was 11.1 (range: 0.1–34.2). A fifth (20%) were stably housed for 24 to 34 months, more than a quarter (28%) between 12 to 23 months, another quarter (24%) between 6 to 11 months, and the remaining (28%) were housed for less than six months. The shorter housing periods were attributed to housing placement in the third year of the Project.

Table 15: Length of Housing Stability among Clients who Remained in Housing

Length	Number of Housed Clients	Percent
Less than 6 months	22	28%
6 to 11 months	19	24%
12 to 23 months	22	28%
24 to 34 months	16	20%
Total	**79**	**100%**

Note: Mean = 13.9 months, median = 11.1 months, and range = 0.1–34.2 months.

Of the 99 clients housed, 13 were relocated one to three times, and 10 of them remained stably housed at the end of the grant while three returned to living on the street. The reasons for relocation were lease violations (5), illegal or drug-related activities (4), client's choice (3), and poor physical housing conditions (1). All clients who relocated due to lease violations, choice and poor physical housing conditions remained housed at the end of the grant. However, only one of the four clients who relocated due to illegal or drug-related activity remained housed at the end of the Project.

Table 16: Housing Relocation

Reasons for Moving Out	Number of Clients Relocated	Number of Clients Remained Housed at the End of the Project
Illegal or drug-related activity	4	1
Other lease violation	5	5
Client's choice	3	3
Poor physical housing conditions	1	1
Total	**13**	**10**

Now I haven't been to the psych ward or the emergency [room] because I have a place I can try to get my head together. It makes so much of a difference. You've got a lock on the door. You can lock the door. I don't know if you guys have ever been homeless, but can you imagine trying to sleep on the street? You wouldn't feel safe. Everybody's trying to steal everything.
—Terrance, client

Of the clients who were housed, many expressed a sense of accomplishment, pride and independence when they obtained a place of their own. Having housing provided them with several positive life improvements such as the ability to more easily access public benefit programs, reconnect with their families, and care for their physical and mental health. Without a place of residence, making mental health and welfare appointments, for example, were difficult. Prior to being housed, many clients' prioritized their immediate safety first. Being housed provided safety and shifted their priorities, allowing clients to focus on other things like their appointments. They also-

became more motivated to do things for themselves, and many of them became sober enough to do so. In addition, the Pathways team members were more easily able to work closely with housed clients to provide them reminders about appointments and even transport them to appointments when needed.

Reconnecting with family members was possible when clients had a place of their own made them easier to locate. As with Bill's case, his son was able to visit, drop off food, and leave notes—things his son couldn't do when Bill was on the streets. Not only did housing stability allow for clients to reestablish relationships with others, it provided clients with opportunities to focus on themselves in ways that were not prioritized when they were homeless. No longer worried about where they would sleep or if they were safe, they were able to reengage in activities that made them happy such as creating art, caring for plants and crafting an exercise routine.

With regards to the housing process, clients had varying experiences. Some were able to get housed quickly, and others enjoyed taking time to look at different places. One participant spoke of his negative experience with signing a lease for an apartment that he later found was not well maintained. While he was unhappy with the apartment itself, he commended the efforts that the support services team provided. Others' opinions about the support staff echoed his thankfulness and appreciation of the team's critical roles in helping the clients view options, secure housing and cope with challenges.

When you're homeless, here are my little rules: in after dark, out before dawn, don't leave a mess, and don't leave a trace… just keep moving…. 5:00 I'm at the storage locker. 6:00 I'm at the Vietnam Vets. 8:00 I'm at the State Capitol…. What I've done since I've [gotten housing]—it should be simple to most people—but what I've really tried to concentrate on doing is organizing my belongings, keep everything clean. Little things like eat breakfast, take a shower, brush your teeth. Eat lunch, take a shower, brush your teeth. Eat dinner, take a shower, brush your teeth…. I've just tried to concentrate on those elements of hygiene and eating because when you're homeless it's real difficult to eat regularly and to bathe regularly. Those things are challenging.
—Richard, client

[You need to learn] how to live again. When you are homeless you have freedom…. You can do anything you like. No one can tell you nothing…. When you live in a house you have freedom, but you have responsibilities. When you are homeless you don't really have responsibilities.
—Danny, client

Acquiring stable housing required adjustments in routines and interpersonal interactions. One client highlighted how his routine consisted of him constantly moving about to survive when he was homeless. He would visit specific agencies at set times for meals and events. But after securing stable housing, his routine mainly revolved around organizing his belongings, feeding himself and taking care of his hygiene. Some other adjustments clients had to make were changing their sleeping habits, interacting with others—such as their neighbors—and personalizing their apartments.

There were challenges that clients faced throughout the housing process including breaking from old routines; creating boundaries with friends who were still homeless; integrating with the community; abiding by restrictions tied to housing arrangements; and coping with loneliness. A client spoke of her need to break routines that she had with people with whom she once used drugs. She emphasized finding other things to do that would not drive her back to homelessness. Several clients faced restrictions while housed. It was common for landlords to restrict house guests, which posed a problem for Mary who hurt her leg and needed her partner to come over to help care for her. Some clients experienced loneliness after being housed, and one client in particular felt that having housing further contributed to her depression. It was likely for clients to still feel a sense of community with their homeless friends and to help them with supplies, money or food helped to ease their loneliness.

8. Quality of Life

Employment and Education

Employment and education provide economic security and more easily allow for social integration. Volunteer work also provides social and psychological benefits. Clients were asked about their employment and education statuses during baseline and follow-up assessments. Employment status referred to whether they had current employment in a full-time (35 or more hours per week) or part-time job, and education status was defined as being enrolled in school, a GED class, or a job training program.

At baseline, 17 clients were working, volunteering or taking classes, with the number dropping by 15% at follow-up. Even though 13 clients found a job at some point during the project period, their employment tended to be volatile to changes in health and job conditions. At follow-up, the number of those looking for work (8) increased slightly and those who reported that they were disabled, retired, or not looking for work (91) dropped slightly. Overall, the changes in employment and education status from baseline to follow-up were found to be not statistically significant (at $p < 0.1$) for all clients, regardless of their housing status at follow-up.

Interestingly enough, we met Jack at 3B2 at Tripler which is the psychiatric floor. He threw something at one of our staff members when she tried to do the assessment. He went from that to housing.... He's still in the same house that he was in, and he now works full time... manages his mental health. He's working on paying his rent.
—Service team member

Table 17: Current Employment and Education Status

Status	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
Working, volunteering, taking classes	17	15	–12%	12	9	–25%
Looking for work	8	11	38%	3	9	200%
Disabled, retired, not looking for work	91	90	–1%	60	57	–5%

Note: Data included all 116 clients who completed the follow-up interview; 75 of them were housed at follow-up. No statistically significant difference (at $p < 0.1$) was found between baseline and follow-up data among all clients as well as the housed clients.

