National Evaluation of SAMHSA's Homeless Programs

Cooperative Agreements to Benefit Homeless Individuals (CABHI)

Portraits from the National Cross-Program Evaluation

Substance Abuse and Mental Health Services Administration
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The Substance Abuse and Mental Health Services Administration (SAMHSA) funds programs and initiatives addressing the treatment and support needs of people experiencing homelessness who have substance use, mental health, or co-occurring disorders. SAMHSA's four major homeless initiatives are Grants for the Benefit of Homeless Individuals (GBHI), Services in Supportive Housing (SSH), Projects for Assistance in Transition from Homelessness (PATH), and Cooperative Agreements to Benefit Homeless Individuals (CABHI). Each program has varying requirements and objectives, but all share the goal of reducing homelessness for this population.

This Program Portrait is a product of the National Evaluation of SAMHSA's Homeless Programs and focuses on a selected grantee under the CABHI initiative. The purpose of CABHI is to develop or expand the community infrastructure that integrates treatment and services with permanent housing for persons who are chronically homeless and have substance use, mental health, or co-occurring disorders. CABHI programs must enroll clients in Medicaid and other mainstream programs and provide treatment and recovery supports for those not Medicaid eligible.

The National Evaluation of SAMHSA's Homeless Programs is a comprehensive, 5-year project that will examine the structural, process, outcome, and cost components associated with SAMHSA's homeless programs portfolio. This Program Portrait is based on site visit findings and is current as of the site visit date.

HEADING HOME
The Smart Way to do the Right Thing

Albuquerque Heading Home – Albuquerque, NM

The grantee agency for the Albuquerque Heading Home (AHH) project is the City of Albuquerque's Department of Family and Community Services (DFCS). DFCS' homeless services include prevention, outreach, shelter and housing programs, and supportive services. DFCS also administers the city's affordable housing programs, including HUD vouchers and Continuum of Care funds. DFCS also funds 3 Assertive Community Treatment (ACT) teams that provide ACT services to homeless persons with serious mental illness. The agency serves approximately 89 clients annually. DFCS operates the CABHI grant, AHH, within its Health and Human Services Division. AHH is a multi-agency collaboration led by Heading Home, and DFCS serves as the contracting and fiscal agent for the project. AHH was designed to expand dedicated treatment and supportive services capacity to house chronically homeless and medically vulnerable people who have mental health and/or substance use disorders. The geographic service area for AHH is the municipal limits of the City of Albuquerque. Prior SAMHSA funding includes a grant on opiate use and a jail re-entry grant. DFCS is part of the Continuum of Care and the city's and state's Plan(s) to End Homelessness.

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CABHI Program: Albuquerque Heading Home

AHH was funded in 2011 under SAMHSA's Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant program. AHH is a multi-agency collaboration that includes DFCS, Heading Home, Albuquerque Health Care for the Homeless (AHCH), St. Martin's Hospitality Center (SMHC), New Mexico Solutions, Albuquerque Police Department's Crisis Outreach and Support Team (COAST), First Nations, University of New Mexico Project ECHO (Extension for Community Healthcare Outcomes), New Mexico Coalition to End Homelessness, and the Supportive Housing Coalition of New Mexico. These partners have been working together for several years on a larger homelessness initiative (Heading Home) that began prior to the receipt of the CABHI grant. CABHI funding allows Albuquerque to hire case managers, SOAR and housing specialists, and staff to oversee the initiative's infrastructure.

The goal of this project is to house the most vulnerable homeless individuals and create system changes to make homelessness rare, short-lived and non-recurring. To that end, AHH seeks to expand treatment and supportive services capacity to house chronically homeless and medically vulnerable people who have mental health and/or substance use disorders. In its first 3 years, the program has served 267 individuals (approximately 89 people per year). AHH uses Housing First and collaborative case management to provide services to clients "where they're at". This case management model allows the Care Team (grant-funded case managers at AHCFH and SMHC and a COAST crisis outreach specialist) to link clients to a wide range of resources and services across organizations.

