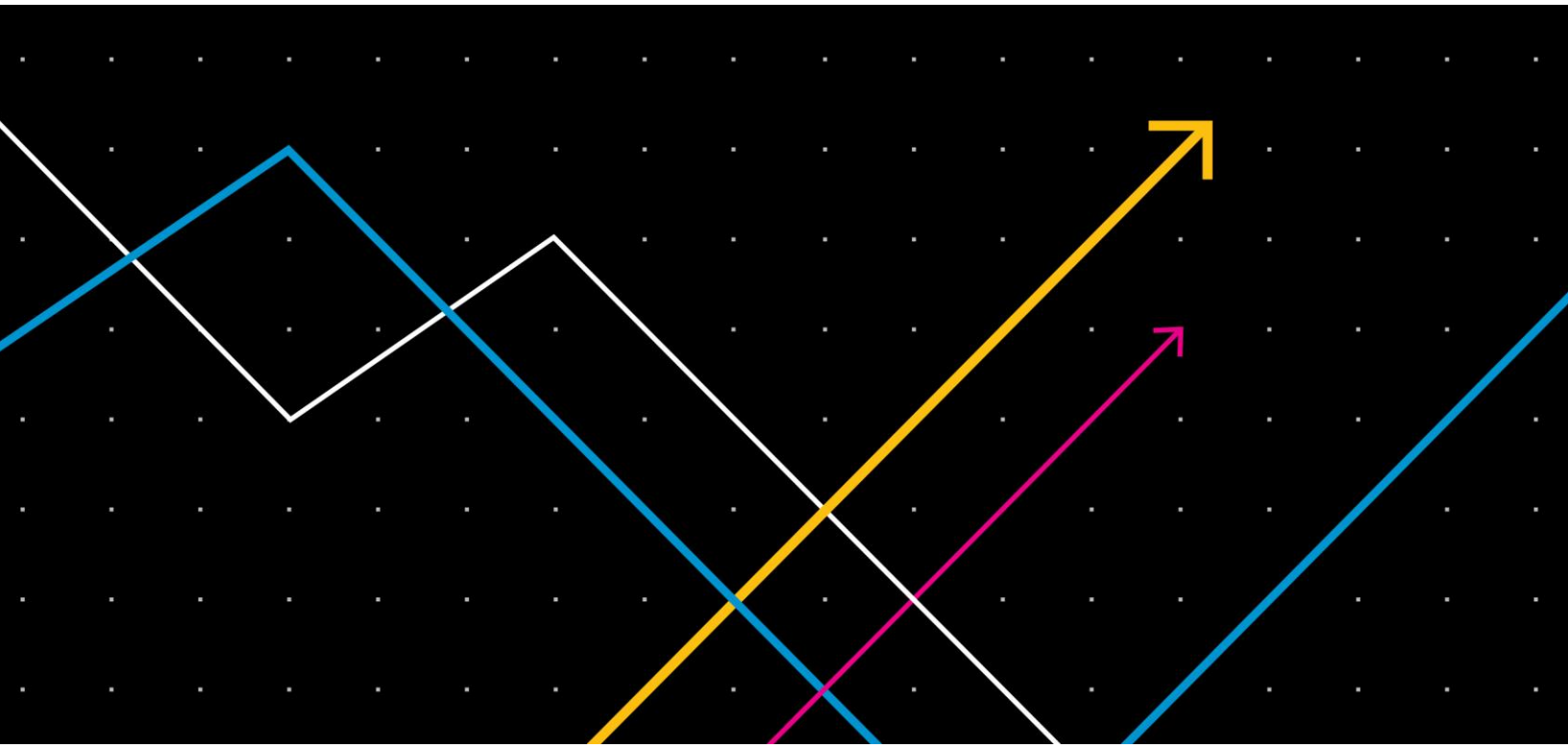

RESEARCH REPORT

From Homeless to Housed

Interim Lessons from the Denver Supportive Housing Social Impact Bond Initiative

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Contents

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Introduction

People who experience chronic homelessness cycle in and out of jail, which affects their well-being and comes at a significant cost to taxpayers. Recognizing the gap in housing service provision for this vulnerable population and the substantial cost this has on taxpayers, the City and County of Denver, along with eight private investors, funded the Denver Supportive Housing Social Impact Bond Initiative (Denver SIB). The program launched in January 2016. Two and a half years since then, the Colorado Coalition for the Homeless (CCH) and the Mental Health Center of Denver (MHCD) have engaged some of the city's most vulnerable homeless residents and placed them in supportive housing.

This report highlights key lessons and outcomes from the first two and half years of the Denver SIB program. We start by describing the problem of chronic homelessness in Denver and the role of supportive housing as a potential solution. Next, we provide an overview of the initiative, including the key partners, program model, engagement and enrollment process, and move into supportive housing. Finally, we discuss successes and challenges of engaging and enrolling participants in supportive housing and examine housing stability and jail stays, two of the Denver SIB project's key program outcomes. A companion brief, "Denver Supportive Housing Social Impact Bond Initiative: Housing Stability Outcomes," describes the housing stability payment outcomes for the Denver SIB to date.

Chronic Homelessness in Denver

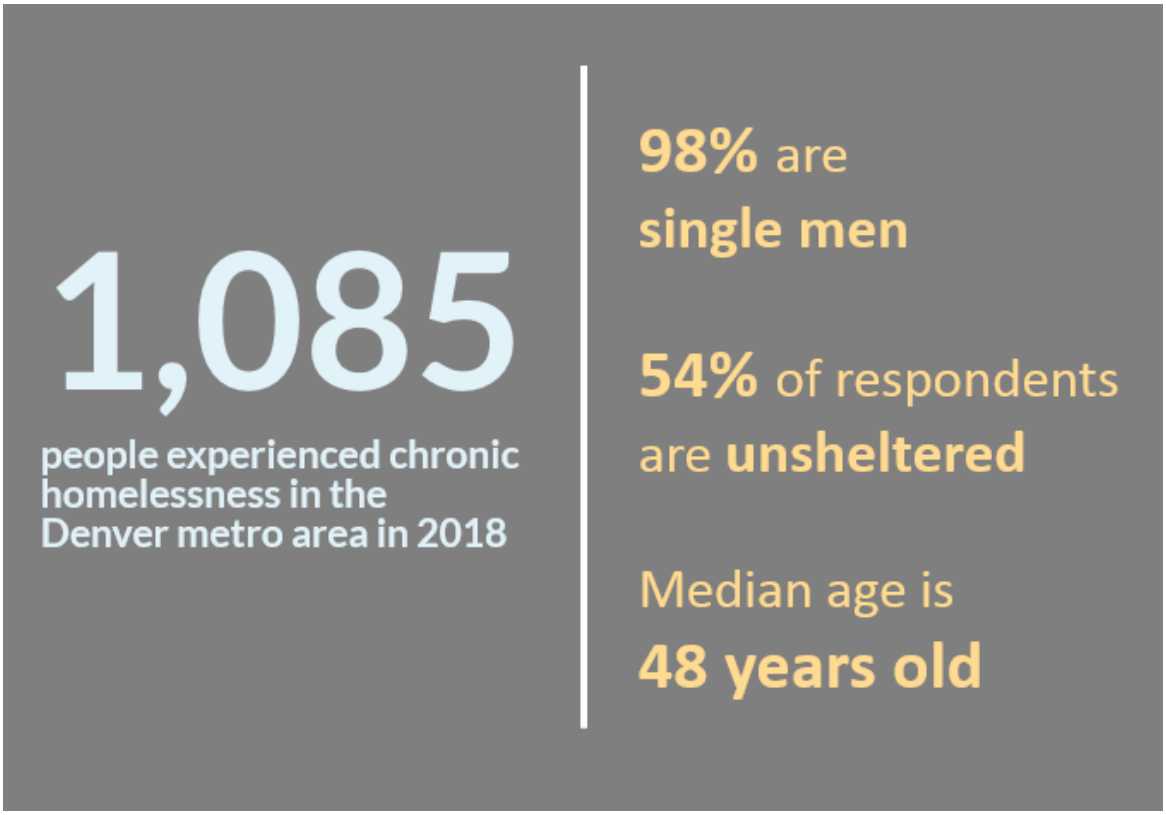
Denver has an especially high number of residents experiencing chronic homelessness compared with other US cities (HUD 2017). According to the 2017 point-in-time count, 1,085 individuals experienced chronic homelessness in 2017, and over half of these individuals live in the city of Denver (figure 1). Fifty-eight percent of people experiencing chronic homelessness are white, and 19 percent are black. The chronically homeless population represents one-fourth of the total homeless population in Denver. The number of people experiencing chronic homelessness in the metro Denver region has steadily increased since 2012, putting the city in dire need of effective programs that target chronic homelessness (Metro Denver Homeless Initiative 2017).

The rising cost of rent and limited housing supply has made securing and maintaining affordable and safe housing an increasing challenge citywide. Housing prices in Denver are increasing at a rate exceeding the national average, and there is an estimated shortage of 32,000 units in the Denver area, leading to a market with limited supply (Newcomer and Resnick 2018).[1] In the Denver metro area, the

average rent increased by 49 percent over the last decade.[2] With rising home prices and a statewide minimum wage of $9.30 per hour, a family must have almost 2.5 full-time wage earners to afford a two-bedroom apartment in the city of Denver.[3]

FIGURE 1

Population Experiencing Chronic Homelessness in Denver



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Source: Metro Denver Homeless Initiative, "2017 Point-In-Time Report. Seven-County Metro Denver Region" (Metro Denver Homeless Initiative, 2017).
Notes: The 2017 Denver point-in-time count was on January 30, 2017, and includes information on people experiencing homelessness on that night.