I was a waiter. I had a business of my own at one point. I've had quite a bit of good [work] experiences before [my mental illness crisis] started. Those I can't really forget, so just not really having that level of respect [working as a busboy at my age], I was not able to keep that job because it became stressful in another way. Ever since then, the team is just recommending that I just really not work right now and focus on myself, to just make sure that I'm really stronger from not drinking.
—Steve, client

Violence Victimization

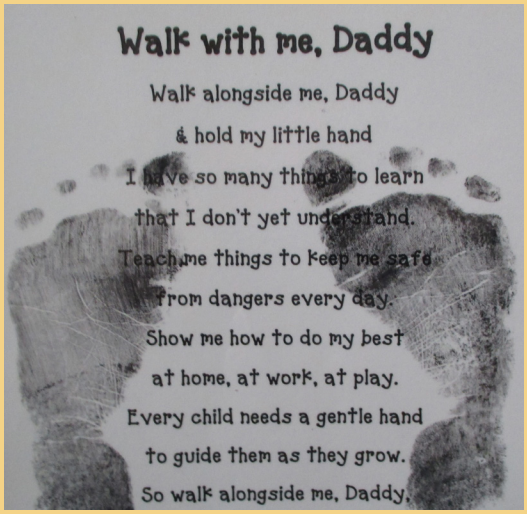
The number of clients that stated they had not been hit, kicked, slapped or hurt physically in the past 30 days increased by 23% from baseline to follow-up. For those that stated that they were physically hurt a few times or more than a few times, the number of clients decreased (60% and 33%, respectively). Positive and statistically significant changes ($p < 0.01$) were seen for those who were housed, with more of them never having been physically hurt (38% increase) and less of them being hurt (a few times: 75% decrease; more than a few times: 75% decrease).

For the last two and a half, three years, I slept underneath that truck. After living on the streets for many years, your defense mechanisms become sharpened and you know when it's peaceful. You can almost feel things coming before they come…. Sleep an hour at a time if you could, and then just wake up and then look around. If it's okay go back to sleep for a while. You never really sleep deeply.
—Richard, client

Table 18: Had been Hit, Kicked, Slapped, or Otherwise Physically Hurt in the Past 30 Days

Status	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change ***
Never	74	91	23%	48	66	38%
A few times	25	10	–60%	20	5	–75%
More than a few times	6	4	–33%	4	1	–75%

Note: Data included 105 clients who completed the follow-up interview; 72 of them were housed at follow-up. Eleven clients (including three housed clients) were excluded due to missing data. Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. Three asterisks (***) denotes $p < 0.01$, meaning that the probability for the change to occur by chance is less 1%. A significant level of $p >= 0.1$ is not presented.



My kids are my backbone in life. They are the reason I am still alive. I don't want to be a deadbeat dad, so I try to be a part of my kid's lives.
—Kale, Client

Social Connectedness

Being connected socially and positively could provide individuals with productive support that influences their progress. Clients were asked several questions that aimed to determine their social connectedness. Social connectedness comprised of their involvement within the past 30 days in religious- or faith-affiliated recovery self-help groups, other self-help groups, other organizations that support recovery, and interactions with family and/or friends who were supportive of their recovery. Overall, 74 clients reported that they were socially connected at baseline, but that number dropped by 7% at follow-up. The observed changes for all clients, as well as the housed clients, were not found to be statistically significant ($p >= 0.1$).

With regards to attending self-help groups or recovery meetings, 56 clients reported at baseline that they participated in these activities in the past month, but that number dropped by 29% ($p < 0.05$) by follow-up. A drastic and statistically significant decrease was observed among the housed clients (–38%, $p < 0.05$), with the largest decrease in their participation of religious- or faith-affiliated recovery self-help groups (–63%), followed by other recovery meetings (–47%).

A total of 60 clients stated that they had interactions with family and/or friends that were supportive of their recovery at baseline, and the same number stated the same at follow-up (60). The number of clients who were housed and interacted with friends and/or family increased slightly (by 7%) from baseline to follow-up.

Fortunately, I have a psychiatrist. I have a therapist. I have these home visits. Normally, Sao [case manager] is here at 9:30 every Monday, and then Wednesday I have my therapist visit. There's a food bank that I go to on Thursday. I'm working on getting my knee fixed…. I could just stay [in the apartment] all day and all night every day, but that's not good either. So what I'm trying to do is figure out a new routine. And it doesn't happen overnight. Sometimes I think I've done really well for the last two months, but I still have a long way to go.
—Richard, client

Table 19: Social Support for Recovery

In the Past 30 Days...	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
Socially connected	74	69	–7%	51	47	–8%
Had attended any self-help and recovery groups or meetings	56	40	–29% **	39	24	–38% **
…Number of times	*550*	*494*	*–10%*	*402*	*236*	*–41% **
Voluntary self-help groups	33	27	–18%	22	16	–27%
…Number of times	*397*	*291*	*–27% **	*292*	*142*	*–51% ***
Religious/faith-affiliated recovery groups	26	16	–38% *	16	6	–63% **
…Number of times	*81*	*105*	*30%*	*61*	*48*	*–21%*
Meetings of organizations	22	15	–32%	17	9	–47% *
…Number of times	*72*	*68*	*–6%*	*49*	*16*	*–67% *
Had have interaction with family and/or friends that are supportive of [client's] recovery	60	60	0%	41	44	7%

Note: Data included 116 clients who completed the follow-up interview, with 12–15 missing responses in each question. The number of housed clients was 75. Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. An asterisk (*) denotes $p < 0.1$, meaning that the probability for the change to occur by chance is less 1%; ** denotes $p < 0.05$; and *** denotes $p < 0.01$. A significant level of $p >= 0.1$ is not presented.

9. Involvement in the Criminal Justice System

Upon entering the Project, nine clients reported that they had been arrested in the last 30 days, with a cumulative total of 13 arrests. The number of clients and arrests decreased 33% and 54%, respectively, at follow-up. Among the housed clients, the number of clients reported being arrested in the last 30 days remained unchanged at follow-up while the number of total arrests decreased.

The number of clients (7) who had been in jail or prison in the past 30 days did not change from baseline to follow-up, but the total number of nights spent in jail or prison (40) increased by 50%. Of the housed clients, the numbers of clients and nights spent in jail or prison increased 33% and decreased 55%, respectively.

The number of clients awaiting charges, trial, or sentencing (16) decreased by 38% from baseline to follow-up. A 75% decrease (statistically significant at $p < 0.05$) was observed among the housed clients.

By follow-up, there was a 14% increase in those who were currently on parole or probation (from 14 at baseline), though not statistically significant; and there was no change among the housed clients.

Table 20: Crime and Criminal Justice Status

Status	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
Had no involvement in the system in the past 30 days	93	96	3%	63	63	0%
Had been arrested in the past 30 days	9	6	–33%	5	5	0%
…Number of arrests	*13*	*6*	*–54%*	*9*	*5*	*–44%*
Had been in jail/prison	7	7	0%	3	4	33%
…Number of nights in jail	*40*	*60*	*50%*	*29*	*13*	*–55%*
Currently awaiting charges, trial, or sentencing	16	10	–38%	12	3	–75% **
Currently on parole or probation	14	16	14%	10	10	0%

Note: Data included 116 clients who completed the follow-up interview; 75 of them were housed at follow-up. The number of missing responses for each question was: 14 for arrests, 20 for in jail or prison, 12 for awaiting charges, and 9 for parole. Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. Two asterisks (**) denote $p < 0.05$, meaning that the probability for the change to occur by chance is less 5%. A significant level of $p >= 0.1$ is not presented.