Key features of AHH are summarized in the Schematic Overview (page 3), which illustrates the core program features and how clients are enrolled in and obtain services through the grant program. All programs include some aspects of outreach and referral, intake and assessment, case management, service delivery and housing, and discharge. This structure is common to all GBHI, SSH, and CABHI grant programs; the client flow chart shows how these common elements have been adapted and integrated to fit the local context and client needs.

Community Context and Stakeholder Coordination

AHH's service system is fairly resource rich. Key service partners include AHCH, SMHC, COAST, New Mexico Solutions, Project ECHO, First Nations and the Supportive Housing Coalition of New Mexico. In addition to grant-funded services such as case management, housing supports, medical and behavioral health care, AHH clients have access to a wide variety of services at each of these partner agencies. All AHCFH and SMHC services are available to AHH clients. These services include intensive addiction treatment, individual therapy, job training, art therapy and dental care. Similarly, AHH clients can access culturally competent services, such as medicine men, sweat lodges and traditional food at First Nations. The housing environment is resource rich, with a good supply of fair market rate apartments and housing vouchers, allowing AHH to house clients quickly. With the exception of high rent districts, AHH clients are housed in scattered site apartments throughout Albuquerque. The Supportive Housing Coalition of New Mexico oversees housing, working with both landlords and tenants (AHH clients). There is both strong political and community support for the project.

AHH has both a Steering Committee and a Community Consortium. The Core Vision Team is comprised of the AHH project director, project managers and housing specialist, representatives from DFCS, AHCH, SMHC, New Mexico Coalition to End Homelessness, the Supportive Housing Coalition of New Mexico and the Downtown Action Team (business development organizations), and essentially serves as the project's Steering Committee. Brought together by the current mayor prior to CABHI-funding, the Core Vision Team is charged with implementing the city's Plan to End Homelessness. It meets weekly to develop and implement strategies to end long-term homelessness and resolve AHH challenges related to multi-agency collaborations and systems change. The Albuquerque Strategic Collaborative to End Homelessness, comprised of representatives from homeless services and advocacy agencies, foundations, DFCS and consumers, serves as the CABHI-required Community Consortium. This large group (32 members) seeks to improve the system of care that exists in Albuquerque for people experiencing homelessness through collaborative, proactive planning. Many of the same stakeholders serve on both the Core Vision Team and the Strategic Collaborative, and have been working together for several years in strategic ways to end homelessness. AHH's success is instrumental to the mission: they can demonstrate that their model of Housing First and collaborative case management effectively reduces homelessness for the most chronically homeless, medically vulnerable individuals.

Albuquerque Heading Home (AHH)

City of Albuquerque

CABHI – PSH
2-3-14

Community Consortium/Steering Committee

- Steering Committee: Core Vision team comprised of AHH project director, project managers, staff from DFCS, SMHC, AHCFH, NM Coalition to End Homelessness, Downtown Action Team, and the project housing specialist.
- Community Consortium: Albuquerque Strategic Collaborative to End Homelessness

Target Population

Medically vulnerable, chronically homeless with mental health and/or substance abuse needs, ranked as "high need" on the Vulnerability Index (VI) that identifies risk indicators, special population, and disability, substance abuse, and co-occurring disorders. VI conducted as a mass survey of homeless in 2011, 2013 and conducted on an ongoing basis by partners and stakeholders.

Outreach and Referrals

Outreach, Referrals, and Registration

- AHH targeted individuals on the 2011 & 2013 survey of individuals living in the street or shelters
- Ongoing referrals from partner agencies (HH, AHCH, SMHC, NM Solutions)
- Outreach infrastructure includes partners and other community groups – VA Veteran Outreach Program, First Nations Community Health Source for Native Americans, NM Aids Services, NMDH, Project Echo, Agave, Catholic Charities, Open Skies, and hospitals.
- Screening

Assessment and Intake

- The VI is given at outreach and by case managers and other agency intake personnel.
- Registry prioritizes clients based on health risks and homelessness scores on VI, and is updated on a ongoing basis for clients
- Intake is done when applying for housing

Housing Intake

Outreach will be carried out in the current systems as well as in areas where homeless may stay. Case managers will join the outreach team to engage participants to streamline referral to project housing and other PSH county housing.