Local leaders have taken steps toward providing housing for individuals experiencing chronic homelessness. Denver's eight-step coordinated entry system launched in 2014 to ensure that individuals experiencing chronic homelessness in Denver are assessed and placed in permanent supportive housing through a coordinated, regional approach across the seven metro Denver counties. Over the past year, this program leased up 105 individuals, 26 families, 526 veterans, and 32 youth households (Denver's Road Home, n.d.). In 2016, the City of Denver created the Affordable Housing

Fund, which is estimated to raise $150 million by 2026 for the creation and preservation of affordable homes for low- and moderate-income families, including those experiencing chronic homelessness.[4]

Across all of these initiatives, permanent supportive housing (PSH) is a key tenet to ending chronic homelessness. There are 735 PSH beds in the Denver city and county area for single adults who experience chronic homelessness (HUD 2017). Even with these efforts, there remains a large gap in the number of beds needed to house all individuals experiencing chronic homelessness.

Supportive Housing

Permanent supportive housing combines a permanent housing subsidy with wraparound services to help people gain increased stability in their lives. Often, PSH is offered using a Housing First approach, which does not require that participants meet preconditions to entry, such as entering treatment, achieving sobriety, or committing to ongoing service participation requirements.

There is strong evidence that the supportive housing model positively affects individuals experiencing chronic homelessness. Research that focuses on housing stability finds that as many as 80 percent of chronically homeless individuals who receive PSH remain housed after one year and that shelter use significantly decreases amongst PSH recipients (Byrne et al. 2014; Listwan and LaCourse 2017). In addition, after a year in PSH, studies have found that participants have fewer days in jail than they did before their stay in PSH (Aidala et al. 2014). Not only does the evidence suggest that PSH improves outcomes for this vulnerable population, but it also shows that this intervention has promising cost offsets because of decreased jail utilization among the population receiving PSH. In New York City, Culhane, Metraux, and Hadley (2002) found that placing individuals who are chronically homeless and have mental health issues into supportive housing led to a reduction in service usage and the city's overall spending on those services. Other research found that people placed in PSH generated fewer jail costs than those who were not placed in PSH (New York City Department of Health and Mental Hygiene 2013). Though these studies emphasize the strong link between PSH and positive outcomes, rigorous research on the longitudinal effects of PSH and the mechanisms of PSH that contribute to these outcomes is more limited.

What Is the Denver SIB?

The Denver SIB aims to help people caught in a homelessness-jail cycle by providing them with supportive housing. The goals of the initiative are to increase housing stability and decrease jail stays for 250 individuals who experience long-term homelessness and have frequent interactions with the criminal justice and emergency health systems.

Innovative Funding Mechanism and Potential Cost Savings

The City of Denver and eight private investors pooled resources to fund the initiative, which uses an innovative mechanism called social impact bonds (SIB) to fund part of the program. The City signed a performance-based contract with eight private investors that provided $8.6 million in up-front capital.[5] If the program works, as indicated by performance measures outlined in the contract and validated by a rigorous evaluation, the City will repay, with a potential positive return, the private investors. If the program does not achieve its performance measures, the City will not repay the investors. The Denver SIB is one of the first supportive housing programs funded through a social impact bond financing mechanism. In addition to the funding from private investors, the initiative is leveraging additional funding through local and state housing resources from the Colorado Division of Housing and the Denver Housing Authority, and Medicaid reimbursement for supportive services.

In shifting from the frequent use of costly emergency services to preventive services, the City of Denver hopes to realize future cost offsets or savings. The Denver Crime Prevention and Control Commission estimated that chronically homeless frequent users spent an average of 59 nights in jail each year and visit detox facilities a total of over 2,000 times in a given year. The frequent interaction with jails, detox facilities, and other systems and interactions with other systems, such as detox and emergency care, cost the city an estimated $7.3 million a year.

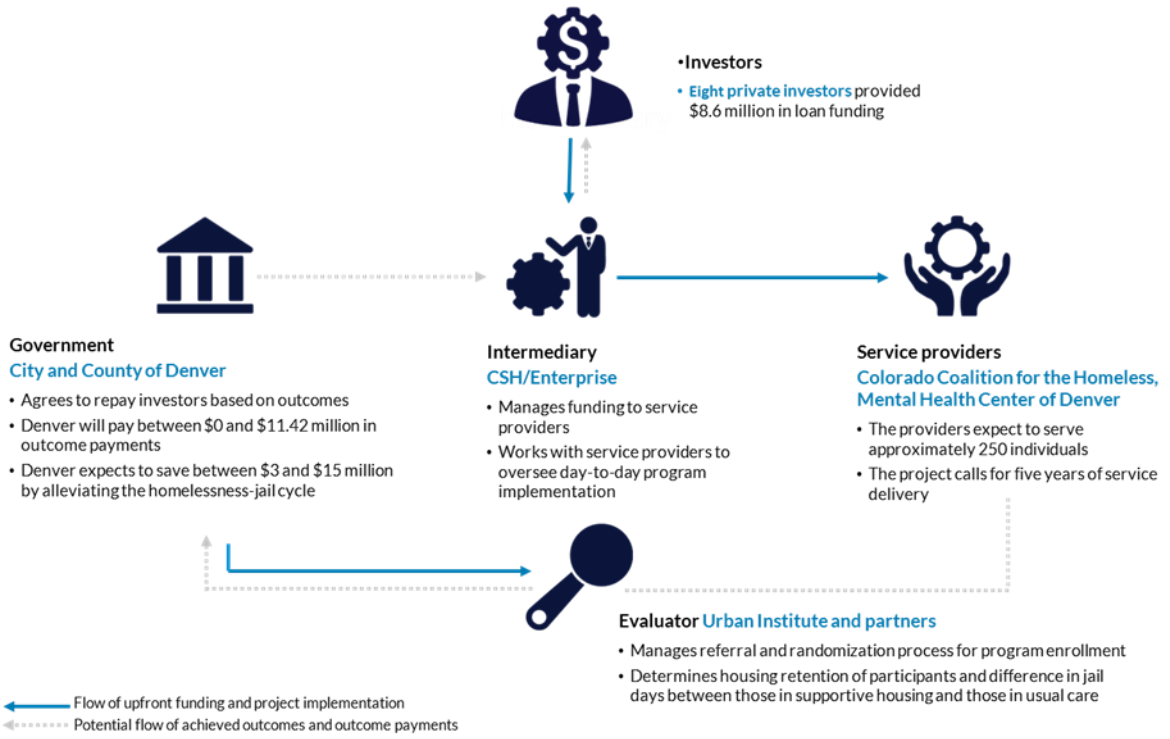
Partners

In launching the program, the City and County of Denver developed an agreement with Denver PFS LLC, an entity established by the Corporation for Supportive Housing and Enterprise Community Partners, to execute the Denver SIB. In the first year, CCH provided supportive housing services. Along with CCH, MHCD is now also providing supportive housing services in the second year of the program. Denver Crime Prevention and Control Commission provided staff for the program referral process, and the Denver Police Department (DPD) provided administrative data for the evaluation. The Urban

Institute is conducting a five-year randomized controlled trial evaluation and implementation study in collaboration with partners from the Evaluation Center at the University of Colorado Denver and the Burnes Center on Poverty and Homelessness at the University of Denver. Figure 1 shows the basic structure of the SIB project.

FIGURE 1

The Denver Supportive Housing Social Impact Bond Initiative Partners



Source: Adapted from US Government Accountability Office (GAO), "Pay for Success: A Look at a New Way for Government to Finance Prevention Programs Based on Measured Results" (Washington, DC: GAO, n.d.) and the Urban Institute Pay for Success Initiative.

Target Population

The supportive housing initiative targets people experiencing homelessness with additional challenges that result in frequent use of the criminal justice and other public systems. To create a list of eligible people, project partners defined the target population as all people having eight or more arrests with the DPD over three consecutive years. Three of these arrests had to be marked as transient, meaning the person had no address or gave a shelter's address. The DPD identified eligible people through a data pull and created a master eligibility list.

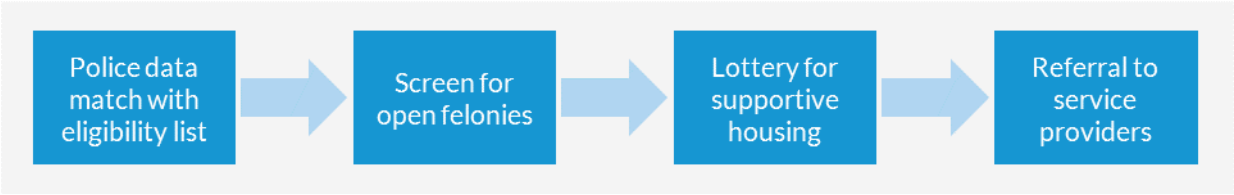
Referral Process

To refer people from the eligibility list to the supportive housing program, the DPD established an automatic report that matches daily police data with the eligibility list to identify people from the list who had a police contact or arrest in the past 24 hours. This process ensures those who are referred are still in the community and interacting with the police. Then, Crime Prevention and Control Commission screens out people with open felonies in the past two years. Project partners added this step in the first months of implementation, as these individuals were likely awaiting sentencing and may not have been able to engage in supportive housing. These individuals may still be referred later in implementation if their felony charge is closed.

Next, the Urban Institute conducted a lottery to randomly assign people for the supportive housing program (see details in the Research Design and Data Collection Methods section). Because there was not enough housing for all who were eligible, the lottery provided a fair way to allocate housing and conduct a rigorous evaluation. The individuals assigned to the supportive housing program (SIB participants) were referred to CCH or MHCD, the service providers tasked with finding them in the community and engaging them in the program. This referral process is detailed in figure 2.

FIGURE 2

Social Impact Bond Supportive Housing Referral Process



Participants were referred to the supportive housing program on a rolling basis starting in January 2016. In total, 409 individuals have been referred to MHCD or CCH. This report focuses on the 363 referred participants who were referred to the program as of January 1, 2018, using data on the first six months after each person's referral to understand progress toward participant engagement and housing.

Program Model

Supportive housing combines a permanent housing subsidy with intensive wraparound services. The Denver SIB program provides the following services:

- Subsidized housing[6]
- An Assertive Community Treatment (ACT) team
- Behavioral health services, including psychiatric services,[7] individual and group therapy, and substance use treatment
- Links to community resources[8] (e.g., food resources, legal referrals and advocacy) and to integrated health services[9] (e.g., medical, dental, vision, and pharmacy services)
- Transportation assistance and referrals

HOUSING

The program model uses a Housing First approach. To meet its goal of providing 250 individuals with supportive housing units, the initiative is using a combination of housing models, including scattered-site units rented with a housing subsidy in the private market and single-site buildings with designated units in the following apartment complexes: North Colorado Station, Sanderson Apartments, and Renaissance Downtown Lofts.