10. Progress in Personal Recovery Goals

Abstinence

From baseline to follow-up, the number of clients who reported that they abstained from alcohol or illegal drugs in the past 30 days (23) increased by 48%. For those who continued to use alcohol, the number of days where alcohol was consumed decreased (–33%). Similarly, the total number of clients who used illegal drugs and the number of days used decreased 37% and 52%, respectively. All the aforementioned changes were statistically significant ($p < 0.1$) among housed clients. In addition, the number of clients who used alcohol to intoxication with more than five drinks in one sitting, as well as the number of days intoxicated, decreased by 25% and 40%, respectively, even though the strength of evidence was low ($p >= 0.1$).

[Pathways is] keeping tabs on me. That way every week I can kind of tell them what I'm doing this week, what are my goals.... What this is all about is trying to build a new reality. The other one [homeless reality] I had down to a science, but it was tiny and it wasn't very fulfilling. What I'm trying to do is figure out fulfillment.
—Richard, client

Table 21: Drug and Alcohol Use

In the Past 30 Days...	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
Had abstained from alcohol or illegal drugs	23	34	48% *	17	24	41%
Used any alcohol or drugs [a]	74	63	–15% *	48	41	–15%
Used alcohol	51	45	–12%	30	29	–3%
...Number of days	*788*	*526*	*–33% ****	*425*	*290*	*–32% **
Intoxicated (5+ drinks in one sitting)	24	18	–25%	15	10	–33%
...Number of days	*434*	*259*	*–40%*	*261*	*109*	*–58%*
Used illegal drugs	52	33	–37% ***	35	23	–34% **
...Number of days	*771*	*367*	*–52% ****	*530*	*280*	*–47% ****

Note: Data included 98 clients who completed the follow-up interview and answered this set of questions; 65 of them were housed at follow-up. Eighteen clients didn't respond and 10 of them were housed clients. [a] Nine clients used both alcohol and drugs for a total of 97 days. Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. An asterisk (*) denotes $p < 0.1$, meaning that the probability for the change to occur by chance is less 1%; ** denotes $p < 0.05$; and *** denotes $p < 0.01$. A significant level of $p >= 0.1$ is not presented.

Of the 52 clients who used illicit drugs, the most commonly used drugs were marijuana/hashish (65%) and methamphetamine or other amphetamines (63%), followed by OxyContin/oxycodone (13%), heroin (12%) and cocaine/crack (10%). From baseline to follow-up, all five top drugs saw a decrease in the number of users and the frequency of use. Clients who were housed at follow-up reported a decrease across all individual drugs and frequency of use.

Table 22: Illegal Drug Use

In the Past 30 Days, Clients Used...	All Clients: Baseline	All Clients: Follow-up	All Clients: Change	Housed: Baseline	Housed: Follow-up	Housed: Change
Marijuana/hashish	34	19	decreased	23	12	decreased
...Number of days	*294*	*214*	*decreased*	*154*	*140*	*decreased*
Methamphetamine or other amphetamines	33	14	decreased	20	7	decreased
...Number of days	*364*	*118*	*decreased*	*195*	*58*	*decreased*
OxyContin/oxycodone	7	6	decreased	6	5	decreased
...Number of days	*85*	*81*	*decreased*	*75*	*51*	*decreased*
Heroin	6	3	decreased	5	3	decreased
...Number of days	*69*	*40*	*decreased*	*68*	*40*	*decreased*
Cocaine/crack	5	0	decreased	4	0	decreased
...Number of days	*12*	*0*	*decreased*	*11*	*0*	*decreased*

Note: Data included clients who reported using illicit drugs: 52 clients at baseline and 33 clients at follow-up. The housed group consisted of 35 at baseline and 23 at follow-up. Drugs used by less than five clients are not presented in the table.

Health, Behavioral and Social Consequences

At the follow-up interview, there was a 31% increase in the total number of clients who reported that they did not experience any alcohol or illicit drug-related health, behavioral, or social consequences. From baseline, there were fewer clients who said that their use of alcohol or drugs contributed to their stress, caused them to reduce or give up important activities, and caused emotional problems. This pattern of change was statistically significant ($p < 0.01$) among all clients and housed clients.

There really isn't a place to go if you're not ready to go through detox.... you have to be ready, and you have to show up... Steve is a great example of that. After two and a half years of us talking about it, he's finally showing up at IOP [Intensive Outpatient Program] treatment center three days a week.... he's doing it!
—Service team member

Table 23: Health, Behavioral and Social Consequences

In the Past 30 Days...	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
Had experienced no alcohol or illegal drug-related health, behavioral or social consequences	62	81	31% ***	42	57	36% ***
Had stress due to alcohol or drug use	61	33	–46% ***	40	17	–58% ***
Use of alcohol or drugs caused clients to reduce or give up important activities	46	23	–50% ***	29	11	–62% ***
Use of alcohol or drugs has caused emotional problems	51	27	–47% ***	34	17	–50% ***

Note: Data included 98 clients who completed the follow-up interview and answered this set of questions; 65 of them were housed at follow-up. Eighteen clients didn't respond and 10 of them were housed clients. Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. Three asterisk (***) denotes $p < 0.01$, meaning that the probability for the change to occur by chance is less 1%. A significant level of $p >= 0.1$ is not presented.

11. Health Status and Health Care Service Utilization

Health Status

At baseline, 70 clients rated their general heath as being fair or poor, but by their follow-up interviews, that number decreased significantly by 26%. The same positive change was observed and found to be statistically significant among those who were housed at the follow-up interviews.

The number of clients who experienced mental, emotional and behavioral hardships not due to substance abuse in the past 30 days decreased from baseline to follow-up. Drastic and significant drops (18%–38%, $p < 0.1$) were seen for those who experienced serious depression, serious anxiety or tension, cognitive difficulties, and trouble controlling violent behavior. There was also a significant decrease (47%, $p < 0.01$) in those who were considerably to extremely bothered by psychological or emotional problems not related to non-substance abuse in the past 30 days. Most of these positive changes were observed in among the housed clients, except the improvement in controlling violent behavior, which was not statistically significant.