Intake to Housing/ Enrollment

Severe Mental Illness/Health Issues

Assertive Community Treatment (ACT)

- Mental Health ACT Team - NM Solutions
- Medical ACT Team – Project ECHO for persodn with 3 or more co-morbidity indicators
- Interdisciplinary ACT Team provides direct care and links to services
- Services provided 24/7
- Services provided in community-based setting and context of client's life.
- Team provides tailored and responsive mix of services as needed, not predetermined
- Team members collaborate and integrate service provision.
- Health screening (coordinated with AHCFH, First Nations, University Hospital)

Co-Occuring Disorders

Comprehensive Case Management SMHC +AHCFH

- Support in navigating and accessing services and resources
- Expedited access and entry to housing and care
- Client directed priorities
- Therapeutic working alliance
- Smaller caseloads
- Enrollment (with the support of SOAR) in General Assistance, SNAP, Medicaid, SSI/SSDI, TANF, Veterans Benefits, Income supports
- Data collection -GPRA, costs, process

Transitional housing

Used only while awaiting PSH

Case Management (ACT and Comprehensive Case Management)

Service Delivery

Housing Supports

- Rapid connection to permanent housing independent of other services
- Home team volunteers to support transition to housing
- Furniture
- Moving
- Home visits
- Third party payee

Treatment/Services

- Screening
- Counseling (Individual outpatient counseling
- Detoxification center (Turquoise Lodge), Substance Abuse counseling
- Mental Health pharmacotherapy
- Health Clinic, primary care providers
- Psychosocial rehabilitation
- Dental services
- UNM expansion
- Comprehensive recovery team
- Home therapy
- Art therapy

Other Services

- Life Skills
- Social Skills
- Educational support
- Employment
- Voluntary supportive services
- Vocational training (Goodwill)
- Transportation, bus passes
- Peer-to-Peer support to increase social connections (Volunteers)
- Field Trips
- Clothing bank
- Mail service and long-term storage

Permanent Housing All Scattered Housing

SHC (Housing First) – 30 units
AHCFH (Shelter Plus Care) – 20 units
SMHC – (Shelter Plus Care) – 20 units
TLS (Shelter + Care) – 5 units

SAMHSA Discharge/No discharge from local program

SAMHSA Discharge

- Incarcerated more than 3 years
- Left Albuquerque
- No longer working with a case manager

Key

AHH = Albuquerque Heading Home
SHC = Supportive Housing Coalition of New Mexico
SOAR = SSI/SSDI Outreach, Access, and Recovery
AHCFH = Albuquerque Health Care for the Homeless
VI = Vulnerability Index
TSL- Transitional Living Services
COAST= Crisis Outreach and Support Team
SNAP=Supplemental Nutrition Assistance Prgram
SMHC = St. Martin's Hospitality Center
Project ECHO – Extension for Community Health Outcomes

Grey filled boxes indicate the activity is contributed (not directly funded by a Homeless project) to the project.

Green – SAMHSA program linkages Blue – Service linkages Red – SAMHSA program services

WHO receives services

- ***Target Population***
  - Chronically homeless and medically vulnerable people who have mental health and/or substance use disorders
- ***Exclusion criteria or other requirements***
  - Vulnerability is determined by the Vulnerability Index (VI); this instrument assesses individuals' health, homelessness, mental health and drug use histories. An individual's VI score determines his/her rank on the housing list, with the most vulnerable taking precedence (i.e., an individual with a higher VI score will always be placed at the top of the housing list regardless of when he/she enrolls in the program).

HOW are they recruited and enrolled?