THE ASSERTIVE COMMUNITY TREATMENT MODEL

The SIB service providers employ the ACT model of intensive clinical treatment, support, and case management for residents living in PSH. The core components of the ACT model are smaller shared caseloads, a multidisciplinary team approach, clinical services provided in the home, and unlimited time frame. Largely because of resources and funding constraints, some SIB teams practice a modified ACT model where the staff-to-client ratio is slightly higher than the 1:10 ratio required in ACT. In addition, the SIB provides care to everyone in the program, regardless of diagnosis, which differs from how the ACT model is often deployed in basic health settings. But residents are served by CCH and MHCD's multidisciplinary ACT teams in their project-based buildings and at scattered-site locations.

The ACT teams can be made up of a program manager, case managers, administrative assistants, peer specialists, and nurse practitioners. Though each member has his or her role, ACT teams work fluidly together to ensure that SIB participants are provided the support they need. Service providers also have positions such as the residence service coordinator and the behavioral health therapist who work closely with the housing teams and the ACT teams to enhance communication and ensure

seamless transitions for SIB participants. In addition, service providers offer an array of programs, such as vocational training, a peer-mentor training program, money management, and grocery preparation.

Though both CCH and MHCD case managers regularly check on all their clients, residents are not required to engage in support services of any kind. Providers individualize care by assessing the needs of each client and then tailoring services with the goal of maintaining clients' housing. Overall, the ACT teams provide case management, therapeutic, and clinical services. Each case manager has a client caseload, allowing for a continuity of care. The ACT model also incorporates a team approach, as any team member—whether that be a nurse, peer specialist, or case manager—can check in with residents and provide them essential services.

Evaluation

The Urban Institute is conducting this evaluation in collaboration with partners from the Evaluation Center at the University of Colorado Denver and the Burnes Center on Poverty and Homelessness at the University of Denver. The evaluation has several components that will be reported at different stages during the five-year project: implementation, outcomes, impact, and costs.

The evaluation uses a randomized controlled trial design. Eligible individuals are randomly assigned to one of two groups—one that receives supportive housing as part of the initiative and one that receives usual care services. From January 2016 to December 31, 2017, 363 individuals were assigned to the treatment group and 361 to the control group. We restrict our analysis to the treatment group so that we can track their engagement patterns for the six months after referral. To measure outcomes and impact for these individuals, we are collecting administrative data from a variety of sources, described below. In addition, we are conducting key informant interviews with the service providers and other key stakeholders. This report largely focuses on understanding the implementation of the program and tracking housing stability and jail outcomes. In 2021, we will measure differences in key system outcomes between the groups using administrative data from the primary systems of interest, such as jails, courts, detox units, homeless shelters, and hospitals.

Research Questions

The report answers the following questions:

- How is the program implemented?
- How are eligible individuals located and engaged?
- How do participants take up housing and services?
- What are the key strategies and challenges?
- Do housed participants retain housing?
- Do supportive housing participants spend time in jail?

These questions will be answered through two primary components of the evaluation, including a process study and an outcomes and impact study, which are described in the next section. For more information on the methodology, see appendix.

Research Design and Data Collection Methods

PROCESS STUDY

Members of the research team from the Evaluation Center at the University of Colorado Denver conducted site visits and interviews with service providers and other important stakeholders. Between May and June 2018, the Evaluation Center conducted 24 interviews with leadership and key staff from CCH, MHCD Corporation for Supportive Housing (CSH), Crime Prevention and Control Commission (CPCC), Denver County Court, Denver District Probation, and the City of Denver.

OUTCOMES AND IMPACT STUDY

To collect outcomes on enrollment, engagement, and lease-ups in housing, the research team manages a program dashboard, which collects data from CCH and MHCD and tracks information on these key indicators, as well as program exits. The program dashboard data have tracked the Denver SIB since its beginning in 2016 through June 2018. We also collect administrative data on jail stays from the Denver Sherriff's Department. The jail data include information on the start date, end date, length of stay, and jail facility for each jail stay that an SIB participant had between February 2009 and July 2018. Employees at the Denver Sherriff's Department link the jail data in the Denver Sherriff Department's Jail Management System database to the SIB program participant using his or her name and CD number. Our research team worked with the data point of contact to run quality checks on the data and ensure there were no errors in the data pull process.

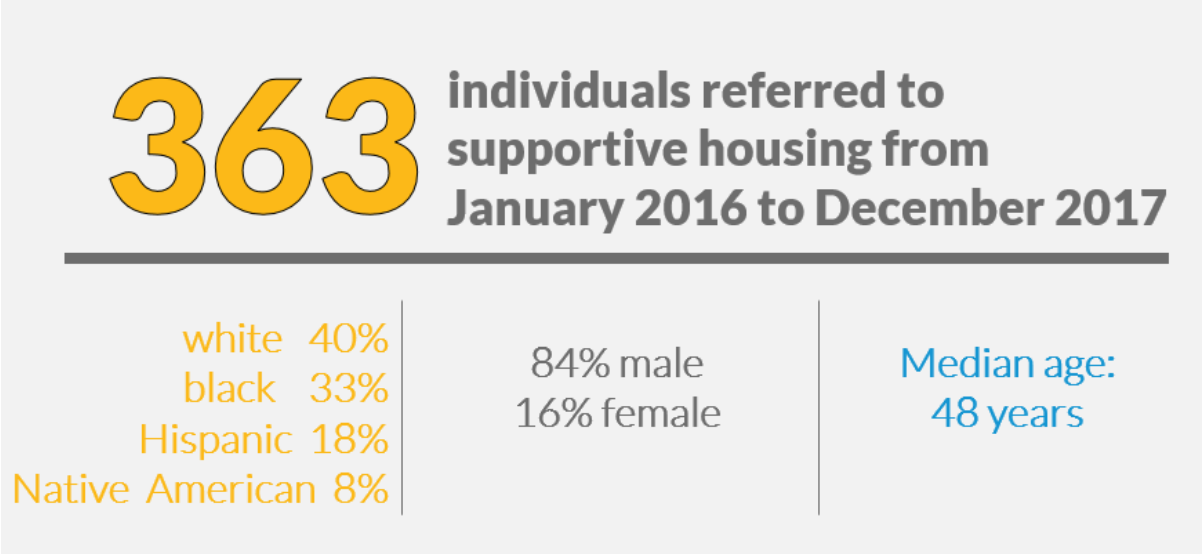
Who Is the Program Serving?

Demographics, Homelessness Histories, and Criminal Justice Involvement

Between January 2016 and December 2017, 363 individuals were referred to the Denver SIB program. As shown in figure 3, the SIB referrals are 40 percent white, 33 percent black, and 18 percent Hispanic. Most individuals referred to the Denver SIB are male, and the median age is 48.

FIGURE 3

Demographic Characteristics of Participants Referred to Supportive Housing



Source: Denver Police Department.

Individuals referred to the program had high rates of arrest during the three years before referral, with an average of 14 arrests per person from 2013 to 2015 (figure 4). On average, 12 of these 14 arrests happened when the individual identified as transient. Program participants typically interacted with police in DPD District 6, which is the downtown district and the smallest of the six police districts (figure 5). A few contacts and arrests happened in other police districts. On average, seven arrests were noncustodial (i.e., people were given a ticket but not booked into jail), and seven arrests were custodial (i.e., people were subsequently booked into jail). In the month before referral to supportive housing, 67 percent of participants had at least one interaction with the DPD: 42 percent had at least one police contact, 19 percent had at least one noncustodial arrest, and 5 percent had at least one custodial arrest.

Compared with the 2,347 people who remain on the eligibility list, the 363 participants referred to the program as of December 31, 2017, include a slightly higher proportion of men and are slightly older, but these differences are not statistically significant (appendix table A.1). There are no statistically significant differences in the number of times individuals have been arrested in the two years before the beginning of the SIB program.

FIGURE 4

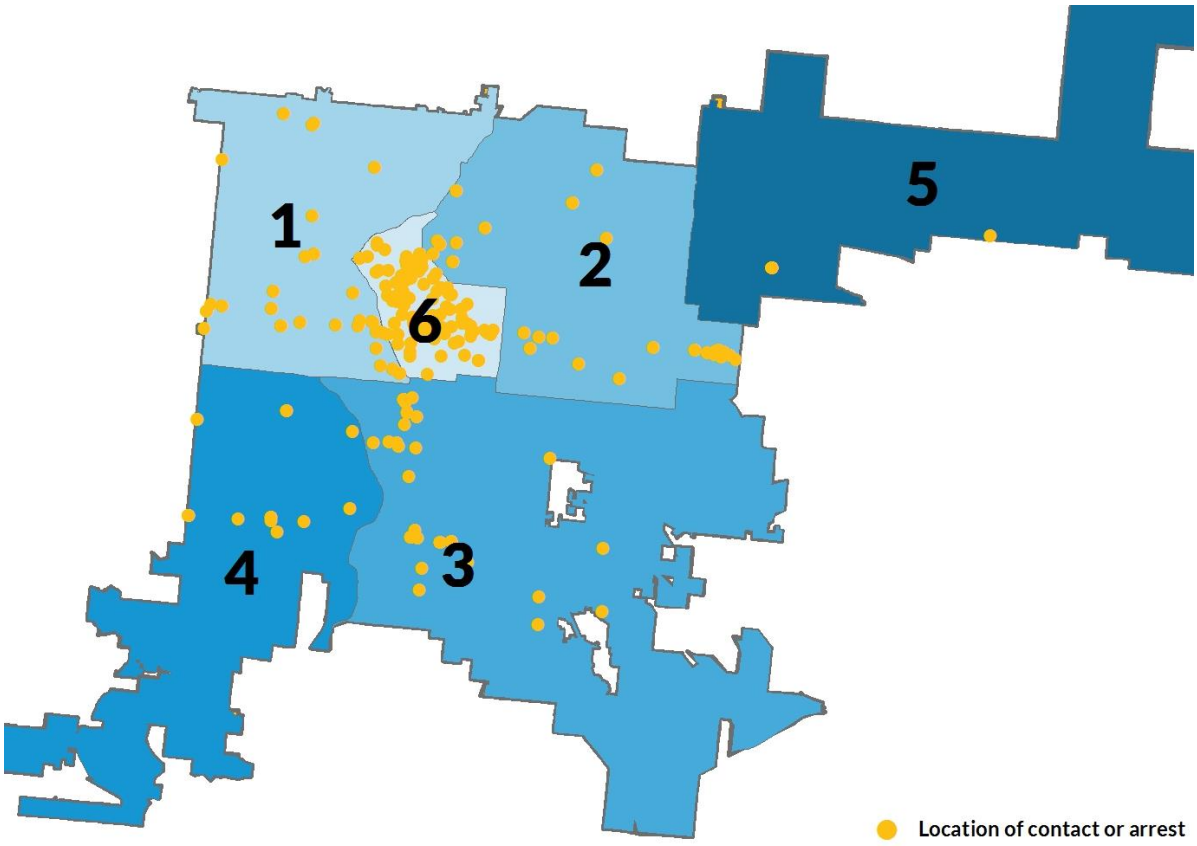
History of Arrest and Police Interaction among Social Impact Bond Participants