Table 24: Health Status

Status	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
General Health Status			*			*
Excellent, very good, good	34	52	53%	24	34	42%
Fair, poor	70	52	–26%	45	35	–22%
In the Past 30 Days, not Due to Substance Use, Experienced…						
Serious depression	85	67	–21% ***	55	46	–16% *
Serious anxiety or tension	82	67	–18% **	53	44	–17% *
Trouble understanding, concentrating, or remembering	76	54	–29% ***	47	35	–26% **
Trouble controlling violent behavior	26	16	–38% *	17	10	–41%
Hallucinations	27	19	–30%	16	11	–31%
Attempted suicide	6	2	–67%	4	2	–50%
Been prescribed medication for psychological or emotional problem	43	38	–12%	31	24	–23%
Bothered by Non-substance-use-related Psychological or Emotional Problems in the Past 30 Days			***			***
Not at all, slightly, moderately	27	52	93%	19	35	84%
Considerably, extremely	53	28	–47%	34	18	–47%

Note: Data included 116 clients who completed the follow-up interview; 75 of them were housed at follow-up. Missing data for each question were: general health (12), various psychological or emotional problems (14–24), bothered by these problems (12). Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. An asterisk (*) denotes $p < 0.1$, meaning that the probability for the change to occur by chance is less 1%; ** denotes $p < 0.05$; and *** denotes $p < 0.01$. A significant level of $p >= 0.1$ is not presented.

Health Care Service Utilization

The number of clients who reported using inpatient treatment and emergency room treatment in the past 30 days decreased 50% and 19%, respectively, from baseline to follow-up. The number of clients utilizing outpatient treatment increased slightly (4%) at follow-up. For the different treatment services, clients were asked if they received care for physical complaints, mental or emotional difficulties, or alcohol or substance abuse. Except for those who sought outpatient treatment for physical issues, the number of clients dropped who sought care across all settings. A statistically significant decline was found in the use of any inpatient treatment for all clients ($p < 0.05$). The same decline applied to inpatient treatment for alcohol or substance abuse for all clients ($p < 0.01$) and for those who were housed ($p < 0.1$).

I'm trying to get back into drawing. I like to do design. I couldn't when I was on the street; things always get lost or wet or stolen. I wasn't feeling very creative. When I feel like I'm creative, I feel better, especially [with] plants because they are alive. I can't have a pet, so [the plant] is my pet [in my apartment]. They're doing really good too.
—Terrance, client

Table 25: Health Care Utilization in the Past 30 Days

Utilization	All Clients: Baseline	All Clients: Follow-up	All Clients: % Change	Housed: Baseline	Housed: Follow-up	Housed: % Change
Any Emergency Room Treatment	31	25	-19%	23	15	-35%
For physical complaint	27	22	-19%	21	13	-38%
For mental or emotional difficulties	7	3	-57%	4	2	-50%
For alcohol or substance abuse	4	1	-75%	3	1	-67%
Any Inpatient Treatment	24	12	-50% **	14	8	-43%
For physical complaint	12	9	-25%	9	7	-22%
For mental or emotional ifficulties	6	3	-50%	2	1	-50%
For alcohol or substance abuse	10	1	-90% ***	6	0	-100%*
Any Outpatient Treatment	50	52	4%	35	38	9%
For physical complaint	29	31	7%	23	23	0%
For mental or emotional difficulties	33	26	-21%	21	20	-5%
For alcohol or substance abuse	12	9	-25%	7	6	-14%

Data included 116 clients who completed the follow-up interview; 75 of them were housed at follow-up. There were about 9–13 missing responses for this set of quesions. Tests of significance were conducted on the changes from baseline to follow-up for all clients and housed clients. An asterisk (*) denotes $p < 0.1$, meaning that the probability for the change to occur by chance is less 1%; ** denotes $p < 0.05$; and *** denotes $p < 0.01$. A significant level of $p >= 0.1$ is not presented.

The number of visits for emergency room treatments, outpatient visits, and nights for inpatient treatments, all dropped from baseline to follow-up for an average of 53% decrease across settings. The decline was statistically significant for all clients, as well as the housed group (–63%, $p < 0.05$), but insignificant for the non-housed group across all settings (–33%, $p >= 0.1$).

Table 26: Frequency of Health Care Utilization in the Past 30 Days

Type of Setting	Baseline	Follow-up	% Change
All: ER, number of visits	94	43	–54% **
All: Inpatient, number of nights	355	126	–65% ***
All: Outpatient, number of visits	402	231	–43% **
All: Total	**851**	**400**	**–53%** **
All: Average per client	***8.0***	***3.7***	***–53%***
Housed: ER, number of visits	74	26	–65% **
Housed: Inpatient, number of nights	231	42	–82% ***
Housed: Outpatient, number of visits	267	145	–46% *
Housed: Total	**572**	**213**	**–63%** **
Housed: Average per client	***7.9***	***3.0***	***–63%***
Un-housed: ER, number of visits	20	17	–15%
Un-housed: Inpatient, number of nights	124	84	–32%
Un-housed: Outpatient, number of visits	135	86	–36%
Un-housed: Total	**279**	**187**	**–33%**
Un-housed: Average per client	***8.0***	***5.3***	***–33%***

Note: Data included 107 clients who completed the follow-up interview and answered this set of questions; 72 of them were housed and 35 were un-housed at follow-up. Nine clients didn't respond and three of them were housed clients. Tests of significance were conducted on the changes from baseline to follow-up for all clients, as well as housed clients and un-housed clients. An asterisk (*) denotes $p < 0.1$, meaning that the probability for the change to occur by chance is less 1%; ** denotes $p < 0.05$; and *** denotes $p < 0.01$. A significant level of $p >= 0.1$ is not presented.

It's a real blessing now, that's a peace of mind. Before I felt more [of an] outcast in society. [This] is just a step toward normalcy.
—Danny, Client

SYSTEM OUTCOMES

12. Cost Reduction

The public costs of managing the service needs of the chronically homeless people with behavioral health disorders created a significant financial burden to the criminal justice and health care systems.[13] One of the objectives of the Hawai'i Pathways Project was to reduce public costs by providing stable housing and supportive services for this population based on the Housing First approach. Due to the small number of Pathways clients reporting involvement with the criminal justice system and no significant changes found from baseline to follow-up interviews, this section focuses on analyzing cost reduction through the health care system rather than the criminal justice system.

Table 27: Estimated Health Care Cost

Type of Setting	Estimated Cost: Baseline	Estimated Cost: Follow-up	Estimated Cost: Difference
All: ER, number of visits	$115,902	$53,019	–$62,883
All: Inpatient, number of nights	$681,245	$241,794	–$439,451
All: Outpatient, number of visits	$79,998	$45,969	–$34,029
All: Total	**$877,145**	**$340,782**	**–$536,363**
All: Average per client	***$8,198***	***$3,185***	***–$5,013***
Housed: ER, number of visits	$91,242	$32,058	–$59,184
Housed: Inpatient, number of nights	$443,289	$80,598	–$362,691
Housed: Outpatient, number of visits	$53,133	$28,855	–$24,278
Housed: Total	**$587,664**	**$141,511**	**–$446,153**
Housed: Average per client	***$8,162***	***$1,965***	***–$6,197***
Un-housed: ER, number of visits	$24,660	$20,961	–$3,699
Un-housed: Inpatient, number of nights	$237,956	$161,196	–$76,760
Un-housed: Outpatient, number of visits	$26,865	$17,114	–$9,751
Un-housed: Total	**$289,481**	**$199,271**	**–$90,210**
Un-housed: Average per client	***$8,271***	***$5,693***	***–$2,577***

Note: Data included 107 clients who completed the follow-up interview and answered this set of questions; 72 of them were housed and 35 were un-housed at follow-up. Nine clients didn't respond and three of them were housed clients. Estimated costs were calculated by multiplying the total usage (Table 26) with the average cost for each type of service based on recent research literature.