Outreach: In February 2011, the mayor organized a citywide survey of the homeless. The survey included administration of the VI. A homeless registry was created ranked-ordered by VI scores (those with higher VI scores were placed at the top of the registry). Outreach to those on the original registry and to newly identified chronic homeless persons is conducted by the range of AHH partners (most of which were part of the original survey) and includes grant-funded partners (case managers, Heading Home volunteer coordinator, and COAST) as well as those who work with the project on an in-kind basis (shelter workers, clinic staff, volunteers). Referrals to AHH also come from the jail, hospitals and courts.

Screening and Assessment: The VI is administered to prospective clients by the AHH Housing Specialist, Care Team members, and other direct service providers as they encounter homeless individuals. Completed VI assessments are sent to and scored by the AHH Program Manager. She updates the registry as new scores come in, and immediately informs referral sources and potential clients of their place on the registry. Housing priority is given to those on the top of the registry. Clients are formally enrolled when they apply for housing. They are assigned to a partner agency; this agency does additional behavioral health assessments to determine whether individuals have mental health and/or substance use disorders. Additional screening is done by clinicians as needed. The VI is routinely re-administered to clients to make decisions about the level of support needed and informs the step-down approach to program services.

WHAT services do clients receive?

TREATMENT AND WRAP-AROUND SERVICES

AHH provides services through an integrated service model with partners funded through the grant, in-kind partner contributions, and other established funding streams such as Medicaid and HUD housing programs. The primary CABHI-funded services are case management, housing applications and supports, benefit application support, outreach and crisis intervention.

- ***Substance abuse treatment:*** Outpatient counseling is provided by AHCFH and SMHC. SMHC provides intensive support through the Comprehensive Recovery Team, though most clients receive services through a 2-year self-sufficiency program. Referrals are made to residential and detoxification treatment programs as needed, such as Casa del Phoenix and Turquoise Lodge (supported by First Nations).
- ***Mental health treatment:*** One ACT team from New Mexico Solutions handles severe mental health issues and the other Project ECHO handles persons with three or more co-morbidity indicators. Services are also provided through the SMHC behavioral health clinic as needed, such as screening, individual or group counseling, mental health pharmacotherapy, psychosocial rehabilitation, and home therapy.
- ***Integrated substance abuse and mental health services:*** These services are provided by licensed counselors through individual and group treatment sessions. Medication prescriptions and monitoring is handled by psychiatrists and nurses working with case managers in each agency.
- ***Trauma services:*** The case management model incorporates a trauma informed care approach in delivering services from mental health and substance abuse treatments to housing, vocational and job development supports, victim assistance and peer support. Both SMHC and AHCFH are trauma informed care agencies. This approach involves understanding the clients, quick and consistent follow up, and respecting the client and his/her culture.
- ***EBP(s):*** AHH incorporates three primary evidence based practices – ACT, SSI/SSDI Outreach, Access, and Recover (SOAR), and Permanent Supportive Housing (PSH). The two ACT Teams are assigned the most severe mental health (uses a 7 person ACT Team) and clients with three or more co-morbidity indicators (uses a 5-person ACT Team).The local evaluation is collecting fidelity data on the ACT teams via the DACT and early findings suggest that ACT is being implemented with fidelity and with little modification.

  The SOAR specialist and trainer, funded through CABHI, sits on the SOAR Steering Committee. Members of the committee stated that the SOAR specialist has been able to develop a level of trust with AHH clientele due to her efficient, effective, and respectful approach. The SOAR specialist provides training in Albuquerque and other New Mexico locations. Training and mentoring are provided to all SOAR trainees. SOAR has been well-implemented and with fidelity.