Source: Denver Police Department.

Of the 298 participants for whom we have homeless status information, 98 percent were experiencing chronic homelessness at the point of engagement with service providers. The total number of months an individual was homeless directly before engaging with the SIB program ranges from 2 months to more than 30 years. Of the 78 participants for whom we have a common assessment of vulnerability using the VI-SPDAT tool (a combination of the Vulnerability Index and the Service Prioritization Decision Assistance Tool), the average score is 12.4 and the median is 12.5 (scores range from 9 to 19). In general, people scoring greater than 10 on the VI-SPDAT are recommended for permanent supportive housing. In qualitative interviews the research team conducted, service providers and program administrators who worked closely on the program throughout the first year confirmed that the first participants were a highly vulnerable group, characterized by their long-term homelessness, mental health diagnoses, substance use, physical health issues, and their resiliency to survive on the streets despite these many challenges.

FIGURE 5

Map of Participant Police Contacts and Arrests by Police District



Source: Denver Police Department.

Note: This map shows the location of social impact bond participants at the time of the new police contact or arrest that made them eligible for referral to supportive housing.

How Is the Program Enrolling and Housing Participants?

After referral, Urban tracked four key milestones in the engagement process, beginning with participant location and participant engagement in the program, followed by housing application approval and lease-up in housing (figure 6). CCH and MHCD moved many participants through the engagement milestones.

We use two types of analysis to discuss the share of participants who made it to each milestone within six months. The conditional analysis (figure 7) shows the share of participants who reached each milestone based on whether they had reached the previous milestone and the average time between each milestone. The unconditional analysis (tables 1–4) shows the share of all referred participants who reached each milestone, regardless of whether they reached the previous milestone, and the average time to each milestone from program referral date.

These analyses are useful for different reasons. The unconditional analysis may help other supportive housing projects and evaluators understand sample size issues and what share of the target population they might expect to lease up in housing. The conditional analysis may provide benchmarks for other supportive housing providers to compare, for example, how many participants they might lease up in housing (and how quickly) once they have a voucher. In addition, we provide findings from qualitative interviews with SIB partners that highlight challenges and successes from each milestone in the referral and engagement process during the first year of implementation.

FIGURE 6

Milestones Tracked in the Engagement Process

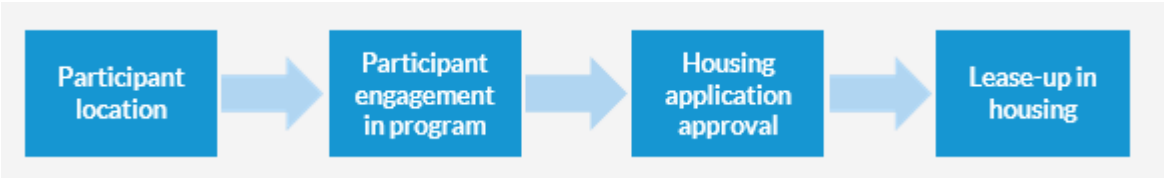
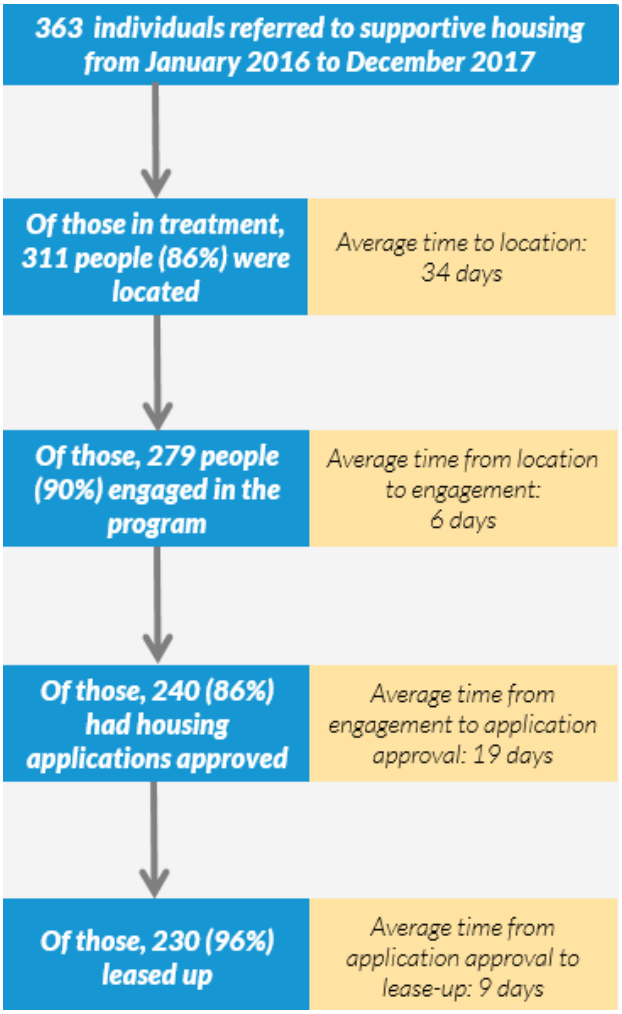


FIGURE 7

Conditional Engagement Analysis



Source: The data are from the Colorado Coalition for the Homeless and Mental Health Center of Denver program data from January 1, 2016, to July 1, 2018.

Note: Only individuals who had been referred to housing before January 1, 2018, are included. The data represent the first six months after referral to the program.

Participant Location

Participant location refers to the date CCH and MHCD made direct contact with the participant. Within six months of referral to the program, 311 people (86 percent) were located. Most of these individuals were located before the six-month mark, with over half located in the first month and 81 percent located within four months. On average, it took 34 days to locate a person referred to the program, with a lower median of 16 days between referral and participant location (table 1).

TABLE 1

From Referral to Participant Location

	N	1 month	2 months	3 months	4 months	5 months	6 months	Mean days since referral	Median days since referral
Locating participants	363	55%	69%	75%	81%	84%	86%	34	16

Source: The data are from the Colorado Coalition for the Homeless and Mental Health Center of Denver program data from January 1, 2016, to July 1, 2018.
Notes: Only individuals referred to housing before January 1, 2018, are included in this table. Only participants located in the first six months after referral are included in this table. Percentages by month after referral are out of all 363 individuals referred between January 2016 and December 31, 2017. The mean and median are calculated only among those who were located.

Partner Perspectives on Challenges and Strategies

Because of individuals' unsheltered status, locating potential SIB participants was challenging for both CCH and MHCD. The most effective strategies for finding participants included building partnerships with service providers outside of the program, coordinating outreach with local health and law enforcement agencies, maximizing internal resources, triangulating data, and educating the community about the Denver SIB program.

As experienced by CCH during their Denver SIB rollout in the first year of the program, many SIB participants were in locations throughout the Denver area, which makes locating them difficult. MHCD team members were spread very thin in their initial attempts to just "hit the streets." MHCD's peer specialist was most successful in the initial outreach attempts. The fact that MHCD is known as a mental health agency and not known particularly as a housing provider was an added challenge. One interviewee described the challenge this way: "Word spreads that the Mental Health Center of Denver is looking for you.... Okay, I'm avoiding that because that can't be good." But interviewees reported that once MHCD staff were able to talk to the individual, they were able to explain that "It doesn't mean that

you are mentally ill…in fact, you don't have to participate in any of that part. We just want to give you housing."

To overcome the challenges associated with locating participants, CCH and MHCD both leveraged long-standing relationships in the community. They relied on other service providers, community centers, churches, and homeless shelters to help locate participants. This grassroots outreach strategy was an "all hands on deck" approach to finding individuals referred to the SIB. One person told us that "outreach came from relationships we already have with [other service providers] in Denver…using community partners to check their databases using [the Homeless Management Information System]." Another interviewee mentioned that, as the service provider, they would provide the names of individuals they were looking for to outreach workers from a homeless shelter; these outreach workers might recognize an individual on that list and say, "Hey, I recognize you from this housing list [for the SIB program]. Would you want to come with me and talk to them about that?" The importance of these community partnerships cannot be understated.

In addition to coordinating with local homeless service providers in the community, CCH and MHCD worked with local health and criminal justice agencies to help locate individuals. Service providers found that this was an effective way to find people before they were released and were, again, difficult to locate. In early implementation, CCH coordinated with the DPD's Neighborhood Impact Team, attending roll call and talking with police officers about the program. Community education was also a key component in getting buy-in and assistance from local agencies. One staff member said, "Really educating [the community] about the project so that they don't just dismiss people [whom] they see constantly…[and] [whom] we're actually looking for." Through MHCD's co-responder program, a partnership with the Denver Police Department where MHCD sends trained clinicians with Denver police officers to help respond to people in need of mental health support, several MHCD staff worked inside the jails and notified the SIB team when someone they were looking for was in jail. Where possible, staff picked up SIB participants upon release and immediately placed them in housing. Doctors and others in emergency rooms often knew the person that a case worker was looking for and contacted the service provider when they saw them next.