[13] Moulton, S. (2013). Does increased funding for homeless programs reduce chronic homelessness? *Southern Economic Journal,* 79(3), 600–620.

Based on clients' self-reported health care utilization for the 30 days prior to their interviews, the estimated health care cost was $8,198 per client at baseline and $3,185 per client at follow-up, representing a 61% decrease and an estimated cost savings of $5,013 per client. Cost reduction was more drastic among clients who were housed at follow-up (76% decrease, estimated cost savings of $6,197 per client) compared to those who were not housed (31% decrease, estimated cost saving of $2,577 per client). The decrease in health care cost was statistically significant ($p < 0.1$) among all clients and the housed clients, but not among the non-housed group. This analysis showed that, while providing treatment and recovery services helped lowering health care cost in general, stable housing was the key contributor to significant cost savings among those who experienced chronic homelessness and behavioral health disorders.

The estimated costs were calculated by multiplying the total usage with the average cost for each type of service:

- ER visit: Median ER charge was $1,233 for the ten most frequent outpatient diagnoses based on a national study utilizing the 2006–2008 Medical Expenditure Panel Survey (MEPS) data.[14]
- Inpatient care: Hospital adjusted expenses per patient day for Hawai'i was $1,919 based on 2013 Annual Survey of the American Hospital Association.[15]
- Outpatient visit: A physician office visit averaged $199 in the U.S. in 2008 based on the Medical Expenditure Panel Survey (MEPS) data.[16]

Results of this analysis should be interpreted with caution due to data sources and certain assumptions involved in the calculations. For one, accuracy of the data relies on clients' abilities to recall health care utilization in the past 30 days. Secondly, individuals' health care utilization levels vary across time. Moreover, this analysis assumed that the 30-day service utilization is the average monthly utilization, which may not be true. An average calculated from 12 months of data could be very different from the 30-day data. Thirdly, cost estimation is based on the average cost for specific types of health services from the latest published studies and may not represent typical health care cost for the chronically homeless population. Nevertheless, these are the best data and methods available for this study.

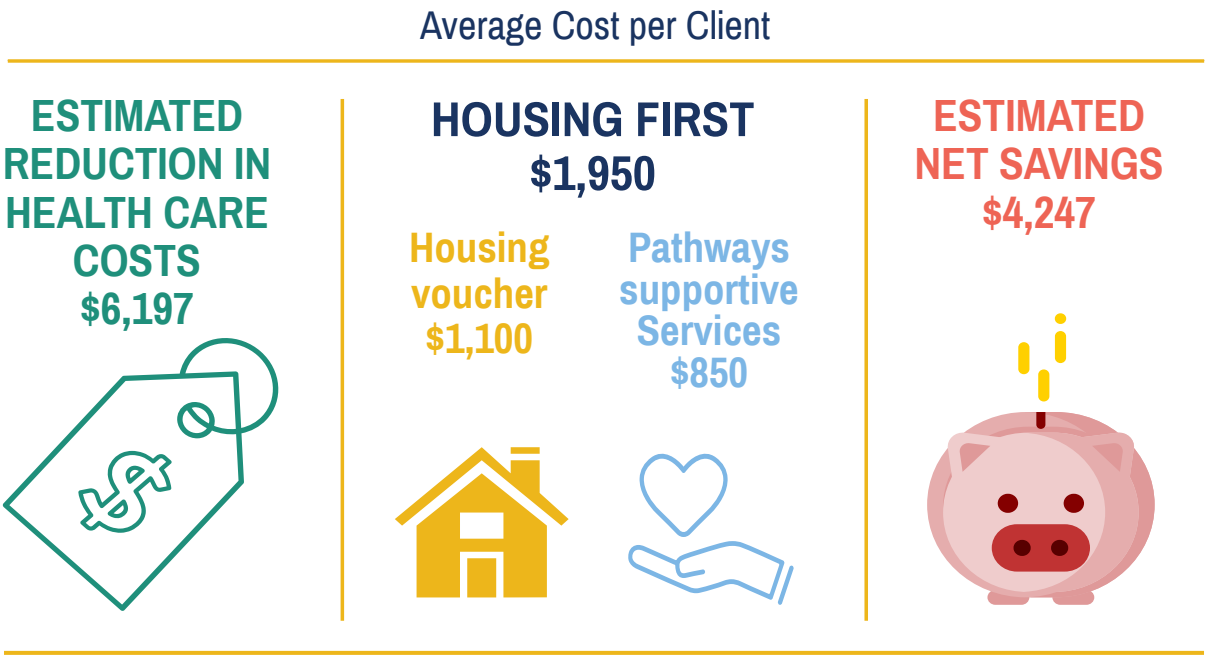
Now I am housed. Over the last seven years, I went from occasional drug user to being a drug addict, to being depressed, [having] anxiety, mental problems, physical problems all because [I was] living in a vicious cycle, you know? I didn't have no mental problems until I became homeless.... I used to run buildings; I'm a building engineer. Because I was homeless [with] no address, it is really tough to get a place. You need an address. The only way to break the cycle is you got to get out of the cycle. You got to go back to reality and get a job... my next move is get my resume together. Get my certificates together. Because now I am thinking clearly because I don't have to deal with drugs. I don't have to deal with alcohol. I deal with stress and anxieties and all of that stuff. But on a clearer level.
—Harvey, Client

[14] Caldwell, N., Srebotnjak, T., Wang, T., & Hsia, R. (2013). "How much will I get charged for this?'' Patient charges for top ten diagnoses in the emergency department. *PLoS ONE,* 8(2), e55491.
[15] The Henry J. Kaiser Family Foundation. (n.d.). Hospital adjusted expenses per inpatient day, Hawaii, 2015. *State Health Facts.* Retrieved from https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22hawaii%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[16] Agency for Healthcare Research and Quality. (2011, April 20). Hospital outpatient care represents more than 20 percent of all ambulatory care costs in U.S.. *AHRQ News and Numbers.* Retrieved from http://archive.ahrq.gov/news/newsroom/news-and-numbers/042011.html

Estimated Cost Savings for Housed Clients

Among the housed clients, the health care costs per client per month decreased by $6,197 at follow-up, which was 76% less than the costs at baseline. The average monthly rent was $1,100 per client housed by the Hawai'i Pathways Project, and the average cost for providing supportive services by Pathways was $850 per month per client. After considering these costs, the net savings equated to $4,247 per month per client.