  PSH has been effectively implemented through AHH. The AHH Housing Specialist has extensive experience in Albuquerque housing and is extremely knowledgeable about housing and related systems, and how to help clients effectively, by identifying landlords appropriate for each client and helping the client through the application process. AHH partners with the Supportive Housing Coalition of New Mexico and the Albuquerque Housing Department, which has extensive experience handling a variety of housing vouchers, including Housing First vouchers. AHH is implementing PSH with fidelity. Clients are offered a choice of housing, with recommendations based on AHH experiences with landlords, client mobility and transportation needs. An estimated 90% of clients receive their first choice. All of the housing units meet HUD standards.
- ***Case Management Model:*** The case management model incorporates approaches from Housing First, Harm Reduction Therapy, and Trauma Informed Care. The two ACT teams handle the most fragile AHH clients. The majority of clients receive case management through the five case managers at SMHC (n=3) and AHCH (n=2). If a client already has a relationship with a case manager in one of the partner agencies (e.g., First Nations, Susan's Legacy, New Mexico Aid Service, Agave, Catholic Charities, and Open Skies), the client will keep his/her own case manager. All case managers (paid and not paid by CABHI funds) attend the Care Team meetings. This approach has resulted in a well-integrated service model that permits access to the portfolio of services across all partners. The Care Team coordinates services on an ongoing basis and meets weekly to discuss clients. While the clients are not the shared responsibility of the Care Team, as they are in ACT, team members often share responsibility across clients as needed. All case

managers are supervised within their agency. Also, the AHH Care Team meets every other week with the AHH Deputy Director to discuss participants and link them to appropriate resources. A representative from the grant-funded ACT teams and other direct service partners (e.g., the AHH Housing Specialist) also attend Care Team meetings. The AHH Deputy Director meets monthly with each of the Care Team case managers' supervisors to ensure that the case managers and agency goals are consistent with the Care Team plans for helping clients (i.e., that a strategy decided upon at a Care Team meeting to help a client can be and is put into place). While AHH uses a Housing First philosophy, case managers stay with clients and promote services as needed.

- ***Other wraparound services:*** Housing supports includes provision of furniture, help with moving, food and hygiene product baskets, and home visits to ensure clients and their families are acclimating to their new environments. Additionally Home Team volunteers are assigned to clients to help them transition to housing and provide information about being a good neighbor. These volunteers also help reduce the isolation newly housed clients experience. Other services include life and social skills training, education support, vocational training and employment, clothing and food banks, mail service and long-term storage, peer-to-peer supports to increase social connectedness, and field trips to introduce clients to different aspects of the community.
- ***Timing of case management or wraparound services:*** Case management officially begins with the housing application (when clients are accepted for housing).However, because AHH targets clients on a registry at outreach, short term case management can begin at outreach and initial contact.

CHOICE

- Clients are authors of their own service plans and can choose which services they use. Case managers or other service providers may make suggestions and provide tools and options, but clients decide whether to participate and under what conditions.

WHERE do clients live?

HOUSING

- ***Grantee role in housing:*** The AHH Housing Specialist works with AHH clients throughout the whole housing process, from administering initial assessments, helping them fill out housing applications. Assiting with housing searches to signing their lease. The Supportive Housing Coalition (SHCNM) of New Mexico administers housing vouchers, educates clients about the rights of tenancy and how to be a good tenant, conducts housing inspections, and is a liaison between the landlord and AHH client.
- ***Housing model(s)/Scenarios:*** The program's housing model is PSH. Clients are homeless at the time of referral to AHH. Clients are assigned to an AHH case manager after the AHH Housing Specialist begins the housing process described above. During this waiting period, clients may be placed in a motel, or they may stay at a shelter or on the streets. Where clients stay while waiting for housing is determined by their needs and stability, and available resources. AHH case managers provide housing supports, visiting clients at their homes at a minimum of twice a month depending on their individual needs. Clients hold their own lease, have choice of where they live, and their apartments are permanently theirs; they do not lose their apartment when CAHBI-funding ends and/or if they chose to no longer receive AHH services.
- ***Criterion for housing:*** Individuals' VI scores determine their place on the housing waitlist. Those who are most vulnerable (highest VI scores) are placed at the top of the list. In accordance with the Housing First model, housing is not contingent on treatment receipt and/or compliance.
- ***Housing legal status*:** Clients hold their own lease, housing is time permanent (time unlimited) and tenant portion of rent is up to 30% for those who with income.

WHERE do clients receive services?