In addition, CCH and MHCD used a variety of tools to locate participants. The CCH team triangulated data using global information system (GIS) maps created by Urban of police contacts, from photographs, and from data from Homeless Management Information System and their own electronic health record. They also distributed program brochures and outreach cards to service providers and co-responders, mental health professionals who work closely with police officers. Similarly, MHCD used a combination of maps and photographs to help locate individuals and to educate their local partners on

whom they were looking for. Occasionally, staff found an individual already in MHCD's medical records system and would connect with their clinician to make contact and offer housing.

Participant Engagement

Participant engagement refers to the date CCH and MHCD conducted the housing screening to verify homelessness status and the person agreed to move forward in the housing process. At the six-month mark, 77 percent of referrals to CCH and MHCD were engaged in the program. More than half of participants (59 percent) were engaged within two months of referral, and 70 percent were engaged within four months. On average, it took 38 days from referral to engagement (table 2), but most of this time was spent locating the person. The median time it took to engage participants was 20 days.

TABLE 2

From Referral to Participant Engagement

	N	1 month	2 months	3 months	4 months	5 months	6 months	Mean days since referral	Median days since referral
Engaging participants	363	47%	59%	65%	70%	75%	77%	38	20

Source: The data are from the Colorado Coalition for the Homeless and Mental Health Center of Denver program data from January 1, 2016, to July 1, 2018.

Notes: Only individuals referred to housing before January 1, 2018, are included in this table. Only participants engaged in the first six months after referral are included in this table. Percentages by month after referral are out of all 363 individuals referred between January 2016 and December 31, 2017. The mean and median are calculated only among those who were located.

When we limit our analysis to only the participants whom CCH and MHCD could locate, all but 32 individuals (90 percent) were engaged in the program within six months. Once people had been located, engagement happened quickly. Of those engaged, 81 percent engaged within a day of being located. Another 7 percent engaged within one week. Nineteen people took between four weeks and five months to engage.

Seventy-seven percent of individuals referred to the SIB program were engaged within six months of referral.

Partner Perspectives on Challenges and Strategies

Service providers were skilled in engaging participants because of their respectful, informed, and supportive approach. Many program participants were apprehensive about their potential involvement in the program, and their consistent interactions with police and the criminal justice system caused fear and distrust. Additionally, some program participants had lost hope in finding housing on their own, as they believed their criminal backgrounds would preclude them from housing opportunities. Engagement demanded skilled, compassionate, and experienced staff and coordination among local agencies.

The service providers used different techniques to help build trust and rapport with participants. All staff were direct in explaining that PSH offered a safe and comfortable home, and they clearly emphasized that participants were not required to engage in any services. CCH used such techniques as motivational interviewing and leveraging partnerships with external community agencies to enable the transition into housing. These techniques, according to program staff, contributed to increased participant trust and buy-in: "We operate [in the] realm of building rapport and trust in a really short period of time, and the way that you do that is through allowing someone to dictate their service provision as much as possible because there is a power dynamic, and we try to minimize that." When staff were introducing the program to potential participants, MHCD realized many were hungry and took them to get a meal while they talked about the program and the supports that would be available.

In addition, both service providers worked with the jail and court system to improve engagement. CCH dedicated one outreach staff member for all jail contact and obtained an approval letter to have access to the jail once a week. Before participating in the SIB, project partners informed and educated individuals working in the court system about the SIB project and its target population. The team worked with individuals who most often are in contact with SIB participants, such as judges, attorneys, and probation officers, and paved the way for incarcerated individuals' potential release to the SIB team. Once the team found individuals who were in jail, they accompanied them to court dates and communicated with the judges and attorneys to encourage their early release.

Though both service providers were ultimately successful, they faced a number of challenges. Despite having access to the jails, staff noted that it was not an environment conducive to establishing trust and relationships with potential participants. Nearly all of the individuals in the target population have significant substance use and mental health issues, which presented challenges during the engagement process.

Housing Application Approval

Housing application approval refers to the date the participant received approval to lease up into a unit. Within six months of referral, 68 percent of referrals had approval to move forward with finding and leasing up in housing. About half had housing approval within two months of referral. The share increased to 66 percent at five months. It took an average of 50 days from referral to housing application approval, with a lower median of 37 days between referral and approval (table 3).

TABLE 3

From Referral to Housing Application Approval

	N	1 month	2 months	3 months	4 months	5 months	6 months	Mean days since referral	Median days since referral
Engaging participants	363	30%	47%	55%	61%	66%	68%	50	37

Source: The data are from the Colorado Coalition for the Homeless and Mental Health Center of Denver program data from January 1, 2016, to July 1, 2018.

Notes: Only individuals referred to housing before January 1, 2018, are included in this table. Only participants approved in the first six months after referral are included in this table. Percentages by month after referral are out of all 363 individuals referred between January 2016 and December 31, 2017. The mean and median are calculated only among those who were located. In cases where the housing approval process was done through the social impact bond subsidy instead of the US Department of Housing and Urban Development subsidy, we use the lease-up date in housing as a proxy for housing application approval.

Partner Perspectives on Challenges and Strategies

The approval of participants' housing applications was a time-intensive process and is the prerequisite to leasing up participants. Successful strategies included the use of bridge housing, the modified ACT model, and team members' communication, flexibility, and commitment.

Once individuals were found and engaged, MHCD and CCH placed them in bridge housing. Bridge housing was used as a safe place for clients to stay while the service providers helped assemble the documents necessary to get them a housing voucher. In addition, bridge housing helped to keep clients engaged before the approval of their application. Examples of bridge housing options within MHCD's portfolio include a group home setting where residents share a common area and kitchen, an apartment complex with entirely separate units, and units that are segregated based on gender. On occasion, MHCD will temporarily house an individual in a local motel, but most often, MHCD clients were placed in an MHCD-owned building.

During the application approval process, ACT team members worked together seamlessly, picking up where another left off. Interviewees described dividing tasks instead of one person managing the process of getting participants from the streets to their apartment. One CCH staff member explained, "We just get together to game-plan what has to happen that day…who needs to get outreached, to go get a birth certificate. We all troubleshoot the problems of the day." Another MHCD interviewee said, "It was, 'Okay. I will take food to these five people at their motels if you take these three people to the DMV,' splitting stuff like that so we could do things the most efficiently. Truly, just depending on each other a lot."

Once individuals were placed in bridge housing, case managers tried to complete the housing screening within the first week after engagement, giving the residents a few days to settle in before launching into the remaining paperwork necessary for signing a lease. It was a challenging and sometimes long process to get the IDs, background checks, and all other paperwork necessary to satisfy the voucher requirements. The number of people with legal issues to resolve, including outstanding warrants, contributed to the difficulty of obtaining a Colorado ID. One interviewee noted "a very high barrier to accessing housing is getting these documents issued [e.g., an ID, a Social Security card, a birth certificate]." Another MHCD interviewee described the impact this challenge had on participant engagement: "We had people waiting in our group homes, and a lot of times, they would [disappear] before we could permanently house them…. That delay was an issue." To expedite the process, service providers worked with the Colorado ID Project, a volunteer-run organization, often staffed by retired lawyers and judges, that can help individuals get an ID quickly and efficiently.

Lease-Up in Housing

Lease-up refers to the date the participant signed a lease to move into a housing unit. Almost two-thirds (63 percent) of referred participants leased up in housing within six months of referral. More than half of all referred participants (56 percent) were leased up within four months. Of those who leased up, the average time from program referral to lease-up was 57 days (table 4).

TABLE 4

From Referral to Lease Up

	N	1 month	2 months	3 months	4 months	5 months	6 months	Mean days since referral	Median days since referral
Leasing up participants	363	21%	38%	48%	56%	61%	63%	57	50.5

Source: The data come from the Colorado Coalition for the Homeless program data from January 1, 2016, to July 1, 2018.
Notes: Only individuals referred to housing before January 1, 2018, are included in this table. Only lease-ups occurring in the first six months after referral are included in this table. Only housing application approvals in the first six months after referral are included in this table. The mean and median are calculated only among those who leased up.

Partner Perspectives on Challenges and Strategies

Leasing up was the final step in the referral and engagement process. As a central tenet of the Housing First model, staff members work with participants in anticipating the most promising housing match for them, and placement is based on a thorough assessment of client needs and desires.

The first step in the lease-up process was determining what type of housing—project-based or scattered-site housing—would best fit the client's choice of where they wanted to live. Both CCH and MHCD have a housing portfolio that includes scattered-site housing (units located throughout the City of Denver) and single-site housing (unit in a provider-owned apartment building), allowing them to provide different types of housing environments to SIB participants based on the clients' needs and desires. CCH owns 17 properties where many SIB clients have been placed, and they recruit and build relationships with private landlords as well. Before the Sanderson building opened, the MHCD SIB team placed SIB participants in MHCD-owned buildings and obtained additional vouchers for other scattered-site units.

SIB teams discuss housing options with each participant and make every effort to show participants the housing units before a final decision is made. Participants have been successful in both single- and scattered-site housing. But depending on clients' needs, staff will help SIB participants understand why one type of housing might be better suited for them. Sometimes, these decisions are based on clinical needs whereby participants with high medical needs are placed in project-based units because of the service program and the proximity of the health clinic. Residents with fewer needs might thrive living in an alternate environment, maybe closer to their family members or their community of origin. Ultimately, client choice and preference are honored in the housing location process.

Once the clients have settled on which housing type makes most sense, the SIB teams work to find a housing unit. For both providers, finding scattered-site housing and managing landlord relationships proved to be an initial hurdle to leasing up individuals.