Figure 11: Estimated Cost Savings for Housed Clients



I just want to get out and really try to work on my physical health. Get back in shape [by] getting out jogging, going around maybe the clubhouse, and then coming back around. Maybe going swimming [too]. Just try to stay really busy and active.
—Steve, Client

13. Impacts on Programs and Policies

The Hawai'i Pathways Project was the first treatment and supportive services project of its kind in the state and was an agent of change that had system level impacts. According to the Governor's Coordinator on Homelessness, Scott Morishige, there was a reciprocal relationship between the Hawai'i Pathways Project and the Hawai'i Interagency Council on Homelessness (HICH) that he chairs: the framework of the HICH assisted the implementation of the Pathways Project, such as opening doors to collaboration between the Pathways Project and other agencies and securing housing vouchers for Pathways clients. In turn, through the barriers and challenges experienced, the Pathways Project helped the council to be more effective and purposeful in addressing systematic issues. A significant step the council took was to seek consultation and training from national experts on the subject matter. As a relatively small part of the Pathways Project grant was dedicated for system-level work, some funding was instead used to secure a contract with the Corporation for Support of Housing (CSH) to contribute technical support and a broad skill set. The CSH provided consultation on matters that included financial modeling for supportive housing, case management for chronically homeless individuals through Medicaid waiver, and strategies for Interagency Council to coordinate services at a system level and to leverage resources from various departments. In addition to CSH, the training and technical assistance the Project received from the Pathways to Housing Institute also made a lasting impact on the state's response to chronic homelessness. The impact the Project had at the system level influenced training, collaboration, Medicaid waiver, and programs.

The CABHI grant was very positive in triggering a lot of things at the system level. It triggered better city-state collaboration, and within the state, [helped us] to look at resources beyond just the Department of Human Services and Homeless Programs Office to address homelessness.
—Governor's Coordinator of Homelessness

System's Capacity Building

The Project has allowed for additional training to better support the chronically homeless population. Examples include trainings on providing housing-focused case management for health plans, trainings for health plans to examine service gaps in the system, and trainings for Community Care Services (CCS) workers to engage more directly with the homeless service sector. These types of training helped health care providers to navigate the homeless service system and be more effective in helping their clients who are homeless. Besides workshops and boot camps, the partnerships that were created between the Pathways Project and the state and city's Housing First programs created a venue through which providers could share their practices.

Collaboration among State Agencies

Another major impact of the Project was the facilitation of collaboration among state agencies and community providers through the HICH. The HICH received technical assistance from the CSH to help with evaluating the coordination of services, with the goal of creating a more streamlined approach to engage various departments and agencies. The technical assistance built stronger relationships with departments such as the Department of Health and the MedQuest Division of the Department of Human Services in creating ways to get homeless people housed at faster rates. The collaboration between the state and Honolulu city and county strengthened as they worked together to see which resources complemented each other. As an example, the state had a list of chronically homeless individuals in Pathways who needed housing, and the city and county had new housing projects that had just become available with the help of the Governor's Emergency Proclamation. As a result of working together, the Project helped house a group of individuals, which accelerated the overall housing placement rate. Beyond the state and city and county agencies, collaboration within the state among the Departments of Human Services, Health, Public Safety, Transportation, and Land and Natural Resources have unfolded, and some departments have established homeless coordinator positions as a result. As different departments, community providers, and agencies encounter homeless individuals, they are better able to link these individuals to the appropriate office to get services.

The relationships between different agencies involved, such as Med-Quest, the State Homeless Coordinator, and ADAD, have gotten better. There's a lot more familiarity between each other and more trust. The relationship is stronger so that we can support each other in multiple efforts and different ways—that's one good thing that has come out of this project.
—ADAD's Project Coordinator

Hawaii's request recognizes that despite the expansive nature of its Medicaid program, it remains difficult to coordinate care for some individuals. The high prevalence of people with complex needs among those who are homeless is evidence that the service system is currently unable to provide effective services to this group…. While Medicaid cannot reimburse providers for the cost of rent or other direct housing costs, Medicaid can provide reimbursement for the health and social services necessary to keep the person housed. Inability to finance services is often the reason new supportive housing units cannot be created. Building owners and landlords are unwilling to lease units to people who are chronically homeless and have behavioral health disorders without the assurance that service providers will handle any problems that arise. Providing Medicaid payment for services increases the capacity of service providers and allows these individuals to be housed.
—Center on Budget and Policy Priorities, public comments submitted on Hawai'i's waiver application.

Medicaid 1115 Waiver Amendment Application

The technical assistance provided through the CSH was critical to the state's submission of the Medicaid 1115 Demonstration Project's amendment on September 19, 2017. The amendments, if approved, would allow for Medicaid to provide supportive housing services for chronically homeless individuals with a behavioral or physical illness, or a substance abuse diagnosis. These services will include pre-tenancy and tenancy support with the goal of assisting the target population to obtaining and maintaining permanent housing. At the time of writing, the Medicaid's decision on the application remains pending. Comments submitted by the Center on Budget and Policy Priorities, a nonpartisan Washington DC-based research and policy organization, on Hawai'i's application during-

the federal public comment period provided strong support for the application, while highlighting the importance of this proposed amendment for Hawai'i to better serve those who experience chronic homelessness.[17]

The process of preparing the application also provoked important discussion among Hawai'i MedQuest Division and contracted health plans on the training, piloting and staffing that would need to occur in order to make the transition possible, once the amendment to provide supportive housing services is approved. The proposed amendment would better align mental health and homeless services that function separately, but often have shared, overlapping interests. With an increased focus on housing and permanent support housing programs, providers in these two service areas would be more likely to hone in on the intersection between the two and what is needed to better assist the chronically homeless.

Housing Plans and Financing Model

The state have been making progress in providing housing assistance for homeless families, making rapid re-housing programs more available, and expanding the Housing First program to Neighbor Islands. However, the biggest challenge continues to be to find housing for people experiencing chronic homelessness due to Hawai'i's tight housing market and scarce supply of supportive housing vouchers. The technical assistance from the CSH through the Pathways Project's funding provided Hawai'i with a snapshot of current housing options, as well as a proposal for how to finance the development of more affordable housing to meet the needs of the homeless population based on the Point-in-Time Count estimation. While it would take time and resources to develop the housing units needed, the housing planning and financial modeling provides the necessary data for policymakers, government agencies, and community development organizations to continue the discussion and determine the feasibility of a broad system change that would house the homeless.

This is the different mix [of] white and Asian tourists. [Here's] what's happening in Hawaii.... [Tourists] think, "Oh gee, [the homeless] could get a job or they could do this [work]." They have no idea how expensive it is to live here.... When they get off the flight or the boat, [they were told,] "Don't be giving money to the homeless people, because all they do is drugs."
—Mary, client

[17] Center on Budget and Policy Priorities. (2017, October 17). Public comments on Hawaii Quest's amendment 17—supportive housing services (ID: #311765). Retrieved from https://public.medicaid.gov/connect.ti/public.comments/ showUserAnswers?qid=1892579&voteid=311765&nextURL=%2Fconnect%2Eti%2Fpublic%2Ecomments%2FquestionnaireVotes%3Fqid%3D1892579%26sort%3Drespondent%5F%5FcommonName%26dir%3Dasc%26startrow%3D1%26search%3D

DISCUSSION AND RECOMMENDATIONS

The Hawai'i Pathways Project demonstrated a successful model in housing the hardest-to-serve population among the homeless—chronically homeless adults with mental illnesses, addictions, or co-occurring disorders. Many of them also suffer from other long-term physical disabilities, HIV or other chronic health conditions. In Hawai'i, the chronically homeless population is relatively small, about 1,600 on any given day.[18] But they represent people who have the most severe service needs, being over-represented in the criminal justice system, and over-utilizing emergency and acute services in the health care system. Most have gone through shelters and attempted to stay off the streets with the help of programs but none of these services seemed to work for them; many have become reluctant to engage in services and lost their sense of empowerment. The Hawai'i Pathways Project service team members showed that, with time and patience, it is possible to engage and build trusting relationships with this highly vulnerable population and to support clients in pursuing their own journey to recovery and re-integrating into the community. The Pathways Housing First model works in Hawai'i!