- AHH serves clients "where they are at": in the community, in clients' homes, and in program partner offices and clinics. For example, case managers meet and work with clients in the community, on the street, and/or in their apartments. AHCH provides medical services at its clinic. Substance use and mental health treatment is provided at AHCH and SMHC offices. Housing supports and assistance are provided to clients in their apartments.

WHEN do clients receive services?

- Services start at referral, as client needs are identified. Clients may start receiving services as they wait to move into their apartments. AHH clients receive priority on all housing lists. They receive their housing voucher at their housing briefing with the Supportive Housing Coalition of New Mexico, and generally are housed within two weeks of after their voucher has been issued.
- Service provision and housing are not conditional on one another. Clients may begin receiving services as soon as they are enrolled in the program and waiting to find and move into their apartment(s). AHH clients can be housed and refuse services.
- There are no time limits on housing or services. AHH uses a step-down approach, moving clients to less intensive services as they become more stable and independent. Clients are discharged if they (1) move out of Albuquerque; (2) are incarcerated for 90 days or more; or (3) are no longer working with an AHH case manager.

HOW are services and housing funded?

- ***Outreach*** (funded by CABHI grant and in-kind by community partners): AHH case managers and COAST do targeted outreach to individuals on the homeless registry as well as identify additional chronic homeless individuals. First responders, shelter workers, and volunteers also support outreach efforts for the AHH program.
- ***Screening and Assessment*** (funded by CABHI and in-kind by community partners): As part of the City's initial homeless outreach, individuals were trained on the Vulnerability Index. The VI is administered during outreach and is repeated by the housing coordinator, case managers and clinicians to fully assess the needs of the individual.
- ***Treatment*** (funded by Medicaid, State funds, private insurance and in-kind by community partners): AHH provides primarily non-clinical cases management, although some clinical case management services are provided by AHCH. Medical treatment primarily in the form medication monitoring, and recovery support services are provided by SMHC and Project ECHO. Other treatment is coordinated by case managers but provided through the above sources at clinics run by community partners. Other treatment services not paid by CABHI but available to participants include dental services, detoxification, and substance abuse counseling.
- ***Case management – ACT teams*** (funded by CABHI grant): The ACT team provides intensive case management to severe mentally ill and medically fragile clients through an integrated ACT team approach, involving regular meetings with clients in the clinic or in the home.
- ***Case management*** (funded by CABHI grant, Medicaid, State funds, and in-kind by community partners): The majority of clients receive case management through the case managers at SMHC and AHCFH. Case managers provide ongoing support to clients in the home, in agency offices, or locations specified by the client. They arrange (or provide) transportation for client treatment and other services. Case managers provide counseling to keep the client housed, arrange peer support visits, ensure clients have food and clothing, and continually attempt to engage the more reluctant clients. They participate in Care Team meetings and arrange for other case managers to provide support if they are not available.