In CCH's early experience with the program, the team had to negotiate landlord relationships and ensure that individuals were placed in the best housing option for them. The CCH team understood that the first property might not be the right placement. When participants needed a different housing option, the team made sure they had different housing options available. One CCH staff shared, "My hypothesis [on our quick lease-up] is that it's the way that services are delivered in this specific model that really focuses in on housing placement as its own special skill set.... [Caring] for people from a clinical lens is a very different skill set than being able to find a person on the street or being able to negotiate business relationships with landlords."

When MHCD joined the SIB program last year, finding scattered-site housing to rent from private-market landlords was very challenging. Some residents did not want to live in the new MHCD building, Sanderson, primarily because they wanted to be closer to downtown. It was harder than anticipated, especially given the background of some of the residents. But MHCD staff have been able to successfully negotiate landlord relationships. MHCD staff used several strategies to recruit scattered-site properties. Staff cold-called owners and managers describing the SIB project and emphasized that every resident would have a case manager who would visit residents at least once a week. Staff reassured the property managers that they would have a direct line of communication with an MHCD staff person and even promised to provide maintenance staff if necessary. Other staff actually walked through neighborhoods to find for-rent signs. Creating a master lease was another strategy. Under this lease, MHCD was the leaseholder for some or all of the apartments in a building. MHCD would pay the landlords directly, ensuring that these units would always be filled. This strategy works well for residents who will not pass traditional resident criteria. One interviewee reported that eventually, the housing market seemed to open up, and some sites were more accepting of vouchers: "We were able to get a lot of people into the apartments that they wanted."

We had a group of men [who] were so excited about their vouchers that they found their own apartments.
—Social Impact Bond Service Provider

Are Participants Stably Housed?

After participants were engaged and in housing, CCH and MCHD worked to maintain the housing stability of participants who leased up. From January 1, 2016, to June 30, 2018, 285 participants leased up. During this time, most SIB participants (85 percent) successfully retained their housing without exits, as defined by the program. After one year, of those who could have been leased up for at least one year, 94 percent of participants were still housed (including housing reentries).

Most SIB participants (85 percent) successfully retained their housing without exits, as defined by the program.

Housing Retention and Exits

Of the 285 SIB participants who leased up in housing by June 30, 2018, 85 percent did not exit housing between the time the time they signed their lease and June 30, 2018 (table 5). Some participants exited housing; these exits are categorized as planned or unplanned. This categorization recognizes that some exits may be intentional and positive, such as a move to other permanent housing. Deaths are also categorized as planned exits so as not to penalize provider performance given the vulnerability of some participants. Unplanned exits included jail stays of more than 90 days or any other interruption that caused the participant to be out of housing for more than 90 days. Unplanned exits are tracked to measure project performance, but these participants can reengage with the program.

During this period, 44 individuals exited housing (15 percent of those who leased up). Of the 44 who exited housing, 14 were planned exits (5 percent of those who leased up), all of whom passed away. Reasons for death included drug and alcohol use (7 participants), being struck by a vehicle (1 participant), and other medical conditions, such as seizures, diabetes, and pneumonia (6 participants). About half of the planned exits occurred within an individual's first six months in housing (table 6). Of the 131 individuals who signed their leases over a year ago, only three have had a planned exit.

Of the 44 who exited housing, 30 were unplanned exits (11 percent of those who leased up). Of these individuals, 15 left the program because of a jail stay that lasted more than 90 days, 4 had their vouchers taken away, 2 left for medical reasons, and the other 9 left for an unknown reason. Sixteen

unplanned exits occurred within the first six months of housing. Eight individuals (3 percent of all participants) of those who leased up and exited the program unplanned, reengaged in the program and re-leased in housing.

TABLE 5

Lease-Ups and Exits for SIB Participants

	N	Share
Housing lease-ups	285	
Individuals who have never exited housing	241	85%
Individuals who reentered housing after an exit	8	3%
Individuals who remain in housing as of July 1, 2018	249	87%
Individuals who exited housing	44	15%
Participant deaths	14	5%
Other exits	30	11%

Source: Days in housing and exit data come from the Colorado Coalition for the Homeless and Mental Health Center of Denver program data from January 1, 2016, to July 1, 2018.

After six months, of those who had leased up at least six months ago, 91 percent of participants were still housed, and after one year, of those who could have been leased up for at least one year, 94 percent of participants were still housed (including housing reentries). These are promising results for housing retention.

TABLE 6

Housing Retention and Exits

	First Six Months in Housing[a]		More Than One Year after Lease-Up[b]	
	N	Share	*N*	Share
Still housed at milestone	222	91%	122	94%
Exited housing	24	9%	9	6%
Planned exits (deaths)	8	3%	3	2%
Unplanned exits	16	6%	6	4%
Reentered housing	1	0%	0	0%

Source: Days in housing and exit data come from the Colorado Coalition for the Homeless and Mental Health Center of Denver program data from January 1, 2016, to January 1, 2018.

Notes: Only individuals who had lease-up dates before January 1, 2018, are included in the six-month column, and only individuals who had lease-up dates before July 1, 2017, are included in the first-year column. Jail stays have not been deducted from days in housing for this table. Planned exits include death, exit to other permanent housing, long-term residential treatment, or incarceration for actions occurring solely before referral. Unplanned exits include any interruption that caused the participant to be out of housing for more than 90 days. Housing reentries are counted when a participant reenters housing after a planned or unplanned exit. Still housed includes all participants who were in housing or had reentered housing as of six months or one year after their initial lease-up date. Stably housed or planned exit includes anyone who met the still housed or planned exit definitions.

[a] *N* = 245.

[b] *N* = 131.

After one year, of those who could have been leased up for at least one year, 94 percent of participants were still housed (including housing reentries).

Partner Perspectives on Challenges and Strategies

CCH and MHCD staff identified challenges and solutions to supporting participants' stability in supportive housing. The challenges included needing to develop guest policies, finding the right housing placement, engaging in services, and billing Medicaid.

CHALLENGES TO HOUSING RETENTION

CCH and MHCD staff reported that program participants often felt torn by having to leave behind the individuals who had made up their social networks—their social safety net or family—on the street. Further, for some participants moving into stable housing represented such a shift that it presented emotional and social challenges. They also wanted to share their home with people who may have felt they were left behind. But interviewees reported that some residents' guests were apt to cause disruptions because of intoxication, drug use, or even violence. "We have a core group of about 10 to 15 people [whom] we are struggling with, trying to get them to keep their housing yet sever some of those challenging relationships that they have. A few people couldn't make that jump and have relinquished their voucher and opted out."

Needing guest policies. To help support its clients, MHCD facilitated the organization of a resident council at Sanderson. The housing manager and the building residents collectively developed essential building rules. The resident council decided that housing staff should track who was entering the building; visitors were required to leave their ID at the front desk. To mitigate any issues or potential eviction of scattered-site residents because of the actions of their guests and to help residents who complain that they have too many people visiting their apartments, CCH works with SIB residents to develop a guest policy that residents can post and refer back to when necessary. A guest policy worksheet is used to help each resident develop a policy that is right for them. As one interviewee described,

> It's a guest policy that is driven by what it is that [residents] want. They might say, "I don't want this person to ever be invited into my house. I will let this person in, but only during these hours

> and these times." We will help them develop that policy and post it on their refrigerator so that they will remember it and utilize it later.

In addition to challenges with guests, the interviewees noted that project-based housing created an environment that sparked specific interpersonal challenges. Though residents with very high needs may benefit from a higher level of on-site support that is present in project-based housing, having a large number of people who are dealing with substance use and mental health issues living in the same location has proven to be difficult for some residents. One interviewee said that it can be triggering for a resident to see someone from their past, either from the street or from jail. Other residents may find that a project-based location is too chaotic and they need a smaller building with fewer units. One interviewee explained, "I think there is something about being in your own space. Not being so connected to everybody else…. Anybody could come knocking on your door at any time…there is just a lot more solace and peace at the scattered sites."

Finding the right housing placement. A key principle to the PSH approach is supporting clients in their choice of housing. The SIB housing options include scattered-site and single-site units in a variety of locations across the city. CCH and MHCD talk frankly with clients about the pros and cons of different buildings and locations and emphasize that clients have the freedom to make their own decisions. Even after a thorough assessment of client needs, sometimes finding the right housing placement fit meant that clients moved several times. As one CCH staff person explained, "A program participant may be challenged in their initial housing placement for a variety of reasons, and it is our role to continue to work with them until we can find a housing location where they are able to thrive." Although clients may make their own decision to relocate, doing so can be extremely stressful. Multiple moves are expected based on what we know of the Housing First model, but it can be taxing on clients and staff alike.

The reasons for moving are unique to each client, although often, they are based on neighborhood preference, availability of transportation and other services, employment, or location of friends and family. Others may wish to avoid certain locations that may trigger behaviors they are trying to change. The perception is often that the SIB participants have caused a problem or created a situation that forces them to move, when the reasons clients wish to move are actually the same as everyone else's. As one interviewee noted,

> Like in any housing situation, there is a combination of circumstances that don't align well for some and do align well for others…whether it's having a secure entry, not a walk-up unit, or a neighborhood preference. [At times], we have had participants request a move because their neighbors [were] causing a huge problem for them…neighbors who were [noisy], or there was drug trafficking in the unit next door. We have had plenty of instances where just the neighborhood, the building itself wasn't conducive for them to thrive…. But the narrative is if there is a problem in the apartment complex, it must be the [SIB participant].

Interviewees explained that people who need a higher level of support may be encouraged to choose one of the providers' buildings to be closer to on-site services, although some clients find a large building with many residents overwhelming and prefer a smaller scattered-site location. Another consideration is that the SIB participants' histories and backgrounds may preclude them from obtaining housing in certain areas of the community; if that is the case, this project has allowed for flexibility.

Organizationally, CCH staff reported that the contractual leasing schedule and randomized controlled trial aspects of the SIB stretched CCH staff as they worked to maintain fidelity to the ACT model as their client loads increased and referral pathways changed. Although CCH had a history of doing this work and established programs and services to draw upon, the organization had to expand and extend these supports to meet the SIB program design requirements. CCH staff reported that trying to find a certain number of clients referred to the program each month and engaging with and leasing up those clients in a certain amount of time could feel rushed to both the clients and the staff, regardless of the specific needs of clients.