In this section, we discuss the accomplishments of the Project, critically examine the barriers and challenges to the Housing First implementation, and offer some recommendations for the future considerations.

Accomplishments

Implementing Housing First with High Fidelity

The Hawai'i Pathways Project was the first and only program to implement an evidence-based Housing First model in the state. The fidelity assessment conducted by the Pathways to Housing Institute concluded that Hawai'i Pathways was implemented with high fidelity. Certain aspects of housing and the Assertive Community Treatment (ACT) approach received lower rating in fidelity and are discussed in the barriers section. Key features of the program implementation were:

a. Housing structure: Offered scattered-site housing, with clients paying 30% of income for rent;
b. Separation of housing and services: Offered housing without preconditions for treatment or sobriety, and with supportive services to maximize housing stability and prevent eviction;
c. Service philosophy: Delivered client-driven services using a harm reduction approach;
d. Service array: Provided supportive services and limited treatment services through a multi-disciplinary team and supplemented treatment services by connecting clients with other community-based providers;
e. Program structure: Delivered services primarily through home visits on a weekly basis, conducted team meetings 2–3 times a week to discuss client needs and service plans, and adopted an individual (versus shared) caseload approach to case management.

[18] Bridging the Gap and Partners in Care. (2017). *State of Hawaii homeless point-in-time count.* Retrieved from http://www.partnersincare-oahu.org/sites/default/files/2017%20Statewide%20PIT%20Report%20-%20Full%20Report%20-%20FINAL.pdf

Achieving High Housing Retention Rate

The Pathways Project served the most vulnerable group of homeless people with complex behavioral health issues. About half of clients had been homeless for a continuous period of six years or more, and almost three-quarters were diagnosed with SMI (serious mental illness) or co-occurring SMI and addiction disorders. The Project successfully placed 99 clients into permanent housing units using vouchers obtained from permanent supportive housing programs on O'ahu. At the end of the grant period, the Project achieved a 90% housing retention rate. The average length of housing was 13.9 months, with a range of 0.1–34.2. Shorter lengths of housing were due to clients being placed in the third year of the Project. The service team was committed to relocating clients. Of those who remained housed, 13 were relocated one to three times due to lease violations, illegal or drug related activities, client's choice, or poor physical housing conditions.

Transforming Clients' Lives

Stable housing transformed the lives of those who experienced chronic homelessness and complex behavioral health issues. Personal stories shared through the PhotoVoice interviews and the focus group interviews conducted by the Pathways to Housing Institute validated the impacts of the Hawai'i Pathways Project on participants' lives. There were many accounts of rebuilding relationships with adult children, slowly regaining self-dignity, feeling safe and peaceful, taking small steps to get well, thriving in keeping their apartment clean and neat, and searching for volunteer and work opportunities. From baseline to follow-up, there were statistically significant increases ($p<0.1$) in housed clients who reported, in the past 30 days, of not being physically hurt; abstaining from alcohol or illegal drugs; and not having experienced drug-use related health, behavioral, or social consequences. They also reported significant decreases ($p<0.1$) in non-drug-related psychological or emotional problems; alcohol and drug use; and decreases in drug-related health, behavioral and social consequences. The number of clients reporting good, very good or excellent health increased almost half at follow-up.

Reducing Costs

Housing takes a fundamental role in our physical and psychological well-being. From baseline to follow-up, Pathways clients reported a 53% reduction in the 30-day health care utilization. However, the decrease was found to be statistically significant ($p<0.05$) only among housed clients and not among un-housed clients. The reduction in health care utilization among the housed clients validated the association between housing and health care. After living in stable and safe housing with supportive services, the estimated 30-day health care costs of Pathways clients dropped 76%, from an average of $8,162 per client at baseline to $1,965 per client at follow-up, representing a reduction of $6,197 per client. The largest drop was found in the costs of hospital stays, followed by ER visits and outpatient visits. Considering the costs of providing permanent supportive housing for Pathways clients were $1,950 per month per client, which included $1,100 for rental subsidies and $850 for Pathways services, the estimated net cost savings was $4,247.

Filling the Service Gap

In the current system, intensive case management is available to people with serious mental illness (SMI) through Medicaid's Community Care Services (CCS) program. The majority of Pathways clients had similar diagnosis as those served by the CCS program. In fact, many of them were enrolled in the CCS prior to becoming Pathways clients, indicating that there were still some service gaps that needed to be met. People suffer behavioral health issues other than SMI are not eligible for the CCS program. While they may have access to a lower level of care-service coordination, it is not enough to meet their needs due to the additional challenges they have from being homeless for a very long time, such as having difficulty in keeping track of appointments and lacking motivation to get well. By providing intensive case management that included tenancy support, the Hawai'i Pathways Project showed that even the most difficult clients of the hard-to-serve population were able to transition successfully from being chronically homeless to stably housed.

Accelerating System Change

The Hawai'i Pathways Project was piloted during a critical time when the state's homeless service system was undergoing a paradigm shift in adopting a Housing First approach to address chronic homelessness. The involvement of the Hawai'i Interagency Council on Homelessness, through the State Homeless Coordinator who chaired the council, ensured that this pilot program was fully integrated into the larger effort of the state's response to homelessness. The State Coordinator's participation contributed to shaping the grant application that aimed to address service gaps in the system and to bring the Housing First approach to the center stage of policy discourse on chronic homelessness. This Project also impacted the system by sharing the evidence-based practices with other organizations providing permanent supportive housing services. Through client advocacy, the Project worked with the Interagency Council to facilitate collaboration across government agencies in housing, health, social service and criminal justice with the goal of stopping the revolving doors in the current service systems. At the program and policy level, the Project consulted with the Corporation for Supportive Housing to identify unmet service needs to be addressed via Medicaid Demonstration Project and to complete a supportive housing and financial plan for the state.