- ***Other wrap around services*** (funded by CABHI, Medicaid, private donations, volunteers, and in-kind community partners): AHH integrated partner programs provide a broad spectrum of services. The CABHI program funds moving services. CABHI also partially funds transportation and bus passes, field trips, mail service, long-term storage, and peer-to-peer support groups. Furniture, clothing, and food are provided through donation. Home Team volunteers work with clients to support transition to housing. In-kind programs provide support for life and social skill building, education and vocational training.
- ***Housing*** (funded by HUD Continuum of Care and Emergency Solutions Grants (ESG) and the City General Funds): Transitional and permanent housing and Shelter-plus-Care housing is primarily funded through HUD Continuum of Care funding. Emergency shelter and permanent housing is funded through HUD ESG and the City's General Fund. There is no sober transitional or permanent housing.
- ***Staffing*** (funded by CABHI): Staffing for the project is maximized through in-kind support from the five partner agencies, each contributing key staff. The City of Albuquerque provides the project director, the crisis outreach specialist, contracts management staff, and the housing specialist. AHCH provides two case managers, a nurse, supervisor, and program coordinator. SMHC staff include three case managers, supervisor, and two nurses to monitor medication. Heading Home provides the program manager, SOAR specialist, volunteer coordinator, data managers, and development director. This staffing represents 10 full-time staff; approximately one-third of their time is paid through in-kind contributions from the agency or city. This is exclusion of in-kind contributions that may be made through contracted agencies. CABHI supports services for AHH clients through an ACT team. Project funding also is provided to research evaluators from the University of New Mexico Institute for Social Research for a local evaluation.
- ***Primary service model:*** AHH provides intensive case management services to clients and also supports client applications for housing (through the housing specialist) and benefits (through the SOAR specialist). Treatment services are provided through linkages with both grant partners (AHCFH and SMHC) and community partners (NM Solutions, First Nation and others). However, treatment services for the most fragile are served through the two ACT teams paid through the CABHI grant. AHH also provides housing supports and coordinates volunteers who work directly with clients. Other services include vocational training by Goodwill.
- ***Partner contributions and roles:*** The roles of the AHH collaboration include: City of Albuquerque DFCS (lead agency and contractual and fiscal agent); Heading Home (project coordination and support services); AHCH (case management, health screening, primary care, behavioral health treatment, medication management, dental care, art therapy); SMHC (case management, behavioral health treatment, housing, housing supports, employment services, food, clothing, medication management); New Mexico Solutions (ACT); COAST (crisis intervention, outreach); Project ECHO (medical ACT); First Nations (outreach, nursing services, empowerment groups, culturally competent services including medicine men, sweat lodges, and traditional food); New Mexico Coalition to End Homelessness; the Supportive Housing Coalition of New Mexico (housing vouchers, housing supports, liaisons with landlords); and the University of New Mexico Institute for Social Research (local evaluation).
- ***Leveraging of resources:*** AHH addresses clients' needs by leveraging resources throughout Albuquerque. The City of Albuquerque provides funds for outreach, non-clinical case management, and trauma services. Heading Home serves as the backbone organization for the collaborative and facilitates leveraging resources across members for case management, co-occurring disorders and medical treatment, testing, counseling, and trauma services. Heading Home, AHCH and SMHC have been the most active partners. It is useful to note that even though AHH pays for case management the partnerships they have developed result in non-grant case managers working with clients. Often these case managers had an existing relationship with the client or have a particular expertise.
- ***What is funded by CABHI, what is contributed and what is referred into the general services system?*** The main services not directly funded or leveraged as a result of CABHI funding are inpatient treatment for both mental health and substance abuse and pharmacotherapy. Medical treatment and testing is leveraged with AHCH and in some cases referred to UNM Cares, the Health Department, and NM Aids Services (NMAS)
- ***What does it cost?*** In FY2013, total funding for the program was approximately $1,063,542; $491,959 was through CAHBI funding and the remaining came from city and county grants ($232,653), and private grants and contributions ($338,922).

Client Perceptions of the Program

- "(Because of AHH) my life turned a complete 180. I'm off the booze, getting my insurance, seeing doctors, talking to my brothers again".
- "At AHH, they welcome you like family and really care about you. They ask you what you need and help you get it (services, furnishings, clothing, etc.)".
- "I got my health problems taken care of. I'm getting the healthcare I wanted and needed".
- "I'm glad I stuck with it. I'm not depressed anymore and can think about helping someone else".

WHAT barriers or challenges were faced, and how were they addressed?