Engaging in services. Clients' readiness to participate in services is individualized based on both their current needs and their life experiences. Some individuals need time to build trust and rapport. Interviewees reported that most clients access services at some level. For example, a resident may choose not to participate in therapy or attend groups, but they see a psychiatrist for medications. Others receive comprehensive case management services from staff who advocate for them in a variety of situations. Some residents access nearly every available avenue of support. As one interviewee described, "There are people who absolutely have taken advantage of every single bit they can. They have an employment specialist, a therapist, they are going to our day programs. They are just really diving in."

With this model, residents have a network of support available to them. One case manager said, "Because we are an ACT team, we all support each other. If I can't do something, one of them will. If they can't do something, one of us will." ACT teams help with scheduling appointments, visiting a food bank, coordinating benefits, navigating the Social Security office or the Denver Human Services agency, and providing health care. Many residents have complex medical needs because of chronic homelessness; the nurses play a critical role in navigating clients' health care. Case managers also help people in their units with activities of daily living, such as teaching them how to cook and clean. People who have been living on the street for years often need this level of support. Staff members see that some residents need help finding something meaningful to do every day. They encourage them to get out of their apartments and connect with other people. "We're trying really hard to get them engaged in community

support. We are trying to help them find their interests." The ACT teams have even helped residents reconnect with family members.

Billing Medicaid. Over the past year, Colorado's Medicaid system has presented challenges to service providers. As of July 1, 2018, Colorado is restructuring the regional accountability entities that now cover both physical and behavioral health. At the time of the interviews in late spring 2018, the new guidelines had not been entirely rolled out, which created uncertainty for service providers and posed challenges to their ability to get reimbursed from Medicaid. With the restructuring, Medicaid has questioned which services are eligible to receive reimbursement based on the Federally Qualified Health Center rate. This poses a problem, as providers are not able to be fully reimbursed for the array of services that they provide to the SIB's high-needs population; providers are seldom reimbursed for the length of time spent with clients. For example, when an individual has not seen a doctor in many years, their primary care visit can take several hours instead of a typical 20 minutes. Further, case managers often transport clients to and from their appointments. As a Federally Qualified Health Center, CCH is reimbursed for only one service per day even though clients may receive multiple services during one visit or day. MHCD has capitated Medicaid funding. It receives a specified amount of Medicaid dollars no matter how many people are served or their level of need. The challenge is that high-needs people draw heavily on this pool of funding.

FACILITATORS TO HOUSING RETENTION

The most effective practices for promoting housing stability, according to CCH and MHCD staff, are individualizing care and providing intensive services based on the specific needs of the SIB clients. The service providers work to build relationships with each client to establish trust and foster understanding. The SIB teams can then surround the individual with robust supports that are uniquely responsive to his or her circumstances. Maintaining and building relationships with property management, responding to resident issues that arise, and consistent response times and check-ins are all key to supporting residents' housing stability.

Having probation officers at on-site locations is a recent practice developed in the second year of the SIB. The ability to meet with residents who are on probation and discuss issues with case managers can mitigate additional jail time for SIB clients and contribute to housing stability.

The project-based housing programs have focused on resident council involvement, community building, and a broad spectrum of social activities offered to the residents. One provider developed a resident incentive program, where residents earn tokens for taking care of their unit or participating in

a group. The tokens may be used for household items, clothing, or food items. These activities and incentives promote resident buy-in and connections.

The individual strength of the SIB participants also contributes to housing stability success. Moving into housing might mean having to leave residents' support systems behind. Although clients are happy to be in their apartment, the quiet and the isolation can be difficult. Being stably housed is largely a result of their courage in facing the challenges of acclimating to their new environment. As one interviewee described, "I think [housing stability] shows their self determination to stay housed. There is this very unfortunate narrative out there that these individuals don't want housing, or they would like to be homeless, or there's some aspect of them not trying to a certain extent, and that's why they're homeless…. This project and certainly the data that's come out so far would dispel that myth."

How success is defined, including housing stability, looks different across all the SIB participants. Some people are working again, others are actively engaged in social activities and groups, and others are "at home." One man who had been homeless for many years has flourished in his project-based apartment:

> He has puzzles, and he is always cooking something, and his apartment is always so tidy and really well stocked with food. He's on top of things, and he runs around to check on his neighbors and tries to be really social with everyone. Many times, I find him sweeping his little front porch…finding him sweeping that front porch just always gets me because it is just the fact of here is this person who he never had somewhere to clean before. He's never had something to sweep and seeing now that he does, he is absolutely just taking that in. Since moving him in, he has gotten himself an income. He has reconnected with a sister [whom] he hadn't been in touch with for years. He is about to travel for a family reunion coming up out of state. He is going to travel there with his sister, which is huge that he is reconnecting with his family again after all these years on the streets.

Opening Renaissance Downtown Lofts. One of the major accomplishments for the CCH SIB team in the second year of the SIB program was the opening of their Renaissance Downtown Lofts building in downtown Denver in May 2018. This building includes 100 units for people experiencing homelessness. Though CCH faced delays in the building opening, the SIB team was able to leverage the delay of the opening to start building community for the residents before moving in. For example, staff held pizza parties and outings for the clients who were planning to move into the building. They also took this opportunity to give future residents an overview of the community policies and share information about the building and the services that would be available. These events facilitated neighbors meeting neighbors.

In addition to the opening of Renaissance Downtown Lofts, CCH also made changes in their program delivery model. For example, CCH hired a resident services coordinator, a new position

intended to help with integration efforts. The new role is a hybrid position between clinical services and property management. To promote this integration, property management and clinical teams have been meeting to discuss their roles and responsibilities and how they can work more collaboratively. The resident services coordinator and the SIB teams worked together to develop a comprehensive schedule of activities that encourage and facilitate client engagement. In an effort to create community and pro-social activities in the building, they created a good-neighbor incentive program where residents may earn tokens when they participate in building activities such as the Resident Council. Client programming includes an extensive schedule of groups, classes, and social activities ranging from anger management, to symptom management, to recovery, to basic cooking classes and meal planning.

Lastly, CCH now offers services to staff to support them in their secondary trauma associated with the trauma the SIB clients experienced, including deaths of clients that have occurred while in the program. Services include debriefings with clinicians not associated with the SIB team, as well as trauma training and compassion and fatigue training.

Opening Sanderson. MHCD recently completed and opened Sanderson Apartments with 60 units. It was built intentionally with trauma-informed design to support safe, secure environments. For example, the hallways are wider than normal and shaped so that residents have a clear view down the length of the hall. Stairways are brightly lit. Each floor is painted a different color to help residents know they are in the right location. Almost 50 percent of the building is engagement space that includes community rooms, comfortable soft furniture lounging spaces, and a library. People can spend time outdoors but feel safe in a contained courtyard. One interviewee explained,

> We try to put in barriers and boundaries without seeing them so that it would support [residents] feeling safe and secure and have the ability to move through our environment and allow us to engage with them and get to know them, form good healthy relationships with them, and…support them in their recovery. We have exercise rooms. We have outdoor gardening areas. We have big glassed-in window wells and a giant glassed in staircase. It is beautiful.

MHCD leadership believes that the concentration of staff at Sanderson facilitates communication among staff and with residents. Leasing and maintenance staff work hand in hand with the clinical team, which includes the peer specialist and the program manager. In addition to intensive case management and mental health treatment, a prescribing nurse visits Sanderson twice a month to manage medications. MHCD offers social group activities, such as fitness, horticulture, cooking, music therapy, and computer skills. Many residents are involved in MHCD's vocational services that help with employment and education. For example, residents can participate in a culinary program and earn a certification; upon completion, this can be used to gain employment.

Jail Stays

Before supportive housing, program participants' experiences of homelessness and housing instability were closely linked to their criminal justice involvement. This program was designed to increase participants' housing stability and reduce their jail stays. After one year in housing, 44 percent of participants had not returned to jail, and 56 percent of SIB participants had at least one jail stay (table 6a). Of the 56 percent who had any jail stays during their first year in housing, most had only one jail stay. The average days in jail among those with at least one jail stay was 34 days, and the median days in jail was 11 days (table 6b). The share of individuals with jail stays within the first six months of housing is lower (47 percent), and the average length of these jail stays is shorter (26 days).

Our analysis before the program began revealed that the target population for the Denver SIB spent many days in jail each year. In the first year after showing a pattern of eight or more arrests over three years, we found individuals in the target population spent an average of 77 days in jail (table 7). In the second year after showing this pattern of frequent arrests, the target population spent an average of 45 days in jails. While participants in the supportive housing program continue to spend some time in jail, they are spending significantly fewer days than before they entered the program; the 131 SIB participants who have been in housing for at least a year have spent an average of 19 days in jail thus far. In future reports, we will compare the days that participants in supportive housing (the treatment group) spent in jail with a group of individuals from the target population who continued to receive usual services in the community (the control group).

We will also explore the reasons for the jail stays. From qualitative interviews with SIB service providers, we know that participants in supportive housing may return to jail for reasons that support their longer-term housing stability. For example, once in housing, some participants may be supported in addressing an outstanding warrant. This may result in a jail stay but may also stop their cycle of criminal justice involvement so they may return to and remain in stable housing.

TABLE 6A

Jail Stays

	First Year in Housing		First Six Months in Housing	
	N	Share	*N*	Share
No jail stays	57	44%	131	53%
Any jail stays	74	56%	114	47%
1 stay	38	51%	67	59%
2 stays	15	20%	27	24%
3 stays	11	15%	14	12%
4+ stays	10	14%	6	5%
Sample total	131		245	

TABLE 6B

Jail Stays

	First year in housing	First six months in housing
Mean days in jail for those with at least one jail stay	34	26
Median days in jail for those with at least one jail stay	11	11
Mean days in housing before first jail stay	120	67

Source: Jail data come from the Denver Sherriff's Department and do not include days spent in prisons or any jails outside of Denver.