Barriers and Challenges

Grant Administration

The first challenge faced by the Project was the lengthy start-up period involved with implementing federal grants in Hawai'i. From the start of the grant period in October 2013 to the first referral received by the Project in August 2014, 10 months were spent on establishing the Project at the Alcohol and Drug Abuse Division (ADAD) of the Department of Health, executing the service contracts, and hiring key personnel for Project coordination at ADAD and the service team at the Helping Hands Hawai'i and Catholic Charities Hawai'i. The delays had detrimental effects on the Project. To meet the grant's enrollment expectation, the Project was given five months to catch up with the enrollment goal set for the first 15 months. While the goal was achieved, the shift of the service team's effort to focus on enrollment caused delays in providing housing and supportive services to clients. In the subsequent months, the team was able to refocus on housing placement, but the opportunity to build rapport with some clients right after enrollment was lost, which contributed to a number of clients (21) who lost touch, were unable to be located, or declined services later on. Due to the compressed Project period, after less than two years of program implementation, the service team had to stop enrolling clients and to shift their effort to transition/discharge planning in case the extension request was not approved by SAMHSA. When the one-year extension approval finally came through in the last month of the original grant period, September 2016, the uncertainty of future employment had already led to several staff members leaving the Project prematurely. Furthermore, the service contract was initially extended for six months only, which added to the challenges of the service team to recruit and retain staff during the last year of implementation. In short, grant administration delays from various sources affected the lower-than expected program enrollment and the Project's ability to recruit staff.

Workforce Availability

Workforce availability was a major challenge experienced by the Hawai'i Pathways Project. The service team had a total of 16 full-time equivalent (FTE) positions, however only eight positions were filled on average throughout the three-year implementation period. Certain positions were more difficult to fill than others due to required work experience or unique qualifications. There were two major negative impacts on the Project due to this. First, some functions of the Assertive Community Treatment (ACT) were restricted because some

positions were filled partially; the plan for establishing a Consumer Advisory Board had to be put aside due to the lack of peer navigators to coordinate the effort; and the total enrollment reached only 86% of the goal. Secondly, the staff members had to take on an increased number of clients and responsibilities, due to the looming pressure of the enrollment target. In order to improve the team's efficiency when serving clients, the team adopted an individual caseload approach, rather than a shared caseload approach that was required by the ACT model. To address staff shortage, the Project sub-contracted with other providers to offer additional services in peer coaching and housing navigation. In addition to the recruitment challenges, the Project also faced with setbacks due to staff turnover that occurred both within the service team and at the grant administration level at ADAD. At the system level, the change of state administration after the 2014 gubernatorial election resulted in a change of leadership and membership for the Interagency Council. Coupled with the staff change at ADAD, the relationship between the Project and the council went through a short period of uncertainty before the partnership regained its strength in the last year of the Project.

Housing Placement

The Hawai'i Pathways Project placed 99 clients in permanent housing with about half of these clients housed within six months upon program entry, including 38% placed within four months and met the benchmark of the Pathways Housing First model. While these could be considered great achievements, the Project was not able to house the remaining 35 clients due to the limited availability of permanent supportive housing vouchers on O'ahu. During the Project's implementation period, the scarcity of housing vouchers was evident in the fact that about 900 people experienced chronic homelessness on any given day on O'ahu but only about 220 permanent supportive housing vouchers were available each year through turnover in existing programs funded by HUD and VA, and through new Housing First programs funded by the state and the city. A second challenge was in quickly placing clients into housing when the vouchers were out of the Project's control, coming into the Project in small installments throughout the three-year period. This caused the Project to halt housing placement periodically when vouchers were out. The process was further complicated by the special conditions attached to certain vouchers, such as those designated for veterans, people with HIV/AIDS, and specific geographic placements, which the pool of clients waiting for housing did not meet. While it took time to look for apartments and engage landlords, the service team did not think these processes caused delays in housing placement. A third challenge was housing choices. O'ahu's tight housing markets and the inadequate supply of low-income apartment units limited the housing choices clients had in location and other features of their housing.[19] Nevertheless, most clients were satisfied with their housing and were appreciative of the assistance received in furnishing their apartments.

Treatment and Recovery

Treatment and recovery is a long journey. During the relatively short time that the Project's service team had in working with the clients, significant improvements were observed in the physical and psychological well-being of clients after they were housed. The use of a client-centered harm reduction approach by the service team contributed to a significant reduction in the use of illicit drugs among clients from baseline to follow-up interviews; however, the same impact is yet to be seen in alcohol abuse as many clients continued to self-medicating with alcohol. Besides, fewer clients reported participation in self-help and recovery groups or meetings after enrolling in Pathways, which was an unexpected outcome due to many clients turning to the Project for recovery support. Hawai'i's current system is not set up for people to get addiction treatment on demand. While the service team utilized a variety of techniques to engage clients for treatment and recovery, only a few clients were admitted to treatment programs during the Project period.

[19] Tsemberis, S., & Walker, J. (2017).

Recommendations

Several recommendations as a result of the Hawai'i Pathways Project pilot are provided and include expanding the Housing First program; prioritizing the needs of chronically homeless individuals and allocating appropriate resources for services; developing a Housing First learning community; and addressing the needs for positive social inclusion.

Expand the Housing First Program

Expanding the Housing First program would assist more of Hawai'i's chronically homeless individuals in getting them off the streets and reintegrated into the community. Housing subsidies and support services are the two main components of Housing First programs and would need to be funded at the levels appropriate to the needs of the participants. As Housing First has been proven to be effective, expanding the program could go a long way in assisting this population, ultimately saving public costs, especially on healthcare. In addition, the Medicaid Demonstration's amendment, if approved, will extend housing support services to the chronically homeless individuals with a behavioral or physical illness, or a substance abuse diagnosis. With a growing program, it is essential that state and counties are equally committed to its effective implementation and that care coordination among programs, providers and other related parties be strong.

Prioritize Needs

The Housing First program is a costly intervention, but when it is implemented effectively to target the hardest-to-serve people among those experiencing chronic homelessness, it is proven to save significant public costs compared to providing services in past traditional ways. The use of the common screening tool, VI-SPDAT, is the first step but should not be the only method for prioritization. It is important that providers and clients alike provide input on how to prioritize needs and how to determine best allocation of appropriate resources for services. Tracking changes in needs, resources expansion, and program outcomes will inform policy and programs to ensure public resources are used responsibly.

Develop a Housing First Learning Community

A learning community composed of Housing First team members and experienced Housing First support professionals could assist in addressing staff shortages, adhering to program fidelity, improving outcomes, and providing professional support. A learning community can take the form of monthly meetings or conference calls that create venues for all Housing First teams to meet and share their practices, challenges and solutions, which will benefit their work and prevent burnout. With the Housing First program being new to the state, many staff may rely on their past knowledge and experiences based on past traditional housing processes. The learning community will help to educate staff and help them to deprogram their thinking about the traditional housing system in order to maximize the benefits of the Housing First program. Professional supports, from technical-assistance consultants for example, could provide needed training to strengthen the effectiveness of the team and program.

Address the Needs for Positive Social Inclusion

Reintegrating those who were chronically homeless back into the community requires positive social inclusion. Part of this inclusion is to address the common resulting loneliness of homelessness and to assist these individuals in finding meaningful volunteer and other social engagement activities and opportunities. Furthermore, opportunities for clients to be included in decision-making about the future directions of the Housing First program should be provided, perhaps through the establishment of a Consumer Advisory Board. They are the ones who know best about being chronically homeless and can inform services that work best in lifting individuals out of homelessness.