- AHH has encountered very few barriers. As described below, this is due in part to the long-standing partnerships and collaborations that were in place prior to SAMHSA funding, as well as fairly rich housing and service resources. The current challenges reported by AHH staff and program partners include: limitations in sharing client data across agencies; need for more transitional housing, particularly for people moving out of nursing homes; and loneliness clients experience when they first move in.
- Challenges are addressed in weekly Core Vision Team meetings. These meetings have been instrumental in allowing the project to build trust among partners, break down barriers and resolve both immediate and long-term issues. Similarly, AHH case managers discuss and resolve issues related to client service needs in weekly Care Team meetings, coordinating care and utilizing resources across agencies. Because this cooperative, collaborative approach to problem-solving occurs at both system and client levels, AHH is able to quickly resolve issues and provide expanded, coordinated, integrated care. Responses to the challenges listed above include creating and maintaining an AHH client database that can be shared among partner agencies; ongoing searches for transitional housing; having Home Team volunteers spend time with newly housed clients and introducing them to their neighborhoods; and hosting social events for clients.
- Several stakeholders and clients stated that as a result of AHH's focus on medically vulnerable individuals—the majority of whom are men—homeless women and families are not getting the services they need. As some members of the Albuquerque Strategic Collaborative to End Homelessness noted, they would like to see AHH "spread the love" (resources) to other homeless populations. The Core Vision Team acknowledges this concern, and their goal is that by demonstrating how the AHH model can reduce homelessness and improve outcomes for this most chronic, medically vulnerable population, they will create new resources for other homeless populations.
- Collaboration at the system and service levels is key to program success. While existing structures, such as the Core Vision Team, were in place pre-SAMHSA funding, AHH has built on and further developed strong working relationships between and across partners. As a result, resources and services are available and coordinated across agencies, allowing AHH to address the needs of its target population.

HOW is the program innovative?

- Perhaps the greatest innovation and strength of AHH is the political will and support it has from the Mayor and the business community. The Mayor publicly supports AHH. A local business leader is a member of the Core Vision Team, and community volunteer teams—Home Teams—do street outreach, provide furniture and clothing, and visit newly-housed AHH clients.
- Heading Home is the backbone organization for AHH and is thus responsible for oversight and ensuring that project activities, include the services provided by the Care Team, take place. By organizing the project in this way under one entity, AHH has been able to integrated the services of several organizations and thus access resources across services partners to ensure that clients' needs are met.
- As noted above, AHH builds on existing collaborative structures, most notably the Core Vision Team led by

Heading Home. This long-standing partnership enables the project to address both immediate issues and long-term challenges. Many CAHBI projects are focused only the short-term project objectives. AHH, via the Core Vision Team, is able to address not only grant-required activities but underlying system needs that will continue to exist after funding ends. It also brings to the table city staff who can immediately address communication or "bureaucratic glitches" that can interrupt program progress (e.g. priority placement on voucher or city housing lists).

- In addition to positive political will, AHH uses evaluation results to promote project successes and sustainability. For example, recent reports have highlighted service cost savings (including reduced shelter, jail, and emergency room costs), helping generate positive project reputation and community support.

Background Information on the National Cross-Program Evaluation

The National Evaluation of SAMHSA's Homeless Programs broadly aims to identify commonalities and differences across SAMHSA's homeless programs by examining which service models are delivered, with what outcomes, for which populations, and with what resulting comparative effectiveness and cost-effectiveness. To compare programs, the evaluation will identify service models based on service approach (e.g., direct vs. referral), services delivered (type of service and adherence to practice), housing types and models, type of partnerships, and factors leading to program sustainability. The resulting models will facilitate interpretation of client- and program-level outcomes and comparative effectiveness and cost-effectiveness analyses.

The study uses a pre/post design to evaluate the SAMHSA homeless program portfolio, combining qualitative and quantitative data to address evaluation goals and objectives. The design includes a structure/process evaluation, outcome study, and cost component and addresses questions at the client, grantee, treatment system, community, and SAMHSA levels.

The evaluation includes the following data sources:

- **Project Director telephone interviews** to collect information on key program characteristics, including target population, partnerships, services, housing models, and sustainability;
- **Web-based surveys of grantee stakeholders** to gather information on stakeholder characteristics and experiences with the program;
- **site visits and related guides,** including staff, client, and other stakeholder interviews, focus groups, and observations;
- **Web-based evidence-based practice (EBP) and Permanent Supportive Housing (PSH) self-assessments,** for information on EBP and PSH implementation and fidelity to practice;
- **client-level baseline and 6-month follow-up Government Performance and Results Act (GPRA) and National Outcome Measures (NOMs) interviews** administered by grantees; and
- **supplemental client interviews** administered by a subset of grantees in conjunction with the baseline and 6-month GPRA/NOMs interviews.

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