Notes: Jail stays are calculated as the number of bookings participants had in the first six months or the first year they were in housing. Days in jail is calculated as the total number of days an individual spent in jail in the first six months or the first year they were in housing. This analysis covers January 1, 2016, through June 30, 2018. Only participants who had lease-up dates before January 1, 2017, are included in the six-month column, and only participants who had lease-up dates before July 1, 2017, are included in the first-year column.

TABLE 7

Jail System Use among Target Population with Eight or More Arrests over Three Years

Time after eligibility	Mean days in jail
First year after eligibility	77 jail days
Second year after eligibility	45 jail days

Source: Mary Cunningham, Mike Pergamit, Sarah Gillespie, Devlin Hanson, and Shiva Kooragayala, "Denver Supportive Housing Social Impact Bond Initiative: Evaluation and Research Design" (Washington, DC: Urban Institute, 2016).

Notes: N = 1,456 individuals. The city's target population for the Denver SIB initiative includes frequent users of public services. Eligible individuals have had at least eight arrests over three years and are identified as transient (having no address or providing the address of a shelter) at the time of their arrest.

Criminal Justice Interaction

Service providers have engaged in consistent education, communication, and advocacy with the criminal justice system since the launch of the SIB project. Since the program's inauguration, service providers and representatives from the city have met with probation officers, the district attorney's

office, judges, and the police department to educate them about the SIB program and to advocate for reduced sentences with the assurance that their clients would be released into a Housing First program.

Providers have needed to be diligent about continuing their communication with the criminal justice system, and the courts have cooperated and collaborated with the SIB to a great extent. One interviewee reported that as they explain the program to officers of the court, they have seen their clients receive lesser sentences. Recently, a judge asked that if case managers are in the courtroom with their clients, they should let the judge know. According to one interviewee, the judge expressed, "I don't want you sitting there for four hours." Now, case managers approach the clerk and are then next in line to be heard.

Interviewees reported that probation officers have worked well with staff and have been flexible with probation requirements. The Denver County Probation Department recognizes that there are many mental health concerns that impede probation success rates. A probation officer visits CCH on a regular basis to help people check in if they are on probation, mitigating jail time. The department has networked with MHCD to meet clients in a more trauma-informed environment. A probation officer from the Denver Probation Department, employed by the Colorado Judicial District Courts, meets with clients on probation at MHCD and discusses cases with MHCD staff. The officer is also a liaison between MHCD staff and others in the department. The officer emphasized how essential it is for people with mental health challenges to be in housing. "It's just done them a world of good to have a roof over their head, to have a meaningful place to go every day and to have that confidence that they can wake up the next day and do well, and they have somewhere to go."

Case managers continue to accompany residents to court dates, which facilitates reduced fines and sentences for residents. One interviewee said they have noticed residents' interactions with the criminal justice system have decreased. MHCD's co-responders program of clinicians who partner with police officers and help to advocate or intervene with calls that involve people with high needs is active and growing in the Denver metro area.

Housing Stability Success Payments

In addition to program performance, another way to understand the progress of the SIB program is to examine the city's repayments to investors. In accordance with the Denver SIB contract, the Urban Institute calculated housing stability outcomes for the second success payment from the city of Denver in fall 2018. The SIB contract requires specific calculations to determine this success payment. More

information can be found in the companion brief to the Denver SIB governance committee ("Denver Supportive Housing Social Impact Bond Initiative: Housing Stability Outcomes").

Conclusion

Over the past two and a half years, the SIB program has housed 285 individuals who experience chronic homelessness in the city of Denver. Eighty-five percent of those individuals remain housed today. These are promising housing stability results and provide strong evidence for the success of the program to date.

After one year in housing, 56 percent of participants had at least one jail stay. While still high, this is lower than what the literature points to for this vulnerable population, which frequently interacts with the criminal justice system. In addition, the average number of days in jail is lower than that of the target population before their referral to the SIB program. We would count these early results on jail stays as promising. The analysis of the randomized controlled trial results—a forthcoming component of the Denver SIB evaluation—will allow us to draw more definitive conclusions about the impact of the PSH model on jail bed–days for this population.

The qualitative findings highlighted in this report emphasize the daily support that CCH and MHCD provide to program participants from the moment they are located on the street. Service providers work with participants to select a housing option that fits their preferences and needs. In addition, they provide individualized support to SIB participants and collaborate with police and medical providers in the community to help promote housing stability. Together, the service providers and other Denver SIB collaborators have helped foster a successful program in which SIB participants can reach and maintain housing stability.

Appendix Methods

Quantitative Methods

Our engagement analysis uses administrative data from the Denver Police Department and program data from the Colorado Coalition for the Homeless. Denver Police Department data provided information on the full program eligibility list, including demographic characteristics and all arrests from 2013 to 2015. It also covered data on the 363 participants referred to the supportive housing program, including information on all arrests and contacts from December 2015 to December 2017. Colorado Coalition for the Homeless data included information on the dates of location, engagement, housing application approval, and lease-up from January to December 2017. Mental Health Center for Denver data included information on the dates of location, engagement, housing application approval, and lease-up from January 2017 to December 2017. For all our engagement analysis, we conditioned our sample on people referred to the program before July 2016 to ensure we could analyze at least six months of data for everyone. We also limited our analysis to the first six months after referral. For example, for participants referred to the program in January 2016, we analyzed data through July 2016, and for participants referred to the program in March 2016, we analyzed data through September 2016. Everyone in our sample is observed for the same length of time.

The housing stability and jail stay calculations use Denver Sheriff's Department data on jail stays, as well as Colorado Coalition for the Homeless and Mental Health Center of Denver data on lease-ups and housing exits. Denver Sheriff's Department data included the booking start and end dates for all jail stays from January 1, 2009, to July 1, 2018, on all individuals randomized into treatment by July 1, 2018. The Colorado Coalition for the Homeless data and the Mental Health Center of Denver data included information on the dates of lease-up and dates of housing exits from November 1, 2015, to July 1, 2018.

Data Quality

The Urban Institute works with the Colorado Coalition for the Homeless and Mental Health Center of Denver on a regular basis to ensure that all tracking of program participants is up to date and accurately reflects the SIB program.

The Denver Sherriff's Department data on jail stays is provided to Urban on an annual basis. In this year's data extract, the Urban team found some internal inconsistencies in the Denver Sherriff Department's data file. Together with the Denver Sherriff's Department, Urban identified the issue leading to the quality error. The Denver Sherriff's Department fixed this error and pulled a new, complete dataset. To ensure that the dataset matched the original raw records in the Jail Management System, the data point person at the Denver Sherriff's Department quality checked a list of randomly selected jail stays for SIB participants. All the information in the quality check was consistent with the files Urban received, leaving no remaining quality concerns.

Qualitative Data Methods

Our qualitative analysis is based on semistructured interviews with program partners. In May and June 2018, the Evaluation Center interviewed 18 people from organizations involved in the SIB implementation. Information from three additional interviews conducted in 2017 also contribute to the qualitative findings in this report. These organizations included the Colorado Coalition for the Homeless, Mental Health Center of Denver, Corporation for Supportive Housing, Crime Prevention and Control Commission, Denver County Court, and the City of Denver. The interviews addressed the strategies and challenges of engagement and lease-up processes, bridge housing, support services, interaction with criminal justice system, scattered- and single-site housing, SIB expansion, environmental factors, and housing stability. These interviews were conducted in person or by phone and, with permission from interviewees, were audio-recorded and professionally transcribed. The evaluators used NVivo 11 to analyze these qualitative data.

TABLE A.1

Study Population

	Treatment Participants		Other Eligible Participants	
	N	Mean	*N*	Mean
Sample	363		2,347	
Gender				
Male	316	87%	1,933	82%
Female	47	13%	414	18%
Age				
Mean		44		42
Median		45		42
Age				
17–20	5	1%	39	2%
21–30	58	16%	515	22%
31–40	82	23%	543	23%
41–50	98	27%	568	24%
51–60	91	25%	535	23%
61–70	27	7%	136	6%
71–100	2	1%	9	0%
Race or ethnicity				
White	52	14%	499	21%
Hispanic	52	14%	241	10%
Black	19	5%	216	9%
Native American or Alaska Native	24	7%	59	3%
Asian or Pacific Islander	24	7%	59	3%
Unknown	2	1%	8	0%

Source: Data from the Denver Police Department.

Notes: None of the differences between the treatment participants and other eligible individuals are statistically significant. "Other eligible participants" have not been randomized.

TABLE A.2

Mean Arrest History of Participants, 2013–15

	Treatment participants	Other eligible participants
Total arrests	14	13
Noncustodial arrests	7	6
Custodial arrests	7	7
Nontransient arrests	3	3
Transient arrests	12	10

Source: Data from the Denver Police Department.

Notes: None of the differences between the treatment participants and other eligible (not yet randomized) individuals are statistically significant. "Other eligible participants" have not been randomized.

TABLE A.3

Treatment Participant Arrests or Contacts in Month before Randomization

	N	Share
No contacts or arrests	192	53%
Custodial arrest	19	5%
Noncustodial arrest	69	19%
Contact	151	42%

Source: Data from the Denver Police Department.

Notes

[1] Aldo Svaldi, "Denver's Chronic Housing Shortage May Peak This Year with Deficit of 32,000 Homes and Apartments," *Denver Post*, January 28, 2018, https://www.denverpost.com/2018/01/28/denver-chronic-housing-shortage-fixes/.

[2] Aldo Svaldi, "Outside California's Bay Area, Metro Denver Had Biggest Rent Increases This Decade," *Denver Post*, March 19, 2018, https://www.denverpost.com/2018/03/19/denver-rent-increases-decade/.

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[5] The investors are the Denver Foundation, the Piton Foundation, the Bend and Lucy Ana Walton Fund of the Walton Family Fund, Laura and John Arnold Foundation, Living Cities Blended Catalyst Fund LLC, Nonprofit Finance Fund, the Colorado Health Foundation, and the Northern Trust Company.

[6] "Housing," Colorado Coalition for the Homeless, accessed August 17, 2018, https://www.coloradocoalition.org/housing.

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